Myanmar is situated between South and Southeast Asia. It is bordered by India, Bangladesh and China to the north and west, and to the east by Thailand and Laos. It has an area of 676,578 square kilometres. Administratively, there are 14 states and divisions (with a further division into 17 states/divisions for the management of health programmes). The states/divisions are further subdivided into 63 districts, 324 townships and 65,148 villages. The total population of Myanmar is estimated at 53.22 million with a population growth rate of just over 2% (MOH, 2003).

In Myanmar, over 60% of the total population are women and children. The population is made up of the Bamar ethnic majority, who live mostly in the lowlands and central part of the country, and some 135 different ethnic groups, mainly living in the highlands and eastern and western borders of Myanmar. More than 70% of the total population lives in rural areas. The lowland delta and central dry zone are highly populated areas.

In 2003, the MOH estimated a crude birth rate of 24 live births per 1,000 populations in urban areas, and 26 per 1,000 in rural areas. Intense efforts have been instigated to improve maternal and newborn health (MNH) services. Various activities have been implemented, with particular emphasis on improving essential obstetric care and post-abortion care. Although there have been significant improvements in quality of MNH service delivery, current estimates indicate that maternal mortality ratio has not declined to the levels anticipated.

Status of maternal health

Approximately 1.3 million women in Myanmar give birth each year, however, as shown by the maternal health indicators in Table 1, childbirth remains potentially hazardous for a number of women and newborns. Thus, maternal health remains an issue of concern for the government, policy makers and health planners as well as individual women, their
families and communities. According to routine reporting, the maternal mortality ratio (MMR), is 110 deaths per 100,000 live births in urban areas, and 190 per 100,000 live births in rural areas (MOH 2003). However, the National Mortality Survey in 1999, conducted by the Central Statistical Organization, showed MMR to be much higher – 255 per 100,000 live births.

Table 1: Summary information on the obstetric care situation in Myanmar

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal mortality ratio (per 1,000 live births)</td>
<td>2.55</td>
<td>CSO 2000</td>
</tr>
<tr>
<td>Antenatal care coverage by trained personnel (%)</td>
<td>73.0</td>
<td>Department of Population (DoP) and UNFPA 2002</td>
</tr>
<tr>
<td>Skilled attendance at delivery (%)</td>
<td>37.4</td>
<td>DoP and UNFPA 2002</td>
</tr>
<tr>
<td>Doctor (%)</td>
<td>13.0</td>
<td></td>
</tr>
<tr>
<td>Nurse/midwife (percent)</td>
<td>24.4</td>
<td></td>
</tr>
<tr>
<td>Pregnant women receiving at least two anti-tetanus immunizations (percent)</td>
<td>71</td>
<td>DoH 2003</td>
</tr>
</tbody>
</table>

Myanmar has a different pattern of causation of maternal death when compared to those of other regional countries; complications following abortion make up a much larger proportion of maternal deaths than in neighboring countries (Figure 1). However, in keeping with most other countries in the region and elsewhere, a large proportion of maternal mortality is found to be preventable.

In response to the challenge of high MMR, an essential reproductive health package, with emphasis on safe motherhood, birth spacing and post-abortion care management, was implemented with momentum during 1996-97 biennium. The number of facilities with functioning basic essential obstetric care is 8 per 500,000 population and for comprehensive essential obstetric care is 4 per 500,000 population. However, as can be seen from Figure 2, much more work is still required to intensify efforts to increase the low proportion of births attended by a skilled health care provider – a skilled attendant, who can institute emergency measures to prevent and manage pregnancy complications leading to mortality.

Family Planning and the burden of unsafe abortion

Birth spacing methods have been available in the Public sector in Myanmar since 1991. The development of the 1992 National Population Policy saw a shift from a pro-nationalist policy to a health-oriented approach. According to the last Fertility and Reproductive Health Survey (FRHS, 2001), in 2001 approximately 37% of currently married women were using a method of contraception. The current total fertility rate (TFR) is 2.8.
According to hospital-based abortion studies and the wide-ranging maternal mortality survey, over one-third of maternal deaths were found to be attributed to abortions and its complications.

**Status of health of children under-five**

Children in Myanmar are regarded as the country’s most important resource and the government has adopted the ‘Child Law’ which emphatically states that “Every child has the right to enjoy health services provided by the State”. Improvement of the health status of children is one of the priority areas for Government of the Union of Myanmar, Ministry of Health. Under the guidelines set by the National Health Committee (NHC), the Ministry of Health, other related Ministries and partner agencies are implementing programmes and projects that are directly or indirectly related to the well-being of children in Myanmar. Major activities include training, provision of logistics and human resources, and supervision. In addition, research and surveys have been conducted to study the baseline situation and effectiveness of health programmes.

Department of Health, Department of Health Planning and Central Statistical Organization, UN agencies and INGOs have conducted a number of research studies and surveys in the area of child health. According to survey data, trend of under-five mortality rate (U5MR) declined from 82.4 per 1,000 Live Births in 1995, to 66.1 per 1,000 live births in 2003, because of effective public health interventions, such as increased access of the community to PHC (Figure 3).

The Overall and Cause Specific under-five Mortality Survey, DOH (2002-03) showed that 87% of death occurred in rural area (Figure 4). Infant deaths account for 73% of all under-five mortality, and neonatal deaths contributed to about 1/3 of infant deaths, as shown by figures 5 and 6. The leading causes for under-five deaths were ARI 25%, brain infections 14%, diarrhoea 13.4%, septicemia, 10.5%, malaria 5.7%, and beri-beri 5.5%. Major causes of neonatal deaths are prematurity 30%, sepsis 25.5% and birth asphyxia 24.5%. Underlying problems for high under-five mortality were malnutrition and weaknesses in some family practices.

**Nutritional status:** The overall nutrition status of children under-five has not significantly improved and malnutrition is still the main underlying cause
under-five deaths. However the prevalence of under weight has dropped from 38.6 % in 1997 to 31.8% in 2003. Prevalence of anaemia in under-five children is high (55 % in 2003). Prevalence of Bitot’s spot was only 0.03% in 2000 and visible goitre rate was 5.5% in 2004, very near to the national target of below 5%.

Health care delivery systems for maternal, newborn and child health

Health care delivery is under the ultimate responsibility of the National Health Committee, a high-level inter-ministerial and policy making body. The National Health Committee provides leadership and guidance in implementation of systematic and efficient health programmes. At each level of administration, down to the village level, a health committee with multi-sectoral representation is organized to oversee local implementation of health services.

The Department of Health (DoH) is responsible for providing promotive, preventive, curative, and rehabilitative health care services. The DoH has nine divisions, each headed by a Director (public health, communicable disease control, medical care, administration, planning, nursing, food and drug administration, laboratory, and occupational health). Programmes and projects related to maternal, newborn and child health are generally under the Director, Public Health.

Public health services in Myanmar are provided through a network of service providers at various levels (Figure 7). The highest-level referral facilities are the tertiary hospitals and the hospitals in state/division capitals. Below this, at the district level, referral hospitals with medical specialists, including an obstetrician/gynaecologist and a pediatrician, who provide specialized services to townships under the district jurisdiction. Most daily health services are managed at the township level. Hospital services are found in the township urban centre, and in one or two strategically placed station hospitals. Below this, each township has approximately five rural health centres. As well as providing services, rural health centre staff oversees the services provided from four or five sub-rural health centres. In addition, voluntary health worker, auxiliary midwives, and community health workers, provide services at the village level.

Human resources for maternal, newborn and child health

Among basic health workers, lady health visitors and midwives provide the backbone of maternal health care service delivery, with the assistance of auxiliary midwives (AMWs). Each township has approximately five rural health centres, staffed by a health assistant, lady health visitor and a midwife. As well as providing services, rural health centre staff oversees the services provided from four or five sub-rural health centres, which are staffed by a midwife. In addition, voluntary health worker, auxiliary midwives, and community health workers, provide services at the village level.

In total, the country has 16,570 doctors (6,157 in the public sector and 10,413 in the private sector), 1,211 dental surgeons, 15,482 nurses, 103 dental nurses, 1,719 health assistants, 2,550 lady health visitors, 14,094 midwives, 529 health supervisors (level 1), and 1,094 health supervisors (level 2)(MOH 2003). In addition to public health services, private general practitioners are active in most urban areas. There are many private drug shops in urban areas and even in rural areas, small shops often sell a limited range of drugs. Traditional medicine practitioners and informal health care providers also serve the population. For urban population, (84) Urban Health Centres and
(348) MCH Centres provide maternal and child health care while (1402) RHCs, and (5608) Rural Sub-health Centres are providing necessary care to the rural community. At the divisional and township level, there are (52) MCH officers, (307) lady health visitors, and (817) midwives. For rural population, (1152) lady health visitors, (7108) midwives and (25,799) AMWs are providing MCH care at the village level.

**Improving maternal, newborn and child health through health policy**

In relation to the time-bound development goals set out in the ICPD Programme of Action (Cairo, 1994), the country has tried to make considerable efforts, to improve maternal and child health especially through
promotion of overall reproductive health. With the heightened interest in reduction of newborn, infant, child and maternal mortality, and by improving the quality and accessibility of birth spacing services, it is anticipated that maternal, newborn and child health indicators will see rapid improvement.

Myanmar’s Reproductive Health Policy was formulated in 2002 and approved by the Ministry of Health in 2003. The Government is aiming to attain a better quality of life for all, by improving reproductive health status of women and men, including adolescents, through effective and appropriate reproductive health programmes undertaken using a life cycle approach.

Implementation and operational constraints

Implementation of maternal and obstetric services, as well as neonatal and child care is constrained by a number of factors, including:

- Scarcity of supplies, equipment, live-saving drugs, and job-aids at the peripheral level. This is the most pressing constraint
- The cost of referral services and frequently delayed referral of clients poses a challenge to the delivery of emergency obstetric services
- Inconsistencies in collection of routine data and other relevant information, turnover of basic health staff, and turnover and quality of voluntary health workers, are also challenges to the provision of consistent quality services
- Putting in place systems that will ensure that the poor have access to safe and effective reproductive health care services will require central level initiation, although they could be implemented on a township or even clinic level
- Other issues such as increasing the availability of adequate supplies and equipment including commodities would require fund mobilization, either at the central government level, or through international donors.

Best practices/innovations to improve maternal, newborn and child health

In order to reflect the worldwide commitment for reducing maternal deaths during childbirth by 75 percent by 2015 as one of the targets set in the Millennium Development Goals, the Safe Motherhood Initiative in Myanmar takes a proactive stance in improving access to skilled birth attendance, including managing obstetric and newborn cases at all levels. In order to be able to provide quality service for the aforesaid tasks, the following have been carried out, namely:

- Regular and refresher technical as well as management training, on-the-job training, curriculum and training materials development, strengthening of health facilities, essential drugs and instruments, regular and refresher AMW training, supervision and monitoring and coordination with related sectors
- To date, considerable emphasis has been placed on improving antenatal care, particularly with regard to antenatal screening for syphilis
- Establishment of infrastructure for basic obstetric care for the management of pregnancy
- As an urgent need, the curriculum for training midwives, auxiliary midwives, and traditional birth attendants was updated to develop competency in the provision of routine maternity care, as well as the recognition of complications and referral
- The development of a competency-based curriculum served as a national standard for high quality maternal health care. In developing this standard important decisions were made regarding the optimal management of obstetrical complications based on a review of current international best practices (for example, use of partograph, routine administration of oxytocin versus ergotamine for prevention of postpartum
haemorrhage and the use of magnesium sulfate versus diazepam for the management of eclampsia)

- Given that most births take place at home, the feasibility of providing a disposable, clean delivery kit has also been considered.

- A checklist of essential equipment and supplies was developed for the first referral level, including surgical instruments for Caesarean section, fluid volume expanders, forceps, examination lamp, labour room table, suction machine, sterilizers, oxygen cylinder, refrigerator for essential drugs, etc. This checklist has been used to strengthen logistic and supply systems to ensure that all referral facilities are equipped to provide essential and comprehensive obstetrical care.

- The first UNFPA’s multi-year special programme of assistance to Myanmar (2002-2005) was approved by the UNFPA Executive Board in 2001. The focus of the UNFPA programme of assistance has shifted from birth spacing to broader aspects of RH, including birth spacing, with a special emphasis on safe motherhood, STIs, prevention of HIV/AIDS, adolescent health and management of post-abortion complications. The special programme now emphasizes reduction of maternal mortality, meeting the reproductive health needs of men and women including adolescents and youths, and prevention of the spread of HIV/AIDS.

- More importantly, multidisciplinary team involvement and effective collaboration with working partners was found to be essential.

- Finally, Myanmar has decided to prioritize achievement of the MDGs in the area of maternal, newborn and child health. Therefore a “Five-year Strategic Plan for Reproductive Health” (2004-2008) and “Five-year Strategic Plan for Child Health Development” (2005-2009) were developed by the Department of Health, Ministry of Health, with inputs from key stakeholders. In response to the felt need, it was decided to have a comprehensive document that embodies the national aspirations on reproductive health and child health development in the country, and the way to achieve it. The comprehensive document bringing together the strategic plans for reproductive health and child health, is a road map for maternal, newborn and child health, as well as for other essential components of reproductive health and for adolescent health strategic plan (under development), as well as to the existing disease specific strategic plans in the country. The strategic plans have the common programme approaches namely:

  1. Improving skills of health care providers
  2. Strengthening the health system to deliver child health services
  3. Improving family and community practices
  4. Improving the enabling environment
  5. Improving the evidence-base for decision making.

**Main sources of data**


