Southern Shan State Family Planning Conference

Taunggyi, May 19-20, 2015

Conference Report

June 23, 2015

Executive Summary

The results of the discussions during the conference have pointed out the need for quality improvements in family planning and other health services. The situation surrounding the supply and usage of IUD highlighted this issue. In the past, large numbers of IUD supplies have been sent out to townships without proper forecasting of needs for IUD. Combined with insufficient number of staff trained for IUD as well as the lack of active promotion of IUD and demand creation activities, it has led to the overstock of expiring supplies in many townships. In particular, there were three bottlenecks that required urgent attentions in improving current service quality: 1. availability of commodities, 2. availability of skilled human resources, and 3. availability of quality supportive supervisions and monitoring.

1. Availability of Commodities

Though the availability of commodities in general is on the rise, the system of commodity management required strengthening. The discussions made it apparent that capacities for proper forecasting was one of the urgent needs as certain supplies such as oral pills tend to be overstocked while other commodities in demand such as injectables are in shortage. Appropriate tools and training are needed to increase the capacity of townships to properly forecast needed commodities. Currently, three townships in Southern Shan State are piloting the use and training of Logistic Management and Information System (LMIS) with the assistance of UNFPA and JSI. The project and trainings that strengthen the existing logistic system and supply chain management would make a valuable contribution to the state.

The conference also brought out innovative ideas from the townships such as the use of Facebook for supply chain management including sharing information about overstocked commodities and redistributing among them. Ability to redistribute excess commodities among townships would be valuable as certain townships that have never received FP commodities would be able to use overstocked supplies.

2. Availability of Skilled Human Resources

Most midwives and nurses are trained in modern contraceptive methods; however, they need more hands on training on Long-Acting Reversible Contraceptives (LARC). Some townships such as Pindaya are providing FP training to BHS and AMWs to increase the coverage, yet for LARC, it requires state and higher-level inputs as townships are required to follow official policies. During the workshop, Shan State officials requested the health ministry and partner agencies for training on LARC to all townships. The central level and partner agencies expressed their willingness to provide the training as soon as needed resources become available.

3. Availability of Quality Supportive Supervision and Monitoring

The discussions during the conference underlined the fact that the key to improving the quality of FP services is to provide closer support, mentoring, and guidance to BHS and volunteer health workers. Basic health staff are overburdened in townships. The ratios between availability of nurses and midwives and the population they serve continue to be high. Training and deployment of AMWs, especially in hard to reach areas, is an urgent task to be done in order to increase the coverage and quality of services. The good news to this end is that as a result of FP2020 advocacy efforts, the MOH

has recently changed its policy to include family planning in the AMW manual and training, which will result in improved quality of services including timely referrals and more comprehensive counseling of options in local languages familiar to the clients.

Introduction

Work towards increased access to family planning in Myanmar has been gaining a momentum in recent years. The Government of Myanmar has joined FP2020 countries and committed to increase the Contraceptive Prevalence Rate from 41 percent to 50 percent by 2015 to above 60 percent by 2020. Myanmar Ministry of Health (MOH) has recently developed the Reproductive Health (RH) Five-Year Strategic Plan (2014-2018) to be implemented by the Department of Health and its partners. In 2014, the FP2020 Costed Implementation Plan has been drafted towards the goal of achieving FP2020 commitments. In line with these developments, Pathfinder International and Myanmar Partners in Policy and Research (MPPR), with seed funds from the David and Lucile Packard Foundation, and in cooperation with major FP/RH partners in the country and with FP2020, organized the Family Planning (FP) Best Practices Conference in the nation's capital, Naypyitaw, in July 2014. The event triggered further developments including the drafting of FP2020 Strategic Plan by the Ministry.

The availability of funding is also on the rise. By 2020, the Myanmar government pledges to increase the health budget to cover nearly 30 million couples under its universal health coverage plan. The health budget has been growing rapidly as well as national and donor commitments towards improving women and children's health, but further work is needed as the efforts towards decentralization demand effective management of funds and supplies at the local level to ensure smooth flow of commodities and service delivery.

Seizing the momentum resulting from these developments, Pathfinder and MPPR with continuing support from the David and Lucile Packard Foundation, have organized a state level FP conference with the MOH. On May 19-20, 2015, one hundred twenty participants of Southern Shan State Family Planning Conference met to discuss solutions to current roadblocks for family planning, including national and state health officials and frontline health staff from all 21 townships alongside international and local technical assistance partners such as UNFPA, PSI, MS.I and Ob/Gyn specialists. The event was a hybrid of a conference and a workshop. The first half of the first day included updates on national policies and global technical inputs, while the rest of the two days were focused on township level FP service delivery bottleneck analysis, planning, and costing.

The objectives of the conference were the following:

1. Provide policy and technical updates to township level officials and health staff.
2. Develop a deeper understanding of the current status of family planning services in the state by sharing experience of providing and receiving FP/RH related activities.
3. Provide an opportunity for township teams to: share their previous experiences on FP service delivery, collectively engage in the bottleneck analysis of FP service delivery, and to develop action plans that include estimated costs to overcome identified bottlenecks.
4. Lay the foundation for promoting and strengthening the institutional capacity to implement and scale-up best FP/RH practices within the state including the DOH, civil societies, and NGOs.

5. Identify organizations and individuals of potential leaders who could collaborate in future program and work for the scale-up of FP service delivery in the state.
6. Distribute international FP training tools that are already available in Myanmar language.

Township and Participants

All 21 townships within Southern Shan State were invited by the Shan State Department of Health. Each township was represented by a team of Township Medical Officer, FP focal person such as Township Health Nurse, and a midwife. Young volunteer Auxiliary Midwives from selected districts were also invited so that they could contribute their knowledge of youth SRH practices.
Members of organizations active in the FP/RH field including MMCWA, PSI, PATH, Community Partners International (CPI), MSI and UNICEF also attended. The opening ceremony was honored with the presence of high level officials including the Shan State Social Minister.

Conference Activities

The event was a hybrid of a conference and a workshop. The first half of the first day provided updates on national policies and global technical inputs, while the rest of the two days focused on township level FP service delivery bottleneck analysis, planning, and costing.

In his opening speech, the State Social Minister stressed the importance of family planning services, commitments of the state government towards FP2020 and urged more coordination among implementing organizations. The UNFPA Representative highlighted the collaboration between UNFPA and MOH regarding family planning and UNFPA's commitment towards improving family planning status in southern Shan. The State Social Minister, officials from the State DOH, representatives of the organizations and other participants all expressed their commitments by signing on the poster saying "*We will work to ensure full choice and full access to women in Myanmar through the Family Planning 2020 commitment*".

Local and international experts and organizations shared their best practices, updates and lessons learned. Topics included FP2020 commitments, national RH strategies, national FP policies, youth friendly reproductive health programs and long-acting reversible contraceptives. A video and models were also used to demonstrate the use of long-acting reversible contraceptives.

Through panel discussions and Q&A section, the officials and experts provided answers to questions raised from the participants and clarifications on issues. The conference then proceeded to workshop section that involved group works on problem analysis, strategy formulation, proposing activities and a costing exercise.

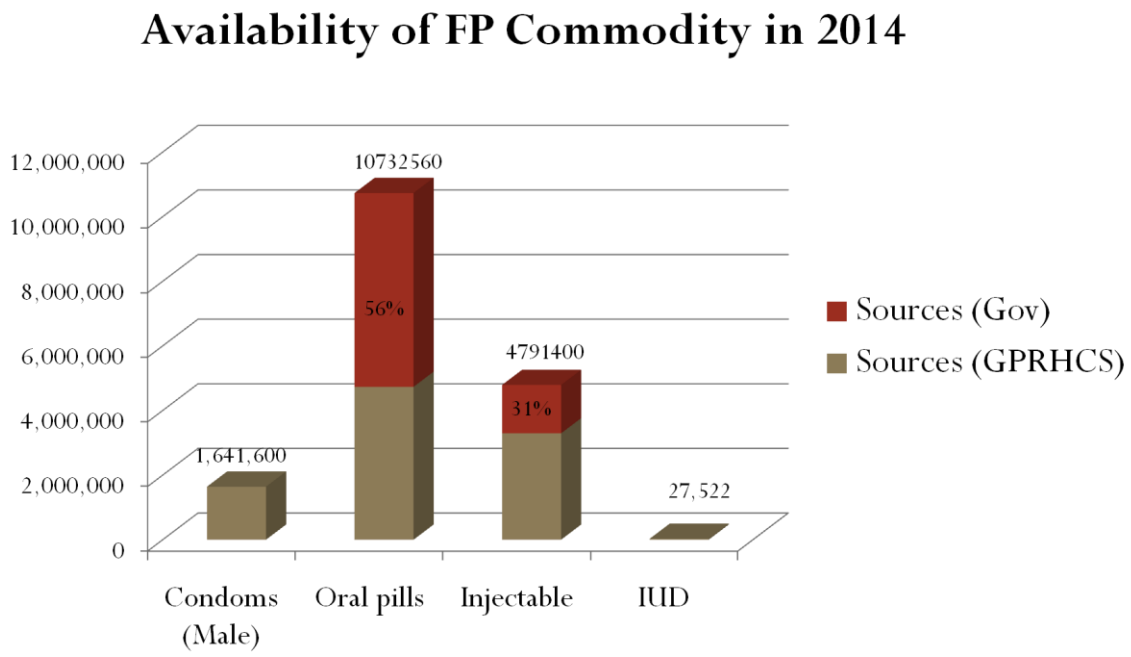
Summary of Presentations

Presentations and discussions during the conference highlighted both the commitments for family planning in the country and the need for improved quality in service delivery.

1. Overview, FP Strategy, Policy, FP Budget Allocations

Dr. Theingi Myint, Director (Maternal and Reproductive Health), Department of Public Health, explained the objectives of the conference, and reiterated the MOH's commitment to need for ensuring the availability of family planning services to all married couples seeking services. She then discussed Myanmar's National Population Policy (Draft 1992), highlighting its goals as follows: (1) Improve the health status of the Women and Children by ensuring the availability and accessibility of birth- spacing services to all married couples voluntarily seeking such services; (2) Provide the Community with information, education and communication measures on birth-spacing in advance as it is important.

Myanmar government's FP2020 commitment made in 2013 was also revisited stressing the increase in Contraceptive Prevalence Rate (CPR), a reduction in unmet need, an increase in demand satisfaction and available mix of methods including Long Acting Reversible Contraceptive (LARC), and decentralization to districts. Dr. Theingi also shared some related statistics, including current availability of different FP commodities from both the Global Programme on Reproductive Health Commodity Security (GPRHCS), and government sources as summarized in the following charts.



The sources of family planning funding for 2014 were explained as 52% from UNFPA, 32% from Ministry of Health, 10% from MSI and 6% from PSI. For the purchase of contraceptives, the levels of central budget in recent years were:

- USD $1.09 million for 2012-2013
- USD $3.27 million for 2013-2014
- USD $1.96 million for 2014-2015

Procurement of contraceptives for 2014-2015 is expected to be smaller than the previous year as the quantity of unused OC pills from year 2013-2014 is significant. The budget is calculated to be sufficient to cover nearly 30 million couples by 2020.

Dr. Theingi further explained that MOH has been working to upgrade the level of management, particularly effective fund flow mechanisms and internal auditing. She also discussed the national level FP strategies and plans which are in line with the Strategic Plan for Reproductive Health (2014-2018). These include: (i) Reinforcing an enabling environment for birth spacing; (ii) Generating demand and sustain behavior change; (iii) Improving the performance of health workforce for birth spacing; (iv) Increasing availability of good quality birth spacing services; (v) Improving the constant availability of contraceptive supplies; and (vi) Incorporating indicators to monitor commitments to FP2020 in the health information system and enhancing the use of data for decision-making. The need for more participation from basic health staff in planning and monitoring in order to achieve the FP2020 targets, as well as the importance of sustaining FP services regardless of funding availability from international donors were stressed.

2. Family planning strategies and budget allocations in Shan State

This presentation by Dr. Khine Maung Yin, District Medical Officer of Taunggyi, briefly discussed Myanmar government's commitment towards FP2020, current situation of some family planning indicators from 10 townships participated in last year's conference, national level resource allocations for FP procurement and the six bottlenecks identified in the last conference – commodity security, human resources, service utilization, long-acting reversible contraceptives, public Vs private, and monitoring. He also reiterated the need for strengthening the logistics management information system (LMIS) as substantial quantities of unused contraceptives from last year were found, and the supply of certain contraceptives (especially implants) was not sufficient enough to satisfy demands for it. Some IEC materials were also found in warehouses without distributed and being damaged by weather. He also shared findings from a *Survey on choice of contraceptive use and child bearing behavior in Shan State* done by MMCWA in 2014. It was a cross-sectional descriptive study with 792 women of reproductive age residing in urban and rural areas of Taunggyi, Lashio and Kentong. The survey revealed that 41.7% of respondents were using 3- month depo injection, 29% using oral contraceptive pills, 8.5% using IUDs and 3.8% using implants. The most preferred methods for future family planning, in order of preference, were 3-month depo injection, OC pills, sterilization, IUD and implants.

3. Introduction to Long Acting Reversible Contraceptives (LARC)

Dr. Candace Lew, Senior Technical Advisor for Contraception, Pathfinder International, introduced LARCs available in Myanmar, their benefits, effectiveness, mechanism of action and sustainability of use. She briefly discussed the differences among Implanon/Implanon NXT® (Nexplanon®), Jadelle® and Sino implant (II)®. The presentation also included slides showing insertion and removal of LARCs. Dr. Lew also stressed the importance of counseling covering balanced information and comprehensive

method choices. She also stressed the importance of counseling for each LARC method. The session also introduced the use of WHO's Eligibility Wheel, task-sharing for family planning services, service integrations and post-partum family planning methods. This was followed by short videos demonstrating procedures for insertion and removal of implants. Dr. Myint Oo, an Ob-Gyn specialist from Taunggyi, assisted the session by narrating the videos to make sure the mixed audience understood the procedures correctly.

4. *Expanding Youth-friendly Services in Shan State*

Ms. Sono Aibe, Senior Advisor for Strategic Initiatives, Pathfinder International, discussed adolescent reproductive health, sharing common barriers to services for adolescents and youth, essential elements of youth-friendly services and demand generation. In her presentation, she also discussed the experience of Pathfinder in Mozambique and Ethiopia, highlighting the importance of community engagement in demand generation and the merits of utilizing information technology. Her examples of the modes of demand generation included peer education, small peer groups for girls or boys (or married girls and boys), comprehensive school-based sexuality education, social marketing, radio/television information, radio/television serial drama and mHealth.

5. *UNFPA Supported Reproductive Health and Family Planning*

Dr. Tin Maung Chit, Program Analyst from UNFPA, talked about UNFPA's support for reproductive health and family planning in Myanmar. Particularly, he explained UNFPA's support through Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) in depth. The program's commodity support includes contraceptives, critical medicines and IEC materials. UNFPA has also been providing support in developing the National RH Strategic Plan (2014-2018), National Action Plan for FP2020 and trainings for health workers including supply chain management training. He highlighted UNFPA's involvement in strengthening family planning services in Shan State, as well as the gaps in family planning commodities and critical RH medicines at national level.

6. *Summary of results from the best practice conference in Naypyitaw*

Dr.Than Min Htut, Township Medical Officer of Pindaya summarized the results of the bottleneck analysis exercise conducted by participating 10 townships in last year's conference in Naypyitaw to share experience. He presented the summary of issues, causes and some potential strategies for addressing them, which were identified during the conference (see the report for Family Planning Best Practice Conference July 2014 for more details).

7. *Family Planning experience in Pindaya Township*

Dr. Than Min Htut also shared his experience of providing FP services in Pindaya township. With an area of 254.89 square miles, the township belongs to the Danu Self-Administrative Area. Total population is 82,649 and there are 138 villages belonging to 27 village tracts. Health facilities include a 50-bedded township hospital, 2 station hospitals, 2 rural health centers and 12 sub-centers. Problems in Pindaya include low service utilization, limited human resources, managing supplies and logistics and poor community participation. These issues are applicable to general healthcare and not limited to family planning services. The TMO also shared his experience in addressing these issues through mobilization of people and resources in the local community. In order to increase service utilization at the hospital, he trained the healthcare team and improved hospital conditions to create a more patient-friendly

hospital environment. Another step was provision of healthcare to the hard-to-access villages through outreach mobile teams led by the TMO. With improved community perception of the healthcare team and growing trust, Dr.Than Min Htut managed to mobilize community members and raise more funds to improve hospital equipment, expand outreach coverage and recruit more health volunteers. In addition, resources were also utilized in other community development areas including improving water supply, building roads, renovating libraries, establishing social support associations, carrying out environmental conservation activities and setting up a senior citizens' home in the town and villages. As a result of these efforts, Pindaya has seen increased AN care coverage and a rise in hospital admissions.

Director of Maternal and Reproductive Health, Dr. Theingi Myint, listens to suggestions from township health staff.

Summary of Bottleneck Analysis, Proposed Strategies, and Action Plans

Based on the bottleneck areas identified in the Best Practices Conference last year, the teams discussed problems they have been facing in family planning services. The township teams participated actively by openly sharing their concerns and real-life experiences. They analyzed the problems, prioritized them, considered possible causes, and formulated strategies to address them. The most relevant problems and proposed strategies were as follows:

1. Commodity Security

Problems	Proposed strategies	Priority action plans
Shortages of commodities in general and stock outs for many months	Encourage States to leverage resources to raise funds for commodities.	
Mismatch between demand and supply. Some items such as injectables have shortage, some such as OC pills are oversupplied, and condoms are underutilized.	Encourage townships to communicate and support redistributions. Shifting to Pull System for requesting commodities. Getting more accurate data for forecasting the demand.	Create a platform in Facebook for township communication for redistributions of surplus commodities. Conduct township level needs assessment and gather information for accurate
No implants in stock while the		

demand is growing. (In some townships, there is demand for Copper T while the supply is for Multi-loop)	Mobilize more resources from donors and government. Increase the proficiency for LMIS.	forecasting. Set up a LMIS system at the township level, and train BHS for the system
Current distribution by quota does not reflect actual needs.	Shift to a Pull system based on demand forecast.	
Transportation of commodities to some townships/villages is difficult and costly. Insufficient budget for transport.	Review current transport system. Coordinate between different townships. Arrange storage of certain quantity of commodities in sub-stores closer to the service delivery.	Request State level and central level to deliver through shorter/better routes (eg. Some townships are more accessible via Kayin State). Create supply depos at the state level closer to townships. Request distributions all the way to township and rural health facilities by the Ministry.
Some commodities are close to expiry as it is difficult to transport them immediately.	Establish timely door-to-door delivery system.	
BHS does not know how to make indents.	Train BHS on making orders and indents.	

2. Human Resources

Problems	Proposed strategies	Priority action plans
Inadequate numbers of AMW and other volunteers, and inadequate training. **Opening of more RHC and sub-centers leads to more shortage of staff.** **Substantial number of vacant positions especially in hard-to-access areas.** **Many of the BHS are on leave or on long trainings.**	Recruit and train more BHS and volunteers. Maintain them by regular meetings, multiplier trainings, refresher trainings and supplies. Advocate for plans to motivate BHS. Appoint staff to substitute BHS who are on long leave. Develop annual work-plans and budgets for BHS capacity building.	Increase the recruitment numbers of midwives and AMWs. Create temporary positions to fill the gap created by midwives on maternal leaves. Provide regular mentoring and supervisions to AMW. Provide OC-pills and condoms to AMWs and VHWs.

High attrition rate of health volunteers (as they seek paid jobs). **Low morale of BHS affecting performance and service quality.**	Provide incentives and morale boosters for longer services.	Create standardized AMWs certificate throughout the nation.
Basic health staff overwhelmed with large coverage area, a large number of programs, record keeping and reporting (one MW has to typically manage 10-15 villages.)	Fill all vacant positions. Train more AMW and volunteers. Retain personnel by providing regular supportive meetings and supplies they need.	Recruit AMWs from local villages and send them back to their own communities.
Language barriers between BHS and clients	Widen the ethnic background of BHS. Assign persons with language skills in appropriate communities.	Recruit local people as BHS.
BHS does not have sufficient skills and experience due to inadequate trainings. **Frequent transfer of skilled BHS to other places.** **Lack of sub-centers in some village tracts.**	Coordinate with higher level departments for more trainings and more recruitment. Provide regular refresher training.	Provide closer mentoring and supportive supervisions to BHS.
Inadequate training particularly for provision of LARC.	Arrange more service provider trainings to BHS. More training on counseling and health-education related to IUD (trainings to PHS).	
Due to security concerns, insufficient fund and difficult terrain, BHS cannot regularly reach areas under their supervision.	Request/mobilize more funds for transportation. Include sufficient funds for transportation in budget.	Develop township costed action plans to leverage partner resources (as public funding is not available).
Unable to efficiently manage time and plan work to handle	Assign focal persons for each projects and tasks.	Assign a township health officer or medical officer as a FP focal

multiple projects and tasks. **Too many tasks to perform.**	Provide basic management training.	person to ensure availability of FP services.

3. Service Utilization

Problems	Proposed strategies	Priority action plans
Intermittent use of contraceptives due to poor knowledge, poverty, busy schedule.	Use volunteers for demand promotion and regular health education contacts. Provide more facilities for service delivery (eg. Delivery rooms).	Use of role model volunteers in villages for health talk among peers
Low utilization due to difficult access (security reason, geographic barriers). **3-month depo or OC pills are still not accessible in some villages.**	Provide services through mobile outreach teams. Integrated service delivery with a package of services. Train AMWs for giving 3 month depo injections and OC pills.	Develop micro-planning before service delivery to integrate services.
Poor knowledge and awareness. **Language barriers.**	Train local volunteers/ AMWs for demand promotion through regular health talk and education. Provide health education in local language.	Produce IEC in local dialects
Traditional beliefs and religious misconceptions in some townships.	Involve more stakeholders and religious leaders in family planning to gain acceptance.	Conduct more advocacy targeting religious leaders. Provide more health education in communities.
Inadequate number of volunteers who can distribute 3-month depo.	Advocate for policy change for allowing MWs to provide 3-month depo.	
Difficult access/reach due to presence of armed forces.	Conduct more advocacy and health education. Recruit local people as BHS/volunteers.	
Low utilization due to low	Provide more training.	

level of service provision skills and knowledge among BHS.		
Low utilization due to inadequate supply for services demanded (e.g. Depo injection, LARC).	To request more commodities according to community demand. To forecast the demand properly.	
Misuse of emergency contraceptive pills.	Provide health education in communities, and instructions for drug stores.	

4. LARC

Problems	Proposed strategies	Priority action plans
Lack of long acting commodities	Accurate forecasting of needs for LARC	Conduct needs assessment for LARC
Demand for IUD is low due to some misconception and low community acceptance, sometimes caused by religious beliefs. **Sometimes sexual partners disprove the use of LARC.**	Educate communities on benefits of IUD. Do more advocacy targeting religious leaders, male partners and stakeholders. Provide trainings to BHS on community education and advocacy.	
Basic health workers have not received proper trainings for providing LARC.	Collaborate with NGO as well as central level for more trainings. Mobilize more resources for trainings.	
The supply of implants does not meet the high demands in some townships. **Lack of skills for implants.**	Request more trainings and commodities.	
Midwives are not authorized to perform insertion of LARCs. (in some townships, people crossed the border into Thailand to get implants for a certain fee.)	Advocate and negotiate for task shifting/sharing and necessary infrastructure.	

5. Public Private Partnership

Problems	Proposed strategies	Priority action plans
Poor collaboration and communication with private sector and community.	Improve coordination with private sector (NGOs, private clinics, drug stores, civil society) especially for ensuring commodity security, trainings and maintenance of volunteers. Involve GPs and pharmacies in increasing and meeting demands for FP Use local language for communication. Request NGOs to share more data and plan with public departments. Work with media and journals for better information sharing.	Set up regular meetings with GPs, pharmacies and community representatives. Create a mechanism for sharing information and communication. Conduct FP advocacy among private health providers.
Private providers lack proper knowledge about contraceptives.	Ensure proper FP knowledge among private providers. Facilitate sharing knowledge and skills among private providers.	Provide training and FP education to GPs and pharmacies. Conduct quarterly meetings with GPs, pharmacies and community representatives.
Lack of support from NGOs as there is no FP/RH projects in the area. **Perceived insecurity due to presence of armed groups in some townships.** **Poor road infrastructure in some places.**	Advocacy for project and support. Peace-building.	

6. Data and Monitoring

Problems	Proposed strategies	Priority action plans
MW have difficulties in ensuring data quality as they	Train and recruit more PHS and AMW.	Update monitoring tools for registry and records to include FP

are overwhelmed with multiple programs, large coverage areas.		information.
Low level of security is a concern for AMW and MW for collecting data in some townships. Inadequate human resource for data collection.	Train and recruit more PHS so that they can substitute AMW. Train more volunteers.	
Basic health staff faces difficulties in understanding and using report forms. Reporting formats not standardized.	Use standardized format at the state/national levels. Provide trainings to BHS who are responsible for filling forms. Assign a focal person for data and LMIS.	
Inadequate facilities/resources for data collection and timely reporting (eg. no facilities for photocopying, no computer, insufficient supplies of paper forms).	Garner support from the higher level authority and NGOs by proposing a workplan. Promote the use of computerized data entry and reporting.	Better forecasting of needed paper forms, and provision of extra forms.
Poor supervision due to hard access in rainy season, high travel costs.	Budget allocation for travel and supervision.	Ensure budget for supervisory visits in micro-planning at township level.
Ineffective supervision/monitoring due to lack of a standard checklist.	Develop a standardized checklist for the purpose of supervision.	Ensure proper provisions of monitoring and supervision at every level of health personnel.
Migratory nature of some villages and households makes data collection extremely difficult. **Some residents not at home at the time of data collection.** **Data collection problems due to language barrier, security and transport conditions.**	Set up strategic meetings to deal with the migration issue. Plan a census-like data collection. Engage local communities.	

Conclusion

In his closing remarks on behalf of the Shan State Health Director, Dr. Khin Maung Yin, District Medical Officer, highlighted the importance of partnerships and the roles of civil society organizations. He then announced that Shan State would recruit and train 8,000 new Auxiliary Midwives and more Public Heath Staff-2 in the southern townships. He also promised that the state health authority would lead the development of one standardized data collection format and guidelines. In addition, he assured that the RH taskforce would keep functioning at the state and district levels, and encouraged the township health teams to further develop their action plans so that the authority can approved them. Dr Hla Hla Aye, Assistant Representative of UNFPA, expressed her appreciation for the engaged discussions by the townships and other participants in the conference, emphasizing the importance of LMIS and the need for all levels of health workers to improve it. Dr. Theingi Myint, the Director of Maternal and Reproductive Health, also expressed her gratitude for the participants' hard work during the conference and workshop, and the MOH's continued commitment to deliver family planning services to people in Myanmar.

Conference Agenda

8:00 am	Registration Opens
Opening Ceremony **8:30 am - 9:00 am**	Chaired by DOPH Welcome remarks (State Social Minister) Welcome remarks (Dr. Theingi Myint) Welcome remarks & UNFPA support to Myanmar's FP Program (UNFPA)
Photo/Coffee Break **9:00 am - 9:30 am**	Group photograph Refreshments and networking Participants put their signatures on the FP2020 commitment banner
Global & National Updates **9:30 am -12:00 noon**	Overview of the conference FP 2020, RH strategy, Youth policy, FP Budget allocations (Dr. Theingi Myint) FP planning strategies & budget allocations in Shan State (State Health Director) Technical updates on Long-Acting and Reversible Contraception (Dr. Candace Lew) Global updates on AYSRH (Ms. Sono Aibe, Pathfinder International) Question and Answer, Discussions
LUNCH **12:00-1:00 pm**	Lunch in MMA Hall
LUNCH Video **12:30-1:00 pm**	Video side show on FP
Workshop Introduction (Plenary) **1:00-2:00 pm**	Objectives and overview of the workshop (State Deputy Health Director) The summary of results from 10 township bottleneck analysis and action plans from the BP conference in NPT (Pindaya TMO) Global examples of FP bottleneck strategies and innovations (Sono & Candace)
Bottleneck Analysis (Township groups) **2:00-3:00 pm**	Icebreaker exercise; participant introductions Outputs: Form 1 • Bottleneck identification and analysis • Problem solving strategies
TEA/COFFEE BREAK **3:00-3:30 pm** **Video or Demonstration**	Refreshments and networking Video and/or demonstration of PPIUD using a uterus model by Dr.. Candace Lew
Bottleneck Analysis Continued (Township groups) **3:00-4:00 pm**	Outputs: Form 1 continued: • Bottleneck identification and analysis • Problem solving strategies 10-minute-presentation preparation
Township Report (Plenary) **4:00 – 5:45pm**	Township groups report back their work and participants provide feedback
Wrap Up and Overview of Wednesday's Agenda **5:45-6:00 pm**	Explanation about the materials in the conference bag Administrative announcements Wrap up of the day Plan for tomorrow
6:00 pm	Dinner at MMA Hall

8:00am	Arrival
Workshop Explanation Recap (Plenary) 8:00-8:00 am	Recap on workshop activities Explanation of form 2 Review on strategies vs. activities/action plans
Action Planning (Township groups) 8:15-10:00 am	Township group work Outputs: Form 2 • Strategies review • Action plans for each strategies
TEA/COFFEE BREAK 10:00-10:15 am	Refreshments and networking
Action Planning Continued (Township groups) 10:15-12:00 am	Township group work continued Outputs: Form 2 • Strategies review • Action plans for each strategies
LUNCH 12:00-1:00 pm	Lunch at MMA Hall
Costing Exercise (Plenary) 1:00 - 1:30pm	Introduction to the costing exercise • Explanation of Form 2- Budget section
Costing Exercise (Township groups) 1:30-3:15 pm	Township group work Outputs: Form 2 • Costing of activities in action plans
TEA/COFFEE BREAK 3:15-3:30pm	Refreshments and networking
Costing Exercise (Township groups) 3:30 – 4:30pm	Township group work continued Outputs: Form 2 • Costing of activities in action plans • Funding source discussions • Q & A, discussions
Feedback Session 4:30 – 5:30pm	Evaluation on the workshop Feedback from 10 groups on the workshop Plans for applying the conference contents in townships
Concluding Session 5:30-6:00 pm	Resources and Tools to Support Implementation: Commitments from the State, and Discussion, Q & A
6:00 pm **7:00 pm**	Dinner at MMA Hall Closing remarks by Pathfinder International Adjourn

The List of Attendants

Sr. No.	*Name*	*Designation*	*Township/Organization*	*Remarks*
1	*Dr. Theingi Myint*	*Director*	*MOH*	
2	*Dr. Myo Myo Mon*	*Assist; Director*	*MOH*	
3	*Dr. Myint Oo*	*ObGyn Specialist*	*Taunggyi*	
4	*Dr. San San Wai*	*Medical Superintendent*	*Taunggyi Hospital*	
5	*Dr. Khin Maung Yin*	*District Medical Officer*	*Taunggyi*	
6	*Dr. Phyo Phyo Mon*	*Township Health Officer*	*Taunggyi*	
7	*Dr. Kyaw Soe Win*	*THO*	*Taunggyi*	
8	*Dr. Zawana Ko*	*THO*	*Taunggyi*	
9	*Dr. Khine Mye*	*THO*	*Taunggyi*	
10	*U Aung Sann Tun*	*Admin Officer*	*DOH, Taunggyi*	
11	*U Win Aung*	*General Administration*	*Taunggyi*	
12	*Dr. Maung Maung Thein*	*Township Medical Officer*	*Hopong*	
13	*Daw Htwe Khin*	*Staff Nurse*	*Hopong*	
14	*Daw Ei Ei Htwe*	*Midwife*	*Hopong*	
15	*Daw Nang Mya Aye Han*	*SN*	*Hsihseng*	
16	*Dr. Than Htut Oo*	*TMO*	*Hsihseng*	
17	*Daw Nang Shwe Ou*	*MW*	*Hsihseng*	
18	*Daw Yee Yee Khine*	*MW*	*Kalaw*	
19	*Daw Yee Yee Nwe*	*SN*	*Kalaw*	
20	*Dr. Khin Moh Moh*	*DMO*	*Kalaw*	
21	*Dr. Khin Maung Yin*	*TMO*	*Kunhing*	
22	*Daw Nang Kham Noom*	*SN*	*Kunhing*	
23	*Nang Seng Khaut*	*Auxiliary Midwife*	*Kunhing*	
24	*Dr. Thant Zin Oo*	*TMO*	*Kyethi*	
25	*Daw Nang Mho Kham*	*SN*	*Kyethi*	
26	*Daw Nang Sein Nyunt*	*MW*	*Kyethi*	
27	*Daw Nang May Lwin Oo*	*Trained Nurse*	*Laihka*	
28	*Daw Nang Whong Kham*	*Lady Health Visitor*	*Laihka*	
29	*Dr. Zin Maung Nwe*	*TMO*	*Laihka*	
30	*Daw Nang Noon Khong*	*TN*	*Langkho*	
31	*Dr. Moh Moh Kyi*	*TMO*	*Langkho*	
32	*Daw Nang Hla Win*	*MW*	*Langkho*	

33	*Daw Nang Hla Kyi*	*AMW*	*Langkho*	
34	*Daw Khet Khet Zaw*	*TN*	*Lawksawk*	
35	*Daw Aye Aye Than*	*LHV*	*Lawksawk*	
36	*Daw Khin Khin Thein*	*TN*	*Lawksawk*	
37	*Daw Naw Bruay Phaw*	*LHV*	*Loilen*	
38	*Dr. Aung Htwe*	*MS*	*Loilen*	
39	*Daw Nang Aye Thazin*	*SN*	*Loilen*	
40	*Daw Nang Ohn Kyi*	*MW*	*Mawkmai*	
41	*Dr. Mya Mya Than*	*TMO*	*Mawkmai*	
42	*Daw Cho Cho Aye*	*SN*	*Mawkmai*	
43	*Dr. San Kyi*	*TMO*	*Mongnai*	
44	*Daw Nang Mya Thein*	*LHV*	*Mongnai*	
45	*Daw Nang Aye Mon Zaw*	*SN*	*Mongnai*	
46	*Dr. La Min*	*TMO*	*Mongpan*	
47	*Daw Nang Hlaing Hlaing Myint*	*SN*	*Mongpan*	
48	*Daw Thida Mon*	*LHV*	*Mongpan*	
49	*Dr. Htoo Tint Wai*	*AS*	*Monghsu*	
50	*Daw Aye Aye Pyone*	*LHV*	*Monghsu*	
51	*Daw Nu Nu Yin*	*SN*	*Monghsu*	
52	*Daw Nang Ohnmar Khin*	*SN*	*Mongkaung*	
53	*Daw Nang Hla Hla Oo*	*LHV*	*Mongkaung*	
54	*Dr. Sai Soe Hein*	*TMO*	*Mongkaung*	
55	*Daw Win Mu Yar*	*LHV*	*Nansang*	
56	*Dr. Thandar Myint*	*AS*	*Nang Khon*	
57	*Daw Nang Khin Saw*	*CSO*	*Nang Khon*	
58	*U Than Aung Htay*	*HA*	*Nansang*	
59	*Daw Khin Hnin Phyu*	*SN*	*Nansang*	
60	*Dr. Myat Moe San*	*TMO*	*Nansang*	
61	*Daw Moe Moe Phyu*	*LHV*	*Nyaung Shwe*	
62	*Daw Yin Moh Moh Win*	*TN*	*Nyaung Shwe*	
63	*Dr. Aung Win*	*TMO*	*Nyaung Shwe*	
64	*Daw Khin Htwe Yee*	*LHV*	*Pekon*	
65	*Daw Nwe Ni Win*	*MW*	*Pekon*	
66	*Dr. Kyaw Kyaw Oo*	*TMO*	*Pekon*	
67	*Daw Lwai Lwai Oo*	*TN*	*Pindaya*	
68	*Naw Sayar*	*SN*	*Pindaya*	
69	*Dr. Than Min Htut*	*TMO*	*Pindaya*	
70	*Daw Cho The*	*MW*	*Pindaya*	
71	*Daw Lei Lei Win*	*AMW*	*Pindaya*	
72	*Daw Baby Anna*	*TN*	*Pinlaung*	
73	*Daw Nang Nwe*	*LHV*	*Pinlaung*	

74	*Dr. Hein Htet Aung*	*AS*	*Pinlaung*	
75	*Dr. Hay Mann Oo*	*Team Leader*	*STBC*	
76	*Daw Cho Cho Aung*	*SN*	*Taunggyi*	
77	*U Myat Thu*	*Development Committee*	*Taunggyi*	
78	*Dr. Moe Tun*	*TMO*	*Taunggyi*	
79	*Daw Ni Ni Tin*	*TN*	*Taunggyi*	
80	*Daw Thuzar*	*SN*	*Taunggyi*	
81	*Daw Khet Htwe Maw*	*LHV*	*Taunggyi*	
82	*Daw Aye Aye Nyunt*	*MW*	*Taunggyi*	
83	*Dr. Than Than Htay*	*THO*	*Taunggyi*	
84	*Dr. Su Su Mar*	*THO*	*Taunggyi*	
85	*Dr. Khin Moe Hlaing*	*TMO*	*Ywangan*	
86	*Daw Aye Aye*	*SN*	*Ywangan*	
87	*Daw Aye Aye Win*	*LHV*	*Ywangan*	
88	*Daw Tin Nilar Min*	*AMW*	*Ywangan*	
89	*Daw Nang Si Si Oo*			
90	*Daw Yin Yin Swe*		*UNFPA*	
91	*Dr. Hla Hla Aye*	*Asst Representative*	*UNFPA*	
92	*Dr. Tin Maung Chit*	*Program Analyst*	*UNFPA*	
93	*Tala Deaton*		*Community Partners International*	*Observer*
94	*Dr. Khun Tun Aung Kyaw*		*PSI*	*Observer*
95	*Dr. Nang Khin Su Yi*		*Relief International*	*Observer*
96	*Dr. Sai Hein Aung*		*Relief International*	*Observer*
97	*Dr. Banyar Aung*		*MSI*	*Observer*
98	*Dr. Nang Mya Nwe Tra Tun*		*UNICEF*	*Observer*
99	*Daw Saw Ohnmar*	*Taunggyi*	*Nurse Association*	
100	*Daw Hnin Wai*	*Nurse Officer*	*Nurse Association*	
101	*Laura Wedeen*		*PATH*	*Observer*
102	*Seema Kapoor*		*PATH*	*Observer*
103	*Dr. Mya Thida*	*Retd. Professor*	*ObGyn Specialist*	
104	*Daw Than Than*	*President*	*Myanmar Maternal and Child Welfare Asso;*	
105	*Daw Nu Nu Yee*	*Member*	*MMCWA*	
106	*Daw Nway Oo*	*Member*	*MMCWA*	
107	*Dr. Aung Kyaw Myint*	*Translator*	*MPPR*	
108	*Rika Morioka*	*Managing Director*	*MPPR*	
109	*Dr. Kyaw Myint Aung*	*Director*	*MPPR*	
110	*Sono Aibe*	*Sr Advisor for Strategic*	*Pathfinder International*	

		Initiatives		
111	*Dr. Candace Lew*	*Sr Technical Advisor for Contraception*	*Pathfinder International*	
112	*Dr Htun Linn Oo*	*Program Manager*	*MPPR*	

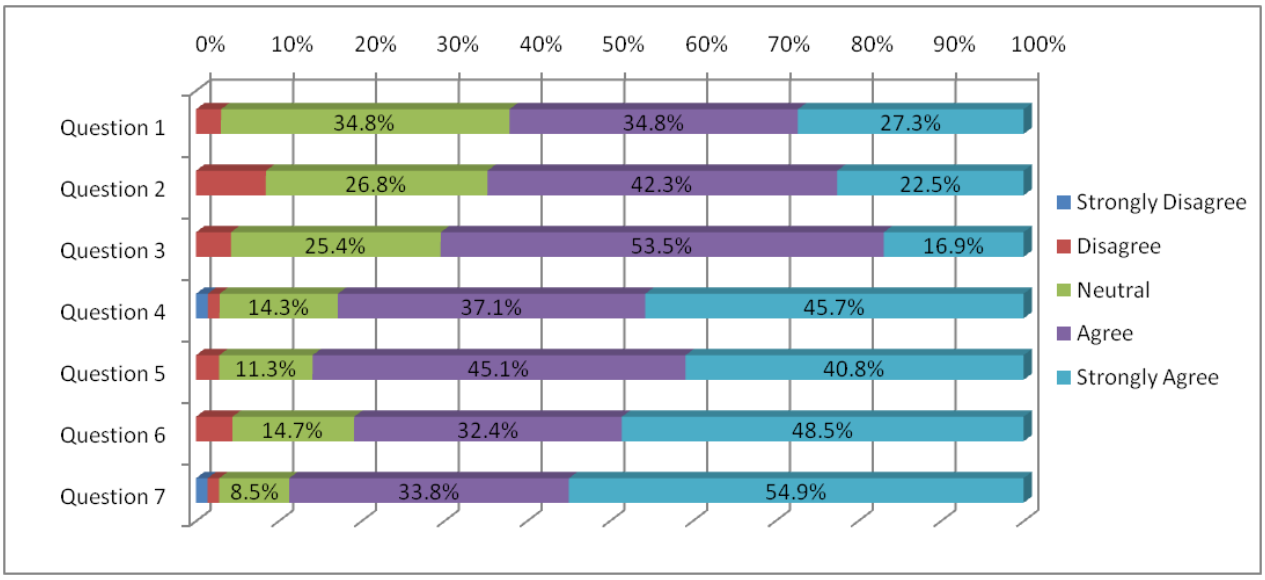
List of Acronyms

AMW– auxiliary midwife
AN care – antenatal care
AYSRH – adolescent and youth sexual and reproductive health
BHS – basic health staff
CPI – Community Partners International
CPR - contraceptive prevalence rate
FP – Family Planning
FP2020 – Family Planning 2020, see http://www.familyplanning2020.org/
GPRHCS - Global Programme on Reproductive Health Commodity Security
IEC – information, education and communication (activities and materials)
IUD – intrauterine devices
LARC – Long Acting Reversible Contraceptive
LMIS – logistics management information system
MMCWA – Myanmar Maternal and Child Welfare Association
MOH – Ministry of Health
MSI – Marie Stopes International
OC pills – oral contraceptive pills
PSI – Population Services International
SRH – sexual and reproductive health
TMO – Township Medical Officer
UNFPA – United Nations Population Fund
UNICEF – United Nations Children's Fund

Summary of Conference Evaluation

The following table and graph summarize anonymous feedback from individual participants regarding the conference and the workshop sessions.

	Strongly Disagree	***Disagree***	***Neutral***	***Agree***	***Strongly Agree***
1. The conference format was well designed and useful.	*0.0%*	*3.0%*	*34.8%*	*34.8%*	*27.3%*
2. The presentations were relevant, easy to understand, added to my knowledge of best practice in family planning	*0.0%*	*8.5%*	*26.8%*	*42.3%*	*22.5%*
3. Workshop sessions were valuable and well facilitated.	*0.0%*	*4.2%*	*25.4%*	*53.5%*	*16.9%*
4. My interest in family planning service has been increased by this conference.	*1.4%*	*1.4%*	*14.3%*	*37.1%*	*45.7%*
5. I feel I can deliver family planning services better than before.	*0.0%*	*2.8%*	*11.3%*	*45.1%*	*40.8%*
6. I am interested in holding a similar conference in my state/region.	*0.0%*	*4.4%*	*14.7%*	*32.4%*	*48.5%*
7. The materials I received from the conference are useful to my work.	*1.4%*	*1.4%*	*8.5%*	*33.8%*	*54.9%*



Many participants reported in comment section that they intended to apply knowledge and skills gained from the conference, and share the knowledge and information with other doctors, basic health staff and volunteers through trainings, refresher trainings, meetings and continuing medical education sessions. Some participants considered including more family planning messages and LARC in community health education sessions at outreach/mobile visits and child vaccination visits. They were also considering the reproduction and use of the IEC materials provided at the conference. Some participants particularly commented on the potential usefulness of flipcharts in service promotion and raising community awareness on family planning. A few also said they would adapt the information and ideas gained from the conference to better suit the local context.

Participants also commented that they learned more about the value of the LMIS system, and aimed to promote the consistent use of LMIS and would try to strengthen the Pull system for better commodity security. A few participants said they would try to improve data management and forecast of demand for commodities.

Participants also mentioned their willingness to promote better FP service utilization and service provision in their communities. They mentioned they were interested to organize a similar conference/workshop involving NGOs, authorities, faith based organizations, social welfare associations, influential people and other individuals who are interested. A few reported that the conference inspired them to work more closely with NGOs, UN agencies and donor agencies.