

Progress towards health systems strengthening in Myanmar

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Objectives This is a commentary on the health care system of Myanmar during the ongoing transition to a new “democratic” government intent on engaging with the international community. In the years Myanmar was isolated, its health system remained undeveloped and underfunded with large disparities in health outcomes for poor, indigenous populations.

Study design Observational, descriptive.

Methods Observations, published reports, data, conferences, and interviews.

Results Decades of under-investment have resulted in critical shortages of human resources for health. Although improvements are slowly being made by government, poor, indigenous people have developed a system of community health workers and auxiliary midwives to meet the needs of their communities. The government plans to develop a national emergency ambulance system but there are systemic factors that delay progress towards modernization and equity in health care.

Conclusions Health care decision-makers remain constrained by the legacy of strict hierarchical structures, limited decision-making capacity and political uncertainty. Structural and cultural factors delay progress in health system strengthening and equity in poor, indigenous regions. In Myanmar change is a slow and complicated process with many obstacles to overcome.

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The Union of Myanmar is in transition from an isolated military regime to a new “democratic” government intent on engaging with the international community. However, decades of underinvestment in health care have resulted in an undeveloped and fragile health care system with poor health outcomes in maternal health, child health, communicable diseases and traffic related incidents. Although morbidity and mortality have improved over the last decade, they still remain the highest in the South East Asia, reflecting the unmet

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health needs of the Myanmar population. Large health disparities between indigenous rural and urban populations are significant since 70% of the population reside in rural areas (1).

Myanmar is an ethnically diverse country divided into mainly Burman dominated divisions and ethnic states populated by indigenous peoples such as the Shan, Karen, Rakhine, Karen, Chin, Kachin, and Mon who are concentrated in the remote and mountainous regions of the east, north and west of the country. It is estimated that 84% of poverty is found in these rural areas with 73% of the population in Chin State, 44% in Rakhine State and 33% in Shan State living below the poverty line (2).

OBJECTIVES

Visitors to Myanmar from developed countries have optimistically described this as a time of re-emergence and a “golden opportunity” for change in the health care system of Myanmar. Although there is visible expansion and modernization of the commercial sector and tourist industry, systems strengthening of health care is a slow and complex process since Myanmar has been closed to the outside world for decades and isolated from developments in medical technology and health care management. Health disparities are an issue that has yet to be adequately addressed.

METHODS

This report, based on four months of observation, interviews, document review and public health participation highlights the prevailing cultural and structural factors that delay progress in health system strengthening in Myanmar and underscores the resourcefulness of communities in providing for their own basic health services.

RESULTS

Human resource disparities

In Myanmar, the situation in indigenous rural areas is particularly critical, with respect to coverage of skilled birth attendants and lack of transportation to reach health facilities. Internal migration of health workers from rural to urban areas, from public to private sectors and from primary health care to specializations has exacerbated the human resource shortage in rural areas. High rates of maternal mortality (MMR) reflect shortages of skilled birth attendants and lack of access to quality emergency care. For example, the urban rate of maternal mortality is reported as 281.6, but reaches as high as 356.7 in some rural states (3). Myanmar's ability to reduce its MMR depends heavily on skilled birth attendants, especially midwives to provide emergency obstetric care and neonatal resuscitation (4).

Resourcefulness of Indigenous communities

In remote locations where there are no midwives or fully trained birth attendants, unpaid local auxiliary midwives (AMWs), who are at best trained high school graduates, provide free maternity services, traveling to patient's homes and buying necessary supplies at their own expense. The AMWs are trained by government, but an institutionalized support system and national policy are needed to improve quality of care and sustain and strengthen their contributions in sharing the workload of midwives in hard-to-reach areas (5).

Health services come with a high price, which poor people often cannot afford to pay. As an example of the resourcefulness of communities lacking government support, volunteer, unpaid community health workers from indigenous villages are recruited from the communities where they live and are well accepted for their contribution to basic health services. Community Health Workers (CHW) promote immunization, advocate for safe water and sanitation and provide health education for rural populations (6).

The key motivations for AMWs and CHWs are altruism in servicing people in their home villages. Despite being volunteers, they receive some financial support from patients and the community for transport costs to households as there is no funding support by the Ministry of Health. Their value is recognized by the populations they serve as they are well accepted and play a bridging role between local communities and health facilities. Their strengths are accessibility, cultural sensitivity, and language-friendly services for the local people they serve (5, 6).

Factors inhibiting change

The shift away from the former political system - a major transition for many - has resulted in a climate of uncertainty and apprehension that persists throughout the hierarchy of bureaucrats, public health planners and practitioners attempting to implement change. A prevalent theme is the perception that government desires to remain in control and be viewed as competent in providing for the people. With this in mind, new and innovative health system strengthening initiatives may be perceived as destabilizing or rebellious if interpreted as criticisms of the prevailing government. The legacy of the autocratic regime lives on through administrative bureaucracy and public uncertainty about government control and health care decision-makers remain constrained by the legacy of strict hierarchical structures, limited decision-making capacity and 'stereotyped thinking' or 'military discipline. If the "Iron Hand" isn't holding them down anymore, public health practitioners and policy makers continue to have that mentality (7). This could take a generation to overcome.

Against this background, change is slowly taking place and there is growing hope and cautious optimism that health systems in Myanmar can be strengthened and extended to all the population for greater impact and improvement of health outcomes. The critical need for modernization, equality and efforts towards system strengthening in remote areas are exemplified by a description of the existing system of emergency care.

Emergency health care

Myanmar has similarities with other developing nations, with traumatic injuries as the leading cause of morbidity and the third highest cause of mortality. It is estimated that 40% of road deaths in Myanmar could be avoided if victims received prompt medical care but there are two factors that prevent effective emergency response. Firstly, there is no nationwide ambulance service capable of providing immediate care en route to a medical facility. Compounding this problem, very few physicians in Myanmar are trained in emergency medicine, and few inhabit indigenous rural areas (8).

Prior to 2014, there were no trained emergency physicians in the country and government investment in developing an emergency care workforce was nonexistent. In a country of 51 million people with large rural populations, there is only one emergency room in each of three major cities, Yangon, Mandalay and Naypyidaw, the capital. In rural areas, junior medical officers with limited training and equipment are the sole providers of emergency care.

Yangon General Hospital is one of only three organized emergency rooms in the entire country and serves a city of five million people. The facility is antiquated but there is a triage system and four operating rooms for emergency cases. Ambulances, private pick-up trucks and taxis arrive daily from outlying regions carrying sick patients. The ambulances are staffed by a driver and an untrained assistant but contain no medical equipment of any kind. At present there are no emergency medical technicians for ambulances in the government medical system but a training program for paramedics will be started by a Western company within the next two years. Until then, each neighborhood in Yangon and each rural township operates an "ambulance" to transport locally occurring casualties and sick patients to Yangon General Hospital. The trip can take hours from outlying regions due to severe traffic congestion and poor roads.

There are plans to create an 18-month postgraduate training program for practicing physicians to be trained in emergency care management and The Ministry of Health has devel-

oped plans to increase the standard of emergency care across the country. The plan also includes availability of ambulances for township public hospitals in rural areas. At this time, data is being collected from hospitals in Yangon to document the need for expansion of the emergency health system.

CONCLUSIONS

There is a growing hope and cautious optimism that health care improvements in Myanmar can reduce disparities and improve health outcomes for all but there are competing public health issues including lack of electricity, roads, safe drinking water, sanitation and malnutrition of children in rural areas. The Ministry of Health has been struggling for funds and resources, but health has been one of the lower priorities in government and resources were lacking, particularly in regions with poor, indigenous populations. An encouraging development is the recent increase in government funds provided for health but government funding for health remains the lowest in the South East Asian Region (9).

Myanmar remains at a critical juncture in its economic, social and political transition towards a democratic and inclusive state. There are substantial challenges to address in how to allocate limited healthcare resources and ensure access to care in poor rural areas if population health is to be improved. Although Myanmar has made demonstrable progress on health over the past two decades, much remains to be done to sustain the gains that have been made and to ensure more equitable levels of health outcomes across populations. Myanmar is a potentially rich country, and is capable of strengthening its infrastructure and workforce, should it realign its priorities.

When providing aid or technical assistance for a country emerging from isolation, we often assume that change from the outside would be enthusiastically received; in Myanmar, change is a slow and complicated process with many obstacles to overcome.

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