



Five-Year Strategic Plan for Reproductive Health (2014-2018)



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Reproductive Health
(2014-2018)**

**MCH section
Public Health Division
Department of Health
Ministry of Health, Myanmar**

Foreword

The National Strategic Plan for Reproductive Health supports the Myanmar Health Vision 2030 of the Ministry of Health through health promotion and service provision to improve the reproductive health of women, men and adolescents. Other areas of the Myanmar Health Vision, i.e. development of human resources for health, health research and strengthening collaboration with national and international partners are integral components in the planning and implementation of the Strategic Plan.

The Ministry of Health developed the National Strategic Plan for Reproductive Health in Myanmar (2014- 2018) to ensure an effective and coordinated response to reproductive health needs in the country. This strategic plan and upcoming operational plans provide the framework from which to advocate reproductive health priorities, engage in annual planning, and mobilise the resources necessary for effective action.

The principles that guide the development, planning and implementation of the Strategic Plan are:

- Implementation in accordance with national development policies, national health plans and in a co-ordinated manner with other national programmes.
- Building on existing programmes and integration in current strategies and programmes.
- Partnership, coordination and joint programming among stakeholders including UN agencies, professional organizations, civil society organizations and communities.
- Employing cost-effective and high impact interventions to promote equitable access to quality, integrated health services with an emphasis on the poor and most vulnerable groups in rural and underserved areas.
- Adopting a life cycle approach to improve the physical, mental and social well-being for mothers and children from adolescence, pregnancy to delivery, the immediate postnatal period and childhood.
- Implementation and scaling up of interventions in phases.
- Adherence to internationally agreed declarations on the right of all persons to the highest attainable standard of health.
- Promotion of gender equity and equality including engagement of men as partners.

The National Reproductive Health Programme used a participatory and consultative approach to develop the National Strategic Plan for Reproductive Health for the next five years, under the auspices of the Ministry of Health. Throughout the developmental process, key staff from governmental, non-governmental, university, and UN organisations provided insight and feedback on critical components of the strategic plan.

We appreciate the contributions of all who attended the participatory workshops and provided their time and expertise to the development of the Strategic Plan. On behalf of the Ministry of Health, the Department of Health and the Reproductive Health Programme, we would like to express our sincere gratitude to those who devoted their efforts in developing this Plan. Particular thanks are to the United Nations Population Fund in Myanmar for providing financial and technical support to develop this strategy.

Executive Summary

The Strategic Plan on Reproductive Health builds on a number of initiatives undertaken to serve the health needs of the population of Myanmar. Included among these are the National Population Policy (1992), the National Health Policy (1993), which was followed by formulation of the Myanmar Reproductive Health Policy (2002). The National Comprehensive Development Plan - Health Sector (2010-2011 to 2030-2031) and the National Health Plan (2011-2016) are the overarching frameworks for the Strategic Plan on Reproductive Health (RH).

The Reproductive Health Policy and Strategic Plans on Reproductive Health (2004-2008 and 2009- 2013) of the Ministry of Health (MoH) are a national response to the Programme of Action of the International Conference on Population and Development (ICPD PoA) and the United Nations Millennium Development Goals (MDG). Building on this momentum, the 2014-2018 Strategic Plan will also respond to the UN Secretary-General's Global Strategy for Women and Children's Health (2010).

The specific objectives of the Strategic Plan on RH (2014-2018) are:

1. To reduce rates of maternal, perinatal and neonatal morbidity and mortality by increasing equitable access to maternal and newborn services; improving quality, efficiency and effectiveness of service delivery at all levels; and improving responsiveness to the client needs
2. To reduce unmet need for contraception, unplanned births as well as socio-economic disparities in access to and use of contraception
3. To strengthen management of miscarriage and post-abortion care as an integral component of comprehensive reproductive health services
4. To expand access to RTI/STI/HIV services within RH programmes, reduce transmission of RTI/STI/HIV including prevention of mother to child transmission of syphilis and HIV
5. To expand reproductive health information and services for adolescents and youth
6. To increase services for screening and treatment of cervical cancer, and
7. To support access to investigation and management of the infertile couple.

An essential package of RH interventions for provision at health centres and township hospitals and in the community has been defined to provide continuous care across life cycle and from home to hospital. The package includes on-going activities that will be expanded as well as additional services that will be introduced in the Basic Health services of the public sector.

The strategies and key activities for effective and efficient implementation are as follows:

1. Strengthening health systems to enhance the provision of an essential package of RH interventions
2. Increasing access to quality, integrated RH services at all levels of care
3. Engaging the community in promotion and delivery of RH
4. Incorporating gender perspectives in the RH Strategic Plan, and
5. Integrating RH in humanitarian settings.

A broad multi-sectoral approach will be adopted in implementing the Strategic Plan for RH. The Reproductive Health Programme will collaborate with other departments and divisions under MoH and will partner with other ministries, professional associations, academia, United Nations agencies, bilateral donors and civil society organizations including NGOs.

The Myanmar Health Sector Coordinating Committee (MHSCC) which is multi-sectoral in nature with participation of representatives of different government ministries, UN agencies, international organizations, donors, international and local NGOs and the private sector will co-ordinate the implementation of the Strategic Plan for RH.

Financial resources and non-financial resources are required to support the implementation of RH interventions. Advocacy will be conducted to obtain commitment and resources from development partners and other agencies for the thematic components of the Strategic Plan.

Monitoring of the Strategic Plan will indicate progress towards and achievement of expected results. The Mid-term Review will allow assessment of the implementation status, management issues and budget expenditure. The final evaluation will determine whether the interventions have had an impact and whether the implementation of the programme has been successful.

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List of Acronyms

AAAQ	Availability, Accessibility, Acceptability and Quality
AEM	AIDS/Asia Epidemiological Model
AIDS	Acquired Immune Deficiency Syndrome
AMW	Auxiliary Midwife
ANC	Antenatal care
ARH	Adolescent Reproductive Health
ART	Antiretroviral therapy
ASEAN	Association of South-East Asian Nations
AusAID	Australian Aid
BCC	Behavioural change communication
BEmONC	Basic Emergency Obstetric and Newborn Care
BHS	Basic Health Staff
BSS	Behavioural Surveillance Survey
CBO	Community-based organization
CEDAW Women	Convention to Eliminate All Forms of Discrimination Against Women
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CSO	Civil society organization
DoH	Department of Health
DSW	Department of Social Welfare
EPI	Expanded Programme of Immunization
FBO	Faith-based organization
FESR	Framework for Economic and Social Reforms
FRHS	Fertility and Reproductive Health Survey
GBV	Gender-based Violence
GEN	Gender Equality Network
GoM	Government of the Republic of the Union of Myanmar/ Government of Myanmar
HCT	HIV counseling and testing
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
HSS	HIV Sentinel Sero-surveillance
ICPD PoA	Programme of Action of the International Conference on Population and Development
IEC	Information, Education and Communication
IHLCA	Integrated Household Living Conditions Assessment
IOM	International Organization for Migration
IUD	Intra-uterine contraceptive device
JICA	Japan International Cooperation Agency
JOICFP	Japanese Organization for International Cooperation in Family Planning
KAP	Key Affected Populations
M-CCM	Myanmar Country Coordinating Mechanism
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MHSCC	Myanmar Health Sector Coordinating Committee
MICS	Multiple Indicator Cluster Survey
MISP	Minimum Initial Service Package
MMEIG	Maternal Mortality Estimation Inter-Agency Group

MMCWA	Myanmar Maternal and Child Welfare Association
MMR	Maternal mortality ratio
MNMA	Myanmar Nurses and Midwives Association
MNCWA	Myanmar National Committee of Women's Affairs
MoH	Ministry of Health
MSWRR	Ministry of Social Welfare, Relief and Resettlement
MVA	Manual Vacuum Aspiration
MW	Midwife
MWAF	Myanmar Women's Affairs Federation
MyMA	Myanmar Medical Association
NAP	National AIDS Programme
NGO	Non-government organization
NMCP	National Malaria Control Programme
NNMR	Neonatal Mortality Rate
NNC	National Nutrition Centre
NSPAW	The National Strategic Plan for Advancement of Women
ODA	Official Development Assistance
OECD	Organization for Economic Co-operation and Development
OECD-DAC	OECD's Development Assistance Committee
PAC	Post-abortion care
PCFS	Population Changes and Fertility Survey
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PPH	Post-partum haemorrhage
RH	Reproductive health
RHC	Rural Health Centre
SBA	Skilled Birth Attendant
SOP	Standard Operating Procedures
TB	Tuberculosis
TBA	Traditional Birth Attendant
TMO	Township Medical Officer
TSG	Technical and Strategy Group
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VAW	Violence Against Women
VHW	Voluntary Health Worker
VIA	Visual Inspection with Acetic Acid
WCHD	Women and Child Health Development
WHO	World Health Organization
3DF	Three Diseases Fund
3MDG Fund	Three Millennium Development Goal Fund

1. Introduction

The health of women and children features prominently in the National Population Policy (Annex 1). This policy, in turn, provides direction to the National Health Policy (Annex 2). The Government of Myanmar has made a strong commitment to the achievement of the goals of the Programme of Action of the International Conference on Population and Development (ICPD PoA) and the Millennium Development Goals (MDGs), as well as other international development goals and targets.

The Reproductive Health Policy (Annex 3) and Strategic Plans on Reproductive Health (2004-2008 and 2009-2013) of the Ministry of Health (MoH) are a national response to the ICPD PoA and MDGs. The Policy and Strategic Plans defined the focus and prioritised the reproductive health components for implementation by MoH and relevant ministries. The Public Health Division, Department of Health (DoH) and the National Reproductive Health Programme led the efforts in the implementation of the Strategic Plans. As a result, Myanmar has made good progress towards the ICPD goals and MDGs in the past years with improvements in coverage and quality of maternal and child health and birth spacing services. Furthermore, Myanmar has also committed to the United Nations Secretary General's Global Strategy for Women's and Children's Health in 2010 and Family Planning 2020 in 2013.

However, despite political commitment and continuous efforts by MoH and its partners, the status of reproductive health in Myanmar remains to be improved further. The government recognizes maternal and newborn health as a priority and a central component in reproductive health together with other core elements of the WHO Global Reproductive Health Strategy. Concerted efforts are required in order to expedite the progress towards improving maternal and newborn health and achieving universal access to reproductive health.

In 2013, the Department of Health reviewed the implementation of the 2009-2013 Strategic Plan for Reproductive Health and conducted an analysis of stakeholders working in the area of RH. The main recommendations of the review of the 2009-2013 Strategic Plan for RH and the findings of the Stakeholder Analysis were taken into account in the formulation of the 2014-2018 Strategic Plan for RH.

The Department of Health took a leadership role in the formulation of the Strategic Plan for Reproductive Health (2014-2018). Directors and responsible staff from the Departments and Divisions under MoH, representatives from Township Health Departments, and representatives of NGOs, professional associations, academia and UN agencies contributed to the development of the Strategic Plan for Reproductive Health.

The Strategic Plan for Reproductive Health 2014-2018:

- provides information on the reproductive health situation in Myanmar;
- identifies key challenges and opportunities;
- describes the strategies, key activities and partnerships towards the attainment of the goals and objectives of the Strategic Plan;
- outlines plans for implementation and coordination; and monitoring and evaluation for tracking progress towards targets set for reproductive health by the year 2018 and
- indicates the estimated budget required for full implementation of the Strategic Plan.

2. Country Context

2.1 Geography and demographic profile

Myanmar covers an area of 676,578 square kilometers and is the western most country in South-East Asia. Myanmar shares borders with the People's Republic of China on the north and northeast; with Lao People's Democratic Republic and the Kingdom of Thailand on the east and southeast, the People's Republic of Bangladesh and the Republic of India on the west. 1760 miles of the coast-line is bounded on the west by the Bay of Bengal and on the south by the Andaman Sea.

The country is divided administratively into Nay Pyi Taw Union Territory and (14) States and Regions. These are further organized into (70) districts, (330) townships, (84) sub-townships, (398) towns, (3063) wards, (13,618) village tracts and (64,134) villages.

In 2011-2012 the population of Myanmar was estimated at 60.38 million with a growth rate of 1.01 percent. About 70 percent of the population resides in the rural areas, whereas the remaining are urban dwellers. The population density for the whole country is 89 per square kilometers. Sixty-two percent of the population is between the age of 15-59 years, 0-14 year group comprise 29.2 percent and those 60 years and above form 8.8 percent of the population².

In 2009, the Central Statistical Organization estimated that half of the population is between the ages of 15 to 49 years and women of reproductive age constitute approximately 30 percent³.

The Republic of the Union of Myanmar is made up of (135) national races speaking over 100 languages and dialects. The major ethnic groups are Bamar, Chin, Kachin, Kayah, Kayin, Mon, Rakkhine and Shan. The large majority of the population is Buddhists, while the rest are Christians, Hindus and Muslims.

2.2 Health System Infrastructure

The Ministry of Health is responsible for raising the health status of the people and accomplishes this through provision of comprehensive health services: promotive, preventive, curative and rehabilitative measures. The Union Minister who is assisted by two Union Deputy Ministers heads the Ministry of Health. The Ministry has seven departments, each under a Director-General.

The Department of Health (DoH) is responsible for providing comprehensive health care services to the entire population in the country. There are 11 divisions under DoH. Among these divisions, the Public Health Division is responsible for primary health care and basic health services, nutrition promotion and research, maternal and child health services, school health services and health education. The Medical Care Division is responsible for setting specific goals for hospitals and management of hospital services. The Department of Health Planning comprises of (5) divisions among which are the Planning Division and the Health Information Division. The Department of Medical Science is responsible for carrying out training and production of all categories of health personnel to have an appropriate mix of competent human resources for delivering quality health services. The Department of Traditional Medicine provides traditional medicine services through the existing health care and reviews and explores means to develop safe and efficacious new therapeutic agents and medicine. (Figure 2.1)

The Township Health System is the backbone of the Myanmar Health System. The Township Health Department provides primary and secondary health care services down to the grassroots level. It usually covers 100,000 to 200,000 population. Under the Township Health Department, there are Urban Health Centres, School Health Team, Maternal and Child Health Team, one to three Station Health Units and four to five Rural Health Centers (RHCs).

¹Health in Myanmar 2013, Ministry of Health

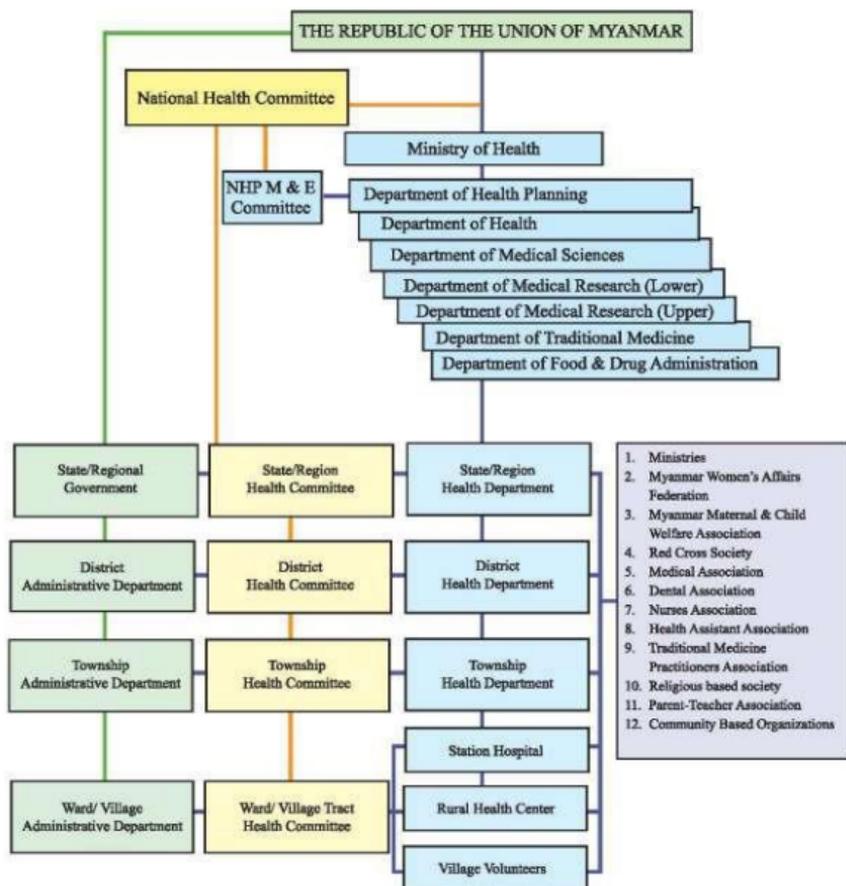
²Population Department, Ministry of Immigration and Population, 2013

³Statistical Yearbook 2008, Central Statistical Organization, Ministry of National Planning and Economic Development

In the Township Health Department, the Township Medical Officer (TMO) is the key person managing health care delivery and is also responsible for administration and implementation of health care activities. Each township has four to five Rural Health Centers and each RHC has four sub-RHCs. One Health Assistant, one Lady Health Visitor, five Public Health Supervisors Grade II and five Midwives (MWs) staff each RHC. They are not only responsible for providing public health, disease control and curative health services but also have administrative and managerial functions. At the village level, voluntary health workers (VHW) provide delivery of and linkages to health services. A midwife located at a sub-rural health centre supervises VHWs - auxiliary midwives and community health workers.

Referral hospitals at the district level with medical specialists including an obstetrician/gynecologist and a pediatrician provide specialized services to townships under the jurisdiction of the district.

Figure 2.1 Health System Infrastructure



Source: Health in Myanmar 2013, Ministry of Health

2.3 Health Policies

The National Health Policy (Annex 2) was developed following the initiation by and guidance from the National Health Committee in 1993. The National Health Policy has placed the "Health For All" goal using Primary Health Care approach as the key objective.

The National Health Committee (NHC) is a high level inter-ministerial and policy-making body concerning health matters. This Committee takes a leadership role and gives guidance in implementing the health programmes systematically and efficiently. The high level policy-making body is instrumental in providing the mechanism for inter-sectoral collaboration and co-ordination and provides guidance and direction for all health activities.

Myanmar Health Vision 2030 (2000-2001 to 2030-2031) (Annex 4) comprises of nine main areas: health policy and law; health promotion; health service provision; development of human resources for health; promotion of traditional medicine; development of health research; role of co-operative, joint ventures, private sectors and NGOs; partnership for health system development; and international collaboration.

The National Comprehensive Development Plan - Health Sector (2010-2011 to 2030-2031) links with related sectors as well as also link with the States and Regional Comprehensive Development Plans. This long-term visionary plan with its objectives will be a guide on which further short-term national health plans are to be developed.

The Ministry of Health has formulated National Health Plan (2011-2016) which was prepared within the framework of National Development Plans for the corresponding period. National plans and strategic approaches in the key programme areas contribute to the realization of the overarching national development plans.

It is widely acknowledged that reproductive health is an indispensable accelerator of sustainable development and investing in universal access to sexual and reproductive health is therefore a crucial investment in healthy societies and a more sustainable future. Access to reproductive health is crucial to achieving national and international development goals as well as realizing vision 2030.

3. Reproductive Health Situation

This section provides an overview of the current situation in relation to a range of reproductive health components. These are maternal and newborn care; birth spacing/family planning; post-abortion care; reproductive tract infections (RTIs), including sexually transmitted infections (STIs) and HIV/AIDS; adolescent and youth reproductive health; gynaecological cancers and infertility, gender mainstreaming and RH in humanitarian settings.

3.1 Maternal and Newborn Health

Maternal Mortality Ratio

According to the estimates of the Maternal Mortality Estimation Inter-Agency Group (MMEIG), Myanmar's MMR stood at 580 per 100,000 live births in 1990 and has decreased to 200(120-350) per 100,000 live births in 2013. This estimate is consistent with the figure of 192 for 2011 MMR reported by the Health Management Information System (HMIS).

Post-partum haemorrhage, eclampsia and abortion-related mortality remain the major causes of maternal deaths in Myanmar (Figure 3.1).⁴ Three quarters of all maternal deaths occur during delivery and the immediate post-partum period. In addition to these direct causes of maternal mortality, a number of household and community level factors as well as social factors such as the nutrition of girls and women and women's educational levels; underpin the high levels of maternal mortality. Further contributing to maternal mortality are weak infrastructure, poor reach of health services and limited access to information.

The Integrated Household Living Conditions Assessment⁵ and the Multiple Indicator Cluster Survey⁶ (MICS) conducted in 2009-2013 provide information on selected indicators on MDG4 - Reduce Child Mortality and MDG5 - Improve Maternal Health. Both Surveys highlight differences in indicators between rural and urban areas and among States/Regions and disparities in the coverage of health interventions.

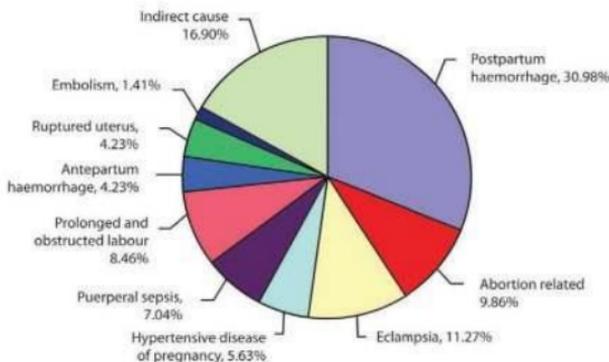
Neonatal Mortality Rate

In 1990, the Neonatal Mortality Rate was estimated to be 42 per 1,000 live births. It fell to 30 per 1,000 live births in 2010. The 2002-2003 nation-wide cause specific under-five mortality survey found that the principal causes of neonatal mortality (under 28 days of age) were prematurity (30.9 percent), birth asphyxia (24.5 percent) and sepsis, including pneumonia (25.5 percent). The 2009-2010 MICS reported that low birth weight prevalence was 8.6 percent.

⁴Nation-wide cause specific maternal mortality survey (2004-2005) UNICEF and Department of Health

⁵Ministry of National Planning and Economic Development, SIDA, UNDP and UNICEF, "Integrated Household Living Conditions Survey in Myanmar 2009-2010 - MDG Data Report," June 2011

⁶Ministry of National Planning and Economic Development, Ministry of Health and UNICEF: "Myanmar Multiple Indicator Cluster Survey 2009-2010", October 2011

Figure 3.1: Major causes of maternal mortality in Myanmar

Source: Nation-wide cause specific maternal mortality survey (2004-2005) UNICEF and Department of Health

Skilled attendance at birth

The 2011 Public Health Statistics Report indicated that the proportion of skilled attendance at birth was estimated at 52 percent in 1990 and 67 percent in 2011. There has been a marginal increase from 64 percent during 2006-2009. The 2009-2010 Multiple Indicator Cluster Survey⁷ validates these estimates according to which, in the two years prior to the survey a skilled attendant, namely a doctor, nurse or midwife, attended to nearly 71 per cent of births. The Survey reports that slightly over a third of the births (36 percent) was attended to by midwives. Doctors assisted with 28 percent of births, traditional birth attendants with 18 percent of births, auxiliary midwives with 8 per cent of births, and Lady Health Visitors/nurses assisted with 6 percent of births. The proportion of skilled attendance at birth was higher (90 percent) in urban than in rural areas (63 percent). The lowest proportion of births attended by skilled personnel (59 percent) was reported among adolescent girls aged 15-19 years. The 2009-2010 MICS also revealed differentials across states and regions.

Antenatal care

The coverage of antenatal care (one or more visits) for Myanmar is reported to be 74 percent in 2011⁸. The lowest rates were reported for Chin and Sagaing. The percentage of women receiving no antenatal care was lowest in Yangon Region (4.2 percent) and highest in Rakhine State (40.8 percent). The 2007 Fertility and Reproductive Health Survey (FRHS) also reported that 66 percent of women received care from midwives and 13.6 percent from doctors. The 2009-2010 MICS reports similar findings: 83 percent of women receive care from a skilled provider, with the levels of antenatal care from a skilled provider ranging from 50 percent in Chin and 54 percent in Shan (North) to 96.7 percent in Mon. The number of antenatal visits and the type of delivery are positively influenced by higher education and higher wealth quintiles.

According to the 2007 FRHS, approximately a quarter of women had four antenatal visits. However, the timing and content of the visits were not mentioned. 2009-2010 MICS, noted that among women who received antenatal care one or more times during their pregnancy, 80 percent had their blood pressure measured, 57 percent had a urine sample taken, 64 percent had their weight measured, and 84 per cent received iron tablets. Immunization with tetanus toxoid has improved through antenatal contacts.

⁷Ministry of National Planning and Economic Development, Ministry of Health and UNICEF: "Myanmar Multiple Indicator Cluster Survey 2009-2010", October 2011

⁸Public Health Statistics Report, 2011

The prevalence of anaemia is high in pregnant women, and estimated to be at approximately 70 percent⁸. The underlying cause in the majority of women is iron deficiency anaemia but the high prevalence of haemoglobinopathies and Thalaesaemia traits in the community also contribute.

Through the concerted efforts of National AIDS Programme, RH Programme, UNICEF, UNFPA and Global Fund, interventions for Prevention of Mother to Child Transmission of HIV currently reach 256 townships and 38 hospitals.

On-going Programmes

Antenatal care is provided at all levels of the health care system, specifically by midwives at the primary health care level while health promotion for maternal and newborn health is also carried out by INGOs and NGOs.

Many initiatives are in place to increase referrals for emergency obstetric care which range from awareness raising on "danger signs" reinforced by community support groups in over 130 townships (DoH, Myanmar Maternal and Child Welfare Association and MyMA initiatives) and assistance during emergencies (Red Cross and MMCWA). In some NGO project townships funds to cover costs for emergency referrals are provided. Midwives provide elements of the signal functions of Basic emergency obstetric and newborn care¹⁰; while Comprehensive emergency obstetric and newborn care is provided at Township and Station Hospitals.

As per the Five-Year Strategic Plan for Child Health Development in Myanmar (2010 - 2014), Essential Newborn Care, Home-based Newborn Care and Integrated Management of Newborn and Childhood Illnesses (IMNCI) are provided. From 2012, neonatal resuscitation has been strengthened in one third of the townships.

The development of Information, Education and Communication (IEC) materials and the conduct of Behavioural Change Communications (BCC) activities are carried out by a range of stakeholders: DoH, NGOs and INGOs. Although the programmes are conducted nation-wide by DoH, improved outcomes are more evident where there are focused programmes for vulnerable populations. Male involvement in reproductive health, particularly for decision-making and support is promoted by the Department of Health and NGOs.

Translation of IEC materials into the Chin and Shan indigenous languages has been conducted and IEC/BCC activities were intensified in 132 townships in Chin, Kachin, Kayin, Mon, Rakhine and Shan States.

Iron and folate supplementation and nutrition education are the main strategies for anaemia control and approximately 70 percent of pregnant women receive supplementation in the last three months of pregnancy.

3.2 Birth Spacing

According to the 2007 FRHS (2009), the Total Fertility Rate of women aged 15 – 49 years is two births per woman and is lower for urban than rural women (1.7 and 2.2). The same survey reported that 38 percent of married women were using contraceptives - 49 percent among urban and 34 percent among rural users. Successive surveys on fertility and reproductive health reveal a steady increase in contraceptive prevalence rates: 28 percent in 1997¹¹ to 33 percent in 2001¹² and 38 percent in 2007¹³.

The most popular contraceptive method is the hormonal injection, which is used by 19 percent followed by the daily pill (10 percent), female sterilization (4 percent) and IUD (2 percent). Other methods including the male condom, the lactational amenorrhoea method, abstinence and withdrawal comprise less than one percent. The 2007 FRHS also noted that a high percentage of women have knowledge of birth spacing methods. However, women aged 15-19 have the lowest scores for knowledge of methods as well as source of supplies. The increase in knowledge is one of the contributing factors leading to the increase in contraception prevalence rate.

⁸National micronutrient survey, National Nutrition Centre, Ministry of Health 2003

¹⁰Administer parenteral antibiotics, uterotonic drugs (parenteral oxytocin) and parenteral anticonvulsants for pre-eclampsia and eclampsia (i.e. magnesium sulfate) and perform basic neonatal resuscitation (e.g., with bag and mask).

¹¹1997 Population Changes and Fertility Survey

¹²2001 Fertility and Reproductive Health survey

¹³2007 Fertility and Reproductive Health survey

Data on unmet need for family planning are available from the 1997 Population Changes and Fertility Survey and 2007 Fertility and Reproductive Health Survey. According to the 2007 FRHS, unmet need for contraception among currently married women decreased from 19.1 percent in 1997 to 17.7 percent in 2007. For 2007, the unmet need for spacing was 4.9 percent and unmet need for limiting was 12.8 percent.

On-going Programmes

Information and services for birth spacing are provided both in the public and private sector and at NGO and INGO clinics. One hundred and thirty-two townships receive additional support for contraceptive commodities. INGOs collaborate with general practitioners for birth spacing services in clinics in urban and peri-urban areas, some through social franchising; and others through fixed and outreach activities.

3.3 Miscarriage and its complications

The nation-wide Cause Specific Maternal Mortality Survey (2004-2005) estimated miscarriage and abortion-related mortality to be 10 percent. Septicaemia was the leading cause of maternal mortality in 2008 in which septic induced abortion occurring as a result of unsafe abortion is one of the contributing factors (Ministry of Health, 2011).

According to the annual hospital statistics report 2010-2011, the abortion¹⁴ rate per 1,000 pregnancies (livebirths, stillbirths and abortion) is 174/1,000 and the hospital statistics of the Central Women's Hospital, Yangon reported similar data, i.e. that miscarriage and abortion-related admissions to delivery ratio is 1:6. At the same hospital, septic abortion comprises 20-25 percent of abortion admissions. Abortion-related complications led to at least half of the maternal death cases: 7/14 cases (50 percent) in 2009, 13/28 cases (46.4 percent) in 2010 and 14/27 cases (51.85 percent) in 2011. Being a tertiary and teaching hospital, there were low case-fatality rates for abortion: 0.62 percent (7/1136 cases) in 2009, 0.95 percent (13/1363 cases) in 2010 and 1.31 percent (14/1066 cases) in 2011.¹⁵

On-going Programmes

Management of miscarriage and post-abortion complications provided at health facilities and project support is provided in approximately one-third of the townships by multilateral agencies and NGOs. Manual Vacuum Aspiration, which is associated with fewer complications than traditional curettage, has been introduced in a few township hospitals.

Maternal mortality and morbidity caused by septic induced abortion could be reduced by prevention, mainly by providing effective birth spacing/contraception and early diagnosis of post-abortion complications and timely and appropriate treatment including uterine evacuation, pain management, and treatment for suspected infection, post-abortion counseling and birth spacing/contraception that address the client's specific needs.

3.4 Reproductive tract infections/Sexually transmitted infections/ HIV

The HIV Sentinel Sero-surveillance Survey (2012) reported that syphilis rate among the low risk group of the sentinel population tested, i.e. syphilis prevalence among pregnant women was 0.3% (45/13995) and in military recruits was 1.5 percent (11/732).

In 2011, Myanmar engaged in modeling the HIV epidemic using the Asian/AIDS Epidemiological Model (AEM)¹⁶. This model provided estimates of incidence in key populations at risk. The results of the AEM suggest that total incidence has peaked in 1999. Since then there has been a steady decline of cases every year.

¹⁴Includes miscarriage and postabortion complications

¹⁵Hospital Statistics, Central Women's Hospital, Yangon

¹⁶In 2011, the Strategic Information and M&E Working Group developed the final version of the Asian Epidemiological Model (AEM) for Myanmar, which was used to establish the HIV estimations for Myanmar covering the period from 2010 to 2015 including the new infections by transmission route. The nomenclature has now been changed to AIDS Epidemiological Model.

The latest modeling exercise in 2011 estimated the HIV prevalence in the adult population (aged 15 and more) at 0.53 percent. It is estimated that 206,395 people were living with HIV (including adults and children), of which 36 percent were female. While HIV prevalence among Key Affected Populations (KAPs) has declined in recent years, HIV prevalence among KAPs remains significantly higher than among the general population. HIV Sentinel Sero-Surveillance Survey 2012 (HSS) found 7.1 percent prevalence among female sex workers.

The uptake of HIV counselling and testing has increased to reach 256 townships and facility-based coverage for HIV testing during ANC is 50 percent (PMCT Programme Report 2013), while 80 percent of HIV positive pregnant women received ART (Global AIDS Response Progress Report 2013).

On-going Programmes

Antenatal syphilis screening is carried out nation-wide. STI management is provided in 46 townships where STI teams are based. Syndromic management of RTI/STI is provided at public sector health facilities, while many clients avail of services in the private sector. Some NGOs organize STI services through general practitioners clinics, while other NGOs operate in "hot spots" - capital cities of some states and regions and junction towns - which also include interventions for key affected populations in Yangon and Mandalay. The RH Programme collaborates with the National AIDS Programme for HIV and syphilis counseling and testing for pregnant women, and follow-up and treatment as required.

3.5 Adolescent and youth reproductive health

The population under 15 years of age is approximately 30 percent and those aged 15 to 24 years are about 18 percent of the country's population¹⁷. It is estimated that ten percent of adolescents are married.

In 2007, the adolescent birth rate was reported as 16.9 per 1,000 adolescent females, a slight reduction from 17.4 per 1,000 in 2001. Among ever-married girls and women under 49 years, the age at first birth of married girls below 15 years was 1.9 percent and 10 percent below 18 years. The average (mean) age at first birth was 22.8 years (FRHS 2009).

According to 2009-2010 MICS, 7.4 percent of young women and girls aged 15-19 years were currently married, with the proportion being higher at 8.4 percent in rural than in urban areas where it was 5.1 percent. The highest rate of early marriage was found in Shan (East) (22.3 percent). It was also high in Shan (North) (13.7 percent) and Shan (South) (11.2 percent). The lowest rate of early marriage was reported in Sagaing at 4.7 percent. The 2004 Family and Youth Survey reported a significant lack of knowledge among adolescents on health issues including fertility and contraception.

On-going Programmes

School-based programmes for life skills are carried out by Ministry of Education, and NGOs have conducted educational activities on adolescent reproductive health (ARH) at township and community levels. In addition, life skills and training on reproductive health issues are provided at Youth Training Schools that are under the Department of Social Welfare. The Central Health Education Bureau (CHEB) and the Reproductive Health Programme have established Youth Information Corners in Rural Health Centres in 67 townships and Youth friendly health services in 28 townships. Sexual and reproductive health information is provided by NGOs while Youth-friendly information and services have been set up by a few NGOs.

Inadequate financial resources to expand youth-related programmes; education programmes not meeting the needs for RH of young people; limited capacity of human resources. e.g. limited numbers of personnel competent to provide RH information and services; and turnover of trained young people and peers every two

¹⁷Statistical Year Book, Central Statistics Organization, 2011

to three years affect the reach and sustainability of programmes to ensure that adolescents and youth have accurate knowledge of sexual and reproductive health and access to reproductive health services, including HIV prevention services.

3.6 Gynaecological cancer

As in other countries in South-East Asia, breast cancer is the commonest and cervical cancer the second commonest malignancy among women. Data from the Cancer Registry Yangon General Hospital (2007) validates that cervical cancer is the second commonest cancer among women. By the time of diagnosis, the cancer is often advanced and difficult to treat.

On-going Programmes

There is no organized screening programme for cervical cancer. Screening services are opportunistic and carried out as part of a medical check-up for women who attend services at tertiary, regional/state and district hospitals where specialists are based. In most of the hospitals, screening is by Papinocolau smears and in addition, in university hospitals, Visual Inspection with Acetic Acid (VIA) or colposcopy is carried out for diagnosis and local ablative therapy performed for premalignant lesions of the cervix. VIA is a relatively simple, accurate and cost-effective screening technique to identify abnormalities including precursor lesions of the cervix, this procedure can be performed in low-resource settings by primary-level health professionals. VIA is currently being piloted in two townships and is offered in a few clinics by NGOs.

Management of cancer cervix by surgery, radiotherapy or chemotherapy or a combination of treatment modalities is provided at tertiary hospitals and radiotherapy departments and is under the purview of the Division of Medical Care.

3.7 Gender mainstreaming

The National Strategic Plan for Advancement of Women (NSPAW) 2013-2022, prepared by the Ministry of Social Welfare, Relief and Resettlement and the Gender Equality Network, has been officially approved.

The Department of Social Welfare (DSW) has taken initiatives to develop laws on Violence Against Women (VAW) in Myanmar, as part of the broader initiative to effect legal reform in other areas related to and impacting on gender equality¹⁸ (Gender Equality Network 2013). Parliamentarians and multiple stakeholders are currently in consultations on the formulation of an Anti-VAW Law and a nation-wide survey and research on VAW is planned for 2013-2014.

On-going Programmes

Training of Basic Health Staff on gender and health and community training using participatory gender analysis tools has been conducted in 38 townships; and midlevel training on gender sensitive policies, gender mainstreaming activities within projects/programmes have been organized by DoH.

NGOs have initiated projects at community level on engaging men and boys to promote male participation and equal sharing of responsibilities.

3.8 Reproductive health in humanitarian settings

Myanmar has experienced the impact of climate change with an increasing frequency and intensity of natural disasters such as cyclones and flooding. In addition to natural disasters, civil conflict has led to internally displaced persons who require national and international responses for humanitarian assistance to improve the lives of displaced and crises affected populations. Reproductive and gender needs of women and young girls

¹⁸Gender Equality Network. *Developing Anti-Violence Against Women Laws: Discussion Paper Part I. Background Information* 2013

need to be adequately addressed within National Disaster Risk Reduction (DRR) and National Plan of action for Rapid Response to emergencies.

On-going Programmes

Training on Minimum Initial Service Package (MISP) and sensitization on Gender-based Violence (GBV) in emergency situations and provision of Emergency RH Kits have been carried out by DoH and humanitarian actors. Other activities include static and mobile clinics providing RH services that include antenatal care, postnatal care, birth spacing, health education and referral services for Internally displaced persons (IDPs). However, gaps remain to adequately address women's protection and gender issues during emergency preparedness, acute emergency, chronic humanitarian situations and transition and recovery phases.

3.9 Other Issues

Infertility

There is dearth of data on infertility in the Basic Health services. While basic diagnostic infertility services can be provided at the primary and township levels, couples would need to visit Regional and State Hospitals or specialized clinics in the private sector for thorough investigations and management.

People with Disability

A pamphlet on "Reproductive health of people with disability" has been developed. Persons with disability can avail of RH services at health facilities, but special arrangements to improve physical access are limited.

4. Opportunities and Challenges

4.1 Opportunities

4.1.1 Economic and Social Reforms

Framework for Economic and Social Reforms and the health sector

Myanmar has witnessed dramatic and progressive changes over the past few years that are in line with the international development agenda. In general, progress has been made towards the attainment of the MDGs, ICPD and other international goals, particularly over the past two and half years. There has been more improvement in some areas while significant challenges remain for a few. Pursuit of key human development priorities is part of the country's political, economic and institutional reforms that aim to promote democracy, foster peace and generate inclusive growth and development. The notable progress seen in poverty reduction is the core of the Government's commitment to achieve balanced growth, reduce inequalities between the rich and the poor, and narrow the development gap between urban and rural areas. In promoting people-centered development, the Government is committed to according special focus to improvements in education, health and living standards and gender equality.

The Framework for Economic and Social Reforms (2013) noted that Myanmar's health indicators are currently much below those of neighbouring countries and the government will double its commitment in improving health care services and increasing public financing of health in order to meet the health MDGs as soon as possible. The Government of Myanmar recognizes that provision of basic health services is constrained by a lack of access to these services, the poor state of infrastructure, low government expenditure in the health sector, a shortage of health personnel as well as weaknesses in training and gaps in the provision of basic materials and services

To address these problems the government has already begun increasing the level of government expenditure on health both absolutely and as a proportion of the total government budget and will focus on a number of innovative measures in health financing such as a voucher system for maternal and child health care, special funds for destitute mothers, strengthening township-level health financing, and greater cooperation with development partners. Particular attention will be paid to allocating more resources to rural primary health care, communicable disease control and maternal and child health, in view of the acute need to improve health indicators in all these areas. The government is also endeavoring to improve the provision of materials and services to hospitals and expand human resources in line with the newly revised structure of the health departments at the community and primary health care levels.

Official Development Assistance

Until recently, apart from humanitarian assistance, Myanmar received a very low level of development aid as compared to other least developed countries. UNFPA, UNICEF, WHO, JICA and AusAID are among the key international partners providing support to RH, particularly on maternal and newborn health. Over the past two years, in response to the political, economic, social and administrative reforms introduced by the Government, the United States, the European Union, Canada, Australia, Japan and many Development Assistance Committee countries have begun to gradually relax restrictions on Myanmar.

The Three Diseases Fund (3DF) was established following the withdrawal of the Global Fund from Myanmar in 2005. The Fund is supported by Australia, Denmark, the European Commission, the Netherlands, Norway, Sweden and the United Kingdom, and was established to reduce the burden of HIV and AIDS, tuberculosis (TB) and malaria in Myanmar. The ability to work with government partners and a wide range of implementing partners to deliver results was established early on and sustained throughout the 3DF implementation period. It was the single largest contributor to all three disease areas in Myanmar during the period 2007-2011 with a

total amount of US\$138 million. Overall, the 3DF contributed between about one to two thirds of total national targets for the three diseases.¹⁹The 3DF concluded in June 2012 and is being replaced by the Three Millennium Development Goal Fund (3MDG).

The Three Millennium Development Goal Fund will continue to provide joint donor support to address the basic health needs of the most vulnerable people in Myanmar, and expand the scope of support beyond the three diseases to encompass maternal and child health and longer-term sustainability. The 3MDG Fund will be supported through a pooled donor fund. Donor commitment is likely to be in the range of US\$250 million to \$300 million over 5 years.

4.1.2 Commitments to Reproductive Health

Health in Myanmar (2013) highlighted that the following activities needed to be strengthened in order to achieve the Millennium Development Goals 4 and 5 to improve maternal, newborn and child health.

- Providing proper antenatal care
- Promoting skilled and institutional delivery and postnatal care
- Expansion of post-abortion care and quality birth spacing services
- Ensuring Emergency Obstetric Care
- Providing Essential Newborn Care
- Strengthening adolescent reproductive health
- Promoting male involvement in reproductive health
- Focusing on cervical cancer screening, early diagnosis and treatment
- Promoting referral system and community volunteers
- Scaling up of community-based newborn care

Commitment of the Government of Myanmar

Myanmar's commitments to improve the reproductive, maternal and newborn health will contribute to the pledges made to the UN Secretary-General's Global Strategy for Women and Children's Health in 2012 which are reflected in the following targets in 2015:

- 80% antenatal care coverage;
- 80% of births attended by a skilled attendant;
- 70% access to emergency obstetric care;
- 80% coverage for PMTCT integration within MCHcare
- universal childhood immunization,
- increased coverage of newborn care,
- increased contraceptive prevalence and reduced unmet need for contraception,
- improve the midwife to population ratio from 1:5000 to 1:4000, and
- develop a new human resources for health plan for 2012-2015.

Myanmar's commitments to FP 2020 are as follow:

1. Increase CPR from 41 percent to 50 percent by 2015 and above 60 percent by 2020
2. Reduce unmet need to less than 10 percent by 2015 (from 12 percent in 2013)
3. Increase demand satisfaction from 67 percent to 80 percent by 2015
4. Improve method mix with increased use of long acting reversible methods (LARC) and decentralization to districts

Commitment of development partners

The centrality of reproductive health in achieving the health-related MDGs, gender equality and empowerment of women and contributing to poverty reduction has been recognized by development partners and evidenced by increased interest and financial support.

¹⁹Euro Health Group: Final Evaluation of the Three Diseases Fund. Final Report. 15 October 2012.

The commitments and initiatives will need to be translated into programmes to improve RH of women, men and adolescents through health promotion, prevention, curative and rehabilitative care; that provide equitable access to care.

4.1.3 Co-ordination Mechanisms

Myanmar Health Sector Coordinating Mechanism

The Myanmar Country Coordinating Mechanism (M-CCM) was established in 2008. The M-CCM has a mandate to oversee responses to AIDS, tuberculosis and malaria, and since 2012, also for maternal and child health and Health System Strengthening. In November 2012 the M-CCM was broadened into the Myanmar Health Sector Coordinating Committee (MHSCC) reflecting its multi-sectoral nature with broad participation, including representatives of different government ministries, UN agencies, international organizations, donors, international and local NGOs, private sector and people living with HIV – all of them selected by their own constituencies. The Myanmar HSCC also supports coordination among implementing partners on specific health issues such as HIV/AIDS, malaria; and tuberculosis, health system strengthening, reproductive, maternal, newborn and child health (RMNCH) and disaster preparedness via technical and strategic groups.

Reproductive, maternal, newborn and child health technical strategic group (RMNCH-TSG) with three working groups has been formed – the Lead RH Working Group, the Lead Child Health Working Group and the Lead Birth Spacing Working Group.

Involvement of civil society and community-based organizations at local level

National NGOs such as Myanmar Maternal and Child Welfare Association, among others, in partnership with INGOs are increasingly involved in social activities at the community level. Professional organizations such as Myanmar Medical Association and Myanmar Nurses and Midwifery Association and Civil Society Organizations are also engaged in similar activities. Communities themselves plan and conduct activities at their local level depending on their collective needs.

4.2 Challenges

Despite the significant decline in MMR between 1990 and 2010, achieving the national MDG 5 MMR target of 129 per 100,000 live births by 2018 remains a challenge. According to the Public Health Statistics Report 2011, progress in improving women's access to skilled birth attendants has been more or less stagnant at around 64 percent since 2006. More than three quarters (76 percent) of births take place at home. While the coverage of antenatal care (one or more visits) for the country is 74 percent, the proportion of women who have four visits is still low at 22.5 percent. Contraceptive prevalence for modern methods has not increased significantly between the two Fertility and Reproductive Health Surveys conducted in 2001 and 2007. There are also persistent differences among states and regions and by rural-urban residence, age and wealth groups. Challenges to achieving universal access to reproductive health that have been identified by the Ministry of Health²⁰ and the review of the 2009-2013 Strategic Plan are summarized below.

4.2.1 Enhancing equitable access to health care

Geographical and coverage gaps have been identified as a key challenge to improve the health status of target populations²¹. Data and analyses indicate significant disparities between regions and groups in access to, and quality of, health services, particularly affecting ethnic minorities, the urban poor, and people living in rural and remote areas. The Strategic Plan will focus on vulnerable groups to address inequalities and disparities in access through facility-based and outreach services and community-based care and in partnership with civil society.

²⁰Health in Myanmar 2013

²¹Health in Myanmar 2013

²²Thematic Analysis 2011 – Achieving the Millennium Development Goals in Myanmar

4.2.2 Strengthening health systems

The health system is constrained because of weaknesses in management and coordination of services, a need for strengthened information and monitoring system and supply chain management which resulted from low investments in the health care system, both from domestic and international sources²².

MoH will continue the investments in health systems strengthening through addressing human resource constraints, building or upgrading health infrastructure, deepening decentralized health system governance, improving supply systems and logistics, and strengthening the health management information system.

4.2.3 Human resources for reproductive health

Inadequate numbers of health work force at different levels and overload of work for BHS especially midwives have been identified as key barriers in spurring progress to improved RH outcomes (Health in Myanmar, 2013). Other critical workforce issues are and equitable deployment and retention of health staff across regions.

While the midwifery curriculum has been revised and the duration of training increased from 18 months to 24 months, there needs to be a strong emphasis on competency-based training and ensuring an enabling environment for carrying out their responsibilities. The MoH has now deployed one midwife per Rural Health Centre and sub-centre and will endeavour to secure at least one midwife or auxiliary midwife per village to provide professional care. In the meantime, additional auxiliary midwives will be recruited, trained and deployed to improve access to key maternal and newborn interventions through task shifting/sharing.

Regular supervision and mentoring mechanisms for midwives who take on new tasks and AMWs who are assuming additional responsibilities need to be systematically strengthened.

4.2.4 Organization of health service delivery

Assessments have indicated that some health facilities lacked adequate infrastructure, equipment and general maintenance; and premises for priority interventions (such as delivery rooms, maternity, laboratories and operating theatres, etc.) while some equipment have not been replaced for a long period, compromising the quality of care. Linkage of health service provision and communication between different levels of care are other factors affecting the timely referral and response to obstetric and newborn emergencies.

Continuum of care across the life cycle and across different levels of service delivery through integrated service delivery; and support for infrastructure, equipment, supplies and commodities will be required.

4.2.5 Health Financing

The gradual increase in health expenditure in the past few years will need to continue for sustaining on-going programmes and expanding new activities on additional elements in the package of essential interventions RH. Health insurance mechanisms, social protection schemes and voucher schemes will be further considered to address the financial barriers to health care and improve access to services by the poorer segments of the population. The Government is aiming towards universal coverage with the objectives of ensuring equity in access to health services, financial risk protection and improving the quantity and quality of services.

4.2.6 Improving community access to health care

Delays in reaching health facilities can be due not only to remote location and limited infrastructure, but also because of lack of knowledge and availability of transportation. A generally low level of health literacy represents a particular barrier. Empowerment of individuals, particularly women, ethnic minorities and those living in remote, hilly areas, will be critical to promote stronger health-seeking behavior and healthy lifestyles. Health promotion at the community level and increasing knowledge and awareness of reproductive health and rights and services at the community level will increase demand and enhance access to health care by the target population, the family and the community.

5. Goal and Objectives

5.1 Guiding Principles

The Strategic Plan for Reproductive Health will be based on a comprehensive definition of reproductive health as elaborated in the Programme of Action of the International Conference on Population and Development (ICPD PoA), in 1994 (Annex 5a). The definition is underpinned by the principles of international human rights and gender equity. The approach to reproductive health and reproductive health care extends before and beyond the years of reproduction, and is closely associated with socio-cultural factors, gender roles, newborn and child health and the respect and protection of human rights.

The principles that will guide the development, planning and implementation of the Strategic Plan are:

- Implementation in accordance with national development policies, national health plans and in a co-ordinated manner with other national programmes.
- Building on existing programmes and integration in current strategies and programmes.
- Partnership, coordination and joint programming among stakeholders including UN agencies, professional organizations, civil society organizations and communities and others to maximize resources and to avoid duplication of efforts. Roles and responsibilities of all stakeholders and partners will be clearly defined in planning, implementation, and monitoring and evaluation of the activities in order to increase synergy.
- Cost-effective and high impact interventions that promote equitable access to quality, integrated health services will be planned with an emphasis on the poor and most vulnerable groups in rural and underserved areas.
- A life cycle approach will be adopted to improve the physical, mental and social well-being for mothers and children from adolescence, pregnancy to delivery, the immediate postnatal period and childhood.
- Implementation and scaling up of interventions in phases will be ensured, wherever applicable.
- Internationally agreed declarations on the right of all persons to the highest attainable standard of health will be adhered to.
- Promotion of gender equity and equality including engagement of men as partners will be an integral part of programme planning and implementation.

The core elements of RH

The Strategic Plan will develop interventions in accordance with the WHO Global Reproductive Health Strategy. WHO has defined the core elements of RH (Annex 5b) as listed below:

- pregnancy, delivery, postpartum and newborn care;
- family planning;
- prevention of unsafe abortion and post-abortion care;
- RTI/STI/HIV/AIDS, cervical cancer and other gynaecological morbidities; and
- sexual health including ARH.

The elements outlined in the essential package of RH interventions will be conducted at different levels: community, Rural Health Centre and Sub-centre and Maternal and Child Health Centre and Station and Township Hospitals.

An element of RH that will be introduced through the RH programme is cervical cancer screening and treatment of premalignant lesions. Preparedness and response to RH in emergencies will be emphasized while gender issues and engagement of men in RH will be considered as cross-cutting issues.

WHO Health Systems Strengthening Framework

The building blocks of the WHO Health Systems Strengthening Framework, i.e. service delivery; health workforce; information; medical products, vaccines and technologies; financing; and leadership and governance will be referred to in the development of the Strategic Plan.²³

AAAQ Framework

The Strategic Plan will follow the principles of the "AAAQ" framework²⁴ to deliver effective, safe, quality health interventions to those in need. This framework identifies *availability, accessibility, acceptability and quality of health care facilities, goods and services* as essential elements of the right to health.

Availability: The national RH programme will aim to make functioning reproductive health care facilities, goods and services, as well as programmes, available in sufficient quantity within the country.

Accessibility: Reproductive health facilities, goods and services will be accessible to everyone without discrimination. Accessibility has four overlapping dimensions:

- **Non-discrimination:** RH facilities, goods and services will be accessible to all, especially the most marginalized sections of the population.
- **Physical accessibility:** RH facilities, goods and services will be within safe physical reach for all sections of the population, especially marginalized groups, such as those living in poverty, disadvantaged adolescents and youth, out-of-school youth, minorities and indigenous people, women survivors of violence and abuse, women living with HIV, women engaged in sex work, women living with disabilities, refugees and internally displaced persons.
- **Economic accessibility (affordability):** RH facilities, goods and services will be affordable for all. Payment for services will be based on the principle of equity, ensuring that these services are affordable for all, including socially disadvantaged groups.
- **Information accessibility:** accessibility includes the right to seek, receive and impart information and ideas concerning reproductive health issues.

Acceptability: RH facilities, goods and services will be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as designed to respect confidentiality and improve the health status of those concerned.

Quality: As well as being culturally acceptable, RH facilities, goods and services will also be scientifically and medically appropriate and of good quality. This requires, for example, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

5.2 Goal

The goal of the Strategic Plan for Reproductive Health is to attain a better quality of life of the people of the Union of Myanmar by contributing to improved reproductive health status of women, men, adolescents and youth.

5.3 Specific Objectives

The specific objectives are:

1. To reduce rates of maternal, perinatal and neonatal morbidity and mortality by increasing equitable access to maternal and newborn services; improving quality, efficiency and effectiveness of service delivery at all levels; and improving responsiveness to the client needs
2. To reduce unmet need for contraception, unplanned births as well as socio-economic disparities in access to and use of contraception
3. To strengthen management of miscarriage and post-abortion care (PAC) as an integral component of comprehensive reproductive health services

²³Strengthening health systems to improve health outcomes: WHO's Framework for action(2007)

²⁴The Right to Health in International Human Rights Law

4. To expand access to RTI/STI/HIV services within RH programmes, reduce transmission of RTI/STI/HIV including prevention of mother to child transmission of syphilis and HIV.
5. To expand reproductive health information and services for adolescents and youth
6. To increase services for screening and treatment of cervical cancer, and
7. To support access to investigation and management of the infertile couple.

The goals and objectives of the Strategy will contribute to reaching the United Nations Millennium Development Goals and the United Nations Secretary General's Global Strategy for Women's and Children's Health – "Every Woman, Every Child" which Myanmar has subscribed to.

6. Essential Package of Reproductive Health Interventions

To contribute to achieving the goal and specific objectives of the Strategic Plan for RH, key effective interventions organized in packages across the continuum of care will be employed. The Essential Package package of RH interventions includes on-going activities that will be expanded as well as additional services that will be introduced in the Basic Health services of the public sector. Existing services will be strengthened and will be used as entry points for new interventions, looking for maximum synergy. The essential interventions will be delivered to provide continuous care across life stages and from home to hospital.

The core elements of RH that will be addressed in the Essential Package of RH interventions are:

- pregnancy, delivery, postnatal and newborn care;
- birth spacing/family planning;
- miscarriage and post-abortion care;
- RTI/STI/HIV;
- adolescent and youth reproductive health;
- screening and treatment of cervical cancer; and
- investigation and management of the infertile couple.

The reproductive health interventions that will be delivered at the community level and through Basic Health services are detailed in Table (6.1).

Table 6.1 Essential Package of Reproductive Health Interventions

Pregnancy, Delivery, Postnatal, Newborn care	Birth Spacing	Miscarriage and Post-abortion care	RTI/STI/HIV/AIDS	Adolescent and Youth RH	Other elements of RH
<p>Level of Care: Community Level</p> <p>Information and counseling/advice on self care, nutrition, breastfeeding, care during pregnancy, labour and postnatal period and danger signs during the same periods, birth plans, and emergency preparedness. Support for routine care and follow up visits and timely care-seeking for mother and baby.</p> <p>Community-based newborn care²⁸ especially in hard-to-reach areas. Kangaroo mother care as required.</p> <p>Promotion and support for early initiation and exclusive breastfeeding and immunization.</p> <p>Establish referral criteria and mechanisms to health centre (RHC) or township health facility. Feedback provided from health centre or township health facility including information and support for follow-up.</p>	<p>Information and advice on birth spacing. Provision of condoms and oral pills.</p>	<p>Information and advice/counseling on birth spacing, symptoms and signs of miscarriage and dangers of unsafe abortion.</p>	<p>Information and advice/counseling on STI and HIV, and safe sexual behavior.</p>	<p>Information and advice/counseling on safe sexual behavior, prevention of unwanted pregnancy and STI and HIV, nutrition and safe motherhood.</p>	<p>Promote male involvement in safe motherhood, responsible parenthood, birth spacing and RTI/STI/HIV interventions. Awareness of signs of GBV and referral. Information and advice on breast and cervical cancer.</p>

²⁸A package of essential newborn care interventions provided in the first week by community volunteers during home visits.

Level of Care : Primary Health Care at Rural Health Sub-Centre, Rural Health Centre and Maternal and Child Health Centre

<p>All of the above services plus:</p> <p>Pregnancy</p> <ul style="list-style-type: none"> • Confirmation of pregnancy • Monitoring of progress of pregnancy and assessment of maternal and foetal well-being including nutritional status • Detection of problems complicating pregnancy (e.g. anaemia, hypertensive disorders, bleeding, malpresentations, multiple pregnancy) • Respond to reported needs • Tetanus immunization, anaemia prevention and control (iron and folic acid supplementation) • Syphilis testing and treatment of syphilis (woman and spouse/partner) • Treatment of mild to moderate pregnancy complications (mild to moderate anaemia, urinary tract infection, vaginal infection) • Pre-referral treatment of severe complications (pre-eclampsia, eclampsia, bleeding, infection, preterm prelabour rupture of membranes<antibiotics and corticosteroids>) • HIV counseling and testing • Rapid diagnostic tests, anti-malarial treatment and promotion of insecticide treated nets (ITN) 	<ul style="list-style-type: none"> • To increase awareness on sex, birth spacing starting from pre-pregnancy period, during pregnancy and after childbirth²⁶ • Counselling and provision of contraceptive methods including emergency contraception • Dual protection: female and male condoms and other contraceptives 	<ul style="list-style-type: none"> • Information and advice/counseling on STI and HIV, and safe sexual behavior. • Syndromic management of RTI/STIs • HIV counselling and testing • Condom promotion and provision 	<ul style="list-style-type: none"> • Information and advice/counseling on STI and HIV and RH commodities. • Peer education and outreach activities in the catchment area according to National Guide-lines. • Youth-friendly RH services/ RH service delivery corner for adolescents and youth in the health facility with provision of educational materials, supplies and equipment and RH commodities. 	<p>Breast and cervical cancer</p> <p>Information and advice/counseling on breast and cervical cancer.</p> <p>VIA for cervical cancer screening.</p> <p>Male involvement</p> <p>Promote male involvement in safe motherhood, responsible parenthood, birth spacing and RTI/STI/HIV interventions</p> <p>Gender-based violence</p> <p>Assessment, immediate response and referral.</p> <p>Infertility</p> <p>Identification of initial needs of the infertile couple, and referral.</p> <p>Individuals with disability</p> <p>Persons with disability have access to RH services</p>
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²⁶Packages of interventions for family planning, safe abortion care, maternal, newborn and child health, WHO 2010

<p><i>Delivery</i></p> <ul style="list-style-type: none"> • Diagnosis of labour • Monitoring progress of labour, maternal and foetal wellbeing with partograph • Social support during labour (companion of choice) • Infection prevention • Supportive care and pain relief • Detection of problems and referral (e.g. malpresentations, prolonged and/or obstructed labour, hypertension, bleeding, and infection) • Pre-referral management of serious complications (e.g. obstructed labour, foetal distress, preterm labour, severe peri- and postpartum haemorrhage - PPH) • Active management of third stage of labour with oxytocin or oral misoprostol to prevent PPH • Delivery and immediate care of the newborn baby • Early initiation of breastfeeding • Hygienic cord and skin care • Thermal protection 			
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<ul style="list-style-type: none"> • Newborn resuscitation (bag and mask) • Rooming in • Eye infection prophylaxis • Immunization • Treatment of congenital syphilis • Monitoring and assessment of wellbeing of newborn and response to maternal concerns • Prevention of mother to child transmission of HIV (PMTCT) • antiretroviral therapy (ART), infant feeding, mode of delivery advice <p><i>Postnatal care</i></p> <ul style="list-style-type: none"> • Emotional support • Monitoring and assessment of maternal and newborn wellbeing, prevention and detection of complications • Nutritional counselling • Treatment of anaemia • Promotion, protection and support for exclusive breastfeeding • Treatment of abnormalities and complications (e.g. episiotomy, repair of genital tears and manual removal of placenta) • Counselling and services for birth spacing/family planning • Detection of danger signs in mother and newborn and early referral • Pre-referral treatment of complications (e.g. severe postpartum bleeding, puerperal sepsis and neonatal sepsis) 					
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<ul style="list-style-type: none"> • Facilitate birth registration <p>Life-saving interventions for PPH, eclampsia and severe pre-eclampsia and sepsis in hard-to-reach areas.</p> <p>Early identification and initiation of antibiotics for neonatal pneumonia and referral.</p> <p>Recording and reporting throughout pregnancy, delivery and postnatal period (mother and newborn).</p> <p>Use of Maternity Waiting Home/Maternity Waiting Area during pregnancy, delivery and postnatal period.</p> <p><i>Referral mechanisms</i> Establish of referral criteria and mechanisms to township health facility. Feedback provided from township health facility including information and support for follow-up.</p>					
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Level of Care: Township level (Station Hospital and Township Hospital)

Comprehensive emergency obstetric and newborn care facility

<p>All of the above services plus:</p> <p>Pregnancy</p> <ul style="list-style-type: none"> • Treatment of severe pregnancy complications (anaemia, severe pre-eclampsia, eclampsia, bleeding, infection, other medical complications) • Management of mal-presentations, multiple pregnancy • Management of preterm rupture of membranes (antibiotics, corticosteroids and referral as appropriate) 	<p>All of the above services plus:</p> <ul style="list-style-type: none"> • Insertion of IUDs • Tubal ligation, insertion and removal of implants 	<p>Station Hospital</p> <ul style="list-style-type: none"> • Uterine evacuation for incomplete abortion (MVA) • Diagnosis and treatment of common complications (infection, bleeding or injury) • Pain control • Diagnosis and treatment of STIs/HIV • Post-abortion counseling and services (psycho-social support and contraception/ birth spacing as appropriate). <p>Township Hospital All of the above services plus:</p>	<p>Station Hospital,</p> <ul style="list-style-type: none"> • Diagnosis and treatment of STIs/ RTIs • Rapid diagnostic tests for syphilis • Treatment of syphilis of pregnant women and partner, follow-up for newborn • HIV counseling and testing and referral for ART • Referral of complicated cases to higher level <p>Township Hospital All of the above services plus:</p> <ul style="list-style-type: none"> • Confirmatory tests for syphilis • Prevention of unintended pregnancies in HIV positive mothers through family planning (including couple 	<ul style="list-style-type: none"> • Youth-friendly RH services/ delivery corner for adolescents and youth in the health facility with provision of educational materials, supplies and equipment and RH commodities. • Peer education and outreach activities in the catchment area according to National Guide-lines. 	<p>Cervical Cancer Screening and treatment of precancerous lesions (Visual Inspection with Acetic Acid) and cryotherapy.</p> <p>Gender-based violence Assessment, response, referral, and follow-up clinical interventions and emotional support</p> <p>Infertility Clinical assessment and basic laboratory tests for the infertile couple Referral to higher level facility</p> <p>Individuals with disability Persons with disability have access to RH services</p>
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Labour

- Induction and augmentation of labour
- Treatment of abnormalities and complications (e.g. prolonged labour, vacuum extraction, breech presentation, multiple pregnancy repair of episiotomy and genital tears, manual removal of placenta)
- Treatment of severe complications in childbirth and in immediate postpartum period (caesarean section, blood transfusion and hysterectomy)
- Management of preterm labour
- Management of other obstetric complications

<p>Postnatal</p> <ul style="list-style-type: none"> • Assessment of maternal wellbeing including maternal nutrition • Prevention and detection of complications (e.g. infections, bleeding, anaemia) • Treatment of anaemia (mild to severe), mild puerperal depression, mastitis <p>Management of newborn</p> <ul style="list-style-type: none"> • Vitamin K • Resuscitation for birth asphyxia • Kangaroo mother care for preterm and babies <2000 grammes <p>Management of newborn with severe problems: general care of a sick newborn and specific care for:</p> <ul style="list-style-type: none"> • Preterm babies with breathing problem or unable to feed orally • Severe infection (pneumonia) • Severe birth asphyxia • Others: severe jaundice, malformations <p>Recording and reporting throughout pregnancy, delivery and postnatal period (mother and newborn)</p> <p>Use of Maternity Waiting Home/Area during pregnancy, delivery and postnatal period</p>		<ul style="list-style-type: none"> • Management of severe complications (haemorrhage, infection, injury) 	<p>provision of contraceptives of couple's choice and condoms for dual STI and pregnancy protection</p> <ul style="list-style-type: none"> • Referral for couples wishing to have children • Targeted interventions for high-risk populations (with NAP) 		
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7. Strategies and Key Activities

Effective implementation of the Strategic Plan for Reproductive Health will require a multi-sectoral approach, and the contribution of all actors in the health sector is essential. A number of cross-cutting strategies will be employed for effective implementation of specific interventions targeting the various components of Reproductive Health.

Efficient and effective delivery of RH services will require availability of adequate financial resources to support infrastructure development and maintenance; sustainable procurement system for drugs, commodities and other medical supplies; and a well-motivated and committed health workforce, with relevant skills and competencies, in the right numbers, at all levels of care.

The strategies and key activities for implementation are grouped as follows:

1. Strengthening health systems to enhance the provision of an essential package of RH interventions
2. Increasing access to quality, integrated RH services at all levels of care
3. Engaging the community in promotion of RH and service delivery
4. Incorporating gender perspectives in the RH Strategic Plan, and
5. Integrating RH in humanitarian settings.

7.1 Strategies and Key Activities for Implementation

Strategies	Key Activities
7.1.1 Strengthen Health Systems to enhance the provision of an essential package of RH interventions	
1.1 Reinforce an enabling environment for reproductive health	<p>Develop advocacy toolkit and materials for decision-makers at central, regional/state and township levels on the role of RH in achieving international development goals, RH, MNH, birth spacing/FP, ARH and cervical cancer screening.</p> <p>Conduct advocacy at the central, regional/state and township levels for increased budgetary allocation and/or resource mobilization for RH interventions.</p> <p>Review/update operational policies to ensure an enabling regulatory framework for service provision by midwives and ANMs so that they can facilitate universal and equitable access to RH information and services. (Components of BEMONC and RTI services, syphilis screening and treatment and PWTCT by midwives; and selected components of BEMONC and birth spacing/FP service provision by ANM)</p> <p>Establish and strengthen partnerships and linkages for commitment to and co-ordinated implementation of the Strategic Plan.</p> <ul style="list-style-type: none"> - Co-ordination with Regional/State governments and other national organizations/institutes, including NGOs who are primarily responsible for the implementation of the Strategy. - Strengthen co-ordination and intensify integrated service delivery modalities with other departments and key programmes under the DoH (e.g. Women and Child Health Development Section, National AIDS Programme, National Nutrition Centre, Central Health Education Bureau(s)). - Mobilize crucial constituencies (e.g. health professionals, women's and faith-based organizations and community leaders) to support a national reproductive health agenda. - Continue inter-sectoral collaboration and partnerships with the United Nations and other development partners through Myanmar Health Sector Co-ordinating Committee.
1.2 Ensure availability of human resources for RH services	<p>Implement national health workforce strategies and plans for workforce development – Human Resources for Health Plan.</p> <p>Build managerial capacity of township health managers.</p> <p>Consider the range, skills/mix and gender balance of health workers (health service providers and management and support workers) needed to deliver the essential package of services.</p>

Strategies	Key Activities
	<p>Consider rational redistribution of tasks among health workforce teams (task shifting/sharing) as one method of strengthening and expanding the health workforce to rapidly increase access to health services. Task shifting/sharing - moving appropriate tasks to less specialized health care workers- will enable MW to focus on maternal and newborn care.</p> <p>Address health workforce education, recruitment, retention and performance and define regulatory options to improve quality of practice, such as licensing and accreditation.</p> <p>Advocate for appropriate deployment and performance incentives.</p> <p>Review the distribution of community health volunteers across villages and townships to ensure that this distribution is rational and cost effective and sustainable.</p> <p>Review of the roles and responsibilities of Auxiliary Midwives in the priority interventions for newborns and mothers and for family planning.</p> <p>Provide incentives to volunteers to compensate for their reduced opportunities for livelihood activities.</p>
<p>1.3 Improve basic infrastructure and strengthen logistics and management systems</p>	<p>Conduct facility assessment to identify the infrastructure and maintenance requirements and supply needs for the provision of the essential package of RH interventions.</p> <p>Improve existing (renovation and refurbishment) or establish new infrastructure/facilities.</p> <p>Advocate for establishment of a supply chain management system, increased budget allocation and uninterrupted availability of commodities.</p> <p>Establish a RH Logistics Management Unit and well-designed supply chain management system with effective logistic management information system and inventory control system for projections, forecasting, procurement, supply, warehousing and distribution of RH commodities.</p> <p>Develop standard operating procedures (SOP) manual and training materials. Train staff on how to use the SOPs.</p> <p>Conduct resource mobilization for computerization of RH Logistics Management Information System (LMS) and continuous monitoring and evaluation for functionality, and to be integrated into national supply chain management system.</p>

Strategies	Key Activities
<p>1.4 Increase utilization of information from monitoring and evaluation, health information systems and other sources and research</p>	<p>Production, analysis, dissemination and use of reliable and timely information on health system performance and health status. (Reproductive Health Programme in collaboration with Division of Health Planning, Department of Planning and Statistics)</p> <p>Review and refine indicators that will reflect scope of coverage and quality; e.g. postnatal care, emergency referrals.</p> <p>Co-ordinate with:</p> <ul style="list-style-type: none"> - DPS for facility and population based information from Health Management Information System (HMIS) - National AIDS Programme (NAP) for data from surveillance systems - Respective ministries for national surveys <p>Facilitate analysis and use of data from HMIS and surveys (with DPS) and disseminate findings to policy-makers and stakeholders involved in implementation.</p> <p>Collaborate with research institutions, universities and other partners on implementation/operations research and other studies for evidence-based decision-making, planning and programme interventions.</p> <p>Collaborate with research institutions and Department of Traditional Medicine to conduct research on effectiveness and efficacy of traditional medicines for selected RH conditions.</p>
<p>7.1.2 Increase access to quality, integrated RH services at all levels of care</p>	
<p>2.1 Implement an essential package of RH services</p>	<p>Develop and implement an integrated package of interventions with core RH elements (Section 5 and Annex 6).</p> <p>Implement health services according to best practices and in adherence to quality assurance measures [six areas/dimensions of quality of care will be followed].*</p> <p>Adopt a client-centred approach that is sensitive, confidential and is respectful of rights and diverse needs.</p> <p>Promote client/provider interaction dialogue and feedback.</p>

*Effective, efficient, accessible, acceptable/aligned, equitable and safe (WHO, 2004)

Strategies	Key Activities
2.2 Expand coverage of services	<p>Conduct geographic and social mapping to identify hard-to-reach and marginalized population sub-groups.</p> <p>Design strategies for improving equity in access to reproductive health care for hard-to-reach populations.</p> <p>Employ different service delivery models: facility-based, outreach, public-private partnerships that provide information and services in hard-to-reach areas.</p>
2.3 Improve performance of health workforce for RH	<p>Review and strengthen pre-service midwifery and medical curricula and training programmes (content and training approaches) to deliver standardized, quality RH care. (with Department of Medical Sciences)</p> <p>Review and improve in-service training curricula of RH service providers in order to improve their skills in both clinical care and service management.</p> <p>Conduct competency-based training and skills assessments.</p> <p>Re-establish State/Regional Training Teams for in-service training programmes and supervision and strengthen their capacity to conduct training on a regular basis. (with State/Regional authorities)</p> <p>Employ e-Health for data input and information sharing and m-Health for data input, monitoring and technical back-stopping of basic health staff. (with Department of Health Planning)</p> <p>Conduct supportive supervision, monitoring and mentoring of MAs and AMAs on a regular basis.</p> <p>Initiate and enhance clinical audits – the systematic and critical analysis of the quality of medical care and build these into performance management system.</p> <p>Conduct maternal and perinatal death reviews and respond to underlying causes at the community and facility levels.</p>
2.4 Strengthen effective systems of referral	<p>Streamline referral systems with standardized, written guidelines, contingency plans and communication of procedures to be followed in emergencies.</p> <p>Improve communication through mobile phones for MCH emergencies.</p> <p>Provide feedback to referring health worker/health facility as a performance improvement mechanism.</p>
2.5 Increase equitable access to quality integrated reproductive health services	<p>Collaborate with Departments under MoH and other Ministries to develop financing mechanisms to increase access to RH services.</p> <p>Pilot and scale up MCH voucher schemes, health equity funds and pre-payment schemes following thorough analysis of the local context. (Concerned Departments under MoH, Ministry of Finance, development partners and NGOs).</p>

Strategies	Key Activities
7.1.3 Community Engagement in Promotion and Delivery of RH	
3.1 Implement behavior change communication for RH	<p>Coordinate multi-sectoral database to establish extent of existing RH IEC materials.</p> <p>Identify themes and key messages for national campaigns for MRH, both spacing and adolescent and youth reproductive health.</p> <p>Define targeted communication messages for different audiences – women, men and adolescents and youth.</p> <p>Develop standardized messages to be used at all levels to harmonize messages with key stakeholders.</p> <p>Ensure that the RH BCC interventions are implemented at regional/state, township and community levels.</p> <p>Conduct RH BCC activities for hard-to-reach populations using innovative approaches.</p> <p>Set standards and guidelines on RH communication.</p> <p>(Reproductive Health Programme in collaboration with Central Health Education Bureau, NGOs and other stakeholders)</p> <p>Conduct capacity strengthening of responsible staff on BCC.</p> <p>Develop training curriculum and job aids for health providers on interpersonal communication skills.</p> <p>Conduct training/capacity building for health providers on interpersonal communication skills.</p> <p>Develop, print and disseminate reference guides, job aids, booklets on safe motherhood (MCH Handbook), contraceptives, post-abortion care, RTI/STI, ARH, cervical cancer and infertility for providers and brochures, flip charts and wall charts for the public and clients.</p> <p>Translate training materials; reprint and disseminate other useful job aids and tools that can be used across language barriers.</p> <p>Conduct print and electronic mass media campaign to provide information and improve access to RH services.</p> <p>Support the organization of community-based activities, including interactive theatre and peer education.</p> <p>(Reproductive Health Programme in collaboration with Central Health Education Bureau, NGOs and other stakeholders)</p>
3.2 Enhance community understanding of RH needs and increase demand for services	<p>Use a mix of the major communication channels— mass media, interpersonal, and community channels.</p> <p>Engage key community leaders, men and women and young people, to become champions and advocates for RH within the communities.</p> <p>Use participatory approaches to work with communities and community-based organizations to overcome barriers and promote appropriate use of available services.</p>

Strategies	Key Activities
	<p>Conduct awareness-raising activities among communities on RH and collaborate with community-based groups and opinion leaders to understand and address underlying cultural values and practices.</p>
<p>3.3 Support health promotion and care activities by community health volunteers</p>	<p>Carry out BCC activities to promote early pregnancy identification, ANC, birth preparedness, skilled birth attendance, essential newborn care, birth spacing/family planning, etc.</p> <p>Sensitize families and communities on care seeking and adherence with treatment.</p> <p>Encourage beneficial traditional practices and discourage harmful practices on core elements of RH.</p> <p>Conduct initiatives for engagement of men and boys in RH, MNH, responsible fatherhood, birth spacing, STI/HIV prevention, infertility, GBV etc.</p> <p>Conduct training for CHV on community organization, behaviour change communication, first aid.</p> <p>Conduct training of AMWs on specific service delivery for reproductive health.</p> <p>Support MWs to supervise service delivery by AMWs at the community level.</p> <p>Build capacity at the community level for early recognition of complications in women and children and for early referral and transfer.</p> <p>Establish functional linkages (transport and communications) from community to different levels of care in order to ensure efficiency in referrals.</p>
<p>7.1. 4 Incorporating Gender Perspectives</p>	
<p>4.1 Gender Mainstreaming</p>	<p>Respect key points for gender mainstreaming¹⁰ in implementing RH Strategic Plan.</p> <p>Ensure women's participation in defining and implementing public health priorities and activities at national, regional/state, township and village levels.</p>
<p>4.2 Strengthening the health sector response to Gender-based violence</p>	<p>Address key issues to enhance identification, care and response for survivors of GBV:</p> <ul style="list-style-type: none"> - To develop and implement guidelines for delivery and care for survivors of GBV; - To ensure that the response becomes institutionalized (i.e. changing individual behaviour and organizational culture); and develop standard operating procedures and protocols; - To maintain multi-sectoral collaboration and collaboration with NGOs; - To ensure a woman-centred approach is adopted and that women are not placed at further risk by any intervention;

¹⁰To change behaviours, attitudes and practices that are harmful to women or men's sexual health status at community and health systems levels, and to address how health problems affect women and men differently (programmatic gender mainstreaming).

Strategies	Key Activities
	<ul style="list-style-type: none"> - To identify health-care settings that are most appropriate for offering these services; and - To improve response and care for survivors including conducting selective enquiry for GBV and provider training. <p>Adapt WHO clinical and policy guidelines – Responding to intimate partner violence and sexual violence against women</p> <p>Build capacity of Central and Regional level Trainers and conduct training for health providers on key issues to detect, care for and refer survivors of GBV i.e. identification, assessment, treatment (emergency contraception, post-exposure prophylaxis and diagnosis and treatment of STIs), crisis intervention, documentation, referral, and follow-up clinical interventions and emotional support, for women suffering from intimate partner violence and sexual violence.</p> <p>Strengthen referral mechanisms to social services, security and legal services, counseling and support.</p> <p>Strengthen the role of opinion leaders to raise awareness of GBV as a public health issue.</p> <p>Raise awareness of the community to prevent GBV and promote identification and early referral of victims.</p> <p>(Reproductive Health Programme in collaboration with Division of Medical Care, DoH, Department of Social Welfare and NGOs)</p>
4.3 Engaging men in reproductive health programmes	<p>Advocate on the value of engaging men in RH and RH care to opinion leaders.</p> <p>Print and disseminate messages and IEC materials on men's shared responsibility in responsible parenthood, sexual and reproductive behavior and RH care²⁹.</p> <p>Conduct training for health providers to engage men as supportive partners to address gender inequality and improve health outcomes.</p> <p>Conduct community-level activities to engage men as supportive partners to address gender inequality and improve health outcomes using group and peer education.</p> <p>(Reproductive Health Programme in collaboration with CHES, NGOs, professional organizations, UN agencies)</p>

²⁹With spacing, informed, IEC, prevention of STIs and HIV, prevention of and care following miscarriage/unsafe abortion, addressing infertility and prevention of violence against women.

Strategies	Key Activities
<p>5. RH in humanitarian settings - Mitigate RH problems consequent to disasters and epidemics through preparedness and effective response</p>	<p>Conduct advocacy and awareness-raising of RH issues in humanitarian settings.</p> <p>Strengthen partnerships with UN and CSOs including faith-based organizations for coordination and programme planning (including comprehensive RH services) after the crisis.</p> <p>Incorporate RH component in Disaster Preparedness and Response Policies and Plans at all levels.</p> <p>Establish Minimum Initial Service Package (MISP) teams in risk prone States/ Divisions and enable them to function well.</p> <p>Conduct training/capacity building of MISP teams and providers at National, Regional and Township levels.</p> <p>Incorporate medical management and support for GBV survivors in humanitarian efforts.</p> <p>Strengthen partnerships among health care providers, volunteers, Traditional Birth Attendants (TBA) on MCH care and support in emergency situations.</p> <p>Conduct rapid assessments and data analysis during the humanitarian response.</p> <p>Provide emergency reproductive health services, supplies and equipment.</p> <p>Document lessons learned after the crisis and incorporate into programme planning.</p> <p>(Reproductive Health Programme in collaboration with Department of Relief and Resettlement, Ministry of Social Welfare, Relief and Resettlement, Central Epidemiology Unit, Department of Health; Myanmar Medical Association; Myanmar Red Cross Society; Myanmar Maternal and Child Welfare Association; Myanmar Women's Affairs Federation and INGOs)</p>

7.2 Strategies and Key Activities for Core Elements of Reproductive Health

The Strategic Plan for RH has prioritized the following elements of RH based on the magnitude and significance of the issue: maternal and newborn health, birth spacing, miscarriage and post-abortion care, RTI/STI and HIV and adolescent and youth reproductive health. The other elements of RH addressed in the Strategic Plan are screening and treatment of cervical cancer and infertility. Cross-cutting strategies of strengthening health systems to enhance the provision of an essential package of RH interventions; increasing access to quality, integrated RH services; and community engagement in promotion and delivery of RH care are crucial to effective and efficient realization of the objectives of the Strategic Plan.

Existing services will be strengthened and used as entry points, i.e. maternal and newborn care and birth spacing. Recognising that there will be a gradual implementation of certain elements of the Strategic Plan based on resource availability and the nature of RH programme - development partner collaboration; the following section outlines Strategies and Key Activities for Core Elements of reproductive health. Each section contains a discrete set of interventions which are self-contained. The on-going programmes that will be intensified and other specific activities for each core element are summarized below.

7.2.1 Pregnancy, Delivery, Postnatal and Newborn care

The focus is to provide continuum of quality care for mothers and newborns: antenatal, newborn and postnatal care, emergency obstetric and newborn care, skilled care during childbirth at appropriate facilities; and extend the reach of existing services, particularly for the remote and rural areas and to the underserved population.

Section 7.1.1 outlines the strategies to reinforce an *enabling environment for reproductive health* (advocacy for decision-makers, review/update of operational policies and regulatory mechanisms for service provision by midwives and AMWs and strengthening partnerships for implementation of the Strategic Plan) and action plans to ensure an optimum number, skill-mix and gender balance for *human resources for RH services* and the education, recruitment and retention of the health workforce. Approaches to *enhance community understanding of RH needs and increase demand for services* are described in Section 7.1.3. These include engaging key community leaders, both men and women and young people, within the communities; using participatory approaches to work with communities and CBOs to address underlying cultural values and practices, overcome barriers and promote use of RH services; and to use a mix of reinforcing and complementary communication channels when conducting awareness-raising activities among communities.

7.2.1.1 Strengthen Health Systems to enhance the provision of an essential package of interventions Strengthen infrastructure, logistics and management systems

Identify the infrastructure and maintenance requirements and supply needs for the provision of essential package of RH services (commodities and medicines) at health facilities providing Basic Health Services.

Improve existing (renovation and refurbishment) or establish new infrastructure (health facilities at township hospital, RHC and sub-centre) and enhance access to the physically disabled.

Make arrangements for Maternity Waiting Homes/Areas near CEMONC facilities.

Project, forecast, procure supply, store and distribute quality MNH commodities to ensure facilities have the required equipment, supplies and medicines to provide to provide facility-based and outreach services.

Conduct training for responsible staff on projecting, forecasting, procuring supplies, storage and distribution of quality MNH commodities.

Increase utilization of information from monitoring and evaluation, health information system and other sources and research

Support and implement review of maternal deaths at all levels and respond to community and facility-related issues leading to each maternal death.

Disseminate results of maternal death reviews.

Implement recommendations of maternal death review reports.

Conduct research to identify and address barriers to access to MNH care including facility delivery and skilled attendance at delivery.

Support research that seeks to understand social and cultural determinants of utilization of MNH services among various social and economic groups to advocate for and promote evidence-based interventions.

Conduct implementation/operations research on task sharing of selected MNH activities to AMWs.

Share lessons learnt from innovative programmes and projects and use the results to Intensify awareness campaigns to address operational barriers.

7.2.1.2. Increase access to quality, integrated MNH services at all levels of care

Implement an essential package of MNH services

Provide package of MNH Interventions (antenatal care, delivery care including BEmONC and CEmONC, postnatal care and essential newborn care) using a client-centred approach and a focus on quality assurance.

Continue Iron-folate supplementation for pregnant women (National Nutrition Centre)

Expand coverage of MNH services

Conduct geographic and social mapping to identify hard-to-reach and marginalized population sub-groups.

Design strategies for improving equity in access to MNH care for hard to reach populations.

Employ different service delivery models: facility-based, outreach and community-based activities that provide information and services in hard-to-reach areas.

Improve performance of health workforce

Conduct refresher training on the components of the essential package of interventions, i.e. integrated package of MNH interventions (antenatal care, delivery care including Basic and Comprehensive Emergency Obstetric and Newborn Care, postnatal care and essential newborn care), with an emphasis on integrated services, client-centred approach and quality assurance measures, for doctors and midwives. The BEmONC training will be organized to cover more signal functions than is currently provided.

Provide supportive supervision and clinical mentoring on a regular basis for MWs and AMWs.

Intensify competency-based training for Skilled Health Personnel/Skilled Birth Attendants in accordance with ASEAN Regional Guideline on Skilled Birth Attendant³⁰.

Strengthen effective systems of referral

Streamline referral systems with standardized, written guidelines, contingency plans and communication of procedures to be followed in emergencies.

Establish village health funds for MNH and other emergencies.

Improve communication with referral centre through mobile phones.

Provide feedback to referring health worker/health facility as a performance improvement mechanism.

Ensure Village Health Workers/Community Health Volunteers are knowledgeable about available referral systems and how to access them.

³⁰The draft guideline is undergoing review.

Increase equitable access to quality integrated reproductive health services

Pilot and scale up health equity funds, MCH voucher schemes and social health insurance to increase health service use by the poor in collaboration with other Departments under MoH, Ministry of Finance, development partners and NGOs.

7.2.1.3. Community Engagement in Promotion and Delivery of MNH

Support health promotion and care activities by community health volunteers

Conduct training on for VHW/CHV on community organization, behaviour change communication and first aid. Conduct training of AMWs on specific service delivery for reproductive health including distribution of iron-folate, misoprostol for prevention of PPH.

Support MWs to supervise service delivery by AMWs at the community level.

Organize meetings between MWs and AMWs on a regular basis.

Carry out BCC activities to promote early pregnancy identification, ANC, preparedness for delivery, skilled delivery attendance and postnatal and newborn care; self-care during pregnancy and early and exclusive breast-feeding; and to promote beneficial cultural practices and avoid harmful practices.

Develop initiatives for greater engagement of men in MNH care-seeking behaviour and care and responsible fatherhood.

Partners

Reproductive Health Programme in collaboration with WCHD Section, National Nutrition Centre, National AIDS Programme, NGOs, professional organizations, UN agencies

7.2.2 Birth spacing

The emphasis is to promote healthy timing and spacing of pregnancies and reduce the unmet need for family planning; to enable and support voluntary decisions on childbearing and birth spacing of their choice. Section 7.1.1 outlines the strategies to reinforce an *enabling environment for reproductive health and human resources for RH services* and 7.1.3 describes approaches to *enhance community understanding of RH needs and increase demand for services*.

7.2.2.1 Strengthen Health Systems to enhance the provision of an essential package of interventions

Strengthen infrastructure, logistics and management systems

Equip facilities with instruments for IUD and implant insertion and removal.

Project, forecast, procure supply, store and distribute quality contraceptive commodities.

Conduct training for responsible staff on projecting, forecasting, procuring supplies, storage and distribution of quality contraceptive commodities.

Increase utilization of information from monitoring and evaluation, health information system and other sources and research

Support research that seeks to understand social and cultural determinants of non-use and unmet need for contraception among various social and economic groups to advocate for and promote evidence-based interventions.

Share lessons learnt from innovative programmes and projects and use the results to intensify awareness campaigns to address operational barriers.

7.2.2.2 Increase access to quality, integrated RH services at all levels of care

Implement an essential package of services

Provide information and services on modern contraceptive methods and dual protection; and follow-up for correct and consistent use.

Broaden contraceptive method mix to include emergency contraception and implants and strive for a balance between long-term reversible and short-term methods.

Strengthen integration of birth spacing into other RH and related programmes e.g. postpartum and post-abortion contraception.

Expand coverage of services

Conduct geographic and social mapping to identify hard-to-reach and marginalized population sub-groups.

Design strategies for improving equity in access to RH/birth spacing care for hard to reach populations.

Employ different service delivery models: public, private, social marketing and community-based distribution.

Engage NGO partners and the private sector through public-private partnerships to provide information and services in hard-to-reach areas.

Improve performance of health workforce for RH

Update clinical standards and guidelines periodically to ensure service provision is in line with evidence-based practices – e.g. updated Medical Eligibility Criteria for Contraceptive Use.

Conduct training on birth spacing with an emphasis on integrated services, client-centred approach and quality assurance measures for doctors and midwives.

Conduct skills-based training on long-term reversible methods.

Conduct training to improve communication skills of health care providers.

7.2.2.3. Community Engagement in Promotion and Delivery of RH

Support health promotion and care activities by community health volunteers

Conduct training to improve communication skills of community volunteers on the benefits of healthy timing and spacing of pregnancies and on modern contraceptive methods and dual protection.

Carry out BCC activities to increase awareness on healthy timing and spacing of pregnancy, birth spacing methods.

Provide information on modern contraceptive methods and dual protection, follow-up for correct and consistent use and dispel myths and misperceptions.

Develop initiatives for greater involvement of men in birth spacing.

Partners

Reproductive Health Programme in collaboration with NGOs, CBOs, professional organizations, UN agencies.

7.2.3. Miscarriage and post-abortion care²¹

The emphasis is to prevent unplanned pregnancies and provide quality care for miscarriage and complications of abortion including post-abortion contraceptive information and services. Section 7.1.1 outlines the strategies to reinforce an *enabling environment for reproductive health and human resources for RH services* and 7.1.3 describes approaches to *enhance community understanding of RH needs and increase demand for services*.

7.2.3.1 Strengthen Health Systems to enhance the provision of an essential package of interventions

Ensure equipment, supplies, commodities, medicines and contraceptives are in place for management of miscarriage and post-abortion complications.

²¹PAC includes evacuation of the uterus, pain management and treatment for suspected infection or other issues. Contraceptive education and method provision are integral parts of post-abortion care. Community and service provider partnerships to prevent unwanted pregnancies and unsafe abortion and to help women receive appropriate and timely care for complications of abortion.

7.2.3.2 Increase access to quality, integrated RH services at all levels of care**Implement an essential package of PAC services**

Prevent unplanned pregnancies through information and services on modern birth spacing/contraceptive methods and dual protection; and follow-up for correct and consistent use.

Diagnose miscarriage and post-abortion complications, conduct resuscitation and emergency treatment and refer as appropriate.

Provide a package of services for miscarriage and post-abortion complications by trained providers at health facilities: i.e. antibiotic therapy, intravenous fluid replacement, oxytocics, uterine evacuation by MVA, pain control and treatment for infection.

Manage or refer severe complications to higher level health facilities.

Strengthen PAC contraceptive information and services.

Increase utilization of information from monitoring and evaluation, health information system and other sources

Collect data on admissions, morbidity and mortality for post-abortion complications.

Improve performance of health workforce for RH

Conduct training for health providers on updated PAC Manual.

Conduct skills-based training for health providers on uterine evacuation of incomplete abortion and early pregnancy failure by MVA.

7.2.3.3 Community Engagement in Promotion and Delivery of RH**Enhance community understanding of RH needs and increase demand for services**

Provide information and advice/counseling on birth spacing, symptoms and signs of miscarriage and dangers of unsafe abortion.

Strengthen community and service provider partnerships to prevent unwanted pregnancies and unsafe abortion and to help women receive appropriate and timely care for miscarriage and its complications.

Support health promotion and care activities by community health volunteers

Conduct awareness-raising/training to recognize signs and symptoms of miscarriage and post-abortion complications.

Organize timely referral to formal health care system.

Develop initiatives for greater involvement of men in prevention of unplanned pregnancies.

Partners

Reproductive Health Programme in collaboration with NGOs, professional organizations, UN agencies

7.2.4 RTI/STI/HIV

The aim is to integrate syphilis and HIV counseling and testing as part of the antenatal package; increased availability of information on RTI/STI and HIV provide RH care for PLWHA. Section 7.1.1 outlines the strategies to reinforce an *enabling environment for reproductive health and human resources for RH services* and 7.1.3 describes approaches to *enhance community understanding of RH needs and increase demand for services*.

7.2.4.1 Strengthen Health Systems to enhance the provision of an essential package of RH interventions

Strengthen logistics and management systems

Strengthen the RTI treatment supply chain management - project, forecast, procure supply, store and distribute RTI/STI drugs and condoms and commodities and medicines for PMTCT (in collaboration with NAP).

Carry out periodic review of the drugs used in syndromic management in order to ensure their effectiveness in curing RTIs (National AIDS Programme).

Increase utilization of information from monitoring and evaluation, health information system and other sources

Support research to determine RTI prevalence and community perceptions on RTI and their care-seeking behaviour.

7.2.4.2 Increase access to quality, integrated RH services at all levels of care

Implement an essential package of RH services

Provide information and services on RTI/STI and integrate RTI/STI screening and management into RH services. Strengthen syndromic management (as appropriate) and laboratory services to support early diagnosis and treatment of RTIs, partner referral and condom provision.(National AIDS Programme)

Develop strategies with NAP to improve access to FP and MCH/PMTCT for female KAPs through bi-directional linkages for delivery of and effective referral to RH or HIV/STI services.

Expand coverage of services

Strengthen RTI/STI prevention activities (safe sexual behavior and comprehensive condom programming) and early detection and treatment, at all levels.

Improve performance of health workforce for RH

Build capacity at all levels of service delivery for effective integration of RTI/STI into RH services that are non-discriminatory.

Conduct training on syndromic management and laboratory investigations to support early diagnosis and treatment of RTIs.

Conduct training on PMTCT and screening and treatment for syphilis (NAP) and birth spacing services for key affected populations (KAP) and People living with HIV/AIDS (PLWHA).

7.2.4.3 Community Engagement in Promotion and Delivery of RH

Enhance community understanding of RH needs and increase demand for services

Carry out community awareness activities on RTI/STI including HIV and safe sexual behaviour and reduction of stigma and discrimination.

Support health promotion and care activities by community health volunteers

Provide information on RTI/STI/HIV, safe sexual behaviour and dual protection.

Develop initiatives for greater involvement of men in prevention STI through safe sexual behaviour.

Conduct training of peer educators including KAP on core RH/STI/HIV and communication skills.

Partners

Reproductive Health Programme in collaboration with National AIDS Programme, NGOs, professional organizations, UN agencies

7.2.5 Adolescent and Youth RH

The objective is for adolescents and youth to be knowledgeable about their health, promote safe sexual behaviour and prevent unplanned pregnancies and STI/HIV among young people. Section 7.1.3 describes approaches to *enhance community understanding of RH needs and increase demand for services*.

7.2.5.1 Strengthen Health Systems to enhance the provision of an essential package of RH interventions

Reinforce an enabling environment for adolescent and youth reproductive health

Conduct communication activities so that local authorities, religious leaders, parents, teachers and peers are knowledgeable about the health of young people and the value of providing RH information and services.

Review/update operational policies and regulatory mechanisms for information and service provision on RH irrespective of age and marital status in order to ensure that adolescents and youth have equitable access to RH services.

Strengthen existing partnerships of NGOs and other partners working with adolescents and youth.

Provide health services in accordance with "National Service Standards and Guidelines on Adolescent and Youth Care" (MoH, UNFPA, WHO).

Ensure availability of human resources for services

Ensure there are sufficient numbers of health workers (doctors or midwives) who have the technical competencies and attitudes to provide services to adolescents and youth sensitively and effectively.

Strengthen infrastructure, logistics and management systems

Ensure health facilities are welcoming and appealing to young people (location, open hours, privacy) and are equipped with educational material, supplies and medicines to deliver RH information and services.

Increase utilization of information from monitoring and evaluation, health information system and other sources

Collect data on core elements of RH disaggregated by age, sex and marital status.

Conduct research to determine approaches to improve utilization of Youth Friendly Services.

7.2.5.2 Increase access to quality, integrated RH services at all levels of care

Implement an essential package of RH services

Expand the scope and coverage of Youth Information Corners (YIC) to provide youth-friendly services.

Engage young people in the design, implementation and service delivery of youth-friendly information and services and in quality improvement activities.

Develop IEC and BCC materials with the involvement of young people.

Develop protocols, guidelines and/or job aid cards for quality reproductive health care for young people.

Expand biweekly supplementation for adolescents school girls (National Nutrition Centre)

Expand coverage of services

Support expansion of the number of facilities offering youth friendly reproductive health services and outreach educational activities.

Develop strategies to reach adolescents, and youth involved in risky behaviours, and the hard to reach e.g. out-of-school, young people living with HIV and adolescents living on the streets.

Improve performance of health workforce for RH

Train staff on technical competencies and attitudes to provide services to adolescents and youth in a sensitive way.

7.2.5.3 Community Engagement in Promotion and Delivery of RH

Enhance community understanding of RH needs and increase demand for services

Engage key community leaders, both men and women, to understand the value of providing RH information and services for young people.

Promote and support school based health education programmes. (School Health Programme)

Conduct training of peer educators on core RH elements and communication skills.

Conduct community and family outreach activities in addition to individual clinic-based services.

Promote initiatives reaching out to out-of-school youths with IEC and BCC interventions through group and peer education.

Support initiatives aimed at creating awareness on RH among youth in difficult circumstances.

Support mass media campaigns on RH among adolescents and youth.

Use social media (internet and mobile phones) to raise awareness and understanding of RH issues of young people.

Partners

Reproductive Health Programme in collaboration with Central Health Education Bureau, School Health Programme, National AIDS Programme, NGOs, professional organizations, UN agencies

7.2.6 Screening and treatment of cervical cancer

The objective is to introduce cervical cancer screening and treatment of premalignant lesions in the Basic Health Services. Service provision will be in accordance with guidance developed by WHO: Monitoring national cervical cancer prevention and control programmes: quality control and quality assurance for visual inspection with acetic acid (VIA)-based programmes (WHO 2013). The programme will be scaled up in an incremental manner. Section 7.1.3 describe approaches to *enhance community understanding of RH needs and increase demand for services*.

7.2.6.1 Strengthen Health Systems to enhance the provision of an essential package of RH interventions

Reinforce an enabling environment for reproductive health

Advocate for a comprehensive approach to cervical cancer prevention and control programme - made up of several key components ranging from community education, social mobilization, vaccination, screening, and treatment to palliative care.

Develop a policy framework for comprehensive cervical cancer control (The RH Programme will focus on screening and treatment of premalignant lesions and will refer women with malignant lesions to tertiary care facilities.)

Strengthen infrastructure, logistics and management systems

Ensure equipment, supplies and commodities are in place for screening for cervical cancer and treatment of premalignant lesions.

Ensure availability of human resources for RH services

Conduct training for doctors and midwives on cervical cancer prevention and control and the "Screen and treat" (VIA followed by cryotherapy) approach in townships where the screening programme will be initiated.

Increase utilization of information from monitoring and evaluation, health information system and other sources

Collect data on screening coverage, screening test positivity rate and treatment rate.

7.2.6.2 Increase access to quality, integrated RH services at all levels of care**Implement an essential package of RH services**

Strengthen RH services at all levels to provide prevention, screening, early diagnosis and management of pre-malignant lesions of the cervix and referral for malignant lesions.

Consider introduction of HPV vaccines in the public sector.

Strengthen oncology services at appropriate levels in order to cater for the needs of prevention, early diagnosis and treatment of cancers of reproductive organs and other emerging technologies (Division of Medical Care).

Expand coverage of services

Expand in an incremental manner secondary prevention for women over 30 years of age using the "Screen and treat" approach with low cost technology – VIA followed by cryotherapy.

Improve performance of health workforce for RH

Conduct training for doctors and midwives on cervical cancer prevention and control and the "Screen and treat" approach.

7.2.6.3 Community Engagement in Promotion and Delivery of RH**Enhance community understanding and increase demand for services**

Conduct awareness - raising activities among communities on breast and cervical cancers and collaborate with community-based groups and opinion leaders to understand and address underlying cultural beliefs, values and practices.

Support health promotion and care activities by community health volunteers

Promote positive health seeking behaviour in the community, including awareness of regular screening for breast and cervical cancer.

Promote community awareness of symptoms of reproductive organ cancers to reduce delay in seeking health services.

Partners

Reproductive Health Programme in collaboration with Division of Non-Communicable Diseases and Division of Medical Care, NGOs, professional organizations, UN agencies

7.2.7 Investigation and management of the infertile couple

Management of the infertile couple will be introduced in the Basic Health Services with well-defined interventions for each level of service delivery.

Support infertility prevention measures including improved postpartum and post-abortion care, and early diagnosis and effective treatment of RTI/STI.

Develop guidelines on the clinical management of and psycho-social support for the infertile couple at RHC and Township and Station Hospitals.

Conduct training for service providers at different levels for appropriate management of infertile individuals and couples, including facilities for early diagnosis and management and referral.

Build capacity of tertiary level facilities to provide specialised infertility management including Assisted Reproductive Technologies services. (Division of Medical Care)

Carry out community education and awareness creation on infertility.

Partners

Reproductive Health Programme in collaboration with Division of Medical Care, NGOs, professional organizations, UN agencies

8. Strategic Information (Monitoring and Evaluation and Research)

Monitoring progress of the Strategic Plan

Through monitoring and evaluation, progress towards and achievement of expected results will be measured and assessed. Impact, outcome and output indicators for the Strategic Plan are outlined in Table 8.1. Data for monitoring of the Strategic Plan will be obtained from several sources and will require close co-ordination with the respective responsible entities. These include the Health Management Information System³², hospital statistics, central and regional government reports and township implementation reports. National surveys and special studies (e.g. HIV and STI surveillance surveys by NAP) carried out periodically will also yield information on impact and outcome indicators.

A few indicators collected through HMIS (e.g. postnatal care) will be refined in consultation with the Department of Planning and Statistics. Additional indicators will be collected for new interventions e.g. cervical cancer screening. HMIS will collect age-disaggregated data and by geographic region and special population groups e.g. adolescents. The challenge is to obtain more complete data collected through HMIS, i.e. to collect data from areas not covered by midwives. Through monitoring, programme processes and changes in conditions of target groups and facilities brought about by programme activities can be discerned.

An internal review will be carried out by the DoH on an annual basis with the key stakeholders and partners, including governmental and non-governmental organizations, to review the implementation of the Strategic Plan.

Interventions on RH information and care are provided by NGOs in several townships. The NGOs will be asked to align their monitoring system to include indicators that are collected by the Health Information Management System, i.e. linking programme/project monitoring to existing data collection and reporting systems.

Maternal Death Review - Maternal Death Surveillance and Responses

Maternal Death Review (MDR) has been conducted in 100 townships as part of routine activities to have a clear understanding of factors leading to death. The purpose is to identify and review causes and identify avoidable factors at facility and community levels. The findings can lead to change in local/national policies and practices, recommendations on clinical or health service issues that are feasible and realistic and may involve community interventions. MDR has been conducted per guidance of "Beyond the Numbers: Reviewing maternal deaths and complications to make pregnancy safer" (WHO 2004).

The *Maternal death surveillance and response* (MDSR) system is a *continuous action cycle* that builds on established approaches such as maternal death review (MDR). It stresses the need to respond to each maternal death with actions to prevent similar deaths in the future, and to collect data on all maternal deaths using clearly defined data sources and processes for identification and notification and will generate comprehensive and feasible recommendations for follow-up action. This linking of mortality surveillance with remedial action is the centre-piece of an accountability framework³³. Efforts will be made to transition from MDR to Maternal death surveillance and response.

Mid-term Review and Final Evaluation

For the *Mid-term Review*, data will be collected and analysed to assess programme, and management issues and budget expenditure. The findings and critical analysis will facilitate evidence-based decision-making with a view to inform the continued implementation of the Strategic Plan for the remaining years. The Mid-term Review is planned for 2016. A set of broad questions with relevant sub-questions, will be formulated with a view to provide information about the extent to which the implementation has progressed so far and what elements have been obstacles and drivers of success to its implementation.

³²Department of Health Planning, Health Management Information System - Data Dictionary for Health services Indicators 2012

³³Maternal death surveillance and response: technical guidance (WHO 2013)

The *Final Evaluation* will determine whether the interventions have had an impact and whether the implementation of the programme has been successful. The relevance, performance effectiveness and efficiency of the Strategic Plan will be established and areas for programme improvement identified. This will be carried out by an external agency in 2018 and will guide the development of the subsequent Strategic Plan for RH. Information on impact indicators will also be obtained from national surveys e.g. the census and the Demographic and Health Survey which are planned in the coming years.

Research

The National RH Programme will collaborate with concerned institutions: i.e. Departments of Medical Research, Universities and NGOs, among others, to undertake research on RH issues where there are significant data and research gaps. The findings will contribute to provide evidence for policy directions and implementation guidance.

Formative research will be crucial to inform programme approaches to improve care-seeking behaviour for maternal and newborn care, increasing availability of and access to key RH services, and expanding individual, family and community knowledge and demand for these services. An implementation research agenda for quality improvement, innovative outreach approaches, health financing etc will be developed. In addition, the effectiveness of traditional medicine for selected RH conditions will be supported.

Studies that will be conducted include (but are not limited to):

- Barriers to access to MNH care including facility delivery and skilled attendance at delivery
- Social and cultural determinants of utilization of MNH services among various social and economic groups
- Implementation/operations research on task sharing of selected MNH activities to AMWs
- Social and cultural determinants of non-use and unmet need for birth spacing/family planning
- RTI prevalence and community perceptions on RTI and their care-seeking behavior
- Demand-side financing mechanisms for equitable access to MNH care
- Provider payment methods to deliver quality and equitable care

Dissemination of data and reports

Data collected from the public sector through HMIS will continue to be reported in the Public Health Statistics Report and Hospital Statistics Report. The Annual Report on Reproductive Health Indicators will also draw on township reports for specific activities (e.g. cervical cancer screening) and certain procedures that have been introduced (e.g. MVA).

Policy briefs based on annual reports will be prepared on a bi-ennial basis summarizing the findings, noting good practices, identifying gaps and proposed solutions and disseminated at national, regional and township levels. Research findings will be disseminated to policy-makers, programme managers and the scientific community as well as the participants in the research, the local community and the general public.

8.1 Logical Framework Matrix

The Logical Framework is based on the Goal and the Specific Objectives mentioned in Section 5.2 and 5.3. The following are key indicators that will be used to monitor trends in the reproductive health of mothers, adolescents and newborns are shown in Table 8.1. Many of these indicators can only be collected through large-scale surveys which are conducted intermittently (every three to five years). The data sources are listed with the corresponding indicators. There are specific targets to be reached by 2018 which can be verified by different means. This Logical Framework is based on the assumptions there will be health policies will continue to be supportive of reproductive health; that resources (human, financial, information, and infrastructure) are available for implementation of the plan; and that there are no serious negative effects due to unexpected events of natural, and socioeconomic environment.

Impact	Indicator	Current Status	Data Source, Year	Target	Year	Data Source
Maternal Mortality Ratio		200 per 100,000 live births	UN inter-agency estimates 2013	120 per 100,000 live births	2018	UN inter-agency estimates Public Health Statistics Report
Neonatal Mortality Ratio		30 per 1000 live births	UN inter-agency estimates 2011	10 per 1000 live births	2018	UN inter-agency estimates
Total Fertility Rate		2 per 1000 women 15-49	FRHS, 2007	2 per 1000 women 15-49	2018	Survey
Contraceptive prevalence rate		38 percent	FRHS, 2007	52 per cent	2018	Survey, Public Health Statistics Report
Unmet need for Contraception		17.7 percent	FRHS, 2007	8 percent	2018	Survey
Adolescent Birth Rate		16.9 per 1000 girls 15-19 years	FRHS, 2007	10 per 1000 girls 15-19 years	2018	Survey, Public Health Statistics Report
Outcome						
	Increased percentage of government health budget allocated to RH				2018	Government Reports
	Principles of equity for vulnerable populations (i.e. adolescents, disadvantaged groups) reflected in the policies and programmes on delivery of reproductive health care	Principles included		Principles reflected more prominently	2016	Government Reports
	Training strategy to address in-service needs of reproductive health service providers in place	Training strategy in place		Training Strategy is competency-based	2016	Government Reports

Outcome	Indicator	Current Status	Data Source, Year	Target	Year	Data Source
Reproductive health commodity logistics management information system established at national and local levels		In preparation phase		LMS established	2016	Government Reports
Percentage of births attended by skilled health personnel		67.1%	Public Health Statistics Report 2011	80%	2018	Public Health Statistics Report
Percentage of deliveries by auxiliary midwife		11.6 %	Public Health Statistics Report 2011	15%	2018	Public Health Statistics Report
Percentage of births taking place in a health facility		23.2 %	Public Health Statistics Report 2011	60%	2018	Public Health Statistics Report
Percentage of women experiencing major obstetric complications who receive emergency care at EmONC facilities ²⁴		NA	Public Health Statistics Report 2011	70%	2018	Public Health Statistics Report 2011
Percentage of women receiving antenatal care (at least one visit)		74%	Public Health Statistics Report 2011	85%	2018	Public Health Statistics Report
Percentage of women receiving antenatal care (at least four visits)		66.9%	Public Health Statistics Report 2012	80%	2018	Public Health Statistics Report
Percentage of women receiving postnatal care –one visit within 3 days after delivery		59.3%	Public Health Statistics Report 2011	75%	2018	Public Health Statistics Report
Percentage of babies receiving postnatal care – one visit within 3 days after delivery		59.3%	Public Health Statistics Report 2012	75%	2018	Public Health Statistics Report
Prevalence of anaemia in pregnant women ²⁵		71%	National Micronutrient Survey 2003	60%	2018	Survey

²⁴Currently Percentage of mothers referred to higher levels during pregnancy, delivery and postnatal periods is collected – data for 2011 – 67 percent. While national anaemia is common, the high prevalence of anaemia during pregnancy and 11.6% during delivery in the community need to be considered.

Indicator	Current Status	Data Source, Year	Target	Year	Data Source
Early initiation of breastfeeding (within the first one hour of birth)	73%	Public Health Statistics Report 2012	87%	2018	Public Health Statistics Report
Knowledge of at least three risk factors/warning signs of pregnancy-related complications	Not available		70%	2018	Survey
Percentage of women using modern contraceptive methods	38%	FRHS, 2007	45%	2018	Survey
Percentage of married women using long-acting reversible methods	1.8% ¹⁸	FRHS, 2007	4%	2018	Survey
Percentage of stillbirths per 100 live births	3.4%	Annual Hospital Statistics 2011		2018	Annual Hospital Statistics
Abortion rate per 1000 pregnancies (live births, stillbirths and abortions)	170 per 1000 pregnancies	Annual Hospital Statistics 2011	100 per 1000 pregnancies	2018	Annual Hospital Statistics
Percentage of clients who received post-abortion counseling and contraceptive services	Not available		80%	2018	Township Reports
Syphilis prevalence among pregnant women ¹⁹	0.3%	HIV sentinel sero-surveillance survey 2012			HIV sentinel sero-surveillance survey 2018
HIV prevalence among pregnant women who came for antenatal HIV counseling and testing	0.7%	HIV sentinel sero-surveillance survey 2012	0.4%	2018	HIV sentinel sero-surveillance survey 2018
Proportion of pregnant women who undergo voluntary counseling and testing and receive results for HIV	27%	Global AIDS Progress Report 2012	50%	2018	NAP Reports, Global AIDS Progress Report 2012

¹⁸Figure 16 in UNICEF (2018)

¹⁹Target for 2018 will be set in the next NAP for HIV 2018-2020

Indicator	Current Status	Data Source, Year	Target	Year	Data Source
Proportion of estimated pregnant women living with HIV receiving antiretroviral prophylaxis during pregnancy	69%	Children and AIDS South Stocktaking Report, 2013	80%	2015 ^a	Children and AIDS South Stocktaking Report
Young men and women (15-24 years) who correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission ^b	37.2% 47.5%	General Population BSS 2009 Out-of-School BSS 2008			Behavioural Surveillance Survey
Policy on cervical cancer screening in place	Policy in preparation		Policy approved	2016	Government Reports
Health sector response to GBV formulated	In preparation		Strategy formulated	2016	Strategy document
RH component integrated into Disaster Preparedness Response policies and plans at all levels	Ongoing		Disaster Preparedness Response policies/plans at all levels	2015	Disaster Preparedness Response policies/plans
Output					
No. of CEMoNC centres per 500,000 population	2	Annual Health Report	4	2018	Annual Health Report
No. of BEMoNC ^c centres per 100,000 population	6	Annual Health Report	8 ^d	2018	Annual Health Report
Number of facilities conducting reviews on maternal deaths (in accordance with Maternal Death Review)	100	2013	300	2016	Township Reports
Number of facilities conducting reviews on neonatal deaths (in accordance with Neonatal Death Surveillance and Report)	(See above)		200	2018	Township Reports
Percentage of HIV receiving training on safe motherhood	80%	DoH Report	100%	2018	Township Reports

^a Targets for 2016 will be set in the next NRP for HIV 2015-2020

^b Targets for 2018 will be set in the next NRP for HIV 2015-2020

^c Facilities offering interventions for PMS, substance and sexual violence prevention and reports

^d The number of sites for these targets will be increased

Indicator	Current Status	Data Source, Year	Target	Year	Data Source
Percentage of MHV receiving training on quality RH	50%	DHR Report	100%	2018	Township Reports
Percentage of doctors receiving refresher training on CE=OC	30%	DHR Report	100%	2018	Training Reports
Percentage of AMMs who receive monthly supervision visits	30%	DHR Report	100%	2018	Township Reports
Percentage of RHC without constant supplies of 5 essential MNCH drugs	Not available		75%	2018	Township Reports
Percentage of facilities offering at least 4 birth spacing methods	Not available		100%	2018	Township Reports
Percentage of Long Acting Reversible Contraceptive Method in method mix	2%		10%	2018	Survey
Number of RHCs providing syndromic management for RTI/STI	Not available			2018	Township Reports
Number of facilities that use manual vacuum aspiration for management of miscarriage/post-abortion complications	4	2012	120	2018	Township Reports
Proportion of facilities providing YFS by geographical area	Not available		65	2018	Township Reports
Number of facilities offering cervical cancer screening and treatment of premalignant lesions (IIA and cryotherapy)	2 Township hospitals		120 Township hospitals	2018	Township Reports
Percentage of health facilities providing a package of GBV-related medical services and referral to social services	Not available		30	2018	Township Reports

*Contraceptive method mix analysis by geographic area in tables (2008-2013), 24.04 (2008-2013)

9. Implementation Mechanisms

9.1 Reproductive health stakeholders

At the central level the Department of Health, Ministry of Health, will be responsible for the implementation of the Strategic Plan for Reproductive Health. The Director General, DoH will take overall responsibility for the coordination, planning and evaluation of the Strategic Plan while the Reproductive Health Programme will be charged with facilitating the development of sub-national plans and implementation, technical backstopping and monitoring. The regional/state, district and township level health authorities will oversee the operational planning, implementation and review of the Plan at their respective levels.

A broad multi-sectoral approach will be adapted in implementation of the Strategic Plan for Reproductive Health. The Reproductive Health Programme will collaborate with other programmes under MoH such as National AIDS Programme, National Malaria Control Programme, Women and Child Health Development Section, School Health Programme, National Nutrition Centre and Central Health Education Bureau. The Department of Health will partner with other ministries (Ministry of Education, Ministry of Social Welfare), professional associations, academia, United Nations agencies, bilateral donors and civil society organizations including NGOs. RH Stakeholders collaborating with the RH Programme at national, state/regional, township and community levels are listed in Annex 7.

9.2 Coordination mechanisms

The Myanmar Health Sector Coordinating Committee (MHSCC) has been described in Section 4. It is multi-sectoral in nature with broad participation, including representatives of different government ministries, UN agencies, international organizations, donors, international and local NGOs and the private sector.

The sub-national level coordination will be through the state/region, district and township level coordination mechanisms. Local authorities and committees will be responsible for the implementation of the Strategic Plans on reproductive health and child health to ensure complementarity and harmonization.

Under the auspices of the reproductive health - RMNCH-TSG, the Lead RH Working Group and the Lead Birth Spacing Working Group will co-ordinate the project activities of NGOs and other stakeholders engaged in delivering RH information and services. Co-ordination among RH stakeholders will avoid duplication of activities and reduce the administrative burden on the Department of Health.

9.3 Annual plans of action

Annual plans will be developed by the township teams with a detailed operational plan to identify activities, responsibilities, resources needed and time-lines for implementation of the essential package of RH interventions. The thrust of the Strategic Plan will be on maternal and newborn care and birth spacing interventions which will be conducted in all townships. The range of services will be expanded in selected townships e.g. cervical cancer screening. In other townships improved clinical procedures will be put in place e.g. MVA and medical management for postabortion care. The scope of activities by midwives and AMWs will be focused to bring MCH services closer to the population. The detailed implementation plans will indicate the association between the core elements of RH and different responsible institutions and implementing partners. It will also include township level monitoring, which is linked to the overall monitoring by national level.

The RH Programme will develop annual operational plans for central/national level activities on national and operational policies, programme guidance, curricula for refresher training for basic health staff, among others. Strategies for technical support for elaboration of township level work plans, implementation and monitoring will be developed.

9.4 Financial resources

At national level, a budget will be attached to the DoH and allied work plans of the Ministry of Health, while at township level, RH activities will be incorporated and earmarked in budgets for delivery of the total health package. Costing of the RH interventions by thematic area will be made to assist in scaling up of the essential package of RH interventions throughout the country.

A number of government policy documents still indicate that the health sector is still under-funded, however modest improvements in budgetary allocations has been made in recent years. There was a significant funding gap during the implementation of the 2009-2013 Strategic Plan for RH. The government expenditures on health increased and a proportional increase will be required at both central and regional/state levels to meet the national and international targets set by the MoH on reproductive maternal and child health.

To address the resource gap, substantial financial and non-financial resources are required to support the implementation of RH interventions. To contribute to poverty reduction strategies and improve equitable access, resources will be shifted from better-served areas to underserved areas of the country. New activities on RH will be introduced in a phased manner.

Advocacy will be conducted to obtain commitment and resources from development partners and other agencies for the thematic components of the Strategic Plan.

9.5 Human resources

Availability of skilled health workers, in adequate numbers, is key to achieving improved service quality and responsiveness in reproductive health service delivery. The DoH will coordinate and focus on capacity building approaches for staff providing basic health services and community volunteers through revitalizing regional/state training teams and support township training teams. The emphasis will be on competency-based training and skills assessment to deliver the essential package of RH interventions.

The midwives are the backbone of basic health services for families at the community level. The midwifery curriculum will be reviewed and updated to ensure that midwives meet the expected standards with regard to service delivery particularly for the new tasks and responsibilities in RH care. Competency-based education and training—both pre- and in-service, will employ evidence-based standards.

An enabling environment—including safe practice sites and living conditions; fair recompense; access to basic amenities; an adequate supply of essential drugs and equipment, and reliable transportation to an EmONC facility; and supportive supervision will be considered when building the capacity of the midwifery workforce.

The managerial capacity of Township Medical Officers and other Basic Health staff will be strengthened for planning, budgeting, logistics management, reporting, monitoring and evaluation.

10. Costing of Five-year Strategic Plan

The costing of the Strategic Plan for Reproductive Health comprises of the cost implications of implementing operational activities and estimation of the additional resources needed. The activities considered for additional resources include maternal health voucher schemes, health equity funds, support for Regional Training Centres and HPV vaccination.

Activity Based Budgeting (ABB) method was followed to estimate the cost of the operational activities of the reproductive health strategic plan 2014-2018. The costing has been carried out in line with the Strategic Plan on Reproductive Health and based on discussions during plenary and group discussions from the workshop on development of the Strategic Plan on RH (2014-2018).

The following principles were used to inform strategic planning and costing.

Birth spacing:

Birth spacing services are most cost-effective if a range of methods is available. This helps clients to select a method that matches their needs⁴³.

STI/HIV/AIDS:

For STI/HIV/AIDS, resources should be focused on prevention activities such as promotion and distribution of condoms to prevent STIs, STI treatment for high-risk groups, and maternal syphilis treatment⁴⁴.

Integration:

Wider integration of STI/HIV and FP services would cost 31% less than separate services for STI/HIV and FP, with savings from reduction in staff costs, supplies, and overhead⁴⁵.

Decentralization:

More women with syphilis will be detected and treated through decentralization of syphilis testing to primary care level.

The costs were calculated for each component area of the Strategic Plan and activities that would be conducted at the national/central level. Targets were fixed in numbers of townships for some components, particularly for activities that had been conducted in selected townships or those that will be introduced during the 2014-2018 period. A township with a population of approximately 180,000 was considered as a standard unit for different activities. The costs for coordination and monitoring of the RH Strategic Plan were also estimated.

The budget to carry out activities for RH in humanitarian settings depends on the occurrence and magnitude of the situation; and if the crisis is of significant magnitude, it is very likely that additional emergency funds and resources will be required.

Unit costs of different operational activities were obtained from the officials of the Reproductive Health Programme of the MoH and UNFPA. MoH officials provided implementation costs of MNCH activities including different training programmes and monitoring related activities. UNFPA officials provided information on unit costs of birth spacing commodities, BCC materials, cervical cancer screening and RH in emergencies. Costs data of Five-Year Strategic Plan for Reproductive Health (2009-2013)⁴⁶ were the sources of unit costs of post abortion care, cervical cancer screening, RTI/STI services and their respective coverage rates. Future years' costs were discounted using the appropriate inflation factor derived from the GDP deflator. Different published reports⁴⁷ were considered as sources of information to estimate the number of 12 year-old female students.

⁴³Sowjanya and Kasriye (2009) Cost Effectiveness of Reproductive Health Interventions in Uganda: the Case for Family Planning Services

⁴⁴Dayaratna et al(2000) Reproductive health interventions: Which ones work and what do they cost? Washington DC: Policy Project

⁴⁵Ross and Elizabeth (1993) Findings from Two Decades of Family Planning Research Population Council.

⁴⁶Five-Year Strategic Plan for Reproductive Health (2009-2013), Department of Health, Ministry of Health, Myanmar

⁴⁷Myanmar Multiple Indicator Cluster Survey 2009-2010

Reproductive Health Statistics 2009 Department of Health Planning and Department of Health

A spreadsheet was prepared with the list of all the operational activities with unit costs and the quantities of units by years. All required activities, irrespective of sources, were identified so that the total cost of the operational activities of the RH strategic plan can be estimated. All costs were estimated in US\$.

Table 10.1 shows the costing of the Strategic Plan for RH (2014-2018) and Table 10.2 summarizes the budget for major activities including for thematic areas. The assumption is that a total US\$ 318.66 million will be required to adequately implement all the operational activities for the period 2014 to 2018, increasing from US\$ 36.85 million in 2014 to US\$ 95.13 million in 2018.

MoH in partnership with development partners will fund the Strategic Plan for RH. Adequate resources will be mobilized from state/regional governments.

Table 10.1 Costing of RH Strategic Plan (2014-2018)

No.	Strategic activities	Level	Activity	2014		2015		2016		2017		2018		Total
				unit	cost									
Table 5: Comprehensive Level RH activities														
1.1	Review/Update operational policies and regulatory mechanisms for service provision by individuals and AHOs	NAT	REG	15,000	1	15,000								15,000
1.2	Revised Health Care Co-ordinating Committee (MCH) (2013-18) (5-year meeting)	NAT	ACC	1,000	4	4,000	4	4,000	4	4,000	4	4,000	4	20,000
1.3	Development of public trials and demonstration (Key-Audit) Reports for reproductive public	NAT	REG	1	100	100			300	300			100	900
1.4	Survey, Review and Update of Guidelines, SOP, Manual and Curriculum	NAT	GLI/IE	10,000	2	20,000	2	20,000	1	10,000	1	10,000	1	70,000
1.5	Need up to date human resources for RH services	NAT	REG	8,000	1	8,000								8,000
1.6	Establish a RH Legal, Management Unit and LMS	NAT	REG	12,000	1	12,000	1	12,000	1	12,000	1	12,000	1	60,000
1.7	Multiple Informal RH Programmes (MIS) and RH implementation pathway	NAT	CON	1,000	4	4,000	4	4,000	4	4,000	4	4,000	4	20,000
1.8	RH community security	NAT	REG	80,000	1	80,000	1	80,000	1	80,000	1	80,000	1	400,000
1.9	Support for Regional training centre and training team	REG	TRN	15,000	2	30,000	7	105,000	5	75,000	14	210,000	14	210,000
1.10	Stocks for service clinics, operational emergency kit, emergency response, manual and print job aids, manuals and SOP documents	NAT	ACC	2,000	3	6,000	3	6,000						12,000
1.11	Stocks for service clinics, operational emergency kit, emergency response, manual and print job aids, manuals and SOP documents	NAT	ACC	1	10,000	1	10,000	1	10,000	1	10,000	1	10,000	40,000
1.12	Conduct user meetings on MCH	NAT	REG	8,000	1	8,000	1	8,000	1	8,000	1	8,000	1	32,000
1.13	State/Regional meetings for MCH	NAT	REG	3,000	14	42,000	14	42,000	14	42,000	14	42,000	14	210,000
1.14	Travel/Regional meetings for MCH (2015-2018)	NAT	ACC	10,000	0	0	50	500,000	10	100,000	10	1,000,000	10	1,000,000
Sub Total For Table 5				295,500		295,500		295,500		295,500		295,500		1,191,000
Table 6: Frequency, Delivery, Postpaid and Non-Paid Care														
Strengthen Health Services														
2.1	Existing Environment	NAT	ACC	10,000	1	10,000								10,000
2.2	Double monthly tasks of rubrics to health workers	NAT	ACC	10,000	1	10,000								10,000
2.3	Build national capacity for MCH	TRN	TRN	9,000	3	27,000	3	27,000	3	27,000	3	27,000	3	108,000

No.	Initiative/Activity	Level	Priority	Impact (\$)	2014		2015		2016		2017		2018		Total
					est.	act.	est.	act.	est.	act.	est.	act.			
62	Infrastructure and Logistics Management														
24	Capital and equipment for health care	TP	60	25,000	0	200,000	15	20,000	15	20,000	15	20,000	15	20,000	1,000,000
Major activity fully integrated in activities															
61	Safe community security														
25	AVI Package	TP	100V	1	4,914,000	1	4,114,000	1	4,114,000	1	4,114,000	1	4,114,000	1	16,456,000
26	Delivery Package	TP	100V	1	151,250	1	1,001,000	1	1,001,000	1	1,001,000	1	1,001,000	1	13,000,000
27	PMU Package	TP	100V	1	12,211	1	16,000	1	15,000	1	15,000	1	15,000	1	47,201
28	Network Care Package	TP	100V	1	21,201	1	203,000	1	203,000	1	203,000	1	203,000	1	805,000
29	Emergency Disaster Care Package (Health)	TP	100V	1	2,481,200	1	2,381,200	1	2,381,200	1	2,381,200	1	2,381,200	1	9,500,000
245	Emergency Disaster Care Package (Community)	TP	100V	1	109,300	1	100,000	1	100,000	1	100,000	1	100,000	1	385,111
63	Expert Knowledge of Services														
210	Stimulants to stimulate medical practice	TP	100V	100	10,000	100	100,000	100	100,000	100	100,000	100	100,000	100	400,000
211	Training to stimulate medical practice	TP	100V	1,000	100,000	1,000	1,000,000	1,000	1,000,000	1,000	1,000,000	1,000	1,000,000	1,000	4,000,000
214	Training to stimulate medical practice & community and health system support	TP	100V	1,000	100,000	1,000	1,000,000	1,000	1,000,000	1,000	1,000,000	1,000	1,000,000	1,000	4,000,000
64	Improve Performance of Health Providers														
216	Preventive care services (community health)	TP	100V	1,000	100,000	1,000	1,000,000	1,000	1,000,000	1,000	1,000,000	1,000	1,000,000	1,000	4,000,000
218	Training to improve medical practice (community health)	TP	100V	1,000	100,000	1,000	1,000,000	1,000	1,000,000	1,000	1,000,000	1,000	1,000,000	1,000	4,000,000
217	Training to improve medical practice (community health)	TP	100V	1,000	100,000	1,000	1,000,000	1,000	1,000,000	1,000	1,000,000	1,000	1,000,000	1,000	4,000,000
218	Supervision and	TP	100V	100	100,000	100	1,000,000	100	1,000,000	100	1,000,000	100	1,000,000	100	4,000,000
64	Strengthen Effective Systems of Health														
219	Support to a primary center	TP	100V	1,000	1,000,000	1,000	1,000,000	1,000	1,000,000	1,000	1,000,000	1,000	1,000,000	1,000	4,000,000
65	Improve Existing Health														
220	Health system support	TP	100V	100,000	100,000,000	100,000	100,000,000	100,000	100,000,000	100,000	100,000,000	100,000	100,000,000	100,000	400,000,000
66	Community Engagement														
221	Community involvement in health and economic development	TP	100V	100,000	100,000,000	100,000	100,000,000	100,000	100,000,000	100,000	100,000,000	100,000	100,000,000	100,000	400,000,000
222	Support health system for community health volunteers	TP	100V	100,000	100,000,000	100,000	100,000,000	100,000	100,000,000	100,000	100,000,000	100,000	100,000,000	100,000	400,000,000

No.	Strategic Objectives	Level	Priority	2015		2016		2017		2018		Total
				start	end	start	end	start	end	start	end	
2.2	80% of all 15-19 year olds in the region are protected from unintended pregnancies	15A	80C	100	70	100	70	100	70	100	300	70,000
Sub Total for table 1				9,000,000		11,677,200		10,000,000		10,000,000		31,687,200

Table 3.5: Core Goals 1

II. Stop plan health systems												
Enabling Environment												
21	Ensure adequate budget and resources for service provision	15A	80B	5	8000							15,000
22	Conduct advocacy	15A	80B	1	8000							75,000
Implementation and Capacity Development												
23	100% Training Community Health Workers	15A	80	1	10,000,000	1	10,000,000	1	10,000,000	1	10,000,000	30,000,000
24	100% of all health workers	15A	19A	100	100,000	100	100,000	100	100,000	100	100,000	300,000
25	Training of health workers on SRH services	15A	19B	100	100,000	100	100,000	100	100,000	100	100,000	300,000
26	Training of health workers on SRH services	15A	19B	100	100,000	100	100,000	100	100,000	100	100,000	300,000
27	Training of health workers on SRH services	15A	19B	100	100,000	100	100,000	100	100,000	100	100,000	300,000
28	Training of health workers on SRH services	15A	19B	100	100,000	100	100,000	100	100,000	100	100,000	300,000
29	Community Health Workers	15A	19B	100	100,000	100	100,000	100	100,000	100	100,000	300,000
Community Engagement												
30	100% of all health workers are trained on SRH services	15A	19B	100	100,000	100	100,000	100	100,000	100	100,000	300,000
31	100% of all health workers are trained on SRH services	15A	19B	100	100,000	100	100,000	100	100,000	100	100,000	300,000
Sub Total for table 3												
				9,000,000		11,677,200		10,000,000		10,000,000		31,687,200

Table 3.6: Core Goals 2

III. Stop plan health systems												
Enabling Environment												
41	Ensure adequate budget and resources for service provision	15A	80B	5	8000							15,000
42	Conduct advocacy	15A	80B	1	8000							75,000
Implementation and Capacity Development												
43	100% Training Community Health Workers	15A	80	1	10,000,000	1	10,000,000	1	10,000,000	1	10,000,000	30,000,000
44	100% of all health workers	15A	19A	100	100,000	100	100,000	100	100,000	100	100,000	300,000
45	Training of health workers on SRH services	15A	19B	100	100,000	100	100,000	100	100,000	100	100,000	300,000
46	Training of health workers on SRH services	15A	19B	100	100,000	100	100,000	100	100,000	100	100,000	300,000
47	Training of health workers on SRH services	15A	19B	100	100,000	100	100,000	100	100,000	100	100,000	300,000
48	Training of health workers on SRH services	15A	19B	100	100,000	100	100,000	100	100,000	100	100,000	300,000
49	Community Health Workers	15A	19B	100	100,000	100	100,000	100	100,000	100	100,000	300,000
Community Engagement												
50	100% of all health workers are trained on SRH services	15A	19B	100	100,000	100	100,000	100	100,000	100	100,000	300,000
51	100% of all health workers are trained on SRH services	15A	19B	100	100,000	100	100,000	100	100,000	100	100,000	300,000
Sub Total for table 3												
				9,000,000		11,677,200		10,000,000		10,000,000		31,687,200

No.	Strategic initiative	Level	Index	2016		2015		2014		2013		2012		2011		Total
				part	new	old	new	old	new	old	new	old	new	old		
	Availability of Human Resources															
	Advanced Care and Support Background															
43	HR Community Learning (Healthcare Support)	TSP	0201	15,100	0	10,400	0	108,700	0	1,201,900	100	1,018,200	100	1,018,200	100	7,029,440
44	Supporter web	TSP	0104	700	0	1,000	0	0	0	60,500	100	70,000	100	70,000	100	40,000
40	Increase access to quality, integrated Wf services															
	Improve the service of health Wf Wf															
45	Therapeutic and Learning Skills Training	TSP	T04	10,000	0	10,000	0	108,000	0	1,000,000	100	1,000,000	100	1,000,000	100	4,000,000
	Strategic Infection Systems of Return															
46	Support for emergency visits	TSP	0001	1,000	0	12,000	0	18,000	0	90,000	100	100,000	100	100,000	100	400,000
40	Community Engagement															
	Behavior Change Communication Strategy															
	Community Accountability of BCI Needs and Initiatives															
47	Community Outreach activities	TSP	0004	0,000	0	24,000	0	0	0	100,000	100	100,000	100	100,000	100	500,000
	Support of Health Advocates by CHD															
48	BCI activities for health, mental health and substance abuse services (strong networks and international connections)	TSP	0002	0,000	0	18,000	0	108,000	0	100,000	100	100,000	100	100,000	100	500,000
	Sub Total for table 1					100,000		1,100,000		3,000,000		3,000,000		6,000,000		12,000,000
Table 5: BUDGETARY																
50	Strengthen local systems															
	Infrastructure and Logistics Background															
51	HR community activity	TSP	0001	40,000	0	1,000,000	100	4,000,000	100	5,000,000	100	5,000,000	100	12,000,000	100	12,000,000
50	Increase access to quality, integrated Wf services															
	Improve the service of health Wf Wf															
52	Train to be health advocates	TSP	T04	1,000	0	18,000	0	18,000	0	90,000	100	100,000	100	100,000	100	400,000
50	Community Engagement															
	Support of Health Advocates by CHD															
53	BCI activities for health, mental health and substance abuse services (strong networks and international connections)	TSP	0002	0,000	0	18,000	0	108,000	0	100,000	100	100,000	100	100,000	100	500,000

Sl. No.	Strategies/Activities	Level	Manpower (FTE)	2014		2015		2016		2017		2018		Total
				cost	unit	cost	unit	cost	unit	cost	unit	cost	unit	
Table 3: Core/ Critical Custom Running														
PH - Strengthening Health Systems														
Building Environment 1														
7.1	Training of health staff and community for disease control	PH/7	400	10000	1	10000								10,000
7.2	Community training	PH/7	400	15000	1	15000								15,000
Infrastructure and Logistics Management														
7.3	Transport, equipment and communication for disease control	PH/7	2000	95,000	10	10,00,000	50	50,00,000	100	1,00,00,000	150	1,50,00,000	150	1,50,00,000
PH - Increase access to quality, integrated PH services														
Expand the Package of the Services														
7.4	MS and commodities (1 each lot)	PH/7	8000	95,000	10	10,00,000	50	50,00,000	100	1,00,00,000	150	1,50,00,000	150	1,50,00,000
7.5	Human Resources (three vaccine specialists in each zone)	PH/7	3000	17,00,000	3	17,00,000	3	17,00,000	3	17,00,000	3	17,00,000	3	17,00,000
Improve Performance of health facilities														
7.6	Training of the staff	PH/7	3000	15,000	10	45,000	50	22,50,000	100	45,00,000	150	67,50,000	150	67,50,000
7.7	Training of the staff (refresher courses)	PH/7	3000	4,50,000	10	45,00,000	50	22,50,000	100	45,00,000	150	67,50,000	150	67,50,000
PH - Community Engagement														
Support Health Promotion by CHV														
7.8	Conduct of door-to-door BCC activities - CHV activities and community mobilization	PH/7	4000	2,00,000	40	10,00,000	100	40,00,000	150	60,00,000	200	80,00,000	200	80,00,000
Table 4: Sub-Total														
8.1	Cost of training in detail incorporated in vaccine supplies	PH/7	5000	2,00,000	10	20,00,000	50	20,00,000	100	40,00,000	150	60,00,000	150	60,00,000
Table 5: Incorporating Gender Perspectives														
PH - Strengthen Health Systems														
Strengthening the Health Sector Response to GAC														
8.3	Mobile equipment of responding to GAC and LCP (PH)	PH/7	30,000	15,00,000	1	15,00,000								15,00,000

No.	Strategic Initiative	Level	Activity	2014		2015		2016		2017		2018		Total	
				unit	cost	unit	cost	unit	cost	unit	cost	unit	cost		
8.0	Strengthened governance of RH services programming	NAT	10,000	10,000	5	50,000								10,000	
8.1	Conduct training of trainers for RH services	NAT	1,000	1,000	5	7,000								7,000	
8.2	Conduct training for RH services	NAT	10,000	10,000	10	20,000	10	20,000	10	20,000	10	20,000	10	20,000	80,000
9.0	Improve access to quality, integrated RH services														
9.1	Printing of materials on targeting step in RH Program tools	NAT	10,000	10,000	1	10,000	1	10,000	1	10,000	1	10,000	1	10,000	40,000
9.2	Advocacy and targeting of health providers for scale up in private	TSP	1,000	1,000	100	100,000	100	100,000	100	100,000	100	100,000	100	100,000	400,000
9.3	Community Engagement														
9.4	Conduct community outreach for RH services	TSP	100	100	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	40,000	160,000
9.5	Scale community outreach for RH & HIV	TSP	100	100	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	40,000	160,000
9.6	Conduct training in awareness	TSP	100	100	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	40,000	160,000
9.7	Scale up for rollout	TSP	100	100	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	40,000	160,000
10.0	Strengthen health systems														
10.1	Establish and strengthen primary health care facilities in 100 PHUs	REG/TSP	100	100	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	40,000	160,000
10.2	Support community health workers for interventions	NAT	100	100	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	40,000	160,000
10.3	Strengthen and Upgrade Management														
10.4	Strengthen and Upgrade Management	TSP	100	100	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	40,000	160,000
10.5	Strengthen access to quality, integrated RH services														
10.6	Strengthen the primary health care workforce	NAT	100	100	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	40,000	160,000
10.7	Strengthen the health care workforce	REG	100	100	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	40,000	160,000
10.8	Strengthen the health care workforce	TSP	100	100	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	40,000	160,000
10.9	Strengthen the health care workforce	TSP	100	100	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	40,000	160,000
10.10	Strengthen the health care workforce	TSP	100	100	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	40,000	160,000

No.	Project/Activity	Level	Priority	Start year (Y)	2014		2015		2016		2017		2018		Total
					USD	CHF	USD	CHF	USD	CHF	USD	CHF			
12.1.9	Year 1000 training for staff of 100 health centres in the north	TSP	1000	1,000	0	100,000	0	100,000	0	100,000	0	100,000	0	100,000	991,000
	Sub-Total for table 10				1,000,000		1,000,000		1,000,000		1,000,000		1,000,000		3,991,000
Table 11: Monitoring & Evaluation activities															
11.1	Monitoring of staff in reproductive health training health	TSP	1000	750	0	247,500	0	247,500	0	247,500	0	247,500	0	247,500	1,237,500
11.2	Training of staff for health centres	TSP	1000	2,000	100	200,000	100	200,000	100	200,000	100	200,000	100	200,000	800,000
11.3	Training of staff for health centres in reproductive health	TSP	1000	2,000	0	0	0	0	0	0	0	0	0	0	800,000
11.4	Training of staff for health centres in reproductive health	TSP	1000	1,000	0	100,000	0	100,000	0	100,000	0	100,000	0	100,000	400,000
11.5	Research on reproductive health in the north	TSP	1000	1,000	0	0	0	0	0	0	0	0	0	0	400,000
11.6	Research on reproductive health in the north	TSP	1000	1,000	0	0	0	0	0	0	0	0	0	0	400,000
11.7	Research on reproductive health in the north	TSP	1000	1,000	0	0	0	0	0	0	0	0	0	0	400,000
	Sub-Total for table 11				100,000		400,000		400,000		400,000		400,000		1,637,500
	GRAND TOTAL				10,000,000		41,700,000		51,690,000		58,260,000		65,710,000		219,660,000

Table 10.2 Summary of Budget for Strategic Plan on Reproductive Health

	Strategies/Activities	2014	2015	2016	2017	2018	2014-2018
1	Central/National Level RH activities	350,500	295,000	282,000	279,000	294,000	1,591,500
2	Pregnancy, Delivery, Postnatal and Neonatal Care	16,348,680	17,517,204	19,258,664	18,920,538	19,444,211	91,489,698
3	Birth Spacing	11,281,804	13,098,022	14,400,160	14,817,774	15,290,241	71,039,101
4	Miscarriage and post-abortion care	980,120	1,775,600	2,840,568	3,551,206	4,261,440	12,009,525
5	RTI/STI/HIV	3,351,536	6,414,672	9,475,008	12,538,044	15,601,000	47,384,049
6	Adolescent and Youth Health	665,500	884,500	1,131,500	1,378,500	1,625,500	5,685,500
7	Cervical Cancer Screening	500,200	1,980,000	3,144,000	35,869,843	36,661,843	78,155,886
8	Infertility	0	30,000	30,000	30,000	30,000	120,000
9	Incorporating Gender Perspectives	269,200	271,200	284,200	284,200	284,200	1,393,000
10	RH in Humanitarian Settings	1,110,635	1,110,635	1,110,635	1,110,635	1,110,635	5,553,175
11	Monitoring & Evaluation and Research	600,500	480,500	780,500	480,500	540,500	2,882,500
	GRAND TOTAL	36,849,675	44,728,033	52,689,827	80,263,134	95,133,950	318,663,529

Annex 1 National Population Policy

Draft (1992)

1. Improve the health status of Women and Children by ensuring the availability and accessibility of birth-spacing services to all married couples voluntarily seeking such services.
2. Provide the community with information, education and communication measures on birth-spacing in advance as it is important.
3. Encourage Myanmar women to fully participate as equal partners in national development by giving them equal status with men.
4. Promote the awareness of citizens of the nation on the responsibility of the reproductive behavior and also educate the male population of their responsibility.
5. Utilization of young people in national development efforts as youth population of under 18 constitutes about 50% of the total population.
6. The government is committed to a strategy of providing essential health care using the primary health care approach. Therefore, to attain the prevention of diseases and promotion of healthy lifestyle, the basic facts included in the primary health must be emphasized.
7. Raise the social status of the rural community by taking into account the internal and international migration issues. Integration of comprehensive urbanization policy into the overall development planning process while ensuring effective economic interdependence between towns and villages.
8. Raise the awareness of the importance of population information and vital statistics for socioeconomic planning.
9. Review and amendment of existing legislation to support the achievement of the objectives of the population policy.

Annex 2 National Health Policy

(1993)

1. To raise the level of health of country and promote the physical and mental wellbeing of the people with the objective of achieving "Health for all by the year 2000" goals, using primary health care approach
2. To follow the guidelines of the population policy formulated in the country
3. To produce sufficient as well as efficient human resources for health locally in the context of broad framework of long-term health development plan
4. To abide strictly by the rules and regulations mentioned in the drug laws and by-laws, which are promulgated in the country
5. To augment cooperative, joint ventures, private sector and non-governmental in delivery of health care in view of the changing economic system
6. To explore and develop alternative health care financing system
7. To implement health activities in close collaboration and in an integrated manner with related ministries
8. To promulgate new rules and regulations in accord with the prevailing health and health-related conditions as and when necessary
9. To intensify and expand environmental health activities including prevention and control of air and water pollution
10. To promote national physical fitness through the expansion of sports and physical education activities by encouraging community participation, supporting outstanding athletes and reviving traditional sports
11. To encourage conduct of medical research activities not only on prevailing health problems but also giving due attention in conducting health systems research
12. To expand the health service activities not only to rural but also border areas to meet the overall health needs of the country
13. To foresee any emerging health problem that poses a threat to the health and wellbeing of the people of Myanmar, so that preventive and curative measures can be initiated
14. To reinforce the services and research activities of indigenous medicine to international level and to involve in community health care activities
15. To strengthen collaboration with other ministries for national health development

Annex 3 Myanmar Reproductive Health Policy (2002)

Goal: To attain a better quality of life by improving reproductive health status of women and men, including adolescents through effective and appropriate reproductive health programs undertaken in a life-cycle approach.

The National Reproductive Health Policy states:

1. Political commitment should be sustained to improve reproductive health status in accordance with the National Health Policy and to promote rules, regulations and laws on reproductive health.
2. Reproductive health care services and activities should be conformed with National Population Policy.
3. Full respect to laws and religion, ethical and cultural values must be ensured in the implementation of reproductive health services.
4. The concept of Integrated reproductive health care must be introduced into existing health services.
5. Effective partnerships must be strengthened among and between government departments, non-governmental organizations and the private sector in providing reproductive health.
6. Reproductive health services must be accessible, acceptable and affordable to all women and men, especially underserved groups including adolescents and elderly people.
7. Effective referral systems must be developed among and between different levels of services.
8. The development of appropriate information, education and communication (IEC) material must be strengthened and disseminated down to the grass-root level to enhance the community awareness and participation.
9. Appropriate and effective traditional medicines and socio-cultural practices beneficial for reproductive health must be identified and promoted.
10. Adequate resources must be ensured for sustainability of reproductive health programme.

Annex 4 Objectives of Myanmar Health Vision 2030

1. To uplift the health status of the people
2. To make communicable diseases no longer public health problems, aiming towards total eradication or elimination and also to reduce the magnitude of other health problems
3. To foresee emerging diseases and potential problems and make necessary arrangements for the control
4. To ensure universal coverage of health service for the entire nation
5. To train and produce all categories of human resources for health within the country
6. To modernize Myanmar Traditional Medicine and to encourage more extensive utilization
7. To develop Medical Research and Health Research up to international level
8. To ensure availability of sufficient quantity of quality essential medicine and traditional medicine within the country
9. To develop a health system in keeping with changing political, economic, social and environmental situation and changing technology

Annex 5 Definitions

Annex 5 a: Reproductive health as defined in ICPD PoA

Reproductive rights and reproductive health. Reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system and to its functions and processes. It implies that people have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this is the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility, which are not against the law, and the right of access to health-care services that will enable women to go safely through pregnancy and childbirth. Reproductive health care also includes sexual health, the purpose of which is the enhancement of life and personal relations.

Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other relevant UN consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence. Full attention should be given to promoting mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality.

All countries are called upon to strive to make reproductive health accessible through the primary health-care system to all individuals of appropriate age as soon as possible and no later than 2015. Such care should include, *inter alia*: family planning counselling, information, education, communication and services; education and services for prenatal care, safe delivery and post-natal care, especially breast-feeding and infant and women's health care; prevention and treatment of infertility; abortion as specified in paragraph 8.25; treatment of reproductive tract infections, sexually transmitted diseases (STDs) and other reproductive health conditions; and information, education and counselling on human sexuality, reproductive health and responsible parenthood.

Annex 5 b: Core elements of WHO Global Reproductive Health Strategy

The five core aspects of reproductive and sexual health of WHO Global Reproductive Health Strategy are: improving ante-natal, perinatal, postpartum and newborn care; providing high-quality services for family planning, including infertility services; eliminating unsafe abortion; combating sexually transmitted infections including HIV, reproductive tract infections, cervical cancer and other gynaecological morbidities; and promoting sexual health.

Annex 6 Contents of Essential Package of RH Interventions

Antenatal Care	Neonatal Care
Scheduling four focused visits (12, 24, 36, 39 wks)	Thermal management
Birth preparedness (birth/emergency plan)	Availability of neonatal resuscitation
Detection and treatment of anaemia	Immediate and exclusive breastfeeding
Detection and treatment of malaria	Care of the umbilical cord
Tetanus immunisation	Early detection and management of infections and jaundice
Screening and treatment of syphilis	Counseling (e.g. nutrition, exclusive breastfeeding, recognition of complications/danger signs)
Detection and treatment of hyperreflexive disorders	Availability of EmONC and management of low-birth weight babies
Availability of HIV counseling and testing	Postnatal care
Availability of parenteral anticonvulsants for pre-eclampsia/eclampsia	Provision of four targeted visits (within 24 hours, day 3, 7-14 day, day 42) for mother and baby
Availability of oral and parenteral antibiotics	Early detection, referral and management of complications in mother and newborn
Availability of corticosteroids for preterm labour, prelabour rupture of membranes	Iron/folate supplementation
Counseling (e.g. nutrition, recognition of complications/danger signs)	Vitamin A supplementation
Availability of EmONC (e.g. referral system, surgery)	Birth spacing plan and service provision
Delivery care	Counseling (e.g. nutrition, recognition of complications/danger signs)
Universal precautions (access to clean delivery)	Availability of EmONC (e.g. referral system, management of emergencies)
Skilled birth attendant at delivery	Miscarriage and postabortion care
Availability of HIV counseling and testing	Counseling (e.g. Birth spacing, signs of miscarriage, dangers of unsafe abortion)
Use of partograph	Management of post-abortion complications (Manual vacuum aspiration at appropriate level)
Active management of third stage of labour	Management of severe complications (e.g. injury, infection, shock, haemorrhage)
Routine placenta examination	Availability of emergency care (referral system, and surgery)
Availability of parenteral anticonvulsants for pre-eclampsia/eclampsia	Post-abortion counseling and service provision
Availability of oral and parenteral antibiotics	RTI/STI and HIV
Availability of EmONC (e.g. referral system, surgery)	Diagnosis and treatment of RTIs/STIs
Birth spacing Services	Condoms
Counseling and follow-up on methods	Availability of HIV counseling, testing, treatment
Availability of oral contraceptives	Cervical Cancer
Availability of three-monthly injectables	Counseling
Availability of IUD services	Screening by VIA and cryotherapy
Availability of condoms for dual protection	Infertility
Availability of implant services	Diagnosis, investigations & referral
Availability of emergency contraception	Gender-based violence
Availability of voluntary surgical contraception (male and female)	Awareness (e.g. gender equity, GBV, engagement of men)
Adolescent and youth RH services	Identification, treatment, referral and social support for women who have experienced GBV
Availability of AY friendly RH information & services	

Annex 7 Reproductive Health Stakeholders

Ministries	Councils	INGOs
Ministry of Health	Myanmar Medical Council	Association Francaise-Xavier Bagnoud
Ministry of Social Welfare, Relief and Resettlement	Myanmar Nurses and Midwives Council	Burnet Institute
Ministry of Education		Care Myanmar
	National NGOs	The Clinton Health Access Initiative (CHAI)
National Programmes	Myanmar Medical Association	Danish Red Cross
National Malaria Control Programme	Myanmar Maternal and Child Welfare Association	Community Partners International
National AIDS Programme	Myanmar Nurses and Midwifery Association	Family Health International (FHI)
National Nutrition Centre	Myanmar Women's Affairs Federation	Health Poverty Action
School Health Programme	Myanmar Health Assistants Association	Japanese Organization for International Cooperation in Family Planning (JOICFP)
MOH Departments and Sections	Multilaterals	JHPIEGO (Johns Hopkins Program for International Education in Gynecology and Obstetrics)
Department of Health	IOM	John Snow International
Department of Planning and Statistics	UNFPA	Marie Stopes International
Department of Medical Sciences	UNICEF	Medecins du Monde
Universities of Medicine, Nursing/Midwifery and Public Health	WHO	Merit
Departments of Medical Research	Bi-laterals	Population Services International (PSI)
Central Expanded Programme on Immunization	Japanese International Co-operation Agency (JICA)	Program for Appropriate Technology in Health (PATH)
Central Health Education Bureau		Pact Myanmar
Medical Care Division		Relief International
Public Health Division		Save the Children
Women and Child Health Development Section		World Vision

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Operation Plan for 2014

Coding of RH Strategic Plan (2014)

No.	Strategies/Activities	Level/Activity	2014		Responsibility							
			staff	cost	UNDP	WHO	WHO/UNAIDS	MSI	PSI	3-MSRG	MSK/PA	MEMBERS Staff
Table 3: Central/National Level RH activities												
1.1	Review/Update operational policies and regulatory mechanisms for service provision by providers and APOs.	SAT RDN	1	15,000	2,705							
1.2	Strengthen Health Sector Co-ordinating Committee (MSCH) (MSCH, RH/NG meeting).	SAT ADN	4	4,000	4,000							
1.3	Development of policy notes and documents on key national priorities and initiatives (MSCH).	SAT RDD	1	1,500	1,514	64,208						
1.4	Develop, Review and Revise of Guidelines, SOP, Manual and Curricula.	SAT CLM	2	20,000	11,000	4,000						
1.5	Advocacy/Training & Monitoring to review human resources for RH activities.	SAT RVC	1	4,000	-	4,000					44,119	
1.6	Establish a RH Logistic Management Unit and LMB.	SAT SDLN	1	12,000	2,000							
1.7	Strengthen existing RH Programs, IMB and RH information systems.	SAT USN	4	4,000	404							
1.8	RH communication activities-3-Backstage	SAT SDCN	1	30,000	30,000						1,411,170	1,401
1.9	Support for Regional training centers and country team.	RDT TRN	7	103,000	4,614				45,000			4,906
1.10	Meetings to develop lessons, standardized messages for behavior change (primarily at the intervention).	SAT DCC	3	6,000	17,332							4,907
1.11	Developing, reviewing, writing and print the job aids, brochures and RC materials.	SAT DCC	1	90,000	13,000				100,204	170,134		4,400
1.12	Standardization of materials and a guide for MNCHE/CHLS-2010.	SAT DCC	10	100,000	2,000				12,400			
Sub-Total for Table 3				874,400	81,862							
Table 2: Programmes, Delivery, Production and Networks Costs												
2b	Strengthen Districts by actions											
2c	Strengthen Communities											
2.1	Develop advisory tools and materials for decision makers	SAT ADN	1	150,000	-				2,000			
2.2	Strengthen activities	SAT ADN	1	150,000	-				12,000			50,300
2.3	Build community capacity for CHLS.	TSP TRN	1	150,000					41,000			14,000
2.4	Information and Logistics Management											
Note: Information and Logistics Management cost (length charges on...)												

No.	Strategic Activities	Level	No. and (B)	2014		Responsibility										
				USP	DFP	USP	DFP	UNFPA	WHO	HRDO/CAV	MSI	PSI	3-MIG/CS	MAN/CS	US-11/0010	
2.4	Expansion and maintenance of health facilities	USP	DFP	20,000	18	200,000										
2B	Improve access to quality, integrated RH services															
2.5	Family Planning	USP	DFP	10,000	1	6,166,400										
2.6	Family Planning	USP	DFP	10,000	1	1,217,770										
	USP	DFP	10,000	1	10,000											
2.7	USP	DFP	10,000	1	17,811											
2.8	USP	DFP	10,000	1	21,150											
2.9	USP	DFP	10,000	1	2,000,207											
2.10	USP	DFP	10,000	1	95,007											
2.11	USP	DFP	10,000	1	100,000											
2.12	USP	DFP	10,000	1	1,100,000											
2.13	USP	DFP	10,000	1	1,200											
2.14	USP	DFP	10,000	1	900,000											
2.15	USP	DFP	10,000	1	1,150,000											
2.16	USP	DFP	10,000	1	252,830											
2.17	USP	DFP	10,000	1	1,100,000											
2.18	USP	DFP	10,000	1	900,000											
2C	Community Engagement															
2.19	USP	DFP	10,000	1	50,000											
2.20	USP	DFP	10,000	1	50,000											
2.21	USP	DFP	10,000	1	50,000											
2.22	USP	DFP	10,000	1	50,000											
2.23	USP	DFP	10,000	1	50,000											
2.24	USP	DFP	10,000	1	50,000											
2.25	USP	DFP	10,000	1	50,000											
2.26	USP	DFP	10,000	1	50,000											
2.27	USP	DFP	10,000	1	50,000											
2.28	USP	DFP	10,000	1	50,000											
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2.96	USP	DFP	10,000	1	50,000											
2.97	USP	DFP	10,000	1	50,000											
2.98	USP	DFP	10,000	1	50,000											
2.99	USP	DFP	10,000	1	50,000											
3.00	USP	DFP	10,000	1	50,000					</						

No.	Strategies/Activities	Level (Agency)	unit cost (\$)	2014		Responsibility						MID-TERM REPORT DATES
				unit	total	UNDP	WFP	UNICEF	WHO	UNFPA	USAID	
4. Building Foundations												
4.1.	Develop advisory panels and networks for decision makers	NAT ADV	15000	1	15000			20,000				
4.2.	Conduct advocacy	NAT ADV	15000	1	15000			15,000	20,000			
4.3.	Strengthen Community Security	TSP RH		1	18,500,000	1,000,000			1,800,000			18,500,000
Improve Performance of Health Workforce												
4.4.	Training for RH on high skilled/Physio Provider	TSP TRN	3,000	09	108,000			18,000	18,000			
4.5.	Training on RDT and Empregin Infection	TSP TRN	10,000	10	100,000			10,000	10,000			
4.6.	Supervision visit	TSP M&E	250	10	2,000,000			50,000	60,000			
Barriers Applicable Items												
4.7.	Support activities by MGF and ADPP	TSP ORA	3,000	10	3,000,000			1,000,000	1,000,000			6,000,000
4. Community Engagement												
Support Health Promotion by Community Health Volunteers												
4.7.	Community Awareness Raising on Birth Spacing (DMP, condom and emergency contraceptive)	TSP DCC	2,000	10	200,000				100,000			
Sub Total table 3												
					13,078,000	1,100,000						1,300,000
Table 4: Overview of unit cost allocation (US\$)												
45. Strengthen Health Systems												
Building Foundations												
4.1	Develop advisory panels and networks for decision makers	NAT ADV	10000	1	10000							
4.2	Conduct advocacy	NAT ADV	10000	1	10000			10,000				
Availability of Human Resources												
4.3.	IMC, community events including MVA equipment	TSP DCCV	30,107	10	101,620				51,408			
4.4.	Supervision visit	TSP M&E	250	10	2,500							
46. Barrier items to quality integrated RH services												
Improve Performance of Health Workforce												
4.5.	Training on POC including MVA (Physician)	TSP TRN	10,000	10	100,000				10,000			
4.6.	Support for emergency referral	TSP DCCV	1,200	10	12,000							
47. Community Engagement												
Behavior Change Communication Strategy												
Community Understanding of RH Needs and Incentive System												

No.	Strategies/Activities	Lead Agency	start end	Feasibility					MILBUDW Start			
				UNRPA	WHO	WORLDWAVE	MSF	PSI		Y-SDGs	SDG17.9	
	Improve Performance of Health Workforce											
6.5	Training for Health Care Providers	TSP	TKSN	3,000	25	15,000			2,600		8,715	
6.6	Training for Youth	TSP	TKSN	4,700	25	117,500			19,400		1,335	
	Community Engagement											
	Community Understanding of RH Needs and Incentives											
6.10	Workshops with community leaders	TSP	ADIC	300	25	65,500					14,000	
	Support Health Providers to CHW											
6.11	CHW related NCT activities (group sessions and	TSP	BOC	2,000	25	60,000			43,000			
6.12	PROVISIONAL COMMUNITY CHW	NSI	BOC	10,000	1	61,000						
	RH Field Test Pilot 1					661,000						
	Table 7: Cervical Cancer Services											
	Strengthen Health Systems											
	Facility Enhancement											
7.1	Develop robust supply and services for decision makers	NSAT	ADIC	100,000	1	100,000						
7.2	Conduct advocacy	NSAT	ADIC	100,000	1	100,000		10,000		6,430		
	Infrastructure and Logistics Management											
7.5	Supply, equipment and commodities for cervical cancer	TSP	SI-PH	10,000	10	100,000			19,200			
									17,800			
	28. Increase access to quality, integrated RH services											
	Revised Package of RH Services											
7.4	AMA and Contraception (1 unit/yr)	TSP	BOCVA	10,000	10	100,000						
7.6	Private Physicians Visit services (consultation to school girls)	NSAT	SI-PH	31,007,840	0	0						
	Revised Package of Health 9 activities											
7.8	Training on AMA (chWs)	TSP	TKSN	1,500	10	15,000			19,200			
7.7	Training on AMA and contraception education	TSP	TKSN	4,500	10	45,000			19,200			
	SC Community Engagement											
	Support health providers by CHW											
7.9	Cervical Cancer related POC activities (10 camp sessions and	TSP	BOC	2,000	10	115,200			2,800			
	Strategic communication)								23,100			
	Table 8: Strengthening Gender Program											
	Table 9: Strengthen Health Systems											
	Table 10: Strengthen Health Services											
	Table 11: Strengthen Health Services											

Source: Ministry of Health Service Programme to-LRIT

No.	Strategic Activities	Level (budget)	est cost (R)	2014		Responsibility											
				unit	cost	UNDEA	WDO	WDR/GAVI	MSR	PSI	J. MENA	MEDICA	MEBROAD				
8.1	Monitor activities of responding to HIV and STI (A101)	NAT (12.1M)	17,000	1	17,000												
8.2	Development of guidelines on GBV services and printing	NAT (12.1M)	10,000														
8.3	Conduct Training of Trainers for GBV services	NAT TRN 1,000	1,000								12,500						
8.4	Conduct training for GBV services	NAT TRN 2,000	2,000								25,314						
8B	Increase access to quality, integrated RH services																
8.5	Stocking of materials on strategic sites in RH programmes	NAT (12.1M)	10,000	1	10,000												
8.6	Advocacy and Training of health providers for safe abortion provider	TRP TRN 2,500	50	50	105,000												
8C	Community Engagement																
8.7	Conduct Community brief activities for each area of treatment	TRP C1001 800	50	50	57,000												
8.8	Radio community interventions on GBV GBV																
8.9	Signage for health services	TRP C1001 800	50	50	25,000												
	S&T Unit for 2014				267,000												
9A	Leadership, HR & Human Resource Skills																
9.1	Advocacy and activities on evidence that need, regional and Department	REGG ADV 1,100	14	14	15,400												
9.2	Sub-national technical working group for RH activities	NAT ADV 300	4	4	2,000												
9.3	Infrastructure and Logistics Management	TRP (6,494)	16,417	5	215,235												
9B	Increase access to quality, integrated RH services																
9.4	Recruitment RH to increase the number of health staff	NAT ADV 7,000	1	1	7,000												
9.5	Recruitment HR to increase the number of health staff	REGG TRN 4,000	3	3	22,000												
9.6	Recruitment HR to increase the number of health staff (up to 100,000 health clinics for 100,000 population)	TRP (6,494)	16,417	5	215,235												
9.7	Business Performance of Health Facilities	TRP TRN 3,000	66	66	191,000												
9.8	Direct observation (DO) for clinics, nurses and health staff	TRP TRN 3,000	66	66	191,000												
9.9	Direct observation (DO) in communities for health staff	TRP TRN 3,000	66	66	191,000												
9.10	Peer days training on use of RH kits (Managers, pharmacists)	TRP TRN 3,000	66	66	191,000												

No	Strategic Activities	Level/Activity	2014		Responsibility									
			sub	total cost (R)	UNFPA	WHO	WHO/CAS	MOH	PIH	3 MDGL	MOH/PA	MY BUDGET (R)		
Sub Total for table 5														
Table 10: Monitoring & Evaluation and Research														
10.1	Monitoring of Contraceptive Use, Training needs	TSP M&E	170	247,500			511,400					8,363	30,171	
10.2	Training on Maternal Death Review	TSP TRS	2,000	3,000,000										
10.3	Training on Maternal Death Surveillance & Response	TSP TRS	2,000			5,000								
10.4	Research (done national level annually)	S&T R&D	1	100,000								4,348		
10.5	Maternal review (2014)	S&T M&E		80,000										
10.6	Annual Evaluation (2015)	S&T M&E		40,000										
Sub Total for table 10														
				867,000										
TOTAL 2014				31,296,471	1,534,348	111,698	4,463,171	4,497,518	3,107,541	3,107,081	369,176	3,270,000		

	Strategies/Activities	Planned Cost
1	Central/National Level RH activities	373,500
2	Pregnancy, Delivery, Postnatal and Newborn Care	15,962,680
3	Birth Spacing	13,078,204
4	Post-Abortion Care	380,120
5	RTI/STI/HIV	3,286,536
6	Adolescent and Youth Health	665,500
7	Cervical Cancer Screening	500,200
8	Incorporating Gender Perspectives	269,200
9	RH in Humanitarian Settings	912,635
10	Monitoring & Evaluation and Research	567,500
	GRAND TOTAL	35,996,075

Planned Cost = 35,996,075

Actual Cost = 19,442,536

GAP = 16,553,539 (46%)

FIVE-YEAR STRATEGIC PLAN FOR REPRODUCTIVE HEALTH
(2014-2018)