Strategy to End Preventable Maternal Mortality in Myanmar (2017-2021)

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Maternal and Reproductive Health Division

Department of Public Health

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"Some of the best indicators of a country developing along the right lines are healthy mothers giving birth to healthy children who are assured of good care and a sound education that will enable them to face the challenges of a changing world. Our dreams for the future of the children of Burma have to be woven firmly around a commitment to better health care and better education."

Daw Aung San Suu Kyi [excerpt from Letters from Burma)

Foreword

Every woman .every newborn has the right to good quality care.

The Strategy to End Preventable Maternal Mortality in Myanmar will address the causes of maternal mortality and morbidity in the current era of rapid demographic. socio·economic and epidemiological transition.

The right to good quality maternal health which is respectful and evidence-based is universally acknowledged. There is an urgent need to reduce disparities in access to care and to improve the timeliness and quality of care. so securing future economic and social development and in turn, supporting the vision of the Sustainable Development Goals and the Global Strategy for Women's. Children's and Adolescents' Health.

Myanmar is committed to the Sustainable Development Goals and the Global Strategy for Women's, Children's and Adolescents' Health to improve the health and well-being of mothers, children and adolescents. Opportunities for progress in improving quality of care and reducing inequities lie not only in wider adoption of effective maternal health interventions .but also in broader developments. These include Universal Health Coverage, increasing fiscal space and expanding the reach of care through mHealth and use of quality data.

The Strategy to End Preventable Maternal Mortality in Myanmar is in line with the goals of the National Health Plan (2017-2021) to strengthen the health system and strive for universal health coverage while having an explicitly pro-poor focus.

The Ministry of Health looks forward to continued collaboration with allied Ministries and Departments of the Government of Myanmar, Non-state Actors. professional bodies, civil society organizations and to build on partnerships with the United Nations system and other development partners for the effective realization of the Strategy to End Preventable Maternal Mortality.

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List of Acronyms

AAAQ	Availability, Accessibility, Acceptability and Quality
ABR	Adolescent Birth Rate
AIDS	Acquired Immune Deficiency Syndrome
AMW	Auxiliary Midwife
ANC	Antenatal Care
ARH	Adolescent Reproductive Health
ARR	Annual Rate of Reduction
ASEAN	Association of South-East Asian Nations
BCC	Behavioural Change Communication
BEmONC	Basic Emergency Obstetric and Newborn Care
BHS	Basic Health Staff
CBO	Community-based Organization
CDSR	Child Death Surveillance and Response
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
Census	Myanmar Population and Household Census
CHD	Child Health Division
CPR	Contraceptive Prevalence Rate
CRVS	Civil Registration and Vital Statistics
CSO	Central Statistical Organization
CSO	Civil Society Organization
DHS	Demographic and Health Survey
DHIS	District Health Information System
DP	Development Partners
DoPH	Department of Public Health
DSW	Department of Social Welfare
EHO	Ethnic Health Organization
EPI	Expanded Programme of Immunization
EPMM	Ending Preventable Maternal Mortality
EWEC	Every Woman Every Child Faith-based Organization
FBO	
GAVI	Global Alliance for Vaccine Initiative
GBV	Gender-based Violence
GoM	Government of the Republic of the Union of Myanmar/ Government of Myanmar
HCT	HIV Counseling and Testing
HEF	Health Equity Fund
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
HSS	Health System Strengthening
IEC	Information, Education and Communication
IOM	International Organization for Migration
IUD	Intra-uterine Device
JICA	Japan International Cooperation Agency
JOICFP	Japanese Organization for International Cooperation in Family Planning
JIMNCH	Joint Initiative for Maternal and Child Health

LMIS	Logistics Management Information System
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MDSR	Maternal Death Surveillance and Response
MDR	Maternal Death Review
MHSCC	Myanmar Health Sector Coordinating Committee
MICS	Multiple Indicator Cluster Survey
MISP	Minimum Initial Service Package
MMEIG	Maternal Mortality Estimation Inter-Agency Group
MMCWA	Myanmar Maternal and Child Welfare Association
MMR	Maternal Mortality Ratio
MNH	Maternal and Newborn Health
MNMA	Myanmar Nurses and Midwives Association
MoHS	Ministry of Health and Sports
MoPF	Ministry of Planning and Finance
MRH	Maternal and Reproductive Health
MSWRR	Ministry of Social Welfare, Relief and Resettlement
MVA	Manual Vacuum Aspiration
MW	Midwife
MWH	Maternity Waiting Home
MyMA	Myanmar Medical Association
NAP	National AIDS Programme
NGO	Non-governmental Organization
NHP	National Health Plan
NMCP	National Malaria Control Programme
NMR	Neonatal Mortality Rate
NNC	National Nutrition Centre
NSCTF	National Supply Chain Task Force
NSPAW	The National Strategic Plan for Advancement of Women
PAC	Post-abortion Care
PMTCT	Prevention of mother-to-child transmission
POQI	Point of Care Quality Improvement
PPH	Post-partum Haemorrhage
QI	Quality Improvement
QOC	Quality of care
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RH	Reproductive Health
RHC	Rural Health Centre
SBA	Skilled Birth Attendant
SDGs	Sustainable Development Goal(s)
SHP	Social Health Protection
SOP	Standard Operating Procedures
TBA	Traditional Birth Attendant
TMO	Township Medical Officer
TSG	Technical and Strategy Group
UHC	Universal Health Coverage
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNFPA	United Nations Population Fund

UNICEF	United Nations Children's Fund
VHW	Voluntary Health Worker
VRS	Volunteer Reporting System
WHO	World Health Organization
3MDG Fund	Three Millennium Development Goal Fund

Executive summary

Over the past three decades high levels of maternal mortality in developing countries have been increasingly recognized as a pressing public health issue by governments. The post-2015 Sustainable Development agenda aims to build upon and expand the unfinished work of the Millennium Development Goals. The Sustainable Development agenda highlights the importance of continued attention to maternal and newborn health by settiing Sustainable Development Goal (SDG) 3. The "Every Woman Every Child" Global Strategy for Women's, Children's and Adolescents' Health was launched by world leaders in September 2015 to build momentum for women's , children's and adolescents' health. The Ending Preventable MatemalMortality (EPMM) Strategy envisions that global, regional. national and community-level commitments are mobilized for EPMM with the overall aim of reducing maternal mortality ratio from 282 per 100,000 live births (2014) to less than 91 per 100,000 live births by 2030.

Myanmar has committed to the SDG agenda and will continue to strive for ending preventable maternal mortality. The National Health Plan (2017-2021) has identified maternal and child health as a critical component, and the Strategy for Ending Preventable MaternalMortalty is a key approach the Ministry of Health and Sports will adopt. The key strategies and strategic objectives are outlined as follows.

1 Address causes of *maternal mortality and morbidities and related disabilities*

Causes of maternal mortality and morbidities will be addressed through implementing the package of essential MNH interventions as defined in the Essential Health Package under the National Health Plan (NHP); and maternal morbidities such as nutritional problems and medical problems through screening and preventive practices and treatment of critical medical and obstetric conditions at tertiary and State/Regional Hospitals. The referral and response system to manage complications and life-threatening emergencies will be streamlined. At the same time. unwanted pregnancies will be prevented and unmet need of contraception addressed through family planning; while management of post abortion complications will be strengthened.

2. *Ensure universal health coverage for comprehensive sexual, reproductive, maternal and newborn health care*

In line with the NHP, universal coverage of the package of evidence-based RMNCAH interventions for essential and comprehensive mothers and newborns will be implemented, through ensuring health financing for universal coverage of mothers and newborn interventions and increasing fiscal space and budgetary allocation for RMNCAH.

3. Strengthen health systems *to respond to the* needs *and priorities of women and girls*

The main building blocks of the health system will be addressed: i.e. ensuring leadership and governance for maternal and newborn health (MINH) at all administrative levels, streamlining MNH service delivery, strengthening the health information system, ensuring competent teams of health care workers provide care during pregnancy, childbirth and postnatal period, ensuring financial security for MNH service delivery and commodity security for high quality medicines.equipment and appropriate technologies for MNH care.

4. Harness the power of communities and civil societies to improve the demand and acceptability of services

Different communication strategies will be employed to engage communities and increase community awareness on maternal and newborn health issues. The role of community volunteers and auxiliary midwives will be strengthened, particularly in hard-to-reach areas while context-specific community interventions will be employed.

5. Ensure accountability to improve quality of care and equity

Civil registration and vital statistics system will be instituted by the Ministry of Health and Sports (MoHS) in partnership with Central Statistical Organization. Monitoring of MNH programme and maternal and perinatal death surveillance will be strengthened at all levels. Data will be analysed and reports disseminated and used for planning and programme improvement. The relationships between civil society, community and health service providers will be nurtured for fair, responsive and inclusive health services.

6. Address inequities in access to and quality of sexual, reproductive, maternal and newborn health care

Context specific plans to address inequities will be implemented in partnership with civil society organizations and ethnic health organizations. Attention will be paid to support maternal and reproductive health (MRH) in humanitarian settings. Quality and respectful care will be accorded to women and their families through adapting and implementing global standards on quality of care in facilities.

The implementation of the Strategy to End Preventable Maternal Mortality in Myanmar will be aligned with the National Health Plan. The EPMM Strategy is an elaboration and update of strategies embedded in the Strategic Plan on Reproductive Health (2014-2018) and is complementary to the National Strategic Plan for Newborn and Child Health (2015-2018) and Casted Implementation Plan to meet Commitments to FP 2020. The principles of inclusiveness and partnerships with a wide range of stakeholders and progressive realization of objectives will be followed.

1. Introduction

Over the past three decades high levels of maternal mortality in developing countries have been increasingly recognized as a pressing public health issue by governments, as well as in international forums and development agendas. Although levels have declined over the past two decades, maternal mortality levels are still comparatively high and more progress is needed. This is the case in most developing countries, including Myanmar.

Ending preventable maternal mortality remains one of the world's most critical challenges despite significant progress over the past decade. There were approximately 303,000 maternal deaths in 2015, largely from preventable causes before, during and after the time of giving birth. Globally among women of reproductive age.maternal mortality is the second leading cause of death, and women currently face a 1 in 180 chance of dying from maternal causes.

Sustainable Development Goals

The post-2015 Sustainable Development agenda aims to build upon and expand the unfinished work of the Millennium Development Goals. The Sustainable Development agenda highlights the importance of continued attention to maternal and newborn health by setting,under the SDG goal 3, targets for achieving a global maternal mortality ratio of less than 70 maternal deaths per 100,000 live births, and aiming for all countries to reduce neonatal mortality to at least as low as 12 per 1000 live births by 2030 and reduction of stillbirths.

In the SDG agenda,universal health coverage is the means to ensure that high-quality, essential health services are available and affordable to all. When universal health coverage is pursued through progressive realization it upholds principles of fairness and equity,setting the course for realizing the right to health.

The Global Strategy for Women's, Children's and Adolescents' Health

The Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health (EWEC Global Strategy) was launched by world leaders in September 2015 alongside the United Nations (UN) General Assembly to build momentum for women's, children's and adolescents' health and well-being and.in so doing,contribute to the achievement of the Sustainable Development Goals (SDGs). The Vision of the Global Strategy for Women's, Children's and Adolescents' Health is "By 2030, a world in which every woman, child and adolescent in every setting realizes their rights to physical and mental health and well-being, has social and economic opportunities, and is able to participate fully in shaping sustainable and prosperous societies."

The human rights-based EWEC Global Strategy prioritizes meeting the needs of the most disadvantaged and marginalized women, children and adolescents. It takes a holistic approach. focusing on reducing inequities, strengthening fragile health systems and fostering multisectoral approaches to address the wide-ranging determinants of health. In this way the EWEC Global Strategy aims to end preventable deaths,illness and injury by 2030 and to unlock the full potential of women, children and adolescents so they can thrive and transform their communities.

Ending Preventable Maternal Mortality

Maternal mortality has nearly halved over the past two and a half decades, yet 289.000 women worldwide still die each year as a result of pregnancy and childbirth. As mortality has declined, disparities have become more apparent. The risk of death is disproportionately highest among the most vulnerable women in the poorest of nations. Yet, most maternal deaths are preventable-as are many

of the other poor health consequences of pregnancy. Among the 189 million women who are pregnant annually, 122 million have a live birth, and nearly 3 million suffer a stillbirth. About 10 percent of mothers suffer a maternal complication during pregnancy or in the intrapartum period, and up to 40 percent may have morbidities or disabilities post-birth that are attributable to the pregnancy or birth.

The link between maternal health and child health is seen most starkly in the neonatal mortality rate (NMR), which is still both too high and declining too slowly. In 2015, 2.7 million newborns died within 28 days of birth, representing 45% of all deaths among children under five and an NMR of 19 deaths per 1000 live births (down from 36 deaths per 1000 live births in 1990). Additionally, there were an estimated 2.6 million stillbirths: 18.4 for every 1000 births. The "Every Newborn Action Plan" target is 12 or fewer stillbirths per 1000 births in every country by 2030. Half of the stillbirths occurred during labour and birth, mostly from preventable conditions, and mostly in low- and middle-income countries.

The Ending Preventable Maternal Mortality (EPMM) Strategy envisions that global, regional, national and community-level commitments are mobilized for EPMM. Through concerted efforts wide disparities in current maternal mortality can be eliminated and the highest levels of maternal deaths worldwide (both within and between countries) can be reduced to the rates now observed in the best-performing middle-income countries.

The EPMM targets and strategies are grounded in a human rights approach to maternal and newborn health, and focus on eliminating significant inequities that lead to disparities in access, quality and outcomes of care within and between countries. Concrete political commitments and financial investments by country governments and development partners are necessary to meet the targets and carry out the strategies for EPMM.

Myanmar National Health Plan

The Myanmar National Health Plan (NHP) aims to strengthen the country's health system and pave the way towards Universal Health Coverage (UHC), choosing a path that is explicitly pro-poor. The main goal of NHP 2017-2021 is to extend access to a Basic Essential Package of Health Services (EPHS) to the entire population by 2020 while increasing financial protection. Efforts will be made into strengthening of the health system to support effective delivery of quality services and interventions; organized along four pillars. namely human resources, infrastructure, service delivery and health financing. While supply-side readiness is at the core of the NHP, elements that will help create or increase the demand for essential services and interventions are included. Focusing on the Basic EPHS, for example, will clarify entitlements and manage expectations.

The NHP also aims to promote further alignment at several levels:

-Among programmes (e.g. by encouraging more integrated training, joint supportive supervision, better aligned referral mechanisms. a more streamlined health information system)

-Among development partners (DPs), through stronger oversight and coordination

- Among the different types of providers, through the engagement of Ethnic Health Organizations (EHOs), Non-Governmental Organizations (NGOs), private-for-profit providers, etc.

- Among implementing agencies by ensuring that projects and initiatives contribute to the achievement of the NHP goals

Reproductive, maternal, newborn and child heallh is one of the programme priority areas under NHP and the unfinished task of MDGs 4 and 5 remains of high importance in the SOG era. Myanmar's commitment to the maternal, newborn and child health agenda remains strong and ending preventable maternal and child mortality is prominent in the NHP. Furthermore, Myanmar will strive towards the

three cardinal objectives of the Global Strategy: not only to end preventable mortality but also to avert illness and ensure well-being.

2. Methodology

Many documents related to the maternal and newborn health (MNH) programme: global, regional and national were reviewed. (Annex 1) Key informant interviews were conducted with a wide spectrum of stakeholders from the different Departments under the Ministry of Health and Sports, United Nations agencies, international and national non-governmental organizations (INGOs and NGOs), professional societies and maternal and newborn health (MNH experts). (Annex 2)

The Global Strategy for Women's, Children's and Adolescents' Health 2016-2030. WHO Every Newborn: An Action Plan to End Preventable Deaths (2014), Strategies to Ending Preventable Maternal Mortality (2015), were particularly perused to ernsure inclusion of evidence based strategies and guidance to achieve SDGs.

The key points on health system and other challenges are collated from discussions with representatives from the Ministry of Health and Sports, United Nations agencies and NGOs working on maternal and newborn health, and reproductive health issues. The deliberations from a Short Programme Review (SPR) on maternal and reproductive health held at the end of August 2017 by Maternal and Reproductive Health Division (MRH) and WHO Country Office where representatives from the Health Departments from 17 States and Regions participated, are also drawn upon.

A dissemination meeting for key maternal and newborn health stakeholders was held on 16 November 2017 to present the draft EPMM Strategy, in particular the strategic objectives, strategies and key activities: and to solicit feedback; which was then incorporated. (See Annex 3 for List of participants)

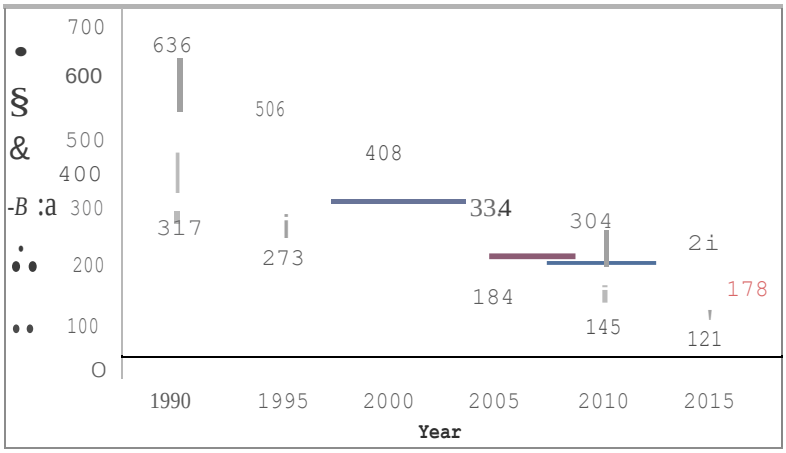
3. Maternal and Newborn Health Situation

3.1 Maternal and Newborn Health

According to the United Nations Inter-agency Estimates for Maternal Mortality, the maternal mortality ratio (MMR) for Myanmar, declined from 453 deaths per 100,000 live births to 178 per 100,000 live births between 1990 and 2015. 178 per 100,000 is: an estimated average of a range varying from 121 (lowest) to 284 (highest) deaths per 100,000 live births. This estimate is consistent with the figure of 282 per 100,000 live births reported by the 2014 Myanmar National Housing and Population Census. Despite the fact that Myanmar reduced MMR by 61per cent, It failed to meet the MDG targets.

The eight Millennium Development Goals (MDG) established in 2000 set time-bound measurable targets to be achieved by UN member countries before end of 2015. Myanmar was among the countries that did not achieve the 2015 MDG target of 113 per 100,000 live births. The Annual Rate of Reduction (ARR) of MMR in Myanmar for the period of 1990-2010 was 3.7 per cent, but for 2010-2015 was 2.8 per cent. Furthermore. the Lifetime Risk of maternal death for a woman in Myanmar is 1 in 260, compared to 1 in 2,900 in Thailand and 1 in 1,400 in Sri Lanka.

Figure 1: Trends in Maternal Mortality Ratio Myanmar 1990-2015



Source: WHO Global Health Repository, data on Maternal Mortality Ratio

Table 1: Comparison of maternal mortality related data in South-East Asia Region

	Maternal Mortality Ratio (maternal deaths per 100,000 births)		Average Annual change Rate (AAR%)	Overall **MMR** reduction(%)
	1990	2015	1990-2015	1990 - 2015
Bangladesh	569	176	4.7	69.1
Bhutan	945	148	7.4	84.3
DPR Korea	75	82	-0.4	-9.3%
India	556	174	4.6	68.7
Indonesia	446	126	5	71.7
Maldives	677	68	9.2	90
Myanmar	453	178	3.7	60.7
Nepal	901	258	5	71.4
Sri Lanka	75	30	3.6	60.0
Thailand	40	20	2.7	50.0
Timor Leste	1080	215	6.5	801
SEAR	525	164	4.7	69.0(-93-90%)

Source: WHO, UNICEF, UNFPA, World Bank Group and UNPD (MMEIG): Trends in estimates of maternal mortality ratio, 2015 Report – From a presentation made by the WHO Regional Office for the South-east Asia Region

Timing and causes of maternal deaths

According to the Myanmar National Housing and Population Census (2014), the highest percentage of deaths take place after delivery (38.5 per cent), followed by deaths during delivery (32.4 per cent), and, lowest of all, during pregnancy (29.1 per cent). This distribution of the timing of maternal mortality is consistent with the experiences of most countries.

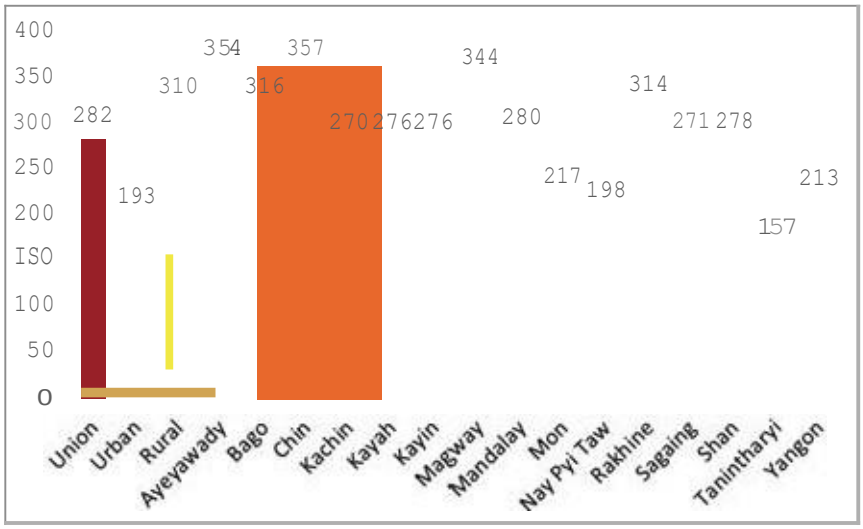
On further analyzing maternal mortality, 74 per cent were direct maternal deaths due to obstetric complications, and 26 per cent were indirect materrnal deaths, i.e. they were caused by existing medical conditions. The main causes of all maternal deaths were postpartum haemorrhage (PPH) (30 per cent);

pre-eclampsia/eclampsia (18 per cent); sepsis **(11** per cent) and abortions (6 per cent). This profile does not significantly differ from the past years. PPH has consistently remained the leading cause of maternal deaths. (Maternal Death Review Report, 2015)

Disparities

There are significant disparities in MMR between rural and urban areas and among States/Regions. The Census reported that the highest level of maternal mortality in terms of Maternal Mortality Ratio (MMR) is 357 deaths per 100.000 live births (Chin).while the lowest level is 157 per 100,000 live births (Tanintharyi) . Also, within the States/Regions. substantial variations were found. There are five States/Regions with maternal mortality levels greater than the Union average - all with MMR well over 300 maternal deaths per 100,000 live births. These are Chin State (357), Ayeyarwaddy Region (354), Magway Region (344), Bago Region (316) and Rakhine State (314).

Figure 2: Disparities in **MMR**



Source: Thematic Report on Maternal *Mortality, 2014 Population and Housing* Census

A review of the profile of maternal deaths in 2015 did not differ significantly from that of 2013 and 2014. The distribution by state/region has not changed; the highest number of maternal deaths were reported in Ayeyawady, Mandalay, Bago and Sagaing. When these absolute numbers are translated into the MMR, the states/regions reporting the highest MMR (exceeding the Union average) are Chin, Ayeyawady, Magway, Rakhine, Kayah, Kachin and Bago (Maternal Death Review Report 2015).

Further, maternal mortality levels in rural areas were found to be higher than in urban areas. An attempt was made to identify possible explanations of these differences. in particular socio-cultural factors.

Socio-cultural determinants

Six variables that refer to State/Region socioeconomic characteristics were correlated with the MMR. These factors relate to the woman's status in the family and in the community (education, occupation, income, social and legal autonomy). her family's status in the community (family income, land, education and occupation), and her community status (aggregate wealth and community resources). They are mainly indicators of economic and social disadvantage. All of them were found to be related to maternal mortality as expected, that is, maternal mortality levels are higher in those households with low socioeconomic status.

The Census also reported that maternal mortality levels are higher among women who live in households without motorized transport, with no electricity, with unimproved sanitation facilities and unimproved sources of drinking water. These differentials confirm the results of previous studies since they are indicators of barriers to access health care services. In addition, they are also indicators of the standard of living of households.

MMR corresponding to the age group 45·49 years was found to be highest; some 1,132.4 deaths per 100,000 live births. This level is about four times higher than the overall ratio. Although women in this age group experience neither the largest number of maternal deaths nor the highest percentage of deaths due to maternal causes, they do have the greatest obstetric risk. that is. the highest risk associated with each pregnancy. The Maternal Death Review Report 2015 noted that the 40 years plus age group contributed to 106 per cent of overall mortality and teenage pregnancies for 7.1 per cent.

The decline in MMR has occurred in consonance with an increase in the proportion of deliveries attended by skilled birth attendants. Thirty-seven per cent of live births in Myanmar are delivered in a health facility and 60 per cent of births are delivered by a skilled provider. The Demographic and Health Survey (DHS) (2017) reported that over 80 per cent of women receive antenatal care (ANC) from a skilled provider. but only 59 per cent received 4+ ANC visits.

The Maternal Death Review 2015 reported that more than half (54 per cent) of deceased women did not seek care on time because either she or her family members were not aware of the need to seek care (first delay). Notably a very small proportion (only 3 per cent) did not seek care because of the second delay, the inability to seek care due to barriers. commonly geographical and financial. A similar proportion of deceased women (3 per cent) experienced the third delay. These are women who had no barriers in reaching the point of care but did not receive appropriate care. There are also women who faced a combination of delays.

Inequities in coverage of health services. in addition to wealth quintiles, also occur across geographical terrain, urban-rural locations and based on the education status primarily of women. In summary, its the poor, those In rural areas and the uneducated who are being left behind. Therefore, the most relevant policy interventions are those that facilitate disadvantaged women looking for. reaching, and receiving health care. especially in remote areas of the country. The results from this analysis indicate that maternal health care services are not reaching all the population groups that they should: women with limited education, in low-income families and living in poor communities are more likely to be marginalized from accessing and receiving basic and emergency obstetric care (in addition to probably having a lower heallh status).

Newborn health

Almost in all settings, newborn health is closely associated with maternal health. the quality of care during pregnancy, delivery and postpartum period. Il has been evident that maternal mortality and morbidity have detrimental effects on the newborn. More than 80 per cent of all newborn deaths result from three preventable and treatable conditions- complications due to prematurity. intrapartum-related deaths (including birth asphyxia) and neonatal infections. Cost· effective, proven interventions exist to prevent and treat each main cause. Improving quality of care around the time of birth will save the most lives, but this requires educated and equipped health workers, including those with midwifery skills, and availability of essential commodities .

The newborn mortality for Myanmar was estimated as 26 per 1,000 livebirths in 2015. The principal causes of neonatal mortality (within 28 days of age) are prematurity, birth asphyxia and sepsis, including pneumonia. Deaths are most common in home-delivered babies in rural areas.

3.2 Other reproductive health issues

The importance of reproductive health and access to family planning in particular are now well recognized, to not only improve women's chances of surviving pregnancy and childbirth, but also to contribute to related issues such as gender equality, better child health, an improved response to HIV, greater education outcomes and poverty reduction.

Family Planning

The Demographic and Health Survey (DHS) (2017) reported that 52 per cent of married women are currently using a method of contraception: 51 per cent use a modern method and 1 per cent use a traditional method. Progestogen injectables are the most common method, used by 28 per cent of married women. followed by the contraceptive pill (14 per cent), and female sterilization {5 per cent).

Use of modern methods by married women is slightly higher in urban areas (57 per cent) than rural areas (49 per cent). Modern method use varies more dramatically by state/region: only 25 per cent of married women in Chin State are using a modern method compared to 60 per cent in Sago Region and Yangon Region. Use of modern methods is lowest among women with no education (38 per cent), while 57 per cent of women with more than secondary education are currently using a modern method; whereas it does not vary very much by wealth and is relatively high among women in all wealth quintiles (46 per cent to 56 per cent).

The public sector supplies over half (54 per cent) of modern contraceptive methods. The private sector supplies 29 per cent of methods, while NGOs provide 3 per cent and other sources provide 12 per cent of methods. About three-quarters of female sterilizations and progestogen injectables are provided by the public sector. The pill is provided primarily by he private medical sector (47 per cent) and shops (38 per cent). These two sources also provide most of the male condoms.

Sixteen percent of married women age 15-49 have unmet need for family planning: 5 per cent for spacing and 11 per cent for limiting. Demand satisfied by modern methods measures the extent to which women who want to delay or stop childbearing are actually using modern family planning methods. Three-quarters (75 per cent) of demand for family planning in Myanmar is currently satisfied in by modern methods. Women with no education are least likely to have their demand for family planning satisfied by modern methods (60 per cent).

Myanmar has committed to Family Planning 2020 (FP2020) in November 2013 and developed and is implementing a Costed Implementation Plan to meet its commitments in relation to policy, programme and service delivery. Myanmar has also set targets to increase the CPR to 60 per cent, reduce the unmet need to less than 10 per cent and Increase demand satisfaction from 67 to 80 per cent.

Miscarriage and its complications

In the Nationwide Cause-Specific Maternal Mortality Survey {2004-2005), abortion-related causes were the third most common cause of maternal mortality in Myanmar, estimated to contribute to neany 10 per cent of maternal deaths. The situation remains somewhat unchanged as a recent review of maternal

death registers in tertiary hospitals found that 12 per cent of maternal deaths were attributable to unsafe abortion with the abortion rate being highest among young women ages 15-19 years at 11.4 per cent.

Findings from the study "Pathways to post-abortion care study in Three Regions of Myanmar", reveals that three-quarters of women experiencing symptoms of postabortion complication delayed seeking treatment, mainly because they thought symptoms would resolve without further treatment (65 per cent) or felt symptoms were not severe (42 per cent), which indicates lack of knowledge on complications of abortion and severity of the symptoms. This same study also indicates that many women rely on themselves (93 per cent) or informal providers for the termination of pregnancy. Methods such as herbal concoctions (68 per cent) or foreign objects inserted into the uterus were used with only 26 per cent women reporting use of menstrual induct orn medicine (misoprostol) at home or with informal providers.

Adolescent and youth reproductive health

Adolescents have been referred to as the SOG generation• as a 10 year-old in 2016 will be 24 in 2030. The 2014 Census enumerated 14.4 million children in Myanmar, constituting 29 per cent of the total population; and 9 million youth, constituting a further 18 per cent of the total population. Adolescents are exposed to risks and diseases that affect the rest of their lives. This includes early and unplanned pregnancies. In low and middle income countries, complications from pregnancy and childbirth are a leading cause of death among adolescent girls.

The 2014 Census reported that at the Union level, 6 per cent of girls aged 15-17 are married, but in Shan State the proportion is 9 per cent and in Ayeyarwaddy and Nay Pyi Taw it's 8 per cent. The adolescent fertility rate at the Union level (live births to 15-19 year olds per 1000 females of the same age) is 33. Shan and Chin have the highest adoleSoCent fertility rates at 59 and 50 respectively.

The 2015-16 Demographic and Health Survey (OHS) reports a similar Adolescent Birth Rate – 36, and that most women in Myanmar have their first births in their 20s, teenage childbearing is relatively rare. Only 6 per cent of young women age 15-19 are already mothers or are pregnant with their first child. Teenage childbearing is most common in Kachin State, Shan State, and Chin State (11 per cent each); and is virtually non-existent among those with more than secondary education, while 19 per cent of young women age 15-19 with no education have begun childbearing.

Anaemia

Anaemia is one of major nutritional problems in Myanmar affecting all age groups. The 2015-16 OHS reported that approximately half of women of reproductive age were anaemic (47 per cent)- 38 per cent having mild, 8 per cent having moderate and 1 per cent severe anaemia. Pregnant women are more likely to be anaemic (57 per cent) than lactating women (48 per cent).

Small scale studies carried out among pregnant women, adolescents and children in different parts of Myanmar indicate that half the study population were anaemic and that hypochromic microcytic anaemia predominates. Where haemoglobin electrophores is was carried out on study subjects, haemoglobin A and E traits are common followed by beta thallassaemia trait.

Among women aged 15 to 49 years, DHS results indicate that 16 per cent of women are thin, 60 per cent have a normal body weight, and 25 per cent are overweight or obese. Overweigh Vobesity in women is more common in urban areas (33 per cent) than rural areas (21 per cent) and increases with

household wealth: only 15 per cent of women in the poorest households are overweight or obese compared with 35 per cent of women from the wealthiest households.

Health Literacy

Almost 90 per cent of Myanmar people (85 per cent of women and 91 per cent of men) are literate. Among the women and men age 15-49 interviewed in the DHS, 13 per cent of women and 12 per cent of men have no education.While the majority of women and men have attended primary or secondary school, only 10 per cent of women and 7 per cent of men have gone beyond secondary school. The education status.in turn, affects health literacy and communication strategies that will be employed.

With respect to reproductive health, almost half of women and men have been exposed to messages about family planning via the media. The internet (30 per cent among women and 38 per cent among men) and television (25 per cent each) are the most common sources of family planning messages (DHS 2017). Further. about 9 in 10 women and men age 15-49 have heard of AIDS. Knowledge of prevenbn measures is lower. Only 54 per cent of women and 62 per cent of men know that using condoms and limiting sex to an uninfected partner can prevent transmission of HIV. About half of women (51 per cent) and men (45 per cent) know that HIV can be spread by breastfeeding and that the risk of HIV transmission from mother to child can be reduced by the mother taking drugs during pregnancy.

Health System challenges and other issues

Myanmar has been implementing the primary health care approach and safe motherhood and reproductive health strategies adopted by the country have further strengthened the service delivery system,the national programmes and development of MNH intervention packages.

In many countries. poor-quality health services and inequities in accessing care are major obstacles to improving health outcomes. Gaps are also exacerbated by the worldwide shortage of qualified health workers: global projections to 2030 estimate that an additonal 18 million health workers will be needed to meet the requirements of the SDGs.

Findings from the Service Availability and Readiness Assessment (SARA) conducted in 2014. and annual Reproductive Health Commodity Security (RHCS) assessments.suggest that the scope and delivery of MNH interventions need strengthening - covering human resources, capacity building. supplies and equipment (S&E) and supervision.

The key points on health system challenges were noted in all six building blocks of the health system during a programme review meeting organized by MRH and WHO Country Office in August 2017. The main deliberations are as follows.

<u>Leadership and governance for MNH</u>

Improved coordination with related Ministries (e.g.. Ministry of Education, Ministry of Social Welfare, Relief and Resettlement, Ministry of Labour and Population and Immigration) are necessary to have a multi-sectoral approach and involvement to improving maternal health.

Harmonization with other Departments and Divisions under the Ministry of Health and Sports (e.g. Department of Human Resources for Health, Food and Drugs Administration, Budget and Planning Division, Department of Medical Services, Health Literacy Promotion Unit, School Health Division. National Nutrition Centre, National AIDS Programme, Expanded Programme for Immunization) and

professional societies and obstetricians and gynaecologists is needed for effective implementation of MNH interventions.

Lack of awareness on Gender mainstreaming, ie.bringing the perceptons,experience, knowledge and interests of women as well as men to bear on policy-making, planning and decision-making,was weak in different programmes.

MNH service delivery

For reducing maternal,newborn and child mortality, the focus has been on reaching higher coverage with key RMNCH interventions. Evidence-based interventions are often delivered with insufficient quality leading to deficiencies in maternal health care,for both routine and emergency care, as well as care provided to neonates and children. Implementation of guidelines was found to be weak. compliance with recommendations in Standard Operating Procedures (SOP) which affected quality. Furthermore, Guidelines need to be widely disseminated and made user-friendly.

Health information system

Collection of data on a regular basis and utilization of findings from surveys and reports lor policy development and programme planning are limited. Data is not disaggregated to allow equity analysis. Weakness in reporting,analysis and dissemination of findings at sub-national and national levels were noted. Furthermore, midwives are completing a multitude of reporting forms not only for HMIS but also lor NGOs working in MNH and other areas.

Human resources for health

A crucial component is teams of health care workers providing care during pregnancy, childbirth and postpartum period, a continuum along the life cycle as well as continuum along service delivery. Delays in filling vacant posts affects the 24/7 requirements lor maternal and newborn care, particularly in responding to emergencies.

Curricula in pre-service training do not emphasize "soft skills such as effective communication, problem solving and resourcefulness, and critical thinking. While increasing emphasis is placed on competency-based training,a post-training follow-up mechanism is needed lor doctors and midwives on emergency obstetric care.Monitoring and supervision needs to be systematic and reinforcing and retaining skills part of the supervision.

Weakness in township planning and in financial management skills was also mentioned. Poor response to recommendations from review and evaluation process and translation into action in future plans and implementation.

Financial security for MNH service delivery

While the government budget or health has increased, the allocation of government budget lor specific reproductive health (RH) programmes is minimal and not in accordance with proposed activities in the RH strategic plan. In addition. while the budget or commodities has increased, operational costs such as for supervisory activities is deficient. There is often non-alignment between donor interest and available financial resource and priorities set by the national programme.

Quality medicines, equipment and appropriate technologies lor MNH care

Insufficient supplies and stock-outs of commodities and drugs affected the implementation of programmes,with improvements needed in supply chain management, storage ,and timely distribution. Gaps in the Essential Medicine List was also noted.

Equity

While geographical coverage of the MNH programme is extensive, there are challenges in providing coverage in hard to reach and conflict areas and to ensure the same standards of care.

Community engagement

Standardized messages for communities on maternal and newborn health is needed. There is insufficient distribution of IEC materials, particularly in major ethnic languages. Language barrier can affect communication between service providers and clients/patients in areas where ethnic minorities reside.

Auxiliary Midwives (AMWs) and Community Health Workers (CHWs) are important as part of the effort to strengthen the delivery of primary health care services, not least in underserved or hard-to-reach areas. Myanmar has experienced a proliferation of volunteers working under different modalities and- to some degree- with different approaches and conditions.

The main implication of these findings is that the physical availability of health services alone is not enough to overcome the barriers to accessing health care. There are also economic,social and cultural obstacles. Hence. policies directed at reducing maternal mortality should also consider these factors. Policies should be directed mainly at the poor, uneducated and women of low status, who live in deprived communities. These policies should aim to increase these women's access to antenatal and emergency obstetric care.

4. Goal and Strategic Objectives

Goal

To reduce maternal mortality ratio from 282 per 100,000 live births (2014) to less than 91 per 100,000 live births by 2030

To reduce neonatal mortality rate from 26 per 1000 live births (2015) to less than 12 per 1000 live births by 2030

To reduce the stillbirth rate from 20 per 1000 births (2009) to less than 10 per 1000 births by 2035

To reduce the prevalence of anaemia in pregnant women from 57 percent to 28 percent

To reduce the adolescent birth rate from 33/1000 births (2015) to less than 10/1000 births by 2020

The recent World Health Organization (WHO) publication, Strategies *toward ending preventable maternal mortality (EPMM),* establishes a supplementary national target that no country should have an MMR greater than 140 per 100 000 live births,and outlines a strategic framework for achieving these ambitious targets by 2030.

Overall objective

The overall objective is to address causes of maternal mortality and morbidities and related disabilities through identification of the most important causes of maternal mortality, their determinants and effective interventions to address them. Strengthening health systems for facility-based care and community-based primary care and effective referral systems will be a major contributory factor.

Major causes of maternal mortality

Based on the national surveys such as the Population and Housing Census and Demographic and Health Survey, Public Health Statistics Report, Maternal Death Review reports, reviews of Maternal

Deaths and "Near Miss at teaching hospitals, the most important causes of maternal mortality and the critical issues that need to be addressed in the EPMM Strategy have been identified. Maternal deaths result mainly from hemorrhage (postpartum and antepartum), hypertensive disorders, sepsis and unsafe abort on. Indirect causes (that include non-obstetric medical and surgical conditions) also contribute toward the maternal mortality burden. Myanmar is undergoing the *obstetric transition* as the causes of death shift from direct causes and communicable diseases to a significant proportion of deaths from indirect causes and chronic diseases, particularly in cities.

Furthermore, complications of preterm birth, birth asphyxia, intrapartum-related neonatal death and neonatal infections together account for a large proportion of newborn mortality. Therefore, the time of childbirth and the period immediately after birth are particularly critical for maternal, fetal and neonatal survival and well-being. Effective care to prevent and manage complications during this critical period is likely to have significant impact on reducing maternal deaths, stillbirths and early neonatal deaths- a triple return on investment.

Within this critical period, quality of care improvement efforts would target essential maternal and newborn care and additional care for management of complications that could achieve the highest impact on maternal.fetal and newborn survival and well-being.

Strategic objectives

4.1 Address causes of maternal mortality and morbidities and related disabilities

Priority Strategies

4.1.1 Implement the package of essential MNH interventions as defined in the Essential Health Package under the National Health Plan

Scaling up of evidence-based MNH interventions

Scaling up of evidence-based interventions across target populations is the key to improving health status. In 2017, an Essential Package of maternal and newborn (MNH) Interventions was developed based on Global Strategy recommended life-course interventions and WHO evidence-based recommendations. The interventions are prioritized based on the major causes of mortality and therefore to prevent maternal deaths, include antenatal care, care during labour and childbirth provided by skilled health personnel (doctors, midwives and nurses). emergency obstetric care (including cesarean section, manual removal of placenta, and blood transfusion), postnatal care, management of post-abortion complications, antibiotics and supportive treatment for sepsis, and treatment of indirect medical and surgical conditions (See Annex 4). A multi-stakeholder workshop to prioritize these interventions led to their inclusion in NHP. Further, these were categorized by levels of service delivery starting from the community up to the State/Regional levels. Following which a list of supplies and equipment for the Essental Package of MNH interventions were identified (See Annex 5).

The Essential Package of evidence-based MNH interventions will be implemented in State/Regions down to township and community levels. While the package of interventions employs a continuum of care approach across levels of care, the major causes of maternal mortality in Myanmar are targeted: i.e. prevention and treatment of postpartum haemorrhage. detection and management of pre-eclampsia and eclampsia, diagnosis and management of difficult labour, observation of infection control measures and prevenbn of unplanned pregnancies and management of post-abortion complications.

Interventions to bring down neonatal deaths will be adopted, i.e. infection prevention practices, Kangaroo mother care. use of low cost incubators. new born resuscitation, early initiation of breast feeding and exclusive breast feeding for 6 months -etc. There will be a focus on ANC for prevention of congenital syphilis, neonatal tetanus, mother to child transmission of HIV, identification of risk factors for mother and baby and in-utero transfer of high risk pregnant women to hospitals with facilities for EmONC. The improved coverage and quality of care around the time of birth will also contribute to reduction of still births, 50 per cent of which occur during the intrapartum period, and preventing disability.

In brief, essential care is obligatory during antenatal period, childbirth and postpartum complemented by additional care for emergencies throughout the same period. Some interventions are already being implemented. However. scaling up is needed to deliver the full complement of interventions and across geographic locations and different segments of the population. The specific needs of adolescents and young people, will be addressed as well as women with disabilities. In addition to expanding coverage to reach vulnerable populations, measures will be taken to improve quality of care. (See *Section 6. Address inequities in access to and quality of sexual, reproductive, maternal and newborn health care)*

4.1.2 Address maternal morbidities such as nutritional problems (anaemia, underweight and overweight) and medical problems (e.g., heart disease, diabetes and infections)

Many factors influence a mother's nutritional status during pregnancy. The mother's own health before conception, her health during pregnancy and her dietary choices will determine how much she eats and the nutrients available for the growing fetus. A mother who is underweight prior to becoming pregnant and maternal malnutrition during pregnancy puts her baby at higher risk for complications.

Effective communication with pregnant women about diet and healthy eating – including providing information about food sources of vitamins and minerals, and dietary diversity – is an integral part of preventing anaemia and providing quality ANC. Before pregnancy and during pregnancy, a pregnant woman needs 400 micrograms of folic acid daily to help prevent major birth defects such as neural tube defects. Daily oral iron and folic acid supplementation with 30 mg to 60 mg of elemental iron and 400 g (0.4 mg) folic acid is recommended for pregnant women to prevent maternal anaemia. puerperal sepsis. low birth weight and preterm birth. Vitamin 81 will need to be provided in areas where the population is thiamine-deficient and calcium supplementation in populations with low dietary calcium intake.

To ensure a life course approach, prevention and treatment of anaemia will be linked to ongoing school health nutritional programmes.

Medical disorders in pregnancy is discussed below.

4.1.3 Implement screening and preventive practices for/and treatment of critical medical and obstetric conditions at tertiary at State/Regional Hospitals

Manage medical conditions in pregnancy using a team approach

Pregnancy in women with pre-existing medical is becoming increasingly common as the treatment of many chronic conditions improve. Women with underlying medical conditions are at increased risk of developing complications in pregnancy and may be associated with significant maternal and fetal morbidity. Common medical conditions are hypertension, kidney disease, cardiac disease and diabetes mellitus which can pose complex management issues and women (and their families) should be seen

since the pre-<:onceptual period by a multidisciplinary team. Women with medical problems that preclude safe pregnancy should be offered safe, effective and appropriate contraception. However, many women present with unplanned pregnancy.

The care will need to cover preconception counselling, specific management during antenatal, childbirth and postnatal period, management of obstetric and newborn emergencies including care of critically ill women. Intensive care may be necessary for poorly controlled or women presenting late in pregnancy. Care of the sick newborn will need to be strengthened in tandem. A multi-disciplinary team approach will be employed to manage women presenting with medical and surgical complications during pregnancy.

Guidelines produced by professional societies and the Department of Public Health, Obstetrics and Gynaecology Management Guidelines are based on WHO recommenda tions, and guidelines developed Royal College of Obstetrics and Gynaecology, among others, will serve as references and standards for care of women with medical disorders in pregnancy. Newborn and Paediatric Management Guidelines developed along similar lines will serve a similar purpose.

4.1.4 Strengthen referral systems and response system to manage complications and life-threatening emergencies with coordination across time, settings and disciplines, and between facilities

The proportion of major direct obstetric complications throughout pregnancy, delivery and immediately postpartum is estimated to be 15 per cent of expected births. Further, maternal mortality occurs most commonly during and in the first 48 hours after delivery, a majority of these may be due to unpredictable obstetric emergencies. Similarly, a majority of neonatal deaths occur on the day of birth, followed by the first week and then the first month of birth, the babies of mothers with complications experiencing difficulties as well. Therefore, a patient who has a severe life threatening illness, or is suspected to have a life threatening illness needs both diagnosis and treatment by a team of skilled health professionals at a health facility .usually the Township Hospital or a Station Hospital. To improve survival rates as well as preventing potential complications , possible barriers from the timely referral of a suspected medical emergency will need to be removed.

Lack of transport and financial constraints play a crucial role in the failure of referral for obstetric emergencies in most developing countries. Rural areas have few roads which are difficult to pass, especially during the rainy season. Moreover, some of the lower level health facilities are far from the referral hospitals making transportation difficult. The transportation related costs of reaching the referral hospitals can be substantial, particularly in an emergency situation. Beyond transport costs, the cost of care, accommodation for accompanying people, food, and sometimes medicines can be of major concern.

Strengthen and/or establish emergency referral systems

Demand side financial support has been provided in townships in states and regions such as Ayeyarwaddy, Magway and Chin. An increase in the numbers of referrals, a steady decline in the maternal case fatality rate and a steep decline in the neonatal case fatality rate followed by a levelling off, have been reported. These changes are possibly due to raised awareness of danger/risk signs at the community level, awareness that support for referrals is available and therefore lowered financial risks, and readiness of community to organize transport. Therefore, the NHP proposes that a government-led emergency referral is developed and adopted by all partners throughout the country, building on experiences of systems that have been used in different parts of the country.

In organizing referral mechanisms, analysis at the local level to determine where emergency transport vehicles should be prioritized, and identifying functioning hospitals and others that should be upgraded to deliver more life-saving care. Local resources and gaps as well as current referral practices and attitudes about referral among health workers and the community will need to be considered. The information gathered can be further discussed during a consultative process with stakeholders to develop localized referral interventions. Functioning BEmONC and CEmONC facilities as per defined norms will need to be available and able to deal with maternal and newborn emergencies. In addition to the obstetric and neonatal team and the requisite supplies and equipment, supportive services such as blood transfusion and laboratory services are critical.

4.1.5 Prevent unwanted pregnancies and address unmet need of contraception

The Safe Motherhood Initiative. a global campaign to reduce maternal mortality, launched in 1987, identified family planning as one of four strategies- with antenatal care, safe delivery, and postnatal care - to reduce maternal mortality in developing countries. Increasingly, family planning (FP) is being recognised as one of the most cost-effective way to improve maternal health for its direct and indirect effects on maternal mortality.

However, there are several factors affecting utilization of FP services, including accessibility of FP services and health facilities, availability and capacity of service providers, availability of commodities, lack of quality and process of managing client's expectation social and cultural beliefs.

Continue efforts to expand contraceptive method mix

On-going activities to support family planning will be consolidated - ensuring correct information about contraception. strengthening family planning provision in public and private sectors and NGO clinics, community-based distribution by midwives and auxiliary midwives {AMWs).and social marketing to promote informed choice for women, men and adolescents and youth. Preventing unintended pregnancy in adolescent girls is a major component of efforls to improve maternal and newborn health as very young mothers and their babies face greater risks from pregnancy and birlh.

While the method mix will be expanded.the availability of long acting reversible contraception (LARC) - IUDs and contraceptive implants and post-partum FP will be enhanced (refer to FP 2020 Casted Implementation Plan). Commodity security will be ensured through strengthening the logistics management information system for medicines, equipment and other supplies for MNH care. (See *3. Strengthen health systems to respond to the needs and priorities of women and girls)*

4.1.6 Strengthen post-abortion care/management of post abortion complications

To reduce aborlion-related maternal deaths, it is essential that awareness on sexual and reproductive health and health care is raised, unplanned pregnancies are prevented through effective contraception, and quality post-aborlion care is provided.

Provide quality post-abortion care

Departments under the Ministry of Health and Sports collaborate to improve the quality of PAC in public facilities in three regions: Magwe, Mandalay, and Yangon where there are high abortion case load through ensuring that providers use appropriate technology for PAC, i.e. vacuum aspiration and/or medical management, based on evidence around safety, acceptability and cost will replace currently used outdated methods such as dilatation and curettage. The use of MVA and medical methods will be expanded.Post-abortion counselling and contraceptive provision will be strengthened to prevent repeat abortions.

1. Address causes of maternal mortality and morbidites and related disabilities

11 Implement the package of essential MNH interventions as defined in the Essential Health Package under the National Health Plan
1.2. Address maternal morbidities such as nutritional problems (anaemia, underweight and overweight) and medical problems (e.g., heart disease, diabetes and infections)
1.3. Implement screening and preventive practices for/and treatment of critical medical and obstetric conditions at tertiary at State/Regional Hospitals
1.4. Strengthen referral systems and response system to manage complications and life-threatening emergencies will! coordination across time, settings and disciplines. and between facilities
1.5. Prevent unwanted pregnancies and address unmet need of contraception
1.6. Strengthen post-abortion care/management of post abortion complications

4.2 Ensure universal health coverage for comprehensive sexual, reproductive, maternal and newborn health care

Universal Health Coverage (SDGs-Goal 3) is to provide all mothers and newborns access to the health care system with good quality and financial protection. Universal Health Coverage (UHC) is defined as "all people receiving quality health services that meet their needs without being exposed to financial hardship in paying for the services". This definition encompasses two equally important dimensions of coverage :reaching all people in the population with essential health care services .and protecting them from financial hardship due to the cost of health *tare* services. Particular emphasis must be plated on ensuring access without discrimination,especially for the poor .vulnerable and marginalized segments of the population. The following pibrity strategies will be adopted.

Priority Strategies

4.2.1 Implement the package of evidence-based RMNCAH interventions for essential and comprehensive MNH care

The National Health Plan has determined the set of essential RMNCAH interventions covering services and commodities , as part of the Essential Package of Health Services (EPHS). The package of essential RMNCAH interventions will be implemented in a phased manner . The coverage will be later expanded to cover the entire country and service packages extended to Intermediate and Comprehensive Package of Health Services. A system to monitor the implementation of the Essential Package of MNH interventions and supportive supervision of health staff implementing this MNH package at institutional and field level will be estab ished at different service delivery levels.

4.2.2 Ensure health financing for universalcoverage of MNH interventions

NHP in its strategic planning includes resource mobilization – government spending for health and development assistance. Financial protection and reducing out-of-pocket expenditure is planned through supply-side investments in primary care facilities and brining services closer to the people. On the demand-side, risk pooling mechanisms will need to be developed to help improve affordability of care and address the substantial barriers to seeking care, especially among the poor and vulnerable.

Financing mechanisms to minimize out of pocket expenditure have been explored. These include fee exemption/free services for the poor and demand-side ' financing interventions that are designed to promote health by providing cash or vouchers to users to offset some of the financial costs of using or getting to maternity care services.

Demand side support for travel and reimbursement of hospital costs

Financial barrier is one of the persistent demand-side factors that affect timely utilization of health services in low and middle income countries. From 2013, the MDH declared that all maternal and child emergencies were to be treated free of cost. Nevertheless, there are still other direct and indirect costs associated with hospitalization.

Health Equity Funds (HEFs) are a social health protection (SHP) and demand-side financing mechanism that are designed to remove financial barriers for the poor to access public health services and reduce financial hardship due to health care. Support to poor patients includes transportation reimbursements, food allowances for care takers and payment for services to health facilities (case based). The GAVI HSS Fund was used by the Ministry of Health since the end of 2011 to support the referral of maternal emergencies amongst poor mothers through the Hospital Equity Fund. The support has now expanded to 115 townships in an states and regions. Maternal referrals were supported (cost of transport, food and hospital care costs for the mother and a caretaker) in six Delta Townships as a continuation of the JIMNCH strategy 2010 to 2012, after the 3 MDG Fund was established in 2013. The 3MDG Fund continued the support in other states and regions including the Shan States.

The ways and means in which partners reimbursed costs also varied: some supported these through the development of Village Health Committee (VHC) revolving funds and some with reimbursement of funds on receipt of documents relevant to the referral, both at the community level and at the hospital level and some linked the payment to a judgement by the hospital as to the economic status of the woman. While the financial reimbursement did not completely offset total cost associated with treatment. the referral programme significantly reduced out of pocket expenditures.

Other mechanisms to increase uptake of maternity services: conditional and unconditional cash transfers and voucher schemes will be explored. For these incentives to succeed in reducing the inequalities in maternal health outcomes, the capacity of local health systems to provide care to women will be paid attention to - this will include emergency transport, round-the-clock opening hours and clearly stated guidelines for onward referrals. Procurement systems for essential medicines may need to be included within programme designs. Performance-based incentives and investments can improve working conditions for staff to improve quality of care and encourage women to seek maternity care will need to be considered.

4.2.3 Increase fiscal space and budgetary allocation for RMNCAH

As proposed in the National Health Plan. MoHS will endeavor that fiscal space is increased and consider internal allocation of the health budget. MoHS and related ministries will take steps forward in conformity with the principle of progressive realization to implement the national health insurance in a phase-wise manner.

Implement advocacy and communications strategy

An advocacy strategy for policy-makers and decision-makers at different administrative levels will be developed and implemented, which is evidence-informed with persuasive points grounded in the burden of disease and the population affected, to make the case to increase budgetary allocation for ending

preventable maternal mortality. This will be in tandem with development of State/Region policy briefs which will be context specific.

2. Ensure universal health coverage for comprehensive sexual, reproductive, maternal and newborn health care

21 Implement the package of evidence-basad RMNCAH interventions for essential and comprehensive MNH care

22 Ensure health financing for universal coverage of MNH interventions

23 Increase fiscal space and budgetary allocation for RMNCAH

4.3 Strengthen health systems to respond to the needs and priorities of women and girls

Health system strengthening will include both the "hardware" (including ensuring the availability of essential health infrastructure, amenities and commodities) and the "software" (including attention to organizational development and management, prioritizing respectful care norms and values, ensuring mechanisms for participation and community engagement and improving transparency).

Priority Strategies

4.3.1 Ensure leadership and governance for **MNH**

The SDGs and NHP highlight a multi-sectoral approach; interventions across core sectors to address health determinants. In the areas of leadership and governance. increased cooperation with other sectors (such as education. social welfare, finance. mobile telecommunications technology and private health care services) is needed to promote good reproductive and maternal health outcomes. and to realize the potential impact of health care financing mechanisms to strengthen the system.

Collaboration with all concerned departments and programmes of the MoHS (human resources, child health, nutrition, immunization, communicable and non- communicable disease, water and sanitation, etc) will be improved to ensure continuum of care throughout the life cycle and at the level of the health system to deliver essential interventions to prevent maternal mortality. MRH Division will ensure that the Strategy for Ending Preventable Maternal Mortality is complementary to the National Strategic Plan for Newborn and Child Health (2015-2018). and other related plans such as the Costed Implementation Plan to meet FP 2020 Commtments and Five Year Strategic Plan for Young People's Health (2014-2018).

The RMNCAH Technical and Strategy Group (TSG) will be strengthened with participation of departments of the MoHS and development partners working in the area of maternal and child health to provide oversight to implement the EPMM Strategy. Central and state and regional and township health departments' processes on RMNCAH programming planning. implementation, review and monitoring will be supported. Programme planning and review will be mainstreamed at national, state/regional and township levels.

A survey was conducted by the Regional Office for the South-East Asia region to assess RMNCAH policies in 2016. It was found that while certain clinical practices for emergency obstetric care are carried out in Myanmar, these are not compulsory. Therefore, these policy gaps will need to be addressed.

4.3.2 Streamline **MNH** service delivery

Strengthen service delivery mechanism

The service delivery mechanism for antenatal. childbirth and postnatal care per WHO guidelines will be strengthened at all levels. Priorities in the area of service delivery include, expanding health promotion and preventative services, in particular nutrition, and improving integrabn of prevention, screening, and treatment for infectious and non-communicable diseases (e.g. HIV, malaria, cardiovascular disease) into routine RMNCAH care.

Ensuring basic MNH service availability and readiness at the facility level (presence of competent staff, essential quality maternal and newborn health commodities and equipment) with a particular focus on: upgrading of rural and sub rural health centers, strengthening of station and township hospitals and setthg up maternity waiting homes (supply side). Basic amenities include an adequate number of beds, WASH, rooms or dividers that ensure privacy, communication and computer equipment with good connectivity and access to emergency transportation. Support services to provide essential and emergency care for women and newborn, particularly those who are critically ill, will be strengthened.

Advocate for institutional delivery and pilot incentive schemes to promote institutional delivery for vulnerable populations

The three delays: delay in 1) deciding to seek medical care, 2) reaching health facilities and 3) receiving adequate obstetric care, are stl contributing to maternal dealhs in Myanmar. Most maternal dealhs occur during labour, delivery, or the first 24 hours postpartum, and most complications cannot be predicted or prevented. The time of childbirth and the peiod immediately after birth are particularly critical for maternal, fetal and neonatal survival and well-being. Identification of problems will be sooner In case of an Institutional delivery as it is carried out in equipped health facilities that would be able to provide as a minimum basic emergency obstetric and newborn care.

The 37 per cent facility delivery rate reported in DHS needs to be further improved through advocacy to decision makers as well as communication to the public of the benefits of institutional delivery and incentive schemes to mothers. Ensuring service availability and readiness at health facilit es would target essential maternal and newborn care and additional care for management of complications that could achieve the highest impact on maternal, fetal and newborn survival and well-be ing. In remote areas Maternity Waiting homes (MWH) could contribute to increasing institutional delivery. (See *Section 6: Harness the power of communities and civil societies to improve the demand and acceptability of* seNices)

While attention has been focused on increasing facility-based care, it is equally important to focus on community-based primary care and effective referral systems, ensuring seamless coordination across time, settings and disciplines, and between facilities.

Institute preconception care

Preconcepbn care - implementing a package of promotive, preventive and curative health interventions is shown to have been effective in improving maternal and child health. Preconception care is the provision of biomedical, behavioural and social heallh interventions to women and couples before conception occurs.

Certain aspects of preventive and promotive interventions have been carried out in Myanmar, e.g. nutritional - Information, education and counselling, supplementing iron and folic acid; advice on

tobacco use: promoting safe sex practices through individual, group and community-level behavioural interventions for STI and HIV prevention; promoting condom use for dual protection against STIs and unwanted pregnancies; family planning to prevent too-early, unwanted and rapid successive pregnancies; educating women and couples about the dangers to the baby and mother of short birth intervals; and building community support for preventing early pregnancy and contraceptive provision to adolescents. In addition, screening and management of anaemia and diabetes; and screening and referral or treatment for STIs and HIV are conducted. However, the coverage and scope of care provided varies on the different levels of health facilities.

As preconception care aims at improving the health status. and reducing behaviours and individual and environmental factors that contribute to poor maternal and child health outcomes, it will be strengthened through health education and behavioural change interventions at community and facility levels. *(Link to 6: Harness the power of communities and civil societies to improve the demand and acceptability of* seNices)

4.3.3 Strengthen the health information system

Monitoring of MNH interventions will be strengthened in collaboration with Health Management and Information System Division for the availability of up-to-date information for monitoring, planning and decision-making in MNH care, as well as communication and coordination between levels of care, and between providers and patients. (See *Section 5. Ensure accountability to improve quality of* care *and equity).*

4.3.4 Ensure adequate numbers of competent teams of health care workers provide care during pregnancy, childbirth and postnatal period

Midwifery is a key element of RMNCAH care and midwifery practice has contributed to significant reductions in maternal and infant mortality. MRH will collaborate with Department of Human Resource for Health and professional societies to address education, deployment, retention, and motivational efforts of health workers in particular midwives, including incentive schemes.

Human resource plan for RMNCAH team

Challenges in MNH service delivery stem from a limited number of competent midwives and inappropriate distribution and insufficient capacity of providers due to deficiencies in training and education. A human resource plan for RMNCAH team will be developed so that staffing levels for each facility providing maternal and newborn care will guarantee that services can be provided on a continuous basis, 24 hours a day, seven days a week. In line with the Human Resource for Health Policy, health care providers (doctors, midwives, and other skilled maternity care providers, including specialists) will be deployed in adequate numbers to meet population needs. Locally based recruitment and deployment of health workers will help to ensure understanding of the local context and languages. Team work is essential: teams in first and second-level referral hospitals should be multidisciplinary and include specialized obstetric, paediatric and anaesthetic staff to manage maternal and neonatal complications.

Strengthen competency based training programmes

On-going work to identify gaps in training programmes will continue and midwife education programmes will be regularly reviewed and updated to include the latest knowledge and evidence. Adherence to high-quality clinical practice guidelines. when combined with simulation-based training. can improve providers' knowledge. clinical skills, attitudes, and women-centred approaches. Competency based

training for ANC, safe childbirth, PNC, immediate newborn care and immunization, health education including nutrition, birth spacing services, post-abortion care according to national and ASEAN guidelines, in pre-service and in-service training will be developed and implemented. Faculty development to strengthen midwife teachers who are competent in all aspects of midwifery practice and education, including teaching and learning strategies will continue.

Continuing professional development through in-service training on MNH, with a focus on QoC streamlined. This includes sensitisation. raising awareness of health workers to respectful care and companion at birth.

Provide appropriate regulatory support

The Nursing and Midwifery Council will provide appropriate regulatory support for midwives to practice the full scope of emergency obstetric and newborn care; and establish norms for the regulation of health midwives and set standards with regard to their education and core competencies. Monitoring and feedback systems will be strengthened at primary care level by District and Township Training Teams and plans for mentoring by academic institutions, professional societies, retired/formal civil servants will be developed.

Utilize community-based volunteers

To improve coverage of and access to basic health services, including maternal and newborn health (MNH).family planning. and nutrition. MoHS is striving to increase the numbers of skilled providers. However, human resources for health remains one of the most critical system challenges. In this context, the appropriate role of community health workers, in particular auxiliary midwives in reducing maternal, infant, and under-five mortality has been underscored. In this regard, task sharing for critical MNH interventions in hard-to reach areas may need to be instituted; reviewing responsibilities of AMWs and their reimbursement and replenishing and providing basic supplies and commodities. (See *4: Harness the power of communities and civil societies to improve the demand and acceptability of* services)

4.3.5 Ensure financial security for **MNH** service delivery

It is important to have adequate and sustainable resources for maternal and newborn health, to end preventable maternal and neonatal mortality and reduce maternal and neonatal morbidity and stillbirths. Acceleration in mortality reduction is dependent on health investments, especially to address infrastructure and human resource. The following will be highlighted:

- Identify a separate budget line for RMNCAH with a focus on EPMM
- Mobilize resources from development partners for RMNCAH interventions
- Strengthen collaboration with development partners and other stakeholders to generate additional resources to strengthen MNH services and address inequity.
- Address EPMM as a priority strategy in the Global Financing Facility and Investment Case

4.3.6 Ensure high quality medicines, equipment and appropriate technologies for **MNH** care

The essential equipment and commodities list at each level for MNH has been developed. It is important that the RH/MNH essential medicines list is aligned with the EPHS for NHP implementation.

Efforts to strengthen the logistics management information system, improve the availability of logistics data and RH/MNH commodity security will continue. The Reproductive Health Commodity Logistics System (RHC-LS) standardizes storage, distribution, quantification and procurement practices at

township, state/region. and central levels while strengthening management and coordination structures '.Adding a Quality Improvement Team (QIT) component to the RH LMIS system ensures that data and information provided by the system via web-based database software called "Logistimo" are accurate,and health officials at different levels can review these data and information for appropriate decision making. The system is aligned with the MoHS's National Health Supply Chain Strategy for medicines and medical supplies (2015-2020) and supports the National Health Plan (2017- 20121) in the area of the development of capacity to gradually move to a 'pull system' as per local needs.

By the end of 2016, the system was expanded to 72 townships in six states and regions. and more than 4,000 basic health stall who received the training have been using LMIS forms by following the well-defined standard operating procedures. It is envisaged that the system will cover the entire country by 2018.

It is proposed in NHP that the National Supply Chain Task Force (NSCTF) will develop a centralized procurement system and existing parallel systems will be integrated into one LMIS, starting with essential medicines and reproductive health products. and subsequently expanded to also include vertical programmes.

The interventions to save maternal and child lives are the same for all settings. It is the strength and resilience of the health system that determines the coverage. equity and quality of service delivery. which may be different in different settings with its own unique characteristics and challenges. Each one of the building blocks of the health system (namely. infrastructure. human resources. service delivery,commodities, finances .governance and information system) has to be in place to make an impact.

3. Strengthen health systems to respond to the needs and priorities of women and girls

3.1. Ensure leadership and governance for MNH

3.2. Streamline MNH seNice delivery

3.3. Strengthen the health information system

3.4. Ensure adequate numbers of competent teams of health care workers provide care during pregnancy, childbirth and postnatal period

3.5. Ensure financial security for MNH seNice delivery

3.6. Ensure high quality medicines. equipment and appropriate technologies for MNH care

4.4 Harness the power of communities and civil societies to improve the demand and acceptability of services

Greater emphasis needs to be placed on health and social determinants requiring more community engagement. The SDGs and NHP highlight equity:a focus on reaching the most vulnerable and leaving no one behind.

The interventions aim *to* increase access *to* timely and appropriate health care. to address underlying determinants of health, to address gender and equty and to achieve community participation in programme planning and in improving services :addressing the different factors that affect use of care

[1] Myanmar receives support from UNFPA Global Programme of RH Commodty Security

and the ability of women and families to improve care practices in the home. Any intervention designed to increase access to health services should be implemented in tandem with strategies to improve health services.Where the quality of services is poor.women may understandably choose not to use them despite mobilization efforts.

Priority Strategies

4.4.1 Implement communication strategies to engage communities

A communications strategy to gamer the support of the general public. the news media, development partners,women's organizations, and religious and community leaders for maternaland newborn health will be developed and implemented in collaborattion with the Health Literacy and Promotion Unit. Effective communication strategies are needed to empower and engage families and community to take an active part in improving their own health outcomes. Health promotion and preventative services through developing and implementing communication strategies will be expanded for ending preventable maternal deaths, including using technologies such as social media and Mobile Apps. The messages and media will need to take into account the low health literacy levels of certain segments of the population and the different major ethnic languages.

4.4.2 Increase community awareness and engagement on maternal and newborn health issues

Increase awareness on health matters related to maternal and newborn health issues among individuals, families and communities through equipping these groups with knowledge and capacities to promote good maternal and newborn care in the community.

- Conduct demand generation for institutional deliveries
- Strengthen links between community, AMWs and MW and the health facilities using approaches - transport, prevent delays
- Galvanise community support for midwives and auxiliary midwives
- Establish/strengthen social support networl<s in the community and link with the health system
- Strengthen male involvement in antenatal, delivery, postnatal care (including breast feeding support) and family planning
- Promote community involvement in Matemal and Child Death reviews

4.4.3 Strengthen the role of community volunteers,auxiliary midwives

For the purpose of ending preventable maternal and neonatal mortality,and in the context of shortage of MWs in hard-to-reach areas,AMWs will continue to play a role in health promotion and prevention activities, distribution of commodities, diagnosis of complications, and assistance in referrals. The level of training AMWs receive, whether they are supported by a nongovernmental organization or the government and whether they are paid or volunteer. varies widely within the country. Training and supervisory systems are often deficient for AMW.

Shortages in human resources and expanding populations have given relevance to training AMWs in more complex tasks. MoHS will define the competencies and skills required for the delivery of services and interventbns included in the Basic EPHS; provide motivation through standardized financial and non-financial incentives: and build in the potential for employment and career development. Further,to realistically meet the community needs. midwives will need to provide continuous supervision. and support.

Task shifting may allow AMWs to receive training and perform interventions that might have been

performed by midwives. In remote areas, in the absence of a skilled birth attendant, AMWs have been trained to administer misoprostol (600 micrograms by mouth) for prevention of post-partum haemorrhage.

Mobile technology will be considered for a variety of purposes, from helping AMWs correct timely, and precise health data to providing them with information and reminders about health care practices and protocols via text messaging.

On the other hand, community ownership of community volunteers and auxiliary midwives will be encouraged as a *way* of recognition of their contribution to improve MNH in their areas.

4.4.4 Employ context-specific community interventions

Communities and service users have a critical role in identifying their own needs and preferences, and in managing their own health. Perspectives of women. their families and communities, on the quality of maternity care services influence decisions to seek care and are essential components for creating a demand for and access to quality maternal and newborn services. Community engagement, therefore, is an important aspect to be considered and may *vary* depending onhe context

Birth and complication preparedness -A birth preparedness and complication readiness (BPCR) plan contains the following elements: he desired place of birth; the preferred birth attendant; the location of the closest facility for birth and in case of complications: funds for any expenses related to birth and in case of complications: supplies and materials necessary to bring to the facility; an identified labour and birth companion: an identified support to look after the home and other children while the woman is away; transport to a facility for birth or in the case of a complication; and identificabn of compatible blood donors in case of complications. Every pregnant woman will need to be counselled by MW and encouraged to have a BPCR plan with the help of her family and community.

Partnership with TBAs - Due to their cultural and social acceptability, knowledge and experience, TBAs are considered an important ally for health education and social support and can provide a positive link between women, families, communities and the formal health care system.

Women's groups

The implementation of facilitated participatory learning and action cycles with women's groups should focus on creating a space for discussion where women are able to identify priority problems and advocate for local solutions for maternal and newborn health.

Community participation in Quality Improvement programmes, MDSR

The perspectives of women, families and communities on the quality of maternity care services influence decisions to use this care. Nearly all quality improvement (QI) frameworks include the community/user perspective as a key element Community members may participate in reviews of quality as informants or in discussions about health care information to identify ways to improve services.

There is recognition that maternal mortality is more than a medical issue and socio-cultural determinants play an equally critical role. While verbal autopsy helps in the determination of the cause of death, social autopsy increases awareness in the community of measures to prevent the occurrence of similar mishaps. As such, it is imperative to sensitise and engage communities and community-based organizations in counting *every* maternal death, assessing the magnitude of the issue and crafting actions to reduce its occurrence. (See *4.5.4 Strengthen maternal and perinatal death* surveillance).

Transport schemes

Community-organized transport schemes are recommended in settings where other sources of transport are less sustainable and not reliable. However. measures should be taken to ensure the sustainability, efficacy and reliability of these schemes while seeking long-term solutions to transport. Harness the on-going efforts of CSOs for emergency transport ,blood banking etc especially at township levels.

Maternity waiting homes

Maternity waiting homes (MWH) - lodgings or accommodation close to a health facility where women can stay before and sometimes after they give birth - are recommended to be established close to a health facility where essential childbirth care and/or care for obstetric and newborn complications is provided to increase access to skilled care for populations living in remote areas or with limited access to services. MWHs should be designed using a health systems perspective, taking account of women and community perspectives. the quality of the MWH structure and the care provided at the health facility.

4. Harness the power of communities and civil societies to improve the demand and acceptability of services

4.1. Implement communication strategies to enga,ge communities

4.2. Increase community awareness and engagement on maternal and newborn health issues

4.3.Strengthen the role of community volunteers, auxiliary midwives

4.4. Employ context-specific community interventions

4.5 Ensure accountability to improve quality of care and equity

Priority Strategies

Concerned units of MoHS in collaboration with partners wilt implement key recommendations within the context of the SOGs on strengthening country health data systems.

4.5.1 Establishment of Civil Registration and Vital Statistics

At present. estimation is necessary to infer MMRs. A priority for the post-2015 strategy is to move towards counting every maternal and perinatal death through the establishment of effective national registration and vital statistics systems. Civil registration systems (CRVS) are being strengthened to track progress and ensure accountability for maternal health outcomes. The ongoing collaboration between health and statistical constituencies wil I be enhanced - CSO, Health Management and Information System Division and other relevant stakeholders - particularly for CRVS systems (i.e. for birth and death registration;and establishing reliable cause of death) and to ensure quality data through validation.

4.5.2 Strengthen monitoring of MNH programme at all levels

The Strategic Action Plan *for* Strengthening Health Information System (HIS) 2017-2021 aims to improve the quality of health facilities' medical record units and thus hospital information, at all levels; improve management of health care financing information and obtain disaggregated data to assess equity across multiple dimensions, including by age,sex,geography and household income level. This

Plan tor Strengthening HIS will support a key aim of EPMM which is to improve the availability and effective use of MNCH data. Achieving the SDG targets will require strong and effective strategies but also accurate measurement and monitoring of progress on key maternal and newborn health indicators.

Regular monitoring and accountability are vital to track equity and to ensure programme effectiveness to assure that all people at all ages are getting the quality care they need for their health and well-being, to find where gaps exist and to act to ensure universal health coverage. MRH will define a monitoring framework to measure impact, coverage and output level indicators;collaborate with HMIS to have in place monitoring systems and indicators using routine health information. In collaboration with partners, MRH will conduct annual programme reviews and evaluations.

MNCH indicators collected by HMIS will be reviewed and updated, in-line with SDG targets and updated global recommendations on MNH;and indude programme coverage indicators to measure quality and effectiveness of care. Monitoring of health system resources e.g. human workforce ,access to medicine including supply chain will be conducted through annual health facility assessment for reproductive health commodities and services.

The District Health Information System, or DHI$2, is one part of the overall health management information system.It is an electronic platform to manage, aggregate and analyze data collected at health facilities. MoHS has been collaborating with development partners in the implementation of the Health Management Information System (HMIS) module of the DHIS2 in 49 townships across the country. MoHS will conduct further training to improve state and regional data utilization. Findings from this training will inform strategic planning and programme monitoring.

HMIS unit will continue to strengthen data collection (conduct training and ensure supportive supervision) and data quality assurance. Collection of data will be disaggregated by age, wealth quintile,education levels,residence (through routine reporting and surveys) and the data will be used to understand the determinants of inequity and to take action. Further. the quality of data will be assessed and analysed,and reports disseminated for decision-makers and planning purposes.

Explore new methods and approaches for data collection
New methods and approaches of data collection will be considered. Creation of electronic systems to establish linkages between hospital and field levels and new technologies, including mobile and mapping applications to improve the quality of data collected will be explored. Collection of data (mortality,morbidity and care-seeking behavior) from vulnerable populations e.g. migrants, who might not be covered by midwives will be investigated. A Volunteer Reporting System (VRS) recording and reporting by community health workers who were supported by different NGO implementing partners has been piloted. The volunteers work in hard-to-reach or underserved areas and the data collected covers issues that midwives report for HMIS and is thus aligned with the national system. This system could help capture information regarding the health and treatment situation, stock-outs etc. for segments of the population where information may otherwise be scarce, and thus provide data for documentation,planning and corrective action.

4.5.3 Disseminate and use data for planning and programme improvement

A conscious effort will be made to disseminate information to reach all levels of decision-makers for planning and to feed-back to health workers, community members, civil society, and professional organizations to improve the management and quality of programmes and inform resource allocation.

The capacity of health care workers at all levels will be developed to monitor and interpret data. The importance of data and how to use data for quality improvement will be included in the training of health workers and improve their capacity to monitor and interpret data.

Monitoring and evaluation capacity and usage of data for decision making and planning at different levels will be enhanced and regular MCH reviews and hospital progress reviews will be conducted at different administrative levels to monitor service provision using data.

4.5.4 Strengthen maternal and perinatal death surveillance

Maternal Death Surveillance and Response (MDSR) and perinatal death surveillance and collection of quality of care data on near misses and severe morbidities are also important mechanisms for ensuring that every death is counted. The primary goal of MDSR is to eliminate preventable maternal mortality by *obtaining and strategically using information* to guide public health actions and monitoring their impact. The overall objectives of MDSR are to *provide information that effectively guides immediate as well as longer term actions to reduce maternal mortality;* and to count every maternal death, permitting an assessment of the true magnitude of maternal mortality and the impact *of* actions to reduce it.

The causes and conditions of every maternal death will be collected, analysed, disseminated and acted on the through MDSR. The implementation of recommendations from maternal death reviews will be monitored. The related surveillance systems - MDSR, child death surveillance and response (CDSR). stillbirth registers and routine information systems (HMIS) will be linked with each other to ensure uniformity of data and prevent duplication. The data collection, analysis and corrective actions undertaken during MDSR will be monitored and the report published annually.

Collect data on "near-miss"
In low maternal mortality settings, maternal morbidity was suggested to be a more useful indicator of obstetric care than mortality to understand health system failures in relation to obstetric care and addressing them to reduce related mortality and long-term morbidity. Therefore, data on severe maternal morbidity through a "near-miss·reporting approach at central/tertiary care centres, State/Regional and District levels will be collected, analysed, disseminated and used.

4.5.5 Improve evidence base through research

Research will be conducted to strengthen the evidence base. Formative research will be conducted to identify factors influencing and barriers to institutional delivery such as socio-cultural norms on childbearing and pregnancy practices and their Impact on pregnancy and birth outcomes, factors that lead to low adoption of beneficial maternal and newborn care-seeking practices, among others. Operations research for service delivery, e.g. demand for and utilization of services by incentives for the most vulnerable and innovative approaches for service delivery for hard-to-reach areas, will be conducted at state/region and township levels.

4.5.6 Ensure social accountability

Participatory mechanisms will be created at every level of health system across public and private sectors for effective social accountability. Facility and clinical auditing systems will be strengthened to ensure accountability for quality of care.

A system to generate community accountability to improve MNH outcomes through participation of community support groups and community leaders of their rights to participation but also their right to remedy will be introduced.

5. Ensure accountability to improve quality of care and equity
5.1 Establishment of Civil Registration and Vital Statistics
5.2 Strengthen monitoring of MNH programme at all levels
5.3 Disseminate and use data for planning and programme improvement
5.4. Strengthen maternal and perinatal death suNeillance
5.5 Ensure social accountability

4.6 Address inequities in access to and quality of sexual, reproductive, maternal and newborn health care

Priority Strategies

4.6.1 Implement context specific plans to address inequities

State and regional specific plans to address inequities.in collaboration with non-health sectors and non-state actors will be developed. Information fronn surveys, reports including maternal death reviews and MDSR will be further analysed by geographic areas and population groups to develop targeted solutions. DHS data will be analysed to identify equity gaps.

State/Region and Township Health Working Groups will prepare and implement plans with specific goals and targets. with different strategies to address vulnerable groups (remote hard-to·reach areas, peri-urban poor, migrants) in their respective areas in partnership with State and Non-State actors and the community. Special population groups with poor access to quality care and the reasons (mapping and categorization) will be identified according to servicer provider, delivery point and user-related cause.

Equitable coverage and equal access to MNCH care and services will be promoted by identifying and addressing barriers to access e.g. reproductive health education and mobile clinics for young migrant factory workers. For hard-to-reach populations to partner with local CBOs and have ethnic liaison officers at health facilities (RHCs. Station and Township Hospitals) in States to ease communication with health workers and address cultural differences.

Partnership and collaboration with Ethnic Health Organizations is proposed in NHP. EHOs are health providers for areas and populations often beyond the reach of public health services and facilities. Development partners are financing health care in conflict-affected areas where the Ministry of Health and Sports has identified challenges to serve the population through the public health system. These partners act as a bridge between Ethnic Health Organizations, local authorities and the Ministry of Health and Sports, enabling greater coordination, communication and information sharing, thereby improving access to health services in areas that are not regularly accessible to government health staff . Standardization of services among the different EHOs and between EHOs and public sector will be conducted as part of the implementation of NHP and the EPMM Strategy.

4.6.2 Support Maternal and Reproductive Health in humanitarian settings

MoHS and secloral partners use a risk-informed programming approach in counlry development plans. includng risk assessments. risk mitigation, disaster planning and contingency funding and invest in the capacity to build resilience, through simulations, preparedness and planning for reconfiguration of resources.MRH Division ensures that reproductive health care is integrated into the public emergency response,in particular, provision of the Minimum Initial Service Package (MISP) for reproductive health in both national plans and systems.In humanitarian settings, the objectives are to reduce maternal death, HIV transmission , unwanted pregnancy, and gender-based violence during these crises. Health care,emergency referrals and clean delivery kits are provided to pregnant women.In addition, national health systems and externalpartners in emergencies promote sustainable service delivery programmes that transition from the emergency response to health systems strengthening for the long term.

Mobile medical clinics are employed by MoHS and partners, including ethnic health organizations to serve people who are affected by conflict,and who have little or no access to regular medical care. The mobile clinics operate in for internally displaced people (IDPs) and in villages in conflict-affected areas. Mothers visit the clinics for antenatal, postnatal and newborn care while contraceptive services are also available. The reproductive health activities in conflict zones integrate gender-based violence services while health workers, women's organizations and the public are sensitised to this issue.

4.6.3 Ensure quality and respectful care through adapting WHO global standards on Quality of Care and implement in facilities

The right to health contains four elements - all health related facilities, goods and services must be available, accessible, acceptable, appropriate and of good quality (AAAQ). In addition, research has shown that it is necessary to go beyond maximizing coverage of essential interventions to accelerate reductions in maternal and perinatal mortality and severe morbidity. Moreover, there is a complex interplay of experiences of mistreatment and lack of support that impact women's childbirth experiences and outcomes. Quality of care,i.e. that women and newborns receive care with respect and dignity is considered a key component of the right to health.

The WHO global standards on Quality of care (QoC) for mothers and newborns in facilities will be adopted. This framework requires *competent and motivated human resources,* the *availability* of essential *physical resources* and *evidence-based practices for routine and emergency* care. *Actionable information* systems where record keeping enables review and audit mechanisms, and *functional referral* systems between levels of care should be in place. Experience of care includes firstly *effective communication*- a woman (or her family if required) feels that she understands what is happening, what to expect and knows her rights. Secondly, that she receives care with *respect and dignity* and thirdly,she has access to social and *emotional support* of her choice.

The system building strategies implemented in NHP will have a positive effect on quality of care in strategies to end preventable maternal mortality as health systems create the structure which enables access to quality care and allows for the process of care to occur along two important and inter-linked dimensions - provision and experience of care.

To improve the health system component, leadership and management at the national level for policies and designs for implementation and scale up, assessment and provision of resources and setting standards will be critical. These will be complemented by education and training and supportive supervision of clinical and system activities which is on-going.At the facility level, adaptation of QoC

recommendations and regular data audit and continuous data to support improvement will contribute to learning systems for accelerating improvement. Engaging women, families, communities in their care is another critical component of the process.

There have been initiatives on quality improvement and quality assurance in Myanmar, e.g. the Point-of Care Quality Improvement (POOI) developed by the Regional Office of the WHO South-East Asia region has been piloted in Myanmar and this model will be expanded through capacity strengthening and providing the required system support. MRH Division in collaboration with partners plans to set up a unified national system and support the incorporation of QoC in the EPHS. In parallel, the adoption of quality improvement processes at the level of the health facility will be encouraged and facilitated.

These quality assurance initiatives are in line with NHP's objectives to promote technical and service quality which emphasizes a positive client experience; and relates to effective communication, respect, confidentiality and responsive services.

4.6.4 Develop a systematic approach to adapting and implementing evidence-based standards, guidelines and protocols to suit the Myanmar context, and to monitoring adherence and evaluating their outcomes

Recently, evidence-based practices for quality antenatal care and for quality postnatal care have been updated in accordance with WHO guidance. In addition, WHO recommendations on postpartum haemorrhage, management of pre-eclampsia, detection and management of difficult labour and infection prevention have been incorporated into existing guidelines. Further, family planning guidelines and Standard Operating Procedures for post-abortion care have been reviewed or developed. Effective implementation will require widespread dissemination of guidelines, improving provider knowledge and skills, ensuring that facilities have the infrastructure and commodities and monitoring adherence to recommendations will be necessary and could be carried out by training teams who could also carry out supervision.

6. Address inequities in access to and quality of sexual, reproductive, maternal and newborn health care

6.1. . Implement context specific plans to address inequities

6.2. Support MRH in humanitarian settings

6.3. Ensure quality and respectfvl care throvgh adapting WHO global standards on Qvality of Care and implement in facilities

5. Cross-cutting issues

Maternal health is dependent on many economic, social and environmental factors. SDGs encompass several determinants including gender equality, empowerment of women and girls, education, employment, water, sanitation, among others. Progress on these vital determinants would have a decisive impact on the health of women and adolescents.

Access to rights-based maternal health services and respectful maternity care are essential to women's reproductive health and rights. Evidence shows that access to health care alone is not enough to promote maternal health and decrease maternal morbidity and mortality. Reproductive rights include a woman's right to safely bear children and *to* freely decide whether *to* have them, how many to have.

and when. A rights-based approach will be followed in implementing the Strategy to End Preventable Maternal Mortality: to go beyond the prevention of morbidity or mortality to encompass respect for women's basic human rights - privacy, informed oonsent and respectful care or during pregnancy and childbirth. A gender focus will be integrated in MNH policies and programmes, i.e. identifying the distinct health needs of women, their health-related behaviours, and inequalities in their exposure to risk, health-seeking behaviour, access to health services, and control of the resources required to stay healthy. It also requires working jointly with men and women, particularly to improve women's decision-making power and access to resources related to sexual and reproductive health.

Integrated services lead to higher utilization of services and improved quality of care and health outcomes. During implementation at the service delivery level, maternal health services will be integrated with family planning. newborn and child -care.nutrition. immunization and HIV prevention.

Support for provider training in client-centered approaches; accountability of programmes on integration and rights-based care; and meaningful participation of women and girls in the design, implementation, and evaluation of programs.

6. Implementation Mechanisms

6.1 Maternal health stakeholders

At the central level.the Department of Public Health (DoPH).Ministry of Health and Sports, will be responsible for the implementation of the Strategy to End Preventable Maternal Mortality.which is aligned with the National Health Plan (2017-2021) and the National Strategic Plan for Reproductive Health. In this regard, DoPH will collaborate with development partners. United Nations agencies, donors, Funds and NGOs.

The Director General, DoPH will take overall responsibility for the coordination. planning. implementation and evaluation of the Strategy while the Maternal and Reproductive Health Division will be charged with setting technical standards and guidelines. providing inputs to township-level innovative approaches, developing frameworks for monitoring and evaluation, technical backstopping and facilitating the development, implementation and monitoring of sub-national plans.

A broad multi-sectoral approach will be adopted in implementation of the Strategy to End Preventable Maternal Mortality. The Maternal and Reproductive Health Division will collaborate with other Departments (Department of Medical Services. Department of Human Resources and Development and Department of Medical Research); Divisions (Child Health Development Division. Health Management and Information System Division, School Health Division) and Programmes under MoHS (National AIDS Programme, National Malaria Control Programme. Expanded Programme on Immunization); National Nutrition Centre and Health Literacy and Promotion Unit. The Department of Public Health, MoHS will partner with other ministries (Ministry of Education.Ministry of Social Welfare). professional associations, academia, United Nations agencies, bilateral donors and civil society organizations including NGOs. Maternal health stakeholders collaborating with the Maternal and Reproductive Health Division at national, state/regional, township and community levels are listed in Annex 6.

The State/Regional ,district and township level health authorities will oversee the operational planning, implementation .monitoring and review of the Strategy at their respective levels.They will partner with the General Administration and other Departments, CBOs and EHOs and employ a multi-sectoral and participatory approach for political and financial support. The health authorities will take the lead in

mapping health facilities.identifying vulnerable populations in their respective areas, testing innovative approaches to reach them, and strengthening community-level activities; among others.

6.2 **Coordination mechanisms**

The Myanmar Health Sector Coordinating Committee (MHSCC) is multi-sectoral in nature with broad participation, including represenlatives of different government ministries. UN agencies. international organizations, donors.international and local NGOs and the private sector. Under the auspices of the reproductive health - maternal and child health technical and strategy group. the RH Working Group will co-ordinate the project activities of development partners,NGOs and other stakeholders engaged in delivering maternal health interventions. As the EPMM Strategy is an elaboration and update of strategies embedded in the Strategic Plan on Reproductive Health and is complementary to the National Strategic Plan for Newborn and Child Health (2015-2018) and Costed Implementation Plan to meet Commitments to FP 2020. co-ordination among MH stakeholders will avoid duplication of activities and reduce the administrative burden on the Department of Public Health.

At the sub-national level coordination will be through the state/region, district and township level coordination mechanisms. State/Region and Township Health Working Groups will be responsible for providing oversight the implementation of the Strategy to End Preventable Maternal Mortality.

6.3 **Annual plans of action**

The Strategy will be implemented in all townships addressing the main causes of maternal mortality employing a differentiated approach. The diversity of geographic locations will be considered and interventions adapted to be context-specific. In townships where the first phase of NHP will be implemented, the overall health systems strengthening activities will enhance the coverage and quality of interventions through support for infrastructure, human resources, supplies and equipment and social health protection schemes.MRH Division will engage with and support states and regions where the number of maternal deaths are high and other health and social indicators are below the national *average.* The components of the EPMM Strategy will be incorporated in the Prioritized Township Health Plans (PTHP).

Budgeted annual plans will be developed by the Maternal and Reproductive Health Division to identify activities. partners. resources needed and time-1ines for responsibilities at the central-level. MRH Division and State/Region MCH Officers will support township teams to develop operational plans with detailed activities, assign responsibilities at the local level, develop and strengthen partnerships with CBOs, EHOs and the private sector, identify and mobilize resources and set time-lines for implementation. The detailed implementation plans will indicate the association between the evidence-based interventions in the Essential Package of MNH Services and the core elements of RH which impact on ending maternal mortality- family planning and post-abortion care - and different responsible institutions and implementing partners. It will also include township level monitoring, which is linked to the overall monitoring by the national level.

State/Region and Township Health Departments will engage with EHOs to co-ordinate and complement interventions and harmonize planning for remote and hard-to-reach areas.These Departments will work with EHOs and development partners to strengthen capacity for routine and emergency maternal and newborn care in line with national standards.

The principles of equity and rights will be underscored in development and implementation, i.e. coverage of high impacl interventions, encompassing all population groups, ensuring equity. The

principles and standards derived from international human rights treaties will guide all planning and programming for maternal and newborn health, with a focus on respect for the patient or client and treating them with dignity. The needs of populations such as adolescents and youth, women with disabilities, migrants and the poor will be addressed to emphasize that "no-one will be left behind .

6.4 Implementation plan

Providing maternity care in a given setting is, in part. a function of available resources and existing infrastructure - including human resources, financing, the private sector; and factors such as geography, population density, facility density and capability, and distance between peripheral and referral centres.

Context-appropriate implementation strategies will be employed. While the national level of maternal mortality has improved, there are areas where MMR is higher than the national average. In general, these areas lack basic infrastructure (such as roads, transportation and health facilities), have low levels of education (particularly female literacy), weak health systems, shortages of skilled health personnel and low capacity to deliver essential life-saving interventions. In this context, poor quality of care is a deterrent for generating demand for health services. In these areas, development and support for front·line infrastructure and availability of competent human resources is a critical issue. Provision of routine maternal health-care components (eg. antenatal care and uterotonics post-delivery) and response and referral for life-threatening emergencies are mandatory to reduce major direct causes of mortality. In addition. access to preventive interventions, including family planning for prevention of unwanted or poorly timed pregnancy, management of post-abortion complications and preventative actions for anaemia will be provided. Improvement of service quality with provider training, including respectful treatment of women, ready access to basic equipment and supplies, supportive supervision, and other key support to providers.

In most places in Myanmar where the MMR is 70-420, access remains an issue for a proportion of the population, but for pregnant women who reach health facilities. quality of care becomes a major determinant of health outcomes, especially with regard to overloaded health facilities. In addition to primary prevention , secondary and tertiary prevention are critical for improving maternal health outcomes in this stage. The following will be prioritized : improved management of routine delivery and of complications. addressing barriers for a timely referral process. and institutionalization of quality of care including respectful services based on women's needs and perspectives. Furthermore, to increase demand for services, with specific focus on the vulnerable, to address transport or location needs, and to make effective use of financial initiatives.

7. Monitoring and Evaluation

Regular monitoring of the EPMM Strategy will be conducted using appropriate indicators to review progress made, and to highlight where policy and programme adjustments may be needed. Without monitoring, systemic failures in reducing maternal mortality and morbidity cannot be corrected.

Monitoring of the underlying physical and socio-economic determinants of health that affect women's health and ability to exercise their rights is a critical component of accountability. Monitoring helps the Ministry develop a better understanding of the problems and shortcomings encountered in realizing rights, providing them with the framework within which more appropriate policies can be devised. Data based on appropriate indicators should be disaggregated to monitor the elimination of discrimination as well as to ensure that vulnerable communities are benefiting from. A strong M&E framework will allow

to track and measure progress in the implementation of the NHP. The framework will also look explicitly at equity.

MRH Division will co-ordinate with HMIS Division at the central level and support state/region and township teams and their implementation partners in monitoring the implementation of the Strategy.

The main data source will be HMIS which routinely collects public health and hospital health indicators. More specific information will be obtained from annual Training and Programme Reports of MoHS, Reports of the National AIDS Programme, Maternal Death Surveillance and Response Reports and Health Facility Assessments for Reproductive Health Commodities and Services. In addition. special surveys will need to be conducted every five years to obtain data related to quality of service provision. Information will be generated from SARA survey. DHS, National Housing and Population Census and other national surveys.

Formative and operational research will be conducted in partnership with the Department of Medical Research, State/Region Health Departments. UN agencies and development partners.

Monitoring and Evaluation Framework: Ending Preventable Maternal and Newborn Deaths in Myanmar 2017-2021

The Logical Framework is based on the Goal and the Strategic Objectives mentioned in Section 4. The indicators are in line with the targets under Sustainable Development Goals (SDGs) related to health.

Goal

To reduce maternal mortality ratio from 282 per 100,000 live births (2014) to 91 per 100,000 live births (2030); to 173 per 100,000 live births (2021)

To reduce neonatal mortality rate from 26 per 1000 live births (2015) to less than 12 per 1000 live births by 2030

To reduce the stillbirth rate from 20 per 1000 births (200g) to less than 10 per 1000 births by 2030

Objectives and Priority Strategies	Indicators	Current status	Data source	Target by 2021	Target by 2030	Means of Verification	Responsible Institutions
Strategic Objective 1 To Address causes of maternal and newborn mortality and morbidities and related disabilities							
1.1 Implement the package of essential MNH interventions as defined in the Essential Health Package under the National Health Plan	Percentage of births taking place in a health facility (overall and by age and particularly among lowest income and educational groups)	37%	DHS 2015-2016		90%	DHS	MRH, OMS
	Percentage of women experiencing major obstetric complications who receive emergency care at EmONC facilities	NA		70%	90%	special Survey	DMS, MRH
	Percent of pregnant women with pre-eclampsia who are treated with intramuscular magnesium sulfate (4-6g).	NA		4%	5%	As a proxy, it is assumed that 5% of women who attend 4 or more ANC visits will be screened and managed	OMS, MRH
	Abortion rate per 1000 pregnancies (live births, stillbirths and abortions)	0.17	Annual Hospitals Statistics		0.05	Annual Hospitals Statistics	OMS. MRH
	Percentage of premature/low birth weight infants receiving the three levels of management of prematurely born infants in the	NA		75%	90%	Special survey	OMS, CHD

Objectives and Priority Strategies	Indicators	Current status	Data source	Target by 2021	Target by 2030	Means of Verification	Responsible Institutions
	neonatal period: thermal care, Kangaroo mother care, and full supportive care for prematurity						
1.2 Address maternal & neonatal morbidities (such as nutritional problems (anaemia, underweight and overweight, congenital defects, prematurity & low birthweight) and medical problems (e.g., heart disease, diabetes and infections} during the present pregnancy (overall and by age and part cularly among lowest income and educational groups)	Percentage of pregnant women who had at least 4 antenatal clinic visits	59%	DHS 2015-2016	70%	80%	DHS	MRH
	Percentage of pregnant women who had more than 4 antenatal clinic visits during the present pregnancy (overall and by age and particularly among lowest income and educational groups)	NA		70%	80%	DHS	MRH
	Percentage of pregnant women taking Folic Acid supplementation during the peri-conception period	NA		70%	90%	DHS	MRH
1.3 Implement screening and preventive practices for/and treatment of critical medical and obstetric conditions at tertiary	Proportion of pregnant women tested positive for HIV receiving antiretroviral prophylaxis during pregnancy	27%	NAP Report	75%	99%	NAP Reports, Global AIDS Progress Report	NAP,DMS
	Percent of pregnant women tested for syphilis and given treatment if needed	NA		75%	99%	NAP Reports, Global AIDS Progress Report	NAP,DMS
	Percent of women screened and managed for moderate to severe hypertension during pregnancy	NA		4%	5%	Special survey	DMS.MRH

Objectives and Priority Strategies	Indicators	Current status	Data source	Target by 2021	Target by 2030	Means of Verification	Responsible Institutions
State/Regional Hospitals							
	Percent of pregnancies screened for fetal growth restriction (fundal height, ultrasound)	NA		75%	90%	Special survey	DMS, MRH, DMR
1.4 Strengthen referral systems and response system to manage complications and life-threatening emergences with coordination across time, settings and disciplines. and between	Percentage of births taking place in a health facility (State/Region and township-wise) (overall)	NA		70%	98%	DHS	MRH
	Percentage of births taking place in a health facility (State/Region and township-wise) (by age and particularly among lowest income and educational groups)	NA		70%	98%	DHS	MRH
1.5 Prevent unwanted pregnancies and address unmet need of contraception	Adolescent Birth Rate	33/1000 15-19 years		20/1000	Less than 10	DHS	MRH
	Modern Contraceptive prevalence rate (mCPR)	52%		65%	80%	DHS and FamPian modelling	MRH
	Unmet need for family planning	16%		10%	Less than 5%	DHS and FamPian modelling	MRH
	Use of Long-acting Reversible Contraception	2%	RHCS Survey	8%	15%	DHS	MRH

Objectives and Priority Strategies	Indicators	Current status	Data source	Target by 2021	Target by 2030	Means of Verification	Responsible Institutions
1.6 Strengthen post-abortion care/ management of post abortion complications	Percent of women who have had an abortion who receive post-abortion case management at a Township Hospital	80%		90%	100%	Special survey	DMS, MRH
	Percentage of clients who received post-abortion counselling and contraceptive services	NA		60%	80%	Township reports	MRH
	Percentage of health facilities applying procedures -manual vacuum aspiration, or medical methods for management of miscarriage/post-abortion complications	NA		60%	80%	Health Facility Assessment	DMS, MRH
	Strategic Objective 2 To ensure universal health coverage for comprehensive sexual, reproductive, maternal and newborn health care						
2.1 Implement the package of evidence-based RMNCAH interventions for essential and comprehensive MNH care	Percentage of births attended by skilled health personnel (State/Region and township-wise) (overall and by age and particularly among lowest income and educational groups)	60%		70%	90%	DHS	MRH
	Percentage of women receiving postnatal care – one visit within 3 days after delivery (overall and by age and particularly among lowest income and educational groups)	70%		80%	90%	DHS	MRH
	Percentage newborns receiving postnatal care within two days (48 hours) of childbirth (home visit or clinic visit)	36.4%	DHS 2015-2016	80%	90%	DHS	CHD

Objectives and Priority Strategies	Indicators	Current status	Data source	Target by 2021	Target by 2030	Means of Verification	Responsible Institutions
	Percentage of pregnant women taking iron supplementation	NA			90%	DHS	NNC
	Proportion of pregnant women who undergo counselling and testing and receive results for HIV	27%			90%	NAP Reports, Global AIDS Progress Report	NAP
2.2 Ensure health financing for universal *coverage* of MNH interventions	Proportion of women of reproductive age covered by social health protection schemes (overall and by age and particularly among lowest income and educational groups)	N/A			TBD	MPLS	DSW
	Proportion of out-of-pocket spending as %of total health expenditure	70%			Less than 20%	Myanmar Poverty & Living Conditions Survey (MPLCSI	MoPF
2.3 Increase fiscal space and budgetary allocation for RMNCAH	Proportion of general government health expenditure as compared to GDP	3.65%		5%	More than 5%	World Bank Data	MoPF
	US$ spend per capita in order to deliver essential health interventions	40 (EPHS)		50%	More than 80%	World Bank Data,NHA	MoPF
	Strategic Objective 3 To strengthen health systems to respond to the needs and priorities of women and girls						
3.1 Ensure leadership and governance for MNH	RMNCAH TSG is functioning and meeting regularly at least 3 times per year	0			3	DoH report	DoH
	Principles of equity for vulnerable populations (i.e. adolescents, vulnerable groups) reflected in the	Partial	Short Programme Review		Evident	Short Programme Review	MRH

Objectives and Priority Strategies	Indicators	Current status	Data source	Target by 2021	Target by 2030	Means of Verification	Responsible Institutions
	policies and programmes on delivery of reproductive health care						
	National RMNAH strategies and plans with mainstreamed risk reduction/resilience, inclusive of climate change available	NA	Review		Evident	Evaluation of national health and RMNAH strategies and plans	DoH
	RH/MNH component integrated into Disaster Preparedness Response policies and plans at all levels	NA			Evident	Evaluation of national health and RMNAH strategies and plans MoHS Reports	DoH
3.2 Streamline RMNH service delivery	Proportion of health facilities (township level) practicing active management or third stage for prevention of postpartum haemorrhage	NA	SARA	70%	90%	SARA	DoH
	Percentage of facilities offering at least 4 modem contraceptive methods	NA	SARA	70%	90%	SARA	MRH
3.3 Strengthen the health information system	Health Management Information System generates periodic reports with data disaggregated by age and sex (for relevant indicators) at national and sub-national level	Partial	HMIS Review 2014	In progress	Evident	Annual HMIS Review	HMIS Unit
	Existence of age-and sex-disaggregated data on HIV testing and counselling among adolescents 15-19 years	NA		Evident	Evident	Annual HMIS Review	HMIS Unit, NAP

Objectives and Priority Strategies	Indicators	Current status	Data source	Target by 2021	Target by 2030	Means of Verification	Responsible Institutions
	Reproductive health/MNH commodity logistics management information system established at national and local levels as part of national LMIS	Partially		Evident	Evident		Procurement & Supply Division
3.4 Ensure adequate numbers of competent teams of health care workers provide care during pregnancy, childbirth and postnatal	Training strategy to address in-service needs of reproductive health/maternal & neonatal health service providers in place	NA		Annually evident	Annually evident		
	Percentage of MW receiving training on safe motherhood, BEmONC	NA		75%	90%		MRH
	Percentage of doctors receiving training on CEmONC	NA		75%	90%		MRH
35 Ensure financial for MNH service delivery	Costed implementation plans for RMNAH care is available	RH Strategic Plan Newborn Action Plan	Newborn Action Plan			Evaluation of national health and RMNAH strategies and plans	DoH
	Increased percentage of government health budget allocated to RMNAH	?	NHA	Increase by 10%	Increase by 20%	NHA	
3.6 Ensure high quality	Percentage of facilities with no stock-outs of MNH medicines		SARA2014		80%	SARA	DoH

Objectives and Priority Strategies	Indicators	Current status	Data source	Target by 2021	Target by 2030	Means of Verification	Responsible Institutions
medicines, equipment and appropriate technologies for MNH care	Percentage health facilities offering delivery services with functional newborn resuscitation equipment (functional bag and mask in neonatal size)	66%	Health Facility Assessment		80%	SARA	DoH
	Percentage of facilities that that use manual vacuum aspiration for management of miscarriage/post-abortion complications (see 1.6)	NA	Health facility assessment	60%	80%	SARA	DoH
	Proportion of health facilities using MgS04 for prevention and management of eclampsia	NIA	Health facility assessment	70%	90%	SARA	DoH
	Percentage health care facilities with functioning basic water, sanitation and hygiene facilities	53%	Health facility assessment 2014	70%	90%	SARA	DoH
Strategic Objective 4 To harness the power of communities and civil societies to improve the demand and acceptability of services							
4.1 Implement communication strategies to engage communities	Existence of a budgeted integrated multi-sectoral communication strategy/plan to support the promotion of the priority life-saving and protective behaviours within affected communities.	NA	HLPU Report		Evident	National health communication programme reports	HLPU
	Percentage of townships facilitating regular community dialogue with caregivers to improve knowledge, attitudes and practices and address related social/cultural norms on SRH, maternal and newborn and health	16%	HLPU report	70%	90%	National health communication programme reports	HLPU

Objectives and Priority Strategies	Indicators	Current status	Data source	Target by 2021	Target by 2030	Means of Verification	Responsible Institutions
	Proportion of service delivery points (health facility or community) with adequate materials for health counselling, support and communication	NA	HLPU report	60%	90%	National health communication programme reports	HLPU
4.2 Increase community awareness and engagement on maternal and newborn health issues	Percentage of women with knowledge of at least three risk factors/warning signs of pregnancy-related complications (overall and by age and particularly among lowest income and educational groups)	NA		70%	90%	Special survey	HLPU
	Proportion of women who have a companion of choice during labour and childbirth	NA		70%	90%	Special survey	HLPU
	Increase knowledge and practice on ANC4+ and PNC4 for both mothers and newborns	NA		70%	90%	Special survey	HLPU
	Increase knowledge and awareness of the dangers of unsafe abortion	N/A		70%	90%	Special survey	HLPU
4.3 Strengthen the rote of community volunteers, auxiliary midwives	Percentage or Community Health Workers (volunteers and AMWs) trained to implement community-based newborn care (% or actually trained against the planned)	0.03%	Training reports, Programme Reports; MoHS	70%	90%	Training reports, Programme Reports; MoHS	CHD
	Percentage of deliveries by auxiary midwife (State/Region and township-wise)	11.6%	Public Health Statistics Report	7%	Less than 5%	Public Health Statistics Report	MRH

Objectives and Priority Strategies	Indicators	Current status	Data source	Target by 2021	Target by 2030	Means of Verification	Responsible Institutions
	Percentage of AMWs who receive monthly supervision visits		Public Health Statistics Report	60%	80%	Public Health Statistics Report	MRH
4.4 Employ context-specific community interventions	Percentage of Community Health Workers (volunteers and AMWs) in remote regions: Chin, Kachin, and Shan states trained to implement Kangaroo Mother Care (% of actually trained against the planned)	NA	Training reports, Programme Reports; MoHS	70%	90%	Training reports, Programme Reports; MoHS	CHD
	Percentage of AMWs in remote regions: Chin, Kachin, and Shan states providing misoprostol for prevention of postpartum haemorrhage	NA	Programme Reports; MoHS	70%	90%	Programme Reports; MoHS	MRH
	Percentage of AMWs in remote regions: Chin, Kachin, and Shan states providing ANC according to national guidelines	NA	Programme Reports; MoHS	70%	90%	Programme Reports; MoHS	MRH
Strategic Objective 5 To ensure accountability for improving quality of care and equity							
5.1 Establishment of Civil Registration and Vital Statistics	Civil Registration and Vital Statistics system	Piloting	CSO Reports HMIS Reports		Established		CSO Reports HMIS Reports
	Number of townships conducting reviews on maternal deaths at township level (in accordance with Maternal & Perinatal Death Surveillance and Response)	NA	Programme report	200	330	Programme report	MRH

Objectives and Priority Strategies	Indicators	Current status	Data source	Target by 2021	Target by 2030	Means of Verification	Responsible Institutions
	Number of districts conducting **reviews** on neonatal and child deaths at district level (in accordance with Child Death Surveillance and Response)	NA	Programme report	200	330	Programme report	CHD
5.3 Disseminate and use data for planning and programme improvement	Number of township plans based on HospitalReports,Township Reports, HMIS and national surveys	NA	Township Health Plans	200	330	Township Reports	MoHS
5.4 Improve evidence base through research	Number of research studies conducted on quality of Clinic,socio-cultural factors and MNH care and operations research on service delivery and utilization at State/Region levels	NA		At least 2 per State/Region	At least 5 per State/Region	Research Reports	State/Region Authorities and affiliated research and academic institutions
5.5 Ensure social accountability	Number of CSOs and women's groups involved in planning, implementation and monitoring of Township Health Plans	NA		At least 2 per township	Atleast 4 per township		Township Authorities,CSOs
Strategic Objective 6 To address inequities in access to and quality of sexual,reproductive, maternal and newborn health care							
6.1 Implement context specific plans to address inequities	Principles of equity for vulnerable populations (i.e. adolescents, vulnerable groups) reflected in the policies and programmes on delivery of reproductive health care	NA			Evident	MoHS Reports	MRH,MoHS
	Prioritised Township Health Plans develop ointly_by Township	NA			Evident	MoHS Reports	THD,MoHS

Objectives and Priority Strategies	Indicators	Current status	Data source	Target by 2021	Target by 2030	Means of Verification	Responsible Institutions
	Health Departments, CSOs, EHOs, Development Partners					CSO and Development Partners Reports	
6.2 support MRH in humamtanan settings	RH/MH componenl integraled into Disaster Preparedness Response policies and plans at all levels				Evident	Evaluation of MRH, MoHS national health and RMNAH strategies and plans MoHS Reports	MoHS
6.3 Ensure quality and respectful care through	Proportion of health facilities (township level) practsing active management or third stage for prevention of postpartum haemorrhage (see 3.2)	NA			90%	Special Survey	MRH
adapting WHO global standards on Quahty of Care and implement in facilities	Proportion of health facilities (townsh_ip level) using MgS04 for prevention and management of eclampsia (see 3.6)	NA			90%	Spedal Survey	MRH
	Proportion of health facilities (township level) using manual vacuum aspirat on for management of miscarriage/post-abortion compl cations (see 1.6)	NA			90%	Special Survey	MRH
	Proportion of health facilities (township level) allowing companion of choice at birth	NA			90%	Special Survey	MRH
	Implementation Plan developed	NA			Evident		

Objectives and Priority Strategies	Indicators	Current status	Data source	Target by 2021	Target by 2030	Means of Verification	Responsible Institutions
6.4 Develop a systematic approach to adapting and implementing evidence-based standards, guidelines and protocols to suit the Myanmar context, and to monitoring adherence and evaluating their outcomes	Number of monitoring visits by State/Region monitoring Team to Township Hospitals	NA				State/Region monitoring reports	State/Region Health Departments
	Proportion of health facilities (township level) practising active management or third stage for prevention of postpartum haemorrhage (See 3.2)	NA			90%	Special Survey	MRH
	Proportion of health facilities (township level) using MgS04 for prevention and management of eclampsia (See 3.6)	NA			90%	Special Survey	MRH

8. Conclusion

The ultimate goal of this Strategy is to end preventable maternal deaths. The implementation will adopt a rights-based approach to reproductive. maternal and newborn health, which is context-specific and woman-centred.

The focus on ending maternal deaths due to hemorrhage, eclampsia, obstructed labor, infection and unsafe abortion will be intensified.along with emphasis on the coverage and quality of skilled care at birth and of emergency obstetric care. Interventions across the continuum of maternal-newborn care: access to contraception,prevention of adolescent pregnancy, minimum four antenatal care visits, birth allended by skilled personnel, post-natal care and birth spacing will be prioritized.Continuum of care from the home to facilities at the different levels of the health care system. the need to link across services and ensure emergency transport systems will be emphasized.

The defining principle of the SDGs is equity and to leave no one behind. Towards that end,the universal health coverage target 3.8 (achieving 'universal health coverage, including financial risk protection, access to quality essential health-care services,medicines and vaccines for all) is an overarching target that underpins equity,and is key to the achievement of all others.

Within the overall national framework, coverage of care will be enhanced through working in partnerships. Improving quality of services at the point of care at the health facility/hospital level will be the critical factor to ensure desirable improvement in health care outcomes like reduction in case fatality rate,reduction in hospitalization days and client satisfaction. Furthermore,sharing innovations,learning from each other's experiences and cultivating cross-sectoral partnerships will be fostered.

Providing maternity care in a given setting is dependent on existing infra structure - including human resources, financing, the private sector; and factors such as geography, population density, facility density and capability, and the distance between peripheral and referral centres;and the availability of resources. The Strategy to End Preventable Maternal Mortality will be used as overall guidance and context-appropriate implementation strategies will be employed.

Annexes

Annex 1. Documents reviewed

WHO - Strategies towards Ending Preventable Maternal Mortality
The second Global Strategy for Women's Children's and Adolescents' Health (2016-2030) Implementation guide - the Global Strategy for Women's Children's and Adolescents' Health
The Global Strategy for Women's Children's and Adolescents' Health - Indicators and monitoring framework
WHO - UNICEF - Every Newborn -An Action Plan to End Preventable Deaths
WHO • South-East Asia Regional Office - Remarkable progress, new horizons and renewed commitment: Ending preventable maternal, newborn and child deaths in South-East Asia Region 2016
Guideline on Investment Case preparation for Global Financing Facility (GFF)
From MDGs to SDGs unfinished agenda
Every Women Every Child 2017 Progress Report Partnership in maternal. newborn and child health
WHO, 2015. Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva: WHO Press.
WHO - Working with Individuals, Families and Communities to Improve Maternal Health
WHO - Quality of Care guidelines
SEAR Framework for Point of Care Quality Improvement
WHO- Preconception care - policy brief
WHO Recommendations on Postpartum Hemorrhage
WHO Recommendations on Augmentation of labour
WHO Recommendations on antenatal care for a positive pregnancy experience
Ministry of Health and Sports- National Health Plan 2017-2021
Ministry of Health - UNICEF- National Strategic Plan for Newborn and Child Health (2015-2018)
Ministry of Health - UNFPA - Casted Implementation Plan to meet FP 2020 Commitments Myanmar
Strategic Action Plan for Strengthening Health Information System (HIS) 2017-2021
Data Dictionary for Health Services Indicators
Ministry of Health - WHO - Nation-wide Service Availability and Readiness Assessment Myanmar 2015
Ministry of Health- UNFPA- Myanmar Midwifery Situation 2014 Synthesis Report
Ministry of Health and Sports- Health Workforce Strategic Plan
Ministry of Health- Five-Year Strategic Plan for Reproductive Health (2014- 2018)
Ministry of Labour, Immigration and Population - UNFPA - 2014 Myanmar National Housing and Population Census
Ministry of Labour, Immigration and Population - UNFPA - 2014 Myanmar National Housing and Population Census- Thematic Report on Maternal Mortality (2016)
Ministry of Labour, Immigration and Population - UNFPA - 2014 Myanmar National Housing and Population Census - Thematic Report on Children and Youth (2017)
Ministry of Labour, Immigration and Population - UNFPA - 2014 Myanmar National Housing and Population Census - Thematic Report on Fertility and Nuptiality (2016)
Ministry of Labour, Immigration and Population - UNFPA - 2014 Myanmar National Housing and Population Census - Thematic Report on Gender Dimensions (2017)
Maternal Death Review Report Myanmar 2015 (September 2017)
Reasons for Optimism - 3 MDG Annual Report 2016
Ministry of Health and Sports- DHS Program- Myanmar Demographic and Health Survey 2015-2016
Public Health Statistics. Health Management Information System (HMIS). Government of Myanmar. 2011

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

Annex 2. Persons met

Name	Department
Dr Hla Mya Thway Einda	MRH, Department of Public Health
Dr Hnin Hnin Lwin	MRH, Department of Public Health
Dr Khaing Nwe Tin	MRH, Department of Public Health
Dr Myo Myo Man	MRH, Department of Public Health
Dr Thet Thet Mu	HMIS
Dr Theingi Aung	Child Health
Dr Thant Zin Htoo	NHP Implementation Monitoring Unit
Dr May Khin Than	National Nutrition Centre
Dr Swe Le Mar	National Nutrition Centre
U Win Mvint	Health Literacy Promotion Unit
Daw Tin Ma Ma Kyaw	Assistant Director, Nursing
Daw Tin Tin Wai	Basic Health Staff
Daw Mya Lay Nwe	Deputy Director, Human Resources for Health
Dr Kyi Kyi Nyunt	Prof/Dir Gyn, University of Medicine 2
Ms Piyamal Pichaiwongse	Deputy Liaison Officer, ILO
Ms Catherine Vallancourt-Laflamme	ILO
Dr Aye Thidar	IOM
Ms. Kristin Parco	IOM
Dr Anoma Jayathilaka	WHO SEARO
Mrs. Phavady Bollen	WHO
Dr Shwe Sin Yu	WHO
Dr Kyaw Nyunt Sein	Senior National Advisor. 3MDG Fund
Dr Panna Erasmus	MNCH Specialist, 3MDG Fund
Dr Yin Yin Htun Ngwe	3MDG Fund
Daw Nwe Nwe Khin	Myanmar Nursing and Midwifery Council
Daw Yin Mya	Myanmar Nurses and Midwives Association
Dr Hla Hla Aye	Assistant Rep, UNFPA
Dr Tin Maung Chit	Programme Analyst (RH). UNFPA
Dr Budhi SEtiawan	UNICEF
Dr Sarabibi Thuzar Win	UNICEF
Dr Ni Ni Lwin	UNICEF
Dr Ni Ni	Ipas
Dr Myint Thu Lwin	Ipas
Dr Khin Wuit Yee Hla	Save the Children
Mr Adam Hubener	Relief International
Dr Sid Naing	Marie Stopes International
Dr Zaw Hein	Danish Red Cross
Dr Sein Hlaing	International Red Cross

Annex 3.Persons attending stakeholder dissemination meeting (16 November 2017)

Name	Department
Dr Thaung Hlaing	Deputy Director-General
Dr Hla Mya Thway Einda	MRH. Department of Public Health
Dr Hnin Hnin Lwln	MRH,Department of Public Health
Dr Khaing Nwe Tin	MRH, Department of Public Health
Dr Myo Myo Mon	MRH,Department of Public Health
Mrs. Phavady Bollen	WHO
Dr Shwe Sin Yu	WHO
Dr Hla Hla Aye	Assistant Rep,UNFPA
Dr Tin MaunQ Chit	PrOQramme Analyst (RH), UNFPA
Dr Ni Ni Lwin	UNICEF
Dr Yin Yin Htun Ngwe	3MDG
Dr Than Than Nwe	MMCWA
Dr Hpone Mu Hlaing	Myanmar MedicalAssociation
U Pye Sene	IOM
Dr Phyu Phyu Kyaing	Ob Gyn. University of Medicine 1
Dr Hla Myat Mo Mo	Ob Gyn , University of Medicine 2
Dr Aye Pe	Ob Gyn, University of Medicine, Mandalay
Dr Aye Thida	Ob Gyn . University of Medicine, MaQway
Dr Ni Ni	Ipas
Dr Tin Moe Moe Win	John Snow International
Dr rni Soe	John Snow International
Dr Thandar Soe	Save the Children
Dr Moe Moe AunQ	Marie Slopes Intematlonal
Dr Aye Min Tun	Population Services International

Annex 4. Essential Package of maternal and newborn (MNH) interventions

PREGNANCY (antenatal)
Preventive measures
• Diagnosis of pregnancy•
• Early and appropriate antenatalcare•
-Accurate determination of gestational age•
• Screening of risk factors and danger signs (previous LSCS scar.bleeding, hypertensive disorders)
• Tetanus immunization·
• Deworming with Mebendazole'
• Prevention (insecticide treated bed nets) and treatment of malaria
• Counselling on family planning, danger signs, birth, emergency preparedness, exclusive breastfeeding and immunization of mother and newborn•
-Screening and treatment of eclampsia and pre-e-clampsia (including timely delivery)'
Maternal and fetal assessment
• Monitoring weight gain of mother
• Monitoring fetus- symphysio-fundal height measurement)'
• Screening and treatment of anemia'
·Screening for and prevention and management of sexually transmitted infections (syphilis and HIV)*
Interventions for common physiological symptoms
-Counselling and treatment of common physiological symptoms•
Nutritional interventions
• Counseling and education on healthy eating, keeping physically active and smoking cessation during pregnancy and postpartum period'
• Iron and folic acid supplementation•
• Vitamin B1 supplementation in third trimester•
Health systems interventions to improve the utilization and quality of ANC
-Complication and birth preparedness plan•
• Task shifting for promotion of healthy behaviours by AMWs
Management of complications
• Management of urinary tract infection•
• Management of chronic medical conditions (e.g. hypertension. heart diseases, pre-existing diabetes mellitus)
• Management of obstetric complications (preterm premature rupture of membranes. antepartum haemorrhage)'
• Detection and management of malpresentation and multiple pregnancy (at term)'
• Antenatal corticosteroids for women at risk of birth from 24-34 weeks of gestation when appropriate conditions are met
• Management of abortion, post abortion family planning counseling and services (including threatened or complete abortion. incomplete abortion with manual vacuum aspiration. complicated abortion)'
• Management of ectopic pregnancy'
LABOUR AND CHILDBIRTH (including Immediate Postnatal)
Routine Care
• Facility-based childbirth with a skilled birth attendant (institutional delivery)'
• Routine monitoring with partograph with timely and appropriate care•
• Active management of third stage of labour (oxytoxic drugs and controlled cord traction)'
• Episiotomy and repair of tears•
Additional care (Complications of labour and childbirth)
• Management of prolonged or obstructed labour including assisted delivery and caesarean section·

- Caesarean section for maternal/ foetal indications•
- Induction of labour for medical indications'
- Management of post-partum haemorrhage including manual removal of retained placenta•
- Prevention and management of eclampsia (including with magnesium sulphate)'
- Management of convulsions and unconsciousness with fever (malaria, sepsis)'
- Screening for HIV (if not already tested) and prevention of mother to child transmission'
- Hygienic management of the cord at birth, including use of chlorhexidine where appropriate'

POSTNATAL (mother) (Early and Late Postnatal)

Timing

- Postnatal contact with an appropriately skilled health-care provider, at home or in the health facility, within 24 hours, around day 3, 7 14 days and at 6 weeks after birth'
- Monitor vital signs, state of uterine contraction and vaginal bleeding•

Health Promotion

- Promotion, protection and support of exclusive breastfeeding for 6 months'
- Nutrition and lifestyle counselling, and personal hygiene
- Provision of postnatal vitamin A·
- Provision of Vitamin B1'
- Provision of prophylactic iron and folic acid'

Postpartum contraception

Family planning advice and contraceptives•

Management of complications

- Management of eclampsia'
- Treatment of maternal anaemia'
- Detection and management of post-partum sepsis'
- Early detection of postpartum morbidities (postpartum depression, fistula, intimate partner violence)
- Screening for HIV and initiation or continuation of antiretroviral therapy'

FAMILY PLANNING AND OTHER REPRODUCTIVE **HEALTH** CONDITIONS (including pre-pregnancy, adolescents and youths)

Information, counselling and services for comprehensive sexual and reproductive health including contraception to all women'

- Prevention, detection and treatment of sexually transmitted and reproductive tract infections
- Screening for and management of cervical cancer'
- Counseling and management for infertility
- Comprehensive sexuality education and SRH services for adolescents and youths'

(Note: Categorization of the effective interventions for the maternal and reproductive health is made on the principle of continuum of care. The intervention marked with • should be the minimal essential interventions)

Annex 5: List of Medicines and Equipment for Essential Package of maternal and newborn **(MNH)** interventions

	Interventions and Services Provided	List of Essential Medicines and Equipment Required
I	Routine Care	
1	Diagnose pregnancy (Clinical diagnosis)	Pregnancy test kit, Tape measure, weighing scales Sphygmomanometer and stethoscope, trumpet, doptone, Haemoglobin colour scale, urine test strips for protein and glucose, thermometer). ultrasound scanner
2	Identify/ Screen for danger signs including bleeding, high blood pressure, abnormal presentation, etc.	
3	Monitor growth of fetus (Fundal height)	
4	Monitor mother's weight-gain	
5	Give tetanus toxoid	Vaccine (TT vaccine)
6	Give prophylactic iron and folic acid	Iron and folic acid
7	Give B1 in third trimester	Vitamin B1
8	Give Mebendazole for deworming	Mebendazole
9	Screen for pre-eclampsia or hypertension	Sphygmomanometer
10	Screen for anaemia	Haemoglobinometer at Township level or Haemoglobin colour scale
11	Manage severe anaemia (< 7 gm/dl) with symptoms or in last trimester	Ferrous Salt (liquid or tablet) Ferrous Salt+ Folic Acid (tablet) Folic Acid (tablet) Hydroxycobalamine (injection) Blood products
12	Counselling & Screening for Syphilis & HIV	<u>For Syphilis</u> Onsite tests and laboratory equipment Penicillin Counselling material For HIV HIV test kits Antiretroviral drugs Cotrimoxazole Counselling material
13	Provision of CDK	Clean Delivery kits
14	Examination for malpresentation or multiple Pregnancy	Tape measure, Ultrasound scan for Township level, Stethoscope
15	Health education on the importance of antenatal care, maternal nutrition, birth preparedness and danger signs in pregnancy, institutional delivery, family planning, immunization & exclusive breast feeding	BCC/IEC materials (posters, pamphlets, CD, DVD)

	Interventions and Services Provided	List of Essential Medicines and Equipment Required
II	Manage complications of pregnancy	
16	Manage threatened or incomplete abortion (<22 week of Pregnancy)	Ultrasound scan Materials for counselling, health education and health promotion Manual Vacuum aspiration equipment Uterotonics (Misoprostol, Oxytocin) Sphygmomanometer Analgesics and local anesthetics Full range of contraceptive Parenteral and oral antibiotics Intravenous fluids Oxygen Blood and transfusion sets Operating theatre drugs, and equipment Surgical procedures as required
17	Bleeding per vagina (>22 week of pregnancy)	
18	Manage incomplete abortion (Manual Vacuum Aspiration)	
19	Manage complicated abortion	
20	Manage ectopic pregnancy	
21	Manage urinary tract infection	Antibiotics in line with essential medicine guidelines
22	Manage fever / malaria (Rapid diagnostic test)	Antimalarial drugs Insecticide Treated Nets
23	Management of absence of fetal movements	
24	Manage preterm prelabour rupture of membranes	For induction of labour Uterotonics (Oxytocin and/or Misoprostol) Partograph Stethoscope. Sphygmomanometer Antibiotics Erythromycin <u>For prevention of neonatal respiratory distress syndrome</u> Corticosteroids (Betamethasone . Dexamethasone)
25	Manage PIH/Eclampsia/Hypertension	Calcium Low dose aspirin (for prevention of eclampsia in high risk women) Methyldopa, Hydralazine, Nifedipine (for treating severe hypertension in pregnancy) Magnesium sulphate injection (for prevention and treatment of eclampsia)
III	Labor and childbirth	
26	Assess and monitor progress of labour/Recognize delay	Thermometer Partograph Stethoscope Fetal stethoscope

	Interventions and Services Provided	List of Essential Medicines and Equipment Required
27	Active management of third stage of labour Oxytoxic drugs and controlled cord traction)	Uterotonics (Oxytocin, Misoprostol)
28	Episiotomy and repair of tears	Episiotomy set, delivery kit (sponge forceps, cotton swabs, etc)
29	Manage Breech presentation and delivery	
30	Manage Transverse lie	
31	Conduct Vacuum extraction	Vacuum extractor
32	Cord clamping	Delivery kit
33	Hygenic management of the cord	7.1% chlorhexidine
34	Forceps delvery	Forceps Delivery kit
35	Induction of labour	Uterotonics (Oxytocin and/or Misoprostol) Partograph
36	Caesarean section	Infusion fluids Antibiotics (Ampicillin or Cefazolin) Operating theatre Surgical equipment Anaesthetic medicine and equipment Bload and blood transfusion kits Laboratory equipment for biochemical and microbiological tests sphygmomanometer
37	Treat shock	Infusion fluids,drip set,needles, cannula
38	Give blood transfusion	Transfusion set and needles Tests for HIV,Hepatitis B,C, grouping & matching
39	Manage PPH	Long gloves Uterotonics (Oxytocin, Ergometrine,Misoprostol) Equipment to repair tears
40	Manual removal of retained placenta	Long gloves Uterotonics (Oxytocin,Ergometrine,Misoprostol) IV fluids Blood transfusion Facilities for surgery and anaesthesia
41	Manage convulsions or unconsciousness: eclampsia	Antihypertensives, Magnesium sulphate injection
42	Manage maternal sepsis	Antibiotics (Ampilcillin, Gentamicin, Metronidazole)
IV	Postnatal care (mother)	
43	Monitor vital signs, state of uterine contraction and vaginal bleeding	
44	Give postnatal vitamin A	Vitamin A
45	Give Bt	Vitamin Bt
46	Give prophylactic iron and folic acid	Iron and folic acid
47	Detect postnatal danger signs and complications	Lab tests for detection of maternal anemia

	Interventions and Services Provided	List of Essential Medicines and Equipment Required
48	Manage postnatal danger signs and complications	For treatment of maternal anemia Ferrous Salt (liquid or tablet) Ferrous Salt+Folic Acid (tablet) Fotic Acid (tablet) Hydroxycobalamine (injection) Blood products For treatment of QOStQartum seQsis Antibiotics (Ampicillin, Gentamicin, Metronidazole)
49	Counselling on postpartum family planning and maternal nutrition	Counseling materials on nutrition and contraception sarier methods (mate and female condoms) Oral contraceptives (Progestin only pills) Injection depo provera Subcutaneous depo provera Implants IUD Female sterilization (tubectomy services)
V	Family Planning	
50	Health Literacy on family planning and contraception	Counseling materials and job aids
51	Counselling for informed choice of contraceptive methods	Counseling materials and job aids
52	Distribute mate and female condoms and explain their use	Male and female condoms Counselinq materials and job aids
53	Distribute Emergency Contraceptive Pills and explain their use	Emergency contraceptive pills Counseling materials and job aids
54	Distribute Oral Contraceptives and explain their use	Oral contraceptives (combined pill, progesterone only pil) Counseling materials and job aids
55	Administer i.m Depot Provera and explaints use	IM depo provera Counseling materials and job aids
56	Administer subcutaneous Depot Provera and explain its use	Subcutaneous depo provera Counselinq materials and iob aids
57	Insert IUD and explain its use, remove IUD	IUDS, copper T Equipment for IUD insertion Counseling materials and job aids Equipment for IUD removal
58	Insert Contraceptive Implant Remove Implant	Implants Equipment for implant insertion Counseling materials and job aids Equipment for implant removal
59	Permanent surgical methods (female)	Operating theatre Surgical equipment Counselinq materials and iob aids
60	Health education for adolescents on reproductive health	Counseling materials and job aids

	Interventions and Services Provided	List of Essential Medicines and Equipment Required
VII	Cervical cancer	
61	Screening of cervical cancer	Equigment Needed for Visual Insgeclion with Acetic Acid (VIA) Examination table Adequate light source (halogen torch or nashlight) Instrument tray Cotton swabs Vaginal speculum New examination gloves or high-level disinfected surgical gloves 3% to 5% acetic acid (white table vinegar) solution Report form or register to record the result
62	Cryotherapy	Cryosurgical devices Gas supplies and gas cylinders Necessary connectors

Annex 6. Maternal Health Stakeholders

Ministries	Councils	INGOs
Ministry of Health and Sports	Myanmar Medical Council	Burnet Institute
Ministry of Social Welfare. Relief and Resettlement	Myanmar Nurses and Midwives Council	Care Myanmar
Ministry of Education		Danish Red Cross
Ministry of Labour, Immigration and Population		Community Partners International
		Health Poverty Action
MOHS Departments, Divisions and Programmes	**National NGOs**	John Snow International
Department of Public Health	Myanmar Medical Association	Marie Slopes International
Department of Medical Services	Myanmar Maternal and Child Welfare Association	Japanese Organization for International Cooperation in Family Planning (JOICFP)
Department of Human Resources and Development	Myanmar Nurses and Midwifery Association	JHPIEGO (Johns Hopkins Program for International Education in Gynecology and Obstetrics)
Department of Medical Research	Myanmar Women's Affairs Federation	Medecins du Monde
Universities of Medicine, Nursing/Midwifery and Public Health	Myanmar Health Assistants Association	Population Services International (PSI)
Maternal and Reproductive Health Division (MRH)	Myanmar Red Cross	Program for Appropriate Technology in Health (PATH)
Child Health Development Division (CHDI	**Multilaterals**	Ipas
Expanded Programme on Immunization	IOM	Pact Myanmar
Health Literacy and Promotion Unit	UNFPA	Relief International
Health Management and Information System Division	UNICEF	Save the Children
School Health Division	WHO	Pathfinder
National Nutrition Centre	3 MDG Fund	International Rescue Committee
National Malaria Control Programme	**Bilaterals**	
National AIDS Programme	UK Aid	
	Japanese International Co-operation Agency (JICA)	
	USAID	

Annex 7: Objectives and core targets of the Global Strategy for Women's, Children's and Adolescents' Health (SDG targets in parentheses)

Survive

Reduce global maternal mortality to less than 70 per 100 000 live births (SDG 3.1)

Reduce newborn mortality to at least as low as 12 per 1000 live births in every country (SDG 3.2)

Reduce under-5 mortality to at least as low as 25 per 1000 live births in every country (SDG 3.2)

End epidemics of HIV, tuberculosis, malaria, neglected tropical diseases and other communicable diseases (SDG 3.3)

Reduce by 113 premature mortality from non-communicable diseases and promote mental health and well-being (SDG 3.4)

Thrive

End all forms of malnutrition and address the nutritional needs of adolescent girls, pregnant and lactating women and children (SOG 2.2)

Ensure universal access to sexual and reproductive health-care services (including for family planning) and rights (SDG 3.7 and 5.6)

Ensure that all girls and boys have access to good-quality early childhood development (SDG 4.2)

Substantially reduce pollution-related deaths and illnesses (SDG 3.9)

Achieve universal health coverage, including financial risk protection and access to quality essential services, medicines and vaccines (SDG 3.8)

Transform

Eradicate extreme poverty (SDG 1.1)

Ensure that all girls and boys complete free, equitable and good-quality secondary education (SDG 4.1)

Eliminate all harmful practices and all discrimination and violence against women and girls (SDG 5.2 and 5.3)

Achieve universal and equitable access to safe and affordable drinking water and to adequate sanitation and hygiene (SDG 6.1 and 6.2)

Enhance scientific research, upgrade technological capabilities and encourage innovation (SDG 8.2)

Provide legal identity for all, including birth registration (SDG 16.9)

Enhance the global partnership for sustainable development (17.16)