



Research Paper

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Situation Analysis of Access to Healthcare Services in Myanmar: Overview of Maternal Healthcare

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Acronyms

ANC	Antenatal Healthcare
ASEAN	Association of South-east Asia Nations
Aus AID	Australian Aid
HEF	Health equity Fund
JICA	Japan International Cooperation Agency
MDG	Millennium Development Goals
MDHS	Myanmar Demographic Health Survey
MDSR	Maternal Death Surveillance and Response
MHC	Maternal Health Care
MMR	Maternal Mortality Ratio
MWs	Midwives
MoHS	Ministry of health and Sports
NHP	National Health Plan
RH	Reproductive Health
RHC	Rural Health centers
SDGs	Sustainable Development Goals
UN	United Nations
UNICEF	United Nations International Children's Emergency Fund
UNFPA	United Nations Population Assistant Fund
U5MR	Under five Mortality Fate
VHW	Voluntary Health Worker
WHO	World Health Organization
3MDG Fund	The three Millennium Development Goal Fund

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1. Introduction

Myanmar is a Southeast Asian country with a low Human Development Index, reflecting the limited access to quality health services and largely underdeveloped healthcare systems [1]. By 2014, the Maternal Mortality Ratio (MMR) was 282 per 100,000 live births or 2,800 per year – the second highest among ASEAN countries [2, 3]. High MMR has been associated with limited access to contraceptives and maternal health services and poor quality of health services for women [4, 5]. Low or inadequate access to modern maternal health services were found particularly among poorer, less educated women from the rural households [6, pp.3-4, 7]. This highlights the inequality in access to health services. Some studies also suggest that the lack of women's empowerment in family decision making, particularly on Reproductive Health (RH), financial resources allocation, as well as the upholding of traditional norms (e.g. the man makes most the decisions) prevents women from receiving adequate maternal healthcare services [6, 8, 9]

Myanmar has adopted goal three of the Sustainable Development Goal (SDG) aimed at promoting health access and enhancing the quality of the services for citizens and SDG 5 for promoting gender equality and empowerment [10]. The government and development partners have made significant efforts to improve the access to, and quality of health services. However, limited budget allocation, lack of healthcare workers, under provision of health facilities and poor health education remain long-term challenges for equitable healthcare services [11, 12].

This research paper aims to provide: (1) an overview of the general characteristics of the health sector development in Myanmar, highlighting the issues and challenges in reproductive and maternal health among women; and (2) a summary of policies and programs that are related to Maternal Health Care (MHC). Gender inequality and empowerment are the basis for the discussion.

The key research questions are:

1. What have been the trends and the present situation regarding maternal health in Myanmar?
2. How has gender inequality, lack of women's empowerment, and social norms hampered the ability of women in receiving maternal healthcare? What are the challenges in delivering effective and equitable maternal healthcare services?
3. What have been the policies/programs of the government and stakeholders regarding maternal healthcare?

This research is based entirely on available secondary documents and data. The information was collected from journal articles, policy documents, and program implementation and evaluation reports. The quantitative outputs were extracted from Myanmar Demographic Health Survey (MDHS) 2015 and World Development Indicators and other available sources. The report consists of four parts. The first section provides an overview and trends regarding maternal health in Myanmar. The second deals with the situation regarding maternal health focusing on three main issues: (1) the availability of the services, (2) the accessibility and (3) the affordability. The third part focuses on government policies and contributions of stakeholders to maternal healthcare. Section four is the conclusion.

1. The situation regarding maternal health

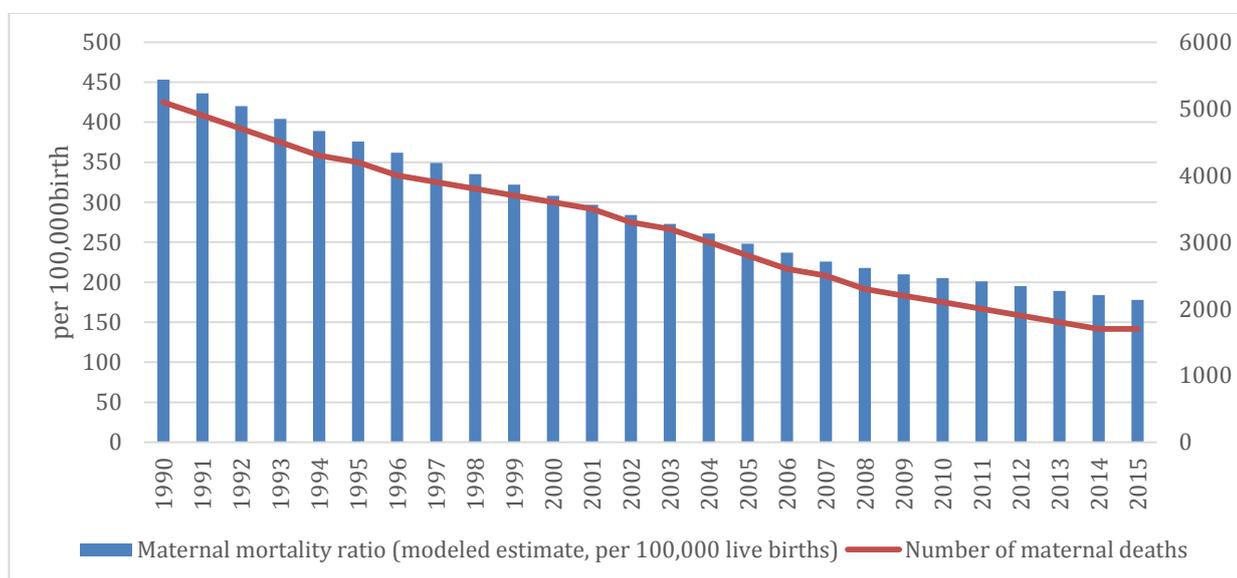
2.1 Current trends in maternal health

Improving maternal health and child health services is the main priority of the National Health Plan (NHP) of Myanmar. The government has made a significant effort to promote overall reproductive health to reduce maternal mortality and improve the quality and accessibility of reproductive health services [13]. The goal of SDGs 3 is to attain a better quality of life for people by improving the reproductive health status of women, men, adolescents, and youth [2]. The Ministry of Health and Sports is the key player in promoting and improving the health sector towards achieving the aim of “Health for all Goal” [14].

Myanmar currently faces many challenges regarding its underdeveloped healthcare system. This includes inadequate health of the workforce, poor physical infrastructure (e.g., inadequate hospitals), lack of healthcare equipment, and limited financial resources for this sector [15, 16]. The health status among population is still poor compared to other countries in the region. Statistics in 2010 showed that Myanmar had a total population of 51.9 million with average annual growth rate of 0.68 percent and by 2018, it is estimated to be 54million. Life expectancy is 64.7 years, the lowest among ASEAN countries [17]. According to 2014 census, one of the most significant health issues for the country is the high MMR. The country’s MMR is estimated the second highest among ASEAN countries, recorded at 282 deaths per 100,000 live births. Every year, approximately 2,800 women die during pregnancy or childbirth [16]. World Development Indicators 2018 estimated that, teenage mothers (age 15-19) accounted for 6 percent of total pregnant women.

Figure 1 shows the trend of Maternal Mortality deaths and the MMR since 1990. Since 1990, the MMR has dropped significantly, by more than half, from 450 deaths per 100,000 live births to 178 deaths per 100,000 live births in 2015. The MMR varies by age, location, educational level and socioeconomic group, which highlights the disparity in access to maternal healthcare by different clusters of population [18]. Similarly, the drop in MMR corresponds to the drop in the number of maternal deaths. The number of annual maternal deaths was 5,100 in 1990 and reduced by half in 2006 before continuing to drop to 1,700 in 2015. However, the figure remains high when compared to other countries in the region, meaning that to achieve the goal of SDG 5 the country needs to accelerate its efforts in promoting better healthcare systems.

Figure 1: Trend in maternal mortality since 1990 (per 100,000 live births)



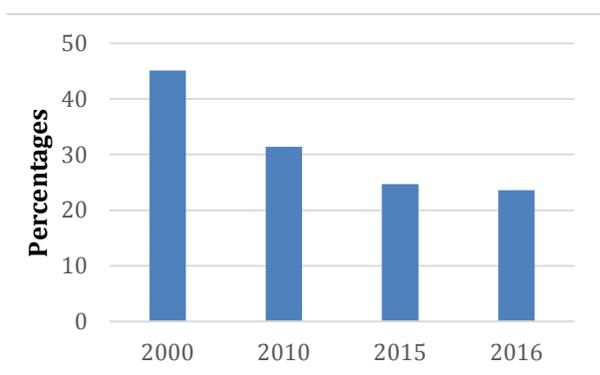
Source: World Development Indicators 2017

The causes of deaths by maternal, prenatal and malnutrition nutritional conditions and communicable diseases combined accounted for 24 percent of deaths throughout the country in 2016 – this was a reduction from 45 percent in 2000 (Figure-2). Most maternal deaths are from avoidable consequences during pregnancy and at childbirth and are largely preventable [9]. The leading direct cause of maternal deaths in 2010 was postpartum haemorrhage (31 percent), followed by hypertensive disorders during pregnancy (11 percent), and abortion-related causes (10 percent) [9, 19]. The majority of women (62.7 percent) deliver at home which can be high risk for some women as they lack medical treatment if difficulties arise. Not being able to reach health facilities on time was among the major causes of maternal deaths [19]. This indicates the need for improvements in delivery, antenatal and postnatal care which require the availability of better-

skilled professionals within a reachable distance as well as the availability of medicines at an affordable cost [9].

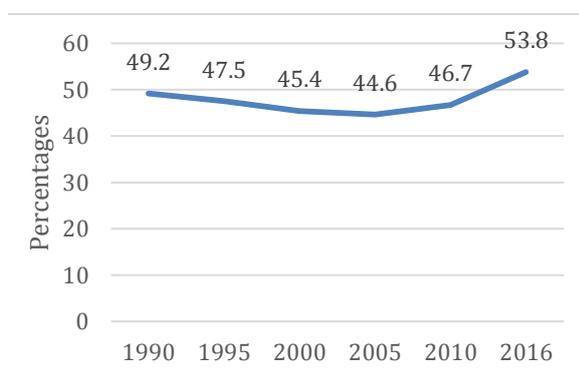
A study in 2010 showed that only 38 percent of women with complications were referred to a hospital, and only 24 percent reached a hospital for proper healthcare services, while 14 percent died on their way to the hospital due to long travel distances [20, p.93]. One of the main health problems in maternal death is caused by anaemia[21, p-240]. There are geographical disparities in anaemia prevalence and women in the coastal zone were more vulnerable to the disease [22, p-112]. Figure 3 shows a worrisome picture in relation to anaemia among pregnant women. Despite a slight drop from 59.2 percent in 1990 to 44.6 in 2006, the number rises again to 53.8 percent in 2016. Malnutrition and lack of education about maternal nutrition education was the main cause [23, p-966]

Figure 2: Cause of death, by communicable diseases and maternal, prenatal and nutrition conditions (percentage of total)



Source: World Development Indicators 2018

Figure 3: Prevalence of anaemia among pregnant women (percent)



Source: World Development Indicators 2018

2.2 Availability of maternal health services and workforce

Strengthening the community-based health care work force is essential for ensuring equity and access to basic healthcare services at the grass-roots level [24]. In 2014, there were 1,056 public hospitals with 56,748 beds in total and the number of public health facilities in Myanmar consisting of 87 primaryⁱ and secondary health centreⁱⁱ, 348 maternal and child health centres, and 1,684 rural

ⁱ Primary healthcare center refer to Primary level Facilities/Hospitals (Sub-Centre, Rural Health Center, Maternal and Child Health Center (MCH) and Urban Health Center)

ⁱⁱ Secondary healthcare center is defined as station or Township Hospital without Obstetrics and Gynecology (ObGy) Specialist)

health centres. According to the World Health Organization (WHO) health statistics, in 2013–2014 the number of doctors, nurses and midwives, and dental surgeons per 100,000 people in Myanmar was 61, 100, and 7 respectively, while in South-East Asia as a whole there, there were 59, 153, and 10, respectively [25]. Given the lack of health workers, maternal healthcare related activities, especially in rural areas, are carried out by midwives. Midwives and Lady Health Visitors were the main service providers for maternal and reproductive health at the grass roots level [26].

Basic Health Staff are the main health providers for rural area. There are community-based health workers in charge of providing some basic healthcare services. Midwives are basic health staff providing basic health services for families at the community level [27]. Midwives have to take responsibility for maternal and child healthcare as well as immunization, nutrition promotion and disease control activities in their respective communities. Due to the heavy work load, midwives cannot prioritize their activities so maternal and child healthcare activities are affected to some extent. There are 64,134 villages in Myanmar and having one health staff per village has not yet been achieved. Community health care volunteers are one component of the health care workforce and some health activities including maternal healthcare, still rely on them especially in emergency situations [24]. Lack of healthcare workers significantly impeded progress toward the realization of health-related Millennium Development Goals and SDGs [28]. The number of healthcare workers in Myanmar is shown in Table (1).

Table 1: Sector workers in Myanmar (2005-2015)

Indicators	2005- 2006	2010- 2011	2011- 2012	2012- 2013	2013- 2014	2014- 2015
Doctors	18,584	26,435	28,077	29,832	31,542	32,861
(i) State Service	6,941	10,450	11,675	12,800	13,099	14,050
(ii) Private Practice	11,643	15,985	16,402	17,032	18,443	18,811
Health Assistant	1,771	1,883	1,893	2,013	2,026	2,074
Nurse	19,776	25,644	26,928	28,254	29,532	32,609
midwife	16,745	19,556	20,044	20,617	21,435	22,258
Lady Health Visitor	3,025	3,344	3,371	3,397	3,467	3,578
Indigenous Medical	819	890	885	875	1,048	1,033

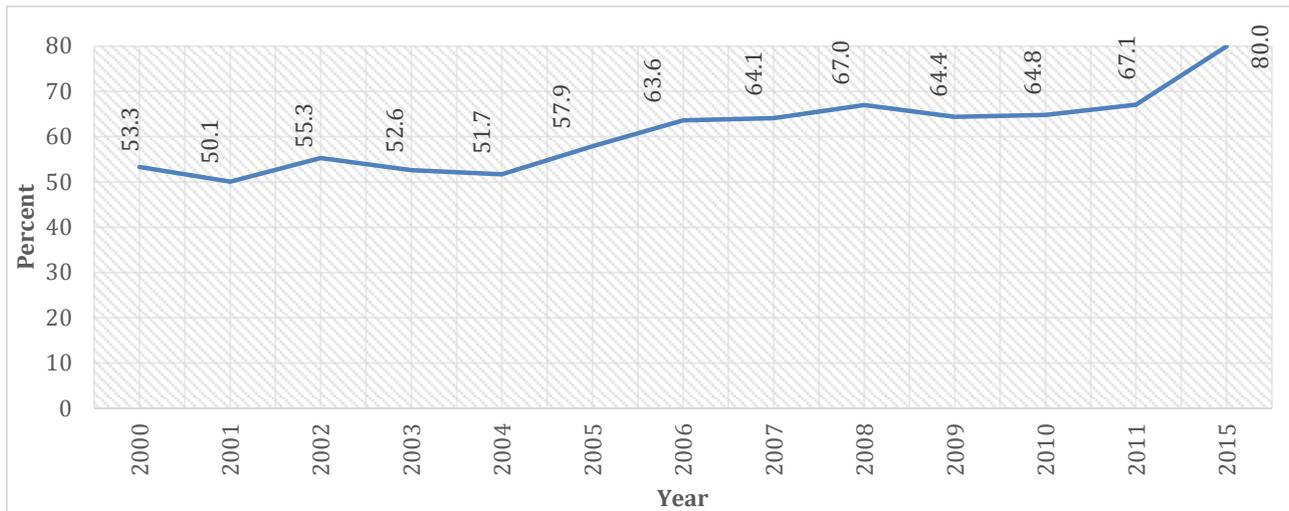
In relation to healthcare, the country's common issues include: (1) inadequacy of health infrastructure, (2) lack of human resources, particularly in remote areas, and conflict-affected areas; and (3) poor communications and infrastructure especially in Chin state and Ayeyarwaddy. All of these barriers prevent communities, particularly in rural and remote areas, from properly receiving or accessing health information, health education, and services. Poor roads and challenging weather conditions, reduce the ability of healthcare providers to access people in remote areas[15].

Wide geographic, ethnic and socio-economic disparities are among the challenges in delivering healthcare services[16]. Ethnic minorities and people in remote areas, such as in Mon and Chin States, expressed their concerns that there were not adequately trained healthcare workers and a lack of healthcare facilities to address common illnesses and health needs of their communities[15]. The lack of trained health staff and health facilities is the leading cause of high MMRs and Under Five Maternal death Rate (U5MR) in these remote states.

By 2016, there were 1.33 healthcare workers (doctors, nurses and midwives) per 1,000 people (MoHS), well below the WHO minimum recommended threshold of 2.3. In terms of distribution, health workers were largely concentrated in urban areas, including Yangon and Mandalay[16]. The proportion of births attended by skilled personnel increased from 56 percent average in 1997 to 78 percent in 2010 [16]. These indicators show some differences in achievements between rural and urban areas[9].

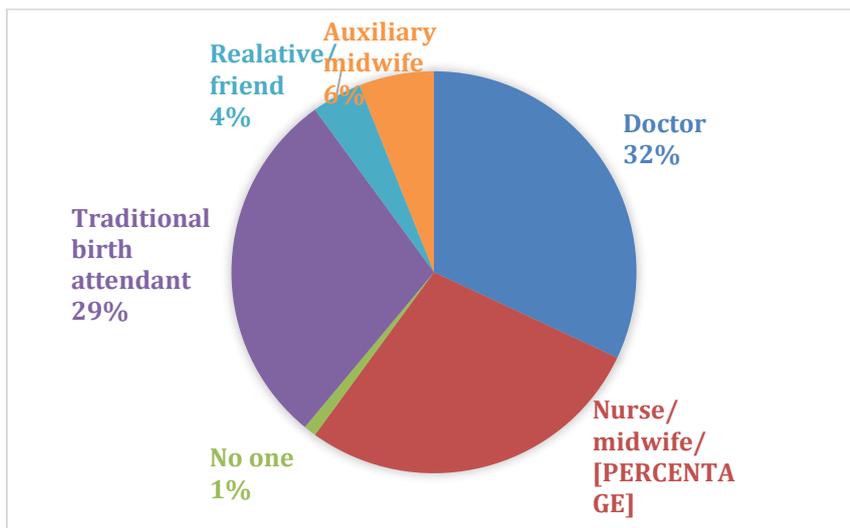
Figure 4 shows the percentage of births attended by skilled staff from 2000 to 2015. About half of total births were assisted by skilled health staff in 2000. The situation has been progressively improved and by 2015, around 80 percent of births had support from skilled staff. Figure 5 provides details in relation to having skilled staff attending during deliveries in 2014. Three-fifths of births are assisted by skilled providers (60 percent) that includes nurses, midwives, and doctors. It is notable that almost one in three births are still assisted by traditional birth attendants [18].

Figure 4: Percentage of births attended by skilled health personnel



Source: Health Management Information System

Figure 5: Skilled assistance during delivery



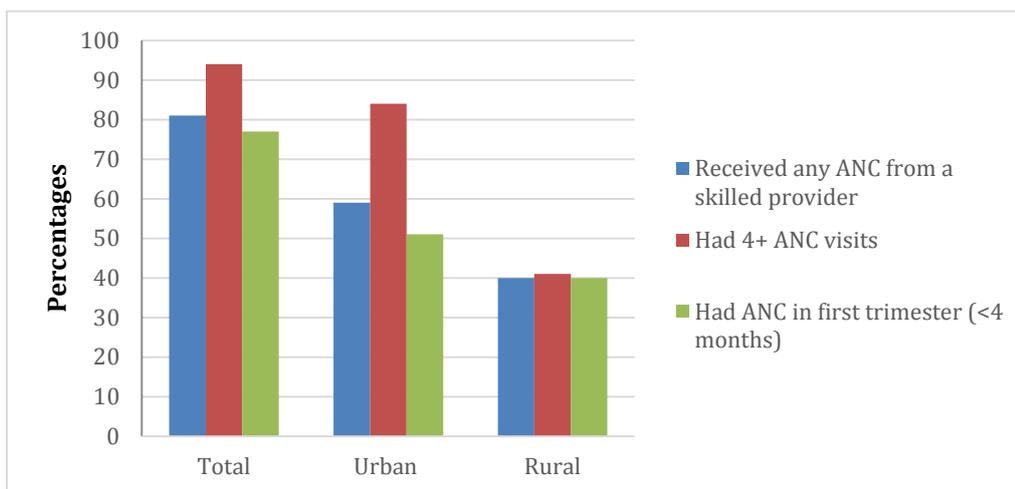
Source: Demographic Health Survey 2015-2016

2.3 Accessibility and utilization of maternal health services

The latest data from Myanmar Demographic and Health Survey (2015-2016) indicates that, approximately one in 200 women in the country died from pregnancy complications or childbearing [7]. The ability of women to access timely healthcare services during pregnancy (Antenatal care), delivery and postnatal, is vital given that the majority of the population require such services during their child bearing years [9]. The perceived problems in accessing healthcare services including maternal healthcare are: (1) lack of finances to pay for services, (2) patients not wanting to travel alone to receive healthcare (3) health facilities being too far to reach and (4) lack of modern health services [18, 29].

Figure 6 shows the percentage of women who had access to antenatal care coverage in 2015. The survey reveals that 81 percent of women aged 15-49 received at least one antenatal care session with skilled providers during their pregnancy for their most recent birth. Of women who live in urban areas, 84 percent have at least four ANC (Antenatal Healthcare) visits compared to 51 percent for those in rural areas. The lowest access to ANC was found in Shan (below 70 percent) and Rakhine States (71.1 percent). It is worth noting that access to ANC is positively associated with the education level of women (i.e., the higher the education level the more likely the woman will access healthcare) [30, p-129]. Additionally, women in urban areas have wider access to ANC, due to the availability of services within their reach [14, 18]. There is a gap regarding access to vaccinations; 81 percent of women in urban areas versus 69 percent of those in rural areas can access this service.

Figure 6: Percentage of women age 15-49 who had antenatal care coverage

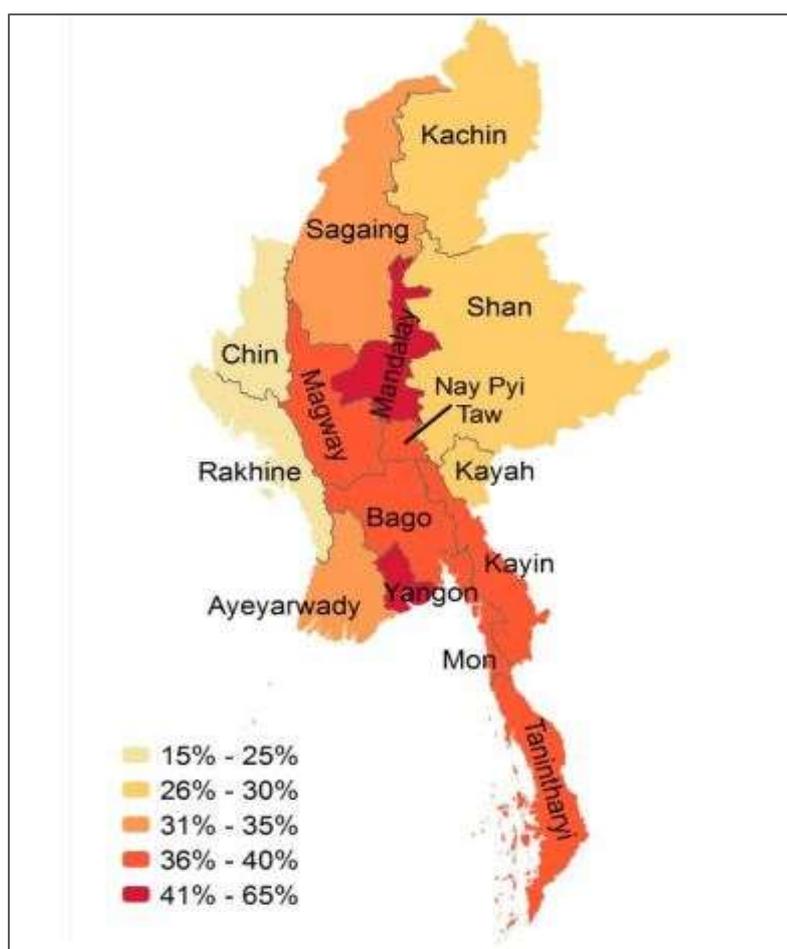


Source: Demographic Health Survey 2015-2016

Three quarters of all maternal deaths occur during delivery and in the immediate post-partum period [14]. Getting to appropriate health facilities remains a big challenge for many people living in rural and remote areas. Hence, home delivery is still common at these locations [31]. The 2015-2016 MDHS indicates that only 37 percent of live births take place in a health facility and 60 percent of these births are delivered by skilled providers [18]. There is inequality in access to services between rural and urban areas with only one in five women from rural areas able to access services versus 70 percent for urban dwelling women.

Figure 7 presents a map on institutional deliveries by state. It shows that cities like Yangon have the highest accessibility rate (65 percent). In other states, institutional deliveries vary between 30-40 percent. In most remote states such as Chin, the institutional delivery rate was as low as 14 percent. The possible causes are that the areas in conflict zones and the transportation systems are poor, preventing people from accessing health services. This means efforts to improve maternal healthcare systems should be prioritised in such states. The survey confirmed that the higher the women’s education the more likely they are to access institutional delivery services [18].

Figure 7: Institutional deliveries by states and regions



Source: Demographic Health Survey 2015-2016

Women who deliver in a health facility are more likely to receive a postnatal check-up than those who deliver elsewhere. According to 2015-2016 DHS, 71 percent of mothers and 36 percent of newborns receive postnatal check-ups within the first two days after birth. Women in urban areas receive more postnatal check-ups than women in rural areas with the incidence in Chin State remaining the lowest (21 percent) and the Magway region being the highest (92 percent) [18].

A number of studies found that poverty and remoteness were not the only factors that hamper women's access to maternal health services. Lack of women's empowerment through poor education, ethnicity and religious diversity, linguistic limitations, cultural and gender norms are also found to have an impact on women's ability to access maternal healthcare services, which in turn can have a negative effect on their health outcomes[10, 15, 18].

Lack of women's empowerment is found to be associated with lower access to health services for women across the states. Lack of education may also lead to earlier marriages resulting in unwanted pregnancies and births, illiteracy which limits health awareness, reduced ability to understand the cause of ill health, and lack of awareness of when and where to seek healthcare[15].

The country is a multicultural society with extensive cultural, linguistic, and religious diversity. The country has about 135 ethnic groups and thus different cultural practices and languages are present. There is also a widespread belief across the country and among different religious and ethnic groups that differential treatment of men and women originates in religious texts. For example, the high prevalence of traditional birth practices among ethnic women in rural and remote areas reflects both the unavailability of modern healthcare services and their preference for the use of traditional over modern delivery practices. Traditional beliefs and practices regarding pregnancy and childbirth are passed down inter-generationally from mothers and mothers-in-law to daughters and daughters-in-law[32]. Lack of education and knowledge could be a contributing factor to these decisions.

Cultural norms that position women as inferior in the household impact women's opportunities for a healthy life and limit their choices for their maternal health and family planning [33]. Gender norms, in particular, tend to describe women's bodies as dirty or shameful, and equate women's health concerns with reproductionⁱⁱⁱ. These norms can lead to limited access to sexual and reproductive health and proper access to healthcare; justification of men's violence

ⁱⁱⁱ Reproductive health is "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" 34. World Health Organization. (n.d). *Reproductive Health* [Online]. World Health Organization. Available at: http://www.wpro.who.int/topics/reproductive_health/en/ [Accessed 5 Sep. 2018].

against women, including sexual violence; and allegations that women fail to conform to cultural norms[33].

2.4 Affordability of maternal health services

Socioeconomic barriers, poverty, and limited access to public healthcare force many households to rely on for-profit healthcare providers which are frequently overpriced and of poor quality [15]. Access to private health services is barely affordable for those who live below the poverty line. In 2015, the country poverty rate was 32 percent where 38.8 percent of the rural population are estimated to be poor compared to 14.5 percent of those in its towns and cities [35]. The poverty rate is twice as high in remote and hard-to-reach areas. Household economic status significantly impacts affordability of maternal health services [18].

Table 2 summarises the access to maternal healthcare services by women from different socioeconomic groups. The incidence of receiving ANC across Myanmar was 67 to 98 percent, varying between the lowest to highest quintile. The coverage for vaccinations against neonatal tetanus was slightly above 62 percent for the lowest wealth quintile group compare to 81 percent for the highest quintile group. The data is more staggered when it comes to access to institutional deliveries. Home delivery is common for women from the lowest quintile group (more than 80 percent), particularly in remote rural areas. The incidence of deliveries in health institutions varies between 25 and 50 percent among the second, middle and fourth quintile. However, access to institutional delivery is more common among women with at least secondary education (83 percent). While the deliveries assisted by skilled providers help ensure safe and clean delivery, less than 40 percent of the women from the lowest, and half from the second quintile can afford the services. The fourth quintile had the highest incidence of receiving postnatal check-up (89 percent), followed by the middle quintile (77.1 percent). About half of women from the lowest wealth quintile had received the services.

Table 2: Women’s access to maternal health services by wealth quintile

Indicator Names	2015				
	Lowest	Second	Middle	Fourth	Highest

Percentage receiving antenatal care from a skilled provider (ANC)	67.1	75.0	83.8	90.4	98.1
Percentage whose last birth was protected against neonatal tetanus	62.3	70.1	74.1	78.5	81.3
Percentage receiving deliveries in a health facility	16.8	25.5	37.2	50.1	82.5
Percentage of deliveries by a skilled provider	36.3	50.7	64.7	79.6	97.0
Percentage of women with a postnatal checkup in the first two days after birth	58.0	66.5	77.1	89.0	71.2

Source: Myanmar Demographic and Health Survey 2015-2016

Financial constraints and poverty are the major factors limiting the access to maternal healthcare services. Women from high poverty, coastal^{iv} and mountainous areas^v have lower access to health services than in other states [36]. Additionally one study shows health expenditures are one reason poor households fall into poverty [24].

Affordability of health services is also determined by women's participation in household decision making. Their participation in household decision making is an important factor in women's ability to have control over their lives or to allocate household financial resources for her healthcare (e.g., for ANC visits, birth delivery and postnatal care and the use of contraceptives to control unwanted births). According to 2015-2016 DHS, 65 percent of married women participate in decisions in three specific areas (i.e. women's own healthcare, major household purchases, and visits to their family or relatives). All three participation rates are higher in urban areas than in rural areas, and also higher for women with secondary or higher education as well as among the richest women, indicating inequality among different groups of women in decision making capacity.

2. Government policies and stakeholders contribution to maternal health programs

The government is aiming towards universal healthcare coverage with the objectives of ensuring equity in access to health services, financial risk protection and improving the quantity and quality of services. The government's on-going policy is to target maternal health as a priority and focus on vulnerable people and cooperating with development partners.

3.1. Institutional structure

The Ministry of Health and Sports is the major player in providing comprehensive health care throughout the country including remote and hard to reach border areas. Health care in Myanmar

^{iv} Coastal areas cover the state such as Rakhaing and Tanyintharyi

^v Mountainous areas covering Chin, Kachin, Kayah, Kayin, and Shan

is provided by both the private and public sector. The private sector mainly provides ambulatory (i.e., outpatient) care though some provide institutional care (i.e., hospitals) which has developed in Nay Pyi Taw, Yangon, Mandalay and some large states in recent years [24]. The Department of Public Health is mainly responsible for public sector that provides primary healthcare and basic health services; nutrition promotion, environmental sanitation, maternal and child health, school health, and health education[25]through various national programs and collaboration with development partners, civil service organizations and community based organizations.

Myanmar's health system follows the country's administrative structure, with health departments at regional/state, district and township levels [37]. The Township Health System is the backbone of the Myanmar Health System. The Township Health Department provides primary and secondary health care services down to the grassroots level. Each Township has about five Rural Health Centers (RHC) and each RHC has four sub-RHCs. Each RHC has one Lady Health Visitor, five Public Health Supervisors Grade II and five Midwives (MWs). At the village level, Voluntary Health Workers (VHW) provide some support to midwives in hard to reach areas. Also a midwife is stationed at a sub-rural health center, offering maternal health service at the commune level [14].

3.2 Government policy

According to the 2008 Myanmar Constitutional, Article 32, "the union shall care for mothers and children, orphans, fallen Defence Services personnel's children, the aged and the disabled", Article 351, "Mother, children and expectant women shall enjoy equal rights as prescribed by law" and Article 367, "Every citizen shall, in accord with the health policy laid down by the Union, have the right to health care" [38]. The government places emphasizes on improving maternal and child health services and recognizes the importance of universal access to reproductive health in achieving the Millennium Development Goals[39].

To achieve the targets of the Sustainable Development Goals (SDGs), the Ministry of Health and Sports has been planning and implementing interventions to improve the health status of mothers, newborns and children by reducing maternal, neonatal and child mortality and morbidity. Core strategies include: 1) creating an enabling environment; 2) improving the information base for decision-making; 3) strengthening health systems and capacity for the delivery of reproductive health services; and 4) improving community and family practices [13].

The most comprehensive health policy is the NHP 2017-2021 which aims to reduce maternal, newborn, and infant and child morbidity and mortality. Reproductive Health Strategic Plans (RHSP) (2009–2013 and 2014–2018) were developed by the Department of Health’s RH programme with the support of all implementing partners as a continuation of the first 5-year RHSP 2004–2008. These plans set core strategies for improving antenatal, delivery, post-partum and newborn care, providing quality services for birth spacing and prevention and management of unsafe abortions, preventing and reducing reproductive tract infection, STIs (including HIV), cervical cancer and other gynaecological morbidities, and promoting sexual health, including adolescent RH for both females and males [27].

3.3 Maternal health financing

According to the World Health Organization (WHO), Myanmar health expenditures relative to GDP is among the lowest. The Myanmar government’s health expenditures increased from USD 279 million in 2012-2013 to USD 789 million in 2017-2018 which represents just over one percent of Myanmar GDP[40, 41]In 2014, 81 percent of Myanmar’s total health expenditures came from out-of-pocket^{vi} financing[41]. While government expenditures increased a proportional increase will be required at central, region and state levels to meet national and international targets set by the Ministry on reproductive maternal and child health. In 2012, the Three Millennium Development Goal Fund (3MDG Fund) ^{vii} provided funds ranging from USD 250 million to USD 300 million over five years to address the basic health needs of the most vulnerable people in Myanmar including maternal [14, p-25].

As a proportion of the total government budget, the WHO is focussing on a number of Innovative measures in health financing such as a voucher system for maternal and child health care[14]. The World Bank’s Essential Health Services Access Project is a USD 100 million project running from 2014 to 2019 with aims to increase coverage of essential health services. The

^{vi} Out of Pocket Financing refer to any expenses for medical care that are not reimbursed by insurance 42. Health Care.gov. (n.d). *Out-of-Pocket Costs*, [Online]. Available at: <https://www.healthcare.gov/glossary/out-of-pocket-costs/> [Accessed 24 Oct. 2018].

^{vii} The Three Millennium Development Goal Fund strengthens the national health system at all levels, extending access for poor and vulnerable populations to quality health services 43. The Three Millennium Development Goal Fund. (n.d). *About 3MDG*, [Online]. Available at: <https://www.3mdg.org/en/about-the-3mdg-fund> [Accessed 8 Nov. 2018].

focuses were on maternal, newborn and child health. In spite of this, government policy documents indicate that the health sector is still under-funded [44].

3.4 Program coverage and focuses

Myanmar is cooperating with United Nations Population Assistant Fund (UNFPA), United Nations International Children's Emergency Fund (UNICEF), Japan International Cooperation Agency (JICA), Australian Aid (AusAID) and international partners in providing support for reproductive health, particularly on maternal and newborn health [14]. To identify the root sexual and reproductive health and rights causes of maternal mortality, UNFPA supports technical and financial assistance towards the government's new program launched in 2016, which is the introduction of a Maternal Death Surveillance and Response (MDSR) action program [45]. To reduce maternal and child mortality, the UN helps develop policies, and strengthens health care systems to reach everyone in need [46]. The 3MDG Fund is also cooperating with the Ministry of Health in the implementation of their health workforce strategy; generating evidence through supporting research and sector-wide assessments to inform national policies and strategies; financing the training of more than 5,000 volunteer 'auxiliary' midwives nationwide and providing technical assistance to the Ministry of Health to strengthen midwifery across Myanmar[47].

3. Conclusion

Maternal health care remains an acute health issue for the Myanmar health sector. Despite the progress and efforts made by the government and development partners, it is still not clear whether the country can reduce the maternal mortality rate to meet the SDG3 target. The country faces numerous challenges in developing its healthcare systems, ranging from limitation of the healthcare workforce, poor physical infrastructure, lack of healthcare equipment and lack of financial resources. The political transition, however, paves the way for accelerating country development as well as the health sector.

The MMR vary by age, states, education status and by socioeconomic group, resulting from a disparity in access to maternal healthcare by different clusters of population. The causes of MMR are mostly preventable. Home delivery without skilled assistance and not being able to reach health facilities in time exacerbate maternal health risks for women. The availability of maternal health services have increased both in number of health facilities and staff. But wide geographic, ethnic and socioeconomic disparities are among the challenges in delivering health services to all

areas especially to rural and remote areas. Nonetheless, the latest data show that the majority of pregnant women have received ANC services. The data also reveals that accessibility is lower for women from rural areas, with lower educational backgrounds and from lower wealth economic status. This also applies in terms of receiving vaccinations, institutional deliveries and the postnatal care. Poverty and remoteness can also be factors hampering the access to, and the affordability of, MHC by some groups of women. Lack of women's empowerment over their healthcare decision making, ethnicity, religious diversity, linguistic weakness, and cultural and gender norms are also a root cause.

Improving maternal health and child health services has been the main priority for the NHP of the country. But the implementation of the policy is hindered by underfunding. Out-of-Pocket remain the largest source of healthcare funding. This means that the government shall continue investing more to improve both the quantity and quality of health services and develop a health related social protection programs such as the Health Equity Fund (HEF) to expand the program to cover poor and vulnerable groups.

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