

DRAFT

**Greater Mekong Subregion
Health Cooperation Strategy
2019–2023**

06 December 2018

ABBREVIATIONS

ADB	–	Asian Development Bank
AMR	–	Antimicrobial resistance
ASEAN	–	Association of Southeast Asian Nations
AUN	–	ASEAN University Network
CSO	–	Civil society organization
GMS	–	Greater Mekong Subregion
GMS ECP	–	Greater Mekong Subregion Economic Cooperation Program
GMS SF	–	Greater Mekong Subregion Strategic Framework
HAP	–	Ha Noi Action Plan
HIA	–	Health impact assessment
IAI	–	Initiative for ASEAN Integration
ICT	–	Information and communications technology
IHR	–	International Health Regulations
JEE	–	Joint external evaluation
MCH	–	Maternal and child health
MDR TB	–	Multidrug resistant tuberculosis
NCD	–	Non-communicable disease
PDR	–	People's Democratic Republic
PRC	–	People's Republic of China
RCI	–	Regional cooperation and integration
RIF	–	Regional Investment Framework
SARS	–	Severe acute respiratory syndrome
SDGs	–	Sustainable Development Goals
UHC	–	Universal health coverage
WGHC	–	Working Group on Health Cooperation
WHO	–	World Health Organization

GLOSSARY

Greater Mekong Sub-region	A natural economic area bound together by the Mekong River encompassing Cambodia, the People's Republic of China (specifically Yunnan Province and Guangxi Zhuang Autonomous Region), Lao People's Democratic Republic, Myanmar, Thailand, and Viet Nam.
Health in all policies	An approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity.
Health security	The activities required, both proactive and reactive, to minimize vulnerability to acute public health events that endanger the collective health of populations living across geographical regions and international boundaries.
Health impact assessment	A means of assessing the health impacts of policies, plans and projects in diverse economic sectors using quantitative, qualitative and participatory techniques.
International Health Regulations (2005)	An international legal instrument involving 196 countries across the globe, the aim of which is to help the international community prevent and respond to acute public health risks that have the potential to cross borders and threaten people worldwide.
Joint External Evaluation	A voluntary, collaborative process to assess a country's capacity under the International Health Regulations (2005) to prevent, detect, and rapidly respond to public health threats whether occurring naturally or due to deliberate or accidental events.
One Health	An approach to designing and implementing programs, policies, legislation and research in which multiple sectors communicate and work together to achieve better public health outcomes.
Regional public good	A good, service or resource that is produced and used collectively by two or more countries and that once provided, is available to all, with an individual country's use not limiting use by another country.
Universal health coverage	Ensuring that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship.
Zoonotic disease	A disease caused by viruses, bacteria, parasites, or fungi that spreads between animals and people.

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EXECUTIVE SUMMARY

Regional health cooperation is a priority under the Greater Mekong Subregion (GMS) Economic Cooperation Program. Efforts to enhance regional cooperation and integration, while fundamental to economic growth in the subregion, expose GMS countries to an evolving layer of health challenges.

Increased mobility and trade, including trade in agricultural and food products, facilitates cross-border movement of disease agents and their vectors. Greater intra-regional population movement brings risk of marginalisation of migrant and mobile persons and their exclusion from social protections, most critically access to essential health services. Growth in investment for transport infrastructure and border zone development, while central to GMS country's efforts to diversify their economies and integrate with regional value chains, carries inherent risk of adverse public health impacts.

In parallel with these threats, regional integration creates opportunities to draw on the subregion's health leadership, human resource skills and programming experience to address common health challenges.

Acknowledging the pivotal role of health cooperation to the GMS vision of an integrated, prosperous and equitable subregion, the 22nd GMS Ministerial Conference endorsed the creation of a new GMS Working Group on Health Cooperation (WGHC) and the development of a GMS Health Cooperation Strategy.

The GMS Health Cooperation Strategy 2019–2023 (the Strategy) provides a framework to guide the collective efforts of GMS countries in tackling health issues impacting the subregion. Regional cooperation will focus around three priority outcomes:

- i. Improved GMS health system performance in responding to public health threats.
- ii. Strengthened protection for vulnerable communities from the health impacts of regional integration.
- iii. Enhanced human resource capacity to respond to priority health issues in the GMS.

Three pillars, aligned with each outcome, form the strategic framework (Box 1). Programming areas under each pillar constitute the operational priorities of the Strategy and the basis for project development.

Strategic Pillar 1: Health security as a regional public good tackles the subregion's vulnerability to acute public health events. Ensuring robust national health systems with capacity to prevent, detect and respond to transnational health threats is the cornerstone of health security. Strengthening mechanisms for multi-sector cooperation under a 'One Health approach' is a further building block, crucial for effective response to zoonotic diseases, antimicrobial resistance, and food safety threats. Enhancing cross-border cooperation serves to maximise synergies between the health systems of GMS countries, consolidating health security as a regional public good that carries benefits for people across the subregion.

Strategic Pillar 2: Health impacts of connectivity and mobility responds to health challenges stemming from an increasingly interconnected GMS. Strengthening health systems in border areas where migrant and mobile populations pass and reside is an entry point for programming. Beyond border areas, extending access to essential health services to documented and undocumented migrants throughout the subregion is a priority focus as GMS countries strive to achieve universal health coverage. As investment in GMS urban and transport infrastructure increases, integrating health impact assessment during project planning and implementation will serve to mitigate the unintended health impacts of these developments.

Strategic Pillar 3: Health workforce development builds on the subregion’s existing human resource capacity to address common health challenges. Establishing the GMS WGHC provides a platform for regional leadership and the stewardship of health cooperation initiatives. Strong leadership in turn opens opportunities for intra-regional capacity building, utilizing the subregions’ depth of health human resource and health programming experience to tackle shared health issues and enhance country efforts to attain Sustainable Development Goal targets.

Three themes—policy convergence, gender mainstreaming, and inclusive and equitable development—cut across each pillar. Health cooperation is enhanced by five enabling factors: (i) synergies between regional platforms and programs, (ii) stakeholder engagement, (iii) research and knowledge products, (iv) information and communications technology, and (v) cross-sector cooperation and coordination.

Box 1: GMS Health Cooperation Strategic Framework

STRATEGIC PILLARS					
Pillar 1: Health security as a regional public good		Pillar 2: Health impacts of connectivity and mobility		Pillar 3: Health workforce development	
PROGRAMMING AREAS					CROSS CUTTING
1.1: Core IHR capacities of national health systems	2.1: Border area health systems strengthening	3.1: Regional health cooperation leadership			
1.2: One Health response to public health threats	2.2: UHC for migrant and mobile populations	3.2: Intra-regional capacity building			
1.3: Cross-border and subregional cooperation on health security	2.3: Health impact assessment of GMS urban and transport infrastructure development				Inclusive and equitable development
ENABLERS	Synergies between regional platforms and programs	Stakeholder engagement	Research and knowledge products	Information and communications technology	Cross-sector cooperation and coordination

GMS = Greater Mekong Subregion, IHR = International Health Regulations (2005), UHC = universal health coverage.

Implementation of GMS health cooperation will follow the institutional mechanism of the GMS Program. The newly convened GMS WGHC will lead Strategy implementation. A regional action plan, to be prepared by GMS WGHC core members, will detail output-based and time-bound actions towards agreed milestones under each strategic pillar. The achievements of health cooperation will be gauged through an operational results framework, developed in tandem with the regional action plan.

A product of extensive consultation with GMS partners backed by a robust situational analysis, the Strategy is intended as a tool to guide forward programming and mobilise new project financing towards realizing GMS health stakeholders’ vision of

Health and wellbeing shared by all in an integrated, prosperous, and equitable subregion.

I. INTRODUCTION

1. The Greater Mekong Subregion (GMS)—comprising Cambodia, Yunnan Province and Guangxi Zhuang Autonomous Region in the People’s Republic of China (PRC), the Lao People’s Democratic Republic (Lao PDR), Myanmar, Thailand, and Viet Nam—is a natural economic area bound together by the Mekong River. Launched in 1992, the GMS Economic Cooperation Program (GMS Program) aims to enhance integration, prosperity and equity in this subregion.¹ The strategic direction and priorities of the GMS Program are set out in the GMS Strategic Framework 2012–2022 (GMS SF 2012-2022).²

2. Connectivity, competitiveness and community remain the core building blocks of the GMS Program under GMS SF 2012-2022, with a focus on:

- i. Increasing connectivity through sustainable development of physical infrastructure and the transformation of transport corridors into transnational economic corridors;
- ii. Improving competitiveness through efficient facilitation of cross-border movement of people and goods and the integration of markets, production processes, and value chains;
- iii. Building community through projects and programs that address shared social and environmental concerns.

3. Regional health cooperation is a GMS priority, integral to the GMS SF 2012–2022. Demand for health cooperation is driven, in part, by the threats and opportunities flowing from enhanced connectivity and competitiveness. With increased cross-border mobility and trade comes the risk of movement of disease causative agents and their vectors. Growing cross border population movement brings risk of marginalisation and the exclusion of migrant, mobile and vulnerable persons from social protections, in particular access to health care. Transport corridor and economic zone development has the potential to create adverse public health impacts.³ In parallel with these threats, regional integration creates opportunities to draw on the subregions’ health leadership, human resource skills and planning and programming experience to address common health challenges and enhance country progress toward the Sustainable Development Goals (SDGs).

4. Acknowledging the pivotal role of health cooperation to the GMS vision of an integrated, prosperous and equitable subregion, the mid-term review of GMS SF 2012–2022 called for health cooperation to be more strongly embodied in the GMS Program. Recommendations, encompassed in the Ha Noi Action Plan 2018–2022 (HAP 2018–2022) and endorsed during the 22nd Ministerial Conference, sought the creation of a new GMS WGHC and the development of a GMS Health Cooperation Strategy.

5. This GMS Health Cooperation Strategy sets out the strategic and operational priorities for health cooperation for the period 2019–2023. The Health Cooperation Strategy is a product of extensive consultations with GMS partners, at both country and regional level. The strategic pillars and programs reflect the priorities identified, backed by a robust situational analysis.

6. Consistent with the GMS Program’s mandate, the Strategy focuses on health issues that are regional in nature and require collective action to address. The Strategy is intended as a tool to guide forward programming and mobilise new project financing

¹ In this document subregion refers to the Greater Mekong Subregion.

² ADB. 2011. *The Greater Mekong Subregion Economic Cooperation Program Strategic Framework 2012-2022*. Manila.

³ ADB. 2017. Briefing Note: Special Economic Zones and Health Impact Assessment. Manila.

towards the realization of GMS health stakeholders' vision for health cooperation in the subregion.

II. BACKGROUND

7. The GMS has experienced rapid socio-economic development over recent years. However, behind the impressive gains for the subregion as a whole is a less homogenous picture. Socio-economic conditions between, and within, individual GMS countries vary significantly. The demographic profiles of individual countries are similarly divergent, as illustrated by key indicators - population size, population growth rates and population age distribution. Key socio-economic and demographic statistics for GMS countries are detailed in Appendix 1.⁴

8. Reflecting the heterogeneity of the socio-economic and demographic make-up of the subregion, the epidemiological profile of GMS countries is similarly non-homogenous. Relative burden attributable to communicable diseases, maternal and neonatal illnesses, and malnutrition is highest amongst lower income GMS countries. Burden attributable to non-communicable diseases (NCD) and other lifestyle related health threats, while a common challenge across the subregion, is highest amongst the more developed countries. Variations on key health indicators observed across GMS countries are attributable, in-part, to differences in national health expenditure, health service coverage and health human resource capacity. Key health statistics for GMS countries are detailed in Appendix 1.

9. Efforts to enhance regional cooperation and integration (RCI), while fundamental to economic growth in the subregion, have exposed GMS countries to an evolving layer of health challenges. Regional in nature, these health challenges pose a simultaneous threat to multiple countries. Responding to these challenges requires collective action.

10. At the fore of regional health challenges is the threat of cross-border disease spread. The GMS is a global hotspot for the transmission of emerging, reemerging and epidemic prone diseases, particularly zoonoses.⁵ The impact in the subregion of severe acute respiratory syndrome (SARS) and influenza A (H5N1) was significant, both in terms of fatalities and economic loss.⁶ Dengue, malaria, rabies and novel human coronaviruses are amongst the infectious diseases affecting, or posing a potential threat to, the subregion. Combatting communicable disease threats requires strong capacity for surveillance, risk assessment, laboratory diagnostics, risk communications and response, across both the public health and animal health sectors. The increasing prevalence of antimicrobial and other drug resistance⁷ compounds the dangers posed by infectious diseases. Efforts to address the drivers of drug resistance are urgently required.⁸

11. As GMS economies grow, and populations become richer and more urbanized, GMS consumers are increasingly aware of issues concerning food safety and quality assurance. The cost of food-borne illness in the GMS, while difficult to estimate due to underreporting, is likely high. Studies indicate that levels of chemical residues, such as

⁴ The [GMS Statistical Database](#) provides a comprehensive set of GMS country statistics, covering multiple sectors.

⁵ Approximately 75% of emerging infectious diseases over the past three decades originated from animals. In: WHO. 2011. *Asia Pacific Strategies for Emerging Diseases (2010)*. Geneva.

⁶ The estimated direct cost of SARS to Canada and Asian countries was US\$ 50 billion. In: WHO, 2014. *A Brief Guide to Emerging Infectious Diseases and Zoonoses*. New Delhi.

⁷ Artemisinin resistant malaria in the GMS presents a global risk. The growth of population movement in the subregion creates potential for the spread of resistance within, and beyond, the GMS.

⁸ Drivers include the misuse of antibiotics in human and animals, suboptimal dosing, inadequate adherence to prescribed treatment regimens, and substandard forms of drugs.

pesticides and veterinary drugs, are well above the internationally acceptable level.⁹ As the GMS positions itself as a global supplier of safe agricultural and food products, the control of trans-boundary diseases and the harmonization of food safety standards is receiving increasing attention.

12. Population movement facilitated by RCI generates a unique set of public health challenges. Labor migration within the subregion is estimated to involve up to 5 million people,¹⁰ however the true magnitude is unknown as a significant proportion of migrants are undocumented. Labor mobility cuts across the GMS, with Thailand the subregional hub hosting an estimated 3 to 4 million migrants in cities and rural areas across the country.¹¹ A collective challenge for GMS countries as they strive to attain the SDGs is to ensure the target of universal health coverage (UHC) is extended to all migrants and mobile populations.

13. Health impacts linked to labor migration, population displacement, and other population movement are most pronounced in border areas where large migrant populations pass through or reside. Characterized by geographic remoteness, ethnic diversity, below-average socio-economic conditions, and weak service infrastructure, border areas generally perform poorer on key health indicators compared to less peripheral areas.¹² Determinants of health in border areas are complex. Linguistic, cultural and financial barriers limit access to essential health services. Policies and practices pertaining to migrant populations impinge health-seeking behaviours. Socio-economic inequalities increase vulnerability to disease. Social harms are prevalent as are harms linked to counterfeit health products.

14. Increasingly, border areas are a focus for GMS investment. The development of economic zones in border areas is central to the GMS Program's core strategy to widen and deepen the scope of economic corridors.¹³ Viewed as highly beneficial by GMS governments as they seek to diversify their economies and integrate with regional value chains, economic zone developments carry an inherent risk of adverse public health impacts. These include impacts stemming from the environmental and social aspects of the development, occupational hazards, and cross-border labor movement.¹⁴

15. Similarly, development of transport corridors carries a risk of adverse public health impacts. The link between transport infrastructure and communicable disease spread is well documented.¹⁵ Increasingly, attention is focusing on the issue of road safety.¹⁶ The expansion of transport networks, and the associated growth in vehicle and motorcycle numbers, has led to an increase in the incidence of injury and fatality from road traffic accidents, and associated economic loss.¹⁷

⁹ GMS Core Agriculture Support Program. *Strategy for Promoting Safe and Environment Friendly Agro Based Value Chains in the Greater Mekong Subregion and Siem Reap Action Plan, 2018–2022*. Bangkok. 2017.

¹⁰ ADB. 2013. *Facilitating safe labor migration in the Greater Mekong Subregion: Issues, challenges, and forward-looking interventions*. Manila.

¹¹ IOM. 2017. *IOM Thailand National Strategy 2017–2020*. Bangkok.

¹² WHO. 2013. *Meeting Report: Bi-regional Meeting on Healthy Borders in the Greater Mekong Subregion*. Manila.

¹³ ADB. 2011. *The Greater Mekong Subregion Economic Cooperation Program Strategic Framework 2012–2022*. Manila.

¹⁴ ADB. 2017. *Briefing Note: Special Economic Zones and Health Impact Assessment*. Manila.

¹⁵ ADB. 2009. *Intersections. Gender, HIV and Infrastructure Operations. Lessons from Selected ADB-Financed Infrastructure Projects*. Manila.

¹⁶ ADB. 2018. *GMS Transport Sector Strategy 2030*. Manila.

¹⁷ ASEAN estimates indicate over 75,000 people die and more than 4.7 million are injured annually, costing the region around \$15 billion. In: ADB. 2018. *GMS Transport Sector Strategy 2030*. Manila.

16. The GMS Program's record as a platform for launching cooperation on health, as a regional public good, is impressive. This cooperation has traditionally focused on communicable disease control, combining disease specific initiatives to tackle SARS, highly pathogenic avian influenza and HIV, with cross-border programs to strengthen health system capacity for communicable disease prevention, surveillance and response. Building on the successes, cooperation has moved to tackle more complex issues, including regulatory convergence for medical goods and pharmaceuticals, UHC, and mitigating the health impacts from environment and climate change. Increasingly the GMS Program's institutional mechanisms are being leveraged to embed health as a cross cutting issue in the projects of other sectors—most notably HIV mitigation in transport infrastructure development and the assessment of health impacts in special economic zone developments.

17. Moving forward, priority setting for regional health cooperation must consider and ensure alignment with the national sector strategies¹⁸ and legal frameworks of GMS countries, and the wider strategies and frameworks to which GMS countries subscribe. The SDGs, the Association of South East Asian Nations' (ASEAN) Post-2015 Health Development Agenda, the International Health Regulations (IHR),¹⁹ the Asia Pacific Strategy for Emerging Diseases,²⁰ amongst others²¹ provide key references for determining programming priorities under this GMS Health Cooperation Strategy.

III. GMS HEALTH COOPERATION STRATEGY 2019–2023

A. GMS Health Cooperation–Vision and Outcomes

18. The GMS Health Cooperation Strategy provides a five-year framework to guide collective efforts between GMS countries, health sector stakeholders and development partners. Aligned with the GMS SF 2012–2022, the collective vision for GMS Health Cooperation is:

*Health and wellbeing shared by all in an integrated, prosperous,
and equitable subregion.*

19. Three outcomes of GMS health cooperation, central to the attainment of this collection vision, have been determined:

- i. Improved GMS health system performance in responding to acute public health threats.
- ii. Strengthened protection for vulnerable communities from the health impacts of regional integration.
- iii. Enhanced leadership and human resource capacity for responding to priority health issues in the GMS.

20. Outcomes of GMS health cooperation are elaborated in the Summary Results Framework in Section IV, Table 1.

B. GMS Health Cooperation–Strategic Framework

21. The GMS health cooperation strategic framework is depicted in Figure 1. The framework comprises three strategic pillars, aligned with each GMS health cooperation

¹⁸ Strategies of the health sector and other relevant sectors.

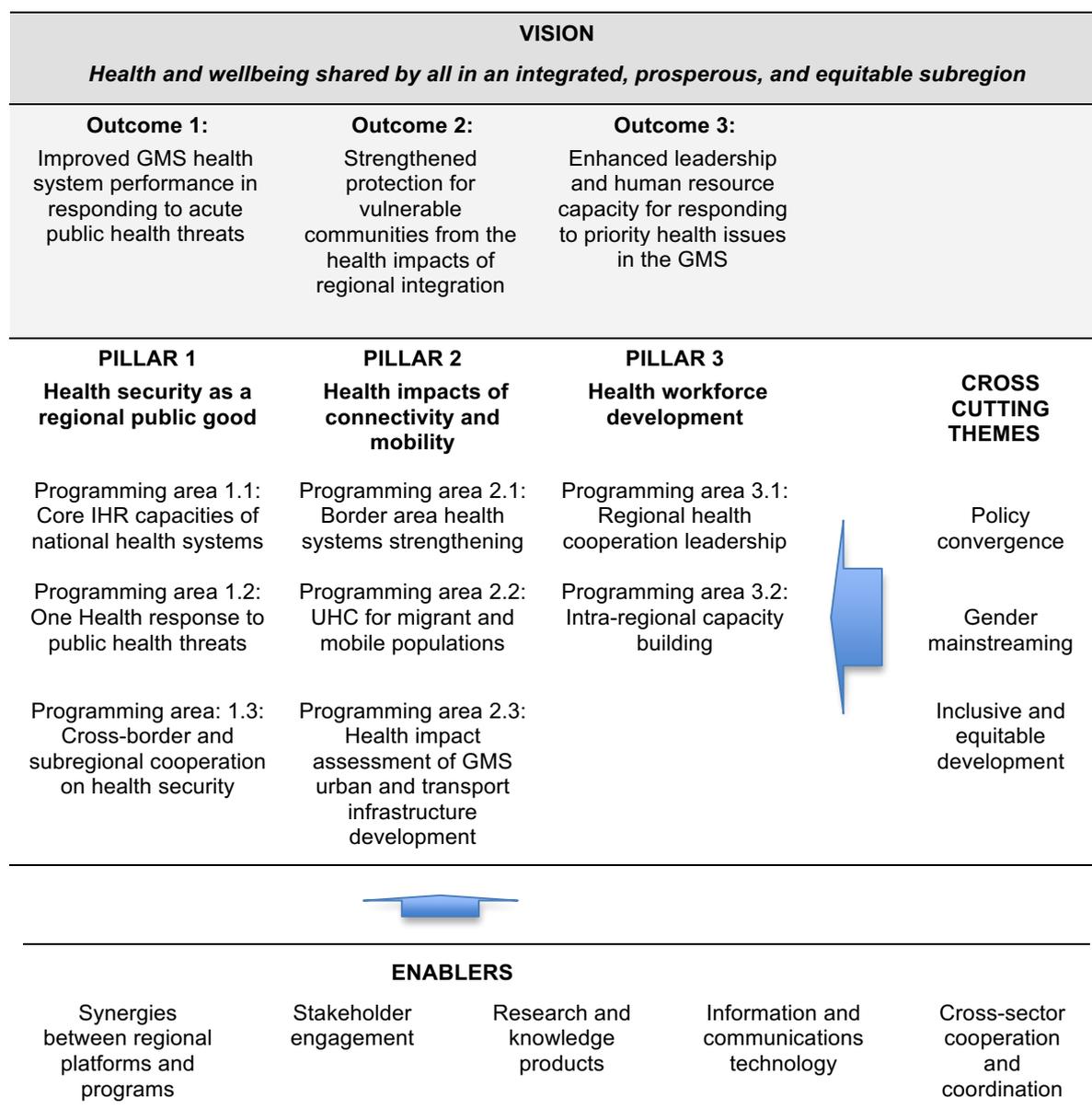
¹⁹ WHO. 2008. *International Health Regulations* (2005). Geneva.

²⁰ WHO. 2016. *Asia Pacific Strategy for Emerging Diseases and Public Health Emergencies*. Geneva.

²¹ For example, global and regional strategies on migrant health and anti-microbial resistance.

outcome. Programming areas under each pillar constitute the operational priorities for GMS health cooperation and form the basis for project development. Three themes—policy convergence, gender mainstreaming, and inclusive and equitable development—cut across each programming area. The delivery of health cooperation will be enhanced by five enabling factors: (i) synergies between regional platforms and programs, (ii) stakeholder engagement, (iii) research and knowledge products, (iv) information and communications technology, and (v) cross-sector cooperation and coordination.

Figure 1: GMS Health Cooperation Strategic Framework



GMS = Greater Mekong Subregion, IHR = International Health Regulations (2005), UHC = universal health coverage

C. Strategic Pillars and Programming Areas

1. Strategic Pillar 1 – Health security as a regional public good

22. The GMS is vulnerable to acute public health events that endanger populations within and across countries in the subregion. Health security is a product of country specific and collective actions. Strong national public health systems with capacity to prevent, detect and respond to transnational health threats are the cornerstone of health security. Strengthening mechanisms for multi-sector cooperation under a 'One Health approach' is a further building block, crucial for effective response to zoonotic disease, antimicrobial resistance (AMR), and food safety threats. Cross-border and subregional cooperation serves to maximise synergies between the health systems of GMS countries, consolidating health security as a regional public good that carries benefits for people across the subregion.

Programming area 1.1: Core IHR capacities of national health systems

23. The IHR establish the core capacity requirements of national health systems for preparing and responding to public health threats of international concern. Strengthening national health and laboratory systems to meet IHR requirements is a focus of ASEAN member states under the Post-2015 Health Development Agenda.²² Within ASEAN, Cambodia, Lao PDR, Myanmar and Viet Nam are prioritized for support in a bid to narrow the development gap between member states.²³ Programming under area 1.1 will focus on strengthening national health systems in Cambodia, Lao PDR, Myanmar and Viet Nam. Each country has participated in a joint external evaluation (JEE) of IHR capacities. JEE reports and corresponding country action plans will be drawn on to inform entry points for programming. Programs will leverage the Asian Development Bank's (ADB) extensive experience in health regional public goods,²⁴ link and build on investments of other development and technical partners, and maximise opportunities for intra-regional cooperation with neighbouring GMS countries – Thailand and PRC.²⁵

Programming area 1.2: One Health response to public health threats

24. A One Health approach promotes the operational linking of sectors - public health, animal health, wildlife, environment, agriculture - to enable multi-stakeholder cooperation, information sharing and action for an effective response to health threats originating at the human-animal-ecosystems interface. A One Health approach is essential for tackling zoonotic diseases, AMR, and food safety threats. Programming under area 1.2 will strengthen the foundation for One Health by integrating One Health principles in the projects of other GMS Program sectors.²⁶ Action will focus on developing governance frameworks for the operational linking of health and non-health sectors, building animal health system capacity to align with that of public health systems, and harmonizing food safety systems. Opportunities to build on existing One Health programs, including those linking veterinary and public health workforce²⁷ and veterinary and human health

²² The JEE includes assessment of capacities for AMR, zoonotic diseases and food safety.

²³ ASEAN. *Initiative for ASEAN Integration (IAI) Work Plan III*. Jakarta 2016.

²⁴ These include investments under (i) GMS Health Security Project (Project Number 48118-002); (ii) [Regional Malaria and other Communicable Disease Threats Trust Fund](#).

²⁵ The engagement of Thailand and PRC in programming area 1.1 includes the provision of technical inputs, financing, and/or direct participation in program activities.

²⁶ For example, the proposed agriculture sector initiative for the development of border livestock disease control zones in the GMS.

²⁷ Food and Agriculture Organization Regional Office for Asia and the Pacific—Field Epidemiology Training Program for Veterinarians.

laboratory networks,²⁸ will be explored.

Programming area 1.3: Cross-border and subregional cooperation on health security

25. Building links between the health systems of GMS countries for collective action to mitigate acute public health threats reinforces health security as a regional public good. Programming under area 1.3 will strengthen cross-border cooperation on health security. Existing and new Memorandums of Understanding will serve as the building block for cross-border initiatives in priority locations,²⁹ including cooperation in the areas of disease surveillance, point-of-entry, risk assessment, joint outbreak investigation, and information sharing. At a subregional level the GMS WGHC provides a platform for action, including GMS-wide capacity building and policy and regulatory harmonization. Ongoing efforts to tackle artemisinin resistant malaria and other regional threats will be supported through linkages between the GMS WGHC and existing subregional platforms.³⁰

2. Strategic Pillar 2 – Health impacts of connectivity and mobility

26. GMS economic cooperation creates the conditions for major population movement within the subregion, and associated health challenges. Strengthening border area health systems while simultaneously working with non-health sectors is required to address the complex and interconnected determinants of health in these areas. While border areas are a key focus for programming, health challenges linked to people movement are not confined to these locales. With increasing population mobility across the whole of the subregion comes the need to extend social protections, including the guarantee of access to essential health services, to documented and undocumented migrants throughout the GMS. As investment in GMS urban and transport infrastructure increases, assessment and mitigation of the unintended health impacts of these developments, at the planning and subsequent phases, is required.

Programming area 2.1: Border area health systems strengthening

27. Border area populations encompass native, migrant and transient residents. The diverse ethnic, cultural and socio-economic characteristics of these populations, coupled with the geographic and political characteristics of border regions, converge to impact on health outcomes in these areas.³¹ Programming under area 2.1 will address the health needs of populations in locations along borders where migrant populations pass through or reside. Health system and health workforce strengthening will improve access to and quality of health services, with attention to building parity in service capacity on either side of the border. Better linking of health systems in departure and destination countries will improve cross-border patient management and referral. Programming will follow a multi-sector approach, with civil society organisations (CSOs) and other non-state actors engaged in intervention design and delivery.

Programming area 2.2: UHC for migrant and mobile populations

28. GMS countries are committed to the SDG target of UHC and the goal of ensuring access to essential health services for all people. Regional connectivity and the resulting

²⁸ ASEAN. 2013. *Regional Strategic Framework for Laboratory Capacity Building and Networking in ASEAN*. 35th Meeting of the ASEAN Ministers on Agriculture and Forestry. Kuala Lumpur.

²⁹ Priority border locations will be determined by GMS countries.

³⁰ For example: Mekong Basin Disease Surveillance consortium, Asia Pacific Leaders Malaria Alliance, Regional Artemisinin-resistance Initiative.

³¹ WHO. 2013. *Meeting Report: Bi-regional Meeting on Healthy Borders in the Greater Mekong Subregion*. Manila.

increase in formal and informal population flows within the GMS create challenges to realizing this goal, particularly with respect to undocumented migrants. Programming under area 2.2 will build on the momentum within GMS countries to promote UHC by extending essential elements of coverage to migrant, mobile and vulnerable populations, both undocumented and documented. Efforts will focus on ensuring financial risk protection through health insurance, improving access to quality essential health-care services through migrant sensitive health policy and service delivery, and strengthening the regulatory environment for service delivery partnerships with the private sector and CSOs.

Programming area 2.3: Health impact assessment of GMS urban and transport infrastructure development

29. The GMS Urban Development Strategic Framework³² and GMS Transport Sector Strategy 2030³³ provide a blueprint of proposed infrastructure development for the GMS. Health impact assessment (HIA) can be used to mitigate health externalities of this development. Programming under area 2.3 will advance current efforts of GMS countries to develop capacity, tools and partnerships for HIA, create an enabling regulatory environment for HIA through a ‘health in all policies’ approach, and integrate HIA implementation into key urban and transport sector projects.³⁴ Mitigating the negative health impacts and enhancing the positive impacts of urban and transport infrastructure development will require collaboration between sectors –urban, transport, trade, and health – as well as with investment partners, including the private sector.

3. Strategic Pillar 3 – Health workforce development

30. Regional integration creates opportunities for cooperation on common health issues impacting GMS countries. Maximising these opportunities requires regional leadership and capacity for the effective stewardship of collective actions. Strong leadership for health cooperation in turn opens the potential for intra-regional capacity building, utilizing the subregions’ depth of health human resource and health programming experience to tackle shared health issues and enhance country efforts to attain SDG targets.

Programming area 3.1: Regional health cooperation leadership

31. Strong leadership and capacity for health diplomacy is the foundation for effective collective action to address health issues of regional concern. Programming under area 3.1 will consolidate the GMS WGHC as a governance platform to facilitate collective action. WGHC members will comprise senior officials of GMS countries. An agreed regional research agenda, including policy-based research, will provide WGHC members with a shared understanding of the GMS’s health issues and an evidence-base for determining high-level programmatic and policy solutions. Regional action plans will be prepared to guide health cooperation activities and project development.

Programming area 3.2: Intra-regional capacity building

32. A strong health workforce underpins the efforts of GMS countries to address off-track SDG targets as well as emerging challenges to goal attainment, including those posed by rapid economic development. Programming under area 3.2 will enhance intra-

³² ADB. 2015. *Greater Mekong Subregion Urban Development Strategic Framework 2015–2022*. Manila. 2015.

³³ ADB. 2018. *GMS Transport Sector Strategy 2030*. Manila.

³⁴ ADB. 2018 (forthcoming). *GMS Health Impact Assessment Framework for Special Economic Zones*. Manila.

regional capacity building and experience exchange. Cooperation will focus on areas aligned with ASEAN's Post 2015 Health Development Agenda, agreed and endorsed by the WGHC. Short-term trainings and learning exchanges will facilitate knowledge and skills transfer in the agreed areas. Higher education scholarships will support human resource development in key disciplines including medicine, nursing, public health, field epidemiology, and traditional and indigenous medicines. Opportunities to build on the activities of existing academic and training networks that are relevant to the Health Cooperation Strategy programming areas will be explored.³⁵

D. Cross Cutting Themes

33. Three cross cutting themes will be mainstreamed under each strategic pillar.

- i. **Policy convergence.** Policy convergence concerns subregional harmonization of national policies that have regional implications for health. It ensures that standards, guidelines, and regulations in these policies are aligned, creating the governance framework for sustained cooperation on regional health issues. The institutional mechanism of the GMS Program, through the WGHC and the meetings of GMS Senior Officials and GMS Ministers, provides a platform for dialogue and high-level action on policy convergence.
- ii. **Gender mainstreaming.** Accelerating progress in gender equality is recognized as a driver of development.³⁶ Efforts to progress gender equality will cut across health cooperation through gender mainstreaming in all areas of strategy implementation. Regional action plans will actively address participation by and for women. Gender perspectives will be integrated in all research and knowledge products, providing the evidence-base for gender-inclusive programming and policymaking. Gender equality will be a focus in efforts to build regional health cooperation leadership and decision-making. Gender mainstreaming will feature in all regional health projects.
- iii. **Inclusive and equitable development.** Burden from health threats is disproportionately borne by disadvantaged and vulnerable segments of the population. Inclusive and equitable development aims to ensure the GMS's most disadvantaged and vulnerable groups share in the health, social and economic benefits from regional health cooperation. Participation of CSOs and affected communities in the development and implementation of health cooperation plans and projects will be central to strategy delivery.

E. Enablers

34. Five primary enablers will facilitate effective delivery of the Health Cooperation Strategy and attainment of the intended outcomes.

- i. **Synergies between regional programs and platforms.** The GMS WGHC provides a governance platform for regional cooperation on health and the mechanism to coordinate and progress the agreed upon actions under this Health Cooperation Strategy. The Strategy's pillars and

³⁵ These include: ASEAN University Network (AUN); AUN-Health Promotion Network; GMS Public Health Academic Network; ASEAN Plus Three Field Epidemiology Training Network (ASEAN+3 FETN); and the GMS Health Impact Assessment Network.

³⁶ ADB. 2018. *Strategy 2030. Achieving a Prosperous, Inclusive, Resilient and Sustainable Asia and the Pacific*. Manila.

programming areas have been formulated to align with relevant work plans of ASEAN and other regional initiatives. Maximising synergies with the platforms linked to these initiatives while leveraging the strength of the GMS Program as an activity-based and results oriented platform, will serve to maximise the impact of GMS health cooperation.

- ii. **Stakeholder engagement.** International finance institutions, development partners, civil society organizations, agencies of the United Nations,³⁷ and academic institutions are an important source of technical knowledge and financing. Mobilizing stakeholders' resources through their engagement in the WGHC will enable strategy implementation. This includes using the WGHC platform to further link the development assistance programs of Thailand and PRC to GMS health cooperation.
- iii. **Research and knowledge products.** High-quality research will provide the evidence-base that drives GMS health cooperation programming and policy-making. Research networks and research capacity within the GMS will be developed through knowledge partnerships with international centres and institutes. Country capacity to undertake operational research, economic analyses and policy-based studies will be strengthened. Knowledge products will be action-oriented, linked to the Health Cooperation Strategy and its programming areas.
- iv. **Information and Communications Technology.** Innovation in the use of information and communications technology (ICT) will feature as an enabler of GMS health cooperation. Opportunities to leverage appropriate and cost effective ICT solutions will be explored and integrated into programming.
- v. **Cross-sector cooperation and coordination.** Determinants of health are broad, with many falling outside the immediate sphere of influence of health sector agencies. Collaboration and coordination with non-health sectors—agriculture, urban development, environment, tourism, and transport—is pivotal to strategy implementation. Cross-sector collaboration and coordination will be facilitated through links between the GMS Program's sector-working groups and with the region-wide networks that convene under each.

³⁷ World Health Organization, Food and Agriculture Organization, International Organization for Migration, the World Organization for Animal Health.

IV. IMPLEMENTING GMS HEALTH COOPERATION

A. GMS Economic Cooperation Program Regional Investment Framework 2022

35. The *GMS Economic Cooperation Program Regional Investment Framework 2022* (RIF 2022) sets out a medium-term pipeline of projects across all sectors of the GMS Program. RIF 2022 is the instrument through which the GMS SF 2012–2022 and HAP 2018–2022 are operationalized and through which sector outcomes and regional impacts of the GMS Program Results Framework are delivered.³⁸

36. GMS health cooperation projects form an integral part of RIF 2022. Projects included in RIF 2022 must align with the sector's operational priorities and address criteria for regionality—that is, projects that contribute to GMS health cooperation outcomes through either:

- i. a joint initiative of two or more GMS countries, or
- ii. a single country initiative that has demonstrable spill-over effects to other GMS countries.

37. RIF 2022 is intended as a living document to guide forward programming and mobilise development partner resources. RIF 2022 includes initiatives financed by ADB, GMS governments, other development partners, and initiatives for which a financing source is not yet identified. The current investment and technical assistance projects endorsed by GMS WGHC members to support strategy implementation can be viewed in the [RIF 2022 Project Pipeline](#). The project pipeline is updated on a regular basis as regional programming priorities of GMS countries, including priorities for health cooperation, evolve.

B. Implementation Mechanisms

38. Implementation of GMS health cooperation will follow the existing institutional mechanism of the GMS Program. This mechanism is depicted in Figure 2.

39. The newly convened GMS WGHC will serve as a platform for health cooperation amongst GMS countries. The WGHC's core membership comprises four nominees from the Health Ministry of each GMS country, representing a cross-section of departments and divisions including international relations, planning, and communicable disease control.³⁹ These core members are responsible for regional action planning and to develop a portfolio of projects for inclusion in RIF 2022. A regional secretariat to the WGHC provides administration, coordination, and technical support.

40. GMS countries each nominate a WGHC Country Focal, who serves as the contact point with the regional secretariat and the focal point for in-country liaison within the Health Ministry and with non-health sectors. At the country level, WGHC core members lead the planning and delivery of health cooperation projects and activities, conducting coordination and consultation meetings on an as-needed basis. The terms of reference for the WGHC, including the roles of core members and the WGHC Secretariat, is in Appendix 2.

41. Other departments and agencies of each country's Health Ministry, development partners, CSOs, and representatives from non-health sectors may be nominated to join

³⁸ ADB. 2011. *The Greater Mekong Subregion Economic Cooperation Program Strategic Framework 2012–2022*. Manila.

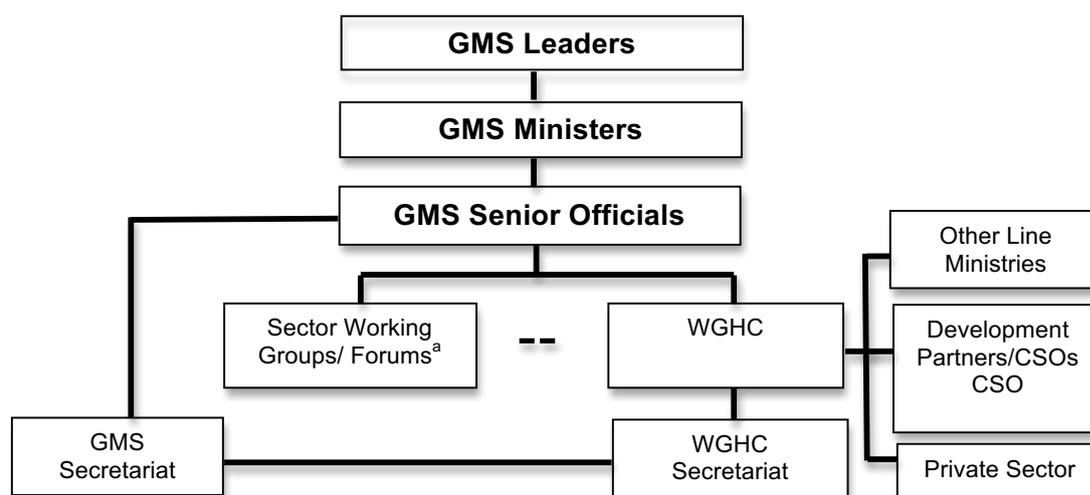
³⁹ PRC has up to 6 core members to including up to 2 members from each of Yunnan and Guanxi provinces.

WGHC meetings, thematic meetings, country working sessions, and other forums as associate members. Responsibilities of associate members will be defined on an as-needed basis and may include contributing to work plan delivery, project design and project implementation.

42. The institutional mechanism of the GMS Program serves to facilitate and strengthen GMS health cooperation. Horizontal linkages between GMS sector working groups – health, agriculture, transport, tourism, and urban development – enables cross-sector collaboration that is core to several program areas. Linkages between working groups will be formed through a variety of means, including the participation of non-health sector stakeholders in WGHC meetings, convening of cross-sector thematic groups, and engagement of non-health stakeholders in project fact-finding and project preparation missions.

43. Vertical linkages between the WGHC and the meetings of GMS Senior Officials and GMS Ministers provide a mechanism to elevate the profile of health cooperation within the GMS Program. Following the example of other GMS sectors, the opportunity to convene periodic meetings of GMS Health Ministers will be explored as a mechanism to support high-level decision-making on issues critical to health cooperation in the region.

Figure 2: GMS Economic Cooperation Program Institutional Mechanism for Health Cooperation



CSO = Civil Society Organizations; GMS = Greater Mekong Subregion; WGHC = Working Group on Health Cooperation.

^a Sector Working Groups/Forums: 1.Subregional Transport Forum; 2.Tourism Working Group; 3.Working Group on Environment; 4.Cross-Border Transport Agreement National Transport Facilitation Committee; 5.Regional Power Trade Coordination Committee; 6.Working Group on Agriculture; 7.Urban Development Working Group; and 8.GMS Railways Association.

Source: Asian Development Bank

C. Regional Action Plans and Reporting

44. A regional action plan (RAP) will provide the roadmap for strategy implementation. Prepared by WGHC core members as a three-year rolling plan, the regional action plan will detail output-based and time-bound actions towards agreed milestones under each strategic pillar. Outputs may include research, knowledge products, capacity building, policy-related actions, or other deliverables linked to milestone attainment. Outputs will

contribute to the formulation of new regional projects for inclusion in RIF 2022.⁴⁰

45. Implementation progress against the regional action plan will be assessed annually. Findings will inform forward planning and milestone review. This in-built process of reflection and review ensures flexibility during strategy implementation to respond to the evolving programming context. The WGHC, through the Secretariat, will track and compile results for reporting within the GMS Program.

D. Monitoring Outcomes of GMS Health Cooperation

46. The summary results framework for GMS health cooperation is shown in Table 1. The framework sets out select indicators under each of the Strategy's three pillars that capture key achievements of GMS health cooperation. Several SDG indicators are included in the framework, linking the Strategy to higher-level outcomes. Improvements in these SDG-linked indicators are only likely to be apparent over the medium- to long-term and are not attributable solely to programming under this GMS Health Cooperation Strategy.

47. An operational results framework will be developed in parallel with the regional action plan. The operational results framework will elaborate on the output and outcome level indicators contained in the summary results framework, providing a more specific measure of accomplishments directly attributable to health cooperation projects and activities. The operational results framework will be aligned with the sector outputs and outcomes contained in the wider GMS Program Results Framework. In this way monitoring outcomes of GMS health cooperation will inform progress towards the overall results of GMS Economic Cooperation.

Table 1: GMS Health Cooperation Summary Results Framework

Summary Indicator	Means of Measurement	Data Source
PILLAR 1: HEALTH SECURITY AS A REGIONAL PUBLIC GOOD		
Pillar Outcome: Improved GMS health system performance in responding to acute public health threats		
IHR capacity of GMS countries (SDG Indicator 3.d.1)	IHR core capacity index ^a	WHO Global Health Observatory data ^c
Increase in the average score for JEE indicators under the technical areas relating to (i) Antimicrobial resistance, and (ii) Zoonotic diseases	(i) JEE indicators P.3.1, P.3.2, P.3.3, P3.4 (ii) JEE indicators P.4.1, P.4.2, P.4.3	JEE Reports of GMS countries
Cooperation between health systems of GMS countries	Number of cross-border activities relating to: (i) point of entry; (ii) joint outbreak investigation; (iii) joint training and simulation exercises.	GMS Health Cooperation PMRS- GMS country data sources.

⁴⁰ Pending preparation and endorsement of the regional action plan, strategy implementation will be guided by the preliminary investment and technical assistance projects for GMS health cooperation listed in the [RIF 2022 Project Pipeline](#).

PILLAR 2: HEALTH IMPACTS OF CONNECTIVITY AND MOBILITY		
Pillar Outcome: Strengthened protection for vulnerable communities from the health impacts of regional integration		
Coverage of essential health services (SDG Indicator 3.8.1)	UHC index of coverage of essential health services ^b	WHO Global Health Observatory data ^d
Financial accessibility of health services for migrant workers	Percentage increase in the number of (i) documented and (ii) undocumented migrants in recipient countries within the GMS that are covered by health insurance	GMS Health Cooperation PMRS - GMS country data sources.
Uptake of HIA by GMS countries	Increase in the number of SEZ and transport infrastructure projects completing HIA and having a resulting health management plan in place	GMS Health Cooperation PMRS - GMS country data sources.
PILLAR 3: HEALTH WORKFORCE DEVELOPMENT		
Pillar Outcome: Enhanced leadership and human resource capacity for responding to priority health issues in the GMS		
GMS health leaders' collaboration in implementing the GMS Health Cooperation Strategy	Number GMS government and development partner implemented regional health cooperation initiatives under each Health Cooperation Strategy programming area. Number of policy actions, linked to the Health Cooperation Strategy programming areas, facilitated by the WGHC.	GMS Economic Cooperation Program Regional Investment Framework ^e GMS Health Cooperation PMRS
Implementation of the GMS health cooperation capacity development plan ^f	Number of officials completing training or study on the priority health issues in the GMS	GMS Health Cooperation PMRS

ADB = Asian Development Bank; GMS = Greater Mekong Sub-region; IHR= International Health Regulations (2005); JEE = joint external evaluation; PMRS = performance monitoring and reporting system; SDG = Sustainable Development Goals.

Sources:

^a [Technical note on means of measurement](#) (accessed 21 August 2018); World Health Organization.

^b World Health Organization and International Bank for Reconstruction and Development / The World Bank. 2017. *Tracking universal health coverage: 2017 global monitoring report*; and World Health Organization.

^c [Global Health Observatory data](#). (accessed 21 August 2018); World Health Organization.

^d [Global Health Observatory data](#). (accessed 21 August 2018); World Health Organization.

^e [RIF 2022 Project Pipeline](#). ADB. March 2018. *Greater Mekong Subregion Economic Cooperation Program. Annex to the Regional Investment Framework Project Pipeline*. Ha Noi Viet Nam.

^f The GMS health cooperation capacity development plan, to be prepared by WGHC members, will identify priority areas for capacity building that are aligned with GMS health challenges and the ASEAN Post 2015 Health Development Agenda.

KEY SOCIO-ECONOMIC, DEMOGRAPHIC AND HEALTH DATA FOR GMS COUNTRIES

Table A1.1: Socio-economic indicators for GMS countries

Indicators	Cambodia	PRC	Guangxi	Yunnan	Lao PDR	Myanmar	Thailand	Viet Nam
GDP growth rate (annual %) 2017 ^e	7.0	6.9	7.3	9.5	6.8	6.8	3.9	6.8
GDP per Capita, PPP, current international \$, 2016 ^f	5,921	15,559	9,465	8,895	6,196	5,732	16,946	6,435
GDP per Capita, Atlas Method, current \$, 2016 ^f	1,270	8,123	4,941	4,644	2,353	1,196	5,911	2,214
GDP per Capita, PPP constant 2005 International \$, 2016 ^f	2,671	...	6,383	5,998	3,305	2,367	9,940	4,023
GDP per Capita, Atlas Method, Constant 2005 \$, 2016 ^f	834	...	2,685	2,524	927	577	3,938	1,195
GNI per capita, Atlas method, current \$, 2017 ^g	1,230	8690	...	...	2,270	1,190	5,960	2,170
Poverty headcount ratio at \$1.90/day, 2011 PPP, % of population ^g	...	1.4 ^c	...	...	22.7 ^a	6.4 ^d	0.4 ^b	2.6 ^c
Gini Index (%) ^g	...	42.2 ^a	...	...	36.4 ^a	38.1 ^d	37.8 ^b	34.8 ^c
Current health expenditure per capita, current US\$, 2015 ^g	69.6	425.6	...	...	53.0	59.1	217.1	116.7
Current Health Expenditure per Capita, PPP (current international \$), 2015 ^g	209.6	762.2	526.0	664.0	165.8	267.2	610.2	334.3
Current Health Expenditure, % of GDP, 2015 ^g	6.0	5.3	6.0	8.0	2.8	4.9	3.8	5.7
Out-of-pocket expenditure, % of current health expenditure, 2015 ^g	59.4	32.4	...	...	45.4	73.9	11.8	43.5

GDP = gross domestic product, GNI = gross national income, Lao PDR = Lao People's Democratic Republic, PRC = People's Republic of China, PPP = purchasing power parity, ... = data not available from source at the time of publication.

^a 2012

^b 2013

^c 2014

^d 2015

Sources:

^e Asian Development Outlook, April 2018.

^f Asian Development Bank. GMS Secretariat estimates; Asian Development Bank. [GMS Statistical Database](#). (Accessed 23 August 2018).

^g World Bank. [World Development Indicators database](#). (Accessed 23 August 2018).

Table A1.2: Demographic indicators for GMS countries

Indicators	Cambodia	PRC	Guangxi	Yunnan	Lao PDR	Myanmar	Thailand	Viet Nam
Total population (million) 2016 ^a	15.76	1378.67	55.79	47.71	6.76	52.89	68.86	94.57
Population, female (% of total), 2016 ^a	51.2	48.5	...	...	50.1	51.2	51.2	50.5
Population, male (% of total), 2016 ^a	48.8	51.5	...	...	49.1	48.8	48.8	49.5
Annual average population growth rate (%) 2011–2016 ^b	1.6	0.5	1.3	0.6	1.3	0.9	0.4	1.1
Population ages 0-14 (% of total) 2016 ^b	31.4	...	21.4	19.5	33.3	28.3	17.7	23.1
Population ages 15-64 (% of total) 2016 ^b	64.4	...	69.0	72.1	62.8	65.8	71.4	70.0
Population ages 65 and above (% of total) 2016 ^b	4.3	...	9.7	8.4	4.0	5.9	11.0	6.9

Lao PDR = Lao People's Democratic Republic, PRC = People's Republic of China, ... = data not available from source at the time of publication.

Sources:

^a World Bank. World Development Indicators database. <http://data.worldbank.org/data-catalog/world-development-indicators> (Accessed 23 August 2018).

^b Asian Development Bank. GMS Secretariat estimates; Asian Development Bank. [GMS Statistical Database](#) (draft).

Table A1.3: International migrant stock in GMS countries

	Cambodia	PRC	Guangxi	Yunnan	Lao PDR	Myanmar	Thailand	Viet Nam
Number of immigrants into country ^a	76,329	999,527	...	...	45,466	74,660	3,588,873	76,104
Immigrants as a % of national population	0.5	0.1	...	...	0.7	0.1	5.2	0.1
Female immigrants as a % of all immigrants	46.1	38.6	...	...	46.3	45.2	49.8	42.1
Type of data ^b	B	C			C,R	C	B,R	C,R

Lao PDR = Lao People's Democratic Republic, PRC = People's Republic of China, ... = data not available from source at the time of publication.

^a Totals are only an estimate given that numbers of informal migrants cannot be accurately counted.

^b The row labeled "Type of data" indicates whether the data used to produce the estimates refer to the foreign-born population (B) or to foreign citizens (C). It also indicates in which cases the number of refugees, as reported by UNHCR, were added to the estimate of international migrants (R).

Source: United Nations, Department of Economic and Social Affairs. Population Division (2017); and United Nations. [Trends in International Migrant Stock: The 2017 revision \(United Nations database, POP/DB/MIG/Stock/Rev.2017\)](#). (Accessed 21 August 2018).

Table A1.4: Migrant stock by origin and destination (GMS)

Country of Origin ^a	Country of Destination ^a							
	Cambodia	PRC	Guangxi	Yunnan	Lao PDR	Myanmar	Thailand	Viet Nam
Cambodia	...	...	...	...	3,568	...	680,686	1,035
China	1,566	...	...	...	13,951	34,276	76,595	3,141
Lao PDR	268	...	...	...	...	...	923,050	7,272
Myanmar	53	...	...	...	259	...	1,835,106	11,695
Thailand	31,791	15,525	...	...	3,428	...	...	12,077
Viet Nam	37,601	28,712	...	...	19,716	...	7,255	...
All source countries worldwide^b	76,329	999,527	...	...	45,466	74,660	3,588,873	76,104
Type of data ^c	B	C			C,R	C	B,R	C,R

Lao PDR = Lao People's Democratic Republic, PRC = People's Republic of China, ... = data not available from source at the time of this publication.

^a Totals are only an estimate given that numbers of informal migrants cannot be accurately counted.

^b Total number of immigrants into country, from all source countries worldwide.

^c The row labeled "Type of data" indicates whether the data used to produce the estimates refer to the foreign-born population (B) or to foreign citizens (C). It also indicates in which cases the number of refugees, as reported by UNHCR, were added to the estimate of international migrants (R).

Source: United Nations, Department of Economic and Social Affairs. Population Division (2017); and United Nations. [Trends in International Migrant Stock: The 2017 revision \(United Nations database, POP/DB/MIG/Stock/Rev.2017\)](#). (Accessed 21 August 2018).

Table A1.4: Selected health indicators for GMS countries

Indicators	Cambodia	PRC	Guangxi	Yunnan	Lao PDR	Myanmar	Thailand	Viet Nam
Life expectancy at birth, female (years), 2016 ^e	70.9	77.8	...	...	68.2	68.9	79.1	80.9
Life expectancy at birth, male (years), 2016 ^e	66.8	74.8	...	...	65.1	64.2	71.6	71.5
Maternal mortality ratio (modelled estimate, per 100,000 live births) 2015 ^e	161.0	27.0	...	...	197.0	178.0	20.0	54.0
Mortality rate, infant (per 1,000 live births) 2016 ^e	26.3	8.5	...	...	48.9	40.1	10.5	17.3
Mortality rate, under-5 (per 1,000 live births), 2016 ^e	30.6	9.9	...	...	63.9	50.8	12.2	21.6
Neonatal Mortality Rate (per 1,000 live births), 2016 ^e	16.2	5.1	...	...	28.7	24.5	7.3	11.5
Cause of death, by communicable diseases and maternal, prenatal and nutrition conditions (% of total), 2016 ^e	25.6	3.8	...	...	31.4	23.6	15.8	11.5
Cause of death, by non-communicable diseases (% of total), 2016 ^e	64.4	89.3	...	...	59.6	67.8	74.0	77.2
Mortality from CVD, cancer, diabetes or CRD between exact ages 30 and 70 (%), 2016 ^e	21.1	17.0	...	...	27.0	24.2	14.5	17.1
Births attended by skilled health staff (% of total) ^e	89.0 ^b	99.9 ^c	...	...	40.1 ^a	60.2 ^d	99.1 ^d	93.8 ^b
Medical Doctors, per 1,000 population, 2016 ^f	0.1 ^b	...	1.4	2.6	0.6	0.2	0.5	0.8
Nurses, per 1,000 population, 2016 ^f	0.6 ^b	...	2.2	2.2	1.1	0.4	2.3	1.2
Pharmacists, per 1,000 population, 2016 ^f	0.04 ^b	...	0.30	0.22	0.26	...	0.18	0.36
Hospital beds, per 1,000 population, 2016 ^f	0.8 ^c	...	3.7	4.1	1.2	1.0	1.7 ^c	2.5

CRD = chronic respiratory disease, CVD = cardiovascular disease, GDP = gross domestic product, Lao PDR = Lao People's Democratic Republic, PRC = People's Republic of China, PPP = purchasing power parity, ... = data not available from source at the time of this publication.

^a 2012

^b 2014

^c 2015

^d 2016

Sources:

^e World Bank. [World Development Indicators database](#). (Accessed 23 August 2018).

^f Asian Development Bank. GMS Secretariat estimates; Asian Development Bank. [GMS Statistical Database](#). (draft)

GMS WORKING GROUP ON HEALTH COOPERATION: TERMS OF REFERENCE

I. Rationale for a GMS Working Group for Health Cooperation

1. Through various consultations, GMS countries (Cambodia, Lao PDR, Myanmar, People's Republic of China, Thailand and Viet Nam) have acknowledged the need for more comprehensive, coordinated and proactive approaches to address regional health issues. Countries have supported the creation of a GMS governance platform 'Working Group on Health Cooperation' (WGHC) to fulfill this need. The creation of WGHC is also confirmed through a recent review on the Strategic Framework and Action Plan (SFAP) for Human Resource Development in the GMS (2013-2017), which recommends: *"a GMS Health Cooperation Working Group is created to serve as a regional platform for health issues focusing on cross-border health issues and communicable diseases control, including those associated with migrant and mobile populations (MMPs) and on emerging health issues in economic corridors."*

2. The terms of reference below outlines (i) GMS WGHC functions, (ii) GMS WGHC composition and member roles and (ii) GMS WGHC reporting mechanisms.

II. GMS WGHC Functions

3. The GMS WGHC will serve as a platform to promote multilateral and bilateral coordination among GMS countries, particularly for cross-border health initiatives. Core functions of the WGHC are to:

- Develop and work for the endorsement of the GMS Health Cooperation Strategy; coordinate its implementation and assist to monitor impact.
- Facilitate policy coherence and alignment of current regional and national policies and guidelines on health coordination and collaboration.
- Promote knowledge sharing and information exchange on regional health issues through multiple channels, including online database, links and regular workshops/meetings.
- Provide guidance on operational research, reviews, assessments, surveys, and other knowledge products relevant to health cooperation, working with relevant research networks and institutions as necessary.
- Develop and promote a supportive policy environment for health cooperation such as forging MOUs among countries for common issues (e.g. health security, migrant health, drug regulation, food safety, etc.).
- Work with existing GMS networks and regional mechanisms/initiatives on health and health cooperation, including academic and education networks (university alliance for academic exchange, medical education and public health training).
- Coordination with relevant sector working groups/forums under the GMS Program including Transport (cross border movement of goods and people), Agriculture (zoonosis), Tourism (immigration), Environment (impact of climate change), Urban Development (urbanization and health impacts)
- Work with relevant national and international non-governmental organizations (NGOs) and civil society organizations (CSOs) providing technical support or guidance on health cooperation
- Work with national line ministries as appropriate on cross cutting issues.
- Report on progress of WGHC to GMS secretariat and higher-level bodies as appropriate.
- Review reports and relevant documents to be shared in relevant leaders' and ministers' meetings.

- Develop a GMS regional health investment portfolio as input to the GMS Regional Investment Framework.
- Work with development partners to identify and mobilize possible sources of funds for proposed regional investments in health.

4. Detailed annual work plans will be developed to operationalize the functions above and identify concrete outputs and costs.

III. GMS WGHC Composition and Member Roles

A. Core Working Group Members

5. To encourage sustained participation and ensure functionality of the group, the WGHC will be composed of up to 4 core members, comprising incumbents of nominated positions from within International Relations, Planning, and Communicable Disease Control divisions/departments of the Ministries of Health of the GMS countries. In the case of PRC, up to 6 core members may be nominated, to include up to 2 members each from Yunnan and Guangxi provinces. It is proposed that Directors or Director-Generals will be a part of the core group, nominated and endorsed by their respective national health authorities. WGHC core members are nominated for a fixed term of three years. Core members may be replaced, such as in instances where their incumbency of the nominated position ends, subject to formal advice from the government to other WGHC members and the Secretariat. To the extent possible, multiple changes in membership are discouraged, to encourage continuity of activities.

6. Key responsibilities of GMS WGHC core members are to:

- Attend GMS WGHC meetings
- Participate in strategic and annual planning sessions
- Ensure regular intersession communication (for example, shared communications e-bulletin board; occasional video chats)
- Tap experts to provide technical expertise on GMS WGHC activities, as appropriate
- Support the implementation of activities outlined in the GMS WGHC Action Plan
- Share/report information from WG meetings with national government authorities for their acknowledgement and approval of issues
- Coordinate/monitor the implementation of activities (i.e. meetings and consultations) at country level when necessary
- Share information relevant to GMS health cooperation
- Represent the GMS WGHC in regional events relevant to promoting health cooperation and in joint initiatives with other GMS working groups
- Review strategy, action plan, annual report and other documents as appropriate prior to dissemination
- Review WGHC reports before submission to higher-level offices
- Perform other advisory/coordinative tasks as agreed by the GMS WGHC
- Participate in meetings and conferences organized by the GMS Secretariat where appropriate

7. Relevant Committees/sub-committees may be established to operationalize the functions of the WGHC and/or effectively implement the pillars/programs of the GMS Health Cooperation Strategy.

8. **Country Focal.** From the core group, the national health authorities in each country will designate a country focal. Responsibilities of the country focal are to:

- Serve as the contact point for the secretariat and liaise with other sectors in-country and within the GMS
- Review periodic progress on the implementation of the endorsed GMS Health Cooperation Strategy and Action Plan, at regional and country levels, including country level coordination with non-health sectors relevant to health cooperation
- Participate in WGHC special meetings
- Assume the role of WGHC Chair when it is the country's turn to host.

9. **Strategy Development Focal.** The national health authorities of each country will designate a strategy development focal. Responsibilities are to:

- Lead the country's engagement in the development of the GMS Health Cooperation Strategy and Action Plan
- Participate in regional drafting meetings
- Coordinate country level consultations with health and non-health sectors
- Facilitate country endorsement of the Strategy and Action Plan
- Oversee strategy implementation

B. Associate Members

10. Officers from departments/divisions of national health authorities in each country, development partners, CSOs and networks, and non-health sectors may be nominated to join WGHC meetings, thematic meetings or other forums as associate members. Example themes include HIV/AIDS, universal health coverage, integrating community-based health responses, migrant health, and cross-sector interventions in agriculture, trade and transport. Responsibilities of associate members will be defined on an as-needed basis and include contributing to work plan delivery, project design and implementation, and other programming related activities.

C. Regional Secretariat

11. The WGHC will be supported by a regional secretariat, the officers of which will be located within GMS countries, based either at the ADB resident mission or an office of the national health authority. Responsibilities of the Secretariat are to:

- Convene WGHC meetings and support communications between members, ADB, and other development partners and agencies in the GMS.
- Manage day-to-day operations, serve as the central contact point and coordinate WGHC activities.
- Bring together key stakeholders and technical experts to cooperate on the development and implementation of responses to regional health issues.
- Assist in monitoring and preparing reports on the status and impact of implementation of the GMS Health Cooperation Strategy and Action Plan as input to relevant GMS meetings.

IV. GMS WGHC Operational Mechanisms

12. The WGHC, supported by the regional secretariat, will conduct the following activities throughout the year:

- An annual meeting of the WGHC, development partners, CSOs and other relevant organizations working on health cooperation in the GMS, held in the last quarter of each year. The WGHC meeting will serve as a forum for strategic discussion and

planning. The annual WGHC meeting will be hosted by one country, rotating on an alphabetical basis. The host country is delegated as the 'rotating chair'.

- WGHC business/operational meetings, convened on an as-needed basis throughout the year, via teleconferences, videoconferences or face-to-face meetings, to address administrative and operational issues related to the WGHC and health cooperation strategy implementation.
- Thematic meetings or workshops (when needed).
- In-country coordination meetings and cross-border meetings (when needed).

13. A regional action plan and accompanying M&E framework will be prepared by the WGHC to guide activity implementation and monitoring. External or independent impact evaluation will be undertaken when necessary.

14. The GMS WGHC secretariat will prepare and share progress reports and the minutes/reports of the meetings with governments, development partners and other relevant GMS groups. This includes preparation of periodic reports to the GMS Senior Officials on outcome of WGHC meetings, and to the GMS Ministers and Leaders on overall progress of subregional health cooperation. WGHC members will review and approve the reports before dissemination.