



Myanmar and Birth Spacing: An Overview

Background

Myanmar shares borders with India, Bangladesh and China. The annual population growth rate in Myanmar is 2%, and approximately 30% of Myanmar's 52 million people live in urban areas. The population is made up of the majority Bamar ethnic group, living predominately in the lowlands and central dry zone, and some 135 ethnic groups who live mainly in the highlands and on the far eastern and western borders of Myanmar.

Administratively, there are 17 states and divisions in Myanmar, which are divided into 324 townships. Each township has a hospital providing tertiary level health services and at least one Maternal and Child Health Centre.

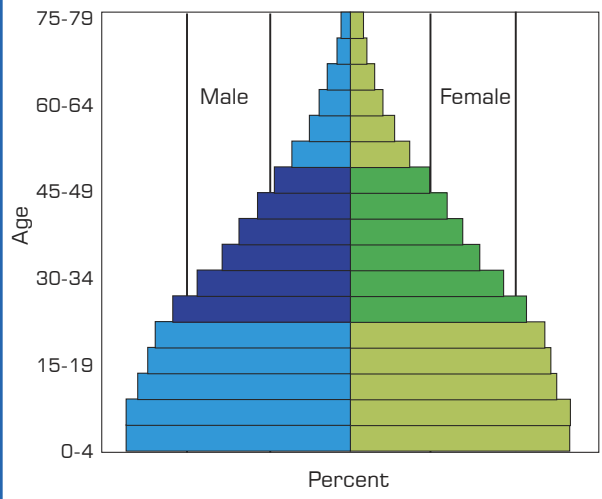
Situation Analysis

Birth spacing methods have been available in the public sector in Myanmar since 1991. Myanmar formulated a draft National Population Policy in 1992, **shifting from a pro-nationalist policy to a health-oriented approach**. This included the promotion of birth spacing to improve the health status of women and children, community level IEC, promotion of responsible reproductive behaviour, male involvement in reproductive health, and efforts to address adolescent and youth needs. Reproductive health, as an inclusive and coherent approach, has been in place in Myanmar since 1996. By 1995, the government's birth-spacing project covered 33 townships, and by 2001 it covered 117 of the country's 320 townships.

According to the 2001 Fertility and Reproductive Health Survey (FRHS), **approximately 37% of currently married women are using a method of contraception**, including traditional methods (see Figure 2). **Method failure appears to be a common problem** in Myanmar, as 37% of women seeking treatment for complications of abortion report contraceptive use at the time the pregnancy occurred.

Myanmar is bordered by three of the most populous countries in the world.

Figure 1: **Population Pyramid Myanmar**

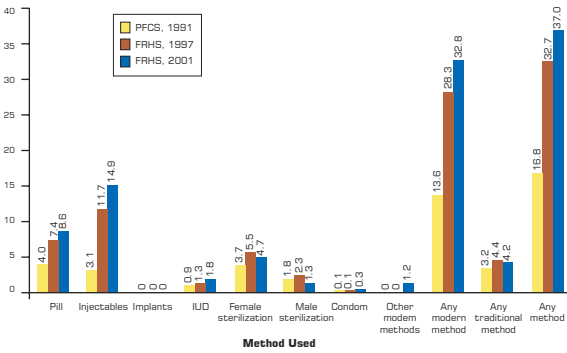


Source: *Epidemiological Fact Sheet on HIV/AIDS and Sexually Transmitted Infections: Myanmar, 2002*

Rise in birth spacing since 1997 is mostly due to increased use of pills and injectables, the two most common contraceptive methods used in Myanmar. Use of female and male sterilization is low, due to a lengthy and difficult approval process. Female sterilization is only available after approval by a sterilization board. Male sterilization is restricted by law to those men whose wives have been approved but are unable to undergo sterilization for medical reasons. The IUD is not commonly used in Myanmar for a number of reasons, including its association with the Lippes Loop (although no longer available in Myanmar, the Lippes Loop caused many problems). Figure 3 shows the breakdown of contraceptive methods used by married women.

Training in birth spacing methods was first included in pre-service midwifery training in 1998. Midwives are now trained in provision of methods, including injections of **(although they are not legally authorized to give injections)** and insertion of IUDs, indications,

Figure 2: Trends in Contraceptive Method Use



Source: PFCS, 1991; FRHS, 1997; FRHS, 2001

contraindication, side effects and warning signs. In addition, there is in-service training of all basic health staff in UNFPA-supported townships. **Provision of birth spacing services has increased dramatically over the last decade and provider knowledge and practice have improved as birth spacing services have been introduced in more townships across Myanmar.**

There is almost universal knowledge of at least one modern method of contraception. While knowledge of most modern methods of birth spacing has increased, knowledge of condoms to prevent pregnancy

The use of birth spacing methods doubled between 1991 and 1997, and continues to increase at a slower pace.

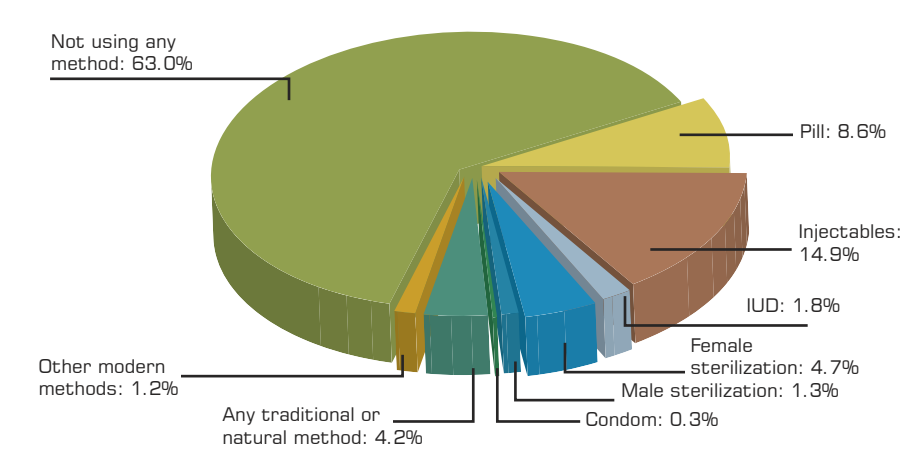
has remained the same. **Condoms tend to be associated with prevention of sexually transmitted infections** and for use by men with sex workers; they are not seen as a birth spacing method. Provides bias further contributes to low use of condoms. Less than 50% of all providers interviewed in one study said that they would provide condoms to unmarried women.

In Myanmar the average age at first marriage is relatively late. Only 2.2% of men and 6.6% of women get married before the age of 20. While there are strong cultural values against premarital sex, **there is a high demand for reproductive health information and services from married and unmarried adolescents.**

Young women in particular face barriers based on social and cultural values, in accessing reproductive health services, including those for birth spacing. Adolescent fertility in Myanmar is mostly related to early marriage. Forty-three percent of married women aged 15 have started childbearing, by 19 years this number reaches 73.9%. Limited evidence suggests that premarital sex among young men is rising through an increased use of commercial sex.

Abortion is illegal in Myanmar, and is considered the leading cause of maternal mortality, with at least 50% of maternal deaths

Figure 3: Contraceptive Method Use by Married Women in Myanmar, 2001



Source: FRHS, 2001



and 20% of all hospital admissions resulting from complications from unsafe abortions. One study found that the smaller the health institution in an area the higher the abortion rate in the surrounding area due to lack of access to contraceptive methods.

Resorting to the use of illegal and unsafe abortion is in large part the result of unmet contraceptive need among women. The Fertility and Reproductive Health Survey (FRHS) found that **20% of women did not want to get pregnant but were not using contraception and were at risk of pregnancy** 14% wanted to limit their births and 6% wanted to delay their next pregnancy. This suggests at the lack of acceptable long-term methods of contraception.

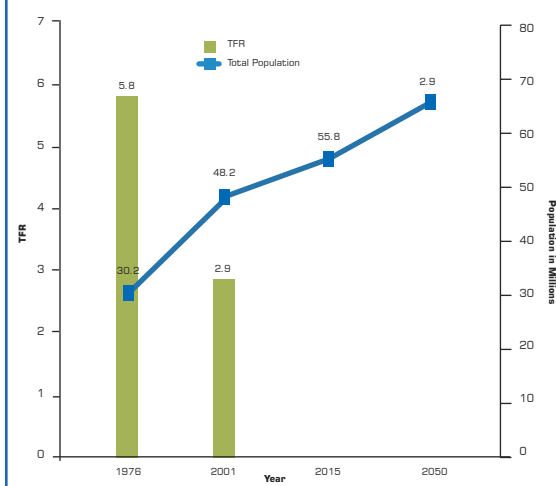
Birth Spacing Related Efforts

Key players include UNFPA, UNICEF, UNDP, WHO, MSI, PSI, MSF-Holland, and the Myanmar Maternal and Child Welfare Association. In the UNFPA programme townships, birth spacing services are provided at urban health centres, maternal and child health centres, and rural health centres and sub-centres. **In townships that are not externally supported there is very little provision of birth spacing services.** The majority of international support for birth spacing comes from UNFPA, which increased its

Key Indicators:

Total Population, 2003 (in millions)	52.17
Population Growth Rate, 2003	2%
Population Density, 2003 (people per square km)	73
Urban Population, 2003	29%
Population <15 years of age, 2003	33%
Total Fertility Rate (TFR), 2000-2005	2.8
Contraceptive Prevalence Rate (CPR), 2000	37%
- Pills	8.6
- Injectables	14.9
- Implants	0
- IUD	1.8
- Female Sterilization	4.7
- Male Sterilization	1.3
- Condom	0.3
- Traditional or natural methods	4.2
- Other Modern Methods	1.2
Unmet Need, 1997	20%
- For spacing births	14
- For limiting births	6
Average age at first marriage, 2003	22.4
Average age at first birth	N/A
Crude Birth Rate (CBR) (per 1,000 population), 2003	25.3
Maternal Mortality Ratio (MMR), 2000-2005	360
Infant Mortality Rate (IMR), 2003	87
HIV adult prevalence, 2001	2%

Figure 4: **Population Projection: Myanmar**



Source: NHDR, 2003; PRB, 2003

township support of birth spacing services to 93 townships in 2004.

Reproductive health services are provided by the public sector, private sector, and national and international NGOs. A number of NGOs are involved in reproductive health services and advocacy. **The role of the private sector in Myanmar is important as many people go to private general practitioners for reproductive health services such as birth spacing.** Clients often go directly to drug shops to buy contraceptives and medications.

A draft reproductive health policy was debated in 2001 and 2003 and now being finalized and



officially adopted. The key features include:

- Integration of reproductive health services into existing services;
- Partnership between government, NGOs, and the private sector;
- Research and monitoring of services to identify priorities and needs;
- Assuring that services are accessible, acceptable, and affordable;
- Incorporation of a gender-based approach to ensure equity and equality;
- Implementation of appropriate socio-cultural approaches; and
- Sustainability of services.

Future actions include the approval of a national five-year strategic plan for reproductive health. It will focus on five strategic approaches: improve health workers' skills, the health system and family and community practices, foster an enabling environment, and ensure use of evidence base for decision making. A separate five-year adolescent health and development strategic plan will focus on adolescent reproductive health as a major component.

The Department of Health is currently conducting a study on safety and efficacy of the one-month injectable approved by WHO, in the hope of adding it to Myanmar's contraceptive method mix.

Challenges and Opportunities

Myanmar faces the challenge of improving the consistent and correct use of birth spacing methods in order to reduce unplanned pregnancies and the recourse to abortion.

1. **Limited data and resources.** Myanmar is data-poor, and official statistics are often dated and inaccurate¹. It is a conservative country with strong cultural norms regarding sexual behaviour. As a result, research to identify priorities is challenging. While a shortage of funds remains, NGOs are playing an increasing role in birth spacing.

2. **Provider bias.** Provider opinion can also be a barrier to women receiving appropriate contraception. Even many private sector providers refuse to provide methods to unmarried women.

3. **Insecure contraceptive supplies in public sector.** Even where contraceptive services are available in the public sector, commodities may not be. Women turn to the private sector as an alternative source. Some providers or clients buy IUDs or injectables from drug shops for insertion or injection. Oral contraceptives and injectables are available from drug shops, and markets.

Birth spacing has been identified as a reproductive health priority area for policy implementation.

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¹The main sources of demographic data for Myanmar are the vital registration and statistics system and population census. The last population census was in 1983. Other sources of demographic data in Myanmar are the Fertility and Reproductive Health Survey (FRHS) conducted in 1997 and 2001.



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