Report from Community and Country Level Consultations on GMAP2 "Action and Investment to defeat Malaria (AIM)" in Myanmar

22nd - 28th June 2014

Prepared for

Roll Back Malaria Partnership

Submitted by:

Swiss Tropical and Public Health Institute

Deloitte. Consulting LLP

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Abbreviations

ACT	Artemisinin-based Combination Therapy
AIM	Action and Investment to defeat Malaria
ASEAN	Association of Southeast Asian Nations
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GMAP	Global Malaria Action Plan
IOM	International Organization for Migration
ITN	Insecticide Treated Nets
LLIN	Long Lasting Insecticide Treated Nets
M&E	Monitoring and Evaluation
MCH	Maternal and Child health
MOH	Ministry of Health
NGO	Non-governmental Organization
PMI	President's Malaria Initiative
RBM	Roll Back Malaria Partnership
RDT	Rapid Diagnostic Test
SEA	South-East Asia
Swiss TPH	Swiss Tropical and Public Health Institute
TB	Tuberculosis
UNOPS	United Nations Office for Project Services
USAID	United States Agency for International Development
WHO	World Health Organization

1. Introduction

The consultation in Myanmar was convened by the Myanmar Health and Development Consortium, a local firm, which has also a social vocation and has already been engaged in mobilizing the business constituencies for the fight against Malaria. The Managing Director of MHDC, Dr. Sandii Lwin and her team, National Malaria Control Program (NMCP), and WHO Country Office prepared the consultation and assisted in the facilitation of the various consultative meetings.

The country consultation was assisted by Nicolaus Lorenz, of the Swiss TPH/Deloitte AIM Consultants' Team and Dr. Vanessa Racloz, focal point for the AIM at RBM.

Three half-day consultative meetings took place at central level, and one half-day event at regional level. At the national level the second generation Global Malaria Action Plan "Action and Investment to defeat Malaria (AIM)" was discussed with the Myanmar Technical Steering Group, with participants from MoH, WHO, bilateral and multilateral donors, and implementation partners. A separate half-day event was organised at central level for Civil Society and Implementation partner. A third half-day consultation took place with Private Sector stakeholders only. A regional half-day consultation was organized in Mon State bringing together all constituencies. In addition individual meetings were organized with a major implementation partner and a local NGO. In total it was possible to reach out to 177 professionals.

Also two communities of migrant labourers were visited in Mon State. In total 75 community members participated in these discussions. Details of the community engagement visits, as well as the points discussed at the national and regional level are in the annexe.

1.2 Malaria Situation in Myanmar

According to an external review (WHO/GFATM) from August 2012 around 70% of the population of Myanmar lives in malaria endemic areas. For the past several years Myanmar reported the highest malaria morbidity and mortality rates, both in the WHO SEA region and in the Greater Mekong Sub-Region. Malaria control has improved over the past years, and there is today a good coverage with LLINs and ITNs, early diagnosis and treatment. Myanmar is lagging behind in elimination phase because topography and coverage is much wider than in Thailand and Cambodia. Myanmar aims to begin with elimination phase in 2018.

> *"In spite of difficulties and challenges, Myanmar has made tremendous progress in recent years in reducing malaria morbidity and mortality"*
>
> **Participant with Development Partner Background**

Challenges are insufficient manpower, both in terms of quantity and quality. The health information system is considered to be robust. The highest malaria incidence is reported in Rakhine State. The situation there is aggravated by civil unrest. Although ACT are national policy there is still widespread availability of artemisinin mono-therapy. Vector control and prevention is weak at all levels. A particular challenge is the containment of artemisinin-resistance, which has been found in some regions.

1.3 Community Consultation Overview

The engagement visits to Mon State in south-eastern part of Myanmar were scheduled on 16-17th June, for logistical reasons after the consultations at national level.

Mon State is located between Kayin State on the east, the Andaman Sea on the west, Bago Region on the north and Tanintharyi Region on the south, and it has a short border with Thailand's Kanchanaburi Province at its south-eastern tip. The state's capital is Mawlamyaing it is located around 320 km from Yangon.

In Mon State mostly rice is cultivated. The major secondary crop is rubber. Orchards and rubber plantations work mainly with migrant workers. The origin of these migrant workers is either from within the state but mainly from Kayin State. Other industries include paper, sugar, and rubber tires. Thaton has a major factory (Burmese, Ka-Sa-La) of rubber products run by Ministry of Industry (1). Forests cover approximately half of the area and timber production is one of the major contributors to the economy. Minerals extracted from the area include salt, antimony, and granite. Natural resources such as forest products, and onshore and offshore mineral resources, are exploited only by government and foreign companies. The biggest foreign investment into Myanmar is for the exploitation of natural gas reserves in Mon State.

Discussions took place with two communities living on two rubber plantations. In total 75 people participated. In depth exchanges took place with:

- 7 Community members
- 2 Community Volunteers
- 3 Front line workers (Nurse Midwifes, Project Workers)

1.3.1 Community Consultation Objectives

The main objectives of the community level consultation were to:

- Gain a first-hand understanding of community level priorities
- Better understand the impact of poverty and disease in the context of household vulnerabilities and learn more about family coping strategies
- Create a shared understanding of the contribution of community development workers to basic service provision, including in the fight against malaria
- Find ways to support community development workers to play their role more effectively
- Use malaria as an entry point to gain insights on ways to strengthen governance and accountability for the consequences of non-availability of services
- Enable community level stakeholders to set the agenda for the next iteration of the Global Malaria Action Plan

1.3.2 Summary of key themes emerging from the discussions and implications for AIM

> *„There is no point in asking for repellents – we won't get them anyhow“*
>
> **Male Community Member**

Community priorities and how malaria features. Two rubber plantations were visited. One of the plantations is in private ownership; the other owned and managed by the government. In each of these around 150 individuals live and work during six to seven months per year. In total 75 community members participated in the discussions. In depth information was obtained from 11 community members. Details are in the annexe.

The community members, community development workers and front line health workers at village level described the following major concerns: difficult temporary livelihoods and little income, poor access to schooling and other governmental services. It became also apparent that population at this level seems to have little sense of asking for its right from their employers.

When asked about the burden of disease, malaria does not figure at the top of issues. Respiratory diseases and diarrhoea and other communicable diseases are seemingly more common. In the visited communities Rapid Diagnostic Testing is available. Around 150 tests have taken place in the past year. However only very few malaria cases (3 in one community one in the other) were detected. Malaria was diagnosed only in adults, due to the fact that in

one community there are very few children, in the other community there are children, because of the closeness of schooling. However, the only malaria case detected (out of around a 100 febrile cases tested) was also in an adult.

In case of non-malaria cases people have to consult more or less close by health facilities, but in both communities this seems to be rarely the case. The main reason forwarded for not consulting health services was the cost which such visits tended to create, and which corresponded to always at least a daily wage.

Bed nets are available in both communities and seem to be well used, although the work on the rubber plantation is night work. However the bed nets are much appreciated for getting a quiet rest in the mosquito infested forests, even during daytime.

In one of the communities, people are provided with repellents from an externally funded project. In the second village such support has stopped for quite some time and people would have to procure the repellents at their own cost, which they cannot or do not want afford. This is in line with the fact that the workers have to pay out of her own pocket not only for the annual travel, but also for her working gear like boots (essential protection against snakes) and head lamps (and the batteries).

In both communities the employer does not provide any social security. A sick person who is unable to work does not get paid.

Community members do not seem to ask for benefits, nor do they perceive themselves as having much negotiation power.

In both communities' external projects, such as from the IOM are active in addressing malaria. While the success in the pilot areas is undeniable, major difficulties in changing e the behaviour of communities, and in particular difficulties in organizing and recruit RDT providers, who have a volunteer status, but receive some compensation. There is a high drop-out rate of these volunteers. Health facilities have difficulties in reaching out to remote areas, partly linked to transport issues, but also to poor motivation.

- **Implications for AIM: it** needs to show that malaria is also an occupational health issue. At this point in time the legal framework in Myanmar does not offer much in this regard. However, as it is getting increasing difficult for employers to find workforce for these hard working conditions, employers may want to begin offering benefits, such as repellents, which make their workplace more attractive than their competitors. For the time being such initiatives have not yet developed as external projects are funding these "fringe" health benefits.

- **Implication for AIM:** The role of volunteers in contributing to the reduction/elimination of malaria needs to be discussed. Their status and funding needs to be discussed. For the time being such volunteers are funded by external sources. Often there is little to no integration with other community volunteers working in the area of HIV or TB. Apart from the operational challenges like the high dropout rate, the difficult to upscale activities there is the issue of long-term sustainability as a major question mark behind this approach.

2. Overview of the Consultative Meetings at national and regional level

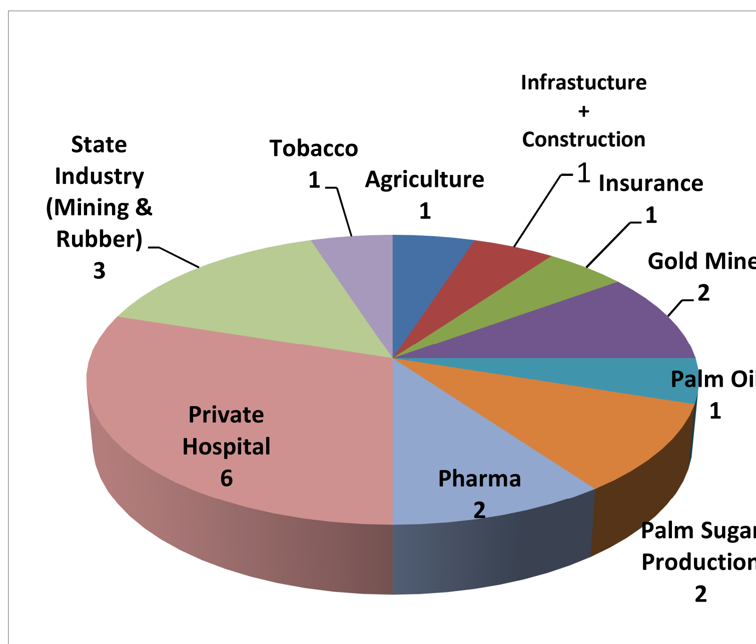
2.1 Objectives of the consultative meetings

The main objectives of all consultative meetings were to:

- Enable country stakeholders to help set the agenda for the next iteration of the Global Malaria Action Plan
- Help to better position malaria within the country's broader development context
- Learn how other programs have successfully engaged communities e.g. polio, HIV/AIDS, TB, MCH etc.
- Create a shared understanding of the current status of the country's response to malaria
- Identify high priority actions for progress towards control/elimination goals
- Sensitize country stakeholders for the future implementation of AIM
- Network, build relationships, and identify new opportunities for partnership

2.2 Private Sector consultation

In total 20 representatives of the private sector participated in the half-day consultation. Their background is presented in the box 1. Private Sector representatives participating in the consultation are quite well aware of issues related to malaria, in particular the need of adequate treatment, prevention through LLIN and environmental issues. In terms of priorities this constituency rated people at the centre, as being most relevant for Myanmar, followed by multi-sectorial action and changing funding policies.



Participants considered people centred approaches as key. However, the position was that it is up to the individual to look after him- or her. Company owners should not get involved in taking responsibility for the health of their workforce. However, representative express interest in assisting in health education and promotion activities for their workers.

With the private sector representatives present, malaria did not seem to be a major occupational health issue. Although none of the participants is able to enumerate the productivity loss due to malaria, there is the impression that this is not a major problem.

The need of having a better funding basis for the fight against malaria is considered to be important, particularly in the areas of advocacy and health promotion. Some private sector representatives argue that the private sector should increase its contributions. However, none would commit a figure or become more specific for a possible engagement. Concrete proposals for support refer to distribution

> *"It only takes 1 – 2 months to get license to sell drugs, but most drug stores are operated by inadequate staff"*
>
> **Participant with Private Sector Background**

Participants call for stronger law enforcement in supervising non-governmental health facilities, particularly at the primary care and drug dispensing level. Drug sellers often do not have the necessary qualification to do their job.

- **Implication for AIM:** The importance of both regulatory and more broadly governance frameworks needs to be highlighted. Just as the respect and eventually enforcement of labour laws the enforcement of combination therapies and the banning of mono-therapies would benefit.

2.3 Key national opportunities and challenges prioritized for discussion

During a Technical Steering Group meeting in Yangon (participants' list in the annexe) national opportunities and challenges were discussed on the basis of findings of the SEARO- and WPRO meetings and findings. Participants considered issues related to migrant populations as a top priority, strengthening multi-sectorial action and common bottlenecks were considered to be particularly relevant for Myanmar. A consultation with Civil Society and Implementing Partners focussed more on multi-sectorial action, and migrant populations, and having people at the centre. Surprisingly common bottlenecks did not figure high in the rating for this constituency. At the regional consultation in Moulmein, the multi-background participants rated issue related to migration as the most problem in fighting Malaria in Myanmar, followed by "people at the centre approach" and common bottlenecks, which would need to be addressed to step up speed towards reduction and elimination of Malaria.

2.4 Summary of key points emerging from the consultative meetings

Address issues of migrant populations: Internal labour migration and to some extend cross border migration is a common phenomenon in Myanmar. The ASEAN free trade agreement will most certainly increase the cross border migration. These hard to reach populations often working/living in high-risk areas are a particular challenge for addressing malaria in Myanmar.

Common bottlenecks of implementation: As in other countries insufficiencies in data collection are rampant, even basic knowledge on where agencies intervene are not readily available. Mapping of intervention areas of different development partners have started and better coordination capacities of the MoH are beginning to become effective.

Promotion of multi-sectorial action: Public Private Partnerships are still uncommon in Myanmar, but the mining and forestry industry offer opportunities. There are examples, where private health care providers could be involved in implementing treatment policies, in particular ACT.

People centred approaches: Although there is widespread acknowledgement that people should be at the centre, there is little innovative thinking on how to involve communities in the reducing and eliminating malaria. Standard approaches with paid volunteer outreach workers do generate positive results; however major questions around the sustainability of such approaches have not found satisfactory answers.

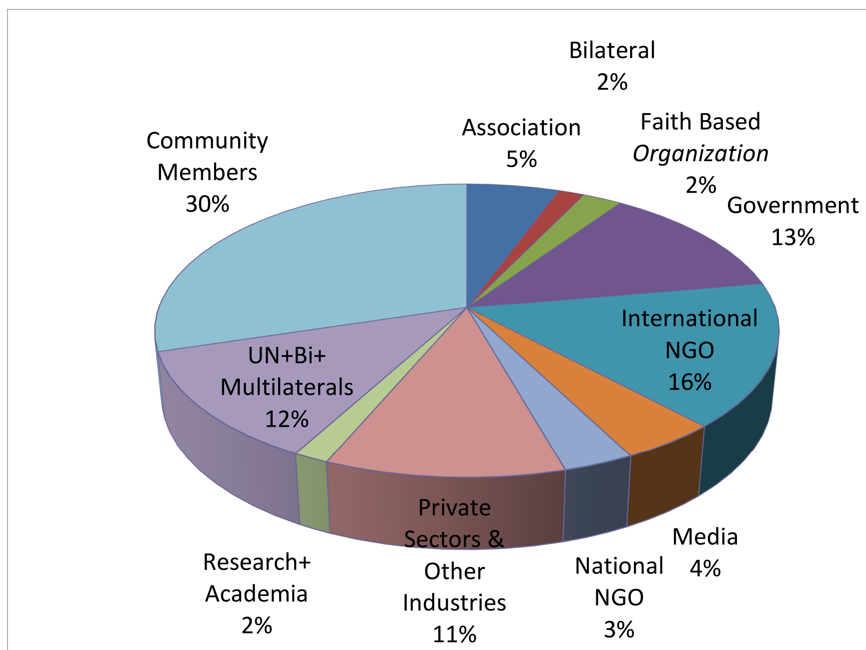
Malaria reduction and elimination in zones of civil unrest: In cease-fire areas of Myanmar access to health facilities and thus contribute to peace building. However if one aims for up-scaling intervention in conflict areas, such as Rakhine and Kayin, all communities must be involved, and their culture, tradition, political parties, socio-economic status and last but not least government policies have to be taken into account. The best way to achieve this is to put flexible low profile services into place.

Lessons from other progammes in Myanmar: Rather than the polio eradication programme, the EPI programme could serve as a role example for addressing malaria reduction and elimination in Myanmar, as EPI is familiar with hard to reach regions, and has similar data and surveillance requirements.

- **Implication for AIM:** The complex situation of Myanmar shows that AIM is a point in case showing that in order to address malaria reduction and elimination more is necessary than purely technical aspects.

3 Assessment of the success of the consultative process

The country consultation was successful in bringing together a comparatively balanced group of the different constituencies. Noteworthy that community members represent 30% of the people who were involved in the country consultation.



At community level a total of 75 people were spoken to at community level around 50% of them were women. A total of 177 people attended national and regional consultative meetings given for the consultation. 74 (42%) of them were female. The other indicators concerning whether topics from community level were discussed at national level, actions steps suggested and areas where AIM could provide guidance were all fully met, although as mentioned before the community engagement visits had to take place after the national consultations. However, the important issue of migrant populations was covered by discussions at the regional and the national level.

There was no formal evaluation of the country consultation, but numerous participants expressed their satisfaction with the participatory approach.

4 Conclusion and Recommendations

Overall, the consultation went very well, thanks to the excellent local preparation and organization. It paid off to go for a non-governmental convener.

It was possible to reach out to more than 250 individuals, 75 of whom from the community level. The community engagement was positive, although it was not possible to reach out to conflict areas of Myanmar, which would have allowed addressing these aspects.

The report of the consultation will be posted soon on the AIM – website.

Efforts were undertaken to engage the press and the consultation resulting in good media coverage in the written press, but also on TV. Two TV-emissions and three newspaper articles stemmed from the consultation.

Annexe 1

Community Engagement visits in Mote Pa Lin plantation site and Mudon Government Rubber Plantation Site on 26 and 27 June 2014

1. What are the most pressing concerns/priority issues in this village?

The difficult working conditions and the poor pay (daily wage on the privately owned plantation is 3'000 Kyat (around 3US$) day, and around 1'500Kyat (around 1.5 US$)/day in the governmental plantation) are major concerns for both communities. There is no social security, and if somebody is unable to work for sickness reasons he or she is not paid. In both communities the employers do not provide basic working gear e.g. boots (as a protection against snakes), nor the head torches, nor the batteries to run these head torches. Daily working time is from 10pm to 10am. Workers and their families also have to cover their seasonal transport to the plantation and back to their home village.

Schooling is impossible for children in the privately owned plantation, as the next village is too far away, in the governmental plantation schooling is possible in a close by village). In the privately run plantation workers leave their school age children in their home villages. Both communities say that they have no alternative income possibilities (apart from working on agricultural plantations with similar conditions). In their home villages, each between 150 and 300 km away, there is no work.

In both communities respiratory diseases and gastrointestinal diseases are the most common health problems. Malaria is mentioned, however it does not seem to be a major problem in both communities visited.

2. What are the implications of the mentioned problems for families (probes: costs in social and economic terms etc). How do households try and cope with the problems?

People seemingly accept these working conditions. There seems to be no auto-organisation of the plantation, the manager sets rules and conditions.

3. How much of a concern is malaria for families in this village?

Probably because of on-going malaria projects, malaria is mentioned. However, in both communities it does not seem to be a major health problem. In the privately owned plantation 84 rapid tests had been conducted (only in men, none in children), and only 5 have been positive. The manager of the privately owned plantation, who lives with the community, is the one who does the testing and provides anti-malarial drugs, if necessary. He has also oral rehydration in his scope of treatment, but no other medical item. In the governmental owned plantation volunteers from a nearby village pass by regularly. In the

past year they have performed almost 200 rapid tests, but only one proved to be positive. The treatment was successful.

4. What actions are ongoing at community level to provide basic services, build a safety net to stop households falling further into poverty and to fight malaria?

   There is seemingly no safety net what so ever. Nobody really likes the job, but people have no real alternatives.

5. Which other people or organizations support you in this work? If so, how and how could they support you more effectively?

   A project of IOM (with funding from GFATM) supports both communities LLIN, funds volunteers, and trains them in using rapid diagnostic tests and delivering antimalarial drugs if necessary. A Malariaconsortium project provides repellents in the privately owned plantation. Another project (it could not be explored which) had provided repellents in the governmentally owned plantation, but it had come to an end. Workers do not buy the repellents, which are available in the village pharmacy, but are considered to be too expensive.

6. If someone here falls sick what are the possibilities to get help quickly? (probes: explore options e.g. community health workers, local drug shop or pharmacy, public health centre, private facility, traditional healer etc).

   In the privately owned plantation the patient has to be brought by bike/bicycle to the nearest hospital, allegedly 20km away. In the governmental hospital, which is close by a village with a health centre. A nurse midwife passes by regularly and provides health promotion and vaccination.

7. What needs to happen to increase access to basic services in this village?

   The regular presence of the outreach facilities of health services is much appreciated in the governmental rubber plantation, also the closeness to basic services in the nearby village. Also the fact that a school is close by makes the governmental site attractive and some community members mention that it is for this reason that they accept a lower pay than they might get in a privately owned facilities, which for distance reasons does not provide this opportunity.

8. What role do you expect your local politicians and village leaders to play? What further steps could you take as a community? What would need to happen to be able to take those steps?

   The reference point in both communities is the manager. However, this person has little decision power himself. In the privately owned plantation he is the owner of a television set

and satellite dish, and gets from the owner now and then some fuel to run a generator. Seemingly this is the only fringe benefit the migrant workers have on that plant.

9. Are you consulted by ward/district managers when they undertake their planning for e.g. community development, health etc.? How extensively are community representatives involved in the governance of nearby health facilities, schools and other public institutions?

   There is little to no involvement in decision making. Seemingly communities are not consulted for issues, which are relevant for them.

10. Do you think sufficient resources are allocated to tackling community concerns? Where would you like to see more 'investment' (of attention, funds and other resources)?

    Community members stay quiet on this topic. In the first rubber plant the presence of some outreach health worker would be appreciated.

11. Do you have any lessons learned on any aspects discussed (positive or negative) that could be shared with other villages or communities?

    People in the governmental plantation would like a project to come back, which had provided repellents in former times.

Annexe 2

Meeting Minutes

AIM INTRODUCTION

MINUTES JUNE 23, 2014 1:00PM – 4PM MI CASA HOTEL

MEETING CALLED BY	MHDC, RBM, WHO, MOH
FACILITATOR	Dr. Nicolaus Lorenz

DISCUSSION	Agenda Topics • Putting people at the center is key for further progress • Persistence of bottlenecks that hinder efficient response • Challenges to addressing malaria in mobile migrant populations • Challenges to put multisectoral action against malaria into practice • Changes in development partners funding policies will lead to shortfalls in funding elimination of malaria
CONCLUSIONS	Relevant findings to Myanmar: People are key: 25 **Multi-sectorial action: 25** **Common bottlenecks: 26** **Mobile migrant pop: 43** External funding: 21

1:00 PM – 4:00 PM INTRODUCTION TO AIM

DISCUSSION	How relevant are these topics to Myanmar?

- Myanmar lagging behind in elimination phase because topography and coverage is much wider than in Thailand and Cambodia. On this background tremendous progress has been made. Myanmar will begin elimination phase in 2018 (committed to this phase in New Delhi).
- Elimination strategy - Late because funding was received very late. Cambodia and Thailand received their funding in early 2000s
- Integration between public sectors (I.e. education sector) is equally important to working with private sector
- People-centered approach - Agrees with strong economic agenda and would like to encourage social investment
- Look beyond health sector to PPP's, particularly in mining, forestry, etc. However, SE Asian framework for multisectoral action is necessary
- Private-sector can be utilized for anti-malarial medication
- Suggests trust fund for malaria endemic countries (regional trust fund) with allocation based on extent of problem
- Migrant workers - Government did not previously recognize migrant workers
- Wants to emphasize BCC component. BCC is lacking in border areas with poor communication among partners. Harmonization needed for BCC in border areas.
- Challenges - Health care has been unequal based on geography, ethnic groups, etc., but new strategic health plan with 3 components needs to be considered. These 3 components include: Universal health coverage, customer satisfaction, and health financing (people should not be put into poverty as a consequence of seeking health care)
- Potential of moving towards integrated community case management
- ASEAN free trade agreement will lead to more mobile migrant populations and therefore greater risk. Multisectoral approach is necessary to help deal with this future influx.
- Mobile-migrant populations - Border areas and internal migrants both exist.

AIM CIVIL SOCIETY & IMPLEMENTING PARTNERS

MINUTES JUNE 24, 2014 9:00AM – 2:00PM ZEPHYR COFFEE & RESTAURANT

MEETING CALLED BY	MHDC, RBM, WHO, MOH
FACILITATOR	Dr. Kyi Min
ATTENDEES	Civil Society & Implementing Partners

9:45 – 11:00 KEY FINDINGS OF REGIONAL CONSULTATIONS

CONCLUSIONS	Relevant findings to Myanmar: **People are key: 12** **Multi-sectorial action: 23** Common bottlenecks: 3 **Mobile migrant pop: 22** External funding: 8
IOM Comment: Migration dynamics are changing, transitional period lead to influx of internal migrants in rural context. Once projects are complete, dynamic environment occurs again and spread resistance to other areas. ASEAN integration plan for 2015 is going to increase movement even more.	

SESSION 1: FACILITATE DISCUSSION

DISCUSSION	1. **People centered approach** - knowledge, attitude, and practice of traditional medicine - religious leader involvement and advocacy - prioritize stakeholder involvement and advocacy - better control and tracking of vector control → personal protection by everyone → community empowerment and capacity building - BCC, PLA, community led action plan, community mobilization and commitment. - transparency and accountability through mass media to share data to communities. Involvement in research will lead to more transparency. - exit plan and sustainability workshops in villages and communities; funded organizations
2. Multi-sectorial cooperation - currently weak cooperation with other sectors (vertical approach) - need to have high level advocacy meetings with representatives from parliament, Ministry of Finance, Ministry of Health, Ministry of Commerce, Ministry of Tourism, Ministry of Social Welfare, etc. (cross ministry) - advocacy package well prepared and produced - public-private partnership in business case ideas for private sector - development of joint responsibility (e.g. CSR, labour protection) - mandatory regulations to commercial firms including SMEs, logging/mining (through TMOs and Home Affairs) - standardization of BCC methodologies and treatment guidelines for military and ethnic armed groups - volunteer sustainability - clearer selection criteria and more recognition for participation - joint responsibility by other related sectors and development partners - higher level involvement for elimination; high level advocacy - well forced policies and guidelines (malaria training) - centralization in align with GMAP - incentive schemes (24hr service for referral cases in hard-to-reach areas) - data collection and strengthening of HMIS system to include private sector	

Comment: - sustainability of AIM - *technical support to communities (capacity building, income generation activities)* - *community and township level linkage and coordination (monthly meeting with other stakeholders)* - *expand community base projects yearly* - *ministries (social welfare, health) collaborate to relay information* - *community leadership commitment and support*
3. Mobile migrant population – Volunteers high turnover rate due to security and safety concerns; leave hard-to-reach areas to find work elsewhere; communication issues therefore reporting concerns - Reporting issues to township level - Migrant/ mobile population inconsistence coverage; dynamic routes of migration; - use mobile and mhealth technology to improve mapping and tracking - private sector involvement through CSR; government involvement in Special Economic Zone for health and environment assessments *Comments: - how to collaborate inter-country and border areas*

SESSION 2: FACILITATED DISCUSSION

AGENDA TOPICS	1. Looking across the list of actions, which ones can you begin to take action on immediately with resources available to you? 2. Which actions would benefit from guidance, best practices or other resources that could be included in AIM? 3. Any lessons learned in Myanmar that could be relevant to other countries?
DISCUSSION	**Group 3: Mobile Migrant Population** Lessons learnt - GPS-mapping to target implementation - Social marketing and bilingual material to utilize in border areas - Use mass media to reach all ethnicities - Interpersonal communication through hired locals Success stories - Behavior Change Communication workshop and group discussion in smaller groups in their convenient time and place (homes) to send shorter, concise messages - Involvement of private pharmaceutical companies to reduce monotherapy drugs - (Monetary and HR) incentives for volunteers to perform at higher standard Comment: standardized incentive; National guidelines don't allow monetary incentive; volunteers compare incentives given between organizations to do work, therefore must standardize incentive scheme *- IOM case study: WHO and MOH collaboration to map migrant population to target interventions and raise awareness around issue; township/village-level data to cover basic utilities and patterns of movement; review relations of business and resistant areas.* Future Action - Village health committee formation with village fund - leads to sustainability - School Health Curriculum (malaria as subject) - Leverage media through panel discussions - Recruit religious and village leaders as volunteers
Group 2 Multisectoral approach Immediate actions - country-level / ministry-level / PPP-level / grass root-level advocacy - resource mobilization strategy through international funding and support (taxation) - strengthening of HMIS (capacity building, support technical and IT) Assistant required - technical support for advocacy and resource mobilization	

- elimination strategy assistance for Myanmar that is sustainable

Lessons learnt

- create channel to share best practices
- create motivation (by incentives, or recognition of communities) that is sustainable
- ceasefire areas can promote health accessibility (health interventions to promote peace and understanding)

Comment – competition between NGOs and organizations to share ideas and success stories

- *Elimination strategy and costing will not include in AIM*
- *AIM will focus on benefits and arguments*

Group 1 People centered approach

Immediate actions

- community- based malaria prevention and control (capacity building, community empowerment and commitment)
- accessibility of malaria testing kit and treatment and LLINs
- traditional medicine and healers recruited as volunteers to treat and advocate
- stakeholder analysis (religious and village leaders)
- link volunteers between cross-border and inter-country to test treatment and track migrant population
- linkage between health service providers and community AND intersectoral linkage
- village fund for long term sustainability

Assist require

- transparency and accountability to donor and community
- integrated community case management for other diseases (TB, HIV) to continue volunteer for other cases

Success story

- 2007 dramatic decrease in mortality and incidences in malaria (success in community-based approach in malaria)

CONCLUSIONS	AIM should include control activities and identify cases for rapid response Trends are decreasing but resources shouldn't decrease.

AIM PRIVATE SECTOR

MINUTES JUNE 24, 2014 2:00PM – 5:00PM ZEPHYR COFFEE & RESTAURANT

MEETING CALLED BY	MHDC, WHO, RBM, MOH
FACILITATORS	Martin Pun, MBCA and Ma Hsu Hsu, MBCA
ATTENDEES	Private sector

KEY FINDINGS IN REGIONAL MEETINGS

DISCUSSION	**1. People centered approach: 1** **2. Multi-sectorial action: 2** 3. Persistence of bottlenecks 4. Mobile Migrant **5. Funding: 3**

FACILITATED DISCUSSION

DISCUSSION	**1. People centered approach:** - TB, HIV, and Malaria treatment makes you weak therefore patients don't take the full dosage and treatment; villagers like to reserve pills for later sickness therefore develop a resistance to disease; village leaders, healers, and religious

	leaders themselves have no awareness of symptoms, personal care or treatment. - Company owners don't get involved in health issues – therefore farmers themselves need to be aware and educated of the health implications and incidences. Health education is a concern. 165 of 500,000 workers get sick from malaria – not a big proportion therefore is overlooked by company owners and managers. - Marketing Manager of Private pharmaceutical companies: We meet drug sellers and owners that have insufficient knowledge of the drugs they're selling and side effects; villagers refuse to go seek help at public health clinics because it's expensive therefore prefer to go to local drug store and purchase individual pills that are given by unqualified people; if multisectoral efforts collaborate we can prevent this.
CONCLUSIONS	- Ways to facilitate Health education meetings and workshops (venue, transportation provided) and distribute brochures, conduct surveys, distribute bed nets provided that people come in for the program; advocacy meetings; private sector participation → not just money, but time networking with businesses); World Malaria Events - Use of mobile phones for diagnosis of symptoms will be helpful - Coordination and collaboration from private hospitals with public health services through proper reporting and data sharing is required.

CHALLENGES AND OPPORTUNITIES

DISCUSSION	**2. Multisectorial approach** - Prior 2008, public and NGOs sectors were present but now it is necessary for private sector to get involved. If Private, Public, and NGOs collaborate, the effects will be long term. However, even if Public and NGOs stop contributing, the private sector (workers, farmers) must know how to sustain livelihood by themselves. - It only takes 1 – 2 months to get license to sell drugs, but most drug stores are operated by inadequate people. - Primary prevention knowledge is insufficient. Most people lack communication with nurses due to no time or knowledge to ask. Nurses and doctors need to elaborate the consequences of not taking full dose of treatment, the side effects, and easy ways to treat common side effects. - Market and create awareness through popular ideas and beliefs (e.g. Bednets can also be used to prevent dengue fever from their children) - Need to promote private sector CSR and need to collaborate with CSO to track cases and promote primary personal care. (e.g. MBCA) - Popular physicians and well-known doctors need to be more proactive in media and forums to send across healthcare advices and messages to public. (e.g. Through repetition, everyone now knows that condoms prevent the spread of AIDs) **3. Funding policies** - Messages are better sent across and implanted in people's mind through higher-level advocacy and frequent repetition. Private sector therefore need to increase funding and contribute more. - Market and create awareness through popular ideas and beliefs (e.g. Bednets can also be used to prevent dengue fever from their children) - Need to highlight the importance of personal care and prevention of diseases. Promote the usage of insecticide treated nets rather than normal bed nets. Private sector need to distribute more bednets, insecticide tablets
Comment from palm oil plantation owner: Work on large scale with many employees. WHO and PSI conduct workshops and give guidelines, but about 8 volunteers are present therefore 1:300 ratio of volunteers to workers. Too many workers therefore cannot take care of everyone. Malaria volunteers need to be taught how to refer workers to relevant doctors.	

AIM MOULMEIN CONSTITUENCY

MINUTES JUNE 27, 2014 9:30AM – 1:00PM ATTRAN HOTEL

MEETING CALLED BY	MHDC, WHO, RBM, MOH
ATTENDEES	Civil Society, Implementing Partners & Private Sector

9:45 – 11:00 KEY FINDINGS OF REGIONAL CONSULTATIONS

CONCLUSIONS	Relevant findings in Mon state: **People are key: 23** Multi-sectorial action: 8 **Common bottlenecks: 16** **Mobile migrant pop: 30** External funding: 15
ACTION ITEMS	
1. Mobile migrant population	
2. People centered approach	
3. Common bottlenecks	

11:15AM – 11:45AM SESSION 1: FACILITATE DISCUSSION

DISCUSSION	**1. Mobile migrant population** *Challenges:* - Unstable community; dynamic working environment - Remote areas; hard to estimate population - Non-malaria affected areas - Hard to reach Health Education sessions; lack in follow-up cases - Little collaboration with private sector; lack in malarial prevention activities - Some migrant clusters in Non-Government/ Non-State areas (eg. Gold mines) - No appropriate prevention or surveillance for night time workers - Language barriers with ethnic groups; hard to communicate in health education sessions - Need to standardize treatment guidelines especially in border areas - Harder to reach areas during rainy season *Opportunities:* - Strengthen screening point (e.g. Information sharing, full package for prevention, health care services) - Strengthen health care services in Non-state holders - Political change *Future plans:* - Media to communicate and advocate behavioral change courses - Migrant mapping and coordination with private and public sectors (immediate action) - Information sharing and regular coordination with implementing partners
2. People centered approach *Challenges:* - language barrier, traditional beliefs, and cultural differences - hard-to-reach areas do not exhibit health education sessions (transportation and communication difficulties) - low social-economic status	

- Roles of volunteers need to be properly outlined - Reporting system is not aligned due to language differences - Local authorizes lack participation and trust with locals - Traditional medicine are unknown *Opportunities:* - Test, Treat, Track due to volunteers - Health services can be accessed due to volunteers *Future plans* - Increase socio-economic status (education, transportation) - Sustain volunteers through continuous funding and regular supervision and training - Infrastructure development through collaboration with all stakeholders
<u>3. Common bottlenecks</u> *Challenges:* - Insufficient data collection - Multiple stakeholders in overlapping areas lead to double counting and reporting - Data collection from secondary sources - Malaria knowledge in hard-to-reach areas is limited in prevention and control *Opportunities:* - Standardize reporting system and immediate reporting after collection for data quality reassurance - Primary data collection - Malaria prevention and control advocacy utilized in ethnic languages *Future plans:* - Coordination meeting for area mapping to avoid overlapping; register format for malaria be in multiple languages - Advocacy and training for data quality assurance - Focal staff and training for data collection and increase funding for tools - Screen target audience for malaria and conduct small group discussion to educate and then communicate messages through mass media

12:15PM – 12:45PM SESSION 2: FACILITATED DISCUSSION

DISCUSSION	**<u>1. Mobile Migrant population</u>** - Coordination with Business department and regular coordination and information sharing with implementing partners - Business owners and managers nominate local ethnic peer educators (previously suffered malaria) and support IEC, incentive material - Migrant mapping and follow up action (immediate) with GPS board data - Mass media (radio, vinyl, posters, billboards, and videos) *Lessons learnt:* - Worksite volunteers - Coordination and using human resources from NSA to cover NSA areas
<u>2. People centered approach</u> - Close collaboration with stakeholders; quarterly meetings - Decrease uncovered areas through collaboration with DOH, NGOs - Target focus areas, focus groups, and special regions - Increase community participation - Discover overlapping areas - Know baseline data - Volunteer sustainability through selection criteria (internet, goal attitudes, influential, self motivated) - Regular support and monitoring and capacity building training - recognized by community for his/her achievement - ACSM: Advocacy, communication and social mobilization - Research activities	
<u>3. Common bottlenecks</u> - Data quality assurance through coordination meetings and supervisions and monitoring	

- Familiarize with local language and identify focal staff - share data through advocacy - conduct training in target areas - IEC (conduct review survey), capacity building for health educators - Multimedia development through strategic communication and increased volunteers

3MDG MEETING MINUTES

JUNE 25, 2014 11:00AM – 1:00PM 3MDG OFFICE

MEETING CALLED BY	MHDC
ATTENDEES	MHDC, 3MDG, Relief International

FACILITATED DISCUSSION

DISCUSSION	MOH has own agenda for malaria action but little achievements due to constraints. Challenges exist- financial and technical needs- therefore required to link current strategies to implementing partners. → Mobilizing resources
Private sector has potential for large contribution → 30,000 medical doctors but less than 10,000 in public sector governmental careers. Private practitioners and pharmaceuticals key players in multi-sectorial plan. Must motivate private sector to increase CSR to include malarial awareness and health knowledge in mass media for prevention.	
Scaling up projects in conflict areas (eg. Rakhine, Kachin) must consider all communities involved → culture, tradition, political parties, socio-economic status, government policies and administration. Best way is to adapt flexible services that are more practical with low prior expectations. *Paul Sender comment*: Government needs to come up with a solution. We must liberalize action and increase access amongst conflict.	

FUNDING

DISCUSSION	3MDG lesser focus on malaria than 3DF. Not enough action now and in medium term, therefore less funds available in future → funding horizon is grim
Multiple fragmented initiatives for malaria but not enough capacity to be a game changer. Addressing resistance is not business as usual. Funding structure not helpful to cause substantial change → distribution of bednets, or mass drug elimination or case management?? Who advices MOH? Lack of strong advice causes challenge in what to focus. No clear direction of what to do.	
Challenge in strengthening health system. Gaps in ministries are common bottlenecks.	

AIM DOCUMENT FOR 2016 - 2025

DISCUSSION	Stratification and sub-regional elimination – AIM has fluidity – focus on surveillance, new strategy for elimination (non-existent), last case management (new strategy to maintain efforts of malaria-free zone).
WHO unfamiliar how to deal with elimination strategy (newly appointed 52 township, new budgeting)	
Multiple issues: Artemisinin-resistant issue, elimination issue…	
Shouldn't be distracted from long-term goals to deal with current issues. Ethnic areas are challenging therefore scaling up is difficult. Leadership of government and accountability is an issue.	
CONCLUSIONS	AIM intends to mobilize resources for advocacy

Hopeful: Opportunities for new stakeholders.
Clear set of accountability around financing, technical partners (Myanmar as part of SEARO). A simple document for everyone to read. Feedback to communities after country consultations.
Percentage of financing has to go towards M&E and surveillance, private sector delivery, strengthening health systems (DHIS2.0). Conceptualization of financing to public and private sector is important or it will be business as usual.

Annexe 3

Participants' List

Myanmar Country Consultation on AIM (23- 27 June 2014)

AIM Planning Committee

No.	Organization	Name
1	AIM Consultation Team (SwissTPH)	Dr. Nicolaus Lorenz
2	Consultation Team (RBM)	Dr. Vanessa Racloz
3	Ministry of Health, National Malaria Control Program (NMCP)	Dr. Thaung Hlaing
4	Myanmar Health & Development Consortium (MHDC)	Ms. Sandii Lwin
5	Myanmar Health & Development Consortium (MHDC)	Dr. Kyi Minn
6	Myanmar Health & Development Consortium (MHDC)	Mr. Max Travers
7	Myanmar Health & Development Consortium (MHDC)	Ms. Isabella Sway-Tin
8	Myanmar Health & Development Consortium (MHDC)	Dr. Thi Thi Win
9	Myanmar Health & Development Consortium (MHDC)	Ms. Khat Khat Nwe
10	World Health Organization (WHO)	Dr. Krongthong Thimasarn

Yangon, Technical Strategic Group (23 June 2014)

No.	Organization	Name
11	3 Millenium Developmental Goals Fund (3MDG) / UNOPS	Mr. Sai Kyaw Han
12	3 Millenium Developmental Goals Fund (3MDG) / UNOPS	Dr. Aye Yu Soe
13	3 Millenium Developmental Goals Fund (3MDG) / UNOPS	Dr. Phyu Phyu Thin
14	3 Millenium Developmental Goals Fund (3MDG) / UNOPS	Ms. Aye Mar Lwin
15	American Refugee Committee (ARC)	Dr. Gary Dahl
16	Community Partners International (CPI)	Dr. Si Thura
17	Department of International Development (DFID)	Ms. Louise Mellor
18	Department of Medical Research (Lower Myanmar)	Dr. Myat Phone Kyaw
19	Department of Medical Research (Lower Myanmar)	Dr. Ye Htut
20	Food & Drug Administration (FDA)	Dr. Thin Zar Theingi
21	International Organization for Migration (IOM)	Dr. Patrick Duigan
22	International Organization for Migration (IOM)	Dr. Theint Theint Hlaing
23	International Organization for Migration (IOM)	Dr. Pyae Phyo Htoon
24	Japan International Cooporation Agency (JICA)	Ms. Hla Yin Kyawt
25	Malaria Consortium (MC)	Dr. Yasum Padaiuree
26	Malaria Consortium (MC)	Dr. Arantxa Roca
27	Malaria Consortium (MC)	Mr. Myo Win Tin
28	Malaria Consortium (MC)	Mr. Aung Naing Cho
29	Malaria Consortium (MC)	Dr. Htike Htike Htet
30	Malaria Consortium (MC)	Mr. Glaister Leslie
31	Malteser International	Dr. Myo Zin Oo
32	Medical Action Myanmar (MAM)	Dr. Frank Smthuis
33	Medical Emergency ReLief International (MERLIN)	Dr. Khine Haymar Myint
34	Ministry of Health (MOH)	Dr. Khin Phyu Pyar
35	Myanmar Council of Churches (MCC)	Dr. Khin Maung Wynn

36	Myanmar Medical Association (MMA)	Dr. Soe Aung
37	Myanmar Red Cross Society (MRCS)	Dr. Maung Maung Hla
38	National Malaria Control Program (NMCP)	Dr. Khin Nan Lon
39	NMCP, Vector Borne Disease Control	Dr. Than Naing Soe
40	Pact Myanmar	Dr. Wai Wai Lwin
41	Population Service International (PSI)	Dr. Hnin Su Su Khin
42	President's Malaria Initiative (PMI) / USAID	Dr. Mya Sapal Ngon
43	President's Malaria Initiative (PMI) / USAID	Mr. David Sintasath
44	Private Consultant	Dr. Khin Mon Mon
45	Save the Children	Dr. Min Min Thein
46	Save the Children	Dr. Aye Thet Oo
47	Save the Children	Dr. Kyaw Zay Ya
48	Save the Children/ CAPM	Dr. Adelaida Degregorio
49	United Nations Office for Project Services (UNOPS)	Dr. Faisal Mansoor
50	United Nations Office for Project Services (UNOPS)	Dr. khin Pa Pa Naing
51	United Nations Office for Project Services (UNOPS)	Dr. Zaw Win Tun
52	United Nations Office for Project Services (UNOPS)	Dr. Su Mon Kyaw
53	United Nations Office for Project Services (UNOPS)	Dr. Aye Yupar
54	United Nations Office for Project Services (UNOPS)	Dr. Kyaw Zan Lin
55	University of Maryland	Mr. Myaing Nyunt
56	URC- CAP Malaria	Dr. Saw Lwin
57	US Pharmacopeial Convention	Dr. Lu Lu kyaw Tin Oo
58	World Health Organization (WHO)	Dr. Sai Nan Ngin
59	World Health Organization (WHO)	Dr. Myo Myint Naing
60	World Health Organization (WHO)	Dr. Win Htike
61	World Health Organization (WHO)	Dr. Tet Toe Tun
62	World Health Organization (WHO)	Dr. Khin Than Win
63	World Health Organization (WHO)	Dr. Nay Lin Yin Maung
64	World Health Organization (WHO)	Mr. Sithu Kyaw
65	World Health Organization (WHO)	Dr. Ye Win

Yangon, Malaria SR/ IP (24 June 2014, 9am- 1pm)

No.	Organization	Name
66	American Refugee Committee (ARC)	Ms. Aye Aye Than
67	Burnet Institiute	Dr. Htin Kyaw Thu
68	Burnet Institiute	Dr. Wai Yan Min Htay
69	Community Partners International (CPI)	Dr. Win Thu
70	Cooperazione e Sviluppo (Cooperation & Development) - Cesvi	Ms. Mireia Llach
71	International Organization for Migration (IOM)	Dr. Patrick Duigan
72	Malteser International	Dr. Myo Zin Oo
73	Myanmar Council of Churches (MCC)	Dr. Khin Maung Wynn
74	Myanmar Health Assistant Asssociation (MHAA)	Mr. Yan Naing Oo
75	Myanmar Medical Association (MMA)	Dr. Soe Aung

76	Myanmar Red Cross Society (MRCS)	Dr. Maung Maung Hla
77	National Malaria Control Program (NMCP)	Dr. Khin Nan Lon
78	NMCP, Vector Borne Disease Control	Dr. Than Naing Soe
79	Pact Myanmar	Dr. Wai Wai Lwin
80	Pact Myanmar	Dr. Cho Myat Nwe
81	Population Service International (PSI)	Dr. Yan Myo Aung
82	Save the Children	Dr. Kyi Kyi Ohn
83	Save the Children	Dr. Aye Thet Oo
84	Save the Children	Dr. Phone Si Hein
85	Save the Children	Dr. Kyaw Zay Ya
86	United Nations Office for Project Services (UNOPS)	Dr. Aye Yupar
87	URC- CAP Malaria	Dr. May Aung Lin
88	World Concern	Dr. Khayae Htun
89	World Concern	Dr. Nyi Nyi Zaw
90	World Health Organization (WHO)	Dr. Myo Myint Naing
91	World Vision International (Myanmar)	Dr. Hnin Yee Mon Kyaw
92	World Vision International (Myanmar)	Dr. Aye Aye Khaing

Yangon, Private sector (24 June 2014, 2pm- 5pm)

No.	Company	Name
93	Aung Yadanar Hospital	Dr. Ei Ei Han
94	Aung Yadanar Hospital	Dr. Thiha Soe
95	Aung Yadanar Hospital	Dr. Kyi Pyar New
96	GINI	Ms. Nan Kyu Kham
97	Global World Insurance Co., Ltd	Ms. Mya Mya
98	Golden Flower Co., Ltd	Dr. Theingi Myint
99	Kyaw Wynn & Co., Ltd. (Pharmaceutical)	Mr. Maung Maung Lwin
100	Myanmar Business Coalition on AID (MBCA)	Mr. Martin Pun
101	Myanmar Business Coalition on AID (MBCA)	Ms. Hsu Hsu Phyo
102	Myanmar Business Coalition on AID (MBCA)	Dr. Kay Zin Soe
103	Myanmar Business Coalition on AID (MBCA)	Dr. Htay Mg
104	Myanmar Computer Industrial Association (MCIA)	Dr. Myo Naing
105	Myanmar Construction Enterpreneur Association (MCEA)	Ms. Htun May San
106	Myanmar Construction Enterpreneur Association (MCEA)	Ms. Aye Aye Pyone
107	Myanmar Professional Social Workers Association (MPSWA)	Mr. Swe San Oo
108	Poly Gold Co., Ltd	Mr. Kyaw Kyaw
109	Rothmans of Pall Mall Myanmar Pte Ltd	Mr. Edgar RohanmTennekoon
110	Shwe Lwin Pyin Agriculture Farm	Mr. Kyaw Aung
111	Shwe Taung Development Co., Ltd	Ms. Chan Mya Shwe Chu
112	Upper- Mandalay Molasses Trading	Mr. Soe Naing
113	Zabutun Molasses Trading	Mr. Maung Aye

Media & Photographer

No.	Organization	Name
114	Photographer (MLM)	Mr. Nyi Zaw
115	Photographer (Ygn)	Mr. Kaung Thain Kha
116	Photographer (Ygn)	Mr. Sai Naing Lin
117	Sky Net Health Channel	Ms. Hsu Myat Nandar Aung
118	Sky Net Up To Date	Ms. Wint Shwe Yee Win
119	Sky Net Up To Date	Mr. Myo Swe Oo
120	Sky Net Up To Date	Ms. San San Kyi
121	The Myanmar Post	Ms. Khine Khine Tun
122	The Voice	Ms. Aye Thandar Htu
123	The Voice	Mr. Htun Htun Myint
124	7 Days	Ms. Yamin

Mawlamyaing, Private sector, Government & IP (27 June 2014)

No.	Organization	Name
125	American Refugee Committee (ARC)	Dr. Nant Khin Thuzar Than
126	American Refugee Committee (ARC)	Mr. Khin Zaw
127	American Refugee Committee (ARC)	Mr. Saw Hsar Khae Lav
128	Community Partners International (CPI)	Dr. Nay Nyi Nyi lwin
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130	Department of Industrial Crop Development (DICT)	Mr. Tin Win
131	Food & Drug Administration (FDA)	Dr. Soe Naing
132	Food & Drug Administration (FDA)	Ms. Hnin Hnin Wint
133	Gold Mine	Mr. Kaung Htut Zaw
134	Gold Mine	Mr. Ye Min Oo
135	Government Administration Department, Mon State	Mr. Khin Mg Zin
136	International Organization for Migration (IOM)	Dr. Zaw Win Maung
137	Medical Action Myanmar (MAM)	Dr. Htet Wai Lin
138	Medical Action Myanmar (MAM)	Dr. Yu Zin Wint
139	Medical Action Myanmar (MAM)	Dr. Aung Thant Tin
140	Ministry of Health (MOH)	Dr. Nyan Sint
141	Ministry of Health (MOH)	Dr. Sithu Ye Naung
142	Ministry of Mining	Mr. Thein Zaw
143	Myanmar Children & Women Association (MCWA)	Ms. Mon Mon Khin
144	Myanmar Children & Women Association (MCWA)	Ms. Yin Yin Oo
145	Myanmar Medical Association (MMA)	Dr. Aung Than
146	Myanmar Medical Association (MMA)	Dr. Myo Thiri Lwin
147	Myanmar Red Cross Society (MRCS)	Mr. Kyaw Myint
148	Myanmar Rubber Plantation	MEHM Kyan Yint
149	Myanmar Rubber Plantation	Mr. Aye Aung
150	NMCP, Vector Borne Disease Control	Dr. Than Naing Soe
151	NMCP, Vector Borne Disease Control	Mr. Sitt Aung

152	NMCP, Vector Borne Disease Control	Ms. Nu Nu Aye
153	NMCP, Vector Borne Disease Control	Ms. Wint Lai Han
154	NMCP, Vector Borne Disease Control	Mr. Aung Win Soe
155	NMCP, Vector Borne Disease Control	Mr. Wanna Aung
156	NMCP, Vector Borne Disease Control	Mr. Chan Aye Aung
157	NMCP, Vector Borne Disease Control	Mr. Tun Zaw Latt
158	NMCP, Vector Borne Disease Control	Mr. Paw Tun Kyaw
159	Population Service International (PSI)	Dr. Tin Aung Kyaw
160	State Health Department	Dr. Khaing Thuzar Tun
161	State Health Department	Dr. Su Su khaing
162	State Health Department	Dr. Wut Hmone
163	State Health Department	Dr. Khin Aye Khaing
164	State Health Department	Ms. Kay Thi Kyaw
165	State Health Department	Dr. Phyu Phyu Khin
166	State Health Department	Mr. Aung San
167	State Health Department	Dr. Wint Lai Phyo
168	Township Health Department	Dr. Mg Mg Lwin
169	United Nations Office for Project Services (UNOPS)	Ms. Tin Tin Oo
170	World Concern	Mr. Saw Naing
171	World Concern	Ms. Ei Mon Soe
172	World Concern	Mr. Nay Myo Zaw
173	World Concern	Dr. Aung Kaung Khant
174	World Health Organization (WHO)	Dr. Myo Myint Naing
175	World Health Organization (WHO)	Dr. Zaw linn Htet
176	Zar Ni Bwar Private Hospital	Dr. Kin Kyi
177	Zar Ni Bwar Private Hospital	Mr. Zay Htet Aung

Annexe 4

Media Coverage

Sky Net Television channel	**Sky Net Health Channel** Aired Interview on 29.6.2014
	Sky Net Up to Date Channel Aired Interview on 25.6.2014
ELEVEN Media Press Article	**ELEVEN Newspaper** Published on 7.7.2014
The Myanmar Post Media	**The Myanmar Post Newspaper** Published on 26.6.2014
The Voice Media	**The Voice Newspaper** Published on 26.6.2014