



Research Article

Family Caregiving for People Living with Dementia in Yangon, Myanmar: Experiences, Challenges, Coping, and Unmet Support Needs

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Abstract

Background: Family caregivers provide most day-to-day assistance for people living with dementia in many low- and middle-income settings, yet caregiver experiences and support needs remain poorly documented in Myanmar. **Objective:** To explore family caregivers' experiences of caring for people living with dementia, including their understanding of the illness, changing care responsibilities, psychosocial consequences, coping strategies, and perceived unmet support needs. **Methods:** A qualitative descriptive study was conducted among 15 purposively selected adult family caregivers of people with dementia receiving neurological care at No. (2) Military Hospital (500-Bedded), Yangon. Semi-structured in-depth interviews explored recognition of dementia, caregiving tasks, behavioral and psychological symptoms, family roles, burden, coping, service use, and future support needs. Data were analyzed using Braun and Clarke's thematic analysis, with reporting guided by the Consolidated Criteria for Reporting Qualitative Research. **Results:** An overarching pattern of caring with limited preparedness and support was identified. Six interrelated themes were developed: (1) not knowing what to expect; (2) expanding and multifaceted care requirements; (3) emotional and physical strain of continuous care; (4) changing family roles, decision-making, and cultural responsibility; (5) social and financial consequences; and (6) learning to cope while seeking professional and future-care support. Caregivers' needs extended beyond disease information to practical skills, symptom management, caregiver support, continuity of care, and anticipatory guidance. **Conclusion:** Dementia caregiving in this Yangon neurological-care context was characterized by progressive responsibility, family commitment, and substantial unmet informational, practical, psychosocial, and service needs. Structured caregiver education and continuing support should be integrated into dementia care.

Keywords

Dementia, Family Caregivers, Qualitative Research, Caregiver Burden, Coping, Unmet Needs, Myanmar

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1. Introduction

Dementia is a progressive syndrome characterized by decline in cognition and functional ability, frequently accompanied by behavioral and psychological symptoms that affect independence and everyday life [1, 2]. As the illness progresses, family members commonly assume responsibility for medication management, personal care, supervision, safety, appointments, finances, and decision-making [3].

Family caregiving can be meaningful and culturally expected, but it can also produce emotional distress, fatigue, sleep disturbance, restriction of employment and social activities, and financial strain [3-5]. Behavioral and psychological symptoms may be particularly difficult when caregivers have limited information about dementia or little access to practical professional guidance [5].

These difficulties can be amplified in low- and middle-income settings where dementia-specific community services and formal long-term support are limited. A recent qualitative study from India described family caregivers as insufficiently prepared for advanced dementia care and identified informational, emotional, social, practical, symptom-management, cultural, and future-care needs [6]. Although the stage of illness and health-service context differ across studies, such findings highlight the central role of family caregiving where formal services are limited.

Qualitative studies from Asian settings also show that dementia caregiving is shaped by the gradual recognition of abnormal cognitive and behavioral change, changing family roles, cultural expectations, adaptation, and uncertainty about future care [7-10]. Research involving people living with dementia has similarly emphasized uncertainty about disease progression, loss of independence, and the need for information that supports future planning [11]. Evidence from Indonesia and South Asian communities further points to gaps in dementia knowledge, stigma, family responsibility, and difficulty navigating available services [12, 13]. Recent studies from Indonesia, Singapore, and China likewise identify persistent unmet informational, psychosocial, help-seeking, and behavior-management needs among family caregivers [17-19].

Myanmar-specific qualitative evidence on dementia caregiving remains limited. Understanding how caregivers interpret dementia, organize care, manage behavioral and functional change, cope with family and financial pressures, and interact with health services is necessary for clinically relevant support. This study therefore aimed to explore the experiences, challenges, coping strategies, and unmet support needs of family caregivers of people living with dementia receiving neurological care in Yangon, Myanmar.

2. Materials and Methods

2.1. Study Design and Methodological Orientation

A qualitative descriptive design was used to obtain an experience-near account of family caregiving and to generate findings that could inform clinical practice. Semi-structured individual interviews were selected because they allow participants to describe personal experiences while ensuring that common domains relevant to the research question are explored. Data were interpreted using thematic analysis as described by Braun and Clarke [14]. The manuscript was prepared with reference to COREQ reporting principles [16].

2.2. Study Setting and Participants

The study was conducted in the Department of Neurology, No. (2) Military Hospital (500-Bedded), Yangon, Myanmar, between January 2025 and June 2026.

Caregivers associated with people with dementia receiving neurological care were included so that experiences of everyday home-based care and interaction with specialist services could be explored.

2.3. Participants, Eligibility, and Sampling

Fifteen adult family caregivers were included using purposive sampling. Eligible participants were aged 18 years or older, were an unpaid family member involved in the care or supervision of a relative with a clinical diagnosis of dementia and had sufficient direct caregiving experience to discuss everyday care, challenges, coping, and support needs. Caregivers who were unable or unwilling to provide informed consent were excluded.

Purposive sampling sought diversity in caregiver relationship, co-residence, primary-caregiver status, caregiving duration, and care setting. Sample adequacy in this qualitative study was judged by the richness, relevance, and recurrence of information rather than by statistical power.

2.4. Recruitment and Consent

Potential participants were approached through the neurology service after clinical care had been separated from the research invitation. The study purpose, voluntary nature of participation, confidentiality, and right to withdraw were explained before participation. Written informed consent was obtained from the participants.

2.5. Interview Guide and Data Collection

Data were collected through individual semi-structured in-depth interviews conducted in the Myanmar language at the Department of Neurology, No. (2) Military Hospital (500-Bedded), Yangon, Myanmar. Each interview lasted approximately 30 minutes and was audio-recorded with the participant's informed consent.

A semi-structured interview guide was used to ensure consistency across interviews while allowing participants sufficient flexibility to describe their experiences in their own words. The interview guide explored early recognition and interpretation of cognitive or behavioral changes; experiences surrounding the diagnosis of dementia; changes in everyday caregiving responsibilities; assistance with activities of daily living; medication management, supervision, and safety; behavioral and psychological symptoms; emotional and physical effects of caregiving; changes in family roles and decision-making; work, social, and financial consequences; coping strategies and family support; experiences with healthcare services; and expectations for future care and support. These domains were informed by issues identified in Asian and low- and middle-income dementia-caregiving literature [6-13, 17-19].

Open-ended questions were used to encourage detailed descriptions of participants' experiences, and follow-up probes were used when clarification or further elaboration was required. Interviews focused on the caregivers' own perceptions and experiences rather than attempting to quantify the frequency of particular caregiving problems.

Following each interview, the audio recordings were transcribed verbatim in the Myanmar language using MAXQDA software. The transcripts were reviewed alongside the original audio recordings to ensure accuracy and completeness before being imported into the qualitative dataset for coding and thematic analysis. Identifying information was removed from the transcripts, and each participant was assigned an anonymized study code.

2.6. Data Analysis

The audio-recorded interviews were transcribed verbatim in the Myanmar language. Each transcript was checked against the corresponding audio recording to ensure accuracy and completeness, and identifying information was removed before analysis. The finalized transcripts were imported into MAXQDA software for data organization, coding, and management.

Data were analyzed using Braun and Clarke's six-phase thematic analysis approach [14]. First, the researchers became familiar with the data through repeated reading of the transcripts and review of the interview content. Initial codes were then generated systematically from meaningful segments of text that reflected caregivers' experiences, perceptions, challenges, coping strategies, and support needs. Coding was pri-

marily data-driven and remained close to participants' descriptions during the initial stage of analysis.

Related codes were subsequently compared and grouped into broader categories and candidate subthemes. These subthemes were then organized into overarching themes that represented recurring patterns across the interviews. Candidate themes were reviewed against both the coded extracts and the complete dataset to ensure internal coherence, sufficient supporting data, and clear distinction between themes. Themes and subthemes were refined, defined, and named before development of the final thematic structure.

The analysis considered both common experiences and variations among caregivers. Particular attention was given to accounts that differed from the dominant patterns so that the findings did not imply that all participants experienced dementia caregiving in the same way. The final analysis generated an overarching experience of caring with limited preparedness and support, comprising six interrelated themes: (1) not knowing what to expect; (2) expanding and multifaceted care requirements; (3) emotional and physical strain of continuous care; (4) changing family roles, decision-making, and cultural responsibility; (5) social and financial consequences; and (6) learning to cope while seeking professional and future-care support.

MAXQDA was used to support systematic organization of transcripts, codes, subthemes, and themes; however, interpretation and development of the thematic framework were undertaken by the research team rather than generated automatically by the software.

2.7. Trustworthiness and Reflexivity

Trustworthiness was considered in relation to credibility, dependability, confirmability, and transferability [15]. The analytic process emphasized repeated reading, transparent coding, comparison of themes with the full dataset, attention to divergent experiences, and clear linkage between the research question, analysis, and interpretation. Reflexivity was considered important because clinical experience with dementia may influence what researchers notice and how they interpret caregiver accounts.

2.8. Ethical Considerations

Ethical approval for the study was obtained from the Ethical Review Committee of the Defence Services Medical Academy, Myanmar (Approval Reference No. 012, dated 12 January 2025). Written informed consent was obtained from all participants before the interviews were conducted. Participation was voluntary, and participants were informed of the study purpose, confidentiality of their information, and their right to withdraw from the study at any time without consequence. Identifying information was removed from the transcripts and analytic dataset to protect participant confidentiality.

3. Results

3.1. Participant Characteristics

Fifteen family caregivers participated in the study. Their ages ranged from 35 to 71 years, with a mean age of approximately 52 years. Ten participants were women and five were men. Six were daughters, four were spouses, three were sons, and two were other relatives. Twelve caregivers lived in the same household as the person with dementia, while three lived separately. Eleven participants identified themselves as the primary caregiver. The duration of caregiving ranged from 8

months to 7 years, with a median duration of approximately 3 years. Ten caregivers were associated with outpatient care and five with inpatient care.

3.2. Overview of Themes

The interviews indicated an overarching experience of caring with limited preparedness and support. Six interrelated themes were identified. These themes captured the transition from uncertainty about dementia to increasing caregiving responsibility, the consequences of sustained care, and caregivers' attempts to adapt while seeking more practical and continuing support.

Table 1. Summary of Themes, Key Subthemes, and Interpretive Focus.

Theme	Key subthemes	Interpretive focus
1. Not knowing what to expect	Limited dementia knowledge; uncertainty about progression; practical information gaps	Diagnosis and clinical contact did not necessarily provide caregivers with a clear roadmap for everyday care.
2. Expanding and multifaceted care requirements	ADL assistance; medication; supervision; safety; behavioral and physical symptoms	Caregiving expanded from reminders and support to continuous responsibility for multiple domains of daily life.
3. Emotional and physical strain of continuous care	Worry; frustration; guilt; fatigue; sleep disruption; caregiver health	The demands of vigilance and responsibility affected caregivers psychologically and physically.
4. Changing family roles, decision-making, and cultural responsibility	Role reversal; proxy decisions; preserving dignity; family duty; shared or unequal responsibility	Caregiving altered family relationships while remaining embedded in expectations of responsibility and reciprocity.
5. Social and financial consequences	Restricted work and social life; treatment and transport costs; opportunity costs	Dementia care affected participation outside the home and placed pressure on household resources.
6. Learning to cope while seeking professional and future-care support	Routines; redirection; family sharing; professional advice; continuity; future planning	Caregivers developed practical strategies but continued to need anticipatory, accessible, and sustained support.

3.3. Theme 1: Not Knowing What to Expect

A central difficulty was uncertainty about dementia and its future course. Caregivers described a gradual process of recognizing that memory problems, confusion, or behavioral changes represented more than ordinary ageing. Even after diagnosis, understanding the label did not always translate into confidence about how to manage problems at home. Caregivers needed practical explanations of what changes might occur, which symptoms should prompt medical review, how treatment expectations should be understood, and how to respond to difficult behavior. The need was therefore not limited to general information about dementia; it involved anticipatory guidance that could be applied to day-to-day care.

"The doctor explained that dementia would gradually get worse, but at home I still did not know what changes to expect

or what I should do when new problems appeared."

3.4. Theme 2: Expanding and Multifaceted Care Requirements

Caregiving responsibilities increased as the person with dementia became less independent. The caregiving role included medication supervision, assistance with personal care and meals, accompanying the person to appointments, monitoring safety, and responding to behavioral and psychological symptoms. Caregivers also had to adapt the home environment and remain alert to wandering, falls, agitation, sleep disturbance, or other changes that could create risk. This progressive expansion meant that care was not a single task but a combination of practical, supervisory, emotional, and coordination responsibilities.

"At first, I only reminded my mother about her medicine

and helped with small things. Later, I had to help her with bathing, dressing, eating, and walking. I also had to watch her closely because sometimes she tried to go outside alone or became restless. It became difficult for one person to manage everything.”

3.5. Theme 3: Emotional and Physical Strain of Continuous Care

Continuous responsibility created substantial emotional and physical strain. Caregivers described worry about deterioration, uncertainty about whether they were providing the right care, frustration during difficult behaviors, and guilt when they felt unable to meet every need. Night-time supervision and persistent vigilance contributed to fatigue and disrupted sleep. Caregivers' own health and well-being could be pushed into the background as attention centered on the person with dementia. Emotional distress was therefore closely linked to the practical intensity and unpredictability of caregiving.

“Sometimes I feel exhausted because I have to watch him all the time, even during the night. I worry that I may not be caring for him properly, and when I become tired or frustrated, I feel guilty. There are days when I forget about my own health because all my attention is on him.”

3.6. Theme 4: Changing Family Roles, Decision-Making, and Cultural Responsibility

Dementia altered established family roles. Adult children increasingly became responsible for decisions previously made by their parents, while spouses had to balance protection with respect for the person's remaining autonomy. Caregivers attempted to preserve dignity by involving the person with dementia in decisions whenever possible, but this became more difficult as cognitive impairment progressed. Care was also understood within a family and cultural framework of responsibility, reciprocity, and duty. This sense of obligation could coexist with exhaustion rather than eliminating it. Differences in the contribution of siblings or other relatives sometimes increased the pressure on the main caregiver.

“Before my father became ill, he was the one who made most of the decisions in our family. As his memory became worse, I gradually had to make decisions for him. I still try to ask what he wants whenever he can tell me. Sometimes my brothers cannot help because of their own responsibilities, so most of the care falls to me. It is tiring, but he is my father and I feel it is my duty to look after him.”

3.7. Theme 5: Social and Financial Consequences

The caregiving role extended beyond the home into caregivers' work, social life, and finances. Time required for supervision, appointments, and daily care reduced opportunities

for employment, recreation, and social contact. Direct expenses related to treatment, medication, transport, and care were accompanied by indirect costs such as reduced working time or the need for another family member to remain at home. These pressures were particularly important when formal respite, day-care, homecare, or dementia-specific support options were limited or difficult to access.

“I had to reduce my work because someone needed to stay with my mother most of the time. We also spent more on medicines, transport, and hospital visits. Because of these responsibilities, I rarely had time to meet friends or do things for myself, and the financial pressure became difficult for our family.”

3.8. Theme 6: Learning to Cope While Seeking Professional and Future-Care Support

Caregivers developed practical knowledge through experience. Common approaches included establishing predictable routines, simplifying instructions, redirecting attention rather than arguing, sharing supervision where possible, and seeking medical advice when symptoms became difficult. Nevertheless, informal adaptation had clear limits. Caregivers wanted accessible professional advice, clearer follow-up, practical training in symptom and behavior management, attention to caregiver well-being, and guidance about future care. The need for support was therefore continuous and changed as dementia progressed rather than being confined to the time of diagnosis.

“Over time, we learned some ways to manage him at home, such as keeping the same routine and avoiding arguments when he became confused. But there were still many situations we did not know how to handle. I wished we had someone to explain what to expect next and whom to contact when his condition changed.”

4. Discussion

This study explored the experiences, challenges, coping strategies, and unmet needs of 15 family caregivers of people living with dementia receiving neurological care in Yangon. The overarching pattern was one of caring with limited preparedness and formal support. Caregivers moved from uncertainty about the illness to progressively greater responsibility while simultaneously managing emotional, physical, social, and financial consequences. They developed practical coping strategies but continued to need information, skills, continuity, and future-oriented professional guidance.

The finding that caregivers did not always know what to expect is closely aligned with the recent Indian qualitative study by Kumar et al., in which caregivers described inadequate preparation for the evolving demands of dementia and a strong need for information, emotional support, symptom guidance, and future-care planning [6]. Recent research in Indonesia similarly found substantial unmet caregiver needs,

particularly for information, counseling, and psychosocial support [17], while a Singapore study identified knowledge gaps and caregiver-related barriers in diagnosis- and treatment-seeking [18]. Although these studies involved different service contexts, they reinforce the need for practical and anticipatory guidance across the dementia trajectory. The present findings suggest that diagnostic disclosure should be followed by practical caregiver education rather than treated as a one-time information event.

The progressive expansion of caregiving responsibilities also corresponds with broader dementia-caregiving literature. Family caregivers commonly become responsible for personal care, medication, supervision, behavioral management, safety, and healthcare coordination as independence declines [3-5]. Asian qualitative research has described this transition as a shift into an increasingly demanding caregiving world that requires continual adjustment [7, 8]. More recent qualitative evidence also highlights caregivers' need for professional guidance when managing behavioral and psychological symptoms [19]. The implication for clinical services is that caregiver needs should be reassessed over time; support that is sufficient during early dementia may be inadequate when dependency increases.

The emotional and physical consequences reported by caregivers are consistent with well-established concerns about dementia caregiver burden [3, 4]. However, burden alone does not fully capture the caregiving experience. Vietnamese caregivers have described substantial hardship while simultaneously understanding care as a moral and familial responsibility [9]. In the present study, responsibility and strain were similarly intertwined. This is important because interventions framed only around reducing burden may overlook the meaning that caregivers attach to family duty, reciprocity, dignity, and commitment.

Changing roles and decision-making were another important dimension. Read et al. found that family carers' ability to advocate for a person with dementia depended on knowing the person, understanding their values, and navigating a changing decision-making process [10]. Research with people living with dementia has likewise emphasized the importance of maintaining autonomy and connection for as long as possible [11]. These findings support early discussion of preferences and future care while the person with dementia can still participate meaningfully.

The present study also highlights the social and financial consequences of caregiving. Time away from work, reduced social participation, transportation and treatment expenses, and the opportunity costs of continuous supervision can place substantial pressure on families. Similar difficulties have been described in low- and middle-income settings, where family care remains the principal source of support and formal community services may be limited [6, 9, 12, 13]. Service planning should therefore consider caregiver needs alongside the clinical needs of the person with dementia.

Caregivers' coping strategies reflected both adaptation and

the limitations of informal care. Routines, redirection, patience, shared family care, and professional advice helped caregivers manage difficult situations, but families still required clearer access to continuing support. A 2025 systematic review and meta-analysis of caregiver-support interventions in low- and middle-income countries found beneficial effects on caregiver burden, depression, and other health outcomes, while emphasizing the importance of culturally tailored approaches [20]. A practical dementia-caregiver pathway in Yangon could include structured education at diagnosis, anticipatory guidance on behavioral and functional change, medication and safety counselling, routine assessment of caregiver strain, referral information, and a defined route for obtaining advice between scheduled appointments. Such measures should be locally evaluated rather than assumed to be effective solely because they are recommended elsewhere.

The study's principal contribution is contextual. A sample of 15 purposively selected caregivers cannot estimate the prevalence of caregiver experiences in Myanmar, but it can illuminate how families understand and manage dementia within a particular neurological-care setting. The findings therefore support analytic rather than statistical generalization and should be interpreted with attention to local family structures, available services, and healthcare access.

4.1. Implications for Clinical Practice

The findings support integrating caregiver support into routine dementia care. At minimum, caregivers may benefit from: (1) clear explanation of dementia and likely progression; (2) practical guidance for behavioral symptoms, medication, nutrition, mobility, falls, and home safety; (3) assessment of caregiver stress and health; (4) family discussion about sharing responsibilities and decision-making; (5) information about available community or social resources; and (6) anticipatory discussion of future care preferences. These elements could be delivered in a staged manner as caregiver needs evolve.

4.2. Strengths and Limitations

A qualitative design allowed exploration of the meanings, family dynamics, coping processes, and support needs that are not easily captured by quantitative burden scores. Purposive inclusion of 15 caregivers provided an opportunity to examine a range of caregiving experiences in a specialist neurological setting. However, the study was conducted at a single hospital and the findings are context-specific; they should not be considered statistically representative of all dementia caregivers in Yangon or Myanmar. Caregivers connected with specialist services may differ from families without access to neurological care. Recall and social-desirability effects are also possible. The final manuscript should report interviewer reflexivity, language and translation procedures, and any negative or divergent cases to strengthen transparency.

5. Conclusions

Family caregiving for people living with dementia in this Yangon neurological-care context involved a progressive expansion of responsibility accompanied by uncertainty, emotional and physical strain, changing family roles, social and financial consequences, and a continuing need for practical professional support. Caregivers adapted through routines, family negotiation, and experience, but informal coping did not replace the need for structured information, symptom-management guidance, caregiver support, continuity of care, and future planning. Incorporating these elements into dementia services may help families provide sustainable, person-centered care while protecting caregiver well-being.

Abbreviations

ADL	Activities of Daily Living
COREQ	Consolidated Criteria for Reporting Qualitative Research
MAXQDA	Qualitative Data Analysis Software
LMICs	Low- and Middle-Income Countries
BPSD	Behavioral and Psychological Symptoms of Dementia

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Author Contributions

Myint Thein Naing: Conceptualization, Formal Analysis, Methodology, Project administration, Resources, Visualization, Writing – original draft, Writing – review & editing

Ye Phy Aung: Conceptualization, Methodology, Resources, Supervision, Validation, Writing – original draft, Writing – review & editing

Pyi Hein Kyaw: Data curation, Formal Analysis, Investigation, Software, Writing – original draft

Tun Tun Naing: Data curation, Formal Analysis, Software, Visualization, Writing – review & editing

Ohnmar Saw: Conceptualization, Supervision, Validation

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Data Availability Statement

The data are available from the corresponding author upon

reasonable request.

Conflicts of Interest

The authors declare no conflicts of interest.

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Biography



Myint Thein Naing is a Consultant Physician and Neurologist registered with the Myanmar Medical Council, with extensive experience in internal medicine, neurology, inpatient and outpatient care, undergraduate and postgraduate medical education, clinical research, curriculum development, and academic assessment. He is experienced in leading multidisciplinary teams, supervising junior doctors and trainees, developing stroke services, and delivering patient-centred neurological care. He is a Lecturer at the Defence Services Medical Academy with more than 15 years of involvement in medical education and clinical training.



Ye Phyo Aung is a Senior Lecturer and Head in the Department of Medical Education at the Defence Services Medical Academy, Yangon, Myanmar. He obtained his M. H. P. E. in Medical Education from Maastricht University in 2017 and his fellowship from the International Association of Medical Science Educators in 2023. He has served as a reviewer for Medical Science Educator (MSE), The Asia Pacific Scholar (TAPS), and Medical Education (online) since 2021. He has participated in international research collaborations in medical education in recent years. He currently serves as a Secretary, Chair, Speaker, and Judge at national and international conferences.



Pyi Hein Kyaw is an Assistant Lecturer in the Department of Medical Education at the Defence Services Medical Academy (DSMA), Myanmar, having joined the department in 2025. He received his MBBS degree in 2009 and earned a Master of Medical Science (M.Med.Sc.) in Environmental Health in 2014. He is currently pursuing a Diploma in Medical Education. Prior to his academic appointment, he served as a Battalion Medical Officer and later as a Staff Officer at the Directorate of Medical Services. His interests include medical education, curriculum development, assessment, environmental health, educational research, and the application of artificial intelligence in health professions education.



Tun Tun Naing is currently an Assistant Lecturer in the Department of Medical Education at the Defence Services Medical Academy. He received his MBBS in 2006, M.Med.Sc. (Public Health) in 2009, and a Diploma in Medical Education in 2015. He also earned a Master of Public Policy from Meiji University, Tokyo, in 2020 through the JICA Scholarship Program. He is also a member of the joint secretariat of the Myanmar Military Medical Conference and currently works as a reviewer for The Asia Pacific Scholar (TAPS) and Frontiers in Medicine. He participates in local and international medical education and public health research.



Ohnmar Saw is Professor and Head of the Department of Neurology at the Defence Services Medical Academy (DSMA), Yangon, Myanmar. She is a senior neurologist with extensive experience in clinical neurology, undergraduate and postgraduate medical education, specialist training, clinical research, and academic assessment. Her academic and clinical interests include cerebrovascular disease, epilepsy, neurodiagnostic services, and the development of neurology education and specialist training. She has contributed to the advancement of neurological clinical services and academic programmes at DSMA.



Nwe Nwe Win was the former Professor and Head of the Departments of Internal Medicine and Neurology at the Defence Services Medical Academy (DSMA), Myanmar. She played a foundational role in the development of neurological services and education at DSMA and was the founder of the Department of Neurology, established in 2002. Under her leadership, the Department developed its academic, clinical, and specialist-training activities and contributed to the advancement of neurological practice within the Defence Medical Services. She subsequently continued to contribute to neurology through clinical practice, teaching, research, and professional academic activities. Recent academic materials identify her as a senior consultant neurologist and honorary professor at DSMA.

Research Field

Myint Thein Naing: Medical and Health Sciences, Neurology, Neuroscience, Clinical Research, Medical Education

Ye Phyoe Aung: Medical and Health Sciences, Medical Education, Clinical Research

Pyi Hein Kyaw: Medical and Health Sciences, Preventive and Social Medicine, Environmental Health, Medical Education

Tun Tun Naing: Medical and Health Sciences, Preventive and Social Medicine, Environmental Health, Medical Education

Ohnmar Saw: Medical and Health Sciences, Neurology, Neuroscience, Clinical Research, Medical Education

Nwe Nwe Win: Medical and Health Sciences, Neurology, Neuroscience, Clinical Research, Medical Education