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Pathfinder International and Myanmar Partners in Policy and Research

Accelerating Progress by Sharing Knowledge: Report of the Family Planning Best Practices Conference in Myanmar

June 30, 2014 to July 2, 2014 Nay Pyi Taw

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Pathfinder International, originally incorporated as The Pathfinder Fund in 1957, is a nonprofit, nongovernmental organization based in Watertown, Massachusetts.

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Myanmar Partners in Policy and Research

Myanmar Partners in Policy and Research is a local organization that specializes in health-related research and policy development in Myanmar. The organization was founded by a group of physicians, public health practitioners, and social scientists who are concerned with the conditions in which children and their families live in the country.

Myanmar Partners in Policy and Research (MPPR) assists international organizations with research, policy advising, and project implementation related to the improvement of health conditions. MPPR also engages in evidence-based research that influences policies for health system strengthening. It seeks to help increase the effectiveness of aid through research, and at the same time, strengthen the capacity of local public health professionals by engaging them in international collaborations.

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We dedicate this report to all of the conference participants, especially those from the ten townships, who travelled long distances to Naypyitaw to share their experiences with others. We look forward to being part of Myanmar's continuing efforts to bring essential sexual and reproductive health services and contraceptive supplies closer to its people, and improving lives of millions.

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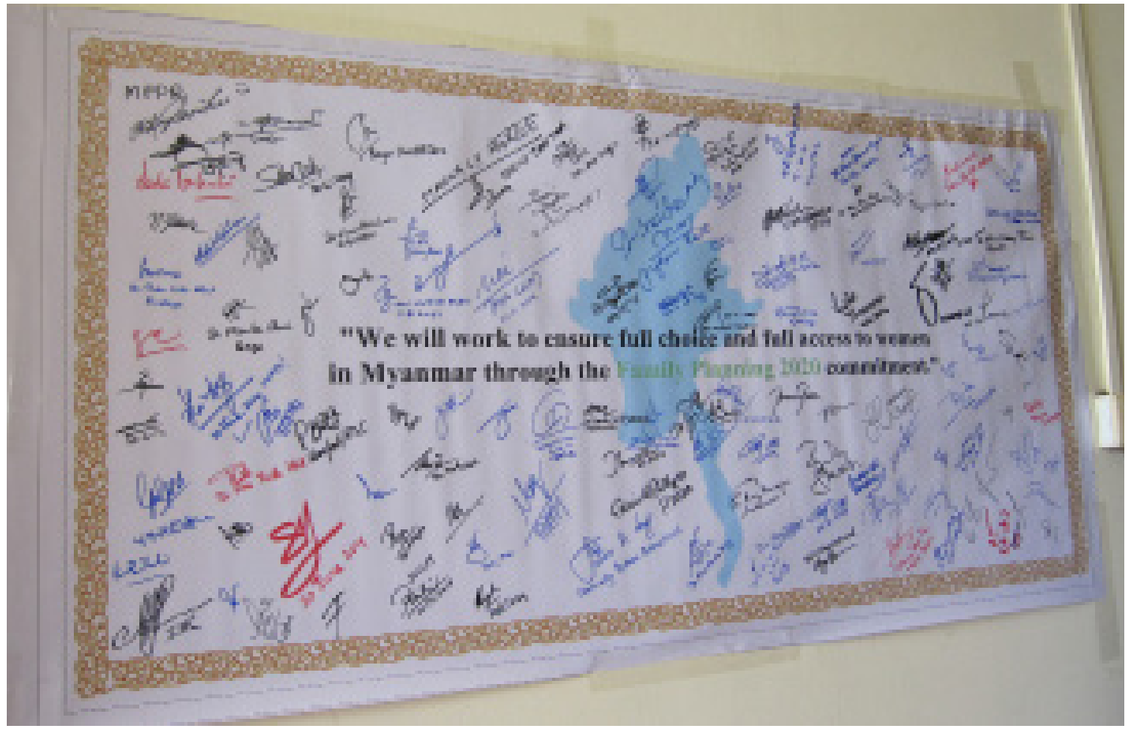

PHOTO: Sono Aibe

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Acronym List

AMW	Auxiliary Midwife
ASHA	Accredited Social Health Activist
ASRH	Adolescent Sexual and Reproductive Health
BCC	Behavior Change Communication
BHS	Basic Health Staff
BKKBN	National Population and Family Planning Board of the Government of Indonesia
CBD	Community Based Distribution
CBD and BC	Community Based Distribution and Behavior Change
CHW	Community Health Worker
CME	Continuing Medical Education
CPR	Contraceptive Prevalence Rate
CSG	Community Support Group
CSO	Civil Society Group
EC/ECP	Emergency Contraception/Emergency Contraceptive Pill
EPI	Expanded Program of Immunization
FDA	Food and Drug Administration
FP	Family Planning
GDP	Gross Domestic Product
GP	General Practitioner
GPRHCS	Global Program on Reproductive Health Commodity Security
HA	Health Assistant
HE	Health Education
HMIS	Health Management Information System
HRP	The UNDP/UNFPA/ UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction
HW	Health Worker
ICPD	International Conference on Population and Development
INGO	International Non-governmental Organization
IRC	International Rescue Committee
IUD	Intrauterine device
LARC/PM	Long-Acting Reversible Contraception/Permanent Method
LAPM	Long-acting and Permanent Method
LHW	Lady Health Worker
LMIS	Logistics Management Information System
MDGs	Millennium Development Goals
MIS	Management Information System
MMCWA	Myanmar Maternal and Child Welfare Association
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
MSH	Management Sciences for Health
MSI	Marie Stopes International
PoA	Program of Action
PSI	Population Services International
NGO	Non-governmental Organization
PMA 2020	Performance Monitoring and Accountability 2020
PP	Post-partum
PPP	Public Private Partnership
QA	Quality Assurance
QI	Quality Improvement
RH	Reproductive Health
RHC	Rural Health Center
RHCLS	Reproductive Health Commodities Logistic System
RHCS	Reproductive Health Commodity Security
SDM	Standard Days Method
SEARO	South-East Asia Regional Office
SH	Station Hospital
SMO	State Medical Officer
SPIRES	Stanford Program for International Reproductive Education and Services
SRH	Sexual and Reproductive Health
SRHC	Sub-Rural Health Center
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TMO	Township Medical Officer
TOT	Training of Trainers
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WRA	Women of Reproductive Age
YDP	Youth Development Program
3MDG Fund	Three Millennium Development Goal Fund

Executive Summary

Background

The Myanmar Family Planning Best Practices Conference was a three-day event from June 30 to July 2, 2014 that convened more than 160 participants from Myanmar and around the world in the capital city of Naypyitaw. The aim of the conference was to share best practices in family planning, engage in dialogue and discussion to identify challenges and solutions, as well as develop township level action plans to enhance the quality of family planning services.

The conference was hosted by the Ministry of Health (MOH) and supported through anchor funding from the David and Lucile Packard Foundation and additional funding from 3MDG Fund, UNFPA and FP2020. Other contributing technical partners included Marie Stopes International (MSI), Population Services International (PSI), World Health Organization (WHO), Gates Institute for Population and Reproductive Health at Johns Hopkins Bloomberg School of Public Health, Stanford Program for International Reproductive Education and Services (SPIRES), and the National Population and Family Planning Board (BKKBN) of the Government of Indonesia.

The first day consisted of discussions and presentations from local and international experts to learn from their experiences. The second and third days involved group break-out sessions with 10 township teams to identify bottlenecks and challenges in provision of FP services. These groups worked in collaboration with state and national health officials to develop action plans to overcome identified obstacles.

Challenges at the Township Level

The conference provided a platform for township health care providers to engage in dialogue with national and international experts in identifying local challenges encountered in the delivery of family planning and reproductive health (FP/RH) services. Some of the main bottlenecks are highlighted below.

Commodity Security

While government financial commitment for FP/RH commodities have increased, FP/RH commodities are only 8–10% of total government health budget. Moreover, there is no storage and distribution budget available. Forecasting of supplies continues to be weak and problematic due to lack of a centralized logistical information management system (LMIS) that is exacerbated by poor communications and integration of information. Forecasts do not include private sector purchases providing an incomplete picture of national supply and demand. A gap between supply and demand remains, with demand greater than availability of supplies. A mix of contraceptive methods is not readily available, especially with limited availability of long-term methods, such as IUDs and implants, at station hospitals.

Human Resource (HR)

Health care staffing is a significant challenge as a result of low provider to patient ratios, particularly in rural and hard-to-reach areas, combined with high staff turn-over. Staff workloads are overwhelming because of many different responsibilities tied to various health issues. Lack of well-trained staff, especially on long-acting methods, and limited opportunities for hands-on or refresher trainings also affect quality of care, client satisfaction and demand for FP methods.

Service Delivery

In hard-to-reach or remote areas where many ethnic minorities reside, service delivery is a challenge due to lack of transportation and language barriers. More demand generation is needed at the community level, but there are language barriers and limited availability of linguistically- and culturally-appropriate educational materials. Religion is also a barrier that deters acceptance of FP. There is a need to pay attention to the needs of youth and adolescent reproductive health since this age group is a significant proportion of the population. There is a dearth of adolescent reproductive health services and information, as well as engagement with youth to develop programs and information that meet their needs.

Use of LARCs

The demand and use of long-acting reversible contraception and permanent methods are low due to limited and inconsistent availability of supplies and lack of providers offering these options. Weak provider skills for IUD/PPIUD insertion and implants, inadequate counseling, coupled with information gaps contribute to low demand and acceptability, along with misconceptions about these methods.

Public private partnerships (PPP)

PPP is improving, but there remain gaps in linkage, collaboration and inclusion of the private sector/non-state providers. Often non-state providers such as pharmacists, drug sellers and general practitioners (GPs) are not included in advocacy meetings and trainings. Referrals are weak between state and non-state sectors. Data collection does not include data from the private sector (where usage and purchase of FP can be high) to inform overall supply and demand issues.

Monitoring

Monitoring and supervision of staff/providers to ensure quality service delivery and improvement, as well as data collection are weak and uncoordinated. There is a need to develop a standardized checklists and tools for monitoring of staff performance and FP supplies to inform forecasting. Logistics Management Information Systems (LMIS) are weak and data collection is inconsistent and not integrated. Insufficient allocation of resources and lack of strong monitoring systems and tools contribute to these particular challenges.

Recommendations

As a conclusion to the conference, participants (township teams in collaboration with state and national level experts) presented recommendations in alignment with the Government's family planning and reproductive health targets.

- Improve data collection for public health that feeds into the LMIS to ensure commodity security. Training of basic health staff as well as private providers, and coordination of sharing of this information from state, non-state (private sector and NGOs) is necessary to enhance data collected to inform supply and demand for FP.
- Ensure equitable access of FP services. Geographical and language barriers in service delivery have been challenging, particularly for ethnic minorities and people in rural, hard-to-reach areas. It is recommended to use the task-sharing or task-shifting approach through training of auxiliary midwives (AMWs) in these areas as an effective solution where little to no presence of trained medical staff is available. This has been proven to be effective in India, Bangladesh and other low-resource settings.
- Strengthen provider skills to offer a full range of methods. Township teams recommended the need for more trainings, especially on counseling, so that providers are able to offer accurate information and have knowledge on the different types of contraceptive methods. There is a need to focus on the development of providers' awareness, knowledge and skills to introduce and provide long-acting and reversible methods. Private providers should also be trained and incorporated into the service delivery system, especially around promoting LARC/PM in order to increase coverage.
- Promote contraceptive security. A commitment to guarantee contraceptive security through increased government budget for contraceptives, human resources, reliable transportation to rural areas, and community mobilization were highlighted. It was strongly recommended to improve township's capacity to forecast and procure supplies to prevent stock-outs and/or surpluses, and to ensure a steady supply and a variety of methods that are available. Coordination and collaboration with the private sector, NGOs and donors is also necessary.
- Enhance adolescent reproductive health. Youth engagement was highlighted in order to better reflect services that meet their needs. More services for youth can mean developing youth-friendly service delivery guidelines for both public and private sector providers; launching a hotline for young people to access information (and in different languages); training additional peer educators at the community level; and making more educational materials locally available in different languages.

Renewed Commitments

The conference renewed the commitment of the Government of Myanmar for family planning. Coupled with its announcement on its partnership with FP2020 in 2013 and a new Five-Year Strategic Plan for Reproductive Health (2014–2018), this conference provided an unprecedented opportunity to focus national attention and resources on improving the health care system's overall delivery of FP services as well as maternal, newborn and child health (MNCH) and related RH services that serve the needs of millions of women, men and young people.

The Government of Myanmar has made a commitment to create a working group focused on FP2020. The group's goal is to ensure coordination among NGOs and government partners in meeting Myanmar's key strategies and outcomes in the new RH strategic plan. This joint effort of local and global experts will continue to work together to strengthen FP service delivery to meet the needs of women, men and youth in Myanmar.

Introduction

I. SETTING THE STAGE FOR THE MYANMAR FAMILY PLANNING BEST PRACTICES CONFERENCE

Country Context

Myanmar's recent transition from a military-led government towards more openness that ushers in democratic reforms and economic liberalization holds many opportunities to improve the quality of life for its people. Progress has been made around some of the country's health indicators, including increased life expectancy, reduced total fertility, total birth and adolescent birth rates, and decreased maternal mortality.

Population Census

In the latest provisional government population census data recently released by Myanmar's Ministry of Immigration and Population, the population of Myanmar is estimated to be at 51.4 million. There are 26.5 million females and 24.8 million males, and a gender male/female ratio of 93.3 percent.[1] The census was conducted in compliance with international standards with technical and funding assistance from international experts, including the United Nations Population Fund (UNFPA). It is the first population census taken in 30 years.

Reproductive Health in Myanmar

Reproductive health indicators have progressed in the past two decades. According to the Maternal Mortality Estimation Inter-Agency Group (MMEIG), from 1990 to 2010, the maternal mortality

[1] UNFPA Press Release: Myanmar releases population count from census, August 30, 2014, http://countryoffice.unfpa.org/myanmar/2014/08/30/10473/unfpa_press_release_myanmar_releases_population_count_from_census

ratio (MMR) decreased from 520 to 200. In 2011, MMR was estimated at 192/100,000 live births. Total fertility rate (TFR) is at 2, and is lower for urban (1.7) compared to rural women (2.2) as reported in the 2007 Fertility and Reproductive Health Survey. The adolescent reproductive birth rate is 16.9 (per 1,000 adolescent females) in 2007.[2] The 2011 Public Health Statistics Report points to gradual progress of antenatal coverage (74%) and deliveries with skilled birth attendants (67%).[3]

Statistics from the government's Five-Year Strategic Plan for Reproductive Health (2014–2018) show steady increases in contraceptive prevalence rates (CPR) for all methods from 2001–2007. However, there is room for improvement, as contraceptive prevalence remains low at 38%.[4]

While the MMR has fallen, maternal mortality continues to be a problem with significant disparities between urban and rural areas. The 2004–2005 Department of Health/UNICEF maternal mortality survey reported that 89% of maternal deaths were in rural areas. Contributing factors to higher rates of maternal mortality in rural areas include lack of access to health services and information due to poverty and low education, poor nutrition, shortages of health workers (particularly midwives) in hard-to-reach areas, high rates of home deliveries without trained medical care and challenging geographic terrain. The top three causes of maternal deaths are post-partum hemorrhage, eclampsia and unsafe abortion. In 2015, the first Demographic and Health Survey will be conducted, after which new data for many of these indices will be updated.[5]

Myanmar's Adolescent and Youth Reproductive Health

Thirty percent of Myanmar's population is under age 15, and youth aged 15–24 comprise 18% of the population. Adolescent birth rate has decreased and remains the one of the lowest compared to its neighboring countries. From 2001 to 2013, adolescent birth rates went from 17.4 per 1,000 adolescent females to 12.[6] The average age at first birth is 22.8 years old. Early marriage rates are low at 7.4%, and this rate is higher in rural compared to urban areas. The 2004 Family and Youth Survey pointed to a significant gap in knowledge among adolescents on health issues, particularly on fertility and contraception.[7]

II. INTERNATIONAL FP MOVEMENT AND COLLECTIVE ACTION

An international FP movement has been gaining traction to mobilize more resources and national commitments to meet unmet FP needs. The evidence is clear that the cost-benefits of FP provide positive multiplier effects in reducing poverty, increasing education and economic participation, and improving maternal and child health. From the inaugural 2009 Kampala International Family Planning Conference to the 2012 London Summit on Family Planning, which raised billions of dollars for FP, to the upcoming 2015 International FP Conference in Jakarta, there is larger movement-building to increase access to FP for women and men worldwide. One of the follow-up initiatives of the 2012 London Family Planning Summit was the formation of FP2020 to help developing countries actualize their family planning and reproductive health goals through the coordination and facilitation of technical assistance and resource mobilization.

The Government of Myanmar has joined many countries with a pledge to FP2020 in 2013. Following the FP2020 agenda, the Government of Myanmar is committed to increasing CPR to 60%. Pathfinder International has been working closely with the Ministry of Health (MOH) since 2013 and shares the common goal of increasing access and decreasing unmet need in family planning. The collaboration led to the convening of this conference "Myanmar Family Planning Best Practices Conference" held from June 30 to July 2, 2014.

III. OBJECTIVES OF THE CONFERENCE

Pathfinder International and MPPR, in collaboration with MOH and local partners, developed an agenda to meet the RH/FP needs for Myanmar, and to bring together ideas and experiences highlighting global best practices for FP to adapt within Myanmar's local context. The conference objectives included:

1. Through state-of-the-art technical presentations by global and national experts, introduce evidence-based, high-impact best practices for FP/RH.
2. Provide an opportunity for state health officials and township teams to share their previous experiences on planning and budgeting to implement FP/RH activities in order to identify bottlenecks and challenges they are currently facing, and problem-solve recommendations.
3. Work with ten townships on a pilot basis to create action plans that reflect proposed priority best practices in policies, plans and resource allocation for implementation.
4. Lay the foundation for promoting and strengthening the institutional capacity to implement and scale-up best FP/RH practices within the MOH, other quasi-governmental institutions, and local NGOs, as well as private sector active in the area.
5. Identify a critical mass of technical experts and vehicles such as Implementing Best Practices (IBP) who would lead the application and scale-up of best practices in Myanmar, and who could provide ongoing technical support on various topics related to family planning.
6. Distribute international FP training tools that are already available in Myanmar language.

[2] Statistical Year Book, Central Statistics 2011

[3] Public Health Statistics Report, 2011

[4] 2007 Fertility and Reproductive Health Survey included in the Five-Year Strategic Plan for Reproductive Health (2014–2018)

[5] Five-Year Strategic Plan for Reproductive Health (2014–2018), Government of Myanmar, Ministry of Health, Department of Health

[6] Sources: PRB Datafinder 2013/2014 and Myanmar MOH Five-Year RH Strategic Plan (2014–2018)

[7] "Five-Year Strategic Plan for Reproductive Health (2014–2018), Department of Health, Ministry of Health, Myanmar, March 17, 2014 version)

ALL PHOTOS: U Thaw Zin

Day 1 | June 30, 2014

Opening Ceremony and Setting the Stage

Myanmar FP2020 Objectives:

- Increase CPR from 41% to 50% by 2015 and over 60% by 2020
- Reduce unmet need from 12% to less than 10% by 2015
- Increase demand satisfaction from 67% to 80% by 2015
- Improve method mix, including increased use of long-acting and permanent methods (LAPM), and through decentralization to the districts

Government Revitalized Health Commitments

In his opening speech at the conference, the Minister of Health Dr. Pe Thet Khin emphasized the Government's renewed commitment to health. Since 2012, the budget for health has increased four-fold. The Government of Myanmar's Health Vision 2030 is committed to ensuring universal health coverage for the entire nation.[8] Last year in 2013, the Government announced its commitment to Family Planning 2020 at the International Conference of Family Planning in Addis Ababa, Ethiopia. He emphasized that "the country is making swift progress towards the goals with a rights-based approach that targets poor, vulnerable and remote populations" and that "this conference is part of our efforts to acknowledge the importance of family planning in improving the health of the nation."

Sono Aibe, Senior Advisor for Strategic Initiatives from Pathfinder International, reminded the audience that Myanmar had also signed onto the UN Secretary-General's Every Woman Every Child campaign and pledged to increase contraceptive prevalence to 50% and to reduce unmet need for contraception to under 10%; as well as to improve the ratio of midwife to population from 1/5000 to 1/4000. She pledged Pathfinder International's continuing support to bring this type of workshop to states and regions, which are ready to engage in state-wide program improvements for meeting the unmet need for contraception.

Dr. Yin Thandar Lwin of the Department of Health followed with a presentation on Myanmar's Birth Spacing Program. She pointed that the Ministry of Health's budget line for contraceptives increased from $1.2 million USD in 2012–13 to $3.2 million USD in 2013–14. By increasing the national health budget overall, nearly 30 million eligible couples will be served with FP cumulatively by 2020, and service delivery will be strengthened. This health vision supports the development of the country's health system to adapt to changing political, economic, social, environmental situations, as well as technological changes.

Myanmar's Birth Spacing program has been supported by UNFPA and INGOs since its establishment in 1991. According to Dr. Yin, UNFPA covers 163 townships out of the total 220. Unmet need for FP is 17.7[9] However, long-term methods are not easily available. Dr. Yin pointed to funding gaps for commodities at an estimated $6.9 million (total commodity costs approximately $18 million), a shortage of supplies and providers for long-term methods, weak coordination between key government partners and other stakeholders, limited access to services, and the need to strengthen the health care system, especially in the public sector.

Dr. Theingi Myint from Department of Health presented on the Five-Year Strategic Plan for Reproductive Health (2014–2018). The goal of this strategic plan is to improve the quality of life for the people of Myanmar by "contributing to improved reproductive health status of women, men, adolescents and youth." The provision of an essential package of reproductive health interventions and strategies will focus on a continuum of care from pregnancy, delivery, postnatal and newborn care to family planning/birth spacing to post-abortion care. Interventions also address sexually transmitted infections/reproductive tract infections (STIs/RTIs) and cervical cancer, adolescent and youth reproductive health, and infertility.[10] The Government's strong commitment towards strengthening the national health care delivery system and a revitalization of family planning and reproductive health services shows a positive step in improving the lives of its people and sets the stage for long-term economic growth.

FP2020: Partnership in Action (Valerie Defillipo, Director FP2020)

Valerie DeFillipo, Director of FP2020, stated that FP2020 builds from the outcome of the 2012 London Summit on Family Planning where 20 governments made commitments to address policy, financing, delivery and socio-cultural barriers for women to access contraceptives, information and services. To realize the goals of the additional $2.6 billion pledged in FP funding at the Summit, FP2020 works as a technical resource and accountability hub for commitment-making countries and organizations. FP2020 will partner closely with governments to understand their needs, priorities and gaps in resources; mobilize global and local financial and technical resources; support country coordination efforts; and monitor and review progress. FP2020 has also established a rapid response mechanism to provide fast and flexible resources where needed.

[8] "Five-Year Strategic Plan for Reproductive Health (2014-2018)," Department of Health, Ministry of Health, March 17, 2014 version.

[9] 2007 Fertility Reproductive Health Survey

[10] "Five-Year Strategic Plan for Reproductive Health (2014-2018)," Department of Health, Ministry of Health, March 17, 2014 version.

Commitment to FP2020 so far includes 75 partners (donor and partners countries, foundations, multilaterals, private sector, CSOs and existing partnerships). One significant achievement is that "40% of the 69 focus countries made commitments, representing 80% of the total WRA (women of reproductive age)." This includes Myanmar's Ambassador Ko Ko Latt announcing the government's pledge to FP2020 at the 2013 International FP Conference in Ethiopia. This occurred simultaneously as the Deputy Minister of Health Dr. Thein Thein Htay announced the commitment in Naypyitaw, Myanmar. The Government of Myanmar's pledge towards FP2020 to realize its reproductive health and family planning goals is a positive step in setting the stage for country to improve the health of its citizens and strengthen its economic development.

Audience Discussion

Following the opening remarks from the Dr. Pe Thet Khin and presentations of the Government's Five-Year RH Strategic Plan (2014–2018) and FP2020, Dr. Mya Thida moderated the audience discussion. Audience members raised some key questions and concerns followed by responses from the presenters.

- In response to a question about innovations in the new RH plan, Dr. Theingi Myint pointed out one of the new initiative included in the Five-Year Strategic Plan is treatment for cervical cancer, given the high rates and problems faced by women. It has only started in a few townships at this time.
- Emergency obstetric care training has been provided at all township hospitals, and every township hospital can perform all nine signal functions of emergency obstetric and newborn care. Midwives have also received training.
- Data collection on abortion cases has been inconsistent. There are concerns with data collected that are to be included in the health management information system (HMIS), since guidance has not been provided. However, the MOH encourages that this data be collected under a separate public health data column when a case occurs at a hospital. Another concern is the under-reporting of abortions because not every case will take place in a hospital or within the hospital's catchment area.

Family Planning in the Context of Global Health and Development

I. Why Family Planning is a Cost-Effective Intervention for Health and Development

(Dr. Jose Rimon II, Gates Institute for Population and Reproductive Health, Johns Hopkins University)

Linkage to Millennium Development Goal S (MDGs)

Dr. Jose Rimon II of the Gates Institute for Population and Reproductive Health presented on the linkage and cost-effectiveness of family planning in contributing to achieve the MDGs. The role of family planning (FP) is critical in achieving the Millennium Development Goals (MDGs) because it is directly tied to reproductive health and population rates. An estimated 222 million women of reproductive age worldwide have an unmet need for family planning.[11] Fulfilling this unmet need in developing countries "would prevent 54 million unintended pregnancies, 26 million abortions, 79,000 maternal deaths and 1.1 million newborn deaths. The unmet need for family planning is anticipated to grow by 40% over the next 15 years."[12]

Additionally, investing in FP is cost-effective, saving public sector spending for other investments and yielding return on investment. According to a USAID/Futures Group International report, "Each dollar spent on FP can save governments up to 6 dollars on health, housing, water, and other public services....Every US$1 invested in FP yields $2–$6 in Sub-Saharan Africa, and up to $13 in South Asia, relieving pressure on social services and scarce national resources."

MDG 1—Eradicate extreme poverty and hunger.

The use of FP contributes to lower fertility rates that lead to lower population growth, which positively impacts economic growth, female labor force participation, and income distribution. Population programs can contribute to halving the number of people living on less than $1 day by 2015 by providing the poor with quality voluntary FP services.

MDG 2—Achieve universal primary school education

Access to FP would allow girls to delay early pregnancy, stay in school and complete their education. Girls staying in school and receiving more education can contribute to them being more likely to attain gender equity and have greater economic opportunities to reduce poverty addressing both MDGs 1 and 3.

MDG 3—Promote gender equality and empower women.

FP provides women and girls with the means to make decisions on childbearing and to control their reproductive health and plan their families. This is key to creating gender equality and is central to the autonomy of women.

MDGs 4 (Reduce infant mortality) and 5 (Improve maternal health).

The evidence is clear linking FP's contribution in achieving MDGs 4 and 5. Access to FP contributes to better maternal, infant, and child health. If unmet need for FP were met, this could result in a 67.5% decline in unintended pregnancies, 64% decline in unsafe abortion, 27% decline in maternal deaths, and 19% reduction in infant deaths.

[11] Singh S and Darroch JE, "Adding It Up: Costs and Benefits of Contraceptive Services," Guttmacher Institute and UNFPA, 2012.

[12] Partnership for Maternal, Newborn and Child Health (PMNCH), Knowledge Summary #20 Access to Family Planning, http://www.who.int/pmnch/knowledge/publications/summaries/ks20/en/

MDG 7—Ensure environmental sustainability.

Increased population place pressures on the existing environment and limited natural resources. Access to a variety of family planning methods offers families with choices to plan their families and space their births that can contribute to stable population growth, therefore, minimizing environmental pressure.

OPPORTUNITIES PRESENTED BY THE DEMOGRAPHIC DIVIDEND

The global population is experiencing a "youth bulge" as 15–29 years old account for more than 40% of all adults. Countries can capitalize on the youth bulge that feeds into a country's demographic dividend. With more young people at working age, this has the potential to contribute to economic growth and stability if education and employment opportunities are available. The "East Asian miracle" is an example of countries reaping the benefits of a youth bulge in creating a robust labor force that contributed to a stronger tax base and economic growth.

Myanmar's young population under age 15 accounts for a quarter of its population. There are opportunities to capitalize on this demographic dividend potential if government ***invests in adolescent sexual and reproductive health (ASRH),*** with an emphasis on providing information and services, combined with ***access to education and economic opportunities.*** The provision of reproductive health services for young people can help to prevent unintended pregnancies and minimize unsafe abortions.

Audience Discussion

Dr. Theingi Myint moderated this panel with audience members.

- FP is an important human rights issue and that access to FP should be universal to enable couples to plan their families and space their births.
- FP should be incorporated into different sectors. It is critical to look at a multi-sector approach to increasing access to FP.
- Dr. Rimon cautioned that the benefits of the demographic dividend are not automatic. The ***right policies have to be in place,*** and it is the consequences of thoughtful policymaking ***investing in human capital*** (health, education, economic opportunities), ***including women and girls,*** that can unleash the potential of the demographic dividend. Women need to be absorbed in the workforce so a country could multiply its workforce, which is good for the economy.
- An older population does not mean that there will be dependency problems. This age group can contribute to building the economy through encouraging personal savings and a higher tax base, revenues can be used by the government to pay for other services. However, governments do need to think about the addressing long-term, chronic health.

II. Ensuring Continuity of Contraceptive Methods: Reproductive Health Commodity Security

(Ms. Janet Jackson, United Nations Population Fund/UNFPA)

Consistent and reliable provision of contraceptives is key to ensuring that demand for FP is met. The mantra, "no product, no program," is a reminder of the need to focus on reproductive health commodity security (RHCS). Janet Jackson presented on UNFPA's Global Program on Reproductive Health Commodity Security (GPRHCS) established to ensure reproductive health commodity security. This consists of a mixture of pooled funding from multiple donors that can provide flexible, multi-year funding sources to catalyze national action to minimize stock-outs and mainstream reproductive health commodity security.

Phase II of GPRHCS just began with a re-focus on 46 countries, including Myanmar. The program has seen improved contraceptive prevalence rate (CPR), reduced stock-outs, increased availability of contraceptive methods and national funding. The second phase will concentrate on scaling-up best practices to address demand for RHCS and FP by using a catalytic funding mechanism that is flexible in addressing gaps in the context of national efforts. The program promotes alignment of all pro-RHSC/FP efforts.

Effective Practices

Ms. Jackson stressed that efforts should be ***country-driven*** to promote national ownership and leadership, and at the same time, requires broad, ***multi-sectoral partnerships.*** It should focus on ***building national capacity and systems,*** and move towards unitary supply systems that enhance ***alignment, harmonization and mutual accountability. Rights-based and gender equity*** approaches are principles that should be reflected in the programming. A focus on results, efficiency, impact and evidence-building is important to document lessons learned, best practices, and success. In order to achieve sustainability and increase government-controlled funding, it is critical to ***mainstream RHCS into national health policies,*** programs, supply systems, plans and budgets.

Key implementation strategies and mechanisms include various components to ensure commodity security:

- Capacity development
- Total market approach
- Reporting and monitoring
- Integration and institutionalization of processes and systems
- Resource mobilization

UNFPA's RHCS is linked to Myanmar's FP2020 commitments and MOH's Five-Year RH Strategic Plan (2014–2018) by providing women and couples with choices, reducing unmet need for FP, strengthening RHCS systems and providing capacity building, which started in 2013. Roll-out of the program will be in 12 townships in four states and regions, with more expansion in 2014 and beyond.

III. Indonesia's FP2020 Commitment: Revitalization of the Family Planning Program in the Decentralization Era

(Dr. Julianto Witjaksono, Deputy Chairman, National Family Planning and Population Board, Government of Indonesia)

Dr. Julianto Wijaksono from the Government of Indonesia presented the country's experiences in keeping the FP momentum in the context of rapid decentralization. Indonesia has the fourth largest population in the world with 248.6 million people and is the world's largest archipelago country. An overview of the country's success in reducing total fertility rate (TFR) and increasing contraceptive prevalence rate (CPR) provides key lessons learned in strengthening the national FP program and implementation of its strategy to address population growth and high TFR.

BEFORE DECENTRALIZATION: 1970 TO EARLY 2000

From 1970 to 2003, Indonesia reduced its TFR from 5.6 to 2.3 by increasing CPR from 10 to 60. This resulted in a population growth rate that was reduced from 2.13 to 1.45 in the span of three decades. Indonesia's census in 2010 showed that the successful impact of FP evened out the country's population structure. Life expectancy at birth also increased from 46 years to 70 years. Additionally, investment in FP in the late 1960s yielded a return on investment to national GDP per capita, from $57 USD in 1967 to $3557 USD by 2011.

Indonesia's FP early success story before decentralization is due to the government's commitment to invest in FP starting in the 1970s and spanning over three decades. During this period, a centralized government authorized the National Population and Family Planning Board of the Government of Indonesia (BKKBN) to partner with the private sector and community organizations to ensure access to FP. Combined with other external factors at the time, this lead to an increased utilization of FP as well as improved health status. In 2001, the Decentralization Law went into effect that provided provinces and the state departments of health with more control over health care service and delivery. By 2007 however, successful FP utilization rates were declining. While decentralization allowed provinces to have more decision-making over their health care, overall, there was confusion about the role of the BKKBN and this contributed to an evening out in CPR starting in 2007.

Effective Practices

There were many factors that contributed to Indonesia's FP success story in increasing CPR and reducing TFR and unmet need. The ***establishment and investment*** in a ***central agency*** (BKKBN) with direct access to and strong support from the President demonstrates ***political will and commitment. Funding was provided for contraceptives*** with the establishment of a ***national distribution system*** to provide contraceptive commodity and supporting supplies. A government mandate to ***coordinate all government agencies with private groups*** was critical to enhance the service delivery points. The ability to ***organize vertical programs*** with lines of control and structures for implementation of actions, combined with a ***close working relationship with the Ministry of Health*** was also important. A growing structure of ***field operations*** was established with ***highly qualified professional staff*** at the centers. International donors provided strategic financial and technical support.

DECENTRALIZATION: 2007 TO 2012/PRESENT

Starting in 2007, decentralization of the health care system saw less priority and support for FP. While CPR for modern methods as at 57.9, the method mix was skewed towards temporary, short-acting methods primarily injectables (31.9%) and pills (13.6%) that are accessed more at private vendors. Long-term or permanent methods such as IUDs, implants, sterilizations combined make up only 11%, and are mainly accessed at government hospitals, centers, or other public facilities. Demand for FP is high; however, more women who want to stop childbearing are continuing to use less effective FP methods. This creates a challenge in the distribution system as access to more choice and effective method mix is skewed.

A new national FP program revitalization plan has been underway to raise awareness and mobilize involvement with better coordination between the BKKBN with other line ministries and subnational governments in the provinces, districts and cities. There is the need to work with private sector providers to understand how to leverage or scale-up implants or other long-term methods at these service delivery points.

New Challenges

The effects of decentralization has changed the functions of the government organizations involved in RH/FP leading to differences in alignment of national health priorities that are often not the district's priorities. This is especially challenging for newer or poorer districts that did not have strong programs before decentralization. There are an increasing number of women needing RH/FP from 64 million to 68 million by 2015 along with unmet need for FP as women enter reproductive age. Additionally, CPR is stagnant and declining among under-educated women, and is a challenge that the government needs to address in terms of the supply and demand issue. Current monitoring systems do not adequately measure the FP/RH needs of adolescent women that can lead to growing unmet need. Quality of care in the private sector also needs to be monitored.

Recommendations

The government needs to address these challenges by building core analytical and technical competencies for FP at all levels of government and both the public and private spheres. This includes developing capacities of provincial FP/RH offices; initiating leadership capacities for FP/RH in districts and municipalities; and strengthening

the role and functions of the new district level office, boards of FP and women's development. It also means promoting the availability and accessibility of long-acting contraceptive methods, reaching disadvantaged women, engaging with the private sector, and developing and promoting national communications strategies focusing on unmet needs and unreached groups.

New Effective Practices

At the 2012 London Summit on FP, Indonesia made significant commitments to expand access to FP by ***providing free FP services nationwide through the Universal Health Care Program*** in 2014; ***strengthening public and private clinic services*** and the ***provision of preferable long-acting methods; investing in South-South exchanges*** to share experiences and best practices; and ***maintain high government investment in FP.***

In generating demand for long-acting and permanent methods (LAPM), the government has put in place a ***communications campaign*** that uses mass media (TV), outreach through community groups, consumer hotlines (phone and texts), tailored FP counseling materials, and dialogue with religious and social leaders to support FP. On the supply side, the government is ***scaling-up government trainings to improve quality of care;*** supporting peer-to-peer coaching for midwives and doctors; strengthening static clinics and increasing mobile services' quality; and holding multi-stakeholder coordination meetings. On the organization and management side, the policy response has been the ***development of a Population—Family Planning Strategic Planning document;*** advocacy for the establishment of district offices; capacity-building on advocacy and management; advocacy for a policy in favor of LAPMs in FP services; and monitoring and evaluation.

Audience Discussion

Some key points were discussed about the challenges and current state of contraceptive security in Myanmar.

- Participants stressed that universal access to FP is important. Provision of FP should occur at all levels from townships to villages through different sources such as hospitals, private sector, NGOs, and other places. FP should be provided to midwives and training provided in midwifery school. Provision of free FP services, information and methods will enable universal coverage.
- There continues to be a shortage of contraceptives in Myanmar, and once supplies are used up, they are not replenished. People in villages do not have consistent access. Dr. Theingi Myint responded that there are limited resources in the country to address this issue but the situation is improving.
- Myanmar's health care system is decentralizing. This means that contraceptive supplies will not be centrally supplied, but will be decentralized to regions and states within the country. The strategy includes task-shifting to train and enable midwives and auxiliary midwives to offer FP services. Advocacy and use of information, education and communications strategies need to be used at all levels to increase awareness, acceptability and utilization.

Discussions also centered on the lessons learned from the Indonesian Government's experiences.

- Indonesia has a total of 77,000 clinics, and the majority is run by the private sector. There are 66,000 clinics operated by the private sector, and 17,000 clinics operated by the government. The majority of midwives work in the private sector.
- In order to address quality care in the private sector, the Government of Indonesia provides contraceptive technology updates to professional organizations in collaboration with national training centers. At all levels of care, including tertiary, district and primary, primary care providers are the decision-makers. They are connected to each other and conduct quality control visits regularly. In villages, professional midwives provide care. Trainings are provided every five years and professional organizations provide these trainings to ensure qualifications are met.
- Contraceptive methods preference change as more method mix is provided, particularly towards long-term reversible methods. The trends in Indonesia and Myanmar are similar. In Myanmar, people are gradually shifting from injectables to LARC. In Indonesia, the discontinuation rates for pills and injectables are high, but not for long-term methods. Now the Indonesian strategy is to shift focus to IUDs and implants.
- In Indonesia, relationship building with community, religious, and political leaders are key to getting support for FP to raise public awareness and acceptability. Of course not all leaders will want to be an ally and the initial rolling out of FP programs in religious communities can be challenging. If there is opportunity for a study tour, Indonesia can host Myanmar in learning more about how FP programs can work in Muslim and Hindu communities.

Introduction of Best/Effective Practices, Part 1

The Myanmar Family Planning Best Practices Conference convened international and national experts to highlight effective, high-impact practices in family planning. Below are the summaries of their presentations followed by audience discussions.

I. Latest Global Trends in FP Service Delivery and Guidelines

(Dr. Mario Festin, WHO/HRP Geneva)

In Dr. Mario Festin's (WHO/HRP) presentation, he stated that having access to a choice of method mix, especially both short- or long-term (reversible or permanent) contraceptive methods, is critical in meeting individual and couple's needs to prevent unintended pregnancy, space births and plan their families. In least developed countries, the use of long-acting reversible contraceptives or permanent methods (LARCs/PMs) is less than 20% of the method mix.

> ***The most urgent priority is to expand contraceptive use and method choice to prevent unintended pregnancy.***
>
> — DR. MARIO PHILIP FESTIN
> WHO/HRP

Tools and resources are updated for family planning guidelines, including mobile phone apps, global handbooks, decision-making tools, selected practice recommendations and other resources to help both providers and consumers make more informed decisions. Training modules and curriculum for lay health workers, auxiliary midwives and mid-level providers are available. There are resources in different languages as well.

Dr. Festin reminded the conference participants that in order to improve maternal health, it is important to continue advancing a comprehensive sexual and reproductive health (SRH) agenda enshrined in the ICPD Programme of Action. This includes monitoring and addressing inequities and unmet need, using the available updated and new tools and guidelines, and ensuring quality of care and enhancing accountability.

II. Health System Approach to Integration of Family Planning and Maternal, Newborn, and Child Health (MNCH) Services

(Dr. Arvind Mathur, WHO-SEARO (South-East Asia Regional Office))

Introduction

Two key strategies in Myanmar's new RH Strategic Plan (2014–2018) identify the need to strengthen health systems to enhance a package of essential RH interventions and to increase access to quality, integrated RH services at all levels. This includes looking at entry points or points of opportunities within the continuum of care from pregnancy to birth to post-partum services in integrating FP with MNCH care.

Dr. Arvind Mathur spoke about the complexity of maximizing prevention of unwanted pregnancies and providing quality MNCH services simultaneously because of the various situations that put people at risk for pregnancies and the different approaches that can be combined. When identifying linkages to create synergies,[13] they must respond to meet individual needs and situation, as well as be "acceptable, feasible and cost-effective."

A continuum of care spans across life, from beginning (before conception to childhood through pregnancy, childbirth, and infancy) to the home, health care center to hospital facility. Dr. Mathur spoke about the challenges within health systems to provide a continuum of care from nonfunctional equipment to insufficient health workers to lack of appropriate skills mix to negative perceptions from consumers. In addressing these challenges, there is the need to develop a common agenda, develop efficiencies, and identify better outcomes to get results. ***A strengthened health care system needs to have strong leadership, health financing, human resources, information systems, medical product technologies and service delivery.***

Opportunities

There are many opportunities during the provision of MNCH services that can serve as entry points for the provision of post-partum FP (PP FP). This includes the first six weeks during the post-partum period, and can extend to 12 months, where women should be provided with PP FP counseling. Additionally, during neonatal and child health check-ups in weeks 6, 10, 14 and during child's feeding trainings and 9-month measles immunization, women who bring their children for these check-ups can also access PP FP.

Dr. Mathur pointed to key principles for linking services. Services being linked should be effective individually, need a common "field of operation" and audiences, and enhance each other so that impact is both increased. For example, this can mean "offering women a broad set of family planning and maternal child health services during the same appointment, at the same service delivery site, and from the same provider." This one-stop shop model of accessing FP and MCH will enable women to use their time efficiently and productively.

Examples of integration from India, Bangladesh and Uganda were provided.

- In India, the ***National Rural Health Mission,*** using community health volunteers to create demand for MNCH and FP, provides programmatic integration at all different levels from community mobilization to service delivery at facility level. This has resulted in continued progress in the demand and utilization of services with increasing coverage of maternal, newborn, child and adolescent health, as well as FP services.
- The ***MaMoni Project*** in Bangladesh is an integrated safe motherhood, newborn care, and FP. During post-partum (post-natal) sessions, women are provided with information family planning and transition. Service delivery for this package is often at the household/community and facility levels. The results are increased CPR (of modern methods from 2007 to 2010) and LAPM use within a year's timeframe.
- The ***MSH STRIDES Project*** in Uganda addresses building the foundation of a quality continuum of care, including leadership, health workforce, service delivery, financing, medical commodities, and information. The results showed increased rates of new users of FP. Within nine months at health care facilities, over 4,000 women were reached, 78% used ANC, 73% of women delivered here, and 40% of women enrolled for FP, nutrition counseling.

[13] Dr. Mathur clarified the following definitions. "Integration has meant offering comprehensive services that meets several needs simultaneously. Linkages have emerged to reflect programmatic realities of alternative ways of combining services. Synergies imply that outcomes of integrated/linked services are greater than the outcomes of individual services."

Tools and Guidelines

WHO offers a variety tools and guidelines such as the "Package of Interventions for Family Planning, Safe Abortion care, Maternal, Newborn and Child Health," "A Guide to Family Planning," "Essential Interventions, Commodities and Guidelines," and "Optimizing health care worker roles to improve access to key maternal and newborn health interventions through task shifting."

Operationalizing Integration in Myanmar

In Myanmar, the foundation for a RH strategy with an essential package of interventions has already been identified, as well as the implementation research for an integrated model that includes task-shifting. There is a need for the development of a capacity-building strategy and plan that offers training for different cadres of health providers. It is important to have community-based activities to generate demand as well as manage the supply side (facility and human resource strengthening).

Dr. Mathur concluded by saying that what is also needed is to explore and institute mechanisms for involvement and collaboration with NGOs and private sector providers; ensure supplies and prevent stock-outs; conduct closer monitoring, reviewing, supervising and documenting; and think about scaling up delivery of integrated service delivery early on.

Key Messages

- Health system strengthening is key to delivery of integrated MNCH and FP services.
- An essential package of integrated RMNCH interventions should be delivered at township level through competent health workers and community-based workers/ volunteers.
- Optimize every contact opportunity with mothers.
- With increasing institutional deliveries, post partum period offers a unique opportunity for integration.
- Health care providers equipped with adequate skill mix are required for provision of integrated package.
- Delivery of integrated services is a cost-effective strategy, and is women-friendly.

III. Promoting Quality Service Delivery and Care for Long-Acting Reversible Contraceptives (LARCs)

(Dr. Paul Blumenthal, Stanford Program for International Reproductive Education and Services/SPIRES, Stanford University)

Dr. Paul Blumenthal presented on the need to integrate and reinforce quality service delivery for LARCs in order to address clients' and providers' concerns and ensure satisfaction. He pointed to opportunities within the maternal health spectrum of care, particularly during the post-partum period, where FP can be provided through counseling to inform choice and provision of quality LARCs services that meet the post-partum FP needs of women.

Quality Assurance and Quality Improvement Implementation

Quality assurance (QA) and quality improvement (QI) implementation needs to be built from the "ground up" and requires external support during the building process. This eventually will need both an "inside-out" approach. The "standards" model includes training, service delivery and evaluation that feed into and reinforce each component. The three pillars of quality assurance involve developing 1) quality assurance standards and guidelines, 2) country-level QA training and supervision plans, and 3) independent QA audits.

Effective Practices and Recommendations

In order for clinicians to adopt quality care service provision, a ***regionalization strategy*** needs to be in place. Building and ***strengthening local capacity*** for local supervision, enhancing ***local and regional expertise*** in QA/QI programs and philosophies, providing ***incentives*** to implement audit recommendations, and cultivating capacities for ***locally-generated responses*** to adverse events are critical. Quality assurance activities can be undertaken in a ***nonthreatening, constructive manner.***

The integration of QA/QI in service provision requires a combination of ***audits/evaluations*** within and between states/regions in addition to ***routine supportive supervision.*** It is important to think about creating a "sustainable" network and QA/QI programs through ***standardization and institutionalization*** of both internal audits and routine supportive supervision. Sustainability of programs depends on internal and ***local commitment to fund QA/QI activities.***

Post-Partum (PP) Contraception

In many developing countries, the rate of institutional deliveries is low, and provision of post-partum contraception is especially challenging due to breastfeeding/nursing, lack of access to health care facilities and travel constraints. One possible solution to address these barriers is a ***"one-stop shopping"*** approach with the benefits of improving spacing of births and reducing unplanned pregnancies.

Post-partum contraception methods include IUDs, implants or injectables. The advantage of providing contraception after delivery can cut down on an additional trip to the provider, the cervix is opened, minimal time involved for insertion, less noticeable side effects, and there are fewer accessories needed than for interval insertion.

Dr. Blumenthal concluded by saying that PPIUDs have been tested and evaluated in India, and they are important additional services that are inexpensive in low-resource settings. They are socially acceptable and feasible, and can be done by a variety of provider types.

Audience Discussion

Some key challenges were discussed, mainly around the need for training for midwives and other health care workers on IUDs. There was mention midwives' reluctance in implementation of IUD service provisions, even when they have been trained. Expulsion rates of IUDs were also a concern.

- Training on PP-FP will be provided for both doctors and midwives. Using a task-shifting approach to include training health care cadres providing deliveries is important to enhancing access and quality of care for PP-FP.
- Anecdotal observations show that midwives have been reluctant to insert IUDs even though they have been trained due to the risks of complications. Midwives are providing mainly injectables such as Depo Provera.
- In hard-to-reach areas, has there been consideration for using community health workers (CHWs) to provide IUD insertions. Population Services International introduced this a few years ago in the public sector for MOH to consider.
- A new WHO publication just came out on post-partum strategies for FP.
- Expulsions of IUDs are a concern, however, it is a small percentage and the overall benefits are still greater. Re-insertion can be done at low-cost. Unknown expulsions of IUDs are the greater concern, but with this new method, the string is longer, so women would know.

Introduction of Best Practices, Part 2

I. Community Based Distribution for FP and Behavior Change Approaches"

(Dr. Candace Lew, Pathfinder International)

Background

Dr. Candace Lew of Pathfinder International presented on CBD and BC experiences for FP. Behavior change is a critical component of CBD. The goal of CBD is to affect behavior change at the individual, family and community levels that lead to better health. CBD and BC conducted together provide an effective FP service delivery model that can be used in low-resource settings to reach particularly under-served communities. CBD uses a task-shifting approach that transfers skills to lower-level providers.

CBD and BC is as an effective FP delivery model that can be used in low-resource settings to reach particularly under-served communities. CBD uses a task-shifting approach that transfers skills to lower-level providers. Healthcare can be provided by community health workers (CHWs) and supported by clinic-based programs on areas such as education, preventive care, selected services and referrals. CHWs are provided with supplies, supervision and mentorship where they can go door-to-door to conduct home visits and community meetings.

The CBD model has a long history, including the barefoot doctors in China. Current examples include using CHWs for counseling, referrals, giving out information and supplies of condoms and pills. In Bangladesh, CHWs provides injectable contraceptive, while in Ethiopia, CHWs provide sub-dermal contraceptive implants such as Jadelle© and Implanon.© Pathfinder produces many reference materials such as a "Community-Based Family Planning Toolkit" that could be adapted and shared.

Effective Practices

One of the best practices for building CBD to increase FP delivery is to ***share the skills and knowledge with lower level providers*** by providing ***comprehensive training for contraceptive method provision.*** Behavior change strategies used to influence FP demand and usage include increasing awareness of FP and available methods, clarifying myths and misconceptions, and minimizing and addressing social, cultural and religious barriers to FP. ***Interpersonal communications*** among CHWs and clients, within community groups, and through peer education; mass media messaging using radio, TV, printed materials, or community theater; ***and community mobilization of gatekeepers*** are effective BC methods to influence FP knowledge, attitudes, and utilization.

Pathfinder International's Prachar project in Bihar, India demonstrates a successful intervention of ***intensive messaging by audience segmentation*** in achieving behaviors that lead to healthy timing and spacing of pregnancies, delay of first marriage, girls staying in school longer and other improved RH behaviors.

It is essential to address training quality and turn-over of staff, ensure a stable commodity supply chain, and provide continuous supervision and refresher training to make CBD and BC a success. This approach also requires ***broad support at the political, professional, community and religious levels.*** Long-term sustainability is critical to consider the longevity of impact.

Within the Myanmar context, Dr. Lew concluded with some ***key recommendations*** to consider when establishing and implementing the CBD and BC model including:

- Engage with all relevant stakeholders in the development of a CBD and BC plan
- Conduct an assessment of current guidelines and status of human resources and capacities at the community level
- Advocate at all levels for filling gaps in health personnel
- Consider a phased approach by first identifying pilot townships in developing both CBD and BC frameworks
- Monitor and evaluate to identify the most appropriate and best practices for the Myanmar context

II. Adolescent & Youth Reproductive Health

(Dr. Ne Win, Assistant Representative, UNFPA)

Dr. Ne Win of UNFPA presented on the need to focus on the provision of ASRH as many developing countries' population age structure experience a "youth bulge." Addressing ASRH needs is part of Myanmar's MOH 2014–2018 RH Strategic Plan to provide adolescent and youth RH as part of the essential package of RH interventions. In addition, engagement with and participation of youth in identifying their ASRH needs is critical to develop youth-friendly services. This, too, is aligned with the key strategy to engage with the community in promotion of RH and service delivery.

GLOBAL CONTEXT

Worldwide, people aged 10–24 make up one-quarter of the world's population at 1.8 billion.

Adolescent sexual and reproductive health needs to address behaviors that lead to unprotected premarital sex, unintended pregnancy, unsafe abortion, and limited access to contraception. Within many of these contexts, adolescent pregnancy happens in early marriage, during incidences of sexual coercion or through limited access to contraceptives, as well as use of appropriate contraceptives.

Pregnancy and childbirth are the leading cause of death among girls ages 15–19 in low- and middle-income countries, and 15 million girls in this age range give birth every year. Adolescent girls account for an estimated 3.2 million unsafe abortions annually in developing countries.

In Southeast Asia, young married women ages 20–24 reported a higher rate of modern contraception compared to married girls age 15–19. Myanmar has the third best CPR, with close to 55% of married women ages 20–24 using modern methods compared to 48% of married girls ages 15–19. Adolescent fertility rate in Myanmar is the third lowest in the region at 17%.[14]

UNFPA YOUTH DEVELOPMENT PROGRAM

UNFPA has developed a five strategy pronged approach, together with INGOs, WHO, UNICEF, to tackle these issues. This includes enabling evidence-based advocacy for comprehensive policy and program development; promoting comprehensive sex education; building capacity for SRH service delivery; supporting bold initiatives to reach marginalized and disadvantaged youth, especially girls; and promoting youth leadership and participation.

Many youth encounter questions, concerns and challenges when accessing contraception from lack of comprehensive sex education to limited user-friendly services and access to contraceptives to untrained drug sellers.

[14] DHS and MICS reports

Effective Practices

UNFPA's ***Youth Development Program (YDP)*** model goes beyond the traditional approach by providing ***training, health discussions, peer education, youth events, and using traditional and social media*** to engage with youth. In addition, ***hotlines*** are ***key for providing information and referrals*** to health facilities, pharmacies and drug stores. Hotlines are highlighted as a best practice because it is an ***accessible and user-friendly*** approach and allows for ***youth participation*** and with each other. Hotlines are anonymous, provide ***updated information*** that is current, and can respond and tackle issues quickly. It also provides a ***safe space*** that is ***confidential and anonymous*** that enables youth to ***speak freely*** and is ***less embarrassing*** for them to access.

Implementation Challenges

There are challenges in implementing hotlines due to the lack of hotlines established, no 24-hour service, high costs associated with raising awareness and calling is not affordable for many. There is lack of user-friendly services, and informed choice is not addressed. Non-state service providers such as drug store owners and pharmacists lack training to dispense over the phone. Significant investments are still needed in social science and operations research, specifically around ASRH, and health management information systems need to be modified to collect and analyze data by age group and identify other critical determinants of adolescents' contraception needs.

In conclusion, Dr. Ne Win said it is important to ***provide accurate information,*** offer a ***variety of health services,*** and support ***counseling*** on premarital sex, contraception, teen pregnancy, abortion, STIs and sexual abuse/violence.

III. Laputta Township

(Dr. Saw Lwin, Medical Superindent, Laputta Hospital)

Dr. Saw Lwin spoke about the township's reproductive health care situation and services. Laputta township is characterized by difficult geography and accessibility to villages, including six hard-to-reach villages. It is also vulnerable to disasters. There is a significant migrant population and high illiteracy.

Reproductive Health

In 2013, there were 74,059 females of reproductive age (15–49 years old), of which 39,228 women were current contraceptive users. The contraceptive prevalence rate was 68% and the abortion rate was 2%. The majority of women used Depo Provera injections followed by oral contraceptive pills. As of June 2014, injectables were available but condoms were out.

Health Service Delivery and Health Care Practices

Government healthcare facilities include one 200-bed hospital, one township 25-bed hospital and three station 16-bed hospitals. There is one maternal child health center, 15 reproductive health centers and 70 sub-reproductive health centers. Population Service International's (PSI) Sun runs 16 private clinics. At these service delivery points, different types of contraceptive methods are provided. There is one TB control team and one village-based disease control team. Two other NGOs, Merlin and Marie Stopes International, provide community health, MNCH, RH and mobile outreach clinics. At the village level, there are many para-professionals that provide education and services, with over 700 community health workers (CHW) and 500 auxiliary midwives (AMW).

In terms of reproductive health capacity in family planning for basic health staff (BHS), 13 health assistants, 66 midwives and 10 lady health volunteers (LHVs) were trained in quality reproductive health training. Two midwives and six LHVs received IUD service delivery protocol.

Rural residents utilize all FP service delivery points at the 200-bed hospital, station hospital (SC), rural health center (RHC), sub-rural health center (SRHC) and Marie Stopes Centers, while urban residents mainly used the 200-bed hospital and also Marie Stopes Centers.

People receive a variety of information and services for family planning, including from visits to RH clinics, mobile outreach clinics, village and home visits, out-patient delivery service and family planning education sessions. Mobile outreach clinics are conducted in rural areas with limited access to services. The clinics are operated by midwives and partner INGOs, in collaboration with village leaders, health volunteers and health committee members.

Effective Practices

These combined services and activities are working well, with high utilization of Depo injections and oral contraceptive pills, leading to a 68% CPR, and low 2% abortion rate and maternal mortality rate. Clients are satisfied with the safety, easiness, comfort, un-interruption of breastfeeding, and that these methods last at least three months. What contributes to effectiveness are the ***investments in human resources at SHs, RHCs and SRHCs, trained AMWs in FP, and uninterrupted commodity supply for health facilities through joint partnerships with INGOs and donors. Contraceptives were also supplied free of cost*** at any level of service delivery point, and ***health awareness training*** were conducted by midwives during outreach, immunization days and home visits. Women also reported no problems with their periods and no delay in conception after discontinuing usage.

Challenges

However, there are areas that are not yet working well, such as low interest in long-term methods. This includes very low usage rate of IUDs (1.4%) and implants (0.5%). Many challenges continue to exist that make uptake for RH/FP difficult, and those result in low rates of behavior change in FP practices. The challenging terrain makes follow-up visits hard since water transportation is the only available option in the township. A mobile migrant population and language barriers for RH counseling and health education are problems. There is no HIV/STD team for the township. More FP capacity building and training for MWs are needed on implants.

Recommendations

To address these issues, the township needs uninterrupted commodity supplies (implants and IUDs), more capacity building (implants training in particular for Ob/Gyn doctors and medical officers), RH MIS reporting format orientation, and awareness sessions and advocacy for IUDs with community members.

IV. Family Planning Services in Kayin State

(Dr. Khin Moe Thwe, Deputy State Health Director)

Dr. Khin Moe Thwe, Deputy State Health Director, presented on Kayin state's family planning program. Kayin state has a total population of 1.3 million. It has 1807 villages/wards, seven townships, 61 rural health center and 265 sub-centers. Health care providers are scarce, with one doctor per 88,824 residents, one health assistant per 29,228 residents, and one mid-wife per 4,261 residents.

Reproductive Health Care

Health care practices seem to be improving with a steady trend of women accessing antenatal care (ANC), although the challenge is getting more women to get four or more ANC check-ups. Many women still have home deliveries by a midwife rather than delivering in institutional care, pointing to the critical role of midwives. Maternal deaths are mainly linked to post-partum hemorrhaging (39%) and other non-pregnancy related diseases (22%). The abortion rate varies throughout the seven townships, with four townships having less than a 5% rate, while three have between a 6% to over 9% rate in 2013.

Health Service Delivery

Provision of family planning services is free of charge, and includes health education during ANC and counseling for women of reproductive age in health centers and hospitals. In Hpa township, International Rescue Committee (IRC) carried out a reproductive health project in 2009. The project supported maternal health and birthing by providing capacity building to BHS and health education in the community, supplying medicine, IUDs and IUD kits, organizing and referring clients, and PAC support and referrals to township hospitals.

Challenges

However, challenges remain, as there is lack of community awareness for family planning and contraceptive methodologies. Given that the RH project was only in one township, there are still many uncovered, hard-to-reach areas, in addition to migrant populations who need these services.

Recommendations

Suggestions to improve quality of care include provision of quality RH and refresher trainings, reinforce the role of AMWs in birth spacing/FP, ensure regular drug supply, conduct awareness raising activities, and provide supportive monitoring, supervision and feedback for providers. There is a need to address the abortion rate and cases.

Effective Practices

Overall, some of the strengths in achieving improved maternal health include mobilizing ***political support*** and having a ***commitment from the state*** to achieve the MDGs, as well as receiving ***funding*** from the Rural Development Fund. ***Capacity building and trainings for AMWs*** (auxiliary midwives) were conducted in five townships, in addition to committing to having ***presence of one AMW in villages without a MW.*** ***Advocacy and coordination*** are conducted with other development sectors, local and INGOs to achieve MDGs 4 and 5. There are plans to provide traditional birth attendant (TBA) refresher trainings and develop a referral fund in every village.

V. Women's and Children's Health Situation in Pindaya Township

(Dr. Than Min Htut, Township Medical Officer, Pindaya Hospital)

Dr. Than Min Htut presented on the reproductive health and family planning situation in Pindaya township.

Health Care Service Delivery

Pindaya township has over 81,000 people, with the majority of over 71,000 living in the rural areas. Of the 41,000 women, over 23,000 of women are of childbearing age, and 1,606 women are currently pregnant. Health facilities in this township consist of a 50-bed township hospital, 16-bed station hospital, one station health unit, one maternal child health center, two rural health centers and 12 sub-centers.

Health Care Practices

From 2012 to 2014, there continues to be a promising trend of increased hospital deliveries and referrals, while deliveries by midwives and auxiliary midwives are decreasing. Increasing utilization of skilled birth attendants for deliveries can be attributed to upgrading of AMW and communication services, better transport in the form of ambulances, and satisfaction with health care services. Antenatal care coverage remains high due to more home visits, improved relationships between AMWs, MWs and hospitals, and patient satisfaction. Immunization coverage for children in the same period also remains stable and high, except for Hepatitis B. Health education in the village, home visits, village clinics, and international supervision for pentavalent vaccine delivery have been critical in maintaining high coverage rates.

Challenges

Many challenges remain in attaining improved health indicators, particularly for maternal mortality and morbidity rate. A number of factors are attributed to risks in maternal and child mortality, such as lack of transportation, knowledge about danger signs, accessibility to services, and communication. Low birth weight, premature babies, malnutrition and poor diet, and limited knowledge about danger signs, such as climate and environmental changes, are other factors that can lead to child mortality. There is inadequate data collection and monitoring, particularly of civil registration and vital statistics. The system has security and communication problems. There is lack of awareness for registration of births and deaths, and death certificates are not required in villages. Ethnic minorities encounter language barriers when navigating and using the health care system.

Effective Practices

Pindaya township highlighted some of its best practices: ***rural health development, resource mobilization for hard-to-reach areas, and provision of essential newborn care and referral services for emergency care.*** It is important to influence positive behavioral change among families and to get more community participation. There has been ***cooperation among relevant stakeholders,*** departments and organizations to avoid overlapping and get more cost effective benefits. ***Quality assurance of health care services*** includes monthly meetings with basic health staff (BHS) and auxiliary midwives (AMW), combined with monitoring and supervision during site visits. There is a review process at the end of the month, yearly evaluation meetings and a SWOT (Strength, Weakness, Opportunity, Threat) analysis conducted to improve service delivery.

Technological advances in e-health and innovative solutions, such as through free wi-fi throughout the hospital, reports sent through email, continuing medical education (CME) and journal reading, and libraries in patients' wards, have helped to increase efficiency and satisfaction in communications and health care delivery.

Surveillance of maternal deaths have improved with township medical officer (TMO) and team conducting health investigations for every maternal death in the villages, providing health education in the villages, and holding review meetings for every maternal death. Additionally, funeral services are also available at the hospitals.

Advocacy and awareness-raising activities are important and need to be conducted at the village level to engage people and communities. ***Topics have to be relevant to local problems,*** and ***site visits are the best way to get information to people in the villages.***

Audience Discussion

Dr. Yin Yin Zaw moderated the audience discussion.

Conference participants pointed to current services and needs to address ARSH in Myanmar.

- The Department of Health has established a RH hotline to provide information for adolescents and youth. It has also discussed with a local university to help set up a health corner to address the problem of unintended pregnancies and abortions. There is hope of expansion if this model works. However, funding is needed to expand this concept.
- Language barriers, especially for ethnic minorities, pose a challenge in accessing the hotlines. The Government has not addressed this issue yet but is trying to find ways to reach these marginalized groups. It is trying to increase demand among these populations, but the service and demand have been unequal.
- Provision of comprehensive SRH education in Myanmar currently includes provision of a combination of sex education and life skills training in line with international standards using UNICEF's curriculum. Teachers are trained to provide this curriculum in school. RH information is also provided outside of the school for children not in school. The curriculum also includes role-plays and discussions on teen pregnancy, menstruation and masturbation.
- Pharmacies and drug-sellers, including students in pharmacy programs, are provided with training to help provide accurate information to their clients.
- The age of menarche is getting younger, and it is important for parents and schools to speak about SRH issues with starting with their 12-13 year old children.

Discussions on township FP experiences centered on unmet need in townships, advocacy campaigns and community participation, AMW service provision, training provision for townships, and UNFPA's projects to train local pharmacies/drug sellers.

- Statistics for FP unmet need are currently unavailable at the township level; there is only national level statistics. The upcoming Demographic Health Survey (DHS) will provide that information.
- In Laputta township, there are close partnerships between the government and private sectors and NGOs to ensure quality control. Monthly meetings are hosted by the Township Health Committees with local authorities' participation. These meetings help to identify facilities to visit to provide support.
- Midwives work in accordance to the guidelines and are involved in vaccination and birth spacing initiatives.
- During advocacy meetings, the township works with INGOs to provide information about FP/RH, including pregnancy at old age.
- There is the need to provide training across all townships to update their practices and service delivery, given that decentralization for FP will take place at the state level.
- In trying to get more information out about FP, UNFPA had a program to work with pharmacists and drug sellers. However, there were many challenges in recruiting drug store owners, so the program is no longer running.

PHOTOS: U Thaw Zin (top, lower left); Nichole Zlatunich (lower right)

Day 2 | July 1, 2014

Leveraging Expertise and Knowledge-Sharing

I. Scaling Up What Works in Family Planning/ Reproductive Health

(Suzanne Reier, IBP Initiative/WHO)

Suzanne Reier presented on opportunities for scaling-up and technical assistance provided to in-country partners. She points to various tools and guidelines available in different formats that are available on their website.

The IBP Initiative

While there is a plethora of information, knowledge, skills and experiences learned from different FP interventions across the globe, there remains a gap in sharing, transferring and translating this body of knowledge and content to improve practice. People are "re-inventing the wheel", and there is insufficient coordination in the field on a systematic basis. The IBP initiative was developed to address this gap, as well as problems of inaccessibility of information when it is needed.

The IBP consortium offers countries a range of supportive activities, including reinforcing existing coordination mechanisms to facilitate the implementation of the national FP strategy; supporting a process to identify, document and scale up effective practices in FP/RH; capturing country experiences to learn and publicize; build on complementary FP/RH initiatives; and helping to develop a new way of working. Examples include IBP partners working together to develop capacity to foster change for scaling up effective practices, disseminate FP high-impact practices, and orient and support countries to use the FP Training Resource Package (see below).

II. Family Planning Tools and Training Resources (Suzanne Reier, IBP Initiative/WHO)

Tools and Resources

The IBP Initiative's website features free information on "curriculum components and tools for trainers to design, implement, and evaluate family planning and reproductive health (FP/RH) training." Materials can be downloaded and adapted for customized use. The training materials were developed to keep in mind adult-based educational methods and include specific competency areas.

The Training Resource Package can be used to implement high quality training and education, integrate updated technical content and proven training methodologies, customized to meet specific training audiences, used by different trainers with different levels of training experience. Materials are also relevant for use in pre- or in-service training.

Formats include powerpoint slides, handouts, evaluation tools, references, facilitator's guide and module session plan. Training modules are provided for different types of contraceptives, with modules under development for emergency contraception (EC) and standard days method (SDM).

III. Myanmar's Challenges and Bottlenecks with Recommended Strategy Development: Discussions among participants from ten townships

GROUP WORK FOR PROBLEM IDENTIFICATION AND DEVELOPMENT OF STRATEGIES AT THE TOWNSHIP LEVEL

Six project townships and four non-project townships participated in the conference and provided their on-the-ground experiences. In groups of two townships, they identified problems and developed strategies to address these issues.

Laputta and Bogalay Townships

	LAPUTTA CHALLENGES	LAPUTTA STRATEGIES	BOGALAY CHALLENGES	BOGALAY STRATEGIES
Commodity Security	There is limited storage capacity for commodities Limited distribution budget	Advocate for more reproductive health commodities from government	Demand is increasing, but not enough supply	
Human Resources	Many vacancies (10%) for health care providers in hard-to-reach communities IUD training needed	Recruit AMWs (more than 50–60 a year) and train them on FP estimate needs for hard-to-reach areas Fundraise to sustain services to hard-to-reach areas	Only LHVs get trained on some FP methods (no IUD training yet)	Expand FP training and refresher training for AMWs, including Depo
Service Utilization	Claims 65% CPR	Integrate FP into essential services package	Need for ASRH programs/ services with trained staff	Develop guidelines for youth-friendly FP and RH activities Develop learning materials and IECs to be used in youth RH programs Ensure trainers are trained in SRH education curriculum Conduct Training-of-Trainers (TOT) for villages and wards on RH and FP on youth programs
Use of LARCs	Proper counseling needed, removal rate is high, implant not well socialized, turn-over of trained personnel		Implant supply is not continuous; implant is more expensive than IUD, need informed consent	Train midwives on IUD insertion and removal, and provide health education on LARCs Train peer educators to give health education on IUDs
Public Private Partnership	Pharmacies and drug shop owners not included in advocacy meetings Poor alignment with GPs and limited referrals	Work with township's Food and Drug Administration (FDA) committees to include the private sector and general practitioners (GPs) representatives	More orientation of FP needed for private sector	
Monitoring	No government budget line for supervision, supervision vehicle		DOH budget line needed for supervision	
Others	FP integrated as part of MCH tasks and universal health care		Need more prioritization of FP and RH in UHC	Develop IEC materials in seven, local main ethnic languages

Audience Discussion

- **Laputta Township.** While there are 500 villages, it is important not to duplicate MWs and AMWs. Training AMWs will be relatively easy, but the challenge is how to monitor, supervise and mentor them.
- **Bogalay Township.** Dr. Theingi Myint stated that currently AMWs are not allowed to give injections. AMWs need to get permission to do pilots and demonstrations.
- Dr. Paul Blumenthal of Stanford University said that insulin is self-injected. Drug sellers and CHWs are doing injections in many countries. Insulin overdose could kill you, but Depo cannot kill you. This can be an excellent innovation, and township should join with other townships to propose demonstration projects.
- There was a case in the past where an AMW gave an injection to a woman, but did not counsel the woman about amenorrhea, so the woman thought she was pregnant and got an unsafe abortion and died. Doctors themselves are not great counselors sometimes as they are rushed.
- Dr. Arvind Mathur of WHO commented that lay health workers need to be supervised carefully.
- Dr. Mario Festin of WHO asked to please document Myanmar cases so we could share globally.

Pindaya and Pyinmana Townships

	PINDAYA CHALLENGES	PINDAYA STRATEGIES	PYINMANA CHALLENGES	PYINMANA STRATEGIES
Commodity Security	Even with government supply since 2012, no implant supply (except by PSI in 20 townships, finished within one month), no regular and adequate supply		Inadequate budget for contraceptives LMIS planning and policy change needed at the central level Communication gap, no integrated forecasting, no LMIS	Forecast commodities to adequately meet demand
Human Resources	AMW training budget needed, AMWs cannot provide FP services IUDotrained midwives are present, but not for all areas Inadequate counseling, MWs are providing OCs, Depo and ECP, but TMOs have to be brought in to solve many problems	Recruit AMWs from villages to provide FP (pills and condoms) Conduct AMW refresher trainings for FP Continue refresher trainings over the longer term	FP has to be included in the AMW training curriculum Need to budget and provide IUD trainings for all MWs Counseling training needed Work towards 1 AMW per village	
Service Utilization	Low accessibility and availability for villages with no MWs MWs only go to villages for immunizations Low utilization of ECP	Increase awareness-raising and peer education among clients	MCH center in hospital compound needed Need better language/ local dialect insert on ECP packaging	Promote service utilization and information dissemination in Kayin languages, and conduct community mobilization meetings in 32 sub-centers Conduct refresher training for community support groups (CSGs) in 32 sub-centers Open new 30 sub-centers with full FP facilities
Use of LARCs	Inadequate supply IUD complications, no PPIUDs	Promote IUDs for PPIUDs at hospitals Find volunteer role models for peer education (such as satisfied users of PPIUDs)	Lack of skills, need training of PPIUD	Provide skills-based training on IUDs and removal, and PPIUD to midwives in 32 sub-centers (who will also be trained on skilled birth attendance)
Public Private Partnership	Collaboration with GPs, INGOs, NGOs (only 2 GPs in his township) but lack of proper collaboration at State/Region/Township levels		Inadequate advocacy to local authorities including health	
Monitoring	Monthly report on B/S, but no regular reporting		Need more budget and staffing	
Other	Religious issue Rakhine State (2 child policy)—population will increase		Ambulance costs covered by renting out to monks for funeral services, library and TVs	

Zeegone and Wet Let Townships

	ZEEGONE CHALLENGES	ZEEGONE STRATEGIES	WET LET CHALLENGES	WET LET STRATEGIES
Commodity Security	UNFPA support and govt support not enough, demand exceeds supply, need to buy from market	Indent to central MCH section Calculate commodities need by using annual ELCO data Calculate commodity needs based on demographic data	Requirement vs. actual usage Report for project commodities only	Use the pull system for RH commodities (improve data collection in HMIS on RH commodities consumption), provide timely requests to regional level before stock-outs happen Offer training of LMIS for TMO, SMO and HA
Human Resources	Overworked BHS, limited manpower, no clear roles and responsibilities or sense of ownership	Information-sharing by VHWs and task-sharing with AMWs and MMCWA members on OC pills and condoms for hard to reach villages—Reduce workload by MWs and better compliance	Transportation difficulty, no support for fuel, vehicle	Upgrade counseling skills for both private and public providers Involve junior trained peer groups (competency core group, including youth) on RH township committee Implement task shifting to lay health workers/grassroots level on demand creation, health promotion Increase understanding of actual health situation by all BHS
Service Utilization	No FP clinic Low drug compliance	Conduct social mobilization and awareness raising Regular health education session by health staff and peer educator for awareness raising, IUD insertion training, monitoring	Low client awareness Transportation problems	
Use of LARCs	Low demand for IUDs and PPIUDs Skills needed for implant Only one township receiving the training	Promote IUD and condom utilization Install labor room in RHC for IUD insertion	Misconceptions, fear Skill and capacity building for implants Implants expensive	
Public Private Partnership	30% using private sector PPP only for health education Few numbers of INGOs in the region		No reported data from private sector, weak linkage between public and private sectors	
Monitoring	Weak in level by level monitoring and supervision, and low practice in on-the-job training and feedback up the chain of command (too busy to give feedback), lack of authority to support the requirements	Recognize and reward outstanding MWs and volunteers	Low funding and time constraints	Provide resource allocation and planning for monitoring and supervision activities Conduct mid-term and annual reviews to evaluate, feedback, corrective actions Conduct data quality assessment and service quality assessment/Improve data and service quality
Others	Lack of motivation of BHS caused by law salary		Low government budget	Develop plan, identify requirements, develop tools and mobilize resources

Nga Phe and Paung Townships

	NGA PHE CHALLENGES	NGA PHE STRATEGIES	PAUNG CHALLENGES	PAUNG STRATEGIES
Commodity Security	Surplus of IUD, near expired commodities PSI is coming in soon	Not provided	Distribution from central, not aligned with demand No proper instructions, provider bias, client misconceptions	Establish proper monitoring and LMIS at the township level to address weaknesses in the reporting system Track commodities to avoid expired IUDs, as midwives have been given speculums to insert IUDs Develop demand-based pull system for commodities—accurate data for monthly and annual use of commodities
Human Resources	Rapid turnover of staff in remote areas, only 1 MW per 500, some places 10,000		Retention policy is weak and manpower is unevenly distributed	Provide capacity development: Update training manuals for FP best practices for both BHS and volunteers, including curriculum Collect training tools Conduct 7-day TOT, as well as multiplier training at townships (20 per time) to get skill based training Outcome: By 1–2 tears all BHS (MW) and AMWs will be trained after 1–2 years Ensure regular follow-up supervision and refresher training for newcomers
Service Utilization	Low utilization in rural areas, IUD not preferred		Accessibility, lack of information, cultural beliefs Educational sessions only reach elderly and children	
Use of LARCs	Implant is preferred but not enough commodities, no PPIUDs, low number of sterilizations.		No supply Concern of expulsion among providers IUD training provided, but providers do not know how to insert IUD because there were no demonstrations provided Peer educators from PSI do peer counseling and demonstration of IUDs, but no clients yet	Provide year's supply of contraceptive pills for providers
Public Private Partnership	Weak coordination No outreach to rural area			
Monitoring	No LMIS, NGO data not available		Not included in HMIS	Develop simplified reporting formats for FP, including commodities for both public and private sector (GPs, INGOs, NGOs, CSOs) Assign focal person to monitor, check and give feedback on FP reporting Conduct regular evaluation by all partners to identify successes and challenges
Demand Generation	Low awareness		Language barriers (Chin), limited IEC materials	

Pyaw Bwe and Hlaing Bwe Townships

	Pyaw Bwe Challenges	Pyaw Bwe Strategies	Hlaing Bwe Challenges	Hlaing Bwe Strategies
Commodity Security	Implants inadequate and IUD nearly expired	No strategies provided	Not project township site, so have limited budget	No strategies provided
Human Resources	Vacancies when MWs, CHWs and AMWs go for training, manpower shortage of AMWs—they cannot do injections, language barriers Non-state actors having difficulty Weak in counseling skills		Policy barriers for AMWs No negotiation between government and non-state actors	
Service Utilization	Geographical barrier, information gap, religious barrier		Not enough commodities, particularly for Depo	
Use of LARCs	Information gap, not enough supplies		Bleeding is a concern	
Public Private Partnership	Drug sellers training needed as they are dispensing			
Monitoring	No checklist and data format developed, no proper monitoring or record keeping system		No standardized monitoring tools	
Other	Youth SRH in some schools, but not enough awareness, evaluation or IEC		Not enough IEC materials	

SUMMARY FROM TOWNSHIP RECOMMENDED STRATEGIES

Dr. Theingi summarized township recommended strategies as follows:

Commodities

- Develop Logistical Management Unit at all levels of the health/admin system, a long- term computerized LMIS system and encourage pull system
- Plan for sustainability of commodities with the Government and donors

Human Resources

- Plan deployment of human resources to meet needs of remote and underserved areas, including incentives (Central intervention needed, such as the Department of Medical Science)
- Need to develop additional health workforce such as AMWs for providing FP services. AMWs need to be trained, supported, supervised
- Update pre-service curricula

Public Private Partnerships

- Engage NGOs and GPs
- Provide standardized training for all FP providers
- Offer capacity-building, supervision, monitoring, supplies and equipment
- Implement task-shifting to lay health workers on demand creation and health promotion
- Use AMWs to dispense and provide information on pills, condoms and Depo (under close monitoring)

Demand Generation (Use of LARCs)

- Provide social mobilization with advocacy (village leaders, non state leaders, local authority)
- Translate information into local dialect
- Conduct refresher trainings in FP to community support groups
- Identify role models and sharing experiences
- Improve counseling skills of FP for both public and private sectors

Service Utilization/Delivery

- Provide essential service packages integration for hard-to-reach areas
- Promote IUD including PPIUD at hospitals
- Provide skills-training for midwives on IUD insertion and removal

Data and Monitoring

- Develop standardized reporting forms on contraceptive use of private sector
- Develop standardized monitoring forms
- Develop manuals for monitoring and supervision
- Central government could provide advocacy toolkit to state/regional level, also need to educate about FP benefits, including population and social development to decision makers at state level

GROUP WORK FOR IDENTIFYING SYSTEMIC PROBLEMS WITH RECOMMENDED STRATEGIES

Dr. Katherine Ba-Thike, an independent consultant, facilitated the group identification of problems session and summarized the main issues presented by each group.

Commodity Security

While government budgets for commodities have increased, RH commodities are still not a high priority for government budget at only 8–10% of the total budget. There are no storage and distribution budgets. The demand is greater than the supplies available. Shipments of commodities arrive with short expiration dates. Forecasting of supplies does not include private sector purchases. Depo and OCs are procured by and available at 100-bed hospitals, but other station hospitals are not including these items. Some TMOs request these methods, but others not.

Strategies proposed:

- Find more donor support
- Use pull system for procurement
- Strengthen LMIS (UNFPA will be working on this)
- Get more recommendations from donors.

Human Resources (HR)

Staff turn-over is high as FP-trained staff leaves. The number of providers is insufficient. There is inadequate hands-on training. AMWs need FP training, even though some can dispense OCs. Non-state actors have more human resources capacity that can compensate for staffing shortages.

Strategies proposed:

- Human Resource Staffing
    - Review and revise HR development plans according to needs, but need to collaborate with stakeholders on the supply and demand sides
    - Develop staff retention and transfer policies, especially for hard-to-reach and remote areas (even if their salaries were tripled)
    - Provide additional health care workforce, such as AMWs for providing FP services (task-shifting)
- Roles and Responsibilities
    - Review roles and responsibilities of existing workforce
    - Suggest to do fewer reports to simplify workloads
    - Clarify AMWs' roles for FP. According to policy, it is referrals and health education for FP, plus they can distribute pills and condoms.
- Training
    - Review and assess capacity development of health workforce
    - Establish a regional training center

Service Delivery

In hard-to-reach or remote areas where many ethnic minorities reside, service delivery is a challenge due to lack of transportation and language barriers. More demand generation is needed, but there are language barriers and limited number of linguistically- and culturally-appropriate IEC materials.

Additionally, religion can be a barrier that deters acceptance of FP.

Strategies Proposed:

- Conduct social mobilization with advocacy
- Promote services and disseminate information in ethnic languages
- Provide peer education, collaborate with other sectors on education/information
- Clarify roles and responsibilities of AMWs, not just for FP but for the whole integration package

Use of LARCs

Directives and guidance on reversible contraception are contradictory, which creates confusion. With regard to female sterilizations, women need to get permission from the state health board to get this service. The application process is long and supporting documents are still tedious. However, the opportunities include a bright spot for implants in the market, and ECP is available in the private sector.

Strategies Proposed:

- Review use of task-shifting for long-term contraceptive methods, PPIUDs
- Ensure sustainable supply mechanisms
- Address commodities that are given free of charge
- Build capacity building of drug sellers and pharmacy students to dispense accurate information, particularly around emergency contraceptive pills (ECPs)
- Regulate private providers who sell ECPs

Public private partnerships (PPP)

PPP is improving, but general practitioners (GPs) are not included. NGO training has enhanced quality of service.

Strategies proposed:

- Linkage
  - Create linkage through quarterly meeting of township's FDA committee with all private sector stakeholders, including involvement of GPs
- Data Collection, Sharing and Coordination
  - Strengthen data management
  - Need data collection tools for private sector to report FP work. PSI is collecting data from private sector, but based on new users, some clinics only (2000 out of the 20,000 in the country). Only clinics receiving commodities from government are tracked.
  - Manuals are given to private hospitals to provide information to government, and all manuals should be standardized. Township level demand is difficult to assess without private sector data.
- Training
  - Work with Myanmar Medical Council for accreditation of GPs, including update on FP and RH in the process of licensing. Training for GPs on standardized FP service package collaboration with MMA.
  - Provide FP for continuing medical education (CME), and include private sector doctors, as CME program is the only opportunity for the private sector doctors to collaborate with public sector
- Planning and Services
  - Provide integrated essential services package
  - Include FP and MH in township and regional development plans
  - Involve youth groups in FP services

Monitoring

There is a need to develop a standardized checklist for monitoring and RH LMIS. There is no functioning LMIS, and data collected are inconsistent.

Strategies proposed:

- Allocate budget for monitoring and supervision
- Strengthen HR
- Scale-up Reproductive Health Commodity Logistic System (RHCLS) in all townships
- Set up reporting system for PPP
- Conduct advocacy at the local levels
- Develop standardized monitoring tools

NOTE: See appendix for Tables 1 for working groups' identification of bottlenecks.

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Action Plans of Participating Townships to Address Key Bottlenecks

The ten townships provided their action plans following identification of problems, challenges and bottlenecks to FP programs and service delivery. **Futures Group led a session entitled "Action Planning for Family Planning" in which township teams learned a process to develop action plans to implement strategies in the next 1–2 years, 3–4 years, and 5–10 year periods. Township participants were given templates to help support action planning and future refinement. By the end of this session, township participants had developed useable short-, medium-, and long-term township action plans which they could begin to implement after the conference.**

Following are each township's action plans. Please refer to the appendix (Tables 2) for more detailed information on each township's action plan.

PHOTO: Sono Aibe

TOWNSHIP	BOTTLENECK/CHALLENGE	STRATEGY
Bogalay	Additional health workforce needed to provide FP Young people lack FP/RH knowledge Misconceptions about IUDs	Train AMWs on FP Involve young people in FP/RH programs/services Disseminate information about IUDs
Hlaing Bwe	Lack of FP competency among health workforce	Provide capacity building on FP Establish regional training center
Laputta	No coordination between public and private sectors Shortage of health workforce providing FP Essential service package not present in many areas, especially in remote places	Create linkage through quarterly meeting of township Food and Drug Administration (FDA) committee with all private sector stakeholders Train AMWs for provision of FP services Provide Essential Services Package, especially for hard-to-reach
Nga Pe	Commodity security Human resource shortage for FP Low Service Utilization	Develop pull system for demand generation (bottom-up approach) Capacity development of health workforce—establishment of regional training center & linkage with tertiary hospitals Social mobilization with advocacy (community and religious leaders, village leaders, local authorities, non-state leaders)
Paung	Health workforce lack skills and competency on FP Weak reporting on FP practices, including logistics management at township level Lack of forecasting on commodities and inefficient supply system	Offer capacity development for township health workforce, including volunteers Establish proper monitoring and LMIS at the township level Develop a pull system approach to increase demand in the township
Pindaya	Shortage of health workforce providing FP Low utilization of IUDs Lack of shared experiences and effective practices among stakeholders	Develop competency of AMWs to provide FP Promote use of IUD, maybe during PP FP to increase PPIUD at the hospital Identify role models and share experiences
Pyaw Bwe	Poor communication and awareness about FP Inadequate human resource in family planning services Shortage of contraceptive commodities supply and inadequate budget	Conduct social mobilization and advocacy (include village leaders, non-state authorities, community leaders) Offer capacity development on FP best practices to health care providers Use a pull system to generate increase demand (Bottom-up Approach)
Pyinmana	Low service utilization	Provide social mobilization with advocacy (village leaders, non-state leaders, local authority)
Wetlet	Contraceptive security Inadequate counseling and service delivery skills by health care providers (both public and private) Inadequate monitoring and supervision	Use of pull system as demand generation (Bottom Up Approach); Responsible Person TMO/THO/BHS Provide capacity building on counseling and FP provision for both public and private sector providers Allocate sufficient resources and conduct planning for monitoring and supervision activities
Zeegone	Not enough commodities (Injectable Depo) Low usage of IUDs & condoms (but have excess stock) Low compliance	Make requests to central MCH section (based on demand) Promote condom and IUD utilization Conduct social mobilization and awareness-raising activities

During the second session on costing action plans for family planning, Futures Group demonstrated a tool for activity-based costing and facilitated a discussion about how to use the costing process to improve stakeholder engagement, implementability of the plan, and to increase advocacy for the plan. By the end of this second session, township participants had an understanding of the methodology for costing action plans for family planning, and were provided with digital copies of a tool they could use to develop family planning budgets for the township level after returning home. Futures Group's contributions to the conference, provided by Nichole Zlatunich and Joni Waldron, were supported by FP2020 Country Engagement Working Group.

Recommendations to Myanmar Ministry of Health (MOH) Policy and Technical Recommendations to MOH

Data

- Need better data for Myanmar for FP—recommendation —request support from PMA2020
- Re-institute a functional RH MIS and LMIS and ensure that collected data is consistent and that the MOH can compile it to the national level; develop a standardized reporting form for public and private
- Include PPP in the national MIS reporting system
- Improve documentation for abortion cases so they are recorded and reported on
- Train TMO, SMO, HA in logistics management system

Programs

- Develop programs for a greater focus on reaching marginalized young people, including: developing youth-friendly service delivery guidelines, starting a hotline for young people; training peer educators
- Need to increase participation of private pharmacies, including training providers on commodities (pills)
- Improve infrastructure at clinics (solar power to facilitate deliveries at night, etc.)
- Development and translation of IEC materials in Burmese as well as local languages
- Training—Senior midwives to be trained on implant insertion
- Training—AMWs to be trained to dispense pills and condoms, and to counsel and provide referrals on all methods
- Ensure appropriate aids and materials are available for training (models, etc.)
- Social mobilization with advocacy (village leaders, non-state leaders, local authority): dissemination of information in local dialect, role model and sharing experiences, refresher training on FP to community support group; develop role model program, for users to share their experiences
- Institute a program to improve communication and counseling of all service providers (public and private)
- Increase number of providers trained in implants
- Peer education and service provision (volunteer recruitments and training)
- Improve PPP—coordination: Include PP GPs in training; provide capacity building, supervision, and supply
- Review and revise human resource development plan in relation to supply and demand, including developing a retention and incentive policy
- Set up long-term method mobile clinics (IUDs and implants) to serve hard-to-reach areas, including for PP IUD; skills training for midwives on IUD insertion and removal
- Institute regular coordination meetings at all levels (township to national)
- Plan and budget for monitoring and supervision (plan, tools, financing, mid-term and annual reviews)
- Conduct pilot/demonstration study for AMW and pharmacies to do injectable contraceptives;
- Recognition and rewards for AMW and volunteers
- Hire additional health workforce such as AMW for providing FP services- trained, supported, supervised

Technical Guidelines and Curricula

- Update guidelines to include best practices in FP, to include all methods- implant, PP IUD, BCC
- Develop appropriate training materials for volunteers and translate into local language
- Revise guidelines for post-partum IUD, ensure training curricula is aligned with current best practices
- Revise auxiliary midwives (AMW) training and refresher training curricula to include FP
- Develop standardized monitoring guidelines/checklist
- Review roles and responsibilities in line with task-shifting: senior midwives to allowed to do implant insertion; AMW to dispense pills and condoms and injection (under monitoring), and counseling and referral on all methods
- Clarify all guidelines to remove any potential contradictions (e.g. IUD insertion in some settings)
- Reduce/eliminate requirements for female sterilization to be less tedious/burdensome on clients

Commodities

- Need more continuous supply of implants when demand is increased
- Improve forecasting (include private sector in joint procurement forecasting and planning); set up a contraceptive security task force—to advocate to donors when there is a shortage
- Plan for storage and stock keeping at all levels
- Increase supply of implants
- Develop a pull system for commodities to pull commodities based on demand—collect actual RH commodity consumption through HMIS; forecast based on demand; make timely request to supply agencies

Financing

- Increase government budget for contraceptives (including for implants)
- Increase budget line item for human resources
- Institute budget for transportation
- Institute government (DOH) budget line items for supervision
- Support to townships to conduct social mobilization campaigns with village leaders, non-state leaders, and local authorities

Looking Ahead

The Myanmar Family Planning Best Practices Conference highlighted an example of cross-collaboration among global, national and local experts to address Myanmar's family planning needs in alignment with the Government new Five-Year Strategic Plan for Reproductive Health and its FP2020 Commitment.

In line with the Government of Myanmar's new Health Vision 2030 plan, Five-Year Strategic Plan for Reproductive Health (2014–2018) and Myanmar's FP2020 Commitment, the outcomes from the Myanmar FP Best Practices Conference provides a blueprint for next steps in implementing shared effective practices and programming from around the world. The Government's renewed interest in prioritizing FP provides a critical foundation to usher in sustained social, health and economic growth and stability.

What Pathfinder and MPPR plan to do in the next few years as follow-up is to take this conference format to states/regions to reach more townships, and to provide technical support where requested by MOH or by state/regional health offices.

One regret was not to have young people participating to discuss the important issue of ASRH, but in the next stage, Pathfinder International, MPPR, with MOH guidance, look forward to implementing similar workshops at the state and region levels and would hope to include youth among the participants.

We thank the Government of Myanmar, Ministry of Health, Department of Health, township partners, and international donors and technical experts for engaging in an enriching and successful three-day conference.

Appendices

Myanmar Family Planning Best Practices Conference
June 30-July 2, 2014, Mingalar Thiri Hotel, Nay Pyi Taw

CONFERENCE SCHEDULE

Day 1: Monday, June 30, 2014

7:15 am	Registration Opens
Opening Ceremony **7:45 am** **8:00–8:30 am**	Master of ceremony: Khin Sandar Aung Participants assemble Welcome remarks by H.E. Minister of Health Dr. Pe Thet Khin Group photograph
Setting the Stage **8:30–9:30 am**	Opening remarks and meeting objectives, Sono Aibe, Pathfinder International Myanmar's Birth Spacing Program and FP2020, Dr. Yin Thandar Lwin, Director of Public Health, Department of Health National Five-year RH strategy, Dr. Theingi Myint, Deputy Director (MCH), Department of Health FP2020: Full Access, Full Choice, Valerie DeFillipo, FP2020 Moderator/ Prof. Dr. Mya Thida
Coffee Break/Group Photo **9:30–10:00 am**	Participants start putting their signatures on the FP2020 commitment banner
Family Planning in the context of global health and development **10:00–12:00 pm**	Why Family Planning is a Cost-Effective Intervention for Health and Development (Dr. Jose Rimon, Gates Institute for Population and RH, Johns Hopkins Bloomberg School of Public Health) Global Program for enhancement for Reproductive Health Commodity Security and its implications to FP 2020 goals in Myanmar (Ms. Janet Jackson, UNFPA) Indonesia's FP2020 commitment: revitalizing FP in a decentralized government (Dr. Julianto Witjaksono, National Family Planning and Population Board, Indonesia) Facilitated Question and Answer session : Moderator/Dr. Theingi Myint
Lunch **12:00–1:00 pm**	Lunch in the hotel
Introduction of Best Practices, Part 1 **11:00–2:30 pm**	Latest global trends in FP service delivery and guidelines (Dr. Mario Festin, WHO Geneva) Health system approach to integration of FP and MNCH (Dr. Arvind Mathur, WHO SEARO) Best Practices in Quality Assurance for Long Acting Reversible Contraception (Dr. Paul Blumenthal, Stanford University) Facilitated Question and Answer session : Moderator/ Prof. Dr. Khin Htar Yi
Tea/Coffee Break **2:30–3:00 pm**	Refreshments and networking
Introduction of Best Practices, Part 2 **3:00-4:45 pm**	Community based FP and behavior change communication (Dr. Candace Lew, Pathfinder International) Adolescent and youth reproductive health (Dr. Ne Win, UNFPA) Current Status of Family Planning Service Provision in Laputta Township, presented by Dr. Saw Lwin, Medical Superintendent, Laputta Hospital Current Status of Family Planning Service Provision in Kayin State, presented by Dr. Khin Moe Thwe, Deputy State Health Director Facilitated Question and Answer session: Moderator/Prof. Dr. Yin Yin Zaw
Wrap Up **5:00 pm**	Nine key learnings of the day by Sono Aibe, Pathfinder International Facilitators meet to prepare for day 2 Adjourn
6:30 pm	Welcome Dinner hosted by the Ministry of Health (Mingalar Thiri Hotel conference hall)

Day 2: Tuesday, July 1, 2014: Conference Hall

7:30am	Arrival
Workshop Introduction (Plenary) 8:00-9:00 am	Introduction of Training Resource Package and Implementing Best Practices, WHO (Suzanne Reier, WHO/IBP) Introduction of townships Objectives and overview of the workshop Moderator: Dr. Katherine Ba-Thike
Identification of Bottlenecks and Analysis 9:00–11:00 am	Facilitators and participant introduction Explanation of group work for problem identification and analysis Township group work
Tea/Coffee Break	Refreshments and networking
Presentation (Plenary) 11:00–12:10pm	Presentation of group work on problem identification and analysis
Lunch 12:00–1:00 pm	Lunch in the hotel/ energizer
Identification of Strategies (Township groups) 1:00–2:30 pm	Explanation of group work for strategies Township group work
Tea/Coffee Break 2:30–2:45 pm	Refreshments and networking
Presentation (Plenary) 2:45–4:00 pm	Presentation of group work on strategies
Action Planning (Plenary & Group) 4:00–5:00 pm	Explanation of group work for action planning Township group work
Wrap Up & Overview of Tomorrow's Agenda 5:00–5:15 pm	Preview of Day 3

Day 3: Wednesday, July 2, 2014: Conference Hall

7:30am	Arrival
Presentation (Plenary) 8:00-10:00 am	Presentation of group work on action planning Discussion, Q&A
Tea/Coffee Break 10:00–10:15 am	Refreshments and networking
Costing (Plenary) 10:15–11:30 am	Demonstration of costing tool and exercise by Futures Group, Dr. Nichole Zlatunich and Ms. Joni Waldron
Concluding Session 11:30–12:00 pm	Summary of workshop activities and recommendations: Comments from DOH Discussions, Q & A Closing speech from Director-General Dr. Min Than Nyunt delivered by Dr. Yin Thandar Lwin, MOH, and remarks from Sono Aibe, Pathfinder International Adjourn
Lunch 12:00–1:00 pm	Lunch in the hotel

Myanmar Family Planning Best Practices Conference Participants List

GOVERNMENT OF MYANMAR

H.E. Dr. Pe Thet Khin	Minister of Health, Ministry of Health
Dr. Than Aung	Deputy Minister, Ministry of Health
Dr. Min Than Nyunt	Director General, Ministry of Health
Dr. Than Zaw Myint	Director General, Ministry of Health
Dr. Tun Naing Oo	Director General, Ministry of Health
Dr. Nwet Oo	Director General, Ministry of Health
Dr. Myint Han	Director General, Ministry of Food and Drug Administration
Dr. Kyaw Zin Thant	Director General, Department of Medical Research (lower state)
Dr. Ye Ye Myint	Director General, Department of Medical Research (upper state)
Dr. Htay Aung	Deputy Director General (Public Health) DOH
Dr. Soe Lwin Nyein	Deputy Director General (Disease Control) DOH
Dr. Than Win	Deputy Director General (Leprosy)—Deputy Director General
Dr. Yin Thandar Lwin	Director (Public Health)
Dr. Thandar Lwin	Director (Disease Control)
Dr. Nwe Ni Ohn	Director (Planning)
Dr. Thar Tun Kyaw	Director (General Administration)
Dr. Win Naing	Director (Epidemics)
Dr. Moe Swe	Director (Administration)
Dr. Khin Win Thet	Director (Leprosy)
Dr. Nwet Nwet Khin	Director (Nursing) Dept of Medical Science
Dr. Theingi Myint	Deputy Director (MCH)
Dr. Thuzar Chit Tin	Deputy Director (BHS)
Dr. Myint Myint Than	Deputy Director (WCHD)
Dr. May Khin Than	Deputy Director (Nutrition)
Dr. Kyi Lwin	Deputy Director (School Health)
Dr. Khin Mar Kyi	Deputy Director (Nursing)
Dr. Htin Lin	Deputy Director (Nutrition)
Dr. Hla Mya Tway Eaindra	Deputy Director (Health Education)
Dr. Hnin Hnin Lwin	Assistant Director (MCH)
Dr. Myintmo Soe	Assistant Director (MCH)
Dr. Khine Nwe Tin	Assistant Director (MCH)
Dr. Thida Win	Assistant Director (WCHD)
Dr. Nang Naing Naing Shein	Assistant Director (BHS)
Dr. Khin Sanda Aung	Assistant Director (BHS)
Dr. Khine Mar Zaw	Assistant Director (Nutrition)
Dr. Su Su Lynn	Assistant Director (School Health)
Prof: Dr. Mya Thida	Professor/ Department Head (OG), UM(1)
Prof: Dr. Khin Htar Yee	Professor/ Department Head (OG), UM(2)
Prof: Dr. San San Myint	Professor/ Department Head (OG), Magway
Prof: Dr. Kyi Kyi Nyunt	Professor/ Department Head (OG), Mandalay
Dr. Nay Soe Maung	Professor Head, University of Public Health
Dr. Aye Kyi Kyi	Department Head, University of Public Health
Dr. Sandar	Regional MCH director, Yangon Division
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Dr. Yu Yu Lwin	OG Specialist, Kachin State
Dr. Su Thiri	Kayah State Health Department
Dr. Thanda Kyaw	OG specialist, Kayah State
Dr. Soe Oo	State Health Director, Chin State
Dr. Khin Moe Thwe	THO / Kayin State
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Daw Nan Myint Sein	LHV, Hlaing Bwe
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Dr. Myo Moet Moet	OG Specialist, Magway Division
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Daw Khin Than Aye	THN, Nga Phe
Daw Wai Wai	LHV, Nga Phe
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Dr. Win Win Mar	OG Specialist, Ayeyawaddy Division
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Dr. Myint Myint Mon	THN, Bogalay
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Dr. Saw Lwin	Medical Superintendent, Laputta
Daw Kyi Kyi Win	THN, Laputta
Daw Thin Thin Aye	LHV, Laputta
Representative	Ministry of Social Welfare
Representative	Department of Relief and Resettlement
Representative	Ministry of Immigration
Representative	Ministry of Education
Dr. Thet Thet Mu	Director (HMIS), DHP
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Dr. Rika Morioka	MPPR
Dr. Candace Lew (SP)	Pathfinder International
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President Dr. Mon Mon Aung	MMCWA
Dr. Ko Ko Maw	MMCWA
Dr. San San Hlaing	MMCWA
Dr. Yin Yin Zaw	President, OG Society, MMA
Dr. Khin Thida	GP Society, MMA
President (Daw Khin Mar Shwe)	MNMA

ALL PHOTOS: U Thaw Zin

Table 1: Group Work Identifying Bottlenecks

Commodity Security

	PROGRESS MADE	BOTTLENECKS	WHY?
Group 1	Supply of 4 main methods of contraceptives have been received from different sources (UNFPA, 4CMS, 3MDG) and is sufficient for the year	Distribution Costs Limited Storage Capacity (New hospital has no storage room)	Lack of distribution budget Supplies have not kept pace with increased demand
Group 2	UNFPA and Government support (Increased Government budget for health)	Demand is greater than supply (Not enough in-stock to support commodities of client's choice, such as Injectable Depo, Implants—need to purchase from commercial market)	Requirement versus Actual Usage Report for project commodities only
Group 3	Supply from government started in 2012	No regular and inadequate supply (No implant supply)	Inadequate budget for contraceptives Logistic management information system (LMIS) planning and policy change needed at the central level Communication gap—no integrated forecasting, no LMIS
Group 4	Commodities sufficient PSI coming soon	Surplus of IUDs Near-expired commodities	No proper instructions, client's misconceptions, provider bias Distribution from central system not aligned with demand
Group 5	Available (public and private)	Inadequate stock, IUDs are nearly expired, implants supply not enough	Not project township Low priority—limited government budget

Human Resources

	PROGRESS MADE	BOTTLENECKS	WHY?
Group 1	Training of RH received Mobile teams with IPs	Vacancy at 10%, including hard to reach Some specific training (e.g. IUD training) is needed	Vacancy, especially in hard to reach area, has not yet been filled. Limited training for LHVs on FP but no training on IUDs
Group 2	Fully Sanctioned Plan to assign PHS II for sharing workload of MW	High workload of BHS Manpower (no clear roles and responsibilities), no sense of ownership	BHS have high workload, 1 MW for over 5,000 people Transportation difficulty No support for transport such as motorcycle, fuel
Group 3	More AMW recruitment started with the aim to have one AMW per village for health education FP service provision by MWs (only for COC, Depo, ECP) IUD service provision by only IUD-trained MW (small number)	Inadequate budget for AMW trainings AMW are not able to provide FP services MWs are trained in IUDs but not in all township; MWs are providing oral contraceptives, Depo, emergency contraceptive pills Inadequate counseling TMOs have to be brought in to solve many problems	AMW training curriculum does not include FP session No budget for IUD trainings and inadequate counseling skills for all MWs Target is to work towards 1 AMW per village

Human Resources, continued

	PROGRESS MADE	BOTTLENECKS	WHY?
Group 4	Partially filled	Rapid turn-over of staff, especially in remote areas Population of health staff: 1 MW per 500 people; in some places, 1 MW per 10,0000	Retention policy is weak Uneven distribution of manpower
Group 5	Enough basic health staff	Vacancies when MWs, CHWs, and AMWs go for trainings Manpower shortage AMWs—not allowed to do injections, language barriers Non-state actors have difficulty, weak in service provider skills (counseling)	Policy barriers for AMWs No negotiation between government and non-state actors

Service Utilization

	PROGRESS MADE	BOTTLENECKS	WHY?
Group 1	Contraceptive prevalence rate high (over 65%) Comprehensive condom program	Low awareness about birth spacing Low preference for some long-term methods (IUDs)	Limited awareness raising activities and counseling training
Group 2	CPR – 65% (project and non-project areas) Skills training Counseling	No Family planning clinic and PN clinic Low Drug Compliance	Low client awareness Transportation problems
Group 3	Increased demand for COC and Depo	Low accessibility and availability at villages with no MWs; MWs only go there for immunizations Low utilization of emergency contraceptive pills (ECP)	Refer to commodity security and HR Maternal child health center needed in the hospital compound Lack of information and better language/ local dialect on insert provided for ECP
Group 4	Some methods are popular like Depo	Low utilization in rural area IUDs not preferred	Accessibility, lack of information, cultural beliefs Inadequate staff competency and skills, clients' misconceptions Educational sessions only reach elderly and children
Group 5	Utilization increased	Geographical barriers Information gap Religious barriers	Not enough commodity choices, especially Depo

Long-Acting Contraception

	PROGRESS MADE	BOTTLENECKS	WHY?
Group 1	Utilization potential for Implants Training for Implants provided	Proper counseling is essential for implant clients, as removal rate within 1yr is high Implants are not well-received in the community Loss or drop-out of service providers due to turn-over of trained staff	No continuous supply of Implants when demand is increased Implants more expensive than IUDs Need informed consent
Group 2	IUDs Implants	Low demand for IUDs & PPIUDs (-) Skills needed for Implant insertion (only one township getting training)	Misconceptions, fears Skills & capacity building for Implants Implants are expensive
Group 3	Increased demand for Implants	Inadequate supply Low utilization of IUDs; IUD complications No PPIUD	Lack of skills No trainings for PPIUDs
Group 4		Preference for implants, not enough commodities No PPIUDs Low number of sterilizations Paung township: IUD trainings provided but no demonstrations provided so providers do not know how to insert Magway township: Peer educators from PSI provide counseling and demonstrations of IUDs, but no clients	No supply Recently new and concern of expulsion by providers (Need many documents, strict criteria, infrequent board meeting)
Group 5	Community prefers implants	Information gap Not enough commodities	Bleeding related to IUDs is a concern Medical doctors are not well trained

Public Vs. Private

	PROGRESS MADE	BOTTLENECKS	WHY?
Group 1	Advocacy meetings being conducted with all sectors but less orientation on family planning	Pharmacy shop owners and drug sellers are not included in advocacy meetings Poor linkage with GPs and poor referral	Less coordination with private sector; more orientation of FP needed for private sector
Group 2	70% public sector use; 30% private sector use	PPP only for Health Education Few number of INGOs in the region	No reported data from private sector Weak linkage between public and private sectors
Group 3	Collaboration with GPs, INGOs, NGOs (only 2 GPs in township)	Lack of proper collaboration at State/Region/Township levels	Inadequate advocacy with local and local health authorities
Group 4	Private sector providing FP services	Weak coordination and collaboration No out reach to rural area	Only initial consultation and no further contact
Group 5	NGOs—Available in project townships,	Not covered whole townships Follow-up with GPs—not effective GPs are not included (in trainings) Complications Drug sellers—selling drugs without knowledge	Work in piece-meal in project township GPs not receive trainings (LAC)

Monitoring

	PROGRESS MADE	BOTTLENECKS	WHY?
Group 1	Monthly supervision according to plan Package tour	No government budget line for supervision Supervision vehicle	DOH budget line for supervision needed
Group 2	Tour program Checklist (+)	Weak in level-by-level monitoring and supervision Little opportunities to practice during job (on-job training) and feedback up the chain-of-command (too busy to provide feedback) Lack of authority to support the requirement	Low funding Time constraints
Group 3	Monthly reports on birth spacing	No regular monitoring	No budget for monitoring Inadequate HR for monitoring
Group 4		No LMIS data NGO data not available	Not included in HMIS
Group 5	Monitoring system and record-keeping system are in place	No checklist and data format developed No proper monitoring or record-keeping system	No standardized monitoring tools

Others

	PROGRESS MADE	BOTTLENECKS	WHY?
Group 1	FP as part of MCH tasks but needs to become prioritized service	MCH/RH component need to be integrated into universal health coverage of Myanmar	Less prioritization on RH and FP component in universal health care coverage
Group 2		Lack of motivation of BHS due to low salary	Low government budget
Group 3		Religious issues, Rakhine State (2-child policy)	Ambulance costs covered by renting out to monks for funeral services, library, and TVs
Group 4		Not enough demand generation and low awareness	Language barriers (Chin), limited IEC materials
Group 5	Demand generation School curriculum for youth on RH already exists	Poor awareness No evaluation yet Not enough IEC	Not enough IEC materials

Tables 2: Township Action Plans

Township/State: Bogalay, Ayeyarwady

PROBLEM 1: Additional health workforce is required for providing FP services
STRATEGY 1: Auxiliary midwives to be trained for FP services

	ACTIVITY 1	OUTCOME 1	ACTIVITY 2	OUTCOME 2
1–2 Years	Health education, contraceptive pills, and condoms to be distributed by AMWs. Add FP section in AMWs training which will cover HE about RH and FP, provision of CP, condoms, and referral to health facilities for other methods.	Improved accessibility to FP and RH services. Reduced unwanted pregnancies	Prepare lesson for FP using OC Pills and condoms in AMW curriculum.	Community will be aware of FP and there will be increase in FP services.
3–4 Years	Expansion of FP training & refresher training for AMWs, including Depo injectables	All AMWs will be competent for FP	OC pills, Depo & condom supply	Easily accessible by community
5–10 Years	Refresher training for all AMWs in every village	All villages in BGL township will have well trained AMWs		

PROBLEM 2: Young people do not have enough knowledge about FP and RH
STRATEGY 2: Involvement of youth groups in FP services

	ACTIVITY 1	OUTCOME 1	ACTIVITY 2	OUTCOME 2
1–2 Years	Develop guidelines for youth-friendly FP and RH activities	Young people will become aware of FP and RH issues and practices	Develop learning materials and IECs to be used in youth RH programs	Learning materials developed with participation of young people
3–4 Years	Discussions with school authorities, GAD and health sector to launch school-based school activities Test and disseminate guidelines among youth (TMO, MMCWA GA, youth groups)	Youth guidelines disseminated and planned	Training of trainers for youth SRH education programs	Trainers trained in SRH education program
5–10 Years	Echo training for villages and wards	RH and FP knowledge disseminated in the community	Monitoring and evaluation (half year, end year) for TMO, community leaders, program participants Preparation of report and dissemination of results	Youth program monitored and evaluated. Report disseminated to relevant sectors.

PROBLEM 3: Myths and misconceptions about IUDs still exists in the community
STRATEGY 3: Information dissemination about IUDs in the community

	ACTIVITY 1	OUTCOME 1	ACTIVITY 2	OUTCOME 2
1–2 Years	Train midwives on IUD insertion and removal, as well as HE about advantages of IUDs and provision of long-term contraception as well as removed at anytime	IUDs will be the choice of contraception among women and will be well-utilized among local residence	To develop IEC materials in local 7 main ethnic dialects and language	Dissemination of IUD IEC materials in local 7 main ethnic languages
3–4 Years	Train peer educators to give HE on IUDs in RH project townships	Well-trained peer educators mobilized and IUD information disseminated	Identified women willing to utilize IUDs and provide services in RH project townships	Increased acceptability and utilization of IUDs among women
5–10 Years	Establish network for client-to-client information regarding the benefits of long-term contraception that will further promote utilization	Women will learn that PPIUD is beneficial and safe	Educate the public about advantages of PPIUD	Women will accept PPIUD

Township/State: Hlaing Bwe, Kayin

PROBLEM 1: Lack of health workforce competency in provision of FP
STRATEGY 1: Capacity development of health workforce; establishment of regional training center

	ACTIVITY 1	OUTCOME 1	ACTIVITY 2	OUTCOME 2
1–2 Years	QRH training to all BHS (FP training package) → obtain from DOH/Donors Qualified training team & then qualified BHS FP training to new AMWs & existing AMWs at township level Skills-based FP training to all GPs Provide information guidelines for FP drug sellers		Extending QRH training (New, old, BHS) Look at lessons learned from model RHCs (BHS from other RHCs) Provide motivation to BHS	

PROBLEM 2: Not provided
STRATEGY 2: Social mobilization with advocacy

	ACTIVITY 1	OUTCOME 1	ACTIVITY 2	OUTCOME 2
1–2 Years	Advocacy with township health community (non-state actors; general administration; Department KWAG; religious leaders IEC developed in Kayin language Billboards at every RHC and public place Role-plays during special events and activity			
3–4 Years	Share M & E results		Re-planning based on M & E results	
5–10 Years				

PROBLEM 3: Not provided
STRATEGY 3: Create linkage with GPs/INGOs/NGOs for regular CME focus on FP

	ACTIVITY 1	OUTCOME 1	ACTIVITY 2	OUTCOME 2
1–2 Years	Township Medical Department should focus on data collection from GPs and private sector Strengthen data management (collection, analysis, and sharing) and information system Training GPs for standardized FP service package in collaboration with MMA			
3–4 Years	Establish coordination with GPs/INGOs/NGOs			
5–10 Years				

Township/State: Laputta, Ayeyarwady

PROBLEM 1: Lack of coordination among public and private sector stakeholders
STRATEGY 1: Create linkage through quarterly meeting of township FDA committee with all private sector stakeholders

	ACTIVITY 1	OUTCOME 1	ACTIVITY 2	OUTCOME 2
1–2 Years	Conduct meeting to advocate with FDA committee members for inclusion of GPs and private sector representatives	GPs and private sector involved in FDA committee meeting and increased awareness in FP services	Develop information and data sheet for GPs and private clinics	Information from private sector will be received
3–4 Years	Conduct regular meetings	Regular linkage with public and private sectors	Analyze and disseminate Information	Data and information can be evaluated
5–10 Years	Conduct regular meeting	Regular linkage with public and private sectors	Analyze and disseminate Information	Data and information can be evaluated

PROBLEM 2: Shortage of health workforce to provide FP
STRATEGY 2: Additional Health Workforce such as AMW for providing FP services

	ACTIVITY 1	OUTCOME 1	ACTIVITY 2	OUTCOME 2
1–2 Years	Recruitment of new AMWs (60 AMWs per year)	Increased number of AMWs in township	Integrate FP topics in AMW curriculum	AMWs receive updated FP information
3–4 Years	Recruitment of new AMWs (60 AMWs per year)	More coverage of villages by AMWs in township	FP topics will be included in refresher trainings for AMWs	AMWs are knowledgeable on updated information
5–10 Years	Recruitment of new AMWs (60 AMWs per year)	All villages will be covered by MWs or AMWs	FP topics will be included in refresher trainings for AMWs	AMWs are knowledgeable on updated information

PROBLEM 3: Many areas not receiving essential service package, especially hard-to-reach areas
STRATEGY 3: Provision of Essential Services Package, especially for hard-to-reach

	ACTIVITY 1	OUTCOME 1	ACTIVITY 2	OUTCOME 2
1–2 Years	Integration of FP services into package—MCH services + EPI + Nutrition + ES + HE	Hard-to-reach community will receive services, including FP		
3–4 Years	Finding ways for sustainability (finding support, partners)	Essential Services Package, especially for hard-to-reach, will be sustained		
5–10 Years	Finding ways for sustainability (finding support, partners)	Essential Services Package, especially for hard-to-reach, will be sustained		

Township/State: Nga Pe, Magway

PROBLEM 1: Commodities
STRATEGY 1: Pull system as demand (bottom-up approach)

	ACTIVITY 1	OUTCOME 1	ACTIVITY 2	OUTCOME 2
1–2 Years	BHS collects data required for contraceptive commodities for TMO, and provides data to central level every 6 months	Reduced wastage of commodities, no expired drugs .	Evaluate the system	Know strengths and weaknesses of pull system and develop solutions to improve
3–4 Years	Continue implementing same activity with some modifications depending on review findings	Less stock-outs and wastage; more effective commodity security in township		
5–10 Years				

PROBLEM 2: Human Resources
STRATEGY 2: Capacity development of health workforce - establishment of regional training center & linkage with tertiary hospitals

	ACTIVITY 1	OUTCOME 1	ACTIVITY 2	OUTCOME 2
1–2 Years	Strengthen the training team by appointing focal person and complete training materials in regional training centers	Able to conduct proper trainings, possess skills and on-the-job trainings	Conduct regular training for to BHS (Training plan)	Trained BHS who have skills in providing FP services
3–4 Years	Continue support of training center and conduct training	Maintain capacity of training center to provide skills-based training	Regional team provides training to township training team	Township team have skills and continue multiplier training to other BHS and CME
5–10 Years				

PROBLEM 3: Service Utilization
STRATEGY 3: Social mobilization with advocacy (villages leaders, non-state leaders, local authorities, community)

	ACTIVITY 1	OUTCOME 1	ACTIVITY 2	OUTCOME 2
1–2 Years	Coordinate with local authorities and advocate with them	Awareness of the importance of FP	Get permission letter from township authorities for conducting activities in villages	Ability to conduct health discussions and activities in villages to raise awareness about FP
3–4 Years	Approach religious leaders and raise awareness about FP	FP is accepted and religious leaders help to support FP services and provide information in villages	Conduct FP awareness for community members	Increased awareness in community to use FP
5–10 Years	Select peers/champions in the village	Sustained FP information and services		

Township/State: Pindaya, Shan

PROBLEM 1: Shortage of health workforce providing FP
STRATEGY 1: Additional health workforce, such as AMWs for providing FP services (pills and condoms)

	ACTIVITY 1	OUTCOME 1	ACTIVITY 2	OUTCOME 2
1–2 Years	Recruit AMWs from villages	Increased number of AMWs	Conduct AMW training	Increased number of AMWs who can provide FP services (one AMW per village)
3–4 Years	Provide FP services (Pills and condoms)	Increased CPR	Regular monthy meeting	Increased CPR
5–10 Years	Conduct AMW refresher trainings	Sustain skills and knowledge of AMW to provide FP services	Conduct new AMW training	Cover the drop-out AMW and promote FP

PROBLEM 2: Low usage of IUDs
STRATEGY 2: Promotion of IUD using for PPIUD at the hospital

	ACTIVITY 1	OUTCOME 1	ACTIVITY 2	OUTCOME 2
1–2 Years	Conduct competency- based PPIUD training for hospital staff —doctors, nurses	Competent IUD service providers	Provide PPIUD service at the hospital	Increased CPR for IUDs
3–4 Years	Implement awareness raising activities—outreach education on IUD in community	Increased awareness and utilization	Conduct peer education for clients	Increased PPIUD usage among clients
5–10 Years	Conduct refresher training	Sustained skills and knowledge of IUDs		

PROBLEM 3: Lack of shared experiences and effective practices among stakeholders
STRATEGY 3: Identify role models and sharing experiences

	ACTIVITY 1	OUTCOME 1	ACTIVITY 2	OUTCOME 2
1–2 Years	Find volunteer role models for family planning	Role models are identified and commitments are obtained to participate in awareness-raising activities	Conduct peer education for role models	Role models can share their experiences to increase awareness
3–4 Years	Hold yearly gathering among role models and clients	Share knowledge among clients		
5–10 Years	Conduct refresher training on peer education	Sustained skills and knowledge	Replace new role models with drop-out role models and new peer education training	Sustained skills and knowledge

Township/State: Paung, Mon

PROBLEM 1: Inadequate skills for FP
STRATEGY 1: Capacity development of township health workforce, including volunteers

	ACTIVITY 1	OUTCOME 1	ACTIVITY 2	OUTCOME 2
1–2 Years	Update manual for FP practices for both BHS and volunteers, including curriculum	Updated training manual, including implant, PPIUD, BCC for health staff and appropriate training manuals for volunteers	Collect models and equipment for training and training tool development	Complete training tools for training at S/R and Tsps
1–2 Years	Conduct 7-day TOT at S/R	Qualified trainers developed	Hold multiplier training in townships (20 per one time) to provide skills-based training	All BHS MWs and AMWs will be trained after 1–2 years
3–4 Years	Provide regular follow-up supervision and refresher trainings to newcomers	Quality FP services provided	Continue capacity development activity	Sustained quality service provision

PROBLEM 2: Weak proper reporting FP practices, including logistics management at township level
STRATEGY 2: Establish proper monitoring and logistic management system at township level

	ACTIVITY 1	OUTCOME 1	ACTIVITY 2	OUTCOME 2
1–2 Years	Develop simplified reporting formats for FP, including commodities for both public and private sector (Consult with S/R)	Simplified reporting formats will be developed	Advocate and discuss with private sector (GPs, INGOs, NGOs, CSOs) on regular reporting for FP	GPs and private sector providers understand the importance of data on FP practices Data provided by private sector providers
1–2 Years	Train BHS and volunteers on filling out report formats	Proper reporting from BHS MWs and volunteers AMWs	Assign focal person to monitor, check and give feedback on FP reporting	Completed and timely reporting, as well as corrective action achieved
3–4 Years	Provide regular evaluation, including all partners (Quarterly, six months, or annually)	Achievements, weaknesses, strengths identified and agreed		
5–10 Years	Continue similar activities			

PROBLEM 3: Lack of forecasting on commodities and inefficient supply system
STRATEGY 3: Develop pull system to increase demand in townships

	ACTIVITY 1	OUTCOME 1	ACTIVITY 2	OUTCOME 2
1–2 Years	Record and calculate commodities usage from reports	Accurate data provided for monthly and annual usage of commodities		
3–4 Years	Forecast supply needs based on data received from monitoring mechanism	Sufficient supply of commodities ordered and available	Distribute commodities to providers according to actual need	No shortage o supplies Supplies are more available and accessible Clients more satisfied
5–10 Years	Continue similar activities			

Township/State: Pyaw Bwe, Mandalay

PROBLEM 1: Poor community awareness on family planning best practices
STRATEGY 1: Social mobilization with advocacy

	ACTIVITY 1	OUTCOME 1	ACTIVITY 2	OUTCOME 2
1–2 Years	Hold advocacy meetings with township authority and health committee	Improved awareness on family planning best practices	Advocacy meetings with village health team (BHS, VHW) and local authority (grassroot level)	Improved awareness on family planning best practices
3–4 Years	Provide IEC materials at all level	Sustainable awareness on family planning best practices	Provide free service (vinyl, posters)	Improved awareness on family planning best practices
5–10 Years	Monitor and conduct survey on community awareness	Assess their awareness and apply family planning best practices	Scale-up and update family planning best practices based on survey data and lesson learned	Universal access to family planning best practices

PROBLEM 2: Inadequate human resource in family planning services
STRATEGY 2: Capacity development on family planning best practices for health workforce

	ACTIVITY 1	OUTCOME 1	ACTIVITY 2	OUTCOME 2
1–2 Years	Develop standardized training guidelines – by DOH (RH section)	Standardized training guideline from DOH available	Provide intensive courses for health care providers regarding family planning best practices	Well-trained functioning champions on family planning best practices
3–4 Years	Offer refresher courses for health care providers regarding family planning best practices	Well-trained champions on family planning best practices	Prevent health care providers' attrition	Sustainable family planning best practices
5–10 Years	Offer refresher courses (new technology) for health care providers regarding family planning best practices	Sustained family planning best practices	Provide monitoring and on-the-job training	Sustainable family planning best practices

PROBLEM 3: Shortage of contraceptive commodities supply and inadequate budget
STRATEGY 3: Use pull system as demand generation (Bottom-up Approach)

	ACTIVITY 1	OUTCOME 1	ACTIVITY 2	OUTCOME 2
1–2 Years	Forecast the demand for contraceptive commodities based on population data	Adequate supply of commodities	Draw budget, procurement, storage, and distribution plan	Budget well-allocated and sustainable supply for family planning services
3–4 Years	Conduct data analysis	Adequate amount of contraceptive supply		
5–10 Years	Monitor and supervise demand and supply gap	Adequate contraceptive supplies (e.g. no expired date, good quality)		

Township/State: Pyinmana, Nay Pyi Taw

PROBLEM 1: Service utilization
STRATEGY 1: Social mobilization with advocacy (village leaders, non-state leaders, local authority)

	ACTIVITY 1	OUTCOME 1	ACTIVITY 2	OUTCOME 2
1–2 Years	Promote service utilization and disseminate information (in Myanmar and in Kayin language)	Advocacy meetings to be conducted in 32 sub-centers within 1-2 years	Provide refresher training on family planning to Community support group (CSG) of UNFPA	Refresher training for CSG in 32 sub-centers conducted within 1-2 years
1–2 Years	Provide skills based training for midwives on IUCDs insertion, removal, and on PPIUDs	Midwives in 32 sub-centers trained in IUCD insertion, removal, and on PPIUDs within 6 months		
3–4 Years	Open new 30 sub-centers with full facilities to provide family planning services	30 new sub-centers (with full facilities) opened	Forecast commodities to meet the needs according to demand	All sub-centers have adequate commodities
5–10 Years	Coordinate/advocate with other sectors such as Road and Transport Ministry	No more outreach areas	Train midwives for provision of long-term contraceptives (Implants)	All midwives are capable of providing implants

Township/State: Wetlet, Sagaing

PROBLEM 1: Inadequate supply of RH commodities
STRATEGY 1: Use of pull system as demand generation (Bottom Up Approach); Responsible Person TMO/THO/BHS

	ACTIVITY 1	OUTCOME 1	ACTIVITY 2	OUTCOME 2
1–2 Years	Collect actual RH commodities usage through HMIS forms (Improve data collection) Provide forecasting that is dependent on demand Send timely requests to supply agencies in advance	Regional/MCH know actual needs Receive adequate RH commodities	Distribute RH commodities based on requests from BHS	BHS distribute based on needs of clients
3–4 Years	Conduct training of LMIS for TMOs, SMOs, HAs Set up IT solutions	Establishment of Logistic Management System No stock out, no Surplus and no expired date commodities	Establish LMS	No stock outs, surplus, or expired products
5–10 Years	Monitor and evaluate LMIS system	Sustain and improve system (RH commodities shortage issue will be resolved) Fulfill the FP 2020 to increase CPR from 41% to 50%		

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Township/State: Wetlet, Sagaing *continued...*

PROBLEM 2: **Inadequate counseling and service delivery skills by health care providers (both public and private)**
STRATEGY 2: **Capacity building on counseling and provision FP service delivery to health care providers in both public and private sectors**

	ACTIVITY 1	OUTCOME 1	ACTIVITY 2	OUTCOME 2
1–2 Years	Conduct multiplier training/ CME on FP services to BHS	Improved competency and skills on RH services for BHS	Training of GPs/drug stores on RH services	Improve competency and skill on RH Services of private providers
1–2 Years	Provide supportive supervision/ training follow-up to both public and private providers	Improved competency and skills on RH services		
3–4 Years	Involve junior trained peer groups (competency core group; including youth) on RH Township committee	Ability to share skills, competencies, knowledge to increase CPR		
5–10 Years	Implement task-shifting to lay health workers for demand creation, health promotion	Improved access to RH services, increased utilization (CPR), reduced unmet need to fulfill FP2020 commitment		

PROBLEM 3: **Inadequate monitoring and supervision activities**
STRATEGY 3: **Resources allocation and planning for monitoring and supervision activities**

	ACTIVITY 1	OUTCOME 1	ACTIVITY 2	OUTCOME 2
1–2 Years	Develop monitoring and supervision plan Identify Requirement for monitoring & supervision (M&S) plan Develop M & S tools Conduct resource mobilization for M & S plan	Ability to monitor and supervise at all levels	Conduct mid-term and annual reviews	Ability to give feedback and to take corrective actions
1–2 Years	Conduct regular M & S at all levels	Understand the actual health situation by all BHS		
3–4 Years	Conduct Data Quality Assessment (DQA) and Service Quality Assessment (SQA)	Improved data quality and service quality		
5–10 Years	Utilize findings for further Comprehensive Township Health Plan	Improved township level health system to meet FP2020 commitment		

Township/State: Zekone, Bago

PROBLEM 1: **1) Not enough commodities (Injectable Depo); 2) Low usage of IUDs & condoms (but have excess stock); 3) Low compliance**
STRATEGY 1: **1) Make requests to central MCH section (according to demand); 2) Promote condom and IUD utilization; 3) Social mobilization and awareness-raising**

	ACTIVITY 1	OUTCOME 2	ACTIVITY 2	OUTCOME 2
1–2 Years	Determine commodities needed by using annual ELCO data	Adequate commodities next year to prevent excess or stock-outs	Hold information sharing with Volunteer Health Worker & implement task-sharing with AMWs and Myanmar Maternal & Child Welfare Association (MMCWA) members (OC pills and condom for hard-to-reach villages)	Reduced workload by MWs Better Drug Compliance
1–2 Years	Hold regular HE sessions by health staff and peer educators Conduct awareness-raising of IUD insertion training Monitoring	Better drug compliance Increased utilization of IUDs		
3–4 Years	Determine commodity needs by using demographic data Conduct refresher training and sharing of updated issue for BHS and health volunteer Implement monitoring, supervision and evaluation	Increased knowledge on updated issues	Install labor room in RHC (it can also be used for IUD insertion)	Increased utilization of IUDs
3–4 Years	Provide recognition and rewards to outstanding MWs and volunteers	Increased motivation of MWs and volunteers for improved FP services		
5–10 Years	Determine commodity need by using demographic data from Family Planning Clinic daily	Increased CPR, increased usage of IUDs, condoms	Conduct monitoring, supervision, reporting, and evaluation	Improved BHS and volunteers' activities

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