Costed Implementation Plan to meet FP2020 Commitments Myanmar

2014

Costed Implementation Plan

to meet

FP2020 Commitments

Myanmar

2014

Department of Public Health

Ministry of Health

(April 2015)

Acknowledgement

Family planning has numerous health benefits for women, their sexual partners, and their children. Family planning helps to prevent unintended pregnancies and the number of unsafe abortions, thereby reducing maternal deaths and disabilities. The global consensus that family planning is a human right was recognised at the 1994 International Conference on Population and Development, in Principle 8 of the Programme of Action: “All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so.”

Myanmar first committed itself in the wake of the landmark Summit of Family Planning 2020, which was launched on 11 July 2012 in London, United Kingdom. At the Summit, Heads of State and Governments pledged to reduce unmet needs for family planning across the globe.

Family Planning 2020 (FP2020) is a global initiative which works with governments, civil society, multi-lateral organisations, donors, the private sector and the research and development community. The goal is that by 2020, 120 million more women and girls will have access to contraceptives. This will support the rights of women and girls to decide, freely, and for themselves, whether, when, and how many children they want to have.

At present only 39.5% of women of reproductive age are able to access modern methods of contraception that enable them to practice voluntary family planning. Official figures show that the unmet need for contraception has increased from 17.7% in 2007 to 24.2% in 2010. About 24.2% of Myanmar women of reproductive age want to delay or end childbearing but are not using modern contraception.

In its FP2020 commitment, Myanmar has promised to invest more resources to reduce the current unmet need for contraception to less than 10% by 2015 and to increase the Contraceptive Prevalence Rate to 50% by 2015.

We congratulate the Government of the Republic of Union of Myanmar for its commitments to FP2020 and the swift actions taken by the Ministry of Health in its efforts to achieve the targets. Much needs to be done to improve and strengthen the supply chain, thereby avoiding bottlenecks and ensuring that important life-saving commodities, including contraceptives, reach the hands of women who need them.

This costed implementation plan to meet FP2020 is the first in Myanmar and UNFPA is proud to have worked very closely with the Ministry of Health in the development. We acknowledge with thanks the technical contribution of Dr. Katherine Ba Thike, UNFPA consultant and Ms. Nichole Zlatunich, Lucile Packard Foundation’s support for the costing. I am certain that this costed implementation plan will be the road map for all stakeholders to contribute complementarily to make the FP2020 commitment a reality in Myanmar.

We look forward to strengthening our relationship and collaboration with the Government of the Republic of Union of Myanmar in its national efforts to attain the highest level of health for its people and the Ministry of Health’s efforts to provide universal access to Reproductive health services including Family planning.

Janet E Jackson,

Country Representative, UNFPA-Myanmar

Foreword

The Costed Implementation Plan to meet FP2020 commitments supports the Myanmar Health Vision 2030 of the Ministry of Health and National Population Policy in 1992, shifting from a pronatalist policy to a health-oriented approach. This includes the promotion of birth spacing to improve the health status of women and children and for eligible couples to decide on the number of children as their individual rights.

The Goal of the Implementation Plan to meet FP2020 commitments is to contribute to:

(i) improved reproductive health of women, men and adolescents

(ii) reduction in maternal and infant mortality and morbidity

through scaling up the provision of quality integrated birth spacing services.

The Plan complements the National Strategic Plan for Reproductive Health in Myanmar (2014- 2018) through focused activities that are aligned with the Strategic Plan for RH. These are on advocacy to reinforce an enabling environment for birth spacing; generating demand and sustaining behavior change among clients and providers; increasing availability of good quality birth spacing services through improving the capacity of the health workforce and the availability of a reliable supply of contraceptives. Commitments to FP2020 will be monitored and data will be used for evidence-based decision-making.

The Implementation Plan to meet FP2020 commitments was developed through a participatory approach involving senior staff from Departments under the Ministry of Health (MoH), obstetricians and gynaecologists from central, state and regional levels, representative of national and international NGOs, multilateral and bilateral donors and UN agencies. Discussions emanating from a three-day *Family Planning Best Practices Conference* held in Nay Pyi Taw from June 30 to 2 July 2014 which brought together international experts and key stakeholders from Myanmar contributed in the development of the Plan. Teams from 10 townships comprising of the Township Medical Officer, Assistant Surgeons/Medical Officers, Lady Health Visitors and Midwives from each township ensured inputs from grass-roots level and front-line workers.

We appreciate the contributions of all who participated in the national workshop and meetings and provided their time and expertise to the development of the Costed Implementation Plan to meet FP2020 commitments. 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 for the development of the Costed Implementation Plan.

Dr Thein Thein Htay

Deputy Minister

Ministry of Health

Table of Contents

Acronyms

AAAQ	Availability, Accessibility, Acceptability and Quality
AIDS	Acquired Immune Deficiency Syndrome
AMW	Auxiliary Midwife
ANC	Antenatal Care
ARH	Adolescent Reproductive Health
BCC	Behavioural Change Communication
BHS	Basic Health Staff
BS	Birth spacing
CBO	Community-based organization
CIP	Costed Implementation Plan
CHEB	Central Health Education Bureau
CHV	Community Health Volunteer
CME	Continuing Medical Education
CMSD	Central Medical Stores Depot
CSO	Civil society organization
CYP	Couple Years Protection
DMPA	Depot-medroxyprogesterone
DoH	Department of Health
EPI	Expanded Programme of Immunization
FHI 360	Family Health International 360
FP	Family planning
FP2020	Family planning 2020
FRHS	Fertility and Reproductive Health Survey
GoM	Government of the Republic of the Union of Myanmar/ Government of Myanmar
GPRHCS	Global programme to enhance reproductive health commodity security
HCT	HIV counseling and testing
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
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
IPPF	International Planned Parenthood Federation
IUD	Intra-uterine contraceptive device
JICA	Japan International Cooperation Agency
JOICFP	Japanese Organization for International Cooperation in Family Planning
KAP	Key Affected Populations
Lao PDR	Lao People's Democratic Republic
LARC	Long-acting reversible contraception
LARM	Long-acting reversible methods
LMIS	Logistics Management Information System
M4RH	Mobile for reproductive health
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
MMCWA	Myanmar Maternal and Child Welfare Association
MMR	Maternal mortality ratio
MNCH	Maternal, newborn and child health
MNMA	Myanmar Nurse and Midwife Association
MNCWA	Myanmar National Committee of Women's Affairs
MoH	Ministry of Health
MRTV	Myanmar Radio and Television
MSI	Marie Stopes International
MVA	Manual Vacuum Aspiration
MW	Midwife
MyMA	Myanmar Medical Association
NAP	National AIDS Programme
NGO	Non-government organization
PAC	Post-abortion care
PCFS	Population Changes and Fertility Survey
PMTCT	Prevention of mother-to-child transmission
PPFP	Post-partum family planning
PPH	Post-partum haemorrhage
PPIUD	Post-partum IUD
PROGRESS	Program Research for Strengthening Service
PSI	Population Services International
RH	Reproductive health
RHC	Rural Health Centre
RHCS	Reproductive health commodity security
SBCC	Social and behavioural change communication
SDP	Service delivery points
SOP	Standard Operating Procedures
TMO	Township Medical Officer
TSG	Technical and Strategy Group
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VHW	Voluntary Health Worker
WHO	World Health Organization
3MDG Fund	Three Millennium Development Goal Fund

Executive Summary

Myanmar formulated the National Population Policy in 1992, shifting from a pronatalist policy to a health-oriented approach. This includes the promotion of birth spacing to improve the health status of women and children and for eligible couples to decide on the number of children as their individual rights.

The Reproductive Health Policy and Strategic Plans on Reproductive Health (2004-2008, 2009- 2013 and 2014-2018) of the Ministry of Health (MoH) are continued commitments to the Programme of Action of the International Conference on Population and Development (ICPD PoA), the United Nations Millennium Development Goals (MDG) and the UN Secretary-General's Global Strategy for Women and Children's Health (2010). Birth spacing is one of the core elements in the successive Strategic Plans for Reproductive Health.

Myanmar has also pledged to the global partnership initiative - Family Planning 2020 - in November 2013 at Addis Ababa in Ethiopia and has made the following commitments:

- to strengthen the policy of providing clinical contraceptive methods by trained/skilled nurses, midwives and volunteers through better collaboration among multi-stakeholders within the context of the Nay Pyi Taw Accord.

- to implement people-centered policies to address regional disparity and inequity between urban and rural and rich and poor.

- to expand the forum of family planning under the umbrella of the Health Sector Coordinating Committee and to create a Working Group on Family Planning as a branch of the MNCH Technical Strategy Group.

The Implementation Plan to meet FP2020 commitments will accelerate action to meet Myanmar's commitments and was developed within the framework of the Reproductive Health Policy and the Five-Year Strategic Plan for Reproductive Health (2014-2018).

The Goal of the Implementation Plan to meet FP2020 commitments is to contribute to:

(i) improved reproductive health of women, men and adolescents

(ii) reduction in maternal and infant mortality and morbidity

through scaling up the provision of quality integrated birth spacing services.

The specific objectives of the Implementation Plan are:

- To increase CPR from 41 per cent to 50 per cent by 2015 and above 60 per cent by 2020

- To reduce unmet need to less than 10 per cent by 2015 (from 12 per cent in 2013)

- To increase demand satisfaction from 67 per cent to 80 per cent by 2015

- To improve method mix with increased use of long acting reversible methods

- To reduce adolescent pregnancy rate from 16.9 per 1,000 to 10 per 1,000 (2018) and

- To improve access by decentralizing the management of reproductive health programmes including birth spacing programmes to districts and townships.

The Strategies are aligned with the Strategic Plan for RH (2014-2018) and are to (i) Reinforce an enabling environment

for birth spacing; (ii) Generate demand and sustain behavior change; (iii) Improve performance of health workforce for birth spacing; (iv) Increase availability of good quality birth spacing services; (v) Improve availability of a reliable supply of contraceptives and (vi) Incorporate indicators to monitor commitments to FP2020 in the health information system and enhance the use of data for decision-making

The Department of Health will collaborate with other departments and divisions under the Ministry of Health and will partner with other ministries, professional associations, academia, United Nations agencies, bilateral donors and civil society organizations including NGOs. The Reproductive, Maternal, Newborn and Child Health Technical Support Group (RMNCH TSG) through the Lead Family Planning Working Group will co-ordinate the realization of the objectives of the Implementation Plan.

Monitoring of the Implementation Plan will indicate progress towards and achievement of the expected results and the indicators will link with the national Health Management Information System (HMIS). A Mid-term Review to assess whether the implementation is proceeding as planned and a Final Evaluation to determine whether the interventions have had an impact will be conducted in conjunction with the review and evaluation of the Strategic Plan for RH (in 2016 and 2018). Achievements of the Implementation Plan will be measured in 2020 in terms of its effects on the impact indicators, such as contraceptive prevalence and unmet need for family planning.

Costing elements are described and costed based on specific data from the Department of Health and UNFPA. Contraceptive costs are calculated for the period from 2015 to 2020. The total of the Implementation Plan is estimated at US Dollars 261,871,113 and over US Dollars 182 million or 70 per cent of the costs are in commodities, including contraceptives and consumables.

1 Introduction

Family planning (FP) has for several decades been well documented as a key strategy to promote social and economic development, to improve the health of women and their children and one of the most cost-effective ways to prevent maternal, infant, and child mortality. Family planning can reduce maternal mortality by reducing the number of pregnancies, the number of abortions, and the proportion of births at high risk.[1] It has been estimated that meeting women's need for modern contraceptives would prevent about one quarter to one-third of all maternal deaths, saving 140,000 to 150,000 lives a year.[2] Family planning offers a host of additional health, social, and economic benefits: it can help reduce infant mortality, slow the spread of HIV/AIDS, promote gender equality, reduce poverty, accelerate socioeconomic development, and protect the environment.

The International Conference on Population and Development (ICPD) recognized that voluntary, good quality family planning services that include counselling and access to contraceptives must be available, accessible and affordable as one of the core elements of a comprehensive sexual and reproductive health services package. Furthermore, the contribution of family planning to achieve MDG 5 - to improve maternal health cannot be overstated. It is one of the three agreed pillars by which to accelerate reduction of maternal and newborn mortality and morbidity – alongside emergency obstetric and newborn care, and skilled birth attendance.

Availability of contraception and dual protection are also important ways to reduce potential HIV infection in children through rights-based prevention of unintended pregnancies in women living with HIV, while condoms will also prevent new HIV infections in women, men, and adolescents, and contribute to reducing maternal mortality (MDGs 4, 5, and 6). Access to contraception is integral to efforts to reduce recourse to abortion.[3]

It is stated in the ICPD Programme of Action that: "All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so."

On 11 July 2012, family planning stakeholders from around the world united for the London Summit on Family Planning. The UK government through the Department for International Development (DFID) and the Bill and Melinda Gates Foundation partnered with UNFPA to host a gathering of leaders from national governments, donors, civil society, the private sector, the research and development community, and other interest groups to renew and revitalize global commitment to ensuring the world's women and girls, particularly those living in low-resource settings, have access to contraceptive information, services, and supplies.

The objective of the summit was to "mobilize global policy, financing, commodity and service delivery commitments to support the rights of an additional 120 million women and girls in the world's 69 poorest countries to use contraceptive information, services and supplies, without coercion or discrimination, by 2020." Doing so would prevent a staggering 100 million unintended pregnancies, 50 million abortions, 200,000 pregnancy- and childbirth-related maternal deaths, and 3 million infant deaths.[4]

---

[1] Lule E, Hasan R, Yamashita-Allen K. Global trends in fertility, contraceptive use and unintended pregnancies. In: Lule E, Singh S, Chowdhury SA, eds. Fertility Regulation Behaviors and Their Costs: Contraception and Unintended Pregnancies in Africa and Eastern Europe & Central Asia. Health, Nutrition & Population Discussion Paper. Washington, DC: World Bank; 2007:8–39. Available at: http:// go.worldbank.org/BZSBN-C53A0

[2] Singh S, Darroch JE, Vlassof M, Nadeau J. Adding It Up: The Benefits of Investing in Sexual and Reproductive Health Care. New York: Alan Guttmacher Institute; 2003. Available at: www.guttmacher.org/pubs/addingitup.pdf.

[3] Choices Not Chance – UNFPA Family Planning Strategy for 2012-2020

[4] Family Planning Summit 2012, Technical Note: date sources and methodology for calculating 2012 baseline, 2020 objectives, impacts and costings, Family Planning Summit Metrics Group, 2012

The London Summit on Family Planning committed to:

1) Increase demand and support for family planning by removing barriers to access and use
2) Improve supply chains, and systems and service delivery models and procure more affordable and quality contraceptives through better global coordination and include new methods for expanded choice
3) Improve market dynamics, including country forecasting capabilities and increased availability and quality of a range of family planning methods
4) Promote accountability at global and country levels through improved monitoring and evaluation
5) Advocate for sustained government and donor funding

On a country level, the key steps to ensure increased uptake of family planning include:

- Promote best practices,
- Support new innovations,
- Improve supply chains,
- Increase contraceptive supply,
- Strengthen accountability, and
- Support advocacy.

Myanmar is among the countries that have pledged commitment to FP2020 since the Government of Myanmar views family planning as critical to saving lives, protecting mothers and children from death, ill health, disability and underdevelopment. It views access to family planning information, commodities and services as a fundamental right for every woman and individual in the community if they are to develop to their full potential.

Myanmar has defined clear objectives and made commitments related to programme and service delivery and finance/budget allocation and at the policy and political level to achieve its pledge. (Annex 1: Myanmar's commitments to FP2020)

2 Methodology

The Implementation Plan to meet FP2020 commitments was developed within the framework of the pre-existing strategies developed by the Ministry of Health (MoH): the Reproductive Health Policy and the Five-Year Strategic Plan for Reproductive Health (2014-2018).

A document review of key publications on reproductive health and birth spacing programmes in Myanmar, survey reports, stakeholder analysis and programme reports of the Department of Health, UNFPA Country Office in Myanmar and NGO reports was conducted. Publications on contraceptive methods, family planning programmes and health systems developed by WHO, UNFPA and major NGOs working in family planning were consulted.

A three-day *Family Planning Best Practices Conference* was held in Nay Pyi Taw from June 30 to 2 July 2014. The conference brought together more than 100 guests from Myanmar and around the world to discuss best practices in family planning. The participants included senior staff from Departments under the Ministry of Health (MoH), obstetricians and gynaecologists from central, state and regional levels, representative of national and international NGOs, multilateral and bilateral donors and UN agencies.

Teams from 10 townships comprising of the Township Medical Officer, Assistant Surgeons/Medical Officers, Lady Health Visitors and Midwives from each township ensured inputs from grass-roots level and front-line workers. Township representatives shared their experiences and worked in groups with other participants to identify bottlenecks and challenges currently faced and developed innovative solutions and plans for actions for the future. They developed township action plans on family planning and related reproductive health services. The outputs from this conference were included in the preparation of the Implementation Plan.

During the drafting of this Implementation Plan, working sessions were held with personnel from Reproductive Health Programme, DoH, UN agencies, national NGOs and INGOs. Revisions and feedback were included and reviewed in consultative meetings.

3 Country Context

3.1 Geography and demographic profile

Myanmar covers an area of 676,578 square kilometers and is the westernmost country in South-East Asia. Myanmar shares borders with the People's Republic of China in the north and northeast; with Lao People's Democratic Republic (PDR) and the Kingdom of Thailand in the east and southeast, the People's Republic of Bangladesh and the Republic of India in 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[5].

According to the Population and Housing Census conducted in 2014, the population of Myanmar was estimated at 51.42 million[6]. About 70 percent of the population resides in the rural areas, whereas the remaining are urban dwellers.[7]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[8].

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[9].

3.2 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 eight departments, each under a Director-General. The Ministry of Health formulates National Health Plan (NHP) s which are 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. NHP 2011-2016 is currently being implemented.

The Department of Health (DoH) is responsible for providing comprehensive health care services to the entire population in the country. The Public Health Division is responsible for primary health care and basic health services, nutrition promotion and research, environmental sanitation, 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 Departments of Medical Research (Lower Myanmar) and (Upper Myanmar) strive towards a common vision, to achieve a healthier nation through application of research findings. The Department of Traditional

[5] Health in Myanmar 2013, Ministry of Health

[6] Department of Population, Ministry of Immigration and Population, 2014

[7] Health in Myanmar 2013, Ministry of Health

[8] Department of Population, Ministry of Immigration and Population, 2013

[9] Statistical Yearbook 2009, Central Statistical Organization, Ministry of National Planning and Economic Development

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.

At the State/Regional level, the State/Regional Health Department is responsible for planning, coordination, training and technical support, supervision, monitoring and evaluation of health services; and managing the provision of tertiary care and referral services.

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).

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 volunteers.

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.

4 Situational Analysis

4.1 Birth spacing situation

Demographic and health indicators are widely accepted measures to assess a country's health situation. Key indicators for Myanmar are shown in Table 4.1.

Table 4.1 – Demographic and Health Indicators

Population in millions	51.42 million	Census, 2014
- Men	24.82 million	Census, 2014
- Women	26.6 million	Census, 2014
Population growth rate	1.75	CSO, 2009
Total Fertility Rate	2.0	2007 FRHS
Contraceptive Prevalence Rate	40.9 per cent	2007 FRHS
Unmet need for contraception	17.7 per cent	2007 FRHS
Adolescent Fertility Rate	16.9 per 1,000	2007 FRHS
Maternal Mortality Ratio	200 per 100,000 live births	UN estimates, 2013
Infant Mortality Rate	48 per 1,000 live births	UN estimates, 2013

Total Fertility Rate

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). There is geographical variation with the highest in Rakhine State at 2.87 children per woman and lowest in Yangon and Mandalay Regions (1.72 and 1.69) with TFR just over 2.0 in the remaining states/regions. In this survey, the TFR is calculated for married women.

Contraceptive Prevalence Rate

The 2007 FRHS (2009) reported that 38 per cent of married women were using contraceptives - 49 per cent of urban and 34 per cent of rural women. Successive surveys on fertility and reproductive health revealed a steady increase in contraceptive prevalence rates: 28 per cent in 1997[10] to 33 per cent in 2001[11] and 38 per cent in 2007[12]. Fertility-related reasons and method-related issues were attributing factors to non-use of contraceptives. CPR was directly related to educational level, being highest in more educated women.

The most popular contraceptive method is the hormonal injection, which is used by 19 per cent of women followed by the daily pill (10 per cent), female sterilization (4 per cent) and IUD (2 per cent). Other methods including the male condom, the lactational amenorrhoea method, abstinence and withdrawal comprise less than 1 per cent. The highest contraceptive prevalence rates were reported in Yangon (57 per cent) and Bago (45 per cent) and the lowest in Chin and Sagaing (28 per cent).

The 2007 FRHS also noted that a high percentage of married women (97 per cent) have knowledge of at least one birth spacing method. The increase in knowledge is one of the contributing factors leading to the increase in contraception prevalence rate. However, women aged 15-19 have the lowest scores for knowledge of at least one method as well as the source of supplies. Women who live in rural areas or are of lower educational levels have low scores as well.

[10] 1997 Population Changes and Fertility Survey

[11] 2001 Fertility and Reproductive Health survey

[12] 2007 Fertility and Reproductive Health survey

Unmet Need for Family Planning

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

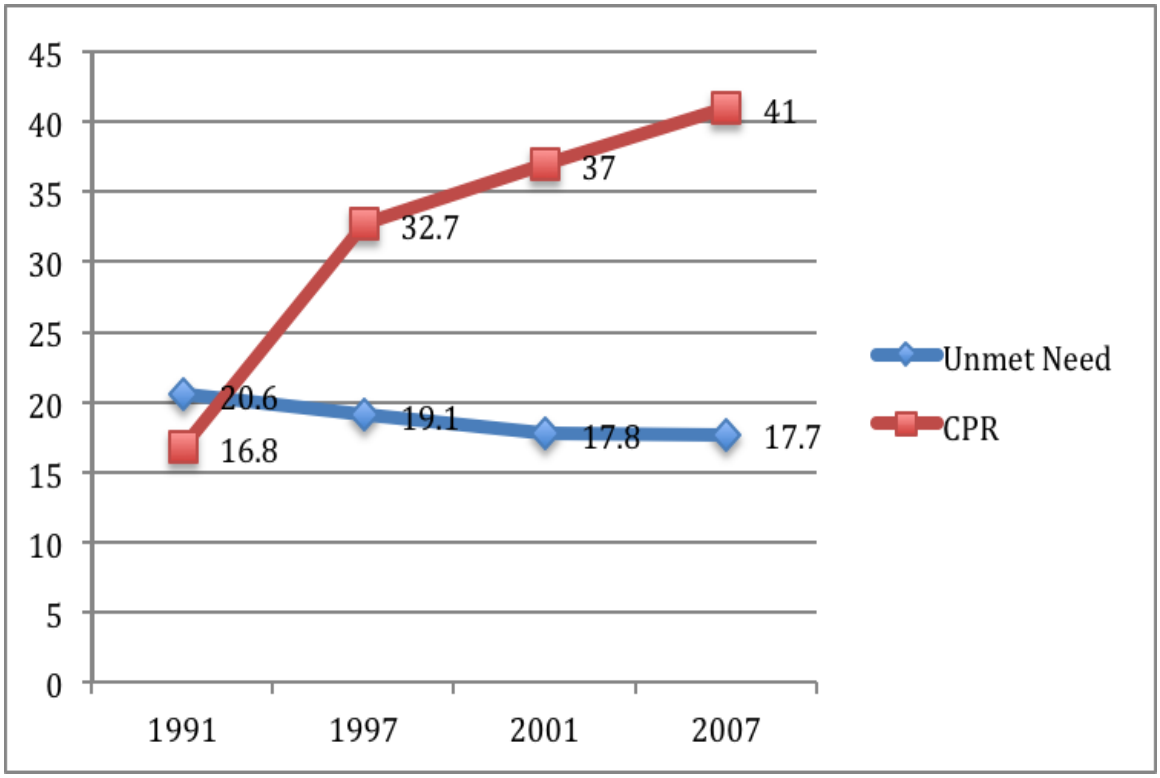


Figure 4.1: Trends in Contraceptive Prevalence Rate and Unmet Need, 1991-2007

Miscarriage and post-abortion complications

The nation-wide Cause Specific Maternal Mortality Survey (2004-2005) estimated Maternal Mortality Ratio (MMR) at the national level at 316 per 100,000 livebirths and miscarriage and abortion-related mortality to be 10 percent. Septicaemia was the leading cause of maternal mortality in 2008 of which septic induced abortion occurring as a result of unsafe abortion is one of the contributing factors (Ministry of Health, 2011). FRHS (2009) reports that approximately 5 per cent of all pregnancies end in abortion with the highest rate occurring among women aged 15-19 years.

Fertility Preference

The mean ideal family size has declined slightly from 3.3 children in 1991 to 3.2 children in 2006. About half of currently married women of reproductive age do not desire to have any more children. Approximately five per cent have had a tubectomy and 15 per cent would like to space their next child for two years. Six per cent are believed to be infecund. Twelve per cent of those with no living children and 21 per cent of currently married youth want no more children. (FRHS, 2009)

4.2 Policies and programmes on birth spacing

Myanmar formulated the National Population Policy in 1992, shifting from a pronatalist policy to a health-oriented approach. This includes the promotion of birth spacing to improve the health status of women and children and for eligible couples to decide on the number of children as their individual rights.

The birth spacing programme was initiated in the public sector in 1991 funded by Family Planning International Assistance. UNFPA provided support to 20 townships in 1992 and the programme was gradually expanded to other townships. By 2014, UNFPA support for reproductive health covered 163 out of 330 townships.

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 family planning commodities. INGOs collaborate with general practitioners for birth spacing/family planning services in clinics in urban and peri-urban areas, through social franchising and social marketing; and through fixed clinics and outreach activities.

Birth spacing is one of the core elements in the successive Strategic Plans for Reproductive Health. The package of birth spacing services is outlined in Table 4.2.

Efforts are underway to foster the *integration of BS* with other reproductive health services, such as HIV/AIDS, postnatal care and postabortion care. Integration of services will help to reach new populations who may need BS and who must be reached. Adolescents and youth need special attention, both in increasing their access to information and friendly services and in helping them to choose and use contraceptive methods effectively. In addition to clinic-based services, community-based services include provision of information on birth spacing and contraceptives and community-based distribution of short-acting methods and mobile clinics.

Table 4.2: Package of birth spacing services

Information and counselling	Clinical services
Information and counselling on contraception and methods	Contraceptive pills (combined and progesterone only)
Post-abortion counselling	Progesterone injectables
Postpartum counselling	Condoms
Counselling on female sterilization	Emergency contraception
Follow-up of contraceptive users	Insertion and checking of IUCDs and removal
Referral for services that are available at higher referral centres	Progesterone implant insertion and removal
	Lactational Amenorrhea Method
	Female sterilization (tubectomy)

Demand generation and service delivery

Development of Information, Education and Communication (IEC) materials and conduct of Behavioural Change Communications (BCC) campaigns are carried out by Department of Health (DoH), NGOs and INGOs to increase women's accessibility to information and counselling on sexual and reproductive health. Improved outcomes are more evident where there are focused programmes for vulnerable populations, e.g. by UNFPA, Myanmar Medical Association (MyMA) and Myanmar Maternal and Child Welfare Association and INGOs. Translation of IEC materials into the Chin and Shan indigenous languages was made and UNFPA has supported IEC/BCC activities in 132 townships in Chin, Kachin, Kayin, Mon, Rakhine and Shan States.

RH services cover maternal and newborn health, birth spacing, post-abortion care and RTI/STI treatment. However, coverage and quality of care are better in areas where specific projects operate. The UNFPA Country Programme provides support for family planning commodities in 132 townships and to general practitioners in urban and peri-urban areas (244 townships) who provide family planning services through social franchising {Population Services International}[13].

Reproductive Health Commodity Security

The availability of commodities and consumables in the right quantities at the public sector service delivery points is an integral component of good quality RH/BS services. DoH and the Central Medical Stores Department are responsible for forecasting, procurement and distribution. UNFPA has provided supplies and commodities for several years. More recently, the multi-donor 3MDG Fund has made provisions for contraceptives through the Essential MNCH service package in the pre-pregnancy and postpartum components.

In the fiscal year 2011-2012, the Government of Myanmar allocated US$ $1.29 million for the purchase of contraceptives during 2012-2013. It is anticipated that the health budget will be increased to cover approximately 30 million couples by 2020. Myanmar has been included in the list of 46 focus countries to be supported by the Global Programme to enhance Reproductive Health Commodity Security (GPRHCS).

5 Opportunities and Challenges

5.1 Opportunities

Commitments to reproductive health

Myanmar formulated the National Population Policy in 1992, shifting from a pronatalist policy to a health-oriented approach. The Reproductive Health Policy and Strategic Plans on Reproductive Health (2004-2008, 2009-2013 and 2014-2018) of the Ministry of Health (MoH) are continued commitments to the Programme of Action of the International Conference on Population and Development (ICPD PoA), the United Nations Millennium Development Goals (MDG) and the UN Secretary-General's Global Strategy for Women and Children's Health (2010). Myanmar has also pledged to the global partnership initiative - the Family Planning 2020 (FP 2020) - in November 2013 at Addis Ababa in Ethiopia.

The Government of Myanmar views family planning as critical to saving lives and protecting the well-being of mothers and children. Access to family planning information, commodities, and services is a fundamental right for every woman and individual in the community if they are to develop to their full potential.

[13] ICPD Beyond 2014: Country Review – the Republic of the Union of Myanmar Synthesis Paper (Ministry of Immigration and Population - UNFPA, 2012)

Commitments to FP2020

The Government of Myanmar has made the following commitments to FP2020:

- to strengthen the policy of providing clinical contraceptive methods by trained/skilled nurses, midwives and volunteers through better collaboration among multi-stakeholders within the context of the Nay Pyi Taw Accord.

- to implement people-centered policies to address regional disparity and inequity between urban and rural and rich and poor.

- to expand the forum of family planning under the umbrella of the Health Sector Coordinating Committee and to create a Working Group on Family Planning as a branch of the MNCH Technical Strategy Group.

Myanmar pledged to increase the health budget to cover nearly 30 million couples by 2020 and committed to increase the resources allocated to family planning in state budgets. The government will also ensure results-based management through new initiatives for effective fund flow mechanisms and internal auditing.

Other operational strategies include continued strengthening of the Logistics Management Information System (LMIS) to ensure reproductive health commodity security (RHCS); implementing a monitoring system to strengthen quality of care and ensure contraceptive options; address regional disparities and inequalities and to improve the method mix with increased use of long-acting methods (Annex 1 – Myanmar's commitments to FP2020).

Global Programme to enhance Reproductive Health Commodity Security

Myanmar has been included in the list of 46 focus countries to be supported by the Global Programme to enhance Reproductive Health Commodity Security (GPRHCS). These countries, in general, have a low CPR with a high unmet need while the governments have made strong commitments to RH/FP and RHCS. GPRHCS is an instrument to guarantee predictable, planned and sustainable country-driven approaches for securing essential supplies and ensuring their use.

The objectives of GPRHCS at national level are:

- To ensure RHCS needs are met consistently and reliably for all who need them;
- To enhance capacity of national stakeholders and improve systems [RH commodity supply, quality of care, demand and access];
- To mainstream RHCS into national health policies, programmes, supply systems, plans, budgets [particularly by increasing government-controlled funding to procure reproductive health commodities];

Through the Global Programme to enhance Reproductive Health Commodity Security (GPRHCS), UNFPA aims to provide reproductive health commodity support for the public sector via the Ministry of Health (MoH) and to the social marketing sector via the three major NGOs, namely International Planned Parenthood Federation (IPPF), Marie Stopes International (MSI), and Population Services International (PSI).

5.2 Challenges

Significant challenges remain to achieve universal access to RH, including to voluntary birth spacing; and information and access to affordable, quality reproductive health supplies. The challenges described below are a summary of findings from published reports, meetings with key informants and group discussions. During the *Family Planning Best Practices Conference* held in Nay Pyi Taw from 30 June to 2 July 2014, participants from regional/state and township levels of service delivery and frontline field workers, representatives from NGOs, UN agencies and professional societies identified bottlenecks and issues to ensuring that the target population have equitable access to quality contraceptive methods. The challenges in implementing BS programmes and suggestions to be considered were identified. The issues are related to demand generation, service delivery, commodity security and data to improve programmes. (Annex 2: Outputs of Family Planning Best Practices Conference, Nay Pyi Taw - 2.1 Issues and challenges for birth spacing programmes and 2.2 Strategies to improve access to birth spacing)

Demand Generation

Low awareness among certain segments of the population due to language barrier and limited IEC materials were recognized as bottlenecks to contraceptive use. Misconception and myths on BS methods perceived by clients and the community are acknowledged to be a barrier to use of modern contraceptives, particularly IUD. To respond to these challenges, social mobilization with advocacy (for village leaders, local authorities and non-state leaders) was proposed.

To increase awareness on BS, dissemination of information on the health and social benefits of RH/BS; contraception for healthy timing and spacing of pregnancy; and on how to access services through fixed site or outreach mobile clinics are critical. The information should be available in Myanmar and in major ethnic languages to ensure improved understanding and access to BS services.

While many women would prefer to use long-acting reversible contraception, the implant is not well socialized within the community while misperceptions on IUD persist. Proper counseling is essential for implant users, as removal rate appears to be high within the first year.

Service delivery and utilisation

Public sector

General issues

Contraceptive commodities need to be an integral part of Essential Package of RH Interventions as detailed in the Strategic Plan for RH (2014-2018). Maternal and child health (MCH) and birth spacing components should be more prominent in state/ regional and township development plans. When universal health coverage schemes are introduced in Myanmar, MCH and BS will need to be integrated into the Essential Package of Interventions that will be covered.

Human resources

Equitable distribution of key categories of health workers (doctors and MW) in hard-to-reach areas and quality assurance in training to ensure health staff have the requisite competencies to conduct cost-effective and high-impact interventions was the over-riding issue identified. The need to improve population to health staff ratio and measures to address rapid turnover of staff especially in remote areas was highlighted.

Lack of time for counselling due to work overload and inadequate counseling skills have a negative effect on demand for BS services. On the other hand, where demand has been created, not all health staff may have the skills to provide BS methods that require a certain level of clinical skills. This is in turn related to the budget allocation for capacity strengthening as not all midwives have attended RH/BS training.

Task shifting of BS counselling and services to AMW was proposed to expand the outreach to remote and underserved areas. Therefore, upgrading the training programme for AMWs to optimize BS services and reporting on demand creation and use of contraceptives would need to be considered.

Supervision and monitoring

A budget line for supervision and monitoring would ensure that MWs receive supportive supervision and feedback from their immediate supervisors on newly acquired skills.

Method mix - LARC

Short-acting methods are the most prevalent contraceptives in the current method mix, according to the FRHS (2009) and Multiple Indicator Cluster Survey <MICS> (2010), which include injectable depot-medroxyprogesterone (DMPA) and oral pills. These methods require regular resupply, hence successful use must include access to a consistent supply of the product. Each 'resupply' visit to a service delivery point (SDP) entails additional costs. Pills

and condoms also require high levels of user adherence and motivation, with inconsistent and incorrect use leading to method failures and high rates of discontinuation.

Long-acting methods, i.e. intrauterine devices (IUDs) and implants give contraceptive protection for a year or more. These methods have higher initiation costs than short-acting methods, but because they can be used without resupply for several years, they are often less expensive per year of use. Initiation costs for these methods are higher because the costs of the commodities themselves are higher. In addition, they require providers to have special training and skills for insertion and removal as well as good counselling skills to ensure that clients can make informed choices about these long-acting methods. Unlike short-acting methods, which can be discontinued simply by the user stopping the method, discontinuation of IUDs and implants requires removal by a trained provider.

FRHS (2009) reported that most women would prefer to have long birth intervals and therefore use of long-term methods, either IUD or implants, would meet their needs. To have a balanced method mix, the different components of the health system: trained health workforce conducting clinic-based as well as outreach mobile clinics; commodities and supplies to meet the demand; and services that are either subsidized or free-of-charge will help to ensure equitable access to quality BS services. Health system support will need to go hand-in-hand with information and counselling on Long-acting reversible contraceptions (LARC).

At the moment there is minimal involvement of youth groups in planning and implementing BS services. Furthermore new approaches to meet the needs of population groups such as migrants, the urban poor and key affected populations are essential.

Private sector

The number of pharmacy shops owners and drug sellers included in educational programmes on BS is limited and therefore they are not able to provide accurate information on contraceptive methods, including use, continuing use and side effects. Weak coordination and collaboration between the public and private sector leads to poor linkage between general practitioners' clinics and the township hospital which affects referral. Strengthening linkages through information sharing at quarterly meetings of township Food and Drug Association committee with all private sector stakeholders was suggested. Involvement of general practitioners (GPs) for regular Continuing Medical Education (CME) programmes with a focus on BS by Myanmar Medical Association and for inclusion of credits on BS and RH for re-accreditation of GPs by Myanmar Medical Council was suggested. It was noted that in some townships, there are only a few NGOs working on BS, whereas in others, there are many actors working on similar issues.

RHCS

The availability of commodities and consumables in the right quantities at public sector service delivery points continues to be a problem in some townships as current forecasting falls short of the country requirements. MoH will need to leverage available resources to support all interventions effectively and coherently and find additional support or donors/partners to meet the funding gaps.

Delayed shipments of procured commodities cause emergency stock level situations and getting products from the state or township storage to the service delivery points (SDPs) remains critical. While distribution has improved in recent years, it is still an ad-hoc system with delays in shipments to SDPs.

Collection and reporting of the essential data items for logistics management, reporting procedures and data flow in a timely fashion and the use of LMIS data by programme managers for decision- making were identified as issues affecting service delivery. Different strategies will need to be taken into consideration to respond to the needs resulting from geographical variation.

Data for decision-making

FRHS (2009) reports that approximately 50 percent of couples seek services from the private sector and as data from the private and NGO sectors are not available on a regular basis, a significant percentage of BS data is not

reported. It was suggested that the Township Medical Department should assign a focal person to collect data from the private sector and set up a reporting system. Simple forms for private and NGO hospitals and clinics to report on BS would give a more complete picture of the BS situation.

6 Underlying Principles

The Implementation Plan to meet FP2020 commitments is guided by the underlying principles established in the Strategic Plans for Reproductive Health. The comprehensive definition of reproductive health as elaborated in the Programme of Action of the International Conference on Population and Development (ICPD PoA) in 1994 implicitly includes "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". The definition is underpinned by the principles of international human rights and gender equity.

The principles that guide the development, planning and implementation of the Strategic Plan for Reproductive Health will be adhered to in the Implementation Plan:

- Implementation in accordance with national development policies, national health plans and in a coordinated 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.

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 Implementation Plan.

AAAQ Framework

The Implementation Plan will be aligned with Strategic Plan for Reproductive Health and follow the principles of the "AAAQ" framework[14] 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. In summary, these are:

Availability: The national RH programme will aim to make functioning reproductive health care including BS services and contraceptives available in sufficient quantity within the country.

[14] The Right to Health in International Human Rights Law

Accessibility*:* Accessibility has four overlapping dimensions:

- *Non-discrimination:* BS services will be accessible to all, especially the most marginalized sections of the population.
- *Physical accessibility*: BS services will be within safe physical reach for all sections of the population, especially marginalized groups.
- *Economic accessibility (affordability)*: BS commodities and services will be affordable for all. Payment for services will be based on the principle of equity, ensuring that these services are affordable for all, including socially disadvantaged groups.
- *Information accessibility*: accessibility includes the right to seek, receive and impart information and ideas concerning BS services and contraceptives.

Acceptability: BS services will be respectful of medical ethics and culturally appropriate, 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, BS services will also be medically appropriate and of good quality.

By focusing on improving access and demand for quality sexual reproductive health services including family planning as an essential element among the most vulnerable populations, including women, the poor, and marginalized adolescents and youth through programme interventions targeting both duty-bearers and rights-holders the Implementation Plan is founded on a human rights based approach.

7 Goal and Objectives

Goal

The Goal of the Implementation Plan to meet FP2020 commitments is to contribute to:

(i) improved reproductive health of women, men and adolescents

(ii) reduction in maternal and infant mortality and morbidity

through scaling up the provision of quality integrated BS services.

The Plan is in line with the Myanmar Health Vision 2030 of the Ministry of Health, the National Population Policy (1992), the National Health Policy (1993) and 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. The Reproductive Health Policy and Strategic Plans on Reproductive Health (2004-2008, 2009- 2013 and 2014-2018) 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). The 2014-2018 Strategic Plan for Reproductive Health will respond to the UN Secretary-General's Global Strategy for Women and Children's Health (2010) and the commitments made to FP2020. The Implementation Plan to meet FP2020 commitments reinforces the third Strategic Plan for Reproductive Health to fulfill the increasing demand for birth spacing by improving access to and use of birth spacing services.

Objectives

The specific objectives of the Implementation Plan are in line with the commitments made at the MDG Summit and FP2020, which are:

- To increase CPR from 41 per cent to 50 per cent by 2015 and above 60 per cent by 2020

- To reduce unmet need to less than 10 per cent by 2015 (from 12 per cent in 2013)

- To increase demand satisfaction from 67 per cent to 80 per cent by 2015

- To improve method mix with increased use of long acting reversible methods (LARM)

- To reduce adolescent pregnancy rate from 16.9 per 1,000 to 10 per 1,000 (2018) and

- To improve access by decentralizating the management of reproductive health programmes including birth spacing programmes to districts and townships

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 which are reflected in the targets of: increased contraceptive prevalence and reduced unmet need for contraception.

8 Strategies to achieve objectives

The strategies and key activities for the Implementation Plan to meet FP2020 commitments are within the framework of the strategies of the National Strategic Plan for RH which are grouped as follows:

1. Strengthening health systems to enhance the provision of an essential package of reproductive health (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.

Health in Myanmar (2013) highlighted the activities that need to be strengthened in order to achieve the Millennium Development Goals 4 and 5 to improve maternal, newborn and child health. Among these activities, the following are of particular relevance to birth spacing:

- Expansion of post-abortion care and quality birth spacing services
- Strengthening adolescent reproductive health
- Promoting male involvement in reproductive health
- Promoting referral system and community volunteers

Programme areas or components essential for implementing a successful BS programme include: a consistent and adequate supply of contraceptive commodities; sufficient numbers of health providers who have the necessary knowledge and the technical and client interaction skills to deliver services safely and effectively; appropriately equipped facilities with a flexible array of service delivery modalities and systems to meet the needs in different sociocultural contexts and levels of development in the different regions/states; advocacy and social mobilization to increase support for the programme and address the knowledge-use gap among clients for demand generation; and strong management systems and leadership to ensure efficient and effective programme implementation.

Strategy 1: Reinforce an enabling environment for birth spacing

Outcome

Outcome 1: A supportive environment for comprehensive BS programmes as an integral part of reproductive and sexual health and rights strengthened and sustained.

Strategy

The Strategic Plan for RH (2014-2018) will implement activities to reinforce an enabling environment for reproductive health, which encompasses a core element - providing high-quality services for birth spacing. The Implementation Plan to meet FP2020 commitments will be the main instrument to ensure advocacy and coordination activities for BS.

To increase the financial commitment to RH within the various government budgets commensurate to need, the

RH Programme, Department of Health and partners will advocate for increased funding within national or state/ regional budgets, in addition to funding secured from development partners (See Annex 3 for List of stakeholders working on birth spacing). DoH will advocate within other ministries, to ensure that the national budget includes a line item for RH (including BS), which is increased over time, to meet FP2020 commitments and meet the needs of the population for BS.

Myanmar is currently introducing health insurance schemes in a phased manner with the long-term objective of Universal Health Coverage. Advocacy for inclusion of BS as a component of the Essential Package of MCH services will be conducted with the responsible ministries and development partners.

DoH will strive for coordination among different administrative levels and among various partners at each level to ensure efficient and effective programme implementation through regular meetings of the Lead Reproductive Health Working Group and Lead Family Planning Working Group at the central level and state/regional and township coordination meetings of stakeholders working on RH issues.

Activities

The RH Programme, Department of Health, in cooperation with national and international partners, will advance evidence-based advocacy for BS, emphasizing the benefits (health, social and economic) and cost-effectiveness of healthy timing and spacing of pregnancies. Advocates at the national, state and local levels can increase interest in BS within communities, producing a supportive environment, reducing normative barriers and mobilizing community support.

Activity 1: Development of advocacy plan and materials for advocacy and social mobilization

Development of an advocacy plan and materials for advocacy and social mobilization is a critical element to create an enabling environment. The messages in Myanmar and in the major dialects would be on the important role of BS in promoting health and supporting development and of the benefits to couples, families and community to garner support for BS programmes.

Step 1. Establish an advocacy committee/group

The committee members would include members of the Lead Family Planning Working Group and other partners from bilateral or multilateral agencies, professional organizations, news media, among others.

Step 2. Careful analysis of the situation and context

The Lead Family Planning Working Group and other partners will analyze the demographic, reproductive health, birth spacing and contraceptive information and related health and social information.

Step 3. Identify advocacy objectives and expected outcomes

The main objectives would be to reinforce the awareness of key decision-makers about the social and economic benefits of BS, to influence the budget allocation process and to encourage changes in the way services are organized or regulated. Advocacy to development partners such as the World Bank, Asia Development Bank, UNFPA, WHO, UNICEF, IOM and others to integrate BS services in their health programmes.

Step 4. Identify key audiences

Primary audiences are those who will ultimately influence the national policy for programmes and budget allocation or make decisions for operational programmes. Secondary audiences are all the individuals or groups who can influence policy-makers and policy decisions. They are the opinion leaders and include community and administrative leaders, academics, researchers, heads of professional associations, women's groups, the news media, and donors. A third potential audience is opposition forces to understand and allay their concerns.

Step 5. Build networks and partnerships

Networks and partnerships will be built with the groups listed in Step 4, at the national level.

Step 6. Develop, tailor and pretest messages

The messages would include: "BS is an essential tool to accomplish the Millennium Development Goals (MDGs) and Post 2015 Sustainable Development Goals"; "Healthy timing and spacing of pregnancies saves the lives of women and newborns and empowers women and promotes equity"; "correct and consistent use of condoms helps prevent HIV"; etc.

Step 7. Select channels of communication, activities, and materials

These channels include face-to-face communication, mass media communication, information materials and social media. Policy briefs, fact sheets, summaries of relevant research on the benefits of BS for reproductive and children's health, and power point slides for advocating for BS among key decision-makers. Basic information about FP2020, birth spacing, how programmes are organized and their beneficial impact on couples, families and the community will be presented in a clear, concise and non-technical way.

Activity 2: Develop an action plan and conduct advocacy and social mobilization

The RH Programme and partners will identify activities, audiences and venues to engage with different audiences and conduct social mobilization and advocacy through organizing meetings and other events for national, regional/ state, township and village authorities/leaders, non-state actors and NGOs. The Department of Health will build on advocacy efforts on RH which have been conducted in seven states/regions and 160 townships.

(i) Identify number and types of activities, audiences, venues and materials required at central and state/regional levels to advocate successfully for the commitment of influential leaders for BS programmes and responsive policies including BS as a component of the Essential package of MCH services under Universal Health Coverage.

(ii) Identify number and types of activities, audiences, venues, materials at township and community levels to empower community leaders to become advocates for provision of better quality and more accessible BS services, to accurately inform their constituencies on the health and social benefits of family planning for establishment of youth friendly corners/services offering youth-friendly health services (YFHS). Community leaders include administrative, village, women's groups and youth group leaders. User-friendly briefing papers will be prepared in the major dialects and training or information sessions will be provided on how to communicate effectively.

Step 9. Monitor advocacy and social mobilization activities

The advocacy and social mobilization events will be monitored for progress and their reach and impact will be evaluated.

Activity 3: Conduct training and refresher training on communication skills and BS for Township and Community Support Groups

Community administrative and village leaders, women's groups and youth group leaders will be trained on interpersonal communication skills and benefits of birth spacing to empower them to carry out social mobilization activities. The training will be carried out in an incremental manner with the objective of covering 100 townships in 2015, then 100 new townships in 2016 and 100 more townships in 2017. Refresher training will be conducted from 2017 till 2020 as there could be changes in the membership of the groups.

Activity 4: Identification of "role models" and sharing experiences

While some women would prefer to use long-term reversible methods, there are myths and misperceptions and fear of side effects, particularly for IUD. Couples who are using short-term methods often experience contraceptive discontinuation and unplanned pregnancy due to disruption in use of these methods. A few NGOs have seen

success with identifying couples who have used long-term reversible methods such as IUD and encouraging them to share their experiences with the community. These NGOs will consolidate and expand the identification of "role models" and sharing of favourable experiences in their areas of work while the public sector will also employ such models.

Activity 5.1: Conduct quarterly co-ordination meetings of Lead FP Working Group at national level

Coordination of activities conducted by various RH stakeholders through regular meetings of Lead RH Working Group Lead and Family Planning Working Group to better coordinate and monitor government and partner activities on resource mobilization, planning and implementation.

Activity 5.2: Conduct quarterly co-ordination meetings of RH (BS) Working Group at township level

Coordination of activities conducted by various RH/BS stakeholders in the public and private sector will be through regular meetings at township level to review coverage, demand generation activities, service delivery, contraceptive security and supervision.

Strategy 2: Generate demand and sustain behavior change

Outcome

Increased knowledge of the full range of contraceptives and available BS services leading to increased demand and voluntary use of contraceptives and BS services by the community

Strategy

The strategies employed will complement the interventions of the National Strategic Plan for RH (2014-2018) to implement behavior change communication for RH which includes:

- enhancing community understanding of RH needs and increase demand for services
- supporting health promotion and care activities by health workers and community health volunteers
- engaging men in reproductive health programmes

Enhanced knowledge and increased demand will come from wide dissemination of accurate information about contraceptive methods and their availability, in addition to encouragement of their use to promote the health of women and their families. This will empower each individual to make fully informed choices regarding contraceptive use.

DoH has conducted IEC activities in approximately 130 townships in collaboration with national and international NGOs and CBOs in the past two years. However, programme approaches such as postpartum family planning (PPFP) and postabortion counselling and services and recently introduced methods e.g. subdermal implants will be elaborated to raise awareness of the expanded method mix.

Strategic communication programmes use a mix of three major communication channels: mass media, interpersonal and community channels and all these will be applied in the Implementation Plan. High-impact demand generation activities for women and men of reproductive age are included to close the knowledge-use gap by addressing myths and misinformation about contraceptives and fear of side effects and health concerns that impede its adoption and use. Specific demand generation efforts will be targeted at identified high-priority segments (e.g. young people).

Mobile technology e.g. m4RH which is an on-demand text message-based mobile phone service that provides information about contraceptives and locations of nearby clinic services will be adapted to the Myanmar context.

Activities

Activity 1.1: Conduct a workshop to develop standard messages for postpartum family planning (PPFP) and subdermal implants and determine approaches to be used at different levels for priority target audiences.

Standardized messages for BS have been developed by the RH Programme and a few NGO partners and used for advocacy and information sharing. These messages will be reviewed and updated to cover the broader social benefits to communities and its' contribution to the national development agenda. Furthermore, messages for newer aspects of programme approaches e.g. postpartum family planning (PPFP) and recently introduced methods e.g. subdermal implants will be developed to broaden the method mix.

Activity 1.2: Develop and test messages on BS

Messages on the health and social benefits of BS, PPFP, modern methods (including LARC) will be developed and tested. The messages will address myths and misconceptions on contraceptive methods and target diverse populations (women, men and adolescents) and will be translated and adapted into different dialects.

Activity 1.3: Develop, print and disseminate RH/BS IEC materials for diverse populations and in different dialects

Pamphlets for clients on oral pills, progesterone injectables, emergency contraception, condoms and IUD have been updated in 2014 and pamphlets on newer issues such as PPFP and subdermal implants will be developed and pre-testing of concepts, messages and materials carried out. RH/BS IEC materials will be printed and widely disseminated by DoH and national and international NGOs at clinic facilities and in communities.

Activity 2.1: Review guidelines on interpersonal communication skills and counseling and choice and use of community channels

RH Programme and NGOs have been following guidelines on interpersonal communication skills and counseling developed by DoH and UNICEF and by the RH Programme and UNFPA (Handbook on Quality RH). These will be reviewed and revised as necessary. (For guidelines for quality RH, link to Strategy 3 - Improve performance of health workforce for birth spacing)

Activity 2.2: Update training materials for Basic Health Staff (and private sector providers) on BS methods

The booklet adapted from the Decision Making Tool for Family Planning Clients and Providers (WHO, JHPIEGO) and the handbook on Quality RH have served as references for basic health staff. The existing materials on contraceptive methods and BS services used for training will be reviewed and updated to emphasize PPFP, LARC and integration of services to optimize access.

(Link to Strategy 3- Improve performance of health workforce for birth spacing)

The Activity to conduct Training of Trainers will be conducted together with Activity 2.3 under Strategy 3 - Improve performance of health workers for BS.

Activity 2.3: Conduct training for LHVs, HAs, MWs and community volunteers to enable them to carry out social mobilization in the community

Conduct training for LHVs, HAs, MWs and community volunteers particularly in townships that have not been covered by BS training programmes to improve (i) interpersonal communication skills and counseling (ii) knowledge of the benefits of healthy timing and spacing of pregnancies (iii) modern contraceptive methods (including LARC and emergency contraception) and dual protection and (iv) where services can be obtained and follow-up for correct and consistent use. The capacity strengthening will include counselling that responds to the various needs of women, men, couples and adolescents. (Link to Strategy 3)

Activity 2.4: Conduct training for private sector providers

Similar training will be conducted for private sector providers: both medical professionals and pharmacists by national and international NGOs.

Activity 3: Conduct BCC activities

Health workers at different levels will conduct group sessions and inter-personal communication to increase awareness on BS methods and availability of services, both in facilities and during outreach activities. The messages will cover healthy timing and spacing of pregnancy, modern contraceptive methods and dual protection, follow-up for correct and consistent use and to dispel myths and misperceptions. Counselling of couples will be reinforced to engage men in RH and promote their responsibilities and behavioral change towards gender equity.

Community volunteers (AMWs and VHWs) will inform target audiences through outreach community dialogue sessions and household visits about BS services. The clients will be guided through learning about different family planning methods to:

- reinforce knowledge or clear up misconceptions about family planning methods
- leave information with clients if short on time or to reinforce after they leave
- refer clients to a clinic for services, particularly if they want methods that the AMW cannot provide.

In addition to providing information, AMWs role will be expanded to provide a specified package of BS services. (Link to Strategy 3)

BCC activities will be conducted in townships in an incremental manner. In 2015, 100 townships where demand generation activities have not been carried out before will be identified. In the subsequent years, the activities will be expanded to 100 additional townships each year.

At the township level, *mapping of existing organizations/partners* conducting BS activities and establishment of partnerships with relevant organizations that reach out to target populations will be conducted. Partnerships will be broadened with non-governmental and community-based organizations including women's organizations, youth organizations, networks of key affected populations, etc so as to reach directly marginalized women and young people. The most disadvantaged populations and their access to BS will be identified and assessed and programmes to reach, engage and include these groups will be implemented. Initiatives for greater involvement of men in birth spacing will be developed.

The Township Health Departments and NGOs will *develop specific approaches* and conduct outreach BCC activities (and services) for populations living in hard-to-reach areas and vulnerable populations e.g. in Pyay and Monywa, which are major commercial hubs for migrants and in large cities for the urban poor. In collaboration with the ARH Programme, peer educators will be trained to help with information dissemination and linking young people to service delivery points if and when they need the services. Provision of adolescent and youth friendly services will be mainstreamed into pre-service and in-service training of health care providers at all levels. The role of RH promoters trained by NGOs who provide information on contraceptive methods and either offer services or refer clients as required will be expanded.

Mass media campaigns on RH/BS will be conducted through national media and local radio stations to raise awareness and create demand among vast audiences. The multi-media campaign will promote RH information and services in all states/regions and will be broadcast in the major dialects.

The media will be engaged as partners in reporting on and advocating for RH including MNCH and FP. Other mass media channels such as newspapers, magazines and internet will be employed to directly reach people with RH and BS messages. A limited number of telephone hotlines were established for youth in Yangon and Mandalay and were found to be a popular channel to receive information and address misinformation. Setting up of additional hotlines in the capital cities of states/regions will be explored.

Programmes via *internet and mobile phones* to provide information and improve access to YFHS will be tested by RH programme in partnership with NGOs. Projects that have been successfully implemented in other countries will be assessed and adapted to the local context. For example, the Mobile for Reproductive Health (m4RH) programme is an automated, interactive, and on-demand system using short message service (SMS) or "text messaging." The m4RH system provides basic information about the full range of short-acting and long- acting contraceptive methods and addresses common misconceptions. The text messages present information in a concise format consisting of three to four screens per method. Messages were developed using best practices for health communication programs, global guidance from the World Health Organization, country-specific national family planning guidelines, and assistance from local agencies. (FHI 360, PROGRESS, pivot access, UNFPA)

Research that seeks to understand social and cultural determinants of non-use and unmet need for birth spacing/ family planning among various social and economic groups to advocate for and promote evidence-based interventions will be supported.

Activity 4: Social marketing

INGOs have used social marketing principles and through existing commercial and noncommercial distribution networks and retail shops have made subsidized commodities from donor agencies available to the target population. The objective is to increase subsidized commercial distribution to 331 townships. Social marketing of contraceptive commodities will be expanded to cover populations in difficult-to-reach areas of identified states/regions.

Monitoring and evaluation of the implementation of demand generation activities will be carried out as part of a programme quality improvement process.

Strategy 3: Improve performance of health workforce for birth spacing

Outcome

Strengthened capacity of providers at different administrative levels and from various sectors (public, private and NGO sectors) providing information and counselling on contraceptives and offering BS services

Strategy

The activities will complement the health systems strengthening strategies employed by the Strategic Plan for RH, i.e. to improve performance of the health workforce for RH.

Improve performance of health workforce for BS

The core of service availability is ensuring that health workers at each level have the appropriate competencies to provide the necessary services. Therefore, training programmes will be developed so that health providers already in service, as well as those in training and those to be recruited, have the appropriate knowledge, skills, supervision, and support to provide safe, effective, acceptable BS services.

The training of health workers will be both in general and based on immediate scale-up needs for particular methods (i.e. LARC). A training plan will be developed based on an analysis of health worker skills and will undergo annual reviews to meet the country's human resource needs. Standardized curricula will be updated and implemented, for both pre-service and in-service training. All partners involved in training will work in coordination with the RH Programme to reach the training goals and objectives. Mentorship and supervision following formal training will be a key activity in going forward. Pre-service education will be strengthened under the direction of the Department of Medical Sciences so that providers entering the health care workforce are competent to provide all contraceptive methods.

Activity 1: Update clinical guidelines to ensure service provision is in line with evidence-based practices

Activity 1.1: Update clinical guidelines to ensure service provision is in line with evidence-based practices – e.g. updated Medical Eligibility Criteria for Contraceptive Use, PPFP and LARC.

(Link to Strategy 4 - Increase availability of good quality birth spacing services)

Activity 1.2: Print copies of updated clinical guidelines and BS manuals.

Activity 1.3: Procure teaching/learning aids, training materials and models for RH/BS particularly for IUD and implants. In the initial phase, support will be directed towards State/Regional Training Centres located in strategic cities that can cover three to four states or regions.

Activity 2: Conduct training programmes on birth spacing

Activity 2.1: Update inventory of BS Trainers in both the government and NGO sectors.

Activity 2.2: Develop training programmes for national Trainers and public sector providers on: updated BS guidelines and manuals.

Activity 2.3: Conduct comprehensive in-service training of national trainers TOT on BS (in public and private sectors) on:

- healthy timing and spacing of pregnancy, - modern contraceptive methods and dual protection,
- LARC,
- follow-up for correct and consistent use,
- male involvement in BS,
- youth-friendly services,
- integration of services,
- client-centred approach,
- quality assurance measures and
- interpersonal communication and counseling skills

(Link to Strategy 2 - Generate demand and sustain behavior change and Strategy 4 - Increase availability of good quality birth spacing services)

Activity 2.4: Conduct training for public sector providers on the topics listed above.

(Link to Strategy 2 and Strategy 4)

Activity 2.5: Conduct skills-based training on long-term reversible methods IUD insertion and subdermal implants for doctors and IUD insertion for midwives.

Training on healthy timing and spacing of pregnancy, LAM, safe and effective family planning methods in the postpartum period, appropriateness of postpartum IUD as a method, insertion procedures, infection prevention, routine side effects, timing of routine follow-up visits, and other issues.

IUD and subdermal implant training will be conducted through a step-by-step process. This process will begin with Training of Trainers at the national level and cascade down through states/regions, districts and townships. This training process will ultimately build a sustainable self-renewing system of trainers responsible for preparing doctors to competently provide IUD and subdermal implant and midwives to provide IUD services. In the initial phase, training for subdermal implants will be focused primarily for doctors.

The competency building will be first imparted on pelvic models prior to hands-on experience on clients. Approximately

10 participants will attend a three-day training using models at the District or Township Hospital. The participants will gain clinical experience at township hospitals under supervision of trained medical officers over a three-month period. The Township Medical Officer will issue a Certificate of Competency within a period of 3 months. If the MW does not achieve competency within 3 months, training on models will need to be repeated.

The trainer will evaluate each participant using the IUD counselling and clinical checklist to assess competency demonstrated on models and on clients. The Trainer should be confident that the participant will be able to independently provide IUD services at her work place.

Activity 2.6: Conduct training for private sector providers on:

- topics listed in Activity 2.1.

- skills-based training on long-term reversible methods

- communication skills

(Link to Strategy 2 – Generate demand and sustain behavior change and Strategy 4 -_Increase availability of good quality birth spacing services)

Activity 2.7: Conduct training for community volunteers on communication skills, benefits of BS, basic information on BS methods, available service delivery sites and how to engage men and the community to support RH/BS. Training will be conducted in 100 townships each year from 2015 to 2017 and the second round of workshops will be conducted between 2018 and 2020. Key stakeholders are local chapters of Myanmar Maternal and Child Welfare Association, 3MDG Fund and NGOs.

Activity 2.8: Conduct follow-up to ensure quality service provision.

Follow-up of trained providers through supportive supervision will be performed and feedback provided. In a few NGO programmes, dedicated interpersonal communication supervisors independently observe the communication process and counselling sessions on a regular basis. The supervisors provide feedback on medical accuracy, communication skills and effectiveness and adherence to the strategy developed (targeting, messaging, etc). Township Health Nurses and Lady Health Visitors will take on this role and trained on supervision and giving effective feedback. Supervisory visits will be carried out at least once per month.

Activity 3: Conduct supervision

Township Health Nurses who supervise midwives will assess midwives on medical/technical aspects of contraceptives, communication skills (e.g. using open-ended questions, reflective listening, etc) and the midwife, in turn, will assess the community volunteers. Community volunteers need support from supervisors to receive reliable answers to problems and questions.

Activity 4: Update pre-service curricula (doctors, nurses, MW) to (i) incorporate newer contraceptive methods, (ii) integrated approaches for service delivery and (iii) provision of care of high quality

Update pre-service curricula for doctors, nurses, MW and conduct training on birth spacing with an emphasis on integrated services, client-centred approach and quality assurance measures. The curricula will focus on health workers acquiring skills to provide long-term reversible methods and to improve social mobilization and interpersonal communication skills.

Activity 5: Training of pharmacy staff

Other approaches to enhance BS availability will be expanded, including training of staff at pharmacies to provide counseling for the methods that they are legally permitted to disburse. The training for pharmacists in the private sector on contraceptive methods conducted by the General Practitioners Society of the Myanmar Medical Association will be expanded.

Strategy 4: Increase availability of good quality birth spacing services

Outcome

Availability and use of good quality birth spacing services (through informed choice) in public and private sectors sustained.

Strategy

The Strategy will be fully aligned with the Strategic Plan for RH (2014-2018) which specifically aims to *Increase access to quality, integrated RH services at all levels of care* through (i) implementing an essential package of RH services (ii) expanding coverage of services and (iii) increasing equitable access to quality integrated reproductive health services.

Good-quality care

Good-quality care includes a range of contraceptive methods, sensitive counseling and meeting other related reproductive health needs as well as providing BS services. As quality of care improves, clients are healthier, more satisfied, better abled to make informed choices and to use contraception effectively, and to continue using it. Birth spacing services are closely linked to other health system elements such as having a continuous supply of contraceptive commodities (Strategy 5 - Improve availability of a reliable supply of contraceptives) and having skilled providers offering services (Strategy 3 - Improve performance of health workforce for birth spacing).

The package of services that will be provided at different levels of care (Primary health care at Rural Health Sub-Centre, Rural Health Centre and Maternal and Child Health Centre) has been defined in the Strategic Plan for RH. Information and services on contraceptive methods feature in other core elements of RH, i.e. pregnancy, delivery, postnatal and newborn care; miscarriage and post-abortion care; RTI/STI/HIV; and adolescent and youth reproductive health.

New service approaches

To provide adequate and equitable BS services to the population in some settings, it will be necessary both to reinforce the current delivery system through improving access and quality and to employ new FP service approaches. Integration of BS into other health services will be explored as a key strategy to enhancing its' availability.

Different service delivery models will be employed to increase the proportion of modern contraceptive methods: public, private, social marketing and community-based distribution. In particular, NGO partners and the private sector will continue to be engaged through public-private partnerships to provide information and services in hard-to-reach areas.

The contraceptive method mix will be broadened to include emergency contraception and subdermal implants and a balance between long-term reversible and short-term methods will be strived for. Short-acting methods are the most prevalent contraceptives in the current method mix, which includes oral pills and injection depot-medroxyprogesterone (DMPA). These methods require regular resupply, hence successful use requires access to a consistent supply of the product. Each resupply visit to a service delivery point entails additional costs. Oral pills require high levels of user adherence and motivation, with inconsistent and incorrect use leading to method failures and high rates of discontinuation.

Long-acting reversible contraception

The low current use and low ever use of LARC suggest that women do not have sufficient access to and/or knowledge about the methods; it is assumed that if LARC were made more available and knowledge increased, then women would voluntarily choose it and national prevalence would increase.

Women have a high demand for both limiting and spacing pregnancies in the postpartum period. Births that are spaced too closely together pose substantial health risks for the mother and child. Women have a high likelihood

of contact with the health care system, making the postpartum period a time for high- impact, cost-effective programmes. Postpartum IUD service provision can be incorporated into routine services at public sector district and township hospitals and health centres, including provision by nurses. Programmes will integrate this service into maternal care, monitor performance, provide supervision, recognize outstanding performance, and generate demand. Comprehensive contraceptive information and services be routinely integrated with post-abortion care in accordance with Guidelines on Post-abortion Care for Public Sector Facilities.

Service integration

Through infant immunization visits, mothers have multiple contacts with health care providers in the year after their children are born. The recommended routine immunization schedule calls for vaccinations at birth, 6 weeks, 10 weeks, 14 weeks and 9 months. The 12 months following birth is a time period when women may be highly receptive to messages about healthy timing and spacing of pregnancy. Services (including provision of contraceptive methods) will be offered during routine child immunization contacts at fixed clinics or during routine outreach services (by midwives or other providers).

Approaches for difficult-to-reach areas

Women and couples in difficult-to-reach areas have low contraceptive prevalence, high unmet need, poor access to a range of methods and limited contact with clinic-based services. Partners among NGOs and private sector will be identified and innovative solutions to reach rural and underserved populations will be employed through mobile clinics organized by NGOs and community-based outreach programmes.

An example from Lao PDR that has improved access is through the voluntarism of community-based promoters. They are members of ethnic minority communities in remote areas who visit every household once a month and are trained to provide counseling and services to the couple and to other family members with reproductive health needs at the client's residence, including non-married people. They speak the same ethnic language, belong to the same community, and share the same social norms. In addition, they submit a report that feeds into the contraceptive logistics management information system.[15]

Task shifting to increase access

Task shifting is founded on a policy of training and retraining the health workforce. It involves a rational redistribution of tasks between the existing workforce teams. It is a process of delegation in which tasks are usually moved, where appropriate, to less specialized health-care workers. Expansion of cadres with adequate skills will be critical to increasing access to certain contraceptive methods as well as reducing maternal mortality, as they will be instrumental in providing education, advising on reproductive health, and distributing services to those most in need. DoH will implement task shifting to village health volunteers on demand creation, health promotion and to AMWs for distribution of oral contraceptive pills and condoms, with a focus on hard-to-reach areas. The programme will be reviewed in the respective communities and if the communities are receptive, AMW training and supervision will be reinforced for the provision of injection depo provera.

Activities

Activity 1: Develop guidelines for integration of birth spacing into related programmes

Guidelines will be developed for integration of BS into postpartum programmes and immunization and child health services and other services. The Guideline on Post-abortion Care for Public Sector Facilities (2014) outlines post-abortion contraceptive counselling and services.

Activity 2: Ensure availability of contraceptive commodities, supplies and equipment in the public and private sectors

The Department of Medical Research (Upper Myanmar) with support from UNFPA conducted a baseline survey for

[15] United Nations Population Fund – Global Programme to Enhance Reproductive Health Commodity Security – Ten Good Practices in Essential Supplies for Family Planning and Maternal Health, 2012

RHCS in 2014 which reviewed availability and stock out of RH commodities (contraceptives and maternal health medicines), supply chain (including cold chain); staff training and supervision; availability of guidelines and protocols, Information Communication Technology, method of waste disposal and user fees. In addition the survey obtained the views of clients about services. Renovation of existing health facilities, including health centres, is part of the Strategic Plan for RH (2014-2018). Measures for RH commodity security are described in detail in Strategy 5 - Improve availability of a reliable supply of contraceptives.

Activity 3: Conduct training programmes for public and private sector providers

Activity 3.1: Conduct training for public and private sector providers on: healthy timing and spacing of pregnancy, modern contraceptive methods and dual protection, LARC, follow-up for correct and consistent use and dispel myths and misperceptions, integration of services. (Described in Strategy 2 – Generate demand and sustain behavior change and Strategy 3 - Improve performance of health workforce for birth spacing)

Activity 3.2: Conduct skills training for public and private sector doctors on PPIUD insertion and implant insertion. (Described in Strategy 3 - Improve performance of health workforce for birth spacing)

Activity 4: Broaden contraceptive method mix to include long-acting reversible contraceptives

Activity 4.1: Equip facilities with instruments and equipment for IUD and implant insertion and removal.

Activity 4.2: Initiate and scale up provision of LARC (implants) at district and township hospitals and IUDs at township hospitals and health centres.

Activity 4.3: Initiate and scale up provision of LARC (implants, IUDs) from district and township hospitals to health centres through mobile clinics.

Activity 4.4: Integrate birth spacing into postpartum care including PPIUD.

Activity 4.5: Integrate contraception into post-abortion care.

Activity 4.6: Integrate birth spacing with immunization and child health services.

Post-partum family planning (PPFP) will be integrated into routine postpartum care. However, postpartum IUD will be introduced in an incremental manner. Since township hospitals receive referrals of women who have prolonged labour, it is likely that there could be pelvic infection or sub-clinical infection prior to admission. Medical Officers working in township hospitals would insert PPIUD for women who choose a hospital delivery and deliver in hospital. As the number of hospital deliveries increase, and post-partum women receive counselling for informed choice, there could be a corresponding increase in the number of women who accept PPIUD.

The Strategic Plan for RH (2014-2018) has outlined plans to integrate contraception into post-abortion care in an incremental manner, including introducing manual vacuum aspiration. It is proposed to cover 66 townships a year until the coverage becomes nation-wide. Coordination with the Expanded Programme of Immunization (EPI) and UNICEF will be strengthened for integration of birth spacing with immunization programmes for both clinic-based and outreach activities.

Activity 5: Conduct outreach activities for hard-to-reach and marginalized population sub-groups. (Link to Strategy 2 - Generate demand and sustain behavior change)

Conduct geographic and social mapping to identify hard-to-reach and marginalized population sub-groups, identify barriers to services and means to overcome barriers and optimize service delivery). Strategies for improving equity in access to birth spacing care for hard-to-reach populations will be designed together with locally-based NGOs and relevant development partners such as Asian Development Bank and International Organization for Migration.

Activity 6: Youth friendly services provide contraceptive methods

Enhance the delivery of youth friendly services within the service delivery system through expanding the network of youth-friendly health centres and ensuring that information materials and contraceptive commodities are available. Youth friendly services will be designed to meet the criteria for quality, i.e. equitable, accessible, acceptable, appropriate and effective (See Annex 5 – Characteristics of youth-friendly health services). The RH programme will collaborate with Central Health Education Bureau and INGOs to be able to comprehensively implement this activity.

Activity 7: BS services provided for Key Affected Populations

A few NGOs have organized drop-in-centres providing RH/BS information and services to key affected populations in collaboration with the National AIDS Programme. The RH Programme will support these efforts with contraceptives and commodities and IEC/BCC materials.

Activity 8: Task shifting to AMWs to optimize access to BS services

DoH will implement task shifting to village health volunteers on demand creation, health promotion and to AMWs for distribution of oral contraceptive pills and condoms, with a focus on hard-to-reach areas. The programme will be reviewed in the respective communities and if the communities are receptive, AMW training and supervision will be reinforced for the provision of injection depo provera.

(Link to Strategy 1 - Reinforce an enabling environment for birth spacing and Outcome 3 Improve performance of health workforce for birth spacing).

Activity 9: Conduct supervision

Township Health Nurses who supervise midwives will assess midwives on medical/technical aspects of contraceptives, communication skills (like using open-ended questions, reflective listening, etc) and the midwife, in turn, will assess the community volunteers. Community volunteers need support from supervisors to receive reliable answers to problems and questions (Link to Strategy 3 - Improve performance of health workforce for birth spacing).

Activity 10: Quality assurance mechanisms

Quality assurance and supervisory tools will be reviewed and standardized to include quality standards e.g. youth-friendly service provision. Supervisors will receive training in providing supportive supervision. In order to be able to offer performance feedback to let staff know if their performance meets expectations, supervisors will be trained to give feedback better, encourage comments from clients or give staff members opportunities to assess themselves better.

Activity 11: Conduct social marketing

Social marketing of contraceptive commodities will be expanded to cover populations in difficult-to-reach areas of identified states/regions. (Link to Strategy 2: Generate demand and sustain behavior change)

Activity 12: Include contraceptives in MISP (Minimum Initial Service Package)

Advocate and collaborate with partners such as National and State level disaster preparedness and response committees, Government health authorities, humanitarian community, and stakeholders involved in Disaster Preparedness and Response such as health teams and Myanmar Red Cross Society to include contraceptives in humanitarian preparedness and humanitarian response plans as per the Minimum Initial Service Package (MISP) while providing emergency RH services, supplies and equipment.

Strategy 5: Improve availability of a reliable supply of contraceptives

Outcome

Health systems strengthened for the procurement, distribution, warehousing of BS commodities and associated consumables from the central level to service delivery points and logistics information and management improved

Strategy

Providing a choice of contraceptive methods to meet the changing needs of clients throughout their reproductive lives increases overall levels of use and enables individuals and couples to meet their reproductive goals. The method mix available influences not only successful client use and satisfaction, but also has implications for provider skills confidence and competence. In addition, it is necessary to ensure that the contraceptives available in the country are of high quality and affordable. Currently several challenges limit the availability of high quality contraceptives. Specific activities will be undertaken to ensure that contraceptives are delivered through the "last mile" to the health facility to ensure RHCS throughout the country, including to rural and hard-to-reach areas.

The sustained, secure and timely availability of a wide range of quality contraceptives requires a well-functioning health system including supply chain. To provide equitable access to a range of contraceptives for all populations, the procurement of the necessary method mix of contraceptives and contraceptive commodities and related supplies should be adequate to meet the needs and choices of clients. In addition, the rising demand for BS services will require programmes not just to maintain the flow of supplies but in fact to increase it. The development of national capacity on effective procurement procedures according to national standards and management of its supply chain will address these challenges.

The activities of this strategic priority will be implemented in line with the Strategic Plan for RH (2014-2018) which includes strategies for Reproductive Health Commodity Security. Within the framework of this Plan, MoH is committed to make contraceptive security a top priority, to implement supportive policies and regulations, to ensure financing, to develop coordination mechanisms and to ensure staffing for managing supply chains.

A strong supply chain, which covers planning, procuring, transporting, warehousing, and distributing contraceptives and other RH commodities, is essential for contraceptive security. Consistent supply depends upon a supply chain management system that is capable of timely and accurate integrated procurement planning based on estimates of needs using demographic data; appropriate software for forecasting, in addition to utilization of viable data on contraceptives. The concept of RHCS can only be successfully achieved with a series of functional systems, capacity development and technical support, and above all, access to affordable, timely, quality products in the sphere of RH. The success of the programme relies on a continuous flow of quality, timely, supplies at all levels of the community, and for these supplies to arrive in-country there must be a continuous learning programme to build procurement capacity in country for efficient procurement practices. In addition adequate and proper ware-housing and a reliable distribution system need to be in place.

The Ministry of Health (MoH) increased its investment in reproductive health including birth spacing, making resources available for local procurement of RH commodities in 2014. Through the Global Programme to enhance Reproductive Health Commodity Security (GPRHCS), the Department of Health and UNFPA will collaborate to provide reproductive health commodity support for the public sector via the MoH and to the social marketing sector via the three major NGOs, namely International Planned Parenthood Federation (IPPF), Marie Stopes International (MSI), and Population Services International (PSI).

<u>Activity 1: Organize meetings of Lead Family Planning Working Group with stakeholders working on contraceptive security</u>

RH Programme, Central Medical Stores Depot (CMSD), UNFPA and other key stakeholders will coordinate to optimize coverage and avoid duplication of effort. The Lead Family Planning Working Group which was established in August 2014, will provide a forum for all parties to share information and to discuss status of on-going programmes, identify bottlenecks and the stock situation nation-wide. The Group will take the lead for integrated procurement

planning, RH-LMIS functionality and will review how the pull-system of commodity distribution ensures continuous flow of RH commodities according to need.

Activity 2: Streamline forecasting, procurement and distribution

RH Programme and UNFPA Country Office have organized training workshops to enhance capacity of national level stakeholders and improve systems [RH commodity supply, quality of care, demand and access] at the central level: namely personnel from Central Medical Stores Depot (CMSD), state and regional health administration and RH Programme; and staff from twelve pilot townships in four states and regions.

Activity 3: Procure birth spacing commodities

MoH, donors, multilateral agencies, NGOs and the private sector will co-ordinate and make every effort to procure quality assured contraceptives. The contraceptives currently contained in the WHO Model List of Essential Medicines are:

- Oral contraceptives (combined and progestin-only),
- Emergency contraceptive pills,
- Progestin-only injectable contraceptives (NET-EN and DMPA),
- Copper IUDs,
- Barrier methods (condoms and diaphragms), and
- Levonorgestrel implants

Activity 4: Conduct training for township level staff for forecasting, procurement, distribution, reporting, maintaining of RH LMIS

Training for Master Trainers on Standard Operational Procedures for RH-LMIS was conducted in 2014 on projecting, forecasting, procuring supplies, storage and distribution of quality contraceptive commodities and maintaining RH LMIS. Multiplier training will be gradually expanded to cover 12 townships and the respective RHC and sub-centre levels. During 2015 and 2016, training will continue in a phased manner to cover 170 townships by 2016 and the entire country by 2018.

Activity 5: Conduct supervision and monitoring visits

Follow-up supervision visits will be conducted to support contraceptive logistic supply in townships.

At township level regular monitoring will assess whether data on commodities is collected and entered into the system and the functionality of Reproductive Health Commodity Logistic Supply system i.e. the flow of information on commodities from the Sub Centre, RHC and townships onward to state/region level and central level.

Monitoring visits will also check if integrated procurement planning is functional, i.e. the procurement is according to real need and utilization, and conducted in a timely manner with the contribution of different development partners and MoH. Spot checks on RH commodity availability and utilization data to feed into RH-LMIS will be assessed.

Activity 6: Develop an automated system to capture facility-level reproductive health commodities

An automated system LMIS will be introduced at all levels of the health/administrative system within the long term objective to have a computerized LMIS that will establish and encourage the “pull” system for RH commodity distribution. Data from LMIS will be made available to township, state/region and central levels.

UNFPA will support automation of RH-LMIS using “Logistimo“ software that will start at the central and state and

regional level whereas at township level and below, initially it will be manual LMIS. In 2017, training will be conducted on use of the software. Support will be provided for automation of RH-LMIS using "Logistimo" software and for automation of functional RH-LMIS in township level and reporting via mobile phones from RHC and sub-RHC levels.

For these plans to proceed in a timely manner, MoH will advocate and coordinate with Myanmar telecommunications and concerned authorities to ensure internet access is intensified at state/regional and central levels in 2014-2015, and access is expanded to townships in 2016 and to sub-township levels in 2017.

Activity 7: Conduct annual Facility Assessment for RH Commodities and Services

The Department of Medical Research (Upper Myanmar) and UNFPA Country Office are conducting annual Facility Assessment for RH Commodities and Services. The first assessment was conducted in 2014 and service delivery points will be equipped with necessary supplies and commodities as per assessment findings. Sustainable supply and maintenance will be ensured through conducting annual forecasting, and quantification of contraceptive commodities. The survey will all allow regular updates of the data base on FP commodities and related supplies.

Activity 8: Institutionalization of good procurement practices in Universities of Pharmacy.

Within the framework of the national efforts to enhance RHCS; DoH, the Department of Medical Sciences and UNFPA will collaborate with national institutions to further institutionalize procurement training and promote communities of practice/networks. This will include steps to incorporate RHCS training into the current curricula of the Universities of Pharmacy. Training modules will cover national policy on commodity security, technical aspects of RHCS, and the tools used in assessing RH commodity security. Other important topics include logistics management information systems and advocacy for RHCS.

Strategy 6: Incorporate indicators to monitor commitments to FP2020 in the health information system and enhance the use of data for decision-making

Outcome

Inclusion of indicators to monitor commitment to FP2020 in the Health Management Information System (HMIS)

Increased utilization of information from different sources (monitoring and evaluation, HMIS and other sources and research) for decision-making

Strategy

The monitoring and evaluation (M & E) plan will be within the M & E framework of the National Strategic Plan for RH and the aim to *Increase utilization of information from monitoring and evaluation, health information system and other sources and research.*

Currently, HMIS includes a limited number of indicators for BS and indicators to monitor commitment to FP2020 will be included after consultation with the Department of Health Planning. This will entail the revision of existing data collection tools and data dictionary while new tools will be developed to closely track a revised list of BS indicators consistently. Data collection tools will be designed to disaggregate data by sex and age in addition to geographic areas.

HMIS obtains data from health facilities under the Departments of Health and Medical Care. Data flow is from midwives to the central level via township hospitals. Health centres will utilize updated standard reporting templates and submit data to the township hospitals. Townships in turn will receive, aggregate and analyze collected data to assess performance of individual health centers and provide feedback. Township hospitals will then submit aggregated data to the regional/state level and then to the central level where nationwide aggregation and performance analysis takes place and feedback will be sent to township hospitals.

NGOs have established monitoring systems and collect data on clinic and outreach services which, in turn, will feed into the M&E Plan to monitor FP2020 commitments. As approximately half the population of reproductive age obtains services from the private sector, efforts will be made to obtain data from the private sector. This will provide a better picture of contraceptive needs and preferences. However, the challenges of obtaining complete and accurate data from the private sector are acknowledged.

A survey to guide the implementation of RHCS was conducted in 2014 to cover both the availability of RH commodities and salient aspects of service delivery facilities that underpin good RH programmes. The survey was conducted in all states and regions and will be repeated on an annual basis and form another source of data for monitoring.

The Lead Family Planning Working Group will undertake periodic review of key FP data sources and reports to track progress made and identify areas for improvement.

Activities

Activity 1: Establish mechanism for reporting on FP2020 and other global indicators.

Review existing HMIS and BS indicators; agree on additional indicators for reporting to global programmes with key stakeholders and build capacity of national counterparts to collect and process disaggregated data on BS to update HMIS.

Activity 2: Establish guidance and methods for collecting and reporting data

Standardized reporting forms and data collection tools will be updated to include indicators to monitor commitment to FP2020.

Activity 3: Develop standardized reporting forms for private sector

Develop standardized and simple reporting forms on contraceptive use to be completed and submitted by health workers practising in the private sector. This effort will be carried out in a phased manner to cover larger facilities providing services in cities and towns.

Activity 4: Conduct operations research on newer contraceptives

Operations research will be conducted on contraceptives recently introduced into the programme, in particular on acceptability by clients and providers on different types of implants and on pilot introduction of non-clinic delivery of Sayana Press.

The Strategies and Key Activities are presented in a summary table in Annex 4 in which Lead agencies and Key stakeholders are identified.

9 Institutional Arrangements for Implementation

The realization of the objectives of the Implementation Plan through its' six strategies will require leadership and governance at the different administrative levels of the public health system and co-ordination and collaboration with CSOs, namely INGOs and NGOs working on RH and BS at national, state/regional, township and community levels; development partners and UN agencies. Partnerships will be strengthened with other departments under the Ministry of Health, particularly the Departments of Health Planning and Medical Sciences to achieve strategies related to their domains.

The Myanmar Health Sector Coordinating Committee (MHSCC) includes representatives of 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, maternal, child and reproductive health and disaster preparedness via technical and strategic groups.

The Reproductive, Maternal and Child Health Technical and Strategy group with three working groups has been formed – the Lead RH Working Group, the Lead Child Health Working Group and the Lead Family Planning Working Group.

Partnerships and networks will be forged to realize the six strategies, cognisant of their inter-related nature.

Strategy 1: Reinforce an enabling environment for birth spacing

Strategy 2: Generate demand and sustain behavior change

Strategy 3: Improve performance of health workforce for birth spacing

Strategy 4: Increase availability of good quality birth spacing services

Strategy 5: Improve availability of a reliable supply of contraceptives

Strategy 6: Incorporate indicators to monitor commitments to FP2020 in the health information system and enhance the use of data for decision-making

At the township level, Township Health Authorities will lead the collaboration among public, private and NGO sectors and different segments of the community.

Specific roles and responsibility of the Department of Health

As the leading institution responsible for implementation of Implementation Plan to meet FP2020 commitments, DoH and the Lead Family Planning Working Group will:

- Ensure periodic review of the programmes of ministries, departments, agencies and engagements with NGOs and other institutions involved in the implementation of the Implementation Plan within the framework of the Strategic Plan for RH (2014-2018).
- Strengthen linkages with other ministries and departments, development partners, NGOs and the private sector involved in BS programming.
- Advocate for policies that facilitate BS programmes and services at the national, district, township and village levels.
- Conduct resource mobilization for RH/BS services and RH commodity security.
- Advocate, promote and coordinate the operationalization of Implementation Plan at both national and sub-national levels.

- Convene meeting with relevant stakeholders to discuss the Implementation Plan and agree on priority activities, select townships for interventions in year 1 (and later years) and focal points.
- Track M&E data to improve programme performance
- Coordinate capacity strengthening of providers to ensure that the services they provide conform to the standards and quality care set out in DoH guidelines and protocols.
- Facilitate and support operations research on RH/BS, document best practices and disseminate results.

The Collective Role of Partners of the MoH

The need to harness the shared roles and responsibilities of all stakeholders will be critical in the realization of the objectives of the Implementation Plan. The DoH will ensure that complementarities of the roles and responsibilities of concerned ministries and the departments under the ministries, universities of medicine, nursing and midwifery, professional organizations, research institutions, CBOs and NGOs, development partners, faith-based organizations, are identified in line with their mandates. Linkages will be further strengthened to ensure joint formulation, implementation, monitoring and evaluation of the Implementation Plan and BS programmes.

Township Health Department

Township planning and budgeting for health service delivery is a critical part of ensuring that BS programmes are designed so that "all individuals can make informed choices and access the services they choose in seeking to space births, to avoid unwanted pregnancy and to determine the size of their families". There are differences within townships related to geographical location, socio-cultural context and health service organization; and approaches employed will need to respond to the context as well as to the individual practices of users. A number of groups such as adolescents, young people, the urban poor, rural communities and key affected populations often face a combination of access barriers. This leads to limited choice of contraceptive methods, and higher levels of unmet need for family planning. These groups require particular attention to promote their reproductive rights and ensure their access to contraceptives and other RH services.

The specific roles and responsibility of the *Township Health Department* will include:

- Planning and budgeting of the Township Health Plan so that RH/BS are prioritized in the Plan

- Coordination with other partners and stakeholders for training, supervision and outreach activities

- Lead capacity strengthening activities with NGO partners and participate as a Trainer

- Conduct training on RH/BS and communication for midwives

- Provide services on LARC at the township hospital and during outreach mobile clinics

- Develop approaches with local NGOs to meet the needs of specific population groups

- Strengthen linkages with community leaders, women's groups and youth groups

- Adopt procurement procedures that are demand-based

- Assist in functionality of LMIS and the flow of information on commodities from the Sub-centre, RHC and townships onward to state/region level and central level

- Ensure that RH/BS is included in MISP in Disaster Preparedness and Response plans

- Participate in supervision and monitoring of MWs and provide feedback to improve performance

- Provide inputs and feedback on township experiences to national planning processes

- Identify "Best Practices" and document them

Development Partners

Included in this category are the bilateral and multilateral donors and implementing partners that provide technical assistance and expertise in support of the national BS programmes. Donor agencies will be called upon to increase their support and to augment the resources that will be required for the Implementation Plan.

Civil Society Organizations

This includes ensuring coordination and training, procurement of contraceptive commodities, and ensuring adherence to service protocols and guidelines. These organizations are also expected to contribute their service data for M&E, to assist the Departments of Health and Planning and Statistics in maintaining a comprehensive picture of implementation of BS programmes, as well as identifying needs and opportunities and developing specific approaches to expand services to the underserved population.

10 Strategic Information (Monitoring and Evaluation and Research)

Monitoring success of the Implementation Plan

Monitoring and Evaluation of the process as well as the outcome of the implementation will inform MoH of the progress being made. It will identify gaps and suggest adaptation and remedial measures during the operational phase of the Implementation Plan to meet FP2020 commitments.

The M&E Framework of the Implementation Plan is aligned to the M&E Plan of the Strategic Plan for RH (2014-2018). Core indicators including those that will measure long-term targets for monitoring and evaluating of the impact of the BS programmes and services have been developed. These include indicators identified by FP2020 that countries should report on as well as those monitoring the implementation of the Strategic Plan for Reproductive Health (2014-2018). Additional indicators to monitor commitment to FP2020 will be included after consultation with Department of Health Planning. (Table 10.1 - Logical Framework Matrix)

Indicators of success for the Implementation Plan are expressed in terms of outputs and outcomes to be achieved by each activity. Outcome indicators such as increases in contraceptive use will suggest how the programme is affecting health and well-being. Output indicators check whether intended improvements occurred in the products or services – for example, in accessibility and quality of care or service utilization. Ultimately, successful implementation of the Plan will be measured in terms of its effect on contraceptive prevalence; and measures of MMR, CPR and other impact indicators of the proposed M&E system will be provided by the Demographic and Health Survey planned for 2015.

Monitoring of this Implementation Plan will rely greatly on routine data generated through the reporting systems of the HMIS and LMIS. The annual RHCS review will also provide information on the availability and stock out of RH commodities, supply chain, staff training and supervision, availability of guidelines and protocols and user fees, among others.

Mid-term Review and Final Evaluation

A *Mid-term Review* (MTR) is planned for the Strategic Plan for RH in 2016. As BS is an integral component of the Strategic Plan, the Implementation will be assessed as well. For this 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 for the remaining years. 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. The MTR will be designed to encompass the implementation of BS interventions, in particular demand generation and use of long-term reversible contraception.

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 for RH and Implementation Plan to meet FP2020 commitments 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 Demographic and Health Survey. Impact and Outcome indicators will be reviewed again in 2020 to assess the realization of the commitments made and the objectives of the Implementation Plan.

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 BS 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 inform BS programme approaches to improve care-seeking behaviour, increasing availability of and access to key RH/BS 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.

Case studies of Best Practices in Birth Spacing

Case studies of innovative programmes developed by the MoH or NGOs and good practices that include integrated approaches to voluntary, rights-based BS at country level will be identified systematically and where possible, scaled up for greater impact.

Logical Framework Matrix

The Logical Framework is based on the Goal and the Objectives mentioned in Section 7. The following are key indicators that will be used to monitor trends in BS. There are specific targets to be reached by (i) 2018 as part of the Strategic Plan for Reproductive Health and (ii) 2020 as part of commitments made to FP2020, which can be verified by different means. 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. This Logical Framework is based on the assumptions that health policies will continue to be supportive of reproductive health and birth spacing; 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.

Table 10.1: Logical Framework Matrix

Indicator	Current Status	Data Source Year	Target	Data Source Year (2018)***	Target	Data Source Year (2020)***
Impact						
Maternal Mortality Ratio	200 per 100,000 livebirths	UN Inter-agency estimates 2010	120 per 100,000 livebirths	UN Inter-agency estimates Public Health Statistics Report		UN Inter-agency estimates Public Health Statistics Report
Total Fertility Rate	2 per 1000 women 15-49	FRHS, 2007	2 per 1000 women 15-49	Survey	2 per 1000 women 15-49	Survey
Contraceptive prevalence rate	41 per cent 38 per cent	MICS FRHS, 2007	52 per cent	Survey, Public Health Statistics Report	60%	Survey, Public Health Statistics Report
Contraceptive prevalence rate (modern)*	38 per cent	FRHS, 2007	45%	Survey	60%	Survey
Percent of women with unmet need for contraception*	17.7 per cent	FRHS, 2007	8 per cent	Survey	6%	Survey
Percent of women demand for contraception satisfied (Met need for contraception)*	Not available		60%	Survey (DHS) Public Health Statistics Report	80%	Survey (DHS) Public Health Statistics Report
Adolescent Birth Rate	16.9 per 1000 girls 15-19 years	FRHS, 2007	10 per 1000 girls 15-19 years	Survey, Public Health Statistics Report	8 per 1000 girls 15-19 years	Survey, Public Health Statistics Report

Indicator	Current Status	Data Source Year	Target	Data Source Year (2018)***	Target	Data Source Year (2020)***
Outcome						
Annual expenditure on FP from Government domestic budget*	1.29 million US$ (2012) 3.27 million US$ (2013)	Govt Reports		Govt Reports		Govt Reports
Couple Years Protection*	3,044,648 (2012) 3,501,539 (2013)	Public Health Statistics Report		Public Health Statistics Report		Public Health Statistics Report
Inclusion of BS services in universal health coverage insurance schemes	Not included as yet		BS Included in UHC	Govt Reports	BS Included in UHC	Govt Reports
Percentage of married women who know at least four modern contraceptive methods	Not available			Survey		Survey
Percentage of men who know at least four modern contraceptive methods	Not available			Survey		Survey
Percentage of youth (girls) who know at least four modern contraceptive methods	Not available			Survey		Survey
Percentage of youth (boys) who know at least four modern contraceptive methods	Not available			Survey		Survey
Contraceptive use by method (method mix) disaggregated by age and geographical area[1]	Data in MICS IHLCA	MICS, 2010		Survey, Public Health Statistics Report		Survey, Public Health Statistics Report
Percentage of married women using long-acting reversible methods**	1.8%[2]	FRHS, 2007	4%	Survey, Public Health Statistics Report	8%	Survey, Public Health Statistics Report
Percentage of clients who received post-abortion counseling and contraceptive services**	Not available		80%	Township Reports	90%	Township Reports
RH/BS component integrated into Disaster Preparedness Response policies and plans at all levels**	Not available		BS component integrated	2015 Disaster Preparedness Response policies/plans	BS component integrated	Disaster Preparedness Response policies/ plans
Reproductive health commodity logistics management information system established at national level	Not established yet		LMIS established	2016 Government Reports	LMIS established	Government Reports

Indicator	Current Status	Data Source Year	Target	Data Source Year (2018)***	Target	Data Source Year (2020)***
Reproductive health commodity logistics management information system established at township levels	Not established yet		LMIS established	2016 Government Reports	LMIS established at all levels	Government Reports
Existence of a co-ordination mechanism at township level for RH/BS activities between public and private sectors	Not available		Quarterly co-ordination meetings	Township Reports	Quarterly co-ordination meetings	Township Reports
Principles of equity for vulnerable populations (i.e. adolescents, disadvantaged groups) reflected in the policies and programmes on delivery of BS services	Not available		Principles reflected	2016 Government Reports	Principles reflected	Government Reports
Output						
Number of national and state/regional advocacy events on RH/BS	Not available		At least one high-level advocacy event per year in all states/ regions	2015 - 2018- DoH Reports	At least one high-level advocacy event per year in all states/ regions	DoH Reports
Number of Training courses on BS focusing on counselling, LARC, quality of services and integration of services	Not available		At least two training courses per year in 100 townships	2015 – 2018 Training Reports	At least two refresher training courses per year in 100 townships	Training Reports
Number of Township Medical Officers and medical officers receiving skills training on subdermal implant insertion	Not available		At least two doctors trained in courses per year in 100 townships	2015-2018 Training Reports	90% of doctors trained in courses per year in all townships	Training Reports
Number of general practitioners receiving skills training on IUD insertion	Not available		XX GPs trained	NGO Training Reports	XX GPs trained	NGO Training Reports
Percentage of MW receiving training on postpartum family planning	Not available		80 per cent of MW trained on PPFP	Township Reports	90 per cent of MW trained on PPFP	Township Reports

Indicator	Current Status	Data Source Year	Target	Data Source Year (2018)***	Target	Data Source Year (2020)***
Number of youth-friendly services supplied with contraceptives	Not available			2018		Township Reports
Percentage of AMWs who receive monthly supervision visits including in part on BS	Not available			2018		Annual Township Reports
Percentage of RHC without constant supplies of 3 birth spacing methods	Not available		10 per cent do not have constant supplies	Annual RHCS Facility Assessment	5 per cent do not have constant supplies	Annual RHCS Facility Assessment
Percentage of Township Hospitals offering at least 4 birth spacing methods at any point in time	Not available		At least 80 percent of Township Hospitals	Annual Township Reports LMIS	At least 90 percent of Township Hospitals	Annual Township Reports LMIS
Percentage of facilities implementing PPFP integrated with child health programmes	Not available		At least 80 percent of Township Hospitals	Annual Township Reports	At least 90 percent of Township Hospitals	Annual Township Reports
Proportion of township hospitals providing subdermal implants	Not available		At least 80 percent of Township Hospitals	Annual Township Reports	At least 90 percent of Township Hospitals	Annual Township Reports
Number and type of outreach activities conducted to reach the urban poor in Yangon				Regional Health Reports NGO Reports		Regional Health Reports NGO Reports
Number and type of outreach activities conducted to reach the urban poor in Mandalay				Regional Health Reports NGO Reports		Regional Health Reports NGO Reports

* FP2020 indicator

** Strategic Plan for Reproductive Health indicator

***** Targets for 2018 and 2020 unless indicated specifically in the Table**

11 Costing of the Implementation Plan to meet FP2020 commitments

11.1 Costing of the implementation plan

Costing Assumptions

Costing elements are described and costed based on specific data from the MoH, UNFPA, partners implementing programmes, and regional and global estimates. Each source for each input is cited in the costing tool; all inputs are also editable in the costing tool. In addition, each activity's costing inputs for both unit costs and quantities can be changed (e.g., the specific input costs for producing a radio programme, the number of programmes to be produced, the cost of broadcasting the programme, and the number of times it will be broadcast, etc.).

Contraceptive costs are calculated for the period from 2015 to 2020, utilizing a method mix (current estimate for 2014 and predicted for 2020) based on the following variables:

1) Data from the 2007 FRHS, 2015 commodity requirements from UNFPA to create a 45.7% CPR mix, and data for the latest 2010 Cambodia DHS for all, married and unmarried women was used to inform the best estimation for the 2014 method mix. The estimated 2014 married women method mix was calculated based on discussions with UNFPA and the MoH, and included information from the Access RH- Summary of Shipments.

2) The current method mix for unmarried women was calculated based on the following estimations: Starting from the 2010 data for Cambodia for unmarried women, adding 10% of unmarried sexually active women using EC to the method mix, as local expert opinion viewed EC as a very popular method for unmarried women. As the Cambodia data had a low CPR for unmarried women, the addition of 10% emergency contraception (EC) to CPR increased the overall CPR for unmarried women (projected for 2014) to about 36%. However, this is still a very low CPR for unmarried women compared to married women (in other countries—Nepal and India CPR is higher for unmarried women; in the Philippines CPR is about the same for married and unmarried women; in Indonesia it is also significantly lower for unmarried women). Unfortunately the Laos indicator survey did not include CPR data for unmarried women (it only had contraceptive use for married women included in the report). The method mix for unmarried women is similar to the married women CPR method mix, with a bent towards a modern method mix for unmarried women, as is likely to be popular in 2020 if social and behavioural change communication (SBCC) and services are scaled up (e.g. injectables, pills and implants), and with the idea that the CPR for unmarried sexually active women should be at least the same, if not higher than married women.

3) The 2020 method mix was calculated based on the current method mix, and estimates of what was possible to reach 60% CPR according to consultations with the MoH and UNFPA, and refined based on stakeholder input.

Unless otherwise noted, all consumable costs (e.g., salaries, per diem rates, fuel costs, venue hire, etc.) are based on costs as of October 2014 and have been automatically adjusted for a base rate of inflation of 2.5 percent over time. The inflation rate can be adjusted to accommodate changing conditions. All costs have been calculated in USD dollars and converted to local currency.

Costing Summary

The costs of this plan have been calculated using a tool developed specifically for this purpose, with methodology borrowed from other FP plan costing activities regionally and globally. The tool allows for a calculation of the overall costs of the plan, as well as a disaggregation of the costs by activity area and year. It includes both initial (investment) costs and ongoing or sustainability costs for the duration of the plan.

The total cost of the plan from 2015–2020 is $261,871,113 USD.

Overall, $182 million USD or 70% percent of the overall costs are in commodities, including contraceptives and consumables. Costs are spread over the duration of the plan, with commodity costs increasing over time as more women are reached.

The costs of the plan are comparable to other countries' similar FP costed implementation plans. The cost per woman of reproductive age for activity costs is $0.67 in 2015 to $1.30 USD in 2020 per year, which is lower than costs in other countries of about $2–5 USD. The cost per user for FP commodities is $6.80 USD, significantly higher than the costs of $4–4.20 USD seen in other countries.[1] However, this is likely due to the costs being derived from actual national where possible rather than international estimate costs and the inclusion of a variety of additional loaded costs for each commodity (e.g., pre-shipment inspection, wastage, contraceptive procurement fees, clearing fees, freight charges, testing and oversight costs, insurance, storage fees, distribution fees/ last mile costs), which were not included in the standard costing for commodities for other Costed Implementation Plans (CIPs).

Programme Costs, in USD								
		2015	2016	2017	2018	2019	2020	Total
Strategy 1	EE: Reinforce an enabling environment for birth spacing	$ 424,728	$ 281,875	$ 440,758	$ 296,145	$ 365,495	$ 214,968	**$ 2,023,968**
Strategy 2	DBC: Generate demand and sustain behavior change	$ 1,634,958	$ 2,501,697	$ 3,920,806	$ 5,208,252	$ 6,615,239	$ 8,629,907	**$ 28,510,859**
Strategy 3	HW: Improve performance of health workforce for birth spacing	$ 1,564,365	$ 1,575,774	$ 1,587,053	$ 1,601,573	$ 1,641,613	$ 1,676,996	**$ 9,708,478**
Strategy 4	QS: Increase availability of good quality birth spacing services	$ 4,273,130	$ 5,355,553	$ 6,532,713	$ 5,779,026	$ 6,158,614	$ 6,553,569	**$ 34,681,124**
Strategy 5	CS: Improve availability of a reliable supply of contraceptives	$ 423,575	$ 1,573,636	$ 2,120,951	$ 106,612	$ 109,277	$ 112,009	**$ 4,587,870**
Strategy 6	DDM: Incorporate indicators to monitor commitments to FP2020 in the health information system and enhance the use of data for decision-making	$ 155400	$ 282285	$ 37192	$ 0	$ 0	$ 0	**$ 474,877**
Program Areas Total		**$ 8,476,156**	**$ 11,570,820**	**$ 14,639,474**	**$ 12,991,609**	**$ 14,890,237**	**$ 17,187,448**	**$79,987,177**

	2015	2016	2017	2018	2019	2020	Total
Contraception Costs, in USD							
IUDs	$ 46,075	$ 58,674	$ 73,084	$ 89,448	$ 102,153	$ 115,623	$ 485,056
Implants	$ 1,645,010	$ 2,285,189	$ 3,027,149	$ 3,879,155	$ 4,588,422	$ 5,341,695	$ 20,766,620
Injections	$ 13,374,138	$ 14,268,798	$ 15,273,587	$ 16,397,203	$ 17,579,841	$ 18,824,223	$ 95,717,790
Pills	$ 3,874,887	$ 4,072,480	$ 4,283,372	$ 4,508,945	$ 4,750,129	$ 6,554,863	$ 28,044,675
Male condom	$ 572,233	$ 615,276	$ 664,061	$ 719,049	$ 777,022	$ 838,122	$ 4,185,763
Female condom	$ 481,875	$ 1,079,796	$ 1,803,983	$ 2,665,321	$ 3,583,504	$ 4,561,415	$ 14,175,893
Emergency contraceptive pill	$ 2,422,806	$ 2,468,690	$ 2,509,404	$ 2,544,355	$ 2,578,759	$ 2,612,537	$ 15,136,552
Contraception Total	$ 22,417,023	$ 24,848,903	$ 27,634,640	$ 30,803,475	$ 33,959,830	$ 38,848,478	$ 178,512,349
Contraception Consumables, in USD							
Implants	$ 77,412	$ 104,915	$ 135,590	$ 169,514	$ 195,618	$ 222,178	$ 905,228
IUDs	$ 49,810	$ 61,884	$ 75,203	$ 89,796	$ 100,049	$ 110,480	$ 487,222
Female ster.	$ 241,560	$ 270,125	$ 300,621	$ 333,093	$ 349,248	$ 365,666	$ 1,860,313
Male ster.	$ 8,032	$ 16,021	$ 19,533	$ 23,281	$ 25,069	$ 26,888	$ 118,825
Consumables Total	$ 376,815	$ 452,946	$ 530,947	$ 615,684	$ 669,984	$ 725,212	$ 3,371,587
WRA Users- Contraception Costs (Commodities and Consumable costs per WRA using contraception), in USD							
Commodities total cost	$ 22,417,023	$ 24,848,903	$ 27,634,640	$ 30,803,475	$ 33,959,830	$ 38,848,478	$ 178,512,349
Consumables total cost	$ 376,815	$ 452,946	$ 530,947	$ 615,684	$ 669,984	$ 725,212	$ 3,371,587
Commodities and Consumables Total	$ 22,793,838	$ 25,301,850	$ 28,165,586	$ 31,419,159	$ 34,629,814	$ 39,573,690	$ 181,883,936

11.2 Projected method mix and contraceptive needs

Assumptions

The current CPR for all women was estimated and the method mix assumptions for the baseline year 2014, were estimated as described above. A target method mix for 2020 was projected for the CIP and considers various factors, including availability of infrastructure, provider capacity, and historical trends. The method mix projections are to be understood as the best-guess projections for future method mix, and are not to be interpreted as reducing user choice for any particular method. As such, the actual forecasting and procurement for FP commodities should be regularly reviewed and adjusted based on new and emerging data, including information on user preference and choice.

The 2014 baseline method mix and the 2020 objective method mix assumptions, for all women, are outlined below.

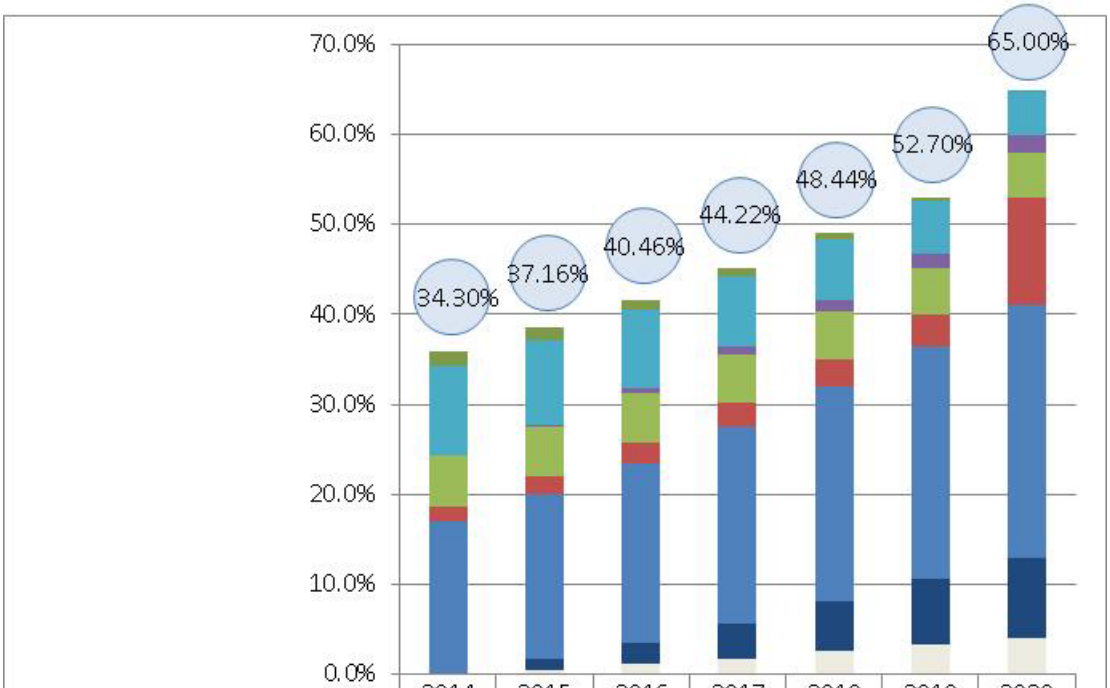
Total Method Mix, all women - Method Mix to CPR, Projected 2014 to Objective 2020								
		2014	2015	2016	2017	2018	2019	2020
CPR- all women	**28.51%**	**29.75%**	**31.20%**	**32.84%**	**34.68%**	**36.53%**	**40.25%**	
Male sterilisation	0.00%	0.00%	0.01%	0.01%	0.02%	0.02%	0.03%	
Female sterilisation	0.50%	0.53%	0.57%	0.61%	0.66%	0.70%	0.75%	
IUDs	0.95%	1.28%	1.67%	2.12%	2.62%	3.13%	3.63%	
Implants	0.50%	1.11%	1.83%	2.65%	3.57%	4.50%	5.42%	
Injections	15.06%	15.48%	15.97%	16.52%	17.15%	17.78%	18.41%	
Pills	5.43%	5.52%	5.61%	5.70%	5.81%	5.91%	7.89%	
Male condom	1.08%	1.12%	1.17%	1.22%	1.27%	1.33%	1.39%	
Female condom	0.00%	0.04%	0.09%	0.15%	0.22%	0.28%	0.35%	
Emergency contraceptive pill	1.99%	1.96%	1.93%	1.90%	1.86%	1.82%	1.79%	
Lactational Amenorrhea	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
Withdrawal	1.90%	1.70%	1.47%	1.20%	0.90%	0.60%	0.30%	
Safe period/ standard days	1.00%	0.91%	0.81%	0.69%	0.56%	0.43%	0.30%	
Moonbeads	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
Other traditional (e.g. massage)	0.10%	0.09%	0.07%	0.06%	0.04%	0.02%	0.00%	
Other (unstated)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	

Details of the annual method mix, services/commodities, and contraceptive prevalence by methods are shown in the following figures. Standard global Couple Years Protection (CYP) conversion factors and standard units needed for one year of use were used for these calculations.[2]

Contraceptive prevalence by method, married and women in union, 2014 baseline, projected 2015–2020

	2014	2015	2016	2017	2018	2019	2020
Other (unstated)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other traditional (e.g. massage)	0.20%	0.18%	0.15%	0.11%	0.08%	0.04%	0.00%
Moonbeads	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Safe period/ standard days	2.00%	1.83%	1.62%	1.39%	1.13%	0.86%	0.60%
Withdrawal	3.30%	2.96%	2.57%	2.12%	1.61%	1.11%	0.60%
Lactational Amenorrhea	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Emergency contraceptive pill	0.82%	0.97%	1.14%	1.34%	1.56%	1.78%	2.00%
Female condom	0.00%	0.01%	0.02%	0.03%	0.04%	0.05%	0.06%
Male condom	0.37%	0.47%	0.59%	0.73%	0.89%	1.04%	1.20%
Pills	10.36%	10.43%	10.50%	10.57%	10.65%	10.72%	12.00%
Injections	24.76%	25.17%	25.64%	26.18%	26.79%	27.39%	28.00%
Implants	1.00%	1.88%	2.90%	4.06%	5.38%	6.69%	8.00%
IUDs	1.89%	2.41%	3.00%	3.69%	4.46%	5.23%	6.00%
Female sterilisation	1.00%	1.06%	1.14%	1.22%	1.31%	1.41%	1.50%
Male sterilisation	0.00%	0.01%	0.02%	0.03%	0.04%	0.05%	0.06%

Contraceptive prevalence by method, unmarried sexually active women, 2014 baseline, projected 2015–2020



	2014	2015	2016	2017	2018	2019	2020
Other (unstated)	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other traditional (e.g. massage)	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Moonbeads	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Safe period/ standard days	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Withdrawal	1.6%	1.40%	1.17%	0.90%	0.60%	0.30%	0.00%
Lactational Amenorrhea	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Emergency contraceptive pill	10.0%	9.38%	8.65%	7.81%	6.88%	5.94%	5.00%
Female condom	0.0%	0.25%	0.54%	0.88%	1.25%	1.63%	2.0%
Male condom	5.7%	5.61%	5.51%	5.39%	5.26%	5.13%	5.0%
Pills	1.6%	1.92%	2.26%	2.64%	3.06%	3.51%	12.0%
Injections	17.0%	18.38%	19.98%	21.81%	23.88%	25.94%	28.0%
Implants	0.0%	1.13%	2.44%	3.94%	5.63%	7.31%	9.0%
IUDs	0.0%	0.50%	1.08%	1.75%	2.50%	3.25%	4.0%
Female sterilisation	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Male sterilisation	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Annexes

Annex 1: Myanmar's commitments to FP 2020

The Government of Myanmar views family planning as critical to saving lives, protecting mothers and children from death, ill health, disability, and under development. It views access to family planning information, commodities, and services as a fundamental right for every woman and community if they are to develop to their full potential.

Objectives

Increase CPR from 41 per cent to 50 per cent by 2015 and above 60 per cent by 2020
Reduce unmet need to less than 10 per cent by 2015 (from 12 per cent in 2013)
Increase demand satisfaction from 67 per cent to 80 per cent by 2015

Improve method mix with increased use of long acting permanent methods (LAPMs) and decentralization to districts

Policy and Political Commitments

Myanmar aims to strengthen the policy of providing clinical contraceptive methods by trained/skilled nurses, midwives and volunteers through better collaboration among multi-stakeholders within the context of Nay Pyi Taw Accord. The government of Myanmar also pledges to implement people-centered policies to address regional disparity and inequity between urban and rural and rich and poor populations. In addition, Myanmar commits to expanding the forum of family planning under the umbrella of the Health Sector Coordinating Committee and to creating an Executive Working Group on Family Planning as a branch of the Maternal Newborn and Child Health Technical Strategic Group.

Financial Commitments

In fiscal year 2011-2012, Myanmar committed USD $1.29 million for the purchase of contraceptives during the 2012-2013 financial period. Myanmar pledges to increase the health budget to cover nearly 30 million couples by 2020. The Myanmar Ministry of Health commits to working toward increasing the resources allocated to family planning in state budgets. The government is also committed to ensuring results-based management through new initiatives for effective fund flow mechanisms and internal auditing.

Programme and Service Delivery Commitments

Myanmar seeks to boost partnership with the private sector, civil society organizations, and other development partners for expanded service delivery. The government of Myanmar will continue to strengthen the logistics management information system to ensure reproductive health commodity security through improved projection, forecasting, procurement, supply, storage, systematic distribution, and inventory control. In addition, Myanmar will implement a monitoring system to strengthen quality of care and ensure women have a full range of contraceptive options.

The Government of Myanmar will review and develop a five-year strategic plan for reproductive health through a consultative process, and Myanmar's family plan will address regional disparities and inequalities. The government also commits to improving the method mix with increased use of long-acting methods.

Myanmar will host a national conference focused on family planning and reproductive health best practices in 2014 and the 8th Asia Pacific Conference on Reproductive and Sexual Health and Rights in 2016.

http://www.familyplanning2020.org/reaching-thegoal/commitments/allcommitments/commitment/40

accessed 11 September 2014

Annex 2:

Outputs of Best Practices in Family Planning conference –

Nay Pyi Taw

2.1 Issues and challenges for birth spacing programmes

Issue	Challenges
Demand Creation	Low awareness on birth spacing Advocacy to local authorities and local health authorities inadequate Insufficient production and distribution of IEC materials Limited IEC materials in dialects for ethnic minorities Subdermal implants are not socialized adequately in the community Removal rate within 1year is high for implant user (proper counseling is essential for clients) Lack of information regarding ECP

Issue	Challenges
Human Resources	Rapid turnover of trained service providers, especially in remote areas Overall vacancy rates of 10% including in hard-to-reach areas Population: service provider ratio not equitable Midwives overburdened with responsibilities, i.e. multipurpose health workers (immunization, antenatal, delivery, postnatal, Under 5, nutrition, school health, elderly health care, reporting, etc) MW: Population = 1:>5000 Medical doctors are not well trained on BS service provision nor on counselling skills Inadequate budget to cover IUD training for all MWs Manpower shortage, but AMWs are not allowed to give injections AMW training curriculum – no sessions on BS Training courses not well-planned in advance, i.e. vacant seats during training for MW, CHW and AMW Non-state actors providing RH/BS services not covered by training organized by public sector
Service Delivery	Travel to remote areas is a problem due to poor infrastructure, weather conditions Transportation difficulty for service providers and clients Limited outreach to rural areas No support for transport such as fuel for motorcycles
Long Acting Contraception	Low preference for some long term methods (IUD) Limited skills e.g. for PPIUD and therefore, no PPIUD services Insufficient commodities to meet the demand for implants Low number of female sterilization/tubectomy procedures as clients need to submit many supporting documents, couples may not meet criteria for approval and infrequent sterilization board meetings to review applications

Issue	Challenges
Commodity Security	Inadequate budget for contraceptives Shortage of commodities even though received from multiple sources Demand is more than supply (health facility/hospital needs to buy from market because of shortage of commodities) Not enough stock for commodities of client's choice such as Injection Depot Provera, Implant Commodities distributed are close to expiry dates Surplus of IUD in some facilities Even though operational policy changes in support of BS are made at the national level, communication gap between central and regional/state and township levels No integrated forecasting as LMIS was just initiated Lack of distribution budget New hospital has no storage/warehouse facilities
Public and private sector collaboration	Pharmacy shop owners and drug sellers are not included in social mobilization and training Poor linkage between GPs and township hospitals and poor referral mechanisms Weak coordination and collaboration between public and private sectors Poor co-ordination among BS stakeholders, working piece-meal in project townships GPs did not receive training on IUD, implant insertion
Monitoring	No government budget line for supervision No vehicle for supervision Limited budget and inadequate HR for regular monitoring No standardized monitoring tools No LMIS data NGO data not available
Others	Low prioritization on RH and FP component in universal health care coverage

2.2 Strategies to improve access to birth spacing

Commodity Security

- Allocation of contraceptives for 100- bedded hospital and above
- Support for distribution cost of commodities by MoH, UN, INGOs
- Budget allocation for warehouse/storage of BS commodities
- Development of logistic Management Unit at central level to plan proper distribution system (LMIS)
- To use “Pull System” for demand (bottom up approach)
- Resource mobilization from donors and development partners
- Adopt different strategies for different geographical locations
- IEC for different ethnic languages

Demand Generation

- Social mobilization with advocacy (village leaders, non-state leaders, local authority)
- Promotion of BS service and dissemination of information (in Myanmar and ethnic languages) on universal access to family planning services
- Identification of BS role model and sharing of experiences
- Disseminate information on the benefits of using IUD
- Coordination with other sectors – especially with education sector
- Integration of counseling on family planning during postnatal visit
- Public and private sector should collaborate to disseminate information on family planning best practices

Human Resources for Health

- Review and revise human resource development plan according to needs
- Improve retention of staff and review transfer policy especially for hard-to-reach and remote areas
- Capacity development of health workforce
- Establishment of Regional training centre
- Task shifting to AMW for providing FP services (pills, condoms and injectables)
- Review of roles and responsibilities of existing health workforce, especially midwives
- Capacity building on counseling and provision of quality BS practices by health care providers in both public and private sectors

Service Utilization

- Accurate forecasting of BS commodities which the community might need and keep stock for 6 months etc.
- Ensure sustainable supply mechanism
- Peer education and service provision (volunteer recruitment and training)
- Capacity building of pharmacists, drug sellers
- Task shifting for long term contraceptive methods
- Promotion of IUD - particularly for PPIUD at the township hospital
- Provide BS services free of charge
- Develop standardized guideline and manual
- Supply training materials

Public Private Partnership	Data and Monitoring
• Create linkage through quarterly meeting of township FDA committee with all private sector stakeholders • Involvement of GPs in regular Continuing Medical Education (CME) programmes which focus on BS • To work with Myanmar Medical Council for accreditation of GPs including updated knowledge and skills on BS and RH in the process of licensing • Township Medical Department should assign focal person for collecting data from GPs and private sector • Strengthening data management (collection, analysis and sharing) and HMIS • Provision of Integrated Essential Services Package which includes BS • Training of GPs for standardized BS service package in collaboration with MyMA • Include BS as a priority issue together with maternal health in township and regional development plans • Involvement of youth groups in designing services	• Allocate budget for monitoring and supervision • Strengthen HR for monitoring • Develop standardized monitoring tools • Scale up RH LMIS in all townships • Set up reporting system for public-private partnership

Annex 3: Stakeholders working on birth spacing

Ministries

Ministry of Health

Ministry of Social Welfare, Relief and Resettlement

Ministry of Education

National Programmes

National AIDS Programme

National Nutrition Centre

MOH Departments and Sections

Department of Health

Department of Health Planning

Department of Medical Sciences

Universities of Medicine, Nursing/ Midwifery and Public Health

Departments of Medical Research

Central Expanded Programme on Immunization

Central Health Education Bureau

Medical Care Division

Public Health Division

Women and Child Health Development Section

Councils

Myanmar Medical Council

Myanmar Nurse and Midwife Council

National NGOs

Myanmar Medical Association

Myanmar Maternal and Child Welfare Association

Myanmar Nurse and Midwife Association

Multilaterals

IOM

UNFPA

UNICEF

WHO

Bilaterals

Japanese International Co-operation Agency (JICA)

INGOs

Association Francois-Xavier Bagnoud

Burnet Institute

Care Myanmar

The Clinton Health Access Initiative (CHAI)

Danish Red Cross

Community Partners International

Family Health International (FHI)

Health Poverty Action

Japanese Organization for International Cooperation in Family Planning (JOICFP)

JHPIEGO (Johns Hopkins Program for International Education in Gynecology and Obstetrics)

John Snow International

Marie Stopes International

Medecins du Monde

Merlin

Population Services International (PSI)

Program for Appropriate Technology in Health (PATH)

Pact Myanmar

Relief International

Save the Children

World Vision

Adapted from Strategic Plan on Reproductive Health (2014)

Annex 4: Summary of Strategies and Key Activities

Activities	Inputs	Indicator	Lead agency	Stakeholders	Timeline
Strategy 1: Reinforce an enabling environment for birth spacing (EE)					
EE.1.1. Develop an advocacy plan and materials for advocacy and social mobilisation on BS • Establish an advocacy committee • Identify advocacy objectives and expected outcomes • Identify key audiences • Develop, tailor and pretest messages • Select channels of communication, activities, and materials	Local consultant to lead development of advocacy and social mobilisation plan • Consultant- daily rate for 60 days 4 stakeholder meetings • 1 full day each • At hotel in Nay Pyi Taw • 20 people • Travel reimbursement for 10 people- flight, perdiem, hotel- 2 days per meeting • Small meeting printing, communications and refreshments 2 small meetings to test messages • Half day each • One at hotel in Nay Pyi Taw, one in Yangon • Travel reimbursement for 2 people- flight, perdiem, hotel- 2 days per meeting • Small meeting printing, communications and refreshments	Advocacy materials and toolkit developed	RH programme, DoH	DoH, State/ regional, township, UN agencies and development partners	2015
EE.1.2. Print advocacy materials (briefs, fact sheets) on the important role of BS in promoting health and supporting development, in the major dialects for decision makers and community leaders	Printing • 3 briefs/fact sheets (2 pages A4, full colour)- 6,000 copies (2,000 per dialect) • Translation fee (3 dialects) • Graphic design fee for printing and editing of accompanying PowerPoint presentations	Print advocacy materials and toolkit	RH programme, DoH	DoH, State/ regional, township and NGOs	2015 2017 2019

Activities	Inputs	Indicator	Lead agency	Stakeholders	Timeline
EE.2.1. Conduct advocacy through organizing meetings and other events at central, state/regional for decision-makers and authorities/leaders for increased budgetary allocation for RH/BS and inclusion of BS as a component of the package of MCH services under Universal Health Coverage	1 central meeting to develop an action plan for conducting advocacy • Full day meeting • At hotel in Nay Pyi Taw • Travel reimbursement for 5 people- flight, perdiem, hotel- 2 days per meeting • Small meeting printing, communications and refreshments State/regional meetings • Half day meetings • At hotel in each state • Travel reimbursement for 2 people- flight or car transit, perdiem, hotel- 2 days per meeting • Local travel reimbursement for 30 people per state meeting • Small meeting printing, communications and refreshments	At least one meeting conducted in - 7 states /regions - 7 other states/ regions - 2nd round of meetings in 7 states/ regions	State/regional, authorities and NGOs	DoH, World Bank, State/regional, township and NGOs	2015 2017 2019
EE.2.2. Social mobilization and advocacy through conducting meetings at township and village authorities/leaders, non-state actors, NGOs	Township meetings • Half day meetings • Travel reimbursement for 2 people- car transit, perdiem, hotel- 2 days per meeting • Local travel reimbursement for 30 people per township meeting • Small meeting printing, communications and refreshments	At least one meeting conducted in -170 townships and major village tracts - 160 townships and major village tracts - 2nd round in 150 townships and major village tracts	Township and NGOs	DoH, State/ regional, township and NGOs	2015 2017 2019

Activities	Inputs	Indicator	Lead agency	Stakeholders	Timeline
EE.3.1. Conduct training on effective communication, the role of BS in health and development and establishment of youth friendly corners/services offering YFHS to Township and Community Support Groups	Training sessions • Two-day meetings • At office in each township • Travel reimbursement for 2 people- car transit, perdiem, hotel- 2 days per meeting • Local travel reimbursement for 30 people per township meeting • Small meeting printing, communications and refreshments	Training sessions conducted in - 100 townships in 2015 - 100 townships in 2016 - 100 townships in 2017	Township authorities and NGOs	Township authorities and NGOs	2015 2016 2017
EE.3.2. Conduct refresher training on effective communication, the role of BS in health and development and establishment of youth friendly corners/services offering YFHS to Township and Community Support Groups	Refresher training sessions • Two-day meetings • At office in each township • Travel reimbursement for 2 people- car transit, perdiem, hotel- 2 days per meeting • Local travel reimbursement for 30 people per township meeting • Small meeting printing, communications and refreshments	Refresher Training sessions conducted in - 100 townships in 2017 - 100 townships in 2018 - 100 townships in 2019	Township authorities and NGOs	Township authorities and NGOs	2017 2018 2019

Activities	Inputs	Indicator	Lead agency	Stakeholders	Timeline
EE.4. Identification of "role models" of BS users and sharing of experiences	Brief on "role model" program printed and disseminated to township authorities and community support groups • 1 brief (2 pages A4, black and white)- 2,500 copies (500 per dialect) • Translation fee (5 dialects) "Role model" communication training sessions • Half-day meetings • Local travel reimbursement for 25 people per township • Small meeting printing, communications and refreshments Facilitation of "role models" • T-shirts and certificates for 20 "role models" per township	Role models share experiences on LARC Training sessions conducted in - 100 townships in 2015 - 100 townships in 2016 - 100 townships in 2017 - 100 townships in 2018 - 100 townships in 2019 - 100 townships in 2020	TMOs and Local NGOs	TMOs and NGOs	2015 2016 2017 2018 2019 2020
EE.5.1. Conduct quarterly co-ordination meetings of Lead Family Planning Working Group at national level	4 meetings per year • Half-day meetings • At hotel in Nay Pyi Taw • 50 people • Travel reimbursement for 10 people- flight, perdiem, hotel- 2 days per meeting • Small meeting printing, communications and refreshments	Co-ordination meetings conducted	DoH, State/ regional, township representatives, development partners and NGOs	DoH, State/ regional, township representatives, development partners and NGOs and NGOs	2015 2016 2017 2018 2019 2020

Activities	Inputs	Indicator	Lead agency	Stakeholders	Timeline
EE.5.2. Conduct quarterly co-ordination meetings of RH (BS) Working Group at township level	4 meetings per year • Half-day meetings • At township offices • 20 people • Small meeting printing, communications and refreshments	Co-ordination meetings conducted	Township authorities, local NGOs and private sector	Township authorities and local NGOs	2015 2016 2017 2018 2019 2020
Strategy 2: Generate demand and sustain behavior change					
DBC.1.1. Conduct a workshop to develop standard messages for PPFP, subdermal implants and approaches to be used at different levels for priority target audiences	60 days local consultant to lead development of SBCC campaign and messages • LOE 4 stakeholder meetings • 1 full day each • At hotel in Nay Pyi Taw • 40 people • Travel reimbursement for 20 people- flight, perdiem, hotel- 2 days per meeting	1-2 workshops conducted	DoH, State/ regional, township and NGOs	DoH, State/ regional, township and NGOs	2015

Activities	Inputs	Indicator	Lead agency	Stakeholders	Timeline
DBC.1.2. Develop and test messages on health and social benefits of BS, modern methods (including LARC) and to address FP myths and misconceptions, targeting diverse populations (women, men and adolescents) and in different dialects.	40 message testing workshops • Half-day meetings • At township offices • In 10 townships, 4 groups per township (men, women, youth, other key population groups), 20 people per group • Travel reimbursement for 2 people- perdiem, hotel- 2 days per meeting • Small meeting printing, communications and refreshments • Local travel reimbursement for 20 people	BS messages developed	RH Programme, DoH, CHEB, NGOs	Township and sub-township health staff, private sector providers and NGOs	2015

Activities	Inputs	Indicator	Lead agency	Stakeholders	Timeline
DBC.1.3. Develop, print and disseminate RH/BS IEC materials for diverse populations in different dialects.	15 Populations/dialects/groups for materials • 5 dialects • Simplified fact sheets/leaflets for DBC.3.3 (populations living in hard-to-reach areas), DBC.3.4 (migrants), and DBC.3.5 (urban poor) • 7 other dialects/groups TBD during IEC development planning (e.g. men, youth, people with disabilities, etc.) Printing (one-time costs) • Translation fee • Graphic design fee for publications Printing (annual costs) • 20 Newspaper publication - black & white • Pamphlet printing – colour, 5,000 copies per group • Pamphlet printing- black & white, 20,000 copies per group • Poster printing - 18” x 24” poster, 10,000 copies per group • Poster printing - 24” x 36” poster, 5,000 copies per group • 5 Billboards - printing, installation and lease Dissemination (annual costs) • Dissemination to township level through quarterly co-ordination meetings of RH (BS) Working Group at township level (EE.5.2.) • Dissemination to clinics and through community outreach included in other DBCC activities	RH/BS IEC materials - pamphlets Dissemination of RH/BS IEC materials – pamphlets in Myanmar and different dialects	RH Programme, DoH, CHEB, NGOs	RH Programme, State/regional, township and NGOs	2015 2016 2017 2018 2019 2020

Activities	Inputs	Indicator	Lead agency	Stakeholders	Timeline
DBC.2.1. Review guidelines on interpersonal communication skills and counseling and choice and use of community channels.	Small meetings at MOH • Travel reimbursement for 5 people- flight, perdiem, hotel- 2 days per meeting • Small meeting printing, communications and refreshments 2 stakeholder meetings • 1 full day each • At hotel in Nay Pyi Taw • 20 people • Travel reimbursement for 10 people- flight, perdiem, hotel- 2 days per meeting • Small meeting printing, communications and refreshments	Guideline on interpersonal communication skills and counseling	RH Programme, DoH, CHEB, UNICEF, NGOs	RH Programme, CHEB, NGOs	2015
DBC.2.2. Update training materials for Basic Health Staff (and private sector providers) on communication skills and BS methods. (*Update of guidelines on BS will be conducted under Activity 1.1 under Strategy 3 - Improve performance of health workers for BS)-*	Included under HW.1.1.	Training materials on communication and counselling skills	RH Programme, DoH, CHEB, NGOs	RH Programme, CHEB, NGOs	2015
DBC.2.3. Conduct Training of Trainers (*This activity will be conducted together with Activity 2.3 under Strategy 3 - Improve performance of health workers for BS)-*	Included under HW.2.3.				

Activities	Inputs	Indicator	Lead agency	Stakeholders	Timeline
DBC.2.4. Conduct training for TMOs, LHVs, HAs, MWs and community volunteers to improve (i) interpersonal communication skills and counseling (ii) knowledge of the benefits of healthy timing and spacing of pregnancies (iii) modern contraceptive methods (including LARC and emergency contraception) and dual protection and where services can be obtained (*link to Activity 2.4 - Strategy 3*)	Included under HW.2.4.	In each township. 1 Training workshop for TMOs and THNs 2 Training workshops for MW 2 Training workshops for AMW Training workshops (5) conducted in -100 township in 2015 -100 township in 2016 -100 township in 2017 Conduct 2nd round of workshops in 2018 - 2020	Township authorities and NGOs	Township and sub-township health staff, private sector providers and NGOs	2015 2016 2017 2018 2019 2020
DBC.2.5. Conduct similar training for private sector providers	Included under HW.2.3.	Training conducted for GPs in selected townships on an incremental basis	MyMA, NGOs	MyMA, NGOs	2015 2016 2017 2018 2019 2020

Activities	Inputs	Indicator	Lead agency	Stakeholders	Timeline
DBC.3.1. Carry out BCC activities (group sessions, inter-personal communication and outreach at community levels) for women, men and adolescents to increase awareness on healthy timing and spacing of pregnancy, modern contraceptive methods and dual protection, LARC, follow-up for correct and consistent use and to dispel myths and misperceptions.	Training and incentives for volunteers included in DBC.3.11. • 5 days of transportation allowance per volunteer- 11,000 in 2015; 22,000 in 2016; 33,000 in 2017; 44,000 in 2018; 55,000 in 2019; 66,000 in 2020	BCC activities conducted in 100 townships in 2015, 100 new townships in 2016, BCC activities continue in all townships in 2017, 2018, 2019 and 2020	Township and community groups, NGOS	Township and community groups, NGOS	2015 2016 2017 2018 2019
DBC.3.2. Community health volunteers (CHVs) auxiliary mid wives (AMWs) and village health workers (VHWs) inform target audiences through outreach community dialogue sessions and household visits about BS services *(AMWs will provide a specified package of services – Link to Strategy 4)*	Included in MOH and township staffing budget	BCC activities conducted in 100 new townships in 2015, 100 new townships in 2016, BCC activities continue in all townships	Township and community groups, NGOS	Township and community groups, NGOS	2015 2016 2017 2018 2019 2020
DBC.3.3. Develop specific approaches and conduct outreach BCC activities (and services) for populations living in hard-to-reach areas.	Printing included under DBC.1.3. • Additional transportation outreach top-up for 60 townships	Fact sheets and leaflets simplified. Outreach activities for populations living in hard-to-reach areas conducted in 60 townships.	Township and village health authorities, National and INGOs	Township and village health authorities, National and INGOs	2015 2016 2017 2018 2019 2020

Activities	Inputs	Indicator	Lead agency	Stakeholders	Timeline
DBC.3.4. Develop specific approaches and conduct outreach BCC activities (and services) for vulnerable populations e.g. migrants.	Printing included under DBC.1.3. • Additional transportation outreach top-up for 60 townships	Fact sheets and leaflets adapted. Outreach activities for vulnerable populations e.g. migrants conducted in 60 townships.	Township and village health authorities, National and INGOs, UNAIDS, IOM	Township and village health authorities, National and INGOs	2015 2016 2017 2018 2019 2020
DBC.3.5. Develop specific approaches and conduct outreach BCC activities (and services) for vulnerable populations e.g. urban poor.	Printing included under DBC.1.3. • Additional transportation outreach top-up for 40 townships	Fact sheets and leaflets simplified. Outreach activities for vulnerable populations e.g. urban poor conducted in 40 townships.	Township and village health authorities, National and INGOs	Township and village health authorities, National and INGOs	2015 2016 2017 2018 2019 2020
DBC.3.6. Develop specific approaches and conduct BCC activities for engaging men in RH/BS	Message development and testing included under DBC.1.2.; materials printing included under DBC.1.3.; group meetings included under DBC.3.1	Group meetings for men and women conducted in 100 new townships in 2015, 100 new townships in 2016, BCC activities continue in all townships.	Township and village health authorities, National and INGOs	Township and village health authorities, National and INGOs	2015 2016 2017 2018 2019 2020

Activities	Inputs	Indicator	Lead agency	Stakeholders	Timeline
DBC.3.7. Conduct mass media campaigns on RH/BS at national media and local stations.	Engage a consultant to develop family planning media scripts for radio and TV • Hire consultant for 30 days Stakeholder meeting to review and approve scripts: • 1 full day meeting • At hotel in Yangon • 20 people • Travel reimbursement for 2 people- flight, perdiem, hotel- 2 days per meeting • Small meeting printing, communications and refreshments Purchase media space • Buy 30 second radio ad space to play 3 times a week quarterly • Buy time to host 3 TV spots each year	Radio and TV spots developed 3 Radio spots broadcasted each year 3 TV spots aired each year	RH Programme, CHEB	RH Programme, CHEB, Radio stations, MRTV	2015 2016 2017 2018 2019 2020
DBC.3.8. Conduct programmes via internet and mobile phones to provide information and improve access to YFHS.	• YFHS IEC management and staffing ○ Salary- manager ○ Salary- counsellors (1 in 2015 growing to 3 by 2020) • Website design and management of website and Facebook page • SMS hosting line • SMS per message (10,000 in 2015 growing to 100,000 SMS annually by 2020) • Server, computers, other equipment	Messaging via mobile phone, website, and Facebook	RH Programme, CHEB, NGOs, young people	RH Programme, CHEB, NGOs, young people, phone/network companies	2015 2016 2017 2018 2019 2020

Activities	Inputs	Indicator	Lead agency	Stakeholders	Timeline

DBC.3.9. Establish hotlines for RH/ BS information for young people.	• Hotline management and staffing-
	  ○ Salary- manager
	  ○ Salary- counsellor
	• Hotline, annual fee
	• Server, computers, other equipment
		Hotlines established in capital cities of states/ regions:
		- 5 states/regions in 2015
		- 5 states/regions in 2016
		- 5 states/regions in 2017
		- Continues in all states/regions - 2018-2020
			RH Programme, NGOs, young people	RH Programme, CHEB, NGOs,
				young people, phone companies
					2015
					2016
					2017
					2018
					2019
					2020

DBC.3.10. Engage the media as partners in reporting on and advocating for RH including MNCH and BS.	National training meetings to educate media on in reporting on and advocating for RH including MNCH and BS. • Half-day meeting • At hotel in Nay Pyi Taw • Travel reimbursement for 1 person- flight, perdiem, hotel- 2 days per meeting • Small meeting printing, communications and refreshments	Educational message and case studies published in newspapers and journals	RH Programme, CHEB,	RH Programme, CHEB, Media	2015 2016 2017 2018 2019 2020

Activities	Inputs	Indicator	Lead agency	Stakeholders	Timeline
DBC.3.11. Training of Dedicated Birth Spacing Promoters.	Transport allowance for volunteers included in DBC.3.1. • Develop guidelines for Dedicated Birth Spacing Promoters (volunteer position)- 30 days local consultant • Develop TOT for Dedicated Birth Spacing Promoters- 60 days local consultant • Printing of materials for TOT-100 pages black and white- per Master Trainer= 2,500 pages • Train 250 Master Trainers for Dedicated Birth Spacing Promoters at state/regional level (25 per sessions, 10 sessions)- 5 day training- per diem and transportation • Select Dedicated Birth Spacing Promoters at village level- 11,000 copies of A4 black and white informational flier to guide selection • Training of 11,000 Dedicated Birth Spacing Promoters per year (110 per township, 100 townships per year) by Master Trainers- transport allowance for two Master Trainers to 100 townships per year • Printing of materials for Dedicated Birth Spacing Promoters- 50 pages A4 black and white x 11,000 copies per yearIncentive hat, bag, uniform (one set blouse/shirt – longyi/ trousers), coat for volunteers- 11,000 of each item per year	Dedicated Birth Spacing Promoters trained in 100 townships each year (goal= 66,000 in country by 2020)	RH Programme, NGOs	RH Programme, NGOs, Township Health Department	2015 2016 2017 2018 2019 2020
DBC.4.1. Conduct social marketing programmes	• Materials development and translation • Printing- fliers, posters, billboards • Radio and other media communications • Commodities included in commodity costing	Social marketing programmes expanded to 331 townships	INGOs	INGOs, Township Health Department	2015 2016 2017 2018 2019 2020

Activities	Inputs	Indicator	Lead agency	Stakeholders	Timeline
Strategy 3: Improve performance of health workforce for birth spacing					
HW.1.1. Update clinical guidelines and manuals to ensure service provision is in line with evidence-based practices – e.g. updated Medical Eligibility Criteria for Contraceptive Use. Develop guidelines on PPFP and LARC. (*Link to Strategy 4. Increase availability of good quality birth spacing services*)	National consultant- 20 days to adapt guidelines 8 stakeholder meetings (2 per guideline/manual) • 1 full day each • At hotel in Nay Pyi Taw • 20 people • Travel reimbursement for 10 people- flight, perdiem, hotel- 2 days per meeting • Small meeting printing, communications and refreshments	Updated clinical guidelines on PPFP and LARC	DoH, UNFPA, NGOs	DoH, UNFPA, NGOs, WHO	2015 2016
HW.1.2. Print copies of updated clinical guidelines and BS manuals, PPFP and LARC.	Printing (one-time costs) • Graphic design fee for 4 publications Printing • 10,000 copies of updated clinical guidelines • 10,000 copies of BS manuals • 10,000 copies of PPFP guidelines • 10,000 copies of LARC guidelines	10,000 copies printed of each document	DoH, UNFPA, NGOs	DoH, UNFPA, NGOs	2015 2016
HW.1.3. Procure teaching/learning aids and training materials – models and for RH/BS.	Purchase teaching/ learning aids • Printed materials, books- 500 copies of set of 10 books • Training materials and models • 100 IUD insertion (plastic uterus) • 500 Implant insertions (plastic arms) • 250 Implant insertions replacement skins (plastic skins) • 66,000 Condom demonstration units	Teaching/learning aids and training materials procured	DoH, UNFPA, NGOs, WHO	DoH, UNFPA, NGOs, WHO	2015 2016 2017 2018 2019

Activities	Inputs	Indicator	Lead agency	Stakeholders	Timeline
HW.2.1. Review and update inventory of BS Trainers.	Included in MOH and NGO staffing budget	List of Trainers	DOH, NGOs	DoH, NGOs	2015 2018
HW.2.2. Develop training programmes for National Trainers and public sector providers on updated BS guidelines and manuals.	• Engage a consultant for 30 days to develop training programme on updated BS guidelines and manuals • Printing of 300 copies of ToT documents- 100 pages A4 black and white	Long-term training programme	DoH, UNFPA, NGOs	DoH, UNFPA, NGOs, State/ Region and Township Health Departments	2015
HW.2.3. Conduct comprehensive in-service training of national trainers – Training of Trainers on BS (in public and private sectors) on. - healthy timing and spacing of pregnancy, - modern contraceptive methods and dual protection, - LARC, - follow-up for correct and consistent use, - male involvement in FP, - youth-friendly services, - integration of services, - client-centred approach, - quality assurance measures, - interpersonal communication and counseling skills *(Link to Strategy 2. Generate demand and sustain behavior change* *and Strategy 4. Increase availability of good quality birth spacing services)*	• Training of 50 national trainers per year through one week ToT on BS (10 trainers per state/region, 5 states/regions per year), including doctors and midwives as expert and master trainers in IUD and implant insertion- Per diem state/regional meeting for 12 participants per training	Training of Trainers conducted in. - 5 states/ regions in 2015 - 5 new states/ regions in 2016 - 5 new states/ regions in 2017	DoH, UNFPA, NGOs	DoH, UNFPA, NGOs	2015 2016 2017

Activities	Inputs	Indicator	Lead agency	Stakeholders	Timeline
HW.2.4. Conduct training for public sector providers on the topics listed above. *(Link to Strategy 2 and Strategy 4)*	Training for public sector providers (annually)- one week each, local travel reimbursement for 30 people per workshop; per diem state/regional meeting for 2 trainers per training; travel- by car to townships (from state/ regional): • 100 training workshops held for TMOs and THNs • 200 training workshops for MW • 200 training workshops for AMW	In each township. 1 Training workshop for TMOs and THNs 2 Training workshops for MW 2 Training workshops for AMW Training workshops (5) conducted in -100 township in 2015 -100 township in 2016 -100 township in 2017 Conduct 2nd round of workshops 2018 - 2020	DoH, UNFPA, NGOs	DoH, UNFPA, NGOs, Township health authorities	2015 2016 2017 2018 2019 2020
HW.2.5. Conduct skills-based training on long-term reversible methods IUD and subdermal implants for doctors and on IUD for midwives.	Training for public sector providers (annually)- one week each, local travel reimbursement for 30 people per workshop; per diem state/regional meeting for 2 trainers per training; travel- by car to townships (from state/ regional): • 100 training workshops on IUD and implants for doctors • 100 training workshops on IUDs for midwives	Training conducted in -100 township in 2015 -100 township in 2016 -100 township in 2017 Conduct 2nd round of workshops 2018 - 2020	DoH, UNFPA, NGOs	DoH, UNFPA, NGOs	2015 2016 2017 2018 2019 2020
HW.2.6. Conduct training for private sector providers on - topics listed in Activity 2.1. - skills-based training on long-term reversible methods - communication skills (Link to Strategy 2 - and Strategy 4)	Training for private sector providers (annually)- one week each, local travel reimbursement; per diem state/ regional meeting for 2 trainers per training; travel- by car to townships (from state/regional): • 500 private sector providers trained in BS, LTRM, and communication skills	Training conducted for GPs on an incremental basis	MyMA, MSI, PSI, Ob Gyn Society	MyMA, MSI, PSI	2015 2016 2017 2018 2019 2020

Activities	Inputs	Indicator	Lead agency	Stakeholders	Timeline
HW.2.7. Conduct training for community health volunteers on communication skills, benefits of BS, basic information on BS methods and available service delivery sites.	Included in DBC.3.1. and DBC.3.11.	Training conducted in -100 township in 2015 -100 township in 2016 -100 township in 2017 Conduct 2nd round of workshops 2018 – 2020	Township Health Department, NGOs	Township Health Department, NGOs	2015 2016 2017 2018 2019 2020
HW.3.1. Conduct supervisory visits (*This activity will be conducted together with Activity 9 under Strategy 4: Q.S.9. Increase availability of good quality birth spacing services*)	• Conduct supervision in 330 townships each month	At least 1 supervisory visit conducted by respective supervisor each month	Township Health Department	DoH, Township Health Department	2015 2016 2017 2018 2019 2020
HW.4.1. Update pre-service curricula (doctors, nurses, MW) with updated BS methods and procedures.	4 stakeholder meetings with Department of Medical Services (2 in 2015 and 2016) • 1 full day each • DoH in Nay Pyi Taw • 10 people • Travel reimbursement for 4 people- flight, perdiem, hotel- 2 days per meeting • Small meeting printing, communications and refreshments	Update pre-service curricula for doctors, nurses and MW	Department of Medical Sciences	DoH, Universities/ Colleges of Medicine, Nursing and Midwifery	2015 2020
HW.5.1 Training of private pharmacy staff	Training for private pharmacy staff (annually)- one week each, local travel reimbursement; per diem state/regional meeting for 2 trainers per training; travel- by car to townships (from state/regional):: • 100 private pharmacy staff trained in BS and communication skills	Private pharmacy staff trained in townships on an incremental basis	NGOs – MyMA, PSI	NGOs – MyMA, PSI	2015 2016 2017 2018 2019 2020

Activities	Inputs	Indicator	Lead agency	Stakeholders	Timeline
Strategy 4: Increase availability of good quality birth spacing services					
QS.1. Develop guidelines for integration of birth spacing into related programmes e.g. postpartum and post-abortion contraception and immunization and child health services and other services	30 days national consultant 2 stakeholder meetings to develop integration guidelines • 1 full day each • At hotel in Nay Pyi Taw • 20 people • Travel reimbursement for 10 people- flight, perdiem, hotel- 2 days per meeting • Small meeting printing, communications and refreshments Printing (one-time costs) • Graphic design fee for 1 publication • 10,000 copies of integration guidelines	Guidelines on BS methods and integration	DoH, UNFPA, NGOs, WHO, UNICEF	DoH, UNFPA, NGOs, Township health authorities	2015
QS.2.1. Ensure availability of contraceptive commodities, supplies and equipment in the public sector. (*Link to Strategy 5. Improve availability of a reliable supply of contraceptives*)	Procure commodities for the public sector: • Male sterilisation consumables • Female sterilisation consumables • IUDs, devices and consumables • Implants, devices and consumables • Injections • Pills • Male condom • Female condom • Emergency contraceptive pills	Continuous supply of contraceptive commodities, supplies and equipment. Absence of stock-outs	DoH, UNFPA, NGOs	DoH, UNFPA, NGOs, USAID, Township health authorities	2015 2016 2017 2018 2019 2020

Activities	Inputs	Indicator	Lead agency	Stakeholders	Timeline
QS.2.2. Ensure availability of contraceptive commodities, supplies and equipment in the private sector. (*Link to Strategy 5*)	Procure commodities for the private sector: • Male sterilisation consumables • Female sterilisation consumables • IUDs, devices and consumables • Implants, devices and consumables • Injections • Pills • Male condom • Female condom • Emergency contraceptive pill	Continuous contraceptive commodities, supplies and equipment	UNFPA, NGOs,	DoH, UNFPA, NGOs, Township health authorities	2015 2016 2017 2018 2019 2020
QS.2.3. Renovate existing health facilities, including health centres, to provide FP services (*This will be conducted under Strategic Plan for RH (2014-2018*)	• Renovate 20 public health clinics and centres to allow for provision of FP services, per year • Renovate 200 private health facilities, per year				2015 2016 2017 2018 2019 2020
QS.3. Conduct training for public and private sector providers on BS (*Described in Strategy 2 and Strategy 3*)	Included in HW.2.3. and HW.2.4.				
QS.4.1. Equip facilities with equipment and instruments for IUD and subdermal implant services	Purchase 500 sets of IUD and implant equipment (5 sets per township, 100 townships per year for three years) • Equipment= Sponge Forceps, Tenaculum, Steel Speculum, Uterine Sound, Scissors, Alligator, Solution Cup, Kidney Tray, Cheatle forcep, Cheatle Jar, Steel Tray	Township hospitals equipped: - 100 townships equipped in 2015 -100 new townships in 2016 -100 new townships in 2017	DoH, UNFPA, NGOs	DoH, UNFPA, NGOs, Township health authorities	2015 2016 2017

Activities	Inputs	Indicator	Lead agency	Stakeholders	Timeline
QS.4.2. Provision of LARC (implants) at district and township hospitals and IUDs at township hospitals and health centres.	Supplies and equipment included in QS.2.2. and QS.2.3.; training of providers included in HW.2.5. and HW.2.6.	Services provided: - 100 townships in 2015 -100 new townships in 2016 -100 new townships in 2017 Services expanded to all townships in 2018	DoH, UNFPA, NGOs	DoH, UNFPA, NGOs, Township health authorities	2015 2016 2017 2018 2019 2020
QS.4.3. Initiate and scale up provision of LARC (implants, IUDs) from district and township hospitals to health centres through outreach programmes.	Supplies and equipment included in QS.2.2. and QS.2.3.; training of providers included in HW.2.5. and HW.2.6.	Services expanded to - 100 townships in 2015 -100 new townships in 2016 -100 new townships in 2017 Services expanded to all townships in 2018	Township health department, NGOs	DoH, UNFPA, NGOs, Township health department	2015 2016 2017 2018 2019 2020

Activities	Inputs	Indicator	Lead agency	Stakeholders	Timeline
QS.4.4. Integrate birth spacing into postpartum care including PPIUD.	Guideline development included in QS.1. Training (in-service and refresher) and supervision included in SPRH 2014-2018, Table 2: Pregnancy, Delivery, Postnatal and Newborn Care, 2B: Increase access to quality, integrated RH services.	Birth spacing integrated into postpartum care in - 100 townships in 2015 -100 new townships in 2016 -100 new townships in 2017 Services expanded to all townships in 2018 PPIUD introduced in - 20 townships in 2015 - 20 new townships in 2016 - 20 new townships in 2017 - 40 new townships in 2018 - 40 new townships in 2019 - 40 new townships in 2020	DoH, State/ region, township health authorities and NGOs	State/ region, township health authorities, NGOs and 3MDG Fund	2015 2016 2017 2018 2019 2020

Activities	Inputs	Indicator	Lead agency	Stakeholders	Timeline
QS.4.5. Integrate contraception into post-abortion care.	Guideline development included in QS.1. Training (in-service and refresher) and supervision included in SPRH 2014-2018, Table 4: Miscarriage and post-abortion care, Pregnancy, Delivery, Postnatal and Newborn Care, 4B: Increase access to quality, integrated RH services.	Contraception integrated into post-abortion care in - 66 townships in 2015 - 66 new townships in 2016 - 66 new townships in 2017 - 66 new townships in 2018 All townships by 2020	DoH, State/ region, township health authorities and INGOs	State/ region, township health authorities and NGOs	2015 2016 2017 2018 2019 2020
QS.4.6. Integrate birth spacing into immunization and child health services and other services.	Guideline development included in QS.1.	Birth spacing integrated into immunization and child health services – both clinic-based and outreach	EPI, UNICEF, State/ regional, township authorities and NGOs	RH Programme, State/ region, township health authorities and NGOs	2015 2016 2017 2018 2019 2020

Activities	Inputs	Indicator	Lead agency	Stakeholders	Timeline
QS.5. Conduct geographic and social mapping and outreach activities for hard-to-reach and marginalized population sub-groups. (*Link to Strategy 2 - Generate demand and sustain behavior change*)	Geographic and social mapping included in MOH and township staffing budget. Mobile clinics (per 100 townships) • 20 teams conducting outreach • 80 staff members/service providers (4 per team) • 20 vehicles • 20 equipment bags (replaced every 3 years) • 20 tents (replaced every 3 years) • 20 collapsible tables (replaced every 3 years) • Fuel for 20 vehicles, 200 days per year	Geographic and social mapping in -100 townships in 2015 -100 townships in 2016 -100 townships in 2017 Outreach activities (mobile clinics) conducted in -100 townships in 2015 -100 additional townships in 2016 -100 additional townships in 2017 Outreach activities conducted through 2020	Township authorities and NGOs	Township health authorities and NGOs	2015 2016 2017 2018 2019 2020

Activities	Inputs	Indicator	Lead agency	Stakeholders	Timeline
QS.6. Youth friendly services provide contraceptive methods	Included in SPRH 2014-2018, Table 6: Adolescent and Youth Health • Reorganize health facilities to be youth friendly, multimedia and sports equipment • Outreach activities for out of school youth • Training for health care providers • Training for youth Per year: • 2015: 35 • 2016: 45 • 2017: 55 • 2018: 65 • 2019: 75 • 2020: 85	Condoms and oral pills offered at youth-friendly services in townships	CHEB, Township authorities	RH Programme, Township health authorities and NGOs	2015 2016 2017 2018 2019 2020
QS.7. BS services provided for Key Affected Populations (KAP) at drop-in centres and through outreach activities	Included in SPRH 2014-2018, Table 5: RTI/STI/HIV • 66 trainings for BHS per year • 566 RTI/STI/HIV related BCC activities per year • 66 Peer educator trainings per year	BS information and services at drop-in-centres and through outreach activities for KAP	NAP, UNAIDS, RH Programme, NGOs	Township health authorities and NGOs	2015 2016 2017 2018 2019 2020
QS.8. Task shifting to AMWs to provide oral contraceptive pills and condoms. To consider provision of injection depo provera in hard-to-reach areas	6 stakeholder meetings (2 per year) • 1 full day each • At hotel in Nay Pyi Taw • 20 people • Travel reimbursement for 10 people- flight, perdiem, hotel- 2 days per meeting • Small meeting printing, communications and refreshments	Operational policy in place. BS included in training programmes for AMWs	DoH, RH Programme, Township Health Department	DoH, Township Health Department	2015 2016 2017

Activities	Inputs	Indicator	Lead agency	Stakeholders	Timeline
QS.9. Conduct supervisory visits (*Link to Strategy 3*)	Included under HW.3.1.	1 supervisory visit conducted by respective supervisor each month	Township Health Department	DoH, Township Health Department	2015 2016 2017 2018 2019 2020
QS.10. Quality assurance mechanisms established	Local consultant to lead development of quality assurance tools • Consultant- daily rate for 60 days 2 stakeholder meetings • 1 full day each • At hotel in Nay Pyi Taw • 20 people • Travel reimbursement for 10 people- flight, perdiem, hotel- 2 days per meeting • Small meeting printing, communications and refreshments Printing of quality assurance tools for supervision • 20,000 copies of quality assurance tool (40 pages A4, B&W)	Quality assurance tools developed	RH Programme, INGOs	NGOs, Township Health Department	2015
QS.11. Conduct social marketing for BS methods (Link to Activity 4 -Strategy 2 - Generate demand and sustain behavior change)	Included in DBC.4.1	Social marketing programmes expanded to 331 townships	INGOs	INGOs, Township Health Department	2015 2016 2017 2018 2019 2020
QS.12. Include BS as a component of RH package in emergency situations (Minimal Initial Service Package)	Contraceptive costs included in QS.2.1. Costs of disseminating directive to order RH packages for emergency situations with the BS options is included in core MOH operating communication costs.	BS included as a component of RH package in emergency situations	DoH, RH Programme, UNFPA	DoH, Myanmar Red Cross Society, Township Health Department	2015 2016 2017 2018 2019 2020

Activities	Inputs	Indicator	Lead agency	Stakeholders	Timeline
Strategy 5: Improve availability of a reliable supply of contraceptives					
CS.1. Organize meetings of Lead FP Working Group to discuss status of on-going programmes, identify bottlenecks and stock situation nation-wide	Hold quarterly meetings of the Lead FP Working Group • 1 half- day each • At hotel in Nay Pyi Taw • 8 people • Travel reimbursement for 5 people- flight, perdiem, hotel- 2 days per meeting • Small meeting printing, communications and refreshments	At least one meeting conducted each quarter	RH programme, DoH	CMSD, UNFPA, USAID	2015 2016 2017 2018 2019 2020
CS.2. Streamline forecasting, procurement and distribution	Roll out pilot program for streamlining forecasting, procurement and distribution to all townships • Assign one international consultant for assessment, meetings with DOH, States/ Regions. • 4-5 day field visits to MOH and four (at least two) States/Regions. • Three-day training workshop on forecasting, procurement and distribution in Nay Pyi Taw. • Conduct brief based line assessment on existing procedure of forecasting, procurement at both MOH/CMSD and UNFPA sides. • Central review meeting (1-2 –Day) in Nay Pyi Taw followed by technical training for MOH (and UNFPA) staff • Development of guideline for clear understanding on R&R, reporting system, method to be used, and supervision for forecasting and quantification. Mapping UNFPA townships for distribution plan.	Integrated procurement plan and commodity distribution plan in place and being implemented. Reduced leg – time and days out of stock for selected RH items. Reduced stock imbalance for RH commodities at different levels (mainly tsp and facilities) Improved availability of RH commodities.	RH programme, DoH , CMSD, MOH	CMSD, UNFPA	2015 2016 2017 2018 2019 2020

Activities	Inputs	Indicator	Lead agency	Stakeholders	Timeline
CS.3. Procure BS commodities	Commodities included in QS.2.1. and QS.2.2. Management and technical support for procurement in public and private sector • Hire one new MoH staff at managerial level	Different types of BS commodities procured	DoH, CMSD, UNFPA	DoH, CMSD, UNFPA, Township Health Departments, INGOs	2015 2016 2017 2018 2019 2020
CS.4. Conduct training for township level staff for forecasting, procurement, distribution, reporting and maintaining LMIS	Conduct training workshops for townships for forecasting, procurement, distribution, reporting and maintaining LMIS	Training workshops conducted for - 12 townships in 2015 - 158 townships in 2016 - 172 townships in 2017	RH programme, DoH	CMSD, UNFPA	2015 2016 2017
CS.5. Conduct supervision and monitoring visits (to assess functionality of Reproductive Health Commodity Logistic Supply system, integrated procurement planning and spot checks on RH commodity availability and utilization data)	Conduct supervision and monitoring visits • One international consultant assigned for development of M&E tools, training curriculum development and training for Quality Improvement for RHC LS system. • Biannual Quality Improvement Team meeting @ Nay Pyi Taw. • Two national level trainings on RHC LS quality improvement in Nay Pyi Taw (2016 and 2017) • Organize RHC LS quality improvement team composed of RMH, State/Region, UNFPA and JSI representatives) • Develop M&E tools for RHC LS system upon existing MOH supervision guideline and procedures. • Provide training on Quality Improvement for senior health staffs (central, States/Regions and townships) • Develop (annual) M&E plan at different level.	Supervision and monitoring visits conducted for - 12 townships in 2015 - 45 townships in 2016 - 89 townships in 2017 Increased reporting rates at township and State/ Region levels. Reduced lag – time and days out of stock for selected RH items. Reduced technical errors in filling LMIS forms. Improved availability of RH commodities at different levels.	RH programme, DoH	CMSD, UNFPA	2015 2016 2017

Activities	Inputs	Indicator	Lead agency	Stakeholders	Timeline

CS.6. Develop an automated system to capture facility-level RH commodities	Develop an automated system to capture facility-level RH commodities, phased into national HMIS post-2017
	• Two-day automation workshop for those whom assigned to take care of data at township level.
	• Set up computer with automation system in townships.
	  • 11 computer sets for 11 townships (in 2015)
	  • 34 computer sets for 34 townships (in 2016)
	  • 44 computer sets for 44 townships (in 2017)
	  • Installation and monthly cost for internet use
	• One or two international trainers from Logistimo to come and provide training
	• Automation workshop two sessions in Nay Pyi Taw (2016, 2017)
		System in place from township, state/region through to central levels.	RH programme, DoH	CMSD, UNFPA	2015

CS.7. Conduct annual Facility Assessment for RH Commodities and Services	Conduct annual facility assessment study for RH commodities and services	Annual Facility Assessments conducted	Dept of Medical Research	DoH, UNFPA	2015 2016 2017 2018 2019 2020
CS.8. Institutionalize good procurement practices in Universities of Pharmacy	4 stakeholder meetings • 1 full day each • At hotel in Nay Pyi Taw • 20 people • Travel reimbursement for 10 people- flight, perdiem, hotel- 2 days per meeting • Small meeting printing, communications and refreshments	RHCS incorporated into the current curricula of the Universities of Pharmacy	Dept of Medical Sciences, UNFPA	UNFPA, Universities of Pharmacy	2015

Activities	Inputs	Indicator	Lead agency	Stakeholders	Timeline
Strategy 6: Incorporate indicators to monitor commitments to FP2020 in the health information system and enhance the use of data for decision-making					
DDM.1. Establish mechanism for reporting on FP2020 and other global indicators	Included in quarterly meetings in CS.1.	BS indicators to report to FP2020 included in national reporting systems, HMIS	DoH, DHP, NGOs	DoH, DHP, NGOs	2015
DDM.2. Establish guidance and methods for collecting and reporting data - standardized reporting forms	Review included in quarterly meetings in CS.1.	Standardized reporting forms and data collection tools	DoH, DHP, NGOs	DoH, DHP, NGOs	2015
DDM.3. Develop standardized reporting forms on contraceptive use for private sectors	Included in DDM.2.	Standardized reporting forms	DoH, DHP, NGOs, private sector	DoH, DHP, NGOs	2015
DDM.4. Reporting on FP2020 and other global indicators by public and private sectors	Included in MOH and NGO staffing budget.	Data collected and analysed	DoH, DHP, NGOs, private sector	DoH, DHP, NGOs, private sector	2015 2016 2017 2018 2019 2020
DDM.5. Establish budget line and budget allocation for monitoring and supervision	Hold 2 advocacy meetings per year to develop and establish budget lines and budget allocations for monitoring and supervision • 1 full day each • 30 people • Travel reimbursement for 20 people- flight, perdiem, hotel- 2 days per meeting • Small meeting printing, communications and refreshments	Budget line and allocation	DoH, DHP	RH Programme, Township Health Departments	2015 2016 2017
DDM.6. Conduct operational research on implants, Implanon and Sayana Press	Conduct operational research (3 projects: 1 in 2015, 2 in 2016)	Operational research reports	DoH, DHP, NGOs	DoH, DHP, NGOs	2015 2016

Annex 5 :

Characteristics of youth friendly health services

EQUITABLE: All adolescents, not just certain groups, are able to obtain the health services they need.

ACCESSIBLE: Adolescents are able to obtain the health services that are provided

- policies or procedures are in place that ensure that services are free or affordable to adolescents.

- the point of health service delivery has convenient hours of operation.

- adolescents are well-informed about the range of available reproductive health services and how to obtain them.

- Community members understand the benefits that adolescents will gain by obtaining the health services they need, and support their provision.

ACCEPTABLE: Health services are provided in ways that meet the expectations of adolescent clients

- Policies and procedures are in place that guarantee client confidentiality.

- The point of health service delivery ensures privacy.

- Health-care providers are non-judgmental, considerate, and easy to relate to.

- Adolescents are actively involved in designing, assessing and providing health services.

APPROPRIATE: The health services that adolescents need are provided either at the point of health service delivery or through referral linkages.

EFFECTIVE: The right health services are provided in the right way and make a positive contribution to the health of adolescents

(Adapted from Quality Assessment Guidebook: A guide to assessing health services for adolescent clients – WHO <2009>)

Annex 6: List of References

Ministry of Health - Health in Myanmar 2013

Ministry of Health - Five-Year Strategic Plan for Reproductive Health (2004-2008)

Ministry of Health - Five-Year Strategic Plan for Reproductive Health (2009- 2013)

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

Ministry of Health, Department of Health, WHO, UNFPA - National Service Standards and Guidelines on Adolescent and Youth Care 2013

Public Health Statistics, Health Management Information System (HMIS), Government of Myanmar, 2011

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

Department of Health - Programme Review on Reproductive Health – Maternal and Child Health 2013

Department of Health - Reproductive Health Stakeholder Analysis 2013

Ministry of Immigration and Population, UNFPA - Country Report 2007 Fertility and Reproductive Health Survey, 2009

Ministry of Immigration and Population, UNFPA - Country Report 1997 Population Changes and Fertility Survey

Ministry of Immigration and Population, UNFPA - Country Report 2004 Family and Youth Survey, 2006

Ministry of Immigration and Population, UNFPA – ICPD Beyond 2014 Country Review, Myanmar, 2012

Ministry of Immigration and Population – Myanmar Population and Housing Census, Provisional Results, 2014

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

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

Central Statistical Organization, Ministry of National Planning and Economic Development - Statistical Yearbook 2009

Central Statistical Organization, Ministry of National Planning and Economic Development - Statistical Yearbook 2011

Government of Myanmar - Framework for Economic and Social Reforms, November 22, 2012.

Family Planning Division, Ministry of Health and Family Welfare, Government of India – Repositioning IUD in Family Welfare Programme - 2008

United Nations Population Fund – Report on Situation Analysis of Population and Development, Reproductive Health and Gender in Myanmar, 2010

United Nations Population Fund – Global Programme to Enhance Reproductive Health Commodity Security – Ten Good Practices in Essential Supplies for Family Planning and Maternal Health, 2012

United Nations Population Fund – Choices not Chance: UNFPA Family Planning Strategy 2012-2020, 2012

United Nations Population Fund – UNFPA Family Planning Strategy Choices not Chance 2012-2020 – Ten Steps Operational Guide for UNFPA Country Offices

United Nations - Programme of Action of International Conference on Population and Development 1994

United Nations Secretary-General's Global Strategy for Women and Children's Health - 2012

Trends in Maternal Mortality: 1990-2010 WHO, UNICEF, UNFPA, The World Bank Maternal Mortality Estimation Inter-Agency Group, 2011

HIV Estimates and Projections Myanmar – AIDS (Asian) Epidemiological Model (AEM) 2010-2015; Strategic Information and M&E Working Group, March 2012

Elements of success in family planning programming - Population Reports Series J, Number 57 Family Planning Programs - 2008

WHO - Global Reproductive Health Strategy 2004

WHO - Strengthening health systems to improve health outcomes: WHO's Framework for action 2007

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

WHO, UNFPA - National-level monitoring of the achievement of universal access to reproductive health 2008

WHO, USAID, MCHIP - Programme strategies for postpartum family planning (2013)

WHO-USAID – Repositioning Family Planning: Guidelines for advocacy action (2008)

WHO - Task shifting to improve access to contraceptive methods (2013)

WHO – Eliminating systemic barriers to family planning (2012)

WHO – Optimizing the health workforce for effective family planning (2012)

WHO - Quality Assessment Guidebook: A guide to assessing health services for adolescent clients (2009)

Lule E, Hasan R, Yamashita-Allen K. Global trends in fertility, contraceptive use and unintended pregnancies. In: Lule E, Singh S, Chowdhury SA, eds. Fertility Regulation Behaviors and Their Costs: Contraception and Unintended Pregnancies in Africa and Eastern Europe & Central Asia. Health, Nutrition & Population Discussion Paper. Washington, DC: World Bank; 2007:8–39. Available at: http:// go.worldbank.org/BZSBNC53A0

Singh S, Darroch JE, Vlassof M, Nadeau J. Adding It Up: The Benefits of Investing in Sexual and Reproductive Health Care. New York: Alan Guttmacher Institute; 2003. Available at: www.guttmacher. org/pubs/addingitup.pdf.

References for Costing

Ministry of Community Development, Mother and Child Health (MCDMCH). 2013. Family Planning Services: Integrated Family Planning Scale-up Plan 2013–2020. Retrieved 2 October 2014 from http://www.healthpolicyproject.com/ns/docs/CIP_Zambia.pdf.

RESPOND Project/EngenderHealth. 2011. Project TR. New Developments in the Calculation and Use of Couple-Years of Protection (CYP) and Their Implications for the Evaluation of Family Planning Programmes. New York.