SECTOR ASSESSMENT (SUMMARY): HEALTH

Sector Road Map

1. Sector Performance, Problems, and Opportunities

1. **Sector performance.** Myanmar has made impressive progress in improving population health indicators since 1980 (Table 1). Life expectancy at birth has risen from 42.4 years in 1980 to 66.9 years in 2018 (63.8 years for males and 69.9 years for females). The disability-adjusted life years (DALYs) lost from communicable, maternal, perinatal, and nutritional conditions were reduced to 25.7% of all DALYs in 2017 from 39% in 2010.[1] There is still much room for improvement and an increasing need to respond to the risks related to noncommunicable diseases (NCDs).

Table 1: Selected Health Indicators

Indicator	1980	1990	2000	2010	2017	2018
Life expectancy at birth, total (years)	42.4	52.9	60.1	63.5	66.6	66.9
Infant mortality rate (per 1,000 live births)	97.6	81.5	65.0	48.5	38.0	36.8
Maternal mortality rate (modeled estimate, per 100,000 livebirths)	…	…	340.0	265.0	250.0	…
Under-five mortality rate (per 1,000 live births)	140.4	115.1	89.1	63.3	47.9	46.2

Note: … indicates data not available.
Source: World Bank. World Development Indicators (accessed 16 May 2020).

2. **Development context and problems**. The fundamental development problem in the health sector is the limited equitable access to affordable and high-quality health care due to chronic resource constraints. In 2017, total health expenditure per capita was $58, of which 14.8% was government expenditure ($8.6). Private health expenditure accounted for 76.2% of total health expenditure, one of the highest in the world, and a factor causing and perpetuating poverty. Low public health expenditure strains the already limited capacity and results in chronic underinvestment in quality improvement of public services and leads to patients bypassing lower level facilities and overcrowding higher level facilities. The health system also continues to rely on external aid (9% of total health expenditure). The coronavirus disease (COVID-19) outbreak will inevitably increase health sector expenditures and exacerbate existing system constraints.

3. **Gaps in health facilities and access to services.** Health service delivery in Myanmar is a mixed system of public, private for-profit, private not-for-profit, and ethnic health organizations (EHOs). Physical coverage of health services has improved though still limited. As of March 2020, the number of beds per 1,000 population in Myanmar is 0.9, compared with an average of 2.4 for lower middle-income countries. Public investment in the past focused on tertiary care resulting in poor service availability, coverage, and quality of primary health care at the township level and below. Coordination with EHOs on services for the ethnic population, particularly in conflict-affected areas, can be difficult at times. In theory, all citizens have access to free health care at public facilities. However, resource shortages—including funding, equipment, medical products, and staff—severely limit the ability of public providers to deliver services. Most facilities operate with inadequate and outdated buildings and equipment, and many still struggle with the basics like stable electricity, access to clean water, and waste treatment. The 2015 Service Availability and Readiness Survey found that on average, less than 50% of facilities surveyed have the requisite amount of essential medicines (43%), diagnostic capacity (37%), and basic amenities (41%). Budget flexibility for maintenance of facility and equipment is low. The shortages of

[1] IHME GBD Study 2017. Myanmar Country Profile.

medicines and other supplies imply rationing in practice, although it is unclear how these decisions are made. Overall, patients who have the ability and willingness to pay have better access to healthcare services. Some opt to seek care abroad in neighboring countries such as Thailand and the People's Republic of China.

4. **Shortages in health human resource.** Myanmar faces a health workforce crisis characterized by severe shortage, inappropriate skill mixes, and gaps in service coverage.[2] In 2020, Myanmar has 0.68 doctors (1.58 for urban areas and 0.29 for rural areas) and 1.0 nursing and midwifery personnel per 1,000 population, compared with an average of 1.2 and 1.85 per 1,000 among lower middle-income countries, respectively. New health professional education institutions were established to increase the production of doctors and other skilled health personnel. However, it was difficult to recruit new graduates to work in the public health sector due to limited budgeted positions and a lack of harmonized human resource planning within the government. Retainment is a challenge, particularly in rural and hard-to-reach areas. The long working hours, heavy workload, unfavorable working environment, and low remuneration made working in the public health sector unattractive, and resulted in decreasing number of medical doctors in the public sector since 2006.[3] The need for health staff continues to far exceed the number of budgeted positions, thus Myanmar continue to rely on voluntary community workers. Finally, there is not yet a formalized qualification system for health professional education institutions and health professionals, let alone volunteer community workers who receive very limited training. The Ministry of Health and Sports (MOHS) does not have a human resource contingency plan for a crisis like COVID-19, where surge capacity needs to be immediately mobilized.

5. **Limited governance and institutional capacity.** Capital planning and expenditure continue to be an area for improvement. Budgets are structured around line items for inputs rather than outputs or functional areas. Significant variations between original and revised budget estimates are commonly observed. MOHS had 3 consecutive years of extremely low capital budget execution (12% to 19% in FY2013 and FY2015) after the sharp increase in budget allocation, then in FY2015 they experienced overspending, suggesting consistently low budget accuracy. Imbalances in the financing of health systems persist, as the existing funding sources and implementation of vertical programs are highly fragmented and there is no fund flow to facilities at township levels and below. Low budget execution is symptomatic of broader challenges in the public financial management system, which affects health service delivery. Aside from weak public financial management, MOHS also have limited capacity and in other essential function areas including supply chain, health management information system, procurement, engineering, supportive supervision, and referral. Underinvestment in the MOHS procurement and supply chain management system has translated into limited management capacity, infrastructure, and technology. The lack of accountability and appropriate incentives hamper staff performance.

6. **COVID-19 outbreak and pandemic preparedness.** Myanmar reported only a limited number of confirmed cases and associated deaths (353 cases and 6 deaths as of 3 August 2020). Of all cases, 70.5% (249 out of 353) were from the Yangon region.[4] The risk of community outbreaks remains high among vulnerable populations due to mobility, poor and crowded living conditions, and poor water and sanitation infrastructure. Examples include: (i) returning migrants;

[2] WHO. 2006. *World Health Report: Working Together for Health.* Geneva.
[3] These doctors may switch to work in the private sector, international organizations, or pursue administrative positions.
[4] Other states and regions that reported cases include Chin, Sagaing, Bago, Shan (North), Shan (East), Mandalay, Naypyidaw, Mon, and Magway. For brevity, "states and regions" include Naypyidaw Union Territory.

(ii) people living in overcrowded urban and peri-urban areas in Yangon; and (iii) residents of conflict-affected areas who lack basic livelihood and health care services. Myanmar health system's abilities to detect, prevent, and respond to pandemic situations are all rated as limited by the World Health Organization (WHO).[5] The government has scaled up laboratory testing capacity from only 320 tests per day in April 2020 to 2,000 tests per day in June 2020. However, the total number of tests performed per million population (2,064 as of 3 August 2020) remains the lowest in the Southeast Asia region.[6] The country currently has only 200 functioning intensive care beds equipped with skilled healthcare team and equipment, mostly in urban areas including Yangon and Mandalay. Although a limited number of cases have been reported to date, the country has low preparedness for potential widespread community transmission and resurgence of COVID-19. The upcoming monsoon season is likely to further strain the public health services due to increased service demands caused by flood event, dengue, and seasonal flu.

2. Government's Sector Strategy

7. **Myanmar National Health Plan (NHP) 2017–2021.**[7] Myanmar aspires to achieving universal health coverage by extending access to a free Basic Essential Package of Health Services (EPHS) to the entire population. The plan is guided by the principles of equity, inclusiveness, accountability, efficiency, sustainability, and quality. It emphasizes improving supply-side readiness, particularly the ability of townships to provide quality essential health services, as well as active engagement of health providers outside the public sector, including private providers, EHOs, and nongovernment organizations. Strategic directions to improve key health financing areas (revenue raising, pooling, and strategic purchasing) and reduce out-of-pocket payment were laid out.

8. **The Health Sector Contingency Plan (HSCP) for outbreak response on COVID-19 and other emerging respiratory disease.** The MOHS, in dialogue with ADB and other development partners, developed an HSCP that lays out interventions under eight pillars: (i) surveillance; (ii) points of entry; (iii) laboratory; (iv) clinical management; (v) infection prevention and control; (vi) non-pharmaceutical interventions; (vii) risk communication; and (viii) operational support and logistics management. It is expected that the responsible state and regional authorities will develop a local response plan based on the HSCP. Various outbreak scenarios were considered for resource planning purposes. The plan calls for enhancing the health system capacity particularly in laboratory testing (up to 3,010 tests per day) and clinical case management (up to 500 intensive care unit beds) and ensuring all health workers are adequately protected with personal protective equipment.[8] MOHS is also developing a monsoon emergency preparedness resource mapping in the context of COVID-19 to ensure disaster preparedness in flood events and regular services for dengue, malaria, and other seasonal illness.

9. **Initial outbreak prevention and containment measures.** The government has taken decisive actions in responding to COVID-19 and set up coordination mechanisms at central, states, and regional levels. The National Central Committee for COVID-19 Prevention, Control and Treatment, chaired by the State Counsellor, coordinates with lower level committees. Initial public health interventions include: (i) implementing travel restrictions and temperature screening at points of entry; (ii) closing of schools and non-essential businesses, and a nationwide "stay at

[5] Myanmar was rated 2 out of 5 or less than 60% accomplished in each capacity area (i.e., detect, prevent, respond and others). WHO. Joint External Evaluation Dashboard (accessed on 16 May 2020).
[6] A total of 110,526 tests were conducted from 22 March 2020 to 27 July 2020 (2,030 tests per million population).
[7] Ministry of Health and Sports. 2016. Myanmar National Health Plan 2017–2021. Naypyidaw.
[8] An estimated minimum of 300,000 PPE sets; 688,450 N95 masks; and 4.3 million surgical masks are needed every month.

home" order; (iii) isolating suspected cases at designated hospitals and conducting contact tracing;[9] (iv) distributing COVID-19 information to the public, including daily updates on the MOHS website; (v) multiagency efforts[10] to improve hygiene in public areas; and (vi) procuring essential medical products including test kits, ventilators, and personal protective equipment.

3. Major Development Partners: Strategic Foci and Key Activities

10. WHO provided technical support to MOHS in the formulation of the HSCP and have helped coordinate among the United Nations agencies and nongovernment organizations. The World Bank approved a $50 million emergency loan and $8 million emergency grant to support COVID-19 response. Other major development partners in the health sector had restructured their existing investment programs to support the immediate and medium-term health expenditure needs.[11]

4. ADB Sector Experience and Assistance Program

11. In the health sector, Myanmar participated in a series of projects aiming to enhance regional health security in the Greater Mekong Subregion (GMS) as a regional public good. This includes a grant project funded by the Japan Fund for Poverty Reduction on capacity building in HIV/AIDS prevention since 2013 in five border townships targeted at high risk populations.[12] ADB has supported Myanmar through the ongoing GMS Health Security Project,[13] which helps to strengthen regional cooperation in health security and subnational communicable disease control systems. ADB has reprogrammed $6.6 million under this ongoing project to support the early COVID-19 response and is also preparing a $30 million additional financing to further help implementation of the HSCP for COVID-19. Myanmar participates in the GMS Health Cooperation Working Group, a regional policy dialogue mechanism supported by ADB, and benefits from regular information exchange and technical workshops.[14] Through these projects, ADB has assisted MOHS in strengthening health sector governance and localized health planning, building human resources and capacity in communicable disease control, expanding public health service network, and engaging communities in health security. Another project focusing on NCDs' prevention and treatment has been under preparation since 2019 and will support the expansion of service capacity at regional hospitals for cancers and other emerging NCDs. ADB's programs intensely focus on capacity development and governance as a driver for transformation, provision of innovative knowledge and high-level technology solutions, and the use of a conflict-sensitive approach.

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[9] As per WHO guidelines, persons who have been in close contact with a confirmed patient 2 days prior to the onset of symptoms and within 14 days from the onset of the symptoms are identified and observed in designated isolation facilities.

[10] Involves Ministry of Health and Sports, General Administration Department, and local governments.

[11] They include: the Access to Health Funds ($11 million; the Global Fund for AIDS, Tuberculosis, and Malaria ($7.1 million); the Global Alliance Vaccine Initiative ($8.7 million); WHO ($3.0 million); the governments of the People's Republic of China ($3.8 million) and Japan ($1.5 million); the United States Agency for International Development ($1.3 million); and the United Nations High Commission for Refugees ($1.4 million).

[12] ADB. Myanmar: Greater Mekong Subregion Capacity Building for HIV/AIDS Prevention Project.

[13] ADB. Regional: Greater Mekong Subregion Health Security Project.

[14] ADB. Regional: Strengthening Regional Health Cooperation in the Greater Mekong Subregion.

PROBLEM TREE