Myanmar Country Report to
The 6th ASEAN & Japan High Level Officials Meeting on Caring Societies:
"Healthy Next Generation"
under the Tight Collaboration between Health and Social Welfare
8-11 September 2008, Tokyo, Japan

I. Introduction

1. The Union of Myanmar is geographically situated in Southeast Asia between latitudes 9°, 32’N and 28°, 31’N and longitudes 92°, 10’E and 101°, 11’E. Myanmar is bordered on the north and northeast by the People's Republic of China, on the east and southeast by Lao PDR and the Kingdom of Thailand, on the west by the People's Republic of Bangladesh and the Republic of India, on the south by the Andaman Sea and on the west by the Bay of Bengal.

2. The total surface area of Myanmar is 676,578 square kilometers. It has 6151 kilometers of international boundary and 2229 kilometers of coastal line. Myanmar is constituted with seven States and seven Divisions including 65 Districts and 365 Townships.

3. Myanmar has over 100 national races living together in unity and in amity. The estimated population of Myanmar, according to year 2006-2007, is 56.52 million and the population growing rate is 2.02%. Out of this population 28.42 million is female and 28.10 million is male.

4. Myanmar has been led to become a modernized and developed country by materializing the 12 national objectives; namely political, social and economic objectives. One of the four social objectives has stated to uplift the health, fitness and education standards of the entire nation. Under the guidance of National Health Committee, the Ministry of Health formulated its medium and long-term plan in order to launch the effective implementation, in coordination with related ministries and departments, UN organizations, national as well as international NGOs.

5. Maternal, child and youth health has been accorded as a priority issue since Maternal Mortality Rate, Neonatal Mortality Rate, Infant Mortality Rate and Under-5 Mortality Rate are the critical and sensitive indicators of the country’s health, social and economic status. In Myanmar, Maternal and Child Health including newborn care has been accorded as a priority issue in the National Health Plan, aiming at reducing the maternal, newborn, infant and children morbidity and mortality. The Millennium Development Goals (MDGs) also signify the country's commitment to achieving time-bound improvements of the defining global targets 4 and 5 in maternal and child health. The last half-decade has seen major gains in maternal and newborn health as benefited from making pregnancy safer evolution, expanding
availabilities and heightened emphasis on safe motherhood initiatives using a rights-based approach.

6. National Population Policy has been drafted since 1992. Myanmar has been striving to achieve the MDGs in the area of maternal, newborn and child health and plan and implement the strategies and interventions to reduce the U5MR to 38.5/1000 LB in 2015. Therefore the "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.

7. The Department of Social Welfare under the Ministry of Social Welfare, Relief and Resettlement is carrying out preventive, protective and rehabilitative measures for vulnerable groups such as child, women, youth, disabled persons and elderly.


II. Current situation

General Information

9. According to the "The State of the World's Children 2008" Myanmar youth literacy rate (15-24 years) is 96% (male) and 93% (female). Gross Primary school Enrolment ratio is 99 (male) and 101 (female). Net Primary school Enrolment ratio for male is 89 and for female is 91. Primary school attendance ratio for male is 83 and for female is 84 in 2000-2006. In Multiple Indicator Cluster Survey, 2003 (Department of Health Planning), population access to safe water is 92.1% in urban and 74.4% in rural areas.

Vital Statistics

- Crude Birth rate - 19 / 1000 population (urban )
- 21.9 / 1000 population (rural ) (2005)
- Crude Death rate - 5.5 / 1000 population (urban )
- 6.4 / 1000 population (rural ) (2005)
- Average life expectancy - urban (male) – 62.5 year
- urban (female) – 66.6
- rural (male) – 62
- rural (female) – 64.9
- Total Fertility rate - 2.4

Maternal health

10. According to the “Nationwide Cause-specific Maternal Mortality Survey”, carried out by the Department of Health in 2004-2005, maternal mortality ratio was estimated at 316 per 100,000 live births at the national level and 89% of all maternal deaths were reported from the rural areas.
The main causes of maternal deaths are found to be as follows:

<table>
<thead>
<tr>
<th>No</th>
<th>Cause of death</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Post-partum haemorrhage (PPH)</td>
<td>30.98</td>
</tr>
<tr>
<td>2</td>
<td>Eclampsia</td>
<td>11.27</td>
</tr>
<tr>
<td>3</td>
<td>Abortion related complications</td>
<td>9.86</td>
</tr>
<tr>
<td>4</td>
<td>Puerperal Sepsis</td>
<td>7.04</td>
</tr>
<tr>
<td>5</td>
<td>Hypertensive disorders</td>
<td>5.63</td>
</tr>
<tr>
<td>6</td>
<td>Prolonged/Obstructed labour</td>
<td>8.46</td>
</tr>
<tr>
<td>7</td>
<td>Ante partum haemorrhage (APH)</td>
<td>4.23</td>
</tr>
<tr>
<td>8</td>
<td>Ruptured uterus</td>
<td>4.23</td>
</tr>
<tr>
<td>9</td>
<td>Embolism</td>
<td>1.41</td>
</tr>
<tr>
<td>10</td>
<td>Indirect causes</td>
<td>16.90</td>
</tr>
</tbody>
</table>

The study on Anemia and worm infestation among under 5 children and pregnant women carried out by Nutrition Section of the Department of Health indicated that it has shown as 71% of anemic pregnant mothers in 2004, the special interventions to prevent and correct anemia during pregnancy needed to be strengthened.

Development of MCH hand book has been started with the collaboration of different section under the Department of Health and also involved with UN agencies (UNICEF, UNFPA and WHO) and INGOs (JOICFP).

**Emergency Obstetric Care**

11. According to the “Nationwide Cause-specific Maternal Mortality Survey” (2004-2005), maternal death in rural areas was found 2.5 times higher than that in urban areas. The findings showed that the complications during Antenatal and delivery periods were the main causes of maternal mortality and morbidity and 80% of the maternal deaths were mostly at home. The majority of this mortality is found to be preventable. The number of facilities with functioning basic essential obstetric care is 8/500,000 population and that of comprehensive essential obstetric care is 4/500,000 population. 40 per cent of pregnant mothers delivered with skilled birth attendants mainly midwives, 12.5per cent with Auxiliary midwives and 7.5 per cent with TBAs. (Community Health Care Project, 2004) Only 50% of the whole country is covered with Safe motherhood activities (162 townships) which points out that EOC activities is needed to be implemented in National Health Plan period. (2006-2011).

**Newborn Health**

12. There is an urgent need to elaborate the management of newborn care in order to have a comprehensive document that embodies the national aspirations on quality newborn care.

The followings are findings of nation wide cause specific under five mortality survey which was carried out by DOH, in 2002-2003.
- Neonatal Mortality Rate – 16.3/1000 LB
- Peri-natal Mortality Rate – 26.2 /1000 LB
- Still Birth Rate - 16.6 /1000 LB

Other important findings from this survey are:

- Three leading causes of Neonatal Deaths are low birth weight/prematurity-30.9%, neonatal sepsis-25.5% and birth asphyxia-24.5%
- 25% of all under five deaths are neonatal deaths and 68% of neonatal deaths occurred during 1st week of life.
- 78% of neonatal deaths were home delivery and 53%of deceased were delivered by Voluntary Health Workers (Auxiliary Midwives and Traditional Birth Attendants)

Neonatal deaths were directly related to health status of mother especially maternal nutrition status, health care services during delivery and post natal period. Therefore quality antenatal care, skilled birth attendance and skill and facilities for essential newborn care are crucial requirements for reducing neonatal mortality.

**Child Health**

13. In Myanmar, although under five mortality rate reduced significantly during past decade, Infant Mortality Rate did not change significantly. The findings from the Under 5 Mortality Rate (2002-2003) survey were as follows:

- Under Five Mortality Rate - 66.1/1000 LB
- Infant Mortality Rate - 49.7/1000 LB
- Leading causes of deaths are - ARI (27.6%)
  - Diarrhoea (17.6%)
  - Brain infection (17.12%)
  - Malaria (7.64%)
  - Beri Beri (7.12%)

Other important findings were 87% of all under five deaths occurred in rural area, 73% of deaths occurred before their 1st birth day and 44 % of deceased children did not receive appropriate treatment before death. Therefore the following issues need to be strengthened to meet the expected targets.

- Interventions to reduce IMR
- Reduction of prevalence and case fatality rate of main killers
- Rural health development
- Family practices and community participation
- Taking treatment during illness.
Adolescent reproductive Health

14. Adolescent reproductive health is one of the major components of the essential reproductive health package. In accordance with the changing social and economic policies, it calls for provision of special attention to ‘young people’ segment of the community, focusing on reproductive health within the present demographic and socio-economic context. The reproductive health programme officially defines adolescents to include youth and covers the age range 10-24. According to the statistical profile, compiled and published by Central Statistical Organization (2002), young people from age 10 to 24 years constituted about 29 percent of the total population. There is still limited information about adolescent health situation and just a few models of health services designed to meet the needs of young people. A hospital-based study of age group between 20 to 24 years supported global indications that delivery complication and low birth-weight babies were common among adolescents. Besides, 20 to 30 percent of maternal deaths were found to be among women below 25 years old. Studies also showed that adolescent pregnancy were more prone to face maternal and neonatal complications such as pre-matured births and neonatal mortality.

Social Services

15. The main categories of social services are as follows:-
   (a) Early Childhood Care and Development Services
   (b) Children and Youth Welfare Services
   (c) Women Welfare Services
   (d) Care of the Aged
   (e) Rehabilitation of the Disabled
   (f) Rehabilitation of Ex-drug Addicts
   (g) Grants in Aids to voluntary organizations
   (h) Public Welfare Services

16. The Department of Social Welfare provides social services for children and women through institutional based and community based approach so as to reintegrate into the society.

(2) Legislation and Institutional framework for Maternal and Child Health and Welfare

18. The National Committee on the Rights of the Child and its Working Committee were formed in line with the Child Law in 1993 for effective implementation of provisions of the child law. State, division and township level committees were also established for the same purpose.

19. The respective Ministries are implementing measures on protection, survival, development and participation that children may fully enjoy there right in accordance with the law.

20. Myanmar regards children as precious gems for a future community and a society and therefore all around measure have been taken under the Myanmar National Plan of Action for the Children in conformity with the CRC, the child law, the Millennium Development Goals (MDGs), the World Fit for Children (WFFC) and various regional plans of action drawn up for the implementation of child rights.

21. Myanmar acceded to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1997. Myanmar National Committee for Women's Affairs (MNCWA) and Working Committee has been formed and various activities implemented in the area of education, health, violence against women, economy, the girl-child, culture, environment and media. Myanmar Women's Affairs Federation (MWAF) has been formed and the executive committee at the State/Division, District, township, ward and village tract levels has also been formed throughout the country with the aim of preserving the development momentum of the women sector.

22. The following Laws and Regulations are promulgated in order to implement social services effectively:-

(a) The Child Law (1993)
(b) Rules related to Child Law (2001)
(c) Kattima Adoption Act (1941)
(d) Anti-Trafficking in Persons Law (2005)
(e) Regulation for Voluntary Institutions
(f) Regulation for Voluntary Day – Care Centres and Pre –Primary School
(g) Regulation for the establishment of Voluntary Primary Night School
(h) Regulation for Youth centres
(3) Good Practices of the Activities related to support from the community and the family, the role of professionals, or the administrative system enabling the continuum of care.

23. With a view to ensuring development of socially disadvantaged and young children, the Department of Social Welfare established six Residential Nurseries which provide parental love, care, health and nutrition to the orphans, distributes, abandoned and socially distressed children of both sexes ranging from the newly born to those up to age of five. The Department of Social Welfare provides “Adoption Services” in accordance with the 1941 Registration of Kittima Adoption Act to have and opportunity to grow up and develop in a normal family environment with full legal right.

24. In order to provide the children with a foundation in life with full opportunity of physical, mental, spiritual and all-round development, pre-primary school, have been established by the Department of Social Welfare. In those centres and schools, the age of 3 to 5 years children are being nurtured for their physical, linguistic, intellectual, social, cognitive and hygienic development. Moreover, regarding to the promoting of child nurturing technology, Multi Media Class Rooms have already been set up in pre-primary schools.

25. In Myanmar, regarding abuse and exploited children not only provisions are enacted in Child Law but also practices are being taken. Awareness training courses on prohibition of all kinds of child abuse for the staff of the institutions and those who are involved in taking care of children have been conducted.

26. In order to raise public awareness of the provision of the CRC, particularly among members of the CRC, and for the effective implementation of the CRC, workshops on child protection and on child abuse, neglect and exploitation are being conducted under the Myanmar UNICEF Country Programme.

27. The Department of Social Welfare is taking care for women who are socially handicapped. In order to support and reintegrate into the society, the Department has established (2) Women Development Centres, (4) Vocational Training Centres for Women and (2) Centres for Women Care. The DSW implements remedial measures for vulnerable women through institutional care. Moreover, (10) Voluntary Women Centres are run by NGOs.
28. The Social Welfare Training School in Yangon under the Department is providing regular course & special course to service-providers from GOs and NGOs as well as Government social workers and voluntary social workers. The Department with the collaboration of Psychology department, Yangon University is providing Diploma in Social Work course for one year at the Yangon University. State and Division Social Welfare Offices give basic courses of social work in the area of children, women and drug-addicts. Social workers and voluntary social workers are implementing social welfare services for socially disadvantaged group by providing prevention, protection and rehabilitation measures in institutions and community.

29. In order to reduce the country’s burden of maternal and perinatal morbidity and mortality, safe motherhood initiatives have been expanded into a national movement. Continuum of care for maternal and newborn health has then been focused as a priority in preventing maternal and newborn deaths and morbidities. It was ensured that increased availability of cost-effective health care intervention would have an immediate impact if women and babies were able to access them. In response to this challenge, the essential package of reproductive health interventions emphasizes Emergency Obstetric Care and neonatal care.

Since improving the skills of health care providers has been one of the major program approaches in the strategic plans, the proposed activities will be focused on the review and development of newborn care manuals, essential newborn care training for midwives and Auxiliary Midwives, expansion of the training on pregnancy, childbirth, postnatal and newborn care (PCPNC) for midwives and AMWs to new townships, and Behavior Change Communication training on maternal and newborn health among Maternal and Child Welfare Association members. The system of MCH Promoters has been started since 2006 by the Department of Health, only in two townships working with JOICFP international organization.

Experiencing from the research findings, evaluation workshop, educational seminars and meetings’ recommendations, the following activities were needed to be strengthened in order to achieve the Millennium Development Goals 4 and 5 regarding maternal, infant and child mortality. These activities are:

- Improving the health status of rural community
- Promoting community awareness and involvement
• Providing proper antenatal care, skilled and institutional delivery, post-abortion care and quality birth spacing services
• Ensuring essential obstetrical care
• Proving essential newborn care
• Establishing adolescent reproductive health
• Strengthening male involvement in reproductive health care provision

As of end 2005, there have been a number of programmes implemented that addressed young people’s knowledge of reproductive and sexual health, including life skills and peer education programmes, which will indirectly support in reducing MMR and IMR. Health status of mothers and children including adolescents are greatly influenced by behavior and access to reproductive health services. The things that people undertake or do not undertake for their health are influenced by many forces, including various aspects of socio-economic status. Utilization of health care services especially prenatal care among young women has strong relationship with their chances of having maternal morbidity and mortality.

The age of women when she gives birth affects her chances of having complications. Sometimes, it has an effect of social factor such as low-level of education or young unmarried women which are likely to resort to illegal abortion. Some factors such as age and pregnancy order which affect infant survival also affect maternal survival. General health status of mothers and children indicate that much more needs to be done to improve reproductive health, including adolescents as a central component of women’s health.

Thus, continuum of care for reproductive health implies the importance of improving and strengthening supply side, i.e. improving quality of reproductive health service; as well as improving demand side, i.e. through empowerment of individual, family and community capacities in maternal, newborn and adolescent care and in utilizing reproductive health service, including timely referral when complications/problems arise. Such approach would contribute significantly on reduction of maternal and newborn deaths.

(4) Challenges and actions for the collaborative between health care and social welfare services for mothers and children.

30. In implementing social services for women and children, the challenges are follows:-
(a) Extension and expansion of community based services at the community.
(b) Promotion of community-awareness for CRC and CEDAW.
(c) Strengthening the capacity building for social workers and voluntary social workers.
(d) Developing network mechanism of cooperation at various levels.
(e) Promoting family based and community based programmes in the area of prevention, protection and rehabilitation.
(f) Strengthening analysis and data collection for children and women.

Some of these lessons learned are as follows:

- Basic health staff are found to be in need of leadership and management skills
- Development of community ownership needs to be materialized
- Coordinated and sustained resource commitment, which support developing country-led policy making should be considered.
- Supervision and monitoring is the most crucial component.

**Future Plans**

31. In order to overcome the challenges the following actions will be taken:-

(a) Promoting the prevention, protection and rehabilitation programmes through community based, family based and institutional based.

(b) Development and establishment of a network by exchanging of information and strengthening of network programme.

(c) Raising the capacity-building of persons and organizations by providing trainings and workshops.

**Conclusion**

32. The Department of Social Welfare is carrying out social welfare services for vulnerable group such as children and women as a focal point of ASEAN social welfare and development. Strengthening cooperation among Regional and ASEAN countries should be extended in the area of protection of women and children. Regional cooperation for the social work practice and social services should be explored and exchanged in order to carry out social services with social work practice and methods.

33. The Ministry of Health together with efforts of the other Ministries including Ministry of Social Welfare, UN organizations, the national and international non governmental organizations and active participation of entire communities can attain higher level of success in providing quality health care to Myanmar people according to the changing needs and context of Myanmar nation.
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Department of Health (Ministry of Health)

and

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