MYANMAR

FIND
Because diagnosis matters

HEALTHCARE PROFILE

HEALTHCARE STATUS

POPULATION (2017)	LIFE EXPECTANCY AT BIRTH (2016)	TOP 3 CAUSES OF DEATH (2012)	HEALTH INSURANCE COVERAGE
53M	67 — 75 AVG IN EAST ASIA & PACIFIC	23% INFECTIOUS DISEASES 17% HEART DISEASES 12% PERINATAL CONDITIONS	NEGLIGIBLE

FINANCING AND EXPENSES

TOTAL HEALTHCARE EXPENDITURE (2015)	HEALTHCARE BUDGET PER CAPITA	DOMESTIC GOV. HEALTH EXPENDITURE AS % OF GOV. EXPENDITURE (2015)	BREAKDOWN OF HEALTHCARE EXPENDITURE (2015)
$2.9 BN (4.9% OF GDP)	$55-59 — $332 AVG IN EAST ASIA & PACIFIC*	4.9%	8% FOREIGN DONORS 22% GOVERNMENT 70% HOUSEHOLDS

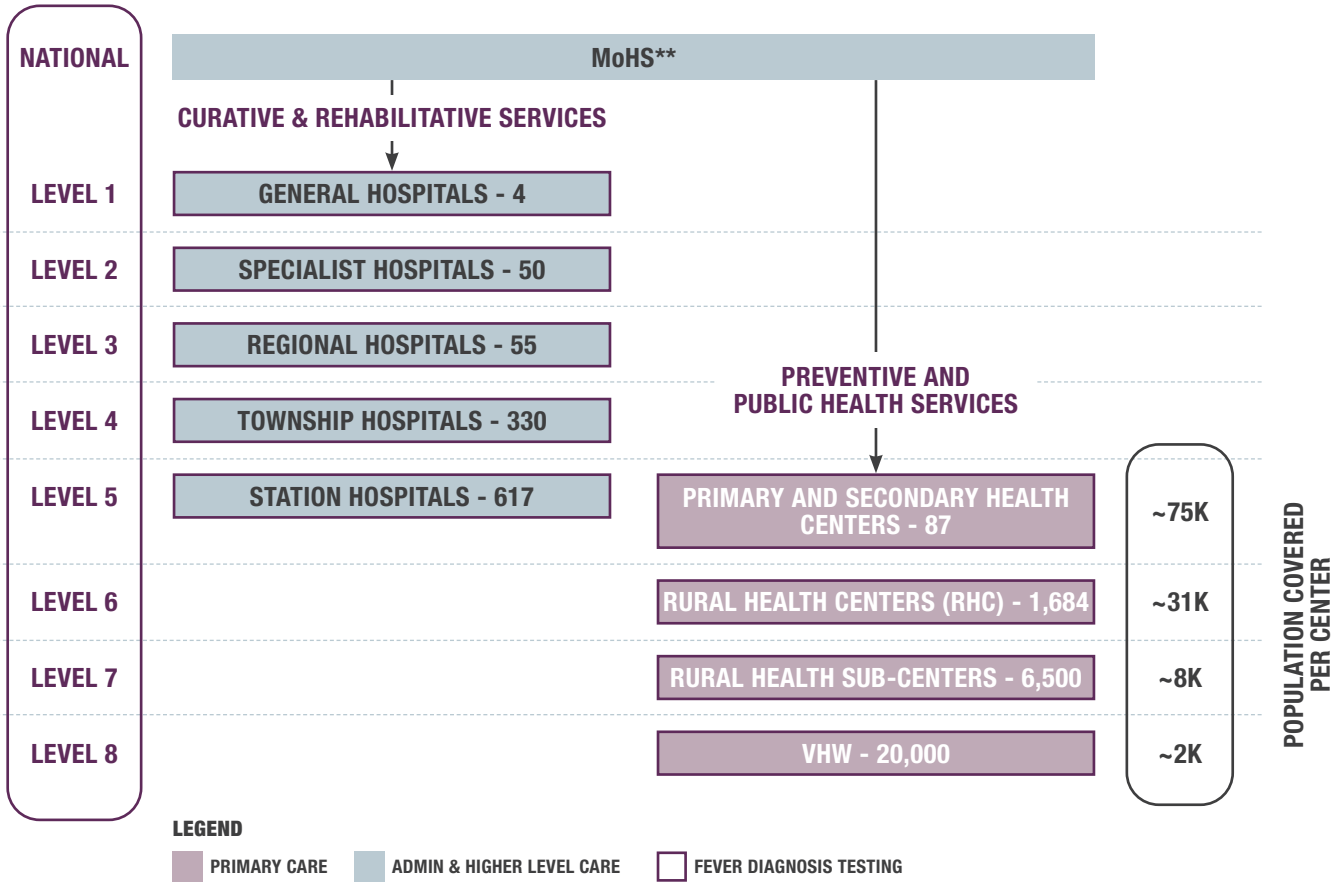
INFRASTRUCTURE

UNIVERSAL HEALTH COVERAGE (UHC): SERVICE COVERAGE INDEX (2015)	DENSITY OF PHYSICIANS (PER 1,000 POP.)	DENSITY OF NURSING & MIDWIFERY (PER 1,000 POP.)	NUMBER OF PUBLIC HOSPITALS	NUMBER OF HEALTH CENTER & SUBCENTER
60	~0.6	~0.9	~1,000	~8,200

Health in Myanmar, mainly privately funded, is underfinanced, even when related to other low-income neighboring countries, resulting in a shorter life expectancy

Note: (*) includes long term care, preventive care, ancillary services and other unclassified health expenditures. Sources: WHO, World Bank, Advention

PUBLIC HEALTHCARE INFRASTRUCTURE*



COMMENTS

Overall, the public sector accounts for 86% of the total health facilities in the country

Community-level healthcare:

- RDTs are the diagnostic method of choice at the community-level
- **Rural health centers are the backbone of the Myanmar health system.** They are notably responsible for community health education, environmental sanitation, disease surveillance, treatments of common illnesses, referral services, and training of volunteer health workers (VHW)
  - RHC are generally staffed with one public health supervisor grade I, one midwife, one lady health visitor, and one health assistant
  - Rural health sub-centers (RHSC) are generally staffed with one public health supervisor grade II and one midwife
- **VHW are present at the village level,** there is ~20,000 of them that are still active (out of the ~40,000 who were trained), they are unpaid which contribute to their attrition
  - They treat minor illnesses and assist in the control of various infectious diseases using an integrated approach
  - Some are auxiliary midwives and some are village malaria workers (VMWs) who are the mainstay of malaria control activities

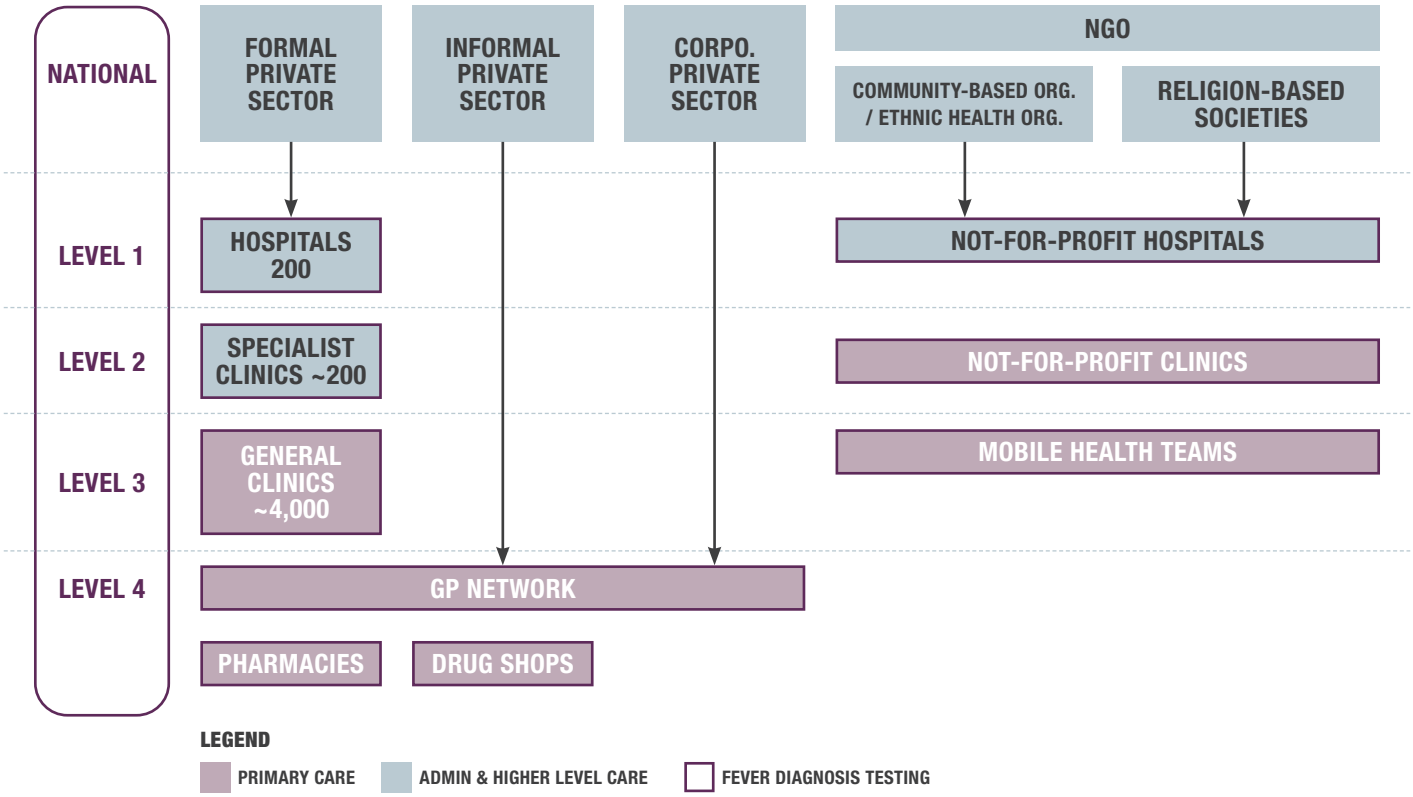
Regional and national healthcare:

- In hospitals and higher-level health facilities, microscopy is the preferred diagnostic method
- Microscopy availability is limited primarily to townships

Preventive health services are mostly provided through rural health centers & sub-centers and VHWs that are equipped with RDTs

Notes: (*) Data from 2014; (**) Ministry of Health and Sports. Sources: USAID / PMI, MoHS, Advention

PRIVATE HEALTHCARE INFRASTRUCTURE*



COMMENTS

The private sector, usually made up of smaller facilities than the public, is according to our interviews **the first point where patients seek care when febrile** ~65% (formal and informal)

- "A large proportion of people tend to seek care in the private sector. This is particularly true in rural areas." PSI, Myanmar, Malaria Elimination Director

Formal private sector is mostly present in urban areas

- Large private hospitals are mainly located in urban areas
- Sun Network, which is the name of the franchised formal private clinics network, is mainly present in urban or semi-urban areas and staffed with GPs

While **the informal private sector,** a much larger network that encompasses former GPs, mobile drug vendors, retail shops or pharmacies, **is mostly present in rural areas.**

- "Myanmar has a very liberal approach to the private sector. Informal private sector is where most rural communities are going. Since 2017, PSI support ~22,000 non-formal providers and has trained most of them to use mRDTs" PSI, Myanmar, Malaria Elimination Director 2

Corporate private sector is providing a growing support for malaria control activities (education, health insurance, prevention, testing and treatment, etc.).

Community-based organization and religion-based societies promote increased access to health services for vulnerable populations through notably mobile health teams

- "Ethnic Health Organizations are operating in areas beyond government control, they are quite highly skilled." PSI, Myanmar, Malaria Elimination Director

Many stakeholders are complementing the public sector ranging from NGOs to formal and informal private sector

Note: (*) data from 2013-2014. Sources: NCBI, PSI, Advention

MALARIA DIAGNOSIS PROVIDERS' BUSINESS MODEL

PUBLIC HEALTHCARE FACILITIES

~70% of the healthcare services were paid through out-of-pocket payments in 2015.

A trial prepaid health insurance system started in July 2015 with customers able to buy between one to five units of coverage (one unit costs approximately 50 USD), with a single unit providing the most basic level of coverage. Insurers will pay approximately 15 USD per day of hospitalization per unit.

Myanmar has a social security system called "the Social Security Scheme" that covers 600,000 individuals out of ~54M citizens (~1%). Otherwise, health insurance is only provided for government employees by the government, and for employees of international organizations by private insurers.

The government of Myanmar has committed itself to attain universal health coverage by 2030. The main goal of the first phase of the NHP 2017-21 is to extend access to a basic essential package of health services to the entire population (including malaria-related services) by 2021 and increase financial protection for those who need it the most.

Malaria treatment and diagnosis is free at public facilities.

PRIVATE HEALTHCARE FACILITIES

Private sector costs are covered by patient OOP payments as Myanmar's private health insurance segment is in its infancy. In FY 2016/17, private health insurance premiums totaled just over $74,900. By law, insurers offer the same product as the government health insurance system which guarantees partial payment of hospitalization costs and covers accidental deaths.

As part of the 2016-2020 NSP (National Strategic Plan), unlicensed drug vendors will be prohibited from treating malaria and selling antimalarials to avoid irrational treatment

- During the elimination phase, selling of over-the-counter antimalarial drugs will be strictly controlled

At present, a small proportion of private providers working in endemic areas are receiving sponsored commodities by NMPC and PSI Myanmar

- Expansion of this initiative is perceived as necessary, but mapping needs to be carried-out beforehand in order to minimize the risk of overlap resulting from support from multiple donors

NGO facilities provide care at no cost to the patient, with tests funded by donations.

The Myanmar health system is mainly financed through out-of-pocket expenditures and is highly unregulated

Sources: Central Bank of Myanmar, MoHS, PMI, interviews, Advention

HEALTHCARE STAFF AND TRAINING

	PHYSICIANS	BASIC HEALTH STAFF	VILLAGE HWs
GENERAL JOB DESCRIPTION	Examines in and out patients in line with standard medical procedures using various types of diagnostic mechanisms Administers and prescribes drugs based on examination, test reports and findings and counselling services	Promotes maternal and child health, school health, nutrition, immunization, community health education, environmental sanitation, disease surveillance and controls, treatments of common illnesses, referral services, birth and death registration, and training of volunteer health workers	Helps on community mobilization strategies, education sessions and use of communication tools Treats minor illnesses and assist in the control of various infectious diseases
MALARIA SPECIFIC TASKS	Use IMCI and IMAI approach to diagnose through clinical diagnostic and microscopy confirmation for severe cases	Use iCCM diagnostic approach to diagnose through clinical and RDTs and treat	Use iCCM diagnostic approach to diagnose through clinical and RDTs and treat
MEDICAL TRAINING	7 years	>1 Year	<1 Year
RDT USE KNOWLEDGE	✓	✓	✓
BLOOD SAMPLING KNOWLEDGE	✓	✓	✓

LEGEND

✓ COMPLETE KNOWLEDGE − INCOMPLETE / PARTIAL KNOWLEDGE ✗ NO / VERY LIMITED KNOWLEDGE

In Myanmar, many doctors (>50%) and other staff in the public health service are also engaged in private practices after official working hours to supplement their income.

Recognizing that human capacity is lacking in Myanmar and well-trained staff are critical, the MoHS is focusing on rebuilding the NMCP's health workforce with different skill sets to improve management at various levels of field operations and offering integrated community approaches (including possibly HIV, TB, leprosy and malaria services).

To produce qualified medical doctors, the MoHS agreed to halve the annual student intake of four medical schools and to extend the study period of medical students from 6 years to 7 years.

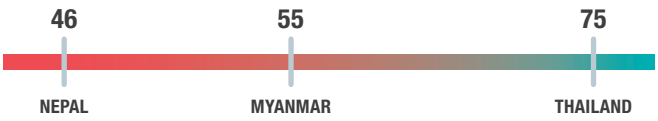
For capacity building, candidates from different disciplines have been selected and sent for overseas training in the course of their PhDs, master's degrees, and other diplomas, as well as for short term training.

Myanmar lacks qualified healthcare staff and rolled out a 5Y National Health Plan in 2017 to overcome that issue

Offering an integrated community approach will be one of the key levers to improve the level of care

Sources: PMI, Advention

ACCESS TO CARE

UNIVERSAL HEALTH COVERAGE INDEX (SOUTH EAST ASIA, UHC)*, 2015	
NO. OF HOSPITAL BEDS FOR 1K POPULATION, 2012	~0.9
NO. OF PHYSICIANS FOR 1K POPULATION, 2012	~0.6

The healthcare system has been neglected by the government in the past 50 years and access to care is a huge challenge, particularly in rural areas. Since the country opened to foreign investments in 2011, the situation has improved. Yet health expenditures per capita remain low (~$55).

A 2011 assessment identified large gaps such as a shortage and misdistribution of primary healthcare workers, lack of essential medicines, equipment, infrastructure.

After decades of under investment in the health system, strengthening primary healthcare has become a central focus of Myanmar's National Health Plan (NHP) 2017- 2020.

The Plan was drafted with various stakeholders from across health and health-related sectors, including Ethnic Health Organizations (EHOs) that promote increased access to health services through mobile health teams in non-state areas.

This plan focuses not only on disease priority but also on health inequities as it aims at an "Essential Package of Health Services" to the entire population by 2030.

ADDITIONAL COMMENTS ON ACCESS TO CARE DYNAMICS, SPECIALLY IN RELATION TO FEBRILE ILLNESSES

Access to care is uneven amongst the various territories of Myanmar, notably along the borders, and has a strong impact on malaria cases.

Border states, where access to healthcare services is poor or has been disrupted by armed conflict and force displacement, have higher malaria mortality rates. Chin and Karenni states have mortality rates that are four times the national rate, and Kachin state is almost five times higher than the national average, according to PMI.

- "Government coverage is not good everywhere. There are areas in Myanmar that are 'no man's land', where there is no primary healthcare because government and NGOs have no access and obviously prevalence of malaria is higher in these areas. Otherwise, primary care is relatively good." ICEMR, Myanmar, Researcher

Myanmar has under invested in its health infrastructure for years, leaving the country with major gaps that are expected to be addressed (NHP 2017-2020)

Note: (*) UHC index is made of 16 indicators such as child treatment, malaria prevention, hospital access, health worker density.
Sources: Center for Global Development, World Bank, PMI, Advention