Health Policy Mapping

Myanmar

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Introduction

Different definitions and interpretations of 'health' have implications for health policy. 'Health' is influenced by health care, but more importantly, reflects a wide range of other determinants, such as income, food security, availability of housing and employment opportunities, educational status and water and sanitation. The narrowest conceptions of 'health' see it as a measure of the functional ability of parts of the body. Other definitions see health in slightly less mechanistic terms, reflecting the ability of the body, as a whole, to function. A third, broader definition has been promoted by the World Health Organization (WHO): “a state of physical, mental and social well-being, and not merely the absence of disease or infirmity” (World Health Organization, 1948). Health is seen to relate not only to physical and mental health status, but also to social and economic relationships. The WHO definition has been criticized as idealistic, unachievable and immeasurable, although no alternative notion of 'health' has achieved greater currency.

There are also different perspectives on how 'health' should be viewed by policy makers: as a *right,* a *consumption good,* or an *investment.* Each influences how one perceives the role of different actors in promoting health, notably the relative roles of the individual and the state, a recurring theme in health policy debate. The Constitution of the WHO states that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”. Believing health to be a right provides a basis for a strong government role in promoting its achievement: overcoming the impediments to health gain, such as poverty and health-damaging development activities, promoting equitable access to health care and assuring the quality of available services.

Conceptualizing health as a consumption good focuses on individuals: protecting, promoting or maintaining health is seen as a matter for individual choice. Health as an investment recognizes the influence of the health of individuals, notably those active in the labour market, on productivity and overall development. Health in this context is seen as a means to an end, rather than an end in itself. Historically, governments have intervened in a number of settings to promote the health of the working classes in order to ensure their continued reproduction and productive activities. Seeing health as an investment has been criticized for failing to recognize that improved health status alone does not necessarily raise levels of productivity—complementary actions are likely to be required; and for implying that non-productive members of society are not worthy of such 'investment'.

Health policy 'embraces courses of action that affect the set of institutions, organizations, services and funding arrangements of the health care system.**It** goes beyond health services, however, and includes actions or intended actions by public, private and voluntary organizations that have an impact on health'(Walt,1994). In distinguishing between the health system and the health

care system, the health system reflects the relationships between five major groups of actors: health care providers, the population, the state, the organizations that generate resources and the other sectors that produce services which impact upon health. The health care system, on the other hand, can be seen as the 'vehicle for the organized social response to the health conditions of the population'(Frank, 1994). Much health policy debate focuses on the health care system: the broader health system issues nevertheless need to be constantly kept in mind.

Health systems need to relate to the culture and socio-economic milieu in which they operate. This extends beyond individual providers and consumers' of health care, to an appreciation of systems of accountability and participation. Traditional health care practices have existed in all societies for generations. These systems help maintain the health of individuals and of society at large: traditional practitioners often have important roles in sustaining the culture and belief system of the population.

In the process of colonial expansion, Western concepts of health and health care were actively promoted, notably through churches and missions. Traditional practice has had to compete, increasingly, with Western biomedical practice: more traditional holistic systems are challenged and questioned in respect of their scientific basis, the value of resources spent seeking care from these practitioners, and the effectiveness of their remedies. In Asia, traditional forms of health care proved more resilient in their clash with Western medicine. In China and India, traditional health systems operate alongside Western medicine, although these systems do not necessarily have the same status.

During the colonial days including in Myanmar, organized health care services were initially introduced to care for the needs of the military, civil service and settler communities, it was soon apparent that a *cordon sanitaire* was not possible and that protecting the health of expatriates required addressing health needs among colonized subjects. This was particularly evident **in relation** to communicable diseases: typhoid and tuberculosis in the community were readily brought into the kitchens and nurseries of the colonizers. Economic interests which invested in exploiting natural resources in the colonies often recognized that a healthy workforce was necessary for maximizing wealth production.

Medicine acted in part as an agency of Western expansion. Medical services overseas, particularly between 1815 and the Second World War, were, in part, a 'tool' of the imperial forces, assisting their political, economic and military interests. Some argued that 'going to see the doctor, the administrator, the constable or the mayor [became] identical moves'. While the language of 'settler medicine' was the language of practical public health and professional advancement, the discipline and practice of tropical medicine embodied the discourse of military and political conquest. Tropical health practitioners were encouraged to 'secure the safety and improve the productivity of the British Empire'.

The period after the Second World War was dominated by anti-colonial struggles. With independence came attempts by many newly established regimes to consolidate their power and to

deliver real gains, in the form of social services, education and health care, to their supporters. In many countries these services were provided free of charge to the user, a policy which has, more recently, proved difficult to sustain. A notable feature of Latin American health systems, compulsory health insurance for the employed, developed largely for political reasons; to gain the support of industrial workers and their leaders (Abel-Smith, 1976). Health care provided through employment-based insurance ensured that workers in the formal sector had good access to health care. The unemployed and marginalized, however, were very poorly served, and right wing military dictatorships took their toll in human rights abuses, inequalities and ill-health. Because of the limited supply and quality of charitable and public hospitals, separate hospitals, sometimes quite lavish, were built for a variety of social security funds in many countries (Roemer, 1993). Social security became a divisive rather than unifying force as it reflected the social stratification of the population and covered only a minority (Abel-Smith, 1976).

Popular mobilization and radical theology helped promote concepts of community participation in health and health care. These progressive models were taken up by a variety of social movements across central and southern America: links between poor health and adverse social conditions were made explicit and challenged. A range of innovative community-based approaches were developed in countries of the region; Cuba extended primary health care through its national health system. In China, the barefoot doctors and the somewhat romanticized popular campaigns to eradicate flies, snails and a variety of vector-borne diseases such as schistosomiasis, were an important influence on international health policy in the 1970s.

Experiences in a variety of poor countries greatly influenced accepted wisdom on the means to improve health. In Kerala state (India) considerable health status advances were made despite limited resources: achievements resulted from limited income variation between rich and poor, emphasis on female education, and behavioural factors (Abel-Smith, 1994).

Poor countries such as Sri Lanka, China, Costa Rica and Cuba showed that it was possible to achieve significant health improvement if suitable policies were actively implemented. In Sri Lanka, infant mortality decreased from 175/1000 in 1930 to 32/1000 in 1984; life expectancy increased from 40 to 69 years over the same period. Addressing basic needs (food distribution, free education, poverty alleviation, agricultural investment, public transport, housing, safe water, economic growth, free health services) within a multisectoral framework provides much of the explanation (Hertz *et al.,* 1994).

A number of countries can be said to be **in transition**, experiencing major political and economic changes. The recent spectacular growth of a number of South East Asian countries has challenged the role of the state in the presence of a rapidly expanding private health sector. Malaysia for example, and Thailand to a slightly lesser extent, built up a country-wide network of publicly-provided health services. Growing affluence among consumers together with preferences for private

providers, and pro-market government economic policies, have raised questions regarding the appropriate extent of government involvement in service provision.

The role of the state in addressing issues of inequity has been highlighted in Malaysia, for example, where active attempts to redress a legacy of underdevelopment led to strong state intervention in favor of the Malay population, the bumiputera. One feature of this has been the increased availability of resources for public health services in historically disadvantaged areas. More recent policies of privatizing health services and deregulation will not necessarily consolidate these earlier equity-directed initiatives.

China has changed dramatically over the past decade, as market forces and neoliberal economic discourse have gained acceptance. This has led to a revolution in health care provision and financing: barefoot doctors and 'public' hospitals operate more-or-less as private providers, mass mobilization for disease control is no longer easy, and the collectivized communes and agricultural settlements have been undermined by increased marketization. As highlighted by Bloom *et al.* ,this issue), a key challenge is to ensure that the poor have access to affordable health care; a theme to which we will return.

Related to the development of health policy in industrialized countries, well developed state-dominated health systems have been seeking efficiency gains by separating the roles of purchaser and provider, and encouraging competition between providers. Social-insurance based systems with substantial private provider participation, such as in the Netherlands, France and Germany, have since the 1970s been seeking to contain costs by a combination of supply-side and demand-side measures (Abel-Smith, 1992). More recently they also have begun to look to competitive mechanisms to improve health system performance, though generally without disturbing collective financing arrangements. In Canada, reforms have been directed in part at cost-containment (Rosenberg and James, 1994): as elsewhere, the implications for equity are of concern to some researchers, policy-makers and elements of civil society. In the USA, efforts at radically transforming the financing of health care to ensure universal access have been greatly undermined; there remain ongoing debate, innovation and experimentation in many states.

Reductions in poverty and provision of water and sanitation, employment opportunities and housing, lead to considerable health benefits.. Early public health practitioners were well aware of these environmental influences and promoted improvements in working conditions, housing, pollution control, and water and sanitation as the key public health interventions. Maternal education exerts a particularly significant influence on health, in part from improved economic circumstances and access to health care and other resources, but also reflecting influences on maternal behaviour.

The demographic make-up has changed due to reduced mortality and fertility, population growth and ageing populations. In countries where the demographic and epidemiologic transitions are well advanced, key shifts have occurred: from a predominance of common infections, malnutrition and reproductive events as the leading causes of death to a preponderance of non-

communicable diseases, injuries and new infections; from an emphasis on child to adult mortality, especially among the elderly; from a predominance of mortality to morbidity in defining the overall health status of the population; and in modifications in the social meaning of disease. Life expectancy has increased greatly and the population pyramid has assumed a narrower base.

Health problems associated with alcohol (cirrhosis, violence, road traffic accidents, gastrointestinal complaints), smoking (chronic respiratory diseases, lung, throat and lip cancer), diet (heart disease, obesity, malnutrition, dental caries), and stress (violence, heart disease, gastrointestinal disorders) are also increasing. Grouping them in this way indicates part of the way forward, which necessarily entails 'upstream' actions within and outside the health sector. The shift in disease patterns towards chronic diseases and diseases affecting adults has raised questions as to whether attention should be directed specifically at individuals at high risk or at populations in general. High-risk interventions focused upon individuals may provide a high benefit-to-cost ratio, but little may be achieved at a population level because these high-risk individuals comprise only a small proportion of the total disease experience within a population. The medical profession is more comfortable with the individual-oriented approach, usually practiced on a one-to-one basis within the consulting room. The population approach is, however, far more radical and challenging. Shifting dietary habits, changing sexual behavior, or reducing exposure to violence on a population-wide basis, all require a strong government role in such spheres as taxing tobacco and smoking, regulating living and work environments, public and media educating the, and the pricing, labelling and marketing of food. In order to increase health gain for all sections of society, therefore, relative differences in socio-economic status should be targeted. This finding is important given the evidence that certain macroeconomic and development strategies may increase inequalities in income and access to other determinants of health.

Nature and Form of Health Systems

Despite all that has been written and said on reforming health systems in favour of primary care, health systems in most countries remain biased towards hospitals and curative medicine. Hospitals absorb 50-60 per cent of government recurrent health sector expenditure, and of this hospital expenditure, 60-80 per cent often goes to central and general hospitals leaving district hospitals with a small share . In the poorest countries, heavily reliant on external assistance, donor funds support primary and preventive care, while government funds support the hospital infrastructure. Public health suffers from low status within the medical profession, which tends to dominate resource allocation decisions. The medical profession operates in a similar way in many countries: systems of medical education, exchange of academic and professional views through academic journals, and the reliance on medical technology, are remarkably similar across the globe. In virtually all settings it is the clinicians, not the public health planners and policy makers, who influence the allocation of resources within the health sector. One of the main thrusts of health sector reform is arguably an attempt to wrest control away from the profession, and to place it in the hands of managers. The long-term impact of this has yet to be assessed.

Health systems in the poorest countries remain predominately publicly financed and provided, although there is an expanding private for-profit sector (consisting mainly of individual practitioners) even in the poorest countries.

In wealthier countries, a rapidly expanding private sector, encompassing individual practitioners, hospitals, and high technology diagnostic services, is common. Few low and middle income countries have got to grips with regulating the private sector. Private providers in these settings operate with much greater freedom than they would in developed countries, leading to problems of cost inflation, overcharging, and low-quality care amongst certain providers. There is widespread agreement that the public sector requires reform. Allocative and technical inefficiencies have led to sub-optimal use of scarce resources. As public funds have been squeezed, partly in response to macroeconomic reforms and structural adjustment programmes, the quality of care offered in many settings has deteriorated; drug supplies, for example, are often erratic or drugs inappropriately prescribed, and poorly paid staff are unable to offer the caring service users demand. Managerial skills warrant improvement; staff establishments need pruning; accountability and transparency need to be increased.

Financing of Health Services

In recent years, innovative and more powerful medical technologies have transformed medical practice. The availability of funds to purchase such technologies, in both high and low income countries, is increasingly limited. In the poorest countries a gross lack of resources places a cap on expenditure; in others, health systems have suffered from inflationary pressures, which have greatly increased the unit costs of delivering services. Many countries have sought to relieve funding constraints by seeking additional sources of revenue. User fees (or co-payments in insurance systems) have been one of the most popular policies. In many countries with tax-based funding, there has been considerable interest in compulsory insurance. It is viewed in effect as an earmarked tax, less vulnerable than general public revenue to cuts and macroeconomic policy changes.

Worldwide, efforts have been widespread to contain the costs of expanding health sectors and to ensure that greater impact is achieved from funds invested. Inflationary pressures have been worst in insurance-based systems with third-party fee-for-service payment: some such systems have reformed their payment systems (involving case-based payment or capitation), with some success. Control of the introduction of new technology has proved problematic: for example, South Korea has three times the ratio of CAT scanners to population as Canada, and the city of Bangkok a higher ratio than any developed country except the US and Japan.

Increasingly, emphasis is also being placed on improving operational efficiency. Views differ, however, as to whether the solution is to be found in improved management systems, or the introduction of market approaches such as competition. It should be noted that there is little evidence that private health care is more efficient, neither is it likely to promote equity objectives. Despite efforts to increase health sector efficiency and revenue, availability of funds remains a major constraint on health policy formulation. Increasingly the emphasis is being placed on setting

priorities and rationing care, especially for those services financed by the state. Hence means of priority setting are becoming a major issue, an issue discussed below.

Approaches to Health Planning and Priority Setting

Since the 1960s, there has been increasing emphasis on planning health system development, rationalizing resource use and setting priorities. Sustained interest in 'rational' planning methods first appeared in the 1960s, stimulated by developments in corporate planning systems in private industry and health planning methods developed in the command economy of the USSR

An early approach was developed by the Pan American Health Organization and the Centre for Development Studies in Venezuela (hence referred to as PAHO/ CENDES). This explicitly recognized the scarcity of resources and was based on economic principles of cost-benefit analysis: resources should be used in activities where net benefits (benefits minus costs) are greatest. Because of the difficulties of quantifying benefits, however, the objective of minimizing deaths given a fixed budget dominated.

Abel-Smith (1994) critiqued such 'economic rationality'. He argued that such a simple objective was unacceptable to doctors, the public and politicians: it raised concerns about medical care for conditions not leading to death, about the acceptability of making priorities explicit, and about equity if cost-effectiveness criteria led to resources being concentrated in particular geographical areas. Moreover, information was simply not available to judge cost-effectiveness. Despite widespread training in the approach, it was never applied much in practice, and thus presumably did not meet the needs of planners and politicians at that time.

In the late 1960s, WHO was active in developing planning approaches. Its first attempt, Country Health Programming, followed the conventional rational planning cycle of situation analysis, identification of needs, formulation of health policies and strategies, broad programming (to develop strategic plans) and detailed programming. Country Health Programming activities were carried out in a number of countries, particularly in South East Asia supported by WHO staff and consultants. By the late 1970s, there was considerable doubt about its value: despite the enormous amount of information collected, plans were developed that were neither affordable nor implemented. A new approach, the Managerial Process for National Health Development, was adopted which deliberately avoided the term 'planning', introduced consideration of resource availability earlier in the cycle, and included the steps of budgeting and implementation. .

By the 1980s, considerable disillusionment had developed with rational planning methods in both rich and poor countries. Decisions made bore little relationship to plans, and technical analysis was increasingly recognized to be only one input to decision making, a point explored recently in an analysis of policy choice in low income countries. The political and incremental nature of planning decisions was more explicitly recognized. In addition, planning systems which had been developed in the context of a strong public presence in health care financing and provision were less relevant in the context of a reduced state role, deregulation and liberalization.

Key Actors

A variety of important actors influence health policy: at country level they include the professionals, the managers, policy-makers, commercial interests, nongovernmental organizations, communities, and civil society more generally. At the international level, key roles are played by bilateral and multilateral organizations, the worldwide network of medical professionals, and transnational corporations, notably those involved in the pharmaceutical and medical technology industries.

Since its establishment in 1948, one key health policy event associated with the WHO was the promotion of primary health care in 1978. A radical agenda was put forward for equitable health care available to all and promoted worldwide. It called for a significant degree of intersectoral collaboration, the promotion of development across all sectors, and a high degree of popular participation. The rhetoric and discourse of PHC have profoundly shifted debates around health policy; achievements have been many, but 'Health for All by the Year 2000', remains a distant dream.

Intense debates took place about whether primary health care should be 'selective' or 'comprehensive'. Selectivity implied identifying and promoting a small range of highly cost-effective, health sector-based strategies to promote health, such as childhood immunization. Comprehensive primary care entailed focusing on a wider range of approaches to promoting health, seeing the importance of multisectoral and development-oriented activities, providing a broader range of health service inputs at peripheral levels, instead of focusing only on a narrowly defined set of highly cost-effective interventions.

It sees the government as its client, a welcome alternative to approaches which place the provider of services, often the private sector, at the centre. In the years to come, developing government skills in devising an appropriate mix of public and private services, developing the government regulatory and quality assurance roles, ensuring universal access to at least basic health care and equitable distribution of public resources, would benefit from a strong WHO.

The World Bank has also rapidly emerged in the health policy arena, where *Investing in Health* pulled together the various strands of World Bank health sector policy-making and outlined a comprehensive package aimed at improving the functioning of the health sector in countries. This was based partly upon estimating the global and national burdens of disease, and involved identifying the most cost-effective health-related interventions currently available, reducing the role of government, providing a minimum package which meets the needs of the poor, deregulating the health care industry and facilitating the involvement of the private sector.

Future Challenges as we approach the Millennium

Policy Analysis

Understanding the reform process in individual countries will depend upon increasing our understanding of the political economy of health and of the factors driving health policy at a variety of levels. A range of desirable reforms have been spelt out by a variety of health policy actors; what is less clear is what range of options to use in what context and to what effect. Some have also

argued for more attention to policy analysis both in order to understand and to predict the likely success of a given range of measures. Developing methods of policy analysis for use within the health sector will assist the processes of agenda setting, policy formulation, policy implementation and evaluation. The implementation of policy is perhaps even more important than its statement and formulation: what happens on the ground, not simply what is stated in the media or on paper, needs to be the measure of policy content and commitment. Increasing awareness of policy processes is of value in determining the degree of support and opposition, by various stake-holders, for a particular policy, and will be of use in determining which of a range of options has the greatest chance of successful implementation. It may also be of value in examining the consequences of policy choices; issues such as the impact on equity can be kept high on the agenda by continually reassessing their impact.

Evidence-Based Policy Making

Improvements in the availability of technical information, such as national and global burdens of disease, and the cost effectiveness of available interventions, are valuable. At the same time, however, it is necessary to recognize explicitly their limitations and to appreciate that policy is only in small part driven by data. Good quality data are a necessary but insufficient basis for policy choices, and priority-setting and decision-making systems need to be sensitive to local concerns which operate on other, less quantifiable levels.

In relation to any of the policy options put forward, there is a need for careful evaluation and documentation, not only of content, but of processes and, where possible, impact. Such impacts may be desirable or undesirable, anticipated or unanticipated: all bear examination. A recent study in Papua New Guinea, for example, indicated that decentralization may have negative effects, contrary to intuition (Campos-Outcalt *et al.,* 1995). In particular, the authors note that if decentralization is to be successful, a longer period of planning, defining and clarifying responsibilities, training, preparation and implementation is required: this comment is relevant to all major reforms.

Pilot testing should be encouraged and the focus should be not simply on health effect, but on perceptions, attitudes, processes systems and institutions. We call for those promoting significant policy changes to ensure that their effects are carefully monitored and to give adequate priority to research and building research capacity. Evidence-based policy-making should be as actively promoted as evidence-based health care.

Increasing Accountability and Sensitivity

Donors are more and more explicit about promoting good governance, democratic processes and increased transparency and accountability. For the health sector, these concerns are relevant in that health systems and decision-making processes need to reflect local concerns and preferences and need to take on board a sensitivity not just to content but to process. Mechanisms of ensuring accountability to local representative structures, an issue raised in earlier debates on primary health care, should be developed and enhanced. The role of elected local government is likely to be

increasingly important, especially in the context of decentralized decision making, priority setting and control of resources.

Promoting and Protecting Equity

Virtually most commentators on health policy, recognize the importance of promoting equity through policy change. What differs between the Development Partners, however, is how much weight, attention and resources are directed at protecting and promoting equity concerns, and what strategies are suggested. While a number of policy reforms identify equity as an objective, it is often unclear whether this is met. Indeed there is emerging evidence, for example, of the adverse effects on equity of the introduction of user fees, of structural adjustment policies, and of privatization. There is little evidence that resource mobilization through, for example, user fees has led to an increase in public sector support to the poorest. The state has a major role to play in ensuring equity is not sacrificed.

Equity on a geographical and class basis is important; so too is gender. Increasing attention needs to be devoted to the gender dimensions of health needs and health policy formation. The NGOs have been at the forefront of focusing attention on gender dimensions of policy and policy reforms; analysing the likely impact of policy reform on gender issues should be a basic consideration in assessing policy options.

Myanmar Framework for Economic and Social Reform

Myanmar National Health Policy has been adopted since 1993, based on prevailing political, socio-economic, health system development of the country at that time; and also based on consequences of decades of country's experience on health system and health care services. As the country is rapidly moving into a new dimension of socio-economic and political system, national policy reform process is undertaking under 'Framework for Economic and Social Reform - FESR'.

In this regard, FESR is an essential policy tool of the government to realize both the short-term and long-term potential of Myanmar. First, it provides a reform bridge linking the ongoing programs of government to the National Comprehensive Development Plan, a 20-year long-term plan, which the government is drawing up in consultation with parliament for the country's economy to grow on a par with the dynamic Asian economies. Secondly, FESR serves as a required reference for various entities of the government to develop more detailed sectoral and regional plans. Third, it conserve as a guide for building lasting cooperation with development partners as well as international bodies to obtain mutual benefits. Last but not least, it focuses on potential "quick wins" that the government will consider implementing to bring tangible and sustainable benefits to the population.

Chapter 5 of the Framework comprises of sectoral policies, largely developed by line ministries and departments and with a primary objective of collectively contributing to people-centered development and inclusive growth. FESR emphasizes the importance of rapidly improving both the quantity and quality of primary health care and basic education in Myanmar. International

experience confirms the critical importance of such improvements as well as the possibility for "quick wins" with respect to innovative health financing, school grants and student stipends/conditional cosh transfers. In respect of h*ealth financing*, GOM will focus on a number of innovative measures in health financing such as a voucher system for maternal and child health care, special funds for destitute mothers and strengthening township-level health financing. Particular attention will be paid to allocating more resources to rural primary health care, infectious disease controls and maternal and child health, in view of the acute need to improve health indicators in all these areas.

In reviewing and revising, it is critical to have a sound understanding of the developmental evolution of the existing health policies. As such a summary of the evolution of the global health policies and its reform has just introduced and will now proceed with the national perspective. As the main intent is to facilitate in systematic review of the policy brief, the presentation is divided into three chapters. First chapter confine with policies, strategies and plans of currently operating health program. All attempts have been made to retrieve the historical background of emergence of the problem and its intervention strategies, if records available starting from the colonial days. It is crucial to perceive the then cultural background in shaping up the policy of the future challenges. It is an obligatory approach as the country's morbidity and mortality pattern has rapidly moved more towards non-communicable diseases and the principal determinant factor where the legislation has a huge limitation is the lifestyle and behavior of the people especially the young and mid-aged population of the nation. It is then followed with second part on mapping the health policies and plans, identifying the strengths and weaknesses and areas that need further strengthening. This part is presented in six building blocks to have a more coherent visualization of policy mapping. Part three comprises of the existing laws, legislations, notifications and orders related to health. Though all effort have been made to include all policies that related to health, there may still be more to cover the concepts of Health in All Policies – HiAP.

National Constitution and Health Policy

National Constitution

Policy guidelines for health service provision and development have also been provided in the Constitutions of different administrative period. The following are the policy guidelines related to health sector included the Constitution of the Republic of the Union of Myanmar (2008). In the Article 28 it stated as, 'The Union shall (a) earnestly strive to improve education and health of the people, and (b) enact the necessary law to enable National people to participate in matters of their education and health. In the article 32 it stated as, 'The Union shall: (a) care for mothers and children, orphans, fallen Defence Services personnel's children, the aged and the disabled'; in article 351, it stated as, 'Mothers, children and expectant women shall enjoy equal rights as prescribed by law;' and in article 367, it stated as, 'Every citizen shall, in accord with the health policy laid down by the Union, have the right to health care'.

Based on the constitutional provision and in line with the then prevailing health condition, political, socio-economic environment, **the National Health Policy 1993**, was developed with the initiation and guidance of the National Health Committee. The National Health Policy has placed the Health For All goal as a prime objective using Primary Health Care approach. The National Health Policy is designated as follows:

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

Reflections on Health in the Previous National Constitution

It is interesting to note that the constitutional mandates on health has generally been consistent from the day country attained the independence. The right to health is the common stand throughout for the nation. It has persistently accorded a well touched space for mothers and children.

1947 Constitution

Article 33

The State shall direct its policy towards securing to each citizen the right to work,

(i). the right to maintenance in old age and during sickness or loss of capacity to work

(ii). the right to rest and leisure and to education in particular the State shall make provision for free and compulsory primary education.

Article 36

The State shall regard the raising of the standard of living of its people and the improvement of public health as among its primary duties.

Article 37

1. The State shall ensure that the strength and health of workers and the tender age of children shall not be abused and that they shall not be forced by economic necessity to take up occupations unsuited to their sex, age and strength.
2. The State shall specially direct its policy towards protecting the interests of nursing mothers and infants by establishing maternity and infant welfare centres, children's homes and day nurseries and towards securing to mothers in employment the right to leave with pay before and after child birth.

Article 38

The State shall promote the improvement of public health by organizing and controlling health services, hospitals, dispensaries, sanatoria, nursing and convalescent homes and other health institutions.

Article 39

The State shall take special care of the physical education of the people in general and of the youth in particular in order to increase the health and working capacity of the people and in order to strengthen the defensive capacity of the State.

Article 40

The State shall ensure disabled ex-Servicemen a decent living and free occupational training. The children of fallen soldiers and children orphaned by wars shall be under the special care of the State.

1974 Constitution

Article10

The State shall cultivate and promote the all-round physical, intellectual and moral development of youth.

Article149

Every citizen in sickness shall have the right t to medical treatment as arranged by the State.

Article 151

(a) Every working citizen shall e enjoy benefits as prescribed by law for injury due to occupational accidents or when disabled or sick or old.

Article154

(a) Women shall enjoy equal political, economic, social and cultural rights as men.

(b) Mothers, children and expectant mothers shall enjoy those rights prescribed by law.

Planned Programming

Introduction

Based on Primary Health Care approaches the Ministry of Health has formulated four yearly People's Health Plans from 1978 to 1990 followed by the National Health Plans from 1991-1992 to 2001-2006. These plans have been formulated within the frame work of National Development Plans for the same period. National Health Plan (2006-2011) in the same vein is formulated in relation to fourth five year National Development Plan. It is also developed as a continuation of the previous National Health Plan (2001-2006) in the objective frame of the short term second five year period of the Myanmar Health Vision 2030, a 30 year long term health development plan.

Considering the rapid changes in demographic, epidemiological and economic trends both nationally and globally, Myanmar Health Vision, a long-term (30 years) health development plan has been drawn up to meet any future health challenges. The plan encompasses the national objectives i.e. political, economic and social objectives of the country. This long term visionary plan with its objectives will be a guide on which further short-term national health plans are to be developed. The objectives of the Myanmar Health Vision 2030 are:

- To uplift the Health Status of the people.
- To make communicable diseases no longer public health problems, aiming towards total eradication or elimination and also to reduce the magnitude of other health problems.
- To foresee emerging diseases and potential health problems and make necessary arrangements for the control.
- To ensure universal coverage of health services for the entire nation.
- To train and produce all categories of human resources for health within the country.
- To modernize Myanmar Traditional Medicine and to encourage more extensive utilization.
- To develop Medical Research and Health Research up to the international standard.
- To ensure availability in sufficient quantity of quality essential medicine and traditional medicine within the country.

- To develop a health system in keeping with changing political, economic, social and environmental situation and changing technology.

The National Health Plan (2006-2011) has been developed around 12 broad programmes, covering Community Health Care, Disease Control, Hospital Care, Environmental Health, Health System Development, Health Promotion, Health Management Information System, Human Resources for Health Development, Health Research, Laboratory Services and Blood Safety, Food and Drug Administration and Traditional Medicine.

NHP Process

In formulating the NHP the Ministry of Health have formed the central committee and working committee, comprising responsible persons from the departments under the ministry, related ministries and social and nongovernmental organizations to undertake plan formulation activities in a coordinated way. The department of health planning is a focal department for formulating the NHP.

National development programmes are based on political, economic and social objectives laid down by the State. Health sector development plans are formulated within the context of these objectives. In implementing activities for health sector development the objectives of the Ministry of Health are "to enable every citizen to attain full life expectancy and enjoy longevity" and "to ensure that every citizen is free from diseases".

For fulfilling these objectives in accordance with the National Health Policy, priority has been given to border areas where development had is still in need, in addition to the rural areas, to ensure universal access to health services based on Primary Health Care. In accordance with market economy practiced in national development activities, involvement of cooperatives and private sector in health sector development is also taken into consideration.

Though facing and tackling problems relating to communicable diseases like other developing nations, prevalence, disability and deaths from non-communicable diseases like cardiovascular diseases, malignancies and mental illness are expected to be on the rise with changes in social status and life styles of the people following development and affluence of the country. Negative impact on environment consequent to industrialization and urbanization, is foreseen and partnership with related departments and organizations are promoted so that environmental health problems including water and air pollution and occupational health problems in addition to those consequent to existing environmental hazards can be solved.

The following factors provide the basis for identification of country health problems

(a) Policy guidelines and framework for the National Health Plan

(b) Problems related to service provision

(c) Problems related to human resources for health

(d) Problems related to traditional medicine

(e) Problems related to health research

(f) Country's health problems as evidenced in the National Health Information System

(g) Country's health problems as evidenced from in country research and surveys

(h) Key out puts of the National Health Plan 2001-2006 evaluation

Broad objectives for the National Health Plan have been developed within the confine of the objectives of Myanmar Health Vision 2030, a thirty year long term visionary health plan. Besides, objectives of the previous national health plans for the period since 1993-1996 were also taken into consideration in developing the objectives for the current national health plan.

The broad objectives of the National Health Plan adopted are as follows:

- To facilitate the successful implementation of the social objective, "uplift of health, fitness and education standards of the entire nation"
- To implement the National Health Policy
- To strive for the development of a health system, that will be in conformity with political, economic and social evolutions in the country as well as global changes
- To enhance the quality of health care and coverage
- To accelerate rural health development activities

Indicators applied in the previous national health plans, were taken as the basis in identifying indicators. Indicators for these previous plans had been developed within the premise of achieving Health for All goals. As for the current plan consideration has been given to achieving Millennium Development Goals in addition. Target indicators adopted are as follows:

- Health service indicators
- Health status indicators
- Nutritional indicators
- Environmental health indicators
- Health outcome/impact indicators

National Health Plans have been formulated with the concerted and collaborative efforts of responsible personnel from the departments under the ministry of health, health related departments, and volunteer social organizations. For formulating the National Health Plan 2006-2011, the ministry of health has formed the "central committee for formulating national health plan" to provide coordination and support necessary, and the "work committee for formulating the national health plan" for drawing up the plan, in September 2005.

The "central committee for formulating the national health plan" is headed by the minister for health with the membership of directors general from health and related departments, responsible personnel from non-governmental, social and volunteer organizations. Director General of the department of health planning is assigned as the secretary of the committee. The "work committee for formulating the national health plan" is chaired by the director general of the department of health planning with the membership of directors and programme directors from the health departments. The work committee has developed the framework for developing the national health plan under the guidance of the central committee and the following factors have been taken into consideration in developing the framework:

- Social objectives of the state
- National health policy
- Objectives of the ministry of health
- Myanmar health vision 2030 (30 year long term health development plan)
- International health agenda
- Activities in the National Health Plan 2001-2006 that are to be carried on. Based on the factors mentioned, the National Health Plan 2006-2011 is formulated according to the following stages:
- Holding a "Workshop for Developing the National Health Plan 2006-2011"
- Detailed formulation of the plan
- Inalizing the National Health Plan formulation

Each of 12 broad programmes was composed of projects and project managers are again assigned for each project. Every project managers and programme directors are provided with the NHP document. As such dissemination and clarification of roles and responsibilities seem inadequate. Since the current NHP is formulated in connection with previous NHPs and most of the project managers have experience with implementing their respective projects, only the newly assigned managers need orientation and clarification.

Information System for Monitoring and Evaluating NHP - Health Management Information System has been in place since 1995. Monitoring and evaluation of NHPto certain extent is based on this information system. However availability of timely, reliable and complete data and information is still a challenge. Besides, most of the data available are institutional based. The need to further promote application of computers in relation to health data, inadequate conceptual knowledge on health information in basic health staffs and inability to provide maintenance for computer network system and components because of inadequate skills of users were the shortcomings encountered.

Currently, annual evaluation is only the means available and implemented for review and formulation of successive NHPs.

Primary Health Care and Health System Strengthening in NHP - Primary health care is addressed through inclusion of a community health care programme. Likewise Health system development programme is included with the objective of strengthening health system. Overall in process of plan formulation, inclusiveness is confined mostly to governmental sector and at the central level. There still is a need for involving other remaining stakeholders particularly the academia. The process also is limited mostly to formulation and approval. The remaining stages though included are less dynamic.

Linkage with other policy/plans - NHP is developed as a means to implement theNational Health Policy. National Health Policy in turns provides the policy basis for formulating the NHP. NHPis intended to provide frame and guidance for sub-national and vertical plans. To what extent there are consistency and synergies with other plans and strategies in place is questionable and still need to be determined.

Health infrastructure, particularly provision of public health services and basic health services, is oriented towards PHC approach. In addition the National Health Policy explicitly stated the adoption of PHC approach in attaining Health for All. Functional referral system to higher level of care is ensured with the inclusion of one project "primary medical care and referral of patients" in one broad programme "community health care". Deployment and distribution of human resources is also oriented towards PHC approach. Successive NHPs have been developed within the framework of overall national development plans.

Integrating health activities of other sectors - Ministry of health is the main and major provider of comprehensive health care. NHP in this context provides the framework for health efforts of other sectors. A thorough assessment of the mechanism for the integration and extent and effectiveness of the framework of the NHP willfurther provide measures needed to be taken to improve the integration.

Link with the budget and medium term expenditure framework - NHPdocument includes assessment and determination of financial requirement. However State budget procedures and financial requirement for implementing NHP activities are developed and implemented separately. This is the area to be strengthened both in technical and managerial aspect, if the plan is to be adequately resourced and implemented. However, financial requirement for programme implementation could be estimated according to the work-plans with respective agencies like WHO, UNICEF and UNFPA.

Summary of NHP Process

NHPs are formulated within the guidelines and policy frame of the State. Sectoral involvement in formulating the current NHP is limited mostly to the governmental sector. Previous health plans have been formulated using Country Health Programming approach. Since then formulating successive NHPs have been based on adapting this approach. Sectoral involvement that used to be strong initially in the process of formulation need to be sustained and strengthened. Involvement of remaining stakeholders is also necessary and need to be encouraged. Process is mostly confined to plan formulation with remaining stages still limited.

National Health Plan (2011-2016)

Based on Primary Health Care approaches the Ministry of Health had formulated four yearly People's Health Plans from 1978 to 1990 followed by the National Health Plans from 1991-1992 to 2006-2011. These plans have been formulated within the frame work of National Development Plans for the corresponding period.

National Health Plan (2011-2016) in the same vein is to be formulated in relation to the fifth five year National Development Plan. It is also developed within the objective frame of the short term third five year period of the Myanmar Health Vision 2030, a 30 year long term health development plan. With the ultimate aim of ensuring health and longevity for the citizens the following **objectives**

have been adopted for developing programs for the health sector in ensuing five years covering the fiscal year 2011-2012 to 2015-2016.

- To ensure quality health services are accessible equitably to all citizens
- To enable the people to be aware and follow behaviors conducive to health
- To prevent and alleviate public health problems through measures encompassing preparedness and control activities
- To ensure quality health care for citizens by improving quality of curative services as a priority measure and strengthening measures for disability prevention and rehabilitation
- To provide valid and complete health information to end users using modern information and communication technologies
- To plan and train human resources for health as required according to types of health care services, in such a way to ensure balance and harmony between production and utilization
- To intensify measures for development of Traditional Medicine
- To make quality basic/essential medicines, vaccines and traditional medicine available adequately
- To take supervisory and control measures to ensure public can consume and use food, water and drink, medicines, cosmetics and household materials safely To promote in balance and harmoniously, basic research, applied research and health policy and health systems research and to ensure utilization as a priority measure
- To continuously review, assess and provide advice with a view to see existing health laws are practical, to making them relevant to changing situations and to developing new laws as required
- In addition to providing health services, to promote collaboration with local and international partners including health related organizations and private sector in accordance with policy, law and rules existing in the country for raising the health status of the people

Consequently, to achieve these objectives current National Health Plan (2011-2016) is developed around the following 11 program areas, taken into account prevailing health problems in the country, the need to realize the health related goals articulated in the UN Millennium Declaration, significance of strengthening the health systems and the growing importance of social, economic and environmental determinants of health. For each program area, objective and priority actions to be undertaken have also been identified.

Program Areas

1. Controlling Communicable Diseases
2. Preventing, Controlling and Care of Non-Communicable Diseases and Conditions
3. Improving Health for Mothers, Neonates, Children, Adolescent and Elderly as a Life Cycle Approach
4. Improving Hospital Care

5. Development of Traditional Medicine
6. Development of Human Resources for Health
7. Promoting Health Research
8. Determinants of Health
9. Nutrition Promotion
10. Strengthening Health System
11. Expanding Health Care Coverage in Rural, Peri-Urban and Border Areas

Framework for Economic and Social Reforms (FESR)

(Policy Priorities for 2012-2015) (September -2012)

As recently as 2011, Myanmar was still labelled as a pariah state. A year after a series of politically liberalizing measures were introduced, a "second stage of reforms" took place in May 2012, focusing on the social and economic transformation of Myanmar. In accordance with the vision and guidelines of the President, the Framework for Economic and Social Reforms (FESR) was developed in consultation with senior officials of various ministries and departments of the government from the period of May to October, 2012. This revised draft of FESR outlines policy priorities for the government in the next three years while identifying key parameters of the reform process that will allow Myanmar to become a modern, developed and democratic nation by 2030.

In this regard, FESR is an essential policy tool of the government to realize both the short-term and long-term potential of Myanmar. First, it provides a reform bridge linking the ongoing programs of government to the National Comprehensive Development Plan, a 20-year long-term plan, which the government is drawing up in consultation with parliament for the country's economy to grow on a par with the dynamic Asian economies. Secondly, FESR serves as a required reference for various entities of the government to develop more detailed sectoral and regional plans. Third, it con serve as a guide for building lasting cooperation with development partners as well as international bodies to obtain mutual benefits. Last but not least, it focuses on potential "quick wins" that the government will consider implementing to bring tangible and sustainable benefits to the population.

FESR has twelve chapters, starting in the first chapter with an introduction on the background to and sources of the proposed reforms. After reviewing recent developments in Chapter 2, FESR articulates the broad goals of the reforms as well as specific objectives the government is targeting in the medium term in Chapter 3. A key set of macroeconomic policies to promote inclusive growth, stability and poverty reduction is highlighted in Chapter 4. 5ectoral policies, largely developed by line ministries and departments and with a primary objective of collectively contributing to people-centred development and inclusive growth are compiled in Chapter 5. Chapters 6, 7 and 8 address a wide range of other necessary policy conditions conducive to achieving people-centred development and inclusive growth; e.g. social, cultural and environmental aspects of development, national harmony and regional development, and improving governance. Chapter 9 outlines strategies for Myanmar to reposition herself in the international community through strategic engagements with

neighbouring economies, the ASEAN Economic Community (AEC), the Greater Mekong Sub-region and the rest of the world. Chapter 10 summarizes the required changes in the magnitude and composition of public expenditure and the likely sources of financing. Chapter 11 details policies on synchronizing the division of labour for devising necessary reforms between parliament and other key stakeholders, developing an effective aid management framework, as well as consultative mechanisms with civil society actors. The final chapter of FESR describes how the reforms outlined in this document will be implemented, monitored and evaluated.

Quick Wins - In each of the major areas of economic and social reform, the FESR discusses the Government of Myanmar's (GOM) overall approach and actions already undertaken and then goes on to set out the policy agenda for the coming three years, focusing on immediate actions or "quick wins" as well as on those issues which require more analysis and/or consensus building before specific decisions can be taken. The following paragraphs summarize some of the quick-wins that will guide the country to succeed not only in her transitional reforms but also to set sound foundations for medium and longer-term development transformation, which will essentially change Myanmar into a modern, developed and democratic country.

Few of the selected health sector related components are as follows, and the whole executive summary of the document is presented in section II.

Health and Education - FM emphasizes the importance of rapidly improving both the quantity and quality of primary health care and basic education in Myanmar. International experience confirms the critical importance of such improvements as well as the possibility for "quick wins" with respect to innovative health financing, school grants and student stipends/conditional cash transfers.

Health financing- In the health sector, GOM will focus on a number of innovative measures in health financing such as a voucher system for maternal and child health care, special funds for destitute mothers and strengthening township-level health financing. Particular attention will be paid to allocating more resources to rural primary health care, infectious disease controls and maternal and child health, in view of the acute need to improve health indicators in all these areas.

Food Security and agricultural growth - Given a high percentage of agricultural contribution to GDP and employment in the country, agricultural growth is critical for inclusive development. GOM will ensure that food security is achieved throughout the country, and will develop strategies that will channel benefits of reforms and growth strategies towards helping improve the welfare and income of farmers, farm labourers and their dependent families. Immediate measures on boosting agricultural productivity can be achieved by increasing extension services and government loans, removing barriers throughout the supply chain and promoting demand-oriented market support mechanisms, which will pave the way for long-term structural and institutional reforms needed in the sector. Options for improving agricultural performance in the near term centre around the following key interventions: improving productivity of rice sector (through improved seed quality, better agronomic practices, optimized fertilizer and input dosages, and integrated pest management); promoting dry season diversification into high-value horticulture, fresh fruits, poultry and small

livestock by both small farmers and landless; improving water management at the farm level through low-cost micro-irrigation and expanding micro-finance activity in rural areas, to improve access to inputs and reduce reliance on money lenders.

Governance and Transparency - From its very inception last year, GOM has been emphasizing the importance of "good governance, clean government" and international experience certainly reinforces the fundamental importance of positive and sustained interventions to improve governance for both growth and poverty reduction. The government has already taken a series of actions to improve governance and FESR lays out a range *of* future actions the government proposes to take across the core areas of public administrative reforms, information access and transparency, control of corruption, rule of law and participation and consultation. In many of these areas, implementation of specific actions will need to wait until strategies have been prepared or laws have passed. In the interim, therefore, it is important to consider what further actions can be taken immediately in the form of quick wins. In this regard GOM intends to move ahead with the following actions.

National Budget Transparency - Budgets are a critical link for citizen participation in the new democratic process of national development; and international experience certainly shows that civil society engagement can significantly improve budget processes, decisions and outcomes and thus transform the lives of people. To make this possible, international experience also demonstrates the critical importance of at least eight key budget documents being released to the public and made available for discussion, namely the pre-budget statement, executive's budget proposal, enacted budget, citizens' budget or guide to the budget for citizens, in-year reports, mid-year review, end-year report, and audit report. In this regard and building on the progress made last year, GOM will consider preparing, publishing and making easily accessible for citizens as many of these reports as possible.

FESR represents a fist bold initiative of the Government of Myanmar to reform an economy once predicted as doomed. As such, FESR is a starting point, not the end point of various initiatives that the country will undertake in the next few months. It is also subject to public consultation, comments and criticisms; therefore, FESR will serve as a roadmap for continuous improvement of reform strategies for the next three years, and it looks forward to deepening the planning process as well as covering new areas for reform in guiding Myanmar on to a path of restoring the glory and growth she has enjoyed in a long period of her history.

In short it may be summarized as:

- Sustained industrial development in catching up with global economics while keeping up momentum of agricultural reforms and attaining poverty alleviation and rural development
- Equitable sharing of resources, budgetary or foreign aids, among regions and states while promoting foreign and local investment for regional development.
- Effective implementation of people-centred development through community-driven, participatory approaches to improvement of education, health and living standards

- Reliable and accurate statistics and information to inform public policy decisions

National Comprehensive Development Plan - Health Sector (2010-11 to 2030-31)

As an integral component of the long-term visionary plan, the National Comprehensive Development Plan (NCDP) - Health Sector (2010-2011 to 2030-2031) has been formulated based on changing situation. The formulation of the NCDP must link with related sectors as well as also link with the States and Regional Comprehensive Development Plans. This long term visionary plan with it objectives will be a guide on which further short-term national health plans are to be developed. So also it links with the Spatial Planning.

With the objective of uplifting the health status of the entire nation, the State *has* provided policy guidance for implementing health development activities through the National Health Plans. With expansion of health services to improve the health care coverage including hard to reach and remote border areas, promoting quality of health care services with competent health care providers by using advanced technologies and modernized equipment, improving socio-economic standard and health knowledge of the people, morbidity and mortality of communicable diseases have been decreased significantly and life expectancy and health status of the people has been increased.

The Ministry of Health is providing comprehensive health care services, covering activities for promoting health, preventing diseases, providing effective treatment and rehabilitation up to the grass-root level.

Aiming towards the "Health for All Goal**",** series of National Health Plans based on primary health care services have been systematically developed and implemented. The Ministry of Health has formulated four yearly People's Health Plans starting from 1978. From 1991 onwards, successive National Health Plans have been formulated and implemented. Thus, the health status of the people has been raised in all aspects. In 1990, maternal mortality ratio was 1.87 per 1000 live births in rural and 1.02 per 1000 live births in urban and has reduced to 1.52 per 1000 live births in rural and 1.13 per 1000 live births in urban in 2009. Infant mortality rate has decreased to 27.8 per 1000 live births and 25.7 per 1000 live births in rural and urban respectively in 2009 compared to 1990 where mortality rate was 48.8 per 1,000 live birth in rural and 47.0 in urban area. The under-five mortality rate has declined from 72.2 per 1,000 live births in 1990 to 36.5 in 2009.

In 1988, the life expectancy at birth was 56.2 years for males and 60.4 years for females in rural area and 59 years for males and 63.2 years for females in urban area. In 2009, life expectancy at birth has improved to 64.1 years for males and 67.5 years for females in rural area and65.5 years for males and 70.7 years for females in urban area. It is needed to ensure qualify and comprehensive health services are accessible equitably to all citizens and also required to promote the quality health care services of private sector by proper supervision and monitoring mechanism.

Review of issues in health sector - In Myanmar, communicable diseases; non-communicable diseases; injury; maternal, neonatal and child health conditions; and geriatric health were identified

as priority country health problems. Moreover, utilization of qualified human resources for health, expansion of health infrastructure in rural area, provision of drugs and medical equipment, strengthening of administrative management of health care delivery system, proper allocation of budget and reduction of catastrophic health expenditure are current challenges for health sector. Besides, there is still needed to improve rural health development and poverty alleviation, better transportation, widespread dissemination of health education and information, utilization of modern technology, prevention of natural disasters, recruitment of voluntary health workers, reduction of out-of-pocket health expenditure and establishment of community-based health insurance system.

Among challenges of the health system, transportation, literacy, culture and belief, socio-economic condition, migration and co-operation and coordination with health related sectors are the key influencing factors. According to IHLCA Survey (2009-2010), the literacy rate was 95.8%. The literacy rate was higher in the plain region than the hilly region because of good transportation system and the availability and accessibility of schools. The health care coverage is difficult to reach the mobile population. For example, the vaccine preventable diseases and infectious diarrhea are common among the mobile population and it is difficult to control.

Although there is collaboration and co-operation between health and health related sectors including NGOs, formulation of health care programs and accessibility and availability of information are still necessary.

Policy and Institutional Arrangements - With the ultimate aim of the raising the health status of the people, Ministry of Health has adopted the following policies-

1) To uplift the health status and ensuring health and longevity for the citizens
2) To strive the sustainable development of the health care services in accordance with international standard
3) To improve the determinants of health
4) To implement health development programs appropriately according to international declarations, agreements and commitments
5) To accelerate the health sector development in line with the ASEAN Economic Community

Comprehensive health care covering promotive, preventive, curative and rehabilitative services are provided by various categories of health institutions at Central, State & Regional, District, Township and Village/Ward levels. National Health Committee is composed of health, health related ministries and NGOs. The National Health committee takes the leadership role and gives guidance in implementing the health programs systematically and efficiently. Under the guidance of the National Health Committee, various health committees had been formed at each administrative level for monitoring, supervision and coordination with health related sectors and NGOs. Infrastructure for service delivery is based upon sub-rural health centre and rural health centre where Midwives, Lady Health Visitors and Health Assistant are assigned to provide primary health care services to the rural community. Those who need to special care are referred to the Station Hospital, Township Hospital, District Hospital and to Specialist Hospitals successively.

The rural health centre takes the responsibility of health care in the rural areas. There is 13 basic health staff in the rural health centre and one midwife is taking care of about 5,000 to 10,000 people.

Barriers to Health Sector Development - Population density, transportation and communication, socio-economic condition, culture and belief, migration and geographical distribution are the major challenges for the health care delivery in some areas.. The major sources of finance for the health care services are the government budgets, community contributions, social assistance and in some regions/ states, contribution of local government. However, inadequate finance still exists for the vulnerable people. In remote areas, difficulties in the field visit and attrition of health staff and voluntary health workers including auxiliary midwives are the barriers for the provision of health care services. The on-job training, continuing medical education and fulfilling of necessary supports are needed in all levels.

Strategies for Development of the Health Sector - Aiming towards the health sector development, the following objectives and strategies has been being implemented.

The following strategies are formulated in order to meet the objective of the review and development of the health policy and legislation for the health system strengthening,

1) Organize the health policy and legislative committee and sub-committee according to the procedures
2) Review and revise the existing health policy and laws
3) Provide the suggestions in formulation and development of health policy and laws

Aiming towards the universal health coverage, the following strategies are formulated for exploration and development of alternative health care financing system.

1) Strengthen the primary health care and rural-based activities
2) Initiate the nationwide effective and efficient interventions such as maternal and child health care and free provision of essential drugs
3) Plan to implement the social protection program for accessibility of health care services
4) Manage the effective utilization of international aids on the national health development activities
5) Perform the health policy analysis

Strengthening of Health Information System

To strengthen the health information system, the following strategies are laid down.

1) Develop the National HIS Policy and e-Health Policy
2) Produce and deployment of the health information staff at all levels
3) Strengthen the Health Management Information System according to the International standard
4) Include the private health sector in National Health Information System
5) Encourage the utilization of information for management and decision making up to the

grass root level

6) Promote the utilization of advanced information communication technology in health information system

7) Strengthen the cooperation and coordination among stakeholders

e-Health Development

The following strategy has been identified to assist the health system development by using the advanced information and communication technology.

1) Establish the expanded information network by using ICT for the health care and health related activities in various levels of health system.

Township Health System Development

To meet the Millennium Development Goal (4), reduce child mortality, and Goal (5), improve maternal health, the following strategy is drawn up;

- Formulate the strategy of coordinated township health plan for the strengthening of health care system

Disease Control Programme

National AIDS and Sexually Transmitted Disease Control

To reduce HIV transmission and HIV-related morbidity, mortality, disability and social and economic impact, the following three strategic priorities are set up;

1) Prevention of the transmission of HIV through unsafe sexual contacts and use of contaminated injecting equipment
2) Comprehensive continuum of care for people living with HIV (PLHIV)
3) Mitigation of the impact of HIV on people living with HIV and their families

National Tuberculosis

To reduce the mortality, morbidity and transmission of TB until it is no longer a public health problem; strategies are formulated as follows;

1) Pursue high quality DOTS expansion and enhancement
2) Address TB/HIV, MDR-TB and the needs of poor and vulnerable population
3) Contribute to health system strengthening based on primary health care
4) Engage all health care providers
5) Empower people with TB and communities through partnership
6) Enable and promote research

Malaria Control

To reduce of malaria morbidity and mortality, prevent socio-economic losses due to disease burden, eradicate malaria in 2015, National malaria control strategies are set as follows;

1) Prevention and control of malaria by providing information, education and communication up to the grass root level

2) Prevention and control of malaria by promoting personal protective measures and/or by introducing environmental measures as principle methods and application of chemical and biological methods in selected areas depending on local epidemiological condition and available resources
3) Prevention, early detection and containment of epidemics
4) Provision of early diagnosis and appropriate treatment
5) Surveillance on the information and the morbidity of malaria
6) Promote capacity building and programme management of malaria control programme (human, financial and technical)
7) Strengthen the partnership by means of intra-sectoral and intersect oral cooperation and collaboration with public sector, private sector, local and international non-governmental organizations, UN agencies and neighboring countries
8) Intensify community participation, involvement and empowerment
9) Promote basic and applied field research

Lymphatic Filariasis Control

To eliminate the Lymphatic Filariasis from health problems by the end of year 2020, the strategies are:

1) Provide information, education and communication up to the grass root level
2) Mass drug administration, DEC (Diethylcarbamazinecitrate)and Albendazole, in the target areas
3) Community based self-help morbidity control
4) Comprehensive vector control
5) Capacity building for vector borne disease control team and basic health staff
6) Building and sustaining partnership
7) Community ownership of the MDA programme

Dengue Hemorrhagic Fever Prevention and Control

Dengue Hemorrhagic Fever prevention project has the following six strategies for reducing the disease morbidity and mortality.

1) Disease surveillance by laboratory diagnosis and case reporting
2) Anti-mosquito measures are carried out with the co-ordination of other vector born disease control programs
3) Increase health knowledge of the public in prevention of DHF, improving the technical skill of the health care staffs and upgrading laboratory diagnosis facilities for effective treatment
4) Speed up the health education concerning DHF prevention

5) Disease surveillance and collaboration with other related sectors for effective control of the disease
6) Conducting research to enhance effective prevention and control activities

Leprosy Elimination

Leprosy elimination project also formulates the eight strategies for reduction of the disease burden on the public, quality and equity health care services. They are —

1) Early detection of new leprosy cases and provision of quality health care
2) Prevention of disability
3) Provision of rehabilitation services
4) Capacity building for health care staffs
5) Advocating and coordinating with governmental organizations, non-governmental organizations, private and local authorities
6) Disease surveillance, field supervision and evaluation
7) Increase knowledge and change attitude and behavior of community on leprosy
8) Conducting research

Trachoma Control and Prevention of Blindness

Trachoma control and prevention of blindness project aims to eliminate avoidable blindness by the year 2020 and reduce the blindness rate to 0.5% with the following seven strategies:

1) Expanding the primary eye care services all over the country and community involvement
2) Develop human resources such as eye specialists, eye care nurses, technicians and primary eye care staff
3) Increasing the number of eye care centers
4) Quantitative as well as qualitative eye care and treatment services for preventable eye diseases such as cataract and glaucoma
5) Disseminating health information on primary eye care management
6) Promoting surgical care for eye diseases
7) Effective case detection and treatment of infectious trachoma patients

Prevention and Control of Non-communicable Disease and other Related Conditions

The strategies to prevent and reduce disease, disability and premature death from chronic non-communicable diseases and conditions are as follows:

1) Establish the national institution for NCD and formulation of basic principle
2) Adopt the healthy life styles and reduction of risk factors
3) Provision of effective and equitable access to those who need health care services

4) Conducting research for effective and efficient method of prevention and control

Public Health Programme

Basic Health Services

Topromote the coverage and quality of health services, the following strategies are laid down.

1) Expand the number of rural health centers, sub-centers and urban health centers to meet the minimum requirements
2) Appointment of health staffs in line with number of health centers
3) Production of voluntary health workers with community involvement
4) Supply and replenishment of kits for rural health centres, basic health staffs and voluntary health workers
5) On-job and refresher training for BHS and VHWs.

Maternal and Child Health

The following strategies are laid down for implementing of the health status of mothers, newborns and children by providing quality health services.

1) Strengthening reproductive health services at all levels
2) Promote the quality of health care services to reduce the maternal mortality
3) Collaborating with other related sectors regarding reproductive health
4) Strengthening monitoring, supervision and resource allocation

Adolescent Health

The following strategies are used for provision of quality health care services for adolescents,

I) Implementing the accessible health care services for the adolescents
2) Enhancing the skill of the BI-ISs on adolescent health care services
3) Wide dissemination of correct health knowledge among adolescents

School Health

School health project aims to adopt healthy life style among students by the following strategies.

1) Increase the correct health knowledge among students for adoption healthy life style
2) Organize National, State/ Regional, District and Township school health committees
3) Improve research on school health
4) Enhance multi-sect oral cooperation
5) Increase collaboration and coordination with UN agencies and national and international organizations

Nutrition Promotion

By adequate food supply at household level for ensuring nutritional well-being and longevity of all citizens, the strategies are mentioned below:

1) Encourage household food production

Community involvement in nutrition promotion

3) Nutrition supplementation

4) Drug supplementation

5) Food fortification

6) Health education

7) De-worming

8) Surveillance and research

9) Behavioral change on nutrition habits

10) Human resource development for nutrition promotion

11) Multi-sectoral cooperation

Food Safety

The Food Safety project is responsible for the long-term health development of the nation. The following strategies were identified-

1) Expanding the human resources for food and drug administration division

2) Quantitative and qualitative improvement of the laboratory services on food and drug administration

3) Improve the collaborative effort within the regional and international standards on food and drug control

Pharmaceuticals, Medical Devices and Cosmetic Quality and Safety

To supervise and control of production, import, distribution and sale of quality assured and efficacious drugs, cosmetic and household commodities, the following strategies are undertaken;

(1) Capacity building of FDA staff from central, state and regional level

(2) Monitoring, supervision and assessment of drugs, medical devices and cosmetics control activities at State and Region levels

(3) Co-operation of related departments and manufacturers

(4) Monitoring the occurrence of adverse effects of medicines and cosmetics

Curative Services Programmes

Promoting Quality of Hospital Services

To promote the quality of health care services at all levels of hospitals, the following strategies have been implementing;

1) Develop the equitable access to health services by establishing new hospitals in rural and special regions

2) Provision of human resources, sufficient supply of drugs and medical equipment

3) Capacity building for health care providers

Expanding Health Care Coverage in Border Areas

With the aim of improving the health status of the national races residing in remote border areas, health development and health care activities have been implemented according to the following strategies;

1) Provision of hospital-based and community based health care services in border areas
2) Construction and maintenance of hospitals and health centres in border areas
3) Increase appointment of health staff
4) Supply of essential drugs and medical equipment
5) Special training course for doctors and nurses serving at health institutions in border areas
6) Award to outstanding health care personnel
7) Support to the health personnel
8) Prioritize and address the health problem in respective remote areas encompassing preventive, promotive, curative, rehabilitative aspects of health care and field supervision and primary health care services
9) Control of drug abuse and treatment of drug addicts
10) Coordination of health and health related departments and NGOs
1 1) Monitoring and field supervision
12) Evaluation of border areas health care services annually

Promoting Laboratory and Blood services

To expand and upgrade the diagnostics and public health laboratory services and provide adequate supply of safe blood in every hospital, the following strategies are applied;

1) Expansion of laboratory services by establishing laboratories in townships, station and border hospitals where there are non-existent and deployment of staff and supply of drugs and equipments
2) Establishing standard staff strength for every categories of laboratory in the whole country
3) Facilitating the high standard of diagnostics and public health laboratory services according to category of laboratory
4) Expanding blood centers to provide comprehensive blood bank services and transfusion services in Yangon, Mandalay and other regions and states
5) Ensuring increasing availability of blood and blood products
6) Mobilizing and recruiting more voluntary donors to provide adequate supply of safe blood

Provision of Essential Medicine

Following strategies are implemented in order to ensure that every citizen have regular access to safe, quality, efficacious and low-cost essential medicines and rational use of essential drugs in every health care facilities.

1) Promoting the rational use of drugs by providing comprehensive knowledge management, laws and regulations
2) Supply essential drugs based on public demand
3) Reinforcement of sufficient drugs and medical equipment supply system as well as health care system
4) Edition and distribution of Hospital Formulary and standard Treatment Guidelines in every four year
5) Updating and distribution of the national list of Essential Medicines

Development of Myanmar Traditional Medicine Programme

To promote the quality health care services by traditional medicine, the followings are implemented as strategies;

1) Upgrading of the quality of teaching skills in traditional medicine
2) Expansion and Upgrading of traditional medicine clinics and hospitals
3) Supervision and monitoring of safe and quality assured traditional drugs manufacturing
4) Strengthening the capability of research in traditional medicine
5) Conservation of scarce medicinal plants and production of quality raw materials for traditional medicine drug factory

Human Resources for Health Development Programme

To raise the health status of the people and to ensure sustained development of comprehensive health services through production of quality human resources according to the needs of the country and planning for effective utilization, the following strategies are laid down.

1) Produce different categories of health professionals according to the human resources for health needs
2) Development of infrastructure, teaching/learning materials, technology, libraries, upgrading laboratories to meet the international standard
3) Regular review, revise and update of curricula for relevance to the changing trends in medical education
4) Strengthening of human resource information and research activities

Promoting Health Research Programme

The following strategies are taken in order to solve the public health problems and to contribute to comprehensive health care services:

1) Conduct health research programme especially health policy and system research
2) Conduct research on emerging and re-emerging communicable diseases
3) Conduct research on non-communicable diseases increasing with the changing life style
4) Implement research on the danger of environmental pollution
5) Conduct research activities concerned with traditional medicine
6) Explore technologies for the diagnosis, management and control of common diseases/conditions
7) Strengthen research capacity through development of infrastructure and manpower, and human resources development, necessary for effective health research

Dissemination of research findings through websites of Departments of Medical Research

Policy and Institutional reforms priorities and Indicative programs

Priority Programmes

National Comprehensive Development Plan (Health Sector) (2011-12 to 2030-31) will be implemented with the following seven priority programme areas.

Health System Strengthening Programme

1) Health Policy and Legislation
2) Universal Health Coverage
3) Strengthening of the Health Information System
4) e-Health Development
5) Township Health System Strengthening

Disease Control Programme

1) National AIDS and Sexually Transmitted Disease Control
2) National Tuberculosis Control
3) Malaria Control
4) Lymphatic Filariasis Control
5) Dengue Hemorrhagic Fever Prevention & Control
6) Leprosy Control
7) Trachoma Control and Prevention of Blindness
8) Prevention and Control of Non-Communicable Diseases and Conditions

Development of Public Health Programme

1) Basic Health Services
2) Maternal and Child Health
3) Adolescent Health
4) School Health
5) Nutrition Promotion
6) Food Safety

7) Pharmaceuticals, Medical Devices and Cosmetic Quality and Safety

Improving Hospital Care Programme

1) Promoting Quality of Hospital Services
2) Expanding Health Care Coverage in Border Areas
3) Promoting Laboratory and Blood services
4) Provision of Essential Medicines

Traditional Medicine Development Programme

Human Resources for Health Development Programme

Promotion Health Research Programme

Health Reform Strategies and Priority Areas (June,2012)

- Rural Health Development
- Poverty Alleviation and Universal Health Coverage
- Exploration of Opportunities for Effective Provision of Health Services Effective Cooperation with NGOs and INGOs and Monitoring and Evaluation
- Development of Human Resources for Health

Myanmar Comprehensive Development Vision (MCDV) (ERIA) (August -2012) Fast Track Areas

- Integrated Energy
- Rural Development and Poverty Reduction including Microfinance
- Agriculture Sector Development /Fisheries and Livestock sector
- Infrastructure and Integrated Energy Development

National Development Plan (Health Sector) (2011-2015) Direction

- Solving priority health problems of the country
- Rural health development
- Realizing Millennium Development Goals
- Strengthening health system
- Improving determinants of health

National Comprehensive Development Plan (Health Sector) *(2011-2012 to 2030-2031)*

- To uplift the health status and ensuring health and longevity for the citizens
- To strive the sustainable development of the health care services in accordance with international standard
- To improve the determinants of health
- To implement health development programs appropriately according to international declarations, agreements and commitments

- To accelerate the health sector development in line with the ASEAN Economic Community

Health Care System

Myanmar health care system evolves with changing political and administrative system and relative roles played by the key providers are also changing although the Ministry of Health remains the major provider of comprehensive health care. It has a pluralistic mix of public and private system both in the financing and provision. Health care is organized and provided by public and private providers.

Evolution of Organization and Administration Services

Following complete colonization of the country by the British in 1886, Health Services Administration, a centralized body responsible for both the curative as well as the preventive health services was set up and a post of Sanitary Commissioner was created. Later in 1889, the two services were separated and a new post of Inspector General of Hospitals was created for administration of hospital services. In addition to the control of government hospitals, the Inspector General of Hospitals controlled the following government institutions, the Chemical Examination Laboratory, the Pasteur Institute (a large bacteriological laboratory) and the Burma Government Medical School. The Sanitary Commissioner, renamed Director of Public Health Services was responsible for the public health aspect of the administration. These two centralized bodies controlled the health services.

At the peripheral level where the geographic regions were called districts, health services under the central control, was managed by senior doctors called Civil Surgeons. In the larger districts curative and preventive services ran parallel and the latter was managed by senior medical officer called the District Health Officer. The post did not exist in smaller districts and both services were managed by the Civil Surgeons.

Hospitals were then divided into two categories by virtue of ownership. These were Governmental and Local Fund Hospitals. The former hospitals included the Rangoon General Hospital, the Rangoon Dufferin Hospital, the Tadagalay Mental Hospital, the Mandalay General Hospital, the Maymyo Civil Hospital and the Myitkyina Civil Hospital. Virtually all other hospitals in the districts and the townships belonged to the local fund group of hospitals. All financial commitments of the government institutions and hospitals were the responsibility of the Government while the local fund hospitals were financed from a collection of funds called the “Hospital Finance Scheme.” The sources of income for this scheme were; funds from respective local bodies, government contributions and subscriptions and donations from the public. These Local Fund Hospitals were managed by Hospital Management Committees the members of which were determined by the Divisional Commissioner.

During the Japanese occupation the general administration remained the same though new posts namely, Director of Medical Services and the Director of Public Health Services replaced the two earlier posts. With return of the British administration the health services were reintegrated under a

single director called Director of Medical and Health Services. Another directorate was set up, called the Directorate of Women and Child Welfare, previously the Women and Child Welfare Board. Following the Independence and in 1951 a Directorate of Child Health Services was formed. This directorate functioned as a separate body and was responsible for both the social welfare (including control of juvenile delinquents) and health of the children. Consequently there was some overlapping of work with incompetency in administration.

Following reorganization of health services in 1953, with the assistance from the World Health Organization which assigned an advisor in Public Health Administration, these shortcomings were redressed. Consequently these independent directorates were unified into a single directorate called "the Directorate of Health Services", fore-runner of the current "Department of Health". The directorate was headed by a Director of Health Services. In 1953 all local fund hospitals were nationalized by the Government. But at the peripheral level, hospitals still remained separate from public health services.

In 1965 the Directorate of Health Services was again re-organized to expand the coverage of health services to reach the rural areas, to ensure a uniform increase in the level of health of the Union, to integrate health services, to eliminate duplication of work through unification of different sections of the health services and to decentralize health administration by delegation of authority to the Divisional and Township Health Departments. In addition to undertaking reorganization at central level, an intermediate level of health administration was introduced in six among nine of administrative regions in the Union. These were; Rangoon Special Division, the Central Division, the North Western Division, the South Western Division, the South Eastern Division and the Eastern Division. They are now called State/Division (State/Regional) Health Departments. Township became the basic health unit at the peripheral level and Township Medical Officers were assigned responsibilities for all health services (curative and preventive). Organization and administration of health services by levels at different administrative period are shown by organization charts in the following pages.

Current Health Care System

In implementing the social objective laid down by the State, and the National Health Policy, the Ministry of Health is taking the responsibility of providing promotive, preventive, curative and rehabilitative services to raise the health status of the population. Department of Health one of 7 departments under the Ministry of Health plays a major role in providing comprehensive health care throughout the country including remote and hard to reach border areas. Some ministries are also providing health care, mainly curative, for their employees and their families. They include Ministries of Defense, Railways, Mines, Industry I, Industry II, Energy, Home and Transport. Ministry of Labour has set up three general hospitals, two in Yangon and the other in Mandalay to render services to those entitled under the social security scheme. Ministry of Industry (1) is running a Myanmar Pharmaceutical Factory and producing medicines and therapeutic agents to meet the domestic needs.

The private, for profit, sector is mainly providing ambulatory care though some providing institutional care has developed in Yangon, Mandalay and some large cities in recent years. Funding and provision of care is fragmented. They are regulated in conformity with the provisions of the law relating to Private Health Care Services. General Practitioners' Section of the Myanmar Medical Association with its branches in townships provide these practitioners the opportunities to update and exchange their knowledge and experiences by holding seminars, talks and symposia on currently emerging issues and updated diagnostic and therapeutic measures. The Medical Association and its branches also provide a link between them and their counterparts in public sector so that private practitioners can also participate in public health care activities. The private, for non-profit, which is another sector also providing ambulatory care though some providing institutional care has developed in large cities and some townships.

One unique and important feature of Myanmar health system is the existence of traditional medicine along with allopathic medicine. Traditional medicine has been in existence since time immemorial and except for its waning period during colonial administration when allopathic medical practices had been introduced and flourishing it is well accepted and utilized by the people throughout the history. With encouragement of the State scientific ways of assessing the efficacy of therapeutic agents, nurturing of famous and rare medicinal plants, exploring, sustaining and propagation of treatises and practices can be accomplished. There are a total of 14 traditional hospitals run by the State in the country. Traditional medical practitioners havebeen trained at an Institute of Traditional Medicine and with the establishment of a new University of Traditional Medicine conferring a bachelor degree more competent practitioners can now be trained and utilized. As in the allopathic medicine there are quite a number of private traditional practitioners and they are licensed and regulated in accordance with the provisions of related laws.

In line with the National Health Policy NGOs such as Myanmar Maternal and Child Welfare Association, Myanmar Red Cross Society are also taking some share of service provision and their roles are also becoming important as the needs for collaboration in health become more prominent. Recognizing the growing importance of the needs to involve all relevant sectors at all administrative levels and to mobilize the community more effectively in health activities health committees had been established in various administrative levels down to the wards and village tracts. These committees at each level were headed by the responsible person of the organs of power concern and include heads of related government departments and representatives from the social organizations as members. Heads of the health departments were designated as secretaries of the committees.

Governance structure

The Ministry of Health is headed by a Union Minister who is assisted by two Deputy Ministers. There are seven departments within the Ministry of Health (MoH), each responsible for different aspects of health care. These are:

- Department of Health Planning - responsible for developing the National Health Plan and managing the health information system;

- Department of Health - responsible for provision of health services and deployment of health workers;
- Department of Medical Science - responsible for the production of health workers;
- Departments of Medical Research (Lower, Upper & Central) – responsible for conducting medical research and provide evidence based data for policy making; and
- Department of Traditional Medicine – responsible for the development of Myanmar Traditional Medicine (Myanmar Ministry of Health, 2011, WHO, 2006, Myanmar Ministry of Health, 2007).

The Department of Health Planning is responsible for formulation, monitoring and evaluation of the National Health Plan. In formulating health plans and data sets, the Department obtains information from many sources within the Ministry of Health and beyond and disseminates the information through regular publications and consultations.

The Department of Health has primary responsibility for health service provision for the entire population of the country. Under the management of the Director General, there are ten different sections comprising of: Administration; Planning; Public Health; Medical Care; Disease Control; Central Epidemiology; Food and Drug Administration; National Health Laboratory; Occupational Health; and Nursing.

The Department of Medical Science is mainly responsible for medical education and human resource production for health. There are seven different sections under the management of the Director General comprising of: Administration; Planning; Undergraduate; Postgraduate; Nursing; Foreign Relation; and a Medical Resource Centre.

The Department of Medical Research(Lower Myanmar) comprises of 22 research divisions, eight supporting divisions and ten clinical research units of various disciplines. The Department conducts research on six major diseases (tuberculosis, malaria, hypertension, diabetes mellitus, diarrhoea and dysentery); investigates reputed medicinal plants; and health system research under the guidance of Ministry of Health.

The Department of Medical Research (Upper Myanmar) consists of ten research units and eight supporting units. They conduct research in areas such as reproductive health, malaria prevalence, antimicrobial drugs, medicinal plants and some operational studies. This department is also involved in research aimed at identification of novel medicinal plants for treatment of six major diseases.

The Departments of Medical Research (Central Myanmar) conducts research on cancers, infectious diseases, drug sensitivity testing, and health system research. Advanced molecular biological techniques have been well established such as RNA technology, Polymerase Chain Reaction (PCR) technology, in-situ hybridisation, Real Time (RT-PCR) and sequencing techniques.

The Department of Traditional Medicine is responsible for provision of comprehensive traditional medical care services, production of competent traditional medical practitioners and investigating to produce safe and efficacious new traditional therapeutic agents.

The Myanmar health care system has evolved, with the changing political and administrative system. The roles played by the key providers are also changing, although the Ministry of Health remains the

major provider of comprehensive health care. Myanmar has a pluralistic mix of public and private systems both in terms of financing and provision.

Health services organisation

Health services are provided by the public, private and non-government organisation (NGO) sectors. The health system is decentralised, with services being offered to patients at the ward/village, township, district, state/regional and national level according to complexity of needs.

The health system is networked by 1,558 rural health centres (RHC) under the administration of the Township Medical Officer (TMO). Each township serves approximately 100,000 to 200,000 people (Tin et al., 2004) and is responsible for providing primary and secondary care services. Each RHC has four satellite sub-rural health centres that serve 1,000 to 6,000 people and are staffed by a midwife and a public health supervisor grade 2 (PHSII). Supporting these sub-rural health centres are volunteer health workers who provide a smaller range of primary health care services (Tin et al., 2010). These volunteer health workers include auxiliary midwives and community health workers who are recruited and trained by the township health authority to provide basic health care services, primarily health promotion, to areas not serviced frequently by midwives (WHO, 2006).

At each RHC, an average of 20,000 people are served by a team of health workers collectively known as Basic Health Staff (BHS) (Tin et al. 2004). The minimum set of sanctioned staff in each RHC and its sub-centres include one Health Assistant (who heads the RHC), one lady health visitor (LHV), five midwives (one in main centre and four in sub-centres), five public health supervisor II (one in main centre and four in sub-centres) and one watchman (Myanmar Ministry of Labour, 2010). In 2009, 57% of BHS were midwives, 15% PHSII, 11% LHV, 10% Health Assistants, 5% PHSI and 2% Township Health Nurse. 45% of voluntary health workers were community health workers, 38% were auxiliary midwives and 17% were traditional birth attendants (Department of Health Planning and Department of Health, 2011). These voluntary health workers are not paid but are considered nevertheless to be BHS helpers, supporting midwives and PHSII in hard to reach regions. Thus, their capacity to contribute to the health system depends on the individual CHW and their community's support (Tin, 2009).

These BHS cover 18.9% of the population, with each village averaging 22 visits each year from a BHS. However, urban areas receive far more visits, with the Yangon region averaging 42.9 visits, Mandalay 27.2 and Magway 25.0. In comparison, the most remote states of East Shan and Chin received only 8.0 and 9.1 visits annually. On average, 22.4% of the population receive general medical services, increasing year on year for the past 13 years. However, this milestone is still less than half of the target of 50% set by the MoH (Department of Health Planning and Department of Health, 2011). There is a push to improve health services in rural and border areas, but many of the improvements seen in the health sector are not at the grassroots level (Myanmar Ministry of Health, 2006a).

Within each township, there is one Township hospital with 16, 25 or 50 beds; at least 1-2 Station hospitals; and 4-7 RHC. Station hospitals, including sub-township hospitals, are equipped with general medical, surgical and obstetric facilities and resources. Each Station hospital has a minimum

of 18 staff, including one Station Medical Officer (SMO), who is the head, one assistant medical officer, two staff nurses, four trained nurses, one PHSI, one pharmacist (grade 4), one laboratory technician (grade 4), two dressers, one watchman and four domestic and ancillary workers.

Township hospitals have facilities to provide laboratory, dental, major surgical procedures, and are the first place of referral for patients requiring higher level care. The larger (50-bed) Township hospitals and District hospitals have specialist and intensive care services available. More advanced secondary and tertiary health care services are available at the State/Regional level hospitals, Central and teaching hospitals (Myanmar Ministry of Health, 2011). Traditional medicine clinics are available at the township level and beyond.

In urban areas, urban health centres, school health teams and maternal and child health centres provide most of the health services. Increasingly specialist care is provided to patients up the referral pathway from Station hospital, Township hospital, District hospital and to a specialist hospital successively (Myanmar Ministry of Health, 2011).

There were 3,167 public health facilities in 2010-2011, including:

- 924 government hospitals, holding 43,789 beds;
- 86 primary and secondary health centres;
- 348 maternal and child health centres;
- 1,558 rural health centres;
- 14 traditional medicine hospitals; and
- 237 traditional medicine clinics (Myanmar Ministry of Health, 2011).

Other public service sectors provide health care (mostly curative) for their employees and their families. These include the Ministries of Defence, Railways, Mines, Industry I&II, Energy, Home and Transport. The Ministry of Labour has set up three general hospitals for its employees. The Ministry of Industry I operates a pharmaceutical factory that produces medicines for the nation (Myanmar Ministry of Health, 2011).

Since 2010, private sector (both for-profit and not-for-profit) facilities and practitioners are required to be registered under law. In 2010, there were 103 private hospitals (87 general, 16 specialists), 192 special clinics and 2,891 general clinics in the private sector. These provide mostly outpatient services in larger cities and townships (Myanmar Ministry of Health, 2011). The regulation of the quality of services provided by the fast growing private sector is an important issue that need to be addressed by the Ministry of Health and other regulating authorities.

NGOs also play a more important role, with 31 international and 14 national NGOs providing services for 10-20% of the population in 41% of Townships (Tin et al., 2010). In addition to primary and secondary services, international NGOs, along with individual donors, provide high level specialist outreach services throughout the country (Myanmar Ministry of Health, 2011).

Traditional medicine is practiced alongside conventional medicine and is well supported by the government through the establishment of traditional medicine universities, hospitals and health clinics(Myanmar Ministry of Health, 2011).

Sources of funding

Health care is funded by a mix of government revenue, private household expenditure, the social security system, community contributions and donor assistance. Public hospitals are required to establish a trust fund to pay for services, with payments coming from user fees. In August 2010, the accumulated amount in the trust funds amounted to 6.4 billion kyat (Myanmar Ministry of Health, 2011).

Myanmar is attempting to improve the health financing system in order to reduce out-of-pocket payments. Ongoing health care financing initiatives include:

- Increasing tax based financing (government expenditures for health will be increased four times higher than the previous financial year 2011-2012);
- Expansion of coverage for social health insurance from the Social Security Board by preparing the Social Security Law in 2012 which includes amending the Social Security Act 1954 and adding new concepts appropriate for the current situation;
- Maternal and Child Health Voucher Scheme will be introduced in one pilot township in 2012 based on the results of the feasibility study for MCH Voucher Scheme which was conducted in 2010;
- Township Based Health Protection Scheme (TBHP) in terms of Community Based Health Insurance will also be introduced in one pilot township in coming soon based on the results of the feasibility study for TBHP which was conducted in 2011;
- Proper documentation of the social assistance in relation to health done by Community Based Organisations (CBOs) and Faith Based Organisations (FBOs); and
- Increasing and sustainable assistance from the international donors (Myanmar Ministry of Health, 2012).

In addition to these initiatives, the Ministry of Health in collaboration with WHO, is planning to conduct a broad assessment of the health system. Assessments on some building blocks, including HRH, service delivery and health financing has already commenced. A Health Systems in Transition (HiT) assessment will be conducted by the Asia Pacific Observatory on Health Systems and Policies (APO). This review will include a critical assessment of the existing health care financing initiatives, explore sustainable financing options and propose a Universal Health Coverage model suitable for the Myanmar context.

Rural Health Development

The State has laid down the political, economic and social objectives as the basis for building the modern and developed nation. Efforts have been made for the development to encompass all parts of the country – urban, rural and border areas. Using Primary Health Care approach, the Ministry of Health formulated and implemented Country Health Plans covering the periods 1978 through 1990, and NHP covering the periods 1991 to 2001. In conformity with the policy statement included in the National Health Policy, “to expand the health activities not only to the rural but also to

border areas so as to meet the overall needs of the country". Rural health services also covering border areas will be planned and implemented systematically. This plan will be implemented to realize the policy objective of improving the health status of the rural population and to narrow the gap between urban and rural in health status and health service delivery.

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

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

- Ensuring smooth and better transportation in the rural areas;
- Securing water in the rural areas;
- Uplift of the education standard of the rural people;
- Uplift of health care system for the rural people;
- Development of the economy in rural regions.

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

In order to foster homogenous development in the country, the Government has established 24 special zones where each zone consists three Universities/Colleges and a 200-bedded hospital areopened. A total of 134 Universities/Colleges, 7434 schools from primary level to high level and 17 hospitals, 32 general hospitals and 64 under 100-bedded hospitals have been constructed in 24 Special zones.

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

All of basic health staff (BHS) are mainly trained for providing primary health care and integrated health service delivery. The RHCs and sub-RHCs are responsible for all elements of Primary

Health Care. Their main function is for health education, immunization, and nutrition, control of endemic diseases, MCH, water and sanitation.

As of April 2011, there were only one rural health centre for 26567 rural population and one sub-centre for 5820 rural population. On the average, one health assistant had to look after 23828 population, one LHV – 23925 population, one midwife – 4462 population and one PHS Grade II – 25285 population. One Rural Health Centre had to take care of 42 villages where one sub-centre had to cover up to 9 villages.

Primary Health Care

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

Change of the government in 1988 resulted in setting up of political, economic and social objectives; one of the four social objectives is uplift of health, fitness and education standards of the entire nation. The government has shown its commitment to ensure highest possible standard of health as one of the fundamental rights of every citizen. The National Health Committee was formed on 28 December 1989 as part of the policy forms. It is a high level inter-ministerial and policy making body concerning health matters. This Committee takes the leadership role and gives guidance in implementing the health programmes systematically and efficiently. It is chaired by the Secretary (1) of the State Peace and Development Council and includes Ministers of related Ministries as members. The Deputy Minister for Health is secretary of the National Health Committee.

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

In addition to achieve these objectives, the Ministry of Health summarized its two main objectives as "to enable every citizen to attain full life expectancy" and secondly "to ensure every citizen is free from disease". Myanmar has been implementing all elements of PHC from the beginning and has never promoted selective PHC such as GOBI-FFF (growth monitoring, oral rehydration, breast feeding and immunization-female education, family spacing, food-supplements). The National Health

Plan covers all elements of PHC with four basic underlying principles embedded in the PHC approach for health development, as enshrined in the Alma Ata Declaration: (1) universal access to health care in addressing health needs (equity) (2) community involvement and self-reliance (solidarity) (3) use of appropriate technology and cost-effective interventions (technology) and (4) multisectoral actions for health.

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

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

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

Factors facilitating achievements related to PHC within the structural capacity

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

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

- Routine health information systems.
- Surrveillance system for AFP and epidemic outbreaks.

Lesser achievement related to PHC

- Weaknesses in the health service delivery within the framework of PHC had also been identified by several studies.
- Access to primary health care has increased but yet to meet universal coverage of health care. BHS still have to take care of large areas /villages under their jurisdiction; the target of one RHC/20000 population has not met.
- Current rates of maternal mortality have not achieved its targets. The majority of maternal deaths could have been prevented as the main cause of maternal mortality and morbidity are due to complications arising during antenatal periods and 80% of maternal deaths occurred at home.
- Sanitary latrine coverage still fluctuates around 80-90% in spite of efforts to achieve 100% coverage; diarrhoea diseases still remain at the top ten list of morbidity.
- In spite of growth monitoring and nutrition education, PEM still remains high and is still a public health concern. Beri-beri becomes an issue during the past decade.
- HIV/TB co-infection and multi-drug resistant TB have become issues of public health concern during the past decade.
- After the declaration of polio-eradication in 2003, wild polio viruses had been reported sporadically.
- Health Information System fails to cover the private sector. Private Sector Law has been adopted but need strengthening of law enforcement measures.
- NCDs are on the rise. Public awareness of NCD is negligible. Tobacco Control Law has been enacted but still requires multisectoral partnership for full enforcement.
- Lack of health insurance system and paucity of alternative health care financing could lead to catastrophic out-of-pocket expenditures on health, the majority of which will have to be borne by the poor. There is no safety-net system.

PHC and Current Health Issue

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

With rapid urban growth and globalization, there will be change in values and change in the structure of nuclear families; with both parents working and less time for family and child care, adolescent reproductive health issues will become a major challenge. Problems such as STD, HIV, TB-HIV co-infection, teen age pregnancy, unwanted pregnancy and abortion etc will continue to be public Like all developing countries in the region, there are many challenges and issues that lie ahead. Communicable diseases still remain to be conquered whereas on the other hand, NCDs continues to

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

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

Internal migration will continue in the coming decades; epidemic outbreaks are likely to occur due to large population movements to development areas such as industrial zones, mines, road construction, dam construction etc. Loss of family life and loss of traditional and social values could lead to spread of HIV/TB, STI and adolescent RH problems. Emerging diseases such as Avian Influenza, SARS, HIV/TB co-infection will continue to threaten in the coming years. Drug-resistance could become a major concern.

Public private partnership

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

Integrating vertical programme and improving quality of care

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

Conclusion

Revisiting PHC has strongly indicated that PHC has brought about marked gains in the health system of Myanmar. Principles of PHC are still relevant for Myanmar and MOH will continue to adopt the PHC approach in all its health policies, plans and programmes. The policies and plans may be

needed to adapt to global challenges within the context of PHC. MOH has never promoted "Selective PHC" and will move on implementing health services with the comprehensive PHC package towards HFA and MDG goals.

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

Ongoing programmes such as Rural Health Development Plan, Myanmar Health Vision 2030 will be continued both of which are based on PHC approach. New programmes such as Health Systems Strengthening for GAVI/HSS will further enhance the commitment towards PHC. All efforts will be directed to achieve Millennium Development Goals. Health development plans will also be in line with other programmes such as poverty alleviation, economic development, border-area development, special development zones etc.

Since the Alma Ata declaration and the inception of Health For All using Primary Health Care approach in 1978, Myanmar as member states of WHO has adopted and successfully prevailed many major public health problems. It is our vision that Myanmar will achieve the Millennium Development Goals by revitalizing Primary Health Care with concerted efforts of individuals, community national and international partners.

Universal Health Coverage

The new constitution enacted by the Union of Republic of Myanmar in May 2008 provided the legal framework for a series of institutional and policy reforms to advance the country's democratization, including a core commitment for the state to 'strive earnestly' to improve the health of its people. The Article 367 states that 'every citizen shall, in accord with the health policy laid down by the Union, have the right to health care.'

As early as 1953, the country had laid the foundations of a comprehensive health care system, establishing a network of township hospitals and rural health centres that, by the mid-1960s, covered every administrative district. Over the next 20 years, with health accounting for more than 10 per cent of government

expenditure, life expectancy increased rapidly and infant dropped by third. After 1988, a series of free-market macroeconomic reforms led to sharp reductions in social sector and health spending. A new National Health Policy in 1993 introduced health financing models based upon community cost

sharing (user fees) hospital trust funds and drug revolving funds to raise additional revenues for the health sector. By the year 2000, spending on health had fallen to 1.2 per cent of the total government expenditure, and many health indicators, particularly maternal and child mortality, tuberculosis and malaria prevalence has slowed down their declining trend.

Guided by the 2008 constitution, government investment in the social sectors and the concept of Universal Health Coverage and social protection are currently higher up in the policy agenda. In the Social Protection Conference, Nay Pyi Taw, on 25 June 2012, the President's speech includes: ' *the basic need of every citizen is comprehensive health care as well as income security or in other words job security. This requirement calls for opportunities such as the access to education and social security. The government has been enacting new laws, amending the existing ones and revoking out-of-date law as necessary to promoting rights of workers and farmers and holding workshops on the establishment of a universal health insurance system for low-income rural people..'*

Universal Health Coverage (UHC) is defined as securing access for all to appropriate promotive, preventive, curative and rehabilitative services at an affordable cost. In Myanmar, where 70% of the population lives in rural areas and 80% of the health expenditure is out of pocket, available evidence shows that non accessibility to health care services is associated with socio-economic status, location and availability of services. Therefore UHC has become the agreed key policy in Myanmar for securing access for all to appropriate promotive, preventive, curative and rehabilitative services at an affordable cost.

A technical consultation on Issues and Challenges for UHC in Myanmar was conducted at Nay Pyi Taw in July 2012. The consultation has recommended:

Immediate Actions

- Supply side strengthening especially PHC
- Financing – Critical assessment of ongoing pilots
- Managing donors effectively
- Strengthening institutional capacity to generate evidence

Short Term Actions

- Health Sector Investment Plan
- National HRH Master Plan
- Plan Financial risk protection and move towards UHC
- Strengthen institutional capacity to generate evidence

Long Term Actions

- Strengthen institutional capacity to generate evidence
- Effective interface of evidence for priority formulation.

The next steps identified were (a) Finalization of UHC and financing strategies and (b) development of a UHC investment plan with short, medium and long term components in line with the National and sub-National Health Plans.

Health financing aiming towards Universal Coverage

Promoting and protecting health is essential to human welfare and sustained economic and social development. This was recognized more than 30 years ago by the Alma-Ata Declaration signatories, who noted that "Health for All" would contribute both to a better quality of life and also to global peace and security. There are many ways to promote and sustain health. Some lie outside the confines of the health sector. The "circumstances in which people grow, live, work, and age" strongly influence how people live and die. Education, housing, food and employment all impact on health. Redressing inequalities in these will reduce inequalities in health. It determines whether people can afford to use health services when they need them. Recognizing this, the countries committed in 2005 to develop their health financing systems so that all people have access to services and do not suffer financial hardship paying for them. This goal was defined as Universal Health Coverage.

The goal of the strategy is to help country attains universal coverage that ensures access to quality health services for better health outcomes. Evidence suggests that universal coverage is more likely in countries where public financing of health, including tax financing and social health insurance, is around 5 % of GDP. Universal coverage aims to improve the health status of the poor and vulnerable, especially women and children. Attaining universal coverage requires urgently government attention and action. It advocates substantial reductions in out-of-pocket payments, which remain both the single main cause of household impoverishment and a financial barrier in accessing health services.

The following target indicators are proposed to monitor and evaluate overall progress in attaining universal coverage in country: out-of-pocket should not exceed 30% - 40% of total health expenditure; total health expenditure should be at least 4% - 5% of the gross domestic product; over 90% of the population is covered by prepayment and risk-pooling schemes; and close to 100% coverage of vulnerable populations with social assistance and safety-net programmes.

For achieving that goal, Myanmar is trying to improve the health financing system for reducing of out-of-pocket payments and increasing of prepayment through:

- Increasing tax based financing (government expenditures for health will be increased four times higher than the previous financial year 2011-2012)
- Expansion of coverage for social health insurance from social security board by preparing the social security law in 2012 which includes amending the social security act 1954 and adding new concepts appropriate for the current situation
- Maternal and Child Health Voucher Scheme will be introduced in one pilot township in 2012 based on the results of the feasibility study for MCH Voucher Scheme which was conducted in 2010

- Township Based Health Protection Scheme (TBHP) in terms of Community Based Health Insurance will also be introduced in one pilot township in coming soon based on the results of the feasibility study for TBHP which was conducted in 2011
- Proper documentation of the social assistance in relation to health done by Community Based Organizations (CBOs) and Faith Based Organizations
- Increasing and sustainable assistance from the international donors

Challenges and Conclusion

The challenges in health financing include:

- More attention required for raising of sufficient revenues to cover the needs of poor (safety net);
- Policy and procedures for poverty identification;
- Financial management capacity
- Ongoing operational research;
- Pro-poor health financing strategies;
- Increased tax bases financing by the government;
- Sustained investment by international partners;
- Overall health system strengthening.

Myanmar is at a turning point, with far reaching implications for its health sector. Progress towards decentralized governance, economic growth, privatized services and a proactive civil society has taken place. The government has demonstrated an early commitment by significantly boosting its health expenditure in the latest national budget. It is believed that changing policy environment and potential for economic growth, along with willingness of the international development partners to support and facilitate the process will provide a great opportunity to move towards Universal Health Coverage.

Traditional Medicine

Introduction

WHO defines traditional medicine as including diverse health practices, approaches, knowledge and beliefs, incorporating plant, animal, and/or mineral based medicines, spiritual therapies, manual techniques and exercises applied singularly or in combination to maintain well-being as well as to teat, diagnose or prevent illnesses. The term ‘complementary’ and ‘alternative’ are used in some developed countries to refer to a broad set of health care practices that are not part of a country’s own tradition, or not integrated into its dominant health care system.

According to the Traditional Medicine Drug Law of 1996, Traditional Medicine is defined as medicine for the physical well-being and longevity of people in accordance with anyone of the four

nayas (subjects) of traditional medicine, namely *Desana naya, Bethitsa naya, Netkhata veda naya, and Vissadara naya. Desana naya* is based on natural occurrences enshrined in Buddhist Philosophy. *Bethitsa naya* is based on Ayurvedic concepts with extensive use of herbal and mineral compounds to establish balance among three *dosas* namely *Kapha, Vata,* and P*itta. Netkhata veda naya* is based on the calculations of zodiac of stars, planets and the time of birth and age. These calculations are linked to prescribed dietary practices. The *Vissadara naya* largely depends on meditation and practices of alchemy. The skill, know-how and techniques of the drug preparations are such that they are derived fom heavy metals such as lead, mercury and poisonous substances such as arsenic and its compounds after they are converted into inert ones by means of series of chemical processes in order to obtain supernatural power.

Historical evolution of the Myanmar Traditional Medicine

Myanmar traditional Medicine had been introduced since the early times of the country cultural history and had been handed down through generations. According to the *Hman Nan Yazawin,* it was accepted that since *Tagong Dynasty,* the earliest Myanmar era, Traditional Medicine from India had been practiced successfully. It was recorded that during the *Pagan Dynasty* (10-11 Century) under the reign of *King Narapati*, the names of some books on traditional medicine were firmly mentioned on *Tet Nware Kyaung* stone inscription. Holy Buddhist monks *Taung Pheelar sayadaw and Shwe U Min Sayadaw had written books on Myanmar traditional medicine.* Durin the reign of *King Mindone of Yadanabon* era 19th Century, *Yaw Atwin Win U Po Hlaing* compiled and wrote *Kaya Noppathana Kyan* and *Utu Bawzana Thingaha Kyan* which were the significant textbooks of Myanmar Traditional Medicine. At the same time, a physician named *Taungthar Sayargyi Sayar Hmone* initiated *Thaung Chauk Lone Kyauk Treatment* signifying that the traditional medicine must be the one based on medical science, must be firm and certain and must be invented by Myanmar people in their own native land.

During the colonial days starting 1885, patriotic Myanmar traditional physicians maintained their practices and continuing the flourishes of the traditional medicine. During the second World War, a Buddhist monk named *Thabawa Dhama Sayardaw* promoted *Thaung Thar Chauk Lone Kauk* treatment to *Thabawa Dhama* treatment. During the Second World War period, the people had to rely more on the Myanmar Traditional Medicine. During the Japanese occupation, *Paramatta* Teatment was introduced to Myanmar Traditional Medicine.

After having her Independence in 1948, the government formed a preliminary survey committee to implement the report submitted by the Myanmar Traditional Medicine Enquiry Committee formed during the pre-war days. In 1953, Myanmar Indigenous Medicine Practitioners Act was enacted and Myanmar Traditional Medicine Development Programme Office was founded and under the supervision of Enquiry Committee, nine dispensaries each, altogether 18 were opened in Yangon and Mandalay.

In 1955, the Act for the Myanmar Indigenous Medicine practitioners was enacted and formal registration procedures were prescribed. When the Revolutionary Council Government was formed in

1962, aiming to develop traditional medicine systematically, the 1953 Act was amended and the organization for traditional medicine practitioners was formed on 11th March 1962. Formally registered traditional medicine practitioners were cancelled on 19th March 1962. Eleven traditional medicine textbooks were prescribed for three *naya* and examinations were held for five times. Successful candidates were allowed to register and 7462 traditional practitioners were properly legalized.

Free dispensaries for traditional medicine were opened in cities and towns of States and Divisions in Myanmar beginning from September 1963. Manufacturing of traditional medicine was also stated by cooperation with Burma Pharmaceutical Industy in 1964. To prevent the traditional valid treatments from being forgotten and to achieve the unity between Myanmar Traditional Medicine practitioners, the first seminar on traditional medicine was held on 5-6 April 1965 and the second from 5-7 July 1972 at the Kyaikkasan ground, Yangon. The Institute of Traditional Medicine was opened in Mandalay on 31 January 1976 and traditional medicine hospital with 25 beds for clinical works was opened on 14 October 1976. To support the institute and hospital, a traditional medicine production department, now renamed as Traditional Medicine Factory, a library, a museum and a herbal garden were also opened.A preliminary research hospital of traditional medicine with 16 beds was opened in Bogyoke Aung San Road in 1980 and transferred to the present place in Ngar Htat Kyee Road in August 1982.

Progress of Traditional Medicine after 1982

After the National Health Committee has been formed, it has laid down the National Health Policy where it states' *To reinforce the service and research activities of indigenous medicine to international level and to involve in community health care activities.'* In line with the emphasis given in National Health Policy, a department was set up in 1989with a staff strength of 700, and then later in 1997 upgraded to a department with staff strength of over 1800. Currently, the Department of Traditional Medicine (DTM) is implementing its objectives with over 2500 staff by four main depertments: Administration, Medical Care, Research and Development, and Herbal Garden and Drug Production together with the University and Institute of Traditional Medicine under the same Director General. The principal objectives of the DTM are:

1. To participate in the medical are of the people beginning from the basic level and gradually rising its role;
2. To make use of medicinal raw materials produced within the county and formulate the appropriate basic method of treatment in order to gain the acceptance and confidence of consumers;
3. To review efficacious indigenous medicine which have been used by traditional medicine practitioners for ages, for preservation, research and standardization;
4. To search for and collect treaties of indigenous medicine published during the past eras;
5. To train new traditional medicine practitioners;

6. To work side by side with Western Medicine after Traditional Medicine is generally accepted by the people as a reliable health aid;
7. To produce sufficient quantities of traditional medicine raw materials for commercial use;
8. To obtain international recognition of Myanmar Traditional Medicine on equal status with Western Medicine.

Currently, with the aim to extend the scope of health care services for both rural and urban areas, health care by Myanmar Traditional Medicine services is provided through out Myanmar. Myanmar traditional medicine has flourished over thousands of years and has become a distinct entity. With the aim to extend the scope of health care services by traditional medicine, two (100) bedded Traditional Medicine hospitals in Yangon and Mandalay; three (50) bedded Traditional Medicine hospitals in Monywar, Myitkyinar and Magway; ten (16) beded Traditional Medicine hospitals in States and Regions; and total number of (237) Traditional Medicine clinics are providing health care services all over the country.

Provision of Traditional Medicine Kits for emergency use is one of the special achievements of traditional medicine in Primary Health Care with the objectives of making essential traditional medicines easily accessible for rural people especially in hard to reach areas and minimizing the cost of treatment for minor illnesses. The Provision of Traditional Medicine Kits for emergency use is one of the special achievements of traditional medicine in Primary Health Care with the objectives of making essential traditional medicines easily accessible for rural people especially in hard to reach areas and minimizing the cost of treatment for minor illnesses. The provision of traditional medicine kits is effective and beneficial to the rural dwellers. It also supports and uplifts the health status of the people of Myanmar in context of primary health care. At the end of 2012, 11359 Traditional Medicine Kits were distributed to all States and Regions.

Herbal Gardens and Traditional Medicine Museums

With the aims of perpetuation of medicinal plant species, sustainable development of herbal medicines and provision of quality raw materials for public and private pharmaceutical factories, the department developed eight herbal gardens around the country. The largest one which is designated as the National Herbal Park is situated in Nay Pyi Taw covering 196.4 acres of land since its inception on 4th January 2008. Thousands of medicinal plants of nearly 500 different species are grown and nurtured, and commonly used and valuable herbs according to regional habitat can also be studied. There are three TM museums run by the department: one in University of Traditional Medicine, Mandalay and two in National Herbal Park, Nay Pyi Taw. People from all walks of lives can study the roots and current situation of Myanmar Traditional Medicine at one sitting. The raw materials from animal, plant, mineral and acquatic sources used in TM drug formulations are also displayed colorfully. Hundreds of herbarium sheets are also prepared to disseminate the knowledge of medicinal plants.

Manufacturing of Traditional Medicine

Traditional Medicines have been manufactured by both public and private sectors. The Department of Traditional Medicine is responsible for manufacturing in the public sector and owns two pharmaceutical factories. Medicines are produced according to the national formulary and Good Manufacturing Practice (GMP) standards. These two factories manu-facture twenty one kinds of Traditional Medicine powders which are provided free of charge to be dispensed in public Traditional Medicine facilities, and the factories al so produce 12 kinds of Traditional Medicine drugs in tablet form for commercial purpose.

The private Traditional Medicine industry is also developing and undertaking mass production of potent and registered medicines according to the GMP standard. Some private industries are now exporting traditional medicines to neighbouring countries. Due to the encouragement and assistance of the government and the manufacturing of standardized traditional medicine under GMP, public trust and consumption of TM have greatly been enhanced.

Traditional Medicine Laws

Traditional Medicine Council Law – The Myanmar Indigenous Medicine Act was enacted in 1953. The State Traditional Medicine Council, a leading body responsible for all the matters relating to traditional medicine, was formed according to that law. In the year 2000, the Myanmar Indigenous Medicine Act was replaced by the Traditional Medicine Council Law. One of the objectives of the law is "to supervise traditional medicine practitioners for abidance by the rule of conduct and discipline".

Traditional Medicine Drug Law – The Government has promulgated the Traditional Medicine Drug Law in 1996, in order to supervise systematically the production and sale of traditional medicine in the country. One of the objectives of the law is "to enable the public to consume genuine quality, safe and efficacious traditional drugs". According to the law, all the traditional medicine drugs produced in the country have to be registered and the manufacturers must have license to produce their products. Manufacturing of traditional medicine drugs must follow the good manufacturing practice. The department also supervises and monitors the advertisement of traditional medicine drugs.

Myanmar Traditional Medicine Practitioners Association

Myanmar Traditional Medicine Practitioners Association has been established in 200 after unification of various TM groups of different disciplines. The objectives of the association are to provide consolidated efforts and contribution of TM practitioners in implementation of National Health Plan; provide community health care through TM approaches; do research and strive for the development of TM; conserve the endangered species of medicinal plants and animals while revitalizing the almost extinct TM textbooks and therapies and uplift of the dignity of TM profession and practitioners. The most important missions are to conduct continuing TM educational programs,

to provide quality services and to encourage the development of evidence based TM through systematic research.

Traditional Medicine Practitioners' Conference

In order to promote the development of Myanmar Traditional Medicine, Myanmar Traditional Medicine Practitioners Conferences has been held annually since the year 2000. Traditional medicine practitioners from various parts of the country gathered and exchanged their knowledge at the conference, new policies and objectives are proposed, discussed and also reiterated the unity of TM healers for perpetuation and propagation of Myanmar Traditional Medicine. 13th Myanmar Traditional Medicine Practitioners ' Conference was successfully held in December 2012 at Nay Pyi Taw

Harmonization of Traditional Medicine Standards among ASEAN member states

The Inter-sessional Meetings on ASEAN Traditional Medicines and Health Supplements Scientific Committee (ATSC) and Task Force on Regulatory Framework Meetings were held from 11-15 March, 2013 in Nay Pyi Taw, Myanmar and was attended by delegates from Burnei Darussalam, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, the Philippines, Singapore, Thailand, Viet Nam, and representatives from ASEAN Alliance of Health Supplements Associations (AAHSA) and ASEAN Alliance of Traditional Medicine Industry (AATMI).

Education and Training for Human Resources Development in TM Sector

There had been no training school for generations. The students of ancient times had to study under a TM Physician at different situation for several years. As Myanmar tries to preserve the delicate MTM to be handed over through generations, Institute of Traditional Medicine was opened in Mandalay on 31 January 1976. It was a four year diploma course followed by one year internship till 1997. The duration of training is now 2 years with one year internship after completion of the training. In line with the National Health Policy directives, University of Traditional Medicine was opened in Mandalay on 19 December 201. It is a five year course including one year internship and will be conferred Bachelor of Myanmar Traditional Medicine (BMTM).Yearly intake is about 200. Besides the above mentioned courses, one year course for traditional medicine practitioners are opened in Yangon and Mandalay to upgrade the quality of private TM Practitioners who have been practicing without proper training.

Research and Development

The main task of R&D sector is to carry out basic analysis for traditional drugs for registration purpose and standardization of commonly used medicinal plants and quality control analysis for department owned drug factories. Besides, in order to control the quality and safety of drugs produced from the private factories R&D takes sample of drugs randomly from the market and analyse to assess whether they are adulterated with WM and whether toxic substances are included.

Research on Traditional Medicine and herbal plants are being conducted by the DMR-Upper Myanmar at Pyin Oo Lwin.

Reproductive Health Policy

In Myanmar, mothers and children constitute 60% of total population and the government has consistently given maternal and child health services as priority in national health plan. Maternal and child health services are provided both in urban and rural settings and have being increasing coverage of quality antenatal services to achieve goals set from the 1994 International Conference on Population and Development (ICPD) and the Millennium Development Goals, to reduce Maternal Mortality Ratio of 1990 to ¾ by 2015.

As early as 1992, the National Population Policy was drafted, with focus on improving the health status of the Women and Children by ensuring the availability and accessibility of birth-spacing services to all married couples voluntarily seeking such services. It also directed to provide Community with information, education and communication measures on birth spacing in advance and providing essential health care using primary health care approach to attain the prevention of diseases and promotion of health life-style. Specific policy directions are provided in the Myanmar Reproductive Health Policy (2002) to attain a better quality of life by improving reproductive health status of women and men, including adolescent through effective and appropriate reproductive health programme undertaken in a life-cycle approach. Policy statements called for operationalizing reproductive health programmes including an integrated and core package of priority interventions for pre-pregnancy, adolescent health, birth spacing, and obstetric care for pregnant women covering antenatal, delivery, neonatal, postnatal and post-abortion care. It also directed for a seeking a sustained political commitment to improve reproductive health status in accordance with the National Health Policy and to promote rules, regulations and laws on reproductive health and also directed that the Reproductive health services and activities should be conformed with National Population Policy. It also encouraged for an effective partnerships to be strengthened among and between government departments, non-governmental organizations and the private sector in providing reproductive health.

The first Five Year Strategic Plan for Reproductive Health for the period 2004-2008 implemented a set of strategies which aimed at strengthening and expanding the provision of health services and improving performance of the health systems. It contributed to improved service coverage demonstrated by increased use of modern contraception, increased proportion of births assisted by skilled attendants and higher proportion of pregnant women attending antenatal services. It was then followed with a second Five-year Strategic Plan for Reproductive Health (2009-2013) based on a review of the first Strategic Plan. It defines and promotes the implementation of the essential package of reproductive health services by level of care and sets national targets against selected key reproductive health indicators. In addition to the national Reproductive Health Policy and Strategic Plan, the issues relevant to reproductive health services are crossed-referenced in the

draft 1992 National Population Policy, Adolescent Health Development Strategic Plan (2009-2013) and the Child Health and Development Strategic Plans (2005-2009 & 2010-2014). The third Five-Year Strategic Plan for Reproductive Health (2014-2018) is currently at the drafting stage and the goal of the programme is to attain a better quality of life of the people by contributing improved reproductive health status of women, men, adolescents and youth. The Strategies Include: providing a comprehensive package of essential interventions and services; ensuring an integrated care; strengthening health systems for RH; building the health workforce capacity; promoting research and innovations for evidence based responses; and strengthening community participation. The guiding principles also include Myanmar's commitment to achieving the MDGs and achieving universal access to reproductive health by 2015 and also pledged to the 'UN Secretary General's Global Strategy for Women's and Children's Health' which claimed to make a decisive move to improve the health of women and children.

The Ministry of Health takes the key role for health development and uplifting the status of health of the population. In line with the National Health Policy, national NGOs such as Myanmar Maternal and Child Welfare Association (MMCWA), Myanmar Red Cross (MRCS) and Myanmar Medical Association (MMA) play a proactive role in the promotion of reproductive health. The Ministry of Health works in close collaboration with INGOs, Bilateral and Multilateral organizations.

Components of Reproductive Health

The components of reproductive health comprises of:

- Maternal and Neonatal Health
- Abortion
- Birth Spacing
- Reproductive Health of Adolescent and Youth

Maternal and Neonatal Health

Approximately 1.3 million women give birth each year in Myanmar. The burden of maternal mortality and newborn mortality and ill-health is considerable. The maternal mortality ratio (MMR), referring to the number of pregnancy related maternal deaths per 100,000 live births remains elevated: for every 100,000 live births there were estimated 316 maternal deaths in 2004-2005. Bringing maternal mortality down and reaching the national MDG5 target of MMR less than 145 per 100,000 live births by the year 2015 is an ongoing challenge.

Maternal, child and youth has been accorded as a priority issue since Maternal Mortality Rate, Neonatal Mortality Rate, Infant Mortality Rate and Under-5 Mortality Rate are critical and sensitive indicators of the country's health social and economic status. It has given as a priority issue in the NHP, aiming at reducing the maternal newborn, infant and child morbidity and mortality. Commitments to MDGs also signify to achieve the time-bound improvements to targets 4 and 5. The first, second and third Five-year Strategic Plans for Reproductive Health and Five-year Strategic Plan for Child Health Development (2005-2009) were developed with inputs from key stakeholders. The

Department of Social Welfare under the Ministry of Social Welfare, Relief and Resettlement is carrying out preventive, protective and rehabilitative measures for vulnerable group such as child, women, youth, disabled persons and elderly. Myanmar National Plan of Action for children (2006-2015), which consists of plans based on the MDGs and the WFFC, is being carried out by focussing in 4 areas: health , nutrition, water and sanitation, and child development and child protection.

Abortion

Under the Penal Code of Myanmar, section 312 states that ' whoever , voluntarily causes a woman with child to miscarry shall, if such miscarriage be not caused in good faith for the purpose of saving the life of the women , be punished with imprisonment of either description for a term which may extend to three years, or with fine, or with both; and if the woman be quick with child, shall be punished with imprisonment of either description for a term which may extend to seven years and shall be liable to fine.

However, a pregnancy may be legally terminated in good faith to save the life of the pregnant woman. A family planning association was established in Myanmar in 1960, but its activities virtually ceased as of 1963. Evidence suggests that women undergo abortion unsafe conditions and tend to approach health care provides late for management of complications. Provision of services for management of complicated abortions, post-abortion counselling and post-abortion birth spacing services have imposed slightly. However, these factors still poise a challenge. According to the 2007 FRHS, almost 5% of all pregnancies end in abortion. This proportion was higher among urban women (6.89%) than rural (4%) and higher in pregnancies of young women. The abortion rate is positively associated with the level of education; women with a higher education are more likely to choose abortion.

Birth Spacing

The official recognition of birth spacing strategies began in 1992 with UNFPA assistance and has been actively promoted since then. Before that female sterilization services were common and other methods of contraception were available through private pharmacies. It has been demonstrated a gradual increase in its contraceptive prevalence rate (CPR) reaching 37% in 2001 (32.8% using modern methods and 4.2% - traditional methods) and 41% in 2007 (38.4% for modern methods). The 2009-2013 Reproductive Health Strategic Plan sets the target for CPR of 45% (modern methods) by the year 2013.

Government Health Centres provide facilities and manpower for contraceptives provided by UNFPA at subsidized rates in 132 of the county's 325 townships. PSI/Myanmar signed a MOU with MOH which allows PSI/Myanmar to work in the field of Reproductive Health. It has the privilege of having tax exemption to procure quality contraceptives internationally. It has provided highly subsidized price so that even low income women and men could afford them. Marie Stopes International (MSI) also has MOU with MOH and is implementing social marketing of contraceptives

in their project townships, approximately 24 townships. MSI opens RH clinics and they reach communities using different approaches providing capacity building for youth through ASRH training and supports tertiary hospitals with emergency obstetrics commodities. Myanmar Medical Association has well established partnership with both public and private sectors providing training for skills in Reproductive Health services including birth spacing and provides mobile services. Other NGOs such as MDM, AMDA, AMI, SC, YWCA and Malteser also have demonstrated a potential to improve to birth spacing commodities.

Recognizing the urgent need to address the contraceptive shortfalls, a high level stakeholder meeting chaired by the Deputy Minister for Health was held in Nay Pyi Taw in December 2008. A National Reproductive Health Commodity Security Sub-Committee was formed to assess current situation on RH commodities in both private and public sectors, identify and coordinate efforts in securing supply of commodities, including improving Reproductive Health information system and strengthening logistic management information system (LMIS) for forecasting, procurement, supply, storage and distribution of contraceptive commodities. At the last coordinating meeting all partners, UN, NGO who work in the area of Reproductive Health and Birth Spacing were invited in October 2010. The Deputy Minister provided policy directions and advocacy for resource mobilization to meet RH commodity requirements. The MOH also requested UNFPA, as the sole provider of Birth Spacing commodities, to expand project townships as many as possible in order to expand the coverage and to achieve universal access although they do not allocate any budget for contraceptives.

Reproductive Health of Adolescent and Youth

Young people are the future of every society and also a great resource of the nation and they constitute one fifth of the total population. Sixteen percent of youth approved of pre-marital sex for boys while only seven percent of youth approved of pre-marital sex for girls. Protection of the youth and adolescents from sexual and reproductive health problems essentially depends on the correct knowledge of the physiology of human reproduction. Reproductive health services and information can improve the health status of adolescents and help them attain the level of understanding required to make responsible decisions.

The 2009-2013 National Strategic Plan for Adolescent Health and Development addresses general issues of adolescent health and define strategies for adolescents' reproductive health in particular by supporting adolescent-friendly health services. The latter includes, among others, provision of diagnosis and treatment of sexually-transmitted infections, provision of voluntary counselling and testing for HIV, provision of counselling and contraceptive services, antenatal, delivery, post-natal and post-abortion care. A strategy promoting HIV related reproductive and sexual health education for young people has been developed in cooperation with Maternal Child Health, Reproductive Health and School Health Section of DOH. National AIDS Programme in coordination with Department of Educational Planning and Training (DEPT), Ministry of Education and UNICEF, has introduced **S**chool Based **H**ealthy Living and **A**IDS **P**revention **E**ducation" ***(SHAPE)*** Programme since

1997. In 2006, *National Life Skills Curriculum*based on SHAPE developed by Ministry of Education and is being implemented in schools all over the country. HIV education is part of the curriculum in primary, secondary schools and teacher training in cooperation with Ministry of Education.

Myanmar National Strategic Plan on Adolescent Health and Development

In the overall context of National Health Plan 2006-11, MOH aims at contributing to "the uplift of the health standards of the entire nation by promoting adolescent health activities". The MOH is striving to achieve better coordination among several primary health care projects and has incorporated Adolescent Health component into School Health and Adolescent Health in 2001-2006 National Health Plan. The National Health Plan 2006-11 also states the need for continuing strengthening of the health services to reduce the adolescent health problems.

Several primary health care projects are currently addressing different aspects of adolescent health and development issues. In order to converge the adolescent portions under these projects, a. strategic plan for adolescent health and development has been evolved. All the stakeholders who are interested in the area of work will be participating with deliberating on it and contributing to it. This sets out priority health issues, and expected outcomes, and including implementation activities with building capacity. This strategic plan will encourage coordinated and expanded implementation and monitoring of activities by various programmes as to common goals/targets. The strategic plan is guided by a vision of sustainable adolescent health and provides a logical framework for decision making for the achievement of the objectives. The strategic plan also calls for a commitment by a wide coalition of forces within the country and among external partners to working together in new ways on the adolescent health frontier. It is geared towards full participation at all levels, donor partners, NGOs and the community groups.

Key Principles are:

- A strong partnership between these stakeholders is a key element. The plan draws on the strength of existing resources within the country and engages all potential stakeholders;
- Activities integrated and coordinated with focus on adolescents and their social environment with a mix of promotive, preventive and curative health care programme;
- Supportive environment and services for all adolescents for making progress on specific health outcomes;
- Common goals and operational strategies arc outlined to adapt at township level as to the local needs and priorities;
- The resource reality worked and an incremental scaling up promoted;
- Participation of adolescents themselves in the development activities;
- Advocates for multisectoral approach while focusing on health sector response.

The Goalis to improve knowledge, attitudes and skills of young people thereby encouraging adoption of healthy lifestyles, and increase adolescents' access to appropriate health services.

The Priority Areas of Plan were: Reproductive health and HIV/AIDS; Nutrition; Substance abuse (tobacco, alcohol); and Injuries. The strategic plan for Adolescent Health and Development derives its overall direction from the National Health Plan (2006-2011) and aims to achieve the following

Objectives:

- To promote the health and development of young people by providing accurate and culture specific information through appropriate channel of communications;
- To increase utilization of health services by young people through orientation of existing ones to Youth Friendly Health Services;
- To reduce the morbidity and mortality in adulthood resulting from preventive conditions and behaviours during adolescence.

Strategic Directions are:

- Creating supportive and enabling environment;
- Improving the provision of information and skills to adolescents;
- Improving accessibility and utilization of health services.

The Adolescent Health and Development Strategic Plan was developed by a vision of sustainable adolescent health and provides a logical framework for decision making of the achievement of the objectives by the Department of Health and other partners. The plan also called for a commitment by a wide coalition of forces within the country and among external partners on working together in new ways and means on the adolescent health frontier. It was geared towards reaching at all levels of the NGOs, donor partners and community groups.

Myanmar Maternal and Child Welfare Association

The Government of Republic of Union of Myanmar is implementing the National Health Policy in order to fulfil the requirement of the health needs of the people of Myanmar in accordance with one of the social objectives : to uplift health, fitness and educational standards of the entire nation. In the National Health Policy of Myanmar, one of the statements has been articulated as 'to augment the role of cooperative, joint venture, private sector and non-governmental organizations (NGOs) in delivery of health care in view of changing economic system.' In line with National Health Policy, Myanmar Maternal and Child Welfare Association (MMCWA) has been contributing complementary assistance in service provision in health care delivery as leading NGO of the Ministry of Health. Role of MMWCA provide a fruitful shouldering to achieve Development Goals (MDGs).

The State Law and Order Restoration Council has adopted Law no. 21/90 – Myanmar Maternal and Child Welfare Association Law. MMCWA, a voluntary organization was founded on 30 April 1991 on the basis of this Law. As the name implies, the mission statement is to serve Myanmar society by improving the health and well-being of mothers and children and in turn aiming to improve the quality of life of the people. It has four main objectives and the first objective is to strive to

achieve the stated mission with special interest in health and wellbeing of mothers and children. The second objective is to carry out four major activities, namely: education, health, economic and social activities down to the wards and villages all over the country. The third one is to provide necessary assistance from the Central Council to various levels, and the fourth objective is to cooperate with related departments and other NGOs.

MMWCA inherents multi-sectoral dimension approach in every of its health intervention. The understandings of health purely as a technical issue no longer exist. Education and socio-economic development are now required to consider health in a broader context. Health has a mutually reinforcing relationship with community development. MMWCA has been working closely with the Government Departments, Mutilateral and Bilateral partners, other Development Partners, INGOS and NGOs in areas of health, education and socio-economics with particular focus on achieving MDGs. In this perspective, MMWCA provides Reproductive Health Services at Maternity Homes with the aim to reduce maternal, newborn and infant mortality rate. There are 133 maternity homes throughout the country. Maternity homes health care services include antenatal care, safe and clean delivery by skilled birth attendants (midwifes, doctors), post natal care, promotion of exclusive breast feeding, birth spacing, counselling and immunization. Eleven Maternity Waiting Homes are also established to provide a shelter for risk pregnancy from remote areas. Activities such as eye care for cataract patients, corrective surgery for congenital defects including harelip and cleft palate, prevention and control activities of malaria, tuberculosis, HIV/AIDS, environmental health activities are also provided. Nutrition promotion and growth monitoring is an important activity of the Association at different levels. Elderly care and anti-tobacco activities have also been carried out throughout the nation. Training on indigenous medicine has been provided to housewives and they are encouraged to practice within their family. Another focus of the Association is dissemination the information among youth on the effect and consequences of drug using and its related HIV infection. For prevention and control activities of malaria and TB as well, MMCWA and branch members have participated as frontline volunteers in case finding, referral and provision of DOTS, provision of Insecticide Treated Bed Net (ITBN) and antimalarial treatment.

To raise the standard of living of families and in line with its mission statement, MMWCA is actively engaged in humanitarian activities. Future plans are laid down every year. Under the guidance of the Executive Committee, close supervision and monitoring to States and Regional Supervisory Committees and in collaboration with local authorities and stakeholders at different level, activities under the work plan are being implemented. MMCWA strives to consolidate the strengths so identified while rectifying its weaknesses in order to attain its goal and mission objectives for the development of the entire nation.

Draft National Population Policy (1992)

1. Improve the health status of the Women and Children by ensuring the availability and accessibility of birth- spacing services to all married couples voluntarily seeking such services.

2. Provide the Community with information, education and communication measures on birth-spacing in advance as it is important.
3. Encourage Myanmar women to fully participate as equal partners in national development by given them equal status with men.
4. Promote the awareness of the citizens of the nation on the responsibility of the reproductive behaviour and also educate the male population of their responsibility.
5. Utilization of young people international development efforts as the youth population of under 18
6. constitutes about 50% of the total population.
7. The government is committed to a strategy of providing essential health care using the primary health care approach. Therefore to attain the prevention of diseases and promotion of healthy life-style, the basic facts included in the primary health must be emphasized.
8. Raise the social status of rural community by taking into account the internal and international migration issues. Integration of comprehensive urbanization policy into the overall development planning process while ensuring effective economic interdependence between towns and villages.
9. Raise the awareness of the importance of population information and vital statistics for socio-economic planning.
10. Review and amendment of existing legislation to support the achievement of the objectives of population policy.

Myanmar Reproductive Health Policy 2002

Goal: To attain a better quality of life by improving reproductive health status of women and men, including adolescents through effective and appropriate reproductive health programmes undertaken in a life-cycle approach.

The National RH Policy states:

1. Political commitment should be sustained to improve reproductive health status in accordance with the National Health Policy and to promote rules, regulations and laws on reproductive health.
2. Reproductive health care services and activities should be conformed with National Population Policy
3. Full respect to laws and religion, ethical and cultural values must be ensured in the implementation of reproductive health services
4. The concept of integrated reproductive health care must be introduced into existing health services and programmes. Quality reproductive health care must be provided in integrated packages at all levels of the public and private health care systems

5. Effective partnerships must be strengthened among and between governmental departments, nongovernmental organizations and the private sector in providing reproductive health
6. Reproductive health services must be accessible, acceptable and affordable to all women and men, especially underserved groups including adolescents and elderly people.
7. Effective referral systems must be developed among and between different levels of services.
8. The development of appropriate information, education and communication [IEC] material must be strengthened and disseminated down to the grass-root level to enhance the community awareness and participation.
9. Appropriate and effective traditional medicines and socio-cultural practices beneficial for reproductive health must be identified and promoted.
10. Adequate resources must be ensured for sustainability of reproductive health programmes.

Myanmar Reproductive Health Strategic Plan 2009-2013

Goal: To attain a better quality of life of the people of the Union of Myanmar by contributing to improved reproductive health status of women, men, adolescents and youth and achieving MDG 5 targets of reducing maternal mortality by three quarters and achieving universal access to reproductive health by the year 2015.

Core Objectives:

- Improving antenatal, delivery, post-partum and newborn care.
- Providing quality services for birth spacing and prevention and management of unsafe abortions.
- Preventing and reducing reproductive tract infections (RTIs); sexually-transmitted infections (STIs),
- including HIV; cervical cancer and other gynaecological morbidities.
- Promoting sexual health; including adolescent reproductive health and male involvement.

Priority areas for action:

- *Setting enabling environment* with strong local, national and international support. This implies advocacy and strong political will to galvanize resource mobilization and investments in reproductive health, establishing regulatory frameworks and mechanisms to coordinate performance and high standards of accountability.
- *Improving information base for decision making* on reproductive health and maternal and newborn health for advocacy and decision making. Analysis of data on epidemiological variables, service availability and its utilization, social science data on reproductive health, improved data availability and its analysis.
- *Strengthening health systems and capacity for delivery of reproductive health services*: to invest for

- availability of essential services at the primary health care level with effective linkages to referral hospitals at the secondary and tertiary levels.

Strategic directions of NSP (2006-2010) for HIV and AIDS

Highest priority: (highest risk population groups with HIV prevalence of above 5%)

- Reducing HIV-related risks, vulnerability and impact among sex workers and their clients.
- Reducing HIV-related risk, vulnerability and impact among men who have sex with men.
- Reducing HIV-related risk, vulnerability and impact among drug users.
- Reducing HIV-related risk, vulnerability and impact among partners and families of people living with HIV.

***High priority*:** (vulnerable population groups with HIV prevalence of 1-5%)

- Reducing HIV-related risk, vulnerability and impact among institutionalized population
- Reducing HIV-related risk, vulnerability and impact among mobile population
- Reducing HIV-related risk, vulnerability and impact among uniformed service personnel
- Reducing HIV-related risk, vulnerability and impact among young people

***Priority*:** (lower-risk population groups with HIV prevalence of less than 1%)

- Enhancing prevention, care, treatment and support in the workplace
- Enhancing HIV prevention among men and women of reproductive age
- Fundamental overarching issues:
- Meeting needs of people living with HIV for comprehensive care, support and treatment
- Enhancing the capacity of health systems
- Monitoring and evaluating

Active Aging

Myanmar's population is beginning to age rapidly. Although demographic information for Myanmar is limited because the last national census was in 1983, long term estimates and projections are available from the United Nations Population Division. As in other countries across Southeast Asia, the number of older people in Myanmar is increasing rapidly, having virtually quadrupled over the past 60 years. Moreover, due mainly to the ongoing decline in fertility and to some extent improved life expectancy, the proportion of the population that is 60 years and older is increasing. Currently older people account for about 9% of the country's population. This proportion has grown at a gradual pace over the past 50 years but will accelerate rapidly over the next four decades.

In old age, the spouse or adult children are usually a vital source of material and emotional support and serve as caregivers when the need arises. Because just over half of older women are widowed, they must rely more heavily on their children, while three fourths of older men are still married. Older people today have an average of four to five living children and only 6% are childless.

But fertility rates in Myanmar have already fallen to two children per woman, so older people in the future will have fewer adult children available to provide support.

Older people in Myanmar typically live in low income households. Almost 10% report that their household has a monthly income of no more than 25,000 kyat, or less than US$ 1 per day (at current rates) and just over 60% report that their household income is no more than US$ 3 per day. Less than one in five older persons has savings in the form of money or gold and are twice as likely to have debts as savings. Only 55% of older people feel that their income is regularly adequate to meet their daily needs.

Health can greatly affect quality of life, physical independence and financial security. Only a third of older people in Myanmar say that their health is good or very good. Reports of poor health increase from 17% to over 30% between those aged 60–64 and those aged 80 and older. A large majority of older persons experienced one or more symptoms of ill health during the previous month, the most common being pain in their joints and spells of dizziness. Just over one-third of respondents had illness or injury during the past 12 months that prevented them from carrying out normal activities. Overall, nearly 15% of older people indicate problems with hearing and close to 30% with sight. Many older people in Myanmar remain active and independent. They work for income or else provide help around the home and with grandchildren, thus allowing their adult children to be economically more productive. However, many others are vulnerable and need assistance, especially as they reach advanced years.

With the objectives to promote health of the older people and increase the accessibility of geriatric care services for them, Elderly Health Care Project has been formulated the following strategies;

- Promotion of effective geriatric health care services through proper training of basic health staff and volunteers.
- Establishing geriatric clinics in the existing health facilities.
- Increasing awareness of healthy ageing among the family and community through various media.
- Promoting community participation through social mobilization.
- Promoting healthy living in older people focusing on behavioral aspect (life styles modification) such as nutrition, physical exercise, cessation of tobacco and alcohol consumption.
- Strengthening the cooperation and collaboration with related sectors, NGOs and INGOs in well- being of older people

Elderly Health Care Programme is under the Improving Health for Mothers, Neonates, Children, Adolescent and Elderly as a Life Cycle Approach Programme Area of National Health Plan (2011-2016). This programme is based on comprehensive health care; promotive, preventive, curative and rehabilitative care. Health personnel from both clinical side and public health side are jointly implementing the activities of this programme. Department of Health takes part in leading role for

healthy ageing programme and it is also responsible for coordination and partnership with related ministries, UN agencies, INGOs, NGOs and CBOs.

Raising awareness on active and healthy ageing among stakeholders is an important issue, therefore World Health Day talks on “Good health add life to years”, workshop on “Promoting Active and Healthy Ageing through health care professional”, symposium on “Challenges of Active and Healthy Ageing in Myanmar” in 41st Myanmar Health Congress were conducted in 2012-2013.

At present dementia is one of the commonest health problem in older people but awareness on dementia is very low even among health care professionals especially psychosocial support for dementia. Symposium on Dementia in Myanmar organized by Health Care for the Elderly Programme in Myanmar was held in 2012.

National policy and legislation on social, economic and health actions for aging population in Myanmar is the important addressing issue and formulation of national policy and legislation will be come out with the collaborative effort of all stakeholders.

Due to the improvement in health care technologies and socio economic conditions, lifeexpectancy becomes longer and elderly population is increasing worldwide. One third ofcountries in Asia Pacific Region are now occupied with elderly population from 8%, includingMyanmar, to 26.4% of total population in Japan.[1] As the globalization interconnected betweenmany countries, such effects have many impacts on health and wellbeing of older people.[2]Unlike industrialized countries, developing countries have less comprehensive policy and elderlyhealth agenda. These need to be addressed as there will be potential threat for burden of aging.Although Old Age Right was proposed since UN general assembly 1948, it becomes inactive until1991 when the charter for the UN principles of older persons was adopted.

As major interest of international agencies focus on diseases control and primary health careactivities, governments have to take sole responsibilities for elderly health care comprehensively.However, elderly programmes have many challenges in both technical and resource efficiency.In developing countries, socio-economic and gender development issues that interact elderlyhealth are less addressed in political as well as public agendas. Furthermore, there are manyunequal facilities in basic health, medical care and social support for elderly those live in ruralareas in many countries, including Myanmar.

Health Workforce Strategy

Introduction

The country has committed to the Millennium Development Goals and all efforts are currently being directed to it collectively by both the Government and Development Partners. To achieve the health goals of the MDGs by 2015, sufficient quantity, quality, appropriately skill mixed and need based distribution of human resources is critical.

It was estimated there were 88,975 health workers, including 26,435 medical practitioners, 25,544 nurses and 19,556 midwives in 2010-2011. Together, this equalled to 1.49 health workers (doctors, nurses and midwives) per 1,000 population, well below the recommended WHO minimum threshold of 2.3 health workers needed to support the achievement of the Millennium Development Goals. However, these estimates include non-practicing health workers, and those who are employed by other Ministries, including Labour and Defence.

The health workforce has a high proportion of women, with almost 75% female health workers. There is an even spread of health workers in urban and rural areas even though only 34% of the Myanmar people living in urban areas. Furthermore, health facilities in the rural areas are mostly staffed with Basic Health Staff (BHS) – health assistants, midwives, public health supervisors, lady health visitors and community health workers, who require further training and logistical support.

Due to limited information on the private sector, it is difficult to estimate the availability and deployment of health personnel and ascertain the true state of HRH in Myanmar. It is known however, that the private sector is playing an increasingly important role in the Myanmar health system, particularly in ambulatory care. It is essential to understand the contribution of the private sector and to regulate its involvement.

The main HRH issue is the shortage of health workers in rural areas. Basic health staffs are responsible for providing health services to approximately 70% of the population, largely in rural areas. These workers face many challenges in their effort to reach out to remote villages, with meagre resources and support. Accessibility to health services is hampered by health worker shortages, particularly in conflict areas near the borders, high levels of private financing of health services, security issues, poor infrastructure and transport, lack of equipment, resources and drugs, cultural and language difficulties and geographic isolation.

In view of these constraints, there has been a focus on extending the coverage and access to services through up scaling the production of health personnel without sufficient emphasis on their capacity to deliver quality health services. Furthermore, production and recruitment of health workers are often not well synchronised, with an excess number of doctors relative to recruitment quota, and lack of nursing personnel to fill vacancies in rural areas. Pre-service education is also affected by inadequate funding and infrastructure which in turn affects the capacity of the institutions to offer quality programs.

In the absence of a focal point unit/department in the Ministry of Health to coordinate all aspects of HRH; HRH planning, management and production are not sufficiently aligned and impacts on the efficiency and effectiveness of health personnel development and deployment.

Underpinning many of the difficulties associated with HRD is the insufficient investment and allocation of resources for improving all aspects of HRH production and deployment.

HRH policies and plans

The current National Health Plan 2011-2016 recognized the urgent need to develop a strategic plan for the health workforce. With the support of WHO, the formulation of the strategic plan commenced in August 2012 and it is expected that a first draft will be available by April 2013. The four objectives related to HRH identified in the National Health Plan are:

- To collect and compile health workforce related data and information from both public and private sector;
- To conduct research for finding HR gaps and evidence-based data for future plan;
- To involve as many stakeholders as possible in drawing health workforce strategic plan; and
- To analyse data, project and draw the National Health Workforce Strategic Plan for the next five years using HRH software.

The Ministry of Health has convened a working group to harmonize HRH policies across all government ministries. This group includes representatives from:

- Ministry of Health (all departments);
- Ministry of National Planning and Economic Development (planning department);
- Ministry of Finance and Revenue;
- Union Civil Service Board;
- Ministry of Defence (health directorate);
- Myanmar Medical Association;
- Myanmar Health Assistant Association;
- Myanmar Nursing and Midwife Association; and
- Myanmar Medical Council.

Policy development, planning and managing HRH

The Myanmar Health Vision 2030 was developed in 2000 and encompasses the national objectives (political, economic and social). It is a long term plan to guide shorter term national health plans. There are nine objectives in the Myanmar Health Vision 2030, one of which focuses on HRH (*To train and produce all categories of human resources for health within the country)*

From the Myanmar Health Vision 2030, there have been four types of health development plans prepared. These include:

- Special Four Year Plan for Promoting National Education: Health Sector (2000/2001-2003/2004);
- National Health Plan (2001-2006, 2006-2011 and 2011-2016);
- Rural Health Development Plan (2001-2006); and
- Hospital Upgrading Plan (2001/2002-2005/2006) (Myanmar Ministry of Health, 2011).

The current National Health Plan (2011-2016) was developed by the Steering and Working Committees, formed by the Ministry of Health. These Committees include stakeholders from all health related ministries and other stakeholders, but a key stakeholder excluded from such decision making is the Universities. The plan is developed through a series of meetings and workshops and is

formulated within the objectives of the Myanmar Health Vision 2030 and any uncompleted objectives of the previous health plan. National Health Plans are evaluated on yearly basis (Myanmar Ministry of Health, 2011).

The previous National Health Plan highlighted the fact planned expansion of health personnel and facilities have not met set targets as expansion has occurred mostly at a higher level (hospitals) than at grassroots level, namely the development of more rural health centers, school health teams and maternal and child health centers. It also noted that the public health workforce needs to be strengthened.

The Basic Health Service and Public Health Divisions at the Department of Health are responsible for administration, management, implementation, supervision, monitoring and evaluation of health care activities, particularly in rural areas. There are dedicated personnel at the State/Regional Health Departments that are responsible for supervising and monitoring of health services to improve the performance of BHS (Myanmar Ministry of Health, 2011). However, the depth and coverage of supervision is not adequate enough to cover the entire country.

The Department of Health Planning has developed a four-year plan to promote National Education and the Myanmar Health Vision 2030. This was completed with the collaboration of all departments under the MOH. Both the National Health Plan and Health Sector Technical Working Paper highlight problems attributed to vertical program planning that has led to the development of parallel systems of planning, reporting and implementation. This affects efficiency, with health workers spending more time doing administrative tasks rather than providing clinical or public health services.

Planning, management and production of HRH requires intensive coordination at both policy and operational level. In the absence of a focal point unit with responsibility for coordinating and monitoring all aspects of HRH, it is challenging for the Ministry of Health and other government agencies to ensure efficient exchange of information and coordination in this area. The Department of Medical Science, for example is responsible for the production of health workers but graduates are deployed by the Department of Health. Production and employment is often not matched, with surpluses in some professions and shortages in others. Health workforce demand is determined by the expansion of health facilities, procurement of new technology and population growth. However, increasing hospital bed numbers or increasing rural health facilities is the responsibility of the Ministry of National Planning and Economic Development, which in turn is constricted by the budget set out by the Ministry of Finance, who also determines any salary increases. This has resulted in an overproduction of some health workers (e.g. doctors) but not enough in other areas (e.g. in nursing) (Myanmar Ministry of Health 2006b).

Professional Regulation

Currently, only doctors, nurses, dentists and traditional medical practitioners are required to be registered and licensed to practice. All other health workers are not required to be regulated.

Medical practitioners

The Myanmar Medical Council Law was passed in 2000 and defines medical duties and rights. The Myanmar Medical Council is responsible for:

- Registration and licensing of generalist, specialist and foreign medical practitioners;
- Control of professional practice and conduct through supervisory bodies appointed by Council; and
- Setting standards and professional practice guidelines for medical education and practice (The State Peace and Development Council, 2000a).

The Myanmar Medical Association has approximately 17,000 members, approximately half of the medical practitioners in the country. It assists the Ministry of Health in implementing primary health care services and providing CPE to doctors (information dissemination) through conferences, workshop seminars, refresher courses, CPE package courses and the Myanmar Medical Journal.

Nursing and midwifery personnel

The State Law and Order Restoration Council Law Relating to the Nurse and Midwife was enacted in 1990 and amended in 2002. The Act defines in general terms, nursing and midwifery duties and rights. The Myanmar Nurse and Midwife Council are responsible for:

- Registration and licensing of nurses and midwives;
- Control of professional practice and conduct through supervisory bodies appointed by Council;
- Setting standards and professional practice guidelines for nursing and midwifery education and practice; and
- Prescribing conditions of professional practice of nurse aides and auxiliary midwives with the approval of the Ministry of Health (The State Law and Order Restoration Council, 1990).

Registration of nurses is given by showing their graduating certificate provided from the training schools. Once registered, nurses are required to renew their license every two years.

The Myanmar Nurse and Midwife Association functions much like a union and its role is mainly to increase capacity building and continuous professional development of nurses and midwives. It also looks after the welfare of the nurses and midwives, especially in provision of aids for elderly retired or sick nurses.

Dentists

Dentists are registered through the Myanmar Dental Council. However, there is currently no information available on the registration process.

The Myanmar Dental Association is a dental union and was formed in 1979. It currently has over 1,500 members across 15 branches.

Traditional medicine practitioners

The Traditional Medicine Council was formed under The Traditional Medical Council Law 2000. It is responsible for:

- Registration and licensing of traditional medical practitioners;
- Control of professional practice and conduct through supervisory bodies appointed by Council; and
- Setting standards and professional practice guidelines for traditional medicine practice (The State Peace and Development Council, 2000b).

Applicants to the Council need to have graduated from the University of Traditional Medicine or the Traditional Medical Institute; pass a qualifying examination set by the Council; or be recognised by the Council as possessing qualifications deserving of a traditional medical practitioner (The State Peace and Development Council, 2000).

HRH information systems

There is a national health information system but no current national health workforce database. However, it will be created as part of the development of the National Health Workforce Strategic Plan under the current National Health Plan 2011-2016. Each of the departments under the Ministry of Health has their own health workforce database but there is no central one. In addition, health workers are also employed in other ministries, including Ministry of Labour, Ministry of Mining and Ministry of Power and Energy. In 2008, it was reported that information collected on the public health workforce by the Department of Health were standardized across all cadres and included: name, date of birth, national registration number, race, religion, place of birth, address, patient's names and occupation, spouse's name and occupation, formal qualification and year of completion, children's names and date of birth, siblings names and occupation, disciplinary record, medical history, salary, speciality (if any), training attended, and employment history.

The national health information system uses a minimum dataset and has been decentralized across the health system to facilitate completeness and validity of data collection. It has been used to plan, monitor and evaluate health service implementation and also for disease surveillance. Data is collected from all health facilities using collection tools and procedures that have been standardized (WHO, 2006). Health staff at all levels of the health system are responsible for collecting health data and report monthly for mid-year and yearly monitoring and evaluation. Monthly reports are collected from all government hospitals. Medical record technicians are also trained in data collection. Assistant medical superintendents or medical officers responsible for medical record department also attend short courses to facilitate for supervising the performance of medical record technicians .

In 2010, a National Workshop reviewed the dataset of public health information system to determine relevance and gaps in information collection. Evaluation of the Health Management Information System was conducted at the Township, State and National level to determine difficulties in data collection, management, and analysis .

Health workers at national level in 2006-2007 and 2010-11

Health Occupational Categories/Cadres	2006-2007		2010-2011	
	Total	HW/1000 population (Pop. 46,605,278)	Total	HW/1000 population (Pop. 47,963,012)
Medical practitioners	20,501	0.44	26,435	0.55
Health assistants	1,778	0.04	1,899	0.04
Graduate/registered/professional nurses	21,075	0.45	25,644	0.53
Midwives	17,703	0.38	19,556	0.41
Dentists	1,732	0.04	2,562	0.05
Dental technicians and assistants	165	0.00	287	0.01
Lady health visitors	3,137	0.07	3,344	0.07
Public health supervisors I & II	1,923	0.04	2,621	0.05
Traditional medicine practitioners	5,841	0.13	6,627	0.14
Total	73,855	1.58	88,975	1.86

Source: Myanmar Ministry of Health

Distribution of health workers by urban/rural areas

Overall, there are about the same number of health workers in urban and rural areas (Table 8). However, as only 34% the population live in the urban areas this distribution is inappropriate. Most highly skilled and specialist health workers are based in urban areas, with rural Myanmar populations having access only to lesser skilled, community based health workers including auxiliary midwives and public health supervisors.

Distribution of health workers by urban/rural areas in 2008

Health Occupational Categories/Cadres	Total	Urban		Rural	
		%	HW/1000 population (Pop. 15,394,153)	%	HW/1000 population (Pop. 31,856,162)
Generalist medical practitioners	2,472	84.7	0.14	15.3	0.01
Specialist medical practitioners	1,713	100.0	0.11	0.0	0.00
Graduate/registered/professional nurses	9,363	89.4	0.54	10.6	0.03
Midwives	105	100.0	0.01	0.0	0.00

Midwifery associate professionals	21,789	0.0	0.00	100.0	0.68
Generalist dental practitioners	484	98.3	0.03	1.7	0.00
Specialist dental practitioners	62	100.0	0.00	0.0	0.00
Dental technicians and assistants	10	100.0	0.00	0.0	0.00
Pharmacists	32	100.0	0.00	0.0	0.00
Pharmaceutical technicians and assistants	877	68.1	0.04	31.9	0.01
Physiotherapists	146	100.0	0.01	0.0	0.00
Nutritionists and dieticians	14	100.0	0.00	0.0	0.00
Optometrists	27	100.0	0.00	0.0	0.00
Medical and pathology laboratory technicians	2,681	100.0	0.17	0.0	0.00
Medical imaging and therapeutic equipment technicians	466	100.0	0.03	0.0	0.00
Medical and dental prosthetic technicians	22	100.0	0.00	0.0	0.00
Environmental health and hygiene professionals	4,500	64.1	0.19	35.9	0.05
Community health workers	12,998	16.9	0.14	83.1	0.34
Non-health professionals not elsewhere classified	2,193	100.0	0.14	0.0	0.00
Ambulance workers	145	100.0	0.01	0.0	0.00
Traditional and complementary medicine associate professionals	5,953	88.2	0.34	11.8	0.02
Personal care workers	442	100.0	0.03	0.0	0.00
Clerical support workers	320	100.0	0.02	0.0	0.00
Domestic and ancillary workers	20,989	76.2	1.04	23.8	0.16
Total	87,803	52.7	3.00	47.3	1.31

Source: WHO Myanmar HRH country profile 2011 (unpublished)

Distribution of health workers by sector

Little is known about the private sector workforce due to the lack of reliable data. According the Ministry of Health, it is estimated that 59% of medical practitioners, 68.3% of dentists and 86.6% of traditional medicine practitioners are employed in the private sector. However, it is unknown whether these health workers practice solely in the private sector or have dual roles.

Distribution of health workers by public/private sector in 2010-2011

Health Occupational Categories/Cadres	Total	% Public	% Private
Medical practitioners	26,345	41.5	58.9
Health assistants	1,899		
Graduate/registered/professional nurses	25,644		
Midwives	19,556		
Dentists	2,562	31.7	68.3
Dental technicians and assistants	287		
Lady health visitors	3,344		
Health supervisor	2,621		
Traditional medicine practitioners	6,627	13.4	86.6
Total	**88,885**		

Source: Myanmar Ministry of Health

Skills distribution

The overproduction of medical graduates and underproduction of nurses has caused significant mal-distribution of skills, with approximately one nurse for every doctor in 2010-2011 (Table 10). Between 1988 and 2007, the number of medical doctors has more than doubled from 3,242 to 6,814. However the number of midwives has increased by just 11% (Tin et al., 2010).

A HSS assessment in 20 Townships showed that eight out of 108 RHC surveyed had the minimum standard of 13 BHS staff. 71% of RHC surveyed had less than nine staff. In 2011-2012, the ratio of midwives to PHSII was 11:1 when it should be 1:1. This has resulted in midwives taking up many public health duties that is beyond their scope of practice, such as immunisation. This increased responsibility takes away time to complete midwifery duties. There is currently a proposal before the Ministry of National Planning and Economic Development to increase the number of established posts of PHSII by 5,000 to reach the desired midwife-to-PHSII ratio.

Skills distribution in 2010-2011

	Ratio
Nurse: Physicians	0.97:1
Private: Public providers by HRH category	1:3.98
Medical practitioners	1:0.7
Dental practitioners	1:0.46
Traditional medicine practitioners	1:0.16

Source: Myanmar Ministry of Health

Health workforce requirements

A systematic assessment of the requirements for production and recruitment of the health workforce and associated costs is being undertaken as part of the formulation of the strategic health workforce plan. The projection tool used is based on assumptions concerning the optimal staffing level and mix at the different levels of the health system, with reference to catchment population served, coverage plans and functional analysis.

Health Professions Education

Under the leadership of the Ministry of Health, the Department of Medical Science is responsible for training and production of all categories of health personnel with the objective to attain appropriate mix of competent human resources for delivering the quality Health Services.

Considering the changes on demographic, epidemiological and socioeconomic trends both nationally and globally, it is imperative to produce efficient human resources for health for providing quality health care services to the entire population in the country. In addition, it is also crucial to produce competent human resources for health who are capable to keep abreast with the advanced global health standards. The appropriate mix of different categories of health professional is being produced from the 14 medical and allied universities and 46 nursing and midwifery training schools under the Department of Medical Science. In addition, postgraduate training courses are being conducted for higher learning. Currently are 36 doctorate courses, 8 PhD courses, 29 Master courses and 6 diploma courses are being conducted in universities under the Department of Medical Science.

In order to train and produce qualified human resources for health, specific administrative and academic issues in universities as well as existing under graduate curricula should be reviewed, revised and updated for relevance to the health needs, competency needs and training needs by conducting Medical Education Seminar periodically. The Department of Medical Science convened the '9th Medical Education Seminar in July 2011 to review and revise the curricula of Medical and Allied Universities. Diploma Midwifery curriculum had been developed in 2011 would be started in 2012 Academic year. Lady Health Visitor curriculum was reviewed and revised to change from "competency–based" to "task oriented" curriculum in 2011.

The Universities of Medicine under the Department of Medical Science had gradually increased the intake of students since the year 2000 according to the country needs. Previously, the intake of the students was about 550 in all 3 medical universities. In May 2001, University of Medicine, Magway was newly established and (1300) medical students entered to all 4 medical universities in 2000-2001. According to the National Health Plan 2001-2006, it was expected that the annual student intake would be (2400) students at the end of the project period. In 2005-2006, the student intake was (2403) in all 4 medical universities. And yearly intake of (2400) students is planned for the next project period of 2006-2011. It is in line with the National Health Plan and also as the requirement for National Education Promotion Special 4 year Plan for Promoting National Education. In 2006-2011, (10394) medical doctors could be produced, whereas the expectation of the project was about (12400). Based on records of July 2006, the available medical doctors and population ratio

in the country was 1:2980 and while completing the National Health Plan (2006-2011) period it was increased to 1:2261.Similary the yearly intake of Dental Medicine, Pharmacy and Medical Technology were of 300 students each, during the NHP 2006-2011 period, 1153 Dental Surgeons, 1416 Pharmacists and 1291 Medical Technologists could be produced.

In 2010-2011, the intake of nursing students (Generic) is (307) and nursing students (bridge course) is (94) and the two universities had produced (273) nurses from generic course and (147) nurses from bridge course. The intake of BNSc bridge course is planned to increase to (150) and intake of Specialty nursing is planned to increase (20) students each in six area yearly. In the Nursing Training Schools, the student intake had increased to (1000) students since 2001. Starting from 2003, it has been increasing up to (1200) students from previous intake of (500) students. In Midwifery the yearly intake was 900 students. Till end December 2010, it has produced (4103) nurses holding BNScdegree and (24231) nurses holding diploma degree. At present doctor and nurse ratio is (1:1.4). It is planned to increase this ratio up to (1:3) in line with that of ASEAN countries

The Department of Medical Science is responsible for production of Basic health workers who serve for delivery of health care services in rural area, where 70% of the population resides. The basic health category consists of health assistants, lady health visitors, midwives, public health supervisor 1 and public health supervisor 2.University of Community Health is responsible for production of Health Assistants (holding B.Comm.H Degree) and Health Assistants (Condensed Course). During the project period of 2006-2011, it was planned to take (150) students yearly. In the year 2011, (142) Health Assistants holding B.Comm.H degree and (50) from condensed course, (132) LHVs, (890) MWs and (75) PHS I were produced. As the ratio of RHC and population coverage in 2011 is 1:26567 compared to that of 2006 which was 1:26633, it is found that there is no significant difference. The ratio of midwife population in 2011 is 1:4462, which was (1:4144) in 2006.

For provision of comprehensive and quality health care to the community and uplifting of the health standard of the nation it is crucial to have qualified health personnel sufficiently. This project is envisaged to produce adequate and qualified postgraduates in various disciplines according to the needs of the National Health Plan. Six postgraduate diploma courses, (29) Master courses, (7) Ph.D and (30) Dr.Med.Sc courses are being conducted in Universities under Department of Medical Science. In the year 2010-2011, there were 1021 medical doctors are attending the postgraduate training. As requirement of postgraduates varies with different categories, training and production of postgraduates in various disciplines should be according to the needs, if necessary postgraduate programmes are being arranged in foreign countries.

The population growth, high expectations of the populace and emergence of new technology in the medical field- all have impact on the plan formulation for training and production of balanced Human Resource for Health. Among the health plan for the future, since the numerical expansion had been carried out in the previous years, quality and new products should be emphasized in the following years. The task of Infrastructure development of MedicalUniversities and various affiliated Institutes and training schools is a main component. It is therefore, this project is spelled out mainly

on the aspects of appointments of teachers, building class rooms, laboratories and libraries, repair and renovation of structures for academic activities and related activities.

The infrastructure development so that students could have an ambience where they can pursue their areas of interest effectively and without distraction is very important. Actually it would determine how well they can achieve to the highest level of their potential. On the other hand postgraduate studies in medical field are areas where cutting edge technology and advances in medicine are explored by students of medicine. Postgraduate diploma, master, doctorate and PhD courses are also running in different Medical Universities. To produce not only sufficient but also efficient graduates is the prime objective of our academic institutions. Improvements in teaching facilities starting from teaching hospitals to provision of laboratory and library with modern equipment are also prerequisite for academic excellence. The training of trainers, on the other hand, is another facet that we cannot neglect.

The globalization and impact of ICT development is felt worldwide and Myanmar medical academia is no exception. Innovative ways of training, totally new crops of health care givers and even new categories of health workers are needed to make headway in effective health care delivery. It is time for developing a new University of Public Health in Myanmar and so this item would be a major component of the project as espoused below. The objectives are: to provide established academic institutions with dedicated teachers, modern teaching aids and support staff and facilities such as libraries, research laboratories, training laboratories and ICT components; to establish a new category of post graduate training school viz. the University of Public Health; to see that students are trained mainly in self-learning and to become ethical, accountable and of towering moral fibre.

To keep abreast with advanced South East Asian Countries, Universities and Training Schools under Department of Medical Science are producing increasing numbers of different categories of human resources for health yearly in line with the need of National Health Plan. The department is managing for increased number of students to have effective learning opportunities with modern technologies. On the other hand, it is also necessary to develop a system for Continuing Medical Education to provide effective health care and to study updated advanced methods. Regarding Continuing Medical Education Post-graduate trainings are being conducted within the Country for enhancement of education of Medical Doctors, Dental Surgeons and Nurses. To apply Information Communication Technology (ICT) in Continuing Medical Education, Network Systems are already setup among Department of Medical Science(Head quarter), Medical Resource Centre, University of Medicine (1), New Yangon General Hospital and Yangon General Hospital ; between University of Medicine (2) and North Okkalapa General Hospital ; and between University of Medicine (Magway) and New 200 Bedded Hospital (Magway); and among Mandalay General Hospital ,Mandalay Child Hospital and University of Medicine (Mandalay). A plan for Video Conferencing between teaching hospitals of Yangon University of Medicine (1) and Medicine (2), University of Medicine (Mandalay) and University of Medicine (Magway) has already been developed.

Nursing education

There are a total of 45 nursing and nurse-related training schools spread throughout the country. At the university level, there are two nursing schools offering undergraduate and postgraduate formal qualifications. These are:

- University of Nursing, Yangon
    - Bachelor of Nursing Science (4 years)
    - Nursing Science bridging course (2 years)
    - Master of Nursing Science
    - Diploma speciality nursing – dental; eye, ear, nose and throat (EENT); mental health; paediatrics; critical care; and orthopaedics
- University of Nursing, Mandalay
    - Bachelor of Nursing Science (4 years)
    - Bridging course of Nursing Science (2 years)
    - Master of Nursing Science
    - Diploma speciality nursing: mental health; paediatrics; critical care; and orthopaedics (Myanmar Ministry of Health, 2012).

The non-university regional nursing schools offer a Diploma in Nursing. In essence, the Diploma-level students follow a similar program to the university curriculum and are expected to perform similar duties and receive similar salaries upon graduation. The Bachelor degree holders, however, have more avenues for career progression and further studies than the Diploma-level nurses. Outstanding Diploma-level nurses can join Bachelor degree courses by completing a 2-year Nursing Science bridging course as career development activity. Alternatively, nurses who have Diplomas can apply for the Nursing Science bridging course after three years of service to upgrade their qualifications to Bachelor-level.

Midwives, who are the backbone of the rural health services, are expected to contribute to all primary health care (PHC) activities at the community level beyond their work in reproductive health. They are trained in Midwifery Training Schools and are conferred a Certificate-level qualification following two years of study. Currently, the 1.5 year Certificate-level course is being upgraded to a 2-year Diploma course in midwifery. Nursing Field Training Schools and Domiciliary Midwifery Training Schools do not confer formal qualifications. Outstanding midwifery training school students can apply for entry to medical school.

Auxiliary midwives do not have formal qualifications and undergo a six month training program. Some only have a basic high school education. It is hoped in the medium term (3-6 years), auxiliary midwives will have the opportunity to progress their study to be fully qualified midwives. This is an important retention strategy as most auxiliary midwives are from villages and are more likely to stay and work at the grassroots level.

The last review of the nursing curriculums occurred in 2010. The Nursing and Midwifery Educational Seminar was convened by the MoH and reviewed and revised both the 3-year Diploma in

Nursing and 1.5-year Certificate in Midwifery curricula. Participants in this meeting included faculty members from all nursing universities, nurse training schools and nursing and midwifery professionals from the Department of Health and Department of Health Planning.

Basic health staff education

The University of Community Health, Magway offers a 4-year Bachelor of Community Health. Graduates of this course become Health Assistants who provide primary health care in rural areas as team leaders of the Rural Health Centres. The University plans to commence courses for Community Health Workers and Public Health Inspectors I and II in 2012.

The Lady Health Visitor (LHV) Training School in Yangon produces approximately 100-200 LHVs each year. It provides a 9-month Certificate-level course and is open to midwives with at least three years of experience. Admission requires passing an entry examination. The number of enrolments and quota is dependent on each respective State/Region's LHV vacancies. Potential students are selected and recruited in the same region, promoting rural retention of the health workforce.

LHV and PHSII who serve at least three years in their current post can complete a 12 month bridging course to become Health Assistants. In addition, an annual selection of 50-60 Community Health Assistants is undertaken through written examinations at the Department of Health and successful candidates are invited to attend courses at the University of Community Health, Magway.

Traditional medicine education

The University of Traditional medicine was established in 2001. The five-year Bachelor of Myanmar Traditional Medicine includes a one year internship in traditional medicine, basic sciences and basic medical sciences of Western medicine. The yearly intake is approximately 100 students (Myanmar Ministry of Health, 2012).

Basic concepts of traditional medicine are included into the curriculum of third year MBBS students. It is a 36-hour module and integrates both traditional and Western systems of medicine (Myanmar Ministry of Health, 2012).

Education capacities

The Ministry of Education is responsible for pre-university education. Public investment in education is among the lowest in South East Asia at less than 1% of GDP. Significant underfunding over many years, migration of skilled teachers, poor teacher training

and inadequate resources have resulted in only 54% of children completing five years of primary schooling. Of those who have completed primary school in 2010, 77% progressed to secondary school and 11% enrolled into tertiary education.

The shortage of health workers has resulted in a focus on quantity of health program graduates rather than quality . The increasing number of medical enrolments has raised concern there are not enough supervised internships available to accommodate students . Current regulations restrict intake into health profession education programs to adjust for the institutions capacity to provide quality education and up-scale quality of graduates. For example, the intake of medical students has been halved to 1,200 in 2012.

There are several challenges and national targets that have been highlighted to improve the health system. To meet these, the training and up-skilling of health workers needs to increase significantly. These targets include:

- Minimum of 13 BHS per rural health centre (including the network of sub-centres);
- 50% of the population to receive general medical services (22.4% in 2009); and
- Increase the number of public health workers. At present approximately 1,000 students are admitted to PHSII training each year, after more than ten years of stoppage to implement health promotion projects and allow midwives more time for clinical care.

In addition, the need to recruit and train health workers from rural areas and minority groups is hampered by the poor quality of secondary education that prohibits students from qualifying to enter health training. The national curriculum is in the Myanmar language, but many people from minority ethnic backgrounds are illiterate in this language. To circumvent this, since 2012, the top 3% of secondary students, based on matriculation marks, from hard to reach areas are allowed to enter medical school directly. These students must return to their local communities when they graduate to serve for 3-5 years.

All health professional training curricula are regularly reviewed and updated, according to needs and competency standards, through Medical Education Seminars conducted periodically since 1964. The 2009 seminar (the 8th) focused on the assessment component of medical education (Myanmar Ministry of Health, 2012). The 9th seminar conducted in 2012 convened faculty members from medical and related universities. During this seminar agreements and recommendations were made for the consideration of policy makers.

Number of training institutions by type of ownership in 2012

Health Professional Group/Cadre	Public Education Institutions
Generalist medical practitioners	5
Specialist medical practitioners	3
Advanced practice nurses	2
Graduate/registered/professional nurses	2
Nurse training schools	23
Midwifery training schools	20

Dentists	2
Dental technicians and assistants	2
Pharmacists	2
Medical imaging and therapeutic equipment technicians	2
Medical and pathology laboratory technicians	2
Public health	1
Community health workers	1
Health service management	1
Traditional and complementary medicine practitioners	1
Lady health visitors	1

Source: Myanmar Ministry of Health

The production of health workers is not synchronised with the country's needs and the Ministry of Health's ability to deploy them. There is an overproduction of doctors resulting in an excess number of unemployed doctors. The data collected are an estimate of the number of enrolments between 2008-2012 and graduates between 2008-2011.

Number of enrolments by year

Health Professional Group/Cadre	**Number of entrants**				
	2008	**2009**	**2010**	**2011**	**2012**
Generalist medical practitioners	2,400	2,400	13,604	2,400	1,200
Specialist medical practitioners					597
Health assistants	180	670	745		161
Advanced practice nurses					27
Nursing personnel (Bachelor)	300	1,633	5,042	300	322
Nursing personnel (Diploma)	1,200	3,728		1,200	1,390
Midwives	1,050	1,318	1,387	1,050	1,100
Dental workers	300	1,944	1,610		339
Pharmaceutical workers	300	1,438	1,016	300	228
Laboratory and medical imaging technicians	300	1,336	1,028	100	87
Public health specialists					300
Lady health visitors		132		120	78
Traditional medicine practitioners	100	100	100	100	100
Total	**6,130**	**14,699**	**24,532**	**5,570**	**5,929**

Source: Myanmar Ministry of Health

Number of graduates by year

Health Professional Group/Cadre	Number of graduates			
	2008	**2009**	**2010**	**2011**
Generalist medical practitioners	2,603	2,474	2,108	2,108
Specialist medical practitioners	271	329	294	294
Health assistants	231	164	244	122
Advanced practice nurses				27
Nursing personnel (Bachelor)	1,660	1,625	1,620	360
Nursing personnel (Diploma)				1,196
Midwives	749	807	879	913
Dental workers	299	162	257	460
Pharmaceutical workers	395	299	298	228
Laboratory and medical imaging technicians	322	278	263	159
Physiotherapists			5	88
Public health specialists				285
Lady health visitors	123	114	105	61
Traditional medicine practitioners	2,478	2,631	2,838	
Total	**9,131**	**8,883**	**8,911**	**6,301**

Source: Myanmar Ministry of Labour

The cost of training is borne roughly half by the government and half by the student (Table 14). However, anecdotally it is thought that students need to pay extra fees for private tuition (from the lecturers themselves) to help them pass. Not all students undertake private tuition and there is no data available on the amount paid out-of-pocket by students.

There is no information available on the extent of donor support to health worker training through scholarships or fellowships.

Overall cost of training/education per graduate in 2012

Health Professional Group/Cadre	Average cost of training ($USD)
Generalist medical practitioners	11,200
Specialist medical practitioners	9,900
Health assistants	3,600
Advanced practice nurses	28
Graduate/registered/professional nurses	1,050
Midwives	525
Dentists	3,400
Pharmacists	4,400
Medical and pathology laboratory technicians	9,900

Medical imaging and therapeutic equipment technicians	6,400
Physiotherapists	6,400
Public health specialists	9,900
Lady health visitors	350

Source: Myanmar Ministry of Health

Accreditation mechanisms

Currently, there is no formal accreditation system for educational programs and institutions by external bodies. The Ministry of Education plays a role in approving the curriculum but has no direct responsibility for regulating or accrediting the educational institutions for the health professions. The respective professional councils are expected to develop an accreditation system in line with standards set through the ASEAN network. This development will require significant investment to enhance the capacity of the professional councils to meet these challenges. Currently, the University Senates plays major role and take responsibility for quality assurance of all universities.

In-service and continuing professional education

Previously, continuing professional education (CPE) was the responsibility of the national government but has gradually been decentralised to each area of health (e.g. immunisation, maternal and child health, HIV/AIDS, malaria etc.) and funded by international aid agencies. The Central Training Team (CTT) within the Department of Health is responsible for coordinating CPE training. CTT has also aimed to standardise training requirements for all public service health workers (Tin, 2009) and operates in all Township hospitals. However, the multiple training sessions has resulted in a large number of absent days taken which affects health service delivery.

Medical staff

The Myanmar Medical Association offers CPE opportunities to both the private and public sector. These events can include seminars, talks and symposia on new emerging issues; updating diagnostic and therapeutic measures; and also participation in public health activities (Myanmar Ministry of Health, 2012). At this stage, the Medical Council has not established a compulsory CPE for re-licensing, but are contemplating introduction of such requirements in the future.

Each year, each individual medical specialty society within the Myanmar Medical Association conducts refresher courses for its members. It is the main CPE activity for the country's medical practitioners. There are over a dozen courses available covering topics on general practice, emergency management, diagnostic and surgical procedures, research methodology and family medicine. Specialist staff also conduct field visits and tours of rural areas to provide health education for the public as well as provide training opportunities for rural staff. The quarterly-published Myanmar Medical Journal serves as a CPE resource for doctors across the country (Myanmar Medical Association, 2009).

Nursing staff

The Ministry of Health's *Health in Myanmar 2011* report reported the Nursing Division under the Department of Health, with technical assistance from WHO and the International Council of Nurses (ICN), had provided nurse leadership training to strengthen nursing services since 2000 (Myanmar Ministry of Health, 2012). To date, five batches, totalling 130 hospital and community nurses, have been trained in leadership and management. Each successive group of nurses who receive training from the ICN have gone on to become trainers themselves. A certificate is given to those nurses who are trained by ICN, WHO and the Government. For the continuation of training, a Letter of Agreement is signed between the partners every two years.

While there are several nursing CPE programs, there are still not enough nurses completing post-basic courses and up-skilling. The lack of career progression and poor utilisation of post-training skills is a significant barrier in increasing the number of advanced practice nurses.

Dental staff

The Myanmar Dental Association organises a CPE programs throughout the year. There were nine courses in 2011 and eleven in 2010 (Myanmar Dental Association, 2012).

Basic health staff

Workshops and training sessions are regularly provided to BHS in rural areas to update their technical skills and public health procedures (e.g. prevention of avian flu infections). In addition, health assistants are also given training to improve managerial and technical skills at the central level. Previously, refresher courses were conducted each year for 50 health assistants and management courses for 50 Township Medical Officers per year through support from WHO. Health Assistant refresher training focus mainly on public health and disease control skills as well as planning and management. Priority is given to those who have not had a refresher course for many years.

CTT has developed a log book, with JICA assistance, that documents the training provided to BHS and includes information such as the date of training, type of training, duration, and content delivered. Currently, the Department of Health organises an in-service training program for BHS which is delivered primarily at the township level. Courses are offered on pay day at the end of each month when all staff go to the Township to collect their wages. By using this arrangement, additional funding is not needed to transport health workers to CPE sessions. Training topics are usually related to seasonal issues such as dengue haemorrhagic fever during rainy season and other major topics according to the international days for HIV/AIDS, malaria, tobacco etc. Other vertical CPE by different programs and projects are funded by respective donor agencies and often last more than one day.

BHS in-service training is taught by supervisory staff from the State and Divisional level and the Township Medical Officer. However, these staff are often not trained educators and their lack of teaching skills is hampered by a shortage of training aids and resources. Training is mostly focused on technical skills rather than community or public health, but the education is usually delivered in a didactic manner which does not necessarily improve practical skills. As a result, the training is not

seen as being very effective in up-skilling and there is little follow-up of these training sessions. There is also no evaluation or assessment of the effectiveness or relevance of the training provided (Tin 2009). The National Health Plan 2006-2010 had planned to conduct yearly training sessions for 150 Village Health Workers (VHW) trainers, who in turn can train 1,000 new VHW each year and deliver refresher courses to 1,000 existing VHW. It was expected this plan would cover 20-25 Townships each year (Myanmar Ministry of Health, 2006a). However, it is not known if this plan has been implemented or its success.

In 2009, the *Strengthening Capacity of Training Teams for Basic Health Staff* project was launched by the Ministry of Health, with assistance from JICA. The five-year project aims to up-skill health personnel trainers and improve the teaching capabilities of staff who train basic health staff. This project was rolled out across the country at the central, state and township level. In 2009, a survey was conducted in eight states and townships to determine needs of training teams. Teaching aids were supplied to those who required them and a handbook was developed to standardise training (Myanmar Ministry of Health, 2010).

HRH Utilisation

Recruitment

Currently, deployment and recruitment of health workers are guided by protocols. However, due to the lack of a central HRH database and the lack of private sector information, it is difficult to project future health workforce needs (Myanmar Ministry of Health, 2007). The recruitment mechanism needs to be reviewed and priority given to rural areas and ethnic balance (Myanmar Ministry of Health, 2006b).

Prior to 1993, doctors were deployed after passing an examination set by the Union Civil Service Board (UCSB) after completing their internship. Doctors were also required to apply for practicing license. The reduction in the number of doctors entering public service forced the Ministry of Health to declare a decree to make doctors compulsorily enter public service for three years. After this mandatory service, doctors are then given a registration number. Recruitment responsibility shifted from the UCSB to the MoH. By 2008, deployment responsibility was returned to the UCSB and doctors needed to gain recommendation from the Ministries of Home Affairs, National Planning and Economic Development, Finance and Labour, and the Prime Minister's office before being appointed under the MoH.

Currently, all medical doctors are still required to pass an examination set by the UCSB. In 2011, 500 doctors were recruited by the MoH and increased to 1,500 in 2012.

There is currently no information available on the recruitment process or any information on recruitment quotas by regional areas. In general, there are more health workers being produced than can be recruited by the public service. Graduates who are not able to find employment upon

completing their training are allowed to work in the private sector or abroad to ensure their skills are not wasted.

Deployment and distribution policies and mechanisms

Implementation of health care services has been affected at multiple levels. Many programs, including those in primary health care, disease control, hospital care, environmental health and health management have not been able to be implemented fully due to frequent turnover of staff, budget constraints, staff shortages, low health worker density and coverage and inadequate equipment and resources (Myanmar Ministry of Health, 2006a).

Staff turnover and stability

There is little data kept on staff turnover. It is known however that lower skilled health workers, including voluntary health workers, have high rates of workforce instability and high rates of staff turnover. The turnover and stability of rural health workers is likely to be higher than those working in larger urban centres.

Attrition

There is little data kept on attrition from the public service. It is known the annual attrition rate for medical doctors is 2.02%; however the best estimate of the annual attrition rate of the entire health workforce is approximately 5%. It is not known what the causes of attrition are, or if exiting workers are seeking opportunities in the private sector, with NGOs/CBOs, in other non-health sectors or overseas.. Major causes of attrition include poor staff motivation, lack of an incentives system, lack of effective township-level leadership and management and high workloads (Myanmar Ministry of Health, 2006).

There is no formal support system, transport allowances, per diems or hardship allowances for rural health workers in hard to reach areas). Burnout of nurses and other health staff in rural areas is not uncommon with many reporting high levels of stress and long hours. Some midwives have reported that they are overworked doing project and administrative tasks (including disease control and nutrition) and are not able to spend more time doing tasks in which they were trained to do (i.e. maternal and child health. There is a lack of proper job descriptions and role delineation, and cultural and language barriers are significant inhibitors of workforce retention in rural areas. There is some consideration of shifting project work from midwives to PHSII. PHSII are in the same pay grade as midwives but have responsibilities in public and environmental health. However, there are not enough PHSII to allow this strategy to happen. Travel costs for midwives working in rural areas are greater than those in urban areas, which encourages midwives to work in private practice to earn a liveable wage.

Only one third of midwives posted in rural areas wish to stay in their current post. Others, while still intending to continue in their post, wish to be given LHV training and move out of rural areas. The main reasons for wanting to transfer posts are to be closer to their families (50%), improve their children's educational opportunities (13%) and to work in an area that is accessible to other services (8%). Of the midwives who

wished to stay in their current post, most were from rural areas. Therefore it is vital that rural students are recruited for health training to ensure these areas are better served by health workers. When midwives are absent from work due to LHV or nursing training (usually 1-3 years), their post is not considered to be vacant. As such, there is no replacement for them and the workload increases for the remaining staff. This is a major cause of job dissatisfaction.

User fees for midwives are higher than for auxiliary midwives or traditional birth attendants, encouraging many women to choose these options instead, even in situations of high risk pregnancies. In addition, midwives are required to refer high risk pregnancies to referral hospitals but the cost can be prohibitive for many women, thereby further increasing the incentive to seek the services of cheaper auxiliary midwives or TBAs instead. Successful deliveries by these health workers can reduce trust in professional midwives and reduces midwives job motivation. Newly graduated midwives are often posted to rural areas and those who are not well supported by their supervisors and families are less likely to continue working in their position.

Most students entering medical schools are from urban backgrounds and are often unwilling to work in rural areas. In addition, salaries and remuneration in the public service are less than that offered in the private sector or with international NGOs. The nursing and midwifery professions have similar challenges but to a smaller scale as many midwives are posted in areas close to their home village.

Average number of hours worked per week per HRH category

There is no information available on the average number of hours worked each week by cadre. It is known that health workers in rural health facilities often work long hours, and for those health workers who work alone and have little support, can be on-call 24 hours per day to serve the local community. Overtime worked is not compensated, financially or otherwise.

Motivation

Motivation is affected by high work levels, infrastructure, supervisory support, local community support, transport, training and operational costs. The five main reasons for job satisfaction were good quality facilities and housing; well stocked pharmacies and functioning equipment; travel allowances; improved transportation (including provision of motorcycles or bicycles and better road conditions); and appreciation of their work by the community. It is important that health workers who are posted to rural areas are able to return to their home community or be able to get further training after a set period of compulsory rural posting. Most BHS (90%) suggested they would like to either remain in their present post or be in a higher post. Very few reported wanting to leave the health profession.

Motivated midwives have similar characteristics: are able to live with their family; able to work in own home village; have good relationships and support from the community; have supportive supervisors; are provided with good housing and have access to adequate medicines and equipment

at work. Many midwives are dissatisfied with rural health centres and housing as they are poorly maintained and they rely on the community for repairs .

Basic health staff and voluntary health workers who perform well are given study tours so they can share their experience with other health workers and learn from each other (Myanmar Ministry of Health, 2009). Every two years, Township selection committees put forward 5-10 BHS and VHW to the State selection committees, totalling 150-200 health workers nationally. VHW and BHS from lower Myanmar (e.g. Yangon) visit upper Myanmar Townships (e.g. Mandalay or Bagan) and vice versa. Health workers gain knowledge from their colleagues, are able to do some domestic sight-seeing and are finally presented an award of recognition from the Minister for Health. Costs associated with these tours are incurred by the WHO in a recurring budget.

High levels of work stress due to health worker shortages are a cause of attrition. One study suggested increasing the number of midwives to at least one midwife for every ten villages and to recruit more community health workers so that there is at least one health worker in each village will help reduce workloads. Other suggestions to improve motivation include providing housing, improving transportation (such as the provision of bicycles and better road conditions), increased salaries, performance based bonuses, increased opportunities for CPE, better supervisory visits and support from State and National level, and increasing the number of ethnic health workers will improve health service deliver.

Policies have been developed in an effort to solve retention challenges in rural areas, as outlined in the National Health Plan 2006-2010, although there is still much room for improvement. New medical graduates are given an option of either being contracted to serve in rural areas for three years and then being released to serve abroad or in the private sector. Alternatively, they can join the public service as a permanent staff and be eligible for postgraduate studies after two years of service. Priority and extra credit towards enrolling in a postgraduate course are given to those who have served in a rural area. The National Health Plan highlighted the need for better remuneration and compensation, effective managerial support and supervision, well-resourced facilities and better coordination between stakeholders. However, evidence of this is not available.

A financial allowance scheme was trialled in 20 townships in an effort to increase retention of midwives and PHSII in rural areas, and improve the service delivery and enhanced access of service especially in hard to reach areas. This trial was supported by GAVI and it had been anticipated that this trial would be expanded to 55% of the townships by 2011.

Management structure

The National Health Committee is a high level, health policy making body that provides direction for the health programs and services implemented. It is composed of 18 members:

- Union Ministers from the Ministries of Health and Labour;
- Deputy Ministers from the Ministries of Home Affairs; Border Affairs; Information; National Planning and Economic Development; Social Welfare, Relief and Settlement; Labour; Education; Health (2); Science and Technology; Immigration and Population; and Sports;

- Nay Pyi Taw Council member;
- Myanmar Red Cross President;
- Myanmar Maternal and Child Welfare Association President; and the
- Director General of the Department of Health Planning at the MOH (Myanmar Ministry of Health, 2011).

Overall health policy is set out by the National government. At each level of government (State, District, Township and Village), there is a Health Committee (National Health Committee representatives) and Peace and Development Council (Union of Myanmar representatives) that directs the activities of each Health Department. Each Health Committee is headed by a chairman and includes the heads of related government departments and representatives from social organisations as members. The heads of the health departments are secretaries of these committees.

The National Health Plan is divided into 12 broad programs and 78 projects. These programs are Community Health Care; Disease Control; Hospital Care; Environmental Health; Health System Development; Health Promotion; Health Management Information System; Human Resources for Health Development; Health Research; Laboratory Services and Blood Safety; Food and Drug Administration; and Traditional Medicine. The National government is responsible for providing necessary resources to implement these programs. The Township level governments are responsible for planning and implementing of health care services and also monitor and evaluate the projects. The State and National level governments also conduct monitoring and evaluation of projects on a half-yearly basis.

Supervision mechanisms

There is a lack of effective supervision of health workers, particularly in rural areas. Some health workers have expressed a desire to have State or National level supervision and for good performance to be rewarded with bonus payments.

Physical environment and access to essential equipment and supplies/resources

Every five years, a hospital upgrading project plan is developed and implemented. It includes establishment of new hospitals in remote areas and increasing hospital beds in high density populations (Myanmar Ministry of Health, 2011).

The lack of essential equipment and supplies, along with poor quality services, encourages many people to seek health services from NGOs. Township level hospitals in particular have a lot of staff but few patients (Andre, 2012). In addition, poor infrastructure and lack of essential medicines reduces staff morale and contributes to attrition.

Unemployment

There is little information available on the unemployment rate of health workers. It is known that production of health workers is not synchronised with deployment and demand needs. There is an oversupply of doctors, of which many are unable to find positions in public service. New medical graduates who are unable to find a government post are able to work in the private sector to maintain their skills until a position is made available.

There is also no data available on the number of vacant posts, but it is likely that most vacancies will be for BHS (PHSII in particular) in rural and hard to reach areas.

Employment of health workers in the private sector

There is little information available on the private health sector and the exact number of private practice practitioners is not known. In 2007, it is estimated of the 20,501 medical practitioners, 13,251 (64.6%) were employed in the private sector and 59.1% of dentists were private practitioners (Myanmar Ministry of Health, 2007).

The private sector is growing in Myanmar and many health workers practice in both public and private sectors to supplement a public service income, although the exact number who do this are not known. Dual practice also results in double counting of health workers and can lead to neglect of public service duties to focus on higher income generating private sector work.

Medicinal Policy

Project (MEDP) is working very hard on **"Drugs and Drug Policy for the Nation", in** many directions in collaboration with several other organizations for realizing the nation's fourth social objective to uplift health, fitness and education standards of the entire nation. In deed national drug programme is a broad based technical programme with a strong community involvement in the implementation. With all ramifications in Biochemistry, Pharmacology, Pharmaco-kinetics, etc., as the driving force of high level Biotechnology, the programme is implemented by medical scientists-Physicians, Nurses, Pharmacists, Para-medicals, and others etc. who permeate into the community. If we might analyze the situation, we still belong to the group of many countries, those three quarters of the world's population whose procurement of drugs is only 15% of the world's total production. The affliction is heavy mainly in the rural areas and the misfortune of inadequate supply is further magnified by irrational prescribers, dispensers and consumers. Reckoning this problem of drug shortage being enlarged by the world-wide increase in population and health-care demands, the WHO established the Action Program on Essential Drugs in 1981, and, here in Myanmar, under that program of WHO, the **Myanmar Essential Drugs Project**was started in 1988, which in 1995 was transformed into **Myanmar**

Essential Drugs Program, MEDP

The first supply of Essential Drugs was availed as an initial stage for (9) townships in 1989 after field epidemiology studies. But provision of drugs is only one part of the MEDP programme, another celebrated accomplishment is replenishing the drugs by way of the Community Cost Sharing System for erecting the **Revolving Drug Fund.** All 324 townships in Myanmar have their own Revolving Drug Fund capable of replenishing the Essential Drugs, independently. This relieved the Ministry a large load of budget for other expenditures. All the health workers in those (324) townships have also been trained to rationally use the drugs.

Indeed, provision of drugs is only one half of the MoH's duty, the other more important half is to use them rationally. To this effect, the MEDP furnished all those health workers with **Standard Treatment Guides,**additional to training them on the **Concept of Essential Drugs,** their estimation, storage and distribution. The MEDP, having completed the Essential Drugs Program at the Primary level, is now preparing strategies to extend its activities into the Secondary and Tertiary referral levels, all including private health care centers, GP clinics, private dispensaries and hospitals. completed the Essential Drugs Program for all its townships at the Primary Health Care level.

This was implemented by financing the township with Revolving Drug Funds with which to facilitate health workers in solving health problems guided by Standard Treatment Guides prepare for each level of health care facilities in the primary health care area. As such the gap of health care level between rural and urban centers have been substantially narrowed in the country. The current reality is that each and every township in Myanmar is running on its own **Revolving Drug Fund**for the perpetual supply of **Essential Drugs.**

Concept and evolvement of essential drugs in Myanmar

After the Second World War II developing countries have been facing the problem of inadequacy in drug budgets for the health care as the result of gradually increasing population without concomitant increase in drug budget. 75% of the world population resides in the developing countries, which were struggling to improve the above problem. Finally, the developing countries, which are member states of WHO, approached the WHO to help in solving the above problem in the process of health care in 1971. WHO has assigned a committee to go into the above matter and find suitable solution. The committee collected morbidity data of the developing countries and found that 75% of these are almost the same. The committee selected drugs based on each morbidity and they have recommended that drugs around 200 + or - 20% will be able to solve the health problems of the developing countries. In that way country has to collect morbidity data properly and select the essential drugs, which will solve the health problems based on the standard treatment. The selected drugs should be in generics, correct dosage and of good quality.

Estimation of the required amount of Essential Drugs should be done by the prescriber of health care centers at different level of health care facilities, dispensaries, hospitals_ followed by procurement of drugs, storage, quality assessment and distribution should be observed systematically. In solving the health problem the prescribing of drugs should be rational followed by drug counseling, which includes information, education and communication in regards to the effectiveness of drugs, possible side effects, contra indication, cautions in the use of drugs prescribed to them and that they should utilize the drugs accurately according to the instructions. Essential drugs are those that satisfy the health care needs of the majority of the population; they should therefore be available at all times in adequate amount and in the appropriate dosage forms.

Implementation of the essential drugs programme

The following steps were strictly observed and followed for the successful implementation of Essential Drugs Programme :-

Identifying therapeutic needs -To do so the morbidity or health problem was identified and focus its pathophysiology to the therapeutic objective in selecting the appropriate drugs.

Selecting essential drugs - The health workers should be able to select the essential drugs, which will be required for their respective health care facilities, based on the established health need for the drugs. And the list be reviewed annually and made changes accordingly.. Criteria for selection of the essential drugs could be: Mortality and morbidity statistics; and the efficacy and safety of the drug, its suitability and the cost of the drug. The list of essential drugs for teaching hospital will be very different from the list of drugs to be used at the primary health care level. A list of essential drugs does not imply that no other drugs are useful, but simply that in a given situation these drugs are the most needed for the health care of the majority of the population and therefore, should be available at all times in adequate amount and in the proper dosage forms. The choice of such drugs depends on many factors, such as the pattern of prevalent diseases; the treatment facilities; the training and experience of the available personnel, the financial resources; and genetic, demographic, and environmental factors.

Estimating the quantity needed - To estimate or quantify the required quantity of each item of essential drugs was based on the Past-Consumption- Method, which is the most appropriate one for selection of essential drugs provided that the essential drugs are available at all time in adequate amount in solving the health problem based on Standard Treatment Guides.

Improving the drug supply system - To improve the drug supply system it is important to procure the essential drugs of good quality with adequate dosage after proper estimation of drug requirement according to the National Drug Policy in the areas **of** procurement, storage, quality checked and distribution. It should also reflect the principles of the Revolving Drug Fund". It should be stored properly with regular quality checked and distributed accordingly.

Ensuring the proper use of essential drugs -For its purpose it is essential **to** adopt rational use of drugs. Rational use of drugs.literally means reasonable or sensible use of drugs. Medically rational use of drugs demands that, the appropriate drug must be prescribed for a health problem, must be available at the right time, at a price people can afford, must be dispensed correctly and that be taken in the right dose at the right intervals and for the right length of time. The appropriate drug must be effective, safe and of acceptable quality. It is also essential to adopt and practice the essential drugs programme with active participation by the health workers and community with all out backing and support by the Government to implement meaningfully the rational use of drugs.

Rational Prescribing should meet certain criteria as: Appropriate indication; appropriate drug; appropriate patient; appropriate information; appropriate monitoring; providing the public with information and education; achieving local production; ensuring quality control; monitoring adverse reaction; introducing appropriate legislation; meeting manpower requirement; ensuring coordinated multi-sectoral action; and establishing monitoring and evaluation procedures.

The Role of Drugs in Health Care

Drugs are essential for both preventive and curative health care. Globally, the cost ofdrugs in health care is not only rising, but takes up a considerable amount of the government health budget, and Myanmar is no exception. It has therefore become increasingly important and necessary, especially in the developing countries, for systematic planning of drug supply for optimal utilization of available manpower and financial resources. Pharmaceutical companies market expensive new drugs with brand names, latest antibiotics, tonics and vitamins, which differs little from one another. These are imported by developing countries at great cost, used mostly in the urban areas, while in the rural population there is shortage of even the most essential drugs that could be life-saving, prevent illness or alleviate suffering.

The government of Myamnar is committed to the goal that total community in the country should enjoy quality health care through Primary Health Care approach. For achievement of this goal, provision of good quality drugs and vaccines is essential.

In the late 70s the World Health Organization made an effort to solve drug shortage problem in developing countries through the Drug Action Program (DAP). It showed that with *a sound National Drug Policy and a limited number of carefully selected drugs used rationally, it was possible to take care of the majority of the health problems its a country, although it may not provide for the need of every person.* About 1981, Essential Drugs programs were launched in those countries where basic needs could not be met by existing supply systems. Countries were required to develop their own E.D. lists based on need, prioritize import to ensure availability of good quality essential drugs at minimum cost.

At that time, the same situation existed in Myanmar. The Drug Advisory Committee was responsible for drug regulatory activities, but there was shortage of basic essential drugs in the public health facilities. Patients had to buy drugs in the open market, where drugs are imported with or without permission from DAC are sold, and where storage conditions and quality assurance is poor. The Department **of** Food and Drug Administration had not yet been established, and legislative control of import, and market surveillance could not be done effectively. MEDP launched in 1989 aimed to ensure availability of good quality essential drugs at minimum cost to the rural community.

Objectives of MEDP were to:

- develop a comprehensive National Drug Policy and strategy,
- make good quality essential drugs and dressings available in sufficient quantities and at

minimum cost in the townships,

- design and test a pilot project in one area (9 pilot townships) for eventual national replication
- provide resources and training to improve Drug Supply System for essential drugs and

It is considered that many problems of drug supply and availability in many countries stems from lack of an organized National Drug Policy, shortage of technical and managerial ocpertise, and inefficient distribution and supply system. The National Drug Policy Meeting preparation of a draft policy document was one of the first actions of MEDP. Drug Laws based on the draft document were prepared, and were promulgated in 1993. These were used for enforcement procedures, and the original draft policy was not formally endorsed. It is now b6n.v, revised for submission and approval.

Use of the laws instead of having a drug policy is possible as seen in some countries Like Bangladesh, but WHO-EDM has emphasized that a National Drug Policy which is consistent with the essential drug concept should be part of the National Health Policy, Myanmar Nat. Drug Policy covers key components identified by WHO/ EDM.

Objectives of Myanmar National Drug Policy:

1. To ensure good quality, effective, and safe drugs can easily be purchased by the community- accessibility &availability.
2. To ensure that adequate quantities of essential drugs are available at all times for the community, based on its needs, the prevailing disease pattern and national health programs.- availability
3. To make drugs easily accessible to the community by establishing an effective procurement, storage & distribution system throughout the country.
4. To make essential drugs available to the community, at a price they can afford, by establishing an appropriate drug pricing system.- affordability
5. To promote development of a habit for efficient & rational use of drugs.
6. To develop mechanisms for protection of the individual and the community from drug abuse, including narcotics and psychotropic agents, which are known to be harmful.
7. To establish a drug **information** system for availability of adequate information about drugs, especially newer preparations.
8. To promote and strengthen the use of Myanmar **Traditional** Medicine.

To promote local **production** of drug formulations and availability of raw materials, and to encourage integration of drug production, distribution and utilization in health programs with national economic and industrial development.

10 To enable systematic assessment of the country's needs for technical manpower in the fields of drugs and related activities, and to take effective steps for technical manpower development, including development of pharmacy, pharmacology, clinical pharmacology & pharmaceutical sciences.

11 To promote research to identify priority areas in drug programs and supply management, and implement activities for development in these areas.

12 To ensure allocation of adequate financial and manpower resources for implementation of drug programmes.

13. To take appropriate steps for identification of sub-standard and counterfeit drugs and their removal from the market

The following are some examples of Myanmar National Drug Policy objectives, which complement the objectives of MEDP.

Availability and accessibility will be enhanced by the MNDP components.

- Good quality, effective, safe drugs can be easily purchased by the community.
- Adequate quantities of EDs are available at all times for the community, based on its needs, disease pattern and national health programs, will ensure proper selection, legislation and registration according to the ED concept.
- Establishment an effective procurement, storage and distribution system throughout the county will ensure safety and good quality.
- To promote local production of formulations and availability of raw materials, encourage integration of drug production, distribution and national economic and industrial development. Affordability " drugs at minimum cost". This will be complemented by activities that
- establish appropriate drug pricing system.- affordable to the community.
- develop a more efficient supply system for local manufaCture and production of drugs and raw materials. This will save transport charges and foreign exchange.
- will encourage production and marketing of drugs under generic names, which are less expensive than brand name preparations, etc.

Quality assurance.As mentioned before, it is very difficult to see that "only good quality and safe drugs" get to, the local markets and to the community. With the long border adjoininv, other countries it is extremely difficult to control smuggling, and prevent illicit substandard and /or counterfeit' drugs getting into the country. This issue is highlighted by a recent WHO publication ``Counterfeit drugs in Myanmar and Vietnam".

Important activities to reduce the incidence of this underlies the objective:

- To take appropriate steps for identification of sub-standard and counterfeit drugs, and their removal from the market.
- To develop mechanisms for protection of the individual and the community from abuse of drugs, including narcotics and psychotropic agents.

Mechanism for this has been difficult in the past due to lack of adequate financial resources and manpower for market surveillance and for regulatory control and inspection. There was also no

separate department responsible for these procedures or definite laws for concrete action. Under the section which deals with Legislation, The *Department of Food ('. Drag Administration (FDA),* has been established, and is now responsible for quality control and assurance, legislation and regulatory control of western medicines, registration and import

Traditional Medicine.Promotion of use of Myanmar Traditional icine", will require assurance that the traditional drugs are authentic, and their quality, efficacy and safety assured. There is a in the Myanmar NDP which covers this issue. *The Department of Traditional Medicine(*DTM), with the Traditional Medicine Law (1996,) & Notification (7) is responsible for cultivation, production, standardization, regulatory & quality control of traditional medicines.

Veterinary drugsThere is also a section on the NDP for these drugs The National Drug Law states that veterinary drugs will be subject to the same regulatory control as drugs for human use. A Veterinary Drug Supervisory Committee (VDSC) the Drug Advisory

Rational use of drugs

- To promote development of a habit for rational and efficient use of drugs would require collaboration with the teaching / training institutes and schools. Advocacy of the concept and training of clinical staff and township staff will be needed and this would be more effective by senior prescribers serving as role models.

Supportive component

- To narrow the gap in knowledge and technical expertise between neighbouring ASEAN countries. " inter- country linter- regional collaboration" is required.
- To promote research to identify priority areas for development in drug programs and supply management. Collaboration with DIM.. Will be needed.
- Allocation of adequate government funds, financial and manpower resources would be required for import and local production of essential drugs Other Source of funds - Donor agencies and Organizations, and Private donors, UN Agencies, WHO, UNICEF, and UNDP, National and international NGOs. SCF, WV, ICRC and private donors like Sasakawa Foundation and JICA etc. would be helpful.

Control of Drug Import, Production, Quality Assessment

Myanmar Food and Drug Board of Authority (MFDBA) is the competent authority for control of allopathic and traditional medicine. It has delegated some of its powers in licensing of manufacturer and importation to Central • Food and Drug Supervisory Committee(CFDSC), licensing of drug shops to Township Food and Drug Supervisory Committee (TFDSC) and registration to Drug Advisory Committee.

The Food and Drug Administration Department (FDA) was the latest department under the Department of Health, newly established in 1995 January to carry out the objectives of the National Drug Law.

Drug Registration

Evaluation of drugs applied for registration is the responsibility of Drug Advisory Committee (DAC). The guideline for registration of drugs issued by the Food and Drug Administration (FDA) is available for those who wish to apply for drug registration. The detail procedures are clearly stated in the guideline. The application form, the documents on product information and drug samples for confirmatory testing are required to be submitted to the FDA. The original certificate of pharmaceutical product (COPP) in WHO format issued by the drug regulatory authority of the exporting country is an essential pre-requisite in applying for registration.

Only the completed documents will be accepted and evaluation is based mainly on the quality, safety and efficacy of the drug. The particulars in the documents are checked by technical Staff in FDA before submitting to the Drug Advisory Committee The decision for approval of drug registration is decided at the DAC, meeting and once approved , the drug registration certificate will be issued which has a validity for 5 years.

Measures for the safety of Drugs and PMS

Only the registered drugs are allowed to be imported. The registered drugs bear the Myanmar Registration number and customs authorities checked them at the port of entry. The Drugs on Register books are also distributed to these departments concerned with drug importation. Post marketing Surveillance (PMS) was carried out by taking random samples ti¯om the drug shops and tested at FDA.

Guidance and Inspection in Pharmaceutical Administration

Under the National Drug Law, the Food and Drug Board of Authority (MFDBA) is the competent authority for Pharmaceutical Administration. It has however delegated some of its duties to various administrative and technical committees like FDSC& DAC:, MFDRA's primary Itinction is thus giving policy guidance to FDA, FDSC & DAC, Good Manufacturirkg Practice (GMP) inspection of drug manufacturing establishments and inspection of warehouse of drug importers are conducted by the responsible persons in FDA, whereas inspection of drug shops are carried out by inspectors from Township Food and Drug Supervisory Committee. The FDA carries out its enforcement activities in co-ordination with Regional FDSC.

List of Law & Regulation covering pharmaceutical affair.

1. Food and Drug Act (1928)
2. The Dangerous Drug Act.(1931)

3. Public Health Law (1972)
4. National Drug Law (1992, October)
5. Formation of Food and Drug Supervisory Committee(1992)
6. Formation of Drug Advisory Committee(1992)
7. Formation of National Formulary Committee(1992)
8. Notification for exemption of tax on 36 drugs and raw materials (1993, February)
9. Notification for Narcotics and Psychotropic Substances. (1993, January)
10 Notification for Drug Registration, Drug Production, Drug Importation, Retail & Wholesale of Drugs, Labelling and Advertising of Drug **(1993,** August) 1 **1.** Traditional Medicine Law (1996, July)

Health Financing

Promoting and protecting health is essential to human welfare and sustained economic and social development. Education, housing, food and employment all impact on health. Redressing inequalities in these will reduce inequalities in health. It determines whether people can afford to use health services when they need them. Health financing is an important part of broader efforts to ensure social protection in health: coverage with needed health services and coverage with financial risk protection, for everyone. Recognizing this, Myanmar committed to strengthen the health financing systems so that all people have access to services and do not suffer financial hardship paying for them.

Methods of health care financing experienced in Myanmar were varied from the time period. During the period of 1948 to 1962, Myanmar followed the National Health Services (NHS) which was provided mainly by the general government tax revenue. Government taxation was also the major source of finance for health sector during 1962 to 1974. The other source of finance for health sector at that time was the international assistance. The private sector started to grow that period and regulated doctors provided the health care services in inpatient delivery homes. A new constitution was adopted in 1974 and afterwards health care services were provided according to the National Development Plan. Other source of financing for that time was donation, not only the buildings of the station hospital but also some of the buildings for the central hospital. Community Cost Sharing Scheme was developed in 1992 with the objective of affordable people who need to pay some share for curative health care services but exemption for the poor. Trust fund was another source of finance for health care and the interest of the trust fund would be used for the poor.

In regards with health expenditures, the per capita health expenditures was (49,743) kyat in 2007. There was increasing trend of government health expenditures since 1988-89 to 2006-07 (464.1 million kyat to 24178.6 million kyat) but the per capita government health expenditure is still low which was only (427.8) kyat in 2006-2007. The financial burden for health care is 20 to 30 percent of

households suffered catastrophic payment for heath. Hence it is imperative that need to find alternative health financing mechanisms. In Myanmar, the National Health Committee has laid down the National Health Policy in 1993. Among fifteen guidelines, one guideline stated "To explore and develop alternative health care financing system" which is directly concerned with health care financing reforms in Myanmar. Following the policy guideline, a number of financing reform activities had been undertaken in the health sector since 1993. However, much of the payment made by the households in time of illness is out of pocket in nature with potential for catastrophic spending.

Following these policy guidelines, a number of financing reform activities have been undertaken in health sector since 1993. Generally six different types of financing reforms can be classified as: (1) introducing of paying wards or rooms in public hospitals; (2) introducing of user charges for Government Drug Supplies from Central Medicine Store Depot (CMSD); (3) introducing user fees for diagnostic services such as laboratory, X-ray, ECG; (4) Community Cost Sharing (CCS) for essential drugs; (5) introducing private service by in service staff at public hospitals; (6) establishment of Trust Funds.

In line with new health policy the paying wards or rooms are opened at government hospitals and charges are set according to quality and quantity of facilities provided. A rule has been set for utilization of revenue collected at paying wards. According to the rule, collected revenues have to be used in four equal ways (i.e. 25 percent each): (1) retain as government revenue; (2) maintenance fund for the hospital; (3) fund for procurement of drugs at the hospital; and (4) fund for welfare of hospital staff. This is a unique characteristic of new system of alternative financing in health sector of Myanmar. Now most of the large hospitals including specialist hospitals, general hospitals and divisional and district hospitals have opened the paying or private rooms.

In regard with the drug supply, in the past all government health institutions were providing free medical care including free supply of drugs. Starting from 1994 Department of Health introduced a user charges system for selected items of drugs. Firstly 20 items of drugs and later additional 23 items are included to charge at factory price of Myanmar Pharmaceutical Factory. This is the cost recovery scheme for selected items of drugs supplied at public hospitals. Exemption can be made for those who can not afford, by the decision of respective medical superintendent or township medical officer. All revenue except a small margin added for overhead charges of drug stores, are credited to government accounts. The revenue collected from selling drugs supplied by Central Medicine Store Deport (CMSD) in 1999 was kyat 19.9 million.

Starting from 1993, the user fee system was imposed for some diagnostic services such as laboratory tests, radiography services and ECG etc. The income from this system follows the rules of allocation of 25 percent each into four as mentioned earlier. Income from various user fees for diagnostic services using machines at Yangon General Hospital (YGH) in 1997 was kyat 28 million and it equals to 90 percent of recurrent budget of YGH in that year.

Myanmar Essential Drugs Project (MEDP) was implemented in 1989 and all essential drugs are provided free of charge at four pilot townships till 1993. Later MEDP introduced cost sharing

system for essential drugs. Price of essential drugs is set based on the market price. Following the concepts and principles of essential drug the basic health division of Department of Health introduced the drug financing for essential drugs using Community Cost Sharing (CCS) system in additional townships with the assistance of Nippon Foundation in 1994. Up to 1999, CCS for essential drugs was operating in 54 townships by MEDP and 72 townships by basic health division.

Community Cost Sharing (CCS) approach in Myanmar started in 1989 when the WHO introduced the Essential Drugs (ED) Programme. The government provided funds and technical assistance to assist the ED project in nine pilot townships for four years. Since then the developments of the project began and has been followed by various CCS projects, namely the Community Health Management and Financing (CHMF) project funded by the Nippon Foundation; the Myanmar Essential Drug Project (MEDP) funded by WHO; the Human Development Initiative-Extension (HDI-E) project funded by UNDP; the Central Medicine Store Deport (CMSD) funded by the government.[14]

Regarding to HDI-E project, improving rural community access to Primary Health Care aims to enhance accessibility of health care services and healthy lifestyle for the most vulnerable and disadvantaged in selected eleven townships. The project interventions are designed to address the issues of accessibility, availability and affordability of health care and healthy lifestyle for the poor and disadvantaged rural population through appropriate technologies including prevention and self care, improvement of health care facilities and services, and community participation and empowerment.[15]

Trust funds for drugs are established in some hospitals by the donation of well wishers. Trust funds are kept normally as saving accounts at banks and the annual interests earned from that account can be utilized according to the rules set by trust fund management committee or hospital management committee. Normally certain amount from earned interests is put into main trust fund account in order to increase the fund. One of the main objectives of trust funds is to finance the cost for waiving poor patients who can not pay for the costs of care at public hospitals. A trust fund with large amount by collective donations was established in Yangon General Hospital initiated by Chairman of National Health Committee in 1997. In 1999, a total of 139 hospitals in all states and division have trust funds with total value of kyat 135.7 million.

There is no comprehensive health insurance system in Myanmar. A social security system was established since 1956 under Ministry of Labour according to Social Security Act 1954. This system covers social services including health care for insured workers. Benefits provided by the scheme are free medical care during illness, payment of seventy five percent salary during maternity leave, full salary for one year for severely injured worker, cash payments for death and injury and survivors' pension. Three sources of financing to the scheme are contributions from employees, employers and government

According to the National Health Accounts data (2008 and 2009), health expenditures by financing agents taken into account for: Ministry of health 10%, other Ministries 0.8% to 0.9%, social

security board 0.15%, private household out of pocket 82% to 85% and Non-profit Institutions serving household 4% to 6%. For the long run, the government health expenditures (tax based financing) will be increased for all dimensions. Social health insurance under the social security board will be expanded. Health financing schemes financed by GAVI HSS assistance (Hospital Equity Fund, MCH Voucher scheme and Township based health protection scheme) will be covered by the tax based financing, CBOs and donors (for which beneficiaries going to the poor).The major sources of finance for health care services are the government, private households, social security system, community contributions and external aid. Government has increased health spending on both current and capital yearly. Total government health expenditure increased from kyat 464.1million in 1988-89 to kyat 86547 million in 2010-2011.

Social security scheme was implemented in accordance with 1954 Social Security Act by the Ministry of Labour. According to the law factories, workshops and enterprises that have over 5 employees whether State owned, private, foreign or joint ventures, must provide the employees with social security coverage. The contribution is tri-partite with 2.5% by the employer 1.5% by the employee of the designated rate while the government contribution is in the form of capital investment. Insured workers under the scheme are provided free medical treatment, cash benefits and occupational injury benefit. To effectively implement the scheme branch offices, workers' hospitals, dispensaries and mobile medical units have been established nation-wide. Social Security Board is now preparing the Social Security Law (2012) for increasing the coverage by compulsory contributions from the formal sector as well as voluntary contributions from the informal sector and the community.

Health insurance is one such alternative. Health insurance protects people against catastrophic financial burden resulting from unexpected illness or injury and an efficient system ensures the pooling of resources to cover risks. Although it is the ideal condition, there are so many issues challenging to initiate new system: political commitment, quality of health care services, providers' payment, administrative structure, fund management system, donor's backing, community awareness and community demands.

As health financing refers to the function of a health system concerned with the mobilization, accumulation and allocation of money top cover the health needs of the people, individually or collectively, in the health system. The purpose of health financing is to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care. Realizing the importance of its role, it has been so decided that, the main focus of the present situation to have a quick win in achieving the set goal is to formulate an effective strategy on health care financing.

With expansion of health services to cover the whole country not excluding border areas more financial resources will be required and it is necessary to explore means to cover this additional financial requirement. In exploring and implementing alternative means for financing health in conformity with the national health policy, user fees have been collected in government --

investigation services on cost sharing basis. For the indigents exemption mechanism is in place with establishment of trust funds in these hospitals.

Based on household income and expenditures surveys conducted in the country it is estimated that households are spending 2%-3% of total household expenditure on health. It is also estimated that 80% of national health expenditure are from household almost entirely out of pocket spending with consequent financial burden for the households. With economic development of the country individual and household income will also be rising and establishing a prepayment scheme with pooling of the revenue will provide more financial resources for health and at the same time protect households from financial burden following health care. In exploring alternative mechanisms for financing health and allocating the collected revenue efficiently in line with changing economic and social conditions of the country it is essential that basic and policy relevant information are available. It will be necessary to develop and institutionalize National Health Accounts in the country.

The Government has been providing budgetary allocation for public health services and free medical care since the country regained independence in 1948. According to religious and social customs Myanmar people are eager to provide assistance for social works. Individually or along with fellow members they are contributing in cash, labour or in kind for developing health infrastructure and procuring medicine and equipment. The extent and proportion contributed by the community in the national health expenditure could be more accurately estimated with availability of data and development of a system for recording and registration.

The total government health expenditure in 2010-2011 was 86,547 million kyat. With expansion of health services to cover the whole country not excluding border areas more financial resources will be required and it is necessary to explore means to cover this additional financial requirement.

In exploring and implementing alternative means for financing health in conformity with the national health policy, user fees have been collected in government hospitals from those who can afford for medicine, rooms, laboratory, imaging and other investigation services on cost sharing basis. For the indigents exemption mechanism is in place with establishment of trust funds in these hospitals.

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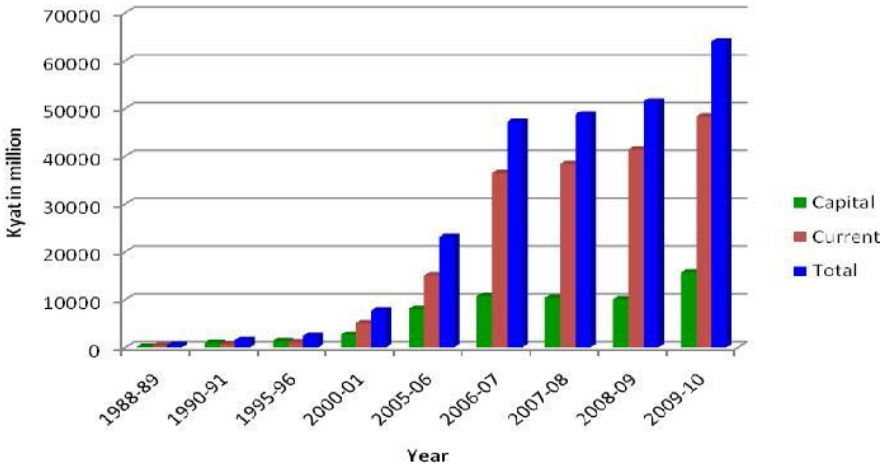
Sources of Financing

The major sources of finance for health care services are the government, private households, social security system, community contributions and external aid. Government has increased health spending on both current and capital yearly. Total government health expenditure increased from kyat 464.1 million in 1988-89 to kyat 64001.2 million in 2009-2010.



As spending by Ministry of Health as a financing agent constitutes the major share in the public spending on health and also taken into account the availability of data, estimates on public expenditures on health by financing entities were based solely on spending by the ministry. By functions curative and rehabilitative services accounted for around 32 to 38 % followed by 30% to 34% of spending devoted to health related functions. Prevention and public health accounted for about 22% to around 33% and Health Administration & Health Insurance accounted around 3% to 4%.

Government Health Expenditures by functions (2006-07 to 2009-10)

Functions (%)	2006-07	2007-08	2008-09	2009-10
Curative & Rehabilitative	37.03	37.72	32.05	31.64
Ancillary Services	0.28	0.24	0.37	0.63
Medical Goods Dispensed	3.73	3.44	3.60	3.16
Prevention & Public Health	21.62	24.03	30.59	32.29
Health Administration & Insurance	3.68	3.86	3.63	2.86
Health Related Services	33.66	30.71	29.76	29.42

Health expenditure

Health expenditure per capita in 2010 was USD$17.1, one of the lowest in the world and the lowest in the Asia-Pacific region. Only the sub-Saharan nations of Eritrea (USD$12), Ethiopia (USD$16), Democratic Republic of Congo (USD$16) and Madagascar (USD$16) spent less on health care.

Public expenditure on health care has increased from 461.1 million kyat in 1988-1989 to 64 billion kyat in 2009-2010, an increase of almost 14,000% (Myanmar Ministry of Health, 2011). However, this only accounted for 12.2% of total health expenditure in 2010 (World Bank, 2012b). The health budget is expected to quadruple for 2012-2013 (Andre, 2012), although this is coming from a low base. The National Health Account report from 2006-2007 stated that 84.5% of total health expenditure in 2007 were from private sources, with 10.1% coming from the government. The percentage of external funding has increased from 1.2% in 1998 to 5.4% in 2007 (WHO, 2007).

Government health expenditure is split roughly three-ways, with prevention and public health services accounting for 32.3% in 2009-2010, curative and rehabilitative (31.6%) and health related services (29.4%). 3.2% is spent on medical supplies, 2.9% on health administration and insurance and 0.6% on ancillary services (Myanmar Ministry of Health, 2011). In 2007, 5.7% of total health expenditure was allocated for prevention and public health, 30.6% for curative services and 46% for medical goods (WHO, 2007).

Nutrition Promotion

It is now well-recognized that under-nutrition during pregnancy increases the risk of non-communicable disease in later life. For the latter, the vital roles of agriculture, health, education, social welfare, employment, economic sectors, development partners, CSOs, INGOs and donor agencies, among others are highlighted. Lastly, that while poverty plays a major role in malnutrition it is not a problem of poverty alone — there is also a need for promoting a healthy environment and lifestyle particularly consumption of healthy diets.

Overall, Myanmar has achieved modest improvements across a range of dimensions that measure the general well-being of the citizens of the country over a five year period starting from 2005. These indicators which also assess progress made against Millennium Development Goals (MDGs) showed that while major areas that relate to poverty, employment, education and improved sanitation have significantly improved, the country continues to lag behind gender equality, immunization against measles, antenatal care. Out of the 8 MDGs, the country is still off track in so far as MDGs 1, 2, 4, 5 are concerned with general but modest improvements noted between 2005 and 2010. It is recognized the world over that in almost all of the 8 MDGs, nutrition is a cross cutting concern where it is either an input or an output of development processes that can help fast track the attainment of MDGs.

In 1992 the International Conference on Nutrition (ICN), convened by FAO, UNICEF and WHO, the Ministers and the Plenipotentiaries representing 159 countries and states and the European Economic Community had declared *"Hunger and malnutrition are unacceptable in a world that has both the knowledge and resources to end this human catastrophe ... that access to nutritionally*

adequate and safe food is a right of each individual... that the nutritional well-being of all people is a precondition for the development of societies and that it should be a key objective of progress in human development . It must be the center of all our socio-economic development plans and strategies... Furthermore, that each government has the prime responsibility to protect and promote food security and nutritional well-being, especially the vulnerable groups".

As an expression of its commitment to this World Declaration and Plan of Action on Nutrition, Myanmar has since 1994 formulated its 5 year National Plan of Action for Food and Nutrition (NPAFN). Now, on its third successor plan, with strong resolve is embarking on a national strategy for action that recognizes that food security and nutrition deserves to be an area of public policy and should be a major driver for public investments. Thus, the NPAFN for 2011-2016 clearly underscores the need to make investments in nutrition if Myanmar is to achieve its long term goal of national socio-economic development and attain its Millennium Development Goals (MDGs). It is now widely recognized that better nutrition leads to improved intellectual capacity, greater economic productivity and lowered risk of non-communicable diseases. In short, better nutrition is a vital element to ensuring long-term national development. The vital roles of agriculture, health, education, social welfare, employment, economic sectors, development partners, CSOs, INGOs and donor agencies, among others are highlighted. Lastly, that while poverty plays a major role in malnutrition it is not a problem of poverty alone — there is also a need for promoting a healthy environment and lifestyle particularly consumption of healthy diets.

The NPAFN is a strategic guideline based on a holistic causal analysis of the malnutrition situation in Myanmar. As such, it forms a comprehensive approach to address the immediate, underlying and basic causal factors from a farm to table food chain perspective and along the different life stages. On the basis of these analyses, strategic directions and objectives are outlined: (1) To address the immediate causes at the individual level, focus will be on improving nutrient intake and reducing food and water-borne as well as infectious diseases that affect the biological utilization of food. (2) To address the underlying causes (mainly at the household and community level), there is a need to improve food availability and accessibility. Further, mother and child care practices and environmental health/sanitation and access to health services should be improved. (3) Lastly, a number of strategies to address basic causes (mainly at the national level) have been identified. This includes improving institutional and human capacity, the collection and dissemination of relevant information, and advocating for investments in food based and health based interventions. The breadth and depth of the NPAFN aims to fast track and break the current trends in some forms malnutrition (under as well as over nutrition) and sustain any cumulative gains made in the past to achieve the priority national development goals of the government including the MDGs, National Socio-economic Development Plan, National Health Plan and National Agricultural Plan.

The ultimate aim of the nutrition program is "Attainment of nutritional well-being of all citizens as part of the overall social-economic development by means of health and nutrition activities together with the cooperative efforts by the food production sector".

To ensure that all citizens enjoy the nutritional state conducive to longevity and health by means of improving nutrient intake and household food security, NNC is implementing five major Nutritional problems with following specific objectives throughout the country:

1. To improve household food security
2. To promote nutritional status of the population by educating and practicing balanced diet
3. To prevent and manage properly under-nutrition, over-nutrition and diet-related chronic diseases
4. To observe periodically nutritional status under nutritional surveillance system
5. To strengthen nutritional infrastructure

Myanmar has identified five nutrient deficiency states as its major nutritional problems. They include Protein Energy Malnutrition (PEM) and four micronutrient deficiencies, namely, Iodine Deficiency Disorders (IDD), Vitamin A Deficiency (VAD), Iron Deficiency Anaemia (IDA) and Vitamin B1 Deficiency (VBD). Most of the nutrition interventions are implemented in all townships throughout the country.

1. Control of Protein Energy Malnutrition (PEM)

According to Multiple Indicator Cluster Surveys (MICS), prevalence of under-weight among under-five children in 2010 was 28.0%; meanwhile, MDG goal for under-weight prevalence is 20.0% by 2015. Prevalence of stunting was 28.6% in 2010, and that of wasting was 7.7% in 2010. The rate of Low Birth Weight was 24 % in 1994 (hospital based study) while 10% in 2004 and 7.9 % in 2010 by community surveys (NNC, DOH) comparing to 8.6% in 2010 (MICS). Exclusive breast feeding rate was increased from 16% in 2000 (IYCF survey, NNC) to 23.6% in 2010 (MICS).

The National Nutrition Centre has been implementing following projects in order to control Protein Energy Malnutrition among children.

1. Growth Monitoring and Promotion for children under five years (GMP).
2. Community Nutrition Centre (CNC) for moderately malnourished children in urban areas.
3. Hospital Nutrition Unit for severely malnourished children (HNU)
4. Community based Nutrition program comprising GMP, CNC and Village Food Bank (VFB) for malnourished children in rural areas
5. Community based Nutrition program comprising GMP, CNC and Village Food Bank (VFB)Strategy on Infant and Young Child Feeding in Myanmar was developed in 2003 and revised. Coordination meeting for review and revise of 5 year strategy for Infant and Young Child Feeding (2011-2016) was conducted in 2011 and has endorsed.
6. Training workshops for pediatricians on management of severely malnourished children were conducted in 2004, 2007, 2010, 2011 and 2012.

2. Iodine Deficiency Disorders (IDD) Elimination

According to surveys conducted by NNC the proportion of household consuming iodated salt was 18.5% in 1994, 79.9% in 2000, 86% in 2003 and 87% in 2007. Percentage of household consuming adequately iodized salt was 65% in 2003, 73% in 2005. But it was declined in 2006 to 47% in 2008. However, assessment of iodine status by clinical examination (visible goitre rate) and biochemical examination (median urinary iodine excretion) cannot be performed again after 2006.

Universal Salt Iodization (USI) has been adopted as the single, long-term strategy for eliminating iodine deficiency disorders since 1997. Accordingly, the Ministry of Mines, in 1999, issued a regulation, which required that all factories licensed for production of salt for human and animal consumption only produced iodized salt with iodine level between 40 ppm and 60 ppm. In collaboration with the Ministry of Mines, the Ministry of Health is striving for virtual elimination of Iodine Deficiency Disorders; though still need to make more commitments.

3. Control of Iron Deficiency Anaemia (IDA)

According to community surveys by NNC-DOH, the prevalence of anaemia was 45% among non pregnant women (2001), 26% among adolescence school girls (2002), 71% among pregnant women (2003) and 75% among under-five children (2005). The survey results by NNC (2003) indicated the prevalence of worm infestation as 30.8% among under-five children and 44.3% among pregnant. The prevalence was more common in delta region and coastal region.

Iron supplementation, integrated de-worming and nutrition education are main strategies for anaemia control in Myanmar. Iron folate tablets are distributed once a day for six months for pregnant women throughout the country (180 tablets in total per pregnant woman), biweekly iron supplementation for adolescent school girls in (20) townships. Starting from January 2006, integrated de-worming is implemented all over the country twice a year for all children aged 2-9 years and once during pregnancy period after 1st trimester. According to scientifically proven findings and its remarkable effect, since 2012, micronutrient sprinkle supplementation has been started for under-three children, giving daily for total 4 months per year in 11 townships and will expand up to 25 townships in coming years.

4. Vitamin A Deficiency (VAD) Elimination

Vitamin A deficiency used to be a public health problem among Myanmar children during the early 1990s. Although clinically deficient children are hard to be found, sub-clinically deficient ones are still common. Assessment of serum vitamin A status in children from the survey conducted in 2000 indicated that all children in the rural community and 96% of urban children had normal serum vitamin A status while only 4% of the urban children had mild sub-clinical deficiency. In 2012, NNC in collaboration with Department of Medical Research (Lower Myanmar) has assessed the status of vitamin A among under-five children in 15 townships countrywide. The result has been still processing to declare out.

Biannual supplementation with high potency Vitamin A capsule is the main strategy against vitamin A deficiency among under-five children to reduced morbidity and mortality rate and to enhance the growth of children. One dose of vitamin A (200,000 IU) is distributed for all lactating mothers within 42 days after delivery. At the same time, age specific dose of vitamin A capsules are distributed every six months for under-five children.

5. Control of Vitamin B1 deficiency

According to cause specific under five mortality survey (2003), infantile Beriberi is the fifth leading cause of death among children between 1-12 months (7.12%) in Myanmar. For children under-six months, deaths due to Beriberi were nearly 9%. The prevalence of Vitamin B1 deficiency was 6.8% among pregnant women and 4.4 % among lactating women (NNC, 2009).

Infantile BeriBeri surveillance was started from May 2005 and control of Infantile Beriberi project was initiated in June 2006. Vitamin B1 supplementation is distributed to all pregnant women starting from last month of pregnancy till 3 months after delivery. Injection B1 ampoules are distributed to hospitals for treatment of BeriBeri cases.

6. Nutrition Promotion Month (NPM) campaign By concerning public motivation and improving nutrition activities with integrated approach, 10th Anniversary of Nutrition Week Campaign (since 2003) has been celebrated as Nutrition Promotion Month in August 2012 as a whole month since 2009. Varieties of Nutrition promotion activities and all categories of nutrition interventions are conducted as a mass campaign all over the country.

7. Household Food Security (HHFS) Myanmar is self-sufficient in food production at national level. However, food is not secured at household level in some areas in terms of low income, constraints in food production, transportation, poor knowledge in feeding practices and poor care-giving. Food and nutrition survey were done in Kachin, Chin and Magway States/Regions in 2012, and the data analysis is not available yet.

8. Nutrition Laboratory Nutrition laboratory is concerned mainly for (1) Dietary and food analysis for Nutrient content and (2) Biochemical analysis of nutritional assessment such as urinary iodine content. **Training** Regarding Exclusive Breast Feeding, Infant and Young Child Feeding Practices, timely warning (one component in Nutrition Surveillance System) and nutrition component in HMIS, central NNC and State/Regions Nutrition Teams have conducted monthly trainings in many townships. Collaborating with the Department of Medical Science, NNC has developed the Nutrition Manual for Midwifery School and Nursing Diploma, which can also be applied for all basic health staffs.

9. National Nutrition Surveillance System

National Nutrition Surveillance System are composed of monthly food price and cost assessment, hospital nutritional deficiency cases, regular health management information system data collection, sentinel townships including timely warming surveillance and intervention system, yearly anthropometry and household food intake assessment in Region and State capital cities, regular food and nutrition survey and infantile Beri Beri surveillance systems. Since 2011-2012,

National Nutrition Surveillance System has been strengthening year by year to cover all age groups and all geographical areas.

10. Over-nutrition and obesity

National Nutrition Centre examined the body mass index (BMI) of 3828 fathers and 5504 mothers of under-5 children in the year 2000. It was found that 4.5% of mothers and 7.5% of fathers were over-weight (BMI 25-29.9), while 0.7% of fathers and 1.8% of mothers were obese (BMI ≥ 30). A more recent study done in 2009 (STEPS, 2009) revealed that among 7429 aged of 15-64, 25.4% were found to be overweight or obese, more female were overweight (30.3%; BMI>25kg/m2) and obese (8.4%; BMI>30kg/m2) than males.

Major achievements during 2012

- Growth Monitoring and Promotion activities are extended to under-five children (previously, only under-three children).
- Since January 2012, BHS training for nutrition information of HMIS was monthly conducted by central NNC and State/Regions Nutrition Teams.
- In February 2012, the Finalization Workshop on Strategy for Infant and Young Child Feeding (IYCF) was successfully conducted.
- Co-ordination meetings on Scaling up nutrition (2012).
- Co-ordination meetings on Sports Nutrition dedicated to 27th SEA Games.
- Coordination meeting including nutrition programs for mid level managers was held at central level, attended by Directors of State and Regions specifically Rakhine and Kayin.
- National Plan of Action for Food and Nutrition (2011-2015) was reviewed and revised by collaboration with multi-sectors. The draft could be able to finalize in 2013.

Control Communicable Diseases

Communicable diseases prevention and control is one of the priority tasks of Ministry of Health in achieving its objectives of enabling every citizen to attain full life expectancy and enjoy longevity of life and ensuring that every citizen is free from diseases. The ultimate aim of the Communicable Disease Control Programme is to minimize prevalence and entrenchment of communicable diseases, mortality and social and economic sufferings consequent to these and to provide rehabilitation.

As emphasis has been given for control of communicable diseases, plans have been developed systematically for preventing and controlling diseases like malaria, tuberculosis, leprosy, filariasis, dengue haemorrhagic fever, water borne epidemic diseases - diarrhoea, dysentery, viral hepatitis- and other preventable diseases.

As in many other countries, AIDS, TB and Malaria primarily affect the working age. These three diseases are considered as a national concern and treated as a priority. The ministry has

determined to tackle these diseases with the main objectives of reducing the morbidity and mortality related to them, of being no longer a public health problem, and of meeting the Millennium Development Goals.

Other communicable diseases and emerging communicable diseases that have regional importance are also tackled through activities encompassing surveillance and control.

Under the Disease Control Division and with the support of Central Epidemiological Unit, supervision, monitoring and technical support are provided by disease control teams at central level and state/regional levels.

Diseases of National Concern

HIV/AIDS

Introduction

AIDS is one of the priority diseases of the National Health Plan of Myanmar. The national response to the HIV epidemic was commenced in 1985. The first person with HIV infection was diagnosed in 1988, and the first person with AIDS diagnosed in 1991. The National Health Committee has laid down clear guidelines to fight AIDS as national concern. A multisectoral National AIDS Committee chaired by the Minister of Health was established in 1989 and a short term plan for the prevention of HIV transmission was launched in the same year. The first comprehensive surveillance system was developed in 1992, including surveillance among blood donors and AIDS reporting by health facilities. Sentinel Surveillance System is strengthened by Behavioural Sentinel Surveillance System, STD (Syphilis) Surveillance and establishment of Second Generation Sentinel Surveillance.

Since the earlier days of the surveillance system established, one finding of concern in the pattern of HIV infection is that it is spreading significantly among younger people. Data from 2002 suggests that in some areas up to 1.8 per cent of young people aged 15-24 are living with HIV. MoH and UNAIDS HQs, Geneva jointly held a workshop from 11-12 March 2002, for estimates of people living with HIV/AIDS in the county. The outcome was that there were a total of 177,279 people living with HIV/AIDS at end 2001. It was also agreed that cases were concentrated to higher risk groups and border areas. Based on AIDS case reporting in 2005, it has been estimated that 67 per cent of cases were attributable to sexual transmission, and 30 per cent to injecting drug use. HIV and tuberculosis (TB) combine their effects as a dual epidemic of increased concern in Myanmar. It is estimated that approximately 7 per cent of adult TB patients are also co-infected with HIV, with nearly 70 per cent developing nearly active tuberculosis at some point of time. Formal structures for cooperation between TB and HIV programmes have been established and are currently active.

National Strategic Plans for HIV/AIDS

In the beginning, the National AIDS Programme (NAP) was formed by forty AIDS/STD Prevention and Control teams. The teams were strategically situated in all States and Divisions of Myanmar. The AIDS programme is under the Disease Control Division in the Department of Health

and the action plan for AIDS and STD prevention and control activities is subsumed under the National Health Plan. The latest strategic plan on AIDS covered the period 2001-2005. In 2002, the UN developed the Joint Programme for HIV/AIDS Myanmar 2003-2005 to support the national response. The multi-sectoral National Strategic Plan 2006-2010 was prepared following a series of reviews which looked at the progress and experiences of activities during the first half of decade. The magnitude of the epidemic had been recognized and the efforts to respond to it had been indicated strong commitments of many partners to focus prevention, care and support efforts on the most vulnerable populations. This led to the development of National Strategic Plan on HIV and AIDS 2011-2016 as NSP II.

In accordance with **Three ones principle: "One HIV/AIDS Action Framework, One National Coordinating Authority and One Monitoring and Evaluation System"**, national response to HIV and AIDS is being implemented in the context of National Strategic Plan (2011-2015) developed with the participatory inputs from all stakeholders, under the guidelines given by the multi-sectoral National AIDS Committee and is monitored according to the National Monitoring and Evaluation Plan. The National Strategic Plan (2011-2015) has a vision of achieving the HIV related MDG targets by 2015. It's main aims are to cut new infections by half of the estimated level of 2010; and to reduce HIV transmission and HIV-related morbidity, mortality, disability and social and economic impact. National level dissemination workshop on NSP (2011-2015) was conducted in Nay Pyi Taw during June 2011 followed by State and Regional level dissemination workshops.

NSP II identifies the key guiding principles as essential to ensuring a more effective national response to the HIV epidemic. The guiding principles will underpin more effective national and local responses to the challenges of the meeting the objective of the strategic plan. The summary of guiding principles are: the 'Three Ones' principles; achieving Universal Access and MDGs on HIV/AIDS; evidence-informed and results-oriented programing; protection of human rights; cost effectiveness, cost efficiency, prioritisation; scaling up; partnership; coordination; participation; favourable policy and legal context; gender, and GIPA principle.

The Strategic framework of NSPII identifies three priorities to address the most pressing needs of populations at higher risk;

Strategic Priority I: Prevention of the transmission of HIV through unsafe behaviour in sexual contacts and use of contaminated needles;

Strategic Priority II: Comprehensive continuum of Care for people living with HIV;

Strategic Priority III: Mitigation of the impact of HIV on people living with HIV and their families.

Cross cutting interventions for all three strategic priorities will include:

- Health system strengthening (including private sector health services)
- Favourable environment for reducing stigma and discrimination;
- Monitoring and evaluation, research, advocacy and leadership.

At the level of interventions, target populations, implementing partners and activies are identified for each of the strategic priorities.

The **major activities** to be implemented in accordance with 3 Strategic Priorities include: Advocacy, awareness raising on HIV/AIDS for various population groups, prevention of sexual transmission of HIV and AIDS, prevention of HIV transmission through injecting drug use, prevention of mother to child transmission of HIV, provision of safe blood supply, provision of care and support, enhancing the multi-sectoral collaboration and cooperation, Special intervention programmes- cross border programme and TB/HIV programme, and supervision, monitoring and evaluation are being implemented by National AIDS Programme.

Strategic Information, Monitoring and Evaluation, and Research

In order to provide strategic information to Technical and Strategy Group on HIV and Myanmar Country Coordinating Mechanism for planning and decision making, Strategic Information and Monitoring & Evaluation (SI M&E) working group chaired by National AIDS Programme with members comprising of representatives from Department of Health Planning, Department of Medical Research, UN agencies, and INGOs has been formed in early 2011. National M&E plan, finalized with inputs of the working group was approved by Ministry of Health.

Trends of HIV/AIDS in Myanmar

The active surveillance of HIV/AIDS has begun in Myanmar since 1985. The first comprehensive surveillance system was developed in 1992 and HIV sentinel sero-surveillance survey among target groups has been carried out since then. Trends analysis of the HIV sentinel surveillance data revealed that HIV prevalence levels among low risk populations in 2012 continued the general decline observed since their peak in the late 1990s. Newly diagnosed TB patients has begun one of the sentinel groups since 2005, and the HIV prevalence has been fluctuating round about 1% above and below the 10% level since 2011. Among high risk populations, a significant decline was observed among Men who have sex with Men, Female Sex Workers and Injecting Drug Users in 2012 round of HSS; while the decline for male STI patients was very slightly.

Since early 2010, NAP with the technical support from Strategic Information and M&E working group and inputs from implementing partners has developed Asia Epidemic Model spreadsheet for Myanmar. With the model, the distribution of new cases (incidence) of HIV among populations was estimated and projected. Myanmar has gained the advantages of the concerted efforts of all implementing partners; the incidence of HIV has been declined yearly following its peak in late 1990s. However, the new infection is leveling out after 2011 indicating the need to intensify the momentum of prevention and control measures as well as to provide interventions tailored to MSM, IDU and female partners of these Most at Risk Populations (MARPs).

Globally 30 years has passed since AIDS was first reported and ten years since the landmark adoption of the 2001 declaration of commitment on HIV/AIDS at the United Nations Special Section

on HIV/AIDS (UNGASS). In Myanmar, over 20 years has passed since the first reported case of HIV in 1988, but with limited resources various achievements have been gained with high political commitments also towards 2001 UNGASS declarations. Although Myanmar has successfully gained Global Fund Round 9 Grant for scaling up of activities in the coming years, the next NSP (2011-2015) need to be fully funded by both international and domestic sources for achievements of MDGs, Universal Access and getting to Three Zeros; Zero New HIV infections, Zero Stigma & Discrimination, and Zero Death.

Tuberculosis

Introduction

Myanmar is one of the 22 TB high burden countries that account for 80% of all new TB cases arising each year, and the 27 countries that account for 85% of the global MDR-TB burden. Moreover, and due to a high and growing HIV prevalence, the country is included in the 41 global priority countries for TB/HIV. TB control activities are considered as national concern and the political commitment is in place through supporting human resources and financial in puts. Cross border collaboration of TB control activities with neighbouring countries such as Thailand, India and Bangladesh are essential to reduce TB morbidity and mortality and to prevent the development of drug resistant TB.

Historical Perspectives

After gaining independence, Myanmar established campaigns to fight against major infectious diseases. In 1964, the government of Myanmar signed an agreement with WHO and UNICEF to develop a National TB Programme and to elaborate a five year activity plan. Two years later the NTP started its activities. Later, these campaigns or vertical programmes were integrated with the primary health care system in the People's Health Plan and the National Health Plan. In 1978, the NTP became an integral part of the basic health services under the primary health care system.

In 1994 The NTP introduced short course chemotherapy started with 18 townships and gradually expanded to the remaining townships based on its epidemiology and covered all townships by 2003.The NTP also started Private-Public Partnerships with the MMA according to the plan for involvement of private sector in TB control. Three schemes of PPM DOTS were developed out of which the private practitioners could choose the most suitable for them to participate in TB control. The three schemes were: health education and proper referral; health education, proper referral and act as a DOT provider; to run an affiliated DOT clinic. In 2004, the Global Fund grant agreement of 17 million US$ for TB control was signed in August with UNDP as the principal recipient. In December, UNDP signed agreements with two sub-recipients, the NTP and Population Services International. The National Reference TB Laboratory was upgraded with the support of the International Union Against TB and Lung Disease (IUATLD).

In 2005, an Integrated HIV Care Pilot project (IHC) that provided anti-retroviral therapy to co-infected TB/HIV patients started in Mandalay Division. The Stop TB Partnership approved a second

GDF three year grant agreement for anti-TB drugs. The Global Fund signed an agreement with the third sub-recipient, the Myanmar Medical Association to scale-up PPM DOTS activities. The National Strategic Plan for 2006-2010 was developed. The Global Fund grant was withdrawn from Myanmar. In 2006 a group of six donors (Australia, UK, European Commission, Netherlands, Norway and Sweden) established a new trust fund called the Three Disease Fund (3DF), to address the critical funding gap caused by the termination of the Global Fund grant. GF round 2 termination plan was implemented and ended at the end of 2006. The External Quality Assessment System (EQAS) was introduced in 2006 and 415 laboratories are under EQAS at the moment.

In 2007 the Stop TB Strategy was adopted. The Green Light Committee approved a project in Myanmar for the treatment of 275 MDR-TB patients. The second anti-TB drug resistance survey started. In 2008 UNITAID committed to support the supply of second-line anti-TB drugs and paediatric formulations to fight TB in children. The Global Laboratory Initiative, the Foundation for Innovative New Diagnostics (FIND), GDF and UNITAD started supporting access to rapid diagnosis for patients at risk of MDR-TB. In 2009 The International Standards of TB Care were launched on World TB Day and were planned to be adopted by NTP and followed by the Myanmar Medical Association, public health facilities like teaching hospitals and institutes. DOTS Plus project was launched on 9 July 2009 at Yangon, Aung San TB Hospital in collaboration with Medecins Sans Frontières (MSF) and on 15 July at Patheingyi TB Hospital with the funding of WHO/3DF/USAID/UNITAID**. In** 2010 Biosafety level 3 laboratories for rapid diagnosis for TB were established on 12th July at Yangon National TB Reference Laboratory and Pathology and Pathengyi TB Reference Laboratory.

In 2011, the results of the 2009-2010 nationwide tuberculosis (TB) prevalence survey were finalized.[2]The survey confirms a much higher TB burden than previously estimated by the World Health Organization (WHO) and gives insights into the health-seeking behavior and profile of TB patients as well as a better understanding of TB risk factors. With the results of the prevalence survey, the NTP has revised the TB epidemiological data, impact targets, policies and control strategies and funding requirements to be better equipped to reach the Millennium Development Goals (MDGs). Apart from the revisions needed to the National Strategic Plan due to the higher TB burden, the pace of the scale-up of the diagnosis, treatment and care for patients suffering from multidrug-resistant TB (MDR-TB), and efforts to reduce the dual burden of TB and HIV/AIDS among populations at risk and affected by both diseases, was felt to be too slow.

Myanmar is one of the countries hit by the HIV epidemic in Asia. The reported HIV prevalence among adults of 15 to 49 year age group in 2009 is 0.61% but much higher rates have been reported in risk groups such among female commercial sex workers (11.3%) and injecting drug users (34%). In 2009, it was estimated that 238,000 people in Myanmar were living with HIV/AIDS. An estimated 75,000 Myanmar people are in need of antiretroviral treatment today, but only 21000 (28%) of this number are receiving it. Only 50% of estimated HIV positive pregnant women are receiving assistance to prevent transmission of the virus to their babies in Prevention of Mother to Child Transmission

(PMCT) project areas. Prevalence of HIV sero-positive among new TB patients was 9.7% according to the sentinel surveillance done at 25 sites in 2012. Prevalence of multi-drug resistant TB (MDR-TB) was 4.2% among new TB patients and 10% among previously treated patients based on the results of second nationwide drug-resistant survey completed in 2008. Third nationwide drug-resistant survey was started in 2012, and it will be finished during 2013.

Policy, Objectives and Strategies

The government of Myanmar has adopted the Millennium Development Goals (MDGs) including the targets and indicators under the MDGs that relate to health and disease control and prevention programmes, including tuberculosis control.

Goal

To reduce dramatically the TB morbidity, mortality and transmission, in line with the MDGs and the Stop TB Partnership targets, until it no longer a poses a public health threat in Myanmar.

Objectives

The objectives of NTP Myanmar are:

- To move towards universal access to TB diagnosis, treatment and care by reaching a 95% case detection rate of new sputum smear positive cases and by curing at least 85% of cases.
- To reach the interim targets of halving TB deaths and prevalence towards achieving the MDGs for 2015 which will improve universal access to high-quality diagnosis and patient-centred treatment and protect poor and vulnerable populations from TB, TB/HIV and MDR -TB

Targets

In line with the MDGs as well as the targets set by the Stop TB Partnership and the World Health Assembly, the targets of the NTP of Myanmar are:

- To halt and begin to reverse the incidence of TB by 2015
- To reduce the TB prevalence and death rates by 50% relative to 1990 levels by 2015 (MDG Goal 6, target 8, Indicator 23)
- To detect at least 70% of new sputum-smear positive TB patients and thereafter achieve universal case detection (MDG Goal 6, target 8, Indicator 24)
- To achieve and then surpass the 85% treatment success rate of new sputum smear positive TB patients under DOTS (MDG Goal 6, target 8, Indicator 24)
- To achieve and then surpass a 50% treatment success rate among MDR-TB cases

Specific objectives are set towards achieving the Millennium Development Goals (MDGs) by 2015 as follows:

- To reach and thereafter sustain the targets- achieving at least 70% case detection and successfully treat at least 85% of detected TB cases under DOTS,
- To reach the interim targets of halving TB deaths and prevalence by 2015 from the 1990

situation.

Totally 143,164 TB patients (all forms) were notified in Myanmar (Case Notification Rate of 294/100,000 population) in which 42,335 patients were new smear positive cases. NTP achieved case detection rate (CDR) of 77% and treatment success rate (TSR) of 85.4%for 2011.

According to the Global TB Control Report by WHO, incidence of TB was 381/100,000 population, prevalence was 506/ 100,000 population, and mortality was 48/100,000 population. Regarding MDG to halve TB deaths and prevalence from the 1990 situation, mortality rate has already reached the target since 2010 although prevalence rate is still on trial.

On the other hand, NTP is implementing TB control activities in line with the National Strategic Plan (2011-2015). This strategy covers the following six principal components:

1. Pursue high quality DOTS expansion and enhancement
2. Address TB/HIV, MDR-TB and the needs of poor and vulnerable population
3. Contribute to health system strengthening based on primary health care
4. Engage all health care providers
5. Empower people with TB and communities through partnership
6. Enable and promote research

The Plan was developed through the Technical Strategy Group TB (TSG-TB) jointly with all partners. The Plan takes into account the needs of diverse national populations, addresses issues as stigma and discrimination and broadens the partnership for implementation of the Stop TB Strategy in hard-to-reach areas. At the end of the five year implementation of the National Strategic Plan, by 2015, it is expected that Myanmar will reach the TB-related Millennium Development Goals 6 Target 8: to begin to reverse the TB incidence to less than 75/100,000 and to halve TB prevalence and TB mortality relative to 1990, to 210 and 25/100,000 respectively. It is also expected that the MDR-TB rate among new smear positive patients will be contained at 4%.

The government increased the budget for TB control gradually, especially for anti-TB drug procurement. Active case finding strategies have been improved by conducting initial home visits & contact tracing, by setting up sputum collection centres in hard to reach areas and by performing mobile team activities. National TB/HIV coordinating body has been formed since 2005 and reformed in 2011. Collaborative TB/HIV activities are carried out in the areas where NAP could provide ART and technical assistance was provided by WHO. Totally 28 townships are implementing TB/HIV collaborative activities. Nationwide TB/HIV scale up plan is developed, and almost all townships will be covered with collaborative TB/HIV activities by 2015.

With the results of the prevalence survey, the NTP has revised the TB epidemiological data, impact targets, policies and control strategies and funding requirements to be better equipped to reach the Millennium Development Goals (MDGs). The update includes three new/revised plans. The first plan, on active TB case-finding, has been developed as a direct result of the outcomes of the TB prevalence survey. With additional interventions to find the many undetected/unreached TB cases in

Myanmar, such as screening of risk groups, contact investigations and mobile team activities in high-prevalence communities, it is envisaged that 33 000 additional TB cases will be detected in 2012-2015. The two other plans on MDR-TB and TB/HIV offer a much more ambitious scale-up than that outlined in the National Strategic Plan. Almost 10 000 MDR-TB cases will be managed during the five-year period, and MDR-TB services will be available in 100 townships compared to 22 in 2011. By the end of 2015, TB/HIV collaborative activities should be available all over the country, and as much as possible TB and HIV health services should be integrated at the township level.

Programmatic Management of Drug Resistant TB PMDT) is one of the integral parts of Five Year National Strategic Plan (2011-2015). National Drug Resistant TB committee was formed in 2006. Standard Operation Procedure (SOP) for management of MDR-TB was finalized in 2009. National DR-TB Expert Committee is still updating that SOP to be transformed as a national guideline. DOTS-Plus Pilot Project was started in 2009, and concluded in 2011. MDR-TB pilot project could cover 10 townships (5 townships each from Yangon & Mandalay Regions). A total of 307 MDR-TB cases were enrolled. A scaling up towards 1800 MDR-TB patients is envisaged under the Global Fund Round 9 TB component (2011-2015), for which 492 patients could be put on treatment during Phase I (2011-12) in 22 townships (11 townships each from Yangon & Mandalay Regions). Now, Myanmar PMDT is applying community based model for uncomplicated cases. In 2013, altogether 38 townships are expanded for treating MDR-TB patients.

In area of Health System Strengthening, two MDR-TB pilot hospitals are following infection control measures recommended by infection control mission. Health personnel from MDRTB project townships were also trained for infection control measures, equipment in need were installed and infrastructures were renovated. Bio-safety Level-3 Laboratories in Yangon and Mandalay are also functioning under proper maintenance.

For the capacity building, NTP is carrying out various kinds of trainings at different levels covering laboratory aspect, data management, MDR-TB management and TB/HIV collaborative activities. NTP co-ordinates with national NGOs such as Myanmar Women's Affairs Federation (MWAF), Myanmar Maternal and Child Welfare Association (MMCWA), Myanmar Medical Association (MMA), Myanmar Red Cross Society (MRCS) and Myanmar Health Assistant Association (MHAA) in DOTS implementation.

International NGOs and Bilateral Agency co-operating with NTP are the UNION, Population Services International (PSI), International Organization for Migration (IOM), Pact Myanmar, Malteser, World Vision, Merlin, Asian Harm Reduction Network (AHRN), MSF (Holland), MSF (Switzerland), Cesvi, FHI-360, Japan Anti-TB Association (JATA) and JICA (Major Infectious Disease Control Project; MIDCP).

Conclusion

The target for MDG 6 of halting and beginning to reverse the TB epidemic by 2015 is on track, since the TB incidence rate has been declining since 1995.[3] Likewise, the target of halving the rate of TB mortality compared with 1990 levels has already been met (in 1990 there were 110 TB deaths per

100 000 population, compared to 41 in 2010). However, the prevalence must decrease further to reach the MDG target of 447 TB cases per 100 000 population in 2015 (in 2010 the prevalence rate was estimated at 525 TB cases per 100 000 population). Additional implementation targets guided by the Global Plan to Stop TB, 2011-2015, indicate that the case detection and treatment success rates as well as geographical/population coverage targets have to be further improved by 2015.

Malaria

Malaria is one of the major public health problems in Myanmar. It causes high morbidity and mortality leading to socio-economic loss and delay national development. Prior to 1950, malarial control measures were limited to a few places and consisted of anti-larval measures and distribution of antimalarial drugs. Among the Vector Borne Diseases in Myanmar, malaria was the first against which control efforts were started in 1950. From October 1951 to March 1954, the Government and WHO jointly set up a Malaria Control Demonstration Project at Lashio, and then replicated in Kyaukphyu and Taunggyi. The demonstration projects proved the efficacy of DDT – house spraying in controlling transmission of malaria. In 1953, the Government launched a countrywide malaria control project with the assistance of WHO and UNICEF. During that year, large-scale residual spraying of houses using DDT was carried out which covered about one million population.

In 1957, Malaria Control Programme was converted into Malaria Eradication Programme with the assistance of WHO and UNICEF protecting about 8.8 million population and using 766 metric tons of DDT. Death rate from malaria was found to decline from 217 per 100,000 population in 1950 to 82 in 1953 and 65.7 in 1957. In 1963, a seven-year plan was drawn up and Malaria Eradication Programme was implemented. Malaria mortality rate in 1966 was 3.8 per 100,000 population. In 1967, the population covered by spraying operation was 4.6 million. Death rate from malaria was 3.2 per 100,000 population in that year. Malaria death rate was 3.2 in 1968, 2.8 in 1970, 2.7 in 1971 after which it rose up to 9.2 in 1972, 11.6 in 1973 and 16.2 in 1974. Increasing number of malaria positive cases had been observed since 1970 together with rising API and SPR.

In 1972-73, Malaria Eradication Programme was revised in accordance with the global strategy of malaria and again converted into Malaria Control Programme with the final objective of achieving malaria eradication. There were various factors affecting the progress of the programme resulting in resurgence of malaria. The most important operational factor was in-accessibility of many of the hilly malarious areas. Poor coverage was sometimes unavoidable due to shortage and delayed delivery of DDT in some years. Human habits like sleeping outdoors for various reasons during peak vector activity period played a major role in the process. Disturbances in spray surfaces like renewal of walls and roofs, removal of DDT particles from the wall after spray season, etc., and many poorly constructed structures diminished the quality of spray. There was considerable movement of population across the international borders as well as migration within the country, so that large number of people from non-malarious areas contracted the disease from areas with active transmission.

As a result of Country health Programming conducted in 1976, with the assistance of WHO, Vector Borne Diseases Control Programme (VBDC) was developed encompassing malaria, Dengue Haemorrhagic Fever, Lymphatic filariasis and Japanese encephalitis, and the formulated progrmme was implemented since April 1978. Since from that period, VBDC has been integrated with Basic Health Services for its implementation. In revision for the second phase of People's Health Plan, VBDC was formulated as part of the Diseases Control Programme. In l PHP (1978-82), malaria topped the 51 priority diseases/conditions whereas in II PHP (1982-86), it was second to diarrhea diseases (out of 56 priority diseases/conditions identified). Then in III PHP (1986-1990) it again topped the list of sixty priority diseases/conditions.

In 1992, inter-ministerial level meeting was conducted in Amsterdam and Global Malaria Control Strategy (GMCS) was laid down during that meeting. In July 1993, country working group meeting to implement revised malaria control strategy was conducted. During that meeting, the programme approaches and policies were reviewed, revised and changed according to Global Malaria Control Strategy. In year 1999-2000, Roll Back Malaria concept was also accepted for strengthening partnership.

National Health Policy and Myanmar Health Vision 2030

The National Health Committee, formed on 28 December 1989, takes a leadership role and gives guidance in implementing health programmes systematically throughout Myanmar. Under the guidance of the National Health Committee, State and Divisional, District, Township, Ward and Village Health Committees had been formed at each and every administrative level. Built in monitoring and evaluation process is undertaken at Sate/Division and Township level on regular basis. Implementation of National Health Plan at various levels is carried out in collaboration and cooperation with health related sectors and NGOs.

The National Health Policy was laid down with the initiation and guidance of the NHC in 1993. It has adopted the Health for All goal as a prime objective through Primary Health Care approach. Health policies that are particularly relevant to RBM are:

- To produce sufficient as well as efficient human resource for health locally in the context of broad framework of long term health development plan.
- To augment the role of co-operative, joint ventures, private sectors and non-governmental organizations in delivering of health care in views of the changing economic system.
- To implement health activities in close collaboration and also in an integrated manner with related ministries.
- To expand the health service activities not only to rural but also to border areas so as to meet the overall health needs of the country.

Considering the rapid changes in demographic, epidemiological and economic trends both nationally and internationally and globally, a long-term health development plan has been drawn up

to meet the any health challenges in the future. The plan encompasses the national objectives, i.e., political, economic and social objectives.

Rural Health Development Plan - As 70% of the population resides in the rural areas priority has been accorded to rural health development. The health needs are more pronounced in the rural areas and as health has assumed a pivotal role for all round development, rural development has become essential. The overall objective of the plan is to improve the health status of rural population. The various components of the plan ***(Annex 3)*** are highlyrelevant to Roll Back Malaria.

National Health Plan (2001 – 2006) - The National Health Plan (2001 – 2006) is an integral part of the National Development Plan and in tandem with the national economic plan. The plan will ensure the effective implementation of the National Health Policy. Among others, it aims to strengthen health services in rural areas and one of its components is disease control.

National Malaria Control Programme

- Prior to 1950, - anti-larval measures and distribution of anti-malaria drugs, limited to a few places
- 1953- feasibility study of DDT residual spraying, a countrywide malaria control programme was established.
- 1957 - Malaria eradication programme
- 1973 - long-term malaria control programme, still vertically organized
- 1978 -Vector Borne Diseases Control (VBDC) Programme (Malaria, DHF, Filariasis and JE); implemented through Primary Health Care Approach.
- 1992 - adopting the Global Malaria Control Strategy formulated at the Ministerial Conference in Amsterdam
- 1999- Roll Back Malaria concept has been adopted (through partnership approach.
- Under NHP, the Central Supervisory Committee on Management and Control of Malaria was formed and is chaired by H.E. Minister for Health. Up to State/Division level, malaria teams were formed with some functional units like epidemiology unit, laboratory unit, entomology unit and administrative unit etc. From township level up to grass root sub-rural health center level, it is integrated with basic health services and implemented through primary health care approach. At the village level, voluntary health workers are present and they need capacity building and logistic support to become functional malaria volunteer.

Policies directly related to National Malaria Control Programme

- Case finding activities and case definition
- Improving access to and quality of malaria diagnosis
- Improving access to and quality of malaria microscopy in the public sector
    - Improving access to diagnosis through the use of quality-assured RDTs for Malaria
    - Improving quality of and access to malaria diagnosis and treatment by private medical practitioners**.**
- Empowering voluntary health workers (VHW) and NGO workers

- New antimalarial treatment policy – where Artesunate-Mefloquine was introduced.
- Intervention to reduce the burden of malaria during pregnancy
- Indoor Residual Spray
- Insecticide Treated Mosquito Nets Policy
- Indicators for Monitoring Progress and Outcomes and Evaluation of impact of Malaria Control
- Area stratification - The following variables were made use of for stratification.

  Epidemiological : ecology, vector, endemicity, epidemic potential.

  Operational : health infrastructure, accessibility community participation.

  Soci-economic : major economic activities, development Projects, immigration.

Based on that areas were stratified into forested related malaria, coastal malaria, plain areas malaria, urban or peri-urban malaria and area free from malaria. Approaches were identified according to stratification, namely personal protection, chemoprophylaxis, malaria clinics in underserved less accessible areas, epidemic preparedness including indoor residual spray, EDPT, use of larvivorous fishes in some areas, environmental management**.**

Drug resistant malaria has been detected along the international border areas particularly Myanmar Thai border and in some pocket areas in other parts of the country. The Myanmar Artemisinin Containment (MARC) framework was endorsed in April 2011 and the National Malaria Control Programme (NMCP) together with implementing partners initiated immediate containment actions in July 2011. It is also essential to have collaborative effort by the different ministries such as Ministry of Construction, Ministry of Agriculture, Ministry of Mining, Ministry of Forest and Companies working in development projects in the regions which are enormously important and without their awareness and collaboration the goal cannot be achieved.

Myanmar is on track to achieve the malaria-related Millennium Development Goals. Objectives of National Malaria Control Program are reduction of malaria 50% in 2016 (baseline 2009) and to contribute socioeconomic development and achievement of health related MDG in 2015.

National Malaria Control strategies:

- Prevention and control of malaria by providing information, education and communication up to the grass root level
- Prevention and control of malaria by promoting personal protective measures and/or by introducing environmental measures as principle methods and application of chemical and biological methods in selected areas depending on local epidemiological condition and available resources
- Prevention, early detection and containment of epidemics

  Provision of early diagnosis and appropriate treatment
- To promote capacity building and programme management of malaria control programme (human, financial and technical)

- To strengthen the partnership by means of intrasectoral and intersectoral cooperation and collaboration with public sector, private sector, local and international non-governmental organizations, UN agencies and neighboring countries
- To intensify community participation, involvement and empowerment
- To promote basic and applied field research

For the time being, National Malaria Control Program has accelerated its efforts to perform control and preventive activities under the guidance of MOH and technical support of Technical Strategic Group on Malaria. The activities of malaria control programme includes:

Information, Education and Communication - Dissemination of messages on malaria is carried out through various media channels with the emphasis on regular use of bed nets (if possible appropriate use of insecticide treated nets) and early seeking of quality diagnosis and appropriate treatment (if possible within 24 hours after onset of fever). Production and distribution of IEC materials is also carried out in different local languages for various ethnic groups and different target groups such as forest related travelers, pregnant women and general population. Advocacy activities are conducted to public and private sectors, NGOs, religious organizations and local authorities at different levels

Stratification of Areas for Malaria Control - Risk area stratification was carried out in 80 endemic townships in 2007, 50 townships in 2011 and 50 townships in 2012. Up to end of 2012, risk area stratification has been carried out in total 180 townships. About 61.7 % of population (30,196,214) and 38.3 % of population (18,744,165) was residing in malarious areas and non-malarious areas respectively. In malariou s areas, 21.4% of population (10,473,241) was residing in high risk areas, 17.9 % of population (8,760,328) was residing in moderate risk areas and 22.4 % of population (10,962, 645) was residing in low risk areas. Package of malaria control activity has been given according to the result of risk area stratification that ensures the effective resource allocation. Validation on micro-stratification process was done by mal ariometric survey in some targeted townships.

Insecticide Treated Mosquito Nets - Selective and sustainable preventive measures are carried out emphasizing o n personal protection and environmental management. With limited resources, areas were prioritized for ITN Program either distribution of Long Lasting Insecticidal Nets (LL IN) or impregnation of existing nets. During 2 011, the total numbers of 800,000 LL INs were distributed and 1,062,723 existing bed nets wereimpregnated . During 20 12, the total numbers of 1,450,978 LLINs were distributed. And 1,829,631 existing bed net s were impregnated. These LLIN/ITN activities covered 5,627,445 population at malaria high risk areas.

Epidemic preparedness and response- Number of epidemics became reduced during last five years. Ecological surveillance and community based surveillance were implemented together with early case detection and management and preventive measures like Indoor Residual Spray (IRS) in development

projects and impregnation of existing bed nets in epidemic prone areas. There is no reported malaria epidemic in 2012.

Early diagnosis and Appropriate treatment- According to the new anti-malarial treatment policy, case management with ACT (Artemisinin based combination therapy) was practiced in all 330 townships. For malaria diagnosis, since 2005, 7 00 microscopes were distributed up to rural health center level and RDT (Rapid Diagnostic Test) were also distributed up to sub-centers as well as community level. There were 887,969 fever cases were tested by RDT, out of which 294,173 confirmed P.f cases were treated with ACT (Coartem) and 1 59,482 P.v c a ses were treated with Chloroquine in 2012.

Assessment and quality control of malaria microscopy was done in 193 malaria microscopic centers by laboratory technicians from Central and State/Regional VBDC team in 2012. Monitoring therapeutic efficacy of anti-malarial drugs particularly ACTs in collaboration DMR (Lower Myanmar) and DM R (Upper Myanmar). Quality assurances of RDT (Paracheck) were also done in collaboration with DMR (Lower Myanmar). Malaria mobile teams reached up to rural areas and hard-to reach border areas for improving access to quality diagnosis and effective treatment. Community based Malaria Control Program has been introduced and implemented in some selected townships of Eastern Shan State since 2006-2007 and expanded in total 131 townships and 3280 volunteers were trained in 2012.

Capacity building - Different categories of health staff were trained on different technical areas:

- Training on malaria microscopy was conducted for 141 malaria microscopists;
- Different categories of 13,079 health care providers were trained on capacity on skill development of malaria cases management ;
- 530 VBDC Staffs were trained on malaria prevention and control emphasize on preventive measures, vector control, case management (diagnosis and treatment), recording and reporting.

Conclusion

The country is on track to achieve the malaria-related MDGs. Malaria mortality is below 25% of the 2005 level, and that malaria is no longer a barrier to socio-economic development. All patients with malaria symptoms have access to early diagnosis and effective treatment. All people living in areas of malaria risk are able to protect themselves to reduce risk . Malaria outbreaks are prevented or effectively controlled. The State, Regional and Township Health Departments plan, implement, monitor and evaluate malaria control interventions with the VBDC Programme determining policies strategies, organizing training sessions, providing oversight and implementing surveillance, monitoring and evaluation activities at national level. National Research Institutions develop and evaluate novel control tools and implantation strategies, and with the VBDC Programme regularly

exchange findings and know-how with countries with similar problems. Political will to control malaria at all levels and in all sectors concerned is based on a thorough understanding of the problem and its social and economic dimensions, the risks of resurgence and the benefits of sustained control. In a spirit of partnership and solidarity, the international community provides essential support to strengthen the national response against malaria, led by the Ministry of Health.

Disease Surveillance and Response

Communicable diseases still pose major health problem and outbreaks of communicable diseases cause substantial morbidity and mortality, consume scare national health resources, and affect economic productivity. Rapid and appropriate response to emerging infectious diseases depends on efficient surveillance at national, regional and global levels. Disease outbreaks need to be recognized promptly and controlled immediately in order to minimize their impact, as the impact finally ends up to loss of life and economy of the country. Many deaths in the country are attributable to diseases that are preventable or can be treated in simple measures. Illnesses among school children cause a setback in educational process and progress. Communicable diseases are caused by transmission of a specific infectious agent or its toxic products from a reservoir to a susceptible host; mat it be a direct or through a person, animal, vectors or inanimate environment.

Going back to historical evolution of communicable diseases, the country suffered from the ravages of smallpox since the fourteen century, long before colonial doctors commenced vaccination operations It was not until the nineteenth century, however, when the country fell under British administration where records showed that it caused 8,717 deaths in 1898 and 10,754 deaths in 1899. Preventing smallpox was a necessity for protecting British military serving in the country. It was no wonder that the British administration considered vaccination against smallpox their utmost priority in the province of Burma as elsewhere in British India.

Historical documentation of smallpox in the county is difficult to find before the British arrival except a few short notes and vague reports made by European travellers and early missionaries. The earliest recorded incidence of smallpox occurred in 1367 when a Myanmar King died from the disease (*Hman-nan Maha-ya-zawin Tawgyi*). When *King Taninganwei* (1714-1733) led his army against Gharib Newaz of Minipur, smallpox decimated the force after they reached the Chindwin river. *King Alaungphaya* who founded the *Konbaung Dynasty* (1752-1885) was also reported to have been a victim of smallpox. Europeans noted smallpox cases in the country, at least from the early eighteen century. Alexander Hamilton, for example, recorded smallpox in Pegu about 1709, writing that smallpox was ‘dreaded as pestiferous’ and that the neighbours of the stricken would flee two to three miles as soon as anyone caught it. As he also observed in 1727, a smallpox victim was left with ‘a jar of water, a basket of raw rice, and some earthen pots to boil it in, then they (neighbours) bit him farewell for twenty-one days. The actual magnitude of smallpox epidemic in the country did not become clear, however, until British doctors began to compile statistics on local deaths and diseases under British rule.

When the British general administration consolidates itself and governed the country by appointing a Chief Commissioner in 1862, a Sanitary Commissioner was appointed to look after Public Health which in practice was for sanitation in urban areas and prevention and control of epidemic diseases. In 1908, Office of the Director of Public Health was formed and taking in charged of public health functions including disease control. With Burma Act of 1935, the country got separated in 1937 from Indian Empire from Ministry of Education handled health matters. In the field of Public Health, the Director of Public Health initiated in the 1930s, health activities in various public health disciplines: MCH societies were encouraged, nutrition section established; anaemia, beri beri and goitre surveys conducted. Malaria was recorded in reports of hospitals as well as in studies. Epidemiological surveys by spleen index and identification of mosquito vectors were conducted and also sample surveys on leprosy prevalence. A health propaganda officer began work on health education. The main task of the DPH office was to investigate and control of outbreaks of 3 main principal epidemic diseases – smallpox, cholera and plague, which occur in turn every year. In support of disease control, Pasteur Institute and Harcourt Butler Institute of Public Health were established in 1915 and 1927 respectively.

After the war, when civil administration was set up in 1946, health services was reorganized and formed the office of Director of Medical and Health Services (DM&HS), taking care of hospital administration and public health mainly epidemic control and environmental sanitation. On recommendation of WHO Enquiry Committee the Directorate of Health Services was re-organized with 3 major divisions: Hospitals, Public Health and MCH. At the district level, it has been reorganized as Civil Surgeon for the hospitals and District Council Health Department for public health including MCH and special campaigns. As to epidemiological services, Junior Doctors, LMPs were designated as Epidemic Sub-assistant Surgeons – Epidemic SAS, their activities having a semblance of an epidemiological nature. Later on expansion of epidemic control activities took place and formed into Epidemic Mobile Teams, stationed at divisional headquarters, strategic or epidemic prone districts and moved in area for surveillance and control of epidemics.

In 1964, the Directorate of Health Services and entire Basic Health System was again reorganized and basically remain the same till date. One important aspect of the reorganization is the creation of divisional administration with new conceptualization of decentralized administration in supervision. In rural health area, station health complex was introduced. Among technical groups, Central Epidemiological Unit – CEU, Aedes Control Unit, Filariasis Control Group, and Trachoma Control under Disease Control; Environmental Health, Health Education, Occupational Health, and Health Statistics were formed under Public Health. The CEU operates under Assistant Director – Epidemiology and under CEU, 10 Epidemic Mobile Teams – EMTs, operate at States and Divisions level. EMTs were later renamed as Special Disease Control Programme Teams (SDCP).

For an effective surveillance and control of communicable diseases, the British has adopted the Municipal Act 1898 during the Imperial period and later modified as Rangoon Municipal Act 1922. This has been maintained during the colonial time and amended in 1955 and 1961. The Municipal Act

1898 was again later repealed by the Development Committee Law (1993). The Municipal Act 1898 covered two sections on Dangerous and Epidemic Diseases (para 167 to 178) and Entry of Inspection in case of emergency (para 179-185).In 1972, the Revolutionary Council of Burma, enacted the Law no. 1 – Public Health Law 1972.This law covers environmental health activities, food related activities, home utility, infectious diseases, private clinic, drugs for public use. This law refers to various act important for the surveillance and control of communicable diseases, such as: Dangerous Drug Act, Epidemic Disease Act, Ghee Adultration act, Food and Drugs Act, Leprosy Act, Vaccination Act, Animal Pest Act, City of Rangoon act, Cantonments act, Municipal act, Rural Self-Government Act, Towns Act and Village Act.

In 1995, the State Law and Order Restoration Council, enacted the Law no. 1/95 – The Prevention and Control of Communicable Disease Law 1955. The law comprises of prevention, environmental sanitation, reporting communicable disease, measures taken in respect of an outbreak of epidemic diseases, quarantine, and functions and duties of the Health Officer. In order to prevent the outbreak of Communicable Diseases, the Department of Health shall implement the project activities:- (a)immunization of children by injection or orally; (b)immunization of those who have attained majority, by injection or orally, when necessary; and (c) carrying out health educative activities relating to Communicable Disease.When a Principal Epidemic Disease or a Notifiable Disease occurs: (a) immunization and other necessary measures shall be undertaken by the Department of Health, in order to control the spread thereof: and (b) the public shall abide by the measures undertaken by the Department of Health under sub-section (a). In case of reporting, the head of the household or any member of the household shall report immediately to the nearest health department or hospital when any of the following events occurs:- (a) rat fall, (b) outbreak of a Principal Epidemic Disease; and (c) outbreak of a Notifiable Disease. Traditional medicine practitioners, health assistants and doctors shall report immediately to the nearest health department or hospital if a case of Principal Epidemic Disease or Notifiable Disease if found during practice.

In order to prevent and control the spread of a Principal Epidemic Disease, the Health Officer may undertake the following measures: (a) investigation of a patient or any other person required: (b) medical examination; (c) causing laboratory investigation of stool, urine, sputum and blood samples to he carried out: (d) causing investigation by injection to he carried out; and (e) carrying out other necessary investigations. The Health Officer has the right to do laboratory investigation of any food, water and other necessary materials and shall report immediately the source to the relevant Department of Health, of the Principal Epidemic Disease. For prevention of the outbreak of Communicable Disease and effective control of Communicable Disease when it occurs, the public shall, under the supervision an guidance of the Health Officer of the relevant area, undertake the responsibility carrying out the following environmental sanitation measures: (a) in-door, out-door sanitation or inside the fence, outside the fence sanitation; (b) well, ponds and

drainage sanitation; (c) proper disposal of refuse and destruction there of by fire: (d) construction and use of sanitary latrines; and (e) other necessary environmenta1 sanitation measures.

The Central Epidemiology Unit (CEU), acts as the National Focal Point for the Communicable Disease Surveillance and Response, is functioning well in collaboration with related ministries, departments and organizations. National Surveillance System targets epidemic prone communicable diseases, Diseases under National Surveillance (DUNS), emerging infectious diseases, climate related communicable diseases and vaccine preventable diseases. The eventual intend of communicable disease control is the reduction of morbidity and mortality while some of the diseases like poliomyelitis, measles and neonatal tetanus (NNT) are targeted for eradication and elimination goal.
The national surveillance system is sensitive enough to detect the outbreaks even in the small scale. Most of the outbreaks are reported through the event based reporting system. On the other hand, media surveillance and rumor surveillance has been strengthening by active and prompt verification of news and rumors on the media including electronic media. That improvement enhances the flexibility of the surveillance system and enables the system to be in line with the developing social and economic system of the country.

Similar to other part of the world, the epidemiology of communicable diseases and the emergence and re-emergence of infectious diseases in Myanmar are also greatly affected by climate change. Thus, expanding the “One World One Health Approach”, enhancing the international networking and capacity building of the health staff are essential for strengthening of National Surveillance System in the modern era. For this reason, more and more collaboration with animal health sector, international and regional organizations such as ASEAN(Association of South East Asia Nations), ACMECS (The Ayeyawady - Chao Phraya - Mekong Economic Cooperation Strategy), MBDS (Mekong Basin Disease Surveillance Network), GMS (Greater Mekong Sub-region) are also intended for information sharing and human resources development of the surveillance system.

Among the communicable diseases, Vaccine Preventable Diseases are of the national concern. Myanmar is striving to attain the polio eradication goal at the national level by strengthening Acute Flaccid Paralysis (AFP) surveillance system and routine immunization activities. National certification ensured by accomplishment of the standard surveillance indicators brings Myanmar to a closer step in realizing the Regional Polio Eradication Goal of South East Asia Region in 2014. Measles Elimination is also aimed to achieve in 2014 through strengthening of case based measles surveillance. In the mean time, the elimination status of maternal and neonatal tetanus accomplished in 2010 has been sustaining through the effective strategies.

The CEU is also keep enhancing its capacity in emerging diseases. Avian Influenza is reported in neighboring countries in early 2013 and Ministry of Health has been alerted for diseases surveillance in point of entries and active surveillance sites as the preparation for the best with the worst scenario. The preparedness is undertaken in accordance with existing Strategic Plan for Prevention and Control of Avian Influenza and Human Influenza Pandemic Preparedness and Response endorsed by the National Health Committee in 2006. The table top exercise and simulation

exercise on pandemic preparedness and response, updating of National Influenza Preparedness Plan and Pandemic Vaccine Deployment Plan and Business Continuity Plan were already endorsed and exercised by related Ministries and agencies.

In respect of international coordination, being the focal point for Working Group on Human Resource Development (WGHRD), Department of Health actively participates in the regional collaboration with GMS countries. The Department of Health hosted the WGHRD and related meeting in the recent years. On 1-2 November 2012, 11th Meeting of the GMS Working Group on Human Resource Development (WGHRD-11) was held in Yangon, Myanmar and the GMS HRD Strategic Framework and Action Plan (SFAP) 2013-2017 was discussed and endorsed at that meeting. The SFAP was subsequently endorsed by the 18th GMS Ministerial Meeting held in Nanning, People Republic of China on 12 December 2012. National Working Group on HRD (Myanmar) has conducted the National Consultation Meeting in 7-8 March 2013 for prioritization of the technical and investment projects in the Regional Investment Framework.

The emergence, development, and value of regional infectious disease surveillance networks that neighboring countries worldwide are organizing to control cross-border outbreaks at their source. Distinct from more formal networks in geographic regions designated by the World Health Organization (WHO), these networks usually involve groupings of fewer countries chosen by national governments to optimize surveillance efforts. Sometimes referred to as sub-regional, these ‘‘self-organizing’’ networks complement national and local government recognition with informal relationships across borders among epidemiologists, scientists, ministry officials, health workers, border officers, and community members. Their development over time reflects both incremental learning and growing connections among network actors; and changing disease patterns, with infectious disease threats shifting over time from local to regional to global levels. Today, several of these networks are linked through Connecting Organizations for Regional Disease Surveillance (CORDS). It is time to explore how regional disease surveillance networks add value to global disease detection and response by complementing other systems and efforts, by harnessing their power to achieve other goals such as health and human security, and by helping countries adapt to complex challenges via multi-sectoral solutions.

International Health Regulation

In this age of globalization, no single country alone has the capacity to prevent the international spread of diseases. Recent events have clearly demonstrated that global cooperation decreases the vulnerabilities of individual countries and promotes global public health security. The world is witnessing new and emerging diseases which challenge public health and international health security. Countries have to prepare for such events as well as hazards due to chemical or nuclear sources. It is in this spirit, the WHO’s International Health Regulation (2005), a revised version that marks a milestone in public health and heralds a new era of information sharing in real time among the member states. The scope of IHR 2005 has expanded from just reporting on selected diseases to

all events representing a public health emergency of international concern. It also provides a legal framework for the rapid gathering of information and assessing the public health consequences of any events, irrespective of source of origin.

The embodying principle of IHR 2005 implementation is transparency and accountability. Complying with the IHR in the past was fraught with many predicaments, for instance, some Member States imposed excessive protective measures such as strict trade and travel restrictions. IHR 2005 provides a framework whereby all Member States are ensured that control measures are commensurate with and restricted to public health risks and avoid unnecessary interference with international trade and travel.

There is needed to be fulfilled International Health Regulation (2005) to prevent the international spread of Public Health Emergency of International Concern (PHEIC) including communicable diseases and the Central Epidemiological Unit works closely in collaboration with the International Health Division of the Ministry of Health which take as National Focal Point. National IHR core capacity was assessed in 2012 and based on that IHR Action Plan 2013-2014 was developed to meet the timeline challenges of IHR. All public health emergencies has been managed by the Central Commend System. In case of emergency, Strategic Health Operation Centre is activated and all the response activities were carried out based on response plan. National Infection Control Committee has been organized since 2009 and policies and guidelines on infection control are available. But the evaluation and updating of guidelines are still needed to be carried out. However there is a sound national capacity on preparedness for emerging pandemic threats and national disasters except the capacity to manage chemical and radiological hazards.

The assessment of core capacity at Points of Entry including airports, seaport and ground cross points were also conducted in 2012 and Department of Health has been putting its efforts in following recommendations of the regional assessment team. In this connection, National laboratory policy and formation of National biosafety committee are currently in process. After the Regional Workshop on IHR legislation in April 2013, the Communicable Disease Law and the Law Amending the Communicable Disease has been distributed to the State and Regional Health Department. It is planned to advocate to authorities and relevant stakeholders and to be distributed as well. The national Surveillance worksop was also conducted in 2013 to enhance the surveillance capacity. The guideline and manuals were updated according to the recommendations of the workshop.

Myanmar has enhancing the collaboration with neighboring countries in the implementation of IHR. Recently, Myanmar-Thailand Collaborative Workshop on Disease Surveillance & Control at Border Areas was conducted in Yangon in April 2012. Moreover, Myanmar-Thailand Local Joint Coordination Meetings were organized at the three ground cross points at border areas; Myawaddy-Tak (24-25 October 2012), Tachileik- Chaiang Rai (25-26 October 2012), Kawthaung - Ranong (21-22 November 2012) respectively.

The role of WHO country office in implementation of IHR 2005 is to collaborate with MoH through the provision or facilitation of technical cooperation, financial and logistical support in building, strengthening and maintaining the capacities required under the IHR 2005.

Expanded Programme on Immunization

Immunization programme has initiated in the country since the Imperial period of British rule. Smallpox epidemic has been recorded since 1898 and vaccination programme has been scheduled since that TIME. Legislation on smallpox vaccination was promulgated in 1880 through the Burma Vaccination Act 1880 which was subsequently amended and consolidated by the Burma Vaccination Law 1908, Burma Vaccination Law Amended Act (1909) and the Burma Vaccination Law Amendment) Act 1928. Variolation was banned from the very beginning of the legal enactment of the vaccination act of 1880. The legal power on prohibition of variolation was reinforced by the Burma Prohibition of Inoculation and Licensing of Vaccinators Act 1908, as amended by the Burma Prohibition of Inoculation and Licensing of Vaccinators Amendment Act 1916. By these Acts, primary vaccination should be given to infants at the age of six months and revaccination to the population periodically. Though the law existed, strict enforcement of the law was not carried out. Rather Smallpox Eradication Programme - SPEP was implemented through cooperation of the public which was generated by constant and adequate health education at personal and community level.

Freeze-dried vaccine has been used since the beginning of the programme. Vaccine was received from the WHO special fund, and from the USSR on bilateral assistance. The USSR donated sufficient quantity to satisfy the programme needs between 1963 and 1972, a total 59 331 600 doses, complemented by 3 500 000 doses received from Who in 1964, 1966 and 1967. Since 1973, Burma Pharmaceutical Industry has produced sufficient vaccine. Every bath is tested for potency and purity by WHO reference Laboratories, and all batches except one met WHO requirement.

In accordance with the decision of the Eleventh World Health assembly (1958) and of the Regional Committee of SEARO (1960), Myanmar implemented SPEP in 1963. Within seven years disease was eradicated. This success was achieved by mass vaccination of the population aiming at 95% coverage. The Government /WHO Assessment Team stated in 1971 that Burma has attained a small pox free status, the International Commission on Smallpox eradication on 30 November 1977 certified that smallpox was eradicated in the country since 1970. Smallpox vaccination was discontinued in the country since January 1978.

The World Health Organization initiated the Expanded Programme on Immunization (EPI) in 1974 with the objective to vaccinate children throughout the world. Ten years, later, in 1984, the WHO established a standardized vaccination schedule for the original EPI vaccines: Baccilus Calmette-Guerin (BCG), diphtheria-tetanus-pertussis (DPT), oral polio, and measles. Increased knowledge of the immunologic factors of disease led to new vaccines being developed and added to the EPI's list of recommended vaccines: Hepatitis B (HepB), yellow fever in countries endemic for the disease, and Haemophilus influenzae meningitis (Hib) conjugate vaccine in countries with high burden of disease.

The EPI in Myanmar was launched in 1978 in 104 townships, along with the commencement of the First Peoples Health Plan 1978-1982, when Bacillus Calmette-Guerin (BCG), DPT and tetanus toxoid (TT) vaccines were introduced. BCG vaccine had been in use in the country since the 1950s. Children under one year of age were protected against DPT and TB. In order to prevent neonatal tetanus, pregnant women were given two doses of TT.

In 1990, there were 211 townships implementing EPI, by 1995, 305 townships were covered and by 1997 almost all areas of all townships were covered. From 1998 onwards strategies like expansion of the cold chain using solar-powered refrigerators and conducting outreach immunization sessions during the dry season (Crash programme) were initiated for hardto-reach and remote border areas to make EPI operationally cover the whole country.

Measles and polio vaccines were introduced into the routine EPI programme for infants in 1987. HepB vacciwas introduced in phases from 2003 and covered the whole country in 2005. A combination of fixed, outreach and crash immunization delivery systems was used to achieve nationwide coverage.

T*heNational Immunization schedule being implemented in Myanmar is*:

Target Groups	Time of immunization	Antigen
Child	Birth	HepB birth*
	6 weeks	BCG,DPT1,oral polio vaccine1 (OPV1) HepB1*
	10 weeks	DPT2,OPV2,HepB2
	14 weeks	DPT3,OPV3,HepB3*
	9 months	Measles 1
	18 months	Measles 2nd dose [1]
Pregnant woman	1st antenatal contact	Tetanus toxoid 1st dose (TT1)
	4 weeks after first dose	Tetanus toxoid 2nd dose (TT2)
*Birth dose of HepB is given only in big hospitals with a paediatric ward. In these instances, the child is given HepB 2nd dose at 6 weeks and 3rd dose at 14 weeks of age.		

Routine measles 2nd dose planned from 2012

In addition to routine immunization activities outlined above, supplementary immunization activities such as National Immunization Days (NIDs) and Mop-Up for polio eradication, mass campaigns for measles control and maternal and neonatal tetanus elimination have been undertaken since 1996. The Central EPI (CEPI) and Central Epidemiology Unit (CEU) of the DoH are responsible for formulation and development for planning, management of vaccine and cold chain, supplies and logistics, surveillance and outbreak management of vaccine-preventable and other emerging diseases, as well as training, supervision, monitoring and evaluation. CEPI and CEU of DoH, WHO and UNICEF collaborate closely in implementing priority vaccine-preventable disease control activities. While

immunization is an important strategy for disease control and mortality reduction in its own right, it is also a proven cost-effective intervention yielding broad benefits to both mothers and children. Completing a child's immunization series in a timely manner requires that the child-and, most often, the mother - be seen by a health-care provider (usually midwife) in Myanmar at least four or five times during the first year of life. This repeated contact with the health-care system provides opportunities for general health screening and provision of timely health information and advice.

The EPI is administered by central-level staff assigned to the programme and working through state/regional counterparts and TMOs and other public health staff at townships, RHCs and subrural health centres. Special Diseases Control Units (SDCUs) provide supervisory, monitoring and technical support to the Central EPI unit at state/regional level. Vaccination is delivered through a combination of approaches like fixed, outreach, mobile and crash. Expanded Programme on Immunization has adopted Global Vaccine Action Plan (2011-2020) (GVAP),

which is the framework approved by World Health Assembly in May 2012. The mission of GVAP is to improve health by extending by 2020 and beyond. All people achieve the full benefits of immunization regardless of where they are born, who they are, or where they live thereby accomplishing

the vision of Decade of Vaccine by delivering universal access to immunization.

Adopting the GVAP (2011-2020), the objectives of National Immunization Programme are:

(1) To achieve the country free of poliomyelitis
(2) To reach global and regional elimination targets for Vaccine Preventable Diseases
(3) To get vaccination coverage targets in every district and community
(4) To develop and introduce new vaccines and technologies
(5) To achieve and exceed the Millennium Development Goal 4 target for reducing child mortality

There are (5) principles which are guiding the elaboration of Global Vaccine Action Plan (2011-2020). They are country ownership, shared responsibility and partnership, equity, integration, sustainability and innovation. The costed multiyear plan of EPI, Comprehensive Multiyear Plan (cMYP 2012-2016) is being amended accordingly.

The cMYP is a continuation of the previous five-year plan 2007-2011, during which period Myanmar was able to reach high coverage of most antigens: DTP3 and HepB coverage reached around 90% in the country. There was significant improvement in programme management, injection safety, cold chain and vaccine management. The country was able to reduce outbreaks and incidence of VPDs and MNTE was validated.

Goals of the multi-year plan

The vision of the immunization programme during the next five years is to contribute towards achieving the MDG 4 goals by 2015 by reducing under-five morbidity and mortality caused by VPDs.

The overall objectives are to achieve the routine immunization coverage of 95% nationally with minimum 80% coverage in every township for all antigens by 2016 and to accelerate disease control.

The specific objectives as aligned to the GIVS strategic areas

- **Protecting more people in a changing world**

  To achieve the routine immunization coverage of 95% nationally with at least 80% coverage in every township for all antigens by 2016.

  To accelerate disease control activities: polio eradication, measles elimination and MNTE status maintenance.

- **Introducing new vaccines and technologies**

  To reduce burden of diseases for which sufficient disease burden data is now available in the country, efficacious and safe vaccines are available and which are economically beneficial to immunize such as of Hib and rotavirus.

- **Integrating immunization, other linked interventions and surveillance in the health system context**

  To increase coverage of other PHC interventions through improved linkages with immunization.

  To align national policies and programmes to the regional and global priorities and to ensure sustainability of the national immunization programme.

  To achieve the routine immunization coverage of 95% nationally with at least 80% coverage in every township for all antigens by 2016.

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- **Integrating immunization, other linked interventions and surveillance in the health system context**

  To increase coverage of other PHC interventions through improved linkages with immunization.

  To align national policies and programmes to the regional and global priorities and to ensure sustainability of the national immunization programme.

This cMYP and its consequent annual plans will help accelerate the rate of decline of childhood morbidity and mortality due to VPDs. The focus strategies to be used are:

- Strengthening routine immunization
- Rolling out reaching the unreached through REC strategy
- Accelerating measles elimination activities by systematic introduction of measles second dose
- Strengthening ongoing polio eradication activities
- Maintaining MNTE status and introducing Td vaccine through school-based immunization

programme

- Introduction of Hib vaccine in 2012
- Estimation of disease burden for other diseases for which vaccines are available
- Developing mechanisms for sustainable

Milestones in 20 12-2013

New vaccines introduction in Myanmar. In November 2012, Myanmar launched two new vaccines *Haemophilus Influenzae* type b (Hib) as Pentavalent vaccine (DPT, Hepatitis B and Hib) and second dose o f Measles vaccines into National Immunization schedule. An official launch of introduction of these new vaccines was held at Nay Pyi Taw on 6thNovember 2012. Union Minister for Health H.E. Professor PeThet Khin inaugurated the launching ceremony. Union Minister for Health expressed that "In 5 years co-financing plan with. GAVI, Government spends 5.35 millions of US Dollars for introduction of Hib containing Pentavalent vaccine.At this historic launching ceremony, National Health Committee, a high level delegation of GAVI and parliamentarians from Australia and New Zealand, Non-governmental Organization such as Myanmar Maternal and Child Welfare Association (MMCWA) and Myanmar Women Affairs Federation (MWAF) and International Non-governmental Organization were also present to be grateful for the Government of Myanmar which has co-financed Pentavalent vaccine. *Haemophilus Influenzae* type b (Hib) is the leading cause of childhood bacterial meningitis, pneumonia and other serious infections among children in Myanmar

Intensification of Routine Immunization (IRI) in Myanmar (2012) In Myanmar, out of 330 townships, there were altogether 36 townships in 2009, 42 townships in 2010 and 78 townships in 2011 which had achieved DPT3 coverage less than 80%. Therefore, it indicated that the immunization coverage gap for DPT3 has been increased year after year.

Revised National Policy and Strategy on Routine Immunization and Vaccine Preventable Diseases (2012) In August 2012, a National Workshop on "Review and Revision of National Policy and Strategy on Routine Immunization and Vaccine Preventable Diseases" had been conducted in order to review the existing policy and strategy of EPI and to revise it according to revolution of the programme including new vaccine introduction and transformation of Government administration and policy. The recommendations from the workshop approved by Ministry of Health had been disseminated as **"***Revised National Policy and Strategy on Routine Immunization and Vaccine Preventable Diseases (2012)"*on 18th October 2012. The areas of revised policy are (1) Immunization service delivery policy, (2) Vaccine policy, (3) Cold chain logistics policy and (4) Programme related policy where the strategies are revised accordingly.

National Committee for Immunization Practices (NCIP) The NCIP of Myanmar was established in 2007. Currently it has 25 members and is chaired by the Director General of Department of Health. These members provide diverse representation to include Epidemiologists/ Public Health experts, professionals from Child Health, experts from the Food and Drug Administration, the National Health

Laboratory, Department of Medical Research and Myanmar Pediatric Society and the EPI team. In July 2012, a set of terms of reference were identified to reflect Myanmar's NCIP current needs together with next steps to develop NCIP charter which included the reform of NCIP. The NCIP recognized the value of being an advisory body in making independent recommendations to the Government, Ministry of Health. The composition of NCIP has been arranged in 2013 with the development of NCIP charter.

Cold Chain Logistics Strategic Planning Cold chain is regarded as the vital part of the EPI. To strengthen the system concerning cold chain logistics, EPI had conducted a series of assessment and studies in 2011 and 2012. The findings and recommendations were disseminated in Cold Chain Logstics Strategic Planning Workshop, made on 8 areas of Strategic Objectives, the cold chain logistics system of EPI is planned to be established as an international standardized system.

Supplementary Immunization Activities (SIA)

- **Mopping up Polio Immunization in Northern Shan State**

After a comprehensive risk assessment and analysis of the immunity profile in Northern Shan State where there are some special regions which are self-administrative area since 1989, house to house immunization (Mopping up immunization) had been conducted in the entire health centers, vaccinating all children 0-5 years. Altogether (281,026) children were vaccinated against polio by two rounds of Mopping up in October and November 2012.

- **Polio Catch up Campaign in Rakhine**

A Polio catch-up campaign was planned to be conducted in (12) Townships in Rakhine State with the following background and rationale:

(1) Rakhine State has the history of wild polio virus importation and transmission in 2006-2007.
(2) Populous Townships in Northern border have weak population immunity.
(3) Myanmar has set the target to eradicate Polio in February 2014 along with South East Asia Regional countries.
(4) Immunity gap becomes wider in (12) Townships in Rakhine State after Riots.

Reaching Hard to Reach Population In 2012, the areas previously uncovered by routine immunization services and the areas where there was unstable population due to displacement and conflicts, were paid attention by Central EPI. After intensive advocacy to the local authority, the self-administrative areas in Eastern Shan State had been visited by Central EPI and State Health Department to cover routine immunization services with all antigens in (3) consecutive months. The temporary camps for Internally Displaced Person in Kachin State were covered by Measles catch-up immunization which was followed by monthly routine immunization services with all antigens.

Newly developed IEC materials in new era of EPI Starting from November 2012, that has been the time of new vaccine introduction, all IEC materials, immunization cards, forms and formats using in EPI have been changed into new ones.

Conclusion

To ensure sustainability of the programme, the government means to focus its attention on creating/strengthening mechanisms for sustainable financing and vaccine supplies. Mobilizing of the fund for the country programme in the next multiyear plan period will be made through traditional and new partners. All efforts will be made to leverage GAVI resources to facilitate introduction of new and underused vaccines like measles second dose, Hib, pneumococcal and rotavirus in the country programme. These activities will focus on mobilizing resources to close the identified gap. As Myanmar has manufacturing capacities for TT and HepB vaccines there will be a need to start a "vaccine sufficiency initiative" so that over a period of time the country can try to become self-reliant in a few traditional vaccines, so that the resources saved could be used to support or co-finance other high-value vaccines.

Sustaining Achievement

Leprosy

Leprosy has been endemic in the country for many centuries. The earliest scientific record of leprosy in Myanmar was provided in the report of Leprosy Commission in India 1890-1891. At that time Myanmar was a province of Indian Empire under the British rule. In 1891, the total reported prevalence was 8.6 per 10 000 population for the whole country and 14.4 per 10 000 in Central Myanmar. 1932 census report shows 11 127 leprosy cases in the country, which was recorded by unprofessional enumerators, the prevalence being 0.76 per 1 000. In 1935 Dr Santra reported prevalence of 25 per 1 00 in Mandalay area. Dr Dharmendra, WHO Consultant reported in 1951 an estimate of 5 per 1 000 (about 100 000 cases) in the country. Dr Lamp, WHO Consultant to Myanmar from 19953 to 1955 estimated 10 per 1000 (about 200 000 cases) in the county.

WHO Leprosy Advisory Team in 1963-64 estimated an average of 25 per 1 000 (about 590 000 cases) where in some areas in Central Myanmar the prevalence can be as high as 40 per 1 000. At the time of their survey, the prevalence of leprosy in Shwebo district was 32.16 per 1 000 and in Myingyan district the prevalence was 44.34 per 1 000. The National Leprosy Programme Prevalence and Assessment

Survey report estimated the prevalence of 24.24 per 1 000 population in the country. In consultation with the WHO the Government launched an intensive programme for leprosy control under Plan No. 9 of the Health Department Plan since 1952. As per recommendation of Dr Dharmendhra during the Plan covering the period 1952-1957, the Government established treatment centres in 27 districts attached to the Civil Hospitals. The Dapsone was used for mass treatment. In 1957-1962, an expansion pilot project was introduced in 2 district in central Myanmar (Shwebo and Myingyan) and one district in Shan (Taungyi district). With experience gained, it was then extended in later years to the neighboring districts till 1961. Then from plan period 1963 – 1969, the expansion

programme covered the whole country with the consideration of the gravity of leprosy programme in the country. The reatment target then was for 200 000 cases. The programme was well carried out according to the 5-Year Plan and case finding and treatment activities were effectively throughout the country.

Partial integration with People's Health Plan started in 1977. In 1988, WHO recommended MDT service was started in six hyper-endemic regions (Yangon, Mandalay, Upper Sagaing, Magway. Ayeyawady and Bago) and it was fully integrated into Basic Health Services in 1991. MDT services covered the whole country in 1995. Myanmar has achieved Leprosy Elimination Goal at the end of January 2003. It means that the registered prevalence rate per 10,000 population was less than one. It also means that leprosy was eliminated as a public health problem.

Before introduction of MDT services, registered prevalence rate was 54.3/10,000 in 1987. Prevalence rate was obviously reduced at the end of 2012 (0.43/10,000). Total registered cases at the end of 1987 were 204282 and it reduced significantly to 2680 at the end of 2012. A total of 286,718 leprosy cases have been treated with MDT and cured since 1988.

After achieving elimination of leprosy, leprosy control activities have being sustained to reduce the burden due to leprosy. In 2010, National strategies for leprosy control were developed based on "Enhanced Global Strategy for Reducing the Disease Burden due to Leprosy (2011- 2015) and National Guidelines (2011-2015) was also developed based on WHO Operational Guidelines (Updated).

Case finding activities and treatment with MDT are being carried out by Basic Health Staff with technical support of leprosy control staff. In 2012, dissemination of knowledge on leprosy is carried out through various medias with emphasis on early signs and symptoms, curability, availability of free-of-charge MDT drugs and prevention of disability by early diagnosis and treatment. Training on Leprosy Control for Newly Promoted Leprosy Inspectors was conducted in Nay Pyi Taw. Capacity buildings of Township Focal Persons for Leprosy Control were conducted in Kayin, Kayah, Shan (south) states and Tanintharyi region. Leprosy awareness campaign activities participated by leprosy affected persons were conducted in five selected townships (Pyinmana, Wetlet, Nyaungdone, Minhla (Bago Region) and Moenyo) where case detection was high within 5 years.

Since achieving the leprosy elimination goal, the programme emphasized more on prevention of disability and rehabilitation. At the end of the year 2012, prevention of disability activities (POD) are being carried out in 137 townships with regular follow up case assessment, self-care training and provision of necessary drugs, aids and services. Out of 184 previously hyper-endemic townships, POD project are being implemented in 130 townships. The area coverage in these areas was 70.65 percent. Leprosy Control Programme has planned to expand POD activities in the remaining townships. In 2012, training on Prevention of Disability due to leprosy were conducted in 10 townships in Yangon urban area and 10 town ships in low disease burden areas (Tanintharyi , Sagaing (upper) Regions, Kachin , Kayin ,Kayah , Chin and Shan States). The recent years indicators stand as:

Indicators	2010	2011	2012
Registered cases	2558	2542	2680
Prevalence rate/ 10,000 population	0.42	0.41	0.43
New cases detected and treated	2947	3043	3013
Cases release from treatment (during the year)	3155	2638	3006
Cases of released from treatment (cumulative)	280,556	283,194	286,718

Since 1999, all the case detection rates by different methods were declining. The case detection rate by contact survey was much higher (6-15 times) than other case detection methods. But the number of new case detected by these ACD methods were less than 20% of total new cases detected. Even case detection rates by Mass Survey were less than NDCR of total new cases. At the end of 2003, a total of 2742 leprosy cases were registered for MDT treatment and so registered prevalence was 0.51 per 1000 population.

Conclusion

The National Control Programme is well organized and integrated in the Basic Health Services, in an efficient and effective way. As a result, leprosy control services are delivered close to the community and the patients. The strengths of the program include the strong commitment of the Government, the consistent set of rules and instructions for all levels of health personnel, the vast reservoir of excellent staff, the enthusiasm and hard working in all levels, and integration at implementation level with the support of leprosy technical staff. Cooperation with the partners is the cornerstone of the success of the leprosy elimination program. Collaboration and mutual support among the partners to develop one fully comprehensive and consistent Leprosy Control Program will be advantageous.

Trachoma Control and Prevention of Blindness

Trachoma Control and Prevention of Blindness project was launched in 1964. At that time trachoma was one of the major cause of blindness in Myanmar. With the concerted effort of the program and support of Government, WHO, UNICEF and INGOs, active trachoma rate was reduced from 43% in1964 to to under 1% in 2000. As trachoma blindness is greatly reduced, cataract becomes main cause of blindness in the country.

Blindness rate in all ages is 0.52 % and main causes of blindness are -

- Cataract 61 %
- Glaucoma 19 %

• Posterior segment diseases	8	%
• Trachoma	1.9	%
• Corneal opacity	1.3	%
• Trauma	2	%
• Others	6.8	%

Myanmar Prevention of Blindness project is trying the best to fight against avoidable blindness in line with the strategy laid down by WHO "Vision 2020, The Right to Sight : Elimination of avoidable blindness by the year 2020." There are 20 secondary eye centers in Prevention of Blindness program at Mandalay, Magway, Sagging (lower part), Bago (east) and Ayarwaddy regions headed by ophthalmologists. The program is covering 20.85 million people in 81 townships of those regions and promoting to increase the Cataract Surgical Rate in Myanmar.

National objective

- To reduce the blindness rate of all ages to less than 0.5%.
- Improving cataract surgical rate and quality of surgery.
- Making Primary Eye Care available to all BHS and to eliminate avoidable blindness.
- Promoting community participation in prevention of blindness.
- Provision of cataract surgical services at affordable price and free services to poor patients.
- Provision of outreach eye care services down to grass root level.

In the year 2012, there were 21 mass outreach cataract surgeries in Township and rural areas with the partnership activities of many stakeholders, local NGOs, INGOs, and local donors

Major expected results are reduction of blindness rate less than 0.5 % and to control the prevalence rate of active trachoma (under 10 year of age) is less than 5 %. Finally the activities will support to achieve the goal of Vision 2020: The Right to sight, to eliminate the avoidable blindness by the year 2020.

Conclusion

It is calculated that the trachoma control activities carried out in Myanmar for 40 years have prevented 300 000 cases of severe visual impairment and blindness and saved a total of almost 3 million Handicap Adjusted Life Years (HALYs). The extraordinary decline in the incidence of trachomatous visual impairment and the dramatic deceases in the prevalence of trachoma infection and potentially disabling lesions, appear to have been accompanied by a decline in incidence of blindness and low vision. It is obvious that 100% of the achievements is attributable to Trachoma Control Progrmme, supported by multisectoral contributions and the whole hearted participation of the people.

National Policy on Non-Communicable Diseases

Introduction

The national policy, which is still in drafting stage, sets out the broad path that Myanmar would pursue in its efforts to prevent and control the non-communicable diseases (NCDs). It draws inspiration from various policy and strategy papers in the country. NCDs have been defined as diseases or conditions that occur in, or are known to affect, individuals over an extensive period of time and for which there are no known causative agents that are transmitted from one effected individual or another. The World Health Organization (WHO) defines the scope of NCDs include cardiovascular diseases, mainly heart disease and stroke; cancers; chronic respiratory diseases; diabetes; others, such as mental disorders, vision and hearing impairment, oral diseases, bone and joint disorders, and genetic disorders.

In September 2011 the UN General Assembly convened a high level meeting to focus on NCDs. The *Political Declaration* from this meeting highlights a set of actions for countries to scale up their actions to address the burden of non-communicable diseases (NCDs) affecting their populations. NCDs have potentially serious socioeconomic consequences, through increasing individual and household impoverishment and hindering social and economic development. The NCD epidemic exacts a massive socioeconomic toll throughout the world. It is rising rapidly in lower-income countries and among the poor in middle- and high-income countries

As Myanmar moves on the path of socioeconomic development and changing lifestyle, there is a shift in epidemiological transition towards NCDs. Myanmar is now facing double burden of diseases – Communicable Diseases and Non-Communicable Diseases. As such in the National Health Plan (2011-2016), priorities actions has been developed with the aim to prevent, control and reduce disease, disability and premature deaths from chronic non-communicable diseases and conditions. A large percentage of NCDs are preventable through the reduction of their four main behavioral risk factors: tobacco use, physical inactivity, harmful use of alcohol and unhealthy diet.

According to the WHO SEAR statistic in 2002, NCD accounted for 54% of death, whereas the communicable diseases (in combination with perinatal and maternal conditions and nutritional deficiencies) caused 44% of death. The rest (2%) of the death were due to other chronic diseases including death due to accident and injuries.

C*ardiovascular diseases, mainly heart disease and stroke, Cancers, Diabetes and Chronic respiratory diseases* are common in Myanmar. Studies of risk factors for non-communicable diseases were undertaken according to the WHO STEP survey methodology, at regional level (Yangon Division, 2003-2004) and also at National level (2009). Mortality rate for non-communicable diseases was found to be higher than infectious, maternal, peri-natal and nutritional disorders (3.6 per 1000 person-years vs 2.4 per 1000 person-years). Among non-communicable diseases, mortality rate for cerebro-vascular disease was found to be highest (0.76 per 1000 person-years), followed by liver diseases (0.44 per 1000 person-years) and Chronic Obstructive Pulmonary Diseases (0.34 per 1000

person years).Findings indicated that it is necessary to strengthen and scale up the health intervention programs for non-communicable diseases in the community.

NCDs not only determine the high mortality rates in Myanmar but are the main causes of premature disability and general disability. Comprehensive organization of NCD control will enable not only to stop deterioration of health outcomes, but will improve them in subsequent years.

Tobacco use: The overall percentage of current smokers was (22.0%), the percentage for males being 44.8% and that for females, 7.8%. Nearly 76% of the current smokers were daily smokers. The average age when tobacco users started smoking was 20.8 years and the mean duration of smoking years among daily smokers was 23.3 years. Only 21.5% of daily smokers used manufactured cigarettes.

Alcohol consumption: The percentage of current drinkers was 12.9%, the figure for male respondents being 31.2% and that for females, 1.5%. About 35% of the male respondents and 94% of the female respondents were life-time abstainers. Among drinkers, 15.7% consumed alcohol on a daily basis (17.0% males and 4.6% females), and 35.9% drank alcohol less than once a month (32.1% males and 70.1% females). Among the female daily drinkers, drinking was exceptionally high among the age group of 55–64 years compared to other age groups.

Fruit and vegetable consumption: In general, the consumption of fruit and vegetables was low. Every age group, regardless of sex, had fruit four days a week. The average number of days that fruit was consumed by the female respondents was slightly higher than the average for their male counterparts. The average number of days per week that vegetables were consumed by the male respondents was 5.7. The corresponding figure for women was 5.7 days per week.

Physical activity: Around 10% of males performed a low level of physical activity, while the level was moderate among 27% and high among 63%. As for women, the level of physical activity was low among 14%, moderate among 33% and high among 53.3%. The mean duration of total physical activity on an average per day was 182 minutes (males 211 and females 164). On an average, work-related activity comprised a little more than half of the total physical activity among male respondents, while transport activity formed 31.0% and recreation-related activity comprised 7.9%. For women, work-related activity comprised nearly 60% of physical activity and transport- related activity comprised about 32%.

Blood pressure: The overall percentage of respondents with hypertension, diagnosed within one year, was 10.9%, while 9.3% had been diagnosed more than one year ago. In all, 33.6% of the respondents had never had their blood pressure measured. Among those with diagnosed hypertension, only 43.1% were taking blood pressure drugs prescribed by a doctor or health worker (males 37.4% and females 45.4%).

Diabetes history: Most of the respondents—85.6% of the males and 83.5% of the females—had never had their blood sugar level measured by a doctor or other health worker. Among those respondents diagnosed with diabetes, 10.9% of men and 7.6% of women were taking insulin, while 63.2% of men and 72.6% of women were on oral anti-diabetic drugs prescribed by a doctor or health

worker.

Physical measurement: The mean body mass index (BMI) of the male respondents was 21.9 and of the female respondents, 23.1. On an average, 13.5% of the males had a BMI of 25–29 and 4.3% were obese, with a BMI of more than 30. In the case of females, 22.0% had a BMI of 25–29 and 8.4% were obese, with a BMI of more than 30. The percentage of respondents classified as overweight (BMI>25), excluding pregnant women, was 25.4%.

STEP Survey in Yangon Division(Urban 10 townships and Rural 5 townships) (2003-2004). Total participants=4448; male 1994(44.83%), female 2454(55.17%)Age range25-74 years. Step 1 (Socio demographic and behavioral information), Step 2 (Physical measurements) and Step 3 (Laboratory measurements including OGTT and Fasting Lipid Profiles) were studied. Overall response rate was 80.16%.

National STEP Survey (2009) Total participants=7429; Age range 15-64 years**,** Step 1 (Socio demographic and behavioral information), and Step 2 (Physical measurements) were. Overall response rate was 99.72%. Both of the STEP surveys revealed that risk factors for non-communicable diseases are common in Myanmar and it can be inferred that due to its high exposure to the risk factors it is also likely to have high prevalence of non-communicable diseases among Myanmar, in both rural and urban setting, all across the social strata.

In Myanmar, as the health information system is not comprehensive and efficient, data for death from these chronic diseases for the whole country are not available. In the absence of efficient vital registration system for collecting cause of death information from the community by routine data collection, use of verbal autopsy for determining cause of death patterns is one of the possible methods for filling the information gaps in mortality statistics for health intervention. Verbal autopsy for determining mortality patterns in Pyinmana Township was carried out in 2008-2009.

Findings revealed that during 483,755 person-years of follow up, it was recorded 3,272 deaths, given overall mortality rate of 6.8 per 1000 person-years. Mortality rate for non-communicable diseases was found to be higher than infectious, maternal, perinatal and nutritional disorders (3.6 per 1000 person-years Vs 2.4 per 1000 person-years). Among non-communicable diseases, mortality rate for cerebrovascular diseases was found to be highest (0.76 per 1000 person-years), followed by liver diseases (0.44 per 1000 person-years) and Chronic Obstructive Pulmonary Diseases (0.34 per 1000 person years). Findings indicated that it is necessary to strengthen and scale up the health intervention programs for non-communicable diseases in the community.

Myanmar is included among the 23 high-burden countries that account for around 80% of the total burden of chronic disease mortality in developing countries. In these 23 selected low-income and middle-income countries, chronic diseases were responsible for 50% of the total disease burden in 2005. If nothing is done to reduce the risk of chronic diseases, an estimated US$84 billion of economic production will be lost from heart disease, stroke, and diabetes alone in these 23 countries between 2006 and 2015. Achievement of a global goal for chronic disease prevention and control—an additional 2% yearly reduction in chronic disease death rates over the next 10 years—would avert 24

million deaths in these countries, and would save an estimated $8 billion, which is almost 10% of the projected loss in national income over the next 10 years.

Today Myanmar faces a number of unsolved problems: the role of Public Health should be more clearly defined in NCDs control. At primary health care level, the issues of prevention, early diagnostic and treatment of NCDs require further development, as well as the issues of availability of essential diagnostic and treatment technologies for major NCDs. Introduction of new management approaches will optimize the system of referrals of NCD cases to secondary and tertiary health care levels.

Myanmar Response to NCD Burden

In National Health Plan (2011-2016), priorities actions has been developed with the aim to prevent, control and reduce disease, disability and premature deaths from chronic non-communicable diseases and conditions.

- Chronic non-communicable diseases/conditions with shared modifiable risk factors-tobacco use, unhealthy diet, physical inactivity, harmful use of alcohol
    - Cardiovascular disease
    - Diabetes Mellitus
    - Cancer
    - Chronic respiratory disorders
- Non-communicable diseases/conditions of public health importance
    - Accidents and injuries
    - Disabling conditions (Blindness, Deafness, Community based rehabilitation)
    - Mental Health
    - Substance abuse
    - Snake bite

The Program of prevention and control of NCDs in the country for 2013-2020 is based on WHO recommendations on the need for concerted and coordinated actions, improved integration into NCD control at the national level, based on the Political Declaration of the UN High-level Meeting on NCDs and the new policy of WHO/EURO "Health 2020". The main directions of this program implementation are aligned with the activities, envisaged in the National Health Sector Reform Program for 2013-2020.

The priority actions were as follows:

- Developing comprehensive national policy and plan for the prevention and control of major NCDs
- Establishing high level national multi-sectoral mechanisms for planning, guiding and monitoring
- Implementing cost-effectiveness approaches for the early detection of major NCDs

- Strengthen capacity of HRH for better case management and to help people to manage their own conditions better.

National STEPS Survey (2009) reported that the prevalence of currently smoke was 33.6% in males and 6.1% in females, the prevalence of hypertension was 31% in males and 29.3% in females, and prevalence of overweight (BMI ≥ 25 kg/m^2) was 21.85% in males and 23.07% in females and obesity (BMI ≥ 30 kg/m^2) was 4.3% in males and 8.4% in females among the sample population.

Surveillance System

- STEP Surveys (2003-2004 Yangon Region, 2009-2010 National)
- Global Youth Tobacco Survey (GYTS) 2001, 2004, 2007
- Global School Personnel Survey (GSPS) 2001, 2007
- Global Health Professional Students Survey (GHPSS) 2006, 2009
- Myanmar Surveillance System for NCD still need to be established

National Response to the NCD epidemic

- Multisectoral Meeting to Finalize National Policy on NCDs
- Workshop for Package of Essential NCDs (PEN) intervention for Primary Health Care
- Regional Meeting on NCDs including Mental Health and Neurological Disorders
- Country Level Multisectoral Meeting on NCDs
- National Strategic Plan on DPAS (Draft)
- National Policy on Tobacco Control
- Control of Smoking and Consumption of Tobacco Product Law (2006)
- Specific Programme on Prevention and Control of NCDs in National Health Plan (2011-2016)

Of the two strategic pathways that are employed for prevention and control of NCDs, the "population approach" rather than the "high risk approach", has been advocated. This particular approach aims at reducing the risk factor levels in the population as a whole through community action, in order to achieve mass benefit across a wide range of risks and cumulative societal benefits.

Policy Framework

Policy Statement: *Prevention, control and management of Non-Communicable Diseases and Conditions will be made accessible, using life course approach, for all population with participation in partnership with various stakeholders and integrated into the social, economic and environmental systems to establish a robust platform for effective reduction of these diseases and conditions.*

The policy draws inspiration from the National Health Policy 1993 and Myanmar Health Vision 2030. It also follows the directions of the National Food Law 1997, and the Control of Smoking and

Consumption of Tobacco Product Law, 2006. Both the National Health Policy and Myanmar Health Vision, primary focus is to raise the level of health of the country and promote the physical and mental wellbeing of the people with objective of achieving Health For All goal using PHC approach and to intensify and promote physical fitness through active community participation.

The National Food Law enacted to enable public to consume food of genuine quality, free from danger, to prevent public from consuming food that may cause danger or are injurious to health, to supervise production of controlled food systematically and to control and regulate the production, import, export, storage, distribution and sale of food systematically. The law also describes formation of Board of Authority and its functions and duties.

The Control of Smoking and Consumption of Tobacco Product Law enacted to convince the public that smoking and consumption of tobacco product can adversely affect health, to make them refrain from the use , to protect the public by creating tobacco smoke free environment, to make the public, including children and youth, lead a healthy life style by preventing them from smoking and consuming tobacco product to raise the health status of the people through control of smoking and consumption of tobacco product and to implement measures in conformity with the international convention ratified to control smoking and consumption of tobacco product.

Vision, Mission, Goals and Objectives

Vision A nation free of the avoidable burden of non-communicable diseases.

Mission Create a conducive socio-economic environment, promote healthylifestyle and provide quality care to all with NCDs.

Goal To reduce the preventable and avoidable burden of morbidity, mortality and disability due to non-communicable diseases by means of multisectoral collaboration and cooperation at national, regional and global levels, so that populations reach the highest attainable standards of health, quality of life, and productivity at every age and those diseases are no longer a barrier to well-being or socioeconomic development.

Objectives

i. To raise the priority accorded to the prevention and control of non-communicable diseases in Myanmar development goals, through strengthened international cooperation and advocacy.

ii. To strengthen national capacity, leadership, governance, multisectoral action and partnerships.

iii. To reduce modifiable risk factors for non-communicable diseases and underlying social determinants through creation of health-promoting environments.

iv. To strengthen and orient health systems to address the prevention and control of non-communicable diseases and the underlying social determinants through people-centered primary health care and universal health coverage.

v. To promote and support national capacity for high quality research and development for

the prevention and control of non-communicable diseases

vi. To monitor the trends and determinants of non-communicable diseases and evaluate progress in their prevention and control.

Overarching Principles and Approaches

- **Human rights approach:** It should be recognized that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being, without distinction of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, as enshrined in the Universal Declaration of Human Rights.
- **Equity-based approach:** It should be recognized that the unequal burden of non-communicable diseases is influenced by the social determinants of health and that action on these determinants, both for vulnerable groups and the entire population is essential to reduce the overall burden of non-communicable diseases and create inclusive, equitable, economically productive and healthy societies.
- **National action, international cooperation & solidarity:** The primary role and responsibility of governments in responding to the challenge of non-communicable diseases should be recognized together with the important role of international cooperation in assisting member states as a complement to national efforts.
- **Multisectoral action:** It should be recognized that effective non-communicable disease prevention and control require leadership, coordinated multi stakeholder engagement and multisectoral action for health both at government level and at the level of a wide range of actors with such engagement and action including as appropriate health in all policies and whole of government approaches across sectors such as heath, agriculture, communication, education, employment, energy, environment, finance, food, foreign affairs, housing, justice and security, legislature, social welfare, social and economic development, sorts ,tax and revenue, trade and industry, transport, urban planning and youth affairs and partnership with relevant civil society and private sector entities.
- **Life-course approach:** Opportunities to prevent and control non-communicable diseases occur at multiple stage of life: interventions in early life often offer the best chance for primary prevention. Policies, plans and services for the prevention and control of non-communicable disease need to take count of health and social needs at all stages of the life-course starting with maternal health, including preconception, antenatal and postnatal care, maternal nutrition and reducing environmental exposures to risk factors and continuing through proper infant feeding practices including promotion of breastfeeding and health promotion for children, adolescent and youth followed by promotion of a healthy working life, healthy ageing and care for people with non-communicable diseases in later life.
- **Empowerment of people & communities**: People and communities should be empowered and involved in activities for the prevention and control of non-communicable diseases, including advocacy, policy, planning, legislation, service provision, education and training,

monitoring, research and evaluation

- **Evidence-based strategies:** Strategies and practices for the prevention and control of non-communicable diseases need to be based on scientific evidence and/or best practice, cost-effectiveness, affordability and public health principles, taking cultural considerations into account.
- **Universal health coverage:** All people should have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative and rehabilitative and palliative basic health services and essential, safe, affordable, effective and quality medicines and diagnostics. At the same time it must be ensured that the use of these services does not expose the users to financial hardship, with a special emphasis on the poor and populations living in vulnerable situations.
- **Management of real, perceived or potential conflicts of interest:** Multiple actors, both State and non-State actors including civil society, academia, industry, nongovernmental and professional organizations, need to be engaged for non-communicable diseases to be tackled effectively. Public health policies for the prevention and control of non-communicable diseases must be protected from undue influence by any form of vested interest. Real, perceived or potential conflicts of interest must be acknowledged and managed.
- **Balance between population-based and individual approaches:** A comprehensive prevention and control strategy needs to balance an approach aimed at reducing risk factor levels in the population as a whole with one directed at high-risk individuals.
- **Health system strengthening:** Revitalization and reorientation of health care services are required for health promotion, disease prevention, early detection and integrated care, particularly at the primary care level.

Strategic Action Areas

The strategic action areas are identified as follows:

- Advocacy, partnership and leadership
- Health Promotion and Risk Reduction

  Reduce tobacco use

  Reduce harmful use of alcohol

  Promote healthy diet high in fruits and vegetables and low in saturated fats/trans fats, free sugars and salt

  Promote physical activity

  Promote healthy behaviours and reduce NCDs in key settings

  Reduce household air pollution
- Health System Strengthening for early detection and management of NCDs and their risk factors

  Access to health services

Health workforce

Community-based approaches

- Surveillance, monitoring and evaluation

  Strengthening Surveillance

  Improve monitoring and evaluation

  Strengthening Research

Targets

To achieve the objectives, the followings are the planned targets:

- A **25%** relative reduction in risk of premature mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases.
- At least **10%** relative reduction in the harmful use of alcohol, as appropriate, within the national context.
- A **10%** relative reduction in prevalence of insufficient physical activity.
- A **30%** relative reduction in mean population intake of salt/sodium.
- A **30%** relative reduction in prevalence of current tobacco use in persons aged 15+ years.
- A**25%** relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure, according to national circumstances
- **Halt the rise** in diabetes and obesity.
- At least **50%** of eligible people receive drug therapy and counseling (including glycaemic control) to prevent heart attacks and strokes.
- An **80%** availability of the affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases in both public and private facilities.

Strategic Intervention Plan

The strategic Intervention plan is laid out as follows:

- Surveillance on NCDs and their risk factors
- Develop partnerships among the stakeholders concern with the prevention and control of NCDs so as to achieve the multisectoral response and coordination
- Formulate legislation and regulation for the prevention of NCDs
- Formulate healthy risk behaviours to facilitate risk reduction
- Build physical and socio-economic environment, which is conducive to the adoption of healthy behaviours
- Establish health financing and resource mobilization
- Strengthen health system for screening and cause effective care for major NCDs in their risk factors
- Monitor and evaluate NCDs prevention and control
-

Conclusion

The burden of Non-Communicable Diseases in Myanmar is in the rising trend. The weight of current scientific evidence demonstrates that a significant proportion of NCD and premature deaths from NCD can be averted through prevention, lifestyle modification and the judicious control of a few common risk factors that underlie the major categories of chronic disease.

The national NCD strategic plan and its intervention strategies presents a way to operationalize existing knowledge in reducing the burden of Non-Communicable Diseases in Myanmar, while taking into account the national, social, cultural and economic context of the country. It integrates the various frameworks, strategies and action plans addressing specific risk factors and particular diseases into a holistic and definitive approach to NCD prevention and control. The Ministry of Health will continue to enhance smart partnerships with other relevant sectors and other stakeholders to further reinforce NCDs prevention and control programme and activities in Myanmar.

A five year national strategic plan will be developed along with the national NCD policy. The strategic plan will set out strategies for the prevention, management and control of NCDs with defined targets and outputs. Annual operational plans based on the strategic plan will be developed to reflect national priority actions. The NCD programme will be monitored at all levels through routine administrative reports, surveillance reports and special studies.

Tobacco Control Measures

In Myanmar literature, smoking of cheroots and chewing of betel quid with tobacco are quoted frequently in poems, songs or novels. It is usually quoted as some form of gift between lovers and friends. One popular poem of ancient days cited the names of towns where the best ingredients of betel quid can be found. History books quoted that tobacco was brought to Myanmar during the *King Thalon Mintaya* Era (AD 1131). It was quoted that in the *Myanmar Kyawzar* year AD 1766, Myanmar soldiers that went to battle with the neighbouring countries took the example of the Thai people and smoked tobacco wrapped with corn tusk, betel leaf or banana leaf. Cigarettes were introduced to Myanmar after World War II and cigarette factories were established in Myanmar after 1948, the year Myanmar gained independence from the British rule. However the most common form of tobacco smoked are *cheroots,* which are thin and long and usually wrapped with a specific leaf called 'thenetphet'; other smoking forms include hand-rolled cheroots, cigarettes, cigars, pipes and watery tobacco in some parts of Myanmar.

Since the early 1950s, scientific evidence has been accumulating to the point where more than 25 diseases are known or strongly suspected to be related to smoking. Each year, it has been estimated that tobacco is responsible for more than 4 million deaths and the numbers are increasing. If the current trends are not reversed, it has been estimated that the death tolls will reach to 8 million a year by 2020 and 10 million a year by 2030, with 70% of these deaths occurring in developing countries. Apart from the vast burden of health consequences, the cost of tobacco encompasses large economic and social costs as well.

Recognizing the enormous premature mortality caused by tobacco use and adverse effects of tobacco on social, economic and environmental aspects, the Member States of the World Health Organization unanimously adopted the WHO Framework Convention on Tobacco Control (WHO FCTC) at the Fifty-Sixth World Health Assembly in May 2003. Myanmar had signed the WHO FCTC in October, 2003 and ratified in April, 2004. Myanmar is the 11th member country of the WHO FCTC.

Being the member country of the WHO FCTC, Myanmar has the responsibility to implement according to its' provisions. With the objectives of protecting and reducing the dangers of tobacco among the community and based on the provisions of the WHO FCTC, "The Control of Smoking and Consumption of Tobacco Product Law" was enacted in May, 2006 and it came into effect in May, 2007.

For effective implementation of the WHO FCTC by the member States, WHO recommended the six MPOWER policies in the "WHO Report on the Global Tobacco Epidemic, 2008".The Myanmar Tobacco Control Programme has also been implementing its activities in line with those six policies, namely:

- Monitor tobacco use and prevention policies (M)
- Protect people from tobacco smoke (P)
- Offer help to quit tobacco (O)
- Warn about the dangers of tobacco (W)
- Enforce bans on tobacco advertising, promotion and sponsorship (E)
- Raise taxes on tobacco (R)

Myanmar has been participating in the Global Tobacco Surveillance System since 2001. The prevalence of tobacco use has been monitored through sentinel prevalence surveys, Global Youth Tobacco Surveys (GYTS), Global School Personnel Surveys (GSPS) and Global Health Profession Students Surveys (GHPSS) periodically. Comparing the surveys done in 2001, 2007 and 2011, the smoking prevalence became increased among school boys and adult males in 2011 than 2007, and the smokeless tobacco use was also continuously increased among them. Myanmar men were found alarmingly as the most smokeless tobacco users among the countries of South East Asia Region.

Compliance and enforcement on prevention policies are also monitored through collection of data and reporting instruments such as "WHO Report on the Global Tobacco Epidemic". In order to protect the community from exposure to second-hand smoke, the Law designated the non-smoking areas including public places, public transport, health facilities and educational institutions. In 2011, the President also made the direction that all governmental office buildings and compounds must be tobacco free.

For preventing the community especially the children and the youths from testing and starting the habit of smoking, which is one of the important unhealthy life style, the Law prohibits: sale of tobacco to and by minors, sale of tobacco products within the school compound and within 100 feet from the compound of the school, sale of cigarettes in loose forms and sale by vending

machine. It also bans all forms of tobacco advertisements and requires mentioning the health warnings in local language on tobacco products.

For publishing the 'WHO Report on the Global Tobacco Epidemic, 2013' WHO has done the assessment in all member countries in 2012. According to the experts' views, there was only medium to low compliance in Myanmar regarding the smoke-free law and banning on tobacco advertising, promotion and sponsorship. According to the provision of the National law, the Government has formed the 'Central Tobacco Control Committee' in January, 2011. It is chaired by the Union Minister for Health and includes the Deputy Minister and Head of the Departments from Ministry of Health and related Ministries as the members. The first meeting of the Central Tobacco Control Committee was held in June, 2012 and made the guidance to establish the working committee for developing the necessary bi-laws and pictorial health warnings. So, the relevant photos were collected from Medical Universities, Yangon General Hospital and also from WHO resource centre, and it is underway for testing and assessing the effectiveness of the selected pictures.

With the purpose of advocating and raising awareness of all stakeholders including the community regarding the tobacco-related health problems and control measures, Myanmar has been celebrating the World No-Tobacco Day, both at Central and State and Regional level every year since 2000. The World No-Tobacco Day 2012 was also celebrated on 31st of May, 2012 with the theme: "Tobacco Industry Interference", alerting the government and all stakeholders to be aware of and protected from the tobacco industries' interference in the tobacco control.

As various kinds of tobacco advertising, promotion and sponsorship are the tactics of the tobacco industries/ companies for attracting the people especially youths to become tested and started the tobacco use, and the Corporate Social Responsibility (CSR) activity is also one of the tobacco industry interference to tobacco control, those messages were given at the World No-Tobacco Day ceremony to become the government and all stakeholders to be aware of and de-normalize those activities. On 29 September 2013, the WHO World No-Tobacco Day 2013 Award was presented to HE Prof Pe Thein, Union Minister, Ministry of Health by Dr Samlee Plianbangchang, WHO Regional Director for SEAR. It is a prestigious award bestowed by the Director-General of the World Health Organization, in recognition of His Excellency's outstanding contributions towards tobacco control.

Other significant Non-Communicable Diseases Prevalent in Myanmar

Mental Health and Drug Abuse

During the British colonial regime, they began isolating the mental cases in what is called Lunatic Asylum. Since Independence, the name Lu'natic Asylum was changed into State Mental Hospital, again to Psychiatric Hospital and since 1 March 2002 a new Hospital was established in Dagon Myo Thit under the name of Mental Health Hospital; thus changing in the form and technical contents. Mental Health care was included into National Health Care Projects and Psychiatric

Specialists were appointed in the Division/State and major District Hospitals. Community approach was practiced in coordination with NGOs such as MMA and MMCWA.

The World Health Organization mentions that about one quarter of patients attending primary care clinics in almost all countries of the world suffer from distressing mental disorders. The symptoms most often complained are primarily physical, such as chest pain, low back pain, insomnia or vague physical symptoms. " Nauk-kyaw-tet" is a very common complaint of Myanmar women seen at general outdoor patient departments. In such cases, it was later found that the underlying cause was either Anxiety or Depression. About 10 percent proved to be due to Anxiety and 10.4 percent were Depressive patients. A further 9 percent had sub-threshold mental symptoms. It was revealed that the detection rate of these problems remained poor with only half of them being detected in primary care clinics and only about one third was given appropriate drug treatment. This shows clearly that there is a need for both Psychiatrists and Primary health care providers to be aware of the huge numbers of mental problems, particularly anxiety state and depression that occur in non-psychiatric settings and to detect and treat these conditions satisfactorily.

Anxiety and depression are two of the most common disorders in medicine. Although cause substantial morbidity and mortality, they largely remain under-diagnosed and under-treated. Anxiety disorders can substantially affect quality of life as well. For example, patients with generalized anxiety disorder and panic disorder describe significant impairment to their daily lives. A related illness, obsessive-compulsive disorder, profoundly affects psychosocial functioning by damaging relationships with a spouse and children, and by resulting in job loss.

Because primary care physicians treat most patients with these disorders, helping these clinicians to identify symptoms, to correctly diagnose anxiety and to appropriately treat these patients is critical. This informed care would significantly improve function, quality of life, and overall medical health of patients who suffer from these disorders. Most Physicians understand that many patients with anxiety disorders often do not verbalize their feelings, but rather present with somatic complaints. Therefore, clinicians must openly address these with their patients and help remove the stigma associated with these disorders.

It is also common for anxiety to coexist with depression; about one-half of depression cases and anxiety cases in primary care occur in the same patient at the same time. Patients may be reluctant to discuss problems of this nature because they believe that psychiatric illness carries a stigma. Also they may not have the insight to realize that their physical and emotional symptoms are related to psychiatric problems. Physicians may not immediately recognize the need to look for psychiatric causes in addition to general medical causes for physical symptoms. Anxiety disorders are abnormal states in which the most striking features are mental and physical symptoms of anxiety which are not caused by organic brain disease or another psychiatric disorder.

Abuse and misuse are defined in various ways. To simplify it, use of any drugs where not indicated or in an inappropriate situation is abusing while use of a drug in an indicated situation butnot in a therapeutic range (either low or high) is also abuse. Many psychotropic substances (and

also narcotic drugs) have a pharmacological action of tolerance and dependence, thus use of these drugs are to be more careful when they are prescribed. Drugs are part of medical rather than psychological treatment, and therefore, are more likely to produce unwanted effects.

In a survey of 40,000 prescriptions issued, it was found that psychotropic drugs were prescribed more often than any others, and constitute almost 20% of them. Despite these high rates of prescribing, many prescribed drugs are not taken. A collection of unused drugs from the houses of about 500 patients in the course of 6 days revealed 36,000 tablets of psychotropic drugs (i.e. hypnotics, sedatives, tranquillizers and antidepressants). Also, unused drugs are a danger and for these reasons patients should not be given more drugs than they need.

Provision of mental health care had been started in Myanmar since 1948, when Myanmar regain independence. In the early days, mental health care system began in hospital setting in Yangon and then extended to Mandalay. Care for mentally ill patients in big hospitals is not effective because the patients were stigmatized and later became institutionalized with prolonged stay in hospital. Mental illnesses are now becoming one of the emerging health problems. It is important that approaches for mental health care need to be decentralize and institutionalization and stigmatization should be avoided. Mentally ill persons residing in places beyond the road of hospitals are accessible to proper care and attempts have been made to shift mental health care from hospital settings to community settings to ensure effective care.

Drug abuse has become a global problem during the past decade. The problem of Heroin use became acute and widespread during the early 1970, and had started to infiltrate into the mainland cities, especially among the youth. As a result of this changing pattern of involvement, Myanmar economy and Myanmar society is facing a serious threat form it. ATS problem emerged starting from 1999: it is anticipated that ATS would become a major problem in future. The Health sector was assigned to carry out of the following tasks: case detection, treatment and after-care; case follow-up and management; training of health personnel in drug abuse; registration of drug addicts. The Department of Health, has set up a total of (26) major Drug Treatment Centers (40) Subsidiary Centers and (2) Rehabilitation Centers making a total of (68)treatment centers in the whole country. A new rehabilitation center named "Shwe Pyi Thit" is now preparing to open at Tima area in Muse Township of Shan (North) State. For further control, the Government has enacted the Narcortic Drugs and Psychotophic Substances Act 1985 and later issued the Narcortic and Drugs and Psychotic Substances Rules, 1985.

Snake Bite

Snake Bite has been a hazard in rural in Myanmar for centuries. Farmers and forest workers in the 15-45 years age group are particularly affected resulting in great socioeconomic loss. As an agriculture country undergoing great developmental changes in every sector including agriculture and forest increasing demand for their labor exposes their workers to greater risk of snake bite. Snake bite is included in the 17 diseases under national surveillance. The poisonous snakes found in

Myanmar are Russell's viper bite contributing 90% of poisonous snake bite in Myanmar. Number of poisonous snake bites is more or less increasing during the period 1999-2002 and morbidity rate is ranging between7-8. It is obvious that both number of snake bites and morbidity need health reduction.

Disability

In Myanmar, there will be between 1.5 and 2.5 million disabled according to the past experiences. The majority of the disabled are residing in the rural villages and are virtually inaccessible to rehabilitation services. The country provides rehabilitation services for people with disability through institutional based rehabilitation since 1959. The institutional based rehabilitation service is provided by National Rehabilitation Hospital. Two Departments of Physical Medicine and Rehabilitation in Yangon and Mandalay and Physiotherapy Units attached to General and Specialist Hospital in the State & Division.

However, about 70% of the country's population are residing at the rural villages and virtually inaccessible to the rehabilitation services. To expand the Rehabilitation facilities to cover the rural population in near future is impossible. Therefore, the community based rehabilitation services was considered in response to global change of strategy concerning rehabilitation. It has covered (588183) population from 218 villages, 88 wards of 27 townships. Identified 9416 disabled of various categories, ie nearly 2%. International evaluation team (External Review) which came to evaluate the program impact and strongly recommended to expand the program to cover the whole country in phase wise manner.In addition, not only the general population but also the many health professional are still not adequately aware of the disability related issue and how, after proper rehabilitation, the disabled persons can contribute towards socio-economic development of the country.

These non-communicable chronic conditions usually affect those who are in the most productive period of life causing high premature mortality rates and reducing efficiency and productivity. Most of the people are not under the protection of social security arrangements and these disease conditions by their nature of requiring life-long treatment and care impose high burden of health care costs for the poor. If the disease process cannot be controlled properly diseases like diabetes mellitus and hypertension can lead to severe complications like blindness and stroke.

Based on hospital statistics these chronic disease and conditions are found to be increasing in numbers and mortalities are also high. According to the statistics released from the South East Asia Region of the World Health Organization these conditions need to be solved as public health problems. Arrangements are also in need for the availability of more complete data and information.

In the NHP, the general objective of the programme is to prevent and reduce disease, disability and premature deaths from chronic non-communicable diseases and conditions and the specific objectives are: to develop policy, legislative and financial measures to build environment supportive for reduction of risks; to reduce level of exposures of individuals and populations to the common risk factors; to strengthen health care delivery for people with non-communicable diseases

by developing norms and guidelines for cost-effective interventions with the aim to improving case management; and to Establish Surveillance System for monitoring risks, and chronic disease and conditions .

The strategies of the intervention programme are: developing a national multi-sectoral framework for the prevention and control of non-communicable diseases; reducing risk factors for non- communicable diseases aiming at providing and encouraging healthy choices for all; enabling health system to respond more effectively and equitably to the health-care needs of people with chronic non-communicable diseases and conditions; and developing a coordinated agenda for research on non-communicable diseases in order to generate or strengthen the evidence base for cost effective prevention and control. The priority actions are: developing comprehensive national policy and plan for the prevention and control of major NCDs; establishing high level national multi-sectoral mechanisms for planning, guiding, and monitoring; implementing cost effective approaches for the early detection of major NCDs; and strengthen capacity of HRH for better case management and to help people to manage their own conditions better.

A partnership approach is well maintained for an effective and efficient engagement of these issues. A close collaboration with the following programmes of the National Health Plan and related departments and sectors will be undertaken: health promotion, tobacco control, health system strengthening, nutrition promotion, school health, adolescent health, maternal, neonatal and child health, related ministries and organizations, private sector, and social organizations.

Health Information System Strategy

Health Information System

Ministry of Health has adopted two policy objectives: “Enabling every citizen to attain full life expectancy and enjoy longevity of life” and “ensuring that every citizen is free from diseases”. In order to fulfill these objectives the ministry identified three strategies which are “wide spread dissemination of health education and information to reach rural areas”, “enhancing diseases prevention activities” and “providing effective treatment for prevailing diseases to upgrade health status of entire nation”. Health Management Information System is one of twelve programs under the National Health Plan (2006–2011). Hospital information, public health information, human resource information, logistic information and information communication technology development are the projects under this HMIS program. Based on the guidelines provided by the Health Metrics Network, systematic assessment of current health information system was done in 2006 and reviewed again in 2009. HIS strategic plan was developed based on findings of HIS assessments with technical and financial assistances from WHO and Health Metrics Network from Geneva.

Health information system started in 1978, in contemporary with the first People’s Health Plan (1978-1982). Initially main source of data was hospital records and later public health care

services and administrative records are used as data sources. In July 1995, integrated health management information system was established with new concept of minimum essential data set with the aim to reduce the workload of basic health staff. The National Health Committee is a multisectoral policy making body and it gives the guidance and has the responsibility of coordination among health and health related sectors for health information management. Central Statistical Organization has the responsibility for generating, analysis and dissemination of statistics for the country according to central statistical authority act of 1952. According to the act, there are regulations and procedures for collection, analysis and dissemination of data related to vital events and notifying diseases and social insurance.

In 2003, workshop on review of existing public health data set was held. After that a number of meetings were conducted during 2004 and new data set was revised and collected in 2005. It includes mainly data on health services. Data on infrastructure, manpower and voluntary contribution are also collected through routine public health information system. Hospital information is collected on monthly basis from all public hospitals and a major gap in existing health information system is lack of private sector information. Central Epidemiological Unit under Department of Health takes care on disease surveillance system. Health researches are under taken by three Medical Research Departments as well as by remaining departments based on their areas of interest.

Two interdepartmental meetings for planning HIS assessment were conducted in September 2006. Various departments under the Ministry of Health, Central statistical Organization, Ministry of National Planning and Economic Development attended these meetings. The workshop on HIS assessment was done in October 2006. Then series of consultative meetings for workshop findings was held in February - April 2007.

Core group for developing Myanmar Health Information System Strategic Plan was established in September 2009. Preliminary meetings to develop Myanmar Health Information System Strategic Plan have been carried out. Three series of meetings were conducted to revisit new version assessment tool and all agreed the previous results and identified vision, goals and objectives for future health information system. A national level workshop was later carried out for the development of strategies and activities. Decision makers, state/divisional health directors and representatives from UN agencies and INGOs participated in this workshop. Consensus on objectives, strategy and activities described in Myanmar Health Information System (2011 – 2015) was received among stakeholders on 14th July 2010.

The vision of Health Information System Strategic Plan is “a simple, effective and systematic health information system established at all levels of health care delivery for the strengthening of health system”. To improve the availability, accessibility and utilization of quality health information is general objective of drawing HIS strategic plan. Specific objectives are as follow:

- To enhance the HIS commitment, coordination and HIS resources
- To improve the quality of the hospital data recording and reporting

- To improve the quality of the public health data recording and reporting
- To develop a reporting system for private health sector
- To improve the coverage and quality of vital registration system
- To improve surveillance system on disease and health
- To encourage population based survey
- To improve data management, and data sharing encompassing IT development
- To promote utilization of health information in decision making process

Specific performance objectives are then developed under each of specific objectives.

To enhance the HIS commitment, coordination and HIS resources

- To enhance Commitment and co-ordination for HIS
- To expand and strengthen the HIS staff
- To ensure adequate financial management support
- To improve working environment for health information management

To improve the quality of the hospital data recording and reporting

- To standardize the medical record forms for both public and private hospitals
- To develop guidelines for medical record documentation and ICD 10
- To improve the quality of service records and reports

To improve the quality of the public health data recording and reporting

- To develop national core indicators on health
- To update, produce and disseminate minimum essential data set for public health information periodically
- To strengthen supervision and monitoring

To develop a reporting system for private health sector

- To ensure availability of health information from private hospitals

To improve the coverage and quality of vital registration system

- To increase coverage of vital registration system
- To improve the quality of collecting reporting and recording vital events

To improve surveillance system on disease and health

- To improve disease and health surveillance system

To encourage population based survey

- To improve availability and quality of population based survey

To improve data management, and data sharing encompassing IT development

- To expend appropriate application of information and communication technology in current health information system
- To strengthen data sharing and analysis at all levels

To promote utilization of health information in decision making process To create the culture of evidence based decision making

Health Research System

Background

Medical Research developed to some extent in British Burma during the years of colonial rule. By about 1900 the early glimmerings of medical research could be detected, but it was unorganized, sporadic and on an individual basis; only around the 1920's was it possible to discern some public health and epidemiological research that was directed and systematically carried out; clinical and biomedical research were unremarkable excepting the single instance of the discovery of Melioidosis.

The period of 15 years approximately after Independence marked the beginning of medical research by Myanmar into the health problems of people in Myanmar. Significant epidemiological studies and operational research was begun in several areas of public health importance: malaria, leprosy, tuberculosis, filariasis, nutrition, indigenous medicinal plants. The findings were directly utilized in launching national health programs.

The decade 1962-1972 was a period of rapid growth of medical research in Myanmar. Establishment of a medical research career structure took place with a new permanent cadre of full time researchers at BMRI comprising basic scientists, medical scientists and clinical scientists forming a core of small but influential medical researchers. Rapid growth in organization, promotion and support of medical research because of the establishment of the Burma Medical Research Council and its executive arm, the Burma Medical Research Institute; and the formation of the Medical Sciences Division under the Research Policy Direction Board of the government.

The period, 1973-1986 was a sustained development time where the volume, scope and depth of medical research capacity in Myanmar increased remarkably. There were large inputs of physical, technological and manpower resources into the Department of Medical Research by government as well as from international sources, particularly from the Japanese Government and JICA. The Clinical Research Centre and the Biomedical Research Centre complex including fully equipped modern laboratories, library, conference centre, and laboratory animal facilities were completed. DMR was transformed into a modern, up-to-date medical research institution.

The Ministry of Health of Myanmar undertakes the responsibility of improving the health status of the people through its six Departments, namely: Department of Health (DOH); Department of Medical Science (DMS); Department of Traditional Medicine (DTM); Department of Health Planning (DHP); Department of Medical Research (DMR) (Lower Myanmar); and DMR (Upper Myanmar). All the Departments under Ministry of Health are involved in conducting health research. However, the two Departments of Medical Research, although the one in Upper Myanmar is still developmental stage, are the key Departments responsible for undertaking health research in Myanmar.

The National Health Policy gives proper attention to health research as can be seen in Article 11 of the Policy statement. The statement says:

"to encourage conduct of medical research activities not only on prevailing health probleths but also giving due attention in conducting Health Systems Research"

In Myanmar, national priority health problems identified during formulation of National Health Plans form the broad areas on which to embark health research. In 1994, the Health Research Policy Board under the Ministry of Health was reformed with the Minister for Health chairing the Board and Director General of the DMR (Lower Myanmar) acting as the Secretary. The members are heads of all Departments under the Ministry of Health. The following two guidelines were included among the guidelines laid down by the Health Research Policy Board.

- *to promote health research by strengthening research capability through development of manpower, technologies and infrastructure; and*
- *to translate research findings into practical applications.*

Health Research System (HRS) (existing situation)

Health Research System in relation to health system development

For many decades, Myanmar has recognized the vital role of research in health development and thus encourage the research activities in different areas of health development. Realizing the importance of medical research for the improvement of the health of the population, Revolutionary Government promulgated the Burma Medical Research Council Act in October, 1962 and set up the Burma Medical Research Council with the Burma Medical Research Institute as the executive arm of the Council. Consequent to the reorganization of all Government Departments in 1972, the Burma Medical Research Institute was renamed the Department of Medical Research (DMR) and became one of the Departments under the Ministry of Health (MOH).

The importance of health research being well recognized by the Myanmar Government, a new DMR for Upper Myanmar was established in 1999 and it is in the developing stage to become a full fledged Department under the MOH. At the present there are six Departments under the Ministry of Health, and each department is headed by a Director General and they are:

1. Department of Health (DOH) (for prevention and curative services)
2. Department of Medical Science (DMS) (for human resource development)
3. Department of Traditional Medicine (DTM)
4. Department of Health Planning (DHP)
5. Department of Medical Research (DMR) (Lower Myanmar)
6. Department of Medical Research (DMR) (Upper Myanmar)

The Health Research Policy Board is the highest body concerned with direction of health research activities in Myanmar. The Minister for Health functions as the Chairman and the Director General (DG) of the DMR (Lower Myanmar) acts as the secretary of that board. Member are Director General from the above mentioned departments under the M.O.H, Rectors from Medical Institute and

representatives from other health related ministries (e.g, Vetenary Sciences Institute, Defense Services Institute etc.)

Under the Health Research Policy Board, Health Research Working Committee was established with the aim of facilitating health research activities in Myanmar. The Director General of the Department of Medical Research (Lower Myanmar) is the Chairman of the Committee, and the members are Directors from other departments under Ministry of Health, academics from Institutes of Medicine, representatives from the Myanmar Medical Association, and Dental Association etc.

Although all the departments under the MOH are involved in conducting health research, the two Department of Medical Research are the principle organization responsible for implementing health research in Myanmar. Health Research activities were emphasized towards the priority health problem identified during formulation of National Health Plans.

Overall objectives, scope and architecture of the national health research system

The government of the Union of Myanmar sets political, economic and social objectives for all round development of the country. The National Health Committee (NHC) has been organized for proper direction towards health sector development, and is chaired by Secretary I of the State Peace and Development Council and members are Minister of Health and ministers of health related ministries Under the guidance of NHC, the National Health Plan has been formulated with six broad programmes viz. Community Health Care Programme, Disease Control Programme, Hospital Care Programme, Environmental Health Programme, Health Systems Development Programme, and Organization and Management Programme. Health Research Programme has been identified under the Health Systems Development Broad Programme.

The health research programmes have been conducted by various departments under Ministry of Health in collaboration with other related health ministries. In order to conduct and promote health research within the country the following objective have been laid down.

1. To improve the health of the people of Myanmar
2. To contribute towards improvement of the economy of the country
3. To impart scientific knowledge
4. To apply research findings in evidence-based decision-making leading towards solution of health problems up to grass roots level
5. To provide infrastructure necessary for effective health research
6. To provide training in health research

Short term plan of Health Research System

As the general objective of Health Research Programme is to conduct research in order to solve the priority health problems of the country, the following short term plan (for 2001 - 2006) has been laid down:

- Development of proposals and implementing research activities in the six priority diseases (malaria, TB, diarrhoea, dysentery, diabetics, hypertention) as outlined by the National

Health Committee;

- Implementing research activities on communicable and non-communicable diseases (other than above disease);
- Conducting research and development of traditional medicine with emphasis on herbal drugs;
- Performing research activities for the development of technology on diagnosis, management, prevention and control of health problems in Myanmar;
- Implementing research activities on health problems which need further elucidation;
- Strengthening research capability and support research by carrying out activities on research capacity strengthening.
- Conducting rural area-based research and research on improving health behaviour of the people in rural areas and
- Implementing effective monitoring and evaluation activities as an are integral component of each research project.

Long term plan of Health Research System

Being a developing country, Myanmar envisages that it will face the double burden of infectious diseases as well as chronic diseases. It also has to take consideration of the advances in genetics, molecular biology & biotechnology, behavioural sciences, information science and communication technology and also the globalization phenomena.

Accordingly, a 30 year plan (Myanmar health vision 2030) has been visualized which includes health research vision. In that long term plan the above mentioned scenarios have been well thought of.

National Health Research Policy

The Health Research Policy Board is the highest body concerned with direction of health research activities in Myanmar. The Minister for Health functions as the chairman and the Director General (DG) of the DMR acts as the secretary.

The Health Research Policy Board has laid down the following guidelines:

1) To promote health research by strengthening research capability through development of manpower, technologies and infrastructure;
2) To identify factors affecting national health, and to conduct research for effective control and therapeutic measures;
3) To identify factors promoting national health and to institute appropriate measures for community practice;
4) To promote and conduct health systems research;
5) To investigate major communicable and non-communicable disease problems prevalent in Myanmar for effective control and therapeutic measures;
6) To investigate major nutritional problems prevalent in Myanmar for effective control

and therapeutic measures;

7) To promote and conduct reproductive health research in accordance with the National Health Population Policy;

8) To translate research findings into practical applications.

Function of Health Research System

Under the health research programme the Department of Medical Research (DMR) is the principal organization which sponsors and conducts research in Myanmar. Moreover, the Departments of Health, Medical Sciences, Traditional Medicine, Health Planning and related departments under Ministries also implement research activities in addition of their principal functions.

The DMR conducts medical research. It promotes and supports medical research in the country. It is also generally responsible for coordination, organization, and general supervision of all medical research in Myanmar.

The principal aim of research conducted at the DMR is to improve the health of the people of Myanmar. Within this context, the programmes are directed (i) to identify the current and future health problems and their determinants; (ii) to discover or develop new and improved methods for control, diagnosis and management of the identified major health problems and diseases in Myanmar. In selecting projects for research in the various areas the following criteria are used:

1. Magnitude and priority as a health problem;
2. Probability of findings a solution or an important clarification;
3. Benefits expected from the application of the results of successful research efforts;
4. The potential usefulness of the research in finding solutions to other problems; and
5. The existence of a situation which covers a special advantage for a particular research and which should be exploited.

Dissemination

The research findings are disseminated among researchers and scientist, health services managers, and finally the public through the following means:

Publications:

(a) Myanmar Health Sciences Research Journal, Myanmar Medical Journal, Journal of Myanmar Military Medicine, Myanmar Journal of Current Medical Practise.

(b) Current Awareness Services published by DMR library.

(c) DMR Bulletin

(d) Periodic reports on research findings applicable to health care, and formulation of health programmes

(e) Special Technical Report Series

(f) Abstracts of papers read at Annual Health Research Congress, Myanmar Medical Association Conference, Myanmar Military Medical Conference.

(g) Local News papers/magazines by local language by researchers themselves

Presentations

(a) Annual Health Research Congress

(b) Annual Associations Meetings related to health (Myanmar Medical Association, Myanmar Nurses Association etc.)

(c) Specialty Conferences (Medical Specialists Conference, Surgeon Conference)

Scientific meetings (formal and informal)

Reports

(a) Annual reports published annually and submitted to decision makers.

(b) Health planning and health care meetings to senior administrators.

Key challenges

The challenges are identified at institutional, national and international level.

Institutional level

- Creation of research environment at the institute by providing training, research facilities and upgrading of network system among departments.
- Promotion of research finding utilization.
- Motivation and recruitment of young scientists for research carrier development.
- Creationof synergy andpromotion, collaborationand multidisciplinary linkage among institutions.

National level

- Infrastructure and capacity building.
- Development and upgrading of existing information retrieval system including library facilities and information technology.
- Improvement of inter-networking for research information, and sharing of resources for research mobilization.
- Sustainability of existing research infrastructure and human resource. International level
- Conduct of health research to meet its ultimate goals of equity and development challenges at international level.
- Adoption of a system which meets the national and local research priorities. Strengthening of the international network communication mechanism for better research co-ordination, collaboration and development.

Strategies for strengthening the NHRS

- To advocate the importance of the health research programme in the nation's health development scheme.
- To improve the national and international information communication channels.
- To utilize different media (documents, electronics, CDs, Intranet, web site, internet web site, etc.) for easy availability of funds for research activities from the potential donors.
- To expand the existing research infrastructure and to establish the new facilities for

commercial branches.

- To open appropriate research units at different disciplines at various health institutions and to promote utilization of research facilities.
- To upgrade the co-operation and collaboration of stakeholders.

Mechanism and processes for monitoring and evaluation

Monitoring and evaluation has been undertaken as a routine mechanism at three levels namely Institutional level, Ministerial level and National level.

Institutional level

(1) Research projects undertaken by the various research divisions are monitored and evaluated closely by the Head of the divisions;

(2) Three monthly progress reports are prepared and reported to the Ministry of Health;

(3) Six monthly progress are prepared and evaluated by respective Directors (Research);

(4) Annual review of the research projects of the individual division are carried out by the Board of Directors headed by the Director General; and

Evaluation is carried out by using the indicator, number of research projects/activities reported (interim/final) per year.

Ministerial level

Regular reporting mechanism has been introduced for each research project of all the departments under the Ministry of Health. This mechanism includes monthly and four-monthly progress report using the standard format.

National level

At the national level, a regular monitoring system to evaluate health activities, including research activities and program, has been launched by the Minister of Health under the guidance of the National Health Committee.

Future plans for further development of national health research systems

Short term plan

(1) Development of critical mass of National researchers

(2) Establishment of infrastructure and research facilities, technical and financial inputs.

(3) Ethical issues on research activities should be further enhanced. Standardized ethical issues to deal with all aspects of health research need to be developed.

(4) Improvement of research management.

Long term- plan

(1) Enhancement of research culture at all levels of health environment.

(2) Evaluation and updating of existing guidelines of the Health Research Policy Board accordingly.

(3) Country-focused plan for research priority setting especially in national priority health problems,

(4) Development of a regular forum to facilitate stakeholders' interaction and empowerment of people by partnership.

(5) Plan for establishment of dissemination of research findings relevant to specific policy issues.

(6) Creation of a dynamic health research system by providing career opportunities, research motivation, opportunity to upgrade and improve knowledge, and appropriate research infrastructure.

Environmental Health

Introduction

The Environmental Health Programme in Myanmar has been included in part 9 of the National Health Policy (1993): *To intensify and expand environmental health activities including prevention and control of air and water pollution.* It is also integrated into the National Health Plan since its inception, based on the attainment of the objectives and targets of Health For All 2000, along with the principles of 'healthy settings'. The environmental health programme consists of 5 projects:

a) Environmental Health Risk Assessment and Control

b) Community Water Supply and Sanitation

c) Occupational Health

d) Air and Water Pollution Control

e) Food and Drug Control

The National Environment Policy of 1994 was gazetted in accordance with Notification No. 26/94 dated 5 December 1994 of the Government of the Union of Myanmar. It stipulates the direction for environmental protection and conservation. Myanmar has also prepared programs and strategies as part of its Agenda 21.

There is an active Myanmar Tobacco Free Initiative. With guidelines from the National Health Committee, the National Tobacco Control Programme was launched in 2000 and the national tobacco control committee was formed in 2002. Tobacco advertisement was banned on television, radio and billboards.

Relevant legislation addressing environmental health issues

There are 15 legislations pertinent to environmental health exists in place in Myanmar such as:

a) Forestry Law 1992

b) Protection of wildlife and Wild Plants and Conservation of Natural Areas Law 1994

c) Public Health Law 1972

d) Factory Act 1951

e) Territorial Sea and maritime Zone Law 1977
f) National Environment Policy 1994
g) Draft Environment Law 2000
h) Mines Law 1994
i) Plan Pest Quarantine Law 1993
j) Freshwater Fisheries Law 1991
k) Marine Fisheries Law 1990
l) Pesticide Law 1990
m) Law on Aquaculture 1989
n) Law on Fishing Rights of Foreign Fishing Vessels 1989
o) Irrigation Laws and Regulations 1982

The law on environmental impact assessment is being drafted in 2004. Despite the absence of regulation, health risk assessment is already included as part of the environmental health programme.

Decentralization and / or privatization policies dealing with environmental health

There is no policy on decentralization or privatization of environmental health services in Myanmar.

Institutional Structure for Environmental Health

Administrative / organizational set-up of the country

The environmental health functions in Myanmar rest with the Department of Health under the Ministry of Health. The relevant division its mandate includes aspects of environmental health. This division is composed of occupational and health promotion unit, laboratory unit, and toxic vigilance and prevention of poisoning. This division also deals with prevention of adverse health effects due to air and water pollution, toxic and hazardous wastes and chemical safety. Also under the Department of Health is the Environmental Sanitation Division, which is responsible for water supply systems for health and institutions such as dispensaries, rural health centers, station hospitals and schools. It is also in charge of rural sanitation for community as well as health and educational institutions.

Role of other agencies and partners other than government

There is a Forest Resource and Environment Development Association (FREDA) and at least 10 national NGOs, which are active in Myanmar. About 27 international NGOs are involved in health development activities in the country. UN agencies such as WHO, UNICEF, UNDP, UNFPA, and UNHCR have been supporting the government in their respective areas.

Relevant agencies involved and their respective functions

Aside from the Department of Health, there are at least 15 other government agencies whose functions are supportive of environmental health. These are the following:

a) National Commission on Environmental Affairs
b) Ministry of Industry

c) Department of Irrigation
d) Ministry of Transportation
e) Factories and General Labour Laws Inspection Department
f) Yangon City Development Committee
g) Department of Meteorology and Hydrology
h) Department of Population
i) Department of Forestry
j) Department of Health Planning
k) Department of Human Settlement and Housing Development
l) Department of Water Resources Utilization
m) Department of Agriculture
n) Department of Medical Research
o) Department of Development Affairs

Relevant International Conventions and Agreements Ratified or Signed

Myanmar is a party to a number of international agreements related to environment and environmental health such as:

Accession:

- International Convention for the Prevention of Pollution from Ships, London 1993
- Protocol of 1978 Relating to the International Convention for the Prevention of Pollution from Ships, London 1973
- Vienna Convention for the Protection of the Ozone Layer, Vienna 1985
- Montreal Protocol on Substances that Deplete the Ozone Layer, Montreal 1987 -
- London Amendment to the Montreal Protocol, London 1990
- ICAO Annex 16 Annex to the Convention on International Civil Aviation Environmental Protection Vol. I Aircraft Noise
- ICAO Annex 16 Annex to the Convention on International Civil Aviation Environmental Protection Vol. II Aircraft Engine Emission
- United Nations Convention to Combat Desertification in those Countries Experiencing Serious Drought and/or Desertification, Particularly in Africa, Paris, 1994
- Convention on International Trade in Endangered Species of Wild Fauna and Flora(CITES), Washington 1973 and this Convention as amended in Bonn, Germany 1979 Signed:
- Convention on the Prohibition of the Development, Production and Stockpiling of Bacteriological (Biological) and Toxin Weapons, and their Destruction, London, Moscow, Washington 1972
- Convention on the Prohibition of the Development Production, Stockpiling and Use of Chemical Weapons and their Destruction, Paris 1994

Ratification:

- United Nations Convention on the Law of the Sea, Montego Bay, 1982
- United Nations Framework Convention on Climate Change, New York, 1992 - Convention on Biological Diversity, Rio de Janeiro, 1992

Priority Environmental Issues

The following concerns were raised as priority environment and health issues:

- Deforestation
- Inland Water Pollution
- Urban Pollution
- Waste Management
- Soil Erosion

As Myanmar is still an agricultural country (2,113,000 ha is irrigated agricultural area), this sector is expected to grow over the years as part of the government's intensive development programs. In 2002, the fertilizer consumption has been estimated to be about 132,300 metric tons per year but the application is still comparably low at 17 kg/ha. There is no information on pesticides consumption in Myanmar.

The national government recognizes the tasks ahead as it stated the following policy:
"Health, environment and sustainable development programmes should be integrated to build a modern and developed nation. The Ministry of Health and its partner agencies will ensure the reduction of traditional hazards and at the same time establish health and environmental safeguards to prevent the modern hazards of environmental pollution and uncontrolled consumption of national resources resulting in environmental degradation".

Water Supply, Sanitation and Hygiene

Five Year Stategic Plan on Water Supply, Sanitation and Hygiene

Currently, around 82.3% of the population in the Republic of the Union of Myanmar have use of improved water supply, while 84.6% have access to improved sanitation (sanitary means of excreta disposal). However, there are wide disparities in coverage between different States or Regions of the Republic of Union of Myanmar, and similarly between rural and urban areas in both use to improved water supply and access to improved sanitation. On average only 53% of rural schools have a water supply, and in some townships this coverage figure is as low as 10%. It is also the case that improved water supply does not necessarily imply improved water supply. The continued sporadic outbreak of diarrhoeal disease which significantly contribute to infant and under-five mortality rates indicate that not enough promoting good hygiene practices or ensuring the safety of the water supply chain.

Diarrhoea is major leading cause of death among under five children. Overall, 6.7% of the under-five had diarrhoea, second only to ARI.

The background to this Five year Strategic Plan on Water Supply, Sanitation and Hygiene (WASH) needs to be understood in the context of both global and regional policy development. In particular the Millennium Development Goals (MDG) have established the policy backdrop for development progress in general. More specifically, under the goal to *"Ensure Environmental Sustainability"* an important target was set, namely to: *"Halve, by 2015, the proportion of people without sustainable access to safe water supply and improved sanitation."*

While the overarching aim of the MDG is to reduce poverty, it can be seen that improving health is central to achieving this aim. In fact a direct link can be made between improving use to safe water supply and access to sanitation, and health-related goals, particularly as concerns child mortality. Water and sanitation related diseases contribute significantly to under-five mortality. In addition, providing use to improved water and access to sanitation can positively impact on maternal health, HIV/AIDS patients and carers, enabling access to education for girls, and poverty alleviation in general through better health and freeing-up time for more productive purposes. The World Summit on Sustainable Development (Johannesburg, 2002) endorsed a sanitation target to complement that of improved water supply so that by 2015 the number of people without access to basic sanitation would be halved. Sanitation is given a broad interpretation, and it is worth citing the exact phrasing used at the Summit:

"*…access to basic sanitation…include[s] actions at all levels to: develop and implement efficient household sanitation systems; improve sanitation in public institutions, especially schools; promote safe hygiene practices; promote education and outreach focused on children, as agents of behavioural change; promote affordable and socially and culturally acceptable technologies and practices; develop innovative financing and partnership mechanisms; integrate sanitation into water resources management strategies."*

Within the United Nations system, WHO and UNICEF share responsibility for reporting on health-related goals including child mortality, maternal health, childhood nutritional status, malaria prevention measures and access to clean water. However, at country level, WHO is the lead authority for the health content of the MDG within the UN Country Team.

Goal of the Strategic Plan

The overall goal of the strategic plan is to reduce the burden of water and sanitation-related disease, especially among children, thus improving the quality of life of the Myanmar people. The achievement of the goal will be measured using standard indicators such as U5MR with regard to diarrhoea and diarrhoea morbidity in the general population.

Purpose

The purpose of the strategic plan is to significantly increase access to water and sanitation facilities, and maximise the health benefits through the widespread adoption of good hygiene practices.

Strategic objectives

The four strategic objectives are:

1. Increased resources are made available to ensure greater and more equitable use of water supply and access to sanitation
2. Sector actors implement water supply, sanitation and hygiene projects which are effective, appropriate, and sustainable
3. Institutional capacity of appropriate MOH Departments strengthened in key programme areas
4. Effective sector coordination and cooperation, and working partnerships encouraged among stakeholder agencies

Although the strategic plan is designed to be a component of the national water and sanitation policy, it is envisaged that several of the proposed activities will have a geographical focus. For some activities this is justified on the basis of redressing the present inequity of access to services, while for others it is because of a specific set of environmental or physical conditions such as the need for modified latrine design, and research into arsenic mitigation. It is also important that an increased level of resources is not spread too thinly as this puts at risk the long-term sustainability of the interventions. The strategic plan has also been designed to progressively increase the scale and diversity of activities on the assumption that there will be a concomitant increase in the level of resources.

Water supply, sanitation systems and hygiene messages must be capable of being sustained by the intended beneficiaries. Therefore programmes addressing these needs should be demand-driven and participative if they are to be effective and appropriate to the needs of the communities. This means that alternative solutions must be found to meet the different needs and contexts of the population that are determined by geographic, economic, demographic and cultural factors. Therefore, it is evident that the process of research and development is fundamental to achieving the second strategic.

The outputs proposed under this strategic objective consist of the development of appropriate and sustainable solutions to the technical and methodological problems faced by the sector. The results of research and development will also feed into the advocacy strategy. Therefore, the research must be of high quality, properly documented and widely disseminated among sector actors. The aim is to ensure the uptake of best practices and most appropriate technologies as quickly and efficiently as possible. This is important not least because it becomes more difficult to motivate community involvement and participation where a failed project has been experienced. For

example, in the Delta region the standard latrine design has met with limited success because of flooding. The communities concerned may be less willing to participate in latrine building a second time around. Here too is an argument for ensuring that communities are involved in the research as they are able to contribute important knowledge about local conditions. There is also a strong argument for involving the private sector in research and development. If appropriate technologies are to be sustainable and scaled-up, the private sector might have an important role to play in both production and in the supply chain. In the evaluation of a technology it is essential to determine whether it would be affordable, and consulting the private sector on this aspect would be very useful.

Among the main water supply, sanitation and hygiene issues identified in this document and in other sector literature, include the inadequate monitoring and management of water quality; the inequality of access when comparing rural and urban contexts and also between certain States and Regions; the lack of effective sector coordination, and need for participative hygiene promotion methods over didactic approaches. It is encouraging that there is high level commitment to the importance of water supply and sanitation and recognition that development in rural areas needs to be accelerated. Ambitious targets have been set for the sector, though there is no reason to consider them unrealistic assuming that the necessary resources are made available. For rural areas the target is for very village to have access to at least one improved source of drinking water by 2015.The programme known as National Sanitation Week will continue until there is 100% coverage of improved sanitation.

The MOH has the qualified and diverse human resource base that has potential to be much more effective as an agent of change for the sector. The professional skill base is further complemented by an extensive preventive health care network that can be harnessed to instigate change from the grass-roots level upwards. However, it is inevitable that the overall level of resources available to the sector will continue to be among the principal determinants of progress in increasing coverage. All agencies involved in the sector must advocate for a greater commitment of human and material resources so that the health status of the population, especially young children, is safeguarded from infectious water and sanitation-related disease. This represents nothing less than an investment in Myanmar's future and describes the goal of work plan.

Occupational Health

Occupational Health Division under the Department of Health provided training on occupational health and safety and occupational first aid to employers & factory workers of factories under Ministry of Industry and private factories during 2012.

Occupational Health Division (OHD) has performed factory visit, inspection, ambient air quality monitoring and medical check-up to factory workers during 2012. OHD also investigated the industrial accidents in various states and regions to prevent the occurrence of similar episodes.

Occupational Health Division involved in assessing the environmental impacts and health consequences. Air quality monitoring of Nay Pyi Taw and Yangon at administrative areas had been

implemented during 2012. The Division performed surveillance on acute poisoning cases and investigated heavy metal poisoning all over the country.

In collaboration with UNICEF, Occupational Health Division performed assessment of lead content in 617 drinking water sources and 32 soil samples in Myeik Township, Thanintharyi Region in September, 2012 and assessment of urinary delta-aminolevulinic acid level, Urinary Copoporphyrin level in 904 under five children and blood lead level in 323 under five children at five wards in Myeik Township, Thanintharyi Region in October, 2012.

In collaboration with Oral Health Unit from DOH and UNICEF, Occupational Health Division conducted "A Survey on Fluoride Content in Drinking Water Sources and the Prevalence of Dental Fluorosis" in October, 2012 at Wet-Let Township, Saging Region. Fluoride contents of 1123 water samples from twenty villages were tested. Total of 702 students from five high schools were also examined for dental fluorosis status.

To promote drinking water standard, in collaboration with UNICEF, Occupational Health Division conducted "Technical Workshop on Standardization of Pesticides Residues in Drinking Water Quality of Myanmar" in Yangon, in May, 2012,"Technical Workshop on Laboratory Procedure for Phsical, Chemical and Bacteriological Parameters of Drinking Water Quality Standard in Myanmar" in Yangon, November, 2012 and "Advocacy Workshop for Arsenic Mitigation, Provision of Safe Water Option and Township Level Planning in Ayeyarwaddy Region" in Pathein, in January, 2013.

According to section 24 of Myanmar's 2008 constitution, the government must provide the means to protect labourers. The first law on safety and health in workplaces is being drafted by the Ministry of Labour and was planned to be promulgated in 2013. The law will aim to prevent air and water pollution and improve safety at worksites, including fire prevention, ensuring construction workers use protective equipment, ensuring the safety of worksite operators and taking precautions for natural disasters. The draft law will provide the safety of all workers in Myanmar's construction industry. It is also essential from the workers side to strictly abide with the safety procedures and regulations enacted in the law and collective collaboration of worksite supervisors are obligatory to ensure reduction of accidents.

The draft law provision also includes the need for a drain for waste, a good sanitation system, fire alarms and a safety net for construction workers at new construction sites. These precautions need to be widely understood by workers entering the industry. The functions of Electric Power's Electrical Inspection Department also included for a thorough and constant inspection for electrical power usedin the worksites. Emphasis on keeping more attention to implementing a means of protection is also spelled out in the draft law. Most contractors may not aware of the safety [precautions] very well. For an effective implementation of the draft law, further conceptualization programme to prevent the workers from harm systematically. The construction site is full of danger, and many workers die falling down elevator shafts or from electrocution.

Disaster Management

Myanmar has a long coastline of 2 400 km, which covers almost the entire east coast of the Bay of Bengal. It is situated on the highly active fault line called the Sagaing fault. This leaves Myanmar a very short lead time for warning. Most of the coastal areas of Myanmar are within the risk zone. However, deadly tsunamis are rare in Myanmar. Though the country is relatively protected from natural disasters, floods occur in areas traversed by rivers, often after a storm or torrential rain. However, they cannot be predicted.

Other hazards faced include cyclones, storms, earthquakes and landslides. Urban fire in the central areas of the country is common during the hot, dry season and is huan induced. The country has a high burden of tuberculosis, with about 1.5% of the population infected each year. Climate change has led to a re-emergence of malaria, which is largely due to multi-resistant Plasmodium falciparum, and an insecticide-resistant vector. Avian and human pandemic influenza are other health hazards, though Myanmar is well prepared to tackle these.

Myanmar, a country prone to natural hazards, has shown positive progress in the areas of early warning, emergency preparedness and responses in recent years. Now, the Government is stepping up cooperation with global and regional partners to reach its long-term target of becoming a disaster resilient country. This was a key message from the Vice-President at the commemorative event on the occasion of the International Day for Disaster Risk Reduction held in Nay Pyi Taw on 13 October 2011. His Excellency also reiterated that the Government would continue to do its utmost to build a better disaster management mechanism, with support from the international community. “While Myanmar is trying to strive for rural development and poverty alleviation, the disasters cause damage to livelihoods of individual citizens and critical infrastructures of the affected regions. Thus, it is important to link up the disaster reduction endevours with poverty alleviation programmes as not to hinder development tasks,” said the Vice-President. The government is thus highly committed to the prevention and response of the any threat to the nation either man-made or nature.

Over the past three years, the Government, together with the humanitarian and development aid community have sought to invest in disaster risk reduction and disaster preparedness measures and programmes in support to communities, in order to reduce their vulnerability and increase their readiness in case of disasters. At this commemorative event the Government announced its intention to ensure that schools, hospitals and rural health centres across the country are better prepared to cope with the impact of natural hazards.

Initiatives by the Government in the area of disaster risk reduction include several milestones such as the Myanmar Action Plan on Disaster Risk Reduction, the drafting of the Disaster Management Law and National Building Codes and the commitment to mainstream disaster risk reduction in sector work such as education and health.

This is very much appreciated by international leaders such as Ms. Margareta Wahlström who expressed in that occasion “I have observed positive progress in disaster management and risk reduction in Myanmar over the last years. The response to Cyclone Giri in 2010 and Shan State

Earthquake in March 2011 by the Government, UN agencies, NGOs and other partners have reflected many of the lessons learned from Cyclone Nargis and are the manifestation to the capacities developed in the areas of early warning, emergency preparedness and response at both the central and regional levels, and the increased attention to the losses caused by disasters,". "But of course we all have much work to do, as disaster frequency is increasing and in spite of an improved preparedness and response, economic losses continue to rise due to high vulnerability and expression. A lot of disasters are the result of development pathways we choose: in land use, in urbanization, and increasing complexity and economic interdependency. It is vital that a comprehensive legislation and policy framework is in place to guide the implementation by all sectors, regions and states to allow for wise allocation of resources for vulnerability reduction and building resilience of communities at risk," she said.

The government also called on all relevant governmental departments and NGOs for stepping up efforts for fulfilling the needs of the disabled and for organizing and educating the people to actively take part in Myanmar's disaster preparedness and reduction drive as part of efforts for building up strength for disaster preparedness. The government has planned to establish a training school for disaster risk management in Hinthada, Ayeyawady Region in a move to raise awareness of disaster reduction and preparedness among the local governments and people. The government is also coordinating with the UN agencies, INGOs and NGOs to conduct disaster reduction training courses and disaster preparedness drills. Myanmar has worked together with INGOs and ASEAN countries for exchanging experiences and drawing disaster reduction plans as the world has seen bigger and increasing number of disasters, he said. Myanmar enacted the Disaster Management Law on 31 July, 2013.

To have a well coordinated and coherent action in preparedness for disaster management, the Government has formed the ' Formation of National Natural Disaster Preparedness Central Committee" with its Notiffication No. 45/2013, and ' Formation of National Natural Disaster Preparedness Management Work Committee' with its Notification No. 46/2013 on 14 May 2013.

Myanmar carried out a series of workshops in 2011 at the subnational levels with relevant stakeholders in order to assess country progress in implementing the 12 EHA benchmarks. The workshops were jointly conducted by the Myanmar Emergency Preparedness and Response (EPR) Programme of the Department of Health and the EHA Programme of the World Health Organization. Technical working groups meeting was conducted on 22n^{d} December 2011, lead by Deputy Director General (Disease Control) and participants of Directors from DOH, Department of Meteorology and Hydrology, Department of General Administration of Ministry of Interior Directors from Department of Relief and Resettlement, Ministry of Social Welfare, Relief and Resettlement, Department of Fire Brigade, Secretary of Myanmar Maternal and Child Welfare association and Directors from MRCS were attended. Also the State and Regional RRT members are presence. The member are divided into three group and assessment of emergency preparedness and response was done on following days to discuss the tools and make necessary changes and amendment to the tools to fit and finalize

the tools to be used in the assessment. An emergency preparedness and response assessment workshop using the adopted tools was held at conference room of Disease Control Unit, Department of Health, Nay Pyi Taw on 23-24 December, 2011.

Goal of the Assessment

- To combat the disaster and its grave consequences by effective implementation of Emergency Preparedness and Response (EPR) Program in Myanmar.

General Objective

- To develop plan of action for emergency preparedness and response programme in Myanmar through assessment of implementation status of key elements of the SEAR Benchmarks.

Specific Objectives

- To review the 12 EHA SEARO benchmarks through consultative workshop.
- To assess country progress in terms of implementation of the benchmarks.
- To prepare strategies and plan of actions for updating and efficient implementation of the benchmarks.

The Benchmarks include:

Benchmark 1. Legal framework coordination mechanisms and an organizational structure

Benchmark2: Regularly updated action plan and SOPs for disaster preparedness and response

Benchmark 3: Emergency financial, physical and regular human resource allocationand accountability procedures established

Benchmark 4: Rules of engagement (including conduct) for external humanitarian agencies based on needs established

Benchmark 5: Community plan for mitigation, preparedness and response developed, based on risk identification and participatory vulnerability assessment and backed by a higher level of capacity

Benchmark 6: Community-based response and preparedness capacity developed, supported with training and regular simulation/mock drills

Benchmark 7: Local capacity for emergency provision of essential services and Supplies (shelters, safe drinking water, food, communication) developed

Benchmark 9: Capacity to identify risks and assess vulnerability at all levels established

Benchmark 10: Human resource capabilities continuously updated and maintained

Benchmark 11: Health facilities built/modified to withstand the forces of expected events Benchmark12: Early warning and surveillance systems for identifying health concerns established. Each benchmark was assessed and identified its achievements and gaps and recommendations were given for each benchmark. The general comments are:

The rapid assessment of emergency preparedness and response of the health sector of Myanmar had still needs to do a lot to strengthen its capacity and capability to prepare and response to disaster situation. It is needed to strengthen multi-sectoral coordination at central and district

level, train more health workforce on emergency preparedness and response with close supervision, allocate adequate budget to regional, district and local level based on evidence, ensure clear roles, responsibilities and regulations to external agencies working on health sector emergency preparedness and response and finally massive awareness raising at the community level. There should be strengthen of national health contingency plan, emergency logistics plan and drills and simulation exercises to test the contingency plans. The public private partnership must be strengthened for ongoing funding for EPR and higher involvement of private sectors, academic institutions and others for EPR in Myanmar. So that this rapid assessment of emergency preparedness and response on disaster for health sector in Myanmar is very useful for our country especially for health sector development on disaster management and so also for emergency preparedness and response action for future. EPR has followed the mentioned recommendation and started fulfilling the gaps for our further improvement of emergency preparedness and response of health sector in Myanmar.

Myanmar Red Cross

The 1959 (MRCS) Act confers responsibility to the National Society in implementing humanitarian activities and alleviating human suffering. The St. John Ambulance Brigade Overseas was taken over by the Society as Burma Ambulance Brigade under the 1959 Act. The Society was renamed Myanmar Red Cross Society in accordance with legislative change of the name from Burma to Myanmar in 1989. In line with country's policy and general environmental developments, the following amendments have been done till date:

(1) 1964 Law of Amending the Myanma Red Cross Society Act,1959: insertion of words in s. 12;

(2) 1971 Law of Amending the Myanma Red Cross Society Act,1959: Substitution of s. 5 and 7;

(3) 1988 Law of Amending the Myanma Red Cross Society Act, 1959: Substitution of s. 7'4

The objective of the Society is to alleviate human suffering. Three activities such as promoting health, preventing diseases and providing help to those in distress are supportive activities to meet the objective.

As the leading humanitarian organization, Myanmar Red Cross Society (MRCS) is committed to assist vulnerable people and to improve and maintain their health and well-being. The Society obtains the best relations with UN Agencies, Non Government Organizations, Press and other public information media. News coverage of Red Cross Activities in the whole country is constantly made by the press, radio and television news stations.

Vision and mission

MRCS' vision is "to be the leading community-based humanitarian organization throughout Myanmar acting with and for the most vulnerable at all time."

Mission

Through its nationwide network of volunteers, the Myanmar Red Cross Society will work to promote a healthier and safer environment for the people of Myanmar giving priority to the most vulnerable communities and individuals. In times of distress and disaster, MRCS will assist those affected and help them return to normal life.

Strategic plans

Future plans and actions are clearly defined in the MRCS strategic plan (2007–2010). Activities are defined under five programme areas: Organizational Development, Health and Care in the Community, Disaster Management, Cooperation and Coordination and Financial Resources Development, with these, the Society is putting her ablest effort to deliver efficient effective humanitarian services in Myanmar.

Governance and management

The General Assembly is the highest governing body of the Society and is convened every three years. The Central Council is the governing body of the MRCS between the sessions of the General Assembly. The Central Council comprises 40 members, out of which 17 members represent States and Divisions level branches. The governance of the Society is formed by 10 Executive Committee members. 5 out of 10 members are retired professionals and who work full-time on voluntary basis, are responsible for providing guidance for making policy, giving directions and guidance in the implementation of the activities of the Society. The structure of National Headquarters (NHQ) consists of six Divisions and two Units. They are Administrative Division, Disaster Management Division, Finance Division, Health Division, Training Division and Communication Division, Development and Coordination Unit and Protocol Unit.

The management is headed by the Executive Director, who is the full-time Executive Committee member of the National Society. The Executive Director carries out his functions under the authority of the Central Council and the Executive Committee. The Society is the largest humanitarian organization in Myanmar with its nationwide network of 324 branches (townships) with over 250000 volunteers throughout the country.

Awards

A member of Myanmar Red Cross Society won Henry Dunant Medal in 1963 for saving a soldier whose car fell into the Ayeyarwady River which was icy cold at that time . His name was Sai Aung Hlaing Myint. He was from Kachin State.

Part II

Policy Mapping

Leadership and Governance

Introduction

Governance in health is being increasingly regarded as a salient theme on the developmental agenda. Leadership and governance in building a health system involve ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system design and accountability. The need for greater accountability arises both from increased funding and a growing demand to demonstrate results. Accountability is therefore an intrinsic aspect of governance that concerns the management of relationships between various stakeholders in health, including individuals, households, communities, firms, governments, nongovernmental organizations, private firms, and other entities that have the responsibility to finance, monitor, deliver and use health services. Accountability involves, in particular:

- Delegation or an understanding (either implicit or explicit) of how services are supplied;
- Finance to ensure that adequate resources are available to deliver essential services;
- Performance around the actual supply of services;
- Receipt of relevant information to evaluate or monitor performance;
- Enforcement, such as imposition of sanctions or the provision of rewards for performance.

Governance in health is a cross cutting theme, intimately connected with issues surrounding accountability. In the context of health system strengthening, it is an integral part of the health system component. Despite consensus on the importance of leadership and governance in improving health outcomes, they remain inadequately monitored and evaluated. Health legislations play a crucial regulatory role in the governance and leadership component of the health system. As it is so important it will be taken up the whole section of Part III and this section will confine on the followings:

- National Health committee
- Decentralization;
- Universal Health Coverage;
- Framework for Economic and Social Reform;
- Governance – M-HSCC; and
- Health Impact Assessment (HIA)

National Health Committee (NHC)

The National Health Committee (NHC) was formed on 28 December 1989 as part of the policy reforms. It is a high level inter-ministerial and policy making body concerning health matters. The National Health Committee takes the leadership role and gives guidance in implementing the health programmes systematically and efficiently. The high level policy making body is instrumental in providing the mechanism for intersectoral collaboration and coordination. It also provides guidance and direction for all health activities. The NHC is reorganized in April 2011.

Composition of National Health Committee

Union Minister, Ministry of Health	Chairman
Union Minister, Ministry of Labour, Employment and Social Security	Vice-Chairman
Deputy Minister, Ministry of Home Affairs	Member
Deputy Minister, Ministry of Border Affairs	Member
Deputy Minister, Ministry of Information	Member
Deputy Minister, Ministry of National Planning and Economic Development	Member
Deputy Minister, Ministry of Social Welfare, Relief and Resettlement	Member
Deputy Minister, Ministry of Labour, Employment and Social Security	Member
Deputy Minister, Ministry of Education	Member
Deputy Minister, Ministry of Health	Member
Deputy Minister, Ministry of Science and Technology	Member
Deputy Minister, Ministry of Immigration and Population	Member
Deputy Minister, Ministry of Sports	Member
Council Member, Nay Pyi Taw Council	Member
President, Myanmar Red Cross Society	Member
President, Myanmar Maternal and Child Welfare Association	Member
Deputy Minister, Ministry of Health	Secretary
Director General, Department of Health Planning, Ministry of Health	Joint Secretary

National Health Plan (2001-2006) in the objective frame of the short term second five year period of the Myanmar Health Vision 2030, a 30 year long term health development plan.

Considering the rapid changes in demographic, epidemiological and economic trends both nationally and globally, Myanmar Health Vision, a long-term (30 years) health development plan has been drawn up to meet any future health challenges. The plan encompasses the national objectives i.e. political, economic and social objectives of the country. This long term visionary plan with its objectives will be a guide on which further short-term national health plans are to be developed. The objectives of the Myanmar Health Vision 2030 are:

- To uplift the Health Status of the people.
- To make communicable diseases no longer public health problems, aiming towards total eradication or elimination and also to reduce the magnitude of other health problems.

- To foresee emerging diseases and potential health problems and make necessary arrangements for the control.
- To ensure universal coverage of health services for the entire nation.
- To train and produce all categories of human resources for health within the country.
- To modernize Myanmar Traditional Medicine and to encourage more extensive utilization.
- To develop Medical Research and Health Research up to the international standard.
- To ensure availability in sufficient quantity of quality essential medicine and traditional medicine within the country.
- To develop a health system in keeping with changing political, economic, social and environmental situation and changing technology.

National Comprehensive Development Plan - Health Sector (2010-11 to 2030-31)

As an integral component of the long-term visionary plan, the National Comprehensive Development Plan (NCDP) - Health Sector (2010-2011 to 2030-2031) has been formulated based on changing situation. The formulation of the NCDP must link with related sectors as well as also link with the States and Regional Comprehensive Development Plans. This long term visionary plan with it objectives will be a guide on which further short-term national health plans are to be developed. So also it links with the Spatial Planning.

National Health Plan (2011-12 to 2015-2016)

Based on Primary Health Care approaches the Ministry of Health had formulated four yearly People's Health Plans from 1978 to 1990 followed by the National Health Plans from 1991- 1992 to 2006-2011. These plans have been formulated within the frame work of National Development Plans for the corresponding period.

National Health Plan (2011-2016) in the same vein is to be formulated in relation to the fifth five year National Development Plan. It is also developed within the objective frame of the short term first five year period of the National Comprehensive Development Plan (NCDP) – Health Sector, a 20 year long term visionary plan. With the ultimate aim of ensuring health and longevity for the citizens the following objectives have been adopted for developing programs for the health sector in ensuing five years covering the fiscal year 2011-2012 to 2015-2016:

- To ensure quality health services are accessible equitably to all citizens
- To enable the people to be aware and follow behaviors conducive to health
- To prevent and alleviate public health problems through measures encompassing preparedness and control activities
- To ensure quality health care for citizens by improving quality of curative services as a priority measure and strengthening measures for disability prevention and rehabilitation

- To provide valid and complete health information to end users using modern information and communication technologies
- To plan and train human resources for health as required according to types of health care services, in such a way to ensure balance and harmony between production and utilization
- To intensify measures for development of Traditional Medicine
- To make quality basic/essential medicines, vaccines and traditional medicine available adequately
- To take supervisory and control measures to ensure public can consume and use food, water and drink, medicines, cosmetics and household materials safely
- To promote in balance and harmoniously, basic research, applied research and health policy and health systems research and to ensure utilization as a priority measure
- To continuously review, assess and provide advice with a view to see existing health laws are practical, to making them relevant to changing situations and to developing new laws as required

Decentralization

Decentralization of health-care services is an essential element of health systems strengthening. The aims of decentralization are to improve the efficiency and effectiveness of health service delivery and the equity have resulted in the identification of strategic actions that need to be undertaken to address the challenges of capacity-building and management of human resources for health in the context of health systems decentralization and urban health. A regional seminar on "Decentralization of health care services in the South-East Asia Region: perspectives and challenges" was held in July 2010 to guide countries in this effort.

In line with the new National Constitution 2008, the change in governance has already taken place. The governance institutions and central---local relations are critical to the future of Myanmar, and they are undergoing significant change. The new state and region structures created under the 2008 Constitution, and their relationship with broader peace and decentralization processes. State and region budgets are as yet small, and prepared in a way that reinforces central influence. Further reforms are needed to align the new political structures with administrative and fiscal arrangements, broaden the scope of decentralization to more significant areas, and link it with wider democratization, peace and public administration reform processes. The President, in consultation with the Chief Justice of the Union, nominates the state/region Chief Justice. There is a state or region Advocate General, nominated by the Chief Minister. A Constitutional Tribunal of the Union considers constitutional disputes between regions, states and the union. Schedule Two of the Constitution lists areas over which the state or region government has legislative powers; it also assigns the states and regions executive or administrative authority over the same areas, and new responsibilities may be added under union law. These areas are divided among eight sectors, each with specific responsibilities.

Fiscal decentralization is taking place gradually. There is a state/region budget that comprises the income and expenditures of those departments and state economic entities that are associated with the state and region government. The scope of this budget remains small—probably under five percent of public spending when both transfers and local revenues are included. This state/region budget is also not fully devolved, in the sense that control over budget composition and priorities is still limited and centralized. There is limited scope for the state/region to prioritize between sectors, and the budget is subject to central review in the Union Financial Commission. On the other hand, the development of more predictable, transparent, and rule---based intergovernmental fiscal institutions can go a long way towards strengthening fiscal autonomy. States and regions are already collecting significant revenues, but local tax policy and administration is still underdeveloped and there is room to support further improvements. S*ome devolved cross---sector development funds*: The introduction of a cross---sectoral "poverty reduction" grant has been an important innovation that creates a need for planning and prioritization within states and regions. At this early stage implementation of the grant has varied, and currently there is no real rational basis for its allocation across the country, other than giving an equal share to most states/regions. However, this grant creates an opportunity for both central and state/region stakeholders to work together to develop a sound, transparent, and rule---based inter---governmental fiscal system linking the centre with the states and regions.

The formation of state and region governments is a major development. The establishment of *hluttaws* in states and regions has created new opportunities for debate and discussion. In ethnic states, regional and ethnic parties have gained significant representation. Following the space of political, administrative and financial devolution, health sector has initiated meso-planning for the formulation of current NHP 2011-2016. A full scale devolution may take some time.

Universal Health Coverage

The new Constitution enacted by the Union of Republic of Myanmar in May 2008 provided the legal framework for a series of institutional and policy reforms to advance the country's democratization, including, including a core commitment for the state to strive earnestly to improve the health of its people. The *Article 367* states that 'every citizen shall, in accord with the health policy laid down by the Union, have the right to health care. As early as 1953, the country had laid the foundations of a comprehensive health care system, establishing a network of township hospitals and rural health centres that, by the mid-1960s, covered every administrative district. Universal Health Coverage (UHC) has been described in the Part I of this presentation.

However, in shaping up an appropriate UHC Policy, some of the countries experiences will be presented first and will follow with *Myanmar Perspectives in UHC*. This presentation will focus on the historical, political, and economic trends associated with progress toward universal health coverage.

UHC signified that:

- Universal health coverage has been defined in terms of rights to health care, financial protection, and utilisation of health-care services
- Universal health coverage can be achieved through many different health financing systems, although the pooled share of health expenditures predominates in all successful cases
- The political processes leading towards universal health coverage differ between countries, but they are allubiquitous, persistent, and contingent
- Political action to universalise health coverage is the major force behind the rising share of pooled financing of health expenditures
- Growth in health spending is driven primarily by rising national income and the expanding range of medical interventions, with population ageing playing a small part

Countries that want to achieve universal health coverage need to adopt public policies that reduce reliance on out-of-pocket spending and improve the institutions that manage pooled funding to address the equity, efficiency, and sustainability of health expenditures.

The share of the population with financial protection through enrolment in health insurance schemes is a common measure for universal health coverage. It is a useful indicator in health systems that manage access by explicitly enrolling individuals or groups with institutions that pay for or directly provide health-care services. However, enrolment rates will overstate cover age in countries where health-care supply is restricted or geographically concentrated, and where required co-payments are a substantial share of household income. Insurance enrolment also cannot be used to measure coverage in countries that offer all. Rights establish legal entitlements and insurance enrolment establishes a contractual promise, but neither one indicates whether people are effectively using the health-care services that they need. Therefore, a third approach is to use health-care utilisation as a measure of progress towards universal health coverage. Utilisation is a better measure than either rights or enrolmentbecause it is directly related to the aim of providing real access to health services, Beyod rights, enrolment and utilization, progress toward universal health coverage can also be assessed less precisely but more comprehensively with reference to the characteristics of countries that are commonly recognised as achieving it.

Institutionally, one important thing in common: they depend on substantial shares of pooled financing. In health systems, pooled financing is money raised through taxes or premiums that individuals must pay whether or not they need care. The criteria for contribution of funds (such as occupation or residence) are different than the criterion for the receiving of benefits, namely the need for health care. Although political trends drive the key reforms necessary to achieve universal health coverage, economic trends also play a substantial part. In particular, economic growth generates both resources and demand for expanded health-care provision. As a result, countries dedicate increasing shares of national income to health-care services, more

services are provided, and this contributes to better health. The way countries reform their systems also affects the composition of this growing health expenditure.

Increases in national income affect health spending and the cost of universal health coverage in several ways. As households grow wealthier, they are able to purchase more health care and more health insurance. As countries grow wealthier, they can mandate larger contributions by employers and households or they can raise taxes from a larger economic base. At both the household and government level, increasing income raises the eff ective demand for health-care services. This increased demand is off set, to some extent, by the ways income contributes to improved health. With more income, households tend to purchase more food, better clothing, improved sanitation, and other goods and services that contribute to health. Governments in higher-income countries, too, can invest in improved environmental and public health services that improve health and reduce demand for health-care services.

Changing medical practices seem to be the biggest contributing factor to growing health expenditures. Such practices make it possible to prevent or treat more illnesses even as they raise the costs of achieving universal health coverage. These changes are related to technological innovations that substitute for earlierdrugs, diagnostics, and procedures, or address disorders that were previously untreatable. They might also include the application of existing treatments more extensively and intensively. Studies have shown that the application of new medical technologies extensively and intensively accounts for between a third and two-thirds of the growth in health spending in the USA and France.

Low-income and middle-income countries are also affected by changing medical practices. Demand for advanced medical technologies and new drugs have driven-up costs to public health programmes in many of these countries. Adoption of these practices makes the addressing of many illnesses and injuries possible, but also increases the challenge of financing universal coverage. Where health care is restricted to small shares of the population, simply extending existing health services to more people is likely to be the bigger challenge.

Universal health coverage costs money but it doesn't have to be expensive. Good health can be achieved at low cost whenever countries allocate resources towards more cost-effective care as shown in several low-income countries and regions. Countries are likely to be more successful if they recognise that political action is needed to direct future growth in health spending through pooled financing mechanisms that enable the promotion of equitable and efficient health care. Countries are more likely to succeed if they identify and mobilise the groups and institutions that are most favourable to the provision of universal access, negotiate public roles that are compatible with their domestic political institutions, aim to extend health-care access to everyone, and take advantage of cost-effective approaches and cost-constraining strategies.

Myanmar Perspectives - Myanmar Health Vision 2030 aspires to build on the past health status improvements and move towards Universal Health Coverage (UHC). UHC would help

achieve the Ministry's twin goals of improved health outcomes and reduced financial burden on the poor and vulnerable, due to health expenditures. MOH has conducted four consultations on UHC so far (July and November 2012 and September, and November, 2013), involving relevant departments, ministries and development partners. Based on these consultations, this policy brief outlines the main considerations that Myanmar would need to take account of, on this journey towards Universal Health Coverage (UHC).

The Government has set itself a target of increasing health expenditures by 1% of GDP annually between 2011 and 2015 (currently 2.4% of GDP), primarily by increasing public expenditures on health (currently 3.5% of total government expenditures). The Government also plans to extend social security benefits coverage to all Government employees, establish social health protection schemes to vulnerable populations with support from development partners and provide priority to ensuring universal coverage of maternal, neonatal and child health (MNCH) as well as essential drugs. Additionally, the Government is exploring other options both to (a) increase the resources available to health sector and (b) improve the efficiency, effectiveness and equity of health care services. The Government is open to public-private partnerships as one of the approaches to achieving UHC, acknowledging the large role that private financing and provision already play in the health sector of Myanmar.

The Government's commitment to putting Myanmar on the path to Universal Health Coverage is strong. Myanmar recognizes that UHC can be achieved only by sufficient attention being paid to all three of its inter-linked dimensions, i.e., population coverage, service coverage and financial coverage. The Government will soon formalize its commitment to UHC, translate it into policy, allocate adequate financial resources and assign the institutional responsibility of taking it forward to an appropriate department. The UHC movement in Myanmar will proceed through broad consultation and advocacy efforts directed at policy-makers and political leadership, both at the central and regional/state levels. The consultation and participatory engagement process will go beyond the Government and development partners, to include communities across the country - especially to understand the client perspectives on health needs and the related financial needs, their current and future expectations on both aspects.

Increased public financing for health services - be it channeled through the traditional line budget mechanism or through an insurance mechanism which may involve a third-party purchasing agency or a combination of mechanisms - would be the key to mobilizing adequate resources for UHC. In this regard, MOH will work closely with and take account of the social protection policy and social security scheme being established by the Ministry of Employee, Employment and Social Security. Other relevant ministries such as the Ministry of Finance, National Planning and Economic Development, Defense, Forestry and Environment, Transport, Education, etc. will also be engaged actively. The UHC financing mechanism will be set in the context of the Framework for Economic and Social Reforms (FESR: 2012 to 2015) and the long term National Economic Comprehensive Development Plan [NCDP: 2011 to 2030].

Health Systems Strengthening (HSS), so as to ensure supply side readiness is another pre-requisite for UHC, which is not merely about health financing. Achieving UHC critically hinges on ensuring the supply of sufficient quantity and quality of the needed services - from the public and the private providers of health care. Therefore, all the components of health systems, including infrastructure, human resources, supply of essential commodities including medicines, information systems and effective governance will be strengthened sufficiently to assure access to service delivery of acceptable quality across the country.

The UHC consultations have initiated the process of explicitly defining an Essential Package of Health Services (EPHS)**,** i.e., services and interventions to which every citizen of Myanmar would be entitled, regardless of his/her ability to pay for it. This will be an iterative process, involving technical, financial, and socio-political considerations. Taking inputs of other relevant officials and stakeholders, the package will be defined, costed, and revisited as needed. The service coverage may have to be phased in. Different components of the package for universal coverage would be rolled out in phases, e.g., by making MNCH and essential medicines available to all in the first phase, with other services to be added later on, towards the eventual goal of UHC. It is understood that the package would be subject to future updating as the epidemiological, financial and social contexts change.

The population coverage of certain services may also need to be phased in; this shall be achieved in an equitable manner, with a focus on the poor and vulnerable and hard-to-reach areas being a priority. Some services may be extended to the whole country at once, while others may take time to get nationwide coverage.

The Government will appropriately coordinate the support offered by Development Partners**,** based on the Nay Pyi Taw Accord (2012). MOH has upgraded the Country Coordination Mechanism into Myanmar Health Sector Coordinating Committee, under which seven Technical and Strategy Groups (TSG) are being set up. One of the TSGs will focus on Health Systems Strengthening (HSS) and UHC. Development Partner support is going to be vitally important for analytical work, technical assistance and
south-south learning.

The initiatives charted out and essential actions collectively undertaken were to improve health systems, and build capacity, so that universal health coverage could be achieved. Universal health coverage is the overarching goal of health for all, and aims not only to provide financial and social protection against catastrophic health expenditure to the whole population, but also to provide equitable access to necessary health care, including public health interventions. This was particularly relevant to the nation as a large number of people incurred high out-of-pocket expenditure on health, sinking deep into debt in the process, with dire social and economic consequences. It is therefore essential to have a well-defined ESHP, ensuring an equitably access to a need based comprehensive qualitative care to all; a legislative process in this regard will sustain the goal

Framework for Economic and Social Reform

The President announced a "second stage of reforms" in May 2012, focussing on the social and economic transformation of Myanmar. In accordance with vision his and guidelines, the Framework for Economic and Social Reform (FESR) was developed in consultation with senior officials of various ministries and departments of the government from the period of May to October, 2012. FESR outlines policy priorities for the government in the next three years while identifying key parameters of the reform process that will allow Myanmar to become a modern, developed and democratic nation by 2030. In this regard, FESR is an essential policy tool for the government to realize both the short-term and long-term potential of Myanmar.

A detailed discussion on FESR has already been made elaborated in Part I.

Myanmar Health Sector Coordinating Committee (M-HSCC)

In 2011, following decades of isolation, Myanmar embarked on an unprecedented opening up and reform process. These seismic shifts have raised the hopes of its people for democratic rights and have created significant external expectations. Myanmar's reforms have been welcomed by the international community and have been accompanied by rising levels of aid. These funds, if properly handled and spent, offer an opportunity to harness Myanmar's economic potential and make it work for poor people by reducing inequality, providing essential services, building resilience, and promoting sustainable investment. Myanmar's reform commitments are still a long way off delivering a fully functioning democracy, but good-quality aid can help speed up and deepen those democratic reforms if it is delivered in a way that supports accountability to citizens and empowers the government and people to fight poverty and inequality. This means aid needs to:

- Support civil society and the public to voice their concerns to government;
- Help to increase transparency in government processes;
- Build the capacity of civil society to monitor budgetary and other government processes;
- Strengthen the role of citizens in shaping the development agenda by giving them a voice in designing and implementing aid and development policies that target their needs;
- Strengthen core government functions to deliver on essential services and security, maintain human rights and justice, and ensure a fair distribution of growth and prosperity.

The Government of Myanmar has shown leadership in taking the first step towards good-quality aid by agreeing the Nay Pyi Taw Accord for Effective Development Cooperation, a commitment that sets out how the government will ensure that development cooperation is accountable, democratic, and targeted towards reducing poverty and inequality. In addition, key

policy processes, such as the Framework for Economic and Social Reforms and the National Comprehensive Development Plan, have been developed. Critically, the development of Myanmar's aid architecture offers a unique opportunity to bridge this gap and facilitate the building of resilience to shocks, stresses, and uncertainty. Inclusive, equitable, and sustainable growth could help to reduce Myanmar's devastating levels of poverty and lay the foundations for longer-term prosperity. Key obstacles to development and economic growth are conflict and the threat of disasters from natural hazards, and sufficient levels of predictable, good-quality aid are essential to meet immediate humanitarian needs and to build resilience. The international community and the aid it provides can be key catalysts, but to be effective and have a coordinated approach through forming the Myanmar Health Sector Coordinating Committee (M-HSCC).

M-HSCC is the main health sector partner and stakeholders coordination structure in Myanmar, the M-Health Sector Coordinating Committee acts as a "catalyser" to aid the country in obtaining the following expected benefits:

- Improved health care coverage
- Reduction in morbidity
- Improved health status of the people
- Improved medical education
- Development of health research
- Development of traditional medicine
- Improved health knowledge of the people through effective information, education and communication activities

These Governance By-laws were drafted and endorsed by the M-HSCC as a guideline and a reference, and is binding upon the Secretariat and Executive Working Group of MHSCC, M-HSCC Chair and Vice Chair, all Members of the M-HSCC. The Governance Manual should remain a living document and be regularly updated to correspond to the actual situation of the M-HSCC. This on-going review process must be conducted via group discussions and the reception of comments from all M-HSCC members until a final version of the document is officially approved. The Myanmar Health Sector Coordinating Committee has a broad mandate as a national coordinating body for all public health sector issues. The Governance Manual lay out the guidelines for the M-HSCC members to guide the Ministry of Health in strengthening the Health Sector. The M-HSCC was established as an expansion of the scope of work and areas of oversight of the former M-CCM, a Global Fund Country Structure in charge of overseeing the national response to AIDS, malaria, tuberculosis, as well as supervising the implementation of maternal and child health strategies and the achievements of Millennium Development Goals.

The objectives of the M-HSCC Governance Manual are:

1. To provide a reference framework that facilitates the understanding of the organization and general operation of the M-HSCC, the coordination structure in charge of overseeing

the implementation of the National Health Plan.

2. To present the strategic framework that supports the mission, vision, roles, responsibilities, functions, organization and general operation of M-HSCC, as well as the set of organizational systems and structures that integrate it.
3. To serve as a guide for the induction and direction of the new members of the M-HSCC.

M-HSCC Mission

The mission of the M-HSCC is its purpose, its rationale. It guides the orientation, consistency in implementation of decisions and activities carried out by all of its members. It is the central point around which members define their interventions, establish goals, and make progress in a common direction, and concentrate on what they know and do better.

Accordingly, the mission of the M-HSCC is the following:

"The M-HSCC is Myanmar's Health-Sector coordination entity, which exists to contribute to improving the health and well-being of the population, by advising the Ministry of Health in strengthening the Health Sector, while considering and respecting the input of its members. As such, the M-HSCC emerges as a coordination structure for health partners alongside and in support of the Ministry of Health and its ministerial management structures."

M-HSCC Vision

Visions allow organizations to "pave the way", to move away from their current location pointing at the final destination they intend to reach. Accordingly, the vision of the M-HSCC is the following:

"As we move together toward our national objectives of uplifting health, fitness and educational standards of the entire nation; implementing the National Health Policy, developing a new health system in keeping with political, economic and social conditions; and strengthening rural health services, the M-HSCC will support the Ministry of Health in coordinating all strategic efforts to ensure that the National Health Plan and its supporting strategies are implemented via a health sector-wide approach that involves the participation of committed stakeholders and partners."

Objective of the M-HSCC

The main objective of the M-HSCC is to contribute to improving the health and well-being of the population of Myanmar. The specific objectives of the M-HSCC include the following:

1. Advising Ministry of Health in strengthening the health sector
2. Providing a space for strategic discussion on health-related issues
3. Acting as a coordination body for the health sector.

M-HSCC Scope

The scope of M-HSCC actions is determined by the National Health Plan and its sub-strategies, which does not limit itself to just one disease or individual projects and programs, but to all diseases and public health problems facing the people of Myanmar and to all projects and programs linked to the health sector.

M-HSCC Principles

The M-HSCC adheres to the principles of health systems strengthening, selflessness, inclusive participation, cooperative partnership, integrity, objectivity, accountability, openness, leadership, efficient operation, enforcing gender equity and Human Rights.

Overarching principles:

Universal Health Coverage

In line with its objectives, the M-HSCC will conduct its activities with the goal of universal health coverage included in the list of its desired outcomes.

Enforcing gender equity and Human Rights

The M-HSCC will guarantee that gender equity and Human Rights be respected in all its endeavours.

Selflessness

Members of the M-HSCC should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

Cooperative society

The M-HSCC embraces the principle of cooperative society, that is, one that aims at joining efforts with its members to achieve common goals.

Openness

M-HSCC members should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Leadership

M-HSCC members should promote and support these principles by leadership and example.

Operating principles:

Health Systems Strengthening

The process of identifying and implementing the changes in policy and practice in a country's health system, so that the country can respond better to its health and health system challenges.

The Governance Manual has been adopted and instituted all the rights and responsibilities of the Committee Office bearers and members of the M-HSCC.

Health Impact Assessment

The World Health Organization (WHO) defines Health Impact Assessment (HIA) as a combination of procedures, methods and tools to systematically evaluate the potential effects of a policy, programme or project on the health of a population (positive or negative, direct or indirect) and the distribution of those effects within the population. There has been increasing international attention on the potential for using HIA as a way to mainstream health into sector policies, as evidenced during the World Conference on Social Determinants of Health (October 2011) and the United Nations Conference on Sustainable Development (June 2012). A number of countries have adopted legislative frameworks and governance mechanisms to consider the impact of policies, programmes or projects on health. However, differences in political, socioeconomic and administrative settings lead to substantial variations in the use and institutionalization of HIA. There is limited research on the systematic use of HIA and the institutional processes that support or impede its use.

The Adelaide Statement on Health in All Policies (HiAP) emphasized that government objectives are best achieved when all sectors include health and well-being as a key component of policy development. Health Impact Assessment (HIA) is a useful tool to achieve this. HIA provides recommendations on how a proposed project, programme and policy can be modified or adapted to avoid health risks, to promote health gain and to reduce health inequalities.

In 1999, the WHO Regional Office for Europe published the Gothenburg Consensus Paper, which established a framework for HIA based on a social model of health and the values of democracy, equity and sustainability. In some cases, an equity-focused HIA or Health Equity Impact Assessment is carried out, which emphasizes the importance of evaluating the distribution of the impact and whether these impacts are inequitable within a population in terms of characteristics such as gender, occupational status, ethnic background, wealth and other markers of socioeconomic status, as well as area of residence or other factors affecting specific population groups. Public health authorities can use impact assessments that systematically consider equity issues as one key way to ensure that they meet the public sector duty in the development and delivery of equitable policies, practices and services. If it was a societal and political aim to avoid or minimize negative impacts on health, it would be necessary to feed information on the health impacts of a proposal and its alternatives into the decision-making process. HIA has two essential features:

1. It is intended to support decision-making in choosing between options.
2. It does this by predicting the future consequences of implementing the different options.

HIA is so important for addressing population health and health inequities because it tackles health determinants. It has become a common belief that health is determined largely by factors outside the health-care sector. A widely published model describes five determinants of health:

1. biological factors such as age, sex and hereditary factors;

2. individual lifestyle factors such as eating and drinking habits, physical activity, smoking and alcohol consumption;
3. social and community networks;
4. living and working conditions such as agriculture and food production, education, work environment, unemployment, water and sanitation, health-care services and housing;
5. general socioeconomic, cultural and environmental conditions.

As health determinants often are interrelated and can build complex causal pathways when impacting on health, they should not be viewed in isolation. For example, a lifestyle-related habit such as binge drinking may have been influenced, or even caused by, other determinants, the lack of a supportive social network, for example. Its lack may have been caused by poor living conditions (such as unemployment or residing in a deprived area) which, in turn, may have been influenced by general economic factors. This lifestyle example also refers to the determinants of inequities in health. There are a number of determinants of inequity in health. Social position in society (defined by education, occupation or economic resources) exerts a powerful influence on the type, magnitude and distribution of health risks experienced within different socioeconomic groups. In itself it is important determinant of social inequities in health. Different levels of exposure contribute to the determinants of inequity in health too. Examples include exposure to chemical agents at the workplace, or housing close to busy roads, railway tracks or airports.

From the definition of HIA it follows that it is intended to inform decision-makers by predicting the consequences of implementing different options, thereby enabling them to choose the option most beneficial for health and health equity. If there is participation then the HIA has a further purpose: to involve stakeholders in the decision and make the process more open. HIA brings other benefits. It is extremely effective in encouraging cooperation between different agencies (for example health and local authorities). It increases awareness of health in the community and among decision-makers.

The timing of HIA and the importance of early involvement have been widely discussed in relation to projects; however, with regards to policy-making, which is incremental or cyclical, identification of when to begin an HIA or consider an assessment report is not obvious. However it is a consensus that HIA should be integrated into the policy-making process . Those who carry out HIA need to understand that it is important for policy-makers to “conform to the policy-making timetable, furnish information in a form that is policy relevant and fit the administrative structures of the policy makers”

In all countries where a key informant was interviewed, HIA typically takes place in the beginning of the policy, programme or project development processes. Key informants stressed the importance of undertaking the HIA at an early stage of the decision-making process. In South Australia, an HLA takes place at the policy problem identification stage in cooperation with the sector that initiates the policy or programme. In Lithuania, HIA typically takes place in the beginning of all project development processes; however, there was evidence that in the early planning stage of

spatial planning projects there is insufficient information about the details of the project so in-depth assessment is not possible. HIA is also performed at different planning-level stages, depending on the type of project. In Slovakia and Lithuania, during the development of new policies, the draft policy goes through a consultation phase involving all governmental sectors. Based on their experiences, key informants from countries proposed these core recommendations: embed HIA in national normative systems; clarify definition and operationalization of HIA and develop guidelines and methodological criteria; strengthen and build capacity for HIA practice; and improve cooperation between sectors.

To support progress in the institutionalization and systematic implementation of HIA and to build on the work that is already being done, WHO could continue to advocate the systematic assessment of policies, programmes and projects in countries that have not institutionalized any form of HIA; work to improve the definition of health (determinants and impacts) and cooperate with other agencies, institutions, and organizations to develop methodology and guidelines to strengthen and systematize the coverage of health in other forms of assessments; extend work with more countries to develop governance mechanisms for healthy public policy using HIA in other sectors; and establish a global network of centres to support HIA practice.

In the Region, Thailand has institutionalized the HIA and has included in the National Constitution that it is obliged to perform the HIA in adopting any policy and plan. As there are several evidences of its effectiveness in decision making, Myanmar may also consider as a policy making tool for health challenges.

Health Service Delivery

Strengthening service delivery is crucial to the achievement of the health-related Millennium Development Goals (MDGs), which include the delivery of interventions to reduce child mortality, maternal mortality and burden of HIV/AIDS, tuberculosis and malaria. Service provision or delivery is an immediate output of the inputs into the health system, such as the health workforce, procurement and supplies, and financing. Increased inputs should lead to improved service delivery and enhanced access to services. Ensuring availability of health services that meet a minimum quality standard and securing access to them are key functions of a health system.

Enjoyment of good health is an intrinsic human right. This is entrenched in the Myanmar National Constitution- every citizen has the right to health care. The World Health Organization (WHO) in its Constitution considers that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. A human rights approach to health translates into the right to health; it embodies the right to equitable access to health care, including the underlying determinants of health. Hence, the right to health includes the rights to access safe

drinking-water, proper sanitation and an adequate supply of safe and nutritious food, healthy occupational and environmental conditions, access to information, and others. The importance of health in economic development has been acknowledged by the Commission on Macroeconomics and Health established by WHO in 2000. The Commission states that "ill health undermines economic development and efforts to reduce poverty. Investments in health are essential for economic growth and should be a key component of national development strategies. The greatest achievements can be made by focusing on the health of the poor and on the least developed countries." This has been further recognized with three health-related goals being included in the Millennium Development Goals (MDGs).

As part of ongoing socio-political transformation into a modern and developed democratic nation, Myanmar is embarking on significant reforms of the health sector as well The country is consistently endeavouring, with its limited resources to attain its health objectives and trends in key health indicators show a gradual improvement. Between 2001 and 2011 Myanmar was able to reduce infant mortality rate from 59.7 to 40, under-five mortality rate from 77.77 to 52 and maternal mortality ratio from 2.55 to 1.7, all per 1,000 live-births. In respect of immunization data, measles immunization has increased from 67.7 percent in 1990 to 83.6 percent in 2007. MMR has been 170 in 2011 and projected the targets as 130 in 2021 and 90 in 2031. Over the same period, life expectancy has increased for both men and women. In 2007, life expectancy at birth was 64 years for males and 69 years for females in urban area and in rural area life expectancy at birth for males and females were 63.2 years and 67.1 years respectively.

However, it is acknowledged that there is considerable room for further improvement in health outcomes for Myanmar to compare favorably with other countries of the South East Asia Region. Moreover, the Ministry of Health (MOH) is conscious of the potentially catastrophic and impoverishing effect of the high out-of-pocket expenditures (OOPE) being incurred by the population (65-80% of total health expenditures) with serious implications for equity of access to health care services. In an effort to address this issue, the Government has increased its health spending eight-fold over the past five years, with large capital investments in health infrastructure and a free essential medicine program accounting for most of the increased spending. Still, both the total health expenditures (THE) and Government health expenditures (GHE) in Myanmar are among the lowest in South East Asia.

Among specific diseases, the leading causes of death and illness are TB, Malaria and HIV/AIDS. About 10% of TB cases are co-infected with HIV/AIDS. Malaria is a major cause of death and illness in adults and children. As per morbidity trend of 1988-2011, the number of cases of malaria range from 4.2 million to 8.6 million a year and 76 per cent of the population lives in malaria endemic areas. ith regard to HIV/AIDS, the epidemic is considered to have stabilized nationally since 2000, with 'hot spots' of high transmission in several locations. National surveillance system focuses on the surveillance of the epidemic prone communicable diseases,

emerging infectious diseases and post disaster communicable diseases. Currently, the goal of eradicating poliomyelitis and eliminating measles are set up and all the Basic Health Staff are endeavouring to achieve those goals. The country is currently facing double burden of diseases – Communicable Diseases and Non-Communicable Diseases. Chronic non-communicable diseases with shared modifiable risk factors – tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol includes: cardio-vascular disease, diabetes mellitus, cancer and chronic respiratory disorders. Disasters are also a major health concern. Changing life style and dietary habits, lack of physical exercises and other health damaging practices need to be modified and controlled.

However, the country has attained an impressive health achievements at aggregate level achieved in the past few decades. Stark inequities in access to health-care services and health status were evident due to rapid urbanization and also ethnic conflicts taken place for decades. A clear road map was therefore charted out to meet these challenges. Fundamental to this was good health policy and planning, and the need for well-developed health systems that deliver effective, efficient and equitable health care, which is affordable and of good quality, and without which good health of the population cannot be achieved.

Health systems provide both individual care through medical care and community care through various public health actions or interventions. Both are complementary. While medical care is the individual care a person seeks when confronted with illness, public health services focus on maintaining, preserving and promoting the health of the population. There is ample evidence to show that public health is more cost effective than medical care. Put differently, health interventions continue to be overly focused on management of disease when it occurs rather than on preserving, promoting and maintaining health. This imbalance needs further correction. Equity and social justice are seminal values of the primary health care approach. Primary health care, which is essentially a tool for implementing public health, also improves the quality of life of the population an element that is necessary for a socially and economically productive and satisfying life, and the inspirational goal of achieving “Health for All”.

It is fortunate for the nation that the National Health Policy has placed the Health for All goal as a prime objective using Primary Health Care Approach; so also the provision of the Article 367 of the National Constitution 2008, enacted that ‘every citizen shall, in accord with the health policy laid down by the Union, have the right to health care.’ The ultimate aim is an equitable health status from equitable access to health care, has already been addressed firmly both in the Union Health Policy and the Constitution. It is essential to sustain the effort put so far and if necessary to refocus on health systems development through the primary health-care approach ensuring the constitutional provision of rights to all for health care comprising curative, primitive, preventive including the protection of risks to health.

HiAP

The living environment determines health, and therefore good health depends on a number of social, cultural, economic and environmental factors. In cognizance of this, the Commission on Social Determinants of Health was established by WHO in 2005. This Commission recommended tackling the socioeconomic and political aspects of health to improve health and health equity. Neglecting these social determinants, which are considered as the root causes of health inequity, will negate our efforts to improve health equity. Environmental determinants such as pollution, poor housing conditions, urbanization, migration and environmental changes brought about by climate change are also crucial in influencing health equity. It is thus imperative that a multisectoral approach to health development be adopted. Close coordination and collaboration between related sectors is mandatory for attaining well-developed health systems, for example, by the establishment of Health in All Policies or Healthy Public Policies. This becomes all the more important in view of the looming epidemic of non-communicable diseases which, by their very nature, necessitate a multisectoral approach that addresses, among other things, the social determinants of health. Health is closely linked to development, which is why it is important to keep the benefit of the community at large in mind. Development practitioners must acknowledge emerging health concerns and ensure that the development activities agenda does not adversely affect people's health. In fact, the focus should be on ensuring that development activities contribute positively and provide health benefits to people in the community. The responsibilities of various development sectors are part of "healthy sectoral policy". Health development requires actions beyond those of the health sector and is considered to be an area that needs strong multi-sectoral coordination and cooperation. These are the policies under which respective sectors have to invest in order to ensure rational policy and strategy formulation leading to an enhanced sustainability. Rapid urbanization is heavily taxing the available civic amenities and services, with associated problems of drug addiction, crime, violence, indoor and outdoor pollution, overcrowding, poor sanitation, and more. This calls for an urgent need to forge strong partnerships with all sectors and stakeholders, in order to create a viable and supportive environment to combat the problem at hand. The way forward must commence with the acceptance that the health sector alone is not enough to bring about effective changes to ensure health equity and social justice, and that the solutions to many health problems and health-related issues lie in other sectors. This understanding of the multisectoral nature of health needs to be universally recognized at all levels of development and not only at the top.

It is essential to accord the focus towards providing good health to all citizens, regardless of their social and economic strata. This calls for equity and social justice in the provision of health care and services, and recognizes health as a fundamental right of all. Work needs to be directed towards a social control of health technology – a technology that is affordable, socially and culturally appropriate, and acceptable to all people in the community. Such technology

should also include information that enlightens the population to understand and recognize health risks. Primary prevention, which is achieved through public health interventions, targeting management of health risks and health determinants needs to be in place. The future of health is strongly linked with the results of primary health care initiatives.

The meeting of National Health Committee, highest policy making body in Myanmar originally chaired by Secretary I of the national Government and now by the Union Health Minister, is conducted regularly every three months to make decision on health matters. The National Health Committee composed of Deputy Ministers from Health and other Health related Sectors such as Ministry of Agriculture and irrigation, Ministry of National Planning and Economic Development, Ministry of Education, Ministry of Sports and Ministry of Immigration and Population, etc. Cooperation with the NGO sector at all levels (up to the grass-root level), is well established for contribution in implementation of NHP. In order to strengthen inter-sectoral cooperation activities, National Health Plan dissemination workshops are conducted in all regions.

The range of work for stakeholders varies from pushing health promotion as a priority health concern and facilitating the need for legislative action, to provide technical inputs and guidance. It is a crucial to concentrate attention on legislative actions, policy options and innovative financing as far as health promotion, tobacco control and alcohol are concerned. The focus should be on using public health interventions for reducing poverty. To ensure a significant impact, HiAP should be highlighted and coordinated more transparently and effectively with relevant sectors. At the national level in health sector, National Health Committee can effectively coordinate matters related with HiAP effectively.

Health Care Services

The Ministry of Health is providing comprehensive health services covering promotive, preventive, curative and rehabilitative aspects to raise the health status and prolong the lives of the citizens. With the objective of achieving Health for All goals, successive National Health Plans have been developed and implemented in accordance with the guidelines of the National Health Policy.

The basic health staff down to the grass root level are providing promotive, preventive, curative and rehabilitative services through Primary Health Care approach. Infrastructure for service delivery is based upon sub-rural health centre and rural health centre where Midwives, Lady Health Visitor and Health Assistant are assigned to provide primary health care services to the rural community.

Those who need special care are referred to Station Hospital, Township Hospital, District Hospital and to Specialist Hospital successively. At the State/Regional level, the State/Regional Health Department is responsible for State/Regional planning, coordination, training and technical support, close supervision, monitoring and evaluation of health services. At the

peripheral level, i.e. the township level actual provision of health services to the community is undertaken. The Township Health Department forms the back bone for primary and secondary health care, covering 100,000 to 200,000 people.

In each township, there is a township hospital which may be 16/25 or 50 bedded depending on the size of population of the township. Each township has at least one or two station hospitals and 4-7 RHCs under its jurisdiction to provide health services to the rural population. Urban Health Centre, School Health Team and Maternal and Child Health Centre are taking care for urban population, in addition to the specifically assigned functions. Each RHC has four sub-centres covered by a midwife and a public health supervisor grade 2 at the village level. In addition there are voluntary health workers (community health worker and auxiliary midwives) in outreach villages providing Primary Health Care to the community.

Hospital care

The National Development Plan and is in tandem with the national economic plan. The plan will ensure effective implementation of the National Health Policy. It consists mainly of curative services. Curative services are provided by various categories of health institutions, under the Ministry of Health ranging from teaching hospitals, specialist hospitals, state/ division hospitals, district hospitals and township hospitals situated in urban areas down to station hospitals, rural health centres and sub-centres in rural areas. During the plan period of 2006-2011, the country has 897 hospitals with 42,634 hospital beds under the Ministry of Health. Hospital bed per 100,000 population is 71.06, and doctor nurse ratio is 1:1 in current situation.

The Quality of Health Care Services in Hospitals Project addresses not only to the population in urban area but also to the people living in rural area by providing effective medical care and modern health facilities. Hospitals provide comprehensive health care as first referral, secondary and last referral (tertiary) level curative care facility; they also provide emergency care for the casualties due to the natural and unnatural disasters or the critically ill. Medical care encompasses the general and specialist hospitals at the central and divisional/state level as well as the hospitals at the district, township and rural levels. The need for the maintenance and strengthening of referral facilities at the first referral level is becoming increasingly apparent. So it is the need for maintenance of medical supplies and equipment at all levels of care while trying to upgrade the hospitals in terms of the number of beds, extension of specialist services up to the level of the district hospital, according to the requirements of different specialties.

The average hospital admission rate is 17 per 1000 population and bed occupancy rate based on sanctioned bed is 51.8% and bed occupancy rate based on available bed is 41.6%. The average duration of stay in hospitals is 7days. Despite innovative approaches in the health care delivery system, there are still many shortcomings, such as insufficient drugs and equipment in addition to the shortage of manpower and technology. Although it can be claimed that the large teaching hospital should have the most complex kind of hospital services, especially the peri-urban poor and a large share of the rural population have little access to the high level

technology and manpower in these hospitals, which raises the issue of equity in access to hospitals and health care services.

The following weaknesses could be observed in providing health care services in hospitals: inefficient hospital administration and health management at different levels; insufficient drugs and equipment; shortage of manpower and technology; improper referral system; improper hospital waste management system; improper medical recording and information system; ineffective supply system management. The general objective of the project is to improve the quality of health care services in hospitals and its specific objectives are to increase the ratio of bed to population from 62.07 per 100,000 population to 75 per 100,000 population by 201; to increase the hospital performance indicators from existing figures by 2011; and to reduce the mortality rates in hospitals.

In providing comprehensive health care to the community, new hospitals and clinics are being built and put into service as well as recruiting and training of manpower to meet the quantity and quality standards. The Division of Nursing (DON) is responsible for improvement of the quality of nursing services. DON carries out project activities that focus on quality of nursing and midwifery services, on enabling to equip nurses and midwives with requisite knowledge and skills in order to improve contribution of nursing and midwifery services under their own local health care settings. It has been recognized that strengthening of nursing and midwifery services is highly essential to reduce mortality, morbidity, and disability and for promoting of healthy lifestyles. Improvement of the nursing and midwifery service programme is based on on-going improvement of the quality, efficiency, effectiveness of their services to achieve customer's satisfactions.

Under the broad programme for strengthening of nursing and midwifery services in Myanmar, one of the projects is to develop guidelines for implementing a system of total quality management in nursing and midwifery services; this project aims to improve infection control practices in selected health care facilities as part of the total quality management. The infection control practices in health care facilities is being developed according to the WHO'S practical guidelines for infection control in health care facilities manual and will be adapted based on the needs assessment in selected hospitals. The newly adapted guidelines will be reviewed and applied for nursing and midwifery daily practices that would help to prevent spread of cross infection and further to reduce hospital infection rate so as to deal effectively with newly emerging and re-emerging infectious diseases like SARS, HIV/AIDs, Tuberculosis, Hepatitis as well as other hospital-associated infection. For provision of essential supplies and equipment, practical guidelines for infection control practices will be developed. This practical guideline will be translated into local language (Myanmar) as user friendly initiative down to the grass root level health care providers.

Infection in health facilities is a major health problem; nurses and midwives are exposed to infectious micro-organisms in their everyday life. Infection control programme puts together

various practices which, when used appropriately, restrict the spread of infection. It is important for all health care workers, patients, their family members, friends and close contacts to adhere to the infection control guidelines strictly.

Nowadays emergence of life-threatening infections such as AIDS, SARs, H_5 N_1 infection and re-emerging infectious diseases like plague and tuberculosis have highlighted the need for efficient infection control programme in all health care settings. It is needed to provide adequate resources for effective functioning of the infection control such as aseptic techniques, using of single use devices, reprocessing of instruments and equipment, antibiotics usage and management of medical waste. Incorrect sterilization technique, poor practice as well as insufficient instruction about infection control may lead to increase infection rate, sepsis rate and delay wound healing. Control of infection is an important part of every action that a nurse performs. Although surgical asepsis is commonly practiced in the operation room, labour and delivery area and major diagnostics areas, the nurse must also apply surgical aseptic technique at the clients 'bedside. This would include, for example, inserting intravenous or urinary catheters, suctioning the tracheo-bronchial airway secretions, and making surgical dressing. The main objective of the project is to provide administrator and health care workers with the tools to enable them to implement the infection control programme effectively in order to protect themselves and others from transmissions of infections.

Private Medical Care

In line with the provision of Private Medical Facilities act promulgated in 2007, several private medical settings have been started in the country. As of March 1st, 2011, private hospital clinics licensing have be provided to 151 private hospitals and 521 specialist clinics. It is essential that the private medical sector should be conscious and put more effort not only in establishing more number of hospitals but also to impart the quality of health care services, avoiding from depriving of the patient socio-economic situation due to high health care expenditure. As far as sustaining the quality of health care, standardization of accreditation, formation of provider and customer association, establishing an appropriate health insurance scheme and cooperation with international health care organization are some critical measures need to explore further.

Rural, Peri-urban and Border Health

In conformity with the one of the policy objectives of the National Health Policy to extend health services to the border areas in addition to the rural areas, efforts have been made for improving health care coverage and raising health status of the rural population with the aim of narrowing the health gap between urban and rural. Rural health scheme had been initiated since the early 1950s and the momentum was increased in 2001. Compared with the urban population, high infant and maternal mortality with low life expectancy in rural population were the visible health gaps between the two. Notwithstanding the expansion of health facilities in

rural area with the objective of improving access to primary health care and quality services, achieving the ratio of one rural health centre to 20,000 rural population and one sub-rural health centre to 4000 population remains a challenge because of growing population. During the period of implementing the National Health Plan (2006-2011) only 102 new rural health centres could be expanded although the target was to build 60 new rural health centres and 300 new sub-centres annually for the five year period. As of April 2011, there were only one rural health centre for 26567 rural population and one sub-centre for 5820 rural population. On the average, one health assistant had to look after 23828 population, one lady health visitor- 23925 population, one midwife-4462 population and one public health supervisor grade (2)-25285 population. One rural health centre had to take care of 42 villages where one sub-centre had to cover up to 9 villages.

Since 1989 border area development programme has been initiated to improve the overall situation including health for the national races and population residing in the border area. Various levels of committees for implementing activities for development of national races and border have been formed. With achievement of peace and stability in these areas more health infrastructures and health staff could be provided. Although the health development activities could cover only curative services initially, more comprehensive care applying primary health care approach can now be provided.

With changing economic policy and certain extent of industrial development rural to urban migration for seeking job and economic opportunities is another phenomenon raising health issues particularly in the peri-urban areas. Having no better choice these migrants have to live in sub standard dwelling in places which are overcrowded with poor environmental situation. In addition to the need for expanding health service coverage for the rural population and for those in the border area, health sector is now facing another challenge for providing equitable access to health care for the entire population. Current cycle of the National Health Plan will have to take into consideration provision of basic and essential health services for the peri-urban population.

As a result of strengthening the hospitals by deployment of competent human resources and installation of modern diagnostic and therapeutic equipment, various sophisticated surgical and medical interventions could be performed. In addition to structural coverage and functional quality, more patient centered, responsive and accountable curative services are provided by health staff. Regarding equity in health care, more grass root level centers such as RHCs, Sub-centers and Station hospitals are established, renovated and upgraded either for rural areas and border areas. Although curative service used most of the health care budget, transparent and efficient use of these resources will provide not only community needs but also improve country's health system image. This can earn the trust of community and serve as stepping stone for health promotion at this time.

Medicines and medical equipment are also increasingly provided to each and every health facility. Increased budget are allocated by three mechanisms such as directly to central hospitals or over 200 bedded hospitals, indirectly to 16-150 bedded hospitals through respective State and Divisional Health departments, renovation and increasing supply of CMSD drugs and equipment. These mechanisms will also be necessary initial basics for Decentralization. As a complementary approach, public hospitals throughout the country are also stipulated to raise and establish trust fund and interest earned from these funds are used for supporting poor in accessing needed medicinal supply and diagnostic services where user charges are practiced.

The health development and provision of medical care services for border area have been implemented since 1989 and up to March of 2013, 100 hospitals, 97 dispensaries, 123 rural health centres and 314 sub-rural health centres have been established and are now well functioning in co-operation with other related departments and ministries, particularly the Ministry for Progress of Border Areas and National Races and Development Affairs. Private Hospital and Private Health Care Services have been legally allowed to be registered for holding license during 2010 according to the Law relating to Private Health Care Services adopted in 2007. This is to strengthen the Myanmar Health Care System by augmenting the role of private health sector to fulfill the public needs under the relevant National Health Policy. **The** aims of this Law are as follows:

(a) to develop private health care services in accordance with the national health policy;
(b) to participate and carry out systematically by private health care services in the national health care system as an integral part;
(c) to enable utilizing effectively the resources of private sector in providing health care to the public;
(d) to enable the public to choose as desired in fulfilling their needs for health by establishing private health care services;
(e) to enable provision of quality service at fair cost and to take responsibility.

The private health care services includes:

(a) private clinic service:
(b) private hospital service:
(c) private maternity home service;
(d) private diagnostic service;
(e) private nursing home service;
(f) private mobile health care service;
(g) private health care agency;
(h) private general health care service.

The private health care service is in growing trend both in bigger cities and smaller towns. At the same time type of both medical and surgical care services are expanding. At this junction, it

is crucial to promote the strength and capacity of the regulatory process. The health seeker must receive the quality services in returns of his payment, on a need based and in ethical terms. In the interest of the patient, a proper referral system in exchange of both ways, between public and private medical care services need to be developed. Additional issues will be discussed in health financing section.

Reproductive Health

Mothers and Newborn - Improving maternal and child health has been a key priority in the national policy agenda aimed at reducing maternal, newborn, infant and under-five morbidity and mortality in order to achieve MDG 4 and 5 targets by 2015. Progress was made for maternal and newborn health and birth spacing with a reduction in maternal mortality from 380 per 100,000 in 1995 to achieve the MDG target by 2015 is still a challenge. There was an increase in contraceptive prevalence rate from 37% (2001) to 41% in 2007 with reduction in unmet need which was 19.1% in 2001 to 17.7% in 2007. The fall in maternal mortality has largely been due to the increase in the numbers of births attended by skilled birth attendants. However there are inequities in access to skilled birth attendants in rural and out-reached areas of the country.

Ensuring maternal and reproductive health is a compelling human rights dimension to reducing illness and death associated with pregnancy and childbirth. Universal access to key reproductive health services could help avert up to 35% of maternal deaths. Meeting the Millennium Development Goal 5b of "achieving universal access to reproductive health" has been particularly challenging; the reproductive health strategy should focus on improving antenatal, delivery, postpartum and newborn care; providing high-quality services in birth spacing; eliminating unsafe abortion; combating sexually transmitted infections including HIV, reproductive tract infection, cervical cancer and other gynaecological morbidities; and promoting sexual health.

Merely providing services is not enough; their quality must also be assured. For this, it is important to conduct periodic reviews of programmes. The programme is keeping up its strength in conducting these reviews periodically. and using the findings to design strategies that include the development of standards and guidelines, continuous quality improvement mechanisms, accreditation of service provision, and considering incentives for both users and providers of care.

The coverage of services is as important as the quality. Despite the considerable progress made in improving the coverage of maternal and newborn health services over the past decade, there are disparities in access. These deny women their rights. The high neonatal mortality rate continues to be a cause for concern. The inadequate numbers of, and uneven access to, skilled birth attendants is another area that needs to be addressed promptly.

Child Health – The country has made a good progress in improving child health with its annual rate of under-5 mortality rate reduction at 2.6 between 1990 and 2011. Pneumonia, diarrhoea and newborn complications are the leading causes of child mortality. Rural children and the poorest children are less likely to survive than children in urban areas or are a richer socio-economic status. The country has made significant progress towards MDG 5, although the target has to be achieved. Trends for skilled birth attendance reflect significant disparities by residence and wealth quintiles.

The period between conception and the first few years of a child's life is recognized as one of greatest risk and greatest opportunity. The early years of a child's life are the most critical for growth and development. Children do not reach their full human potential if they do not receive adequate nutrition, care and opportunities to learn. Inability to provide support for health and development of children is a violation of their rights, according to the Convention on the Rights of the Child. Evidence shows that early intervention efforts that target disadvantaged children can lead to improvements in survival, growth, and cognitive and social development. It is the right of every child to both survive and develop. The progress made in reducing under-five mortality can be seen by the falling rates over the past two decades, from 77.77 deaths per 1000 live births in 1988 to 34.91 deaths per 1000 live births in 2010.

This became possible largely due to expansion of child health and immunization services. The capacity building of professionals for providing optimum care for sick children in first referral units is the obvious path to optimize the benefits of IMNCI on child survival. Facility-based integrated Management of Neonatal and Childhood illness (F-IMNCI) is a care package to train health care providers in managing newborn and childhood illnesses at the facility level/inpatient care, providing the important link for care of the sick neonates and children reaching these facilities from primary health care level and the community. FIMNCI has been initiated in Myanmar and four international consultants were provided by WHO as technical support in collaboration with national Neonatologists and Paediatricians for F-IMNCI. For health care providers at primary health care level, workshop on integrated management of newborn and childhood illnesses has been conducted to improve their capacity.

Coverage of effective and relatively inexpensive interventions has to be scaled up to improve child health. The need of the hour is to create awareness among the community of the benefits of breastfeeding and target social customs that prevent exclusive breast-feeding through innovative means such as role models. It is the right of every child to survive and reach their full potential. An equity-focused approach that targets disadvantaged and marginalized children will not only address disparities but also accelerate progress towards the Millennium Development Goals.

More emphasis needs to be placed on improving the nutritional status of children through population wide approaches. Sectors such as nutrition, water and sanitation, which have an effect

on child health, would need to integrate their work with that of the health sector to maximize benefits for newborns and children. The private sector also needs to be co-opted. This is the area where cross-sector public policies that have ensured universal access to education for women, clean water and improved sanitation to the majority, and health system developments that have guaranteed universal coverage of essential preventive, promotive and curative health interventions to all women and children. The increasing coverage with measles, diphtheria, pertussis and tetanus vaccine also plays a crucial role.

Adolescence– Adolescence is the phase of transition from childhood into adulthood, and is characterized by rapid physical, sexual, psychological and social changes. It is a period of promise, when opportunities beckon. It is also a period of anxiety, when adolescents must learn how to cope with the psychological stress of growing up, deal with emotions, resolve conflicts, develop self-confidence, and learn to resist peer pressure. Adolescents are generally considered to be a "healthy" population, as mortality is low in this age group. However, adolescents face numerous public health challenges, which are different from the ones they faced as children, and are unique to their age group. This is the phase of life when behaviours that have serious health consequences in adulthood take root. Nearly two thirds of premature deaths and one third of the total disease burden in adults is associated with conditions or behaviours initiated during adolescence. In addition, their health and nutrition status is important, as this has an effect on their future. Adolescents are thus a vulnerable population with special needs that must be fulfilled for them to reach healthy adulthood.

Adolescents deserve a sound public health response within national programs. It is a common observation that, although health services may be available in countries, adolescents and young people hesitate to use them due to lack of privacy and confidentiality, in addition to many other socio-cultural and financial barriers.

School health - A global school based health survey was conducted among (13-15) age group children in 2007 to assess behaviours of school youth related to food, personal hygiene, mental health, physical exercise, tobacco use, violence and accidents. The study found risk behaviour and practices are not high among the students. The main findings are; possessing healthy behaviours like tooth brushing and washing hands before taking food and after toilet, low use of alcohol and tobacco compared with neighbouring countries, proportion of students with potential to become obese was 3.1 per cent although obesity is not prevalent, accidents more likely among male students and high proportion of students with knowledge on HIV/AIDS. Physical exercise was not common and 24.3 per cent of students stated that majority of students were not considerate and not willing to help others.

A constant vigilance should be placed on development and utilization tools for the assessment of quality and coverage of such services. It is also essential to develop a "Healthy Transition Package", which should cover nutrition, healthy and active lifestyles, mental well-being, immunization, pre-conception counselling, and sexual and reproductive health. It is essential to motivate young people engaging in active livelihood with full conceptualization in sportsmanship in preventing risk factors for non-communicable diseases. Collaboration between sectors must be strengthened to maximize their contributions to adolescent health and development. Strengthening school health programmes and linkages with adolescent health services is one such area.

Healthy behaviour starts at school health. 'What we know is what we learnt in kindergarten'. The future challenge in attaining healthy livelihood will mainly be determined by the lifestyle and behaviour. Effective strengthening the school health programme is the best investment for the future.

The Elderly - Healthy ageing is the process of optimizing opportunities for physical, social and mental health to enable older persons to take an active part in society without discrimination, and to enjoy an independent and good quality of life. WHO's emphasis is on "continuing participation in social, economic, cultural, spiritual and civic affairs, and [not] just the ability [of the elderly] to be physically active or participate in the labour force". Ageing populations have their own unique health problems, apart from their need for social and economic security. While the increase in life expectancy can be seen as a success story of medical advancement and technology, it poses a challenge to society to maximize the health and functional capacity of older people, as well as their social participation and security.

The message for World Health Day 2012 was "Good health adds life to years". This can be achieved through a well-articulated combination of healthy lifestyles across life course, age-friendly environments, and improved detection and prevention of disease. The focus would be on how good health throughout life could help older people lead full and productive lives, and remain valuable resources for their families and communities, irrespective of their functional ability.

Building an age-friendly society requires actions across a variety of sectors other than health, such as education, employment, labour, finance, social security, transportation, justice, housing and rural–urban development. This would call for the involvement of policy-makers in national governments, cities and municipalities; civil society groups and senior citizens' forums; academic and research institutions; private sector enterprises; community leaders and youth groups.

In concluding the Reproductive Health session, the goal of RH is to attain a better quality of life by improving reproductive health status of women and men, including adolescents through effective and appropriate reproductive health programme undertaken in life cycle approach. The National RH Policy is a comprehensive policy where a political commitment is

sustained in accordance with the National Health policy, conforming to the national population policy and will full respect to the related established laws, religion, ethical and culture values. It ensures the provision of a quality reproductive care to all level of public and private and NGOs health care services, with effective partnerships with all stakeholders and accessible , acceptable and affordable to all women and men. It will maintain an effective referral system to all levels and develop appropriate mechanism for information, education and communication. At the same time, appropriate and effective traditional medicines and socio-cultural practices be identified and promoted. An adequate resource be mobilized and maintain to sustain the programme activities.

In this endeavour, issues that have been highlighted need to be revisited and it has been noted that the National Population Policy 1992, is still in draft stage. With the prevailing rapid changes in political and socio-economic dimensions, issues related to legislation of safe abortion and family planning may also be revisited.

Control of Communicable Diseases

Communicable diseases prevention and control is one of the priority tasks of Ministry of Health in achieving its objectives of enabling every citizen to attain full life expectancy and enjoy longevity of life and ensuring that every citizen is free from diseases. The ultimate aim of the Communicable Disease Control Programme is to minimize prevalence and entrenchment of communicable diseases, mortality and social and economic sufferings consequent to these and to provide rehabilitation. As emphasis has been given for control of communicable diseases, plans have been developed systematically for preventing and controlling diseases like malaria, tuberculosis, leprosy, filariasis, dengue haemorrhagic fever, water borne epidemic diseases - diarrhoea, dysentery, viral hepatitis- and other preventable diseases. There have been substantial reductions in mortality and morbidity due to communicable diseases. Many old scourges have been eliminated or identified for elimination. These successes are contributing to overall social, economic and health-related benefits.

However, communicable diseases continue to be one of the most important public health problems in the country. The burden of HIV, tuberculosis (TB) and malaria remain high continue to take a heavy toll on the poor. Because of the huge toll taken by these three diseases, they have been targeted for action to Millennium Development Goal 6. New and emerging diseases, such as avian influenza and severe acute respiratory syndrome, tax already overburdened health systems to the utmost. Development of resistance to effective drugs for malaria and TB in a limited arsenal is another serious threat. The country is striving to respond effectively and efficiently to these challenges with active support from the Development Partners.

With greater awareness, strong policies and increased access to drugs, HIV/AIDS is fast becoming a chronic, manageable disease. During this decade, the HIV epidemic has been halted and reversed in the county. This achievement would not have been possible without

commitment at the highest level. Currently, the country joins the South East Asia Regional Health Sector Strategy, which calls for “zero new infections, zero AIDS-related deaths and zero discrimination in a world where people living with HIV are able to live long, healthy lives”. A major concern is the emergence of multidrug-resistance TB (MDR TB) in the country. Partnerships with international and national NGOs have enabled TB service delivery outreach in remote areas and among marginalized population groups.

Malaria remains a major threat to socioeconomic development in the country, although over the past decade, the reported (confirmed) number of malaria cases per 1000 population at risk has reduced to 8.31 and the mortality is 0.20 per 100 000 population in 2011. Drug resistant malaria has been detected along the international border areas particularly Myanmar Thai border and in some pocket areas in other parts of the country. The Myanmar Artemisinin Containment (MARC) framework was endorsed in April 2011 and the Natioanl Malaria Control Programme (NMCP) together with implementing partners initiated immediate containment actions in July 2011. It is also essential to have collaborative effort by the different ministries such as Ministry of Construction, Ministry of Agriculture, Ministry of Mining, Ministry of Forest and Companies working with the development projects in the regions which are enormously important and without their awareness and collaboration the goal cannot be achieved. Myanmar is on track to achieve the malaria-related Millennium Development Goals. Objectives of National Malaria Control Programme are reduction of malaria 50% in 2016 (baseline 2009) and to contribute socioeconomic development and achievement of health related MDG in 2015.

Expanded Programme on Immunization has adopted Global Vaccine Action Plan (2011-2020) (GVAP), which is the framework approved by World Health Assembly in May 2012. The mission of GVAP is to improve health by extending by 2020 and beyond. All people achieve the full benefits of immunization regardless of where they are born, who they are, or where they live thereby accomplishing the vision of Decade of Vaccine by delivering universal access to immunization. There are (5) principles which are guiding the elaboration of Global Vaccine Action Plan (GVAP) (2011-2020). They are country ownership, shared responsibility and partnership, equity, integration, sustainability and innovation. The accosted multiyear plan of EPI, Comprehensive Multiyear Plan (cMYP 2012-2016) has been amended accordingly. Notable milestones that took place in 2012-2013 were: introduction of Pentavalent vaccines; intensification of routine immunization (IRI); revision of National Policy and Strategy on Routine Immunization and Vaccine Prevention; reforming of National Committee on Immunization Practices (NICP); establishing Cold Chain Logistics Strategies Planning after conducting series of assessment; supplementing immunization activities (SIA); reaching hard to reach population; and newly developed IEC materials in new era of EPI. The revision of National Policy and Strategy on immunization and vaccine prevention comprises of: immunization service policy; vaccine policy; cold chain related policy; and programme management related policy.

In order to further increase immunization coverage, access to services needs to be improved for populations located in remote areas and in difficult geographical terrain. Human resource constraints in these areas also need to be addressed. Stronger integration of surveillance systems is an area where synergies need to be mapped to take advantage of existing systems and adapt them to benefit other programmes. Storage capacity for vaccines, distribution systems, inventory control and management plans need to be strengthened so that immunization campaigns and routine immunization activities can be implemented as per schedule. Adequate funding, both domestic and external, needs to be ensured to support immunization activities, so that shortages or delays in supply do not occur. Growing opportunities through new funding as well as research and development initiatives should be prioritized in the coming years as more immunization programmes mature and the number of basic vaccines offered through routine immunization schedules increases.

National Surveillance System targets epidemic prone communicable diseases, Diseases under National Surveillance (DUNS), emerging infectious diseases, climate related communicable diseases and vaccine preventable diseases. The eventual intend of communicable disease control is the reduction of morbidity and mortality while some of the diseases like poliomyelitis, measles and neonatal tetanus (NNT) are targeted for eradication and elimination goal. The national surveillance system is sensitive enough to detect the outbreaks even in the small scale. Most of the outbreaks are reported through the event based reporting system. On the other hand, media surveillance and rumour surveillance has been strengthening by active and prompt verification of news and rumours on the media including electronic media. That improvement enhances the flexibility of the surveillance system and enables the system to be in line with the developing social and economic system of the country. During the period the system could effectively response to all public health events both the man-made and natural disasters.

There is needed to be fulfilled International Health Regulation (2005) to prevent the international spread of Public Health Emergency of International Concern (PHEIC) including communicable diseases and the Central Epidemiological Unit works closely in collaboration with the International Health Division of the Ministry of Health which take as National Focal Point. National IHR core capacity was assessed in 2012 and based on that IHR Action Plan was developed to meet the timeline challenges of IHR. The assessment of core capacity at Points of Entry including airports, seaport and ground cross points were also conducted in 2012 and Department of Health has been putting its efforts in following recommendations of the regional assessment team. The Government has already drafted the 'NationalNatural Disaster Preparedness Law – 2013 and yet to enact it. However Notification No 45/2013 dated 14 May 2013 has already been notified from the President Office for formation of Central Committee and with Notification No. 46/2013, on the same day for the formation of Management Work Group.

The National Health Policy 1933 broadly cover the overall control of communicable diseases, specifically in number 13, which states that" To foresee any emerging health problem

that poses a threat to the health and well-being of the people of Myanmar, so that preventive and curative measures can be initiated;" and in number 11 it states that" To encourage conduct of medical research activities not only on prevailing health problems but also giving due attention in conducting health system research."

Since the colonial days, the country has the Epidemic Disease Act – 1897, and the Vaccination Act – 1909. These two Acts were repealed with the introduction of the Prevention and Control of Communicable Diseases Law – Law No 1/95. In the year 1972, the Revolutionary Council of Burma, enacted the Union of Burma, Public Health Law – 1972 as Revolutionary Council Law No. 1.

In the Public Health Law, the Chapter 2 covers the prevention of public health related to:

- Environmental health activities;
- Food related activities to the production and sale by public;
- Related affairs to the home utility and heavy product to the public;
- Related affairs to the infectious diseases;
- Related affairs to private clinic
- Related affairs to the necessary drugs for the public use.

After prescribing this law, with in the period before prescribing the necessary rules and regulations, the rules and regulations issued under this law may be continued to exercise if it is not contrary with this law:

- Registration of private nursing-home, 1957;
- The dangerous Drugs Act;
- The Epidemic Diseases Act;
- The Food and Drugs Act (Amendment) Act 1949;
- The Ghee Adulteration Act;
- The Food and Drugs Act;
- The Leprosy Act
- The Vaccination Act

So also the public provision of ***other existing Laws:***

- Factory Act, 1961;;
- The Animal Pest Act
- The Burma Merchant Shipping Act;
- The Burma Air Craft Act;
- The City of Rangoon Municipal Act;
- The Cantonments Act;
- The Municipal Act;
- The Pots Act;
- The Rural Self-Government Act

- The Railways Act;
- The Towns Act;
- The Village Act.

The Prevention and Control of Communicable Diseases Law – 1995 covers: environmental sanitation; reporting Communicable Diseases, including rat fall, outbreak of principal epidemic diseases, and outbreak of notifiable disease; measures taken in respect of an outbreak of principal epidemic disease; and quarantine.

The Municipal Act 1898 was then repealed by the Development Committee Law 1993.The City of Rangoon Municipal Act 1922 was repealed by the City of Yangon Municipal Act 1961. In respect of public health safety, the City of Yangon Municipal Act 1961 covers: factories and trade, market and slaughter houses, weights and measures, seizure of animals, food and drinks, disposal of death, and emergency provision. In the Development Committee Law 1993 it also covers: Registration of births and deaths, drainage of sewages, water supply and dangerous epidemic diseases.

For overall communicable diseases control, the National Health Policy, Public Health Law and Communicable Disease Control Law, Development Committee Law and the City of Yangon Municipal Amendment Act have covered all the essential components comprehensively. The major disease of concern to the country: HIV/AIDS, TB and Malaria, EPI and IHR have its own significant policy, strategies and plans. In all these Policies and Law provisions, multi-sector collaboration and Health in All Policy is deliberately emphasized. However it will provide a higher impact of its intended objectives if the system could further emphasized on regulatory process.

Non-Communicable Diseases Control

Non-communicable disease is a growing burden to the country. It is responsible for about 41 percent of deaths and most common ones are cardiovascular diseases, cancer, diabetes and chronic respiratory diseases, which are the same four global target diseases. The country has conducted several chronic disease risk factor surveillance survey (STEP) and studies based on those results have initiated variable levels of intervention strategies in tackling the main risk factors which are amendable to modification by simple health promotion measures which include the use of tobacco and alcohol, an unhealthy diet (high in total energy, fat, salt and sugar, low in fruit and vegetables).

It is a multi-sectoral issue and involves various ministries in which a multi-sectoral meeting to formulate draft NCD policy and a multi-sectoral meeting to formulate draft alcohol policy have been conducted to address issues that can only be collectively addressed. In case of tobacco, 44.8 percent of males and 7.8 percent of males and 7.8 percent of females are regular smokers. Myanmar Tobacco Free Initiative Project was launched in 2000 and the Control of Smoking and Tobacco Products Consumption Law was enacted on 4 May 2006. Myanmar became a party to the WHO FCTC in2005 and signed the protocol to Eliminate Illicit Trade in Tobacco

Products on 10 January 2010. Health promotion activities including the practice of healthy lifestyles such as healthy diet and physical activity and controlling the use of tobacco products have been on-going in the community.

Chronic diseases, mainly CVD, diabetes, cancer and CRD have a large but unappreciated negative impact on individuals, families and countries and as such are major barriers to human development. Treatment of diabetes, cancer, CVD and CRD are extremely expensive and the cost involved, force families into catastrophic spending and improvement. Injury surveillance, prevention and care programme needs to be further strengthened through multi-sectoral collaboration. The impact goals of 12 GPW with regard to NCD is the reduction in the probability of dying from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases for people aged 30-70 years by 25 percent by 2025.

As Myanmar moves on the path of socioeconomic development there is a shift in epidemiological transition towards non-communicable diseases, out of which accidents and its squeal are the transport and communication. Road traffic accident becomes one of the major public concerns throughout the country with the better transportation. As industrialization is going on the industrial accident is also rising, the next to road traffic accident, and measures should be undertaken for industrial accident prevention also.

Provision of mental health care had been started in Myanmar since 1948, when Myanmar regain independence. In the early days, mental health care system began in hospital setting in Yangon and then extended to Mandalay. Care for mentally ill patients in big hospitals is not effective because the patients were stigmatized and later became institutionalized with prolonged stay in hospital. Mental illnesses are now becoming one of the emerging health problems. It is important that approaches for

mental health care need to be decentralize and institutionalization and stigmatization should be avoided. Mentally ill persons residing in places beyond the road of hospitals are accessible to proper care and attempts have been made to shift mental health care from hospital settings to community settings to ensure effective care.

Drug abuse has become a global problem during the past decade. The problem of Heroin use became acute and widespread during the early 1970, and had started to infiltrate into the mainland cities, especially among the youth. As a result of this changing pattern of involvement, Myanmar economy and Myanmar society is facing a serious threat form it. ATS problem emerged starting from 1999: it is anticipated that ATS would become a major problem in future. The Health sector was assigned to carry out of the following tasks: case detection, treatment and after-care; case follow-up and management; training of health personnel in drug abuse; registration of drug addicts. The Department of Health, has set up a total of (26) major Drug Treatment Centres (40) Subsidiary Centres and (2) Rehabilitation Centres making a total of

(68)treatment centres in the whole country. A new rehabilitation centre named "ShwePyiThit" is now preparing to open at Tima area in Muse Township of Shan (North) State.

The NCD Policy is still in the drafting stage, which is already reflected in the relevant section of Part I. At the Regional level, the Global Framework Convention for Tobacco Control (FCTC) gave a fillip to the efforts. As a member of the FCTC, Myanmar is putting all efforts in aspects of fiscal and legislative measures addressing both demand and supply side of tobacco use.The demand side was addressed by regulating the advertisement and labelling whereas the supply side was addressed by restriction of its sale. The success of tobacco controls depends on a combination of good science (support by professionals), social participation and a high political commitment.

Myanmar launched its Tobacco Free Initiative Programme in 2000. Prior to this, health education and tobacco control measures have been conducted by different organizations, but the launching of a specific TFI project reorganized the efforts and increased the momentum. The National Policy on Tobacco Control and National Plan of Action was approved by the Ministry of Health in June, 2000.

The National Tobacco Control Committee was formed in March 2002. The formation of this Committee by the highest office of State Peace and Development Council shows the high political commitment towards tobacco control. It plays a major role in setting policy guidelines for tobacco control and in coordinating and collaborating multisectoral mechanism for anti-tobacco activities. Salient policy and legislative documents related to tobacco control are:

Legislation, rules and regulations related to The National Tobacco Control Policy are:

- Prohibition of Smoking at Theatre's Act – 1959
- Commercial Tax Law - 1990
- Public Health Law – 1972
- Child Law – 1993
- Protection of Non-smokers' Helath Act – 2002
- Standing orders from DoH, Department of Sports and Physical Education,
- Schools – DoH and Department of Basic Education
- Factories Occupational Health Department
- MCWA
- Regulation concerning Tobacco Advertising
- Department of Developmental Affairs, Ministry of Progress of Border Area

For the effective implementation of comprehensive tobacco control measures, the State Peace and Development Council has officially formed the *National Tobacco Control Committee* which is headed by the Minister of Health and consists of heads of departments from various sectors such as education, sports, information, revenue, agriculture, trade etc and also chairs of local NGOS. The Secretary of the Committee is the Director General of the Department of Health and the Joint Secretary (1) is the Director (Public Health) of the Department of health. This

committee has *set guidelines for tobacco control measures* which include widespread health education on dangers of tobacco use, banning of tobacco advertisement from all forms of media, putting up of health warning signs on cigarette packages, inclusion of ant-tobacco message in school curriculum of basic education and all medical and para-medical schools, collaboration and co-ordination between different sectors and local as well as international NGOs.

The National focal point for tobacco control is the project manager of Tobacco Free Initiative Project which is currently taken responsibility by the Assistant Director (Primary Health Care) of the Department of Health. The focal point is also joint secretary (2) of the National Tobacco Control Committee and is fully responsible for coordinating between related departments and NGOS for the successful implementation of the National Tobacco Control Programme. The programme activities are well coordinated among all the governmental and NGOs: Office of the Attorney –general; Ministry of Information and Department of Public Relations and Psychological Welfare; Ministry of Education; Ministry of Sports; Ministry of Trade; Ministry of Finance and Revenue; Ministry of Border Area Development and Developmental Affairs; Ministry of Transport and Ministry of Railway Transportation; Ministry of Labour; Ministry of Agriculture; UN Agencies and INGOs; Myanmar Maternal and Child Welfare Association.

For narcotic control, the following law and rules are enacted:

1. The Narcotic Drugs and Psychotropic Substance Rules – 1985; and
2. The Narcotic Drugs and Psychotropic Substances Law – 1993

The Narcotic Drugs and Psychotropic Substance Rules, 1985 covers: opium poppy cultivation and protection of opium poppy straw; manufacture, sale, export of opium; manufactured drugs, import, export and transhipment of narcotic drugs and psychotropic substance; and psychotropic substances. The principal aim of the Narcotic Drugs and Psychotropic Substance Law, 1993 is to prevent dangers of narcotic drugs and psychotropic substance which can cause degeneration of mankind. It covers: formation of Central Body and its functions and duties; formation of Working Bodies and Regional Bodies; Registration, medical treatment and cancellation of Registration of a drug user; Rehabilitation; and Search, Arrest and Seizure of Exhibit.

As described, the non-communicable diseases, both the morbidity and mortality tend is rising in the country. Among the disease burden, the accident rates excluding the traffic accident is also at the higher end. The Developmental Committees Law provides several preventive measures not only in sanitary practices but also hazards related to structural development. Due to unique situation of the development sector, Yangon and Mandalay Cities have separate laws to cover their special situation. Recently in March 2012, the Pyithu Hluttaw also enacted the Environmental Conservation Law 2012, which has covered all the reservation of resources and production without deteriorating the environment and dramatically reduce the detrimental risk factors to health of the people

In non-communicable disease control, several law and legislation have been enacted which are very much in line with the objectives of the National Health Policy. Of the two strategic pathways that are employed for prevention and control of NCDs, the 'population approach' rather than the "high risk approach", should be focused and advocated. This particular approach aims at reducing the risk factor levels in the population as a whole through community action, in order to achieve mass benefit across a wide range of risks and cumulative societal benefits. Tobacco and narcotics can be controlled by law and legislation, but physical inactivity and unhealthy diet are also major contributing factors for NCDs. A change in lifestyle approach should be appropriately advocated.

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Nutrition Promotion

About 10 percent of the population of 60 million is estimated to be below the official food poverty line, with many pockets of high levels of food and nutrition insecurity across various states/regions and villages despite the country being a net exporter. Generally, food poverty is higher in states than regions and in rural (which comprise 69% of the entire population) than in urban areas. Household income food expenditures have increased sharply, to as high as 73 percent of many population groups, which has also increased indebtedness. The IHLCA survey (2007) has also shown increased incidences of landlessness in recent years (in the range of 30 percent of the rural population).

The goal of the National Plan of Action for Food and Nutrition (NPAFN) is to ensure adequate access to, and utilization of food that is safe, adequate and well-balanced on a long term basis in order to enhance the physical and mental development of the people of Myanmar.'
The Guiding Principles are:

- The overall goal of the NPAFN is food and nutrition security for all. This implies the need for improvement of in-country responses to achieve food security such as improved production of foods that will enhance the diversity and nutritional quality of local foods, improved complementary foods using locally available and affordable foods, improving nutritional content of processed foods
- Advocate for nutrition-focused development. There is a need to promote nutrition as the goal of national development as well as relevant sectoral policies.
- Evidence based nutrition-specific as well as food based interventions proven to be cost-effective will be promoted and scaled up
- Priority will be given to households and individuals with less access and most food insecure and nutritionally vulnerable
- Good governance is at the centre of all efforts to promote food security and nutrition wellbeing but equally considers the responsibility of families and communities to ensure nutritional well-being of its members through provision of adequate care. In short, bottom up approach will also be espoused.

Strategic Objectives:

Ten (10) strategic objectives that will have to be met if food and nutrition security is to be achieved:

1. Promote consumption of healthy foods and Improve Nutrient Intake
2. Prevent and reduce food, water, vector —borne and infectious diseases
3. Increase and diversify domestic food production
4. Improve access to food
5. Improve mother and child care practices
6. Improve environmental health and food safety
7. improve institutional capacity and coordination
8. Improve Human capacity
9. improve quality and quantity of information
10. Increase investments in nutrition and food security

The NPAFN implementation roadmap is based on the prioritization and sequencing principles. For this NPAFN roadmap implementation will be carried out over a time frame of 5 years which can be considered medium term. However, some of the interventions can be implemented over a short-term period. Hence, the interventions can either be implemented on the following time periods:

- Short-term: Implementation over the next 2 years (2011— 2014)
- Mid-term: Implementation over the next 5 years (2011-- 2016)
- Long-term implementation over the next 20 years (2011-2030)

While there is not an exact match between the three strategic dimensions of the NPAFN and time periods mentioned above, the goal is to largely address all immediate causes in over the next two years. The underlying causes will be largely addressed over the next five years (coinciding with rapid scale up) and the basic causes will be addressed starting the period covered by this NPAFN but may have to be extended beyond the scope of this NPAFN.

Working and Governance Structure

Policy framework

The NPAFN will not operate in a vacuum. In fact, it will leverage on a number of existing relevant policies, legislations, laws and regulations developed by different sectors, and by international treaties and conventions including its constitution that will contribute towards the creation of an enabling macro-environment. It is recognized that the interventions identified to address the causality of food insecurity and malnutrition require a nutrition sensitive policy environment. Foremost of these policies and strategy papers are:

National priorities

The *National Economic and Social Development Plan 2011/12-2015/16*sets a vision for the country to become a peaceful, modern and developed nation. Some immediate objectives set for the financial year 2011-2012 include: (i) continuation of the infrastructure development, (ii) development of border areas, (iii) development of rural areas, (iv)poverty alleviation, (v) achieving MDGs 1 and 7, and (vi) maintaining good economic foundations and financial conditions. To achieve these objectives, the following planned interventions, relating to the agriculture, livestock, fisheries and forestry sectors, are prioritized for implementation in 2011-2012:

- To encourage the establishment of agriculture-based industries and other industries for building an industrialized nation.
- To expand agriculture, livestock and fishery sectors in order to meet ever-increasing local demand and to promote exports.
- To endeavour to meet the targeted yields of designated crops.
- To expand new cultivable land for agricultural use.
- To address shortages in edible oil and lubricant oil.
- To promote widespread use of biodiesel to supplement lubricant and fuel needs.
- To restore and expand forest area coverage.
- To conserve natural resources and protect the environment.

In November 2011, the government launched a *National Strategy on Rural Development and Poverty Alleviation* focusing on the following eight priority areas: 1) agriculture production; 2) livestock and fisheries production; 3) rural productivity and cottage industry; 4) micro savings and credit enterprises; 5) rural cooperatives; 6) rural socio economy; 7) rural renewable energy; and 8) environmental conservation.

The agriculture sector has declared as one of its priority areasthe needs of local consumers, the export of surplus agricultural products, and contributing to rural development. It allows freedom of choice in agriculture production, expansion of agricultural land and safeguarding the right of farmers, and engages the participation of private sector.

Key strategies for agriculture development include development new agricultural land, providing sufficient irrigation water, supporting agricultural mechanization, applying modern agro-technologies, and developing and using modern varieties.

The *Agriculture Sector Review* undertaken in 2004 recommended to focus on i) developing a consolidated database on rural statistics, ii) developing poverty profile for all townships, iii) mainstreaming of landless households, iv) addressing land tenure right issues, v) developing potentially viable livelihood options, vi) developing viable farming system options, vii) investing more on rural infrastructure development, and vii) improving access to education and health services for rural population.

Sub-sectoral priorities have been articulated in various national policies and priority frameworks, notably the National Economic and Social Development Plan 2011/12-2015/16, the

National Strategy on Rural Development and Poverty Alleviation, the 2004 *Agriculture Sector Review,* **and** the *National Millennium Development Goals.* What follows summarizes these priorities.

Crop subsector priorities The responsibility for the development of the crop subsector to achieve the planned targets of the National Economic and Social Development Plan 2011/12-2015/16 rests with the Ministry of Agriculture and Irrigation (MoAI). In this context, the MoAl has adopted the following policies and measures:

- To emphasize production and utilization of high yield and good quality seeds
- To conduct training and education activities for farmers and extension staff to provide advanced agricultural techniques and to introduce agricultural knowledge with primary and secondary level students to produce qualified agricultural technicians from State Agricultural Institutes and Yezin Agricultural University
- To implement R&D activities for sustainable agricultural development
- To protect farmers' rights and benefits
- To assist farmers to get fair price on their produce
- To assist in lowering the production costs, increasing high quality crop production, developing and strengthening of markets
- To encourage transformation from conventional agriculture to mechanized agriculture
- To undertake renovation and maintenance works on old irrigation, pumping and underground water systems
- To support rural development and poverty reduction activities through development of agriculture sector
- To help strengthening of markets and allowing farmers freedom of choice for crop cultivation
- To encourage local and international investment in agriculture sector for the development of advance dagricultural technology and comer cialagriculturalproduction, and
- To justify and amend the existing agricultural laws and regulations in line with current economic situation

Five key priorities were set to ensure the development of the crop subsector: (i) strengthening of profitable and sustainable market for farmers, (ii) utilization of good quality seeds to produce quality products for higher price, (iii) utilization of Good Agricultural Practices (GAP), (iv)application of agricultural inputs such as irrigation water, chemical and natural fertilizers efficiently, and (v)reduction of production costs and transactional costs along the supply chain. Efforts are being made to improve the production and productivity of ten principal crops namely rice, sugar cane, long staple cotton, maize, groundnut, sunflower, black gram, green gram and pigeon pea.

Livestock and fisheries subsector priorities The Ministry of Livestock and Fisheries (MoLF) is responsible for ensuring that the targets set in the National Economic and Social Development Plan 2011/12-2015/16 are met. The objectives of the livestock sector are to: (a) improve livestock and livestock products for domestic consumption through improved animal health care, (b) increase the draught cattle population, proportional to crop area expansion, (c) promote trade in livestock and livestock products, and (d) investigate identified products and conduct related research on various aspects related to biological production.

The fisheries subsector aims to: (a) support rural development through the extension of aquaculture activities, (b) increase export earnings from shrimp aquaculture, (c) sustain and increase the fisheries resources of both inland and marine waters, (d) accelerate the integrated fisheries development process without impacting on the natural environment and (e) adopt and implement an extension programme to ensure sustainable fisheries development. Priority areas for intervention by the MoLF to ensure the development of the fisheries subsector are: (a) expansion of shrimp breeding farms, (b) prevention of natural resource spoilage by inland and offshore fisheries, (c) acceleration of development momentum for inland fisheries in order to satisfy domestic consumption needs.

Overall, the MOLF plans to (a) promote sufficient investment in the livestock and fisheries subsectors through private-public partnership, and (b) upgrade the socio-economic status of communities whose livelihoods are dependent on the livestock and fishery subsectors in a gender-equitable manner. This has a bearing on the extent to which women are engaged in the livestock and fishery subsectors and are dependent on them, often as their primary livelihood.

Forestry subsector priorities -The National Forest Master Plan (NFMP), a 30-year roadmap (2001/2002-2030/2031) for effective and efficient conservation of forest resources, reflects not only the current status of forests in Myanmar but also the social and macroeconomic policies of the country. The Plan's focused objectives are developing rural communities, alleviating poverty and conserving the environment; this is to be accomplished through the creation of job opportunities, affording permission to use forest lands and extraction of NWFPs and diversification of cooking energy sources and incomes. Establishment of forest plantations and community forests, promotion of bio-energy and NWFPs, human resource development and forestry extension services are major thrusts of the NFMP.

Myanmar's Rural Development and Poverty Reduction Strategy - aims to reduce poverty levels to 16 per cent by 2015. The strategy prioritizes agricultural production, livestock and fishery, rural productivity and cottage industries, micro saving and credit enterprises, rural cooperative, rural socio-economy, rural energy, and environmental conservation.

The National Health Policy (1993) aims for "Health for All", with primary health care as the main approach. Since 1991, short term National Health Planshave been developed and implemented, as an integral part of the National Comprehensive Development Plan**,** in tandem with the National Economic Plan**.** The main objectives of the National Health Plan (2006-2011)

included are to develop the national health system, enhance the quality of health care and coverage, and accelerate rural health development activities.

Achievement of the long-term Myanmar Health Vision 2030**,** set out in 2001, will contribute significantly to reducing malnutrition in Myanmar. Eliminating or reducing communicable diseases will positively impact on nutrition status, since infectious diseases like diarrhea, ARI, malaria and measles are important causes of malnutrition. Similarly, universal health services coverage will help prevent malnutrition, and will facilitate early diagnosis and treatment. Obesity, caused by changing food consumption patterns and unbalanced diets, cause non-communicable disease like cardio vascular diseases, high serum cholesterol, hypertension, diabetes mellitus and cancer. Good nutrition can help in the prevention and control of overweight and obesity, and associated health problems.

The Public Health Law and related notifications and updates have been issued by the Ministry of Health since 1972. These include laws related to food and drug activities. In addition to guidance from the Public Health Law, Myanmar food control activities are conducted in line with the National Food Law(1997), Departmental Directives and refer to **Codex** guidelines and standards.

Multi-sectoral and multi-stakeholder coordination mechanisms

The working and governance structure for the implementation of the NPAFN builds on the existing structures however, it should be recognized that there are organizational constraints that may warrant the establishment of a new multi-stakeholder platform for the NPAFN. A robust decision-making process and mechanisms by which those decisions are implemented are extremely important for translating NPAFN into operational terms. As such the National Nutrition Centre (NNC) of the Department of Health should perform the following functions:

- Overall design and implementation of the programme and its results
- Channeling and mobilizing appropriate resources for the different strategic directions)=-
  Monitoring and evaluation
- Aligning with broader development strategies
- Aligning with sectoral policy processes
- Setting priorities a, targets and guidelines for the programmes
- Identifying key implementation functions
- Diagnosing capacity and capacity gaps
- Providing overall supervision

Coordination among the various institutional and non-institutional stakeholders is important to effectively address the NPAFN focus areas, ensure smooth planning, mobilize and allocate human and financial resources and create legislative and policy support for the interventions. The actual effectiveness of the coordination mechanisms depend on the power of the institution that is accountable for it. The institutional home, NNC, is also the "guardian of the coordination process".

High-level leadership

The institutional mechanism that provides high-level leadership is organized as the Central Board for Food and Nutrition to be chaired by the Deputy Minister for Health and co-chaired by Deputy Minister for Ministry of Agriculture and Irrigation and Deputy Minister for Ministry of Livestock and Fishery and Directors General of relevant sectors as members. The concerned institution acts as the high-level reporting and decision making body, takes policy and major strategic decisions, and ensures full commitment from all relevant stakeholders.

Inter-Ministerial / Inter-Agency Technical coordination

An interagency technical working group that includes the senior technical staff or representatives of the public sector and other important groups such as academia, national and international NGOs, civil society and bilateral donors will be (re)established. This body will function as an oversight committee, requesting groups to assume accountability for programme components and activities and reinforcing internal control mechanisms including the monitoring of the implementation and progress and effectively coordinate all cross-cutting issues related to nutrition and food security, and report to the high-level leadership body.

It was also recommended and has been approved to form the Food and Nutrition Working Group (FNWG) and Food and Nutrition Advisory Group (FNAG) composed of retired technical experts or those working with UN agencies be constituted to provide technical advice to this high level body. The composition is given in Annex 11

Ministry / agency level coordination

Each of the Ministries / agencies involved in the implementation of the NPAFN will outline arrangements for planning and implementation of the sector-specific interventions and for coordinating activities with actors within their respective organizations that participate in the promotion of improved nutrition and food security in Myanmar. Each ministry involved in the implementation of the NPAFN, will report on a regular basis to an inter-ministerial coordination body.

The final governance structure will be decided by the Government and communicated to all policy and implementing bodies.

Regarding monitoring and evaluation - To ensure a solid planning process, guide implementation and measure outcomes and impact, a solid basefining in terms of a National Survey on the key indicators is most urgent and important. This type of survey should take place also midway the implementation road map and at the end.

In addition, a National Monitoring and Evaluation (NME) system will be put in place but will build on existing information systems like census, IHLC, M ICS, Integrated Food Security

Phase Classification (IPC) and Food Security Information Network (FSIN). FSIN is a network of technical experts and information managers from lead food security stakeholders in Myanmar. The FSIN seeks to improve food security information systems by linking local knowledge with national strategic bodies and policy makers. To do so, the FSINfocuses on building local capacities in terms of information collection and manages a joint food security monitoring system in some of the most food insecure states/regions in Myanmar. Food security monitoring activities are conducted pre-monsoon, mid monsoon and post monsoon, covering approximately 60 townships. There are currently 12 members of the FSIN including UN agencies, international NOs, local NGOs and community-based organizations. On the other hand, the Integrated Food Security Phase Classification (1PC) is an analysis tool to consolidate food security and nutrition indicators and produces a concise statement on food security situation. It is being successfully introduced in Asia by FAO, WFP and other global 1PC partners, with financial support from the European Union.

Reports and other dissemination materials will be prepared based on the information generated by NME to inform and advocate among politicians, policy makers, and donors. Moreover, it will guide program planners and implementers and other stakeholders on the progress of the implementation of the NAPFN to ensure effective and efficient implementation of identified interventions. NAPFN will be associating with the following POAs:

- National strategy on Infant and young child feeding (IYCF) and Home fortification
- The Five-Year Strategic Plan for Child Health Development (2010 – 2014)
- The Myanmar National Strategic Plan on Adolescent Health and Development (2009-2013)
- The Five Year Strategic Plan for Reproductive Health (2009-2013)

Health Workforce and Professional Ethics

Introduction

A competent and motivated health workforce forms the core of a high-quality and efficient health system. Countries need to have adequate numbers and types of health workers with the appropriate mix of skills and required competencies. These health workers should be equitably distributed to provide high-quality and responsive health services that meet the needs of the individuals, families and communities. The country is currently challenged with problems of health workforce shortages, mal-distribution, inappropriate skills mix, and limited capacity for the management and deployment of human resources for health.

In 2006, the Health Ministers of the Region adopted the Dhaka Declaration on “Strengthening Health Workforce in Countries of the South-East Asia Region”, in which they

reaffirmed their commitment to an effective and motivated health workforce. A regional consultation on "Strengthening human resources for health management in countries of the South-East Asia Region" was convened in February 2012 to review the progress made in implementing the recommendations of the Dhaka Declaration. WHO, SEARO also supported countries to strengthen their information systems for national human resources for health, including development of their country human resource profiles to provide comprehensive and up-to-date information for informed policy- and evidence-based decisions. In addition, countries were encouraged and supported to establish a national human resources for health "Observatory" and strengthen existing mechanisms to provide a forum for generating evidence, monitoring progress and policy dialogue on human resources for health. The Regional Committee in its Sixty-fifth Session in September 2012 adopted a resolution on "Strengthening health workforce education and training in the Region" to draw the attention of Member States to the urgent need for improving health workforce education and training.

To effectively address the crisis in human resources for health, as it is highlighted in NHP 2011-2016, the Ministry of Health through multi-sectoral consultation has adopted the Health Workforce Strategic Plan (2012-2017), which is composed of four principal pillars of action plan:

1. Strengthen the leadership and management;
2. Ensure availability and deployment of adequate number and mix;
3. Ensure availability of a competent and motivated health workforce;
4. Ensure efficiency and address equity issue.

It is truly an impressive and promising Strategic Plan in addressing the HR issues and the effective implementation will certainly strengthen the health system and will accelerate achieving MDG in short term and sustaining the momentum of the Universal Health Coverage.

Currently health workforce programming are implanting with to objectives of: to produce different categories of human resources for health in accordance with the National Health Plan which is in line with the National Health Policy; to produce adequate and qualified postgraduate health personnel for delivery of comprehensive, health care to the community effectively and efficiently; to strengthen the infrastructure of institutes and training schools for production of human resources for health sufficiently and efficiently; to develop a system for continuing medical education in accordance with the progressive and changing trends in medicine, science and technology; and to promote educational research in medical and health professional institutes and to develop ICT network system in order to improve teaching/learning activities to keep abreast with global standard. In order to achieve these objectives, the strategies include: production of different categories of human resources for health by coordination and cooperation with other programmes; opening of new institutes and training schools systematically in accordance with human resources for health needs; production and provision of teaching/learning materials with advances in technology; review and revision of the curricula

according to the changing trends in medical education; provision of continuing education opportunities for different categories of health personnel; and promotion of educational research activities for the teaching/learning activities.

The priority activities include: training and production of qualified medical doctors and postgraduates medical professionals; training and producion of Basic Health Services workers; expansion of postgraduate training programmes based on the country needs; effective utilization of modern technology in provision of medical education programme; and to develop a master plan for human resources for health. The activities being carried out in partnerships with: a close collaboration among the departments within the ministry, intersectoral cooperation, cooperation with NGOs and UN Agencies and China Medical Board.

Retention

Myanmar is included in the 57 countries having a number of health workforces (doctor, nurse and midwife) below the World Health Organization (WHO) benchmark of 2.28 per 1,000 populations which fail to attain the 80% coverage rate for deliveries by skilled birth attendants or for measles immunization (WHO, 2006). Also in 16 member countries of the Asia Pacific Action Alliance for Health (AAAH), as of 2010 there have been 7 countries that were under threshold level where Myanmar was one of it. Any shortage of health workforce could lead to poor access to health services and become a barrier to universal coverage. In addition to critical shortage, mal-distribution between rural and urban area was still pronounced and this could make a dramatic impact on health care to rural communities. According to worldwide distribution of physicians and nurses it was found to be 24% rural: 76% urban for physicians and 38% rural: 62% urban for nurses .

Even though rural retention of HWF has been conducted by MOH in many ways, there is a lack of thorough assessment whether the interventions or strategies on promoting rural retention work are working well or not and also there is a need to identify of areas for improvement of policies that have been operated for many years without evaluation. A study was conducted in order to better understand the content, process and outcome of various existing government policy interventions on retaining health workforces in underserved areas in Myanmar, as regards continuous professional development, compulsory rural service and financial incentive. It was convened by the representatives from the Department of Health (DOH), Department of Medical Science (DMS), Department of Medical Research (DMR) and the Department of Health Planning (DHP) under the Ministry of Health (MOH) in collaboration with the World Health Organization (WHO) in order to enable stakeholders to assess the potential channels for the country to take action on policies concerning “Increasing access to health workers in remote and rural areas through improved retention”. The main goal was : To better understand the content, process and outcome of various existing government policy interventions on retaining health workforces in underserved areas in Myanmar and link to six different country contexts in Asia Pacific Region, with two research questions:

1. What kind of policies has been developed and endorsed by MOH and/or line ministries to retain the rural health workforce in Myanmar?
2. What are possible recommendations to improve effectiveness of policy implementations in Myanmar?

The review covered the period from 1980 to 2009. Some policies were directly set from the central government at that time (Socialist Republic of Union of Burma, Sate Council-1980) and some were directives produced by the Executive Committee Meeting at the MOH following the policy/guidelines from the central government that were later internally circulated as standing orders. During 1990's at the State Law and Order Restoration Council (SLORC) and State Peace and Development Council (SPDC) period, the National Health Committee was formed (28-12-1989) chaired by the Secretary General 1.

The most common problems or difficulties met in serving at hardship areas mentioned by the participants from township level (TMOs, HAs and MWs) were:

- Security
- Transportation
- Accommodation
- Insufficient salary
- Lack of specific rules or criteria for posting at hard-to-reach (i.e. duration of stay and for getting transfer from hard-to reach areas)
- Some also mentioned cultural beliefs, language barrier and lack or limited facilities at health centers.

Most respondents gave common suggestions for rural retention of health workforce such as--

- *Providing accommodation for BHS*
- *Getting enough facilities at health centre*
- *Applying reward and punishment policy*
- *Providing support in terms of food (eg. Rice)*
- *Appointing vacancies of health staff*
- *Ensuring security for health staff*
- *Providing communication and transportation facilities*
- *Recognition and appreciation*

Clinical rotations for the health professionals at rural areas during studies happened to be mandatory for doctors, nurses and BHS in the country and the curricula also reflects rural health issues. As for CPD for doctors, policies on post graduate studies were found in desk review but as far as linking to the qualitative results, most of the health professionals did not believe in obtaining post graduate degrees will make them retain in service, further less for serving in rural areas. From the FGD it was discovered the importance of pre-service attitudinal training for making them serve the country and rural communities after graduation. Also development of

tutor mentor system for assessing the improvement of students will make CPD happen. The country do not practice mandatory CPD for nurses associated with relicensing every 5 years which is practiced in Thailand (ibid) but we have in-service continuous medical education (CME) which was not considered by the respondents as CPD.

In-depth analysis of compulsory service reveals the policy formulation, contents, the effect of implementation and changes in policies during these decades. By exploring the opinions and outlook of senior level officials, both from academic and service side, many long term experiential comments upon this theme were revealed. As for compulsory rural service, though it was not set as such for medical doctors many policies reflected the theme such as NSM, Junior AS posts, Rural Health Doctors, compulsory entry into service in 1993 and followed by 3-year bonders. However all categories of BHS and nurses are tuned to the fact that they have to serve in the rural areas. It was highlighted that although policy on compulsory rural service or compulsory service was there, it was not accompanied by any kind of incentive or support to serve in the rural communities.

As regards policy formulation it was based upon the situation and need at that time for making a change in situation like creating Junior AS post at the time of People's Health Plan 1 where rural health care was given more attention and rural health development was working hand in hand with Farmer's Organizational Plan. Also there has been a concept behind creation of Rural Health Doctors, assigning medical officers at those RHCs liable to become Station Hospital or Station Health Unit in the future which was also in the era of enhancing rural development. Policy for recruitment of doctors changes with time, set by highest authorities from MOH, UCSB and Ministry of Finance & Revenue with no involvement of stakeholders' assessment for acceptability. It was according to need based during 1993 when three years compulsory service was set due to shortage of medical doctors graduating from the three medical institutes but there was no plan for rural retention of health workforce at that time. It was not accompanied by any kind of incentives instead dismissal from service was there if failed to continue serving in hard to reach areas. The only compensation after years of experiment was giving a month's training course and providing Sa Ma to all graduates including those three years bonders who had left the service without any Sa Ma because of dismissal at that time. It was found that once notified a policy, all doctors have to follow if they are entering the service, without any knowledge on contents of the policy and go wherever posted. Many doctors and BHS reflected the hardship they had to face in the rural and remote areas and wished fairness and transparency in posting and transfer. No indicators have set for measuring progress or monitoring the implementation of any policy and this is the weakness found to be reviewed.

Actually rural retention is linked with all three policies and implementation on compulsory service, continuous professional development and financial incentive Myanmar having 70% of total population residing in the rural areas and to cover health care for them, first referral level 16-bedded Station Hospitals of more than 500 in number should be strengthened

and many discussions from FGD catered towards how to make it happen. Many respondents reflected that for rural retention the doctors at station hospitals were to be well equipped with skill training, medicines, facilities, financial incentive, good communication and transportation means and promise to call back after one or two years so that they will have sense of belonging while staying there and will work well and rural retention will be sustained.

Apart from medical doctors, rural retention of BHS is also very important as they are the first line cadres of HWF. Financial incentive and supportive measures including opportunities for continuous professional development was also mentioned to be put into policies for rural retention. Although met with hardships at the remote and rural areas with meagre amount of support such as rainy season ration of rice, most BHS had faced those difficulties and endured in service as they have the sense of belonging to rural and remote places. Their needs of supportive measures have to be considered seriously and more widely in addition to what central level think for them as their needs especially recognition and awards for their achievement. As the midwives have to perform multipurpose health activities, the UN agencies and Implementing Partners who are supporting the health programmes of MOH should also pay attention to these kinds of incentive creation for sustainability of improved performance by them. For instance the best retention strategies appear to be those that combine financial and non-financial incentives by GTZ in Africa. Experiences from applying a mix of financial and non-financial incentives in Zambia, Ethiopa and Ghana with the support of GTZ shows positive impact after introduction of refresher training course (a mix of continued medical education), providing housing, establishment of clear career structure and defined number of services in hospitals; and creating an award scheme, closer supervision and team building efforts respectively. Service output indicators such as antenatal care and EPI coverage have improved with lesser applications for transfer from the health workers.

There were many reflections upon effect of changes in policy as regards recruitment of health workforce according to high school final markings could end up in having nurses, midwives, health assistants with less dedication and could lose workforce when posted to rural and remote places. Suggestions were made to incorporate attitude and mental test at the entrance into training. Another issue on human resource policy for consideration were exclaimed such as having similar pay roll to senior junior posts which need to be corrected in the future.

According to several surveys results revealed the extent of the issue is such that many of the rural areas are not running with the standard strength or skill-mixed staffing and the likely contributing factors are:

- Poor and un-attractive conditions of service;
- Qualified staff feel intellectually and socially isolated in rural communities and hence reluctant to work in rural areas;
- Poor standard of accommodation;

- Amenities, such as electricity and phones, that staff have been accustomed to elsewhere, are absent in rural areas;
- Transport to maintain contact with family and colleagues is limited;
- Professional support and staff development is lacking in rural areas;
- Educational facilities for children are below the standards that they are used to; and
- The range of professional skills required may not be matched by prior training.

Apart from rural retention, there are other retention issues, especially among well qualified professionals, either they move to attractive positions outside the country or for many reasons, abandoned the profession. Bond and penalty schemes have been instituted in this regard but seem to be not that effective.

Human resources management issues related to career expectation, motivation, push and pull factors for retention and support mechanism for newly staff to prevent attrition need further review and develop policy directives related to selection of candidates, deployment, posting and transfer, further training programmes, promotion and separation. Especially in management of Basic Health Staff and volunteers, keeping a space authoritative ownership for decentralized management is crucial.

In health workforce management, Retention is the major issues. It is a negative impact on the progress of all programme performance because of rapid turnover by any reason. This should be avoided. The county is committed for Universal Health Coverage and one of the principal components is accessibility. Availability of appropriate skill mixed workforce is essential for this purpose. It is crucial to revisit, review and revise if necessary on rules, regulation, legislation and policy that can effectively streamline this issue.

Finally, it is timely to have a HRH Policy to cover all prevailing issues, such as staff training, retention, motivation and attractiveness of working environment, and also embracing on community/volunteer health workforce policy.

Professional Ethics

Introduction

Ethics or Moral Philosophy are related to societal values characteristic of personal morality and attitude and philosophy; Ethics is the understanding of moral values. Socrates, Plato, Aristotle, and Aquinas, each in turn approached Ethics in their own ways but examining what counts as excellence or wellbeing in order to discover how we should act. One should agree that Medical Ethics is an applied branch of ethics or moral philosophy. Hippocrates born in 460 BC in use of Cos, Greece, formulated and applied Hippocrates Oath, which is the oldest code of Medical Ethics. Though modified and adapted by Arab physicians 7^{th}/8^{th} century, Roman Universities in 10^{th} to 12^{th} Century and later on elsewhere in Europe, the core contents and basic

features of Medical Oath remain the same for about 25th centuries. During the 20th Century various Academic Bodies, Teaching Institutes and Universities, adopted their own Oaths for new physicians, again based on the same old oath of Hippocrates. The Geneva Declaration (1948) and **the** International Code of Medical Ethics of World Medical Association (1949) both reflect the wisdom and practice of Hippocrates Oath. In Myanmar, all the medical graduate, take the oath, as administered to them by the Rector in the Graduation Ceremony.

WHO and UNESCO jointly founded and supported Council for International Organiszations of Medical Sciences (CIOMS) in 1949, whose main area of interest is in science and education. Apart from many activities in science and education, CIOMS is keenly interested in Ethics. CIOMS organized every year International Seminars on Ethics, changing the subject and focus every time and they have covered a variety of aspects of Medical Ethics. China Medical Board (CMB) and World Medical Association (WMA) also show continuing interest in Medical Ethics.

WMA in 1999 passed a resolution at 51st Annual General Assembly, that Medical Ethics and human rights be included as obligatory courses in all medical school curriculums. Subsequently WMA went through an extensive consultation process resulting in the publication of Medical Ethics Manual (2005). This publication is of great interest to all concern and responsible for teaching of Medical Ethics in Medical Schools.

Country Setting

In Myanmar, the importance of ethics was recognized for a long time. During the British administration, doctors employed in Myanmar were drawn from the Indian Medical Service. In 1907, the Burma Government Medical School was formally started with the introduction of a four-year medical course known as L.M.P (Licentiate of Medical Practitioner). Forensic medicine was included in the third year of the course. A medical department at the University College of the Rangoon University was formed in 1923 and a degree course for the Bachelor of Medicine and Bachelor of Surgery (MBBS) was introduced the same year. Medical ethics was taught by the department of forensic medicine in the final Part **1** MBBS class.

After the enactment of the Burma Medical Act, 1957, the Burma Medical Council was formed in 1959. The Burma Medical Act laid down some guidelines to regulate medical practice. The main functions of the Council were: Registration of qualified medical doctors; Supervision of medical education in medical colleges, and Disciplinary action against doctors who were found guilty of serious professional misconduct. The Council published a booklet titled 'Simple Code of Medical Ethics' for the newly-qualified medical doctors. However, the Council could only perform its role fully up to 1978 after which, due to the policy of the government, re-election of its members was not possible. It became a regulatory body, which has no mechanism to help doctors resolve ethical issues.

The Council has no subcommittees to look after the educational and ethical aspects or professional misconduct. The registration and disciplinary functions were taken over by the Sama Registration Board (Medical Registration Board) with the Director-General of the Department of Health as its Chairman. The Myanmar Medical Association is the only professional organization of doctors in Myanmar. **It** is in no way connected with the Myanmar Medical Council and is active in the continuing medical education programs and primary health care services. It has no subcommittee to handle ethical issues for Myanmar doctors.

In the 1960s Department of Medical Research constituted an Ethics Committee to look into the ethical aspects of research proposals. At the same time, the Faculties of Medicine also look into the ethical aspects of research which later on were taken care of by Institute Ethical Committee. Many senior physicians in their own sphere recognized the role of clinical ethics in practice of medicine. But coordinated concerted action in ethics is lacking. Recently, at the turn of the Century, Myanmar Medical Association organized a number of meetings and seminars on Medical Ethics, with particular emphasis on clinical ethics. MMA sent their representatives to WHO and ASEAN Meetings on Medical Ethics.

When Myanmar Medical Council was formed in the year 2000, Ethics Committee features as one of the important committees of the Council. MMC has taken action on a few cases of breach of conduct, when reported. Department of Medical Science (DMS) whose main interest is in teaching of medial ethics organized a number of internal meetings on the subject. The Department organized a Seminar on Teaching of Medical Ethics with the University of Medicine (2) sponsored by CMB. Soon after DMS organized a Seminar on Ethics, MAMS has interest in Medical Ethics particularly as applied to the front line doctors. The subject of medical ethics was included in the MAMS Task Force on General Practitioners reported in 2001. The DELPHI Study also highlighted the significance of ethics in medical practice. Consequent to the DELPHI report, the problem of the Ethics, Morality and Professionalism was studied in depth and submitted a Report to the Ministry of Health recently.

Medical ethics is included in the curriculum of forensic medicine for medical students in the final Part **I** MBBS class. Three hours of lecture time is devoted to the subject as other medico-legal topics demand more attention. The emphasis is on negligence, malpractice and medico-legal implications. Some clinical ethical issues are touched upon by interested clinicians as occasions arise during the clinical training period but are not dealt with in an organized and comprehensive manner. In order to promote teaching and practical application of medical ethics in clinical decisions and health policy making an integrated research cum teaching project has been carried out in (6) countries in the WHO - South East Asia Region: Myanmar, along with Bangladesh, India, Indonesia, Nepal and Sri Lanka participated.

The project has (4) elements.

1. A multicentre base line study on ethical values in teaching hospital.
2. Establishment of a regional health ethics network.

3. Preparation of teaching modules in health ethics.
4. Promotion of health ethics through national workshops.

The first regional training workshop was conducted in Sri Lanka in 1996. A series of workshop and seminars followed. The guidelines for teaching ethics were developed in 2002 and were revised twice in Bangkok Aug 2004, January 2005. Professors of forensic medicine from Myanmar participated.

Currently efforts are being made to develop a curriculum which will satisfy the needs of Myanmar Medical Community as well as be in consonance with the culture and tradition of the country while keeping in conformity with the global requirements. It eventually aims at changing the attitude and thence the behavior of learner. Teaching of medical ethics should be continued dynamically reflecting the prevailing situation. It will be supplemented by the Professional and Personal Development Program that is being developed for medical and allied universities. Teaching by example and appropriate role modeling of the trainers is a method par excellence. The social and moral environment of the society in general is also very important in influencing the humanistic and ethical behaviour in medical students.

Ethics

Ethics has been defined as the branch of philosophy concerned with conduct and character and systematically study the principles and methods of distinguishing right from wrong, good from bad. Medical ethics may be defined as the study and application of moral values, rights and duties in the fields of medical treatment and research.

From these definitions one can see that ethics deals with professional values, guiding the members of the profession in the course of their practice. Medical ethics thus guides the medical profession in their relationships with the patients and their families, the community and with other members of the profession. It need be pointed out that Codes of Ethics will also evolve from secular and religious underpinnings.

Over the years the practice of medical ethics has drawn upon many philosophical concepts and theories to deal with ethical issues in medicine. The most relevant theories in the practice of (western) medicine are: *Deontology, Utilitarianism, Rights Theory, Virtue theory, Casuist theory*. These theories are indeed abstract and are difficult to apply to complex situations in medicine as there are flaws with each theory. More specific ethical framework are needed for decision making in medical issues. Torn Beauchamp and James Childress therefore proposed their "Principalism or the Four Principles Approach" which was later adopted as the fundamental principles of medical ethics.

Fundamental Principles of Medical Ethics are:

1. Beneficence (do good)
2. Nonmaleficence (do no harm)
3. Autonomy (respect for the person)

4. Justice (fairness, equality and equity)

Beneficence

Ethically correct activities are those that help people and "do good" for them. Doctors treating patients is an example of this principle. To achieve this principle, benefits must be balanced against risks and harm. In treating patients with antibiotics there is always the possibility of side-effects and reactions. The doctor has to weigh the benefits against possible harm and decide. The action also must protect and defend the rights of others (e.g., the right to life, the right to receive best possible care) and also prevent harm to them.

Non-maleficence

This is similar to beneficence and may be involved together with it in many instances. It deals with situations where neither choice is beneficial. For example, in giving antibiotics to patients there is always the possibility of side-effects and selecting the one with fewest side-effects will be observing this principle. Avoiding the antibiotic with known hypersensitivity to the patient is also a good example. According to this principle, a decision to be ethical must "do no harm" or "least harm to fewest people." It was felt by some people that to prevent harm to people is more important then doing good for them.

Autonomy

This is to show respect for the person by giving the right of choice to another person or patient. It means that the patient is free to choose the type of health care or even refuse it. The doctors are to respect the patient's choice, respect his privacy, protect his confidential information, obtain patient's consent for interventions and act as guides, not as parents, i.e., making decisions for him like parents do for children. The important thing here is to provide the patient with necessary information so that he may make an informed choice. In case of minors (children) and mentally disabled persons including comatose persons the decisions have to be deferred to the guardian, parents or next of kin (spouse, close relatives).

Justice

This principle is to consider all people, regardless of socio-economic, literacy, race, religion and other factors equal in providing care. However, it will be very difficult to treat all persons equally so that one has to consider other options which will be fair, and equitable. That is, in place of giving an equal share to all, one may have to provide care according to need, according to effort and or contribution. This principle will have to be considered not only for benefits but also for burdens. This also means that each case has to be decided based upon the prevailing circumstances. These then are the basic ethical principles to be considered in making decisions for ethical issues in medical practice. All ethical issues can involve more than one principle.

Bioethics

Bioethics or Medical Ethicsis the study of moral issues in the fields of medical treatment and research. The term is also used more generally to describe ethical issues in the life sciences

and the distribution of scarce medical resources. Bioethics can also be described as a quasi-social science that offers solutions to the moral conflicts that arise in medical and biological science practice.

The list of technologies which are of concern is daunting:

- The ability to clone humans
- Pre-determination of the sex of children and their genetic make-up
- Pharmacogenomics, which directs and tailors drugs to the genetic make-up of individual patients
- Gene therapies for the prevention and cure of most cancers, heart disease, AIDS and other diseases, including those caused by vaccine-resistant strains such as malaria
- The ability to "program out" of human genes the propensities to contract various diseases and illnesses
- Repair of damaged brain cells, spinal cords and other diseased or damaged human tissues
- Animals that grow replacement organs for the 50% of humans who die before getting a transplant organ from a human donor
- A "smart mouse" that points the way to eliminating ageing in humans

The only basis for human rights in medicine can be **the Nuremberg Code** which was established during the war crime trials at the close of World War II (1939 — 1945) in response to the gross abuses in human experimentation and the eugenic crimes conducted in Nazi Germany. According to the Nuremberg Code, the human being with his/her individual, guaranteed fundamental human rights is th,2 main concern of medicine, not medical research, scientific progress nor the benefit of society. The Nuremberg Code must remain the foundation for the future of medicine and the application of biomedical sciences on man.

The Declaration of Helsinki, first drawn up in 1964, has become standard guidance for all medical research that involves human beings. It contains a specification that medical examinations which are useful for the patient are defined as clinical research and can, in the case of persons not able to consent, be legitimated, by way of substitute, through the consent of the legal guardian. This excludes any research for the benefit of third parties, carried out without the consent of the patient. The revision of the declaration, issued by the World Medical Association in October 2000, has been appropriately strengthened in several areas and its relevance and value remains as great as ever.

Genetic engineering involves the transfer of genetic material into living organisms or modification of the genetic properties of organisms. The transfer or alteration of genetic material can lead to new therapeutics and treatments such as gene therapy. Many aspects of **recombinant DNA technology,** particularly the manipulation of human, animal and plant genomes, require regulation in order to protect the public, the researchers themselves and the environment and to minimize the potential risks of social and political misuse. Many countries do not have adequate safeguards against these risks and hazards.

Genomics is the study of the structure of the genome and its action, while functional genomics allows understanding of how the structure of the genome operates. With the advent of genomics, the human genome as well as many viral, bacterial and parasitic genomes have been sequenced, most of them pathogens.

Genomics could lead to the creation of synthetic agents — for example, synthetic replica of existing viruses has already been reproduced. Similarly, new synthetic viruses could also be produced.

Genetic Screening - Two central issues must be addressed before engaging in human genetic research or initiating genetic screening: **informed consent** and **confidentiality** of genetic information. Genetic counseling also reflects the values incorporated into the doctrine of informed consent, which is a cornerstone of bioethics.

The case for genetic testing and screening to prevent genetically transmitted disabilities and to prevent the birth of disabled, unhealthy people is stronger in some countries where they often carry greater stigma and can constitute more serious disadvantages because of limited resources available to treat or accommodate them.

Prenatal screening is, on the other hand, criticized as eugenic, replacing "defective" with "non-defective" individuals, rather than providing therapy to benefit existing individuals.

Gene therapy - Genetics is redefining the boundaries of medical science — using genetic engineering to treat patients raises hopes as well as scientific and ethical questions. Gene therapy is a process which results in the correction of a genetic disorder by the addition of a piece or fragment of DNA into the genetic material of a living cell.

Specific genes have been identified that cause hereditary illnesses like cystic fibrosis and sickle-cell anaemia and those that contribute to cancer and heart disease. Genes are transferred into a human being for a therapeutic purpose — e.g. the gene for tumor necrosis factor into cancer patients.

The fear was that once the technology is established, the next step eventually would be to alter human capabilities and produce inheritable changes — the so-called **"enhancement engineering",** to make an individual taller or smarter or more attractive.

Though germ-cell therapy might seem like the ultimate in preventive medicine, critics focus on its darker side. It would permanently change the gene pool of the species — no doubt with some totally unpredictable results. By eliminating all problem genes, scientists may unwittingly eliminate some traits that are actually beneficial. The recessive gene for sickle- cell anaemia, for instance, is known to cause problems only for people who inherit it from both parents. A single sickle- cell gene has a surprise benefit: it confers resistance to malaria.

Human cloning, for reproductive purposes in particular, is perhaps the area of biotechnology with the highest potential for controversyat the moment, as evidenced by the high level of attention in the media and of policy making at the international and national levels. A clone-child thus produced would have a genetic make-up identical or virtually identical to that of

another individual. If genetic copies of identical clones are created, either of one's self or of others, fundamental issues concerning human dignity and identity would undoubtedly arise

The creation of Dolly the sheep at Roslyn, Scotland did not involve any of the hallmarks of what is known socially, religiously and scientifically as conception. Thus, many have speculated as to whether:

- a human clone lacks traits necessary for true independence from "parent" progenitors
- a clone is entitled by contrast to feel that a progenitor (genetically its monozygotic twin) is an appropriate parent
- a clone would have a **soul**

Human reproductive cloning to create genetically identical babies is unsafe, dangerous and unethical. However, some advocate therapeutic cloning, the creation of cloned stem cells which could form tissue for transplant into diseased or injured patients (rejection-free transplants) or for treatment of many diseases such as Parkinson's, heart diseas,2 and diabetes.

Medical Ethics comprises of two main sectors.

1. one concerning those ethical issues arising from and during the treatment and management of diseases or patients, in other words the broad area of patient care.
2. Medical Research

Clinical ethics can simply be denoted as medical ethics as applied to clinical incidents — involving ethics. It is estimated that of the 26,435 medical practitioners in Myanmar (about 7000) or so are in-service personnel and the rest general practitioners, i.e. in private practice be they general practitioners or specialists. Obviously more members belong to this sector rather than in research and equally logically, this sector form the major area where ethical problems, issues and dilemmas are encountered. The natural consequence is the majority of misconducts, violations and infringements of ethical codes occur here too.

The principle s involved in clinical ethics are:

- Automy (patients right)
- Informed consent,
- Equity: It is about sharing equally, the medical facilities and attention amongst all who need, not neglecting or discriminating for reasons of economic status, social status and standing and power, and for belonging to a disadvantaged group. It should be seen that to such inequality and injustice of only the fortunate few getting all the advantages, be avoided. In a larger context, the doctor should deem, as part of his duty, to improve the health of the community and extending further that of the public in general.
- Responsibility
- Honesty in patient / doctor relationship (truth-telling)
- Confidentiality.

Research ethics refers to ethics involved in conducting research on human being. The core contents of research ethics covering principles of research ethics, responsible conduct of research and special issues in research will be presented.

The fundamental principles of research involving humanshould be conducted in accordance with three basic principles namely respect for person, beneficence and justice. These principles are considered universal. Researchers, institutions and human society are obligated to assure that these principles are followed wherever research on human is conducted.

Respect for personsrefers to the respect of the autonomy, self-determination of all human beings, acknowledging their dignity and freedom and right to make their own choices and decisions. One important component of this principle is the need to provide special protection to vulnerable groups-namely people with limited education, living in poverty, those with difficult access to health services, children, mentally handicapped persons and women (in some culture could not make a true voluntary consent). Respect for persons is embodied in the informed consent process. Informed consent is designed to empower the individual to make a voluntary informed decision making regarding participation in the research.

Beneficencemakes the researcher responsible for the participant's physical, mental and social wellbeing as related to the study. Beneficence also refers to as the principle of non-maleficence (do no harm). All risks should be kept to a minimum. Protection of the participant is the overriding responsibility of the researcher. Beneficence also refers to obligation to maximize benefits and minimize harms and wrong doing. Research design must be sound, risks should be reasonable; investigator must be competent in order to safe guard the welfare of the participants.

Justicerefers to ethical obligation to treat each person in accordance with what is morally right and proper to give each person what is due to him or her. The obligation of researcher is equitable distribution of the risks and benefits of participation in the research study. Equitable recruitment and selection of research participants should be done. Special protection for vulnerable groups must be considered.

Guidelines, codes and regulationshave been created in recent decades to guide the conduct of research involving human participants. All are fundamentally based on the principles of respect for persons, beneficence and justice. The Codes and guidelines are Nuremberg Code, Declaration of Helsinki, Belmont Report (USA), International guidelines for Biomedical Research (WHO/CIOMS), US code of Federal regulations (The Common Rules), Ethical guidelines for Epidemiological Research/Biomedical Research (WHO/CIOMS), International Conference on Harmonization ICH-GCP guidelines, National Bioethics Advisory Committee (NBAC). Based on these fundamental principles of human research ethics-respect for person, beneficence and justice and international recommendations, National and local ethical guidelines must be drawn in order to guide planning, review, approval and conduct of human research.

Responsible conduct of research

Research with human participants is a privilege, not a right. The wellbeing of the participant is paramount importance. Ethical considerations are important in doing research involving human. The common rule defines **Research** as "a systematic investigation, designed to produce generalisable knowledge. Research participants are living individuals about whom a researcher conducting research obtains data through intervention or interaction with the individual. It is essential to obtain informed consent from participants in human research study before the study is initiated.

The C1OMS guidelines define **informed consent** as "consent given by a competent individual who has received the necessary information, has adequately understand the information after considering the information, has arrived at a decision without having been subjected to coercion, undue influence or inducement or intimidation.

Essential elements of informed consent are:

(1) Description of research: the objective, purpose, procedures involved and duration of research study should be explained to the participants. Explanation of the procedure randomization or possible use of placebo should also explain to the participant.

(2) Description of risks: the anticipated or reasonably foreseeable risks including physical, social and psychological associated with participation in the study must be carefully explained.

(3) Description of expected benefit: the benefits resulting from participation in the research must not be exaggerated and should be reasonable.

(4) Description of potentially advantageous alternatives: the informed consent form must describe treatment alternatives that exist so that the participant will be able-to choose between research procedures or standard procedures.

(5) Explanation of confidentiality: in the informed consent form the degree of confidentiality that will be provided should be given. This information should indicate persons or organizations that may have access to the information. Special attention to confidentiality is necessary when public knowledge of participation is potentially damaging.

(6) Explanation of compensation for injuries: clear information must be provided about any compensation related to injury. Information must be disclosed about the treatment that would be available and who would pay for it in case of injury. Fair payment for time, travel or inconveniences is permissible. Compensation should not be so high as to unduly influence a potential participant's decision to participate in the study.

(7) Whom to contact: information must be provided on whom to contact if research-related questions arises. The contact information should be realistic, economically viable and culturally appropriate.

(8) Voluntary participation: in the informed consent form, it is necessary to state that participation is absolutely voluntary. It should also indicate that refusal to participate in the research or the desire to withdraw from the study will not result in any penalties or loss of benefits to which the participant is otherwise entitled.

Researcher's responsibilitiesare protection of human participants, scientific correctness; seek appropriate informed consent before starting the research study, protection of confidentiality, conduct of research according to the protocol, compliance with ethical committee requirements, reporting on adverse experiences, protocol violation, participant complaints and post study benefit to the participant.

Researcher's human qualityinclude integrity, respect, co compassion, professionalism, courtesy and sensitivity.

Sponsor's responsibilities are ensurement of appropriate review, approval and supervision by an ethical committee, monitoring the research, selection of qualified researchers and provide policies and procedures.

Sponsor's responsibilities in international research are sponsor must comply with the local ethical, regulatory and legal requirements; ensure the local relevance of the research and promoting research integrity.

Scientific misconduct includes wilful fabrication, falsification and plagiarism. **Authorship** should be based only on substantial contributions to conception and design or analysis and interpretation of data, drafting the article or critically revising for important intellectual content and final approval of the version to be published.

Conclusion

Historically health care has been given free of charge to all the citizens in Myanmar for a long time. There were a few medical practitioners who worked as full-time general practitioners, while in-service doctors worked as general practitioners in their off hours. In 1989, the State Law and Order Restoration Council introduced a market economy, and the National Health Policy encourages the involvement of the private sector in health care delivery. Since then there has been an enormous growth in the number of private hospitals, clinics (polyclinics) and diagnostic centers. It is the financiers and health care providers who manipulate prices and regulate its quantity and quality. No wonder therefore that many ethical issues are bound to arise from these existing conditions.

The people of Myanmar are traditionally courteous, nurturing deep respect towards their elders, teachers and healers. These sentiments are also reciprocated. However, current societal issues and cultural mores tend to influence this relationship. The ethics of conduct of the medical profession may be adversely affected by the "life getting into the fast lane". The medical profession should try its utmost to uphold its tradition despite modern influences. The ethics of practice should be maintained despite efforts of entrepreneurs of the market-oriented economy who cater for a consumer society. Efforts are required so that the medical profession has good

conduct and ethical practices imbued in them. The presence of a disciplinary body that will enforce the code of conduct is important. The Myanmar Medical Association may play an important role as the regulatory body. Only then a general environment where the medical profession is ethical can prevail.

It is timely, to review the health professionals ethical policy to be observed in their professional practices and accordingly legislative measures may be adopted and regulated effectively in ensuring the access to qualitative and accountable health care to all.

Health Information and Research

Health Information

The National Health Management Information System is crucial in effective and efficient management of restricted resources in health care delivery system in order to fulfil one of the national social objectives of the State which is "Uplift of health, fitness and education standard of the entire nation." A Health Management Information System is an organized system of record keeping, reporting, processing, analysis, usage and feedback of information. The system ought to be designed as an integrated format based upon the minimum information requirements for decision making at all levels to formulate policy, plan, implement, monitor, supervise and evaluate health program activities. It is not only based on routine data collection and is complemented by other sources of information such as community surveys, clinical studies, health system research and census data etc.

For an effective health care system, it is essential to have comprehensive health management information system (HMIS). It is vital for health development of a country as relevant information enables management to arrive at sound decisions and judgments. It is a major tool in management of the integrated health services and is one of the managerial processes for national health development. In this contemporary situation, annual evaluation of HMIS was performed at all levels in townships, State/Division and Central level. Although there is improvement in data validity and reliability in collected information, data completeness problems are still existed in some townships. At the same time, in order to work out the above problems, pilot testing of Computer applied Public Health Information System has performed in some selected townships in few districts by utilizing advanced modern technology. It is to sustain from a pivotal role in computing country's health related indicators while depicting national health plans and projects and to analyse health status improvement and declination provincially or throughout the nation and in prioritizing health problems and formulating localized micro-planning in the basic unit, sub-centre (village) level to national planning at the central level. Similarly hospital statistics also plays a crucial role for hospital care in relation with patient records, availability of equipment and drug resources.

Health information plays a vital role in the development of present and future health care system. Establishing of health information network (Internet) could bring out many benefits, so

that health information could be exchanged and evaluated between ministry of health and its departments, timely correction the information can be made and direction and instruction can be given within short period, the health care service programmes can be implemented and continuous surveillance can enable to undertake control and preventive measures effectively. In the Ministry of Health, the central source of information with the use of Internet, Intranet and e-mail is required to fulfil the needs of health planners, implementers of health activities, experts in medical research or medical science. The central source could help them to achieve their aims and objectives effectively and immediately. Computer Network has been established in NayPyiTaw using ICT. After establishing this computer network system, any place could be informed and message sent on internet either locally or aboard. Through this network of internet health information and facts of hospital can be accessed without any delay. National health information could also be accessed through Intranet Servers. With introduction and utilization of Medical Record System at Hospitals and Teaching Hospitals of state and divisions, the inpatient records and information data could be sent successfully to the head quarter.

Web Page of Ministry of Health also has been established, making it possible to search literatures on any subjects, and research paper through Electronic Medical Library of medical institutes. To be in line with government ICT system Ministry of Health also use Myanmar Unicode font in Computer System, and conduct training and update new version whenever necessary.

Research

Research and development play an important role in fulfilling the two main objectives of the Ministry of Health: to enable every citizen to attain full life expectancy and enjoy longevity of life, and to ensure that every citizen is free from disease. The Article 11 of the National Health Policy promulgated in 1993, states "*To encourage conduct of medical research activities not only on prevailing health problems but also giving due attention in conducting health systems research*". The Ministry of Health has given priority towards the implementation of research in accordance with the National Health Policy, especially research which is applicable to national health development. To strive for the attainment of the above-mentioned objective, the Health Research Policy Board has laid down the following guidelines: to promote health research by strengthening research capability through development of manpower, technologies and infrastructure; to identify factors affecting national health, and to conduct research for effective control and therapeutic measures; to identify factors promoting national health, and to institute appropriate measures for community practice; to promote and conduct health systems research; to investigate major communicable and non-communicable disease problems prevalent in Myanmar for effective control and therapeutic measures; to investigate major nutritional problems prevalent in Myanmar for effective control and therapeutic measures; to promote and conduct reproductive health research in accordance with the National Health Policy; to translate research findings into practical applications. Moreover, one of the nine objectives of Myanmar

Health Vision 2030 is "*to develop medical research and health research up to international standards*".

The Department of Medical Research (Lower Myanmar), and the Department of Medical Research (Upper Myanmar) and are the principal organizations that sponsor and conduct research in Myanmar. Moreover, the Departments of Health, Medical Science, Traditional Medicine, Health Planning, and related departments under various Ministries also implement research activities in addition to their principal functions, in a cohesive and concerted effort for the maximum achievement of national health.

Health Research Programme (HRP), formulated in accordance with the National Health Policy and the Health Research Policy Board guidelines, was implemented mainly by the Departments of Medical Research. The main objective of the HRP is to conduct research in order to solve the health problems of the community. Proposal development and implementation of research activities were carried out in the six priority diseases, on communicable and non-communicable diseases, traditional medicine with emphasis on herbal drugs; development of modern and advanced technology in disease diagnosis, management, prevention and control; other health problems which need further elucidation, and activities on research capacity strengthening. In the HRP of the National Health Plan (NHP) (2006-2011), a total of 1129 research activities had been conducted. They were 308, 139, 237, 61, 180, 129, and 75 research activities on communicable and non-communicable diseases, health system, environmental health, traditional medicine, technology development, and research capability strengthening, respectively. In the conduct of these research activities, monitoring and supervision activities were built in line with the research management system and includes; a) close monitoring by head of divisions, b) three-monthly progress reports, c) six-monthly progress reports, and d) annual reviews. Overall achievement of the HRP was 61.7%. The research activities that have achieved more than 60% of the planned activities are: communicable diseases (67.5%), non-communicable disease (66.6%), traditional medicine (66%), and technology development (65.5%). The main deficiencies encountered in the last plan period were in human and financial resources.

The major research activities could be broadly classified into three areas; a) research on diseases and disorders of prime importance, b) socio-medical research and c) technology development and research capability strengthening. During the last NHP period, the most frequently focused research activities were on TB, malaria, traditional medicine, cancer, dengue haemorrhagic fever, HIV/AIDS, viral hepatitis and CVD. More research studies involving non-communicable diseases such as hypertension, diabetes and cancer are also needed. Among socio-medical research activities, health systems research was the area most frequently explored followed by reproductive health research.

One of the of Health Research Policy guidelines is to disseminate research findings and application in solving health problems. Dissemination of the results was achieved mainly by presentations at congresses, seminars, conferences and symposia and by publications in national and international journals. Health information is provided to the public through printed and electronic media such as newspaper articles, radio talks and TV programmes. Almost all of the findings of research activities were promulgated to the health and allied profession through the annual health research congresses. *Ad hoc* reports of commissioned research were also presented to the Ministry of Health. However a systematic assessment on the utilization and application of research findings in solving health problems needs to be promoted.

General Discussion

Sound information plays an increasingly critical role in the delivery of modern health care and efficiency of health systems. In 2004, a WHO biregional Consultation on Strengthening Health Information Systems in Asia and the Pacific was held to discuss and formulate a frame-work for strengthening the health information system in the South-East Asia and Western Pacific Regions of WHO. The key challenge in this area is to strengthen country health information systems to facilitate evidence-based decision-making at the national and subnational levels. Other challenges include the limited use, quality and availability of data, poor analytical capacity and fragmented support for harmonizing information-related initiatives at the country level. These challenges were discussed and addressed during the formulation of the Regional Strategy on Strengthening health information systems in the South-East Asia Region through various meetings, workshops and the Fifty-ninth session of the Regional Committee for South-East Asia held in 2006. Based on the feedback from the Member States, the Regional Strategy for Strengthening Health Information Systems was further amended and endorsed by the Sixty-third session of the Regional Committee in 2010.

From 2007 to 2009, WHO, together with the Health Metrics Network (HMN), collaborated with Bangladesh, Bhutan, Indonesia, Myanmar, Sri Lanka and Timor-Leste to assess their health information systems and encouraged them to realign their country systems with the regional strategies as well as the HMN framework and Standards for Country Health Information Systems. Bangladesh, Bhutan, Indonesia, Myanmar and Thailand have, to some extent, realigned their national strategies for health information systems with the HMN framework.

Assessment in countries was initiated on the 10 recommendations of the Commission on Information and Accountability for Women's and Children's Health (COIA) established in 2010. Bangladesh, Democratic People's Republic of Korea, India, Indonesia, Myanmar and Nepal have made a commitment to implement the 10 recommendations and have finalized their action plans by using the country accountability framework (CAF) tool. The Regional Office has been engaging with countries, utilizing different platforms including the COIA to implement the 10-point

Regional Strategy to strengthen health information systems. Countries are at various stages of strengthening their health information systems.

Reliable information on the supply and quality of health services is necessary for health systems management, monitoring and evaluation. Several countries in the Region have taken measures to map their health facilities and assess the availability of the services at these facilities. The Service Availability and Readiness Assessment (SARA) is a health facility assessment tool designed to assess and monitor the service availability and readiness of the health sector, and to generate evidence to support the planning and management of a health system. The Regional Office engaged in discussions to implement SARA in all six COIA countries. Currently, SARA has been taken up in Democratic People's Republic of Korea and Nepal. Other WHO tools for data quality are also being applied in countries with technical support of the Regional Office.

Strengthening vital registration systems

Availability of up-to-date and good-quality health information is the *sine qua non* for health policy, strategy and planning. All births and deaths, as well as causes of death, must be registered for producing vital statistics, as many health indicators use these as denominators. To facilitate the collection and reporting of vital statistics, a Regional Consultation on mortality statistics was held in 2007. WHO headquarters developed a tool to assess country vital registration systems, which was pilot-tested in Sri Lanka in 2009 with technical support from the Regional Office.

Since 2010, comprehensive assessment of civil registration and vital statistics (CRVS) systems using the WHO tool has been completed or is in the process of being completed in 7 of the 11 countries of the Region, and strategic plans are being developed for improvement of the CRVS system in these countries. In April 2013, WHO in collaboration with the Health Metrics Network, hosted a Global Summit on CRVS, at which 10 of the 11 Member States participated. The Regional Office is working closely with Bangladesh and Nepal to develop an integrated cause of death and birth reporting system for hospital- and community-based data collection, and facilitating funding from development partners to implement this in both countries.

The Regional Office is promoting the use of the WHO Family of International Classification (WHO-FIC) and the ICD-10 (International Classification of Diseases and Related Health Problems, Tenth Revision). Work on the implementation of the ICD-10 in Bangladesh, India, Indonesia, Maldives, Nepal and Sri Lanka has been supported since 2004.

Generating health information

As many countries in the Region have decentralized their health systems to district level, they need health status indicators to assist in resource allocation, health service coverage, and access to and quality of health services.

In 2007, health system profiles of all 11 Member States were posted on the Regional Office web site. To facilitate exchange of knowledge among all 11 countries of the Region, a health system mini-profile, entitled *11 Health questions about the 11 SEAR countries,* was published and disseminated. This publication has been updated in 2013 along with Core Health Indicators for Member States. The web site includes links to related web sites of relevant and respective governments, technical departments of WHO, and development partners.

The Regional Office launched the Regional Health Observatory (RHO) in 2013, which is an online integrated database of all important health issues in the Region. The RHO addresses the growing demand for health information at regional and country levels. It not only increases access to available data but also stimulates future collection of complete, reliable and accurate data. National Health Observatories (NHOs) focusing on key health indicators at the national and subnational levels will be developed using the RHO platform.

plans to produce an e-learning platform for Member States.

e-Health, m-Health and telemedicine

Globally, e-Health and m-Health are gaining importance and increasingly being used for all aspects of health. The Regional Office provided technical inputs for the development of e-Health strategies in countries

Access to Essential Medicine and Technology

Essential drugs are those that satisfy or most needed for the health care of the majority of the population; they should therefore be available at all times in adequate amounts and in the appropriate dosage forms, and at a price that individuals and the community can afford. National Drug Law was promulgated in 1992 to ensure drugs (medicines) consumed by the community to be safe and efficacious and of good quality. The Myanmar Essential Drug Project (MEDP) has replicated its activities phase by phase and now, all townships in primary health care level have been covered with essential drugs concept, rational use of drugs, estimation of drugs requirement, systematic management of drugs supply system and drugs counselling, Information, Education and Communication relating to use of drugs to community for compliance to essential drugs.

During replication of project activities, it has adopted Community Cost Sharing (C.C.S) system for the drugs in all townships in the primary health care area. And then, the project has incorporated with Revolving Drug Funds (RDF) system in which some township and district hospitals are now being implemented. The respective township (or) district medical officer have to establish the drug shop with revolving drug funds and replenish the required essential drugs

with the approval and agreement by the Township Health Supervisory Committee, and they are proceeding with the system of Community Cost Sharing for the drugs only by the user. RDF will serve as mean of establishing drug financing for the townships in primary health care area so that the Ministry of Health will be relieved of the drug budget for the primary health care area and may use the budget in other activities of health care in the country. MEDP has been replicating its activities in the health care facilities under other Ministries by giving training to the health workers concerned. Some of the health care facilities under this respective ministry may adopt the charging for the drugs only as Community Cost Sharing based on the MEDP activities.

MEDP has also extended its activities to the General Practitioners of the country through the good offices of the Myanmar Medical Association and advocated them to select their essential drugs lists according to their area organization and services on the principles of essential drugs programme of WHO. After covering the primary health care area under the first referral level of the country, MEDP has planned to extend its activities to the secondary referral level and then to the tertiary referral level for identification of their Intermediate List of Essential Drugs together with development of their Hospital Formularies and Standard Treatment Guides under the guidance and supervision of the Hospital Therapeutic Committees. The general objective of the project is to ensure that every citizen have regular access to safe, quality, efficacious, low-cost and available essential medicines in every health care facility and its specific objectives are: to increase the number of trainers for multiplier course of concept of essential drugs, rational use of drugs, estimation of drugs requirements and systematic management of drug supply system; to disseminate the knowledge of revolving drug funds among District and Township Medical Officers; and to increase the number of health related institutes for integration of concept of essential drugs, rational use of drugs into their undergraduate and post-graduate curriculum.

CMSD is responsible for procurement, storage and distribution of medical supplies for all hospitals, Urban Health Centre, Rural Health Centre, MCH, School Health Teams and Health Centres under Ministry of Health. It is also responsible for clearance, storage and distribution of UNICEF, WHO and other donation supplies. CMSD also take, the responsibility for repair & maintenance of all biomedical & hospital equipment. At present Computerized Inventory Control System & Local Area Network has been set up with the co-operation of Myanmar Computer Company. There are network connections between CMSD Yangon, CMSSD Mandalay and Taunggyi by remote access server. In Yangon there is one main server and 16 stations. Further expansion of networking is in place. At present inventory control is carried out manually and computerized inventory control system is in trail stage using 16 computers by 27 trained staffs. As for training, basic computer course, computer programming course and refresher courses are being conducted. CMSD received the drug & medical equipment from various sources and supply to the CMSSD (Mandalay, Taunggyi), Transit Camps and to State & Division health department. No difficulty is encountered in distribution from State & Division to district & Transit camps due

to information gap. To overcome this difficulties setting up communication Network is mandatory. The communication systems are developing rapidly & easily communicate to the States & Divisions by the Auto telephone systems.

The Health Care System aims primarily at improving the quality of life of every citizen through activities designed to enable citizens to have lives which are as free from disease as possible and to increase their life span. Health Laboratory Services, an integral part of the National Health Services, provide the essential backbone support for Primary Health Care by: assisting in early and reliable diagnosis and treatment; investigating outbreaks of disease; collecting reliable surveillance data for effective disease control; collecting and providing data for disease prevention; monitoring the quality of water and food; providing appropriate support for related health care programmes such as rehabilitation; and if possible, monitoring the various vertical national health programmes. In order to fulfil these essential functions, the country has established and sustained a nationwide health laboratory services network extending from the rural (peripheral) to urban (intermediate and central) levels so as to provide: effective diagnosis and monitoring of disease; proper and prompt communications enforced by smooth functional coordination, cooperation and timely referrals; timely, adequate and effective logistics support at all times, especially in emergency situations. In the near future, laboratories performing simple microscopy alone will be centred at rural health centres and categorized as type D. The general objective is to establish new Clinical Pathology and Public Health Laboratories in township, station hospital and remote border area locations phase-by-phase and to upgrade the respective intermediate and central level referral laboratories in order to enhance the effectiveness and success of the National Health Care Delivery System.

Following World War II, transfusion medicine has evolved, together with other diagnostic, curative, preventive and rehabilitative aspects of the Health Care Delivery System, to become one of its essential important themes. Transfusion of specific blood and blood products has become an established standard way of treating patients who are deficient in one or more blood components, and has replaced the traditional trend of giving whole blood only. Meanwhile, enhanced knowledge on the inherent dangers of blood transfusion, including not only of reactions from mismatching, but also of transmission of infectious diseases such as HIV, HBV, HCV, malaria, syphilis and many others, have led to the realization that a universal goal of ensuring timely and adequate supply of safe blood and blood products must essentially be set. In order to achieve this ultimate goal, it is of prime importance to successfully establish a system of a 100% voluntary, non-remunerated blood donation and to employ ways and means of operating the National Blood Transfusion Services on a comprehensive cost-recovery basis in addition to promoting and sustaining the rational use of blood and blood products appropriate to the country situation. Blood Transfusion Services (BTS) are operated by hospital-based blood banks which are part of the hospital laboratory.

In accordance with notifications issued and provisions of Public Health Law, National Drug Law and National Food Law, the ministry of health is undertaking regulatory measures in matters relating to food and drug, cosmetics and household commodities. In general, public is found to have inadequate health knowledge and it is necessary to collaborate with related departments, non-governmental organizations and private sector, disseminate health education messages and take quality control measures systematically to safeguard consumers against hazards relating to consumption of food and drugs. Government has established food and drug administration division under the department of health to undertake these measures. The main objective is to establish an effective and appropriate control and regulatory mechanism to supervise and control production, import, distribution and sale of quality assured and safe food, medicine, cosmetics and household commodities. The programme comprises of three projects: Consumer Protection Project, Food Quality Control Project , Drug Quality Control Project.

However, government has insufficient funds to supply the required quantity essential medicines tohealth facilities, which have been reporting many stock-outs. In addition, there have been concerns about irrational use of medicines. For these reasons and the prospect of a more liberal market in the future, the government is now wishing to update its National Drug Policy of 2001 and form an implementation plan. Drugs are procured and distributed by the Central Medical Store Depot (CMSD) of the Division of Medical Care under the Department of Health within the MOH and distributed to government health facilities. It is the policy that medicines are dispensed free of charge to patients in the public sector but in practice, medicines supplied by the CMSD cover so little of the need and are finished so quickly that they are generally reserved for use by poor patients, all other patients buying medicines from outside pharmacy shops.

Public purchase by the CMSD is based on the past 3 year's consumption, 70% from government facilities (mostly Myanmar Pharmaceutical Factory – MPF) and 30% from outside companies. The central budget allocation has been estimated for each health facility according to the number of beds of the facility and past usage. Although drugs may be requested by facilities in practice allocated drugs are "pushed" from the centre to district level. The problem with this method is that it greatly under-estimates the need as there are very frequent stock-outs. In addition, the government budget has not covered the request of the CMSD.

It was estimated that government expenditure on general drugs (excluding the various vertical programs e.g. HIV/AIDS, TB, malaria) in 2010 was less than USD 0.2/capita/year – Furthermore, only 92 out of 341 items on the National List of Essential Medicines were procured. A further problem is that there is no electronic management inventory control system and no analyses of consumption.

Distribution

Medicines are distributed from the centre to the concerned facility – twice a year for hospitals and once a year for Rural Health Centres and sub-centres. Until recently a RDF operated in all health facilities whereby drugs were charged to patients and the funds received used to

purchase medicines.. One of the reasons given for failure was that health facilities were constrained to buy generic drugs from Yangon and the price of these was more expensive than what could be purchased locally. Now, most patients must buy their medicines from pharmacy shops.

However, in some RHCs and sub-centres with no pharmacy nearby, the health worker is buying medicines from the nearby town and selling them to patients in the health facility. There is weak supervision of this process and it was noticed that not all such purchased medicines were on the national EML for the level of facility concerned.

Several site visit reports noted that is was generally observed that many drugs were out of stock, i.e. not on the CMSD shelves, in many health facilities, particularly antibiotics, contraceptives and paracetamol. Also some drugs not supplied by the CMSD for the concerned category of health facility were available in some health facilities. Central procurement is done by tender for the 30% of drugs not procured from the Myanmar Pharmaceutical Factory (MPF). The procurement committee consists of the Director General of the Department of Health , the Director of the Myanmar Food and Drug Administration, Deputy DG of the division of Medical Care, the Chief of the CMSD and the

Director of Finance, within the MOH. The vertical disease control programs and other projects procure and distribute their own medicines and store them separately in their own warehouses.

It is critical that pharmacist should be made available in all many hospitals, townships or districts

Often the duties of managing the drug store fell to a non-pharmacist may not be seen appropriate. Myanmar produces 100 graduate pharmacists per year but only 10% find employment in the public sector. Even the CMSD has only few pharmacists, most of whom are in junior positions. However, the activities of drug procurement, quantification, storage and distribution involve technical activities that only pharmacists have been trained to undertake – particularly at the central, provincial and district levels. Furthermore, there is a need for monitoring of drug consumption, prescription audit and supervision of drug management in all facilities from sub-centre to district/township level.

There is a National Drug Law 1992 (Myanmar government 1992). It is not clear if this encompasses all the regulations or not – but no drug schedules are described. In practice, all medicines (with the exception controlled drugs) are available over-the-counter without prescription. The Myanmar Food and Drug Board of Authority (MFDBA) is highest authority of Food and Drug Regulation/ Control. The Myanmar Food and Drug Administration, DOH is responsible for enforcing the National Drug Law. The MFDA has difficulty to enforce all aspects of the National Drug Law due to a shortage of human and financial resources. There is a Central Food and Drug Supervisory Committee which oversees all the activities of the MFDA. An

equivalent supervisory committee exists at each administrative level of state, region, district and township.

Regulation of outlets and drug schedules

By law a diploma pharmacist is only required to be present in a retail pharmacy if controlled drugs are sold. All pharmacies are supposed to receive a visit at least 4 times a year by the relevant local supervisory committee and need to renew their license once every 3 years. If controlled drugs are sold, they should be visited monthly and renew their license annually. There is a checklist for retail pharmacy inspection which covers many issues such premises and storage conditions, stock management, drug labeling, presence of banned or expired drugs, knowledge of the retailer and documentation on controlled drugs. Township committees are supposed to examine all these things and report quarterly to the central level. In practice, township medical officers mentioned that they undertook inspections to verify that record keeping for controlled drugs was being done properly and that they could only cursorily look at storage and a random selection of drugs and submitted report to central food and drug supervisory committee.

Medicine Policies and Health system issues

There is an extensive health care system where patients are supposed to receive free health care. However, many patients have to pay out of pocket as many essential medicines are not supplied by the government and often there are shortages of those medicines that are supplied. Health insurance system is still quite primitive. Most MOH officials felt that there was inadequate supervision of many medicine-related activities. There is a national drug (medicines) policy (NMP) 2001. The key components comprises of: selection of essential medicines, affordability, financing, regulation and quality assurance, rational use, research, HR development and distributed into 13 objectives:

The objectives related to drug availability and supply are:

- To ensure that good quality, effective and safe drugs can easily be purchased by the community;
- To ensure that adequate quantities of essential drugs are provided at all times to the community, based on the needs, the prevailing disease pattern and national health programmes;
- To make drugs easily accessible to the community by establishing an effective procurement, storage and distribution system throughout the country;
- To make essential drugs available to the community at a price they can afford by establishing an appropriate drug pricing system.

The objectives related to rational use of drugs are:

- To promote the development of a habit for rational and efficient use of drugs

- To develop mechanisms for protection of the individual and the community from abuse of drugs, including narcotics and psychotropic agents, which are known to be harmful
- To establish drug information system for availability of adequate information about drugs, especially newer preparations
- To promote and strengthen the use of Myanmar Traditional Medicine

The objectives related to manufacture, human resources and regulation:

- To promote the local production of drug formulations and availability of raw materials and to encourage integration of drug production, distribution and utilization in health programs with the national economic and industrial development
- To enable systematic assessment of the country's needs for technical manpower in the field of drugs and related activities, and to take effective steps for technical manpower development, including the development of pharmacy, pharmacology, clinical pharmacology, and the pharmaceutical sciences
- To promote research to identify priority areas in drug programs and supply management, and implement activities for development in these areas
- To ensure allocation of adequate financial and manpower resources for implementation of drug programs
- To take appropriate steps for identification of sub-standard and counterfeit drugs and their removal from the market

However, the NMP does not have a section on monitoring and evaluation and is also lack details with regard to many of the components. In addition, there is no implementation plan. Myanmar has not participated in the global surveys of the pharmaceutical sector conducted by WHO through questionnaires sent to MOHs in 2003 and 2007.

For an effective implementation of the NMP, it is necessary to strengthen the MFDA with improving its manpower strength and competencies in drug registration, GMP, Good Laboratory Practices and M&E. It is also essential to revise and update the SOPs and review the drug schedules. In respect of drug supply, CMSD be well equipped with electronic inventory management and upgrade its workforce capacity. In drug selection, it is essential to ensure the consistency between the NEML, other list used by CMSD and the National Standard Treatment Guidelines. Relevant mechanisms be developed in monitoring adherence and justifying the quantity of non-EEML drugs. Drug therapeutic Committees be established to ensure transparency and inclusiveness of the process to improve acceptability to prescribers. Widely disseminating the NEML to all facilities and including it in pre-service and inservice training curricula in order to further sensitize doctors to the utility of the NEML.

In promoting the rational drug use, monitor the drug use including: analysis of consumption data both centrally and in each referral hospital and district/township to identify high consumption drugs and to make comparisons between districts/townships and between primary and hospital care; adherence to the NEML; prescription audit and feedback targeting the

gross areas of potential misuse as identified through monitoring of consumption; use of clinical pharmacology and clinical pharmacy students to undertake drug use studies; annual publication (ideally as a statutory requirement) in all major hospitals and districts/townships of drug consumption analysis and prescription audit, with analysis of all publications in the MOH/EDP.

Establish functional DTCs in all major hospitals with an obligation to: monitor drug use; develop their own formulary from within the NEML, monitor compliance and justify non-EML use; coordinate CPD in their institutions; report annually to MOH on their activities so enabling MOH to know what is and is not going on and what needs to be done; Develop an accreditation system for hospitals which includes a functional DTC as one of; develop and regularly update national STGs, for both primary care and hospitals, disseminate them to all doctors, and incorporate them into both undergraduate and postgraduate CPD curricula; Encourage the MMA and MMC to develop a credit system to encourage voluntary CPD and to incorporate prescription audit and feedback and ethics into CPD. disseminate to the public of core pharmaceutical messages through the RHC and subcentre health workers, community midwives and the media; strengthen pharmaceutical disciplines in the university system: clinical pharmacology in all university hospitals teaching medical students; clinical pharmacy (which includes the skills of drug monitoring, prescription audit DTC management, drug evaluation) into all pharmacy courses; establish a National Drug Information Centre; employ more pharmacists such that every township and referral hospital has a pharmacist who can undertake monitoring of drug use, prescription audit and act as the secretary of a DTC..

For drug regulation: strengthen the MFDA by appointing sufficient staff, particularly inspectors and graduate pharmacists, one per district, to deal with all the required activities, training existing staff for certain specialist activities such as dossier evaluation for drug registration, Good Manufacturing Practices, Good Laboratory Practices, Pharmaco-vigilance in community and hospital pharmacies; amending the current regulations to increase punitive action; revise and update the standing operating procedures (SOPs) so as to improve the way in which many procedures are conducted, how various committee meetings are currently managed, particularly with regard to membership and possible conflict of interest in members who sit on many committees; improve the process of drug registration by installing an electronic system for drug registration to ease the process, reviewing the criteria for drug registration so as to reduce the number of applications of me-too products, raising the registration fee so as to reduce the number of brands of the same active pharmaceutical ingredient being registered, publishing the number of products approved by the technical advisory committee and the number of products approved without review by the committee; Strengthen the drug testing laboratory to test more samples per year and to include bioequivalence testing; start a unit within the MFDA dedicated to monitoring drug promotional activities, starting with pre-approval of adverts and package inserts for all medicines and gradually expanding the system to monitor all promotional activities – all of which would require establishing an adverts approval committee; review the drug schedules to

consider whether there should be an extra drug schedule consisting of drugs that should be only available on prescription in specialist centres and not available even with prescription in ordinary pharmacies, e.g. oncological drugs, anti- TB drugs and very new antimicrobials. Such a schedule could prevent misuse in the private sector, particularly of newer antimicrobial drugs, where misuse will lead rapidly to antimicrobial resistance.

For a sound National Structure & Drug Policy: establish a permanent, independent, national statutory committee, with wide membership of all the major stakeholders, (including laypersons, professional bodies, academicians, consumers and all concerned departments/divisions in the MOH), under the chairmanship of the Minister of Health, to advise the Secretary of State on Pharmaceuticals; could be done by reforming the currently inactive Food and Drug Board of Authority but would require establishment of a working group; Establish an Executive Division in the MOH to carry out the statutory committee recommendations – a strengthened Essential Drug Program Division; to coordinate action between all MOH divisions and different Ministries; to be responsible for rational use of drugs: NEML, STGs, DTCs, monitoring drug use, CME, Drug Information Centre, public education; could liaise with universities to provide students to collect information needed by the MOH as part of their research studies; to update the National Medicines Policy to be more specific and to include an implementation plan and time line; update the National Medicines Policy so as to be more specific and with provision for implementation.

Health System Financing

Health financing is a key building block of a primary health care-oriented health system and plays a critical role in advancing towards the goal of universal coverage. Health financing is subject to five main constraints: high and even impoverishing out-of-pocket expenditures by households; inadequate public investment in health; a large informal sector in the economy where the poor are mainly located; a substantial share of service provision by a largely unregulated private sector; and an increasing burden of high-cost non-communicable diseases.

Government revenue is the most equitable means to financing health, especially the public health needs of the poor. It allows resources to be pooled and allocated to priority health areas and target groups, which is the most effective way to strengthen health systems within a primary health-care approach. However, government revenue is limited in developing countries and health is only one of many sectors competing for scarce public resources. Additionally there is the pressure of an increasing burden of non-communicable diseases, which require high-cost, personalized care but fall in the domain of public health.

Some Member States have explored innovative alternative health financing mechanisms. It embodies the essence of the primary health-care approach: it is anchored at the community

level and is responsive to its specific health needs, operating in the context of the overall socioeconomic structure. Looking back to the country's health financing background:

1. 1948 – 1962 Myanmar followed the British National Health Services (NHS) during this period. All types of health care services were provided mainly by general government tax revenue. There were free health care services including curative services after independence and all type of expenditures were born by the government through general taxation. Social security scheme was started to implement in 1956 according to 1954 Social Security Act. It composed of social health insurance services and which was implemented by the Ministry of Labour. It is the only prepaid system in providing health care services.
2. 1962 – 1974 Government taxation was the major source of finance for health sector. The other sources were the international assistance like WHO, UNICEF supported in disease control activities. Private sector started to grow during this period. There was one special allowance provided to the THOs and doctors who worked in public health activities: getting extra 100 kyats than other doctors in public sector.As the socialist system flourishing, the private sector gets much limited and even mission hospitals were nationalized to government ownership.
3. 1974 – 1988 The new constitution adopted in 1974 and then health care services were provided according to the National Development Plan. Cohesiveness between financing and planning was very high. In accordance with the People's Health Plan (1978-1990), there were annual increase of 10 station hospitals, 25 RHCs. Regarding source of financingboth the private and external sources came in. Public Health activities were funded by UN Agencies.
4. 1988 – till now, Since independence, a free medical care was practised. Growing population together with border area development and extensive coverage of health care delivery to the population demands more and more expenditures to use in public health. In such situation and with the considered not only the sole responsibility of the government but also the coordinated effort or shared responsibility of the community and also the willingness in contribution of the NGOs. The MoH in the implementation of the NHP in accordance with health policy guidelines, encourages to explore alternative mechanisms for health care financing, such as introducing of paying wards, community cost sharing (CCS) schemes in laboratory and x-ray services and other medical checkups, drug store for community cost sharing. The cost recovery schemes with the provision of essential drugs are also implemented. Such exploration on alternative ways of health financing is being implemented to be in with the changing socio-economic conditions of the country.

The CCS scheme, which started in 1992, the revenue for CCs scheme was divided into four portins, 25% each: going to government revenue, maintenance, drug and medical equipment replenishment and staff welfare. In 2007, this revenue is divided into only three portions: 50% going to revenue, 25% is for drug and medical equipment replenishment and 25% is for maintenance. Fund going to revenue is used for HR and capital assets for high technology medical ebuipnent.

The concept of CCS is perfect: people who can afford have to pay for the health care services but who cannot afford couldn't need to pay anything but in practice there are difficulties. There was absence of clear policy, guidelines and procedures for operating CCS scheme at all levels. And also absence of formal authorization of full cost sharing at all levels. There was lack of well-designed exemption mechanism that includes guidelines and procedures. In case of emergencies, like traffic accident and outbreak cases, whether the patients are affordable or not, hospitals provide free of charge for all services.

Revoling Drug Fund (RDF) is effected by exchange rate, for example at the time of starting MEDP, the exchange rate for a USD was 100 kyat but the value of seed money drop with rapid changes in exchange rate. There is a rule and regulation for this system including voucher system, daily account, monthly account but there is some difficulties in township level because there is no additional staff for accounting system.

There is lack of unified mechanism within the DOH to formalize and coordinate the various cost sharing projects. And poor financial management capability of the health services at the township level, district levels and even in the states and divisional level. There was poor quality and high cost of locally available drugs. At times drugs are supplied in sufficient amount, nearly expired, the costs of supplied drugs are very high.

Trust fund is more or less dead money as most of the TMOs are not familiar to operate financial accounts. Fund management and systematic utilization is necessary. Fund raising is still weak. Assessment has been required for actual situation. Is the interest for Trust Fund sufficient for all unaffordable patients? How to define unaffordable patient?

In regard with the government budget, government expenditure on health is the increasing trend. THE as a percentage of GDP in 1999 was 1.8% to 2.8% in 2003.According to the report on Commission on Macroeconomic on Health, this percentage should be increased additional 1% in every year up to 2015. Not only increased amount of government health expenditure is important for health development but also efficient utilization and its accountability.

Out of payment OOPs is becoming more than 80%. This is relatively high to the common standard of the developing country, which should be less than 30%. The costs of curative services are so expensive both the drugs and diagnostic procedures. An effective regulatory procedure and supervisory mechanism need to impose on private health care services, ensuring the provision of services on need based and observing standard ethical practices in a strict manner.

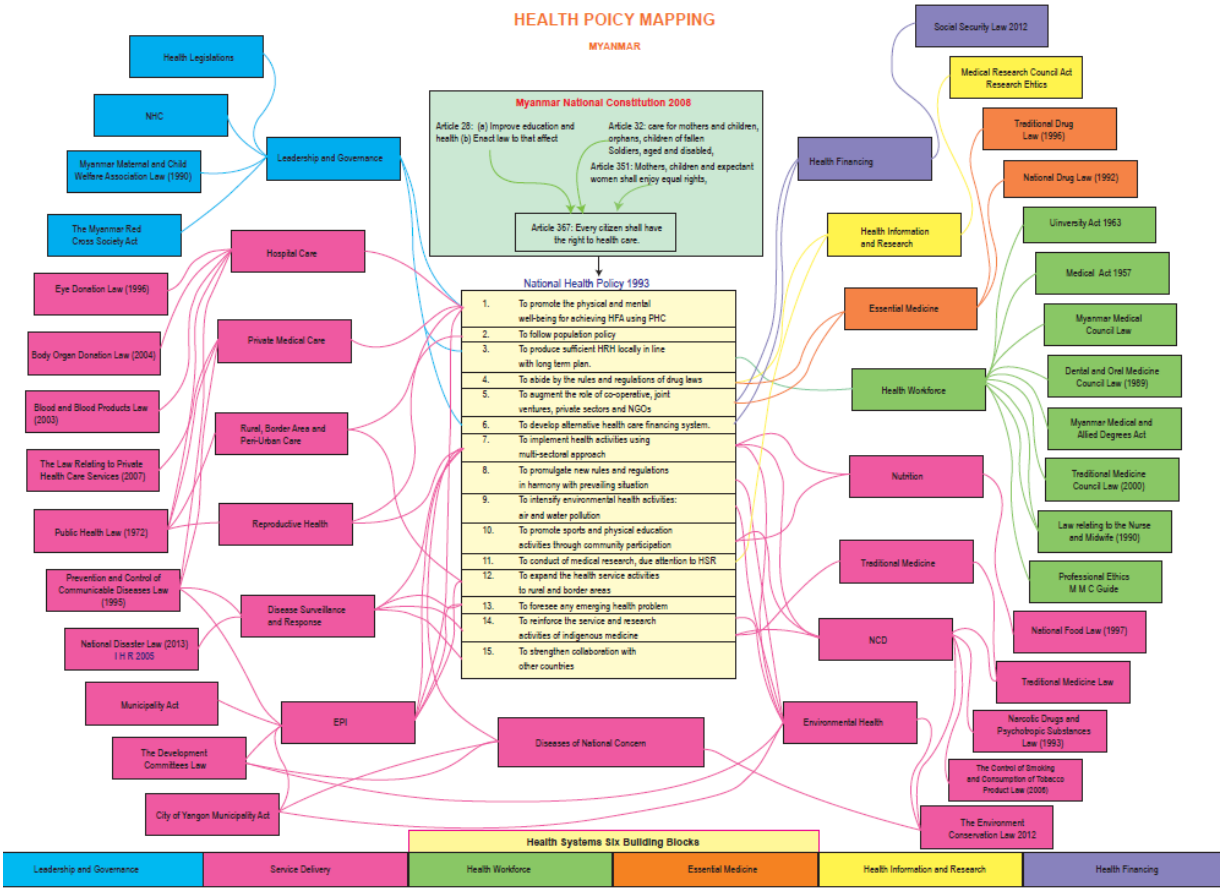
This is the right time to introduce one of the prepayment schemes to prevent catastrophic payment at the time of seeking treatment. Community Based Health Insurance Scheme is most appropriate and starting with pilot townships and then expands phase by phase.

Policy Mapping and Observations

In this presentation, a careful study has been taken place on the three National Constitutions 1947, 1974 and 2008. In some specific disease or health problems, subject to the availability of valid records it has been traced back to colonial administration. From National Constitution to National Health Policy has been developed and at the same tie how the National Health Policy directives ensure the constitutional provisions reaches to the people. The strengths and weaknesses or any gaps that have been observed were reflected in the presentation. Apart from the programs, to support or follow the guidance of the Constitution, in line with the prevalent political, socio-economic, epidemiological environment and the lifestyle of the people Laws are being enacted and amending or repealing as and when necessary. So the mapping is a picture of the Constitution, National Health Policy, National Health Plan (Health Programmes) and its governing Legislation, Laws, Bye-Laws, Notifications and Orders. The mapping is depicted in the diagram. In addition to points that have already highlighted in the course of presentation, the followings are few selected observations:

- *In the Leadership and Governance of the health system building block, both the policy and the structure is very strong. The governance manual and its network arrangements are very much conducive to the present circumstances. However, if micro-planning component could be emphasized, efficiency and accountability issues can easily be overcome.*
- *In health care, private sector is growing in a speedy manner. The Law related to Private Health Care Services has recently been enacted in 2007. However, the country's general situation is changing rapidly. In health financing area, OOP is inclining dramatically and some surveys have already shown to 92% and many stories have been heard about their catastrophic financial issues of the patients. To ensure the rights to health, it is necessary to strengthen the regulatory process.*
- *Both globally and the country's morbidity and mortality trend has strongly indicated, the challenge in health is non-communicable diseases. This is the area need further strengthening. Tobacco control is keeping up, together with narcotic and psychotropic substance control. But intensive legislations and effective policy for other risk factors engaging with other sectors is vital.*
- *Lifestyle will be a major social determinant factor for health and Legislation has marginal influence on it. Teaming up with healthy lifestyle for the future is to promote strategically at the primary and secondary schools through school health programme. A joint policy deliberation to this affect between Health and Education Sectors is imperative.*

- *In the health workforce building block, the country needs to realize a wholesome policy inclusive of production, deployment and retention. Apart from national drug policy, a 'quick win' - Evidence Informed Health Workforce policy is a priority need.*
- *Access to essential drugs is the main building block in attaining the UHC. The Essential Drug Policy can guide appropriately.*
- *HMIS has a sound strategic programme; but still need further strengthening with appropriate policy with extension of e-health, telemedicine and standardization of informatics technology in a need-based approach.*
- *A high level of OOP is a barrier for attaining UHC. Enacting the Social Security Act 2012 is very timely to expand scopes of insurance schemes will definitely reduce the OOP.*



Conclusion

Throughout the presentation emphasis has been made on the emergence of health issues and evolvement of the health policy till to the current practices, highlighting the historical perspectives, recalling wherever the records are available, starting from the colonial days. It is

apparent that the policy, either in totality or for specific issues, either at the national level or at the local community level, it is a dynamic one and always keeps changing with the prevalent political, socio-economic, epidemiological and demographic situations. Currently in Myanmar, rapid socio-economic changes are being taking place hand in hand with a high momentum of democratization. The system is thus looking into the policy review and revising process; and also to fill the gaps so as to ensure that the health policy will be able to meet the current and future challenges. The principal intend of this collection of papers and information is to facilitate in systematic review while preparing the evidence informed policy brief for the policy makers.

In health policy deliberation, it is essential to note that **'rights to health'** has been accorded to the people in all the consecutive three National Constitutions consistently since the country attained the Independence and thus by all means the necessary National Health Policy should be further strengthened and ensuring the ethical practices are strictly observing by the system through effective enforcement with regulatory process. As health issues are beyond the health sector, Health in All Policy – HiAP be promoted at the same time.

Part III

Legislations, Laws, Notifications and Orders

PART III

Legislations, Laws, Notification and Orders

Introduction

Both nationally and internationally the field of public health and the execution of public health powers and services depend on public health law. In its early history public health and its legal regulations covered communicable disease prevention and environmental sanitation. It included some limited control of the disposal of human and other wastes, some concerns for water purity and the hygiene of housing, a limited interest in food and milk sanitation, some incipient school health controls, and very little else.

To protect health government directed industry, business and people generally what to do and what not to do. Public health programmes seek to enhance public health not only by prohibiting harmful activities or conditions, but also by providing preventive and rehabilitative services to advance the health of the people. Instead of regulating, policing, and prohibiting unwholesome conduct or conditions, public health laws establishes services to create a more healthful environment and provides the facilities and trained professionals to prevent and treat disease, to educate people to protect themselves, and to improve their conditions.

As part of fulfilling the responsibility to improve and protect health of the citizens the government has enacted some health laws. Majority of current health laws are found to be related to the public health law promulgated in 1972. Existing health laws may be categorized as; health laws for promoting or protecting health of the people, health laws concerned with standard, quality and safety of care and laws relating to social organization.

To enhance systematic thinking, the legislations related to promoting and preventing health may be classified into health system six building blocks:

Leadership and Governance

Myanmar Maternal and Child Welfare Association Law (1990) (Revised in 2010)

The Myanmar Red Cross Society Act

Service Delivery

Public Health Law (1972)

Prevention and Control of Communicable Diseases Law (1995) (Amended in 2011)

Epidemic Diseases Act

Notification of formation of National Disaster Central Committee

Notification of formation of National Disaster Work Management Committee

Municipality Act

The City of Yangon Municipality Act

The Development Committees Law

The Yangon Development Committee Law

The Environmental Conservation Law 2012

The Law Relating to Private Health Care Services (2007)

The Control of Smoking and Consumption of Tobacco Product Law (2006)

Narcotic Drugs and Psychotropic Substances Law (1993)

National Food Law (1997)

Eye Donation Law (1996)

Blood and Blood Products Law (2003)

Body Organ Donation Law (2004)

Health Workforce

University Act 1963

Myanmar Medical Council Law (2000)

Dental and Oral Medicine Council Law (1989) (Revised in 2011)

Traditional Medicine Council Law (2000)

Law relating to the Nurse and Midwife (1990)(Revised in 2002)

Principles of Medical Ethics

Ethical Misconduct

Myanmar Medical Council Guidelines for General Medical Doctors

Access to Essential Medicine and Technology

Nation Drug Law (1992)

Traditional Drug Law (1996)

Health Information and Research

Myanmar Medical Research Council Act

Health Financing

Social Security Law 2012

Leadership and Governance

The Myanmar Maternal and Child Welfare Association Law is enacted with objectives of (a) to form a permanent organization in order to carry out effectively welfare work and assistance relating to the health and social affairs of mothers and children throughout Myanmar; (b) to organize and disseminate basic education in maternal and child health and welfare to the Township Association and Branch Association formed throughout the country; (c) to render aid and assistance relating to health and social affairs to the Township Associations and Branch Associations formed throughout the country; (d) to render aid and assistance relating to health and social affairs to the public, when necessary, and (e) to co-ordinate so as to ensure a convenient and smooth performance of works to be carried out in co-operation among the

Township Associations and Branch Associations. The law was initially enacted in 1990 and has been amended in 1993 and 2003.

The Myanmar Red Cross Society Act was enacted in 1959 and later amended in 2001. The Union of Myanmar is a signatory to the Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armies in the Fields (1929), And whereas it is provided in the Geneva Convention Implementing Act for discharge of the obligations imposed under that Convention, It is also expedient for each State Party to constitute a permanent organization for discharge of works according to the sympathetic purposes of that Convention - an organization named "The Myanma Red Cross Society" has already been constituted with its scheme as agreed by the High Court. The main functions are:

1. Caring of wounded and sick of the Defence Services of the Union of Myanmar, whether they are enrolled in the service or are dismissed from enrolment;
2. Protection of child;
3. Formation of working committees to aid with clothes to hospitals and other health units where are in need of such clothes;
4. Aiding in all round efforts to nursing, health and care services which are under the subsidy of any organization recognized by the Society whether they are already existed or to be existed in Myanmar;
5. Nursing service for local service personnel;
6. Carrying out salvation works voluntarily with approval of the Defence Services of the Union Of Myanmar acting as conduit between the civilian and armed forces;
7. Carrying out salvation works in peace time from the outbreak of epidemic diseases, or from the starvation, fire-spread or floods, or any other countrywide calamities, or carrying out any preventive works against such dangers;
8. Acting as the representative of the Society in the International Committee or other committees which are encouraging the same or similar purposes of the Society;
9. Other similar purposes as occasionally approved by the Society.

Myanmar Maternal and Child Welfare Association and Myanmar Red Cross Society are well deep rooted at the community level and in many instances especially towards mothers and children, they are led societies in the community.

The Myanmar Maternal and Child Welfare Association Law, No. 21/90 9th November, 1990 (I/16)

The State Law and Order Restoration Council hereby enacts the following Law: -

ChapterI

Title and Definition

1. This Law shall be called the Myanmar Maternal and Child Welfare Association Law.

2. The following expressions contained in this Law shall have the meanings given hereunder: -

(a) Township Association means the Township Maternal and Child Welfare Association;

(b) Branch Association means the branch of the Township Maternal and Child Welfare Association;

(c) Member means the members of the Myanmar Maternal and Child Welfare Association, Township Associations and Branch Associations.

ChapterII

Objectives of the Association

3. The Myanmar Maternal and Child Welfare Association is formed with the following objectives: -

(a) to form a permanent organization in order to carry out effectively welfare work and assistance relating to the health and social affairs of mothers and children throughout Myanmar;

(b) to organize and disseminate basic education in maternal and child health and welfare to the Township Association and Branch Association formed throughout the country;

(c) to render aid and assistance relating to health and social affairs to the Township Associations and Branch Associations formed throughout tl~e country;

(d) to render aid and assistance relating to health and social affairs to the public, when necessary

(e) to co-ordinate so as to ensure a convenient and smooth performance of works to be carried out in co-operation among the Township Associations and Branch Associations.

ChapterIII

Formation

4. Associations relating to Maternal and Child Welfare shall be formed as follows: -

(a) Myanmar Maternal and Child Welfare Association;

(b) Township Maternal and Child Welfare Association;

(c) Branch of the Township Maternal and Child Welfare Associations.

5. In forming a Branch Association it may only be formed with the approval of the relevant Township Association.

6. The Myanmar Maternal and Child Welfare Association is also the Central Council.

7. The Ministry of Health shall form the Central Council comprising the following persons, with the approval of theGovernment

(a) a person appointed by the Government Chairman

(b) (12) persons appointed by the Government Member

(c) a representative each from the respective State and Member Division, total (14)

(d) (2) representatives from the Member Myanmar Medical Association

(e) (2) representatives from the ....Member Myanmar Red Cross Associatio

(f) (2) representatives from the Member Myanmar Nurses Associatio

(g) a representative from the Member Union of Myanmar Chamber of Commerce and Industry

(h) (5) persons interested in Member voluntary service, selected by the Ministry of Health

8. The members of the Central Council shall elect from among themselves, two Vice-Chairmen, a Secretary, two Joint Secretaries, a Treasurer and an Auditor in the Central Council, with the exception of the Chairman.

9. The Executive Committee of the Central Council shall be formed with the persons mentioned in section 8 and 3 members of the Executive Committee elected by the members of the Central Council.

10. The Central Council may, after forming the Executive Committee determine the number of honoured members of the Central Council and may make selection and appointment.

11. The annual meeting of the Central Council shall be convened once every year. If necessary, special meetings may be convened at any time.

12. Ministry of Health shall convene the First Meeting of the Central Council.

13. The formation, of the Executive committee of the Township Associations and Branch Associations may be determined as may be appropriate by such Associations and Branch Associations.

14. The members of the Executive Committee of the Township Association and Branch Association shall elect from among themselves a Chairman, a Vice-Chairman, a Secretary, a Joint-Secretary, a Treasurer and an Auditor in the Executive Committee of such Association and Branch Association.

15. The Township Medical Officer shall be included as an Adviser in the Executive Committee of the Township Association. -

16. The tenure of the Executive Committee of the Central Council, Township Association and Branch Association respectively is 4 years.

17. The Township Association and Branch Associations shall convene the annual meeting every year. If necessary, special meetings may be convened at any time. In the event of a vacancy in the membership of the Executive Committee it may be filled up at such meetings.

18. Members of the Central Council and members of the Executive Committee of the Township Association and Branch Associations shall be free from party politics and shall also be citizens.

19. The Executive Committees of the Central Council, Township Association and Branch Association shall comply with the prescribed procedures relating to the convening of meetings.

ChapterIV

Membership and Termination of Membership

20. In the Township Association and Branch Association membership is categorized as follows -

(a) ordinary member:

(b) life member:

(c) honoured member:

21. Persons who fulfil the following qualifications may apply for membership in the Township Association or Branch Association

    (a) being a person who has completed the age of 18;

    (b) not being a person of unsound mind;

    (c) not being a member of the religious order;

    (d) being a person who is able to pay admission fee, monthly and annual subscriptions.

22. Admission of a member, admission fee, monthly subscription, annual subscription and life membership fee shall be as prescribed in the procedures

23. If any of the following events occurs, membership shall be terminated:-

    (a) being convicted of any offence prescribed by the Central Council;

    (b) misappropriating funds or property belonging to the Central Council, Township Association or Branch Association;

    (C) Obstructing, abolishing and disturbing the work of the Central Council, Township Association or Branch Association,

    prejudicing the dignity of the Central Council or the relevant Executive Committee.

24. The Executive Committee of the relevant Township Association or Branch Association shall decide on the membership and termination of membership.

25. A person who is dissatisfied with the decision made under section 24 may file an appeal to the Central Council within 30 days of the receipt of such decision.

26. The decision of the Central Council in respect of the appeal under section 25 shall be final and conclusive.

27. The Central Council shall carry out the followings : -

    (a) electing its Executive Committee:

    (b) prescribing the code of discipline and ethics to be observed by the members;

    (c) prescribing from time to time works relating to health and social affairs to be carried out by the Township Associations and Branch Associations;

    (d) forming and appointing the office staff of the Council in accordance with the strength of personnel sanctioned by the Ministry of Health at the pay scales prescribed;

    (e) stipulating the conditions relating to the execution of contracts and agreements on. behalf of the Myanmar Maternal and Child Welfare Association;

    (f) communicating and co-operating with organizations in and outside the country, having the same interests and objectives and utilizing beneficially the funds and property procured;

    (g) carrying out other matters relating to Maternal and Child Welfare.

28. The Central Council shall decide appeal cases submitted under section 25.

Chapter V

Duties and Powers

29. Executive Committee of the Central Council -

(a) shall undertake the responsibility of performing the duties of the Central Council mentioned in sections 27 and 28, when the annual meeting or regular meeting of the Central Council is not in session. Such measures shall be submitted to the nearest session of the Central Council and approval obtained thereat;

(b) shall implement the programmes of work laid down by the Central Council;

(c) shall assist the works of the Township Associations and Branch Associations;

(d) shall carry out the duties assigned from time to time by the Central Council.

Chapter VI

Finance

30. The Central Council and the respective Township Association and ~ranch Association –

(a) shall subsist on its own funds;

(b) shall open a bank account and deposit its receipts and shall have the right to use funds for Maternal and Child Welfare works, if necessary. It may invest funds not immediately required for use by . purchasing saving certificates;

(c) shall maintain and keep the accounts systematically;

(d) shall, in respect of procuring funds, utilization of funds, obtaining sanction for such utilization comply with and carry out as prescribed in the procedures;

(e) shall cause the income and expenditure within the financial year to be audited by the honorary auditors and shall cause the statement of accounts to be prepared.

31. The Central Council, Township Associations and Branch Associations may, if necessary request the assistance of the relevant Audit Office with respect to the maintenance of accounts and auditing thereof.

32. The financial year of the Central Council, Township Associations and Branch Associations is the same as the financial year of the Government.

Chapter VII

Miscellaneous

33. With the exception of the Myanmar Maternal and Child Welfare Association and the Township Associations and Branch Associations formed in accordance with this Law, no association using the name of such associations or a similar name shall be formed.
34. The Myanmar Maternal and Child Welfare Association and the respective Township Association and Branch Association shall operate under its own name and a common seal, and shall have perpetual succession and the right to sue and be sued in its corporate name.
35. The code of discipline and ethics to be observed by the members, and matters relating to enquiry and taking of action against members for violation of the code of discipline and ethics shall be as prescribed by the Central Council.
36. No suit or prosecution shall lie against members of the Central Counciland members of the Executive Committees of the Township Associations and Branch Associations for anything which is done in good faith under this Law.
37. The Township Associations and Branch Associations which have submitted that they have been formed in accordance with the stipulation of the Ministry of Health shall be deemed to be Township Associations and Branch Associations formed under this Law on the day this Law is enacted.
38. For the purpose of carrying out the provisions of this Law: -
    (a) the Ministry of Health may issue procedures as may he necessary, with the approval of the Government;
    (b) the Central Council may issue orders and directives as may be necessary.

Sd./ Saw Maung
Senior General
Chairman
The State Law and Order Restoration Council

The Law Amending the Myanmar Maternal and Child Welfare Association Law (No. 12/93)
1st September, 1993

The State Law and Order Restoration Council hereby enacts the following Law:-

1. This Law shall be called the Law Amending the Myanmar Maternal and Child Welfare Association Law.
2. In the Myanmar Maternal and Child Welfare Association Law –

(i) Sub-section (a) of section 3 shall be substituted by the following sub-section:-

(a) to form a voluntary organization in order to carry out effectively welfare work and assistance relating to the health and social affairs of mothers, children and families throughout Myanmar;

(b) in sub-section (d) of section 3 the expression "public" shall be substituted by the expression "families";

(c) the following shall be inserted as sub-section (f) of section 3: (f) to co-operate with the Government, non-governmental organizations and international organizations, in implementing maternal and child welfare work and family planning

(d) after section 7 the following section shall be inserted as section 7A:-7A. The respective Head of the State, Divisional Department of Health shall be ex-officio member of the Central Council.

(e) in section 21 before the expression "the following qualifications" the expression "without discrimination with regard to race, religion, status or sex" shall be inserted;

(f) the following shall be inserted as sub-section (c) of section 29: -(c) shall form, at the respective State and Division, the State, Divisional Supervisory Committees consisting to the extent of 5 members, with the Head of the State, Divisional Department of Health, as Chairman, and shall determine the duties and powers thereof.

(g) sub-section (c) and (d) of section 29 shall be renumbered as subsection (d) and (e);

(h) sub-section (a) of section 30 shall be substituted by the following sub-section:-(a) shall operate as an organization without a profit-making motive and shall subsist on its own fund;

(i) the following shall be inserted as section 30 A, after section 30:-30 A. The Central Council shall open a separate Bank Account for foreign currency accrued to it and has the power to utilize such foreign currency for the maternal, child and family welfare work in accordance with the existing regulations and bye-laws.

Sd./ Than Shwe
Senior General
Chairman
The State Law and Order Restoration Council

The Law Amending the Myanmar Maternal and Child Welfare Association Law

The State Peace and Development Council Law No. 7/2003) 22nd April, 2003

The State Peace and Development Council hereby enacts the following law:-

1. This Law shall be called the Law Amending the Myanmar Maternal and Child Welfare Association Law.
2. In the Myanmar Maternal and Child Welfare Association Law -

(a) The expression "a representative each from the respective State and substituted by the expression "a representative each from the respective State and Division, total (16)".

(b) The expression "three members of the Executive Committee" contained in section 9 shall be substituted by the expression "7 members of the Executive Committee".

(a) The expression "5 members" contained in sub-section (c) of section 29 shall be substituted by the expression "7 members"

(Sd). Than Shwe
Senior General
Chairman
The State Peace and Development Council

The Myanmar Red Cross Society Act, 1959

Act No. 25/1959 (21 September 1959)*(As amended up to May 2001)*[*]

Whereas the Union of Myanmar is a signatory to the Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armies in the Fields (1929), And whereas it is provided in the Geneva Convention Implementing Act for discharge of the obligations imposed under that Convention,Whereas it is also expedient for each State Party to constitute a permanent organization for discharge of works according to the sympathetic purposes of that Convention; Whereas an organization named "The Myanma Red Cross Society" has already been constituted with its scheme as agreed by the High Court;

Whereas should the Myanma Red Cross Society be necessary to be organized by enactment:

For these reasons, it is hereby enacted as follows:

1. This Act shall be called "The Myanmar Red Cross Society Act, 1959".
2. In this Act, unless there is anything repugnant in the subject or context,-
   (a) "Council" means the Central Council of Red Cross formed under this Act;
   (b) "Prescribe" means prescription by Rules made under this Act;
   (c) "Scheme" means the scheme of trustee approved by the High Court in its Civil Suit No. 23/1958 for the constitution and administration of the Myanmar Red Cross Society;
   (d) "Society" means the Myanma Red Cross Society.
3. The Society shall be a body corporate having perpetual succession and a common seal, and shall also by its name sue and be sued.
4. The Society shall continue by itself to take the possession of all rights, properties and funds owning and possessing at present under the Scheme. The Society shall continue its works, and also be responsible for complete settlement of all debts.
5. If any Myanmar citizens want to be members of the Society, they shall abide bythe regulations prescribed for members to be observed.
6. The President of the Union of Myanmar shall be the patron of the Society.
7. (1) Basic sub-societies may be formed as necessary.
   (2) The State Convention of the Society shall be the policy-making authority. The Convention shall be convened at least once in every three years.

It's amendments:

(1) 1964 Law of Amending the Myanmar Red Cross Society Act,1959; *Insertion of words in s. 12;*

(2) 1971 Law of Amending the Myanmar Red Cross Society Act,1959: *Substitution of s. 5 and 7;*

(3) 1988 Law of Amending the Myanmar Red Cross Society Act, 1959; *Substitution of s. 7(4).*

(3) The first State Convention of the Society as referred to in sub-section (2) shall be convened within 18 months from the date of effectiveness of the 1971 Law Amending the Myanmar Red Cross Society Act.

(4) A Central Council of the Red Cross shall be formed, and it shall also be the administrative authority. The Council shall consist of the following persons:-

(a) one representative from each States and Divisions elected in the State Convention of the Society- totaling 14 representatives;

(b) Director General, the Directorate of Health;

(c) Director General, the Relief and Resettlement Department;

(d) Director General, the Department of Basic Education;

(e) Director General, the Department of Fire Brigate;

(f) Director General, the Customs Department;

(g) Managing Director, Port Corporation;

(h) Director of Medical Staffs, Ministry of Defence;

(i) Persons not exceeding 10, occasionally appointed by the Government;

(j) One person appointed by the Commander in Chief of the Defence Services;

(k) One person appointed by the Chief Justice;

(1) One person appointed by the Attorney General;

(m) One person appointed by the Auditor General;

(n) Chairman or a member of the Yangon City Development Committee;

(o) Assistant Director (Nursing), the Directorate of Health.

(5) Councillors among themselves shall select one Chairman, two Vice Chairmen and one Secretary.

(6) The Council may add up as councillor of persons not more than eight should there be in its opinion beneficial to the activities of the Society.

8. The Council may elect one or more honourable person from those who have served the country in brilliance.

9. Notwithstanding anything contained in section 16, the first Council formed under this Act, shall prescribe without delay the following matters:

(a) appointing an executive committee among the councillors for administrative works of the Society;

(b) constituting and administering the Myanmar Ambulance Brigade as a part of the Society; and causing it to succeed immediately all the rights, properties, funds and lien of debts of the Myanmar Ambulance Brigade having been formed under the Scheme and to undertake immediately of all tasks of the same;

(c) defining the qualifications and conditions required for the members of the Society;

(d) forming necessary sub-committees for further effective working on matters and activities of the Society;

(e) appointing permanent officers and employees and designating of their salaries and other regulations;

(f) contract-signing on behalf of the Society;

(g) defining in general working programmes for the Society, the Cc•ncil and committees;

(h) communicating with unions or organizations referred to in section 15 and allotting funds therefor; and

(i) others matter the Society thinks justified.

10. Among the powers of the Council, the followings shall be included:

(a) power to take loans from a bank or banks in necessary for works of implementation to the purposes of the Society;

(b) power to make decisions in necessary of taking loans or paying of interest due on such loans;

(c) power to open a special account in regard of loans for reservation to be applied authentically for the specific purposes;

(d) power to convert the investment money of the Society for its liquidity by way of redeeming or selling of the securities referred to in section 20 of the Trustees Act, or repurchasing the securities with those money.

11. The Council may receive and keep in possession of any things donated for any works of the Society or for any specific work applicable of its property or of interests from such property, and on receipt of such donations, may use either directly or through the sub-committees, leagues or organizations in relation with.

12. The Society shall submit its report annually after the date of 1$^{s`}$ October but not later than 15^{1h} November to the Minister of the Health Ministry on its performances committed during the period of each financial year which ends up on 30 September. The said report shall include each and every receipt of the Society fully stating under respective heads and having been duly audited in the prescribed manner.

13. The first Council shall be formed within 3 months from the date of effectiveness of this Act. Before such formation, the administrative body of the Society shall, by adding up therein the persons under section 7, sub-section (1)(a), (b), (f) and (g), perform the duties and take the responsibilities of the Council. And it shall also comply during the transit period with the Scheme, or any rules and bye-laws made thereunder, the constitution of the Myanmar Ambulance Brigade and any rules and bye-laws made thereunder, so far as not contrary with this Act.

14. No act or proceeding done by the Council or any committee or sub-committee formed under this Act shall be deemed to vitiate by reason only of any vacancy of councillor or any member of such committee or sub-committee, or any omission, or defect or irregularity in the election or appointment of any councillor or any member of such committee or sub-committee.

15. The Council may cause the Society for making communications with any unions or organizations which uphold all or any purposes stated in the Schedule of this Act, and may appropriate funds for all or any of such purposes by allotting through those unions or organizations.

16. The Council may by the prior approval of the President of the Union of Myanmar make rules in accordance with provisions of this Act for materialization of the purposes of the same.

SCHEDULE

17. Caring of wounded and sick of the Defence Services of the Union of Myanmar, whether they are enrolled in the service or are dismissed from enrolment;
18. Protection of child;
19. Formation of working committees to aid with clothes to hospitals and other health units where are in need of such clothes;
20. Aiding in all round efforts to nursing, health and care services which are under the subsidy of any organization recognized by the Society whether they are already existed or to be existed in Myanmar;
21. Nursing service for local service personnel;
22. Carrying out salvation works voluntarily with approval of the Defence Services of the Union Of Myanmar acting as conduit between the civilian and armed forces;
23. Carrying out salvation works in peace time from the outbreak of epidemic diseases, or from the starvation, fire-spread or floods, or any other countrywide calamities, or carrying out any preventive works against such dangers;
24. Acting as the representative of the Society in the International Committee or other committees which are encouraging the same or similar purposes of the Society;
25. Other similar purposes as occasionally approved by the Society.

MYANMA RED CROSS SOCIETYYANGON

Direction 1/98

Dated 8 June 1998

By the resolution in the Extraordinary Meeting of the Central Council of Myanmar Red Cross Society dating 11th August 1998, and also by the resolution of the 45th Regular Meeting of the Central Council. the structural reformation of the Myanmar Red Cross Society is hereby made as follows:

(a) State/Divisional Red Cross Supervision Committee

(1) State/Divisional Health Director as *Chairman;*

(2) State/Divisional Head of Myanmar Police Force as *Vice Chairman (1);*

(3) State/Divisional Head of Education Department as *Vice Chairman (2);*

(4) State/Divisional Head of Account Office as *Treasurer;*

(5) State/Divisional Head of Fire Services Department as *Member;*

(6) State/Divisional Head of General Administrative Department as *Member;*

(7) State/Divisional Head of Social Welfare Department as *Member:*

(8) Any Health Executive who is appointed by the Chairman, as *Secretary.*

(b) **District Red Cross Supervision Committee**

(1) State/Divisional Health Director or a Representative of Health Directorate (District Health Officer) as *Chairman;*

(2) District Head of Myanmar Police Force as *Vice Chairman (I);*

(3) District Head of Education Department as *Vice Chairman (2);*

(4) A Representative of State/Divisional Account Office or District Head of Account Office as *Treasurer;*

(5) A Representative of State/Divisional Fire Services Department or District Head of Fire Services Department as *Member;*

(6) A Representative of State/Divisional General Administrative Department or District Head of General Administrative Department as *Member;*

(7) Any Health Executive who is appointed by the Chairman. as *Secretary.*

(c) **Township Red Cross Supervision Committee**

(1) Township Health Officer as *Chairman;*

(2) Township Head of Myanma Police Force as *Vice Chairman (1);*

(3) Township Head of Education Department as *Vice Chairman (2);*

(4) Township Head of Account Office as *Treasurer;*

(5) Township Head of Fire Services Department as *Member;*

(6) Township Head of General Administrative Department as *Member;*

(7) Any Health Executive who is appointed by the Chairman, as *Secretary;*

(8) Sub-battalion Commander of the Township Red Cross Battalion as *Joint-Secretary.*

3. By this Direction, the former Direction No. 1/88 dated 17.11.1988 is hereby repealed.

Sgd.
Colonel Aung Than
Executive Director

Service Delivery

The Legislations related to Service Delivery may be subdivided into three components:

Component I: Public Health Law (1972)
Prevention and Control of Communicable Diseases Law (1995) (Revised in 2011)
Epidemic Diseases Act
Notification of formation of National Disaster Central Committee
Notification of formation of National Disaster Work Management Committee

Component II: Municipality Act
The City of Rangoon Municipality Act
The City of Yangon Municipality Act
The Development Committees Law
The Yangon Development Committee Law
The Environmental Conservation Law

Component III: The Law Relating to Private Health Care Services (2007)

Component IV: The Control of Smoking and Consumption of Tobacco Product Law (2006)
Narcotic Drugs and Psychotropic Substances Law (1993)
National Food Law (1997)

Component V: Eye Donation Law (1996)
Blood and Blood Products Law (2003)
Body Organ Donation Law (2004)

Component I

The Public Health Law is concerned with protection of people's health by controlling the quality and cleanliness of food, drugs, environmental sanitation, epidemic diseases and regulation of private clinics.

The Public Health Law also associated with the rules and regulations issued under these laws, if it is not contrary with this law: Registration act of private nursing-home, 1957; The dangerous Drags Act; The Epidemic diseases Act; The food and Drugs Act (Amendment) Act 1949; The Ghee Adulteration Act ; The food and drugs Act; The leprosy Act; The vaccination act; Factories Act, 1961; The animal pest Act; The Burma Merchant shipping Act; The Burma Air craft Act; The city of Rangoon Municipal Act; The cantonments Act; The Municipal Act; The pots Act; The Rural Self-Govern men Act; The Railways Act; The Towns Act; and The village Act.

Prevention and Control of communicable Diseases Law describes functions and responsibilities of health personnel and citizens in relation to prevention and control of communicable diseases. It also describes measures to be taken in relation to environmental sanitation, reporting and control of outbreaks of epidemics and penalties for those failing to comply. The law also authorizes the Ministry of Health to issue rules and procedures when necessary with approval of the government. It also spelled out the duties and functions of the Health officer in disease surveillance and in disease outbreak. The Epidemic Diseases Act, 1897 and The Vaccination Act 1909 were repealed with this Law.

Disaster Law 2013, has already been drafted and it is on the way to be enacted. However Notification for formation of National Disaster Central Committee and Work Management Committee has already been issued as Notification No. 45/2013 and 46/2013 respectively on 14 May 2013.

Union of Burma Public Health Law

Union of Burma 1972, Revolutionary Council Law No.1

Revolutionary Council of Burma

12nd pyartho of 1333 ME, Rangoon (12nd January of 1972)

Under This Law is announced as follow

(*Un-Official Translation)*

Introduction

Revolutionary Council of Burma builds the Nation with socialism, So Building the socialist state, not only to up lift the economy life of the people and but for social life of the people when the social life of the people is as the under is higher and the lotus is more elegant, success of the economic system for the better improvement of the interest of the health of the people is to be carried out the health activities systematically. The Chairman of the Revolutionary Council of Burma enacts this law.

Chapter (1)

(1) This law is called Public Health law of The Union of Burma, 1972.

Name and date of enactment.

(2) This law shall be come into force immediately around the Burma (Myanmar). **Definition**

1. The expression and words in this law shall be meat as under the following.

    (a) rubbish, waste means rubbish, food remain, sewage waste water and animal or human dead bodies,

    (b) Residence, building or places mean market, school, cinema hall, theatre, garden, play ground, Hotel, restaurant and lodging-house.

Food means, vegetables, meat, fish, cooking and preserved food, liquor and canned food, human take these any food.

Drugs mean in addition to the definition of the food and drugs Act, aliment, injection, inhaler by the use of vapour, liquid, powder and solid to use for the treatment of diseases issued by the Order of the Government from time to time.

Home utility means materials use for social welfare, materials for child play or physical and sport materials.

Private clinic means hospital, dispensary, its premises and give treatment for unhealthy, injured, pregnant as internal and external patients and its asd work as rado graphy, medical examination and laboratory Test.

Chapter(2)

Prevention for public health

3. Notwithstanding anything contained in any existing law, the government must, make the prohibition, amendment, inspection and supervision under the following health activities for the prevention of health failure and for the development of public health.

(1) Environmental health activities

(a) Rubbish and waste are kept and discharged in the community.

(b) Prevention of the drinking water and demarcation of the water quality in line with international standard.

(c) Prevent from the pollution of smoke, gas, smell, dust and radioactive rays.

(d) Performance for health and sanitation in township, village development, building and places.

(2) **Food related activities to the production and sale by public.**

(a) Registration, cancellation of registration and re-registration of food production factory, work and business.

(b) To be clean and healthy the selling food to the public.

(c) Prevention from mixing with other materials, extraction from original materials and the imitation food sold to public.

(d) To be clean and healthy for food production work, building, factory and business.

(e) To be clean and healthy for the food selling premise and building. Prevent not to serve in the food production and Selling place, business and factory, anyone who suffers from infections disease.

(g) Seize and destroy the hazardous food.

(h) Send the food to state laboratory for inspection of related affairs.

(i) Carry out the standards provided by the Government.

(3) **Related affairs to the home utility and beauty product to public.**

(a) Registration, cancellation from register and re-registration of home utility and beauty products factory and work place.

(b) Prohibited for production of home utility and beauty products when these are poisonous and dangerous for radioactive rays.

(c) Destroy the hazardous, home utility and beauty products that has been produced by the way that is harmful to public.

(d) Seize and destroy the harmful home utility and beauty products at shops.

(e) Perform the standards of home utility and beauty products provided by the Government from time to time.

(4) Related affairs to the infectious diseases

(a) Declare the statement list of diseases applied timely the respective regions, to be

prevented from spread of infectious diseases.

(b) Perform the necessary activities and killing the pest and insects, immunization, immunization scheme for public, searching for the prevention of infectious diseases.

(c) Necessary preventive measures for infectious diseases, declaration and emergency place "curfew area" of village, Quarter, Township, District, State, Region, by the government. If there occurs in hazardous condition for public health.

(5) **Related affairs to private clinic**

(a) Provide the necessary rules and regulation for the private clinic.

(b) Re-registration, cancellation from register and registration of the private clinic.

(6) **Related affairs to the necessary drugs for public use**

(a) Production and distribution of drugs, registration, re-registration and cancellation from register for whole sales and retails.

(b) Send the specimen of pharmaceuticals and formulae to the Food and Drags. Administration Board, for the fullness of efficiency and pharmaceuticals may not be harmful to public.

(c) Prohibition for Advertisement of fraud (or) than has being much more efficiency.

(d) Make distribution after inspecting the efficiency of pharmaceutical imported by abroad.

(f) Assign the duties to the Food and Drugs Administration laboratory in order to inspect the pharmaceutical efficiency

Chapter (3)

Rights and duties

4. To carry out any provision of the law, Government may assign duties.

(a) Constitute the necessary committee, and those committees may advise supervise, amend, prohibite and dismantle.

(b) Have the right to assign the duties to any department and sub-department of the state.

(c) Organizations, committee constituted by this law, persons who assigned by organization (or) committee, state department and sub-state department assigned by this law have right to enter, inspect and instruct the work, factory, Shop, premise places and buildings in any time for the environmental health affair, respective. Food staff affairs, home utilities and beauty products affairs related to the infections disease, private clinic and concerning with public use drugs.

Chapter (4)

Provisions of existing law, known as rules.After prescribing this law, with in the period before prescribing the necessary rules and regulations, the rules and regulations issued under this law may be continued to exercise if it is not contrary with this law.

1. Registration act of private nursing-home, 1957
2. The dangerous Drags Act
3. The Epidemic diseases Act
4. The food and Drugs Act (Amendment) Act 1949
5. The Ghee Adulteration Act
6. The food and drugs Act
7. The leprosy Act
8. The vaccination act

After prescribing this law, with in the period before prescribing the necessary rules and regulations, the rules and regulations issued under this law may be continued to exercise if it is not contrary with this law.

1. Factories Act, 1961
2. The animal pest Act
3. The Burma Merchant shipping Act
4. The Burma Air craft Act
5. The city of Rangoon Municipal Act
6. The cantonments Act
7. The Municipal Act
8. The pots Act
9. The Rural Self-Govern men Act
10. The Railways Act
11. The Towns Act
12 The village Act

([1])Contined to perform the affairs by committe (2)before prescribingthe lawState in Section (6)and (7) ofthis law committees related to the public health (or) persons assigned, may be continued to carry out according to this method and system before amending.

With in the period before prescribing the rules, regulations, by-law, procedures, instruction and directives Related to the public heath affair under the provision of section (6) and Section (7) may be continue to carried out in accordance with the provision of this Law.

([3])With in the period before repealing of the rules, regulations, by law,procedures, instruction and directives by this law section (6), (7) may continueto be complied so far as they are not in consistent with the provision of this law, Know as rules , regulations, by law, procedures instruction and directives.

Chapter (5)

Penalties nad provision related to the taking actions

9.(I) Notwithstanding anything contained in the existing laws, anyone who violatesthe provision of section (6), (7), provision of law, order, regulation, procedures, directives, instruction and any rules related to public heath. Fail to abide byBreachCommission to breachAssist to breach for being realized reasons.

(a) If this provision is related to environmental health, related to the home utilities and beauty products for the use of worker, on conviction, be punishable with imprisonment for a term which may extend to **1** year or, with fine, which may extend to Kyats 500/- or with both, as may be confiscated.

(b) Whether this provision is related to the food products, related to the infectious disease and drugs used for public, on conviction firstly, be punishable with imprisonment for a term which may extend to 3 years or, with fine, may extend to Kyats 1000/- or both, as may be confiscated.

(c) If this provision is relation with private-clinic on conviction, be firstly punishable with imprisonment for a term which may extend 5 years or, with fine, may extend to Kyats 5000/- or, both, as may be confiscated.

2.On conviction for first time, second time, or again, provision in sub section (1),fail to abide by breach (or)take enforce to commit commission on conviction

(a) This provision included in sub-section (1)(a), be punishable with imprisonment for a term which may extend to (3) years (or) both, may be confiscated.

(b) This provision related to sub-Section (1)(b)and (c), be punishable with imprisonment for a term which may extend to (10)years (or) both, may be confiscated.

3. The government, persons (or) committee assigned by the state can liquidate from time to time according to the directives.

4. May be punishable with imprisonment for a term which may extend to (3)years, (above 3 years), any prosecution can't be taken without being granted for prosecution.

Anyone, related law for public health, sect 9(1).

- Fail to comply with
- Breach the provision of the law

Commission to breach the provision of the law whether it is realized or not. Anyone, who is assumed as a supervisor, a company may prosecute this offence, may be liable to be punished.

But offence is not known for anyone's prosecution, no offence is anyone's performance, it may be clear evidence, may not be punished.

Miscellaneous Provisions

(1) To carry out the aim of the provisions of this law, the Government may issue rules, regulations, by-law, orders and directive(2)Government may substitute, revoke and issue the list names of law, stated in section (6)(7)

Anyone who performs his activities in accordance with the provision of this law, whom is assumed as "public servant" provided in section (21)of Criminal Act.

Anyone who may not be prosecuted for anyone's honest performance, by issued rules, regulations, procedures, by laws, instructions and intention to carry out the provision of this law under Criminal Act (or) Civil Procedure Code.

Government or Under Government Organization, concerned with Government Factory, Mill, Work, People's Worker Council, People's Peasant Council, Clinic opened by cooperative Society isn't related to the provision of the registration under Section (3) paragraph (2) (A), paragraph (3) (A), paragraph (5) (B) and paragraph (6) (A).

Provisions included the directives, orders, by-laws, rules, regulations concerned with the public health under the law, section (6), (7), is meant, may be with the contrary, to the aims of this law or not, decision by the Government may be final.

16. Government may, exemption by issuing order (or) with provide the rules(or) without having rules to anyone (or) any port of the provision of this law.

For the purpose of carrying out all the provision (or) a part of provision of this law, Government sometime issued Order in according to fulfill the difficulties.Yangon,12nd Waxing of Pyatho 1333 ME l2nd January, 1972.

The Prevention and Control of Communicable Diseases Law

(The State L{aw and Order Restoration Council Law No 1/95)

The 5th Waning of Taboung, 1356 ME

(20th March, 1995)

The State Law and Order Restoration Council hereby enacts the following Law: -

Chapter I

Title and Definition

1. This Law shall he called the Prevention and Control of Communicable Diseases Law.

2. The following expressions contained in this Law shall have the meanings given under:-

(a) Communicable Disease means an infections disease which can be transmitted from man to man and from animal to man;

(b) Principal Epidemic Disease means Cholera, Plague, Dengue Hemorrhagic Fever (DHF) or Acquired Immunodeficiency Syndrome (AIDS). This expression also includes Communicable Diseases prescribed as Principal Epidemic Disease by the Ministry of Health by notification:

(c) Notifiable Disease means an Communicable Disease prescribed by the Ministry of Health by notification, the occurrence of which, when discovered is to he reported

immediately to the authority concerned;

(d) Refuse means garbage, food remnants, human and animal excreta, polluted water, filth and dead body of human or animal;

(e) Food means fruits, vegetables, meat, fish, prepared food, beverages, canned foods and any other food consumed by man;

(f) Health Officer means an officer from the Department of Health assigned to perform the duties of a Health Officer mentioned in this Law. This expression also includes officers from other Government department and organizations, assigned duties of a Health Officer bythe Ministry of Health after co-ordination with the Government department and organizations concerned:

(g) Health Personnel means a personnel assigned by the Health Officer;

(h) Traditional Medicine Practitioner means a person who is practicing medicine on a principle based on one of the four nayas namely Desana naya, Bethitsa naya, Netkhata vedanaya and Vissadara nay

3. In order to prevent the

Chapter II

Prevention

outbreak of Communicable Diseases, the Department of Health shall implement the following project activities:-

(a) immunization of children by injection or orally;

(b) immunization of those who have attained majority, by injection or orally, when necessary;

(c) carrying out health educative activities relating to Communicable Disease.

4. When a Principal Epidemic Disease or a Notifiable Disease occurs:-

(a) immunization and other necessary measures shall be undertaken by the Department of Health, in order to control the spread thereof:

(b) the public shall abide by the measures undertaken by the Department of Health under sub-section (a).

Chapter III

Functions and Duties of the Health Officer

5. When a Principal Epidemic Disease or a Notifiable Disease occurs in an area to which Health Officer is assigned, he shall perform the following duties:-

(a) inspection of the infected house, food processing industry, factory, place of work, markets and shops, other necessary houses. premises, location, buildings and

causing sanitation and other necessary measures to he carried out;

(b) causing disinfection to he carried out in the locations mentioned in sub-section (a) and of articles, clothes. utensils and other household goods in such locations;

(c) causing disinfection to be carried out in trains, motor vehicles, aircrafts, vessels and other vehicles;

(d) causing chlorination of wells and ponds to be carried out;

(e) causing destruction of the vector;

(f) causing necessary measures to be carried out against transmission of disease from Principal Epidemic Disease infected corpse;

(g) submitting and reporting the situation concerning the Principal Epidemic Disease to the relevant authorized body or person to enable the issue of the restrictive or prohibitive order under section 14;

(h) directing the ban or destruction of food which are unfit for human consumption;

(i) directing the destruction of or ban on the sale of food causing or suspected of causing the spread of a Principal Epidemic Disease or the closure of the factory, mill, place of work, market or shop producing or selling such food;

(j) inspection of water supply works and laundry services and directing closure of such places if proved to be a source of transmission.

6. The Health Officer may assign the duties which he is to perform or which he is authorized to perform to a Health Personnel.

7. The Health Officer shall obtain the cooperation of suitable persons from the Government departments and other organizations of the relevant area in performing duties mentioned in section 5.

Chapter IV

Environmental Sanitation

8. For prevention of the outbreak of Communicable Disease and effective control of Communicable Disease when it occurs, the public shall, under the supervision an guidance of the Health Officer of the relevant area, undertake the responsibility carrying out the following environmental sanitation measures:

(a) in-door, out-door sanitation or inside the fence, outside the fence sanitation;

(b) well, ponds and drainage sanitation;

(c) proper disposal of refuse and destruction there of by fire:

(d) construction and use of sanitary latrines;

(e) other necessary environmenta1 sanitation measures.

Chapter V

Reporting Communicable Disease

9. The head of the household or any member of the household shall report immediately to the nearest health department or hospital when any of the following events occurs:-

(a) rat fall

(b) outbreak of a Principal Epidemic Disease;

(c) Outbreak of a Notifiable Disease.

10. Traditional medicine practitioners, health assistants and doctors shall report immediately to the nearest health department or hospital if a case of Principal Epidemic Disease or Notifiable Disease if found during practice.

Chapter VI

Measures taken in respect of an outbreak of

Principal Epidemic Disease

11. In order to prevent and control the spread of a Principal Epidemic Disease, the Health Officer may undertake the following measures:-

(a) investigation of a patient or any other person required:

(b) medical examination;

(c) causing laboratory investigation of stool, urine, sputum and blood samples to he carried out:

(d) causing investigation by injection to he carried out;

(e) carrying out other necessary investigations.

12. The Health Officer has the right to do laboratory investigation of any food, water and other necessary materials.

13. The Health Officer shall report immediately the source to the relevant Department of Health, of the Principal Epidemic Disease.

Chapter VII

Quarantine

14. An organization or an officer on whom power is conferred by the Ministry of Health may issue a prohibitive order or a restrictive order in respect of the following matters:-

(a) right of the person suffering from Principal Epidemic Disease to leave and return to his house;

(b) right of people living in the house, ward, village or township infected by Principal Epidemic Disease to leave and return thereto;

(c) right of people from outside to enter the house, 'ward, village or township infected by Principal Epidemic Disease;

(d) if there is a person suffering from Principal Epidemic Disease among those people arriving by train, motor vehicle, aircraft, vessel or any other vehicle, right of such person put under quarantine up to a period necessary for medical examination, to leave and return thereto;

(e) when an outbreak of Principal Epidemic Disease occurs during the time of fair and festival, right of the public to visit the site and right to continue the festival.

Chapter VIII

Penalties

15. Whoever fails to comply with any of the measures undertaken by the Department of Health under sub-section (a) of section 4 shall, on conviction he punished with fine which may extend to Kyats 1000.

16. Whoever tails to comply with the directive of the Health Officer under sub-section (h), sub-section (i) or sub-section (j) of section 5 shall, on conviction he punished with imprisonment for a term which may extend to six months or with fine which may extend to kyats 10000 or with both.

17. The head of the household or any member of the household who fails to comply with the provision of section 9 or any traditional medicine practitioner, health assistant or doctor who fails to comply with provision of section 10 shall, on conviction be punished with imprisonment for a term which may extend to one month or with fine which may extend to kyats 5000 or with both.

18. Whoever violates the prohibitive or restrictive order issued by the relevant organization or officer under section 14 shall, on conviction he punished with imprisonment for a term which may extend to six months or with fine which may extend to kyats 10000 or with both.Department of Traditional Medicine

19. Notwithstanding anything contained in the Union of Myanmar Public Health Law 1972, the provisions of this Law shall be complied with in respect of matters relating to Communicable Diseases.

20. Prevention, control of the spread and necessary investigations in respect of AIDS shall he carried out in accordance with the orders and directives issued specifically by the Ministry of Health.

21. In order to carry out the provisions of this Law:-

(a) the Ministry of Health may issue such rules and procedures as may he necessary, with the approval of the Government;

(b) the Ministry of Health or the Department of Health may issue such orders and directives as may be necessary.

22. The following Acts are hereby repealed:

(a) The Epidemic Diseases Act, 1897;

(b) The Vaccination Act, 1909.

Sd./ Than Shwe
Senior General

Chairman

The State Law and Order Restoration Council

Republic of the Union of Myanmar

President Office

Notification No. (45/2013)

5th Waxing of Kason, 1375 ME

14th May, 2013

Formation of National Natural Disaster Preparedness Central Committee

1 Aiming at caryin out preparedness and safety measures for possible danger of natural disaster in the county and ensuring prompt and effective risk response in time of emergency, National Natural Disaster Preparedness Committee comprising of the following persons was formed as follows:

(a)	Vice-President (2)	Chairman
(b)	Union Minister Ministry of Home Affairs	Vice Chairman
(c)	Union Minister Ministry of Social Welfare, Relief and Resettlement	Vice Chairman
(d)	Union Minister Ministry of Defence	Member
(e)	Union Minister Ministry of Border Affairs	Member
(f)	Union Minister Ministry of Foreign Affairs	Member
(g)	Union Minister Ministry of Information	Member
(h)	Union Minister Ministry at the President Office (5)	Member
(i)	Union Minister	Member

	Ministry of Agriculture and Irrigation	
(j)	Union Minister	Member
	Ministry of Livestock and Fisheries	
(k)	Union Minister	Member
	Ministry of Communications and Information Technology	
(l)	Union Minister	Member
	Ministry of Transport	
(m)	Union Minister	Member
	Ministry of Energy	
(n)	Union Minister	Member
	Ministry of Commerce	
(o)	Union Minister	Member
	Ministry of Education	
(p)	Union Minister	Member
	Ministry of Health	
(q)	Union Minister	Member
	Ministry of Finance and Revenue	
(r)	Union Minister	Member
	Ministry of National Planning and Economic Development	
(s)	Union Minister	Member
	Ministry of Construction	
(t)	Union Minister	Member
	Ministry of Rail Transportation	
(u)	Chief Minister	Member
	All Region/State Governments	
(v)	Deputy Minister	Secretary
	Ministry of Social Welfare, Relief and Resettlement	
(w)	Director General	Joint Secretary
	Union Government Office	

(2) Duties and responsibilities of National Natural Disaster Preparedness Central Committee are as follows:-

(a) To form committees needed for implementation of the work procedures of the central committee, to outline polices on important tasks among various stages of works and to give necessary guidelines after reviewing the work progress.

(b) Laying out of the polices and directives for the use of domestic forces in the face of natural disaster as necessary.

(c) Formulation of basic principles of coordination for the decisions that calls for international assistance.

(d) Distribution of State funds and State resources to places which are in need of help.

(e) Issuing orders and directives, if necessary, in the aftermath of natural disaster in order to perform relief and management works without having any difficulties and obstacles, to avoid malpractices on relief supplies and to ensure the rule of law, community peace and tranquility.

Sd/ Thein Sein
President
Republic of the Union of Myanmar

Republic of the Union of Myanmar
President Office
Notification No. (46/2013)
5th Waxing of Kason, 1375 ME
14th May, 2013

Formation of National Natural Disaster Preparedness Management Work Committee

1. **National Natural Disaster Preparedness Management Work Committee** is formed with the following persons so as to systematically undertake preparedness measures for natural disasters, to swiftly carry out reliefs and aids and to implement policies and directives set by National Natural Disaster Preparedness Central Committee.

(a) Union Minister — Chairman
Ministry of Social Welfare, Relief and Resettlement

(b) Deputy Minister — Vice-Chairman
Ministry of Home Affairs

(c) Deputy Minister — Vice-Chairman

Ministry of Social Welfare, Relief and Resettlement

(d) Deputy Minister — member
Ministry of Information

(e) Deputy Minister — member
Ministry of Education

(f) Chairman — member
All Subcommittees

(g) Minister — member
Ministry of Security and Border Affairs
All Region/State Governments

(h) Director-General — secretary
Relief and Resettlement Department
Ministry of Social Welfare, Relief and Resettlement

(i) Director-General — Joint secretary
General Administration Department
Ministry of Home Affairs

2. Natural Disaster Preparedness Management Work Committee is to form the following subcommittees with the appropriate persons.
   (a) Information subcommittee
   (b) Hotline subcommittee
   (c) Search and rescue subcommittee
   (d) Collecting of preliminary damages news and emergency aids subcommittee
   (e) Confirmation of damages and losses subcommittee
   (f) Transport and route clearance subcommittee
   (g) Disaster risk reduction and building of emergency tents subcommittee
   (h) Healthcare subcommittee
   (i) Rehabilitation and reconstruction subcommittee
   (j) Security subcommittee
3. Duties of National Disaster Preparedness Management Work Committee are as follows:-
   (a) to implement natural disaster preparedness management works such as disaster risk reduction, preparedness, reliefs, rehabilitations and reconstruction in line with policies, directives and procedures set by National Disasters Preparedness Central Committee

(b) to manage local aids for relief, resettlement and reconstruction and foreign aids when National Disasters Preparedness Central Committee assigns duties

(c) to encourage mass participation in natural disasters preparedness educative programme and tasks

(d) to occasionally report Management Work Committee's undertakings to National Disasters Preparedness Central Committee

(e) to set up natural disasters forecasting system and the early warning system and to distribute news to the grass-root level in time when the warning is received from the warning system

(f) to assign duties to departments and organizations according to the size of natural disasters

(g) to supervise undertakings of Subcommittees and to coordinate Subcommittees

(h) to supervise works of subcommittees and coordinate their tasks

(i) to report Management Committee's progresses to the Chairman of the Central Committee quarterly

(j) to supervise relief and resettlements in case of natural disasters

Sd/Thein Sein

President

Republic of the Union of Myanmar

The Government of the Union of Myanmar

The Ministry of Home Affairs Yangon, 1S^{t} Waxing of Tazaungmon 1362, M.E.

(27th October, 2000)

ORDER SUPPLEMENTING ORDER NO. 1/99

The Ministry of Home Affairs of the Government of the Union of Myanmar, under the direction of the State Peace and Development Council, hereby directs that the following amendment shall be made to Order No. 1/99 dated 14th May, 1999 as requisition of forced labour is illegal and is an offence under the existing laws of the Union of Myanmar:-

1. Clause 5 of the said Order 1/99 shall be substituted with the following:-

(2) Responsible persons including members of the local authorities, members of the Armed Forces, members of the Police Force and other public service personnel shall not requisition work or service notwithstanding anything contained in Sections 7(1) and 9(b) of the Towns Act, 1907 and Sections 8(1) and 11(d) of the Village Act, 1907.

(3) The above Clause (a) shall not apply to requisition work or service when an emergency arises due to fire, flood, storm, earthquake, epidemic disease, war, famine and epizootic disease that poses an imminent danger to the general public and the community.

2. When the responsible persons have to requisition work or service for purposes mentioned in Clause 1(b) of this Supplementary Order the following shall be complied:-

(ii) The work or service shall not lay too heavy a burden upon the present population of the region.

(iii) The work or service shall not entail the removal of workers from their place of habitual residence.

(iv) The work or service shall be important and of direct interest for the community. It shall not be for the benefit of private individuals, companies or associations.

(v) It shall be in circumstances where it is impossible to obtain labour by the offer of usual rates of wages. In such circumstances, the people of the area who are participating shall be paid rate of wages not less favorable than those prevailing in the area.

Component II

This component comprises of Municipality Act, The City of Rangoon Municipality Act, The City of Yangon Act and The Development Committee Laws and The Yangon City Development Committee Law.The Municipality Act was enacted in 1898, during the colonial days and later it was amended. The City of Rangoon Municipality Act was also enacted during the colonial days and later re-enacted as the Yangon City Municipality Act.All these Municipality Acts take care of Public Health and Disease Control at the urban areas. The Development Committee Laws take care of buildings and structural safety, sanitation and many other aspects of occupational health. The Yangon City and Mandalay has separate Acts and Laws, due to its unique size of the urban areas, those days.

In 2012 the Pyithu Hluttaw enacted the Environmental Conservation Law which has a huge impact on reservation of all natural resources and side by side in controlling of risk factors leading to non-communicable diseases. It certainly revealed the collection of effort among all not only in prevention but very much on health promotion as well. This is a strong illustration of the effectiveness of HiAP which is so critical on the country's pathway on Universal Health Coverage. Basically municipality engages in all the sanitary work such as water, sewage, market, street, building, etc., which are the major essential components of a livelihood. In this due to its limit in space, the Development Committee law and the Environmental Conservation Law will be presented.

The Development Committees Law

(The State Law and Order Restoration Council Law No. 5/93)

1993-05: The Development Committees Law

The State Law and Order Restoration Council

The 10th Waxing Day of Hnaung Tagu, 1354 M.E.

(1st April, 1993)

The State Law and Order Restoration Council hereby enacts following Law: -

Chapter I

Title and Definition

1. This Law shall be called the Development Committees Law.

2. The following expressions contained in this Law shall have the meanings given hereunder: -

(a) Development Committee means an organization formed carry out the development works within the specified bound an limit, This expression includes committee and service organization;

(b) Ministry means the Ministry of Home Affairs;

(c) Minister means the Ministry for Home Affairs;

(d) Department means the Department of General Administrator;

(e) Director General means the Director General of the Department of the General Administration;

(f) Officer in charge of State/ Division means the Officer of the State/ Division Department of the General Administration;

(g) Committee means the Development Committee constituted under this Law;

(h) Service Organization means the service personnel of the Development Committee Office;

(i) Executive Officer means the Head of the service personnel of the Development Committee Office;

(j) Bye-laws means the bye-laws issued by the Ministry or the Department in respect of works prescribed under this Law;

(k) Dangerous Trade means any work which may cause danger to human life or its health, destruction or obstruction to property either due to the nature of the work or the manner it is carried out;

(l) Tax means any tax assessed under this Law. This expression also includes taxes, rates, duties and fines;

(m) Slow-moving Vehicle means any vehicle such as side-car, push-cart, peddled or pushed by a person or cart drawn by animals and used or hired for the purpose of transporting passengers and merchandise on payment of fare;

(n) The Driver of Slow-moving Vehicle means any person who peddles, pushes, pulls or drives a Slow-moving Vehicle;

(o) Ferry Service means any public undertaking whereby passengers, merchandise. animals and vehicles are transported across a river, a channel or a lake by boat, mechanically powered river craft or ship etc. on payment of a fare or hire, The expression also includes ferry, jetty, ferry terminal, ferry terminal buildings

Chapter II

Formation of Development Committees

3. The Ministry, except within the limits of the City of Yangon Development and the City of Mandalay Development areas may from Committees in the remaining areas in the manner :-

(a) development committees either for a township or for adjoining townships collectively forming for the purpose development work;

(b) in forming under sub-section (a) specify the Town Development boundary limit for the purpose of carrying out works, in the Township Development areas.

Chapter III

Formation of Committee

4. The Ministry shall form the Development Committee with suitable citizens in order to carry out the duties and functions of the Committee,

5. In forming the Committee, the Ministry shall at the same time, appoint the Chairman of the Committee.

6. The Executive Officer is the Secretary of the Committee.

7. When the Ministry is unable to form the Committee or the Committee is unable to carry out its duties and powers, the Executive Officer or a suitable citizen may be assigned with responsibilities to carry out the duties and powers of the Committee.

8. The Committee shall be a body corporate, operate under its own name and have a common seal and perpetual succession and right to sue and be sued in its corporate name.

Chapter IV

Duties and Function

9. The Committee shall, in respect of the following duties and functions, implement and supervise in accordance with the existing laws;

(a) drawing up plans and carrying out town planning;

(b) carrying out works for water supply;

(c) carrying out works for sanitation;

(d) carrying out works for disposal of sewage;

(e) carrying out works for lighting of roads;

(f) construction, supervision and maintenance of markets owned by the Committee;

(g) granting permission for the establishment of privately-owned markets and supervising them;

(h) establishing cattle markets and supervising them;

(i) stipulation of conditions in respect of roadside stalls;

(j) stipulation of conditions in respect of bakeries and restaurants;

(k) stipulation of conditions in respect of dangerous trade;

(l) carrying out precautionary measures against fire, flood, storm and natural disaster;

(m) establishing cattle slaughter houses, granting permission for slaughtering of cattle for public consumption and Supervising sale of meat;

(n) administration of ferries;

(o) stipulation of conditions in respect of small loan business;

(p) administration of Slow-moving Vehicles;

(q) construction and maintenance of roads, bridges;

(r) prescribing road bye-laws and the use of road, name of road and number for the building;

(s) construction and maintenance of buildings under the charge of the Committee;

(t) granting permission for construction of private buildings within the Development Committee boundary limit and supervision thereof;

(u) with the approval of the Ministry, granting permission for the construction and supervision of private buildings in rural area outside the Development Committee boundary limit specified by notification;

(v) demolition of squatter buildings;

(w) granting permission for opening lodging houses and supervision thereof;

(x) supervising the keeping and breeding of animals within the Development area and disposal of carcasses;

(y) arresting of wandering insane persons, lepers, beggars and handing over to the authority concerned;

(z) rounding-up, keeping in custody of wandering animals and disposing them;

(aa) construction and maintenance of gardens, parks, play grounds, swimming pools, public baths and recreation centres;

(bb) allotting and supervising cemeteries, constructing and maintaining crematoriums;

(cc) with the approval of the Ministry, demolishing of cemeteries and using of land for other purposes;

(dd) executing other development works in the public interest;

(ee) carrying out other duties assigned by the Ministry from time to time.

Chapter V

Powers of the Committee

10. The Committee may, with the sanction of the Ministry, carry out the following :_

(a) prescribing, revising, assessing and collecting various duties and taxes and their rates relating to development works in accordance with the existing laws and rules;

(b) having the right to take loans and grants from the Government or from local or foreign organizations on its own responsibility;

(c) having the right to carry out works contributing to the development of the town area or township area by making contact with local and foreign organizations or with local and foreign individuals;

(d) having the right to use the foreign currency delivered from the lease of buildings or lands or by any other means for development works;

(e) inspecting and submitting reports in respect of construction and maintenance of State-owned buildings except those buildings relating to the defence of the State or those classified as secret.

11. The Committee may carry out the following : -

(a) drawing up bye-laws in respect of development works in accordance with existing laws and rules;

(b) implementing works with funds owned by the Committee in accordance with existing laws and rules;

(c) carrying out works if necessary, by forming sub-committees;

(d) applying modern and advanced methods and technique in order to execute the development work more effectively;

(e) consulting and co-ordinating, if necessary, with government departments and organisations concerned in the execution of its duties and functions;

(f) exercising the powers conferred from time to time by the Ministry.

Chapter VI

Collection of Taxes

12. The Committee may, with the sanction of the Ministry, levy the following taxes either within the township development area or in town area:

(a) building and land tax;

(b) water tax, street lighting tax, garbage tax and public sewage tax;

(c) taxes collected on vehicles, beasts of burden and domesticated pets;

(d) tax on vehicles and beasts of burden parking or stopping within the town area;

(e) other taxes related to development permitted by this Law.

13. The Committee shall assess and collect taxes based on the following

(a) to assess not more than 10% of the annual value of the rent in the case of buildings and lands;

(b) to balance income and expenditure in assessing taxes on utility services;

(c) to expand and improve development works;

(d) to assess and collect taxes on buildings and lands from the owner and taxes on utility services from the occupants;

(e) to assess not more than 5% of the total income derived from the privately owned land and building under Government management.

14. The Committee may prescribe or revise the annual rental value of the land and building from time to time for the purpose of assessing and collecting taxes on land, building and utility services.

15. The Committee may from time to time prescribe, revise and collect licence fees for trade connected with the development works, rent for stalls owned by the Committee, taxes on market and licence fees for grant of establishment of private markets.

16. The Committee in connection with abolishing any tax or exempting or remitting payment of any tax may carry out in the following manner: -

(a) temporally suspending the abolishing or revising or collecting any tax assessed with the approval of the Ministry;

(b) exempting, remitting or abolishing of tax payable by a tax payer on sufficient grounds.

17. The Executive Officer may, in respect of arrears of taxes, carry out in I the following manner: -

(a) recovery of arrears of taxes as If they were arrear of and revenue;

(b) exercising powers of the Collector under existing Laws in order to execute the matter under sub-section (a).

Chapter VII

Administration of Development Works

18. The Committee may direct the owner of any building or land or the occupant thereof to comply with the following matters in respect of any building located within the town area in accordance with the relevant Laws, rules and bye-laws : -

(a) suspending or altering or demolishing the construction or renovation of any building which has been carried out without prior permission or without compliance with the specifications contained in the permission.

(b) removing any building or part of any building which encroaches upon any public road, drain, water supply pipe, sewage, etc;

(c) removing any building or part of any building which obstructs the construction or repair of public roads and bridges;

(d) repairing, demolishing or removing any dangerous building or building unfit for human habitation or any part thereof;

(e) white-washing or painting buildings and fences;

(f) erecting fences around unfenced land or repairing of unrepaired fences;

(g) clearing and removing any noxious or untidy trees, bushes and undergrowth and also filling up ravines, pitches.

19. If the present occupant is directed to comply with section 18 subsections (e), (f) and (g) the occupant shall comply as directed. If the occupant is the lawful tenant he has the right to request such expenses from the owner or set-off from the rent.

20. The Committee may direct the owner of the building or land or the occupant thereof comply with the following matters in respect of surface well, lake, drainage and sewage in accordance with the relevant laws, rules and bye-laws : -

(a) erecting enclosure or repairing any dangerous surface well, lake or pool of water;

(b) cleaning, repairing, filling tip or covering up any unhygienic surface well, lake, water storage tank or receptacle used for storing water;

(c) constructing or repairing drains, drainage pipe or drains for proper flow of water discharged from factories, workshops buildings and so as not to damage any street or public property;

(d) repairing and improving the lay-out of the earth-work so as to drain off water properly from factories, workshops and buildings;

(e) maintaining flushing-type toilet with, flush tank water-closet, sewage pipe and septic tank in factories, workshops, buildings and compounds;

(f) closing or demolishing or altering and repairing the toilet with flush tank, water-closet, sewage pipe and septic tanks which have been installed either without prior permission or without compliance with the specifications contained in the permission;

(g) constructing of sewage pipe or water pipe passing through adjacent land owned by some other person;

(h) compensating for damages if any, incurred to the owner in constructing sewage or water pipe passing through another persons land.

21. The Committee may direct the owner of the building or land or the occupier thereof within the town area to comply with the following matters in accordance with the provisions contained in the relevant laws, rules and bye-laws -

(a) keeping and maintaining suitable garbage bins for the collection of rubbish and offensive matters prior to their disposal;

(b) prohibiting the use of public or private water supply system found to be unhygienic;

(c) maintaining the rest house room or room rented in whole to be in a clean and sanitary condition;

(d) keeping and maintaining the buildings used for public entertainment in clean and sanitary condition as well as to ensure safety from fire hazards

(e) prohibiting the use of or altering or maintaining the work premises dealing in dangerous enterprises if it becomes dangerous or nuisance to the neighbourhood.

22. The Committee may direct the owner or relevant organization of the unsuitable cemetery land to comply with the relevant law, rules and bye-laws regarding the following matters; -

(a) not to permit to use as cemetery land and to close it;

(b) with the permission of the Ministry to transfer or demolish the burial place.

Chapter VII

Administration of Slow-moving Vehicles

23. The Committee may carry out the following in respect of Slow-moving Vehicles:-

(a) drawing up and submitting bye-laws with regard to Slow-moving Vehicles classwise;

(b) prescribing licence fees for Slow-moving Vehicles and assessing and collecting thereof;

(c) prescribing the driving licence fees for Slow-moving Vehicles and assessing and collecting thereof;

(d) issuing, suspending and cancelling licence for Slow-moving Vehicles;

(e) issuing, suspending and cancelling driving licence for Slow-moving Vehicles;

(f) inspecting and controlling the Slow-moving Vehicles;

(g) inspecting and controlling the drivers of Slow-moving Vehicle.

24. Only a person who obtains a licence issued by the Committee has the right to operate the business of Slow-moving Vehicle,

25. Only a person who obtains a licence issued by the Committee has the to drive a Slow-moving Vehicle.

26. The owner and the driver of Slow-moving Vehicle shall comply with the bye-laws as prescribed.

Chapter IX

Administration of Ferries

27. The Committee may as controller of ferries within the township area, carry out in accordance with the bye-laws in respect of ferries as follows -

(a) granting permission to establish ferry business or cancelling thereof;

(b) demarcating and revising the ferry limit;

(c) controlling ferry business;

(d) regulating the route for ferry;

(e) cancelling ferry licence on sufficient grounds;

(f) deciding payment of compensation and assessing the amount of compensation for ferry licence the cancellation of which is not due to violation of bye-laws;

(g) prescribing fares for ferry service;

(h) exempting Government Service personnel travelling on duty, departmental vehicles, animals and goods from payment of ferry charges for their transportation;

(i) remitting ferry licence fees or exempting thereof on sufficient ground;

28. The Officer in charge of State/Division may, as the controller of ferry service and in respect of ferry service serving two or more adjoining Townships, carry out the following in accordance with the bye-laws : -

(a) granting permission for establishment of ferry service or cancelling thereof;

(b) prescribing and revising the ferry limit;

(c) controlling the ferry service;

(d) regulating ferry route;

(e) allocating income from ferry service proportionately among the Committees which have adjoining ferry limits;

(f) cancelling ferry licence on sufficient grounds;

(g) appointing as the Controller of ferry service suitable Executive Officer of a Committee;

(h) deciding payment of compensation and assessing the amount of compensation for ferry licence cancellation of which is not due to violation of bye-laws;

(i) prescribing fares for ferry service;

(j) exempting Government Service personal travelling on duty, departmental vehicles, animals and goods from payment of ferry charges for their transportation;

(k) remitting terry licence fees or exempting thereof on sufficient grounds.

29. The Executive Officer shall be responsible as the administrator of the ferry service. The administrator of the ferry service may, in respect of ferry service, carry out as follows : -

(a) administering the ferry service;

(b) selling the ferry service licences In the prescribed manner;

(c) requiring the ferry service licensee to make arrangements to ensure the safety and convenience for the genera public;

(d) selling again the ferry service licences which are cancelled due to violation of the bye-laws.

30. Only a person who obtains the ferry service business licence has the right to operate within the ferry service limit.

31. The ferry service licensee shall comply with the instruction issued by the administrator of the ferry service regarding the proper maintenance and repair of either ferry boat or the equipments concerned thereof.

32. The ferry service licensee shall comply with the instruction of the administrator of the ferry service to discontinue the use of unsuitable boat or unsuitable equipments concerned thereof.

33. The Director General may decide disputes between one State/Division and another n respect of location of ferry Service.

34. If the decision or order passed by the administrator of ferry service in respect of any provision contained in section 29 or section 31 or section 32 is not satisfied, appeal may be submitted to the Controller concerned of the ferry service within 30 days from the date of passing such decision or order

35. (a) If the decision or order passed by the Controller of the ferry service under section 27 or section 28 is not satisfied, appeal may be submitted to the Director General within 60 days from the date of passing such decision or order;

(b) If the decision or order passed by the Controller of the ferry service under section 34 is not satisfied, appeal may be submitted to the Director General within 60 days from the date of passing such decision or order.

Chapter X

Administration of Animal Slaughter

38. The Committee may grant permission for the slaughter of buffalo, cow, horse, sheep, goat and pig in animal slaughter house owned by the Committee for the purpose of consumption by the general public and sale of meat thereof at specified places in accordance with the regulations.

37. The Staff Officer of Township General Administration Department may, under the supervision of the Officer in charge of State/ Division concerned, grant permission for the slaughter of cattle, at anywhere, for religious and other occasions other than for the purpose of public consumption under specified conditions.

38. The Committee and Staff Officer or Township General Administration Department shall in granting permission for cattle slaughter carry out, in accordance with the instruction, to prevent the wastage of cattle used in agriculture.

39. The Ministry may issue necessary instruction in respect of animal slaughter.

40. Only person with permission granted under section 36 or section 37 :-

(a) may slaughter, cattle, sell meat, or possess meat and skin

(b) may slaughter horse, sheep, goat, pig and sell meat.

Chapter XI

Supervision

41. The Minister may confirm, revise or cancel the decision or measure made by the Director General or Officer in charge of State/ Division or the Committee in respect of development works.

42. The Director General shall after scrutinizing the execution of works by the Officer in charge of State/Division or the Committee, submit to the Minister.

43. The Director General shall supervise the development works.

44. The Officer in charge of State/Division shall carry out the following in respect of the development works:-

(a) scrutinizing and submitting to the Director General annual budget estimates, short-term and long-term projects drawn up and submitted by the Committee.

(b) supervising the budget and for efficient development works in exercising powers conferred by the Director General.

(c) co-ordinating development functions so as to be in conformity with the law, rules, bye-laws and directives,

(d) inspecting works, buildings, proceedings, documents and accounts relating to the Committee and reporting to the Director General;

(e) suspending the Committee's decision, order, action or directive when it is found. to be illegal and reporting the finding to the Director General.

Chapter XII

Appeal

45. If any decision or order made by the Committee under section 14, 18(c) (e) (f), 20 (c) (d) (g) (h), 21(b) (e), is not satisfied an appeal may be submitted to the Officer in charge of State/Division concerned within 30 days from the date of such order or decision.

46. If any decision or order passed by the Officer in charge of State/ Division concerned section 45 is not satisfied, appeal may be submitted to the Director General within 30 days from the date of such order or decision.

47. In respect of the appeal :-

(a) no legal action to be taken against the person concerned pending appeal;

(b) the decision of the Director General is final.

Chapter XIII

Finance

48. The Minister shall approve the budget of the Committee. Collection and expenditure may be made only in accordance with the budget approved by the Minister.

49. The Committee shall : -

(a) scrutinise and submit to the Director-General, the annual budget which has been submitted to him by the Executive Officer through the Officer in charge of State / Division ;

(b) submit the annual financial and auditing situation to the Director General through the Officer in charge of State/ Division within 90 days of the expiry of the financial year.

50. The Committee shall open a separate bank account for its funds and use the funds for development works. The funds which are not required immediate use may be utilised as prescribed.

51. The Committee may open a separate Foreign Exchange Account and may utilise it in accordance with the existing laws and regulations with the permission of the Director General.

Chapter XIV

Organizational Set-up

52. The Ministry shall prepare and maintain as prescribed the necessary organizational set-up based on the duties and function of the development works and the amount of its income. In preparing the organizational set-up, if necessary, service personnel carrying out disciplinary measure may be included.

53. The Ministry has the power to appoint the service personnel within the organizational set-up in accordance with the existing regulations. The Executive Officer may be delegated with power to exercise over the matters related to affairs of certain level of service personnel.

54. The expenditure on service personnel shall not be incurred more than 30 per cent of the annual income accrued.

55. The Ministry may appoint by transfer service personnel who are capable of carrying out the development works effectively in co-ordination with other Ministries concerned.

Chapter XV

Maintenance of Fund and Auditing of Accounts

56. In order that the Executive Officer may maintain the accounts systematically and to enable auditing thereof, the Ministry shall prescribe the accounting procedure in consultation with the Auditor-General. Accounts shall be maintained in accordance with the accounting procedures so prescribed.

57. The accounts maintained by the Executive Officer shall be audited by the person assigned for this purpose by the Auditor-General.

Chapter XVI

Prohibitions

58. No person shall, within the limit of the town area, without the permission or without being in conformity with the specifications contained in the permission of the Committee or without being in conformity with the terms and conditions issued :-

(a) erect any building or part of a building encroaching on public street, drain, water pipe or sewage pipe;

(b) spread, hang any textile or mat or other thing road, drain, water pipe or sewage pipe causing obstruction thereof.

59. No person shall, within the limit of the town area, without the permission of the Committee or without being in conformity with the specifications contained in the permission or without being in conformity with the terms and conditions issued;

(a) play any kind of game on public road;

(b) sell any merchandise or other things kept on display on a table, bench, box or any receptacle by placing them either on the road or over the drain causing obstruction thereof;

(c) dispose garbage, offensive matters, etc. on the road or in any place not specified for such disposal;

(d) build private road;

(e) erect any building on land where there is no entrance or exit.

60. No person shall, within the limit of the town area, without the permission of the Committee or without being in conformity with the specifications, contained in the permission or without being in conformity with he terms and conditions issued;-

(a) erect, re-erect, renovate or extend a building;

(b) make use of water from public water supply system owned by the Committee;

(c) establish private water supply system for gain;

(d) establish camping ground or bathing places for the public.

61. No person shall, within the limit of the town area without the permission of the Committee or without being in conformity with the specifications contained in the permission or without being in conformity with the terms and conditions issued;-

(a) keep a corpse unburied or uncremated beyond the specified period,

(b) keep a corpse unburied or uncremated beyond 12 hours if the cause of death was due to contageous disease;

(c) bury or cremate a corpse at no other place than that specified as cemetery

62. No person shall, within the limit of the town area, without the permission of the Committee or without being in conformity with the specifications, contained in the permission or without being in conformity with the terms and conditions issued :-

(a) establish a lodging house;

(b) open restaurant, tea shop and shop for selling milk;

(c) establish bakeries and manufacture candies and all kinds of preserved fruit.

63. No person shall in a building within the limit of the town area, without the permission of the Committee or without being in conformity with the specifications, contained in the permission or without being in conformity with the terms and conditions issued :-

(a) engage in enterprise which may involve danger:

(b) store and sell merchandise and related materials which may involve danger.

64. No person shall, within the limit of the town area, without the permission of the Committee or without being in conformity with the specifications, contained in the permission or without being in conformity with terms and conditions issued;-

(a) keep or raise animals;

(b) dispose of carcasses in a manner not being specified.

65. No person shall, without the permission of the Committee or without being in conformity with the specifications, contained in the permission or without being in conformity with the terms and conditions issued;-

(a) establish private market or shift the market from one place to another or re-establish a market previously closed or expand the permitted area of the market;

(b) sell anything by using incorrect weights, scale and measures;

(c) sell anything in the market owned by the Committee in violation of the bye-laws;

(d) establish cattle market and effect sale thereof;

(e) establish ice factories and aerated water plants;

(f) establish small loans enterprise.

66. No person shall within the limit of the town area;-

(a) prohibit the Committee or a member of the Committee or any duly authorized service personnel from entering any land or building in the day time to carry out their duties under this Law or under the rules and bye jaws made under this Law;

(b) hinder or obstruct a contractor who is under contract with the Committee from carrying out the development works or any other work connected therewith without legal authority.

Chapter XVII

Imposition of Administrative Penalty

67. The Committee or the Chairman of the Committee or Executive Officer may impose administrative penalty on a person who fails to comply with or violates any provision contained in the Schedule under section 72 and the relevant rules and bye-laws.

68. Notwithstanding any provision contained in section 72, the Committee or the Chairman of the Committee of Executive Officer may compose an administrative penalty of a minimum sum of K 100 to a maximum sum of K 1000 on the first Offender.

69. Any offence for which administrative punishment has already been imposed shall not be prosecuted again in a Court of Law.

70. On failure to pay fine ordered for an administrative punishment such fine shall be recovered as if it were an arrear of and revenue.

71. The Ministry may prescribe the procedures for imposing administrative penalty.

Chapter XVIII

Offences and Punishments

72. If any person fails to comply with or violates any of the provisions of the following sections or sub-sections or rules and bye-laws concerned, he shall be fined on conviction for a minimum sum of K 500 to a maximum sum of K 5000.

Section, sub-section	Brief Provision
(1)	(2)
18 (e)	Required to paint or whitewash the building, fence.
18 (g)	Required to clear trees undergrowth and to fill up the uneven ground;
20 (a)	Required to erect or repair fences around dangerous surface wells, lakes or pools of water;
20 (b)	Required to clean up surface wells, lakes, reservoir, water tank and pools of water or to fill with water and cover up;
20 (c)	Required to construct or repair channel, drainage pipe or drains for water discharged from factories, workshops, buildings and high ground so not to damage any street or public property;
20 (f)	Required to close, demolish or repair flush type toilet, water-closet, sewage pipe or septic tanks
20 (g)	Required the owner of the land to allow the construction of sewage pipe or water pipe owned by another person passing through his land if it necessary;
21 (a)	Required to keep and maintain garbage bins for the disposal of rubbish;
21 (d)	Required to keep and maintain buildings used for entertainment in accordance with the prescribed regulations;

24	Prohibiting to operate the business of Slow-moving Vehicles without licence
25	Prohibiting the driving of Slow-moving Vehicles without licence;
26	Requiring the owner and the driver of Slow-moving Vehicles to comply with prescribed bye-laws;
40 (b)	Prohibiting the slaughtering of horse, sheep, goat, pig and selling the meat without permission;
58 (b)	Prohibiting the spreading or hanging of anything obstructing the street, drains, water pipe or sewage pipe;
59 (a)	Prohibiting the playing of games or sports on public roads,
59 (b)	Prohibiting the display and sale of merchandise over the drains obstructing thereof;
59 (c)	Prohibiting disposal of garbage, offensive matters, etc. on the road or in any place not specified for such disposal;
60 (b)	Prohibiting the securing of water against the bye-laws from public water supply system owned by the Committee;
64 (a)	Prohibiting the keeping or raising of animals;
65 (b)	Prohibiting the sale of using incorrect weights, scales and measures;
65 (c)	Prohibiting the sale of merchandise in the market owned by the Committee in violation of the bye-laws.

Explanation. The statements mentioned above the heading "Brief provision" in column (2) of the above Schedule are not the definitions of the offences but are mere reference to the subject matters contained in the section and subsections.

73. If any person fails to comply with or violates any of the provisions of the following sections or sub-sections or any directive contained in the rules and bye-laws concerned, he shall be fined on conviction for a minimum sum of K. 1000 to a maximum sum of K. 10000.

Section, sub-section	**Brief Provision**
(1)	**(2)**
18 (a)	Requiring to suspend, renovate or demolish the construction of buildings against the bye-laws ;
18 (b)	Requiring to remove building which encroaches upon road, drain, water pipe and sewage pipe;
18 (c)	Requiring to remove building which obstructs the construction or repair of roads and bridges;

18 (d)	Requiring to repair or demolish dangerous building and to evacuate the occupants thereof;
20 (d)	Requiring to repair and improve the ground work for the efficient drainage of water discharged from factories, workshops and buildings;
20 (e)	Requiring to maintain flush-type toilet, water closet sewage pipe and septic tank in factories and workshops;
20 (h)	Requiring to pay compensation for the injury due to construction of sewage pipe or water pipe passing through the land owned by another person;
21 (b)	Requiring to close the unhygienic water supply System;
21 (c)	Requiring to carry out the maintenance of rest house or lodging house in accordance with the prescribed bye-laws;
22 (a)	Causing the closure of the cemetery land which is not proper for use;
58 (a)	Prohibiting the erection of building encroaching on street, drain, water pipe or sewage pipe.
59 (d)	Prohibiting the construction of private road ;
59 (e)	Prohibiting the erection of buildings on land where there is no entrance or exit there from;
60 (a)	Prohibiting the erection, renovation or extension of a building;
60 (c)	Prohibiting the establishment of private wafer supply system for gain;
60 (d)	Prohibiting the establishment of camping ground or bathing places for the public;
61 (a)	Prohibiting the keeping of a corpse for more than the specified period;
61 (b)	Prohibiting the keeping of a corpse for more than 12 hours if the cause of death is due to epidemic disease
61 (c)	Prohibiting the burial or cremation of corpse at no other place than that specified as cemetery;
62 (a)	Prohibiting the establishment of lodging house;
62 (b)	Prohibiting the opening of restaurant;
62 (c)	Prohibiting the establishment of bakeries and manufacturing candies and all kinds of preserved fruit;
65 (a)	Prohibiting the establishment of private market or shifting the market or re-opening already closed market or the expansion of the permitted area of the market.
65 (d)	Prohibiting the establishment of cattle market and sale thereof;

65 (e)	Prohibiting the establishment of ice factories and aerated water plants;
65 (f)	Prohibiting the establishment of small loan enterprises.

Explanation. The statements mentioned under the heading "Brief provision" in column (2) of the above Schedule are not the definitions of the offences but are mere reference to the subject matters contained in the sections and sub-sections.

74. If any person fails to comply with or violates any of the provisions of the following sections or sub-sections or any directive contained in the rules and bye-laws concerned, he shall be fined for a minimum sum of K. 2000 to a maximum sum of K. 20000 or punishable with imprisonment for a term which may extend to one year or both.

Section, sub-section	**Brief Provision**
(1)	**(2)**
21 (e)	Prohibiting the use of work-premises in respect of dealing in dangerous trade or requiring the necessary repair to the premises if it becomes dangerous;
22 (b)	Demolishing the cemetery land which is. not proper for use;
63 (a)	Prohibiting the engagement in dangerous trade;
63 (b)	Prohibiting the storage and sale of merchandise related to dangerous trade:
64 (b)	Requiring to dispose of carcasses as prescribed.

Explanation. The statements mentioned under the heading "Brief provisions" in Column (2) of the above Schedule are not the definitions of the offences but are mere reference to the subject matters contained in the sections and sub-sections.

75. Whoever contravenes any of the provisions under sections 30, 31 and 32 or fails to comply with the rules and bye-laws concerned, shall be punished on conviction with fine which may extend from a minimum sum of K.1000 to a maximum sum of K. 10000.

76. Whoever contravenes any of the provisions contained in the Schedule mentioned under section 72 or fails to comply with the rules and bye-laws concerned and after being convicted for commission of aforesaid offences, shall be punished for each day that he continues so to contravene or for noncompliance with a fine of K. 50.

77. Whoever contravenes any of the provisions contained in the Schedule mentioned under section 73 or fails to comply with the rules and bye-laws concerned and after being convicted for commission of aforesaid offences, shall be punished for each day that he continues so to contravene or for noncompliance with a fine of K. 100.

78. Whoever contravenes any of the provisions contained in the Schedule mentioned under section 74 or fails to comply with the rules and bye-laws concerned and after being convicted for commission of aforesaid offences, shall be punished for each day that he continues so to contravene or for noncompliance with a fine of K. 200.

79. Whoever contravenes any of the provisions under section 66 shall be punishable on conviction with fine which may extend from a minimum sum of K. 2000 to a maximum sum of K. 20000.

80.(a) Whoever slaughters buffalo or cow or keeps in possession meat or skin of buffalo or cow shall be punished with imprisonment which may extend to one year and may also be fined.

(b) In prosecuting under this section the burden of proof is on the person to show that the meat is that of buffalo or cow slaughtered with the permission of the authority concerned or that the meat found in possession is that of buffalo or cow slaughtered lawfully or the meat is that of buffalo or cow that have died from any other cause.

81. (a) The Staff Officer of the Township General Administration Department concerned shall prosecute the cases for violation of section 37;

(b) The Committee concerned or the person delegated by the Committee shall prosecute the cases other than those mentioned in sub-section (a).

82. The Committee may, in carrying out its duties and powers under this Law, request for the assistance from the Police Department if it is necessary. The Police Department shall give the assistance on such request.

Chapter XIX
Miscellaneous

83. If any development work is connected with two or more than two Committees, the two or more than two Committees concerned may, in carrying out the operation, co-operate among them with the approval of the Ministry.

84. Notwithstanding anything contained under any existing law, the Ministry may co-ordinate with the other Ministry concerned for the allocation of suitable proportion of taxes for the Committee out of taxes levied by other Government Departments in respect of development works performed by other Government Departments.

85. Funds owned by the Municipality, formed under the laws which are repealed by this Law, moveable and immoveable property, works in the process of execution, work which has been completed! assets and liabilities shall devolve respectively on the Committee.

86. The department concerned shall give advance information to the Committee concerned regarding their work programme in respect of construction or demolition of State-owned buildings except buildings related to the security of the State or classified as secret.

87. The existing bye-laws orders and directives in respect of development works shall remain in force so long as they are not repugnant to the provisions of this Law.

88. The City of Mandalay Development Committee may apply the provisions of this Law in so far as they are not contrary to the City of Mandalay Development Committee Law.

89. In order to be able to carry out the provisions of this Law;-

(a) the Ministry may, with the approval of the Government, issue necessary rules and procedures;

(b) the Ministry or the Department may issue the necessary bye-laws, orders and directives.

90. The following laws are repealed by this Law:

(a) The Hackney Carriage Act, 1879.

(b) The Government Management of Private Estates Act 1892.
(c) The Municipal Act, 1898.
(d) The Ferries Act, 1898,
(e) The Government Buildings Act, 1899.
(f) The Local Authorities Loans Act, 1914.
(g) The Myanmar Rural Self Government Act, 1921.
(h) The Local Authorities (Suspension) Act, 1946.
(i) The Buildings (Regulation of Construction and Repair) Act, 1946,
(j) The Cattle Slaughter Prohibition Act, 1947.

Sd./ Than Shwe
General
Chairman
The State Law and Order Restoration Council

The Environmental Conservation Law

The Pyidaungsu Hluttaw Law No. 9 / 2012
The 8th Waxing Day of Tagu, 1373 M. E.
(30th March, 2012)

The Pyidaungsu Hluttaw hereby enacts this Law:

Chapter I
Title and Definition

1. This Law shall be called **the Environmental Conservation Law.**

2. The following expressions contained in this Law shall have the meanings given hereunder:

(a) **Environment** means the physical factors in the human environment, including land, water, atmosphere, climate, sound, odour, taste, the biological factors of various animals and plants and historical, cultural, social and aesthetic factors;

(b) **Environmental Quality** means the balance of nature including man made objects and also animals, plants, natural resources for the benefit of sustainability of nature and human beings;

(c) **Environmental Quality Standard** means the parameters of general quality for enhancement and conservation of environmental quality for environmental situations;

(d) **Environmental Audit** means periodic, systematically documented and objective evaluation to determine the followings:

(i) correspond with regulatory requirements on environmental conservation;

(ii) environmental management system;

(iii) various possible environmental risks to the buildings, plots and premises.

including land, water and atmosphere by discharging, emitting or depositing environmental hazardous substances, pollutants or wastes so as to affect beneficial use of environment, or to affect public health, safety or welfare, or animals and plants or to contravene any condition, limitation or prohibition contained in the prior permission issued under this Law;

(f) **Noise Pollution** means the occurrence of sound unit which causes annoyance, fatigue, loss of hearing or interference with the perception of other sounds;

(g) **Pollutant** means solid, liquid, or vapour which directly or indirectly alters the quality so as to affect beneficial use of any segment or element of the environment or is hazardous or potentially hazardous to health or causes pollution;

(h) **Waste** includes solid, liquid, or vapour and also includes anything which is classified as waste in accord with this Law including radioactive substance which is discharged, emitted or deposited in the environment in such volume, constituency or any manner which causes environmental pollution;

(i) **Hazardous Substance** means a substance or object which may affect health including explosive substance, substance which may be created and used as a biological weapon, substance which may be used as a nuclear weapon, inflammable substance, oxidizing and peroxidizing substance, toxic substance, pathogenic substance, radioactive substance, genetic transforming substance, corrosive substance, irritating objects, whether chemical or not, which can be harmful to human being, animal, plant, property or environment;

(j) **Beneficial Use** means the use of the environment or any element or segment of the environment after making required protections from the adverse effects of wastes, discharges, emissions and deposits so as to cause public health, safety or welfare;

(k) **Cleaner Production** means the continuous application of multi-strategy on environmental conservation to processes, products and services to improve the use of resource efficiently, minimize waste, polluted water and emissions and conserve the healthy nature and human environment;

(l) **Control Equipment** includes the followings:

(i) any apparatus for collecting waste;

(ii) any automatic device which can be used for more effective operation of any equipment;

(iii) any device for indicating or recording pollution or warning of excessive pollution;

(iv) any other device or facility used for the purpose of limitation of pollution;

(m) **Ecosystem** means the natural system existing living, non-living substances and plants in compatibility and the natural environment which have been evolving due to such system;

(n) **Owner** means owner, proprietor, operator in charge, lessor or receiver of any building, plots, or vehicle, or heir, trustee or representative of such person;

(o) **Occupier** means any person in occupation or control of any building, plot or any part of it, or any vehicle;(p) **Environmental Emergency** means the situation which may affect the safety and health of the public or the environment and ecosystem if natural or man-made disaster or pollution is not taken action immediately;

(q) **Committee** means the Environmental Conservation Committee formed under this Law;

(r) **Ministry** means the Union Ministry assigned by the Union Government to perform the matters of environment;

(s) **Department** means the relevant Department formed under this Law.

Chapter II

Objectives

3. The objectives of this Law are as follows:

(a) to enable to implement the Myanmar National Environmental Policy;

(b) to enable to lay down the basic principles and give guidance for systematic integration of the matters of environmental conservation in the sustainable development process;

(c) to enable to emerge a healthy and clean environment and to enable to conserve natural and cultural heritage for the benefit of present and future generations;

(d) to reclaim ecosystems as may be possible which are starting to degenerate and disappear;

(e) to enable to manage and implement for decrease and loss of natural resources and for enabling the sustainable use beneficially;

(f) to enable to implement for promoting public awareness and cooperation in educational programmes for dissemination of environmental perception;

(g) to enable to promote international, regional and bilateral cooperation in the matters of environmental conservation;

(h) to enable to cooperate with Government departments, Government organizations, international organizations, non-government organizations and individuals in matters of environmental conservation.

Chapter III

Formation of the Environmental Conservation Committee

4. (a) The Union Government shall form the Environmental Conservation Committee with the Union Minister for the Union Ministry assigned by the Union Government as the Chairman and with suitable members to conserve the environment of the Republic of the Union of Myanmar;

(b) In forming the Committee, the Vice Chairman, Secretary and Joint Secretary shall be assigned among the members of the Committee;

(c) The Union Government may re-form the Committee.

5. The Union Government shall stipulate functions and duties of the Committee to enable to implement the objectives contained in this Law.

6 The powers of the Committee are as follows:

(a) carrying out organizational education and activities relating to environmental conservation;

(b) suggesting to enable to amend and insert, as may be necessary, the lessons on environmental conservation contained in school lessons after coordinating with the relevant departments;

(c) accepting donations, grants, materials and technological aids from local and foreign and managing and using such money, materials and technologies as may be necessary in environmental conservation works;

(d) sending suitable suggestions and encouragements relating to environmental

conservation to the relevant Government departments and organizations;

(e) asking necessary proposals and suggestions from the relevant Government departments and organizations for conservation and enhancement of environment;

(f) prohibiting the relevant Government departments and organizations if the environmental damages arise or situations for damage arise and, if necessary, asking policy to the Union Government;

(g) laying down and carrying out the Myanmar national environmental policies and other environmental policies for conservation and enhancement of environment with the approval of the Union Government.

Chapter IV

Duties and Powers relating to the Environmental Consenvation of the Ministry

7. The duties and powers relating to the environmental conservation of the Ministry are as follows:

(a)implementing the environmental conservation policies;laying down, carrying out and monitoring programmes for conservation and enhancement of the environment, and for conservation, control and abatement not to cause environmental pollution;

(c) prescribing environmental quality standards including standards on emissions, effluents, solid wastes, production procedures, processes and products for conservation and enhancement of environmental quality;

(d) submitting proposals to the Committee for economic incentive mechanisms and terms and conditions which may not affect the environment or cause least environmental affect for sustainable development in addition to legal affairs and guidelines relating to environment;

(e) facilitating for the settlement of environmental disputes and, if necessary, forming bodies to negotiate such disputes;

(f) specifying categories and classes of hazardous wastes generated from the production and use of chemicals or other hazardous substances in carrying out industry, agriculture, mineral production, sanitation and other activities;

(g) prescribing categories of hazardous substances that may affect significantly at present or in the long run on the environment;

(h) promoting and carrying out the establishment of necessary factories and stations for the treatment of solid wastes, effluents and emissions which contain toxic and hazardous

substances;

(i) prescribing the terms and conditions relating to effluent treatment in industrial estates and other necessary places and buildings and emissions of machines, vehicles and mechanisms;

(j) negotiating, cooperating and implementing in respect of international, regional and bilateral agreements, instruments and programmes relating to matters of environment;

(k) implementing the international, regional and bilateral agreements accepted by Myanmar for environmental conservation and enhancement of environmental quality in accord with the guidance adopted by the Union Government or the Committee;

(m) causing to lay down and carry out a system of environmental impact assessment and social impact assessment as to whether or not a project or activity to be undertaken by any Government department, organization or person may cause a significant impact on the environment;

(n) laying down guidances relating to the management, conservation and enhancement of environment for the matters of protection of ozone layer, conservation of biologial diversity, conservation of coastal environment, mitigation and adaptation of global warming and climate change, combating desertification and management of non-depleting substances and management of other environmental matters;

(o) managing to cause the polluter to compensate for environmental impact, cause to contribute fund by the organizations which obtain benefit from the natural environmental service system, cause to contribute a part of the benefit from the businesses which explore, trade and use the natural resources in environmental conservation works;

(p) carrying out other functions and duties assigned by the Union Government relating to environmental conservation.

8. The Ministry shall establish an Environmental Management Fund in the Union Budget in accord with the financial regulations and by-laws of the Union for effective implementation of environmental conservation works in addition to the receipt from the Union Consolidated Fund.

ChapterV
Environmental Emergency

9. (a) If the Committee is aware that an event of environmental emergency has occurred or may occur in the entire Myanmar or any Region or State or any area, it shall immediately report to the Union Government so as to declare the occurrence of

such event;

Environmental Quality Standards

10. The Ministry may, with the approval of the Union Government and the Committee, stipulate the following environmental quality standards:

(a) suitable surface water quality standards in the usage in rivers, streams, canals, springs, marshes, swamps, lakes, reservoirs and other inland water sources of the public;

(b) water quality standards for coastal and estuarine areas; (c) underground water quality standards;

(d) atmospheric quality standards;

(e) noise and vibration standards;

(f) emissions standards;

(g) effluent standards;

(h) solid wastes standards;

(i) other environmental quality standards stipulated by the Union Government.

11. The Ministry may, with the approval of the Union Government and the Committee, insert, modify and stipulate the environmental quality standards for the interests of the public in accord with the scientific and technological advances or requirement of work according to time and area.

12. If any environmental quality standard stipulated by any Government department, Government organization under any existing law is more than the quality standard stipulated by the Ministry, it shall remain in force; however if it is less than such standard, only the standard stipulated by the Ministry shall be in force.

Chapter VII
Environmental Conservation

13. The Ministry shall, under the guidance of the Committee, maintain a comprehensive monitoring system and implement by itself or in co-ordination with relevant Government departments and organizations in the following matters:

(a) the use of agro-chemicals which cause to impact on the environment significantly;

(b) transport, storage, use, treatment and disposal of pollutants and hazardous substances in industries;

(c) disposal of wastes come out from exploration, production and treatment of minerals, industrial mineral raw materials and gems;

(d) carrying out waste disposal and sanitation works;

(e) carrying out development and constructions;

(f) carrying out other necessary matters relating to environmental pollution.

14. A person causing a point source of pollution shall treat, emit, discharge and deposit the substances which cause pollution in the environment in accord with stipulated environmental quality standards.

15. The owner or occupier of any business, material or place which causes a point source of pollution shall install or use an on-site facility or controlling equipment in order to monitor, control, manage, reduce or eliminate environmental pollution. If it is impracticable, it shall be arranged to dispose the wastes in accord with environmentally sound methods.

16. A person or organization operating business in the industrial estate or business in the special economic zone or category of business stipulated by the Ministry:

(a) is responsible to carry out by contributing the stipulated cash or kind in the relevant combined scheme for the environmental conservation including the management and treatment of waste;

(b) shall contribute the stipulated users charges or management fees for the environmental conservation according to the relevant industrial estate, special economic zone and business organization;

(c) shall comply with the directives issued for environnmental conservation according tothe relevant industrial estate, special economic zone or business.

Management of Urban Environment

17. The Ministry shall, for the management of urban environment, advise as may be necessary to the relevant Government departments and Government organizations, private organizations and individuals in carrying out the following matters in accord with the guidances laid down by the Committee:

(a) land use planning and management including zoning;

(b) management of the construction industry in pivotal urban centres;

(c) management of housing settlements;

(d) management of wastes;

(e) pollution control including land, water, air and noise pollution;

(f) other necessary environmental management.

Chapter IX

Conservation of Natural Resources and Cultural Heritages

18. The relevant Government departments and Government organizations shall, in accord with the guidance of the Union Government and the Committee, carry out the conservation, management, beneficial use, sustainable use and enhancement of regional cooperation of the following environmental natural resources:

(a) forest resources;

(b) land resources;

(c) fresh water resources including underground water;

(d) mineral resources;

(e) agricultural resources;

(f) fisheries resources;

(g) marine resources;

(h) natural ecosystems;

(i) natural areas, wildlife, natural plants and biological diversity;

(j) other natural resources stipulated by the Union Government.

19. The Ministry shall cooperate with the relevant Government departments and Government organizations in the matters of environmental conservation for perpetual existence of cultural heritage sites and natural heritage sites, cultural monuments and natural areas stipulated under any existing law.

20. The Ministry shall provide necessary technologies to the relevant Government departments and Government organizations in implementing the matters contained in sections 18 and 19.

Chapter X
Prior Permission

21. The Ministry may, with the approval of the Union Government, stipulate the categories of business, work-site or factory, work-shop which may cause impact on the environmental quality that requires to obtain the prior permission.

22. The owner or occupier of the category of business, work- site or factory, workshop stipulated by the Ministry under section 21 shall apply for the prior permission to the Ministry in accord with the stipulations.

23. The Ministry may, after scrutinizing whether or not the application made under section 22 is in conformity with the stipulations, grant or refuse to issue the prior permission by stipulating terms and conditions.

24. The Ministry may, in issuing the prior permission, stipulate terms and conditions relating to environmental conservation. It may conduct inspection whether or not it is performed in conformity with such terms and conditions or inform the relevant Government departments, Government organizations to carry out inspections.

25. The Ministry may, if it is found that a holder of the prior permission fails to comply with any of the terms and conditions relating to environmental conservation contained in the prior permission, pass any of the following administrative penalties:

(a) causing to comply with in accord with the terms and conditions after warning, causing to sign the bond;

(b) causing to comply with in accord with the terms and conditions after paying a fine.

Chapter XI
Insurance

26. The holder of the prior permission shall effect insurance according to the category of his business, work-site or factory, workshop for any accident that may cause impact on the environment, in accord with the existing law.

27. The Ministry shall give the remark if it is requested by the Myanmar Insurance on the extent and potential environmental impact in respect of the business, department or organization which carries out the business to be insured under section 26.

Chapter XII

Prohibitions

28. No one shall, without the prior permission, operate business, work-site or factory, workshop which is required to obtain the prior permission under this Law.

29. No one shall violate any prohibition contained in the rules, notifications, orders, directives and procedures issued under this Law.

30. No one shall, without permission of the Ministry, import, export, produce, store, carry or trade any material which causes impact on the environment prohibited by the Ministry.

Chapter XIII

Offences and Penalties

31 Whoever, without the prior premission, operates business, work-site or factory, workshop which is required to obtain the prior permission under this Law shall, on conviction, be punished with imprisonment for a term not exceeding three years, or with fine from a minimum of one hundred thousand kyats to a maximum of one million kyats,or with both.

32 Whoever violates any prohibition contained in the rules, notifications, orders, directives and procedures issued under this Law shall, on conviction, be punished with imprisonment for a term not exceeding one year, or with fine, or with both.

33 Whoever shall:

(a) if convited under section 32, be passed an order to compensate for damage due to such act or omission;

(b) if ordered under sub-section (a), and fails to pay the compensation to be paid, be recovered in accord with the existing revenue laws.

34 Whoever imports, exports, produces, stores, carries or trades any material prohibited by the Ministry due to its impact on environment shall, on conviction, be punished with imprisonment for a term from a minimum of three years to a maximum of five years, or with fine from a minimum of one hundred thousand kyats to a maximum of two million kyats, or with both. Moreover, he shall incur the expenditure for the treatment and disposal of such material until the process that has no impact on the environment.

Chapter XIV

Miscellaneous

35. In prosecuting an offender under this Law, prior sanction of the Ministry shall be obtained.

36. The Ministry may, with the approval of the Union Government, exempt or relieve any Government department, organization or private business from complying with any provision contained in this Law for the interests of the Union and its people.

37. If any Government department, organization or individual incurs the expenditures for any action due to the declaration of environmental emergency, such expenditures are entitled to claim from the environmental management fund.

38. The relevant Government department, Government organization authorized to issue licence, permit or register for enabling operation of category of business, work-site or factory, workshop which is required to obtain the prior permission shall issue such licence, permit, or register only to the business, work-site or factory, workshop which has obtained the prior permission under this Law.

39. (a) The Ministry shall, if the person obtained the prior permission who was imposed with administrative penalty under section 25 fails to comply with the terms and conditions, inform the relevant Government department, Government organization authorized to issue licence, permit or register for the relevant business, work-site or factory, workshop to enable to take action as may be necessary.

(b) The Government department, Government organization received information under sub-section (a) may, after making necessary inquiries if it is found that any terms and conditions of environmental conservation contained in the prior permission is not complied with, cancel the issued licence, permit or register or suspend it for a limited period.

40. The offence contained in section 32 is determined as the cognizable offence.

41. The provisions relating to environmental conservation contained in the laws, rules, orders, directives and procedures issued before the enactment of this Law shall remain in force unless it is contrary to the provisions contained in this Law.

42. In implementing the provisions contained in this Law:

(a) the Ministry may issue necessary rules, regulations and by-laws with the approval of the Union Government;

(b) the Committee and the Ministry may issue necessary notifications, orders, directives and procedures.

I hereby sign under the Constitution of the Republic of the Union of Myanmar.

(Sd.) Thein Sein

President of the Union

Republic of the Union of Myanmar

Component III

This component will confine on The Law Relating to Private Health Care Services. The Law is enacted to develop private health care services in accordance with the national health policy, to enable private health care services to be carried out systematically as an integrated part in the national health care system, to enable utilizing the resources of private sector in providing health care to the public effectively, to provide choice of health care provider for the public by establishing public health care services and to ensure quality services are provided at fair cost with assurance of responsibility.

The Law Relating to Private Health Care Services

The State Peace and Development Council Law No. 5/2007
The 4th Waning Day of Hnaung Tagu, 1368 M.E.
(5 April, 2007)
The State Peace and Development Council hereby enacts the following Law:

Chapter I
Title and Definition

I. This Law shall be called the Law Relating to Private Health Care Services. 2. The following expressions contained in this Law shall have the meanings given hereunder:

(a) Health care services mean any service with respect to knowledge, technology and expertise relating to health care, including promotion knowledge and behaviour on health, prevention of disease, diagnosis of disease, treatment of disease, rehabilitation of health and research;

12. Health care means the activities with respect to knowledge, technology and expertise relating to health, including promotion of physical, mental and social well-being, prevention of disease,

diagnosis of disease, treatment of disease, rehabilitation of health and research;

13. Private health care services mean any health care services contained in section 7 carried out by any private organization or individual with the intention to or not to obtain profit;

14. Private clinic means the clinic established systematically in accordance with the stipulations to carry out healthcare services as a private service for out-patients;

14. Private general clinic means the private clinic where medical treatment is provided, using relevant knowledge and skill by the person who has obtained the general medical practitioner's licence issued by Myanmar Medical Council, or the person who has obtained dental and oralsurgeon registration certificate or licence issued by the Dental and Oral Medical Council;

- ❖ Private specialist clinic means private clinic where medical treatment is provided using relevant knowledge and skill by the person who has obtained specialist medical practitioner's licence issued by the Myanmar Medical Council, or the person who has obtained specialist dental or oral surgeon registration certificate or licence issued by the Dental and Oral Medical Council for special treatment;
- ❖ Private hospital means the hospital established systematically to carry out health care activities as a private service in accordance with the stipulations for outpatients and in-patients;
- ❖ Private general hospital means the private hospital where health care is undertaken and provided by the health care personnel who has obtained general medical practitioner's licence or specialist medical practitioner's licence issued by the Myanmar Medical Council, or the person who has obtained dental and oral surgeon registration certificate or licence issued by the Dental and Oral Medical Council;

17. Private specialist hospital means the private hospital where health care is undertaken and provided by the person who has obtained one or more speciality's licence issued by the Myanmar Medical Council for specialist health care, or the person who has obtained specialist dental or oral surgeon registration certificate or licence for specialist treatment issued by the Dental and Oral Medical Council;

❖ Private maternity home means the maternity home established systematically in accordance with the stipulated characteristics to carry out ante-natal care normal delivery and health care during and after child birth by admitting the pregnant women as a private service;

18. Private diagnostic service means provision of laboratory analysis of disease, radiological imaging and any other means ofassistance in diagnosing andmedical treatment as a private service;

(I) Private nursing home means the premises established systematically in accordance with the stipulations to carry out nursing service after admission to persons suffering from physical or mental disease, persons in need of medical rehabilitation and aged persons as a private service;

(in) Private mobile health care service means the health care services provided by the provider of health care as a mobile private service;

19. Private healthcare agency means the health care services for transportation of patient or undertaking local and foreign communication for health care as a private service;

20. Private general health care service means the health care service carried out by using or not

using the electricity, heat, light, any kind of chemical or any instrument by any other means with respect to any physical or mentalcondition as a private service;

20. Technician means the person who has obtained the certificate, diploma, title or degree conferred by the training, school, institute, college or university established to teach the relevant technologies with respect to health care by any government department and organization or with the permission of any government department and organization. The said expression also includes the person who has obtained the certificate, diploma, title or degree conferred by a foreign country and also recognized by the Ministry of Health.

21. Person-in-charge means the person who has established, supervised or taken charge of the administrative duty of any private health care services;

22. Health care *service* provider means the person who has obtained medical practitioner's licence issued by the Myanmar Medical Council, dental and oral surgeon registration certificate or licence issued by the Dental and Oral Medical Council, nurisng or midwifery licence issued by the Nurse and Midwifery Council and technicians;

23. Central Body means the Central Body relatin g to private health care services formed under this Law;

24. Supervisory Committee means the Supervisory Committee relating to private health care services formed under this Law.

Chapter II
Aims

3. The aims of this Law are as follows:

25. to develop private health care services in accordance with the national health policy;

26. to participate and carry out systematically by private health care services in the national health care system as an integral part;

27. to enable utilizing effectively the resources of private sector in providing health care to the public;

28. to enable the public to choose as desired in fulfilling their needs forhealth by establishing private health care services;

29. to enable provision of quality service at fair cost and to take responsibility.

Chapter III
Formation of the Central Body relating to
Private Health Care Services

4. The Government:

28. shall form the Central Body relating to private health care services with not more than 21 persons consisting of the Minister for the Ministry of Health as Chairman, the Deputy Minister for the Ministry of Health as Deputy Chairman, the Director General of the Department of Health as Secretary, the heads and representatives of the relevant government departments

and organizations and representatives of the non-governmental organizations as members.

29. in forming under sub-section (a), may, if necessary, determine and assign duty to a suitable person out of the members as Joint Secretary;

30. my reorganize the Central Body formed under sub-section (a) as may be necessary.

Chapter IV

Duties and Powers of the Central Body

5. The duties and powers of the Central Body are as follows:-

(a) giving guidance in accordance with the national services;

(b) giving guidance to maintain and promote the quality of private health care services by the relevant responsible persons in conformity with the stipulated standards and criteria;

(c) granting or refusing to grant prior permission in respect of application to obtain prior permission to build new building or renovate a building to establish any private health care services other than private mobile health care service, private healthcare agency and private general clinic service;

(d) determining the types of private hospital and kinds of curable disease;

(e) issuing or refusing to issue licence in respect of application to grant the operation of any private health care services other than application for the operation ofprivate general clinic service;

(f) inspecting and supervising the private health care services as to whether or not they comply with the prescribed terms and conditions;

(g) forming the necessary bodies comprising suitable persons to perform special matters and assigning duty thereto inrespectofprivate health care services;

(h) issuing directives for the private health care services to comply with and exercise the modem and developed medical technologies and methods;

(i) determining necessary characteristics and requirements for private health care services;

(j) forming supervisory committees relating to private health care services at the State, Divisional, District and Township levels and assigning functions and duties thereto;

(k) giving decision on matters submitted by the different levels of supervisory committees;

(I) forming the working committee for implementation of its duties and powers effectively;

(l) revising or setting aside any decision of the State and Divisional SupervisoryCommittees;

(m) determining the term of licence, licence fee and renewal fee ofprivate health care services;

(n) submitting, if necessary, to the Government through the Ministry of Health on matters relating to private health care services.

6. The Central Body may, if necessary, delegate its duties and powers to the working committee or the different levels of supervisory committee or any organization or department.

Chapter V

Private Health Care Services

7. **The** private health care services are as follows:

(a) private clinic service:

(I) private general clinic service;

(2) private specialist clinic service;

(b) private hospital service:

(f) private general hospital service;

(g) private specialist hospital service:

(c) private maternity home service;

(d) private diagnostic service;

(e) private nursing home service;

(f) private mobile health care service;

(g) private health care agency;

(h) private general health care service.

Chapter VI

Characteristics of the Private Hospital

8. **The** private hospital shall be in conformity with the following characteristics:

(a) having sufficient specific land area and constructing at the place permitted;

(h) the structural design and partition of rooms being in conformity with stipulated standards;

(i) having arrangement to keep the interior, exterior and premises of the hospital clean and tidy in conformity with health;

(j) having arrangements to carry out 24 hours duty by the stipulated health care service providers;

(k) having arrangement to provide 24-hour health

(l) care service to emergency out-patients and inpatients;

(m) enabling to provide emergency life-saving health care service to patients;

(n) having disinfected and well-equipped operation theatre for operating out-patient or in-patient, having equipment and medicines in conformity with stipulated standard;

(o) enabling diagnosis of disease according to the class and type of hospital;

(p) having patient referral system; havingarrangementforthesafebloodtransfusion; maintaining the systematic medical record; having accountable supervisory and administrative system according to the class and type of hospital;carrying out for not affecting the environment, non-dissemination of infectious disease and systematic disposal of wastes according to the stipulated standard;(^{0}) having arrangement for obtaining safe drinkingwater and water for domestic use sufficiently;

(n) constructing a systematic water supply and sewerage system;

(o) having systematic arrangements for preventive measures for disasters and emergency rescue;

(p) having good communication system;

(q) having arrangement toobtain 24 hours electricity;

(r) having stipulated arrangement for diseased patients;

(s) carrying out other requirements stipulated by the Central Body from time to time.

Chapter VII

Characteristics of the Private Clinic

9. The private clinic shall be in conformity with the following characteristics;

(t) being a building or room having suitable area;

(u) providing treatment only to out-patient, having no permission to admit in-patient;

(v) having arrangement to keep the interior and exterior of the clinic clean and tidy in conformity with health;

(w) having patient referral system;

(x) maintaining the systematic medical record,

(y) carrying out for not affecting the environment, non-dissemination of infectious disease and systematic disposal of wastes according to the stipulated standard;

(5) having arrangement for obtaining safe drinking water and water for domestic use sufficiently;

(a) constructing a systematic water supply and sewerage system;

(b) providing health care services by stipulated health care service providers;

(c) carrying out other requirements stipulated by the Central Body from time to time.

Chapter VIII

Characteristics of the Private Maternity Home

10. The private maternity home shall be in conformity with the following characteristics;

(a) having specific premises and specific building;

(b) having arrangement to provide 24-hour health care for maternity patients and new-born children;

(b) arranging to keep the interior, exterior and premises of the maternity home clean and tidy in conformity with health;

(c) enabling to provide emergency life-saving health care service to patients;

(d) having disinfected well-equipped operation theatre for operating the out-patient or in-patient;

having equipment and medicines in conformity with stipulated standard;

(e) having patient referral system;

(f) having arrangement for the safe blood transfusion;

(e) maintaining the systematic medical record;

(f) carrying out for not affecting the environment, non-dissemination of infectious disease and systematic disposal of wastes according to the stipulated standard;

(g) having arrangement for obtaining safe drinking water and water for domestic use sufficiently;

(I) constructing a systematic water supply and sewerage system;

(m) having systematic arrangement for preventive measure for disasters and emergency rescue;

(n) having good communication system;

(o) having arrangement to obtain 24 hours electricity;

(p) providing health care services by stipulated health care service providers;

(q) carrying out other requirements stipulated by the Central Body from time to time.

Chapter IX

Prior Permission for Private Health Care Services

11. A person desirous of constructing a new building or renovating the existing building for establishing any private health care services other than private mobile health care service and private health care agency shall, to obtain prior permission, apply to the relevant Township Supervisory Committee together with the recommendation of the relevant development committee or development body in accordance with the stipulations mentioning the following facts;

(1) the health care service to be established;

(2) location, area and address of the service to be established;

(3) land and buildings surrounding the location;

(4) constitution of building and rooms;

(5) health care programme;

(6) other requirements stipulated by the Central Body from time to time.

12. The relevant Township Supervisory Committee shall, after scrutinizing the application made under section 11, submit to the District Supervisory Committee, and the District Supervisory Committee shall submit to the State and Divisional Supervisory Committee stage by stage together with remarks.

13. The State and Division Supervisory Committee, in respect of the application made under section 11:

(b) shall, if it is of matter for prior permission to construct a new building or renovate the existing building for establishing any private health care services other than private general clinic services, submit to the Central Body together with remarks;

(c) may, after scrutiny, if it is of matter for prior permission to construct a new building or renovate the existing building for establishing private general clinic services, issue the prior permission together with the stipulated terms and conditions or refuse to issue the prior permission.

14. The Central Body may, after scrutinizing the application for the prior permission submitted by the State and Divisional Supervisory Committee to construct a new building or renovate the existing building for establishing any private health care services under sub-section

(a) of section 13, issue the prior permission togetherwith the stipulated terms and conditions or refuse

(h) arranging to keep the interior, exterior and premises of the maternity home clean and tidy in conformity with health;

(i) enabling to provide emergency life-saving health care service to patients;

(j) having disinfected well-equipped operation theatre for operating the out-patient or in-patient;

(k) having equipment and medicines in conformity with stipulated standard;

(l) having patient referral system;

(m) having arrangement for the safe blood transfusion;

(n) maintaining the systematic medical record;

(o) carrying out for not affecting the environment, non-dissemination of infectious disease and

systematic disposal of wastes according to the stipulated standard;

(p) having arrangement for obtaining safe drinking water and water for domestic use sufficiently;

(I) constructing a systematic water supply and sewerage system;

(r) having systematic arrangement for preventive measure for disasters and emergency rescue;

(s) having good communication system;

(t) having arrangement to obtain 24 hours electricity;

(u) providing health care services by stipulated health care service providers;

(v) carrying out other requirements stipulated by the Central Body from time to time.

Chapter IX

Prior Permission for Private Health Care Services

11. A person desirous of constructing a new building or renovating the existing building for establishing any private health care services other than private mobile health care service and private health care agency shall, to obtain prior permission, apply to the relevant Township Supervisory Committee together with the recommendation of the relevant development committee or development body in accordance with the stipulations mentioning the following facts;

(7) the health care service to be established;

(8) location, area and address of the service to be established;

(9) land and buildings surrounding the location;

(10) constitution of building and rooms;

(11) health care programme;

(12) other requirements stipulated by the Central Body from time to time.

12. The relevant Township Supervisory Committee shall, after scrutinizing the application made under section 11, submit to the District Supervisory Committee, and the District Supervisory Committee shall submit to the State and Divisional Supervisory Committee stage by stage together with remarks.

13. The State and Division Supervisory Committee, in respect of the application made under section 11:

(d) shall, if it is of matter for prior permission to construct a new building or renovate the existing building for establishing any private health care services other than private general clinic services, submit to the Central Body together with remarks;

(e) may, after scrutiny, if it is of matter for prior permission to construct a new building or renovate the existing building for establishing private general clinic services, issue the prior permission together with the stipulated terms and conditions or refuse to issue the prior permission.

14. The Central Body may, after scrutinizing the application for the prior permission submitted by the State and Divisional Supervisory Committee to construct a new building or renovate the existing building for establishing any private health care services under sub-section

(a) of section 13, issue the prior permission together

with the stipulated terms and conditions or refusethenumber of health care serviceproviders and whether their qualification and equipment are sufficient or not;

(b) whether or not performing in accordance with the practices prescribed by the World Health Organization and relevant international organizations of respective subjects for each service;

(c) whether or not the measures are arranged to promote the quality in performing the health care services in accordance with the stipulations;

(d) whether or not strict measures have been taken so that health hazard may not occur and infectious disease may not spread to the health care service provider, patient, public and environs;

(e) whetherornot the health care users are satisfiedwith the provision of health care service;

(f) whether or not the working condition of the health care service providers is satisfactory;

(g) whether or not the terms and conditions prescribed by the Central Body from time to time are complied with.

(p) The Private Health Care Quality Control and Promotion Bodies and the different levels ofsuperviscny committee may direct the relevant person-in charge and health care service providers as may be necessary to maintain and promote the quality of private health care services.

Chapter XII

Duties and Obligations of Person-in-Charge andHealth Care Service Provider

(q) The duties and obligations of the person-in-charge and health care service provider are as follows:

(a) Providinghealthcaremainly for the requirement of patient's health;

(b) complying in accordance with the notifications; orders and directives issued by the Central Body, the Ministry of Health and Department of Health;

(c) complying in accordance with the existing laws, rules, notifications, orders and directives relating to health;

(d) complying with and exercising the modem and developed medical technology and methods in accordance with the directives issued by the Central Body;

(e) complying in accordance with the directives relating to the highly infectious disease and criminal cases stipulated by the Ministry of Health, from time to time;

(0) if necessary, referring in time to the relevant specialist, department and hospital aiming for the benefit of the patient;

(g) providing life-saving treatment to any emergency patient and making referral if necessary;

(h) providing high quality service to the public at fair service charge;

(i) complying with the directives of the Private Health Care Quality Control and Promotion Body and the different levels of supervisory committee.

(j) laying down plans to be able to appease the dissatisfaction of health care user,

(k) forming the administrative sub-body, the sub-body for quality control and promotion and other necessary sub-bodies as may be required according to the size and type of hospital;

(1) keeping confidential of the patient's personal health matter except on official request of the relevant government department and organization;obtaining permission of the Ministry of Health, if it is required to do research by making *use* of patients;

(h) paying stipulated taxes and revenues regularly;

(i) avoiding from performing any other services without permission or licence, in carrying out private health care services permitted under the relevant licence.

Chapter XIII

Taking Administrative Action

26. If the private health care services licence holder fails to comply with any duty contained in section 19 or has been convicted for committing any offence contained in this Law or if the person-in-charge fails to comply with the duties and obligations contained in section 25, the Central Body and the State and Divisional Supervisory Committee authorized to issue licence forrelevant private health care services, may pass any of the following administrative orders on the relevant licence holder,

(a) warning;

(b) imposing the stipulated fine;

(c) suspension of the licence for a limited period;

(d) cancellation of the licence;

27. The Central Body or the State and Divisional Supervisory Committee that takes action under section 26, shall inform the relevant Myanmar Medical Council, Dental orOral Medical Council, orNursing and Midwifery Council to take necessary action if the health care service provider fails to comply with any of the duties and obligations contained in section 25.

Chapter XIV

Appeal

28. Any person dissatisfied with an administrative order passed by the State and Divisional Supervisory Committee under section 26 or any other order passed under this Law may file an appeal to the Central Body within 60 days from the date of passing such order.

29. The Central Body may in appeal under section 28, revise, set aside, or confirm the decision passed by the State and Divisional Supervisory Committee.

30. The order or decision passed by the Central Body under this Law shall be final and conclusive.

Chapter XV

Offences and Penalties

31. Whoever carries out the private hospital service without licence may, on conviction, be punished with imprisonment for a term which may extend from a minimum of 1 year to a maximum of 5 years and may also be liable to a fine.

32. Whoever carries out the private maternity home service or private clinic service without licence shall, on conviction, be punished with imprisonment for a term which may extend from a minimum of 6 months to a maximum of 3 years and may also be liable to a fine.

33. Whoever performs any other Health Care Services except private hospital service, private maternity home service and private clinic service without licence shall, on conviction, be punished with imprisonment for a term which may extend from a minimum of 3 months to a maximum of 1 year and may also be liable to a fine.

34. Whoever has obtained licence:

(e) in carrying out services at the place permitted under relevant licence, by virtue of the private

health care services, carries out any other services without permission or licence with the exception of the matter prohibited under any existing law shall, on conviction, be punished with imprisonment for a term which may extend from a minimum of 1 year to a maximum of 5 years and may also be liable to a fine;

(f) in carrying out services at the place permitted under relevant licence by virtue of the private health care services, violates the matter prohibited under any existing law shall, on conviction, be punished under relevant existing law.

35. Whoever transfers or hires a licence that he has obtained under this Law to another person without the permission of the Central Body or State and Divisional licence shall, on conviction, be punished with imprisonment fora term not exceeding 3 years or with fine orwith both.

Chapter XVI

Miscellaneous

36. The Ministry of Health shall:

(m) bear the expenses of the Central Body and otherbodies formed by the Central Body under this Law;

(n) make arrangement to enable the Central Body and different levels of supervisory committee to perform the office work.

37. If a person who has carried out the private health care clinic registered under the Union of Myanmar Public Health Law, 1972 before this Law has come into force is desirous of continuing his services, he shall apply for a temporary licence in accordance with the stipulations within 90 days commencing from the date of coming into force of this Law and;

(a) if he carries out private hospital service, or private maternity home service, he shall, after fulfilling the relevant characteristics and requirements prescribed under this Law, apply for a licence in accordance with the provisions of this Law, within a year commencing from the date of coming into force of this Law.

(b) if he carries out private specialsiat clinic service or private diagnostic service, he shall, after fulfilling therelevantcharacteristic and requirements prescribed under this Law, apply for a licence in accordance with the provisions of this Law, within 9 months commencing from the date of coming into dorce of this Law.

(c) if he carries out any other private health care services, with the exception of services contained in sub-section (a) and sub-section (b), he shall, after fulfilling the relevant characteristics and requirements prescribed under this Law, apply for a licence in accordance with the provisions of this Law, within 6 months commencing from the date of coming into force of this Law.

38. The Central Board may exempt any private healthcare services from all or part ofthe provisions contained
in this Law, subject to time limit if it is in public interest.

39. (a) The person injured due to the negligent act of the person-in-charge or health care service provider at any private health care services, may sue the relevant person-in-charge or health care service provider under the Law of Tort to obtain damages for his injury;

(b) The person-in-charge or health care service provider, sued under sub-section (a), shall not be exempted from administrative action token under any relevant existing law.

40. In respect of private clinics before this law has come into force, the notifications, orders and directives issued by the Ministry of Health and Department of Health under the Union of Myanmar Public Health Law, 1972 may continue to be applicable in so far as they are not inconsistent with this law.

41. The provisions of this Law shall not apply to the private traditional hospital and private traditional clinic which conduct treatment by the traditional medicine.

42. For the purpose of implementing the provisions of this Law:

(a) The Ministry of Health may, with the approval of the Government, issue such rules as may be necessary;

24. The Central Body and the Ministry of Health may issue such procedures, notifications, orders and directives, and the Department of Health may issue such orders and directives, as may be necessary.

(Sd)
Than Shwe
Senior General
Chainnan
The State Peace and Development Council

Component IV

This component comprises of;

The Control of Smoking and Consumption of Tobacco Product Law (2006)

Narcotic Drugs and Psychotropic Substances Law (1993)

National Food Law (1997)

The Control of Smoking and Consumption of Tobacco Product Law (2006), Enacted to convince the public that smoking and consumption of tobacco product can adversely affect health, to make them refrain from the use, to protect the public by creating tobacco smoke free environment, to make the public, including children and youth, lead a healthy life style by preventing them from smoking and consuming tobacco product, to raise the health status of the people through control of smoking and consumption of tobacco product and to implement measures in conformity with the international convention ratified to control smoking and consumption of tobacco product.

Narcotic Drugs and Psychotropic Substances Law (1993), related to control of drug abuse and describes measures to be taken against those breaking the law. Enacted to prevent danger of narcotic and psychotropic substances and to implement the provisions of United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. Other objectives are to cooperate with state parties to the United Nations Convention, international and regional organizations in respect to the prevention of the danger of narcotic drugs and psychotropic substances. According to that law Central Committee for Drug Abuse Control (CCADC), Working Committees, Sectors and Regional Committees were formed to carry out the designated tasks in accordance with provisions of the law. The law also describes procedures relating to registration, medication and deregistration of drug users.

The National Food Law (1997) enacted to enable public to consume food of genuine quality, free from danger, to prevent public from consuming food that may cause danger or are injurious to health, to supervise production of controlled food systematically and to control and regulate the

production, import, export, storage, distribution and sale of food systematically. The law also describes formation of Board of Authority and its functions and duties.

The Union of Myanmar
The State Peace and Development Council

The Control of Smoking and Consumption of Tobacco Product Law *(I/14)*

(The State Peace and Development Council Law No 5/2006)
(The 8th Waxing Day of Kason, 1368 ME)
(4 May, 2006)
The State Peace and Development Council hereby enacts the following law;

Chapter I

Title, Commencement and Definition

1. (a) This Law shall be called the Control of Smoking and Consumption of Tobacco Product Law. (b) This Law shall come into force on the date of completion of one year from its promulgation.

2. The following expressions contained in this Law shall have the meanings given hereunder;

(a) Cigar means any cigarette, cheroot, cigar, smoking pipe and any other similar material prepared by any means for inhalation of smoke emitted from the burning of tobacco product;

(b) Tobacco product means any material prepared for the purpose of smoking or consumption of the whole or part of the tobacco plant, leaf or stalk of the same;

(c) Cigar smoke means smoke emitted from the burning of cigar or smoke emitted from smoking, exhaling or inhaling of cigar;

(d) Sale means retail and wholesale of any material or display of the same for sale;

(e) Cigar package means a packet, bottle, card or any other similar material into which the cigar or tobacco product is collected and inserted and which packs the same;

(f) Label means a name, sign, shape or mark denoted by any means to make known any kind of cigar and tobacco product;

(g) Central Board means the Central Board for the Control of Smoking and Consumption of Tobacco Product formed under section 4;

(h) Supervisory Body means the Supervisory Bodies for the Control of Smoking and Consumption of Tobacco Product formed under sub-section (i) of section 5 at the State, Division, District and Township levels;

(i) Person-in-Charge means the owner or person who administers the places designated in sections 6 and 7. This expression also includes a person who has been assigned duty by the said owner or person;

(j) School includes Basic Education High School , Basic Education Middle School , Basic Education Primary School , Nursery School, Pre-School and Monastic Education School ;

(k) Training School means a course for the teaching of educational and technical knowledge of ten or more trainees.

Chapter II

Objectives

3. The objectives of this Law are as follows;

(a) to convince the public that health can be adversely affected due to smoking and consumption of tobacco product and to cause refraining from the use of the same;

(b) to protect from the danger which affects public health adversely by creating tobacco smoke-free environment;

(c) to obtain a healthy living style of the public including child and youth by preventing the habit of smoking and consumption of tobacco product;

(d) to uplift the health, economy and social standard of the public through control of smoking and consumption of tobacco product;

(e) to implement measures in conformity with the international convention ratified by Myanmar to control smoking and consumption of tobacco product;

Chapter III

Formation of the Central Board of the Control of Smoking and

Consumption of Tobacco Product, and

Functions and Duties thereof

4. The Government:

(a) shall form the Central Board of the Control of Smoking and Consumption of Tobacco Product comprising Minister of the Ministry of Health as Chairman, Deputy Minister of the Ministry of Health as Vice-Chairman, Director-General of the Department of Health as Secretary, a person assigned with duty to lead the task for control of smoking and consumption of tobacco product as joint secretary and service personnel and experts from the relevant government department and organizations as members.

(b) may re-organize the Central Board formed under sub-section (a), as may be necessary.

5. The functions and duties of the Central Board are as follows;

(a) laying down policy to implement the objectives of this law;

(b) carrying out measures to create tobacco smoke-free environment for protecting the public from the dangers of tobacco smoke;

(c) giving guidance to lay down and carry out tobacco cessation programmes;

(d) giving guidance to carry out educative work to let the public be aware extensively that smoking and consumption of tobacco product are dangerous to health;

(e) giving guidance to hold exhortative exhibitions, seminars, workshops and health talks for reduction of smoking and consumption of tobacco product;

(f) giving guidance to carry out research works in respect of smoking and consumption of tobacco product;

(g) co-operation and co-ordination with the relevant Government departments and organizations for enabling the control of smoking and consumption of tobacco product;

(h) communicating with international organizations, regional organizations, local and foreign non-governmental organizations for carrying out effectively the control of smoking and consumption of tobacco product;

(i) formation of the supervisory bodies at the State, Division and Township levels and determining the functions and duties thereof for carrying out the control of smoking and consumption of tobacco product;

(j) formation of necessary committees and determining their functions and duties to implement them.

Chapter IV

Non-Smoking Areas

6. The following compounds, buildings, rooms and places are non-smoking areas:

(a) hospital buildings, offices, compounds and other buildings in the compound except staff houses and apartments in the hospital compound;

(b) medical treatment centres and clinics;

(c) stadium and indoor playing fields;

(d) children drill sheds and playgrounds;

(e) teaching buildings, classrooms, offices, compounds and other buildings in the compound except staff houses and apartments in the school compound;

(f) teaching buildings of universities, degree colleges, colleges and institutes, classrooms and offices;

(g) opera houses, cinema halls, video halls and other buildings of entertainment;

(h) marts, department stores, stores and market sheds;

(i) museums, archives, public libraries and reading rooms;

(j) elevators and escalators;

(k) motor vehicles and aircrafts for passenger transport;

(l) air-conditioned public rooms;

(m) public auditoriums;

(n) teaching buildings and classrooms of private tuition classes and training schools;

(o) other public compounds, buildings and places prescribed through notification by the Ministry of Health.

7. Places to which the public have access in the following buildings, vehicles and crafts are non-smoking areas except the private offices and rooms. However, specific places where smoking is allowed, shall be arranged in such areas:

(a) buildings of offices and departments;

(b) buildings of factories and workshops;

(c) buildings of hotels, motels, guest houses and lodging houses;

(d) buildings of railway stations, airports, ports and highway bus terminals;

(e) restaurants;

(f) trains and vessels for passenger transport:

(g) other public buildings, rooms and places prescribed through notification by the Ministry of Health.

Chapter V

The Functions and Duties of the Ministry of Health

8. The functions and duties of the Ministry of Health relating to the control of smoking and consumption of tobacco product are as follows:

(a) implementing the policies and guidelines laid down by the Central Board;

(b) implementing the works of control of smoking and consumption of tobacco product in accordance with the objectives of this Law;

(c) determining the requirements to be arranged at the specific area where smoking is allowed as mentioned in section 7;

(d) determining the caption and marks referring to make known the non-smoking area and specific smoking area;

(e) determining the caption of warning in Myanmar language, to be mentioned on the package of cigar that smoking can seriously affect health and other necessary warnings;

(f) arranging and carrying out counselling and treatment for cessation of smoking and consumption of tobacco product;

(g) in performing the functions of the control of smoking and consumption of tobacco product, communicating and coordinating with the relevant government departments and organizations, international organizations, regional organizations and local and foreign non-governmental organizations;

(h) laying down and carrying out the necessary arrangements to enable implementing effectively the measures for control of smoking and consumption of tobacco product;

(i) submitting to the Central Board the report of actions in respect of the control of smoking and consumption of tobacco product.

Chapter VI

Functions and Duties of Person-in-charge

9. The person-in-charge shall:

(a) keep the caption and mark referring that it is a non-smoking area at the place mentioned in section 6 in accordance with the stipulations.

(b) arrange the specific place where smoking is allowed as mentioned in section 7, and keep the caption and mark also referring that it is a specific place where smoking is allowed, in accordance with the stipulations.

(c) supervise and carry out measures so that no one shall smoke at the non-smoking area.

(d) accept the inspection when the supervisory body comes to the place for which he is responsible.

Chapter VII

Actions taken by Administrative Means

10. The person-in-charge of any university, degree college, college, institute, school, private tuition class and training school may pass any of the following orders on a person who smokes or holds lighted cigar at the place mentioned in sub-sections (e), (f) and (n) of section 6:

(a) educating, warning and informing the parents or guardian for the first offence;

(b) taking action in accordance with the rules and regulations prescribed by the relevant ministry in

cordination with the Central Board, for subsequent offences.

Chapter VIII

Offences and Penalties

11. Whoever commits any of the following acts to publicize for wide distribution and sale of cigar and tobacco product shall, on conviction, be punished with a fine from a minimum of kyats 20000 to a maximum of kyats 50000, for the first offence and be punished with imprisonment for a term which may extend to 2 years and shall also be liable to a fine from a minimum of kyats 50000 to a maximum of kyats 200000 for second and subsequent offences:

(a) setting up signboard of advertisement, advertising by drawing, hanging the advertisement, affixing advertisement, distributing pamphlet of advertisement or advertising by other means;

(b) broadcasting or displaying by radio, film, television and video or by communication system using high technology from the mass media chamels;

(c) describing by publishing in newspapers, journals, magazines and pamphlets or distributing the same;

(c) distributing free of charge, handing out or giving as present goods containing the label of cigar and tobacco product;

(d) sponsoring or rendering service to hold athletic game, funfair or exhibition or any welfare activity;

(e) describing the label of cigar and tobacco product on any personal goods;

(f) carrying out by any other means.

12. Whoever commits any of the following acts shall, on conviction, be punished with imprisonment for a term which may extend to two years or with fine or with both:

(a) obstruction, distrubance, prohibition or commission of assault to any member of Supervisory Body who comes and inspects under this Law;

(b) obstruction, distrubance, prohibition or commission of assault on the person-in-charge who supervises to prevent smoking at the non-smoking area.

13. Whoever commits any of the following acts shall, on conviction, be punished with a fine from a minimum of kyats 10000 to a maximum of kyats 30000 for the first offence and be punished with imprisonment for a term which may extend to one year and shall also be liable to a fine from a minimum of kyats 30000 to a maximum of kyats 100000 for second and subsequent offences:

(a) production, distribution or sale of cigar without mentioning the caption of warning in Myanmar language to be mentioned on the package of cigar that smoking can seriously affect health and other necessary warnings in accordance with the stipulations;

(b) production of cigar and tobacco product fraudulently mentioning that the toxic chemical potency is less than the amount prescribed by the Central Board in cigar and tobacco production, distribution or sale thereof in spite of knowing such fact mentioned;

(c) production, distribution or sale of cigar and tobacco product without label for commercial purpose;

(d) production, distribution or sale of any other goods showing the label of any cigar and tobacco product;

(e) production, distribution or sale of toys, edibles or wares made in the form of cigar.

14. Whoever commits any of the following acts shall, on conviction, be punished with a fine from a minimum of kyats 10000 to a maximum of kyats 30000 for the first offence and be punished

with imprisonment for a term which may extend to one year and shall also be liable to a fine from a minimum of kyats 30000 to a maximum of kyats 100000 for second and subsequent offences:

(a) selling cigar within the compound and within 100 yards from the compound of a school;

(b) giving in addition, giving as present or jointly giving directly or indirectly, any cigar and tobacco products in distributing or selling any goods, or any article in distributing or selling cigar and tobacco products;

(c) selling the cigar by vending machine;

(d) selling or giving cigar to a person who has not attained the age of eighteen;

(e) employing a person who has not attained the age of eighteen in distributing or selling cigar;

(f) exchanging the cigar with any goods from a person who has not attained the age of eighteen;

(g) destroying the caption and mark showing the place where smoking is not allowed or where smoking is allowed.

15. Whoever commits any of the following acts shall, on conviction, be punished with a fine from a minimum of kyats 1000 to a maximum of kyats 3000 for the first offence and be punished with a fine from a minimum of kyats 3000 to a maximum of kyats 10000 for second and subsequent offences:

(a) sale of cigarette singly or in a package containing less than 20 to enable easy purchase and smoking;

(b) if being a vendor of cigar, fails to mention conspiciously at the place of sale, the caption of warning in Myanmar language that smoking can seriously affect health;

(c) if being a vendor of cigar, fails to mention conspiciously at the place of sale, the caption informing in Myanmar language that sale is not made to a person who has not attained tha age of eighteen.

16. Any person-in-charge who fails to comply with any duty contained in section 9 shall, on conviction, be punished with a fine from a minimum of kyats 1000 to a maximum of kyats 3000 for the first offence and be punished with a fine from a minimum of kyats 3000 to a maximum of kyats 10000 for the second and subsequent offences.

17. Whoever commits smoking or holding lighted cigar in any non-smoking area under sections 6 and 7, except places prescribed in sub-sections (e), (f) and (n) of section 6 shall, on conviction, be punished with a fine from a minimum of kyats 1000 to a maximum of kyats 5000.

ChapterIX

Miscellaneous

18. (a) Offences contained in Chapter VIII of this Law are determined as cognizable offences.

(b) The responsible Police Officer concerned shall cause the person apprehended under section 17 to give a surety on a personal bond or other appropriate bond to appear before the relevant Court on the appointed day.

19. In implementing the provisions of this Law:

(a) the Ministry of Health may, with the approval of the Government, issue necessary rules and procedures;

(b) the Ministry of Health and relevant ministries may issue necessary notifications, orders and directives and the Department of Health may issue necessary orders and directives.

18. The Prohibition of Smoking at the Entertainment Buildings Act, 1959 is hereby repealed.

(Sd.) Than Shwe
Senior General
Chairman
The State Peace and Development Council

The Narcotic Drugs and Psychotropic Substances Rules 1985

In exercise of the powers conferred by section 9, read with section 76 of the Narcotic Drugs and Psychotropic Substances Act, 1985 (61 of 1985), the Central Government hereby makes the following rules, namely:—

CHAPTER 1

PRELIMINARY

(a) **Short title and commencement.—(I)** These rules may be called the Narcotic Drugs and Psychotropic Substances Rules, 1985.

(2) They shall come into force on the date of their publication in the Official Gazette.

(b) **Definitions.—In** these rules, unless the context otherwise requires,—

(a) "the Act," means the Narcotic Drugs and Psychotropic Substances Act, 1985 (61 of 1985);

(b) 'Appellate Authority" means any authority to whom an appeal may lie under any provision of these rules;[2][(c)"Chemical Examiner" means the Chemical Examiner or Deputy Chief Chemist or Shift Chemist or Assistant Chemical Examiner, Government Opium and Alkaloid Works, Neemuch or, as the case may be, Ghazipur;]

(a) "Chief Controller of Factories" means the Chief Controller of Government Opium and Alkaloid Factories;

(b) "crop year" means the period beginning on and from the 1st October of any year to the 30th September of the following year;

(t) "General Manager" means the General Manager, Government Opium and Alkaloid Works, Neemuch or, as the case may be, Ghazipur;

(a) "Issuing authority" means the Narcotic Commissioner or any other officer who may be authorised in this behalf by the Central Government for issuing a licence under Chapter V of these rules or issuing an import certificate or export authorisation under Chapter VI of these rules in respect of narcotic drugs or psychotropic substances;

(b) "licence" means a licence issued under these rules;

(c) "Proper Officer", in relation to any function to be performed under these rules, means the officer of Narcotics Department who is assigned those functions by the Narcotics Commissioner;

(d) 'Schedule" means a Schedule annexed to these rules;

(e) Vide G.S.R. 837(E), dated 14th November, 1985, published in the Gazette of India, Extra., Pt. II, Sec. 3 No. 491, dated 14th November, 1985.

(h) Subs. G.S.R. 82, dated 14th February, 1995 (w.e.f. 25-2-1995).

(k) words and expressions used herein and not defined, but defined in the Act shall have the meanings respectively assigned to them in the Act.

COMMENTS

Article(s) seized in connection with an offence may be sent for chemical analysis to any laboratory in the country, which is permitted to do such analysis, *Ram Dayal v. Central Narcotics Bureau,* (1993) 3 Crimes 818 (MP) (FB).

CHAPTER II

POWERS OF OFFICERS

(a) **Delegation of** powers.--Subject to such directions as may be given by the Central Government, the Narcotics Commissioner appointed by the Central Government under sub-section (1) of section 5 of the Act, may authorise any officer subordinate to him, to exercise all or any of his powers under these rules.

(b) **Narcotics Commissioner and other officers to exercise the powers of their subordinates.—The** Narcotics Commissioner and such other officer as may be appointed by the Central Government under sub-section (1) of section 5 of the Act may perform all or any of the functions, or exercise any of the powers, assigned under these rules to the officers subordinate to them.

CHAPTER HI

OPIUM POPPY CULTIVATION AND PRODUCTION OF

OPIUM AND POPPY STRAW

(c) **Opium poppy cultivation and production of opium or poppy straw.—The** opium poppy for production of opium or poppy straw shall not be cultivated save on account of the Central Government and in the tracts notified by it from time to time and in accordance with the conditions of a licence issued by the District Opium Officer under rule 8.

(d) **Fee for grant of licence.--The** licence of cultivation of opium poppy may be granted by the District Opium Officer on payment of a fee of '[rupees twenty-five].

(e) **Form of licence for cultivation of the opium poppy.—The** licence for cultivation of opium poppy for the production of opium or poppy straw shall be issued in Form No. 1 appended to these rules.

(f) **Issue of licence.—Subject** to the general conditions relating to grant of licence notified by the Central Government, the District Opium Officer may issue licence to any person for a crop year for cultivation of the opium poppy for production of opium or poppy straw on receipt of an application made by that person in Form No.2 appended to these rules.

(g) **Licence to specify the area,** *etc.—The* licence for cultivation of opium poppy issued under rule 8 shall specify the area and designate the plots to be cultivated with opium poppy.

(a) **Designating of Lambardar.—The** District Opium Officer may designate one of the cultivators of opium poppy as Lambardar in each village where opium poppy

1. Subs. by G.S.R. 543, dated 24th October, 1994 (w.e.f. 5-11-1994).cultivation is permitted, who shall perform such functions and on such terms and conditions as may be specified from time to time by the Narcotics Commissioner.

11. **Withholding or cancellation of licence.—(1)** An officer higher in rank than the District Opium Officer may, for sufficient reasons to be recorded in writing, withhold or cancel a licence already issued.

1. No order shall be passed under sub-rule (1) unless the cultivator has been given a reasonable

opportunity of showing cause against the said order or is heard in person, it he so desires.

2. Where opium poppy has been cultivated under a licence which is subsequently withheld, or cancelled, the standing crop, if any, shall be destroyed under the supervision of the proper officer in such manner as may be specified by the Narcotics Commissioner.

12. Procedure with regard to measurement of land cultivated with opium poppy.—(1) All plots of land cultivated with opium poppy in accordance with the licence issued under these rules, shall be measured in metres by the proper officer in the presence of the cultivator concerned and the Lambardar of the village and the concerned cultivator and the Lambardar of the village shall attest the entries made in the records to be maintained by the Lambardar, as may be specified by the Narcotics Commissioner in this behalf, under their signature/thumb-impression with date, in token of having satisfied themselves regarding the correctness of the measurement.

(2) The measurement conducted by the proper officer shall be subject to such further checks by such officers as may be specified by the Narcotics Commissioner in this behalf.

13. Procedure with regard to preliminary weighment.—(1) The cultivator shall, during the course of harvesting, produce daily before the Lambardar, each day's collection of opium from his crop for weighment.

(a) The 'Lambardar shall make arrangements to weigh such opium and make necessary entries in the records to be maintained by him as may be specified by the Narcotics Commissioner in this behalf.

(b) The cultivator and the Lambardar shall attest the entries made in such records under their signature/thumb-impression with date, showing the quantity of opium weighed on a particular day.

(c) The proper officer shall conduct check weighment of the opium collected by the cultivators with reference to the entries in the Lambardar's record and indicate his finding therein which shall be attested by him and the Lambardar under their signature with date.

(d) The variations between the quantity of opium produced by the cultivator indicated in the Lambardar's record and as found by the proper officer during his check, shall be inquired into by the proper officer in order to ascertain the liability of the cultivator for punishment under section 19 of the Act.

14. **Delivery of opium produced.—All** opium, the produce of land cultivated with **opium** poppy, shall be delivered by the cultivators to the District Opium Officer or any other officer duly authorised in this behalf, by the Narcotics Commissioner at a **place as** may be specified by such officer.

(d) **Opium to be weighed, examined and classified.—All** opium delivered by the cultivators to the District Opium Officer or any other officer authorised as aforesaid, shall, in the presence of the concerned cultivator or any person authorised by him and the Lambardar of the village, be weighed, examined and classified according to its quality and consistence and forwarded by the District Opium Officer to the Government Opium Factory in such manner as may be specified by the Narcotics commissioner.

(e) **Procedure where cultivator is dissatisfied with classification of opium.—**Any cultivator who may be dissatisfied with the classification of his opium done by the officer referred to in rule 15

may have it forwarded by such officer to the Government Opium Factory separately, after having it properly sealed in his presence and in the presence of the concerned Lambardar.

(f) **Procedure for sending opium suspected to be adulterated.—** When opium delivered by a cultivator to the District Opium Officer or any other officer authorised in this behalf, is suspected of being adulterated with any foreign substance, it shall be forwarded to the Government Opium Factory separately, after it is properly sealed in the presence of the cultivator and the concerned Lambardar.

(g) **Drawing of samples from opium sent to Government Opium Factory under rule 16 or rule 17.—The** sealed opium received separately in accordance with rule 16 or rule 17, shall be opened and sample drawn thereof in the presence of the cultivator, if he so desires, to whom, a notice intimating the date and time in this behalf, shall be sent well in advance.

(h) **Fixation of price of opium.—(1)** The Central Government shall, from time to time, fix the price of opium, to be paid to the cultivators, in such manner as it may deem fit.

(2) Such price shall be fixed per kilogram of opium of a standard consistence.

(i) **Provisional payment of price.—(1)** The District Opium Officer shall, having regard to the weight and consistence of opium delivered by individual cultivators, work out the weight of such opium at the standard consistence and determine provisionally the total price payable to such cultivators.

(2) The said officer, shall, pay to the cultivators, ninety per cent of the price so determined which shall be subject to adjustment against the final price payable to the cultivators to be determined as provided hereinafter.

(j) **Weighment and examination of the opium at the Government Opium Factory.—The** opium forwarded by the District Opium Officer shall be received, weighed, examined, and classified in the Government Opium Factory under the supervision of the General Manager in such manner as may be specified by the Narcotics Commissioner.

(k) **Confiscation of adulterated opium.—All** such opium received separately under rule 17, if found to be adulterated on examination by the Chemical Examiner in the Government Opium Factory may be liable to confiscation by the General Manager.

(l) **Adjudication of confiscation of adulterated opium.—No** such confiscation shall be ordered by the General Manager unless the concerned cultivator is given a reasonable opportunity of showing cause against the **proposed** order and is heard in person, if he so desires.

(g) **Determination of final price of opium.—(1)** Subject to rule 21, the final price of opium payable to the cultivator shall, having regard to the price fixed by the Central Government under rule 19, be determined by the General Manager on the basis of analysis report of the Chemical Examiner [1][***] and communicated to the concerned District Opium Officer.

(2) The price payable in respect of any opium which is delivered to the District Opium Officer or any other officer authorised in this behalf under rule 14 and is not initially suspected to be adulterated but found to be adulterated on examination in the Government Opium Factory, shall be subject to reduction at such rates as may be specified by the Central Government.

(g) **Adjustment of cultivators' account and recovery of dues from the cultivators.—The** accounts of the cultivators for a particular crop year shall be adjusted by the District Opium Officer at the

time of issuing of licences for the subsequent crop year and any balance that may remain due from the cultivators shall be recovered and any amount due to them be paid.

(h) **eights and scales.—The** weights and scales to be used for weighing the opium at the weighment centres and the Government Opium Factory shall be caused to be examined at the appropriate time by the Deputy Narcotics Commissioner or the General Manager, as the case may be.

(i) **Cultivation of opium poppy for exclusive production of poppy straw.—**The Central Government may, if it considers it expedient so to do, permit cultivation of the **opium** poppy for the exclusive production of poppy straw in accordance with a licence issued under rule 8 in such tracts and subject to such conditions as may be specified by it, by notification in the Official Gazette in this behalf:

Provided that the poppy straw produced by the cultivators or a result of the cultivation of opium poppy for production of opium, shall be deemed to have been produced under a valid licence issued under rule 8.

(j) **Appeals to the Deputy Narcotics Commissioner and Narcotics Commissioner.—(1)(a)** Any person aggrieved by any decision or order made or passed under these rules relating to refusal, withholding or cancellation of a licence for opium poppy cultivation by an officer of the Narcotics Department, lower in rank than the Deputy Narcotics Commissioner, may appeal to the Deputy Narcotics Commissioner within thirty days from the date of the communication to him of such decision or order.

(b) Notwithstanding anything contained in clause (a), if the decision or order regarding withholding or cancellation of licence for opium poppy cultivation is passed by the Deputy Narcotics Commissioner, such appeal shall lie to the Narcotics Commissioner:

Provided that the Deputy Narcotics Commissioner or, as the case may be, the Narcotics Commissioner may, if he is satisfied that the appellant was prevented from submitting his appeal within the time limit specified in clause (a) due to reasons beyond his control, allow such appeal to be presented within a further a period of thirty days.

(2) Every appeal under this rule shall be accompanied by a copy of the decision

I. Omitted by G.S.R. 82. dated 14th February, 1995 (w.e.f. 25-2-1995).

or order appealed against and shall be in such form and in such a manner as may be specified by the Narcotics Commissioner in this behalf.

29. Appeals to the Chief Controller of Factories.—(1) Any person aggrieved by any decision or order made or passed under rule 21 or rule 23 by the General Manager may appeal to the Chief Controller of Factories within thirty days from the date of the communication to him of such decision or order:

Provided that the Chief Controller of Factories may, if he is satisfied that the appellant was prevented from submitting his appeal within the said time limit due to reasons beyond his control, allow such appeal to be presented within a further period of thirty days.

(2) Every appeal under this rule shall be accompanied by a copy of the decision or order appealed against and shall be in such form and in such manner as may be specified by the Narcotics Commissioner.

30. Procedure for appeal.—(1) The Appellate Authority shall give an opportunity to appellant to be heard, if he so desires.

1. The Appellate Authority may, at the hearing of an appeal, allow the appellant to go into any ground of appeal not specified in the grounds of appeal, if the Appellate Authority is satisfied that omission of that ground from the grounds of appeal was not wilful or unreasonable.

2. The Appellate Authority may, after making such further inquiry as may be necessary, pass such orders as he thinks fit confirming, modifying or annulling the decision or order appealed against: Provided that any order relating to the quantum of adulterated opium to be confiscated in addition to the opium already confiscated under rule 23 shall not be passed unless the appellant has been given a reasonable opportunity of showing cause against the proposed order.

3. The order of the Appellate Authority disposing of the appeal under this rule shall be in writing and shall state the points for determination, the decision thereon and the reasons for the decision.

4. On the disposal of the appeal, the Appellate Authority shall communicate the order passed by him to the **appellant and** the officer who passed the order or made the decision appealed against.

5. No further appeal or revision shall lie against the order passed by the Appellate Authority under this rule.

CHAPTER IV

MANUFACTURE, SALE AND EXPORT OF OPIUM

31. Manufacture of opium.—Opium shall not be manufactured save by the Central Government Opium Factories at Ghazipur and Neemuch:

Provided that opium mixtures may be manufactured from opium lawfully possessed by a person authorised under the rules made by the State Government for the said purpose.

32. Export of opium.—The export of opium is prohibited save when the export is on behalf of the Central Government.

33. Sale to State Governments or manufacturing chemists.—(1) The sale of opium to State Governments or, as the case may be, manufacturing chemists shall be only from the Government Opium Factory, Ghazipur.

6. The sale of opium from the Government Opium Factory at Ghazipur to manufacturing chemists shall be only under a permit granted by or under the orders of the State Government within whose jurisdiction the chemist resides or has his place of business in the form prescribed by that Government.

7. The permit referred to in sub-rule (2) shall be issued, in quadruplicate and,—

3. the quadruplicate copy shall be retained by the issuing authority and the remaining copies forwarded to the Government Opium Factory, Ghazipur;

4. the said factory shall retain the duplicate copy for record, send the origi nal copy with the consignment of opium and return the triplicate copy to the issuing authority after endorsing thereon the quantity actually supplied and the date of despatch.

30. **Fixation of sales price of opium.—The** price to be charged for opium sold under this Chapter shall be fixed, from time to time, by the Central Government in such manner as it may deem fit.

CHAPTER V

MANUFACTURED DRUGS

35. General prohibition.—The manufacture of crude cocaine, ecgonine and its salts and of diacetyl morphine and its salts is prohibited.

'[Provided that nothing contained in this rule shall apply in case the drugs are manufactured by Government opium factory or by chemical staff employed under the Central Board of Excise and Customs or any person authorised by the Narcotics Commissioner by a special licence for purposes mentioned in Chapter VIIA:

Provided further that the Narcotics Commissioner shall consult the Drugs Controller-General of India before issuing a licence under this Chapter,]

36. Manufacture of natural manufactured drugs.—(1) The manufacture of cocaine and its salts is prohibited save the manufacture of cocaine hydrochloride by the chemical staff employed under the Central Board of Excise and Customs from confiscated cocaine.

5. The manufacture of morphine, codeine, dionine, thebaine, dihyrocodeinone, dihydrocodeine, acetyldihydrocodeine, acetyldihydrocodeinone, dihydromorphine, dihydromorphinone, dihydrohydroxycodeinone. pholocodine and their respective salts is prohibted save by the Government Opium Factory.

6. The manufacture of medicinal hemp shall be under a licence granted by the State Government on payment of such fees and in accordance with such conditions as may be prescribed by that Government in this behalf.

37. Manufacture of synthetic manufactured drugs.—{l) The manufacture of manufactured drugs notified under sub-clause (b) of clause (xi) of section 2 of theAct (hereafter referred to as the drug) is prohibited save under and in accordance with the conditions of a licence granted by the Narcotices Commissioner or such other officer as may be authorised by the Central Government in this behalf, in Form No.3 appended to these rules.

(2) A fee of rupees fifty shall be payable in advance to the Central Government for each licence issued under this rule for renewal thereof.

38. Application for licence.—Every application for a licence or for renewal thereof under rule 37 '[or under the proviso to rule 35] shall be in such form as may be specified by the Narcotics Commissioner.

39. Conditions for issue of licences.—No licence shall be issued under rule 37 l[or under the proviso to rule 35] unless the applicant therefore has—

(2) produced to the issuing authority licences granted to him under (a) the Drugs and Cosmetics Act, 1940 (23 of 1940) for the manufacture of the drug, and (b) the rules framed under section 10 of the Act by State Government of the State in which he has his place of business, for the possession, sale and distribution of the drugs; and

(3) made a deposit of Rs. 5,000.00 as security in the manner specified by the issuing authority for the due observance of the conditions of the licence and has furnished proof to the satisfaction

of the issuing authority that he is equipped as to the land, building and other paraphernalia to properly carry on the business prescribed in the application and is of good financial standing.

40. **Manufacture only from materials lawfully possessed.—The** licensee shall not manufacture the drug save from materials which he is lawfully entitled to possess.

41. **Limits of manufacture.—The** issuing authority, while issuing the licence, shall take into account all relevant factors for permitting the quantity of the drug to be manufactured by a licensee including the following:

(2) quantity allotted by the State Government for processing into any preparation in licensee's own manufactory;

(3) quantity required for supply to other firms within or outside the country;

(4) quantity required for reasonable inventory:

Provided that the total quantity of the drug manufactured during any one year does not exceed the estimated requirements of this country for the relevant year as furnished to the International Narcotics Control Board.

42. **Security arrangements.—The** licensee shall ensure all necessary security arrangements in the manufacturing premises as may be specified by the issuing authority.

43. **Advance notice for commencement and cessation of manufacture.—The** licensee shall give at least 15 days' notice in writing to the issuing authority of the date on which he proposes to commence manufacture of the drug and at least one month's notice before he ceases to manufacture the same.

44. **Cessation of manufacture.—Where** the licensee ceases manufacturing operations for any reasons whatsoever, he shall forthwith inform the issuing authority in this behalf indicating the date on which he proposes to recommence manufacture:

Provided that the issuing authority may prohibit all further manufacture in case the period of cessation of manufacture exceeds 30 days.

45. **Possession, sale and distribution.—The** licensee shall not possess or sell or distribute the drug otherwise than in accordance with the rules made by the State Government under the Act.

46. **Maintenance of accounts and submission of returns.—The** licensee shall maintain true accounts of all transactions including the accounts of materials used for the manufacture of the drug, the quantities manufactured, sold or otherwise disposed of and furnish returns in such forms and in such manner as may be specified by the Narcotics Commissioner.

47. **Inspection of stocks,** *etc.—(1)* The stocks of the drug and the materials used for its manufacture and all accounts and records of transactions relating thereto, shall be open to inspection by any officer authorised by the issuing authority.

(2) A serially numbered Inspection **Book** shall be maintained by the licensee in good condition for the use of such officer.

48. **Suspension and revocation of licence.—(I)** Without prejudice to any action that may be taken under the provisions o_f the. Act, the issuing authority may suspend or cancel a licence-

15. if the licence is transferred or sublet without the prior approval of the issuing authority; or

16. in the event of any breach of any conditions of the licence; or

17. if the licensee is convicted for any offence under the Act or under any other law relating to the

narcotic drugs for the time being in force in any • State.

(2) No order shall be passed under sub-rule (1) unless the licensee has been given a reasonable opportunity showing cause against the said order or is heard in person, if he so desires.

49. Appeal.—(I) The licensee may file an appeal against the decision or order made or passed under rule 48 to-

24. the Narcotics Commissioner where such decision or order was made or passed by any officer subordinate to him; and

25. the Board, in any other case, within 30 days from the date of communication to him to such decision or order.

(2) Every memorandum of appeal shall be accompanied by a copy of the decision or order appealed against.

(3) Every appeal under this rule shall be filed in such form and in such manner as may be specified by the **Board.**

50. Procedure for appeal.—(1) The Appellate Authority shall give an opportunity to the appellant to be heard in person, if he so desires. The Appellate Authority may, at the hearing of an appeal allow the appellant to go into any ground of appeal not specified in the grounds of appeal, if the Appellate Authority is satisfied that omission of that ground from the grounds of appeal was not wilful or unreasonable.

(2) The Appellate Authority may, after making such further inquiry as may be necessary, pass such orders as it thinks fit, confirming, modifying or annulling the decision or order appealed against.

(3) The order of the Appellate Authority disposing of the appeal under this rule shall be in writing and shall state the points for determination, the decision thereon and the reasons for the decision.

(a) **Surrender of licence.—A** licensee may, if he so desires, surrender his licence, by giving not less than 15 days' notice in writing to the issuing authority.

(b) **Disposal of stocks of drugs on cancellation of licence,** *etc.—Such* stocks or drugs as may be in the possession of a licensee, on the expiry or cancellation or surrender of his licence, shall be disposed of in such manner as may be specified by the Narcotics Commissioner in this behalf.

CHAPTER VI

IMPORT, EXPORT AND TRANSHIPMENT OF NARCOTIC DRUGS AND PSYCHOTROPIC SUBSTANCES

(c) **General prohibition.—Subject** to the other provisions of this Chapter, the import into and export out of India of the narcotic drugs and psychotropic substances specified in Schedule I is prohibited.

'[Provided that nothing in this rule shall apply in case the drug substance is imported into or exported out of India subject to an import certificate or export authorisation issued under the provision of this Chapter and for the purpose mentioned in Chapter VIIA.]

[2]**153A.** (1) Subject to the provisions of sub-rule (2), no person shall export any of the narcotic drug or psychotropic substance or preparation containing any of such narcotic drug or

psychotropic substance specified in '[Schedule II] to the countries or to the region of such country specified therein.

(2) Notwithstanding anything contained in sub-rule (1) above, the Narcotics Commissioner may authorise export of specified quantities of such narcotic drug or psychotropic substance or preparation containing such narcotic drug or psychotropic substance on the basis of special import licence issued by the Competent Authority of the country mentioned in Schedule IV which intends such import by way of issuance of special import licence. The shipment of the consignment so allowed shall be accompanied by a copy of such special import licence duly endorsed by the Narcotics Commissioner.]

(2) Ins. by G.S.R. 350(E), dated 25th June, 1997 (w.e.f. 27-6-1997).

(3) Ins. by S.O. 599(E), dated 10th August, 1993 (w.e.f. 10-8-1993).

(4) Subs. by G.S.R. 556(E), dated 14th July, 1995 (w.e.f. 20-7-1995).

4. Import of opium, *etc.—The* import of-

(i) opium, concentrate of poppy straw, and

(ii) morphine, codeine, thebaine, and their salts is prohibited save by the Government Opium Factory.

55. Application for import certificate.—'[(3) Subject to rule 53, no narcotic drug, or psychotropic substance specified in the Schedule of the Act shall be imported into India without an import certificate in respect of the consignment issued by the issuing authority, in Form No. 4 appended to these rules.]

(a) The importer applying for an import certificate under sub-rule (1) in relation to narcotic drug shall submit along with his application the original or certified copy of the excise permit issued by the concerned State Government.

(b) The application for the import certificate shall state such details as may be specified by the Narcotics Commissioner.

56. Issue of import certificate.—(I) The issuing authority shall prepare seven copies of the import certificate referred to in sub-rule (1) of rule 55 and deal with them in the manner hereunder provided, namely:—

(a)(i) original and duplicate copies should be supplied to the importer who should transmit the original copy to the exporting country and shall produce the duplicate copy at the Customs House, Land Customs Station or Airport where the consignment arrives or, in the case of imports by parcel post, at the post office of delivery, in order to obtain delivery of the consignment of narcotic drugs or psychotropic substances;

(ii) the Collector of Customs or Post Master shall state on the copy presented by the importer that the narcotic drugs or the psychotropic substances have actually been imported and return the document to the importer who shall indicate on it that he has received the goods; •

(iii) the importer shall return the duplicate copy of the import certificate incorporating the endorsement from the Collector of Customs or Post Master and his own endorsement to the issuing authority—(1) where the import certificate relates to narcotic drug, through the excise authorities of the State from which excise permit for purposes of sub-rule (2) of rule 55 was

produced; (2) where the import certificate relates to psychotropic substance, through the Drugs Controller of the concerned State;

(b) triplicate copy should be supplied to the Collector of Customs concerned who shall return it to the issuing authority along with the copy of the export authorisation to be received at the time of receipt of the consignment from the Government of the exporting country, with an endorsement as to actual quantity of narcotic drugs or psychotropic substances cleared;

(c) quadruplicate copy of the import certificate in relation to narcotic drug should be supplied to the excise authorities of the State into which thenarcotic drug is to be imported, and the said copy of the certificate in relation to psychotropic substance should be supplied to the Drugs Controller of the concerned State for comparison with the copy produced before them, by the importer under sub-clause (a) of this sub-rule.

(i) qunituplicate copy should be supplied to the Government of the exporting country for comparison with the copy furnished to them by improter under sub-clause (a) or this sub-rule;

(ii) sextulplicate copy should be retained to the Drugs Controller, Government of India;

(iii) septuplicate copy should be retained by the issuing authority in his office.

(2) An import certificate issued under sub-rule (1) of rule 55 may allow the importation of the quantity of the concerned drug or the substance in more than one consignment.

(i) **Transit.—Subject** to the provisions of section 79 of the Act and rule 53, no consignment of any narcotic drug, or psychotropic substances specified in '[Schedule of the Act], shall be allowed to be transited through India unless such consignment is accompanied by a valid export authorisation in this behalf, issued by the Government of the exporting country:

Provided that the provisions of this rule shall not apply to the carriage by any ship or aircraft, of small quantities of such narcotic drugs **and** psychotropic substances which are essential for treatment of, or medical aid to, any person on board the ship or aircraft.

(ii) **Application for export authorisation.—(1)** '[Subject to rules 53 and 53A, no narcotic drugs, or psychotropic substances specified in the Schedule of the Act, shall be exported out of India without an export authorisation in respect of the consignment issued by the issuing authority in Form No. 5 apperrded to these rules]

(2) The exporter applying for an export authorisation **under** sub-rule (1) shall submit,—

(2) where the export authorisation relates to narcotic **drug,** along with his application the original or an authenticated copy of the excise permit issued by the concerned State Government; and

(3) the import certificate in original, issued by the Government of the importing country certifying the official approval of the concerned Government. 2[***]

[3][(3) The application for the export authorisation shall state such details as may be specified by the Narcotics Commissioner.

(2) Subs. by G.S.R. 556(E), dated 14th July, 1995 (w.e.f. 20-6-1995).

(3) Sub-rule (3) omitted by G.S.R. 556(E), dated 14th July, 1995 (w.e.f. 20-7-1995).

(4) Sub-rule (4) renumbered as sub-rule (3) by G.S.R. 556(E), dated 14th July, 1995 (w.e.f. 20-7-1995).

59. **Issue of export authorisation.—(l)** The issuing authority shall prepare five copies of the export authorisation referred to in sub-rule (1) of rule 58 and deal with them in the manner hereunder provided, namely:—

51. the original should be supplied to the consignor which shall accompany the consignment;

52. the duplicate copy should be forwarded to the Collector of Customs of the port who will return it to the issuing authority indicating on it the date of export and the quantity exported;

53. the triplicate copy should be forwarded to the Government of the importing country;

54. the quadruplicate copy should be forwarded to the excise authority of the State in which the exporter has his place of business;

55. quintuplicate copy should be retained by the issuing authority in his office;

(2) Where the consignment of narcotic drug or psychotropic substance is to be transhipped or transited through one or more countries, such additional number of copies of export authorisation as may be required shall be prepared and sent to the concerned country or as the case may be countries.

60. **Transhipment.—Subject** to the provisions of section 79 of the Act and rule 53, no consignment of narcotic drug, or psychotropic substance specified in '[Schedule of the Act], shall be allowed to be transhipped at any port in India save with the permission of the Collector of Customs.

61. **Procedure for transhipment.—The** Collector of Customs while allowing any consignment of narcotic drug, or psychotropic substances, specified in '[Schedule of the Act,] to be transhipped shall, *inter alia,* satisfy himself that the consignment is accompanied by a valid export authorisation issued by the exporting country. •

62. **Diversion of consignment.—(1)** The Collector of Customs shall take all due measures to prevent the diversion of such consignment to a destination other than that named in the aforesaid export authorisation.

(2)(a) The Collector of Customs may permit diversion of such a consignment to a country other than that named in the accompanying copy of the export authorisation subject to the production of export authorisation issued by the issuing authority as provided under rule 58, as if the diversion were an export from India to the country, or territory of new destination.

(b) The Collector of Customs shall inform the issuing authority regarding the actual quantity of the narcotic drug or psychotropic substance, the diversion of the consignment of which was allowed under clause (a), whereupon the issuing authority shall, inform the country from which the export of the consignment originated.

63. **Prohibition of import and export of consignments through a post office box,** *etc.—The* import or export of consignments of any narcotic drug or psychotropic substance through a post office box or through a bank is prohibited.

CHAPTER VII

PSYCHOTROPIC SUBSTANCES

64. **General prohibition.—No** person shall manufacture, possess, transport, import inter-State, export inter-State, sell, purchase, consume or use any of the psychotropic substances specified in Schedule 1.

65. **Manufacture of psychotropic substances.—(1)** Subject to the provisions of sub-rule (2), the manufacture of any of the psychotropic substances other than those specified in Schedule I shall be in accordance with the conditions of a licence granted under the Drugs and Cosmetics Rules, 1945 (hereinafter referred to as the 1945 Rules) framed under the Drugs and Cosmetics Act, 1940 (23 of 1940), by an authority in charge of Drugs Control in a State appointed by the State Government in this behalf.

1. The authority in charge of drugs control in a State (hereinafter referred to as the Licensing Authority) shall consult the Drugs Controller (India) in regard to the assessed annual requirements of each of the psychotropic substances in bulk form referred to in sub-rule (1) in the country and taking into account the requirement of such psychotropic substances in the State, the quantity of such substance required for supply to other manufacturers outside the State and the quantity of such substance required for reasonable inventory to be held by a manufacturer, shall specify, by order, the limit of the quantity of such substance which may be manufactured by the manufacturer in the State.

2. The quantity of the said psychotropic substance which may be manufactured by a licensee in an year shall be intimated by the Licencing Authority to the licensee at the time of issuing the licence.

'[Provided that nothing contained in this rule shall apply in case the psychotropic substances specified in Schedule I are manufactured, possessed, transported, imported inter-State, exported inter-State, sold, purchased, consumed or used subject to other provisions of this Chapter which applies to psychotropic substances which are not included in Schedule I and for the purposes mentioned in Chapter VIIA:

Provided further that the authority in charge of the drug control in a State referred to in sub-rule (2) of Rule 65 shall consult the Narcotics Commissioner before issuing a licence under rule 65 in respect of psychotropic substances included in Schedule I.]

66. **Possession,** *etc.* **of psychotropic substances.—(1)** No person shall possess any psychotropic substance for any of the purposes covered by the 1945 Rules, unless he is lawfully authorised to possess such substance for any of the said purposes under these Rules.

(2) Notwithstanding anything contained in sub-rule (1), any research institution or a hospital or dispensary maintained or supported by Government or local body or by charity or voluntary subscription, which is not authorised to possess any psychotropic substance under the 1945 Rules, or any person who is not so authorised under the 1945 Rules, may possess a reasonable quantity of such substance as may be necessary for their genuine scientific requirements or genuine medical requirements, or both for such

1. Ins. by G.S.R. 350(E), dated 25th June, 1997 (w.e.f. 27-6-1997).

period as is deemed necessary by the said research institution or, as the case may be, the said hospital or dispensary or person:

Provided that where such psychotropic substance is in possession of an individual for his personal medical use the quantity thereof shall not exceed one hundred dosage units at a time.

(3) The research institution, hospital and dispensary referred to in sub-rule (2) shall maintain proper accounts and records in relation to the purchase and consumption of the psychotropic substance in their possession.

67. Transport of psychotropic substance.—(1) Subject to the provisions of rule 64, no consignment of psychotropic substance shall be transported, imported inter-State or exported inter-State unless such consignment is accompanied by a consignment note in Form 7 appended to these Rules and in the manner as provided hereinafter.

(i) The consignment note referred in sub-rule (1) shall be prepared in triplicate, and the original and duplicate copies of the said note shall be sent along with the consignment of psychotropic substances to the consignee who shall return the duplicate copy of the note to the consignor for his use after endorsing on the original and duplicate copies the particulars of the receipt of the quantity consigned.

(ii) The consignor shall make necessary entries on the triplicate copy of the said note with reference to the receipt of quantity of the psychotropic substances indicated on that duplicate copy of the note.

(iii) The consignor and consignee shall keep such consignment note for a period of two years and the said note may be ihspected at any time by an officer authorised in this behalf by the Central Government.

CHAPTER VIIA

Special provisions regarding manufacture, possession, transport, import-export, purchase and consumption of narcotic drugs and psychotropic substances for medical and scientific purposes.

67A. Notwithstanding anything contained in the foregoing provisions of these rules—

(a) a narcotic drug and psychotropic substance may be used for—

(2) scientific requirement including analytical requirements of any Government laboratory or any research institution in India or abroad;

(3) very limited medical requirements of a foreigner by a duly authorised person of a hospital or any other establishment of the Government especially approved by that Government;

(4) the purpose of de-addiction of drug addicts by Government or local body or by an approved charity or voluntary organisation or by such other institution as may be approved by the Central Government.

(b) persons performing medical or scientific functions shall keep records concerning the acquisition of the substance and the details of their use in Form 7 of these rules and such records are to be preserved for at least two years after their *(sic);*

(c) a narcotic drug and psychotropic substance may be supplied or dispensed for use to a foreigner pursuant to medical prescription only from the authorised

1. Ins, by G.S.R. 350(E), dated 25th June, 1997 (w.e.f. 27-6-1997).licensed pharmacists or other authorised retail distributors designated by authorities responsible for public health.]

CHAPTER VIII

MISCELLANEOUS

68. Repeal and savings.—(1) The Central Opium Rules, 1934, the Dangerous Drugs (Import, Export and Transhipment) Rules, 1957, and the Central Manufactured Drugs Rules, 1962 are hereby repealed.

(2) Notwithstanding such repeal, anything done or any action taken or purported to have been done or taken under any of the rules repealed by sub-rule (1) shall, in so far as it is not inconsistent with the provisions of these rules, be deemed to have been done or taken under the corresponding provisions of these rules.

SCHEDULE I

***(See* rules 53 and 64)**

I. Narcotic drgus

(d) Coca Leaf

(e) Canabis (Hemp)

(f) (a) Acetorphine

57. Diacetylmorphine (Heroin)

58. Dihydrodesoxymorphine (Desmorphine)

59. Etorphine

60. Ketobemidone

and their salts, preparations, admixtures, extracts and other substances containing any of these drugs.

II. Psychotropic substances

Si. No.	International non-proprietary names	Other non-proprietary nameNames	Chemical Names
1***]			
21.	METHAQUALONE		2-Methyl-3-o-toly1-4(3H)-
'2.	AMFEPRAMONE		2-(Diethylamino) propiophenone
(a)	BENZPHETAMINE		*N-13enzyl-N-dimethyl-*
1.	BROMAZEPAM		7-Bromo-1, 2-dihydro-5-(2-pyridy)- 2H-1,
2.	CAMAZEPAM		7-Chloro-1,3-dihydro-3-hydroxy-1-1 methyl-5-phenyl 2-H-1, 4- 2-one dimethyl carbamat (ester).

(a) Entries 1 to 16 and 18 omitted by S.O. 786(E), dated 26th October, 1992 (w.e.f. 26-10-1992).

(b) Entries 17 and 19 to 33 re-numbered as entires 1 to 16 by S.O. 786(E), dated 26th October, 1992 (w.e.f. 26-10-1992).

(c) Entry 6 omitted by G.S.R. 509(E), dated 4th November, 1996 (w.e.f. 4-11-1966).

(d) Entry 7 omitted by G.S.R. 748(E), dated 14th December, 1993 (w.e.f. 14-12-1993).

(b) Entries 35 to 51 re-numbered as entries 17 to 33 by S.O. 786 (E), dated 26th October, 1992 (w .e. f. 26-10-1992).

(c) Entries 33A to 33F added by G.S.R. 25 (E), dated 12th Janurary, 1996 (w.e.f. 12-1-1996).

(d) Entry 53 re-numbered as 34 and entry 52 omitted by S.O. 786 (E), dated 26th October, 1992 (w.e.f. 26-10-1992).

The National Food Law

The State Law and Order Restoration Council

(The State Law and Order Restoration Council Law No. 5/97)

The 9th Waning Day of *Tabodwe,* 135S M.E.

(3rd March, 1997)

The State Law and Order Restoration Council hereby enacts the following Law: -

Chapter I

Title and Definition

1. This Law shall be called the National Food Law.

2. The following expressions contained in this Law shall have the meanings given hereunder:-

(a) **Food** means edible thing that human beings can readily eat or drink, ingredient included therein or food additives except drug. This expression also includes thing determined as food by the Ministry of Health by notification from time to time;

(b) **Board of Authority** means the Myanmar Food and Drug Board of Authority formed under the National Drug Law and supplemented under section 4 of this Law;

(c) **Controlled Food** means food determined as controlled food by the Board of Authority from time to time;

(d) **Food Additive** means the ingredient used in the production and preparation of food, or ingredient for colour, odour and taste in the food, determined by the Board of Authority;

Food differing from Standards means the food which is not in conformity with the specifications in respect of the relevant food, or food which is lower or higher than the minimum or maximum

(e) standards, prescribed by the Board of Authority;

(f) **Licence** means a permit granted by the relevant Government department or organization under any existing law for production of food ;

(g) **Unhygienic Condition** means the condition which may cause injury or danger to the health of the consumer due to contamination of food with dirt and filth;

(h) **Production** means the operations to he carried out in the manufacture of food for the purpose of sale. This expression also includes the performance of any stage or all stages in

the operations carried out. in processes:

(i) **Quality Assurance** means the warranty that food is of genuine quality, free from danger and hygienic for the consumer;

(j) **Labelling** means the act of displaying labels on the container, bottle, pack, outer package or any packing material in which the food is contained;

(k) **Advertising** means carrying out measures to inform the public directly.or indirectly in order to promote distribution and sale of the food;

(1) **Primary Laboratory** means the laboratory prescribed by the Board of Authority, by notification to analyse samples of the food;

(m) **Appellate Laboratory** means the laboratory specified by the Board of Authority by notification in order that a final and conclusive decision may be made in respect of analysis of samples of food, after reanalysis of samples, when a problem arises with respect to analysis of food from primary laboratory or when either party is dissatisfied and files an appeal.

Chapter II

Aims

3. The aims of this Law are as follows:-

(a) to enable the public to consume food of genuine quality, free from danger and hygienic;

(b) to prevent the public from consuming food that may cause danger or are injurious to health;

(c) to supervise production of controlled food systematically;

(d) to control and regulate the production, import, export, storage, distribution and sale of food systematically.

Chapter III

Formation of the Board of Authority

4. In order to carry out measures relating to food contained in this Law,the Government shall supplement the following persons as members in the Myanmar Food and Drug Board of Authority:-

(a) Director-General,

Development Affairs Department,

Ministry of Progress of Border Areas and National Races and Development Affairs;

(b) A representative each from the following organizations:-

(1) Yangon City Development Committee;

(2) Mandalay City Development Committee;

(c) An expert each relating to the following subjects:-

(1) Food Science,

(2) Food Microbiology,

(3) Food Industrial Technology,

(4) Toxicology.

5. The non-governmental member of the Board of Authority is entitled to such remuneration as may be prescribed by the Ministry of Health.

Chapter IV

Functions and Duties of the Board of Authority

6. The functions and duties of the Board of Authority formed under section 4are as follows:-

(a) laying down the policy relating to the production, storage, distribution and sale of food;

(b) determining good production practices with respect to quality assurance of food;

(c) laying down the policy relating to the inspection, control and laboratory analysis of food;

(d) laying down the policy relating to labelling and advertising of food;

(e) determining the kinds of controlled food and food additives;

(f) determining detailed criteria and standards for food, differing from standards;

(g) co-ordinating with the relevant Ministries with respect to import and export of food for the safety of consumers;

(h) determining primary laboratories and appellate laboratories;

(i) forming committees in respect of matters relating to expertise and determining the functions and duties of such committees;

(j) supplementing functions and duties of the State/Divisional, District, Township Food and Drug Supervisory Committees formed under section 5 sub-section (1) of the National Drugs Law to enable supervision of matters relating to food.

7. A Government department or organization that produces food shall co-ordinate with the Board of Authority prior to the production.

8. The Board of Authority may delegate any department or organization to carry out its functions and duties.

Chapter V

Application for Licence

9. A person desirous of producing controlled food shall apply for a licence to the Government department or organization which is authorized to issue the licence, only after obtaining recommendation from the Department of Health.

10. The Department of Health may in respect of the producing of controlled food scrutinize as to whether or not it is in conformity with the stipulations, and may issue or refuse to issue the recommeadation.

11. A person desirous of producing food other than controlled food shall apply for the licence to the relevant Government department or organization which is authorized to issue the same, in accordance with the existing laws.

12. The relevant Government department or organization which is authorized to issue the licence shall determine the conditions of the licence, tenure, licence fees and licence extension fees.

Chapter VI

Temporary Revocation Subject to a Time Limit and

Cancellation of Licence

13. The Township Food and Drug Supervisory Committee may pass a temporary or permanent prohibitory punishment on the person who commits any of the following acts:-

(a) production, storage or sale of food under unhygienic conditions;

(b) causing a person who has contracted food-borne infection or who is a carrier of the germs of the said infection to enter or work on the premises for production, storage or sale of food.

14. If a person who has obtained a licence violates or is considered to have violated any order, directive, condition or any condition of the licence issued by the relevant Government department or organization, the Government department or organization which is authorized to issue the licence may revoke the licence temporarily subject to a time limit or cancel it,

15. The Board of Authority may direct the relevant State/Divisional, District and Township Food and Drug Supervisory Committees to seize the food produced and distributed by a person whose licence has been cancelled due to infringement of any condition relating to quality assurance.

Chapter VII

Appeal

16. A person dissatisfied with a decision made by the authorized Government department or organization in respect of the refusal to grant licence, temporary revocation subject to a time limit or cancellation of licence, may file an appeal to the relevant Minister or the Chairman of the Yangon City Development Committee within 60 days from the date of such decision.

17. The decision of the relevant Minister or Chairman of the Yangon City Development Committee shall be final and conclusive.

Chapter VIII

Quality Assurance, Labelling and Advertisement

18. A person who produces, imports, exports, stores, distributes or sells food shal1 strictly abide by the order, directive and conditions issued by the relevant Government department or organization or Board of Authority in respect of quality assurance of food, labelling and advertisement.

Chapter IX

Assigning of Responsibility as Inspectors

19. The Ministry of Health:-

(a) shall assign responsibility as Food Inspectors to the staff subordinate to it in order to carry out inspection of food and inspection as to whether or not there is observance of good production practices;

(b) shall assign responsibility as Food Inspectors to suitable staff in coordination with the relevant Development Committee, in Yangon City Development Areas and Mandalay City Development Areas and in coordination with the relevant Ministry in other areas;

(c) shall determine the duties and powers of the Food Inspector.

20. (a) The Food Inspector shall submit his findings on inspection to therelevant Township Food and Drug Supervisory Committee.

(b) The Township Food and Drug Supervisory Committee after scrutinizing the report of the Food Inspector:-

(1) shall, if infringement of the provision of sub-section (a) or (b) of section 13 is found, pass any relevant administrative punishment;

(2) shall, if infringement of the prohibition contained in section 22, section 23, section 24' or section 25 is found, take action under this Law;

(3) shall, it cause to take administrative action arises, submit to the relevant Government department or organization which is authorized to issue licence.

Chapter X

Prohibition

21. No one shall fail to abide by any order passed under section 13.

22. No one shall produce import, export, store, distribute or sell the following food:-

(a) food that may be poisonous, dangerous or injurious to the health of the consumer;

(b) food wholly or partly substituted or adulterated so as to affect or endanger the nature, substance or quality of the food;

(c) food in which food additive is used in excess of the prescribed limit;

(d) food containing agricultural chemicals in excess of the maximum permissible level determined by the authority concerned;

(e) food containing substance prohibited or not allowed by the authority concerned;

(f) food containing putrid, deteriorated substance or substance unfit for human consumption;

(g) food differing from standards;

(h) food, on the label of which property not included in it is wrongly stated;

(i) food, which does not include the information to be stated, as determined by the relevant Government department or organization which is authorized to issue the licence.

23. No one shall produce controlled food without a licence.

24. No one shall without a licence export, store, distribute or sell controlledfood produced.

25. No one who produces, imports, exports, stores, distributes or sells foodshall fail to abide by the order, directive and conditions issued by the relevant Government department or organization or the Board of Authority in respect of the following

(a) quality assurance;

(b) labelling;

(c) advertisement.

Chapter XI

Offences and Penalties

26. Whoever violates the provision of section 21 shall, on conviction, bepunished with imprisonment for a term which may extend to 1 year or with fine which may extend to kyats 10000) or with both.

27. Whoever after conviction for failing to abide by any provision ofsection 21, fails continuously to abide by the same, shall be punished with a further fine of kyats 500 for each day during which the failure continues.

28. Whoever violates any provision of section 22 shall, on conviction:-

(a) if it is an offence relating to food contained in sub-section (a), sub-section (b), sub-section (c), sub-section (d), sub-section (e) or sub-section (f), be punished with imprisonment for a term which may extend to 3 years or with fine which may extend to kyats 30000 or with both;

(b) if it is an offence relating to food contained in sub-section (g), sub-section (h), or sub-section (i), be punished with imprisonment for a term which may extend to 1 year or with fine which may extend to kyats10,000 or with both;

(c) the exhibits involved in the offence shall also be liable to be confiscated.

29. Whoever violates the provision of section 23 shall, on conviction, bepunished with imprisonment for a term which may extend to 5 years or with fine which may extend from a minimum of kyats 5,000 to a maximum of kyats 50,000 or with both. In addition, the exhibits involved in the offence shall also be liable to be confiscated.

30. Whoever violates the provision of section 24 shall, on conviction, bepunished with imprisonment for a term which may extend to 3 years or with fine which may extend from a minimum of kyats 1,000 to a maximum of kyats 30,000 or with both. In addition, the exhibits involved in the offence shall also be liable to be confiscated.

1. Any person who produces, imports, exports, stores, distributes or sells food and who violâtes the provision of section 25, shall on conviction, be punished with imprisonment for a term which may extend to 3 years or with fine which may extend from a minimum of kyats 1000 to a maximum of kyats 30,000 or with both.

Chapter XII

Miscellaneous

32.a. In areas other than the Yangon City Development Area and Mandalay City Development Area the Township Food and Drug Supervisory Committee may carry out inspection of food.

In Yangon City Development Area and Mandalay City Development Area, the Township Food and Drug Supervisory Committee shall carry out the inspection of food, in co-ordination with the relevant Health Department of the Yangon City Development Committee or the Mandalay City Development Committee.

33. The provisions of this Law shall not apply to food brought into or taken out of the country together with a person for personal consumption.

34. In instituting legal proceedings under this Law, prior sanction of the Ministry of Health or the organization or person delegated with powers for this purpose shall be obtained.

35. The Government department or organization which is authorized to grant permission to import or export food for commercial purpose shall only grant permission to the person who can submit a certificate of recommendation of the Department of Health.

36. The orders, directives and conditions issued by the Government department or organization which is authorized to issue licence shall be deemed to be the orders, directives and conditions issued under this Law. The orders relating to the inspection of food issued under the National Drug Law and the orders relating to the standardization of food issued under any existing law may continue to be applicable in so far as they are not inconsistent with this La The State Law and Order Restoration Council

Component V

Component V compriseas of: Eye Donation Law (1996)
Blood and Blood Products Law (2003)
Body Organ Donation Law (2004)

The Eye Donation Law (1996) enacted to give extensive treatment to persons suffering from eye diseases who may regain sight by corneal transplantation. Describes establishment of National Eye Bank Committee and its functions and duties, and measures to be taken in the process of donation and transplantation.

Blood and Blood Products Law (2003) Enacted to ensure availability of safe blood and blood products by the public. Describes measures to be taken in the process of collection and administration of blood and blood products and designation and authorization of personnel to oversee and undertake these procedures.

Body Organ Donation Law (2004) enacted to enable saving the life of the person who is required to undergo body organ transplant by application of body organ transplant extensively, to

cause rehabilitation of disabled persons due to dysfunction of body organ through body organ donors, to enable to carry out research and educational measures relating to body organ transplant and to enable to increase the numbers of body organ donors and to cooperate and obtain assistance from government departments and organizations, international organizations, local and international NGOs and individuals in body organ transplant.

The State Law and Order Restoration Council

The Eye Donation Law

(The State Law and Order Restoration Council Law No.2/96)
The 2nd Waxing Day of Tabaung, 1357 M.E.
(19th February, 1996)
The State Law and Order Restoration Council hereby enacts the following Law:

Chapter I

Title and Definition

1. This Law shall be called the Eye Donation Law.

2. The following expressions contained in this Law shall have the meanings given hereunder:-

(a) Eye means a spherical visual sense organ of the human body bounded anteriorly by the cornea and posteriorly by the sclera;

(b) Eye Bank means an organization formed under this Law to procure, store and distribute the eye for medical treatment, scientific research or other therapeutic purposes;

(c) Eye Donor means a person who has given prior consent to donate his eyes after death;

(d) Person authorized to procure the eye means a person determined under this Law to remove the eyes for the Eye Bank;

(e) Removal of the eye means removing the eyes of a deceased person by an authorized person in accordance with this Law.

Chapter II

Objectives

3. The objectives of this Law are as follows:-

(a) to give extensive treatment to persons suffering from eye diseases, who may regain their sight by corneal transplantation;

(b) to remove systematically the eyes of the donor;

(c) to carry out effective treatment of eye diseases through systematic storage and distribution of the donated eyes from the Eye Bank;

(d) to carry out successfully the functions of the Eye Bank with the assistance and cooperation of the Government Departments. Government Organizations, International Organizations, local and foreign Non-governmental Organizations, local and foreign Companies and local and foreign individuals.

Chapter III

Establishment of the National Eye Bank Committee

4. The Government shall:-

(a) from the National Eye Bank Committee consisting of the following persons:-

(1) Minister

Ministry of Health — Chairman

(2) Representatives from the relevant Government Departments and Government Organizations — Members

(3) Representatives from the relevant Non-governmental Organizations — Members

(4) Appropriate experts and professional personnel — Members

(5) A person assigned responsibility by the Chairman — Secretary

(b) If necessary, a Vice-Chairman and a Joint Secretary may be determined.

5. Members of the National Eye Bank Committee who are not Government servants are entitled to receive remunerations prescribed by the Ministry of Health.

Chapter IV

Functions and Duties of the National Eye Bank Committee

6. The functions and duties of the National Eye Bank Committee are as follow

(a) laying down the policy for carrying out successfully the Eye Bank functions in accordance with the objectives of this Law;

(b) giving guidance for carrying out incitement and educative measures in order to enhance the number of eye donors;

(c) giving guidance for proper procurement, quality control, storage and distribution of the eye tissue;

(d) stipulating conditions for exporting eye tissue to other countries and importing eye tissue from other countries;

(e) carrying out measures to nurture expert personnel and technicians for the Eye Bank;

(f) giving guidance for conducting works of research relating to the functions of the Eye Bank;

(g) supervising the functions of the Eye Bank;

(h) obtaining assistance from the Government Departments, Government Organizations, International Organizations, local and foreign Nongovernmental Organizations, local and foreign Companies and local and foreign individuals and accepting donations, grants supply and equipment and allocating and making use of them appropriately.

7. The National Eye Bank Committee may direct the Department of Health to establish Eye Banks in areas needing the same.

8. The National Eye Bank Committee may form technical working Committees as may be necessary and determine the duties and functions thereof.

Chapter V

Eye Donation

9. A person who has attained the age of 18 or a person under 18 who has received the consent of his guardian may donate the eyes.

10. The Eye Bank may accept eye donations in accordance with the

11. The Eye Bank, on accepting the eye donation shall:-

(a) register the donor's name and particulars in the eye donor's register;

(b) issue eye donor card to the donor.

12. If the eye donor dies in a hospital or dispensary, the responsible officer in-charge thereof shall inform the Eye Bank immediately about the death.

13. If the eye donor dies in a place other than a hospital or dispensary, the relative shall inform the Eye Bank immediate1y about the death.

14. (a) The eye donor may inform the Eye Bank to cancel eye donation and surrender the eye donor card;

(b) If the Eye Bank is informed under sub-section (a), it shall remove the name of the donor from the eye donor's register.

Chapter VI

Removal of the Eye

15. The following persons are authorized to remove the eye:-

(a) ophthalmologist;

(b) resident ophthalmologist;

(c) doctor, nurse or technician who is assigned responsibility by the Eye Hospital to remove the eyes;

(d) a person who has completed the training course relating to removal of the eye, recognised by the Department of Health;

(e) police surgeon.

16. A person authorized to remove the eye has the right to remove the eyes of any of the following decedents:-.

(a) eye donor;

(b) person who has donated his body;

(c) unclaimed body;

(d) a person whose relative has given consent to the removal of the eyes;

(e) a deceased victim of a crime, the removal of whose cornea has been permitted by the Police Surgeon and which has also not been objected to by the closest relative.

17. When the Eye Bank is informed about the donor's death under section 12 or section 13, it shall arrange for the removal of the eye within the prescribedtime.

Chapter VII

Storage and Distribution of the Eye

18. The Eye Bank shall store the locally removed eyes and those imported in accordance with the prescribed procedures.

19. The Eye Bank shall distribute the stored eyes in accordance with the prescribed procedures.

Chapter VIII

Miscellaneous

20. No suit or prosecution shall lie against any person who is authorized to remove the eye, for anything which is done in good faith under this Law.

21. For the purpose of carrying out the provisions of this Law:-

(a) the Ministry of Health may issue such procedures as may be necessary, with the approval of the Government;

(b) the Ministry of Health the National Eye Bank Committee or the Department of Health may issue such orders and directives as may be necessary.

Sd./ Than Shwe
Senior General
Chairman
The State Law and Order Restoration Council

The State Peace and Development Council

The Blood and Blood Products Law

(The State Peace and Development Council Law No. 1/2003)

The 12th Waning day of Pyatho, 1364 M.E

(29th January 2003)

The State Peace and Development Council hereby enacts the following Law:-

Chapter I

Title and Definition

1. This Law shall be called the Blood and Blood Products Law.

2. The following expressions contained in this Law shall have the meanings given hereunder:-

(a) Blood means naturally occurring fluid in the human body consisting of red blood cells, white blood cells, platelets, plasma and biochemical substances contained in the plasma.

(b) Blood product means element of blood such as red blood cells, white blood cells, platelets, plasma and biochemical substances contained in the plasma which is obtained in any manner as a result of processing.

(c) Blood transfusion instruments mean needle, syringe, tube, bottle, bag and other materials used in extracting, injecting or collecting blood and blood products.

(d) Sharp instruments mean needle, knife, and any instrument which can cause bleeding in surgical operation oron contact with any part of the human body.

(e) Committee means of the National Blood and Blood Products Committee formed under

section 4.

(f) National Blood Centre means the main centre established by the Ministry of Health for enabling the discharge of functions contained in section 7.

(g) Blood Bank means the establishment for enabling the discharge of functions contained in section 8.

(h) Small-Scale Blood Bank means the establishment for enabling the discharge of functions contained in section 9.

(i) Blood transfusion service means the functions assigned to be performed by the National Blood Centre, Blood Bank and Small-Scale Blood Bank.

(j) Disposing of waste means administering by any means to eliminate blood and blood products unsuitable for use, and used blood transfusion instruments and sharp instruments.

(k) Licence means the permit issued under section 11 to establish and operate private Small-Scale Blood Bank.

Chapter II

Aims

3. The aims of this Law are as follows:-

(a) to enable saving and looking after patients' life by transfusion utilizing quality-assured blood;

(b) to prevent transfusion transmissible infection through blood and other dangers, and to enable assuring both mental and physical safety;

(c) to enable systematic supervision of extracting, collecting, storing, issuing, distributing, transfusing and disposal of waste of blood and blood products;

(d) to carry out implementation of blood donor system on voluntary basis;

(e) to contribute towards health care of patients not taking into consideration of profit in performing blood transfusion service; (f) to enable promotion, dissemination and research in respect of blood and blood products and to nurture experts thereof.

CHAPTER III

Formation or National Blood and Blood Products

Committee and Duties and Functions There of

4. The Government

(a) shall form the National Blood and Blood Products Committee comprising not more than 2.1 members with the Minister for Ministry of Health as the Chairman Director-General of the Department of Health as the Secretary, heads of the relevant ministries, government departments and organizations and representatives of the non-governmental organizations as members;

(b) may, in forming under subsection (a), determine suitable persons from among the members as the Vice Chairman and the Joint Secretary ;

(c) may re-constitute, if necessary, the National Blood and Blood Products Committee formed under sub-section (a).

5. The functions and duties of the Committee are as follows;

(a) laying down policy to perform blood transfusion service successfully in accordance with the aims of this Law;

(b) giving guidance to carry out measures as may be necessary for the prevention of blood transfusion transmissible infections; (c) issuing licence to establish Small-Scale Blood Bank, refusing to issue licence thereof , suspending the licence subject to a time limit and canceling thereof;

(d) stipulating conditions in respect of extracting, collecting, storing, importing , exporting, issuing, distributing and disposal of waste of blood and blood products;

(e) stipulating the conditions that are to be abided by in performing blood transfusion services systematic, and supervising thereof;

(f) giving guidance to carry out exhorting and organizing work for increasing the number of voluntary blood donors;

(g) giving guidance to stipulate the requirements of voluntary blood donors;

(h) giving guidance for sufficiency of required skilled persons and facilities for blood transfusion service;

(i) giving guidance to determine conditions that are to be abided by in utilizing blood and blood products, in utilizing blood transfusion instruments and sharp instruments, and in carrying out other tasks that may possibly cause transmissible infectious through blood;

(j) giving guidance on holding seminars and meetings. and conduction of training courses for the promotion and development of knowledge on blood transfusion service. and prevention of transmissible infections through blood;

(k) giving guidance to conduct research in respect of transmissible infections through blood and blood products;

(l) issuing permit to the government departments and organizations and Red Cross Society desirous of establishing Blood Bank or Small-Scale Blood Bank;

(m) communicating and cooperating with the government departments and organizations, international organizations, and local and international non-governmental organizations for, effective and successful implementation 'of blood transfusion service;

(n) forming of required State Divisional District and Township Blood Bank Committees to supervise the Blood Bank and Small-Scale...Blood Banks .and stipulating functions and duties thereof;

(o) submitting recommendation to the Ministry of Health to proceed with the conferring of honour by the State to voluntary blood donors who conform to the stipulations including the number of times of blood donation.

(p) forming required Sub-Committees and stipulating functions and duties thereof to carry Ot1t the functions and duties of the , Committee effectively.

6. The Committee may delegate its functions and duties to any organization or department.

CHAPTER IV

Functions of the National Blood Centre

7. The functions or the National Blood Centre are as follows :

(a) carrying out the functions of extracting t calming, storing, distributing and disposing of waste of blood and blood products that conform to the standard and are free from micro-organism causing acquired immune deficiency syndrome {AIDS), viral hepatitis, venereal disease, malaria and other transmissible infections through blood :

(b) prescribing norms and standards on matters of skill and technology in respect of blood .transfusion service ;

(c) carrying out exhorting and organizing work to increase the number of blood donors and to obtain safe blood ;

(d) safeguarding the reputation and interests of the voluntary blood donors;

(e) making necessary arrangements for re-vitalization of voluntary blood donor during the process of blood donation ;

(f) awarding blood donor badges and certificates of honour to the voluntary blood donors ;

(g) submitting to, the Committee for enabling conferring of honour by the State to the voluntary blood donors who conform to the stipulations including the number of trines of blood donation ;

(h) disseminating and promoting knowledge in respect of blood and blood products ;

(i) conducting training courses, holding meetings, conducting research and nurturing experts in respect of blood and blood products ;

(i) manufacturing and di5tributing required reagent to enable grouping and screening of blood and blood products ;

(k) performing functions and duties assigned by the Committee from time to time.

CHAPTER V

Functions of the Blood Bank and Small-Scale Blood Bank

8. The functions of the Blood Bank are as follows :

(a) Carrying out the functions of the extracting collecting, storing, issuing, distributing and disposal of waste of blood and blood products in conformity with the conditions as stipulated ;

(b) Carrying out exhorting and organizing work to increase the number of blood donors and to obtain safe blood;

(c) Carrying out the functions of collecting & storing, issuing, distributing and disposal of waste of blood that conform to the standard, and are free from micro-organism causing AIDS, viral hepatitis venereal disease, malaria and other transmissible infections through blood ;

(d) Safeguarding the reputation and interests of the voluntary blood donors

(e) Making necessary arrangements for re-vitalization of voluntary blood donor during the process of blood donation ;

(I) Awarding blood donor badges and certificates of honour to voluntary blood donor ;

(g) Submitting to the Committee for enabling conferring of the relevant award of honour to the voluntary blood donors who conform to the. stipulations including the number of times of blood, donation;

9. The Small-Scale Blood Bank shall comply with the conditions stipulated in carrying out the works of storing, issuing and disposal of waste of blood and blood products received .from National "Blood Centre arid Blood Banks, or of blood products imported legally for treatment of the patient.

Chapter VI

Application and Issuance of Licence

10. A person desirous of establishing a private Small-Scale Blood Bank shall apply to the organization or department assigned duty by the Coma licence, in conformity with the stipulations.

11. The organization or department assigned duty by the Committee under section 10 may, after scrutiny of the application, issue or refuse to issue the licence.

12. The organization or department assigned duty by the Committee may, after scrutiny of the application for renewal of licence in conformity with the stipulations renew the licence.

13. The Ministry of Health shall determine the tenure of licence, licence fees and licence renewal fees.

Chapter VII

Administrative Action

14. If the licence holder violates any of the conditions contained in the licence or fails to abide by any notification, order and directive issued under this Law, the organization or department assigned duty by the Committee may pass any of the following administrative orders:-

(a) warning;

(b) suspending the licence subject to a time limit;

(c) cancellation of licence.

Chapter VIII

Appeal

15. A person dissatisfied with the order or decision passed on him in respect of refusal to issue licence, or suspending the licence subject to a time]i1nit, or cancellation of licence by the organization or department assigned duty by the Committee. may file an appeal to the Committee within 60 days from the date on which such order or decision had been passed.

16. The Committee may, in respect of the appeal under section 15, confirm. revise or cancel the order or decision passed by the organization or department assigned duty by the Committee.

17. The decision passed by the Committee under section 16 shall be final and conclusive.

Chapter IX

Offences and Penalties

18. Whoever, without permission , extracts. collects, stores, issues or distributes blood or blood products shall. on conviction, be punished with imprisonment for a term which may extend to seven years. and may also be liable to a fine.

19. Whoever without licence, establishes a private Sma1I-Scale Blood Bank shall, on conviction , be punished with imprisonment for a term which may extend to five years, and may also be liable to a fine.

20. Whoever. without consent of the person extracts blood from the said person shall on conviction, be punished with imprisonment for a term which may extend to five years, and may also be liable to a fine.

21. Whoever. without consent of the person or in the case of a person incapable of giving consent of the person who is capable of giving consent on his behalf transfuses blood or

blood product shall, on conviction, be punished with imprisonment for a term which may extend to five years, and may also be liable to a fine.

22. Whoever commits any of the following acts shall on conviction, be punished with imprisonment for a term which may extend to three years, or with fine or with both:-

(a) transfusing into any person blood or blood products not obtained from the National BIood Centre, Blood Bank or Small-Scale Blood Bank, or of blood or blood products not imported legally.

(b) transfusing into any person blood or blood products without grouping and matching the blood and blood products of patient and of donor.

(c) transfusing of blood or blood products past the expiry date into any person:

(d) extracting from or transfusuig into any person blood or blood products by using blood transfusion instrument past the expiry date or which is not free from micro-organism or which has been utilized once;

(e) using sharp instrument not in conformity with the stipulations.

23. Whoever sells or buys blood with money or other consideration for business purpose shall, on conviction, be punished with imprisonment for a tern which may extend to three years, or with fine, or with both.

24. Whoever violates any prohibition or fails to abide by any duty contained in the notification, order and directive issued under this Law in order to prevent the transmissible infection through blood shall, on conviction be punished with imprisonment for a term which may extend to six months, or with fine, Or with both.

25. Whoever abets in the commission of any offence contained in this Law shall be liable to the penalty provided for such offence under this Law.

Chapter X

Miscellaneous

26. Prior sanction of the Ministry of Health shall be obtained in prosecuting under this Law .

27. No suit or prosecution shall lie against any medical practitioner or any person who performed under the instruction of the medical practitioner, or any person who is skilled, experienced and competent in transfusing blood and blood products for transfusing blood or blood products in good faith, to save the life of the patient in an emergency case.

28. The Central National Blood Bank and the Blood Banks established by the Ministry of Health prior to the enactment of this Law shall be deemed to be the National Blood Centre and Blood Bank and Small-Scale Blood Bank respectively according to the nature of blood transfusion service, and shall carry on the blood transfusion service as stipulated.

29. The government department or organization and Red Cross Society desirous of establishing the Blood Bank or Small-Scale Blood Bank shall seek the permission of the Committee.

30. On a dispute arising as to whether or not a substance is blood or blood products, the decision shall be made by the Committee. The decision of the Committee shall be final and conclusive.

31. The Ministry of Health-

(a) shall bear the expenditure of the Committee;

(b) shall make arrangements for enabling the discharge of the office work of the Committee;

(c) may grant suitable remuneration to non-goven1Jnental members of the Committee.

32. The notifications orders and directives issued by the Ministry of Health and Department of Health in respect of blood donation, extracting, collecting, storing, issuing, distributing, transfusing and disposal of waste of blood and blood products or utilization of sharp instruments prior to the enactment of this Law may continue to be applicable in so far as they are not inconsistent with this Law.

33. In implementing of the provisions of this Law:-

(a) the Ministry of Health may. with the approval of the Government, issue such rules and procedures as may be necessary ;

(b) the Committee, the Ministry of Health and the Department of Health may issue such notifications, orders and directives as may be necessary.

(Sd.) Than Shwe
Senior General
Chairman
The State Peace and Development Council

The State Peace and Development Council

The Body Organ Donation Law

(The State Peace and Development Council Law No. 1/2004)

The 14th Waning Day of Tabodwe 1365 ME

(19th February, 2004)

The State Peace and Development Council here by enact the following Law:-

Chapter I

Title and Definition

1. This Law shall be called the Body Organ Donation Law.

2. The following expressions contained in this Law shall have the meanings given hereunder:-

(a) Body Organ means any part of the body composed in the human body. This expression also includes the whole of the human body;

(b) Death means the condition of termination of all brain functions of a person;

(c) Body Organ Donor means a person who has authorized to remove any body organ, if there is no danger to life by removal of such organ, or a person who has given prior consent to remove his body organ after death;

(d) Person who is Authorized to Procure the Body Organ means a person prescribed by the Ministry of Health under this Law as the person authorized to remove body organ;

(e) Removal of the Body Organ means removing the body organ by the person authorized in accordance with the stipulations;

(f) Receiving Unit means the unit which receives donation of the body organ;

(g) Committee means the committee relating to Donation of Body Organ, formed under section 4 of this Law.

Chapter II

Aims

3. The aims of this Law are as follows:-

(a) to enable saving the life of the person who is required to undergo body organ transplant by application of body organ transplant extensively;

(b) to cause rehabilitation of disabled persons due to disfunctioning of body organ through body organ transplant;

(c) to enable carrying out research and educational measures related to body organ transplant;

(d) to enable increasing the number of body organ donors;

(e) to cooperate and to obtain assistance from government departments and organizations, international organizations, local and international non-governmental organizations, companies and individuals in body organ transplant.

Chapter III

Formation of the Committee relating to Donation of Body Organ

4. The Government:-

(a) shall form the Committee relating to Donation of Body Organ consisting of the following persons:-

(1)	Minister The Ministry of Health	Chairman
(2)	Representatives from the relevant Government departments and organizations	Members
(3)	Appropriate experts and professional personnel	Members
(4)	A person assigned responsibility by the Minister of the Ministry of Health	Secretary

(b) may if necessary, determine a Vice-Chairman and a Joint Secretary in the Committee.

5. A member of the Committee relating to Donation of Body Organ who is not a Government servant is entitled to receive remuneration prescribed by the Ministry of Health.

Chapter IV

Functions and Duties of the Committee relating to Donation of Body Organ

6. The functions and duties of the Committee are as follows:-

(a) laying down the policy for carrying out successfully the work of donation of body organ in accordance with the aims of this Law;

(b) giving guidance for carrying out educative measures in order to enhance the number of body organ donors;

(c) giving guidance to be systematic in respect of quality control, procurement, storage and

issuance of body organs;

(d) in carrying out body organ transplant giving guidance for conducting research and educational measures relating to the said task;

(e) carrying out measures to nurture expert and research personnel and technicians for body organ transplant;

(f) giving guidance and supervising the functions relating to donation of body organ;

(g) stipulating terms and conditions for exporting body organs to other countries and importing body organs from other countries;

(h) obtaining assistance from the government departments and organizations, international organizations, local and international non-governmental organizations, local and foreign companies, individuals and accepting donations and equipment, maintaining systematically, allocating and permitting use of them.

7. The Committee may direct the relevant Department to determine the receiving units in areas needing the same.

8. The Committee may form technical working committee as may be necessary, and determine duties and functions thereof.

Chapter V

Donation of Body Organ

9. A person who has attained the age of 18 may donate his own body organ.

10. The surviving wife, husband, son or daughter, parent, brother, sister or one of the relatives may donate the deceased's body organ if there is no objection in the family.

11. The receiving unit may accept donation of the body organ in accordance with the stipulations.

12. The receiving unit on accepting the donation of the body organ shall:-

(a) register the donor's name and particulars in the body organ donors' register;

(b) issue body organ donor card to the donor or the surviving wife, husband, son or daughter, parent, brother, sister or one of the relatives who donated the body organ.

13. On knowing that the deceased is the donor of the body organ, the responsible person of the hospital or clinic where the donor died, or a responsible person from home shall inform the nearest receiving unit immediately.

14. (a) The body organ donor may, by surrendering the body organ donor card inform the receiving unit to cancel the donation of the body organ

(b) If the receiving unit is informed under subsection (a), it shall cancel the name of the donor from the body organ donors' register.

Chapter VI

Removal of the Body Organ

15. Only the expert or technician who is prescribed by the Ministry of Health is authorized to remove the body organ.

16. A person who is authorized to remove the body organ has the right to remove the body organ of any of the following persons:-

(a) person who donated his body organ;

(b) unclaimed body of the deceased;

(c) the deceased person whose body organ has been donated by the surviving wife, husband, son or daughter, parent, brother, sister or one of the relatives under section 10.

17. The police surgeon shall, if requested by the person who is authorized to remove the body organ, permit the removal of the body organ of the deceased person involved in any crime. However, it shall not permit on the occurrence of any of the following:-

(a) being a person who prior to his death has written a letter of having no desire to donate the body organ;

(b) in completeness of the post-mortem examination by the relevant police surgeon of the body organ to be removed;

(c) objection by the surviving wife, husband, son or daughter, parent, brother, sister or one of the relatives.

18. On being informed under section 13, the receiving unit shall arrange to remove or take away the body organ within the prescribed time.

Chapter VII

Storage and Distribution of the Body Organ

19. The receiving unit shall store the body organ which is removed in accordance with the stipulations.

20. The receiving unit shall carry out the following in accordance with the stipulations:-

(a) distribution of the body organ that has been received for transplant;

(b) distribution of the body organ which is of no use in transplant for educational purpose or research.

Chapter VIII

Offences and Penalties

21. Whoever sells or buys the body organ for consideration shall, on conviction, be punished with imprisonment for a term which may extend to three years, and may also be liable to a fine.

22. Whoever abets the commission of the offence provided in section 21 shall, on conviction, be punished with imprisonment for a term which may extend to three years, and may also be liable to a fine.

Chapter IX

Miscellaneous

23. With respect to donation of the eye, which is part of the body organ, it shall be carried out in accordance with the provisions contained in the Eye Donation Law.

24. The Ministry of Health may form necessary working committees.

25. The Ministry of Health:-

(a) shall bear the expenditures of the Committee;

(b) shall undertake to carry out the office work of the Committee.

26. No suit or prosecution shall lie against the person who is authorized to remove the body organ for any activity which is done in good faith under this Law.

27. The provisions contained in section 21 shall not apply to the matters carried out in accordance with the terms and conditions prescribed by the Committee.

28. For the purpose of carrying out the provisions of this Law:-

(a) the Ministry of Health may issue such rules and procedures as may be necessary, with the approval of the Government;

(b) the Committee and the Ministry of Health may issue such notifications, orders and directives as may be necessary.

(Sd.) Than Shwe
Senior General
Chairman
The State Peace and Development Council

Health Workforce

Legislations and its relevant principles may be grouped it into two components:

Component I Myanmar Medical Council Law (2000)
Dental and Oral Medicine Council Law (1989) (Revised in 2011)
Traditional Medicine Council Law (2000)
Law relating to the Nurse and Midwife (1990)(Revised in 2002)

Component II Principles of Medical Ethics
Ethical Misconduct
Myanmar Medical Council Guidelines for General Medical Doctor

Component I

Myanmar Medical Council Law (2000)-Enacted to enable public to enjoy qualified and effective health care assistance, to maintain and upgrade the qualification and standard of the health care assistance of medical practitioner, to enable studying and learning of the medical science of a high standard abreast of the times, to enable a continuous study of the development of the medical practitioners, to maintain and promote the dignity of the practitioners, to supervise the abiding and observing in conformity with the moral conduct and ethics of the medical practitioners. The law describes the formation, duties and powers of the Myanmar Medical Council and the rights of the members and that of executive committee, registration certificate of medical practitioners, medical practitioner license, duties and rights of registered medical practitioners and the medical practitioner license holders.

Dental and Oral Medicine, Council Law (1989) (Revised in 2011) - Provides basis for licensing and regulation in relation to practices of dental and oral medicine. Describes structure, duties and powers of oral medical council in dealing with regulatory measures.

Traditional Medicine Council Law (2000) - Enacted to protect public health by applying any type of traditional medicine by the traditional medical practitioners collectively, to supervise traditional medical practitioners for causing abidance by their rules of conduct and discipline, to carry out modernization of traditional medicine in conformity with scientific method, to cooperate with the relevant government departments, organizations and international organization of traditional medicine. The law describes formation, duties and powers of the traditional medical council, registration as the traditional medical practitioners and duties and registration of the traditional medical practitioners.

Law relating to the Nurse and Midwife (1990) (Revised in 2002) -
Provides basis for registration, licensing and regulation of nursing and midwifery practices and describes organization, duties and powers of the nurse and midwife council.

Myanmar Medical Council Law

The State Peace and Development Council enacts the *Myanmar Medical Council Law* **on 14 January 2000 as follows**: (II/1)

Chapter 1

Title and Definition

1. This Law shall be called the Myanmar Medical Council Law.

2. The following expressions contained in this Law shall have the meanings given hereunder:

(a) Medical Science means branch of studies related to all health care activities including upgrading of health status, prevention of disease, diagnosis of disease, treatment of disease, rehabilitation and research;

(b) Council means the Myanmar Medical Council formed under this Law;

(c) Council Member means any member of the Myanmar Medical Council;

(d) Registration Certificate means registered medical practitioner certificate granted under this Law by the Myanmar Medical Council;

(e) Registered Medical Practitioner means a person whose name has been entered in the medical practitioners' registration list and has been granted medical practitioner registration certificate;

(f) Medical Practitioner Licence means a General Medical Practitioner Licence, Special Medical Practitioner Licence and Limited Medical Practitioner Licence granted under this Law by the Myanmar Medical Council;

(g) General Medical Practitioner Licence means a medical practitioner licence granted by the Myanmar Medical Council to the registered medical practitioner who has obtained a recognized basic medical science degree and has completed the prescribed interne period;

(h) Special Medical Practitioner Licence means a medical practitioner licence granted by the Myanmar Medical Council to a qualified registered medical practitioner who has obtained a recognized post- graduate degree or postgraduate diploma and a registered medical

practitioner who is determined as being qualified and having expertise in the relevant branch of medical science;

(i) Limited Medical Practitioner Licence means a medical practitioner licence granted by the Myanmar Medical Council to a foreigner medical practitioner limiting the branch of medical science in which practice is allowed, the locality in which and the period during which practice is allowed.

Chapter II

Objectives

3. The objectives of this Law are as follows:-

(a) to enable the public to enjoy qualified and effective health care assistance;

(b) to maintain and upgrade the qualification and standard of the health care assistance of medical practitioner;

(c) to enable studying and learning of the medical science of a high standard abreast of the times;

(d) to enable a continuous study of the development of the medical science by the medical practitioners;

(e) to maintain and promote the dignity of the medical practitioners;

(f) to supervise the abiding and observing in conformity with the moral conduct and ethics of the medical practitioners;

Chapter III

Formation of the Myanmar Medical Council

4. The Minister for the Ministry of Health shall:-

(i) with the approval of the government form the Myanmar Medical Council comprising the following persons:-

(a) the respective Directors-General under the Ministry of Health:

(b) Director of Medical Service, Ministry of Defence;

(c) Rectors of the Institutes of Medicine;

(d) Rector of Tatmadaw Institute of Medicine;

(e) Chairman of the Myanmar Medical Association;

(f) Heads of States and Divisions of the Department of Health;

(g) Professors/Heads of Faculty of Forensic Medicine, Institutes of Medicine;

(h) one Professor-cum -head of Faculty of Forensic Medicine, Tatmadaw Institute of Medicine;

(i) one senior Professor-cum -medical practitioner from each Institute of Medicine;

(j) one senior Professor-cum-medical practitioner from the Tamadaw Institute of Medicine;

(k) three representatives from the Myanmar Academy of Medical Science;

(l) three retired medical practitioners;

(m) one non-government servant medical practitioner elected by medical practitioners holding licence from respective States and Divisions.

(ii) in forming the Council under sub-section(a), a Chairman, a Secretary and a Joint Secretary shall be determined.

5. The Council may assign duty as a Treasurer to any Council member. If no such assignment has been made, the Secretary of the Council shall act as Treasurer.

6. The Minister for the Ministry of Health shall form the Executive Committee comprising the following persons to carry out the duties and functions of the Council:-

(a) Chairman of the Council - Chairman

(b) Two Council Members - Vice-Chairmen

(c) Ten Council Members - Members

(d) Secretary of the Council - Secretary

(e) Joint-Secretary of the Council Joint-Secretary

7. (a) The tenure of the Council for one term shall be four years commencing from the date of its formation.

(b) The term of office of the Council members shall be the same as the tenure of the Council.

(c) A Council member may act as such only for three consecutive terms.

(d) When a vacancy occurs in the post of any Council member it shall be filled by substitution or election as contained in sub-section(a) of section 4.The term of office the Council member so appointed shall be till the expiry of the tenure of the existing Council.

(e) The Council shall, on the expiry of its terms of office, carry out the function till the formation of a new Council.

8. The formation of the Council, the formation of the Executive Council, holding of meetings and financial matters shall be carried out in accordance with the stipulations.

Chapter IV

Duties and Powers of the Council

9. The duties of the Council are as follows:-

(a) recognition or refusal of recognition of medical degrees conferred by any local or foreign Institute of Medicine or Medical College or any other organization formed for the purpose of medical science;

(b) issuing notification form time to time on the medical degrees recognized by the Council;

(c) determining moral conduct and ethics to be observed by the medical practitioners and supervision thereof;

(d) compiling and keeping the list of registered medical practitioners and the list of licensed medical practitioners and publishing the said lists from time to time;

(e) studying, examining, taking appropriate action and communicating with the Government departments and organizations to enable maintaining and upgrading of the qualification and standard of the medical practitioners in the performance of health care;

(f) prescribing necessary norms and standards for maintaining and upgrading the level of health care of the State-owned and private hospitals and clinics, and submitting suggestion thereof to the Ministry of Health;

(g) submitting suggestions, after studying and reviewing the teaching systems of medical science which are being developed and changed ,to the Ministry of Health for upgrading the standard of teaching medical science and emergence of qualified medical experts;

(h) submitting suggestions to the Ministry of Health for enabling medical practitioner to study medical education continuously in conformity with the health care requirements of the

State;

(i) submitting suggestions to the Ministry of Health for upgrading health care and standard of medical science;

(j) investigating, examining and taking action in case of failure to abide by and observe in conformity with the moral conduct and ethics of the medical practitioner.

10. The powers of the Council are as follows:-

(a) forming the following committees and prescribing the functions and duties thereof:-

(1) Committee for Scrutiny of Registration Certificate and Medical Practitioner Licence;

(2) Committee for Observance of Moral Conduct and Ethics;

(3) Committee for Maintenance of Discipline;

(4) Standardization Committee;

(5) Committee for Continuous Medical Education;

(6) Health Committee;

(7) Other necessary committees;

(b) issuing, refusing to issue and cancelling registration certificate;

(c) issuing refusing to issue, cancelling and revoking subject to a time limit of medical practitioner licence;

(d) determining the tenure, extending the tenure and refusing to extend the tenure of medical practitioner licence;

(e) communicating and cooperating, with the approval of the Ministry of Health, with international, regional, Local and foreign government departments, organizations and experts on matters that will prove beneficial to the State and the Council;

(f) prescribing and collecting the registration fees, liences fees, extension of tenure of medical practitioner licence fees and late fees;

(g) exercising the other powers conferred from time to time by the Ministry of Health for successful implementation of the objectives of the Council.

Chapter V

Rights of the Members of the Council and Members of the Executive Committee

11. The rights of the members of the Council and members of the Executive Committee are as follows: (a) having the right to enjoy the benefits prescribed by the State from time to time;

(b) having the right to receive travelling allowance actually incurred and daily subsistence allowance prescribed from time to time if travelling on duty is involved;

(c) having the right to receive remuneration prescribed from time to time if attending meetings relating to the Council is involved.

Chapter VI

Cessation of Membership of Council

12. If any of the following events has occurred, the Council shall, with the approval of the Ministry of Health, cease the Membership of any member: -

(a) resignation;

(b) failure to attending the meeting for three consecutive times without applying for leave to the Council;

(c) going abroad for six months and above without applying for leave;

(d) cancellation from the medical practitioners' registration list;

(e) cancellation of the medical practitioner licence or revocation of the same subject to a time limit;

(f) action being taken and subsequently convicted for any offence relating to misconduct or affecting security of the State;

(g) finding by the Council on examination to have failed to observe the moral ethics.

Chapter VII

Holding Meetings

13. The meetings shall be held as follows

(a) holding regular meeting of the Council once in every three months and holding extraordinary meeting when necessary;

(b) holding the Executive Committee meeting once a month and holding extraordinary meeting when necessary;

(c) submitting the activities of the Executive Committee to the nearest regular meeting of the Council and obtaining the approval thereof;

14. The Council and the Executive Committee shall report their activities to the Ministry of Health once in every three months regularly. In addition, they may report as may be necessary from time to time.

Chapter VIII

Formation of Staff Office and Assigning Duties Thereto

15. In order to carry out the functions and duties of the Council and the Executive Committee, the Council shall, with the permission of the Ministry of Health form the Staff Office as follows: -

(a) appointing a Head of Staff Office and a Deputy Head of Staff Office and assigning duties thereto;

(b) constituting the staff as may be necessary and assigning duties there t

Chapter IX

Finance

16. The Ministry of Health shall bear the expenditures of the Council, the Executive Committee and the Staff Office.

17. The Council may, with the approval of the Ministry of Health, accept donations, property and other assistance from organizations and donors locallyand abroad.

18. The Council shall accept, utilize and keep the accounts of income and expenditure in accordance with the existing financial rules and directives.

Chapter X

Registration Certificate of Medical Practitioner

19. Any of the following persons desirous of obtaining the registration certificate may apply to the Council in accordance with the stipulations; -

(a) a person who has obtained the degree of medical science conferred by any local Institute of Medicine;

(b) a person who has obtained the degree of medical science conferred by any foreign Institute of Medicine, any Medical College or any organization formed for medical education and also recognized by the Council

(c) a person who has obtained a degree conferred by any foreign Institute of Medicine, any Medical College or any organization formed for medical education but not yet recognized by the Council.

20. The Council may, after scrutinizing the application made under section 19 in accordance with the stipulations and causing the registration fees to be paid, issue or refuse to issue the registration certificate.

21. The Council shall ,in respect of any registered medical practitioner, cancel from the registration list on finding out that any of the following events has occurred: -

(a) using narcotic drugs and psychotropic substances;

(b) being convicted by the Court for any offence related to the moral conduct and ethics of a medical practitioner and determined by the Council as being not suitable to continue serving as a medical practitioner;

(c) although not convicted by a Court, perversion of moral conduct and ethics of a medical practitioner and being not suitable to continue serving as a medical practitioner;

(d) surrendering the citizenship, cessation or revocation of citizenship, or adopting the citizenship of other country.

Chapter XI

Medical Practitioner Licence

22. The registered medical practitioner desirous of performing medical practice shall apply to the Council to obtain the General Medical Practitioner Licence in accordance with the stipulations.

23. The Council may, after scrutinizing the application made under section 22 in accordance with the stipulations and causing the licence fees to be paid, issue or refuse to issue the General Medical Practitioner Licence.

24. The registered medical practitioner who has already obtained the General Medical Practitioner Licence and is fully qualified may apply to the Council to obtain the Special Medical Practitioner Licence.

25. The Council may, after scrutinizing the application made under section 24 in accordance with the stipulations, and causing the licence fees to be paid, issue or refuse the Special Medical Practitioner Licence.

26. A foreign medical practitioner desirous of performing medical practice in the Union of Myanmar shall apply to the Council to obtain the Limited Medical Practitioner Licence in accordance with the stipulations.

27. The Council may, after scrutinizing the application made under section 26 in accordance with the stipulations, and causing the licence fees to be paid issue the Limited Medical

Practitioner Licence limiting the branch of medical science in which practice is allowed, the locality in which practice is allowed and the period during which practice is allowed or refuse to issue.

28. A General Medical Practitioner Licence holder or Special Medical Practitioner Licence holder desirous of continuing his medical practice after expiry of the tenure of the medical practitioner licence shall apply to the Council in accordance with the stipulations for the extension of the tenure of his licence before the expiry of the tenure of the relevant medical practitioner licence.

29. The Council may, after scrutinizing the application made under section 28 in accordance with the stipulations for the extension of the tenure of medical practitioner licence, extend the tenure or refuse to extend the tenure.

30. The Council may, in respect of any medical practitioner holding medical practitioner licence, cancel the medical practitioner licence or revoke it subject to a time limit on finding out that any of the following events has occurred;-

(a) being cancelled from the medical practitioner registration list;

(b) being unable to carry out the functions and duties of a medical practitioner due to mental illness, being devoid of knowledge or physical disability;

(c) failure to carry out the duty assigned by the State;

(d) carrying out the duties of a medical practitioner inconsiderately and negligently;

(e) failure of compliance and observance in conformity with the moral conduct and ethics of a medical practitioner;

(f) being unable to carry out in accordance with the qualification of a medical practitioner;

(g) failure to extend the tenure of the medical practitioner licence without sufficient ground during the period determined by the Council.

Chapter XII

Duties and Rights of the Registered Medical Practitioner and the Medical Practitioner Licence Holder

31. The registered medical practitioner: -

(a) shall abide by the rules, procedures, notifications, orders and directives issued under this Law;

(b) shall observe the moral conduct and ethics of medical practitioner prescribed by the Council;

(c) has a right to advise the Council for progress and achievement of the functions and duties of the Council;

(d) has a right to submit his grievances of the Council and may also have a right to obtain the advice of the Council.

(e) shall abide by the rules, procedures, notifications, orders and directives issued under this Law;

(f) shall observe the moral conduct and ethics of medical practitioner prescribed by the Council;

(g) has a right to advise the Council for progress and achievement of the functions and duties

of the Council;

(h) has a right to submit his grievances of the Council and may also have a right to obtain the advice of the Council.

32. The medical practitioner licence holder has a right to carry out the medical practice according to the type of licence which he holds in accordance with the stipulations.

33. In electing the member of Council contained in clause (13) of sub-section (a) of section (4) the medical practitioner licence holder: -

(a) has the right to vote;

(b) has right to be elected as a member of Council if he possesses qualification determined by council.

Chapter XIII

Appeal

34. A person dissatisfied with an order or decision passed under section 20 or section 23 or section 25 or section 27 or section 29 or under section 30 that the medical practitioner licence is revoked for a period under 5 years by the Executive Committee may file an appeal to the Council within 60 days from the date of passing such order or decision.

35. The decision of the Council passed in an appeal under section 34 shall be final and conclusive.

36. A person dissatisfied with an order or decision passed under section2l or under section 30 that the medical practitioner licence is revoked for a period of 5 years and above or cancelled by the Executive Committee may file an appeal to the Minister for the Ministry of Health within 60 days from the date of passing such order or decision.

37. The decision of the Minister for the Ministry of Health passed in an appeal under section 36 shall be final and conclusive.

Chapter XIV

Prohibitions and Penalties

38. No one shall give medical treatment without a medical practitioner licence granted by the Council under this Law.

39. No medical practitioner licence holder in performing the medical treatment work, shall assign duty to any other person except one who has obtained a licence, registration certificate, permit, certificate of completion of attendance of a training course or documents granted by the relevant department, organization that he is skillful in the relevant medical treatment work.

40. No registered medical practitioner shall use the terms and expressions which are inappropriate with the degree which he has obtained, rank and technical know-how together with his name.

41. Whoever violates the prohibition contained in section 38 shall, on conviction, be punished with imprisonment for a term which may extend to 5 years and may also be liable to a fine.

42. Any medical practitioner holding the medical practitioner licence who violates the prohibition contained in section 39 shall,on conviction, be punished with imprisonment for a term which may extend to 5 years or with fine or with both.

43. Any registered medical practitioner who violates the prohibition contained in section 40 shall, on conviction ,be punished with imprisonment for a term which may extend to 3 years or with fine or with both.

Chapter XV

Miscellaneous

44. The provisions contained in this Law shall not apply to persons who have the right of medical treatment under any other existing law.

45. A medical certificate which is not signed by a medical practitioner licence holder himself shall not be deemed to be a legal medical certificate.

46. In prosecuting an offender under section 42 or section 43 of this Law, prior sanction of the Ministry of Health shall be obtained.

47. Rules, orders and directives issued under the Myanmar Medical Act,1957 may continue to be applicable in so far as they are not inconsistent with this Law.

48. Funds owned by the Union of Myanmar Medical Council formed under the Myanmar Medical

Act,1957 movable and immovable property, works which are in the processes of being performed,

works which have been completed, assets and liabilities shall devolve respectively on the Council.

49. The Union of Myanmar Medical Council formed under the Myanmar Medical Act, 1957 may continue to carrying out its duties and powers until the formation of the Myanmar Medical Council under this Law.

50. For the purpose of carrying out the provisions of this Law: -

(a) the Ministry of Health may, with the approval of the Government, issue such rules and procedures as may be necessary;

(b) the Ministry of Health and the Council may issue such notifications orders and directives as may be necessary.

51. The Myanmar Medical Act, 1957 is hereby repealed.

Sd ./-Than Shwe
Senior General
Chairman
The State Peace and Development Council

The State Law and Order Restoration Council hereby enacts The Law Amending the Myanmar Medical Act, 1957 as Law No. 3/89 on 24 January 1989, as follows:

1. This Law shall be called the Law Amending the Myanmar Medical Act,1957.

2. In Section 2 sub-section (a) of the Myanmar Medical Act. 1957, the expression "science of the treatment of uterine disease" shall be substituted by the expression "science of the treatment of gynaecological disease".

3. In Section 3 sub-section (3) of the Myanmar Medical Act, 1957, the expression "15 Council

Members" shall be substituted by the expression "11 Council Members"; in Section 3 sub-section (3) clause (b) the expression "4 Council Members" shall be substituted by the expression ”5 Council Members"; in Section 3 sub-section (3) clause (d) the expression "ten Council Members" shall be substituted by the expression ”5 Council Members".

4. In Section 5 sub-section (2) of the Myanmar Medical Act, 1957, the expression "shall have the right to be re-appointed on the expiry of the term of service" shall be substituted by the expression "has the right to be elected or appointed for only three consecutive terms".

5. In the Proviso to Section 25 of the Myanmar Medical Act, 1957, the expression "Registration Officer" shall be substituted by the expression "Chairman of the Council".

6. In paragraph I of the Schedule of the Myanmar Medical Act, 1957, the expression "from the University" shall be substituted by the expression "from any Institute of Medicine".

Sd./ Saw Maung
General
Chairman
The State Law and Order Restoration Council

The Dental and Oral Medicine Council Law

The State Law *and Order Restoration Council hereby enacts The Dental and Oral* Medicine Council Law as Law No. 5/89 on 10 March 1989 as follows: (II/2)

Chapter I

Title and Definition

1. This Law shall be called the Dental and Oral Medicine Council Law.

2. The following expressions contained in this Law shall have the meanings given hereunder:-

(a) **Dental and Oral Medicin**e means medical science which includes the treatment of dental, gingival, periodontal and oral diseases by medical means and surgical means, prosthetic dentistry, conservative dentistry, correction of dento-facial anomalies by ortho-dontic means, preventive and community dentistry;

Council means the Dental and Oral Medicine Council constituted under this Law:

(b) **Registration** means the entry of names in the Register of Dental and Oral Surgeons maintained under this Law;

(c) **Registrar** means the Registrar appointed under this Law;

(d) **Dental and Oral Surgeon** means any dental and oral-surgeon who has been registered under this Law. This expression includes persons who have been registered under the Myanmar Dental Surgeons Law, 1970;

(e) **Institute of Medicine** means any Medical University, Medical College or Medical School which can confer Dental and Oral Medicine degree or diploma.

Chapter II

Constitution of the Council

(a) The Government shall constitute a Dental and Oral Medicine Council. Such Council shall consist of eleven council members whose appointment and election shall be made as follows:-

(1) One Dental and Oral Surgeon appointed by the Government Chairman

(2) Four Dental and Oral Surgeons appointed by the Government Council members

(3) Five Dental and Oral Surgeons elected from amongst themselves Council members

(4) The Registrar appointed under this Law Secretary

(b) The Council may assign any Council member the duties of a Treasurer. If no such assignment has been made, the Secretary shall act as a Treasurer.

(a) The tenure of the Council for one term shall be four years commencing from the date of its constitution.

(b) The term of office of the Council members shall be the same as the tenure of the Council.

(c) A Council member shall have the right to be appointed or elected for three consecutive terms.

(d) Should a vacancy occur in the membership of the Council, appointment or election of a new Council member shall be made in accordance with the provisions of this Law.

(e) The term of office of the Council member who has been appointed or elected under sub-section (d) shall be till the expiry of the tenure of the existing Council.

A Council member shall cease to be a Council member, should any of following events occur:-

a. submission of resignation;

b. failure to attend a Council meeting for three consecutive times without the consent of the Council;

c. travelling abroad for more than six months without the consent of the Council;

d. cancellation of registration.

Chapter III

Duties and Powers of the Council

6. (a) The Council shall, with the approval of the Ministry of Health, setup the establishment of the office of the Council with pay scales prescribed by the same Ministry.

(b) The Council shall appoint a Registrar with the approval of the Ministry of Health and the remaining personnel on its decision.

(c) The Council shall prescribe the duties of the Registrar.

7. (a) The Council may, in accordance with the provisions of this Law, permitor refuse to register a person applying for registration as a Dental and Oral Surgeon.

(b) The Council may in accordance with the provisions of this Law, cancel the registration of any Dental and Oral Surgeon.

(c) The Council may permit registration of any Dental and Oral Surgeon whose registration has been refused or cancelled if it is in conformity with the provisions of this Law.

(d) In cases where persons who have obtained certificates inferior to a degree or an L. D. S Diploma of any Institute of Medicine make a living with any technical skill pertaining to

dental and oral medicine, the Council may, with the approval of the Ministry of Health, prescribe conditions and may also issue a certificate permitting such livelihood.

8. Regarding matters contained in Section 7:-

(a) the Council may, if necessary, form an enquiry committee comprising three Council members and cause and enquiries to be made;

(b) the Council shall decide after examining the report and findings of the enquiry committee.

(c) The Council shall take measures in connection with the recognition by foreign countries of Dental and Oral Surgeons and degrees of Dental and Oral Medicine of the Union of Myanmar.

(d) The Council may recognize the Dental and Oral Surgeons, denial and oral medicine degrees and diplomas of foreign countries.

10. The Council may, regarding the reciprocal recognition mentioned in Section 9, call for reports and particulars necessary to determine whether or not the respective Institutes of Medicine have facilities to teach the subjects competently and may send one or more Council members in order to take measures in matters relating to examinations conducted by any such institute.

11. Matters relating to Council meetings and finance shall be carried out in the manner prescribed in the procedures.

Chapter IV

Registration

12. Any person shall be permitted to practise dental and oral medicine whether with or without fees only after being registered under this Law.

13. The following persons shall be entitled to apply for permission to beregistered as a Dental and Oral Surgeon:-

(a) persons who, after obtaining the B.D.S degree from any Institute of Medicine of the Union of Myanmar, have served for a period of one year as a dental and oral house surgeon in accordance with the stipulations of the Ministry of Health;

(b) persons who, after obtaining a degree in dental and oral medicine or a diploma not inferior to L.D.S from any foreign Institute of Medicine recognized by the Council, have served for a period of one year as a dental and oral house surgeon, in accordance with the stipulations of the Ministry of Health, if the Council deems it necessary.

14. If there is sufficient evidence that a person applying for permission to register under Section 13 infringes any of the following matters he may be refused registration permanently or for a specified period:—

(a) conviction by a Court of Law of an offence specified and declared by the Council in this behalf to be an offence pertaining to character;

(b) having sufficient evidence of being guilty of professional misconduct;

(c) not being able to practise dental and oral medicine due to physical deformity or any other disease;

(d) being a narcotic drug user;

(e) having committed any act prejudicial to the interest of the Union of Myanmar which is specified an declared for this purpose by the Ministry of Health.

15. On the occurrence of any of the following events, in addition to the matters contained in Section 14, registration as a Dental and Oral surgeon shall be cancelled permanently or for a specified period:-

(a) death:

(b) application for cancellation of registration on his own initiative;

(c) cessation of practice of dental and oral medicine.

16. (a) An applicant who conforms to the provisions of this Law shall be permitted to be registered.

(b) A person permitted to be registered shall pay such registration fees as are prescribed by the Council.

(c) A Dental and Oral Surgeon Registration Certificate shall be issuedto a person permitted to be registered.

(d) Renewal of Dental and Oral Surgeon Registration Certificate shall be made as prescribed in the procedures.

17. (a) Persons who have obtained certificates inferior to a degree or an L.D.S.diploma of any Institute of Medicine are entitle

to apply forpermission to make a living with any technical skill pertaining to dental and oral medicine.

(b) An applicant under sub-section (a) who conforms to the prescribed conditions may be issued a certificate permitting him to make a living with any technical skill pertaining to dental and oral medicine.

Chapter V

Appeal

18. The Ministry of Health shall for the purpose of this Law, constitute an Appellate Committee comprising the following persons:-

(a) Person assigned by the Minister,
Ministry of Health..... Chairman

(b) Head of Department of Dental Health,
Directorate of Health..... Member

(c) Chairman of the Council.....Member

19. (a) A person who is not satisfied with any decision of the Council underthis Law may appeal to the Appellate Committee within 90 days. (b) The decision of the Appellate Committee shall be final.

Chapter VI

Penalties

20. Whoever, not being a Dental and Oral Surgeon impersonates as such orprefixes before his name the title "Doctor" or "*Sayawun",* or acts like a Dental and Oral Surgeon shall be punished with imprisonment for a term which may extend to five years, and shall also be liable to a fine which may extend to kyats five thousand.

21. Whoever, although having obtained a degree or a diploma from anyInstitute of Medicine, practises dental and oral medicine with or without fees without being registered under this Law or without holding a certificate under Section 17 shall be punished with imprisonment

for a term which may extend to three years or with fine which may extend to Kyats five thousand or with both.

Chapter VII

Miscellaneous

22. The Council shall be a body corporate with perpetual succession and common seal and shall have the right to sue or be sued in its corporate name.

23. The Appellate Committee and the Enquiry Committee constituted underthis Law, shall abide by such procedures, as may be relevant, relating to Departmental Enquiries and Appeals issued by the Government from time to time.

24. In order to carry out the provisions of this Law:-

(a) The Ministry of Health may, with the approval of the Government, prescribe necessary procedures;

(b) The Ministry of Health or the Council may issue such orders and directives as may be necessary.

25. The Myanmar Dental Surgeons Law, 1970 is hereby repealed.

Traditional Medical Council Law

The State Peace and Development CouncilThe State Peace and Development Council hereby enacts The *Traditional Medical Council Law* No 2/2000 on 14 January 2000 as follows: (II/3)

Chapter 1

Title and Definition

1. This Law shall be called the Traditional Medical Council Law.

2. The following expressions contained in this Law shall have the meanings given hereunder -

(a) Traditional Medicine means medicine for the physical well-being and longevity of people in accordance with anyone of the four nayas of traditional medicine, namely Desana naya, Bethi tea naya, Netkhata veda naya and Vissadara naya;

(b) Council means the Traditional Medical Council formed under this Law;

(c) Council Member means any person included as member in the Traditional Medical Council formed under this Law;

(d) Traditional Medical Practitioner means any person qualified in traditional medicine and registered under this Law;

(e) Registration Certificate means the certificate issued by the Council to the person entitled for registration as a traditional medical practitioner.

Chapter II

Aims

3. The aims of this Law are as follows: -

(a) to protect public health by applying any type of traditional medicine by the traditional medical practitioners collectively;

(b) to supervise traditional medical practitioners for causing abidance by their rules of conduct and discipline;

(c) to carry out modernization of traditional medicine and conformity to scientific method;

(d) to cooperate with the relevant government departments, organizations and international organization in carrying out modernization of traditional medicine.

Chapter III

Formation of the Traditional Medical Council

4. The Ministry of Health shall, with the approval of the Government form the Traditional Medical Council comprising the following persons:-

(a)	Director-General	Chairman
(b)	four traditional medical practitioners assigned duty by the Ministry of Health	member
(c)	five persons elected by the traditional medical practitioners from among themselves	member
(d)	officer assigned duty by the Ministry of Health	Secretary

5. The council may assign duty to any Council member as the Treasurer, If no such assignment has been made, the Secretary shall act as the Treasurer.

6. (a) The tenure of office of the Council member is the same as the tenure of the Council.

(b) A Council member has the right to act as such only for 3 consecutive tenures of the Council.

(c) When a vacancy occurs in the post of any Council member: -

(i) if it is the post of a Council member assigned duty by the Ministry of Health such Ministry shall assign duty for it in substitution;

(ii) if it is the post of a Council member elected by the traditional medical practitioners, they shall elect for it in substitution;

(d) The tenure of a Council member assigned duty or elected in substitution under sub-section (c) shall only be till the expiry of the current tenure of the Council.

7. (a) The tenure of the Council is 4 years at a time commencing from the date of its formation.

(b) The Council shall, although its tenure has expired, carry out its functions and duties until a new Council has been formed.

8. Matter relating to convening of meetings and financial matters of the Council shall be disposed of in accordance with the stipulations.

9. The Council shall have perpetual succession and a common seal with the right to sue or be sued.

Chapter IV

Duties and Powers of the Council

10. The duties and powers of the Council are as follows: -

(a) issuing registration certificate after scrutinizing the applications for registrations as traditional medical practitioner:

(b) prescribing registration fees and annual fees for registration as traditional medical practitioner;

(c) stipulating the rules of conduct and discipline to be abided by traditional medical practitioners;

(d) taking action against traditional medical practitioners who have violated the rules of conduct and discipline;

(e) submitting necessary advice to the Ministry of Health in respect of modernization and development, conformity to scientific method and instructions of traditional medicine;

(f) tendering advice and recommendation to the Ministry of Health in respect of granting a right of practice to medical practitioners who practice by applying traditional medicine of any foreign country;

(g) communicating and coordinating with the relevant government departments and organizations, international organizations, regional organizations and non governmental organizations to enable modernization to traditional medicine;

(h) forming necessary committees and organizations and prescribing the duties and powers thereof in order to carry out the duties assigned and exercise the powers conferred by the Council.

Chapter V

Registration as the Traditional Medical Practitioner

11. A person possessing any of the following qualifications may apply to II' Council for registration as traditional medical practitioner:-

(a) a person who has graduated from the Traditional Medical Institute Traditional Medical University;

(b) a person who has attended and passed the Traditional Medical Practitioner Training Course opened by the Department of Traditional Medicine;

(c) a person who has passed the qualifying examination held by Traditional Myanmar Medical Practitioners Board or the of Traditional Medicine

(d) a person who is recognized as possessing qualifications deserving of a traditional medical practitioner, according to the scrutiny of Council.

12. If, after scrutinizing the application under section lithe Council finds that is in conformity with the stipulations, it shall issue the registration certificate to applicant, after causing the prescribed registration fees to be paid.

Chapter VI

Duties and Rights of the Traditional Medical Practitioner

13. The traditional medical practitioner shall:-

(a) abide by the rules, procedures, orders and directives issued under this Law;

(b) abide by and observe the rules of conduct and discipline prescribed by the Council;

(c) pay the annual fees prescribed by the Council from time to time.

14. The traditional medical practitioner has the right to:-

(a) be assigned the duty of ,be elected and to elect as a Council member;

(b) practice traditional medicine as a profession;

(c) tender advice to the Council;

(d) submit his/her grievances to the Council.

Chapter VII

Functions and Duties of the Ministry of Health

15. The Ministry of Health:-

(a) may appoint and assign duty to any officer from the Department of Traditional Medicine to act as a Registration Officer for the purpose of this Law;

(b) shall prescribe the duties and powers of the Registration Officer.

16. The Ministry of Health may, in respect of issuing certificate for practice and taking of actions against the medical practitioners who practise by applying traditional medicine of any foreign country, assign duty to the Department of Traditional Medicine

Chapter VIII

Taking Action

17. (a) The Council shall, after forming an investigation body comprising 3 members, assign duty there to enable investigation of the traditional medical practitioner who is alleged to have violated any provision of section 1 3.Such body shall consist of at least one Council member.

(b) The investigation body shall submit a report of its findings to the Council.

18. If, after scrutinizing the report submitted to it under sub-section(b) of section 17,the Council finds that the alleged traditional medical practitioner:-

(a) is not guilty of the allegation ,it shall pass an order for the closure of the case;

(b) is guilty of the allegation, it shall pass any of the following administrative penalties;

(i) giving a warning;

(ii) revoking the registration certificate subject to a time limit;

(iii) cancellation of the registration certificate.

19. The Council shall pass any of the following administrative penalties on the traditional medical practitioner who has been convicted by a court of an offence determined by the Council amounting to misconduct:

(a) revoking the registration certificate subject to a time limit; (b) cancellation of the registration certificate.

20. (a) The person whose registration certificate is revoked subject to a time limit may, if desirous of obtainingthe registration certificate again apply to the Council on expiry of the said time limit;

(b) lf, after scrutiny, the application is in conformity with the stipulations, the Council may re-issue the registration certificate.

Chapter IX

Appeal

21. (a) A person who is dissatisfied with an order or decision passed by the Council may file an appeal to the Minister for the Ministry of Health within 60 days from the date on which such order decision ha been passed.

(b) The decision of the Minister for the Ministry of Health shall be final and conclusive.

Chapter X

Prohibitions and Penalties

22. No person shall, without obtaining the registration certificate issued by the Council, practise the profession of medical treatment by accepting money or benefit for personal interest.

23. No person shall, without having a right of practice certificate issued by the Department of Traditional Medicine, practise by applying traditional medicine of any foreign country.

24. Whoever

(a) violates the provision of section 22 or section 23 shall, on conviction, be punished with imprisonment for a term which may extend to I year, or with fine which may extend to Kyats 10,000 or with both.

(b) violates subsequently the provision of the relevant section after a pervious conviction under subsection (a) shall, on conviction, be punished with imprisonment for a term which may extend from a minimum of 1 year to a maximum of 5 years and may also be liable to a fine.

Chapter Xl

Miscellaneous

25. The Department of Traditional Medicine shall, in respect of issuing of right of practice certificate and taking of actions against the medical practitioners who practise by applying traditional medicine of any foreign country, carry out in accordance with the directive of the Ministry of Health.

26. The Department of Traditional Medicine shall:

(a) bear expenditures of the Council;

(b) undertake to perform the office work of the Council.

27. Whenever a traditional medical practitioner passed away or is unable to practise, anyone of his family members shall inform, in writing, to the Council.

28. In prosecuting an offender under this Law, prior sanction of the Department of Traditional Medicine shall be obtained.

29. (a) The orders and directives issued under the Traditional Myanmar Medical Practitioners Board Act, 1315 M.E.(1 953) may continue to be applicable in so far as they are not inconsistent with this Law.

(b) The Traditional Myanmar Medical Practitioners Board formed shall, before the formation of the Traditional Medical Council under this Law, be entitled to continue performance of the duties and exercise of the powers thereof.

30. In order to carry out the provisions of this Law;

(a) the Ministry of Health may, with the approval of the Government, issue such rules and procedures as may be necessary;

(b) the Ministry of Health ,the Council and Department of Traditional Medicine may issue such orders and directives as may be necessary.

31. The Traditional Myanmar Medical Practitioners Board Act ,1315 M.E.(1953) is hereby repealed.

Sd./ Than Shwe

Senior General

Chairman
State Peace and Development Councilil

The State Peace and Development Council hereby enacts The Law Amending the Law Relating to the Nurse and Midwife on 26 February 2002 as follows:

1. This Law shall be called the Law Amending the Law relating to the Nurse and Midwife.

2. In section 2 of the Law Relating to the Nurse and Midwife

(a) sub-section (h) shall be substituted as follows : -

"(h) Licence means the permit issued by the Council for the services of nurse or midwife or both."

(b) sub-section (i) shall be substituted as follows

"(i) Nurse and Midwife Training School means a school, institute, college, degree college or university opened by any government department or organization or by the permission of any government department or organization for the training of nursing profession or midwifery profession or both."

(c) sub-section (j) shall be substituted as follows

"(i) Supervisory Body means the State, Division, District and Township Supervisory Bodies formed under this law to supervise whether or not the services of the nurse or midwife are in accordance with the stipulations."

3. Section 3 of the Law relating to the Nurse and Midwife shall be substituted as follows: - "3. The Ministry of Health : -

(a) shall, with the approval of the Government, form the Myanmar Nurse and Midwife Council consisting of at least 11 Council members as follows:one nursing chief assigned duty by

(1)	the Minister of the Ministry of Health	Chairman
(2)	persons from the Government departments and organizations related to nurse and midwife	Council members
(3)	representatives from the associations relating to nurse and midwife	Council members
(4)	suitable nurses and midwives	Council members
(5)	Registrar appointed under this law	Secretary

(b) in forming the Council under sub-section (a), a vice chairman and a joint secretary may be determined and assigned duty, if necessary.

4. In section 7 of the Law relating to the Nurse and Midwife : "

(a) sub-section (e) shall be substituted as follows : -

"(e) prescribing the duties and powers of the Registrar,"

(b) sub-section (i) shall be substituted as follows "

"(i) issuing the nurse, midwife or nurse and midwife licence extending the tenure thereof, suspending subject to a time limit and ca the same,"

(c) sub-section (I) shall be substituted as follows :-

"(I) forming the following bodies with suitable persons and prescribing their duties and powers and supervising such bodies : "

(i) State, Division, District and Township Supervisory Bodies;

(ii) body for raising the standard of nursing, midwifery profession and practice."

(d) sub-section (m) shall be substituted as follows:-

"(in) raising the standard of nursing profession or midwifery profession to reach the international level, and if necessary, -suggesting and submitting to the Ministry of Health in respect of teaching of such profession."

5. The expression "to the respective Supervisory Body with the prescribed application form in the prescribed manner" contained in section 11 of the Law relating to the Nurse and Midwife shall be substituted by the expression "to the Council in the prescribed manner."

6. The expression "and the respective Supervisory Body" contained in subsection (i) of section 14 and sub-section (i) of section 15 of the Law relating to the Nurse and Midwife shall be deleted.

7. Section 16 of the Law relating to the Nurse and Midwife shall be substituted as follows -

"16. If it is found after scrutiny that a licence holder has violated the provision contained in sub-section (d) or (e) of section 14 or the provision contained in sub-section (d) or (e) of section 15 : -

(a) the Council may pass any of the following orders : -

(i) suspending the licence subject to a time limit;

(ii) cancelling the licence.

(b) the State or Division Supervisory Body may pass any of the following orders : -

(i) warning;

(ii) determining an appropriate fine and causing it to be paid."

8. Section 17, section 18 and section 19 of the Law relating to the Nurse and Midwife shall be substituted as follows:-

"17. A person dissatisfied with the order or decision of the respective State or Division Supervisory Body may appeal to the Council, within 30 days after the receipt of such order or decision.

19. A person dissatisfied with the order or decision passed by the council, may appeal to the Minister of the Ministry of Health, within 30 days after the receipt of such order or decision.

20. (a) The decision of the Council in an appeal under section 17 shall be final and conclusive.

(b) The decision of the Minister of the Ministry of Health in an appeal under section 18 shall be final and conclusive."

9. Section 20 of the Law relating to the Nurse and Midwife shall be substituted as follows : -

"20. The Minister of the Ministry of Health:

(a) shall appoint a Registrar.

(b) may suspend, revoke, terminate or cancel the registration certificate or licence issued by the Council.

(c) may amend, alter or cancel the order or decision passed by the Council or the State or Division Supervisory Body.

(d) may pass any appropriate order after reviewing the order passed under sub-section (b) or subsection (c)."

10. The expression "or with fine which may extend to kyats 3000" contained in section 24 of the Law relating to the Nurse and Midwife shall be substituted by the expression "or with fine."

11. Section 28 of the Law relating to the Nurse and Midwife shall be substituted as follows:-"28. The Department of Medical Sciences shall draw up the curriculum relating to the nursing profession and midwifery profession and hold the entrance examination of the Nurse and Midwife Training School and internal school examinations.

12. Sub-section (b) of section 33 of the Law relating to the Nurse and Midwife shall be substituted as follows :

(b) the Ministry of Health, Council and the Department of Medical Sciences may issue necessary notifications, orders and directives."

(Sd.) Than Shwe
Senior General
Chairman

Law relating to the Nurses and Midwife Law

No. 19/90 on 17 October 1990 as follow:

Chapter I

Title and Definition

This Law shall be called the Law relating to the Nurse and Midwife.

The following expressions contained in this Law shall have the meanings hereunder: -

(a) Nursing Profession means a profession capable of rendering physical, mental, social nursing care needed .by a sick person and also health care, mental and social needs of the family and relatives or such sick person. This expression includes rendering services in respect of better health care and disease preventive measures to the healthy persons;

(b) Midwife Profession means rendering pre-natal care to pregnant women before delivery, and rendering safe delivery at the time of birth. This expression includes rendering care to mother and new born baby;

(c) Nurse means a person having passed the basic nursing examination, holding registration and licence and being permitted to practise in the Nursing Profession under this Law;

(d) Midwife means a person having passed the prescribed basic midwife examination, holding registration and licence and being permitted to practise in the Midwife profession under this Law;

(e) Council means Myanmar Nurse and Midwife Council established under this Law;

(f) Registration means entering of names in the register relating to Nurse and Midwife, maintained under this Law;

(g) Registrar means the registration officer appointed under this Law;

(h) Licence means the permit issued by the Supervisory Body established by the Council, for nursing or midwifery or both;

(i) Nurse and Midwife Training School means a school, college or university recognized by the Council for the training of Nursing Profession or Midwife Profession or both;

(j) Supervisory Body means a body established by the Council under this Law for issuing, revoking, suspending, cancelling the nurses and midwives licences, in accordance with the supervision and direction of the Council, and to supervise whether or not the services of the nurse or midwife are in accordance with the stipulations prescribed.

Chapter II

Formation of Council

3. The Ministry of Health shall form the Nurse and Midwife Council, consisting of the following members, with the approval of the Government –

(a) one Nursing Chief appointed by the Government – Chairman

(b) four persons appointed by the Government – Council Members

(c) three persons elected by the nurses – Council Members

(d) two persons elected by the midwives – CouncilMembers

(e) Registrar appointed under this Law - Secretary

4. The Council may assign any member of the Council as treasurer. If there is no such assignment the secretary shall act as treasurer.

5. (a) The term of office of the Council shall be four years from the date of establishment

(b) The term of office of the members of the Council is the same as that of the Council.

6. The membership of the Council shall be terminated on the occurrence of one of the following: -

(a) death;

(b) permission to resign has been obtained;

(c) not being re-appointed.

Chapter III

Duties and Powers of the Council

The duties and powers of the Council are as follows: -

(a) undertaking responsibility for giving effect to the provisions of this Law;

(b) convening the meeting once in three months and emergency meetings may be convened if necessary;

(c) performing the duties and functions until a new council is formed and transferring its duties and functions to the succeeding council

(d) forming necessary committees for the effective functioning of the work of Council, and prescribing the duties and powers of such committees;

(e) appointing a registrar with the approval of the Ministry of Health and prescribing his duties and powers;

(f) permitting an applicant for registration as a nurse, midwife or anurse and midwife to register in accordance with the provisions of this Law, refusing or suspending, issuing a Registration Certificate, issuing the true copy of the Registration Certificate;

(g) revoking or cancelling the registration of a nurse, midwife or a nurse and midwife in accordance with the provisions of this Law

(h) permitting registration and reissuing the Registration Certificate' if it is discovered after scrutiny that the refusal, revocation or cancellation of the registration of a nurse, midwife or nurse and midwife is in accordance with the provisions of this Law;

(i) forming an inquiry body consisting of three members of the Council, and causing the inquiry body to inquire matters mentioned in sub-sections (f) (g) (h) if necessary, and after scrutinizing the report and findings passing the decision;

(j) scrutinizing and deciding the appeal cases filed by any person dissatisfied by the order or decision of the Supervisory Body;

(k) prescribing the terms and conditions relating to the professional practices of an ordinary nurse-aid below the rank of a nurse or midwife or ordinary auxiliary midwife, with the approval of the Ministry of Health;

(I) forming the following bodies with the suitable persons and prescribing their duties and powers and supervising such bodies;

(i) board of examiners for holding entrance examination of Nurse and Midwife Training School;

(ii) board of examiners for nurse and midwife;

(iii) body for the drawing up of curriculum for the nursing arid midwife professions;

(iv) State, Division or Township Zone Supervisory Body;

(v) body for raising the standard of nursing or midwife profession and practice;

(vi) raising the standard of Nursing Profession or Midwife Profession to reach the international level;

(vii) submitting suggestions to the Ministry of Health for the effective implementation of primary health care;

(viii) scrutinizing and accepting those who have passed the Nursing Profession or Midwife Profession examination from abroad for recognition of the said examination;

(ix) forming and appointing office staff in accordance with the sanctioned strength and prescribed rate of salary approved by the Ministry of Health;

(x) carrying out matters relating to meetings and monetary matters as prescribed in the procedures;

Chapter IV

Application for Registration and Payment of Registration Fees

8. Any person desirous of registration as nurse or midwife of both, shall apply to the Council with the prescribed application form in the prescribed manner.

9. In submitting the application under section 8, the Degree, Diploma or Examination Certificate in original shall be attached to the application form.

10. In submitting the application under section 8, registration fee as prescribed shall be paid by the applicant in the prescribed manner.

Chapter V

Application for Licence

11. Any registered nurse or midwife or registered nurse and midwife, desirous of applying for a licence for practising as nurse or midwife or both shall apply to the respective Supervisory Body with the prescribed application form in the prescribed manner.

12. In submitting the application under section 11, the Degree, Diploma, or Examination Certificate in original and Registration Certificate in original shall be attached to the application form.

13. In submitting the application under section 11, licence fee as prescribed shall be paid by the

applicant in the prescribed manner.

Chapter VI

The Duties and Rights of Nurse

14. A person who has obtained a licence for practising the Nursing Profession; have the right to practise for the period stipulated in the licence

(b) have the right to use trappings pertaining to the nurse;

(c) shall pay the registration fee and licence fee due;

(d) shall comply with the terms and conditions stipulated in the licence;

(e) shall abide by the nursing professional ethics and shall avoid such behaviours, utterances and acts which may affect the nursing ethics;

(f) shall render the best possible nursing care to the people through the Nursing Profession;

(g) shall be responsible for his or her own activities;

(h) if desirous of continuing to practise after the expiry of the validity of the licence shall apply for the extension of the licence

(i) after the registration or after the receipt of the licence, if any additional Certificate, Diploma or Degree ecetera relating to Nursing Profession is obtained within the State or from abroad shall submit to the Council, to he recorded;

(j) shall comply with the terms and conditions and directives issued from time to time by the Council and the respective Supervisory Body.

Chapter VII

The Duties and Rights of Midwife

15. A person who has obtained a licence for practising the Midwife Profession;

(a) have the right to practise for the period stipulated in the licence;

(b) have the right to use trappings pertaining to midwife;

(c) shall pay the registration fee and licence fee due;

(d) shall comply with the terms and conditions stipulated in the licence;

(e) shall abide by the midwifery professional ethics and avoid such behaviours, utterances and acts which may affect the midwifery ethics;

(f) shall render the best possible care to mother and child, through the Midwife Profession;

(g) shall be responsible for his or her own activities;

(h) if desirous of continuing to practise after the expiry of the validity of the licence shall apply for the extension of the licence;

(i) after the registration or after the receipt of the licence, if any additional Certificate, Diploma or Degree ecetera relating toMidwife Profession is obtained within the State or from abroad shall submit to the Council to be recorded;

(j) shall comply with the terms and conditions and directives issued from time to time by the Council and the repective Supervisory Body.

Chapter VIII

Suspension or Cancellation of Licence

16. The Council or respective Supervisory Body may make any of the following orders, if it is discovered after scrutiny, that any of the terms and conditions stipulated in the nursing or

midwife licence or any of the provisions contained in section 14, sub-section (e) or in section 15, sub-section (e) is violated; -

(a) warning;

(b) determining an appropriate fine and causing it to be paid;

(c) suspending the licence for a limited period ;

(d) cancelling the licence.

Chapter IX

Appeal

17. Any person dissatisfied with the order or decision of any Supervisory Body may appeal to the Council, within 30 days after the receipt of such order or decision.

18. Any person dissatisfied with the order or decision passed by the Council relating to any other matter or with the order or decision passed by the Council in an appeal under section 17, may appeal to the Minister of the Ministry of Health, within 30 days after the receipt of such order or decision.

19. The decision of the Minister of the Ministry of Health shall be final.

Chapter X

The Powers of the Minister of the Ministry of Health

20. Should it be necessary in the interest of the State or in the interest of the public the Minister of the Ministry of Health may;

(a) suspend, revoke, terminate or cancel the Registration Certificate issued by the Council or the licence issued by the Supervisory Body;

(b) amend, alter or cancel the order or decision passed by the Council or the Supervisory Body;

(c) pass any appropriate order after reviewing the order passed under sub-section (a) or sub section (b);

Chapter XI

Prohibition, Offence and Penalty

21. No one shall practise as nurse, midwife or both, without licence.

22. No one who is not a nurse or a midwife shall use such trappings pertaining to a nurse or midwife.

23. No one shall utter, write or behave with the intention of slandering and defaming the reputation of nurse or midwife.

24. Whoever violates any provision contained in sections 21, 22 or 23 shall, on conviction be punished with imprisonment for a term which may extend to one year or to fine which may extend to kyats 3000 or both.

Chapter XII

Miscellaneous

25. The provisions contained in this Law shall not apply to the doctors.

26. The Council shall be a body corporate with perpetual succession anda common seal and shall have the power to sue or be sued in its corporate name.

27. The Council or the Supervisory Body shall comply with the procedures relating to Departmental Inquiry and Appeal.

28. If there is any dispute as to whether there is any violation of nursing or midwife professional ethics or not, it shall be decided by the majority votes of the Council members.

29. Any nurse of midwife who is convicted of any offence prescribed by the Council shall have his or hername struck-off from the register by the Council.

30. No suit or prosecution shall lie against the members of the Council, members of any body formed by the Council or members of Supervisory Body for any act done in good faith in pursuance of this Law.

31. Offences under this Law are prescribed as cognizable.

32. In prosecuting any offence under this Law, prior sanction shall be obtained from the respective State or Divisional Head of the Department of Health.

33. For implementing the provisions of this Law; -

(a) the Ministry of Health may, with the approval of the Government, issue necessary procedures;

(b) the Council may issue necessary orders and directives.

34. The Midwives and Nurses Act is hereby repealed.

Sd/. Saw Maung
Senior General
Chairman
The State Law and Order Restoration Counc

Component II

The component II comprises of three essential concerns for ethical professional practices :

Principles of Medical Act
Ethical Misconduct
Myanmar Medical Council Guidelines for General Medical Practice

In provision of health care to mankind, strictly obliging the principles of professional ethic is far more essential than that of a sound clinical skill. The guidelines on duties and responsibilities of general medical doctors by Myanmar Medical Council is presented.

Principles of Medical Ethics

Adopted by the AMA House of Delegates June 17, 2001

Preamble

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognise responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standard of conduct which define the essentials of honourable behaviour for the physician.

A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

A physician shall respect the law and also recognised a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

A physician shall respect the rights of the patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

A physician shall recognise a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

A physician shall support access to medical care for all people.

MEDICAL ETHICS AND PROFESSIONALISM

Ethics:A system of moral principles governing the appropriate conduct for an individual or group

Medical ethics:is therefore ethics that is governed by the collective opinion and behaviour of the medical profession

Profession: An occupation that requires a high level of training and/oreducation

Professionalism: The skill, competence or character expected of a member of a highly trained profession

Ethical Misconduct

What is ethical misconduct?

The following represent the main acts of ethical misconduct:

(a) Negligence

Failure to exercise the care that would be used by a reasonably prudent physician in the same situation.

Doctors have a responsibility to exercise reasonable care when treating their patients. When a doctor deviates from accepted medical standards in the treatment of a patient, he or she has breached that, responsibility and is negligent.

(b) Incompetence

A physician who does not posses the requisite skill and knowledge to practice medicine is considered incompetent.

(c) Impairment

This does not mean the doctor is disable. It only means that those doctors whose physical or mental impairments compromise their patients' safety are regarded as being impaired; e.g. doctors practicing while under the influence of substance abuse.

(d) Sexual abuse

Sexual abuse may include inappropriate and/or suggestive remarks, improper touching and actual physical violations such as rape.

OTHER MISCONDUCTS

Fraud

The intentional misrepresentation or concealment of a known fact within the practice of the profession.

Examples:

(a) Knowingly submitting false bills for services Submitting false or exaggerated medical report. Giving false statements for the sake of privilege (e.g. hospital privileges) Prescribing controlled substances for other than a good faith medical purpose.

Conviction/Discipline by other jurisdictions

34.ng found guilty of a crime

35.ing been disciplined by another regulatory agency

Referral fees and Fee splitting

(a) Offering, giving, soliciting or receiving any fee or consideration from a third party for a referral of a patient or in connection with the performance of professional services Permitting any person (except partners, employees) to shares in the fees.

Advertising/Self-promotion Doctors found to be exercising undue influence on a patient by promoting the sale of services, goods, appliances or drugs to exploit the patient for financial gain can be persecuted for misconduct.

Doctors may also be cited for guaranteeing satisfaction or a cure will result from services provided, and for claiming or using

Patient abandonment/Staff supervision

Doctors may not abandon or neglect patients under their care who are in need of immediate services. They must make reasonable arrangements for continuation of care. Doctors must adequately supervise the staff under them and not delegate professional responsibilities to unqualified individuals.

Myanmar Medical Council Guidelines for General Medical Practice

Duties and responsibilities of doctors

July 2003

Patients must be able to trust doctors with their lives and well-being. To justify that trust, we as a profession have a duty to maintain a good standard of practice and care and to show respect for human life. In particular as a doctor you must:

(a) Make the care of your patient your first concern;

(b) Treat every patients politely and considerately;

(c) Respect patients' dignity and privacy;

(d) Listen to patients and respect their views;

(e) Give patients information in a way they can understand;

(f) Respect the right of patients to be fully involved in decisions about their care;

(g) Keep your professional knowledge and skills up to date;

(h) Recognise the limits of your professional competence;

(i) Be honest and trustworthy;

(j) Respect and protect confidential information;

(k) Make sure that your personal beliefs do not prejudice your patients' care;

(l) Act quickly to protect patients from risk if you have good reason to believe that you or a colleague may not be fit

(n) Practice; Avoid abusing your position as a doctor; and

(m) Work with colleagues in the ways that best serve patients' interests.

In all these you must never discriminate unfairly against your patients or colleagues. And you must always be prepared to justify your actions to them.

Providing a good standard of practice and care

All patients are entitled to good standards of practice and care from their doctors. Essential elements of this are professional competence; good relationships with patients and colleagues; and observance of professional ethical obligations.

Good clinical care

- **Good clinical care must include:**

(i) An adequate assessment of the patient's condition, based on the history and clinical signs and, if necessary, an appropriate examination;

❖ Taking suitable and prompt action when necessary;

3. **In Providing care you must:**

(ii) Recognise and work within the limits of your professional competence;

(iii) Prescribe only the treatment, drugs or appliances that serve the patient's need.

Maintaining good medical practice

Keeping up-to-date

- You must keep your knowledge and skills up-to-date throughout your working life. In particular, you should take part regularly in educational activities, which develop your competence and performance.
- Some parts of medical practice are governed by law or are regulated by other statutory bodies. You must observe and keep up to date with the laws and statutory codes of practice, which affect your work.

Maintaining your performance

- Take part in regular and systematic medical and clinical audit, recording data honestly. Where necessary you must respond to the results of audit to improve your practice, for example by undertaking further training;
- Respond constructively to assessments and appraisals of your professional competence and performance.

Teaching and training

- If you have special responsibilities for teaching you must develop the skills, attitudes and practices of a competent teacher. You must also make sure that students and junior colleagues are properly supervised.
- You must be honest and objective when assessing the performance of those you have supervised or trained. Patients may be put it at risk if you confirm the competence of

someone who has not reached or maintained a satisfactory standard of practice.

References

- When providing references for colleagues your comments must be honest and justifiable; you must include all relevant information, which has a bearing on the colleague's competence, performance, reliability and conduct.

Maintaining trust

Professional relationships with patients

- Successful relationships between doctors and patients depend on trust. To establish and maintain that trust you must:

(iv) Treat patients politely and considerately;

(v) Respect patients privacy and dignity;

(vi) Treat information about patients as confidential. If in exceptional circumstances you feel you should pass on information without a patient's consent, or against a patient's wishes, you should follow or guidance on confidentially and be prepared to justify your decision;

(vii) Give information to patients in a way then can understand;

(viii) Be satisfied that, wherever possible, the patient has understood what is proposed, and consent to it, before you provide treatment or investigate a patient's condition;

(ix) Respect the right of patients to be fully involved in decisions about their care;

(x) Respect the right of patients to decline treatment or decline to take part in teaching or research;

(xi) Respect the right of patients to a second opinion;

· The investigations or treatment you provide or arrange must be based on your clinical judgment of the patient's needs and the likely effectiveness of the treatment. You must not allow your views about a patient's lifestyle, culture, belief, race, colour, gender, sexually, age, social status, or perceived economic worth to prejudice the treatment you provide or arrange.

· If you feel that your beliefs might affect the treatment you provide, you must explain this to patients, and tell them of their right to see another doctor.

If things go wrong

+ **If** a patient under your care has suffered serious harm, through misadventure or for any other reason, you should act immediately to put matters right, if that is possible. You should explain fully to the patient what has happened and the likely long and short-term effects. When appropriate you should offer an apology. If the patient is under 12 and lacks the maturity to consent to treatment, you should explain the situation honestly to those with parental responsibility for the child.

· If a patient under 12 has died you must explain, to the best of your knowledge, the reasons for, and the circumstances of the death to those with parental responsibility. Similarly, if an adult patient has died, you should provide this information to the patient's partner or next of kin, unless you know that the patient would have objected.

Abuse of your professional position

· You must not abuse your patients' trust. You must not, for example:

m Use your position to establish improper personal relationships with patients or their close relatives;

m Improperly disclose or misuse confidential information about patients;

Working with colleagues

v You must always treat your colleagues fairly. In accordance with the law, you must not discriminate against colleagues, including doctors applying for posts, on grounds of their sex, race or disability. And you must not allow your views of colleagues' lifestyles, culture, belief, race colour, gender, sexually, or age to prejudice your professional relationship with them.

v You must not make any patient doubt a colleague's knowledge or skills by making unnecessary or unsustainable comments about them.

- **If you lead the team you must:**

m Take responsibility for ensuring that the team provides care which safe, effective and efficient.

- Do your best to make sure that the whole team understands the need to provide a polite, responsive and accessible service and to treat patient information as confidential.

Delegation and referral

+ Delegation involves asking a nurse, doctor, medical student or other healthcare worker to provide treatment or care on your behalf. When you delegate care or treatment you must be sure that the person to whom you delegate is competent to carry out the procedure or provide the therapy involved. You must always pass on enough information about the patient and the treatment needed. You will still be responsible for the overall management of the patient.

Providing information about your services

+ If you publish or broadcast information about services you provide, the information must be factual and verifiable. It must be published in a way that conforms with the law and with the guidance issued by the Advertising Standards Authority.

+ Information you publish must not make claims about the quality of your services not compare your services with those your colleagues provide. It must not, in any way, offer guarantees of cures, nor exploit patient's vulnerability or lack of medical knowledge.

+ lamination you publish about your services must not put pressure on people to use a service, for example by arousing ill-founded fear for their future health. Similarly, you must not advertise your services by visiting or telephoning prospective patients either in person or through a deputy. The signboard should only indicate the name, degree or diploma, speciality recognised by Myanmar Medical Council and rank or title, if any.

Financial and commercial dealings

+ You must be honest in financial and commercial matters relating to your work. In particular:

(xii) If your charge fees, you must tell patients if any part of the fee goes to another doctor.

(xiii) There are no fixed fees in the medical profession however the fees should not be exuberant or extortionate and should not be related to irrelevant investigations or treatments.

Conflicts of interest

1. You must act in your patient's best interests when making referrals and providing or arranging treatment or care. So you must not ask for or accept any inducement, gift or hospitality which may affect or seen to affect your judgement. You should not offer such

inducements to colleagues.

Financial interests in hospitals, nursing homes and other medical organisations

2. If you have financial or commercial interests in organisations providing health care or on pharmaceutical or other biomedical companies, these must not affect the way you prescribe for treat or refer patients.

Accepting gifts or other inducements

3. You should not ask for or accept any material gifts or loans, except those of insignificant value, from companies that sell or market drugs or appliances. You must not ask for or accept fees for agreeing to meet sales representatives.

Hospitality

4. You may accept personal travel grants and hospitality from companies for conferences or educational meetings, as long as the main purpose of the event is educational. The amount you receive must not be more than you would normally spend if you were paying for yourself. The objective of the travel grants hospitality should not influence the use of their products.

Signing certificates and other documents

5. Registered medical practitioners have the authority to sign a variety of documents, such as death certificates, on the assumption that they will only sign statements they believed to be true. This means that you must take reasonable steps to verify any statement before your sign a document. You must not sign documents, which you believe to be false or misleading.

Research

6. If you take part in clinical drug trials or other research involving patients or volunteers, you must make sure that the individual has given written consent to take part in the trial and that the research is not contrary to the individual's interests. You should always seek further advice where your research involves adults who are not able to make decisions for themselves and children. You must check that the research protocol has been approved by a property constituted research ethics committee.

Access to Essential Medicine and Technology

It comprises of - Nation Drug Law (1992) and Traditional Drug Law (1996)

Nation Drug Law (1992) - enacted to ensure access by the people safe and efficacious drugs. It describes requirement for licensing in relation to manufacturing, storage, distribution and sale of drugs. It also includes provisions on formation and authorization of Myanmar Food and Drug Board of Authority.

Traditional Drug Law (1996) - Concerned with labelling, licensing and advertisement of traditional drugs to promote traditional medicine and drugs. It also aims to enable public to consume genuine quality, safe and efficacious drugs. The law also deals with registration and control of traditional drugs and formation of Board of Authority and its functions.

The National Drug Law

The State Law and Order Restoration Council enacted *The National Drug Law* as the SLORC Law No. 7/92 on 30 October 1992 as:

Chapter I

Title and Definition

1. This Law shall be called the National Drug Law.

2. The following expressions contained in this Law shall have the meanings given hereunder: -

(a) Board of Authority means the Myanmar Food and Drug Board of Authority formed under this Law.

(b) Drug means a substance for use, whether internal or external in the diagnosis, prevention and treatment of disease, birth control or for any beneficial effect in human beings and animals. This expression also includes a substance determined as a drug by the relevant Ministry by notification from time to time;

(c) Essential Drug means a drug which is determined by the Board of Authority and which is essential for the health care of the majority of the people;

(d) Fake Drug means the following

(i) a drug the whole or part of the label of which is an imitation or a resemblance by various means or is written similarly:

(ii) a drug in respect of which the expiration date or manufacturer or distributor or place of manufacture or country of manufacture is fraudulently shown;

(iii) a drug in respect of which it is fraudulently shown that it is manufactured according to the formula mentioned at the time of registration of the drug;

(e) **Drug Differing from Standards** means a drug which is not in conformity with the specifications of a relevant drug or a drug which is lower or higher than the minimum or maximum standards prescribed by the Board of Authority in respect of the standard of drugs;

(f) **Drug Specifications** mean a statement of complete specifications relating to such drug or complete specifications mentioned in the pharmacopoeias recognized by the Board of Authority.

(g) **Deteriorated Drug** means a drug the expiration date of which has been reached or is past or a drug which has so denatured in any manner that it has become a drug differing from standards;

(h) **Adulterated Drug** means a drug which contains wholly or partly, a deteriorated drug, other drugs or substances;

(i) **Expiration Date** means the date mentioned on the label of a drug to indicate that such drug no longer possesses the claimed efficacy, safety and quality;

(j) **Label** means the indication in manuscript or printed, which is displayed on the container, bottle, pack, outer package or any packing material in which the drug is contained;

(k) **Labelling** means the act of displaying labels on the container, bottle, pack, outer package or any packing material in which the drug is contained;

(l) **Pharmaceutical Raw Material** means the substance to be used in the manufacture of a drug and which is determined by the Board of Authority.

(m) **Drug Registration** means the registration of the drug with the Board of Authority for the purpose of manufacture, import, export, storage, distribution and sale of the drug;

(n) **Licence** means a permit granted for the manufacture, storage, distribution and sale of pharmaceutical raw material or drug;

(o) **Drug Manufacture** means the operations to be carried out in the manufacture of a drug. This expression also includes the performance of all operations carried out in processes commencing from the pharmaceutical raw material or performance of any stage of those processes. However, it does not include compounding of drugs according to medical practitioner's or dentist's or veterinarian's prescription for the relevant patient at a hospital, dispensary and drug retail shops;

(p) **Sale of Drug** means an offer, agreement, attempt, exhibition, storage, possession, distribution and sale for the purpose of selling the drug;

(q) **Storage of Drug** means systematic storage to preserve the efficacy of the drug;

(r) **Quality Assurance** means the warranty of the whole process including obtaining of pharmaceutical raw material, manufacture of the drug, packing, storage, distribution and sale, with the object of enabling every consumer of the drug to use genuine quality, safe and effective drug;

(s) **Advertising** means carrying out measures in a direct or indirect manner to inform the public in order to promote distribution and sale of the drug;

(t) **Primary Laboratory** means a laboratory prescribed by the Board of Authority by notification to analyse samples of the drug;

(u) **Appellate Laboratory** means a laboratory specified by the Board of Authority in order that a final and conclusive decision may be made in respect of analysis remarks of drugs from primary laboratories or when either party is dissatisfied and files an appeal.

Chapter II

Aims

3. The Myanmar Food and Drug Board of Authority is formed with the following aims: -

(a) to enable the public to use genuine quality, safe and effective drugs;

(b) to register drugs systematically;

(c) to enable the public to consume genuine quality and safe food;

(d) to control and regulate systematically manufacture, import, export, storage, distribution and sale of food and drugs.

Chapter III

Formation of the Myanmar Food and Drug Board of Authority

4. The Government shall form the Myanmar Food and Drug Board of Authority consisting of the following persons: -

(a) Minister — Chairman
Ministry of Hearth

(b) Deputy Minister — Vice-Chairman
Ministry of Health

(c)	Director-General Department of Health Ministry of Health	Member
(d)	Director of Medical Services Ministry of Defence	Member
(e)	Director-General General Administration Department Ministry of Home Affairs	Member
(f)	Director-General Livestock Breeding and Veterinary Department Ministry of Livestock Breeding and Fisheries	Member
(g)	Managing Director Medicines and Medical Equipment Trading Ministry of Trade	Member
(h)	Managing Director Myanmar Phamacecutical Industries Ministry of No 1 Industry	Member
(i)	Managing Director Myanmar Agriculture Service Ministry of Agriculture	Member
(j)	Managing Director Myanmar Foodstuff Industries Ministry of No 1 Industry	Member
(k)	An expert each relating to the following subjects:	Member
(1)	Medicine	
(2)	Pharmacology	
(3)	Pharmacy	
(4)	Veterinary Science	
(5)	Chemistry	
(6)	Pharmaceutical Industry	
(l)	A person assigned responsibility by the Chairman	Secretary

Chapter IV

Functions and Duties

5. The functions and duties of the Board of Authority are as follows:-

(a) laying down the policy relating to registration of drugs;

(b) laying down the policy relating to determination of an essential drug;

(c) laying down the policy relating to the utilization of drug;

(d) determining the qualifications of persons entitled to apply for licence and the terms and

conditions thereof for the manufactures, storage, distribution and sale of pharmaceutical raw material or registered drug;

(f) determing good practices for assurance of quality in respect of manufacture, clinical tests and laboratory analyses of the phamaceutical raw material or registered drug and all matters relating to drugs;

(g) permitting, refusing, temporary revocation and cancellation of registration of drug;

(h) granting, refusing, temporary revocation and cancellation of a licence;

(i) stipulating terms and conditions relating to labelling of drugs, and advertising;

(j) determining and cancelling any type of substance as a drug;

(k) forming committees in respect of matters relating to expertise and determining the functions and duties of such committees

(l) forming Food and Drug Supervisory Committees in the States, Divisions, Districts and Townships in order to supervise matters relating to food and drug; determining the functions and duties of such committees;

(m) prescribing primary laboratories and appellate laboratories;

(n) stipulating terms and conditions relating to food.

6. The Board of Authority may delegate any organization or any person to carry out its functions and duties.

Chapter V

Registration

7. A person desirous of manufacturing, importing, exporting, storing, distributing and selling phamaceutical raw material or drug shall register the relevant drug with the Board of Authority in the prescribed manner.

Chapter VI

Application for Licence

8. A person desirous of manufacturing storing, distributing and selling pharmaceutical raw material or registered drug shall apply for a licence in the prescribed manner.

Chapter VII

Quality Assurance

9. A person who has been granted the right to manufacture, import, export, store, distribute or sell pharmaceutical raw material or registered drug shall abide strictly by the order, directive and conditions issued by the Board of Authority in respect of quality assurance of the drug.

10. A person who has been granted registration of the drug or who has obtained a licence shall abide strictly by the order, directive and conditions issued by the Board of Authority in respect of labelling and advertising.

Chapter IX

Temporary Revocation or Cancellation of Licence

11. A person who has obtained a licence violates or is considered to have violated any order, directive or condition issued under this Law in respect of the manufacture, import, export,

storage, distribution and sale of pharmaceutical raw material or registered drug, the Board of Authority or the organization which has been delegated for such purpose may revoke temporarily or cancel the licence subject to a time limit.

12. A person whose licence has been cancelled may hand over or drugs in his possession to another person who has obtained a licence, within 30 days with the approval of the Board of Authority or the relevant organization.

Chapter X

Appeal

13. A person dissatisfied with a decision made by the organization or person delegated by the Board of Authority, in respect of the refusal to grant a licence, temporary revocation or cancellation of the licence may file an appeal to the Board of Authority within 60 days from the date of such decision.

14. The decision made by the Board of Authority shall be final and conclusive.

Chapter XI

Prohibition

15. (a) No one shall manufacture, import, export, store, distribute or sell the following drug;

(i) a drug which has not been registered;

(ii) a drug whose regulations has been revoked temporarily or cancelled;

(iii) fake drug, drug differing from standards, deteriorated drug, adulterated drug;

(iv) a drug which has been manufactured with harmful substances;

(v) a dangerous drug which is determined as not fit for utilization by the Ministry of Health by notification.

(b) No one shall import or export a registered drug without permission under any existing law.

16. No one shall manufacture, store, distribute or sell a pharmaceutical raw material or drug without a licence.

17. A person who has obtained a licence -

(a) shall not fail to abide by any condition of the licence;

(b) shall not fail to abide by the orders and directives issued by the Ministry of Health or by the Board of Authority under this Law.

Chapter XII

Offences and Penalties

18. Whoever violates any provision of section 15 shall, on conviction be punished with fine which may extend from a minimum of kyats 5,000 to a maximum of kyats 50,000 or with imprisonment for a term which may extend to 7 years or with both. In addition, the exhibits involved in the offence shall also be liable to be confiscated.

19. Whoever violates any provision of section 16 shall, on conviction -

(a) if it is an offence relating to an unregistered drug, be punished with fine which may extend from a minimum of kyats 5,000 to a maximum of kyats 50,000 or with imprisonment for a term which may extend to 7 years or with both;

(b) if it is an offence relating to a registered drug, be punished with fine which may extend from a minimum of kyats 1,000 to a maximum of kyats 10,000 or with imprisonment for a term which may extend to 2 years or with both;

(c) the exhibits involved in the offence shall also be liable to be confiscated.

20. A person who has obtained a licence and who violates any provision of section 17 shall, on conviction be punished with fine which may extend from a minimum of kyats 500 to a maximum of kyats 5,000 or with imprisonment for a term which may extend to 1 year or with both.

Chapter XIII

Miscellaneous

21. Notwithstanding anything contained in the Union of Myanmar Public Health Law, 1972, the provisions of this Law shall be complied with in cases relating to drugs, with the exception of traditional drugs;

22. The Ministry of Health may exempt any Government department or organization from compliance with any provision of this Law.

23. The provisions of this Law shall not apply to drugs brought personally from abroad for personal use.

24. The Government department or organization which is authorized to grant permission to import or to export may grant permission for import or export only of drugs registered under this Law.

25. Persons engaged in drug business on the day this Law is enacted shall carry out registration and obtaining of licence within the period prescribed by the Board of Authority.

26. In instituting legal proceedings under this Law, prior sanction of the Ministry of Health or the organization or person delegated with powers for this purpose shall be obtained.

27. When a drug which has been imported or exported without any permission under any existing law is seized by the relevant Government department or organization, it shall be handed over or disposed of in the manner prescribed by the Board of Authority.

28.(a) The expenditures of the Board of Authority shall be borne by the Ministry of Health.

(b) The Ministry of Health shall employ the staff required for performance of the office work of the Board of Authority.

28. In order to administer all food and drug matters, the Ministry of Health shall form the Food and Drug Administration Department and determine the functions and duties thereof.

29. The Ministry of Health shall assign responsibility as Drug Inspectors to the staff subordinate to it, in order to carry out inspection of the drugs. In addition, it may also assign responsibility as Drug Inspectors to suitable staff, in co-ordination with other Ministries.

30. The orders and directives issued under the Union of Myanmar Public Health Law, 1972 may continue to be applicable in so far as they are not inconsistent with this Law.

31. For the purpose of carrying out the provisions of this Law -

(a) the Ministry of Health may issue rules and procedures as may be necessary, with the approval of the government;

(b) the Ministry of Health and the Myanmar Food and Drug Board of Authority may issue orders and directives as may be necessary.

Sd./ Than Shwe
General
Chairman
The State Law and Order Restoration Council

The Traditional Drug Law

ChapterI

Title and Definition

1. This Law shall be called the Traditional Drug Law.

2. The following expressions contained in this Law shall have the meanings given hereunder:-

Traditional Drug means a local concoction for use either directly of indirectly, whether internally or externally, in the diagnosis, prevention and treatment of diseases, promotion of health or for any beneficial effect in human beings and animals. This expression also includes a substance determined as a traditional drug by the Ministry of Health by notification from time to time;

(a) Traditional Medicine means medicine for the physical well-being and longevity of people in accordance with anyone of the four nayas of traditional medicine, namely Desana naya, Bethitsa naya, Netkhata vedanaya and Vissadara naya;

(b) Board of Authority means the Myanmar Food and Drug Board of Authority constituted under the National Drug Law and incorporated under the provision of section 4 of this Law;

(c) Essential Traditional Drug means a traditional drug which is determined by the Board of Authority and which is essential for the health care of the majority of the people;

(d) Traditional Drug Differing from Standards means traditional drug which is concocted not in conformity with the formula mentioned at the time of its registration;

(e) Deteriorated Traditional Drug means a traditional drug, the expiration date of which has been reached or passed or a traditional drug which has so denatured in any manner that it has become a traditional drug differing from standards;

(f) Expiration Date means the date mentioned on the label of a traditional drug by the producer of the traditional drug with the approval of the Board of Authority to indicate that such a drug no longer possesses the claimed efficacy, potency, safety and quality;

(g) Label means the indication in any manner, displayed on the material in which the traditional drug is contained or with which the traditional drug is packed;

(h) Traditional Pharmaceutical Raw Material means the substance to be used mainly in the manufacture of a traditional drug and which is determined by the Board of Authority;

(i) Traditional Drug Registration means the registration of the traditional drug which is to be manufactured, with the Board of Authority;

(j) Licence means a permit granted for the manufacture of the traditional drug;

(k) Traditional Drug Manufacture means the operations to be carried out in the manufacture of a traditional drug. This expression also includes the performance of all or any one of the operations carried out in processes. It does not, however, include compounding of drugs according to traditional medical practitioner’s prescription for use in his treatment of patients at a hospital, dispensary or pharmacy for indigenous medicinal ingredients or to the prescription of any drug or homely remedy ofany person for his own personal use;

(l) Homely Remedy means a traditional concoction from readily available materials, ingredients, or folk medicine;

(m) Quality Assurance means the warranty of the manufacturer of the traditional drug that it is effective, genuine and safe in the treatment of one or more diseases it claims to cure;

(n) Advertising means carrying out measures in any manner to inform the public in order to promote distribution and sale of the traditional drugs;

(o) Primary Laboratory means a laboratory prescribed by the Board of Authority by notification to analyse samples of the traditional drug;

(p) Appellate Laboratory means a laboratory specified by the Board of Authority in order that a final and conclusive decision may be made in respect of analysis of the traditional drug after re-analysis of samples, when a problem arises in respect of the analysis report of drugs from primary laboratories or when either party is dissatisfied and files an appeal.

ChapterII

Aims

3. The aims of this law are as follows:-

(a) to promote and develop traditional medicine and traditional drugs;

(b) to enable the public to consume genuine quality, safe and efficacious traditional drugs;

(c) to register traditional drugs systematically;

(d) to control and regulate systematically the manufacture of traditional drugs.

Chapter III

Formation of the Board of Authority and Functions thereof

4. For the purpose of carrying out measures relating to traditional drugs mentioned in this Law, the Government shall incorporate in the Myanmar Food and Drug Board of Authority expert pharmacologists and other qualified persons.

5. Non-governmental members of the Board of Authority are entitled to remuneration prescribed by the Ministry of Health.

6. The functions and duties of the Board of Authority formed under section 4 are as follows:-

(a) laying down policy relating to registration of traditional drugs;

(b) causing experiments, analyses and tests to be carried out as may be necessary, in order to determine whether the traditional drugs for which registration is applied for are in conformity with the traditional medicine treatises used by generations of traditional medical practitioners, whether they are up to the standard in quality and effectiveness, whether they are safe for consumption;

(c) determining the qualifications of persons entitled to apply for licence and the terms and conditions thereof for the manufacture of the registered traditional drug;

(d) stipulation terms and conditions relating to labelling of drugs, altering of labels and advertising;

(e) stipulating terms and conditions relating to the quality assurance of the registered traditional drug;

(f) selecting and determining essential traditional drugs;

(g) declaring substances determined as traditional pharmaceutical raw materials;

(h) determining traditional drugs and raw materials which are unfit for use by the public and submitting them to the Ministry of Health;

(i) co-ordinating with the Ministries concerned to conserve and prevent the traditional

pharmaceutical rawmaterials from the danger of extinction;

(j) disseminating of techniques and methods relating to collection, production, storage and preservation of traditional pharmaceutical raw materials;

(k) giving guidance to conduct research work for raising the standard and modernization of traditional drugs;

(l) giving advice to Government departments and organizations which produce or import traditional pharmaceutical raw materials;

(m) carrying out educative activities for extensive use of traditional drugs by the public;

(n) forming of committees as may be necessary to deal with technical matters and determining the functions and duties thereof;

(o) forming of Traditional Drug Supervisory Committees in States and Divisions, Districts and Townships and determining the functions and duties thereof;

(p) determining Primary and Appellate Laboratories.

7. If there arises a controversy or dispute with respect to a substance, the Board of Authority shall determine whether it is a traditional drug or a traditional pharmaceutical raw materials.

8. The Board of Authority may co-ordinate with the Ministry concerned in order to supervise the collection, production, storage, marketing, export and import of traditional pharmaceutical raw materials.

9. The Board of Authority may delegate any organization or any person to carry out its functions and duties.

ChapterIV

Registration of Traditional Drugs

10. A person desirous of registering a traditional drug with the Board of Authority may do so in accordance with the stipulations.

11. The Board of Authority may, after carrying out analyses, experiments and tests, as may be necessary, permit or refuse the registration.

12. The tenure of registration, registration fees and the fees for extension of the tenure of registration are as prescribed by die Bi~m’t1 of Authority.

13. A person who is permitted to register the traditional drug:-

(a) shall pay the prescribed registration fees;

(b) shall abide by the conditions relating to registration and shall also abide by the orders and directives issued by the Board of Authority;

(c) on the expiry of die tenure of registration, may extend it by paying the prescribed fees for extension of the term of registration.

14. If a person who has been permitted to register the traditional drug is found on investigation to have violated any condition relating to permission for registration or any order or directive issued by the Board of Authority the organization or person to whom the Board of Authority has assigned responsibility may revoke the registration subject to a time Limit or cancel it.

15. A person whose registration has been revoked subject to a time limit may apply for renewal of the registration to the Board of Authority on the expiry of the time limit.

16. A person whose registration of the traditional drug has been cancelled shall, with respect to the traditional drugs in his possession comply with the direction of the Board of Authority.

ChapterV

Application for Licence

17. A person desirous of manufacturing a registered traditional drug shall apply for a licence to the Board of Authority in accordance with the stipulations.

18. The Board of Authority may cause scrutiny to be made as to whether or not the application is in conformity with the stipulations and may if necessary issue the licence or refuse to issue the licence.

19. The tenure of the licence, the licence fees and the fees for extension of the tenure of the licence shall be as prescribed by the Board of Authority.

20. A person who has obtained a licence shall:-

(d) pay the prescribed licence fees;

(e) abide by the conditions contained in the licence as well as the orders and directives issued by the Board of Authority;

(f) on expiry of the tenure of the licence pay the fees for extension of the tenure of the licence and extend the tenure of the same.

21. If a person who has obtained a licence is found on investigation to have violated any condition of the licence or any order or directive issued by the Board of Authority, the organization to which or the person to whom the Board of Authority has assigned responsibility may revoke the licence subject to a time limit or cancel it.

22. A person whose licence has been revoked subject to a time limit may apply for renewal of the licence to the Board of Authority on expiry of the time limit.

23. A person whose licence has been cancelled:-

(m) shall not apply for a new licence;

(n) may hand over or sell the traditional drugs in his possession which are determined by the Board of Authority as of standard quality to another person who has obtained a licence, within 60 days;

(o) with respect to traditional drugs in his possession, which are below standard quality shall dispose them of as directed by the Board of Authority.

24. The Department of Traditional Medicine may direct the State and Divisional, District and Township Traditional Drugs Supervisory Committees to seize the traditional drugs which are below standard quality and which have been manufactured and distributed by a person whose licence has been cancelled.

ChapterVI

Appeals

25. A person dissatisfied with any of the following decisions made by the organization or person assigned responsibility by the Board of Authority in respect of a traditional drug may file an appeal to the Board of Authority within 60 days from the date of such decision:-

(a) Refusal to permit registration, revocation subject to a time limit or cancellation of

registration;

(b) Refusal to grant licence, revocation subject to a time limit or cancellation of licence.

26. The decision of the Board of Authority shall be final and conclusive.

ChapterVII

Prohibition

27. No one shall manufacture the following traditional drug:-

(a) a traditional drug which has not been registered;

(b) a drug for which registration has been revoked subject to a time limit or cancelled;

(c) a traditional drug differing from standards;

(d) a traditional drug which is determined as unfit for use by the Ministry of Health by notification.

28. No one shall sell the following traditional drug:-

(g) a traditional drug which has not been registered;

(h) a traditional drug for which registration has been revoked subject to a time limit or cancelled;

(i) a deteriorated traditional drug;

(j) a traditional drug which is determined as unfit for use by the Ministry of Health by notification.

29. No one shall manufacture a traditional drug without a licence.

30. A person who has obtained a licence:-

(k) shall not fail to abide by any condition of the licence;

(l) shall not fail to abide by the orders and directives issued by the Ministry of Health, the Board of Authority, or the Department of Traditional Medici~

ChapterVIII

Offences and Penalties

31. Whoever violates any provision of section 27 or section 28 of this Law shall, on conviction, be punished with fine which may extend to kyats 30,000 or with imprisonment for a term which may extend to 3 years, or with both. In addition, the exhibits involved in the offence shall also be liable to be confiscated.

32. Whoever violates any provision of section 29 shall, on conviction:-

(a) if it is an offence relating to an unregistered traditional drug, be punished with fine which may extend to Kyats 30, 000, or with imprisonment for a term which may extend to 3 years, or with both;

(b) if it is an offence relating to a registered traditional drug, be punished with fine which may extend to Kyats 10,000, or with imprisonment for a term which may extend to two years, or with both;

(c) the exhibits involved in the offence shall also be liable to be confiscated.

33. A person who, has obtained a licence and who violates any provision of section 30 shall, on conviction, be punished with fine which may extend to Kyats 5,000, or with imprisonment which may extend to one year, or with both.

ChapterIX

Miscellaneous

(a) Notwithstanding anything contained in the Union of Myanmar Public Health Law, 1972, the provisions of this Law shall be complied with in cases relating to traditional drugs.

(b) The Ministry of Health may exempt any Government department or organization from compliance with any provision of this Law.

(c) The Government department or organization which is authorised to issue export permits may issue export permits only for traditional drugs registered under this Law.

(d) A person engaged in manufacturing of traditional drugs shall, on the day this Law is enacted, take steps to register and obtain the required licence within the period perscribed by the Board of Authority.

(e) In instituting legal proceedings under this Law, prior sanction of the Ministry of Health or the organization or person delegated with powers for this purpose shall be obtained.

(f) When a traditional drug which is exported without any permission under any existing law is seized by the relevant Government department or organization, it shall be handed over or disposed of in the manner prescribed by the Board of Authority.

(g) The office work of the Board of Authority shall be carried out by the Department of Traditional Medicine.

(h) The Ministry of Health shall assign responsibility as Traditional Drug Inspectors to the staff subordinate to it for inspection of traditional drugs. In addition, it may also assign responsibility as Traditional Drug Inspectors to suitable staff in co-ordination with other Ministries.

(i) The orders and directives issued under the Union of Myanmar Public Health Law, 1972,may continue to be applicable in so far as they are not inconsistent with this Law.

(j) For the purpose of carrying out the provisions of this Law:-

(a) the Ministry of Health may issue rules and procedures as may be necessary, with the approval of the Government;

(b) the Ministry of Health, the Board of Authority and the Department of Traditional Medicine may issue orders and directives as may be necessary.

Sd./ Than Shwe
Senior General
Chairman
The State Law and Order Restoration Council

Health Information and Research

The vision statement for HIS is - A simple, effective and systematic health information system established at all levels of health care delivery for the strengthening of health system with the general objective of to improve the availability, accessibility and utilization of quality health information. Its strategy and planned activity dimensions in the health care system has already been elaborated previously.

Myanmar Medical Research Council Act

The Burma Medical Research Council was formed by an Act of the Revolutionary Government of the Union of Burma which was promulgated in October 1962 as the 37'h Act of the Revolutionary Government.

The Preamble of the Act states that:

"The Revolutionary Government of the 'Union of Burma desirous of

(a) improving the health of the people residing in the 'Union of Burma;

(b) advancing azalea(and allied sciences in this country through research;

(c) co-ordinating the work, of individual scientists and organizations interested in. medical research, hereby form the Burma Medical Research

The fact that the Act was promulgated just seven months after the formation of the Revolutionary Government signifies the importance it attaches to medical research for the improvement of the health of the population. Colonel Hla Han the Minister of Health and Education, in his inaugural address delivered at the 2nd Burma Medical Research Council Conference held in 1968 gave the background for the decision to form the Burma Medical Research Council. He said :

"Some years back a group of doctors who realized that medical research is important and essential for the country got together and formed the Burma Medical Research Society. The Society did not get the financial support of the Government and had to be content with supporting medical research within its own financial resources permit"

"It is because we believe that the government should actively support research that the Burma Medical Research Council Act of 1962 was enacted and the Burma Medical Research Institute established. It is because we believe that no matter how poor the country may be, research, should he supported" because it is essential for progress. It is because of these reasons that the Government has been supporting medical research as much as its financial resources permit ..."

Composition of the Burma Medical Research Council

The Council was composed as follows:

(a) Member of the Revolutionary Council responsible for Health (as the Minister of Health was then designated) ... Chairman

(b) Director, Directorate **of** Health Services ... Vice-Chairman

(c) The Rector, Institute of Medicine 1, Rangoon

(d) The Rector, Institute of Medicine, Mandalay

(e) The President, Burma Medical Research Society

(f) The Director-General, Union of Burma Applied Research Institute

(g) The Director of Medical Services, Ministry of Defence

(h) Five members nominated by the Revolutionary Government of the Union of Burma

(i) The Director, Burma Medical Research Institute - Secretary

There were also members nominated by the Government.

The Council existed as a separate semi-autonomous organization under the Ministry of Health. The BMRC Act, (now it is MRC Act) provided for a separate Council Fund which would receive government's allotment to the Council to carry out itsits mandate as well as income and contributions from other sources, and from which the Council was empowered by its Bye-laws to

prepare, approve and administer its own budget, create and abolish posts and make rules for disbursements of research grant.

With regard to the formulation and execution of research policy, the Council sought to obtain representative views from the medical scientific community and formed Scientific Advisory Committees covering a wide range of subjects, with membership comprising experts and leaders in different disciplines from the health services, medical education and medical research.

The Burma Medical Research Institute established soon after in 1963 became the executive arm of the Council and under its supervision took care of administrative and financial matters as well as research management functions in accordance with the policy, general directives and authorization of the Council.

Health Financing

Health financing is one of the major issues currently the country is facing health care system. Out-of-Pocket expenditure is inclining and some studies has already reflected more than 92%. *The Social Security Law* has made a huge pave way for the nation release the burden. The main objectives are: to support the development of the State's economy through the development of production by causing to enjoy more security in social life and health care by the workers who are major productive force of the State by the collective guaranty of the employer, worker and the State; to enjoy more security in social life and medical care by the public by effecting their insurance voluntarily; to raise public confidence upon the social security scheme by providing benefits which are commensurate with the realities; to have the right to draw back some of the contributions paid by the employers and the workers as savings, in accord with the stipulations; to obtain the right to continued medical treatment, family assistance benefit, invalidity benefit,superannuation benefit, survivors' benefit, unemployment benefit, the right to residency and ownership of housing after retirement in addition to health care and pecuniary benefit for sickness, maternity, death, employment injury of the workers.

The Social Security Law, 2012

The Pyidaungsu Hluttaw hereby enacts this Law.

Chapter I

Title, Coming into Force and Definitions

1. (a) This Law shall be called the Social Security Law, 2012.

(b) This Law shall come into force commencing from the date of notification determined by the President of the Union.

(c) This Law shall continue to be in force in areas where the Social Security Act; 1954 has been in force. In addition to those areas, the areas where this Law shall extend to apply may be determined , by notification, by the Ministry of Labour in co-ordination with the Social Security Board with the approval of the Union Government.

2. The following expressions contained in this Law shall have the meanings given hereunder:

(a) Worker means a person who is employed permanently or temporarily in any establishment and who earns a living with wages earned by physical or mental capacity. In such expression, it also include apprentices and trainees whether they are paid remuneration or not. However, it does not include members of the family of employer who live together with and depend upon the employer.

(b) Employer means a person who is responsible to pay remuneration to an employee, who employs an worker by employment agreement, or who manages on behalf of the employer. Unless otherwise provided in this Law, such expression includes a person who carries out private enterprise or joint venture enterprise, inheritor, successor or legal representative when the employer is expired..

(c) Insured person means a worker who is working at any establishment covered by this Law and who has insured through registration under the Social Security System and Employment Injury Benefit Insurance System, or a worker who is responsible to insure, or a person who effects insurance voluntarily under the Social Security System and Employment Injury Benefit Insurance System although he is not working at any establishment covered by this Law.

(d) Establishment means mills and organizations contained in sub-section (a) of section 11. In such expression, it also include any work- place working for the said establishment.

(e) Social Security Fund means health and social care fund, family assistance fund, invalidity benefit, superannuation benefit and survivors' benefit fund, unemployment benefit fund, Social Security Housing Plan fund for insured persons in order that they may have peacefulness in mind and not to have worry aboutthe future, and other social security fund specified by the Ministry of Labour, in co-ordination with the Social Security Board with the approval of the Union Government.

(f) Employment injury means an injury, death or occupational disease occurred to a worker in and out of workplace due to employment, or in relation to duty of the employment, or in carrying out other works for the benefit of the employer, or in travelling to or from the workplace. In such expression, it does not include injury obtained due to willfully failure to abide by the orders and directives, regulations, bye-laws relating to industrial safety, or discarding or not using prescribed safety devices, or drinking alcohol or using drug.

(g) Invalidity means permanent incapacity for work arising out of injury or disease obtained for any other causes including sickness and maternity but not for employment accident.

(h) Employment injury benefit fund means a fund established by the employer's contributions for his workers to enjoy employment injury benefit.

(i) Social security and employment injury benefit means benefit paid under this Law to insured persons from Social Security Fund and Employment Injury Benefit Fund.

(j) Wages means all remunerations entitled to be received by a worker for the work done by him and employed by the employer. In such expression, it includes the overtime-fee and other incomes which may be determined as income. However, it does not include the travelling allowance, pension, gratuity, annual bonus, and income specified as irrelevant to wage by the Ministry of Labour with the approval of the Union Government.

(k) Medical certificate means medical examination certificate issued after medical examination is carried out to an insured person or a person to effect insurance for the matter of benefit

contained in this Law, by a doctor appointed or recognized by the Social Security Board.

(l) Dependent means wife or husband of a worker or children of 18 years of age and under of such worker or unmarried children of 21 years of age and under who pursue education for full-time, or parents of such worker.

(m) Executive Committee means Executive Committee of the Social Security Board formed under this Law.

(n) Ministry of Labour means the Ministry of Labour of the Union Government.

Chapter II

Objectives

3. The objectives of this Law are as follows:

(a) to support the development of the State's economy through the development of production by causing to enjoy more security in social life and health care by the workers who are major productive force of the State by the collective guaranty of the employer, worker and the State;

(b) to enjoy more security in social life and medical care by the public by effecting their insurance voluntarily;

(c) to raise public confidence upon the social security scheme by providing benefits which are commensurate with the realities;

(d) to have the right to draw back some of the contributions paid by the employers and the workers as savings, in accord with the stipulations;

(e) to obtain the right to continued medical treatment, family assistance benefit, invalidity benefit,

superannuation benefit, survivors' benefit, unemployment benefit, the right to residency and ownership of housing after retirement in addition to health care and pecuniary benefit for sickness, maternity, death, employment injury of the workers.

Chapter III

Establishment of the Social Security Board and Functions Thereof

4. The Union occupational diseases; Government:

(a) shall establish the national level Social Security Board comprising suitable persons from the Ministry of

Labour and the relevant Union Ministries, Government departments, organizations, representatives of employers and workers, and experts;

(b) the Social Security Board formed under sub-section (a) may be reconstituted as may be necessary.

5. The functions of the Social Security Board are as follows:

(a) carrying out necessary management and supervision for enabling to implement the provisions contained in this Law;

(b) forming the Executive Committee with suitable persons in co-ordination with the relevant Government

departments and organizations to carry out the functions assigned by the Social Security Board, and determining the functions of such committee;

(c) causing to carry out the work of Social Security Board by laying down research and

development
programmes and plans and causing to report the finding;

(d) forming the Medical Advisory Board in co-ordination with the Ministry of Health and specifying the functions thereof;

(e) arranging and carrying out the health promotion works, works of occupational health, and works to create healthy environment;

(f) advising and submitting to the Ministry of Labour in coordination with the Ministry of Health to issue the
percentage of loss of capacity for work to be based upon in determining permanent disability benefit;

(g) advising and submitting to the Ministry of Labour in coordination with the Ministry of Health to issue the list of

(h) specifying the ratio of vacancies to be reserved in minimum according to the type of establishment to appointthose who have lost capacity for work due to employment injury;

(i) assigning duties to the suitable department, organization or person if it is necessary to carry out any
functions of the Social Security Board after coordinating with the relevant Union Ministry;

(j) guiding and supervising relating to the functions of the Social Security Head Office and various levels of regional Social Security Offices, or relating to the functions of hospitals and clinics owned by the Social Security Board or those entered into agreement with that Board;

(k) establishing Social Security Housings by laying down plans at land plots allowed by the State, or at land plots bought with the Social Security Fund and the Employment Injury Benefit Fund with the permission of the Ministry of Labour;

(l) granting permission to live, lease and live, use, own, buy, sell or transfer in any other means in accord with the stipulated terms and conditions and to borrow loan for purchasing that housing;

(m) assigning duty to the relevant social security officer to take action against persons who obtained permission under sub-section (l) and violate the stipulated terms and conditions, and if it is necessary, to remove them from the Social Security Housing in accord with the stipulations;

(n) communicating, coordinating and carrying out with the international organizations and regional organizations in order to give more effective social security and employment injury benefits;

(o) submitting report on the performance of the work of the Social Security Board to the Union Government in accord with the stipulations;

(p) carrying out other functions and duties assigned by the Union Government and the Ministry of Labour.

6. The Social Security Board shall:

(a) devolve with the immovable property, movable property and funds owned by the Social Security Board established under the Social Security Act; 1954, social security matters, businesses being undertaken to raise the Social Security Fund, and the rights and liabilities of the Social Security Board;

(b) have the right to carry out under its own name and seal, the right to undertake in continuous succession, and the right to sue and be sued.

7. The allowances and remunerations for the members of the Social Security Board and of the Executive Committeewho are not the members of civil service shall be incurred from the Social Security Fund and Employment Injury Benefit Fund for the days discharging duties of the Social Security Board under this Law.

Chapter IV

Formation of Social Security Offices, Hospitals, Clinics and Appointing Staff

8. (a) The Ministry of Labour may establish the following social security offices, hospitals and clinics as may be necessary and appoint and assign duty to necessary staff in conformity with the staff set-up sanctioned by the Union Government to carry out necessary responsibilities and office works of the Social Security Board in implementing the provisions contained in this Law in co-ordination with the Social Security Board:

(i) Social Security Head Office;

(ii) Regional and State Social Security Offices;

(iii) Self- Administered Division Social Security Offices, Self- Administered Region Social Security Offices;

(iv) District Social Security Offices;

(v) Township Social Security Offices;

(vi) Social Security Hospitals;

(vii) Social Security Clinics.

(b) The officials and staff appointed in the social security offices formed under sub-section (a) may enjoy salaries, allowances, honorariums or other benefits in conformity with laws, rules, regulations, by-laws, orders and directives relating to Government servants and shall abide by and comply with the Civil Service Regulations and duties.

(c) The Social Security Board may allow to enjoy salaries, allowances and honorariums or other benefits from its fund instead of the benefits contained in sub-section (b) relating to the establishment of social security offices, hospitals and clinics and appointing necessary officials and staff contained in sub-section (a) based on the situation of its fund in order to enable to carry out duties and functions which are necessary in implementing the provisions contained in this Law and office duties of the Social Security Board.

9. (a) The Ministry of Labour, to enable providing health care and medical treatment under this Law,

(i) may carry out assigning duty jointly or assigning duty by transfer or appointing of doctors, dental and oral surgeons, nurses, midwives, and technicians who obtained medical practitioner licence or registration certificate issued by the Medical Council of the Republic of the Union of Myanmar, the Dental and Oral Medicine Council, and the Nurses and Midwives Council of the Republic of the Union of Myanmar, or practitioners of traditional medicine who obtained registration certificate issued by the Indigenous Medicine Council in coordination with the Ministry of Health;

(ii) if it is necessary, may appoint doctors, dental and oral surgeons, nurses, midwives, technicians and also practitioners of traditional medicine who obtained medical

practitioner license or registration certificate issued by the respective council by hiring for a limited period or concluding agreement and determine the functions thereof.

(b) The persons who are appointed and assigned duty under sub-section (a) may, unless there is specificagreement, may enjoy salaries, allowances and honorariums, gratuities, pensions and other benefits in accord with laws, rules, regulations, by-laws, orders, and directives relating to civil servants, and shall abide by and comply with the Civil Service Regulations and by-laws.

10. The Director General of the Social Security Head Office:

(a) shall be responsible to perform necessary functions and duties in implementing the provisions contained in this Law and office duties relating to the Social Security Board;

(b) shall supervise the performance of the functions of the following social security offices, hospitals, and clinics in accord with the guidance of the Social Security Board;

(i) Social Security Head Office,

(ii) Regional and State Social Security Offices,

(iii) Self- Administered Division Social Security Offices, Self- Administered Region Social Security Offices,

(iv) District Social Security Offices,

(v) Township Social Security Offices,

(vi) Social Security Hospitals,

(vii) Social Security Clinics,

(viii) Hospitals and clinics which are concluded agreement with the Social Security Board.

Chapter V

Social Security System and Benefits

The Establishments Applied

11.(a) The following establishments shall be applied with the provisions for compulsory registration for socialsecurity system and benefits contained in this Law if they employ minimum number of workers and above determined by the Ministry of Labour in co-ordination with the Social Security Board:

(i) production industries doing business whether or not they utilize mechanical power or a certain kind of power, works of production, repairing or services, or engineering works, mills, warehouses, establishments;

(ii) Government departments, Government organizations and regional administrative organizations doing business;

(iii) development organizations;

(iv) financial organizations,

(v) companies, associations, organizations and their subordinate departments and branch offices doing business;

(vi) shops, commercial establishments, public entertaining establishments;

(vii) Government departments and Government organizations doing business or transport

businesses owned by regional administrative body, and transport businesses carried out with the permission of such department, body or in joint venture with such department or body;

(viii) construction works carried out for a period of one year and above under employment agreement;

(ix) works carried out with foreign investment or citizen investment or joint ventured businesses;

(x) works relating to mining and gemstone contained in any existing law;

(xi) works relating to petroleum and natural gas contained in any existing law;

(xii) ports and out-ports contained in any existing law;

(xiii) works and organizations carried out with freight handling workers;

(xiv) Ministry of Labour and its subordinate departments and organizations;

(xv) establishments determined by the Ministry of Labour from time to time, in co-ordination with the Social

Security Board and with the approval of the Union Government; that they shall be applied with the provisions of compulsory registration for Social Security System and benefits contained in this Law.

(b) Any establishment which is applied with the provisions of compulsory registration under sub-section (a) shallcontinue to be applied by this Law even though any of the following situations occurs if it continues to carry out such work:

(i) carrying out work by employing under stipulated minimum number of workers but more than one worker;

(ii) changing the employer or changing the type of business.The Establishments and Workers Not Applied

12.(a) The following establishments shall not be applied with the provisions of compulsory registration for Social

Security System and benefits contained in this Law:

(i) Government departments, Government organizations or regional administrative bodies which do not carry out the business;

(ii) international organizations, embassies or consulates of foreign governments;

(iii) seasonal farming and fishery works;

(iv) non-profit companies, associations or organizations;

(v) establishments working only for a period less than three months;

(vi) private establishments working only by the family members and without worker;

(vii) domestic services not for business purpose;

(viii) establishments exempted under section 99.

(b) The following workers shall not be applied with the provisions of compulsory registration for Social Security System and benefits contained in this Law even though they may be working at any establishments:

(i) workers who have not attained the working age in accord with the existing law and workers who have

completed the age entitled for superannuation pension under section 34;

(ii) street vendors and vendors using bicycle, push-cart etc.;

(iii) daily wages earners, part-time workers, piece-workers or outside workers employed from time to time;

(iv) other workers determined by the Ministry of Labour, in co-ordination with the Social Security Board, with the approval of the Union Government that they shall not be applied with the provisions of compulsory registration for Social Security System and benefits contained in this Law.

(c) If the workers from establishments which are not applied with the provisions of compulsory registration for Social Security System and benefits voluntarily register, made contribution and effect insurance, they shall be entitled to the social security benefits contained in this Law.

Social Security System

13. The Social Security Board shall manage and keep the following social security systems in accord with thestipulations that insured persons may enjoy social security benefits:

(a) Health and Social Care Insurance System:

i) medical care and cash benefits for sickness;

ii) medical care and cash benefits for maternity and confinement;

iii) continued medical care for insured persons after retirement;

iv) funeral benefit for death due to any cause.

(b) Family Assistance Insurance System:

i) education allowance benefit for the children of insured persons who earn below the specified amount of income;

ii) health care and aid benefit in time of natural disaster;

iii) suitable benefit for dependent family members.

(c) Invalidity Benefit, Superannuation Pension Benefit and Survivors' Benefit Insurance System:

i) invalidity benefit;

ii) superannuation pension benefit;

(iii) survivors' benefit arising out of death not owing to employment.

(d) Unemployment Benefit Insurance System:

(i) medical care to persons who are entitled to unemployment benefit;

(ii) cash benefit for unemployment.

(e) Other Social Security System:

(i) the right of insured persons to live, hire and live, purchase, own or use the Social Security Housings established under housing plans in accord with the stipulations;

(ii) Social Security System of compulsory registration and contribution specified by notification issuedby the Ministry of Labour, in co-ordination with the Social Security Board, with the approval of theUnion Government, or other social security systems of voluntary contribution.

14. The Government servants shall not be applied with the insurance systems contained in sub-sections (c) and (d) of section 13. However, if the Government servants voluntarily register and pay contribution to insurance system contained in sub-section (c) of section 13, they shall be entitled to relevant benefits in accord with the stipulations.

Social Security Fund

15.(a) The following funds are included in the Social Security Fund:

(i) health and social care fund;

(ii) family assistance fund;

(iii) invalidity benefit, superannuation pension benefit, and survivors' benefit fund;

(iv) unemployment benefit fund;

(v) other social security fund for social security system of compulsory registration and contribution specified by the Ministry of Labour, in co-ordination with the Social Security Board, according to clause (2) of subsection (e) of section 13;

(vi) other social security fund specified as to which contribution may be paid after voluntary according to clause (2) of sub-section (e) of section 13;

(vii) fund for Social Security Housing Plan;

(b) The employers and workers of establishments shall pay contributions to the funds contained in clauses (1), (3),(4) and (5) of sub-section (a) after effecting compulsory registration.

(c) The contribution for family assistance benefit fund contained in clause (2) of sub-section (a) shall not be specified in particular, but it shall be re-appropriated from health and social care fund in stipulated ratio.

(d) The employers and workers of establishments may pay contribution voluntarily to the funds contained in clauses (6) and (7) of sub-section (a).

Effecting Insurance after Registration for Social Security and Contributions

16.(a) The following employers shall effect insurance for the workers working at their establishments bycompulsorily registering at the relevant township social security office and contribute to the social security fund contained in clauses (1),(3),(4), and (5)of sub-section (a) of section 15 in accord with the stipulations to enable to enjoy social security benefits:

(i) employers of establishments;

(ii) employers of establishments employing the number of workers, including the relatives of the employers except at least one worker and their wife, husband, children and parents depending upon them, under sub-section(a) of section 11 ;

(iii) employers of unpaid apprentices and trainees.

(b) employers and workers of establishments who are not applied to the Social Security System, or persons under section 20, if they desire to enjoy social security benefits under this Law, shall register voluntarily according to each insurance system at the respective township social security office and contribute to the funds under section 15 in accord with stipulations.

(c) before effecting insurance under sub-section(a) and (b) after registration, a person to be insured shall undergo medical examination in accord with the stipulations and shall submit the medical certificate when effecting registration as an insured person.

17. In order to incur the costs for the benefits provided under this Law to insured persons and to the remainingdependents of the deceased insured persons, and for administrative purposes; the Ministry of Labour, in co-ordination with the Social Security Board, shall determine, by notification, with the approval of the Union Government, the rates of

contribution which shall be paid into various social security funds under section 15 by employer and worker depending upon a months' remuneration of the worker.

18.(a) Regarding to the workers in establishments applied by the social security system, the contribution which shall be paid by the employer and workers according to the remuneration of worker shall be paid according to the rates stipulated under section 17 to the relevant social security fund in accord with stipulations until the completion of the age of pension specified under section 34 or, if he continues to work after such completion of pensionable age, until such working period.

(b) The employer shall deduct contributions to be paid by worker from his remuneration and pay to the social security fund together with contribution to be paid by him. The employer shall also bear the expenses for such contribution.

(c) The Social Security Board may decide to impose defaulting fee specified under section 88 on the employer who defaults to pay the contribution in addition to the contribution.

Establishment of Hospitals, Clinics and Bearing of Expenses

19. The Social Security Board may carry out establishing and opening of hospitals, clinics or hiring them or incurringexpenses for them for the medicines and equipments with the capital allotted from the Union Consolidated Fund or aid or loan if its fund is not adequate to provide health care and medical treatment to insured persons.

Effecting Insurance Voluntarily for Social Security

20. To enable to enjoy the social security benefits under this Law, the following persons may contribute and collect thespecified contribution voluntarily to the respective social security fund they prefer and enjoy the relevant social security benefits in accord with the stipulations:

(a) employers and workers of establishments which are not applied by the provisions of compulsory registration under this Law;

(b) public who are not working at the establishments;

(c) students, persons who do not keep in touch with work place, housemaids and persons who have gone abroad and worked there;

(d) persons doing private business, persons doing collective work, professionals and farmers;

(e) persons from establishments specified by the Ministry of Labour from time to time, in co-ordination with the Social Security Board, with the approval of the Union Government, that they may register voluntarily and effect insurance.

Health and Social Care Insurance System Benefits

21. Relating to the health and social care insurance system benefits:

(a) insured person may enjoy the following benefits in accord with the stipulations:

(i) health care, medical treatment, and cash benefits depending upon the type of disease in times of sickness owing to any cause;

(ii) health care, medical treatment, and cash benefits in times of pregnancy and confinement for woman insured person;

(iii) the right to infant care and cash benefit in times of confinement of insured person's wife;

(iv) the right to continued medical care after retirement of the insured person.

(b) When the insured person dies, a person nominated by that person or if there is no such nomination,dependent of that person or a person who incurred the expenses of the

funeral has the right to claim for funeral benefit in accord with provision contained in section 30.

The Right to Take Medical Treatment for Sickness and Incurring of Expenses

22 . In times of sickness, the insured person who had paid contribution to health and social care fund:

(a) has the right to take medical treatment at the permitted hospital or dispensary for a period of up to 26 weeks starting from the date of treatment taken. However, for repeated sickness, chronic disease and suffering more than a disease or sickness of special importance, it has the right to take medical treatment up to 52 weeks or to a period specifically prescribed by the Social Security Board;

(b) has the right to take health care and medical treatment at the hospitals and clinics owned by the Social Security Board or at the State owned or private hospitals and clinics concluded agreement with that Board, or at hospitals and clinics arranged by the employer;

(c) if he is unable to attend at the hospitals and clinics owned by the Social Security Board or hospitals and clinics concluded agreement with that Board, has the right to take health care and medical treatment by coming to the establishment where the insured person works as arranged by the Social Security Board;

(d) in taking health care and medical treatment in accord with section 21 and this section, relating to the expenses incurred for health care and medical treatment, has the right to enjoy from the health and social care fund in accord with the stipulations.

Cash Benefits Relating to the Sickness

23. The insured person:

(a) has the right to enjoy sickness cash benefit only if he had worked at the establishment for a minimum of six months before the starting day of sickness and had paid contribution for a minimum of four months during the said six months;

(b) on presentation of medical certificate for sickness and if reduction or suspension of earnings involved, shall enjoy sickness cash benefit of 60 percent of average wage of previous four months for up to 26 weeks in accord with the stipulations contained in sub-section (a).

24. The Social Security Board may, on arising of any of the following matters as regards insured person who isenjoying sickness cash benefit, suspend the said benefit in whole or in part:

(a) wilfully provoking self-sickness;

(b) sickness as a result of own criminal act;

(c) willful failure without sufficient cause to avail himself of medical care or to follow the instruction of the medical practitioner;

(d) making deceitful claim for sickness cash benefit;

(e) failure to carry out rehabilitation measures without sufficient cause;

(f) leaving for foreign countries for good;

(g) failure to comply with other terms and conditions prescribed by the Social Security Board.

The Right to Take Medical Treatment for Insured Women in Cases of Pregnancy and Confinement

25. Notwithstanding anything contained in the laws, rules, regulations, by-laws, orders, and directives regardingGovernment servants, the insured woman worker has the right to enjoy the following benefits in accord with the stipulations;

(a) the right to take free medical care at the permitted hospital and clinic in cases of pregnancy and confinement;

(b) the right to take medical care for her child for a period of not more than one year after birth;

(c) the right to enjoy maternity leave of six weeks before confinement and a minimum of eight weeks after confinement, altogether a minimum of 14 weeks, moreover, another four weeks, after enjoying maternity leave, for child care if it is the twin delivery;

(d) the right to enjoy a maximum of six weeks as maternity leave in case of miscarriage being not a criminal abortion;

(e) the right to enjoy full remuneration for prenatal examination at the permitted hospital or clinic, on the basis of one session per day and up to a maximum of seven days;

(f) if a child under one year of age is adopted in accord with existing law by registration, has the right to enjoy leave not exceeding eight weeks for child care, until that child has completed one year of age. Such leave shall only be entitled for one adopted child. During such enjoyment period, cash benefit under sub-section (a) of section 27 shall be entitled subject to the provision contained in section 26.

Maternity Benefits

26. The insured man and woman shall be entitled to enjoy maternity cash benefit under section 27 and 28 only if they

have worked a minimum of one year before the commencement of leave period at the relevant establishment and paid contribution for a minimum of six months within the said one year.

27.The insured woman worker is entitled to the followings in accord with the stipulations of medical certificate:

(a) 70 per cent of average wage of a year as maternity benefit during maternity leave period entitled in accord with sub-section (c) of section 25;

(b) 50 per cent of average wage of a month as maternity expenses for single delivery, 75 per cent of average wage of a month for twin delivery, and 100 per cent of average wage of a month for triplet delivery and above; c) 70 per cent of average wage which is entitled for the maternity leave period in the case of miscarriage under sub-section(d) of section 25.

28. An insured man is entitled to enjoy the following paternity benefit for confinement of his wife in accord with the

stipulations of the medical certificate:

(a) 15-days leave to care for an infant on confinement of his wife who is an insured person;

(b) the right to enjoy 70 per cent of average wage of previous one year as maternity benefit for the leave period contained in sub-section (a) on confinement of his wife who is an insured person;

(c) in addition to the benefits contained in sub-section (a) and (b), half of maternity grant contained in subsection (b)of section 27 on confinement of his wife who is not an insured person.

The Right to Take Medical Treatment for Pensioners

29. The insured Government servants , after having retired; or the insured person, after having received invalidity

benefit and superannuation pension benefit under sections 33 and 35, have or has the right to enjoy medical care in accord with the stipulations if it is involved with the followings:

(a) being a person who had paid contribution for 180 months and above;

(b) being a bearer of pensioner's identity card issued by the township social security office after retirement. Funeral Benefit

30. If an insured person dies of employment injury or any other cause, if a person nominated by the insured person or if

there is no such nomination, dependent of that person or a person who incurred the expenses of the funeral, it is entitled to enjoy up to a maximum of five times of the average of the wage for a month during the last four months of that deceased person in accord with the stipulations.

Family Assistance Insurance System Benefits

31. (a) Relating to the education allowance for children pursuing education:

(i) if an insured person who has paid contribution for a minimum of 36 months and who earns less than the specified amount of income, has the children pursuing a full time education, it is entitled to enjoy education allowance from family assistance fund in accord with the stipulations;

(ii) for the children who are born of an insured couple who earn less than the specified amount of income, only one insured person is entitled to enjoy education allowance contained in sub- sub-section (1).

(b) When the insured person and family encounter natural disaster, it is entitled to enjoy the following health care, relief material and cash assistance from the family assistance fund in accord with the stipulations:

(i) the right to take medical treatment if it is suffered from physical and mental injury or if it is contracted disease because of encountering natural disaster;

(ii) if the contribution had been paid for a minimum of 36 months prior to natural disaster and thereafter encountered the natural disaster and lost own properties, 40 percent of average wage per a month within one year before the day of such encountering natural disaster as cash assistance and relief materials provided by Social Security Board.

(c) The insured person is entitled to enjoy suitable benefits allowed by the Social Security Board for his dependent family from the family assistance fund in accord with the stipulations.

Invalidity Benefit

32.An insured person is entitled to enjoy invalidity benefit according to medical certificate, in accord with section 33, if he is totally incapable to work not for employment injury but for any other cause including sickness and maternity.

Cash Benefit for Invalidity

33.(a) When the insured person becomes totally incapable to work in accord with section 32, he is entitled to enjoy the following benefits from the fund for invalidity benefit, superannuation benefit, and survivors' benefit in accord with the stipulations:

(i) if contribution has been paid for 180 months before the date of invalidity allowed by

medical
certificate, the right to enjoy 15 times of average wage for a month obtained by him during the period of such contribution in installment or in lump sum according to his desire;

(ii) if contribution has been paid for more than 180 months, as regards such period of contribution in excess, the right to enjoy in addition to benefit contained in sub-sub-section(1) in accord with the stipulations;

(iii) in case where contributions have been paid for 12 months and above but under 180 months, the right to enjoy 40 percent of employer's paid contribution and contribution paid by that insured person together with interest in accord with the stipulations;

(iv) in case of contribution paid for less than 12 months, the right to withdraw the money contributed by that person in lump sum.

(b) When the insured person obtains the right to enjoy invalidity benefit, the employer has the right to obtain 25 percent of his contribution for 12 months and above paid to the fund under clause (3) of sub-section (a) of section 15 together with interest in accord with the stipulations.

Age Limit for Superannuation Pension and Cash Benefit

34. The pensionable age for superannuation pension of the insured person shall be as specified by the Ministry of Labour, in co-ordination with the Social Security Board, with the approval of the Union Government.

35.(a) When the insured person retires for superannuation pension, the following benefits are entitled from invalidity benefit, superannuation pension benefit and survivors' benefit fund in accord with the stipulations;

(i) if contribution has been paid for 180 months prior to the date of superannuation pension granted, the right to enjoy 15 times of an average wage of a month obtained within the periods of contribution of that insured person in installment or in lump sum according to the desire of that person;

(ii) if contribution has been paid for more than 180 months, relating to such period of contribution in excess, the right to enjoy in addition to benefit contained in clause (1) in accord with the stipulations.

(iii) in case where contribution has been paid for 12 months and above but under 180 months, the right to enjoy 40 per cent the contribution paid by the employer and contribution of that insured person together with interest in accord with the stipulations.

(iv) in case where contribution has been paid for less than 12 months, the right to withdraw the money contributed by that insured person in lump sum.

(b) When the insured person receives superannuation pension benefit, the employer has the right to 25 per cent of his personal contribution paid to the fund under sub-sub-section (3)

of sub-section (a) of section 15 for 12 months and above, together with interest in accordance with specifications.

Survivors' Benefit due to Death not from Employment Injury

36. When the insured person dies not for employment injury but for any other cause before the completion ofpensionable age for superannuation pension:

(a) a person nominated by the insured person is entitled to enjoy survivors' benefit same as the invaliditybenefits contained in section 33, in installment or in lump sum as desired by that person in accord with the stipulations;

(b) if there is no nominated person contained in sub-section (a), dependents of the said insured person in thefollowing order are entitled to enjoy the benefit, same as the invalidity benefit contained in section 33, in installment or in lump sum as desired by that person in accord with the stipulations:

(i) wife or husband of the deceased person;

(ii) if there is no wife or husband of the deceased person, children of that person ;

(iii) if there is no wife, husband and children of the deceased person, mother and father of that person;

(c) if there is a beneficiary entitled to enjoy benefits contained in clauses (a) and (b), the employer has the right to obtain 25 per cent of contribution paid by him into the fund for invalidity benefit, superannuation benefit, and survivors' benefit for 12 months and above together with interest in accord with the stipulations;

(d) if there is no beneficiary entitled to enjoy benefits contained in sub-sections (a) and (b), the employer has the right to withdraw his contribution paid into the fund for invalidity benefit, superannuation benefit, and survivors' benefit together with interest in accord with the stipulations.

Requirements for Unemployment Benefit

37. The insured person shall be entitled to enjoy unemployment benefit if he has paid contribution for a minimum of 36 months and involved with the followings:

(a) being unemployed not for voluntary resignation but for being removed from work or job terminated because of permanent close-down of work;

(b) not being a person dismissed from work on conviction of work related offence or not being a person dismissed or removed from work for misappropriation, violation of Civil Service Regulations or intentionally failing to a abide by the workplace regulations;

(c) being a person of good health, capable to work and willing to work;

(d) being a person registered at the relevant township labour exchange office in accord with the stipulations and reporting monthly to that office and township social security office.

Unemployment Benefit Period and Benefits

38. The insured person, on receiving unemployment benefit in accord with section 37:

(a) if he has already paid contribution for 36 months, he is entitled to enjoy 50 percent of average wage for a month within the last one year as the unemployment benefit up to two months. If he is a person who has paid contribution for more than 36 months, one more month of unemployment benefit shall be entitled for every additional 12 months of

contribution paid. However, total period of unemployment benefit shall be entitled only for up to six months;

(b) if being a married person while unemployed, depending upon the condition of dependents, cash not more than 10 per cent of additional unemployment benefit contained in sub-section(a), awarded by the Social Security Board shall be entitled during the above mentioned relevant period in monthly installment;

(c) if he suffers sickness; health care, medical treatment and cash benefit contained in clause (1) of sub- section(a) of section 21 and sub- sections (a) and (b) of section 23 shall be entitled in accord with sub- section(a) of this section;

(d) for maternity and confinement; has the right to health care, medical treatment, and cash benefit contained in clause (2) of sub- section(a) of section 21, section 26, section 27, and section 28, for a minimum of 2 months to a maximum of 6 months in accord with sub-section(a) of this section;

(e) has the right to attend skill trainings allowed by the Social Security Board;

(f) if the insured person dies while enjoying unemployment benefit contained in sub-section (a), funeral grant may be entitled in accord with stipulations.

Limitations on Unemployment Benefit

39. (a) The insured person:

(i) has the right to enjoy unemployment benefit contained in sub-sections (a) and (b) of section 38 for only once at an establishment;

(ii) after having enjoyed the unemployment benefit once in accord with clause (i) and then, if he rejoins with the same establishment and becomes unemployed again, unemployment benefit is entitled to be enjoyed in accord with the stipulations only if another payment of contribution for 36 months has been made.

(b) The employer may deduct the amount of unemployment benefit; entitled to the insured person out of compensation money liable to that insured person in accordance with the existing laws concerning labour, or employment agreement; in line with specifications and in accordance with this Law.

Termination of Unemployment Benefit

40. The unemployment benefit shall be terminated if any of the following situations arises:

(a) rejecting the job informed by the relevant labour exchange office or by the releavnt township social security
office without sufficient cause;

(b) rejecting to attend vocational training course as directed by the Board without sufficient cause;

(c) re-obtaining a new job;

(d) being convicted with imprisonment for the commission of any criminal offences under any criminal laws;

(e) leaving for foreign country for good or leaving for foreign job.

The Right to Draw Back from the Social Security Fund after Receiving Unemployment Benefit

41. If an insured person is unable to join with and work his former job or any other job relating to the Social Security

Insurance System under this Law after termination of unemployment benefit period:

(a) the insured person has the right to draw back 40 per cent of contribution paid for him into the fund for invalidity benefit, superannuation pension benefit and survivors' benefit for 36 months and above by the employer, and his contribution together with interest in accord with the stipulations;

(b) the employer has the right to draw back 25 per cent of his contribution paid into the fund contained in subsection (a) for 36 months and above together with interest in accord with the stipulations.

Benefits and Responsibility for Other Social Security Systems

42.(a) A person who has paid voluntary contribution to the Social Security Housing Fund contained in clause (7) ofsub-section (a) of section 15, relating to the Social Security Housing, has the right to live, hire and live, use, own, buy, sell or transfer by any other means and to obtain loan in priority to purchase that housing if it is in conformity with the stipulations.

(b) If an insured person who has not paid contribution to the Social Security Housing Fund contained in clause (7) of sub-section (a) of section 15 is in conformity with the stipulations, relating to the Social Security Housing, he is entitled to live, hire and live, use, own, transfer by any other means or to borrow loan to purchase that housing.

43. A person who is entitled to enjoy the right contained in section 42 concerning Social Security Housing:

(a) shall comply with the stipulated terms and conditions,

(b) if he violates the said terms and conditions, shall be taken action and ejected from the Social Security Housing.

44. The persons who have contributed to each of the Social Security Fund contained in clauses (5) and (6) of sub-section (a) of section 15 shall have the right to enjoy benefits specified by the Ministry of Labour, in co-ordination with the Social Security Board, with the approval of the Union Government.

Chapter VI

Application to Employment Injury Benefit Insurance System, Employment Injury Benefit Fund and Benefits

Application

45. The provisions contained in this Law relating to the employment injury benefit insurance system shall apply to thefollowing workers:

(a) workers at establishments which are applied to social security system who have registered compulsorily in accord with sub-section (a)of section 16 and contributed to the social security funds contained in clauses (1),(3),(4) and (5) of sub-section (a) of section 15;

(b) workers specified as being applied to provisions of compulsory registration for employment injury benefit insurance system by notification of the Ministry of Labour, in co-ordination with the Social Security Board with the approval of the Union Government.

46. If the employers of establishments contained in sub-section (a) of section 12 which are not applied to provisions ofcompulsory registration for social security insurance system have

not compulsorily registered and paid contribution for their workers to enjoy employment injury benefit, the provisions of employment injury insurance system shall not be applied.

Employment Injury Benefit Insurance System and Registration

47. The Social Security Board shall manage to avoid from paying to the employment injury benefit insurance system bythe employer in lump sum and to enable the worker enjoy the following benefits in accord with the stipulations:

(a) medical treatment;

(b) temporary disability benefit;

(c) permanent disability benefit;

(d) survivors' benefit of death owing to employment.

48.(a) The employer shall effect insurance by registering for employment injury benefit insurance system containedin section 45 at the relevant township social security office and pay contribution to employment injury benefit fund in accord with stipulations in order that workers applied to provisions of compulsory registration may obtain the employment injury benefits;

(b) The employers may effect insurance by registering voluntarily for insurance of the workers who are not applied to provisions of compulsory registration for employment injury benefit insurance system, by paying stipulated contribution to employment injury benefit insurance fund;

(c) When registering to effect insurance for employment injury benefit in accord with sub-sections (a) and (b), the worker shall submit medical certificate.

Non-application to the Workmen's Compensation Act

49.(a) The employers and insured persons of establishments where the employer had registered compulsorily in accordance with sub-section (a) of section 48 or where the employer had registered voluntarily in accord with sub-section (b) of section 48 who have paid contribution to employment injury benefit fund shall not apply to the provisions contained in the Workmen's Compensation Act as regards the employment injury benefit;

(b) The insured persons who has effected insurance for employment injury benefit in accord with sub-sections (a) and (b) of section 48 shall be entitled only to the employment injury insurance benefits contained in this Law.

Contributions for Employment Injury Insurance System

50.As regards employer's contribution to employment injury benefit fund for the worker's entitlement to employmentinjury benefit under section 47, rates of contribution shall be determined according to worker's remuneration and degree of possibility of occupational hazard, by the Ministry of Labour, by notification, in co-ordination with the Social Security Board, with the approval of the Union Government.

51.The employer:

(a) shall pay contribution monthly to Employment Injury Benefit Fund at the rates stipulated under section 50. Moreover, he shall also bear the expenses for paying as such;

(b) shall pay defaulting fee stipulated under section 88, in addition to the contribution if fails to contribute after effecting insurance for employment injury benefit.

The Right to Take Medical Care and Other Benefits Regarding Employment Injury

52.(a) The insured person has the right, if the employment injury occurs, to take medical care in accord with thestipulations and to enjoy other benefits contained in this chapter.

(b) The types of occupational diseases contained in sub-section (a) shall be as specified by the rules and regulations.

Occupational Safety

53.(a) The employers and workers shall co-ordinate, co-operate and carry out with the Board or insurance agentdepartments in carrying out workers' occupational safety measures and keeping health plan in order to prevent employment accident, or employment injury or disease contracting and death in addition to safety and educational work of the workers.

(b) The costs of medical care regarding employment injury resulting from criminal action or omission of theemployer, or resulting from employer's failure to keep occupational safety plans and protections; and other benefits under this Law shall be borne without fail by the employer in accord with the stipulations.

54.(a) The employer shall report to the relevant township social security office immediately if a serious employmentaccident occurs to his insured worker. There shall not be any delay without sufficient cause to report as such.

(b) A team of officers and other staff who inspect the establishments, if it is found out the employment injury,death, and contracting disease, shall report to the relevant township social security office in accord with the stipulations.

Temporary Disability Benefit

55. The insured person who, by reason of employment injury, became incapable to work which involves reduction orsuspension of earnings; free medical care and temporary disability benefit of 70 per cent of average wage during four months prior to employment accident shall be entitled, commencing from the date of incapacity for work, to a maximum of 12 months upon medical certificate.

56.(a) The temporary disability benefit under section 55 shall be terminated from the date on which the insured person becomes capable for work within 12 months.

(b) If an insured person continues to be incapable to work after the expiration of 12 months period of temporary disability benefit, it shall be converted into permanent disability pension.

(c) If permanent disability for work of an insured person can be expected by the medical certificate even during 12 months while temporary disability benefit has been enjoyed, it has the right to terminate the temporary disability benefit, convert into permanent disability benefit and enjoy it.

Permanent Disability Benefit

57. The insured person has the right to enjoy, owing to an employment accident, permanent partial disability cashbenefit if there is likely to cause partial loss of capacity for work; or permanent total disability cash benefit if there is likely to cause total loss of capacity for work.. As regards that benefit, fixation for a month benefit which may be enjoyed in accord with section 58 shall be calculated upon 70 per cent of a months' average wage during four months before employment injury occurs, in relation to percentage of loss of capacity for work decided by the Medical Board.

58.The person who suffers loss of capacity to work may enjoy permanent disability benefit calculated basing upon 70 per cent of a months' average wage contained in section 57, in relation to percentage of loss of capacity for work, as specified hereunder:

(a) in cases in which the degree of incapacity is less than 20 per cent, the right to enjoy monthly cash benefit entitled to such person for five years in lump sum;

(b) in cases in which the degree of incapacity is above 20 per cent to 75 per cent, the right to enjoy monthly cash benefit entitled to such person for seven years in installment or in lump sum, according to the desire of that person;

(c) in cases in which the degree of incapacity is above 75 per cent, the right to enjoy monthly cash benefit entitled to such person for nine years in installment or in lump sum or in monthly installment until death, according to the desire of that person;

(d) if the medical certificate is submitted that permanently disabled person contained in sub-section (c) requires the constant attendance of another person, the right to enjoy the supplement of 10 per cent of his benefit in installment, or in lump sum, or in monthly installment until death, according to the desire of that person, in addition to the benefit contained in sub-section (c).

59.(a) The ratio of permanent partial disability benefit and permanent total disability benefit shall be proportionate tothe loss of capacity for work contracted by employment injury.

(b) If an insured person who obtained the permanent partial disability benefit suffers another employment injury,his percentage of loss of capacity for work shall be fixed afresh taking into consideration of his former percentage of loss of capacity for work. The combined percentage of loss of capacity for work shall not exceed his overall loss of capacity for work. For the new fixing as such, due cash benefit is entitled for added loss of capacity for work in accord with the stipulations.

Rehabilitation and Job Reservation

60.If it is necessary to rehabilitate those who have lost their limbs owing to employment injury, or to make themcapable of work from being incapable, the Social Security Board shall:

(a) perform in making, fixing, and providing instruments to operate, instruments to make up and to fix,uponmedical certificate;

(b) provided vocational training courses and nurturing measures for reintegration into community .

61.The Social Security Board may, in co-ordination with the Ministry of Labour, specify the ratio of the minimum number of jobs to be kept according to the establishment for appointing workers whose organs are damaged and become disabled and lost their capacity for work owing to employment injury at the establishments which are applied to this Law in addition to the stipulated number of worker.

Survivors' Benefit for Employment Death

62.When the insured person died of employment injury:

(a) a person nominated by the insured person shall be entitled to enjoy survivors' benefits in installment or inlump sum, up to the desire of that person, according to the average wage based on contribution period within four months before the death of that insured person as follows:

(i) if it is contributed for 60 months and under, 30 times of an average wage for a month;

(ii) if it is contributed for above 60 months to 120 months and under, 50 times of an average wage for a month;

(iii) if it is contributed for above 120 months to 240 months and under, 60 times of an average wage for a month;

(iv) if it is contributed for above 240 months, 80 times of an average wage for a month;

(b) if there is no nominated person under sub-section (a), persons who have depended upon the earnings ofthat insured person shall enjoy the survivors' benefit in installment or in lump sum according to the desires of those persons, in accord with the stipulations in the following order :

(i) wife or husband of the deceased person;

(ii) if there is no wife or husband of the deceased person, his children;

(iii) if there is no wife, husband and children; mother and ther of that person.

Chapter VII

Provisions Relating Both to Social Security Fund and Employment Injury Benefit Fund

Benefits not Payable Simultaneously

63.(a) The following benefits shall not be payable simultaneously to an insured person:

(i) sickness benefit and maternity benefit;

(ii) sickness benefit and temporary disability benefit;

(iii) maternity benefit and temporary disability benefit;

(iv) sickness, maternity, temporary disability benefits and unemployment benefit.

(b) In cases in which two of the benefits contained in sub-section (a) are payable but their amounts are different,

the beneficiary shall be paid the larger of the two amounts.

Suspension of Benefits

64. If the insured person who is enjoying any of the sickness benefit, maternity benefit and temporary disability benefitshall be suspended if an insured person enjoying one of those benefits engages in a work for which he has been certified to be incapable or in any other work for wages, such benefits shall be suspended for him.

Entitlement for Reimbursement of Payment

65. The employer:

(a) has the right to reimbursement out of benefits granted under this Law, for payments made as social obligation for an insured person in cases of health care, medical treatment and other matters entitled to benefit;

(b) if the total amount of wages and cash benefit paid to the insured person during a period of sickness benefit, or maternity benefit, or employment injury benefit under this Law exceeds the normal wages of that insured person; may deduct the amount in excess out of benefits granted under this Law. Such payment of excess amount shall be informed to the relevant township social security office.

Restrictions to Employment

66.(a) The employer, subject to health care and medical treatment in accord with sections 67 and 68:

(i) shall not remove or terminate the insured person from work or reduce his wage level during the period during which an insured person is enjoying any of the sickness benefit or maternity benefit or temporary disability benefit due to employment injury under this Law;

(ii) shall not reduce or deduct wages and fees of his worker because of liability for contribution payable under this Law;

(b) The insured person, as regards his injury due to employer's violation of restrictions under sub-section (a), may submit the matter to the relevant township social security office for settlement in accord with the stipulations.

Providing Health Care and Medical Treatment

67.(a) The employer may; in order to provide medical treatment to his insured workers, after obtaining permission and terms and conditions of the Social Security Board, establish private hospital and clinic in accord with the existing law and give health care and medical treatment in accord with the stipulations through doctors and nurses appointed by him.

(b) The Social Security Board shall carry out to enable opening of clinics at the establishments which have many insured persons and have stipulated number and above, according to the proportion of labour force.

(c) The Social Security Board shall support medical stores and expenses for doctors and nurses at the hospitalsand clinics opened under sub-sections (a) and (b) in accord with the stipulations.

68.The Social Security Board, to be able to perform relating to health care and medical treatment successfully:

(a) shall specify functions and duties to social security medical staff relating to health care and medical treatment in co-ordination with the Medical Advisory Board;

(b) shall educate, inspect and supervise matters relating to occupational safety and health, and health care and medical treatment works in establishments applied by this Law in co-ordination with the relevant departments;

(c) shall supervise, arrange and carry out in giving necessary health care and medical treatments to insured persons who come to hospitals and clinics owned by the Social Security Board;

(d) if it is necessary, may conclude agreement in co-ordination with the Ministry of Health, and give medical treatment at the State owned hospitals and clinics or incur the cost of health care and medical treatment in accord with the stipulations;

(e) after concluding agreements with responsible persons from departmental hospitals and clinics or owners of private hospitals and clinics, may allow them giving health care and medical treatment in accord with the stipulations;

(f) shall carry out health promotion, disease prevention, and health education works by adopting plans.

Not Losing the Right to Benefit despite Defaulting in Contribution

69.(a) Even if the employer who has registered under section 16 and section 48 or the employer liable to register has not paid contribution or even if the contribution was not

deducted from the worker's wage and paid for contribution; an insured person or .after the death of the insured person, a person nominated by that person or, if there is no such nomination, his dependent shall be entitled to the benefits under this Law.

(b) The employer who fails to pay contribution shall pay contribution liable under section 17 and section 50 and also defaulting fee specified under section 88, and bear the cost of benefits payable to the insured person and all expenses.

The Right to Draw from the Relevant Social Security Fund

70.(a) When the insured person voluntarily resigns from work or transfers to any other establishment not applied by this Law before the completion of age specified for superannuation pension benefit under section 34:

(i) if an insured person has paid contribution for up to 180 months to the fund for invalidity benefit, superannuation pension benefit and survivors' benefit; he has the right to enjoy 12 times of a months' average wage of the period of contribution in installment or in lump sum according to his desire;

(ii) if an insured person has paid contribution more than 180 months, in addition to benefits under clause (1), he may draw back 40 per cent of contribution paid by the employer during that period and contribution paid in excess by himself as such from that fund, together with interest in accord with the stipulations;

(iii) if an insured person has paid contribution to the fund contained in clause (1) for more than 36 months to under 180 months, he has the right to draw 40 per cent of contribution paid for him by the employer to the fund for invalidity benefit, superannuation pension benefit, and survivors' benefit andcontribution paid by him during such period together with interest from that fund in accord with the stipulations;

(iv) the employer has the right to draw 25 per cent of contribution paid by him for insured person to thefund for invalidity benefit, superannuation benefit, and survivors' benefit for 36 months and above, together with interest from that fund in accord with the stipulations;

(b) In the case of permanent total disability or death of an insured person resulting from employment injury:

(i) The insured person or a person nominated before his death or if there is no such nomination, his dependent has the right to draw the contribution paid by the insured person to the fund for invalidity, superannuation pension benefit, and survivors' benefit for 36 months and above, and 40 per cent of contribution paid by the employer, together with interest, in accord with the stipulations;

(ii) the employer has the right to draw 25 per cent of contribution paid for 36 months and above to the fund under clause (1) for insured person, together with interest in accord with the stipulations;

(c) If the voluntary resignation or transfer to any other establishment which is not applied by this Law or takingsuperannuation pension or becoming invalidity, permanent total disability owing to employment injury, or death resulting from any cause of an insured person occurs:

(i) the insured person or after the death of the insured person, a person nominated by that

person or, if there is no such nomination, his dependent has the right to draw contribution paid by the insured person to the unemployment benefit fund for 36 months and above, together with interest in accord with the stipulations;

(ii) the employer has the right to draw contribution paid for that insured person to the fund for unemployment benefit for 36 months and above, together with interest in accord with the stipulations.

(d) If any of the following situations arises before a person who has paid contribution to the fund for Social Security Housing Plan receives any benefit in respect of housing; the insured person or ,if that insured person has died, a person nominated before his death or, if there is no such nomination, a person depending upon the insured person has the right to draw all contributions paid by that insured person to the fund for Social Security Housing Plan, together with interest in accord with the stipulations:

(i) retiring for superannuation pension;

(ii) being incapable to work;

(iii) being permanently and totally disabled owing to employment injury;

(iv) resigning from work, being dismissed from work or death.

Prohibitions Relating to Benefits

71.Any person shall not:

(a) attach warrant or transfer or accept benefits granted in conformity with this Law without permission of the Social Security Board;

(b) claim for social security and any employment injury benefit dishonestly. Survivors' Benefit

72.If an insured beneficiary dies, the remaining benefit which is due but not yet paid up to the day of his death shall beentitled to by enjoyed by the person nominated by the insured person or, if there is no such nomination, his dependent in accord with the stipulations.

Time Limit to Claim for Benefits

73.Relating to any benefit paid to the beneficiary from Social Security Fund and Employment Injury Benefit Fund:

(a) if the benefit is granted in installment or monthly, the person who has the right to claim shall claim, withdocuments attached, to the relevant township social security office within the following period commencing from the date of entitlement;

(i) for superannuation pension benefit, one year from the day of completion of the age, specified in accord with section 34 , of insured person;

(ii) for invalidity benefit, one year from the day of the issue of medical certificate;

(iii) for survivors' benefit of death, not owing to employment, one year from the day of death of the insured person;

(iv) for benefit of permanent disability due to employment, one year from the day of accident of the insured person, or from the day temporary disability benefit period terminated;

(v) for survivors' benefit of employment death, one year from the day of the death of the insured person.

(b) For the rest of benefits under this Law except benefits contained in sub-section (a), it shall be claimed withinthree months commencing from the date they should be claimed, with documents attached , to the relevant township social security office.

(c) Though the period specified under sub-sections (a) and (b) has been passed, the claim may be made withsufficient cause. However, it shall not have the right to claim if there is no sufficient cause.

Keeping and Submitting Records on Contribution and Benefit

74. The employer of each establishment applied by this Law shall keep record of contributions paid to the SocialSecurity Fund and Employment Injury Benefit Fund for himself and his insured workers, keep the record of benefits received for each insured person, and open account for each insured person. Those records and accounts shall be submitted to the relevant township social security office in accord with the stipulations.

Keeping Work Records and Accounts

75.The employer of establishments applied by this Law:

(a) shall prepare and keep the following records and lists correctly and submit to the relevant township social

security office in accord with the stipulations:

i) records and lists of workers' daily attendance;

ii) records of appointing new worker, employing worker by changing of work, suspension from work, dismissal from work and resignation from work;

iii) records of promotion and paying remuneration ;

iv) records and lists of employers, managers, and administrators; and records of changes of them;

(b) shall inform the relevant township social security office if the following matters arise:

i) change in number of workers and address of establishment;

ii) change of employer, change of business, suspension from work, and termination of work;

iii) employment injury, employment death, and occupational diseases;

(c) shall produce work records and lists on requirement of inspection team or official assigned duty under this Law by the Social Security Head Office and various Regional Social Security Offices.

Investigation

76.Relating to the social security and employment injury benefit:

(a) the Social Security Board may, to know and decide whether or not the employers keep work record and lists to be kept under this Law systematically, keep records of contribution paid to the social security fund and employment injury fund, contribute correctly, open accounts for each insured person, and the insured workers receive social security and employment injury benefits correctly, and whether or not the stipulated reports are submitted, require the relevant department to investigate or cause to investigate by a suitable person or body by forming it;

(b) if it is necessary, the Social Security Board or person assigned duty by that Board or the investigation team may summon and examine the relevant employers and workers and other necessary persons, and require them to submit evidence;

(c) the Social Security Board or the person assigned duty by that Board or the investigation team may, if it is necessary, enter into and investigate the establishment.

Prohibitions Relating to the Responsibilities of Employers

77.Any employer of establishments concerning with the social security and employment injury benefit:

(a) shall not maintain incorrectly, alter or delete records contained in section 74,and sub-section (a) of section 75;

(b) shall not report incorrectly to the relevant township social security office relating to the number of workers and contributions;

(c) shall not refuse when the inspection team or the official requires under this Law or in accord with duty assigned by the Social Security Board, to produce those records, reports, and other necessary documents;

(d) shall not fail to attend when he is summoned by the inspection team or the official under this Law or in accord with the assignment of the Social Security Board or various regional Social Security Office.

Recovery of Contributions and Defaulting Fees

78.(a) The official assigned duty by the Social Security Board shall, if it is failed to pay contributions under sections

17, 50 and 88 and defaulting fees or benefits liable and expenses which are due under sub-section (b) of section 69, recover them as if they were arrears of land revenue or as if a decree is executed in civil suit, by exercising necessary power in accord with the stipulations.

(b) In managing recovery in accord with sub-section (a), the fund for social security and employment injury benefit shall have priority over other debts resulting from Insolvency Act or liquidation of a company under the Myanmar Companies Act, a partnership under the Partnership Act or under any other existing law.

(c) The person who fails to pay money collected in accord with sub-section (a) shall not obliterate or transfer his moveable and immovable property during such recovery period by any means without permission of the Social Security Board or the official assigned duty by that Board.

Chapter (8)

Establishing and Maintaining the Social Security Fund and Employment Injury Benefit Fund

79.(a) The Social Security Board shall establish and maintain the Social Security Fund and Employment InjuryBenefit Fund to implement the objectives contained in this Law.

(b) The Social Security Board shall stand on its Social Security Fund and Employment Injury Benefit Fund.

(c) The Social Security Fund shall be established by contributions of employers and workers, and contribution and subsidy from the Union Consolidated Fund granted by the Union Government.

(d) The employment Injury Benefit Fund shall be established by contributions of employers and subsidy from the Union Consolidated Fund.

(e) The established Social Security Fund and Employment Injury Benefit Fund shall be deposited, by opening bank account, with any State Bank, or any other bank directed by the Social Security Board in accord with the stipulations.

(f) The Social Security Fund and Employment Injury Benefit Fund include the followings, in

addition to the contribution and the subsidy contained in sub-sections (c) and (d):

(i) saving from fund, depositing and interests from loans;

(ii) defaulting fees imposed under this Law;

(iii) increased money from investments;

(iv) money donated by well wishers from local and abroad.

80.The following two main funds shall include in the account of the Social Security Board:

(a) The Social Security Fund:

(i) health and social care fund;

(ii) family assistance fund;

(iii) invalidity benefit, superannuation pension benefit and survivors' benefit fund;

(iv) unemployment benefit fund;

(v) Social Security Housing Plan Fund;

(vi) other social security fund stipulated under clauses (5)and (6) of sub-section(a) of section 15.

(b) The Employment Injury Benefit Fund.

81.The Social Security Board may, if it is necessary for the interest of insured persons, allow to transfer the head of thefund and use the fund for which bank account is opened and maintained under section 80 .

82.(a) The Social Security Board has the right, in conformity with the stipulated accounts procedures:

(i) to use its fund only for the social security system, employment injury insurance system and administrative matters contained in this Law;

(ii) if the foreign currency is received, to keep it in separate bank account and use only for the social security system, employment injury insurance system and administrative matters contained in this Law.

(b) As the Social Security Fund and the Employment Injury Benefit Fund are the savings of contribution ofinsured persons for the social security and employment injury benefit, it shall not be transferred and deposited as credit to the Union Consolidated Fund.

83.The Social Security Board shall, in order to maintain and audit the Social Security Fund and Employment InjuryBenefit Fund methodically, draw up the accounting procedures in co-ordination with the Office of the Union Auditor-General, and maintain the accounts in conformity with such procedures.

84.The Social Security Board may, in order to increase the Social Security Fund and Employment Injury Benefit Fundestablished under section 79 and section 80, carry out the following works which are in conformity with the existing law and which may be profitable with the fund which are not yet necessary to be used for the time being:

(a) depositing, saving, purchasing saving certificates and securities at any State Bank or other bank;

(b) carrying out and investing in any investment business;

(c) issuing loans to contributors by prescribing the interest rate under appropriate terms and conditions;

(d) investing by establishing Social Security Housing by adopting plans;

(e) hiring movable property and immovable property owned by the Social Security Board,

selling any of those property which are not necessary to be used in accord with the stipulations or transferring by any other means;

(f) carrying out any other business for the interest of the Social Security Board.

85.The Social Security Board shall, relating to the Social Security Fund and the Employment Injury Benefit Fund,prepare the budget mentioning estimate incomes and expenditures for the coming financial year and submit to the Union Government through the Ministry of Labour.

Chapter IX

Providing Contribution and Subsidy from the Union Consolidated Fund

86. Before the Social Security Board may carry out the matters contained in sub-section (c) of section 8, the Ministry ofLabour shall allow to incur the salaries, allowances, pensions and other benefits, in accord with relevant laws, rules, regulations, by-laws, orders and directives concerning the Government servant, of the service personnel who are appointed and assigned duty at the Social Security offices, hospitals and clinics in conformity with the organizational setup of the service personnel, in co-ordination with the Social Security Board and with the approval of the Union Government, from the Union Consolidated Fund.

87.(a) The Social Security Board shall stand on the Social Security Fund and Employment Injury Benefit Fund and,if it is not sufficient to give benefits from that fund, may submit and request, together with explanation, to the Union Government through the Ministry of Labour, for contribution, subsidy or loan from the Union Consolidated Fund.

(b) The Union Government may, after scrutinizing the request made under sub-section (a), contribute, subsidize, or issue loan of the appropriate amount from the Union Consolidated Fund under appropriate terms and conditions.

(c) The Ministry of Labour shall, relating to the money, contributions, subsidies incurred from the Union Consolidate Fund, submit an annual budget estimate to the Union Government for approval and cause the Social Security Board to manage it.

(d) The Social Security Board shall, relating to the money, contributions, subsidies incurred from the Union Consolidated Fund; conduct regular audit and accept the audit of the Office of the Union Auditor-General. Moreover, an annual audit report shall be submitted to the Union Government through the Ministry of Labour.

(e) The Union Government may, relating to the land plots for Social Security Housing Project which shall be implemented under clause (1) of sub-section (e) of section 13 and sub-section (d) of section 84; grant the use of suitable land plots, upon the request of the Social Security Board, out of the lands managed by the Government, by stipulating terms and conditions. Moreover, the Union Government may subsidize for the Social Security Housing from the Union Consolidated Fund as may be necessary.

Chapter X

Taking Administrative Action, Adjudication of Disputes and Appeal Defaulting Fee for Failing to Pay Contribution

88.(a) The employer ,who is responsible to pay contribution under this Law, shall:

(i) if he fails to pay contribution to the relevant Social Security Fund and Employment Injury Benefit Fund, pay 10percent of the contribution, in addition to the contribution defaulted, in accord with the stipulations. Moreover, if he continues failing to pay contribution, such defaulting fee for each month of contribution defaulted shall be paid in addition.

(ii) if reduced statement of insured workers' wages is made and reduced contribution is made in payingcontribution to the relevant Social Security Fund and Employment Injury Benefit Fund or if the contribution is made by concealing the number of workers or if he fails to pay contribution deducted from the workers' wages; such reduced amount of contribution for the month defaulted and deducted contribution, and 10 percent of the reduced amount of contribution shall be paid as the defaulting fee to the relevant fund in accord with the stipulations. If the default to pay contribution continues as such, the mentioned defaulting fee for each month of contribution defatulted shall be paid in addition.

(b) The relevant township social security office shall calculate the amount of contribution and defaulting fee to be paid under sub-section (a) and inform the relevant employer to contribute within the stipulated time. Moreover, the contribution paid shall be credited to the relevant fund.

Settlement of Disputes

89.(a) It may be submitted to the relevant township social security office to settle disputes arising out of any of the following matters:

(i) matter whether or not any establishment is applied by this Law;

(ii) matter whether or not the employer and the worker are applied by this Law;

(iii) matter relating the liability for contribution and amount of contribution, amount of defaulting fee under this Law;

(iv) matter whether or not it is entitled to benefits;

(v) matter whether or not the benefit is received in full, the amount of benefit or means of awarding such benefit;

(vi) matter submitted by the insured person relating to the injury due to violation of prohibition contained in sub-section (a) of section 66 by the employer.

(b) The officer-in-charge of the township social security office shall initially negotiate and settle on mutual consent, the disputes relating to social security and any employment accident among the disputes contained in sub-section (a) and dispute relating to injury caused by violation of prohibition contained in sub-section (a) of section 66 by the employer.

(c) The officer-in-charge of the township social security office shall submit the records of enquiry together with remarks, on the matter which cannot be settled although it is negotiated on mutual consent under subsection (a) or any dispute contained in sub-section (a), after making enquiry in accord with the stipulations, to the Region or State Social Security Office so as to enable to pass decision.

(d) Relating to the disputes contained in sub-section (a), civil suit shall not be instituted before any court.However, relating to the disputes whether or not the remaining dependents are legal heirs and whether or not they have legal right to inherit shall be as decided by the relevant court.

90.The Region or State Social Security Office:

(a) after scrutinizing the report submitted under sub-section (c) of section 89, may conduct or cause to conduct further enquiries as may be necessary;

(b) after carrying out according to sub-section (a), and after allowing the persons in dispute to defend and after hearings the both parties, a decision may be made as appropriate.Forming the Social Security Appellate Tribunal and Appeal

91.(a) The Social Security Board shall form the Social Security Appellate Tribunal comprising suitable persons in order to hear the appeal against the decision of the Region or State Social Security Office.

(b) The person who dissatisfies with the decision of the Region or State Social Security Office made undersub-section (b) of section 90 may appeal in accord with the stipulations to the Social Security Appellate Tribunal within 60 days from the day such decision was made.

(c) The Social Security Appellate Tribunal may, after hearing the appeal made under sub-section (b), approveor set-aside the decision of the Region or State Social Security Office or may require to make further enquiry as may be necessary and re-submit it, and make the decision.

Prosecuting for Wilfully Failing to Pay Contribution and Defaulting Fee

92. The relevant township social security office may, when it is found out that the employer is wilfully failing to paycontributions and defaulting fees, and if any of the following facts arises, prosecute such employer defaulted at the relevant court:

(a) failing to pay contributions and defaulting fees within 30 days from the last date stipulated by the township social security office to make such payment due to failure of the employer to pay the contributions and defaulting fees;

(b) expiration of appealable time limit by the employer under sub- section (b) of section 91;

(c) failing to pay the contributions and defaulting fees by the employer although the Social Security Appellate Tribunal, after hearing the appeal of the employer made under sub-section (b) of section 91, has decided that the employer shall pay the contributions and defaulting fees.

Chapter XI

Offences and Penalties

93. Any employer who is prosecuted under section 92 shall, on conviction that he has willfully failed to pay contributionsand defaulting fees, be punished with imprisonment for a term not exceeding one year, or with fine, or with both.

94.(a) Any employer who fails to comply with any responsibility to register and effect insurance contained in subsection (a) of section 16 and sub-section (a) of section 48 shall , on conviction, be punished with imprisonment for a term not exceeding one year or with fine or with both.

(b) Any employer who violates any prohibition contained in sub-section (b) of section 53, section 77 and sub-section (c) of section 78 shall, on conviction, be punished with imprisonment for a term not exceeding six months or with fine or with both.

(c) Any person who violates any prohibition contained in section 71 shall, on conviction, be punished with imprisonment for a term not exceeding six months or with fine or with both.

(d) Any employer who fails to comply with and carry out any responsibility contained in sub-section (a) of section 54, section 74 and section 75shall , on conviction, be punished with imprisonment for a term not exceeding three months or with fine or with both.

(e) Any person who violates any prohibition contained in the rules, regulations, by-laws and orders issued under this Law shall , on conviction, be punished with imprisonment for a term not exceeding three months or with fine or with both.

Chapter XII

Miscellaneous Provisions

95.(a) The relevant township social security office shall prosecute the offences under section 93 and section 94, only if it obtains the prior sanction of the Social Security Board.

(b) When the person prosecuted under sub-section (a) has credited all the due contributions and defaulting fees to the relevant fund after being prosecuted and before the final order has been passed, the relevant social security office shall, after obtaining the permission of the Social Security Board, apply to the relevant court to withdraw that case.

95. No criminal or civil proceeding shall lies against any person or organization that discharges functions and duties assigned under this Law in good faith.

96. The member of the Social Security Board, member of the Executive Committee, member of the Appellate Tribunal, member of the Medical Advisory Board, and any other member or person assigned duties under this Law, who are not Government servant, shall be deemed as Government servant while discharging duties assigned under this Law,.

97. Relating to the payment of contributions and defaulting fees made under this Law to the Social Security Fund and the Employment Injury Benefit Fund, or benefits provided under this Law; it shall be exempted from stamp duty and income tax.

98. The President of the Union may, for the interest of the State, by notification, exempt the areas in which immediate implementation of work plan to be implemented is not yet necessary or any establishment applied by this Law or any category of employer or worker from all or any part of the provisions contained in this Law.

99. The Ministry of Labour may, by notification, carry out amending the stipulated rates of contributions and benefits relating to the Social Security Fund and the Employment Injury Benefit Fund and implementing insurance systems in phases, based on the economic development of the State, financial sufficiency and economic development of establishments or changing social needs or situations of development according to regions and zones, in co-ordination with the Social Security Board and with the approval of the Union Government.

100. (a) The employers and workers who have paid contribution to the insurance system stipulated by the Social Security Act,1954 shall continue paying the contribution in accord with the stipulations to the Social Security Fund and the Employment Injury Benefit Fund established in conformity with this Law.

(b) Relating to all benefits claimable after this Law comes into force, the benefits allowed under this Law shall be enjoyed in accord with stipulations only if the contribution period

stipulated under this Law is fulfilled.

(c) The General Insurance benefits payable under the Social Security Act,1954 shall be borne from the Health and Social Care Fund contained in this Law.

(d) The Employment Injury Benefits payable under the Social Security Act. 1954 shall be borne from theEmployment Injury Fund contained in this Law.

102. If the insured person earns his wages in foreign currency, contribution shall be paid to the Social Security Fund andthe Employment Injury Benefit Fund in foreign currency and each benefit of social security and employment injury shall also be enjoyed in foreign currency in accord with the stipulations.

103. In implementing the provisions contained in this Law:

(a) the Ministry of Labour may, in co-ordination with the Social Security Board and with the approval of the Union Government, issue necessary rules, regulations and by-laws;

(b) the Ministry of Labour and the Social Security Board may issue necessary notifications, orders, directives, and procedures.

104. The Social Security Act,1954 shall cease to be in force commencing from the day on which this Law comes into force.I hereby sign according to the Constitution of the Republic of the Union of Myanmar(Sd.)

Thein Sein
The President of the Union
The Republic of the Union of Myanmar

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Acronyms and Abbreviations

3DF	3 Diseases Fund
AFP	Acute flaccid paralysis
AI	Avian Influenza
AMW	Auxiliary midwife
ART	Anti-retroviral therapy
ARV	Antiretroviral
BHS	Basic Health Staff
CEU	Central Epidemiological Unit
CNDP	Comprehensive National Development Plan
CNR	case-notification rate
CSO	Central Statistical Organization
CVD	Cardiovascular disease
DOH	Department of Health
DOTS	Directly Observed Treatment Short-course (for tuberculosis)
DST	Drug Sensitivity Test
EC	European Commission
ECE	Early Childhood Education
EPI	Expanded Programme on Immunization
GDP	Gross Domestic Product
GF	Global Fund against AIDS, Tuberculosis and Malaria
GAVI	Global Alliance for Vaccines and Immunization
GMP	Good manufacturing practices
GSM	Global Management System
HA	Health Assistant
HMIS	Health Management Information System
HIV/AIDS	Human immunodeficiency virus/acquired Immunodeficiency syndrome
ICC	Interagency Coordination Committee (for GAVI)
ICD-10	International Statistical Classification of Diseases
IEC	information education and communication
INGO	International Non-Governmental Organization
IMMCI	Integrated management of maternal and childhood illness
IHLCA	Integrated Household Living Condition Assessment
IHR	International Health Regulations
IDD	iodine deficiency disorders
IMR	Infant Mortality Rate
IDA	Iron deficiency disorder
JICA	Japan International Cooperation Agency
LHV	Lady Health Visitor
LCS	local cost subsidy
MDR-TB	Multi-drug resistant tuberculosis
MEP	Management Effectiveness Programme
MW	Midwife
MNPED	Ministry of National Planning, Economic And Development
MOH	Ministry of Health
MoU	Memorandum of Understanding
MICS	Multiple indicator cluster survey
MMCWA	Myanmar Maternal and Child Welfare Association
MDGs	Millennium Development Goals
MRCS	Myanmar Red Cross Society
NAP	National AIDS Programme
NEQAS	National External Quality Assessment Scheme
NCDs	Non-communicable diseases
NGO	Non-Governmental Organization
NIPPP	National Influenza Pandemic Preparedness Plan
NMR	Neonatal Mortality Rate
NSP	National Strategic Plan
NSS	New sputum smear
NTP	National Tuberculosis Programme
ODA	Official Development Assistance
PMCT	Prevention of Mother-to-child transmission
PHC	Primary Health Care
PEM	Protein energy malnutrition
PHS	Public Health Supervisor
RHCs	Rural Health Centers
TB	Tuberculosis
TMO	Township Medical Officer
VPD	Vaccine Preventable Diseases
WCO	WHO Country Office