

Report on Situation Analysis of Population and Development, Reproductive Health and Gender in Myanmar



July, 2010



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Foreword

The Programme of Action of the International Conference on Population and Development (ICPD), the Beijing Platform of Action and the Millennium Declaration are international commitments reflecting a common vision of a world free from poverty, illiteracy and HIV/AIDs where all people have information and means to safe and planned reproduction and where women and men enjoy equal rights.

Throughout the world, nations strive to fulfill their international obligations and achieve the Millennium Development Goals (MDGs). With only five years away from 2015, the target year of achieving ICPD goals and MDGs, Myanmar stands at a crossroads in its endeavour to achieve the Millennium targets. Issued at the 10th anniversary of the Millennium Summit, this situation analysis report provides valuable inputs in reviewing Myanmar's progress in achieving MDGs.

UNFPA has the honour to present a situation analysis of population and development, reproductive health and gender issues in Myanmar. This study, the most comprehensive of its nature to date, serves as a foundation for policy making, strategic planning and programming by Government, NGOs, INGOs, the international community and the UN.

The Situation Analysis report has identified the need to strengthen data systems and improve availability and quality of data. A population and housing census should be conducted to obtain comprehensive population and demographic data at the national and sub-national levels. Census data should be disaggregated by age, sex and locality and be gender sensitive to reflect the situation of women and men. The census will provide an up to date statistical sampling frame to be used for subsequent data collection activities.

To realize the 2015 targets of reducing maternal mortality ratio and the infant mortality rate, there is an urgent need for substantial investments to strengthen both health systems and health human resources to deliver quality reproductive health services including prevention and treatment of HIV/AIDS. Financial requirements are estimated for the implementation of the National Reproductive Health Strategic Plan (2009-2013). The Situation Analysis recommends that the Government of Myanmar and all other stakeholders identify financial commitments from existing and potential sources and join together to bridge the remaining resource gaps. Only through concerted efforts of all partners in the field of population and development, reproductive health and gender will there be advancement of the quality of life of the people of Myanmar.

This year-long study adopted a participatory and inclusive approach involving various national and international stakeholders. The study is enriched through its sound methodology, the involvement of a multi-sectoral team of national and international experts and the exhaustive review process of its findings and recommendations.

On behalf of UNFPA, I would like to extend sincere thanks and appreciation to all of our partners who provided invaluable inputs to the Situation Analysis. In this respect, I wish to thank the Ministry of National Planning and Economic Development, the Ministry of Health, the Ministry of Immigration and Population and the Ministry of Social Welfare, Relief and Resettlement, our sister UN agencies, NGOs and INGOs. I wish to thank colleagues at the Asia and Pacific Regional Office

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Given the transition that the country is going through and the anticipated data from the on-going Integrated Household Living Condition Assessment and the Multi-Indicator Cluster Survey, this study will remain a living document that will be regularly updated.



Mohamed Abdel-Ahad
Country Representative, UNFPA Myanmar

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The Situation Analysis (SA) Team express their heartfelt appreciation to UNFPA Myanmar for initiating and supporting this cross cutting study of population and development, reproductive health and gender; the first-ever analysis of this scope in Myanmar. Despite challenges in the form of scarcity of data and information in some of the areas covered, the SA team is indebted to the staff of the Ministry of National Planning and Economic Development, the Ministry of Health, the Ministry of Immigration and Population, and the Ministry of Social Welfare, Relief and Resettlement for their time and inputs given towards the success of this SA.

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Abbreviations and Acronyms

AD	Assistant Director
ADB	Asia Development Bank
ADPC	Asian Disaster Preparedness Centre
AIDS	Acquired Immune Deficiency Syndrome
AMTSL	Active Management of Third Stage of Labour
AMW	Auxiliary Midwife
AN	Antenatal
ANC	Antenatal care
APRO	Asia and the Pacific Regional Office
ARH	Adolescent Reproductive Health
ARI	Acute Respiratory Infection
ART	Anti Retroviral Therapy
AS	Assistant Surgeon
ASEAN	Association of South East Asia Nations
ASFR	Age Specific Fertility Rate
BCC	Behaviour Change Communication
BHS	Basic Health Staff
BNSC	Bachelor of Nursing Science
BS	Birth Spacing
BSC	Birth Spacing Commodities
BSS	Behavioural Surveillance Survey
CAPS	Continuous Assessment and Progression System
CBR	Crude Birth Rate
CDR	Crude Death Rate
CEDAW	Convention on Elimination of All Forms of Discrimination Against Women.
CFC	Chloro Fluro Carbon
CFR	Case Fatality Rate
CH	Child Health
CHEB	Central Health Education Bureau
CHW	Community Health Worker
CME	Continuous Medical Education
CMW	Currently Married Women
COMMIT	Coordinated Mekong Ministerial Initiative against Trafficking
CoRH	Community operated Reproductive Health
CPR	Contraceptive Prevalence Rate
CSG	Community Support Group
CSO	Central Statistical Organization
CTOC	Convention against Transnational Organized Crime (CTOC)
CWH	Central Women's Hospital
DAC	Development Assistant Committee
DEPT	Department of Educational Planning and Training
DG	Director General
DHP	Department of Health Planning
DHS	Demographic and Health Survey
DIC	Drop-in Centre
DMR	Department of Medical Research
DMR (LM)	Department of Medical Research (Lower Myanmar)
DOH	Department of Health
DOL	Department of Labour
DOP	Department of Population

DSW	Department of Social Welfare
DTC	Drug Treatment Centre
EB	Executive Board
EDEP	Equally Distributed Equivalent Percentage
EFA	Education for All
EMIS	Education Management Information System
EmOC	Emergency Obstetric Care
EMW	Ever Married Women
ENC	Essential Newborn Care
EPI	Environmental Performance Index
EPP	Estimation Projection Package
ESCAP	Economic and Social Commission for Asia and Pacific
ESD	Environmental Sanitation Division
EU	European Union
FAYS	Family and Youth Survey
FDA	Food and Drug Administration
FGD	Focus Group Discussion
FHAM	Fund for HIV and AIDS in Myanmar
FHP	Frontline Health Promoter
FIGO	Federation of International Gynecologists and Obstetricians
FRHS	Fertility and Reproductive Health Survey
FSW	Female Sex Worker
GAVI	Global Alliance from Vaccine Institute
GBV	Gender Based Violence
GDI	Gender related Development Index
GDP	Gross Domestic Products
GEM	Gender Empowerment Measures
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GMT	Greenwich Mean Time
GNI	Gross National Income
GNP	Gross National Product
GoUM	Government of Union of Myanmar
GP	General Practitioner
GTG	Gender Theme Group
HA	Health Assistant
HDI	Human Development Index
HIES	Household Income and Expenditure Survey
HIPC	Heavily Indebted Poor Countries
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRDI	Human Resource Development Indicator
HRH	Human Resources for Health
HSS	HIV Sero-surveillance Survey
IASC	Inter Agency Standing Committee
ICD	International Classification of Diseases
ICPD	International Conference on Population and Development
ICPD PoA	International Conference on Population and Development Programme of Action
IDU	Injecting Drug User
IEC	Information Education Communication
IHLCA	Integrated Household Living Conditions Survey in Myanmar
IMR	Infant Mortality Rate
INGO	International non- governmental organization
INRD	Immigration & National Registration Department

IPU	Inter-Parliamentary Union
IUD	Intrauterine Device
KAP	Knowledge, Attitude and Practice
LB	Live Birth
LF	Labour Force
LFPR	Labour Force Participation Rate
LFS	Labour Force Survey
LHV	Lady Health Visitor
LICs	Least Income Countries
LMIS	Logistic Management Information System
MARP	Most at risk population
M-CCM	Myanmar Country Coordination Mechanism
MCH	Maternal and Child Health
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Survey
MIES	Myanmar Income and Expenditure Survey
MISP	Minimum Initial Service Package
MMR	Maternal Mortality Ratio
MNH	Maternal and Newborn Health
MNPED	Ministry of National Planning and Economic Development
MO	Medical Officer
MOE	Ministry of Education
MOF	Ministry of Forestry
MOH	Ministry of Health
MOHA	Ministry of Home Affairs
MOIP	Ministry of Immigration and Population
MSWRR	Ministry of Social Welfare Relief and Resettlement
MSM	Men who have sex with men
MW	Midwife
NAP	National AIDS Program
NCEA	National Commission for Environmental Affairs
NCSMM	Nationwide Cause Specific Maternal Mortality Survey
NDPCC	Natural Disaster Preparedness Central Committee
NEQAS	National External Quality Assurance Scheme
NGO	Non Governmental Organization
NHC	National Health Committee
NHL	National Health Laboratory
NRS	Northern Rakhine State
NSDS	National Sustainable Development Strategy
NSP	National Strategic Plan
ObGyn	Obstetrics and Gynecology
ODA	Official Development Assistance
ODS	Ozone Depleting Substance
OECD	Organization for Economic Co-operation and Development
OG	Obstetric and Gynecologist
OHD	Occupational Health Division
ORS	Oral Rehydration Salt
OVC	Orphans and Vulnerable Children
P & D	Population and Development
PCFS	Population Changes and Fertility Survey
PDC	Peace and Development Council
PHC	Primary Health Care
PLHIV	People Living with HIV/AIDS

PMCT	Prevention of Mother to Child Transmission of HIV
PNC	Post Natal Care
PNM	Proportion Never Married
PONJA	Post Nargis Joint Assessment
PONREPP	Post Nargis Recovery and Preparedness Plan
PPP	Purchasing Power Parities
PWDs	Person with disabilities
RH	Reproductive Health
RHC	Rural Health Centre
RHMIS	Reproductive Health Management Information System
ROK	Republic of Korea
RS	Richter Scale
RTI	Reproductive Tract Infection
S/D	State / Division
SA	Situation Analysis
SBA	Skilled Birth Attendant
SH	School health
SHAPE	School Based Healthy Living and AIDS Prevention Education
SLORC	State Law and Order Restoration Council
SLRD	Settlement and Land Record Department
SMAM	Singulate Mean Age at Marriage
SMO	Station Medical Officer
SQH	Sun Quality Health Clinics
SRGs	Self reliance groups
SRH	Sexual and Reproductive Health
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infections
TB	Tuberculosis
TBA	Traditional Birth Attendant
TCG	Tripartite Core Group
TFR	Total Fertility Rate
THO	Township Health officer
3DF	Three Diseases Fund
TMFR	Total Marital Fertility Rate
TMO	Township Medical Officer
TOP	Targeted Outreach Project
ToR	Term of Reference
TSG	Technical and Strategic Group
UAE	United Arab Emirates
UHC	Urban Health Centre
U 5MR	Under 5 mortality rate
UN	United Nations
UNCT	United Nations Country Team
UNGASS	United Nations General Assembly Special Session
USDA	Union Solidarity and Development Association
VCCT	Voluntary Confidential Counseling and Testing
VDC	Village Development Committee
VDRL	Venereal Disease Research Laboratory Test
VIA	Visual Inspection with Acetic Acid
VRS	Vital Registration Survey
VV-MCH-P	Volunteer Village MCH Posts
WB	World Bank
WCHD	Women and Child Health Development
100%TCP	100% Targeted Condom Promotion

Abbreviations of Organizations

ACF	Action Contre le Faim
ADRA	Adventist Development and Relief Agency
adpc	Asian Disaster Preparedness Centre
AFXB	Association Francois-Xavier Bagnoud
AHRN	Asian Harm Reduction Network
Alliance	International HIV/AIDS Alliance
AMCWA	Asian Maternal and Child Welfare Association
AMDA	Association of Medical Doctors of Asia
AMI	Aide Medicale International
ARHP	Asia Regional HIV/AIDS project
AUSAID	Australian Agency for International Development
AZG	Medecins Sans Frontieres Holland
Burnet	Burnet Institute
Care	Care Myanmar
CD network Consortium	Consortium of Dutch NGOs Myanmar NGO Consortium on HIV/AIDS
DFID	Department for International Development
EC	European Commission
EDMH	Enfants du Monde
FAO	Food and Agriculture Organization
FREDA	Forest Resource Environment Development and conservation Association
FXB	Francois Xavier Bagnoud International
GRET	Groupe de Recherche et d' Echanges Technologiques
IDE	Myanmar International Development Enterprises
ILO	International Labour Organization
IMF	International Monetary Fund
IOM	International Organization for Migration
IUSSP	International Union for Scientific Study of Population
JICA	Japan International Cooperation Agency
JOICFP	Japanese Organization for International Cooperation in Family Planning
LRC	Local Resource Centre
Malteser	Malteser International
MANA	Myanmar Anti-narcotic Association
MBC	Myanmar Baptist Council
MBCA	Myanmar Business Coalition on AIDS
MCC	Myanmar Council of Churches
MDM	Medecins du Monde
MHAA	Myanmar Health Assistant Association
MIMU	Myanmar Information Management Unit
MMA	Myanmar Medical Association
MMCWA	Myanmar Maternal and Child Welfare Association
MMRD	Myanmar Marketing Research and Development
MNCWA	Myanmar National Committee for Women's Affairs
MNMA	Myanmar Nurse and Midwife Association
MPG	Myanmar Positive Group
MRCS	Myanmar Red Cross Society
MSF-CH	Medecins Sans Frontieres Switzerland
MSI	Marie Stopes International
MWAF	Myanmar Women's Affairs Federation
MWEA	Myanmar Women Entrepreneurs' Association
NZAID	New Zealand Aid

PACT	Pact Institute
PGK	Pyi Gyi Khin
PSI	Population Services International
SC	Save the Children
SIDA	Swedish International Development Agency
TLMI	The Leprosy Mission International
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNCBD	United Nations Convention on Biological Diversity
UNCED	United Nations Conference on Environment and Development
UNDP	United Nations Development Programme
UNEP	United Nations Environmental Programme
UNESCAP	United Nations Economic and Social Commission for the Asia and Pacific
UNFCCC	United Nations Framework Convention on Climate Change
UNFPA	United Nations Population Fund
UN- Habitat	United Nations Human Settlements Programme
UNHCR	United Nations High Commissioner for Refugees
UNIAP	United Nations Inter-Agency Project on Human Trafficking
UNICEF	United Nations Children's Fund
UNION	International Union Against Tuberculosis and Lung Diseases
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
UNODC	United Nations Office on Drugs and Crime
UNOPS	United Nations Office for Project Services
WC	World Concern
WFP	World Food Programme
WHO	World Health Organization
WHO-SEARO	World Health Organization – South-East Asia Regional Office
WV	World Vision
YMCA	Young Men's Christian Association
YWCA	Young Women's Christian Association

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Executive Summary

This situation analysis aims to analyse the situation of population and development, reproductive health and gender in Myanmar and their linkages, to serve as a reference for informing policy makers and programme planners from both the government and the international community involved in protecting the rights and improving the lives of Myanmar's population and furthering sustainable development. The situation analysis (SA) has been conducted by an independent team, which was supported by UNFPA. It was carried out between the period of July 2009 to July 2010, using a lifecycle perspective to understand the totality of population, the forces that contribute towards development and their interrelations with reproductive health and gender. Existing causalities between the issues of population development, reproductive health and gender require a holistic approach that unifies many sectoral and contextual issues.

Myanmar is committed to the 1994 International Conference on Population and Development (ICPD) programme of action and also to fulfilling the Millennium Development Goals (MDGs). This situation analysis cuts across population and development, reproductive health and gender and is the first ever done analysis in Myanmar. Although there is limitation in geographic coverage and scarcity of data to be analysed in further depth, this review should be considered as a living document and a template for future documentation when new information and data becomes available. A notable challenge in the preparation of this situation analysis has been the limited scope of available data. The information gaps for evidence-based planning are well recognized as the most recent census was in 1983, after which there have only been a few nationally representative sample surveys for specific purposes. There is a great need to strengthen statistical services in Myanmar and foster greater data consistency.

The summary of findings of the situation analysis for population and development shows that as of October 2007, the population of Myanmar was 57.5 million, with the growth rate at 1.75 percent. The sex ratio 98.9 males per 100 females at the national level, but there are variations among the states and divisions. Fertility in Myanmar has been declining and is at post-transitional stage with the total fertility rate (TRF) at the national level standing at 2.03, decreasing from 2.9 in 1991. Urban TFR is 1.68 and is lower than the rural TFR of 2.18. Marital fertility is high at 4.7 children per married woman decreasing from 4.9 in 2001. The effect of change in marital fertility has played a large role in the fertility decline during the ten years between 1997 and 2006.

Nuptiality in Myanmar is in transition with the proportion never married (PNM) for both sexes at 39.6 percent in 1973 increasing with time to reach a peak in 2001 of 55.7 percent. This number has decreased to 54.1 percent in 2006, but still shows a net increase from 1973 to 2006. Mean ideal family size has declined slightly from 3.3 children in 1991 to 3.2 in 2006. About half of currently married women of reproductive age have no desire for any more children.

Myanmar population is in its last stages of a **demographic transition** where there is a decline in proportion of those under age 15 and increase in the proportion of working age (15-59) population and elderly population 60 years and above. This pattern of decline in fertility below replacement level and low dependency ratio and increase in the working age group has been regarded as a “**demographic window of opportunity**” or a “**demographic gift**”. If taken advantage of by proper economic planning and investment in human capital, job creation to absorb the increasing working age population could result in economic growth and increase in GDP per capita.

One in every ten persons in Myanmar moves from their resident state or division at least once in their lifetime. Yangon Division sends and receives migrants from every other state/division in substantial numbers. **Internal migration** from rural to urban exceeds that of urban to rural, however, government rural development strategies and decentralization of industries has narrowed the gap between the two streams of migration. There is no official study on **international migration** pertaining to age, sex,

educational level and reasons for migration, however, data from official air and sea ports, border check-points indicate that departure exceeds arrival by 1 to 4 million persons per year since 2001. Freedom of movement is basic human right, but a detailed analysis of international migration of citizens would help to monitor and plan for a specialized labour force and mitigate negative impact of brain-drain on national capacity building.

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

Myanmar is rich in forests, land and water resources in addition to unique biodiversity. The GoUM has founded national mechanisms such as the **National Commission on Environmental Affairs** (NCEA) and documents such as Agenda 21 and National Sustainable Development Strategies, for the protection and sustainability of the environment for present and future generations. However, the majority of the public is unaware of these strategies and there is weaknesses in control over consumption of environmental resources, which can become a challenge to sustainability. There is a lack of funding support for practical implementation of these environmental programs.

Approximately one million women give birth each year in Myanmar, and the **maternal mortality ratio** (MMR) remains high; for every 100,000 live births there were an estimated 316 maternal deaths in 2004-2005¹. Bringing maternal mortality down and reaching the national MDG5 target of a maternal mortality rate of less than 145 per 100,000 live births by the year 2015² remains an on-going challenge. Myanmar women face three major delays when it comes to seeking seek medical care for reproductive health and deliveries. These include, (1) a delay in decision making at home, (2) a delay in reaching health facility, and (3) delays in getting adequate care at health facility. These factors are common and reflect the vicious cycle of poverty, inadequate transportation infrastructure in remote areas, and lack of quality care.

Antenatal care (ANC) coverage improved from 63.1% in 2005 to 64.6% in 2007. The proportion of births delivered by a traditional birth attendant reduced from 8.8 in 2005 to 8.6 in 2007. The proportion of deliveries attended by skilled birth attendants (doctors, nurses and midwives) reached 64% in 2007, compared to 57%³ in 2001. Proportions of birth attended by skilled birth attendants was the highest in the age group 45-49 years old, followed by women of 15-19 year old age group. 76.4% of deliveries occurred at home, 16.6% at government facilities and the rest at private clinics. The majority of maternal deaths occurred at home (62%). Only 38% of women with complications were referred to a hospital and only 24% reached the hospital for proper management, while 14% died on their way due to late referral and delays in transportation.

The greatest barriers to **quality reproductive health care** in midwifery services are inadequate supplies of essential drugs, non-adherence to established standards due to lack of knowledge and skills, unavailability of supplies and availability of authorization for a staff to perform the clinical intervention.

The 2009-2013 Reproductive Health Strategic Plan sets the target for a contraceptive prevalence rate (CPR) of 45% (modern methods) by the year 2013. CPR for married women has gradually increased from 37% in 2001 to 41% in 2007. According to the 2007 FRHS, almost 5% of all pregnancies end in

¹ Nationwide Cause Specific Maternal Mortality Survey 2004-2005. Yangon: MOH, UNICEF, 2006

² Five Year Strategic Plan for Reproductive Health, 2009-2013

³HMIS, Department of Health Planning, 2007

abortion⁴. Abortion rate was highest in 15-19 years age group and university-educated youth, with 11.39% and 9.07% respectively.

Induced abortion is illegal in Myanmar. According to the 2004 Family and Youth Survey, 78% of interviewed youth indicated that homes of Traditional Birth Attendants is the main place where abortions are performed. The majority of these procedures are likely to be unsafe. Abortion is the third most common cause of maternal death, and with the growing proportion of never married and high abortion rate of youth, sexual and reproductive health education and contraceptive services should cover not only married women but also be targeted towards youth, adolescents and the unmarried.

The unmet need for contraception moderately decreased from 20.6 in 1991 to 17.7 in 2006. Though the GoUM and UNFPA are putting efforts into **Reproductive Health Management Information System (RH MIS)** and in setting up efficient Logistic Management Information Systems (LMIS), the situation analysis team found that in five out of six States and Divisions monitored, stock-outs of contraceptives were present at all levels for one or more contraceptive methods for women to choose from. There are low rates of use of long-term methods and it is common for mixed methods to be used. The RH MIS is not able to predict and deal quickly with stock-outs. Better planning and projections of requirements could be done if planning was brought down to the township level.

According to WHO estimates, countries with fewer than 23 **human resources for health** (physicians, nurses and midwives) per 10,000 people are likely to experience shortage in coverage rates for the basic primary health care interventions prioritized by the Millennium Development Goals⁵. Twenty three health care providers (doctors, nurses and midwives) per 10,000 people is the threshold to achieve 80% coverage for skilled attendance during deliveries.⁶ In Myanmar, the doctor to population ratio is 1:3315 while nurse/midwife to population ratio is 1:1195. There are about 14 health care providers per 10,000 people. The majority of highly-skilled medical doctors are concentrated in urban locations, where only 30% of the total population resides. To meet the international threshold and secure availability of skilled birth attendants at deliveries, strategic planning should be done to ensure the sustainability of the health workforce.

In Myanmar, the percentage of **GDP spent on health** is only 2.2%, and for reproductive health it is even less. Government expenditure on reproductive health was 13.1% out of total expenditure on health in 2006. There are high out-of-pocket expenditures on health (86.9% in 2006), including obstetric and neonatal emergencies. Women of a lower socio-economic status, those with less education and employment opportunities, rural poor and those with limited geographical access to basic reproductive care⁷ suffer most. The key challenge is to provide a comprehensive package of essential reproductive health services available that are affordable and accessible at the primary health care level.

There was a funding gap of 75% for implementation of the **Five year national RH Strategic Plan (2004-2008)**⁸ and there is no dedicated national budget line for birth spacing commodities. A shortfall of approximately 66% for contraceptive requirements can be expected for the current 2009-2013 RH Strategic Plan. With the global economic downturn, overseas development assistance will be face dramatic cuts. Thus, it is imperative to explore resource mobilization from multiple donors. There are data and information gaps for decision making in RHCS, as there is limited disaggregated data. There is need to strengthen capacity to analyse and use data in reproductive healthcare programme planning. Opportunities for improvement of RH exist. The GoUM's commitment should be reflected in national

⁴ Nationwide cause specific Maternal Death Survey, 2004-2005, Yangon, UNICEF, 2006.

⁵ Working together for Health, World Health Report 2006

⁶ World Health Report 2006, WHO

⁷ Reproductive Health Care - methods, techniques and services which contribute to RH and well-being through preventing and solving RH problems (ICPD, 1994).

⁸ Source- MCH, DOH, 2010

policies and plans. Partnerships and the goodwill of all stakeholders including public and private sector needs to be maintained, and coordination mechanisms need to be revitalized. Other ongoing challenges include participation in global initiatives for effective resource mobilization, encouraging the GoUM's stewardship and regulatory roles, and opportunities for public-private partnerships towards universal access to RH services.

The estimated **prevalence of HIV** in Myanmar is 0.61 %. The estimated number of people living with HIV (PLHIV) between 15 to 49 years of age is 230,000 (35% were female) in 2009. The main mode of infection of HIV is sexual transmission (73%). HIV prevalence is high amongst vulnerable groups; 37.5% of injecting drug users (IDUs), 28.8% of men who have sex with men (MSM), and 18.4% of female sex workers (FSW) and 5.4% of Male with sexually transmitted disease (STD) patients are infected with HIV/AIDS. HIV prevalence of pregnant mothers was 1.26%, prevalence in blood donors was 0.48%, in new military recruits was 2.5 % and in new Tuberculosis patients was 11.1%⁹. Only 36.6% of the general population (37.7% of youth and 36% of adults) knew about three methods of HIV prevention and 42% of people (47.5% of youth and 39.1% of adults) were able to correctly reject common misconceptions about HIV prevention. Stigma and discrimination remains among general population. In addition, knowledge and treatment seeking behavior of sexually transmitted disease infected persons was limited. Consistent condom use with FSW was 80.7%, whereas with a casual partner was only 17.2% among the general population¹⁰.

Although the **level of knowledge on HIV and AIDS** was high in FSW and IDU, there was low knowledge about PMCT and ART. Almost all of FSW used condoms at last sex with clients (95.8% and 96.3%) at two survey sites, but only half of FSW reported condom use at last sex with their regular partners. About 5-31% of IDU still share needles. Among IDU, condom use with FSW differs from 46% to 87% at four survey sites, but is much lower than with casual partners and regular partners¹¹. Among MSM, knowledge on HIV/AIDS was high. Only 50% of MSM reported consistent condom use in the past 6 months¹². Treatment seeking behavior for STI was high in FSW but low in IDU and MSM. In 2008, prevention services reached 61% of total estimated sex workers whereas prevention service provided only 16% of the total estimated MSM and 22% of estimated size of IDU. There remains a gap to meet the MDG target of universal condom use in high risk groups such as MSM and IDU by 2010.

The current situation of **out-of-school youth** shows that not enough have knowledge about sexual and reproductive health and STDs. School dropout rate is highest at Grade 11 (55.4%). The percentage of youth with high school and above education is almost 60% for both sexes in urban whereas it is less than 25% in rural areas.¹³ Employment opportunities for out-of-school youth are very limited; an estimated 90% are unemployed¹⁴.

In relation to MDG indicator 6.1, **HIV prevalence among pregnant women** aged 15-24 years declined from 2.78% in 2000 to 1.01% in 2008. However, there is large gap to achieve MDG target 6B of universal access to treatment for HIV/AIDS for all those who need it by 2010 for Universal Access and by 2015 for MDG targets. The proportion of population with advanced HIV infection with access to antiretroviral drugs is only 20%. In addition, only 38.7 % of people in need of PMCT received a complete course of antiretroviral prophylaxis in 2008.

⁹ Report of the HIV Sentinel Sero-surveillance Survey 2008, Myanmar, National AIDS Programme, Department of Health, Ministry of Health

¹⁰ Dr. Aye Myat Soe, Daw Aye Aye Sein, Dr.Khin Ohnmar San, Behavioural surveillance survey 2007 (general population) National AIDS Programme, Department of Health, Ministry of Health, Myanmar

¹¹ The Behavioral Surveillance Survey, Injection Drug Users and Female Sex Workers, 2008, National AIDS Programme, Department of Health, Ministry of Health

¹² Pyae Sone Tun M.B.,B.S, Knowledge, Attitude and Practice (KAP) Regarding HIV/ AIDS Among Men (MSM) Who Visited Taung Pyone Festival, Matayar Township, Mandalay division, 2009

¹³ Family and Youth Survey, 2004 country report, Yangon, October 2006, Department of population, Ministry of Immigration and Population and UNFPA

¹⁴ A Synopsis on Reproductive and Sexual Health, Professor Dr. Mya Oo (Annex 4: Adolescent Reproductive Health at a Glance in Myanmar) (WHO-SEARO-2007)

There is a chronic funding gap, which currently stands at a shortfall of approximately 38% according to the operation plan of NSP in 2008. There needs to be health system strengthening, reduction of stigma and discrimination of PLHIV and increased reaching out to remote population groups. Programmes also need to be targeted to the large mobile population of internal and international migrants. There is an inadequate full range of services with low VCCT coverage.

Gender is cross cutting theme in human development, quality of life and wellbeing of the population. Myanmar has a rich traditional heritage which respects and delineates strong social roles between the sexes. In education, enrolment ratios of girls and boys in primary and secondary education have practically achieved parity. On socioeconomic grounds, some educated, urban women in Myanmar participate almost equally at home and private business and enjoy joint-decision making. This is not always true for rural women and ethnic minorities.

At all levels of national politics and governance, female representation in positions of authority and management still lags behind. The **Gender related Development Index (GDI)** for Myanmar (calculated by using the same indicators as the HDI but capturing inequalities in achievement between women and men) could not be calculated in 2007 or 2009 due to inadequate data. Myanmar's position on the GDI table equates it to a score just below that of Cambodia, or around 0.58. This slight reduction is from the HDI value results from women's lower adult literacy rate as a percentage of men's (92%) and lower estimated earned income (61%). Regarding the **Gender Empowerment Measurement**, figures for Myanmar could not be calculated, particularly since Myanmar does not have a parliament. There is a need to provide high quality sex disaggregated data in order to analyse Myanmar's gender situation for benchmarking Myanmar internationally in regards to gender and women's empowerment.

The Ministry for Social Welfare Relief and Resettlement is the focal ministry for implementation of the CEDAW plan of action together with MNCWA and MAAF. While a number of formal organizations exist to represent women and implement CEDAW in Myanmar, the effectiveness of their activities are as they are somewhat limited in terms of the issues they address, their role is an extension of government structures, they have budget constraints and are staffed mainly by volunteers. There is need for capacity building for gender research, gender sensitive data collection and gender mainstreaming for all levels of programme planning and implementation.

There is no data on **gender-based violence (GBV)** and in general women and girls do not experience many of the extreme manifestations of discrimination and seclusion exhibited in other countries. Perhaps because of the invisible nature of GBV issues, it has become normal for many gender gaps and inequalities to be overlooked by both national and international organizations working in Myanmar's development sector. A study carried out by MAAF on reported cases of sexual assault revealed that in 17 states and divisions of Myanmar there were 209 reported cases in 2001 and 338 cases in 2004. A study on marital violence against women revealed that the most common causes were financial difficulties, alcohol consumption and incompatibility with in-laws. This study provided fascinating introductory information, but its limited scope calls for more in-depth research on GBV in Myanmar.

The UN Gender Theme Group (GTG) is to mainstream gender in the humanitarian and development interventions of the UN in Myanmar, such as poverty alleviation and livelihood development, improving access to health care, information and education, prevention of HIV/AIDS, prevention of trafficking of women and girls, promoting reproductive health and rights, and combating gender based violence.

Major recommendations are:

Population and Development

- **Take advantage of the demographic transition**, there should be national economic planning with tangible increase in investments in human capital, health and education, to create job opportunities to absorb the increasing working age population for real economic growth and increase the GDP per capita.
- **Conduct a nationwide census** as soon as possible, and the GoUM must adopt and begin to action the draft population policy.
- **Analyze the international migration** of Myanmar nationals so as to monitor and plan for specialized labour force and mitigate the negative impacts of migration on national capacity building.
- **Expand the availability of quality statistics**, disaggregated to a sufficient depth by sex, age, ethnic group, basic demographic characteristics and geography. This could be facilitated by an international/external partnership.
- **Encourage data harmonization** involving technical personnel from GoUM, NGOs, external consultants and the UN should be conducted, in order to agree upon a single set of national data.
- **Incorporate** the integration of **environmental protection** in the formulation of population and development plans at all levels. Enhancing reforestation, investment in green technology and employment opportunities for landless rural poor and remote border areas to improve the income and livelihood options and to attain MDGs.
- **Allocate funding** support for practical implementation of National Sustainable Development Strategies and **raise public awareness** to refrain from uncontrolled consumption of **environmental resources**.

Reproductive Health, HIV and AIDS

- **Ensure** greater access to emergency obstetric care and support (EmOC) including adequacy of equipment and reproductive health commodities, skilled health workforce, accessibility and affordability to services.
- **Mobilize resources** from a variety of international resources and promote an increased governmental contribution to investments in reproductive health. Mobilize resources from pooled mechanisms such as Three Diseases Fund (3DF), bilateral development agencies and other sources. Implementation of the Reproductive Health NSP (2009-2013) should have government inputs and multiple pledges from multiple donors. It should feature phased and implemented prioritization of underserved regions where maternal mortality and morbidity is high, such as Northern Rakhine State (NRS), Sagaing Division, semi-urban areas of Yangon and Mandalay divisions, Northern Shan and Kayah state
- **Strengthen the health care system and public health infrastructure** by (a) setting-up and upgrading health facilities, (b) scaling up of the essential reproductive health package, (c) improving referral facilities and linkages with primary health care facilities, (d) improve responsiveness and linkages between health systems and communities, and (e) develop budget lines for reproductive health commodity support to the 193 townships not currently covered by RH projects.
- **Formulate a comprehensive health workforce strategic plan** to support delivery of the reproductive health services including HIV and AIDS
- **Conduct a review** of the existing technical and clinical guidelines to align national and international standards to support provision of quality RH services and HIV/AIDS prevention and care services and linked programmes to staff competencies and training.
- **Improve decentralization of data management** by increasing capacity building on use of data and information for local decision making at sub-national level and coordinated programme management and replace paper based data collection to modern IT systems.

- **Conduct regular coordination** meetings of National RH committee, AIDS committees at national and every administrative level with the aim of improving multi-sectoral cooperation and collaboration at each level.
- **Strengthen the advocacy** to promote involvement of many sectors such as law enforcement from the central to the field level to develop an enabling environment especially for prevention programme and care services for HIV/AIDS to MARP such as FSW, MSM and IDU. **Promote the knowledge and acceptance regarding HIV/AIDS** among not only communities, but also institutions such as hospitals, schools and the workplace through various strategies and channels by all stakeholders to reduce the stigma and discrimination,
- **Strengthen the involvement and empowerment of PLHIV and vulnerable groups** by means of financial and technical support for capacity building for organization and networks of PLHIV and high risk groups of HIV and strengthening the peer education and outreach service for MARP
- **Scale up the programme coverage and use of services** effectively and consistently to meet the targets of operational plan of NSP particularly ART and comprehensive PMCT programme with expanding access to ART therapy for mothers with advanced HIV infection in need of their own health
- **Strengthen** the access and coverage of relevant prevention and care and support services for **out-of-school youth** in not only urban areas but also rural areas by means of expanding the youth centers and peer education programmes in coordination with various stakeholders, strengthen HIV prevention interventions and referral for care services
- **Increase** prevention programs **among mobile and migrant populations and migrants** by at border points and transit zones, improving bilateral collaboration among neighboring countries to facilitate referrals, transport, safe return, continuity of care for mobile population,
- **Expand VCCT services** including outreach VCCT services to strategic and high risk areas of townships along with maintenance of confidentiality and quality of counseling and testing,
- **Strengthen** the collaboration and cooperation **between NGOs and Public sector** for approval and sharing of HIV related **data and information** to reduce the data gap. **Conduct cohort study of children of HIV infected mothers** to observe the impact of the PMCT programme. Initiate **research on access to SRH services for PLHIV** in order to see if PLHIV receive adequate SRH services in addition to HIV treatment.
- **Assess** local patterns of mobility and related vulnerability and risk behaviors at the township level and between townships and states and division in order to get the information and services needs of this population

Recommendations for Gender equality and women empowerment

- **Advocacy** to raise awareness of the concepts of gender and gender based violence so as to fulfil CEDAW commitments at different levels of administration, down to the community level.
- **Develop** strategies for better cooperation and linkages between Ministry of Health, MSWRR, MIOP, MNPED and the Ministry of Education in order to strengthen gender equality in institutions.
- **Build** capacity for gender research and collection of gender sensitive data, train staff in all sectors of government departments as well as UN, NGOs for gender research and data collection of gender sensitive and sex and age disaggregated data for effective gender analysis. Support dissemination and continuous publication of gender statistics by MAAF.
- **Conduct** research on gender based violence to determine extent of GBV. Planned research on the extent and severity of GBV in Myanmar communities should be conducted. Research on elderly women, growing proportion of elderly women in the population calls for research on the specific health, socio-cultural needs to provide care and support.

- **Raise** awareness of legal rights for women, educate the community in a culturally sensitive manner on the concepts of GBV so that women, boys and girls will realize their vulnerable position in socio-cultural context of Myanmar and their rights to enjoy equity.
- **Scale up** gender equality and women empowerment activities in humanitarian assistance work. There is a need to gender mainstream humanitarian aid work by incorporation of gender concepts in all stages of rehabilitation work.
- **Develop** interventions for all spheres of development including economic empowerment of women to include vulnerable, poor and marginalized women in planning, programming and implementation stages.
- **Develop** Strategic actions to ensure equal male partnership and mutual understanding which are critical for good outcomes of pregnancy. Develop gender sensitive strategies for HIV programs and RH service delivery through better coordination with health sector.
- **Conduct** impact assessment and monitoring of the work of anti-trafficking units (ATU) and document and disseminate lessons learnt and good practices of anti- trafficking interventions. Strengthen capacity of MOHA staff and scale up and support programs for rehabilitation and reintegration of trafficked women.
- **Review and revision** of existing laws, rules, regulations and policies to identify gaps in relation to CEDAW, Support the implementing of a national plan of action for gender equality and women's empowerment in line with CEDAW.
- **Review** institutional mechanisms that hinder gender equality and advocate for policy change. There should be revision of the selection process and policy to ensure gender equality and empower women to enter health and technical professions on equal basis.

Introduction to the Situation Analysis (SA)

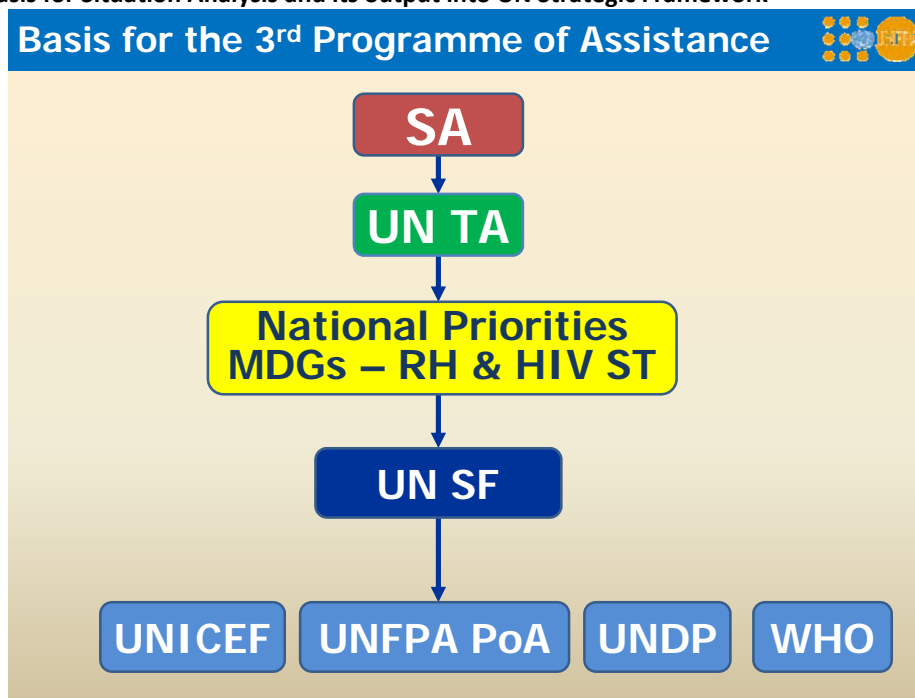
UNFPA Myanmar supported and organized an independent situation analysis for population and development, reproductive health and gender in Myanmar. A participatory approach was used in coordination and consultation with the UNFPA country office in Myanmar as well as UNFPA's Asia Pacific Regional Office. Inputs were made by implementing partners and stakeholders such as MOH, MNPED, MOIP, MOSWRR, UN agencies including WHO, UNICEF, UNDP, UNAIDS, IOM & UNIAP, as well as various INGOs and NGOs. It was undertaken from July 2009 to July 2010.

Objectives of the Situation Analysis

The objectives of the Situation Analysis are as follows:

- Guide to development of UNFPA's programme of assistance and other programmes
- Inputs for reviewing progress in achieving the Millennium Development Goals (MDGs) and ICPD Programme of Action, as well as other international conferences and conventions.
- Inputs for formulation of population policy, directives and plans
- Basis for resource allocation, coordination and partnerships in the field of population, reproductive health and gender

Figure 1: Basis for Situation Analysis and its output into UN Strategic Framework



The Situation Analysis has identified critical national needs and priorities in population and development, reproductive health and gender. It contains analysis using causal analysis, stakeholder analysis and capacity analysis, and it includes strategic recommendations for policies, strategies, plans and programmes. In addition, the SA contains recommendations on the roles and responsibilities of various stakeholders (government, NGOs, UN, donors) in order to achieve productive partnerships and external cooperation. This situation analysis was conducted to identify gaps and develop strategic recommendations, which will feed into the UN strategic framework and to the various UN agencies' programming.

Methodology for SA

The situation analysis was carried out by an independent team consisting of one team leader, and four team members, one each responsible for population and development, RH, HIV/AIDS and Gender. The team was helped by a team assistant. The methodology used in this situation analysis is a participatory approach where stakeholders and beneficiaries such as pregnant mothers, youth, FSW, MSM and PLHIV, peer educators and community members from the central to the field level were consulted and interviewed.

At the beginning the team conducted a desk review by identifying and gathering information from available relevant documents and literature. The team participated in the coordination meetings and workshops of UNFPA's Mid Term Review. The team developed the methodology, tools, schedule for assessment, framework and questionnaires for interview and discussion with stakeholders.

Concerning Population and Development, discussions with senior personnel from the Department of Population, Central Statistical Organization, Department of Health Planning, Department of Social Welfare, NGOs, international organizations (such as ADPC, TCG) and UN Agencies (UNDP, UNICEF, IOM, UNHCR, FAO, UNIC) were conducted on relevant topics for reference in the analysis.

Concerning RH, HIV/AIDS and Gender, in coordination with UNFPA country office, Department of Health and NGOs, the team visited urban and rural areas of 19 selected townships in 7 States and Divisions These were Ayeyarwady, Sagaing, Yangon, West Bago and Mandalay Divisions, as well as Mon and Shan States. The visits were conducted between the period of September 2009 to December 2009. Key informant interviews were conducted as well as in-depth interviews. Focus group discussions were held with 122 government personnel including directors, deputy directors and assistant directors of the Department of Health, Department of Health Planning, Ministry of Health, State/Divisional Health officers, Deputy State Health officers, Township medical officers, Township Health officers. In addition, focus groups were held with field level service providers such as township health nurses, health assistants, Lady Health Visitors, midwives and public health supervisors as well as with 24 staff from national NGOS (including MMA, MMCWA, MWAF, MANA and MRCS), 25 staffs of INGOs (including JOICFP, SC, AFXB, MSI, AMI, PSI and AZG). Finally, interviews were conducted with beneficiaries including 94 pregnant women undergoing antenatal and post-natal care including HIV positive mothers, 45 youth, 26 members of community support groups, 27 female sex workers (FSW) and 15 men who have sex with men (MSM).

Moreover, the team observed the implementation of activities at field level and an observational checklist was done to objectively observe facilities and services provided for reproductive health care, emergency obstetric care facilities, birth spacing facilities, standard operational procedures and guidelines at service delivery points. For detailed information on findings of field visits, please see Annex 3.

Selection criteria for site visits

The selection of sites was based on the diversity in geographic terrain, diversity in occurrence of MMR, prevalence of HIV, performance in RH and HIV project implementation..

No.	Hilly	Delta	Coastal	Central Plains
1.	Chin	1. Ayeyarwaddy	1. Mon	1. Bago (West)
2.	Kachin	2. Yangon	2. Rakhine	3. Mandalay
3.	Kayah	3. Bago (East)	4. Tanintharri	4. Magway
4.	Kayin			5. Sagaing
5.	Shan (East)			
6.	Shan (North)			
7.	Shan (South)			

(See Annex 6: Lists of townships visited and list of person met in details)

Findings of field visits were compiled and available in detail in Annex 3. According to the findings of document reviews and field visits, the SA team identified critical needs and gaps and priorities in population and development, RH and gender. Based on these findings, challenges, opportunities and strategic recommendation in the respective areas were identified and drafted in report format.

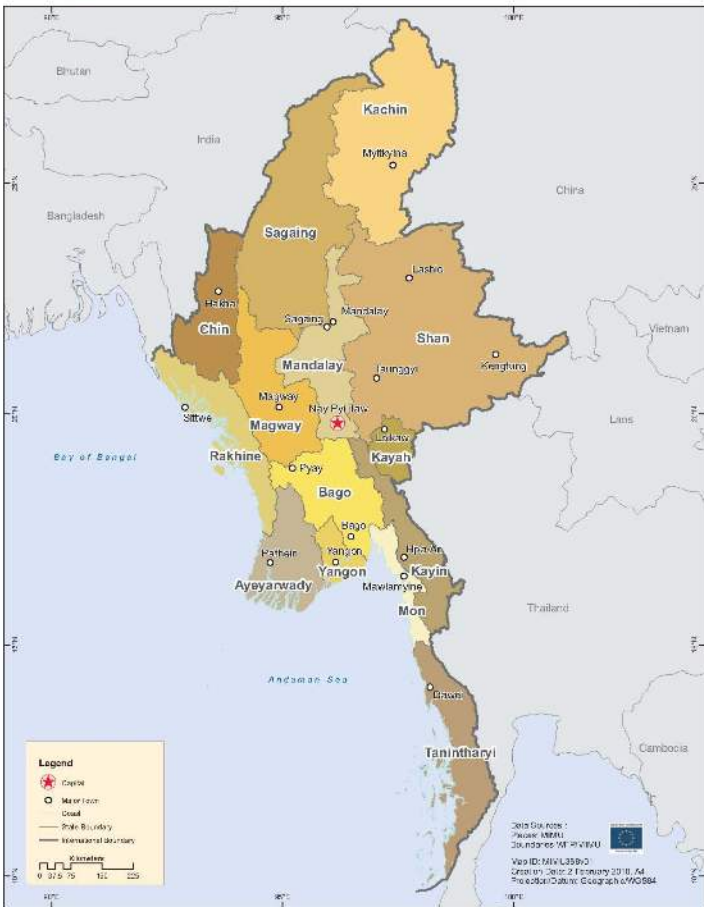
The draft report was reviewed by staff of UNFPA Myanmar as well as UNFPA's regional team based at the Asia Pacific Regional Office (APRO). The draft report was also shared with implementing partners such as UNAIDS, UNICEF, WHO, PSI and MSI for peer review and comments. These were fed in at revision stages of the report for dissemination.

A dissemination workshop to review the draft report of the Situation Analysis of Population and Development, Reproductive Health and Gender in Myanmar, was held at Nay Pyi Taw on 24th March 2010 and chaired by His Excellency Prof. Mya Oo, Deputy Minister for Health. It was attended by senior officials from Myanmar government ministries, regional advisors from UNFPA Asia Pacific Regional office, staff of UN agencies and implementing partners from national and international NGOs. A participants list is available in Annex 7. At this workshop, an overview and presentations regarding each topic were presented by the team leader and respective team members followed by group discussions. The recommendations from participants, stakeholders and regional advisers from APRO were taken into account for finalizing and revising the SA report which was later edited and printed. Launching of the report took place in Yangon on 16th July 2010.

The views expressed in this report are those of an independent SA team, consisting of national and international consultants with technical input from UNFPA country office, APRO and inputs from MOH, MOP, MNPED, MSWRR and stakeholders working in the field of RH, P&D, and gender in Myanmar. Where divergence exists, it is hoped that this will be helpful in providing reflections from a different standpoint, one that has only one concern: the well-being and progress of the population of Myanmar.



Myanmar Country Map



Chapter One: General Overview



CHAPTER I: General Overview

1. Population

Myanmar's population is estimated at 57.5 million, with 28.6 million males and 28.9 million females in 2007. The increase in population for the year 2006-2007 was 0.98 million with an annual growth rate of 1.75 percent. About 70 percent of the population resides in rural areas.¹

Myanmar's population was relatively young as indicated in 1973 census, with the proportion of those under 15 years over 40 percent. By 1983 it had become intermediate², with the proportion of population under 15 at 38.6 percent. 2001 estimates place the under 15 population at 30.3 percent and as such it appears that Myanmar is steadily moving towards an old population. Myanmar is sparsely populated and has a favourable population and land ratio with a population density of only 85 persons per sq. km in 2007. In Myanmar, there is freedom of worship since ancient times³. About 90 per cent of the population are Buddhists. Christians and Muslims comprise about 5 and 4 percent, and other religions together comprise about one percent.⁴

The people of Myanmar are made up of 135 national races belonging to eight major groups: Kachin, Kayah, Kayin, Chin, Bamar, Mon, Rakhine and Shan. There are more than 100 languages and dialects spoken across the nation. According to the 1983 Population Census, Bamars (also known as Burmans) form the majority of the population with 69 percent. A relatively large number of Bamars live in the central and delta regions and in the lower part of the country. The largest minority race group are the Shan, who make up 8.5 percent of the total population and live in the Shan plateau in the northeast and east of the country. The Kayin make up 6.2 percent of the total population, and generally inhabit the southeastern region and Ayeyarwady Delta areas. Rakhine people are 4.5 percent of the whole population and are mainly found in the western coastal region. Kachins, with 1.4 percent, live in the upper north of the country, Chins constitute 2.2 percent and inhabit the western mountainous region, Kayahs make up 0.4 percent of the population and live in the eastern hilly region, and the Mons represent 2.4 percent of the nation and are found in the southern part of the country.⁵

2. Geography

The Union of Myanmar lies between latitudes 09°32' and 28°31'N and longitudes 92°10' and 101°11'E with an area of 261228 square miles (approximately 676,578 square kilometres). It is the largest country in Southeast Asia in terms of land area and the fifth largest country in terms of population. Myanmar Standard Time is six hours and thirty minutes ahead of GMT. The length of contiguous frontiers 3,828 miles (6,129 kilometres). Borders are shared with the People's Republic of China to the north and east, Lao Peoples' Republic and the Kingdom of Thailand to the east, and Republic of India and People's Republic of Bangladesh on the west respectively⁶. The Bay of Bengal lies in the west and the Andaman Sea in the south of the country.

The topographical conditions of the country can be roughly divided into three sections – western ranges, central plains and eastern hill regions. The western ranges serves as a natural border between India and Myanmar. The Ayeyarwady Delta Region, and the Sittaung and Thanlwin basins make up

¹ Health in Myanmar, Ministry of Health, 2009

² The population is in the intermediate state when proportion of population under 15 to the total population is between 30 and 39 percent.

³ 1947, 1974 and present Constitutions of Union of Myanmar (Burma) guarantee Freedom of Worship to all residing in the country

⁴ 1983 Population Census, Burma, IMPD, 1986

⁵ Ibid

⁶ Ministry of Information, Chronicle of National Development, Comparison between Period Preceding 1988 and after (up to 31.12.2005)

the Central Plain. The central plain has extensive alluvial lowlands and has a lengthy dry season. Shan Plateau is the eastern mountain range with an average height of 3000 to 4000 feet above sea level. For administrative purposes, the country is divided into 7 States and 7 Divisions. The states and divisions are sub-divided into 66 districts and 325 townships, 60 sub-townships⁷, 2781 wards, 13,714 village tracts and 64,910 villages⁸. In recent years, for better systems management and administration, some of the larger states and divisions have been reclassified. For example, Shan State is divided into Shan (North), Shan (South), and Shan (East). Bago is often considered as Bago (East) and Bago (West). As such, in total, administratively, there are 17 states and divisions.

3. Climate

Myanmar has two major climate regions: the tropical region and the sub-tropical or temperate region. About 75 percent of the country lies in the tropics. Myanmar has three seasons: summer, rainy season and winter. Summer months are from March to mid-May, the rainy season is from mid-May to the end of October and winter is from November to end of February. Generally, Myanmar has a tropical monsoon climate. However, climatic conditions differ widely from place to place due to widely differing topographical situations.

The average highest temperature in Central Myanmar during the summer months of March and April is about 110° F (43.3 ° C) while in Northern Myanmar, it is about 97° F (36.1° C) and on the Shan Plateau between 85° F and 95° F (29.4° and 35°C).

4. Natural Disasters

Myanmar is exposed to multiple natural hazards including cyclone, earthquake, floods and fire. Fire is the most frequent disaster in Myanmar and accounts for 71 percent of the disasters within the country. Storms and floods account for 11 percent and 10 percent of the disasters respectively, while other disasters including earthquakes and landslides, account for the remaining 8 percent of the disasters.

Cyclone: Previous to Cyclone Nargis in May 2008, the frequency of cyclones that made landfall on Myanmar's coast was usually about one in every three years. However, since 2000, cyclones have hit the Myanmar coast every year. During the period of 1947 to 2007, 34 cyclones crossed the Myanmar coast, 7 of which claimed lives, mainly due to the accompanying storm surge. The highest death toll was 1,037 during the Sittwe Cyclone in May 1968. Ayeyarwady Division was affected by a cyclone in May 1975 when 304 people died and the Mala Cyclone of April 2006 claimed 37 lives. The Bay of Bengal cyclones have never hit the southern coast in Mon State and Tanintharyi Division in Myanmar. However, in May 2008, a southward shifting cyclone tract called Cyclone Nargis struck Myanmar in Ayeyarwady and Yangon Divisions, causing unprecedented loss of life, damage to infrastructure, and general disaster.⁹

Earthquakes¹⁰: Geographically, a large part of Myanmar lies in the southern part of the Himalayan range, and also in the Eastern margin of the Indian Ocean, hence exposure to earthquakes is quite large. There has been at least 16 earthquakes with Richter scale 7.0 or over within Myanmar territory. Historical records gave accounts of costly and terrifying earthquake disasters in earlier times of Myanmar. The Sagaing Earthquake (7.0 RS) of 16 July 1956 caused rather large damage to ancient structures. Most of the *stupas* in the Sagaing area were destroyed.

The most memorable recent earthquake that struck Myanmar was the Bagan Earthquake, which occurred on 8 July 1976 in Central Myanmar. Its magnitude was 6.8 on the Richter scale, but as the epicentre was located close to Bagan, it devastated Myanmar's 11th to 13th Century royal capital very

⁷ Sub townships are towns or villages/village tracts upgraded into sub-township, not township status as yet but not under the township.

⁸ Health in Myanmar, 2009, Ministry of Health, 2009

⁹ Hazard Profile of Myanmar, Department of Meteorology and Hydrology, Forest Department, Relief and Resettlement Department, Irrigation Department, Fire Services Department, Union of Myanmar, MES, MGS, MIMU, ADPC, July 2009

¹⁰ Ibid

severely. An earthquake of moment magnitude of 6.8 occurred in Central Myanmar on 22 September 2003 causing severe damage to rural homes and religious buildings. The 2004 Tsunami that occurred as a result of a shift of the Burma plate in the Indian Ocean claimed 61 lives.

Fire: Fire is the most frequent disaster in Myanmar. On average, about 900 cases are reported every year. From 2000 to 2007, the total number of fire cases reported was 6915 causing an estimated loss of 11.3 billion kyats¹¹. The 64 percent of the fire cases during this period were concentrated in the three divisions of Yangon, Mandalay and Sagaing. The major causes of fire are kitchen related fire due to negligence, which together accounted for 78 percent of fires.

Floods: Flooding has always been a major hazard in Myanmar, accounting for 11 percent of disasters, second only to fire. Between 1910 and 2000 there were 12 major floods. The Ayeyarwady River basin alone covers 404,200 kilometres, with water flows constantly rising and subsiding over the seasons of the year. Over 2 million people are exposed to flood hazards in Myanmar every year.

Floods lead to loss of lives and properties, damage to critical infrastructure, economic loss, and health related problems such as outbreak of water borne diseases. Flooding can lead to lakes, ponds and reservoirs becoming contaminated. Ravine flooding is very common, occurring when monsoon troughs or low pressure waves superimpose on the general monsoon pattern resulting in intense rainfall over river catchment areas. There were 21 major floods during 1997-2007, affecting some 500,000 people, with loss of live and livelihoods, properties and assets amounting to about US\$550,000.00.

4.1 Disaster Preparedness and Risk Reduction

For national development and stability of the country, short- and long-term plans have been developed to minimize losses by ensuring preparedness in the face of unexpected natural disasters. The ‘Standing Order for Natural Disaster Management in Myanmar’ was issued in 2009¹² with the aim to ensure immediate emergency relief and rehabilitation work according to the contingency plan and that the people are mobilized at the national level for participation in such efforts. The National Disaster Preparedness Central Committee was formed after Cyclone Nargis made landfall on 2nd May 2008, in Ayeyarwady and Yangon Divisions which was one of greatest natural disasters that cause severe loss of lives and devastation to property.

4.2 Donor Involvement in Cyclone Nargis relief and recovery operations

After Cyclone Nargis made landfall in Myanmar, the UN, ASEAN and the GoUM formed the Tripartite Core Group (TCG) as a mechanism for coordination of relief and rehabilitation work. Cyclone Nargis left an estimated 140,000 people dead or missing. Some 2.4 million people were severely affected by the cyclone. In addition to the tragic loss of lives, the total amount of damage and losses in the Nargis-affected areas is estimated at around US\$ 4 billion.¹³ The cyclone was accompanied by winds over 200 km per hour and a tidal storm surge of up to 3.6 meters (12 feet), causing immense damage. Approximately 800,000 people were displaced, 450,000 homes destroyed and substantial amounts of assets such as food stocks, livelihood-related equipment, infrastructure and paddy were lost.

After the disastrous storm dissipated, thousands of civic-minded individuals, small community-based organizations, the GoUM, the UN, and the local and international NGO community, faith based organizations began intense efforts to provide relief and recovery needs of the affected population. Before many national and international NGOs could begin their response, individuals throughout the country joined together spontaneously to form community groups to provide assistance. Members of

¹¹ Ibid

¹² Standing Order on Natural Disaster Management in Myanmar , 2009

¹³ Post-Nargis Social Impacts Monitoring: TCG, June 2009, December 2009

various religious orders provided substantial assistance in terms of money, foodstuffs, clothes, and health services. Bilateral and multilateral relief aid was also made available and distributed through various channels. ASEAN, as a regional body, stepped in to provide the coordination and technical assistance to the GoUM, UN agencies and humanitarian community. For the first time since its inception, the regional bloc helped put in place a transparent aid mechanism and facilitated effective needs assessments and necessary follow-up on recovery plans.

The successes in providing adequate disaster relief to victims of the Cyclone would not have been possible without the strong commitments from international donors. Some of the countries that contributed to Nargis relief efforts are Australia, Japan, Belgium, Austria, Norway, the United Kingdom, The United States of America, Sweden, South Korea, China, India, and the European Community. The funds that were mobilized were used by UN agencies, INGOs, local NGOs, and community-based organizations. UN agencies active in Nargis relief efforts are UNDP, WFP, UNFPA, WHO, UNICEF, UNHCR, UNHABITAT, FAO, UNAIDS, UNODC, ILO, OCHA, UNESCAP, UNIAP, and IOM. Non-governmental organizations working as implementing partners include International Federation of Red Cross and Red Crescent Societies, Myanmar Red Cross Society, IRC, World Vision, Care Myanmar, ADRA, CDC, Action aid, Action Contre le Faim (ACF), CD Network, Burnet Institute, MMRO Research Services, Idem, FREDDA, ADPC, Mercy Corps, Save the Children, Help Age International, NRC, Network Activities Group, iMMAP, Thingaha Gender Working Group, Oxfam, the Leprosy Mission International, MSP Limited, ACTED, EMDH, CDN, and Myanmar EGRESS.¹⁴

Nearly two years after the cyclone, considerable progress has been made towards easing the hardship and physical devastation that the cyclone inflicted. Much assistance has been provided since May 2008 by the Myanmar Government, local private donors, ASEAN member countries, the United Nations, and International communities from around the world. However, much work still needs to be done. The vital livelihoods and shelter sectors stand out as being in need of much more funding and technical assistance. Combined requirement for the two sectors alone is estimated in the PONREPP to be US\$158 million in 2009, out of which only 40 percent (US\$ 63.5 million) of the requirements were covered.¹⁵

5. Overall socioeconomic characteristics

5.1. Socio-economic characteristics

Household size and headship: In Myanmar, there are about 5 persons in a household on average for the whole country. There is very little difference in household size between urban and rural locations.¹⁶ One fifth of the households are female-headed households and this proportion is higher in urban areas than in rural areas. The mean number of household members in a female headed household is smaller than that of a male-headed household by about one person.¹⁷

Sex Ratio: The sex ratio (males per 100 females) of the population at the national level is estimated to be 98.8 in 2007-2008¹⁸.

Child-Women Ratio: There are about 29 children under 5 years of age for every 100 women in the age bracket of 15 – 49 in 2006¹⁹. These figures were 53.5 children in 1983 and 32 in 1999²⁰, indicating a decline in fertility.

¹⁴ Post-Nargis Periodic Review I, II, III and Post Nargis Social Impacts Monitoring: June 2009

¹⁵ Monthly recovery updates, April 2010, Tripartite Core Group

¹⁶ “Country Report on 2007 Fertility and Reproductive Health Survey”, DOP and UNFPA, and “Poverty Profile”, IHLCA Survey 2003-2005, Planning Department and UNDP,

¹⁷ “Poverty Profile”, IHLCA Survey, 2003-2005, Planning Department & UNDP

¹⁸ Statistical Yearbook, 2008, CSO, 2009

¹⁹ “Country Report on 2007 Fertility and Reproductive Health Survey”, DOP and UNFPA 2009

²⁰ National Mortality Survey, 1999, CSO

Dependency: The overall dependency ratio (calculated as the number of young people under 15 and elderly people over 60 years of age depending on 100 people in the working age group) is about 58 in 2006²¹. This means that for every one young or aged person there are about two persons in the working age group supporting them. UNDP reported this ratio as 47.2 (child dependency ratio as 39.1 and old age dependency ratio as 8.1)²² The explanation of a lower dependency ratio reported by the UN is purely statistical. The UN calculates aged dependency for population as 65 years and above, while the national figure is measured as persons 60 years and above. As for economic dependency, there is one non-working member of the household depending on every two working members, that is, the economic dependency ratio at the national level is 0.48.²³

Employment: Of the total population 10 years and over, 72.6 percent is employed; 75.6 percent for men and 67.8 percent for women. It was reported that among hired workers in agriculture, 69.4 percent of these workers were women. Regarding full-time employees, 38.9 percent were women. 68.1 percent of part-time employees, 67.4 percent of seasonal workers and 70.1 percent of occasional employees were women.²⁴

Occupation: At the national level, 56.7 percent of employed persons are agricultural workers, and in the rural areas, this proportion is 71 percent. Gender-wise, 58.5 percent of men and 54.5 percent of women are engaged in agricultural occupations at the national level while the corresponding values in rural areas are 73.8 percent for men and 68.4 percent for women. The next highest proportion of employed persons are elementary workers (unskilled labourers) and service workers, 13.7 percent in elementary occupations and 11.8 percent is service workers.²⁵

Employment Status: At the national level, 45.5 percent of the working population are employers or own account workers self-employed. (9.1 percent are employers, 36.4 percent are own account workers), 17.6 percent are employees, 16.9 percent are contributing family workers and 15.9 percent casual labourers.²⁶ In the rural areas, 37.8 percent of the working population are own account workers and 11.9 percent are employees, 18.7 percent contributing family workers and 18.6 percent casual labourers. A higher proportion of men (27.2 percent) than women (18.3 percent) are employers or own account workers.²⁷

5.2 Economy

Since its independence, Myanmar has followed three different economic systems: a capitalist type economic system from 1948 to 1962, a centrally planned socialist economic system from 1962 to 1988, and a market oriented economic system from 1988 onwards.

After independence, Myanmar was leader in Southeast Asia's regional economy due to its abundant and untapped natural resources, favourable land-person ratio, and being sparsely populated with no population pressure. Myanmar was once the largest exporter of rice in Asia. In addition, the high literacy rate and education attainment of its population led to a high level of skilled workers.

During 1948 to 1962, the state-led industrialization overemphasized the industrial sector and ignored development of the primary sectors such as agriculture. From 1962-1988, the disregarding of market mechanisms, misallocation of scarce resources, inefficient production and shortage in foreign exchange led to the failure in developing the economy and maintaining a competitive position in the regional economy.

²¹ National Mortality Survey, 1999, CSO

²² Human Development Report 2009, UNDP

²³ PD & UNDP, "Poverty Profile", IHLCA Survey, 2003-2005

Provides the information on the number of economic dependents depending on the economically active persons in the household

²⁴ Report on Myanmar Census of Agriculture 2003, (UNION) 2007, Settlement and Land Records Department and FAO

²⁵ Country Report on 2007 Fertility and Reproductive Health Survey, Department of Population and UNFPA, 2009

²⁶ Poverty Profile, 2007, IHLCA Survey 2003-2005, Planning Department and UNDP

²⁷ Ibid

The Myanmar economy is currently at the developing and transitional stage to a market-oriented economy. The Myanmar economy is heavily dominated by the agriculture sector which accounted for about 48 percent of the economy in 2004. Thus, focusing on agricultural sector development is a compulsory course of action for economic growth and capital accumulation. Promotion of the agricultural sector could raise the overall standard of living in rural areas and would contribute to poverty reduction.

Myanmar is rich in natural resources. Myanmar's forests cover about half the land area of the country²⁸. Myanmar also has an abundance of arable land, with only about 28.4 million acres (approximately two-thirds of the total arable land) under cultivation in 2007-2008 and another 14 million acres standing untouched²⁹ indicating a vast potential for increased agricultural production. About 70 percent of the population works in agriculture and forestry, and rice accounts for about half of the agricultural output. For overall economic growth of the country, the Government of the Union of Myanmar (GoUM) has accorded top priority to agricultural development as the base for all round development of the country. In order to support and to render assistance to small and medium size industries scattered all over the country in an organized manner, the GoUM has established 19 industrial zones in its 17 states and divisions.

Regarding international trade, Myanmar exports gas, wood, beans and pulses, seafood, rice, and gemstones among others. The main imports are fabric, petroleum products, fertilizer, plastics, machinery, transportation equipment, construction materials, crude oil, food products, and edible oil. Myanmar trades mainly with Asian countries. The top trading partners are Thailand, China, Singapore, and India.

Following the adoption of a market-oriented economy after 1988, the government carried out liberal economic reforms to ensure participation of the private sector in every sphere of economic activities. Increased private and foreign investment, and efforts to liberalize the economy were stalled in the late 1990s as restrictions and sanctions on foreign investments were imposed which became challenges for further economic development.

Social sector development is expanded throughout the country; twenty four special development regions have been designated throughout the whole country where health and education facilities have been developed or upgraded along with other developmental activities. Under this project, new universities, colleges and 200-bed hospitals in respective regions were established. Some towns or villages in these regions have also been upgraded to the sub-township level with development of infrastructure to ensure proper execution of administrative, economic and social functions.

Myanmar has developed National Development Plans as a series of short-term economic plans. The first short-term Four Year Plan (1992-93 to 1995-96) and the second short-term Five Year Plan (1996-97 to 2000-2001) were implemented and the economy was increased by 1.34 times and 1.5 times over the base year. The third short term Five-Year Plan (2001-02 to 2005-06) was completed in March 2006 and achieved an increase of 1.8 times growth. The fourth short-term Five Year Plan (2006-07 to 2010-11) has been formulated to achieve an average annual growth rate of 12.0 percent. Among the main objectives of the Fourth Short-Term Five Year Plan are (a) to extend the setting up of agro-based industries as a foundation for building an industrialized nation, (b) to extend the agriculture, livestock and fishery sectors in order to meet local demand for self-sufficiency and to promote exports, (c) to establish forest areas for greening, (d) to conserve the natural environment, (e) to carry on the development of border areas, and (f) to alleviate poverty³⁰.

²⁸ Myanmar Millennium Development Goals Report 2006

²⁹ Statistical Yearbook, 2008, CSO 2009

³⁰ Myanmar Millennium Development Goals Report 2006

GDP growth of the country has risen from 11.3 percent in 2001-2002 to 13.1 percent in 2006-2007 but has decreased to 12.0 percent in 2007-2008³¹. This decline in growth was a result of a steep decline in 2008 in addition to which there was severe damage and loss of lives due to Cyclone Nargis in May 2008.

Table 1.1: Gross Domestic Products (Kyats in billions)

GDP	2001-2002	2002-2003	2003-2004	2004-2005	2005-2006	2006-2007	2007-2008
Current	3,548.47	5,625.25	7,716.61	9,078.92	12,286.76	16,852.76	23,336.11
Constant Producers Price	2,842.31	3,184.12	3,624.93	4,116.64	4,675.22	13,893.39	15,559.41
Growth (%)	11.3	12.0	13.8	13.6	13.6	13.1	12.0

Source: IMF Article IV Consultation

Myanmar, along with other developing countries in Asia, had weathered the global economic downturn relatively well compared to other emerging markets; in spite of a double hit from Cyclone Nargis, a recession has been avoided.³² Year-on-year percent change of GDP growth according to this source is 4.5 in 2005 increasing to 5.5 in 2007 and to 5.0 in 2010. Per capita GDP (at current price in US\$) was 153.76 in 2006³³.

The inflation in Myanmar is high at 10.7 year-on-year percent change in 2005 compared to other Asian LICs (7.3). It has increased to 32.9 in 2007 and declined to 8 and 7 in 2009 and 2010 respectively while the peak inflation in Asian LICs was 16.4 in 2008 declining to 5.8 in 2009 and increased again to 7.7 in 2010³⁴.

Asian LICs are expected to recover as external demand conditions begin to improve. In Myanmar, growth effects and continued recovery from Nargis are expected to remain positive and a strong rebound in Asia will likely help pull up Myanmar's exports in the coming year, contributing further to growth³⁵.

³¹ Statistical Yearbook 2008, CSO 2009

³² Myanmar, 2009 Article IV Consultation, "Impact of the Global Crisis on the Region and Myanmar", December 2009

³³ Regional thematic Working Group on International Migration including Human Trafficking, "Report on Myanmar" in Situation Report on International Migration in East and South east Asia, "Report on Myanmar"

³⁴ Myanmar, 2009 Article IV Consultation: Impact of the Global Crisis on the Region and Myanmar, 16 December 2009

³⁵ Ibid

Chapter Two: Population and Development



CHAPTER II: Population and Development

The everyday quality of life of all human beings is interconnected with population change, patterns and level of use of natural resources, the state of the environment, and the pace and quality of economic and social development. Factors such as the persistent wide spread poverty and serious social imbalances and gender inequalities have significant influences on, and are in turn influenced by, demographic parameters such as population growth, structure and distribution.¹

ICPD has recommended that population issues should be integrated into the formulation, implementation, monitoring and evaluation of all policies and programmes relating to sustainable development, and that governments, international agencies, NGOs and other concerned parties should undertake timely and periodic reviews of their development strategies with the aim of assessing progress towards integrating population into development and environment programmes.

This chapter presents the situation of population in Myanmar; its size, structure, composition, changes over time and the impact population has on social and economic development processes. This chapter also discusses the situation of the environment and the impact of population growth and development on environmental changes, which, in turn, affect the development process of the population. The final goal of this chapter is to provide information on past trends of change in order to contextualize the present situation of population, environment and development. The chapter will serve as a reference for development of national programmes and UN strategic framework at the same time help identify the country's socio-economic needs and priorities and addressing them in partnership with the GoUM and other partners. Thus, the ultimate aim is human-centered development for the present and future generations of Myanmar people. References were made to different sources of data in the country if there was more than one source available for one indicator, and also to international and UN data for comparison and to fill in the gaps where there is no existing national data.

1. Demographic Situations and Trends in Myanmar

1.1. Population size, growth and spatial distribution

The population of Myanmar was estimated at 57.5 million in 2007 (as of 1 Oct) with a growth rate of 1.75 percent over the preceding year.² The population is expected to grow to about 60 million by the end of 2010, 62.6 million in 2015 and 66 million by the year 2020 as estimated at the present decreasing trend of the growth rate. The United Nations estimated Myanmar's population for 2007 at 49.8 million with a natural annual increase of 0.9 percent and estimated that the population would grow to 55.4 million by 2025.³ Other UN⁴ and international⁵ sources estimated Myanmar's population in 2009 at 50 million with a natural increase rate of 0.9 to 1.1 percent. The population of Myanmar is in the late transitional stage with declining fertility accompanied by moderate and declining mortality.

Studying the past population trends, the population has increased steadily from 10.7 million in 1901 to 28.9 million in 1973 (the pre-war census populations estimated as of 1973 census area)⁶. At the last census in 1983, population stood at 35.3 million. Absolute increase was the lowest in 1911-21 decade due to the influenza epidemic. The population has progressively increased at the growth rate of 0.82 percent in 1911-21 to 2.51 percent in 1963-73, but has come down to 2.02 percent during the decade 1973-83. Since then, the growth rate is assumed to continuously decline at the same trend as is in the

¹ Programme of Action Adopted at the International Conference on Population and Development, United Nations, Cairo, 1994

² Statistical Yearbook, 2008, Central Statistical Organization, 2009

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

⁴ ESCAP Population Data Sheet 2009

⁵ 2009, 2009 World Population Data Sheet, Population Reference Bureau

⁶ Analysis of population trends, Census Division, Immigration, National Registration and Census Department, Yangon

seventies, coming down to 1.87 percent in 1995 and 1.84 percent in 1996-1997. From 1998 to 2007 the growth rate was estimated to be 2.02 percent⁷ and then decreased to 1.75 percent from 2007 to 2008⁸, and 1.52 percent from 2008 to 2009. Without considering migration, the natural growth rates (the balance of birth rate and death rate) are 1.17 percent in 1991 and 1.07 percent in 2006, which are much lower than the present estimated growth rates. The UN estimates of the growth rate are nearer the natural growth rate than the official rates. If migration were taken into account, the growth rate would still be lower, and closer to the UN estimates.

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

The sex ratio is 98.9 males per 100 females at the national level, however there are variations among the states and divisions, ranging from over 100 in Kayah, Bago, Mon, Shan and Ayeyarwady to 95 in Chin. The sex ratio of over 100 in the above 5 regions indicates the excess of males, and this is probably due to the fact that these areas have favourable employment opportunities and attract male internal migrants. The sex ratio is a proxy indicator showing the absence of sex selective abortion and infanticide. Unlike Asian nations with a preference for male children such as China, India and Pakistan (which have national sex ratios of 108, 107 and 106 respectively⁹), an impartial attitude on sex preference appears to be the case in Myanmar, at least as reflected in numbers of males vis-à-vis females. The estimated population by region, density and sex ratio is given in Table 2.1.

Table 2.1 Population, density and sex ratio by state and division, 2007-2008

SN	State/ Division	Population (in '000)			Density* (Per sq km)	Sex Ratio*
		Total	Males	Females		
	Union	57504	28586	28918	85	98.9
	States					
1	Kachin	1511	747	764	16	97.8
2	Kayah	336	170	166	28	102.4
3	Kayin	1740	861	879	58	98
4	Chin	533	260	273	14	95.2
5	Mon	2997	1506	1492	244	100.9
6	Rakhine	3183	1586	1592	87	99.6
7	Shan	5464	2738	2726	35	100.4
	Divisions					
8	Sagaing	6274	3084	3190	67	96.7
9	Tanintharyi	1632	814	818	37	99.5
10	Bago	5793	2912	2881	146	101.1
11	Magway	5392	2653	2739	120	96.9
12	Mandalay	8062	3984	4078	172	97.7
13	Yangon	6724	3338	3386	661	98.6
14	Ayeyarwady	7863	3934	3929	224	100.1

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

* Calculated based on the data from the Statistical Yearbook

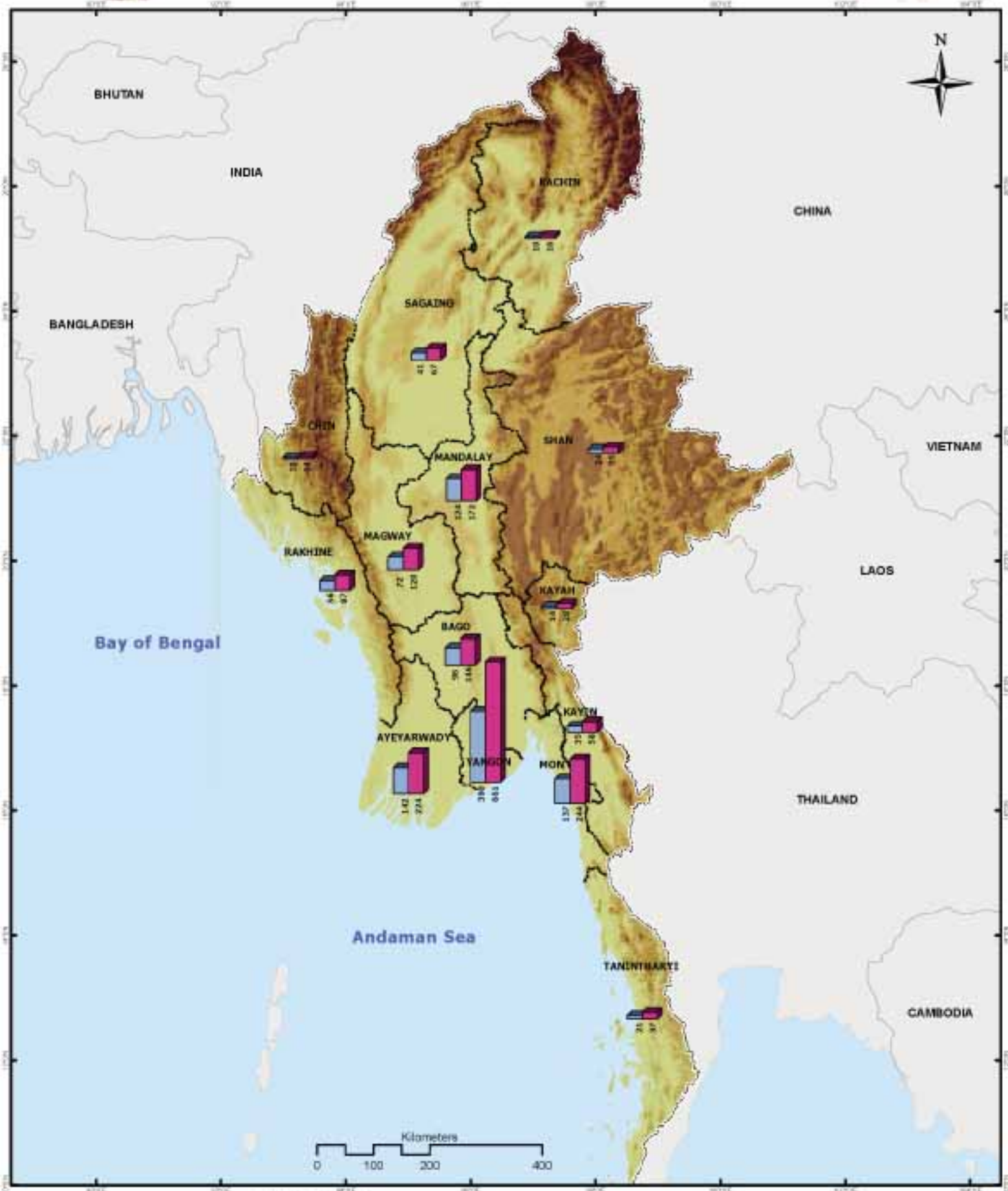
⁷ Handbook on Human Resource Development Indicators, 2006, Special Edition, Department of Labour and UNFPA,

⁸ Statistical Yearbook, 2008, Central Statistical Organization, 2009

Central Statistical Organization, 2009

⁹ World Population Prospects: The 2008 Revision, Highlights, Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat (2009), New York

Map of Myanmar Showing Geographical Terrain and Population Density by State and Division



Map ID: MIMU356v01
 Creation Date: 13 January 2010, A4
 Projection/Datum: Geographic/WGS84
 Map produced by the MIMU - info.mimu@undp.org

Elevation (meter)

- 0 - 250
- 251 - 500
- 501 - 1,000
- 1,001 - 2,000
- 2,001 - 5,000

Pop Density Per sq_km

225

Pop_Density/sq_km

- Year 1983
- Year 2007

Legend:
 - State/Division Boundary
 - International Boundary

Data Sources:

- 1 - 1983 Population census
 Immigration & Manpower Dept,
 Ministry of Home Affair
- 2 - Statistical Yearbook-2008 (CSO)

Boundaries-WFP modified by MIMU

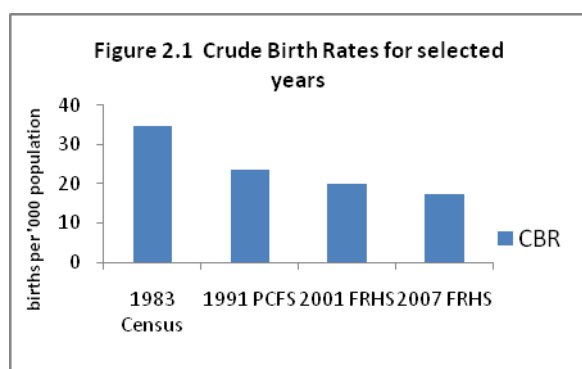
Disclaimer: The names shown and the boundaries used on this map do not imply official endorsement or acceptance by the United Nations.

Myanmar has an average population density of 85 per square kilometer in 2007 and is sparsely populated compared to neighboring countries such as Bangladesh (1127 per sq. km), India (356 per sq. km), Thailand (132 per sq. km), and China (139 per sq. km).¹⁰ Chin State is the most sparsely populated region, with the density of 14 persons per square km. Yangon Division which includes the former capital, Yangon, is the most densely populated division with 661 persons per sq. km. (see map showing population density of states and divisions)

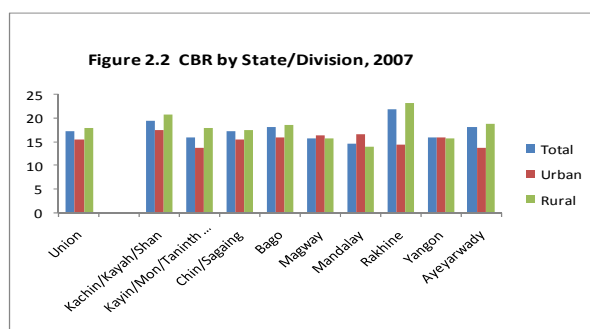
1.2 Fertility – Levels, Trends and Determinants

Fertility varies with race, religion and culture and it effects the age composition of a population more strongly than mortality. Fertility in Myanmar has been declining and is at post-transitional stage. Myanmar's Crude Birth Rate (CBR) at the national level was 17.3 births per thousand population in 2006, totaling to approximately one million births a year. This has decreased from 34.8 births per thousand population in 1983 (about 1.34 million births a year). As such, the rate has almost been halved over the span of 25 years¹¹.

The CBR from Health Management Information System (HMIS) also reported a CBR of 17.3 for 2008. The Nationwide Cause Specific Maternal Mortality Survey 2004-2005 reveals CBR at 18.39 in 2004 which is close to the 2006 rates and the rates from vital registration system (VRS) also showed a declining trend. Urban-rural differential for 2006 is about two, with urban CBR less than rural CBR. The 2007 FRHS shows the lowest CBR nationwide to be in Mandalay Division where it stands at 15, and the highest CBR of 22 was found in Rakhine State¹². See Figures 2.1 & 2.2 below for more details. Myanmar's national CBR is lower than Laos (28), Cambodia (25), India (23), Bangladesh (23), Malaysia (21) and the South East Asia region CBR of 21, but is higher than Thailand (15), China (12) and Singapore (10).¹³



Source: 1983 Census, 1991 PCFS, 2001 FRHS, 2007 FRHS



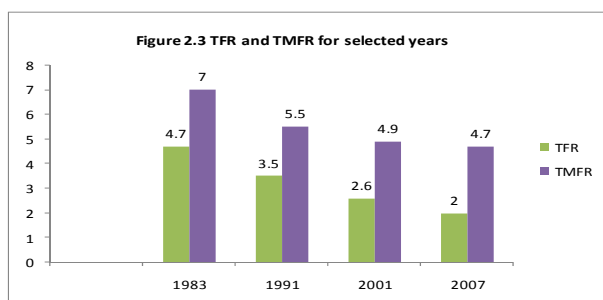
Source: Country Report, 2007 Fertility and Reproductive Health Survey, Department of Population, Nay Pyi Taw

¹⁰ 2009 World Population Data Sheet, Population Reference Bureau

¹¹ Country Report on 2007 Fertility and Reproductive Health Survey, Department of Population and UNFPA

¹² Ibid

¹³ 2009 World Population Data Sheet, Population Reference Bureau



Source: Country Report, 2007 FRHS, Department of Population and UNFPA

In 1983, a woman would have had 4.7 children at the end of her reproductive age if she experienced the prevailing age specific birth rates. The birth rate decreased to 2.9 children in 1991 and to 2.0 children in 2006, a Total Fertility Rate¹⁴ (TFR) below replacement level. (Figure 2.3) In 2006 an urban woman would have on average 1.68 children, which is considerably lower than her rural counterpart who would have had 2.18 children. The gap between urban and rural birth rates (TFR) was wide in both 1983 and 1991; a woman living in urban would have had one to two children less than a rural-residing woman. The gap became narrower by 2001 and 2006, where it was less than one child, reflecting a sharper decline of rural fertility probably due to the emergence of positive attitudes and practices towards birth spacing in rural areas.¹⁵ TFR also varies geographically. The highest TFR is in Rakhine State with 2.87 children per woman, while Mandalay Division and Yangon Division have the lowest TFR of 1.69 children and 1.72 children per woman respectively. The remaining regions have TFR of just over 2.0¹⁶.

Since reproduction takes place primarily within marriage in Myanmar, marital fertility (Total Marital Fertility Rate - TMFR) is studied to get a picture of the true performance of fertility of married Myanmar women. In Myanmar a married woman would have 7 children in 1983 if she were to experience the prevailing age specific birth rates during her reproductive span. This marital fertility rate (birth rate among married women) has declined to 4.9 children per married woman in 2001 and to 4.7 children in 2006. The number of children a married woman can expect to give birth to is still high though it has declined, somewhat slowly during 1983 to 2001 and faster during 2001 and 2006. Rural TMFR stands at 4.69, national TMFR at 4.7, and urban TMFR is a little higher, at 4.8 children per married woman. The difference between TFR and TMFR is significant ranging from 2.2 to 3.1 children.

Fertility decline in Myanmar is likely to be influenced by factors such as education, employment, and increase in age at first marriage and age at first birth, increase in proportion never married, increase in contraceptive use of modern methods and abortion, and a decline in fertility preference. One of the important factors contributing to the fall in fertility rate is the increase in proportion of never married women up to 1997 and the marital fertility use of contraception from 1997 onwards. During 1983 to 1997, the effect of nuptiality changes in the fertility decline was estimated within the range of 41 to 47 percent compared to 53 to 59 percent by marital fertility effect including the share of contraception in the decline of overall level of fertility in the range of 26.5 to 29.5 percent¹⁷. However, effect of change in marital fertility in the fertility decline has increased to over 80 percent during 1997-2006 decade¹⁸.

Though the fertility rates have declined considerably and even with about half of reproductive age women being not married, we can still expect about a million live births in 2007 (891,000 births as per UN estimates) which will have a significant impact at the individual, community and national levels in regards to economy, health and social services. Population issues need to be addressed

¹⁴ TFR is the number of children a woman would have during her reproductive life if she experienced the prevailing rates of fertility at each age

¹⁵ Country Report on 2007 Fertility and Reproductive Health Survey, Department of Population and UNFPA, 2009

¹⁶ Ibid

¹⁷ "Nuptiality Transition" in Detailed Analysis on Fertility and Reproductive Health Survey, 2001, Department of Population and UNFPA

¹⁸ Research calculations from FRHS data, Department of Population

especially since the majority of the people are in rural areas, where provision of services such as education and health services are already deficient. Taking the impact of population growth into consideration is integral to future programme planning.

As the age at marriage is relatively high, most adolescents (aged 15 to 19) are unmarried. The proportion of female adolescents marrying has declined from 10.2 percent in 1991 to 6.8 percent in 2006. There are 16.9 live births per thousand female adolescents and its contribution to total fertility is 4 to 5 percent.¹⁹ Comparison among some Asian countries shows Myanmar's adolescent fertility as relatively low; it is higher than Malaysia and comparable to Vietnam. (Table 2.2)

Table 2.2 Adolescent fertility rates for selected Asian Countries

Country	2009
Phillipines	45
Thailand	37
Indonesia	40
Vietnam	17
Brunei Darussalam	25
Cambodia	39
Malaysia	13
Myanmar	17

Source: State of the World Population 2009, UNFPA, NY

Age at first birth: Mean age at first birth for Myanmar women has increased from 21.2 years in 2001 to 22.8 years in 2006. There is little variation among various age groups of women. Only 1.5 to 2 percent had their first birth before age 15. Ten percent of women age 15-49 have given birth before they were 18. Over 20 to 30 percent had their first birth before age 20. Nearly half of married women had given birth before they were 22 and about 40 percent had their first birth between age 20 and 24. The low proportion of women giving birth in their teens can be attributed to the high age at first marriage; it could also be due to a high abortion rate of 11.39 percent of teenage ever-married²⁰. Regionally, Rakhine State has the lowest age at first birth. Women in urban areas are one year older than rural women when they have their first birth. The duration between first marriage and first birth was 1.9 years in 1991 increasing to 2.3 years in 1997²¹. Studying both age at first marriage and age at first birth from 2007 FRHS suggests that the average Myanmar woman has her first child about two years (22 months) after the date of her marriage.

Pregnancy Outcome: Overall 94 percent of all pregnancies of ever-married women aged 15-49 are live births, 4.7 percent are aborted and 1.33 percent are stillbirths. The rural live birth rate is slightly higher than the urban and the rate increases with age. Adolescents have the highest abortion rates of 11.39 percent and university educated women have the next highest rate of 9 percent. In other words, more educated women have a higher abortion rate. This is a strong reason why RH education and contraceptive services should be targeted towards adolescents and university students. Pregnancy outcome varies among different regions. Yangon Division has the highest abortion rates, while Magway, Mandalay and Rakhine have the lowest abortion rates.²²

Fertility Preference: Fertility preferences can be used as one of the instruments to forecast fertility behaviour of any given population. The mean ideal family size has declined slightly from 3.3 children in 1991 to 3.2 children in 2006. About half of currently married women of reproductive age have no desire for any more children. About five percent are already sterilized and six percent believed to be infecund. Another 15 percent want to space their next child after two years. It is also to be noted that

¹⁹ Country Report on 2007 Fertility and Reproductive Health Survey, Department of Population and UNFPA, 2009

²⁰ Ibid

²¹ Detailed Analysis on Fertility and Reproductive Health Survey, July 2001, Department of Population and UNFPA

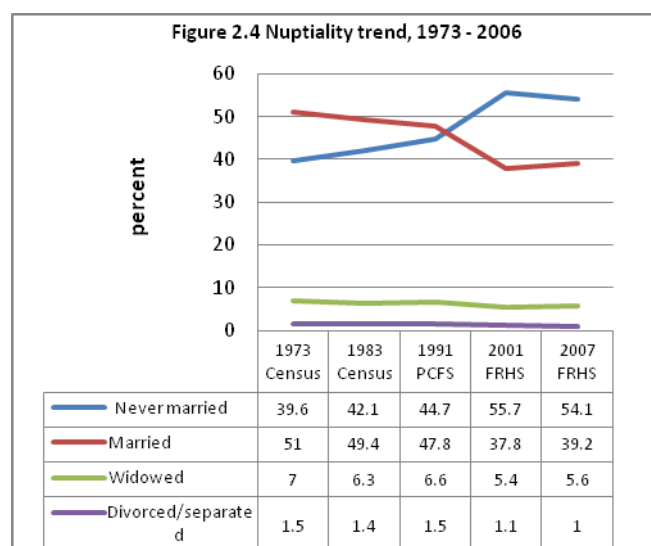
²² Country Report on 2007 Fertility and Reproductive Health Survey, Department of Population and UNFPA, October 2009.

12 percent of those with no living children and 21 percent of currently married adolescents want no more children.²³ All in all, it seems that preferred or desired family size is becoming smaller.

The trends of increased use of modern contraceptive methods, decreased desired family size, higher age at marriage, higher proportion of never married and higher age of first birth will lead to continuation of the decreasing trend of fertility in Myanmar. This phenomenon has an impact on the age structure of the population. Declining fertility will produce fewer births, resulting in a lower proportion of younger age groups. This will narrow the base of the age structure especially the 0-14 age group – the grouping that will soon grow into the working age group. With the reduction in mortality, life expectancy will increase which will result in a more elderly population than before, and also an increasing elderly population proportion. These facts would have an influence on the formulation and implementation of development strategies and plans for the achievement of MDGs by 2015, as well as policies and strategies in the context of welfare, education, livelihoods training, employment for youth, social services and health services for the elderly population.

1.3 Nuptiality Levels and Trends

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



Source: 1973 Population census and 2007 FRHS, DoP and UNFPA

In Myanmar, reproduction is predominantly confined to marriage. Early marriage and universality of marriage are not features of marriage patterns in the country. Myanmar does not practise arranged childhood marriage and only about 5.2 percent of adolescents of both sexes aged 15-19 are married in 2006²⁴. Among the population aged 15-49, over half of both males and females are married.

²³ Country Report on 2007 Fertility and Reproductive Health Survey, Department of Population and UNFPA, October 2009.

²⁴ Detailed Analysis on Fertility and Reproductive Health Survey, July 2001, Department of Population and UNFPA

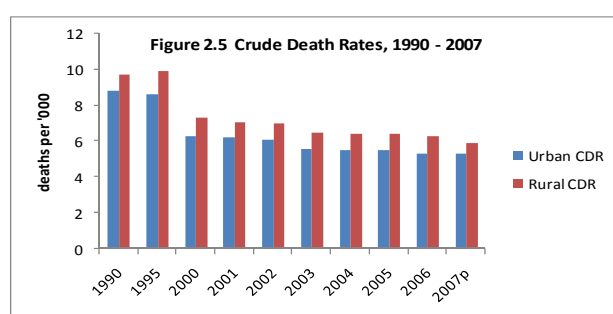
Singulate Mean Age at Marriage (SMAM): The age specific never married can conveniently be summarized into a single measure known as Singulate Mean Age at Marriage (SMAM). This measure is not the actual age at marriage among ever-married but the indicator derived from never married proportion.²⁵ There has been a continuous increase in SMAM for both men and women, For women, SMAM has increased from 21.2 years in 1973 to 26.1 years in 2006 and the increase in men was from 23.8 years to 27.6 years for the same points of time. The SMAM is higher in urban than rural areas and the values are higher for men. Both hold true in all regions and for all levels of education.

Age at first marriage: Age at first marriage is the age at which the marriage occurs for the first time for both men and women and the indicator is calculated from the age at first marriage among ever-married persons. In 1997, among women 15-49 years of age who have ever married, they were on average 20 years old when they first got married, and their husbands were on average 23.3 years of age.²⁶ By 2006, a decade later, the average age at first marriage among the ever- or currently married women 15-49 was 21 years and their husbands 24 years on average – an increase of one year for both men and women over the decade.²⁷ Age at marriage varies with age, rural-urban residence and educational attainment. The urban women and men, and the more educated tend to marry later. Older cohorts tend to marry at a later age²⁸.

Given that age at marriage is increasing, effective mechanisms need to be developed to reach unmarried people with appropriate RH information and services. The prevalence of unwanted births and unmet need called for a need to expand contraceptive services.

1.4 Mortality Levels, Trends and determinants

The **Crude Death Rate (CDR)** for Myanmar was 9.1 deaths per thousand population in 1990 and has dropped to 6.0 in 2006. Urban CDR is lower than rural CDR. The CDR in urban areas was 7.9 in 1990, declining to 6.6 in 2006. The corresponding values for rural areas were 9.6 and 5.7 respectively²⁹. According to the 2008 HMIS, the CDR was 8.0 at the national level but as high as 24.6 in Ayeyarwady, 8.2 in Yangon, and around 6 in Mon, Bago (West) and Magway, with the lowest being 2.3 in Shan State (East)³⁰. As the data is for 2008, the numbers for Ayeyarwady Division reflect the devastating death toll of Cyclone Nargis. The CDR for 2007 according to Vital Registration System (VRS) for urban is 5.3 and for rural areas it is 5.9. The data are lower than the survey rates, probably due to underreporting in VRS as the majority of the deliveries (76 percent) are at home³¹.



Source: (VRS) Statistical Yearbook, 2008, CSO, 2009

²⁵ It is the average length of single life expressed in years among those who marry before age 50. <http://www.nips.org.pk/fag.htm> downloaded on 29-6-2010

²⁶ Country Report, 1997 FRHS, Department of Population and UNFPA

²⁷ Country Reports, 1997 and 2007 FRHS, Department of Population, Nay Pyi Taw and UNFPA,

²⁸ Ibid

²⁹ FRHS Country Reports, Department of Population, Nay Pyi Taw and UNFPA,

³⁰ HMIS Report 2008, Department of Health Planning

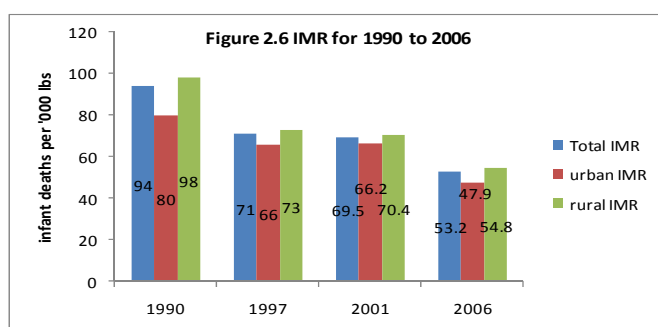
³¹ Country Report on 2007 Fertility and Reproductive Health Survey, Department of Population, Nay Pyi Taw and UNFPA,

Neonatal Mortality Rate: Neonatal deaths are those occurring within the first 28 days of life. The neonatal death rate in Myanmar was 43 infant deaths per thousand live births in 1991-2001, and has decreased to 33.8 infant deaths in the period 1996-2006.³² Urban-rural differences are substantial with the urban rate almost 15 deaths per thousand live births lower. The difference between male infant and female infant mortality is also significant – more male infants pass way than female infants. Birth interval has a strong influence on mortality. A baby born less than 2 years after its sibling has less chance of surviving than those born after more than a 2 year interval. Regional variations also exist. Magway Division has the highest neonatal mortality rate of over 50, followed by Chin, Sagaing and Mandalay, while the lowest rate was observed in Yangon Division in 2001.

Infant Mortality Rate (IMR): In 1990, for every thousand live births, 94 infants died before they reached their first birthday. The IMR has decreased to about 53 infant deaths in 2006. Following a major pattern in Myanmar, the IMR varies according to the urban-rural residence. According to 1990 measurements, in urban areas, for every thousand live births, 80 infants died before they turned one. This number reduced to 48 in 2006, a decline of 27 percent during 2001-2006. In rural areas it has declined from 98 in 1990 to 54.8 in 2006. The decline is consistent at national and urban and rural levels. Male IMR and rural IMR are higher than that of female IMR and urban IMR.³³

It was reported in The State of the World’s Children 2009 that, in Myanmar, for every thousand live births in 1990 there were 91 infants dying before they were one year old and this has decreased to 74 infant deaths in 2007.³⁴ The State of the World Population 2009 reported Myanmar IMR for the year 2009 at 72 infant deaths per thousand live births. IMRs estimated in different reports of UN are consistent and show a declining trend. Other UN estimates for both 2007 and 2009 for Myanmar is 75 per thousand live births³⁵.

It is useful to compare IMR values for countries in the region. Pakistan stands at 67, Laos at 64, Cambodia at 62, India at 55, Bangladesh at 48, Bhutan at 40, Malaysia at 9 and Thailand at 7 respectively. In comparison, Myanmar IMR is considered to be comparatively high. IMR is related to health provision, nutrition practices, maternal education, socioeconomic development, and hygiene, as all these factors directly affect the health of a baby in its first year. Myanmar’s comparatively high IMR indicates low levels of socioeconomic development, health, sanitation and hygiene awareness and nutritional practices of the majority of the population about 70 percent of which is rural.



Source: FRHS Country reports, Department of Population, Nay Pyi Taw

The **under-five mortality rate (U5MR)** for urban areas was 105 per thousand children in the period 1981-1990, 72 during 1987-1996, and declined to 56.3 from the period of 1997-2006. For rural areas, the U5MR was 152 during 1981-1990, and has declined to 83.3 from the period 1997-2006. Clearly, urban-rural differences are very significant³⁶. The Overall and Cause Specific Under Five Mortality Survey 2002-2003 reported an U5MR of 66.1 for the country, varying between 48.2 and 83.9. The

³² Country Reports, 2001 and 2007 FRHS, Department of Population, Nay Pyi Taw and UNFPA,

³³ Country Report, 2007 FRHS, Department of Population, Nay Pyi Taw and UNFPA,

³⁴ World Population Data Sheet 2009, Population Reference Bureau

³⁵ 2007 and 2009 World Population Data Sheet, Population Reference Bureau,

³⁶ Country Reports, FRHS, Department of Population, Nay Pyi Taw, UNFPA

urban U5MR was reported as 37.3 and the rural U5MR as 72.5.³⁷ According to UN estimates, U5MR of Myanmar was estimated at 130 in 1990, decreasing to 103 in 2007, indicating a decline of 21 percent during 17 years³⁸. While differing in their hard numbers, all three mortality indicators are declining. It could be argued that the decline in under-five mortality resulted from improvements in standard of living, personal hygiene, sanitation and health care services provided by national and international organizations. However, the average rate of reduction in U5MR has been assessed as 'insufficient' in the countdown to 2015 MDG goals. With the UN observed rate of 103 in 2006, it will be very difficult to meet the targeted figure of 43 by 2015.³⁹

Maternal Mortality Ratio (MMR): Data on maternal mortality is not collected in most surveys as it is difficult to cover the required size of population for direct calculation, as estimating MMR requires a large sample. MMR is typically difficult to measure for both conceptual and practical reasons, as maternal deaths are hard to identify precisely.⁴⁰ Only three large countrywide surveys – the 1997 and 2007 FRHS and the 1999 National Mortality Survey – included questions concerning maternal mortality. The Nationwide Cause Specific Maternal Mortality Survey (2004-2005) was specially designed to collect information on maternal mortality. Myanmar's Maternal Mortality Ratio (MMR) was 283 per 100,000 live births for the period 1986-90.⁴¹ According to the 1999 National Mortality Survey, it was 255 at the national level, 178 in urban areas and 281 in rural areas.⁴² The value varies widely among the regions. It is as high as over 500 in most of Shan State, and as low as 136 in Sagaing Division. The Nationwide Cause Specific Maternal Mortality Survey estimated MMR at the national level at 316 (ranging from 177 to 451) per 100,000 live births, 140 for urban and 363 for rural areas in 2004-2005.⁴³ The HMIS reported MMR in 2008 to be 150 per 100,000 live births, varying among regions, from 220 in Kayah State, Chin State, and Shan State to 110 in Bago (West) and Magway and 90 in Yangon.⁴⁴ Vital Statistics reported MMR at 94 for urban and 136 for rural for the year 2007.⁴⁵

State of the World Population stated Myanmar's MMR at 380⁴⁶. This also reflects 2005 estimates developed by WHO, UNICEF and UNFPA that also place Myanmar MMR at 380⁴⁷. Under MDG Goal 5 "Improve Maternal Health", Target 6 is to reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio and the GoUM has set down the target of MMR at 290 by 2013 and 145 by 2015.⁴⁸ With the estimate of MMR at 316 in 2004-2005, to meet the Myanmar MDG target of reducing MMR to 145 by 2015⁴⁹ is a challenge and will need greater concerted efforts of the GoUM, UN and international community.

Life Expectancy at birth: In Myanmar, life expectancy at birth has increased for both men and women. The estimated life expectancy at birth for both sexes in 1991 was 61 years, 61.7 for women and 59.2 for men⁵⁰. The values for 2006 are 65 years for both sexes (66 years for women and 63 years for men), showing a continuous increase from 1991⁵¹. UN estimated Myanmar's life expectancy at birth as 63.4 years for women and 59.0 years for men for 2007. These estimates are lower than national estimates.⁵²

³⁷ Women and Child Health Project, 2003, Overall and Cause Specific Under Five Mortality Survey 2002-2003, Department of Health and UNICEF,

³⁸ The State of the World's Children 2009, , UNICEF

³⁹ Countdown to 2015, Tracking Progress in Maternal, Newborn & Child Survival, The 2008 Report

⁴⁰ Maternal mortality in 1995, Estimates developed by WHO, NICEF, UNFPA

⁴¹ Country Report, 1997 FRHS, Department of Population, Nay Pyi Taw and UNFPA

⁴² National Mortality Survey, 1999, Central Statistical Organization, Nay Pyi Taw

⁴³ Nationwide Cause Specific Maternal Mortality Survey 2004-2005, Department of Health and UNICEF,

⁴⁴ HMIS 2008, DHP

⁴⁵ Statistical Yearbook 2008, Central Statistical Organization, Nay Pyi Taw

⁴⁶ State of the World Population 2009, UNFPA

⁴⁷ Maternal mortality in 2005, Estimates developed by WHO, UNICEF, UNFPA and World Bank

⁴⁸ Five Year Strategic Plan for Reproductive Health , 2009-2013, Department of Health

⁴⁹ Five-Year Strategic Plan for reproductive Health 2009-2013), Department of Health, Ministry of Health

⁵⁰ HRDI 2006, Special Edition, DOL and UNFPA

⁵¹ Country Report on 2007 Fertility and Reproductive Health Survey, Department of Population, Nay Pyi Taw, and UNFPA

⁵² Human Development Report 2009, UNDP

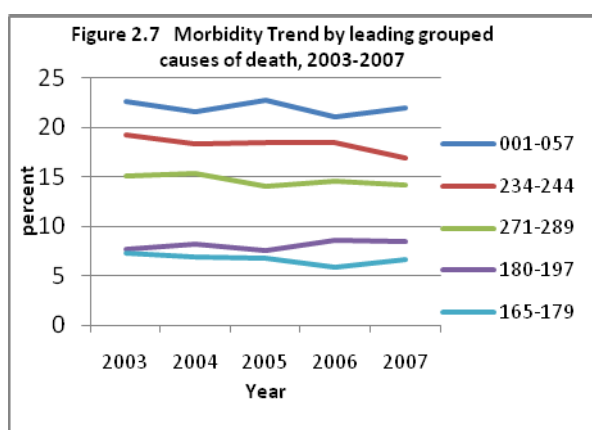
1.5 Morbidity

1.5.1 Morbidity levels and trends

The study of morbidity is the investigation of illness, sickness, ill health or disease in a population.⁵³ Morbidity incidence was studied in IHLCA Survey conducted in 2004-05. This report considered self-reported morbidity incidence by season and found that there were seasonal variations. The morbidity rate at the national level was 6.5 percent at the end of the rainy season while it was 4.0 percent at the end of the dry season. This is probably due to the fact that the rainy season usually brings higher rates of malaria and other water-borne diseases. Morbidity rates at the end of the rainy season were found to be higher in rural areas at 7 percent, compared to 5.2 percent in urban areas. The corresponding figures at the end of dry season are 4.2 percent and 3.4 percent respectively.

Though data on national-level causes of death is not available, hospital records are available for analysis. In Myanmar, Annual Hospital Statistics Reports and Annual Public Health Statistics Reports are prepared and published by the DHP and DOH and Health in Myanmar published by Ministry of Health. While many deaths do occur at the home, mining hospital sources for data provides some interesting information. The leading grouped causes of morbidity for Myanmar, as reported in Annual Hospital Statistics Report 2007 are (a) certain infectious and parasitic diseases (22 percent), (b) pregnancy, child birth and puerperium (16.9 percent), (c) injuries, poisoning and certain other consequences of external causes (14.2 percent), (d) diseases of the digestive system (8.5 percent), (e) diseases of the respiratory system (6.7 percent).⁵⁴ Among under-five deaths, 61.9 percent had single cause of death and 18 percent had multiple causes of death. The main leading causes identified were ARI, Diarrhoea, Brain Infection (including Cerebral Malaria) and prenatal problems.⁵⁵

For males, the leading grouped causes of morbidity are certain infectious and parasitic diseases, injuries, poisoning and certain other consequences of external causes, diseases of the digestive system, diseases of respiratory system, and symptoms, signs and abnormal clinical findings not elsewhere among others. For females, the leading grouped causes of morbidity are pregnancy, child birth and puerperium, certain infectious and parasitic diseases, injuries, poisoning and certain other consequences of external causes, diseases of the digestive system, and diseases of respiratory system, mentioned in detail in Chapter 3.



Over the five years from 2003 to 2007, all categories of morbidity are in the increasing trend except diseases such as pregnancy, child birth and puerperium, disease of respiratory system and congenital malformations, deformations and chromosomal abnormalities, which are in stable trend.⁵⁶ (Figure 2.7)

Source: Annual Hospital Statistics Report 2007⁵⁷

⁵³ Multilingual Demographic Dictionary, English Section, IUSSP

⁵⁴ Annual Hospital Statistics Report, 2007, Department of Health Planning and Department of Health, Nay Pyi Taw, Myanmar, March 2009

⁵⁵ Ibid

⁵⁶ Ibid

⁵⁷ Note: Leading grouped Causes of Morbidity: 001-057 Certain Infections and parasitic diseases; 165-179 Diseases of the respiratory system; 180-197 Diseases of the digestive system; 234-244 pregnancy, childbirth and puerperium; 271-289 Injury, poisoning and certain other consequences of external causes

1.5.2 Disability levels

While making efforts to achieve the social objective to ‘Uplift the health, fitness and education standards of the entire nation’, Myanmar is emphasizing development of vulnerable groups such as children, women, elderly and persons with disabilities⁵⁸ (PWDs). The constitution of the Union of Myanmar, 2008 states in Section 32 that the Union shall care for the disabled. The Department of Social Welfare together with The Leprosy Mission International (TLMI) developed and adopted the National Plan of Action on Persons With Disabilities (PWD) for 2010-2012 in May 2010. A Disability Survey was conducted on 108,000 households in 17 States and Divisions based on which the National Plan of Action on PWDs is developed. The survey results revealed that 2.32 percent of the total population in Myanmar are disabled, that is, about 1.3 million people. Only 15 percent of PWD are employed and only 1.5 percent are university graduates. Only 27 percent of PWDs are aware of existing social services and a similar number know of the existence of government social welfare services. Among those who know of government social welfare services, only about one third ever contacted the government agencies. It was mentioned in the Plan of Action that issues concerning PWDs are mainly the responsibility of The Department of Social Welfare and that the Plan involves cooperation of a wide range of stakeholders from government, national and international NGOs and the private sector. Lessons learned and models from the Emergency Plan of Action for PWDs affected by Cyclone Nargis are incorporated into the National Plan of Action for PWDs.⁵⁹

The Goal of the National Plan of Action is that, “persons with disability have increased mobility, access and opportunity to be able to participate in society as equal members, and contribute to the economic and social goals of the State as active and responsible citizens.” The Plan of Action will follow a twin-track approach of ‘advocacy’ and ‘action’, by mainstreaming disability into all areas, and to support specific initiatives for persons with disability.

The Plan of Action will undertake the following strategies:

- Advocacy to all sectors of needs and rights of persons with disability
- Policy and strategy development for disability issues
- Capacity building of all sectors for inclusive approach to disability (mainstreaming)
- Short, medium and long term needs assessment for PWDs
- Expand the availability of community based rehabilitation (CBR) through a network approach (enabling Communities)
- Expansion of livelihood programmes for PWDs (both as mainstreamed and ‘step-up’ specialist programmes)
- Media and awareness raising campaigns to communities to raise awareness of disability issues
- Expanding access to mainstream education for children with disability

Autism and cerebral palsy are conditions affecting young children, and a major challenge to families. There is only one functioning day treatment public facility - The School for Disabled Children – which is for children with autism, Down’s syndrome, mental retardation, and cerebral palsy⁶⁰. Several faith based and private-for-profit institutions have been established lately such as Mary Chapman’s school for Deaf, Eden school for disabled, New World Training Centre and Flowers special education for Disabled Children. There is a need to conduct a base-line study on the types, magnitude and prevalence of children with disabilities for future support, regulation and appropriate development.

⁵⁸ Note: Disability is an evolving concept and that disability results from the interaction between persons with impairment and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others

⁵⁹ Myanmar National Plan of Action for persons with Disabilities 2010-2012, Department of Social Welfare, Ministry of Social Welfare, Relief and Resettlement

⁶⁰ WHO-AIMS REPORT ON MENTAL HEALTH SYSTEM IN MYANMAR, using the World Health Organization - Assessment Instrument for Mental Health Systems (WHO-AIMS). Yangon, Myanmar, 2006, MOH-WHO

1.6 Migration

In Myanmar, like most countries, the scale, composition and causes of population mobility is not accurately known. To date, there is no nationally representative migration surveys conducted in Myanmar as yet. However, 1991 PCFS, 2001 and 2007 FRHS, and 2004 Family and Youth Survey include questions on migration such as place of birth, place of residence last 5 years, duration of residence at current place etc. 1991 PCFS Country Report and 2001 FRHS Preliminary Report and 2004 FAYS research papers include analysis on migration. Scattered data is available on a few migrant related factors, but the characteristics of migrants such as their reasons for migration, preferred destinations, and method of transport, have not been collected. The DOP is planning to undertake a Migration Survey in 2011 with assistance from UNFPA.

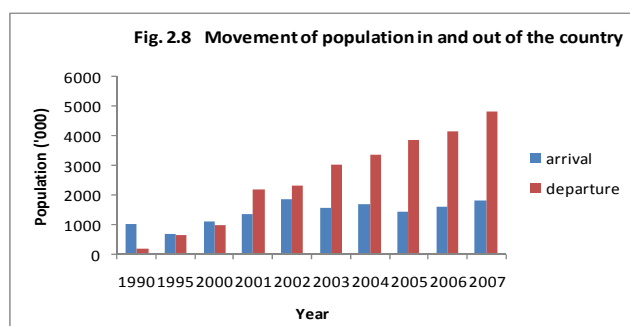
1.6.1 International Migration

International migration plays an important role as it regards the flow of people between sovereign countries. Economic imbalances, poverty and environmental degradation combined with degrees of development affect the volume and direction of migration flows. Most international migrants are skilled members of the productive age group as well as young people in search of education and professional training.

Myanmar has a long history of both immigrants and emigrants. Under British colonial administration, large numbers of Indian nationals were brought to Myanmar. Skilled migrants were placed in administrative and military posts, and lesser skilled migrants were used as abundant cheap labour in agriculture. Most of the migrants were concentrated in urban areas, and in 1931, almost 70 percent of Yangon's population were foreigners. The proportion of foreigners to total population gradually increased from 8.5 percent in 1901 to 10.3 percent in 1931. But due to the government's closed immigration policy, the proportion of foreign races to total population diminished to 5.4 percent in 1983. In 1991, the proportion of foreign-borns was 1.02 percent (about 40 thousand).

At present, raw data on international migration is scarce but is available by official count of the number departing from international airports, seaports, and land border checkpoints. International out-migration was negligible in the past; however, it is now more significant with the country's movement towards open policies and a move to a privatized economy. The size of temporary movements of people across the border at check-points is on the increase particularly in connection with the development of border areas and border trade.

Statistical Yearbook provides data on movement of population into and out of the country for persons holding various types of visas except tourist visa. (Figure 2.8)



Source: Statistical Yearbook 2008, CSO, 2009

There are the years where departure exceeds arrival by one to four million, starting from year 2001 to 2007. The explanation would be Myanmar nationals and their accompanying family members leaving the country for short- or long-term visits, studies abroad and for employment. Most of them would be skilled members of the productive age group and some would be young people in search of

knowledge, higher education and skilled and low-skilled jobs. The result is a brain drain and/or talent drain of skilled nationals, potential workforce members as well young people. Persons leaving or arriving are kept at a database at Immigration and National Registration Department (INRD) and reports of the arrivals and departures are being prepared by nationalities, passport and visa type and country of origin etc., but are only available for internal use. This tremendous movement of population out of the country needs to be studied in terms of the type of personnel, level of education and reasons for leaving. Age and sex disaggregated data on migrants could be analyzed so as to study the impact of migration.

Statistics from the United Nations Human Development Report 2009 reveal that about 0.7 percent of Myanmar's population emigrated during 2000-2002. This totals to about 358,000 in three years. 2009's Human Development Report emphasized the impacts of human mobility on development. It stated that 77.6 percent of total emigrants from Myanmar went to other Asian countries, 5.9 percent to Europe, 11.8 percent to Northern America, and 0.9 percent to Africa during 2000-2002⁶¹. Another source estimated that up to 10 percent of Myanmar's population migrates internationally. Data is hard to obtain as the large majority of Myanmar migrants are irregular migrants⁶². At least 3 million people from Myanmar have migrated to neighbouring countries for economic, social and political reasons. Some migrated through legal channels provided by receiving countries although those numbers are rather limited. Official data reported on Myanmar labour migrants show there are 16,000 Myanmar in Malaysia, 3000 in Japan and 529 in Republic of Korea.

Recently, Thai authorities began implementing a policy to formalize the legal status of migrant workers across Thailand. As part of the process, migrant workers must apply to verify their nationality. The national verification process is especially challenging for Myanmar migrant workers. It is claimed in a recent report that many barriers prevent Myanmar workers from applying for the process, the most important of which are the high costs involved for Myanmar migrants that must be paid to both the Thai and Myanmar governments⁶³. Arrangements have been made between the two governments and Myanmar authorities from Ministry of Home Affairs, Ministry of Foreign Affairs, Ministry of Labour and Ministry of Immigration and Population are implementing the national verification process at the border towns of Tachileik, Myawaddy and Kawthoung, by issuing temporary passports to migrant workers after verification.⁶⁴

According to IOM there are two million migrants in Thailand, the majority of which are with irregular status. Significant numbers of migrants are from Myanmar, Bangladesh, India and Malaysia.⁶⁵ Of the 2 million migrants in Thailand, 485,925 have work permits as of 30th June 2007. According to official data from Thailand, there are 6267 registered professionals from Myanmar working legally in Thailand. Those who can afford recruitment fees or have necessary contacts migrate through legal channels provided by receiving countries.⁶⁶

For legal and illegal migrants, there are no arrangements in Thailand to provide reproductive health information as yet. The great majority of Myanmar migrants in Thailand are of reproductive age. Undocumented migrants who lack legal identification are especially hard pressed to access affordable health care services. There are many significant health risks for vulnerable migrants, including STIs and HIV infection. The migrant population arrives in Thailand with very little knowledge on health risks, weak social and/or family support networks, and is confronted with new pressures, experiences and situations that may cloud their ability to consistently choose healthy behaviours.⁶⁷

⁶¹ Human Development Report 2009, UNDP

⁶² Situation report on International Migration in East and South East Asia, Regional Thematic Working Group on International Migration including Human Trafficking, 2008

⁶³ Akito, Yoshikane, In Thailand, Migrant Workers Struggle With New Verification Policy download from internet on 16-6-2010

⁶⁴ Department of Immigration and National Registration, Nay Pyi Taw, 16-6-2010

⁶⁵ Situation Report on International Migration in East and South East Asia,, IOM, Regional Thematic Working Group on International Migration including Human Trafficking,

⁶⁶ Ibid

⁶⁷ Migration and HIV/AIDS in Thailand: a Desk Review of Migrant Labour Sectors, International Organization for Migration

It was also noted that of the Myanmar migrants in OECD countries, 25 percent have education less than upper secondary, 26.4 percent have upper secondary education and 40.9 percent have tertiary education, indicating that a high percentage of Myanmar migrants are highly educated⁶⁸. Although freedom of movement is a basic human right, it must be regulated so as to prevent a significant brain drain of highly trained professionals out of the country, which would weaken the country's operational system. Therefore, ethical recruitment policies, remittance policies and bilateral agreements should be properly formulated and implemented so as to safeguard the rights of the sending and receiving countries and those of the migrants themselves.

1.6.2 Refugees and other socially and economically disadvantaged population

Though no information can be obtained from government, neighbouring countries claim that considerable numbers of Myanmar refugees and displaced persons are present on their side of the boundary. Thailand claimed that there were about two million people from Myanmar trying to make a living inside Thailand bordering Myanmar⁶⁹. They may be undocumented migrants or displaced persons. It was also claimed that there were Myanmar nationals in Cambodia and Laos as well. However there is no document published by the GoUM related to internally displaced persons.

There have been large outflows of the Muslim population, decedents of Bengali tribes from Northern Rakhine State into Bangladesh. The first outflow in 1978 was followed by a second wave in 1991 and 1992, in total approximately 250,000 people left the country. Repatriation was initiated in 1979 according to a bilateral agreement between the Bangladesh and Myanmar governments and the returnees were duly resettled in reception camps. A total of 54,571 returnees were repatriated between September 1992 and April 2004. UNHCR established a presence in Myanmar in 1994 in order to facilitate the repatriation and reintegration of the returnees. Over 236,000 have returned and approximately 24,000 remain in two camps in Bangladesh.⁷⁰

Information on other socially and economically disadvantaged population such as orphans, street children, is not available and hence a study should be made on the concept and definition so as to identify them and analyze their situation and address their needs.

1.7 Population Issues

1.7.1 Changing age structure

The age structure of the population can be studied by three broad age groups: under 15 years, 15 to 59 years and 60 years and above (Table 2.4 and Figure 2.9). The population under 15 years of age was 41 percent at the national level in 1973 (Table 2.4). In 1983, this proportion had decreased to 38.6 percent and to 28.3 percent in 2006. The decline during the decade 1991-2001 was faster than the decline during 1973-83. 1973 portrayed Myanmar's population to be a young one. A transition began in the 1980s towards a more mature population in the twenty-first century.

The proportion of working age group 15-59 years to the total population can be used as a proxy for employment data. The proportion was 53 percent in 1973 and has progressively increased to 63 percent by 2006 (Table 2.3), indicating the entrance of large birth cohorts in the past into this age group, accompanied by the decline in proportion of children under 15 due to a decline in fertility. The age group 60 years and over has also increased from 6.0 percent in 1973 to 8.7 percent in 2006. Figure 2.9 portrays the broadening share of age groups 15-59 and 60 years and over.

⁶⁸ Human Development Report 2009, UNDP

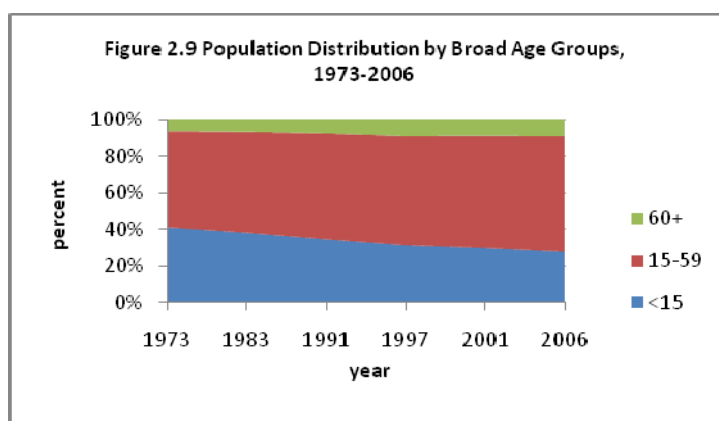
⁶⁹ Forced Migration Review, University of Oxford, Refugee Studies Centre. Issue 30, April 2008,

⁷⁰ Reproductive Health Assessment, Northern Rakhine State, Myanmar., 2006, UNHCR.

Table 2.3 Percent distribution of population by broad age groups, 1973 to 2006

Census/Survey	Broad Age Group		
	<15	15-59	60+
1973 Census	41.5	52.5	6.0
1983 Census	38.6	55.0	6.4
1991 PCFS	35.0	57.8	7.2
2001 FRHS	30.3	61.2	8.4
2007 FRHS	28.3	63.0	8.7

Source; Country Report, 2007 FRHS, DOP, 2009



Source: Department of Population and UNFPA, Country Report, 2007 FRHS

For those under 15, the rural proportions are consistently higher than urban, but the urban proportions are higher for the age groups of 15-59 and 60+. This age structure suggests higher fertility in rural areas. This rural population momentum calls for more facilities for rural children's education and health, more job opportunities and more reproductive health services for the increasing proportion of working age group (15-59).

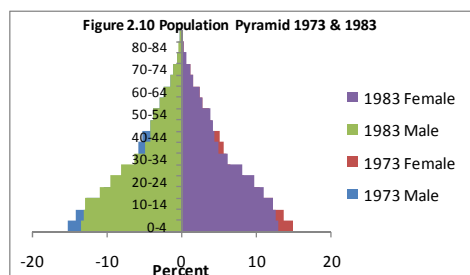
The distribution of the official estimated population by broad age groups shows the proportion of children under 15 years of age was 32.3 percent, that of the working age group (15-59 years) at 58.9 percent and the population aged 60 years and over at 8.8 percent. The proportion of the first broad age group is higher than the survey data and that of the working age group is less than the survey data. The survey data may have some sampling errors and misreporting and/or under-reporting of age, but it is presumed to be much nearer the ground situation. In the absence of complete census figures, the survey data is the best alternative. There is an urgent need for a population census.

Data from the broad age groups offer the chance to calculate dependency ratios. According to 2006⁷¹ data, there are 45 children or youth under 15 and about 14 elderly persons aged 60 years and over depending on every 100 working age person, in other words, there are 17 persons in working age group to support 10 young and old dependents and the ratio of workers to dependents has improved.

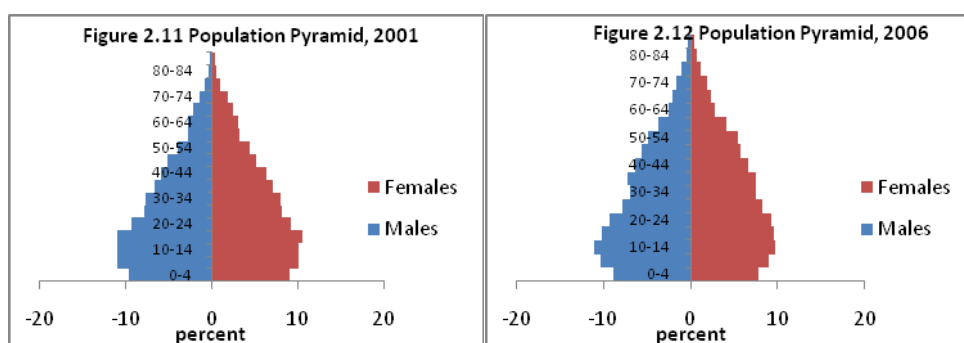
If the population is studied in five-year age groups, in both 1973 and 1983, a general decline was apparent at successive age groups (Figure 2.9). 1983 had a lower proportion of age groups 0-14 than 1973. In 1983, urban age distribution had age groups 0-4 and 5-9 remarkably smaller than age group 10-14 while the national and rural age distributions showed no such features. The lower proportion in age group 0-9 in 1983 urban reflected the declining fertility during the prior decade. The ratio of urban children under 5 to women aged 15-49, also had a lesser ratio than the national and rural figures, showing a lower fertility in urban locations.

⁷¹ Country Report on 2007 fertility and Reproductive Health Survey October 2009, 2007FRHS, Department of Population and UNFPA

The percent distribution of population by five-year age groups for 1973, 1983, 2001 and 2006 are shown below as population pyramids in Figures 2.10, 2.11 and 2.12. Age structure in 2001 has the proportion in age group 0-4 smaller than 5-9, showing a decline in fertility in the 1996-2001 period. This can be traced by looking at 2006 age structure in age groups 5-9. The later age structure has a lower 0-4 cohort than 5-9, and 5-9 is again lower than 10-14, showing continued fertility decline.



Source: 1973 and 1983 Census Reports



Source: Country reports, 2001 and 2007 FRHS, Department of Population, Nay Pyi Taw

1.7.1.1 Population and Demographic Window of Opportunity

Myanmar has traditionally been a pro-natalist country without any explicit fertility intervention policy. However, fertility has declined organically, and this is due to a number of reasons, including the postponement of marriage, the advent of contraception, and people's choices about their family size. As already mentioned, mortality has also declined, due to relative improvements in sanitation and health care services.

The increase in the proportion of the working age group and declining youth dependency ratio seen in Myanmar (Figure 2.9) translates into a demographic window of opportunity, which could result in a rise in the rate of economic growth if properly taken advantage of. The demographic dividend usually occurs late in the demographic transition when the fertility rate falls and the youth dependency rate declines. During this demographic window of opportunity, output per capita rises. It has been argued that the demographic dividend played a role in the "economic miracles" of the East Asian Tigers. Notably, the economic boom in Ireland in the 1990s was in part due to the legalization of contraception in 1979 and subsequent decline in the fertility rate. In Ireland, the ratio of workers to dependents improved due to lower fertility but was raised further by increased female labour force participation and a reversal from a trend of outward migration to a net inflow. The magnitude of the demographic dividend appears to be dependent on the ability of the economy to absorb and productively employ the extra workers⁷², rather than be a pure demographic gift.

The age structure in Myanmar resembles that of many of the Asian Tigers during 1965-1990, when these E. Asian nations were able to utilize the demographic window of opportunity to advance economic growth. In those countries, investments in job creation and social services (health,

⁷² http://en.wikipedia.org/wiki/Demographic_dividend#cite_note-4#cite_note-4, accessed on 5Jan2010.

education, and housing) resulted in increased per capita GDP. Due to small family norms and a low dependency ratio, people were able to make savings. Savings translated into investments, which led to greater productivity and eventually boosted economic growth. Myanmar could take advantage of the situation, in order to lead to economic growth as in the Asian Tigers, but time is running out. Myanmar is in the last stage of demographic transition and, as such, the demographic dividend will last only for a decade or two in which strategic investments on human capital and infrastructure could bring about economic growth. The fertility decline gives rise to a smaller average Myanmar family size, creating a condition that is conducive for better education and economic opportunities for women. If more women joined the workforce, the increase in female labor force participation would have a positive effect on increasing the total labour force. Decentralization, economic development and privatization result in job creation for the expanding workforce, which could result in economic growth and increase in per capita GDP of the country. The GoUM's construction of new mega cities, bridges and dams creates jobs for local people especially in rural areas.

1.7.1.2 Young population

As of 2007, there is about 10.1 million young people aged 15 to 24 in Myanmar, out of which 5.1 million are males and 5.0 million are females. This youth group constitutes about 19 percent of the total population. They are part of the workforce and also at the initial years of the reproductive span. The number of youth has increased by 0.6 percent in 2001-02, 0.9 percent in 2004-05 and by about 3.8 percent in 2007 from the previous year, indicating an increasing growth of young people.

In Myanmar, there is one youth in every household on the average. About 11 to 13 percent of male youth and about 20 percent of the female youth have ever been married. About five percent of youth have no education. 34 percent for male youth and 39 percent of female youth have primary education, and the percentages are higher for both sexes in rural areas. The proportion of youth with high school education and above is higher in urban than rural areas, indicating the existence of urban and rural disparities in education. More female youth have a university education in both urban and rural areas. Youth often discontinue their education due to financial problems and need to work to subsidize their family income. About 70 percent of male youth and 55 percent of female youth are in the labour force. Forty percent of the youth labour force in urban areas are employed privately, and 32 percent of youth work in unpaid family work in rural areas. A relatively high share of the youth unpaid family workers in rural areas are females.⁷³

In 2004, for the first time in Myanmar, the DOP has conducted a Family and Youth Survey and collected information on the characteristics and behaviours of youth on a national scale so as to provide in-depth knowledge on the background characteristics of youth, their behaviour and attitude towards sexuality, and their knowledge on STI, HIV/AIDS and trafficking in persons. For more details on youth behavior and attitudes towards sexuality and knowledge on STI and HIV/AIDS, please see Chapter 3.

1.7.1.3 Elderly Population

Myanmar's elderly population (60 years and above) stands at 5.06 million in 2007-2008, having increased from 4.08 million in 2001-2002. The proportion of population that the elderly represents has increased from 7.94 percent of the total population to 8.08 percent for the same points of time. At this increasing rate, it can be expected to become 8.8 percent in 2010 and 10.5 percent in 2020. A similar pattern of increase was found in the age group 75 years and above. To compare, the percent of elderly population 65 years and above for other countries in the region are China 8%, Laos 4%, Singapore 8%, Thailand 7%, Bangladesh 3% and Cambodia 3%⁷⁴.

⁷³ Myanmar, Country Report 2006, Family and Youth Survey 2004, Department of Population and UNFPA.

⁷⁴ World Population data Sheet, Population Reference Bureau, 2007

In 1973, the elderly male population comprised 6.0 percent of the total male population and elderly females comprised 6.3 percent of total female population. The proportions increased to 8.0 percent for elderly males and 9.4 percent for elderly females in 2006. The sex ratio of the elderly population had declined from 91.7 in 1973 to 76 in 2006 indicating a heavy predominance of women among the elderly⁷⁵.

In 2006, very few elderly people (4.4 percent) remained never-married. Over half were married and about 39 percent widowed. Very few elderly were divorced (about 1 percent). There are discrepancies among marital status of elderly males and females; three in every four elderly men are married while only one in every two elderly women remains married. Likewise, only one in four elderly men were widowed whereas about half of elderly women were widowed (23 percent against 51 percent). Among elderly women higher proportions of never married, widowed and divorced are found in urban areas compared to rural areas.⁷⁶

Most of the elderly remain economically active well into old age; 55 percent of elderly men and 22 percent of elderly women were economically active in 2001 and the activity rate is much higher in rural areas as the majority of rural people in Myanmar remain engaged in agricultural work well into their old age. In 2006, 37.3 percent of the elderly were economically active. The activity rates were 52.7 percent for elderly males and 25.6 percent for elderly females. The activity rates have increased for both sexes from 2001-2006.

Regarding old age dependency, there are 11 persons aged 60 years and over depending on 100 working age population increasing to 13.7 in 2001 and 13.8 in 2006 and the increase is more rapid for females. A faster increase in the old age dependency ratio was found in urban areas. The disparities between dependency ratios for males and females increased more rapidly in rural areas. The index of ageing, i.e. the number of persons aged 65 years and older per 100 persons aged 0-14 years, was 8.8 in 1973, increasing to 12.8 in 1991, 18.4 in 2001 and 21.3 in 2006. As such, there has been a significant increase in the proportion of aged population to children 0-14 years, as it has almost tripled over 33 years.⁷⁷ By 2025, the proportion of older population is expected to rise to 13.2 percent and old age dependency ratio will be 11.8. In other words, there will be 12 older persons for every 100 working age persons. The ageing index is estimated at 53 and the potential support ratio (the number of people in the working age group per person 65 and older), will be about 9.

The parent support ratio is the number of persons aged 85 years and over in relation to those between 50 and 64 years. In Myanmar it is estimated to be 3. Compared with Malaysia, Singapore, Thailand and Brunei, the ageing process in Myanmar is proceeding at a similar although slightly slower pace. With the increase in the number as well as the proportion of elderly people, more interventions for the welfare of the elderly population will be needed from the government, local and international communities. The recent preparation of a Draft Policy document and Plan of Action for the elderly population undertaken by the Department of Social Welfare in collaboration with UNFPA and Help Age International has been under process. An International Day for Older Persons is being observed every year in October, and a national committee for the ageing is being formed. The Home Care project has been expanded to 25 more towns in 2006-2009 and to 37 towns in 2008-2010. Little Sisters' Home for the Aged Poor and Hninzigone Home for the Aged in Yangon are some excellent examples of faith-based homes for poor and aged, but there is still a dire need to expand similar havens for the aged throughout the nation.

Clinics for health care of the elderly are opened in Rural Health centres once a week. Basic health staff are trained to be able to detect minor as well as some major illnesses of the elderly. Myanmar has begun to establish the necessary institutional infrastructure for responding to issues of population

⁷⁵ Country Report 2007 FRHS, DOP and UNFPA, 2009,

⁷⁶ Ibid

⁷⁷ Country Reports, FRHS and DOP and UNFPA, a monograph on "The Elderly Population in Myanmar: Trends , Living Conditions, Characteristics and Prospects", Department of Population and UNFPA , 2005

ageing and has adopted ROK-ASEAN Home Care for older people , jointly implemented by the NGOs in Insein and Hlaingtharyar Townships in 2003-2006, the second phase in 2006-2009 in 25 townships throughout 10 states and divisions organized and supervised by the Ministry of Social Welfare, Relief and Resettlement, Department of Social Welfare in collaboration with local NGOs, an INGO (World Vision) starting from 2007. USDA, MWAFA, MMCWA, MRCS and World Vision participated in the programmes on Home Care for the Elderly and the project is planned to cover the whole country after 2009.

1.7.1.4 The impact of changing age structure of the population

Population growth enlarges the labour force and therefore, increases economic growth. A large population also provides a large domestic market for the economy. In addition, population growth encourages competition, which induces technological advancements and innovations. However large population growth is not only associated with food problems but also imposes constraints on the development of savings, foreign exchange and human resources. Rapid population growth tends to depress savings per capita and slows growth of physical capital per worker. The need for social infrastructure is heightened and broadened and public expenditures must be absorbed in providing the need for a larger population.

The rapid increase in school age population and the expanding number of labour force entrants put even greater pressure on educational and training facilities, reducing improvements in the quality of education. This is a common problem in developing economies. In Myanmar, children between five and nine years of age constituted 9.6 percent in 2007, declining from 10.5 percent in 2001. However, in absolute numbers, this age group is increasing by more than half a million during this period⁷⁸. With the net school enrolment rate of 89.5 percent, there is a great need for substantial investment in primary school education and poverty alleviation strategies so that all the school-going children will have universal access to education.

Among the children 5 to 9 years of age, about 10 percent are not enrolled in school. Twelve percent of enrolled children do not complete the first school year. Among those who enter school, 19 percent will not complete more than 5 years of primary school. Many of them work as domestic help, join family businesses and some work outside the home to supplement household income. To address their health, education, life skills and livelihood development needs, the issue of these out-of-school children needs to be tackled by the families, community government, and NGO sectors.

Due to the total fertility rate of about 3 in the 1990s, there are currently a large cohort of youth (aged 15-24), with 5.15 million males and 5.0 million females totaling to 10.14 million in 2007⁷⁹. With the rising age at marriage, reproductive health education, counseling and services need to be targeted towards unmarried young people, as a total of 8.5 million youth are single (83.5 percent of total youth). They will also need to have access to higher education, be trained for various skills and professions and new jobs created so that they will be productively occupied. The population of the working age group in Myanmar increases by a million annually. The number of people in the labour force also is projected to increase by more than half a million. Unemployed persons will total about one million.

During Myanmar's stabilization programme from 1989/90 to 1991/92, the economy was revitalized and registered an average annual growth rate of 5.9 per cent. The reported GDP growth rate from 1992/93 to 1995/96 was 7.5 percent. From 1996/97 to 2000/2001 it was 8.5%, and from 2001/2002 to 2005/2006 it was 12.9 percent⁸⁰. This economic growth is happening together with the growth of the population. The population growth rate of Myanmar is 1.75. As Myanmar's growth currently surpasses the population growth, a sustainable and healthy economy could emerge. However, wealth

⁷⁸ Country reports, FRHS, Department of Population and UNFPA

⁷⁹ Statistical Yearbook 2008, CSO

⁸⁰ Myanmar Millennium Development Goals Report 2006, MNPED 2006, December

is not evenly distributed across the population with widening of gaps between the haves and the have-nots⁸¹ and hence there is need for careful planning and formulation of policies and programmes so as to address the sufferings of the poor and the vulnerable and thus eradicate poverty.

1.7.2 Urbanization

A gradual absorption of villages into towns and reclassification of human settlements into urban areas has contributed to urban population growth. Natural increase, net in-migration, and expansion of urban areas are also factors that are leading to an increased size of the urban population.

The ICPD PoA calls upon countries to ensure that population distribution policies are consistent with other development goals so as to manage economic and environmental policies, sectoral priorities, infrastructure investment and balance of resources among regional, central, provincial and local areas.

1.7.2.1 Growth of urban population and its spatial distribution

The UN has estimated that the percentage of urban population to total population in Myanmar was 24.9 percent in 1990 and has risen to 33.9 percent in 2010.⁸² Comparable data for 2010 for some countries from the region are 34 percent in Thailand, 33.2 percent in Laos, 22.8 percent in Cambodia, 72.2 percent in Malaysia, 28.8 percent in Vietnam and 28.1 percent in Bangladesh.

The most recent census in Myanmar was in 1983, after which there has been no information available for classification of urban and rural population. The DOP estimates the population as of 1 October of each year and the CSO's Statistical Yearbook includes this estimate in its publication that is shared with government agencies and data users. However, population by urban residence is only mentioned for the last census year (i.e. 1983) in each annual issue. The urban population for each town is available at the City Development Committees and General Administration Department but is only compiled for internal use. The Immigration and National Registration Department (INRD) has its own data compiled by each township, but is again, only for internal use. As such, the only concrete data for studying urbanization is from 1973-83. One may use UN estimations for urban dwellers, but these estimates do not go into any disaggregation.

Concerning urban settlement, in accord with economic policy adopted by the GoUM since 1989, the housing sector has been dealt with systematically to capture true characteristic of a town and standards and guidance of the public sector was laid down. Low-cost housing projects were implemented with establishment of new satellite towns in the vicinity of mega cities in every state and divisions, the setting up of higher education institutions in suburban areas, and the development of industrial zones are also aspects of urbanization. Some more heavily populated rural areas have been reclassified into sub-townships, signifying the beginning of urbanization.

Nay Pyi Taw, the administrative capital of the GoUM, was established in 2005 and other strategic towns such as Yadanarbon (an IT city) in Pyin Oo Lwin were also established in line with the prevailing development plans of the nation.

1.7.2.2 Internal Migration

According to the 1991 Population Changes and Fertility Survey, one in every ten persons in Myanmar changed the state or division of their residence at least once since birth⁸³. One fifth of persons aged 50 years and over had moved at least once. Lifetime migrations are heavily concentrated among a small number of geographic streams, which account for 29 percent of all non-return migrants. These flows accounted for 29 percent of all non-return migrants. Yangon is the only place to gain population as a

⁸¹ Revisiting Primary Health Care, Country experience: Myanmar, GAVI-PHC conference, WHO, Myanmar 2008

⁸² Human Development Report 2009, UNDP

⁸³ 1991 Population Changes and Fertility Survey, Country Report, Department of Population and UNFPA, 1996

result of lifetime migration. Being the economic focal point of Myanmar, Yangon sends and receives migrants from every other state/division in substantial numbers. 1.5 percent of the population reported a net move during 1986-1991. The age pattern of five year migration (migration in the five years prior to the survey) is typical, showing a concentration of movement in young adult ages.

In 2001, the percentage of urban-to-urban migrants (33.5 percent) exceeds that of rural-urban migrants (25.4 percent)⁸⁴. The movement is a shift from small towns or cities to bigger towns or cities, where social, economic and cultural benefits are to be found. Another migration stream that involved a relatively large proportion of migrants is the movement within the rural areas. Seasonal agricultural work in different rural locations, GoUM planned raw material extraction, and expanding domestic manufacturing industries all attract internal rural-rural migrants. Internal migration in Myanmar is age selective. There is an obvious overrepresentation of young adults of both sexes among urban and rural migrants. The peak occurs at the age group 30-34 for both sexes. Among the age group 15-29, the proportion of female migrants is higher than male migrants in both urban and rural areas by about 2 percentage points, indicating that females tend to move at the younger ages than males.⁸⁵

In both points of time, the main migration stream was urban-to-urban followed by rural-to-urban movement. (Table 2.4) Although the urban-destined migrant stream is greater than that of rural-destination migrant stream, the gap seems to have narrowed during the ten year period 1991-2001. Studies of internal migration from the 2004 Family and Youth Survey indicate that among youth, rural-to-rural migration is the main stream, urban-to-urban is second strongest, and the smallest stream is rural-to-urban. It seems that young people in rural areas are moving to more developed rural areas, while youth in small urban settings are moving to bigger urban settings.

Table 2.4 Lifetime migration streams by residence, 1991, 2001 and 2004

Migration stream	1991 PCFS	2001 FRHS	2004 FAYS
Urban-to-urban	38.6	33.5	32.3
Rural-to-urban	30.4	25.4	22.4
Urban Destination	69.0	58.9	54.7
Rural-to-rural	18.1	32.0	32.8
Urban-to-rural	12.9	9.1	12.5
Rural destination	31.0	41.1	45.3

Source: Research Papers on 2004 Family and Youth Survey, 2009, Department of Population, Nay Pyi Taw

Studying the volume of in-migration, Yangon Division received 194,700 in-migrants in 1991, followed by Kachin, Kayah and Shan States with 81,400 migrants. Mandalay stood third receiving about 56,500. In 2001, Yangon had the highest in-migrants with 221,000, Kayah received the second highest number of in-migrants (132,900) and Kachin third with 90,700. As observed, the volume of in-migrants has increased significantly for Yangon Division. The lowest in-migration receiving regions were Rakhine (7,100), Chin-Sagaing (15,100) and Magway (16,000) in 1991 and Magway (12,3000), Rakhine (138,000) and Ayeyarwady (17,500) in 2001⁸⁶.

Concerning out-migration, Mandalay, Bago and Ayeyarwady sent out from between 72,000 and 77,000 migrants out of each of their divisions in 1991. By 2001, the source states of migrants seems to have changed completely. 2001 saw Chin State sending 159,000 migrants, Kayin sending 116,000 and Kayah sending 114,000 out of their territories. Kachin, Kayah and Shan sent out the lowest numbers of migrants in 1991. In 2001, it was Yangon, Sagaing and Rakhine that had the lowest numbers of out-migration.⁸⁷ In the context of direction and magnitude of migration streams, in 1991, Ayeyarwady to Yangon was the highest migration stream. The second highest was Mandalay to Kachin, Kayah and

⁸⁴ Country Report, 2001 Fertility and Reproductive Health Survey, 2002, Department of Population, Nay Pyi Taw, and UNFPA

⁸⁵ Ibid

⁸⁶ Country Reports, 1991 and 2001 FRHS, Department of Population, Nay Pyi Taw and UNFPA

⁸⁷ Ibid

Shan. Bago to Yangon came third. A decade later, in 2001, the highest migration streams, in order, were from Shan (South) to Kayah, Mandalay to Shan (South) and Sagaing to Kachin in that order.⁸⁸

The evidence that rural-rural migration is still strong should have significant implications for development policies. Although high levels of out-migration have occurred at less developed states and divisions, the gap in terms of proportion between rural migration and urban migration stream have narrowed. This is yet another reason why focusing development, extension of social services, and expansion of the economy should focus on rural areas.

1.7.3 Population and Poverty

Globalization has brought about many economic benefits which have led to the material wellbeing of hundreds of millions of people, uplifting the quality of life and increasing life expectancy. That being said, while the benefits of globalization have an incredible impact, millions upon millions of people are left behind, and see no benefits of the ever-changing world around them. The power and effects of the crises from economic downturns to natural disasters strike the poor disproportionately. Aware of this fact, at the United Nations Millennium Summit in September 2000, the Member States of the UN adopted a programme of Measures of the Millennium Declaration in response to the challenges facing the international community at the beginning of the 21st century.

Myanmar has adopted the MDGs within the context of the National Development Plans. The main objectives of the National Development Plans are to accelerate economic growth, to achieve equitable and balanced development and to reduce the socioeconomic development gap between remote border areas, rural areas, and urban locations.

The Food poverty headcount index⁸⁹: In 2004, at the national level, 10 percent of the population falls under the food poverty line, the proportion of individuals whose normalized consumption per adult equivalent is lower than the food poverty line.⁹⁰ In urban areas, 6 percent of the population falls under food poverty line and in rural areas it is 11 percent. Food poverty is highest in Chin State with food poverty headcount index of 40 percent followed by Shan (North) and Shan (East). It is the lowest in Kayin (2 percent), Yangon and Mon.

The poverty headcount index:⁹¹ Another measure that allows for monitoring the proportion of the national population that is considered poor by the national standard is the poverty headcount index. The poverty headcount index at the national level is 32 percent in 2004. In urban areas 22 percent of the population falls under poverty line and in rural areas, it is 36 percent. There are disparities among the regions. Chin State is the poorest with 73 percent poor followed by Shan (East) and Shan (North) with about 50 percent.⁹² This index is also the lowest in Kayin State (12 percent) followed by Yangon Division (15 percent). To measure the progress made in this area would be possible when the ongoing IHLC Survey produces the necessary indices for 2009-2010.

Poverty incidence: Another indicator of measuring poverty is poverty incidence which is about 23 percent in Myanmar according to a household survey conducted by the Central Statistical Organization in 2001. Though similar to the poverty headcount they are not strictly comparable due to methodology, concept adopted and method of calculation and thus neither trend analysis nor conclusion can be drawn from these two indicators.

⁸⁸ Country Reports, 1991 and 2001 FRHS, Department of Population, Nay Pyi Taw and UNFPA

⁸⁹ Note: The food poverty headcount index is the proportion of individuals whose normalized consumption expenditure per adult equivalent is lower than the Food Poverty Line.

⁹⁰ Poverty Profile, 2005, IHLC, Ministry of National Planning and Economic Development and UNDP,

⁹¹ Note: The poverty headcount index is the proportion of individuals whose normalized consumption expenditures per adult equivalent is lower than the Poverty Line.

⁹² Poverty Profile, IHLC Survey in Myanmar, Ministry of National Planning and Economic Development and UNDP

The **human poverty index** as mentioned in Human Development Report 2009 is 20.4. The poverty gap index measures the intensity of poverty, and it is 0.07 (7 percent), 0.04 in urban areas and 0.07 in rural areas⁹³. Comparable figures for other Southeast Asian countries are given in Table 2.5.

Table 2.5 Poverty Headcount Index in Southeast Asia countries

Country	Year	Population in poverty		
		Total	Urban	Rural
Southeast Asia				
Cambodia	1999	35.9	18.2	40.1
Indonesia	2002	18.2	14.5	21.1
Laos PDR	1997	38.6	26.9	41.0
Malaysia	1999	7.5	3.4	12.4
Myanmar	2003-5	32	22	36
Phillipines	2000	30.4	-	-
Thailand	2002	9.8	4.0	12.6
Vietnam	2002	28.9	6.6	35.6

Source: Poverty Profile, IHLCA Survey in Myanmar, Planning Department and UNDP, 2003

In Target 2 of MDG Goal 1, the first official indicator is the prevalence of underweight children under five years of age. The prevalence of moderately underweight children at the national level in Myanmar is 34 percent and it is slightly higher in rural areas than urban areas.⁹⁴ Findings from four MICS reveal that, at the national level, the proportion of moderately and severely underweight children under five years of age was 42.9 percent in 1995, decreasing to 31.8 in 2003⁹⁵. In other words, there has been a significant decline. In 1997, half of children were moderately or severely underweight, declining to less than one third underweight in 2003. Additionally, the sex differential has almost disappeared by 2003. Urban-rural variation is observed, with a higher proportion of underweight in rural areas. There is also a higher proportion of male children underweight than their female counterparts.⁹⁶ There also exist regional variations; the highest observed underweight population was in Rakhine State, followed by Chin State, Ayeyarwady and Tanintharyi divisions.⁹⁷

Table 2.6 Percent of under five who fall below -2SD from Median weight for age of NCHS/WHO standard (Underweight moderate and severe)

	1995	1997	2000	2003
National	42.9	38.6	35.3	31.8
Urban	39.9	32.9	29.6	25.3
Rural	44.0	40.4	37.0	33.5
Male	44.2	39.5	35.3	31.1
Female	41.0	37.9	35.4	32.4

Source: Trend assessment of indicators for children from MICS, 1995, 1997, 2000, 2003, DHP in collaboration with UNICEF

There is no significant difference between boys and girls in terms of moderate malnutrition. However there is great difference among regions; moderate malnutrition is highest in Rakhine State (60 percent), Magway (42 percent) Ayeyarwady (36 percent) and is the lowest in Kayah (21 percent), Bago (West) (24 percent) and Shan (East) (25 percent). Progress on the underweight prevalence index will be better determined pending data processing for the ongoing IHLCA survey as well as MICS 2008-2010. MICS also provides more detailed indicators, including those measuring underweight, stunting, and wasting.

⁹³ Poverty Profile, IHLCA Survey in Myanmar, Ministry of National Planning and Economic Development and UNDP

⁹⁴ Ministry of national Planning and Economic Development and UNDP, Poverty Profile, 2007, IHLCA Survey

⁹⁵ Various MICS reports, Department of Health Planning and UNICEF

⁹⁶ MICS reports, Department of Health Planning and UNICEF

⁹⁷ Country Report, 2003 MICS, Department of Health Planning and UNICEF,

The GoUM has laid down comprehensive development programs that aim to improve socio-economic conditions of the country by raising the standard of living of the entire population, especially those who reside in rural, remote and border areas.

Concerning Poverty incidence among disadvantaged section of the population, poverty incidence is derived from household surveys and the data collection is based on household approach and hence institutions or moving population or street children are not covered. There is no figure available on disadvantaged section of the population except elderly population and disabled in recent data collection by Department of Social Welfare. So there appears a gap for study for identification and compiling of information and indicators for each type of disadvantaged section of the population.

Profile of the poor

Rural population constitutes about 70 percent of the total population of Myanmar, and the majority of impoverished people reside in rural areas. The rural poor are mostly landless (25.7 percent of the population working in agriculture are landless). They work as hired hands on farms owned by wealthier agriculturists are casual labourers and some depend on non-agricultural activities. About two thirds of poor households work in the agriculture sector and most own/farm small land or are landless. Poor households usually live in lower quality dwellings and about two-thirds of them have improved sanitation as well as safe drinking water.

In terms of occupational categories, the proportion of the working population in poor households that are casual labourers is almost twice the proportion in non-poor households. There is a strong association between agriculture and poverty. The proportion of individuals from poor households working in agriculture is 59.4 percent.

The poor in both urban and rural areas have, on average, a large household size. Having a female head-of-household does not appear to correlate with poverty. The proportion of poor households headed by women is slightly lower than the proportion of non-poor households headed by women (18.3 percent compared to 19.1 percent). For policy or programming purposes a better disaggregation of the category of female-headship is required and identifies subgroups that face particular hardship. Fertility is high and so is mortality. Illiteracy, ignorance and lack of knowledge on health services, health care, and nutrition contribute to both high fertility and high mortality in poor communities. The level of education amongst impoverished people is low. Illiteracy rate (28.3 percent) is double than in non-poor households. Almost half of the members of poor households have never attended schools or attended only monastic schools. Lower education is symptomatic of reduced access to income earning opportunities and lower returns/remuneration for economic activities.

Poor households have lower access to a range of health services and worse health outcomes. Only 44.5 percent of women from poor households have access to antenatal care and only 64.6 percent have births attended by skilled health personnel. Indicators for immunization rates, antenatal care, and skilled birth attendance are all low for poor households. This is in part due to the higher proportion of poor households that live in remote rural areas where physical access to these services is lower. Thirty eight percent of children from poor households are moderately underweight while 11.3 percent are severely underweight. Poor households also have lower access to education. The net enrolment rate is low for children from poor households at 80.1 percent. Low education is likely to be both a cause and consequence of poverty.

1.7.4 Population and environment

Population and environment are closely related, but the links between them are complex and varied depending upon specific circumstances. Even before the Millennium Summit, the United Nations Conference on Environment and Development (UNCED), held in Rio de Janeiro in June 1992 expressed new thinking about sustainable development of human society reflecting political

commitments at the highest level on the need for extensive cooperation in relation to environment and development.

As human populations increase and globalization proceeds, key policy questions develop around how to use available resources of land and water to produce food for all and promote economic development while simultaneously addressing the human and environmental consequences of population growth, industrialization and concerns like global warming, climate change and the loss of biological diversity. Population factors such as population base and growth rates, distribution patterns, migration and urbanization have an impact on a country's resources and environment.

When Myanmar became an independent nation, it had many untapped natural resources and was the least densely populated country in the region. Myanmar is rich in forests, land resources and water, in addition to unique bio-diversity.⁹⁸ However, population growth as well as density has tripled since 1948. Although there exists untapped arable land, access to natural resources should have limitations. As such, proper management is needed to avoid environmental problems as there is a growing concern to address the issue of population and environment. The National Commission for Environmental Affairs (NCEA) was established in Myanmar in February 1990 under the Ministry of Forestry. Four specialized committees were formed under the NCEA. They are (a) Committee on Natural Resources, (b) Committee on Control of Pollution, (c) Committee on Research, Education and Information, and (d) Committee on International Cooperation.

The NCEA serves as a coordinating agency, collaborating closely with government departments in matters relating to the environment. A National Environmental Policy was adopted in December 1994. The objective of this policy is "...the integration of environmental considerations into the development process to enhance the quality of life of all its citizens. ...It is the responsibility of the State and every citizen to preserve its natural resources in the interests of present and future generations. Environmental protection should always be the primary objective in seeking development." Population and environment interactions were taken into account in the formulation and implementation of most of the sectoral plans of various line ministries. Plans and programmes were targeted towards meeting the need of the growing population without undesirable impacts on the natural environment.

1997's Myanmar Agenda 21 was the expression of the political commitment of the GoUM to the historic Earth Summit in 1992 for achieving sustainable development in Myanmar. Despite some achievements, the implementation of this Agenda has been less than satisfactory due to difficulties ranging from lack of public and government awareness to lack of funding and capacity. As such, the National Sustainable Development Strategy (NSDS) was drawn up by NCEA under the Ministry of Forestry in 2009. The NSDS is an important guiding document to fully harmonize and balance the three pillars of environment, economic and social sectors in poverty alleviation.

As in most other ASEAN countries, the key environmental issues and causes in Myanmar are deforestation, loss of biodiversity, urban air pollution, soil erosion, water contamination and water-borne diseases. Some key causes of these issues are land clearance, excessive mineral extraction, vehicular congestion and emissions, deficiencies in urban infrastructure and unmanaged industrial and municipal effluents. The 2008 Environmental Performance Index (EPI) deployed a proximity-to-target methodology, which quantitatively tracks national performance on a core set of environmental policy goals for which every government can be – and should be – held accountable. By identifying specific targets and measuring the distance between the target and current national achievement, the EPI provides both an empirical foundation for policy analysis and a context for evaluating performance. Issue-by-issue and aggregate rankings facilitate cross-country comparisons both globally and within relevant peer groups such as geography or economy.

⁹⁸ National Sustainable Development Strategy, 2009, NCEA and UN

The Environmental Performance Index (EPI) for Myanmar for 2008 is 65.1, with the ranking position 105 (out of 149 countries).⁹⁹ To compare with countries in the region, Myanmar stands in an average position. Bangladesh 58, Cambodia 53.8, Pakistan 58.3, India 60.3, Laos 66.3, Indonesia 66.2 and Thailand 79.2. In order to improve environmental performance, implementation of the national strategies should be monitored closely as well as enhancing capacity building and funding from both the government and external sources. Public and government awareness of environmental protection should also be promoted to ensure sustainability of environment.

1.7.4.1 Deforestation

Goal 7 of the MDG is “ensure environmental sustainability” and indicator 25 is “proportion of land area covered by forest”. Of the country’s total land area, in 2005, 50.2 percent are covered by natural forests and other open wooded lands 17.66 percent¹⁰⁰. But studying the forest coverage at different periods suggests a decline in the coverage. In 1925, the forest covered area was 65.3 percent of the country’s total land area, but at the first appraisal in 1955, it had decreased to 57.2 percent. The decline progressed persistently to 52.7 percent in 1975 at the second appraisal and 50.8 percent in 1989 at the third appraisal. In 1999 it had increased slightly to 52.3 percent.¹⁰¹

Forestry of local tree varieties such as teak has been a major source of income for commercial forestry. Timber and firewood came under control and regulation beginning in 1989. According to the Myanmar Millennium Development Goals Report 2006, total forest area had increased back to 55.97 percent of the total land area in 1990, but decreased again to 52.13 percent in 2000 and 50.20 percent in 2005. The annual deforestation rate is about 544,060 acres, that is, 0.3 percent of total country’s area. Another source indicates that the annual deforestation rate is about 5200 square km, that is, 1.4 percent of the total country’s area. This rate is one of the highest (other than the Phillipines) among ASEAN countries.¹⁰² Hence deforestation is an existing phenomenon which should be addressed to ensure a sound and favorable environment for human development and healthy living and for sustainable environment resources for the future generations. This would affect the source of livelihood for the poor as they depend on the forest for food by hunting and foraging and also depend on wood for dwellings and fuel. This environmental income, along with foraging and other activities, is vitally important to a majority of the poor and under the right policy conditions can offer a pathway out of poverty. In the spirit of the Millennium Development Goals (MDGs), within the context of the National Plan and as per stipulation in the 1995 Myanmar Forest Policy, 30 percent of the total land area of the country will eventually be gazetted as Reserved and Protected Public Forests. By March 2006, the total area already constituted as both types of forests is 60,679 square miles (157,158 km²) or 23.23 percent of the total land area. For sustainable development of the forestry sector, the number of trees and acres planted from 1988-89 to 2005-2006 was 107 million trees and 2.4 million acres.¹⁰³ The main problems currently encountered are encroachment into natural forests for agriculture, infrastructure, factories and settlements, illicit and/or illegal cutting of trees for commercial purpose, extension of grazing land, shifting cultivation, and excessive utilization of firewood¹⁰⁴. Many forest resources are threatened by overexploitation, degradation of environmental quality and conversion to other types of land uses. About 30 percent of total land area is still unclassified forest. These areas should be brought under the reserved forests system and protected areas system as soon as possible to get firm legal jurisdiction over their usage. The permanent forest estate (includes reserved forest, protected public forest and protected area system) was about 21 percent of the total land area in 1999 and had increased to about 28 percent in 2007-2008 (Figure 2.13).

⁹⁹ Environmental performance index 2008. Yale University

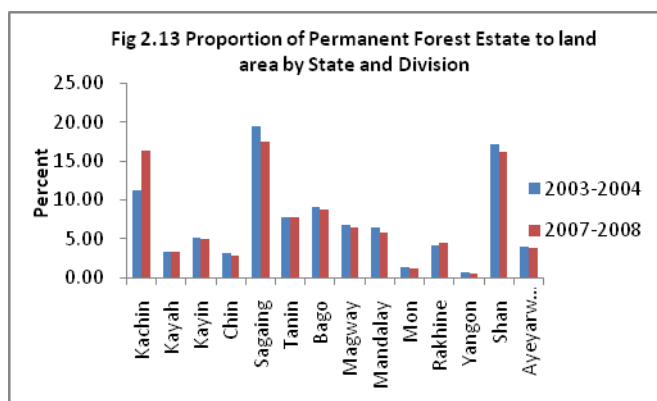
¹⁰⁰ Myanmar Millennium Development Goals Report 2006, MNEP

¹⁰¹ Forestry in Myanmar, Yangon, 2000, Forest Department, Ministry of Forestry

¹⁰² National Sustainable Development Strategy Myanmar, NCEA

¹⁰³ Myanmar Millennium Development Goals Report 2006, MNEPD

¹⁰⁴ Ibid



Source: Statistical Yearbook 2008, CSO, 2009.

1.7.4.2 Global Green New Deal and Myanmar

In response to the financial and economic crisis, UNEP has called for a “Global Green New Deal” for reviving the global economy and boosting employment, while simultaneously accelerating the fight against climate change, environmental degradation and poverty. UNEP is recommending that a significant portion of the estimated US\$3 trillion in pledged economic stimulus packages be invested in five critical areas:

- Raising the energy efficiency of old and new buildings;
- Transitioning to renewable energies including wind, solar, geothermal and biomass;
- Increasing reliance on sustainable transport including hybrid vehicles, high speed rail and bus rapid transit systems;
- Bolstering the planet's ecological infrastructure, including freshwaters, forests, soils and coral reefs;
- Supporting sustainable agriculture, including organic production.

UNEP's Global Green New Deal also calls for a range of specific measures aimed at assisting poorer countries in reaching the Millennium Development Goals (MDGs) and greening their economies. These include an expansion of microcredit schemes for clean energy, reform of subsidies from fossil fuels to fisheries, and the greening of overseas development aid.

Myanmar as member state of the UN needs to be aware of the results of policy and recommendations prepared by over 20 UN agencies and intergovernmental organizations and shared with members of the G20 (“London Summit”) meeting in April 2009. UNEP followed-up on this initial brief with a Global Green New Deal update that was launched during with the G20 (“Pittsburgh Summit”) in September 2009. If G20 countries do pledge about 1 per cent of global GDP towards building a green economy – one that reduces carbon dependency, addresses poverty, generates good quality and decent jobs, maintains and restores natural ecosystems, and moves towards sustainable consumption – Myanmar could be greatly helped in achieving environment-related MDG goals.

1.7.4.3 Land use change

Since Myanmar is an agriculture-based country, great emphasis is placed on the sustainable development of agriculture. In 2003 net sown area was 23.33 percent, permanent forest estate and unclassified forest together 52.29 percent and cultivable waste land 11.05 percent (Table 2.7). According to other sources, the net sown area has increased significantly from 20,568 thousand acres in 1990 to 32,677 thousand acres in 2007, with the impact of double cropping and year-round growth cycles.¹⁰⁵ The increase in net sown area was 58.9 percent during the 17 years period, with an average annual increase of 3.5 percent.

¹⁰⁵ Statistical Yearbook 2008, CSO, 2009

Table 2.7: Land use in Myanmar (2003)

Land use type	Area (sq.km.)	% of land area
Net Sown area	157831	23.33
Fallow land	8922	1.33
Cultivable waste land	74759	11.05
Permanent Forest estate	173739	25.68
Unclassified forest	180008	26.61
Other lands	81268	12.01
Total	676577	100.00

Source: Forestry in Myanmar, 2003, Department of Forestry, Nay Pyi Taw

With population growth at 1.75 percent, there will be an increase of around 1 million persons in Myanmar annually. To ensure food security for this additional population, 14 million acres of untouched arable land could be put under cultivation. This would provide not only food but also increase the rural economy to provide for socioeconomic services and investments.

In Myanmar, poverty is a major factor in land degradation. Land degradation leads to a significant reduction of the productive capacity of land. Human activities are contributing to land degradation with unsustainable agricultural land use, poor soil and water management practices, deforestation, removal of natural vegetation, overgrazing, and poor irrigation practices. Soils are an important natural resource and it is important to conserve soil fertility and to improve degraded soils. In Myanmar, there is need to restore fragile and degraded lands, and immediate actions are required to resolve issues in specific areas, namely soil erosion and degradation in the mountainous areas and dry zone, salinity problems occurring in the delta and coastal areas; alkalinity problems in the dry zone and acidity problem in some laterite areas by introduction of agricultural technology.

Desertification is land degradation in arid, semi-arid, and dry sub-humid areas. The most obvious impact of desertification is decline in soil fertility. This is a significant problem that needs to be addressed, especially in Myanmar's central dry zone, where the weather is dry and hot and the soil is sandy and poor. The hilly areas are another terrain that needs attention in regards to desertification. In the hilly areas, itinerant cultivation has been practised by cutting down trees. As such, the topsoil has been eroded by heavy rains and the absence of trees to prevent the topsoil from erosion is missing, thus creating land degradation and making these areas unfit for productive cultivation.

1.7.4.4 Pollution

Air pollution, is brought about by the fumes from motor vehicles, domestic fuels and industrial emissions. Water pollution is brought about by the improper disposal of wastes, industrial wastes and chemicals into public water ways. High population densities and inadequate infrastructure for waste and sewage disposal cause pollution to water and to the environment. Industrialization and the establishment of factories and manufacturing plants in town and city areas is also a major factor in increasing all forms of pollution.

Myanmar signed the United Nations Framework Convention on Climate Change (UNFCCC) in 1992 and ratified the convention in 1994 and accorded to the Kyoto Protocol in 2003. The emission of carbon dioxide was estimated in 1997 under the Asian Least Cost Greenhouse Gas Abatement Strategy (ALGAS) Project. CO₂ emission in metric tons per capita of 0.9 metric tons in 1990 decreased to 0.725 in 1997 and was lower than Indonesia, Malaysia, Philippines and Vietnam. However the CO₂ emission has to be updated. Regarding ozone depletion, in 2001 Myanmar consumed 39 metric tons per annum compared to 1950 metric tons per annum consumed by Malaysia, 3380 metric tonnes by Thailand and 243 metric tonnes by Vietnam. Myanmar has an annual consumption of 54.3 metric tons of Ozone Depletion Substances, particularly CFC 12. Myanmar's

level has been frozen during the last decade and it is planned to be phased out in 2010 under the Ozone Country Programme.

Air pollution emissions in Myanmar are Carbon Monoxide – 6710 ug/m³, Nitrogen Oxide – 194 ug/m³, non-methane Volatile Organic Compound – 572 ug/m³, and Sulphur dioxide 56.6 ug/m³. The effect of Myanmar on global warming and climate change on the whole is minimal due to large area of forest cover, which acts as carbon sink. Indoor air pollution is negligible, as Myanmar is a primarily agricultural country. As much as 95 percent of households use solid fuels such as firewood for cooking, however among ASEAN countries, Myanmar has the lowest carbon dioxide emission ranging from 4 percent to 7 percent¹⁰⁶.

Solid wastes include all domestic refuse, commercial wastes, hospital wastes, street sweepings, construction debris, and septic tank sludge. Myanmar's solid waste management problem is concentrated mainly at urban centres. Industrial wastes are being disposed by factories. Some factories discharge industrial waste water and effluents into the rivers via open drains or existing natural streams without any proper treatment. These practices are causing pollution and need to be addressed consistently.¹⁰⁷

Climate change is caused by increased concentration of greenhouse gases due to combustion of fossil fuel, industrialization, deforestation and agricultural practices. Land use changes and forestry also contribute to the greenhouse effect by altering carbon sinks. Climate change is of concern mainly as it relates to the impact on ecosystems (biodiversity), human settlements and agriculture, and possible consequences for other socio-economic activities that could affect global economic output.

One of the guidelines of the National Health Policy (1993) is to intensify and expand environmental health activities including prevention and control of air and water pollution. The Occupational Health Division (OHD) of DOH monitored the ambient air quality in four states and five divisions in 2008. The OHD has also been implementing an "Air Quality Monitoring Project for Yangon City" in collaboration with WHO since October 2008. The MOH has also collaborated with NCEA in developing the National Environmental Health Action Plan.¹⁰⁸ The Environmental Sanitation Division (ESD) under the Public Health section of DOH, founded in 1952, aims to attain universal coverage of safe water supply and sanitation and to reduce – and eventually eliminate – the incidence of water- and excreta-related diseases. ESD is implementing Environmental Sanitation activities such as fly-proof latrine construction for communities, schools and health institutions, and providing clean water supply for health and school institutions in rural areas. Sanitation coverage has increased from 45 percent in 1997 to 80.2 percent at the national level in 2008 following the National Sanitation Weeks. In 2008, an Arsenic Mitigation Project has been implemented in Southern Shan State, one township in Mandalay Division, one township in Rakhine State, and three townships in Sagaing Division.¹⁰⁹

1.8 Data issues

1.8.1 Population Related Data System

In Myanmar, the main sources of population related data are (a) population censuses, (b) demographic surveys, and (c) the vital registration system. Population census is the primary source of demographic data in Myanmar. The first modern census was taken in 1872 in Lower Burma under the British administration. The second one was in 1881, and the third in 1891, but they did not cover the entire country. From 1891 on, censuses were taken every ten years till 1941. After independence, a population census and six other types of censuses were conducted in stages over 1953 and 1954, due to unsettled conditions in parts of the country. The first nationwide population census was taken in

¹⁰⁶ National Sustainable Development Strategy, Myanmar –NSDS, National Commission for Environmental Affairs, Ministry of Forestry and UNEP.RRC.AP

¹⁰⁷ Ibid

¹⁰⁸ Health in Myanmar 2009, Ministry of Health

¹⁰⁹ Ibid

1973 and a subsequent one in 1983. The 1993 census was postponed due to the fact that the National Convention for drafting of State Constitution was set to convene in 1993. As such, the last true census conducted in the country was in 1983. There is a need to conduct a nationwide census tailored to attain gender sensitive data. Disaggregated data will provide rich information for planning and development of the nation.

The second key source of population-related data is the various demographic surveys. Several departments and institutions conducted nationwide nationally-representative surveys, mostly funded by UN agencies and with technical assistance of international experts. The Planning Department, Department of Health Planning, Department of Health, Department of Population, Department of Labour and Central Statistical Organization all have conducted nationwide surveys as well as some specialized surveys.

The third is a vital registration and statistics system. In Myanmar, the collection of vital statistics is confined only to live-births, late foetal deaths and deaths. The data is collected by DOH and compiled and published by CSO. The system was first established in Myanmar in 1907. However the present Vital Registration and Statistical System were introduced in Myanmar in 1962 in the urban areas. CSO and DOH launched and implemented the nation-wide Modified Vital Registration during 2000-2005. Since 2007, the system covers the entire population of the entire country.

An Agriculture Census was conducted by Census Department in 1953 in 252 towns in urban areas, and in 1954 in 2143 village tracts in rural areas. An Agriculture Census covering the whole country was conducted by the Settlement and Land Records Department (SLRD) in 1993 with the assistance of FAO and again in 2003. Now SLRD is planning to conduct another Agriculture Census in 2010 with assistance from FAO.

In addition, each government ministry and/or department has its own planning and statistics department/division which collects and compiles relevant data for its internal use as well as for sharing with other departments. These are normally of restricted circulation and classified confidential. But concerted efforts were made to compile and publish the official statistics. The Statistical Yearbook and Agriculture Statistics are compiled and published annually by CSO. A Handbook on Human Resource Development Indicators was published annually from 1994 to 2006 by the Department of Labour. Additionally, there are bottom-up reporting systems for health and education related information. There is a Health Management Information System (HMIS) established within the framework of Department of Health Planning and Education Management Information System (EMIS) by Department of Educational Planning and Training and Reproductive Health Management Information System (RHMIS) by Department of Health Planning and UNFPA.

1.8.2 Population Projections

Formulation of short-term and long-term developmental plans for the socioeconomic development of the country and peoples requires basic data such as the total population size and its age-sex distribution, as well as the dynamics affecting population growth for the period under consideration. Without these, no reliable plans can be made for the population. Estimates of future population are also needed to anticipate the population's impact on the country's resources and to help formulate population policies aimed at modifying future population trends. One of the mandates of the DOP is to prepare population projections and provide them to policy makers, decision makers, line ministries, departments and other institutions. Projections are prepared for states and divisions and sometimes at the township level when the occasion arises.

In Myanmar, population projections were made by the Census Department (now DOP) for the post-war period from 1960 to 2001.¹¹⁰ These projections were based on the population of the 1941 census and 1953-54 censuses using the component method. The official estimates projected were used in

¹¹⁰ National Report to World Population Conference, Bucharest, 1974, Htain Lin, 1976.

various sectors of the government and by foreign agencies until 1970s. Usually projections are more realistic and reliable when made for a short term (between 5 years and 20 years). After every census and survey, basic information on age-sex structure, population size, geographical distribution and assumptions for birth, death and migration are updated, revised and modified and fresh projections were made. After the 1983 census, a new projection was made. Again in the 1990s after the 1991 PCFS provided new vital indicators revisions were made. Usually a projection was made for 10 to 20 years. However it was only used for providing necessary population figure for the current year and no estimates were made available for the longer term.¹¹¹

1.8.3 Labour force projections

A Labour Force Survey was conducted in 1990 by the Department of Labour with technical and financial assistance from UNFPA. A report was prepared and published. Since then no LFS was conducted either by DOL or any other agency, government or NGOs to date. At present, DOL is arranging to conduct a Labour Force Survey in the coming year and has approached UNFPA for assistance. Information on labour force, occupation, industry, employment status, and reasons for not working were collected by the household questionnaires in FRHS and MICS as well as in IHLCA Survey. Although this information is not as in-depth as desired, it is still possible to obtain data from demographic and health surveys.

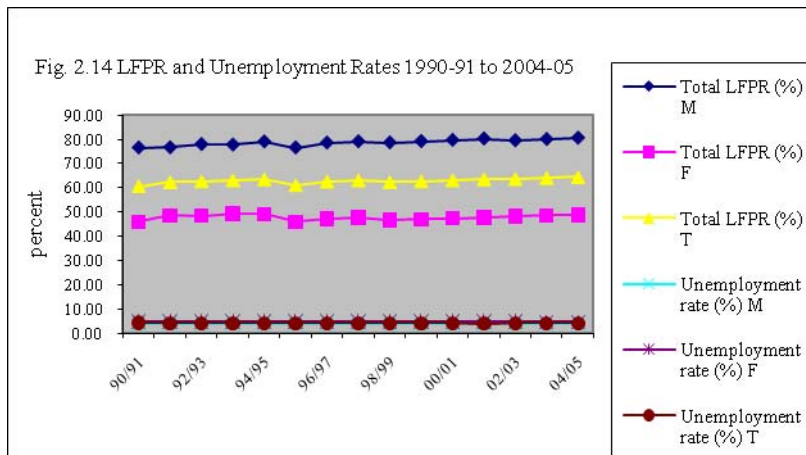
DOL has, based on LFS and the prevailing situations projected the LFPRs, unemployment rates and the information are made available in its HRDI publications.

The labour force was projected to increase from 16.53 million (9.96 million males and 6.57 million females) in 1990-91, to 24.30 million (15.02 million males and 9.28 million females) in 2000-2001 and to 27.09 million (16.7 million males and 10.34 million females) in 2004-2005. Please see Figure 2.11. The percent increase in labour force is significant with 11 percent increase from 1990-91 to 1991-92. Most other years have a yearly increase of only about 2 percent, as shown in Figure 2.12.¹¹² The overall labour force participation rate (LFPR) has increased from 60.59 percent in 1990-91 to 63.18 percent in 2000-01, and was projected to increase to 64.56 percent in 2004-05. This increase could be attributed by the decline in fertility resulting in an increasing female labour force participation rate which, in turn, has increased the total labour force participation rate. The yearly increase of LFPR is negligible. The highest increase between 1994-95 to 1995-96 was nearly one percent, though the actual numbers in labour force increased a great deal. The male LFPR and female LFPR typically follow a pattern whereby male LFPR is higher by about 30 percentage points than females. The participation of youth in the labour force has also increased from 59 percent in 2001 to 64 percent in 2004. The labour force participation rates of youth in urban areas are lower than those in rural areas. Boys' labour force participation rate is higher than that of girls', which may be due to the fact that males are typically the breadwinners of most households. Myanmar's youth labour force participation rate is relatively higher than Philippines and Thailand but lower than other countries such as Vietnam (87.8), Singapore (75.3), and Malaysia (74.6)

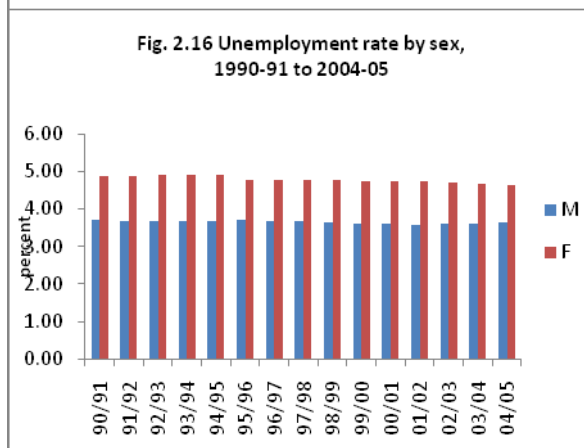
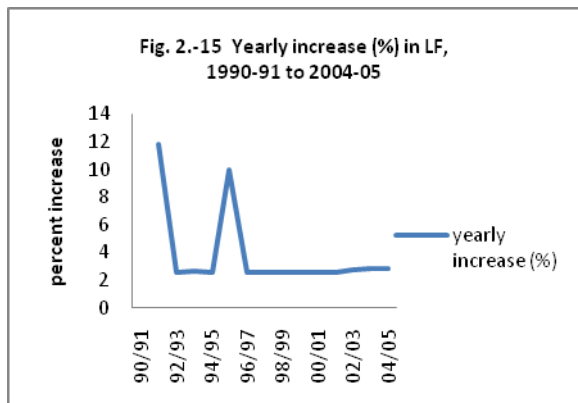
Unemployment Rate: Unemployment rate is the percentage of unemployed population against the total labour force within a country. The unemployment rate for females is higher than males, and the unemployment rate is around 4 percent. From 1990-91 to 2001-2002 it ranged from 4.17% to 4.01%. Please see Figures 2.14, 2.15 and 2.16. The male unemployment rate is between 3.57 percent and 3.71 and the female unemployment rate is between 4.64 percent and 4.91 percent. This may be due to females working at home, owning businesses or participating in non-remunerated household tasks. Further study needs to be carried out to ascertain female contribution towards economy of the family, community and nation.

¹¹¹ Interview with Department of Population

¹¹² Handbook on Human Resource Development Indicators 2006, Special Edition,, Department of Labour and UNFPA,



Source: Handbook on HRDI 2006, Special Edition, DOL and UNFPA



Source: Handbook on HRDI 2006, Special Edition, DOL and UNFPA

The labour force is increasing by 0.7 million annually. Unemployed persons are increasing by 1 million annually. As such, the GoUM, together with the private sector, needs to create over one million jobs annually, if one calculates those leaving the work force from death or retirement subtracted from those unemployed entering the labour force. Agricultural works are labour intensive and would absorb a large bulk of the new labour force. That being said, there will still be an additional need for jobs through new enterprises and industries. Construction works such as building roads, bridges, town housings, dams, railroads, etc., would provide jobs for manual and semi-skilled labourers and could have a great potential for absorbing local workforce participants in the countryside and remote areas. If offered inducements and attractions, foreign investments could be lured to Myanmar. These investments would provide jobs for skilled and experienced workforce members in the managerial, manufacturing, marketing, construction and service sectors. Revitalizing schemes for foreign investment should be explored and implemented.

1.9 Data needs/gaps for Population Information

In Myanmar population information such as population size, composition, spatial distribution etc. are integrated in the formulation of development plans and programmes. So availability of information and the gaps need to be identified. Population as to its size, composition and distribution is only projections based on the information from the last census of 1983 and the parameters updated whenever fresh data is available. Many development plans and programmes need different sets of indicators and some of them are not readily available and hence some ad hoc studies and/or surveys were undertaken to meet the needs.

Though Myanmar is implementing the development plans and expanding urban areas and facilities, there is no concrete data on urban centres at the national level and their characteristics, growth and their effect on socioeconomic development and strategies to address them. Migratory movements although have to report to the local authorities such as Township Immigration offices, no data is compiled and analyzed on internal or international movements of the nationals and their impact on the development of the country. So research studies on urbanization should be carried out to identify the patterns and extent of urbanization and for formulation of appropriate strategies or to strengthen the existing programmes. At the time of reporting DOP is planning to undertake a survey on internal migration in 2011 and is collecting relevant information for planning stage such as questionnaires, data processing packages etc.

Labour statistics are also projections based on 1990 LFS and should be updated by conducting new surveys periodically. LFS is now planned to be taken in 2011 by the Department of Labour. Statistical compilations and publications such as Statistical Yearbook, Agriculture Statistics and Handbook on Human Resource Development Indicators (HRDI) should be maintained as the latter has lagged behind and no new issue after 2006 is found as yet, but it was learnt that a new handbook on HRDI is under preparation and will be released later this year.

1.10 Data needs/gaps to integrate population and RH concerns

An assessment of data availability/accessibility was made by the UN Data Mission on Strengthening MDG indicators during their visit to Myanmar in September 2009. The mission pointed out areas and indicators that are satisfactory, those that need to be strengthened and the gaps or those that need to be identified. For detail information, please see Annex 4, Table 5.

MDG Goals 4 and 5 include a reduction of MMR, IMR, U5MR and promotion of antenatal care and attendance at birth and immunization. Achievements of MDGs can only be accurately monitored from quality population data of targeted population to assess against baseline indicators. As such basic population data is required to identify targets and to calculate indicators in order to formulate policy documents and draw strategic plans.

1.11 Population and RH data quality

Basic population data are collected by censuses collected according to standard definitions, concepts and methodologies used worldwide. However, in Myanmar the most recent population census was conducted in 1983 and the data collected are approximately accurate. The data at the lowest level of administration and for detailed categories (eg. population by detailed race, detailed occupation etc), at any reliability and accuracy, are only available from censuses and censuses cannot be replaced by any other statistical data collection. But at present, in the absence of recent population census data, the population figures at national and sub-national levels are projected to meet the current needs and they have shortcomings and may not reflect the real situation.

Nationwide surveys such as FRHS and MICS are taken with the technical assistance from the international subject matter experts and national consultants who can provide the latest techniques, methodologies and best practices from other countries. They adopted the global and regional modules

adapted to suit prevailing Myanmar country situations and needs; so they are up-to-date and have the advantage of the experience in other countries. IHLCA, for example, works with the technical assistance of IDEA international institute and national consultants. Myanmar MICS is linked with the regional and global MICS and the methodologies and technologies are updated at each round of the MICS. PCFS in 1991 was designed after World Fertility Survey and adopted the methodologies and DHS data processing modules.

The later surveys were designed after the first one with technical assistance from international consultants with close collaboration with UNFPA. So the nationwide surveys have the advantage of international and national technical experts and the best tools. Some other cause specific surveys have also the best technical help as well as technical staff specifically trained in specific topics and are efficient and capable. At the training for the field data collections for the surveys, personnel from relevant institutions/departments were invited to participate in the training so that the trainees will have the advantage of the knowledge from the person who is competent in the particular subject – for example, in gathering RH related information medical personnel concerning the subjects (RH, contraception) were invited to give lectures on the subject. Concerning sampling, the international experts who have experience on many DHS/MICS surveys and who have experience of many surveys and national consultants from academic fields were called upon for advice and designing etc, so the results are representative of the nation and/or the sub-national level. However, for the long term implementation of such surveys, there is a need for national staff to be specially trained in that particular field.

Health Management Information System (HMIS) is established within the framework of Department of Health Planning and implemented since 1995. Funding as well as technical expertise was provided by various UN agencies: UNICEF, WHO, UNFPA. HMIS includes community-based as well as institutional based information as a means to support making evidence-based decisions in policy design, planning and management so as to improve overall health system performance.

1.12 Constraints in data harmonization and development of an integrated data base

Data are collected by separate ministries supported and financed by different UN agencies for the need for specific purposes. For example, FRHS were collected to have developed a system of periodic estimates of demographic indicators needed for policy formulation and development planning, to provide up-to-date information on changes in fertility, mortality and RH related indicators and information on knowledge of STDs, HIV/AIDs and trafficking. MICS is conducted with the main objective of producing MDGs related indicators concerning women and children. Mortality Survey was conducted by CSO to get information on mortality and many other demographic indicators and MIES was conducted to gather information on household income, expenditure, poverty indicator in the country. So also are many surveys collected by different agencies for different mandates but sometimes they collect the information for the same indicator coming up with different values, sometimes close enough but sometimes very different.

The differences may be due to concept and definition, different base population data, method of collecting data etc. So data harmonization is needed, that different financing agencies and different implementing agencies should have a very sound and thorough knowledge of what other institutions are doing in that field and if they are adequate for the requirements for their specific needs and coordinate among all agencies concerned to have a very fruitful and cost-effective method of gathering indicators for their use. The constraint with regard to data harmonization is there is a need to assign a team of experts a specific task to review all currently available data from diverse sources and depending on validity and reliability, a consensus should be built on an acceptable data set for national policy use. At present UN Monitoring and Evaluation Group is making tremendous effort in that direction and to strengthen/design the statistical system of the country.

1.13 Population and Education

Myanmar recognizes that education is a key factor in sustainable development, is a component of wellbeing, and a means to enable an individual to gain access to knowledge. "Every school-age child in school" and "education for all" are the mottos that guide Myanmar's educational efforts. Primary school enrolment is 89.5 percent for year 2004-2005 and there is almost gender parity between boys and girls.¹¹³ However, mass activities such as "School enrolment week" are still being undertaken in order to get all school-going-age children in school. Net enrolment rates for primary level is 77.4 percent and the proportion of Grade 1 students reaching Grade 5 is 84. percent in 2009¹¹⁴. The literacy rate for young people aged 15-24 years is 98.0 percent in 2010. Adult literacy rate of persons aged 15 and above was 94.9 percent in 2009.

In accordance with the Education for All (EFA) Goals adopted in 1990, the EFA Programme was launched in the 1996-97 school year in order to improve accessibility to primary education. The Myanmar Educational For All National Action Plan (EFA-NAP) 2003-2015 was formulated in line with long-term education development plans, and is based on the framework of Dakar EFA Goals as well as the MDGs. This plan has four goal areas: access to and quality of basic education, early childhood care and education, non-formal and continuing education, and education management and Education Management Information System.

Efforts to improve the quality of primary education include adoption of teaching methodologies changing from subject-centered approach to a child-centered one, and from lecture methods to active participation methods. The assessment system has been changed from year-end examination to a continuous assessment system¹¹⁵. The Continuous Assessment and Progression System (CAPS) was first implemented in 67 towns during from 1991 to 2001 and was funded by UNICEF.

The literacy rate for young people aged 15-24 years has increased during the last decades and is 98.0 percent in 2010¹¹⁶. The adult literacy rate has also increased from 83.6 percent in 1991 to 94.1 percent in 2005.¹¹⁷ There was only a small discrepancy between sexes with 94.5 percent for males and 93.7 percent for females. However, UNDP estimates for the adult literacy rate from 1999-2007¹¹⁸ are 89.9 in total, with 93.9 for males and 86.4 for females¹¹⁹. The State of the World Population 2009 mentioned Myanmar's adult illiteracy rate to be 11.4 percent for males and 12.6 percent for females. In other words, their estimate is that the adult literacy rate for males is 88.6 percent and for females it is 87.4 percent, also indicating very little gap between the sexes¹²⁰.

Among the total population 5 years and over, about 40 percent have completed primary education in 2004. About one-fifth have lower secondary school education. There are more males with lower and upper secondary school level education but the proportions are higher for females in primary and university level education. Though there is a small gender difference in educational attainment in older cohorts, but the gender gap is negligible in the younger generation.¹²¹

The GoUM is committed to the uplift of education standards for the entire nation; one of the four objectives of the country is formulating plans, strategies and programmes for improving education of the entire populace. However, UN agencies in Myanmar citing government official sources mentioned that one in three children of school-age never enrolled in primary school in 1990 which by 2005 has decreased to about one in every six children of that age. In other words, about 1 to 1.6 million school-

¹¹³ Handbook on Human Resources Development Indicators 2006, Special Edition, Department of Labour and UNFPA

¹¹⁴ Handbook on Education Indicators, 2004-2005, Department of Education Planning and Training and UNICEF

¹¹⁵ Myanmar Millennium Development Goals Report 2006

¹¹⁶ Ibid

¹¹⁷ Handbook on Human Resources Development Indicators 2006, Special Edition, Department of Labour and UNFPA,

¹¹⁸ Human Development Indices. A statistical update 2008, UNDP; Human Development Report, 2009, UNDP,

¹¹⁹ Human Development Report 2009, UNDP,

¹²⁰ State of the World Population 2009, UNDP,

¹²¹ Poverty Profile, IHLCA Survey 2003-2005, Planning Department, Ministry of National Planning and Economic Development and UNDP,

age children never begin school in 1990 and 2005 respectively.¹²² However, according to official figures provided for Handbook on Human Resource Development Indicators, the gross enrolment rate at primary school was over 100 in 1990-91, indicating a larger proportion of school-going children enrolled than mentioned previously. According to HRDI, by 2004-5, it was 89.9 percent indicating one in 10 primary school-going age children being out of school.¹²³ Most of the out-of-school children would be in rural areas and some are in remote and inaccessible areas. Official sources acknowledged that some villages are more than three kilometers from any school.

The education index for Myanmar in 2009 is calculated at 0.787. This can be compared with 0.530 for Bangladesh, 0.570 for Nepal, 0.683 for Laos, 0.704 for Cambodia, 0.840 for Indonesia, and 0.851 for Malaysia¹²⁴. That being said, UN agencies in the country have assessed the education attainment of the Myanmar population as low. They claim that the low education attainment is depriving many Myanmar children of a good start in life, thus significantly lowering their income earning capacity and productivity in their adult life¹²⁵. The UN has also assessed that the literacy rate of over 80 does not adequately reflect the level of functional literacy¹²⁶ and that there are disparities among different regions of the country, seeing as remote and hard to reach area have the lowest literacy rates. For example, Shan (East) stands at 41.6 per cent, and Rakhine State at 65.8 per cent.¹²⁷

1.14. Linkages between population and development at the macro and micro level

Poverty rates are approximately the same in urban and rural areas, but most of the poor (71 percent) live in rural areas. A substantial share of the rural poor has either no land or plots that are too small to be viable. Rural poverty can therefore be traced to low output and low prices for the output of small farmers, as well as to the limited availability of off-farm work. In urban areas, the poor tend to be concentrated in peri-urban locations lacking proximity to jobs and good services. Subsistence based on home production is generally not available to the urban poor.

The level and depth of hardship among families in Myanmar is vividly reflected in high rates of malnutrition among preschool-aged children. Even based on official statistics, far too many of Myanmar's children suffer from wasting and stunting. Moderate wasting affects almost three out of ten children under three years of age, and one in ten is severely malnourished.¹²⁸ This has been described elsewhere as a "silent emergency" in Myanmar, and deprivation on this scale indicates not only immediate need, but also adverse long-term repercussions for the health and intellectual development of affected children.

Death rates for infants and children figures are high for a country of Myanmar's level of GDP per capita. In particular child mortality rates failed to improve over the past decade. Among four other Southeast Asian countries with a similar level of GDP per capita in current US dollar terms in 1997 (US\$ 323- US\$ 396), Myanmar has a slightly higher infant mortality rate (71 per 1,000 live births compared with an average of 68) and a significantly higher child mortality rate (113 compared with an average of 77). Countries with infant mortality rates similar to those of Myanmar (75 – 85) are Bangladesh, Nepal, Nigeria, Gambia, and Tanzania, all of which have lower average GDP per capita income than Myanmar. Comparisons for child (under-five) mortality rates yield similar conclusions.

1.15 National poverty reduction strategies

Poverty incidence in Myanmar is about 23 percent in 2001. In 2004, at the national level, 10 percent of the population falls under the food poverty line, the proportion of individuals whose normalized

¹²² Myanmar Education Research Bureau, Education Sector Study Phase I 1992, cited in Situation Assessment and Analysis, UNICEF, Myanmar2001

¹²³ Handbook on Human Resource Development Indicators, Special Edition, 2006, Department of Labour and UNFPA

¹²⁴ Human Development Indices, A Statistical Update 2008, UNDP

¹²⁵ Strategic Framework for UN Agencies in Myanmar, Yangon, 22 April 2005.

¹²⁶ Ibid

¹²⁷ Poverty Profile, IHLCA Survey, June 2007, Ministry of National Planning and Economic Development and UNDP

¹²⁸ Ibid

consumption per adult equivalent is lower than the food poverty line. In urban areas, 6 percent of the population falls under food poverty line and in rural areas it is 11 percent.¹²⁹ The poverty headcount index at the national level is 32 percent. In urban areas, it is 22 percent and in rural areas, it is 36 percent.

The poverty gap index measures the intensity of poverty i.e the average shortfall from the poverty line of the poor multiplied by the poverty headcount. At the national level, the poverty gap index stands at 0.07 which means that the total sum required to eradicate poverty equals 7 percent of the poverty line multiplied by the population (assuming perfect targeting, no disincentive effects etc.) In urban areas the index is 0.04 and for rural areas, it is 0.07.¹³⁰

Myanmar, in trying to build a modern developed nation, has formulated the first short-term four year plan from 1992-93 to 1995-96, the second short-term five year plan from 1996-97 to 2000-01 and achieved increase in economy by 1.34 times and 1.5 times over the base year. The third short-term five year plan from 2001-02 to 2005-06 has achieved an increase of 1.8 times of the economy¹³¹. The most recent – the fourth Five-Year Plan (2006-07 to 2010-11) has been formulated with the intention to achieve an average annual growth rate of 12.0 percent. Among the main objectives are ¹³²

- To extend the setting up of agro-based industries and other required industries in building an industrialized nation
- To extend the agriculture, livestock and fisheries sectors in order to meet the local demand for self sufficiency and to promote exports
- To expand new cultivable land for agriculture use
- To establish forest areas for greening
- To conserve natural environment
- To extend education and health sectors for human resource development
- To have continuous development for the infrastructure sectors
- To carry on the development of border areas
- To carry on the development of rural areas
- To alleviate poverty
- To exceeds the targets of MDGs in implementing the national plans

Myanmar has made some progress since 1994 ICPD with respect to some of the PoA such as reduction in general mortality accompanied by IMR, U5MR, increased life expectancy and reduced fertility. Projection of LF based on 1990 LFS yielded an annual increase of 0.7 million in total labour force. Unemployment rate was about 4 percent, it is expected that in the future this rate may grow higher if the growth of the economy could not grow with the population growth. The movement of population from rural to urban areas and from smaller towns to bigger towns and cities in search of better employment and social services will put a bigger pressure to the big towns and cities in terms of environment, housing accommodation, employment opportunities as well as social services especially health and education.

1.16 National Population Policy

Myanmar is sparsely populated, and with rich natural resources, particularly its broad agricultural base, it can support a far larger population than the current size.¹³³ Hence GoUM had maintained a pronatalist policy. Among several reasons for this attitude, the important ones are:

- (a) the country is considered to be under-populated, compared to other countries in the region
- (b) availability of natural resources, arable land, forests, marine resources ,

¹²⁹ Ibid

¹³⁰ Ibid

¹³¹ Ministry of National Planning and Economic Development, Myanmar Millennium Development Goals Report 2006

¹³² Ibid

¹³³ ,1994 National Report on Population to 1994 ICPD, Cairo, National Population Commission, Myanmar

- (c) low population density, and
- (d) perception of population growth as an asset for development.

The draft National Population Policy is developed in 1992 under the guidance of the National Health Committee, discussed and deliberated at different levels of government departments concerned (Annex 1, Box 3). The ultimate goal of the population policy is to contribute towards improvement of the quality of life of the people through better health conditions, higher educational levels and increased employment opportunities.

The draft national population policy highlighted the need for birth spacing as an important issue for a "Happy Healthy Family" on health grounds. The policy recognizes the fact that "the improvement in the quality of life would inevitably come from reduced population growth", and aims to improve the health status of women and children by ensuring the availability and accessibility of birth spacing services among all married couples that voluntarily seek such services.

The draft policy had presumably served as a general guideline for population matters for the past one and a half decade. It is envisaged that the formal adoption of the population policy would enhance the implementation of ICPD PoA as well as Programmes for achieving MDGs by 2015 and in promoting population and development concerns.

Many actions were taken to implement the objectives set in the policy such as formation of Ministry of Immigration and Population, Department of Population, Myanmar National Committee for Women's Affairs (MNCWA) and Myanmar Women's Affairs Federation (MWAFF). National Health Policies, Health Plan and strategies for different time periods, and Five Year Strategic Plans for Reproductive Health in Myanmar, Environmental Policy, Plan of Action for Sustainable Development also known as Agenda 21 and National Sustainable Development Strategy (NSDS), to mention a few, were formulated and implemented.

Challenges and opportunities

Challenges

- One of the main challenges is the official adoption of the National Population Policy. The enforcement of the National Population will create an authoritative body that will be responsible for the population issues and activities and thus solve most of the existing or emerging situations/issues.
- Another challenge concerning information/data is the lack of recent population census for basic socio-economic information at the lowest administrative level and for detailed categories of demographic characteristics such as detailed race, occupation. In the context of ICPD PoA/MDG relevant indicators, there certainly are data gaps and these should be addressed. But there also is the situation where the issue is not the gap or absence of these data/information but the accessibility and awareness of the concerned authorities of the need of such data/information or indicators. For instance, most surveys collect information on employment and reasons for not working. This can provide MDG indicator 1.5 employed persons to population ratio as a proxy to employment to population ratio and indicator 1.7 own account and contributing family workers to total employment.
- Not all the information collected in surveys are used or analyzed and those not familiar with these surveys nor the data collection tools (questionnaires and data collection instructions) will not be aware that the surveys could provide such data. Some departments/institutions collect information but only for internal use and those outside the system have no access to them. Some data are not available from any source and this has been identified by the mission

in September 2009. Information in the data matrix is summarized and presented in section 1.10.

- The government institutions need trained personnel to implement the development strategies, plans and programmes and as the skilled/ professionals retired, the new generation of personnel skilled in demography and statistics need to be empowered. But most of the institutions are short of highly and medium trained professionals/technicians and capacity building of the population and related institutions is greatly felt. Thus, technical capacity of population related/ statistical institutions should further be strengthened through local and overseas training to bridge the existing inadequacy of national technical capacity and generation gap.
- Detail information and data on international migration is important as there are many regular and irregular migrants out of the country due to various reasons and to monitor and legalize their movements and at the same time look for the root causes and address them.
- There is also a need for more cooperation and coordination among different government departments, international, national NGOs and UN agencies concerning the data in the integration of population in development policies, plans, strategies and programmes.
- The number of out-of-school children is quite large and it is a challenge to adequately and effectively provide development programs as they will constitute the future workforce. They are out of school to work to supplement the family income or help in family work as unpaid family workers or to look after the younger siblings.
- There is general lack of awareness among all levels of administration and the community of the National Sustainable Development Strategy (2009) resulting in weaknesses in control over consumption of environmental resources such as fuel wood, fossils, timber, shifting farming, land clearance for agriculture and for grassland. Advocacy and support for actual implementation of NSDS is recommended for sustainability of the environment and its protection thereof to ensure the quality of life for the present and future generations.
- Availability of quality statistics, disaggregated to a sufficient depth by sex, age, ethnic group, basic demographic characteristics and geography, which may be facilitated by external partnership.
- Data harmonization involving technical personnel from GoUM, NGO, external consultants and UN should be conducted to discuss and accept agreed upon set of national data.
- Integration of environmental protection in formulation of population and development plans at all levels. Enhancing aforestation, investment in green technology and employment opportunities for landless rural poor and remote border areas to improve the income and livelihood options and to attain MDGs.
- Baseline study on childhood disabilities to identify types, causes, and specific measures for prevention, treatment and care and support needs to be established at national level.

Opportunities

- Myanmar is experiencing the demographic transition and is at the last stage. Fertility is declining and with comparatively high fertility in the past resulting in a high proportion of population in the working age group, GoUM should take this opportunity to enhance economic development. It is the time to create jobs all over the country enough to absorb/attract the growing working age population so that there will be less emigration of

skilled workforce for better job opportunities outside Myanmar. Greater investments in human capital to develop skills in green technology, development of agro-forestry strategies, mechanical farming, and necessary programmes for vocational and life-skill training for the growing 15 to 59 age group.

- Myanmar is rich in natural resources- forests, fresh water, bio-diversity, flora and fauna, minerals and gas. Some are of limited nature and must be used with proper planning but others are abundant and should maintain sustainable management of these.
- National Plan of Action of elderly citizen had been developed which needs to be championed with funding support for multiple donors and government input.
- Currently the Department of Social Welfare has adopted the Myanmar National Plan of Action for People with Disabilities (2010-2012). This will open ways for the DSW to work with Ministry of National planning and Economic Development, Ministry of Health, Ministry of Transportation, Ministry of Home Affairs, Ministry of Labour, Ministry of Construction, UN and INGOs to provide means for people with disabilities to be mobile and productive.

Chapter Three: Reproductive Health, HIV and AIDS



CHAPTER III: Reproductive Health, HIV and AIDS

The adoption of comprehensive definitions at the International Conference on Population and Development (ICPD) in 1994 initiated a new era whereby the concept of reproductive health began to be widely accepted by governments and international health and development bodies. Myanmar has made considerable progress towards the ICPD goals and MDGs in recent years, with improvements in coverage and quality of maternal and child health care, birth spacing services, as well as HIV/AIDS prevention, care and support. However, despite political commitment and continuous efforts by multiple partners, the status of reproductive health in Myanmar remains a challenge, marked by a high maternal mortality ratio, neonatal mortality rate and high burden of HIV infection. Concentrated efforts are essential in order to expedite the progress towards reducing child mortality, improving maternal health and reversing the spread of HIV/AIDS in order to attain, by the year 2015, the targets of the Millennium Development Goals 4, 5 and 6.

1. Policy framework

Improving maternal and child health has been a key priority in the national policy agenda aimed at reducing maternal, newborn, infant and under-five morbidity and mortality in order to achieve MDG 4 and 5 targets by 2015.

The MOH is presently implementing the National Health Plan 2006-2011 prepared under the guidance of the National Health Committee. The National Health Plan was formulated within the framework of the Myanmar Health Vision 2030 and the National Health Policy of 1993 with the ultimate goal of achieving Health for All and the Millennium Development Goals (included in Annex 1, Boxes 1, 2). The National Health Plan consists of twelve main programs for health development, namely: community health care, disease control, hospital care, environmental health, health systems development, human resources for health, health research, traditional medicine, food and drug administration, laboratory service, health promotion and health information systems. Maternal, newborn and child health are the main components of the community health program. Implementing the reproductive health strategies assumes intrinsic linkages and programmatic support across all major components of the National Health Plan.

Specific policy directions are provided in the Myanmar RH Policy document for operationalizing reproductive health programmes including an integrated and core package of priority interventions for pre-pregnancy, adolescent health, birth spacing, and obstetric care for pregnant women covering antenatal, delivery, neonatal, postnatal and post-abortion care (Annex 1, Box 4).

The first Five Year Strategic Plan for RH for the period 2004-2008 implemented a set of strategies which aimed at strengthening and expanding the provision of health services and improving performance of the health systems. The implementation of the Strategic Plan contributed to improved service coverage demonstrated by increased use of modern contraception, increased proportion of births assisted by skilled attendants and higher proportion of pregnant women attending antenatal services. However, due to inequalities in access to maternal and reproductive health services, the expected impact of lowering the aggregate level indicators of maternal and neonatal morbidity and mortality has not been met. When reflecting on how to strengthen the health system, the key to achieving reproductive health goals will be achieved by considering inequalities of access to services and underutilization, and acknowledging socio-economical determinants.

A second Five-year Strategic Plan for RH (2009-2013) was formulated based on a review of the first Strategic Plan, and is currently being published and implemented (Annex 1, Box 5). It defines and

promotes the implementation of the essential package of reproductive health services by level of care and sets national targets against selected key reproductive health indicators. In addition to the national RH Policy and Strategic Plan, the issues relevant to reproductive health services are cross-referenced in the draft 1992 National Population Policy (Annex 1, Box 3), Adolescent Health and Development Strategic Plan (2008-2012) and the Child Health and Development Strategic Plans (current 2005-2009 plan and the draft for 2010-2014).

2. Health care system and Institutional Framework for service delivery

In Myanmar, the health care system evolved with the changing political and administrative system of the nation. The Ministry of Health takes the key role for health development and uplifting the status of health of the population. Myanmar has a mix of public and private health care. In line with the National Health Policy, national NGOs such as Myanmar Maternal and Child Welfare Association (MMCWA), Myanmar Red Cross (MRCS) and Myanmar Medical Association (MMA) play supportive roles in health development. The Ministry of Health works in collaboration with 34 International NGOs and 7 UN organizations.

The National Health Committee (NHC) formed in 1989 provides policy directions, and coordinates with other pertinent Ministries. The Ministry of Health, under the guidance of the NHC, provides comprehensive health services covering health promotion, preventive, curative and rehabilitative aspects in order to improve the health status and longevity of the citizens. MOH oversees health service provision and health care implemented through seven departments in the State/Division, District, Township and village tract levels. One unique and important feature of Myanmar's health system is the existence of traditional medicine along with allopathic medicine. There are a total of 14 traditional hospitals run by the MOH in the country.

To enhance coordination and community participation, health committees are formed at all levels of administration. The membership of these committees includes representatives from related government departments and social organizations. The head of each health department usually acts as a secretary and head of the General Administrative Department as chair.

Apart from MOH, other ministries providing health care to their employees and dependants are the Ministries of Defense, Railways, Mines, Industry I, Industry II, Energy, Home Affairs and Transport. The Ministry of Labour has set up two hospitals, one in Yangon and the other in Mandalay, to render services to those entitled under the social security scheme.

Maternal and Child Health Services at operational level¹

The main provider of health services is the Department of Health (DOH). It is headed by a Director General who is assisted by three Deputy Director Generals; one is responsible for Disease Control, another for Public Health, and the third for Medical Care. Under the Director of Public Health there are Deputy Directors for Maternal and Child Health, Women and Child Development, Primary Health Care, and Training of Basic Health Staff (BHS). These sections are supported by Assistant Directors, Medical Officers and support staffs at Nay Pyi Taw in central level. There are State/ Division Health Departments, District and Township Health Departments at all levels of administration to village tract level.

Service delivery of maternal and child health services occurs through different mechanisms. There are three types of MCH services in urban settings, depending on the size of the town and population served:

¹ Maternal and Child Health section, DOH, 2009

a) **Maternal and Child Health (MCH) Centres:** In small towns with a population of less than 10,000, MCH activities are carried out by the Lady Health Visitor (LHV) and 2-3 midwives (MWs) under the supervision of the Township Medical Officer (TMO)/Township Health Officer (THO) and with the assistance of the medical officer (usually female) from the hospital. At last count in 2008-2009, there were 348 MCH centres nationwide.

b) **School Health (SH) Teams:** In towns with a population over 10,000, in addition to MCH centres there are School Health Teams (featuring Doctors, Nurses, Dental Surgeons, Medical Social Workers, pharmacists and clerical staff) taking charge of the MCH activities as well as the school health work. There are 80 such teams operating in 51 towns across the country.

The school health sector of the Department of Health in collaboration with the Ministry of Education forms school health committees at each administrative level to carry out school health activities, training of teachers on health promotion, and developing the knowledge and skills of young people to adopt healthy life styles. The MOH included school health programme activities on Adolescent Reproductive Health (ARH) in its 2001-2006 National Health Plan. The MOH collaborated with other ministries, such as Ministry of Education, Ministry of Sports and Physical Education, Ministry of Immigration and Population and Ministry of Information. To integrate school health and adolescent sexual and reproductive health, the national five-year Adolescent Health and Development Strategic Plan (2009-2013) was developed to address priority issues affecting the health of young people across the nation.

c) **Urban Health Centres (UHC):** In cities with a population over 100,000, UHCs operate on the Ward level in addition to the MCH and SH mechanisms described previously. MCH functions are taken over by the UHC in partnership with the SH Team to function as full-time service providers. There are 83 UHCs in 17 large cities in Myanmar. Each UHC has a specified number of health staff which carries out preventive, curative, educational and environmental activities and refer of serious cases to the hospital.

The organization of health services in rural areas is as follows:

a) In rural areas, there are 16 bedded hospitals known as a Station Hospital. Strategic RHC is usually upgraded by the addition of a Station Medical Officer (SMO) and other staff to provide services for in-patients. If a station hospital and RHC co-exist in the same village, they form a Station Health Unit (SHU) providing both preventive and curative activities under the charge of the SMO. It runs Out Patients' clinic for MCH and usually about 6-8 beds are allocated for women and children. There are (270) SHU in the rural area.

b) **Rural Health Centres (RHC):** RHCs are centres each responsible for a population of about 26,633 in about 7 to 14 villages (national average)². One RHC consists of a Health Assistant (HA) as team leader, a LHV, 5 midwives and 1-5 Public Health Supervisors (Grade II – Multipurpose Health Worker) and a watchman.

MCH care is carried out by the Lady Health Visitors (LHV) and Midwives (MW). There are 1481 RHCs throughout the country.³ Under each RHC, there are usually five sub-RHCs and each midwife is given charge of (1-3) village tracts with a population ranging from (2000-4000). Thus, the four MWs at the periphery of the main RHC become four Rural Health sub-Centres which are functionally MCH Centres. There are 5824⁴ sub-Centres in Myanmar. According to the National Health Plan (2006-2011), one RHC covers 26,633 people, one sub-centre covers 6658 people, and one MW has an

² National Health Plan, 2006-2011

³ Health in Myanmar 2009, Ministry of Health, 2009

⁴ National Health Plan, 2006-2011

average 4,144 people under their care.⁵ At the rural health centres, midwives open clinics for two days and then do field touring for three days. During their field visits they provide Ante Natal care (ANC), deliveries, Post Natal care (PNC), and conduct weighing and immunization of children under three. They also give health education regarding safe motherhood, nutrition and promote breast-feeding during their field visits. In the clinic days, they provide antenatal care for mothers and other health problems and look after PN patients in the afternoon. The Lady Health Visitor and midwife train and supervise the Auxiliary Mid Wives (AMW) and Traditional Birth Attendants (TBA) for Maternal and Child Health (MCH) activities.

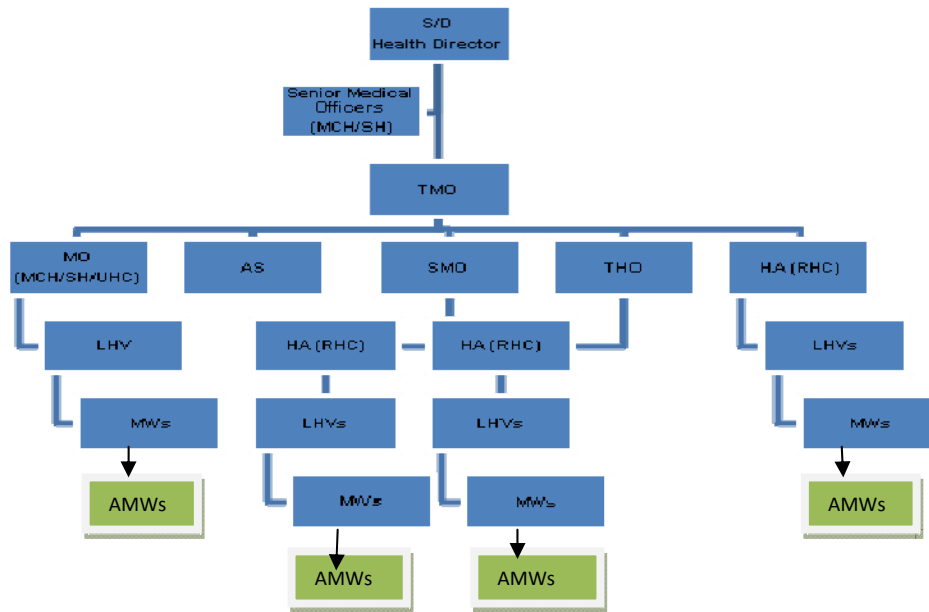
c) **Volunteer Village MCH Posts (VV-MCH-P):** Direct access to MCH Care by a MW is reaches only about 10% of rural people; the rest are regarded as underserved⁶. To increase MCH coverage to the underserved villages, a new category of volunteer village health worker called **Auxiliary Midwife (AMW)** was created. AMWs are selected from underserved villages, trained for three months in the hospital and then for three months in their nearest RHC. While AMWs are not regarded as skilled birth attendants, there is a heavy reliance on them in Myanmar in the absence of other health personnel in rural remote villages. Working under the supervision of the MW and Village Health Committee, the main activities of AMWs are antenatal care, care for uncomplicated delivery, referral of at-risk mothers and new born, PN Care, minor ailment treatment such as fever or diarrhoea, and first aid. AMWs also provide health education, particularly to mothers on nutrition, personal hygiene, immunization, infectious disease-surveillance, growth monitoring and referrals to MW and LHV. AMW are volunteers filling the gap for provision of the MCH services in hard-to-reach areas. Township Medical Officers arrange for LHV or MW to provide continuing education and supervision to update AMWs knowledge and upgrade their skills. Being volunteers they do not have regular salary or travel support for home ANC or PNC visits. For their services AMWs may receive in-kind support from villagers. However, the absence of adequate incentives may be a hindrance to longer-term sustainability of these cadres.

Finally, there is another type of volunteer village health worker called the Community Health Worker (CHW) who delivers Primary Health Care at the village. Community Health Workers are selected from an underserved village, trained for one month at the Township Health Department or RHC sub-centre and then receive 1-2 months field training with the their local RHC staff. A CHW's main function consists of disease surveillance, first aid and minor ailment treatment (including diarrhoea by ORS, Malaria), health education (concerning personal hygiene, nutrition, immunization etc.) and improvement of environmental sanitation (water supply, sewage and refuse disposal).The outreach work of CHWs and AMWs at the community level is the extension of the public sector services of the rural sub-centres. At the community-level Traditional Birth Attendants (TBAs) are still relied upon for the provision of reproductive health care. Oftentimes they are reported to provide attendance at deliveries and perform illegal (and as such, often unsafe) abortion services.

⁵ Ibid

⁶ MCH service delivery at operational level, MCH, DOH, 2009

Figure 3.1: Organizational Set-up of State and Divisional level, Township level and Rural Health Centre



Source: Maternal and Child Health Section, Department of Health,

The number of hospitals in the public sector has increased from 824 in 2004-2005 to 846 in 2008-2009; a 2.67% increase. The number of RHCs providing basic maternal and child health services grew from 1456 in 2004-2005 to 1481 in 2008-2009⁷; an increase of only 1.72%.

The NGO sector in Myanmar also contributes to reproductive health care, consisting of local and international NGOs partnering with MOH to implement the reproductive health services through clinics mainly catering for urban clientele. There are also private pharmaceutical vendors selling RH medications and birth control pills. Some Government health staff also has private practices of their own.

The private, for-profit sector is mainly providing ambulatory care, though in recent years there is an increase in number of private hospitals providing institutional care in Yangon, Mandalay and other big cities. Funding and provision of care is fragmented, as the private sector fills niches responding to customer demand. The Ministry of Health stipulated the Law Relating to Private Health Care Services in 2007⁸, however, there is still an urgent need to issue rules and regulations to practically enforce this law. The private sector has potential to positively contribute to the concerted efforts to meet the RH needs of the population; however, there is need for consistent monitoring to follow national guidelines and standard operational procedures, standard costing for quality assurance in practice.

The Government has a stewardship and regulatory role to take measures to protect its citizens from potential harmful practices and improve availability of information and quality services, in both the public and private sectors. Some private pharmacies are a source for the trade of low-cost, low-quality, and counterfeit and/or illegal drugs. The Food and Drug Administration (FDA) of the Ministry of Health has mechanisms for registration, licensing and regulation of the quality and safety of food and drugs⁹. There is a need to strengthen consistency and regulate post-market surveys of drugs and food available. Local non-profit organizations are also taking some share of service provision and their roles are also becoming important as the needs of collaborative actions for health care become more pertinent.

⁷ Health in Myanmar 2009, Ministry of Health, 2009

⁸ Ibid

⁹ Ibid

3. Human resource requirements for health services

Training and production of Human Resources for Health (HRH)

The Ministry of Health recognizes that the key to provision of comprehensive health care is the optimal adequate numbers of well-trained medical professionals with adequate deployment across both the public and private sectors. As such, there are four Universities of Medicine, two Universities of Dental Medicine, two Universities of Nursing, two Universities of Pharmacy, two Universities of Medical Technology, one University of Community Health, one University of Public Health and one University of Myanmar Traditional Medicine under the Ministry of Health in Myanmar. There are also 46 nursing and midwifery related training schools across the country¹⁰. Traditional medical practitioners are trained at the University of Traditional Medicine, which confers Bachelor of Myanmar Traditional medicine since 2001, with the first cohort of graduates in 2007¹¹. According to the Traditional Medicine Council there are 5470 registered traditional medicine practitioners, as of 2006.

According to the WHO estimates, countries with fewer than 23 health care professionals (counting only physicians, nurses and midwives) per 10,000 persons are likely to experience shortage in coverage rates for the basic primary health care interventions prioritized by the Millennium Development Goals. Twenty-three health care providers with midwifery skills (doctors, nurses and midwives) per 10,000 persons is the threshold to achieve 80% coverage for skilled attendance during deliveries¹².

In Myanmar, (Table 3.1) the doctor/population ratio is 1:3315 and the nurse/midwife population ratio is 1:1195. There are about 14 health care providers per 10,000 populations. However, the majority of medical doctors are concentrated in the urban locations, where only 30% of the total population resides. To meet the international threshold and secure availability of skilled birth attendants at deliveries, the production, deployment and retention of a well-trained health workforce with midwifery skills needs to be reinforced. When considering these issues, it is noteworthy to take into account the clinical skills of health personnel and not only the quantitative ratios when considering adequacy of coverage as not all doctors and nurses possess satisfactory midwifery skills.

Physicians per 10,000 population	4
Nursing and midwifery personnel per 10,000 population	10
Community health workers per 10,000 population	9
Other health service providers per 10,000 population	>2
The level of health care professionals (counting only physicians, nurses and midwives) recommended by WHO per 10,000 population	23

Source: World Health Statistics 2009.

Human Resources for HIV/AIDS

The National AIDS Programme (NAP), under the Disease Control Division, Department of Health, Ministry of Health provides the leadership in the national response to HIV/AIDS within the health sector and plays a key coordinating role across non-health sectors. The NAP consists of the office of the National Programme Manager in Nay Pyi Taw and an AIDS counselling team in Yangon. The NAP office includes one Deputy Director, Assistant Directors, Medical Officers and other support

¹⁰ Health in Myanmar 2009 Ministry of Health, 2009

¹¹ National Health Plan 2006-2011, DHP, MOH

¹² World Health Report 2006, WHO, Geneva

staff. They are responsible for national level planning, programme management and resource mobilization as well as monitoring and supervision of implementation. In addition, they facilitate procurement and supply of HIV medicines and other related commodities.

NAP has organized forty-six AIDS/STD teams nationwide, including six State and Divisional level AIDS/STD teams in high prevalence or vulnerable townships. Each of the AIDS team has a staff of 3 to 15 members, including a medical doctor (team leader), nurses, counsellors, investigator/outreach workers, laboratory technicians and support staff. The AIDS/STD teams implement projects at the local level in harmony with national public health strategies. Team leaders are in charge of the team and provide counselling, Sexually Transmitted Infections (STI) management, and some basic HIV/AIDS treatment and care with nurses. They refer People Living with HIV/AIDS (PLHIV) in need of Anti-Retroviral Therapy (ART) to physicians and also perform monitoring, supervision and reporting as necessary. Investigators and outreach workers provide contact tracing for STI, PLHIV and support outreach activities. Laboratory technicians carry out tests related to STI and HIV testing. Many AIDS/STD team leaders are stationed in townships that are also district centres and thus provide guidance to all townships that come under their administrative authority. State/Divisional AIDS/STD officers oversee the activities of the teams of the related townships in their States and Divisions including coordination and advocacy to local authorities and other stakeholders.

In townships without AIDS/STD teams, HIV/AIDS interventions are implemented by other responsible officers, notably the township medical officer. Township hospitals provide basic services on HIV/AIDS clinical management to outpatients where AIDS/STD teams are not present and to patients with advanced HIV and AIDS.

Other departments under Ministry of Health are also involved with the implementation of HIV/AIDS prevention and care activities such as Division of Medical Care including physicians and paediatricians for ART programme, Obstetrician/Gynaecologist (OG) for Prevention of Mother to Child Transmission of HIV (PMCT) programme, drug treatment centres for harm reduction activities particularly drug addiction treatment and oral substitution treatment (methadone), Division of Public Health including Maternal and Child Health, Reproductive Health section for PMCT, State/Division health committees, Health laboratories at each level, Occupational health section and Food and Drug Administration. In cooperation with National TB programme, DOH, WHO and Union, TB/HIV programme is implemented.

The private for profit sector provides ambulatory HIV/AIDS and STI clinical services including ART and HIV testing. General practitioners from the private sector are part of Myanmar Medical Association (MMA), whose representatives in turn communicate with the NGOs and the public sector. In addition other related Ministries, UN agencies, NGOs and community based organization are concerned with providing HIV prevention and care services in collaboration with the NAP.

4. Health profile of population and burden of diseases

The World Health Organization defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The Health for All (HFA 2000) protocol was adopted in 1977, which aims to provide all people with a level of health which will allow them to lead socially and economically productive lives. Myanmar implements its health development programs based on the principles¹³ of Primary Health Care (PHC) to deliver the following eight PHC activities: health education, quality maternal and child health care (including family planning), adequate supplies of food and nutrition, adequate supply of safe water and sanitation, prevention and control of

¹³ Five principles of PHC: equity, community participation in decision-making, multi-sectoral approach, appropriate technology and health promotion.

locally endemic diseases, immunization, provision of essential drugs and treatment of common diseases and injuries.

Incremental progress has been achieved in raising the health status of the population, as seen in table 3.2. Life expectancy at birth has risen for males and females from 59.2 years and 61.7 years in 1991-92 to 62.0 and 65.1 years respectively in 2004-05¹⁴. A decrease in the crude birth rate and crude death rate and an increase in percent coverage of Universal Child Immunization indicate improvements in health care delivery.

Table 3.2: Health Development Indicators

No.	Indicator	1991-92		2004-05	
1.	Life Expectancy at Birth (CSO)	Male	59.2 years	Male	62.0
		Female	61.7 years	Female	65.1
2.	Crude Birth Rate (CSO)		29.9		21.1
3.	Crude Death Rate (CSO)		9.6		6.1
4.	Percentage coverage of Universal Child Immunization		66.9		83.0

Source: Handbook on Human Resources Development Indicators, 2006, DOP & UNFPA. To check data consistency with other Chapters

Along with many other developing countries, Myanmar has a double burden of communicable and non-communicable diseases. The fight against HIV/AIDS, TB, Malaria, diarrhoeal/dysentery diseases, cholera, Dengue Haemorrhagic fever, vaccine preventable diseases and new emerging infections is a continuing battle, in addition to the growing burden of non-communicable diseases, such as ischaemic heart disease, diabetes mellitus, and degenerative disorders¹⁵.

Improving reproductive health (including maternal health and nutrition) is amongst the highest national priorities. Promotion of household food security and initiation of exclusive breast feeding for 6 months has paved the way for better nutritional status of population as evidenced by reduction in percentage of severe and moderately malnourished children under 5 from 36.7% in 1991-92 to 31.8% in 2004-05¹⁶.

Nutrition promotion and growth monitoring of children under three years is carried out nation-wide with community-based nutrition rehabilitation centres for moderately malnourished children in urban areas. A food and nutrition assessment survey carried out in Yangon and Ayeyarwaddy division after Cyclone Nargis by DOH, UNICEF and WFP revealed that 11% of under three-year old children were malnourished and 2% of them were severely malnourished¹⁷.

5. Components of Reproductive Health

5.1. Maternal and Neonatal Health

Approximately 1.3 million women give birth each year in Myanmar¹⁸. The burden of maternal mortality and newborn mortality and ill-health is considerable. The maternal mortality ratio (MMR), referring to the number of pregnancy related maternal deaths per 100,000 live births remains elevated:

¹⁴ Handbook on Human Resources Development Indicators, 2006

¹⁵ Health in Myanmar 2009, Ministry of Health, 2009

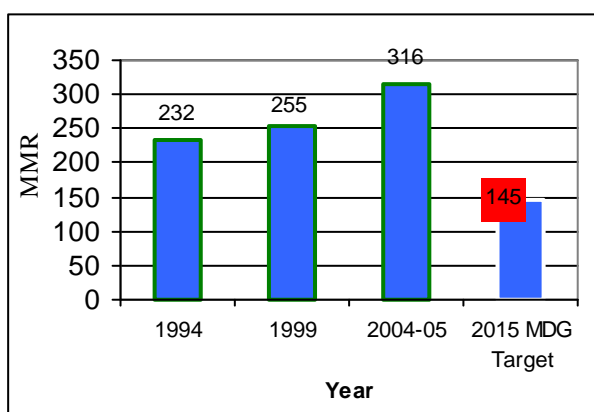
¹⁶ Ibid

¹⁷ Ibid

¹⁸ Ibid

for every 100,000 live births there were estimated 316 maternal deaths in 2004-2005¹⁹. Bringing maternal mortality down and reaching the national MDG5 target of MMR less than 145 per 100,000 live births by the year 2015²⁰ is an ongoing challenge. The fact that MMR estimates were higher in 2005 than estimated levels in 1994 and 1999 (Figure 3.2) is suggestive that the impacts of the poor economy, the intense vulnerability of women's health and psycho-social factors have compounded negative effects on women's health and survival. The rise in MMR could also be due to better reporting of maternal deaths due to increased awareness and improved data collection methods.

Figure 3.2: Maternal mortality ratio (per 100,000 live births), 1994-2005



Source: Five Year Strategic Plan for Reproductive Health, 2009-2013
MMR: number of maternal deaths per 100,000 live births

The Nationwide Cause Specific Maternal Mortality Survey analyzed a number of aspects in relation to MMR according to the geographical location, age group, urban-rural residency and place of birth. In urban localities, the MMR was estimated at 140 per 100,000 live births while in rural areas, it is much higher, with 363 maternal deaths per 100,000 live births. At the sub-national level the lowest MMR of 132 per 100 000 live births is in the Hilly Region (Shan, Kachin, Kayin, Chin and Kayah) and the highest (449 per 100,000 live births ranging from 317 to 581) is in the Central Plains (Magway , Sagaing & Mandalay). MMR in the Coastal Region (Mon, Rakhine, Tanintharyi) is equals to 264 (ranging from 52-477) and 337 in the Ayeyarwady Delta region (337, ranging from 266-409) per 100,000 live births respectively. According to other routine health information, in 2007 the highest maternal mortality ratios were observed in Kayah, Rakhine, and Shan States²¹. These states represent populations of ethnic minorities and national races, with own native languages, and where development indicators such as low literacy rates, indicate that overall human development is lower than national level average. The limited availability and access to comprehensive SRH services such as birth spacing and MNH services, lack of information and awareness in communities on SRH issues, adverse effects of some traditional practices, and low literacy rates are all factors contributing to a significantly higher MMR in remote areas.

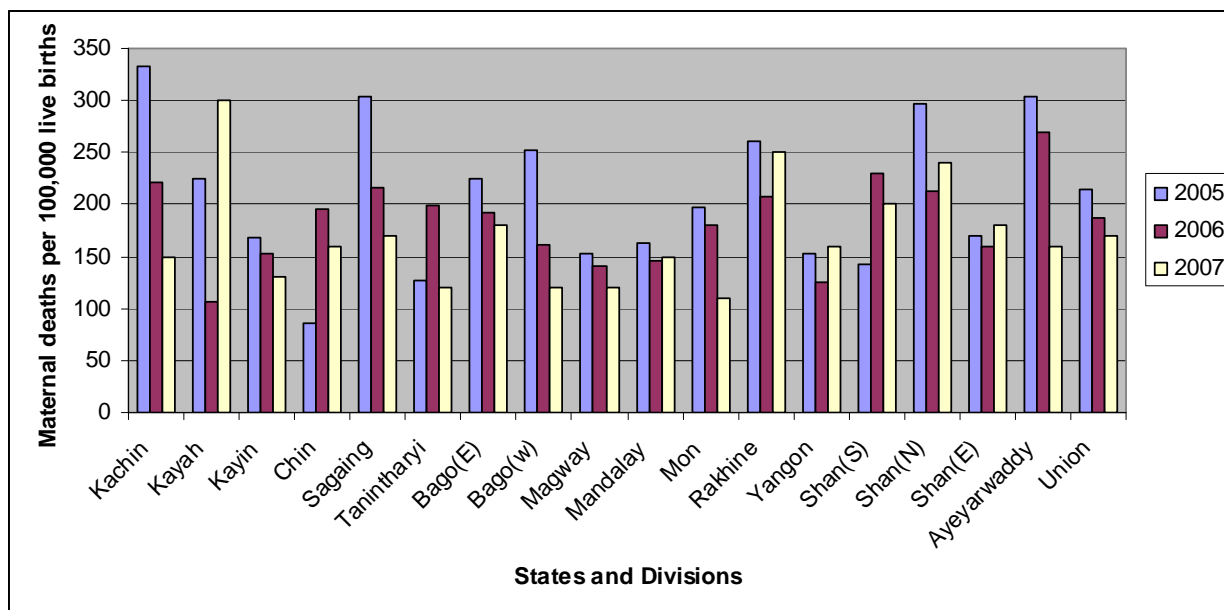
Compounding the situation is the fact that, as a rule, population groups with high maternal mortality rates also experience comparatively higher fertility rates. An example of an extreme case of a population group with limited access to SRH services are the Bengali population of the Northern Rakhine State. This group of people were issued temporary registration card (TRC) in Myanmar but has not been established or regularized by the government. As such, they face restrictions in their movement and have limited access to adequate health services.

¹⁹ Nationwide Cause Specific Maternal Mortality Survey 2004-2005. Yangon: MOH, UNICEF, 2006

²⁰ Five Year Strategic Plan for Reproductive Health, 2009-2013

²¹ Health Management Information System, 2007

Figure 3.3: Maternal Mortality Ratio by States and Divisions in 2005, 2006 and 2007 (HMIS, DOH)



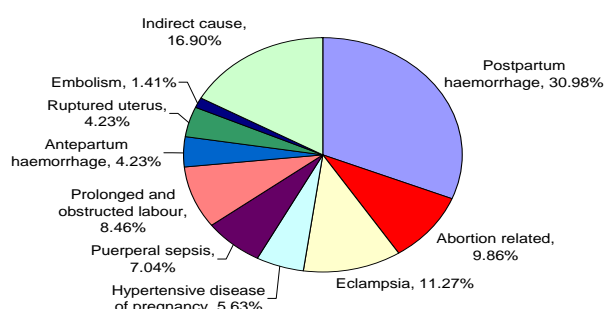
The Maternal Mortality Ratio (MMR) was the highest in the age group 45-49 years old, followed by women of 15-19 year old age group. The majority of maternal deaths occurred at home (62%). Only 38% of women with complications were referred to the hospital and only 24% reached the hospital for proper management, while 14% others died on their way due to late referrals, primary delay, and long distances to travel. Although 48% of the deceased women were seen by a skilled provider at least once during her pregnancy, only 22.5% were actually delivered by skilled care providers and 33.8% by traditional birth attendants.

The leading direct obstetric cause of maternal deaths is postpartum haemorrhage (30.98%), followed by hypertensive disorders of pregnancy including eclampsia (16.9%). Abortion-related causes accounted for 9.86% of maternal deaths (Figure 3.4). Indirect causes of maternal deaths include heart disease (45.45%), malaria (36.36%), tuberculosis (9%) and chronic obstructive airway disease (9%). Often symptoms suggestive of anaemia are often present. HIV/AIDS can also predispose and/or aggravate pregnancy complications.²² Malaria and high rates of maternal parasitaemia are two other causes of chronic anaemia exacerbating maternal health in Myanmar. The review of studies on burden of malaria in pregnancy in Myanmar²³ reported maternal parasitaemia rates in ANC population of between 3% and 37.2% and in intrapartum patients, 12.9%.

²² Five year strategic plan for Reproductive health 2009-2013, MOH

²³ Mya Thida. Burden of malaria in pregnancy in Myanmar. Malaria Technical Advisory Group Meeting: Yangon: VBDC, DOH, MOH and WHO Country Office, Myanmar: 2003

Figure 3.4: Causes of maternal mortality, 2004-2005



Source: Nationwide Cause Specific Maternal Mortality Survey (2004-2005), DOH/ UNICEF.

According to global epidemiological data about two third of maternal deaths occurs during childbirth and within first 24-hours after delivery. Thus, timely access to professional services and skilled care and available emergency obstetric services are crucial. With 4 out of every 5 deliveries taking place at home²⁴, 90% of maternal deaths in Myanmar occur at home or on the way to healthcare facility²⁵.

All women coming for Ante Natal Care (ANC) at government health facilities are provided with ferrous sulphate tablets and folic acid supplementation throughout the term of pregnancy free of charge. However, when interviewed, the majority of women demonstrate low compliance with prescriptions. Unfortunately, many women discontinue use of ferrous sulphate tablet intake mainly due to underestimation of benefits vis-à-vis side effects and cultural misconceptions. Among the reasons women site are the unpleasant irony taste in the mouth, black colour of stool, constipation and, among others, the damaging perception that iron tablets can cause their child to have dark complexion²⁶. As in many Asian cultures, Myanmar cultural aesthetics value fair skin over dark skin. Some NGOs have responded to this cultural norm. For example, MSI provides pre-natal tablets consisting of multi-vitamins and iron, but in a lower concentration than ferrous sulphate tablets. These pills are more costly than ferrous sulphate, but they are well accepted by women in rural communities²⁷. A culturally-based strategy could be a potential solution to improve prevention and treatment of anaemia in pregnancy. In addition, the education of pregnant women and communities about the dangers of anaemia in pregnancy and the benefits of iron supplementation will help to create better awareness and eliminate misconceptions in the fight against anemia.

The status of maternal health and existing perinatal services intrinsically relate to pregnancy outcomes and newborn health. It has been argued that nearly three quarters of all neonatal deaths and stillbirths could be prevented if women were adequately nourished and received appropriate care during pregnancy, childbirth and the postnatal period. Promoting women's health and nutritional status before they become pregnant, or as early into their pregnancy as possible will influence acute and chronic conditions. Antenatal care interventions to promote the use of bed nets for prevention of malaria, nutrition education to increase consumption of iron-rich food, and provision of deworming medicine are all interventions needed in the RH sector.

²⁴ Fertility and Reproductive Health Survey 2007, DOP and UNFPA, October 2009

²⁵ Nationwide Cause Specific Maternal Mortality Survey 2004-2005. Yangon: MOH, UNICEF, 2006

²⁶ SA team findings, Annex 3

²⁷ FGD with ANC clients, SA field work, UNFPA, 2009

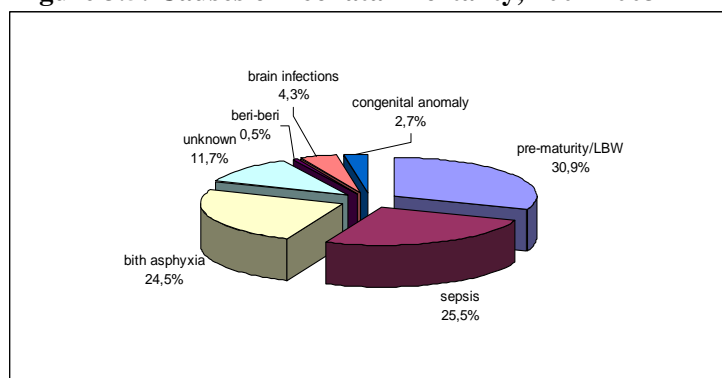
According to WHO estimates, in 2004 the number of stillborn in Myanmar was 46,000, and the number of neonatal deaths was 48,000²⁸. Neonatal mortality (16.3 per 1000 live births) contributes to approximately one third of the infant mortality rate (9.7 deaths per 1,000 live births) in 2003²⁹.

The 2003 under-five mortality survey³⁰ showed that 73% of under-five deaths occurred during infancy (0-11 months) and the proportion of deaths was higher in the first month of life as well as disproportionately higher in rural areas (87%) compared to that of urban areas (13%).

When these deaths were further analysed by region, the Central plain region (Mandalay, Magway, Sagaing) was found to have the highest proportion. This is likely due to low utilization of Primary Health Care services. As is the case with maternal deaths, the majority of neonatal deaths (87.77%) occur at home.³¹

The main causes of neonatal mortality in Myanmar are illustrated in Figure 3.5. They are prematurity and low birth weight (30.9%), sepsis (25.5%) and birth asphyxia (24.5%). Immediate and effective professional care before, during and after delivery can make the difference between life and death for both women and their newborns.

Figure 3.5: Causes of neonatal mortality, 2002-2003



Source: Overall and Cause Specific Under-5 Mortality Survey 2002-2003. Women and Child Health Development Project, DOH, Myanmar, 2003

The coverage of ANC service, across the country has improved from 42.2% in 2002 to 47.2% in 2005³² and in 2007 antenatal care coverage was 79.8%³³. About one third of pregnant mothers made only one to two ANC visits, while 23% made three to five ANC visits, and 8% made more than six visits. Mothers in remote regions lack health care facilities and are likely not to see any carers for ANC. In Rakhine State, 40.8% of pregnant women receive no ANC, while in Yangon Division only 4.2% do not receive ANC. There is a distinctive differential between urban and rural women in receiving ANC services both in terms of service utilization, frequency of visits and components of care received³⁴.

In 2007, the proportion of deliveries attended by skilled birth attendants reached 64% compared to 57%³⁵ in 2001 (Figure 3.6). However these figures include number of deliveries attended by AMWs and trained TBAs, which are not regarded as SBA by WHO. Thus, there is still need to deploy more

²⁸ Neonatal and Perinatal Mortality - Country, Regional and Global Estimates 2004, WHO/HQ, 2007

²⁹ Overall and Cause Specific Under-5 Mortality Survey 2002-2003. Women and Child Health Development Project, DOH, Myanmar, 2003

³⁰ Ibid

³¹ Ibid

³² Myanmar RH end of programme community survey, 2005, UNICEF

³³ Fertility and Reproductive Health Survey, 2007, DOP and UNFPA, October 2009

³⁴ 5 year RH National Strategic Plan, 2004-2008, MOH

³⁵ HMIS, Department of Health Planning, 2007

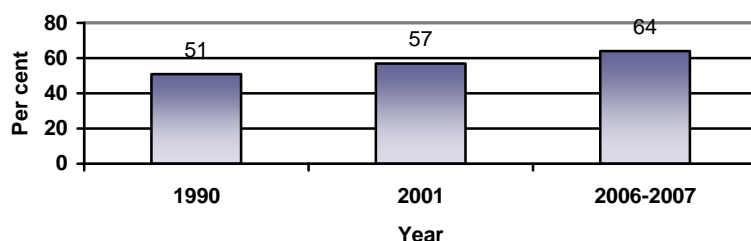
SBA to unreached population for better outcomes of pregnancy. In addition to deliveries assisted by professional skilled birth attendants (doctors 17%, nurses/midwives-47%), deliveries are also assisted by traditional birth attendants (32.6%), relatives (1.7%) and other community members (1.2%). Nationwide the proportion of deliveries assisted by SBAs is slowly but steadily increasing and the proportion of TBA-assisted deliveries is decreasing (Figure 3.7). Again, there is a noticeable difference between urban and rural practices with TBAs still being the sole assistant in almost 40% of deliveries in rural areas compared with only 16% in urban settings³⁶.

The international definition states that a skilled birth attendant (SBA) is:

"an accredited health professional — such as a midwife, doctor or nurse — who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns."

Making pregnancy safer: the critical role of the skilled attendant. A joint statement by WHO, ICM and FIGO, WHO, Geneva 2004

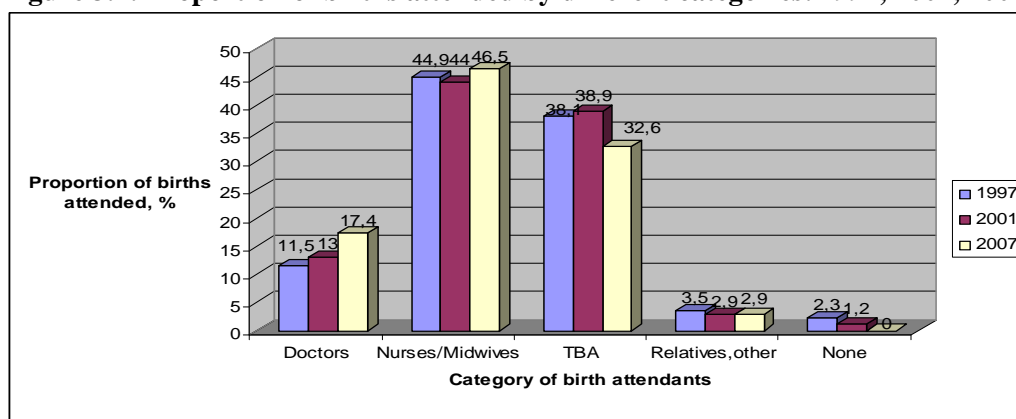
Figure 3.6: Proportion of births assisted by skilled attendant: trends, 1990-2007



Source: HMIS, Department of Health Planning, 2007.

Figure 3.7 shows the proportion of births attended by different categories of personnel and it is evident that midwife, AMW and TBA remain highest of all and delivery at home constitutes 76.4% of all deliveries.

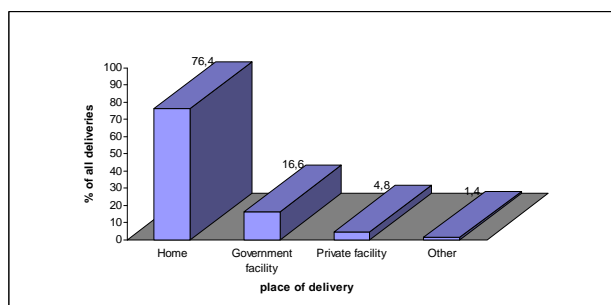
Figure 3.7: Proportion of births attended by different categories: 1997, 2001, 2007



Source: FRHS 1997, 2001, 200

³⁶ Fertility and Reproductive Health Survey, 2007, DOP and UNFPA, October 2009

Figure 3.8: Proportion of deliveries by place, 2007



Source: FRHS, 2007

The government's goal to secure at least 1 midwife per village to provide professional care during pregnancy and childbirth is a challenge. The quoted 1:2 ratio of MW and AMW per village reflects a current status of a heavy reliance on the AMWs who work as volunteers, are not trained to a high level of proficiency and are not in a position to handle a full range of midwifery services, especially those related to life saving skills.

A needs assessment on RH³⁷ found that there are three common delays in seeking medical care: 1) delays in decision making at home, 2) delays in reaching health facilities, and 3) delays in getting adequate care at the health facility.

Socio-economic status and psycho-social aspects of reproductive health behaviour are among important determinants influencing health seeking behaviour. There is need for further research to understand the causalities in Myanmar's context. In connection to this, the initiatives on promoting qualitative studies such as community-based verbal autopsy for investigating maternal death cases are underway in selected townships to find the gaps in the community support and maternal healthcare.

To support the provision of professional childbirth care at home, midwifery kits are made available for every midwife at the rural sub-centers so they can carry and use it for assisting home deliveries at the community level. However, oftentimes the quality of midwifery services is confronted by inadequate supplies of essential drugs, non-adherence with the established standards due to lack of knowledge and skills, unavailability of supplies and availability of authorization for a staff to perform the clinical intervention. In the event of complications during pregnancy, delivery or postpartum, the role of established active home care practices in the community becomes crucial along with the capacity of communities to recognize danger signs for both mother and newborn and in order to seek timely professional care.

Some of the field observations in this regard include the following:

- while Oxytocin is the first line drug for the Active Management Third Stage Labour (AMTSL), MWs and AMWs do not have official permission to administer Oxytocin;
- most health personnel do not have experience and confidence to administer Magnesium Sulphate for the management of hypertensive disorders in pregnancy;
- there is discrepancy in dosage guidelines within DOH, some suggest 600 mg misoprostol for the AMTSL, and some 400mg dose, with differences in mode of administration;³⁸
- albeit a number of trainings being received, the use of "Partograph" is very limited in actual practice;
- newborn resuscitation is limited to suction ball and tube and there is little or no facility for care of low birth weight newborn at RHC level.

Community Support Groups (CSGs) are formed in townships, a partnership between UNFPA and Central Health Education Bureau (CHEB) implemented in 40 townships. The CSG members are volunteers from the village and are assigned one for every 30 households. They support the community with health education and form a bridge between BHS and the community. The Myanmar

³⁷ A reproductive health needs assessment in Myanmar, 1999, MOH-UNFPA.

³⁸ WCHD and MCH guidelines for use of Misoprostol

Red Cross Society (MRCS) and Myanmar Maternal and Child Welfare Association (MMCWA) are national NGOs with wide network of volunteers at all levels of administration that form a bridge between the patient and health care provider in times of emergencies.

Women are encouraged to come to the RHC for postnatal care (PNC) 45 days after delivery. The content and coverage of PNC services needs to be strengthened to include postnatal check-ups, management and referral in case of maternal and newborn emergencies, counselling for birth spacing, follow-up on exclusive breast feeding, newborn care, and immunization. Value would be added to PNC by including an educational component teaching women and their families good self-care practices in order to improve linkages between the communities and health system.

5.2. Abortion

Induced abortion is illegal in Myanmar. There is a high unmet need for birth spacing services and a significant number of unwanted pregnancies. These factors result in a large number of induced abortions under unsafe conditions³⁹, leading to complications, maternal morbidity and mortality. According to hospital statistics, the number of abortion per 100 deliveries slightly declined from 27 in 2005 to 24.7 in 2007.⁴⁰ Evidence suggests that women undergo abortion under unsafe conditions and tend to approach health care providers late for management of complications. Provision of services for management of complicated abortions, post-abortion counselling and post-abortion birth spacing services have improved slightly. However, these factors still pose a challenge.

The Union of Myanmar Penal Code section 312 states that “whoever, voluntarily causes a woman with child to miscarry shall, if such miscarriage be not caused in good faith for the purpose of saving the life of the woman, be punished with imprisonment of either description for a term which may extend to three years, or with fine, or with both; and if the woman be quick with child, shall be punished with imprisonment of either description for a term which may extend to seven years and shall be liable to fine.

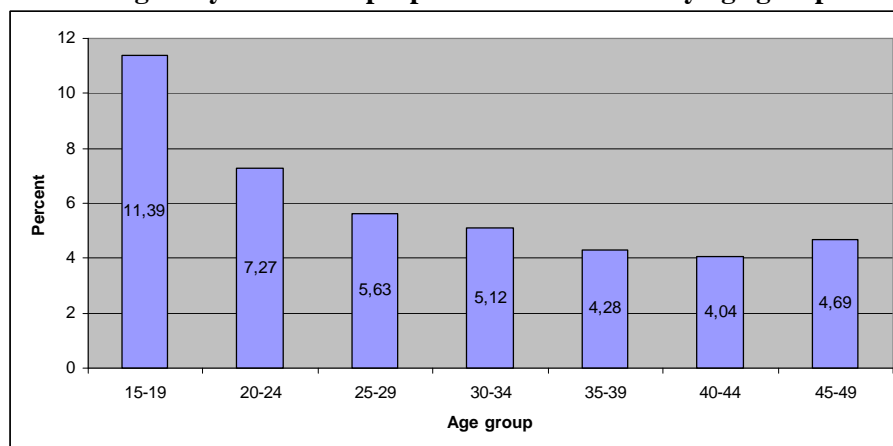
According to the 2007 FRHS, almost 5% of all pregnancies end in abortion⁴¹. This proportion was higher among urban women (6.89%) than rural (4%) and higher in pregnancies of young women (Figure 3.8). The abortion rate is positively associated with the level of education; women with a higher education are more likely to choose abortion.

³⁹ WHO, 2005

⁴⁰ Annual Hospital Statistics Report, 2007, MOH, DHP, page 32, Table 11: Number and percent of delivery, live birth, still births and abortions in 2005 to 2007. (States, Division and Union)

⁴¹ Nation-wide cause specific Maternal Death Survey, 2004-2005, Yangon, UNICEF, 2006.

Figure 3.9: Pregnancy outcomes: proportion of abortions by age group



Source: 2007 FRHS

According to the 2004-2005 NCSMM Survey, 9.86% of maternal deaths were due to complications of unsafe abortion⁴². The proportion of deaths due to abortion related complications are very high in some rural areas. For example, the proportion was 15.39% in the coastal region (Mon, Rakhin and Tanintharyi) and as high as 23.81% in the Ayeyarwady Delta region. Specific hospital studies can have shocking statistics. A study of maternal deaths at North Okkalapa General Hospital in Yangon, which has a very large sub-urban catchment area, show that septic abortion contributed to 53% of all maternal deaths⁴³.

According to FRHS 2007, abortion is highest in the youngest age group 15 to 19 years amounting to 11.39 % of total pregnancies of that age group.

A hospital based cross-sectional descriptive study on the socio-demographic determinants of abortion and assessment of contraception knowledge conducted with 100 patients admitted for abortion showed that the determinants of repeated abortion were very early age of marriage, increasing number of children alive, unplanned pregnancy and poor practice of birth spacing methods.⁴⁴

A small study on septic abortion showed that majority of abortions were performed illegally and while women did know about the dangers of induced abortion they conducted abortion due to economic reasons⁴⁵. According to the 2004 Family and Youth Survey⁴⁶, the traditional birth attendant's home was the most often sited place for inducing abortion. Unsafe abortion practices by an unqualified practitioner are predominantly responsible for complications post-abortion and deaths of young mothers. Lack of access to birth spacing services, unawareness of dangers of induced abortion if performed by untrained birth attendants, and delays in accessing qualified care all affect the tragedy of abortion-related deaths.

The Situation Analysis (SA) team found that when asked about unintended pregnancies, the majority of young people stated that abortion should not be an a primary option in managing unintended pregnancy, and that both partners should take responsibility, and jointly make decisions on how to face the consequences of pregnancy. Most young people were able to name at least 6 methods of contraception as mentioned in the analysis and with regard to HIV and STI and young people are

⁴² Nationwide Cause Specific Maternal Mortality Survey 2004-2005. Yangon: MOH, UNICEF, 2006

⁴³ Win Win Mya. Causes of maternal death, North Okkalapa General Hospital (1992-1998)

⁴⁴ Theingi Maung Maung, determinants of abortion in Thingangyun San Pya hospital, 2003.

⁴⁵ Win, Nellie. Septic abortion is associated with economic factors. Thesis, BNSc; Yangon: Institute of Nursing.

⁴⁶ Ministry of Immigration and Population and UNFPA. Family and Youth Survey 2004: Country Report. Yangon, October 2006

aware of the mode of transmission and prevention of HIV and STI. They also stated that they need sufficient SRH services tailored to adolescents' need⁴⁷.

5.3. Birth Spacing

The total fertility rate (TFR), indicating the mean number of children born to a woman⁴⁸, indicates a post-transitional stage in fertility in Myanmar, with a below-replacement level of 2.03 (urban 1.68, rural 2.18) in 2007⁴⁹, a gradual decline from 3.4 in 1990 and 2.4 in 2000-2001⁵⁰ (refer to the Chapter 2 for more information). While the rural TFR declined sharply from 3.28 in 1997 and 2.8 in 2000-2001 to 2.18 in 2006, urban fertility remains substantially lower (TFR 1.97 in 2001 and 1.68 in 2007). The mean number of children born to married women was 4.7 (FRHS 2007) in 2006.

The decline in fertility levels could be attributed to delays in age of marriage and first birth, an increase in proportion of never-married women⁵¹ and increased use of modern methods of contraception among women. Again, remote areas such as Rakhine, Chin and Sagaing States have vulnerable populations with high fertility rates. Language barriers of ethnic minorities who are not literate in the Burmese language hinder effective use of RH services.

Although the legal age of marriage is 20 years for a woman by Customary Law, she may marry younger by parental consent, and consent is usually given if marriage partners are deemed suitable.⁵² The singulate mean age at marriage increased from 21.2 years in 1973 to 25.8 in 2001 for women and 23.8 years in 1973 to 27.6 years in 2001 for men. The proportion of never married has increased over the years for both females and males. It is 44.9% and 46.4% for women and men of age 15-49 respectively⁵³.

According to the 2007 FRHS, the mean age at marriage was 21 years for women and 24.1 years for men and. There is a direct correlation with level of education; the higher level of education, the older age at marriage. The changes in demographics of high proportion of never married as well as the high level of abortion in 15-19 age group, implies that RH care and support need to specifically target 15-19 adolescents, and the population of never married women and men in age group 15 to 49 year old who are likely to be sexually active. While there are strong cultural values against premarital sex, there is a high demand for reproductive health information and services from married and unmarried adolescents. Young women in particular face barriers based on social and cultural values, in accessing reproductive health services, including those for birth spacing. Adolescent fertility in Myanmar is mostly related to early marriage.⁵⁴

As mentioned in Chapter 2, the mean age at first birth for Myanmar women is 22.8 years. A very low proportion of women (1.9%) had their first birth before age 15. Slightly over one quarter had their first birth before age 20 (FRHS, 2007). Forty five percent of women had given birth before age 22 and another 41% had their first birth between age 20 and 24. These are suggestive of a good standard of reproductive management.

The official recognition of birth spacing strategies began in 1992 (with UNFPA assistance) and has been actively promoted since then. Before that, female sterilization services were common and other

⁴⁷ Annex 3, Findings of FGD, Situation Analysis, UNFPA 2009

⁴⁸ Actually this indicates the number of children a woman would have during her reproductive life if she experienced the prevailing rates of fertility at each age.

⁴⁹ TFR in 2006 was 2.1 according to UNICEF Myanmar: http://www.unicef.org/infobycountry/myanmar_statistics.html

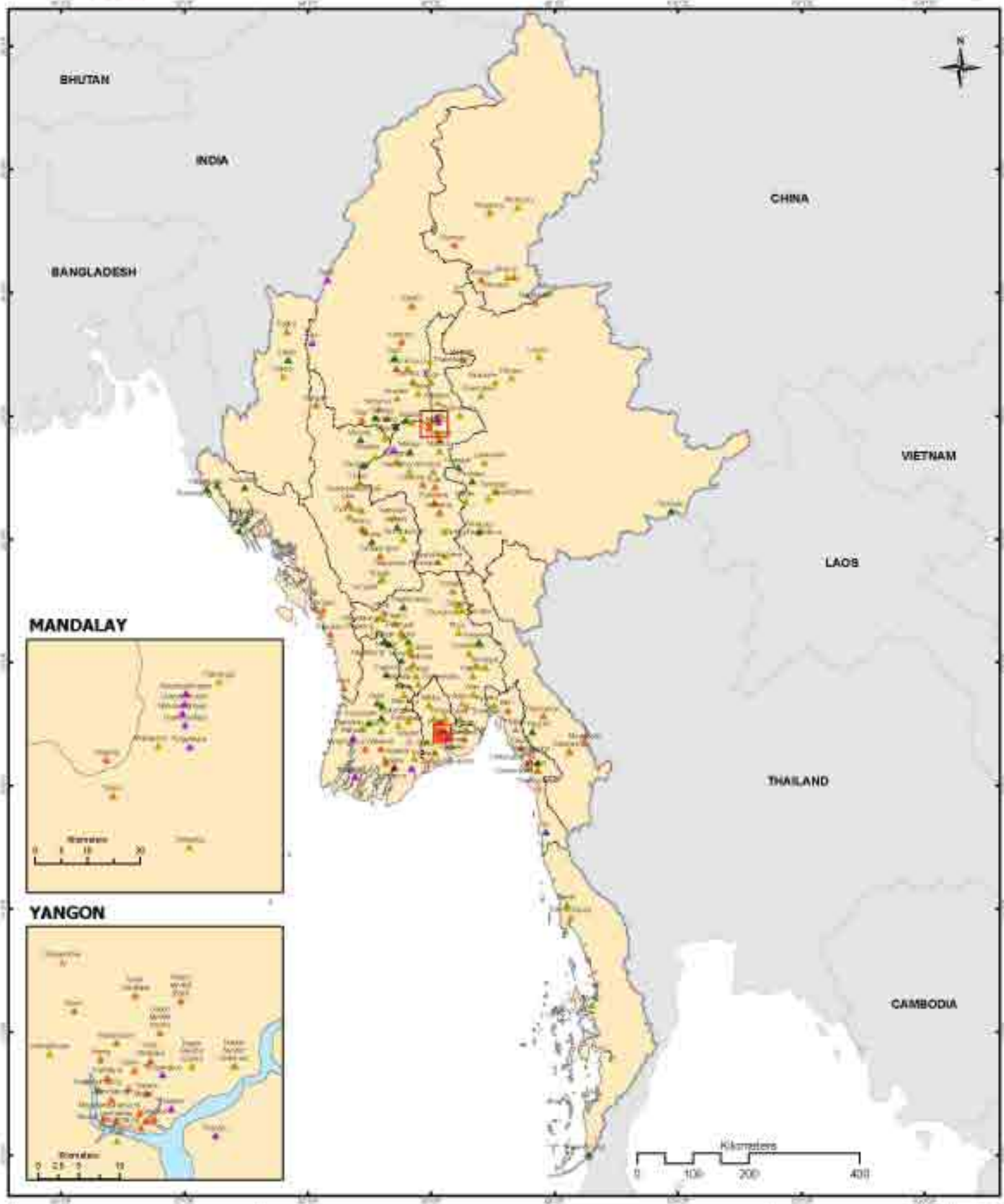
⁵⁰ Ministry of Immigration and Population and UNFPA The 2001 Myanmar Fertility and Reproductive Health Survey, Yangon, December 2003

⁵¹ Ministry of Immigration and Population and UNFPA Detailed Analysis on Fertility and Reproductive Health Survey Yangon, 2001

⁵² Myanmar FRHS Detailed Analysis Report 2001, Yangon Myanmar 2004.

⁵³ Myanmar FRHS 2001 Country Report, Yangon, Myanmar 2003

⁵⁴ Myanmar, Birth Spacing review, http://www.searo.who.int/linkfiles/family_planning_fact_sheets_myanmar.pdf, accessed on 11 June 2010.



MANDALAY



YANGON



Legend

- | | | |
|-----------------|-----------------|------------------------|
| UNFPA, ISI | UNFPA, MSI | State Boundary |
| UNFPA, ISI, MSI | UNFPA, ISI, MSI | International Boundary |
| ISI | MSI | |

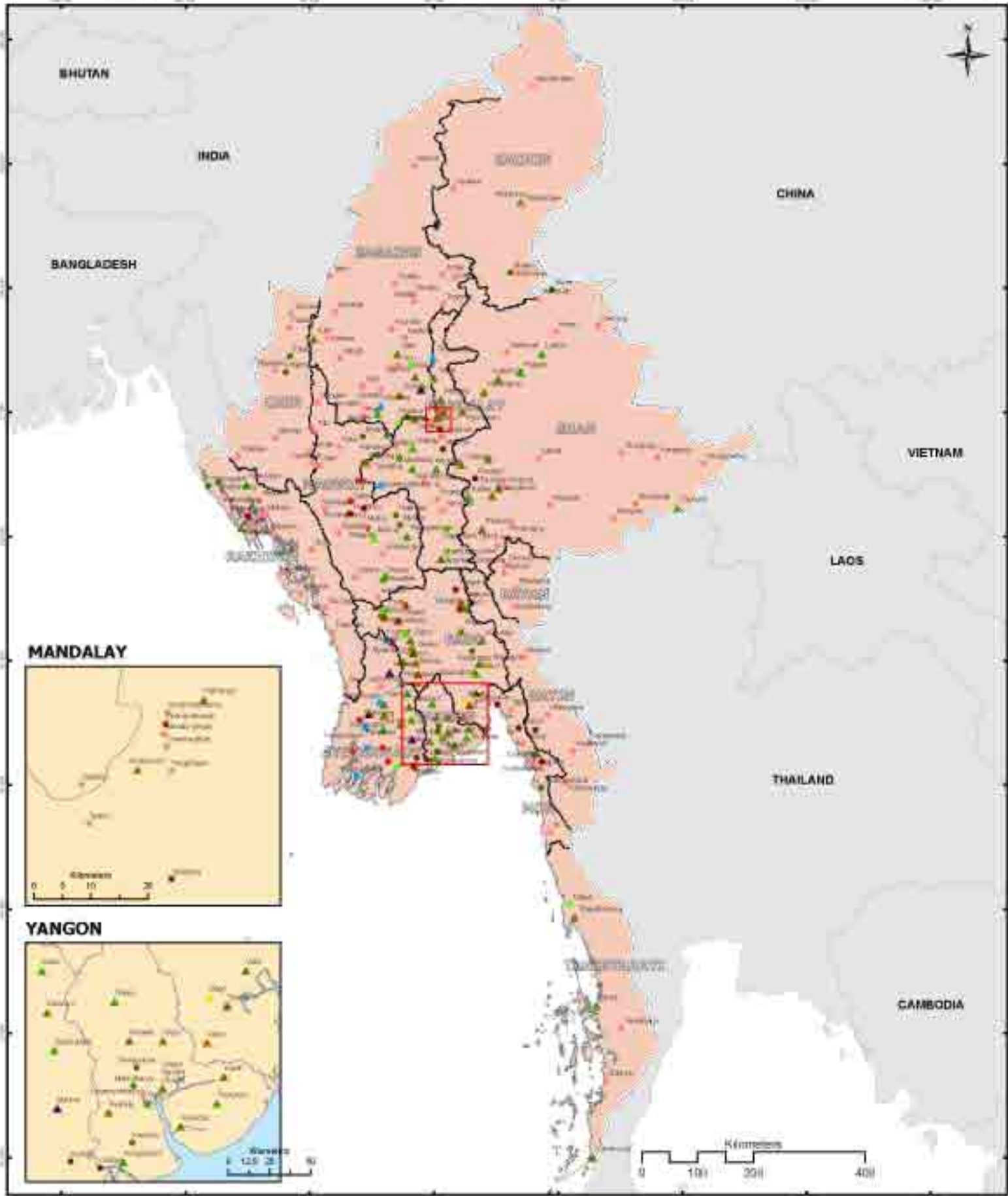
Map ID: MIMU460v01
 Creation Date: 26 April 2010, A4
 Projection/Datum: Geographic/WGS84
 Map produced by the MIMU - info@unmim.org



Data Sources: UNFPA, PSI, MSI
 Boundaries: WFP modified by MIMU



Integrated Map of DOH Service Delivery Points Supported by UNFPA, UNICEF and WHO working in Myanmar



MANDALAY



YANGON



Map ID: MIMU348v02
 Creation Date: 23 April 2010, A4
 Projection/Datum: Geographic/WGS84
 Map produced by the MIMU - info.mimu@unm.org

- | | | |
|------------------|----------------|---------------------------|
| ● WCHT | ● WCHD/ENC | ● RH/ENC |
| ● WCHD/RH | ● RH | ● RH/ENC/CH |
| ● WCHD/RH/HV | ● RH/HV | ● RH/CH |
| ● WCHD/RH/HV/ENC | ● RH/HV/ENC | ● ENC |
| ● WCHD/RH/ENC | ● RH/HV/ENC/CH | — International Boundary |
| ● WCHD/RH/CH | ● RH/HV/CH | — State/Division Boundary |

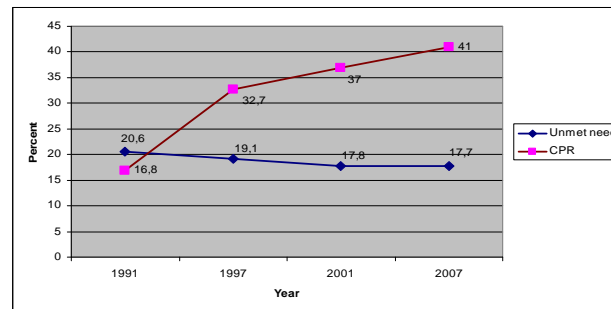
Data Sources:
 UNFPA, UNICEF/WHO
 Boundaries-WFP modified by MIMU



methods of contraception were available through private pharmacies. Myanmar demonstrated a gradual increase in its contraceptive prevalence rate (CPR) reaching 37% in 2001 (32.8% using modern methods and 4.2% - traditional methods) and 41% in 2007 (38.4% for modern methods). The 2009-2013 Reproductive Health Strategic Plan sets the target for CPR of 45% (modern methods) by the year 2013.

With the increase in the contraceptive prevalence rate, the unmet need for contraception of currently married women has moderately decreased from 20.6 in 1991 to 17.7 in 2007 (Figure 3.10).

Figure 3.10: Trends in Contraceptive Prevalence Rate and Unmet Need among married women, 1991-2007



Source: FRHS, 2007

Nationally, the unmet need for contraception in 2006 was estimated at 17.7% of all currently married women of reproductive age (4.9% for spacing and 12.8% for limiting)⁵⁵, a slight reduction from 19.1% in 1997 (5.8% for spacing and 13.3% for limiting)⁵⁶. The unmet need for contraception may be underestimated and would probably appear to be much higher if unmarried women were also included in the data.

The choice of contraceptive method is usually influenced by the availability of options locally and the influence of the method promoted by national family planning programmes. Birth spacing services in Myanmar are provided through both the public and private sectors. Oral contraceptives, injectable contraceptives, condoms and IUDs have been made available through the public sector since 1991, and are currently provided at the subsidized rates in 132 of the country's 325 townships. Myanmar has limited resources for RH commodities and UNFPA supplies contraceptives to 122 townships across the country. Another 10 townships are supported through German bilateral assistance.

The MOH logistics supply chain transports oral pills, injectables and condoms for distribution at the RHC level, while IUDs are made available at the township level. There are 193 townships without public health support for contraceptive commodities. In these locations, it is common for private vendors to fill the gap for demand for contraception by supplying mainly condoms and oral contraceptives. The most widely used methods of contraception are three-monthly injectables (14.9%), followed by daily combined oral pills (8.6%) (Figure 3.10). There is a minimal use of IUDs and condoms. While promotion programmes are in place, the use of condoms for dual protection is not a common practice.

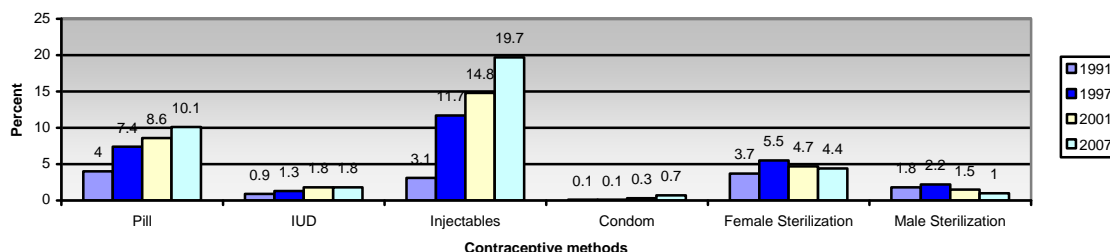
In theory, female sterilization is available through the public sector in all township hospitals. However, permission for sterilization procedures must be granted from a state/division-level board. Female sterilization is more likely to be performed under certain conditions, for example if the patient has health complications or is HIV positive. Due to the tedious amount of paper work for patients to obtain a formal clearance for sterilization (approval can take between 3 to 5 months), the choice of

⁵⁵ Fertility and Reproductive Health Survey 2007, DOP and UNFPA, October 2009

⁵⁶ Ministry of Immigration and Population, UNFPA. Detailed Analysis on Fertility and Reproductive Health Survey. Yangon, 2004

this permanent method has not been widely used⁵⁷. Male sterilization is restricted by law to men whose wives have been approved for female sterilization, but are unable to undergo sterilization for medical reasons⁵⁸. A study in the Pyin Oo Lwin military community showed that male sterilization is not a method of choice as 30% of married couples held the cultural misconception that a vasectomised male loses his strength and stamina, and cannot do hard work very well.⁵⁹

Figure 3.11: Contraceptive method mix among currently married women, 1991-2007



Source: Myanmar Fertility and Reproductive Health Survey 2007.

Emergency contraceptive pills are included in the public supply chain and are also available in private pharmacies. Anecdotal evidence suggests that women often obtain low quality or counterfeit drugs from the private market. Data on quality, use and effects of contraceptives available from private pharmacies is not depicted in health statistics and remains a subject for further research. More evidence is required to learn about the magnitude and consequences of the use of monthly contraceptive pills available over-the-counter in private pharmacies.

Knowledge of different methods is a crucial determinant of contraceptive use. According to the 2007 FRHS, over 95% of the population have the knowledge of at least 3 methods of contraception. Fifty-two percent of respondents mentioned private sources and forty-two percent mentioned government outlets as sources for contraceptive supplies. Government facilities are known as the main source for female sterilization (84.2%) and the IUD insertion (51.2%), while private drugs stores and shops are known as the major source for contraceptive pills (over 70%) and condoms (61.1%). Respondents cited private health clinics as a major source for injectable contraceptives, followed by government nurses or midwives and private drug stores.

There are considerable differentials in the use of contraceptives, both among urban-rural and rich-poor population groups. Nearly 49% of currently married urban women are using a modern contraceptive method compared with only 34% of rural married women. Among the regions, contraceptive use is the highest in Yangon Division (57%) followed by Bago (45%) and Mandalay (42%). The lowest CPR rates are in Chin and Sagaing (28%). The use of traditional methods among married women in 2007 accounted to 2.5%, a decline from 4.3% in 1997 and 4.2% in 2001.

⁵⁷ Field Assessment, 2009

⁵⁸ Myanmar-Birth Spacing overview, http://www.searo.who.int/linkfiles/family_planning_fact_sheets_myanmar.pdf, accessed on 11 June 2010

⁵⁹ Thein Myint Thu, Kyaw Min et al, Perceptions, beliefs, acceptability, agreement between husband and wife about vasectomy and female sterilization in military community, 5th Myanmar military medical conference, Yangon, 1995.

An NGO case study: Population Services International Myanmar (PSI-Myanmar)

Population Services International Myanmar (PSI-Myanmar) operates social franchising programmes in 162 townships in Myanmar, making available five contraceptive methods (combined oral contraceptives, one-month injectables, three-month injectables, male and female condoms and emergency contraceptive pills). IUD insertion has not been a very popular method of contraception with women coming to government health facilities*. However, PSI has been able to encourage IUCD use in recent years. A total of 11,570 IUCDs have been inserted by six PSI/Myanmar IUCD teams at 214 reproductive health events between July 2008 and April 2009. IUCD insertions have also increased at PSI affiliated Sun Quality Health clinics. A total of 5,938 IUCDs were inserted in from July 2008 to April 2009, as compared to 200 in 2007**. PSI/Myanmar IUCD teams have been successful in increasing the availability of long-term methods at Sun Quality Health clinics, by utilizing existing clinics within their social franchise network to conduct reproductive health events which target broad sectors of Myanmar society. The success of PSI's IUCD promotion shows that NGOs have a strong role to play in promoting contraceptive use. It is important that all actors of public, private and NGOs working in RH should follow Standard Operational Procedures in the providing contraceptive services.

* SA findings, Annex 3, UNFPA- 2009

** Increasing Availability of Intrauterine Contraceptive Device Within A Social Franchised Network Through Use Of Reproductive Health Days, [Jayne Rowan](#)¹, [Nyo Nyo Minn](#)¹, [Dan Rosen](#)², ¹PSI/Myanmar, Myanmar; ²PSI, International Conference on family Planning , research and best practices, Kampala, Nov 15-18, 2009

The effective implementation of a pro-poor cost-sharing policy for contraceptive supplies remains a challenge to make the availability of modern contraceptive methods free-of-cost or at subsidized rates in reality. Problems also exist for sound logistic management system for forecasting, procurement, warehousing, distribution and inventory control of reproductive health commodities. This includes supply of reproductive health commodities and contraceptives resulting in intermittent stock-outs at the facility level and affecting the end-user.

Out of six selected states and divisions visited by the Situation Assessment team five had stock-outs of contraceptives at all levels for one or more contraceptive methods. All five methods of contraception were not available at a given time for a woman to choose. Basic health staff is responsible for recording and reporting of requirements and utilization of contraceptives through completion of RHMIS forms on a regular (monthly) basis in the UNFPA-supported project township which is compiled by the DHP. However, distribution of RH commodities are done by the MCH, DOH by quota system which is a “push” system based on a quota developed at the central level. The basic health staffs need to be trained in projection of contraceptive requirements, and the needs-based supply is yet to be implemented.

Though the Government is putting its efforts with the assistance of UNFPA to set up efficient Logistic Management Information System (LMIS), the system is not able to predict and deal quickly with stock-outs. Better planning and projections of requirements should be done at the Township level. Weakness in accountability, knowledge on proper warehousing and distribution of contraceptives and RH kits amidst disrupted infrastructure after the cyclone Nargis proves to be a barrier for timely distribution of supplies to hospitals and health centers in post crisis situation. However, the report of national advocacy meeting on Reproductive Health Commodity Security showed high level commitment in the MOH to ensure RHCS in the country.⁶⁰

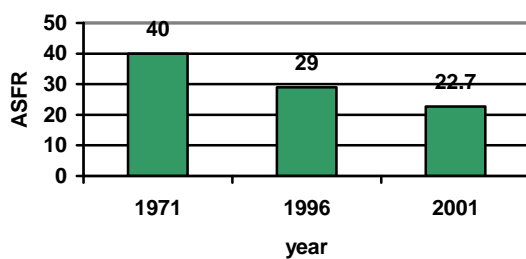
⁶⁰ Report on national level advocacy meeting on RHCS, Nay Pyi Taw, UNFPA-MOH, Jan 2009

5.4. Reproductive health of adolescents and youth

Adolescence has been defined by the World Health Organization as the period of life spanning the ages between 10 and 19 years, and youth as between 15 and 24 years. Myanmar has estimated population of 57.5 million⁶¹ and is estimated that the proportion of young people is reduced to 19.2% from 20% in 2001. Young people are the future of every society and also a great resource of the nation and they constitute one fifth of the total population⁶². They are also a large population group, with widely varying risk behaviours and vulnerabilities to reproductive health problems and HIV/AIDS. They also include high risk population such as mobile population and sex workers and their clients.

Trends in age specific fertility rate for the age group 15-19 are declining (Figure 3.12). Percent of TFR attributed to age group 15-19 was 3.37% in 2002⁶³ and was less than 4 to 5% in 2007⁶⁴ (with urban ASFR proportion of 1.2% and rural of 0.7%). According to the 2007 FRHS only 1.9% of women had their first birth before age 15 and slightly over 25% had their first birth before age 20. Rakhine State has the lowest age at first birth (refer to Chapter 2 for details).

Figure 3.12: Trend in age-specific fertility rate (per 1000 women) among girls aged 15-19, 1971-2001



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

Usually married adolescents 43.8% uses modern methods of contraception single women were not included in the survey questions on contraception use, since pre-marital sex is discouraged and considered a sensitive issue⁶⁵. However, unmarried adolescents may not use contraception due to lack of knowledge or limitation in access or due to social barriers and may be prone to unsafe abortion in case of unwanted pregnancy. Sixteen percent of youth approved of pre-marital sex for boys while only seven percent of youth approved of pre-marital sex for girls.⁶⁶ FGD conducted during field trip revealed that all young people perceived that socio-culturally Myanmar youth should not be involved in pre-marital sex, however, majority expressed that there is increased numbers of young people engaged in pre-marital sex in Myanmar and result in unsafe abortion which might be the tip of the iceberg⁶⁷.

Among currently married women, knowledge of at least one contraceptive method and its source is high among age group 15-19 (97.3% and 97.3% respectively, 2007 FRHS). According to the 2007 FRHS 11.39% of pregnancies in married adolescent aged 15-19 ends in abortion. The 2004 Family and Youth Survey conducted by the Department of Population, Ministry of Immigration and

⁶¹ CSO, 2009, Statistical Yearbook 2008

⁶² Family and Youth Survey, 2004, MIP, DOP.2006.

⁶³ Myanmar Reproductive Health Baseline Community Survey, 2002

⁶⁴ Fertility and Reproductive Health Survey 2007

⁶⁵ Country report FRSH, 2007

⁶⁶ Family and Youth Survey, 2004 country report, Yangon, October 2006, Department of population, Ministry of Immigration and Population and UNFPA

⁶⁷ Annex 3, Findings of FDG, with adolescents, 2009

Population and UNFPA⁶⁸ reports that 78% of interviewed youth indicated TBAs home as the place where abortion can be done. Home (40%) and private clinic (36%) were the other often cited places

Adolescent and RH issues, the study of reproductive health issues among 15 to 24 years old out of school young people indicated that 45% and 21% of married boys and girls respectively expressed that they had sexual experience before marriage whereas 20% and 2.5% of unmarried boys and girls respectively admitted they had sexual experience before marriage. This study also noted that during first time sex usual partners for girls are mostly spouse (79%) and boyfriends (13%) and fiancée (6%) whereas 32% of boy's first time sexual partners are casual acquaintances (5%) and CSW (27%) and spouse (34%), girl friends (31%), fiancée (3%). The median age of first time sex for boys is 19 years with the range of 13 to 24 years and for girls is 18 years with the range of 13 to 23 years⁶⁹.

Protection of the youth and adolescents from sexual and reproductive health problems essentially depends on the correct knowledge of the physiology of human reproduction. According to the Family and Youth Survey 2004, young population has reproductive and sexual health information and is aware of the issues; however correctness and accuracy of knowledge is not warranted of a high standard. More than half of youth responded that they are having some information about sexuality related health while 76 % of males and 69% of females expressed that they are willing to get information about sexuality⁷⁰.

For contraceptive awareness among youth is very common (85%) and an average youth knows about 5-6 types of contraceptive methods. The major reproductive health information source for young people is reportedly their peers. Evidence suggests that sexual issues are discussed openly between peers, particularly boys⁷¹.

Concerning health seeking behavior, this survey observed that most of the youth have self medication and it was found that the more educated, the more they use something to prevent pregnancy, STIs and HIV/AIDS and 4% of male youth had sex outside wedlock and among them 80% use condom⁷².

Concerning the adolescent pregnancy, adolescent Reproductive Health at a Glance in Myanmar (WHO-SEARO-2007) reported that adolescent pregnancies in 1998 were reported to 8.9% of total pregnancies in Yangon. Unmarried girls and young women are especially to unwanted pregnancies because reproductive health services are targeted only at married women.

A WHO study of risk behavior and attitudes among ninth standard students showed that 2.9% of them had engaged in unprotected sex. In addition, one study showed that a sizeable number of pregnant adolescents (e.g. 26% of 15-19 years old and 20% of 20-24 years old) sought no antenatal care. This may have been due to the lack of awareness regarding pregnancy related issues and available services. Many factors increase young people's vulnerability to HIV during these years of rapid physical and psychological development. These factors include lack of knowledge about HIV/AIDS, lack of education and life skills, poor access to health service and commodities, early sexual debut, sexual coercion, violence, trafficking and growing up without parents or other forms of protection from exploitation and abuse. Influenced by socio-economic factors, contemporary social norms and life-styles, young adults tend to acquire risky sexual behaviours. While adolescents do have high level of awareness on STIs/HIV (75% for STI and 91% for RTI)⁷³, detailed knowledge is limited.

Trafficking is a criminal and illegal trading of human beings for the purpose of exploiting their labour. Young people are more likely to be the victims of trafficking. This is particularly true for crisis and

⁶⁸ Family and Youth Survey, 2004 country report, Yangon, October 2006, Department of population, Ministry of Immigration and Population and UNFPA

⁶⁹ Ibid

⁷⁰ Ibid

⁷¹ Ibid

⁷² Ibid

⁷³ Than Nu Shwe, Socio-economic background and behavior of adolescent pregnancy, 1999, Yangon

post-disaster situations when there is a breakdown of community norms and protection. While there is no national level data on trafficking, the 2004 FAYS reported that 87% of youth had ever heard about the term trafficking and out of them 71% suggested that 15-19 age group was most likely target for trafficking and another 20% suggested age group 20-24. Girls are especially vulnerable and are likely to be influenced by false job offers, promises of marriage and better life.

Adolescent population in general enjoy good health and are less likely to seek health care by their own initiative unless referred by older family members or guardians for health problems. Thus problems related to reproductive health would pose a real challenge to adolescents due to lack of knowledge, cultural expectations and economical dependency. In the absence of acceptable services, adolescents might be prompted to seek health care outside the formal system to resolve the problem discreetly and at the lowest cost. There is the need to promote responsible sexual behaviour, increase access to sexual education and methods of preventing STD/HIV infection. Reproductive health services and information can improve the health status of adolescents and help them attain the level of understanding required to make responsible decisions. Participation of young people in planning, implementation and monitoring of services could ensure they are adolescent friendly. Adequate support from the education sector and the community should be encouraged to support the initiative. The 2008-2012 National Strategic Plan for Adolescent Health and Development addresses general issues of adolescent health and defines strategies for adolescents' reproductive health in particular by supporting adolescent-friendly health services. The latter includes, among others, provision of diagnosis and treatment of sexually-transmitted infections, provision of voluntary counselling and testing for HIV, provision of counselling and contraceptive services, antenatal, delivery, postnatal, and post-abortion care.

A strategy promoting HIV related reproductive and sexual health education for young people has been developed in cooperation with Maternal Child Health, Reproductive Health and School Health Section of DOH. National AIDS Programme in coordination with Department of Educational Planning and Training (DEPT), Ministry of Education and UNICEF, has introduced **School Based Healthy Living and AIDS Prevention Education" (SHAPE)** Programme since 1997. In 2006, **National Life Skills Curriculum** based on SHAPE developed by Ministry of Education and is being implemented in schools all over the country. HIV education is part of the curriculum in primary, secondary schools and teacher training in cooperation with Ministry of Education.

In coordination with UNFPA and Central Health Education Bureau, Department of Health, JOICEP and NGOs such as MMA, MRCS, AFXB and MSI, adolescent and youth programme are established in both in urban and rural areas of 75 townships in order to educate youth on Reproductive Health including HIV/AIDS prevention and develop social skills through formation of youth centre, peer education programme, Quiz competitions, song competition and youth fair on HIV/AIDS. In coordination with NGOs, such as Population Services International, condom social marketing and condom promotion activities are being conducted for youths engaged in high risk behaviours. UNICEF in coordination with MRCS has also conducted Prevention of HIV/AIDS among young people in 8 townships.

6. Gynecological cancer and other reproductive morbidities

Gynaecological morbidity refers to reproductive morbidity other than related to pregnancy, abortion, childbearing, and contraception. Gynaecological morbidities, especially reproductive tract and sexually transmitted infections (RTIs/STIs) and cancer of reproductive tract (breast cancer and cervical cancer) significantly contribute to the burden of disease.

In Myanmar the Yangon Cancer Registry Unit was established as part of the Radiotherapy Department of Yangon General Hospital in 1974 and is now headed by the Consultant Medical Oncologist. Currently, cancer registry has been kept in three Radio-oncology therapy units located in Yangon, Mandalay and Taunggyi General Hospitals. The International Classification of Diseases

(ICD-9 and ICD-10) was used and working in collaboration with other clinical departments, the unit publishes yearly reports⁷⁴. According to the cancer registry (1993-2000) three most common cancers for women are cervical cancer, breast cancer and lung cancer, the incidence being 27.4% to 30.7% and 25.3 to 30.6% respectively⁷⁵.

Both cancer cervix and cancer breast present rather late in their disease staging which increases public health burden to the family and country as a whole⁷⁶. However, there is limited information and support from the current programmes to address gynaecological morbidities in Myanmar:

- Myanmar conducted in 2000, a hospital-based case control study which revealed that there was increased risk of cervical cancer in the older age group (40 and above), postmenopausal population, women from family with higher income, smokers and occasional drinkers, education level is inversely related to risk of cancer. Other significant risk factors were teenage marriage, first pregnancy at teenage, multi-parity, especially grand multi-parity and history of stillbirth. Reduced risk was found in contraceptive users. The study concluded that risk factors for cervical cancer in Myanmar women are compatible with known factors of worldwide with few exceptions. There is need to evaluate the association of cervical cancer with Human Papilloma virus infection in patient and her partner husband's sexual behavior⁷⁷.
- Analysis of the Yangon Cancer Registry Report showed that carcinoma cervix had a crude incidence rate of 17.03 among greater Yangon population, and is the leading cause of morbidity and mortality among female cancer patients, and tops the female genital cancer list from 1993 to 1998. Thus, it was suggested that effective screening program needs to be installed for peri-menopausal and post menopausal women nationwide.⁷⁸
- VIA: Visual inspection of the cervix, using acetic acid or Lugol's iodine to high-light precancerous lesions by naked eye shifts identification of cancer cervix from laboratory to clinic. Doctors, nurses and trained midwives can perform this method for early detection of cancer cervix. As a screening test, VIA performs equal to or better than cervical cytology and should be considered in resource limited situations.⁷⁹ VIA could be one way for early detection of Cancer cervix in Myanmar women.
- Of the total malignant neoplasms reported in Hospital statistics neoplasms of female genital organs constitutes 11.7% and breast cancer constitutes 8.8%. Facility-based data suggests that cervical cancer is most common cancer treated at the radiotherapy ward in Yangon General Hospital (28% of all female clients and 17% of all clients). In 2007, hospital statistics showed 69 deaths due to Ca Cervix and 64 patients due to Ca Breast⁸⁰

Cancer Breast: In Myanmar together with cancer cervix, breast cancer is also common cancer according to Cancer Registry of Yangon General Hospital. In 1993, total number of cases was 352, which constituted 26.35% of total female cancer patients and rose gradually to 28.53% in 2006 with a total number of cases 738.

Infertility

Sub-fertility is believed to be a relatively common gynaecological problem in Myanmar, although there is little data available and the community prevalence of sub-fertility is unknown. Causes of infertility vary per studies, most of which are small scale, hospital based studies. In 1995, clinico-epidemiological study on 140 female infertile women attending Gynecological clinic in CWH was done and it showed that disorders of ovulation was 63.3%, bilateral tubal occlusion was 32.1%,

⁷⁴ Interview with Prof. Soe Oo Maung, Prof. and Head, Radio Therapy Department, YGH Nov, 2009

⁷⁵ Cancer statistics , 2000, Yangon Cancer Registry Unit, Department of Radio Oncology, Soe Aung.

⁷⁶ A clinical study of breast cancer patients with HER -2/neu expression status, Myat Soe Khine, 2008

⁷⁷ Than Than Tin, Thidar San, Mya Thida, Saw Ohnmar. Myanmar Health Research Congress, Progr & Abstr, Yangon, 2001:14.

⁷⁸ Soe Aung, Epidemiology of Cervical cancer. 46th Myanmar medical Congress, Yangon, MMA, 2000.

⁷⁹ Sherris J, et al. Evidence -based cervical cancer screening approaches in Low-resource settings. International perspectives on Sexual and reproductive health volume 35, No3, September 2009

⁸⁰ Annual Hospital Statistics Report, 2007, DHP, March 2009,

acquired tubal lesion was 17.8%, abnormal post-coital test 16.4% and acquired uterine and cervical lesions accounted for 9.2%.⁸¹

In another study, primary infertility was found among 95 males, however, no demonstrable cause could be found through available diagnostic facilities for 60% of them. Of the 91 males, who gave a medical history which could be related to infertility, 24 gave a history of having had an STD and 15 had experienced a urinary tract infection⁸². Abnormal semen results, abnormal hormonal results, and abnormal testicular volume were cited as most prevalent indications for infertility among men according to another small study⁸³. In 2007, across all ages, 8.9 percent of the ever-married women (EMW) and 9.1 percent of the currently married women (CMW) have no children⁸⁴. These proportions of women having no children are slightly higher than those from the 2001 FRHS (8.2% for EMW and 8.3% for CMW).

Counselling and basic treatment of sub-fertility is available at township hospitals. Services that are more comprehensive including counselling, physical examinations, investigations, treatment, and follow-up and management are available at the central women's public hospitals in Yangon and Mandalay. Private hospitals may have a limited role in provision of services for management of infertility for the population, but mainly to those who can afford and to those in central urban locations.

Ongoing and expanding services for STIs could be built upon and links made with the provision of sub-fertility services. However, the limited availability of services, and the associated time and costs, make access to services difficult. This is compounded by a low level of community awareness regarding prevention and service availability.

Other morbidities

Obstetric fistula is a medical condition consisting an abnormal opening between the vagina and the bladder resulting from unrelieved obstructed labour⁸⁵. Obstetric fistula is a devastating and preventable tragedy primarily affects poor young women who lack means to access quality maternal obstetric care. Women living with fistula are constantly wet from leakage, have ulceration in genital area, prone to infections and a humiliating stench.

In Myanmar results of a community-based survey in 5 Delta townships in Myanmar involving 333 ever married women of 15-50 years of age to explore situation of physical disabilities following child birth revealed women had urethralcoele (22%), cyctocoele (83%), cervical descent (22%), rectocoele (32%), perineal tear (32%) and enterocoele (14%) and there were only 2 (0.6%) women suffering from vesico-vaginal fistula.

A study by health agencies carried out in Northern Rakhine State (NRS) with a population of 855,000 showed that there were 10-12 cases of obstetric fistula reported, but the number may be higher due to the likely underreporting. Teenage pregnancies and lack of timely obstetric assistance are among common contributing factors resulting in fistula. There is no surgery available in NRS and as women cannot travel to higher levels of care within Myanmar the other option is to go to Bangladesh for treatment; however due to the costs involved, illegality and logistical constraints this option is only available for a very few. Obstetric fistula is reportedly not a problem in other parts of Myanmar illustrating the particularly dire state of EmOC services in NRS⁸⁶.

⁸¹ Khin Pyone Kyi. Clinico-epidemiological study of female infertility 1995

⁸² Than Than Tin et al., 1995

⁸³ Hta Hta Yi, *Infertility in Myanmar*, in *National Seminar on Women's Health: Myanmar, 2001, Yangon*

⁸⁴ Fertility and Reproductive Health Survey, 2007, DOP and UNFPA, October 2009

⁸⁵ Arrowsmith, S., Hamlin C.E., Wall L.L. Obstructed labour injury complex: obstetric fistula formation and the multi faceted morbidity of maternal birth trauma in the developing world. *OB and Gyn Survey*. 51:1996;568-574

⁸⁶ RH Assessment in NRS, Dr. Ann Burton, Dr. Mizamur, 2006, UNHCR, UNFPA,

Detailed research on prevalence of obstetric morbidities need to be conducted at the same time work needs to be strengthened for prevention of genital prolapse and obstetric fistula by improving quality of obstetric care. Dissemination of information about existing care at government health facilities for repair of obstetric morbidities including prolapse and fistula available in State and Divisional Hospitals to the general public will allow women to access health care without further suffering.

Menopause

Post menopausal period is a transitional period in the life of every woman and menopausal symptoms are manifested in varying degrees.

A cross-sectional descriptive, community based study on 1019 post menopausal women from 2116 households in a peri-urban town-North Okkalapa was conducted. Women aged over 45 constituted 11.43% of the total population and 89.5% of age over 45 were post-menopausal. The highest percentage became menopausal between the ages 46 and 50. Approximately 82% of women gave history of climacteric symptoms and the commonest being hot flushes, night sweats, insomnia, irritability, and mental depression. Over half of women never took treatment and 42.5% gave history of taking indigenous medicine and 0.2% took high potency vitamins.

In addition to physical symptoms psychosexual problems are not uncommon and it should be taken into consideration in the management of menopausal symptoms⁸⁷. Out of 194 married post menopausal women studied, 89.2% said that they were sexually active, among which 74.6% responded to have psychosexual problems and sexual interest decreased with age. The study revealed that only 16.2% had frank discussions on psychosexual problems with their husbands and most were reluctant to declare their problems to a stranger but discussed with intimate peers and took advice from them.

While the health care for problems associated with menopause is largely ignored, the researchers recommend that care for menopausal women should be established and definite guidelines to be laid down with operational research as part of the clinical work⁸⁸.

7. Reproductive health in emergencies

Reproductive health services in emergencies are considered as “life-saving” as women and girls continue to get pregnant and give birth during and after crises. Lessons from humanitarian actions for victims of devastating cyclone Nargis (May, 2008) which affected 37 townships in Ayeyawady and Yangon Divisions, demonstrated the necessity for actions to ensure reproductive health in emergencies and to reduce the elevated risks of morbidity and mortality among displaced populations as a priority for emergency preparedness and response actions. Vulnerable groups requiring special consideration include very poor households, pregnant and lactating women, female-headed households, widows with young children, elderly and people with HIV.

The Post-Nargis Joint Assessment carried out by the Government of Myanmar, ASEAN and the United Nations (June 2008), the Periodic Review and the Initial Social Impact Monitoring study (October-November 2008) build an information for the formulation of the Post-Nargis Recovery and Preparedness Plan (PONREPP, December 2008 prepared by the Tri-partite Core Group: Government of the Union of Myanmar, ASEAN and UN with support from Humanitarian and Development Community) which proposed recovery strategies to address the needs of communities in the Delta.

⁸⁷ Moo K’Baw, Saw, Psycho-sexual problems in postmenopausal women . 53rd Myanmar Medical Conference, MMA, 2007.

⁸⁸ Than Than Tin, Mya Thida, Kyu Kyu Swe, Lhin Saw Mu, Myint Thet Mon. Menopause in North Okkalapa, Myanmar Med J.1993,38(1-4):34-

The PONREPP emphasizes on the community-driven recovery strategies and cross-sectoral approach and presents costing for the needs of the sector. The Plan also builds on the document “Programme for Reconstruction of Cyclone Nargis Affected Areas and Implementation Plans for Preparedness and Protection from Future Natural Disasters” which was issued by the National Natural Disaster Preparedness Central Committee (NDPCC) in August 2008 to assemble sectoral submissions from the concerned ministries. According to Post –Nargis Periodic review III⁸⁹, in the aspect of reproductive health there has been increase in total post-cyclone birth attendance by skilled health personnel and post delivery examinations of mothers. Also the coverage of the tetanus toxoid vaccination and follow up examinations of both newborns and mothers were significantly increased⁹⁰.

The destruction of health facilities and large number of victims with physical and psychological injuries posed a challenge to the health sector. This challenge was met through the GoUM’s plan including reconstruction of facilities, provision of supplies and placement of staff for delivery of essential services, immunization and including an array of essential reproductive health services and supply of hygiene kits to safeguard women’s dignity. Psychosocial support was given a priority and provided as part of RH services in coordination with the Working Group under the Health Cluster.

The combined efforts to address reproductive health needs after the cyclone Nargis included: establishment of the reproductive health coordination mechanisms through the cluster approach (Sexual and Reproductive Health and HIV Technical Working Group under the Health Cluster), national and local capacity building activities, procurement of RH kits and response to and prevention mechanisms for gender-based violence in collaboration with the Ministry of Social Welfare. Despite enormous challenges faced in terms of logistics, warehousing, timely distribution to the hard-hit areas, and destruction of some health facilities, the immediate measures were taken in accordance with the Minimum Initial Service Package (MISP) for Reproductive Health in emergencies. These measures addressed: 1) coordination through a cluster approach, 2) prevention of excess maternal and neonatal mortality and morbidity, 3) prevention of HIV transmission, 4) planning for comprehensive reproductive health and 5) addressing gender issues and protection of women.

Concerning the HIV and AIDS, NAP conducted a situation assessment in 15 townships of the Nargis affected areas. Coordination meeting with all stakeholders, training of basic health staff in 13 townships as well as workplaces for HIV prevention education in 8 townships was carried out. Additionally, not only the existing programmes are strengthened and but also expanded the 100% targeted programme, blood safety programme and PMCT programme in 2, 12, 4 townships respectively and ART therapy programme in 2 hospitals.

8. Community involvement

Male involvement in Reproductive Health

Traditionally, men have remained not well informed about their wives’ pregnancy-related experience and needs. Yet they are the decision makers with regard to pregnancy-related care and expenditure. Evidence suggests that men are interested and do want to be more involved. In relation to the ICPD program of action and to achieve the MDGs Myanmar has introduced strategies for “male involvement” and “male participation” to improve RH care and support. These interventions focus on improving males’ knowledge in safe motherhood, prevention of HIV/ STI, and also recruitment and training of male volunteers to reach the community.

DOH, CHEB, DHP, UNFPA, JOICFP, MMA worked together from 2005 to 2007 with an intervention supported by UNFPA to develop strategies and modalities of behavioural change communication for increasing male involvement and support in reproductive health at community

⁸⁹ Report by Tripartite Core Group, Jan 2010, Post Nargis Periodic Review III.

⁹⁰ Post-Nargis Periodic Review III, tripartite Core Group, January 2010

level in Bago and South Dagon townships with a focus on reducing maternal mortality and morbidity. The intervention included development TV drama and broadcasted nation wide, male involvement TV spots, posters, picture and TV quiz contests, bill boards were set up in project sites and training and recruiting of FHP (Frontline Health Promoter) male for local BCC activities at local level.

At the end of the two-year project it was found that men's knowledge on RH, ANC, PNC, danger signs of pregnancy, indications for institutional delivery, complications of abortion, skilled birth attendant, birth spacing, consequences of HIV/STI, had increased in the male population of project townships⁹¹. Despite attrition of Frontline Health Promoters (FHP), difficulty in reaching all corners of the area, they try their best and were accepted by the community as peer educators. However, systematic expansion of interventions need to be supported within the RH Strategic Plan and programmes to promote participation of men in actions for reproductive health.

Community support

Community support groups (CSG) are formed by volunteers in the community to act as a bridge between health care providers and people. This program is a joint initiative between UNFPA, Central Health Education Bureau, of DHP and JOICFP in 2002⁹². The main aim of CSG are to train community volunteers to be able to give health education, improved knowledge in reproductive health and to support the community in behavioral change for healthy living. Based on three objectives the CSG activities are planned and implemented. They are- to disseminate RH knowledge to the population in the township, to initiate behavioral change with improved RH knowledge, to form a bridge between health care provider and patients in times of obstetrical emergencies so that proper and timely referral can be provided.

Members of CSG were selected from the community by the midwife and village health committee, and the criteria are persons who are interested in health and welfare of the community, male and female who are active, between 18 to 50 years of age. Each CSG member is given training on reproductive health and is given charge of 30 households and given a record booklet. They give health education to their assigned households, provide help and support for transportation when there is need to be referred to the hospital or health care provider, raise funds from the community if there is a need in emergency situations, assists the midwives or health care providers in health activities. CSG work very closely with village health committee members and the basic health staff and were successful in providing timely referral and support in obstetric emergencies.

It was implemented as a model project in Dalah Township in Yangon division, Sarmalauk village in Nyaung Done Township. The model CoRH project was assessed and was found that the CPR rose by 50% from existing situation, increase in level of awareness to about 50% on RTI, STDs, HIV/AIDS. The CPR in Sarmalauk rose from 31% in 2001 to 42.6% in 2003⁹³ and was later expanded to reach 64 townships by the end of ⁹⁴2010. SA team found also observed success stories during their visits to the RHC and this program has potential to bring down maternal mortality in rural areas.

⁹¹ End-line data collection & Behavioral study report on male involvement in RH in Myanmar, UNFPA, JOICFP, MMA, MOH, 2007

⁹² Community Operated- RH/BCC project in Myanmar, documentation of the model project outcomes, national level assessment reports, 2003

⁹³ The community operated RH/BCC project in Myanmar, documentation of model project outcomes and national level assessment, 2003.

⁹⁴ UNFPA project townships, 2010

Findings of FDG with Community Support Group members

*by SA team at Sarmalauk RHC, Nyaung Done Township, Ayeyarwaddy Division,
4 Male and 4 female CSG of Sarmalauk village*

One CSG is assigned for every 30 households of Sarmalauk village- They are to take care of family's health in the assigned households. CSG selection is done by the village authorities and midwife from those who volunteer to be CSG. The training is 7 days at Township Health Office. CSG members described that their HA as very diligent and he meets with them every Sunday at 12 noon for Continuing Health Education. They have time of discussion and sharing of information with regards to health issues in assigned house holds. There have been no maternal deaths as yet for the year 2009. They advocate exclusive breast feeding for 6 months. CSG supports the MW in health care and was successful. CSG supports the MW in health care. The village health committee is active and works well with BHS.

Issues and Challenges

1. Expenditure on health and reproductive health – health financing

The Government of Union of Myanmar has increased its spending on health over the last decade⁹⁵. However, health expenditure constitutes 2.2% of GDP and relatively small portion of it goes for reproductive health interventions allocated to mainly financing the established health posts. GoUM expresses political commitment in maternal health however, the 5 year National Strategic Plan for Reproductive Health (2004-2008) was implemented with a shortfall of approximately 75% of planned funding. Social security expenditure on health is 1.3% out of general government expenditure on health.

There is large portion of out-of-pocket expenditure on health (80%) which creates a high economical burden on healthcare users, especially those from poor households who will have to spend large proportions of their income on health, including obstetric and neonatal emergencies. Oftentimes, financial barriers limit access to reproductive health and emergency obstetric and neonatal health services for poor and disadvantaged thus resulting in adverse health outcomes.

Donor and international aid agencies fund essential reproductive health services and interventions agreed upon in the RH Strategic Plan through joint cooperation agreements with the GoUM. However the budget predictability and donor funding are becoming even less given the global financial crisis.

2. Availability of Quality RH care

The quality of reproductive health care is centred on availability, accessibility and affordability. Women of lower socio-economic status, those with less education and employment opportunities, rural poor, and those in remote geographical locations suffer most in terms of access to basic RH care⁹⁶. The unmet need for contraception is a major concern in Myanmar. Despite a pro-poor cost-sharing policy for contraceptive supplies, in actuality, the availability of modern contraceptive methods free of cost or at subsidized rates is very low. While contraceptives are always available at pharmacies, financial barriers restrict access to birth spacing methods. In addition, lack of information on proper use and the questionable quality of contraceptives in the market may lead to contraception failure, unintended pregnancies, or discontinuation of contraceptive use.

⁹⁵ Health in Myanmar 2008, Ministry of Health, 2008

⁹⁶ Reproductive Health Care - methods, techniques and services which contribute to RH and well-being through preventing and solving RH problems (ICPD, 1994).

The key challenge is to provide a comprehensive package of essential reproductive health services available at the primary health care level. Currently some elements of reproductive health services, such as management of abortion complications and management of STIs are lacking in attention. The birth spacing programme meets the needs of only a small fraction of townships. As such there is a lack of programmatic coverage in the remaining two thirds of Myanmar’s townships. Lack of integration between reproductive health and other health programmes and services, such as maternal nutrition, STI/HIV/AIDS, anaemia and prevention and treatment of malaria is an area, that if improved, would have great value added to reproductive health on a large scale.

3. RH commodity requirements

While the government bears the costs of personnel and logistics supply, there is no national budget line for procurement of contraceptive commodities. Over the past decade, a supply of contraceptives to the public sector is solely supported by international aid from donors such as UNFPA. These programmes are able to channel contraceptives to approximately one third of the townships in the country.

The funding gap for provision of contraceptive commodities in 2009 was over US\$5.5 million. If UNFPA continues to support contraceptives even at the current level, increased financial commitments are required from the national budget as well as donor contributions to fill a shortfall of US\$26 million, which is about 60% of contraceptive requirements for the period of 2010 – 2013. Figure 3.13 below depicts the predicted shortfall of funds against contraceptive requirements. Readers may also want to consult the map showing gaps in Birth Spacing commodities available in Annex 5.

Figure 3.13: Projected costs against contraceptive requirements and funds committed (for supplies only), 2009-2013

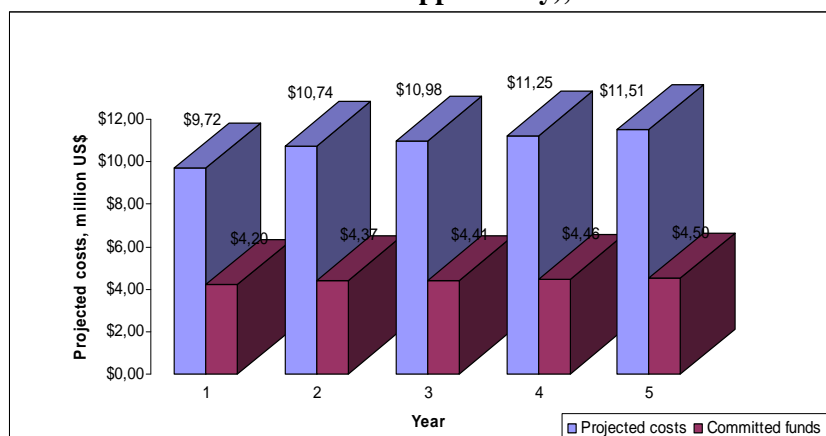
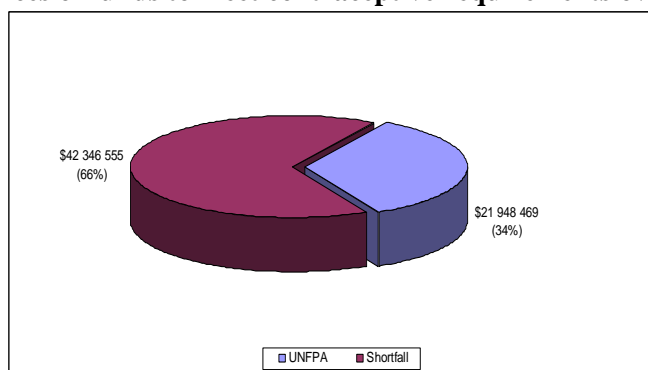


Figure 3.13 assumptions: method-mix does not change over the next five years, inflation not accounted for. If prices go up the gap would be even greater.

Figure 3.14: Sources of funds to meet contraceptive requirements over 2009-2013, US\$



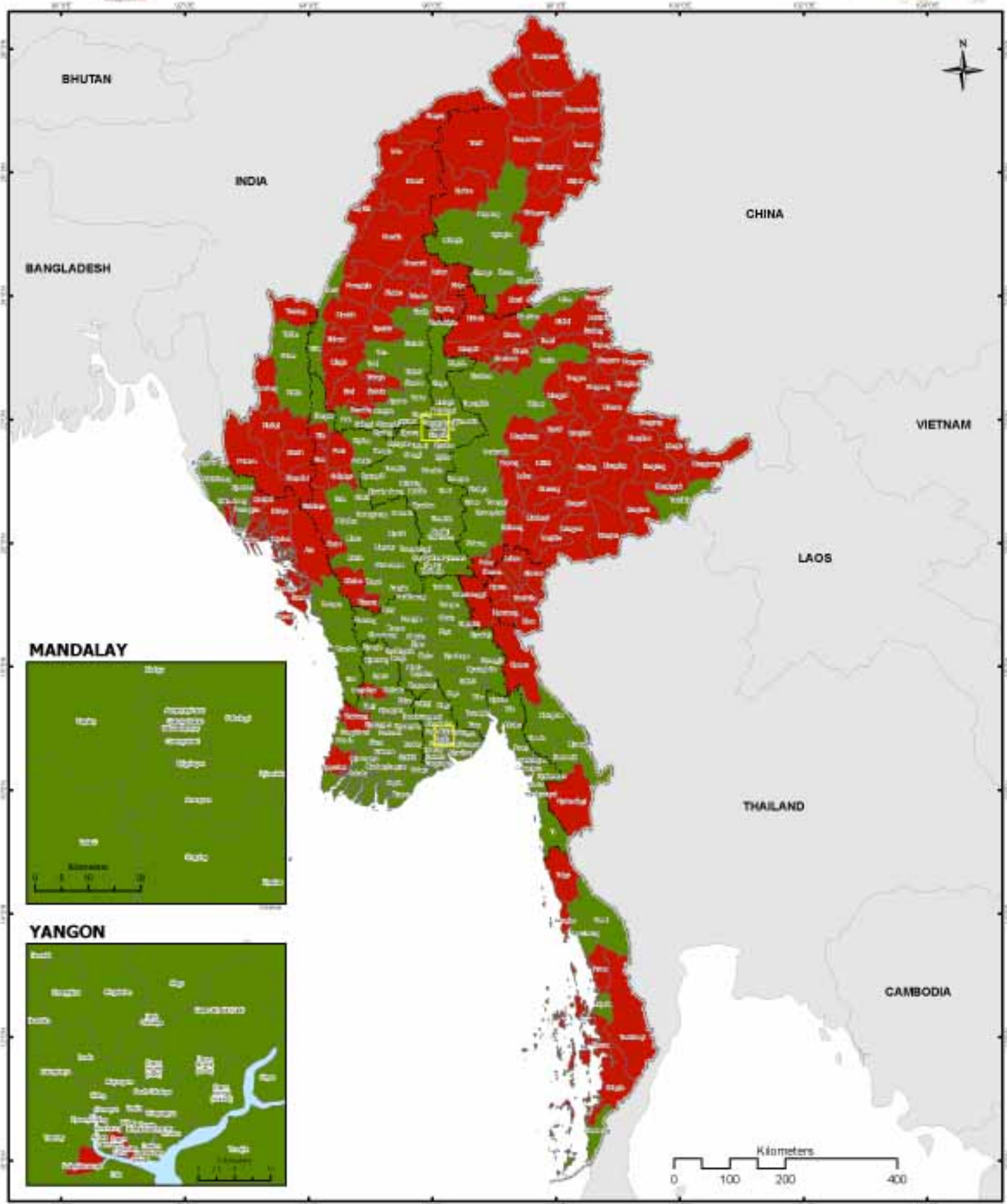
Recognizing the urgent need to address the contraceptive shortfalls, a high level stakeholder meeting chaired by the Deputy Minister for Health was held in Nay Pyi Taw in December 2008. A National Reproductive Health Commodity Security Sub-Committee was formed to assess the current situation on RH commodities in both private and public sectors, identify and coordinate efforts in securing a supply of commodities. Also discussed was the improvement of reproductive health information systems and strengthening logistic management information system (LMIS) for forecasting, procurement, supply, storage and distribution of contraceptive commodities⁹⁷. The Committee is expected to advocate in order to mobilize resources to meet RH commodity requirements.

⁹⁷ UNFPA, Reproductive Health Commodity Security Report, 2009



Myanmar Information Management Unit

Map of Myanmar Showing Gaps in Birth Spacing Commodity Availability



MANDALAY



YANGON



Map ID: MIMU460v03
 Creation Date: 28 April 2010, A4
 Projection/Datum: Geographic/WGS84
 Map produced by the MIMU - info.mimu@undp.org

Legend

- State Boundary
- International Boundary
- Township with BSC supported
- Township without BSC



Data Sources: UNFPA, PSI, MSI
 Boundaries-WFP modified by MIMU

- Staff at the forefront of rural health systems who are able to deliver essential reproductive health care to communities – health assistants, lady health visitors and midwives – have manifold responsibilities and often much of their time has to be dedicated to non-RH service provision functions. At the grassroots level, AMWs play a unique role in provision of basic reproductive health services, however their formal training is limited to six months of midwifery after middle school education, and their competencies do not meet the WHO stipulated requirements of skilled birth attendants. Efforts have been made to upgrade the skills and build competencies of AMWs and strengthen linkages with health systems through continuous training and supervision. Currently the ratio of health providers with midwifery skills and AMWs to a village is 1:2, while the GoUM aims to secure at least one skilled health provider for each and every village.
- In Myanmar the proportion of births attended by skilled health personnel was reported by the Health Management Information System (HMIS) as 64.2% in 2007, and is likely to reach the MDG target of 80% by 2015. However, this is aggregate-level data and does not represent regional variations. Qualitative factors such as adequacy of staff skills and competencies are not taken into account. A wide variation in clinical management and standards of care were observed across Divisions and States during the field assessment for this report.
- Along with pre-service education for health personnel, the quality and quantity of in-service training needs to be streamlined through the assessment of training needs, review and inventory of training courses and standardization across the country. The SA team findings emphasized the need for skills development and improved clinical/practical sessions for midwifery training prior to service deployment. Post-training assessment and support should be built-up in order to ensure knowledge, skill acquisition and imparting change in practice. In addition to clinical and technical competencies, at the operational level in selected areas, managerial skills, including the ability to analyze epidemiological data and planning skills needs improvement.
- According to DHP's profile there are 1627 posts for midwives with 1563 appointed and 64 posts vacant.⁹⁸ The intake of students per year for 43 midwifery training schools all over Myanmar totals 1050⁹⁹. It is ironic that there is surplus of trained midwife graduates over and above the government posts in the public sector, while there is shortage of midwives in remote rural areas. The fresh midwifery graduates are typically employed in the private sector, or leave Myanmar's health sector to look for other economic opportunities available abroad. This indicates the need for review and planning of the development of a dedicated workforce for maternal and newborn care. Training and supervision, staff deployment policies, incentive and promotion policies could improve the management of the workforce and encourage graduates to spend a certain percentage of their career in remote rural areas.
- According to FRHS 2007, the abortion rate was highest not only in the 15 – 19 years age group, but also in youth with university education. Demographic changes indicate that there is increase in proportion of working age group 15 to 49 with also an increase of never married population. However, the current RH programme is focused mainly on married women and there is thus a gap in dissemination of RH education among youth as well as in the growing proportion of those never married in the 15 – 49 age group.

⁹⁸ Health Manpower at MCH section , Department of Health Planning, 1996-2001

⁹⁹ Health in Myanmar 2009, Ministry of Health

- There are efforts to revitalize the existing coordination mechanisms to strengthen coordination at all levels for the management of reproductive health, maternal and newborn health programmes. Monitoring of the implementation progress for maternal, newborn and reproductive health service delivery requires integration. There is an urgent need to streamline public-private partnerships for reproductive health programming. Directly integrating and analysing the health information from the private sector and studying overall demand and supply patterns will help in the overall assessment of the reproductive health situation in Myanmar.

Opportunities

- The commitment of the Government reflected in the national policies and plans require further resource mobilization efforts and allocation of funding to priority areas.
- Global initiatives and funding sources for resource mobilization. There are opportunities the current global initiatives provide for mobilizing financial and technical resources for reproductive health.
- Partnership and goodwill of all stakeholders including those in public and private sectors.
- Re-vitalized coordination mechanisms. The National Working Committee and Technical Working Group for RH will support the implementation of the 2009-2013 RH Strategic Plan.
- CSG program is contributory to better coverage of RH care. Strengthening of CSG training and expansion of CSG programme nationwide can contribute towards better RH outcome

9. Sexually Transmitted Infections (STI) and HIV & AIDS

9.1. Situation and trend of sexually transmitted infections

Sexually transmitted infections are often thought of as a hidden global epidemic. This is because STIs are often asymptomatic nature, taboo in discussion, but have enormous medical and socioeconomic consequences. There is an increasing evidence of HIV-STI interaction, and the issues of STI drug resistance and higher vulnerability of women to STI infection are pressing concerns. STI infections exacerbate gynaecological morbidities such as pelvic inflammatory disease, infertility, ectopic pregnancy and carcinoma of cervix.

Although a Venereal Disease Research Laboratory (VDRL) test may not be the best indicator of STI prevalence, according to the report of the 45 AIDS/STD clinics¹⁰⁰ the trend of the VDRL sero-positive rates among pregnant women declined from 3.1 % in 1999 to 0.81% in 2008 among primipara, whereas from 3.6% in 1999 to 1.09% in 2008 among multipara. (Figure 3.14) The HSS 2008¹⁰¹ showed that the prevalence of syphilis was highest amongst MSM (14.1%). The prevalence of STIs is higher in people living with HIV than who do not have HIV.

According to reported cases from 45 AIDS/STD clinics in 2008¹⁰², the proportion of genital ulcerative disease (GUD), genital discharge disease (GDD) and others were 16%, 25% and 59% respectively. Among GUD cases, the most common cause was syphilis (31%) (Fig 3.16) and among GDD cases, the most common cause was non-gonococcal urethritis. (Fig 3.17)

¹⁰⁰ Power point presentation of global burden of STI and STD control in Myanmar, National AIDS Programme, Department of Health

¹⁰¹ Report of the HIV Sentinel Sero-surveillance Survey 2008, Myanmar, National AIDS Programme, Department of Health, Ministry of Health

¹⁰² Power point presentation of global burden of STI and STD control in Myanmar, National AIDS Programme, Department of Health

Figure 3.15: Trends of VDRL Sero-reactive Pregnant Women: 1999-2008
VDRL Sero-reactive Trends of Pregnant Women, through 1999-2008
 (Reported figures from 45 AIDS/STD Clinics)

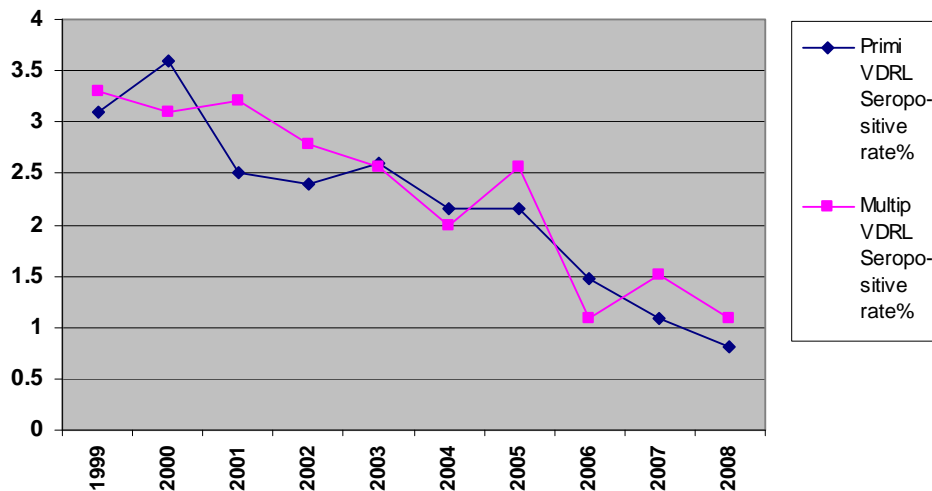


Figure 3.16: Proportion of reported ulcerative STD from 45 AIDS/STD clinics (2008)

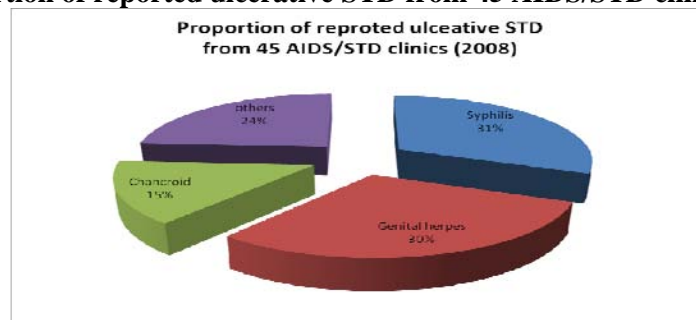
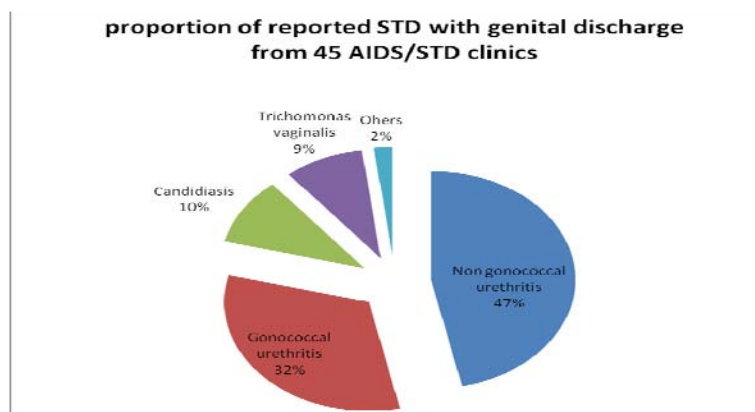


Figure 3.17: Proportion of reported STD with genital discharge from 45 AIDS/STD clinics (2008)

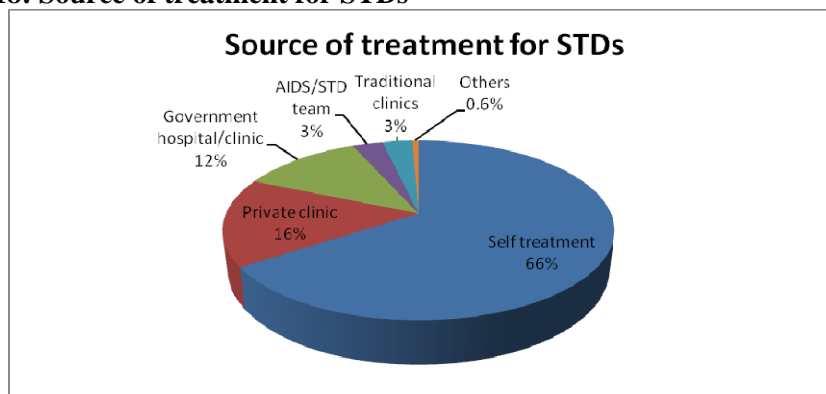


The NAP has conducted training on syndromic management for BHS in a total of 318 townships. It works with over 20 NGO partners and UN agencies to deliver STI services within the country. Altogether, over 90,000 STI patients were treated in 2007¹⁰³. Nevertheless, the number of STI patients was underestimated since most of STI cases self-treated and others sought treatment at private clinics. Only one third of STI patients sought treatment at public centres; the most common source of treatment for STI symptoms was a self treatment (66%) (Figure 3.18). Awareness and knowledge on

¹⁰³ Power point presentation of global burden of STI and STD control in Myanmar, National AIDS Programme, Department of Health
 Chapter 3 : Reproductive Health, HIV and AIDS

STI remains limited in Myanmar.¹⁰⁴ There was limited partner notification for primary contact (e.g. sex workers) but partner notification and treatment for secondary contact (spouse) was relatively good in clinics of AIDS/STD teams. The SA team observed that although VDRL test is routine procedure for AN Care, most of the townships did not perform this test at AN care visit except townships with AIDS/STD teams

Figure 3.18: Source of treatment for STDs



Source: Behavioural Surveillance Survey 2007, General Population, NAP, Ministry of Health, March 2009

9.2. Current situation of HIV and AIDS in Myanmar

(a) Epidemiological situation of HIV and AIDS

Myanmar has the third highest HIV prevalence rate in the Southeast Asia, following Thailand (1.4%) and Cambodia (0.8%).¹⁰⁵ The first person with HIV infection in Myanmar and the first person with AIDS were detected in 1988 and 1991 respectively. Although the adult prevalence in South and South East Asia region was 0.3% in 2008¹⁰⁶, adult HIV prevalence was 0.61%. 230,000 adults between 15 and 49 years of age were living with HIV (35% were female) in Myanmar in 2009. The need for ART for adults and children was 72000 and 1900 respectively. Estimated annual deaths from the disease were 17,566¹⁰⁷. The epidemic reached a peak in the year 2001-2002 with prevalence of 0.94% followed by a decreasing trend thereafter. The main mode of transmission is through sexual transmission (73%). (Figure 3.19) The male and female ratio was 2.4:1 and the highest percentage of HIV positive cases were seen in 30-34 years age groups and followed by 25-29 years age group¹⁰⁸.

HIV is largely concentrated in high-risk behaviour groups and settings and prevalence varies greatly by geographic locations and by population subgroups. A high prevalence of HIV is observed in the border areas, large cities, the northern and eastern states of the country where there is a large cross-border mobile population, and mining areas where there is a highly mobile migrant worker population and compounded with easy money, sex work and drug use is common.

¹⁰⁴ Dr. Aye Myat Soe, Daw Aye Aye Sein, Dr.Khin Ohnmar San, Behavioural surveillance survey 2007 (general population) National AIDS Programme, Department of Health, Ministry of Health, Myanmar

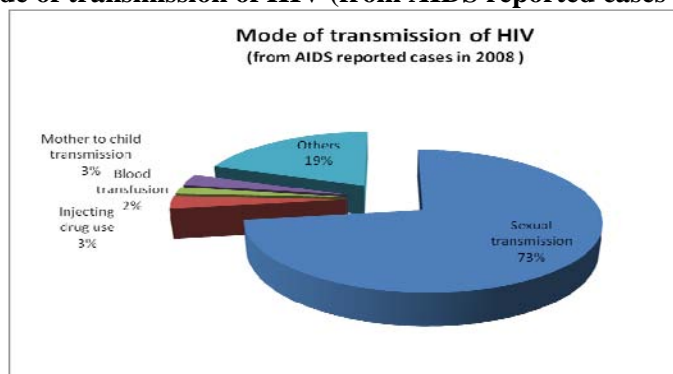
¹⁰⁵ Report on the global AIDS epidemic 08, UNAIDS

¹⁰⁶ 2009, AIDS epidemic update, UNAIDS and WHO

¹⁰⁷ Estimation workshop, 2009 (EPP package), MOH, UNAIDS, WHO,

¹⁰⁸ National Strategic Plan for HIV & AIDS in Myanmar, progress report 2008, Ministry of Health

Figure 3.19: The mode of transmission of HIV (from AIDS reported cases in 2008)



In Myanmar, the HIV Sero surveillance Survey (HSS) was started in 1991, consisting of high-risk groups (IDU, MSM, FSW & Male STI patients) and low-risk groups (pregnant women, blood donors, new military recruits & new TB patients). As in other Asian countries, in 2008, HIV prevalence is highest among IDUs (37.5%) followed by MSM (28.8 %) and FSW (18.4%). The HIV prevalence of male STD patients was 5.42%; it is a proxy indicator for HIV prevalence of clients of sex workers. The HIV prevalence of pregnant woman was 1.26% among women attending ANC clinics whereas the HIV prevalence of blood donors was 0.48%; it is a proxy indicator for the prevalence of general population. The HIV prevalence of new military recruits was 2.5% and among new tuberculosis patients was 11.1%. Annex 4, Table 1 illustrates these statistics in greater detail. The HIV prevalence was higher in males than females among TB patients (11.9% and 9.6% respectively) and blood donors (0.55% and 0.24% respectively). Among the Most at Risk Population (MARP) groups, HIV prevalence appears to be higher after 30 years of age¹⁰⁹.

(b) Trends of HIV prevalence in Myanmar

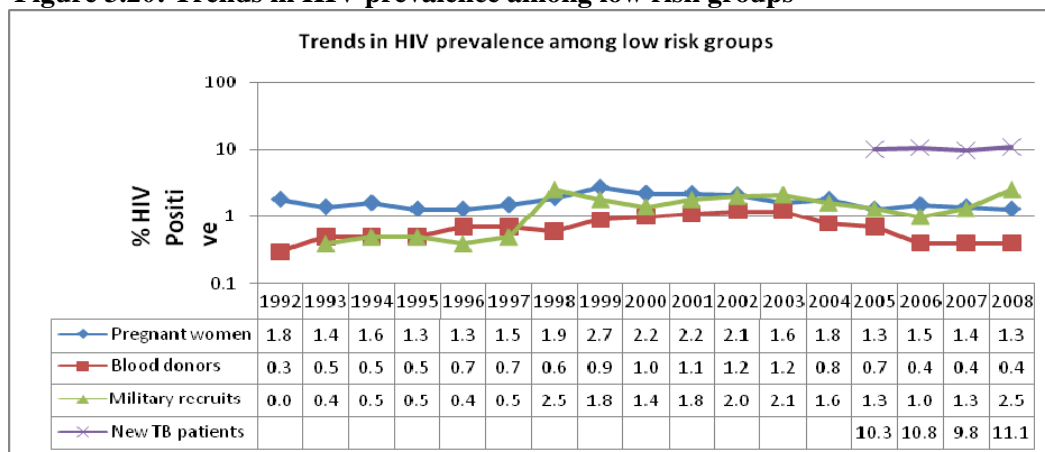
Asia's epidemic peaked in the mid-1990s, and annual HIV incidence has subsequently declined by more than half. Regionally, the epidemic has been considered as 'stabilized' since 2000¹¹⁰. Likewise, in Myanmar, the rates of prevalence in the low-risk groups have fluctuated within a narrow range of margin (0.1% to 2.7%) with a peak in late 1990s. In 2008, the trend of HIV prevalence among new military recruits was slightly increased compared to 2006 (Figure 3.20). The prevalence of HIV among high-risk groups reached a peak in 2000-2001. Since then, a declining trend has been observed. A decreasing trend was observed among IDUs and FSWS in 2007, but it could be explained by improved methodology of the survey, including larger sample sizes¹¹¹. HIV prevalence among IDUs and FSWS slightly increased in 2008, and HIV prevalence among MSM remained at a high level (Figure 3.21).

¹⁰⁹ Report of the HIV Sentinel Sero-surveillance Survey 2008, Myanmar, National AIDS Programme, Department of Health, Ministry of Health

¹¹⁰ 2009, AIDS epidemic update, UNAIDS and WHO

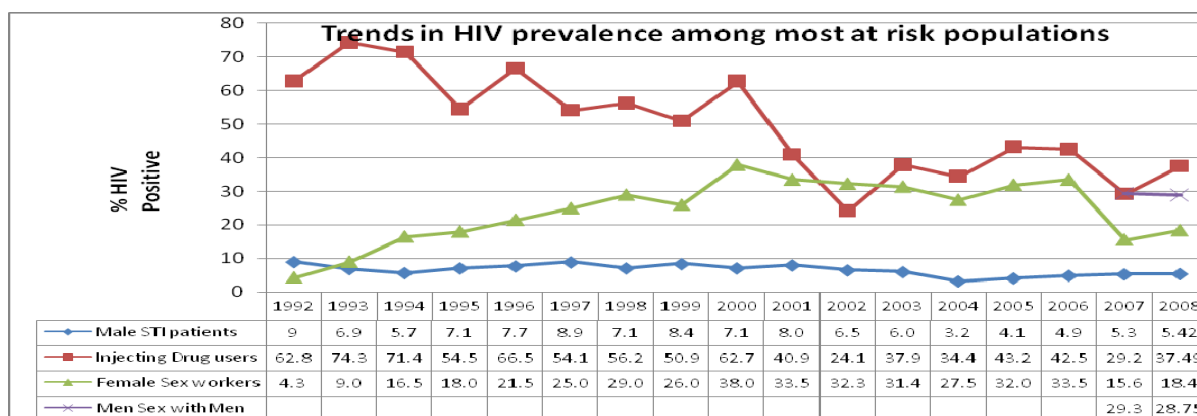
¹¹¹ Report of the HIV Sentinel Sero-surveillance Survey 2008, Myanmar, National AIDS Programme, Department of Health, Ministry of Health

Figure 3.20: Trends in HIV prevalence among low risk groups



Source: Report of HSS 2008, National AIDS Programme, Department of Health

Figure 3.21: Trends in HIV prevalence among high risk groups



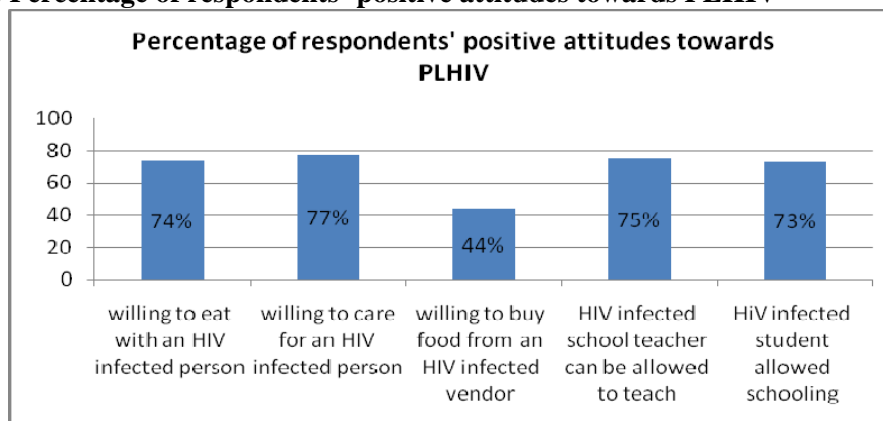
Source: Report of HSS 2008, National AIDS Programme, Department of Health

(c) Knowledge and behavioural situation among general population including youth in Myanmar

There remains a large gap on knowledge about HIV/AIDS in the general population of both youth and adults. The BSS report (2007)¹¹² showed that only 36.6% (37.7% of youth and 36% of adults) knew about three methods of HIV prevention and only 42 % (47.5% of youth and 39.1% of adults) were able to correctly reject common misconceptions about HIV prevention. Women have lower knowledge about HIV/AIDS than men, and young women (15-24 years) were found to be the least educated on knowledge of HIV prevention. There is still major stigma and discrimination against PLHIV in most communities in Myanmar (Figure 3.22). Behaviour surrounding safe sex is limited. Consistent condom use with a commercial sex worker was 80.7%, whereas condom use with a casual acquaintance was only 17.2%. The utilization of VCCT service is low; only 19% of the general population actually was tested and received results.

¹¹² Dr. Aye Myat Soe, Daw Aye Aye Sein, Dr. Khin Ohnmar San, Behavioural surveillance survey 2007 (general population) National AIDS Programme, Department of Health, Ministry of Health, Myanmar

Figure 3.22: Percentage of respondents' positive attitudes towards PLHIV



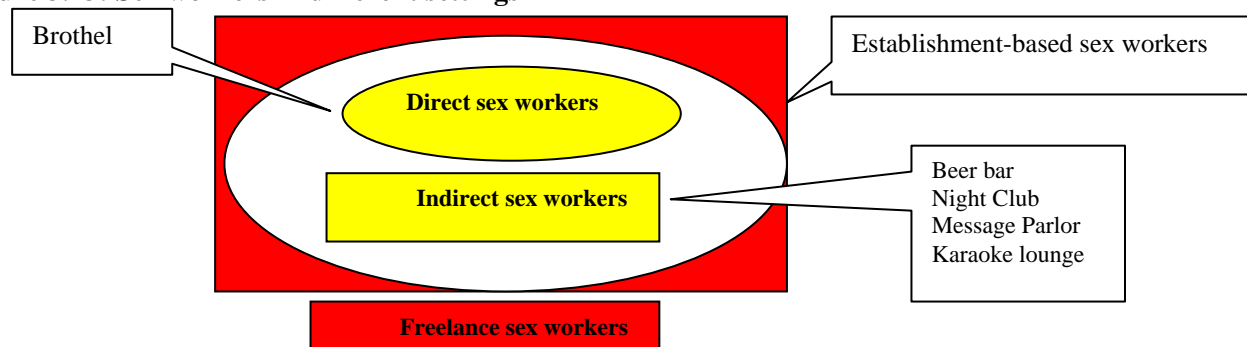
Source: BSS, General population, 2007, NAP, DOH

9.3. Summary situation relating to Most at Risk Population (MARP) (highest priority)

(a) Situation of Female sex workers (FSW)

As in many Asian countries, prostitution is illegal and not encouraged in Myanmar. Sex work settings are complex and varied in nature. The site of negotiation for sex differs from place to place (Figure 3.23)¹¹³. There are two types of sex workers, “establishment sex workers” which include direct sex workers and indirect sex workers, and “freelance sex workers”.

Figure 3.23: Sex workers in different settings



In Myanmar, the estimated number of sex workers is 60,000¹¹⁴. Based on HSS 2008, the HIV prevalence among direct sex workers (21.4%) was twice of indirect sex workers (9.8 %). A declining trend was observed in female sex workers from 2000 (38.0%) to 2007 (15.6%) but slightly increased in 2008 (18.4%).

According to the BSS¹¹⁵, the median age of starting sex work in Yangon and Mandalay was 23-24 years whereas the median age of first sexual experience was 18 years. This survey indicated that condom use amongst FSW is high (more than 90% reported they ‘almost always’ used a condom). Only around 50% of FSW reported condom use at last sex with their regular partners as well as consistent condom use with regular partners in the last six months. More than half of the FSW reported either a genital ulcer or discharge in the past year. Regarding female condoms, 71% of FSW had heard of them, while one third of them had used it. Among them, treatment seeking behaviour is

¹¹³ National Guideline for 100% Targeted Condom Promotion (100% TCP) Programme, National AIDS Programme, Department of Health, Ministry of Health

¹¹⁴ Myanmar National Strategic Plan on HIV and AIDS, Operational Plan 2008-2010, Ministry of Health

¹¹⁵ The Behavioral Surveillance Survey, Injection Drug Users and Female Sex Workers, 2008, National AIDS Programme, Department of Health, Ministry of Health

high (>70%) and the vast majority sought treatment at a clinic. The majority of FSW respondents received an HIV test in the past 6 months (62%-74%) and testing was done mostly in INGO clinics. Although the level of knowledge about HIV was moderately high, there is limited knowledge about ART and PMCT. The Situation Analysis team noted that criminalization of sex work and sex workers unintentionally lead to exploitation of women with sex work. Most of the sex workers expressed that they have chosen this occupation as part of their limited livelihood options. Please see Annex 3, Section 6 for Focus Group Discussion (FGD) with FSW.

(b) Situation of Clients of sex workers

The estimated number of clients of sex workers is 1,100,000 as per National Strategic Plan (NSP) on HIV and AIDS 2006-2010. There is no detailed information available related to clients of sex workers in Myanmar. While at least 75 million men regularly buy sex from sex workers in Asia, many of these men are in steady relationships. It is estimated that 50 million women in the region are at risk of acquiring HIV from their regular partners¹¹⁶.

(c) Situation of Men who have sex with men (MSM)

In Myanmar, as in other Asian countries, homosexuality is a lifestyle that is considered to be socio-culturally taboo. Many people consider homosexuality as an abnormal sexual behaviour, and open same-sex partner relationships are practically non-existent. As such, men who have sex with men (MSM) are a hidden population group. MSM pose a high risk for HIV transmission. Limited prevention, care and support activities are targeted towards MSM due to societal stigmatization against MSM. In 2008, the HIV prevalence among MSM was 28.8%¹¹⁷.

There is sizeable number of MSM existing in Myanmar. The estimated number of MSM is 240,000 (Operational Plan 2008-2010). Although there is no wide systematic study of risk behaviour among MSM, the report of a knowledge, attitudes, and practice (KAP)¹¹⁸ study regarding HIV/AIDS among MSM who visited the Taung Pyone in Mandalay in 2009 presents some key information. The Taung Pyone festival occurring annually in Matayar Township, Mandalay Division is a *nat-pwe* festival, or spirit festival. Oftentimes, spirit mediums are transgendered, and festival activities include colourful ritual singing and dancing often performed by cross-dressing males. The festival attracts MSM from all over the country. Surveys showed that the median age of first sexual experience with men was 15 years. The average number of sexual partners in the past 6 months was nearly 8 partners. About half of respondents reported consistent condom use during receptive anal sex in the past 6 months, whereas condom use at last receptive anal sex was 87.8%. Almost all respondents know the modes of HIV transmission and prevention methods but only a few respondents (9%) knew about the high prevalence of HIV transmission amongst MSM. More than half of the group's self-perceived their risk of HIV transmission due to their sexual behaviour to be very low. One third of respondents had suffered an STI in the past six months. A few had sought treatment at the government clinics or hospitals and about half at private or NGO-run clinics. Among them, two third of the respondents had reported HIV testing in the past 6 months. Sixty percent of these took their HIV test at an NGO clinic. Research done by the Situation Analysis team revealed that MSM have multiple partners (10 partners) and that the age of first exposure to sex is generally 12-13 years of age. For most MSM, their first partner is male. There also seems to be an increasing trend of sex work among MSM as a result of financial constraints of this stigmatized group. Many MSM have limited knowledge and attitude to HIV and STD and social stigma prevents MSM from seeking prevention, care and treatment services for HIV and STD. Please see Annex 3, Section 7 for FGD with MSM

¹¹⁶ HIV transmission in intimate partner relationships in Asia, <http://www.unaids.org/en/knowledgecentre/resources/featurestores/archi>

¹¹⁷ Report of the HIV Sentinel Sero-surveillance Survey 2008, Myanmar, National AIDS Programme, Department of Health, Ministry of Health

¹¹⁸ Pyae Sone Tun M.B.,B.S, Knowledge, Attitude and Practice (KAP) Regarding HIV/ AIDS Among Men (MSM) Who Visited Taung Pyone Festival, Matayar Township, Mandalay division, 2009

(d) Situation of Injecting Drug Users (IDU)

Injection Drug Users (IDU) form a major risk group for transmission of HIV infection in Myanmar although the trend in HIV prevalence among IDUs does appear to be downwards. The estimated number of IDU is 75,000 (Operational Plan 2008-2010). The main reasons for using drugs are peer pressure and ease of availability of drugs.

The BSS 2008¹¹⁹, noted that almost all IDU knew that sharing needles could result in transmission of HIV. Knowledge about prevention and methods of transmission of HIV was moderately high in 3 townships but much lower in one township. There is limited knowledge about ART and PMCT. There is still needle sharing amongst IDU (5-31%) even though most IDU know where to obtain clean or new needles. The most common person to share injecting equipment with was a friend. Heroin is the most commonly used drug in all sites, but the use of amphetamine was relatively high across all townships. Experience with detoxification or methadone maintenance therapy was very low (only 4-7%). About 50-70 % of the respondents took VCCT service. The proportion of IDU who had sex with FSW was 9% to 48% in these 4 townships. Consistent condom use with FSW was limited amongst IDU (46% to 87% at last sex with FSW). Generally, condom use at last sex with casual partners as well as regular partners was very low.

9.4. Summary situation of PLHIV and their families

In Myanmar, there is an increase in numbers of PLHIV self-help groups. PLHIV are also involved in a wide variety of activities at all levels of the fight against AIDS. PLHIV representatives were given full participation in the development of the National Strategic Plan in 2006 and actively involved in Myanmar- Country Coordination Mechanism (M-CCM) as well as Technical and Strategic Group (TSG) for HIV and AIDS.

Nonetheless, the networks of PLHIV face many challenges including weak management, low skill levels and funding constraints. Many PLHIV must spend most of their energy on basic survival, including financial security and access to treatment for HIV and opportunistic infections. The disease presents many obstacles for the participation of PLHIV in their own organization and networks. There are also many societal barriers to the effective implementation of Greater Involvement of People living with HIV/AIDS (GIPA) which include poverty, gender inequality, stigma and discrimination. Furthermore the coverage of ART and other care, support and prevention activities of PLHIV and their partners and families remains very low. The lengthy and complex procedures for these groups to get official registration also hamper them to directly receive financial support from donor communities.

9.5. Summary on the situation of youth with HIV

(a) Epidemiological situation of youth with HIV

Globally, HIV prevalence among youth is used as a proxy indicator of incidence of HIV. According to HSS, 2008, the prevalence of HIV among pregnant women aged 15-24 years was 1.01% and the prevalence of HIV among youth group was high in most sub population group of this survey. This survey also noted that there was decreased trend among young pregnant women whereas upward trend was seen among young military recruits.

¹¹⁹ The Behavioral Surveillance Survey, Injection Drug Users and Female Sex Workers, 2008, National AIDS Programme, Department of Health, Ministry of Health

(b) Knowledge and behavioural situation of youth with HIV

The knowledge levels among young people are still well below the global goal of ensuring comprehensive HIV knowledge by 2010¹²⁰. Similar to Cambodia and Thailand¹²¹, the percentage of youth who identify ways of preventing the sexual transmission of HIV was 37.7% and those who reject major misconception about HIV transmission was 47.5%. Young females are notably less likely than young males to have an accurate, comprehensive knowledge of HIV¹²².

Moreover, knowledge, practice and prevention of HIV/AIDS is still limited among out of school youth (48% of youth had comprehensive and accurate knowledge and 37% of respondents were aware of ART programme). The level of knowledge was the same between male and female. 25.7% and 29.7% of the male and female respondents were sexually active (having sex in the past 12 months) respectively. 7.4% of young men reported having sex with a sex worker in the past six months. Among them 90% youth reported using a condom at last sex with sex workers whereas only 52% of male respondents who had casual sex reported using condom at last sex. About 2.3% of men reported ever having sex with another man. Consistent condom use with youth MSM was 56%. About 64% of male respondents and 30% of female respondents knew where to obtain a condom. Youth reported low service utilization, as 31% of those who had STI self-medicated, and 28% of sexually active youth reported having ever taken an HIV test. There remains stigma and discrimination amongst youth in regards to PLHIV. Only 41% of youth were willing to buy food from an HIV infected vendor and 69% were willing to eat with HIV infected person¹²³.

9.6. Summary of the situation of pregnant mother and HIV & PMCT

In 2008, globally nearly 10% of maternal deaths were associated with HIV, and yet less than half of HIV positive pregnant women received ARV drugs to prevent HIV transmission to their children¹²⁴. In Myanmar, HIV infection was observed initially amongst high-risk groups. The first wave of infections came from IDU, FSW, and MSM. However, it has taken some time to understand that a secondary wave of infection effects population groups with lower levels of risk-taking behaviour, such as the wives or partners of IDU, FSW, and MSM.

The estimated number female and children with HIV was 80,616 and 4,651 respectively. The estimated number of HIV positive mothers needing ARV prophylaxis to prevent mother to child transmission of HIV was 4,300¹²⁵. As per report on HSS 2008, HIV prevalence among pregnant women was similar in primipara and multipara women (1.26%). The HIV prevalence among pregnant women was twice as high (1.5%) in urban areas compared to those living in rural areas (0.8%) and highest in the 35-39 years of age group (1.7%). The figure below shows the trend of HIV prevalence among pregnant women peaked in 1999 and since then began to decline.

¹²⁰ According to Declaration of commitment on HIV/AIDS, United Nations General Assembly Special Session on HIV/AIDS, 2001 (UNGASS) outlined a number of goals and targets such as: by 2005, ensure that at least 90% and by 2010 at least 95% of young men and women aged 15-24 have access to the information, education and services necessary to develop life skills, required to reduce their vulnerability to HIV infection. Services should include female and male condoms, voluntary testing, and counseling and follow up and HIV infection rates in persons 15 to 24 years of age, with the goal of ensuring that by 2005 prevalence in this age group is reduced globally, and by 25% in the most affected countries and that by 2010 prevalence in this age group is reduced globally by 25% (United Nations, Declaration of commitment on HIV/AIDS, United Nations General Assembly Special Session on HIV/AIDS, 2001(<http://www.un.org/ga/aids/coverage/FinalDeclarationHIV/AIDS.html>))

¹²¹ 2008 report on the global AIDS epidemic, UNAIDS

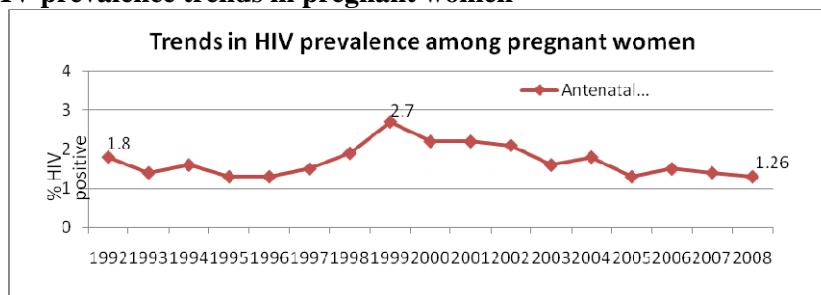
¹²² Dr. Aye Myat Soe, Daw Aye Aye Sein, Dr.Khin Ohnmar San, Behavioural surveillance survey 2007 (general population) National AIDS Programme, Department of Health, Ministry of Health, Myanmar

¹²³ Behavioural surveillance survey 2008 (out of school youth) National AIDS Programme, Department of Health, Ministry of Health, Myanmar

¹²⁴ UNFPA- Executive director's message for World AIDS Day, 09

¹²⁵ Estimation workshop, 2009, MOH, UNAIDS, WHO

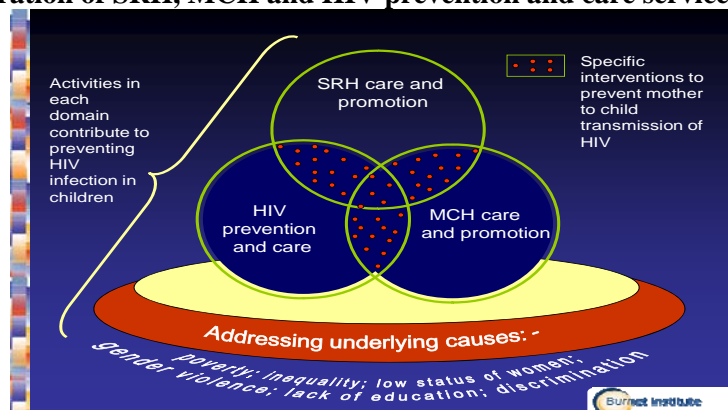
Figure 3.24: HIV prevalence trends in pregnant women



Source: HSS 2008, NAP, DOH

Based on international experience and best practices, the best way to stop children from becoming infected with HIV is to stop men and women getting infected. The diagram below shows activities in each domain contribute to PMCT¹²⁶. Investment in prevention and care of HIV infection in mothers and children should also contribute towards improving reproductive, maternal and child health¹²⁷.

Figure 3.25: Integration of SRH, MCH and HIV prevention and care services



Like other countries, prevention of HIV and AIDS among men and women of reproductive age and PMCT are the priority strategic directions of the NSP, 2006-2010 in Myanmar. In addition, the Five Year Strategic Plan for Adolescent Health (2006-2010) and the Five Year Strategic Plan for Reproductive Health (2009-2013) contribute to the reproductive health of young people and provide VCCT and ART prophylaxis to HIV positive mother. The PMCT programme in Myanmar began in 2001 by DOH. It has led to greater coordination between NAP, relevant public health programmes (including Reproductive health, MCH, Women and Child Health Development (WCHD), nutrition, adolescent health), UN agencies, and international and local NGOs.

Recent evidence shows that HIV has a significant impact on maternal mortality. Research models estimate that about 50,000 maternal deaths were associated with HIV in 2008. The two programme areas of maternal/child health and HIV/AIDS must work in synergy to achieve a common goal of saving mothers and babies.¹²⁸ There are opportunities for integration of HIV and RH because target groups and target behavioural messages are concordant. Pregnant women are the key target group for antenatal care and safe delivery and are also a primary target group for HIV testing and counselling. Condom promotion will not only prevent STI transmission including HIV and but also prevent unwanted pregnancy. Correct knowledge, access to commodities and services, and the confidence and skills to negotiate safe sex in a gender sensitive manner are complimentary objectives of sex education, family planning, STI programmes and HIV intervention.

¹²⁶ Power point presentation on PMCT by Wendy Holmes, Centre for International Health, Burnet Institute, October 2006

¹²⁷ Report of the joint PMCT program review in Myanmar, November, 2007, NAP, UNFPA, UNICEF and WHO

¹²⁸ UNAIDS outlook report, 2010, UNAIDS

Although the PMCT programme in Myanmar has had good progress in implementing and expanding the programme in 2008, the Southeast Asian region, including Myanmar, is far behind in reaching UNGASS targets¹²⁹ for preventing HIV infection from mother to child. There is limited access to ART therapy for mothers with advanced HIV in need of treatment for their own health. The uptake of PMCT intervention for HIV positive pregnant women is principally associated with AN care coverage, % of skilled birth attendance and contraceptive rates. The use of condom in stable relationships was negligible (0.7 %)¹³⁰.

Among both general population and high-risk populations, the number of people who knew that HIV can be transmitted from mother to child is commonly high whereas knowledge of methods of preventing mother to child transmission were relatively low.¹³¹ According to findings of the SA team, the awareness and knowledge about HIV & STI and PMCT is lower in townships without PMCT programme than townships with PMCT. Almost all of the interviewed women have no history of condom used and they didn't know how to use condom properly. It is known that women have little negotiation power for condom use even if they suspect their partner of having sex outside their relationship. There is a great lack of open spousal communication about sexual matters and HIV/AIDS. Young women are supposed to be sexually innocent and may therefore be reluctant to carry or suggest using condoms for fear of being seen as promiscuous.

There is low male involvement in RH including PMCT programme, as is the case in many countries. Husbands' attitudes and knowledge on the PMCT programme was limited, even in urban areas. Men from rural areas regard RH and PMCT to be of only concern to women. Men's sole responsibility was to contribute financial support. Unfortunately, cultural superstitions include ideas that a man would lose his power (*phone naint*) if he visited birthing sites. This and other traditional attitudes hinder men's involvement in the PMCT programme¹³².

9.7. Factors driving the spread of HIV epidemic in Myanmar

The factors driving the spread of the HIV epidemic depend on complex behavioural factors and other determinants such as age, gender, migration, mobility and displacement, as well as socio economic characteristics of the population being considered. Economic, social and cultural factors render a person more likely to engage in risk-taking behaviour or to become exposed to risk generating situations. Societal and environmental factors underlie behaviours that eventually predispose to HIV infection. In order to reach MDG and ICPD goals of universal access to HIV prevention and treatment care and support, there is need to pay attention to these drivers of the epidemic.

(a) Out of school youth

Out-of-school youth remain one of the most vulnerable populations in Myanmar because the school dropout rate is highest at grade 11(55.4%). Currently, out-of-school youth have low knowledge about sex, reproductive health and STI. The percentage of youth with high school and above education is almost 60% for both sexes in urban areas whereas that number is less than 25% in rural areas.¹³³ Employment opportunities for out of school youth are very limited and an estimated 90% are

¹²⁹ By 2005, reduce the proportion of infants infected with HIV by 20%, and by 50% by 2010, by ensuring that 80% of pregnant women accessing antenatal care have access to: information, counseling and other HIV- prevention services, effective treatment (ARVs and infant feeding support) to reduce mother-to-child transmission of HIV, effective interventions for HIV-infected women, including voluntary and confidential counseling and testing, access to treatment, especially anti-retroviral therapy and the provision of a continuum of care for HIV positive women and their families

¹³⁰ Fertility and Reproductive Health Survey, 2007, DOP and UNFPA, October 2009

¹³¹ The Behavioral Surveillance Survey, Injection Drug Users and Female Sex Workers, 2008, National AIDS Programme, Department of Health, Ministry of Health

¹³² Report on operational research: improving awareness on prevention of mother to child transmission and VCCT of HIV among pregnant women and their husbands at Magwae Township (2004-2005)

¹³³ Family and Youth Survey, 2004 country report, Yangon, October 2006, Department of population, Ministry of Immigration and Population and UNFPA

unemployed¹³⁴. Moreover, there remains limited access to information, education and services amongst out of school youth which increases their vulnerability to HIV and other reproductive health problems.

(b) Gender

Gender issue is one of the key factors to enhance the spread of the epidemic of HIV in Myanmar (detail described in Chapter IV: Gender Equality and Women Empowerment in Myanmar)

(c) Internal and external Migration

There is a significant increase of men and women who migrate to places to seek better economic opportunities, both internally within Myanmar, and migration to other countries in the region. These mobile populations engaged in high-risk behavior and have increased vulnerability to HIV exposure. They are also a 'bridge population' as they get infected with HIV while away from home and families, and return home and subsequently infect their spouses/partners.

While no nation-wide migration survey has been conducted in Myanmar as yet, many uneducated young people from rural areas and different ethnicities have migrated to Yangon, other larger towns or even neighboring countries such as Thailand and China for employment opportunities. It also noted that a study carried out among migrant children and youth in the areas bordering China, Myanmar and Thailand found that there is a greater demand for migrant workers who are adolescents or young adults and there is an increasing demand for female workers. The study identified that the majority of cross-border migrants were youth from rural areas with little or no formal education.¹³⁵

Although there is limited data and information about migrant and mobile population with HIV in Myanmar, one assessment reported that migrants arriving in Thailand have little or no knowledge about HIV/AIDS, sexual health and reproductive health. Migrant men and women are more vulnerable to sexual exploitation, discrimination and poverty and have limited access to social, education and health care services.¹³⁶

Increased in vulnerable and risk to adolescents and youth

According to a monthly report of a PSI-affiliated TOP drop-in centre, a greater number of under-19 MSM have been dropping in for clinical care. The highest rate of new STD cases is in the under-19 MSM category. MSM self help group of one township also reported that they have an MSM client taking ART who is only 17 years old.

The Situation Analysis team also visited a brothel in the slum area of a township in Ayeyarwaddy Division. We interviewed three sex workers who were 17 to 19 years of age. All were migrants from other towns. The three girls started working at the brothel two months ago. When asked how and why they chose to do this work, one 17 year old said that she lived in a village hit by Cyclone Nargis. She lost both parents and her remaining family struggled for survival. When a lady came to her village and promised her a job in the city she followed her and was brought to the brothel. The second girl said that because both her parents were divorced and both remarried, she was brought up by her elderly and impoverished grandmother. Life was tough and survival was difficult, so she was forced to resort to sex work to live. The third girl was from a suburban area of Yangon. She reported that she started sex work because her family had economic problems and could not survive.

One of the sex workers never attended school, and the other two attended only up to primary school. At this particular brothel, they received only 500 kyats (about US\$0.50 per client), and provide services for 5-10 clients per day. All three respondents said that they use condoms consistently and are able to obtain condoms from their pimp, the girls had no knowledge about HIV/AIDS and STIs whatsoever. All three expressed a desire to quit sex work if they had alternative livelihood options.

¹³⁴ A Synopsis on Reproductive and Sexual Health, Professor Dr. Mya Oo (Annex 4: Adolescent Reproductive Health at a Glance in Myanmar) (WHO-SEARO-2007)

¹³⁵ Ibid

¹³⁶ IOM and UNAIDS, Assessment of Mobility and HIV vulnerability among Myanmar migrant sex workers and factory workers in Mae Sot District, Tak Province, Thailand 2005

(d) Socio-Economic factors

In Myanmar, the poverty headcount index at the national level is 32%. Ten percent of the population falls under the food poverty line at the national level. Disparities exist especially in remote and border areas that lag behind compared to the more developed urban cities. The scarcity of job opportunities and economic difficulties result in vulnerability to HIV as people revert to survival and livelihood strategies that may include social and cultural uprooting, mobility, displacement and engagement in riskier behaviours. Economic factors drive young women and increasingly young MSM to become sex workers. People with low economic status have limited access to education, lack of knowledge on health as well as limited access to health care, compounding the effects of protection against HIV/AIDS.

9.8. National Response to HIV and AIDS in Myanmar

Under the National Health Committee, a multi-sector National AIDS committee was established in 1989 and chaired by the Minister for Health. It is a multi-sector body and includes Ministries and representatives of local NGOs that oversee the development and implementation of the National Strategic Plan. Under this National AIDS committee are state/division-, district- and township-level AIDS committees (For more information, please see Annex 2, Figure 2). A short-term plan for the prevention of HIV transmission was also launched in 1989 and developed the strategic plan of the GoUM (2001-2005).

Some policies and legislation¹³⁷ have been amended to the benefit of some at-risk and vulnerable population groups. The Ministry of Home Affairs issued a circular in 2000 citing that condoms should and cannot be used as circumstantial evidence for prostitution. The Ministry of Health issued a circular in 1994 to public sector health facilities informing that requests for sterilization from HIV infected women should be permissible regardless family size. National blood and blood law has issued in 2003. In addition there is a policy for developing and importing generic HIV drugs.

The NAP and DOH have produced tools and national guidelines for a broad range of programme components with inputs from national and international partners. The National guidelines for the clinical management of HIV infection in adults and children was revised in 2007 collaboratively via a consensus approach by the NAP, NGO partners and WHO. These guidelines now serve as a national treatment reference. However, other guidelines and manuals need to be reviewed and revised such as 100% TCP programme, and manuals on counselling. There is no approved guideline on VCCT yet to be adopted and there is a need to develop National Guideline and Standard Operation Procedure on PMCT as well as National guidelines for youth friendly services and a standard package of services for young people.

In 2002, the UN agencies developed the Joint Programme for HIV/AIDS Myanmar 2003-2005 to support the national response by a multi-year pooled funding mechanism known as The Fund for HIV/AIDS in Myanmar (FHAM). In 2005, the Global Fund round 3 supported the national response for one year. The three diseases fund established to support the national response in Myanmar brought in US\$100 million for AIDS, TB and Malaria for five years in 2006, after the termination of Global Fund money to Myanmar. Round 9 of the Global Fund for HIV saw Myanmar listed as category 1 (out of five categories) and recommended 5 years of funding to the tune of 157.7 million \$.¹³⁸

The National Strategic Plan (NSP) on HIV and AIDS 2006-2010 was the first in Myanmar developed using participatory processes, with direct involvement of all sectors which includes Ministry of Health, several other government Ministries, UN agencies, both local and international NGOs, PLHIV

¹³⁷ UNGASS- National Composite Policy Index (NCPI) 2007, Myanmar, UNAIDS

¹³⁸ The report of the Technical Review Panel of GFATM round 9

and people from vulnerable groups. In order to achieve aims and objectives¹³⁹ of the NSP, 2006-2010, a five year vision is prescribed for how a multisectoral and multipartner response to the HIV epidemic can be expanded significantly by 2010 with roles and responsibilities of key contingency groups. It identifies 13 strategic directions based on the 3 priority levels of the risk and vulnerability of beneficiary population and fundamental overarching issues. (For more information, please see Annex 1- Box 6)¹⁴⁰. The operational plans of NSP (2006-2008 and 2008-2010) along with yearly progress reports have been developed.

There are 10 key interventions of National response to HIV and AIDS are advocacy, health education, prevention of sexual transmission of HIV and STD, prevention of HIV transmission through injecting drug use, PMCT, provision of care and support, provision of safe blood supply, enhancing the multisectoral collaboration and cooperation, special intervention programme including cross border programmes and TB/HIV joint programmes and supervision, monitoring and evaluation¹⁴¹.

Progress towards 'Universal Access'¹⁴² of prevention, treatment, care and support in Myanmar (including UNGASS indicators) in 2008

The national progress report 2008¹⁴³ noted that government allocation for HIV and AIDS in health sector amounts annually to 1,488 million kyat (UNGASS Report 2008). The available amount of external resources for the national response to HIV is estimated at US\$31.3 million in 2008, which was only US\$0.4 million increase above the previous year. The actual amount received for the programmatic areas of prevention, care & treatment & support, programmatic areas of health system strengthening and monitoring & evaluation are 54%, 65%, 79% and 80% of planned amounts respectively. Highest priority areas (FSW and clients, MSM, IDU, PLHIV and families) were most resourced at 62% of planned, with high priority (mobile, institutionalized, uniformed, young,) at 46% and priority (work place, men and women of reproductive age) at 42% respectively. Although the HIV epidemic in Myanmar is concentrated, in 2000-2006, resources were mainly spent for HIV prevention programme for non-high-risk groups. This changed with the development of the 2006-2010 National Strategic Plan on HIV and AIDS and the introduction of the Three Diseases Fund which gives preference to funding targeted interventions.

- **Progress on highest priority groups (MARP) - FSW, MSM, IDU and PLHIV**

In 2008, around 60.7% to 81.4 % of total estimated sex workers were provided with prevention services through both public and private sectors – including clinics, drop-in centres and outreach projects. These numbers are 8% more than in 2007. The number of free and socially marketed condom distribution was increased to 34 millions in 2008 from 28 million in 2007. Currently NAP is implementing 100%TCP programme in 170 townships but only 40 townships and 11 townships received funding support from UNFPA and WHO respectively. In common with other Asian countries, the utilization of services by MSM is also low in Myanmar. Globally, where countries report on coverage, only around 40% of MSM have access to the HIV prevention and care services they need, whereas in Myanmar 16% of the total estimated MSM population accessed HIV prevention

¹³⁹ NSP aims at reducing HIV transmission and HIV-related morbidity, mortality, disability and social and economic impact and its objectives are to: reduce HIV transmission and vulnerability, particularly among people at highest risk; improve the quality and length of life of people living with HIV through treatment, care and support; and mitigate the social, cultural and economic impacts of the epidemic

¹⁴⁰ Myanmar National Strategic Plan on HIV and AIDS, 2006-2010, Ministry of Health

¹⁴¹ Health in Myanmar, 2009, Ministry of Health, 2009

¹⁴² 2006 Political Declaration, (UN General Assembly, 15 June 2006) declared that “(We) commit ourselves to pursuing all necessary efforts to scale up nationally driven, sustainable and comprehensive responses... towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010.” Universal access implies that all people should be able to have access to information and services that are: *Equitable – accessible – affordable – comprehensive – sustainable*. In 2006, countries worldwide committed to setting ambitious national targets for scaling up towards Universal Access to HIV prevention, treatment, care and support by 2010.

¹⁴³ National Strategic Plan for HIV & AIDS in Myanmar, progress report 2008, Ministry of Health

services, and only 11% of the total estimated MSM accessed VCCT service. In cooperation with PSI and UNFPA, 15 drop-in centres for MSM and FSW were established across 12 townships.

UNODC estimates that available financial resources for harm reduction programs in Asia represent only about 10% of actual needs. In Myanmar, the number of drug users who reach the service package by outreach and drop in centres was 22% of estimated size of IDU. A total of 36 drop-in centres have been established across 16 townships. A total of around 3.5 million needles and syringes were distributed and 580 former drug users are currently on methadone maintenance therapy.

The number of PLHIV involved in self-help groups was 13,247, of which 40% are females. These groups are increasingly playing coordinating and networking roles between individual groups throughout the country as well as established regional branches.

- **Progress on higher priority group-institutionalized population, mobile population, uniform personnel and out of school youth**

The number of prisoners reached with health education was significantly increased to 9930 in 2008 from 160 in 2007. In 2008, 28% of planned target (246,000) of mobile and migrant people has been reached by a package of prevention programme. In addition, a package of prevention programme has been carried out to 2,635 uniform personnel. HIV training is integrated in police cadet training and the trainings have been provided in police training depots and border areas. Almost all of the school teachers who have been trained in life skills based HIV education and who taught it during the last academic year whereas the number of out of school young people reached for HIV prevention activities was 46% of 2008 planned target (300,000) and around 46% of them were female.

- **Progress on priority group- workplace, men and women of reproductive age**

The number of people reached by package of prevention programme in workplace was 25% of the planned target (200,000). Among them, 28% are female. The 63% of 2008 planned target (1,000,000) of men and women of reproductive age has reached by prevention programme which included 21% of female.

- **Progress on comprehensive care, support and treatment**

The number of people receiving HIV tests and post-test counselling increased in 2008 from 2007 as adults receiving HIV test and post-test counselling was 83,996 (excluding MARP), whereas MARP receiving HIV test and post-test counselling was 13,612 including 7791 sex workers, 4031 MSM, 1731 IDU and 59 TB patients.

The percentage of people reached by services by those in need of treatment remains inappropriately low. In 2008, 20% of the estimated people in need received ART (of which 44% are female), somewhat below the coverage in Asia (37%) and the global coverage (42%) for all low and middle-income countries.¹⁴⁴ Please see Annex 4, Table (3) for more information on the coverage of antiretroviral therapy for adults and children with advanced HIV. About 23,451 patients are receiving home based care with male and female of equal proportion. The TB/HIV programme is implemented in 20 townships currently.

Currently The PMCT programme was implemented in 217 sites. In 2008, the number of pregnant mothers who have access the VCCT service was 315,920 and 51% of them receiving HIV test results and post-test counselling. Care and support was provided to 9527 orphans and vulnerable children (38% of the 2008 planned target of 25,000). 38.7% of the estimated need of PMCT (1780 mother baby pairs) received a complete course of antiretroviral prophylaxis. It is higher than percentage of

¹⁴⁴ Report on the global AIDS epidemic 2008 (Executive summary), UNAIDS

regional coverage (25%) (WHO, UNICEF, UNAIDS, report 2009) whereas less than the global coverage (45%) for low and middle income countries. Please see Annex 4 –Table (4) for more information.¹⁴⁵

- **Progress on capacity of health system**

With the aim to improve the capacity of the health system, 190 HIV testing laboratories participated in the National External Quality Assurance Scheme (NEQAS) for HIV serology and 199 service delivery points offered VCCT in 2008. In addition, 75% of transfused blood units screened for HIV in a quality assured manner.

- **Progress on monitoring and evaluation**

In 2008, NAP carried out the HSS in 34 townships to track the epidemic. Moreover, with the support of FHAM, 3DF and WHO, the NAP also conducted the behavioural surveillance surveys, 2007-2008 which include not only general population but also selected populations such as out of school youth, female sex workers as well as injection drug users.

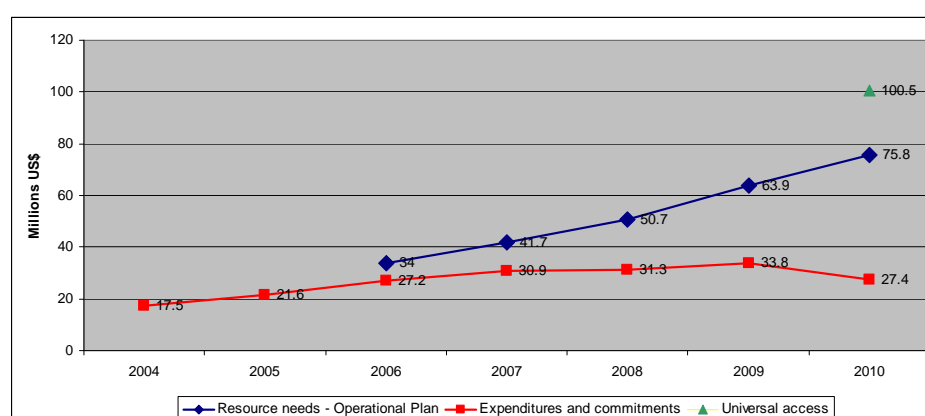
(Please see Annex 4 Table (2) on Progress towards Universal Access to prevention and care services in Myanmar for more information)

Issues and challenges for HIV & AIDS

(1) Gaps to meet the targets: It will be a challenge for Myanmar to meet the targets for condom use in high risk groups of MSM and IDU by 2010, and Myanmar is unlikely to meet the target of universal access to treatment for HIV/AIDS for all those who need it by 2010, and MDG target by 2015.

(2) Chronic Funding Gaps: Currently, projected resources are not sufficient to fund the scaling up of programmes, secure continuous support and provide affordable commodity access. The widening resource gap from 2006-2008 does not fit with the amount needed in the National Operational Plan. In 2008, this represents a shortfall of approximately 38% compared with the operational plan. Moreover, the people of Myanmar comparatively receive less development assistance than other countries in the region. Myanmar receives roughly US \$3-5 in foreign aid per capita, as compared to US\$30-50 per capita enjoyed by residents of Cambodia, Laos, and Vietnam¹⁴⁶. In addition, health expenditure as a percentage of GDP is the lowest in the region, at 2.2% in 2006 (World Health Statistics 2009).

Figure 3.26: Planned, reported and expected funding for HIV 2006- 2010, Myanmar



¹⁴⁵ Ibid

¹⁴⁶ UNAIDS, country situation, Myanmar, July 2008, UNAIDS

(3) Need for Health System Strengthening: There are weaknesses in the health care system and public health infrastructure. The AIDS/STD teams have limited resources to provide support to neighbouring areas that do not have AIDS/STD teams. Shortage and rapid turnover of staff implementing HIV programme activities, particularly at the township level which includes both AIDS/STD teams and BHS of different categories in the public health care facilities is a challenge especially those who are specifically trained for HIV/STI and RH programs. There is limited technical skill in leadership, programme planning, monitoring and reporting¹⁴⁷.

(4) Hard to reach population: In Myanmar, population is spread over a large geographical area. Infrastructure such as highways and roads are weak, transport facilities limited, and a great deal of the population is far from urban centres.

(5) Inadequate full range of services: As in many developing countries, the availability of a full range of services for continuum of care for PLHIV and their families in each area is inadequate, especially with low coverage of people receiving ARV therapy and limited socio-economic support in many areas of HIV services.

(6) Stigma and Discrimination are still major barriers to successful implementation of HIV/AIDS prevention and care. The root causes of stigma and discrimination in Myanmar are ignorance and lack of knowledge on the realities of HIV infection. Many people have a fear of acquiring HIV through casual contact because they lack access to information and knowledge on realities of the disease.

(7) Increased mobile population among high risk groups: There is difficulty to cover all vulnerable and higher risk populations because many of these groups are mobile in nature. For example, the SA team noted that it is hard to hold health education sessions for high risk groups who are potential clients of sex work such as transport workers, as these workers have no spare time and are constantly on the move. There is also difficulty in recruitment of sex workers for peer education because they move one township to another township frequently. A follow-up system for HIV positive mothers and their children is weak in PMCT programme, because some of the HIV positive mother moved away when they knew their HIV status or want to conceal their HIV status so they deliver the baby away from home.

(8) Low VCCT coverage: VCCT services are provided by NAP AIDS/STI clinic, PMCT townships, MSI clinics with free of charge for services and TOP, PSI with subsidized price and provide referral linkage with other departments (ART, TB, DTC &etc) and organizations. However, there is limited access and demand for VCCT services both general and most at risk population as well as gap in VCCT acceptance among male partners in PMCT programme. Moreover, there is limited access to clinical and support services for HIV positive people and so it makes hurdle to promote the VCCT and motivate referral services to VCCT.

(9) Need to strengthen as comprehensive PMCT programme: There is not only a large gap in need of PMCT but also limited access to ART services for mothers with advanced HIV infection. In Myanmar, PMCT programme started to be implemented as community based PMCT and followed by hospital based PMCT in tertiary and State and Divisional level hospitals. According to experience and review of the programme, hospital based PMCT obtained more uptake of PMCT service so that later change to township based PMCT focus on township hospitals. However, uptake continues to be relatively low for reasons probably related to stigma in being tested and the associated risk of being found positive, plus negative service provider attitudes and weakness of referral network from rural to township hospital due to transportation difficulties and etc.

¹⁴⁷ Review of the Myanmar National AIDS Programme, 2006, MOH and WHO

(10) Gaps in Data and Research on HIV and AIDS: Lack of availability of reliable data lowers the actual numbers of people with HIV and STI because many areas of the country are not covered by the government AIDS/STD teams, and there is widespread underreporting of AIDS cases from all townships. Although there has been a number of surveys and studies by NGOs working in Myanmar, it is not accessible resulting in data gap. Moreover, data gaps in some UNGASS indicators such as data related to OVC. Information on socio-behavioural characteristics on MSM and female injecting drug users is still limited. Similarly there is inadequate information on trends and socio-behavioural situation among higher risk groups such as migrant and mobile groups, institutionalized population and unformed services. There is large gap in research and studies that focus on gender and HIV as well as socio economic impact of HIV among PLHIV and their families. Knowledge and information about children infected and affected by HIV is minimal. Finally, there is lack of information on the sexual and reproductive needs of PLHIV.

Opportunities

(1) Political commitment and Policy: HIV/AIDS is a disease of national concern and highest priority of diseases included in the National Health Plan of Myanmar¹⁴⁸.

(2) Multisectoral cooperation and coordination: Myanmar-Country Coordination Mechanism (M-CCM) for the Three Diseases (transformed from 3DF Country Coordination Body) is chaired by Minister for Health, MOH, under which AIDS Technical and Strategic Group on AIDS (TSG) and its working groups have been formed with broad participation of stakeholders in line with a global policy approach. Please see Annex II figure 3 for more information. Moreover, the national multisectoral strategy/framework for 5 years (National Strategic Plan, 2006-2010) with its three year rolling operational plans include targets and indicators for key service areas and detailed budget cost per programmatic area. A monitoring and evaluation framework has also been developed.

(3) Involvement and empowerment of PLHIV and vulnerable groups: The network and number of self help groups of PLHIV and people with high-risk behaviour or vulnerable population (MSM, FSW and IDU) are rising across the country and actively and meaningfully participating in the response of HIV than before. These efforts should be encouraged and expanded.

(4) Partnership among all stakeholders: There is increased involvement of partners in the development of the national plan. These efforts should also be expanded.

¹⁴⁸ Health in Myanmar 2009, Ministry of Health, 2009

Chapter Four: Gender Equality and Women Empowerment



CHAPTER IV: Gender Equality and Women Empowerment

1. Introduction

Gender is a cross cutting theme in human development, quality of life and the wellbeing of any population. “Gender” and “Gender Based Violence” are still relatively new concepts in Myanmar culture and knowledge. Myanmar has rich cultural heritage which respects and acknowledges the differences between the sexes. An analysis of gender in Myanmar cannot take place without reference to the predominant gender roles, which are heavily entrenched in all aspects of society, culture and religious beliefs. There are limitations in data and information with regard to gender equality and women empowerment measures, however, this chapter analyzes gender in Myanmar, in the context of socio-cultural norms, educational attainment, gender and health, demographic changes linked to gender and development, gender based violence, human trafficking, and international measurements, benchmarks and tools such as the ICPD, Beijing Platform of Action and CEDAW. Also discussed is the national mechanism for gender equality, challenges, opportunities and recommendations for gender equality.

2. Socio-cultural context of gender

Myanmar is a multi-cultural society made up of 135 national races with different cultural habits and norms¹. Buddhism is the major religion of Myanmar practiced by 89% of the population². Traditional views surrounding women’s sexuality, strong patriarchal hierarchy within families and villages, and the style of governance (both nationally and locally) influences the gender-based division of labour of men and women in Myanmar.

Family Practices, Religious and Cultural Norms

Marriage in Myanmar is usually consensual rather than arranged, although a woman’s choices may decrease with the income circumstances of her family – a situation that is not unique to Myanmar. The average age of marriage among married people in Myanmar is 21 for women and 24 for men³. The country’s customary law sets the legal age of marriage at 20 years for women and at puberty for men, which refers to boys reaching physiological maturity to reproduce.⁴ This implies that males have greater liberty for marriage without age limitations and parental consent, unlike their female partners.

Since the early days of Burmese kings, there have been laws in Myanmar protecting women’s rights and gender equality. However, customary laws in Myanmar are defined by tradition and set by usage. Their interpretation usually rests with the elders who decide on individual cases and as such there are often discrepancies in interpretation.⁵ The following are some summaries of laws, rules and regulations regarding basic women’s rights in Myanmar

¹ Gender equality in Myanmar, http://www.wikigender.org/w/index.php/Gender_Equality_in_Myanmar accessed 6/3/2010

² <http://en.wikipedia.org/wiki/burma.religion> accessed on 2 June 2010

³ Country Report FRHS 2007

⁴ Gender equality and Social Institutions in Myanmar <http://genderindex.org/country/myanmar> , Accessed on 1.4.2010

⁵ Myanmar Gender Profile, UN Thematic Group on Gender 2000

Marriage, Divorce and Inheritance

Myanmar's customary laws deal mainly with personal affairs such as marriage, divorce and inheritance. A woman having reached 18 years of age, a widow or divorcee of any age, may marry anyone of her own free will and choice⁶. A single woman under 18 years of age needs the consent of her parents or guardian to marry.⁷ The matrimonial rights of a Myanmar woman include the right to property, the right to restitution of a conjugal relationship, the right to claim maintenance, and the right to divorce (which includes guardianship of children and the right to a part of shared property on settlement and) The Christian Marriage Act, 1872 (still in effect), Section 60 also states that in marriages between native Christians, the man must be above 16 years of age, and the woman must be above 13 years of age.

Under the Buddhist Women Special Marriage and Succession Act 1954, marriage between a non-Buddhist man (defined by puberty-attainment) and a Buddhist woman not under 14 years of age may marry. When a non-Buddhist man decides to divorce a Buddhist woman or leaves the woman, asserts acts of violence or acts of cruelty against the woman or causes psychological trauma:

1. The man shall dispose his rightful belongings and give to the woman as compensation.
2. The Buddhist wife has the right of custody over their children
3. The man shall provide support for the up keep of under-age children.

It is significant to note that Myanmar Buddhist traditions as well as the legal system allow polygamy. This stands in direct contradiction with CEDAW. While the state allows polygamous families, Buddhist society usually frowns upon the event of a man taking a second wife. The law recognises all wives equal to each other.⁸ Myanmar Buddhist women have the same legal rights to own property and land as their male counterparts. In marriage the husband and wife are considered co-owners under the following rules:

1. Either spouse is entitled to one third of the property owned by the other spouse before the wedding (*paryin*)
2. One half of the property accumulated or increased during the marriage (*lathtatpwar*), or property given to them at the wedding (*khanwin*) and property earned through work of both spouses (*hmar-par-sone*)

Women have equal legal rights to bank loans and other types of contracts. This shows an equal status of women under Buddhist law⁹. However, as customary law differs between ethnic groups, this equality does not hold true for all of the ethnic groups or national races that exist throughout the nation¹⁰. Chin women for example, traditionally cannot inherit property. When a husband dies, the son inherits the property and the wife must stay with their husband's parents. If the wife does not bear sons, she is to leave the house when the husband dies and leave the daughters with the husband's parents.¹¹ A Chin man is entitled to take another wife if the first wife does not produce a son.¹²

It is difficult to generalize legal rights since family dynamics are undoubtedly different according to culture, race, and religion. Differences in age of the partners, rural or urban settings, and level of education can also have an impact on how customary traditions regarding property ownership and inheritance are played out in different ethnic groups. Unfortunately, strong socio-economic or ethnographic studies with regional differentials and relevant data are presently limited in Myanmar.

When discussing gender equality, well-known Myanmar author Khin Myo Chit once wrote:

“Myanmar women never seemed to have need for liberation movements throughout history. Their right to own property had never been challenged and in fact some control the family

⁶ Abstracts from laws, rules and regulations and manuals for Myanmar women's rights , MSWRR, 1998 (*in Myanmar language*)

⁷ In contrast, Burmese Buddhist Law does not prevent a male youth who has reached puberty from contracting valid marriage without parental consent.

⁸ Myanmar gender profile, UN-Gender Theme Group, 2000

⁹ Gender equality in Myanmar, http://www.wikigender.org/w/index.php/Gender_Equality_in_Myanmar, accessed on 22 June 2010.

¹⁰ Country Report, FRHS, 2007

¹¹ Myanmar Gender Profile, UN Thematic Group on Gender, 2000

¹² Chandler, Glen. 1998. “Addressing Gender Issues within a Community Development Approach”. Yangon, UNDP/UNOPS.

finances, they never had impediments like *purdah* or *bound feet*, in spite of all this, there is an undercurrent of male chauvinism, in the relationship between men and women in society and this also can be more damaging to women as much as any written law.”¹³

Despite what may appear as relative equality when it comes to major decisions, property ownership or financial control, in Myanmar, there is a deep-rooted cultural norm of considering sons to be superior. The roles that girls and women assume throughout their lives are still based on the idealized culturally accepted notions of womanhood in Myanmar.

Religious Beliefs

At the root of these ideals is the notion in Myanmar Buddhist culture of males possessing “*phon*”, or religious superiority over females. The findings of research on “Knowledge, Attitude and Practice on gender issues amongst Basic Health Staff (BHS)” conducted by the Department of Health involving 88 BHS in four study townships, consisting of 52 females and 36 males revealed mainstream social norms emanating from religious beliefs. The majority of respondents believe that males have “*phon*” which is superior power as they can attain monkhood, and can enter certain holy places which are not accessible to women (especially during menstrual cycles). The majority of the participants expressed that they do not feel that this social norm can be changed because it is a deep-rooted religious belief.

The power, glory, and influence of *phon*

Many females argued that females also possess “*Phon*”. There is an old Myanmar saying that states, “*yauk kyar doe phon let yone; mein ma doe phon hsa htone*”. This translates as, “the power of a man lies in his strength; the power of women is her long hair tied into a big knot. As such, some female participants expressed concepts of female empowerment, given the saying states that women also have a form or aspect of “*phon*”.

However, some said females did not want to change this concept and noted that these notions were an integral part of Myanmar’s culture linked to religious teaching. They reciprocated with a quote that says, “people should not step on the shadow of a female who has given birth to sons”. They interpreted that this was not due to the “*phon*” of the mother, but due to the revered “*phon*” of the son whom she had delivered. The majority of male participants wanted to maintain this concept as males benefit culturally from their own “*phon*”.

KAP study on gender issues amongst BHS, DOH-DMR(LM), 2006, Nilar Tin et al.

The authors of the study inserted that “Asian theological scholars had written that in basic religious texts of Christianity, Buddhism, Islam and Hinduism, that there was no mention of inequality in the attributes and value of men and women. But as the interpretation of the text from the original version was done by men who were influenced by male dominant cultural values, women have been placed in a secondary role”¹⁴. It was found by the SA team that the concept of equal partnership is constrained in Myanmar, especially at the village level, as the belief of “*phon*” is regarded heavily in both religious and cultural practices and serves to promote men’s superiority over women¹⁵. On a programmatic level, these notions have the potential to negatively impact individual health and development, as well as increase women’s vulnerabilities in sexual and reproductive health.

One of the minority religions of Myanmar is Christianity. Christians constituted about 5% of the population in 1983. A key belief of Christianity is that men and women were created by God equally, with specific roles¹⁶. Husbands are to be the head of the family, wives to obey their husbands and

¹³ Khin Myo Chit, 1976, International Women’s Year (1976), Colourful Myanmar, p.187-205

¹⁴ Knowledge, attitude and practice on gender issues amongst Basic Health Staff, DOH-DMR (LM) Nilar Tin, Than Tun Sein, Kyu Kyu Than and Mar Mar Aung, Nay Pyi taw, 2006

¹⁵ Annex 3: Findings of SA, UNFPA, 2009

¹⁶ Holy Bible, Genesis Chapter 1, Ephesians 5: 6-9

wives are to be loved by their husbands, just as Jesus Christ loved the church and gave His life for the church.¹⁷ In practical situations however, the role of women in leadership positions in church is limited in most denominations in Myanmar. However, trends have been changing and there has been an increase in the ordination of female pastors, especially in the Methodist Church (Lower Myanmar) which used to be an exclusively male domain. The year 2010, marks the successful election of the first female President of the Myanmar Council of Churches, the highest government recognized Christian organization in the nation¹⁸.

The Muslim population in Myanmar constituted about 4% of the total population¹⁹ in 1983. However, according to some Muslim leaders it has been estimated to be as much as 20%.²⁰ Muslim women who are citizens of Myanmar enjoy equality in access to education, health and have freedom of worship according to the Constitution of the Union of Myanmar. However, the majority population of Northern Rakhine State (NRS) are a Muslim population, who speak a different dialect of Bengali that is spoken in southern Bangladesh and are linguistically different from the native Rakhine. Most of them are given temporary registration cards (TRC) issued by the Union of Myanmar²¹. As such, there are a number of restrictions imposed by the GoUM on these people, such as restrictions in movement resulting in limitations in access to higher education, access to health care affecting their quality of life.²² They need permission for marriage and permission to travel. Socio-cultural concepts compounded with these restrictions have significant impact of the status of women and adolescent females in NRS. After puberty women are confined to the house and only permitted to go out in the company of a male family member. As a result most Muslim girls if they are attending school withdraw after fourth grade in NRS. This results in low literacy rate in females, leading to disempowerment. Because of restrictions, delays in decision to seek assistance and access to health care have a major negative impact on the reproductive health of women in NRS.

3. Analysis of the status of women and girls in Education

The 2nd MDG Goal is to ensure, by 2015, that both boys and girls will complete a full course of primary education. In Myanmar, the ratio of girls to boys in primary education is almost in parity. However, women in certain ethnic groups have low status, and the high degree of illiteracy and isolation of many rural women is not conducive for optimum development. In Kachin, Kayah, Shan, Rakhine, Kayin, Mon and Tanintharyi, a larger percentage of the population than in other states have less than a Grade One level education, implying that there is lower educational status in the states of national races.²³

3.1 School enrolment ratio: Enrolment ratios for girls and boys in primary and secondary education have practically achieved parity in Myanmar. In tertiary education, girls have predominated since data was first available in 1990 and were at a ratio of about 136.35:100 in 2006²⁴. About 84% of those enrolling in Year one continue to Year 5 (no sex disaggregated data is available for retention rates). At the national level, the ratio of girls to boys at primary school level is 96.1 in 2004²⁵ and 101.69 in 2006. (Figure 4.1) The 2004 data shows the level is higher in rural areas at 98, where presumably there is attrition of boys into productive work, whereas the opposite is true in urban areas with 87.8 girls per 100 boys. It is significant to note that considerable regional variation exists. For example, in rural Kayah state it is 73.5 and in urban areas of Chin state it is 73.8, while in urban East Bago Division it is 71.3. These ratios indicate that girls have less access to education in some regions.²⁶ (Figure 4.2.) The largest gender gap (the enrolment for girls less than that of boys) can be found in

¹⁷ Holy Bible, Ephesians 5: verses 6-9

¹⁸ Interview with General Secretary of Myanmar Council of Churches, 2 June 2010

¹⁹ 1983 Population census, Burma, Department of immigration and Manpower, 1986

²⁰ US Department of State Report, "Burma-International Religious Freedom Report, 2006. <http://www.state.gov/g/drl/rls/hrrpt/2001/eap/8260.htm>. accessed on 25 June 2010.

²¹ Household survey in NRS, UNHCR, 2006

²² Reproductive Health Assessment, Northern Rakhine State, Myanmar, UNHCR-UNFPA, 2006

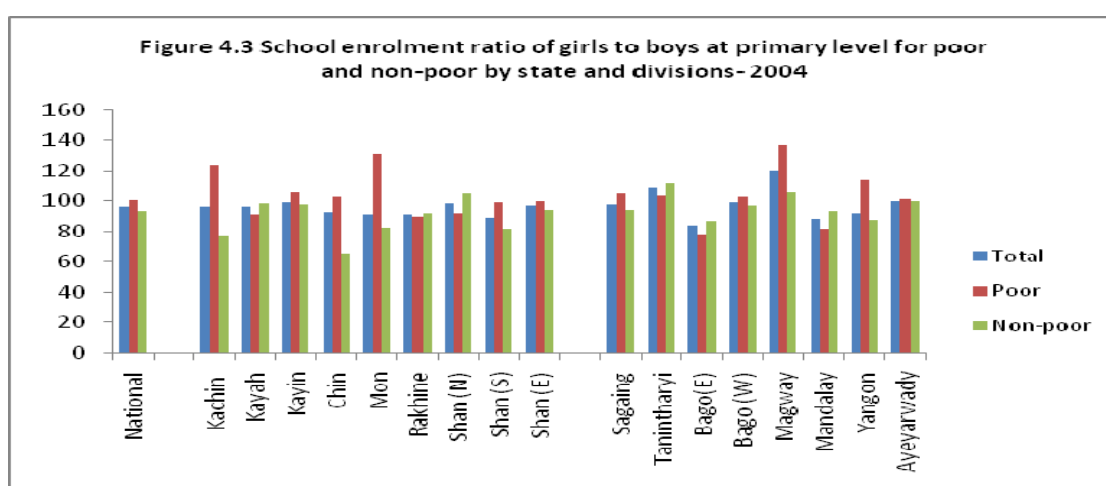
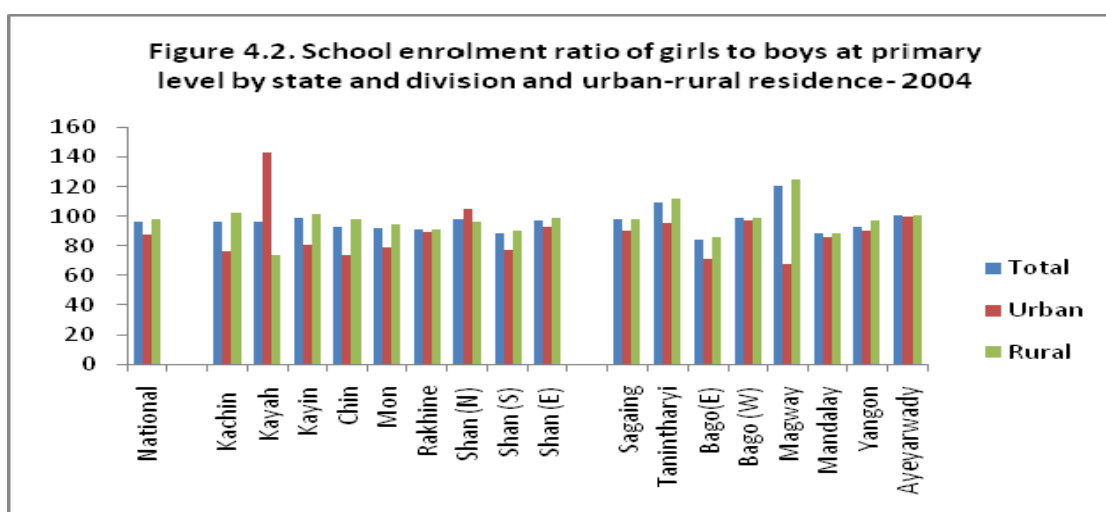
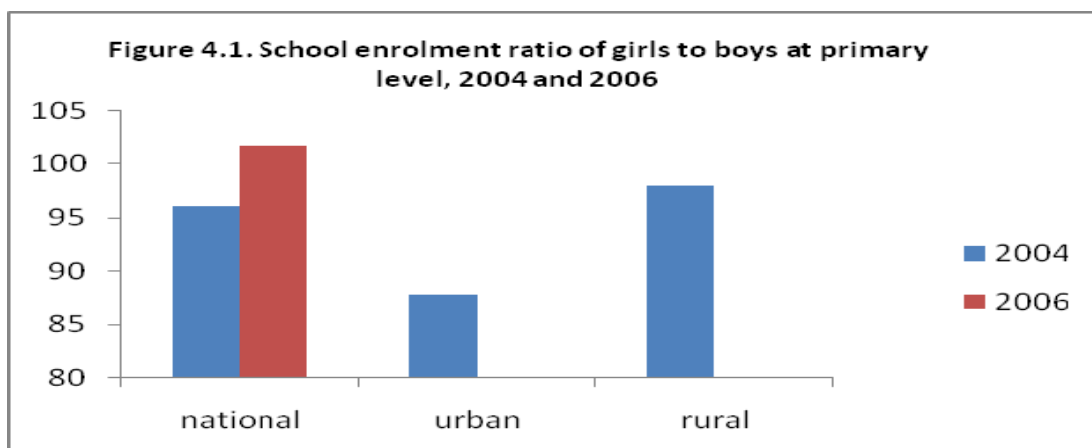
²³ Country report, FRHS 2007, page 24.

²⁴ Union of Myanmar *Millennium Development Goals Progress Report 2006*, Ministry of Planning and Economic Development

²⁵ 2007, *Poverty Profile*, Integrated Household Living Conditions Survey in Myanmar, UNDP & UNOPS

²⁶ Poverty Profile, MNPED and UNDP, 2007

Eastern Bago (83.9), particularly the poor in Eastern Bago (78.4), followed by Mandalay poor and Southern Shan urban (both with ratios below 90). Please see Figure 4.3 for more details.



Source: Poverty Profile, Integrated Household Living Conditions Survey in Myanmar, M N P E D & UNDP, 2003-2005

At the other end of the scale, there is a large gender gap in terms of boys missing from primary institutions in Magwe (120.2 girls per 100 boys), particularly the poor in Magwe (137.1) followed by Tanintharyi (108.9)²⁷. In Myanmar, the poorer a family, the less likely boys are to be in primary school, therefore the higher ratio of girls to boys.

²⁷ 2007, *Poverty Profile*, Integrated Household Living Conditions Survey in Myanmar, UNDP & UNOPS

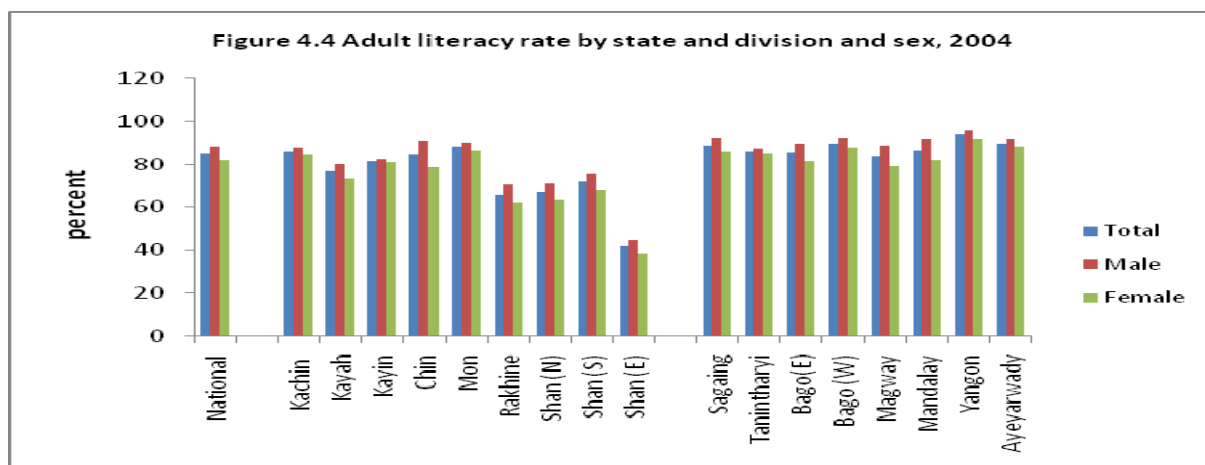
The quality of education is also recognizably variable in different parts of the country, with hard-to-reach areas struggling to retain teachers as the majority of teachers are women and if they are single, their families are reluctant to send them to remote villages for safety and sustainability reasons. In these areas, often the parents of school children and community must contribute to sustain education.

3.2 School Dropout rate

According to the Handbook on Education Indicators (2005-06), the total dropout rate by grade varies from a low of 1.17% at Grade 5 to a highest rate at Grade 11 of 54.29%. The dropout rate of boys at grade 11 is 56.11% whereas for girls it is lower 52.48%²⁸ There is no gender difference in school dropout rate at Grade 1 for boys and girls, which are 16.12% and 16.03% respectively (2003-2004 data). Among the States and Divisions, the dropout rate was highest at grade 11 in boys (72.85%) in Bago (West) Division and Grade 11 Girls (66.83%) in Chin State. As Grade 11 is the final year in the Myanmar basic education system, the high dropout rate at Grade 11 implies that less young people will proceed to pursue higher education. The gender difference is not significant – both boys and girls enter into employment to cope with financial constraints. There is need for a detailed study on the causes and the level at which they dropout.

3.3 Literacy rates

Literacy rate is not in parity when it comes to gender. In Myanmar, 88.2% of men and 82% of women are literate. Again, there is considerable regional variation, with the lowest levels of literacy in Eastern Shan (female 38.4%, male 44.8%) and Rakhine (female 61.7% and male 70.3%). Northern and Southern Shan and Kayah also register adult literacy rates of 80% or less for both females and males. The average gender gap in adult literacy for Myanmar is 6.2%, however the gap is largest in Mandalay (9.7%) followed by Magwe (9.2%)²⁹.



Source: Poverty Profile, Integrated Household Living Conditions Survey in Myanmar, Ministry of National Planning and Economic Development and UNDP, 2003-2005

4. Analysis of Gender and Health:

According to gender research carried out by DOH under the project of "Role of gender in rural communities in Myanmar", in most communities, families do give RH priority and men did not avoid household chores especially at the moment of puerperium, (a 7days period after the baby is born)³⁰. The SA team found in their in-depth interviews that of 58 interviewees all answered that in RH care and support the burden and responsibility of pregnancy and childbirth is mainly placed on the women

²⁸ Handbook for Educational Indicators 2005-06, MOE_UNICEF

²⁹ Poverty Profile, Integrated Household Living Conditions Survey in Myanmar, UNDP & Planning Department.

³⁰ Nilar Tin et al 2005, Role of gender in rural communities of two selected townships in Myanmar.

and male involvement is limited even in accompanying the women for regular Antenatal care.

In 2006, the Department of Health carried out a gender action research study with participation by Basic Health Staff (BHS) of Mandalay, Bago (East) Division, Yangon Division and Shan (South) State. The study identified that gender-related attitudes of BHS were framed around differences in sexual functions, existing female-male biases due to administrative regulations, cultural beliefs, social perceptions, social norms and religious beliefs. The study highlighted that many BHS expressed that they could not change issues relating to biological differences between male and female and issues relating to religious teachings.

Only some of the participants expressed the aspiration to change female-male biases due to administrative regulations, cultural beliefs, social perceptions, and social norms while some BHS emphasized the need to retain cultural norms. In this difference of opinions, it was the females that highlighted the desire for equal rights between women and men among BHS providers within the context of Myanmar culture.³¹

Female–male biases: should women become community leaders?

Opinions differed among female participants. The majority of respondents wanted to change this administrative arrangement as leadership should be given according to capabilities and merit and not because of gender. A minority said they agreed that women should be community leaders, but are concerned that these women might not be able to fulfil their household duties as wives.

KAP study on gender issues amongst BHS, DOH-DMR(LM), 2006, Nilar Tin et al.

4.1 Analysis of Demographic changes, Reproductive Health and Gender

As mentioned in detail in Chapter 2, the age structure of Myanmar population under 15 years of age had decreased from 41 percent in 1973, to 28.3 percent in 2006. The proportion of working age group 15-59 years was 53 percent in 1973 and had progressively increased to 63 percent in 2006, indicating the entrance of large birth cohorts in the past into this age group accompanied by the decline in proportion of children under 15 due to the decline in fertility in the past decades.

Looking at mortality and morbidity patterns it was found that Maternal Mortality Ratio (MMR) was the highest in the age group 45-49 years old, followed by women of 15-19 year old age group. The leading direct obstetric cause of maternal deaths is postpartum haemorrhage (30.98%), followed by hypertensive disorders of pregnancy including eclampsia (16.9%) and abortion related causes (9.86%). A small study on septic abortion showed that majority of abortions was performed illegally and while women did know about the potential dangers of induced abortion they conducted the procedure due to economic reasons³². According to the 2004 Family and Youth Survey³³, the traditional birth attendant's home was the most often sited place for inducing abortion. Predominantly unsafe abortion practices by an unqualified practitioner are responsible for the development of complications and deaths of young mothers. Lack of access to birth spacing services, unawareness about dangers of induced abortion in unsafe conditions, and delays in seeking qualified care are all factors contributing to the tragedy.

It was found that nuptiality in Myanmar is in transition as the proportion never married (PNM) for both sexes was 39.6 percent in 1973, increasing with time reaching the peak in 2001 at 55.7 per cent and decreased to 54.1 percent in 2006. The age at marriage is relatively high in Myanmar, and most

³¹ 2006, Knowledge, Attitude and Practice on gender issues amongst Basic Health Staff, Nilar Tin, Than Tun Sein, Kyu Kyu Than, Kywe Kywe Thein & Mar Mar Aung, DOH –DMR (LM)

³² Win, Nellie. Septic abortion is associated with economic factors. Thesis, BNSc; Yangon: Institute of Nursing.

³³ Ministry of Immigration and Population and UNFPA, Family and Youth Survey 2004: Country Report. Yangon, October 2006

adolescents (aged 15 to 19) are unmarried. The proportion of female adolescents marrying has declined from 10.2 percent in 1991 to 6.8 percent in 2006 and about 4 to 5 percent of total female adolescents (or 54.5 percent of ever-married adolescents) are either pregnant with their first child or are already mothers.³⁴ Myanmar women of reproductive age group are vulnerable to preventable pregnancy-related maternal deaths.

It was also found that there is limited male involvement in ANC and decision on contraceptive choice. It was found that the risk taking behaviour of males puts women at increased risk of HIV and gender-based violence. In both urban and rural settings, the majority of Myanmar men stated that work and business were top priority concerns and women's health stood third on the priority list³⁵. Development projects to increase male involvement in decisions about reproductive health achieved significant success in improving men's engagement with their partners, helping to increase their knowledge and care, prioritize financial support and redistribute household tasks³⁶.

The Situation Analysis (SA) team conducted 6 sessions of focus group discussions with a total of 45 youth participated which included male and female from urban, suburban and rural areas between the ages of 18 to 24 years from five townships. It was found that when asked about un-intended pregnancies, the majority of young people expressed that abortion is not the best option and that both partners should take responsibility – joint decision-making should be encouraged to face the consequences of pregnancy³⁷. All young people know at least 6 methods of contraception as mentioned in the analysis with regard to HIV and STI and young people are aware of the mode of transmission and prevention of HIV and STI. They also expressed that there are no sufficient services tailored for adolescent sexual and reproductive health needs.

The data on MMR and demographic changes (including the increased proportion of never married and increased percentage of abortion in the 15 to 19 age group) calls for improved adolescent RH knowledge sharing, better birth spacing services targeted to adolescents and non-married women, improved male involvement RH programs, and better RH care and support for the increasing 15-19 age group.

Demographically, the age group 60 years and over has also increased from 6.0 percent in 1973 to 8.7 percent in 2006³⁸. Thus, there is a broadening share of the over-60 years group impinging on the post-parenthood age group. Analysis of the data in the increasing elderly population found that Myanmar women live longer than their male counter parts.

By 2025, the proportion of elderly population is expected to rise to 12.1%³⁹. Average life expectancy for male is 62.9 for urban males and 62.5 for rural males, whereas for female it is 67.3 for urban females and 65.5 for rural females.⁴⁰ Women in Myanmar live longer and with the increasing proportion of elderly population there will be more elderly women who will need health care and support specific for the elderly. There will be more elderly women living in rural areas than urban areas. A needs assessment on the geographic distribution and social support for elderly females should be conducted.

4.2 Analysis of HIV and Gender

At the 2006 High Level Meeting on AIDS, all member states of the United Nations pledged “to eliminate gender inequalities, gender-based abuse and violence” and to “increase the capacity of

³⁴ Department of Population and UNFPA, Country Report, 2007 FRHS, 2009

³⁵ Report on baseline data collections & behavior study on male involvement in RH, Myanmar. UNFPA-MOH-MMA-JOICFP, 2005

³⁶ End-line data collection & behavior study report on male involvement in RH in Myanmar, 2007, UNFPA, MOH, MMA, JOICFP.

³⁷ Annex 3: SA Findings, UNFPA, 2009

³⁸ Country report, FRHS, Department of Population and UNFPA, 2007

³⁹ The Elderly Population in Myanmar: trends, Living Conditions, Characteristics and Prospects, DOP& UNFPA, April 2005

⁴⁰ Health in Myanmar, 2009, Ministry of Health, 2009

women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and services, including, inter alia, sexual and reproductive health, and the provision of full access to comprehensive information and education.”⁴¹

According to an AIDS epidemic update, in 2009⁴² the proportion of women living with HIV in the Asia region rose from 19% in 2000 to 35% in 2008. In particular countries, the growth in HIV infection among women has been especially striking. In India, women accounted for an estimated 39% prevalence in 2007. During this decade, women’s share of HIV cases in China doubled⁴³. In the same way, in Myanmar, based on an estimation workshop report 2009, the epidemic also spreads to women where an estimated 35% cases are female. The routine monitoring report of NAP indicated that the ratio of AIDS cases in female to male has increased from 1 to 3.6 in 2000 to 1 to 2.4 in 2008.⁴⁴ While the HIV prevalence among pregnant mothers from Ante Natal clinic from 32 sites has decreased.

Women’s personal risk perception was also low in spite of the existence of high-risk behaviour of some men and the prevalence of HIV infection in their community⁴⁵. In 2007, the behavioural surveillance survey (BSS) of the general population, noted that women had lower knowledge of HIV transmission than men and uneducated women dependent on their partners were less knowledgeable.⁴⁶ In common with other countries in Asia, a 2009 draft desk review of gender and HIV in Myanmar⁴⁷ indicated that the increasing HIV transmission to females is thought to be due to sexual relationships with their husbands or long term sexual partners who have also patronized sex workers. This process is termed ‘intimate partner transmission (IPT)’

Social norms and unequal gender roles in the family in Myanmar may render women more vulnerable to HIV as women generally fail to negotiate condom use with their partners.⁴⁸ A culture of submissiveness and the one sided faithfulness of wives may lead to women’s heightened risk of HIV infection. Due to fear of accusations of infidelity including fear of being labelled as sexually promiscuous, disclosure of HIV status to sexual partners and spouses is thought to be low⁴⁹. The SA team found that a majority of Myanmar women are economically dependent on men and this means that they have less decision-making power than men. Moreover, women have more responsibility for looking after children as well as the care of other family members such as the elderly, orphaned relatives, and those living with long term illnesses (including PLHIV), and orphaned relatives. An HIV positive woman who is pregnant is definitely more disadvantaged, since she must look after both herself and her unborn child also.

From the findings of the field report, the SA team noted that although the knowledge and reported use of condom have considerably increased among sex workers, some are not used consistently because they fail to negotiate with clients to use condoms, especially clients under influence of stimulant drugs and alcohol. Consequently, there is a higher risk of further transmission of HIV among HIV-positive FSW to their sexual partners and clients as well as from HIV-positive clients to sex workers⁵⁰. Although there is no in depth study for female condom use among sex workers, the 2008 BSS found that among interviewed FSW, 71% of FSW have heard of the female condom while only one third of them had used it. According to SA team interview with female sex workers, they have experience with female condoms and usually use female condoms when they cannot negotiate with the clients to use male condoms if they have enough time and at the time of their menstrual period. However, they

⁴¹ UNAIDS, Gender.<http://www.unaids> accessed on 9.4.2010.

⁴² AIDS epidemic update , UNAIDS and WHO, 2009

⁴³ Ibid

⁴⁴ National Strategic Plan for HIV & AIDS in Myanmar, progress report 2008, Ministry of Health

⁴⁵ Report on Baseline data collection & behavior study on male involvement in Reproductive Health Myanmar

⁴⁶ Dr. Aye Myat Soe, Daw Aye Aye Sein, Dr.Khin Ohnmar San, Behavioural surveillance survey 2007 (general population) National AIDS Programme, Department of Health, Ministry of Health, Myanmar

⁴⁷ Dr. Aye Myat Soe, Draft Desk Review of Gender and HIV in Myanmar, , September 2009

⁴⁸ Reproductive health needs of HIV positive women:client perspective, Kyu Kyu Than, Poe Poe Aung, Htin Aung Saw, Tin Tin Wai, The Maung Maung& Nyo Aung, Myanmar Health Science Research Journal,Vol.19, No 3, 2007

⁴⁹ Draft report of Desk Review of Gender and HIV in Myanmar, Dr. Aye Myat Soe, 2009

⁵⁰ Annex 3: Findings of SA, UNFPA, 2009

expressed barriers in both the availability of female condoms and their price as female condoms are more costly than the male version.

Currently, the harm reduction programme for IDU expanded in strategic areas but the numbers of female IDUs who receive services is extremely small. Among IDU who utilizes services in outreach and Drop in centers, female proportion is only 6% and 2% respectively. Female IDUs may be at high risk of HIV transmission through not only injecting drug use but also through potential overlapping risk behaviour such as sex work or through being the intimate partner of a male IDU⁵¹.

Although globally, coverage of antiretroviral treatment for women is higher than or equal to that of men, access to retroviral treatment for female was lower than male in Myanmar (among those who received ART in Myanmar in 2008, 44% were females and in terms of overall people in need of ART, 25% of men needing ART and 19% of women needing ART received ART). Similarly, VCCT services and prevention programmes reach more of male population than females among the general population. In addition, services of drug users, including HIV prevention interventions are generally targeted towards male users, who still form the vast majority of Drop In-center clients.

The draft report of the desk review of research on Gender and HIV in Myanmar explained that the factors which may limit women's access to HIV services are: their lower status or social value in the household, lower literacy rate, less access to health information, and being excluded from decision making in terms of health action and expenditure. Self-stigmatization and discrimination by the community are other factors.

HIV positive women who live in an extended family receive sympathy and support within families. They said that if their communities knew their HIV status, acceptance and support would not be likely. These women kept their status strictly confidential. They felt that if they made public their HIV status, they would be stigmatized and isolated at home. The SA team noticed a high degree of self-stigmatization in women living with HIV, that needs to be addressed. The SA team met one HIV positive mother who said that she found out about her HIV positive status when she became pregnant. She said that she lived alone in her house and would not go outside of the home because she was afraid of discrimination from her friends and others if they knew her HIV status”

SA team FGD with pregnant mother, 2009

5. Gender Based Violence

Gender Based Violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed differences between males and females.⁵² Violence Against Women (VAW) refers to any act of GBV that results in or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life⁵³. All forms of VAW when perpetrated against a women's will are GBV. However, all GBV may not be VAW because it may involve groups of people, such as groups of men, women, boys and girls who express gender power over the other⁵⁴.

Although it is difficult to get official information on the level of physical⁵⁵ gender based violence in Myanmar, knowledge on GBV is very rare as most cases are under-reported. There are however, standard operational protocols for survivors of sexual abuse who generally end up at hospitals as police cases, rather than with a reproductive health care provider¹. This results in under-reporting as

⁵¹ Draft report of Desk Review of Gender and HIV in Myanmar, Dr. Aye Myat Soe, 2009

⁵² Guidelines for Gender-based Violence interventions in humanitarian settings, IASC, 2005

⁵³ UNESCO, 1999, Article 1 of the UN declaration on Elimination of violence against women (DEVW), UN general assembly resolution 48/10 of 20 December 1993

⁵⁴ This is an additional expression of SA team's definition of GBV in Myanmar context.

⁵⁵ Noting that GBV includes physical, sexual and psychological harm/suffering, including the threat of such harm

many women are afraid of being exposed.

GBV in Myanmar

Due to the fact that there is no data on gender based violence and that in general women and girls do not experience many of the extreme manifestations of discrimination and seclusion, it has become normal for many gender gaps and inequalities to be overlooked by both national and international organizations working in Myanmar's development sector.

A study carried out by MWAF on reported cases of sexual assault revealed that in 17 states and divisions of Myanmar there were 209 cases in 2001 and 338 cases in 2004. A study on marital violence against women revealed that the most common causes were financial difficulties, alcohol consumption and incompatibility with in-laws⁵⁶. Programmatic measures taken by MWAF to eliminate violence against women include:

- (a) Counselling Centres set up to help women gather and solve their own problems.
- (b) Training for service providers on violence against women in all states and divisions.

A study on psychological trauma on rape victims showed that there were 150 cases of rape committed to women and girls in Yangon Division (2004-2005). The study showed that the age range of victims varied from 10 years to 42 years, while half of the cases were under 15 years of age. Half of the cases occurred in the victim's house, with the highest proportion by persons known to the victim. The highest period of the day of the offence is in the afternoon and at night. Most of the victims suffered severe anxiety and depression. The findings revealed that most of the rape victims want protection and support for their future from the MWAF. They expressed that they want legal protection and services.⁵⁷

Findings of the SA team include that at township level, incidences of domestic violence against women were reported to the MWAF who take up the case on behalf of the victim after investigation. The current procedure for women to report and complain about discrimination and violence through MWAF is functional and known by public. However, more in-depth studies, systematic documentation, sharing of information on data, analysis of complaints filed and their outcomes need to be studied to assess effectiveness on issues handled and supported by MWAF⁵⁸.

The CEDAW committee expressed concern about domestic violence and sexual violence, including "rape in Myanmar which appears to be accompanied by a culture of silence and impunity, [and] that cases of violence are thus underreported and that those that are reported are settled out of court".⁵⁹

⁵⁶ Gender Statistics in Myanmar, 2006

⁵⁷ Psychological trauma of rape victims, Nwe Ni Hla, Ph.D dissertation 2006

⁵⁸ Annex 3: Findings SA team, *See annex 11- for interview question component, 12 to 13 for gender.*

⁵⁹ Concluding observations of the CEDAW 42nd session, 20 October-7 November 2008.

Gender Based Violence (GBV)

At least one in three of the world's female population has been either physically or sexually abused at some time in her life.¹ Gender-based violence is the most extreme manifestation of gender inequality, which is defined as any act of violence based on gender that results from or in physical, sexual or psychological damage or suffering for women.

This kind of violence is mainly perpetrated against women precisely because there are some men who wish to assert their male power over women. The high levels of this kind of violence in most societies and its serious consequences both in health and socio-economic areas make this a priority problem in the human rights and public health agendas.

Types of GBV

The most common manifestation of this kind of violence is abuse within couples; however, there are other forms that occur frequently, like rape, violence against girls, sexual exploitation and abuse, discrimination, intimidation, forced sterilization, trafficking, sexual harassment and forced prostitution. These manifestations highlight the extent of violence against women, which can be physical, psychological and/or sexual, and distinguished by the relationship with the aggressor.

¹ <http://www.who.int/gender/violence/en/ accessed on 2 July 2010>

The Women's Protection sub-cluster of cyclone Nargis reported that as is common in many other countries, many women present with symptoms consistent with GBV at clinics report that they have had an accident, rather than been victims of abuse⁶⁰. This makes creating a GBV response mechanism particularly challenging. Presumably this is due to a reluctance to report violence to the authorities. A major point of concern is that in the legal handling of GBV cases, because when a victim reports to a clinic the medical service provider is required to report the case to the police before treating the survivor. Thus, most survivors are reluctant to report and gain access to health care.

The issue of violence is complex and difficult to tackle. For programmatic responses to be effective a multi-sectoral approach and more research are both required. The four main pillars of GBV prevention and responses are based in health, psychosocial, legal and security sectors.

Of particular interest are the various manifestations of sexual violence, such as forced sexual initiation, sexual harassment in the workplace, sexual abuse of female migrants, sexual abuse against sex workers, and forced prostitution. Violence during pregnancy and its consequences are issues that are extremely important to address.

Around the world, GBV has greater impact on women and girls than men and boys.

The term GBV is often used interchangeable with the term "violence against women". However, GBV highlights the gender dimension; in other words, the acts involve the relationship between female's subordinate status in society and their increased vulnerability to violence.

The majority of men are aware of physical violence as gender-based violence but a significantly lower percentage of men are aware of psychological sexual violence which can be equally traumatizing to women.

In Myanmar, while there are Standard Operating Procedures for reporting rape, domestic violence and GBV in times of emergency are not well understood and have yet to be studied in Myanmar. Additionally, both the public and medical personnel need more information on women's protection laws and procedures for reporting and taking action for violence against women in Myanmar. In 2006, DOH in partnership with WHO, Myanmar trained BHS staff in 20 townships in ten States and Divisions on gender and health and developed training modules for BHS and community⁶¹. However, there is a great need for nationwide capacity building for addressing gender based violence⁶².

GBV in Emergency situations

After Cyclone Nargis, UNFPA and the Women's Protection Technical Working Group members provided series of trainings on Gender-based Violence to humanitarian actors. To date, more than 200 humanitarian staff working in the Delta received training on GBV, however, training for female police officers, female lawyers and female counsellors should also be considered in order to provide prevention actions and immediate responses to GBV survivors.

A post Nargis assessment carried out by the Women's Protection Working Group highlighted the change in household composition where 14 out of 100 were headed by female and most of them were widows. Sixty percent of the female-headed

households lived in unsatisfactory shelters and in many children were likely to drop out of school due to financial constraints. 38.8% of male headed households own agriculture land compared to 31.3% of the female-headed households. There is minimal difference between male-headed (11%) and female-headed (13%) in terms of their possession of draught cattle however, a greater % of male-headed

⁶⁰ Field interviews with 40+ women in the delta over a 6 month period, 2008-2009, Shanny Cambell

⁶¹ UNDP Gender Tracking Study (draft interim report, February 2009),

⁶² Community Module for Gender and Health, DOH, MOH-WHO, 2008

⁶² Annex 3: Findings of the situational analysis key informant interviews.

households possess boats (19%) then female-headed households (9%) and fishing nets.⁶³ The same study found that 80% of respondents were in debt, alcoholism was on the rise, and there were higher incidences of domestic violence. Respondents indicated that female workers earn only 66% of the salary of male workers and number of women engaging in sex work for money, food and favours was increasing⁶⁴.

The topic of gender-based violence is considered quite sensitive in Myanmar. Interestingly then, the Post-Nargis Periodic Review III revealed that there was increased reporting of gender-based violence. 20 % of respondents reported knowledge of such acts of violence occurring in their village.⁶⁵ This can be seen as a positive sign of increased awareness and willingness to overcome social taboos.

6. Human Trafficking

Human trafficking has become a challenging issue in Myanmar with serious implications for both economic and social development. Myanmar has adopted combating human trafficking as a national cause since 1997. With an aim for coordinated efforts to curb trans-national crime including human trafficking the UN adopted the UN Convention against Transnational Organized Crime (UNTOC) in 2000, which was supplemented by the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children. In 2004, the ASEAN summit adopted the Declaration on Anti-trafficking in persons among the ASEAN countries.

The Ministry of Home Affairs, is the focal point for trafficking of women and children. It works with MNCWA, UN agencies and NGOs to combat trafficking of women and children Table 4.1 shows record of trafficking cases.

Table 4.1: Recorded Trafficking Cases, 2002-2005

No.	Years	Cases	Offenders		Rescued persons	
			Male	Female	Male	Female
1.	2002	99	75	88	272	268
2.	2003	195	229	148	523	409
3.	2004	180	235	164	611	546
4.	2005	169	162	178	355	327

Source: Gender statistics in Myanmar, MWAF-MNCWA, 2006

Trafficking of women and girls is a gender issue and the Myanmar National Committee on Women's Affairs has developed and implemented preventive measures for human trafficking and these are included in its plan of action. Dissemination of information and awareness-raising with regard to trafficking of women, its dangers, threats, and consequences has been carried out by MWAF through its networks in different levels of the administration from state/division to district and township level. MWAF works in collaboration with UNIAP, UNICEF, IOM and other NGOs for combating human trafficking.⁶⁶ The first ever National Seminar of trafficking in persons was held by MWAF in 2003 in cooperation with UNIAP, UNICEF and SC-UK. The topics discussed were Conceptualizing Trafficking, Global perspectives of trafficking in persons, a Myanmar perspective on trafficking in person, and community-based initiatives for prevention of trafficking in Myanmar.⁶⁷

⁶³ Women's protection assessment, Post cyclone Nargis, Myanmar, 2010

⁶⁴ Post-Nargis Joint Assessment, Review 3, Tripartite Group, 2010

⁶⁵ Post-Nargis Periodic Review III, Tripartite Core Group, January, 2010

⁶⁶ 2005, Myanmar Women's Affairs Federation (MWAF) profile

⁶⁷ New Light of Myanmar, 26 May, 2003

Ministers from the Greater Mekong Sub-region signed an MOU on the Coordinated Mekong Ministerial Initiative against Trafficking in Persons (COMMIT) in 2004 and Myanmar as a signatory developed the National Plan of Action in 2007, with an objective to effectively eliminate internal and transnational human trafficking.

The Central Supervisory Committee for Illegal Migration with sub-committees were formed and led by the DG of Myanmar Police Force in 2001 and this enabled education, prevention and law enforcement of illegal migration. In 2001, MNCWA and UNIAP formulated mobile teams to Combat Trafficking of Women and Children and conducted training of trainers in the country. These mobile teams included personnel from the Myanmar Police Force, Ministry of Immigration, Attorney General's Office, Ministry of Health, Ministry of Education and MMCWA.⁶⁸

“The Handbook on Trafficking in persons: Myanmar initiatives” was published in 2002, a joint effort between MNCWA and UNIAP. The handbook is in both English and Myanmar languages and highlights an interactive participatory method of training to build capacity of service providers for prevention and reduction of trafficking. It also provides knowledge and relevant information on gender, international instruments that relate to trafficking such as CEDAW, Convention on the Rights of the Child, (CRC), the Protocol to Prevent, Suppress and Punish Trafficking in Persons especially Women and Children, supplementing the UN Convention Against Transnational Organized Crime.

An outcome of the MNCWA-UNIAP work has been the establishment of the Myawaddy receiving centre. Illegal migrants lured by brokers or voluntary migrants who faced difficulties and who wished to return home were received and repatriated. In the period of 2001 to 2007, 17,967 males and 6,522 females, and 19 children were received and returned to their families⁶⁹.

Anti-trafficking units/Task Force: According to the MOU signed between the GoUM and the Government of Australia, as a result of the Regional Cooperation to prevent people trafficking project, 40 Police officers were trained and 18 anti-trafficking taskforces were formed and assigned at Yangon, Mandalay, Bhamo, Kalamyo, Muse, Tachileik, Myawaddy, Kawthaung, Myitkyina, Kyaingtone, Taungyi, Lashio, Myeik, Meikhtila, Magwe, Maungdaw and Bago.

An anti-trafficking law was enacted in 2005, followed by a national seminar organized by MOHA and UNIAP in 2006. The objective of the seminar was to raise awareness of the public and relevant responsible persons regarding this law and to have better cooperation between criminal justice sectors, government departments, NGOs and civil society.

Organizations have been tasked with different mandates in relation to human trafficking issues: UNICEF for child protection, UNFPA for reproductive health, gender and prevention of human trafficking, IOM for victim protection and reintegration, UNIAP for coordination in policy formulation, prevention of human trafficking, prosecution, law enforcement and victim protection, and UNODC in law enforcement for crime and trafficking. There are many INGOs and NGOs involved in prevention and awareness raising for human trafficking, including World Vision

Human Trafficking

Trafficking means recruitment, transportation, transfer, sale, purchase, lending, hiring, harboring or receipt of persons after committing any of the following acts for the purpose of exploitation of a person with or without his or her consent, thus trafficking in persons is the act of trading human beings as goods. This can include acts of torture, prostitution and exploitation for profit. Trafficking in persons has physical, psycho-social, and mental negative effects, and erodes the dignity of the human being. According to a UNODC report 2005, 54% of all the human trafficking cases occurring in South East Asia countries, occur in the Greater Mekong Sub-region.

⁶⁸ 2002, Handbook on Trafficking in persons: Myanmar initiatives, MNCWA-UNIAP

⁶⁹ 2007, Five-Year National Plan of Action for Combating Human Trafficking (2007-2011)

Myanmar, AFXB, Save the Children Myanmar, and national NGOs such as MNCWA, MWAF, Myanmar Council of Churches, Myanmar Baptist Convention, Karen Baptist Convention, Good Shepherd, Young Men Christian Association and Young Women Christian Association⁷⁰.

7. Measures of Gender in Development

Gender related Development Index (GDI)

Myanmar's population is estimated to be 57.5 million (CSO, 2008), with life expectancies of 63 years for women and 59 years for men (UNDP, 2009). Categorized as a 'medium human development' country, Myanmar is ranked 138 of 177 countries listed on the United Nation's Human Development Index (HDI)⁷¹, with a score of 0.586 (UNDP, 2009). HDI is calculated using non-income indicators of human development covering the areas of: living a long and healthy life, having access to education, and to a decent standard of living.⁷²

The gender related development index (GDI) for Myanmar, which uses the same indicators as the HDI but captures inequalities in achievement between women and men, could not be calculated in 2007 or 2009 due to inadequate data. However, Myanmar's position on the GDI table equates it to a score just above that of Cambodia, ranking 117 among 179 countries with a score of 0.581. This slight reduction from the HDI value results from women's lower adult literacy rate of women 86.4% compared to male of 93.9% and lower estimated earned income of male (women can expect to earn 65% of the income of their male counterparts)⁷³.

Gender Empowerment Measures in Myanmar

The Gender Empowerment Measure (GEM) is perhaps more reflective of the relative position of women and girls in society, since it captures the extent to which women take an active part in economic and political life. It tracks the share of seats in parliament held by women; of female legislators, senior officials and managers; and of female professional and technical workers, and the gender disparity in earned income, reflecting economic independence⁷⁴. Again, figures for Myanmar could not be calculated since Myanmar does not have a parliament. Gender disaggregated data on economic decision-making is scarce, much like many other countries as it can only be calculated for about 100 countries in the world. However, GEM have been calculated for Norway-0.906, USA-0.767, Maldives- 0.429, Thailand-0.514, Iran- 0.331, Indonesia-0.408, Bangladesh-0.264 and for Vietnam-0.554⁷⁵. Thus, provision of quality sex disaggregated data to fill this gap would enable Myanmar to benchmark itself internationally with regard to gender and empowerment⁷⁶.

8. Analysis of gender and Economic participation

The Asian Development Bank estimates that in the Asia-Pacific region alone, between \$42 and \$47 billion is lost per year due to restrictions on women's access to employment opportunities, plus another \$16 to \$30 billion per year due to gender gaps in education⁷⁷.

The 2007, Poverty Profile makes the important point that in Myanmar there is no relationship between economic dependency ratio and poverty, which suggests that low return on labour or low remuneration are much more important determinants of poverty than unemployment or low

⁷⁰ Interview with National Coordinator, UNIAP, Myanmar, 2010.

⁷¹ HDI is calculated using non-income indicators of human development covering the areas of living a long and healthy life, having access to education, and a decent standard of living

⁷² Human Development Indices, A Statistical update 2008, UNDP

⁷³ Gender Related development index, A Statistical update 2008, UNDP

⁷⁴ 2009 Human Development Report, UNDP, based on data from 2007

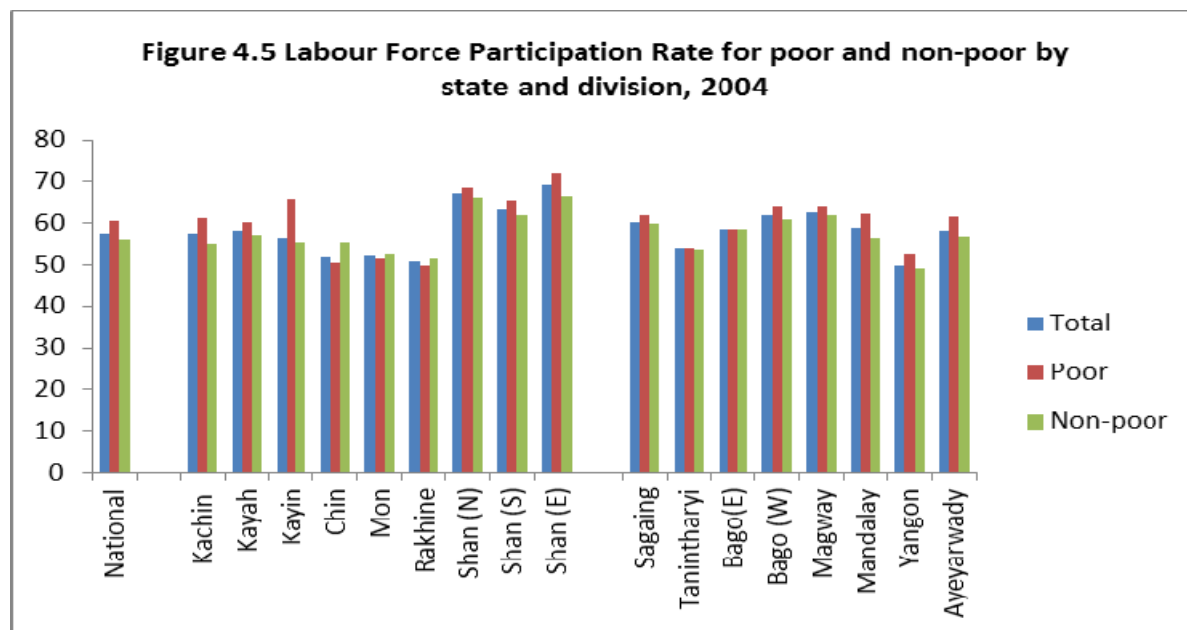
http://hdrstats.undp.org/en/countries/country_fact_sheets/cty_fs_BGD.html

⁷⁵ Human Development Report, 2009, Overcoming barriers: Human mobility and development, UNDP.

⁷⁶ Gender Empowerment Measure, http://en.wikipedia.org/wiki/Gender_Empowerment_Measure, accessed on 23/2/2010

⁷⁷ 2007, Asian Development Bank, *Gender Action Plan*

participation rates in the labour force⁷⁸, It can be seen in Figure 4,5 that the poor households has a higher labour force participation rate than the non-poor households. In other words in Myanmar salary earned is a better determinant than employment rate to gauge poverty.



Despite legal provisions for equal pay for men and women, both the unskilled agricultural daily wage and the off-farm unskilled daily wage for women were consistently below that of men for all five townships monitored by UNDP throughout 2008, usually by a factor of 25-33%.

The MWAFF operates a micro-credit scheme for women. In 2006, this scheme provided temporary loans of 72.4 million Myanmar kyats to a total of 8608 women.⁷⁹ Women’s participation in self-help groups and microfinance have shown that access to capacity building, community mobilization techniques and affordable credit have significant impacts on women’s participation in economic decision making. Such programs, currently managed by NGOs such as World Vision, World Concern, Care, Pact, Save the Children, AFXB, MSI, AMDA show there is progress made in terms of promoting women’s economic and social empowerment, particularly in rural areas.

Labour force participation

Although there is equal opportunity for employment, 48.84% of women are in labour force as compared to 80.57% of men. This means that only 38.2% of the labour force is female⁸⁰. The share of women in wage employment in the non-agricultural sector is the third indicator for MDG 3 (Promote Gender Equality and Empower Women) Target 4 (regarding gender disparities in primary and secondary education).

The share of women in wage employment in the non-agricultural sector is low at 40-41%⁸¹, however, the percentage of hired women employees/laborers in agriculture sector is 69.4% in 2003.⁸² (Table 4.2) This indicates that there are significant gender differences in the integration of women in labour force in the non-agriculture and agriculture sectors as 49.37 % of female are non-agricultural workers

⁷⁸ 2007, *Poverty Profile*, Integrated Household Living Conditions Survey in Myanmar, UNDP & Planning Department

⁷⁹ Gender equality and social institutions and gender index (SIGI) in Myanmar, OECD, <http://genderindex.org/country/myanmar> accessed on 1/4/2010.

⁸⁰ Handbook on Human Resource development indicators, DOP& UNFPA, 2006

⁸¹ UNDP and UNOPS, 2007

⁸² Report of Myanmar census of Agriculture, 2003-Union, Settlement and Land Records Department Ministry of Agriculture and Irrigation, 2003

and 44.1% female are of agricultural workers⁸³. This does not include unpaid family workers and those seeking work.

Table 4.2 Type of employment of hired labour by sex, 2003

(Percent)			
Type of Employment	Total	Male	Female
(1)	(2)	(3)	(4)
Union Total	100.0	31.0	69.3
Full time	0.4	0.7	0.2
Part time	2.9	3.1	2.9
Seasonal	18.3	19.5	17.6
Occasional	78.4	76.7	79.1
Household based total	100.0	30.6	69.4
Full time	0.4	0.7	0.2
Part time	2.9	3.0	2.9
Seasonal	18.3	19.6	17.8
Occasional	78.4	76.7	79.2

Source: Report on Myanmar Census of Agriculture, 2003 (Union), March 2007, SLRD and FAO

It is worth noting that the recently adopted State Constitution of the Republic of the Union of Myanmar, 2008 states in Chapter VIII, section 348 that the Union shall not discriminate any citizen of the Union of Myanmar based on race, birth, religion, official position, status, culture, sex and wealth.

In section 350 it states that women shall be entitled to the same rights and salaries by men in respect of similar work⁸⁴. However, a research study by Dr. Khin Saw Nyein and May Kyi Myo Win of Institute of Economics, in 1983 at the Burma Pharmaceutical Industry factory concluded that women workers are more productive than men, yet are paid the same wages, and thereby are effectively discriminated against in lack of remuneration for their contribution.⁸⁵

Other research⁸⁶ shows that women have increased levels of self and community respect as a result of their successful participation in self-reliance groups (SRGs) demonstrating their ability to participate in both family- and village-level decision-making. Such groups use microcredit and savings, as well as livelihood and associated training, to create small businesses, diversify production, boost family income and improve development outcomes for households and communities.

Inequalities in migrant workers

According to information from 2004, 70% of the total migrant population in Thailand comes from Myanmar.⁸⁷ By the end of 2008, 790,861 people from Myanmar were listed by UNHCR as ‘people of concern’, including stateless and other displaced persons⁸⁸.

Female migrant workers can earn substantial amounts in the sex trade which is thriving in Thailand as girls from neighbouring countries are regarded as exotic, more attractive, and “clean, beautiful and

⁸³ Calculated from data provided in table 2.17 and 2.18 , FRHS 2007

⁸⁴ State Constitution of Republic of Union of Myanmar, 2008

⁸⁵ Khin Saw Nyein & May Kyi Myo Win, 1983, “Efficiency and socioeconomic conditions of working women in the Myanmar Pharmaceutical Industry”, Institute of Economics, University of Yangon

⁸⁶ See for example Reid Smith, 2005, *A Hen is Crowing*, UNDP Myanmar, and Aung, Lwin Lwin, 2009, *SRG Case Studies*, UNDP Myanmar, for evidence of empowerment outcomes of SRGs.

⁸⁷ Migration & HIV/AIDS in Thailand: a desk review of migrant labour sectors. MOPH, Thailand & IOM

⁸⁸ Report of the United Nations High Commissioner for Refugees, 2009

AIDS free” by their clientele in relation to their Thai counterparts.⁸⁹ Many migrant sex workers lack knowledge and skills for prevention of HIV/AIDS and STIs.⁹⁰ There are many incidences where young Myanmar girls in search of jobs across the border are exploited for sex industry by unscrupulous brokers.

Migration poses socioeconomic problems and there is identifiable gender discrimination in salary earned among Myanmar migrants. A study on migrants residing in Chiang Mai, Ranong and Mahachai in Thailand revealed that in Chiang Mai, 96% were Shan and the remainder consisted of other ethnic minority people, whereas in Ranong, 84% were Myanmar originating from Dawei in Thanatharyi Division, 12% Mon, 4% Karen and Arakanese. Unmarried women worked largely in factories and as domestic servants and unmarried men commonly worked on fishing boats. Women consistently received lower salaries than men, even in similar occupations. In Chiang Mai males earned 5.4% more than females whereas in Ranong salaries are 2.1 times higher for males.⁹¹

Gender and division of labour

Myanmar women work together with the men to shoulder responsibilities for the well-being of the whole family, however, women are the primary care-takers for children and the elderly⁹². In many cases women also work outside the home, which is a common strategy to cope with economic difficulties. However, women typically continue to cook and manage the house when they return from work. This is not to say that men do not help with domestic and child-rearing tasks. In fact, the social analysis accompanying this report found it is common for men to take on these tasks – particularly when their wives are in the late stages of pregnancy or caring for small infants⁹³.

Gender and Poverty

The incidence of female-headed households in Myanmar is 18.9%, and is higher in urban areas (25.1%) than rural areas (16.7%), suggesting urban women can better afford to head their own households rather than merging with those of relatives subsequent to divorce, separation or widowhood.⁹⁴ Although 29% of female-headed households are in poverty, female headship is not positively correlated to poverty in Myanmar, with about the same (30%) likelihood of a male-headed household living in poverty.

This statistics can be attributed partially to higher numbers of urban female heads (who are less likely to be poor) and significant receipt of remittance income. Notably, a higher proportion of female household heads are illiterate than male household heads (37.6% and 16.1% respectively). Literacy of the household head is an important dimension of poverty in Myanmar, with households headed by an illiterate member almost twice as likely to live in poverty⁹⁵. Vulnerability of particularly rural female-headed households, therefore, is very likely, but is an area that requires further research.

9. Analysis of gender and political participation

Women in Myanmar received the right to vote in 1935 and the right to stand for election in 1946. In its 42nd session, the CEDAW committee said the following: “While noting that the majority of university graduates are women, the Committee is concerned at the very low rate of participation of women in all areas of public, political and professional life, including in the National Assembly and the realms of government, diplomacy, the judiciary, the military and public administration, especially

⁸⁹ Cross border transportation infrastructure development and HIV vulnerability. Asian Research Centre for Migration, Institute of Asian Studies, Chulalongkorn University, 2002..

⁹⁰ Migration & HIV/AIDS in Thailand: a desk review of migrant labour sectors. MOPH, Thailand & IOM

⁹¹ 2000, Sexuality, Reproductive Health and Violence: Experience of Migrants from Burma in Thailand. By Therese Caouette, Kritaya Srchavankul, Hnin Hnin Pyne

⁹² Gender equality and social institutions in Myanmar, <http://genderindex.org/country/Myanmar> accessed on 1.4.2010

⁹³ Findings of UNFPA situation analysis field work. 2009

⁹⁴ Poverty Profile, Integrated Household Living Conditions Survey in Myanmar, UNDP & Planning Department.

⁹⁵ Ibid

at senior levels”. National Convention was held in Myanmar in 2006-07 with the participation of representatives from various social strata, for the preparation of State Constitution. Out of total 1080 delegates, 67 delegates were women which constitute 6.2%. However, these women were not elected officials representing a constituency, with legislative power. Representatives from national races constitute 71.64% of the total women delegates and 59% of the total male delegates.⁹⁶

The CEDAW Committee also regrets “the low number of women in senior management in general.⁹⁷” Publication of GoUM states that 34.34% of the workforce serving at State Organizations and Ministries are women and among them 12.71% hold high ranking position.⁹⁸ However, as of early 2010, all Ministers and Deputy Ministers are men. Myanmar does not have a parliament thus, this indicator cannot be measured and compared.

10. Institutional Framework for the Advancement of Women

In Myanmar, it is most apparent that strategic investments to advance the status of women and improve gender relations will bring large dividends in support of poverty alleviation. Below are lists of key mechanisms that are in place to move forward to improve gender equity nationally.

The Myanmar State constitution Gender equality and priorities under the State Constitution

The 1947, Myanmar State Constitution, clearly states concerning sexual equality and the rights of women in Articles 13-15. All citizens, irrespective of birth, sex or race are equal before the law. It also states that there shall be equal opportunity for all citizens in matters of public employment and in exercise of or carrying on of any occupation, trade business or profession. Article 15 states that women shall be entitled to the same pay as that received by men in respect of similar work.

These considerations were repeated again in the constitution of the Socialist Republic of the Union of Myanmar, 1974. This constitution outlines that all citizens regardless of race, religion, cast or sex are equal by law. Separate policies or programs for gender empowerment have been developed by MWAF, however these policies and program areas need to be systematically developed together with gender mainstreaming strategies.

CEDAW Committee’s comments on laws pertaining to women

Considering the cross-cutting nature of gender issues, all actors involved in developmental endeavors need to cooperate in aspects of policy development, planning, programming and implementation to ensure gender balance in Myanmar. In line with its commitment to the CEDAW mandate there is a need to strike a balance between preserving religious beliefs, tradition and culture as well as transforming the underlying structures to attain gender balance for the holistic development of Myanmar. There are laws which are contrary to CEDAW’s mandate and contribute towards discriminatory acts against women and this need to be revised.

The CEDAW committee’s final responses to the submissions of the State in late 2008 noted some key areas where national laws are not aligned with the government’s commitment to CEDAW:

- Legislation and customary laws that discriminate against women and are incompatible with CEDAW, particularly those that permit discrimination on the grounds of ethnicity and within ethnic groups, remain in force in Myanmar⁹⁹.
- The CEDAW committee expressed concern regarding the multiple marital systems which exist in Myanmar. Although polygamy is discouraged, discriminatory customary practices surrounding marriage persist, especially in ethnic minority communities regarding marriage,

⁹⁶ 2006, Myanmar MDG, FERD

⁹⁷ Concluding observations of the Committee on the Elimination of Discrimination against Women, CEDAW 42nd session, 20 October-7 November 2008.

⁹⁸ CEDAW , Myanmar report, 2007

⁹⁹ Concluding observations of the Committee on the Elimination of Discrimination against Women, CEDAW 42nd session, 20 October-7 November 2008.

its dissolution, family relations and inheritance¹⁰⁰. Reference to CEDAW in court decisions indicates lack of acknowledgement of CEDAW amongst government and judiciary¹⁰¹: It therefore follows that women themselves are unaware of their rights under CEDAW and lack the capacity to claim them¹⁰². Large scale awareness-raising at all levels is recommended.

- The current (1982) citizenship law appears to contravene CEDAW in that women's citizenship is not automatically passed on to their children born outside the country or to non-national husband and their children. This law also appears to discriminate against some minorities in Northern Rakhine State, and Northern Shan State in particular. Restrictions on the movement of this segment of population will have negative impacts on the access to education, health services and employment opportunities of women and girls.

A: International Commitments

A.1 International Conference for Population and Development (ICPD)

The UN has identified that the process of economic development and transformation could have possible negative effects on women, especially the change in traditionally accepted values and morals of customary status¹⁰³. Poverty and inaccessibility to resources including water, sanitation, markets and transportation are instrumental in marginalising women more than men.

Myanmar is a signatory to ICPD and in order to implement the Program of Action (POA) countries needed to mobilize their resources. In the case of developing countries, resource mobilization through bilateral, multilateral and private sources needs to occur¹⁰⁴. Two of the key points of discussion at the ICPD¹⁰⁵ were the “life cycle approach” which encompasses care from “womb to tomb” for RH and population development, and enforce gender equality and equity, through empowerment of women..

A.2 Fourth World Conference on Women (Beijing, 1995)

The Beijing Conference was also instrumental in introducing gender mainstreaming as the key driver to promoting equal consideration of women and men in all development activities. On 2 March 2010, the Commission on the Status of Women adopted a Declaration on the occasion of the fifteenth anniversary of the Fourth World Conference on Women and adopted seven resolutions among which “Eliminating maternal mortality and morbidity through the empowerment of women” is one.¹⁰⁶ Myanmar's participation in 1995's 4th World Conference on Women in Beijing, which later acceded to the Convention on the Elimination of all forms of Discrimination against Women (CEDAW) in 1997 brought about more commitment, interest and awareness of gender issues in Myanmar.

A.3 The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). CEDAW is an international human rights treaty for women promoting gender equality and the elimination of discrimination in all aspects of women's lives and it was adopted by the United Nations General Assembly in 1979. Made up of a preamble and 30 articles, the Convention defines what constitutes discrimination against women, giving a powerful framework for concrete changes to guarantee women's human rights, prohibiting any distinction, exclusion or restriction made on the basis of sex¹⁰⁷.

The United Nations encourages and assists countries to take appropriate measures to implement CEDAW and uphold the international obligations made under the Convention. The Myanmar

¹⁰⁰ Concluding observations of the Committee on the Elimination of Discrimination against Women, CEDAW 42nd session, 20 October-7 November 2008.

¹⁰¹ Ibid

¹⁰² Results of in-depth interviews by SA team, 2009

¹⁰³ Gender Profile Myanmar, UN 2000.

¹⁰⁴ Gender profile, UNThematic group, 2000,

¹⁰⁵ 2009, A Synopsis on Reproductive and Sexual Health, Professor Dr. Mya Oo

¹⁰⁶ 54th session of Commission on Status of women: Beijing plus 15 review. March 2010

¹⁰⁷ CEDAW, accessed on 9.4.2010, <http://www.un.org/womenwatch/daw/cedaw> Report by the CEDAW committee(A/CONF.177/7)

Government ratified CEDAW in 1997 and reports regularly to the CEDAW Committee¹⁰⁸.

A.4 Millennium Development Goals

The spirit of the Beijing Declaration and CEDAW, along with other international agreements made towards gender equality in the 1990s, was reaffirmed in the United Nation's Millennium Declaration. Within the framework of this declaration, 189 countries pledged to reduce extreme poverty by 2015 adopting eight Millennium Development Goals.

The Millennium Declaration recognized the special needs of women, affirming that gender inequality slows development. The goals have explicit targets and indicators for gender equality, with MDG Goal 3 to 'Promote gender equality and empower women'. Myanmar has huge limitations to assess its need for fulfilment under MDG 3, as GDI and GEM cannot be calculated due to lack of data, and as such it is difficult to understand the baseline or conduct a needs assessment¹⁰⁹.

B: National Mechanisms

Myanmar is signatory to a number of international conventions relevant to gender and development, including the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Convention Against Transnational Organized Crime (CTOC), the Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children (TIP), Convention on the Rights of the Child and the Protocol to Combat the Smuggling of Migrants by Land, Sea and Air (SOM). The diagrams below detail the institutional and operational frameworks to address Myanmar's responsibilities under CEDAW.

B.1 Ministry of Social Welfare Relief and Resettlement and partners

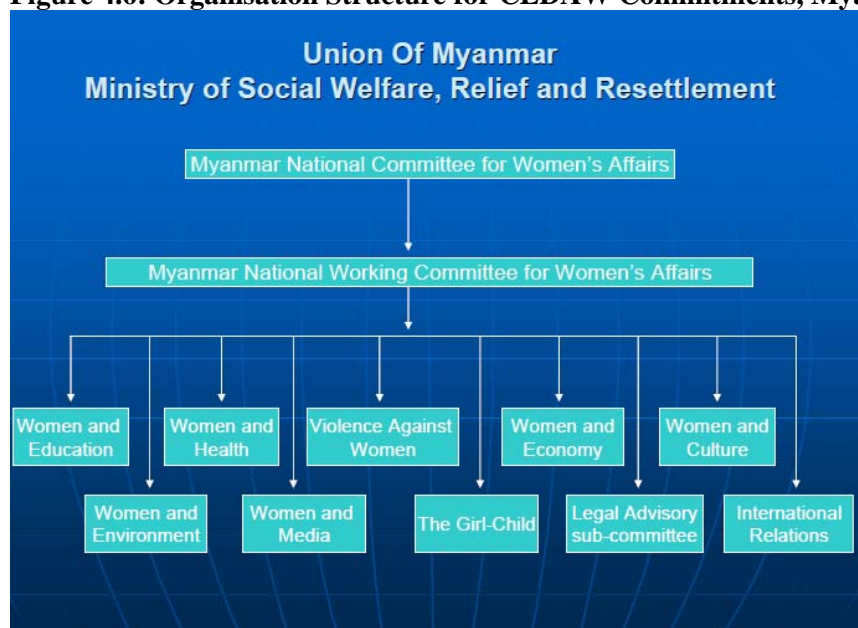
The Ministry of Social Welfare, Relief and Resettlement have three departments: Department of Social Welfare, Myanmar Fire Services Department and Department of Relief and Resettlement. It is also the focal ministry for the advancement of women and provides six major services. These are: Women Welfare Services (which runs vocational training centers for women and Women Development centers especially for court ordered women development), Child Welfare Services, Youth Welfare Services, Resettlement and Rehabilitation of Vagrants, and Rehabilitation of the Disabled and Care of the Aged Services. The Ministry is also focal point for rights of the Child, for MNCWA and social development.¹¹⁰

¹⁰⁸ Governments that have ratified the treaty have a legal obligation to implement the Convention and are required to submit regular reports on their progress to the CEDAW Committee. All reports are reviewed in CEDAW Committee sessions held several times a year. The Committee also reviews country-specific 'shadow' reports submitted by civil society representatives. Upon review, the Committee forms *Concluding Observations*, which provide guidance to member countries in areas needing improvement, and requiring strengthened capacity to fulfil CEDAW obligations beyond just reporting requirements

¹⁰⁹ Myanmar MDGs Report, 2006

¹¹⁰ Country gender profile: Myanmar, 2009

Figure 4.6: Organisation Structure for CEDAW Commitments, Myanmar



Source: Proceedings of the East Asia Gender Equality Ministerial Meeting (Tokyo, Japan, 2006), Report by Ministry of Social Welfare, Relief and Resettlement.

The Ministry of Social Welfare, Relief and Resettlement is the line ministry with its Department of Social Welfare (DSW) as focal point to address gender issues. Gender equality is a cornerstone of UNFPA and its implementing partners including DSW’s approach to development and humanitarian relief and rehabilitation.

“Gender is cross cutting in socioeconomic, humanitarian and development in Myanmar and has a significant influence on the quality of life and wellbeing of the population. However, we need to clarify to the public the difference between ‘sex’ and ‘gender’, ‘rights’ and ‘responsibilities’, ‘roles’ and ‘opportunities’ of both sexes. We need to advocate at all levels of our society for gender equity for the future good of our people”. DSW will have a separate “Gender section” in 2010 for more effective implementation of the CEDAW commitments.

- Interview with Deputy Director General of the Department of Social Welfare said, with regard to gender issues in Myanmar

Myanmar, which targets women’s physiological needs. There is great potential to influence strategic gender needs and improve women’s position compared to men especially in reproductive health care and support, in order to close the gender gap.

DOH, UNFPA, JOICFP and their implementing partners have been supported a project called *Increasing Male Involvement in RH in Myanmar* (2004-07) which achieved significant success in improving men’s engagement with their partners in all aspects of reproductive health, from knowledge and care through to financial provision and redistribution of household tasks.

Although DSW is the focal point for gender equality and implementation of CEDAW commitments, for actual gender mainstreaming to take place there is a dire need for better coordination and linkages between Ministries of Health, Education, Social Welfare, Relief and Resettlement, Immigration and Population and National Planning and Economic Development to come on board in placing gender in all aspects of planning, programming and evaluation of national programs.

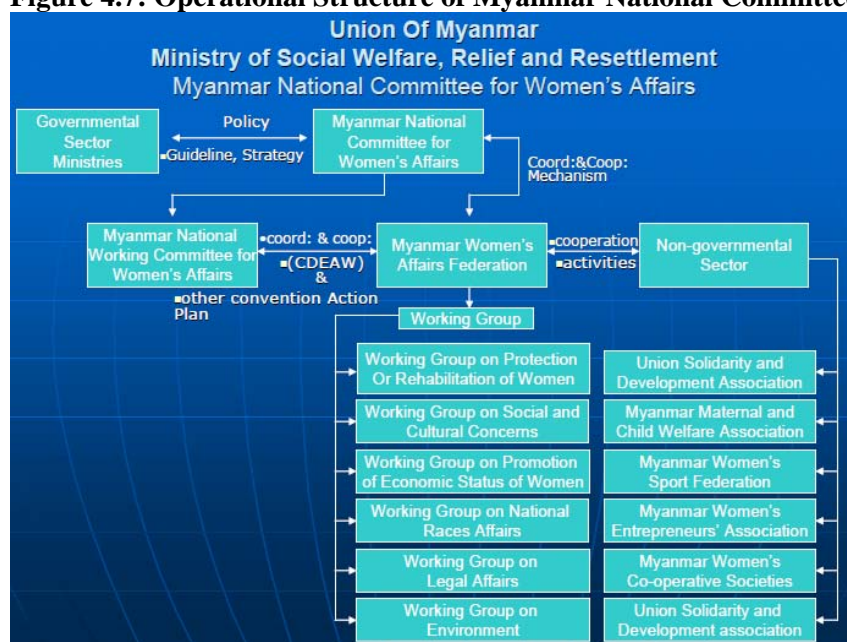
B.2 National Committee for Women’s Affairs

The focal organization for advancement of women in Myanmar is the Myanmar National Committee for Women’s Affairs (MNCWA), which was formed in 1996. The key implementation body in terms of CEDAW commitments is the Myanmar Women’s Affairs Federation (MWAFF), formed in 2003 to organize women all over the country to carry out activities to ensure the security and advancement of women’s life. This is a national NGO, but operates¹¹¹ under the Ministry of Social Welfare, Relief and Resettlement. It is therefore government funded and staffed. Additionally, there is the Myanmar Maternal and Child Welfare Association (MMCWA), which functions under the guidance of the Ministry of Health and Myanmar Women Entrepreneurs’ Association (MWEA) which have similar institutional arrangements.

MWAF implements a National Plan of Action drawn from, but not including, all twelve action areas from the Beijing Platform of Action.¹¹² However, there is need to disseminate information regarding baseline, coverage, methodology, funding, participants, program effectiveness, impacts and stakeholder feedback. This forms a useful entry point for any capacity building or partnership program aimed at enhancing the effectiveness of this organization.

During a meeting with leaders of MWAF, the President, and executive secretary, expressed the need for comprehensive capacity building to apply tools and techniques for gender research and needs assessment to be strengthened to enhance implementation of gender sensitive program for advancement of women.

Figure 4.7: Operational Structure of Myanmar National Committee for Women’s Affairs



Source: Proceedings of the East Asia Gender Equality Ministerial Meeting (Tokyo, Japan, 2006), Report by Ministry of Social Welfare, Relief and Resettlement.

The above formal structures show a political commitment and will to implement CEDAW plan of action by the GoUM. While a number of formal organizations formed by the GoUM exist to represent women and implement CEDAW in Myanmar, they are somewhat limited in terms of the issues they address, their role as an extension of government structures, budget constraints and the fact that they are staffed mainly by volunteers.

¹¹¹ CEDAW report, Myanmar, 2007

¹¹² Myanmar Women’s Affairs federation, 2005

B3. Ministry of Immigration and Population

The Ministry of Immigration and Population is the focal ministry for generating population information and data. It has the Department of Immigration and National Registration and the Department of Population under its auspices. In addition to being the main source of demographic data in Myanmar it conducts periodic demographic surveys, as well as the national census starting from 1953. However, the last census was taken in 1983¹¹³. To support gender analysis there is need for large scale nationally representative research data disaggregated by *sex, age, ethnic group and geographic distribution* in the following areas, to inform policy makers for the all-round development of the country and for real gains towards gender equity and equality:

1. National level mortality and morbidity data, indicative of the whole population rather than only those who present at government health facilities
2. Data to capture different experiences and status among women based on regions, ethnicities, and income status.
3. Research and analysis on elderly population from a gender perspective.
4. Research and analysis on internal and international migration, with age, sex, and educational-level disaggregated including reasons for migration
4. National level criminal information, including data on victims, perpetrators and resolutions
- 5 Analysis on existing laws with reference to CEDAW commitments
6. Data required for the calculation of the GEM, GDI measurements
7. Data on GBV reported at health facilities and Standard Operational Procedures for care of GBV survivors.

B.4 Civil society Organisations working for Gender Equality

Myanmar-based civil society organizations focused on women, gender, and empowerment issues, while undertaking some activities, face constraints in their ability to openly comment on government policy or advocate for change¹¹⁴. In addition, these NGOs are underfunded, understaffed and lack capacity to take on more than a series of small projects and exercises. The first National Conference of Women's Organizations was jointly organized by Thingaha and Women's Organizational Network (WON) (an NGO network of 24 women's organizations of which 42% of them have official registration with Ministry of Home Affairs). It was held in November 2009, and was a forum to discuss common issues that Myanmar women are experiencing and develop collaborative action to respond to these issues¹¹⁵. The issues presented and discussed were "Situation of Women in Myanmar, challenges and opportunities", "Women's issues in the light of CEDAW's 12 critical areas", "Networking and its benefits" and "The role of Women's Organization in Nation Building". At this meeting the WON was officially formulated, and actions were taken on its mission statement and its proposed actions, and the formation of a steering committee and a secretariat.

It marked the beginning of the Myanmar-based consultative conference of women's organizations for advancement of women. This is in contrast to the many organizations advocating strongly for Myanmar women's rights and publishing research-based reports that are based outside the country. Many of those organizations are formed of ethnic minority women from current or former conflict zones. Given that members of some of these groups have lived away from the country for many years, there are always questions about reliability, validity and legitimacy.

11. UN and Gender Equality

UN Gender Theme Group

Certainly the most important role of the UN in terms of gender is one of advocacy. In the past, within

¹¹³ Immigration and Manpower Department, Burma 1983, Population census

¹¹⁴ This comment relates to State censorship of the media, a climate of fear regarding political participation due to a number of well publicised, seemingly arbitrary arrests of political figures, and difficult registration procedures for local organisations.

¹¹⁵ First National Conference of Women's Organization's 2009

its mandate many UN agencies that operate in Myanmar were limited to advising on policy development and capacity building. The UN declared the 'International Women's Year' in 1975 and this has been celebrated ever since by countries around the world, however it is not officially celebrated by Myanmar. The Decade of Women 1976-1985 was not recognized.¹¹⁶ The first International Women's Day was celebrated in Yangon on the 12 March 2010.¹¹⁷ The 3rd of July is the inaugural day of Myanmar National Committee for Women Affairs and has been declared by the government as "Myanmar Women's Day."¹¹⁸

However, with all of the collaborative work that took place in the wake of Cyclone Nargis since May 2008, working relationships with concerned government departments have moved forward significantly. The Women's Protection Technical Working Group was developed under the Inter Agency Standing Committee (IASC) through relief and rehabilitation work carried out in collaboration with The Ministry of Social Welfare, Relief and Resettlement. This Working Group includes not only UN organizations but also national and international NGOs. The establishment of clusters in response to Cyclone Nargis resulted in the recent reestablishment of the UN Country Team Gender Theme Group (chaired by UNFPA) see annex for terms of reference. This is another positive development that should positively impact upon the UN's ability to deliver as one and also towards the development of the UN Framework of Cooperation in Myanmar (2012-2015).

UNAIDS made significant progress in terms of addressing gender issues in the National HIV response. A Desk Review on Gender and HIV and the multi-stakeholder review of the National Strategic Plan for HIV 2006-2010, conducted jointly by NAP and UNAIDS highlighted challenges in the prevention of HIV transmission resulting from gender issues in Myanmar. The key challenges identified were that there are few studies related to gender and HIV in Myanmar and much focus is needed on research and studies in this area to inform policy and programming. The review highlighted significant gender disparity in HIV programme activities observed and suggested that multi-disciplinary research is needed of the way gender factors affect vulnerability to HIV infection. Research from public health, epidemiological and social scientific research perspectives and both quantitative and qualitative methods should be considered¹¹⁹.

The Gender Theme Group includes representatives on gender appointed by their respective UN agencies as well as selected representatives of NGOs and INGOs. The Gender Theme Group coordinates its work with various stakeholders from Government and civil society organizations. Representatives of such stakeholders are invited to Gender Theme Group meetings based on the agenda. This ensures coordination and complementarities among inputs of various partners on gender equity, equality and women's empowerment and maximizes utilization of available resources. The Gender Theme Group coordinates closely with the Women's Protection Sub-Cluster. As requested by the UN Resident Coordinator and UN Country Team, the Gender Theme Group is chaired by the UNFPA Representative, to be assisted by an International Gender Coordinator and a National Officer. Both positions are to be recruited in the future pending funding availability.

The renewed cooperation of the Ministry of Social Welfare, Relief and Resettlement with the activities of the Protection cluster and in particular the Women's Protection Sub-Cluster provided an invaluable entry point for a women's protection assessment that was conducted in cyclone-affected areas. The recommended National Plan of Action for Women's Protection in Emergencies is being developed and will be widely disseminated amongst government and non-government stakeholders; it forms the basis for a wider and more widely relevant National Plan of Action for Women's Development. It is particularly important that the capacity of national staff is fostered in terms of gender mainstreaming for humanitarian emergencies. This is both because of the temporary nature of international deployments, and due to the fact that there are travel restrictions for international citizens residing in Myanmar.

¹¹⁶ Khin Myo Chit, 1976, International Women's Year (1976), Colourful Myanmar,

¹¹⁷ New Light of Myanmar, 13 March, 2010.

¹¹⁸ Myanmar National Plan of Action for the Advancement of women, MNCWA, 2000

¹¹⁹ Draft Gender -HIV desk review report, 2009

12. Gender and Humanitarian Assistance

Cyclone Nargis struck the Ayeyarwaddy and Yangon Divisions of Myanmar on May 2, 2008. Although estimates vary, about 2.4 million people were severely affected. Many of those affected lost everything they had. More women than men died, distorting the existing social structures¹²⁰. According to the initial Post Nargis Joint Assessment (PONJA) assessment data, 55% of those dead or missing were females. In ten severely affected villages where more comprehensive data was collected, in the key productive and reproductive age group of 18-60, more than two times more women died than men.

Gender mainstreaming of the humanitarian response

UNDP and UNFPA became active in the Women's Protection Technical Working group under the protection cluster system that was activated after the emergency. Gender professionals also provided ongoing advice to all the clusters, as well as national NGOs, over the first year after the disaster.

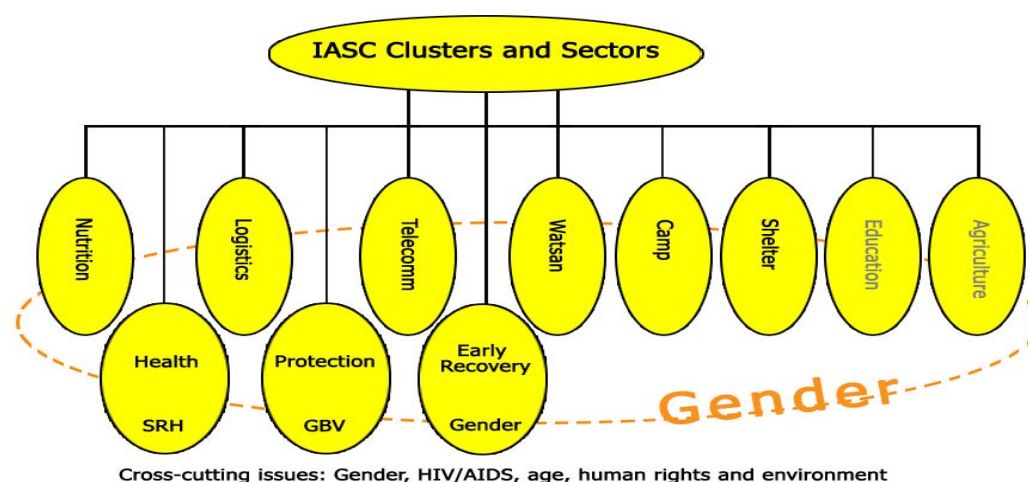
Secondly, a number of additional assessments were undertaken (some under the auspices of the women's protection sub-cluster, others implemented by UNDP) to complement the wider impact assessments of the Tripartite Core Group (known as the TCG, a group made up of the GoUM, UN, and ASEAN), such as a women's livelihood study, a women's protection assessment and a one year gender tracking study in order to learn from the different impacts, coping mechanisms and rates of recovery of affected women and men in the delta.

Thirdly, capacity building of staff of UN and NGOs involved in relief and rehabilitation work were undertaken by the women's protection sub-cluster for gender equality and prevention of GBV training. UNFPA distributed hygiene kits and Minimum Initial Service Package for Reproductive Health in Crisis Situations (MISP). UNFPA collaborated with MSI and MMA for mobile service clinics and maternity waiting homes. AFXB developed women friendly spaces for livelihood training and rehabilitation programs. UNDP led activities for gender mainstreaming in humanitarian response and early recovery, gender and disaster risk reduction.

In addition, those with gender capacity assisted a spectrum of agencies in terms of planning recovery activities, advocating for women (who tended to be less visible and less vocal in requesting assistance, especially in terms of their livelihood recovery), informing studies and publications and disseminating gender disaggregated data and results. The implementation of gender mainstreaming in the cluster system is illustrated in the following diagram.

¹²⁰ Post-Nargis Joint Assessment report, 2008

Figure: 4.3: Gender Mainstreaming in the cluster system



Source: UNFPA Myanmar, 2010

Several programs emerged to complement the more general reconstruction and rehabilitation projects to specifically meet the different needs of women. In the initial stages of the disaster, UNFPA provided MISP training, reproductive health kits, established clinics attached to maternity waiting homes and deployed mobile health care services to attend to the needs of the thousands of women in the later stages of pregnancy in affected areas.

Later in response to the women’s livelihood assessment, which showed women’s livelihoods were receiving a fraction of the attention of men’s, UNFPA and partners set up three “women’s spaces” in Labutta Township to provide vocational skills training as well as psychosocial support to vulnerable women so as to mitigate the risk of gender-based violence and improve their well-being. UNDP rehabilitated and substantially expanded its pre-cyclone Human Development Initiative activities in the delta, which included a microcredit program with mostly female clients, and a system of self-reliance groups, which includes microcredit and livelihood assistance. UNICEF, along with MMA, MSI, RI, ACTED and AFXB operated programs for women protection, setting up maternity waiting homes and¹²¹, setting up women friendly spaces for women empowerment programs in Labutta, Dedaye and Bogalay townships. Child protection groups set up Child Friendly Spaces, which released women from child care duties for some time each day in order that they could participate in reconstruction and income earning activities.

Gender mainstreaming in the humanitarian response

While gender was mainstreamed in the humanitarian response to some extent, and by many accounts far more comprehensively than in past international disaster responses, any success is largely down to the activities of one or two key agencies, centered around a few full-time experts, and with the partnership of a few international and national NGOs. Clearly this is not sustainable and should a similar disaster strike Myanmar in the future it is unclear whether such staff would be available or whether the humanitarian and development communities as a whole would have learnt sufficiently from Cyclone Nargis in order to improve performance in terms of gender mainstreaming. A recent internal Oxfam document sums up the gender mainstreaming efforts following Nargis in the following way:

“While some agencies have provided gender training for their staff, and many agencies are now implementing activities that target women as beneficiaries, gender has not been a central focus of the emergency response as a whole. Sex and age disaggregated data has not been widely collected, and gender mainstreaming is not yet at the core of every agency’s response. There have also been lost opportunities to collect gender-related data on a broader scale.”

¹²¹ Report of Evaluation of Humanitarian assistance program in the Delta, UNFPA-AusAID, June,2010

Almost all of the organizations consulted for this study stated that they needed to strengthen gender programming”.¹²²

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Recent studies of the Cyclone Emergency Relief and Rehabilitation (CERR) Phase II, program of World Concern Myanmar in Labutta revealed that women’s participation in leadership position has been evidenced at village level. Although all the leaders of the Village Disaster Management Committees in eight villages of Labutta townships are male, women’s membership in these committees ranged from 2.5% to 46.42% which marks a breakthrough for the women in the Delta who used to have limited livelihood options, and minimal engagement in decision-making processes. Women have now become active and verbal to express the needs for women empowerment in the Village Development Committee meetings also.

* World Concern, CERR Phase II, end of year one program evaluation report, N.Pepito, H. Aye &M.Nweni ,2010

National Plan of Action for Women and Emergencies

In order to consolidate responses of multiple actors in humanitarian assistance to natural disasters the MSWRR in corporation with its partners ministries developed the Myanmar Action Plan on Disaster Risk Reduction (MAPDRR) 2009-2015. In line with this comprehensive plan the Sub-Committee for Women and Emergencies drafted the National Plan of Action for Advancement of Women (2010-2013). This plan of action consists of mechanisms to ensure women’s protection and participation in emergency preparedness and response which also includes capacity building of staff of Ministry of Social Welfare, Relief and Resettlement and institutionalizing commitment to gender equity in emergencies¹²⁴.

It is most apparent that close cooperation of line Ministries, partners of the UN system, and all NGOs is mandatory for strategic investments to advance the status of women and to improve gender relations in order to bring large dividends in support of poverty alleviation. Below are the lists of key recommendations that should be taken forward to improve gender equity nationally.

13. Review of the 12 areas of the Beijing PLA for Myanmar

The UN [Commission on the Status of Women](#) and the commission of the Economic and Social Council of the United Nations is concerned about the status of women in different societies and issued a Platform of Action, focusing on 12 "critical areas of concern" during the Beijing Conference in 1995¹²⁵. These areas have been identified as obstacles to the advancement of women and related to these concerns, the commission proposes to mitigate and later eliminate these areas of concern. In this light, the twelve areas of the Platform of Action are analyzed and presented in the form of a table with notes regarding areas for improvement:

Platform Area	Reason for Global Concern	Myanmar situation and reasoning
1. Women and Poverty	The persistent and increasing burden of poverty on women	Poverty incidence for female-headed households is comparable to male-headed households at 29% and 30% respectively. ¹²⁶ The lack of relationship

¹²² 2009, Oxfam GB, *Gender Impacts: Cyclone Nargis, Myanmar* (internal document, not published, quoted with permission)

¹²³ World Concern, CERR Phase II, end of year one program evaluation report, Normand Pepito & Hla Hla Aye, 29 May 2010

¹²⁴ Draft POA women and emergencies, DSW-UNFPA, May 2010

¹²⁵ <http://www.thefreelibrary.com/Draft+Platform+for+Action:+12+critical+areas+of+concern.-a017369700>

¹²⁶ Integrated Household Living Conditions Survey in Myanmar, MNPED, 2007.

Platform Area	Reason for Global Concern	Myanmar situation and reasoning
		<p>between poverty and female headship in Myanmar may be attributable to receipt of significant remittance income, better off urban women contributing to female headship, or because poverty in general is high in Myanmar. A better disaggregation of the categories of female headship is required to identify sub-groups who face hardships and poverty. Women who are illiterate, who have fewer options available to them to escape poverty such as migration or modern sector skills, compared to men, in addition to higher burdens of care for the young and the old. UN reports show that women are more likely to experience food poverty and accept lower wages than men.</p>
2. Education and Training of Women	Inequalities and inadequacies in and unequal access to education and training	<p>Access is equal in primary education for both sexes. It is understood that restrictions in travel and movement of some peoples such as in Northern Rakhine State may be an obstacle to access higher education. Need to improve women's access to and provide funding for better access to higher education in science and technology, vocational training for ethnic minorities, development of teaching/learning materials, IEC materials for health education free of gender stereotypes and according to local needs and languages. Inequality of cut-off point between the two sexes favoring males for entry into Government Technical College, University of Medicine, and University of Forestry needs attention in Myanmar.</p>
3. Women and Health	Inequalities and inadequacies in and unequal access to health care and related services	<p>It is the GoUM's mandate to provide equal access to health care however, responsibilities and burden of pregnancy and child birth lies mainly upon women. Decision making to seek health care in obstetric emergencies is dependent upon husbands who are breadwinners in rural communities. However access to health care is limited in difficult-to-reach areas where quality of services is also a challenge.</p>
4. Violence against Women	Violence against women	<p>GBV in particular has extremely negative consequences for women and their families. Physical consequences may include injuries, unwanted and early pregnancies, and abortion. There is need for research with regard to linkages between GBV and HIV. Damage to mental health may lead to anxiety, post-traumatic stress disorder, depression, and suicide. In many communities, rejection and stigmatization occur. Therefore, community awareness, capacity</p>

Platform Area	Reason for Global Concern	Myanmar situation and reasoning
5. Women and Armed Conflict	The effects of armed or other kinds of conflict on women, including those living under foreign occupation	building to service providers as well as strengthening referral mechanism are important areas for future improvement. Sexual violence, assault or criminal force to woman with intent to outrage her modesty, kidnapping, abducting or inducing woman to force marriage are the types of GBV most commonly seen in the Supreme Court of Myanmar ¹²⁷ . Trafficking of women is also a GBV issue and needs attention for research.
6. Women and the Economy	Inequality in economic structures and policies, in all forms of productive activities and in access to resources	Patriarchal cultural norms and values favor the economic activities of men over those of women, with, sometimes, explicit gender roles in livelihood activities. This was seen especially in Cyclone Nargis recovery activities, where men's work was consistently prioritized over women's.
7. Women in Power and Decision-making	Inequality between men and women in the sharing of power and decision-making at all levels	From the national to village level, decision making is a predominantly male domain in Myanmar, however it has not always been this way and may change with progress if constitutional /democratic systems are in place.
8. Institutional Mechanism for the Advancement of Women	Insufficient mechanisms at all levels to promote the advancement of women	MWARF was formed to implement CEDAW commitments and while undertaking some good work such as encouraging the appreciation of Myanmar tradition and culture, women's protection, screening and reviewing letters of complaint and taking necessary action for reported violence against women, MWAF has limited capacity to transform existing structural impediments to women's empowerment in Myanmar and is limited in its mandate, resources and capabilities especially at the village level.
9. Human Rights of Women	Lack of respect for and inadequate promotion and protection of the human rights of women	Insufficient information regarding the accessibility of complaint mechanisms or the outcomes to public. In addition to several high profile rights abuse cases there is a culture of silence surrounding GBV and an 'unsafe' public

¹²⁷ Gender Statistics in Myanmar, 2006, MWAF

¹²⁸ Report of the United Nations High Commissioner for Refugees, 2009

Platform Area	Reason for Global Concern	Myanmar situation and reasoning
		arena for complainants.
10. Women and the Media	Stereotyping of women and inequality in women's access to and participation in all communication systems, especially in the media	In Myanmar, women have equal access to and participation in all media and communications systems. However, there is censorship of the media and speech protocol and stereotyping of women in the media needs considerable action. The media stereotypes women as mothers, caregivers, and someone who only cooks and washes clothes, while males are stereotyped as the bread winner, working class man who comes home from the office and whom women constantly serve. It is recommended to encourage elimination of gender stereotyping in the media through studies, campaigns and various forms of self-regulation by media organizations.
11. Women and the Environment	Gender inequalities in the management of natural resources and in the safeguarding of the environment	In Myanmar, rural women, as well as men (the population is 70% rural) have been shown to be good managers of natural resources once given adequate training. Sustainable development is a socio-ecological process characterized by the fulfillment of human needs while maintaining the quality of the natural environment needs further research.
12. The Girl-child	Persistent discrimination against and violation of the rights of the girl-child	In this limited scope of study there is no evidence to suggest girls suffer persistent discrimination and violation of rights in Myanmar. Though sons are believed to have <i>phon</i> or superior religious power, the girl-child is also treasured in families. Gender-based infanticide is rare.

14. Challenges for engendering Development in Myanmar

For all actors working in the field of development in Myanmar gender equality and empowerment of women has to be mainstreamed into the policy development, program planning and implementation phases. The challenges that need to be addressed are highlighted below.

- **Deep-rooted cultural norms** of considering sons having “*phon*” or religious superiority over females and the roles that girls and women assume throughout their lives are still based on the idealized culturally accepted notions of womanhood in Myanmar, this notion can still be embraced but women should bear in mind that it should not be a hindrance to health and development of an individual.
- **Lack of awareness** of the concepts of gender and gender based violence and CEDAW commitments at different levels of administration and community level.
- **Weak linkages between gender equality and development.** DSW and MNCWA, MWAFF are focal points for gender and development. All stakeholders including GoUM, UN, NGOs and civil society need to work together in a common framework to reflect women’s empowerment and gender equality in its program, planning and implementation
- **Research and Data :** Research and data on gender in Myanmar is segmented, collected in an ad- hoc and/or project specific manner. The bulk of national level data is insufficiently, or only superficially disaggregated and therefore of limited use in any gender analysis.
- **Capacity Building.** Reflecting the need for national capacity building for collecting quality

data which goes beyond the general household level; or simply records participation rates (numbers in education, institutions, accessing services etc) rather than impacts or outcomes. Capacity building for gender mainstreaming and program planning that encourages gender equity.

Opportunities for Gender equality and women empowerment

- The DSW, MOHA, MOIP, MOH and MNCWA, MAAF with their nationwide network of infrastructure and volunteers have potential to advocate gender equality and women empowerment at all levels of administration and service provision in Myanmar provided there is appropriate support and capacity building of core staff in gender analysis much can be done for advancement of women nationwide. The UN theme group for Gender and Women's organization network are possible mechanisms for advocacy and sharing of experiences and concepts for gender equality.
- Furthermore, additional detailed information is required on legal rights, participation in industry, government service by level, self-employment, access to credit, and participation in local and national level decision-making, Availability of quality statistics, disaggregated to a sufficient depth by sex, age, ethnic group and geography, is an area of need to be developed in Myanmar.
 - MAAF and MNCWA compiled gender statistics that were published in limited distribution till 2006. There is a growing need for quality data to reflect the GoUM's efforts for gender equality and need of disaggregated data for policies, plan and programs for advancement of women and to bring into light the areas in which more progress is required for women. Data of its kind need to be continuous, regular and widely accessible by all partners and stakeholders.
 - NGOs and UN organizations, civil society involved in Cyclone Nargis relief and rehabilitation work are now headed towards developmental mode. Holistic development of the community entails gender equality and women empowerment. This is an opportunity to incorporate gender mainstreaming in the planning, programming and actual implementation of development programs in Nargis-affected villages.

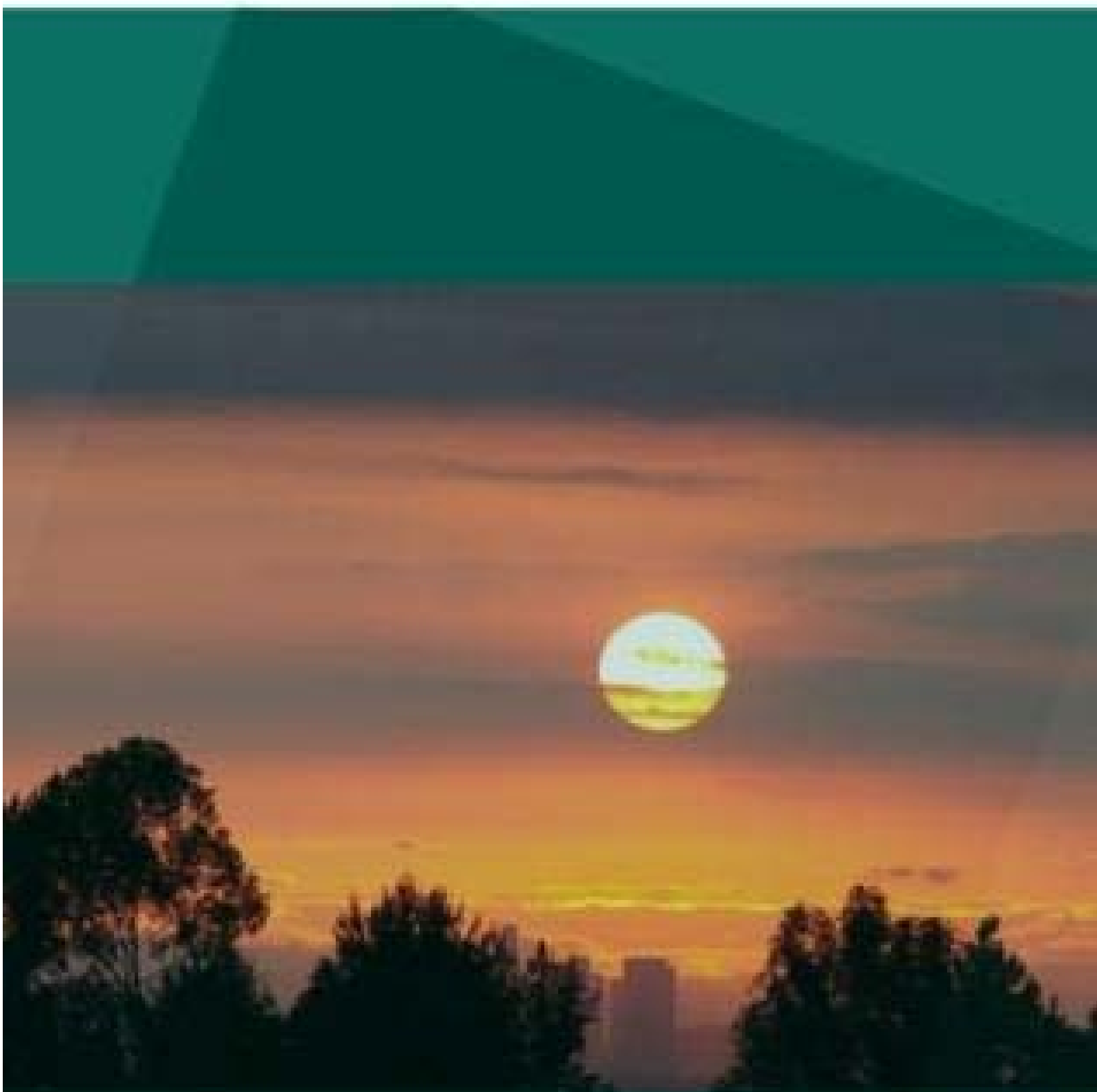
“ It is not enough that women to just fall into the rat race for careers without stopping to think whether they have the special aptitude or talent for any chosen field. But the freedom of choice and the opportunity for choice is what makes a difference”.

“ Myanmar women should not forget their cultural roots and moral values regarding home and family. Such traditions will have to be upheld – for society will surely be poorer for the loss of them.”

Khin Myo Chit, International Women's Year, Myanmar Women, 1976, Colourful Myanmar.

Myanmar is unique with its ancient cultural heritage embedded in Buddhism and multiple ethnic minorities living together in the land. Educating girls and young women and empowering them is one of the most powerful ways of breaking the vicious cycle of poverty. Thus, it is imperative for the GoUM to implement the CEDAW commitments, ICPD and MDGs and accelerate the momentum of development in Myanmar. There is a need to maintain a balance between preserving tradition and culture, whilst at the same time transforming the underlying structures in order to improve gender equality and women's empowerment for the holistic development of Myanmar.

Chapter Five: Progress Towards ICPD and MDGs



CHAPTER V: Progress Towards ICPD and MDG Goals

Myanmar is a signatory to and is committed to fulfil the ICPD and MDG Goals. This chapter describes Myanmar's situation in population and development, reproductive health and gender issues with reference to ICPD and MDG Goals and it highlights where Myanmar stands in terms of its efforts and the progress made against the targets with specific indicators so that data gaps can be identified for future planning and project focus.

Goal 1: Eradication of extreme poverty and hunger

Poverty is the most significant factor affecting people's quality of life and eradication of poverty is one of the main goals of the ICPD Programme of Action. Principle 7 says that, "All states and people shall cooperate in the essential task of eradicating poverty." ICPD expands on this by recognizing the interrelationship between poverty and population dynamics which affect the variables of fertility, mortality, morbidity, migration and spatial distribution.

MDG Goal 1 is that the proportion of people whose income is less than one dollar a day should be halved between 1990 and 2015. The baseline and target for poverty level has not been fixed in Myanmar. However, the poverty incidence rate in Myanmar is estimated to be 26.6 percent at national level, 20.7 percent for urban and 28.4 percent for rural in 2001¹. In 2004, the poverty headcount index was 32 percent at the national level with 22 percent for urban and 36 percent for rural. The food poverty index was 10 percent for the nation, 6 percent for urban and 11 percent for rural.² The majority of the total population (about 70 percent) resides in rural areas and all indicators imply that the proportion of rural poor is higher than their urban counterparts. The ongoing IHLCA survey will be able to provide trend analysis on poverty.

There are no targets set for Goal 1 poverty reduction indicators except for measure of percent of under-weight children under five³. The Government of the Union of Myanmar is implementing poverty reduction strategies with the Ministry of National Planning and Economic Development as the focal ministry. The poverty reduction strategies adopted are:

- (a) The Border Area Development Plan launched in 1989 to fulfil basic needs of the nationalities residing in remote and border areas,
- (b) 24 Special Development Zones designated in the states and divisions in order to achieve equitable and balanced development over the whole country, and the
- (c) Integrated Rural Development Plan launched to improve the status and well being of the rural populace.

As such, the GoUM has directly focused its development efforts on increasing job opportunities and achieving better economic status for rural people. In particular, government efforts have centered on encouraging industries to be located in non-urban areas, emphasising agricultural development and regional development in border areas, and improving health, education, transport, communication and electrical supply facilities in 14 under-developed regions of the country. However, there is still much

¹ Household Income and Expenditure Survey (HIES), CSO, Nay Pyi Taw, 2001

² Poverty Profile, Integrated Household Living Conditions Survey in Myanmar, Ministry of National Planning and Economic Development and UNDP, 2003-2005

³ Myanmar Millennium Development Goals Report 2006, MNPED

to be improved on providing basic necessities such as universal access to safe water and electricity in Myanmar.

There is high landlessness in rural areas. Differing by geographical location, a range of 30 to 70 percent of people in rural areas depends on non-farm economic activities or as hired hands. In the context of land reform, land use rights should be secured and access to common property rights such as forest land and grazing land has been suggested as a means.⁴ Some UN agencies, INGOs and NGOs are providing and/or arranging to provide micro-finance programmes, small loans, and skill development training to vulnerable households including landless, female headed households, large households, and households with orphans. Women empowerment programmes need to be implemented. In rural areas, investment in livelihood and small-scale businesses needs to be scaled up for sustainable economic development. There is also a critical need to support small-scale farmers with minimal interest loans to buy seeds and fertilizers so that they can break the cycle of poverty at harvest instead of paying high interest loans to brokers and money lenders⁵.

Data for indicators 1.4 to 1.7 are not available at present. Indicators 1.5 (Employment to population ratio) and 1.7 (Proportion of own account and contributing family workers in total employment) can be calculated from FRHS or IHLCA Survey data which needs attention by respective Government institutions.

Achievements and gaps for Goal 1

MDG goal	Indicator	1995	2005	2015	Source
Goal 1: Eradicate extreme poverty and hunger	1.1 Proportion of population below \$1 per day (PPP-values)		Food Poverty Headcount Index 10%, Poverty Headcount Index 32 % (2003-2005)		IHLCA , MNPED & UNDP
	1.2. Poverty gap ratio [incidence x depth of poverty]		Union- 0.07, Urban 0.04 Rural 0.07		IHLCA, MNPED & UNDP
	1.3. Share of poorest quintile in national consumption		Union -12.2, Urban 11.6, Rural 12.4		IHLCA, MNPED & UNDP
	1.4. Growth rate of GDP per person employed		Na		
	1.5. Employment to population ratio		Na		FRHS/IHLCA
	1.6. Proportion of employed people living below \$1 (PPP) per day		Na		
	1.7. Proportion of own-account and contributing family workers in total employment		Na		FRHS/IHLCA
	1.8. Prevalence of underweight children (under-five years of age)(%)	38.6 (1997)	31.8(2003)	19.3	MICS (1997,2003) Myanmar MDG Report 2006
	1.9. Proportion of population below minimum level of dietary energy consumption	30.84(1997)			Myanmar MDG Report 2006

⁴ Second Development forum, Prof. Joseph Stiglitz, Nay Pyi Taw, 2009

⁵ HRDI, DOL 2006 and MDG report, FERD 2006.

The Data Mission on Strengthening MDG indicators was in Myanmar in September 2009 and had reviewed the data situation in Myanmar and had prepared a data matrix for MDG 1, 7 and 8. In their Report for Goals 1, 7 and 8, the matrix for MDG Goal 1 is as shown below:

ANNEX II:		TRENDS IN MDG INDICATORS FOR GOALS 1, 7 AND 8				
Goal & Target	Indicators	Data Value				Data Source
		1991-1995	1996-2000	2001-2005	2006-2010	
		a	b	c	d	
Goal 1	Eradicate extreme poverty and hunger					
Target 1A	Reduce by half the proportion of people living on less than a dollar a day					
	1.1 Proportion of population below US\$1 (PPP) per day			26.60%		HIES 2001
				32%		IHLCA 2004/2005
	1.2 Poverty gap ratio			6.80%		HIES 2001
				7.00%		IHLCA 2004/2005
	1.3 Share of poorest quintile in national consumption			12.20%		IHLCA 2004/2005
Target 1B	Achieve full and productive employment and decent work for all, including women and young people					
	1.4 Growth rate of GDP per person employed	2.5			5.5	ADB Report. Need further work for source
	1.5 Employment-to-population ratio	74.6			74.5	ADB Report. Need further work for source
	1.6 Proportion of employed people living below \$1 (PPP) per day					
	1.7 Proportion of own-account and contributing family workers in total employment					
Target 1C:	Halve, between 1990 and 2015, the proportion of people who suffer from hunger					
	1.8 Prevalence of underweight children under-five years of age		38.60%	34%		GoUM MDG report 2006 for b ; IHLCA for c
	1.9 Proportion of population below minimum level of dietary energy consumption		30.84%			GoUM MDG report 2006 for b

Goal 2: Achieve universal primary education

ICPD generic objective 11.5 is, “To achieve universal access to quality education.” 11.6 is “complete access to primary school or an equivalent level of education by both boys and girls as quickly as possible, and in any case before the year 2015.” Generic objective 11.8 regards “closing the gap in

primary and secondary school education by the year 2005.” In this aspect MDG and ICPD are in full agreement. Myanmar has attained equity for both sexes in access to primary and secondary school.

Net enrolment ratio in primary education in Myanmar improved from 73.6 in 1995 to 82.2 in 2005. The target set for 2015 is 95.0 and is likely to be reached.⁶ In order to enhance enrolment of all children in school, every year the last week of May is defined as Enrolment Week and a Whole Township Enrolment Day is designated and observed in every township since 1999-2000 academic year, as a mass movement based on social mobilization whereby school enrolment is compulsorily free without collection of donations of any kind. Committees for All School-aged Children in School have been formed at central, state/division, township, and ward/village tract and school/village levels. Proportion of pupils starting grade 1 who reach grade 5 improved from 37.1 percent in 1995, to 73.4 percent in 2005. The target to be reached in 2015 is 90 percent. To promote access to primary education for over-aged children, a special programme is being implemented at basic education schools to further raise school enrolment and to ensure that all school-going age children are in school. Investing in women and youth is investing for sustainable economy and development. Proportion of pupils starting Grade 1 who reach grade 5 is 81.3 percent in 2010⁷ indicating 19 percent dropping out from school during grade 1 to grade 5. This would be mostly due to poverty. Many activities were initiated to promote primary school enrolment, to have all school-going age children in school but still the issue would remain with growing number of out-of-school children unless poverty reduction is effectively implemented.

Myanmar’s adult literacy rate is reported to be 94.1 percent in 2004-2005⁸ and the literacy rate for young population 15-24 years is almost universal. The primary school enrolment and net enrolment rate are high but the challenge lies in having out-of-school children in school-going age bracket. In accordance with the Education for All (EFA) Goals adopted in 1990, EFA Programme was launched in 1996-97 school year to improve the accessibility to primary education.

Achievements and gaps for Goal 2

MDG goal	Indicator	1995	2005	2015	Source
Goal 2: Achieve universal primary education	2.1.Net enrolment ratio in primary education	73.6	82.2	95.0	Myanmar MDG Report 2006
	2.2. Proportion of pupils starting grade 1 who reach grade 5	37.1	73.4 68(M)/72(F)*	90.0	Myanmar MDG Report 2006 *State of the World Population 2009, UNFPA
	2.3. Literacy rate of 15-24 years old, women and men	87.7	96.8	98.0	Myanmar MDG Report 2006

The indicators on school enrolment and literacy from UN source (The State of the World Population) were provided below to enable comparison with the national figures. Proportion reaching grade five is less than the national figure.

⁶ Myanmar MDG Report 2006, MNPED

⁷ Planning and Training, Myanmar MDG Report, Department of Education, 2006

⁸ Manual on Human Resources Development Indicators 2006, Special Edition, Department of Labour and UNFPA

<i>Education</i>	State of World Population 2000	State of World Population 2002	State of World Population 2009
Primary enrolment (gross) M/F	122/117	115/114	-
Proportion reaching grade 5 M/F	-	-	68/72
Secondary enrolment (gross) M/F	29/30	36/36	54/64
% illiterate (>15 years) M/F	11/20	11/19	11.4/12.6

Goal 3: Promote gender equality and empower women

In Chapter IV, gender equality and empowerment of women has been discussed in detail based on achievements relating to ICPD PoA. It also indicates that the improvement of women's political, social, and economic and health status is highly important end in itself and is essential for achievement of sustainable development.

As described in detail in Chapter 4, Myanmar women enjoy considerable social status but lag behind in politics and governance, and control over resources at the national level. Reproductive health has been regarded by majority as women's business and the bulk of the burden falls on women. At household level, economic decision making is near equal for both sexes especially in urban families with well-educated women. The ratio of girls to boys in primary and secondary education has reached parity however, there is lack of disaggregate data for age and sex to show the share of women in wage employment in the non-agricultural sector. Myanmar has no parliament, thus number of seats occupied by women in parliament is not relevant.

With the change to market economy in Myanmar since 1989, women's participation in private business has increased by leaps and bounds. Many small-scale and medium-scale income generation opportunities in addition to credit and loan programmes were initiated by NGOs such as World Vision, World Concern, and Pact Myanmar. The Myanmar Women Entrepreneurs Association (MWEA), formed in 1995, enhances the role of women in business and encourages rural women in income generation and micro-loan programmes.

To measure gender equity against international bench marks is impossibility, as there are major data gaps to calculate the gender related development index (GDI); an indicator of standard of living developed by the UN. It is one of the indicators used by the UN in its Human Development Report which requires disaggregate data on non-income indicators of human development covering the areas of living a long and healthy life, having access to education, and a decent standard of living. The Gender empowerment measure (GEM) reflects the inequalities between men and women's opportunities in a country. It measures inequality in three areas – political, economic and power over economic resources.

GEM is calculated in two steps. The first step involves a percentage calculation for men and women in three areas: the number of seats held in parliament, number of legislators, senior officials and managers, professional and technical positions, and estimated earned income (by purchasing power parity in US\$). The second step for each of the above areas is that the pair of gender percentage is combined into Equally Distributed Equivalent Percentage (EDEP), a measurement that rewards gender equality and penalizes inequality. The GEM is unweighted average of the three EDEPs.

To be able to calculate and compare GDI and GEM, a nationally representative study needs to be conducted with focus on gender statistics to truly show gender situation in Myanmar. MDGs set goals for equity and empowerment of women. Myanmar has reached parity in primary, secondary and tertiary education however there are data gaps for measuring share of women in wage employment in the non-agricultural sector and proportion of seats held by women is not relevant in Myanmar due to the current political system.

Achievements and gaps for Goal 3

MDG goal	Indicator	1995	2005	2015	Source
Goal 3: Promote gender equality and empower women	3.1. Ratio of girls to boys in -primary education -secondary education -tertiary education	93.86 100.46 152.66	98.8 101.11 151.55		Myanmar MDG Report 2006
	3.2. Share of women in wage employment in the non agricultural sector		2007 FRHS		Collected detailed occupation and tabulation could be done disaggregated by gender
	3.3. Proportion of seats held by women in national parliament		na		

For MDG goal 3, ratio of girls to boys in primary, secondary and tertiary education has reached parity. Indicator 3.2 could be calculated from the information and data collected from the agriculture census, household surveys and 2007 FRHS. For indicator 3.3, it is blank as Myanmar does not have a parliament as yet as of early 2010.

Goal 4: Reduce child mortality

There is overall agreement in concept between MDGs and ICPD in regards to reducing child mortality; however the quantitative measurements are different. ICPD states that:

“Countries should strive to reduce their infant and under-five mortality by one third or 50 and 70 per 1000 live births, respectively whichever is less, by the year 2000, with appropriate adaptation to the particular situation of the country. By 2015, all countries should aim to achieve an infant mortality rate below 35 per 1000 live births and under five mortality rate below 60 deaths per 1000 live births”.

MDGs, on the other hand, specify proportions irrespective of the health situations in each country, which may be difficult for countries with initially low rates.

In Myanmar, infant and under-five mortality rates have been on the decline. The Infant Mortality Rate (IMR) for Myanmar is 94 per thousand live births in 1990 decreasing to 53.2 in 2006 and the Under-Five Mortality Rate (U5MR) was 66.1 in 2003-2004 declining from 82.4 in 1995 (and the targeted rate at 2015 at 38.5). UN estimation of U5MR is 130 in 1990 decreasing to 103 in 2007. With the targeted figure at 38.5 in 2015, the current decline rate of the national figure is feasible but if one considers the UN's estimate, more efforts are needed by the State as well as the community to bring down the U5MR to the targeted rate.⁹

Achievements and gaps for Goal 4

MDG goal	Indicator	1995	2005	2015	Source
Goal 4: Reduce child mortality	4.1. Under-five-mortality rate (per 1,000 live births)	82.4 130*(1990)	66.1(2003) 103*(2007)	38.5	Myanmar MDG Report 2006 * The State of

⁹ Myanmar Millennium Development Goals report 2006, Ministry of National Planning and Economic Development

					the World's Children 2009
	4.2. Infant mortality rate (per 1,000 live births)	55.4 91* (1990)	49.7(2003) 74*(2007) 72**(2009)	28.3	Myanmar MDG Report 2006 *The State of the World's Children ** The State of the World Population 2009
	4.3. Proportion of 1 year old children immunized against measles	80.6% * 81.1%**	86.8% 81%*** (2007)	>90%	*1997 MICS,, **1997 FRHS Myanmar MDG Report 2006 *** The State of the World's Children 2009

Goal 5¹⁰: Improving maternal health

Among the 15 principles of the ICPD PoA, issues such as family planning, infant and maternal mortality and morbidity, and sexually-transmitted infections have been positioned in the broader lens of the human rights perspective as a prerequisite for national and global sustainable development. The central element of the PoA is to advocate for the rights of couples and individuals to take informed decisions on the number, spacing and timing of their children and to have information and means to do so through guaranteed access to information and comprehensive services to attain the highest standard of sexual and reproductive health. It calls for empowering women to give them greater autonomy and to improve their political, social, economic and health status, improving access to education (especially of women and girls), advancing gender equality and equity and the empowerment of women and limiting all forms of violence and discrimination against them.

The MDG Monitoring Framework incorporates all key quantitative goals embedded in the ICPD PoA under the MDGs 1, 2, 3, 4, 5, and 6. Moreover, the aspirations of the ICPD and its central theme found a solid reflection in the revised MDG Monitoring Framework¹¹ as an MDG5 Target B: to "achieve, by the year 2015, universal access to reproductive health". This and the related indicators under the MDG5 (ref: table below) recognize the centrality of reproductive health and reproductive rights in improving maternal and infant health and in reducing poverty.

To promote universal access to comprehensive reproductive health services, the Ministry of Health of Myanmar together with its UN and NGO partners implemented its first five-year National RH

¹⁰ Sixty-second UN General Assembly, Official Records, Annex II, Revised Millennium Development Goal Monitoring Framework, United Nations, 2007

¹¹ The MDG Framework revised to include four additional key targets was adopted by the Sixty-second United Nations General Assembly in October 2007

Strategic Plan (2004-2008). The implementation of the Plan had a shortfall of approximately 75% funding gap against the planned budget of US\$30.1 million¹². Thus, some of the components of the Plan were either not implemented or implemented on a very limited scale. The review of the first five-year RH Strategic Plan showed some positive trends in ANC coverage and the proportion of deliveries attended by skilled birth personnel. An increase in contraceptive prevalence rate corresponded with the moderate decrease in unmet need for contraception. However, progress towards the ICPD and MDG5 goal (Target 5A) of reducing maternal mortality has proven to be slow and unequal among population groups.

The main strategy of a second five-year RH Strategic Plan (2009-2013) is to scale-up the essential package of reproductive health services with improved coordination and resource pooling. The second five-year RH Strategic Plan set in the national targets to monitor the implementation against the MDG5 indicators. MMR, one of the important indicators, is targeted to reach 145 per 100,000 births in 2015. According to the nationwide cause-specific maternal mortality survey (2004-2005), the MMR is 316 and it will be a challenge to reach the target by 2015, unless inputs into emergency obstetric care and support are made and universal access to BS and RH care are provided.

The target for proportion of births attended by skilled health personnel is currently 64%, which is still a long way to reach the target of 80% by 2015. To bring down the MMR, the on-going challenge is to train and employ skilled personnel in proper numbers, and ensure these personnel are placed especially in the remote, hard to reach areas where mothers prefer to deliver at home.

Achievements and gaps for Goal 5

Targets	Indicator	1990-1994	1996-2001	2005-2007	2015 target	Source
Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	5.1. Maternal mortality ratio (number of maternal deaths per 100,000 live births)	232	255	316	145	Five year Strategic Plan for RH (2009-2013)= (RH-SP)
	5.2. Proportion of births attended by skilled health personnel (%)	51	57	64	80	RH-SP 2009-2013
Target 5.B: Achieve, by 2015, universal access to reproductive health	5.3. Contraceptive prevalence rate (%)	16.8	37	41	60	RH-SP 2009-2013
	5.4 Adolescent birth rate		29	22.7, 16.9*	Not set ¹³	*2007 FRHS
	5.5. Antenatal care coverage (at least one visit)**		42.2	64.5	80	RH-SP 2009-2013
	5.6. Unmet need for family planning		19.1	17.7	<10	RH-SP 2009-2013

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

¹² Five year Strategic plan for reproductive health, 2004-2008

¹³ There are data gaps concerning adolescent birth rate, and information can be obtained from surveys such as FRHS and MICS, only it is not normally calculated or was not usually mentioned in reports.

The table below shows Myanmar's progress towards selected ICPD PoA indicators analyzed by the UNFPA State of World Population to enable comparison in relation to indicators from national sources as well as UN sources in relation to progress towards ICPD PoA goals and MDGs:

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

*2009 estimation workshop, Myanmar

Goal 6: Combat HIV/AIDS, Malaria and other diseases

HIV is covered twice in the ICPD Programme of Action, recognizing that large numbers of people remain at risk and countries are to intensify efforts to prevent, detect and treat HIV/AIDS within the context of sexual and reproductive health. The achievements through concerted efforts in Myanmar are evidenced in Malaria and TB.

MDG Goal 6A aims to have halted and begun to reverse the spread of HIV/AIDS by 2015. Indicator 6.1 of HIV prevalence among pregnant women aged 15-24 years has declined from 2.78 percent in 2000 to 1.01 percent in 2008 in Myanmar. However, there is still a large gap to achieve MDG target 6B of universal access to treatment for HIV/AIDS for all those who need it by 2010 for Universal Access and by 2015 for MDG target. The proportion of population with advanced HIV infection with access to antiretroviral drugs is only 20 percent in 2008.

The National Malaria control program aims to reduce malaria mortality and morbidity by 50 percent of the level in 2000 by 2010 and to achieve the MDG by 2015. Malaria mortality and morbidity has a falling trend. Prevalence of death due to Malaria (all ages) has fallen from 8.4 per 100,000 to 3.1 per 100,000 in 1995 and 2005 respectively. Percentage of population under 5 years of age in all malaria risk areas using insecticide treated nets increased from 0.11% in 2000 to 2% in 2005¹⁴.

Myanmar is one of the 22 high burden TB and 37 high multi-drug resistant TB (MDR-TB) countries in the world. The National TB Program is set to halt and reverse incidence by 2015 and half the death rates due to TB by 2015 compared with that of 1990. The Directly Observed Treatment Short Course (DOTS) strategy was introduced in 1997. Tuberculosis prevalence for all cases per 100,000 people was 419 in 1990 and was reduced to 180 cases per 100,000 people in 2005. Tuberculosis death rate for 100,000 was 50 in 1990 and is now reduced to 21 per 100,000 in 2005.

Achievements and gaps for Goal 6

MDG goal	Indicator	1995	2005	2015	Source
Goal 6: Combat HIV/AIDS, Malaria and other diseases	6.1. HIV prevalence among pregnant women aged 15-24 years (%)	1.37	1.31 1.01(2008)		Myanmar MDG Report 2006 & HSS 2008, DOH
	6.2. Condom use at last high-risk sex (%)	76.4(2003)	80.7%(2007)		Myanmar MDG

¹⁴ Health in Myanmar 2009, Ministry of Health, 2009

					Report 2006 & BSS 2007, DOH
	6.3. Percentage of population aged 15-24 years with knowledge about effective HIV prevention methods (%)	21(2003)	37.7.% (2007)		Myanmar MDG Report 2006 & BSS, 2007, DOH
	6.4. Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years		na		DEPT (not required for HIV Concentrated epidemic country)
	6.5. Proportion of population with advanced HIV infection with access to antiretroviral drugs		3% (2005) 20% (2008)		Progress Report – AIDS 2005/2008
	6.6. Prevalence and death rates associated with malaria Deaths per 100,000 (all age) Prevalence per 1,000 (all age)	8.4 14.7	3.1 9.3		Myanmar MDG Report 2006
	6.7. % of population <5 years of age in all malaria risk areas using insecticide treated nets	0.11 (2000)	2(2005)		Myanmar MDG Report 2006
	6.8. % of population ,5 years of age in malaria risk areas with fever being treated with effective (T) (Antimalarial Drugs)	18.9(2000)	24.5		Myanmar MDG Report 2006
	6.9.Prevalence and death rate associated with tuberculosis Tuberculosis prevalence all cases/ 100,000 population Tuberculosis Death rate/ 100,000	419 (1990) 50(1990)	180 21		Myanmar MDG Report 2006
	6.10 Proportion of tuberculosis cases detected and cured under directly observed treatment , short course Proportion of tuberculosis cases detected Proportion of tuberculosis cases cured Proportion of tuberculosis cases treated successfully	38(1990) 61(1994) 78(1994)	95 75 84		Myanmar MDG Report 2006

Goal 7: Ensure environmental sustainability

The ICPD focuses on population, economics, environment and sustainable development. It urges governments to ensure that population, environment and poverty eradication factors are integrated in sustainable development policies, plans and programs.

Of Myanmar's total land area in 2005, 50.2 percent are covered by natural forests and 17.66 percent by other open wooded lands.¹⁵ The permanent forest estate (includes reserved forest, protected public forest and protected area system) was about 21 percent of the total land area in 1999 and had increased to about 28 percent in 2007-2008. The year-to-year increase was the highest in 2003-2004 to 2004-2005 with seven percent.¹⁶

Regarding indoor air pollution, Myanmar had the lowest carbon dioxide emission among ASEAN countries of 1.8 in 1990 increasing in 2005 ranging from 4 percent to 7 percent.

Many indicators are not available but, in the future, National Sustainable Development Strategies have established systems to produce these MDG indicators for monitoring of the progress:

1. Enact the Myanmar Environmental Law.
2. Promote Air Pollution Monitoring sites
3. Capacity building for management and monitoring of air pollution
4. Raise public awareness of environmental preservation and sustainability.

Though deforestation was observed, recent data shows that a favourable situation is evidenced from the result of afforestation activities and greening of the arid zone. National Commission for Environmental Affairs (NCEA) has developed a comprehensive document National Sustainable Development Strategy (NSDS) in incorporating environmental consideration into social and economic development to ensure the achievement of Sustainable Development. NSDS opens the opportunity of the creation of green technology and green policy or in other words the 'green deal', and investment in "green technology" is necessary for the sustainable development and obtaining MGDs in Myanmar. Poverty reduction is expected to occur through the implementation of the 'green deal' strategy whereby G20 countries are expected to contribute towards sustainable development in the developing world.

In connection with population growth and land use, the country has one third of the arable land left untouched and has potential for food security for the growing population.

Achievements and gaps for Goal 7

MDG goal	Indicator	1995	2005	2015	Source
Goal 7: Ensure environmental sustainability	7.1 Proportion of land area covered by forest	52.3 % (1999)	50.2 %*		Forestry in Myanmar, Forestry Dept * Myanmar MDG Report 2006
	7.2. CO ₂ emissions, total, per capita and per \$1GDP (PPP)	1.8(1990)	4 to 7 % (NSDS)		Myanmar MDG Report 2006; NSDS, NCEA
	7.3. Consumption of ozone depleting substances	54.3	27.15		Myanmar MDG Report 2006
	7.4. Proportion of fish stocks within safe biological limits		na		Data gap
	7.5. Proportion of total water		na		Data gap

¹⁵ Myanmar MDG Report 2006, MNPED

	resources used				
	7.6. Proportion of terrestrial and marine areas protected		3.9 3%		Myanmar MDG Report 2006
	7.7. Proportion of species threatened with extinction		na		40 species of mammals, 50 species of birds & 9 species of reptiles have been listed under "Completely protected", 12 species of mammals, 43 species of birds & 6 species of reptiles listed under "protected", and 2 species of mammals, 13 species of birds are listed "Seasonally protected" (NSDS, p19)
	7.8. Proportion of population using an improved drinking water source	30.1% (1997)	57.2% (2006)		1997 & 2007 FRHS
	7.9 Proportion of population using an improved sanitation facility	49.7% (1997)*	77.1% (2006)**		1997 & 2007 FRHS
	7.10. Proportion of urban population living in slum		na		

Note * Piped into residence+ public tap and tube well

** Piped water+ well (protected)

Consumption of ozone depleting substances (ODS) in 2001 is 54.3 metric tons per annum for Myanmar. In comparison, Malaysia consumed 1950, and Thailand consumed 3380 metric tons per annum respectively. There is marked reduction of consumption of ozone depletion substances by Ozone Country Program¹⁷ where ODS particularly Chloro-Fluro- Carbon 12 (CFC)12 is reduced to 27.15 in 2005.

From the above table it is evident that indicators 7.4 the proportion of fish stocks within safe biological limits, 7.5. proportion of total water resources used, 7.7. the proportion of species threatened with extinction, and 7.10 the proportion of population using an improved sanitation facility are as yet not measured and there is need for national studies in these areas.

UN initiated Myanmar Data Mission on Strengthening MDG indicators has identified the indicators for Goal 7 as in the matrix below:

ANNEX II:		TRENDS IN MDG INDICATORS FOR GOAL 7				
Goal & Target	Indicators	Data Value				Data Source
		1991-1995	1996-2000	2001-2005	2006-2010	
		a	b	c	d	
Goal 7	Ensure environmental sustainability					
Target 7A	Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources					

¹⁷ Ozone Country Program, MNPED, 2006

	7.1 Proportion of land area covered by forest	55.97%	52.13%	50.20%		GoUM MDG report 2006 for a, b, & c
	7.2 CO2 emissions, total, per capita and per \$1 GDP (PPP)					
	7.3 Consumption of ozone-depleting substances	54.3 tons	54.3 tons	27.15 tons		GoUM MDG report 2006 for a, b, & c. Note that c was a target. Need to follow up.
Target 7B	Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss					
	7.4 Proportion of fish stocks within safe biological limits					
	7.5 Proportion of total water resources used					
	7.6 Proportion of terrestrial and marine areas protected				3.93%	GoUM MDG report 2006
	7.7 Proportion of species threatened with extinction					
Target 7C	Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation					
	7.8 Proportion of population using an improved drinking water source	32%		63%		GoUM MDG report 2006 for a; IHLCA for c
	Population with access to improved water source					
	7.9 Proportion of population using an improved sanitation facility	35%	63.10%	76%		GoUM MDG report 2006 for a & b; IHLCA for c
Target 7D	By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers					
	7.10 Proportion of urban population living in slums					

Goal 8: Partnerships and Collaborations

Governments are encouraged to have dialogue with NGOs and local community groups and involvement of civil society in planning and programming of national development policies and plans. UN partnership in implementing ICPD Program of Action in Myanmar is through the UNFPA, UNICEF UNAIDS, WFP, UNIAP, UNHCR, WHO, with the Ministry of Health, Ministry of National Planning and Economic Development, Ministry of Immigration and Population, Ministry of Social Welfare, Relief and Resettlement.

There are 40 registered national and 54 registered international NGOs working in Myanmar for improvement of reproductive health, population, humanitarian and development programs and on

cross cutting gender issues. The UN Theme group was formed with national and international partners with the main objective of advocacy for gender equity, gender mainstreaming in national programming and policy development.

Achievements and gaps for Goal 8

MDG goal	Indicator	1995	2005	2015	Source
Goal 8: Develop a global partnership for development	8.1. Net ODA, total and to the least developed countries, as percentage of OECD/DAC donors' gross national income		na		Only have total ODA by bi- and multi-lateral aids and by year up to 2001
	8.2. Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation)		na		
	8.3. Proportion of bilateral official development assistance of OECD/DAC donors that is untied		na		
	8.4 .ODA received in landlocked developing countries as a proportion of their gross national incomes	Not relevant			
	8.5. ODA received in small island developing States as a proportion of their gross national incomes	Not relevant			
	8.6. Proportion of total developed country imports (by value and excluding arms) from developing countries and least developed countries, admitted free of duty				Can be calculated from data from Statistical Yearbook, CSO
	8.7. Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries		na		
	8.8. Agricultural support estimate for OECD countries as a percentage of their gross domestic product				
	8.9. Proportion of ODA provided to help build trade capacity				
	8.10. Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative)				
	8.11. Debt relief committed under HIPC and MDRI Initiatives				

	8.12. Debt service as a percentage of exports of goods and services				
	8.13. Proportion of population with access to affordable essential drugs on a sustainable basis (%)	17.5(1997)	74		Myanmar MDG Report 2006
	8.14. Telephone lines per 1000 people	3.91	10.3		Myanmar MDG Report 2006
	8.15. Cellular subscribers per 100 population		0.93% (2010)		Ministry of Communication, Post and Telegraphs
	8.16. Personal computers per 1000 people	10.6(2004)	11.0		Myanmar MDG Report 2006

Myanmar Data Mission on Strengthening MDG indicators has identified the indicators for Goal 8 as in the matrix below:

ANNEX II:		TRENDS IN MDG INDICATORS FOR GOAL 8				
Goal & Target	Indicators	Data Value				Data Source
		1991-1995	1996-2000	2001-2005	2006-2010	
		a	b	c	d	
Goal 8	Develop a global partnership for development					
Target 8A	Develop further an open, rule-based, predictable, non-discriminatory trading and financial system					
	<i>Some of the indicators listed below are monitored separately for the least developed countries (LDCs), Africa, landlocked developing countries and small island developing States.</i>					
	<u>Official development assistance (ODA)</u>					
	Includes a commitment to good governance, development and poverty reduction – both nationally and internationally					
	8.1 Net ODA, total and to the least developed countries, as percentage of OECD/DAC donors' gross national income					Global
	8.2 Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation)					Global
Target 8B	Address the special needs of the least developed countries					
	8.3 Proportion of bilateral official development assistance of OECD/DAC donors that is untied					Global

	8.4 ODA received in landlocked developing countries as a proportion of their gross national incomes					Not applicable for Myanmar. Only landlocked countries.
	Includes: tariff and quota free access for the least developed countries' exports; enhanced programme of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction					
	8.5 ODA received in small island developing States as a proportion of their gross national incomes					
	<u>Market access</u>					
	8.6 Proportion of total developed country imports (by value and excluding arms) from developing countries and least developed countries, admitted free of duty					Not applicable for Myanmar. Only small islands
Target 8C	Address the special needs of landlocked developing countries and small island developing States (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly)					
	8.7 Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries					Global
	8.8 Agricultural support estimate for OECD countries as a percentage of their gross domestic product					Global
	8.9 Proportion of ODA provided to help build trade capacity					Myanmar is subject to economic sanctions.
	<u>Debt sustainability</u>					
Target 8.D:	Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term					
	8.10 Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative)					Global
	8.11 Debt relief committed under HIPC and MDRI Initiatives					Global
	8.12 Debt service as a percentage of exports of goods and services					

Target 8E	In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries					
	8.13 Proportion of population with access to affordable essential drugs on a sustainable basis		64%	74%		GoUM MDG report 2006 for a, & b
Target 8F	In cooperation with the private sector, make available the benefits of new technologies, especially information and communications					
	8.14 Telephone lines per 100 population	0.21	0.61	1.03		GoUM MDG report 2006 for a, b, & c.
	8.15 Cellular subscribers per 100 population					The data should be available at MPT.
	8.16 Internet users per 100 population					

Social and Economic Development

Currently, the economy of Myanmar is at the developing and transitional stage to a market-oriented economy. In addition, the Myanmar economy is heavily dominated by the agricultural sector. Population growth enlarges the labour force and therefore increases economic growth. The increase in the working age group entails additional jobs in various skills and qualifications and economic development as well as expansion of economic sectors. Changing strategies such as privatization of economic enterprises and industries also provide new job opportunities. Focusing on agricultural sector development is a compulsory course of action for economic growth on the path to national industrialization. A poverty reduction strategy is in place and should be able to promote development process particularly in the achievements towards the realization of ICPD PoA and MDGs.

Achievements and gaps

In 2009, the United Nations has estimated some eleven selected indicators for monitoring ICPD goals as well as 15 demographic, social, and economic indicators, based on available national sources and figures. If national sources were unavailable, indicators were based on assumptions that are nearest to the prevailing situation of the country and estimates based on other available data.¹⁸ These indicators are the ones that can help track progress to meeting the quantitative and qualitative goals of the ICPD PoA and the MDGs in the areas of mortality reduction, access to education, access to reproductive health services including family planning, and HIV/AIDS prevalence among young people. Some six indicators from the State of the World Population for 2000, 2002 and 2009 are given below for studying trend. GNI per capita PPP\$ is left blank for Myanmar in the reports and expenditures per primary student as percent of GDP is only available for 2002. External population assistance has increased for the given three points of time, about nine times of 2000 assistance in 2009. Under-five mortality is decreasing very slightly and its progress is assessed as unsatisfactory by the UN. Per capita energy consumption has stayed the same and access to improved drinking water has improved by 20 percentage points during nine years.

¹⁸ Human Development Report 2009, UNDP

Social and Economic	State of World Population 2000	State of World Population 2002	State of World Population 2009
GNI per capita PPP\$	-	- (2000)	- (2007)
Expenditures / primary student (% of GDP)	-	3.5	-
External population assistance (US\$,000)	884	1,886	8,085
Under -5 mortality M/F estimates	121/104	141/124	120/102 (2005-2010)
Per capita energy consumption	294	273	295
Access to improved drinking water sources	60	68	80

Population and Demographic Window of Opportunity

The population of Myanmar is estimated at 57.5 million in 2007 and the country is sparsely populated compared to other countries. Distribution is uneven with the largest share of population living in Mandalay and Ayeyarwady Divisions with 14 percent each. Due to declining fertility the proportion of children under 15 has decreased over time and the proportion of working age group (those between age 15 and 59) has been increasing on account of the past high fertility. Given these trends, Myanmar's population is in the transition stage from young to intermediate, growing towards the old. Thus, there will be a larger work force available and a lesser proportion of young and elderly people depending on the working age population. In 2006, for every ten dependents (young under 15 and old persons aged 60 and over) there are 17 people in working age group to support them.

With an increasing proportion of working age population (those between age 15 and 59) and the decline in the young and total dependency ratio, a demographic window of opportunity could be taken advantage of. Proper planning could lead to a rise in the rate of economic growth and thus reduce poverty if not totally eradicate it. However, this demographic dividend appears to be dependent on the ability of the economy to absorb and productively employ the extra workers, and the ability to create productive jobs for the additional workforce. It has been observed from data collected of the flow of people moving through international airports, seaports, and border entry points and from various sources concerning international migration in Myanmar, that there are many Myanmar nationals going out to other countries for education and/or for job opportunities. This brain drain and talent drain could be alleviated through better educational and employment opportunities and facilities.

The proportion of the population that has never married is high at around 45.6 percent for both sexes of 15-49. A high proportion (over 80 percent) of youth (aged 15-24) remains single and/or never married. Marriages are postponed and mean age at first marriage has increased among married couples by one year during the decade 1997- 2006. As indicated in Chapter II, the abortion rate is high amongst adolescents and women with university education. As such, there is a need for IEC and services for reproductive health and sexuality to reach unmarried young people and couples.

The fertility rate is declining in Myanmar with Total Fertility Rate (TFR) of 2.0 children in 2006. In other words, today's Myanmar woman can expect to have two children in her life, if she experienced, during her reproductive span, the age specific fertility rates prevailing at the time. But a married woman would have 4.7 children in her life which is still high though it has also been declining.¹⁹ But the Maternal Mortality Rate (MMR) is considerably high and the abortion rate among married adolescents is also high. With the Contraceptive Prevalence Rate (CPR) for modern methods low at 38.4 percent, there is a need to promote use of contraceptives to reduce MMR and abortion rates thus promoting the health and wellbeing of mothers and children.

¹⁹ Country Report on 2007 Fertility and Reproductive Health Survey, Department of Population, Nay Pyi Taw and UNFPA

Amongst vulnerable population groups, a plan of action for disabled persons has already been adopted and a national plan of actions for elderly persons was drafted and on the way to being formally adopted. There is still a great need for research on the vulnerable groups together with compiling of basic statistics concerning them.

Increased urbanization is due to both “pull and push factors”, as well as the reclassification and extending of some urban boundaries. Little is known about urban growth and urbanization although some disparate information is available from different sources. As such, data collection as well as research studies on information of slums in urban areas are not available and studies should be done in this respect. However, city and town development committees in recent years implemented programmes to address the matter through the “from hut to apartment” programme resulting in establishment of new urban areas. The UN estimated data concerning urban population, proportion urban and growth are given below to have some indication of the urbanization situation in Myanmar in the absence of national data.

Monitoring Selected ICPD Indicators of Myanmar

Demography	State of World Population 2000	State of World Population 2002	State of World Population 2009
Total Population(millions)	45.6 (2000)	49.0 (2002)	50.0 (2009)
Projected population (millions)	58.1 (2025)	68.5 (2050)	63.4 (2050)
Average population growth rate (%)	1.2 (1995-2000)	1.2(2000-2005)	0.9 (2005-2010)
% urban	26 (1995)	28(2001)	33 (2009)
Urban growth rate	3.7 (1995-2000)	2.9 (2000-2005)	2.9(2005-2010)
Population / hector arable &-permanent Crop land	3.1	3.3	2.9
Total fertility rate	2.40 (1995-2000)	2.80 (2000-2005)	2.28 (2009)

Data gaps to monitor ICPD goals and MDGs

There are nationwide surveys that collect information to provide indicators needed to monitor the progress towards achieving the ICPD goals, MDGs and targets set for the country.

Surveys such as MICS, FRHS, UNGASS (HIV) and IHLCA produce indicators needed for MDG concerning women and children, poverty measures, maternal and child health, reproductive health, contraception and sexuality, knowledge on HIV/AIDS and trafficking in persons. However, there are gaps in data on migration and urbanization. Migration is one of the determinants of the change in age-sex structure as well as spatial distribution of a population in a region and plays an important role in national policies and plans. To date, no separate migration study is done to collect information on migration. A survey dedicated to migration would be incredibly useful, in order to measure net migration rates, volume of migration, destination, causes of migration, and types of people who migrate. Another area with data gaps is indicator 7.10, the proportion of population living in slums²⁰. The concerned city or township development committees would probably have enough information to report on this indicator. For this indicator, the Data mission has recommended that a locally relevant definition with a focus on quality of housing and a focus on urban shelter upgrading would be useful²¹. A nationally representative Migration Survey and in-depth analysis as well as research study on urbanization should be undertaken. The DOP has indicated that it intends to conduct a Migration Survey in 2011 and arrangements are to be made later this year.

Another gap is information on the labour force. The last labour force survey was in 1990. The current labour force-related data are projections based on the 1990 survey. For the estimation of job

²⁰ Myanmar Data Mission on strengthening MDG indicators, UNFPA, Yangon

²¹ Ibid

opportunities, employment, under-employment and unemployment, and labour force participation and for the planning of human resource development, a labour force survey at the national scale is needed. The focal government department should also be reinforced with technical assistance as well as capacity building. IHLCA, MICS and FRHS provide some information on labour force and employment but not in any detail. Hence information concerning indicators such as the share of women in wage employment in the non agricultural sector is not available. Indicators 1.4 to 1.7 would also be available from a labour force survey. The data mission has recommended a new launch of a labour force survey in order to estimate, among many other indicators, the share of women in wage employment in the non-agriculture sector. The Department of Labour intends to take a labour force survey in 2011 and has approached UNFPA for support.

With regard to education indicators, information on school attendance for household members 5 to 29 years of age are collected in the national surveys and hence school attendance at primary, secondary school levels by age, sex can be obtained. Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years can be obtained from 2003 MICS as well as the ongoing MICS but was not usually tabulated and included in the reports. The survey organizers may not have included at the planning stage but was not included in the reports. It should be included in the subsequent analysis.

Another area of major data gaps is on environmental issues. Compared to indicators of economic and social aspects, environmental and sustainability indicators are a relatively new phenomena. Indicators such as the proportion of fish stock within safe biological limits, proportion of total water resources used, and proportion of species threatened with extinction are not available. It was suggested that the UN M&E group work closely with NCEA to discuss the methodologies and agree on the indicators as locally relevant for Myanmar²².

²² UN Data mission Report on strengthening of MDG indicators

Chapter Six: Partnership and External Cooperation



CHAPTER VI: Partnerships and External Cooperation

In the previous chapters, we have detailed how over the last decade Myanmar has made considerable progress in implementing ICPD and MDG goals for population development in terms of demographic and reproductive health. However, there are areas of concern and challenges which can only be addressed through partnerships, external cooperation and the coordinated efforts of all stakeholders working in these areas.

1. Partnerships in Implementing the ICPD Goals

The ICPD Program of Action urges governments to acknowledge and have open collaboration with UN, NGOs, civil society and donor community in developing, planning and implementation of national programs. In Myanmar as of 2010, the Ministry of Health works in close cooperation with 34 International Non-Governmental Organizations and 7 UN organizations for health development. Multiple actors work in the domain of reproductive health, population and development, and gender equity contributing to government's efforts to achieve national targets for MDGs.

In 2006, the WHO conducted a reproductive health stakeholder analysis involving the contributions of 54 stakeholders (4 Government departments, 7 UN agencies, 24 INGOs, 2 International Red Cross Movement Organizations and 17 national NGOs). Results showed that there are 20 stakeholders with exclusive RH programs in 2006 compared to 18 in 2003.¹

A large concentration of organizations that is (8-12) work, in the Yangon, Mandalay, and Ayeyarwady Divisions, Northern Shan State and Mon state. However, Chin State had only two active agencies presence (MMCWA and UNFPA) and Kayah had only one active organization (MMCWA).² 77.8% of the organizations provide sexual and RH information and only one organization worked on post-menopausal reproductive health. It is noteworthy that 2/3 of the organizations were promoting men's role in reproductive health. The number of organizations implementing sub-component activities of minimum interventions also varies widely. The reasons for this disparity also need to be explored. A cross review between the RH indicators and the stakeholder analysis is suggested to highlight the priority area of implementation³.

To implement the PoA addressing population and RH issues of the ICPD goals, Myanmar implemented the Five Year National Strategic Plan for RH (2004-2008) with DOH, MOH operating as the focal ministry and with UNFPA and its implementing partners supporting towards a common goal. The review showed that implementation of the strategic plan had a serious short fall of approximately a 75% funding gap resulting in some of the activities not being fully implemented.⁴ The new Five Year National RH Strategic Plan (2009-2013) outlines the coordination mechanisms for the implementation of Myanmar's RH Strategy and multi-sectoral collaboration for attaining national targets for MDGs 4 and 5. Coordination is envisioned with the leadership of the Ministry of Health, Department of Health to partner with a wide range of stakeholders, including other ministries (Ministry of Education, Ministry of Social

¹ UN technical working group on Health, Myanmar. Health Stakeholder report, Myanmar ,2003

² Analysis of RH stakeholders in Myanmar.WHO, 2006

³ Ibid

⁴ The review of Reproductive Health Program, MCH, DOH, 2010

Welfare, Relief and Resettlement, Ministry of Information and Communication, Ministry of Sports, Ministry of Immigration and Population), professional associations, academia, donors and non-governmental organizations⁵. It is only by effective internal and external cooperation and resource mobilization that will there be tangible improvement in RH response in Myanmar.

The National Working Committee and Technical Working Group for Reproductive Health are the proposed entities to collaborate with relevant structures. The thematic sub-committees, such as a national sub-committee for Reproductive Health Commodity Security has been established as envisioned. Efficient functioning of these bodies and the local coordination at the sub-national level should be a priority with sufficient commitment from all partners to ensure harmonization according to national priorities.

2. UN partnerships

2.1. UNDP

UNDP is the UN's global development network, advocating for change and connecting countries in sharing knowledge, experience and resources to assist people to build better lives in 166 countries. UNDP operates according to the principles and values of the United Nations and respects each country's control over its future.⁶ UNDP has been implementing the Human Development Initiative (HDI) in Myanmar since 1994. It spearheaded programs for poverty reduction and primary health care, environment, HIV/AIDS, training and education. UNDP currently works in 60 townships around the country. UNDP's initiatives target the most vulnerable communities and work to improve opportunities for sustainable livelihoods. UNDP works closely with the GoUM (with the Ministry of National Planning and Economic Development) and also with the donors around the globe through bi-lateral discussions and field trips to project sites.

Table 6.1: UNDP Myanmar: Human Development Initiative Donors (1994-present)

Donors	Total (US\$)
Australia	8,991,315
UK (DFID)	23,398,973
New Zealand	1,332,873
Japan	1,142,859
Italy	5,536
USAID	1,000,000
Norway	3,841,931
UAE	1,000,000
Switzerland	523,560
Denmark	1,480,000
Netherlands	1,211,745
Germany	22,847
SIDA	8,822,972
TT Fund	150,000
Total	48,082,680

Source: UNDP Myanmar Funding Partners accessed on 8.4.2010, <http://www.mm.undp.org/INGOpartnership>.

⁵ Five-year Strategic Plan for Reproductive Health (2009-2013), Ministry of Health

⁶ Executive Board of UNDP/UNFPA, Assistance to Myanmar. http://www.mm.undp.org/executive_board accessed on 8.4.2010

UNDP works in partnership with other organizations and groups. For example, UNDP works with PACT for micro-finance services, FAO for agricultural inputs and technical support, ILO for community-driven labour-based infrastructure development, UN-Habitat for shelter reconstruction, UNICEF for water, sanitation and hygiene activities and WFP for food delivery.

2.2. UNFPA

UNFPA has over 30 years experience of advocating for women, promoting legal and policy reforms, conducting gender-sensitive data collection, and supporting projects that improve women's health and expand their choices in life. At the global level, UNFPA is a key coordinator in times of crisis through the Early Recovery, Protection and Health clusters and in particular advocating strategies to prevent and respond to gender based violence (GBV).

UNFPA works closely with WHO and UNICEF for improving Maternal and Child Health in Myanmar and also with its implementing partners such as JOICFP, SC, MSI, PSI, AFXB, AZG and AMI. MCH of DOH is the focal point partner responsible for improving reproductive health by life cycle approach, including adolescent RH, antenatal, intra-partum, post-partum and post abortion care, emergency obstetric care and RH commodity security, and capacity building for RH services to reduce maternal mortality and morbidity. Moreover, UNFPA is implementing projects on increasing access by young people to adolescent reproductive health and HIV prevention information, improving access by vulnerable population groups to knowledge on HIV prevention, and increasing access to comprehensive services to prevent mother to child transmission of HIV/AIDS. On this project, UNFPA is cooperating with NAP, CHEB, DOH, JOICEP, MMA, MRCS, MANA, PSI, MSI, and Save the Children.

UNFPA supports Myanmar's population and development, RH, and HIV/AIDS program through the second program of assistance (2007-2010) which will be extended to 2011. UNFPA's total program budget amounted to core resources of \$14.8 million and \$6.4 million from other sources amounting to \$21.2 million. The donors of UNFPA's program of assistance include the governments of Australia, Norway and Germany.

Norway has made tangible commitment towards achieving MDG 4 and 5 on reducing child mortality and improving maternal health by 2015⁷. Postmenopausal health, gynaecological cancers, infertility and sub-fertility are the areas getting least attention from donors. Key players demonstrate strong collaboration and work in close cooperation with the Department of Health in delivering RH interventions. The majority of key stakeholders are planning to focus on improving quality of services and achieving sustainable impact in selected geographical areas whilst few, subject to availability of resources, may be choosing to scale up proven activities.

2.3. UNICEF

The mandate of UNICEF is to help improve lives of children and women living in disadvantaged conditions. UNICEF has been working in Myanmar continuously since 1950 and has successfully initiated programs against small pox, leprosy and yaws. UNICEF addresses ICPD-related issues by supporting prevention of HIV by PMCT program, early childhood development, child protection and education⁸. Using funds donated bilaterally by the Government of Japan, the GoU and MOH expanded programs for immunization and availability of vaccines, resulting in a reduction of vaccine preventable

⁷ Resource mobilization Plan for the UNFPA Country office document, UNFPA, 2009-2011

⁸ UNICEF's commitments to Myanmar's Children accessed <http://www.unicef.org/myanmar/overview>.

diseases and infant mortality. The integrated management of maternal and child care has been covered in a collaboration between UNICEF and DOH entitled the Women and Child Health Development (WCHD) program. This has contributed significantly to the improvement of maternal and child health. Recently a needs assessment on emergency obstetric care was conducted by UNICEF and DOH.

2.4. WHO

WHO is a specialized organization in the UN system providing technical expertise in the field of health. It operates in a two year cycle of country program planning and implementation cycles. Currently the 2010-2011 program is being implemented according to the policy directions of the Country Cooperative Strategy (CCS) 2008-2011. The priorities of WHO in Myanmar for the period 2008-2011 have been identified to (1) improve the performance of the health system, (2) bring down the burden of disease, and (3) improve health conditions for mothers, children and adolescents. WHO commits a biennial budget of approximately \$32.2 million (\$27.6 million Voluntary Contributions plus \$4.6 million Assessed Contributions) for 2010-2011 in Myanmar. WHO significantly contributes towards development of guidelines for safe motherhood, and the care of new borns. Who conducted an assessment of essential new born care program in Ayeyarwady and Magway Divisions in 2007⁹.

2.5. WFP

World Food Program is the food aid branch of UN and provides food to 90 million people per year of which 58 million are children.¹⁰ Although Myanmar is a food-surplus country with significant agricultural potential, unfavorable economic policies, vagaries of weather, impaired social cohesion and the marginalization of some sectors of the population adversely affect livelihood opportunities and adequate access to food requirements¹¹.

Food insecurity is particularly pronounced in border areas, home to the majority of the country's minorities, who face a variety of restrictions including impediments to trade and movement. The GoUM's decision to eradicate opium has pushed the majority of the households in traditional opium-growing areas into chronic poverty and adversely affected their food security. WFP's food assistance strategy in Myanmar aims to meet the emergency needs of disaster-affected populations, bridge the food gap, build on community assets for future livelihoods and prevent a deterioration of the nutritional status of the most vulnerable groups.

WFP's strategy for food assistance to people living with AIDS, and the population affected by Cyclone Nargis in Myanmar includes relief, recovery and supplementary feeding interventions to help maintain adequate food consumption, and to stabilize the nutritional status of the most vulnerable groups and restore livelihoods.

2.6. IOM

IOM is an international organization with creative approaches to improving migrant access to preventative and curative health services for TB, STIs, HIV/AIDS, and other health conditions. Domestic

⁹ Assessment and evaluation of Essential New born Care program in Ayeyarwady and Magway Divisions. WHO, 2007.

¹⁰ http://en.wikipedia.org/wiki/world_food_programme accessed on 4 April 2010.

¹¹ <http://www.wfp.org/countries/myanmar> accessed on 24 April 2010.

conditions, coupled with its geographical location which links the expanding economies of Southeast Asia, China, and South Asia, make Myanmar a country with dynamic internal and cross-border mobility. This mobile population constitutes one of the most daunting challenges facing the Myanmar authorities and partner agencies. The strategy of IOM and its partners is to strengthen the institutional capacity of Myanmar's Ministry of Health and its partners in addressing TB and HIV/AIDS, to take a multi-sectoral approach towards reducing vulnerability to HIV and STIs, to conduct related assessments and/or research, and to improve the diagnostic and treatment capacity of peripheral TB and HIV care providers.

Mobile populations are vulnerable to smuggling, human trafficking, labour exploitation, and the spread of communicable diseases, including tuberculosis (TB) and HIV/AIDS. Significant risks exist for those working in the transport sector, seasonal labourers, seafarers, entertainment and sex workers, and those in mining communities. The mobility process increases vulnerability to contracting sexually transmitted infections (STIs), including HIV/AIDS. Those concerned include migrants and their sex partners, source communities, and the more permanent communities that are affected by mobility and migration. Mobility also presents difficulties in accessing information and diagnostic services for tuberculosis (TB) and STIs (including VCCT for HIV), and poses challenges in facilitating compliance with treatment regimens.

IOM continues to work with counterparts in Myanmar and Thailand to develop and strengthen return and reintegration structures and procedures for returning victims of trafficking from Myanmar, and to establish standard operating procedures for these official returns. Following the success of the Coordinated Mekong Ministerial Initiative against Trafficking (COMMIT) conference held in October 2004, IOM is focusing on training officials in the areas of victim identification, victim assistance and bilateral cooperation for returns with neighboring countries from the Greater Mekong Sub-region.

3. Partnerships for HIV/AIDS

In Myanmar, there are many sectors involved in the national response to the HIV epidemic and to the mitigation of HIV's social and economic impact. These are (1) the Government – Ministry of Health and National AIDS Programme and other Government Sectors, (2) State, Division, District and Township AIDS Committees, (3) United Nations, (4) Non-Government Organizations, (5) Community Based Organizations, (6) People Living with HIV/AIDS, (7) donors and bilateral agencies and (8) the private sector and business coalitions. Detailed roles and responsibilities of all stakeholders are addressed in Myanmar's National Strategic Plan on HIV and AIDS (NSP) 2006-2010.¹²

The Ministry of Health and the National AIDS Programme lead the national response, drawing on the 'Three Ones' principles, i.e. One HIV and AIDS Action Framework, One National Coordinating Authority and One Monitoring and Evaluation System. Coordination is promoted through the Technical and Strategy Group for HIV and the Myanmar Country Coordination Mechanism. These bodies promote agreement and adherence to national guidelines for the HIV response. Other government ministries such as Ministry of Home affairs, Ministry of Education, Ministry of Social Welfare, Relief and Resettlement, Ministry of Information, Ministry of Labour and Ministry of Transport coordinate and facilitate enabling environments for the implementation of the response at all levels and contribute to prevention as well as care and support of people living with HIV. However, there is still a need for continuous advocacy to other ministries to facilitate the enabling environment and cooperate for implementation of activities such

¹² Myanmar National Strategic Plan on HIV and AIDS, Ministry of Health, 2006-2010.

as the 100% TCP programme, the harm reduction programme for IDU, as well prevention and care activities for the institutionalized population and uniformed personnel.

State, Division, District and Township AIDS Committees are operative and they are supported to achieve and promote an enabling environment for the successful implementation of the HIV prevention and care activities by means of coordination, advocacy, monitoring and support. But there is still weakness in coordination in some townships because most of the key persons of the committees have limited time to devote to coordination.

Donors provide funding, oversight and assistance with implementation of programs implemented by all the partners from all sectors involved in the national response to the HIV epidemic. Currently, the majority of funding for the implementation of HIV strategies is obtained from the Three Diseases Fund (established in 2006 by six donors – Australia, EC, UK, Netherlands, Norway and Sweden) to respond to the funding gap for HIV, TB and Malaria as a result of the withdrawal of the Global Fund in 2005. There is also some additional assistance to HIV programs from the EC and AusAID. Aid from a number of donors is provided on humanitarian grounds. The Global Fund Board has approved all three proposals from Myanmar (on HIV, TB and Malaria) in late 2009. Promoting civil society engagement through the M-CCM process is one of the key charters of the Global Fund. JICA is an international donor that mainly supports the NAP, NHL, and National Blood Centre for provision of HIV test kits, quality assessment of HIV test kits and training of the MOH staff.

United Nations (UN) agencies including UNAIDS, UNFPA, UNICEF, UNDP, UNOPS, UNODC, WHO, WFP, IOM and UNHCR provide substantial financial support through their core funds and additional resources raised. In addition, the United Nations provides technical support to government and non-government partners in policy development, research, normative and technical guidance, planning, coordination, monitoring, procurement and implementation.

Under the leadership of NAP and MOH, **UNAIDS** is the lead UN organization on support to strategic, prioritized and costed national plans, financial management, human resources, capacity and infrastructure development, impact alleviation and sectoral work, AIDS workplace policy and programmes, private sector mobilization, overall policy, monitoring and coordination on prevention, coordination of national efforts, advocacy, partnership building and monitoring and evaluation including estimation of national prevalence and projection of demographic impact. **UNFPA** works on provision of information and education, condom programming, prevention of young people outside schools and prevention efforts targeting vulnerable groups such as MSM and FSW. **UNICEF** focuses on PMCT, prevention of HIV among young people, care and support for people living with HIV, orphans, vulnerable children and affected households and procurement and supply management including training. **UNDP** also serves as a lead UN organization on AIDS development, governance and mainstreaming, enabling legislation, human rights and gender, while **UNODC** targets prevention of transmission of HIV among IDU and prisoners. **WHO** provides as the lead UN organization on ART, OI treatment, establishment and implementation of surveillance for HIV, through population-based surveys, prevention of HIV transmission in the health care settings, blood safety, counselling and testing, STI diagnosis and treatment, and the linkage of HIV prevention with AIDS treatment services. **WFP** contributes to dietary and nutrition support, while **UNHCR** addresses HIV among refugees and related populations.¹³

Community based organizations, faith based organizations, local NGOs such as MANA, MBCA, MHAA, MMA, MMCWA, MNMA, and MRCS, International NGOs such as AHRN, Alliance, AMDA, AMI, ADRA, ARHP, AZG, Burnet, Care, FXB, Malteser, MDM, MSF-CH, MSI, PACT, PC, PSI, SC, Union,

¹³ Myanmar National Strategic Plan on HIV and AIDS, Ministry of Health, 2006-210

WC and WV continue to play crucial roles in the response to HIV. These organizations provide services to MARP and vulnerable population groups at the field level by outreach activities and establishment of DIC, facilitate community leadership and guidance, advocate in the interests of affected communities and assist mobilization of human, financial and material resources to support HIV interventions. INGOs work within the context of the national response and facilitate and support capacity building with national partners. Please see Annex 5, Maps 1, 2, 3 for maps showing the distribution by township of services for FSW, MSM and drug users by different implementing partners.

Networks for people living with HIV/AIDS (PLHIV) such as Myanmar Positive Group are involved in national response to HIV by facilitating networking and participating in planning and programme design, implementation of prevention and care and support activities of PLHIV in cooperation with government sectors, UN agencies, NGOs and community based organizations. Presently, there is limited involvement of the private sector working towards the elimination of discrimination against HIV positive workers, ensuring that HIV testing is voluntary and confidential, ensuring that people's HIV status remains confidential and encouraging employers to continue to employ PLHIV.

4. Government contributions, foreign assistance and aid modalities

According to World Health Statistics 2009, for Myanmar there is an increase in external resources for health as the percentage of total expenditure on health increased from 1.1% in 2000 to 12.9 % in 2005 and 11.2% in 2006¹⁴. While the Government expenditure on health as percentage of total government expenditure increased from 1.2% in 2000 to 1.5% in 2006, the proportion of private expenditure slightly increased from 86.6% in 2000 to 86.9% in 2006.¹⁵

According to MOH's National Health Accounts the total expenditures on health (TEH) at current prices were estimated to be 345,481,530,000.00 million Myanmar Kyat for the year 2006 and 453,670,420,000.00 million Kyat for 2007. From the years 2006 to 2007, the amount of funds spent increased, but so did the Gross Domestic Product. As such, funding remained at about 2% of the total Gross Domestic Product of each year.¹⁶ Despite a three-fold increase in government health expenditure from 2000-2001 to 2005-2006, the infrastructure and performance of the health sector has been affected as a result of it being chronically under-resourced.

5. Exploring other Funding Mechanisms

External assistance is a major source of financing in the health sector although information on the exact magnitudes of funding is not available. According to the Organization for Economic Cooperation and Development (OECD), Myanmar in 2004 received total official development assistance (ODA) of US\$ 121 million, of which roughly 13% went to the health sector. Few countries are providing direct financial support to the Government of Myanmar due to restrictions imposed by their national governments. The EU's common position limits funding to humanitarian assistance.¹⁷

In addition to GoUM, UN and NGO support there is a need to strengthen resource mobilization efforts and exploring alternative ways to finance the Five Year National Strategic Plan for RH (2009-2013), one of which is through the Global Fund to Fight AIDS, TB and Malaria (GFATM). WHO provides technical support to countries in accessing and utilizing resources from GFATM¹⁸. The Global Fund (GF) was

¹⁴ World Health Statistics, WHO,2008-2009

¹⁵ World Health Statistics, WHO,2008-2009

¹⁶ Draft National Health Accounts, DHP, MOH & WHO, 2006-2007.

¹⁷ WHO Country Cooperative Strategy, WHO-Myanmar, 2008-2011

¹⁸ Guidance Paper: WHO support to countries in accessing and utilizing resources from GFATM, Geneva, 2009.

established to attract, manage and disburse substantial new resources through public–private partnerships. Its aim was to make substantial and significant contributions to the reduction of morbidity and mortality caused by HIV/AIDS, Malaria and TB in countries in need and to contribute to poverty reduction as part of the MDGs. In recent years, advocacy efforts have been targeted towards support of sexual and reproductive health within HIV related programmes.¹⁹

In 2008, the independent Technical Review Panel of the Global Fund recommended that technical assistance be given to countries for development of proposals which integrate HIV with sexual and reproductive health behaviour as transmission occurs due to unprotected sexual practices, during pregnancy, child birth and breast feeding. Myanmar is a developing country where HIV/AIDS, TB and Malaria are diseases of national concern. Myanmar’s proposal for Global Fund Round 9 for HIV was listed as category 1 (along with only five other countries), and the recommended life-time, upper ceiling of funding, for up to 5 years was US\$157.7 million. Proposals for TB and Malaria, were listed in category 2, (out of 47 countries) with budget ceilings for 5 years of US\$85.5 million and US\$77.3 million, respectively²⁰.

It is important to explore the Global Fund for sexual and reproductive health with PMCT, adolescent reproductive health, and prevention and care of STI and Malaria in pregnant mothers as entry points. Interventions such as PMCT, reproductive health commodities security, and HIV prevention services for young people can and should be implemented as an integrated approach, considering the harmony of targeted groups, targeted behaviors and method of service delivery. In addition there would be more effective use of trained personnel and there could also be better implementation of the Global Fund’s gender equality strategy²¹.

With the advent of the global financial crisis, a global decline in donor financing and downsized contributions to reproductive health programmes might be a serious challenge to implementing strategies and achieving targets set in the National Reproductive Health Strategic Plan 2009-2013 in Myanmar. It is critically important to focus on sexual and reproductive health and would require extra concerted efforts of the UN, NGOs and Government for resource mobilization to attain MDGs 4 and 5 by 2010.

6. Partnerships for Gender

As gender is cross cutting in equal development of both sexes and socio-economic development of the nation, there is need for advocacy and capacity building in all sectors, public, INGO and UN for gender mainstreaming and research. The Gender Theme Group – formed with representatives and focal points on gender from UN agencies as well as selected representatives of NGOs and INGOs – coordinates its work with various stakeholders from the Government and civil society organizations. The UN Theme Group for Gender and the Women’s Organizations Network are mechanisms established to strengthen partnerships that advocate for gender mainstreaming and empowerment of women.

Coordination and complementarity among inputs of various partners on gender equity, equality and women’s empowerment maximizes utilization of available resources through this mechanism. However, there is a need to develop a mechanism to mainstream gender issues in all sectors and other theme groups agreed upon by sectors working towards gender equity in Myanmar.

The Ministry of Social Welfare, Relief and Resettlement, through the activities of the Protection Cluster and in particular the Women’s Protection sub-Cluster provided an invaluable entry point for a women’s

¹⁹ Sexual and Reproductive Health in HIV related proposals supported by GFATM, Manjula, Collin, Mbizvo, WHO Bulletin, 2009;87 816-823.

²⁰ Report of Technical Review Panel, GF Round 9, UN-Geneva, 2009

²¹ Making the case for interventions linking sexual and reproductive health and HIV, in proposals for GFATM, WHO/RHR/2010

protection assessment in Cyclone Nargis affected areas. The findings of the assessment are ready to be published and this will serve as a platform for both government and non-government stakeholders, to work together towards wider horizons for gender equity. The National Plan of Action for protection of women is being developed which will create a plan of action for protection and empowering women as well as fulfilling CEDAW commitments in Myanmar.

7. Partnerships for Population and Development

In matters relating to population, the Department of Population is the focal agency. DOP carries out population-related activities such as the conducting of population censuses and inter-census demographic surveys, estimation of population data for inter-census years, and to study population and its parameters - levels, trends and unusual events – in order to issue findings and advise the relevant authorities/ministries for policy and decision making and for necessary interventions.

UNFPA has supported the DOP in its activities since 1973 on an ad-hoc basis. For example, UNFPA was involved in the 1973 and 1983 population censuses, and the 1991 Population Changes and Fertility Survey. Since 1997, UNFPA has financially and technically supported DOP in its undertakings of FRHS every four to five years period to fill in the gap for reliable national-level basic demographic, socioeconomic, fertility, mortality, maternal and child health and reproductive health statistics. DOP has, in implementing its functions and activities, cooperated closely with population-related line ministries and institutions and NGOs to share findings and results. In the drafting of national level reports and surveys, DOP has held workshops and meetings with data users and funding agencies, and collaborated on the preparatory and implementing stages as well. UNFPA participated and monitored at every stage of the survey. Staff of the Immigration and National Registration Department field offices also participates in the management and monitoring of field operations.

UNFPA has also supported the Department of Labour in its preparation of the Handbook on Human Resource Development Indicators and is a member of the Steering Committee and Technical Working Group, both of which have representatives from many population-related ministries and institutions as members. The committee coordinates among different agencies to compile and publish the handbook. In the context of MDGs indicators related to women and children, Department of Health Planning (DHP) has, in cooperation with UNICEF, conducted MICS five times - in 1995, 1997, 2000, 2003 and 2008-2009. The last one, MICS 2008-2009, is an on-going activity and implemented jointly by Planning Department and DHP. UNICEF has provided both financial and technical assistance using both national and international expertise. UNICEF is member of the technical working group and also participates in the steering committee. State, divisional, and district heads of PD and DOH share the management, supervision and monitoring of field operations.

Integrated Household Living Conditions Survey in Myanmar was implemented by PD jointly with IHLCA Project Technical Unit and IDEA International Institute, Canada with support from the Ministry of National Planning and Economic Development and UNDP. and CSO shared the data processing. The National Commission for Environmental Affairs (NCEA) formulated the 'Myanmar Agenda 21' in 1997. But the implementation of this Agenda has been less than satisfactory and is confronted with difficulties ranging from lack of public and government awareness to lack of funding and capacity. It is essential to renew and reinvigorate Myanmar Agenda 21. Along these lines, in 2007, NCEA prepared a mechanism called National Sustainable Development Strategy (NSDS) to translate the country's goal and aspiration of sustainable development into concrete policies and actions and meeting their targets, which will uplift the quality of life of Myanmar citizens.

NSDS was developed by NCEA in collaboration with Ministry of Forestry (MOF), United Nations Environment Programme, as well as UNEP's Regional Resource Center for Asia and the Pacific

(RRCAP). A Memorandum of Understanding (MOU) for the development of NSDS for Myanmar was signed between NCEA and UNEP in April 2007. The National Sustainable Development Strategy of Myanmar is mainly based on Myanmar Agenda 21 and the Millennium Development Goals (MDGs). Various stakeholders and participants from different professions contributed to further improve the report so that it will reflect up to date information on different environmental situations.

An agriculture Census was conducted by the Census Department in 1953 in 252 towns in urban areas and in 1954 in 2143 village tracts in rural areas. An Agriculture Census covering the whole country was conducted by the Settlement and Land Records Department (SLRD) in 1993 with the assistance of FAO and again in 2003. Now SLRD is planning to conduct another Agriculture Census in 2010 with assistance from FAO.

The mandate of the UN Monitoring and Evaluation Group (chaired by the Country Representative of UNFPA in Myanmar) is to assess the data situation and promote coordination among UN agencies to bridge data and research gaps to ensure sound analysis of development needs and priorities. This group has already conducted a Data Mission on strengthening MDG indicators 1, 7 and 8. The report that came out of that mission is an attempt by the UN M&E Group to implement the mandate and objectives of the Group and should serve as one of the inputs in the development of the UN Strategic Framework for the period 2012-2015.

8. Challenges and Opportunities

- **Coordination among stakeholders:**

The UN system in Myanmar is unique as not all agencies operate under similar modalities. However, there is a drive towards delivering as 'One UN'. In this way, the UN Framework of Cooperation 2012-2015 is being time-lined and developed.²²

Civil society organizations, national NGOs, government-organized NGOs, and professional bodies have unique roles to play in improving reproductive health and population and development in Myanmar. The following organizations have extensive community mobilization networks from central to grassroots levels, which form a bridge between clients and RH service providers, and have not at this stage been heavily involved in coordination with the UN, donors, or INGOs: Myanmar Medical Council, Myanmar Medical Association, Myanmar Dental Association, Myanmar Nurses and Midwifery Association, Myanmar Health Assistants Association, Myanmar Women's Affairs Federation (MWAF), Myanmar Maternal and Child Welfare Association (MMCWA), Myanmar Medical Association (MMA), Myanmar Red Cross Society (MRCS), and the Myanmar Council of Churches (MCC). Coordination with the organizations would be extremely beneficial and productive.

The INGOs, working within the context of the national response, facilitate and support capacity building with national partners. However, there are obstacles and time consuming procedures for renewing Memorandums of Understanding between INGOs and their focal ministries, as well as visa and travel permission for international staff. There is also need for documented instructions and procedures relating to INGOs and civil societies registration process to provide a legal basis for community organization to function in Myanmar.

- **Quality assurance of multiple partners**

²² UN Framework of cooperation, 2012-2015, draft, UNDP, 2010

With a considerable number of agencies involved in RH, HIV prevention, treatment, care and support there is a need for regulatory mechanism for standardization and quality assurance. The role of the private sector is growing and it is appropriate for relevant Government Ministries to take leadership in the regulation of multiple donors/ actors to create an environment of complementarity instead of competition, and to take active steps to maintain the quality of care and support through stipulation of standard operational procedures and enforcement of regulations promulgated through regular and consistent monitoring and supervision.

- **Harmonization and aid alignment to national priorities**

In the meeting in Paris on 2nd March 2005, Ministers of developed and developing nations reaffirmed their commitments to harmonize and align aid delivery. Donors will work with developing countries to agree on mutually agreed conditions based on national development strategies and operational frameworks. Joint assessments will be made to assess donor and developing country performance in meeting commitments to enhance accountability and aid effectiveness²³. It is for all partners and the GoUM to be aware of this fact and carry out fund negotiations according to the principles of the Paris declaration and monitor progress through transparent and accountable manner.

- **Information exchange and documentation**

The Ministry of National Planning and Economic Development, the Ministry of Health, Ministry of Immigration and Population, Ministry of Social Welfare, Relief and Resettlement are key bodies to lead coordinated efforts of all actors involved in RH, PD, gender equality and women's empowerment programmes in Myanmar in order to fulfil the ICPD PoA and MDG goals. An environment of mutual trust and open communication and information sharing between Government Ministries and NGOs, UN and civil society would enhance concerted efforts to move forward in reaching the MDGs.

- **Investment for real economic growth**

ICPD has recommended that population issues should be integrated into the formulation, implementation, monitoring and evaluation of all policies and programs relating to sustainable development and that governments, international agencies, NGOs and other concerned parties should undertake timely and periodic reviews of their development strategies with the aim of assessing progress towards integrating population into development and environment programs.

As mentioned in chapter 2, Myanmar's population is undergoing demographic transition with the increase in the proportion of the working group and a declining youth dependency ratio, Myanmar is actually seeing a demographic window of opportunity, which could result in a rise in the rate of economic growth if properly taken advantage of. The demographic dividend usually occurs late in the demographic transition when the fertility rate falls and the youth dependency rate declines. During this demographic window of opportunity, output per capita rises.

As mentioned in Chapter 2, unemployment in Myanmar in 2004-2005 for male is 3.64% and female is 4.64 % and there is an exodus of people out of the country every year of between 1 and 4 millions persons. The GoUM has shown political commitment by development of policy, plans and strategies for poverty reduction and sustainable development which should be followed by greater government and donor allocation of budget in health, education and regional development and increases public spending for real economic growth.

²³ The Paris Declaration on Aid effectiveness, (2005) and the Accra Agenda for Action, OECD, (2006),

Resource mobilization and partnership building could lead to an “economic miracle” in Myanmar similar to that of the East Asian Tigers or in Ireland. These periods of great economic growth occurred after those countries demographic transitions. As the magnitude of the demographic dividend appears to be dependent on the ability of the economy to absorb and productively employ the growing numbers of extra workers, it is deemed appropriate to suggest increased investments in human capital as well as in technology and infrastructure. Only with lifting of economic sanctions could the World Bank, Asian Development Bank, IMF and OECD respond with higher ODA support to Myanmar. The government also has an important role to play, and that is for increased governmental contributions, in order for the development agenda to become a reality and to foster real economic growth in Myanmar.

Chapter Seven: Strategic Recommendations



CHAPTER VII: Conclusions and Recommendations

Conclusions

Economic policy, development planning, population dynamics and environment all play pivotal roles in the holistic development of a nation. Myanmar's population is in a demographic transition, seeing as there is an increase in the proportion of the working age group, a decline in the youth dependency ratio and a fall in the fertility rate. This demographic window of opportunity, if properly utilized and taken advantage of – with investments in human capital, job creation, infrastructure and other capital inputs – could result in a rise in output per capita and as such a rise in the rate of economic growth. Myanmar is an agriculture-based country with enough arable land to support the population. However, the majority of landless rural poor need capital input and credit strategies in order to improve productivity, break the vicious cycle of debt and get expand beyond basic subsistence agriculture.

In Myanmar, both women and men contribute almost equally towards the labour force. In line with egalitarian development ideals, enrolment ratios of both sexes in primary and secondary education are in parity. Socio-cultural norms create gender inequalities in Myanmar, and these are typically invisible and not easily seen. However, unlike some other countries in the region, Myanmar does not have any extreme forms of gender inequality. That being said, when analyzing gender equality against international benchmarks such as GDI, and GEM, it is apparent that the role of women in political decision making, and in economics and resource control is low. As such, female empowerment still has a place to go in Myanmar. There are however a number of critical gender issues that are being addressed, such as trafficking in persons for the purpose of sex and/or labour, gender-based violence, and mechanisms to implement CEDAW commitments. The burden of reproductive health and its responsibilities have conventionally been placed on women in Myanmar. Programmes for greater male involvement have been initiated, but need stronger support. There is a need for capacity building for gender mainstreaming as well as nationally representative research on gender issues to foster greater understanding and gender equity in all spheres of national development.

There has been considerable progress towards targets of MDG 4, 5 and 6 and the ICPD Plan of Action, however, progress has been uneven in Myanmar, with the levels of maternal and neonatal mortality still remaining high, especially in rural and hard-to-reach areas. The GoUM has prioritized efforts to improve reproductive health, including birth spacing, maternal and newborn health, and improving key health policies and strategies. Effective implementation of those strategies and programmes is challenged by financial shortfalls for reproductive health services coupled by low investments in health system strengthening, and inadequate dedication to improving coverage and availability of quality¹ reproductive health services.

Myanmar has the third highest HIV prevalence rate in the Southeast Asia region. Vulnerable groups such as injecting drug users (IDU), men who have sex with men (MSM) and female sex workers (FSW) still have high HIV prevalence. There remains a large gap on knowledge about HIV/AIDS in the general population of both youth and adults. Stigma and discrimination against PLHIV is still prevalent in most communities. Behaviours on safe sex in the general population is very low. Consistent condom use with a commercial sex worker is moderately high whereas with a casual acquaintance it is extremely low. Similar to other Asian countries, intimate partner transmission remains the major mode of transmission in Myanmar women. Among the most-at-risk populations

¹ Quality reproductive health services in this context means comprehensive components of reproductive health care is available, accessible and acceptable to all population as per their needs.

(MARP) such as FSW, MSM and IDU, there remains unsafe behavior such as inconsistent condom use and needle sharing behavior. According to available UNGASS indicators, only 20% of PLHIV who need ART have access to treatment where as only 38.7% of HIV positive pregnant women have treatment for prevention of mother-to-child transmission. Although there is a substantial increase in sex workers reached by a package of Behavioural Change Communication for prevention and STI prevention, there is low coverage of MSM and IDU. The continuum of care, support and treatment for MARP who are HIV positive is acutely limited. There has been marked progress of PLHIV support networks becoming involved in the national response to HIV/AIDS. However, these groups face many challenges including limited funding, organizational and technical capacity as well as stigma and discrimination. In order to achieve the targets of the ICPD and MDG goals of providing universal access to HIV treatment, care and support, resource mobilization must be strengthened and substantial investments must be made in the public health care system and infrastructure. There also needs to be improvement in the routine data collection system, a scaling up and expansion of programme coverage and improvement of the capacity of all stakeholders to tackle stigma and discrimination.

As stated in the ICPD Program of Action, it is only through substantial investments of national governments as well as external donors in line with national priorities and collaborative efforts of all stakeholders that holistic development can be brought to the entire population. Based on the UNFPA situation analysis findings carried out in 2009-2010, some strategic recommendations for Reproductive Health, Population and Development and Gender have been formulated.

Recommendations for POPULATION and DEVELOPMENT

1. The Draft National Population Policy should be revised and then formally adopted. An appropriate body needs to be formed to coordinate implementation of the plans and strategies in the policy.
2. Adopt the already developed National Policy on Ageing and National Plan of Action and allocate resources to address the growing needs of older persons.
3. The National Plan of Action for disabled persons has been adopted in 2010, and with it, a survey and research study on disabled persons has been conducted for the first time in Myanmar. This needs to be published for better understanding of the situation and the needs and requirements of disabled persons. A baseline study on disabled children needs to be conducted to develop interventions to improve quality of life.
4. A population census must be conducted in order to obtain comprehensive population and demographic data at the national and sub-national levels. The census should provide a valid and up-to-date statistical sampling frame to be used for subsequent data collection activities. To optimize the outcome of the census, maternal mortality questions should be covered. Also, the census should be engendered to provide gender sensitive data that capture the real situation of women and men.
5. The compilation of summary statistics and indicators from different sources such as Statistical Yearbook, Manual on Human Resource Development Indicators, Agriculture Statistics should be strengthened.
6. Make available quality statistics, disaggregated to a sufficient depth by sex, age, ethnic group, basic demographic characteristics and geography. This can be facilitated by external partnership.
7. Data harmonization involving technical personnel from GoUM, NGO, external consultants and UN should be conducted to discuss and accept agreed upon set of national data.

8. Capacity building of the technical and professional staff in population-related institutions should be conducted by training in population studies, statistics, research methodology, surveying and sampling techniques.
9. Research, study/nationwide surveys should be undertaken or repeated at regular/appropriate intervals on the following fields by relevant government agencies:
Labour Force Survey
Migration studies as well as urban growth and urbanization studies
FRHS
MICS
IHLCA survey
10. The literacy, education and life skill development of the out-of-school youth population should be integrated into development plans for young people. If possible, arrange to bring them into school rooms so that their quality of life be enhanced and the quality of their future livelihoods prospectives be ensured.
11. Contraceptive knowledge and use among married couples should be promoted through IEC and current reproductive health care programmes, and contraceptive services should be made accessible and affordable to all.
12. Integrate environmental protection in the formulation of population and development plans at all levels.
13. Enhance reforestation, investment in green technology and create environment-related employment opportunities in rural areas and remote border areas to improve the income and livelihoods.
14. Investment in livelihoods and small-scale businesses in rural areas needs to be boosted for sustainable economic development. There is also a critical need to support small-scale farmers with minimal interest loans so that they can break the cycle of poverty at harvest instead of paying high interest loans to brokers and moneylenders in order to buy seeds and fertilizer.
15. To off-set brain drain and mitigate talent drain there should be creation of job opportunities in sync with skill training so that the human resources will remain in the country contributing to development and economic growth.
16. Freedom of movement and the right to migration is a basic human right however, to mitigate the negative impact of international migration of highly skilled professionals on the country's operational system, there should be legalized, planned, and ethical recruitment policies, remittance policies and bilateral agreements between country of origin and country of destination to benefit both sending and receiving countries.

RECOMMENDATIONS for REPRODUCTIVE HEALTH (RH) and HIV/AIDS

1. Leadership, advocacy, coordination and partnership

Strengthening advocacy, leadership, coordination and partnership among all stakeholders working in the RH and HIV areas is essential for (i) maximizing the use of resources, both financial and technical, (ii) avoiding duplication of activities and (iii) improving effective coverage, especially for underserved populations.

- **Reproductive health**

- National Level: A National Working Committee for Reproductive Health has been recently established to play an advisory role to the DOH on technical and programmatic matters for the implementation of national strategies pertaining to MDGs 4 and 5. In

addition, the Technical Reproductive Health Working Group is to oversee the implementation of the 5-year RH Strategic Plan and to coordinate partnerships in reproductive health. These two mechanisms should be supported in their functions to improve coordination, advocacy, technical excellence and resource mobilization activities for achieving the national targets set for reproductive health, HIV/AIDS and related MDGs in Myanmar. The meetings of the Committee and Technical Working Group should be practically functional, regularized and be held on a 3-monthly basis. For the committee on RH and Technical working groups to be effective there is a need to designate a full time secretariat for coordination, fund negotiation, monitoring of the RH related work and implementation of the national strategic plan for RH.

- Sub-national Level: The functioning of the local RH sub-committees should be promoted at all administrative levels for improved programme management and coordination and for production and use of evidence for informed planning and decision making pertaining to the local context. Local RH sub-committees should take the responsibility of translating and incorporating the national 5-year Strategic Plan for RH (2009-2013) into sub-national level health plans to guide and ensure local implementation.
 - Budget predictability of the donor investments and funding through external aid flow should be improved along with accountability in line with the Paris Declaration. Mapping of the inputs and monitoring mechanisms should be aligned to improve complementarities and technical and allocative efficiency.
 - Implementation of RH National Strategic Plan (2009-2013) should be pledged by government funding and multiple donors, and phased and implemented by giving priority to underserved regions such as Northern Rakhine State, Sagaing Division, Magway Division, Northern Shan, Kayah States. The peri-urban areas of Mandalay and Yangon division also needs attention as maternal mortality and morbidity is relatively high.
 - Advocacy and awareness on rights-based sexual and reproductive health is to be raised at all levels national, sub-national and the communities. The advocacy campaigns for resource mobilization should be based on convincing evidence.
 - Strengthen public-private partnerships through encouraging representation of the private sector in the coordination mechanisms at all levels for planning, progress review and implementation. Under the leadership of MOH establish mechanism for monitoring and supervision for quality assurance of health care given by private sector, establish routine reporting of the relevant data and information on the inputs of the private sector in the field.
 - It is recommended to incorporate and mainstream SRH advocacy, HIV prevention, support to PLHIV, collection of gender sensitive data, and mechanisms for prevention of GBV into developmental programmes.
- **HIV/AIDS**
 - The review and evaluation of both the National Strategic Plan on HIV/AIDS 2006-2010 and its operational plans should be carried out to identify the strengths, weaknesses and gaps with the purpose of obtaining information to develop the next National Strategic Plan 2011-2015. Regular coordination meetings of AIDS committees at national and administrative levels should be held with the aim of improving multi-sectoral cooperation and collaboration at each level and promoting involvement of each sector to develop an enabling environment for advancement.

- Foster an enabling environment for prevention programme and care services for HIV/AIDS to MARP such as FSW, MSM and IDU by means of strengthening of advocacy with other sectors such as law enforcement from central to field level, coordination and multi-sectoral cooperation among stakeholders, increased awareness-raising and education to communities, enhancing community leadership and increased participation of these vulnerable groups and PLHIV in all levels of programmes.
- Multidrug resistant TB remains one of the leading causes of death among people living with HIV, despite being preventable and curable². In order to decrease the double epidemic and morbidity and mortality of HIV and TB, existing coordination should be strengthened by means of expanding TB-HIV programmes, as they are currently active in only 20 townships.
- Training of private practitioners in collaboration with the National AIDS Programme and MMA on standard guidelines and standard operational procedure for prevention, testing, care and support and treatment for HIV and STI should be continued in order to not only improve the coverage to the service but also ensure the quality of services provided by the private sector and its involvement in 100% TCP, PMCT and VCCT programmes.
- Coordination with formal traditional practitioners (registered and licensed) in HIV/AIDS prevention and treatment activities such as counseling, care, support and referral activities should be strengthened.

2. Encouraging positive attitudes towards people living with HIV

- Knowledge and acceptance regarding HIV/AIDS should be promoted through various strategies and channels by all stakeholders in order to reduce stigma and discrimination in communities, including institutions such as hospitals, schools and the workplace.

3. Involvement and empowerment of people living with HIV/AIDS (PLHIV) and vulnerable groups

- Financial and technical support for capacity building for organizations and networks of PLHIV and high risk groups of HIV needs to be strengthened through involving them in all stages of programming including sharing of good practices.
- Encourage the private sector to develop and implement HIV related workplace policy and practices.
- Vocational training for drug users and sex workers, especially those who are HIV positive, and assistance in finding employment and funding for setting up local small scale, income generation activities should be promoted through community programmes.
- Peer education and outreach services for MARP and high vulnerable population should be adequately resourced including provision of more training, support, recognition and incentives.
- Training on negotiation skills and decision-making skills for FSW and MSM and specific skills for MSM (e.g. how to use lubricants) should be strengthened in peer education training and peer education sessions for MARP in order for them to adopt safe sex practices.

² UNAIDS outlook report, 2010

4. Health financing

- Substantial financial investments are required to scale-up reproductive health and HIV/AIDS interventions to achieve the national and international targets. The current investments by the GoUM and contributions by the ODA programmes are less than adequate to meet the financial gaps. Presently, a large proportion of expenses for RH services are covered by clients and their families through the out-of-pocket expenses. This leaves the poor and vulnerable groups with limited choices and unequal access to quality RH services. Resource mobilization from a variety of sources, including increased government investment in health, pooled donor mechanisms such as the Three Diseases Fund, GFATM, bilateral development agencies and other sources should be considered in line with national priorities and principles of the Paris Declaration.
- The 5-year RH Strategic Plan sets an estimated budget for 2009-2013. At the first stage, exercise should take place with all stakeholders to identify financial commitments from existing and potential sources. Secondly stakeholders must analyze possibilities for resource mobilization against remaining resource gaps and explore diverse funding options for reproductive health through HIV/AIDS, Malaria and TB programmes as well as other global initiatives like Global Fund.
- The government should play an important role in investing and mobilizing resources for RH and HIV by:
 - allocating increased government investment in health,
 - considering opening a national budget line to contribute to the procurement and supply of RH commodities against the national requirements,
 - exploring diverse funding options for RH
 - social protection of poor and vulnerable through exemption of user fees and provision of subsidies.

5. Health system strengthening

- Substantial investments are required to strengthen the health system for delivery of RH services and integrated services for prevention and treatment of HIV/AIDS.
- Strengthening of the public health infrastructure at the primary health care level by (a) setting-up and upgrading health facilities for scaling-up the provision of an essential reproductive health package, (b) improving referral facilities and linkages with primary health care facilities, (c) improving responsiveness and linkages between health systems and communities, and (d) developing a budget line for RH commodity support to the 193 townships not currently covered by RH projects.
- Improving forecasting, procurement and logistics systems for efficient and uninterrupted supply of reproductive health and HIV/AIDS commodities through two components: (a) improving technical capacities of staff for accurate projection of needs, managing utilization and inventory records, good warehousing practices for supply with no stock-outs and (b) support for timely and accurate distribution and safe transportation of commodities.
- Maintaining safe blood banks for obstetric and other emergencies and promoting universal precaution with adequate supply of sterile equipments and safe disposal of waste products.

This includes ensuring access for all health care workers to post exposure prophylaxis with antiretroviral medicine in cases of accidental exposure to HIV.

- Expand the national network of VCCT services together with better links between prevention, care and support services as a critical entry point for HIV prevention and care.
- Expand National external quality assurance scheme (NEQAS) network for HIV serology to cover laboratories in public health sector as well as NGOs and private sector in order to improve the quality of HIV testing.
- Issue rules and regulations to practically enforce the Law Relating to Private Health Care Services in 2007 stipulated by the Ministry of Health³. The private sector has the potential to positively contribute to the concerted efforts to meet the RH needs of the population, however, there is need for consistent monitoring to follow national guidelines and standard operational procedures, and standardize costing for quality assurance in practice.
- Strengthen consistency and regularity of monitoring the quality and safety of drugs in private pharmacies The Food and Drug Administration (FDA) has mechanisms for these processes, but these need to be improved and funded in order to ensure that trade of low quality or counterfeit drugs and contraceptives is eliminated.

6. Human resources and technical capacity

- Formulate a comprehensive health workforce strategic plan to support delivery of the reproductive health services including HIV/AIDS⁴. This will entail an assessment of the existing health workforce competencies, quality of pre-service and in-service training as well as issues related to projection of categories of health workforce required, training and production according to projected needs and deployment. To secure performance management deployment and retention in rural areas, the HR policies will need to address staff motivation, including performance-based financial incentive policies and quality improvement cycles, assessment and revision of the workload against current job descriptions and review of staff roles and responsibilities at the PHC level for maximizing provision of reproductive health services. The number of AIDS/STD teams should be expanded to cover all priority districts.
- A review of the existing technical and clinical guidelines should be conducted to align with national and international standards to support provision of quality RH services and HIV/AIDS prevention and care services by the level of care and linked to the staff competencies and training.
- While in-service training in various aspects of RH and HIV/AIDS continues to take place, the technical quality, relevance and consistency of content should be re-assessed and standardized. A Master Training Plan should be developed based on priorities, the assessed training needs and supported by standardized training manuals.
- Improve the skilled birth attendant rate which currently stands at less than 50%. Improve access to emergency obstetric care as it is currently not adequate nor available to the poor as it is too costly. Universal access to reproductive health and family planning services are improving with financial and technical support from UN agencies and INGOs, however the

³ Health in Myanmar 2009, Ministry of Health, 2009

⁴ Refer to the 5-year RH Strategic Plan 2009-2013 for the Essential Package of RH Services.

unmet need of family planning still remains at 17.7%. Antenatal care coverage is only 67.8% in 2008 and the quality of ante-natal care is unequal in diverse regions across the nation.

- Address the current shortage of health providers and skilled birth attendants. Explore various modalities to maximize utilization of trained but unemployed midwife graduates.

7. Scaling up Service delivery

- Strengthen public health infrastructure at the primary health care level by:
 - setting-up and upgrading health facilities for provision of basic RH/HIV services;
 - strengthening referral facilities and linkages with primary health care facilities;
 - improving responsiveness and linkages between health systems and communities.
- Equitable implementation of the RH Strategic Plan. This includes maintaining and improving the availability of quality services in the areas with current programmatic coverage and geographical expansion of the existing birth spacing programme as well as maternal and newborn health services. Adequately re-distribute service delivery points and ensure adequate staffing and supplies throughout the country starting from high-burden areas such as Kayah, Rakhine, Northern Shan, Sagaing, Bago, Ayeyarwaddy, and the semi-urban areas of Yangon and Mandalay. This should be supported by a contingency plan according to the projections of the annual funding in-flow of the consolidated national and external donor commitments.
- Invest in mobile outreach activities for provision of RH services to remote areas and vulnerable population groups after feasibility and cost-effectiveness of such interventions is established through a pilot study. Alternatively, to ensure continuum of care in remote areas, especially during obstetric and neonatal emergencies, encourage pregnant mothers to be near the EmOC facilities around the time of deliveries at maternity waiting homes.
- The abortion rate is highest in 15-19 years of age and youth with university education⁵, but there is a limitation in dissemination of RH education among these groups. Develop RH programmes that focus on adolescents and youth by means of providing awareness and peer education activities in coordination with other related ministries and departments. This should be supported by the adequate service provision to meet the need of young people.
- Prioritize interventions with regard to gynecological morbidities starting with strengthening cervical and breast cancer screening, prevention, and treatment follow-up. For prevention of cervical cancer this should include the establishment of VIA screening and cost-effective treatment options in case of positive diagnosis. The assessment and plan should be undertaken for adequate training of basic health staff and provision of supply and referrals for treatment.
- Use every opportunity for integration of reproductive health and HIV services: STI prevention, treatment and management through antenatal care by improved STI screening such as routine maternal syphilis screening, birth spacing and condom demonstration and distribution for dual protection, PMCT and HIV counseling and testing, follow-up and partner notification, and partner counseling with increased male involvement.
- Direct efforts to improve the quality of midwifery care and reproductive health services. This includes improving the quality of obstetric services and timely referrals for management of complications. Strengthen analytical reviews of maternal and perinatal deaths.
- Postpartum hemorrhage is a leading cause of maternal deaths in Myanmar. Oftentimes these deaths occur at home or on the way to the clinic and in circumstances with no adequate

⁵ Country report on 2007 Fertility and Reproductive Health Survey, Nay Pyi Taw, October 2009

midwifery assistance and in the absence of active management of the third stage of labor. Efforts should be focused on training, supervision and strengthening practical skills of basic health staff providing midwifery care.

- Review policies, standards of service provision and administrative permits to enable midwives to perform life-saving clinical interventions by eliminating discordance and administrative barriers this includes authorization for administration of injectable oxytocin and standards guidelines for dosage and administration.
- Contraceptive choices for end-users should be improved. The use of IUD is negligible in Myanmar and this method may need wider promotion and access. Further operations research to study the availability of IUD, the reasons for why IUD is not preferred and use may be advocated to design appropriate response.
- Promote public-private partnership for delivery of care, including training of private practitioners, social franchising for supplies for providing birth spacing services and strengthen responsiveness, quality assurance and accountability of the private sector through regulations and enforcement of standard operational procedures in provision of health care.
- Behavior change communication and intervention activities and access and coverage of relevant services for out-of-school youth should be strengthened, not only in urban areas but also rural areas by means of expanding youth centers and peer education programmes.
- The coverage and use of services of ART and PMCT programme should be scaled up effectively to meet the target of Universal Access and MDG goals as well as access to ART therapy for mothers with advanced HIV infection in need of treatment for their own health should be expanded in order to improve the quality of life of children, and prevent orphaned children.
- In general population particularly men and women of reproductive age, condom use should be promoted for dual protection, along with other methods of contraception. Availability and access to condoms should be ensured.
- HIV prevention interventions and referral for care services among mobile and migrant populations and migrants should be strengthened by increasing prevention programmes at border points and transit zones, improving bilateral collaboration among neighboring countries to facilitate referrals, transport, safe return, continuity of care for mobile population, implementing more prevention, care and support programmes.
- VCCT services including outreach VCCT services to strategic and high risk areas of townships should be strengthened along with increased services for care and support especially ART programmes. The maintenance of confidentiality and quality of counseling and testing is essential.
- The availability of a full range of services for a continuum of care to PLHIV and their families including clinical or psychosocial services should be strengthened at all levels.
- As 45% of women are never married in Myanmar, RH and HIV service and accessibility has to be geared to cater for women unmarried women as well.

- To maintain mechanisms and networks for supporting efforts of humanitarian community on contingency planning and integration of RH emergency preparedness response in the overall national Disaster Preparedness Plans.

8. Behavior change communication and community involvement

- Demand-driven interventions, aimed at improving individual counseling skills of health providers, provision of health information, education and communication to individuals, families and communities for awareness and positive behavior change have been used by a number of organizations. These interventions, however, lack systematic and consistent approach and oftentimes are not linked to available affordable and accessible services. A comprehensive RH and HIV/AIDS strategy should be developed and implemented to address these inconsistencies. The RH and HIV/AIDS (BCC) Strategy will assess the profiles of population groups, effective channels of communication and amalgamate strategies tailored for the needs of specific target groups.
- The BCC interventions should be tailored to local context and common logic. Evidence suggests that most women deliver at home with the help of relatives and traditional birth attendants and use the RHC as the last resort in case of complications. Advantages of institutional delivery should be promoted where quality services exist at the affordable price for the clients. Sterilized home delivery assisted by skilled birth attendants with a secured referral through a community should be an option.
- Lack of knowledge and information on birth spacing and consequences of unsafe abortion is one of the root causes for high proportion of induced abortions, the majority of which are unsafe and lead to maternal morbidity and mortality. Awareness should be raised among the communities and target groups (including young people, rural communities, TBAs, village leaders) and the information and services on alternative contraceptive methods should be made available.
- Diversified communication channels should be considered for different target audiences. For example, engaging youth using school as a platform or through youth information centers in urban settings; involving men in RH through HIV prevention programmes at the workplaces and recreation sites; targeting brothels, karaoke bars, truck stops, and highway bus stations to target FSW and their clients.
- Community mobilization activities should be strengthened by civil society and/or NGOs to increase social support activities. There are examples from divisions and states where local NGOs and faith-based organizations were able to provide valuable social support, including hospice care, funeral services for the poor, nutrition support, and transportation for those in need. Taking advantage of these networks through a public-private partnership could be a great source of community mobilization and social support.
- Community ownership and participation through the Community Support Group (CSG) programme has potential to improve RH care and support thus, it should be expanded nationwide. To promote intrinsic motivation and improve performance, mechanisms for recognition and incentives for members of CSG through providing uniforms, providing coordination mechanisms between BHS, CSG and hospital staff by TMO and continuing education and close supervision from RH at RHC level.

9. Supplies and commodities

- The sub-committee for Reproductive Health Commodity Security⁶ has been established in 2009 under the National RH Working Committee. The role of the sub-Committee is to coordinate efforts, forecast the needs, oversee quality of supplies, procurement and distribution, identify gaps and advocate meeting financial gaps to secure essential reproductive health supplies and commodities. It is essential to build technical capacity and provide expert support to galvanize the work of the RHCS sub-committee. Given a direct mandate, UNFPA could play a role in coordination, technical support, secretariat, supporting the government's efforts in RHCS.
- Efforts are required to strengthen the Logistics Management Information System (LMIS) for projection, supply, storage, warehousing and timely and accurate distribution of contraceptives. The programmatic inputs in this regard have been minimal so far and further investments will be required for capacity building and improved performance of LMIS. Storage and warehousing is an integral part of LMIS and it requires improving of both infrastructural capacity as well as staff capacity for logistics, storage, inventory control, and good warehousing practices.
- Financial recovery schemes for distribution of contraceptives may need to be reviewed and policy guidelines delineated in order to secure availability of modern contraceptives free-of-charge or at subsidized rates to the end users.
- Sufficient budget should be allocated for provision and/or means of transportation and distribution to the township level in remote areas, so that health products are distributed in a timely manner, and to ensure that there are no stock outs of supplies.

10. Data and information

- Conduct an annual review of RH strategic Plan implementation. Establish a systematic reporting/information hub from all stakeholders contributing to RH programming in Myanmar in terms of financial, technical inputs and supplies for alignment.
- Every effort should be supported to obtain disaggregated statistics to identify vulnerable groups (by age, sex, geographical location, ethnicity, educational level, etc) and improving quality of data especially at the sub-national level.
- Ensure regular updating of programme monitoring health management information system to adequately address the increasing information demand for monitoring RH programme. Align RHMIS with HMIS and ensure data for analyzing the indicators for monitoring of RH Strategic Plan.
- Support management capacity building to analyze and use data for local decision-making and programme coordination.
- There is a gap in data on gynecological morbidities, such as STIs, reproductive cancers, female genital prolapse, obstetric fistula, infertility and sub-fertility. Studies or surveillance sites could be established to determine burden and types of gynecological morbidities in Myanmar for future programmatic responses.

⁶ Report on National Level Advocacy meeting on Reproductive Health Commodity Security, December 2008.

- To reflect the comprehensive data on RH commodity distribution and coverage of birth spacing services there is need to establish a systematic reporting from all stakeholders, including private sector and NGOs contributing to RH programme in Myanmar.
- Encourage reporting from the private sector to contribute to the RHMIS through establishing appropriate mechanisms for improved information base and planning.
- Routine monitoring systems and surveillance systems of HIV/AIDS should be strengthened by expanding to include other vulnerable groups such as MSM and female drug users in Behaviour Surveillance Survey (BSS) and other geographic areas in HIV Sero Surveillance (HSS) that increase representativeness of data and achieve evidence-based strategic information for improving programme coverage and services as well as understanding the impact.
- Research on access to SRH services for people living with HIV needs to be conducted in order to see if HIV positive women receive adequate SRH services in addition to HIV treatment.
- Study on socio economic impact of HIV among PLHIV and their families should be carried out to observe and monitor the impact of epidemic
- Rapid assessment of local patterns of mobility and related vulnerability and risk behaviors should be done at the township level and between states, divisions and townships in order to get information so as to provide for the needs of this population.
- A cohort study of children of HIV infected mothers should be done to observe the impact of the PMCT programme.
- There is a need to strengthen the collaboration and cooperation between NGOs and public sector for sharing of data and information related to HIV/AIDS.
- Allow access to data and information at the sub-national level on township health profile to Implementing Partners and support capacity building on use of data and information for local decision-making and coordinated programme management. Replace paper-based data collection to a modern IT system and improve decentralization of data management
- Further operational research could help to analyze information on staff performance and quality of care followed by health workforce strategic planning based on identified needs to be developed to tackle appropriate mix of different categories of health personnel, appropriate skill mix and task shifting when required to cater to each level of health needs of the population.

RECOMMENDATIONS for GENDER

1. Advocacy to raise awareness of the concepts of gender, gender-based violence and CEDAW commitments at different levels of administration down to community level
 - This requires advocacy and capacity building of government departments and policy makers, teachers, law officers, health services providers, civil society involved in livelihood rehabilitation and poverty reduction to be aware that gender equity and equality is the basis for population development.
2. Develop strategies for better linkages between gender equality and development

- Population, development, reproductive health and gender are cross cutting issues across all human development categories. Thus, line ministries such as Ministry of Health, Ministry of Social Welfare, Relief and Resettlement, Ministry of Immigration and Population,, Ministry of National Planning and Economic Development and Ministry of Education need to develop linkages and strengthen coordination at all levels for effective population development to take place.
- The national ICPD Points of Action for women and emergencies is a way forward where all stakeholders including Ministries of the GoUM, UN, NGOs and civil society can join hands and reflect women's empowerment and gender equality in programme, planning and implementation. Expand the gender theme group and women's organization networks where common problems can be discussed to develop the linkages. Mimic the success of gender mainstreaming in Cyclone Nargis relief and rehabilitation programmes for future development activities.

3. Build capacity for gender research and collection of gender sensitive data

- Training of staff in all sectors of government departments as well as the UN and NGOs for gender research and data collection of gender sensitive data nationwide, including all ethnic minorities for effective gender analysis. Collection of gender sensitive quality data should go beyond the general household level or simply recording of participation rates. Collecting qualitative data rather than only quantitative data should be a priority.
- Training of staff locally to be in line with international standards of gender equality and women empowerment mechanisms, capacity building of staffs and volunteers in gender research, and gender mainstreaming is needed for effective incorporation of gender concepts in all sectors of society. Analysis should also include cultural and social perceptions including superstitions that prevail in Myanmar and ethnic minority communities.

4. Research

- Research on gender-based violence (GBV) is an issue of concern. Presently, it is difficult to determine the extent of GBV. Planned research on the extent and severity of GBV in Myanmar communities should be conducted.
- The growing proportion of elderly women in the population calls for research on the specific health and socio-cultural needs of elderly women in order to plan for provision of support and care.

5. Raise awareness of legal rights for women and victims of gender-based violence

- There is a need for women in public and private sector in both urban and rural areas to have adequate access to information on legal rights and available government services for women. Training and advocacy support should be given to health workers, MWAF staff and NGO staff.
- Educate communities on concepts of GBV so that boys, girls, men and women realize women's vulnerable position in Myanmar's culture and society. A culturally sensitive approach to GBV prevention is needed.
- Develop working linkages between the health sector, MWAF and communities for prevention and response to GBV.

- MAAF in collaboration with MNCWA compile gender statistics with growing awareness for need of disaggregated data for policies, plan and programmes for advancement of women and to bring into light to gender-related areas in which more progress is required for women. However, data of high quality needs to be continuous, regular and widely accessible by all partners and stakeholders. Capacity building and support for MAAF staff for this beneficial activity is required.

6. Scale up gender equality and women's empowerment activities in humanitarian assistance work

- Post-Nargis, several programmes emerged to complement the more general reconstruction and rehabilitation projects to specifically meet the different needs of women. An assessment showed that women's livelihoods were receiving a fraction of the attention of men's in programming. There is a need to mainstream gender into humanitarian aid work by incorporation of gender concepts in all stages of rehabilitation work.
- Agencies working in humanitarian assistance and development work should include vulnerable, poor and marginalized women in planning, programming and implementation stages. There should be greater male involvement in policy development and planning for women's empowerment and equality.

7. Gender issues in RH and HIV

- Develop strategic actions to ensure equal male partnership and mutual understanding which are critical for good outcome of pregnancy. Develop gender sensitive strategies for HIV programmes and RH service delivery through better coordination with health sector.
 - Conduct impact assessment and monitoring of the work of anti-trafficking units (ATU) and document and disseminate lessons learnt and good practices of anti-trafficking interventions, to ensure that ATU's actions are gender sensitive.
 - Strengthen capacity of MOHA staff and scale-up and support programmes for rehabilitation and reintegration of trafficked women.
8. Review of Existing laws, rules, regulations and policies to identify any divergences in legislation that are contrary to CEDAW. If required, revision of laws should occur. Support the implement national plan of action in line with CEDAW.
 9. Review institutional mechanisms that hinder gender equality (such as male biased entrance policies at medical universities and government technical colleges) and advocate for policy change. There should be revision of selection process and policy to ensure gender equality and also to empower women by encouraging their entry into health and technical professions.
 10. Review of job descriptions and selection criteria of government civil servants, private sector and NGOs to ensure gender balance in recruitment of staff, equal pay and equal opportunities for both sexes.

Box 1: Objectives of the 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 standard.
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.

Box 2 National Health Policy 1993

1. To raise the level of health of the country and promote the physical and mental well being 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 the role of co-operative, joint ventures, private sectors and non-governmental organizations 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 services activities not only to rural but also to 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 well-being 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 countries for national health development.

Box 3: Draft National Population Policy (1992)

1. Improve the health status of the 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 given them equal status with men.
4. Promote the awareness of the citizens of the nation on the responsibility of the reproductive behaviour and also educate the male population of their responsibility.
5. Utilization of young people international development efforts as the 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 life-style, the basic facts included in the primary health must be emphasized.
7. Raise the social status of 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 socio-economic planning.
9. Review and amendment of existing legislation to support the achievement of the objectives of the population policy.

Box 4: 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 programmes undertaken in a life-cycle approach. The National RH 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 and programmes. Quality reproductive health care must be provided in integrated packages at all levels of the public and private health care systems
5. Effective partnerships must be strengthened among and between governmental 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 programmes.

Box 5: Myanmar Reproductive Health Strategic Plan 2009-2013 (Draft)

Goal: 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 and achieving MDG 5 targets of reducing maternal mortality by three quarters and achieving universal access to reproductive health by the year 2015.

Core Objectives:

1. Improving antenatal, delivery, post-partum and newborn care.
2. Providing quality services for birth spacing and prevention and management of unsafe abortions.
3. Preventing and reducing reproductive tract infections (RTIs); sexually-transmitted infections (STIs), including HIV; cervical cancer and other gynaecological morbidities.
4. Promoting sexual health; including adolescent reproductive health and male involvement.

Priority areas for action:

- *Setting enabling environment* with strong local, national and international support. This implies advocacy and strong political will to galvanize resource mobilization and investments in reproductive health, establishing regulatory frameworks and mechanisms to coordinate performance and high standards of accountability.
- *Improving information base for decision making* on reproductive health and maternal and newborn health for advocacy and decision making. Analysis of data on epidemiological variables, service availability and its utilization, social science data on reproductive health, improved data availability and its analysis.
- *Strengthening health systems and capacity for delivery of reproductive health services:* to invest for availability of essential services at the primary health care level with effective linkages to referral hospitals at the secondary and tertiary levels.

Box 6: Strategic directions of NSP (2006-2010) for HIV and AIDS

Strategic directions of NSP (2006-2010) for HIV and AIDS

Highest priority: (highest risk population groups with HIV prevalence of above 5%)

- Reducing HIV-related risks, vulnerability and impact among sex workers and their clients.
- Reducing HIV-related risk, vulnerability and impact among men who have sex with men.
- Reducing HIV-related risk, vulnerability and impact among drug users.
- Reducing HIV-related risk, vulnerability and impact among partners and families of people living with HIV.

High priority: (vulnerable population groups with HIV prevalence of 1-5%)

- Reducing HIV-related risk, vulnerability and impact among institutionalized population
- Reducing HIV-related risk, vulnerability and impact among mobile population
- Reducing HIV-related risk, vulnerability and impact among uniformed service personnel
- Reducing HIV-related risk, vulnerability and impact among young people

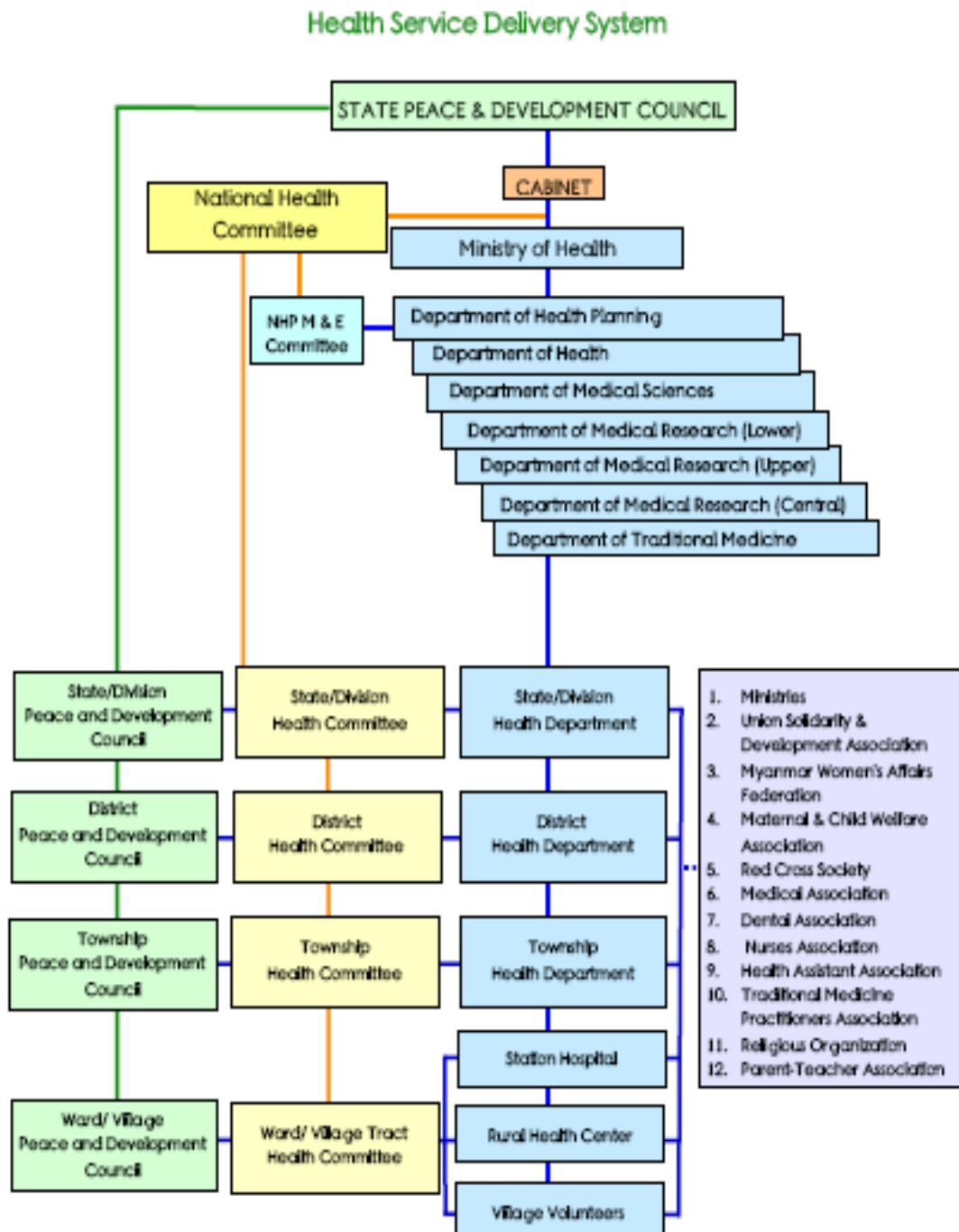
Priority: (lower-risk population groups with HIV prevalence of less than 1%)

- Enhancing prevention, care, treatment and support in the workplace
- Enhancing HIV prevention among men and women of reproductive age

Fundamental overarching issues:

- Meeting needs of people living with HIV for comprehensive care, support and treatment
- Enhancing the capacity of health systems
- Monitoring and evaluating

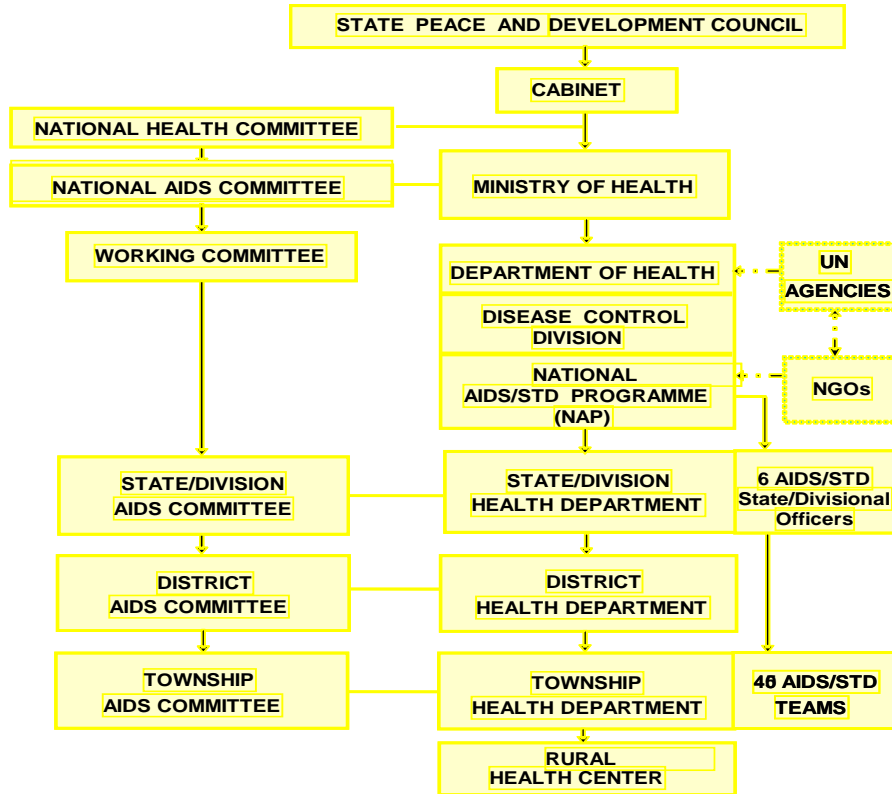
Figure (1): Structure of health service delivery system



Source: Health in Myanmar 2009

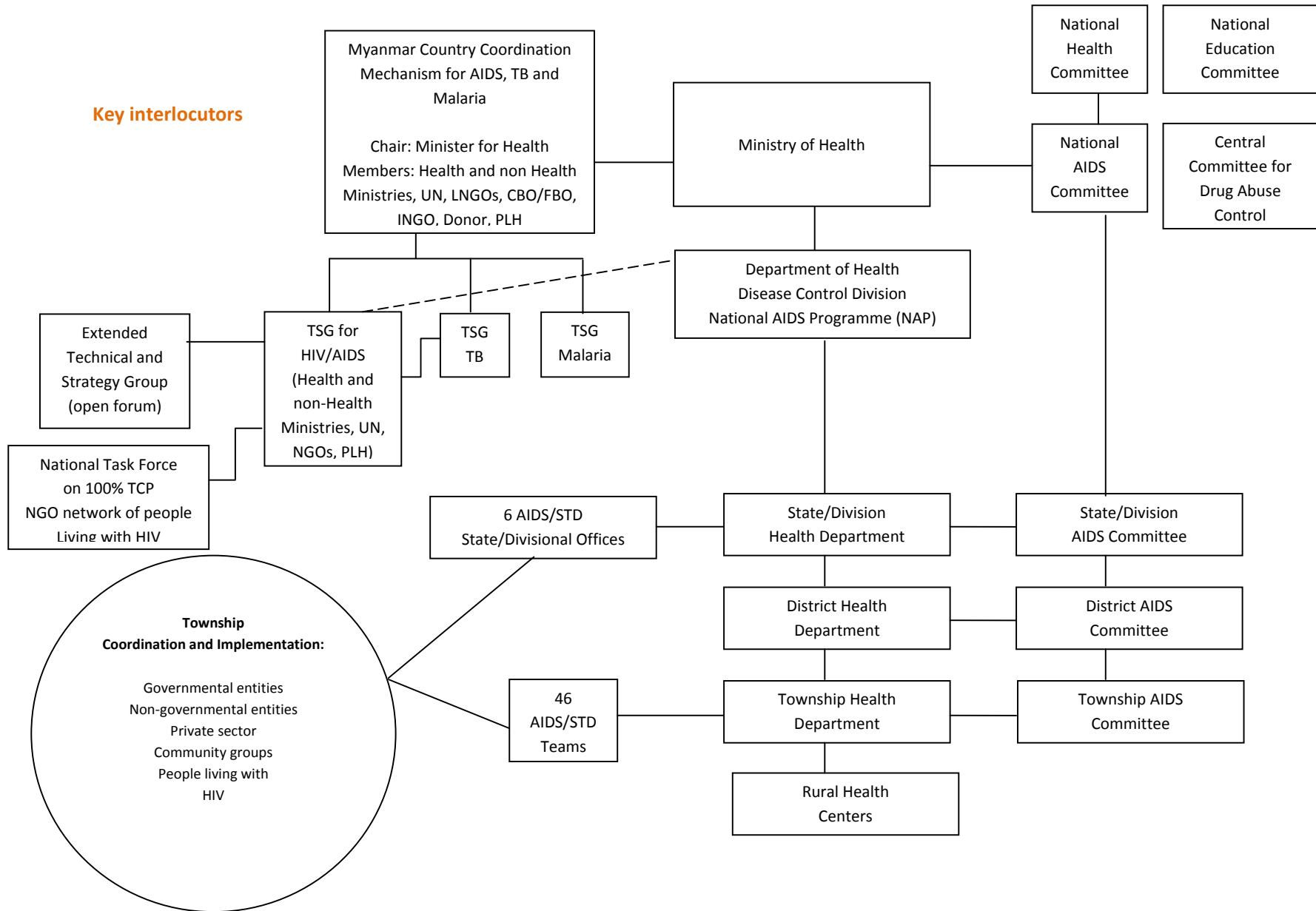
Figure (2): Organization chart of National AIDS Committee and National AIDS Programme

Organization chart of National AIDS Committee and National AIDS Programme



Source: Review of the Myanmar National AIDS Programme, 2006

Figure (3): Coordination Structure for the Myanmar National Strategic Plan on HIV and AIDS 2006-2010



Section 1: Findings for Observational Check List for RH facilities

Sites visited and observed between 7.9.2009 and 5.11.2009

- | | | |
|----|----------------------|--|
| 1. | Mon State | Mawlamyaing Township Health Office, MCH center,
Kyaikmayaw, MCH, Peinegone RHC, Tayana, RHC |
| 2. | Mandalay Division | Mandalay Divisional Health Office, MCH centre
Pyin Oo Lwin, MCH, Pyinsar RHC |
| 3. | Shan (South) | Taunggyi TMO, MCH
Kakku, sub-centre, Humse, RHC |
| 4. | Ayeyarwaddy Division | Nyaungdone
Sarmalauk RHC, Hintada township MCH |
| 5. | Yangon Division | Tone gwa, Kayan |
| 6. | Sagaing Division | Sagaing, TMO, Myonywar, MCH, Chaung Oo Township Hospital, MCH
Myin mu Township hospital, MCH Myaung |

No.	Summary of Observation Check list	Services Available	Commodities and Equipments
1.	Birth Spacing and contraception services	All sites+	Stock out + except townships in Mon State, Myin Mu township. Not all 4-5 methods of birth spacing commodities are present at MCH, RHC and sub-centres. Stock outs are present and MW buys from private drug vender.
	• Oral contraception		
	• Emergency contraception	Counselling services +	Stock out in all sites, can be bought over counter.
	• 3monthly injectables	All sites+	Stock out some times, purchased from private drug store
	• IUDs	All sites+	Clients do not prefer, IUD is less likely to be used and commonest used BS method are pills and Dep-injection.
	• Sterilization	Only at State/ Div hospitals and Township hospitals	Only at State/ Div hospital and Township hospitals
	• Standard Operational Procedures present and followed	National guidelines are published	Not documented and followed at all times in most facilities
2.	RTI/STI/HIV/AIDS		
	• Condom stock	Condoms, services for PCT and STI screening present and functional in project sites.	
	• Diagnosis and Treatment of RTI/STI		
	• PMCT		
	• VCCT for HIV		

No.	Summary of Observation Check list	Services Available	Commodities and Equipments
	<ul style="list-style-type: none"> Syphilis screening and treatment 		
3.	ANC		
	<ul style="list-style-type: none"> Home-based Maternal Record(preparation of birth plans) 	All DOH facilities visited have sufficient IEC material for clients	Record book for all pregnant +
	<ul style="list-style-type: none"> Immunization against tetanus 	All DOH sites +	
	<ul style="list-style-type: none"> Detection and treatment of hypertensive disorders of pregnancy 	All DOH sites +	Urine for Protein and sugar +
	<ul style="list-style-type: none"> Detection and treatment of Malaria 	All DOH sites +	Microscope +
	<ul style="list-style-type: none"> Advice on early detection of complications and dangers of pregnancy 	All DOH sites +	Height and Weight machine + at all facilities visited Replacement of BP cuff needed at Pyin sar RHC, Pyin Oo Lwin hospital
	<ul style="list-style-type: none"> Provision of iron and folic acid 	All DOH sites +, prenatal tabs in MSI clinics	Drugs available from DOH, UNICEF and UNFPA
	<ul style="list-style-type: none"> Detect and treat anaemia 	All DOH sites +, No color scale for Hemoglobin testing at sub-RHC level,	Haemoglobin colorimeter present only to RHC level. Need to supply sub-centre with device.
	<ul style="list-style-type: none"> Syphilis screening and treatment 	Facilities present in all DOH sites but functional only in at STI teams	Only present and followed at STI team townships.
	<ul style="list-style-type: none"> Treatment of intestinal parasites 	All DOH project sites +	Albendazole tablets available at all sites
	<ul style="list-style-type: none"> VCCT for HIV 	All DOH project sites +	Only at project townships
	<ul style="list-style-type: none"> PMCT 	All DOH project sites +but male involvement is not seen in project townships.	Only at project townships
4.	Delivery Care		
	<ul style="list-style-type: none"> Clean delivery services (clean surfaces, use of gloves, sterility in cord cutting) 	All DOH project sites +	stock out + in sub-RHC, for CDK
	<ul style="list-style-type: none"> Administration of oxytocin drugs in the third stage of labour 	All DOH project sites visited +	Mesopresol tablets distributed. Some TMO and RHC in Aye yar waddy div reported that the Mesopresol distributed has reached expiration date on arrival and are not used. Stock out in Aye yar waddy division. In Pyin –sar RHC there is oxytocin but no mesopresol.

No.	Summary of Observation Check list	Services Available	Commodities and Equipments
			Hintada MCH not aware of indications of "Mesopresol"
	<ul style="list-style-type: none"> Routine placenta examination 	All DOH project sites +	
	<ul style="list-style-type: none"> Administration of oral and parenteral anti-convulsants for eclampsia and pre-eclampsia. 	All DOH project sites +,	MgSO4 injection given but MW hardly used. MO in Mandalay Division said they use Mg SO4 and found it is effective.
	<ul style="list-style-type: none"> Administration of oral and parenteral anti-biotics 	All DOH project sites +,	Very little choice of antibiotics.
	<ul style="list-style-type: none"> Use of partogram 	All DOH project sites +,	Partograms are distributed at all levels but in some Townships MW at RHC and Sub-centre level do not use regularly.
	<ul style="list-style-type: none"> Surgery (caesarean section and other essential obstetric surgery) 	Only in Township hospitals.	Equipments present in TMO level.
	<ul style="list-style-type: none"> Standard Operational procedures present and followed 	Health staff said they follow SOP.	But in all facilities visited SOP is NOT documented and audited
5.	Neonatal Care		
	<ul style="list-style-type: none"> Prevention and management of hypothermia 	+ at all sites.	Incubator and O2 only present at State/Divisional Hospitals. RHC & Sub centers use baby blanket, mask and tube.
	<ul style="list-style-type: none"> Prevention and management of infections 	All DOH project sites +	Limited drugs present, most of the time clients has to Pay, available at drug store.
	<ul style="list-style-type: none"> Immediate initiation of breastfeeding (within first hour) 	All DOH project sites +	
	<ul style="list-style-type: none"> Promotion of exclusive breast feeding (first 6 months) 	All DOH project sites +	
	<ul style="list-style-type: none"> Resuscitation of the new born 	mask and suction tube + upto RHC and sub-RHC	O2 and suction machine present in State/Div and TMO hospitals. RHC and sub centre use mask and tube.
	<ul style="list-style-type: none"> Umbilical cord care 	All DOH project sites +	
	<ul style="list-style-type: none"> Early detection and management of neonatal jaundice 	Only in township hospitals	
6.	Postnatal Care		

No.	Summary of Observation Check list	Services Available	Commodities and Equipments
	Development of birth-spacing plan services provision, Early detection and management of puerperial complications (bleeding, involuted uterus, injuries, pyrexia) , Detection and treatment of Malaria, Advice and support for breast feeding, nutrition and healthy life style, Provision of iron and folic acid supplement, Provision of postnatal care within the first week (preferably within 2-3days), Thorough review at 6 weeks postpartum, Immunization against tetanus (if not done during ANC), Syphilis screening (if not done during ANC), VCCT for HIV if not done during ANC	All DOH project sites claim they provide PNC however, the quality of care varies. For puerperial complications (bleeding, involuted uterus, injuries, pyrexia) there is need for SOP and refresher training.	Limited equipment and laboratory support for Malaria, STI, HIV. Most facilities have less emphasis on PN care. Immunization of baby is carried out during PN.
8.	Post-abortion care Post- abortion birth spacing service provision, Counseling on birth spacing and other RH issues , Manual vacuum aspiration for incomplete abortion, Prevention and management of sepsis, haemorrhage, injury, shock and tetanus., Standard Operational Procedures present and followed	Most abortion care is provided only at township hospitals Limited services in RHC + Not documented nor audited	D& C facilities + at Township hospital, in township hospitals +, SOP for post abortion care is not documented and audited
9.	Gynecological cancers		
	<ul style="list-style-type: none"> • Cervical cancer screening and treatment 	-nil as public health program	Only at State/Div level hospitals
	<ul style="list-style-type: none"> • Breast cancer screening and treatment 	- nil as public health program	Only at State/Div level hospitals
10.	Postmenopausal RH		
	<ul style="list-style-type: none"> • Counseling, including life style and 	- nil as public health program	Only at State/Div level hospitals

No.	Summary of Observation Check list	Services Available	Commodities and Equipments
	nutrition		
11.	Men's role in/and RH		
	Counseling for promotion and awareness of STI/HIV	Most sites visited are aware and advocate for increasing men's role	Facilities present only at UNFPA-CHEB project Township sites.
12.	Facility for care and support of Gender based violence survivor	No program as yet, Violence against women is uncommon. In villages where the head of village has authority against domestic violence. Usually occurs in low socio-economic status population when male are under influence of alcohol.	

General remarks by observer:-

1. Generally rural population prefers home delivery. RHC and sub-RHC in Mon State, Kyaik ma yaw township, Paung township (built by UNHCR) and Shan State (East) division in Kattku, have well built small labour rooms some have attached bathroom and toilet built. They are kept clean and well utilized. RHC, labour room is well built but is underutilized. Other RHCs visited in Aye yar waddy division, sagaing division needs to be better built and equipped with facilities.
2. Township hospitals do not have birth spacing counseling and commodities facilities however, they have emergency obstetric care facilities.
3. It was observed that minimal essential package plan for RH is present in the service delivery sites at township, RHC and Sub RHC level. However, the level of delivery of care varies in quality, scope and availability of commodities.
4. Regular use of Partogram should be advocated

Section 2: Findings of focus group discussion with Service providers for Maternal and Child Health

A total of 15 HA, 3 PHSIIs, 9 THNs, 14 LHVs, 51MWs, 2 THOs, 26 CSG members from 6 States and Divisions participated in a total of 12 sessions of Focus Group Discussions. Structured questions were prepared for the FDGs and the leader conducted FDG in a cordial, open and professional manner explaining about how the results would be reported and that confidentiality maintained. There was a note taker assigned in every session.

1. Service Provision

1.1 Birth spacing and contraceptive services-

All RHcare providers expressed that there are 3 to 5 methods available including IUD, pills, Injection depo, condom, and emergency pills are the methods available for women to choose for BS. All said they counsel the women about the advantages and disadvantages of each method before giving BS services. There is no SOP for insertion of IUD, and majority of MW said they receive training from township O/Gist or TMO to insert IUD. In Nyaung done township Usage of IDU becomes more popular but decrease due to lack of supply. Due to frequent stock-out of BS commodities patients lose confidence on the RHC. Clients are given a BS services according to their choice. Rapid turnover of TMO is also a hindrance to RH activities as TMO is the leader.

Husband do not prefer IUD insertion, women are also afraid of being inserted with IUD and BHS need training on advocacy on use of IUD and skill training for insertion.

1.2. IEC materials for RH

Provided with adequate IEC materials and they are easy to understand and use, Relevant and Pamphlets and booklets on HIV and nutrition during pregnancy were given. Useful and sufficient IEC materials are easy to read and share knowledge with villagers. ANC coverage is still not satisfactory. Neikban village, kyaikmayaw township RHC said Women with danger signs of pregnancy have to be closely follow-up.

1.3. Antenatal care provided

Most of the providers said they are satisfied with the ANC they are providing. They described steps of AN care such as history taking, urine RE, taking blood pressure, weight, examination of the abdomen, supply ferrous sulphate and folic acid to pregnant mothers. Health education on nutrition is also given. PMCT service provided.

Neikban village, Hintada township and Pyin sar RHC express concerns for the women who are in difficult geographic terrain needs to have better ANC, MW needs transport facilities to reach them to follow up and be aware of danger sign of pregnancy, Nutritional education, PMCT booklet+, Midwife kit + has been provided,

When asked about multi-task being carried out by MW, majority of MW said although there is over load MW feels she can cope with the work load as long as RH commodities are supplied, drugs and kits are supplied they can help the people who need their services. Mawlamyaing MCH wants to be provided with prenatal tablets to attain more community interest.

1.4. Equipment for emergency obstetric care

EMoC kit is provided only to Township hospitals, No, management of 3rd stage of labour was described. Use ergot Vitamin C. K, and hydrocortisone. We were taught by OG to give injection. No supply of emergency obstetric kit. Although MW and AMW are not officially allowed to administer injections, in practical and emergency situations MWs do give syntocinone IM 10 unit when fetal head is seen. Constraints like stock outs on Mesoprestol tablets in Ayeyarwaddy division, receiving Mesoprestol tablets which have already reached expiry date at the time of receiving the drugs at RHC were expressed by BHS.

1.5. Institutional Delivery

Referrals to hospital are delayed because majority of village population are reluctant to go to the hospital as they are not financially able. Cost sharing system in the government hospitals need to be revised and there should be a standard cost for normal delivery, LSCS, sterilization, D&C so that patients can be prepared and not be surprised with high costs.

1.6. Post abortion care

Majority of MW explained that abortion cases are occasionally (2 to 3cases per year) seen and we usually refer to the hospital. Most are not induced but accidental. With more people having access to BS services there is more improvement in RH knowledge and less abortion. However, mobile /floating population who seek for jobs in Mon State and Ayeyarwaddy division need out-reach RH service

2. Coordination and support

2.1 Improving referral cases of EmOC

Nyaung done BHS expressed that in Ayeyarwaddy division inconvenient transportation Community support group acts as a bridge to bring women to hospital and they need *htawlargyi*, maternity waiting home is not functional and under-utilized. There is need for better birth planning and proactive search for pregnant women in the community and as women prefer to deliver at home. In Mon state BHS expressed that it is inconvenient to refer patients as cost sharing in public hospital is almost as high as private clinics and staff are not friendly. However, BHS of Naikban RHC, Hintada Township said that HA coordinates with hospital ahead of time so that the reception of referral is smooth. Emergency referrals MW accompany the patient and are better.

2.2. MWH and male involvement.

Most male partners are supportive but some are not, Mon State and Mandalay Division, Sagaing division BHS said that husbands are busy working and do not accompany their wives for ANC. Decision making for RH emergencies, husbands are not there to give permission or provide financial support and this cause delays in referral to hospital.

2.3. Post natal care

45 days after delivery the mother and baby comes for PNC and BHS advocate exclusive breast feeding for 6 months, give health education for nutrition, and was found to be successful. Birth spacing counseling done and women prefer injection depo, Beri Beri, Anaemia common nutritional deficiencies seen. Provide advice for BS-6 months exclusive breast feeding. Check for anaemia and provide Fe and Folic acid when required. Some mothers believe that Hepatitis B vaccination can lead to neonatal jaundice and had to advocate the right concept to women.

2.4 Improving home delivery care

BHS said that most of the men are involved in home delivery. Shan and Karen men would prepare a separate room for delivery, clean bowls for washing the baby, sheets and cloth prepared ahead of delivery under instruction of MW for home delivery. Men are responsible and supportive at the time of delivery. Fathers also bring their children for UTI. When men become more educated about RH ANC becomes better. In Mon State the community prefers home delivery and prepare ahead of time for safe delivery with MW. Men are helpful and help with chores during delivery.

2.5 Functionality of Township Health Committee and Village Health Committee

Nyaung Done- It depends on the person. Some have interest in RH care and provides support. Some are too busy carrying out orders from higher authorities.

High CSG number, High Attrition, need annual on job training, Motivation, need bicycle and motorcycle for transportation Sarmaluak Our VHC is active and works well with BHS and CSG. Coordination between public health staff and hospital staff by TMO is important for smooth referral in emergency obstetric cases.

Recommendations:

1. CSG program is contributory to better coverage of RH care. However, CSG trainings too short. They need to meet with BHS more to be motivated and updated. CSG need to be

having incentive and recognition for their participation in the health of the community. Providing uniforms is one way of recognition and are treated with respect when they refer patients to hospital. Need for better coordination between hospital staff and BHS by TMO so that all will be partners in providing quality RH care. It would be good if bicycles can be provided for better transportation.

2. Advocacy for institutional delivery has to be together providing facilities for labour room at the RHC. Sar Ma lauk RHC needs a labour room. Every month there are about 4 to 5 deliveries per month at the RHC ANC room.

Section 3: Focus Group Discussion with Clients utilizing MCH

Compiled Responses on (26.10.09)

A total of 51 pregnant women coming for antenatal care and 43 post natal care seekers from 6 States and Divisions participated in a total of 12 sessions of Focus Group Discussions. Structured questions were prepared for the FDGs and the leader conducted FDG in a cordial, open and professional manner explaining about how the results would be reported and that how individual confidentiality maintained. There was a note taker assigned in every session.

1. Choice of BS services

More than 80% of the clients who utilize MHC AN &PN services said that the BHS counsel to them about 3 different types of birth spacing methods pills, three monthly injection and condoms and ask them to choose the method. 15% said they were given a choice of pills, injection and IUD. The clients said that they paid 200kyats but some said 500 kyats for a strip of oral contraceptive pills. 5% said that they were not told about the advantages and disadvantages of IUD and they are sacred that the IUD will cause ill effects.

2. IEC materials for RH provided

One woman who is pregnant and who came for ANC at Mawlamyine MCH said that 7 years ago when I had my first child there were no pamphlet and knowledge about RH is limited. Now we have colorful materials with knowledge about pregnancy and dangers signs shared by the MW. Literature was given to read at home and ask questions to clarify points that were not clear in the next visit. Majority of women expressed that the information received from the RHC is relevant and helpful.

3. Antenatal care provided

Most of the clients expressed that they were satisfied with the ante-natal care provided. They said they were given tetanus immunization, urine RE, measurement of weight & height, examination of abdomen, health education about STI given. Some women expressed that there was but too much information and cannot remember all points, nurse talks about nutrition but does not explain about the importance of third trimester nutrition. All women said that they received one month's supply of iron and folic acid. Women answered that they come for ANC ranging from 1 to 7 times during last pregnancy.

4. Experience of delivery care

Rural women said they prefer home delivery with MW and LHV because it is safe and cheap. Most of the women said that MWs do not ask for money but we Kandaw (Love gift or honorarium) according to what we can afford only. In private clinics the cost for normal delivery is 40-50 thousand kyats, and CS in private clinic costs 3-4 lakhs kyats. Male partner is quite supportive during labour but most of the time busy with their work to provide for the family. In Mawlamyaing 41.6% of women coming for ANC said they delivered at hospital remaining delivered at home. For normal delivery 2 women said they spent 1.5 lakhs kyats each at private clinic. In the public hospital they spent 60,000 to 70,000 kyats for normal delivery. But still some cannot afford and if they mention that they cannot afford services are provided free service. Pyinoolwin - Home delivery is preferred. Hospital delivery –for normal delivery cost sharing 20,000Kyats. 7 years ago public hospitals does not ask for money for normal delivery.

5. emergency obstetric situation

Women said that they know for sure that hospital will give services in times of emergency. Mawlamyine I want the MW to be available in times of emergency. We are poor and are anxious that health personnel will not attend to us/provide service because we do not have money, thus, we do not want to go to the hospital. On epyung woman Ma Thuzar (23) years said we want MW to communicate with hospital and assist us when we are referred to hospital. Even if we give birth with TBA when there is difficulty was call the MW or LHV. There is a little delay but they accompany us to hospital.

6. Referred to a hospital for EmOC

Three women shared their experience of having PPH where the MW administered medication and accompanied her to the hospital, they said immediate care was given and they received blood transfusion and recovered. Women from Patheingyi, Mandalay shared their experience that in times of emergency they cannot afford to pay for transportation to go to hospital. In times of emergency community support group helps find the money to pay for transportation. Three women from Mawlamyain said there should be better coordination between BHS and hospital staff.

7. post abortion care

Majority of BHS said they have no experience with post abortion care.

8. MWH

All the clients when asked about MWH they answered that they were not aware of MWH and have not utilized its services.

9. Home delivery care

MW comes to our home and we plan ahead for the delivery. Less expense and MW does not ask for money. It is our custom to Kandaw (Love gift) any amount we can afford is given. On women had bleeding after the baby was born, was taken to the hospital with drip line and injection and recovered after blood infusion. Majority of women said home delivery is cheaper than delivering in RHC or hospital. MW does not ask for money. Cheaper to deliver in RHC compared to

hospital. But when there is emergency situation seek MW's help. Clean delivery kits distribution helps many. It is cheaper and more convenient. Husband stays home when delivering baby and helps with household chores. MWs are skilled in delivering the babies.

10. Township health committee and role of male involvement

Women in rural Shan states (south) said most of the coordination done by MW or LHV and the hospital. There are women who are poor and do not have funds for transportation. Local authorities VPDC collect money for her and send to hospital which is far away. There is delay because the terrain is difficult to travel. We need better roads and transportation in times of emergency.

11. Male involvement in RH

Male involvement is very good in first pregnancy, but in subsequent pregnancies they are not too bothered. Most husbands are merchants or farmers need to work. Sarmalauk clients said that VHC is helpful. In emergency situation when patient is poor and cannot afford transportation fare, VHC coordinates for transporting patient to hospital.

RHC has only one bed for delivery. Sometimes when two or three patients have labour pains at the same time it becomes difficult. Need to provide more labour beds at RHC. VHC is helpful but depends on the person. Some are interested in RH and committed to reduce MMR.

Section 4: Responses to In-Depth Interviews on Reproductive Health, Population Development and Gender Issues in Myanmar

In-depth interviews were conducted in 6 states and divisions of Myanmar, between the period of 7.9.09 to first week of December 2009, participated by 3 Directors, 2 Deputy Directors, 2 Assistant Directors of DOH, DHP of MOH, 2 State/Divisional Health officers, 4 Deputy State Health Officers, 14 Township Medical Officers, 15 Health Assistants totaling to 43 service providers of the MOH, 24 staff of 6 national NGOs including MMA, MMCWA, MWAF, MANA, MRCS, 25 staff of 7 INGOs including JOICFP, SC, AFXB, MSI, AMI, PSI and AZG in 27 sessions.

1. Promotion and implementation of essential package of RH interventions

Majority of the service providers and stakeholders involved in RH were appreciative of the implementation of 5 years National Strategic Plan for RH and admit that there is better ANC, PNC, post abortion care, use of clean delivery kits, community mobilization to bridge the gap between service provider and people and availability of birth spacing services. Mobile population for gold mining, rock laying for building roads in this area makes it harder for 100% ANC coverage. However, Patheingyi TMO explained about how micro plan for RH taking a proactive approach to map out pregnant women in townships by BHS so that all deliveries are planned and assisted by skilled birth attendants.

2. Human Resources for Health

HRH for RH is adequate however, existing vertical programs assigned to the MW draws her away from MCH activities. Thus, there should be balanced work distribution among different categories of HRH so that MW can concentrate on MCH care and support. On the long term the training of BHS is the main stay in RH sustainable programs. Refresher training is required as there is transfer and movement of BHS. However, sometimes there is too much training and especially when training period lasts for five days MW is kept away from MCH duties for too long.

Personal and professional development of MW needs to be considered to empower the MW as a community leader in villages. MW needs to have skills for leadership, negotiation, management and communication to gain trust from the community. Language barrier is one obstacle for BHS posted to rural states. MW did their best to learn the language, and cultural sensitivities. Frequent transfers are hindrances to build relationship with the community.

Auxiliary Midwife (AMW) conducts 13% of normal deliveries. As majority of the rural population prefers home delivery one solution is to improve the skills of AMW and to plan pregnancy ahead for complication. Community Support Groups (CSGs) support the MW in RH activities and they need refresher trainings to keep abreast with the changing trends.

HRH management

Majority of TMOs expressed that there is need to revise job descriptions of the BHS so as to avoid overload of duties on MW while LHV has less duty and BHS II can take some of the burden off the MW, especially environmental health, disease control and others so that MW can concentrate in a proactive manner for maternal and child care.

Deployment and sustainability of HRH in hard to reach areas of the country to serve marginalized population is an on-going challenge for DOH. AMI works in the in the Wa Special region 2 where training of auxiliary MW was carried out for MCH care of the people, establish maternity waiting homes and BS services. It was expressed that the attrition rate of trained AMW is high and armed conflicts in these areas make it hard for routine MCH care to be continuous.

Frequent turn-over of TMO especially in Ayeyarwaddy division, Nyaung Done township slows the momentum of RH activities as interest of TMO is essential for implementation of RH program.

Newly appointed MW needs pre-service orientation and training to cope with her duties. MW has skill gaps that need to be addressed before being deployed alone at RHC.

3. Adolescent Reproductive Health

YIC has become a very good model for young people to learn about ARH, socially friendly environment for BCC for adoption of positive habits for safe sex, abstinence of tobacco, alcohol and betel chewing habits. Leadership development and health happy adolescent life program had much success in engaging youth to adopt health behaviour change. This program needs to be expanded to reach other youth in the nation. YIC program by MMA, AFXB and CHEB-JIOCFP are successful in engaging youth but needs further expansion and quality assurance when franchised. It is not enough to give information on health and the young people need support for personal and professional development for holistic growth.

There is migration of community peer educators, trained volunteers, increasing attrition rate of peer educators due to socioeconomic reasons.

4. Birth Spacing

UNFPA's provision of RH commodities to IPs and social franchising of birth spacing commodities has been widely carried out at subsidized rates. This had improved the contraceptive prevalence and reduced unmet need for contraceptives.

Over lapping of BS activities some townships have resulted in competition among IPs while there are still areas where there is lack of BS services. Better coordination among partners is required.

5. ANC

Myin Mu TMO innovative and proactive ways of increasing quality ANC. 28/11/09 to 5/12/09 is designated as AN week and active search for pregnant mothers and birth planning is carried out. This greatly improves ANC and better outcomes of pregnancy. Participatory approach, bottom –up management where TMO listens to the BHS and their problems on day 1 and prepare CME the next day.

ANC varies in different locations. In Mon State all RHC and sub-centres open five days a week where as in others it is only three days-Monday, Wednesday and Friday is regarded as ANC day.

6. Delivery care

Home delivery rate is still high 55.72% in Mon state, culturally Mon people likes to deliver at home, it is important to provide quality care whether delivered at home or in the institution. Human factor is most important in providing quality care. Following SOP, positive attitude and dealing with patients to give responsive care.

Pyin Oo Lwin: area coverage is a constraint as mountainous terrain is difficult to access, MW needs transportation support. BP cuff, stethoscope, bathroom scales needed to be replaced as they have become old and dysfunctional for ANC. Average one MW takes care of 5700 population.

7. Health seeking behavior

Community level RH services are provided by BHS at RHC and sub-RHC by primary health care approach. Even for normal delivery there some amount of cost incurred when delivering at the hospital. EmOC is provided by station hospital, township hospital, District hospital and State/Division Hospitals. Cost sharing practices in hospitals hinder service seeking behavior of poor population. Some ways to overcome is through endorsement by TMO or S/D HO which assists the poor by lowering the price of cost sharing. More expansion and collaboration between hospital staff and MW is needed. The attitude of partnership to lower MMR has to be owned by all actors.

8. Increased access to RH services

In Ayeyarwaddy Division, the terrain is unique as the low fertile land is traversed by multiple tributaries of the Ayeyarwaddy River before it enters into the Bay of Bengal. Access to health care is a challenge as there are villages only accessible by small motorized boats. These villages again become hard to reach during summer when streams and rivers become dried up and there is no way but to walk to reach them across rice fields. The populations in these areas are mainly mobile as their major livelihood is fishery and farming on shoals during summer and other people's farms in winter and rainy weather.

To actually reach these vulnerable group of mobile population mobile clinics for ANC, MCH is one option thus support for vehicle appropriate to this region is required for long term sustainable development. Population coverage and area coverage are two different aspects when considering RH care coverage. One cannot say 3500 population per MW is a good coverage because if the terrain is

very rough and hard to reach this becomes not a good coverage also, thus, access to health care by head count may be a more accurate way of measuring coverage.

Attitude of HRH towards the ability of community is not very positive. It is important to empower the community to reach RH goals. Paradigm shifts from depending only on MW to working together community, health service providers and BHS. Accept the existing situation and readjust to get better outcomes.

In Pyinsar village RHC of Pyin Oo Lwin Township, there are still pregnant women who deliver without ANC. Mountainous terrain there is difficult to travel. Roads are very bad and transportation difficult. MW spends more than 5500 Kyats per visit to the six villages along the Doke-hta- Waddy River. MW of Sub-RHC in Gway –pin had to take care of Thit-taw, Wa-net, Nget Gyi Tike, Mangyi khin villages where transportation is a challenge and maternal mortality is still present. For these MWs special consideration and support is needed for them to perform their duties.

9. Quality of Care

Standard operational procedures inclusive of counseling, choice of BS options, ANc, PNC, Delivery care need to be documented, audited and followed at all times for all staff, (public, NGO and private) at service delivery points involved in RH services, **BS services, ANC, PNC, Post Abortion care, EmOC and IUD insertion** to prevent complications and adverse events. However, the quality of care needs to be assessed. If it should occur proper referral and management of adverse events should be carried out systematically and managed to prevent from occurring again. Refresher training needed for BHS as there are new recruits.

National guidelines for active management of third stage of labour had been developed and published however, in there is discrepancy between States and Divisions RH care procedures. Mode of administration and dosage varies and permission to administer also varied between states and Divisions. In Taungyi all MW's are trained and are given permission to insert IUD as one of BS methods, whereas in Ayeyarwaddy Division only Ob/Gyn insert IUD. Technical revision on best practices needs to be in place for effective management of 3rd stage labour and complications which are the commonest cause of maternal death.

Quality of RH care is assured by proper training, M&E of project as well as program assessment through use of 'mystery patient' to assure patient satisfaction and quality of care as in MSI clinics. PSI does client satisfaction survey, complaint box for feedback for quality assurance in RH care.

Reduce delay in providing RH care: Transportation difficulty, high expense for communication and transportation is an obstacle for timely referral. Establishment of community fund for transporting with available vehicle for emergency RH care is one of the ways to avoid delays in referral. Community support groups that work together to provide means to transport patients to hospital and builds community awareness and participation which can contribute towards reduction of MMR.

10. RH Commodity security

UNFPA supported programs have RH commodities delivered on time but there is stock outs in five states/divisions out of six visited. Mon State has no stock out of BS commodities. Patheingyi

Township, Mandalay Division, Nyaung Done township, of Ayeyarwaddy Division, Pyin sar RHC has stock out of RH commodities.

Not all five methods of contraception are available in 5 out of six states/divisions. It is Important to plan ahead with supply chain forecasting and monitoring to take action on feedback information given to avoid over supply as well as stock out.

RH commodities are purchased in bulk by UNFPA, warehoused in CMSD and distributed according to break down list developed by UNFPA and national RH program manager by quota system and not by demand base.

Township Health Departments send personnel to collect the RH commodities at CMSD and there is cost incurred. Some townships do not know that the cost can be claimed from UNFPA.

PSI there is no stock out as balance report is sent every month and supplies sent accordingly. Multiple donors and funding agencies so supply are continuous.

11. Identify and develop methods of sustainable financing

The most important linkage to be established is the linkage between MW and community volunteers. If this is strong even when project activities stop the linkage will function and RH care and support can be sustained.

Community resource mobilization at grass root level. Office Account (OA) is getting bigger in some townships it is more than 2 million kyats and in some .97 million kyats (Pyin Oo Lwin). Need policy to use the funds for better RH care. Nyaung done has RDF- Revolving drug fund mechanism and works well with good administration.

12. Health Management Information system in relation to RH

Planning from central level HMIS data is used but quality of data is questionable as in some areas IMR is under reported. Ambulance system is not well developed, catchments scaling system is not developed, and transportation is the major problem.

HMIS is a lot of data which needs to be analyzed and converted to relevant information to be disseminated to policy makers and for feedback to service providers and program managers, which does not happen in actual situation.

TMOs expressed that RHMIS data format has been changed to a more user friendly, practical and useful form. DHP conducts training on RHMIS data collection tool to get accustomed and understand the significance and importance of collecting quality data.

13. Improve legal environment for reproductive health

Most of the TMOs and BHS agree that the public need to have knowledge of existing laws with regard to RH, abortion, sterilization laws, procedures, laws with regard to women protection and violence against women.

Some expressed that to reduce maternal mortality abortion and sterilization laws might need to be revised. As abortion is illegal and women with un-intended pregnancy seek abortionist and traditional

birth attendants for induced abortion which can endanger the life of the mother when done in hands of unskilled.

Procedure to get permission for sterilization involves paper work and often women who need sterilization fails to follow the procedure E.g. HIV positive mother, young grand multi-parity with complications. In some states and divisions it takes three to five months for sterilization form to be approved.

Private sector law needs regulations and rules to enforce the laws. Prostitution is illegal however, Commercial Sex Workers (CSW) need rules and regulations to provide protection of CSW from disease and exploitation.

There are still a lot of TBA's without formal training who conduct home deliveries in remote areas and villages resulting in maternal morbidity. Majority of BHS expressed that there is need for legal regulations to check them from doing more harm.

14. Improving evidence base for decision making

There is no operational research carried out in IP (NGO) except for PSI. Most of the IPs agreed that BCC techniques used needs to be assessed for degree of effectiveness. Similarly "mesopresol" has been used for management of third stage labour. The effectiveness and impact on prevention of maternal mortality needs to be studied. So is the effectiveness of MgSO₄ used for Pre eclampsia.

Attrition of trained youth volunteers and auxiliary midwives is increasing. Research on the causes and how to reduce attrition needs to be studied.

MMA has no allocation for operational research, would like to look into effectiveness of program whether there is improvement in KAP and behavioral change or not.

Need to analyze population data for RH services. Now that UNFPA funded programs have being carried out for more than 3 years, impact of community mobilization on RH care and support needs to be studied. PSI and WHO HQ conducting a study on "Quality evaluation for Franchising RH care"

RH operational Research Proposed by DySHO, TMO and BHS

- "Township hospital based strengthening of ANC and its impact on safe delivery"
- "Female adolescent reproductive health behaviour survey"
- "Effectiveness of home vs. institutional delivery"
- PSI is currently conducting "Condom use behavioral surveillance" research working together with NAP, Mandalay.
- "Relationship between socio-economic status, access to ANC and impact on outcome of pregnancy"
- "HRH for RH ratio to geographic and population coverage"
- Impact study on effectiveness of Youth Information Centres.

15. Coordination for better outcomes

Strengthening partnerships at local level for RH

Township/Village Health Committee: In some townships there is close coordination initiated by the Township Health committee which is chaired by the GAD and TMO as secretary. However this was

not the case in some township the THC is non-functional and the chair is not interested in health issues. In Mawlamyaing and Kyaikmayaw, the THC meets monthly and there is close cooperation with the TMO for RH and other health issues. Sometimes when Local authorities are too busy and TMO leads the coordination of health issues. Township health Committee is functional in Nyaung Done and meets regularly twice a month on the 3rd and 18th of the month.

Some are functional but they fail to organize a network for social support for RH care. In Mandalay division the Divisional health committee usually meets every month in previous year but was only able to meet two times in 2009. Partnerships need to be strengthened among INGOs working in the field of RH.

16. Gender Issues in RH

Almost all interviewees said Gender equity is an issue for RH care because depending on geographic area, more so in the rural area where 70% of the total population of Myanmar resides RH is generally regarded as women's affair and more responsibility is placed on the women. Child bearing and rearing is more of women's responsibility and with little male involvement. After advocacy for male involvement in RH, there has been significant change in community level. Male partners accompany the pregnant mother for ANC, birth spacing decisions and post natal care.

Religious and cultural barrier against equity of two sexes as Buddhism reveres male higher than female because of "phon" or "religious authority".

Most of the members of Community Support Group are female. When recruiting volunteers also, mostly females are involved. It is important at planning stage to insert criteria to have male volunteers to reach out to the males in the community so that male involvement in RH is better encouraged.

Female sex workers are vulnerable to violence and exploitation. They need education and regulations to protect them. This contradicts the existing policy because "prostitution is illegal in Myanmar"

WHO funded gender research and training of BHS on gender equity in health care has been carried out. There is need for more awareness raising and dissemination of research findings for Gender issues.

One Director from MOH expressed that Gender mainstreaming activities will create mutual understanding and positive attitude for harmonious existence of both sexes. "Better-half concept should be accepted for gender balance to prevail.

Preservation of virginity has more emphasis on girls than boys. Adolescent RH is less attention to girls more emphasis on boys. Important to have balanced view on both sexes with regards to ARH issues.

Nutritional deficiencies and gender- Women admit that they give preference to husbands when distributing food as they are the bread winner and they need more strength for physical labour. The second preference will be the children. B1, iron and protein calorie deficiency is common in pregnant women. Most townships visited said there is not much nutritional deficiency seen. Occasionally B1 deficiency is seen among women coming for ANC.

17. Gender based violence:

Gender based violence is not very common except when under influence of alcohol or drugs male partners tend to be exhibit violent behavior against female. Myanmar women are very shy and majority would suffer in silence.

There is SOP for reporting “rape” however, domestic violence, GBV in times of emergency situation is not well studied and has no SOP.

A married man with 8 children raped a 15 year old girl which resulted in pregnancy. The survivor’s family reported to MWAF and an investigation was conducted followed by a court case against the offender. He was found guilty and was sentenced to jail with compensation paid to the survivor. The baby was delivered by LSCS in Nyaung Done Township Hospital. There is need for advocacy with regards to GBV, awareness programs should focus on skill based education for prevention of GBV.

Most of interviewees said that Myanmar Federation for Women Affairs is the organization where women can seek help and assistance for protection. They said that victims/survivors need to be empowered with knowledge on the existing laws for protection, legal process on reporting GBV and action against the offender. It was expressed that there are cases of violence against men also and should be researched. Gender mainstreaming activities needed to sensitize and attain gender equity.

Public as well as medical doctors and health personnel do not know exactly know the prevailing women protection laws of our country. We need more education on these laws and the procedure for reporting and action against GBV.

No increase in SGBV due to emergency situation, religious and cultural concept of Myanmar people over rules violent behavior and there is dominance of domestic harmony.

Recommendations from interviewees to reduce MMR

BCC is proven cost effective method for improving RH. Different strategies have been used by organizations but need technical revision of training modules, interventions and strategies. External evaluation of BCC programs to improve effectiveness. Mobile library is one way to increase RH information dissemination.

Net working: Reduction of MMR to achieve MDG is by collaboration with GPs. MMA has a large network of 4000GPs all over the country, 36 centers, 45 GP societies. GP acts as community leader for RH education, RH services and public education and mobilization. O/G section of MMA is also a good entry point to provide specialist care and support.

Community mobilization: Community needs to be educated to seek institutional delivery. In spite of all efforts by BHS to persuade pregnant mothers to come to RHC for delivery, they still prefer home delivery by Traditional birth attendants, and only come to MW when labour is obstructed and prolong.

Supportive supervision and Coordination of service providers: In obstetric emergencies MW accompanies the patient in times of complicated labour and sends to hospital. There are times when MW had to support the patient with her own funds for transportation and get scolded by hospital staff on arrival for bringing in late. There should be better coordination between BHS and hospital staff for the sake of better outcome of obstetric emergencies.

Coordination and provision of transportation- Referral system is in-place but need transportation support, BHS support to ensure quality EmO care. To prevent late referral and emergency obstetrical condition proper birth planning and coordination on the part of village health committee is crucial.

Capacity Building of BHS: Refresher training and capacity building of HE officers of DHP, improve training skills of peer educators, project staff. Multiplier trainings for YCDC staff is needed and requested. Empowering MW acts as leaders of community by providing training for personal and professional development of BHS as well as financial support for RH programs. Trust by the community is important factor in implementing RH programs. To reduce maternal mortality there is need to improve practical clinical skills of midwives. Then only the villagers will transfer their trust from Traditional birth attendants to MW and institutional delivery.

HWF Management: Frequent staff rotation effect the program. Thus, HWF management policies, promotion-transfer policies, incentive policies need to be in place to prevent attrition of trained personnel. It is the same with deployment to border areas.

Adolescent RH: To reach the un-reached youth, university youth, and young adolescents with innovative means of engagement. Youth Information centres are used more by male young people. 2/3 is male. Need to make is more youth friendly in RHCs, more girl friendly. Attrition of youth peer educators is increasing with mobility of population in Mon state for job opportunities abroad.

Monitoring and Supervision: Supervision is weak to assure quality of RH care. There is need to provide specific funding for supportive supervision. It is important when coverage is stretched thin like in Sagaing Division where MW coverage is not so good, and AMW and TBA are being used for delivery services. RH Education and regulation of the quacks, AMW and TBA needs to be addressed in an active manner before much harm is done.

Improve coverage of RH care: There is need to improve geographical coverage of skilled RH care. MW is over burdened. AMW program is good but need to improve skills. Explore innovative ways to meet the gap. One option is to mobilize community volunteers. Idealistically volunteerism is good however for sustainability people need to be supported for survival. Thus, practical solution to select persons who are committed, who will stay in the region for long term as community health worker, train them to attain standardized minimal performance skills and empower community to employ at minimal service fees , establish good linkage with MW and BHS.

Health Financing for RH: To reduce MMR increase government investment on reproductive health. There is giving a lion's share on RH in National health accounts.

Community resources should be mobilized for better coverage. Mandalay division has viable local NGO support for hospice care, funeral services for very poor. Provide nutrition support, transportation support for those in need.

RH education to early adolescents is starting from primary school. Concept for health sexuality, building happy family and morality needs to be addressed to reduce risky and perverted sexual behavior which is not in conformity to the socio, cultural and religious concepts of the Myanmar people.

Regional RH strategies: As every state and division is unique so are the RH needs. Thus, regionalized planning for better RH care and support is needed. There is conflict of roles between

public health personnel and health care delivery service personnel. Better coordination is needed between all stakeholders based on partnership principles.

Others: MSM is becoming more prevalent in 15 to 19 years age group and incidence of HIV among this group is increasing. ARH should start in younger adolescents. Taking into consideration the cultural, socioeconomic and religious convictions of the Myanmar people there needs to be a balance between encouraging MSM to be open to activities which leads to prevention of HIV transmission and discouraging exposure to risky sexual behaviors and preserving cultural norms.

Taking into account the rising trend of MSM, concerns for the future generation to adopt normal healthy sexual practices has been expressed by interviewees. Thus, expression of sexuality in line with cultural, religious and socially acceptable norms in Myanmar should be advocated.

Section 5: Quick facts on adolescents in Myanmar (from the Family and Youth Survey 2004)

- *The percentage of youth with high school and above education is almost 60% for both sexes in urban and less than 25% in rural areas and the youth who have no education is about 5% with the proportion higher among the rural youth. Youth discontinue their education mainly due to financial problems and they want to work to subsidize their family income. This survey noted that the higher proportions of ever married are found among youth with lower education, the proportion decreases with higher education. A greater proportion of female youth in urban are never married compared to their rural counterpart.*
- *Regarding the family environment, this survey observed that the percentage of mothers alone looking after their children was found to be higher than that of fathers and whenever the youth are faced with health problems, nearly 80% received advice and help from mothers and 15 percent from fathers. Over 50% of the youth have freedom in spending their own money, going out to have fun, choosing friends and jobs.*
- *About value and attitude of youth, this survey indicated that most of the youth (more than 92%) generally agree that women should maintain her virginity until marriage, and should not initiate courting and unmarried life is better than married life. One in six youth (16.6%) generally agree with the decision for induced abortion to terminate unwanted pregnancy in unmarried women. 60% of youth approved of premarital sex for boys while only 7% of youth approved the premarital sex for girls. More than half of youth agreed that using birth spacing is solely woman's responsibility.*
- *About reproductive health issues, the study of reproductive health issues among 15 to 24 years old out of school young people²³ indicated that 45% and 21% of married boys and girls respectively expressed that they had sexual experience before marriage whereas 20% and 2.5% of unmarried boys and girls respectively admitted they had sexual experience before marriage. This study also noted that during first time sex usual partners for girls are mostly spouse (79%) and boyfriends (13%) and fiancée (6%) whereas 32% of boy's first time sexual partners are casual acquaintances (5%) and CSW (27%) and spouse (34%), girl friends (31%), fiancée (3%). The median age of first time sex for boys is 19 years with the range of 13 to 24 years and for girls is 18 years with the range of 13 to 23 years.*
- *Protection of the youth and adolescents from sexual and reproductive health problems essentially depends on the correct knowledge of the physiology of human reproduction. According to the Family and Youth Survey 2004, young population has reproductive and sexual health information and is aware of the issues; however correctness and accuracy*

of knowledge is not warranted of a high standard. More than half of youth responded that they are having some information about sexuality related health while 76 % of males and 69% of females expressed that they are willing to get information about sexuality.

- *For contraceptive awareness among youth* is very common (85%) and an average youth knows about 5-6 types of contraceptive methods. Young people, parents, teachers, and even providers, report being reluctant to initiate discussions on sensitive issues related to sexual behavior. The major reproductive health information source for young people is reportedly their peers. Evidence suggests that sexual issues are discussed openly between peers, particularly boys²⁴.
- *Concerning the adolescent pregnancy*, adolescent Reproductive Health at a Glance in Myanmar (WHO-SEARO-2007)²⁵ reported that adolescent pregnancies in 1998 were reported to 8.9% of total pregnancies in Yangon. Unmarried girls and young women are especially to unwanted pregnancies because reproductive health services are targeted only at married women. A WHO study of risk behavior and attitudes among ninth standard students showed that 2.9% of them had engaged in unprotected sex. In addition, one study showed that a sizeable number of pregnant adolescents (e.g. 26% of 15-19 years old and 20% of 20-24 years old) sought no antenatal care. This may have been due to the lack of awareness regarding pregnancy related issues and available services²⁶.
- *Regarding trafficking*, the report of family and youth survey, 2004 showed that 87% of youth have heard about trafficking and 71% of youth reported that 15-19 age groups is the most likely victims of trafficking and 33% of youth reported that the main cause of trafficking is due to economic and social reasons.
- *Concerning health seeking behavior*, this survey observed that most of the youth have self medication and it was found that the more educated, the more they use something to prevent pregnancy, STIs and HIV/AIDS and 4% of male youth had sex outside wedlock and among them 80% use condom.

Section 6: Findings of focus group discussion/in depth interview with Female sex workers

A total of 27 FSW participated in 2 sessions of focus group discussions and 3 sessions of in depth interview which included established direct and indirect sex worker, freelance, street walkers as well as HIV positive sex workers between the ages of 17 to 51 years from 5 townships.

Social and economic characteristics of female sex workers

All are married except 4 FSW and among them 8 sex workers still have husbands. One of them started the sex work since 17 years of age and others are between 20- 30 years of age but one of them started sex work at 40 years of age. One sex worker is a university graduate and 12 only passed the primary and middle school level and 7 are illiterate. Half of them live with families and the remaining come from other townships and live at brothels. The reasons to engage in sex work is mainly socioeconomic difficulties ; husband of one sex worker is in prison, one sex worker lost her family during Nargis, some sex workers returned from working at border areas like Myawaddy and Thachileik.

“The graduated sex worker said that the first exposure for sex with her boy friend when she was in university and then she started to work in beer bar due to economic problems in her family since university student and she do sex work by negotiations with the clients”

The interviewed sex workers all drink alcohol but not regularly and among them 3 clients have history of taking stimulant drugs (Yama). Some find their clients from high way terminals and get 5000-10,000 kyats per client; some are through pimps at brothels and get 500-1000 kyats per client and pimp get 2000 kyats per client, most of the street walkers get 1000-1500 kyats per client. They can get 700 kyats per one hour in massage parlour and clients negotiate for sex there and if an agreement is reached, they take up sex work in other sites (hotels, guest houses) obtain about 5000-10,000 kyats per client depending on the type of client.

Condom utilization

They said that previously they didn't use condom and now that they have more education since last 2-3 years they all used condoms. All sex workers have not only knowledge and but also have positive attitude about condom. However, practically, they admitted that they do not use condom consistently because some client still do not want to use condom, they get more money from some clients if they can accept sex without condom as clients assumed that sex workers are new and do not have any diseases. Besides, sometimes they fail to negotiate condom use because clients are drunk or under influence of stimulant drugs and sometimes they don't have enough condoms that they carry for all clients.

“One FSW said that although they already acquired a habit to carrying condoms with them, they carry only limited numbers because some police may interrogate and search the sex worker and ask for money if they see condoms on them even though there is a standing order that condoms should not be used as circumstantial evidence for prostitution”

When asked about the source of information about condoms, the sex workers said that they get information from NGOs, mostly from PSI, MSI, Care and community based organizations and AIDS/STD team. Majority of the sex workers got information through friends (peer sessions). All of them are aware of sources for obtaining condoms and said they are easily available and accessible. Brothel based FSWs get condoms generally from their pimp or brokers and others obtain from Drop-in- centre, clinics and NGO workers. They have experience with female condoms and they usually use female condoms when they cannot negotiate with the clients to use male condoms if they have time and at the time of their menstrual period. However, there are still sex workers who don't use condom with clients in some townships.

“One female sex worker said that there are some areas in Ye' township in Mon state where clients don't use condom and FSW cannot negotiate with them because they are mobile fishermen, low level of education as well as limited knowledge on HIV/AIDS”

Knowledge and attitude of STD and HIV/AIDS

They said that there is still limited knowledge on STD among sex workers. In the past, they have history of STD but among them, no one suffer STD during this year. They usually take treatment mostly at NGOs (MSI, PSI) and GPs when they get STD because some NGOs arrange to go GPs and give some incentives. All except 3 new adolescent sex workers know that how can people get HIV and how to prevent it and also have positive attitude to PLHA. They all have received VCCT and mostly at AIDS/STD team as they know the benefits of VCCT. Among them, 7 FSWs is HIV positive and 3 of them are on ART. They said that there is not only limited care and treatment support but also lack of socioeconomic support among sex workers who are HIV positive.

Suggestion of the interviewed sex workers on programme

They suggested that there is need for more education of the clients not only high risk group and but also general populations for consistent condom use and need establish coordination with police sector for condom promotion and to avoid arrest. The unmet risk areas of the other townships of the state/division should be looked for at local area with all stakeholders including sex workers by situation assessment and the prevention activities to these areas should be intensified. FSW especially old age suggested that they want to attend appropriate vocational and livelihood training in order to quit from sex work.

Section 7: Findings of focus group discussion with MSM

A total of 15 MSM, who are project staff, including MSM who are HIV positive, participated in 2 sessions of focus group discussions between the ages of 20 to 42 years from 2 townships.

Social and economic characteristics of MSM

They said that there are 3 types of MSM in their community such as “apwint” (opened type MSM, feminised MSM), “apone” (closed type MSM) and “thange” (inserted male partner of MSM, most of them are males). MSM can be found in all levels of education and socioeconomic classes and includes all ages. “Apwint” are more seen in lower education and socioeconomic class and “apone” are in high education and higher socioeconomic class. The occupations of apwint are mostly beautician and natkataw (intermediaries between ‘nat’ (spirit) and human beings) and “apone” have a variety of occupation. Among them 3 are married with male partners. They have multiple sex partners including regular partners and casual partners and some MSM engaging in paid sex work. In addition, they also said that there is an increase in paid sex work among MSM due to financial problem.

“One MSM said that each MSM has an average of 10 sexual partners and the age of first exposure to sex for MSM is generally 12-13 years of age and most of their first partner are male”

Condom utilization All the interviewed MSM said they use condom now but not consistently because most of the MSM perceived that condom use is not necessary and also they have limited access to prevention and care services for HIV and STD since their status is still secretive in nature. They know where the condoms are easily available and obtained. They used mostly “apaw” condom with jel (lubricant).

Knowledge and attitude of STD and HIV/AIDS

The MSM interviewed said that they have ample knowledge about HIV and STD but they said that there is limited knowledge about STD and HIV among other MSM especially young MSMs. Although they have no history of STD this year, their MSM friends had STD. They referred them for treatment to NGO clinics as well as government clinics otherwise and some take treatment from drug shops. They all received VCCT and among them 4 are positive and 2 are on ART.

“One MSM said that most of the adolescent MSM have limited knowledge about HIV, STD and sex education because their families and teachers don’t accept that their children are MSM so they don’t like and not allow to be involved in peer education from other MSM”

“MSM from Monywa Township said that they established the MSM organization in his town and it now includes more than 100 members. Among them 30 MSM are HIV positive. Currently 5 HIV positive MSM needs ART but only one is receiving treatment”

Suggestion of MSM on programme

They suggested that there is need to open more drop in centres and clinics for MSM to ensure prevention and care of HIV activities to be expanded. The care and support especially ART programme should be strengthened. Need to ensure the availability of condom and IEC for peer education to MSM especially targeted at younger MSM.

Section 8: Findings of the focus group discussion with youth

A total of 45 youth participated in 6 sessions of focus group discussions which included male and female from urban, suburban and rural areas between the ages of 18 to 24 years from five townships.

Perception on Reproductive Health, Pre-marital sex and Contraception

All youth perceived that socio-culturally, Myanmar youth should not be involved in pre-marital sex. However, all of them think that there are increase numbers of young people engaged in premarital sexual practices in Myanmar. They said that exposure to foreign media where sex act is very casual, peer pressure, encouragement from older friends, use of psychotropic stimulants are some of the factors which urges youth to deviate from long accepted cultural norms and practices. They said young people started to have sex at about the age of 14-19. In urban boys most of their sexual partners are their girl friends; however sex workers are engaged in sub urban and rural youth. For girls, sexual partners are their boyfriends in almost all cases. *Pre- marital sex has become so common that one young man expressed his fear that he might un-knowingly fall in love with a girl who had multiple pre-marital partners.*

All of the young people knew at least 6 methods of contraception which are every day contraceptive pills, condoms, three monthly injections, emergency contraceptive pills, rhythm method, and insertion of intra-uterine devices. 20% was able to elaborate on permanent sterilization procedures, and cutaneous hormonal stickers. 70% of the young people who took part in the FGD said that knowledge on RH and contraception should be available for all young people to prevent unwanted pregnancies and its consequences.

A young lady said that parents, especially mothers need to talk openly to their teenage children about pre-marital sex and its pit falls.

Perception on HIV/AIDS and precipitating factors towards increased vulnerable and risk

All of the youth knew the mode of transmission and methods for prevention of HIV. However they did not know about anti retroviral therapy (ART) thoroughly. Stigma and discrimination against people with HIV have been reduced as compared to before however, it is still there among their community even though they understood about the mode of transmission of HIV.

They receive most of the information about health through printed media, TV and internet but for out-of-school youth, they get the information mostly from their peer groups. Youth in urban area are interested in health knowledge compared to suburban youth; they perceived that health is not

important and is not concerned. However, they accept that they are vulnerable to contract HIV infection.

Urban youth expressed that the reasons for increased vulnerability is not only change in their life style but also to increase access to varieties of media through internet, freely available DVD disc containing promiscuous materials also change in perception of cultural values. Premarital sex have become acceptable especially university students who live in boarding (or) rented houses where social and family controls on youth are reduced as they live away from home. Many youth are unemployed and spend a lot of time playing TV games and chatting through internet. There is more chance to take alcohol and stimulant drugs which could lead to increased in unsafe sexual behaviors. Girls of low socio-economic standing are seduced to perform sexual acts which promise luxuries of expensive clothes, cosmetics and even school fees. In addition, the easy availability of alcohol and drugs, accessibility of day and night clubs all contribute towards youth to engage in risk behaviors associated with pre-marital sex and HIV transmission.

Whereas the dialogue with the youth from the suburban area revealed that, the causes for increased vulnerability are mainly due to peer pressure and influence from elder to make risky behavior, most of the out of school youth at suburban area didn't know about HIV and STD correctly and completely, low level of education and life skills, limited accessibility of health services and commodities and trafficking due to socioeconomic difficulties. They also mentioned that there is increased sex work among young aged women in sub urban (slum) area in order to solve the economic problem in the families.

One youth from sub urban area said "There are increased sex workers of younger age in suburban area (like HlaingTharyar). He mentioned that one of the sex workers is only 14 years and sex work becomes norm in some communities in suburban (slum) area because of prevailing economic problems".

Youth from rural areas said that most of the rural youth are mobile. They move to urban areas seeking employment opportunities or other countries (mostly Thai, China, and Malaysia) in order to earn more money. Most of the mobile youth have limited knowledge about reproductive health as well as HIV/AIDS. They are generally less educated. As a result they can engage in risk behavior and contract HIV easily.

One youth from rural area said that he recently came back to Mon State after working in Malaysia for five years without precise knowledge on reproductive health and HIV. His friends working with him are in similar situation like him. After his return, he wanted to be involved in youth programmes in his township in order to obtain the knowledge about reproductive health and HIV and also share with others .Now he has already attended the trainings and serve as a peer educator and he would like to go back to Malaysia and work and share his knowledge so that Myanmar youth working in foreign countries will know how to protect themselves from HIV & STI .

In large cities like Yangon, youth usually take stimulant tablets than heroin since opium is hard to get there. They take a variety of stimulants such as amphetamine tablets, and mixed with cough remedies with raw opium. There are fewer numbers of intravenous drug users in Yangon compared to North and East part of Myanmar where the drugs are easily available.

There is increase in drinking alcohol, beer, in large cities as it pushes young people to engage in unsafe sex practices, especially during Thingyan festival and expose them to engage in high risk behaviors.

One youth from suburban area said “Youth of today are now taking more alcohol than before because there are a lot of beer shops all over the country. There are different qualities of alcohol depending on the price which exposes poorer youth to sub-quality alcohol rendering them prone to alcohol related diseases”.

Knowledge and treatment seeking behavior for STD

Young people have incomplete knowledge about sexually transmitted diseases although they have knowledge about HIV/AIDS. Also most of the STI treatment was taken from drug shops and treated by themselves and they have no knowledge of the best places that provide STI care and support.

Condom utilization

All interviewed youth, women and men, have adequate knowledge about condoms, the reason for using condoms, the places and people that can provide condoms. They said most young people are ashamed to ask for condoms at public sector, free supply sites and condom outlets. They also cannot afford and/or afraid to buy at private sector. However, they can get the condom easily through peer educators. Most of the parents and communities have improved understanding about the benefits of the use of condom compared to before although open communication about sexuality between parents and their children is still limited.

VCCT and attitude

About 75% of interviewed youth have limited knowledge about VCCT but the remaining 25% knew the places where VCCT can provide through media and journals as well as through friends from INGOs (PSI, MSI, and AFXB). Among them, 25% received VCCT at PSI through AFXB youth centre.

Responses to intervention of services and programme

Most of peer youth volunteers were informed about youth programs and youth centers from their friends and HIV knowledge fair. They are interested in attending youth trainings because they want to increase the level of their knowledge and share to other friends to avoid risky behavior and contract diseases. In Yangon, some youth volunteers participated in youth activities arranged by their parents. For suburban youth, they want to be involved in youth projects because they like to obtain practical vocational training with the aim of job opportunities and earning money for their families.

Initially, they had difficulties in implementing outreach activities in the community but later people start to understand the objectives of the activities and through much advocacy and their better performance it has become more acceptable.

They have many success stories to change risky behaviors such as abstinence from smoking, drinking, sexual activities and betel chewing and increased involvement in social work. Some youth are now peer educators for youth in their village. They are very committed to their work. They conduct outreach activities providing health education sessions to youth of the village. The community and their families appreciated their activities because many positive changes had been observed in youth

of their community. Increased awareness in health, change in life style and behavior and participation in social work with parents. Besides they become good leaders in the youth community and organize many youth to join the activities.

The constraints for the outreach activities are; working youth can't spare their time at work and becomes difficult to engage as group in community, sometimes they cannot answers some questions that peer asked sometimes during peer sessions

Suggestions from youth for youth programme are; need to produce IEC for STI, provide PE program and sessions at universities, monitoring guidelines for Peer educators, recruit more volunteer peer educators to substitute the dropout rates, develop Q&A books based on the collected frequently asked question from the peer youth and community and distribute to peer educators with the purpose of the sharing precise, correct message to the community, need to expand vocational training which is applicable for career for out of school youth who are jobless, more advocate and expand youth centres to participate youth with high vulnerability, provide transport charges or facilities (bicycles or tawlagy) for outreach activities according to work plan of outreach schedule, provide regular training for the recruitment of new peer educators and refresher training to update information about reproductive health and other health related issues, need to provide forum for experience sharing meeting among youth corner of different townships, need to supply IEC and condom continuously and adequately

Gender equity and unexpected pregnancy

All the female respondents felt that both sexes should take responsibility when a girl gets pregnant out of wed-lock in their relationship. *One young lady said "Let koke hnit phet tee hma ah than myi dae" = "It takes two hands to clap and make noise" Thus, both sexes must take responsibility for their actions.*

They also expressed that most of the time girls are often blamed and it is not fair. Boys will often deny and even accuse the girl for having another relationships resulting in pregnancy and try to avoid the girl. In most cases girls will suffer in silence because they are shy and also do not voice complaints to avoid public ridicule on the family.

Most of the young people said both parties should face the consequences and abortion should not be an option as they have heard about septic abortions leading to death of the girl.

Gender Based Violence and Youth

All interviewed youth, male and female, expressed that they abhor any form of GBV. Most of the youth agreed that violence against girl/boy friend's have increased as boys and girls tend to brag in front of friends by hitting or tapping on the head.

Youth expressed that Myanmar men do not normally beat their spouses except when they are under influence of alcohol, when they drink to ease frustration, financial problems and other factors and bent their anger on the women at home, especially if she is too talkative and judgmental on his actions

One young woman said that it is important to be firm about your values and convictions with regards to violent behavior during the period of courtship. Girls need to express their dislike and intolerance about GBV to their boyfriends. She also expressed that young people of both sexes need to be trained about have mutual respect for each other.

With regard to seeking assistance when GBV occurs, all the youth are aware that MWAF is the organization to seek help for legal action against the offender. *One young woman said that she has heard about some religious organizations, churches and nuns having a support system to take care of young girls with unwanted pregnancy. One young man said he had heard about orphanages and training centers for youth who will accept children borne out of wed-lock.*

Some youth said that GBV can be prevented on the part of the girls by being alert and avoid vulnerable situations e.g walking alone after dark in isolated places, dressing decently and avoid exposing too much of yourself to attract attention of the opposite sex. They also said that girls from low socio-economic status need to work as maids in people's homes and can be sexually exploited.

Section 9: Findings of focus group discussion with pregnant mother

A total of 39 pregnant women and 12 postnatal mothers participated in 6 sessions of focus group discussions and 5 sessions of in depth interview which included HIV positive pregnant women and postnatal mothers between the ages of 18 to 33 years from 8 townships (both township with PMCT and township without PMCT) However, there was no chance to meet the expectant fathers during our field trips.

Perception on HIV/AIDS, STD, condom utilization and treatment seeking behavior

Although all pregnant women & postnatal mothers knew the mode and methods of prevention of HIV, 60% of women have misconception about HIV and AIDS. Among them, 40% pregnant women have positive attitude to PLHIV. Only 20% of pregnant women have awareness on the signs and symptoms of STD and where they can seek the treatment of STD. Besides, there was no routine VDRL test at AN care even in urban area although most of the BHS have received syndromic management on STD training. All interviewed pregnant and postnatal women except one didn't have history of STD.

“One pregnant woman said that she had history of genital discharge for 2- 3 times during this pregnancy and took medicines from drug shop but she didn't complain her symptoms to health care providers during AN care and no tests have been done yet. Her husband is mobile sale man”

Only 50% of interviewed pregnant mother have seen a condom and knew the main reasons why they use condom and where they can get condom. They all used pills and injection depo for contraception. Pregnant mothers from townships without PMCT said that HIV and STD topic was not included generally in health education sessions as well as no condom demonstration at AN care. Almost all of the interviewed women have no history of condom used as well as they didn't know how to use condom properly.

“20 years old HIV positive mother from one township said that she didn't use condom even though she thought her husband had sex with sex workers outside marriage. She knew her HIV status when she was pregnant. She took ARV prophylaxis for PMCT. Now her child is 2 years old and he is HIV negative”

Awareness on prevention of HIV from mother to child and VCCT and care & support

All interviewed pregnant women from townships with PMCT programme knew that HIV infected from mother to child and how to prevent from mother to child transmission of HIV whereas nearly all of the interviewed pregnant mothers from townships without PMCT didn't know about how to prevent from mother to child transmission of HIV. All interviewed pregnant women from PMCT

townships have received VCCT. All of the interviewed HIV positive women (5 in number) knew their HIV status when they were pregnant and now they are on ARV prophylaxis for PMCT. 3 HIV positive women have already delivered. Among them, one baby is HIV negative and the HIV status of the remaining two babies has not been known yet because the babies are less than 9 months old. Although only one of HIV positive mothers is on ART, the remaining obtains OI prophylaxis and other care and support from AIDS/STD teams and NGOs (International and local). The occupations of husbands of HIV positive women are mobile in nature.

Male participation

Only 25% of the husbands of interviewed women came to AN care with their wives because; most of their husbands are workers and they could not spare time during working hours, some think that the pregnancy is not concerned with them, some husbands are ashamed to come with their wives to AN care. However they said that their husbands provided support during their delivery of child at home. In addition, all husbands have not done VCCT yet even though pregnant women explain about PMCT and VCCT to their husbands apart from husbands of the HIV positive women.

Disclosure of HIV status

All the interviewed HIV positive women except one first told their husbands about their HIV status. Only one told first to sisters, although in some countries women are unable to disclose their HIV status to their sexual partners because of fear of being blamed, abandoned or abused for their HIV infection

Future plan and continuum of care for affected family and needs for the family of the HIV positive women

Although they have no future plan for their family and their children, they worried about their children's future and try hard to get saved money for their children. They required medical care for opportunistic infection, ART as well as food and nutrition. Some faced the financial problem especially husbands are not able to do work or lost of job due to disease so they are in very great difficult for survival and received assistance from their parents or relatives. Some NGOs supported them by appointing as peer educator and provided peridium as well as supported the affected families with drugs and food. In addition, they also can't afford to buy ART if there is no ART programme in their township or limitation of ART treatment. Some got the support from INGOs and they said they need not only health care but also their daily needs of food, living and social needs.

Acceptance in the affected families and the community

The HIV positive women who live in extended family receive sympathy and support within families. They said that community acceptance and support is not being likely if they knew their HIV status. They kept it strictly confidential to formalize their relationship with the community and women with HIV are often stigmatized and would be isolated at home.

“One HIV positive mother said that she knew of her HIV positive status when she was pregnant. She also said that lived alone in her house and would not go outside of the home because she is afraid of discrimination from her friends and others if they know her HIV status”

Table (1): HIV prevalence among sentinel populations – HSS 2008

Population Group	No. of Sites	No. Examined	No. Positive	% Sero-positive%	Range			95%CI
					Median	Minimum	Maximum	
Male STI patients	33	4,469	242	5.42	4	0	22.3	4.77-6.12
FSWs	5	838	154	18.38	18.0	15.5	23.58	15.81-21.17
IDUs	6	891	334	37.5	37.22	12.5	54	34.3-40.76
MSM	2	400	115	28.8	29	25	33	24.36-33.46
Pregnant women	32	12,376	156	1.26	1	0	6	1.07-1.47
Blood (units) donors	2	10,629	51	0.48	0.4	0	1	0.36-.63
New military recruits	2	800	20	2.50	2.5	2.5	2.5	15.34-38.35
New TB patients	10	1,496	166	11.1	8.67	4.67	28.77	9.55-12.8
Total		31,926	1,238					

Source: Report of HSS 2008, National AIDS Programme

Table (2): Progress towards Universal Access to prevention and care services in Myanmar

Strategic Direction 1: Reduction HIV related risk, vulnerability and impact among sex workers and their clients				
Impact/outcome Targets	Size estimate	2006	2007	2008
% of sex workers that are HIV infected	60,000	33.5%	15.6%	18.4%
% of sex workers that have an STI (syphilis) (25% in 2005)				5.5%
% of sex workers that report the use of condom with most recent client (62% in 2003)				95%
% of clients of sex workers that are HIV infected		4.9%	5.3%	5.42%
Output/coverage targets				
Sex workers reached by package of BCC prevention and STI prevention/treatment		26000-36000	33512-44648	36390-48860
No of sex workers accessing VCCT			5017	7921
Condom distributed in millions		49	27.9	34

Strategic Direction 2: Reduction HIV related risk, vulnerability and impact among MSM				
Impact/Outcome Targets	Size estimate	2006	2007	2008
% of MSM that are HIV infected	240,000		29.3%	28.7%
% of MSM that have a STI (syphilis)			7%	14.1%
Output/coverage targets				
MSM reached by package of BCC prevention and STI prevention/treatment		28541	31546-39180	32890-38286
Number of MSM accessing VCCT		2931	13180	4097

Strategic Direction 3: Reduction HIV related risk, vulnerability and impact among IDU				
Impact/Outcome Targets	Size estimate	2006	2007	2008
% of IDU that are HIV infected	75000	42.5%	29.2%	37.5%
% of IDU that avoid sharing injecting equipment in last month				81%
% of condom use by IDU at last sex (paid partner) 34% in 2005				78%
Output/coverage targets				
Drug Users reached by harm reduction programme	2 drug users for 1 IDU			8427
IDU reached by harm reduction programme			21050	8274
IDU accessing VCCT			1151	2256
Needles distributed to IDUs (in million)		1,852,384	2,091,166	3,511,232
Number of IDU on MMT		264	390	580

Strategic Direction 4: Reduction HIV related risk, vulnerability and impact among partners and families of PLH				
Output/Coverage Targets	Size estimate	2006	2007	2008
Number of PLHA involved in self help groups	230,000	2601	8257	13247

Strategic Direction 5: Reduction HIV related risk, vulnerability among institutionalized populations				
Output/Coverage Targets	Size estimate	2006	2007	2008
Prisoners reached by health education	62,300		160	9930

Strategic Direction 6: Reduction HIV related risk, vulnerability among mobile populations				
Output/Coverage Targets	Size estimate	2006	2007	2008
Prisoners reached by health education		420,294	183,380	71,140

Strategic Direction 7: Reduction HIV related risk, vulnerability among uniformed services				
Output/Coverage Targets	Size estimate	2006	2007	2008
Uniformed personnel reached by package of prevention programme			490	2635

Strategic Direction 8: Reduction HIV related risk, vulnerability among young people				
Output/Coverage Targets	Size estimate	2006	2007	2008
% of young people that are HIV infected	10,648,000	1.29%	1.27	1.26%
% of condom use by young people at last paid sex 78.4% in 2003				90%
% of youth who correctly identify the three common ways of preventing HIV transmission 21% in 2003				37.7%
% of youth who reject misconception 27% in 2003				47.5%
% of youth expressing accepting attitudes				34.7%
Output/Coverage targets				
Out of school youth (15-24) reached by prevention programme		137,854	175,936	139,416
In school youth (10-16) reached by life skills programme	2,450,000	900,000	NA	
% of schools with teachers who have been trained in life-skills based HIV education and who taught it during the last academic year	37,124		100%	100%

Strategic Direction 9: Enhancing prevention, care, treatment and support in the workplace				
Output/Coverage Targets	Size estimate	2006	2007	2008
Number of people in workplace reached by package of prevention programme		67,378	61,258	52,849

Strategic Direction 10: Enhancing HIV prevention among men and women of reproductive age				
Output/Coverage Targets	Size estimate	2006	2007	2008
% of men and women of reproductive age infected by HIV	31,865,669		0.67%	0.61% (2009)
Output/coverage Targets				
Men and women of reproductive age reached by prevention programme		109282	738,273	633,114
Men and women of reproductive age receiving HIV test results and post test counseling each year (excluding targeted populations)			64,169	83,996
Numbers of patients treated STI			112,000	93625
Number of people receiving HIV test and post test counseling				
		2006	2007	2008
Adults receiving HIV test and post test counseling (excluding MARPs)		70,948	64,169	83,996
MARP receiving HIV test and post test counseling		6,320	6,827	13,612
Sex worker		3,132	3,727	7,791
MSM		2,122	1,980	4,031

IDU	1,038	960	1,731
TB	13	160	59

Strategic direction 11: Package of care and support with or without ART				
Impact/outcome targets	Size estimate	2006	2007	2008
% of people still alive at 1 year after initiation of ART				93%
Output/coverage targets				
Number of people living with HIV in need receiving ART (including package of support)	75,537	6577	11,193	15,191
Number of people receiving cotrimoxazole as prophylaxis		27,523	43,577	30,344
Number of people receiving CHBC package of support(without ART)		10,650	12,356	23,451

Strategic direction 12: Prevention of Mother to Child transmission of HIV				
Impact/outcome targets	Size estimate	2006	2007	2008
% of infant born to HIV infected mother that are HIV infected	4,600			
Output/coverage targets				
Pregnant women having access to VCCT	1,283,382	182,000	294,992	315,920
% of mother baby pairs receiving a complete course of ARV prophylaxis for PMCT	4600	969	1403	1780
Number of orphans receiving support	1,573,676	10,333	8423	9527
Number of children in need provided with ARV	2,199		690	968

Source: Progress report- 2006, 2007, 2008, National AIDS Programme, Ministry of Health

Table (3): Percent Coverage of Antiretroviral Therapy for adults and children with advanced HIV

Percent coverage	Countries
Less than 25% coverage	Bangladesh, China, Indonesia, Myanmar, Nepal, Pakistan, Sri Lanka
25% to 49% coverage	Malaysia, Philippines, Viet Nam
50% to 75% coverage	Cambodia, Thailand
Greater than 75% coverage	Lao People's Democratic Republic

Source: Report on the global AIDS epidemic, 2008 (Executive Summary)

Table (4): Percent coverage of Antiretroviral for Prevention of Mother to Child Transmission

Percent coverage	Countries
Less than 25% coverage	China, India, Indonesia, Malaysia, Nepal, Pakistan, Viet Nam
25% to 49% coverage	Cambodia , Myanmar
Greater than 75% coverage	Thailand

Source: Report on the global AID epidemic, 2008 (Executive Summary)

Table (5): Assessment of data availability/accessibility by the Data Mission on Strengthening MDG indicators: report for Goals 1, 7 and 8

PRELIMINARY CATEGORIZATION OF MDG INDICATORS FOR GOALS 1, 7 AND 8¹

Goal & Target	Indicators	Data Available			Remark
		Satisfactory	To be strengthened	To be identified	
Goal 1	Eradicate extreme poverty and hunger				
Target 1A	Reduce by half the proportion of people living on less than a dollar a day				
	1.1 Proportion of population below US\$1 (PPP) per day	Y			National poverty line is used (No PPP)
	1.2 Poverty gap ratio	Y			National poverty line is used (No PPP)
	1.3 Share of poorest quintile in national consumption	Y			Assume expenditure equals consumption of the poorest quintile.
Target 1B	Achieve full and productive employment and decent work for all, including women and young people				
	1.4 Growth rate of GDP per person employed			Y	Working age (15-60 yrs) population can be used as proxy for employed population right now. IHLCA 2 will provide employment information. FRHS provides percent of employed population to the total population
	1.5 Employment-to-population ratio			Y	Same as 1.4.
	1.6 Proportion of employed people living below \$1 (PPP) per day			Y	Same as 1.4 for employed people. National poverty line can be used instead of \$1 (PPP) per day.
	1.7 Proportion of own-account and contributing family workers in total employment			Y	IHLCA 2/FRHS will provide the information.
Target 1C:	Halve, between 1990 and 2015, the proportion of people who suffer from hunger				

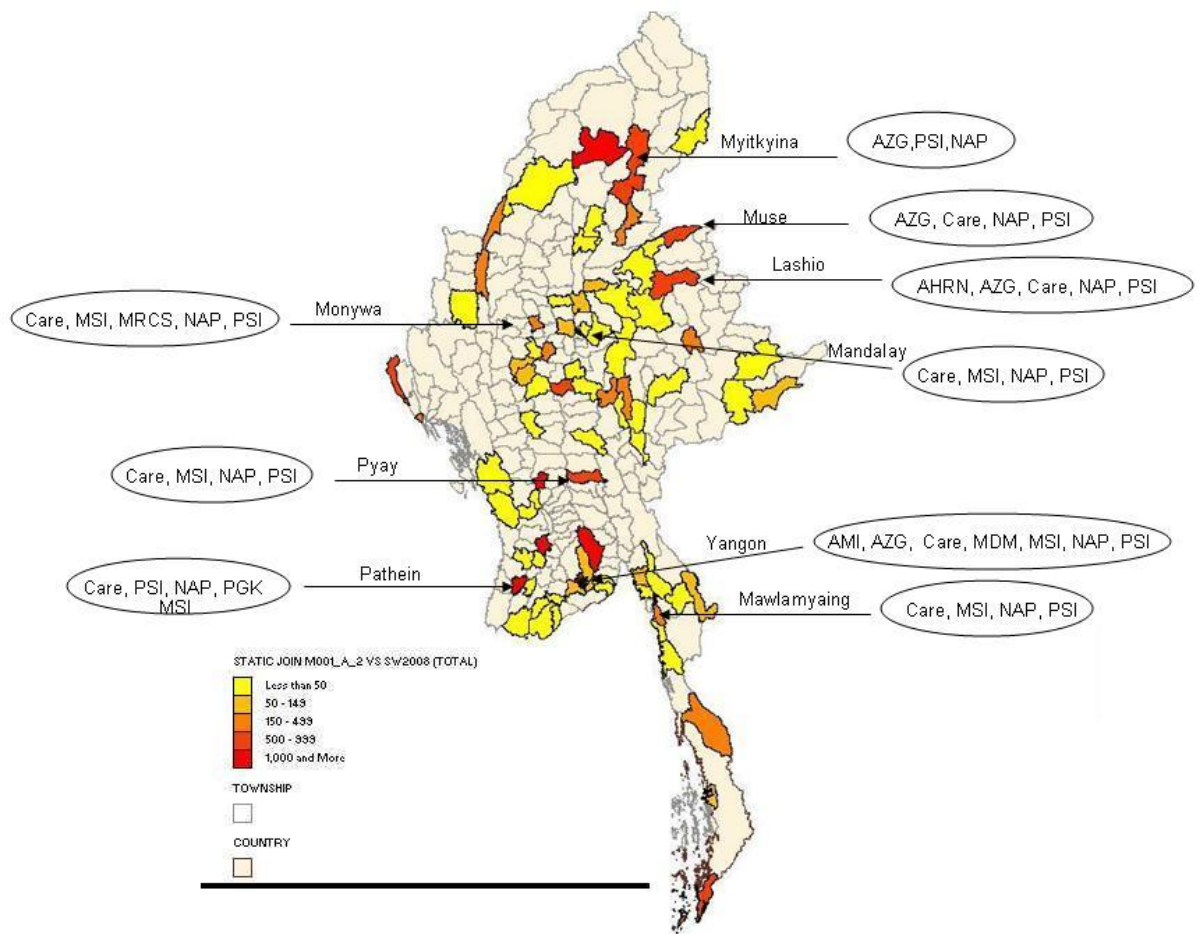
¹ Myanmar Data Mission on Strengthening MDG indicators: Report for Goals 1, 7 and 8.

	1.8 Prevalence of underweight children under-five years of age	Y			Both MICS & IHLCA provide data value.
	1.9 Proportion of population below minimum level of dietary energy consumption	Y			Food poverty headcount is used.
Goal 7	Ensure environmental sustainability				
Target 7A	Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources				
	7.1 Proportion of land area covered by forest	Y			
	7.2 CO2 emissions, total, per capita and per \$1 GDP (PPP)		Y		Varied estimates. Methodologies not known. UNDP to contact NCEA. (No PPP)
	7.3 Consumption of ozone-depleting substances		Y		Varied estimates. Methodologies not known. UNDP to contact NCEA.
Target 7B	Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss				
	7.4 Proportion of fish stocks within safe biological limits			Y	The indicator itself seems to be a bit vague. FAO to contact Fishery Department.
	7.5 Proportion of total water resources used	Y			Need to ask methodology of estimation. FAO to contact MOAI
	7.6 Proportion of terrestrial and marine areas protected	Y			
	7.7 Proportion of species threatened with extinction	Y			Can be calculated from NCEA's 4th National Report to UNCBD 2009
Target 7C	Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation				
	7.8 Proportion of population using an improved drinking water source	Y			FRHS, MICS & IHLCA provide data value.
	Population with access to improved water source				
	7.9 Proportion of population using an improved sanitation facility	Y			FRHS, MICS & IHLCA provide data value.
Target 7D	By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers				

	7.10 Proportion of urban population living in slums			Y	
Goal 8	Develop a global partnership for development				
Target 8A	Develop further an open, rule-based, predictable, non-discriminatory trading and financial system				
	<i>Some of the indicators listed below are monitored separately for the least developed countries (LDCs), Africa, landlocked developing countries and small island developing States.</i>				
	<u>Official development assistance (ODA)</u>				
	Includes a commitment to good governance, development and poverty reduction – both nationally and internationally				
	8.1 Net ODA, total and to the least developed countries, as percentage of OECD/DAC donors' gross national income	Y			Global
	8.2 Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation)	Y			Global
Target 8B	Address the special needs of the least developed countries				
	8.3 Proportion of bilateral official development assistance of OECD/DAC donors that is untied	Y			Global
	8.4 ODA received in landlocked developing countries as a proportion of their gross national incomes	Y			Not applicable for Myanmar.
	Includes: tariff and quota free access for the least developed countries' exports; enhanced programme of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction				
	8.5 ODA received in small island developing States as a proportion of their gross national incomes	Y			Not applicable for Myanmar.
	<u>Market access</u>				
	8.6 Proportion of total developed country imports (by value and excluding arms) from developing countries and least developed countries, admitted free of duty	Y			

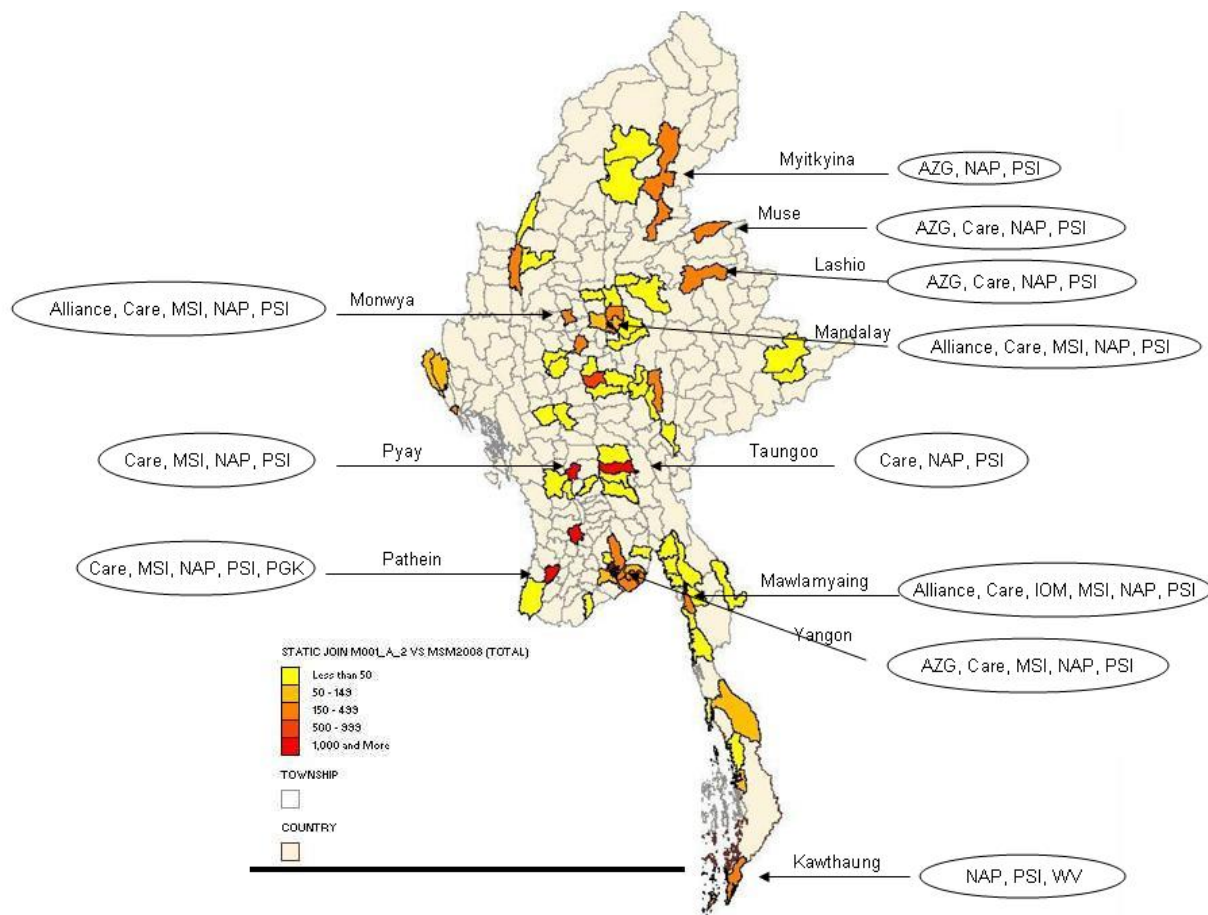
Target 8C	Address the special needs of landlocked developing countries and small island developing States (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly)				
	8.7 Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries	Y			Myanmar is subject to economic sanctions of US, EU, Australia, New Zealand, Canada etc.
	8.8 Agricultural support estimate for OECD countries as a percentage of their gross domestic product	Y			Global
	8.9 Proportion of ODA provided to help build trade capacity	Y			Myanmar is subject to economic sanctions of US, EU, Australia, New Zealand, Canada etc.
Target 8.D:	<u>Debt sustainability</u>				
	Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term				
	8.10 Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative)	Y			Not applicable for Myanmar.
	8.11 Debt relief committed under HIPC and MDRI Initiatives	Y			Not applicable for Myanmar.
	8.12 Debt service as a percentage of exports of goods and services	Y			
Target 8E	In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries				
	8.13 Proportion of population with access to affordable essential drugs on a sustainable basis		Y		
Target 8F	In cooperation with the private sector, make available the benefits of new technologies, especially information and communications				
	8.14 Telephone lines per 100 population	Y			
	8.15 Cellular subscribers per 100 population	Y			Data should be available at MPT.
	8.16 Internet users per 100 population			Y	

Map 5: Distribution of services for sex workers by township



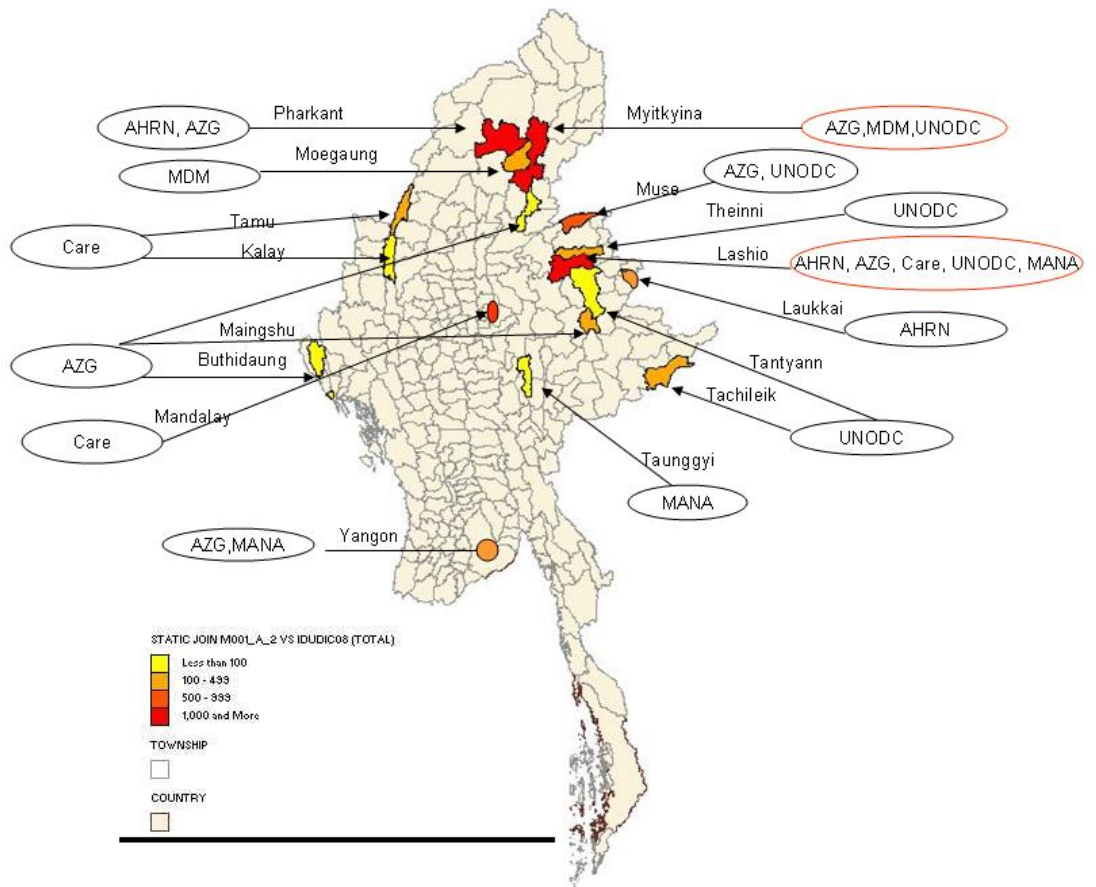
Source: Progress Report, 2008, National AIDS Programme, Ministry of Health

Map 6: Distribution of services for men who have sex with men by township



Source: Progress Report, 2008, National AIDS Programme, Ministry of Health

Map 7: Distribution of services for drug users by township



Source: Progress Report, 2008, National AIDS Programme, Ministry of Health

I. List of visited townships and sites

1. Mon State: Mawlamyaing Township Health Office, MCH centre, Kyaikmayaw, MCH , Peinegone RHC, Tayana, RHC
2. Mandalay Division Mandalay Divisional Health Office, MCH centre
Pyin Oo Lwin, MCH, Pyinsar RHC
3. Shan (South) Taunggyi TMO, MCH
Kakku, sub-centre, Humse, RHC
4. Ayeyarwaddy Division Nyaungdone
Sarmalauk RHC, Hintada township MCH
5. Yangon Division Tone gwa, Kayan
6. Sagaing Division Sagaing, TMO, Myonywar, MCH, Chaung Oo Township Hospital, MCH
Myin mu Township hospital, MCH Myaung
7. Bago (West) Pyay township health office

II. List of persons met

I. Personnel from Ministry of Health

(1) Ministry of Health, Naypyidaw

1. Dr. Win Myint, Director General, DOH
2. Dr. Thein Thein Htay, Deputy Director General (Public Health), DOH
3. Dr. Khin Maung Lwin, Director, CHEB, DOH
4. Dr. Soe Thint, Director, Occupational Health, DOH
5. Dr. Le Le Win, Director, DHP
6. Dr. Nilar Tin, Director (Planning), DOH
7. Dr. Thet Thet Mu, Deputy Director, Health Information Division, DOH
8. Dr. Theingi Myint, Deputy Director, MCH, DOH
9. Dr. Myint Myint Than, Deputy Director, WCHD, DOH
10. Dr. Aye Myat Soe, Assistant Director, NAP, DOH
11. Dr. Theingi Aung, Assistant Director, NAP, DOH

(2) Mon State

1. Dr. Zaw Win, State Health Officer, Mon State
2. Dr. Hla Mya Thwe Eindar, Deputy State Health Officer, Mon State
3. Dr. Khin Maung Twin, Team leader, AIDS/STD team, Mawlamyaing , Mon State
4. Daw Ei Ei Khin, Health Education Officer, Mawlamyaing, Mon State
5. Dr. Hla Hla Oo, TMO, Kyaikmayaw township, Mon State
6. Daw Aye Aye Wai, HA, Peinegone RHC, Mon State

7. Daw Aye Aye Maw, MW, Peinnegone RHC, Mon State
8. Daw Than Soe Maw, PHS II, Peinnegone RHC, Mon State
9. Daw Thein Thein Mon, THN, Kyaikmayaw township, Mon State
10. Dr. Yi Yi Khin, TMO, Mawlamyaing township, Mon State
11. U Min Kan Htun, HA, Tayana RHC, Kyaikmayaw township, Mon State
12. Daw Thein Myint, LHV, Tayana RHC, Kyaikmayaw township, Mon State
13. Daw Mi Tin Hla ,MW, Tayana RHC, Kyaikmayaw township, Mon State
14. Dr. Khin Maung Twin, Team leader, AIDS/STD team, Mawlamyang , Mon State
15. Ma Aye Aye Than, counsellor, AIDS/STD team, Mawlamyaing, Mon State

(3) Mandalay Division

1. Dr. Than Than Myint, Deputy Division Health Officer, Mandalay Division
2. Dr. Kyaw Soe, Division AIDS/STD Officer, AIDS/STD team, Mandalay Division
3. Dr. Thet Aung, TMO, Patheingyi Township, Mandalay Division
4. Dr. Yadana Aung, TMO, Maha Aungmyae Township, Mandalay Division
5. Dr. Daw Tin Nyo, MS, 300 bedded hospital, Pyin Oo Lwin, Mandalay Division
6. Dr. Tin Myo Aung, THO, Pyin Oo Lwin Township, Mandalay Division
7. Dr. Kyaw Hlaing, Team Leader, AIDS/STD team , Pyin Oo Lwin, Mandalay Division
8. Daw Khin Myat Mar, THN, Pyin Oo Lwin Township, Mandalay Division
9. Daw Nwe Nwe Aung, LHV, Pyin Oo Lwin Township, Mandalay Division
10. Daw Khin Ohn Myint, MW, Pyin Oo Lwin Township, Mandalay Division
11. Daw Zin Nwe Oo, MW, Pyin Oo Lwin Township, Mandalay Division
12. Daw Tin Tin, MW, Pyin Oo Lwin Township, Mandalay Division
13. U Soe Myint, Lab technician grade I, AIDS/STD team, Mandalay Division
14. U Min Lwin, Medical Social Officer, 300 bedded hospital, Pyin Oo Lwin, Mandalay Division
15. Yin Yin Soe, TN, AIDS/STD team, Pyin Oo Lwin, Mandalay Division
16. U Kyaw Tint, HA, PyinSa RHC, Pyin Oo Lwin township, Mandalay Division
17. Daw Win May, LHV, PyinSa RHC, Pyin Oo Lwin township, Mandalay Division
18. Daw Ei Ei Nwe, MW, PyinSa RHC, Pyin Oo Lwin township, Mandalay Division

(4) Shan State (South)

1. Dr. Myint Aung, State Health Officer, Shan State (South)
2. Dr. Kyaw Zaya, Deputy State Health Officer, Shan State (South)
3. Dr. Myo Nyunt Oo, TMO, Taunggyi Township, Shan State (South)
4. Dr. Min Yu Aung, Team leader, AIDS/STD team, Taunggyi, Shan State (South)
5. Daw Tin Tin Aye, LHV, Taunggyi Township, Shan State (South)
6. Daw Hlaing Hlaing Tin, HA 1, Taunggyi Township, Shan State (South)
7. Daw Aye Aye Win, MW, Taunggyi Township, Shan State (South)
8. Daw Nan Saing Aung, MW, Taunggyi Township, Shan State (South)
9. Daw Naing Than Hla, MW, Taunggyi Township, Shan State (South)
10. Daw Si Si Maw, MW, Taunggyi Township, Shan State (South)
11. Daw Sandar, MW, Taunggyi Township, Shan State (South)
12. Daw Nan Nwe Aye, MW, Taunggyi Township, Shan State (South)

13. Dr. Thin Thin Lay, Team leader, MCH, Taunggyi Township, Shan State (South)
14. Dr. Ngwe Sandar Lwin, Team leader, MCH, Taunggyi Township, Shan State (South)
15. Daw Aye San, THN, Taunggyi Township, Shan State (South)
16. Daw Nang Cherry Htwe, MW, Subcentre, Kakku village, Taunggyi, Shan State (South)
17. Nang Sein Oo, Counsellor , AIDS/STD team, Taunggyi, Shan State (South)
18. U Sai Aung Tint, Lab Technician, Grade I, AIDS/STD team, Taunggyi, Shan State (South)
19. U Win Min, HA, Humsee RHC, Taunggyi Township, Shan State (South)
20. Ma Htay Htay Myint, LHV, Humsee RHC, Taunggyi Township, Shan State (South)
21. Mee Mee Thar, MW, Humsee RHC, Taunggyi Township, Shan State (South)
22. U Kyaw Win, PHS II, Humsee RHC, Taunggyi Township, Shan State (South)

(5) Ayeyawaddy Division

1. Dr. Win Lwin, TMO, Nyaung Done Township, Ayeyawaddy Division
2. Dr. Thein Myint, THO, Hinthada Township, Ayeyawaddy Division
3. Dr. Aye Aye Nyunt, Team leader, AIDS/STD team, Hinthada Township, Ayeyawaddy Division
4. Daw Thein Nyun, THN, Nyaung Done Township, Ayeyawaddy Division
5. U Soe Naing, HA, Nyaung Done Township, Ayeyawaddy Division
6. Daw Tin Tin Aye, LHV, Nyaung Done Township, Ayeyawaddy Division
7. Daw Than Than Win, MW, Nyaung Done Township, Ayeyawaddy Division
8. Daw Kyi Win, MW, Nyaung Done Township, Ayeyawaddy Division
9. Daw Hnin Si, MW, Nyaung Done Township, Ayeyawaddy Division
10. U Than Htay, HA , Samalauk RHC, Nyaung Done Township, Ayeyawaddy Division
11. Eight Community Support group members, Samalauk Village, Nyaung Done Township, Ayeyawaddy Division
12. Daw Khin Khin Win, THN, Hinthada Township, Ayeyawaddy Division
13. Daw Yi Yi Myint, THA, Hinthada Township, Ayeyawaddy Division
14. U Thein Zaw Oo, HA, Neikpan RHC, Hinthada Township, Ayeyawaddy Division
15. Daw Thidar Lwin, LHV, Neikpan RHC, Hinthada Township, Ayeyawaddy Division
16. Daw Zin Mar Aye, MW, Neikpan RHC, Hinthada Township, Ayeyawaddy Division
17. Daw Khin Khin Win, MW, Neikpan RHC, Hinthada Township, Ayeyawaddy Division
18. Daw San Yin Mon, MW, Neikpan RHC, Hinthada Township, Ayeyawaddy Division

(6) Sagaing Division

1. Dr. Mi Mi Khin, Deputy Division Health Officer, Sagaing Division
2. Dr. Mon Yi Kyaw, MO, MCH, Sagaing Township, Sagaing Division
3. Dr. Cho Cho Lwin, MO, School Health, Sagaing Township, Sagaing Division
4. Dr. Nyunt Sein, Urban Health Officer, Urban Health Centre, Monywa Township, Sagaing Division
5. Dr. Shwe Zin Nwe, MO, Urban Health Centre, Monywa Township, Sagaing Division
6. Dr. Lei Nyo Lwin, TMO, Chaung Oo Township, Sagaing Division
7. Dr. Tin Hla, TMO, Myaung Township, Sagaing Division

8. Dr. Myakyaemon, Team leader, AIDS/STD team, Monywa Township, Sagaing Division Daw Naing Naing Wai, LHV, MCH, Sagaing Township, Sagaing Division
9. Daw Thin Thin Aung, MW, MCH, Sagaing Township, Sagaing Division
10. Daw Hla Kyi, MW, MCH, Sagaing Township, Sagaing Division
11. Daw San San Oo, MW, MCH, Sagaing Township, Sagaing Division
12. Daw Nwe Ni Ohn, MW, MCH, Sagaing Township, Sagaing Division
13. U Myint Paing, PHS I, MCH, Sagaing Township, Sagaing Division
14. Daw Tin Tin Htay, LHV, Urban Health Centre, Monywa Township, Sagaing Division
15. Daw San Hlaing, LHV, Urban Health Centre, Monywa Township, Sagaing Division
16. Daw Mi Mi Khaing, MW, Urban Health Centre, Monywa Township, Sagaing Division
17. Daw Myint Myint Kyi, MW, Urban Health Centre, Monywa Township, Sagaing Division
18. Daw Khin Thein Nyunt, MW, Urban Health Centre, Monywa Township, Sagaing Division
19. Daw Nyo Nyo Thein, MW, Urban Health Centre, Monywa Township, Sagaing Division
20. U Hmat Kyee, HA, Alone RHC, Monywa Township, Sagaing Division
21. Daw Nyunt Nyunt Htay, HA, Alone RHC, Monywa Township, Sagaing Division
22. Daw Tin Tin Aye, LHV, Alone RHC, Monywa Township, Sagaing Division
23. Daw Myint Myint Maw, MW, Alone RHC, Monywa Township, Sagaing Division
24. Daw Kyaw Kay Khaing, Student MW, Alone RHC, Monywa Township, Sagaing Division
25. Daw Phu Phu Than Tun, Student MW, Alone RHC, Monywa Township, Sagaing Division
26. Daw Khin Hnin New, Student MW, Alone RHC, Monywa Township, Sagaing Division
27. Daw Zar Zar Win, Student MW, Alone RHC, Monywa Township, Sagaing Division
28. Daw Zar Zar Win, Student MW, Alone RHC, Monywa Township, Sagaing Division
29. Daw San May, HA I, MCH, Chaung Oo Township, Sagaing Division
30. Daw Khin Myo Thant, LHV, MCH, Chaung Oo Township, Sagaing Division
31. Daw Kyu Kyu Thin, MW, MCH, Chaung Oo Township, Sagaing Division
32. Daw Kyu Tin Sein, MW, MCH, Chaung Oo Township, Sagaing Division
33. Daw Than Than Nwe, MW, MCH, Chaung Oo Township, Sagaing Division
34. Daw Moe San, LHV, MCH, Chaung Oo Township, Sagaing Division
35. Daw Khin Mi, MW, MCH, Chaung Oo Township, Sagaing Division
36. Dr. Myo Thant, TMO, Myin Mu Township, Sagaing Division
37. U Win Aung, HA, Myin Mu Township, Sagaing Division
38. Daw Ahmar Myint, THN, Myin Mu Township, Sagaing Division
39. Daw Baby, MW, Myin Mu Township, Sagaing Division
40. Daw Win Mar, MW, Myin Mu Township, Sagaing Division
41. Daw Win Win Maw, MW, Myin Mu Township, Sagaing Division
42. Daw Aye Moe Htwe, MW, Myin Mu Township, Sagaing Division
43. Daw Naw Julia Win, MW, Myin Mu Township, Sagaing Division
44. Daw Khin Tint, THN, Myaung Township, Sagaing Division
45. Daw Aye Aye Mar, MW, MCH, Myaung Township, Sagaing Division
46. Daw Hla Thein, MW, MCH, Myaung Township, Sagaing Division
47. Daw Htar Sein, MW, MCH, Myaung Township, Sagaing Division
48. Daw Htar Htar San, MW, MCH, Myaung Township, Sagaing Division
49. Daw Thandar Hlaing, MW, MCH, Myaung Township, Sagaing Division

50. Daw Yin Khaing Oo, MW, MCH, Myaung Township, Sagaing Division

(7) Yangon Division

1. Professor Soe Oo Maung, Professor/ Head, Radiotherapy Department, Yangon General Hospital
2. Dr. Nyi Soe, TMO, ThoneGwa Township, Yangon Division
3. Dr. Myint Soe, TMO, Khayan Township, Yangon Division
4. U Thint Swe, HA I, Thone Gwa Township, Yangon Division
5. Daw Khin Win Mar, LHV, Thone Gwa Township, Yangon Division
6. Daw Khin Thidar, MW, Thone Gwa Township, Yangon Division
7. Daw Khin May Nu, Thone Gwa Township, Yangon Division
8. Daw Khin Toe Win, HA I, Khayan Township, Yangon Division
9. Daw Khin Swe Win, MW, Thone Gwa Township, Yangon Division
10. Daw Ohn Mar Win, HA, Khayan Township, Yangon Division
11. Daw San San Win, LHV, Khayan Township, Yangon Division

(8) Bago (West)

1. Dr. Myint Thein Tun, TMO, Pauk Khaung Township, Bago Division (West)

(9) Kachin State

1. U Kyi Win, THA, Bamaw Township, Kachin Township

(10) Shan State (East)

1. Dr. Than Htet Oo, TMO, Thachilieik, Shan State (East)

II. Ministry of Immigration and Population

1. Daw Soe Soe Aung, Director, Department of Population
2. Dr. Nyi Nyi, Deputy Director, Department of Population

III. Department of Social Welfare

1. U Aung Tun Khaing, Deputy Director General, Department of Social Welfare
2. U Myint Thein, Director, Department of Social Welfare

IV. Ministry of National Planning and Economic Development

1. U Tun Tun Naing, Director General, Central Statistical Organization
2. U Tun Hlaing, Deputy Director, Central Statistical Organization
3. Daw Malar Aung, Director, Central Statistical Organization

V. UN agencies

(1) WHO

1. Prof. San San Myint, National Consultant (RH/CHD/ENC)
2. Dr. Franco Debala, Essential Newborn Care Program

(2) UNICEF

1. Ms. Juanita Vasquez, Deputy Representative, United Nations Children's Fund
2. Professor Osamu Kunii, Chief: Health and Nutrition
3. Dr. Siddarth Nirupam, Child Survival Specialist
4. Dr. Yin New Aung, Health Officer (Child Survival)

(3) UNIAP

1. Daw Ohnmar Ei Ei Chaw, National Project Coordinator, UNIAP

VI. National NGOs

1. Prof. Kyaw Myint Naing, President, MMA
2. Dr. Myint Zaw, Project coordinator, MMA
3. Dr. Khine Soe Win, Youth Program Officer, MMA
4. Dr. Aye Aye Than, Project officer, PMCT, MMA
5. Dr. Phone Mu Hlaing, Project office, RH, MMA
6. Ma Su Su Hlaing, Finance assistant, Youth Program, MMA
7. Dr. Hla Pe, Vice President, MRCS
8. Dr. Saw Ni Tun, Project Director, MRCS
9. Daw Ei Hlaing Htet, Project officer, Youth programme, MRCS
10. Dr. Daw Myint Kyi, Former President, MWAF
11. Dr. Thet Thet Zin, President, MWAF
12. Dr. Khin Htar May, Joint Secretary, MWAF
13. Dr. Khin Mar Htun, Secretary, MWAF
14. Daw Nilar Thaw, President, MMCWA
15. Dr. Wai Wai Thar, Vice President, MMCWA
16. Dr. May Marlar, Joint Secretary, MMCWA
17. EC members of MMCWA
18. Dr. Wai Myint, Project officer, MMCWA
19. Dr. Maung Maung Lwin, Program Director, MANA
20. Dr. Theingi Hlaing, Trainer, MANA
21. Dr. Ohnmar, Trainer, MANA
22. Dr. Tin Aye Kyi, Project manager, DIC, MANA, Mandalay
23. Dr. Sai Aung Kyaw, Project officer, DIC, MANA, Taunggyi
24. Nang Hla Win, Nurse, DIC, MANA, Taunggyi
25. Nang San Nyunt, Counselor, DIC, MANA, Taunggyi

VII. INGOs

1. Mr. Ryoichi Suzuki, Country Representative , JOICEP
2. Dr. Aye Aye Thein, Project officer , JOICEP
3. Dr. Nay Min Tun, Project assistant, Male Involvement, JOICEP
4. U San Htun, Project Assistant, BCC, JOICEP
5. Dr. Ni Ni, Program Director, Save the children
6. Dr. Min Min Thein, Project manager, Save the children,
7. Dr. Tin Moe Moe Win, Project officer, Save the children, Mawlamyaing
8. Daw Khin Win Nwe, Project accountant, Save the children
9. Daw Kathy Shein, Director, AFXB
10. Daw Win Win Mya, Youth coordinator ,AFXB, Yangon
11. Dr. Win Win Khine , Project manager, AFXB, Mawlamyaing
12. Daw War War Nwe, Social Mobilizer, AFXB, Mawlamyaing
13. Naw Taw Taw, Social Mobilizer, AFXB, Mawlamyaing
14. Dr. Moe Moe Aung, Sr. Program Manager, MSI
15. Dr. Myo YarZar, Project officer, Youth Project, MSI
16. Dr. Thiha, In charge of Youth Centre, Mawlamyaing
17. Mr. Philippe Hamel, Country Director, AMI
18. Dr. Nyo Nyo Min, Deputy Country Director,PSI
19. Jayne Rowan, Technical advisor, social franchising, PSI
20. Than Naing Oo, Program Officer, DIC, TOP, PSI, Mandalay
21. Dr. Thwe Hinin Zin, Clinic doctor, Drop in centre , TOP, PSI, Mandalay
22. Dr. San Min Tun, Clinic doctor, DIC, TOP, PSI, Mandalay
23. Myo Khin Naing, Site supervisor, DIC, TOP, PSI, Taunggyi
24. Soe Kyaw Aung, community worker, DIC, TOP, PSI, Taunggyi
25. Elodie Andrault , Deputy Head of mission, AZG (Medecins Sans Frontieres- Holland)
26. Dr. Maria S. Guevara, Medical coordinator, AZG (Medecins Sans Frontieres- Holland)
27. Dr.Khin Nyein Chan, Deputy Medical Coordinator, AZG (Medecins Sans Frontieres- Holland)
28. Daw Than Than, Project Associate, Asian Disaster Preparedness Centre
29. Mr. Sudhir, Project Officer, ADPC
30. Mr. Khauns Iwan, Project Co-ordinator, ADPC
31. Mr. Loy, Deputy Executive Director, ADPC, Bangkok

VIII. MTR team (APRO)

1. Dr. Saramma Thomas Mathai, Maternal Health Adviser, APRO, UNFPA
2. Mr.Rabbi Royan, Population and Development Adviser, APRO, UNFPA
3. Dr. Chaiyos Kunanusort, HIV/AIDS Adviser, APRO,UNFPA
4. Ms.Nami Takashi, Programme Specialist, APRO, UNFPA

IX. Beneficiaries and clients

1. 45 youth in 5 townships (Yangon, Shwe Pyi Thar, Kyeikmayaw, Paung, Nyaung Done)
2. 27 FSW including 7 HIV positive FSW in 5 townships (Mawlamyaing, Mandalay, Taunggyi, Hinthada, Monywa)
3. 15 MSM including 4 HIV positive MSM in 2 townships (Mandalay and Monywa)
4. 51 pregnant women including 2 HIV positive pregnant women and 43 PN mother including 3 HIV positive mother in 8 townships (Kyeikmayaw, Taunggyi, Myinmu, Chaung Oo, Monywa, Myaung, Kayan, Thonegwa)

* Self administered questionnaire

1. Dr. Nilar Tin Director(Planning), DOH
2. Dr. Theingi Myint, DD(MCH), DOH

ANNEX 7 :

List of Participants for Dissemination Workshop on Draft Report of Situation Analysis

24-March-2010, Myat Taw Win Hotel, Nay Pyi Taw

1	H.E Prof. Dr. Mya Oo	Deputy Minister	Ministry of Health
2	U Soe Kyi	Director General	Department of Social Welfare
3	U Maung Maung Than	Director General	Department of Immigration and National Registration
4	Daw Lai Lai Thein	Director General	Department of Planning
5	Dr. Thein Thein Htay	Deputy Director General	Department of Health
6	Dr. Phone Myint	Deputy Director General	Department of Health Planning
7	Dr. Tin Tin Lay	Deputy Director General	Department of Medical Science
8	Dr. Yi Yi Myint	Deputy Director General	Department of Medical Research (Central Myanmar)
9	U Aung Tun Khaing	Deputy Director General	Department of Social Welfare
10	Dr. San Shwe	Director	Department of Medical Research (Lower Myanmar)
11	Dr. Le Le Win	Director	Department of Health Planning, MoH
12	Dr. Khin Maung Lwin	Director	Central Health Education Bureau, MoH
13	Dr. Tin Win Kyaw	Director	Department of Health
14	Dr. Win Maung	Director	Department of Health
15	Dr. Nilar Tin	Director	Department of Health
16	Daw Malar Aung	Director	Central Statistical Organization
17	Daw Than Than Lin	Director	Foreign Economic Relations Department
18	U Aung Myo Win	Director	Department of Labour
19	U Myint Thein	Director	Department of Social Welfare
20	U Aung Htay Win	Director	Department of Labour
21	U Sein Tun Linn	Director	Forest Planning & Statistics Department
22	Dr. Theingi Myint	Deputy Director (MCH)	Department of Health
23	Dr. Myint Myint Than	Deputy Director (WCHD)	Department of Health
24	Dr. Hla Myat Thwe Einda	Deputy Director (BHS)	Department of Health
25	Dr. Thet Thet Mu	Deputy Director	Department of Health Planning
26	U Aung Myat Oo	Deputy Director	Foreign Economic Relations Department
27	Dr. Nyi Nyi	Deputy Director	Department of Population
28	U Yan Myo Aung	Deputy Director	General Administration Department
29	Daw Mu Mu Aung	Deputy Director	Department of Education Planning and Training
30	Dr. Maung Maung Than Htaik	Assistant Director (IHD)	Department of Health
31	Dr. Theingi Aung	Assistant Director (NAP)	Department of Health
32	Dr. Aye Myat Soe	Assistant Director (NAP)	Department of Health
32	Daw Htay Htay Hlaing	Assistant Director	Department of Medical Science
33	U Myo Thwin	Assistant Director	Department of Population
34	Dr. San San Oo	Lecturer	University of Public Health, Yangon
35	Daw Khine Khine Soe	Staff Officer	Department of Population
36	Daw May Thu Nyo	Staff Officer	Department of Labour

37	U Min Htut Lwin	Assistant Resident Rep.	UNDP
38	Mr. Bhairaja Panday	Representative	UNHCR
39	Ms. EikoSaito	SPPME section	UNICEF
40	Daw Myat Su Win	National Assistant	UNOCHA
41	Dr Khin Zarli Aye	M&E Officer	UNAIDS
42	Dr. Maung Maung Linn	NPO	WHO
43	Ms. Mariko Tomiyama	Chief of Mission	IOM
44	Dr. May Marlar	Joint Secretary	MMCWA
45	Dr. Lin Lin Khet	Assistant Surgeon	MMCWA
46	U Ye Win	Project Officer	Myanmar Anti-Narcotic Association
47	Dr.Myint Zaw	Programme Coordinator	Myanmar Medical Association
48	Daw Nwe Nwe Aye	Junior Project Officer	Pyi Gyi Khin
49	Dr. Nyo Nyo Min	Deputy Country Director	Population Services International
50	Dr. Aye Mya Thandar	Field Officer	Population Services International
51	Ms. Charlotte O'Sullivan	Country Director	Relief International
52	Dr. Kyaw Hla Myint	Health Adviser	Relief International
53	Dr. Sid Naing	Country Director	Marie Stopes International
54	Dr. Min MinThein	Project Officer	SC in Myanmar
55	Mr. Mitsuji Suzuka	Counselor	Embassy of Japan
56	Dr. Wunna Htay	Programme Officer	AUSAID
57	Mr. Mohamed Abdel Ahad	Representative	UNFPA
58	Pansy Tun Thein	Assistant Representative	UNFPA
59	Dr. Ne Win	Assistant Representative	UNFPA
60	Dr Thwe Thwe Win	National Programme Officer	UNFPA
61	Dr. Daw Khin Aye Myint	National Programme Officer	UNFPA
62	Dr. Win Maung	RH Coordinator	UNFPA
63	Dr. Than Soe	Programme Associate	UNFPA
64	Daw Le Le Mon	Programme Assistant	UNFPA
65	Daw Khine Khine Saw	Programme Assistant	UNFPA
66	Dr. Hla Hla Aye	SA Team Leader	UNFPA
67	Dr. Win Mar	SA Team Member	UNFPA
68	Daw Tin Tin Nyunt	SA Team Member	UNFPA
69	Dr. Mya ThuZar	SA Team Assistant	UNFPA
70	Mr. Rabbi Royan	Technical Advisor	APRO, UNFPA
71	Dr. Saramma Mathai	Regional Coordinator	APRO, UNFPA
72	Ms. Nami Takashi	Programme Specilaist	APRO, UNFPA
73	Dr.Akjemal Magtymova	Medical Officer, MPS,	WHO, SEARO (SA team member)

Glossary of Operational Definitions for Gender

Term	Operational Definitions
Gender	“ Gender ” determines the roles, power and resources for females and males in any culture/society. The term gender refers to the social differences between females and males throughout the life cycle that are learned, and though deeply rooted in every culture, are changeable over time and have wide variations both within and between cultures. ¹
Gender equality	Gender equality is absence of discrimination on the basis of a person’s sex in opportunities and allocation of resources or benefits or in access to services ² . E.g. same pay for same job.
Gender equity	Fairness and justice in distribution of benefits and responsibilities between men and women. This concept recognises that men and women have different needs and roles and power and that these differences should be identified and addressed in a manner that rectifies the imbalance between the sexes. E.g. distribution of rice to villagers by women, packaging rice into smaller bags so that women find it easier to carry.
Gender mainstreaming	Is having the commitment and the strategy to ensure that <i>both women’s and men’s concerns and experiences</i> are integral to the design, implementation, monitoring and evaluation of all legislation, policies and programmes, so that <i>women and men benefit equally and inequality is not perpetuated</i> . This definition accepts that gender inequality exists, manifesting in gender gaps (differences in levels of access to, control over and ability to benefit from social and economic resources). Often, for development results to be achieved and remain sustainable, women need to be specifically targeted in order to address existing gender gaps or prevent the creation of new gaps due to their subordinate position relative to men. This sometimes leads to the misunderstanding that gender refers only to women, or concentrates on women’s roles as mothers. Gender mainstreaming is a fundamental principle for development, social concern rather than women’s issues.
Gender Analysis	Gender analysis examines the relationships between female and male. It examines their roles, their access to and control of resources and the constraints they face relative to each other ³ . A gender analysis should be incorporated in the humanitarian needs assessment and in all sector analysis or situational analysis.
Gender Based Violence	Is an umbrella term for any harmful act that is perpetrated against a person’s will (men, women, boy and girl) , and that is based on socially ascribed (gender) differences or power between males and females. According to CEDAW, GBV is used to distinguish

¹ Inter-Agency Standing Committee, Gender Handbook in Humanitarian Action, Women, Girls, Boys and Men Different Needs-Equal Opportunities

² Gender and Health: Technical Paper, Women’s Health and Development, WHO/FRH/WHD/98.16, 1998

³ Women, girls, boys and men, Different needs-equal opportunities, IASC, Gender Handbook in Humanitarian Action, 2006

violence that targets individuals or groups of individuals on the basis of their gender from other forms of violence. It includes any act which results in physical, sexual, or psychological harm. GBV includes violent acts such as rape, torture, sexual slavery, forced impregnation, murder, domestic violence, trafficking, forced and early marriage.⁴ Harmful traditional practices including female genital mutilation, honour killings, widow inheritance. GBV also defines threats of these acts as a form of violence.

Violence against women

Means any act of GBV that results in or is likely to result in physical, sexual or psychological harm or suffering **to women**, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life⁵.

All forms of VAW when perpetrated against a women's will is GBV.

However, all GBV may not be VAW because it may involve groups of people- men, women boys and girls expressed to show gender power over the other⁶.

Trafficking in persons:

Trafficking means recruitment, transportation, transfer, sale, purchase, lending, hiring, harbouring or receipt of persons after committing any of the following acts for the purpose of exploitation of a person with or without his or her consent;

1. threat, use of force or other form of coercion,
2. abduction,
3. fraud,
4. deception,
5. abuse of power or of position, taking advantage of the vulnerability of the person,
6. giving or receiving of money or benefit to obtain the consent of the person having control over another person⁷.

Thus, trafficking is a form of GBV.⁸

UN Gender Theme Group in Myanmar

Terms of Reference and Activities

The primary purpose of the Gender Theme Group (GTG) is to mainstream gender in the humanitarian and development interventions of the UN in Myanmar, such as poverty alleviation and livelihood development, improving access to health care, information and education, prevention of HIV/AIDS, prevention of trafficking of women and girls, promoting reproductive health and rights, and combating gender based violence.

Objectives of Gender Theme Group

- Help identify and update priority gender issue to be addressed

⁴ Declaration on the Elimination of violence against women, General Assembly, A/RES/48/104, 85th Plenary meeting, 20 December 1993.

⁵ UNESCO, 1999, Article 1 of the UN declaration on Elimination of violence against women (DEVW), UN general assembly resolution 48/104 of 20 December 1993.

⁶ This is an additional expression of SA team's definition of GBV in Myanmar context.

⁷ 2005, The Anti Trafficking in Persons Law, The Union of Myanmar, State Peace and Development Council.

⁸ This is an additional expression of SA team's definition of GBV in Myanmar context.

- Identify mechanisms to foster coordination, collaboration/ joint programming and complementarily among inputs of various UN agencies and with pertinent stakeholders on gender related issue
- Provide inputs to the UN strategic framework in Myanmar
- Consider the cross-cutting aspects of gender and co-ordinate with other UN theme groups and working groups in order to ensure a comprehensive and integrated approach to gender-related issues
- Promote mainstreaming of gender from the human rights perspective into UN supported programmes and interventions as well as into plans and programmes of key organizations/institutions in the country
- Act as an advisory body on gender to all participating organizations and other UN agencies
- Establish a consistent and reliable database on gender-related issues with focus on indicators of MDGs, as well as international conferences and conventions, such as the International Conference on Population and Development (ICPD) Programme of Action, Beijing Platform for Action, and CEDAW.
- Promote networking and information sharing on particular gender-related issues with governmental institutions, other theme groups, civil society and the international community in Myanmar and provide a forum for exchange of ideas, experiences, lessons learned and best practices on gender
- Increase public awareness, advocacy activities and policy dialogue on gender issues
- Strengthen the technical capacity of the staff of UN agencies and other development partners in gender concepts, methodologies, analysis and mainstreaming into various programmes/interventions
- Develop and implement an annual strategic plan of action to achieve the above-cited objectives.

TERMS OF REFERENCE

Situation Analysis of Population Development, Reproductive Health and Gender in Myanmar

I. Background:

The Ministry of Health as well as development partners have been working in coordinated response to the RH needs of the population. The five year strategic plan for RH in Myanmar 2004-2008 was initiated and developed by the Ministry of Health in partnership with WHO, UNFPA and UNICEF. Subsequently the second Strategic Plan for reproductive health (RH) 2009-2013 is in the process of development.

The National AIDS Programme (NAP) leads the national response to HIV in Myanmar in line with the National Strategic Plan for HIV/AIDS 2006-2010, and the national operational plan on HIV/AIDS, 2006-2008 and 2008-2010 with the involvement of stakeholders such as UN agencies, local and international NGOs.

As the Government of Myanmar aims to fulfill its commitment to the Millenium Development goals, UNFPA and other UN agencies, local and international NGOs are working towards attaining those goals, specifically goal 5 on reducing maternal mortality and goal 6 on preventing HIV /AIDS.

UNFPA began supporting population activities in Myanmar on an ad-hoc basis in 1973. The Fund supported the 1973 and 1983 Population and Housing censuses. In the 1990s, UNFPA supported the 1991 Population Changes and Fertility Survey, the 1997 Fertility and RH Survey and the 1999 RH Needs Assessment. In 2001, a second Fertility and RH Survey was conducted making it possible to study trends of various demographic data over the previous decade. In addition, UNFPA provided support to procurement of RH commodities, training of basic health staff and addressing needs for safemotherhood and prevention of sexually transmitted infections (STIs) and HIV/AIDS.

The above-cited activities were implemented through projects. In 2002, UNFPA changed its project by project assistance and adopted a programmatic approach. The first UNFPA Special Programme of Assistance to Myanmar was implemented during the period 2002-2006. Currently, the UNFPA Second Programme of Assistance to Myanmar (2007-2010) is being implemented with a major focus on RH, ARH and HIV/AIDS. The programme covers 138 townships and aims to achieve five outputs:

- Output 1.Improved access to reproductive and maternal health services, including birth spacing, pre and post natal care, delivery services and emergency obstetric care.
- Output 2.Improved availability of disaggregated data for reproductive health programming.
- Output 3. Increased access by young people to reproductive health and HIV-prevention information.
- Output 4.Improved access by vulnerable populations to knowledge about and ways to prevent HIV.
- Output 5.Increased access to comprehensive services to prevent mother to child transmission of HIV.

UNFPA is planning to organise a mid - term review of the second Programme of Assistance 2007-2010 in July 2009. The UNCT has agreed to extend UN Strategic Framework in Myanmar (2005-2009) until the end of 2011. Therefore, UNFPA will request the UNDP/UNFPA Executive Board to extend its current Programme by one year. The third UNFPA Programme of Assistance to Myanmar will be developed for the period of 2012-2015 as an integral component of the UN Strategic Framework which will be developed for the same period. In order to address the RH needs of the

population along with pertinent population and gender issues in a more effective manner, UNFPA would like to undertake a situation analysis by conducting an assessment through a desk review of literature, findings of surveys and studies undertaken on RH and related topics in Myanmar.

II. Situation Analysis

The situation analysis /assessment should focus on :

- Situation analysis and identification of critical needs on population/demographics, RH, HIV/AIDS and gender in the country. The analysis should take into account the needs for emergency preparedness since Myanmar is a disaster prone country.
- Inputs from development partners (Government, UN agencies, INGOs, NGO and donors) in the above areas.
- UNFPA's assistance to address those issues under current programme cycle.
- Challenges, constraints, lessons learned and gaps in addressing those issues.
- Best practices which can be scaled –up or expanded or transferred.
- Existing barriers which need to be overcome through effective programme implementation.
- Recommendations for strategic directions to address population, RH, HIV and gender issues with emphasis on the current programme and for the following next programme cycle (2012-2015)

In this context, Assessment Team will be subcontracted to undertake the following tasks :

1. Undertake desk review of studies, surveys, strategic plans, assessments, etc, (e.g. project documents, technical reports from partners, monitoring reports and other relevant documents) on Population, RH, HIV/AIDS and Gender.
2. Identify the quantitative and qualitative data needs and gaps
3. Identify possible intervention areas as well as strategies for UNFPA in the form of recommendations that should be related to improving existing programmes, innovative interventions to increase utilization of services and improve RH status.
4. Conduct interviews with relevant stakeholders

The situation analysis will provide inputs for the development of the new programme cycle.

III. Assessment Team and Their Tasks

The situation analysis will be carried out by the assessment team which will consist of (1) team leader, (4) team members and (1) team assistant. Their main responsibilities are as follows:

- Team leader has the responsibility of coordinating among team members as well as UNFPA, and is responsible for planning, preparation, organizing, conducting presentation and submitting the situation analysis report to UNFPA in a timely manner.
- Team members, having subject knowledge and working experiences in the selected topics, should be responsible for undertaking desk review of literature, publications, surveys, reports etc. of selected topics to be included in the situation analysis/assessment.

Team leader is responsible for taking the following tasks:

- Provide guidance and leadership to the other member of the assessment team in discharging their duties.

- Ensure coordination and complementarily among the inputs of the members from the assessment team.
- Ensure synergies among the various issues of the analysis to form an integrated, holistic and analytical report
- Liaise with the various institutions to facilitate access to information required for the analysis.
- Ensure quality and timely delivery of assignments of the team.
- Lead/organize the team during presentations of the analysis to UNFPA and other pertinent stakeholders
- Draft on executive summary, general overview, and conclusion and recommendation with inputs by the team members.

Required Qualifications for Team leader:

- Leadership qualities including ability to coach, supervise and guide teams and achieve anticipated results
- At least 10 years of professional experience in the development field , preferably in population and health including RH,HIV/AIDS and gender .Experience in socio-cultural research, epidemiological research, situation analysis and similar undertaking to Programme of Assistance.
- At least Master’s degree in the fields of Public health, Demography/Population Studies or Social Science.
- Familiarity with the work of UNFPA.

Expert on RH and HIV/ AIDS: under the leadership of the team leader and in close collaboration with other two experts, is responsible for the following tasks:

- Carry out and draft the analysis of RH and HIV/AIDS situation in Myanmar covering the various RH components identified in the ICPD and MDGs and covering the area of HIV/AIDS with particular consideration to the development in health system and other national development priorities. The analysis should be based on available research, data and knowledge base and information collected through interviews.
- Provide inputs and recommendations in relation to RH and HIV/AIDS for UNFPA.
- Participate actively with the team leader and other members of the team in presentation and discussions on the content of the analysis.
- Brief along with the team leader and other team members, on the findings of the analysis of RH and HIV situation in the country.
- Incorporate comments from the team leader and other team members in the RH and HIV related issues.
- Work closely with the team leader and other team members to ensure quality report.

Expert on Population and Development: under the leadership of the team leader and in close collaboration with the other experts, is responsible for the following tasks

- Carry out review of population and demographic differentials and trends in the country as well as population policy, strategies and plans, etc. The expert should also address interlinkages between population dynamics, poverty, environment and sustainable development in the context of MDGs.
- Provide inputs and recommendation in relation to population and development.
- Participate actively with the team leader and other member of the team in presentation and discussions on the content of analysis the report.
- Brief along with the team leader and other team member, on the findings of the analysis of population situation in the country.

- Incorporate comments from the team leader and other team members on population related issues.
- Work closely with the team leader and other team members to ensure quality report.

Expert on Gender: under the leadership of the team leader and in close collaboration with other experts, is responsible for the following tasks

- Carry out and draft the analysis of the gender issues in the country Provide inputs in relation to gender issues for situation analysis report on recommendation and conclusion and recommendation for future UNFPA programme.
- Provide inputs in relation to gender issues for situation analysis report.
- Participate actively with the team leader and other member of the team in presentation and discussions on the content of analysis report.
- Brief along with the team leader and other team member, on the findings of the analysis of gender issues in the country.
- Incorporate comments from the team leader and other team members in the gender related issues.
- Work closely with the team leader and other team members to ensure quality report.

Required Qualifications for Team members:

- Ability to analyze and synthesize information and draw conclusions, including conduct of in depth and causality analysis.
- At least 5 years of professional experience in research, situation analysis and assessments in the respective areas of RH,HIV/AIDS ,Gender and their interlinkages with population, Environment and sustainable development.
- At least Master's degree in Medicine, Public Health (preferably RH or HIV/AIDS), Demography, Population Studies or Social Science.
- Experience with the work of UNFPA is valuable.

Team Assistant: Under the over all guidance of the UNFPA Representative and Assistant Representatives, under the supervision of Situation Analysis Team leader, team assistant is responsible for the following tasks:

- Assist Situation Analysis team in undertaking desk review of studies, surveys, strategic plans, assessments etc., (project documents, technical reports from implementing partners, monitoring reports and other relevant documents on Population, RH, HIV/AIDS and Gender
- Assist in identifying the quantitative and qualitative data needs and gaps from implementing partners and gathering the relevant information for developing regular reports to UNFPA representative
- Assist in identifying possible intervention areas as well as strategies for UNFPA in the form of recommendations that should be related to improving existing programmes, innovative interventions to increase utilization of services
- Liaising with various institutions to facilitate access to information required for the analysis
- Assisting in finalizing and development of Situation Analysis Report on Reproductive Health, Population Development and Gender Issues in Myanmar

Required Qualification for Team Assistant:

- A basic university degree in the field of Population, Development, Health or other related field;
- At least 2-3 years of progressive experience in office automation including record-keeping and processing of information
- Experience with the UN organizations is an asset;

- Strong interpersonal and communication skills;
- Demonstrated ability to carry out “multi-tasks”;
- Ability to work efficiently and harmoniously in team;
- Fluency in Myanmar and English languages;
- Strong skills in the use of computers for word processing, spread sheets and power-point presentation

IV. Duration of Situation Analysis exercise: June 2009 to May 2010

V. Suggested Literature Review

- Fertility and RH survey 2007
- Youth and Family Survey 2004
- Other surveys, such as price index, household income and expenditure survey, informal sector survey
- On-going data collection activities (e.g. MICS by UNICEF, Household Living Conditions Survey by UNDP, etc.)
- RH Strategic Plan (2004-2008)
- Draft RH Strategic plan (2009-2013)
- HIV/AIDS Strategic Plan (2006-2010)
- Adolescent Health and Development Strategic Plan (2008-2012)
- RH Assessment in NRS (2006)
- PONREPP Report
- RH Stakeholders Analysis in Myanmar (2006)(WHO)
- RH Needs Assessment (1999)
- Situation Assessment on Women Protection (2008)
- RH Logistic Management Assessment (2002)
- RHMIS Annual Report (2007, 2008)
- Myanmar Dev. Info. data base
- Poverty Profile of Myanmar
- UNFPA’s Special Programme of Assistance to Myanmar (2002-2006) and UNFPA Programme of Assistance to Myanmar (2007-2010) & annual work plans
- Reports on Humanitarian Assistance to areas affected by Cyclone Nargis, such as PONREP, Women’s Protection Assessment 2009
- Mid Term review of UNFPA’s Programme of Assistance (2007-2010) once made available
- UN Strategic Framework (2005-2009)
- MDG Reports 2007 and 2009
- Programme assessment and review: UNFPA special programme of assistance to Myanmar(2002-2005)

VI. Plans for Situation Analysis

- The Team leader and members shall prepare an outline of the situation analysis which will be shared with and approved by UNFPA. The attached is a generic template for the situation analysis
- UNFPA and the Team Leader will prepare a timetable with specific milestones and deliverables for the situation analysis. The timetable will be an integral part of the contract signed with the team leader and team members.

- UNFPA CO team along with UNFPA Asia and Pacific Regional office (APRO) will provide technical and programmatic guidance to the national team throughout the process of situation analysis. Draft chapters and report of situation analysis will be reviewed and commented on by UNFPA CO, APRO and UNFPA Programme Partners from Government, NGOs and INGOs as well as UN agencies and donors.

Question Guide for In depth Interview for RH and Gender

Part 1: Background information: This interview is conducted as part of the Situational Analysis on Reproductive Health, Population Development and Gender issues in Myanmar, conducted by UNFPA. The results analyzed will feed into the next cycle of UNFPA’s program of assistance to Myanmar.

Consent to participate in the interview: Are you willing to participate in this interview?...Yes/No

Interviewer.....Date & Time.....

Interviewee.....

Male/ Female.....Organization.....

Designation.....

1. “Promotion and phased implementation of essential package of RH interventions.”

No.	Question	Response
1.	Are you aware of the “5years National Strategic Plan for RH”? When implementing the phased essential package for RH, was the target to reach all 324 townships of the entire country reached at the end 2008? (<i>93 townships in first year and 58 townships added annually</i>)	
2.	What components of output (1) of UNFPA funded program do you undertake? What are the factors contributed towards successful implementation of RH interventions?	
3.	What were the major constraints encountered?	
4.	What would be the recommended ways to improve MCH care in Myanmar?	

2. “Improved Quality, increased access, and reduced delay in care provision”

Lack of access to care and services , delay in provision of appropriate care for complications and emergencies, provision of poor quality of care especially in emergencies and complications are the three system failure identified that contribute to most maternal deaths”
Improving health workers’ skills was carried out by training of public and private sector providers training.

No.	Questions	Response
5.	How would you ensure quality of RH care for the services provided? Are there standard operational procedures? How frequently do you check on QA? What are the instruments used?	
6.	Do you think that RH care coverage is adequate? What is your suggestion for improvement?	
7.	In establishment of central, regional and township level clinical training centers for training of trainers what were the strengths that contribute to your success in meeting the targets?	
8.	What were the major constraints in establishing these training centres and conducting trainings?	
9.	To improve the training, which change would be best? In what way? Making modules more relevant Emphasis on skills TOT time allocation, Resource allocation or others Monitoring and supervision after training	

3. Improving the Health System

Human Resources for Health are the major corner stone of the health system.

No.	Questions	Response
10.	An assessment for HRH for RH was planned in 2005. What was the major finding?	
11.	Do you think that planning of HRH for RH should be integrated into National Health Workforce strategic planning to strengthen the Health System?	
12.	In strengthening the capacity of state/division and township level management for RH and MCH programs what was the most successful factor that championed this activity?	
13.	What would be the best feasible way to provide supportive supervision to the HRH for RH for better performance?	
14.	Do you think that review and revision of job description of HRH for RH will assist in strengthening the health system?	
15.	What are the hindrances that prevented you from reaching some targets with regard to HRH for RH deployment?	
16.	What would you suggest to overcome the barriers to achieve better results?	

4. Improving the availability of life saving medicines and other RH supplies and equipments.

No.	Questions	Response
17.	Is there a focal person for procurement and supply chain management of RH commodities in CMSD, township and RHC level for efficient distribution of RH commodities according to needs? Does the supply chain of RH commodities deliver goods as planned?	
18.	What were the constraints?	
19.	What are the possible mechanisms to over come these barriers?	
20.	What are the ways of supervision and monitoring the supply chain?	

5. Strengthening Monitoring, Evaluation and supervision.

No.	Questions	Response
21.	Does all the State/Div Health Offices have full time M&E officer for RH programs?	
22.	Do monthly reports on monitoring and supervision of township occur as planned? How will you ensure that supportive supervision is provided by the M&E officer?	
23.	Is there an allotted funds for M&E at township level?	

6. Identify and develop methods of sustainable financing.

No.	Questions	Response
24.	What are the methods identified to ensure sustainable reproductive health financing?	
25.	Which is the most viable and how would you enhance sustainable RH financing?	

7. Strengthening Health Management Information system in relation to RH.

No.	Questions	Response
26.	Does the information collected by the current RHMIS reporting forms conducive for RH program planning? Where do you get RH data for planning?	
27.	Is monthly sharing of information between HMIS office and RH program managers practically feasible?	
28.	What is your suggestion to improve information sharing?	

8. Improved Referral system for RH..

No.	Questions	Response
29.	Is the current referral system at township level functional for the best RH results?	
30.	What are the major constraints in the referral system that hinders efficient RH care?	
31.	How would you recommend to improve the referral system?	

9. Improving family and community practices
(*Strengthening partnerships at local level for RH*)

No.	Questions	Response
32.	We have township health committees in all 324 townships in our nation, with the TMO as secretary and the township GAD as chair. What are the positive community contributions made towards local level partnership with stakeholders in RH?	
33.	Are all the implementing partners aware of and follow the strategic directions of this 5-year RH SP at local and central level?	
34.	How would you ensure that the guidelines for RH care are followed by implementing partners? How often do you have coordinating meetings with IPs?	

10. Improve legal environment for reproductive health

No.	Questions	Response
35.	After analyzing existing laws what are the existing laws that have implications for RH?	
36.	What are the laws with implications for RH that need revision?	
37.	The Law Relating to Private health care Services was enacted in 2007. Which are the areas that need regulation of private sector?	

11. Improving evidence base for decision making

No.	Questions	Response
38.	There were 17 operational research planned for evidence based decision making in RH programs. Were they carried out within the allotted time frame?	
39.	What were the constraints encountered?	
40.	What are the most significant findings of operational research done in RH programs?	
41.	Which findings would you like to recommend for development of policy directions for improvement of RH care in the future?	

12. Gender Issues in RH

No.	Questions	Response
42.	Do you think that gender equality and equity are issues in Reproductive health care and support in Myanmar? How?	
43.	What are the areas where there is gender bias in RH care? Do you feel that families give RH a low priority (for expenditure, for education) because it concerns women only? To what extent are men involved in the RH care of their wives and partners?	
44.	To what extent are men involved in the RH care of their wives and partners?	
45.	What are the difficulties you encountered when	

	conducting gender related activities? How many of your staff have received gender training?	
46.	What is your future plan to promote gender equality and equity in RH care in Myanmar?	
47.	Do you feel there are adequate resources in Myanmar to help organizations seeking to build capacity in gender?	
48.	How common is it for women seeking RH services to present with complications brought on by inadequate nutrition?	

13. Preventing Sexual and Gender Based Violence

No.	Questions	Response
50.	Are women seeking RH services with complications brought on by sexual abuse common? Are there any guidelines and protocols in township hospitals to response SGBV case (including Rape)? What are the services given from the hospital? How does the health sector link with legal protection to survivor by respecting survivor's dignity? Are the guidelines and procedures documented or not?	
51.	Do you think that gender based violence is common in emergency situations in Myanmar? Do you think a coordinated situation analysis is required?	
52.	Do you have any idea to have preventive measures to SGBV? What kinds of community participation are needed to prevent SGBV? What will be culturally appropriate approach?	
53..	Do you think male participation is important to prevent SGBV? How will you sensitize families among the community before the SGBV cases occur?	
54.	Do you think that prevention of SGBV promotes women's and girls' SRH? Why do you think so?	
55	Do you think that womens' law and legal protection is one of the preventive measures of SGBV? What are the legal and regulatory impediments to provision of life saving and psycho-social services to survivors of rape and sexual abuse?	
56	Do you think that gender mainstreaming is important to ensure to prevent SGBV?	

Would you like to give recommendations to reduce MMR in Myanmar?

UNFPA, the United Nations Population Fund, is an international development agency that promotes the right of every woman, man and child to enjoy a life of health and equal opportunity. UNFPA supports countries in using population data for policies and programmes to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV/AIDS, and every girl and woman is treated with dignity and respect.



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