Health Care for the Urban Poor in Myanmar

Assessment to identify the scope of problem and intervention options - consultancy mission report

March, 2014
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Consultant:
Azam Ali
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Azam Ali
Yangon, 13 March 2014
# LIST OF ABBREVIATIONS AND ACRONYMS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AA</td>
<td>Action Aid</td>
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<tr>
<td>ARI</td>
<td>Acute Respiratory Infection</td>
</tr>
<tr>
<td>ARV</td>
<td>Anti-retro virus</td>
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<tr>
<td>BEmOC</td>
<td>Basic Emergency Obstetric Care</td>
</tr>
<tr>
<td>BI</td>
<td>Burnet Institute</td>
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<td>BTS</td>
<td>Blood Transfusion services</td>
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<tr>
<td>CBOs</td>
<td>Community based organizations</td>
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<tr>
<td>CG</td>
<td>Core Group</td>
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<tr>
<td>DOH</td>
<td>Department of Health</td>
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<td>DP</td>
<td>Development Partners</td>
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<td>DSF</td>
<td>Demand-side financing</td>
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<tr>
<td>EC</td>
<td>European Commission</td>
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<td>EHP</td>
<td>Essential Health Package</td>
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<tr>
<td>EmOC</td>
<td>Emergency Obstetric Care</td>
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<td>EPI</td>
<td>Expanded Programme on Immunisation</td>
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<tr>
<td>ESCAP</td>
<td>Economic and Social Commission for Asia and the Pacific</td>
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<tr>
<td>FA</td>
<td>Financing Agreement</td>
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<td>FP</td>
<td>Family Planning</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GFTAM</td>
<td>Global Fund for Tuberculosis, HIV/AIDS and Malaria</td>
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<tr>
<td>HIS</td>
<td>Health Information System</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
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<tr>
<td>HR</td>
<td>Human Resources</td>
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<td>HRD</td>
<td>Human Resources Development</td>
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<td>HSR</td>
<td>Health Sector Review</td>
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<td>HSP</td>
<td>Health Services Package</td>
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<tr>
<td>IGA</td>
<td>Income Generating Activities</td>
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<tr>
<td>IHLCS</td>
<td>Integrated Household Living Conditions Survey</td>
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<td>IMPAC</td>
<td>Integrated Management of Pregnancy and Childbirth</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>JASR</td>
<td>Joint Annual Sector Review</td>
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<tr>
<td>LDC</td>
<td>Least Developed Country</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MAM</td>
<td>Medical Action Myanmar</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MSF</td>
<td>Médecins Sans Frontières</td>
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<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
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<tr>
<td>MIP</td>
<td>Malaria in Pregnancy</td>
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<td>MM</td>
<td>Maternal Mortality</td>
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<td>MMR</td>
<td>Maternal Mortality Ratio</td>
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<td>MNCH</td>
<td>Maternal New-born and Child Health</td>
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<tr>
<td>MNH</td>
<td>Maternal and New-born Health</td>
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<tr>
<td>MoFP</td>
<td>Ministry of Finance and Planning</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<tr>
<td>MoLE&amp;SS</td>
<td>Ministry of Labour Employment and Social Security</td>
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<td>MoU</td>
<td>Memorandum of Understanding</td>
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<tr>
<td>NAP</td>
<td>National AIDS Programme</td>
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<td>NHA</td>
<td>National Health Accounts</td>
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<td>NTP</td>
<td>National TB Programme</td>
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<tr>
<td>PHC</td>
<td>Primary Health Care</td>
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<tr>
<td>PHF</td>
<td>People’s Health Foundation</td>
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<tr>
<td>PHS</td>
<td>Public Health Supervisor</td>
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<tr>
<td>PU-AMI</td>
<td>Première Urgence – Aide Médicale Internationale</td>
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<tr>
<td>PPP</td>
<td>public-private partnerships</td>
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<td>PRSP</td>
<td>Poverty Reduction Strategic Plan</td>
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<td>PSI</td>
<td>Population Service International</td>
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<td>RHD</td>
<td>Regional Health Department</td>
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<tr>
<td>SBA</td>
<td>Skilled Birth Attendance</td>
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<tr>
<td>STDs</td>
<td>sexually transmitted diseases</td>
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<tr>
<td>STIs</td>
<td>sexually transmitted infections</td>
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<tr>
<td>SSB</td>
<td>Social Security Board</td>
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<tr>
<td>TA</td>
<td>Technical Assistance</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<td>--------------</td>
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<tr>
<td>TBA</td>
<td>Traditional Birth Attendants</td>
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<tr>
<td>TMO</td>
<td>Township Medical Officer</td>
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<tr>
<td>ToR</td>
<td>Terms of References</td>
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<tr>
<td>U5MR</td>
<td>Under Five Mortality Rate</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNAIDS</td>
<td>United Nations AIDS Program</td>
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<tr>
<td>UNHABITAT</td>
<td>United Nations Human Settlements Programme</td>
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<tr>
<td>UHC</td>
<td>Urban Health Centre</td>
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<td>UHC</td>
<td>Universal Health Coverage</td>
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<td>UHTF</td>
<td>Urban Health Task Force</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>VCT</td>
<td>Voluntary counselling and testing</td>
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<tr>
<td>WFP</td>
<td>World Food Programme</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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<tr>
<td>YCDC</td>
<td>Yangon City Development Council</td>
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1 INTRODUCTION

1. This consultancy mission has been planned and commissioned by the 3 MDG Fund following a meeting between H.E. Minister of Health and 3MDG Fund Board Representatives held in November 2013. At this meeting, H.E. Minister of Health highlighted the health needs of urban poor population and recommended that the 3MDG Fund consider an expansion of the scope of service delivery coverage under Component 1 of the 3MDG Fund. In particular, the imperative to address high rates of neonatal mortality was highlighted. An in-principle decision to take forward this expanded scope of work was unanimously taken at the 3MDG Fund Board meeting in mid-December 2013 and subsequently ToR ( Annex 1 ) were developed and hera was invited to place a consultant under the 3 MDG Fund/ HERA Technical Support Facility long term agreement. Four CVs were presented and selection of the consultant 1 was endorsed by the MOH.

2. A Core Group (CG) was formed with representatives invited from the Ministry of Health (Naypyitaw and Yangon Regional Health Department), the 3MDG Fund, JICA, the World Bank, the UN Agencies (WHO, UNICEF, UNFPA and UNAIDS) and other relevant stakeholders to steer the direction of the mission and provide guidance and feedback on draft assessment overview and design outlines. In addition to the CG, the 3MDG Fund senior national adviser 2 was assigned to provide the required national perspective technical and management support to the international consultant. The 3MDG Fund planning and coordination specialist 3 acted as the TA task manager.

Objectives of the consultancy

3. Objectives of the mission were to undertake an assessment and pre-design mission to identify the scope of the problem and propose possible options for interventions. The specific objective was to support the Ministry of Health to develop options leading to the design of a comprehensive health care programme for poor populations residing in peri-urban and urban areas of Myanmar, notably in Yangon.

Scope of Work

4. The consultant was expected to follow two areas of work: i. Assessment - Identify the scope of the problem and ii. Propose options to design an intervention programme. Assessment would cover a. Target population and barriers to access services, b. Geographical priorities, c. Mapping of health services provided for urban population – public and private sector (not-for profit and for profit) and d. Identify barriers and potential for the delivery of integrated health care services in urban settings in a context of UHC (Universal Health Coverage). The intervention design would include a. Potential scope of work and prioritized areas of interventions, including possible outcomes and indicators, b. Risks and challenges, c. Estimated prioritized investment needs, and d. Identify opportunities for investments for the different Development Partners, based upon their individual strengths, including the 3MDG Fund.

5. During the briefing of the mission, feasibility of achieving the above stated scope of work as per the ToR by a single consultant within the given time was discussed in the context of a) multi-dimensional nature of the urban poverty and urban health, b) limited data, c) need for different assessments and d) required support for intervention details design. It was agreed between the consultant and the 3 MDG Fund that during this mission the assessment of scope of problem would only provide an overview of the key problems and the interventions would only contain descriptions of the probable outlines of the intervention areas, key activities and risk and assumptions. During the course of the mission it was

1 Dr. Md. Azam Ali
2 Dr. Kyaw Nyunt SEIN
3 Mr. Markus BUHLER
suggested by the 3 MDG Fund that an additional output of this consultancy would be development of a more comprehensive assessment and design mission with an appropriate skill mix of international and national consultants.

**Key activities undertaken**

6. Main activities undertaken during the mission included search and review of available documents and data on urban poverty and urban health care, briefing/debriefing meetings, interview and consultations with key stakeholders, field visits and bilateral and group sharing of draft assessment findings and draft intervention options. Mission activity schedule attached as **Annex 2**.

7. At the central level (Naypyitaw) meetings were held with the Director General (DG-DOH), Deputy DG, Directors, Deputy Directors and other senior officials of various divisions of the Department of Health (DOH), Director General and other senior officials of the Social Security Board (SSB) of the Ministry of Labour Employment and Social Security. At the regional level meetings were held with HE the Yangon Minister of Social Affairs, the Regional Director, Deputy Regional Directors and senior officials of the Yangon Regional Health Department (RHD). Group and individual meetings were held with six Township Medical Officers and their assistants. Consultation meetings were held with WHO, UNHABITAT and UNICEF officials/consultants and NGO representatives (MSI, Alliance, BF, PU-AMI, MSF, PHF, MAM, AA). List of persons met is attached as **Annex 3**. Field visits included SSB hospital and clinic at Hlaing Thar Yar, township hospitals of Shwe Pyi Thar and Hlaing Thar Yar, one Urban Health Centre (UHC), a combined TB and vaccination out-reach session in the community, practice of Sun Clinic general practitioner, settlers area and NGO MAM operated Thazin clinic in Shwe Pyi Thar township.

8. The Core Group (CG) formally met twice for briefing on the 18th of February 2014, debriefing was on the 12th of March 2014 and several informal consultations took place with individual members. Meetings were held with 3 MDG Fund specialists for continued planning and reviewing of ongoing findings. Draft mission findings and recommendations were presented and discussed with the CG and NGO representative in a meeting on 3rd of March 2014 and with the 3 MDG board in another meeting on 4th of March 2014 for presentation to the SCG. Presentation was made for review and discussion at the Senior Consultative Group meeting, held on the 5th of March 2014 in Naypyitaw.
2 SUMMARY ANALYSIS OF THE SCOPE OF PROBLEM

9. This section provides an overview of the problem regarding urban health care, related issues and constraints. The areas of analysis consist of (i) urbanization trends, poverty and targeting; (ii) health status; (iii) the policy, legal, and institutional environment under which urban health operates; and (iv) health care delivery (including facilities) and management systems; and (v) health financing. A problem tree analysis synthesizes the major issues in urban health as described in the succeeding paragraphs is attached as Annex 4.

2.1. Urbanization trends, poverty and targeting

2.1.1. Trends in Urbanization

**Key Issues:**
- Rapid rural-urban migration resulting in increasing numbers of poor and slum populations
- Higher prevalence of communicable and non-communicable diseases in urban areas due to poor living conditions of the poor and urban lifestyle
- Increased concentration of young people in urban areas
- Multi-dimensional factors affecting urban health – water, sanitation, waste, settlement legality, roads and transport, etc.

10. Myanmar’s last population census was carried out in 1983; a new one is due to start in April 2014. Population of the country in 2011 – 2012 is estimated at 60.38 million with the growth rate of 1.01 percent⁴. The population density for the whole country is 89 per square kilometres. According to the United Nations’ Department of Economics and Social Affairs/Population Division, Myanmar has a higher percentage of urban population (32.6%) which is more than most of its neighbouring countries⁵ and very similar to Thailand and Vietnam.

![Figure 1. Increase of urban population in Myanmar 2004 - 2012](image)

**Source:** World Urbanization Prospects 2012

11. Figure 1 above shows the trend of urban population growth in Myanmar over the past eight years. World urbanization prospects estimated that with this trend by 2050 the absolute number of Myanmar urban population will become 31 million, which will be an increase of more than twofold of the 2010 urban population figure. Migration of the poor from rural to urban areas in search of work has been the major cause of this rapid growth of urban population.

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⁴ Myanmar country health profile, 2013 ref. Population Department, Ministry of Immigration and Population, 2013
⁵ Sri Lanka 15.5%, Nepal 17%, Cambodia 20%, Afghanistan 23.5%, Bangladesh 28%, Timor Leste 28.3% and India 31.3% (World Urbanization Prospects 2011 revision).
12. Rural to urban migration has resulted in an increase in the poor, transient, slum population, which requires a multi-dimensional approach to addressing urban health issues – provision of basic health care, water, sanitation, waste, settlement legality, roads and transport, etc. There has been an increased influx of young people to the urban areas in search of economic opportunities. Proportion of these youth belonging to the 20-30 years age group has increased in the past 20 years, breaking the pyramid dynamics and requiring increased need for RH and protection against sexually transmitted diseases (STDs) and HIV/AIDS.

13. New migrants, as well as second-generation migrants, tend to live in temporary shelters and in slums without decent housing or basic services. Urban, poor population concentrated in these informal settlements or slums located in peri-urban industrial zones and in some pockets of the city, located in low-lying, flood prone, poorly drained areas with limited formal garbage disposal and minimal access to safe water and sanitation. These conditions of high population density and poor sanitation exacerbate the spread of diseases. People living in these areas experience social, economic, and political exclusion, which bars them from the community’s basic resources including the required health care.

2.1.2. Urbanization and concentration of poor in Yangon Region

14. The urban population is concentrated in Yangon and its surrounding townships. More than two third (67.1%) of the total population of the Yangon region reside in urban areas which constitutes about one third (33.25%) of the country’s total urban population. Population density in Yangon is 586 per Sq./Km which is more than 6 times (89) of the national figure.

15. UN-HABITAT estimates that at least 40 percent of Yangon’s 5.96 million (2.38 million) are poor or extremely poor, and are living in substandard housing or illegal dwellings. A further report also reveals that an estimated ten percent of Yangon’s population currently live in slum dwellings. The challenge is further compounded by the speculation that Yangon’s population is expected to double to around 10 million over the next 20-25 years. This will require substantial investment in the urban health infrastructure and service delivery systems.

2.1.3. Urban Poverty and Targeting

Key Issues:
- Identification of the poor, particularly “floating populations”
- Access to, and utilization of, services, particularly institutional delivery and child nutrition
- Inadequate and no comprehensive poverty mapping, particularly the urban poor
- Social exclusion and lack of information and assistance

16. According to a recent UNDP report, between 2005 and 2010, Myanmar managed to reduce its poverty incidence and the poverty depth by almost 7 percentage points (from 29.6% to 22.7%), or by 5.2% annually. Though the national poverty rate has declined at a rate of roughly over 5% percentage points per annum over five years, even with this conservative estimate 25% of Myanmar population are below the poverty line. This figure will be much higher if the Integrated Household Living Conditions Survey (IHLCS) 2009-10 used food poverty line of Kyats 754

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6 World Population Prospects: the 2012 Revision, Volume ii: Demographic profile
7 BHS Health Profile 2011
8 AFP, “Frustration fomets in Yangon’s slums despite reforms.” December 5, 2012.
11 A regional perspective on poverty in Myanmar, August 2013. UNDP
per day is adjusted with the increased cost of living of present time. The IHLCs shows that 37.7% of urban houses are built of bamboo and thatch and 19.4% of rough cut wood. It can be assumed that poor families are living in these houses. According to ESCAP 2007, Myanmar has a much higher percentage of population (50 -90%) living on 1 US dollar a day compared to its neighbours\footnote{Laos 27%, Cambodia 34%, Philippine 14.8% and Thailand/Malaysia < 2%}. On all counts poverty level in Myanmar is extremely high by international standards and reflects the widespread poverty and vulnerability in Myanmar.

17. Historically Myanmar poverty has long been associated with the rural masses, but with the growth of cities, poverty has become increasingly urbanized. As expected, poor households tend to have more people, particularly children, than non-poor households. The poor are substantially less educated and have lower school attendance rates than the non-poor. The JICA Structure Plan for Greater Yangon reports 63% drop out from primary to secondary schooling. Due to high informal costs children from poor families could not be retained in the education system. In the labour market, they face the challenges of low skills levels, low wages but overwork. Employment options for poor, female workers are even more limited. The IHLCs 2010 shows the following significant differences between the poor and non-poor:

- Poor households tend to be larger (5.9) than non-poor households (4.5).
- Poor households have less access to housing (32% vs. 59%), safe drinking water (62% vs. 72%), sanitation (72% vs. 84%), and electricity (28% vs. 55%) compared to non-poor households.
- Children of poor households tend to have less immunization coverage (76% vs. 86%) than those of non-poor households. Access to maternal health care of poor households (77% vs. 86%) is less than those of non-poor households.
- Poor households are likely to be less literate than non-poor households (84% vs. 93%). They have lower net primary (81% vs. 90%) and secondary (35% vs. 59%) enrolment rates, and lower educational attainment than non-poor households, with only around 22% of poor household heads having completed middle school or higher, compared to 40% of non-poor household heads.

**Targeting the poor**

18. With the support from the Global Fund, the 3 Diseased Fund and 3MDG Fund component 2, the country’s TB and HIV/AIDS vertical programmes have set up a good network of public, private and NGO care providers with outreach services targeting the poor. This includes out-reach sessions in close proximities of the poor and individual case follow up too. However, similar measures for delivery of integrated basic health services targeting the poor is yet to be developed; also the scope for using the TB and HIV/AIDS network for integrated and comprehensive service delivery targeting the poor is as yet not fully explored.

19. The use of health services by the urban poor are characterized by limited access to the existing health care facilities. Although medicine is recently made available free of cost in public facilities, use of public services by the poor is not satisfactory. Payment for transport to and from health facilities for patients and their attendants make up a large proportion of costs even before diagnosis and follow up treatment. Time lost in repeat visits to health providers is also costly in various ways such as loss of earnings and neglected household responsibilities. Availability of service at close proximity, at a time convenient for the poor, working population is a prime need that remains unmet both at public as well as in NGO facilities. As a result the majority of the poor get their medicines from pharmacies, without the benefit of consultation with trained physicians. In most of the poor households traditional forms of medicine (folk medicine) are also used along with modern forms of medicine. Use of public facilities even for medical advice regarding maternal care is
limited and in some areas poor children are not even vaccinated. There is an absence of demand side financing mechanisms such as health/nutrition vouchers or conditional cash grants.

20. In 2000 recognition of the growing problem of urban slums and its resulting poverty culminated in the world’s richest governments pledging, through the MDGs, to improve the lives of 100 million slum dwellers by 2020. The challenge in dealing with the problems of urban poverty is complex and multi-dimensional. There are hugely divergent views on targeting among governments, academics, NGOs, donors, and civil society. A number of criteria for identifying the poor have been used by different programmes, projects, and agencies. However, all of them revolve around financial aspects, which fail to consider a holistic approach to the identification of the poor.

2.2. Health Status

<table>
<thead>
<tr>
<th>Key Issues:</th>
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<tbody>
<tr>
<td>Institutional delivery by the poor mothers, with impact on MMR</td>
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<tr>
<td>High prevalence of TB/HIV and incidence of Malaria</td>
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<tr>
<td>Location and coordination of health facilities and delivery systems</td>
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<tr>
<td>Inadequate trained staff</td>
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<tr>
<td>Irregular and insufficient outreach activities by health workers</td>
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</tbody>
</table>

21. Key statistics show that the health status in Myanmar is low in comparison with other LDCs in the region. The maternal health is in need of improving as can be seen by the following indicators: (i) high maternal mortality rate (MMR) of 200 per 100,000 live births; (ii) ANC care with 4+ visits 43%; and (iii) Contraceptive prevalence rate of 46%. Although some progress has been achieved, the child health situation is still lagging behind targets with the under-5 mortality rate of 62%. The country has a high burden of Tuberculosis and HIV with higher than average prevalence and incidence in urban areas of the country. Prevalence of Tuberculosis is 434/100,000 in all age groups and prevalence of smear-positive is 172/100,000. TB is higher in the urban than the rural areas and among adults in urban areas prevalence is close to 1%.

22. According to UNAIDS, HIV prevalence in Myanmar is one of the highest in Asia. The epidemic is concentrated more in urban areas with highest prevalence among sex workers, men who have sex with men and injecting drug users. For 2013, UNAIDS estimated that 189,000 people were living with HIV, with 7,000 new infections occurring in the same year. 43% of eligible people are on anti-retroviral treatment. The National AIDS Programme estimates that 7.1% sex workers, 4.1% of clients of female sex workers, 8.9% men who have sex with men, 18% of people who inject drugs and 0.7% of young people aged 15-24 are HIV infected.

23. According to the World Life Expectancy database, Myanmar’s top ten causes of deaths are Injuries, Coronary Health disease, Influenza, Stroke, Tuberculosis HIV/AIDS, Malaria, Lung Disease, Diarrhoeal Diseases and Hypertension. The same source also indicates that the country’s world rank in injuries is No 1, in Peptic Ulcer No 7, in Rheumatic Heart Disease No 10, in Syphilis No 11, in Oral cancer No 16, in Drug Use 19 and in Hepatitis B is 20.

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13 WHO Myanmar Health Profile Last update May 2013.
14 WHO Myanmar Health Profile Last update May 2013
15 WHO Myanmar Health Profile Last update May 2013
16 WHO Myanmar Health Profile Last update May 2013
17 2009 – 2010 TB Prevalence Survey
18 Review of the National TB Programme, Myanmar, 7-15 November 2011, WHO
19 HSS 2012
Table 1: Myanmar’s top ten cause of Deaths

<table>
<thead>
<tr>
<th>Top ten Causes of Deaths</th>
<th>Deaths per Year</th>
<th>% of Deaths</th>
<th>World</th>
<th>nk</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Other Injuries</td>
<td>142,460</td>
<td>26.83</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2 Coronary Heart Disease</td>
<td>58,211</td>
<td>10.96</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td>3 Influenza &amp; Pneumonia</td>
<td>46,761</td>
<td>8.81</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>4 Stroke</td>
<td>33,929</td>
<td>6.39</td>
<td>91</td>
<td></td>
</tr>
<tr>
<td>5 Tuberculosis</td>
<td>28,372</td>
<td>5.34</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>6 HIV/AIDS</td>
<td>18,458</td>
<td>3.48</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>7 Malaria</td>
<td>16,644</td>
<td>3.13</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td>8 Lung Disease</td>
<td>16,338</td>
<td>3.08</td>
<td>58</td>
<td></td>
</tr>
<tr>
<td>9 Diarrhoeal diseases</td>
<td>13,919</td>
<td>2.62</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>10 Hypertension</td>
<td>12,292</td>
<td>2.32</td>
<td>56</td>
<td></td>
</tr>
</tbody>
</table>

Source: http://www.worldlifeexpectancy.com/country-health-profile/myanmar

24. Diabetes Mellitus, Low birth weight, Lung Cancer, Birth Trauma, Kidney Disease, Liver Disease, Asthma, Peptic Ulcer and road Traffic Accidents are the other 10 in addition to the top ten mentioned above.

25. Rapid urbanization has its consequences in terms of hunger, poverty, inadequate shelter, social segregation, unemployment, and pollution which would have contributed to most of the above top ten causes of diseases mortalities. Rapid and unplanned urbanization is also associated with lifestyle changes characterized by unhealthy nutrition, reduced physical activity, and tobacco/drug consumption. These unhealthy lifestyles are associated with common, modifiable risk factors for chronic diseases, such as hypertension and diabetes mellitus.

2.3. Policy, legal, and institutional environment for urban health

Key Issues:
- Stewardship by MOH of non-public urban health services should be stronger (or) leading role of MOH for non-public urban health services
- Weak coordination among stakeholders
- No health policies for urban health
- No policy for addressing special needs of the urban poor

26. The urban health subsector consists of a number of stakeholders. Several ordinances and acts\(^\text{20}\) have clearly assigned the provision of preventive health and limited curative care as a responsibility of the different authorities. MOH is the lead government ministry for health; it remains responsible for emergency, primary, secondary, and tertiary care for urban inhabitants and for providing guidelines and logistic support to other care providers. Though services range from pharmacies to super-specialties, ability to pay and inappropriate operating hours hinder access, particularly for the poor. More than two dozen international and over one dozen national NGOs are engaged in some form of health care delivery for the urban poor in Myanmar. The identification of roles for the various stakeholders and creating a synergy within the legal framework of the country are major tasks towards developing an efficient urban health network.

\(^\text{20}\) Notably; The Public Health Act, 1972, Prevention and Control of Communicable Disease law 1995 (revised in 2001), Law related to Private Health Care services 2007 etc.
27. The current institutional arrangements for urban health care are spread thinly within MOH, MOLE&SS (SSB), Local Government bodies, NGOs, the private sector, and many others, and are not strong enough to cope with the growing needs and challenges of urban health and particularly serving the poor. Although the MOH has its health care service delivery structures with Township hospitals, Urban Health Centres, Sub-Centres and Home visits by Midwives these are unfortunately not fully realized as yet\(^{21}\), and adequate measures have not been taken vis-à-vis the complex urban health problems and challenges. The stewardship role of the public sector is constrained by a weak enforcement of legal framework and institutional linkages and lack of coordination.

28. Due to limited human and financial resources, public sector health services have, thus, not kept up with demand. Private health care providers are the main sources of curative care, including tertiary and specialized services, to the urban population, but they seldom provide preventive health services. MOH remains responsible for primary, secondary and tertiary care of urban inhabitants and for support service delivery in urban areas through others such as the SSB, NGOs and others.

29. In the urban areas of Myanmar, there are many service providers and NGOs providing PHC services. Heterogeneous standards, approaches, and overlapping services create contradiction and confusion both for clients and providers. There is no forum to coordinate the programs provided by different providers. There is absence of a *Myanmar Urban Health Sector Strategic Plan* to establish a mechanism of governance structure incorporating all ministries, agencies, and institutions with responsibility for urban health with the core aim of stimulating the demand for, and provision and monitoring of, services in urban areas, especially for the poorest and most marginalized populations.

### 2.4. Health care delivery and management systems

**Key Issues:**
- Insufficient referral system for urban essential health services
- Inadequate facilities, equipment, and medicine supplies
- No mapping of urban health services
- Existing service outlets and service giving timing not conducive for the poor
- Poor coordination

#### 2.4.1. MOH Facilities

30. The MOH operates different categories of health care service outlets, hospitals, maternity and health centres at different levels. In the Yangon region there are 12 specialist hospitals, 9 general hospitals, 2 hospitals with 100 and 150 beds, 28 Township hospitals, 28 Station Hospitals, 20 Maternity centres, 34 Urban Health centres and 21 School Health Centres for its 5.9 million population, and also to serve others who come from all over the country. In addition to these there are some secondary health centres and sub health centres. For out-reach services a pool of Midwives, Lady Health Visitors and, PHSs are also engaged. Medicine at all levels and outlets is free since the last six months; however due to other resources limitations, the public sector health services have not kept up with demand. Mentioned below are some of the common problems experienced in the public health services limiting service to the poor and also to others:

1. Other opportunity costs such as transport, loss of wage etc. and absence of demand side financing mechanisms is a barrier for the poor even after the provision of free medicine.

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\(^{21}\) During filed visit to Hlaingtharyar and Shwepyithai Townships, Hospital OPD visits on the day were 20-25 and IPD occupancies were 60 – 80%. UHC OPD treated only 6 and its delivery room found not in use due to absence of 24 hour care provider provision. However the combined TB screening and vaccination in the community found to be well attended. MWs finding difficulty going on field visits due to high transportation cost (in some case K 6000 a day).
II. Not enough out-reach sessions within close proximity of poor settlers and at times convenient for them.

III. Due to lack of transport facilities and high transportation cost (at times as high as up to K 6,000 per return visit – around US$ 6), midwives and other field workers cannot visit far away households.

IV. Due to lack of provision for 7/24 operating hours of delivery service at UHCs, the use of delivery room is not satisfactory.

V. Low awareness among the poor about health and availability of health facility and services, operation timing etc. is another barrier for the poor.

VI. Weak social mobilization and use of community network for demand creation.

VII. Lack of comprehensive referral system and follow-up mechanism.

VIII. Inadequate budget for ambulance operation and maintenance.

IX. Inadequate manpower and absence of providers’ incentives for good and additional work.

X. Absence of urban health care delivery plan targeting the poor.

2.4.2. Private Sector

For-profit private sector

31. Private hospitals and private care providers are legally allowed to offer services and undertake practice after registration following the Law related to private care services adopted in the year 2007. Due to limitations of the public sector described above the private health care providers are the main sources of curative care, including tertiary and specialized services, to the urban population. Urban health care facilities are predominantly run by the private for-profit sector, with services ranging from pharmacists to medical specialists, but they seldom provide preventive health services.

Non-Government Organisations (NGOs)

32. Both international and national NGOs play an important role in providing basic health services to the urban population, but their coverage is limited compared to the need. NGO-run health care facilities operate in cooperation with the MOH where screening and treatment of HIV/AIDS and TB is provided in line with national guidelines. NGOs receive funds from the Global Fund, bilaterals as well as other donor agencies. There is also a process of local fund generation through community contribution being tried by some NGOs such as the People’s Health Foundation.

33. Among the national NGOs Myanmar Maternal and Child Welfare Associations (MMCWA) has the largest network across the country, working closely with the MOH. Myanmar Medical Association (MMA) and Myanmar Red Cross are other important local NGO players. Mentioned below are some of the international NGO programmes in the urban areas of the Yangon region. NGO activities widely vary between providing specialized HIV treatment to community level awareness building for preventive and mitigating measures.

34. People’s Health Foundation (PHF): A national NGO, founded in 2012 by a group of senior public health experts and clinicians. It is working to support and improve the universal access to health care by all, with particular emphasis to underserved and underprivileged population in rural and peri-urban areas. PHF has a network of 32 clinics of which 12 are located in the Yangon region. The clinics are run by 3-4 staff including 1-2 medical officers. Daily average attendance in a clinic is around 30 patients. In addition to general treatment, MNCH, HIV and TB, there are also provisions of periodic specialist consultations. Most patients who are poor receive treatment and medicines for free, additionally, when needed, patients are also assisted with transportation costs to reach hospitals in case of referral. In cooperation with Golden Rose Cancer Foundation, PHF’s clinics also offer cancer screening and treatment services.
35. **Medical Action Myanmar (MAM):** Established in 2009, MAM is running two busy clinics, one in Hlaingtharyar and the other one in Shwepyithar. The Thazin Clinic in Hlaing Thar Yar gets about 250 OPD visits a day (60% HIV patients, 20% under five children, 10% family planning, 10% maternal care and 10% other general patients). Services here include health consultation/outpatient, antenatal care, postnatal care (no deliveries), reproductive health support program/products, counselling, feeding centres, health education, de-worming, and malaria. The clinic has 40 staff, including 5 medical officers, nurses, counsellors and health workers and 5 field workers. All treatment is provided free of cost. The clinic does not own an ambulance, but MAM pays transportation costs to patients who need referral elsewhere and sends a staff member to accompany the patient.

36. **Médecins Sans Frontières (MSF) Holland:** Established in 1992, MSF runs an extensive HIV, HIV-TB and MDR-TB programme with 1,200 international and local staff. MSF provides ARV treatment to over 32,000 patients. It also provides annually TB treatment to 2,500 TB patients, Malaria treatment to 122,380 patients and 660,000 primary health care consultations. In Yangon, MSF runs an integrated MDR-TB treatment programme in partnership with MOH. Earlier MSF was running a basic health care programme, but due to its work load on specialized HIV treatment it has handed over its general clinics to other NGOs and is now focusing on HIV and TB.

37. **Première Urgence – Aide Médicale Internationale (PU-AMI):** Started in 2001, PU-AMI operates with 400,000 beneficiaries across the country. In Yangon, PU-AMI works in Dalah, Twantay and Seikkyi Khanaundho townships. PU-AMI has two types of projects, one with an integrated approach covering water, sanitation, health hygiene, livelihood, reproductive health, and prevention and treatment of sexually transmitted diseases and HIV, the other with HIV focused interventions. With the integrated approach, PU-AMI works in communities through community committees and through a network of health volunteers, auxiliary midwives and midwives.

38. **Alliance** has been working with 30 community based organizations (CBOs) since 2004, reaching approximately 13,000 people annually. It focuses on steady improvement in access to HIV prevention, treatment and care. In 2013, Alliance worked with 24 CBOs in Yangon and other areas, and reached 8,165 and 1,459 sex workers. It offered support and care to 4,984 individuals and 1,247 of them were given ART in clinics supported by Alliance. In addition to this, it focused on HIV work through its reproductive health integrated services, offering consultations and care to 3,994 individuals.

39. **Burnet Institute Myanmar** is working at Township level health systems to deliver the essential MNCH services package and community based delivery of essential MNCH activities in Yangon and other areas. Burnet provides capacity building technical assistance for development of Township Health Plans following the GAVI guideline for township health assessment (September 2011). The processes include undertaking need assessment for 3-4 months and facilitating a participatory planning for better delivery of essential MNCH Health Services Package which takes about 2 months. So far a health plan for one township is prepared for these processes. Burnet developed Township level Referral Process Guidelines and supports capacity building of Volunteer Health Workforce (AMW, CHW’s & TBA’s). At the community level they work with partner organizations to undertake community mobilization activities; community knowledge and demand for essential MNCH activities, increased access to birth and emergency preparedness at the community level. In the Yangon region Burnet works in Insein, Thanlyin and South Dagon townships.

40. **PSI** started in Myanmar in 1995 with an early focus on HIV prevention that expanded into reproductive health and STI treatment. In 2001, PSI added malaria prevention products to its portfolio, which now also includes household water treatment, a pre-packaged diarrhoea treatment kit, pneumonia treatment, tuberculosis treatment and voluntary counselling and testing (VCT). With
a $25 million grant from Bill & Melinda Gates Foundation in 2008, PSI started supporting private sector approaches to delivering integrated health services in low-income environments through social marketing. PSI supports the Sun Quality Health (SUN), a network of private physicians who are trained and monitored on reproductive health services and treatment for malaria, tuberculosis, pneumonia and sexually transmitted infections (STIs).

2.4.3. Coordination

41. Urban health care services are the responsibility of MOH, but due to limited resources, facilities and health manpower this responsibility could not be carried out satisfactorily. In addition to its care providers role the MOH has also got an overall health services coordination role. Towards this, limited initiatives have been taken, i.e. mapping and inventory of facilities, establishing coordination mechanisms and effective primary, secondary, and tertiary referrals.

42. In the urban areas of Myanmar, there are many service providers and NGOs providing PHC services. Heterogeneous standards, approaches, and overlapping services create contradiction and confusion both to clients and providers. There is no forum to coordinate the programmes of different providers. There is an absence of an Urban Health Sector Strategic Plan to establish a mechanism of governance structure, incorporating all ministries, agencies and institutions, with responsibility for urban health. Its core aim will be to stimulate demand for and provisions for services and monitoring, especially for the poorest and most marginalized populations.

2.5. Health care financing

**Key Issues:**
- Very low per capita expenditure for health
- Free medicine for all may lead to misuse
- Options for demand side financing mechanisms not fully explored

43. The Ministry of Health (MOH) is the single-largest financing agent in the public domain, responsible for 73 percent of all public funds and 17 percent of all funds from external sources. Expenditures of MOH have increased nearly 10-fold in the last 5 years – from 55.8 billion kyats in 2009-10 (equivalent to less than $1 per person per year) to around 500 billion kyats in 2013-14 (equivalent to over $8 per person per year). The most significant change took place in 2012-13, when MOH expenditures rose from 86 billion kyats to 362 billion kyats, more than three times increase in just one year. As a share of total government spending, MOH expenditures on health increased from a little over 1 percent in 2011-12 to almost 4 percent in 2013-14. Despite this increase, MOH spending on health remains under 1 percent of the country's GDP (Note: Population and exchange rate numbers are taken from IMF Country Report No.13/250).

44. The Social Security Scheme has been introduced with the 1954 Social Security Act and its 2012 amendments by the Ministry of Labour. According to this law, factories having more than 5 workers are liable to contribute to the Social Security Fund @ 3% of workers wage as factory contribution against 2% of wages’ contribution from the worker. Under this scheme 600,000 factory workers are insured for required medical care. The Social Security Board runs one hospital in Yangon and one health centre in Hlaingthayar. Another hospital in the industrial zone of Hlaingthayar and a mobile bus hospital are ready to start operating as from April this year.

45. With the urban population growing at a rapid pace due to the increased migration of the poor from the rural areas, adequate health care facilities are lagging behind. Substantial resources are needed to increase the access of the poor and marginalized urban population to quality health care. Current
level of resources allocated to health facilities for operation and maintenance are inadequate, and plans have to be formulated to ensure a continuous and increasing availability of funds to create a credible urban health care delivery system. Due to deficient financial resources, public health infrastructure and PHC services in urban areas are inadequate.

46. Other financing mechanisms have not been tried out in Myanmar. With its low health budget the provision for free medicine for everybody may use up the scarce resource. What will be more effective is the ring fencing of public resources for the poor and for special needs care. The mechanisms for demand-side financing (DSF) through piloting of a maternal health voucher and other schemes can be explored.
3 **Urban Health for Poor - Proposed Interventions**

47. This section outlines the proposed interventions for the 3MDG Fund to support health for the urban poor against the analysis described in the previous section covering (i) purpose and focus; (ii) result areas; (iii) strategies; and (iii) indication of the ways the activities to be implemented. The recommended further assessment and design missions will work on spelling out these with more descriptions on what, who, how, when etc. with required adjustments.

3.1. Purpose and focus of the intervention

48. The overall purpose is to support the urban health services for the poor i.e. improved health and nutrition status of the urban poor in Myanmar (initially of the Yangon region) through sustainable, integrated services provided and managed in a coordinated national urban health care delivery system.

49. The specific focus will be the achievement of improved provision of integrated essential health services for the urban poor through capacity building of a network of public, private and NGO care providers and communities with guidance and coordination from the Yangon Regional Health Development, under the regulatory and monitoring umbrella of the Union’s Ministry of Health.

50. The above purpose and focus are supportive of the anticipated impact and outcomes of the country health plan 2011-2016 and the overall objective of the 3MDG Fund’s support to the Government’s goal to ensure quality and equitable health care for all citizens, as expressed in the national health policy and country health plan. The objective is to contribute to improved access to and utilisation of essential health, population and nutrition related services, particularly by the poor (initially the Yangon region). This will be achieved through sets of activities under four main result areas:

   **A) Urban health systems capacity building;**

   **B) Creating provisions for increased and improved essential health services for the urban poor of the Yangon region;**

   **C) Enabling the poor to access services and**

   **D) Developing PPP models for delivery of essential health care services.**

3.2. Strategies

51. The 3MDG Fund will support to strengthen urban health service management capacity of the Yangon Regional Health Department and selected township health authorities and assist to foster collaboration between the MOH and all other key urban health care providers such as the Social Security Board of the Ministry of Labour, Employment and Social Security (MOLE&SS), the NGOs and private practitioners, by building mutually supportive capacity and establishing model interventions at the Township level. Support will be provided to the Yangon regional and selected Township health authorities to develop comprehensive urban health plans and support their implementation. Building urban health institutions with support from the urban health task force will be an important aspect of the strategy. Collaboration with the Yangon City Development Council (YCDC) and other municipality authorities and community organisations will be a major strategy. Partnership development and stronger collaboration between MOH, YCDC and MOLE&SS will enable the two ministries and the YCDC local authority involved in urban health to recognize their roles and to collaborate in establishing models for urban essential health nutrition and population services.
delivery for industrial workers who constitute a major portion of urban poor. The collaboration between MOH and the private sector will develop models of public-private partnerships (PPP).

52. It is important to address the urban health issue with a holistic approach and build the required policy, governance and management environment to support urban health. These require a number of processes to be in place and time for existing system to be fully responsive and adjust its priorities in the context of current needs of ongoing activities. However, the urgency of making immediate arrangements for improved and increased health care service delivery to the poor cannot and should not wait until the capacity of the existing health systems is fully developed to serve the urban poor. Therefore, an important strategy of the intervention will be to put a higher priority on activities under intervention result area 2, creating provisions for increased and improved essential health services for the urban poor, and intervention result area 3, enabling the poor to access services and focus on making service delivery.

53. Initially, it is suggested that the intervention will work within selected Townships of the Yangon region to improve their ability to manage health and nutrition services of the public health sector as well as through PPP. This may include the creation of models to contract NGOs and private entities to deliver services particularly in unserved pockets and areas where poor are concentrated. Service delivery packages will be developed based on the need for specific cluster of locations and profile of population including scope for development of community-focused integrated health improvement and Township based health networks. The Urban Health Task Force (UHTF) will develop an urban health country strategy and framework to maintain quality standards, monitor the programs and fine-tune models for replication. The UHTF will assist in implementing the contracting model and coordinating with public and environmental health and other urban and township interests.

3.3. Expected results and result areas

54. The expected results of the health for urban poor intervention are as follows;

A. Effective government management of essential health, nutrition and population services for the urban poor in the Yangon region.
   1. Strengthened capacity of central, regional and township health departments to manage delivery of essential services for the urban poor
   2. Strengthened capacity of central DOH, Yangon RHD to enforce the urban essential health service policy, standards and monitoring system

B. Increased and improved essential health, nutrition and population services provided to the urban poor of the Yangon region
   1. Increased utilization of public sector offered essential health, nutrition and population services by the urban poor in township hospital OPDs, UHCs and in out-reach sessions
   2. Increased utilization of essential health, nutrition and population services by the urban poor offered through NGOs and private health care providers

C. Enabling the poor for increased utilization of services: demand side financing mechanism developed and implemented
   1. Health/Nutrition voucher and conditional cash grant for poor developed and piloted
   2. Community interventions to support the poor

D. PPP models for health care of the urban poor developed and tested
   1. PPP models for health care service delivery to the poor is developed, implemented and evaluated
3.4. Indication of the main activities to be carried out towards achieving results

55. Main activities to be organized towards achieving the expected results and result areas are as follows:

**Result A:**
Effective government management of essential health, nutrition and population services for the urban poor in the Yangon region.

**Results area A1:**
Strengthened capacity of central, regional and township health departments to manage delivery of essential services for the urban poor.

**Main Activities:**
(i) Support the preparation of “health service delivery plans for reaching the urban poor” as part of the existing health plans; (ii) Provide financial and management assistance for the implementation of urban health plans; (iii) support the joint action plan for MOH and MOLE&SS for improved and increased health care service delivery to industrial workers; (iv) Orient RHD and Township health department officials on urban health service delivery planning and implementation through study visits and training; (v) support further building of Management Information System (MIS) with poverty status disaggregated data and reports; (vi) further building of the scopes of hospital trust fund and equity fund; (vii) support roll out of development planning in new Townships, and (viii) Train Urban Health Volunteers on social mobilization for essential health, nutrition and population EHNPs services.

**Results area A2:**
Strengthened capacity of central DOH, Yangon RHD to enforce the urban essential health service policy, standards and monitoring system.

**Main Activities:**
(i) support creation of an Urban Health Task Force (UHTF) for the Yangon region and provide assistance to its functions; (ii) support development of an Urban Health Strategy and QA monitoring framework; (iii) develop procedures to support the implementation of the urban health strategies; (iv) prepare a guidebook on essential health, nutrition and population service specifications, standards/quality and monitoring arrangements for urban health services; (v) design/prepare an urban health service management information system; (vi) develop and implement an “urban health quality contest”; (vii) orientation and training for RHD officials and TMOs on urban health service monitoring and quality assurance (viii) support Townships in managing, administering, coordinating and supervising health care delivery by NGOs and private sector and; (ix) review current urban health policies, strategies, rules and regulations and recommend/develop required new and revised ones (supplementary, complementary and updates).

**Result B:**
Increased and improved essential health, nutrition and population services provided to the urban poor of the Yangon region.

**Results Area B1:**
Increased utilization of public sector offered essential health, nutrition and population services by the urban poor in township hospital OPDs, UHCs and in out-reach sessions.

**Main Activities:**
(i) select townships for health system strengthening; (ii) support development of local plans for mobile/satellite clinics and out-reach services
and their implementation; (iii) support needs assessment for facility renovation/repair, equipment, transport and improvement actions/measures; (iv) support the development and implementation of effective referral mechanism; (v) support skill development training for all categories of health workforce including AMWs and CHWs/CHVs and; (vi) develop performance based incentive system for special services and support implementation.

**Results Area B2:** Increased utilization of essential health nutrition and population services by the urban poor offered through NGOs and private health care providers.

**Main Activities:**
(i) establish a RHD and 3 MDG Fund joint structure to commission and manage PPP, (ii) support NGO and private sector contracting for delivery of selected services and to support public sector to selected clusters of unserved areas and monitoring of service delivery; (iii) develop and implement a network of private providers to service the poor.

**Result C:** Enabling the poor for increased utilization of services: demand side financing mechanisms developed and implemented.

**Results Area C1:** Health/Nutrition voucher and conditional cash grant for poor developed and piloted.

**Main Activities:**
(i) identification of poor to support demand side interventions; (ii) develop and introduce nutrition/health vouchers, (iii) Develop and introduce conditional cash grants for nutrition improvement, completion of TB treatment etc.; and (iv) support social mobilization and health awareness building.

**Results Area C2:** Community interventions to support the poor.

**Main Activities:**
(i) support community referral fund; (ii) support community based water, sanitation, livelihood and Income Generating Activities (IGA) activities for the poor; (iv) support urban health networks for building civil society voice for health of the poor.

**Results D:** PPP models for health care of the urban poor developed and tested.

**Results Area D1:** PPP models for health care service delivery to the poor is developed, implemented and evaluated.

**Main Activities:**
(i) Cross-country study visits to draw lessons learned on PPP to reach urban poor; (ii) Develop and implement models on “PPP for essential service delivery for the urban poor”; (iii) Workshops and conference on PPP models; and (v) Document PPP implementation experiences and facilitate sharing.
## 3.5. Assumptions and Risks mitigation measures

### Identification of potential risks and mitigating measures

<table>
<thead>
<tr>
<th>Assumptions</th>
<th>Mitigation Measures</th>
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<tbody>
<tr>
<td><strong>Political</strong></td>
<td></td>
</tr>
<tr>
<td>a. Government sustains commitment to provide health services to urban poor</td>
<td>• Quick start for “result A and result B1” at least to show the results and facilitate alignment of activities with government policies and effective collaboration with government systems</td>
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<tr>
<td>including in temporary settlements</td>
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<tr>
<td>b. Health allocation of national budget continues to grow</td>
<td>• Form a multi-stakeholder <em>Urban Health Task Force</em> that advocates for health services for urban poor</td>
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<tr>
<td><strong>Policies</strong></td>
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<tr>
<td>a. The Urban Health Strategy is accepted by the Ministry of Health and others</td>
<td>• Regular exchange with MOH, Regional Government, YCDC</td>
</tr>
<tr>
<td>b. The Ministry of Health takes an urban health stewardship role and DOH supports RHD to exercise its decentralized role</td>
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<tr>
<td>c. The Ministry of Labour Employment and Social Security and its SSB remains interested to work jointly for urban health provisions for industrial workers</td>
<td></td>
</tr>
<tr>
<td>d. PPP and engagement of NGOs are recognised as important complimentary services</td>
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<tr>
<td><strong>Financial</strong></td>
<td></td>
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<tr>
<td>RHD and Township administration have sufficient funds to implement programmes and strategies for strengthening pro-poor urban primary health care delivery system</td>
<td>• Continued donor pool fund to support intervention on health care for the poor</td>
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<tr>
<td></td>
<td>• Provision of parallel fund at the disposal of RHD and TMOs for special initiatives</td>
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<tr>
<td></td>
<td>• Advocacy for allocation of fixed percentage of YCHD and Regional Government’s budget for health care for the poor</td>
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<td></td>
<td>• Support dialogue between Ministry of Health and Regional Authority in order to advocate the Ministry of Finance for a special fund for health care for the urban poor</td>
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<td></td>
<td>• Linkage with demand side financing mechanisms</td>
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</tbody>
</table>


4 CONCLUSIONS AND RECOMMENDATIONS

4.1. Conclusions

56. The urban population is growing at a rapid pace in Myanmar, and it is likely to reach 40% of the total population by 2015. Urbanization is also resulting in an increase of the urban poor who are living in poor hygienic conditions of slums and squatters and not receiving basic health care services. Increased and improved health care service provision is needed for the urban poor to have the impact necessary to achieve the Millennium Development Goals (MDGs).

57. Ministry of Health and the 3MDG Fund, keen to support an urban health intervention, commissioned a consultancy mission to undertake an assessment of the scope of problem and to outline probable intervention options. A donor and UN core group and the MOH officials supported the mission that was carried out during 18 February to 13 March 2014, and actively participated.

58. The mission included focused discussions and consultations on issues related to health care for the urban poor with MOH, SSB, NGOs, private practitioners and members of the civil society at national, regional and local levels. Findings of the mission’s initial assessment of the scope of the problem and tentative intervention options were presented and discussed in meetings with the TMOs, the Core Group and the Senior Consultative Group. There is general agreement with the key findings and the proposed intervention areas and related key activities.

59. There is also agreement that further work on designing details of the intervention is to continue. It is proposed for undertaking a more thorough assessment of the scope of the problem covering in-depth review of all important aspects and preparation of a comprehensive intervention plan based on such review by an Urban Health Task Force with the technical assistance of international and national consultants. However, there is consensus that tasks related to these are to be prioritised and sequenced in a way that implementation of the intervention is not delayed, and provision of service delivery to the poor can be undertaken immediately.

4.2. Recommendations

4.2.1. Commissioning the intervention design mission

60. Plan and commission the intervention detailing design mission by engaging a team of international and national consultants. The design phase should be guided by the Urban Health Task Force. As specified in the proposed TOR (Annex 5) the mission should undertake more in-depth assessments and detailed planning (what, how, when by whom etc.) of the intervention activities, but should on a priority basis undertake the following tasks during the first phase of the mission.

i. Map-out geographical areas of unserved/underserved slums, squatters and pockets where poor are concentrated and demarcation of clusters of priority target areas

ii. Undertake a study on health care seeking behaviour of the poor

iii. Design an integrated primary health care service out-reach programme for clusters of target areas to be delivered by NGOs and other private sectors

iv. Prepare a call for proposals for a commissioning partner agency
4.2.2. Continue information collection

61. Continue information collection on urban health problems, conditions of the urban poor, ongoing and future urban health intervention programmes, development cooperation for urban health, roles and activities of different care providers, new and/or revised legal and legislative provisions related to urban heath. Collect and share finding from UNICEF/WFP studies22, upcoming national census and other studies.

4.2.3. Continue discussions and dialogues with key stakeholders

62. Continue discussions with key stakeholders including MOH, SSB, YCDC, Yangon Regional Government and NGOs to sustain generated interests for health care for the urban poor and obtain firm commitments. Core group to continue meetings inviting/arranging presentation/discussion on “health for urban poor” issues and lessons learned stories until the Urban Health Task Force is established.

4.2.4. Support organization of the proposed conference on urban health in May 2014

63. The People Health Foundation planned to hold a conference on urban health in May this year with the purpose to create a platform for discussion on issues related to urban health, consensus building on policies/strategies/approaches and exploring ways to reach out to the poor. The organisers would like to work together with the 3MDG Fund and others who are interested to make this a success. Considering PHF leaders’ professional commitment,23 there is an opportunity to use this conference as a national forum on urban health to be explored quickly. It may also provide opportunity to introduce regional best practice experiences of health for urban poor initiatives to the conference participants.

4.2.5. Support creation of Yangon regional Urban Health Task Force

64. MOH should initiate the process for the creation of the Yangon regional Urban Health Task Force with involvement of the regional Minister of Social Affairs and RHD. Members should represent a large variety of stakeholders and could include YCDC, SSB, MMA, NGOs, and civil society representatives. Introducing the UHTF to other country experiences of health service for urban poor and use of PPP through study visits will provide opportunity to gather insights and an impetus for initiating activities.

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22 Bountry Maxime
23 The PHF founders are retired public health professionals worked in MOH senior positions and WHO in the region with sound understanding of urban health issues, high commitment to serve the poor and considerable understanding of the national environment
Annex 1. Terms of Reference

*Health for the urban poor – a comprehensive approach towards addressing urban healthcare needs through strengthening urban health care delivery systems*

**A. Background**

1. These Terms of References (ToR) have been drafted as a result of a meeting between H.E. Minister of Health and 3MDG Fund Board Representatives held in November 2013. At this meeting, H.E. Minister of Health highlighted the health needs of urban poor population and recommended that the 3MDG consider an expansion of the scope of service delivery coverage under Component 1 of the 3MDG. In particular, the imperative to address high rates of neonatal mortality was highlighted. An in-principle decision to take forward this expanded scope of work was unanimously taken at the 3MDG Fund Board meeting in mid-December 2013.

2. Ongoing discussion both with the Ministry of Health as well as other Development Partners has highlighted consensus around the need for strengthened donor coordination and aid harmonization. The 3MDG Fund therefore intends to develop formulation of this expanded scope of programming in partnership with the MoH and other Development Partners in order to ensure a coordinated, harmonised and agreed approach from the outset of programme design. This will enable the Fund to align with MoH strategies, draw upon the expertise and experiences of other Development Partners and to minimize fragmentation within the sector.

3. The approach proposed in these ToRs builds upon existing discussions with the Ministry of Health, and in particular around donor coordination and aid harmonization themes. 3MDG is currently advancing work which will result in the development of a unified and harmonized approach to direct disbursement of funds to the public sector (Fund Flow Mechanism). It is the 3MDG Fund’s intention to support further harmonization in terms of programmatic approach through a joint donor scoping mission, in order that any further fragmentation of the sector is avoided. This will result in wider consensus amongst donors and with the MoH around programmatic approaches. Current discussions around Myanmar’s commitment to UHC provide further impetus towards development of a unified approach towards aid assistance support to the sector, which is aligned with MoH priorities.

**B. Problem Statement**

4. Myanmar’s economy is rapidly transitioning into a competitive, open and market-driven economy. It is expected that emerging economic opportunities in urban areas will propel the rapid growth in urban populations as a consequence of significant rural to urban migration. Secondary data analysis supports the recommendation to include a focus upon the healthcare needs of the urban and peri-urban poor living in Yangon. UN-HABITAT estimates that at least 40 percent of Yangon’s five million (approximately 2 million) are poor or extremely poor, and are living in substandard housing or illegal dwellings. The challenge is further compounded by the speculation that

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24 AFP, “Frustration fomets in Yangon’s slums despite reforms.” December 5, 2012.
Yangon’s population is expected to double to around 10 million over the next 20-25 years. This will require substantial investment in the urban health infrastructure and service delivery systems.

5. Many of the urban poor reside in satellite townships and peri-urban areas – defined as of or relating to an area immediately surrounding a city or town. Population growth within these areas is widely anticipated as a consequence of growing urbanisation.

6. Although health services (mainly private sector) are more widely available in urban areas than in rural areas, poor people living in slums and sub-standard housing also suffer in terms of poor health status. Low-income groups are generally more vulnerable than other groups because they are the least able to afford treatment when sick. Low income group populations will also live in sub-standard housing and consequently will have limited access to clean water and sanitation.

7. The most recent Integrated Household Living Conditions Assessment undertaken in 2010 determined a poverty incidence was 15% in urban areas, and 29% in rural areas. But an earlier report by the Government of the Union of Myanmar from 2001 stated that the incidence of poverty is 23.9 percent in urban areas and 22.4 percent in rural areas. Further efforts to identify the urban poor and target population are a crucial initial step in terms of the approach, in order to develop an effective and efficient health intervention program.

8. The Ministry of Health has a well-established network of health facilities across Yangon. The largest tertiary and specialised hospitals are located in Yangon. The Ministry of Health plans to construct additional hospitals in urban and peri-urban areas.

9. The Ministry of Health has identified a number of “quick wins” as defined by interventions which can be speedily delivered and which promise an immediate improvement in health outcomes. The Government of Myanmar has allocated a substantial increase in the health budget and these funds are being used by the MoH for the procurement of substantial volumes of essential pharmaceuticals which are made available at health facilities and free of charge. Patient consultations for children under the age of 5 years and pregnancy women are free of charge. Initial reports indicate that the availability of free drugs has already resulted in higher attendance rates at clinics and increased uptake of service at public hospitals. In urban areas, where distance to health facilities and health service providers imposes a lesser financial hardship upon the sick than for those living in rural areas, there is the opportunity to move fast towards universal health coverage.

C. Linkages to other initiatives

10. The work on urban health care systems will build upon analytical work already undertaken by the MoH, the 3MDG Fund and other Development Partners. It will also build upon other on-going initiatives including those developed by the MoH as well those supported by the 3MDG Fund and other Development Partners. A number of streams of work currently being developed by the 3MDG Fund could be practically linked to formulation of this scope of work:

- MoH/3MDG initiative to strengthen midwifery services and in-service training
- 3MDG financing to SCMS to support the strengthening of a MoH-led unified supply chain management system

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27Merriam Webster, 2013.
- 3MDG support towards the development of a unified and harmonized approach towards financing of public sector service delivery ‘Fund Flow Mechanism’
- Integration of health services for the delivery of comprehensive primary health care
- Analytical work on policy options for the role of the private sector within the wider health sector

**D. Objectives of the consultancy**

11. An assessment and pre-design mission will identify the scope of the problem and propose possible options for interventions. A consultant will be engaged to work with the Ministry of Health, the 3MDG and other Development Partners.

12. The specific objective is to support the Ministry of Health to develop options leading to the design of a comprehensive health care programme for poor populations residing in peri-urban and urban areas of Myanmar, notably in Yangon.

**E. Scope of Work**

13. The International Consultant will be based in the 3MDG Fund Management Office under the overall supervision of the Fund Director.

14. S/he will work with the Ministry of Health, the 3MDG Fund, JICA, the World Bank, the UN Agencies and other relevant stakeholders. S/he will consult and collaborate with Development Partners through a Core Group consisting of representatives of the Ministry of Health, Naypyitaw and Yangon Regional Health Department, the World Bank, JICA, WHO, UNICEF, UNFPA and UNAIDS, in addition to the Fund Manager.

15. With the support of the Core Group, the consultant will address the following areas of work:
   1. **Assessment** - Identify the scope of the problem
      a. Target population and barriers to access services
      b. Geographical priorities
      c. Mapping of health services provided for urban population – public and private sector (not-for profit and for profit)
      d. Identify barriers and potential for the delivery of integrated health care services in urban settings in a context of UHC (Universal Health Coverage)
   2. **Propose options to design an intervention programme**
      a. Potential scope of work and prioritized areas of interventions, including possible outcomes and indicators
      b. Risks and challenges
      c. Estimated prioritized investment needs
      d. Identify opportunities for investments for the different Development Partners, based upon their individual strengths, including the 3MDG Fund

**F. Tasks**

16. The following tasks are to be carried out:
   - At an initial briefing meetings and under the guidance of the Core Group, agree upon the scope of work, identify key stakeholders and informants and approach (initial meeting)
   - Collect, review and analyse existing data to create a knowledge base and identify gaps in understanding around issues related to urban and peri-urban health care provision
   - Conduct interviews with MoH officials including Yangon Regional Health Department, Yangon Regional Government and other relevant stakeholders from within and outside the health to seek inputs and recommendations towards design of the proposed intervention
• **Provide feedback to the Core Group during at least 1 debriefing meeting**

• **Facilitate a meeting with Development Partners and other interested stakeholders to present approaches, also building upon options which are successful in other international contexts, in order to develop a possible options for the proposed approach**

• **Provide a briefing for the Ministry of Health on findings and recommendations**

### G. Deliverables

1. **A report on the results of the assessment, consultations held and identification of scope of the problem, target populations, geographic priorities, available services, potential for the delivery of integrated health care services in urban settings**
   
   **Options for the design of a programme in urban areas**
   
   i. **Outcomes**
   
   ii. **Indicators**
   
   iii. **Scope**
   
   iv. **Estimated prioritized investment needs**
   
   v. **Potential roles of different Development Partners, based upon their strengths**

2. **Conduct a debriefing meeting with the MoH to discuss the findings and recommendations**

### H. Duration:

- **21 working days (based in-country)**

### I. Academic and Professional Qualifications

• Masters of Science in public health, social sciences, business administration, or comparable areas.

• Proven track record of at least 10 years in a senior role in the field of planning and management of health care services in a developing country context.

• Previous work experience with different Development Partners, such as the Bretton Woods and UN systems, donors, academia, government, international Non-Governmental Organisations and civil society.

• Publications in peer reviewed journals or key reference documents is an asset
### Annex 2. Programme Schedule of the mission

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Organization</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-02-2014</td>
<td>09:00-17:00</td>
<td>3MDG</td>
<td>Briefing</td>
</tr>
<tr>
<td>Tuesday</td>
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<tr>
<td>19-02-2014</td>
<td>09:00-12:00</td>
<td>3MDG-Fund Director and team</td>
<td>Briefing</td>
</tr>
<tr>
<td>Wednesday</td>
<td>13:00-18:00</td>
<td></td>
<td>Travel to NPT to meet with officials from MoH</td>
</tr>
<tr>
<td>20-02-2014</td>
<td></td>
<td>MOH and DOH</td>
<td>Meetings with MoH officials (division wise meeting)</td>
</tr>
<tr>
<td>Thursday</td>
<td></td>
<td>DG, DDGs, D(DC)D(MC) D(PH)D(OH) D(EH)</td>
<td></td>
</tr>
<tr>
<td>21-02-2014</td>
<td></td>
<td>DG, DDGs, D(DC)D(MC) D(PH)D(OH) D(EH)</td>
<td>Continue meeting with MoH officials (if time available, travel back to YGN)</td>
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<tr>
<td>Friday</td>
<td></td>
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<tr>
<td>22-02-2014</td>
<td></td>
<td>Meeting with National Aids Programme</td>
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<tr>
<td>Saturday</td>
<td></td>
<td>Meeting with National TB Programme</td>
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<td></td>
<td></td>
<td></td>
<td>Travel back to YGN</td>
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<tr>
<td>Weekend</td>
<td></td>
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<tr>
<td>24-02-2014</td>
<td>09:00-12:00</td>
<td>Core Group Meeting</td>
<td>Initial briefing meetings and under the guidance of the Core Group, agree upon the scope of work, identify key stakeholders and informants and approach</td>
</tr>
<tr>
<td>Monday</td>
<td>13:00-16:00</td>
<td>RHD: Regional Director and team</td>
<td>Conduct meeting</td>
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<td></td>
<td></td>
<td></td>
<td>Ask appointment with Yangon Regional Government</td>
</tr>
<tr>
<td>25-02-2014</td>
<td>09:00-16:00</td>
<td>Meeting with WHO</td>
<td>Conduct meeting with NGOs running urban health programmes</td>
</tr>
<tr>
<td>Tuesday</td>
<td></td>
<td>Meeting with MSI</td>
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<tr>
<td></td>
<td></td>
<td>Meeting with Alliance</td>
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<tr>
<td>26-02-2014</td>
<td>09:00-16:00</td>
<td>Meeting with PU-AMI</td>
<td>Conduct meeting with NGOs running urban health programmes</td>
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<tr>
<td>Wednesday</td>
<td></td>
<td>Meeting with Burnet Institute</td>
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</tr>
<tr>
<td>27-02-2014</td>
<td>08:00-12:00</td>
<td>RHD: TMOs from six Townships</td>
<td>Conduct meeting with TMOs and their</td>
</tr>
<tr>
<td>Thursday</td>
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<tr>
<td>28-02-2014</td>
<td>09:00-16:00</td>
<td>Visit two townships: Township Hospitals</td>
<td>Conduct meeting with TMOs, NGOs, GPs, community Site visits</td>
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<tr>
<td>Friday</td>
<td></td>
<td>SSB Hospital/Clinic</td>
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<td></td>
<td></td>
<td>UHC, Sun Clinic</td>
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<tr>
<td>01-03-2014</td>
<td></td>
<td>Prepare Development Partner session</td>
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<tr>
<td>Saturday</td>
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<tr>
<td>Weekend</td>
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<tr>
<td>03-03-2014</td>
<td>09:00-12:00</td>
<td>Core Group and Development Partner’s Meeting</td>
<td>Presentation of tentative options to CG and DP prior to SCG meeting feedback</td>
</tr>
<tr>
<td>Monday</td>
<td>13:00-16:00</td>
<td>Meeting with UNHABITAT</td>
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<tr>
<td></td>
<td></td>
<td>Meeting with Minister of Social Affairs, Yangon Region</td>
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<tr>
<td>Date</td>
<td>Time</td>
<td>Activity</td>
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<tr>
<td>04-03-2014</td>
<td>12:00-01:30</td>
<td>Pre SCG presentation of options to the 3 MDG Fund board</td>
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<tr>
<td>05-03-2014</td>
<td>09:00 – 14:00</td>
<td>SCG meeting in NPT Presentation of outline of options</td>
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<tr>
<td></td>
<td></td>
<td>briefing for the Ministry of Health and SCG members on findings and recommendations</td>
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</tr>
<tr>
<td>06-03-2014</td>
<td>15:00 – 16:30</td>
<td>Meeting with People’s Health Foundation</td>
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<tr>
<td>07-03-2014</td>
<td>09:00-12:00</td>
<td>Field Visit; MAM Thazin Clinic</td>
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<tr>
<td>08-03-2014</td>
<td></td>
<td>Meeting with Action Aid</td>
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<tr>
<td>Week end</td>
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<tr>
<td>10-03-2014</td>
<td></td>
<td>Meeting with UNCEF/WFP Consultant Writing time</td>
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<tr>
<td>11-03-2014</td>
<td></td>
<td>Writing time</td>
<td></td>
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<tr>
<td>12-03-2014</td>
<td></td>
<td>Debrief 3MDG team</td>
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<tr>
<td>13-03-2014</td>
<td></td>
<td>Report Writing Debrief 3 MDG Fund Meeting with MSR</td>
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<tr>
<td>14-03-2014</td>
<td></td>
<td>Report Writing</td>
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<tr>
<td></td>
<td></td>
<td>Departure</td>
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</tr>
</tbody>
</table>
Annex 3. List of people met

**Directorate of Health, Ministry of Health**

1. Dr. Min Than Nyunt, Director General, Department of Health, DOH, Ministry of Health
2. Dr. Than Win, Deputy Director General (Medical Care), DOH, Ministry of Health
3. Dr. Khin Win Thet, Deputy Director (Medical Care), DOH, Ministry of Health
4. Dr. Thida Hla, Deputy Director (Medical Care), DOH, Ministry of Health
5. Dr. Hla Mya Thway Einda, Deputy Director (CHEB), DOH, Ministry of Health
6. Dr. Thu Zar Chit Tin, Deputy Director (Basic Health Section), DOH, Ministry of Health
7. Dr. Myint Myint Than, Deputy Director (WCHD Section), DOH, Ministry of Health
8. Dr. May Kin Than, Deputy Director (National Nutrition Centre), DOH, Ministry of Health
9. Dr. U Htay Win, Deputy Director (Environmental & Sanitation Division), DOH, Ministry of Health
10. Dr. Thandar Lwin, Deputy Director National TB Programme
11. Dr. Myint Shwe, Deputy Director, National AIDS Programme
12. Dr. Win Naing, Director (Epidemiology), DOH, Ministry of Health
13. Dr. Nu Nu Kyi, Deputy Director (Epidemiology), DOH, Ministry of Health
14. Dr. Toe Thiri Lwin, Assistant Director (Epidemiology), DOH, Ministry of Health
15. Dr. Nyan Win Myint, Assistant Director (Epidemiology), DOH, Ministry of Health
16. Dr. Khin Khin Gyi, Assistant Director (EPI), DOH, Ministry of Health
17. Dr. Mya Thein, Assistant Director (Occupational Health), DOH, Ministry of Health

**Social Security Board, Ministry of Labour, Employment and Social Security**

18. U Yu Lwin Aung, Director General, Social Security Board, MoLE&SS
19. Dr. Lwin Lwin Oo Hlaing, Deputy Director (Medical Section) SSB, MoLE&SS
20. Dr. Nilar Tun, Deputy Director (Medical Section) SSB, MoLE&SS

**Yangon Regional Health Department**

21. Dr. Aye Ko Ko, Regional Health Director, Yangon
22. Dr. Swe Zin Win, Deputy Regional Health Director, Yangon
23. Dr. Ni Ni Hlaing, Deputy Regional Health Director, Yangon
24. Dr. Phyu Phyu Aya, Deputy Regional Health Director, Yangon
25. Dr. Sanda, Regional Officer (MNCH), RHD Yangon
26. Dr. Myo Thant, Regional Office AIDS and STD, RHD Yangon
27. Dr. Tin Mi Mi Khailing, Regional TB Officer, Yangon Region
28. Dr. Phyo Phyo Kyaw, Epidemiologist, RHD Yangon

**UN Agencies**

29. Dr. Eva Nathanson, Technical Officer (TB), WHO
30. Dr. Erwin Cooreman, Medical Officer (TB), WHO
31. Dr. Ni Ni Lwin, Health Officer (MNCH), UNICEF
32. Mr. Michael Slingsby, Urban Development and Poverty Adviser, UNHABITAT

**INGOs/NGOs**

33. Dr. Sid Naing, Country Director, MSI Myanmar
34. Dr. Phone Myint Win, Country Representative, Burnet Institute, Myanmar
35. Dr. Nay Win Ko Ko, Burnet Institute, Myanmar
36. Dr. May May Khin, Burnet Institute, Myanmar
37. Dr. Hnin Kolay Kyaw, Burnet Institute, Myanmar
38. Dr. Soe Naing, Executive Director, International HIV/AIDS Alliance
39. Mr. Philippe Schneider, Regional Director, PU-AMI
40. Mr. Gael Thomas CONAN, Country Director, PU-AMI
41. Dr. Zarni Hyun, Medical Coordinator, PU-AMI
42. Dr. Dorian Job, MSF Holland
43. Dr. Than Sein, President People’s Health Foundation
44. Dr. Thein Swe, Vice President People’s Health Foundation
45. Dr. Kyaw Kyaw, People’s Health Foundation
46. Dr. Tin Kyaw Oo, People’s Health Foundation
47. Dr. Ni Ni Tun, Medical and Operational Coordinator, MAM
48. Mr. Shihab Uddin Ahmed, Country Director, Action Aid, Myanmar
49. Mr. Tauhid Ibne Farid, Program Manager, Action Aid, Myanmar
50. Mr. Fahmid Karim Bhuiya, COO, Pact Global Microfinance Fund, Myanmar

Hlaing Thar Yar Workers Hospital (SSB)
51. Dr. Khin Aye Myint, TB Specialist
52. Dr. Nay Chi On, Assistant Surgeon

SSB Clinic, Hlain Thar Yar
53. Dr. Ei Ei Hmwe, Medical Officer
54. Dr. Hnin Thire Maung, Medical Officer
55. Dr. Nay Linn Phoyo, Medical Officer
56. Mr. Uhla Myint, Manager

Hlaing Thar Yar Township Hospital
57. Dr. Daw Khin Yupar Soe, TMO
58. Daw Phy Phy Nwe, Township Health Nurse
59. Daw Nwe Nwe Htay, Health Assistant
60. Daw Thein Thein Tin, Midwife
61. Daw Nan Khin Lay, Health Assistant

Shwe Pyi Thar Township Hospital
62. Dr. Mi Mi Khin, TMO, Shwe Pyi Thar
63. U Tint Lwin, HA 1 Shwe Pyi Thar

Others
64. Dr. Kyaw Myint Oo, Private Practitioner, Sun Clinic
65. Dr, Bountry Maxime, UNICEF/WFP Consultant
66. Dr. San Tun, MSR
Annex 4. The Problem Tree

Progress towards attainment of improved health status of urban poor population constrained

Effects
- Medical skills shortages in urban areas
- Lack of coordination among urban health care service providers
- Uneven access to and quality of urban essential health care services
- Inadequate financial resources for essential health care delivery
- Limited pro-poor access to urban EHC, particularly, urban slum dwellers

Core Problem
- Inefficient resource management and weak coordination throughout the system
- Lack of quality essential health services in urban areas
- Limited access and equity in urban essential health services

Causes
- Access
  - Low EHC utilization rates of urban poor
  - User fees barrier to urban poor
  - Insufficient pro-poor financing schemes
  - Social exclusion and lack of knowledge
  - Limited budgets
- Quality Provision
  - Lack of consistent urban EHC QA and supervision system
  - Insufficient provision of drugs and consumables at urban EHC centers
  - Lack of qualified health staff and high staff turnover
- Policy and Institutional
  - Lack of consistent urban EHC QA and supervision system
  - Insufficient referral system for urban EHC
  - Weak coordination among stakeholders
  - No health policies for urban health
  - Lack of adherence to MOH standards
- Health Care Services
  - Insufficient referral system for urban EHC
  - Inadequate facilities, equipment, and drug supplies
  - No mapping of urban health services
- Health Management
  - Lack of integrated HRD strategies for urban health care delivery
  - Weak health management, clinical supervision, and HMIS
  - Limited quality performance and results monitoring
- PPP
  - Public sector hesitant to adopt PPP
  - Unregulated Private sector
  - Huge variations in service provision among for profit Private sectors and NGOs
- Governance, Finance and HRD
  - Lack of planning and management capacities at Township levels
  - Limited delegation
  - Ineffective community participation
  - Weak compliances of regulation (OTC and Quacks)
- Pro-Poor Targeting
  - Inadequate targeting mechanisms
  - Low awareness of public
  - Inadequate outreach services and social marketing
  - Lack of knowledge/health seeking behavior among urban poor
Annex 5. TOR of the detailed intervention, design mission

HEALTH FOR THE URBAN POOR
INTERVENTION DESIGN TECHNICAL ASSISTANCE

A. Purpose and Output

The purpose of the TA is to continue and spell out details of the urban health intervention preparation work which is initiated in February 2014 by undertaking required in-depth assessments, designing detailed descriptions of the intervention and put in order required actions for its implementation. It will study closely the current urban health vertical and integrated services and design a comprehensive integrated health, nutrition, and population service delivery approach for improvement of health status of the urban poor, particularly women and children, by ensuring that they have access to high-quality, affordable, and sustainable Essential Health Care services. The TA will also identify and plan activities to strengthen the capacity of the Yangon RHD and linkages with YCDC, the Social Security Board of the Ministry of Labour Employment and Social Security, Townships, NGOs, Civil Societies, the private sector and related other institutions.

B. Methodology and Key Activities

A team of international and national consultant will work over a period of 5 – 6 months closely with the 3 MDG fund managers/specialist and the urban health core group and provide required TA in phased manner. The TA will build on the work done by the first consultancy mission on urban health situation analysis and intervention design and prepare an integrated urban health intervention design and implementation plan following a bottom-up, participatory approach. Activities to be undertaken with clear deliverables to discussed and agreed on prior to each phase.

The TA will encompass its tasks in a sequential order as needed for different stages incorporating a set of activities of the following ones. First, the TA will undertake a poverty and social analysis of the conditions in urban slums. This will include (i) mapping locations where poor are concentrated, (ii) assessment of the health care seeking behaviours of the poor and alternative options to improve benefits to the very poor, (iii) process for selecting Community Health Workers and (iv) the potential for organizing communities to solve environmental problems. Second, the TA will help develop the intervention scopes, including (i) development of an integrated essential primary health care package including MNCH, HIV/AIDS, TB, Nutrition, Water and Sanitation etc. and modalities for service delivery at different tiers (ii) social awareness, community involvement and partnership development modalities; (iii) improved out-reach service delivery activities; (iv) environmental improvement; and (v) more convenient and better quality services and referral. Third, The TA will help examine the affordability of health services by the poor, and will propose demand side financing modalities such as health/nutrition vouchers and other supports. The consultants will examine the cost of improving the quality of services, through variations in staff, incentives, and quality control measures. Forth, the TA will review (i) the Ministry of Health (MOH) and other public policy framework, and governance and financing plans; (ii) urban health system’s institutional capacity, linkages, and coordination; and (iii) NGO/CBO capacity building needs, monitoring, and supervision, in particular for quality of services, and access to the very poor. Fifth, the TA will assist in creating an urban health governance and management system with (i) governance and management structures; (ii) management information system, and (iii) quality assurance and compliance of the care providers.

Based on the analysis, the TA will develop (i) a detailed description of a 3 MDG Fund urban health intervention for the urban poor; (ii) modalities to improve and sustain the efficiency and
effectiveness of the Essential Health Care model through public-private partnership; (iii) mechanisms for strengthening the capacity of the RHD and TMOs in planning, financing, supervising, monitoring, and evaluating of Essential Health Care interventions; (iv) estimates of capital and recurrent expenditures; and (v) implementation arrangements and activity schedules, a performance management system, and a draft implementation guideline.

C. Implementation Arrangements

The 3 MDG Fund with technical directions from the Urban Health Core Group will manage the TA. A lead consultant and a pool of experts who will invited in at different stages to be selected. Using its framework contract, HERA will be asked to form the TA team and submit a proposal for review and approval by the 3 MDG Fund.

The TA will comprise with international and national consultants complementing required skill mix and international and national experiences. The three international consultants will include the team leader and urban health planning and management specialist, PPP and governance and health financing specialist and a poverty specialist. The four national consultants will include a urban public health and PPP expert, a health economist, a sociologist and a nutritionist. All consultants will be selected and engaged through HERA, following 3 MDG FUND’s framework agreement with HERA and guidelines on the Use of Consultants, and other arrangements satisfactory to 3 MDG FUND on the engagement of national consultants.

During its first phase over a period 4 weeks the TA will undertake the following:

i. Map-out geographical areas of un-served/under-served slums, squatters and pockets where poor are concentrated and demarcation clusters of priority target areas

ii. Undertake study on health care seeking behaviour of the poor

iii. Design integrated primary health care service out-reach programme for clusters of target areas to be delivered by NGOs and other private sectors

iii. Prepare call for proposals for commissioning partner agency

Work plan indicating Level of Effort (LOE) from consultants and clear list of deliverable for subsequent phases to be agreed during the first mission. The TA will start in June 2014 and will be completed by December 2014.
OUTLINE TERMS OF REFERENCE FOR INDIVIDUAL CONSULTANTS

A. International Consultants

1. Urban Health Planning and Management Specialist and Team Leader

The team leader will be a senior public health specialist with experience in urban primary health care, health sector reform, contracting out of health services, and designing projects/interventions as a team leader. The team leader will be the primary liaison with the 3 MDG Fund, MOH Health, Yangon RHD, the Ministry of Labour Employment and Social Security, the TMOs, municipalities, nongovernment organizations (NGOs), and partner agencies. The team leader will organize and oversee the work and reports of the other consultants, with a focus on intervention planning, and be responsible for the following:

(i) With the team and stakeholders, review the context of the urban Essential Health Care Services, including needs, governance, capacity, policies, and programmes; and ensure that key issues are adequately addressed in the design.
(ii) Coordinate with key stakeholders and the Core Group and draw their contributions into the assessment and design processes.
(iii) Evaluate with other team members, including an assessment of the performance, cost and financing, affordability, quality, and public perception of current health care services.
(iv) Prepare a detailed implementation plan for 3 MDG Fund Essential Health Care interventions for the urban poor with clearly defined project framework, components, implementation arrangements, implementation schedule, and performance management system.
(v) Work with the health economist in preparing the project cost estimates.
(vi) Work with PPP and Governance Specialist in preparing call for proposals.
(vii) Formulate the terms of reference (TOR) and qualifications for consultants, counterparts, and advisers.
(viii) Prepare a written report in response to these TOR, including a final report resembling a report and recommendation of the 3 MDG Fund to the board of directors that incorporates the other consultants’ reports.

2. PPP and Governance and Health Financing (PGHF) Specialist

The PGHF specialist will have had at least 10 years of experience in public sector governance, Public private partnership, health financing and contracting, together with the capacity building specialist and the health economist, will concentrate on developing the policy framework, health financing overview and institutional capacity of the YCDC, Yangon RHD and TMOs to develop Essential Health Care services within their jurisdictions. The consultant will have the following responsibilities:

(i) Provide a general overview of the organization, administration, and financing of public and private health services in urban and rural areas, with particular reference to urban Essential Health Care in Townships of Yangon Regions.
(ii) Assist the team leader in reviewing policies and plans for the health sector to determine the parameters for project design and the role for 3 MDG Fund.
(iii) Prepare the call for proposals
(iv) Identify key governance issues in large and medium municipalities and determine appropriate arrangements under the 3 MDG Fund urban health interventions so that local governance is supported and strengthened in every way possible.
(v) Assess the experience with performance-based contracting in developing countries and prepare performance-based contract mechanism.
(vi) With the RHD develop a joint approach to governance of urban health care
(vii) Assess the capabilities of RHD, TMOs, municipalities, and NGOs regarding urban health care management, including planning, monitoring, evaluation, quality assurance, and use of data.
(viii) Develop an effective strategy and plan for improving the capacity of RHD, TMOs, municipalities, and NGOs, including coordination, training, use of technical advisers, and other inputs.
(ix) Visit a number of candidate Townships to determine which ones can make a serious commitment to developing their urban health programme.
(x) Prepare call for proposal and procurement packages in line with the Guidelines for Procurement under 3 MGD Fund.
(xi) Prepare a written report in response to these TOR.

3. Poverty Specialist

The poverty specialist will have had at least 10 years of experience in social and poverty assessment, design and implementation of pro-poor health interventions and, together with the Sociologist, will undertake the poverty assessment to (a) better understand how present public, private and NGO health care services are reaching the poorest and (b) identify pro-poor actions and approaches in which the proposed “urban health intervention” of the 3 MDG Fund will deliver better results.

i. Undertake an in-depth analysis of pro-poor targeting and operational mechanism to be adopted in the proposed urban health for poor intervention

ii. Undertake analysis of access by the poorest to urban health services offered by current public, private and NGO services

iii. Identify reasons for the slow uptake of these services by the poorest

iv. Identify necessary new and improved measures to enable urban health services to reach the poorest

v. Identifying who in the health sector is reaching the urban poorest – how?

B. National Consultants

4. Urban Public Health and Management Expert

The deputy team leader will be a senior public health specialist with experience in urban primary health care, health sector reform, health services contracting and preparation of project proposals. Along with the team leader, the deputy team leader will be the primary liaison with the MOH, SSB, RHD, TMOs, City Authorities municipalities and nongovernment organizations (NGOs) and partner agencies. The deputy team leader will assist the team leader to organize and oversee the work and reports of the other consultants, with a focus on project planning. He or she will be responsible to

I. review, with the team and stakeholders, the context of the Urban health intervention for the poor in general, including needs, governance, capacity, policies and programs, ensuring that key issues are adequately addressed in the design

II. evaluate the existing urban health service with other team members, including an assessment of the performance, cost and financing, affordability, quality and public perception of services

III. prepare a detailed proposal for the intervention with a clearly defined project framework, components, implementation arrangements, implementation schedule and performance management system

IV. propose policy actions required for successful implementation of the intervention and its sustainability

V. work with a health economist in preparing the project cost estimates
VI. formulate the terms of reference and qualifications for consultants, counterparts and long-term advisers; and

VII. prepare a written report in response to the terms of reference, including a final report.

5. Health Economist

The health economist will have had at least 8 years of experience in the health sector. The consultant will focus on project economic and financial analysis, and cost estimates, and be responsible for the following:

(i) Examine whether and what level of health/nutrition vouchers, conditional cash grants, providers incentive is appropriate.
(ii) Assess financial capacities of beneficiaries and NGOs in Cities and Townships. Examine how beneficiaries manage catastrophic medical expenses, and suggest what could be done to assist the poor in meeting these costs.
(iii) Suggest practical mechanisms for determining and monitoring service charges by for profit sector on ongoing basis.
(iv) Assess the sources and level of financing of essential health care and propose a strategy to cover the costs of NGO-provided services as external funding support is being phased out.
(v) Develop a detailed budget for the intervention.
(vi) Prepare an economic analysis and financial sustainability assessment.

6. Sociologist

The sociologist (or medical anthropologist) will have had at least 8 years of experience in the health and nutrition sector, and in resettlement issues. The consultant will facilitate the participatory planning process, and ensure that the views and conditions of beneficiaries are incorporated in the design of the urban health intervention for the poor. The consultant will be responsible for the following:

(i) Arrange participatory implementation of the technical assistance through consultations, workshops, and group discussions, involving all stakeholders. Ensure that all concepts are adequately discussed, and that the needs of women, children, and other vulnerable groups have been addressed.
(ii) Conduct focus group discussions and in-depth interviews of residents of the project areas (especially the very poor living in slums and squatter areas, as well as the floating population) and staff to determine perceptions of the quality, accessibility, and affordability of health services. Identify the services they feel are priorities.
(iii) Examine what approaches could be used to improve access of the very poor (especially slum-dwellers, informal settlers, and members of the floating population) to services provided by MOH facilities, NGOs and Private Practitioners.
(iv) Assess the situation among the very poor, and in discussions with poor families and with NGO staff, determine the most effective ways to encourage families so that more women, children and men attend health centres and clinics.
(v) Describe beneficiaries’ perceptions and practices regarding hygiene, child nutrition, and health care, as a basis for identifying interventions. Include a discussion of how they can work together to improve their environment, including better access to clean water, better sanitation, and getting rid of garbage.
(vi) Determine strategies whereby communities can identify poor women (living in slums, squatter areas, and among the floating population) who can become community health workers and how NGOs can work with communities most effectively, maximizing community participation.
7. Nutritionist

The nutrition specialist will be a public nutrition specialist with at least 8 years of experience in planning and evaluating nutrition programmes and related health services. The specialist will develop a package of feasible nutrition and related interventions of proven cost-effectiveness as part of an integrated essential urban health page of services for the poor. The consultant will have the following specific responsibilities:

(i) Liaise with stakeholders working in maternal and child nutrition and related health care.
(ii) Review the policy framework and guidelines for improving nutrition in urban areas in Myanmar.
(iii) Collect and collate information on ongoing nutrition interventions and assess current services in public and private sectors through field visits to determine “good practices,” based on the package of six essential nutrition actions;
(iv) Review and discuss with staff and women current nutrition and child health care practices at home and in health centres.
(v) Propose a package of nutrition and health interventions to be built into the design of essential health service package for the urban poor, and identify and prepare the implementation plan including for coordination, related policy actions, and capacity building.
(vi) Prepare a written report in response to these TOR.
Annex 6: Reports and Documents consulted

2. Effective Development Cooperation in the health sector in Myanmar, Report of IHP+ mission, 26 - 31 August 2013, Andrew Cassels, Finn Schleimann, Phyllida Travis
3. Planning Action for Health Sector, YCDC Capacity Building, March 2013
4. The Project for the Strategic Development Plan of the Greater Yangon. April 2013
6. Reducing Poverty in Myanmar: the Way Forward , Dr. U Myint , October 2013
10. A regional perspective on poverty in Myanmar, August 2013. UNDP
13. Review of the National TB Programme, Myanmar, 7-15 November 2011, WHO
15. Law related to Private Health Care services 2007.
19. On the Urbanization of Poverty, Martin Ravallion
23. Three sisters and brother, a story of poverty in Yangon