EVERY WOMAN
EVERY CHILD

EVERY NEWBORN

Progress towards ending preventable newborn deaths and stillbirths

SPOTLIGHT ON MYANMAR

In Myanmar, national leaders are working together with global partners to drive progress on newborn survival. This collaboration has helped to identify the work that needs to be done and a clear plan, the National Newborn and Child Health and Development Strategic Plan (2015–2018), has been put in place to guide efforts. Since the move towards democratic reforms began in 2010, a commitment to under-5 mortality reduction has been made at the highest political level and there has been a steady increase in the financial allocation for child health with a clear focus on newborn health. Collaborative partnerships are supporting the implementation of the national plan to end preventable newborn mortality and stillbirths.

World Health Organization

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COMMITTING TO CHILD SURVIVAL
A PROMISE RENEWED

National Context

Estimated population: 51.4 million

Newborn Mortality Rate (NMR): 26 newborn deaths per 1,000 live births [1]

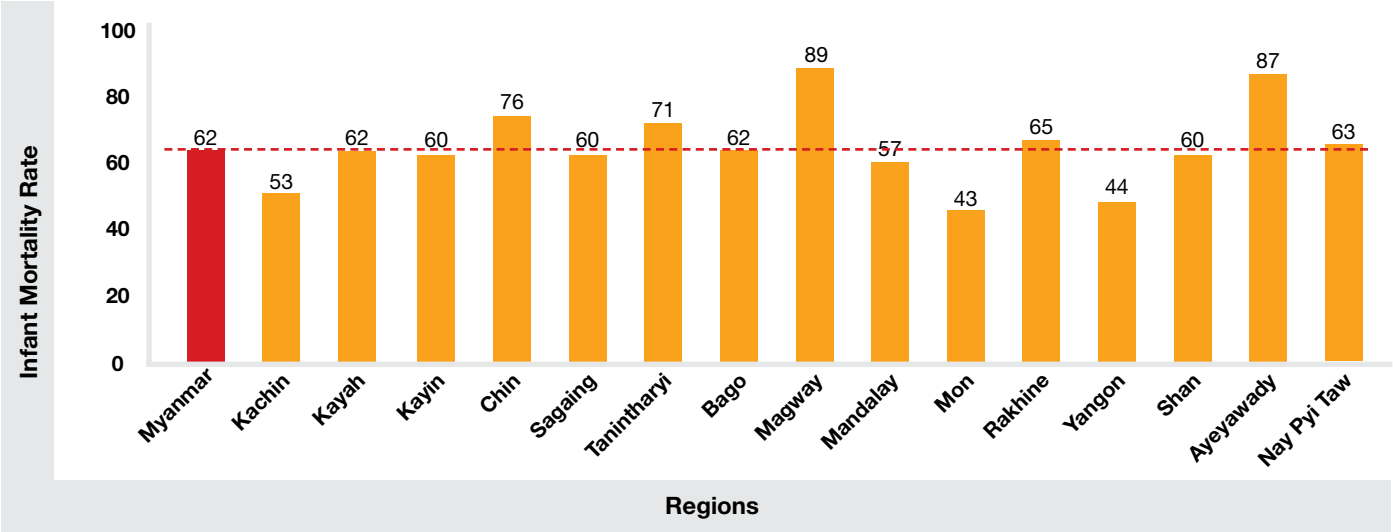
Stillbirth rate: 20 per 1,000 total births [2]

Newborn deaths as a share of under-5 mortality: 51 per cent [3]

Causes of newborn mortality
Approximately half of all deaths in children aged under-5 are among newborns. A 2015 Ministry of Health survey concluded that the great majority of newborn deaths are due to preventable causes or treatable conditions: premature births (36 per cent), birth asphyxia (26 per cent), neonatal jaundice (15 per cent) and sepsis (12 per cent).[4]

Critical disparities in survival
Whether an infant survives or not is greatly dependent on the place of family residence and income. While Myanmar does not have data on newborn mortality rates, the significant inequalities in infant mortality rates can provide some indication of the severity of the disparities.[5] The 2014 National Household Census demonstrates large variations in Infant Mortality rates across the regions in Myanmar. Ayeyawady has twice the infant mortality rate of neighbouring Yangon. See Figure 1

Figure 1: Regional infant mortality rates in Myanmar in 2014



Source: Adapted from the 2014 Myanmar Population and Housing Census, The Union Report, Census Report Volume 2, p 39.
Note: Newborns are children aged 28 days or less and Infants are children aged 12 months or less (WHO).

Approximately 37 per cent of the population lives in abject poverty, below the international poverty line. Figure 2 shows the extent to which household income impacts newborn survival. A child in the poorest household faces a four times greater risk of dying before its first birthday than a child born in the richest household. Infant mortality rates are twice as high in rural areas compared to urban areas and 70 per cent of Myanmar's population live in rural, often remote areas. See Figure 3.

[1] United Nations Inter-Agency Child Mortality Estimates (2015). Levels and Trends in Child Mortality, Report 2015, UNICEF, New York

[2] S. Cousens, H. Blencowe, C. Stanton, D. Chou, et al.,(2011) "National, regional, and worldwide estimates of stillbirth rates in 2009 with trends since 1995: a systematic analysis," The Lancet 377 (9774): 1319–1330, April 2011.

[3] United Nations Inter-Agency Child Mortality Estimates (2015). Levels and Trends in Child Mortality, Report 2015, UNICEF, New York

[4] National Newborn and Child Health and Development Strategic Plan (2015-2018), p. 20.

[5] The Myanmar Population and Housing Census, The Union Report (2014). Census Report Volume p. 39.
At: http://unstats.un.org/unsd/demographic/sources/census/2010_PHC/Myanmar/MMR-2015-05.pdf, accessed 31 August 2015.

Figure 2: Infant mortality rates per wealth quintile

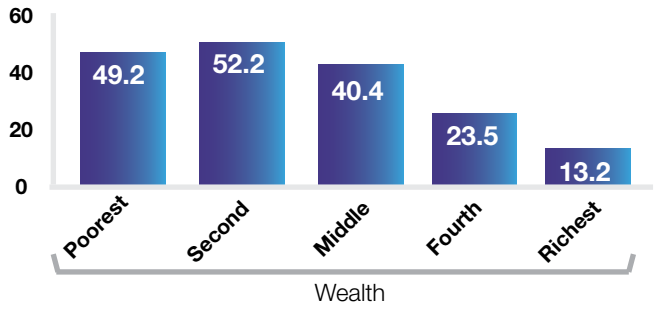
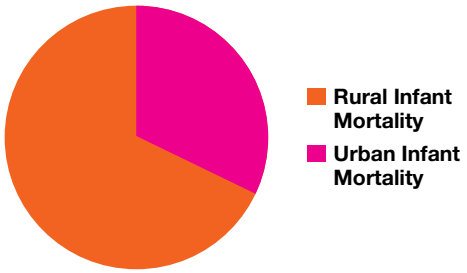


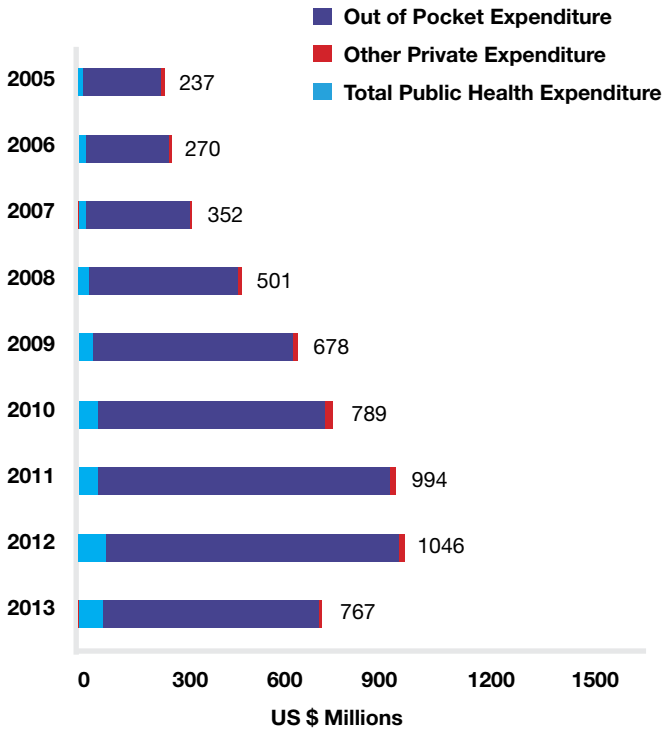
Figure 3: Infant mortality rates by urban and rural residence



Source: National Newborn and Child Health and Development Strategic Plan (2015-2018), p.18.

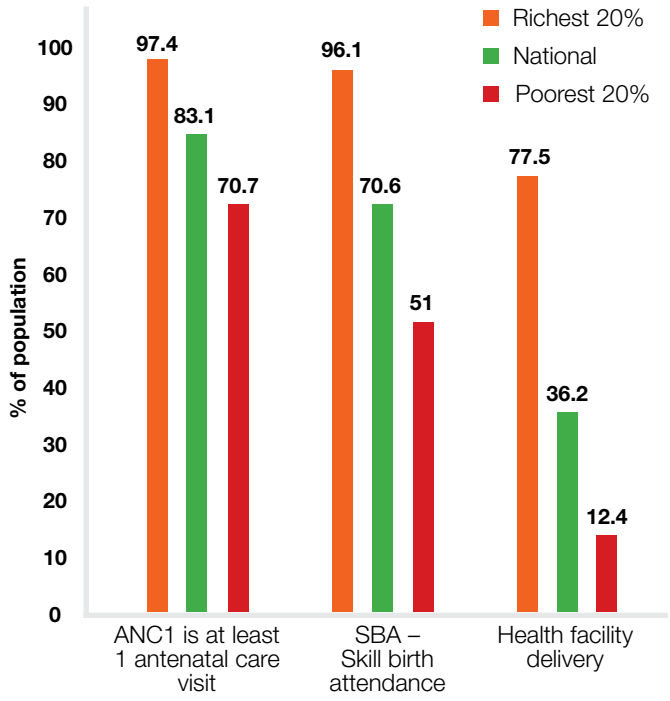
Out-of-pocket expenses in Myanmar are among the highest globally. This dropped marginally from 99 per cent in 2005 to 93.7 per cent in 2014, and continues to constitute the majority of health expenditure in Myanmar, as shown in Figure 4.[6] These extraordinarily high out-of-pocket payments for health care are most likely a major deterrent to care seeking. Facility-based delivery is as low as 12 per cent for the nation's 10 million poorest (See Figure 5). Low care-seeking practices also impact access to care for obstetric and neonatal complications.

Figure 4: Out-of-pocket expenses as a proportion of health expenditure



Source: World Bank 2015.

Figure 5: Disparities in lifesaving care around the time of birth between the richest and poorest wealth quintiles



Source: Data from Multiple Indicator Cluster 2010.

Another substantial factor limiting the coverage of care is the significantly low health-care worker–to-patient ratio in Myanmar. In 2014, there were 1.3 health personnel per 10,000 population,[7] only half the WHO recommended minimum of 2.3 per 10,000 population. It is estimated that an additional 7,000 midwives or skilled birth attendants are needed.[8] Many health workers lack newborn care competencies and those who are well-trained are overutilized.[9]

[6] WHO, Global Health Observatory, Official Development Assistance (ODA) recipient country profiles, 2000–2010. At http://www.who.int/gho/governance_aid_effectiveness/countries/en.

[7] The Republic of the Union of Myanmar Health System Review', Health Systems in Transition Vol 4. No 3, 2014, Asia Pacific Observatory on Health Systems and Policies. At http://www.wpro.who.int/asia_pacific_observatory/hits/series/myanmar_health_systems_review.pdf.

[8] United Nations Populations Fund, 2015. 'Strengthening Myanmar's Midwifery Services'. Accessed September 15 2015, At http://countryoffice.unfpa.org/myanmar/2015/07/02/12405/strengthening_myanmar_rsquo_s_midwifery_services_top_priority_for_unfpa/ report

[9] Isabelle Risso-Gill, Martin McKee, Richard Coker, Peter Piot and Helena Legido-Quigley,2013. "Health system strengthening in Myanmar during political reforms: perspectives from international agencies," Health Policy and Planning. At http://heapol.oxfordjournals.org/content/early/2013/06/06/heapol.czt037.full.pdf+html.

Milestones in progress

High-level political commitment to newborn health

High-level political commitment to reduce under-5 child mortality has galvanized support from the international health community. With the beginning of political changes in 2010, the Ministry of Health developed the first ever Five-Year Strategic Plan for Child Health Development (2010–2014) which had a focus on newborn health, and subsequently developed The National Newborn and Child Health and Development Strategic Plan (2015–2018) that specifically focuses on newborn health as one of only three strategic objectives; reduce preventable newborn deaths through improved home-based care, early identification of sick newborns and improved access to quality institutional newborn care.

Prior to the start of political changes in 2010, the health sector suffered from inadequate leadership and funding. Steps have since been taken to address decades of underinvestment in the health sector, including an increase in total government health expenditure from $6 million for 2000–2001 to $81 million for 2011–2012.[10] The Ministry of Health has costed the implementation over four years for the National Newborn and Child Health and Development Strategic Plan 2015–2018 at $252million (on average 63 million per year).[11]

Increased collaboration between national leaders and partners

The Ministry of Health has engaged global maternal and newborn health initiatives in work to strengthen national plans and programmes to deliver on commitments. Key activities are cited in Table 1.

Table 1: Government commitments to global maternal and newborn health initiatives

A Promise Renewed (2012)	The national government committed to identifying and tracking five-year benchmarks for maternal, newborn and child survival, with the goal of reducing newborn deaths to 16 per 1,000 by 2018.
Newborn Readiness Benchmarking (2013)	An analysis was conducted to assess the readiness to scale-up newborn care using the Scale-up Readiness Benchmarks tool developed by Save the Children that outlines 27 benchmarks that measure the degree to which health systems and national programmes are prepared to deliver interventions for newborn survival at scale.[12]
Bottleneck Analysis in support of Every Newborn (2013)	In 2013, Myanmar joined the process in support of the global Every Newborn Action Plan and undertook a bottleneck analysis. The exercise identified bottlenecks to the scale-up of quality care which provided critical information for development of a national plan.
The National Newborn and Child Health and Development Strategic Plan 2015–2018 (2014)	A Newborn Action Plan was developed following the guidance in the global Every Newborn Action Plan, and WHO and UNICEF Regional Action Plan. This was integrated with the new Child Health Plan, and The Newborn and Child Health and Development Strategic Plan was launched and costed.

[10] National Newborn and Child Health and Development Strategic Plan 2015–2018, p. 12.

[11] Ibid (p. 75).

[12] Newborn Health Assessment Report, UNICEF (2013).

Scaling-up newborn care through the Township Health System

Since March 2015, 330 townships have been the principal unit responsible for planning and implementing health services down to the lowest administrative unit, the village or urban ward.

Each township (with an average population of 200,000 to 300,000) has several Rural Health Centres that deliver services. All townships have a training team which consists of a Township Medical Officer, a health assistant and a nurse. These teams undertake capacity-building on newborn care and other core components of The National Newborn and Child Health and Development Strategic Plan (2015-2018).

Large geographic areas are subdivided into sub-health centres for a cluster of villages (serving 3,000 to 10,000 persons). Community volunteers, such as village auxiliary midwives and community health workers, are the critical link between the community and the formal public health system. These community health personnel provide key high-impact interventions to communities below the township level (see Table 3).

A standardized package of newborn care is to be rolled out in a phased approach in all townships over five years. The approach will require very strong local coordination and management and aims to:

- maximize impact by investing in referral transportation and financial protection
- focus on the underserved population

The effective functioning of this township health system can improve health outcomes for newborn and their mothers.[13]

Table 2: Planned locations for delivery of newborn interventions

Newborn intervention	Township	Station	Rural Health Centre	Sub-Rural Health Centre	Community
Immediate essential newborn care (at birth)					
1. Immediate thermal care	x	x	x	x	x
2. Early initiation of exclusive breastfeeding	x	x	x	x	x
3. Hygenic cord and skin care	x	x	x	x	x
4. Neonatal resuscitation as needed	x	x	x	x	x
5. Newborn infection/sickness management	x	x	x	x	x
Interventions during antenatal and intranatal period					
6. Antenatal corticosteroids for preterm births	x	x			
7. Labour and delivery quality care package	x	x	x	x	x
8. Antibiotics for premature rupture of membranes	x	x	x		
Interventions for small babies					
9. Kangaroo Mother Care for preterm babies and babies with low birth weight	x	x	x	x	x
10. Extra support for feeding small and preterm babies	x	x	x	x	x
11. Newborn care home visits by heath volunteers					x

[13] National Newborn and Child Health and Development Strategic Plan 2015–2018, p. 12.

Increasing the volume and competencies of health care workers skilled in maternal and newborn care

Myanmar's Health Workforce Strategic Plan 2012–2017 outlines activities to increase the availability of suitably qualified health workers for deployment to all levels of the system. The Government of Myanmar is working with partners to increase both the number and competencies of health care workers. Measures undertaken include the following:

Community-based care

The Community Based Newborn Care Programme (CBNC), implemented by the Ministry of Health with support from UNICEF, consists of a range of interventions with an expanded role of auxiliary midwives and volunteers. Beginning in 2011, health volunteers were trained to provide newborn care in hard to reach areas, to minority groups and those in post-conflict areas. The CBNC package includes support for the provision of thermal care; weighing newborns and referring low birth weight, preterm and sick babies for facility care; health education and counselling on clean delivery, infection prevention, breastfeeding and recognizing illness. The Ministry of Health's Newborn Health Assessment in Myanmar (2013–2014) recommended integrating the CBNC package within all existing platforms and programmes that provide care for pregnant women, newborns and children, and scaling-up CBNC nationwide. Fourteen Regional Training Teams were strengthened with improved training methodologies in 2014–2015. In 2015, over 4,000 health volunteers were trained in community-based newborn care.

Strengthening midwifery services

The United Nations Population Fund (UNFPA) in cooperation with the Department of Health Professional Resource Development and Management, Department of Public Health and the Myanmar Nurse and Midwife Council are working closely developing recommendations for higher levels of midwifery skills in order to attain better quality care, developing National Midwifery Standards Guidelines as well as creating a professional development career pathway for midwives.[14]

Collaboration with global partners to improve the provision of quality newborn care includes the following:

- In July 2015, a national workshop, 'Quality of Care for Maternal and Newborn Health', was held with UNICEF's support, and the Ministry of Health is now developing a follow-up action plan.
- WHO with the Ministry of Health has developed standard treatment protocols for managing common newborn conditions at the hospital level to mainstream quality of care into routine clinical practices for newborn and child health.
- USAID supported a national orientation for policy makers on the resuscitation of newborns with birth asphyxia in 2014. The Government used its own resources to procure 20,000 bags and masks for health facilities, which were distributed in 2015. Two hundred master trainers were trained on Helping Babies Breathe for all 72 districts as part of a joint initiative between the Ministry of Health, USAID's Maternal Child Survival Programme, Save the Children, UNICEF and Three MDG fund in July 2015.[15] Cascade training in prioritized townships was provided with the support of Three MDG fund and UNICEF.
- The use of chlorhexidine for cord care is now included in the national action plan. UNICEF is currently procuring chlorhexidine, and pictographs depicting correct use will be added to the clean delivery kits and distributed to all midwives and auxiliary midwives responsible for deliveries in villages. The Ministry of Health is also exploring the possibility of international procurement within the government budget.

[14] http://countryoffice.unfpa.org/myanmar/2015/07/02/12405/strengthening_myanmar_rsquo_s_midwifery_services_top_priority_for_unfpa/.

[15] http://www.3mdg.org/.

Emphasis on reducing out-of-pocket expenditure and increasing demand for care

The current National Strategy emphasizes equitable access to quality newborn and child health intervention packages by targeting the poor, unreached and underserved populations. A key activity of the 2015–2018 strategy is to map the availability, access, acceptability, utilization and quality of care for underserved populations.

Reducing out-of-pocket payments

The Ministry of Health is moving towards the reduction of out-of-pocket expenditures for those seeking care, and information, education and communication activities are being implemented to overcome cultural and social barriers to accessing care.

An integrated maternal and child health voucher scheme project that uses health equity funds was piloted successfully in 2013–2014. The Ministry of Health plans to collaborate with other ministries to establish sustainable financial mechanisms such as cash transfers to help overcome direct and indirect financial barriers to access services.

Also, an innovative, demand-side financing project with multisector partners is being piloted, in the form of a social health insurance. This aims to achieve universal health coverage by removing financial barriers to accessing health care and preventing families from falling into the poverty trap due to high health care costs that include high of out-of-pocket expenditure.

Improving demand for care

A local NGO with a nationwide network, The Maternal and Child Welfare Association, has been involved in providing maternal newborn and child health services and generating demand. The Seven Things This Year initiative has focused on seven key family practices to improve newborn and child health at the family level throughout 2011–2015. It was rolled out in 25 townships with UNICEF support. Further community mobilization for increased knowledge and demand for health care services is being supported through UNICEF's Communication for Development Programme.

ABOUT EVERY NEWBORN

The global Every Newborn Action Plan (ENAP) was endorsed by the 194 Member States of the World Health Organization at the World Health Assembly (WHA) in 2014. It is supported by a WHA resolution that requests the regular monitoring of progress of the ENAP goals and targets and for the WHO Director General to report periodically to the WHA on progress until 2030. It aims to support countries to reach the target of fewer than 12 newborn deaths per 1,000 live births and 12 stillbirths per 1,000 births by 2030. ENAP was developed based on evidence published in the 2014 Lancet Every Newborn Series and consultations with many Member States, organizations and individuals. ENAP provides guidance to policy makers and programme managers on refining national newborn policy and programmes within the context of wider reproductive, maternal, newborn and child health strategies. ENAP is closely linked to Strategies Towards Ending Preventable Maternal Mortality.

Strategic objectives

1. Strengthen and invest in maternal and newborn care during labour, birth and the first day and first week of life
2. Improve the quality of maternal and newborn care
3. Reach every woman and newborn to reduce inequities
4. Harness the power of parents, families and communities
5. Count every newborn through measurement, programme-tracking and accountability

Acknowledgements

Design and layout: Miracle Interactive and Phoenix Designs, Cape Town, South Africa.

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