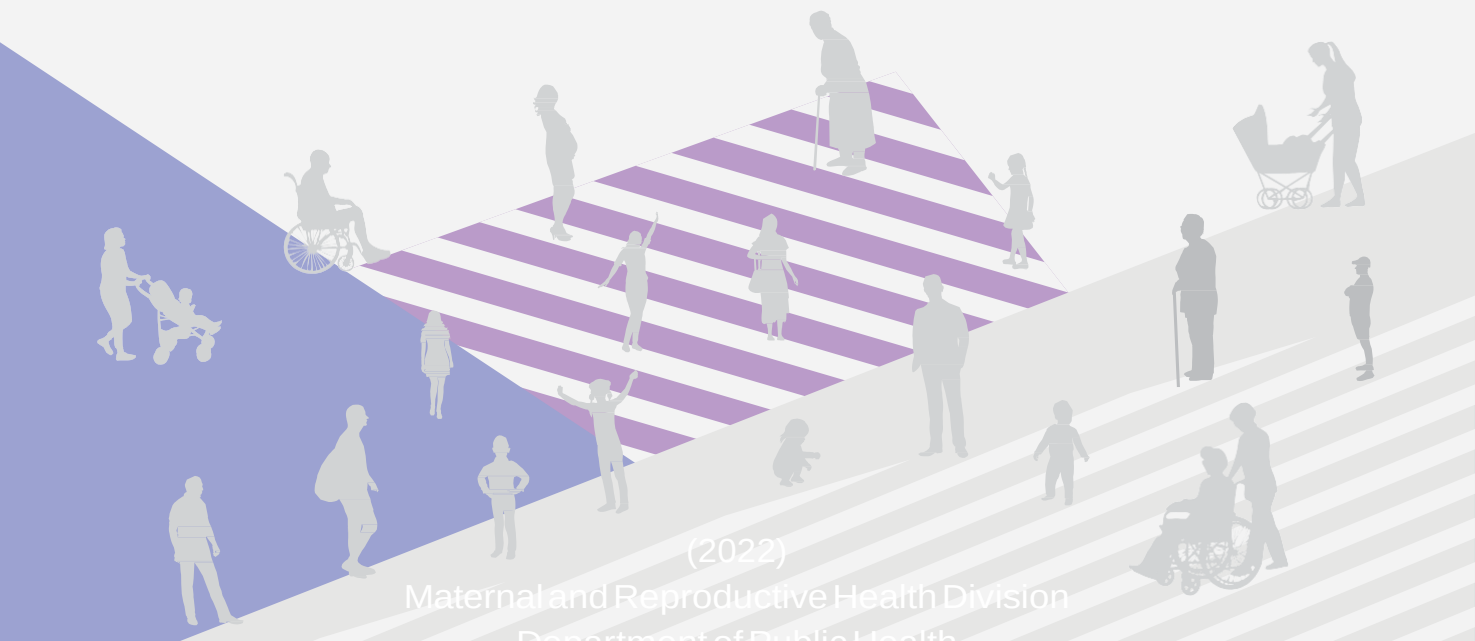
National Sexual and Reproductive Health and Rights Policy



(2022)

Maternal and Reproductive Health Division

Department of Public Health

Ministry of Health

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Foreword

Myanmar's National Population Policy (Draft) was formulated in 1992 in which the needs of reproductive health in the country were highlighted by ensuring the availability and accessibility of birth-spacing services to all married couples.

Moreover, Myanmar has been one of the signatory countries to International Conference on Population and Development Programme of Action since 1994.

A decade later, the Myanmar Reproductive Health Policy of 2002 set a specific goal in reproductive health, "to attain a better quality of life by improving reproductive health status of women and men, including adolescents, through effective and appropriate reproductive health programs undertaken in a life-cycle approach." The Myanmar Reproductive Health Policy also spelled out ten key statements as its core principles.

After that, the first Five Year Strategic Plan for Reproductive Health (2004-2008) was formulated for the implementation of components of reproductive health followed by second (2009-2013) and third Five Year Strategic Plan for Reproductive Health (2014-2018). Those strategic plans were comprehensive in outlining detailed service provisions by the Ministry of Health and all stakeholders, including estimated budget.

In addition to signatory country to International Conference on Population and Development Programme of Action, Myanmar has also pledged commitment to the Family Planning 2020 (FP2020) global partnership which continues as FP 2030. A Costed Implementation Plan to meet Myanmar's FP2020 commitments was developed in 2014, which complements the Five Year Strategic Plan for Reproductive Health.

Myanmar also endorsed the Sustainable Development Goals in 2015, including targets on universal access to sexual and reproductive health care services and reproductive rights by 2030.

The year 2018 marks a policy shift for sexual and reproductive health and rights (SRHR) in Myanmar within the context of its changing needs. To improve availability, accessibility and quality of SRHR services, the National SRHR Policy addresses SRHR challenges faced by people of Myanmar and calls for strengthening of the health sector by increasing sustainable resource allocation to improve access to SRH services. The Policy is formulated based on the situation of SRH in Myanmar, commitments and existing policies and plans, related to SRH as well as lessons learned and best practices from Myanmar and other countries in line within Myanmar context.

I believe that the implementation of SRHR policy will ensure reducing morbidity and mortality of mothers and children, promoting the full potentials of their development and fulfilling the needs of people in Myanmar with no one left behind.

On behalf of the Ministry of Health, I would like to extend my gratitude to each and everyone from ministries, related departments, health institutions, professional organizations, local and international non-governmental organizations, development partners, private sectors, ethnic health organizations, community based organizations and civil society organizations involved in the whole process of formulation of this Policy for dedicating their time and contributing their expertise. I also believe all of you to actively involve and engage in implementation of this policy into actions for betterment of people in Myanmar.

HE Dr Thet Khaing Win
Union Minister
Ministry of Health

Acronyms

- AAAQ Availability, Accessibility, Acceptability and Quality
- ARV Antiretroviral
- CDSR Child Death Surveillance and Response
- CSE Comprehensive Sexuality Education
- EPHS Essential Package of Health Services
- EPMM Ending Preventable Maternal Mortality
- FGM Female Genital Mutilation
- FP Family Planning
- FSW Female Sex Workers
- GBV Gender-based Violence
- HIV/AIDS Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
- HPV Human Papillomavirus
- HTS HIV Testing Services
- ICPD International Conference on Population and Development
- ICT Information and Communication Technologies
- KAP Key Affected Population
- LGBTQIA+ Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Asexual
- MCCT Maternal Child Cash Transfer
- MDSR Maternal Death Surveillance and Response
- MISP Minimum Initial Service Package
- MW Midwife
- MNCH Maternal, Newborn and Child Health
- MOH Ministry of Health

- MRH Maternal and Reproductive Health
- MSM Men who have sex with men
- OSCC One Stop Crisis Center
- PMTCT Prevention of Mother to Child Transmission
- PWID People who inject drugs
- RTI Reproductive Tract Infection
- SDGs Sustainable Development Goals
- SGBV Sexual and Gender Based Violence
- SOP Standard Operating Procedures
- SRH Sexual and Reproductive Health
- SRHR Sexual and Reproductive Health and Rights
- STI Sexually Transmitted Infection
- UHC Universal Health Coverage
- UN United Nations
- UNAIDS The Joint United Nations Programme on HIV/AIDS
- UNICEF United Nations Children Fund
- UNFPA United Nations Population Fund
- WHO World Health Organization

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Executive Summary

The development of Myanmar's first National Sexual and Reproductive Health and Rights (SRHR) Policy represents a historic step forward for the country. It signals Myanmar's commitment to advancing comprehensive, integrated, rights-based sexual and reproductive health for all people and provides important direction for the design of future strategic plans, service delivery guidelines and protocols, and programs.

The National SRHR Policy targets audiences at all levels, including decision-makers in Government; donor constituencies; implementing partners; health providers based in facilities (public and private) and in communities; and beneficiaries, including community members and leaders.

The National SRHR Policy sets out a vision for all persons living in Myanmar to enjoy SRHR to the fullest extent. Its mission is to provide high-quality, rights-based, accessible, acceptable, and affordable services in an equitable and sustainable manner to women, men, children, adolescents, and youth, including marginalized and vulnerable groups.

Overall objectives of the National SRHR Policy are to inform decision makers, development/ implementing partners, health providers, and beneficiaries about the policy and ensure that they use the policy in their work and/or lives. It also aims to aid in the reform of existing laws, regulations, and definitions that restrict access to essential SRHR information and services, especially among adolescents, youth, and marginalized and vulnerable groups.

The following are the policy statements that will guide the implementation of the National SRHR Policy:

- Comprehensive, high-quality health information and services will be provided to all women throughout pregnancy, childbirth, and the postpartum period, and adolescent girls, newborns, and children, especially those who are economically disadvantaged and live in hard-to-reach geographies and including persons with special needs with or without disabilities.
- All individuals of reproductive age, regardless of marital status, will have equitable access to quality family planning information, commodities, and services and will have "the freedom to decide on the desired number of children and determine the healthy timing and spacing of pregnancies".
- The highest achievable standard of sexual and reproductive health for all adolescents will be pursued by protecting and fulfilling adolescents' right to information, quality and inclusive services, in addition to promoting enabling environments and opportunities to develop life skills.

- Assuring gender equality in health through gender-sensitive approaches to be mainstreamed throughout all levels of the health system, and individuals affected by gender-based violence will have ready access to quality, comprehensive sexual and reproductive health services.
- All individuals, regardless of age, sex, sexual orientation, gender identity, ability, disease status, behaviours, work and social movement, will have their dignity and rights upheld, including their right to health.
- All women, men, and young people will have access to information, prevention, early diagnosis, and care for reproductive health morbidities.

Chapter 1 - Background

1.1 Introduction and Rationale

The development of Myanmar's first National Sexual and Reproductive Health and Rights (SRHR) Policy represents a historic step forward for the country. It signals Myanmar's commitment to advancing comprehensive, integrated, rights-based sexual and reproductive health for all people and provides important direction for the design of future strategic plans, service delivery guidelines and protocols, and programs. The policy will also help to achieve the Sustainable Development Goals.

Myanmar is a middle-income country located in the western portion of the mainland of Southeast Asia. According to the 2014 Myanmar Population and Housing Census, its total population is 51.48 million. Females account for 52 percent of the population and males for 48 percent.[1] Myanmar is relatively young, with more than half of the population under 30 years of age. The country is also multicultural and has 135 ethnic races with different cultural habits and norms. Its varying geographical terrains, multi-ethnicity and fragmented health services provision tend to serve as barriers to deliver and access sexual and reproductive health services, including gender-based violence services, in a timely manner. Access to appropriate health services for the wide range of sexual and reproductive health problems is an urgent call.

About 20 years ago, the Ministry of Health (MOH) approved the Myanmar Reproductive Health (RH) Policy (2002), which sought to improve the reproductive health status of women, men, and adolescents. It was the first policy of its kind to set strategic direction for service delivery and resource mobilization related to reproductive health. The Myanmar RH Policy, however, only focused on delivering the essential reproductive health package, and did not explicitly incorporate human rights.

Since the approval of the Myanmar RH Policy (2002), significant social, economic, political, and technological transitions have taken place within the country that have made it necessary and possible for Myanmar to broaden its approach to addressing reproductive health. It has become increasingly clear that if Myanmar is to meet the needs of its entire population, the country must adopt a new policy that advances comprehensive SRHR for all of its people, including marginalized and vulnerable groups.

The National SRHR Policy addresses challenges faced by the people of Myanmar and calls for strengthening the health sector by increasing sustainable resource allocation to improve access to SRH services. It aims to ensure the harmonization of Myanmar's laws pertaining to SRHR with human rights standards to the fullest extent possible in the country's setting. The National SRHR Policy also builds on important international initiatives, endorsements, and commitments made by the Government of Myanmar, including:

1. International Conference on Population and Development (ICPD) Programme of Action
2. Convention on the Elimination of All Forms of Discrimination against Women
3. Convention on the Rights of the Child
4. Beijing Platform for Action
5. Millennium Development Goals
6. Every Woman, Every Child
7. Family Planning 2020 & 2030
8. Sustainable Development Goals (SDGs)

The National SRHR Policy also links with key domestic policies, including:

1. National Health Policy (1993)
2. National Population Policy (Draft) (1992)
3. Myanmar Reproductive Health Policy (2002)
4. National Strategic Plan for the Advancement of Women (2013-2022)
5. National Youth Policy (2018)

1.2 Policy Development Process

The National SRHR policy was developed using an evidence-driven and highly consultative process. The Maternal and Reproductive Health Division of the Ministry of Health in Myanmar, with technical and financial support from PATH and in collaboration with UN organizations, international NGOs (INGOs), other concerned stakeholders, conducted several reviews and consultations to inform policy development. The whole process was prepared by looking into the future as a “beginning with the end” for successful scale-up. Maximum utilization of existing information, both quantitative and qualitative analysis, from available and shared sources was applied for the six main areas of the policy formulation process - Maternal, Newborn, and Child Health (MNCH); Family Planning; Adolescent SRHR; Gender and Gender-Based Violence (GBV); Special Groups (Inclusivity) and RH Morbidities. Reviews undertaken included:

- A situation and gap analysis between November 2017 and February 2018 to assess the status of SRHR in the country;
- An international literature review, whose scope was limited to learning from other countries’ experiences in reproductive health policy development and

implementation;

- A review of national reproductive health policies from selected relevant countries, as well as lessons learned documents and published research articles and reports on reproductive health policy;
- A rapid analysis of current Myanmar legislation and relevant policies to serve as the basis for the legal and policy context of the National SRHR Policy; and
- An assessment, carried out through a desk review, to identify national programmatic needs and priorities and the strategic approach for the National SRHR Policy.

Policy recommendations were obtained through discussions during meetings with Core Working Group members and Technical Advisory Groups (TAG) for each of the six priority areas, as well as focus group discussion (FGD) and in-depth interviews with key populations. Consultations were carried out with key stakeholders to solicit their input and priorities. Key stakeholders included: academics and consultants, RH service providers at different levels of care in urban and rural facilities, including ethnic and hard-to-reach areas, community health workers, youth groups, facility administrators, supply chain managers, RH advocacy groups, gender activists, ethnic health organizations, women groups, beneficiaries and current/potential users. A template for the sessions concerned and background documents were developed and provided for discussions towards policy implications on each topic. TAGs were engaged to validate data and solicit technical input from multisectoral stakeholders. As a final step, stakeholder consultation was conducted to vet and finalize the policy.

1.3 Policy Alignment

The National SRHR Policy links to and aligns with the following national and international policies, strategies, and initiatives:

National (Myanmar)

1. National Health Policy (1993)
2. National Population Policy (Draft) (1992)
3. Myanmar Reproductive Health Policy (2002)
4. Myanmar Health Vision 2030
5. Myanmar National Health Plan (2017-2021)
6. Myanmar UHC 2030
7. Five-Year Strategic Plan for Reproductive Health (2014-2018)

8. Five- Year Strategic Plan for Child Health (2014-2018)
9. Five- Year Strategic Plan for Young People's Health (2016-2020)
10. The Constitution of the Republic of the Union of Myanmar
11. Myanmar Customary Law
12. Myanmar Buddhist Women Special Marriage Law
13. The Penal Code (sections in relation to abortion and sterilization)
14. The Health Care for Population Control Law
15. Domestic Criminal Laws
16. Narcotics Drugs and Psychotropic Substances Law
17. Myanmar Multisectoral National Plan of Action for Nutrition
18. Strategy to End Preventable Maternal Mortality in Myanmar (2017-2021)

International

1. Beijing Platform for Action
2. Every Woman, Every Child
3. Family Planning 2020 & 2030
4. Millennium Development Goals
5. Sustainable Development Goals (SDGs)
6. International Conference on Population and Development (ICPD) Programme of Action
7. Convention on the Elimination of All Forms of Discrimination against Women
8. Convention on the Rights of the Child

Chapter 2- Definitions

1. Reproductive Health

Reproductive health is defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

Implicit in this are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.[2]

2. Reproductive Rights

Reproductive rights are legal rights and freedoms relating to reproduction and reproductive health that vary amongst countries around the world.[3] The WHO define reproductive rights as follows: Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence.[2]

Women's reproductive rights may include some or all of the following: the right to legal and safe abortion; the right to birth control; freedom from coerced sterilization and contraception; the right to access good-quality reproductive healthcare; and the right to education and access in order to make free and informed reproductive choices.[4] Reproductive rights may also include the right to receive education about sexually transmitted infections and other aspects of sexuality, and protection from practices such as female genital mutilation (FGM).[4,5]

Reproductive rights began to develop as a subset of human rights in the United Nations 1968 International Conference on Human Rights.[5] The resulting non-binding Proclamation of Teheran was the first international document to recognize reproductive rights when it stated that, "Parents have a basic human right to determine freely and responsibly the number and the spacing of their children."[6]

States, though, have been slow in incorporating these rights in internationally legally binding instruments. Thus, while some of these rights have already been recognized in hard law, that is, in legally binding international human rights instruments, others have

been mentioned only in non- binding recommendations and, therefore, have at best the status of soft law in international law, while a further group is yet to be accepted by the international community and therefore remains at the level of advocacy.[7]

Issues related to reproductive rights are some of the most vigorously contested rights issues worldwide, regardless of the population's socioeconomic level, religion or culture.[8]

3. Sexual Health

The WHO defines sexual health as a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.[9,10]

4. Sexual Rights

The fulfillment of sexual health is tied to the extent to which human rights are respected, protected and fulfilled. Sexual rights embrace certain human rights that are already recognized in international and regional human rights documents and other consensus documents and in national laws.

Rights critical to the realization of sexual health include:

1. the rights to equality and non-discrimination
2. the right to be free from torture or to cruel, inhumane or degrading treatment or punishment
3. the right to privacy
4. the rights to the highest attainable standard of health (including sexual health) and social security
5. the right to marry and to found a family and enter into marriage with the free and full consent of the intending spouses, and to equality in and at the dissolution of marriage
6. the right to decide the number and spacing of one's children
7. the rights to information, as well as education
8. the rights to freedom of opinion and expression, and
9. the right to an effective remedy for violations of fundamental rights[10]

Audience

The National SRHR Policy targets audiences at all levels, including:

i. Decision-makers, especially the MOH; Ministry of Social Welfare, Relief and Resettlement; Ministry of Education; Ministry of Finance and Planning; Ministry of Labour, Ministry of Immigration and Population; and Parliamentarians at all levels including community (on the state and regional level as well as the township level).

ii. Donor constituencies such as United Nations (UN) organizations (UNFPA, WHO, UNICEF, UNAIDS) and other bilateral and multilateral donors

iii. Implementing partners such as non-governmental organizations (NGOs), civil society organizations, ethnic health organizations, and faith-based organizations- including those with a focus on humanitarian and conflict settings.

iv. Health providers based in facilities (public and private) and in communities.

v. Beneficiaries, including community members and leaders.

Chapter 3 – Vision, Mission, Objectives and Principles

3.1 Vision and Mission

Vision: All persons living in Myanmar enjoy sexual and reproductive health and rights to the fullest extent.

Mission: To provide high-quality, rights-based, accessible, acceptable, and affordable sexual and reproductive health services in an equitable and sustainable manner to women, men, girls and boys, adolescents, and youth, including marginalized and vulnerable groups.

3.2 Objectives

Overall objectives of the National SRHR Policy include:

1. To inform decision makers, development/implementing partners, health providers, and beneficiaries about the policy and ensure that they are supported by the policy in their work and/or lives.

2. To aid in the reform of existing laws, regulations, and definitions that restrict access to essential SRHR information and services, especially among adolescents, youth, and marginalized and vulnerable groups.

3.3 Principles

The following principles guide the implementation of the National SRHR Policy and all related service provision:

1. Human rights: The right of clients to the highest attainable standard of SRH, and to make informed decisions about their health free from discrimination, coercion, and violence, will be respected and upheld.

2. Inclusion: The provision of SRH information and services is accessible and adapted for all people, including those with specific needs, and leaves no one behind.

3. Availability, Accessibility, Acceptability and Quality (AAAQ): Quality will be prioritized throughout all aspects of service delivery, including care provided, health commodities distributed, and information shared, and availability, accessibility and acceptability will be assured.

4. Accessibility: No barrier will exist for the entire population to access to SRH information and services, in particular in terms of communication, physical access/coverage and cost.

5. Equality and non-discrimination: Specific and systematic action will be taken to challenge all the factors that contribute to discrimination against people and that prevent access to SRHR on the grounds of age, ability, gender, religion, ethnicity, sexual orientation, behavior and work or any other criteria.

6. Empowerment: The development of self-protection capacities and the agency of people from marginalized and vulnerable groups to claim their rights to access SRH will be supported.

7. Comprehensive: The full range of SRHR information and services will be available to all clients.

8. Human-centered: Clients' needs and preferences will be the first priority for policymakers, program managers, and health providers in the design and delivery of SRH information and service provision.

9. Life-cycle: SRHR programming will be designed for all ages and will recognize that individuals have different needs at different points over their lives.

10. Community engagement: Community members, including marginalized and vulnerable groups, will be involved in all levels of policy and program design and implementation to facilitate ownership of their SRHR.

11. Coordination: Stakeholders will improve coordination to increase access to SRH information and services, address gaps in coverage, and avoid overlap.

12. Transparency, responsibility, and accountability: Decision makers, implementing partners, and health providers responsible for different areas of SRH policymaking, budgeting, and programming will be transparent in their efforts and accountable for their actions.

13. Sustainability: Approaches that build toward program sustainability will be prioritized, including continued implementation of best practices, introduction of new, high-impact products and practices that are cost-effective, and identification of innovative financing mechanisms.

14. Rights-based approach: includes the right to the highest attainable standard of health and the right to self-determination, which means women being entitled to make their own decisions including sexual and reproductive decisions.

Chapter 4 – Policy Implementation

After consultation with diverse stakeholders, six key areas have been prioritized for the National SRHR Policy:

1. Maternal, Newborn, and Child Health
2. Family Planning
3. Adolescents' SRHR
4. Gender and Gender-Based Violence
5. Special Groups (Inclusivity)
6. Reproductive Health Morbidities

4.1 Maternal, Newborn, and Child Health

Maternal, newborn, and child health (MNCH) interventions promote the health and well-being of women throughout pregnancy, childbirth, and the postpartum period, as well as the health and survival of their newborns and children.

Context

Myanmar continues to face challenges in ensuring good health for its mothers, newborns, and children. Many obstacles relate to poor quality of care and coverage issues, in addition to the "three delays" - delay in the decision to seek care, delay in reaching care, and delay in receiving adequate care. Maternal mortality is a significant concern. According the 2014 Myanmar Population and Housing Census, the maternal mortality ratio is 282 deaths per 100,000 live births,[1] with wide disparities across regions. The Global Strategy for Ending Preventable Maternal Mortality (EPMM) states that, by 2030, to achieve the global maternal mortality ratio of less than 70 per 100,000 live births and no country should have a maternal mortality ratio greater than 140 deaths per 100,000 live births. Abortion accounts for 16% of maternal mortality and is the second leading cause of mortality affecting mothers and young people.[11] Although abortion is an important contributor towards maternal mortality, laws on abortion are restrictive and only permit the procedure, in good faith for the purpose of saving the life of the woman which hinders access to reproductive health services for affected women and adolescents with unwanted pregnancy.

While the majority of women receive antenatal care during pregnancy, 63% of deliveries occur at home, and only 37% of births take place in health facilities. In Myanmar, 60% of births are assisted by skilled providers that include nurses, midwives and doctors and another 29% of births are assisted by traditional birth attendants, 6% by auxiliary midwives.[12]High rates of home deliveries are due to many factors, including ill-equipped

facilities, poor referrals, poor infrastructure, the costs of transport, high costs of medical supplies borne by women, and cultural preferences to deliver in the presence of family members as well as to be delivered by whom of more user-friendly such as traditional birth attendants (TBA). In addition, there are limited human and financial resources in rural and remote areas, urban slums and in conflict- and disaster-affected areas of the country.

There is no data available on the prevalence of Pelvic Floor Dysfunction related to deliveries in Myanmar. However, predictive risk factors for Pelvic Floor Dysfunction and Pelvic Organ Prolapse are present in Myanmar, such as extensive physical labor during pregnancy and immediately after delivery, low availability of skilled birth attendants.[11] According to the 2014 Census, the infant mortality rate in Myanmar is 61.8 deaths per 1,000 live births. Nearly half of the under 5 children deaths are neonatal deaths.[1] Myanmar has one of the higher rates of stillbirths as compared to other countries in the region. Approximately 3% of all reported births are affected by prolonged labor that often causes asphyxia, resulting in death or disabilities like cerebral palsy.[13] WHO estimates that 59 out of 1,000 infants have birth defects, translating to a prevalence rate of 5.8%. [14] Annually, 59,435 children are born in Myanmar with birth defects and there are only a few neonatal screens applied in some hospitals, mainly located in cities.[15] Just over half of all children receive basic vaccinations. Nearly 1 in 3 children are stunted, which stems from poor nutrition, leading to disability-related developmental delays in one or more of the following areas of development: perceptual, fine motor, gross motor, and language skills; as well as cognitive, social and emotional development including self-regulation.[15]

Policy Statement

Comprehensive, high-quality health information and services will be provided to all women throughout pregnancy, childbirth, and the postpartum period and adolescent girls, newborns, and children, especially those who are economically disadvantaged and live in hard-to-reach geographies and including persons with special needs with or without disabilities.

Strategies for Policy Implementation

Laws, legislations and procedures

- Address legal barriers and advocate for the removal of restrictive laws, policies and guidelines to expand towards menstrual regulation or safe abortion services to girls and women who are victims of rape and incest, girls and women with physical and mental disabilities, detected foetal anomalies, as well as women in general who cannot carry the pregnancy further due to health or socio-economic reasons, linkage with problem of abandoned children. Improve access to post-abortion care for those who need it.

- Ensure that all children born in Myanmar are registered and provided with a birth certificate, which is a critical first step towards the fulfillment of a whole range of children's rights.
- Ensure that all maternal and child deaths are notified according to the Maternal Death Surveillance and Response (MDSR) and Child Death Surveillance and Response (CDSR) guidelines and that an effective response is provided by all levels of health care providers.
- Institute a Maternal and Child Health Law with the involvement, coordination and collaboration of all stakeholders.

MNCH service providers

- Support the equitable distribution of health facilities and the health workforce, especially in hard-to-reach areas, and create an enabling environment for health care providers to work in hard-to-reach and conflict-affected areas.

Financing

- Establish a sustainable financial security and protection mechanism available to all women, men, and adolescents to ensure accessible and affordable essential sexual and reproductive health services.

MNCH data & information

- Enhance data collection on MNCH and SRH by integrating operational and implementation research into the existing and new programs.
- Ensure a functional Health Management Information System that can produce real-time reports on updated key MNCH indicators.

Medical products, vaccines, and technologies

- Ensure access and available life-saving commodities and medical supplies for MNCH services through integrated logistic information and management system/supply chain system and strengthening the system.

MNCH Service delivery

- Prioritize institutional delivery with skilled attendants at birth to reduce maternal and neonatal morbidity and mortality.
- Strengthen service coverage and quality of care for MNCH, focusing at the time of birth for women and newborns and ensure services are accessible and inclusive.

- Establish MNCH services for all pregnant women in the Essential Package of Health Services (EPHS) of National Health Plan, which should incorporate interventions with quality antenatal and postnatal care including for adolescent mothers/first-time parents, maternal nutrition, delivery services, post-abortion care, family planning (especially post-partum), newborn care services, management of sick children and newborns, and availability of life-saving commodities.
- Enhance the establishment of a robust referral system for comprehensive and basic emergency obstetric and newborn, under-five children (Emergency Childhood illness and care) and few gynecological emergencies.
- Develop neonatal screening and regular postnatal checking up strategies to ensure early detection of birth defects and disabilities, and to ensure early intervention in line with Early Child Development Strategies to prevent and/or limit the burden of disability and impairment in children 0-5 years of age.
- Develop a strategic plan for reaching every newborn with essential care, including community and home-based care.
- Ensure ending of preventable maternal and newborn deaths with the established EPMM guidelines and establishment of milestones including for adolescent mothers/first-time parents.
- Prevent HIV transmission by integrating Prevention of Mother to Child Transmission (PMTCT) services with MNCH services, including testing, counselling and treatment for HIV positive pregnant women.
- Ensure reduction of vaccine preventable deaths among under-five children with sustained commitment of the Expanded Programme on Immunization.
- Promote task shifting of maternal, neonatal and child health interventions to MW for provision of injection and community-based health workers to reach the most in need communities by ensuring skilled based training, supplies and supervision for village-based health workers.
- Advocate for the provision of free or subsidized public sector MNCH services (free for MNCH services in the EPHS) for prioritized states and regions where the need is greatest.
- Refocus on scaling up Integrated Management of Childhood Illness at all levels of care.
- Ensure access to the Minimum Initial Service Package of Reproductive Health Services (MISP) in acute emergencies, scaling up to comprehensive SRH services in more protracted humanitarian and crisis situations. Enhance the

establishment of comprehensive SRH services in humanitarian and crisis situations.

Community Mobilization

- Create demand for MNCH services especially institutional delivery and skilled birth attendance.

4.2 Family Planning

Family planning is defined as "the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility." This includes a wide range of contraceptives - including pills, injectables, implants, intrauterine devices, surgical procedures that limit fertility, and barrier methods such as condoms - as well as non-invasive methods such as the calendar method and abstinence. Family planning also includes information about how to become pregnant when it is desirable, as well as treatment of infertility.[16,17]

Access to family planning is a fundamental human right and is crucial to empowering women and girls to realize their full potential. It is also one of the most cost-effective investments a country can make toward sustainable development.

Context

Although family planning has been a priority for the Myanmar health system since the 1994 ICPD, and significant progress has been made in increasing voluntary access to contraception, challenges remain. Overall, 16% of married women of reproductive age have an unmet need for modern contraceptive methods, with 5% for spacing births and 11% for limiting births.[12] There are notable regional disparities in unmet need in Myanmar, ranging from a high of 23% in Rakhine State and Chin State to a low of 12% in Yangon region and Nay Pyi Taw.[12]

Unmet need has been driven by a number of factors, such as limited availability of skilled service providers; shortages and stock-outs of critical contraceptive methods; a limited offering of long acting contraceptives; access challenges, especially in conflict settings; and a sizeable funding shortfall for FP commodities and services. Restrictive policies also limit task-shifting and accessibility of various contraceptive options. People with disabilities often face barriers in accessing FP as a result of stigma, ignorance, and negative attitudes from society and individuals, including health care providers. For example, it is often assumed that persons with disabilities are not sexually active and therefore do not need family planning. Existing policies and programmes concentrate on the prevention of pregnancy but ignore the fact that many persons with disabilities will eventually have children of their own. Sometimes, women with disabilities suffer forced medical treatment or procedures, including forced sterilization.[18]

Men are not consistently and effectively engaged as full partners in reproductive health and family planning. Information and access to family planning information and services are limited among adolescents and young people as the majority of family planning service provision focuses on married women of reproductive age. Providers' capabilities to provide youth-friendly reproductive health services, including contraception and comprehensive sexuality education, are also limited. FP data collected is of varying quality and is not always shared efficiently or effectively.

Policy Statement

All individuals of reproductive age, regardless of marital status, ability or special entity, will have equitable access to quality and inclusive FP information, commodities, and services and will have the freedom to decide on the desired number of children and determine the healthy timing and spacing of pregnancies.

Strategies for Policy Implementation

1. Raise awareness and provide life-stage appropriate health education on family planning, using locally appropriate strategies, to all individuals who could benefit from access to contraception.

2. Incorporate trainings for all cadres of service providers in the pre-service and in service training curriculum on how to offer comprehensive, quality, inclusive and voluntary right-based family planning and SRH R counseling and services for women, men and adolescents.

3. Improve reproductive health commodity security, especially in places where stock-outs and unmet need for contraception are high, through approaches such as strengthening the capacity of the Logistics Information Management System and conducting implementation research on commodity availability.

4. Promote availability and accessibility of a wide contraceptive method mix, including new as well as long-acting contraceptive methods, at all levels of the health system.

5. Pursue innovative ways to reach the socially and geographically hard-to-reach with modern family planning, including task-shifting, community-based distribution, self-administered methods of contraception, door-to-door sales as well as social marketing.

6. Implement a total market approach to family planning, which involves strengthening coordination between public and private sector actors to enable efficient use of resources and promote equitable inclusive and sustainable access to family planning.

7. Review and revise existing laws, policies and procedures that limit access to family planning methods including emergency contraception, female and male sterilization, and injectable contraceptives, as well as laws, policies and procedures that limit access to accurate information and quality services by adolescents.

8. Encourage greater male involvement in reproductive health and family planning by advocating with opinion leaders; disseminating messages and materials on men's shared responsibility in parenthood and sexual and reproductive behavior; and training health providers and the wider community on how to engage men as partners in addressing gender inequality.

9. Advocate the importance of SRHR and family planning among various stakeholders including decision makers, community leaders, and media.

10. Enhance data collection on family planning and sexual and reproductive health by integrating operational and implementation research into existing and new programs.

11. Monitor the quality of contraceptives sold in the commercial sector and take corrective action as needed and ensure the provision of correct information and appropriate counseling on the chosen methods by different outlets.

4.3 Adolescent SRHR

Adolescents are defined as individuals who are between 10-19 years of age. Adolescence is a period of life with specific health and development needs and rights. It is a time where lifelong health behaviors are formed, when pathways of opportunity or risk emerge, and when the future life course begins to take shape.

Context

Many adolescents in Myanmar face issues on SRHR, which can be traced to a variety of root causes. Adolescents generally have low awareness or are inaccurately informed about reproductive health and safer sex practices. For example, one qualitative study conducted among out-of-school youth reported that few had accurate and comprehensive understanding of puberty, reproduction, and reproductive health, despite many already engaging in sexual activity.[19]Adolescent SRH is a taboo topic in Myanmar culture, and most parents and children rarely discuss these issues. Adolescents are often reluctant to seek SRH services because healthcare providers may be judgmental toward youth. Several laws, policies and procedures limit the accessibility of SRH services for adolescents and youth.

As a result, adolescents are at particular risk of unintended pregnancy, unsafe abortion, STIs/HIV, sexual abuse, and GBV. The adolescent fertility rate in Myanmar is high at 33.2 births per 1,000 women age 15-19 years, with higher rates in rural areas than urban

areas.[1] Nearly 1 in 5 married adolescents aged 15-19 years have an unmet need for modern contraception.[12] In Yangon, HIV prevalence for key populations under 25 years of age are as follows: female sex workers (9%)[20]; men who have sex with men (14%)[21]; and people who inject drugs (12.5%).[22]

Policy Statement

The highest achievable standard of sexual and reproductive health for all adolescents will be pursued by protecting and fulfilling adolescents' right to information, quality and inclusive services, in addition to promoting enabling environments and opportunities to develop life skills.

Strategies for Policy Implementation

1. Adopt and scale up comprehensive sexuality education (CSE) inside and outside of school settings and integrate CSE with broader life skills education.

2. Develop adolescents' life skills that are linked to positive SRHR outcomes, such as self-esteem, self-control, higher-order thinking skills, communication, and goal orientation.

3. Ensure access to quality, evidence-based and accessible SRHR information using dissemination channels such as CSE, online platforms, mass media, social media, and other information, communication, and technology (ICT) measures.

4. Sensitize healthcare providers to the unique health needs and concerns of all adolescents so that these providers can offer compassionate, confidential, non-judgmental and unbiased care to youth.

5. Draw attention to the need for change in the health system in terms of guidelines and supportive supervision that go beyond sensitizing providers in order to create a welcoming environment and system of provider accountability to quality adolescent sexual and reproductive health. These values need to be included in pre-service as well as in service training.

6. Ensure a continuous, reliable, and affordable supply of an expanded method mix of SRH commodities for all adolescents, so that they have access to all methods.

7. Recognize the diversity among adolescents and design and implement interventions that respond to their different needs.

8. Engage community members, such as parents, teachers, elders, religious leaders, and policymakers, to create an enabling social and cultural environment for adolescent SRHR.

9. Safeguard the sexual and reproductive rights of adolescents including the right to information, to make their own decisions, to healthcare, to self-protection, and to participation.

10. Reform existing laws, policies, and regulations that hinder access to SRH services among adolescents, such as contraception and safe abortion.

11. Strengthen coordination among Ministries and Departments, including the MOH, Ministry of Social Welfare, Relief and Resettlement and the Ministry of Education in order to strengthen joint interventions for young people.

12. Enhance data collection on adolescent sexual and reproductive health by integrating operational and implementation research into existing and new programs.

13. Maximize the use of adolescent and youth sexual and reproductive health information through youth-led organizations.

14. Ensure platforms and opportunities for youth voice and participation in policy development, policy implementation and program design.

4.4 Gender and Gender-Based Violence

Gender refers to the social, cultural, and traditional differences between the two sexes (male and female). Gender is also used to denote a range of identities that do not correspond to established ideas of male and female.

Gender-based violence (GBV) refers to any act that is perpetrated against a person's will that causes suffering and stems from harmful gender norms and unequal power relationships among genders. GBV can be physical, sexual, and/or psychological. Although GBV occurs across demographics, women and girls are disproportionately affected due to the culturally-determined, unequal power relationships between men and women.

Context

Myanmar, as with other countries in the Southeast Asian region, has experienced a wide array of gender inequality issues that most often affect women and girls. Gender inequality negatively impacts women's and girls' ability to obtain and understand important SRHR information, access and benefit from high quality SRH interventions, and exercise their right to health. Gender inequality also shapes other areas of women's and girls' lives related to SRHR, such as education, employment, and political participation. There is low awareness of the importance of gender sensitive approaches to health and how gender equality can promote women's empowerment in all facets of their lives.

The prevalence of GBV in Myanmar is not well characterized due to inadequate national

data. There is no regular reporting practice established for GBV cases, nor is there a nationwide gender-focused information management system. UNFPA estimates that 20% of women experience some form of violence, and 3% experience sexual and gender-based violence (SGBV), though the figures are likely higher due to barriers in reporting. Myanmar Demographic and Health Survey has stated that 15% of women aged 15-49 have experienced physical violence since age 15 among which 55% reported their current husband and 19% reported a former husband as the perpetrator while 3 % of women age 15-49 have ever experienced sexual violence.[12] Other qualitative assessments and surveys also indicate a high level of intimate partner violence. Violence and the threat of violence limit women's autonomy to make decisions about their SRH, and SGBV can leave women at risk of unintended pregnancies, unsafe abortions, and sexually transmitted infections (STIs), including HIV. These concerns are magnified for women and girls living in humanitarian and conflict settings. Comprehensive services for survivors of GBV are not universally available, and health providers are not well-informed about GBV. Coordination among the various sectors involved in GBV response is limited.

Policy Statement

Gender-sensitive approaches will be mainstreamed throughout all levels of the health system, and individuals affected by GBV will have timely access to quality, comprehensive sexual and reproductive health services.

Strategies for Policy Implementation

1. Advocate for gender budgeting in health care to ensure a gender responsive approach throughout programmes.

2. Build the capacity of policymakers, healthcare workers, formal and informal community leaders, and other response providers on awareness of gender, gender sensitivity in health provision, gender equality, and GBV.

3. Ensure that strategies to prevent GBV are incorporated into national legislation, including but not limited to gender equality and parity measures.

4. Improve data collection on gender and GBV by disaggregating data by sex and age, collect data on all aspects of women's empowerment and taking steps to establish a national data collection mechanism or integrate ethical GBV data collection into existing systems

5. Create, fund, and implement One Stop Crisis Centres (OSCCs) for GBV victims/survivors that provide quality comprehensive services in accordance with guiding principles of safety, respect, non-discrimination, and confidentiality through effective linking with related sectors like police, legal and social welfare. Ensure OSCCs are available in high-need areas, especially conflict settings.

6. Strengthen training for GBV and health care providers on referral systems,

rights of survivors, and the provision of comprehensive information and non-discriminative, non-judgmental and confidential services on SRH and GBV and ensure dissemination of and adherence to National Guidelines.

7. Include knowledge of gender, gender equality, GBV prevention and response into university pre-service medical and nursing curricula.

8. Incorporate gender provisions in national laws, policies, plans, and programs into security and justice sector mandates, procedures, and accountability systems to protect women and girls against all forms of GBV.

9. Improve coordination among all relevant stakeholders to prevent, assess, refer, treat, and redress GBV, including healthcare providers, psychosocial counselors, crime police, and legal officials.

10. Develop standard operating procedures (SOPs) or protocols for GBV-affected persons and ensure the utilization by public- and private-sector providers.

11. Reduce social stigma, shame, and discrimination that impact women's options, choices and decisions when it comes to SRH and GBV services.

12. Address legal barriers and advocate for the removal of restrictive laws, policies and guidelines to expand towards menstrual regulation or safe abortion services to girls and women who are victims of rape and incest.

4.5 Special Groups (Inclusivity)

Certain subgroups within the population face additional challenges in fulfilling their right to SRH due to issues such as stigma, discrimination, criminalization, and poor living conditions. In the era of the SDGs, which demands a more holistic and equitable approach to achieving good health for all, the National SRHR Policy will be all-inclusive in nature and identify strategies to strengthen the SRHR of the following five special groups, noting that there are a range of other vulnerable groups that may intersect with the five identified, such as orphans and abandoned children, youth without guardians, street youth, survivors of human trafficking, and child soldiers.

1. Key populations refer to a diverse set of subgroups including Lesbian, Gay, Bisexual, Transgender, Questioning, Queer, Intersex, Asexual (LGBTQQIA+) individuals; men who have sex with men (MSM); sex workers; young key affected populations (YKAPs); people living with HIV (PLHIV) and people who inject drugs (PWID).

2. Migrants refer to individuals who move voluntarily or are forced to move (internally displaced persons), whether within a country or between countries and states.

3. Individuals in emergency situations are those who are affected by natural or manmade disasters/conflicts.

4. The elderly refers to people who are 60 years of age and older.

5. People with disabilities refer to any person who has physical, visual, auditory, and/or intellectual impairments.

Context

While each special group has its specific challenges, there are several cross-cutting issues. All of these groups have limited access to quality, comprehensive, and nonjudgmental SRH information and services. Migrants and individuals in emergency situations can be especially difficult to reach due to poor service coverage in the geographies where they are located. Other groups, including the elderly and disabled, require special arrangements to make services more accessible, like handicap friendly facilities. Stigma, discrimination, and punitive laws that criminalize certain behaviors-such as same-sex sexual relations, sex work, and drug use-drive these groups further underground and away from critical SRH services. Data collection on the health status and needs of these groups is lacking because there are no indicators, and the absence of data makes it harder to secure dedicated SRH resources for these groups. Unintended pregnancies; STIs/HIV; other communicable diseases; GBV and sexual abuse, and water, sanitation, and hygiene issues are common threats.

Policy Statement

- All individuals, regardless of age, sex, sexual orientation, gender identity, ability, disease status, behaviours, work and social movement will have their dignity and rights upheld, including their right to health.

Strategies for Policy Implementation

1. Ensure equitable, widespread access to user-friendly SRHR services in public and private sectors that are responsive to the specific needs and life circumstances of special groups.

2. Reduce stigma and discrimination against marginalized and vulnerable groups, especially through sensitizing decision makers, health providers, and the general public.

3. Integrate STI/HIV and SRHR to foster improved uptake of promotive, preventive, and curative services.

4. Develop SOPs or protocols for special groups and ensure their utilization by public- and private-sector providers.

5. Leverage innovative ICT approaches including social media and evidence-based strategies such as peer education-to reach hard-to-reach populations with SRHR information with adequate consideration for access to technology, language and other cultural considerations.

6. Improve data collection on the health status and needs of special groups and develop a consistent set of indicators where warranted.

7. Allocate a focal point and dedicated budget for special groups including migrants, persons with disability and the elderly.

8. Reform and revise laws that criminalize the behaviors of marginalized and vulnerable groups and those that hinder their ability to seek health services. Encourage the active participation of special groups in the design and delivery of health policies and programs that affect them, to honor the principle 'nothing about us, without us.'

9. Humanize the system to understand and involve special groups as normal human beings affected by SRH issues.

10. Ensure readiness to provide the MISP in acute emergencies through improved integration of SRHR concerns in the Myanmar Disaster Risk Reduction Plan and improved emergency preparedness measures.

4.6 Reproductive Health Morbidities

Reproductive health morbidities can be understood as a wide range of health issues and problems related to reproductive organs and functions. These include obstetric morbidities, which are sustained during pregnancy, delivery, and postpartum; and gynecological morbidities, which include reproductive tract infections, cervical cell changes and malignancies, and sub-fertility.

In the Myanmar context, reproductive health morbidities of note include cervical cancer, breast cancer, STIs/reproductive health tract infections (RTIs), HIV/AIDS, and infertility/ sub-fertility.

Context

Reproductive health morbidities continue to pose a threat to the health and well-being of women, men, and youth in Myanmar. Cervical cancer is the second most common cancer among women in Myanmar. Every year, 7,000 women are diagnosed with cervical cancer, and more than half die from the disease.[23] There is no specific funding source for cervical cancer control and no national body for cervical cancer control and prevention; therefore, these services are not yet available countrywide. In 2020 there were over 6,000 cases of breast cancer reported.[24] Early detection is the cornerstone

of breast cancer control, which involves early diagnosis and screening; yet there is no nationwide screening program in Myanmar. Aside from HIV/AIDS and human papilloma virus (HPV), data on STIs/RTIs in Myanmar is lacking, though there is likely a high burden of both bacterial and viral STIs, some of which can lead to infertility/sub-fertility if left untreated. Epidemiological data on infertility is limited in Myanmar and infertility services are sporadic. While HIV prevalence among adults 15 years and older is below 10%, according to 2015 estimates, national prevalence rates are higher among key populations including PWID (28.5%), female sex workers (FSWs) (14.6%), and MSM (11.6%)[25]. For young people under 25 years of age in Yangon, HIV prevalence rates are as follows: female sex workers (9%)[20]; men who have sex with men (14%)[21] and people who inject drug (12.5%).[22]

Policy Statement

All women, men, and young people will have access to information, prevention, early diagnosis, and care for reproductive health morbidities.

Strategies for Policy Implementation

1. Expand access to early diagnosis, prevention, and treatment of cervical cancer, with particular focus on increasing awareness and availability of screening services and the HPV vaccine.

2. Incorporate HPV vaccination and cervical cancer screening into relevant legislation and policy and include evidence-based recommendations for age of administration.

3. Expand access to early diagnosis and treatment of breast cancer, including educating women on self-examination as a method of early detection.

4. Mobilize resources to support cervical and breast cancer screening countrywide and strengthen data collection on women's cancers.

5. Strengthen the provision of information and services to prevent, screen, diagnose, and treat STIs/RTIs. Create stronger programmatic linkages between STIs/RTIs and infertility/subfertility.

6. Support the implementation of the continuing National Strategic Plan on HIV and AIDS in Myanmar , which among many areas prioritizes reducing new HIV infections and improving health outcomes for all people living with HIV.

7. Accelerate the goal of ending mother-to-child transmission of HIV and Syphilis through the prevention of mother-to-child transmission (PMTCT) program.

8. Advance innovative prevention, testing, treatment, and care efforts that address populations at high risk of HIV, such as PWIDs, FSWs, and MSM.

9. Conduct research on infertility/sub-fertility and develop a reporting mechanism for cases such as sub-fertility as appropriate.

10. Ensure access to early diagnosis, prevention and treatment of sub-fertility/ infertility as and when needed, including assisted reproduction services.

11. Develop specific policies and national guidelines on reproductive health morbidities.

Chapter 5 - Financing

5.1 SRHR's Return on Investment

Investing in SRHR is one of the smartest decisions a government can make. SRHR programs not only improve health and save lives, but also save money and strengthen economies. Family planning, for example, is considered a 'best-buy' in health and development.

Significant investment in both contraceptive services and maternal and newborn health care is needed. Governments, donors, NGOs, households and individuals all need to contribute to closing the funding gap to improve and expand services. Investing in contraceptive services and maternal and newborn health care together, rather than in maternal and newborn care alone, saves money and has a larger impact in preventing deaths and improving the health and well-being of women and their families. The return on these investments goes beyond the critical impacts on health to include broad social and economic benefits for women, families and societies, such as increases in women's and children's education, increases in women's earnings and reductions in poverty.[26]

Because the cost of preventing an unintended pregnancy through use of modern contraception is far lower than the cost of providing care for an unintended pregnancy, for each additional dollar spent on contraceptive services above the current level, the cost of pregnancy-related care would drop by $2.20. Fully meeting the needs for both modern contraception and maternal and newborn care would cost $53.6 billion annually-$8.56 per person-in developing regions. Investing in both contraceptive and maternal and newborn services together results in a net savings of $6.9 billion compared with investing in maternal and newborn health care alone. Fully meeting the global unmet need for modern family planning would result in an estimated 76,000 fewer maternal deaths each year and 480,000 fewer newborn deaths.[26] Investment in RMNCH has a potential return of about US$ 20 for every dollar spent.[27]

A woman's ability to control her fertility has a profound impact on her capacity to make other choices that contribute to stronger and more prosperous nations. This includes staying in school and pursuing higher education; finding employment and increasing her earning potential; feeding, housing and educating her other children; building her household savings; participating in community life; and exercising her rights.

5.2 Sustainable Financing for Policy Implementation

In order to reap the benefits of SRHR for all of Myanmar's people, it will be essential to identify and pursue strategies for sustainable financing for implementation of the National SRHR Policy, including but not limited to:

1. Expressing, maintaining and increasing political and financial commitment at all levels to SRHR.
2. Improving the efficiency of existing resources for health to maximize outcomes. For example:
    a. Strengthening health budget allocations, disbursements, and tracking of resources in the public sector.
    b. Understanding the total pool of health funding provided by partners, including where and how resources are being spent, to reduce overlap.
3. Increasing domestic financing for health, including SRHR, given Myanmar's potential graduation from a Least Developed Country.
4. Promoting innovative financing mechanisms, considering options such as:
    a. Establishing a National Health Fund to create a dedicated and sustainable domestic funding source.
    b. Engaging companies in public-private partnerships and corporate social responsibility initiatives.
    c. Exploring charitable giving by individual citizens.

5.3 Reducing Financial Hardship for Beneficiaries

Strategies for sustainable financing should put people first and ensure every individual in Myanmar has equitable access to SRHR information and services. In line with the SDG framework, SRHR financing should be incorporated into broader discussions on Universal Health Coverage and into any future social protection or health insurance schemes. The Department of Social Welfare's Maternal and Child Cash Transfer (MCCT) program, a cash transfer program for pregnant and breastfeeding mothers, provides a promising example of a social protection scheme in progress.

Chapter 6 - Monitoring

Monitoring will be essential in holding all stakeholders accountable for using and applying the National SRHR Policy in their work. The MOH will be responsible for monitoring policy implementation, including overseeing quality assurance. The MOH will track to what extent the Policy is being linked to and reflected in health sector strategies and action plans. To maximize efficiency, the MOH should consider delegating aspects of service delivery to other partners, as a means to free up human and financial resources for robust policy monitoring. Monitoring is also crucial for clear definition on essential maternal lifesaving medicine at all health facilities.

Finally, establishment of a quality improvement and assurance unit to monitor maternal, newborn, child and adolescent health jointly under the MRH Division, Child Health Development Division and School Health Division, Department of Public Health is a necessity.

Chapter 7 - Coordination and engagement

The success of the National SRHR Policy will depend on the active participation, coordination, and alignment of SRHR stakeholders at all levels. Effective coordination is imperative. The MOH will leverage an appropriate coordination mechanism to carry out joint implementation of the National SRHR Policy, such as the Health Sector Coordination Committee. The coordination mechanism will reflect the wide intersection among health, human rights, beliefs, traditions, economic status, employment, MNCH and FP. MOH can play a role in advancing international norms and standards by advocating for the creation of a technical guidance for Myanmar and states to use inthe application of a human rights-based approach to the implementation of policies, programs and curricula on comprehensive sexuality education and sharing best practices.

Effective coordination will take place among officials within the MOH, among different line Ministries, and among a range of non-governmental partners, and will cut across all three of these groups.

Ministry of Health:

1. Department of Public Health
2. Department of Medical Services
3. Department of Human Resources for Health
4. Department of Medical Research
5. Department of Traditional Medicine
6. Department of Food and Drug Administration

Other Ministries and Institutions

1. Supreme Court
2. Ministry of Defense
3. Ministry of Home Affairs
4. Ministry of Finance and Planning
5. Ministry of Legal Affairs
6. Ministry of Immigration and Population
7. Ministry of Education
8. Ministry of Social Welfare, Relief and Resettlement

9. Related committees in Parliament
10. Ministry of Sports and Youth Affairs

Partners

1. National non-governmental organizations
2. International non-governmental organizations
3. United Nations agencies
4. Professional societies
5. Civil society organizations
6. Ethnic health organizations
7. Faith-based organizations
8. Women's organizations
9. Community leaders and members
10. Academia
11. General Practitioners and other private sector partners

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