Department of Health

Ministry of Health, Myanmar

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

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

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Public Health Division
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Foreword

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

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

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

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

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

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

Executive Summary

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

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

The specific objectives of the Strategic Plan on RH (2014-2018) are:
1. To reduce rates of maternal, perinatal and neonatal morbidity and mortality by increasing equitable access to maternal and newborn services; improving quality, efficiency and effectiveness of service delivery at all levels; and improving responsiveness to the client needs
2. To reduce unmet need for contraception, unplanned births as well as socio-economic disparities in access to and use of contraception
3. To strengthen management of miscarriage and post-abortion care as an integral component of comprehensive reproductive health services
4. To expand access to RTI/STI/HIV services within RH programmes, reduce transmission of RTI/STI/HIV including prevention of mother to child transmission of syphilis and HIV
5. To expand reproductive health information and services for adolescents and youth
6. To increase services for screening and treatment of cervical cancer, and
7. To support access to investigation and management of the infertile couple.

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

The strategies and key activities for effective and efficient implementation are as follows:
1. Strengthening health systems to enhance the provision of an essential package of RH interventions
2. Increasing access to quality, integrated RH services at all levels of care
3. Engaging the community in promotion and delivery of RH
4. Incorporating gender perspectives in the RH Strategic Plan, and
5. IntegratingRH in humanitarian settings.

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

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

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

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

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List of Acronyms

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

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

1. Introduction

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

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

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

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

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

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

2. Country Context

2.1 Geography and demographic profile

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

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

In 2011-2012 the population of Myanmar was estimated at 60.38 million with a growth rate of 1.01 percent. About 70 percent of the population resides in the rural areas, whereas the remaining are urban dwellers. [1]The population density for the whole country is 89 per square kilometers. Sixty-two percent of the population is between the age of 15-59 years, 0-14 year group comprise 29.2 percent and those 60 years and above form 8.8 percent of the population[2].

In 2009, the Central Statistical Organization estimated that half of the population is between the ages of 15 to 49 years and women of reproductive age constitute approximately 30 percent[3].

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

2.2 Health System Infrastructure

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

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

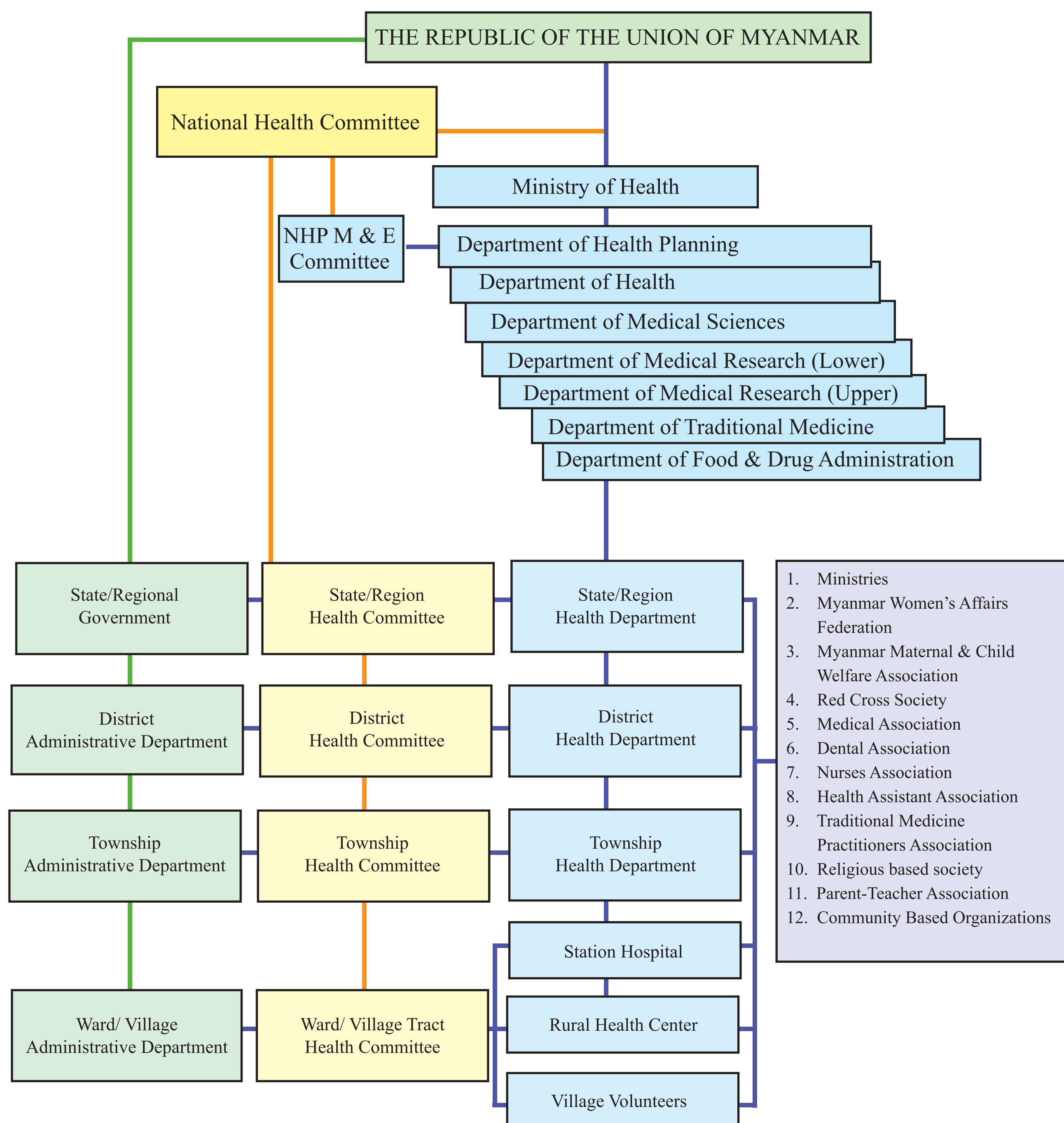
The Township Health System is the backbone of the Myanmar Health System. The Township Health Department provides primary and secondary health care services down to the grassroots level. It usually covers 100,000 to 200,000 population. Under the Township Health Department, there are Urban Health Centres,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

[1]Health in Myanmar 2013, Ministry of Health
[2]Population Department, Ministry of Immigration and Population, 2013
[3]Statistical Yearbook 2009, Central Statistical Organization, Ministry of National Planning and Economic Development

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

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

Figure 2.1 Health System Infrastructure



Source: Health in Myanmar 2013, Ministry of Health

2.3 Health Policies

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

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

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

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

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

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

3. Reproductive Health Situation

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

3.1 Maternal and Newborn Health

Maternal Mortality Ratio

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

Post-partum haemmorhage, eclampsia and abortion-related mortality remain the major causes of maternal deaths in Myanmar (Figure3.1). [4]Three quarters of all maternal deaths occur during delivery and the immediate post-partum period. In addition to these direct causes of maternal mortality, a number of household and community level factors as well as social factors such as the nutrition of girls and women and women's educational levels; underpin the high levels of maternal mortality. Further contributing to maternal mortality are weak infrastructure, poor reach of health services and limited access to information.

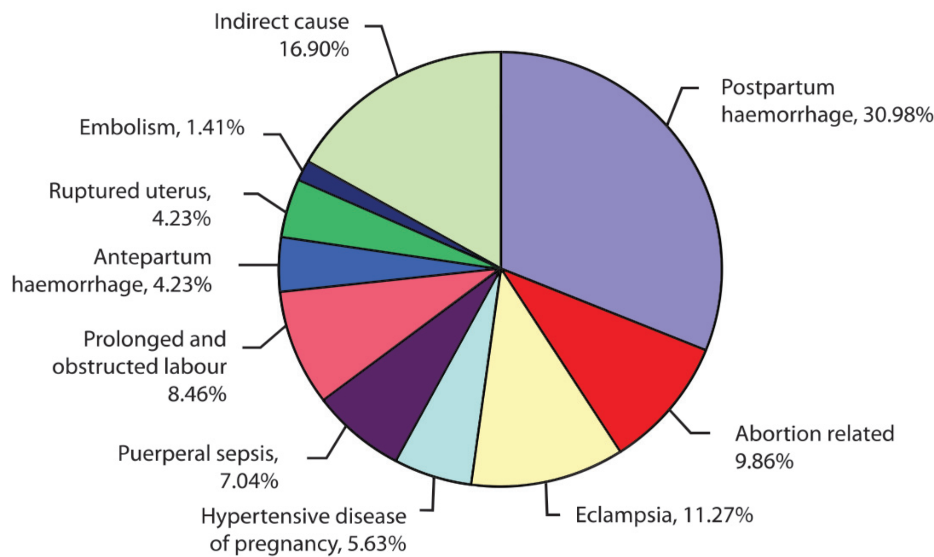
The Integrated Household Living Conditions Assessment[5] and the Multiple Indicator Cluster Survey[6] (MICS) conducted in 2009-2013 provide information on selected indicators on MDG4 - Reduce Child Mortality and MDG5 - Improve Maternal Health. Both Surveys highlight differences in indicators between rural and urban areas and among States/Regions and disparities in the coverage of health interventions.

Neonatal Mortality Rate

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

[4]Nation-wide cause specific maternal mortality survey (2004-2005) UNICEF and Department of Health
[5]Ministry of National Planning and Economic Development, SIDA, UNDP and UNICEF, "Integrated Household Living Conditions Survey in Myanmar 2009-2010 - MDG Data Report," June 2011
[6]Ministry of National Planning and Economic Development, Ministry of Health and UNICEF: "Myanmar Multiple Indicator Cluster Survey 2009-2010", October 2011

Figure 3.1: Major causes of maternal mortality in Myanmar



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

Skilled attendance at birth

The2011 Public Health Statistics Report indicated thatthe proportion of skilled attendance at birth was estimated at 52 percent in 1990 and 67 percent in 2011. There has been a marginal increase from 64 percent during 2006-2009. The 2009-2010 Multiple Indicator Cluster Survey[7] validates these estimates according to which, in the two years prior to the survey a skilled attendant, namely a doctor, nurse or midwife, attended to nearly 71 per cent of births. The Survey reports that slightly over a third of the births (36 percent) was attended to by midwives. Doctors assisted with 28 percent of births, traditional birth attendants with 18 percent of births, auxiliary midwives with 8 per cent of births, and Lady Health Visitors/nurses assisted with 6 percent of births. The proportion of skilled attendance at birth was higher (90 percent) in urban than in rural areas (63 percent). The lowest proportion of births attended by skilled personnel (59 percent) was reported among adolescent girls aged 15-19 years. The 2009-2010 MICS also revealed differentials across states and regions.

Antenatal care

The coverage of antenatal care (one or more visits) for Myanmar is reported to be 74 percent in 2011[8]. The lowest rates were reported for Chin and Sagaing. The percentage of women receiving no antenatal care was lowest in Yangon Region (4.2 percent) and highest in Rakhine State (40.8 percent). The 2007 Fertility and Reproductive Health Survey (FRHS) also reported that 66 percent of women received care from midwives and 13.6 percent from doctors. The 2009-2010 MICS reports similar findings: 83 percent of women receive care from a skilled provider, with the levels of antenatal care from a skilled provider ranging from 50 percent in Chin and 54 percent in Shan (North) to 96.7 percent in Mon. The number of antenatal visits and the type of delivery are positively influenced by higher education and higher wealth quintiles.

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

[7]Ministry of National Planning and Economic Development, Ministry of Health and UNICEF: “Myanmar Multiple Indicator Cluster Survey 2009-2010”, October 2011
[8]Public Health Statistics Report, 2011

The prevalence of anaemia is high in pregnant women, and estimated to be at approximately 70 percent[9]. The underlying cause in the majority of women is iron deficiency anaemia but the high prevalence of haemoglobinopathies and Thallaesaemia traits in the community also contribute.

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

On-going Programmes

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

Many initiatives are in place to increase referrals for emergency obstetric care which range from awareness raising on “danger signs” reinforced by community support groups in over 130 townships (DoH, Myanmar Maternal and Child Welfare Association and MyMA initiatives) and assistance during emergencies (Red Cross and MMCWA). In some NGO project townships funds to cover costs for emergency referrals are provided. Midwives provide elements of the signal functions of Basic emergency obstetric and newborn care[10] ; while Comprehensive emergency obstetric and newborn care is provided at Township and Station Hospitals.

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

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

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

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

3.2 Birth Spacing

According to the 2007 FRHS (2009), the Total Fertility Rate of women aged 15 – 49 years is two births per woman and is lower for urban than rural women (1.7 and 2.2). The same survey reported that 38 percent of married women were using contraceptives - 49 percent among urban and 34 percent among rural users. Successive surveys on fertility and reproductive health reveal a steady increase in contraceptive prevalence rates: 28 percent in 1997[11] to 33 percent in 2001[12] and 38 percent in 2007[13].

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

[9]National micronutrient survey, National Nutrition Centre, Ministry of Health 2003
[10]Administer parenteral antibiotics, uterotonic drugs (parenteral oxytocin) and parenteral anticonvulsants for pre-eclampsia and eclampsia (i.e. magnesium sulfate) and perform basic neonatal resuscitation (e.g., with bag and mask).

[11]1997 Population Changes and Fertility Survey
[12]2001 Fertility and Reproductive Health survey
[13]2007 Fertility and Reproductive Health survey

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

On-going Programmes

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

3.3 Miscarriage and its complications

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

According to the annual hospital statistics report 2010-2011, the abortion[14] rate per 1,000 pregnancies (livebirths, stillbirths and abortion) is 174/1,000 and the hospital statistics of the Central Women's Hospital, Yangon reported similar data, i.e. that miscarriage and abortion-related admissions to delivery ratio is 1:6. At the same hospital, septic abortion comprises 20-25 percent of abortion admissions. Abortion-related complications led to at least half of the maternal death cases: 7/14 cases (50 percent) in 2009, 13/28 cases (46.4 percent) in 2010 and 14/27 cases (51.85 percent) in 2011. Being a tertiary and teaching hospital, there were low case-fatality rates for abortion: 0.62 percent (7/1136 cases) in 2009, 0.95 percent (13/1363 cases) in 2010 and 1.31 percent (14/1066 cases) in 2011.[15]

On-going Programmes

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

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

3.4 Reproductive tract infections/Sexually transmitted infections/ HIV

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

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

[14]Includes miscarriage and postabortion complications
[15]Hospital Statistics, Central Women's Hospital, Yangon
[16]In 2011, the Strategic Information and M&E Working Group developed the final version of the Asian Epidemiological Model (AEM) for Myanmar, which was used to establish the HIV estimations for Myanmar covering the period from 2010 to 2015 including the new infections by transmission route. The nomenclature has now been changed to AIDS Epidemiological Model.

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

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

On-going Programmes

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

3.5 Adolescent and youth reproductive health

The population under 15 years of age is approximately 30 percent and those aged 15 to 24 years are about 18 percent of the country’s population[17]. It is estimated that ten percent of adolescents are married.

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

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

On-going Programmes

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

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

[17]Statistical Year Book, Central Statistics Organization, 2011

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

3.6 Gynaecological cancer

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

On-going Programmes

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

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

3.7 Gender mainstreaming

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

The Department of Social Welfare (DSW) has taken initiatives to develop laws on Violence Against Women (VAW) in Myanmar, as part of the broader initiative to effect legal reform in other areas related to and impacting on gender equality[18] (Gender Equality Network 2013). Parliamentarians and multiple stakeholders are currently in consultations on the formulation of an Anti-VAW Law and a nation-wide survey and research on VAW is planned for 2013-2014.

On-going Programmes

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

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

3.8 Reproductive health in humanitarian settings

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

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

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

On-going Programmes

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

3.9 Other Issues

Infertility

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

People with Disability

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

4. Opportunities and Challenges

4.1 Opportunities

4.1.1 Economic and Social Reforms

Framework for Economic and Social Reforms and the health sector

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

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

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

Official Development Assistance

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

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

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

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

4.1.2 Commitments to Reproductive Health

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

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

Commitment of the Government of Myanmar

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

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

Myanmar's commitments to FP 2020 are as follow:

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

Commitment of development partners

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

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

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

4.1.3 Co-ordination Mechanisms

Myanmar Health Sector Coordinating Mechanism

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

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

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

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

4.2 Challenges

Despite the significant decline in MMR between 1990 and 2010, achieving the national MDG 5 MMR target of 129 per 100,000 live births by 2018 remains a challenge. According to the Public Health Statistics Report 2011, progress in improving women's access to skilled birth attendants has been more or less stagnant at around 64 percent since 2006. More than three quarters (76 percent) of births take place at home. While the coverage of antenatal care (one or more visits) for the country is 74 percent, the proportion of women who have four visits is still low at 22.5 percent. Contraceptive prevalence for modern methods has not increased significantly between the two Fertility and Reproductive Health Surveys conducted in 2001 and 2007. There are also persistent differences among states and regions and by rural-urban residence, age and wealth groups. Challenges to achieving universal access to reproductive health that have been identified by the Ministry of Health[20] and the review of the 2009-2013 Strategic Plan are summarized below.

4.2.1 Enhancing equitable access to health care

Geographical and coverage gaps have been identified as a key challenge to improve the health status of target populations[21]. Data and analyses indicate significant disparities between regions and groups in access to, and quality of, health services, particularly affecting ethnic minorities, the urban poor, and people living in rural and remote areas.The Strategic Plan will focus on vulnerable groups to address inequalities and disparities in access through facility-based and outreach services and community-based care and in partnership with civil society.

[20]Health in Myanmar 2013
[21]Health in Myanmar 2013
[22]Thematic Analysis 2011 – Achieving the Millennium Development Goals in Myanmar

4.2.2 Strengthening health systems

The health system is constrained because of weaknesses in management and coordination of services, a need for strengthened information and monitoring system and supply chain management whichresulted from low investments in the health care system, both from domestic and international sources[22].
MoH will continue the investments in health systems strengthening through addressing human resource constraints, building or upgrading health infrastructure, deepening decentralized health system governance, improving supply systems and logistics, and strengthening the health management information system.

4.2.3 Human resources for reproductive health

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

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

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

4.2.4 Organization of health service delivery

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

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

4.2.5 Health Financing

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

4.2.6 Improving community access to health care

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

5. Goal and Objectives

5.1 Guiding Principles

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

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

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

The core elements of RH

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

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

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

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

WHO Health Systems Strengthening Framework

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

AAAQ Framework

The Strategic Plan will follow the principles of the "AAAQ"framework[24] to deliver effective, safe, quality health interventions to those in need. This framework identifies *availability, accessibility, acceptability and quality of health care facilities, goods and services* as essential elements of the right to health.

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

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

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

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

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

5.2 Goal

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

5.3 Specific Objectives

The specific objectives are:

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

[23]Strengthening health systems to improve health outcomes: WHO's Framework for action(2007)
[24]The Right to Health in International Human Rights Law

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

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

6. Essential Package of Reproductive Health Interventions

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

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

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

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

Table 6.1 Essential Package of Reproductive Health Interventions

Pregnancy, Delivery, Postnatal, Newborn care	Birth Spacing	Miscarriage and Post-abortion care	RTI/STI/HIV/AIDS	Adolescent and Youth RH	Other elements of RH
Level of Care: Community Level					
Information and counseling/advice on self care, nutrition, breastfeeding, care during pregnancy, labour and postnatal period and danger signs during the same periods, birth plans, and emergency preparedness. Support for routine care and follow up visits and timely care-seeking for mother and baby. Community-based newborn care[25] especially in hard-to-reach areas. Kangaroo mother care as required. Promotion and support for early initiation and exclusive breastfeeding and immunization. Establish referral criteria and mechanisms to health centre (RHC) or township health facility. Feedback provided from health centre or township health facility including information and support for follow-up.	Information and advice on birth spacing. Provision of condoms and oral pills.	Information and advice/counseling on birth spacing, symptoms and signs of miscarriage and dangers of unsafe abortion.	Information and advice/counseling on STI and HIV, and safe sexual behavior.	Information and advice/counseling and peer education on safe sexual behavior, prevention of unwanted pregnancy and STI and HIV, nutrition and safe motherhood.	Promote male involvement in safe motherhood, responsible parenthood, birth spacing and RTI/STI/HIV interventions. Awareness of signs of GBV and referral. Information and advice on breast and cervical cancer.

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

Level of Care : Primary Health Care at Rural Health Sub-Centre, Rural Health Centre and Maternal and Child Health Centre					
All of the above services plus: *Pregnancy* • Confirmation of pregnancy • Monitoring of progress of pregnancy and assessment of maternal and foetal well-being including nutritional status • Detection of problems complicating pregnancy (e.g. anaemia, hypertensive disorders, bleeding, malpresentations, multiple pregnancy) • Respond to reported needs • Tetanus immunization, anaemia prevention and control (Iron and folic acid supplementation) • Syphilis testing and treatment of syphilis (woman and spouse/partner) • Treatment of mild to moderate pregnancy complications (mild to moderate anaemia, urinary tract infection, vaginal infection) • Pre-referral treatment of severe complications (pre-eclampsia, eclampsia, bleeding, infection, preterm prelabour rupture of membranes<antibiotics and corticosteroids>) • HIV counseling and testing • Rapid diagnostic tests, anti-malarial treatment and promotion of insecticide treated nets (ITN)	• To increase awareness on benefits of safe sex, birth spacing starting from pre-pregnancy period, during pregnancy and after childbirth[26] • Counselling and provision of contraceptive methods including emergency contraception • Dual protection: female and male condoms and other contraceptives	• Information and advice/counselling on birth spacing, symptoms and signs of miscarriage and dangers of unsafe abortion. • Diagnosis of miscarriage, post-abortion complications, stabilization and referral • Referral mechanisms for timely treatment of miscarriage/ abortion-related complications • Post-abortion counseling and services (psycho-social support and contraception/ birth spacing as appropriate).	• Information and advice/counselling on STI and HIV, and safe sexual behavior. • Syndromic management of RTIs/STIs • HIV counselling and testing • Condom promotion and provision	• Information and advice/counselling and peer education on safe sexual behaviour, prevention of unwanted pregnancy and STI and HIV and RH commodities. • Peer education and outreach activities in the catchment area according to National Guidelines. • Youth-friendly RH services/ RH service delivery corner for adolescents and youth in the health facility with provision of educational materials, supplies and equipment and RH commodities.	*Breast and cervical cancer* Information and advice/counselling on breast and cervical cancer. VIA for cervical cancer screening. *Male involvement* Promote male involvement in safe motherhood, responsible parenthood, birth spacing and RTI/STI/HIV interventions *Gender-based violence* Assessment, immediate response and referral. *Infertility* Identification of initial needs of the infertile couple, and referral. *Individuals with disability* Persons with disability have access to RH services

[26]Packages of interventions for family planning, safe abortion care, maternal, newborn and child health, WHO 2010

Delivery • Diagnosis of labour • Monitoring progress of labour, maternal and foetal wellbeing with partograph • Social support during labour (companion of choice) • Infection prevention • Supportive care and pain relief • Detection of problems and referral (e.g. malpresentations, prolonged and/or obstructed labour, hypertension, bleeding, and infection) • Pre-referral management of serious complications (e.g. obstructed labour, foetal distress, preterm labour, severe peri- and postpartum haemorrhage - PPH) • Active management of third stage of labour with oxytocin or oral misoprostol to prevent PPH • Delivery and immediate care of the newborn baby • Early initiation of breastfeeding • Hygienic cord and skin care • Thermal protection					

• Newborn resuscitation (bag and mask) • Rooming in • Eye infection prophylaxis • Immunization • Treatment of congenital syphilis • Monitoring and assessment of wellbeing of newborn and response to maternal concerns • Prevention of mother to child transmission of HIV (PMTCT) antiretroviral therapy (ART), infant feeding, mode of delivery advice *Postnatal care* • Emotional support • Monitoring and assessment of maternal and newborn wellbeing, prevention and detection of complications • Nutritional counselling • Treatment of anaemia • Promotion, protection and support for exclusive breastfeeding • Treatment of abnormalities and complications (e.g. episiotomy, repair of genital tears and manual removal of placenta) • Counselling and services for birth spacing/family planning • Detection of danger signs in mother and newborn and early referral • Pre-referral treatment of complications (e.g. severe postpartum bleeding, puerperal sepsis and neonatal sepsis)					

• Facilitate birth registration Life-saving interventions for PPH, eclampsia and severe pre-eclampsia and sepsis in hard-to-reach areas. Early identification and initiation of antibiotics for neonatal pneumonia and referral. Recording and reporting throughout pregnancy, delivery and postnatal period (mother and newborn). Use of Maternity Waiting Home/Maternity Waiting Area during pregnancy, delivery and postnatal period. *Referral mechanisms* Establish of referral criteria and mechanisms to township health facility. Feedback provided from township health facility including information and support for follow-up.					

Level of Care: Township level (Station Hospital and Township Hospital)					
Comprehensive emergency obstetric and newborn care facility					
All of the above services plus: *Pregnancy* • Treatment of severe pregnancy complications (anaemia, severe pre-eclampsia, eclampsia, bleeding, infection, other medical complications) • Management of mal-presentations, multiple pregnancy • Management of preterm rupture of membranes (antibiotics, corticosteroids and referral as appropriate) *Labour* • Induction and augmentation of labour • Treatment of abnormalities and complications (e.g. prolonged labour, vacuum extraction, breech presentation, multiple pregnancy repair of episiotomy and genital tears, manual removal of placenta) • Treatment of severe complications in childbirth and in immediate postpartum period (caesarean section, blood transfusion and hysterectomy) • Management of preterm labour • Management of other obstetric complications	All of the above services plus: • Insertion of IUDs • Tubal ligation, insertion and removal of implants	*Station Hospital* • Uterine evacuation for incomplete abortion (MVA) • Diagnosis and treatment of common complications (infection, bleeding or injury) • Pain control • Diagnosis and treatment of STIs/HIV • Post-abortion counseling and services (psycho-social support and contraception/ birth spacing as appropriate). *Township Hospital* All of the above services plus:	*Station Hospital,* • Diagnosis and treatment of STIs/ RTIs • Rapid diagnostic tests for syphilis • Treatment of syphilis of pregnant women and partner, follow-up for newborn • HIV counseling and testing and referral for ART • Referral of complicated cases to higher level *Township Hospital* All of the above services plus: • Confirmatory tests for syphilis • Prevention of unintended pregnancies in HIV positive mothers through family planning (including couple	• Youth-friendly RH services/ RH service delivery corner for adolescents and youth in the health facility with provision of educational materials, supplies and equipment and RH commodities. • Peer education and outreach activities in the catchment area according to National Guide-lines.	*Cervical Cancer* Screening and treatment of precancerous lesions (Visual Inspection with Acetic Acid) and cryotherapy. *Gender-based violence* Assessment, response, referral, and follow-up clinical interventions and emotional support *Infertility* Clinical assessment and basic laboratory tests for the infertile couple Referral to higher level facility *Individuals with disability* Persons with disability have access to RH services

Postnatal • Assessment of maternal wellbeing including maternal nutrition • Prevention and detection of complications (e.g. infections, bleeding, anaemia) • Treatment of anaemia (mild to severe), mild puerperal depression, mastitis Management of newborn • Vitamin K • Resuscitation for birth asphyxia • Kangaroo mother care for preterm and babies <2000 grammes Management of newborn with severe problems: general care of a sick newborn and specific care for: • Preterm babies with breathing problem or unable to feed orally • Severe infection (pneumonia) • Severe birth asphyxia • Others: severe jaundice, malformations Recording and reporting throughout pregnancy, delivery and postnatal period (mother and newborn) Use of Maternity Waiting Home/Area during pregnancy, delivery and postnatal period		• Management of severe complications (haemorrhage, infection, injury)	provision of contraceptives of couple's choice and condoms for dual STI and pregnancy protection • Referral for couples wishing to have children • Targeted interventions for high-risk populations (with NAP)		

7. Strategies and Key Activities

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

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

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

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

7.1 Strategies and Key Activities for Implementation

Strategies	Key Activities
7.1.1 Strengthen Health Systems to enhance the provision of an essential package of RH interventions	
1.1 Reinforce an enabling environment for reproductive health	Develop advocacy toolkit and materials for decision-makers at central, regional/state and township levels on the role of RH in achieving international development goals, RH, MNH, birth spacing/FP, ARH and cervical cancer screening Conduct advocacy at the central, regional/state and township levels for increased budgetary allocation and/or resource mobilization for RH interventions.
	Review/update operational policies to ensure an enabling regulatory framework for service provision by midwives and AMWs so that they can facilitate universal and equitable access to RH information and services. (Components of BEmONC and RTI services, syphilis screening and treatment and PMTCT by midwives; and selected components of BEmONC and birth spacing/FP service provision by AMW)
	Establish and strengthen partnerships and linkages for commitment to and co-ordinated implementation of the Strategic Plan - Co-ordination with Regional/State governments and other national organizations/institutes, including NGOs who are primarily responsible for the implementation of the Strategy. - Strengthen co-ordination and intensify integrated service delivery modalities with other departments and key programmes under the DoH (e.g. Women and Child Health Development Section, National AIDS Programme, National Nutrition Centre, Central Health Education Bureauetc). - Mobilize crucial constituencies (e.g. health professionals, women's and faith-based organizations and community leaders) to support a national reproductive health agenda. - Continue inter-sectoral collaboration and partnerships with the United Nations and other development partners through Myanmar Health Sector Co-ordinating Committee.
1.2 Ensure availability of human resources for RH services	Implement national health workforce strategies and plans for workforce development – Human Resources for Health Plan. Build managerial capacity of township health managers. Consider the range, skill-mix and gender balance of health workers (health service providers and management and support workers) needed to deliver the essential package of services.

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

Strategies	Key Activities
1.4 Increase utilization of information from monitoring and evaluation, health information system and other sources and research	Production, analysis, dissemination and use of reliable and timely information on health system performance and health status. (Reproductive Health Programme in collaboration with Division of Health Planning, Department of Planning and Statistics) Review and refine indicators that will reflect scope of coverage and quality: e.g. postnatal care, emergency referrals. Co-ordinate with: - DPS for facility and population based information from Health Management Information System (HMIS) - National AIDS Programme (NAP) for data from surveillance systems - Responsible ministries for national surveys Facilitate analysis and use of data from HMIS and surveys (with DPS) and disseminate findings to policy-makers and stakeholders involved in implementation. Collaborate with research institutions, universities and other partners on implementation/operations research and other studies for evidence-based decision-making, planning and programme interventions. Collaborate with research institutions and Department of Traditional Medicine to conduct research on effectiveness and efficacy of traditional medicines for selected RH conditions.
7.1.2 Increase access to quality, integrated RH services at all levels of care	
2.1 Implement an essential package of RH services	Develop and implement an integrated package of interventions with core RH elements (Section 6 and Annex 6). Implement health services according to best practices and in adherence to quality assurance measures (six areas/dimensions of quality of care will be followed)[27]. Adopt a client-centred approach that is sensitive, confidential and is respectful of rights and diverse needs. Promote client/provider interaction dialogue and feedback.

[27]Effective, efficient, accessible, acceptable/patient-centred, equitable and safe (WHO, 2004)

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

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

Strategies	Key Activities
	Conduct awareness-raising activities among communities on RH and collaborate with community-based groups and opinion leaders to understand and address underlying cultural values and practices.
3.3 Support health promotion and care activities by community health volunteers	Carry out BCC activities to promote early pregnancy identification, ANC, birth preparedness, skilled birth attendance, essential newborn care, birth spacing/family planning, etc. Sensitize families and communities on care seeking and adherence with treatment. Encourage beneficial traditional practices and discourage harmful practices on core elements of RH. Conduct initiatives for engagement of men and boys in RH: MNH, responsible fatherhood, birth spacing, STI/HIV prevention, infertility, GBV etc Conduct training for CHV on community organization, behaviour change communication, first aid. Conduct training of AMWs on specific service delivery for reproductive health. Support MWs to supervise service delivery by AMWs at the community level. Build capacity at the community level for early recognition of complications in women and children and for early referral and transfer. Establish functional linkages (transport and communications) from community to different levels of care in order to ensure efficiency in referrals.
7.1. 4 Incorporating Gender Perspectives	
4.1Gender Mainstreaming	Respect key points for gender mainstreaming[28] in implementing RH Strategic Plan. Ensure women's participation in defining and implementing public health priorities and activities at national, region/state, township and village levels.
4.2 Strengthening the health sector response to Gender-based violence	Address key issues to enhance identification, care and response for survivors of GBV: - To develop and implement guidelines for delivery and care for survivors of GBV; - To ensure that the response becomes institutionalized (i.e. changing individual behaviour and organizational culture); and develop standard operating procedures and protocols; - To maintain multi-sectoral collaboration and collaboration with NGOs; - To ensure a women-centred approach is adopted and that women are not placed at further risk by any intervention;

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

Strategies	Key Activities
	- To identify health-care settings that are most appropriate for offering these services; and - To improve response and care for survivors including conducting selective enquiry for GBV and provider training. Adapt WHO clinical and policy guidelines – *Responding to intimate partner violence and sexual violence against women* Build capacity of Central and Regional level Trainers and conduct training for health providers on key issues to detect, care for and refer survivors of GBV. i.e. identification, assessment, treatment (emergency contraception, post-exposure prophylaxis and diagnosis and treatment of STIs), crisis intervention, documentation, referral, and follow-up clinical interventions and emotional support, for women suffering from intimate partner violence and sexual violence. Strengthen referral mechanisms to social services, security and legal services, counselling and support. Strengthen the role of opinion leaders to raise awareness of GBV as a public health issue. Raise awareness of the community to prevent GBV and promote identification and early referral of victims. (Reproductive Health Programme in collaboration with Division of Medical Care, DoH, Department of Social Welfare and NGOs)
4.3Engaging men in reproductive health programmes	Advocate on the value of engaging men in RH and RH care to opinion leaders. Print and disseminate messages and IEC materials on men's shared responsibility in responsible parenthood, sexual and reproductive behavior and RH care[29]. Conduct training for health providers to engage men as supportive partners to address gender inequality and improve health outcomes. Conduct community-level activities to engage men as supportive partners to address gender inequality and improve health outcomes using group and peer education. (Reproductive Health Programme in collaboration with CHEB, NGOs, professional organizations, UN agencies)

[29]Birth spacing; antenatal, MCH; prevention of STIs and HIV; prevention of and care following miscarriage/unsafe abortion; addressing infertility and prevention of violence against women.

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

7.2 Strategies and Key Activities for Core Elements of Reproductive Health

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

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

7.2.1 Pregnancy, Delivery, Postnatal and Newborn care

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

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

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

Strengthen infrastructure, logistics and management systems

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

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

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

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

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

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

Support and implement review of maternal deaths at all levels and respond to community and facility-related issues leading to each maternal death.
Disseminate results of maternal death reviews.
Implement recommendations of maternal death review reports.
Conduct research to identify and address barriers to access to MNH care including facility delivery and skilled attendance at delivery.
Support research that seeks to understand social and cultural determinants of utilization of MNH services among various social and economic groups to advocate for and promote evidence-based interventions.
Conduct implementation/operations research on task sharing of selected MNH activities to AMWs.
Share lessons learnt from innovative programmes and projects and use the results to Intensify awareness campaigns to address operational barriers.

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

Implement an essential package of MNH services

Provide package of MNH interventions (antenatal care, delivery care including BEmONC and CEmONC, postnatal care and essential newborn care) using a client-centred approach and a focus on quality assurance.
Continue Iron-folate supplementation for pregnant women (National Nutrition Centre)

Expand coverage of MNH services

Conduct geographic and social mapping to identify hard-to-reach and marginalized population sub-groups.
Design strategies for improving equity in access to MNH care for hard to reach populations.
Employ different service delivery models: facility-based, outreachand community-based activities that provide information and services in hard-to-reach areas.

Improve performance of health workforce

Conduct refresher training on the components of the essential package of interventions, i.e. integrated package of MNH interventions (antenatal care, delivery care including Basic and Comprehensive Emergency Obstetric and Newborn Care, postnatal care and essential newborn care), with an emphasis on integrated services, client-centred approach and quality assurance measures, for doctors and midwives. The BEmONC training will be organized to cover more signal functions than is currently provided.
Provide supportive supervision and clinical mentoring on a regular basis for MWs and AMWs.
Intensify competency-based training for Skilled Health Personnel/Skilled Birth Attendants in accordance with ASEAN Regional Guideline on Skilled Birth Attendant[30].

Strengthen effective systems of referral

Streamline referral systems with standardized, written guidelines, contingency plans and communication of procedures to be followed in emergencies.
Establish village health funds for MNH and other emergencies.
Improve communication with referral centre through mobile phones.
Provide feedback to referring health worker/health facility as a performance improvement mechanism.
Ensure Village Health Workers/Community Health Volunteers are knowledgeable about available referral systems and how to access them.

[30]The draft guideline is undergoing review.

Increase equitable access to quality integrated reproductive health services

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

7.2.1.3. Community Engagement in Promotion and Delivery of MNH

Support health promotion and care activities by community health volunteers

Conduct training on for VHW/CHV on community organization, behaviour change communication and first aid.
Conduct training of AMWs on specific service delivery for reproductive health including distribution of iron-folate, misoprostol for prevention of PPH.
Support MWs to supervise service delivery by AMWs at the community level.
Organize meetings between MWs and AMWs on a regular basis.
Carry out BCC activities to promote early pregnancy identification, ANC, preparedness for delivery, skilled delivery attendance and postnatal and newborn care; self-care during pregnancy and early and exclusive breast-feeding; and to promote beneficial cultural practices and avoid harmful practices.
Develop initiatives for greater engagement of men in MNH care-seeking behaviour and care and responsible fatherhood.

Partners

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

7.2.2 Birth spacing

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

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

Strengthen infrastructure, logistics and management systems

Equip facilities with instruments for IUD and implant insertion and removal.
Project, forecast, procure supply, store and distribute quality contraceptive commodities.
Conduct training for responsible staff on projecting, forecasting, procuring supplies, storage and distribution of quality contraceptive commodities.

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

Support research that seeks to understand social and cultural determinants of non-use and unmet need for contraception among various social and economic groups to advocate for and promote evidence-based interventions.
Share lessons learnt from innovative programmes and projects and use the results to Intensify awareness campaigns to address operational barriers.

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

Implement an essential package of services

Provide information and services on modern contraceptive methods and dual protection; and follow-up for correct and consistent use.
Broaden contraceptive method mix to include emergency contraception and implants and strive for a balance between long-term reversible and short-term methods.
Strengthen integration of birth spacing into other RH and related programmes e.g. postpartum and post-abortion contraception.

Expand coverage of services

Conduct geographic and social mapping to identify hard-to-reach and marginalized population sub-groups.
Design strategies for improving equity in access to RH/birth spacing care for hard to reach populations.
Employ different service delivery models: public, private, social marketingand community-based distribution.
Engage NGO partners and the private sector through public-private partnerships to provide information and services in hard-to-reach areas.

Improve performance of health workforce for RH

Update clinical standards and guidelines periodically to ensure service provision is in line with evidence-based practices – e.g. updated Medical Eligibility Criteria for Contraceptive Use.
Conduct training on birth spacing with an emphasis on integrated services, client-centred approach and quality assurance measures for doctors and midwives.
Conduct skills-based training on long-term reversible methods.
Conduct training to improve communication skills of health care providers.

7.2.2.3. Community Engagement in Promotion and Delivery of RH

Support health promotion and care activities by community health volunteers

Conduct training to improve communication skills of community volunteers on the benefits of healthy timing and spacing of pregnancies and on modern contraceptive methods and dual protection.
Carry out BCC activities to increase awareness on healthy timing and spacing of pregnancy,birth spacing methods.
Provide information on modern contraceptive methods and dual protection, follow-up for correct and consistent use and dispel myths and misperceptions.
Develop initiatives for greater involvement of men in birth spacing.

Partners

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

7.2.3. Miscarriage and post-abortion care[31]

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

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

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

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

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

Implement an essential package of PAC services

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

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

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

Manage or refer severe complications to higher level health facilities.

Strengthen PAC contraceptive information and services.

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

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

Improve performance of health workforce for RH

Conduct training for health providers on updated PAC Manual.

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

7.2.3.3 Community Engagement in Promotion and Delivery of RH

Enhance community understanding of RH needs and increase demand for services

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

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

Support health promotion and care activities by community health volunteers

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

Organize timely referral to formal health care system.

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

Partners

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

7.2.4 RTI/STI/HIV

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

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

Strengthen logistics and management systems

Strengthen the RTI treatment supply chain management - project, forecast, procure supply, store and distribute RTI/STI drugs and condoms and commodities and medicines for PMTCT (in collaboration with NAP).
Carry out periodic review of the drugs used in syndromic management in order to ensure their effectiveness in curing RTIs (National AIDS Programme).

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

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

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

Implement an essential package of RH services

Provide information and services on RTI/STI and integrate RTI/STIscreening and management into RH services.
Strengthen syndromic management (as appropriate) and laboratory services to support early diagnosis and treatment of RTIs, partner referral and condom provision.(National AIDS Programme)
Develop strategies with NAP to improve access to FP and MCH/PMTCT for female KAPs through bi-directional linkages for delivery of and effective referral to RH or HIV/STI services.

Expand coverage of services

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

Improve performance of health workforce for RH

Build capacity at all levels of service delivery for effective integration of RTI/STI into RH services that are non-discriminatory.
Conduct training on syndromic management and laboratory investigations to support early diagnosis and treatment of RTIs.
Conduct training on PMTCT and screening and treatment for syphilis (NAP) and birth spacing services for key affected populations (KAP) and People living with HIV/AIDS (PLWHA).

7.2.4.3 Community Engagement in Promotion and Delivery of RH

Enhance community understanding of RH needs and increase demand for services

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

Support health promotion and care activities by community health volunteers

Provide information on RTI/STI/HIV, safe sexual behaviour and dual protection.
Develop initiatives for greater involvement of men in prevention STI through safe sexual behaviour.
Conduct training of peer educators including KAP on core RH/STI/HIV and communication skills.

Partners

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

7.2.5 Adolescent and Youth RH

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

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

Reinforce an enabling environment for adolescent and youth reproductive health

Conduct communication activities so that local authorities, religious leaders, parents, teachers and peers are knowledgeable about the health of young people and the value of providing RH information and services.
Review/update operational policies and regulatory mechanisms for information and service provision on RH irrespective of age and marital status in order to ensure that adolescents and youth have equitable access to RH services.
Strengthen existing partnerships of NGOs and other partners working with adolescents and youth.
Provide health services in accordance with "National Service Standards and Guidelines on Adolescent and Youth Care" (MoH, UNFPA, WHO).

Ensure availability of human resources for services

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

Strengthen infrastructure, logistics and management systems

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

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

Collect data on core elements of RH disaggregated by age, sex and marital status.
Conduct research to determine approaches to improve utilization of Youth Friendly Services.

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

Implement an essential package of RH services

Expand the scope and coverage of Youth Information Corners (YIC) to provide youth-friendly services.
Engage young people in the design, implementation and service delivery of youth-friendly information and services and in quality improvement activities.
Develop IEC and BCC materials with the involvement of young people.
Develop protocols, guidelines and/or job aid cards for quality reproductive health care for young people.
Expand biweekly supplementation for adolescents school girls (National Nutrition Centre)

Expand coverage of services

Support expansion of the number of facilities offering youth friendly reproductive health services and outreach educational activities.
Develop strategies to reach adolescents, and youth involved in risky behaviours, and the hard to reach e.g. out-of-school, young people living with HIV and adolescents living on the streets.

Improve performance of health workforce for RH

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

7.2.5.3 Community Engagement in Promotion and Delivery of RH

Enhance community understanding of RH needs and increase demand for services

Engage key community leaders, both men and women, to understand the value of providing RH information and services for young people.
Promote and support school based health education programmes. (School Health Programme)
Conduct training of peer educators on core RH elements and communication skills.
Conduct community and family outreach activities in addition to individual clinic-based services.
Promote initiatives reaching out to out-of-school youths with IEC and BCC interventions through group and peer education.
Support initiatives aimed at creating awareness on RH among youth in difficult circumstances.
Support mass media campaigns on RH among adolescents and youth.
Use social media (internet and mobile phones)to raise awareness and understanding of RH issues of young people.

Partners

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

7.2.6 Screening and treatment of cervical cancer

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

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

Reinforce an enabling environment for reproductive health

Advocate for a comprehensive approach to cervical cancer prevention and control programme - made up of several key components ranging from community education, social mobilization, vaccination, screening, and treatment to palliative care.
Develop a policy framework for comprehensive cervical cancer control (The RH Programme will focus on screening and treatment of premalignant lesions and will refer women with malignant lesions to tertiary care facilities.)

Strengthen infrastructure, logistics and management systems

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

Ensure availability of human resources for RH services

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

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

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

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

Implement an essential package of RH services

Strengthen RH services at all levels to provide prevention, screening,early diagnosis and management of pre-malignant lesions of the cervix and referral for malignant lesions.
Consider introduction of HPV vaccines in the public sector.
Strengthen oncology services at appropriate levels in order to cater for the needs of prevention, early diagnosis and treatment of cancers of reproductive organs and other emerging technologies (Division of Medical Care).

Expand coverage of services

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

Improve performance of health workforce for RH

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

7.2.6.3 Community Engagement in Promotion and Delivery of RH

Enhance community understanding and increase demand for services

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

Support health promotion and care activities by community health volunteers

Promote positive health seeking behaviour in the community, including awareness of regular screening for breast and cervical cancer.
Promote community awareness of symptoms of reproductive organ cancers to reduce delay in seeking health services.

Partners

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

7.2.7 Investigation and management of the infertile couple

Management of the infertile couple will be introduced in the Basic Health Services with well-defined interventions for each level of service delivery.
Support infertility prevention measures including improved postpartum and post-abortion care, and early diagnosis and effective treatment of RTI/STI.
Develop guidelines on the clinical management of and psycho-social support for the infertile couple at RHC and Township and Station Hospitals.
Conduct training for service providers at different levels for appropriate management of infertile individuals and couples, including facilities for early diagnosis and management and referral.
Build capacity of tertiary level facilities to provide specialised infertility management including Assisted Reproductive Technologies services.(Division of Medical Care)
Carry out community education and awareness creation on infertility.

Partners

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

8. Strategic Information (Monitoring and Evaluation and Research)

Monitoring progress of the Strategic Plan

Through monitoring and evaluation, progress towards and achievement of expected results will be measured and assessed. Impact, outcome and output indicators for the Strategic Plan are outlined in Table 8.1. Data for monitoring of the Strategic Plan will be obtained from several sources and will require close co-ordination with the respective responsible entities. These include the Health Management Information System[32], hospital statistics, central and regional government reports and township implementation reports. National surveys and special studies (e.g. HIV and STI surveillance surveys by NAP) carried out periodically will also yield information on impact and outcome indicators.

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

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

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

Maternal Death Review - Maternal Death Surveillance and Responses

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

The *Maternal death surveillance and response* (MDSR) system is a *continuous action cycle* that builds on established approaches such as maternal death review (MDR).It stresses the need to respond to each maternal death with actions to prevent similar deaths in the future, and to collect data on all maternal deaths using clearly defined data sources and processes for identification and notification and will generate comprehensive and feasible recommendations for follow-up action. This linking of mortality surveillance with remedial action is the centre-piece of an accountability framework[33]. Efforts will be made to transition from MDR to Maternal death surveillance and response.

Mid-term Review and Final Evaluation

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

[32]Department of Health Planning, Health Management Information System - Data Dictionary for Health services Indicators 2012
[33]Maternal death surveillance and response: technical guidance (WHO 2013)

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

Research

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

Formative research will be crucial to inform programme approaches to improve care-seeking behaviour for maternal and newborn care, increasing availability of and access to key RH services, and expanding individual, family and community knowledge and demand for these services.An implementation research agenda for quality improvement, innovative outreach approaches, health financing etc will be developed. In addition, the effectiveness of traditional medicine for selected RH conditions will be supported.
Studies that will be conducted include (but are not limited to):

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

Dissemination of data and reports

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

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

8.1 Logical Framework Matrix

The Logical Framework is based on the Goal and the Specific Objectives mentioned in Section 52 and 5.3. The following are key indicators that will be used to monitor trends in the reproductive health of mothers, adolescents and newborns are shown in Table 8.1. Many of these indicators can only be collected through large-scale surveys which are conducted intermittently (every three to five years). The data sources are listed with the corresponding indicators. There are specific targets to be reached by 2018 which can be verified by different means. This Logical Framework is based on the assumptions there will the health policies will continue to be supportive of reproductive health; that resources (human, financial, information, and infrastructure) are available for implementation of the plan; and that there are no serious negative effects due to unexpected events of natural, and socioeconomic environment.

Indicator	Current Status	Data Source, Year	Target	Year	Data Source
Impact					
Maternal Mortality Ratio	200 per 100,000 live births	UN Inter-agency estimates 2013	129 per 100,000 live births	2018	UN Inter-agency estimates Public Health Statistics Report
Neonatal Mortality Rate	30 per 1000 live births	UN Inter-agency estimates 2011	10 per 1000 live births	2018	UN Inter-agency estimates
Total Fertility Rate	2 per 1000 women 15-49	FRHS, 2007	2 per 1000 women 15-49	2018	Survey
Contraceptive prevalence rate	38 percent	FRHS, 2007	52 per cent	2018	Survey, Public Health Statistics Report
Unmet need for Contraception	17.7 percent	FRHS, 2007	8 percent	2018	Survey
Adolescent Birth Rate	16.9 per 1000 girls 15-19 years	FRHS, 2007	10 per 1000 girls 15-19 years	2018	Survey, Public Health Statistics Report
Outcome					
Increased percentage of government health budget allocated to RH				2018	Government Reports
Principles of equity for vulnerable populations (i.e. adolescents, disadvantaged groups) reflected in the policies and programmes on delivery of reproductive health care	Principles included		Principles reflected more prominents	2016	Government Reports
Training strategy to address in-service needs of reproductive health service providers in place	Training strategy in place		Training Strategy is competency-based	2016	Government Reports

Indicator	Current Status	Data Source, Year	Target	Year	Data Source
Outcome					
Reproductive health commodity logistics management information system established at national and local levels	In preparation phase		LMIS established	2016	Government Reports
Percentage of births attended by skilled health personnel	67.1%	Public Health Statistics Report 2011	85%	2018	Public Health Statistics Report
Percentage of deliveries by auxiliary midwife	11.6 %	Public Health Statistics Report 2011	15%	2018	Public Health Statistics Report
Percentage of births taking place in a health facility	23.2 %	Public Health Statistics Report 2011	60%	2018	Public Health Statistics Report
Percentage of women experiencing major obstetric complications who receive emergency care at EmONC facilities[34]	NA	Public Health Statistics Report 2011	70%	2018	Public Health Statistics Report 2011
Percentage of women receiving antenatal care (at least one visit)	74%	Public Health Statistics Report 2011	85%	2018	Public Health Statistics Report
Percentage of women receiving antenatal care (at least four visits)	66.9%	Public Health Statistics Report 2012	80%	2018	Public Health Statistics Report
Percentage of women receiving postnatal care –one visit within 3 days after delivery	59.3%	Public Health Statistics Report 2011	75%	2018	Public Health Statistics Report
Percentage of babies receiving postnatal care – one visit within 3 days after delivery	59.3%	Public Health Statistics Report 2012	75%	2018	Public Health Statistics Report
Prevalence of anemia in pregnant women[35]	71%	National Micronutrient Survey 2003	60%	2018	Survey

[34]Currently Percentage of mothers referred to higher levels during pregnancy, delivery and postnatal periods is collected – data for 2011 – 10 percent.
[35]While nutritional anaemia is common, the high prevalence of haemoglobinopathies and Thallaesaemia traits in the community need to be considered.

Indicator	Current Status	Data Source, Year	Target	Year	Data Source
Early Initiation of breastfeeding (within the first one hour of birth)	73%	Public Health Statistics Report 2012	87%	2018	Public Health Statistics Report
Knowledge of at least three risk factors/warning signs of pregnancy-related complications	Not available		70%	2018	Survey
Percentage of women using modern contraceptive methods	38%	FRHS, 2007	45%	2018	Survey
Percentage of married women using long-acting reversible methods	1.8%[36]	FRHS, 2007	4%	2018	Survey
Percentage of stillbirths per 100 live births	3.4%	Annual Hospital Statistics 2011		2018	Annual Hospital Statistics
Abortion rate per 1000 pregnancies (live births, stillbirths and abortions)	170 per 1000 pregnancies	Annual Hospital Statistics 2011	100 per 1000 pregnancies	2018	Annual Hospital Statistics
Percentage of clients who received post-abortion counseling and contraceptive services	Not available		80%	2018	Township Reports
Syphilis prevalence among pregnant women[37]	0.3%	HIV sentinel sero-surveillance survey 2012			HIV sentinel sero-surveillance survey 2018
HIV prevalence among pregnant women who came for antenatal HIV counseling and testing	0.7%	HIV sentinel sero-surveillance survey 2012	0.4%	2018	HIV sentinel sero-surveillance survey 2018
Proportion of pregnant women who undergo voluntary counseling and testing and receive results for HIV	27%	Global AIDS Progress Report 2012	90%	2018	NAP Reports, Global AIDS Progress Report 2012

[36]Data is on IUD use
[37]Targets for 2018 will be set in the next NSP for HIV 2016-2020

Indicator	Current Status	Data Source, Year	Target	Year	Data Source
Proportion of estimated pregnant women living with HIV receiving antiretroviral prophylaxis during pregnancy	69%	Children and AIDS Sixth Stocktaking Report, 2013	95%	2015[38]	Children and AIDS Sixth Stocktaking Report
Young men and women (15–24 years) who correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission[39]	37.2% 47.5%	General Population BSS 2009 Out-of-School BSS 2008			Behavioural Surveillance Survey
Policy on cervical cancer screening in place	Policy in preparation		Policy approved	2016	Government Reports
Health sector response to GBV formulated	In preparation		Strategy formulated	2016	Strategy document
RH component integrated into Disaster Preparedness Response policies and plans at all levels	On-going		Disaster Preparedness Response policies/plans at all levels	2015	Disaster Preparedness Response policies/plans
Output					
No. of CEmONC centres per 500,000 population	2	Annual Health Report	4	2018	Annual Health Report
No. of BEmONC[40] centres per 100,000 population	8	Annual Health Report	8[41]	2018	Annual Health Report
Number of facilities conducting reviews on maternal deaths (in accordance with Maternal Death Review)	100	2013	330	2016	Township Reports
Number of facilities conducting reviews on maternal deaths (in accordance with Maternal Death Surveillance and Report)	(See above)		200	2018	Township Reports
Percentage of MW receiving training on safe motherhood	80%	DoH Report	100%	2018	Township Reports

[38] Targets for 2018 will be set in the next NSP for HIV 2016-2020
[39] Targets for 2018 will be set in the next NSP for HIV 2016-2020
[40] Provides lifesaving interventions for PPH, eclampsia and severe pre-eclampsia and sepsis
[41] The number of signal functions carried out will be increased

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

[42]Contraceptive method mix available by geographic area in MICS (2009-2010), IHLCA (2009-2010)

9. Implementation Mechanisms

9.1 Reproductive health stakeholders

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

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

9.2 Coordination mechanisms

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

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

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

9.3 Annual plans of action

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

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

9.4 Financial resources

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

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

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

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

9.5 Human resources

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

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

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

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

10. Costing of Five-year Strategic Plan

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

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

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

Birth spacing:

Birth spacing services are most cost-effective if a range of methods is available. This helps clients to select a method that matches their needs[43].

STI/HIV/AIDS:

For STI/HIV/AIDS, resources should be focused on prevention activities such as promotion and distribution of condoms to prevent STIs, STI treatment for high-risk groups, and maternal syphilis treatment[44].

Integration:

Wider integration of STI/HIV and FP services would cost 31% less than separate services for STI/HIV and FP, with savings from reduction in staff costs, supplies, and overhead[45].

Decentralization:

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

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

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

Unit costs of different operational activities were obtained from the officials of the Reproductive Health Programme of the MoH and UNFPA. MoH officials provided implementation costs of MNCH activities including different training programmes and monitoring related activities. UNFPA officials provided information on unit costs of birth spacing commodities, BCC materials, cervical cancer screening and RH in emergencies. Costs data of Five-Year Strategic Plan for Reproductive Health (2009-2013)[46] were the sources of unit costs of post abortion care, cervical cancer screening, RTI/STI services and their respective coverage rates. Future years' costs were discounted using the appropriate inflation factor derived from the GDP deflator. Different published reports[47] were considered as sources of information to estimate the number of 12 year-old female students.

[43]Ssewanyana and Kasirye (2009) Cost Effectiveness of Reproductive Health Interventions in Uganda: the Case for Family Planning Services
[44]Dayaratna et al(2000) Reproductive health interventions: Which ones work and what do they cost? Washington DC: Policy Project
[45]Ross and Elizabeth (1993) Findings from Two Decades of Family Planning Research Population Council.
[46]Five-Year Strategic Plan for Reproductive Health (2009-2013), Department of Health, Ministry of Health, Myanmar
[47]Myanmar Multiple Indicator Cluster Survey 2009-2010
Reproductive Health Statistics 2009 Department of Health Planning and Department of Health

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

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

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

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

No.	Strategies/Activities	Level	Activity	unit cost ($)	2014		2015		2016		2017		2018		Total
					unit	cost	unit	cost	unit	cost	unit	cost	unit	cost	
Table-1: Central/National Level RH activities															
1.1	Review/update operational policies and regulatory mechanisms for service provision by midwives and AMWs	NAT	REV	15,000	1	15,000									15,000
1.2	Myanmar Health Sector Co-ordinating Committee, MNCH TSG/L RHWG meeting	NAT	ADV	1,000	4	4,000	4	4,000	4	4,000	4	4,000	4	4,000	20,000
1.3	Development of policy briefs and dissemination from Annual Reports and research studies	NAT	R&D	1	1500	1,500			3000	3,000			5000	5,000	9,500
1.4	Develop, Review and Revise of Guidelines, SOP, Manual and Curriculum	NAT	GLINE	10,000	2	20,000	2	20,000	1	10,000	1	10,000	1	10,000	70,000
1.5	Meetings to review human resources for RH services	NAT	REV	6,000	1	6,000									6,000
1.6	Establish a RH Logistic Management Unit and LMIS	NAT	SDEV	12,000	1	12,000	1	12,000	1	12,000	1	12,000	1	12,000	60,000
1.7	Meetings between RH Programme, HMIS and RH implementing partners	NAT	CDN	1,000	4	4,000	4	4,000	4	4,000	4	4,000	4	4,000	20,000
1.8	RH commodity security	NAT	SDEV	80,000	1	80,000	1	80,000	1	80,000	1	80,000	1	80,000	400,000
1.9	Support for Regional training centre and training team	REG	TRN	15,000	7	105,000	7	105,000	14	2,000	14	2,000	14	2,000	216,000
1.10	Meetings to develop themes, standardized messages for behavior change communication interventions	NAT	BCC	2,000	3	6,000	2	4,000							10,000
1.11	Develop, review, revise and print job aids, booklets and IEC materials	NAT	BCC		1	50,000	1	20,000	1	20,000	1	20,000	1	20,000	130,000
1.12	Central level meetings on MDR	**NAT**	**REV**	**5,000**	**1**	**5,000**	**1**	**5,000**	**1**	**5,000**	**1**	**5,000**	**1**	**5,000**	25,000
1.13	State/Regional meetings on MDR	**S/R**	**REV**	**3,000**	**14**	**42,000**	**14**	**42,000**	**14**	**42,000**	**14**	**42,000**	**14**	**42,000**	210,000
1.14	Establishment of m-health and e-health for MNCH (2015-2018)	NAT	BCC	10,000		0	10	100,000	10	100,000	10	100,000	10	100,000	400,000
	Sub Total For Table 1					**350,500**		**396,000**		**282,000**		**279,000**		**284,000**	**1,591,500**
Table-2: Pregnancy, Delivery, Postnatal and Newborn Care															
2A	**Strengthen Health Systems**														
A1	Enabling Environment														
2.1	Develop advocacy toolkit and materials for decision-makers	NAT	ADV	15000	1	15000									15,000
2.2	Conduct advocacy	NAT	ADV	15000	1	15000									15,000
2.3	Build managerial capacity for TMOs	TSP	TRN	5000	3	15000	3	15000	3	15000					45,000

No.	Strategies/Activities	Level	Activity	unit cost ($)	2014		2015		2016		2017		2018		Total
					unit	cost	unit	cost	unit	cost	unit	cost	unit	cost	
A2	Infrastructure and Logistics Management														
2.4	Renovation and refurbishment of health facilities	TSP	INF	20,000	10	200,000	10	200,000	10	200,000	10	200,000	10	200,000	1,000,000
2B	**Increase access to quality, integrated RH services**														
B.1	MNH commodity security														
2.5	ANC Package	TSP	SDEV		1	4,164,466	1	4,174,638	1	4,015,452	1	3,799,631	1	3,555,853	19,710,040
2.6	Delivery Package	TSP	SDEV		1	1,512,378	1	1,586,609	1	1,589,330	1	1,559,785	1	1,508,665	7,756,767
2.7	PNC Package	TSP	SDEV		1	17,811	1	18,685	1	18,717	1	18,369	1	17,767	91,351
2.8	Newborn Care Package	TSP	SDEV		1	211,351	1	210,892	1	200,401	1	186,026	1	169,628	978,297
2.9	Emergency Obstetric Care Package (Basic)	TSP	SDEV		1	2,699,207	1	2,889,956	1	2,944,812	1	2,932,418	1	2,872,086	14,338,479
2.10	Emergency Obstetric Care Package (Comprehensive)	TSP	SDEV		1	183,367	1	196,325	1	200,052	1	199,210	1	195,111	974,065
B2	Expand Coverage of Services														
2.12	Stakeholders co-ordination meetings (quarterly)	TSP	PLAN	500	330	165,000	330	165,000	330	165,000	330	165,000	330	165,000	825,000
2.13	Township co-ordination meetings (monthly)	**TSP**	**PLAN**	**1,200**	**330**	**396,000**	**330**	**396,000**	**330**	**396,000**	**330**	**396,000**	**330**	**396,000**	1,980,000
2.14	Outreach services provision especially in geographically and socially hard to reach population	TSP	ORA	3,600	330	1,188,000	330	1,188,000	330	1,188,000	330	1,188,000	330	1,188,000	5,940,000
B3	Improve Performance of Health Workforce														
2.15	Pre-deployment competency based training (MW)	TSP	TRN	1,000	330	330,000	330	330,000	330	330,000	330	330,000	330	330,000	1,650,000
2.16	In-service training for Health Care Providers (BHS/Hospital Staff), 4 types of training	TSP	TRN	15,000	66	990,000	66	990,000	66	990,000	66	990,000	66	990,000	4,950,000
2.17	Training & Refresher Training for AMWs	TSP	TRN	17,100	66	1,128,600	66	1,128,600	66	1,128,600	66	1,128,600	66	1,128,600	5,643,000
2.18	Supervision visits	TSP	M&E	750	330	247,500	330	247,500	330	247,500	330	247,500	330	247,500	1,237,500
B4	Strengthen Effective Systems of Referral														
2.19	Support for emergency referral	TSP	SDEV	3,600	330	1,188,000	330	1,188,000	330	1,188,000	330	1,188,000	330	1,188,000	5,940,000
B5	Increase Equitable Access														
2.20	MCH Voucher, hospital equity fund etc,.	TSP	SDEV	150,000	6	900,000	12	1,800,000	18	3,600,000	24	3,600,000	30	4,500,000	14,400,000
2C	**Community Engagement**														
	Community Understanding of RH Needs and Increase Demand														
	Support Health Promotion by Community Health Volunteers														

No.	Strategies/Activities	Level	Activity	unit cost ($)	2014		2015		2016		2017		2018		Total
					unit	cost	unit	cost	unit	cost	unit	cost	unit	cost	
2.21	MNCH related BCC activities (Group sessions and Interpersonal communication)	TSP	BCC	2,400	330	792,000	330	792,000	330	792,000	330	792,000	330	792,000	3,960,000
	Sub Total for table 2					**16,358,680**		**17,517,204**		**19,208,864**		**18,920,538**		**19,444,211**	**91,449,498**
Table-3: Birth Spacing															
3A	**Strengthen Health Systems**														
	Enabling Environment														
3.1	Develop advocacy toolkit and materials for decision-makers	NAT	ADV	15000	1	15000									15,000
3.2	Conduct advocacy	NAT	ADV	15000	1	15000									15,000
	Infrastructure and Logistics Management														
3.3	Birth Spacing Commodity Security	TSP	BS		1	10,514,704	1	10,719,522	1	10,927,260	1	11,128,674	1	11,385,441	54,675,601
	Improve Performance of Health Workforce														
3.4	Training of BHS on birth spacing	TSP	TRN	3,000	66	198,000	66	198,000	66	198,000	66	198,000	66	198,000	990,000
3.5	Training of private providers on birth spacing	**NGO**	**TRN**	**5,400**	**34**	**183,600**	**34**	**183,600**	**34**	**183,600**	**34**	**183,600**	**34**	**183,600**	**918,000**
3.6	**Training on IUD insertion**	**TSP**	**TRN**	**5,400**	**10**	**54,000**	**50**	**270,000**	**80**	**432,000**	**100**	**540,000**	**120**	**648,000**	**1,944,000**
3.7	**Training on Implant insertion**			**5,400**	**10**	**54,000**	**50**	**270,000**	**80**	**432,000**	**100**	**540,000**	**120**	**648,000**	**1,944,000**
3.8	Supervision visits	TSP	M&E	750	330	247,500	330	247,500	330	247,500	330	247,500	330	247,500	1,237,500
	Increase Equitable Access														
3.9	Outreach activities by MW and AMW	TSP	ORA	3,600	330	1,188,000	330	1,188,000	330	1,188,000	330	1,188,000	330	1,188,000	5,940,000
B	**Community Engagement**														
	Support Health Promotion by Community Health Volunteers														
3.10	Community Awareness Raising on Birth Spacing (Group sessions and interpersonal communication)	TSP	BCC	2,400	330	792,000	330	792,000	330	792,000	330	792,000	330	792,000	3,960,000
	Sub Total table 3					**13,261,804**		**13,868,622**		**14,400,360**		**14,817,774**		**15,290,541**	**71,639,101**
Table-4: Miscarriage and post-abortion care															
4A	**Strengthen Health Systems**														
	Enabling Environment														
4.1	Develop advocacy toolkit and materials for decision-makers	NAT	ADV	10000	1	10000									10,000
4.2	Conduct advocacy	NAT	ADV	15000	1	15000									15,000

No.	Strategies/Activities	Level	Activity	unit cost ($)	2014		2015		2016		2017		2018		Total
					unit	cost	unit	cost	unit	cost	unit	cost	unit	cost	
	Availability of Human Resources														
	Infrastructure and Logistics Management														
4.3	PAC commodity security (including MVA equipment)	TSP	SDEV	16,162	10	161,620	50	808,100	80	1,292,960	100	1,616,200	120	1,939,440	5,818,320
4.4	Supervision visits	TSP	M&E	750	10	7,500	50	37,500	80	60,000	100	75,000	120	90,000	270,000
4B	**Increase access to quality, integrated RH services**														
	Improve Performance of Health Workforce														
4.5	Training on PAC including MVA (Two types)	TSP	TRN	12,600	10	126,000	50	630,000	80	1,008,000	100	1,260,000	120	1,512,000	4,536,000
	Strengthen Effective Systems of Referral														
4.6	Support for emergency referral	TSP	SDEV	1,200	10	12,000	50	60,000	80	96,000	100	120,000	120	144,000	432,000
4C	**Community Engagement**														
	Behavior Change Communication Strategy														
	Community Understanding of RH Needs and Increase Demand														
4.7	Community Campaign activities	TSP	COM	2,400	10	24,000	50	120,000	80	192,000	100	240,000	120	288,000	864,000
	Support Health Promotion by CHV														
4.8	BCC activities on birth spacing, signs and symptoms ofmiscarriage, dangers of unsafe abortion (Group sessions and Interpersonal communication)	TSP	BCC	2,400	10	24,000	50	120,000	80	192,000	100	240,000	120	288,000	864,000
	Sub Total for table 4					**380,120**		**1,775,600**		**2,840,960**		**3,551,200**		**4,261,440**	**12,809,320**
Table-5: RTI/STI/HIV															
5A	**Strengthen Health Systems**														
	Infrastructure and Logistics Management														
5.1	RTI commodity security	TSP	SUPPL	46,396	66	3,062,136	132	6,124,272	198	9,186,408	264	12,248,544	330	15,310,680	45,932,040
5B	**Increase access to quality, integrated RH services**														
	Improve Performance of Health Workforce														
5.2	Training for BHS on RTI/STI/HIV	TSP	TRN	1,000	66	66,000	66	66,000	66	66,000	66	66,000	66	66,000	330,000
5C	**Community Engagement**														
	Support Health Promotion by CHV														
5.3	RTI/STI/HIV related BCC activities (Group sessions and Interpersonal communication)	TSP	BCC	2,400	66	158,400	66	158,400	66	158,400	66	158,400	66	158,400	792,000

No.	Strategies/Activities	Level	Activity	unit cost ($)	2014		2015		2016		2017		2018		Total
					unit	cost	unit	cost	unit	cost	unit	cost	unit	cost	
5.4	Peer educator training on RH/STI/HIV	TSP	BCC	1,000	66	66,000	66	66,000	66	66,000	66	66,000	66	66,000	330,000
	Sub Total for table 5					**3,352,536**		**6,414,672**		**9,476,808**		**12,538,944**		**15,601,080**	**47,384,040**
Table-6: Adolescent and Youth Health															
6A	**Strengthen Health Systems**														
	Enabling Environment														
6.1	Develop advocacy toolkit and materials for decision-makers	NAT	ADV	10000	1	10000									10,000
6.2	Conduct advocacy	NAT	ADV	15,000	1	15,000									15,000
6.3	Dialogue with community leaders	TSP	ADV	500	25	12,500	35	17,500	45	22,500	55	27,500	65	32,500	112,500
	Infrastructure and Logistics Management														
6.4	Reorganize health facilities to be youth friendly, multimedia and sport equipment	NAT	R&D	10,000	25	250,000	35	350,000	45	450,000	55	550,000	65	650,000	2,250,000
6B	**Increase access to quality, integrated RH services**														
	Essential Package of RH Services														
6.5	Meetings with youth to design IEC materials and service provision	NAT	BCC	3,000	1	3,000									3,000
6.6	Development and printing of IEC/BCC materials	NAT	BCC	10,000	1	10,000	1	10,000	1	10,000	1	10,000	1	10,000	50,000
	Expand Coverage of Services														
6.7	Outreach activities for out of school youth	TSP	ORA	1,200	25	30,000	35	42,000	45	54,000	55	66,000	65	78,000	270,000
	Improve Performance of Health Workforce														
6.8	Training for Health Care Providers	TSP	TRN	5,400	25	135,000	35	189,000	45	243,000	55	297,000	65	351,000	1,215,000
6.9	Training for Youth	TSP	TRN	4,700	25	117,500	35	164,500	45	211,500	55	258,500	65	305,500	1,057,500
6C	**Community Engagement**														
	Community Understanding of RH Needs and Increase Demand														
6.10	Meetings with community leaders	TSP	ADV	500	25	12,500	35	17,500	45	22,500	55	27,500	65	32,500	112,500
	Support Health Promotion by CHV														
6.11	ARH related BCC activities (Group sessions and Interpersonal communication)	TSP	BCC	2,400	25	60,000	35	84,000	45	108,000	55	132,000	65	156,000	540,000
6.12	BCC using broad casting & social media	NAT	BCC	10,000	1	10,000	1	10,000	1	10,000	1	10,000	1	10,000	50,000

No.	Strategies/Activities	Level	Activity	unit cost ($)	2014		2015		2016		2017		2018		Total
					unit	cost	unit	cost	unit	cost	unit	cost	unit	cost	
	Sub Total for table 6					**665,500**		**884,500**		**1,131,500**		**1,378,500**		**1,625,500**	**5,685,500**
Table-7: Cervical Cancer Screening															
7A	**Strengthen Health Systems**														
	Enabling Environment														
7.1	Develop advocacy toolkit and materials for decision-makers	NAT	ADV	10000	1	10000									10,000
7.2	Conduct advocacy	NAT	ADV	15000	1	15000									15,000
	Infrastructure and Logistics Management														
7.3	Supplies, equipment and commodities for cervical cancer screening	TSP	SUPPL	15,000	10	150,000	50	750,000	80	1,200,000	100	1,500,000	120	1,800,000	5,400,000
7B	**Increase access to quality, integrated RH services**														
	Essential Package of RH Services														
7.4	VIA and cryotherapy (3 sets/ tsp)	TSP	SDEV	15,000	10	150,000	50	750,000	80	1,200,000	100	1,500,000	120	1,800,000	5,400,000
7.5	Human Papilloma Virus vaccine vaccination to school girls	NAT	SDEV	31,957,843	0	0	0	0		0	1	31,957,843	1	31,957,843	63,915,686
	Improve Performance of Health Workforce														
7.6	Training on VIA (MW)	TSP	TRN	1,500	10	15,000	50	75,000	80	120,000	100	150,000	120	180,000	540,000
7.7	Training on VIA and cryotherapy (doctors)	TSP	TRN	4,500	10	45,000	50	225,000	80	360,000	100	450,000	120	540,000	1,620,000
7C	**Community Engagement**														
	Support Health Promotion by CHV														
7.8	Cervical Cancer related BCC activities (Group sessions and Interpersonal communication)	TSP	BCC	2,400	48	115,200	75	180,000	110	264,000	130	312,000	160	384,000	1,255,200
	Sub Total for table 7					**500,200**		**1,980,000**		**3,144,000**		**35,869,843**		**36,661,843**	**78,155,886**
Table-8: Infertility															
8.1	**Conduct training on clinical management for infertile couples**	**TSP**	**TRN**	**3,000**			**10**	**30,000**	**10**	**30,000**	**10**	**30,000**	**10**	**30,000**	**120,000**
	Sub Total for table 8							**30,000**		**30,000**		**30,000**		**30,000**	**120,000**
Table-9: Incorporating Gender Perspectives															
9A	**Strengthen Health Systems**														
	Strengthening the Health Sector Response to GBV														
9.1	Module adaptation of responding to IPV and SV (WHO)	NAT	GLINE	15,000	1	15,000									15,000

No.	Strategies/Activities	Level	Activity	unit cost ($)	2014		2015		2016		2017		2018		Total
					unit	cost	unit	cost	unit	cost	unit	cost	unit	cost	
9.2	Development of guideline on GBV services and printing	NAT	GLINE	10,000			1	10,000							10,000
9.3	Conduct Training of Trainers for GBV services	NAT	TRN	7,000			1	7,000							7,000
9.4	Conduct training for GBV services	NAT	TRN	3,000					10	30,000	10	30,000	10	30,000	90,000
9B	**Increase access to quality, integrated RH services**														
9.5	Printing of materials on engaging men in RH Programmes	NAT	GLINE	10,000	1	10,000	1	10,000	1	10,000	1	10,000	1	10,000	50,000
9.6	Advocacy and Training of health providers for male involvement	TSP	TRN	2,500	66	165,000	66	165,000	66	165,000	66	165,000	66	165,000	825,000
9C	**Community Engagement**														
9.7	Conduct Community level activities for male involvement	TSP	COM	800	66	52,800	66	52,800	66	52,800	66	52,800	66	52,800	264,000
9.8	Raise community awareness on GE & GBV														
9.9	Opinion leaders involvement	TSP	COM	400	66	26,400	66	26,400	66	26,400	66	26,400	66	26,400	132,000
	Sub Total for table 9					269,200		271,200		284,200		284,200		284,200	1,393,000
Table-10: RH in Humanitarian Settings															
10A	**Strengthen Health Systems**														
	Enabling Environment														
10.1	Advocacy and collaborative meetings (National, Regional and Township)	REG/TSP	ADV	1,100	14	15,400	14	15,400	14	15,400	14	15,400	14	15,400	77,000
10.2	National Technical working group for RH collaborators	NAT	ADV	500	4	2,000	4	2,000	4	2,000	4	2,000	4	2,000	10,000
	Infrastructure and Logistics Management														
10.3	ERH kits (12 types)	TSP	SUPPL	46,447	5	232,235	5	232,235	5	232,235	5	232,235	5	232,235	1,161,175
10B	**Increase access to quality, integrated RH services**														
10.4	Incorporate RH in humanitarian settings (workshops)	NAT	ADV	7,000	1	7,000	1	7,000	1	7,000	1	7,000	1	7,000	35,000
10.5	Incorporate RH in humanitarian settings (workshops)	REG	TRN	4,000	3	12,000	3	12,000	3	12,000	3	12,000	3	12,000	60,000
10.6	Set up mobile clinics (10 mobile clinics for 100,000 population)	TSP	SUPPL	10,000	5	50,000	5	50,000	5	50,000	5	50,000	5	50,000	250,000
	Improve Performance of Health Workforce														
10.7	Three days training (MISP) for doctors, nurses and coordinator	TSP	TRN	3,000	66	198,000	66	198,000	66	198,000	66	198,000	66	198,000	990,000
10.8	Three days for RH in emergencies for clinicians	TSP	TRN	3,000	66	198,000	66	198,000	66	198,000	66	198,000	66	198,000	990,000
10.9	**Three days training on support for GBV survivors**	TSP	TRN	3,000	66	198,000	66	198,000	66	198,000	66	198,000	66	198,000	990,000

No.	Strategies/Activities	Level	Activity	unit cost ($)	2014		2015		2016		2017		2018		Total
					unit	cost	unit	cost	unit	cost	unit	cost	unit	cost	
10.10	Two days training on use of RH kits (Managers, pharmacist)	TSP	TRN	3,000	66	198,000	66	198,000	66	198,000	66	198,000	66	198,000	990,000
	Sub Total for table 10					**1,110,635**		**1,110,635**		**1,110,635**		**1,110,635**		**1,110,635**	**5,553,175**
Table-11: Monitoring & Evaluation and Research															
11.1	Monitoring (Central, Regional, State, Township level)	TSP	M&E	750	330	247,500	330	247,500	330	247,500	330	247,500	330	247,500	1,237,500
11.2	Training on Maternal Death Review	TSP	TRN	2,000	100	200,000	100	200,000							400,000
11.3	Training on Maternal Death Surveillance & Response	TSP	TRN	2,000					100	200,000	100	200000	100	200000	600,000
11.4	**Township meetings on Maternal Death Review/Surveillance & Response**	**TSP**	**M&E**	1,00	**330**	33,000	330	33,000	330	33,000	330	33,000	330	33,000	**165,000**
11.5	Research (three national level research)	NAT	R&D	120,000	1	120,000			2	240,000					360,000
11.6	Mid-term review (2016)	NAT	M&E	60,000					1	60,000					60,000
11.7	Final Evaluation (2018)	NAT	M&E	60,000									1	60,000	60,000
	Sub Total for table 11					**600,500**		**480,500**		**780,500**		**480,500**		**540,500**	**2,882,500**
GRAND TOTAL						36,849,675		44,728,933		52,689,827		89,261,134		95,133,950	318,663,520

Table 10.2 Summary of Budget for Strategic Plan on Reproductive Health

	Strategies/Activities	2014	2015	2016	2017	2018	2014-2018
1	Central/National Level RH activities	350,500	396,000	282,000	279,000	284,000	**1,591,500**
2	Pregnancy, Delivery, Postnatal and Newborn Care	16,358,680	17,517,204	19,208,864	18,920,538	19,444,211	**91,449,498**
3	Birth Spacing	13,261,804	13,868,622	14,400,360	14,817,774	15,290,541	**71,639,101**
4	Miscarriage and post-abortion care	380,120	1,775,600	2,840,960	3,551,200	4,261,440	**12,809,320**
5	RTI/STI/HIV	3,352,536	6,414,672	9,476,808	12,538,944	15,601,080	**47,384,040**
6	Adolescent and Youth Health	665,500	884,500	1,131,500	1,378,500	1,625,500	**5,685,500**
7	Cervical Cancer Screening	500,200	1,980,000	3,144,000	35,869,843	36,661,843	**78,155,886**
8	Infertility	0	30,000	30,000	30,000	30,000	**120,000**
9	Incorporating Gender Perspectives	269,200	271,200	284,200	284,200	284,200	**1,393,000**
10	RH in Humanitarian Settings	1,110,635	1,110,635	1,110,635	1,110,635	1,110,635	**5,553,175**
11	Monitoring & Evaluation and Research	600,500	480,500	780,500	480,500	540,500	**2,882,500**
	GRAND TOTAL	**36,849,675**	**44,728,933**	**52,689,827**	**89,261,134**	**95,133,950**	**318,663,520**

Annex 1 National Population Policy

Draft (1992)

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

Annex 2 National Health Policy

(1993)

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

Annex 3 Myanmar Reproductive Health Policy (2002)

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

The National Reproductive Health Policy states:

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

Annex 4 Objectives of Myanmar Health Vision 2030

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

Annex 5 Definitions

Annex 5 a: Reproductive health as defined in ICPD PoA

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

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

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

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

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

Annex 6 Contents of Essential Package of RH Interventions

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

Annex 7 Reproductive Health Stakeholders

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

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Operation Plan for 2014

Costing of RH Strategic Plan (2014)

No.	Strategies/Activities	Level	Activity	unit cost ($)	2014		Responsibility							
					unit	cost	UNFPA	WHO	WHO/GAVI	MSI	PSI	3 MDGs	MMCWA	MCH/DOH /Govt
Table-1: Central/National Level RH activities														
1.1	Review/update operational policies and regulatory mechanisms for service provision by midwives and AMWs	NAT	REV	15,000	1	15,000	2,785							
1.2	Myanmar Health Sector Co-ordinating Committee, MNCH TSG/L RHWG meeting	NAT	ADV	1,000	4	4,000	4,040							
1.3	Development of policy briefs and dissemination from Annual Reports and research studies	NAT	R&D	1	1500	1,500	17,914			64,298				
1.4	Develop, Review and Revise of Guidelines, SOP, Manual and Curriculum	NAT	GLINE	10,000	2	20,000	10,000	22,000		5,000				
1.5	Advocacy/Training & Meetings to review human resources for RH services	NAT	REV	6,000	1	6,000	-			6,000			58,519	
1.6	Establish a RH Logistic Management Unit and LMIS	NAT	SDEV	12,000	1	12,000	2,000							
1.7	Meetings between RH Programme, HMIS and RH implementing partners	NAT	CDN	1,000	4	4,000	404					361,235	3,363	
1.8	RH commodity security/Infrastructor	NAT	SDEV	50,000	1	50,000	30,000	30,000				1,811,720	23,239	3,279,000
1.9	support for Regional training centre and training team	REG	TRN	15,000	7	105,000	6,618			45,008			3,996	
1.10	Meetings to develop themes, standardized messages for behavior change communication interventions	NAT	BCC	2,000	3	6,000	12,222						5,507	
1.11	Develop, review, revise and print the job aids, booklets and IEC materials	NAT	BCC		1	50,000		15,000		160,744	130,000	176,108	4,000	
								2,000			12,000			
1.12	Establishment of m-health and e-health for MNCH (2015-2018)	NAT	BCC	10,000	10	100,000	-							
	Sub Total For Table 1					**373,500**	**85,984**							
Table-2: Pregnancy, Delivery, Postnatal and Newborn Care														
2A	**Stregthen Health Systems**													
A1	**Enabling Environment**													
2.1	Develop advocacy toolkit and materials for decision-makers	NAT	ADV	15000	1	15000	-			2,000				
2.2	Conduct advocacy	NAT	ADV	15000	1	15000	-			12,000			36,286	
										16,074				
2.3	Build managerial capacity for TMOs	TSP	TRN	5000	3	15000			63,000					
A2	**Infrastructure and Logistics Management**													
	Safe motherhood commodity security (including distribution cost, freight charges etc.)													

No.	Strategies/Activities	Level	Activity	unit cost ($)	2014		Responsibility							
					unit	cost	UNFPA	WHO	WHO/GAVI	MSI	PSI	3 MDGs	MMCWA	MCH/DOH /Govt
2.4	Renovation and refurbishment of health facilities	TSP	INF	20,000	10	200,000								
2B	**Increase access to quality, integrated RH services**													
B.1	**Essential Package of RH Services**													
2.5	ANC Package	TSP	SDEV		1	4,164,466			57,789	385,786		965,108		
2.6	Delivery Package	TSP	SDEV		1	1,512,378			486,863					
	(CDK)								204,135					
	(Misoprostol)								130,284					
2.7	PNC Package	TSP	SDEV		1	17,811								
2.8	Newborn Care Package	TSP	SDEV		1	211,351								
2.9	Emergency Obstetric Care Package (Basic)	TSP	SDEV		1	2,699,207								
2.10	Emergency Obstetric Care Package (Comprehensive)	TSP	SDEV		1	183,367								
B2	**Expand Coverage of Services**													
2.11	Develop annual township plan for all components of RH (3 Meetings per year)	TSP	PLAN	500	330	165,000								
2.12	Outreach services provision especially in geographically and socially hard to reach population	TSP	ORA	3,600	330	1,188,000	9,091		1,293,000	64,298		514,938		
	Fixed Clinics									642,977				
B3	**Improve Performance of Health Workforce**													
2.13	Pre-deployment competency based training (MW)	TSP	TRN	1,000	330	330,000	2,298							
2.14	In-service training for Health Care Providers (BHS/Hospital Staff), 4 types of training	TSP	TRN	15,000	66	990,000	123,985					240,275		
2.15	Training & Refresher Training for AMWs	TSP	TRN	17,100	66	1,128,600	-		377,000	6,000		646,175		
2.16	Supervision visits	TSP	M&E	750	330	247,500	3,030	4,000	25,500	77,157		155,078		
B4	**Strengthen Effective Systems of Referral**													
2.17	Support for emergency referral	TSP	SDEV	3,600	330	1,188,000				38,579		1,071,689		
B5	**Increase Equitable Access**													
2.18	MCH Voucher, hospital equity fund etc,.	TSP	SDEV	150,000	6	900,000	-		245,000					
	Hospital Equity Fund								1,200,000					
2C	**Community Engagement**													
	Community Understanding of RH Needs and Increase Demand													
	Support Health Promotion by Communtiy Health Volunteers													
2.19	MNCH related BCC activities (Group sessions and Interpersonal communication)	TSP	BCC	2,400	330	792,000				64,298		112,890	63,850	
	Coordination Meeting								320,000			1,618,832		
	Sub Total for table 2					**15,962,680**	**138,405**							
Table-3: Birth Spacing														
3A	**Stregthen Health Systems**													

No.	Strategies/Activities	Level	Activity	unit cost ($)	2014		Responsibility							
					unit	cost	UNFPA	WHO	WHO/GAVI	MSI	PSI	3 MDGs	MMCWA	MCH/DOH /Govt
	Enabling Environment													
3.1	Develop advocacy toolkit and materials for decision-makers	NAT	ADV	15000	1	15000	100,000							
3.2	Conduct advocacy	NAT	ADV	15000	1	15000	-			16,074	28,000			
	Infrastructure and Logistics Management													
3.3	Birth Spacing Commodity Security	TSP	BS		1	10,514,704	1,000,000			1,709,662		19,599		
	Improve Performance of Health Workforce													
3.4	Training for BHS on birth spacing/ Private Provider	TSP	TRN	3,000	66	198,000				18,000	103,000			
3.5	Training on IUD and Implant insertion	TSP	TRN	10,800	10	108,000					103,000			
3.6	Supervision visits	TSP	M&E	750	330	247,500		5,000		64,298	8,000			
	Increase Equitable Access													
3.7	Outreach activities by MW and AMW	TSP	ORA	3,600	330	1,188,000				1,053,840	1,053,840		6,720	
	Fixed Clinics									578,680	578,680			
B	**Community Engagement**													
	Support Health Promotion by Communtiy Health Volunteers													
3.7	Community Awareness Raising on Birth Spacing (Group sessions and interpersonal communication)	TSP	BCC	2,400	330	792,000				128,595	130,000			
	Sub Total table 3					**13,078,204**	**1,100,000**							
Table-4:	**Miscarriage and post-abortion care**													
4A	**Stregthen Health Systems**													
	Enabling Environment													
4.1	Develop advocacy toolkit and materials for decision-makers	NAT	ADV	10000	1	10000								
4.2	Conduct advocacy	NAT	ADV	15000	1	15000				12,860				
	Availability of Human Resources													
	Infrastructure and Logistics Management													
4.3	PAC commodity security (including MVA equipment)	TSP	SDEV	16,162	10	161,620				51,438				
4.4	Supervision visits	TSP	M&E	750	10	7,500								
4B	**Increase access to quality, integrated RH services**													
	Improve Performance of Health Workforce													
4.5	Training on PAC including MVA (Two types)	TSP	TRN	12,600	10	126,000				10,288	6,825			
	Strengthen Effective Systems of Referral													
4.6	Support for emergency referral	TSP	SDEV	1,200	10	12,000				6,430				
4C	**Community Engagement**													
	Behavior Change Communication Strategy													
	Community Understanding of RH Needs and Increase Demand													

No.	Strategies/Activities	Level	Activity	unit cost ($)	2014		Responsibility							
					unit	cost	UNFPA	WHO	WHO/GAVI	MSI	PSI	3 MDGs	MMCWA	MCH/DOH /Govt
4.7	Community Campaign activities	TSP	COM	2,400	10	24,000				14,146			7,710	
	Support Health Promotion by CHV													
4.8	PAC related BCC activities (Group sessions and Interpersonal communication)	TSP	BCC	2,400	10	24,000								
	Sub Total for table 4					**380,120**	**0**							
Table-5: RTI/STI/HIV														
5A	**Stregthen Health Systems**													
	Infrastructure and Logistics Management													
5.1	RTI commodity security	TSP	SUPPL	46,396	66	3,062,136				96,447				
										321,489				
5B	**Increase access to quality, integrated RH services**													
	Improve Performance of Health Workforce													
	Conduct advocacy Township Level									37,293				
5.2	Training for BHS on RTI/STI/HIV	TSP	TRN	1,000	66	66,000				10,288				
	Peer Education									19,289				
5C	**Community Engagement**													
	Support Health Promotion by CHV													
5.3	RTI/STI/HIV related BCC activities (Group sessions and Interpersonal communication)	TSP	BCC	2,400	66	158,400				100,947			90,093	
													6,865	
	Sub Total for table 5					**3,286,536**								
Table-6: Adolescent and Youth Health														
6A	**Stregthen Health Systems**													
	Infrastructure and Logistics Management													
	RTI commodity security									12,860				
	Enabling Environment													
6.1	Develop advocacy toolkit and materials for decision-makers	NAT	ADV	10000	1	10000								
6.2	Conduct advocacy	NAT	ADV	15,000	1	15,000				6,430				
6.3	Dialogue with community leaders	TSP	ADV	500	25	12,500								
	Infrastructure and Logistics Management													
6.4	Reorganize health facilities to be youth friendly, multimedia and sport equipments	NAT	R&D	10,000	25	250,000								
6B	**Increase access to quality, integrated RH services**													
	Essential Package of RH Services													
6.5	Meetings with youth to design IEC materials and service provision	NAT	BCC	3,000	1	3,000								
6.6	Development and printing of IEC/BCC materials	NAT	BCC	10,000	1	10,000								
	Expand Coverage of Services													
6.7	Outreach activities for out of school youth	TSP	ORA	1,200	25	30,000								

No.	Strategies/Activities	Level	Activity	unit cost ($)	2014		Responsibility							
					unit	cost	UNFPA	WHO	WHO/GAVI	MSI	PSI	3 MDGs	MMCWA	MCH/DOH /Govt
	Improve Performance of Health Workforce													
6.8	Training for Health Care Providers	TSP	TRN	5,400	25	135,000		8,000		2,649		8,715		
6.9	Training for Youth	TSP	TRN	4,700	25	117,500				16,461		1,145		
6C	**Community Engagement**													
	Community Understanding of RH Needs and Increase Demand													
6.10	Meetings with community leaders	TSP	ADV	500	25	12,500							14,350	
	Support Health Promotion by CHV													
6.11	ARH related BCC activities (Group sessions and Interpersonal communication)	TSP	BCC	2,400	25	60,000				43,680				
6.12	BCC using broad casting & social media	NAT	BCC	10,000	1	10,000								
	Sub Total for table 6					**665,500**								
Table-7: Cervical Cancer Screening														
7A	**Stregthen Health Systems**													
	Enabling Environment													
7.1	Develop advocacy toolkit and materials for decision-makers	NAT	ADV	10000	1	10000								
7.2	Conduct advocacy	NAT	ADV	15000	1	15000		15,000		6,430				
	Infrastructure and Logistics Management													
7.3	Supplies, equipment and commodities for cervical cancer screening	TSP	SUPPL	15,000	10	150,000				19,289				
										12,860				
7B	**Increase access to quality, integrated RH services**													
	Essential Package of RH Services													
7.4	VIA and Cryotherapy (3 sets/ tsp)	TSP	SDEV	15,000	10	150,000								
7.5	Human Papilloma Virus vaccine vaccination to school girls	NAT	SDEV	31,957,843	0	0								
	Improve Performance of Health Workforce													
7.6	Training on VIA (MW)	TSP	TRN	1,500	10	15,000				10,288				
7.7	Training on VIA and cryotherapy (doctors)	TSP	TRN	4,500	10	45,000				10,240				
7C	**Community Engagement**													
	Support Health Promotion by CHV													
7.8	Cervical Cancer related BCC activities (Group sessions and Interpersonal communication)	TSP	BCC	2,400	48	115,200				2,500				
										23,147				
	Sub Total for table 7					**500,200**								
Table-8: Incorporating Gender Perspectives														
8A	**Stregthen Health Systems**													
	Strengthening the Health Sector Response to GBV													

No.	Strategies/Activities	Level	Activity	unit cost ($)	2014		Responsibility							
					unit	cost	UNFPA	WHO	WHO/GAVI	MSI	PSI	3 MDGs	MMCWA	MCH/DOH /Govt
8.1	Module adaptation of responding to IPV and SV (WHO)	NAT	GLINE	15,000	1	15,000								
8.2	Development of guideline on GBV services and printing	NAT	GLINE	10,000										
8.3	Conduct Training of Trainers for GBV services	NAT	TRN	7,000						12,860				
8.4	Conduct training for GBV services	NAT	TRN	3,000						25,719				
8B	**Increase access to quality, integrated RH services**													
8.5	Printing of materials on engaging men in RH Programmes	NAT	GLINE	10,000	1	10,000								
8.6	Advocacy and Training of health providers for male involvement/gender	TSP	TRN	2,500	66	165,000		6,000		9,645		1,483		
8C	**Community Engagement**													
8.7	Conduct Community level activities for male invovlvement	TSP	COM	800	66	52,800				12,860				
										22,504				
										9,645				
8.8	Raise community awareness on GE & GBV													
8.9	Opinion leaders involvement	TSP	COM	400	66	26,400								
	Sub Total for table 8					269,200								
Table-9: RH in Humanitarian Settings														
9A	**Stregthen Health Systems**													
	Enabling Environment													
9.1	Advocacy and collaborative meetings (National, Regional and Township)	REG/ TSP	ADV	1,100	14	15,400								
9.2	National Technical working group for RH collaborators	NAT	ADV	500	4	2,000								
	Infrastructure and Logistics Management													
9.3	ERH kits (12 types)	TSP	SUPPL	46,447	5	232,235								
9B	**Increase access to quality, integrated RH services**													
9.4	Incorporate RH in humanitarian settings (workshops)	NAT	ADV	7,000	1	7,000								
9.5	Incorporate RH in humanitarian settings (workshops)	REG	TRN	4,000	3	12,000								
9.6	Set up mobile clinics (10 mobile clinics for 100,000 population)	TSP	SUPPL	10,000	5	50,000								
	Improve Performance of Health Workforce													
9.7	Three days training (MISP) for doctors, nurses and coordinator	TSP	TRN	3,000	66	198,000				7,934				
9.8	Three days for RH in emergencies for clinicians	TSP	TRN	3,000	66	198,000								
9.9	Two days training on use of RH kits (Managers, pharmacist)	TSP	TRN	3,000	66	198,000								

No.	Strategies/Activities	Level	Activity	unit cost ($)	2014		Responsibility							
					unit	cost	UNFPA	WHO	WHO/GAVI	MSI	PSI	3 MDGs	MMCWA	MCH/DOH /Govt
	Sub Total for table 9					**912,635**								
Table-10: Monitoring & Evaluation and Research														
10.1	Monitoring (Central, Regaional, State, Township level)	TSP	M&E	750	330	247,500				321,492		8,563	39,374	
													2,262	
													2,992	
10.2	Training on Maternal Death Review	TSP	TRN	2,000	100	200000		8,000						
10.3	Training on Maternal Death Surveillance & Response	TSP	TRN	2,000								4,348		
10.4	Research (three national level research)	NAT	R&D	120,000	1	120,000					54,000			
10.5	Mid-term review (2016)	NAT	M&E	60,000										
10.6	Final Evaluation (2018)	NAT	M&E	60,000										
	Sub Total for table 10					**567,500**								
GRAND TOTAL						**35,996,075**	**1,324,388**	**115,000**	**4,402,571**	**4,429,776**	**2,207,345**	**7,717,901**	**369,126**	**3,279,000**

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

Planned Cost = 35,996,075

Actual Cost = 19,442,536

GAP = 16,553,539 (46%)

FIVE-YEAR STRATEGIC PLAN FOR REPRODUCTIVE HEALTH

(2014-2018)