Strategic Health Financing to Primary Health Facility Investment in Low Resource Setting in Myanmar

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INTRODUCTION

Amidst the ongoing humanitarian crisis in Myanmar, the allocation of resources for health facilities in rural areas has beena critical concern. Traditionally, rural health facilities were built by local communities, leading to an uneven distribution of infrastructure. With the shift towards democratic governance, the government began funding the capital budget for rural health facilities. However, the current distribution remains influenced by political and population density factors, raising questions about equitable allocation.

OBJECTIVE

General Objectives

- To assess the current distribution on primary public health facilities in Myanmar using equity perspective

Specific Objectives

- To assess the distribution of the existing health facilities by mapping
- To identify different stakeholders' perspectives of equity in health facility allocation
- To explore the influencing factors to strengthen existing platforms for knowledge-sharing in health facility planning processes.

METHODOLOGY

This cross-sectional study, conducted in Myanmar from July to September 2019, employed a participatory approach engaging stakeholders for quantitative and qualitative analyses. Quantitative data involved a desk review of community health data, analyzed using Microsoft Excel and MIMU Excel Mapping Tool. Qualitative data were gathered through key informant interviews and focus group discussions, transcribed and analyzed with ATLAS.ti 8. The Health Equity Assessment Toolkit was utilized, aiming to overcome resistance to equity-focused health facility distribution planning. Findings were presented through frequency tables, figures, and textual quotations, addressing adaptive and technical challenges in the process.

RESULT

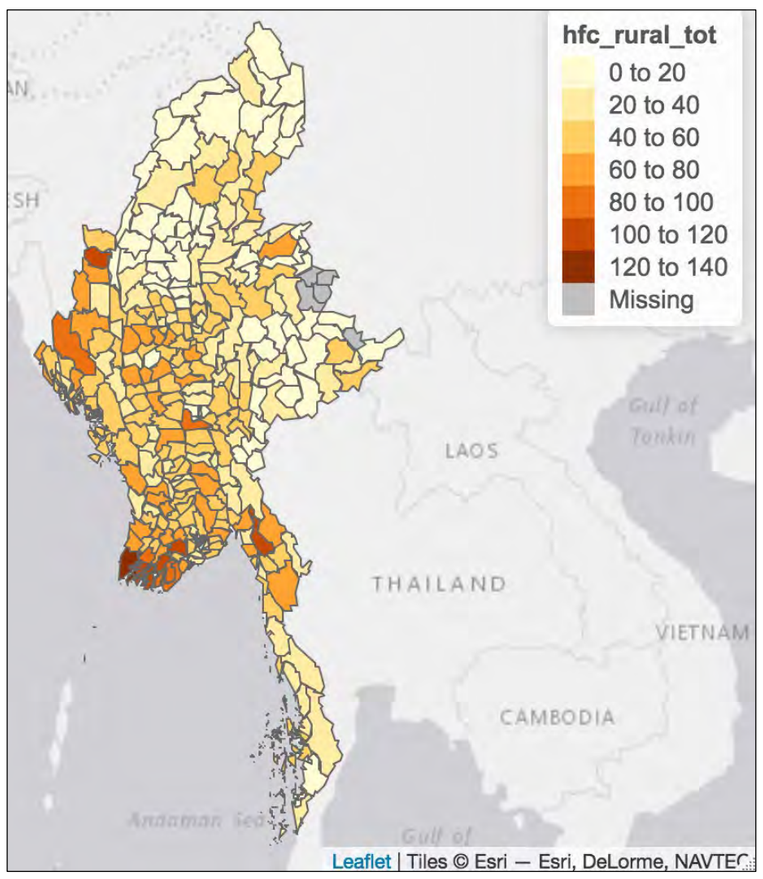

Figure (1) Distribution of the current sanctioned health facilities by townships, absolute number

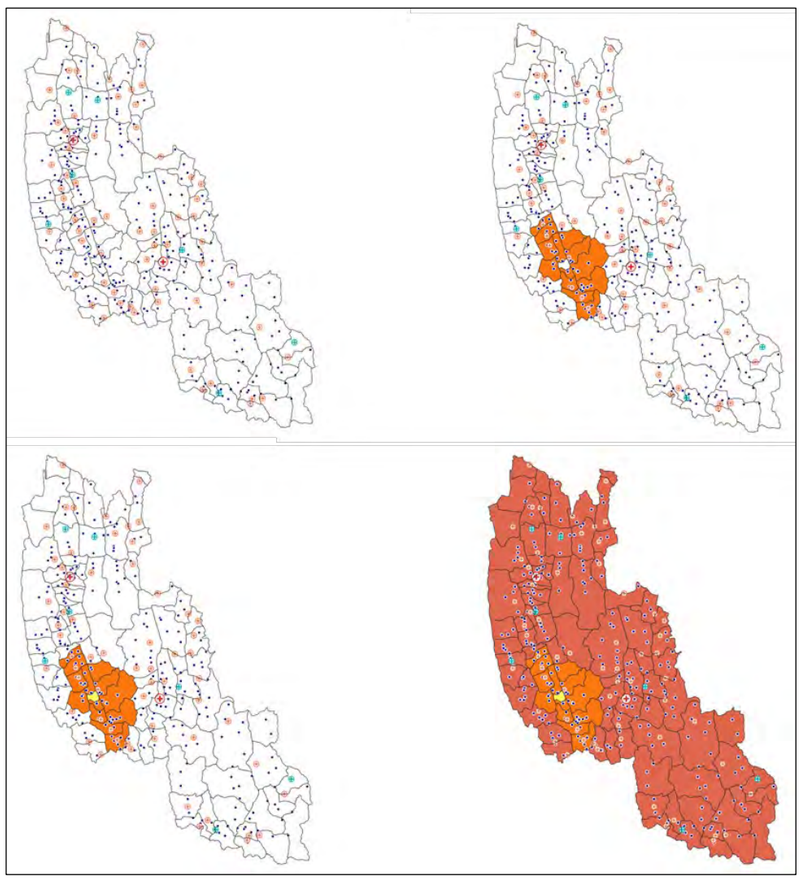

Figure (2) Paletwa township, categorization of geographical coverage of villages according to type of hardness by rural health facilities

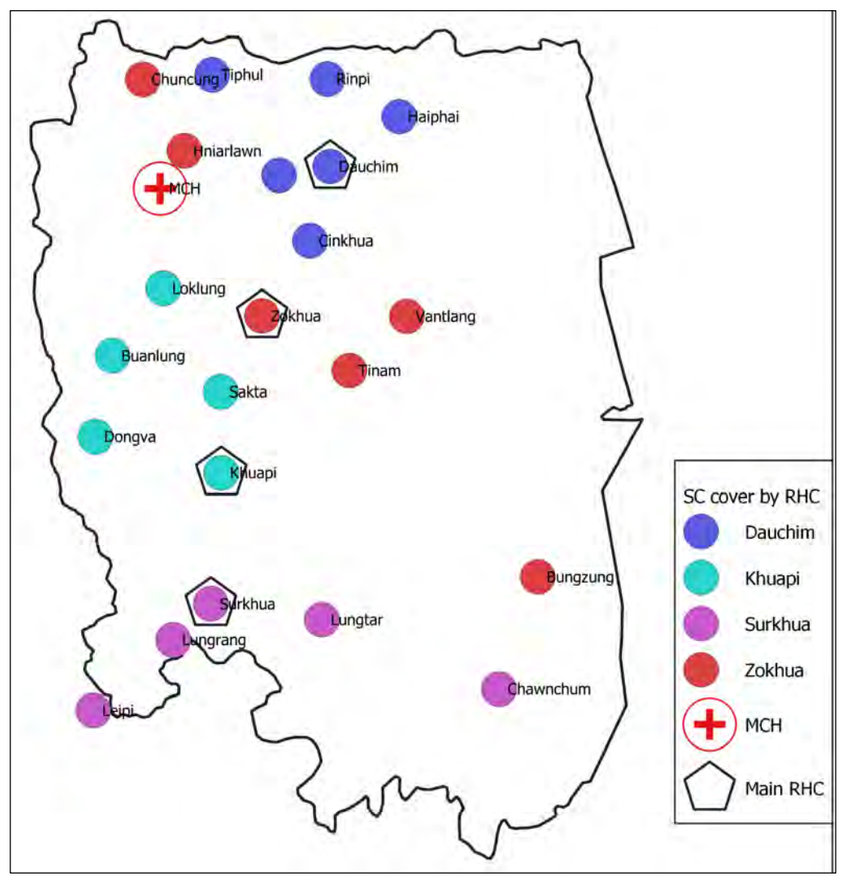

Figure (3) Hakha township, administrative coverage of rural health center and its sub-rural health center

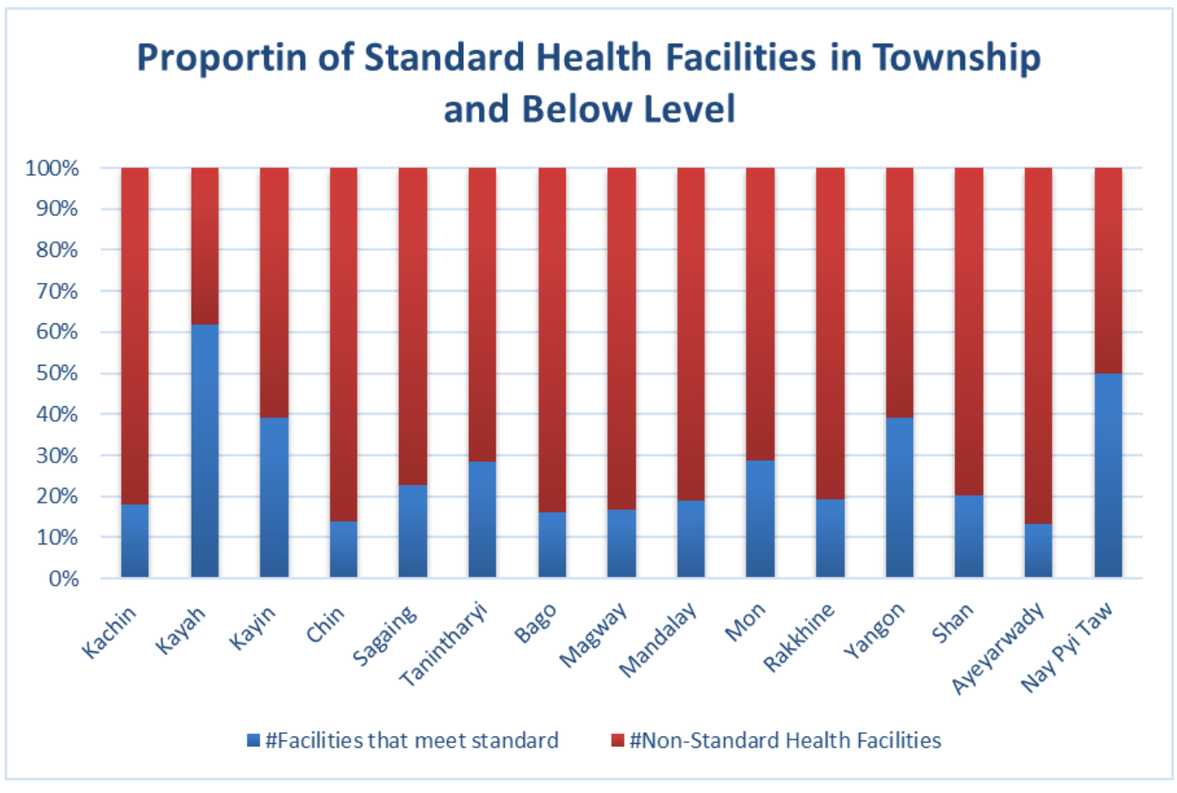

Figure (4) Proportion of standard health facilities in township and below level

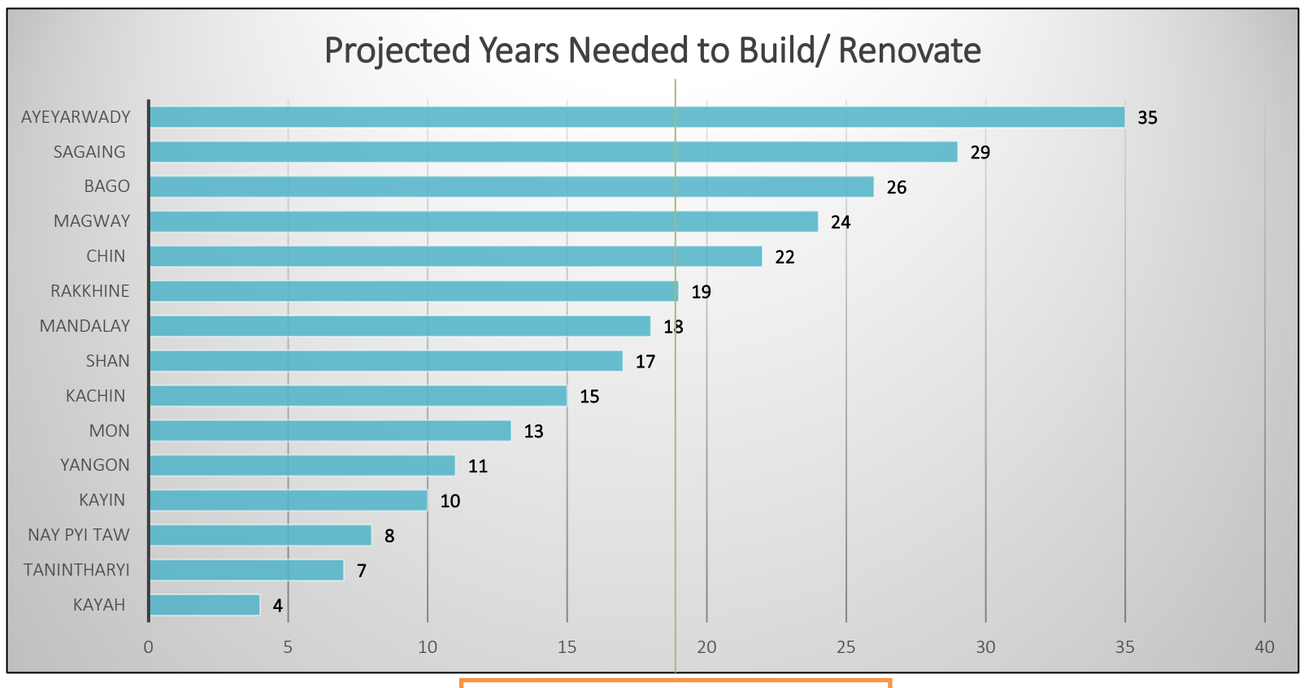

Figure (5) Projected years needed to build or renovate the remaining current sanctioned health facilities to meet standard

CONCLUSION

The study uncovered inequities and inefficiencies in the current distribution of sanctioned health facilities, including slow progress in constructing new facilities in remote areas and mismanagement leading to operational delays and increased budget consumption. A key challenge is the lack of consensus among stakeholders, influenced by differing and politically driven factors.

Urgently needed are context-specific norms reflecting local situations, based on consensus from all stakeholders, to ensure equitable and efficient health resource distribution. The study underscores the importance of establishing a platform for consensus among stakeholders on norms, reallocating health facilities for proper management, and creating a multi-year infrastructure master plan for equitable rural health facility distribution.

POLICY RECOMMENDATION

Allocate most of the health budget (double capital budget) specifically for investing in rural health facilities' capital infrastructure for the next five years.

Reorganize the administration and management of health facilities in order to use resources more efficiently and effectively.

Transfer budgets from the defense budget or the state economic enterprises (SEE) budget to the health sector in order to finance capital investments in rural health facilities.

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