

How can the township health system be strengthened in Myanmar?



Policy
Note #3

Myanmar Health Systems in Transition
Policy Notes Series



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How can the township health system be strengthened in Myanmar?



1. What is the challenge?

A network of basic health facilities has been established in each of the 330 townships, covering both rural and urban areas. For the vast majority of Myanmar's people, particularly the 70% who reside in rural areas, the township health system (THS) is the only government-funded source of preventive, promotive and curative services.

A typical THS has a catchment population of between 150 000 and 200 000, is managed by the Township Health Department, and led by the Township Medical Officer (TMO). At the centre of the system is the township hospital, and below this a network of station hospitals, rural health centres (RHC) and sub-rural health centres (SRHC), each with a specified complement of staff, supported by volunteer health workers.

To achieve the national policy objective of progressing towards universal health coverage (UHC) through a primary health-care approach by 2030, the THS is critical to success. It is responsible for the bulk of health care delivery – particularly in rural areas – and is at the heart of national health development in Myanmar. However, if the THS is to be the *backbone* of health care provision, it currently suffers from a severe case of *osteoporosis*.

Why is this so?

In brief, facility development and staffing levels have not kept up with population growth; investment has favoured hospitals over primary care facilities; few financial resources come to the township in sufficiently flexible form to allow for contextualized service planning and delivery; key staff are overloaded with responsibilities; low levels of pay and allowances undermine motivation and retention; rural facilities are poorly equipped and underutilized; supervisory systems do not work well; and frequent transfers of TMOs undermine effective leadership and management. In addition, the level of development of the THS has been highly inequitable, with some selected for additional support (often by external partners), while others, particularly those in hard-to-reach and conflict-affected areas, are chronically neglected.

2. What do we know?

Evidence confirms that the THS is an important source of care, particularly for the poor. Equally, it needs to be strengthened in both rural and urban areas if it is to be more effective and equitable.

- **Standards exist for staffing levels:** In the urban headquarters of a township, a township hospital with 16–25 beds should have between two and six doctors and up to 16 nurses. In



addition, there should be an urban health unit or maternal health centre providing public health services to the town. For the rural catchment area of a township, there should be one or two 16-bed station hospitals, each with two doctors and two nurses, a lady health visitor, a midwife and a public health supervisor. There should be four or five RHCs, staffed with a health assistant, a lady health visitor, a midwife and a public health supervisor. One midwife with or without a public health supervisor should staff an additional four or five sRHCs. About 600 volunteer health workers (community health workers and auxiliary midwives) work in the rural areas of each township.

- **Close-to-client services do not always exist in practice:** The idea of the THS is that essential health care services are provided as close to where people live as possible. RHCs and sRHCs, with support from volunteers, provide primary care interventions, with referrals for secondary care to station and township hospitals. However the reality, as we discuss later, is far from this ideal.
- **Investment in new hospitals has been given priority over primary care facilities:** In the two decades leading up to 2011 (when the State Peace and Development Council

handed over to the democratically elected government), the number of RHCs increased by 22%. By contrast, the number of hospitals increased by 60%, despite the fact that a new hospital costs 20–50 times more than an RHC.

- **Despite their favoured status, hospitals do not perform well:** A survey conducted in 2011 found that nearly 60% of more than 500 hospitals were performing poorly, as measured by low occupancy and bed turnover rates. Moreover, 90% of the poor performers were station and township hospitals. The reasons for poor performance included inadequate staffing, insufficient supply of medicines and equipment, and financial barriers that deterred the poor.
- **The development of the THS has not kept up with population growth:** While the number of facilities has remained fairly constant, the population grew by 2–3% between 1990 and 2010. As a result, each midwife has more pregnant mothers to care for, more children to immunize, and more patients with tuberculosis, malaria, HIV and leprosy to be identified and treated.
- **Access to services remains highly inequitable:** Despite policies to expand services to rural and border areas, available



evidence indicates persistent disparities. Coverage of basic services in regions and states with significant hard-to-reach areas is considerably lower than in other parts of the country, despite their greater health needs. While more recent policies and programmes have sought to make health services more equitable, monitoring data indicate that disparities still exist in service availability and health outcomes across regions and across socio-economic groups. In particular, there are millions of people living in nearly 100 townships along the border in hard-to-reach areas where civil conflicts are still prevalent, who have even less access to essential health care.

- **Low salaries affect staff retention:** Low salaries in relation to living standards affect the motivation of all public health staff. However, this is particularly problematic when it comes to placing and retaining health workers in remote, border and less-secure areas. The result is that vacant posts are not filled, making it impossible to ensure adequate services in those areas.
- **Sub-centres are not equipped to provide adequate services:** The lack of equipment and basic amenities at sub-centres means they cannot be used as living quarters, nor can they provide round-the-clock services. Instead, midwives

see patients irregularly in the house of village heads. To make a positive impact on maternal, child and neonatal mortality requires not just advice in the village, but facilities that offer good quality care for mothers and children.

- **Donor support results in inequitable health systems development:** Until recently, development partners have focused on selected townships, leaving townships without external support with few resources. An additional issue is that several development partners have introduced their own approach to township health planning (focusing too often on budgeting for their own inputs). A more harmonized approach to planning and management that covers public and private providers is now needed.
- **Management and supervisory practices at township level are weak:** The rapid turnover of TMOs due to transfer and rotation has a detrimental effect on the whole THS. In addition, evidence suggests that midwives are overburdened with various vertical project activities, so much so that they do not have sufficient time to perform their main maternal and child health tasks.



3. What needs to be done?

The 2008 Constitution envisages further decentralization; however, the form this will take remains uncertain. Nevertheless, if townships are to assume greater responsibility for meeting the health needs of people in their catchment area, they need to prepare now. Without meaningful decentralization of some financial responsibilities to township level, planning is likely to remain a purely administrative, rather than a strategic process. If townships do assume more financial responsibility, the aim should then be to work towards one plan – with one budget, one system for monitoring and evaluation, participatory representation by local community representatives, and leadership by township health managers who have the requisite skills to coordinate and manage adequate levels of financial and human resources. This Policy Note makes two *recommendations*.

Declare a decade for THS strengthening (2016- 2026)

The THS is the vital strategic front for strengthening health care in Myanmar. A declaration focusing on the township will signify strong political leadership and long-term sustainable financial commitment. It will also recognize that initiatives to strengthen the THS should not be introduced in isolation, but require support from regional/state authorities in the form of policy frameworks, technical guidance, monitoring and supervision. The declaration

should be supported by the development of a 10-year master plan with a secure budget, clear priorities for actions, and milestones for monitoring and evaluation.

Agree an agenda for THS development

A master plan will need to address a wide range of issues.

- **Reducing inequity is of paramount importance:** Success will require major reforms to ensure health-care services reach the poor and disadvantaged groups. This is particularly so for minority groups and people in conflict-affected areas.
- **Upgrading close to client services is urgent:** Priority should be given to increasing the quality of care provided at RHCs, sRHCs and station hospitals in rural areas, before upgrading secondary and tertiary urban hospitals.
- **Up-to-date service mapping will reveal the current maldistribution of facilities:** Service-delivery infrastructures should be equitably distributed across the country. The most needy areas should be prioritized through rapid assessment, and adequate supply of essential medicines and basic medical equipment, made available on the basis of level-of-care needs of individual localities.



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- **Closer working relationships are needed in townships where ethnic health authorities are providing services:** Recent experience in Kayah and Kayin show the potential for better alignment of parallel systems.
 - **Township health planning should be linked to resources:** Township health plans should be based on comprehensive assessments of needs. Equally, they must ensure that activities, including monitoring and supervision, are adequately resourced.
 - **Monitoring equity is key to ensuring accountability:** Regular monitoring of how health equity has improved, stagnated or regressed is a priority for sound policy-making. Evidence on all dimensions of health inequity – geographical, socioeconomic, ethnicity and maternal educational level – provides a platform for holding different stakeholders accountable. Support will be needed to build the capacity for effective equity monitoring.¹
 - **The THS includes all health providers:** The purpose of coordination at township level is to ensure that different departments and programmes deliver health services responsively and effectively. The THS (and township health plans) must include all providers of health care: public, private and nongovernmental organizations.
 - **Station hospitals can become more efficient:** Many station hospitals do not perform well and provide poor-quality services. Inadequate staffing, insufficient supplies and outdated equipment exacerbate this situation. Station hospitals can save lives; ensuring that they have the means to do so is a priority, given their importance to the rural poor. The failure to establish effective referral systems from township to regional/state level has been one of the main barriers to accessing hospital care for obstetric emergencies.
 - **A more systematic approach to the work of Basic Health Staff is needed:** Basic health staff are the backbone of the THS: making the best use of their skills and enhancing their motivation is critically important. A systematic review of roles, responsibilities and workloads is required. This review should determine: how the tasks should be distributed among rural health team members; what potential tasks should be shifted to others such as auxiliary midwives and community health workers; how the productivity of basic health staff should be assessed; and what skill mix is required to deliver services

1. See **Policy note #2: How can health equity be improved in Myanmar?** for more details on these points and the importance of greater popular participation.



in line with the health needs of the population. The review should take into account changing patterns of disease, notably the growing prevalence of noncommunicable diseases.

- **Services at community level can be made more effective:** Linked to the previous point, there is a need to understand the real potential of the large cadre of unpaid workers at community level. While evidence from the Delta townships indicate that some of the most cost-effective interventions happen at this level, there remain concerns as to the extent to which volunteer workers can make an overall impact on the quality of care and therefore better outcomes particularly for maternal, newborn and child care.
- **Management training is important, but outdated practices also need to be reviewed:** The team managing the THS, including the TMO and other supervisory staff, need to be properly trained to fulfill their roles more effectively. Effective leadership by the TMO has been shown to make a difference to overall performance, which has then declined when key individuals have been transferred. In this regard, training alone will not improve practice; standard operating procedures also need to be reviewed and revised in line with modern work practices.²
- **Interim measures should be introduced prior to an essential package of care:** The Ministry of Health is in the process of developing an essential package of health services that will be covered (and also fiscally sustainable) under universal health coverage. Reaching consensus on this package will take time. In the interim, it is desirable to agree on a more limited range of cost-effective interventions, based on international experience, that target selected services such as maternal, newborn and child health care.
- **Evidence from operational research should guide future THS development:** The future development of the THS should be built on scientific evidence. Key issues include: factors influencing utilization in urban and rural areas; determinants of productivity and motivation among different levels of staff; and the most effective and efficient distribution of tasks among basic health staff, particularly volunteer workers.

² See also **Policy Note # 4: How can financial risk protection be expanded in Myanmar?** on revising outdated financial management systems.



