Myanmar: a primary health care case study in the context of the COVID-19 pandemic

Ann Meng Hsuan Lin
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Acknowledgements

The primary health care (PHC) case studies were commissioned and overseen by the Alliance for Health Policy and Systems Research, a hosted partnership based at WHO headquarters, in collaboration with the WHO regional offices. This case study was authored by Ann Meng Hsuan Lin and Nilar Tin. The WHO Regional Office for South-East Asia, the WHO Country Office for Myanmar, and a team of independent experts provided critical review and input. Special thanks go to Phyllida Travis and Stephanie Topp for their helpful reviews, and Robert Marten, Jeffrey Knezovich, Alexandra Edelman, Yasmine Yahoum, Joanna Fottrell and David Lloyd for their support in the development of this publication.
Executive summary

Myanmar is a diverse country with a complex health care system. Primary health services are provided through a mix of public, private (for-profit and not-for-profit) and ethnic health organizations (EHOs). While an estimated 60% of formal health facilities are public, there is an active and growing private health sector (1). In 2017, the Ministry of Health and Sports (MoHS) put forth the National Health Plan 2017–2021, which outlines the strategy to achieve universal health coverage (UHC) by 2030 through primary health care (PHC) (2). Following the launch of the Plan, the government invested in the PHC system via efforts to strengthen the supply side as well as to address barriers on the demand side.

Despite progress, Myanmar’s health system was challenged by the surge in resource demands brought about by the COVID-19 pandemic. Between March 2020 and December 2020, Myanmar faced two waves of COVID-19 infections – the first wave from March to April 2020, and the second wave from August to November 2020. The cumulative number of cases in 2020 was 125 042, with 2697 deaths (3).

This case study examines PHC in Myanmar in the context of the COVID-19 pandemic between March and December 2020. Several key lessons were drawn from the case study. Elements of Myanmar’s response to COVID-19 at the PHC level that contributed to the control of the pandemic and mitigation of its impact included:

1. **Effective multisectoral engagement:** During the first and second waves of the pandemic, the government focused on controlling the spread of the infection through travel restrictions, stay-at-home and curfew orders, face mask mandates and health education sessions. The community responded positively to the government regulations, and businesses shifted operational modalities to allow people to work from home.

2. **Strong social cohesion and community support:** Volunteer support was critical to ensure families and health staff received adequate assistance. This included food and non-food donations, the construction of temporary shelters, and in-kind support such as the provision of childcare.

3. **Swift response to the crisis:** One month before the first case was detected in Myanmar, the government began active surveillance of the virus, training health providers and stockpiling essential medical commodities. After the first positive case of COVID-19 was detected, the government suspended all inbound international travel, increased social distancing measures and enacted stay-at-home measures. To ease the burden of employment and income losses, the government provided loans to businesses and expanded social protection measures such as food and cash transfers.
There were also notable challenges, including:

1. **Limited testing capacity**: Myanmar’s capacity to conduct tests was constrained by its dependency on other countries for test kits, a shortage of human resources and a lack of laboratories to process tests. The introduction of rapid diagnostic tests in October 2020 dramatically improved testing capacity.

2. **Weak health infrastructure**: Myanmar reported 0.71 intensive care unit beds and 0.46 ventilators per 100,000 population in March 2020. This is insufficient for even a moderate disease outbreak (4).

3. **Lack of public health workforce**: COVID-19 highlighted the shortage in human resources for health, particularly in rural areas of Myanmar. The government called on volunteers to provide support and explored task-shifting options.
Introduction and national context

PHC framework and case study objective

Through the Astana Declaration – signed at the Global Conference on Primary Health Care (PHC) in Astana, Kazakhstan in October 2018 – the global community renewed its commitment to PHC as the means to achieve UHC, as well as Sustainable Development Goal 3 (SDG3) and other SDG goals to which health is a contributing factor (5). Policy-makers, researchers, civil society and community members codified the 2018 Astana Declaration, which describes the PHC framework according to three components: 1) the provision of integrated PHC; 2) multisectoral policy and action; and 3) the empowerment of people and communities (6).

This case study aims to examine PHC through the lens of how the country responded to the first and second waves of COVID-19 during March to December 2020.

Methodology

A desk-top study was conducted to examine PHC in Myanmar and its response to the COVID-19 pandemic in 2020. Between April to June 2021, the team conducted a desk review of key documents, including government policies, guidelines, reports, publicly available data, and peer reviewed articles.

The three PHC components in the Astana Framework guided data collection, synthesis and analysis. The findings pertaining to each of these components were used to identify lessons learned.

The lessons learned, the following key questions were addressed:

• How have primary care and essential public health functions responded to COVID-19?
• How have multisectoral policy and action responded to COVID-19?
• How have communities responded to COVID-19?

National context

Myanmar is a diverse country with an estimated 54 million people of more than 135 ethnicities. Since 2011 the country has embarked on multiple transitions and has seen increased government spending on social sectors including health. Between 1975 and 2011, government spending on health as a proportion of gross domestic product (GDP) was around 0.2%. By 2015, this proportion increased to 1.1% of GDP (7).
Maternal and child mortality and morbidity has declined in Myanmar from 308 deaths per 100,000 live births in 2000 to 178 in 2016, and from 82 deaths per 1000 live births in 2000 to 51 in 2016 (8). The country has successfully achieved several Millennium Development Goals (MDGs) in communicable diseases, while in 2017 the State Counsellor announced an ambitious 15-year plan to ensure that populations have access to UHC by 2030 (2).

However, despite progress, development has been uneven, with improvements in social services benefiting those who are educated and living in urban areas primarily. Coverage of essential services in remote and disadvantaged communities remain poor.

**Myanmar’s PHC system**

Primary health services are provided to the population of Myanmar through a mixed system of public, private for-profit, private not-for-profit, ethnic health organizations (EHOs) and international development assistance. While data on the provision of services by type of organization are incomplete and outdated, the MoHS's registry suggests that, in the areas of the country governed by the Union, a majority of PHC services are delivered through the public sector. In the areas governed by ethnic armed organizations (EAOs), PHC services are largely provided by EHOs (2).

In the public sector, preventive and curative health services are delivered through four main channels: 1) township and station hospitals; 2) rural health centres (RHCs); 3) sub-RHCs in rural areas; and 4) urban health centres. Based on MoHS data obtained in April 2021, PHC services are provided through 149 township hospitals each having at least 25 beds, 1849 RHCs and 8700 sub-RHCs (9).

A unique aspect of Myanmar’s approach to PHC prevention and service delivery is its reliance on an outreach model. Health workers provide the majority of services within villages rather than at clinics. This includes (but is not limited to) nutrition, education, vaccinations, antenatal and postnatal care, and testing and treatment for communicable and noncommunicable diseases.

Over the past decade, availability and utilization of services at private for-profit and private not-for-profit health facilities have steadily increased. According to the Private Health Statistics 2015 compiled by the Department of Medical Services within the MoHS, there were 193 private hospitals, 201 private specialist clinics, 3911 private general clinics and 776 private dental clinics in 2015 (10) (see Table 1). The number of for-profit or not-for-profit private health facilities is likely to have increased since 2015.
### Table 1. The PHC structure in Myanmar

<table>
<thead>
<tr>
<th>Type of organization</th>
<th>PHC centre</th>
<th>Location</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public sector</strong></td>
<td>43 township hospitals (~100 beds)</td>
<td>Less than 5% in urban areas, 95% in rural areas</td>
<td>2021 data</td>
</tr>
<tr>
<td></td>
<td>118 township hospitals (~50 beds)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>149 township hospitals (~25 beds)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>9 township hospitals (~15 beds)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>771 station hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>98 urban health center</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1849 RHCs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8700 sub-RHCs</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Private sector</strong></td>
<td>3911 private general clinics</td>
<td>N/A</td>
<td>2015 data; actual number likely to be more</td>
</tr>
<tr>
<td>(not-for-profit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and for-profit)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>EHOs</strong></td>
<td>N/A</td>
<td>Mostly in rural areas</td>
<td></td>
</tr>
</tbody>
</table>

Source: Ministry of Health and Sports, 2020

Another notable aspect of Myanmar’s PHC system is the role that EHOs play in service provision. An estimated 40% of the population live in areas governed by various ethnic groups (2). For a majority of the population living in areas controlled by EAOs, primary health services are provided by EHOs with the support of non-profit organizations. However, the quality of care as well as the types of services provided vary widely among EHOs. Similarly, there is also wide variability in the level of collaboration between the MoHS and EHOs: some ethnic communities coordinate with the MoHS on delivery of essential health services, while other communities do not.

Since around 2010, development assistance for health has largely skewed towards vertical or condition-specific programmes. Three of the largest funding channels are the Global Fund against AIDS, Tuberculosis and Malaria (The Global Fund), GAVI the Vaccine Alliance, and Access to Health (1).

### Capacity of the health system

Decades of chronic underinvestment has severely limited the ability and capacity of public providers to deliver essential health services. According to the National Health Accounts conducted by the MoHS in 2018, total health expenditure per capita was 85,231 MMK (approximately US$ 63). While official government policy states that services at public clinics are provided to users free of charge, private health expenditure (largely in the form of out-of-pocket payments at the point of service delivery) accounted for 76% of health
 Persistent low public health expenditure has strained the health system in a number of ways. Most notably, Myanmar faces a shortage of human resources, especially with regard to community-based health workers. Real-time electronic data collection systems are at an early stage of implementation, therefore data on utilization of essential health services are often delayed. According to the 2015 Service Availability and Readiness Assessment (SARA), less than 50% of facilities surveyed have the requisite volume of essential medicines (43%), diagnostic capacity (37%), and basic amenities (41%). Budget flexibility is low for the maintenance of facilities and equipment. Such shortages of medicines and other supplies imply rationing in practice, although it is unclear how these decisions are made.

In many parts of the country, EHOs are the main providers in many rural areas. The quality of care, services provided, and the availability of resources to manage health clinics differ among EHOs - with some providing relatively comprehensive health services and others are not able to meet basic needs. During the first and second waves of COVID-19, EHOs were in contact with the MoHS and re-configured clinics to allow for triage. EHO health staff received up-to-date information about COVID-19 from the Ministry.

In contrast to the EHOs, the formal private sector providers are concentrated in urban areas such as Yangon and Mandalay. Services provided range from primary care to tertiary hospital and diagnostic centres. With limited testing capacity at most private clinics, patients were referred to designated COVID-19 public hospitals and care centres during the pandemic. The informal sector for pharmaceuticals in Myanmar is extensive and largely unregulated.

COVID-19 in 2020

The first case of COVID-19 was detected on 23 March 2020. From March to July 2020, the spread of the infection was manageable, with a reported cumulative caseload of 353. A majority of the first wave of COVID-19 infections were detected in major cities, namely Yangon and Mandalay. A second wave of COVID-19 transmission began in Rakhine State around mid-to-late August 2020. Subsequently, more than 120 000 new cases in Myanmar were confirmed, with the total number of cases detected between March 2020 and December 2020 reaching 125 042, with 2697 recorded deaths.

One month before the first case of COVID-19 was detected, Myanmar started active surveillance and began stockpiling essential medical commodities. In March 2020, the government suspended inbound international travel, implemented social distancing measures, and issued guidance to health care workers on COVID-19 prevention, detection and treatment according to guidance issued by the WHO.
To coordinate the pandemic response, an Intersectoral Central Committee was established, chaired by the State Counsellor. The Committee included 15 Union ministers from key line ministries, as well as social ministers of all states and regions to oversee and coordinate the country’s response. The objectives of the Committee were to share critical data among ministries, to develop and implement a multisectoral response to the virus, and to provide a unified communication plan to the public regarding the pandemic. The Committee was also responsible for ensuring operation of essential functions of the government.

Additional committees were also established. Notably, this included the Coronavirus Disease 2019 Containment and Emergency Response Committee, which comprised 10 members including the Vice President, Union Minister of Defense, Union Minister of Border Affairs, Union Minister for Home Affairs and the Union Minister for Labor, Immigration and Population. This Committee was tasked to investigate, detect and handle persons infected with COVID-19.

How primary care and essential public health functions are responding to COVID-19

Scaling up and managing critical emergency services

As part of the COVID-19 response, in 2020 Myanmar updated laws and regulations on key areas specified in the International Health Regulations that govern the public health surveillance and response system in the country (13). Both the National Health Plan launched in 2017 (2) and the National Health Policy drafted in 2019 reinforced the country’s commitment towards an equitable expansion of UHC through strengthening of the PHC system. Despite progress, the health system lacked the capacity to adequately address a nation-wide pandemic in 2020. The MoHS relied, in large part, on community support and multisectoral collaboration to respond to the crisis. Key initiatives are described below.

Strengthening the governance structure to manage emergency services

Two weeks prior to the first confirmed case of COVID-19, the government formed the National-level Central Committee on Prevention, Control and Treatment of Coronavirus Disease 2019. The primary objective of the Committee was to: 1) steer and coordinate the multisectoral emergency response to the pandemic; 2) establish a communication channel between sectors; 3) strengthen data among stakeholders at national, subnational and community levels; and 4) strengthen supply-chain logistics. The establishment of this Committee demonstrated commitment at the highest political level to tackle the COVID-19 outbreak.

Several coordination mechanisms were also established for internal and external stakeholders. Internal coordination focuses on collaboration and communication between the different geographic and political levels of the government – central,
How primary care and essential public health functions are responding to COVID-19

region/state, district and township. In 2021, Myanmar was continuing to work closely with the international community through existing mechanisms such as the Health Sector Coordinating Committee’s Health Cluster. In addition, WHO was regularly convening development partners involved in supporting the emergency response. United Nations (UN) partners also developed a Country Preparedness and Response Plan to further coordinate assistance.

Finally, while the coordination structure to oversee the provision of primary health services was temporarily suspended at the onset of the pandemic, the majority of the technical working groups resumed after April 2020. Key activities included modifying clinical guidelines to ensure staff and patient safety, drafting health messages for the community and ensuring continuity of service provision.

Development and implementation of the Health Sector Contingency Plan

The MoHS, with the support of partners including WHO, developed the Health Sector Contingency Plan. This Plan aimed to: 1) improve the availability of reliable information and accurate knowledge on COVID-19 for health professionals and the public, with a focus on providing timely guidance to all community-based healthcare professionals and workers to protect themselves while serving to prevent the spread of COVID-19; 2) set out the coordination mechanism for key stakeholders at central, state/region and township levels to jointly implement the public health measures identified; and 3) provide guidance and strengthen technical capacities in key priority areas” (14).

To implement the Contingency Plan, the MoHS activated the Incident Management System and established a Central Command Centre with a group of experts including epidemiologists, data analysts, and specialists working across public health, logistics and information technology specialists. The Health Emergency Operation Centre held virtual meetings and capacity-building webinars with their counterparts at state/region, township and community level on a daily basis – focusing particularly on those affected by COVID-19. In addition, the MoHS Central Epidemiology Unit formed Rapid Response Teams (RRTs) in all states and regions. Having the subnational teams in place allowed the MoHS to use a train-the-trainer approach to strengthen the capacities of frontline health workers at PHC level, to conduct active case tracking, and to effectively communicate with the population.
Scaling up the availability of, and support to, frontline staff

In collaboration with medical associations and communities, the MoHS augmented the limited human resources in health by engaging volunteers with a medical background and community health workers. In some communities, volunteer staff were assigned to triage at fever clinics and to support the management and coordination of quarantine centres. Training, supervision and provision of personal protective equipment (PPE) were provided in part by the MoHS and in part through private corporations, foundations and community member donations.

The MoHS recognised the need to be adaptive to the changing context and made adjustments. For example, midwives were deployed to ground crossing points to check temperatures and distribute masks and hand sanitizer. When some essential services were disrupted, midwives were recalled to duty stations while volunteers received training to conduct COVID-19 infection control.

Scaling up communication with the public

In 2020 and 2021, the MoHS used videos and public announcements via television, radio and social media to inform the public about COVID-19 throughout 2020. Celebrities, religious leaders, community leaders and other public figures were also engaged to provide information, while the MoHS and the private sector leveraged the country’s rapid telecommunication expansion to communicate with the public through social media platforms. Communication efforts included:

- live broadcasts by the State Counsellor.
- the Saw Saw Shar mobile application, developed by the Myanmar Computer Federation in collaboration with the MoHS, to provide the public with daily updates on the number of new cases, the location of outbreaks and the number of deaths. The mobile app was launched in June 2020 and was widely promoted via Facebook. As of December 2020, more than 100,000 people had downloaded the Saw Saw Shar app.
- Viber and Facebook used to deliver public health messages and to provide training materials and exchange information among facility managers on supplies and bed availability.
- the MoHS Facebook page, which was used to provide regular updates to the public and to raise awareness. Over 1.6 million subscribers received information on the pandemic a daily basis via this channel.
- the setting up of the MoHS COVID-19 call centre for the public.
Scaling up testing

In 2020, the MoHS expanded its efforts around testing, with the support of the international community. With limited laboratory capacity at the start of the pandemic, Myanmar performed fewer than 400 test per day in April 2020. During this initial phase, the samples were sent to Thailand. By mid-September 2020, with the support of WHO, the National Health Laboratory and other public laboratories were able to conduct rapid diagnostic tests. This contributed to a sharp increase in number of tests provided per day (from 400 per day to estimated 12 000 tests per day). Additional laboratories were set up in major cities including Yangon, Mandalay, Mawlamyine, Lashio and Taunggyi (16).

Maintaining essential services

During the first and second waves of the pandemic in 2020, the MoHS maintained provision of PHC services including for maternal and child health. According to MoHS data, utilization of antenatal care, postnatal care, facility delivery, family planning, and sexual and reproductive health counselling remained at the same level throughout the pandemic (14, 15).

One area where utilization notably declined during the first few months of the pandemic was routine immunization. According to Ministry of Health and Sports, routine immunization for mothers and children came to a halt in April and May 2020 (16). However, services slowly resumed in June 2020 after midwives were trained to provide immunization services during the COVID-19 outbreak.

According to a community-based survey conducted by the World Bank in June 2020, respondents reported closure of local health centres (public and private) and limited space at hospitals due to attempts to enforce social distancing between patients (17).

In 2020 and 2021, steps were taken to protect the communities and health staff at the primary health clinics, with measures put in place such as dedicated periods for the delivery of certain services to avoid overcrowding in the clinics. The MoHS also provided face masks, gloves, hand sanitizer and disposable gowns to midwives and other health staff at primary health facilities. Within several clinics and communities the MoHS refurbished hand-washing stations.

In some communities, several months of medication were dispensed to patients with chronic illnesses in an effort to reduce the frequency of visits to clinics. This was particularly useful for patients with existing noncommunicable diseases. Finally, while telemedicine did not form an official part of the MoHS’s response, teleconsultations were delivered by trained health professionals at UN-supported clinics, as well as by private for-profit and not-for-profit health providers. Myanmar Medical Association’s medical volunteers network provided support for the public through teleconsultations.
How multisectoral policy and action are responding to COVID-19

Access to and utilization of preventive and curative health services are determined by a complex web of factors. Studies have shown that geographic distance to a health facility, education, cultural beliefs, ethnicity and language are associated with a range of health and care-seeking behaviours (18). Studies have shown that social determinants affect utilization of particular PHC services. For example, in a secondary analysis of the Demographic and Health Survey conducted in 2015, incomplete immunization status was associated with low economic status, younger maternal age, fewer antenatal care visits and no maternal tetanus vaccination (19). Other studies have explored the association between education, socioeconomic status and geographic distance to health facility on the treatment of childhood illness, concluding that social factors negatively impact access to care (20, 21).

Catalysed by the launch of the National Health Plan in 2017 (2), the MoHS began working with multiple sectors including education, agriculture, social security, finance and telecommunication to develop multisectoral policies and strategies. In 2017, the Development Assistance Coordination Unit (DACU), a high-level multisectoral development committee tasked with setting the country’s development agenda, established the Nutritional Sector Working Group that included commitments from four line ministries to address maternal and child undernutrition. Other large-scale reforms included work to address the public financial management system across all line ministries, the development of a health information system for both routine data collection and information-sharing with the public using social media platforms, and improvements to school health.

While Myanmar had demonstrated a multisector approach through the examples cited above, the scale of collaboration and cooperation across sectors and between public and private organizations was unprecedented as part of the government’s multisectoral approach to respond to and mitigate the impact of COVID-19 in 2020 and 2021.

In addition to prevention and treatment measures led by the MoHS, the Ministry of Planning, Finance and Industry developed a COVID-19 Economic Relief Plan in April 2020 that provided soft loans and tax deferrals to businesses plus household exemptions for electricity charges. The Ministry of Labour, Immigration and Population coordinated efforts to address issues arising from the return of migrants, while the Ministry of Social Welfare provided cash and food assistance to families affected by COVID-19 measures. Finally, the Ministry of Education temporarily closed schools and attempted to introduce low-tech and no-tech options for alternative education provision, for example by distributing textbooks to students.

Figure 1 (next page) provides a timeline of the policy and coordination measures implemented between January 2020 to December 2020 as part of its COVID-19 response.
### Figure 1. Myanmar’s multisectoral response to COVID-19 (Jan–Oct 2020)

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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</thead>
<tbody>
<tr>
<td>Feb 1</td>
<td>Travel ban; suspension of visa on arrival to tourists from China; flights between Yangon and China suspended after WHO’s declaration of COVID-19 as public health emergency of international concern</td>
</tr>
<tr>
<td>Feb 20</td>
<td>Testing started at National Health Laboratory, Yangon</td>
</tr>
<tr>
<td>Feb 28</td>
<td>Social Restrictions: banned mass gatherings</td>
</tr>
<tr>
<td>Mar 18</td>
<td>The ministry of Planning, Finance and Industry announced soft loans to businesses</td>
</tr>
<tr>
<td>Mar 2-24</td>
<td>Started community-based quarantine sites: 14 days quarantine mandated for incoming travelers from any country; schools closed</td>
</tr>
<tr>
<td>Mar 23</td>
<td>First laboratory case detected</td>
</tr>
<tr>
<td>Mar 31</td>
<td>Travel ban: entry banned for all countries</td>
</tr>
<tr>
<td>Apr 18</td>
<td>Partial Lockdown imposed in some townships in Yangon</td>
</tr>
<tr>
<td>Apr 22</td>
<td>Health Sector Contingency Plan published</td>
</tr>
<tr>
<td>Apr 27</td>
<td>COVID-19 Economic Relief Package announced</td>
</tr>
<tr>
<td>May 9</td>
<td>Unilateral national ceasefire with EAOs announced by Myanmar government: excluded areas where Arakan army were operating</td>
</tr>
<tr>
<td>May 16</td>
<td>Cash assistance of MMK 40 000 (about US$ 31) per household without regular income announced to be disbursed in two installments</td>
</tr>
<tr>
<td>May 14 – Jul 30</td>
<td>Lockdown in Yangon and some other social restrictions eased: reopening of half of the high school; mass gathering restrictions eased</td>
</tr>
<tr>
<td>May 14 – Jul 30</td>
<td>Testing expanded to six laboratories by June</td>
</tr>
<tr>
<td>Apr 18</td>
<td>Start testing of all contacts</td>
</tr>
<tr>
<td>Mar 2-24</td>
<td>Start testing of all contacts</td>
</tr>
<tr>
<td>Feb 28</td>
<td>Social Restrictions: banned mass gatherings</td>
</tr>
<tr>
<td>Feb 20</td>
<td>Testing started at National Health Laboratory, Yangon</td>
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<tr>
<td>Feb 1</td>
<td>Travel ban: suspension of visa on arrival to tourists from China; flights between Yangon and China suspended after WHO’s declaration of COVID-19 as public health emergency of international concern</td>
</tr>
<tr>
<td>Jan 4-5</td>
<td>Preparedness in Myanmar started including surveillance at Point of Entries (POE) and risk communication after MoHS is notified from WHO about unexplained pneumonia cases in Wuhan, China</td>
</tr>
</tbody>
</table>

How communities are responding to COVID-19

Community collaboration and solidarity played a critical role in Myanmar’s COVID-19 response throughout 2020. The level of community engagement and mechanisms used varied widely across states and regions, however. While a few communities used formal channels to engage service providers and policymakers, many communities used informal, social media channels such as Facebook and Viber to share information and to coordinate support.

Community engagement

**Formal channels:** To coordinate activities at the village level, the Ministry of Home Affairs instructed village administrators and leaders to create COVID-19 Protection Committees, which in many cases include village elders, religious and local leaders, and health care workers. The Committees typically focus on social responsibilities, including announcing and enforcing government instructions, encouraging behavioural change and sharing information. Some villages also resurrected their Village Health Committee to facilitate communication with health providers and the coordination of donated goods.

**Informal channels:** With the rapid expansion of the telecommunication industry, the use of social media platforms such as Facebook and Viber to share information has increased over the past five years. According to government statistics, over 40% of the population had at least one social media account in 2020 [1]. Myanmar capitalized on this, with Viber and Facebook used by the MoHS, health service providers and community members in 2020 to exchange information on COVID-19.

Community response and support

During the response to the first and second wave of COVID-19 in 2020, the MoHS coordinated closely with foundations, private philanthropic efforts and communities to meet community needs. Support included:

- food and non-food donations, including food, water, clothing, cell phone minutes and basic supplies;
- establishing and managing community quarantine centres (see example in Box 1);
- training volunteers in contact tracing and supporting community surveillance;
- enlisting retired health professionals as volunteers at so-called fever clinics and community quarantine centres.

Such community support efforts allowed the government to stretch its resources, particularly in rural and hard-to-reach areas. However, the lack of consistency in the support provided and in the standardization of care was a barrier in coordinating and sustaining the pandemic response.
Box 1. Scaling up quarantine centres in the Yangon region through community participation

The centres were run by a team of health workers, including frontline staff from the public sector; volunteers from all states and regions; medical, nursing and midwifery students; Red Cross volunteers; and health providers from the private sector.

Approximately 28 quarantine centres were set up in the region to contain suspected cases of COVID-19.

Medical and non-medical associations, religious communities and community members provided over 1000 free meals for quarantine patients and health care workers.

Private donations by citizens included beds, bedding, utensils, masks and other personal hygiene equipment. These donations proved critical in the setting up and running of quarantine centres.

Source: the authors.
Conclusion and lessons learned

The first and second waves of the COVID-19 pandemic underscored strengths and weaknesses of Myanmar’s PHC system.

Aspects of the PHC system that strengthened Myanmar’s COVID-19 response included strong community support, a newly established health information system that allowed policy-makers timely access to routine data, and a focus on expanding access to essential services. Annex 1 summarizes innovations and efforts made in response to the pandemic across the ten operational levers of WHO’s Operational Framework for PHC (22).

At the same time, COVID-19 underscored gaps and challenges in the primary health system. Obstacles and impediments included lack of human resources and laboratory capacity, few mechanisms to coordinate health services and information provided in conflict-affected areas, weak formal community engagement channels, and limited engagement with the private sector. The MoHS and wider government ministries rolled out an unprecedented multisectoral response to manage and mitigate the impact of COVID-19 in 2020, drawing on trust and collaboration among communities.

Myanmar has an opportunity to accelerate progress towards provision of essential health services and mitigation of more severe outbreaks with investments in human resources, community empowerment and primary care service delivery.
References


### Annex 1. COVID-19 innovations/efforts across the operational levers of the WHO Operational Framework for PHC

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<tr>
<th>Operational levers</th>
<th>Innovation and efforts to address COVID-19 pandemic</th>
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| **Models of care**                                                               | • PHC services resumed within two–three months after the first case was detected.  
• Schools and community centres converted to fever clinics connected with the ambulance network for referral to COVID-19 hospitals or quarantine centres.  
• Quarantine centres were opened with full support provided for quarantined patients (suspected cases, contacts, those with fever and anosmia).  
• Hospitals converted to designated COVID-19 hospitals.  
  This includes four tertiary care hospitals in Yangon and one in Mandalay.  
• Telehealth services were provided by nongovernmental organizations. |
| **PHC workforce**                                                                | • In some communities, community health workers were (re)assigned to provide contact tracing, and health education.  
• All BHS, doctors and nurses from hospitals received training on prevention and control of COVID-19 based on WHO guidelines. |
| **Physical infrastructure**                                                       | • Guidelines for PHC facilities were developed and staff were trained on treatment protocols and referral systems.  
• Hospitals and clinics were repurposed and refurbished to provide COVID-19 treatments. |
| **Medicines and other health products**                                          | • A logistics management information system was used to track the availability and utilization of COVID-19 medicines and supplies. |
| **Engagement with the private sector**                                           | • Private donors set up quarantine centres, donating food and non-food items.  
• Fever clinics were managed by private physicians and volunteers under the guidance of the MoHS. |
| **Purchasing and payment systems**                                                | • Testing and treatment of COVID-19 cases was provided free of charge at clinics and hospitals. |
| **Digital technologies for health**                                              | • The MoHS regularly updated an online data dashboard that provided information and resources to health workers and communities.  
• Community members used Facebook and Viber to exchange information.  
• Tablets were distributed to all midwives in 2019; some utilized the tablets to receive training and information. |
| **Systems for improving quality of care**                                         | • Ongoing COVID-19 training was provided by MoHS to health workers in-person and online.  
• For communities in remote areas, trainings were recorded and distributed to field staff. |
| **PHC-oriented research and monitoring and evaluation**                          | • Analysis of District Health Information Software 2 (DHIS2) data allowed policymakers to understand the effect of COVID-19 on PHC service delivery  
• Community-based surveys included questions on health knowledge and care-seeking behaviour. |
This case study was developed by the Alliance for Health Policy and Systems Research, an international partnership hosted by the World Health Organization, in collaboration with the WHO Regional Office for South-East Asia (SEARO) and WHO country offices. In 2015, the Alliance commissioned the Primary Health Care Systems (PRIMASYS) case studies in twenty low- and middle-income countries (LMICs) across WHO regions. This case study builds on and expands these previous studies in the context of the COVID-19 pandemic, applying the Astana PHC framework considering integrated health services, multisectoral policy and action and people and communities. This case study aims to advance the science and lay a groundwork for improved policy efforts to advance primary health care in LMICs.