Republic of the Union of Myanmar
Ministry of Health and Sports

PRELIMINARY NEEDS ASSESSMENT (FEASIBILITY STUDY) ON STRENGTHENING HEALTH SERVICE DELIVERY AT PRIMARY LEVEL WITH COMMUNITY PARTICIPATION

MAY 2017

JAPAN INTERNATIONAL COOPERATION AGENCY (JICA)

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Executive Summary

(1) Background

Currently, Myanmar is approaching a demographic turning point due to reductions in the birth and death rates, resulting in an increased elderly population. The disease pattern is also in the transition period, as concerns are shifting from maternal and child health and infectious diseases to overnutrition, non-communicable diseases (NCDs) and injuries. Having said that, maternal mortality ratio (MMR) and under-five mortality rate remain high despite some progress in recent years. The country is thus encountering the double burden of the disease structure. Another issue is the widening regional disparity of rural and urban areas, which greatly affects the socioeconomic situation and access to basic health services in the country.

Against this background, the government of the Republic of the Union of Myanmar has set a goal to achieve Universal Health Coverage (UHC) by 2030. As a first step towards achieving UHC, by which the whole population would receive the health services they need without suffering from financial hardship, the Ministry of Health and Sports (MOHS) aims to ensure access to the Basic Essential Package of Health Services (Basic EPHS) for the entire population by 2020. So far, the Annual Operational Plan 2017 has been developed and the contents of the Basic EPHS are currently being listed up. Some of the strategic focus areas of the National Health Plan (NHP) (2017-2021) include formulation of Inclusive Township Health Plan (ITHP), enhanced supply-side readiness, and community engagement to increase service utilization. Although the MOHS recognizes the importance of strengthening health service delivery at the primary level with community participation to reach out to the whole population, especially in rural areas of the country, various challenges pertaining to Myanmar's healthcare provision at the primary level exist.

Under these circumstances, the Japan International Cooperation Agency (JICA) is currently planning new assistance to strengthen health service delivery at the primary level as a basis of achieving UHC. To move forward, JICA carried out preliminary needs assessment from November 2016 to May 2017 to examine present issues and bottlenecks, cooperation direction and plans by other development partners (DPs), and JICA's approach and assistance to Myanmar that are potentially effective in the future.

As for the assessment methodology, besides literature review, information collection was carried out through interviews with the MOHS at all levels (the national, state/regional and district/township levels), and DPs including international and local Non-Governmental

Organizations (NGOs) and any other relevant parties. The assessment team also made site visits to primary level facilities in Magway, Bago and Ayeyarwady regions to learn about the current situation and challenges faced on the ground.

(2) The situation and issues of basic health services

In the three assessment regions, while the indicators for health services show improvements, MMR and infant mortality rates (IMR) remain worse than the national average. In support of this finding, results from the field visits to the health facilities and interviews with health staff showed various challenges at the primary level and limited access to health services, especially in the areas of NCD prevention and control, adolescent health, and elderly health, all of which are important to address from the life course approach perspective. Besides these challenges, the following needs were identified:

- To strengthen health service delivery system to all cohorts, focusing on reproductive, maternal, newborn, child and adolescent health (RMNCAH), and nutrition as well as NCDs
- To strengthen management of Rural Health Center (RHC) micro-planning with community participation
- To establish sustainable financial support mechanisms using government and community resources
- To strengthen health promotion through revitalization of MOHS volunteers
- To improve RHC and Sub-Rural Health Center (SRHC) infrastructure and increase community awareness for participation in provision of basic health services

(3) Assistance and lessons learned by other development partners (including international and local NGOs)

While Official Development Assistance (ODA) to Myanmar was rather limited until recently, the democratic transition from the end of 2010 has brought about a major turning point in Myanmar's development arena. Some of the major DPs including the World Bank, Three Millennium Development Goal Fund (3MDGF), the United States Agency for International Development (USAID), and United Nations (UN) agencies are currently under review in line with the new NHP (2017-2021). Many DPs interviewed expressed the need to replace the vertical issue-based approach with a cross-cutting approach to improve primary healthcare based on the Basic EPHS. The cross-cutting approach would address NCDs and nutrition issues that have often received limited donor assistance thus far.

As for health-specific areas, most of DPs' assistance has focused on three communicable diseases and maternal, newborn and child health (MNCH). On the other hand, as noted earlier,

assistance for NCD prevention and control as well as nutrition has often been limited, apart from the related issues addressed in the MNCH area.

(4) Identification of specific needs and effective aid approaches

Increasing access to the Basic EPHS and strengthening of health systems to enable effective delivery of the Basic EPHS were identified as the future assistance needs. These needs are in line with the NHP (2017-2021) towards achieving UHC by 2030.

The basic approach used for assistance is the life course approach, which addresses health needs at all life stages through health promotion, prevention and awareness activities for health risk reduction and community engagement. Some of the intervention points can be at the continuum of care for MNCH, nutrition improvement for both undernutrition and overnutrition, health promotion activities and NCDs, especially early prevention and screening for hypertension and diabetes.

It would also be beneficial to bring some of the experiences and lessons learned from Japan's past cooperation activities in Myanmar into finalizing the cooperation plan in the coming months. The relevant areas include the effective use of the Maternal and Child Health (MCH) Handbook, training and effectual management of Maternal and Child Health Promoters (MCHPs) and Community Health Workers (CHWs), and provision of support to community micro-planning.

(5) Recommendations for JICA's future assistance

The future direction of assistance was discussed with the MOHS based on the assessment results and the five guiding principles below:

- Provision of support to strengthen primary healthcare system to deliver basic health services (i.e. EPHS) towards the realization of UHC;
- Implementation of the life course approach for the health transition in Myanmar, ensuring the EPHS for all age cohorts throughout the life course;
- Support for both service delivery (supply side) and communities (demand side);
- Emphasis on a holistic approach beyond program-based approach; and
- Sharing of lessons learned from Japan's past experiences in the health transition

It was agreed with the MOHS officials that the title of the future technical assistance will be "Project for Rural Health Development through Strengthening Basic Health Services," and its objective will be that "basic health services are utilized throughout life course at RHC/SRHC

level in XX Region/State." The assistance will put emphasis on basic health services delivery at the township level and below, especially at the RHC/SRHC level. Magway region is proposed as the target site for new technical assistance given high MMR and IMR as well as Japan's past assistance experiences there.

As for the counterpart within the MOHS, the Basic Health Services (BHS) Division was proposed and agreed as the main counterpart because basic health staff and primary level facilities are managed and supervised by the BHS Division, and the Division has staff at all levels from the central to RHC/SRHC. While the BHS Division would be the main coordinating counterpart, the Maternal and Reproductive Health (MRH) and Health Literacy Promotion (HLP) Divisions will be expected to play important roles as sub-counterparts in regard to MNCH-related services and implementation of the life course approach, respectively.

The future assistance consists of three main components:

1. Development of an implementation framework of basic health services
2. Enhancing the capacity to deliver basic health services at the RHC/SRHC level
3. Strengthening community engagement in health activities

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List of Acronyms/Abbreviations

Acronyms/ Abbreviations	Standard Nomenclature
AMW	Auxiliary Midwife
ANC	Antenatal Care
BHS	Basic Health Staff/Basic Health Services (Division)
CDSR	Child Death Surveillance and Response
CHD	Child Health Development (Division)
CHW	Community Health Worker
DFID	Department for International Development
DHS	Demographic and Health Survey
DP	Development Partner
EPHS	Essential Package of Health Services
EPI	Expanded Programme on Immunization
FP	Family Planning
GAVI	Global Alliance for Vaccines and Immunization
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
HA	Health Assistant
HBMR	Home Based Maternal Record
HLP	Health Literacy Promotion (Division)
HMIS	Health Management Information System
HSS	Health System Strengthening
IEC	Information, Education and Communication
IMR	Infant Mortality Rate
IOM	International Organization for Migration
ITHP	Inclusive Township Health Plan
JICA	Japan International Cooperation Agency
KOFIH	Korean Foundation for International Healthcare
LHV	Lady Health Visitor
MCH	Maternal and Child Health
MCHP	Maternal and Child Health Promoter
MDGs	Millennium Development Goals
MDSR	Maternal Death Surveillance and Response
M-HSCC	Myanmar Health Sector Coordinating Committee
MIMU	Myanmar Information Management Unit
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
MOHS	Ministry of Health and Sports
MRH	Maternal and Reproductive Health (Division)

Acronyms/ Abbreviations	Standard Nomenclature
MSI	Marie Stopes International
NCD	Non-Communicable Disease
NGO	Non-Governmental Organization
NHP	National Health Plan
NIMU	NHP Implementation and Monitoring Unit
NLD	National League for Democracy
NMR	Neonatal Mortality Rate
NU	Nutrition (Division)
ODA	Official Development Assistance
OECD	Organisation for Economic Cooperation and Development
PEN	Package of Essential Non-communicable disease
PHS	Public Health Supervisor
PNC	Postnatal Care
PSI	Population Services International
RH	Reproductive Health
RHC	Rural Health Center
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SBA	Skilled Birth Attendant
SH	School Health (Division)
SMO	Station Medical Officer
SOP	Standard Operating Procedure
SRH	Sexual Reproductive Health
SRHC	Sub-Rural Health Center
TB	Tuberculosis
TBA	Traditional Birth Attendant
THN	Township Health Nurse
TMO	Township Medical Officer
U5MR	Under 5 Mortality Rate
UHC	Universal Health Coverage
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNOPS	United Nations Office for Project Services
USAID	United States Agency for International Development
WHO	World Health Organization
WFP	World Food Programme
YIC	Youth Information Center
3MDGF	Three Millennium Development Goal Fund

Chapter 1 Summary of the Assessment

1-1 Background

Despite some progress in recent years, the health sector in the Republic of the Union of Myanmar continues to face maternal and child health (MCH) challenges. Its maternal mortality ratio (MMR) remained high at 282 per 100,000 live births and under-five mortality rate (U5MR) at 72 per 1,000 live births in 2014.[1] High U5MR is primarily due to the high neonatal mortality rate (NMR) and infant mortality rate (IMR). To reduce these mortality rates, it is necessary to expand primary healthcare including MCH services.[2]

In addressing the situation, a national strategy to achieve universal health coverage (UHC) by 2030 was endorsed by Myanmar's Ministry of Health and Sports (MOHS). The strategy is also supported by the new administration established in 2016 as part of its health sector mission; a roadmap on UHC was approved under the leadership of the National League of Democracy (NLD). In April 2016, a "*Programme of Health Reforms – A Roadmap towards UHC in Myanmar 2016-2030*" was announced. As a first step towards achieving UHC, the MOHS aims to ensure access to the Basic Essential Package of Health Services (Basic EPHS) for the entire population by 2020.

It has been recognized by the MOHS that strengthening health service delivery at the primary level with community participation is essential to reach out to all people especially in rural areas. The challenges pertaining to Myanmar's primary healthcare provision include inefficient personnel at the Rural Health Center (RHC) and Sub-Rural Health Center (SRHC) levels, limited activities by health volunteers, and weak emergency referral systems from RHC and SRHC to township and station hospitals. On the other hand, service users have limited access to health facilities.

Against this backdrop, the Japan International Cooperation Agency (JICA) aims to develop new assistance to strengthen health service delivery at the primary level as a basis for achieving UHC including the implementation of the Basic EPHS in line with the National Health Plan (NHP). As a first step, JICA has carried out a needs assessment to identify the present issues and bottlenecks and explore possible future assistance to Myanmar.

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1 The 2014 Myanmar Housing and Population Census.

2 Primary healthcare includes: 1) health promotion; 2) promotion of food supply and proper nutrition; 3) adequate supply of safe water and basic sanitation; 4) maternal and child healthcare including family planning; 5) immunization against major infectious diseases; 6) prevention and control of local endemic diseases; 7) appropriate treatment of common diseases and injuries; and 8) provision of essential drugs.

1-2 Assessment Objectives

The needs assessment was conducted from November 2016 to May 2017 with the following objectives:

- To assess the current situation, needs and challenges in strengthening health service delivery at the primary level, particularly reproductive, maternal, newborn, child and adolescent health (RMNCAH) and its related issues such as health promotion, school health and nutrition; and
- To examine the health assistance by JICA and other Development Partners (DPs) and effective aid approaches and to suggest frameworks for JICA's assistance in strengthening service delivery with community participation at the primary level.

1-3 Assessment Areas

In addition to Yangon and Naypyidaw, the team conducted field assessment in three regions, namely Magway region, Bago region and Ayeyarwady region. The regions were selected based the following criteria: 1) target areas of Japan's past assistance; 2) poor health indicators; and 3) the presence of Maternal and Child Health Promoters (MCHPs). The field data collection placed a particular focus on Magway region where health needs are considerably high and because the region received grant assistance from Japan for improvement of primary and secondary level facilities. Bago and Ayeyarwady regions were targeted as a comparison with Magway region. These regions have also received Japan's technical assistance in the past and faced different geographical challenges.

The data collection in Naypyidaw and Magway region was done by the Japanese assessment team while data in Bago and Ayeyarwady regions were collected by a Myanmar consultant team.

Within Magway region, four townships were selected as target areas of the study based on the following criteria: 1) two townships attached to district offices and two regular townships; 2) areas both supported and un-supported by Japan's grant assistance; and 3) areas with and without the presence of MCHPs. When there were multiple sites that fulfilled the above-mentioned criteria, accessibility was considered.

The four townships highlighted in the table are the selected sites.

Table 1-1 Selection of Assessment Sites in Magway Region

District Name	Township Name	Grant loan assistance (9 sites)	Presence of MCHPs (2 sites)	Access ◎Good ○ Normal x Bad	Remark
Pakkoku	Pakkoku	✓	✓	◎	District with grant loan assistance and MCHPs
	Seik Phyu	✓		x	
	Pauk	✓		○	
	Myaing	✓		◎	Township with grant loan assistance
	Ya Sa Gyo	✓		○	
Magway	Natmauk	✓		x	
Minbu	Minbu			unknown	District with neither grant loan assistance nor MCHPs
	Salin	✓		x	
	Say Toke Ta Yar	✓		x	
	Pwint Pyu		✓	unknown	Township with MCHPs
Gangaw	Saw	✓		x	

For Bago and Ayeyarwady regions conducted by the local consultant team, target areas were selected based on the following criteria: 1) priority areas with high needs based on poor health indicators; 2) areas with typical socioeconomic, demographic and cultural characteristics with access and poverty issues; and 3) areas with good practices and/or existing interventions supported by the government and DPs. As a result, two townships were selected from each region: Yaedashe township and Pandaung township in Bago region, and Pantanaw township and Mawlamyainegyun township in Ayeyarwady region.

1-4 Methodology

The needs assessment consisted of a literature review and field information collection to derive situation analysis and recommendations for JICA's assistance to Myanmar. For the literature review, existing academic research and reports by the government and DPs were collected and analyzed. For the field information collection, the JICA team collected necessary information from the Government of Myanmar, specifically the MOHS at the national, state/regional and district/township levels, DPs including international and local NGOs, and any other relevant parties. In particular, the assessment team conducted key informant interviews with local government officers, health officers (e.g. Township Medical Officers (TMOs)), health service providers (e.g. nurses and midwives) and community representatives (MCHPs, Community Health Workers (CHWs), etc.) in the three target regions to understand the status of health

service delivery at the primary level. Site visits to health facilities at different levels (e.g. regional/district/township/station hospitals, RHCs, SRHCs) were also undertaken.

The following tables indicate target facilities in Magway, Bago and Ayeyardy regions. In addition to RHCs and SRHCs, hospitals were also selected as referral facilities.

Table 1-2 Target Facilities in Magway Region

	Pakkoku District/ Township	**Myaing Township**	**Minbu District/ Township**	**Pwint Phyu Township**
Regional hospital	Magway Regional Hospital			
District/ township hospital	Pakkoku General Hospital	Myaing Township Hospital	Minbu District Hospital	Pwint Phyu Township Hospital
Station hospital	Myit Chay Station Hospital	Let Yet Ma Station Hospital	Mon Daung Station Hospital	Kone Zaung Station Hospital
RHC	Lay Daing RHC	Kyauk Sauk RHC	U Yin RHC	Kyaung Daw Yar RHC
SRHC	Myit Phya SRHC	Ma Gyi Su SRHC	Pa Daung SRHC	Min Mae SRHC

Table 1-3 Target Facilities in Bago and Ayeyarwady Regions

	Bago Region		**Ayeyarwady Region**	
	Yaedashe Township	**Pandaung Township**	**Pantanaw Township**	**Mawlamyainegyun Township**
Regional hospital	Bago Regional Hospital		Ayeyarwardy Regional Hospital	
District/ township hospital	Taungoo District Hospital and Yaedashe Township Hospital	Pyay District Hospital and Pandaung Township Hospital	Maubin District Hospital and Pantanaw Township Hospital	Labutta District Hospital and Mawlamyaingegyun Township Hospital
Station hospital	Swa Station Hospital	Htonbo Station Hospital	Chaung Kalay Station Hospital	Kyaikpi Station Hospital
RHC	Swa RHC	Htonbo RHC	Chaung Kalay RHC	Kyaikpi RHC
SRHC	Kazaung SRHC	Thu Yae Tan SRHC	Ka Paing SRHC	Thit To Seik SRHC

1-5 Assessment Team Members

Name	**Area of work**	**Affiliation**
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Chapter 2 Current Situation and Challenges of Basic Health Services at Primary Level

This Chapter will explain the current situation and challenges of basic health services at primary level based on the desk review, discussions with the MOHS, and results of the field visits to health facilities and interviews with health workers.

2-1 Overall Situation

Currently, Myanmar is approaching a demographic turning point due to reductions in the birth and death rates, resulting in an increased elderly population. The disease pattern is also in the transition period, as concerns are shifting from MCH infectious disease to overnutrition, non-communicable diseases (NCDs) and injuries. Having said that, MMR, U5MR, and IMR remain high despite some progress in recent years. According to the 2014 Myanmar Census, MMR was 282 per 100000 live births as opposed to the Millennium Development Goal (MDG) target at 130, U5MR was 72 per 1000 live births as opposed to the MDG target at 36, and IMR was 62 per 1000 live births as opposed to the MDG target at 26.[3] In this situation, the country could face the double burden of the disease structure. Another issue is the widening regional disparity of rural and urban areas, which greatly affects the socio-economic situation and access to basic health services in the country.

Against this background, the government of the Republic of the Union of Myanmar has set a goal to achieve UHC by 2030. As a first step towards achieving UHC, the MOHS aims to ensure access to the Basic EPHS for the entire population free of charge by 2020. So far, the Annual Operational Plan 2017 has been developed and the contents of the Basic EPHS are currently being listed up. Some of the strategic focus areas of the NHP (2017-2021) include formulation of an Inclusive Township Health Plan (ITHP), enhanced supply-side readiness, and community engagement to increase service utilization. Although the MOHS recognizes the importance of strengthening health service delivery at the primary level with community participation to reach out to the whole population, especially in rural areas, various challenges exist.

[3] 2014 Myanmar Censes.

2-2 Current Situation of Basic Health Services

2-2-1 Characteristics of the Target Sites

Table 2-1 below shows the relevant indicators of the three targets regions, namely Magway region, Bago region and Ayeyarwady region.

Magway region is located in the central Dry Zone of Myanmar, which is characterized by a harsh climate including high temperatures, dry weather and scarce water, affecting the health status of the population. Due to the limited infrastructure and hilly terrain, access to health facilities is a challenge. The health facilities are also underdeveloped. The main industries of the region include oil, mining and agriculture.

Bago region has an abundance of natural resources including oil and teakwood and has the second highest production of rice crops in Myanmar thanks to its fertile land. The region is divided into West Bago and East Bago by highlands in the center. Access to highway facilitates economic activities in the region; however, East Bago region has a higher poverty rate than West Bago region due to its hilly terrain. Health indicators are generally close to the national average while most of the indicators of East Bago are worse than West Bago.

Ayeyarwady region, located in the delta area, is the largest rice producing region in Myanmar. In 2008, the region was heavily hit by Cyclone Nargis. Ayeyarwady River and its tributaries are often flooded in the rainy season, displacing people every year. The rain makes it difficult to access health facilities without a boat. The region's poverty rate is higher than the national average of 26% at 32.2%.

Table 2-1 Characteristics of Three Target Regions

	Nationwide	Magway	Bago		Ayeyarwady
Population	51,486,253	3,917,055	4,867,373		6,184,829
No of townships	330	25	28		26
Life expectancy	66.8	60.6	66.7		61
Poverty rate	26%	27%	16% (West)	20.20% (East)	32.20%
Access to safe water	69.50%	76.60%	73.60%		50.30%
Access to improved sanitation facilities	74.30%	68.40%	74.60%		74.90%
Access to electricity	32.40%	22.70%	27.70%		12%

Source : ① Magway: A Snapshot of Child Wellbeing, Bago: A Snapshot of Child Wellbeing, Ayeyarwaddy: A Snapshot of Child Wellbeing 2014. Myanmar Population and Housing Census A Changing Population: Magway Region Figures at a Glance, Bago Region Figures at a Glance, Ayeyarwaddy Region Figures at a Glance

② UNICEF, The Republic of the Union of Myanmar: A Snapshot of Child Wellbeing

2-2-2 Health Indicators of the Target Sites

(1) MCH Indicators

As shown in Table 2-2, MCH indicators of the three target regions are worse than the national average. MMR is higher than 300 in all regions. In particular, Ayeyarwady region has the highest MMR, IMR and under 5 mortality among the three regions. With regard to IMR, Magway region and Ayeyarwady region are the worst in the country. Under the circumstances, the three regions can be considered as part of the priority regions for the MOHS and DPs in their efforts to improve MCH and basic health services.

Table 2-2 Comparison of MCH Indicators Among Three Regions

	Nationwide	Magway	Ayeyarwady	Bago
Maternal Mortality Rate (100,000 live births)	282.0	344.0	354.0	316.0
Neonatal Mortality Rate (1,000 live births)	25.0	28.0	36.0	43.0
Infant Mortality Rate (1,000 live births)	61.8	83.9	86.2	61.9
Under 5 Morality Rate (1,000 live births)	71.8	100.6	103.6	72.0

Source: 2014 Census

(2) Indicators Related to Service Utilization

Despite the below-the-national-average indicators, the Demographic and Health Survey (DHS) (2015-2016) released in March 2017 show some of the data related to service utilization in the regions are better than the national average. For example, the national average of Skilled Birth Attendant (SBA)-assisted births is 60.2% while it is 68.4% in Magway region and 62.9% in Bago region. The facility-based delivery rate accounts for 37.1% nationwide while it is 37.5% in Magway region and 39.3% in Bago region. Both indicators of Ayeyarwady region are worse than the national average at 50% (SBA-assisted deliveries) and 35% (facility-based deliveries). One of the possible reasons is the common cultural practice of using Traditional Birth Attendants (TBAs) for deliveries; in Ayeyarwady region, 42.9% of the deliveries are attended by TBAs while the national average is 29.2%. Bago region has better MCH indicators compared to Magway and Ayeyarwady regions. However, the disparities of health indicators and service utilization are observed between East Bago and West Bago.

Among the three regions, Magway region in particular has received substantial support from DPs especially the Three Millennium Development Fund (3MDGF) in the past two years to improve the MCH services, resulting in the increased service utilization as explained above. It is necessary to keep the momentum by sustaining the support particularly to improve the health indicators that are still below the national average.

2-3 System of Basic Health Service Provision

The station hospital level (16 beds) and above is managed by the MOHS's Medical Service Department while RHCs and SRHCs in rural areas and Urban Health Centers in urban areas are managed by the MOHS's Public Health Department. RHCs are generally in charge of 4-5 SRHCs, providing public health and basic health services including the treatment of general illnesses, MCH services such as antenatal care (ANC) and postnatal care (PNC), vaccinations, prevention of communicable diseases, nutrition and health education. RHCs and SRHCs are considered as a core pillar of the EPHS provision.

The RHC in Myaing township received assistance from Japan for improvement of its facility and equipment

Both regional hospitals and district hospitals have the capacity to provide various specialized services. On the other hand, township hospitals and station hospitals do not employ any specialists but one medical officer. Limited services are provided there including internal medicine, surgery and obstetrics and gynecology. With regard to MCH services, emergency obstetric care is available at the station hospital level and above. The RHC and SRHC level, without a medical doctor, provides services including the treatment of general illnesses, immunizations and ANC/PNC as well as outreach activities. Many RHCs visited by the assessment team had a delivery room; however, without donor assistance, they did not have sufficient water and electricity systems to operate. Therefore, instead of assisting facility-based deliveries, midwives often assist home deliveries. Services related to NCDs at RHCs and SRHCs are limited to glucose and blood pressure tests.

2-4 Challenges of Basic Health Services in Magway Region

This section discusses the challenges of basic health services at the primary level (i.e. RHCs and SRHCs) observed in Magway region.

Main challenges include a shortage of human resources and capacity, the excess workload of midwives, a lack of facility and equipment, weak referral systems, a lack of community participation and engagement in health activities and a lack of management systems including matters related to finance and health information. Moreover, from a life course approach perspective, the current system has a gap in providing services related to NCDs, adolescent

health and elderly health.

The challenges will be analyzed in the following two categories:

① **Challenges related to the health system:** human resources, health facility, equipment and procurement, referral, financial management, monitoring and supervision, and Health Management Information System (HMIS)

② **Challenges by service category**: reproductive, maternal, newborn, child and adolescent health (RMNCAH), nutrition, NCDs, etc.

2-4-1 Challenges Related to the Health System

(1) Human Resources

Human resources in public health services are limited from the perspective of both quantity and quality. With regard to health workers' capacity, challenges were observed in the areas of HMIS, logistics, health planning and implementation with community engagement. Furthermore, community volunteers face issues such as donor dependency.

Basic Health Staff (BHS)

① Human resources and the workload of midwives at the primary level

Addressing the issue of excess workload of midwives, the MOHS has tried to fill all vacant post of Public Health Supervisor II (PHSII). As a result, SRHC is run by two staff: one midwife and one PHSII. However, the assessment team observed little change in midwives' workload due to the lack of experience and capacity of PHSII. All PHSII interviewed by the team had the experience of less than 3 years, and midwives seemed to continue their responsibility of data management. One midwife who worked with a newly assigned PHSII said that while environmental sanitation activities were now in the hands of the PHSII, a lot of workload had not been reduced and there needed more time until the PHSII could work independently.

As shown in Table 2-3, the vacancy rate of Lady Health Visitors (LHVs) at station hospitals and RHCs is over 10%, leading to the increased workload of midwives. For midwives at RHCs where the LHV position is vacant for a long period of time, there is an extra burden of daily tasks such as reporting of HMIS.

Table 2-3 Human Resources in Magway Region

Position	No of Sanction	No of filled posts	No of vacancies	Vacancy rate (%)
Doctor	72	39	33	45.8%
Nurse	57	51	6	10.5%
Health Assistant	179	177	2	1.1%
Lady Health Visitor	215	181	34	15.8%
PHS I	115	42	73	63.5%
PHS II	1112	589	523	47.0%
Midwife	1329	1270	59	4.4%

Source: Magway Region Health Profile, 2015

② Manpower at referral level hospitals and in referral systems

The lack of human resources was observed not only at the primary level but also at referral level hospitals. As indicated in Table 2-3, close to half (45.8%) of the sanction of medical doctors are vacant at township and station hospitals. The station hospitals with vacant Station Medical Officer (SMO) post said they received limited referral cases from RHCs/SRHCs and communities due to the absence.

Table 2-4 Positions at the Magway Regional Hospital

Position	No of sanction	No of filled Post	No of vacancies	Vacancy rate (%)
Medical Superintendent	1	0	1	100.0%
Senior Consultant Specialist	17	9	8	47.1%
Deputy Medical Superintendent	1	1	0	0.0%
Junior Consultant Specialist	17	5	12	70.6%
Medical Officer (Assistant Surgeon)	77	64	13	16.9%
Nursing Staff	289	195	94	32.5%
Technician and Office Staff	116	62	54	46.6%
Other	76	53	23	30.3%
Total	594	389	205	34.5%

Source: Magway Regional Hospital Profile, 2017

Health Volunteers

① DP's assistance and standard system

Activities done by health volunteers are often dependent on the assistance by DPs. As a result, there were cases in which the activities were stalled or stopped after the assistance was over. For example, in one township where United Nations Population Fund (UNFPA) supported Youth Information Center (YIC) volunteers, few volunteers remained and their activities came to a halt

after UNFPA's funding ended. The YIC was also demolished. The interviewees said some of the reasons for the stagnation include the absence of incentives from DPs, the absence of continuous training and the lack of close relationships among volunteers, basic health staff (BHS) and community members to receive continuous support for the volunteer activities.

Furthermore, DPs have supported training of volunteers on different health issues. The assessment team observed various types of volunteers existed in one community, working on different health issues such as malaria, HIV/AIDS and MCH in an uncoordinated manner. They worked under different systems such as training approaches and incentive mechanisms. For instance, some DPs supported transport fees for referral cases and daily allowances for training while others did not.

Educational materials were created by YIC volunteers but they were no longer in use

② Availability of volunteers

While incentives were provided to some of the volunteers (e.g. on communicable diseases), most of them never received financial incentives aside from training opportunities. In this respect, many volunteers interviewed mentioned financial reasons for the lack of engagement as volunteers. They are busy in the field to earn income for their families and do not have time to attend volunteer activities. The harvesting season is particularly difficult to be away from the field. Planning of volunteer activities should take these circumstances into consideration.

③ Continuous training and educational materials

The assessment team identified a few CHWs who continued to be active and came up with effective approaches such as following up on the midwife's health education sessions by conducting house-to-house visits. These active volunteers were eager to respond to the community's health needs by gaining new knowledge such as on NCDs. Nevertheless, CHW's role is often limited to community mobilization for health education and immunization activities. They are not playing the role of a health educator to raise awareness of community members. Furthermore, educational materials to facilitate their activities were barely seen at the RHCs and SRHCs. Even in the communities with active volunteers, there was a lack of training and educational tools tailored to the community needs to optimize the existing human resources.

④ Auxiliary Midwives (AMWs)

AMWs are promoted to assist with normal deliveries. However, except for Myaing township where the 3MDGF was providing incentives to AMWs, many of them did not seem fully functional. Despite the six-month training after appointment, some of the AMWs interviewed said they had never assisted with deliveries. While many mothers continue to choose home delivery, midwives often bear the burden of delivery assistance in the communities without assistance of AMWs.

(2) Facility and Equipment

In Magway region, out of all RHCs and SHCs, only 15% were built in accordance with MOHS's standards. Many RHCs were not equipped to provide appropriate services including assistance for normal deliveries. Moreover, due to the lack of procurement capacity and system, there were cases of drug stock-outs, resulting in out-of-pocket payments.

① Facility standards

According to the data provided by the Magway Regional Health Office, only 15% of RHCs and SRHCs in the region complied with the MOHS's facility standards, meaning most of the facilities were not equipped to provide appropriate services including normal deliveries at RHCs.

Since 2015, the RHCs and SRHCs visited by the assessment team have received budget funded by the Myanmar Government and the World Bank and distributed by the respective Township Health Offices to conduct small repairs. However, because the funds were disbursed at different times, small repairs were conducted at each SRHC intermittently in an ad-hoc manner. Therefore, effective improvements of the facility did not seem to have been achieved. For example, although some RHCs had a delivery room with a delivery bed, because they were not equipped with water and electricity systems, they were not functional to assist with deliveries at the facility. Even at RHCs where electricity and water systems were installed and equipment was improved through Japanese assistance for promotion of facility deliveries, because of a dysfunctional generator and the lack of community's awareness on the benefits of facility-based delivery, facility deliveries remained limited.

Despite the delivery room and delivery bed, the RHC had never assisted deliveries without proper water and electricity systems

Moreover, the RHCs and SRHCs that were not in line with the MOHS's standards often did not have a housing facility for BHS. The staff had to resort to living in a stranger's house in the community, creating unnecessary stress.

The assessment team also visited one SRHC that was damaged by floods in 2015. Due to a slow reconstruction process, service delivery seemed to have been adversely affected.

② Procurement management and out-of-pocket payments

BHS do not have sufficient capacity to manage procurement partly because the procurement and supply of drugs and equipment used to be handled by DPs instead of the government. The assessment team noted some cases of long-term (e.g. 4 months) drug stock-outs at RHCs and SRHCs because of the delayed procurement by Township and Regional Health Offices. This forced patients to purchase drugs elsewhere out of their pockets.

(3) Referral

Key issues of referral include a lack of transport system to transfer patients from community to RHC or station hospital level, a shortage of health staff to respond to the increasing needs after the introduction of free services, a lack of referral forms and high out-of-pocket rates.

① Referral systems at station hospitals

Station hospital is the lowest level of health facility with a full-time medical doctor (i.e. one SMO). However, many hospitals face the issue of frequent transfer and vacancy of SMO. The SMO in one station hospital mentioned that she could remain in the position longer than usual (for 5 years) because of the strong persuasion by local community members even though SMOs are often transferred or promoted every three years on average. Station hospitals without SMOs cannot receive referral cases from lower level facilities and the community level. Therefore, these cases must be referred to higher level hospitals such as township and district hospitals. As a result, fewer patients come to these station hospitals.

② Response to the increased users

Facilitated by the recent government policy to provide public health services with free of charge, hospitals have experienced an increased number of patients. The Magway Regional Hospital had 180% bed occupancy rate for 200 assigned beds and therefore increased the beds to 380. On the other hand, 205 out of 594 staff posts were vacant. The 34.5% vacancy rate shows the shortage of manpower at the hospital despite the increasing needs.

③ Referral forms

The regional hospital and district hospital visited by the assessment team were not using referral forms when receiving referral cases from lower level facilities. As a result, the receiving hospitals did not have information of the sending facilities, and those cases treated at the hospitals were not captured in the data as referral cases. It means that when a woman is referred to the regional hospital for delivery due to complications, the hospital cannot conduct appropriate follow-up with the sending facility after the delivery.

④ Means and system of transport and out-of-pocket payments

Each township hospital normally owns at least one ambulance. However, some of the station hospitals visited did not have any ambulance. In addition, most of the ambulances were not used for transportation from community but only for referral to higher level facilities.

The interviews with RHC and SRHC staff revealed that, due to the lack of transport to hospitals, those in need had to collect donations or borrow money from relatives and neighbors to arrange a transport by themselves. Some had to return the unpaid debt by harvested crops. Other out-of-pocket payments include purchasing drugs that were out of stock and fees for family members accompanying the patients while being admitted to the hospital.

In Pakkoku district, a renowned monk mobilized donations from a local palm oil company and purchased ambulances for half of the villages. In the communities without DPs, the assessment team observed a lot of such community initiatives

In response to the challenges in Magway region, various DPs including the Global Alliance for Vaccines and Immunization (GAVI), PACT, Marie Stopes International (MSI) and the 3MDGF have targeted pregnant women and their children to support the reduction of out-of-pocket payments. Such support includes the hospital equity fund by GAVI and the reimbursement scheme (for delivery related fees) by PACT. Nevertheless, these mechanisms do not seem sustainable once the DPs end the financial assistance.

(4) Financial Management

The lack of unified systems of budget and planning have affected service delivery at the primary level.

① Financial, planning and monitoring processes

Other than JICA, main DPs in Magway region include the United Nations Office for Project Services (UNOPS), Save the Children, Population Services International (PSI) and MSI as implementing agencies for the 3MDGF, and GAVI. Through MSI and Save the Children, the 3MDGF has addressed MCH issues by supporting the improvement of facilities, capacity building, planning, and monitoring and supervision. The assistance will end by June 2017. GAVI completed the phase 1 of its health system strengthening project and will start the Expanded Programme on Immunization (EPI) as a focus of the phase 2 in 2017.

One of the challenges of assistance provided by DPs in Magway region is different financial, planning and monitoring processes. TMOs who are often the main counterparts of DPs' programmes seemed overwhelmed by fulfilling the different project requirements. One TMO interviewed considers his participation in training provided by DPs as necessary to access DP's funds instead of for the purpose of improving his financial, planning and monitoring knowledge. As part of the effort to address the issue of different processes, the new NHP is planning to develop an ITHP, and all DPs are expected to follow the ITHP.

② The World Bank's loan assistance

The World Bank's loan assistance is expected to improve service delivery at the primary level. Nevertheless, the interviews on the ground revealed the delayed disbursement of funds to the township level. For example, one Township Health Office received the funds for Fiscal Year 2016 (from April 2016 to March 2017) at the end of January 2017. As a result, some of the BHS in the township thought that the World Bank's funds were designed not for one year but for 3-4 months. The delay forced the facilities to complete activities in a matter of two months or less, and the staff struggled with various implementation processes including procurement in a short period of time. As a result, the funds seemed to have been absorbed in an ad-hoc manner. Furthermore, all TMOs and other staff in Township Health Offices received training on financial management for the World Bank's loan, but one TMO interviewed expressed confusion with the procurement rules. The issue revealed the need for continuous training and supervision during the implementation process.

(5) Monitoring and Supervision and Health Plans

Although there are monitoring and supervision templates used by MOHS and DPs, they serve mainly the purpose of stock management and are not effective enough to improve the quality of services. Moreover, community engagement is not fully achieved in the health planning processes.

① Monitoring and supervision

Supervision of BHS at RHCs and SRHCs is conducted by TMOs, SMOs, Township Health Nurses (THNs) and Health Assistants (HAs). According to the interviews, supervision activities are conducted approximately once every quarter. However, some SRHCs mentioned they had not had supervision for more than a year.

Additionally, when the assessment team asked RHCs and SRHCs to share monitoring checklists being used, they showed record books created by GAVI to check the availability of drugs and equipment as well as inspection register books. The inspection register book which was considered as a monitoring checklist by the staff only included the date of the visit, the name and title of the supervisor and his/her short comments. The assessment team could not find evidence of effective supervision activities that could lead to skill and knowledge building of BHS and the improvement of the quality of primary level services.

② Capacity of health management at the township level and below

Township health planning

Although Magway region has received assistance from DPs particularly the 3MDGF and the World Bank to increase the capacity of township health planning, the interview results did not reveal much impact. Some of the possible reasons include a lack of time for BHS particularly TMOs to be engaged in health planning and implementation monitoring, an inconsistency of health planning processes among DPs as mentioned earlier and the focus on one-off training rather than continuous on-the-job training. Moreover, the funds from the World Bank's loan project did not seem to have been used according to the plan; RHCs absorbed them by purchasing items that were easy to procure in a short period of time (e.g. calculators and vinyl posters) due to the delayed disbursement.

Micro-plans at RHC and SRHC level

RHCs and SRHCs develop a micro-plan as an annual health workplan. However, the existing micro-plan is developed in an issue-based manner, mainly focused on three diseases (malaria,

tuberculosis (TB) and HIV/AIDS) and EPI. Therefore, it does not cover all the services provided by RHCs and SRHCs. Additionally, according to the interviews with BHS, it does not include budget nor is linked to other similar health plans (such as those by the World Bank and GAVI). Hence, the micro-plan did not seem to work as an effective planning tool.

Community engagement

Community engagement is key to improve their health status. However, the BHS interviewed explained that community engagement was only limited to the participation of Village Administrators, other equivalent community leaders and health volunteers. It means only community members with certain social status participate and most of the community members are possibly marginalized from the planning, implementation and monitoring of activities unless it was facilitated by DPs.

The new NHP strongly calls for building relationships with community members and incorporating community needs in the process of health planning by BHS especially at RHCs and SRHCs. The current situation on the ground revealed a lack of an effective system to incorporate community members' views and needs in health plans. A limited number of training has focused on improving BHS's communication skills and promoting participatory health planning.

(6) HMIS

In the area of HMIS, there were weakness of BHS's capacity of data collection and reporting and issues related to HMIS indicators.

① Capacity of BHS

RHCs and SRHCs have the task of collecting and reporting on the health profiles that are linked to HMIS. The assessment team noted several misrecordings of the health profiles, revealing the capacity gap of BHS in data calculation, processing and recording. For example, abnormally high rates of abortion were recorded, and MMR was indicated in percentage instead of 100,000 live births. RHCs and SRHCs seemed to lack manpower to check the data quality.

② Indicators for HMIS

The current HMIS have issues around indicators and formulae. For example, RHCs and SRHCs do not collect data of all pregnant and delivery cases in the respective communities. In particular,

MCH indicators do not include facility-based delivery numbers and rates and TBA-assisted delivery numbers and rates. In addition, ANC and PNC rates and SBA-assisted delivery rates use an estimated number of pregnant cases as a denominator, and therefore some of the ANC and PNC rates showed higher than 100%. Furthermore, the RHC and SRHC health profiles indicate MMR and IMR instead of actual numbers of deaths despite the small population size, thereby making it difficult to grasp the situation.

2-4-2 Issues by Service Category

This section explains the analysis of issues by service category from a life course approach perspective.

(1) RMNCAH

Various DPs have supported the area, particularly MCH. Nevertheless, the assessment team identified remaining issues including low facility-based delivery rates and the gap in adolescent health activities.

① Facility-based delivery and SBAs

As explained earlier, the target assessment sites in Magway region continued to face low facility-based delivery rates. More than half of the mothers delivered at home with assistance of SBAs. For instance, the rates were 50.4% in Minbu district and 54.8% in Pwint Pyu township in 2015.[4] In the areas assisted by PACT and the 3MDGF, facilitated by the financial incentives provided to women who delivered at facilities, facility-based deliveries were increasing at the station hospital level.

On the other hand, areas without such external assistance did not show much improvement in the past three years, particularly at the RHC level. Factors hindering facility-based deliveries include a lack of equipment, facility, electricity and water and a cultural aspect that prefers the low-cost delivery at home with support of family members.

A woman who delivered at a township hospital

[4] Minbu/Pwint Phyu Township Health Profile 2015

AMWs are expected to play an important role in assisting deliveries particularly in communities without a midwife. However, the assessment team identified AMWs who had never assisted deliveries despite the six-month training. Moreover, because AMWs are not provided with financial incentives, some of them expressed a lack of time to assist deliveries due to the engagement in economic activities, leading to a high turnover rate. While areas supported by the 3MDGF have achieved high retention rates of AMWs, it is unknown whether the results are sustainable once the funding ends and they are no longer provided with incentives.

② MCH Handbook

Many health workers interviewed pointed out that the benefit of the MCH Handbook was to enable prompt and appropriate treatment and care based on the accurate information in the handbook particularly at the time of emergency referral of mothers. At the same time, they explained that the handbook was only used for the care of pregnant women and another handbook was used for child care (for immunization and growth monitoring). Although the MCH Handbook was designed for the continuum of MCH care, some BHS and mothers did not have the correct understanding.

MOHS's MCH Handbook

Furthermore, although the handbook is an information tool for pregnant women and mothers to understand danger signs and nutritional balance, according to the interviews with midwives, the utilization of the handbook as an educational tool was limited. The reasons include a lack of midwives' understanding of the handbook as an educational tool and the lack of interest of mothers to read the handbook.

③ Adolescent health services

Except for the areas supported by UNFPA (for YIC volunteers), the school health programme is the only adolescent-specific health services. YIC volunteers are trained as peer educators to increase adolescents' knowledge of reproductive health including family planning and sexual health. Their base is in places such as RHCs and sports event venues where accessible for out-of-school youth. However, BHS at the health facilities visited by the assessment team stopped providing supervision to the volunteers after the project ended and some of the volunteers became inactive.

(2) NCD

NCD service delivery system

The NCD Division under the MOHS was established only recently, and they have received limited assistance from DPs so far while in the process of developing policies and the Standard Operating Procedure (SOP).

The BHS interviewed revealed that a number of hypertension and diabetes cases were found at the primary level. In addition, snake bites were often seen in Magway region. Despite the situation, due to the lack of national-level policies and measures, limited NCD services are provided at the primary level. The only NCD services available are blood pressure tests at the SRHC level and glucose tests and blood pressure tests at the RHC level. There are no other health checkups and preventive health education related to NCDs. For the issue of snake bites, some of the RHCs have started to receive serums since 2016.

Capacity building of BHS on NCDs is limited. The BHS interviewed mentioned that some of the NCD information was shared at monthly meetings, but there was no systematic training to increase their knowledge and skills. In addition, health volunteers do not have knowledge of NCDs, and therefore it is presumed that no appropriate information has been shared with community members. Furthermore, according to the NCD Division, the SOP was developed and shared with all Regional/State Health Offices. However, due to the lack of funds, only one copy was distributed to each region/state. As a consequence, when the assessment team checked with the primary level facilities, they had not received the SOP.

(3) Nutrition

Nutrition initiatives beyond MCH and growth monitoring

Nutrition-related services provided at the primary level have so far focused on mothers and children including the provision of micronutrients, promotion of exclusive breastfeeding and growth monitoring. On the other hand, BHS's knowledge and activities have not sufficiently addressed other nutrition issues such as overnutrition, and services for age cohorts other than mothers and children have not been provided at the primary level.

Moreover, although growth monitoring has been conducted once a month in each village, participation was less than half the target population unless EPI and vitamins were distributed. It shows the need to come up with effective awareness-raising and educational activities.

(4) School Health

Programme implementation

The school health programme is implemented by all Township Health Offices. The activities include health checkups including dental (only for primary school students), deworming, the provision of nutritious capsules (e.g. iron and multivitamins), school cleanups and health education including prevention of communicable diseases. BHS at RHCs and SRHCs conduct the programme for all primary schools, and BHS at RHCs, SRHCs and the Township Health Office conduct it for all middle schools and above once a year. All four townships in Magway region targeted by the assessment have achieved almost 100% implementation rates since 2013.

Challenges of the school health programme for the BHS interviewed include the difficulty in scheduling the activities for all schools and the shortage of drugs such as deworming tablets and nutrients. As the programme needs to be implemented between July and October based on the school schedule, BHS tend to overwork during the period.

(5) Community Clinic

① Current situation

Promotion of community clinics is one of the priority policies of the current administration. At present, 2,000 RHCs function as community clinics.[5] As RHCs and SRHCs tended to focus on MCH services in the past, community clinics are expected to strengthen preventive and curative services at primary level to meet the needs of other age cohorts such as the elderly and youth, with an aim to improve the health status of the entire community. For example, some of the RHCs and SRHCs were organizing an elderly clinic.

Elderly Clinic in Pakkoku district initiated by SMO

[5] Dr. Myint Htwe, Union Minister for Health and Sports. November 2016. 9th Global Conference on Health Promotion.

② Definition and role of community clinics

Based on the interviews with the MOHS and DPs, there was no policy or guidelines related to community clinics. Due to the policy gap, the assessment team noted different understandings of the role of community clinics among health practitioners on the ground. Many BHS understood that their facilities were already providing services to any sex and age cohorts, and therefore there was no need for new initiatives. Additionally, because some of the midwives understood that a community clinic was about facility-based services and did not encompass outreach activities, they had to conduct necessary outreach activities on holidays outside the regular working hours.

2-5 Challenges of Basic Health Services at the Primary Level in Bago Region and Ayeyarwady Region

This section summarizes challenges of basic health services provided at the primary level in Bago region and Ayeyarwady region. The overall findings show similar challenges compared to Magway region despite different geographical characteristics of the regions.

2-5-1 Issues Related to the Health System

Just like Magway region, the two regions face challenges including a shortage of human resources at the primary level, the excess bed occupancy rates due to free services and the lack of referral system. The lack of human resources is accompanied by the excess workload of midwives at RHCs and SRHCs, resulting in a lack of service provision. For community members, access to health services is challenged by geographical barriers, a lack of transport, economic burden and poor infrastructure. For instance, there are many hard-to-reach areas in Ayeyarwady region where roads are often blocked during the rainy season. Without improvement of such environmental factors, facility utilization rates (particularly facility-based deliveries) remain low.

Moreover, there were cases where patients refused to be referred because they were afraid of out-of-pocket payments. Out-of-pocket payments also occurred at the RHC and SRHC level due to drug stock-outs. To reduce the financial burden, International Organization for Migration (IOM) provided 3,000-5,000 MMK to patients and the 3 MDGF covered food costs for pregnant women (3,000 MMK/day). The 3MDGF has also provided financial assistance to pregnant women by sharing costs with Village Health Committees. At the hospital level, GAVI and IOM have supported the hospital equity fund and the donation system for patients. Nevertheless, the assistance seems unsustainable once the DPs phase out of the areas.

Moreover, like Magway region, the issue of uncoordinated health planning processes by DPs, the lack of community engagement in health planning and the delayed disbursement of funds for the World Bank's loan assistance were also observed in the two regions.

With regard to HMIS, midwives at RHCs and SRHCs were overburdened by manual reporting of HMIS as well as collection and reporting of data required by different DPs.

2-5-2 Issues by Service Category

In the area of MCH, the two regions have higher rates of home delivery than facility-based delivery. In some of the communities interviewed, more than half of the home deliveries were assisted by TBAs. The reasons for the prevalence of TBA-assisted delivery include low cost, a 24-hour support system by TBAs, a lack of knowledge and the traditional practice of TBA-assisted delivery. Moreover, the reasons for choosing not to deliver at facilities include the financial burden, poor access, poor quality of services and poor attitude of nurses, according to the BHS and volunteers interviewed. On the other hand, some of the hospitals have experienced increased facility-based deliveries. The contributing factors include the effect of health education conducted by BHS and volunteers, improved access, increased awareness of pregnant women and promotion of facility-based delivery by DPs. MCH Handbooks were recognized as an effective tool capturing MCH information. However, district and station hospitals were using a handbook developed by the out-patient department instead, and mothers lacked interest in obtaining information from the MCH Handbook.

From the life course approach perspective, the health workers interviewed pointed out the gaps of services and capacity at RHCs and SRHCs that systematically respond to the increasing needs related to elderly care, NCDs, nutrition for different age cohorts and school health.

Chapter 3 Assistance by Development Partners

3-1 Health Sector Assistance to Date

While Official Development Assistance (ODA) to Myanmar was fairly limited until recently, the democratic transition from the end of 2010 has brought about a major turning point in Myanmar's development arena. In the health sector, support by DPs increased from 75 million USD in 2010 to 243 million USD in 2014.[6] According to the data from the Organisation for Economic Cooperation and Development (OECD) as shown in Table 3-1, Japan has been the largest bilateral donor since 2013. UK's Department for International Development (DFID) and the United States Agency for International Development (USAID) have also increased their support in recent years.[7] The World Bank, GAVI and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) are considered as major donors among multilateral organizations.

Table 3-1 ODA Pledges by Key Health Sector Development Partners (million USD)

	Bilateral				Multilateral				
	Australia	Denmark	Japan	UK	GAVI	GF	World Bank	UNICEF	WHO
2011	7	1.2	2.8	5	5.6	-	-	3.5	3.2
2012	20.5	6.3	20	1.4	21.1	9.2	-	3.7	1.7
2013	15.4	-	16.4	8.8	9	153.5	30.9	2.4	3
2014	21.5	7.1	49.9	-	44.5	-	100	5	3

Source: Creditor Reporting System (CRS), OECD on 2016.10.18

According to the development assistance mapping generated by the Myanmar Information Management Unit (MIMU), health is the largest sector in terms of the number of agencies and projects (86 agencies[8] and 212 active health projects).[9] On the other hand, compared to neighboring Southeast Asian countries, Myanmar received the lowest ODA for health per capita at 2.78 USD in 2010, while Cambodia received 10.54 USD and Lao PDR 6.51 USD.[10]

Table 3-2 shows priority issues addressed by key DPs in the past few years. Many DPs, including the 3MDGF, have focused on three communicable diseases (HIV, malaria and tuberculosis). More

6 Creditor Reporting System, OECD.

7 There is no information regarding USAID's funding between 2011 and 2013; however, their commitment was 8.8 million in 2014.

8 The mapping includes donors, UN agencies, and international and local NGOs. However, MIMU is a self-reporting system, and a lot seems to be reported by NGOs.

9 "MIMU 3W – September 2016 Countrywide Overview."

10 http://equityhealthj.biomedcentral.com/articles/10.1186/1475-9276-12-78, http://www.who.int/gho/governance_aid_effectiveness/countries/en/#C

recently, they have emphasized maternal, newborn and child health (MNCH) as well as health system strengthening to support the Myanmar Government's policy on UHC.

Table 3-2 Key Development Partners' Past Pledges and Priorities

		Pledge	Priority Areas
Fund	World Bank	①IDA：$100 million (2015-2019) ②Technical assistance, capacity building, leadership：$3 million (2013-2017)	UHC, health system strengthening (health financing and essential health services and financial risk protection)
	GF	①UNOPS：$310 million (2011-2016) ②Save the Children：$176 million (2011-2016)	Malaria, HIV, TB, Regional Artemisinin Resistance Initiative
	3MDGF	$272 million (2012-2017)	MNCH, malaria, TB, HIV/AIDS, health system and community strenghening
	GAVI	$95 milliion (2011-2015)	Managerial capacity building, essential health service strengthening, etc.
UN	WHO	$65.3 million (2014-2017)	UHC, health systems, NCDs, communicable disesases, etc.
	UNICEF	$37.7 million (2016-2017)	MNCH, nutrition, WASH, HIV/AIDS
	UNFPA	$71.7 million (2015)	Reproductive health services including commodities, youth friendly health services, etc.
Bilateral	Japan	$125 million (2012-2015)	Infectious disease control, health system strengthening, enhancing human resource for health
	UK	£90 million (2012-2016)	Contribution to 3MDGF, malaria drug quality in the private sector, Rangoon General Hospital Partnership
	US	$31 million (per year)	Health system strengthening, MNCH, HIV, malaria, TB, emerging pandemic threats, contribution to 3MDGF
	Sweden	$28 million (2013-2017)	Contribution to 3MDGF, sexual reproductive health rights, contributions to GAVI, GFATM, UN, World Bank
	Switzerland	$15 million (2013-2017)	Contributions to 3MDGF, GF, UN and NGOs

Source: M-HSCC (December 2015)

Looking at the current health sector assistance by project type, MNCH has the most projects (55 projects), followed by HIV/AIDS (50 projects) and basic healthcare (29 projects).[11] With regard to the regional focus, Yangon and Ayeyarwady regions have received the most assistance while Magway region has been ranked seventh.[12]

With the expanded assistance to the health sector, donor coordination has become increasingly crucial. In 2012, the Myanmar Health Sector Coordinating Committee (M-HSCC) was established. Chaired by the Health Minister and participated by 36 donor agencies, NGOs and private organizations,[13] the M-HSCC provides advice and information to MOHS and functions

11 "MIMU 3W – September 2016 Countrywide Overview."

12 "MIMU 3W – September 2016 Countrywide Overview."

13 As of December 2015 (Development Assistance for Health in Myanmar: http://www.myanmarhscc.org/images/stories/pdffiles/developmentassistantinmyanmar.pdf)

as a coordinating body for DPs that are engaged in health sector assistance. There are 8 Technical and Strategy Groups under the M-HSCC for areas including HIV/AIDS, tuberculosis, malaria, MNCH and health system strengthening, providing technical advice on the respective issues.

3-2 Current Situation and Challenges of Health Sector Assistance

Based on the new NHP as a guiding principle, many DPs are currently developing a new programme and strategies for health sector assistance to Myanmar in 2017. These DPs include a successor fund of the 3MDGF, USAID, United Nations Children's Fund (UNICEF), UNFPA and World Health Organization (WHO). At the same time, they are waiting for the finalization of the NHP operational plan and Basic EPHS, selection of NHP target townships and the national standardization of an ITHP to ensure alignment with the ongoing national efforts. Therefore, as of March 2017, many details of key DPs' future assistance are yet to be determined. Keeping in mind of the limited information, the status and issues of donor assistance are as follows.

(1) Programme/project management and ownership by the government

Although DPs such as the GF and the successor fund of the 3MDGF seem to keep the modality of having UN agencies and NGOs as fund recipients, ensuring the Myanmar Government's involvement in programme/project development, planning and management has been increasingly recognized as crucial for development assistance. Due to the limited diplomatic relations in the past, DP's assistance frameworks (e.g. procurement and supply systems, implementation mechanisms and selection of target areas) used to be decided and managed by DPs themselves. Such processes are changing, albeit slowly. So far, many bottlenecks have been felt on the ground at health service delivery level due to DP's lack of harmonization with the Myanmar Government's health system and with other DPs' efforts. For example, support for township health planning by the 3MDGF and GAVI has been done in an isolated manner, introducing different guidelines, templates and reporting processes. Township health officials are heavily burdened to meet the requirements so as to receive funds from various donors. Under the NHP, this issue will be addressed by developing an ITHP. Furthermore, DPs' projects have addressed different issues, such as MNCH, HIV/AIDS, malaria and TB, in silos; without an integrated system, there has been a mix of volunteers dealing with different issues in each community. Additionally, to reduce out-of-pocket spending, DPs such as the 3MDGF, GAVI and GF have supported various schemes (e.g. reimbursement and equity fund) for referral without sustainability in mind. As a result, the service utilization cannot be maintained despite

improvement once the assistance is discontinued. While strategic purchasing is being considered under the NHP, it is important that DPs devise temporary measures for financial protection of vulnerable populations.

(2) Priority issues

Among priority issues in the health sector, a majority of DPs' assistance has focused on three communicable diseases and MNCH. Some of the outcomes of MNCH programmes and projects include capacity building of midwives and AMWs, development of the Maternal Death Surveillance and Response (MDSR) and Child Death Surveillance and Response (CDSR), development of supply systems, support for emergency referral and promotion of family planning. Nevertheless, in light of the new NHP, many DPs interviewed expressed the need to replace the vertical issue-based approach with a horizontal approach to improve primary healthcare based on the Basic EPHS. Such horizontal approach can encompass NCDs and nutrition that have often received limited donor assistance in the past. Nutrition has been narrowly addressed under MNCH, such as through provision of micronutrients and promotion of exclusive breastfeeding. However, as the Myanmar Government and key donors such as DFID are increasingly prioritizing nutrition as a multi-sectoral issue, donor assistance is expected to rise. On the other hand, while NCDs are also getting increased recognition, the newly established NCD Unit in the MOHS has only received support from WHO and Help Age International, and DPs' focus on the issue seems to remain limited. Among other health issues, the possible substantial decline of support for family planning and sexual health is of concern due to UNFPA's decreasing funds and USAID's policy change.

(3) Sustainability in assisted areas

Another trend currently observed among DPs is a geographical shift to hard-to-reach areas that are particularly affected by conflict and inhabited by ethnic minorities (such as Chin, Rakhine and Shan). On the other hand, areas such as Magway region are considered as a "stable" area, even though they still face substantial health issues such as high MMR. If assistance in those areas is discontinued or substantially reduced without strengthening health systems, some of the gains can be lost.

(4) Coordination in line with the NHP

Each DP currently developing a new framework of assistance needs to ensure alignment with the NHP and other DPs' efforts. Because the frequency and participation of M-HSCC are limited and other DP meetings are organized in an ad-hoc manner, some of the DPs interviewed pointed out the challenge of regular information sharing. Therefore, DPs including JICA should

proactively discuss and coordinate with the Myanmar Government and other partners in 2017 to achieve efficient and synergistic assistance for the implementation of the NHP. Moreover, due to the increasing focus on regional/state capacity building, it is critical to ensure donor coordination not only at a national level but also at a regional/state level.

3-3 Future Direction of Key DPs

Table 3-3 summarizes the past and future aid amounts and areas of assistance of key DPs that are particularly relevant for this preliminary assessment. From a financial perspective, the World Bank and 3MDGF will continue to be the major contributors in health. UN agencies and DFID will keep similar levels of funding as in the past. Although USAID has increased its presence in recent years not only as a contributor to the 3MDGF but also through its own programmes, the new US administration's ODA policy remains uncertain. With regard to the areas of assistance, it is clear that DPs are shifting their focus to health system strengthening related to EPHS. In particular, the World Bank and the successor fund of the 3MDGF will play a leadership role at policy level through supporting the finalization of the EPHS, development of ITHP guidelines and establishment of the NHP Implementation and Monitoring Unit (NIMU).

Furthermore, geographically, many DPs will prioritize hard-to-reach areas. MNCH continues to receive more support than other issues while more DPs are moving away from communicable diseases and increasing support to nutrition. On the other hand, support to NCDs remains to be a gap and there is a growing concern of declining support for family planning.

Table 3-3 Past and Future Assistance by Key DPs (as of March 2017)

		Past aid amount	Future aid amount	Past areas of assistance	Future areas of assistance
Fund	World Bank	$100 million (2015-2017) * EHSAP only	$100 million (2017-2019) * EHSAP only	Nation-wide health system strengthening (EPHS with focus on MNCH and health financing)	Nation-wide health system strengthening (**EPHS with focus on MNCH and nutrition**), NHP implementation (**EPHS finalization, etc.**)
	3MDGF	$272 million (2012－2017)	$120-150 million (2018-2022)	MNCH, HIV, malaria, TB, health system strengthening in all states and regions	**Health system strengthening in hard-to-reach areas (EPHS, financial protection etc.)**, NHP implementation (**development of ITHP guidelines, NIMU support, etc.)**
UN	WHO	$65.3 million (2014-2017)	Not available	Health system strengthening, MNCH, NCDs, communicable diseases, etc.	**Health system strengthening with focus on EPHS, MNCH, NCDs, multi-sector nutrition etc.**
	UNICEF	$37.7 million (2016-2017)	$56 million (2018-2022)	MNCH, nutrition, WASH, HIV/AIDS	**MNCH (focus on EPHS), nutrition**, HIV
	UNFPA	$7.17 million (2015)	$20 million (2018-2022)	Sexual and reproductive health (including adolescent), family planning, etc.	Sexual and reproductive health (**capacity building of midwives, family planning, adolescent reproductive health, etc.**)
Bilateral	DFID	£90 million (2012-2016)	£20 million (per year)	Contribution to 3MDGF,malaria, Rangoon General Hospital Partnership	**Contribution to 3MDGF, family planning,** malaria, **nutrition**
	USAID	$31 million (per year)	$20-30 million (2017-2022) * MNCH-HSS only	Contribution to 3MDGF, health system strengthening, MNCH/reproductive health/family planning, malaria, TB, HIV	**Contribution to 3MDGF**, health system strengthening in hard-to-reach areas (**EPHS with focus on MNCH**) * discontinuation of family planning support

Source: JICA Assessment Team

Chapter 4 Specific Needs and Effective Approaches for Future Cooperation

4-1 Status of Basic Health Services at the Primary Level and Specific Needs Identified

The following five areas of issues and needs were identified from the filed level assessment:

(1) ***To strengthen health service delivery system to all cohorts***

- Remaining needs to ensure continuum of care for reproductive health and MNCH
- Needs to strengthen the service delivery in the areas of adolescent health, nutrition, NCDs, and the elderly care.

(2) ***To strengthen the health system to deliver basic health services***

- Improvement of the health facilities which do not meet the MOHS standards (RHC/SRHC, facilities for delivery services) and provision of necessary equipment
- Ensuring sufficient availability of health manpower at the primary level, the capacity development of health staff and the reduction of heavy workload on midwives
- Strengthening the management capacity (including financial management) of health administration (region/state and township) without depending on the central government and DPs
- Improvement of logistic management of medical supplies and drugs
- Reduction of out-of-pocket expenditure by clients
- Establishment of referral systems including emergency transportation systems

(3) ***To strengthen the RHC microplanning with community participation (improvement of management capacity of BHS, HMIS and supervision)***

- Strengthening the management capacity of BHS at the township level below
- Establishing the formulation of the RHC micro-planning with community participation
- Strengthening monitoring and supervision to RHC/SRHC and the community
- Improvement of the capacity of BHS on HMIS (data collection and record keeping)

(4) ***To enhance the community awareness on basic health services and to strengthen health promotion through revitalization of MOHS volunteers***

- Strengthening health promotion and preventive health activities based upon the different needs of each age cohort
- Establishment of a standardized health volunteer system and ensuring its sustainability

- Continued skills development for community health volunteers and development of necessary information, education and communication (IEC) materials for health promotion

(5) ***To establish sustainable financial support mechanisms using government and community resources***

- Establishment of safety net to reduce the financial risks from the high out-of-pocket expenditure on health care through government and community resources

Table 4-1 is the summary on the status of basic health services at the primary level by age cohort based upon the results of the current JICA assessment.

Table 4-1 Current Situation and Needs of Basic Health Service By Age Cohort

Age group (cohorts)	Health Issues	Present Health Care Service and Interventions	Current Implementing Organizations and Assistances	Needs for Achieving NHP/UHC (from the point of health system)
Pregnancy (including fetus)/ Delivery	• To improve MMR and establish MDSR • To increase the proportion of deliveries by SBA and institutional deliveries • To ensure the quality of ANC • To upgrade/expand basic and comprehensive emergency obstetric care • To improve the nutrition status (e.g. anemia)	• Provide delivery services in health facilities and ANC / delivery services by SBA at the primary level • Provide emergency transportation to secondary and tertiary level referral hospitals (station/township/regional) • Train health volunteers bridging between the community and the health staff and as agents for health promotion • Provide nutritional supplementation through ANC (micronutrient and iron tablets) • Utilize MCH Handbook to ensure continuum of care and for health promotion	• Upgrading / renovation of RHC/SRHC facilities by DPs (including JICA) • Establishing emergency transportation system by DP and charitable organizations in the local community • Training of health volunteers (e.g. MCHP) by INGO/DP • Support for nutritional supplementation by DP (UNICEF, World Food Programme (WFP), INGO, etc.) • Printing and distribution of MCH handbook by MOHS	• Renovation of health facilities • Securing human resources, especially, LHV and midwife, at the primary level (RHC/SRHC) / Capacity development of human resources • Improving the knowledge and awareness of the community people about the benefits of delivery in health facilities and by SBA • Conducting health promotion and health education activities at the community level • Establishing referral and counter-referral system • Establishing standardized volunteer system in the community and ensuring its sustainability • Improving HMIS
Neonate and Infant (under 9 years)	• To improve NMR/U5MR, to establish CDSR • To achieve exclusive breastfeeding for 6 months • To promote the full coverage of immunizations • To improve nutrition status (anemia and growth inhibitions)	• Provide health services for neonate, PNC at the primary level, and emergency transportation to the secondary and tertiary levels • Implement regular growth monitoring for children incl. neonates and infants • Provide immunizations at the primary level (including outreach) • Promote exclusive breastfeeding • Provide nutritional supplementation (micronutrient and iodine) • Utilize MCH Handbook for continuum of care and health promotion	• Upgrading / renovation of RHC/SRHC facilities by DPs (including JICA) • Establishing emergency transportation system by DP and charitable organizations in the local community • Training of health volunteers (e.g. MCHP) by INGO/DPs • Support for nutritional supplementation by DP (UNICEF, WFP, INGO, etc.) • Printing and distribution of MCH handbook by MOHS	• Renovation of health facilities • Securing of the number of human resources (LHV and midwife) at the primary level (RHC/SRHC) and capacity development • Improvement of health services for PNC • Conduct of health promotion and health education activities by community volunteers about exclusive breastfeeding, nutrition improvement, and vaccines • Establishment of referral /counter-referral system • Establishing standardized volunteer system in the community and ensuring its sustainability -Improvement of HMIS
Adolescent (10 to 19 years)	• To promote Sexual Reproductive Health (SRH) including Family Planning (FP) and adolescent health • To improve nutrition status	• Implement school health program (annual health checkup, health education, monitoring of environmental sanitation at each school and per each grade) • Implement health promotion activities regarding HIV/SRH in the limited areas	• School health programs are being implemented by township health department and by BHS at RHC and SRHC • Adolescent health programs are implemented only in certain areas mainly by UNFPA and INGO	• Securing of human resources for BHS to implement school health programs (especially for campaign season from July to October) • Securing of medical supplies (multivitamins, anthelmintic, iron tablets, etc.) for school health checkup • Need for health services for children over age 5 and adolescents (especially out-of-school)

Age group (cohorts)	Health Issues	Present Health Care Service and Interventions	Current Implementing Organizations and Assistances	Needs for Achieving NHP/UHC (from the point of health system)
Adult (20 years and above)	• To improve SRH including FP • To control and prevent NCDs • To improve nutrition status	• Implement vertical programs for HIV, malaria, tuberculosis, nutrition, and RH including FP • Train health volunteers by each program and implement health education to local community • Regarding NCDs, measure blood pressure at SRHC and examine blood pressure and blood sugar at RHCs	• Each program is being implemented in collaborating with MOHS and DPs • Develop health volunteers by various approaches (training, incentive and supervision etc.) by DPs (it might cause sustainability problem) • Package of Essential NCD (PEN) (WHO), Help Age International and KOFIH are supporting NCD programs	• Securing of sustainable services after completion of programs by DPs • Dealing with anticipated decline of future support to FP and SH field • Provision of health screening and health checkup regarding NCD • Securing human resources regarding NCDs: Organizing of training for capacity development of BHS and health volunteers • Provision of guidelines and SOP of NCDs for RHC/SRHC level • Implementation of prevention activity regarding NCDs including production of materials for health promotion
Elderly (over 60 years)	• To manage the prevention of NCDs • To improve nutrition status	• Have launched Elderly Clinic in certain RHC/SRHCs in view of the community clinic • Provide health services regarding NCDs: Measurement of blood pressure at SRHC, examination of blood pressure and blood glucose level at RHC.	• Provision of medical equipment by MOHS with support of PEN by WHO, Help Age International and KOFIH • There are some cases of elderly clinics with support of local SMO and community charity organizations	• Implementation of screening and health checkup regarding NCDs • Securing of health human resources regarding NCDs at the regional/state level: Organizing of training as a part of NHP and EPHS for capacity development of BHS and health volunteers • Provision of guidelines and SOP regarding NCDs for RHC/SRHC level • Conduct of preventive health activities regarding NCDs / production of IEC materials on health promotion on NCDs
In all age groups	• To secure equal access for quality services • To ensure community engagement in health activities • To facilitate the formulation of community-driven health plan • To ensure sustainability of basic health services	• Provide primary health care services for all age groups (through the RHC/SRHC level and community outreach) • Strengthen management capacities (planning, implementation and monitoring) at the township level • Formulate micro-plan (annual plan) for RHC/SRHC including three major diseases and EPI (MRH not included) • Promote community participation and health education through health volunteers	• Improvement of infrastructure and strengthening of capacity for BHS by MOHS in collaboration with DPs • Capacity building at the township level by WB and other DPs (challenges: conduct of on the job training and ensuring continuity of training) • Training of health volunteers by different DPs under different programs (challenges: the issues of sustainability and standardization are identified)	• Consolidation of Basic EPHS under the new NHP • Formulation of micro-plan by community initiative and community participation, and linking the micro plans with ITHP • Establishment of the system of supervision by regional and state health department • Establishment of how to promote community engagement in health activities • Establishment of standardization of health volunteer system, capacity strengthening and sustainability of health volunteers

4-2 Existing Gaps in Health Sector Assistance by Development Partners

As elaborated in Chapter 3, at the time of the JICA assessment, many DPs were in the process of developing their new programmes and the contents of assistance in alignment with the NHP (2017-2021) and its first year Annual Operational Plan for the fiscal 2017. Therefore, at the current stage, the schemes and contents of their assistance remain uncertain. On the other hand, major DPs are prioritizing the support to EPHS and therefore emphasis has been placed on the cross-sectoral assistance towards strengthening primary healthcare based upon the Basic EPHS. As for the level of assistance, the loan by the World Bank and the grant aid by the succeeding fund of 3MDGF would be the biggest in amount and their investments are especially focused on health system strengthening (including health manpower and health facilities).

Among the priority issues, the gaps in the health sector assistance by DPs exist in the areas of responses to NCDs and nutrition improvement for all age groups from the life course approach perspective. Especially in regard to responses to NCDs, a new unit in charge of NCDs was set up within the MOHS as recently as in 2015, and only a few DPs, such as WHO, HelpAge International and KOFIH, are currently providing assistance for NCDs. Furthermore, with the withdrawal of USAID assistance due to the recent change on its aid policy, the support to family planning and reproductive health is expected to decline.

As for the geographical coverage, most of the DPs have not yet finalized the identification of their targeted areas. However, the successor fund of the 3MDGF and USAID are moving towards hard-to-reach areas. Magway region, which is comparatively better in the geographical access from the national standard and is not a conflict-affected area, may face declining assistance. The progress made by the previous assistance may be discontinued even though the region still has high health needs.

4-3 Approaches for Future Cooperation

4-3-1 Basic Concept: Life Course Approach and Community Engagement

Based upon the priority issues for primary healthcare and specific needs and gaps identified for assistance, the basic concept is centered on strengthening the health system to deliver basic health services (cross-sectional approach) for all age groups seamlessly throughout the life course. As shown in Figure 4-1, future cooperation will take a cross-sectoral approach towards EPHS in line with the new NHP, aimed at establishing basic health services through the life

course approach. This approach is not yet fully undertaken by other DPs.

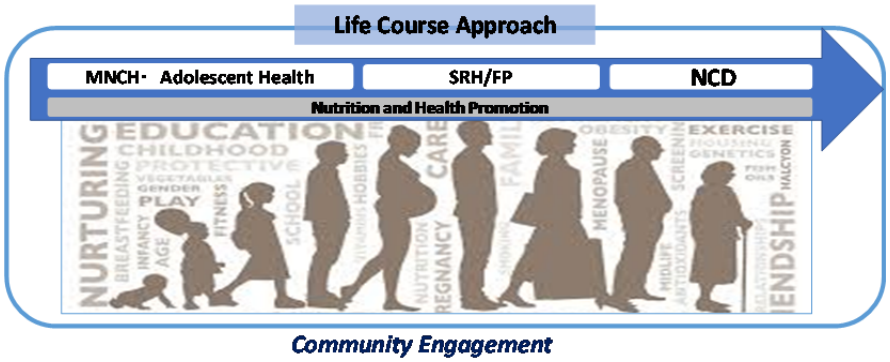

Figure 4-1 Basic Health Services from Life Course Approach (Basic Concept)

Source: JICA Assessment Team

Furthermore, in the new NHP (2017-2021), community engagement has been emphasized, addressing both the supply side to deliver the EPHS and the demand side (the community). This requires strengthening of health promotion for all age groups as well as the promotion of community participation. In other words, future cooperation is aimed at strengthening the health system, enabling the provision of basic health services based upon the needs of different life stages (vertically) and addressing specific issues throughout life course, for example nutrition (horizontally).

4-3-2 Effective Leverage Points for Interventions

Based upon the basic concept of the "life course approach" and "community engagement," the following areas can be identified as effective leverage points for interventions, considering Japan's past aid experiences.

(1) Remaining issues from MDGs: **continuum of care for MNCH**
(2) Emerging challenges: **NCDs such as hypertension and diabetes**
(3) Cross-cutting issues in response to 1) and 2): **health promotion and nutrition improvement**

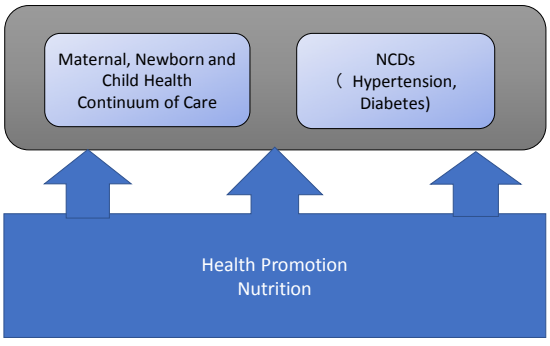

Figure 4-2 Leverage Points for Needs in Basic Health Services based upon Life Course Approach

Source: JICA Assessment Team

(1) Continuum of Care for Maternal, Newborn and Child Health

Based upon the result of the 2014 National Census and the 2015-2016 DHS, the level of MMR, NMR and U5MR have not reached the desirable level and remain as key priority issues. It continues to be important to ensure continuum of care from pregnancy and delivery to child growth monitoring, and JICA's future cooperation will be able to utilize the past accumulated experiences in this area in Myanmar as well as in other countries. Detailed interventions include promotion of continuum of care (safe delivery, newborn care, etc.), strengthening monitoring and supervision, and establishing referral systems. The MOHS has been promoting the utilization of the MCH Handbook as a tool for continuum of care, through printing and distribution with the budget from the MOHS.

(2) NCDs: Screening and Prevention, especially Hypertension and Diabetes

According to WHO, the share of mortality caused by NCDs (cardiovascular diseases, cancer, diabetes, etc.) is 59% of all deaths.[14] The new NHP is aimed at providing basic health services to all age groups in response to the changes in the disease burdens in the country's population. However, the service delivery readiness at the RHC/SRHC level is not yet fully established. In the need to respond to NCDs (e.g. hypertension and diabetes) through early detection of diseases through screening and the provision of early treatment, the capacity of BHS as well as health volunteers needs to be strengthened. In this area, Japan's experience in public health can be utilized.

(3) Nutrition Improvement

Nutrition improvement is a cross-cutting issue for all age groups, and a horizontal approach is required. Detailed interventions include: 1) nutrition from pregnancy to children (e.g. anemia), 2) promotion of exclusive breastfeeding, 3) child growth monitoring, 4) health promotion on health and dietary practices, 5) nutrition education throughout life course, and 6) multi-sectoral approach (e.g. collaboration with the agriculture sector). Japan's experience can be shared, for example health promotion and nutrition improvement thorough school health and various nutrition education activities.

(4) Health Promotion

Through the current assessment, limited awareness and knowledge on health matters were noted as one of the key challenges. HLP Division in the MOHS changed its name from Health Education at the beginning of 2017, aiming at further strengthening their health promotion

[14] WHO. NCD Country Profile 2014.

activities as the priority area designated by the Minister. It is also emphasized to address capacity building of BHS and health volunteers in communication skills with community members and in the conduct of health education in the community. There is a high need for the development of strategies for preventive health activities and the production of IEC materials regarding nutrition and NCDs. Japan's experiences in preventive health and health promotion activities for lifestyle-related diseases can be shared and utilized.

4-4 Effective Approach for Future Cooperation

4-4-1 Utilization of Experiences and Lessons Learned from the Past Japan/ JICA assistance

Various technical cooperation projects have been implemented in Myanmar previously and the experiences and lessons learned could be utilized in planning and developing future cooperation.

The following are some of the examples:

(1) MCH Handbook

Home-based Maternal Record (HBMR) was first introduced in 2000 and later modified to MCH Handbook in 2008. In 2013, the distribution of the single version of MCH Handbook started nation-wide. The review of the content (user-friendliness) and the methods to expand its utilization need to be undertaken.

(2) MCHP

The system of MCHPs was introduced in the 2005 project on Community-oriented Reproductive Health (RH) Project (February 2005 – January 2010) in two townships in Shan state. MCHPs are volunteers focusing on MCH and RH promotion activities, as bridges between community members and health service providers, particularly midwives. Based upon the outcome of the project, the Implementation Guide was developed and as of now the MCH system has been introduced to 34 townships (2 townships in each region/state). Meanwhile, challenges such as continued training, sustainability, task shifting, incentive mechanism and community support system have been noted.

(3) Health System Strengthening (HSS) Project (November 2014 – November 2018)

Towards the achievement of UHC, the HSS Project is aimed at strengthening the capacity of managing the Health Plan at the central and state (Kaya state) levels. The outcomes, good practices and lessons learned can be shared and applied in future cooperation.

(4) The Project for Strengthening Capacity of Training Team for BHS (BHS Project) (May 2009 – May 2014)

The BHS Project was aimed to build the capacity of a training team to manage and implement in-service training. The experiences of the project can be utilized in ways such as the effective utilization of "Continuing Medical Education" for refresher training and updates on new information/knowledge for BHS without using a lot of resources.

(5) The Project for Improving Maternal Health through Enhancement of Community Capacity in Rural Areas of Myanmar (February 2014 – September 2016): JICA Grassroots Project

With the aim to promote the utilization of maternal health services by pregnant women, the project employed a strategy of community capacity building through development and implementation of a community action plan with community participation. This process could provide some lessons for future cooperation regarding RHC micro-planning and ITHP.

(6) Project for Development of Malaria Control (Interrupting Transmission Towards Pre-elimination) Model in Myanmar (March 2016 – March 2020)

The project is aimed to develop an effective Malaria control model applicable nation-wide and verify the effectiveness of the model in Bago region. At the community level, the project utilizes CHWs as frontline workers. The project experiences in linking the central with the regional, township and community levels can be shared with future cooperation.

4-4-2 Strengthening of Community Health Volunteers

Health promotion for community members (the demand side) will be a key pillar in future cooperation. In this regard, community health volunteers are expected to play a crucial role.

In the health sector in Myanmar, various health volunteers are trained and involved in community activities. Major health volunteers under the MOHS are shown in Table 4-2. Most of these health volunteers are trained through the support of DPs and deployed by separate programmes vertically.

Table 4-2 Existing Health Volunteers and MOHS Jurisdiction

Volunteer	MOHS Jurisdiction	Training Period
CHW	BHS Division	1 month (a few days for refresher)
AMW	MRH Division	6 months
MCHP	MRH Division	1 day (1 day for refresher)
YIC Volunteer	HLP Division	5 days
Community Support Group	HLP Division	1 day

There are other groups of health volunteers under the TB and Malaria control programmes and some specific purpose-oriented volunteers trained by DPs.

During the JICA assessment mission, the need for standardization of health volunteers under the MOHS was noted. Some discussions are being held among the MOHS and DPs regarding task-shifting and training of volunteers, as well as the cost-effectiveness of this standardization. In finalizing the detailed plan for future cooperation, it is essential to consider how to establish an incentive mechanism and a community support system for volunteers as well as ways to ensure sustainability of such mechanisms.

Chapter 5 Future Direction of Cooperation

5-1 Guiding Principles for Future Cooperation

Given the background mentioned in the previous chapter, the following five guiding principles for future cooperation are considered.

(1) Provision of support to strengthen primary healthcare system to deliver basic health services (i.e. EPHS) towards the realization of UHC;
(2) Implementation of the life course approach for the health transition in Myanmar, ensuring EPHS for all age cohorts throughout the life course;
(3) Support for both service delivery (supply side) and communities (demand side);
(4) Emphasis on a holistic approach beyond program-based approach; and
(5) Sharing of lessons learned from Japan's experiences in the health transition

5-2 Focused Areas of Future Cooperation

Based upon the leverage points elaborated under thein Chapter 4, it is proposed that the focus for future cooperation be placed on the following three areas in view of providing appropriate services to all age groups at every stage of life course (Figure 5-1).

(1) Remaining issues from MDGs: **Continuum of Care for MNCH**
(2) Emerging challenges: **NCDs such as Hypertension and Diabetes**
(3) Cross-cutting issues in response to 1) and 2): **Health Promotion and Nutrition Improvement**

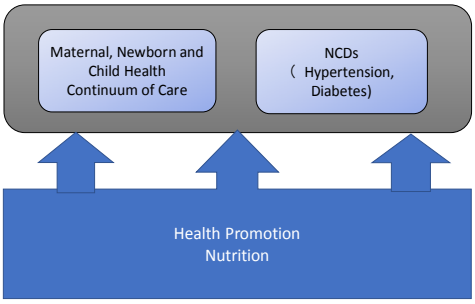

Figure 5-1 Leverage Points for Needs in Basic Health Services based upon Life Course Approach

5-3 Proposed Framework of Future Cooperation

In view of the current needs and policy directions in Myanmar's health sector, the framework of JICA's technical cooperation is proposed as below.

5-3-1 Objectives of Future Cooperation

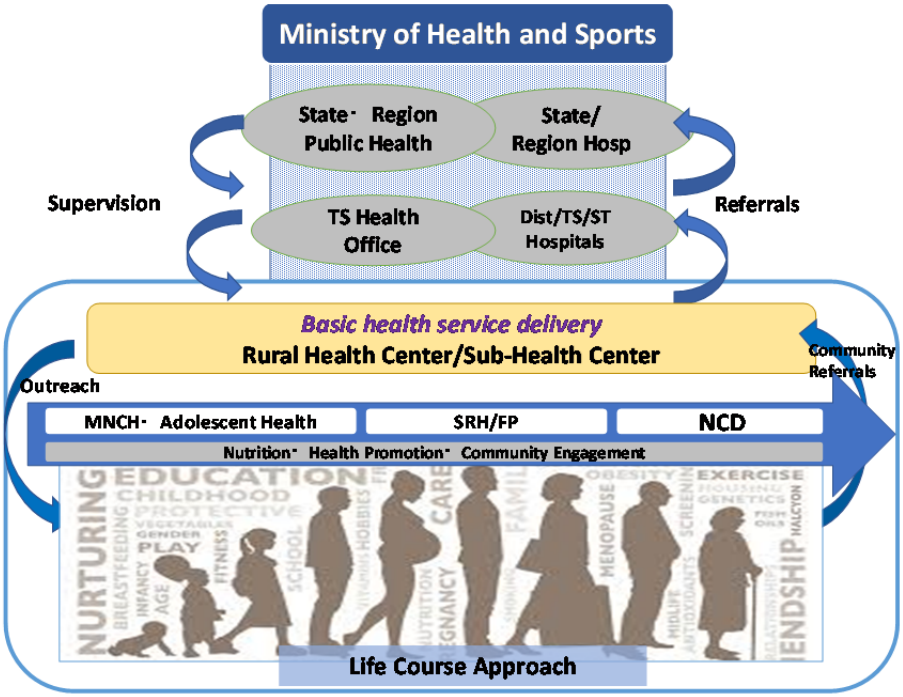

Figure 5-2 Conceptual Diagram for Future Cooperation

In view of achieving the UHC as set by the MOHS, future cooperation needs to focus its main assistance to both the supply side (the service delivery) and the demand side (the community), ensuring access to quality basic health services and protection from financial risks by medical expenditure for all the people throughout the life course.

Thus, it is proposed that future cooperation be aimed at the following objective:

Basic health services are utilized throughout life course at RHC/SRHC level in XX Region/ State.

As shown in Figure 5-2, the focus of future assistance will be placed on the provision of services at the township level and below to the community. While emphasizing the RHC/SRHC level, a comprehensive approach including higher level health facilities should be considered for future assistance in view of the needs to improve such facilities to promote institutional deliveries and strengthen the referral system.

5-3-2 Future Cooperation Counterparts

During the JICA assessment team's missions in Myanmar, a series of meetings were held with the key persons including Director-General of Public Health, Director-General of Medical Services and the 7 divisions in the MOHS, namely BHS, HLP, MRH, Child Health Development (CHD), Nutrition (NU), NCD, and School Health (SH).

After the above discussions within the MOHS, in view of the focus for future cooperation, the BHS Division was proposed and agreed as the main counterpart because BHS and primary level facilities are managed and supervised by the BHS Division, and the Division has staffing at all levels from the central to RHC/SRHC.

While the BHS Division would be the main coordinating counterpart for future cooperation, the divisions of MRH and HLP will be expected to play an important role closely with BHS as sub-counterparts in the areas of MNCH related services and life course approach, respectively.

5-3-3 Key Indicators for Assessment of Future Cooperation

The following list of key candidate indicators for assessment was identified for future consideration during the JICA assessment mission in view of the proposed objective of future cooperation. Further elaboration needs to be made in the process of detailed project formulation in consultation with the MOHS.

Candidates for Assessment Indicators (Concerned Divisions in the MOHS)

(1) Rate of deliveries by SBAs/ institutional delivery; ANC and PNC coverage and quality of services (MRH)
(2) Rate of exclusive breastfeeding for 6 months (CHD, NU, HLP)
(3) Child growth monitoring, full immunization coverage and nutrition-related indicators (CHD, NU)
(4) NCD-related indicators; e.g. Number of clients who received screening and treatment for hypertension and diabetes
(5) Other possible candidates for consideration: assessment indicators under the BHS regarding health promotion and community engagement.

5-3-4 Key Components for Future Cooperation

Based upon the findings and meetings with the concerned persons at the MOHS and DPs during the assessment missions, the three main components were identified for future cooperation as follows:

(1) Development of an implementation framework for basic health services through future assistance;
(2) Enhancing the capacity to deliver basic health services at RHC/SRHC level; and
(3) Strengthening community engagement in health activities

Component 1: Development of an implementation framework for basic health services

The detailed activities proposed under Component 1 in the discussion with the MOHS include: 1) establishment of a taskforce group within the MOHS to develop an implementation framework to deliver basic health services, 2) development of an implementation framework through project implementation, 3) verification of effectiveness of interventions (e.g. costing of actual implementation) and 4) sharing of lessons learned in other areas and with other DPs.

Points for Consideration

(1) Establishment of a taskforce group within the MOHS

It has been agreed that overall coordination for future cooperation will be made under the leadership of Deputy Director-General (Public Health) within the MOHS, and an implementation mechanism also needs to be set up at the township level and below.

(2) Development of an implementation framework to deliver basic health services

"Implementation Framework" to deliver basic health services at the RHC/SRHC level, which has been proposed under the new NHP, is yet to be developed. The idea of "Community Clinic," which has been introduced by the MOHS under the new administration, is not yet ready for institutionalization. Therefore, based upon the discussion with the MOHS, it is agreed that future cooperation will address the development of an implementation framework to deliver the Basic EPHS as envisaged under the new NHP.

In this regard, the following consideration needs to be made:

(1) To undertake close deliberation with MOHS in the process regarding the contents of the framework;
(2) To consider the objectives of an implementation framework, e.g. ultimately aiming at

standardization and nation-wide application. A possible scenario would be: 1) formulation of an implementation framework through the project implementation, 2) presentation to the MOHS, 3) approval by the MOHS, 4) replication within the targeted region/state for standardization, 5) sharing and replicating in other regions/states, and 6) nation-wide application.

(3) To consider specific characteristics and comparative advantages of a to-be-developed implementation framework, compared with assistance by other DPs with regard to cost efficiency, effectiveness, sustainability, etc.

(4) Verification of effectiveness of interventions and approaches

In addition to the utilization of available data through the DHS and the Census, effective methods for data collection for verification of interventions and approaches taken under the new assistance should be considered and planned, for example through the conduct of baseline and endline surveys. This would allow the presentation of evidence which may be applicable for future policy and program development. In this regard, the submission/approval of the ethical review would be recommended for future possible publicity and utilization of these results.

Component 2: Enhancing the capacity to deliver basic health services at RHC/SRHC level

Based upon the discussion with MOHS, the proposed activities under Component 2 include: capacity building (training) of BHS, provision of materials and equipment, monitoring and supervision and strengthening of referral systems.

Focus areas are:

(1) Maternal, newborn and child health (safe delivery, newborn care and promotion of continuum of care)

(2) Nutrition (promotion of exclusive breastfeeding, growth monitoring)

(3) Prevention of NCDs (screening and health education)

Points for Consideration

(1) Prioritization of key activities based upon the existing needs

- Priority areas should be identified for capacity building (training) in service delivery, health promotion, and the area of MNCH based upon the review of on-going training and the existing gaps. The new areas of nutrition and NCDs should be prioritized for the development of training curriculum and method.

- A lack of educational materials for NCDs is witnessed. The areas for possible assistance should be considered in coordination with HLP.
- Synergistic effects should be considered in undertaking training programs in coordination with other DPs by avoiding duplications. For example, other organizations supported by USAID undertake training in the areas of basic emergency obstetric care and midwifery capacity building. By avoiding duplications, future JICA cooperation could focus on community engagement and communication skills development for health personnel, thus generating synergy through collaboration.

(2) Approaches to MCH Handbook

- The current MCH Handbook could be a comprehensive tool for unified record-keeping to facilitate coordination among the different divisions of MRH, CHD, EPI and Nutrition. The utilization of MCH Handbook can be also promoted in coordination with other DPs such as UNICEF and WHO, which have introduced the record cards for immunization and monitoring cards.
- A verification on the content and message of the current MCH Handbook needs to be made. It is recommended to set up an opportunity to review for common understanding among the concerned persons regarding the objectives of the Handbook (for what purpose, for whom and ultimate goal) in order to make it more user-friendly and facilitate its utilization as a unified record keeping tool.
- A trial piloting to introduce a digitalized MCH Handbook in a selected site could be considered in view of advancement of information and communication technology.

(3) Management of data collection

- The areas of assistance in the implementation of MDSR and its coordination with CDSR needs to be considered
- There are high needs for capacity building of BHS in the areas of management of HMIS. Since HMIS covers a wide range of activities, concrete areas for assistance should be narrowed down in the future cooperation.

(4) Formulation of ITHP

- Formulation of ITHP is an essential activity. Future assistance could emphasize setting up an effective mechanism for the formulation of the plan based upon the development of micro-plans at the RHC level incorporating the needs of the community.

(5) Strengthening of referral systems

In identifying areas of future assistance, it is necessary to examine the existing capacity of higher level facilities in receiving clients (e.g. emergency obstetric care and NCD treatment) and consider possible coordination and collaboration with other DPs and implementing organizations when necessary.

(6) Provision of materials and equipment

- Approximately 80% of RHCs in the target areas currently considered for future assistance are not equipped with the facilities for institutional delivery and there is a high need for the improvement of facilities and the provision of materials and equipment. Prioritization and identification of necessary items should be considered. One possible approach is to consider selecting the targeted township designated under the first year NHP and coordinate with the MOHS for facility improvement and materials/equipment provision.[15]

(7) Community engagement

- It was witnessed during the assessment mission that community members do not utilize health services even though the health facilities are upgraded. In order to avoid such conditions, it is necessary to emphasize that future assistance should address not only the improvement of service delivery (the supply side), but also address the needs of the community (the demand side) and undertake health promotion activities throughout life course to facilitate the people's demand for utilizing health services.

Component 3: Strengthening community engagement in health activities

Component 3 includes proposed activities such as: revitalization of community health volunteers (e.g. MCHP, CHW, etc.), development of RHC micro-plans reflecting community needs, establishment of emergency transportation systems, and health education and preventive health activities.

Points for Consideration

(1) Vitalization of community volunteers

- There are various cadres of health volunteers in the community and the needs for standardization of the health volunteer system has been noted. The details of future

[15] The fund from the World Bank does not include financial assistance for upgrading RHC facilities for institutional delivery.

assistance in this area should be carefully considered in view of the unification and standardization of health volunteers in coordination with the development of an implementation framework to deliver basic health services.

- The support to AMWs should be considered based upon the review on the assistance made by the 3MDGF, especially the provision of financial incentives from the point of sustainability. Cost effectiveness also needs to be reviewed for the 6-month training.

(2) Development of RHC micro-plans reflecting community needs

- RHC micro-planning with community participation is one of the key strategies set by MOHS under the NHP. A good implementation system should be well established so that the RHC micro plans be well coordinated with and reflected in the ITHP.
- A feedback system should be introduced in the future assistance in ensuring that the needs of the community is reflected in local health plans.

(3) Strengthening community governance

- Strengthening community governance is essential in establishing a sustainable and resilient system for the provision of basic health services and a well-functioning village health committee plays a key role. It has been witnessed at the time of 2008 Cyclone Nargis that disaster responses were effectively undertaken where a village health committee was well functioning. Community support system can be also facilitated through mobilizing local resources, e.g. setting up community welfare fund, incentives mechanism for health volunteers.

5-3-5 Proposed Target Areas for Future Assistance

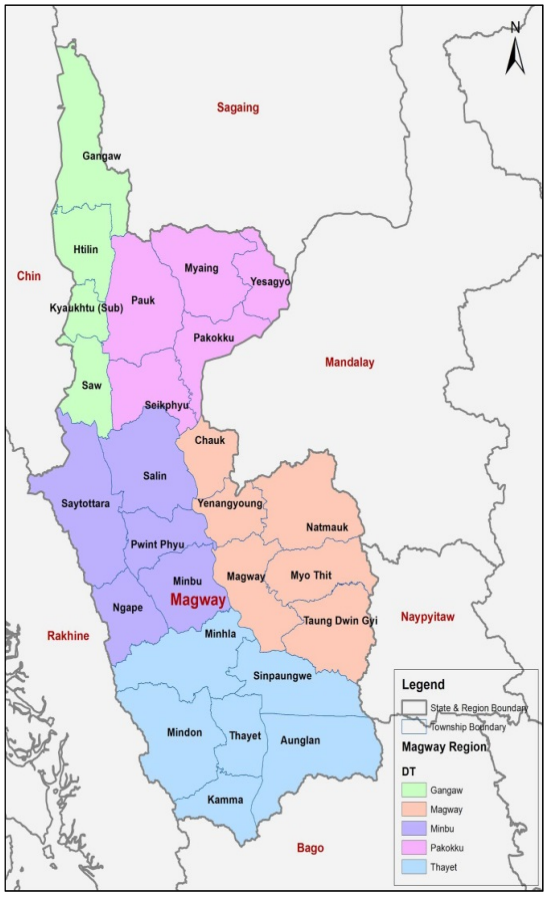

Figure 5-3 Map of Magway Region

Source: 2014 Magway Region Census Report Vol. 3-H

Magway region is proposed as the target site for future assistance based on the following criteria:

- Undesirable health-related indicators (e.g. High MMR, IMR) based upon the 2014 National Census
- Japan's past assistance experience

In addition, the assistance provided by the 3MDGF at the township level and below will end by July 2017 and future assistance is not yet foreseen. Initially, 2 adjacent districts (a total of approximately 10 townships) would be selected. Possible expansion is to be considered later based upon the outcome in and outside of the region.

5-4 Future Direction of Financial Assistance

Future financial assistance should be considered in coordination with the project-based assistance plan mentioned above. The following three scenarios are proposed.

Scenario A:

Initially the project-based technical cooperation will be undertaken to strengthen the system of basic health service delivery based upon the NHP. Thee implementation framework verified through the project will then be expanded within the targeted area, i.e. Magway region, and nation-wide, with additional financial assistance in the following manner.

(1) Improvement of infrastructure (RHC/SRHC)

- Materials/equipment necessary to deliver basic health services (including water, electricity, solar system)
- Building and/or renovation of facilities to deliver basic health services
- Materials/equipment and renovations of referral facilities higher than township level

The infrastructure development can be considered in three stages: 1) target the initial 2 districts in coordination with the MOHS investment plan, 2) expand to other areas within the same region, and 3) expand to other states/regions.

(2) Capacity building (management training) for BHS of SRHC/RHC and higher level facilities receiving referrals (township, district, regional hospitals and health offices)

Scenario B:

The project-based technical cooperation will address the issues of MNCH continuum of care and measures for NCDs (e.g. prevention and health education, screening and early detection) at the RHC/SRHC level and financial assistance will address the infrastructure improvement of station and township hospitals to provide appropriate quality emergency response and treatment at referrals.

Scenario C:

The improvement of road conditions will be undertaken for better access to health facilities.

5-5 Way Forward: Points for Consideration

(1) Collaboration and linkage with other Japanese cooperation schemes:

There are various on-going projects supported by Japan, e.g. grant aid, technical cooperation, grassroots technical cooperation and grant aid by NGOs, training programs in Japan, loan and public-private partnership. Experiences and lessons learned can be utilized in future cooperation. Effective linkages with the existing assistance (e.g. HSS Technical Cooperation Project) should be made to generate synergistic effects.

(2) Approach for increasing the area/facility coverage

In order to cover a wide range of villages/facilities in the targeted area, it might be necessary to consider contracting out selected areas and activities to local NGOs.

(3) Efficient and effective coordination and collaboration with other DPs

As mentioned in Chapter 3, all the DPs aim to focus on the EPHS in alignment with the new NHP. Close coordination and collaboration with other DPs are essential in undertaking JICA's future assistance. Some points for consideration are:

- Synergistic effects should be maximized through coordination of inputs made by different DPs. For example, many DPs are supporting areas of MNCH, and, increasingly, nutrition. Meanwhile, their assistance to NCD issues is still limited. The second phase of the World Bank assistance is expected to focus on RMNCAH and nutrition in the Basic EPHS.
- Collaboration with WHO, UNFPA and UNICEF in the technical aspect can be considered; for example, the utilization of technical guidelines, training manuals and tools developed by these UN agencies (e.g. MDSR, CDSR, etc.) and the skills laboratory currently under construction by USAID in Magway region.

(4) Coordination with the MOHS investment plan under the new NHP

The MOHS is currently finalizing the first investment plan for the fiscal 2017 (starting from April) to the 70 target townships identified for the first year. The investment plan ensures the "service readiness" including the improvement of infrastructures and the provision of essential drugs. For the first round plan, it is said that 5 townships be selected in Magway region, currently considered as the target for assistance. In finalizing the detailed plan for JICA's assistance, close coordination should be made with the MOHS investment plan as well as the second phase of the World Bank assistance.

As of the end of March 2017, the Annual Operational Plan (2017-2018) under the NHP (2017-2021) is in the process of finalization. All the DPs are expected to coordinate their strategies and plans in alignment with the new Annual Operational Plan. The development of JICA's detailed assistance plan needs to be developed and finalized through further deliberations with agencies concerned both at the national and local levels.

ANNEX

Annex 1: Reference List

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Annex 2: Assessment Schedule

First Mission

	Date		Itinerary	Route	Mode of Transportation	MS	RN	RK	NT
1	12/11	Sun	Leave Tokyo for Yangon	NRT - YGN	Flight			1	
2	12/12	Mon	9:00 JICA Myanmar Office PM: Briefing to local consultancy firm		Taxi			1	
3	12/13	Tue	Briefing to local consultancy firm 14:00 Embassy of Japan		Taxi			1	
4	12/14	Wed	AM: Move to NPT (7:00-7:35) 9:30 Meeting with Dr. Thuzar Chit Tun, Director, BHS	YGN - NPT	Flight	1		1	
			Leave Tokyo for Yangon (11:00-16:30)	NRT - YGN	Flight				
5	12/15	Thu	Move to NPT (7:00-7:35)	YGN - NPT	Flight	1		1	
			10:30 Dr. Yin Thandar Lwin, DyDG (PH) 11:45 Dr. Than Win, Acting DG, DOPH 15:00 HSS Project 17:00 Prof. Myint Han, DG, DMS		Car				
6	12/16	Fri	08:30 Dr. Phyu Phyu Aye, Director, Health Education 10:00 Dr. Sandar, Director, School Health		Car	1		1	
7	12/17	Sat	AM: Move to MGY PM:Documentation	NPT - NYU	Car	1		1	
8	12/18	Sun	Documentation			1	1	1	
			Leave Tokyo for Yangon (11:00-16:30)	NRT - YGN	Flight				
9	12/19	Mon	Magway (Day 1) Pakkoku Township -Pakokku District Hospital -Myit Chay Station Hospital		Car	1	1	1	
			AM: Leave YGN for Nyaung U (6:45-8:05) / Meeting within Assessment Team	YGN - NYU	Flight				
			PM: Leave NYU (17:05-18:25) for Tokyo via YGN(22:10-6:45)	NYU - YGN - NRT	Flight				
10	12/20	Tue	Magway (Day 2) Pakkoku Township -Lay Daing RHC -Myit Phya Sub-Rural Health Center -Interview with AMW, CHW and some MCHP at Sub-Rural Health Center		Car	1	1	1	
			Arrive in Tokyo						
11	12/21	Wed	Magway (Day 3) Magway Regional Health Dept & Hospital 11:00 Meeting with Regional Health Officer <Public Health> 12:00 Meeting with MS, Magway General Hospital	NYU-MGY	Car	1	1	1	
12	12/22	Thu	Magway (Day 4) Myaing Township -Myaing Township Hospital -Let Yet Ma Station Hospital Leave NYU for Tokyo via YGN	MGY-NYU	Car		1	1	
13	12/23	Fri	Magway (Day 5) Myaing Township -Kyauk Sauk RHC -Ma Gyi Su Sub-Rural Health Center		Car		1	1	
			Arrive in Tokyo						
14	12/24	Sat	AM: Move to NPT PM:Documentation	NYU - NPT	Car		1	1	
15	12/25	Sun	Documentation				1	1	
16	12/26	Mon	11:00 Dr. Hnin Hnin Lwin, Dy Director (MRH) 14:00 Prof Myint Han, DG (MS)		Car		1	1	
			Move from NPT to YGN (17:40-18:15)	NPT - YGN	Flight				
			Leave Yangon for Tokyo (22:10-6:45)	YGN - NRT	Flight				
17	12/27	Tue	Move from NPT to YGN (08:10-08:45)	NPT - YGN	Flight		1	1	
			Leave Yangon for Tokyo (19:10-21:35)	YGN - NRT	Flight				
			Arrive in Tokyo						
18	12/28	Wed	Arrive in Tokyo					1	
						8	10	18	0
						MS: Makiko SUGHISHITA			
						RN: Ryoko NISHIDA			
						RK: Ryoko KOSHIHARA			
						NT: Nami TAKASHI			

Second Mission

Date		Itinerary 1	Itinerary 2	Route	Stay	MS	RN	RK	NT
1/26	Thu	Leave Tokyo for Yangon		NRT-YGN	YGN				1
1/27	Fri	10:00 Meeting with Myanma Perfect Research 14:00 Interview with Ms. Tomita, Chief Adviser, JICA PEME			YGN				1
1/28	Sat	Documentation			YGN				1
1/29	Sun	Documentation			YGN				1
1/30	Mon	9:00 Meeting with Ms. Nakatani, JICA Myanmar 10:00 Meeting with GFATM 15:00 Interview with UNAIDS 17:00 Interview with UNFPA 17:30 Meeting with Ms. Nakatani, JICA Myanmar	Leave Tokyo for Yangon	NRT - YGN	YGN			1	1
1/31	Tue	10:00 Interview with Save the Children 14:00 Interview with Jhpiego	Move to NPT	YGN-NPT	YGN			1	1
2/1	Wed	9:30 Interview with Myanmar Medical Association 11:30 Web conference with JICA HQ 14:00 Interview with Charity Oriented Myanmar 16:00 Andrew Cassels, 3MDG Fund Consultant	10:00 Interview with Myanmar Maternal and Child Welfare Association (MMCWA) 11:30 Web conference with JICA HQ 13:30 Interview with Dr. Khin May Thant, Director, MOHS Nutrition 15:00 Meeting and interview with Dr. Thuzar Chit Tin, Director, MOHS BHS		YGN/NPT			1	1
2/2	Thu	9:00 Interview with UNICEF 14:00 Interview with KOFIH	13:00 Meeting with Dr. Hnin Hnin Lwin, Deputy Director, MOHS MRH		YGN/NPT			1	1
2/3	Fri	9:30 Interview with USAID 11:00 Interview with UNOPS 13:30 Interview with Dr. Nakamura, Chief Adviser, JICA Malaria Project 16:00 Interview with Dr. Nan Naing Naing Shein, Depuy Director, MOHS NCD	9:00 Meeting with Dr. Than Win, Diector General, MOHS Department of Public Health 10:30 Meeting and interview with Dr. Myint Myint Than, Director, MOHS CHD	NPT-YGN	YGN			1	1
2/4	Sat	Documentation			YGN			1	1
2/5	Sun	Documentation	Move to Magway via Nyaung U	YGN - NYU NYU-MGY	YGN/MGY			1	1
2/6	Mon	10:00 Interview with DFID 14:00 Phone interview with WHO	10:00 Meeting and interview with Dr. Tun Aung Kyi, Director, Regional Department of Public Health, Magway Regional Health Department 13:30 Meeting and interview with Dr. Paw Tun, Medical Superintendent cum Director for Regional Department of Medical Services and Dr. Ohmar Aye, Township Medical Officer, Magway Township		YGN/MGY			1	1
2/7	Tue	Move to Magway via Nyaung U	Mon Daung Station Hospital , Minbu Township Minbu District General Hospital	YGN-NYU NYU-MGY	MGY			1	1
2/8	Wed	Oo Yin RHC, Minbu Township			MGY			1	1
2/9	Thu	Pa Daung SHC, Minbu Township MSI Clinic, Magway			MGY			1	1
2/10	Fri	Pwint Phyu Township General Hospital Kone Zaung Station General Hospital			MGY			1	1
2/11	Sat	Documentation			MGY			1	1
2/12	Sun	Documentation			MGY			1	1
2/13	Mon	Kyaung Taw Yar RHC, Pwint Phyu Township			MGY			1	1
2/14	Tue	Min Myae SHC, Pwint Phyu Township			MGY			1	1
2/15	Wed	Move from Magway to Nay Pyi Taw by car		MGY-NPT	NPT	1		1	1
2/16	Thu	10:00 Meeting with Dr. Kyaw Khaing, Assistant Permanet Secretary, IRD, MOHS AM First Consultative Workshop for Development of National Strategic Plan on NCDs 13:00 Meeting with Myanma Perfect Research			NPT	1		1	1
2/17	Fri	11:00 Meeting with Dr. Thuzar Chit Tin, Director, MOHS BHS 16:30 Meeting with Dr. Mya Shwe, Director, and Dr. Nan Nandar Shein, Deputy Director, MOHS NCD			NPT	1		1	1
2/18	Sat	Internal Meeting			NPT	1		1	1
2/19	Sun	Internal Meeting			NPT	1		1	1
2/20	Mon	9:00 Meeting with Dr. Hla Mya Thwe Einda, Director, MOHS MRH 11:00 Meeting with Dr. Than Zin Htoo, Assistant Secretary, Planning and Statistic, Permanent Secretary Unit, Dr. Ye Min Htwe, Deputy Director, International and National Relations and Information Division, Dr. Min Yu Aung, Assistant Director, State Public Health Department 15:00 Meeting with Dr. Phyu Phyu Aye, Director, MOHS Health Literacy Promotion 16:30 Meeting with Dr. Ishii, Chief Adviser, Ms. Omachi, Coordinator, JICA HSS Project			NPT	1		1	1
2/21	Tue	10:00 Meeting with Dr. Thuzar Chit Tin, Director, MOHS BHS 13:30 Meeting with Dr. May Khin Thant, Director, MOHS National Nutrition Center 15:00 Interview with ADB			NPT	1		1	1
2/22	Wed	9:30 Reporting back to Dr. Yin Thandar Lwin, Deputy Director, MOHS DoPH 13:00 Reporting back to Dr. Myint Myint Than, Director, MOHS, CHD 13:30 Reporting back to Director General, DoPH			NPT	1		1	
2/23	Thu	Move to Yangon Documentation		NPT - YGN	NPT/YGN	1		1	
2/24	Fri	9:00 Debriefing at JICA Myanmar Office 14:00 Debriefing at Embassy of Japan Leave Yangon for Tokyo		YGN-NRT	On flight	1		1	
2/25	Sat	Arrive in Tokyo						1	
						10	0	27	27

MS: Makiko SUGHISHITA
RN: Ryoko NISHIDA
RK: Ryoko KOSHIHARA
NT: Nami TAKASHI

Annex 3: List of Interviewees

Date			Name	Title / Organization
2016/12/13	Tue	①	Mr. Hideaki Matsuo	Councilor, Embassy of Japan in Myanmar
			Mr. Yuichiro Funai	First Secretary, Embassy of Japan in Myanmar
2016/12/14	Wed	②	Dr. Thuzar Chit Tun	Director (BHS), DOPH
2016/12/15	Thu	③	Dr. Yin Thandar Lwin,	Dyputy Director General(DyDG) (Public Health), DOPH
		④	Dr. Than Win	Acting Director General (cum Dy DG, Disease Control), DOPH
		⑤	Mr. Yojiro Ishii	Chief Advisor (HSS project)
			Ms. Mayumi Omachi	Expert on Health Service Delivery, Prj coordinator (HSS project)
		⑥	Prof. Myint Han	Director General, Department of Medical Service
2016/12/16	Fri	⑦	Dr. Phyu Phyu Aye	Director (Health Education), DOPH
			Dr. Nilar Than	Deputy Director (Health Education), DOPH
			Dr. Myat Hus Paing Thaw	Deputy Director (Health Education), DOPH
		⑧	Dr. Sanda	Director (School Health (SH))
			Dr. Hnin Aye Kyu	Assistant Director (SH)
			Dr. Win Lae Htut	Assistant Director (SH)
2016/12/19	Mon	⑨	Dr. Phone Maw	Medical Superintendent cum Acting District Medical Officer (DMO), Pakokku General Hospital
			Dr. Theint Ei Thu	Deputy Township Medical Officer (Deputy TMO), Public Health, Pakokku Township
			Dr. Su Mon Naing	Team Leader (Child Health), Public Health, Pakokku Township Health Department
			Dr. Zin Wai Cho	Team Leader (Maternal Health), Public Health, Pakokku Township Health Department
			Daw Paw Tun Tin Khaing	Township Health Nurse, Public Health, Pakokku Township Health Department
		⑩	Dr Ye Khaung	Station Medical Officer (SMO), Myit Chay Station Hospital/Station Health Unit (SHU), Pakokku Township
			Daw Toe Kyi	Lady Health Visitor (LHV), ditto
			Daw Khaing Swe Lwin	Midwife (Thae Yeataw SHC), under Myit Chay Station Health Unit, Pakokku Township
			Daw Khin Lay Myint	Midwife (Nyaung Pin SHC), ditto
			Daw Thu Thu Win	Midwife (Scabe SHC), ditto
			Daw Thein Thein Swe	Midwife (Ba Gyi SHC), ditto
2016/12/20	Tue	⑪	U Aung Soe Lwin	Health Assistant, Lay Daing RHC, Pakokku Township
			Daw Mie Mie Kyaw	Midwife, Lay Daing RHC, ditto
			U Soe Tint	Village Tract Administrator, Lay Daing
			U Swe Chaw	Chair, Elderly Care Support Organization
			U Mya Khaing	Chair, Village-level Charity Organization
			Daw Khin Htay Min	Midwife, Myit Phya SHC under Lay Daing RHC, Pakokku Township
		⑫	Daw Mar San	MCHP cum CHW
			Daw Nwe Nwe Wln	MCHP
			Daw Mar Naing	MCHP
			Daw Cho Win	MCHP
			Daw Nu Yu Aye Aung	MCHP

2016/12/21	**Wed**	⑬	Dr. Tun Aung Kyi	Regional Health Director, Magway Regional Health Department
			Dr. Mon Mon Myint	Deputy Regional Health Director, ditto
			Dr. Khin Maung Than	Team Leader (PHC), ditto
			Dr. Htet Tun Lwin	Team Leader (School Health and Child Health)
			Dr. Aung Ye Paing	Medical Officer (MO), Procurement and Distribution, ditto
			Dr. Chan Myae Aye Thaung	MO, CEU/EPI, ditto
			Dr. Ryay Kyein Kyaw	MO, TB/Leprosy, ditto
		⑭	Dr. Paw Htun	Regional Director, Medical Services, Magway Region cum MS (Medical Superintendant), Magway Regional Hospital
			Dr. Zin Minn Phway	Deputy MS, Magway Regional Hospital
2016/12/22	**Thu**	⑮	Dr. Thura Zaw	Township Medical Officer (TMO), Myaing Township Hospital
			Daw Moh Moh Myint	HA1 (Health Assistant 1), ditto
			Dr. Su Hlaing Myint	Mdical Officer (MO) (MCH), ditto
			Daw Swe Win Maung	MO (BC), ditto
		⑯	Daw Saw Yu	Health Assistant (HA), Kyauk Sauk RHC, Myaing Township
			Daw Ei Ei Htwe	Lady Health Visitor (LHV), ditto
			Daw Swe Win	Midwife (MW), ditto
			Daw Ei Mon Mon Kyaw	Public Health Supervisor II (PHS II), ditto
			Daw Nwe Ni Myint	MW, ditto
				other 7 MWs and 4 PHS II attended (from 7 SHC under Kyauk Sauk RHC, Myaing Township)
2016/12/23	**Fri**	⑰	Dr. Aung Naing Tun	Station Medical Officer (SMO), Let Ya Ma Station Hospital/Station Health Unit (SHU), Myaing Township
		⑱	Daw Moh Moh Kyu	Midwife, Ma Gyi Su SHC, Myaing Township
2016/12/26	**Mon**	⑲	Dr. Hnin Hnin Lwin	Deputy Director (Maternal and Reproductive Health), DOPH
		⑳	Dr. Thuzar Chit Tun	Director (BHS), DOPH
		㉑	Dr. Phyu Phyu Aye	Director (Health Education), DOPH
		㉒	Prof. Myint Han	Director General, Department of Medical Service
			Dr. Moe Khaing	Director, Department of Medical Services

Date			Name	Title / Organization
2017/1/27	Fri	1	Ms. Akiko Tomita	Chief Advisor, The Project for Enhancement of Medical Education
2017/1/30	Mon	2		Global Fund (GFATM mission's briefing meeting)
		3	Krittayawan Tina Boont	UNAIDS Investment and Efficiency Adviser
		4	Dr. Hla Hla Aye	UNFPA Assistant Representative
2017/1/31	Tue	5	Aung Zaw Lin	Save the Children Head of Program (3MDG)
		6	Leah Thayer	Jhpiego Country Director
2017/2/1	Wed	7	Professor Rai Mra	President, MMA
		8	Dr. Pe Win	Senior Manager of Programme Management Department, MMA
		9	Thazin Aung	Programme Director, Charity Oriented Myanmar (COM)
		10	Andrew Cassels	Senior Fellow, Global Health Centre, The Graduate Institute Geneva
		11	Dr. Nu Nu Tha	President, Myanmar Maternal and Child Welafare Association (MMCWA)
		12	Dr. Thet Naing Oo	Executive Committee Member, MMCWA
		13	Dr. May Khin Than	Director / Programme Director, National Nutrition Center, Department of Public Health (DOPH), MOHS
		14	Dr. Lwin Mar Hlaing	Assistant Director, National Nutrition Center, DOPH
2017/2/2	Thu	15	Penelope Campbell	Chief, Young Child Survival and Development Section, UNICEF
		16	Young Hee Min	Country Representative, KOFIH
		17	Kang Hyunggu	Deputy Country Representative, KOFIH
		18	Dr. Hnin Hnin Lwin	Deputy Director, Maternal and Reproductive Health (MRH), DOPH
2017/2/3	Fri	19	Karen Cavanaugh	Director of Office of Public Health, USAID
		20	Ben Zinner	Deputy Director, USAID
		21	Ma Myo Aye	Project Management Specialist (Maternal and Child Health), USAID
		22	Oren Ginzburg	Director, The Three Millennium Development Goal Fund
		23	Panna Erasmus	MNCH Team Leader, The Three Millennium Development Goal Fund
		24	Dr. Masatoshi Nakamura	Chief Advisor, Malaria Elimination Project
		25	Dr. Nan Naing Naing Shein	Deputy Director of NCD, MOHS
		26	Dr Than Win	Acting Director General, Department of Public Health (DOPH), MOHS
		27	Dr. Thuzar Chit Tun	Director, Basic Health Service (BHS), DOPH
		28	Dr. Myint Myint Than,	Director, Child Health (CH), DOPH
		29	Dr. Hnin Hnin Lwin	Deputy Director (MRH), DOPH
2017/2/6	Mon	30	Mya Maw	Health Advisor, DFID
		31	Alaka Singh	WHO
		32	Dr Paw Htun	Medical Superintendent Director, Magway Regional General Hospital (MRGH)
		33	Prof: NweMar Tun	Professor Head, OBGYN, MRGH
		34	Prof: Thi Tar	Professor Head, Pediatrics, MRGH
		35	Prof: Thin Thin Nwe	Professor Head,Department of Medicine, University of Medicine
		36	Dr Cho Cho Win	Senior Consultant, Pediatrics, MRGH
		37	Dr Myo Mo Mo	Senior Consultant, OG, MRGH
		38	Dr Myo Thinn	Senior Consultant, Department of Medicine, MRGH

2017/2/7	Tue	39	Hnin Hnin Pyne	World Bank Senior Health Specialist
		40	Dr Ye Moe Aung	Station Medical Officer, Mon Daung Station Hospital (MDSH)
		41	Dr Me Me Aung Win	Assistant Surgeon, MDSH
		42	U Myint Oo	Health Assistant, MDSH
		43	Daw Htet Htet Lwin	Senior Nurse, MDSH
		44	Daw Khin Khat Khat Kyaw	Trainned Nurse, MDSH
		45	Daw Zin Mar Htay	Trainned Nurse, MDSH
		46	Dr Myat Soe	Medical Superintendent, Minbu District Hospital (MDH)
		47	Dr Hla Win Myint	Association Professor/Child Health, MDH
		48	Dr Zin Mar Win	Specialist Assistant Surgeon, Pediatrician, MDH
		49	Dr Ye Htut	Specialist Assistant Surgeon, Pediatrician, MDH
		50	Dr Aung Ko Min	Junior Consultant Dental Surgeon, MDH
		51	U Than Tun Aung	Township Health Assistant, MDH
		52	Dr Ni Ni Khaing	Senior Consultant, OG, MDH
2017/2/8	Wed	53	U Thet Mon Hlaing	Health Assistant, Oo Yin RHC, Minbu Township
		54	Daw Hnin Ei Hlaing	PHS-II, Oo Yin RHC, Minbu Township
		55	Daw Khin Thuzar Nyein Zaw	PHS-II, Phayar SC, Minbu Township
		56	Daw Thae Su Hlaing	PHS-II, Padaung SC, Minbu Township
		57	Daw Nu Htay	PHS-II, Padaung SC, Minbu Township
		58	Daw San Mu	Midwife, Min Hla Kyin SC, Minbu Township
		59	U Phyo Thu Aung	Midwife, Min Hla Kyin SC, Minbu Township
		60	Daw Hlaing Thwe Oo	Midwife, Than Payar Gai SC,Minbu Township
		61	Daw Zar Zar Nyein	Midwife, Than Payar Gai SC,Minbu Township
		62	Daw Thida Nyein	Midwife, Oo Yin RHC, Minbu Township
2017/2/9	Thu	63	Daw Nu Htay	Midwife, Padaung SC, Minbu Township
		64	Daw Thae Su Hlaing	PHS-II, Padaung SC, Minbu Township
		65	Daw Nyo	Axillary Midwife, Padaung SC, Minbu Township
		66	U Soe Win	Community Health worker, Padaung SC, Minbu Township
2017/2/10	Fri	67	Dr Moe Myint Zaw Win	Township Medical Officer, Township General Hospital, Pwint Phyu Township
		68	Daw Kay Thi Khaing	Lady Health Visitor, Township General Hospital, Pwint Phyu Township
		69	Daw Hlaing Thandar Ohn	Clerk, Township General Hospital, Pwint Phyu Township
		70	Daw Zin Mar Hlaing	Clerk, Township General Hospital, Pwint Phyu Township
		71	Daw Thi Thi Khaing	Clerk, Township General Hospital, Pwint Phyu Township
		72	Dr Thi Thi Aye	Station Medical Officer, Kone Zaung SHU, Pwint Phyu Township
		73	Daw Khin Khin Win	Lady Health Visitor, Kone Zaung SHU, Pwint Phyu Township
		74	Daw Thein Htay Kyi	Staff Nurse, Kone Zaung SHU, Pwint Phyu Township
		75	Daw NweNwe	Staff Nurse, Kone Zaung SHU, Pwint Phyu Township
		76	U Zaw Win	PHS-I, Kone Zaung SHU, Pwint Phyu Township
		77	Daw Thae Nu Aye	Midwife, Kone Zaung SHU, Pwint Phyu Township
		78	Daw Shwe Ye Lin	Train Nurse, Kone Zaung SHU, Pwint Phyu Township
		79	Daw Khin Shwe Hnaung	Train Nurse, Kone Zaung SHU, Pwint Phyu Township
		80	Daw Aye Mya Thu	Train Nurse, Kone Zaung SHU, Pwint Phyu Township

2017/2/13	Mon	81	U Khaing Myo Min	Health Assistant, Kyaung Taw Yar RHC, Pwint Phyu Township
		82	Daw Mai Thein Kyin	Lady Health Visitor, Kyaung Taw Yar RHC, Pwint Phyu Township
		83	Daw Chaw Su Su Win	PHS II, Kyaung Taw Yar RHC, Pwint Phyu Township
		84	Daw Phyu Phwe Kyaw	PHS II, Kyaung Taw Yar RHC, Pwint Phyu Township
		85	Daw Myo Myo Thin	PHS II, Min Myae Sub Center, Pwint Phyu Township
		86	Daw Sandi Maw	Mid wife, Kyaung Taw Yar RHC, Pwint Phyu Township
		87	Daw Sandar Moe	Mid wife, Kyaung Taw Yar RHC, Pwint Phyu Township
		88	Daw Sandar Win	Mid wife, Min Myae Sub Center, Pwint Phyu Township
		89	Daw Than Than Win	Mid wife, Inn Daung Sub center, Pwint Phyu Township
		90	Daw Khin Aye Thwe	Mid wife, Phalan Taw Sub center, Pwint Phyu Township
2017/2/14	Tue	91	Daw Sandar Win	Mid wife, Min Myae Sub Center, Pwint Phyu Township
		92	Daw Myo Myo Thin	PHS II, Min Myae Sub Center, Pwint Phyu Township
		93	U Htay Lwin	Community Health Worker, Min Myae Sub Center, Pwint Phyu Township
		94	Daw Khin Thant Zin	Axillary Mid wife, Min Myae Sub Center, Pwint Phyu Township
2017/2/16	Thu	95	Dr. Kyaw Khaing	Director, International Relations Department (IRD), MOHS
2017/2/17	Fri	96	Dr. Thuzar Chit Tin	Director, BHS, DOPH
		97	Dr. Myint Shwe	Director, NCD Department
		98	Dr. Nan Naing Naing Shein	Deputy Director, NCD Department
2017/2/20	Mon	99	Dr. Hla Mya Thwe Einda	Director, MRH
		100	Dr. Thant Sin Htoo	Assistant Secretary/Director
		101	Dr. Ye Min Htwe	Deputy Director, International Relations Division
		102	Dr. Min Yu Aung	Assistant Director, State Public Health Dept
		103	Dr. Phyu Phyu Aye	Director (Health Literacy Promotion)
		104	Ms. Ei Ei Su	Assistant Director (AD)
		105	Ms. Su Su Naing	AD
		106	Mr. Yojiro Ishii	Chief Advisor (HSS project)
		107	Ms. Mayumi Omachi	Expert on Health Service Delivery, Prj coordinator (HSS project)
2017/2/21	Tue	108	Dr. Thuzar Chit Thin	Director (Health Promotion / BHS), DOPH
		109	Dr. May Khin Than	Director / Programme Director, National Nutrition Center, DOPH
		110	Dr. Kada Kyaw	Medical Officer, National Nutrition Center, DOPH
		111	Dr. Hnin Darli Win	Medical Officer, National Nutrition Center, DOPH
		112	Mr. Chirs Spohr	Principal Social Sector Specialist, Myanmar Resident Mission (MYRM),ADB
		113	Dr. Yin Thandar Lwin	Deputy Director (Public Health), Department of Public Health
2017/2/22	Wed	114	Dr. Than Win	Director General, DOPH
		115	Dr. Myint Myint Than	Director (CH), DOPH
		116	Dr. Hnin Hnin Lwin	Deputy Director (MRH), DOPH
		117	Dr. Mya Lay New	Deputy Director (BHS), DOPH
2017/2/24	Fri	118	Mr. Yuichiro Funai	First Secretary, Embassy of Japan in Myanmar
		119	Mr. Kotaro Nishigata	Senior Represenatative, JICA Myanmar Office
		120	Ms. Kaori Nakatani	Project Formulation Advisor, JICA Myanmar Office