DEVELOPMENT OF THE HEALTH SYSTEM

Myanmar’s traditional health system underwent profound change during the British colonial period: ‘indigenous practitioners trained in the Ayurvedic tradition were deprived of status and credibility and replaced by medicine from the colonial authorities’ (Than Tun Sein et al. 2014: 32). But under the British, the first medical facilities and hospitals were built, hygiene and sanitation standards were introduced and vaccination programmes were established to protect the population from epidemics. The measures focused mainly on the towns and cities: coverage rarely extended to rural areas. After independence in 1948, the Pyidawtha Plan therefore specifically targeted health care for all population groups; the emphasis was on tackling endemic and epidemic diseases and reducing maternal and child mortality. After 1962 wide-ranging reform of the health sector and nationalisation of the health care system – including the previously private hospitals – significantly reduced the regional disparities in provision. However, investment and service provision declined after 1988, resulting in increasing erosion of services. Fundamental improvement in health care services was not achieved until after 2011 (on the five phases of development of the health system: Than Tun Sein et al. 2014: 32-36). Myanmar currently spends between just 2.0% (2001) and 2.4% (2011) of GDP on health, which places it among the Southeast Asian countries with the lowest expenditure on health care; only 1% of the population is insured under the social security scheme (Than Tun Sein et al. 2014: 61).

LIFE EXPECTANCY, BIRTH AND FERTILITY RATES, MORBIDITY AND MORTALITY

Life expectancy has risen from 55.0 years (1980; 56.5 for women and 53.7 for men) to 61.9
years (2000; 63.3 for women, 60.5 for men; Than Tun Sein et al. 2014: 15). According to the 2014 census, the crude birth rate was 18.9 per 1,000 population, with annual population growth of 0.89% in the period between 2003 and 2014. The total fertility rate has fallen from 6.1 (1965) to 2.3 (2015); in 2015 regional differences ranged from 1.7 in Yangon Region and 1.9 in Mandalay Region, 2.1 in Magway Region and 2.3 in Sagaing Region to 3.4 in Kayin State and 4.4 in Chin State (2015; MoHS 2016: 9, Nyi Nyi Latt et al. 2016: 124).

Mortality rates – especially infant and child mortality – are declining (infant mortality rate: 1990 – 47.0 per 1,000 live births, 2005 – 45.1). Of all under-five deaths, 87% occur in rural areas; infant mortality constitutes 73% of child mortality, and 70% of the infants who die do so in the first three months of life (all figures from Than Tun Sein et al. 2014: 24). Undernutrition and malnutrition in children is widespread, especially in rural areas, as in anaemia in women and children (MoHS 2016: 21-27).

Smallpox, leprosy, trachoma, poliomyelitis and iodine deficiency disorders have been eradicated in recent decades (Than Tun Sein et al. 2014: 110). Non-communicable diseases (NCDs) – principally cardiovascular diseases, malignant neoplasms and respiratory diseases – are the cause of around 40% of deaths; this percentage has been rising for some years. Among infectious and parasitic diseases, tuberculosis, diarrhoeal diseases and HIV/AIDS are the main causes of death (Than Tun Sein et al. 2014: 16). Despite considerable success in tackling malaria in recent years, the disease is still a major problem as a cause of sickness and death (8.1% of total mortality); 71% of the population live in malaria risk areas, 29% of them in high-risk areas. Changes in land use, environmental change, migration (in connection with land development, mining and road construction in peripheral areas), artemisinin resistance and vector adaptation encourage the spread of the disease (2008; Than Tun Sein et al. 2016: 21). Plasmodium falciparum is responsible for 68% of malaria cases and Plasmodium vivax for 23% (WHO 2012). Arsenic contamination of groundwater occurs in some parts of the country, including a number of townships in the Ayeyarwady Region (Mukherjee et al. 2006: 152).

The top five causes of disability-adjusted life years (DALY) are lower respiratory tract infections, tuberculosis, diarrhoeal diseases, HIV/AIDS and stroke; the significance of ischaemic heart disease, road injury and cirrhosis of the liver is also increasing (Than Tun Sein et al. 2014: 16). The top five risk factors are dietary risks, tobacco smoking, household air pollution from solid fuels, high blood pressure and high blood sugar (IHME 2010, quoted after