Public Health Situation Analysis

Myanmar

Conflict and humanitarian crisis

9 March 2026

World Health Organization

Abbreviations and acronyms

AFP	acute flaccid paralysis
AWD	acute watery diarrhoea
DPT	diphtheria, pertussis and tetanus
EPI	Expanded Programme on Immunization
ERW	explosive remnants of war
EWARS	Early Warning, Alert and Response System
GBV	gender-based violence
HIV	human immunodeficiency virus
HPV	human papillomavirus
IDP	internally displaced person
ILI	influenza-like illness
I/NGO	international nongovernmental organization
IPV	inactivated polio vaccine
MDR	multidrug-resistant
MoH	Ministry of Health
MR	measles–rubella
NCD	noncommunicable disease
NHP	National Health Plan
NITAG	National Immunization Technical Advisory Group
OCV	oral cholera vaccine
OOP	out of pocket
OPV	oral polio vaccine
PHSA	public health situation analysis
PLHIV	people living with HIV
SAC	State Administration Council
SSPC	State Security and Peace Commission (SS.
SDG	Sustainable Development Goals
SEAR	South-East Asia Region
SSPC	State Security and Peace Commission
TB	tuberculosis
U5MR	under-five mortality rate
UN	United Nations
UNICEF	United Nations Children's Fund
UXO	unexploded ordnance
VPD	vaccine-preventable disease
WASH	water, sanitation and hygiene

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Republic of the Union of Myanmar

Date: 09 March 2026

Public Health Situation Analysis

Typologies of emergency	Main health threats	WHO grade	Security level (UNDSS) [1]	INFORM (2025) [2]
Conflict Displacement Food security Access challenges Epidemics	Trauma and Injuries Tuberculosis Mental Health Adolescent health Vector-borne diseases Environment and natural hazard Cholera and water-borne diseases	Protracted Grade 3	**Armed Conflict:** Extreme/ High **Terrorism**: Moderate/ Low **Crime**: High/Moderate **Civil Unrest:** Low **Hazards**: Moderate	**INFORM Risk** 6.9 / 13 (Very high) **Global Risk Ranking** 11 out of 191 countries

Summary of Crisis and Key Findings

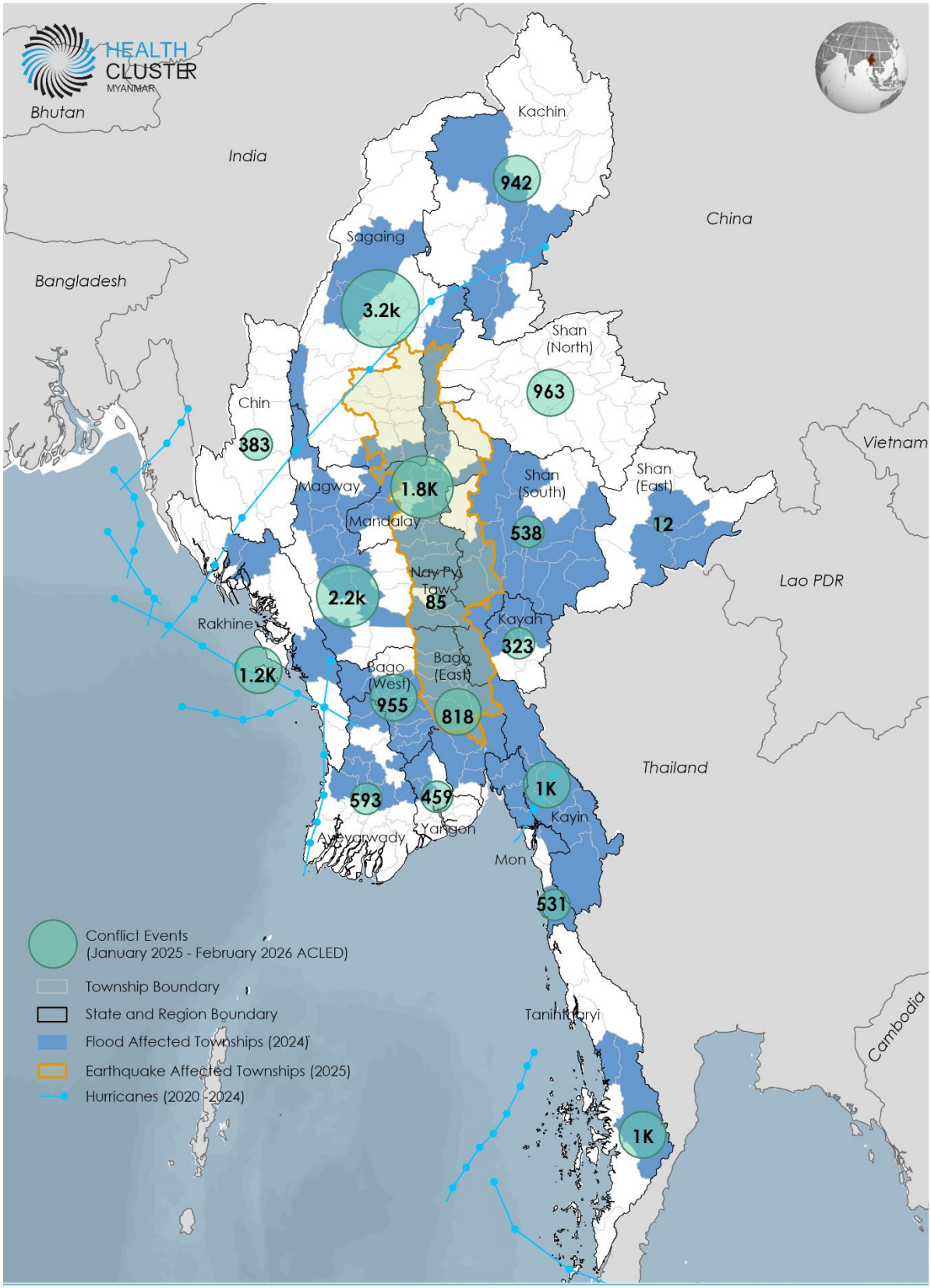
Myanmar's humanitarian crisis has continued to deepen due to intensifying conflict, recurrent natural disasters, and steady economic collapse.[3] In the first half of 2025, Myanmar ranked second globally for conflict intensity, with more than half of the population exposed to conflict. The security situation for civilians is deteriorating, protection risks are severe, and the resilience of communities is stretched to breaking point.[4]

In spite of the high level of needs, the Myanmar 2026 Humanitarian Needs and Response Plan (HNRP) target has been set at 4.9 million people, a 27% decrease from 6.7 million in 2025. The reduction in target is proportional across most clusters and largely a reflection of diminished response capacities foreseen for 2026.[5]

Access to basic health services is particularly dire in Rakhine, Kayah and Sagaing, where nearly half the population faces serious difficulties, while between 25% and 40% of residents in Kachin, Tanintharyi, Kayin, Northern Shan and Chin need humanitarian health assistance. Disease outbreaks are on the rise due to unsafe drinking water, inadequate sanitation and the interruption of routine health programmes.[6]

A nationwide cholera outbreak occurred between June 2024 and April 2025, malaria has resurgeddue to supply shortages and dengue fever continues to affect children under 15.[7] Alarmingly, 1.5 million children under five have missed basic vaccinations since 2018, increasing the risk of vaccine-prevetable diseases, such as measles and diphtheria and the possible re-emergence of polio.[8]

In March 2025, a devastating earthquake struck central Myanmar. The disaster impacted key agricultural regions, destroying crops, irrigation systems, and grain stores—threatening food security for 2 million newly affected people. The earthquake damaged or destroyed tens of thousands of houses, dozens of roads and bridges, and nearly 70 health facilities, severely disrupting access to essential services.[9]



The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.
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Figure 1. Map of Myanmar showing past health events and their impact

Humanitarian Profile

PEOPLE IN NEED 2026[10]

People in need: 16.2 million

Target: 4.9 million

Prioritised: 2.9 million

HEALTH NEEDS 2026[11]

People in need: 9.3 million

Target: 2 million

Prioritised: 1.1 million

DISPLACEMENT

An estimated **3.6 million people** have been displaced by conflict and earthquake, with 1.7 million in the hardest-hit regions.[12]

FOOD SECURITY

In 2026, **8.5 million people in 227 townships** within the HNRP scope are projected to face acute food insecurity.[13]

Humanitarian needs and response plan

As per the Myanmar Humanitarian Needs and Response Plan (HNRP) for 2026, more than 45% of the population (16.2 million people, inluding 5 million children) require life-saving assistance and protection services.[14] Out of these, 9.3 million people need support with accessing basic health services. 2.4 million are women and girls of reproductive age, with an estimated 415 000 births in need of life-saving care.

In spite of the deteriorating situation in the country, funding availability is continuing to diminish, obliging humanitarian actors to prioritize only the most vulnerable populations in the country: in 2026, only 227 out of the 330 townships will be targeted for humanitarian aid, resulting in a significant reduction in the number of people targeted from 6.7 million in 2025 to 4.9 million people in 2026.

For health, only 2 million people are targeted during 2026 as compared to 2.4 million in 2025. The majority of people targeted (74%) are non-displaced individuals affected by ongoing conflict and the March 2025 earthquake, followed by internally displaced people (IDPs) (22%) and returned, resettled or locally integrated IDPs and stateless populations (4%). Priority areas for health interventions include Chin, Rakhine, and Sagaing, with additional needs in Kachin, Kayin, northern Shan and Tanintharyi.[15] Women, children, older people, persons with disabilities and those with mental health conditions face heightened risks and barriers to care, including physical access constraints and financial limitations.[16]

Similarly, funding requirements for the 2026 HNRP from $1.4 billion requested in 2025 to $890 million in 2026: 36 per cent decrease in line with decreased funding availability.[17]

The 2026 HNRP will integrate key components of the ‘Humanitarian Reset’ agenda with a particular focus on community involvement, simplified and locally-led coordination structures and pooling of resources in support of a more efficient, targeted, and localized response.[18]

Humanitarian access

While there have been modest access openings in 2025, such as localized progress to facilitate the earthquake response in Mandalay and Sagaing, the overall access environment is expected to remain heavily constrained.[19] Furthermore, 58% of the 6.7 million people targeted for assistance reside in high-restriction areas, where airstrikes, landmines, and telecommunications blackouts frequently force the suspension of life-saving operations.[20]

During December, the delivery of life-saving support to crisis-affected people was constrained by 86 access-related incidents reported by humanitarian partners across 14 states and regions.[21] Administrative restrictions accounted for 29 incidents (34%) during the reporting period, with the majority reported in Shan (South) and Shan (North). Violence and threats against humanitarian personnel, assets or facilities continue to be a serious concern, with seven incidents (8%) reported in December.[22]

Conflict is a key driver of protection and overall humanitarian needs, with assessed households in conflict-affected areas reporting heightened levels of security-related movement restrictions, and a majority being impacted by explosive ordnance.[23] Military operations and armed activity remained the primary driver of access constraints, accounting for 40 incidents (47%) in December. Incidents related to hostilities between the Myanmar Armed Forces (MAF) and non-State armed groups (NSAGs) were reported across multiple states and regions, including Chin, Magway, Sagaing, Kayin and Rakhine.[24]

Displacement

An estimated 3.6 million people have been displaced by conflict and earthquake, with 1.7 million in the hardest-hit regions in the Northwest, Rakhine, and Southeast, the highest figure on record. Most conflict-displaced people have fled their homes multiple times and often end up in informal shelters with limited access to food, healthcare, and clean water.[25] Before the earthquake, the conflict has driven people to flee their homes and livelihoods in record numbers. It is estimated that almost 3.5 million people across Myanmar are displaced, approximately one-third of them children.[26] Only around 15% of IDPs are in sites/camps. Many displaced people remain in temporary shelters, informal camps or jungles, where they face severe shortages of food, clean water, protection assistance and healthcare.[27] More than 1.3 million people from Myanmar have sought refuge in neighbouring countries.[28]

Food Security

Myanmar has also been classified as one of six global hunger hotspots of “very high concern” in the November 2025 Hunger Hotspot report. The report warns that acute food insecurity is deepening in 16 countries, with Myanmar among those facing the most severe risks. Crisis-level coping mechanisms remain high (40–50%) in conflict-affected areas, especially among the 70% of the population that depend on the agriculture sector for their livelihoods.[29]

Myanmar’s protracted conflict and recurrent disasters continue to drive high levels of food insecurity by disrupting livelihoods, reducing planted areas, and depleting livestock herds. In 2026, 8.5 million people in 227 townships within the HNRP scope are projected to face acute food insecurity. It has projected that 964 000 people would be in phase 4 (emergency) of food insecurity in 2026, mainly IDPs, returnees and stateless persons.[30] Crisis-level coping strategies remain high (40–50%) in conflict-affected areas, especially among the 70% of the population that depends on agriculture for their livelihoods.[31]

The food security situation is further exacerbated by disruptions to agricultural activities, with many households losing access to productive assets, farmland, and essential inputs such as seeds and fertilizers. A total of 67% of rural households across Myanmar who were engaged in farming, reported production difficulties due to conflict, climatic disasters, and rising prices. [32]

Vulnerable Groups

Internally Displaced Persons (IDPs) [33] Internally displaced persons constitute the largest and most vulnerable population group in Myanmar, with projections indicating around 4 million IDPs in 2026. Many have been displaced multiple times due to conflict, airstrikes, and insecurity, and are living in informal camps or temporary shelters with limited access to food, healthcare, clean water, and education. IDPs face heightened exposure to explosive ordnance, poor sanitation, food insecurity, and protection risks. Women-headed households and families with children are especially vulnerable, facing barriers to assistance and increased risks of exploitation and violence. Repeated displacement has exhausted coping capacities, leading to deteriorating physical and mental health and increased mortality.

Returned, Resettled, and Locally Integrated IDPs [34] Returnees and resettled IDPs represent a growing vulnerable group who have returned to their places of origin or settled elsewhere without adequate safety or services. Many return to areas affected by landmines, damaged infrastructure, and disrupted livelihoods. Housing, water, sanitation, and health services remain severely limited, leaving families exposed to disease, malnutrition, and renewed displacement. Insecurity and lack of legal documentation further restrict access to assistance. Without sustained support, these populations remain at high risk of falling back into displacement, poverty, and food insecurity. Their vulnerability is compounded by weak social protection systems and limited livelihood opportunities.

Non-Displaced Stateless People (primarily Rohingya) [35] Non-displaced stateless people, mainly Rohingya communities in Rakhine State, face some of the most severe humanitarian conditions in Myanmar. Lacking citizenship and legal documentation, they experience severe restrictions on movement, employment, education, and healthcare. Many live in overcrowded camps or isolated villages with inadequate shelter, water, and sanitation. More than half of this group falls into catastrophic needs severity. They are highly vulnerable to food insecurity, exploitation, extortion, and arbitrary detention. Ongoing conflict and discrimination further limit humanitarian access, reinforcing long-term dependency and poor health outcomes.

Women and girls The crisis has severely affected women and girls.[36] Many have been forced to resort to negative coping mechanisms due to displacement, financial distress, and the lack of access to basic social services such as education and health care, including mental health care.[37] This has only increased their vulnerability to violence, human trafficking, early or forced marriage, mental health disorders and sexual exploitation and sexual abuse.[38] Fear over forced conscription and rising poverty has driven young men to migrate from their places of origin, leaving women, girls and the elderly as heads of households, with increased protection risks.[39]

Children Pre-earthquake, grave violations against children were increasing due to conflict, creating a dire situation for children across Myanmar.[40] An estimated 16.2 million people, including 4.9 million children, will require humanitarian assistance in 2026.[41] Child protection needs in Myanmar are rising sharply. Many children have been separated from their families and urgently require family tracing, alternative care and psychosocial support.[42] Children experience disrupted education, recruitment risks, malnutrition, and psychosocial distress.

Older People and Persons with Disabilities Older persons often lack access to healthcare and social support, increasing morbidity and dependency. Persons with disabilities face stigma, physical barriers, food insecurity, and limited access to services, contributing to higher mental health and protection risks. The combination of physical impairments and poor communication infrastructure have created additional barriers for persons with disabilities from having access to livelihoods, information and services, including education, protection

services, food, non-food items (NFIs), and healthcare.[43] Of the people in need in Myanmar in 2025, 13% are people with disabilities, and 12% are older people (60+).[44] The earthquake in March 2025 severely disrupted critical services for people living with disabilities. Over half (61%) lost access to electricity, 54% reported damaged or destroyed housing, and nearly 48% lacked safe drinking water. In 2025, only 60% of female-headed and 62% of male-headed households with disabilities reported receiving humanitarian assistance. Women reported higher rates of difficulty than men, with the largest gender gap observed in mobility: 21% of women reported difficulty walking compared to 14% of men.[45]

LGBTQI+ communities: The crisis has severely and uniquely affected lesbian, gay, bisexual and transgender persons. [46]

Health Status and Threats

Population mortality In Myanmar, life expectancy at birth (years) has improved by 9.46 years from 59.4 years in 2000 to 68.9 years in 2020, and then declined to 67.8 years in 2021.[47] This life expectancy in Myanmar in 2021 is below the average life expectancy of the South-East Asian Region (68.4 years).[48] In 2021, the top causes of death in Myanmar were stroke, ischaemic heart disease, tuberculosis, COVID-19 and chronic obstructive pulmonary disease.[49] Recording and reporting have been significantly affected since the state of emergency, and data are not available on how the ongoing conflict is affecting mortality.

Table 1. Key indicator values related to population morality in Myanmar

Mortality indicators	WHO regional average	2018	2019	2020	2021	2022	2023	SOURCE
Life expectancy at birth	68	68.56	68.81	68.87	67.85	N.A.	N.A.	Global health Observatory (WHO)
Newborn Mortality rate (deaths of newborns up to 28 days per 1 000 live births	16	23.18	22.62	22.1	21.59	21.06	20.59	UN Interagency group for child mortality Estimation
Infant mortality rate (deaths < 1 year per 1000 live births)	24	40.2	38.9	37.6	36.35	35.2	34.11	UN Interagency group for child mortality Estimation
Child mortality rate (deaths < 5 years per 1000 live births)	27	45.98	44.4	42.86	41.37	40.03	38.74	UN Interagency group for child mortality Estimation
Maternal mortality rate (MMR)Number of paternal deaths per 100,000 live births	96	200.9	194.9	198.2	231.3	192.9	184.6	UN Interagency estimates/GHO

Immunization coverage Immunization coverage remains critically low, with 1.5 million children under five missing basic immunizations since 2018, increasing the risk of measles, diphtheria and possible polio resurgence.[50] The immunization coverage significantly declined in 2021 dropping to below 50% for all antigens – ranging from 7% to 48% (Figure 2).[51] Although these levels have recovered slightly since then, with a diphtheria–tetanus toxoid and pertussis (DTP3[1]) coverage of 76% in 2023 and 71% in 2024, vaccination coverage is still not back to pre-2021 levels. In response, a large-scale catch-up immunization drive was conducted in a phased manner targeting the more than 1 million zero-dose and under-vaccinated children of 1 to <5 years of age.[52] A total of four vaccines (pentavalent, measles–rubella, oral polio vaccines [OPV] and injectable polio vaccine [IPV]) containing eight antigens are used for the catch-up, with three rounds of immunization at two-month intervals.

However, people in areas not under the control of the military regime have no or very limited access to vaccines, and systematic immunization cannot be carried out in many of those areas. Health workers face security risks and vaccine access, and delivery are restricted. For example, DTP3 vaccination coverage by district (Figure 3) shows an overall decrease in the number of districts reporting vaccination coverage of over 70% in 2024 compared to 2023.[53] Decline in immunization coverage increases the risk of outbreaks of vaccine-preventable diseases (VPDs). Several diphtheria and measles cases and a vaccine derived polio virus event (VDPV) were reported in 2025; however, there are concerns about reporting coverage resulting in substantial underreporting.

[1] Myanmar uses diphtheria–tetanus toxoid and pertussis in the pentavalent vaccine.

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
BCG	94	88	91	90	91	87	48	79	80	78
DTP3	89	90	89	91	90	84	37	71	76	71
OPV3	89	89	89	91	90	86	43	75	80	71
MCV1	84	91	83	93	84	91	44	75	74	71
MCV2	78	86	80	87	80	90	42	64	65	68

Figure 2. Trend of the national immunization coverage (2015-2024)

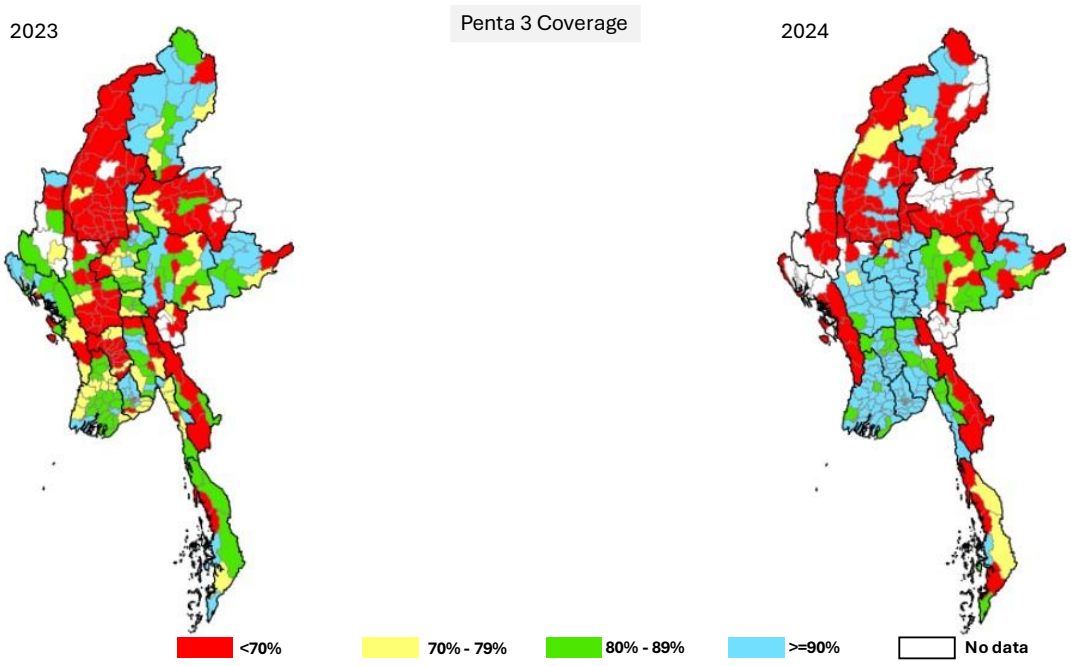

Figure 3. Coverage of DTP3 vaccination by district, Myanmar, 2023 and 2024 [54]

Overview of Key Health Risks

Table 2 summarizes the current assessment of the level of public health risks due to different health problems impacting the crisis-affected population grouped into major hazard types. Changes in the projected level of risks are also shown.

Table 2. Key risks and their estimated evolution in the January to September 2026

Public health risks	Jan – Mar 2026	April – June 2026	July – Sep 2026
Trauma and injuries			
Tuberculosis			
Mental health conditions			
Adolescent health			
Vector-borne diseases (e.g., malaria, dengue)			
Environmental and natural hazards			
Cholera, acute watery diarrhoea & waterborne diseases			
Vaccine-preventable diseases (e.g. measles, polio, diphtheria)			
Noncommunicable diseases (NCDs)			
Malnutrition			
HIV & viral hepatitis B and C			
Antimicrobial resistance (AMR)			
Acute respiratory infections (ARI), including influenza and COVID-19			
Skin infection			
Maternal and newborn health risks			
Sexual and reproductive health			
Leprosy			

Red: **Very high risk**. Could result in high levels of excess mortality/morbidity

Orange: **High risk.** Could result in considerable levels of excess mortality/morbidity

Yellow: **Moderate risk.** Could make a minor contribution to excess mortality/morbidity

Green: **Low risk.** Will very probably not result in any excess mortality/morbidity

Trauma, injuries and disabilities

Trauma and injuries Myanmar faces a severe and escalating health hazard from widespread landmine and explosive ordnance (EO) contamination [55]. Conflicts involving multiple armed actors have led to extensive use of anti-personnel mines, improvised explosive devices (IEDs), and unexploded ordnance (UXO) across most states and regions. In the first nine months of 2024, 889 casualties were recorded—85% of the total reported in 2023 (1,052)—with Shan, Sagaing, and Rakhine among the most affected areas. Children accounted for 28% of victims, highlighting the disproportionate impact on vulnerable populations. In 2023, Myanmar recorded the highest number of landmine and EO casualties globally. Since 2022, contamination has increasingly spread into residential and communal areas such as schools, temples, farmland, and frequently used pathways, exposing civilians to constant risk. These hazards

cause deaths, long-term disability, psychological trauma, and loss of livelihoods. Displacement has further increased exposure, with over 3.2 million people internally displaced since 2021. Nationwide, an estimated 7.3 million people require mine action assistance. Beyond direct injuries, landmine contamination undermines food security, economic recovery, environmental sustainability, and community cohesion. Persistent fear and uncertainty contribute to adverse mental health outcomes and weaken social resilience. The earthquake has significantly increased trauma cases. The earthquake killed approximately 3800 people, destroyed tens of thousands of homes and critical infrastructure.[56] Limited access to emergency care, surgical interventions and rehabilitation services have posed a severe risk to survivors.

Disabilities In 2019, an estimated 5.9 million people in Myanmar—about 12.8% of the population—were living with disabilities, with higher prevalence in states such as Chin, Rakhine, and Ayeyarwady.[57] The number has likely increased due to conflict-related injuries and disruptions to health services caused by the pandemic and political instability. The March 2025 earthquake further intensified challenges for persons with disabilities. Assessments indicate that even before the disaster, households with disabilities had significantly higher health needs and were more likely to report unmet healthcare needs. Post-earthquake barriers include treatment costs, distance to health facilities, damaged infrastructure, and transportation difficulties. Around 27% of households with persons with disabilities reported being unable to access healthcare, while many facilities were damaged or overcrowded.[58] Although mobile clinics have been deployed, they are often not fully accessible. The earthquake also caused over 5,000 injuries, increasing disability cases and placing additional strain on already limited healthcare, rehabilitation, and social support services.

Tuberculosis (TB)

Tuberculosis (TB) is a major public health problem in Myanmar and one of the leading causes of mortality. Myanmar remains one of the highest TB burden countries globally. As per the Global TB report 2025 [59], the estimated TB incidence was 482 per 100 000 population in 2024, an increase of 23% since 2015. An estimated 35 900 TB related deaths occurred, including those due to TB-HIV coinfection. In the year, an estimated 263 000 (167 000–404 000) people are estimated to have newly developed the disease, including 16 000 people with TB living with HIV (9 200–25 000). A total of 2,424 rifampicin resistant (RR-) and multidrug-resistant (MDR-TB) cases initiated on treatment out of an estimated 11 000 cases with those severe forms of resistance; while 44% of the estimated new and relapse TB cases were initiated on treatment. It is also estimated that 60% of families affected with TB are experiencing catastrophic costs. Access to TB care is challenging, especially amongst the displaced population and along with nutrition insecurity is likely to increase vulnerability.

Mental Health Conditions

Conflict and disasters have worsened mental health conditions, including rising concerns about severe distress and suicidality among displaced people, while crowded settlements, unsafe drinking water, poor sanitation and interrupted health programmes pose serious threats to mental health.[60] Pre-earthquake, in 2024, a third of adults in Myanmar are reported a probable mental disorder, with estimated prevalence of post-traumatic stress disorder (PTSD), depression, and anxiety being 8.1%, 14.3%, and 22.2%, respectively [61]. Rapid assessments following the 2025 earthquakes reported psychological distress in 67% of families, with 84% lacking access to psychosocial support. Children are particularly vulnerable to trauma, displacement, and family separation.[62]

Myanmar's mental health system remains severely under-resourced and unable to meet growing needs. Based on Myanmar Mental Health Atlas 2024, mental health infrastructure is limited, with only 0.3 psychiatrists, 0.2 mental health nurses, and 0.1 social workers per 100,000 people, with only two mental health hospitals nationwide.[63] Stigma and a shortage of trained professionals further restrict access to care. Local NGOs and civil society groups provide basic support such as Psychological First Aid and awareness activities, but access to advanced care, including psychiatric medication and psychotherapy, remains limited. Ongoing stigma,

infrastructure constraints, and coordination challenges continue to hinder an effective nationwide mental health response.

Vector-borne diseases

Malaria Myanmar carries the highest malaria burden among the six Greater Mekong Subregion countries, accounting for 95.5% of indigenous malaria cases and 97.7% of indigenous *Plasmodium falciparum* cases in 2024, and the second highest burden in the WHO South-East Asia Region [64]. About 38 million people (70% of the population) are at risk, particularly mobile and migrant populations, internally displaced persons, and communities in hard-to-reach border areas. Malaria cases have rebounded since 2020, increasing threefold to 189,358 cases in 2024, with most occurring in 30 townships. *Plasmodium vivax* accounts for about 90% of cases. Malaria control efforts have weakened due to conflict, workforce attrition, and reduced health facility functionality. Reporting rates, testing coverage, and the annual blood examination rate have declined, while test positivity has increased, indicating under-detection. Vector control is limited, with few long-lasting insecticidal nets distributed. Restricted access to diagnosis, treatment, and prevention services continues to heighten malaria risks, especially in rural and conflict-affected areas.

Dengue Dengue remains a major public health concern, affecting an increasing number of people, mostly children under 15 years of age.[65] Dengue is endemic in Myanmar and, like malaria, sees a seasonal peak in the middle of the year. In 2024, 6,388 dengue cases and 13 deaths were reported, increasing in 2025 (January–December) to 12,040 cases and 41 deaths. [66] Ongoing conflict has significantly disrupted dengue and malaria response activities, including vector control and bed net distribution, increasing the risk of further outbreaks. Myanmar's frequent exposure to severe natural disaster shocks—including cyclones, floods and drought—continues to drive vulnerabilities. Physical damage to ecosystems and water systems, along with power shortages, further raises the risk of spread of as dengue.[67]

Adolescent health issues

The ongoing conflict in Myanmar has severely affected adolescent health, particularly among girls and young women in conflict-affected areas. Conscription and escalating tensions have driven displacement, family separation, and disrupted access to education and health services. Many adolescents experience significant psychological distress, especially those separated from parents [68]. Risks of early and forced marriage, trafficking, and recruitment into armed groups have increased, while limited humanitarian access further deepens vulnerabilities. Drug use among adolescents and youth is an escalating crisis. Even before 2021, young people accounted for a notable share of treatment admissions and arrests. Since the coup, conflict, economic decline, and weakened governance have expanded drug production and availability, especially in Shan and Kachin States and the Golden Triangle. Trauma, limited opportunities, and social pressures heighten vulnerability, resulting in serious health, social, and legal consequences.

Environmental and natural hazards

Myanmar is highly vulnerable to natural disasters due to its geography and climate. The country frequently experiences floods, landslides, cyclones, droughts, earthquakes, and storm surges. Flooding and landslides commonly occur during the monsoon season (June–October), while cyclones typically strike in the pre- and post-monsoon periods. Myanmar's location along active tectonic boundaries also exposes it to significant earthquake risk. From 1995 to 2024, the country ranked among the most affected globally by climate-related hazards. These disasters contribute to displacement, food insecurity, water contamination, and disruptions to public health services, as highlighted by the March 2025 earthquake. Ongoing conflict further weakens protection and response capacity, underscoring the urgent need for resilient infrastructure, safe water and sanitation, and strengthened health and psychosocial support systems.

Cholera, acute watery diarrhoea (AWD) and waterborne diseases

A large-scale cholera outbreak occurred between June 2024 and April 2025.[69] An outbreak of AWD/cholera that started in Yangon in July 2024 have spread to 9 of Myanmar's 17 States and Regions. As per data shared by national programme, 2,139 confirmed cases and 8 deaths were reported in 2024. Conflict, displacement into overcrowded shelters, weak surveillance systems, and poor WASH access have likely contributed to the spread and sustained transmission of cholera. Cross border spread has been documented. From late 2024 to early 2025, cholera outbreak occurred in Kayin State near Shwe Kokko, which borders with Thailand. Since late 2025, new AWD outbreak was recorded in India-Myanmar border, with AWD cases in Paletwa (Chin) and Rakhine, possibly linked to resurgence of confirmed cholera cases reported from crowded temporary settlements in India, close to the Myanmar border.[70] The risk for the first 3 months can be relatively low compared to the monsoon season; however, water scarcity and reliance on unsafe sources can still lead to localized outbreaks. Once the monsoon starts in late April/May, risk of waterborne diseases will be heightened across the country. Several states and regions continue to report cases of AWD, while damage to water and sanitation infrastructure in areas recently affected by the earthquake further exacerbates the threat of disease transmission. There was an increase in hepatitis A cases in Sagaing resulting from an influx of newly displaced populations in areas with high endemicity areas due to poor sanitation and water quality.[71]

Vaccine-preventable diseases

Myanmar faces an elevated risk of vaccine-preventable disease outbreaks due to systemic disruptions and declining immunization coverage. Routine vaccination rates dropped sharply in 2021—falling below 50% for all antigens—and although coverage has gradually improved, it remains well below pre-crisis levels and not able to control or stop transmissions of vaccine-preventable diseases (VPDs), with large pockets of zero-dose and under-vaccinated children persisting nationwide. Conflict, displacement, and severe health-system fragmentation continue to hinder service delivery, leaving many areas—especially those outside military control—without reliable access to vaccines or surveillance mechanisms.

This situation has already contributed to rising risks of diseases such as measles, diphtheria, pertussis, and polio, evidenced by low coverage and surveillance gaps in conflict-affected regions. Together, these factors create conditions highly conducive to VPD outbreaks, underscoring the urgent need for strengthened immunization, surveillance, and humanitarian access. Recent report of vaccine-derived poliovirus (VDPV1) case in 2025 has created serious concerns about suboptimal immunization coverage. The surveillance performance indicators are also below the national targets in many subnational areas indicating very low reporting efficiency of VPDs.

At present, only approximately 30%–40% of townships, which account for 75% of the population, are accessing vaccines provided by the United Nations and other international organizations and covered by the VPD surveillance system managed by the Ministry of Health of the State Security and Peace Commission (SSPC). Those living in areas not under the control of the military are neither receiving vaccines from the national immunization programme, nor are they covered by VPD surveillance. The sensitivity of the VPD surveillance system deteriorated leading to limited availability of reliable data for routine immunization.

Table 3. Reported cases of vaccine-preventable diseases, Myanmar, 2020–2024 [72] [73]

Surveillance	Reported	2020	2021	2022	2023	2024	2025
Acute Flaccid Paralysis (AFP)	Reported AFP cases	187	33	151	265	271	313
	Confirmed polio cases	0	0	0	0	0	1*
Measles	Reported fever with rash cases	682	30	57	180	266	309
	Confirmed measles	444	8	10	15	30	9
Rubella	Tested for rubella	257	25	57	171	266	309
	Confirmed rubella	3	3	0	2	13	9
Diphtheria	Suspected	273	7	41	97	83	107
	Confirmed diphtheria	169	3	3	41	32	45
Acute encephalitis syndrome (AES)/ Japanese encephalitis (JE)	Reported AES cases	871	43	91	385	432	431
	JE confirmed cases	75	2	6	19	19	11
Pertussis	Clinically confirmed cases	13	0	4	50	28	33
Neonatal Tetanus	Clinically confirmed cases	17	8	16	8	7	7

* cVDPV: circulating vaccine-derived poliovirus

Non-Communicable Diseases (NCD)

According to the latest available WHO noncommunicable disease (NCD) country profile for Myanmar, four major NCDs are estimated to account for 71% of all deaths, with a proportional mortality of 31% for cardiovascular diseases, 13% for cancers, 10% for chronic respiratory diseases and 6% for diabetes (2020). Deaths due to NCDs are expected to increase by 21% over the next decade if effective prevention and control measures are not undertaken. The March 2025 earthquake and ongoing conflict exacerbates challenges in managing noncommunicable diseases (NCDs) due to disrupted healthcare services and medication shortages. Limited access to essential treatments for hypertension, diabetes, and cardiovascular diseases poses a serious risk. Strained health systems could lead to gaps in care. Immediate interventions are needed to ensure continuity of treatment and prevent complications.

Malnutrition

In 2026, 2.7 million people will need nutrition assistance, including 2.3 million children under five and 380 000 pregnant and breastfeeding women (PBW). Over 72 000 children risk death without therapeutic feeding for severe acute malnutrition (SAM), while 288 000 face increased mortality risk without targeted supplementary feeding for moderate acute malnutrition (MAM).[74] The combined impact of conflict, displacement, and natural disasters, including the earthquake, continues to put children at heightened risk of malnutrition, especially in remote and underserved communities. The increased cost of heathy diet compound the situation, with the cost of a healthy diet (estimated in 2024) increased by 29% from the previous year, while the increase being even higher in conflict-affected areas such as Rakhine, Chin, Kaya, and Shan states (the cost of a healthy diet in Rakhine was 60% higher than the national average while 9% higher in Shan). [75] Rakhine State faces a severe malnutrition crisis, especially in Northern Rakhine State, with available data showing 13.1% of children categorised with moderate acute malnutrition using mid-upper arm circumference measurements (MUAC)[76].

Maternal and Newborn Health Risks

Women and children encounter numerous obstacles in accessing quality healthcare, exacerbated by limited availability of essential services in remote and conflict-affected areas.[77] The maternal and newborn health services continue to face significant challenges due to a shortage of healthcare workers and essential medical supplies. In conflict-affected areas, many health facilities remain non-operational, forcing communities to rely heavily on maternal and newborn healthcare services provided by NGOs and private-sector providers. The 2025 earthquake further disrupted service delivery by damaging health infrastructure and interrupting supply chains, exacerbating existing gaps in maternal and reproductive health care. Many women still give birth at home, with limited access to emergency obstetric and neonatal care, increasing health risks for both mothers and newborns. Maternal mortality ratio had dropped by 54% (from 375 to 185 maternal deaths per 100 000 live births), with a 3.0% annual rate of reduction between 2000 and 2023 (WHO,2025). Similarly, the under-five mortality rate (U5MR) and the neonatal mortality rate had decreased by 66% (from 115 to 39 per 1000 live births) and 57% (from 48 to 21 per 1000 live births), respectively, between 1990 and 2023.[78] However, maternal mortality is still high. The main causes of deaths are post-partum haemorrhage (bleeding), hypertensive disorders of pregnancy, consequences of unsafe abortions, and sepsis. Most maternal deaths can be prevented through cost-effective interventions such as the presence of skilled birth attendants during deliveries, emergency obstetric care, and access to birth-spacing commodities and services.[79] Abortion complications are one of the leading causes of maternal deaths.[80]

Sexual and reproductive health

Sexual and reproductive health services in Myanmar remain severely constrained, particularly in conflict-affected and disaster-impacted areas where communities increasingly rely on private providers and community-based organizations. Persistent shortages of contraceptives, devices, and essential maternal and reproductive health supplies across both public and private sectors have significantly limited family planning services. Conflict-related disruptions to pharmaceutical supply chains and transportation have further reduced availability, even through pharmacies and NGO-run clinics. As a result, reduced access to contraception has contributed to increased unintended pregnancies, unsafe abortions, and heightened risks of sexually transmitted infections. The contraceptive prevalence rate is 52%, with an unmet need for family planning of 16%, and abortion complications remain a major cause of maternal death. Gender-based violence also remains a major concern, with 18.7% of women aged 15–49 have experienced intimate partner violence, with risks further exacerbated by displacement, insecurity, and weakened protection systems.

Acute Respiratory Infections (ARI), including COVID-19 and Influenza

Influenza activity in Myanmar generally peaks between June and September, coinciding with the monsoon season. On average, in 2023 and 2024, more than 40 clusters of influenza-like illness were reported across the country.[81] Displacement and overcrowding increase transmission risks. Political instability has led to restricted access to health facilities, population displacement – including health-care workers – and a decline in disease reporting.[82] In 2025, some hospitals have resumed submitting samples to the National Influenza Centre (NIC). According to data reported to FluMart under the Global Influenza Surveillance and Response System (GISRS), in 2025, 1,298 ILI/SARI samples were collected and tested through sentinel and outbreak-related surveillance [83].

Human Immunodeficiency Virus (HIV) and viral hepatitis B and C

HIV According to the latest UNAIDS estimates, there are approximately 290,000 [220, 000–370, 000] adults and children living with HIV in Myanmar [84]. The national HIV prevalence among adults is estimated to be below 0.6%. While prevalence has stabilized, Myanmar remains one of the hardest-hit countries in Southeast Asia.

The epidemic is concentrated among key populations, with high prevalence among people who inject drugs (PWID), men who have sex with men (MSM), and sex workers, particularly in Kachin State, Shan State, and Yangon [85]. While approximately 65% of people living with HIV in Myanmar were receiving Antiretroviral Treatment (ART), people face increasing challenges in accessing ART, due to service disruption following the 2025 earthquake, and a directive issued on August 6, 2025, requiring all local and international NGOs/INGOs to immediately stop distributing ART, TB drugs, and malaria treatments.

Viral hepatitis B and C According to a national seroprevalence survey conducted among the general population in 2015, the prevalence of hepatitis B and hepatitis C was high, at 6.51% and 2.65%, respectively. The protracted emergency situation in Myanmar has impacted the uptake of new enrolment for hepatitis C treatment and routine reporting system, as well as the scale up and integration of services. Childhood immunization coverage of timely birth dose and third dose of hepatitis B vaccine are suboptimal (17% and 76%, respectively, in 2023 – WHO, 2024a).

Antimicrobial Resistance (AMR)

In 2023, Myanmar reported antimicrobial resistance (AMR) prevalence data for key priority pathogens across bloodstream and urinary tract infections. Notably high estimated resistance prevalence was observed for *E. coli* to third generation cephalosporins in both bloodstream (78.5%) and urinary tract infections (77.8%). *K. pneumoniae* also showed significant resistance to cefotaxime (71.4%) and imipenem (39.3%) in urinary tract infections. Bloodstream infections caused by K. pneumoniae, and Acinetobacter spp. exhibited estimated imipenem resistance prevalence of 50.9% and 38.2%, respectively. Methicillin-resistant S. aureus (MRSA) bloodstream infections had an estimated prevalence of 51.8% [86]. These findings highlight the critical burden of resistance to key antibiotic classes, particularly third generation cephalosporins and carbapenems, underscoring the urgent need for strengthened AMR surveillance and stewardship in Myanmar. Seven AMR sentinel sites were established in 2019, but the operation of few sites have been further disrupted by the ongoing operational challenges.

Skin diseases

Alarming increase in preventable skin infections, particularly in Kayah, Tanintharyi, Rakhine and Magway, driven by overcrowding, inadequate hygiene, and worsening humanitarian conditions. Since 2024, skin infection outbreaks are frequently reported in conflict-affected areas. Most outbreaks involve scabies with secondary bacterial infections, including poststreptococcal acute glomerulonephritis (PSGN). [87]

Leprosy

The Health Cluster report that a lack of access to leprosy treatment is impeding many health partners from providing relevant medicines to this disabling disease. Without the adequate treatment leprosy may cause progressive and permanent disabilities.[88]

Determinants of Health

Protection risks

Within the humanitarian and protection crisis in Myanmar, widespread abuses affect women, men, girls and boys differently, with women suffering the most due to pre-existing structural gender and social inequalities, discrimination, and patterns of GBV.[89] The expanding conflict has heightened concerns about GBV, livelihoods, human trafficking and illegal migration among young women and men, as well as unsafe movement of young girls and women seeking refuge to safer locations. Myanmar is a high-risk country for sexual exploitation and abuse,30 primarily due to the ongoing humanitarian crisis, with large numbers of vulnerable people in close proximity to armed actors and in need of aid. [90]

Child labour and child marriage are typically underreported and significantly affect girls and boys, particularly displaced children. As found in the 2024 MSNA, roughly 30% of families were aware of children getting married before the age of 18.[91]

The proliferation of landmines and explosive ordnance in Myanmar has reached a critical level, with incidents reported across all regions and states by quarter three of 2024. In 2023, Myanmar also recorded the highest number of landmine and explosive ordnance casualties globally, ahead of Syria, Afghanistan and Ukraine, highlighting the widespread and devastating impact of landmine contamination and the urgent need for increased mine action effort to address this escalating crisis. Myanmar has not signed key international agreements, including the Anti-Personnel Mine Ban Convention, the Convention on Cluster Munitions, and the Convention on Certain Conventional Weapons.[92]

Extreme weather events

Myanmar ranks among the top three countries most affected by extreme weather events globally, according to the latest Global Climate Risk Index.[93] The country is highly vulnerable to climate shocks such as cyclones and monsoon floods. One year after being struck by the devastating Cyclone Mocha in 2023, Myanmar was hit by severe flooding in July and September 2024 due to remnants of monsoon rains and Typhoon Yagi respectively. The floods affected nearly all regions and states, impacting more than 1 million people, including many already displaced by conflict in the Northwest, Rakhine, and the Southeast.[94]

Between July and September, 26% of Myanmar's cropland was flooded. Both the direct and indirect impact of flooding, through the significant risk of disease outbreaks such as acute watery diarrhoea (AWD) and cholera, are further exacerbating the hardships faced by vulnerable populations, highlighting the compounded impact of natural hazards and disasters on an already worsening humanitarian crisis. [95]

Water, Sanitation and Hygiene (WASH)

In 2026, an estimated 8.9 million people across 227 of Myanmar's 330 townships will require WASH assistance. Needs are driven by protracted and new displacement, lingering flood and earthquake damage, market disruption and inflation, as well as recurrent AWD/cholera outbreaks linked to the monsoon and deterioration of WASH services and facilities in many sites and locations.[96]

Education

Increasingly, more boys and girls across Myanmar are failing to safely gain access to learning opportunities within their communities. This is largely related to a mix of disasters and escalating conflict across the country, leading to increased displacement and reduced safety, including deliberate attacks on education.[97] Nearly five years after the February 2021 military takeover, access to safe and protective education remains severely

constrained. Nationwide, 29% of assessed school-aged children were not attending formal school, with rates highest among non-displaced stateless children (74%), followed by IDPs (61%) and returnees (48%).[98]

Rohingya Crisis

Rohingya people are among the most vulnerable populations in Myanmar, having endured decades of violence, systemic discrimination, and persecution. As of 30 June 2025, an estimated 550 000 Rohingya remain in Rakhine, while more than 1.1 million have taken refuge in Bangladesh. Of those still in Rakhine, around 153 000 are living in internally displaced persons (IDP) camps.[99] Another 82n000 remain displaced by clashes between the Arakan Army and Myanmar Armed Forces (MAF) between 2019 and 2025. Systematic discrimination, including the lack of citizenship and documentation targeting Rohingya in both camps and villages severely hampers their freedom of movement, often leading to detention, extortion, and exploitation when traveling, and leaves them at constant risk of harassment and abuse.[100]

Health System Status and Local Health System Disruptions

Pre-crisis health system status

Governance The National Health Plan (NHP) 2017–2021 is the principal policy guiding health governance in Myanmar. It was developed by the Ministry of Health (MoH) through an inclusive, multi-stakeholder process involving government departments, State/Region and Township health authorities, civil society, NGOs, Ethnic Health Organizations (EHOs), private providers, and development partners. The plan sets strategic direction for primary health care, service delivery strengthening, health financing, human resources, infrastructure, and monitoring and accountability. The Strategic Directions for Universal Health Coverage (UHC) (2014) also provided a foundational framework that guided the development of the NHP and oriented Myanmar's health strategy toward UHC. A key objective was extending access to the Basic Essential Package of Health Services to the entire population by 2020, alongside strengthening financial protection. The strategy emphasized primary health care (PHC) services delivered at township and community levels. Despite these policy frameworks and early implementation efforts, progress toward full UHC remained limited.

Service delivery and access to care Myanmar's health system comprises a mix of public and private providers, non-profit organizations, and EHOs. The public sector delivers the majority of services (about 86%) through more than 1,100 hospitals, although service availability varies widely across regions due to conflict and geography. Central, specialist, and teaching hospitals are mainly concentrated in major cities such as Yangon, Mandalay, Naypyitaw, Taunggyi, and Magway. According to the 2021 Myanmar Health Statistics, the country had 131.37 hospital beds per 100,000 population. Private hospitals, clinics, and pharmacies primarily provide outpatient and ambulatory care. Under the MoH, Myanmar maintained a tiered service delivery network from community to hospital levels. A typical township system includes a township hospital providing general inpatient care, supported by 1–2 station hospitals and 4–9 rural health centres (RHCs). Each RHC oversees 4–7 sub-Rural Health Centres serving smaller catchment populations of approximately 5,000–20,000 people. Outreach services are delivered by midwives, auxiliary midwives and community health workers.

Health workforce Myanmar's health workforce density was already below global recommendations prior to the 2021 crisis, with approximately 17.8 doctors, nurses, and midwives per 10,000 population (below the WHO target of 22.8 per 10,000) and a total health workforce density of about 1.33 per 1,000 population in 2016, far below the WHO minimum of 2.3 per 1,000 required for essential services [101]. The distribution of health workers was highly uneven, with a concentration in major urban areas like Naypyitaw, Yangon and Mandalay and lower staffing in smaller states and regions such as Kayah and Chin.

Health finance The latest National Health Expenditure Report for 2019-2022 confirmed, the government health expenditure accounted for a modest 3.25 percent of the total government expenditure in 2019 and 76% of current health spending in Myanmar is paid out-of-pocket by families as per Global Health Expenditure Data Base in 2019. Although it was found to be lower than previous periods, it stands as one of the highest among the regions. It may also be noted that the health expenditure flowing through non-governmental organisations was 6.4 percent in 2019. Historically, international assistance for health service delivery was largely directed through NGOs and EHOs rather than state institutions. However, during the democratic transition from 2012 to 2020, development assistance to Myanmar expanded substantially.

Health supply chain The MOH was responsible for the public supply of essential medicines and health commodities through the Central Medical Store Depot (CMSD), in coordination with State/Regional and Township health departments. Procurement guidelines required annual procurement plans and competitive tendering processes for medicines and supplies, overseen by procurement committees at different government levels. The Food and Drug Administration (FDA), under the MOH, regulated drug registration, licensing, importation, export, storage, distribution, and sale of medicines under the National Drug Law (1992), ensuring their safety and quality. Quality assurance included product registration, inspection, licensing, and post-market surveillance. Medicines registered locally or listed in the National Essential Medicines List were prioritized.

In crisis health system status

Key information on disruption of key health system components

ACCESS TO HEALTHCARE	DISRUPTION TO SUPPLY CHAIN	DAMAGE TO HEALTH FACILITIES	ATTACKS AGAINST HEALTH CARE
			
Access to basic health services is particularly dire in Rakhine and Kayah, **where nearly half the population faces serious difficulties**.[102]	International and domestic supply chains have been **significantly affected by the regime change in 2021,** including through challenges with land and air transportation and security threats [103].	Insecurity Insight **identified at least 1878 incidents of violence against or obstruction of health care** in Myanmar between 01 February 2021 and 28 February 2026.[104]	WHO surveillance system for attacks on health care documented **265 attacks that impacted health facilities** between the 01 February 2021 and 28 February 2026. [105]

Governance Central public health governance structure has been weakened through the prolonged conflict, while parallel governance structures including those associated with ethnic administrations now operate in many areas. Humanitarian responders in Myanmar face administrative restrictions. In October 2022, the Organisation Registration Law was introduced, requiring all organisations in Myanmar to register their presence, for which fees, approvals and other processes are needed, which hinder humanitarian operations . [106] [107]These restrictions also prevent humanitarian travel into Myanmar and the import of key humanitarian supplies.[108] [109]

Service delivery and access to care Access to quality health care continues to deteriorate in hard-to-reach areas, conflict-affected areas and areas not under the control of SSPC. Recent earthquake in Myanmar also severely impacted healthcare access, with damaged facilities, shortages of supplies, and increased risk of disease outbreaks in impacted areas. Many health facilities were destroyed or damaged, including hospitals and clinics, leading to a surge in patients and limited access to care. Security concerns are deterring people from visiting clinics or even hospitals for referral. People are shifting to the use of teleconsultations, with the inherent risk of misdiagnosis. In addition, restriction in access to cash is a serious impediment for non-State health service providers.[110] Non-State health service providers are severely restricted in their ability to provide essential health services because of shortages of skilled health workers and restrictions on the importation of medical supplies, including pharmaceuticals.

Health workforce Since 2021, the situation of health workforce has deteriorated. By 2022–2023, densities of health workers had declined to around 1.01 doctors and 1.96 nurses per 10,000 population [111], which has constrained health system functionality and challenges long-term service sustainability. Health worker retention has been declined by the decline of remuneration, supervision, and training systems. Anecdotal evidence collected from health partners shows that chronic underfunding has reduced salaries and incentives, with many humanitarian-supported health workers now relying largely on in-kind assistance. Financial constraints have compelled NGOs to scale down staffing and compensation, undermining continuity and quality of care. The absence of a nationally coordinated salary and incentive framework has contributed to inequities and instability in deployment. Meanwhile, insecurity and displacement have disrupted pre-service and in-service training, with medical and nursing institutions intermittently closed or operating at reduced capacity, limiting workforce replenishment.

Health financing The latest National Health Accounts (2019-2022) confirmed that in 2022, the Current Health Expenditure (CHE) was estimated to be MMK 5,993,978 million, with a per capita health expenditure of MMK 111, 000 (USD 72.76). 76% of the current health spending in Myanmar is out of pocket (OOP) on the part of families, as per the Global Health Expenditure Database in 2019. [112] Although it was found to be lower than that in previous periods, it is one of the highest in the Region. OOP expenses were already significant and continue to increase, necessitating further household spending in view of depleted government tax resources, on top of declining or inaccessible donor support (multilateral, bilateral donors).

Health supply chain International and domestic supply chains have been significantly affected since 2021 [113], including through challenges with land and air transportation and security threats. Currently, there are shortages of key essential and lifesaving medicines (including injectable drugs) while some key essential medicines were available in only a limited number of private pharmacies. The major reasons that influenced drug availability and pricing included prolonged import licensure procedures, delayed customs clearance and restrictions on drug importation. Reliance on locally-procured medicines increases the risk of suboptimal quality medicines, interruption of treatment and potential emergence of drug resistance.

Surveillance and outbreak response Since 2021, the surveillance and outbreak response systems have become increasingly fragmented and are non-functional in some areas. Access to laboratory diagnosis is also challenging in hard-to-reach and conflict-affected areas, especially areas not controlled by SSPC. The capacity to detect and investigate acute public health events is limited, and complex security and political landscapes make public health response operations to control transmission and care for those affected very challenging. Disease surveillance gaps, combined with the low immunization coverage, pose major health security threats to the population of Myanmar.

Attacks on health care Attacks on health care has significantly increased in 2025, driven by intensified airstrikes and ongoing conflict. To date, WHO's Surveillance System for Attacks on Health Care (SSA) [114] recorded incident reports of 70 verified attacks, 148 deaths, and 186 injuries (1 January -31 December 2025). The number of incidents was consistently higher in 2025 than 2024 across most of the months showing an overall increase in risk from last year. Cumulatively, from 1 February 2021 to 23 December 2025, WHO's SSA documented 535 incidents of attacks on health care, 277 deaths and 487 injuries in Myanmar. During the same period, Insecurity Insights recorded 1878 reported incidents of violence or threat of violence against health care, which includes 475 health facilities damaged, and 171 health workers killed.[115] Many professionals have been forced to suspend clinical practice, flee to safer areas, or leave the country.

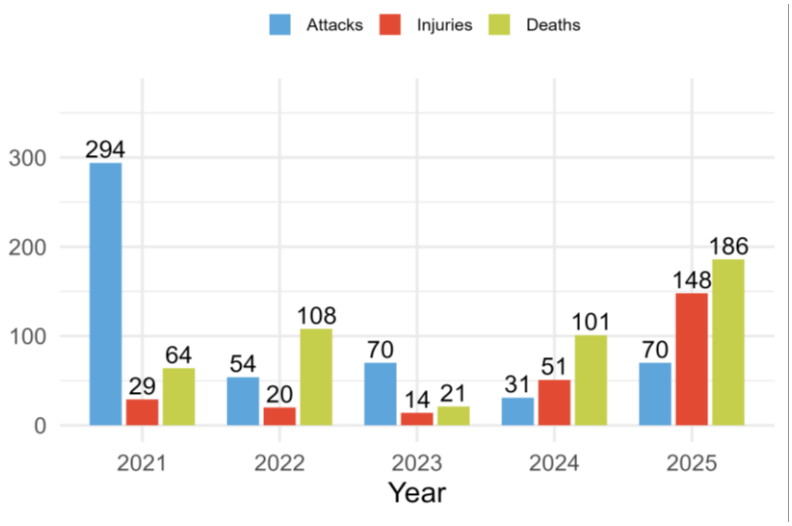

Figure 4. Attack on health care from 2021 to 2025 (WHO SSA)

Humanitarian Health Response

Myanmar Health Cluster

The role of the Health Cluster is to collectively prepare for and respond to humanitarian and public health emergencies to improve health outcomes of crisis affected populations through timely, predictable, appropriate, and effective coordinated health action.

This Health Cluster Objectives for 2026-2027 are in line with the 2026 HNRP for Myanmar:

1. Improve access to life-saving health services, ensuring quality and inclusive healthcare, among displaced, returned, stateless and other shock-affected people.
2. Reduce excess morbidity and mortality through timely detection, prevention and response to epidemic-prone and endemic diseases.
3. Improve accountability towards people in need of humanitarian health assistance through coordination of health partners.

The Health Cluster has been active in Myanmar since 2012. Under the auspices of the World Health Organization as the Health Cluster Lead Agency, the Myanmar Health Cluster currently has 125 health partners including national and international NGOs, the Red Cross Movement, and UN agencies. The Health Cluster is represented in Rakhine (Sittwe), Kachin (Myitkyina), Shan (Taunggyi), Northwest (Mandalay), and Southeast (Hpa-An).

During 2025, Health Cluster partners reached 2.2 million people with life-saving health services in Myanmar, including 355 000 people were provided with life-saving health services in areas affected by the earthquake that struck Sagaing on 28 March 2025. This represents a triple increase when compared to 2024, thanks to improved partner reporting.

Humanitarian Need and Response Plan for Myanmar 2026

In 2026, an estimated 9.3 million people will require support to access basic health services across Myanmar. Among them, 2.4 million are women and girls of reproductive age, with an estimated 415 000 births in need of life-saving care. The majority (74%) are non-displaced individuals affected by ongoing conflict and the March 2025 earthquake, followed by IDPs (22%) and returned, resettled or locally integrated IDPs and stateless populations (4%). Women, children, older people, persons with disabilities and those with mental health conditions face heightened risks and barriers to care, including physical access constraints and financial limitations. Priority areas for health interventions include Chin, Rakhine, and Sagaing, with additional needs in Kachin, Kayin, northern Shan and Tanintharyi.[116]

Information Gaps and Recommended Information Sources

	Gap	Recommended tools/ guidance for primary data collection
Health status & threats for affected population	Actual number of deaths and injuries associated with the crisis	Formal and informal media sources Modelling estimates
	Burden of trauma and disabilities	Community/camp-based trauma survey
	Situation/trend of diseases Where the outbreak-prone disease burden is, to allow rapid targeted outbreak response and disease-control activities	Early warning alert and response system (EWARS)
	First-hand evidence on the current health status and estimation of the burden of disease in the communities/shelters, for prioritization among potential needs	Health needs assessment, regular communication with health cluster and local partners
	Nutritional status	Nutrition assessments/ anthropometric measures
Health resources & services availability	A snapshot on the functionality of health facilities, accessibility and availability of services to help identify the bottlenecks for non-functionality of services	Feasible health service availability mapping
Humanitarian health system performance	Reach of humanitarian health services provided to beneficiaries	Beneficiary satisfaction survey
	Data regarding health needs of population, despite limitations of access and delivery due to conflict	Support from UN, international NGOs, local NGOs and local health authorities

World Health Organization Contact

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