

1. Summary of Crisis

Context
On 1 February 2021, the Myanmar military took over power from the democratically elected government at the time and declared a state of emergency country wide (UNDSS, 2022). Civilians launched a “civil disobedience movement” (CDM) – considered a peaceful form of political protest – with large parts of the civil service across many sectors, including the health sector. There were massive peaceful protests by the general public after the coup with the intent to express dissent and opposition to injustice which impacted the military’s ability to govern (UNDSS, 2022). To date, more than 2,377 people have been killed due to the conflict including an estimated 188 children (OCHA, 2022). Civic society sources indicate that a total of 16,129 protesters were arrested between 1 February 2021 and 9 November 2022 including 12,918 still detained including sentenced by the military (AAPP, 2022).

Overall security and humanitarian needs have worsened across the country as conflict continues to rage, causing unprecedented levels of population displacement, destruction of property, and land mine contamination (OCHA, 2022). Between January and July 2022 alone, UNICEF recorded 206 casualties from landmines and explosive remnants of war (ERW) (OCHA, 2022). As of 7 November 2022, there were an estimated 1,440,100 internally displaced people (IDPs) across the country, including 1,019,700 people who have been newly displaced within the country since 1 February 2021 (UNHCR, 2022). Furthermore, due to the COVID-19 pandemic since 2020 and conflict-induced poverty in late 2021, Myanmar’s economy contracted by at least 10%, triggering a cash crisis (UNDSS, 2022), rapid devaluation of the Myanmar Kyat, and further economic distress with soaring prices of essential commodities, including food and fuel (OCHA, 2022). Compounded by the continuing impact of the COVID-19 pandemic, and more intensifying armed conflicts across the country, the entire country has fallen into a vulnerable state with significant human suffering and with reversal of many of the development gains made in recent years.
Situation in protracted emergency – grade 2 - in Rakhine, Kachin, and Northern Shan

Prior to the takeover, protracted conflict-affected areas had been limited to the states of Rakhine, Kachin and Northern Shan. Since the military takeover, the conflict has further escalated across multiple states and regions in Myanmar, particularly in the Northwest and Southeast, leaving people displaced and in severe humanitarian needs, with no signs of abating. (OCHA, 2022).

Since, the 1 February 2021, and as of the 7 November 2022, the number of people displaced have increased to 188,300 (from 183,300 prior 1 February 2021) in Rakhine State (Central), to 40,300 (from 35,700) in Rakhine State North, to 104,600 (from 91,500) in Kachin and to 16,600 (from 9,000) in Northern Shan (UNHCR, 2022).

People are taking shelter in neighbouring communities and in jungles and forests with limited access to assistance. The majority of those displaced are dependent on humanitarian support for their survival.

Acute armed clashes in Rakhine and Southern Chin

Heavy fighting between the Myanmar Armed Forces (MAF) and the Arakan Army (AA) has continued across Rakhine and Southern Chin in the Northwest. As of 27 September 2022, more than 17,400 people have been newly displaced, bringing the total number of internally displaced persons (IDPs) from past and present AA-MAF fighting to more than 91,000, according to UN latest figures. The affected locations are Buthidaung, Kyauktaw, Maungdaw, Minbya, Ponnagyun, and Rathedaung townships in Rakhine and Paletwa township in Southern Chin. Key roads and waterways remain blocked in Northern Rakhine, restricting the movement of civilians and preventing humanitarian assistance from reaching people in need. Most of the humanitarian response in Buthidaung, Maungdaw, Minbya, Mrauk-U, Myebon and Rathedaung townships has been suspended since 15 September 2022 after the restrictions on the UN and INGOs delivering assistance by the de facto authorities to these key six townships, causing shortages in food, shelter and other relief items. Delays are being observed on the key transportation route between Yangon and Sittwe, Rakhine state capital, which will contribute to the rising prices of commodity and impacted movement of relief items. Safe, unimpeded access and funding are urgently needed to address expected shortages in contingency supplies, especially for WASH, health, food, shelter and non-food items.

Impact on health system and health services

Ongoing hostilities, insecurity, economic stress, and soaring inflation are significantly impacting the health, lives, and safety of people across Myanmar.

The military takeover of 1 February 2021 and, on the other hand, the Civil Disobedience Movement have severely impacted the health system and availability and accessibility of health services, from the highest levels in the Ministry of Health (MoH) to frontline basic health staff within the public sector. The deteriorating health services is continuing worsening from week-on-week. While provision of essential health care services in the public sector has resumed to a certain extent in some big cities like Nay Pyi Taw, Yangon, Mandalay compared to the early days of the military takeover, the overall access environment remains heavily constrained with a strong reliance on and risk transfer to low-profile local responders (OCHA, 2022). Life-saving health services are still seriously disrupted in the conflict-affected areas and current access restrictions are obstructing the transportation of medical supplies and mobile clinic activities, particularly in Rakhine and Kayah states (OCHA, 2022). Curfew orders (12 midnight to 4 am in townships in Yangon) and martial law orders limiting movement at night according to security situation, have also been posing extreme challenges for emergency referral services.

In many places, public health surveillance systems including for communicable diseases have been severely disrupted, affecting overall capacity for early detection, verification, and rapid response. Currently, national reporting systems including the District Health Information Software 2 (DHIS2) are no longer functional, making it difficult to capture granular information on key indicators of health programmes and status of Myanmar’s overall health system and health services.

There also continues to be a shortage of health care workers due to many government workers being involved in the CDMs, with some reportedly being arrested, intimidated, forced to resign, or forced to return to work.
Others have resigned of their own accord, gone into hiding, or are incommunicado with the toll of resigning health care workers mounting, including those in critical strategic and technical roles. Increasing personnel safety concerns have also forced humanitarian health partners to temporarily suspend some mobile clinic outreach services in the conflict-affected areas with many INGOs no longer permitted to continue operations.

Furthermore, a new Organization Registration Law has been adopted on 28 October 2022 and might impact several aspects of the NGO operations. While it has been in discussion before the military takeover, since February 2021, many NGOs with expired registrations who have applied for renewal were informed that the registration process was suspended until the new law comes into effect. As a result, several NGOs with expired registrations have been unable to renew their registrations in the meantime. The impact on health services is currently being reviewed.

This has severely affected access to essential services for some of the most vulnerable populations with pre-existing humanitarian health needs in Rakhine, Kachin and Northern Shan, which are now going unmet.

Myanmar has a history of relatively limited healthcare, understaffed, underfunded and under equipped with low availability of essential medicine in public and private hospitals, especially in rural areas. In 2019, 1.2% or approximately 662 724 people were reported being pushed into poverty (at US$ 1.90 level) because of out-of-pocket health spending – at a level of 76% - and 12.7% of people were spending more than 10% of their household’s total expenditure on health care defined as catastrophic health care expenditure (Source: Monitoring progress on universal health coverage and the health-related Sustainable Development Goals in the South-East Asia Region - 2022 update).

The protracted crisis in Rakhine, Kachin and Northern Shan and across country in Myanmar have had profound impacts on the health system and health services. Combined with political and socio-economic crisis, critical problems related to physical and mental wellbeing have been impacting people living in conflict-affected areas, most felt by the population groups (displaced, returned, stateless and other crisis-affected).

From an operational perspective, procurement and supply management has also been affected as there are severe limitations on both international and local logistics systems. Clearance processing, including tax exemption certificate issuances and customs clearance for importation of goods have been disrupted since 1 February 2021. If this continues, there is a serious risk of shortage of essential medicines supplies in the country, possibly affecting all health programmes.

### Humanitarian profile, Myanmar Humanitarian Response Plan 2022

<table>
<thead>
<tr>
<th>Population in need of humanitarian assistance</th>
<th>Population in need of humanitarian assistance</th>
<th>Returnees/resettled/locally integrated</th>
<th>Non-displaced stateless people in Rakhine state</th>
<th>Other vulnerable crisis affected people</th>
</tr>
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<tbody>
<tr>
<td>14.4 M</td>
<td>556K</td>
<td>74K</td>
<td>470K</td>
<td>13.3 M</td>
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The humanitarian profile is currently being updated for 2023 and should be updated by end of November 2022.

Map 1: Number of people displaced since February 2021 and remain displaced. Myanmar Emergency Overview.
Source: UNHCR. Myanmar Emergency Overview Map, Number of people displaced since Feb 2021 and remain displaced (as of 7 November 2022) [UNHCR, 2022]
2. Health Status and threats

Population mortality

- Maternal mortality ratio 2017: 250 per 100,000 live births (Myanmar Health Statistics 2020, p59)
- Under 5 Mortality Rate (UMMR), 2019: 44 deaths per 1,000 live births (Myanmar Health Statistics 2020, p59); UMR, 2019: 45 per 1,000 live births (Levels and Trends in Child Mortality: 2020 Report. United Nations Inter-Agency Group for Child Mortality Estimation or IGME 2020)
- Infant Mortality Rate (IMR), 2019: 35 per 1,000 live births (Myanmar Health Statistics 2020, p59); IMR, 2019: 36 per 1,000 live births (IGME 2020)
- In 2018, top ten causes of mortality were attributed to pregnancy and delivery-related causes, septicaemia, head and intracranial injuries, heart failure, stroke, primary hypertension, pneumonia, respiratory Tuberculosis (TB) (Myanmar Health Statistics 2020, p58)
- Nearly three-fourths of all deaths in 2016-2017 as per the national causes of death survey were attributable to non-communicable diseases (NCDs); whereas only one-fifth were attributable to maternal, nutritional, neonatal causes (Myanmar Health Statistics 2020, p58)
- Among deaths due to communicable diseases, leading cause is pneumonia followed by TB, HIV-AIDS and malaria (Myanmar Health Statistics 2020, p58)
- Among deaths due to NCDs, leading cause is stroke followed by chronic respiratory diseases, ischemic heart diseases, cirrhosis, diabetes (Myanmar Health Statistics 2020, p58)
- Among deaths due to injuries, leading case is road traffic accident followed by fall. (Myanmar Health Statistics 2020, p58).
- Since 1 February 2021 to date, more than 2,316 people have been killed due to the ongoing conflict including an estimated 188 children (OCHA, 2022).

Vaccination coverage

Routine Immunization (EPI) lunched in 1978 in Myanmar and the country has steadily been improving coverage with support of WHO, UNICEF & GAVI. The Myanmar Expanded Programme on Immunization (EPI) programme has been successfully implementing immunization activities and providing 13 antigens free of cost through a wide network of vaccine delivery points across the country. New immunizations were introduced even during the pandemic year 2020 (rotavirus vaccination, from February 2020, and Human Papilloma virus, from October 2020). Japanese encephalitis had been added to the national EPI calendar from December 2017.

Figure 1: Time trends of childhood immunization coverage in Myanmar. 1980 - 2021.

Data source: WHO. Immunization data. (WHO, 2021)
Impact

The first wave of the COVID-19 pandemic in March 2020 affected many aspects of the health system in Myanmar including routine vaccination (RI), which was suspended for three months and resumed until the military takeover on 1 February 2021, after which EPI activities showed further decline in all states and regions (less so in Rakhine state).

As a result, EPI coverage dropped below 50% or more for many vaccination types in 2021 including for BCG (48.2%), DTPCV1 (44.9%), HEPB3 (37.2%), MCV1 (43.9%), MCV2 (42.2%), and IPV1 (45.8%) (WHO, 2021) thereby increasing the risk for outbreaks of vaccine-preventable diseases (VDP) like measles, diphtheria and polio Figure 1.

However, there is progress in terms of number of townships re-starting Routine Immunization (RI) since mid-2021. Of the total 330 townships, 297 reported RI coverage data in 2021. The annual EPI review meeting was conducted on 6 - 7 June 2022 where further steps to improve vaccination coverage and implementation activities were discussed. Any disruption of immunization services, even for short periods, will result in accumulation of susceptible individuals, higher dropout, and higher likelihood of vaccine-preventable disease (VPD) outbreaks. The EPI programme needs the support and cooperation to implement effective recovery plan for routine immunization of eligible children who missed immunization during service interruption period from the personnel of MoH, some of whom are currently observing civil disobedience.

Priority health threats

Table 1 summarises the current analysis of the magnitude (in terms of excess morbidity and mortality) of different health problems impacting the crisis-affected population, grouped into major disease types. Changes in the projected magnitude of these problems are also shown for the next two (Nov-Dec), five (Jan – May’23), and eight months (Jun – Dec ‘23).

<table>
<thead>
<tr>
<th>Public Health Risk</th>
<th>2022 (Nov – Dec)</th>
<th>2023 (Jan – May)</th>
<th>2023 (June – Dec)</th>
<th>Rationale</th>
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<tr>
<td>COVID-19</td>
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<td>COVID-19 related activities including genomic surveillance, laboratory testing, case management, and vaccinations have been resumed in some parts of the country despite continued limited access to these services in the conflict-affected areas (12 States/Regions out of 18). However, while population immunity is growing (either naturally and vaccination) and currently circulating variant/sub-lineages are not associated with severe diseases in majority of the population, there is still concern about our ability to assess and monitor known and new VOCs because of reduced surveillance and sequencing activities, not just in Myanmar, but globally. Furthermore, it remains unknown whether the next variant will be more or less severe than currently circulating variants and whether the next variant will have further immune escape; the extent of waning in Vaccine Effectiveness (VE) over time across vaccine platforms, particularly in populations at highest risk of severe disease; and the impact of the reduction in testing and sequencing on the ability to detect and monitor the transmission of SARS-CoV-2 variants including new variants. Other factors like the overstretched health care capacity due to concurrent emergencies and humanitarian crises in the country along with general gaps in knowledge about long-term impact of “long COVID” on human health could have devastating impact on overall mortality and/or morbidity in Myanmar.</td>
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<td>Monkeypox</td>
<td>Myanmar has not reported any monkeypox cases to date and only sporadic cases (n=23) have been reported in the region from three countries (India, Thailand, and Indonesia) including one death from India. There are no reports of sustained transmission chains anywhere in the region and the current global case fatality rate (CFR%) for monkeypox stands at 0.04%. However, if cases continue to be reported in neighbouring countries like India and Thailand over the next couple of months, given their long porous borders with Myanmar and high mobility due to the current crisis, there is a moderate risk of imported cases into Myanmar. In such an event – given the vulnerability of health care systems in the country including limited surveillance and response capacities – we can expect monkeypox to make a minor contribution to excess mortality or morbidity over the coming months if current humanitarian crises conditions do not improve. Furthermore, limited access to monkeypox preparedness and response policy/plan may challenge the country’s effort for timely response and control activities and difficulties with access to treatment and vaccination threatens additional risk of morbidity and mortality for the vulnerable groups in the event of an outbreak.</td>
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<td>Vector-Borne Diseases</td>
<td>End of rainy season but VDB cases will continue albeit lower than June-Sept but higher than Jan – May. There are also reports of malaria drug shortages as of October 2022. Excess morbidity and mortality from malaria can continue to be expected in the next two months.</td>
<td>Vector borne diseases (VBDs) like Malaria and Dengue are endemic in Myanmar with seasonal peaks during the monsoon season (June – August). While considerable progress had been made in the previous years with the reduction of morbidity and mortality related to the infections, recent events continue to hamper public health efforts with:  • Limited ability/access to carry out vector control and surveillance activities  • Interrupted test-treat services at public health facilities  • Treatment shortages and inability to access timely diagnosis In addition, many displaced and vulnerable population are living in temporary shelters, and on international borders where almost 80% of the malaria cases are concentrated. In 2022, the number of malaria cases including for P. falciparum + Mix cases, P. vivax, and overall positivity rate (%) were much higher as of June compared to the same periods in the previous two years. Due to significant increase in the number of malaria cases in the monsoon season (June-September 2022), and to constrains on restrictions on the movement of transport of medical supplies in crisis-affected communities, there is continue risk of shortage of drugs, diagnostic rapid-tests and long-lasting insecticidal bed nets (LLINs).</td>
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<td>Risk of epidemics</td>
<td>Risk of resurgence of vaccine preventable diseases (e.g., diphtheria, measles, polio, viral hepatitis etc). Risk for Acute Watery Diarrhoea (AWD) and Cholera given worsening WASH conditions, especially for IDPs internally displaced people in the northwest, southeast and vulnerable populations in the peri-urban areas of Yangon (UNICEF, 2022).</td>
<td>The functions of National surveillance and laboratory system are still very limited especially for the conflict areas which hampers timely detection and rapid response. Immunization (EPI) activities have been disrupted across the country since February 2021 and as a result, EPI coverage dropped below 20% or more for many vaccination types in 2021 including for BCG (48.2%), DTPVCV1 (44.9%), HEPB3 (37.2%), MCV1 (43.9%), MCV2 (42.2%), and IPV (45.8%) (WHO, 2021). By increasing the risk for outbreaks of VDPs like measles, diphtheria and polio. In addition, with more than 1.3 million mobile population across the country, there is a risk for outbreaks occurring across more communities and even putting neighbouring countries with shared borders at risk. Without efficient and effective preparedness, risk for seasonal disease and other outbreaks like influenza, cholera also increases. A Multi-Sectorial Need Assessment in August which showed that 44% of IDP households who reported sharing sanitation facilities, on average shared with 12 households (UNICEF, 2022). Moreover, 31 per cent of IDP households in Rakhine and Sagaing reported not having access to handwashing facilities with both water and soap (UNICEF, 2022).</td>
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<td>Malnutrition and child health</td>
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<td>Five million children in Myanmar need humanitarian assistance and many internally displaced children are living in overcrowded conditions in IDP camps where they cannot access essential health services, including immunization (UNICEF, 2022). In September 2022, approximately 650 children aged 6-59 months (299 boys and 351 girls) with severe acute malnutrition (SAM) were provided with life-saving treatment and at least 37,503 children have been diagnosed as suffering from malnutrition (UNICEF, 2022). The continued public health service disruption in Myanmar will further affect the health promotion and nutrition services at the community level, leading to aggravation of malnutrition and increases in children’s morbidity and mortality. Finally, soaring inflation and subsequent increase in prices for food and fuel increase the risk for food insecurity and malnutrition among the most vulnerable populations.</td>
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Access to antenatal care, delivery care, postnatal care, family planning, and child health care were already suboptimal for many of these areas affected by the humanitarian crises and conflicts compared to the national average even before the current events. The direct impact since has been a scarcity of essential and lifesaving medicines, medical equipment, and medical staff which together has significantly impacted access to all these services for many of the vulnerable population in these states/regions, increasing the risk for morbidity and mortality due to untreated obstetric and neonatal complications among other conditions. This is further exacerbated by the fact that availability and access to contraceptives has worsened for the most vulnerable, increasing unwanted pregnancies and unsafe abortions. In addition, disturbances in transportation and curfews have impacted the emergency referral systems endangering lives of mothers, new-borns and children.

Although some disruptions can be compensated by service provision from charity clinics and private health facilities, these are short-term, non-sustainable measures.

| Reproductive, maternal, new-born, child, and adolescent health | Access to antenatal care, delivery care, postnatal care, family planning, and child health care were already suboptimal for many of these areas affected by the humanitarian crises and conflicts compared to the national average even before the current events. The direct impact since has been a scarcity of essential and lifesaving medicines, medical equipment, and medical staff which together has significantly impacted access to all these services for many of the vulnerable population in these states/regions, increasing the risk for morbidity and mortality due to untreated obstetric and neonatal complications among other conditions. This is further exacerbated by the fact that availability and access to contraceptives has worsened for the most vulnerable, increasing unwanted pregnancies and unsafe abortions. In addition, disturbances in transportation and curfews have impacted the emergency referral systems endangering lives of mothers, new-borns and children.

Although some disruptions can be compensated by service provision from charity clinics and private health facilities, these are short-term, non-sustainable measures. | |
| HIV/TB | Though there was no shortage of ARV supply in general, delivering the medicines to the service delivery sites in conflict areas remain challenging and hampers efforts to maintain essential HIV services. HIV prevention and harm reduction services were being provided but the coverage was low. Rapid ART initiation and comprehensive HIV care need to be reinstated. Due to service interruption and possible drug shortages especially for drug resistant (DR)-TB patients, there is an increased risk for morbidity and mortality among TB patients. This can also increase risk of TB transmission in the community due to the large number of mobile populations, overcrowding in IDP camps, prisons, and detention centres. Nearly 150K TB cases were missed after the crises and almost 30,000 TB deaths are expected in 2022 according to estimates. Furthermore, almost 15% of TB cases also have HIV and an estimated 18K new cases a year are expected. In Yangon, almost 600/100,000 people have Drug Resistant TB (DR-TB) and nearly 80% of the cases are missed. | |
| Viral Hepatitis | Prevalence of hepatitis B is 6.51% and hepatitis C is 2.65% in general population, i.e., approximately 3.5 million and 0.85 million people respectively living with these chronic infections. If undetected, these can cause significant mortality. In 2021, Hep 8 third dose vaccination fell to <40% from an average of 90% over the last few years and the current situation has caused significant disruption in Hepatitis C treatment. According to a recent study, without treatment scale-up, 333,000 new HCV infections and 97,000 HCV-related deaths were estimated to occur in Myanmar 2020–2030 (Scott, 2021). Furthermore, people who inject drugs (PWID) can be more vulnerable to infectious diseases such as HIV, Hepatitis C (HCV), tuberculosis, poor mental health conditions among others. However, the inter-relationship between drug production, conflict and violence and the health of PWID is less well described. A recent study to investigate health outcomes and associated factors including armed conflict and its consequences among people who use illicit drugs in Afghanistan, Colombia and Myanmar found that access to effective harm reduction services in rural locations in Myanmar remain insufficient, creating conditions for rapid rise in HIV and HCV (D’Brien, 2022). | |
| Trauma | Escalating conflict and violence in many parts of the country and particularly in the Northwest and Southeast, along with other fatal incidents, including landmines and explosive remnants of war (ERWs) increases the risk for excess morbidity and mortality from various forms of trauma. Furthermore, limited access to health care hampers much of the affected population from receiving lifesaving injury and trauma care (OCHA, 2022). | |
| NCDs and cancer | According to the latest available data, NCDs and cancer contributed to 71% all deaths in Myanmar with proportional mortality of 31% for cardiovascular diseases, 13% for Cancers, 10% for Chronic Respiratory diseases and 6% for Diabetes (WHO, 2020). Current break down of the health systems which was already over stretched from the COVID-19 pandemic, and ongoing difficulties with humanitarian aid delivery access are affecting continuity of essential drug supply, access to diagnosis and treatment, and over all disruption of NCD prevention and care activities. | |
| Mental Health | A 2020 report indicated that the prevalence of mental distress was 18.0% for men and women aged 18-49 years from Yangon region (Aye, 2020). The rate is higher for women (21.2%) compared to men (14.9%) (Aye, 2020). Another | |
Current support on building climate resilient health systems is on hold. This has impacted the ongoing work on development of climate resilient healthcare facilities, sanitation safety and water safety plans, establishment of air pollution surveillance system, and awareness on climate sensitive diseases. While extreme weather events do not become disasters on their own, the level of impact is influenced by the vulnerability of the affected population. Currently, many in Myanmar are vulnerable to such impacts given their social and economic situation as well as overall conflict and humanitarian crisis situation in the country.

In addition, natural disasters such as flooding and tropical storms increase the risk of zoonotic diseases like leptospirosis and Rickettsioses. In Myanmar – both of which are underreported in the country.

Lastly, in September 2022, rodent infestation (rats) in the crop fields of Kachin was reported. While this is currently a food security issue, the risk of zoonotic diseases from these rodents cannot be ruled out. Historically, these rodent infestations occur right after the rainy season or bamboo flowering event, which occurs every 30–50 years. Furthermore, there have been historic plague outbreaks in Myanmar including bubonic plague—all of which can lead to high morbidity/mortality in the population.

COVID-19

- New COVID-19 cases and deaths continue to be reported in Myanmar. Since the later part of August 2022, the number of weekly COVID-19 cases has been increasing in Myanmar with 21 COVID-19 reported deaths after April 2022. While population immunity is growing (either naturally and vaccination) and currently circulating variant/sub-lineages are not associated with severe diseases in majority of the population, it is unpredictable what types of variants/sub-lineages may emerge, and the possibility of emergence of highly immune invasive variants/sub-lineages or those associated with severe diseases cannot be ruled out. Continued vigilance is critical.

Figure 2: COVID-19 cases and deaths by day. January 2020 - October 2022

COVID-19 response activities including genomic surveillance, laboratory testing, case management, and vaccinations have been resumed in some parts of the country despite continued limited access to these services in the Conflict-affected areas (12 States/Regions out of 18).

Daily testing output for Q3 2022 is 695,412 whereas 1,566,701 for Q3 of 2021. Despite meeting WHO benchmark of COVID-19 testing, the majority of testing happens only in the testing accessible areas. These numbers represent the total of tests on all platforms combined. Information from private sector can’t be integrated to the de facto MoH platform.

Under present circumstances, Covax is unlikely to issue the share of vaccines that had been allocated to Myanmar, and there is also a risk that also bilateral vaccine procurement deals may not proceed further. While the military government reported 1.88 m vaccines utilized (GNLM, 22 Apr 2021), neither WHO nor the partners are able to verify this report.

WHO COVID-19 response is continuing to support the de facto MoH with procurement for commodities like laboratory reagents and consumables including for genomic sequencing, and equipment for clinical care. However, it is still challenging to provide support for the conflict areas either through the de facto MoH or through partners. Access to COVID-19 testing facilities is very limited, particularly for the low socioeconomic population.

Resurgence of COVID-19 in Myanmar is very likely due to; limited capacity for surveillance including genomic surveillance for monitoring of variants and sub-variants, limited and absence evidence informed public health and social measures or PHSM; limitation of skilled health staff; relative lack of infection prevention and control (IPC) measures; and limited treatment and care capacity. In addition, gatherings are allowed, and community mobility is back to normal. In general, most people usually wear masks in such gatherings, but not necessarily to social distancing, hand hygiene or respiratory etiquette. COVID-19 resurgence can affect neighbouring countries of Myanmar, which are also a destination of a significant number of documented and undocumented Myanmar migrants.

Limited access to COVID-19 disaggregated data hampers the country’s effort for timely response and control activities.

**Monkeypox**

- No monkeypox cases have been reported in Myanmar to date.
- The National Health Laboratory as well as National Reference laboratory based in Yangon is currently conducting laboratory diagnosis of Monkeypox (MPX) with PCR testing. Testing accessibility is limited to these labs and due to the limited performance of the surveillance, new infection with MPX may go undetected.
- Procurement support for Monkeypox response, e.g., laboratory reagents and consumables, equipment for Monkeypox is ongoing but, medicines are not available for treatment of Monkeypox.
- Vaccines for monkeypox disease are not available in Myanmar for pre-exposure or post exposure prophylaxis.
- Risk communication and community engagement activities are very limited at national level and provincial levels as well.
- Surveillance and contact tracing mechanisms are not in place and thus, once confirmed cases are reported, there will be a likely surge in cases with limitation to testing, medication and vaccine. The increase in Monkeypox cases could also spread to neighbouring countries which are also a destination of a significant number of documented and undocumented Myanmar migrants.

Very limited information from the de facto MoH which challenges effective implementation of the country’s preparedness and response activities.
Endemic Infectious diseases

Malaria

Situation: Malaria is endemic in Myanmar and had the third highest burden among countries in the Southeast Asia region. Distribution of malaria is heterogenous in the country with peak season occurring during the months of June-August coinciding with the monsoon season. Over 43 million people are at risk for Malaria in Myanmar and over 85% of malaria cases lies along the international border which have ongoing emergencies, and armed conflict. Map 2.

Impact: In 2021, a total of 79,001 malaria cases had been reported with predominant species as P. vivax (81%) (National Malaria Control Programme). While the primary malaria vectors are still susceptible to pyrethroids and antimalarials with over 95% effectiveness, malaria immunity among people residing in low transmission areas is declining. Therefore, migration patterns from low to high transmission areas put those people at risk with high potential for outbreak and resurgences.

The ongoing humanitarian crises and conflict situation has led to a breach in service delivery (malaria test-treat) through public health care facilities and disrupted the supply of malaria commodities. Most of the test-treat activities are ongoing from the integrated community malaria volunteers at the village level. Currently, there is an urgent need for malaria drugs (particularly chloroquine and primaquine), diagnostic rapid-tests and long-lasting insecticidal bed nets (OCHA, 2022). In 2022, the number of malaria cases including for P.Falciparum + Mix cases, P.vivax, and overall positivity rate (%) were much higher as of June compared to the same period in the previous two years Figure 3. Significant increases in the number of reported malaria cases are being driven by the monsoon and restrictions on the movement of people and supplies into crisis-affected communities (OCHA, 2022).

Figure 3: Malaria cases and positivity trends in 2022 vs. 2020 and 2021

Source: WHO Myanmar country office (2022)

Civil disobedience movement as a result of the ongoing conflict has led to shortage of human resources at the grass root level – that was already inadequate to respond malaria. NMCP has 50% vacant positions. The national programme does not have reach in non-government control areas and conflict affected areas where the malaria burden is still high. 80% of malaria are along international borders which are now in active armed conflict. Since February 2021, almost a million people have been internally and internationally displaced, which has given malaria outbreaks in northern and southern part of country
**Dengue**

**Situation:** Dengue has been reported in Myanmar since 1970 and number of cases started rising from 2001 with a cyclical epidemic pattern over the years (Figure 4). The highest number of dengue cases was reported in the 2015 with total of 42,913 cases. The number of cases went down to a very low level in 2016 (total case 10,770) followed by rise in number of cases in 2017 (total case 31,288). In 2020 total reported cases was only 15,131 which is lower than the previous two years – 2018 and 2019 (2018 total case 23,273 and in 2019 total case 24,178). Dengue is usually cyclical in nature and with cases alternating every year, but programme interventions play a critical role in preventing the occurrence of dengue. Total dengue deaths reported in 2020 were 68 and the programme is continuously maintaining case fatality rate below 1% from 2008 which shows improved early diagnosis and effective case management of dengue haemorrhagic fever in healthcare facilities.

*Figure 4: Dengue cases by year in Myanmar. 2007 – 2022 (Incomplete)*

![Graph showing Dengue cases by year in Myanmar from 2007 to 2022.](source)

**Impact:** Dengue transmission tends to have seasonal patterns, with high transmission during monsoon (June to September). Early diagnosis and effective case management of dengue haemorrhagic fever may be greatly impacted due to impaired functionality of public health care facilities in Myanmar. The number of cases increased during 2022 compared to the previous two years and the outbreak began earlier Figure 5. To date in 2022, the case fatality rate (CFR%) is around 0.41% in Myanmar for 2022.

*Figure 5: Dengue cases by epidemiological week (EW). (2020 -2022)*

![Graph showing Dengue cases by epidemiological week in Myanmar from 2020 to 2022.](source)

**Influenza**

**Situation**

Myanmar has both Influenza like Illness (ILI) Surveillance and Severe Acute Respiratory Infection (SARI) Surveillance at sentinel sites (n=10 sites for ILI and n=8 sites for SARI) which covered a total of seven states/regions with case-based data reported on a weekly basis to the national surveillance system (WHO, 2022). Of note, all the sentinel sites were in primarily in the cities of Yangon and Nay Pyi Taw and did not include the rural regions and states.
including those currently affected by the humanitarian crises and conflicts. In 2019, around 159,780 cases of Acute Respiratory Infections (ARI) were reported in Myanmar (Myanmar Ministry of Health, 2021) and according to FluNet, Influenza A(H1N1)pdm09 was predominant strain among influenza subtypes reported by Myanmar Figure 6.

Figure 6: Influenza virus detections by subtype reported to WHO FluNet. Myanmar. 2018 - 2022

Impact

As can be observed in Figure 6, influenza data reporting and virological samples processing has been severely affected by the ongoing humanitarian crises and recent conflict. There is no data for 2022 and the limited data in 2021 shows Influenza A(H3) as the predominant subtype.

Leprosy

Situation: Leprosy has been a public health problem in Myanmar for many centuries. The Integrated Leprosy Control activities into the basic health services (primary health care programme) were initiated in 1978. Myanmar adopted the WHO’s strategy of further reducing the leprosy burden and sustaining leprosy control/elimination activities and focused its effort on improving the quality of care by promoting disability prevention activities. Multidrug therapy (MDT) regime was started in 1988 and expanded phase-by-phase covering all the townships in 1995. Elimination of leprosy was declared in year 2003. However, new cases ranging from 2,000 to 3,000 are detected annually. Programme is now aiming for Leprosy elimination by 2030: Zero leprosy: zero infection and disease, zero disability, zero stigma and discrimination.

Impact: During this critical time most of the health facilities are unable to provide diagnosis, treatment, and referral services for leprosy. All the planned activities starting from capacity building, coordination, case detection, contact tracing, post exposure prophylaxis, prevention of disability activities, sentinel surveillance on drug resistance are on hold. Supply of Leprosy MDT drug from health facilities to the patients is potentially interrupted.

Lymphatic Filariasis

Situation: Lymphatic Filariasis was endemic in 45 districts in 2001. National programme started MDA in year 2001. As of 2020, a total of 30 implementation units (IUs) had stopped MDA, with MDA being continued in 15 IUs and, 13.9 million people administered the medicine with the coverage of 97.2%.

Impact: Pre-Transmission Assessment Survey (Pre-TAS) was planned to be conducted in February 2021 in 15 IUs, but only 3 IU could effectively conduct Pre-TAS, because of the COVID-19 crisis and the current situation. The programme has procured Ivermectin for triple drug mass administration therapy.

Vaccine-preventable diseases and surveillance

Situation

While Myanmar had been maintaining good quality and sensitive surveillance for vaccine-preventable diseases (VPDs), it still has a high burden of VDPs. In 2018, around 1,389 cases of measles, 127 cases of diphtheria, 28 cases of pertussis and 22 cases of neonatal tetanus were reported. In addition, four cases of circulating vaccine-derived poliovirus type 1 were detected in 2019 (WHO SEAR, 2019).
Impact

Following the military takeover in February 2021, surveillance activities have been completely disrupted. Annual Non-Polio Acute Flaccid Paralysis (AFP) rate for 2020 in children < 15 years was 1.29, per million – the rates are much lower since 01 February 2021 due challenges in surveillance and reporting systems Figure 7

Figure 7: Time series of select vaccine preventable diseases in Myanmar. 2011 - 2022 (2021 & 2022 data not complete)

Source: Data from WHO Immunization (WHO, 2021) and visualized by SEARO/WHO

Annual reported number of Diphtheria cases were 121 and 273 in 2019 and 2020 respectively Figure 7. Annual Measles incidence per million was 98.85 in 2019 and 8.22 in 2020 with a total 5,252 confirmed measles cases reported in 2019 and 444 in 2020 Figure 8. There has been no reporting of diphtheria and Measles since 1 February 2021.

Figure 8: Measles cases reported in Myanmar by year. 2011 - 2022 (2021 & 2022 data not complete)

Source: Data from WHO Immunization (WHO, 2021) and visualized by SEARO/WHO

<table>
<thead>
<tr>
<th>Year</th>
<th>Polio</th>
<th>Diphtheria</th>
<th>Pertussis</th>
<th>NT (% of all tetanus)</th>
<th>Measles</th>
<th>Rubella</th>
<th>Mumps</th>
<th>JE</th>
<th>CRS</th>
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<tr>
<td>2013</td>
<td>0</td>
<td>88</td>
<td>14</td>
<td>89 (56%)</td>
<td>1,010</td>
<td>23</td>
<td>ND</td>
<td>3</td>
<td>ND</td>
</tr>
<tr>
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<td>29</td>
<td>5</td>
<td>32 (44%)</td>
<td>122</td>
<td>30</td>
<td>ND</td>
<td>50</td>
<td>ND</td>
</tr>
<tr>
<td>2015</td>
<td>0</td>
<td>57</td>
<td>5</td>
<td>30 (ND)</td>
<td>6</td>
<td>34</td>
<td>ND</td>
<td>113</td>
<td>ND</td>
</tr>
<tr>
<td>2016</td>
<td>0</td>
<td>136</td>
<td>2</td>
<td>21 (11%)</td>
<td>266</td>
<td>10</td>
<td>ND</td>
<td>353</td>
<td>ND</td>
</tr>
<tr>
<td>2017</td>
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<td>4</td>
<td>20 (33%)</td>
<td>1,293</td>
<td>6</td>
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<tr>
<td>2018</td>
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<td>127</td>
<td>28</td>
<td>22 (28%)</td>
<td>1,889</td>
<td>13</td>
<td>ND</td>
<td>126</td>
<td>8</td>
</tr>
</tbody>
</table>
**Gaps and Needs**

- There is a need for a phased multi-antigen catch up immunization campaign to address risks arising from ongoing or escalating vaccine preventable disease (VPD) outbreaks.
- Recommended to urgently conduct measles rubella (MR) vaccination catchup activities or preventive supplementary immunization activities.
- Further risks for the quality of immunization services include reduced opportunities for comprehensive programme assessments as well as introduction of new vaccines required based on disease epidemiology in Myanmar.

**Zoonotic diseases**

**Situation**

**Leptospirosis:** A sentinel study of patients presenting with febrile illness in Sangkhlaburi District, Kanchanaburi Province in western Thailand, on the border with Myanmar (Burma) found that Leptospirosis was the second most frequent etiologic agent after malaria, accounting for 17.5% of cases overall (Ellis, 2006). While the the spectrum of clinical presentations of human leptospirosis ranges from asymptomatic to fatal, the case fatality rate (CFR%) of severe leptospirosis maybe as high as 20%.

**Rickettsioses:** In 2021, serological studies showed that rickettsioses is widespread in Myanmar (Philip N.D. Elders, 2021). In particular, Kachin had the highest percentage of people with antibodies (ELISA OD ≥ 0.5) for scrub typhus group (STG) [59%, 95% CI 49–68%] and Spotted fever group SFG [24%, 95% CI 17–23%] (Philip N.D. Elders, 2021). Overall mortality of rickettsial infections differs by species and can be as low as 0.4% for murine typhus, but has been reported to be approximately 6% for scrub typhus if left untreated, and higher if patients develop complications such as meningitis or meningoencephalitis (Philip N.D. Elders, 2021).

**Rabies:** The total reported number of rabies cases decreased slightly from 198 cases in 2016 to 138 cases in 2019 (Myanmar Ministry of Health, 2021). Confined to the nature of being a most deadly disease, the case fatality rate was 100 percent for all four years

**Impact:** Even though laboratory-based surveillance system and diagnosis for these diseases were project-based before the military takeover, national laboratory-based surveillance system for those diseases became more constrained due to the current situation. If notifiable events cannot be detected, investigated, responded and shared with relevant parties, the risk for communicable disease outbreaks will be high, resulting in significant public health, social, economic and political impacts on health systems and affected populations, and may also impact neighboring countries and the wider international community.

In September 2022, rodent infestation (rats) in the crop fields of Kachin were reported by the WHO Country office. While this is currently a food security issue, the risk of zoonotic diseases from these rodents cannot be ruled out. Historically, these rodent infestations occur right after the rainy season or bamboo flowering event which occurs every 30 – 50 years. Furthermore, there have been historic plague outbreaks in Myanmar including bubonic plague – all of which can lead to high morbidity/mortality in the population.

**Malnutrition and child health**

**Situation**

The Myanmar Micronutrient and Food consumption survey conducted in 2017-18, with the support of WHO, UNICEF, the World Bank, had quantified the prevalence of Sever Acute Malnutrition (SAM) in the country as 0.8% (0.6-1.1). However, this rate was as high as 1.7 (0.9-3.3) and 1.6 (0.8-3.1) in Ayeyawady Region and Kayin State. The Global Acute Malnutrition was 6.7% (6.0-7.4) and the stunting was 26.7%. With regards to the feeding practices of infant and children at national level; exclusive breastfeeding was 51.2% and the minimum acceptable diet among infant aged 6 – 8 months of age was 13%. The Under-five mortality rate was estimated to be 44.7 deaths per 1,000 live births in 2019.

To accelerate the progress toward the UN Decade of Action on Nutrition 2025 and Sustainable Development Goals (SDGs) targets, Myanmar MoH together with multisectoral collaboration had prepared a Multisectoral National Plan of Action on Nutrition (MS-NPAN) in 2019 and started rolling out at sub-national levels.
Impact

Due to the protracted COVID-19 restriction since mid-2020 and with the current political situation in Myanmar, many nutrition-related activities by public sector and partners are on hold. With the prevailing socioeconomic challenges and increasing cost of fuel and food, the availability and affordability of nutritious food is becoming limited which is complicating the food choices and feeding practices. The observed public health service disruption in Myanmar will further affect the health promotion and nutrition services at the community level, leading to aggravation of malnutrition and increase in the child mortality.

According to recent data, five million children in Myanmar need humanitarian assistance and many internally displaced children are living in overcrowded conditions in IDP camps where they cannot access essential health services, including immunization (UNICEF, 2022). In September 2022, approximately 650 children aged 6–59 months (299 boys and 351 girls) with severe acute malnutrition (SAM) were provided with life-saving treatment and at least 37,503 children have been diagnosed as suffering from malnutrition (UNICEF, 2022). The continued public health service disruption in Myanmar will further affect the health promotion and nutrition services at the community level, leading to aggravation of malnutrition and increases in children’s morbidity and mortality. Finally, soaring inflation and subsequent increase in prices for food and fuel increase the risk for food insecurity and malnutrition among the most vulnerable populations.

Reproductive, maternal, newborn, child and adolescent health (RMNCAH)

Situation

Maternal and Reproductive Health

In Myanmar, maternal health care services are delivered by primary health care providers at township level and below, and by specialist obstetricians and gynecologists at the district, state and regional level. While at the national level there was an increasing trend of pregnant women accessing Ante-Natal Care (ANC) at least one time during pregnancy (ANC 1) – increase from 75% in 2012 to 88% in 2019 – and those accessing ANC four times (ANC4) – increased from 66.9% in 2012 to about 78% in 2018 – there were significant variations at the subnational level with some regions and states currently affected by the humanitarian crises and conflicts reporting lower percentages for both indicators compared to the rates at the national level (Union) (Myanmar Ministry of Health, 2021).

Furthermore, among pregnant women, only 59% received at least four visits of antenatal care. In 2019, while 70% of deliveries took place at delivery institutions at the national level – there were already large differences between different states and regions at the subnational level with some vulnerable populations being disproportionally affected. While in the places like Yangon Region achieved 93% for institutional delivery, followed by Nay Pyi Taw Territory at 83% and Mandalay Region at 79%,
remote and currently Conflict-affected areas like Chin State and Rakhine State had the lowest rates at 36% and 40% respectively (Myanmar Ministry of Health, 2021). Figure 10

Similarly, in 2019, postnatal care coverage was around 80% in most states and regions, with the lower coverage (50-60%) seen in Shan (North), Shan (East), and Rakhine States (Myanmar Ministry of Health, 2021). Overall, 1 in 50 girls in 10 to 19 years of age gave births in the year 2019 and the highest rate was observed in Shan (East) State at 42 births among 1,000 adolescent girls (Myanmar Ministry of Health, 2021).

With regards to use of modern contraceptive methods (mCPR) among eligible couples, the rate of usage at the national level increased from around 50 % in 2014 to more than 70% in 2019 (Myanmar Ministry of Health, 2021). However, when comparing rates at the subnational level, it was once again highest in Yangon Region (77%) and the lowest in areas with most rural and vulnerable population including Chin State (34.2%) (Myanmar Ministry of Health, 2021) Figure 11. It was also observed that close birth interval was more than 10% in Chin and Kayah States (Myanmar Ministry of Health, 2021)

Maternal, newborn, and child mortality

Myanmar had been making significant progress in reducing maternal, newborn, and child mortality. Maternal mortality ratio (MMR) had dropped by 26% in 2017 since 2000, from 340 to 250 maternal deaths per 100,000 live births, with 1.8% annual rate of reduction (MMEIG, 2019). Similarly, newborn and under five mortalities had decreased by 53% (from 47 per 1,000 live births to 22 per 1,000 live births) and 61% (from 115 per 1,000 live births to 45 per 1,000 live births) respectively, between 1990 and 2019. Provisional results from the Inter-census Survey indicated a 47% reduction of under-five mortality rate from 72 per 1,000 live births to 38 per live births in 2019.

However, even within the same country, risk of maternal and child deaths is disproportionately high among the most vulnerable segments of society. MMR in Chin State (357 per 100,000 live births) was found considerably higher than other states and regions while under five mortality rates (U5MR) in Magwe was 108 per 1,000 live births which is more than twice of national average. In addition, MMR is particularly higher among girls aged 15-19 years which was 229 per 100,000 live births. It was contributed by the high adolescent fertility rate in the country (33 births per 1,000 girls). Post-partum hemorrhage still remains the first leading cause of maternal deaths, while the abortion-related deaths become the second leading cause. Prematurity, birth asphyxia, and neonatal sepsis are leading causes of newborn deaths.

In terms of health seeking practices, only 54% of children with diarrhea were taken to a health facility for treatment and 86% of them received oral rehydration therapy or increased fluid. In 2019, more than 100 out of 1,000 Under-5 children who resided in Kayah, Chin and Kachin States suffered from diarrhea (Myanmar Ministry of Health, 2021). The lowest morbidity rate was reported from Yangon Region, Nay Pyi Taw Territory and Mandalay Region (Myanmar Ministry of Health, 2021).

Impact:

Like many places around the world, the ongoing COVID-19 pandemic has had significant impacts on the demand for, and provision of, essential health services, especially for the vulnerable populations of women, newborn, children and adolescents. In addition, due to the existing humanitarian crises in Myanmar along with the recent conflict situation, normal health care functioning has almost completely broken down especially in public sector, leading to disruption of access to RMNCAH services. Although comprehensive service coverage data are unavailable, it can be expected that there may be additional mortality and morbidities of mothers, women, children and adolescent resulting from RMNCAH service disruption. In many places across the country, charity clinics and private hospitals (with discounts or sometimes free of charge in selected services) are supporting essential RMNCAH services. However, these are short-term, non-sustainable measures. Health personnel (those observing civil disobedience, those retired, and private practitioners) have been assisting patients through charity services where possible under challenging circumstances.
Curfew orders have been issued which limit movement at night and this poses extreme challenge for emergency obstetric and child referral services. Access to antenatal care, delivery care, postnatal care, family planning and treatments for children (e.g. pneumonia, diarrhoea) can also be constrained due to the interruption in supplies and equipment, and potential stock out in several facilities. Limitation in counselling services and adolescent friendly health services can put additional risks of unwanted pregnancies, adolescent pregnancies, and unsafe abortions. Furthermore, psychosocial impacts on pregnant mothers, young children, and young people could contribute to significant morbidities including anxiety, depression in young people and increased postpartum depression, developmental delays in children and suicidal rates in youths.

**Tuberculosis, HIV, and Viral Hepatitis**

### Tuberculosis

**Situation:** Tuberculosis is one of the major public health problems in Myanmar, which still ranks among the 30 high TB burden countries in the world. In 2019, a total of 137,325 TB cases were notified including 3,205 notified drug-resistant TB (DR-TB) cases. TB treatment coverage was 77% in 2019, and treatment success rate for new and relapse TB cases registered in 2018 was 88%. The estimated TB incidence was 322 (212-454) per 100,000 population in 2019 and prevalence of all forms of TB for all ages was 436 (361–511) per 100 000 population according to the national TB prevalence survey implemented 2017-2018. TB Diagnosis and treatment was provided by public sector as well as private sector as public-private and public-public partnerships, and active case finding, and treatment completion was also supported by community-based TB care services co-ordinated by non-governmental organization (NGOs) and international non-governmental organization (INGOs) through volunteer networks. Availability of GeneXpert testing and chest X-ray facilities has been promoted along with strengthening of diagnostic algorithms. Piloting oral DR-TB regimens was initiated in certain townships of Yangon and Mandalay regions in 2020, and it is planned to extend throughout the country in June 2021. WHO provides technical assistance for applying new regimens as well as strengthening TB services of the National TB Programme and partners.

**Impact:** TB case finding activities has been seriously affected during to the ongoing situation in Myanmar. Following the COVID-19 pandemic and in the context of the ongoing humanitarian crises and conflict situation, almost 150,000 TB cases were missed for detection which in turn represents an additional transmission to 5-7 people each. Although some cases are being diagnosed as TB by CXR, there is limited access to drug susceptibility tests (DST) services to assist and guide the clinicians to start a correct treatment. In Yangon, almost 600/100,000 people have Drug Resistant TB (DR-TB) and is close to crises. Nearly 80% of the cases were missed and continue to transmit and almost 15% of the TB cases also have HIV – nearly 18,000 new cases with both HIV and TB are expected each year now. Finally, rough estimates point at almost 30,000 TB deaths to be expected in 2000, something that can be prevented by improving access to TB services throughout the country.

### HIV AIDS

**Situation:** Myanmar has second highest HIV prevalence (0.58%) in South-East Asia Region and 270,000 estimated people living with HIV. HIV epidemic in Myanmar is concentrated among key populations (people who inject drugs, men who have sex with men, transgender women and sex workers) and the prevalence is 0.58 among adult population. Five high burden states and regions for HIV include Yangon, Mandalay, Sagaing, Kachin and Northern Shan. Estimated new infections are about 9,000 per annum. The estimated People Living with HIV (PLHIV) is around 240,000 and nearly 200,000 around 190,000 patients are on antiretroviral therapy (ART) as of December
2020. Total of 80% ART patients were seeking care at public health facilities and the rest at the implementing partners. As people who inject drugs have the highest prevalence, harm reduction services are a priority intervention, and 26,000 are on Methadone Maintenance Therapy (MMT) in December 2020.

Impact: Limitation in human resource and security situations affected the provision of comprehensive HIV services. Quality and completeness of information is also a challenge in articulating the situation. Adoption and expansion of innovative interventions/new recommendations took more time than expected. Prevention of Mother-to-Child Transmission (PMTCT) was affected in 2021 with only around 1/3 of the achievement reported compared to 2020.

**Viral Hepatitis**

Situation: Myanmar is one of the 28 countries regarded as WHO’s priority countries for Viral Hepatitis (VH) response. According to the national sero-prevalence survey among the general population conducted in 2015, the prevalence of hepatitis B was 6.51% and hepatitis C was 2.65%. The Myanmar National Strategic Plan (NSP) 2016-2020 was developed in line with the WHO’s strategic directions as a roadmap towards elimination of viral hepatitis as a public threat by 2030. Childhood vaccination of hepatitis B is provided through the EPI; completion of the third dose for all children under one year was reported to be an average of 90% coverage annually from 2016 - 2019. Hepatitis C treatment program was initiated in 2017 and mainly provides services at 13 public hospitals across 8 states and regions. Since 2017, total of 17,148 patients started hepatitis C treatment by public sector and implementing partners and 14,806 have completed the full course of treatment as of September 2020.

Impact: With the ongoing disruption of the public health system, diagnostic, treatment, investigations services and routine reporting system for hepatitis C are impacted and uptake of new enrollment is still limited. Childhood hepatitis B vaccination is significantly decreased in 2021 with 37.16% compared to 2019 and 2021 with 90% and 83.66% respectively. The National Strategic Plan (NSP) I review is yet to be endorsed and NSP II development has been reported during 2021 - 2022 though there are no exact data available.

In addition, people who inject drugs (PWID) can be more vulnerable to infectious diseases such as HIV. Hepatitis C (HCV), tuberculosis, poor mental health conditions among others. However, the inter-relationship between drug production, conflict and the health of PWUD is less well described. A recent study to investigate health outcomes and associated factors including armed conflict and its consequences among people who use illicit drugs in Afghanistan, Colombia and Myanmar found that access to effective harm reduction services in rural locations in Myanmar remain insufficient, creating conditions for rapid rise in HIV and HCV (O’Brien, 2022).

**Non-communicable diseases (NCDs)**

Situation: According to the latest available WHO NCD country profile, four major NCDs are estimated to account for 71% of all deaths with proportional mortality of 31% for cardiovascular diseases, 13% for Cancers, 10% for Chronic Respiratory diseases and 6% for Diabetes (WHO, 2020). Approximately one fourth (25%) of deaths occur between 30- 70 years of age (31% male vs. 20% female) and 57% occur under 70 years of age. Deaths due to NCDs are expected to increase by 21% over the next decade if effective prevention and control measures are not undertaken.

**Figure 13: Percentage of Non communicable disease (NCD) deaths occurring under 70 years.**

Source: (WHO, 2020)

During 2019, 1.67 million people was screened for NCDs risk factors and among them, 205,495 diabetes and 429,400 hypertension cases were treated. During 2019-2020, anti-diabetic medication (metformin, sulfonyl urea), anti-hypertensive drugs (ACE inhibitors, ARBs, calcium channel blockers, beta blockers), cardiovascular drugs...
Aspirin, statins), bronchodilator, benzathine penicillin injection, HPV vaccination were available for prevention and control of NCDs in primary care facilities. More than 50% of health facilities were able offer CVD risk stratification.

There are 11 NCD related programmes, including of those regarding 4 major NCDs, tobacco free initiative project, Myanmar Epilepsy initiative project, injury prevention, community based-rehabilitation project, snakebite control and deafness prevention projects, under implementation with technical and financial support mainly from WHO.

**Impact:** Due to the protracted COVID-19 related restrictions since mid-2020, along with the ongoing humanitarian and conflict crisis, many NCD prevention and care activities by the public sector are disrupted. At community-based settings, Hypertension and Diabetes clinics (Wednesday NCD Clinic) cannot be opened for new case finding and elderly health care for nearly one year. At the same time for registered NCD patients, essential drug supply continues to be provided through basic health staff (BHS). However, after February 2021, there are serious risks affecting continuity of essential drug supply.

Services at public hospitals were already limited to varying degrees due to COVID-19. These include outpatient services, in-patient services, emergency unit services, pre-hospital emergency care services, NCD diagnosis, treatment at hospital OPD clinics, treatment for mental health disorders, cancer diagnosis and treatment, dental services, rehabilitation services, 24-hour emergency room services for emergencies, eg myocardial infarct, arrhythmia, stroke, diabetic ketoacidosis or DKA, asthma, chronic obstructive pulmonary disease or COPD, sepsis, serious injury. Such services from public hospitals became partially to fully disrupted since Feb 2021.

World Health Survey plus STEPS survey is important for updating the evidence-base information for NCD and risk factors monitoring for Myanmar. It’s in country implementation has been planned since 2019 and was put on hold in 2020 due to COVID-19. Implementation also looks unlikely this year. WHO Myanmar submitted proposal for life-saving NCD activities to NORAD, via WHO SEARO & WHO HQ, for an initial implementation period of six months (28 May 2021, see health priority activities 11 below), to ascertain delivery models & partnerships to deliver lifesaving NCD prevention and care.

**Trauma care**

**Situation:** According to Myanmar Health Statistics 2020, injury has been one of the top ten causes of morbidity and mortality for more than one decade. There is an increasing trend in the total number of reported injury cases and deaths. The total number of reported cases increased from 370,000 in 2016 to 460,000 in 2019. More than 80% of total incidents were attributable to vehicle accidents (45 to 51%), accident on farm (16 to 25%) and fighting (12 to 14%) across these four years period. Also, the number of deaths increased from 11,300 to 15,300 which corresponded to the increase in dead rate from 3.1% to 3.4% among cases. More than 75% of injury deaths were vehicle accident (41% to 43%), drowning (23%-24%) and suicides (13%-15%).

**Impact:** According to the Assistance Association for Political Prisoners (AAPP), more than 2,400 civilians have been killed as part of the military’s crackdown on the pro-democracy movement since February 2021 (AAPP, 2022). This figure likely does not reflect certain categories of civilian casualties—such as killings by opposition forces or pro-junta vigilante groups—nor does it fully capture the extent of civilian deaths linked to fighting in ethnic areas (Myanmar Institute for Strategy and Policy, 2022). According to a 12 October 2022 Special Rapporteur on the situation of human rights in Myanmar by the United Nations Human Rights Office of the High Commissioner (OHCHR), four political prisoners were executed by the military in July 2022, 84 remain on death row and at risk of imminent execution, and more than 12,000 remain arbitrarily detained in deplorable conditions (OHCHR, 2022).

**Snakebites**

**Situation:** Snake bite has been considered as one of the major occupational hazards in rural areas of Myanmar for many decades (Myanmar Ministry of Health, 2021). About 8,000 – 10,000 poisonous snake bite cases were reported annually during 2016 to 2019, and five% of those cases resulted in fatalities. (Myanmar Ministry of Health, 2021). In 2014, the Myanmar Snakebite Project was established with the joint collaboration between Myanmar and Australia to improve the antivenom production, provide training for healthcare professionals on snake identification and proper management of snakebite and improve the antivenom distribution (Patikorn C, Ismail AK., 2022). However, interviews reveal that the antivenom distribution is still challenging due to the lack of pharmaceutical logistic system in the country (Patikorn C, Ismail AK., 2022).
Impact: With many Internally Displaced Persons (IDP) people living in temporary shelters including new hidden areas in central dry zones and other, there is significant risk of contact between human and animal (snakes) interface which could increase these fatal snakebites. The overall difficulty in accessing and providing care in remote and hard to reach areas, along with hospitals having to pick up antivenoms from a central stockpile in countries like Myanmar further exacerbates the situation.

Gender-based violence (GBV)

Situation: According to the Myanmar Demographic and Health Survey (MDHS) conducted in 2015-16, 23% of households are headed by a woman. Total of 15% women reported that they have ever experienced physical violence since age 15. 9% in the 12 months before the survey; 3% of Myanmar women have ever experienced sexual violence (since age 15); 2% have experienced sexual violence recently [in the year before the survey]; 21% of ever-married women have ever experienced physical, emotional, or sexual violence committed by their husband. Most women do not seek help when they experience domestic violence.

Impact: The current humanitarian crises and ongoing conflict situation has acutely affected groups that have historically suffered from marginalization, discrimination, and violence. According to research by women human rights defenders shared with the Special Rapporteur, soldiers have perpetrated sexual violence both more frequently and in more diverse geographic regions since the coup (OHCHR, 2022). Women’s rights groups have documented more than 100 cases of rape or sexual violence in Myanmar since the coup, the majority of which have been perpetrated by the Myanmar military, Border Guard Forces, or other junta-aligned groups (OHCHR, 2022). Widespread forced displacement has increased the vulnerability of women and girls, who lack access to water, nutrition, and vital services, including sexual and reproductive health services (OHCHR, 2022). Women have been forced to use plastic bags in place of sanitary pads; unwanted pregnancies are increasing due to a lack of access to contraception; and women are giving birth in the jungle without access to medical care. Women’s groups have reported increased cases of domestic violence in IDP camps and in villages as household financial stress and food insecurity have escalated (OHCHR, 2022). In addition, due to the collapse of Myanmar’s economy, civil society groups have reported increases in the trafficking of women and girls to Thailand, China, India, Malaysia, and Dubai. (OHCHR, 2022).

Mental health

Situation: According to the Myanmar Ministry of Health Public Health Statistic Report for 2019, an increasing number of mental disorder cases were reported during the period from 2016 to 2019. Figure 15 (Myanmar Ministry of Health, 2021). In 2019, the prevalence per 100,000 population was 330 for alcohol use disorder, 16 for anxiety disorder, 12 for mental retardation, 12 for psychosis and 7 for depression (Myanmar Ministry of Health, 2021). A 2020 report indicated that the prevalence of mental distress was 18.0% for men and women aged 18-49 years from Yangon region (Aye, 2020). The rate is higher for women (21.2%) compared to men (14.9%) (Aye, 2020). The global School-based Students Health Survey (2016) data revealed that the prevalence of reported depressive symptoms among adolescents in Myanmar is 27.2% and that of suicidal ideation is 9.4%-both of which are substantially higher than the regional averages (Dominic Carroll, 2021).
The same study indicated that 9% of adolescent students aged 13-17 years attempted suicide one or more times during the last 12 months and the reported prevalence of bullying was 50.1% (Dominic Carroll, 2021). Reports of violence include being in a physical fight with a peer was 24.3% and being physically attacked by someone other than a peer was 32.7% (Dominic Carroll, 2021).

**Impact:** While there is currently no single source of verified information compiled for mental health concerns, the current crisis can severely affect mental health wellbeing of individuals, including those directly experiencing violence. Loss of liberty and happiness, as well as of properties or livelihoods, likewise greatly increase the risk of developing depression. Risk for anxiety, post-traumatic distress syndrome, and severe mental traumas may also increase. The impact may affect all age groups, which may have short- and long-term consequences.

Due to the ongoing communications and internet disruptions, online mental health services while available are difficult to be accessed by the public. Inaccessible of timely information can raise worries and anxiety, especially in resource-constraint settings. Disruption to daily routines, sense of personal safety, destruction to possessions such as home, vehicles and shops, loss of income-generating activities and job insecurity, unavailability of mental health services from public hospitals, direct experience of threatened death or serious injuries, threat to physical integrity, or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by someone close, closures of community resources and facilities (including religious centres, childcare centres and welfare centres) may lead to psychological reactions, including grief and complicated bereavement, and possibly post-traumatic stress disorder or PTSD.

**Persons with disabilities**

**Situation:** In Myanmar, persons with disabilities have historically faced discrimination, social stigmatization, and immense challenges relating to the accessibility of public spaces and services (OHCHR, 2022).

**Impact:** Persons with disabilities have been disproportionately impacted by the ongoing humanitarian crises and conflicts in Myanmar. In conflict areas, persons with disabilities, as well as elderly people, are often unable to flee violent attacks because of mobility limitations or because they have not received warnings of impending attacks (OHCHR, 2022). While quantitative data in not available, media and civil society organizations have reported numerous cases in which persons with disabilities have been killed in their homes or villages after other villagers fled an attack (OHCHR, 2022). The displacement of civilian populations has also separated disabled persons from family members and other support networks, deepening their isolation and vulnerability (OHCHR, 2022).

**Determinants of health**

**Health Environment and Climate Change**

**Situation:** Myanmar has been identified as the second most affected country by natural disasters in the past 20 years, based on the average weighted ranking by the Climate Risk Index 2020. Myanmar is already exposed to a multitude of hazards, including extreme temperatures, droughts, cyclones, flooding and storm surges along with...
heavy rainfall events, and half of the population lives in a ‘multi-hazard’ region (IFRC, 2021). Climate change has the potential to trigger wide-ranging and strong negative feedback loops between livelihoods and health (IFRC, 2021). On one hand, climate change threatens all major livelihood sectors, and a loss of livelihoods will negatively impact people’s ability to afford healthcare (IFRC, 2021). On the other hand, impacts on health (notably via direct mortality from the increased frequency and intensity of extreme weather events; malnutrition and increased food insecurity; and the increased burden of waterborne diseases) will reduce people’s ability to work and earn a livelihood (IFRC, 2021). The healthcare inequality gap will likely widen, particularly between internal migrants and local host communities, men and women, and rural and urban areas (IFRC, 2021). A number of adverse sexual and reproductive health outcomes, including risks to maternal mortality and gender-based violence also have links to climatic stressors (IFRC, 2021). Though climate change is the catalyst for these health outcomes, many of these impacts are manifested through destroyed livelihoods, specifically in agriculture and fisheries (IFRC, 2021).

Year-on-year at least 50,000 people are impacted by acute-onset disasters. In recent times, Cyclone Nargis in 2008, Giri in 2010, the extreme heat waves in 2010, and flooding in 2015, and 2018, garbage fire in Hlaingthayar township of Yangon have had disastrous impacts on Myanmar people, environment, and economy (WHO, 2020).

**Impact:** Frequency and intensity of natural disasters and disease outbreaks notably increased during past two decades in Myanmar. While extreme whether events do not become disasters on their own, the level of impact is influenced by the vulnerability of the affected population. Currently, many in Myanmar are vulnerable to such impacts given their social and economic situation as well an overall conflict and humanitarian crisis situation in the country. The current situation has put on hold most support that engages government directly including building climate resilient health systems. This has impacted the ongoing work on development of climate resilient healthcare facilities, sanitation safety and water safety plans, establishment of air pollution surveillance system, and awareness on climate sensitive diseases.

### 3. Health system status & local health system disruptions

#### Pre-crisis health system status

Myanmar’s UHC services coverage index had improved, from 49 in 2010 to 56 in 2020. Services coverage, presented on a scale of 0 to 100, encompasses tracer indicators that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases, service capacity and access. Therefore, the improvement in the service coverage index mirrored the MoH’s success in the implementation of the first strategy of the National Health Plan (NHP) 2017-2021, i.e. expansion of access to services. Meanwhile, available data indicated that Myanmar is yet to accelerate achievements in implementing the second strategy of the current NHP, i.e. financial protection.

The latest National Health Accounts confirmed 76% of current health spending in Myanmar is paid out-of-pocket by families as per Global Health Expenditure Data Base in 2019 https://apps.who.int/nha/database/country_profile/index/en. Although it was found to be lower than previous periods, it stands as one of the highest among the region. In 2017, an estimated 324,00 people were pushed into poverty due to health care expenditure, while 14.4% of households spent more than 10% of their available spending on health, incurring in what is known as catastrophic health expenditure.

#### In crisis health system status:

Previously established monitoring systems, such as DHIS 2 which enables an evidence-based analysis to determine the functionality of the current health system, is currently non-functional. As a result, alternative ad-hoc monitoring systems developed access to health services data dashboard by WHO Country team. The data were collected from 360 townships by WHO field-based staff and Country Office staff since April 2021 by observation. The questionnaire was contributed by related technical units; EPI, RMNCAH, HIV, TB, Malaria, Dengue, Nutrition, NCD, HSS in data collection process.

**Human resources for health situation:**

The sum of doctors, nurses, and midwives results in a density of 17.8 health workers per 10,000 population in Myanmar. The World Health Organization (WHO) suggests an average density of 22.8 health workers per 10,000 population to deliver a package of health services compatible with the health Millennium Development Goals (MDG). A decade later, the estimates had almost doubled, to 44.5 health workers per 10,000 population, to adapt services to the Sustainable Development Goals (SDG) standards. However, Myanmar has yet to reach those benchmarks in terms of health workforce density per 10,000 population. Comparison of health worker density across countries in the South-East Asia Region (SEAR) and with the thresholds just described, Myanmar is one of the countries with the lowest health worker availability, only above Bangladesh.
Beyond the overall limited availability of human resources in the system, deployment is also suboptimal since it is based on norms linked to facility nomenclature and size, rather than need or performance. The resulting allocation brings both insufficient personnel in some areas and exceeding capacity in others plus inadequate skill mix, as proven by the limited number of complete critical care teams to run ICU beds during the COVID-19 crisis.

**In crisis human resource status:** Like other countries the COVID-19 pandemic affected medical and allied health professional universities and training schools nationwide. This resulted in closure of all training institutions throughout the year 2020 with no graduation of all cadres of health workforce adding to the constraints of health workforce. Moreover, health workers were among the first to express dissent to the military takeover through civil disobedience. This translated into a significantly reduced health workforce in the public sector. At the same time, health personnel observing civil disobedience, or those retired, plus private practitioners, have been assisting patients through charity, faith-based or private services where possible under difficult and dangerous circumstances.

National Health Workforce Account is global platform to update the data by national focal point from MoH annually. Limited engagement with de facto authority hindered data validation process from government sector. HRH unit from WHO country team organized professional association and council from nonpublic sector to update data on medical doctors, health assistant, nurses, midwives, pharmacists, traditional medicine practitioners, and other cadres of medical technologist. Some organizations were unable to provide updated and accurate data especially which resulted in difficulties to triangulate and validate the HRH data. There are coping mechanisms in place by the de facto MoH, as some cadres of HRH are recruited from the Military Medical Corps however, health human resource situation is a challenge, both in terms of the numbers as well as in skill level. Rebuilding health workforce for the public system will require much efforts in both production and management.

**Access to health care**

In discussing access to health care, it is helpful to do this from the point of view of service provision. Using Tanahashi’s model, there are five important stages which successively lead to a desired health intervention and to define measurements of coverage appropriate to each stage.

First is availability coverage, where availability of resources (manpower, facilities, essential supplies) limits the maximum capacity of health services. Of these resources, availability of human resources is largely affected by CDM. Some Human Resources are available through networks of partners, including volunteers associated with the civil society organizations, ethnic health organizations, non-government organizations, private sector, and medical military personnel.

Second is accessibility coverage, where resources that are available must be located within reasonable reach of the people. The current crisis has led to significant safety and security concerns that hampers accessibility of services by the population. This is further exacerbated by martial law and curfew imposed in selected townships, and a new Organization Registration Law adopted on 28 October 2022, making access to essential services a critical challenge for patients to receive life-saving interventions.

Third is acceptability coverage, where service is accessible it still needs to be acceptable to the population. Acceptability is influenced by several factors such as service cost. While out-of-pocket expenditure was already high at nearly 76% in 2018, the current situation has further exacerbated the health financing crisis. The breakdown of public health services has severely affected and disrupted availability and access to financing of affordable health care services in Myanmar. Apart from cost, acceptability of services from the few public health care workers who are continuing to deliver care (non-CDM) as well as from the military is largely uncertain.

Fourth is contact coverage (actual contact between service provider and user) and fifth is effectiveness coverage (where service performance is appraised as satisfactory by specific criteria, including quality). Of these last two stages, there is currently no available information.

Phone survey conducted in early 2022 funded by World Bank and technical input from WHO to assess the health services. It was noted that public hospitals are understaffed due to CDM and cannot operate at full capacity. Due to long waiting time at public facility, some patients switched to private facilities despite the significant gap in expenses between public and private facilities. Most rural respondents don’t have challenges in access to healthcare as the facilities are in the villages. There were challenges of transportation and affordability in visiting hospital for secondary level care. Due to long waiting time at public facility, some patients switched to private facilities despite the significant gap in expenses between public and private facilities. Most rural respondents don’t have challenges in access to healthcare as the facilities are in the villages. There were challenges of transportation and affordability in visiting hospital for secondary level care. Some villages have access to ambulance services at times of emergency.
To ensure the evidence-based identification and prioritisation of needs, the REACH initiative, in coordination with OCHA, has conducted an MSNA, structured to inform both the humanitarian needs overview (HNO) and humanitarian resource planning (HRP). A hybrid data collection through face-to-face and phone interviews was conducted, between 13 July-14 August 2022. In total, 6,343 surveys were conducted, among three population groups: 59% with other vulnerable people with humanitarian needs (OVP), 38% with internally displaced people (IDP) and 3% with non-displaced stateless people (NDSP). Household surveys were conducted remotely for other vulnerable people, IDPs and non-displaced stateless population groups in townships across all 18 states, regions and union territory of Myanmar, including the sub-regions of Bago East, Bago West, Shan East, Shan North and Shan South. In-person surveys were collected in eight states, regions and sub-regions of the country with IDP populations. 1% of other vulnerable people, 3% of IDP, 2% of non-displaced stateless people needed health care and were unable to access it. The methodology used to select households for the remote data collection portion of the sample may have led to a bias resulting in under-representation of HHs without access to a mobile phone or areas without mobile phone coverage and electricity.

**Disruptions to supply chain**

International and domestic supply chains have been significantly affected by the military takeover. Land and air transportation are severely hampered and, in some instances, have come to a complete standstill in 2021. Security threats to drivers, road closures, checkpoints, drivers and warehouse staff as well as administrative staff on strike or partaking in civil disobedience, airport closures, reduction of relief flights, all contribute to substantial problems in the efficiency of Myanmar supply chains. The lack of reliable data and systems to make proper projections and forecast aggravates the situation. Hence, availability of essential medicines, technical commodities and supplies for prophylaxis, diagnostics and treatment are affected by the disruption of the supply chain from central, state-region to the lower level.

**Surveillance System of Attacks on Healthcare**

In 2012, World Health Assembly Resolution 65.20 was adopted, which requested WHO to provide leadership at the global level in collecting and reporting information on attacks on health care. Subsequently, WHO corporately implemented the Attacks on Health Care initiative to systematically collect evidence on attacks on health care, to advocate for the end of such attacks, and to promote best practices for safeguarding health care from attacks.

In Myanmar, there have been 334 reported attacks on health care between 1 February 2021 and 9 November 2022. We observed decreasing reported SSA but this situation most probably doesn’t reflect the real situation on ground as partners are facing more and more challenges to work, access reliable information from field level compounded by internet/communication blockage, strict restriction and arrests to the media sectors, social media trend changes towards attack to security forces rather than health session.

**EWARS**

WHO is facilitating the early warning, alerts and response system (EWARS) in Rakhine and Kachin States for internally displaced persons (IDPs) and other vulnerable people living in conflict-affected areas. Health Cluster partners are contributing to EWARS through their mobile clinics and fixed health facilities. Reporting, verification, investigation and response procedures follow the EWARS standard operating procedure. The reports are collected through an online system. Collected information is monitored and analysed regularly and informs decision-making to ensure prompt response.

**Impact:** Comparing 3 similar cohorts during 2020-2022, in both Kachin and Rakhine State, the EWARS outcomes were decreased in the 2021 cohort, however the outcomes were increased in the 2022 cohort.

**Kachin:**
(1 Feb 2020-30 Sep 2020) 1,081 reports covering 102 locations with 25,437 consultations
(1 Feb 2021-30 Sep 2021) 487 reports covering 69 locations with 13,562 consultations
(1 Feb 2022-30 Sep 2022) 1,030 reports covering 114 locations with 39,801 consultations.

**Rakhine**
(1 Feb 2020-30 Sep 2020) 2,584 reports covering 176 locations with 96,399 consultations
(1 Feb 2021-30 Sep 2021) 2,026 reports covering 125 locations with 90,523 consultations
(1 Feb 2022-30 Sep 2022) 3,849 reports covering 195 locations with 186,126 consultations.

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**4. Humanitarian health response (as per Myanmar Humanitarian Response Plan 2022)**

**Health response coordination**

Health Cluster partner coordination is present at national and six field locations: 1. Sittwe (Rakhine); 2. Myikyina (Kachin); 3. Lashio (Northern Shan); 4. Hakha (Northwest); 5. Hpa-An (Southeast); 6. Taunggyi (Kayah and South Shan).

This includes 48 health implementing partners: 30 International NGO; 11 National NGO; 6 UN Agencies and 1 other.

**Mid-year progress 2022 Humanitarian Response Plan (Jan 2022-June 2022)**

Out of 1.4 M targeted population, the Health Cluster reached 427,000 people (30%).

**Health cluster priority activities for 2023**

Planned activities include:

1. Provision of primary health services, through basic and complementary packages
2. Advocacy around de-politicizing the health sector
3. Timely detection and coordinated response to epidemic-prone diseases
4. Continued coordinated response to COVID-19
5. Training & capacity building of health partners in humanitarian response

**Impact:** The current situation continues to pose added challenges to humanitarian actors who are already operating in pre-existing fragile, conflict, vulnerable settings in the country. Disruption of essential services from public health system has increased the caseload for humanitarian actors. Routine referral mechanisms needed to be modified to adapt to the changing operational environment. Referrals to private health facilities consequently increase health expenditure. Inflation has a huge impact on humanitarian response operations. Import of health commodities face serious challenges in tax exemption. Delivery of medicines and medical supplies as well as staff movement to reach the vulnerable hard-to-reach communities became more challenging due to heightened security and other escalating conflicts. Availability of cash for operations is increasingly a serious concern. Severe disruption of internet and communications affect coordination among health actors, including timely notification and investigation of potential communicable disease outbreaks.


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Contacts
World Health Organization 403 (A1), Shwe Taung Kyar St, Bahan township, Yangon 11201, Myanmar
telephone numbers: +95 (1) 7534 300, 7534 307, 7538 620, 7538 621, 7538 474, 7538 475, 7538 476 GPN Extn.: 24200 [reception]
fax numbers: +95 (1) 7538 233, 7538 43