Myanmar's National Response to Three Major Diseases Especially Health Education (awareness raising)

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Abstract

Life expectancy is an important indicator of human development. Improvements of life expectancy have come first of all from better prevention and cure of diseases but also from a better understanding and access to healthy models of living. The main causes of premature death in Myanmar are due to Malaria. HIV/AIDS and acute respiratory infections. Prioritization of communicable diseases such as TB, Malaria and HIV/AIDS are regarded as national concern. In controlling these major diseases, health education is one of the most cost effective intervention. A large number of diseases could be prevented, if people are adequately informed about them and if they were encouraged to take necessary precautions in time. Health education activities include counseling, education on health, safer sex behaviours, condon distribution, needle and syringes distribution and primary health care. Information and education talks, TV spots, short messages and documentaries, movies and song. Community awareness are also being raised by using printed media such as through daily newspaper, magazines, journals, pamphlets, posters, stickers and billboards. School education sessions on HIV/AIDS and adolescent reproductive health were also conducted.

Introduction

Malaria, Tuberculosis and HIV/ AIDS are the first three priority diseases being addressed in the National Health Plan. The National Health Plan (2001-2010) described the general objective of the plan to combat HIV/AIDS that it was to prevent HIV/ AIDS by mean of dissemination health education regarding HIV/AIDS prevention and control among the people and by making people perceive and practice healthy life style and behaviours. Health education campaigns were introduced to explain the benefits of long-lasting Insecticide - treated Nets, resulting in high acceptance of bed net in communities. Health education is an important strategy in TB control because many people with TB lack awareness of the basis symptoms of TB and they do not know that treatment is freely available. Health education is a process that informs, motivates and helps people to adopt and maintain healthy process and lifestyle, advocates and environmental changes as needed to facilitate

this goal and conduct professional Training and research to the same end. According to this definition, there are three component of health education.

(a) Informing people

(b) Motivating people and Guiding into action.

Health education is carried by variety of people. They are parents, teachers, friends, fellow workers, physicians, nurses and numerous others. Health education should be concern of everybody engaged in any form of community welfare work. Myanmar has been making efforts in fighting against three diseases of national concern (HIV/AIDS, Tuberculosis (TB) and malaria. Scoring many achievements in the aspect over the past two decades. According to the country's Health Ministry. Myanmar treats the three diseases as priority with the main objectives of reducing the morbidity and mortality to make no longer a public problem.

Research Method

In doing this research, case study design is used to analyse Myanmar's efforts to combat three major diseases (HIV/AIDS, TB, Malaria) especially awareness raising (health education). This Method is used to illuminate and evaluate Myanmar's efforts in implementing programme projects. After empirical research and data collection assessment of information which are collected, these information and data has been made into a reliable, credible and confirmable. Based on these evidence, the analysis of Myanmar's efforts to combat and control HIV/AIDS, TB, Malaria as descriptive method have been made.

Myanmar's National Response to three major diseases

The National AIDS Programme (NAP) consists of the Programme Manager's Office, Central AIDS/STD Clinic, and Central AIDS Counselling Team at central level, 4 State/ Division AIDS/STD Offices at State/Divisional level, and 40 AIDS/STD Control Teams at the District level. AIDS/STD control teams are strategically located in all States and Divisions. The National AIDS Programme established under the Disease Control Division of the Department of Health is responsible for prevention and control of HIV/AIDS and Sexually Transmitted Diseases (STDs). Both HIV/AIDS and STD prevention and control activities have been identified in the National Health Plan as priority diseases.

General Objective

To increase the awareness and perception of HIV/AIDS in the community by promoting access to information and education leading to behavioural change and adopting of healthy lifestyle.

Specific Objectives

- To increase awareness of HIV/AIDS in the whole community
- To ensure safe blood and blood products
- To prevent transmission of HIV through handling for surgical and medical equipment
- To prevent transmission of HIV among injecting drug users (IDUs).
- To prevent transmission of HIV through sexual activity.
- To systematically collect information regarding the epidemiological pattern of HIV infection in the country
- To provide effective health care and counseling services for people with HIV/AIDS
- To train health workers and Community Based Organizations in health education, counseling and provision of care
- To train public and private sector employees on HIV/AIDS/STD prevention education and condom promotion.
- To strengthen the potential of the individual, the family and community in responding HIV problem
- Advocacy to authorities and decision makers, implementing partners, private sectors and community leaders
- HIV and STD prevention education

Health education (awareness raising)

HIV/AIDS education talks were conducted at various levels by the Ministry of Health in collaboration with related sectors to advocate for increased perception of HIV/AIDS and related issues among general population as well as targeted population groups.

Information and education messages were also conveyed through mass media by means of HIV/AIDS education talks, TV spots, short message and documentaries, movies and songs. Community awareness on HIV/AIDS are also being raised by using printed media such as through daily newspaper, magazines, journals, pamphlets, posters, stickers and billboards. School education sessions on HIV/AIDS and Adolescent Reproductive Health were also conducted in coordination with the

School Health Section and Adolescent Reproductive Health Section of Department of Health.

For out-of school youth, Community based HIV/AIDS and Drug Abuse prevention and education activities as well as peer education programmes are being implemented in coordination with local and international NGOs.

HIV/AIDS Education programmes for women of reproductive age are given as part of life skills training with MMCWA, MWAF, MRCS, MNA, other national NGOs in selected project areas. In coordination with MCH section of DOH and UNICEF, education activities are also being conducted on PMCT, VCT, Infant feeding.

Peer education programmes for CSWs and their clients through condom promotion programmes, IDUs through harm reduction programmes, and high risk population such as migrant mobile population through special programmes. These activities were conducted in partnership approaches with national and international NGOs.

The Fund for HIV/AIDS in Myanmar was established to support the implementation of the Joint Programme. Three donors contributing to the FHAM were the United Kingdom's Department for International Development (DFID), Sweden's Agency of International Development Cooperation (SIDA), and the Governments of the Netherlands and Norway. There is a multiplicity of funding modalities available to donors to fund HIV/AIDS prevention and care activities in the country: (a) Fund for HIV/AIDS in Myanmar; (b) direct official development assistance funding through agencies in Myanmar; (c) direct funding through individual agency core resources; (d) funding through regional United Nations project mechanisms; (e) funding through bilateral projects. Joint Programme Component I (Sexually Transmission of HIV) There are two main outputs of this component :increased access to condoms and increased capacity for the prompt and effective management of Sexually Transmitted Infections (STI).

TCP (Targeted condom Programme)

One of the NAP's HIV/AIDS prevention and control strategies is the 100% Condom Use Programme among targeted populations. TCP is a government-led effort, supported by WHO policies. 100% Targeted Condom Programme (TCP) launched by the National AIDS Programme in 4 pilot sites/ townships (Kawhaung, Tachileik, Bago and Pyay) in 2001, has expanded systematically year after year to cover 154 sites in 2005. This expansion was supported by the FHAM, the Global Fund, UNFPA, WHO, and UNAIDS. The programme was expanded to 110 townships

by early 2005. This expansion was supported by the FHAM, UNFPA, WHO, and the UNAIDS Secretariat.

The programme includes targeted condom distribution and promotion to sex workers and their clients, training and IEC, peer education among sex workers, formation of the Condom Core Group and advocacy with police, local authorities and the owners of entertainment establishments for 100% condom use. FHAM has supported the expansion of the 100% Targeted Condom Promotion programme implemented by the National AIDS Programme (NAP) in 88 of the 154 townships in 2005-2006 FY. In 2006-2007, the programme extended to 170 townships. WHO participated in monitoring visits to Loikaw, Lashio, Mandalay and Yangon, and provided technical support for the development of the national guidelines on 100% TCP.

Comprehensive Harm Reduction Initiative (CHRI)

The UNODC aims to reduce the harmful consequences of injecting drug use among drug users and their families through capacity building and information strategies, and is implemented through a partnership between UNODC, CARE and Medecins du Monde. Its geographical focus is on communities and institutions in Kachin and Shan states, and in selected areas of Bago and Mandalay divisions. Nationality leadership in the field of harm reduction is provided by the Central Committee for Drug Abuse Control (CCDAC) of the Ministry of Home Affairs, along with the Department of Health's Drug Detoxification/ Treatment & Rehabilitation Unit (DDTRU). Services that have been established for drug users include drop-in centres and outreach into the community, with provision of primary health care services, and needle and syringe exchange programmes.

Three of these townships in Northern Shan State (Lashio, Muse and Kutkai) were designated as top priority townships or "Comprehensive Harm Reduction Initiative Townships (CHRI)". In Lasio, a coordinated effort by implementing partners aims to provide high coverage of harm reduction services, including drug-use prevention, treatment and rehabilitation.

In 2007, services are provided for drug users and IDUs in 35 drop-in centres in 17 townships. Certain townships have multiple drop-in centres each providing services for drug users, for example Lashio township has 10 centres. Hpakant has six, while Muse and Myitkyina each have three. There is a need to continue to expand service delivery to new locations, notably the agreed priority townships.

SHAPE (School-based healthy living and AIDS Prevention Education)

Life-skills classes that educate children about the danger of HIV and AIDS are taking place in Myanmar as part of a programme called the School-Based Healthy Living and HIV/AIDS prevention Education(SHAPE). The SHAPE programme, which was introduced by UNICEF in 1998, is now part of the national curriculum in Myanmar. 2.14 million pupils have been reached by the SHAPE programme for the first semester of 2005 only. Through this programme, UNICEF has supported the training of more than 54,000 teachers on a range of health and social issues, including HIV, personal hygiene, nutrition and drugs-knowledge that they can pass on to their students. International NGOs, like AMI and PARTNERS, have been able to support the SHAPE programme with the participation of local authorities in middle and high schools in the suburbs of Yangon. They conducted HIV awareness raising activities both through outreach workers and peer educators and in-house settings (clinics, drop in centre, etc), as well as more focused behavioural change activities targeting the needs of people with high risk behaviour.

VCCT (Voluntary and Confidential HIV Counseling and Testing)

Provision and expansion of voluntary and confidential HIV counseling and testing (VCCT) services for the population is included as one of the strategies in the NAP strategies plan. It has been established through a network of laboratories situated at the AIDS/STD teams of township level. Currently, VCCT services (which include counseling and testing) are only provided in public health setting through the network of 43 AIDS/STD Teams of the DoH/NAP, the National Health Laboratory, and within the facilities of township hospitals.

Other organizations, mainly NGOs provide per-and post-test counseling while referring to a public laboratory or the local AIDS/STD team for HIV testing. In this way NGOs facilitate access to VCCT services to general and vulnerable/high risk populations covered by their programmes such as sex workers, MSM and IDU.

PMTCT (Prevention of Mother to Child Transmission Services)

UNFPA also continues to support community-based PMTCT in ten sites. PMTCT has been delivered in the contexts antenatal and obstetrical care, and maternal-child health programmes. PMTCT services are also provided through the programmes of three FHAM NGO implementing partners, MSF-Holland, MSF-Switzerland and AMI. The largest number of mother-baby pairs received ARV prophylaxis through MSF-Holland network of 16 clinics. Since beginning in 2001 the progamme had been expanded to cover 89 townships, and 37 hospitals were involved

in provision of PMCT services by the end of 2006. There were 151 sites providing PMTCT services in 2007 and covering 182 sites in 2008. PMCT services are also being provided through the projects of AMI, MSF-Holland and MSF Switzerland. In 2006, $27.2 million were spent on the national response to AIDS.

Malaria Control Activities

At present, almost 60% of the population (27.6 million) live in areas that are high and moderate risk for Malaria. National Malaria statistics report that in highly endemic areas every fifth child on adult was found to be slide positive for Malaria. The Malaria component of WCHD project which included IEC for early care seeking, case management training as well as essential anti-malaria drug and ITN. Malaria control activities were implemented through PHC approach by BHS staff in the whole country. Specialized malaria control staff were mainly responsible for training applied field studies, monitoring, evaluation and technical guidance on malaria activities. The vector Borne Disease control Program under the project name MMR VBE 001 had been launched in 1978. In 1992, Myanmar followed the Global strategy of Malaria after Global Conference of the Ministers of Health on Malaria, 1992. The Roll Back malaria programme was launched in 1998 and then WHO adopted the strategies for reduction and treatment of malaria for the world's people by the year 2010. The malaria Component of the WCHD project include IEC for early care seeking, case management training on malaria as well as essential anti-malaria drugs as part of the list of essential drug supplies and insecticide treated nets. The malaria activities were implemented in the context of the Mekong Roll Back Initiative jointly with WHO, UNDP and other partner involved.

UNICEF, WHO and national Malaria Control Programme work together to improve the diagnostic facilities at the peripheral level. UNICEF works with WHO and NMCP in improving peripheral treatment guidelines, and increasing demand for and use of ITNs (200,000 of which have been distributed over focus years). In Myanmar, mobilizing resources and involvement of Key partners in malaria control are some of the most important major challenges to be achieved. One potential source is Global fund for AIDS, TB and Malaria. Since 1998, malaria control activities, in particular community capacity building and provision of supplies and equipment, have been implemented in all the townships of Kayah State under UNICEF/JICA assistance. The funds of $ 27,000 to implements a pilot phase of RBM Projects (2000) in the 16 border townships are being provided by the Japanese Government through UNICEF. JICA, WHO and UNICEF are active in public sector development activities for malaria.

Tuberculosis Control Programme

The GFATM and UNDP signed agreement for the programme grant agreement for the tuberculosis component on 13 August 2004. This agreement is for about US $ 6.9 million over two years (WHO- *Myanmar Newsletter*, 2005, 3). Total project life is 5 years. The project plans to strengthen the DOTs programme (Direct Observed Treatment, Short course: WHO TB control strategy) through a nationwide cascade training of health-care workers, upgrading to laboratory vulnerable group in remote areas, increasing monitoring and supervision, developing of media for behaviour change, piloting and expanding community based supervised treatment and enrolment of private practitioners and private sector. The primary objective of GDF is to provide access to high quality TB drugs, free of charge, for people in the poor countries. This programme provided medicines for 10 million patients over a ten year period. TB drugs were given FOC in Myanmar since 1997 with support of the GDF aimed at increasing quality of services to remote, hard to reach areas of the country. Following a successful pilot project to introduce FDC (Fixed Dose Combination) anti-TB drugs in the divisions of Mandalay and Yangon, all state/Divisional TB officers were trained in FDC anti-TB drug management, and FDCs have been introduced nationwide through cascade training of the TMOs.

In the tuberculosis Control Program, the cure is increased use of the Latest treatment strategy, a short term combined drug therapy- the Directly observed Treatment Short Course (DOTs). Myanmar currently receives anti-TB drugs through the GDF, which will provide a third year's supply of drugs for 2005, including a buffer stock. The GDF is considering a second term of three years beyond 2005. Following a successful pilot project to introduce FDC anti-TB drugs in the divisions of Mandalay and Yangon, all State/Divisional TB Officers were trained in FDC anti-TB drug management, and FDCs have been introduced nationwide through cascade training of the Township Medical Officers. A nationwide drug resistance survey was completed in 2003, with the prevalence of MDR-TB among new cases estimated at 4.0%.

The NTP functions through a central level office and 12 state or divisional TB centres. There is one central drug store and two subnational stores in Upper and lower Myanmar. Township hospitals serve as the DOTs treatment units, and TB registers are mainly at this level for the population in each township.

Collaboration is essential to TB control. There are many existing and potential partners working in TB control. Coordination is important and working together is as effective ways of strengthening partnerships reducing costs, sharing resources and skills and maximizing the value of the contributions of different categories. Collaboration in advocacy, health education and research initiatives is essential.

Equally, a good program needs information to ensure that it is up to date with current developments in TB control.

With the objective to enhance the collaboration and coordination between health and education sectors on HIV/AIDS education activities in schools, co ordination workshops were conducted in (8) States and Divisions during 2004. These workshops were done through intrasectoral coordinated efforts of National AIDS Programme & School and Youth Health Project of DOH with funds for HIV/AIDS in Myanmar. TMO and TEO from 142 townships attended these workshops for HIV/AIDS education activities. Health education was implemented for 4 million school children in 21059 schools. Training for Basic Health staff (BHS/VHW) Drugs assistance, TB, Leprosy and Malaria Control activities and Health education were carried out since 1994. In 1994 HDI-I was launched in Seven Project Townships with financial assistance of U.S $ 3.05 million in April 1994. These Seven Townships were:

(1) Kyauk Pa Daung Township (Mandalay)
(2) Chaung Oo Townships (Sagaing Division)
(3) Magwe Township (Magwe Division)
(4) Nyaung Shwe Township (Southern Shan State)
(5) Ywagwan (Southern Shan States)
(6) Bo Kalay Township (Ayeyarwaddy Division)
(7) Latputta Township (Ayeyarwaddy Division) (*Ministry of Health*, 2005, 2).

HDI-II was implemented from 1996 to 1999. According to the Programme, It aimed eleven Townships with U.S $ (10.2) million. Project Townships were:

(1) Kyauk Pa Daung (Mandalay)
(2) Chaung Oo (Sagaing)
(3) Magwe (Magwe Division)
(4) Nyaung Shwe (Southern Shan)
(5) Ywagwan Township (Southern Shan)
(6) Bakalay Township (Ayeyarwaddy Division)
(7) Latputta Township (Ayeyarwaddy Division)
(8) Mawlamyaing Township (Ayeyarwaddy Division)
(9) Kalaw Township (Southern Shan Division)
(10) Pin Laung Township (Southern Shan)
(11) Pindaya (Southern Shan) (*Ministry of Health*, 2005, 2).

In these project townships, Health education mainly preventive and control measures of Malaria, TB, Leprosy, Nutrition and Reproductive health were carried out.

HDI III was implemented from September 1999 to December 2001. It was funded with U.S $ 5 million and it was expanded to preventive measures and care for communicable diseases in previous project townships. HDI-IV was carried from 2002

January to December 2005. HDI-IV was funded with U.S $ 2.5 million for Enhancing Capacity for HIV/AIDS Prevention and Care activities in 70 Townships in Myanmar. In Project Townships, the programme aimed targeted population for Health Education for HIV, AIDS prevention (*Ministry of Health*, 2005, 4). Basic education school curricula (Grades 2-10) entitled "Healthy Living and HIV/AIDS" had been extensively tested in selected primary, middle and high schools

In the national health plans for 1993-1996 and 1996-2001, the status of health education had changed from that of a support programme to a specific IEC project under the Health Systems Development Programme. Dissemination of health education down to the grass roots levels was one of its major objectives. Accordingly, the Health Education Bureau (HEB) had revitalized and recognized its countrywide health educational activities. As a consequence, the use of mass media for health education (ratio talks, television spots, public service announcement on television) had increased considerably.

Table (I) Target of Community Health Education and Promotion Services Project

Sr. No.	Items	Quantity	2001-2002	2002-2003	2003-2004	2004-2005	2005-2006	Total
1.	Training on Health Education for B.H.S	Frequency	20	20	25	20	25	110
2.	Cooperation and coordination with other project	No.	10	10	10	10	10	50
3.	(a)Conduction reorientation and (b)Further study for Health Education Officers.	Freq. No.	20 2	20 2	50 2	20 2	20 2	125 10
4.	Mass-MEDIA (a) Broadcasting (b) T.V Programme (c) Production of I.E.C materials and distribution	 Freq. Freq. No. S/D	 10 16	 10 16	 15 16	 10 16	 10 16	 55 80
5.	Collection of information for I.E.C production		15	15	15	15	15	75
6.	(a) Pretesting and (b) Productions of I.E.C materials.	Freq.No.	15 10	15 15	15 10	15 10	15 10	75 55

Source: *National Health Plan*, 2005, 232

In like manner, the preparation and dissemination of posters and pamphlets had also increased, with technical inputs given by the central HEB to other health related

projects in the development of pamphlets and posters. More training of various medical and health staff had also been undertaken.

Table (II) Activities and Information in Health Education Programme

Sr. No.	Items	Quantity	2001-2002	2002-2003	20003-2004	2004-2005	2005-2006	Total
1.	Performing Mass Media Activities							
	- Songs		2	2	2	2	2	2
	- Spots		2	2	2	2	2	2
	- Dramas		10	10	10	10	10	10
	- Documentaries		2	2	2	2	2	2
	- News/Articles.		5	5	5	5	5	5
2.	Producing I.E.C Materials		10	15	15	20	10	70

Source: *National Health Plan*, 2005, 228

Outcomes (Research Findings)

There had been an incremental increase in prevention efforts, especially those focusing on condom promotion for sex workers and their clients, with the 100% targeted condom promotion (TCP) programme having expanded from four sites in 2001 to 154 sites in 2006, and on drug users, with various elements of a harm reduction strategy implemented in several regions and gradually improving collaboration between HIV programme implementers and police leading to an improved enabling environment. As a result, the HIV prevalence in Myanmar had decreased from 1.5% in 2000 to 1.3% in 2007. Some effective interventions were in place for mobile populations, the blood safety programme had made good progress, and HIV education was occurring for youth in schools. Voluntary counseling and testing services were available in 43 clinics across the country.

According to a latest remarks of Minister of Health Dr. Kyaw Myint, a workshop involving Myanmar, the World Health Organization (WHO) and UNAIDS stated that 38,911 people were estimated to have lived with HIV/AIDS in 2004 and the HIV prevalence in Myanmar has reduced form 1.5 percent in 2000 to 1.3 percent in 2005. In the course of its endeavors to contain the HIV/AIDS, Myanmar initiated study on prevention and control activities on the disease in early 1985, establishing the National AIDS Committee and laying down control program in 1989.

In its anit-AIDS program, Myanmar launched health education and awareness raising activities against the diseases covering a total of 550,000 people with 40

million condoms distributed in 2005, up from 11 million distributed in 1999. In its harm reduction activities for intravenous drug users, Myanmar educated 10,000 such users and distributed 1.1 million disposable syringes and needles in 2005. In prevention of mother-to-child transmission, 130,000 pregnant women were tested for HIV during 2005. Statistics show that HIV levels of pregnant women have declined from 2.2 percent in 2000 to 1.3 percent in 2005, while that among men seeking treatment for other sexually transmitted infections from 8 percent in 2001 to 4 percent in 2005.

With regard to TB, the minister said it is estimated that about 100,000 new TB patients develop annually and about half of them are infections cases. The minister disclosed that Myanmar achieved 95 percent case detection rate and 84 percent treatment success rate in 2005. With the introduction of Directly Observed Treatment Short Course (DOTS) strategy of the WHO in 1997, the DOTS treatment covered 330 townships in 2002 and extended to the whole country's 324 township in 2003 after DOTS expansion.

As for malaria, the trend of malaria morbidity and mortality has been decreasing at present with malaria morbidity per 1,000 population reducing from 24.5 in 1988-89 to 9.3 in 2005-06, while its mortality down from 10.4 to 3.1 correspondingly. Meanwhile, as part of the special project collaborative activities dealing with the three disease, Myanmar-China and Myanmar-Thailand cross-border activities were also conducted bilaterally since 2000.

UN support should place more emphasis into peripheral capacity building, Malaria Control, tuberculosis and new born care. UN should promote a significant amount of their health effects and resources on ill defined "awareness raising" campaigns. Many campaigns are conducted by people with minimal technical knowledge of the subject and no ability to provide solution efficacy e.g. access to effective preventive tools and treatment.

Myanmar can not solve these disease burden alone with her limited resources. It needs effective collaboration with UN, other partners and INGOs. In order to overcome the anticipated shortage of supplementary funds, active fund raising campaigns are needed.

Discussion

Although the vast network of members of local NGOs like Red Cross, MMCWA, etc are already engaged in various health activities, strong and sustainable community participation and multi-sectoral coordination and cooperation are key issues to the success of malaria control. There is a crucial area for strengthening regular drug supplies, and constant monitoring of drug resistance is crucial for the

success of the malaria control strategy (*Roll Back Malaria*, 2001, 66). Effectiveness of bed nets depend or responsible vectors, and its behaviours, peak biting time and behaviour of the people from that particular area (*Health in Myanmar*, 2001, 26). Voluntary Health worker should be selected and trained for Early Detection and Prompt Treatment and also as social mobilizer and facilitator for early referral to nearest health care facilities. The goal of communication in roll back malaria programme is behavioural change. The communication in RBM should make the people respond in positive behaviour changes, in line with expected roles, tasks, activities, behaviours, habits in the prevention and control malaria in their community or settings. Intensive behavioural change communication is necessary for increase in bed net ownership and regular use of bed nets. ITN policy should be in place and fund to procure insecticides should be made available for yearly mass treatment of existing bed nets particularly in moderate to high endemic areas. The vast network of volunteers and local NGO members should be mobilized to support BHS for mass treatment of mosquito nets. For Malaria prevention and mosquito control to be successful the environmental management by individuals, family, community and the government, separately or in partnership is very important component of concerted and collective action.

Myanmar is close to reaching the targets for case detection and treatment success. Covered population is increased to 95% and coverage township increased to 100 percentage. Case detection Rate is promoted to 81% and total treatment success is increased to 80% of patients in 2004. To be effective way of prevention, a strong grass root health infrastructure is necessary for effective delivery of DOTs programme.

As regards malaria control, funding for effective implementation of malaria prevention and control activities throughout the country is not enough although the government has significantly increased its budget for National Malaria Control Programme and funds for antimalarial drugs, rapid diagnostic test, microscopes, training are provided by WHO and other agencies. In Myanmar, mobilizing sources and involvement of key partners in malaria control is one of the most important challenges. NTB covered the whole country with DOTS strategy in November 2003. But there are weaknesses too. The weaknesses in TB control are low community awareness on TB problem. In the year 2003, a total of 4083 new cases were detected in Myanmar and NCDR was. 7.61 per 100,000 populations. Among 4083 new cases were detected in 2003, 3072e cases (73.5%) were voluntarily reported and 441 cases (10.8%) were detected in special programmes (Focused LEC).

Conclusion

Health education is one of the most-cost effective intervention. A large number of diseases could be prevented, if people are adequately informed about them and if they were encouraged to take necessary precautions in time. The Targets for educational efforts may include the general public, patients, priority groups, health providers, community leaders and decision- makers. The purpose and aim of health education is to bring activities into programme activities and services which are organized for the solution of health problem, it is to help the people voluntarily take the action necessary for achieving the health goal, it is to help people learn to do things themselves for their own health improvement. Health education is a method, an approach for bringing about this action or behaviour change which is necessary to programme effectiveness. The significant outcome of health education is behaviour, action, not only by the public but also by health workers and by others from leaders at the periphery to the highest officials. Health Education Programme (or) awareness raising has taken the supportive role to achieve the goals.

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