



## **UNFPA - ICOMP REGIONAL CONSULTATION**

### **Family Planning in Asia and the Pacific Addressing the Challenges**

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### **The Status of Birth Spacing in Myanmar**

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## **Abbreviations and Acronyms**

<b>AFXB</b>	<b>Association Francoi- Xavier Bagnoud</b>
<b>AIDs</b>	<b>Acquired Immune Deficiency Syndrome</b>
<b>AMDA</b>	<b>Association of Medical Doctors of Asia</b>
<b>AMI</b>	<b>Aide Medicale International</b>
<b>ANC</b>	<b>Antenatal Care</b>
<b>ARH</b>	<b>Adolescent Reproductive Health</b>
<b>ART</b>	<b>Anti-Retroviral Therapy</b>
<b>ASRH</b>	<b>Adolescent Sexual and Reproductive Health</b>
<b>AMW</b>	<b>Auxiliary Midwife</b>
<b>BCC</b>	<b>Behavior Change Communication</b>
<b>BHS</b>	<b>Basic Health Staff</b>
<b>BS</b>	<b>Birth Spacing</b>
<b>BSS</b>	<b>Behavioral Surveillance Survey</b>
<b>CBR</b>	<b>Crude Birth Rate</b>
<b>CDR</b>	<b>Crude Death Rate</b>
<b>CHEB</b>	<b>Central Health Education Bureau</b>
<b>CoRH</b>	<b>Community operated Reproductive Health</b>
<b>CPR</b>	<b>Contraceptive Prevalence Rate</b>
<b>CSG</b>	<b>Community Support Group</b>
<b>CSO</b>	<b>Central Statistical Organization</b>
<b>DHP</b>	<b>Department of Health Planning</b>
<b>DOH</b>	<b>Department of Health</b>
<b>DOP</b>	<b>Department of Population</b>
<b>FAQ</b>	<b>Frequently Asked Questions</b>
<b>FAYS</b>	<b>Family and Youth Survey</b>
<b>FP</b>	<b>Family Planning</b>
<b>FPI</b>	<b>Family Planning International</b>
<b>FRHS</b>	<b>Fertility and Reproductive Health Survey</b>

<b>FSW</b>	<b>Female Sex Worker</b>
<b>GBV</b>	<b>Gender Based Violence</b>
<b>GORM</b>	<b>Government of the Republic of Myanmar</b>
<b>HA</b>	<b>Health Assistant</b>
<b>HIV</b>	<b>Human Immunodeficiency Virus</b>
<b>HMIS</b>	<b>Health Management Information System</b>
<b>ICPD</b>	<b>International Conference on Population and Development</b>
<b>ICPO PoA</b>	<b>International Conference on Population and Development program of Action</b>
<b>IEC</b>	<b>Information, Education and Communication</b>
<b>IMR</b>	<b>Infant Mortality Rate</b>
<b>INGOs</b>	<b>International Non-Governmental Organizations</b>
<b>IPT</b>	<b>Intimate Partner Transmission</b>
<b>IUCD (IUD)</b>	<b>Intra Uterus Contraceptive Device</b>
<b>JOICFP</b>	<b>Japanese Organization for International Cooperation in Family Planning</b>
<b>LHV</b>	<b>Lady Health Visitor</b>
<b>LMIS</b>	<b>Logistic Management Information System</b>
<b>MCH</b>	<b>Maternal and Child Health</b>
<b>MDGs</b>	<b>Millennium Development Goals</b>
<b>MDM</b>	<b>Medicins Du Monde</b>
<b>MMA</b>	<b>Myanmar Medical Association</b>
<b>MMR</b>	<b>Maternal Mortality Ratio</b>
<b>MOH</b>	<b>Ministry of Health</b>
<b>MOIP</b>	<b>Ministry of Immigration and Population</b>
<b>MOU</b>	<b>Memorandum of Understanding</b>
<b>MSI</b>	<b>Marie Stopes International</b>
<b>MW</b>	<b>Midwife</b>
<b>MWAF</b>	<b>Myanmar Women's Affairs Federation</b>
<b>NAP</b>	<b>National AIDS program</b>
<b>NGOs</b>	<b>Non-Governmental Organizations</b>
<b>NRS</b>	<b>Northern Rakhine State</b>

<b>OG</b>	<b>Obstetrics/Gynecologist</b>
<b>PCFS</b>	<b>Population Changes and Fertility Survey</b>
<b>PLHIV</b>	<b>People Living with HIV/AIDS</b>
<b>PMCT</b>	<b>Prevention of Mother to Child Transmission of HIV</b>
<b>PNC</b>	<b>Post natal care</b>
<b>PSI</b>	<b>Population Services International</b>
<b>RH</b>	<b>Reproductive Health</b>
<b>RHCs</b>	<b>Rural Health Centers</b>
<b>RHMIS</b>	<b>Reproductive Health Management Information System</b>
<b>RSH</b>	<b>Reproductive and Sexual health</b>
<b>RTI</b>	<b>Reproductive Tract Infection</b>
<b>SA</b>	<b>Situation Analysis</b>
<b>SC</b>	<b>Save the Children</b>
<b>SH</b>	<b>School Health</b>
<b>SRH</b>	<b>Sexual and Reproductive Health</b>
<b>STDs</b>	<b>Sexually Transmitted Diseases</b>
<b>STI</b>	<b>Sexually Transmitted Infection</b>
<b>TBA</b>	<b>Traditional Birth Attendant</b>
<b>TFR</b>	<b>Total Fertility Rate</b>
<b>THO</b>	<b>Township Health Officer</b>
<b>TMO</b>	<b>Township Medical Officer</b>
<b>TRC</b>	<b>Temporary Registration Card</b>
<b>UHC</b>	<b>Urban Health Center</b>
<b>UN</b>	<b>United Nations</b>
<b>UNAIDS</b>	<b>United Nations Joint Program on HIV/AIDS</b>
<b>UNICEF</b>	<b>United Nations Children's Fund</b>
<b>UNFPA</b>	<b>United Nations Population Fund</b>
<b>VCCT</b>	<b>Voluntary Confidential counseling and Testing</b>
<b>WCHD</b>	<b>Women and Child Health Development</b>
<b>WHO</b>	<b>World Health Organization</b>
<b>YIC</b>	<b>Youth Information Center</b>
<b>YWCA</b>	<b>Young Women's Christian Association</b>

Figure 1a: Map of Myanmar showing Geographic terrain and population Density

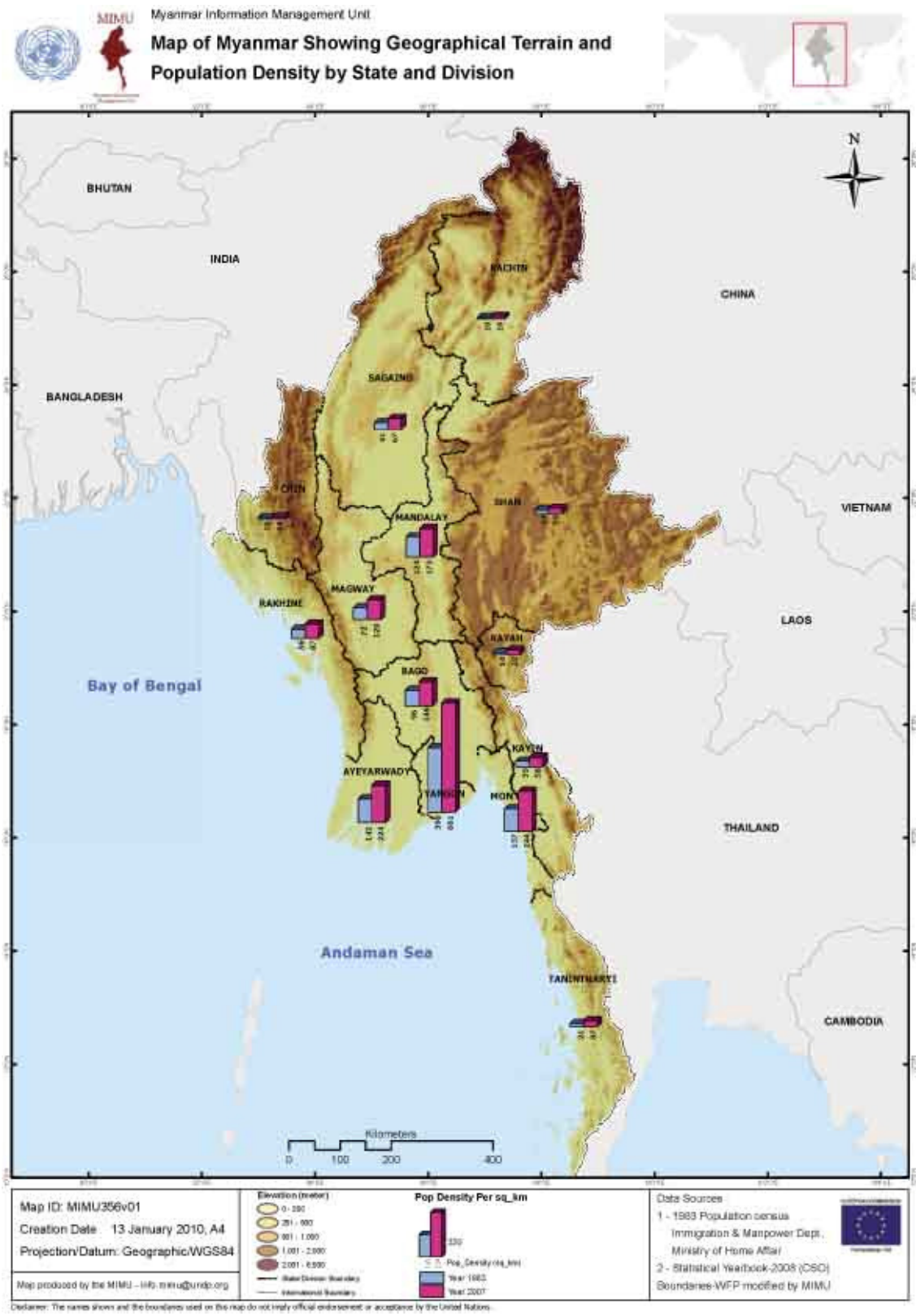
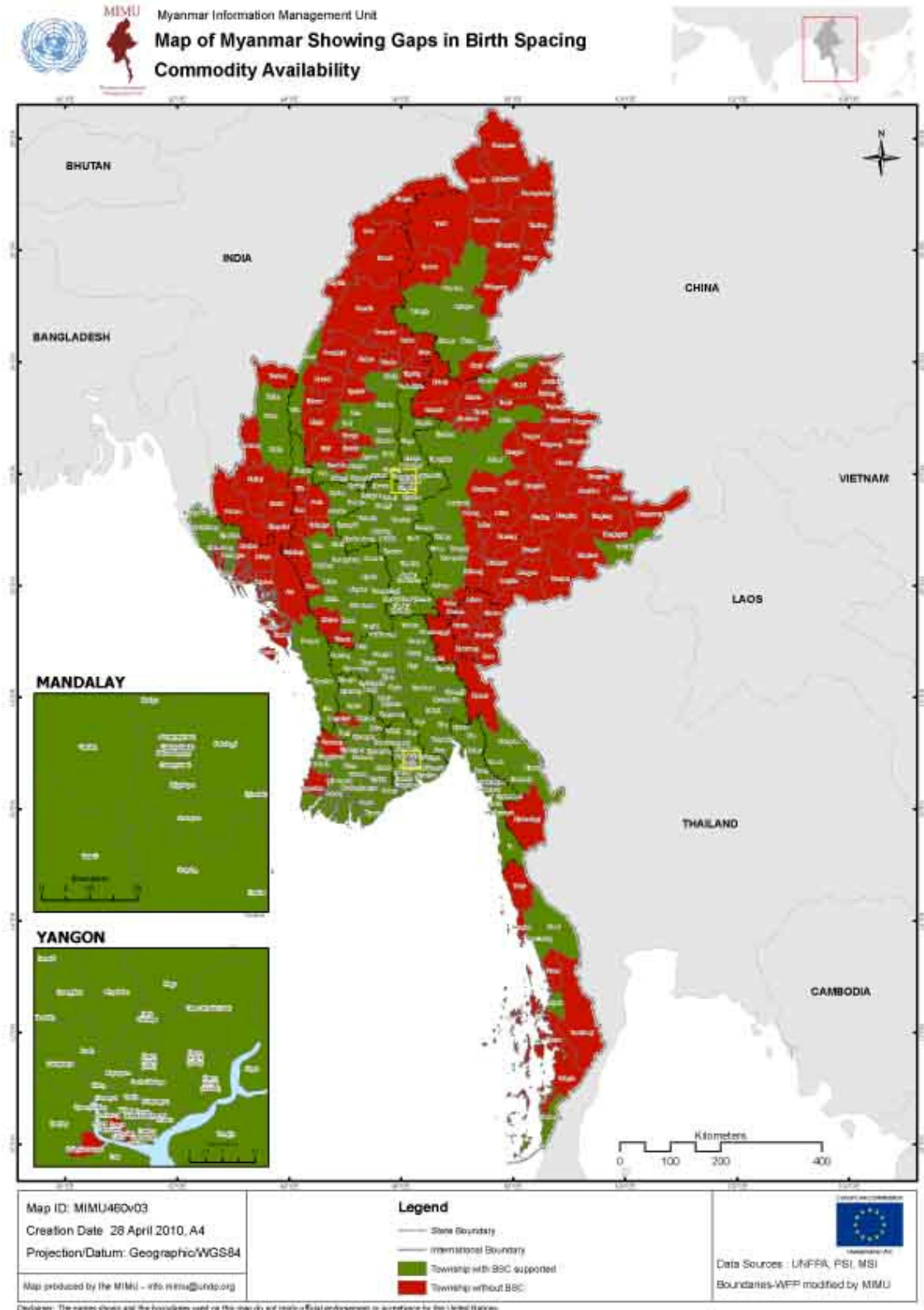


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## Executive Summary

The population of Myanmar is estimated in 2008-2009 at 59.13 million, with the growth rate at 1.29% percent with 70% living in the rural area. Fertility in Myanmar has been declining and is at post-transitional stage with the total fertility rate (TRF) at the national level standing at 2.03, decreasing from 2.9 in 1991. Urban TFR is 1.68 and is lower than the rural TFR of 2.18. The unmet need for contraception moderately decreased from 20.6 in 1991 to 17.7 in 2006. The last census conducted in Myanmar was in 1983. There is a vast difference of the UN estimates of population at 50 million in 2009 and the government's estimate of 59.13 million which reflects that there is a dire need for a population census in the country. The unmet need for contraception is 17.7 percent (FRHS 2006), may be underestimated and could be higher if unmarried women were also included in the calculation. Contraceptive prevalence rate increased from 16.8 in 1991 to 41 in 2007 (all methods). Despite progress made the Maternal Mortality Rate (MMR) is 316 per 100,000 live births but the latest estimates by WHO, UNICEF, UNFPA and the World Bank depicts Myanmar MMR at 240 per 100,000 live births. There is a funding gap for BS commodities in 2009 was over 5.5 million US\$. If UNFPA continues to support contraceptives even at current level increased financial commitments are required from the national budget as well as the donor contributions to fill the shortfall of 26 million US\$, which is about 60% of contraceptive requirements in 2010-2013. As evidence shows that doubling the investment in BS can slash the MMR by 20% it is important for concerted efforts to provide BS for those who need. Challenges exist for sound logistic management system for forecasting, procurement, warehousing, distribution and inventory control of reproductive health commodities is not fully functional. This includes supply of reproductive health commodities and contraceptives resulting in intermittent stock-outs at the facility level and affecting consistent supply for end-user. The huge funding gap for BS commodities, need all stakeholders to be transparent and working together towards pooling of resources to fulfill the ICPD objectives. Areas of concern are Adolescent Reproductive Sexual Health (ARSH), unintended pregnancies and abortions, linkages between RH, BS and HIV services, RH and BS services of migrant population, Northern Rakhine state population and availability of quality BS and RH services. There is need for change in attitudes of all stakeholders as

equal partners, better coordination and flexibility on the part of the national policy on pro-natalist stand and to prioritize the areas that needs most and gear RH and BS program towards critical needs, greater government and donor commitment through increase funding for RH and BS commodities, policy directions towards accumulated drug revolving fund from cost sharing mechanism of BS commodities at township level. Explore and implement ways to reach nationwide population with BS advocacy and ASRH messages using prime time media and adolescent friendly BS services. It is through working together of all stakeholders that MDGs and ICPD goals can be reached.

### **Recommendations:**

#### **Political and Policy commitments**

- Go RM to advocate all partners working in RH in Myanmar for quality as well as quantity of services to be provided for universal access to essential RH and BS services through regulations and consistent monitoring and supervision.
- GoRM to be flexible with its pro-natalist population directions and to expand project townships to cover all 235 townships in the country without over-laps in supply of BS commodities without stock-outs.
- GoRM to create budget line with increased funding for reproductive health commodities.
- Provide policy guidelines for effective utilization of “drug revolving fund” accumulated at Township level for BS commodity security and charge exemption for the needy citizens.
- GoRM to actively engage with donor community with evidence based proposal development for request of additional donor assistance for RH and BS commodities.
- Explore alternative financing options, including finding ways to increase the role of the private sector and NGO partners.
- Supportive supervision and incentives for Basic Health workers who serve at hard to reach rural areas to improve coverage of skilled birth attendants.

#### **RH and BS Program –**

#### Improved access to RH and BS services

- Reduce the MMR , un-intended pregnancies and unsafe abortions, by improved access to Birth Spacing and Reproductive Health care and increased institutional delivery through expansion of Community Support group program in hard to reach and high MMR townships and States and Divisions. Tailoring BS services for young people, the unmarried and the hard to reach populations.
- Work with UN and national NGOs to establish incentive system and empower community support groups to better linkages between community and health care providers for better RH and SB care and support.
- Improve transportation and communication for hard to reach areas to improve referral in emergency obstetric situations.
- Explore and implement ways to reach nationwide population with BS advocacy and ASRH messages using prime time media and adolescent friendly BS services.

#### Improved quality of Care

- Improve quality of RH and BS services should be ensured by skill training, issuance and following through the standard operational procedures and guidelines in practice.
- Employ and deploy health personnel with supportive supervision especially trained Midwives to priority areas for BS and MCH care and support.
- Training of human resources for better coordination and utilization of computerized Logistic Management Information system, projection of Contraceptive needs, mapping out priority areas, monitoring & supervision, and warehousing towards a functional LMIS.

#### **BS and RH Commodity Security**

- Better stewardship of existing resources by strengthening the "supply chain" through capacity building- to forecast, finance, procure, and deliver high-quality and reliable supplies and services.

- Work with WHO to include essential reproductive health supplies in the national essential drug list.
- strengthening logistics management and ensure RH & BS commodity security through sub-committee on RHCS of the national working committee on RH in coordinating efforts to meet the needs for RH Commodities
- Develop flexible and simplified procedures for purchasing commodities and explore new mechanisms for pooling and coordinating international commodity purchases.
- Address RHCS through: provision of low cost contraceptives, sharing of experiences, and providing technical assistance through South-South cooperation modality.
- Test and evaluate innovative strategies for providing quality, cost-effective products and services sensitive to cultural norms and practices of the people of Myanmar.

#### **Coordination with Partners**

- Create strong partnership, understanding and trust among players for better RH outcomes. Demand creation activities related to BS should be allowed to inform and educate women regarding FP.
- PSI, MSI, AZG, AMI, ADRA, Save the Children, and all other actors in the RH need to lobby their national governments to commit an adequate and stable supply of reproductive health and BS commodities, along with quality services and to pledge funding support as projected in the Second Five year National strategic Plan for RH (2009-2013).
- Educate members, constituents, or clients about the need for quality services, including a consistent supply of contraceptives and condoms, and about the importance of voicing concern over inadequate supplies and services.

#### **Donor agency support**

- Meet the needs for RH and BS Commodities to complement the Government's limited investment in the health sector. Bilateral donors such as German fund, US AID, AusAid to support BS and maternal health.

- Consortium of donors like GAVI, World Bank, Global Fund , 3 Disease Fund need to direct efforts to strengthen health system for better RH and BS services.
- Actively review the Second Five Year National Strategic Plan and discuss with MOH on the priority needs to provide more funding for continuous contraceptive supplies. Strive for greater consistency and coherence in policies and programs, to allow for longer-term planning on the part of recipient governments.

### **Methodology for Study**

This case study was conducted through document reviews, key informant interview of program managers working in Birth Spacing and Reproductive Health programs in the public, private and NGOs, population policy makers of Ministry of Population, distribution of self-administered questionnaires, and telephonic interviews of health care providers. For detail see list of persons interviewed /self-administered questionnaire in the annex.

**Table (1) DEMOGRAPHIC DATA SHEET**

Indicator	Number / Rates / Ratios
Total Population	59.13 million (2009)
Population density (Per Sq. Km.)	87 persons (2009).
Population Growth Rate	1.29% (2009)
Crude Birth Rate (CBR) per 1000 live births	17.3 (FRHS 2006)
Crude Death Rate (CDR) per 1000 pop	6.0 (FRHS 2006)
Total Fertility Rate (TFR)	2.03 (FRHS 2006)
Adolescent Fertility Rate (per '000 female adolescents 15-24)	16.9 (FRHS 2006)
Proportion married (among female adolescents 15-24)	6.8 % (FRHS 2006)
Maternal Mortality Rate (MMR) per 1000 live births	3.16 (Cause Specific Nationwide Maternal Mortality Survey 2004-5)
Neonatal Mortality Rate (per 1000 live births)	33.8 (FRHS 2006)
Infant Mortality Rate (IMR) per 1000 live births	53.0 (FRHS 2006)
Child Mortality Rate (under 5)	56.3 (FRHS 2006 for period 1997-2006) 66.1 (Overall Cause specific Under five Mortality Survey - 2002-03)
No. of Women in Reproductive age group (15-49 years)	16.2 million (2009) ----- million (Statistical Yearbook 2008)
Average Age at First Marriage ----- <b>Male</b>	24.0 years (FRHS 2006)
<b>Female</b>	21.0 years (FRHS 2006)
<b>Contraceptive Prevalence Rate (CPR)</b>	41 percent (-2007)
<b>Unmet need for contraception</b>	17.7 percent (FRHS 2006)

Indicator	Number / Rates / Ratios
<b>Antenatal Coverage</b>	64.6 percent (2007)
<b>Deliveries by skilled birth attendants (doctors, nurses, midwives)</b>	64 percent (2007)
<b>Deliveries at home</b>	76.4 percent (2007)
<b>Deliveries at government facilities</b>	16.6 percent (2007)
<b>Life Expectancy at Birth - Both sexes</b>	65 years (FRHS 2006)
<b>Male</b>	63 years (FRHS 2006)
<b>Female</b>	66 years (FRHS 2006)

# **STUDY CASE REPORT ON**

## **THE STATUS OF BIRTH SPACING IN MYANMAR, 2010**

### **1. INTRODUCTION**

Myanmar has undergone demographic, social, economic, environmental and political changes since 1994, when the UN hosted the International Conference on Population and Development and launched its Program of action in Cairo. As a country in the South East Asia region, Myanmar has made considerable progress towards the ICPD goals and MDGs in recent years, and the implementation of the Five Year National Strategic Plan for Reproductive Health (2004- 2008) and the current plan (2009-2013) had resulted in improvements in coverage and quality of Maternal and Child health care (MCH), Birth spacing (BS) services, as well as HIV/AIDS prevention, care and support. Despite political commitment and continuous efforts by multiple partners, the status of Reproductive Health (RH), Birth Spacing (BS) and population development (PD) in Myanmar remains a challenge, marked by a high maternal mortality ratio (MMR), Infant mortality rate (IMR) and high burden of HIV infection which indicates that for successful implementation of the ICPD program of action, much remains to be accomplished.

This case study report on Myanmar is based on primary and secondary data collected and UNFPA's "Situation analysis on population, development, reproductive health and gender in Myanmar" conducted in 2009-2010. The Situation Analysis assessed the reproductive health situation against the objectives and targets of the Cairo- ICPD POA and the MDGs. The report is further updated and analysis made through interviews and self-administered questionnaires distributed to the main stakeholders in the Department of Health, Ministry of Health, Ministry of Immigration Population, UNFPA and INGOs working in the areas of Reproductive Health (RH) and Birth Spacing (BS) in Myanmar. The report also encompasses recommendations for directions and the way forward with emphasis on birth spacing.

The reader will notice that throughout the report the term "Birth Spacing (BS)" has been used as it is the policy of the Government of the Republic of Myanmar (GoRM) that the current population still needs to grow and thus the term "Family Planning" is not the



preferred term. There is no separate Family Planning Program in Myanmar and BS is provided as part of the Maternal and Child Health program of the Department of Health, Ministry of Health in an integrated approach.

There are limitations in this case study as availability of data and information is scarce, and therefore it relied heavily in the Fertility and Reproductive Health Surveys, Nationwide Cause specific maternal mortality survey, Family and youth Survey 2004, Myanmar RH baseline survey, 2002. The views expressed here are the responses made to the self-administered questionnaire and interviews with actors working in the area of RH and BS and the author's analytical comments. Where divergence exists, it is hoped that this will be helpful in providing reflections from a different perspective with only one concern: the well-being and progress of the population of Myanmar.

## **2. POPULATION & RH SITUATION and PAST ACHIEVEMENTS**

**POPULATION-** The population of Myanmar in 2009-2010 is estimated at 59.13 million, with the growth rate at 1.29 percent with 70% living in the rural area.<sup>1</sup> The population of Myanmar was estimated at 57.5 million in 2007 (as of 1 Oct) with a growth rate of 1.75 percent over the preceding year<sup>2</sup>. The population is expected to grow to about 60 million by the end of 2010, 62.6 million in 2015 and 66 million by the year 2020 as estimated at the present decreasing trend of the growth rate.

The United Nations estimated Myanmar's population for 2007 at 49.8 million with a natural annual increase of 0.9 percent and estimated that the population would grow to 55.4 million by 2025<sup>3</sup>. Other UN<sup>4</sup> and international<sup>5</sup> sources estimated Myanmar's population in 2009 at 50 million with a natural increase rate of 0.9 to 1.1 percent. The population of Myanmar is in the late transitional stage with declining fertility accompanied by moderate and declining mortality. Studying the past population trends,

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<sup>1</sup> Health in Myanmar, 2010

<sup>2</sup> Statistical Yearbook, 2008, Central Statistical Organization , 2009

<sup>3</sup> United Nation's Demographic Data and Estimates for the Countries and Regions of the World, 2007

<sup>4</sup> ESCAP Population Data Sheet 2009

<sup>5</sup> 2009, 2009 World Population Data Sheet , Population Reference Bureau

the population have increased steadily from 10.7 million in 1901 to 28.9 million in 1973 (the pre-war census populations estimated as of 1973 census area)<sup>6</sup>. At the last census in 1983, population stood at 35.3 million. There is a vast difference of the UN estimates of population at 50 million in 2009 and the government's estimate of 58.13 million which reflects that there is a dire need for a population census in the country.

Regarding **spatial distribution**, the population is unevenly distributed among the regions. Mandalay and Ayeyarwady Divisions are the most populous regions in the country, each having about<sup>7</sup> 13.5 and 14 percent of the country's population, respectively. Kayah State provides a stark contrast; it is the smallest region in population size with just 336, 000 inhabitants (0.6 percent of the total population).

The **sex ratio** is 98.9 males per 100 females at the national level, however there are variations among the states and divisions, ranging from over 100 in Kayah, Bago, Mon, Shan and Ayeyarwady to 95 in Chin. The sex ratio of over 100 in the above 5 regions indicates the excess of males, and this is probably due to the fact that these areas have favorable employment opportunities and attract male internal migrants. The sex ratio is a proxy indicator showing the absence of sex selective abortion and infanticide. Unlike other neighboring countries, an impartial attitude on sex preference appears to be the case in Myanmar, at least as reflected in numbers of males vis-à-vis females. The estimated population by region, and density and sex ratio is given in Table 1.1.

Table (1.1) Population, density and sex ratio for 2006-2007

3.

SN	State/ Division	Population(in '000)			Density (Per sq km)	Sex Ratio
		Total	Males	Females		
	Union	57504	28586	28918	85	98.9
	States					
1	Kachin	1511	747	764	16	97.8

<sup>6</sup> Analysis of population trends, Census Division, Immigration, National Registration and Census Department, Yangon

<sup>7</sup> Statistical Yearbook, 2008, CSO. Nay Pyi Taw, Myanmar, 2009

2	Kayah	336	170	166	28	102.4
3	Kayin	1740	861	879	58	98
4	Chin	533	260	273	14	95.2
5	Mon	2997	1506	1492	244	100.9
6	Rakhine	3183	1586	1592	87	99.6
7	Shan	5464	2738	2726	35	100.4
	Divisions					
8	Sagaing	6274	3084	3190	67	96.7
9	Tanintharyi	1632	814	818	37	99.5
10	Bago	5793	2912	2881	146	101.1
11	Magway	5392	2653	2739	120	96.9
12	Mandalay	8062	3984	4078	172	97.7
13	Yangon	6724	3338	3386	661	98.6
14	Ayeyarwady	7863	3934	3929	224	100.1

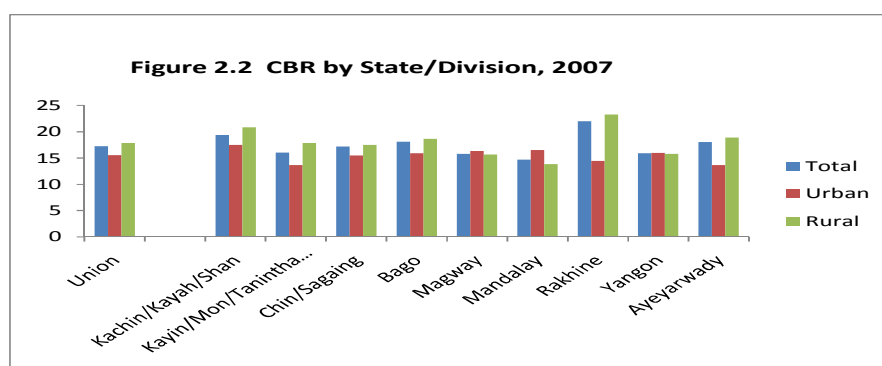
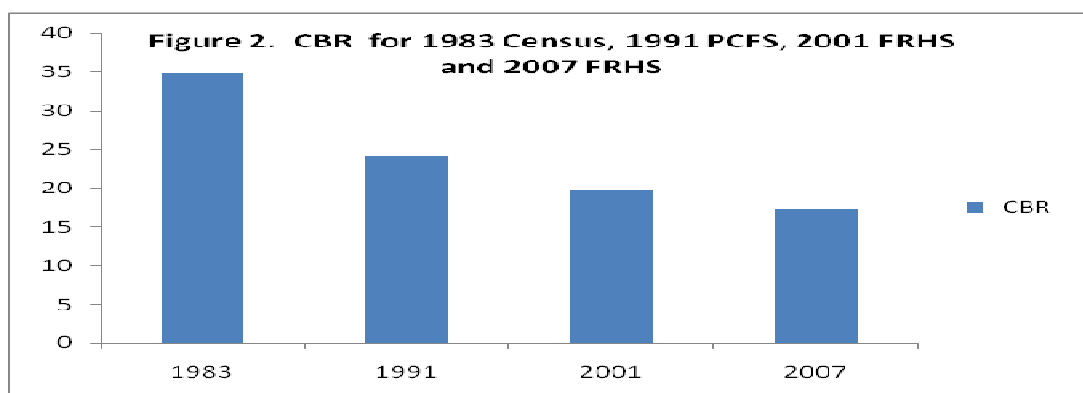
4. Source: Statistical Yearbook, 2008, CSO. Nay Pyi Taw, Myanmar, 2009

5. \* Calculated based on the data from the Statistical Yearbook

**6. FERTILITY-** In Myanmar, fertility has been declining. Crude birth rate (CBR) has decreased from 34.8 births per thousand populations in 1983 to 17.3 in 2006, the fertility halved during a quarter of a century and the fertility decline from 2001 to 2006 is about 30 percent (FRHS reports). The Nationwide Cause Specific Maternal Mortality Survey 2004-2005 reveals CBR close to the 2006 rates (18.4 at the national level, 15.7 for urban and 19.5 for rural). The rates for the national level from vital registration system also showed a declining trend but at somewhat higher figures. Urban-rural and regional variations exist; urban-rural differential is about 2, urban CBR less than rural. The 2007 FRHS shows the lowest CBR of 15 in Mandalay Division and the highest CBR of 22 in Rakhine State. (Fig 2.3 & 2.4)<sup>8</sup> CBRs of some selected countries are given for comparison viz: India (24), Thailand (14), Singapore (10), Malaysia (23), Bangladesh (27),

<sup>8</sup> 2010, Situation Analysis report, UNFPA

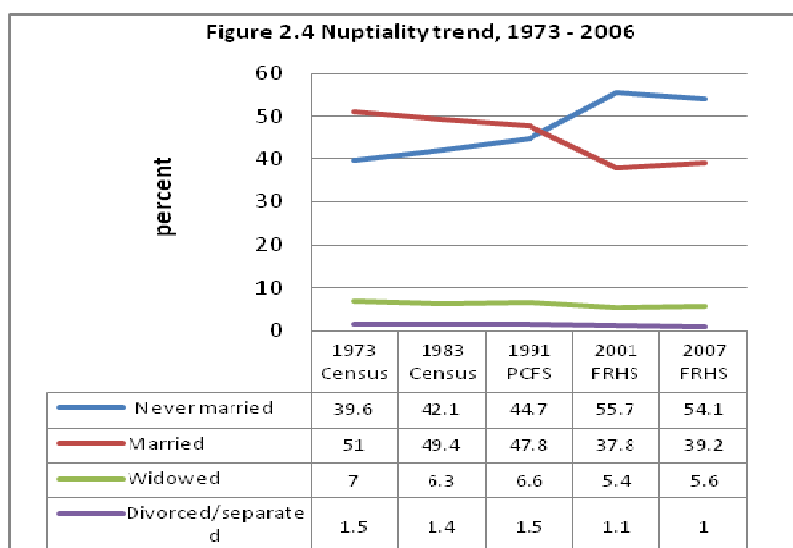
China (12), South East Asia (25) (2007 World Population Data Sheet, Population Reference Bureau)



The Total Fertility Rate (TFR) was 4.7 children per woman in 1983 decreasing to 3.5 children per woman in 1991 and 2.0 children per woman in 2006 (1983 Census, 1991 PCFS and 2007 FRHS). TFR decline during 1983 and 2006 is about 43 percent or 1.8 percent per annum. (Fig 2.7) Urban rural difference exists. Women in rural have two to three children on the average, while women in urban areas have less than two children. Concerning the regional differential, it follows the same trend as in CBR with Mandalay having the lowest TFR of 1.7 and Rakhine State having the highest TFR of 2.9<sup>9</sup>.

<sup>9</sup> Country Report on 2007 Fertility and Reproductive Health Survey, Department of Population and UNFPA

7. **NUPTIALITY**- In Myanmar nuptiality is in transition with the proportion never married (PNM) for both sexes at 39.6 percent in 1973 increasing with time reaching the peak in 2001 at 55.7 percent and decreasing to 54.1 percent by 2006. However, the trend for PNM from 1973 to 2006 still showed an increase. The proportion married was 51 percent in 1973 decreasing continuously to 37.8 percent in 2001 reaching the lowest value, and then increasing slightly to 39.2 percent in 2006. Again, the net trend is a decline though it has increased again in 2001-2006. The gender gap also narrowed in both never married and married over time. (Figure 2.4) It can be assumed that the proportion never married has leveled off at around 50 percent and has now started to stabilize.



Source: 1973 Population census and 2007 FRHS

Age at marriage varies with rural- urban residence and educational attainment, whereby the urban and more educated tend to marry later<sup>10</sup>. Given the age of marriage increasing and increasing proportion never married effective mechanisms need to be developed to reach unmarried persons with appropriate RH information and contraceptive services.

<sup>10</sup> Country Report on 2007 Fertility and Reproductive Health Survey, Department of Population and UNFPA, 2009

Myanmar's population is in its last stages of a **demographic transition** where there is a decline in proportion of those under age 15 and increase in the proportion of working age (15-59) population and elderly population 60 years and above. This pattern of decline in fertility below replacement level and low dependency ratio and increase in the working age group has been regarded as a “**demographic window of opportunity**” or a “**demographic gift**” for a country to make effective investments in job creation, in health and education and which in turn will lead to sustainable economic growth.

#### **Maternal Mortality Ratio (MMR):**

Approximately 1.3 million women give birth each year in Myanmar<sup>11</sup>. The maternal mortality ratio (MMR), referring to the number of pregnancy related maternal deaths per 100,000 live births remains elevated: for every 100,000 live births there were estimated 316 maternal deaths in 2004-2005<sup>12</sup>. Lancet estimated MMR in Myanmar to be 219/100,000 in 2008<sup>13</sup> whereas the UN (WHO, UNICEF, UNFPA, WB) at 240/100,000.

Data on maternal mortality is not collected in most surveys as it is difficult to cover the required size of population for direct calculation, as estimating MMR requires a large sample. MMR is typically difficult to measure for both conceptual and practical reasons, as maternal deaths are hard to identify precisely.<sup>14</sup> Only three large countrywide surveys – the 1997 and 2007 FRHS and the 1999 National Mortality Survey – included questions concerning maternal mortality.

The Nationwide Cause Specific Maternal Mortality Survey (2004-2005) was specially designed to collect information on maternal mortality. Myanmar's Maternal Mortality Ratio (MMR) was 283 per 100,000 live births for the period 1986-90.<sup>15</sup> According to the 1999 National Mortality Survey, it was 255 at the national level, 178 in urban areas and

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<sup>11</sup> Health in Myanmar 2009, Ministry of Health, 2009

<sup>12</sup> Nationwide Cause Specific Maternal Mortality Survey 2004-2005. Yangon: MOH, UNICEF, 2006

<sup>13</sup> Hogan M C et al, “Maternal Mortality for 181 countries, 1980-2008: a systematic analysis of progress towards MGD goal5. <http://press.thelancet.com/mmm.pdf> accessed on 11\_7\_2010.

<sup>14</sup> Maternal mortality in 1995, Estimates developed by WHO, NICEF, UNFPA

<sup>15</sup> Country Report, 1997 FRHS, Department of Population, Nay Pyi Taw and UNFPA

281 in rural areas.<sup>16</sup> The value varies widely among the regions. It is as high as over 500 in most of Shan State, and as low as 136 in Sagaing Division. The Nationwide Cause Specific Maternal Mortality Survey estimated MMR at the national level at 316 (ranging from 177 to 451) per 100,000 live births, 140 for urban and 363 for rural areas in 2004-2005.<sup>17</sup> The HMIS reported MMR in 2008 to be 150 per 100,000 live births, varying among regions, from 220 in Kayah State, Chin State, and Shan State to 110 in Bago (West) and Magway and 90 in Yangon.<sup>18</sup> Vital Statistics reported MMR at 94 for urban and 136 for rural for the year 2007.<sup>19</sup>

**Table (2) Comparison of 1990, 1995, 2000, 2005, and 2008 estimates of maternal mortality ratio (MMR, deaths per 100 000 live births) by country**

Country	Estimated MMRA					Estimated MMRA	% change in MMR between 1990 and 2008	Annual % change in MMR between 1990 and 2008b
	1990	1995	2000	2005	2008			
Myanmar	420	350	290	250	240	-43	-3.1	Making Progress
Bangladesh	870	640	500	420	340	-61	-5.3	making progress
Maldives	510	240	110	52	37	-93	-14.6	on track
Bhutan	940	650	420	260	200	-79	-8.6	on track
India	570	470	390	280	230	-59	-4.9	making progress
Sri Lanka	91	73	59	45	39	-58	-4.8	
Sudan	830	780	770	760	750	-9	-0.5	insufficient progress

Source: WHO, 2010, Trends in Maternal Mortality:1990-2008, estimates developed by WHO, UNICEF, UNFPA and the World Bank.

Bringing maternal mortality down and reaching the national MDG5 target of MMR less than 145 per 100,000 live births by the year 2015<sup>20</sup> has made progress but it is an on-

<sup>16</sup> National Mortality Survey, 1999, Central Statistical Organization, Nay Pyi taw

<sup>17</sup> Nationwide Cause Specific Maternal Mortality Survey 2004-2005, Department of Health and UNICEF,

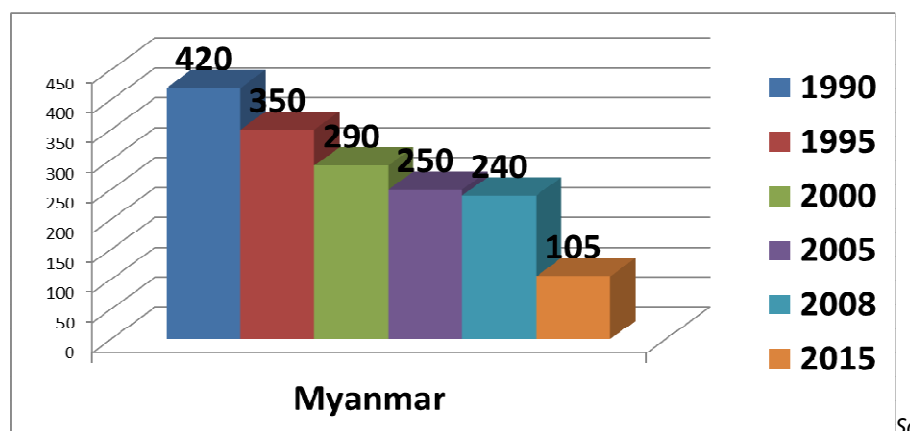
<sup>18</sup> HMIS 2008, DHP

<sup>19</sup> Statistical Yearbook 2008, Central Statistical Organization, Nay Pyi taw

<sup>20</sup> Five Year Strategic Plan for Reproductive Health, 2009-2013

going challenge. The fact that MMR estimates were higher in 2005 from its estimated levels in 1994 and 1999 (Figure 3) is suggestive of the compounded impact that economic and social factors have on women's health and survival and the intense vulnerability of health status of women. It could also be due to better reporting of maternal deaths due to increased awareness and improved data collection methods<sup>21</sup>.

**Figure 3: Maternal mortality ratio (per 100,000 live births), 1994-2005**



WHO, UNCEF, UNFPA & World Bank: 2010

The Nationwide Cause Specific Maternal Mortality Survey depicted wide range of MMR according to the geographical location, age-group, urban-rural residency and place of birth<sup>22</sup>. The leading direct obstetric cause of maternal deaths is postpartum hemorrhage (30.98%), followed by hypertensive disorders of pregnancy including eclampsia (16.9%) and abortion related causes (9.86%) There is evidence that wide use of contraceptives significantly lowers MMR. Thus, BS should be advocated for women who do not want to get pregnant to reduce MMR and unwanted pregnancies.

### 3. BIRTH SPACING

The population density for the whole country is 87 per square kilometers and ranges from 683 per square kilometers in Yangon Division, where in lies the city of Yangon, to 15 per square kilometers in Chin State<sup>23</sup>, the western part of the country which is still

<sup>21</sup> Situation Analysis of RH, PD and Gender in Myanmar, UNFPA, 2010

<sup>22</sup> ibid

<sup>23</sup> Health in Myanmar, 2010



much lesser than its close neighbors in the region. Thus, the draft population policy document of the GoRM<sup>24</sup> had claimed politically and officially a pro-natalist population policy and as of today there is no Family Planning program per se in Myanmar. “Birth Spacing” is the term preferred that we need a larger population whereby use of contraceptives is primarily to space the births for better reproductive outcomes and maternal and child health. The term “Birth Spacing” is also preferred because it gives healthy adult men and women a choice on how many children they want and when<sup>25</sup>.

In Myanmar, birth spacing projects started only in 1991 in 20 townships, prior to which, different contraceptive methods were available only in the private pharmacies and permanent family planning methods for men and women were not popular. It was expanded to 72 townships in 1997 and gradually expanded (7 township/year) during 2002 to 2005, became 100 tsp. In 2006, it was expanded to 12 additional townships to 112, and in 2009 and 2010 10 additional townships each year, and become 132 UNFPA supported project townships, out of 325 township of Myanmar.

### **3.1 Birth Spacing and Contraceptive Prevalence**

The 2009-2013 Reproductive Health Strategic Plan sets the target for a contraceptive prevalence rate (CPR) of 45% (modern methods) by the year 2013. CPR for married women has gradually increased from 37% in 2001 to 41% in 2007; this is still low compared to other countries in the region<sup>26</sup>.

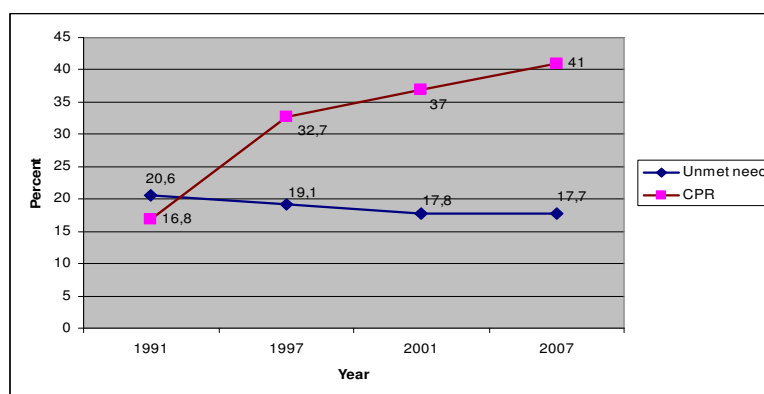
**Figure 4 : Trends in Contraceptive Prevalence Rate and Unmet Need, 1991-2007**

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<sup>24</sup> Draft Population policy, DOP, 1992

<sup>25</sup> Department of Health, MOH and UNFPA, Myanmar, 2010

<sup>26</sup> Country Report on 2007 Fertility and Reproductive Health Survey, Department of Population and UNFPA, 2009



Source: Fertility and Reproductive Health Survey, 2007

Nationally, the unmet need for contraceptives has decreased from 20.6 in 1991, 19.1 in 2001 and 17.7 in 2007 respectively in married women of reproductive age (4.9% for spacing and 12.8% for limiting)<sup>27</sup>, a slight reduction from 19.1% in 1997 (5.8% - unmet need for spacing and 13.3% - for limiting)<sup>28</sup>. The unmet need for contraception moderately decreased from 20.6 in 1991 to 17.7 in 2006. However, the unmet need for contraception may be underestimated and could be higher if unmarried women were also included in the calculation. It shows that there are still a large proportion of women who need or want to use contraceptives the need of which is unmet. Thus, there is need to expand BS commodity provision to reduce the MMR and reach the MDGs through practical innovative methods, youth friendly strategies need to be applied for access to BS services by young people, the unmarried and the hard to reach populations.

**3.2 Contraceptive Methods and Availability** -Methods of contraception practiced today include “modern” and “traditional” methods. The former refers to clinical and supply methods such as voluntary surgical sterilization, the IUD, oral contraceptives, implants, injectables, condoms, and vaginal barrier methods. The main traditional or non-supply methods are periodic abstinence and withdrawal, as well as traditional folk methods with uncertain efficacy<sup>29</sup>. The use of contraceptive methods is usually influenced by the

<sup>27</sup> Fertility and Reproductive Health Survey 2007, DOP and UNFPA, October 2009

<sup>28</sup> Ministry of Immigration and Population, UNFPA. Detailed Analysis on Fertility and Reproductive Health Survey. Yangon, 2004

<sup>29</sup> Future Trends in Contraceptive Prevalence and Method Mix in the Developing World, J Bongaarts and E Johansson, <http://www.popcouncil.org/pdfs/councilarticles/sfp/SFP331Bongaarts.pdf>, accessed on 11\_8\_2010

availability of options or the method promoted by the family planning program of the country. Birth spacing services in Myanmar are provided through the public and private sectors.

Mix of methods for this report means the number of contraceptive methods available for women to make a choice. Knowledge of contraceptive methods and sources are among important determinants of contraceptive use. There are low rates of use of long-term methods and it is common for mixed methods to be used. Although 4 methods are being supported by UNFPA through private sector, use of IUCD and condom for BS is very low. Implant is not widely available until now. Recently, PSI provided implants to Ob/Gynae specialists but the cost is high for communities<sup>30</sup>.

**Female sterilization** -Medical Sterilization can be performed if officially approved and under certain conditions (multi-parity, health complications, medical conditions). Due to tedious paper work for the patients to obtain a formal clearance for sterilization from the sterilization board at State/Division Health Department which might take between 3 to 5 months, the choice of permanent method is not the most widely used method<sup>31</sup>.

**Male Sterilization** is restricted by law to men whose wife had been approved for female sterilization but are unable to undergo sterilization for medical reasons.<sup>32</sup>

**Common Methods Used**-The commonly used methods of contraception are three-monthly injectables (14.9%), followed by daily combined oral pills (8.6%) (Figure 2). There is a negligible use of IUDs and male methods for contraception, such as condoms.

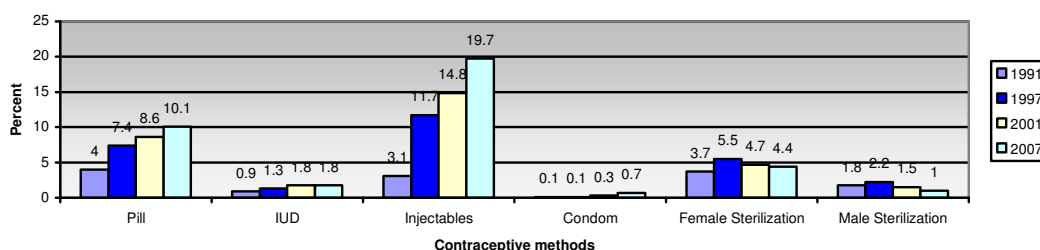
**Figure 5: Contraceptive method mix among currently married women, 1991-2007**

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<sup>30</sup> PSI, Myanmar and MMA, 2010

<sup>31</sup> Situation Analysis Field Assessment, UNFPA, 2010

<sup>32</sup> Myanmar Birth Spacing Overview, [http://www.searo.who.int/linkfiles/family\\_planning\\_fact\\_sheets\\_myanmar.pdf](http://www.searo.who.int/linkfiles/family_planning_fact_sheets_myanmar.pdf) accessed on 10\_27\_2010



**Source: Myanmar Fertility and Reproductive Health Survey 2007.**

According to the 2007 Fertility and Reproductive health Survey (FRHS), over 95% of population have the knowledge of at least 3 methods of contraception and 52% respondents mentioned private sources and 42% mentioned government outlets as sources for contraceptive supplies. 84.2% of Female and 77.2% of Male respondents mentioned that Government facilities are the main source for sterilization, and the IUD insertion, while private drugs stores and shops are known as the major source for contraceptive pills (over 70%) and condoms (61.1%). However, with increase social marketing of contraceptives by NGOs trends have changed over time and the private health clinics are cited as a major source for injectable contraceptives, followed by the government nurses and midwives and private drug stores<sup>33</sup>.

There are considerable differentials in the use of contraceptives, both among urban-rural and rich-poor population groups. Nearly 49% of currently married urban women are using any modern contraceptive methods compared with only 34% of rural women. Among the regions, contraceptive use is the highest in Yangon Division (57%) followed by Bago (45%) and Mandalay (42%) and the lowest Contraceptive Prevalence Rate (CPR) are in Chin, and Sagaing (28%). Quality of service is better in project townships than non-project townships as they did not receive training. In project townships, women live in rural areas have access to BS services, especially where there is a midwife. Quality and cost depend on attitude of midwife as there is cost sharing of BS commodities and the price is fixed by BHS. In 173 PSI project townships, poor women who live in peri-urban areas have access to quality BS services at affordable subsidized price. Contraceptive commodity security is not ensured

<sup>33</sup> FRHS 2007

even in project townships as there are stock-outs due to funding constraints, transportation constraints and weak logistic management and planning.

### **3.3 Scope of coverage and Partnerships for BS services**

**3.3.1 Health facilities under Ministry of Health (MOH)-** Health centers of the Department of Health provide facilities and manpower for contraceptives provided by UNFPA at subsidized rates in 132 of the country's 325 townships. UNFPA also support MSI and MMA with contraceptives thus, the total number of townships receiving birth spacing commodities from UNFPA are around 225 townships out of the total 325 townships<sup>34</sup>. There is still a gap of approximately 100 townships, whereas in some townships there are overlapping of BS services provided by MOH, PSI, MSI and MMA. Currently, UNFPA supports MOH with 5 contraceptive methods (Oral Contraceptive Pills, 3 monthly Depo injections, Intra Uterine Contraceptive Device (IUCD), condom, emergency contraceptive pills). Among them IUCD is the only long term method. Use of IUCD is increasing but still low about 4% (FRHS 2007). Use of condom for BS is even lower. UNFPA also supports MOH with RH commodities and training, etc., in 132 townships (including German-funded townships) up to 2010. In 2011 and 2012, 10 more townships each will be expanded with German bilateral fund to UNFPA. There are low rates of use of long-term methods and it is common for mixed methods to be used<sup>35</sup>.

### **3.3.2 Population Service International (PSI) - Partnerships in Birth Spacing Programs:**

PSI/Myanmar signed a Memorandum of Understanding with GoRM which allows PSI/Myanmar to work in the field of RH. PSI/Myanmar has the privilege of having tax exemption from GoRM and to procure quality contraceptives internationally<sup>36</sup>. PSI/M social markets contraceptives at a highly subsidized price so that even low income women and men could afford them. PSI has secured BS commodities till 2012<sup>37</sup> and operation of

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<sup>34</sup> National Program officer, UNFPA, 2010

<sup>35</sup> UNFPA national Program Officer, 2010.

<sup>36</sup> PSI/Myanmar, 2010

<sup>37</sup> Response to self-administered questionnaire, Dr. Nyo Nyo Minn, Dep-Country Rep, Population Services International-Myanmar, 2010.

extensive social marketing program through franchised GP clinics and primary providers (village volunteers) in 173 townships.

Major portion of the funding budget is spent on commodities and it markets products at highly subsidized price to Sun providers who in turn sell them to the clients (women) at an agreed upon price with PSI/M making a small profit margin which include fees for the services. However, the fee for IUD insertion is Kyats 500 for the woman and PSI/M reimburses Kyats 4,000 to the Sun providers for their IUD service. UNFPA also supports PSI/Myanmar with 6 methods of contraceptives, in 177 townships in 2010 onwards. In addition eight contraceptive products namely OK pills, OK one month injectable, OK 3 month injectable, OK male condoms, OK female condoms, OK IUD, Implant (to trained Ob/Gynae, only, is more expensive than other methods), and Emergency Contraceptive pills are provided through the “Sun Quality Health franchise clinics” in 177 townships. In fact, 25% of the market share for contraceptives in Myanmar is distributed by PSI/Myanmar in 2009.

The target population of PSI is the poor and vulnerable groups. PSI/M procured RH commodities directly from PSI/Washington and logistics management plan are in place to ensure that there is no shortage of products in the program, and have secure commodities till 2012<sup>38</sup>.

Currently a total of 1192 private doctors are trained in RH and are contributing BS services in 177 townships of 13 States/Divisions and social market 8 quality products at highly subsidized prices so that women could select the BS method of their own choice. Yearly RH consultations in the Sun franchise network increased from 2,937 in 2001 to over 1 million consultations (1,039,842) in 2009.

**3.3.3 Marie Stopes International (MSI):** MSI has MOU with the DOH, MOH and is implementing social marketing of contraceptives in their project townships in approximately 24 townships. MSI has capacity building of youth through ASRH training programs and reaches out to peri-urban youth in mega cities such as Yangon and Mandalay.<sup>39</sup> MSI opens

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<sup>38</sup> Population Services International, Myanmar, 2010

<sup>39</sup> MSI annual report to UNFPA, 2009

RH clinics and they reach the communities using different approaches, working in collaboration with Basic health staff, MSI supports tertiary hospitals with emergency obstetric commodities.

**3.3.4 Myanmar Medical Association** has well established partnership with public sector, and the private General Practitioners. MMA trains General practitioners for skills in RH services including BS and provides mobile services. MMA focuses on working women of factories under the Ministry of Industry 2. They provide RH and BS services and RH education to factory workers and supports pregnant women with ANC and birthing kits.

Other NGOs such as MDM, AMDA, AMI, SC, YWCA, and Malteser also have demonstrated a potential to improve access to birth spacing commodities<sup>40</sup>. They provide BS services by social marketing and subsidizing for BS commodities but only a few NGOs are providing totally free of charge services. Findings of situation analysis revealed that in some UNFPA project townships which also has NGO presence (PSI Save the Children, AFXB and MSI), there is overlap of BS services and all organizations involved, in order to meet their project indicators compete for clients. Thus, there is need to coordinate among actors so that tangible improvements in quality and coverage of RH and Birth Spacing services is possible.

Private commercial sectors also import contraceptives. For household and consumers, majority of them had to pay for the services and commodities in the private clinics.

As a rule, contraceptives are available in the pharmacies, however anecdotal evidence suggests that women often either get low quality or imported counterfeit drugs or use the chosen method improperly. Besides, more evidence is required to learn about the magnitude and consequences of the use of monthly contraceptive pills offered over-the-counter in private pharmacies.

**3.4 South-South Cooperation-** is relatively new and has just started where 13 developing countries in the southern hemisphere who cooperate and support each other for RH and BS

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<sup>40</sup> RH Stakeholder Analysis in Myanmar, 2006, WHO

programs through technology and information transfer<sup>41</sup>. UNFPA- Myanmar represented and attended the Global consultation on South-South Cooperation, held in Bangkok 27-29 July 2010. This emerging South-South paradigm in the context of a new aid dynamics and explore the different South-South modalities that are commonly applied to deliver technical cooperation and enhance capacities of recipient partners. One of its objectives was to promote south-south cooperation as an important strategy for implementing ICPD and for capacity development to achieve MDGs<sup>42</sup> and will bring innovative ways of cooperation in addition to North- South cooperation strategies.

The role of South-South cooperation modality could be initiated in the area of RH and BS commodity security through sharing of international best practices, technology transfer and for planning for census, the last census being in 1983. Gender statistics, statistics for international migration and disability statistics are also domains that need to be developed for Myanmar to take forward the South-South cooperation.

**3.5 Contraceptive Commodity Security**-UNFPA launched the Global Program for Reproductive Health Commodity Security at the ICPD- 1994 in Cairo. The program for reproductive health commodity security and all of the combined efforts in the area of reproductive health supplies helps people exercise their right to sexual and reproductive health.

Promotion of family planning in developing countries with high birth rates has the potential to reduce poverty and hunger, and avert 25 to 35 per cent of all maternal deaths and nearly 10 per cent of childhood deaths. It would also contribute substantially to women's empowerment, achievement of universal primary schooling and long-term environmental sustainability<sup>43</sup>. Funding shortages continue to hamper the combined efforts to ensure the adequate provision of contraceptives, condoms and other reproductive health supplies. And

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<sup>41</sup> . Dr. Theingi Myanith, MCH, DOH, 2010

<sup>42</sup> Global Consultation on South-South Cooperation, UNFPA trip report, Pansy Tun Thein, 2010

<sup>43</sup> Reproductive Health Commodity Security – Challenges, *Statement by Thoraya Ahmed Obaid, Executive Director, UNFPA.* <http://www.unfpa.org/public/News/pid/151>. Accessed on 25 Nov, 2010.



the situation is getting worse<sup>44</sup>. In Myanmar, contraceptive commodities are mainly supplied by UNFPA, PSI and MSI. The GoRM does not have a budget line for BS commodities and although there is a national level committee for RH commodity security implementation actually is limited<sup>45</sup>.

In Myanmar, out of six selected states and divisions visited by the UNFPA Situational Assessment team in 2009, five had stock-outs of contraceptives at all levels for one or more contraceptive methods. There were no all methods of contraception available at a given time for a woman to choose<sup>46</sup>. Basic health staffs are responsible for recording and reporting of requirements and utilization of contraceptives through completion of Reproductive Health Management Information System (RH MIS) forms on a regular (monthly) basis in UNFPA supported project townships which are compiled by the Department of Health Planning (DHP). However, distribution of RH commodities are done by the Maternal and Child Health (MCH) unit of the Department of Health (DOH) by quota system which is a “push” system based developed at the national level. This system is slow to respond to stock -outs immediately. The basic health staffs are currently being trained by DHP staff to fill Reproductive Health Information Management forms (RH MIS) reporting forms to ensure quality of data collected however, there is still much more need for capacity building in projection of contraceptive requirements, and the needs-based supply to be functional.

There is a need for better coordination between the program managers and the township and beyond level of the health system. Problems also exist for sound logistic management system for forecasting, procurement, warehousing, distribution and inventory control of reproductive health commodities. This includes supply of reproductive health commodities and contraceptives resulting in intermittent stock-outs at the facility level and affecting the end-user. There is evidence that in Myin Mu township<sup>47</sup>, under the able leadership of the Township Medical Officer, planning and projections of contraceptive requirements was

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<sup>44</sup> Ibid.

<sup>45</sup> Dr. Theingi Myint, Deputy Director, Maternal and Child Health, Department of Health, Myanmar

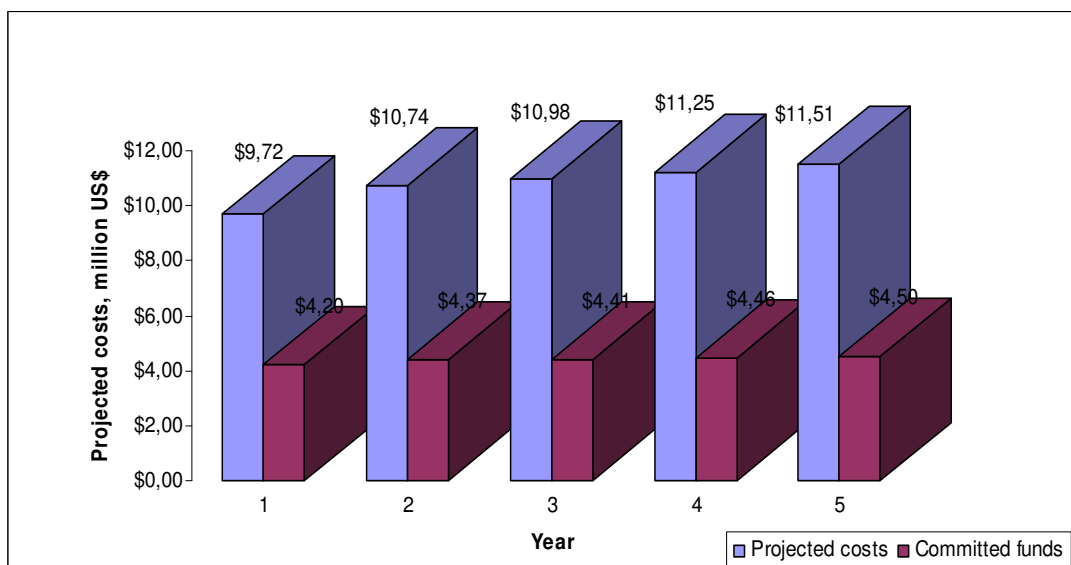
<sup>46</sup> Ibid

<sup>47</sup> <sup>47</sup> Situation Analysis Annex 3, UNFPA, 2010

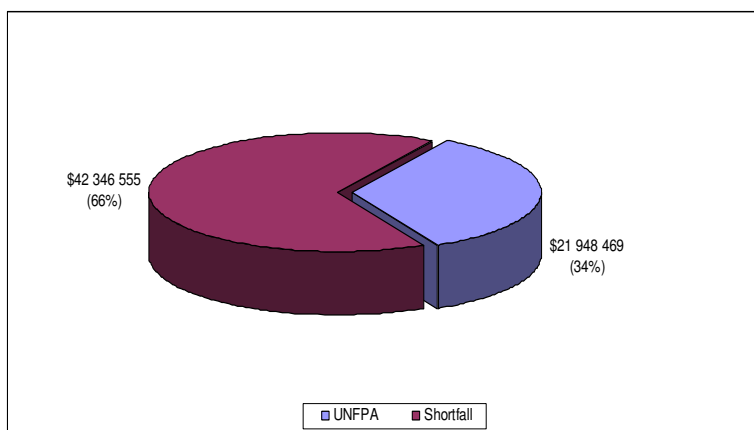
spearheaded at the Township level and there was no stock-puts of commodities. These closer to client good practices need to be expanded throughout the country together with training of human resource, coordination and utilization of computerized LMIS system, mapping, monitoring & supervision, and functional LMIS is needed. Myanmar does not have a viable commodity security plan however; there is the second National Strategic Plan for RH which has an operational plan for RH commodity security. If all partners would complement each other by pledging to the work plan commodity security for BS and RH would be a reality.

**Funding Gap for BS Commodities-** Analysis of the past funding for BS commodities in Myanmar it was found that in 2009, the funding gap was over 5.5 million US\$ and UNFPA is the major source for BS commodities. There is no budget line for BS commodities in the MOH budget. At the current contraceptive prevalence rate of 41% in 2007 and 17.7% unmet need for contraceptives and provided if UNFPA continues to support contraceptives even at current level increased financial commitments are required from the national budget as well as the donor contributions to fill the shortfall of 26 million US\$, which is about 60% of contraceptive requirements in 2010-2013. Figure 3.13 below depicts the predicted shortfall of funds against the contraceptive requirements (assumptions: method-mix does not change over the next 5 years, costs inflation is not calculated) .

**Figure 6: Projected costs against contraceptive requirements and funds committed (for supplies only), 2009-2013**



**Figure 7: Sources of funds to meet contraceptive requirements over 2009-2013, US\$**



*Source: Situation Analysis of Population Development, Reproductive Health, and Gender in Myanmar, UNFPA, 2010.*

#### **4. Funding Mechanism for BS commodities**

Over the past decade a supply of contraceptives to public sector is solely supported by international aid (major support: UNFPA). These programs were able to channel contraceptives to approximately one third, 132 townships of the 325 townships in the country. Main funding for birth spacing program is from UNFPA thematic fund, core fund and trust fund and also from bilateral funds from donor countries such as German Fund. Majority goes to public sector and secondly to PSI, followed by MSI, MMA and other partners. These contribute towards RH commodities and other supportive measures such as training and development and production of IEC materials<sup>48</sup>.

While the Government bears the costs of personnel and logistics supply chain, there is no national budget line for procurement of contraceptive commodities. The initial funding for RH commodities was from Packard Foundation in 2001 and later the project was funded by various donors including UNFPA's donor community. Currently, Bill & Melinda Gates Foundation is the funding source for the implementation of the program.

<sup>48</sup> PSI/M, self-administered questionnaire response, 2010

The NGOs such as PSI and MSI also receive funds from their respective Head Quarters and other donors for BS program<sup>49</sup>. The effective implementation of a pro-poor cost-sharing policy for contraceptive supplies remains a challenge to make the availability of modern contraceptive methods free-of-cost or at subsidized rates a reality.

While contraceptives are also available in private pharmacies and clinics and have been cited as the main source of contraceptive injectables by the FRHS 2007<sup>50</sup>, the costs incurred may pose an obstacle for the poor and quality may not be appropriate to meet the population needs.

## **5. Political Commitment to Birth Spacing and RH Program**

Recognizing the urgent need to address the contraceptive shortfalls, a high level stakeholder meeting chaired by the Deputy Minister for Health was held in Nay Pyi Taw in December 2008<sup>51</sup>. A National Reproductive Health Commodity Security Sub-Committee was formed to assess current situation on RH commodities in both private and public sectors, identify and coordinate efforts in securing supply of commodities, including improving RH information system and strengthening logistic management information system (LMIS) for forecasting, procurement, supply, storage and distribution of contraceptive commodities.

At the last coordinating meeting all partners, UN, NGO who work in the area of RH and BS were invited in October 2010. The Deputy Minister provided policy directions and advocacy for resource mobilization to meet RH commodity requirements. The MOH also requested UNFPA, as the sole provider of BS commodities, to expand project townships as many as possible in order to expand the coverage and to achieve universal access although they do not allocate any budget for contraceptives<sup>52</sup>.

In the public health facilities there is a mechanism for BS commodity sustainability by providing BS service through a cost sharing system, whereby the client pays minimal

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<sup>49</sup> UNFPA/MMR, self-administered questionnaire response, 2010

<sup>50</sup> Situation Analysis Report, UNFPA, 2010

<sup>51</sup> UNFPA RH Comodity Security Report, 2009

<sup>52</sup> Nay Pyi Taw, recorded by Daw Tin Tin Nyunt, Oct 2010

amount for BS commodities. The fund generated is accumulated in health facility account (Official Account) as a revolving fund which is to be utilized if and when UNFPA funds are not available<sup>53</sup>. This however, need policy direction as of how the funds should be managed and utilized effectively as this substantial amount of funds has been accumulated without interest at the township banks.

## **6. RH and BS Program's Relations to health, community and women's empowerment.**

There are a variety of Community Volunteers that provide support for RH and BS care. The Maternal and Child health Promoter (MCHP), Axillary Mid Wives (AMW), Myanmar Maternal and Child Welfare Association (MMCWA) serve to ensure health education, nutritional support and care of the community at grass root level.

Specifically the Community support groups (CSG) are formed by volunteers in the community to act as a bridge between health care providers and people. This program is a joint initiative between UNFPA, Central Health Education Bureau, of Department of Health Planning, MOH and JOICFP in 2002<sup>54</sup>. The main aim of CSG are to train community volunteers to be able to give health education, improved knowledge in reproductive health and Birth Spacing and to support the community in behavioral change for healthy living. There are three objectives of CSG are- to disseminate RH knowledge to the population in the township and provide means of transport, referral to hospital in times of obstetrical emergencies so that proper and timely referral can be provided.

Members of CSG were selected from the community by the midwife and village health committee, and the criteria for selection are persons who are interested in health and welfare of the community, male and female who are active, between 18 to 50 years of age. Each CSG member is given training on reproductive health and is given charge of 30 households and given a record booklet. They give health education to their assigned households, provide help and support for transportation when there is need to be referred to the hospital or health care provider, raise funds from the community if there is a need in

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<sup>53</sup> Situation Analysis field report, UNFPA, 2010

<sup>54</sup> Community Operated- RH/BCC project in Myanmar, documentations of the model project outcomes, national level assessment reports, 2003

emergency situations, assists the midwives or health care providers in health activities. CSG work very closely with village health committee members and the basic health staff and were successful in providing timely referral and support in obstetric emergencies.

It was implemented as a model project in Dalah Township in Yangon division, Sarmalauk village in Nyaung Done Township. The model CoRH project was assessed and was found that the CPR rose by 50% from existing situation, increase in level of awareness to about 50% on RTI, STDs, HIV/AIDS. The CPR in Sarmalauk rose from 31% in 2001 to 42.6% in 2003.<sup>55</sup> and was later expanded to reach 64 townships by the end of <sup>56</sup>2010. SA team also observed success stories during their visits to the RHC and this program has potential to bring down maternal mortality in rural areas.<sup>57</sup>

PSI/M's mission is to serve the poor and vulnerable groups of the country and all program and service deliveries are targeted towards these groups. All Sun providers have been trained on counseling skills and women are empowered to select a method of their choice and had made considerable progress in reaching the communities.

## **7. Role of Youth Volunteers and Youth Information Centers<sup>58</sup>**

**UNFPA** supported youth programs in collaboration with the MSI, AFXB, MMA, DOH and DHP has success stories with regard to Reproductive and Sexual Health education and services through youth programs. **Youth Information Centers (YIC)** have become a good model for young people to learn about ARH, socially friendly environment for BCC for adoption of positive habits for safe sex, abstinence of tobacco, alcohol and betel chewing habits. "Leadership development and healthy happy adolescent life program" had much success in engaging youth to adopt healthy behavioral change. YIC program by MMA, AFXB and CHEB-JIOCFP are successful in engaging youth but needs further expansion and quality assurance

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<sup>55</sup> The community operated RH/BCC project in Myanmar, documentation of model project outcomes and national level assessment, 2003.

<sup>56</sup> UNFPA project townships, 2010

<sup>57</sup> Situation Analysis Report, UNFPA, 2010

<sup>58</sup> Annex 3: Findings of Situation Analysis Report, UNFPA, 2010.

when franchised. It is not enough to give information on health and the young people need support for personal and professional development for holistic growth<sup>59</sup>.

Most of the Youth volunteers were informed about youth programs and youth centers from their friends and HIV knowledge fairs. They attend youth trainings to increase the level of knowledge about RSH and share to other friends to avoid risky behavior and contract diseases. In Yangon, Myanmar Medical Association (MMA) has a comprehensive training for Youth personal and leadership development. For suburban youth, AFXB has youth centers where practical vocational training open to job opportunities were conducted together with peer educator trainings.

Some youth are now peer educators for youth in their villages and conduct outreach activities providing health education sessions to other youth of the village. The community and their families appreciated their activities because many positive changes had been observed in youth of their community. Increased awareness in health, change in life style and behavior and participation in social work with parents. Besides they become good leaders in the youth community and organize many youth to join the activities.

The **constraints** for the outreach activities are the working youth has difficulties to commit time to engage as group in community, sometimes they cannot answers some questions that peer asked sometimes during peer sessions. In Mawlamyaing, Thathone there is migration of community youth peer educators, trained volunteers, increasing attrition rate of peer educators due to socioeconomic reasons. This program needs to be expanded to reach other youth in the nation.

There is need to produce IEC for STI, provide Peer Education program and sessions at universities, monitoring guidelines for Peer educators, recruit more volunteer peer educators to substitute the dropouts. There is need to develop FAQ books based on the collected frequently asked question from the peer youth and community and distribute to peer educators with the purpose of the sharing precise, correct message to the community.

In line with the low economic conditions that prevail there is a need to expand vocational training out-of-school youth who are unemployed and out-of-school. More advocacy to expand youth centers for participation of youth with high vulnerability. Provide transport charges or facilities (bicycles or tawlagy) for peer educators for outreach activities according to work plan of outreach schedule, provide regular training for the recruitment of new peer educators and refresher training to update information about reproductive health and other health related issues, need to provide forum for experience sharing meeting among youth

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<sup>59</sup> Situation Analysis report, UNFPA, 2010

corner of different townships, need to supply IEC and condom continuously and adequately<sup>60</sup>.

These young peer educators can be resource for linking HIV-STD prevention to BS services. They can advocate BS and emergency contraception to reduce un-intended pregnancies in young people. More Youth friendly spaces need to be developed where youth peer educators can interact with other village youths for ARSH education.

## **8. Government, Religious, public support for the RH and BS program**

There are neither significant religious beliefs or political restrictions nor opposition to the birth spacing in Myanmar. However, there are subtle cultural reservations in some rural population and the government's directions and caution to expand contraception and control over population<sup>61</sup>.

Politically, it is becoming more positive towards birth spacing especially in the last 2-3 months<sup>62</sup>. This may be due to the publication of UNFPA's SA report, 2010, which highlighted the BS gaps and recommendations for BS commodity security for better RH outcome. PSI/M has been asked by DoH to support the IUD trainings for Township Medical Officers and requested to allow midwives to refer IUD clients to Sun clinics<sup>63</sup>. This is seen as a major shift from DoH who in the past years persistently discourages PSI/M's IUD activities and reminded repeatedly to work passively and each Sun clinic is to insert not more than 5 insertions a day<sup>64</sup>.

About 90 per cent of the population is Buddhists and Buddhism welcome large families and regard it as a blessing. Christians and Muslims comprise about 5 and 4 percent, and other religions together comprise about one percent.<sup>65</sup> The people of Myanmar are made up of 135 national races belonging to eight major groups: Kachin, Kayah, Kayin, Chin, Bamar, Mon, Rakhine and Shan. There are more than 100 languages and dialects spoken across the nation.

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<sup>60</sup> Situation Analysis report, Annex 3, Findings, 2010.

<sup>61</sup> UNFPA, 2010

<sup>62</sup> PSI, Deputy Country Representative, Dr. Nyo Nyo Minn, 2010

<sup>63</sup> PSI/ Myanmar, 2010

<sup>64</sup> PSI/Myanmar, 2010

<sup>65</sup> 1983 Population Census, Burma, IMPD, 1986



One of the minority religions of Myanmar is Christianity. Catholics do have reservations for contraceptive use which may affect a minor proportion of population in Myanmar. The Muslim population in Myanmar constituted about 4% of the total population<sup>66</sup> in 1983. However, according to some Muslim leaders it has been estimated to be as much as 20% currently.<sup>67</sup>

Muslim women who are citizens of Myanmar enjoy equality in access to education, health and have freedom of worship according to the Constitution of the Republic of Myanmar. However, the majority population of Northern Rakhine State (NRS) is a Muslim population, who speaks a different dialect of Bengali that is spoken in southern Bangladesh and is linguistically different from the native Rakhine. Most of them are given temporary registration cards (TRC) issued by the GoRM<sup>68</sup>. As such, there are a number of regulations by the GoRM on these people, such as permission for movement and travel. This may pose limitations in access to higher education, access to health care affecting their quality of life.<sup>69</sup> Socio-cultural concepts compounded with these regulations have significant impact of the status of women and adolescent females in NRS. After puberty women are confined to the house and only permitted to go out in the company of a male family member. As a result most Muslim girls if they are attending school are withdrawn after fourth grade in NRS<sup>70</sup>. This results in low literacy rate in females, leading to disempowerment and delays in decision to seek assistance and access to health care have a major negative impact on the reproductive health of women in NRS.

## **9. Major socio-cultural and economic issues of relevance with regard to BS**

Conservative of cultural norms can sometimes cause limitations on BS. Myths and beliefs e.g. having an IUD, a foreign body in the uterus, are harmful. Weak public information, education and services related to family planning with little or no knowledge about the

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<sup>66</sup> 1983 Population census, Burma, Department of immigration and Manpower, 1986

<sup>67</sup> US Department of State Report, "Burma-International Religious Freedom Report, 2006. <http://www.state.gov/g/drl/rls/hrrpt/2001/eap/8260.htm>. Accessed on 25 June 2010.

<sup>68</sup> Household survey in NRS, UNHCR, 2006

<sup>69</sup> Reproductive Health Assessment, Northern Rakhine State, Myanmar, UNHCR-UNFPA, 2006

<sup>70</sup> *ibid*

different BS methods. Opposition by husbands and wrong influence of elderly people especially the grand mothers and mothers -in- law who believe that knowledge about Sex and FP is for married women and talking about them to young people is seen as improper conduct.

There are reservations for singles and unmarried women to seek RH services from public RH services and official permission is needed even for married women for sterilization which takes a long process from local and health authorities that before the woman gets it, she is already pregnant.<sup>71</sup> Traditionally, big family is a blessing in Myanmar as a country, which economy is based on agriculture; farmers want to have a big family to work in the farm land<sup>72</sup>.

## **10. FACTORS CONTRIBUTING TO SUCCESS**

Birth spacing and RH program had gained momentum despite challenges as evidenced by decrease in fertility rate, increase contraceptive prevalence rate and decrease unmet need for contraception. The main reason for success is as follows.

1. Political commitment of the DOH, MOH, working together of UNFPA, WHO and INGOs with high level involvement in coordinating for commodity security has moved BS practices to improve resulting in Crude birth rate (CBR) to decrease from 34.8 births per thousand populations in 1983 to 17.3 in 2006. The contraceptive prevalence rate to increase from CPR for married women has gradually increased from 37% in 2001 to 41% in 2007; this is still low compared to other countries in the region<sup>73</sup> given the fact that unmet needs for FP is 17.7 in 2007, there is still much to be done to improve access to BS services.
2. Increase knowledge of different methods of contraceptives available, where? at what cost? so that accessibility and affordability of different methods at public sector. This will empower men and women to overcome cultural barriers and have a

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<sup>71</sup> Self-administered questionnaires response, 2010

<sup>72</sup> UNFPA, RH national program officer, 2010

<sup>73</sup> Country Report on 2007 Fertility and Reproductive Health Survey, Department of Population and UNFPA, 2009

choice of BS and the right to choose to when and how many children they wish to produce and bring up.

3. Improving access to high RH quality services by enhancing providers knowledge and skills on BS through training in SRH and giving women the chance to select a method of their choice by social marketing high quality products which are attractively packaging and social marketing by PSI containing the information for both clients and General Practitioners to give them information on choosing / recommending different contraceptive methods and comparing prices so that they have freedom to choose according to individual affordability<sup>74</sup>.
4. One of the major reason for success of Birth spacing program is because it is not a stand-alone program; it is supported by the national reproductive health behavior change communication activities which create greater demand for birth spacing<sup>75</sup>.
5. Community empowerment contributed to success in selected townships where CSGs and YICs form a link between community and health services providers at grass root level.

## 11. CURRENT ISSUES OF CONCERN

### 11.1 Adolescent Sexual and Reproductive Health and vulnerabilities:

Young people (15 to 24 years) are the future of every society and also a great resource of the nation and they constitute one fifth of the total population in Myanmar<sup>76</sup>. Of the estimated population of 57.5 million<sup>77</sup> and the proportion of young people is reduced to 19.2% from 20% in 2001. Trends in age specific fertility rate for the age group 15-19 are declining (Figure 3.12). Percent of TFR attributed to age group 15-19 was 3.37% in 2002<sup>78</sup> and was less than 4 to 5% in 2007<sup>79</sup> According

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<sup>74</sup> PSI-Myanmar, 2010

<sup>75</sup> MCH Division, DOH and UNFPA, 2010

<sup>76</sup> Family and Youth Survey, 2004, MIP, DOP. 2006.

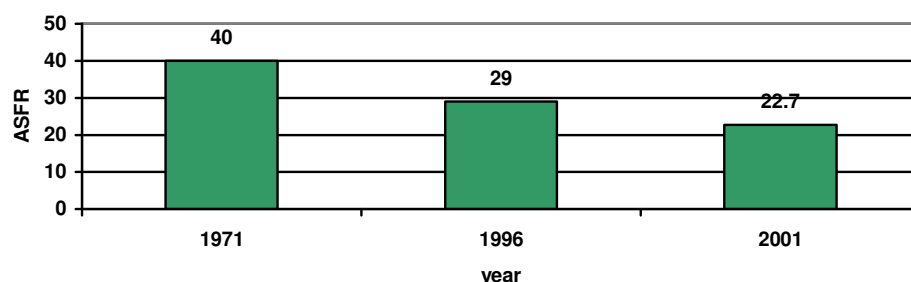
<sup>77</sup> CSO, 2009, Statistical Yearbook 2008

<sup>78</sup> *Myanmar Reproductive Health Baseline Community Survey, 2002*

<sup>79</sup> Fertility and Reproductive Health Survey 2007

to the 2007 FRHS only 1.9% of women had their first birth before age 15 and slightly over 25% had their first birth before age 20. However, there are regional differentials with the Rakhine State having the lowest age at first birth.

**Figure (8): Trend in age-specific fertility rate (per 1000 women) among girls aged 15-19, 1971-2001**



**Source:** For the year 1971 and 1996 -World Fertility Report 2003, Population Division, and DESA, United Nations; for 2001- Myanmar Fertility and Reproductive Health Survey 2001, Ministry of Immigration and Population, Yangon 2003.

Usually adolescents do not use contraception and may be prone to unsafe abortion in case of unwanted pregnancy. Sixteen percent of youth approved of pre-marital sex for boys while only seven percent of youth approved of pre-marital sex for girls<sup>80</sup>. Young people perceived that socio-culturally Myanmar youth should not be involved in pre-marital sex, however, majority expressed that there is increased numbers of young people engaged in pre-marital sex<sup>81</sup>.

According to the 2007 FRHS 11.39% of pregnancies in women aged 15-19 ends in abortion. The 2004 Family and Youth Survey conducted by the Department of Population, Ministry of Immigration and Population and UNFPA<sup>82</sup> reported that 78% of interviewed youth indicated TBAs home as the place where abortion can be done. Home (40%) and private clinic (36%) were the other often cited places. In addition, young people make up a segment of the population that is particularly vulnerable to HIV as specific factors such as lack of knowledge

<sup>80</sup> Family and Youth Survey, 2004 country report, Yangon, October 2006, Department of population, Ministry of Immigration and Population and UNFPA

<sup>81</sup> Situation Analysis on PD, RH, gender in Myanmar, UNFPA, 2010

<sup>82</sup> Family and Youth Survey, 2004 country report, Yangon, October 2006, Department of population, Ministry of Immigration and Population and UNFPA

about HIV/AIDS, lack of education and life skills, poor access to health service and commodities, early sexual debut, sexual coercion, sexual violence, trafficking and growing up without parents or other forms of protection from exploitation and abuse<sup>83</sup>. Influenced by socio-economic factors, contemporary social norms and life-styles, young adults tend to acquire risky sexual behaviors.

According to Behavioral Sentinel Surveillance, 2008 for **out –of- school- youth**<sup>84</sup> 48% of them have complete and accurate knowledge on HIV/AIDS and about half of them did not use condom during last sex with causal partners although 90% of them used condom during last sex with sex workers. Anecdotal evidence suggests that an increase in number of MSMs (men having sex with men) were associated with new registrations of younger men in age group below 19 at PSI youth drop-in centers<sup>85</sup>. While adolescents do have high level of awareness on STIs/HIV (75% for STI and 91% for RTI)<sup>86</sup>, detailed knowledge is limited on RH and STI. School dropout rate is highest at Grade 11 (55.4%). The percentage of youth with high school and above education is almost 60% for both sexes in urban whereas it is less than 25% in rural areas. Employment opportunities for out-of-school youth are very limited; an estimated 90% are unemployed.

**Trafficking** is a criminal and illegal trading of human beings for the purpose of exploiting their labor. Young people are more likely to be the victims of trafficking. While there is no national level data on trafficking, the 2004 FAYS reported that 87% of youth had ever heard about the term trafficking and out of them 71% suggested that 15-19 age group was most likely target for trafficking and another 20% suggested age group 20-24. Girls are especially vulnerable and are likely to be influenced by false job offers, promises of marriage and better life.

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<sup>83</sup> Family and Youth Survey, 2004 country report, Yangon, October 2006, Department of population, Ministry of Immigration and Population and UNFPA

<sup>84</sup> Behavioral surveillance survey 2008 (out of school youth ) National AIDS Programme, Department of Health, Ministry of Health, Myanmar

<sup>85</sup> Information from the PSI drop-in center supported by UNFPA, 2009

<sup>86</sup> Than Nu Shwe, Socio-economic background and behavior of adolescent pregnancy, 1999, Yangon

**Adolescent Sexual and Reproductive Health Education-** Reproductive health services and information can improve the health status of adolescents and help them attain the level of understanding required to make responsible decisions. Participation of young people in planning, implementation and monitoring of services could ensure adolescent friendly health services. Adequate support from the education sector and the community should be encouraged to support the initiative.

PSI/Myanmar and its Sun network members are trained on ARH and special communication materials have been developed for them. One million copies of ARH booklet were distributed during the period of 2006 to 2009<sup>87</sup>. It was funded by UNFPA and the production of the booklet was jointly done by PSI/M and MMA's Youth team members.

UNICEF and Ministry of Education had introduced School based Healthy Living and AIDS Prevention Education program (SHAPE) into the school curriculum since 1997. The 2008-2012 National Strategic Plan for Adolescent Health and Development addresses general issues of adolescent health and defines strategies for adolescents' reproductive health in particular by supporting adolescent-friendly health services<sup>88</sup>.

The latter includes, among others, provision of diagnosis and treatment of sexually-transmitted infections, provision of voluntary counseling and testing for HIV, provision of counseling and contraceptive services, antenatal, delivery, postnatal, and post-abortion care.

**11.2 Unintended Pregnancies:** According to the 2007 FRHS, almost 5% of all pregnancies end in abortion. Abortion rate was highest in 15-19 years age group and university-educated youth, with 11.39% and 9.07% respectively<sup>89</sup>.

Induced abortion is illegal in Myanmar. According to the 2004 Family and Youth Survey, 78% of interviewed youth expressed that homes of Traditional Birth Attendants is the main place where abortions are performed. The majority of these procedures are likely to be unsafe.

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<sup>87</sup> PSI-Myanmar, 2010

<sup>88</sup> Department of Health, School Health Division, National Strategic Plan for Adolescent Health and Development (2008-2012)

<sup>89</sup> Country Report on 2007 Fertility and Reproductive Health Survey, Department of Population and UNFPA, 2009

Abortion is the third most common cause of maternal death, and with the growing proportion of never married and high abortion rate of youth, sexual and reproductive health education and contraceptive services should cover not only married women but also be targeted towards youth, adolescents and the unmarried. Some patients with complications of induced abortion present at hospitals thus, in addition to FRHS and FYS hospital statistics can also reflect abortion rate in Myanmar. Hospital statistics revealed that septic abortion contributed to 53% of all maternal deaths<sup>90</sup>.

A hospital based cross-sectional descriptive study on the socio-demographic determinants of abortion and assessment of contraception knowledge showed that 100 patients admitted for abortion, the determinants of repeated abortion were very early age of marriage, long duration of marriage, increasing number of children alive, multiparity. Determinants of induced abortion were duration of marriage, desire not to have more children, unplanned or by-chance pregnancy and poor practice of birth spacing methods. From these findings information, education and communication were essential to prevent abortion and its complication.<sup>91</sup>

**11.3 Antenatal care (ANC)** coverage improved from 63.1% in 2005 to 64.6% in 2007. The proportion of births delivered by a traditional birth attendant reduced from 8.8 in 2005 to 8.6 in 2007. The proportion of deliveries attended by skilled birth attendants (doctors, nurses and midwives) reached 64% in 2007, compared to 57% in 2001. Proportions of birth attended by skilled birth attendants was the highest in the age group 45-49 years old, followed by women of 15-19 year old age group. 76.4% of deliveries occurred at home, 16.6% at government facilities and the rest at private clinics.

**Linkages and Timely referral:** The majority of maternal deaths occurred at home (62%). Only 38% of women with complications were referred to a hospital and only 24% reached the hospital for proper management, while 14% died on their way due to late referral and delays in transportation<sup>92</sup>.

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<sup>90</sup> Win Win Mya. Causes of maternal death, North Okkalapa General Hospital (1992-1998)

<sup>91</sup> Theingi Maung Maung, determinants of abortion in Thingangyun San Pya hospital, 2003.

<sup>92</sup> Nationwide Cause Specific Maternal Mortality Survey, 2004-2005, Yangon, MOH-UNICEF, 2006

**11.4 Quality reproductive health care** is one of the greatest barriers in the midwifery services and is augmented by inadequate supplies of essential drugs, non-adherence to established standards due to lack of knowledge and skills, unavailability of supplies and availability of authorization for a staff to perform the clinical intervention<sup>93</sup>.

**11.5 Health Workforce:** According to WHO estimates, twenty three health care providers (doctors, nurses and midwives) per 10,000 people is the threshold to achieve 80% coverage for skilled attendance during deliveries. Countries with fewer than 23 **human resources for health** (physicians, nurses and midwives) per 10,000 people are likely to experience shortage in coverage rates for the basic primary health care interventions prioritized by the Millennium Development Goals<sup>94</sup>. In Myanmar, the doctor to population ratio is 1:3315 while nurse/midwife to population ratio is 1:1195<sup>95</sup>. There are about 14 health care providers per 10,000 people. The majority of highly-skilled medical doctors are concentrated in urban locations, where only 30% of the total population resides. To meet the international threshold and secure availability of skilled birth attendants at deliveries, strategic planning should be done to ensure the sustainability of the health workforce.

**11.6 HIV/AIDS:** The estimated **prevalence of HIV** in Myanmar is 0.61 %. The estimated number of people living with HIV (PLHIV) between 15 to 49 years of age is 230,000 (35% were female) in 2009. The main mode of infection of HIV is sexual transmission (73%). HIV prevalence is high amongst vulnerable groups; 37.5% of injecting drug users (IDUs), 28.8% of men who have sex with men (MSM), and 18.4% of female sex workers (FSW) and 5.4% of Male with sexually transmitted disease (STD) patients is infected with HIV/AIDS. HIV prevalence of pregnant mothers was 1.26%, prevalence in blood donors was 0.48%, in new military recruits was 2.5 % and in new Tuberculosis patients was 11.1% .

**11.7 HIV prevalence among pregnant women** -In relation to MDG indicator 6.1, HIV prevalence among pregnant women aged 15-24 years declined from 2.78% in 2000 to 1.01% in 2008. However, there is large gap to achieve MDG target 6B of universal access to treatment for HIV/AIDS for all those who need it by 2010 for Universal Access and by 2015

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<sup>93</sup> Situation Analysis of RH, PD and Gender in Myanmar, UNFPA, 2010

<sup>94</sup> World Health Report, 2006

<sup>95</sup> Health in Myanmar, 2009



for MDG targets. The proportion of population with advanced HIV infection with access to antiretroviral drugs is only 20%. In addition, only 38.7 % of people in need of PMCT received a complete course of antiretroviral prophylaxis in 2008. There is a chronic funding gap, which currently stands at a shortfall of approximately 38% according to the operation plan of NSP in 2008. There needs to be health system strengthening, reduction of stigma and discrimination of PLHIV and increased reaching out to remote population groups.

**RH and HIV support for migrant population:** Programs also need to be targeted to the large mobile population of internal and international migrants. There is an inadequate full range of services with low VCCT coverage.

### **11.8 Condoms for HIV prevention and Gender Issues**

According to an AIDS epidemic update, in 2009<sup>96</sup> the proportion of women living with HIV in the Asia region rose from 19% in 2000 to 35% in 2008. In particular countries, the growth in HIV infection among women has been especially striking. In India, women accounted for an estimated 39% prevalence in 2007. During this decade, women's share of HIV cases in China doubled<sup>97</sup>.

In the same way, in Myanmar, based on an estimation workshop report 2009, the epidemic also spreads to women where an estimated 35% cases are female. The routine monitoring report of NAP indicated that the ratio of AIDS cases in female to male has increased from 1 to 3.6 in 2000 to 1 to 2.4 in 2008.<sup>98</sup> While the HIV prevalence among pregnant mothers from Ante Natal clinic from 32 sites has decreased.

Women's personal risk perception was also low in spite of the existence of high-risk behavior of some men and the prevalence of HIV infection in their community<sup>99</sup>. In 2007, the behavioral surveillance survey (BSS) of the general population, noted that women had lower knowledge of HIV transmission than men and uneducated women dependent on their partners were less knowledgeable.<sup>100</sup>

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<sup>96</sup> AIDS epidemic update , UNAIDS and WHO, 2009

<sup>97</sup> Ibid

<sup>98</sup> National Strategic Plan for HIV & AIDS in Myanmar, progress report 2008, Ministry of Health

<sup>99</sup> Report on Baseline data collection & behavior study on male involvement in Reproductive Health Myanmar

<sup>100</sup> Dr. Aye Myat Soe, Daw Aye Aye Sein, Dr.Khin Ohnmar San, Behavioral surveillance survey 2007 (general population)

In common with other countries in Asia, a 2009 draft desk review of gender and HIV in Myanmar<sup>101</sup> indicated that the increasing HIV transmission to females is thought to be due to sexual relationships with their husbands or long term sexual partners who have also patronized sex workers. This process is termed 'intimate partner transmission (IPT)' and can be prevented by consistent condom use.

Social norms and unequal gender roles in the family in Myanmar may render women more vulnerable to HIV as women generally fail to negotiate condom use with their partners.<sup>102</sup> A culture of submissiveness and the one sided faithfulness of wives may lead to women's heightened risk of HIV infection. Due to fear of accusations of infidelity including fear of being labeled as sexually promiscuous, disclosure of HIV status to sexual partners and spouses is thought to be low<sup>103</sup>.

Majority of Myanmar women are economically dependent on men and this means that they have less decision-making power than men. Moreover, women have more responsibility for looking after children as well as the care of other family members such as the elderly, orphaned relatives, and those living with long term illnesses (including PLHIV), and orphaned relatives. An HIV positive woman who is pregnant is definitely more disadvantaged, since she must look after both herself and her unborn child also.<sup>104</sup>

Although there is no in depth study for female condom use among sex workers, the 2008 BSS found that among interviewed FSW, 71% of FSW have heard of the female condom while only one third of them had used it. Female sex workers expressed that they have experience with female condoms and usually use female condoms when they cannot negotiate with the clients to use male condoms if they have enough time and at the time of

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National AIDS Programme, Department of Health, Ministry of Health, Myanmar

<sup>101</sup> Dr. Aye Myat Soe, Draft Desk Review of Gender and HIV in Myanmar, , September 2009

<sup>102</sup> Reproductive health needs of HIV positive women: client perspective, Kyu Kyu Than, Poe Poe Aung, Htin Aung Saw, Tin Tin Wai, The Maung Maung& Nyo Aung, Myanmar Health Science Research Journal, Vol.19, No 3, 2007

<sup>103</sup> Draft report of Desk Review of Gender and HIV in Myanmar, Dr. Aye Myat Soe, 2009

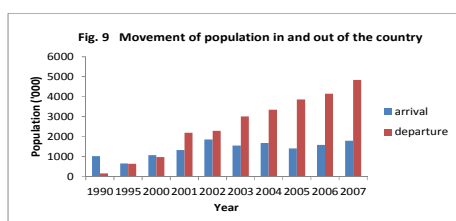
<sup>104</sup> Situation Analysis Report, UNFPA 2010.

their menstrual period. However, they expressed barriers in both the availability of female condoms and their price as female condoms are more costly than the male version<sup>105</sup>.

## 12. SPECIAL AREAS NEEDING ATTENTION

### 12.1 Birth Spacing and RH services for Migrant Population

The scale, composition and causes of population mobility are not accurately known in Myanmar and as of today, there is no nationally representative migration surveys conducted. The Department of Population is planning to undertake a Migration Survey in 2011 with assistance from UNFPA. According to official count of the number departing from international airports, seaports, and land border checkpoints exceeds arrival by one to four million, starting from year 2001 to 2007. (Figure 9) from the Statistical Yearbook provides data on movement of population into and out of the country for persons holding various types of visas except tourist visa.



Source: Statistical Yearbook 2008, CSO, 2009

IOM estimated that there are two million migrants in Thailand, the majority of which are with irregular status.<sup>106</sup> The great majority of Myanmar migrants in Thailand are of reproductive age and their lack of legal identification renders them hard pressed to access affordable health care services. There are many significant health risks for migrants, including STIs and HIV infection. They arrive in Thailand with very little knowledge on health risks, weak social and/or family support networks, and confronted

<sup>105</sup> Ibid

<sup>106</sup> Situation Report on International Migration in East and South East Asia,, IOM, Regional Thematic Working Group on International Migration including Human Trafficking,

with new pressures, experiences and situations that may cloud their ability to consistently choose healthy behaviors.<sup>107</sup>

Recently, UNFPA handed over contraceptives to meet the needs of 8,500 current users and 400 new users for six months to one year. Together with distribution of supplies related counseling, education and hospital referrals were provided in four camps: Umpium, Mae La, Mae Ra Ma Luang and Mae La Oon. Family planning and reproductive health is regarded a basic human right and UNHCR and UNFPA is committed to ensuring that all refugee needs are met.<sup>108</sup>

HIV has continued to spread throughout Asia, especially in border regions, so condom use for prevention is vital. Also, there are many benefits to family planning, including reduced prenatal mortality and improved maternal and child nutrition.

MSF work in Northern Rakhine state had brought positive results. It was critical to gain trust and train the Mullahs—Muslim men educated in Islamic theology who are religious leaders of the community to help health education activities. The local mullahs were very responsive and glad that MSF had come to discuss these ideas and issues with them.<sup>109</sup>

**Poverty and BS** show a 23 percent incidence of poverty in 2001, while poverty headcount index at the national level is 32 per cent. Ten percent of Myanmar people fall under the food poverty line. The landless rate of people working in agriculture is 25.7% at the national level and it is 31.8% amongst poor individuals. These numbers help to illustrate the struggles of the landless poor and small-scale farmers who are at the mercy of high-interest moneylenders. Typically, they require capital for input for loans to buy seeds and fertilizer to break out from the vicious cycle of poverty. Demographic data shows that the rural poor (CBR national level 18.4per thousand population, 15.7 in

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<sup>107</sup> Migration and HIV/AIDS in Thailand: a Desk Review of Migrant Labor Sectors, International Organization for Migration

<sup>108</sup> <http://www.umhcr.org/496f68e82.html>, accessed on 10\_28\_2010

<sup>109</sup> [http://www.doctorswithout borders.org/publication/alert/article\\_print](http://www.doctorswithout borders.org/publication/alert/article_print), accessed, 10\_26\_2010

urban and 19.5 in rural<sup>110</sup>) have higher CBR, fertility rate and lower CPR than the urban educated population. It is also to be noted that 80% of Myanmar's population resides in the rural area and this proportion of the population that requires essential RH care and BS commodities which should be made available at affordable price or even free and easily accessible.

**12.3 Status of reproductive rights in national law and Policies** organize the discussion around data describing the status re these variables in 1990, 2000, and 2010

- **Law pertaining to induced abortion**-The Union of Myanmar Penal Code section 312 states that *“whoever, voluntarily causes a woman with child to miscarry shall, if such miscarriage be not caused in good faith for the purpose of saving the life of the women, be punished with imprisonment of either description for a term which may extend to three years, or with fine, or with both; and if the woman be quick with child, shall be punished with imprisonment of either description for a term which may extend to seven years and shall be liable to fine”*. This law is still in force and like in other countries women with unintended pregnancy finds it difficult to seek skilled help at health facilities.
- The fact that there is a high unmet need for birth spacing services and a significant number of unwanted pregnancies which result in a large number of induced abortions under unsafe conditions<sup>111</sup>, leading to complications, maternal morbidity and mortality. According to hospital statistics, the number of abortion per 100 deliveries slightly declined from 27 in 2005 to 24.7 in 2007.<sup>112</sup> Evidence suggests that women undergo abortion under unsafe conditions and tend to approach health care providers late for management of complications. Provision of services for management of complicated abortions, post-abortion counseling and post-abortion birth spacing services have improved slightly. However, these factors still poses a challenge.

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<sup>110</sup> FRHS , 2007

<sup>111</sup> WHO, 2005

<sup>112</sup> Annual Hospital Statistics Report, 2007, MOH, DHP, page 32, Table 11: Number and percent of delivery, live birth, still births and abortions in 2005 to 2007. (States, Division and Union)

- **Adolescent unintended pregnancies:** Adolescent pregnancies in 1998 were 2.9% of total pregnancies in Yangon<sup>113</sup>. Some of the outstanding challenges of adolescents are unwanted pregnancy is unsafe induced abortion already mentioned in the previous passages. Social norms have been changed and in universities located in outskirts of cities have problems of pre-marital sex leading to unwanted pregnancies and complicates due to unsafe abortions which in some cases might lead to maternal mortality<sup>114</sup>. Abortion laws may need to be revised so that when there is a real danger for the life of the women provision of health services need to be accessible. When asked about their greatest needs adolescents expressed that there are no sufficient services tailored for adolescents' sexual and reproductive health, for unmarried girls/young women as the current RH program in Myanmar is tailored for the married women<sup>115</sup>.
- UNFPA initiated a project with assistance from the Federal Republic of Germany (2009-2011) for reduction of MMR and prevention of HIV/AIDS in five townships using the MCH community promoter modality to improve RH knowledge through behavioral change communication interventions among community adolescents<sup>116</sup>.

**The Draft National Population Policy, 1992:** Myanmar is relatively sparsely populated, and with rich natural resources, particularly its broad agricultural base, it can support a far larger population than the current size.<sup>117</sup> Hence GoUM had maintained a pronatalist policy. Among several reasons for this attitude, the important ones are:

- (a) the country is considered to be under-populated, compared to other countries in the region
- (b) availability of natural resources, arable land, forests, marine resources ,
- (c) low population density, and
- (d) perception of population growth as an asset for development.

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<sup>113</sup> ARH at a glance According to a study by WHO-SEARO 2007.

<sup>114</sup> PSI-Myanmar , 2010

<sup>115</sup> Situation Analysis, UNFPA-Myanmar, 2009-2010

<sup>116</sup> UNFPA-German Find project for Reduction of MMR and prevention of HIV/AIDS 2010-2013, project document

<sup>117</sup> 1994 National Report on Population to 1994 ICPD, Cairo, National Population Commission, Myanmar

The draft National Population Policy was developed in 1992 under the guidance of the National Health Committee, discussed and deliberated at different levels of government departments concerned. The draft national population policy highlighted the need for birth spacing as an important issue for a "Happy Healthy Family" on health grounds. The policy recognizes the fact that “ the improvement in the quality of life would inevitably come from reduced population growth”, and aims to improve the health status of women and children by ensuring the availability and accessibility of birth spacing services among all married couples that voluntarily seek such services<sup>118</sup>.

In line with this policy the DOH clearly informed all INGO partners in the 1990s, working in RH area that GoUM does not allow Family Planning program per se since Myanmar is a pro-natalist country and needs a population growth to reach 150 million in a decade<sup>119</sup>. NGO activities with regard to BS services were discouraged again in 2001, health authorities endorsed to use the term BS instead of FP. After a year, DOH reminded NGOs to limit BS activities. In the Adolescent Reproductive Health booklet there was one chapter on “BS” and an NGO was advised to change the heading to “safe motherhood” without changing the content. Confusing messages without a proper population policy makes it hard for all actors working in the area of BS difficult for long term planning and commitment. In general, all NGOs working in BS in Myanmar follows the directions set by DOH and MOH and could not expand on any demand innovative activities for FP<sup>120</sup>.

Cultural sensitivity still prevails in Myanmar with regard to the topic of pre-marital sexual activities and utilization of contraceptives by unmarried proportion of adults and young people. At policy maker level the pro-natalist policy is rigorously followed and there is denial of the fact that increasing proportion of adolescents and that of never married population may be sexually active and need contraceptives to be prevent un-intended pregnancies.

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<sup>118</sup> Situation Analysis report, 2010, UNFPA

<sup>119</sup> NGO comment. 2010

<sup>120</sup> Response to self-administered questionnaire, PSI/M,2010

It is envisaged that the “Population policy” drafted in 1992 be updated and formal adoption would enhance the implementation of ICPD PoA as well as Programmes for achieving MDGs by 2015 and in promoting population and development concerns.

### **13. Current Challenges for Birth Spacing**

- (1) Availability of contraceptives at affordable price.
- (2) Accessibility of the commodities and services by the remote villages and ethnic minorities, poor, migrant, vulnerable and marginalized people.
- (3) Involve adolescents at appropriate levels of planning and implementation of the RH and BS program to meet their unique needs.
- (4) For unmarried, there are barriers like cultural sensitivity need to be overcome by training of service providers, to ensure equal access to RH and BS care.

The 14 to 49 age group which is the largest proportion of reproductive age group women are at risk. Unsafe abortion is one of the major causes of high MMR in Myanmar. According to FRHS 2007, abortion is highest in the 15 to 19 age group amounting to 11.39% of the total pregnancies of that age group. Women seek unsafe abortion because they cannot afford to bring up a new addition to the family and also as one method for BS. If this practice continues and if women and adolescents continued to face limitations due to financial, logistic or socio-cultural barriers in access to BS services the MDG goals will be hard to reach.

### **14. Linkages between Maternal and Child Health Program and HIV/AIDS and STI service delivery**

**National Level:** In Myanmar the Department of Health (DOH) under the MOH, is headed by a Director General provide comprehensive health care for the whole country. The Maternal and Child Health (MCH), Women and Child Development (WCHD), Primary Health Care, and Training of Basic Health Staff (BHS) are under the DOH each headed by a Deputy Director.

The MCH division is responsible for RH and BS program and works in collaboration with UNFPA, WHO and INGO partners whereas the WCHD emphasized more on new born care and women development activities and works with UNICEF and NGOs. There is integration of safe motherhood and child survival initiatives by WCHD program, as well as HIV through



Prevention of Mother to Child transmission (PMCT), with the national AIDS program. Although complementarity is encouraged some times overlap and role conflict at different levels of the program are seen thus better coordination and role description is needed at program implementation level.

**Linkage with School Health (SH) Teams:** In towns with a population over 10,000, in addition to MCH centers there are School Health Teams (featuring Doctors, Nurses, and Dental Surgeons, Medical Social Workers, pharmacists and clerical staff) taking charge of the MCH activities as well as the school health work. There are 80 such teams operating in 51 towns across the country. The MOH included school health program activities on Adolescent Reproductive Health (ARH) in its 2001-2006 National Health Plan. The MOH collaborated with other ministries, such as Ministry of Education, Ministry of Sports and Physical Education, Ministry of Immigration and Population and Ministry of Information. To integrate school health and adolescent sexual and reproductive health, the national five-year Adolescent Health and Development Strategic Plan (2009-2013) was developed to address priority issues affecting the health of young people across the nation.

#### **Linkages at Primary Health Care level**

**Rural Health Centers (RHC):** RHCs are centers each responsible for a population of about 26,633 in about 7 to 14 villages (national average)<sup>121</sup>. One RHC consists of a Health Assistant (HA) as team leader, a LHV, 5 midwives and 1-5 Public Health Supervisors (Grade II – Multipurpose Health Worker) and a watchman. MCH care and BS services are provided at RHC level and urban MCH by the Lady Health Visitors (LHV) and Midwives (MW). There are 1481 RHCs throughout the country.<sup>122</sup> More than 18000 BHS at township level were given trainings on Maternal, Newborn and Child Health Care during 2009<sup>123</sup>.

**Sub-Centers:** Under each RHC, there are usually five sub-RHCs and each midwife is given charge of (1-3) village tracts with a population ranging from (2000-4000). Thus, the four

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<sup>121</sup> National Health Plan, 2006-2011

<sup>122</sup> Health in Myanmar 2009, Ministry of Health, 2009

<sup>123</sup> Health in Myanmar, 2010

MWs at the periphery of the main RHC become four Rural Health sub-Centers which are functionally MCH Centers. There are 5824<sup>124</sup> sub-Centers in Myanmar.

**Auxiliary Midwife (AMW)** are selected from underserved villages, trained for three months in the hospital and then for three months in their nearest RHC. While AMWs are not regarded as skilled birth attendants, there is a heavy reliance on them in Myanmar in the absence of other health personnel in rural remote villages. Working under the supervision of the MW and Village Health Committee, the main activities of AMWs are volunteers filling the gap for provision of the MCH and BS services in hard-to-reach areas. AMW recruitment was up to 31787 for total 64910 villages and ratio of AMW: Village become nearly 1:2<sup>125</sup>.

It is the above mentioned Basic Health workers who during their field visits they provide Ante Natal care (ANC), deliveries, Post Natal care (PNC), and conduct weighing and immunization of children under three. They also give health education regarding safe motherhood, nutrition and promote breast-feeding and Birth Spacing education and provision. These multi -purpose workers conduct RH, as well as BS and HIV-STI prevention activities however, there is no training or advocacy for dual use of condoms for prevention of STI and BS. Linkages between RH, BS and HIV-STI care is present as Township Medical Officers arrange for LHV or MW to provide continuing education and supervision to update AMWs knowledge and upgrade their skills.

The **National AIDS program (NAP)** responsible for HIV/AIDS and STI is under the Director (Disease control) is headed by a Deputy Director in Nay Pyi Taw. NAP has forty-six AIDS/STD teams nationwide, including six State and Divisional level AIDS/STD teams in high prevalence or vulnerable townships. Each of the AIDS team has a staff of 3 to 15 members, including a medical doctor (team leader), nurses, counselors, investigator/outreach workers, laboratory technicians and support staff.

The AIDS/STD teams implement projects at the local level in harmony with national public health strategies. Medical Officers are in charge of the team and provide counseling, Sexually Transmitted Infections (STI) management, and some basic HIV/AIDS treatment and

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<sup>124</sup> National Health Plan, 2006-2011

<sup>125</sup> *ibid*

care with nurses. They refer People Living with HIV (PLHIV) in need of Anti-Retroviral Therapy (ART) to physicians and also perform monitoring, supervision and reporting as necessary. Investigators and outreach workers provide contact tracing for STI, PLHIV and support outreach activities. Laboratory technicians carry out tests related to STI and HIV testing. In townships without AIDS/STD teams, HIV/AIDS interventions are implemented by other responsible officers, notably the township medical officer. Township hospitals provide basic services on HIV/AIDS clinical management to outpatients where AIDS/STD teams are not present and to patients with advanced HIV and AIDS.

While NAP and MCH programs are in place, with vertical organization mechanism, separate funding and budget line, however all are under the DOH. This makes communication and coordination easier now that all sectors are in Nay Pyi Taw. However, at program level advocacy for the use of condoms for dual protection contraceptive and prevention of HIV and STI is not a common practice<sup>126</sup>. As for NGO staff PSI claims at all Sun providers are trained in SRH, HIV and STIs.

**Studies on Birth Spacing Activities:** Soon after BS program was initiated 1992, research studies were carried out in rural as well as urban population on their knowledge, attitude and practices. A study involving 100 married women aged, 20-49 years attending BS clinic in Waibagi and N.Okkalapa townships on male condom use. It showed that 75% of women heard of condom while only 36% had actually seen one, 86.6% knew that condoms can be used for prevention of STI and contraception, and only 5% had ever used condoms for BS which indicated at that time that there should be more counseling for condom use as BS<sup>127</sup>.

The study is to identify the medical barriers to contraceptive choice in MYA/94/PO1 family planning project at Central Women's Hospital (CWH)- urban site, North Okkalapa health centre, Peri -Urban site and Thanlyin RHC. Methodology adopted is screening of clients for suitability of modern contraceptive methods, counseling, prescribing and follow-up. 1533 were fit for oral pills but only 9.5% chose the methods, 294 were unfit but 24 demanded and were given after re-assessment. For injectables, 1775 were fit to use and 63.8% accepted while 15 out of 52 unfit had to be given injectables after reassessment. 1465 were 'fit' for IUCD out of which only 28.1% accepted and 20 out of 362 who were unfit for the method

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<sup>126</sup> MCH, DOH, 2010

<sup>127</sup> Than Than Tin, San Shwe, Ohn Htwe, Le Le Win and Thein Thein Htay, 1997, Acceptability of condoms among family planning clinic attenders in WB and NO, Myanmar Health Sc. Res., Aug 9(2):55-58

accepted IUCD. Medical barriers to contraceptive choice conflicted with clients' desires in a substantial proportion of the clinic attenders as high-lighted by the study<sup>128</sup>.

Attitudes of rural in In-depth study on population and birth spacing at national level are the Fertility and Reproductive Health Surveys conducted by Department of Population and UNFPA. By DOH there is Contraceptive Method Mix study and small scale research papers on contraceptive method choice and adolescent peer pregnancies<sup>129</sup>. UNFPA conducts regular program evaluations, mid-term review of country program of assistance.

### Reference to ICPD and MDGs

ICPD principle 8 states that *"everyone has the right to the enjoyment of the highest attainable standard of physical and mental health"*. And ICPD also encourages *"States to take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health care services, including those related to reproductive health care, which includes family planning and sexual health"*. To this regard Myanmar as a developing country is committed to fulfill the basis of this principle and has mechanisms and is implementing its second five year national strategic plan for reproductive health (2009-2013). Reproductive health-care programs are provide at basic essential package level and this also has not reached universal coverage, especially in regions where transportation is difficult and geographic terrain prevents easy access to health care. There is no form of coercion in providing a wide range of services within Myanmar's economic and cultural context with regard to BS which is in-line with ICPD principle 8. All couples and individuals do have the basic right to decide freely and responsibly the number and spacing of their children and they do have the information, education to a certain extent which needs further strengthening. The table below shows Myanmar's progress towards selected ICPD PoA indicators analyzed by the UNFPA State of World Population to enable comparison in relation to indicators from national sources as well as UN sources in relation to progress towards ICPD PoA goals and MDGs:

Table (3) Myanmar's progress towards selected ICPD PoA indicators analyzed by the UNFPA

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<sup>128</sup> Than Than Tin, Thein Hlaing, San Shwe, Maung Maung Toe, Ko Ko Zaw. Medical barriers to contraceptive choice. J Myanmar Milit Med. 1998 Sept; 5(1): 4-9. (Page 267)

<sup>129</sup> MCH, DOH, 2010

Reproductive Health	State of World Population 2000	State of World Population 2002	State of World Population 2009	State of World Population 2010
Proportion of births with skilled attendant	57	-	57	
Infant mortality, total per 1000 live births	79	87	72	70
Life expectancy M/F	58.5/61.8	53.8/58.8	59.9/64.4	60.5 / 65.0
Maternal mortality ratio	230	170	380	240-UN 380- SWOP
Births per 1,000 women, ages 15-19	26	29	18	
Contraceptive prevalence (any method)	17	33	37	37
Contraceptive prevalence (modern methods)	14	28	33	33
HIV prevalence rate (%) ages 15-49	-	-	0.7(2007)0.61 (2009)*	0.7

\*2009 estimation workshop, Myanmar

## MDG Goal 5<sup>130</sup>: Improving maternal health

MDG 5 Target B: to "*achieve, by the year 2015, universal access to reproductive health*". This and the related indicators under the MDG5 (ref: table below) recognize the centrality of reproductive health and reproductive rights in improving maternal and infant health and in reducing poverty. To promote universal access to comprehensive reproductive health services, the Ministry of Health of Myanmar together with its UN and NGO partners implemented its first five-year National RH Strategic Plan (2004-2008). The implementation of the Plan had a shortfall of approximately 75% funding gap against the planned budget of US\$30.1 million<sup>131</sup>. Thus, some of the components of the Plan were either not implemented or implemented on a very limited scale. Thus, progress towards the ICPD and MDG5 goal (Target 5A) of reducing maternal mortality has proven to be slow and unequal among population groups. The main strategy of a second five-year RH Strategic Plan (2009-2013) is to scale-up the essential package of reproductive health services with improved

<sup>130</sup> Sixty-second UN General Assembly, Official Records, Annex II, Revised Millennium Development Goal Monitoring Framework, United Nations, 2007

<sup>131</sup> Five year Strategic plan for reproductive health, 2004-2008

coordination and resource pooling. The second five-year RH Strategic Plan set in the national targets to monitor the implementation against the MDG5 indicators. MMR, one of the important indicators, is targeted to reach 145 per 100,000 births in 2015 which will need aggressive inputs into emergency obstetric care and support are made and universal access to BS and RH care is provided. The target for proportion of births attended by skilled health personnel is currently 64%, which still has a long way to reach the target of 80% by 2015.

**Table (4) Myanmar's Achievements and gaps for MDG Goal 5**

Targets	Indicator	1990-1994	1996-2001	2005-2007	2015 target	Source
Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	5.1. Maternal mortality ratio (number of maternal deaths per 100,000 live births)	232	255	316	145	Five year Strategic Plan for RH (2009-2013)= (RH-SP)
	5.2. Proportion of births attended by skilled health personnel (%)	51	57	64	80	RH-SP 2009-2013
Target 5.B: Achieve, by 2015, universal access to reproductive health	5.3. Contraceptive prevalence rate (%)	16.8	37	41	60	RH-SP 2009-2013
	5.4 Adolescent birth rate		29	22.7, 16.9*	Not set <sup>132</sup>	*2007 FRHS
	5.5. Antenatal care coverage (at least one visit)**		42.2	64.5	80	RH-SP 2009-2013
	5.6. Unmet need for family planning		19.1	17.7	<10	RH-SP 2009-

<sup>132</sup> There are data gaps concerning adolescent birth rate, and information can be obtained from surveys such as FRHS and MICS, only it is not normally calculated or was not usually mentioned in reports. ???

**\*\*Note:** data on the proportion of at least four antenatal visits is not available

*Source: Situation Analysis Report, UNFPA, 2010*

**Gender-based violence** occurs more frequently where poverty and social instability are prevalent—for instance, in crises and early recovery situations<sup>133</sup>. Gender-based violence reflects and reinforces gender and social inequities and compromises the health, security, autonomy and dignity of its victims. At least one out of every three women around the world has been beaten, coerced into sex, or otherwise abused in her lifetime. The abuser is usually someone known to her.

In Myanmar, due to the fact that there is no official national level data on gender based violence and that in general women and girls do not experience many of the extreme manifestations of discrimination and seclusion, it has become normal for many gender gaps and inequalities to be often overlooked by both national and international organizations working in Myanmar's development sector. A study carried out by MAAF on reported cases of sexual assault revealed that in 17 states and divisions of Myanmar there were 209 cases in 2001 and 338 cases in 2004. A study on marital violence against women revealed that the most common causes were financial difficulties, alcohol consumption and incompatibility with in-laws<sup>134</sup>.

Programmatic measures taken by MAAF to eliminate violence against women include:

1. Counseling Centers set up to help women gather and solve their own problems.
2. Training for service providers on violence against women in all states and divisions.

Conflicts and natural disasters destabilize social infrastructure, leaving many young people, particularly young women, vulnerable to sexual violence, exploitative labor and trafficking. Minimal services and support are available to gender-based violence survivors and limited law enforcement can result in impunity for perpetrators. The Women's Protection sub-cluster of cyclone Nargis reported that as is common in many other countries, many women present with symptoms consistent with GBV at clinics report that they have had an accident, rather than been

<sup>133</sup> *Source: Youth Zones, by Governess Films in association with UNFPA and the Women's Refugee Commission, State of World's Population, 2010.*

<sup>134</sup> Gender Statistics in Myanmar, 2006

victims of abuse<sup>135</sup>. This makes creating a GBV response mechanism particularly challenging. Presumably this is due to a reluctance to report violence to the authorities. A major point of concern is that in the legal handling of GBV cases, because when a victim reports to a clinic the medical service provider is required to report the case to the police before treating the survivor. Thus, most survivors are reluctant to report and gain access to health care. In addition, young people are also at a formative time in their transition to adulthood when harmful experiences can have long-lasting physical, psychological and social effects. The damage of gender-based violence to young people is profound and requires attention across sectors to assess and implement preventative mechanisms and provide appropriate services. Gender-based violence, especially against young people, is characterized by underreporting because of survivors ‘fear of reprisals’ and the limited availability of services such as health care and justice. Lack of accurate and reliable information on trends and patterns also makes it more difficult to take action and to prevent gender based violence from happening<sup>136</sup>. In most contexts, survivors lack access to emergency contraception to prevent pregnancy, post-exposure prophylaxis to minimize HIV transmission, treatment for sexually transmitted infections, counseling and other psychological support, collection of forensic evidence, and referrals to legal and social support services within the community.

## 16. **Recommendations:**

### **Political and Policy commitments**

- Go RM to advocate all partners working in RH in Myanmar for quality as well as quantity of services to be provided for universal access to essential RH and BS services.
- GoRM to be flexible with its pro-natalist population policy and to expand project townships to cover all 235 townships in the country without over-laps in supply of BS commodities without stock-outs.

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<sup>135</sup> Field interviews with 40+ women in the delta over a 6 month period, 2008-2009, Shanny Cambell

<sup>135</sup> UNDP Gender Tracking Study (draft interim report, February 2009),

<sup>136</sup> *Source: Youth Zones, by Governess Films in association with UNFPA and the Women's Refugee Commission, State of World's Population, 2010*



- GoRM to create budget line with increased funding for reproductive health commodities.
- Provide policy guidelines for effective utilization of “drug revolving fund” accumulated at Township level for BS commodity security and charge exemption for the needy citizens
- GoRM to actively engage with donor community with evidence based proposal development for request of additional donor assistance for RH and BS commodities.
- Explore alternative financing options, including finding ways to increase the role of the private sector and NGO partners.
- Supportive supervision and incentives for Basic Health workers who serve at hard to reach rural areas.

#### **Improved access to RH and BS services**

- Reduce the MMR , un-intended pregnancies and unsafe abortions, by improved access to health care and increased institutional delivery through expansion of Community Support group program in hard to reach and high MMR townships and States and Divisions especially tailoring BS services for young people, the unmarried and the hard to reach populations.
- Work with UN and national NGOs to establish incentive system and empower community support groups to better linkages between community and health care providers for better RH and SB care and support.
- Improve transportation and communication for hard to reach areas to improve referral in emergency obstetric situations.
- Explore and implement ways to reach nationwide population with BS advocacy and ASRH messages using prime time media and adolescent friendly BS services.

#### **Improved quality of Care**

- Improve quality of RH and BS services should be ensured by skill training, issuance and following through the standard operational procedures and guidelines in practice.
- Employ and deploy health personnel with supportive supervision especially trained Midwives to priority areas for BS and MCH care and support.
- Training of human resources for better coordination and utilization of computerized Logistic Management Information system, projection of Contraceptive needs, mapping out priority areas, monitoring & supervision, and warehousing towards a functional LMIS.

#### **BS and RH Commodity Security**

- Better stewardship of existing resources by strengthening the "supply chain" through capacity building capacity to forecast, finance, procure, and deliver high-quality and reliable supplies and services.
- Work with WHO to include essential reproductive health supplies in the national essential drug list.
- strengthening logistics management and ensure RH & BS commodity security through sub-committee on RHCS of the national working committee on RH in coordinating efforts to meet the needs for RH Commodities
- Develop flexible and simplified procedures for purchasing commodities and explore new mechanisms for pooling and coordinating international commodity purchases.
- Address RHCS through: provision of low cost contraceptives, sharing of experiences, and providing technical assistance through South-South cooperation modality.
- Test and evaluate innovative strategies for providing quality, cost-effective products and services sensitive to cultural norms and practices of the people of Myanmar.

#### **Coordination with Partners**

- Create strong partnership, understanding and trust among players for better RH outcomes. Demand creation activities related to BS should be allowed to inform and educate women regarding FP.

- PSI, MSI, AZG, AMI, ADRA, Save the Children, and all other actors in the RH need to lobby their national governments to commit an adequate and stable supply of reproductive health and BS commodities, along with quality services and to pledge funding support as projected in the Second Five year National Strategic Plan for RH (2009-2013).
- Educate members, constituents, or clients about the need for quality services, including a consistent supply of contraceptives and condoms, and about the importance of voicing concern over inadequate supplies and services.

#### **Donor agency support**

- Meet the needs for RH and BS Commodities to complement the Government's limited investment in the health sector. Bilateral donors such as German fund, US AID, AusAid to support BS and maternal health.
- Consortium of donors like GAVI, World Bank, Global Fund , 3 Disease Fund need to direct efforts to strengthen health system for better RH and BS services.
- Actively review the Second Five Year National Strategic Plan and discuss with MOH on the priority needs to provide more funding for continuous contraceptive supplies. Strive for greater consistency and coherence in policies and programs, to allow for longer-term planning on the part of recipient governments.

#### **14. Changes before way forward in RH and BS program**

##### **Supportive Attitude of all Partners**

Myanmar is unique in its political, economic, social-cultural, and environmental diversity and has unique religious and ethical values, diverse ethnicity and philosophical convictions of its people. Thus, when implementing the ICPD program of action it is important to take into account the factors which govern the population and its development and intensified efforts to improve the quality of life of the population of Myanmar and its future generations. It is obvious that like any health system there are strengths and weaknesses.

However, it is timely and appropriate to stop blaming each other and gear towards a positive attitude of working together and pooling resources, more collaboration and coordination and trust between MOH, UN and INGO as equal partners serving for the good of the multitudes of Myanmar to achieve the MDG goals. There should be common goal, common vision and shared ownership with regards to FP among all partners.

### **Transparency in Sharing of Data and Information**

At all levels of planning, program implementation and monitoring and evaluation there should be transparency and sharing of quality data and information and even resources if urgent need arises to effectively implement towards a common goal.

### **Common Platform of Action**

To generate increase level of interest and initiation of the government, UN, NGOs and civil society for the Second five year strategic plan for reproductive health (2009-2013) to be accepted as a common platform of action to which all partners will engage and join hands to work in partnership in the implementation of the ICPD Program of Action and MDG goals.

### **Use of Media and Adolescent Friendly SRH Education**

Demographics show that the proportion of the 14 to 59 age group is increasing and the proportion never married population is increasing. There is a need for improving adolescent sexual and reproductive health education to prevent un-intended pregnancies and complications due to abortions. Ensure wide spread availability and access to contraceptives for the unmarried and young people at the same time address the need to provide SRH education through use of media. Provide “prime time” TV and radio broadcasting services for SRH health education to reach nationwide population. Use ethnic languages to reach the minorities for better conceptualization and acceptance of RH messages.

**IEC materials for ethnic minorities**-There is a need to establish a sense of inclusiveness in all domains of execution of the RH and BS services. Language barrier may impose considerable constraints for ethnic minorities which may need translations and interpretation of IEC materials and broadcasts. Pictorial presentation of RH messages needs to be developed for the less literate population.

## **Focusing on Priority Areas**

- RH and BS are not stand alone entities and the MDGs and ICPD goals cannot be reached by just the MOH in isolation. There should be a paradigm shift from project mode to long term program implementation mode linked with national population development strategies and poverty reduction strategies. All stakeholders and Ministries concerned need to cooperate with authority and flexibility given at regional and township level so that BS and RH commodities can be managed at close to client needs.
- The most vulnerable population that needs the most support in RH and BS as identified by the situation analysis are the under-served population of Northern Rakhine State, Sagaing Division, Magway Division, Northern Shan and Kayah states and not to forget the peri-urban population surrounding the megacities of Yangon and Mandalay where MMR is high. These areas need priority attention for RH and BS services.

## **New advocacy paradigm**

- Partnership building, pooling of resources and working together as equal partners towards joint implementation of Second Five year National Strategic Plan for RH (2009-2013)
- There should be no stock –outs for BS commodities and every pregnancy should be wanted, treasured and planned by both partners with skilled support from health service providers.
- Be transparent about needs, resources are there to be tapped
- Waste not , want not, advocate for proper logistic management of commodities so that no commodity is thrown away because it has reached Expiration date.
- Timely and effective reporting to donors

## 15. Conclusion:

All Public health programs require commitment, funds, and coordinated efforts. In particular, the growing demand for family planning and the growing AIDS epidemic in many parts of the world will require attention to the most basic of tasks: providing the products to people who need them. Although the ICPD program of action has a recommendation that governments should “*meet the family planning needs of their populations as soon as possible and should in the year 2015, seek to provide universal access to full range of safe and reliable family planning methods.....*” no governments of countries around the globe can be expected to meet the goals and objectives of the International Conference on Population and Development single-handedly. All members of and groups in society have the right, and indeed the responsibility, to play an active part in efforts to reach those goals<sup>137</sup>. While it is true that quality service delivery, counseling, and educational efforts are needed to make reproductive health programs effective, without the supplies, the programs cannot operate. And a loss of these programs means a loss of reproductive choices and an increase in health risks for women and men.

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Program of Action of the United Nations International Conference on Population and Development, <http://www.iisd.ca/Cairo/program/p00000.html>

## **Annex (1)**

### **List of Persons Interviewed/ Self-Administered Questionnaire (these are in addition to Situation Analysis study done in 2009-2010, UNFPA)**

1. Mr. Mohamed Abdel-Ahad, Country Representative  
  
UNFPA, Myanmar
2. Dr. Sid Naing, Country Representative, Marie Stopes International.
3. Dr. Nyi Nyi, Director, Director, Population program management, Department of Population, Ministry of Immigration and Population.
4. Daw Pansy Tun Thein, Deputy County Representative. UNFPA.
5. Dr. Theingi Myint, Deputy Director, National Program Manager  
  
Maternal and Child Health, Department of Health, MOH
6. Dr. Khaing Khaing Soe, Deputy Director, Department of Population, Ministry of Immigration and Population.
7. Dr. Nyo Nyo Minn, Deputy Country Representative  
  
Population Service International, Myanmar
8. Dr. Win Mar, HIV/AIDS National Program Coordinator, UNDP.
9. Dr. Thwe Thwe Winn, National Program Officer, Reproductive Health, UNFPA
10. Dr. Than Soe, Assistant Program Officer, RH, UNFPA
11. U Toe Naing, Logistic Management, UNFPA
12. Dr. Kyu Kyu Than, Medical Officer, Burnet Institute, Myanmar