Myanmar and Birth Spacing: An overview

Background

Myanmar is bordered by three of the world’s most populous countries: China, India and Bangladesh. The total population of Myanmar is 59.13 million and, with an annual population growth rate of 1.29%, the TFR is 2.03. Approximately 30% of Myanmar’s population live in urban areas. The population is made up of the majority Bama ethnic group who live predominately in the lowlands and the central dry zone, and some 135 ethnic groups who live mainly in the highlands and on the far eastern and western borders of the country. In 2014, 25.6% of the population is below 15 years old and 56.8% of women are in the reproductive age group (15–49 years) (Figure 1).

There are 14 states and regions in Myanmar, which are divided into 330 administrative units known as townships. Each township has a hospital providing tertiary-level health services and at least one maternal and child health centre.

Situation Analysis

Myanmar formulated draft national population policies 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 information, education and communication; promotion of responsible reproductive behaviour; male involvement in reproductive health; and, addressing adolescent and youth needs. Reproductive health, as an inclusive and coherent approach, has been in place in Myanmar since 1996.
The overall situation is shown by the relevant indicators in Table 1.

**Table 1: Key indicators**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
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<tbody>
<tr>
<td>Total population (in millions), 2012</td>
<td>52.79</td>
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<tr>
<td>Population growth rate, 2012</td>
<td>1.29%</td>
</tr>
<tr>
<td>Population density (people per square km), 2010</td>
<td>76.8</td>
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<tr>
<td>Urban population, 2012</td>
<td>33%</td>
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<tr>
<td>Population &lt;15 years of age, 2012</td>
<td>25%</td>
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<tr>
<td>Total fertility rate, 2012</td>
<td>2.0</td>
</tr>
<tr>
<td>Contraceptive prevalence rate, 2012</td>
<td>46%</td>
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<tr>
<td>– Pill (daily)</td>
<td>10.1</td>
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<tr>
<td>– Pill (monthly)</td>
<td>0.7</td>
</tr>
<tr>
<td>– IUD</td>
<td>1.8</td>
</tr>
<tr>
<td>– Injectable (monthly)</td>
<td>0.4</td>
</tr>
<tr>
<td>– Injectable (3-monthly)</td>
<td>19.3</td>
</tr>
<tr>
<td>– Female sterilization</td>
<td>4.4</td>
</tr>
<tr>
<td>– Male sterilization</td>
<td>1.0</td>
</tr>
<tr>
<td>– Condoms</td>
<td>0.7</td>
</tr>
<tr>
<td>– Traditional or natural methods</td>
<td>2.6</td>
</tr>
<tr>
<td>Unmet need, 2001</td>
<td>19.1%</td>
</tr>
<tr>
<td>– For spacing births</td>
<td>6.3</td>
</tr>
<tr>
<td>– For limiting births</td>
<td>12.8</td>
</tr>
<tr>
<td>Average age at first marriage (in years), 2003</td>
<td>22.8</td>
</tr>
<tr>
<td>Median age at first birth (in years)</td>
<td>22</td>
</tr>
<tr>
<td>Crude birth rate (per 1000 population), 2012</td>
<td>17.4</td>
</tr>
<tr>
<td>Maternal mortality ratio (per 100 000 live births) (2013, UN estimation)</td>
<td>200</td>
</tr>
<tr>
<td>Infant mortality rate (per 1000 live births), 2012</td>
<td>41</td>
</tr>
<tr>
<td>HIV adult prevalence, 2012 (USAID)</td>
<td>0.6%</td>
</tr>
</tbody>
</table>

*Source: CIA World Factbook; World Health Statistics, 2014.*

**Total fertility rate (TFR)**

Myanmar has made a progress in terms of decreasing the TFR, from 4.7 in 1987 to 2.0 in 2012 (Figure 2).
Figure 2: Trends in TFR for women (aged 15–49), 1983–2012

Contraceptive prevalence rate
While the TFR is declining, trends show that the contraceptive prevalence rate (CPR) has been progressively increasing, from 16.8% in 1991 to 46% in 2012 (Figure 3).

Figure 3: Trends in CPR, 1991–2012

In Myanmar, knowledge of at least one modern method of contraception is almost universal. While knowledge of most modern methods of birth spacing has increased, knowledge about use of condoms to prevent pregnancy has remained the same. Condoms tend to be associated with the prevention of sexually transmitted infections and for use by men with sex workers, and are not seen as a birth spacing method.
Early childbearing in Myanmar is unusual. Only 10% of women aged 15–49 years have given birth before the age of 18. The low proportion of women giving birth in their teens can be attributed to the high age of first marriage, which has been around the age of 22 for the past 15 years. Median age at first birth is also 22 years. Only 1.9% of women had their first birth before the age of 15, and slightly more than 25% before the age of 20 years. Forty-five per cent of married women had given birth before the age of 22, and another 41% had their first birth between the ages of 20 and 24.

Abortion is illegal in Myanmar and it is the leading cause of maternal mortality, with at least 50% of maternal deaths and 20% of all hospital admissions resulting from complications due to unsafe abortions. One study found that the smaller the health institution, 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 in Myanmar. The Fertility and Reproductive Health Survey (FRHS) 2007 found that of the 17.7% of women who did not want to get pregnant but were not using contraception and were at risk of pregnancy, 13.3% wanted to limit their births and 4.9% wanted to delay their next pregnancy. This suggests a lack of acceptable long-term methods of contraception.

**Contraceptive method mix**

According to FRHS 2007, approximately 40.9% of currently married women are using a method of contraception, including traditional methods. The use of birth spacing methods continues to increase, but at a slower pace. 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. 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.

*Figure 4: Contraceptive method use by married women, 2007*

The rise in the use of birth spacing methods since 1997 is mostly due to increased use of the pill and injectables, the two most common methods of contraception 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 for, but are not able to undergo, sterilization.

The CPR increased from 16.8% in 1991 to 40.9% in 2007, mainly due to an increase in the use of injectables and oral contraceptive pills. In 2007, the 3-monthly injection was the most common method used by 19.3% of the women.

**Adolescent fertility**

In 2011, the adolescent fertility rate was 17 births per 1000 girls aged 15–19 years, which is well below the regional average of 54.
Current Family Planning Efforts

Birth spacing methods have been available in the public sector since 1991 in Myanmar. That same year, the Government initiated a birth spacing project. By 1995 the project covered 33 townships, by 2001 it covered 117, and by 2011 it covered 132 of the country’s 320 townships.

A draft reproductive health policy was debated in 2001 and 2003, but has not yet been finalized and officially adopted. The key features of this policy are listed below.

- Integration of reproductive health services into existing services.
- Partnership between the Government, non-governmental organizations, 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 sociocultural approaches.
- Sustainability of services.

There are six main aspects of reproductive health that have been identified as priority areas for policy implementation, including birth spacing. Future actions include the approval of a national five-year strategic plan for reproductive health, focusing on four strategic approaches to improve the enabling environment, the evidence base for decision-making, the health system and capacity for delivery of quality reproductive health services, and community and family practices. A separate five-year adolescent health and development strategic plan will focus on adolescent reproductive health as a major component.

Reproductive health services are provided by the public sector, private sector, and national and international nongovernmental organizations. A number of nongovernmental organizations are involved in reproductive health services and advocacy. For example, in UNFPA-supported townships birth spacing services are provided at urban health centres, maternal and child health centres, rural health centres and sub-centres. In townships that are not externally supported there is very little provision of birth spacing services in the public sector.

Training in birth spacing methods was not included in pre-service midwifery training until 1998. Midwives are now trained in the provision of contraceptive methods, including injection of DMPA (although they are not legally authorized to give injections) and insertion of IUDs. They have also been trained in indications, contraindications, 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 has improved as birth spacing services have been introduced in more townships across Myanmar.
Challenges and Opportunities

Myanmar has an explicit pro-natalist policy as there is concern in the political circles that it continues to be under populated. However, use of contraception to space births has been adopted as part of efforts to improve maternal and child health. Hence, the country uses the term “Birth spacing” for its programmes as opposed to “Family Planning”. One of the challenges in Myanmar is to improve 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 inaccurate. It is a conservative country with strong cultural norms regarding sexual behaviour. As a result, research to identify priorities is difficult. Social and cultural values can serve as barriers, particularly for young women, in accessing reproductive health services including those for birth spacing. While there is a shortage of funds, nongovernmental organizations are playing an increasing role in birth spacing.

2. **Limited method mix:** Due to its pro-natalist policy, methods like sterilisation are not easily available, both due to policy barriers and provider biases. Provider opinion is also a barrier to women receiving a suitable method of contraception. Due to cultural sensitivities, providers refuse to provide contraceptives to unmarried women.

3. **Lack of secure contraceptive commodities in the public sector:** Even where contraceptive services are available in the public sector, commodities may not be, leading most women to turn to the private sector as an alternative source. It is normal practice for providers or clients to buy IUDs or injectables from drug shops for later insertion or injection. Oral contraceptives and injectables are readily available from general shops, drug shops and markets.

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1. The main sources of demographic data for Myanmar are the vital registration and statistics system and population censuses. 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.
References:
16. World Contraceptive Use, United Nations, Population Division, Department of Economic and Social Affairs, 2003
18. World Population Policies, United Nations, Population Division, Department of Economic and Social Affairs, 2003
22. The Status of Birth Spacing in Myanmar, UNFPA, 2010