

WHO-AIMS

**WHO-AIMS REPORT ON
MENTAL HEALTH SYSTEM
IN MYANMAR**



**World Health
Organization**



**MINISTRY OF HEALTH
UNION OF MYANMAR**

WHO-AIMS REPORT ON
MENTAL HEALTH SYSTEM
IN MYANMAR

*A report of the assessment of the mental health system in Myanmar
using the World Health Organization - Assessment Instrument for
Mental Health Systems (WHO-AIMS).*

Yangon, Myanmar

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Please refer to WHO-AIMS (WHO, 2005) for full information on the development of WHO-AIMS at the following website.

http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html

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The WHO-AIMS project is coordinated by Shekhar Saxena.

Executive Summary

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Myanmar. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change. This will enable Myanmar to develop information-based mental health plans with clear base-line information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

Policy and Legislative Framework

Myanmar has a mental health policy which is incorporated with the general health policy document. The last version of the mental health plan was revised in 2006. A disaster preparedness plan for mental health is present, and was last revised in 2006. The Mental Health Legislation Lunacy Act was enacted in 1912 and is outdated. Mental health expenditure is 0.3% of total health care expenditures.

Mental Health Services

There are 25 outpatient mental health facilities, 2 day treatment facilities, 17 community-based psychiatric inpatients units and 2 mental hospitals. The majority of beds in the country are provided by mental hospitals, followed by residential units. The percentage of female users is less than 40% of the patient population in all mental health facilities. The population of female users is highest in inpatient units (35%) and out patient units (24%). The diagnosis of schizophrenia and neurotic disorders are the most frequent diagnoses in out-patient facilities, and schizophrenia and mood disorders are the most common diagnoses in mental hospitals. Essential psychotropic drugs from each therapeutic class are available in inpatient units, mental hospitals and out-patient facilities.

Mental Health in Primary Health Care

In terms of refresher training on mental health, 1% of primary health care doctors, 3% of nurses, and 2% of non-doctor/non-nurse primary health care workers have received at least two days of training.

Non-doctor/ non-nurse primary health care workers are not allowed to prescribe psychotropic medications in any circumstance. Nurses are allowed to prescribe, but with restrictions; they are not allowed to initiate prescription but are allowed to continue prescription. Primary health care doctors are allowed to prescribe psychotropic medications without restrictions.

Human Resources

The total number of human resources working in mental health facilities or private practice per 100,000 general population is 0.477. There are 89 psychiatrists (0.016 per 100,000 population), 13 other medical doctors (0.02 per 100,000 population), 127 nurses (0.23 per 100,000 population), four psychologists (0.01 per 100,000 population), 23 social workers (0.04 per 100,000 population), one occupational therapist (0.002 per

100,000 population), and eight other health or mental health workers (0.01 per 100,000 population).

Public Education and Links with Other Sectors

There have been public education and awareness campaigns targeting professional groups including health care providers (traditional medicinal medicine, conventional, and modern). There was an awareness campaign in Nyaungdon Township for epilepsy with the support of WHO.

Monitoring and Research

The Department of Health Planning monitors data collected from the whole country. This data, including data on mental health, is analyzed and published yearly.

Strengths and Weaknesses

Strengths

1. The data collected from the Health Management Information System (HMIS), is community based, so data and indicators represent the whole country.
2. The health management information system has a data dictionary. This is a standardized book that explains/defines psychosis, depression, anxiety, alcohol use disorder, mental retardation and epilepsy. The data dictionary contains a checklist used for diagnosing and reporting the six mental disorders listed above. Almost all the basic health staff (BHS) from states and division has been trained so the results are reliable.
3. Reporting systems were well arranged, and internet computer system were applied, so the data was received in a timely manner.

Weaknesses

1. Data from peripheral and remote areas was difficult to get in time because of poor transportation and communication.
2. The majority of people who seek treatment for mental health concerns consult faith healers. Data on these people is missing, and they did not get proper treatment.
3. Some data was unattainable due to communication difficulties and data unavailability.

Data was collected in 2006 and is based on the year 2005.

WHO-AIMS COUNTRY REPORT FOR MYANMAR

Introduction

Location & Geography

Myanmar is the largest country in mainland South-East Asia with a total land area of 676,578 square kilometers. It stretches 2200 kilometers from north to south and 925 kilometers from east-west at its widest point. It is bounded on the north-east by the People's Republic of China, on the east and south-east by the Lao People's Democratic Republic and the Kingdom of Thailand, on the west and south by the Bay of Bengal and Andaman Sea, and on the west by the People's Republic of Bangladesh and the Republic of India. It lies between 09°32' N and 28°31' N latitudes and 92°10' E and 101°11' E longitudes.

The country is divided administratively, into 14 States and divisions. It consists of 65 districts, 325 townships, 59 sub townships, 2759 wards, 13723 village tracts and 64976 villages. Myanmar falls into three well marked natural divisions, the western hills, the central belt and the Shan plateau on the east, with a continuation of this high land in the Tanintharyi.

The parallel chains of mountain ranges from north to south divide the country into three river systems, the Ayeyarwaddy, Sittaung and Thanlwin. The diversity exists between the regions due to the rugged terrain in the hilly north, which makes communication extremely difficult. In the southern plains and swampy marshlands, there are numerous rivers, and tributaries of these rivers criss-cross the land in many places.

Climate

Myanmar enjoys a tropical climate with three distinct seasons, the rainy, the cold and the hot season. The rainy season comes with the southwest monsoon, which lasts from mid-May to mid-October. Then the cold season follows, from mid-October to mid-February. The hot season precedes rainy season and lasts from mid-February to mid-May.

Demography

The population of Myanmar in 2005-2006 is estimated at 55.40 million, with the growth rate of 2.02 percent. About 70% of population reside in the rural areas, whereas the remaining are urban dwellers. The population density ranges from 390 per square kilometres in Yangon Division, where the city of Yangon is, to 10 per square kilometres in Chin State, the western part of the country.

Estimates of Population and Its Structure

Thirty-three percent of the population is 0 -14 years, 59% of the population is 15-59 years and eight percent are 60 years and above. Males make up 49.72% of the population, while 50.28% is female.

People and Religion

The Union of Myanmar is made up of 135 national groups speaking over 100 languages and dialects. The major ethnic groups are Kachin, Kayah, Kayin, Chin, Mon, Bamar, Rakhine and Shan. About 89.4% of the population, mainly Bamar, Shan, Mon, Rakhine and some Kayin, are Buddhist. The rest are Christian, Muslim, Hindu and Animist.

Government Health Expenditure

The current health expenditure is 13,271 million Kyats and, capital expenditure is 7,578 million kyat. This totals to 20,849 million kyat. Per capita health expenditure is 376 million kyat.

Social Development

Expansion of schools and institutes of higher education has been considerable, especially in states and divisions. Adult literacy rates for the year 2005 were 94.1%, while the school enrolment rate was 97.58%, increasing respectively from 79.7% and 67.13% in 1988.

Health Facilities Development

The total number of government hospitals is 826. There are a total of 34920 hospital beds. There are 86 primary and secondary health centres and 348 maternal and child health centres. There are 1456 rural health centres and 80 school health teams. Finally, there are 14 traditional medicine hospitals and 237 traditional medicine clinics.

Domain 1: Policy and Legislative Framework

Policy, plans and legislation

Myanmar's mental health policy was last revised in 1995, and includes the following components: (1) organization of services; (2) developing community mental health services; (3) downsizing of large mental hospitals; (4) developing a mental health component in primary health care; (5) human resources; (6) involvement of users and families; (7) advocacy and promotion; (8) human rights protection of users; (9) equity of access to mental health services across different groups; (10) financing; and (11) quality improvement and system monitoring. The mental health policy is included within the general health policy.

In addition, a list of essential medicines is present. These medicines include antipsychotics, anxiolytics, antidepressants, mood stabilizers, and antiepileptic drugs.

The last revision of the mental health plan was in 2006. This plan contains the following components: (1) organization of services; (2) developing community mental health services; (3) downsizing of large mental hospitals; (4) reforming mental hospitals to provide more comprehensive care; (5) developing a mental health component in primary health care; (6) human resources; (7) involvement of users and families; (8) advocacy and promotion; (9) human rights protection of users; (10) equity of access to mental health services across different groups; (11) financing; and (12) quality improvement and system monitoring. In addition, a budget and time frame is mentioned in the last mental health plan. Specific goals are mentioned and those identified goals have been reached.

A disaster/emergency preparedness plan for mental health is present and was last revised in 2006.

The mental health legislation was enacted in 1912, and focused on access to mental health care, including access to the least restrictive care; rights of mental health service consumers, family members and other care givers; and competency, capacity and guardianship issues for people with mental illness; voluntary and involuntary treatment; accreditation of professionals and facilities; law enforcement and other judicial system issues for people with mental illness; mechanisms to oversee involuntary admission and treatment practices; and mechanisms to implement the provisions of the mental health legislation. That legislation is entitled The Lunacy Act 1912, and is outdated.

Financing of Mental Health Services

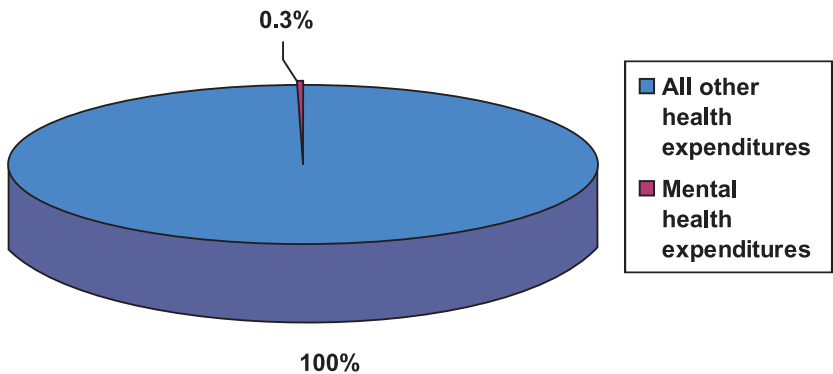
Less than one percent, 0.3%, of health care expenditures by the government health departments are directed towards mental health. Of all the expenditures spent on mental health, 87% is directed towards mental hospitals. Data on financing for mental health services for salaries, buildings, and equipment was not available.

Thirty-one (31%) of the population have free access (at least 80%) to essential psychotropic medicines. This is mental hospital data only because the data from other mental health facilities is unavailable. Poor patients are entitled to free care as well as free psychotropic drugs if a supply is available. Patients who can afford psychotropic drugs have to buy medicines themselves in the “cost sharing drug shop” in the hospital.

For those that pay out of pocket, the cost of antipsychotic medication is 6% and antidepressant medication is 9% of one day’s minimum wages. All mental disorders are covered in social insurance schemes. In addition, free mental health assessments are available for all patients who come to mental health facilities.

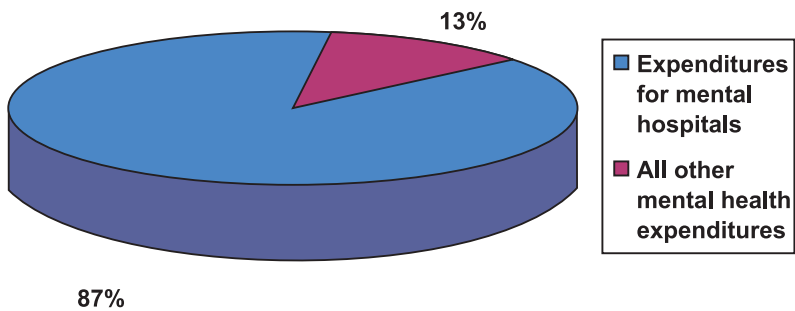
Graph 1.1: Expenditures on mental hospitals as a proportion of total mental health care spending

GRAPH 1.1 – HEALTH EXPENDITURE TOWARDS MENTAL HEALTH



Expenditure on mental hospitals as a proportion of total health care spending is 0.3%.

GRAPH 1.2 – MENTAL HEALTH EXPENDITURE TOWARDS MENTAL HOSPITALS



The expenditure for mental hospitals is 13% compare to all other mental health expenditure 87%. The ratio is 1:6.7.

Human Rights Policies

A regional human rights review body exists, which has the authority to oversee regular inspections in mental health facilities; review involuntary admissions and discharge procedures; review complaints, investigate processes, and impose sanctions. The committee consists of a legislative person, administrative members, a police representative, and medical persons. This committee reviews criminal cases, and patients sent from the courts under section 466 and 471. The committee also determines whether the criminal patients are sound or unsound during their period in hospital. This committee meets in the hospital every three months.

All of the mental hospitals have at least one review/inspection of human rights protection of patients per year, while 89% of community-based inpatient psychiatric units and community residential facilities have such a review. Only 50% of all mental hospital staff have had at least one day training, meeting, or other type of working session on human rights protection of patients in the year of assessment.

Domain 2: Mental Health Services

Organization of Mental Health Services

A national mental health authority exists which provides advice to the government on mental health policies and legislation. The mental health authority also is involved in service planning; service management and co-ordination; and in monitoring and quality assessment of mental health services.

Mental health services are organized in terms of catchments/service areas.

Mental Health Outpatient Facilities

There are 25 outpatient mental health facilities available in the country, of which 4% are for children and adolescents only. These facilities treat 38.175 users per 100,000 general populations. This figure does not include patients treated in primary health care clinics. (the number of patients treated per 100,000 general population in primary health care clinics is 291.415). Of all users treated in the 25 mental health outpatient facilities, 34% are female and less than one percent (98 patients) are children or adolescents.

The users treated in outpatient facilities are primarily diagnosed with schizophrenia, 12%, and mood disorders, 9%.¹ The average number of contacts per user is 12. All of the outpatient facilities provide follow-up care in the community, while there are no mental health mobile teams. In terms of available interventions, there are no psychosocial interventions in outpatient facilities.

All of the mental health outpatient facilities had at last one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility or a near-by pharmacy all year round.

Day Treatment Facilities

There is one functioning day treatment facilities available in the country, which is reserved for children and adolescents only. This facility treats 0.3158 users per 100,000 general population. Of all users treated in the day treatment facility, 30% are female and

¹ Diagnoses are based on the data dictionary. This is a standardized book that explains/defines psychosis, depression, anxiety, alcohol use disorder, mental retardation and epilepsy. The data dictionary contains a checklist used for diagnosing and reporting the six mental disorders listed above.

91% are children or adolescents. On average, users spend 260 days in day treatment facilities.

There was also a day care centre in Yangon Mental Health Hospital, for both children and adults with mental disorders. However, when the hospital moved outside of the city, it was too far for the day patients to travel to the facility. Consequently the day care center is no longer functioning...

The functioning day treatment facility is The School for Disabled Children, which is for children with autism, Downs Syndrome, mental retardation, and cerebral palsy. Fifteen children from this school will become over 17 this year. Thus, the Ministry of Social Welfare Relief and Resettlement plans to open a Pre- Vocational Training for those children in a Separate Building from the School for Disabled Children instead of sending them to adult disable vocational training. Including these patients, the percentage of children and adolescents treated becomes 91%.

Community-Based Psychiatric Inpatient Units

There are 17 community-based psychiatric inpatient units available in the country for a total of 0.3068 beds per 100,000 general population. There are no beds in community-based inpatient units reserved for children and adolescents only. Thirty five percent of admissions to community-based psychiatric inpatient units are female, and 11% are children/adolescents.

The diagnoses of admissions to community-based psychiatric inpatient were primarily from the following two diagnostic groups schizophrenia (36%) and mental and behavioural disorders due to psychoactive substance use including alcohol (23%). On average patients spend nine days per discharge.

Few, 1 - 20%, of the patients in community-based psychiatric inpatient units received one or more psychosocial interventions in the last year. All, 100%, of community-based psychiatric inpatient units had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

Community Residential Facilities

Mental Hospitals

There are two mental hospitals in the country, for a total of 2.527 beds per 100,000 general population. Both of these facilities are organizationally integrated with mental health outpatient facilities. There are no special beds in mental hospitals reserved for children and adolescents only. Twenty percent of the patients are female, and 0.17% are children and adolescents. The number of beds has increased 17% in the last five years.

The patients admitted to mental hospitals belong primarily to the following diagnostic group's: mental and behavioural disorders due to psychoactive substance use including alcohol (34%), schizophrenia (28%) and mood disorders (27%).

The number of patients treated in mental hospitals is 6485, which is 11.7 per 100.000 population.

The average number of days spent in the mental hospitals is 41.06. Ninety six percent of patients spend less than one year, one percent of patients spend 1-4 years, two percent of patients spend five to ten years, and one percent of patients spend more than ten years in mental hospitals. The majority, 51-80%, of patients in mental hospitals received one or more psychosocial interventions in the last year. Both of the mental hospitals had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

Forensic and Other Residential Facilities

In addition to beds in mental health facilities, there are also 120 beds for persons with mental disorders in forensic inpatient units and 270 beds in residential facilities specifically for people with substance abuse (including alcohol) problems, e.g. detoxification inpatient facilities. There are 20 beds in other residential facilities, a disabled care centre for children, including patients with autism, Downs Syndrome, cerebral palsy and polio.

There is one community residential facility available in the country for a total of 0.036 beds/places per 100,000 general population. All 20 beds in this community residential facilities are reserved for children and adolescents only.

Twenty percent of users treated in community residential facilities are female, and 100% are children.

The number of users in community residential facilities is 0.018 per 100000 general population, and the average number of days spent in community residential facilities is 260.

In forensic inpatient units, 40% of patients spend less than one year, 16% of patients spend 1-4 years, 28% of patients spend 5-10 years, and 16% of patients spend more than 10 years in mental hospitals.

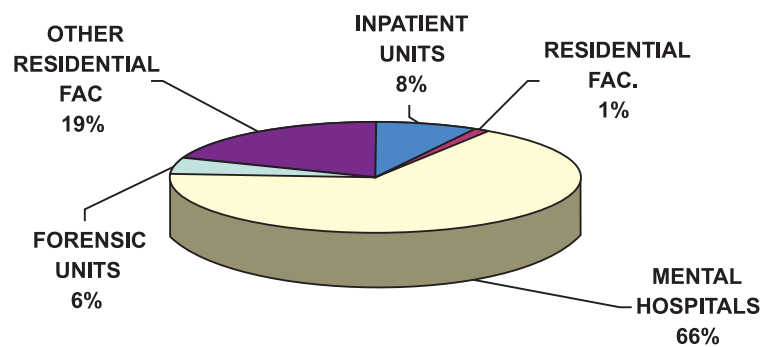
Human Rights and Equity

Less than one percent, 0.26%, of all admissions to community-based inpatient psychiatric units and 1% of all admissions to mental hospitals are involuntary. This figure does not include patients sent by their relatives against their voluntary consent. No official data is available on restraints or seclusion, however, based on best estimates, between 0-1% of patients were restrained or secluded at least once within the last year in community-based psychiatric inpatient units, in comparison to 2-5% of patients in mental hospitals.

The density of psychiatric beds in or around the largest city is 10.79 times greater than the density of beds in the entire country. Such a distribution of beds prevents access for rural users.

Based on best estimates, because data on minority users is not specifically available, inequity of access to mental health services for other minority users (e.g., linguistic, ethnic, religious minorities) is a moderate issue in the country.

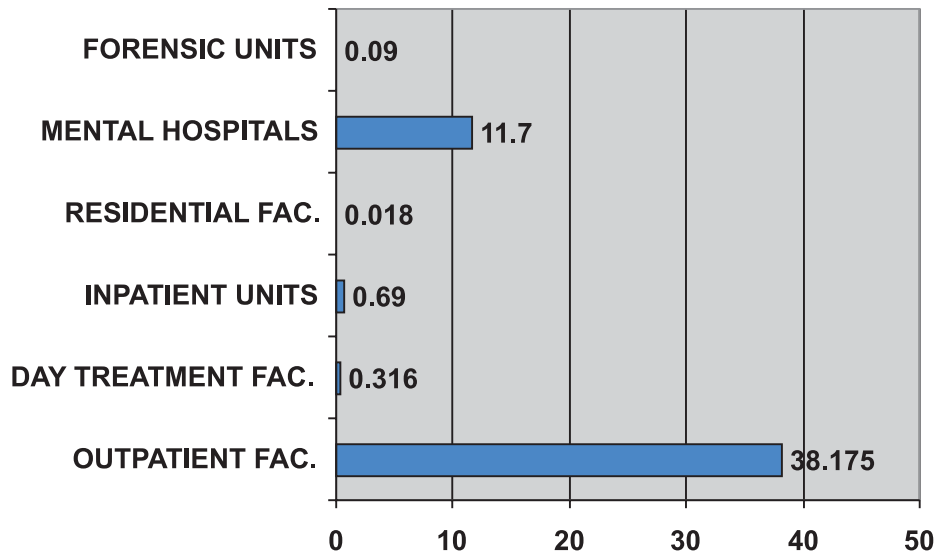
GRAPH 2.1 – BEDS IN MENTAL HEALTH FACILITIES AND OTHER RESIDENTIAL FACILITIES



Summary of Graph 2.1

The majority of beds in the country are provided by mental hospitals, followed by residential units and inpatient units.

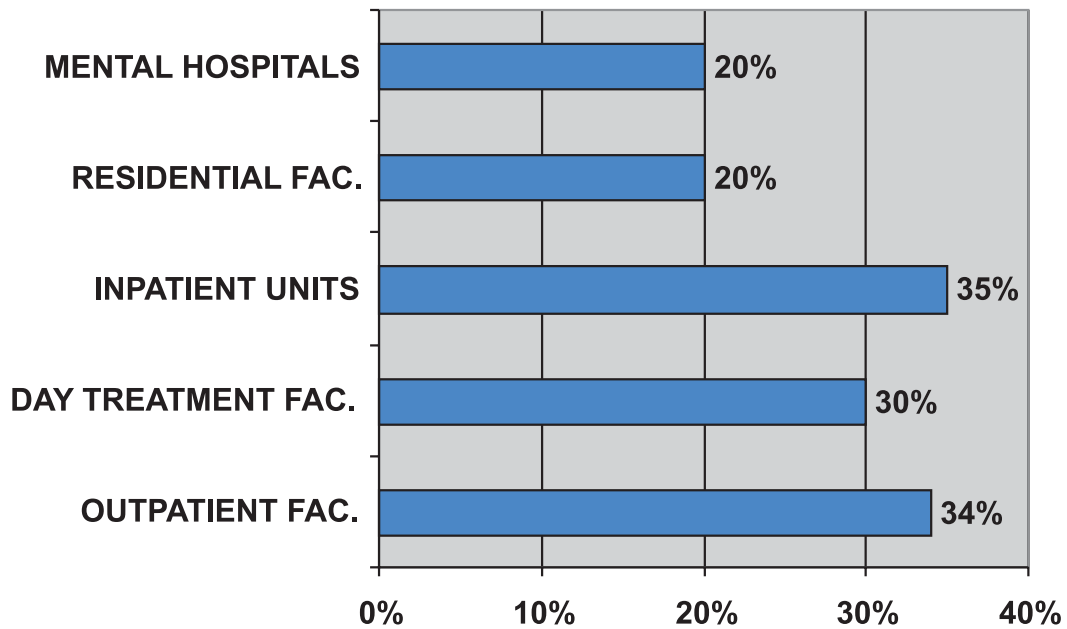
GRAPH 2.2 – PATIENTS TREATED IN MENTAL HEALTH FACILITIES
(rate per 100.000 population)



Summary for Graph 2.2

The majority of the users are treated in out patient facilities and in mental hospitals, while the rate of users treated in inpatient units, day treatment facilities, forensic units and residential facilities is low.

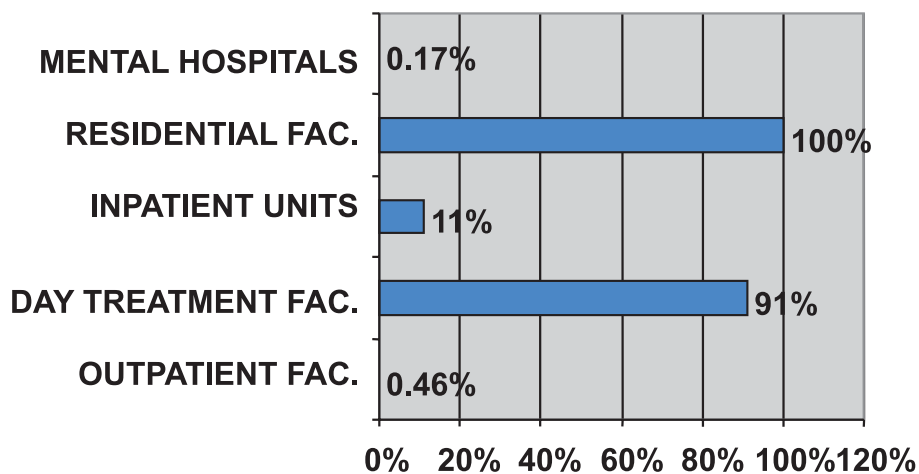
GRAPH 2.3 – PERCENTAGES OF FEMALE USERS TREATED IN MENTAL HEALTH FACILITIES



Summary for Graph 2.3

Female users make up fewer than 40% of the population in mental health facilities in country. The proportion of female user is highest in inpatient units and outpatient facilities and lowest in residential facilities and mental hospitals.

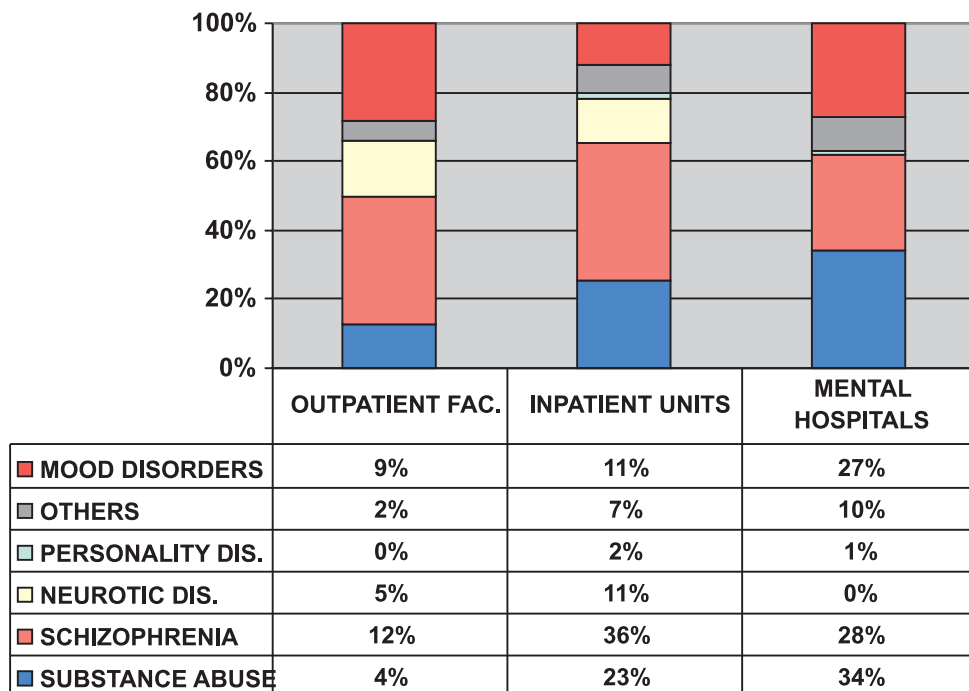
GRAPH 2.4 – PERCENTAGES OF CHILDREN AND ADOLESCENTS TREATED IN MENTAL HEALTH FACILITIES



Summary for Graph 2.4

The percentage of users that are children and/or adolescents varies substantially from facility. The proportion of children users is highest in residential facility (100%) and day treatment facility (91%) and lowest in out patient facilities (0.46%) and metal hospitals (0.17%). The percentage of children users are 100% in residential facility and 91% day treatment facility because of lack of adult residential facility.

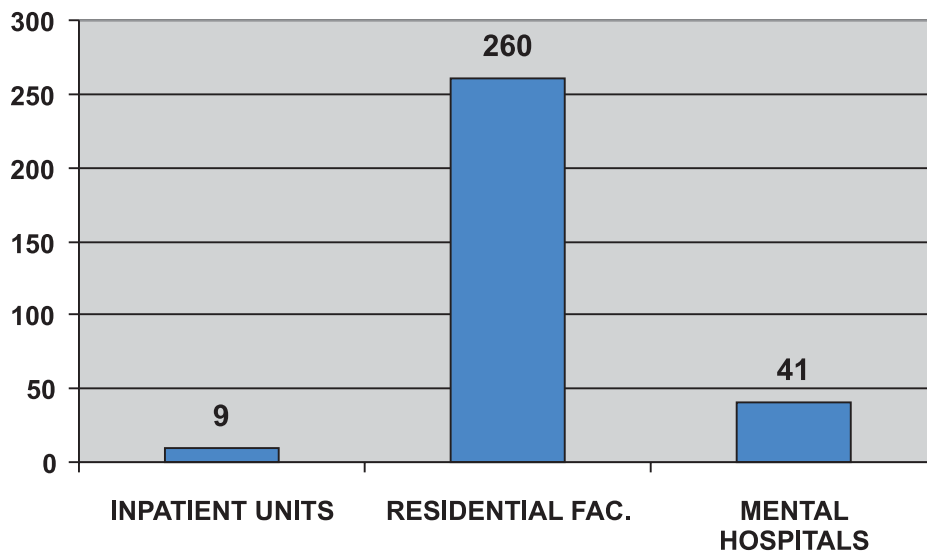
GRAPH 2.5 – PATIENTS TREATED IN MENTAL HEALTH FACILITIES BY DIAGNOSIS



Summary for Graph 2.5

The distribution of diagnoses varies across facilities. In outpatient facilities, neurotic disorders and schizophrenia are more prevalent; while within in-patient unit schizophrenia, substance abuse including alcohol abuse are most common; and in mental hospitals, schizophrenia and affective disorders are most frequently treated.

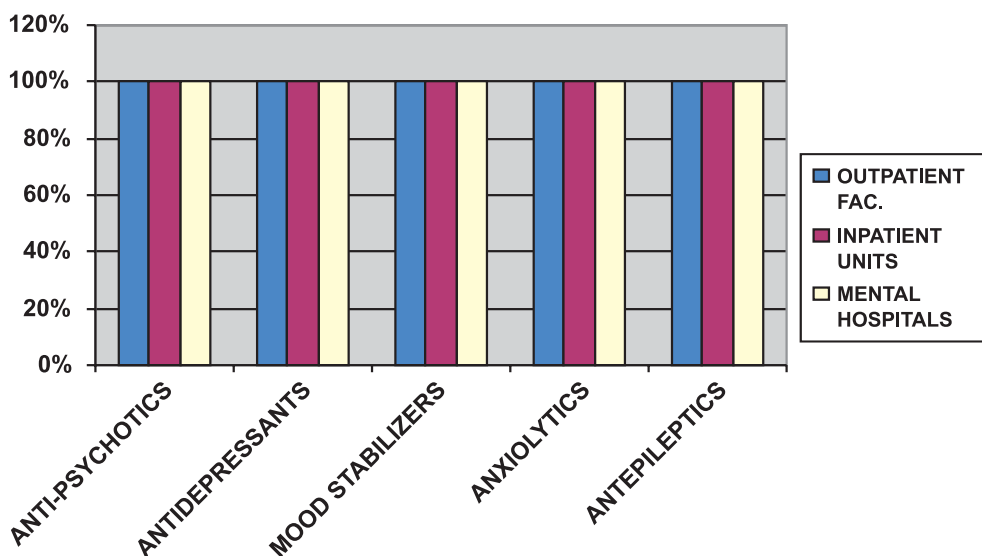
GRAPH 2.6 – LENGTH OF STAY IN INPATIENT FACILITIES (days per year)



Summary for Graph 2.6

The longest length of stay for user is in community residential facilities, followed by mental hospitals and those community-based psychiatric units.

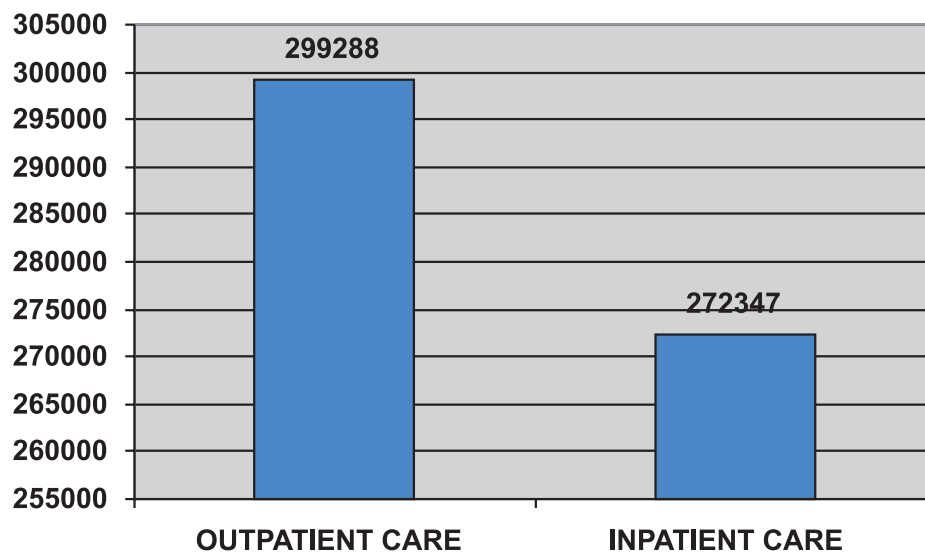
GRAPH 2.7 – AVAILABILITY OF PSYCOTROPIC DRUGS IN MENTAL HEALTH FACILITIES



Summary for Graph 2.7

The availability of psychotropic drugs in mental health facilities is mostly equal in mental hospitals, inpatient units and outpatients.

GRAPH 2.8 INPATIENT CARE VERSUS OUTPATIENT CARE



Summary for Graph 2.8

The ratio between outpatient/day care contacts and days spent in all the inpatient facilities (mental hospitals, residential facilities and general hospital units) is an indicator of extent of community care: in this country the ratio is 1.09:1.

Domain 3: Mental Health in Primary Health Care

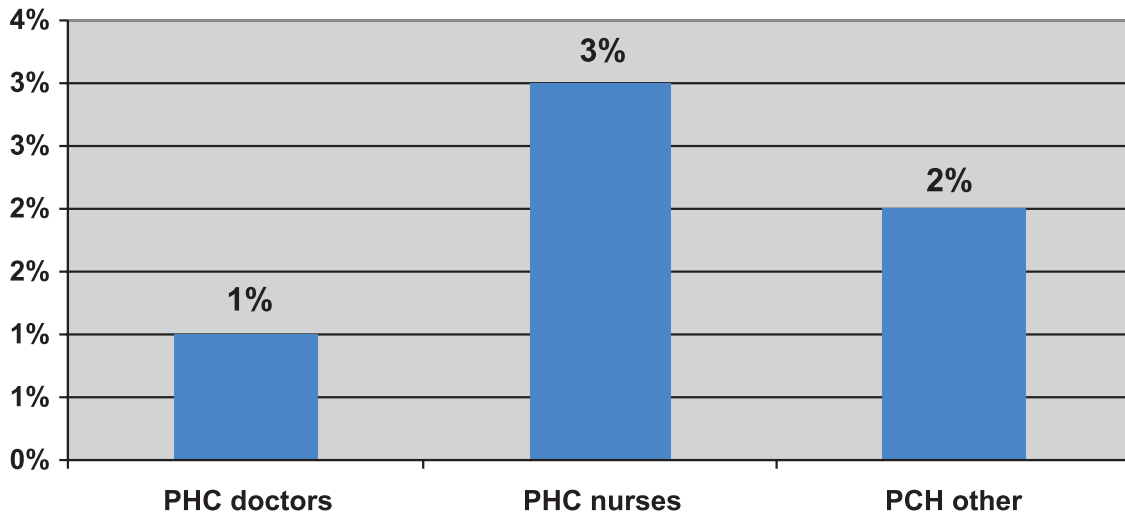
Training in Mental Health Care for Primary Care Staff

One percent of the training for medical doctors is devoted to mental health, in comparison to 13% for nurses and 0.28% for non-doctor/non-nurse primary health care workers. In terms of refresher training, 1% of primary health care doctors have received at least two days of refresher training in mental health, while 3% of nurses and 2% of non-doctor/non-nurse primary health care workers have received such training.

It was not possible to collect data on mental health care training given by other departments on using the health information data dictionary for mental health and their multiplier courses.

Graph 3.1: Percent of primary health care professionals with at least two days of refresher training in mental health in the last year

GRAPH 3.1 – % OF PRIMARY CARE PROFESSIONALS WITH AT LEAST 2 DAYS OF REFRESHER TRAINING IN MENTAL HEALTH IN THE LAST YEAR

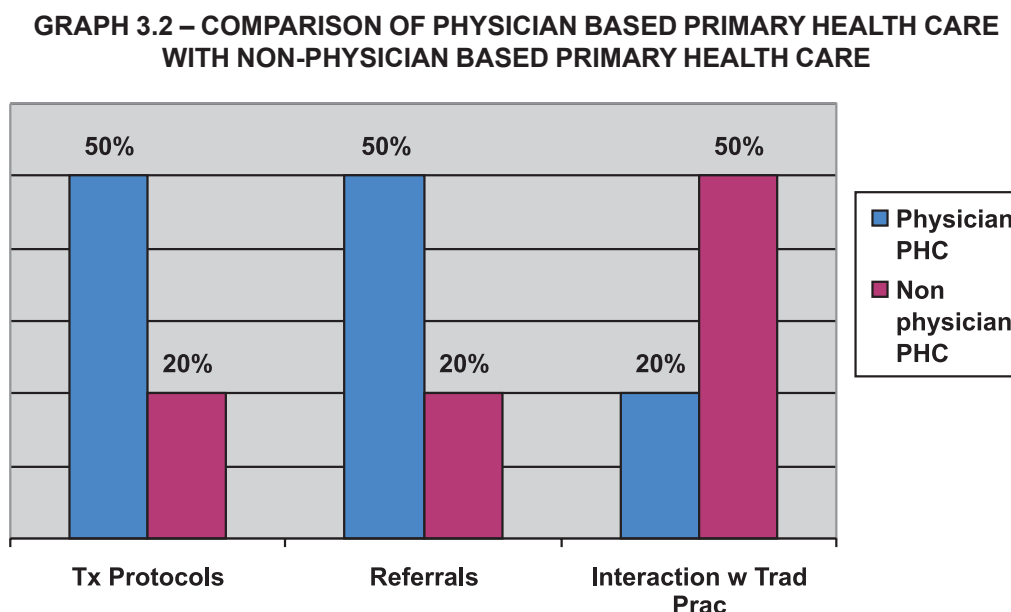


Mental Health in Primary Health Care

Both physician based primary health care and non-physician based primary health care clinics are present in the country. However, data on the rates of referrals, interactions with mental health services, and availability of mental health protocols is not available, so the following are based on best estimates. In terms of physician-based primary health care clinics, it is estimated that 21%-50% have assessment and treatment protocols for key mental health conditions available, in comparison to an estimated 1%-20% for non-physician-based primary health care clinics. It is estimated that 21%-50% of physician-based primary health care clinics make on average at least one referral to a mental health professional. Some, 1%-20%, non-physician based primary health care clinics make a referral to a higher level of care.

As for professional interactions between primary health care staff and other care providers, based on best estimates, 1%-20% of primary care doctors have interacted with a mental health professional at least monthly in the last year. A few, 1%-20% of physician-based primary health care facilities have had interaction with a complimentary/alternative/traditional practitioner, in comparison with an estimated 21%-50% of non-physician-based primary health care clinics, and an estimated 1%-20% of mental health facilities.

Graph 3.2: Comparison of physician-based primary health care with non-physician based primary health care



Prescription in Primary Health Care

Non-doctor/non-nurses primary health care workers are not allowed to prescribe psychotropic medications in any circumstance. Nurses are allowed to prescribe, but with restrictions (they are not allowed to initiate prescription but are allowed to continue prescription.) Primary health care doctors are allowed to prescribe psychotropic medications without restrictions.

In regards to the availability of psychotropic medicines, it is estimated that between 51%-80% of physician-based primary health care clinics have at least one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) in comparison to 1%-20% in nonphysician-based primary health care clinics.

Domain 4: Human Resources

Number of Human Resources in Mental Health Care

The total number of human resources working in mental health facilities or private practice is 265, at a rate of 0.477 per 100,000 general population. The breakdown according to profession is as follows: 89 psychiatrist, 13 other medical doctors (not

specialized in psychiatry), 127 nurses, 4 psychologists, 23 social workers, 1 occupational therapists, 8 other health or mental health workers (including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counsellors).

Seventy four percent of psychiatrists work only for government administered mental health facilities, 26% work only for NGO's, for profit mental health facilities and private practice, while none work for both the sectors.

All psychologists, social workers, nurses and occupational therapists work only for government administered mental health facilities; none work for NGOs, for profit mental health facilities and private practice.

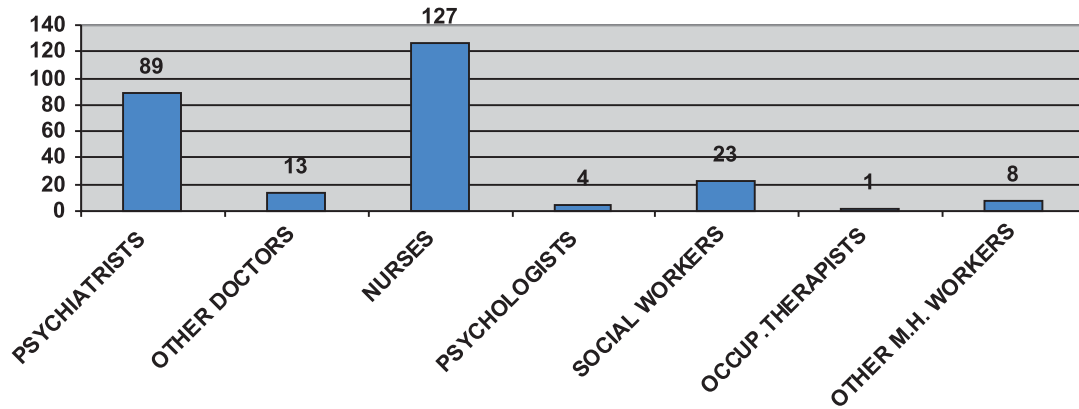
Regarding the workplace, 25 psychiatrists work in outpatient facilities, 19 in community-based psychiatric inpatient units and 18 in mental hospitals. Four other medical doctors, not specialized in mental health, work in outpatient facilities; there are none in community-based psychiatric inpatient units and nine in mental hospitals. As for nurses, 25 work in outpatient facilities, 19 in community-based psychiatric inpatient units and 108 in mental hospitals. There are no psychologists, social workers and occupational therapists in outpatient facilities, 20 in community-based psychiatric inpatient units and 4 in mental hospitals. As regards other health or mental health workers, none work in outpatient facilities or in community-based psychiatric inpatient units, and 8 work in mental hospitals.

In terms of staffing in mental health facilities, there are 19 psychiatrists (0.11 per bed) in community-based psychiatric inpatient units, in comparison to 18 psychiatrists (0.01 per bed) in mental hospitals. As for nurses, there are 19 nurses (0.11 per bed) in community-based psychiatric inpatient units, in comparison to 108 nurses (0.08 per bed) in mental hospitals.

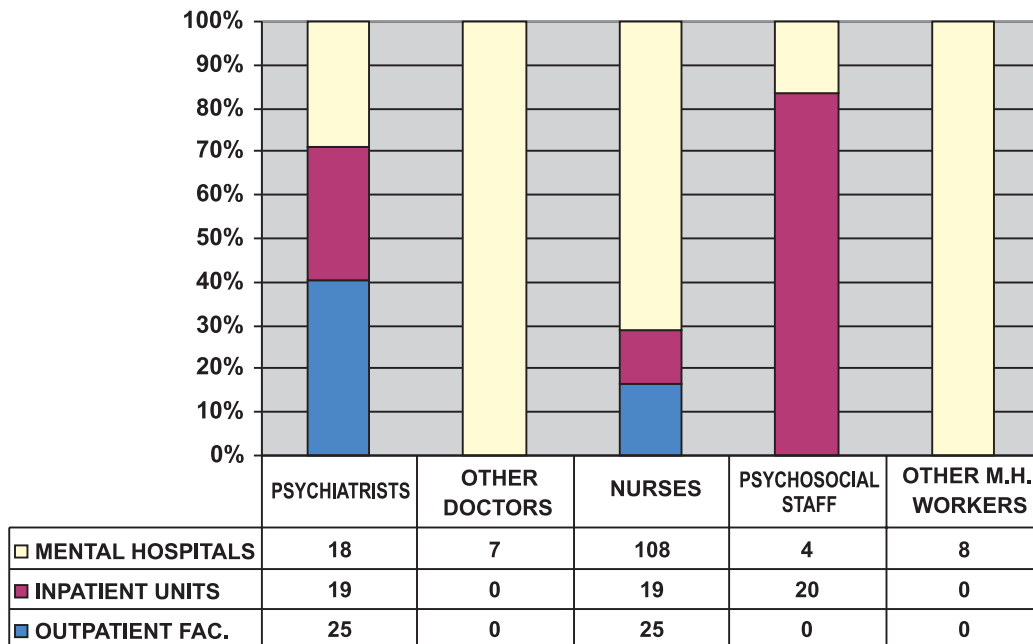
Finally, for other mental health care staff (e.g., psychologists, social workers, occupational therapists, other health or mental health workers), there are 20 social workers (0.12 per bed) for community-based psychiatric inpatient units, and 4 social workers (0.0028 per bed) along with 8 other mental health workers (0.01 per bed) in mental hospitals.

The distribution of human resources between urban and rural areas is mixed in terms of proportions. The density of psychiatrists in or around the largest city is 4.17 times greater than the density of psychiatrists in the entire country. The density of nurses is 1.74 times greater in the largest city than the entire country.

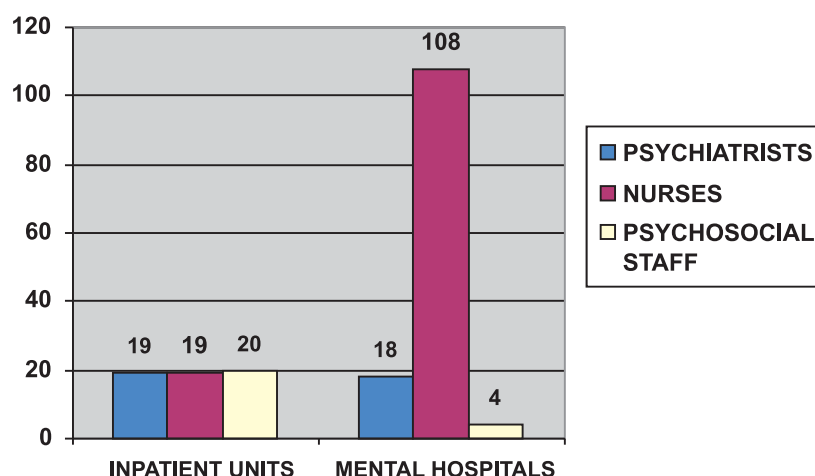
GRAPH 4.1 – HUMAN RESOURCES IN MENTAL HEALTH
(rate per 100.000 population)



GRAPH 4.2 – STAFF WORKING IN MENTAL HEALTH FACILITIES
(percentage in the graph, number in the table)



GRAPH 4.3 – RATIO HUMAN RESOURCES/BEDS



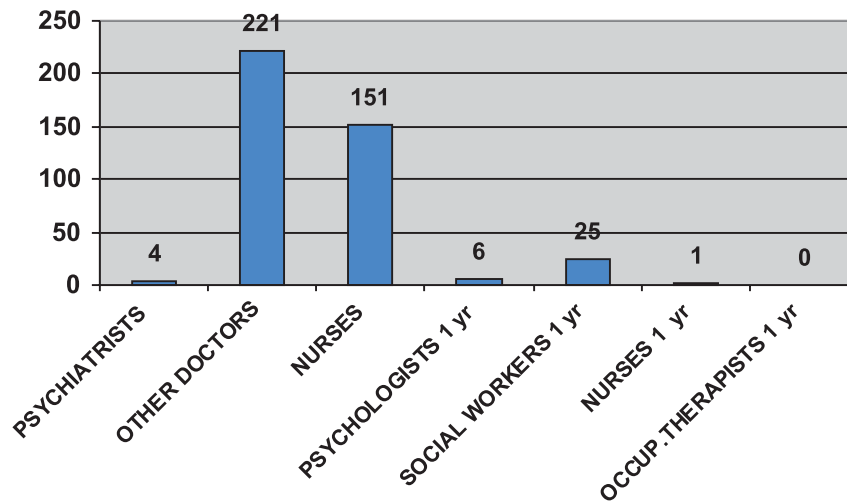
Training Professionals in Mental Health

The number of professionals graduated last year in academic and educational institutions per 100,000 is 0.736. These are as follows: 4 psychiatrists (0.007 per 100,000 general population), 222 other medical doctors (not specialized in psychiatry) (0.4 per 100,000 general population), 151 nurses with at least 1 year training in mental health care (0.27 per 100,000 general population), 6 psychologists with at least 1 year training in mental health care (0.01 per 100,000 general population), 1 social worker with at least 1 year training in mental health care (0.002 per 100,000 general population), and 25 occupational therapists with at least 1 year training in mental health care (0.045 per 100,000 general population).

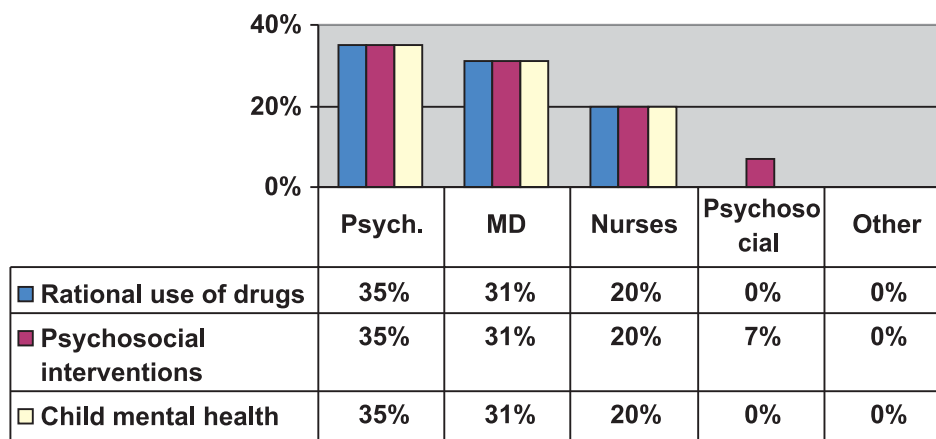
Based on best estimates, 1-20% of psychiatrist immigrates to other countries within five of the completion of their training.

The following graph shows the percentage of mental health care staff with at least two days of refresher training in the rational use of drugs, psychosocial interventions, and child/adolescent mental health issues.

GRAPH 4.4 – PROFESSIONALS GRADUATED IN MENTAL HEALTH
(rate per 100.000 population)



GRAPH 4.5 – PERCENTAGE OF MENTAL HEALTH STAFF WITH TWO DAYS OF REFRESHER TRAINING IN THE PAST YEAR



Consumer and Family Associations

There are neither users/consumers associations, nor family members associations. The government does not provide economic support for either consumer or family associations.

There are two also other NGOs, Myanmar Anti Narcotic Association (MANA) and Myanmar Maternal and Child Welfare Association (MMCWA) which are involved in individual assistance activities such as counselling and support groups.

Domain 5: Public Education and Links with Other Sectors

Public Education and Awareness Campaigns on Mental Health

There is a coordinating body to oversee public education and awareness campaigns on mental health and mental disorders. The government agencies that have promoted public education and awareness campaigns in the last five years are the Ministry of Health and the Department of Mental Health Services. The NGO's also involved in this work are MMCWA and MANA. Finally, there is the professional association, the Myanmar Medical Association (MMA), as well as WHO, who have also promoted public education and awareness campaigns in the last five years. These campaigns have targeted the general population, especially children and adolescent.

In addition, there have been public education and awareness campaigns targeting professional groups including health care providers (traditional medicinal medicine, conventional medicine, and modern medicine), the traditional sector², and teachers. There was also an awareness campaign in Nyaungdon Township for epilepsy with the support of WHO.

Legislative and Financial Provisions for Persons with Mental Disorders

The legislative and financial provisions do not exist to protect and provide support for users.

At the present time, there are no legislative provisions concerning legal obligation for employers to hire a certain percentage of employees that are disabled, concerning protection from discrimination (dismissal, lower wages) solely on account mental disorder, concerning priority in state housing and in subsidized housing schemes for people with severe mental disorders, or concerning protection from discrimination in allocation of housing for people with severe mental disorders.

² In Myanmar there is University of Traditional Medicine and Department of Traditional Medicine. They provide comprehensive health care through existing health care system in line with the National Health Plan.

Links with Other Sectors

In addition to legislative and financial support, there are formal collaborations with the departments/agencies responsible for primary health care /community health, HIV/AIDS, child and adolescent health, substance abuse, education, employment, welfare, and criminal justice.

In terms of support for child and adolescent health, no primary and secondary schools have either a part-time or full-time mental health professional, but 1-20% of primary and secondary schools do have school-based activities to promote mental health and prevent mental disorders.

The percentage of prisoners with psychosis and mental retardation is unknown. Regarding mental health activities in the criminal justice system, 1-20% of prisons have at least one prisoner per month in treatment contact with a mental health professional.

As for training, 1%-20% of police officers and no judges and lawyers have participated in educational activities on mental health in the last five years.

In terms of financial support for users, no mental health facilities have access to programs outside the mental health facility that provide outside employment for users with severe mental disorders.

Domain 6: Monitoring and Research

A formally defined list of individual data items that ought to be collected by all mental health facilities exists. As shown in the table 6.1, the extent of data collection is variable among mental health facilities: 83% in mental hospitals, 83% in community based inpatient units and 50% in outpatient facilities.

The government health department received data from two mental hospitals, 17 communities based psychiatric inpatient units, and 21 mental health outpatient facilities. Based on this data, a report was published which included comments on the data.

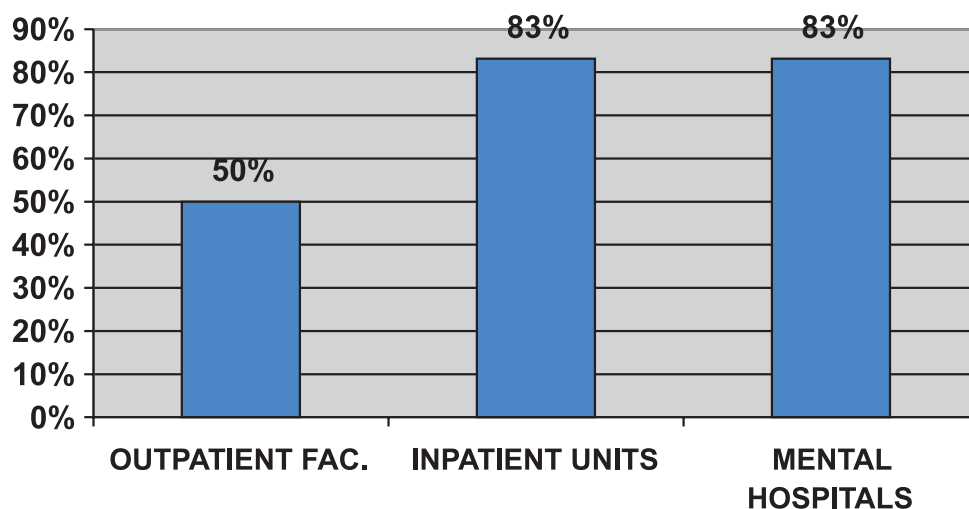
Health management information system (HMIS) data on mental health, including six mental disorders (psychosis, depression, alcohol use disorder, anxiety, mental retardation and epilepsy) from the whole country was collected and published with comments in the HMIS Report.

In terms of research, there were no mental health research publications in the country.

**TABLE 6.1 – PERCENTAGE OF MENTAL HEALTH FACILITIES COLLECTING AND
COMPILING DATA BY TYPE OF INFORMATION**

	MENTAL HOSPITALS	INPATIENT UNITS	OUTPATIENT FAC.
N° of beds	100%	100%	_____
N° inpatient admissions/ users treated in outpatient facilities.	100%	100%	100%
N° of days spent/user contacts in outpatient fac.	100%	100%	100%
N° of involuntary admissions	100%	100%	_____ _____ _____
N° of users restrained	0%	0%	_____ _____ _____
Diagnoses	100%	100%	100%

GRAPH 6.1 – PERCENTAGES OF MENTAL HEALTH FACILITIES TRANSMITTING DATA TO HEALTH



Strengths and Weaknesses of the Mental Health System in Myanmar

Mental Health Hospitals are mainly focused on the curative aspects of mental health and serve as a referral and specialist hospitals. There are both out patient and in patient services in these hospitals. The out patient department in these hospitals are attended by patients with mild psychiatric disorders whereas the in-patients have more severe mental illness. However, these hospitals may also need to look into and also focus on the promotive and preventive aspects of mental health.

There are consultant psychiatrists in States/Divisions as well as in the District Hospitals. The network (i.e. referral system) is well established in which patients may be referred from the district to the State/Division and to the specialist mental health hospital either in Yangon or Mandalay.

A community based mental health care programme has been implemented as a pilot project in one township where basic health workers have been trained to diagnose people with mental disorders and make appropriate referrals to mental health facilities. These basic health workers also monitor whether patients are taking the prescribed medication regularly and monitor progress. However, there is a need to sustain this programme both in terms of being able to provide medication on a regularly basis and also to regularly provide refresher training courses to the basic health workers. There is also a need to expand this programme to other townships in a phased manner.

There is also a need for training and deployment of clinical psychologists in mental health. An appropriate training course is currently being developed for clinical psychologists to address this issue.

The mental health information system is part of the Health Management Information System from the Department of Health Planning which is comprehensive and has been strengthened.

Next Steps in Planning Mental Health Action

WHO AIMS data will serve as a baseline for the future development and capacity building for the mental health care system including community based mental health care in Myanmar.

A workshop for the formulation and development for the five year strategic plan for strengthening mental health is proposed to be conducted. Funds to conduct this workshop may be explored either from the regional office or WHO Headquarters. Participation will be by senior officials from the Department of Health Planning, Department of Health and Consultant Psychiatrists from States/Divisions and districts. The objective of the workshop will be to advocate and formulate strategies for the way forward to further strengthen and build capacity for the mental health care system in Myanmar. The output of this workshop will be the document “Five year strategic plan for strengthening mental health” which will address issue such as:

- Current Mental Health situation
- Goal, objectives and strategic directions
- Programme and implementation approaches
- Logical framework
- Detail work-plan
- Monitoring and evaluation matrix

This document will also serve as an advocacy document and will also serve as a document for resource mobilization.

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Myanmar. This will enable Myanmar to develop information-based mental health plans with clear base-line information and targets.

Myanmar has a mental health policy which is incorporated with the general health policy document. Mental health expenditure is 0.3% of total health care expenditures.

There are 25 outpatient mental health facilities, 2 day treatment facilities, 17 community-based psychiatric inpatients units and 2 mental hospitals. Schizophrenia and neurotic disorders are the most frequent diagnoses in out-patient facilities, and schizophrenia and mood disorders are the most common diagnoses in mental hospitals.

Primary health care doctors are allowed to prescribe psychotropic medications without restrictions. There are 89 psychiatrists (0.016 per 100,000 population), four psychologists (0.01 per 100,000 population), 23 social workers (0.04 per 100,000 population) and one occupational therapist (0.002 per 100,000 population).

There have been public education and awareness campaigns targeting professional groups including health care providers (including traditional medicinal medicine, conventional, and modern practitioners).

The Department of Health Planning monitors data collected from the whole country. This data includes data on mental health, which is analyzed and published yearly.