Family Planning Spending Assessment

in Myanmar

2018

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Special thanks go to the research team who collected data at the national and county levels.

Thwe Thwe Win and FPSA Myanmar Team

List of Acronyms and Abbreviations

3MDGF	Three Millennium Development Goals Fund
AMW	Auxiliary midwife
BMGF	Bill and Melinda Gates Foundation
CGA	Commodity Gap Analysis
CHAI	Clinton Health Access Initiative
CIFF	Children's Investment Fund Foundation
CHW	Community Health Worker
CPI	Community Partners International
CPR	Contraceptive Prevalence Rate
DfiD	Department for International Development
DMPA	Depot Methoxy Progesterone Acetate
DMR	Department of Medical Research
DoPH	Department of Public Health
ECP	Emergency Contraceptive Pill
EU	European Union
FP	Family Planning
FP2020	Family Planning 2020
FPFA	Family Planning Financing Agency
FPFS	Family Planning Financing Source
FPSA	Family Planning Spending Assessment
FPPF	Family Planning Production Factor
FPSC	Family Planning Spending Category
FPSP	Family Planning Service Provider
GFATM	Global Fund for HIV/AIDS, TB & Malaria
GPRHCS	Global Programme for Reproductive Health Commodity Security
IEC	FPPF 1.4.1: Information, education and communication
IRC	International Rescue Committee
INGO	International Non-government Organizations
IUD	Intra-uterine Device
JHPIEGO	Johns Hopkins Program for International Education in Gynecology & Obstetrics
JSI	John Snow's Inc.
LHV	Lady Health Visitor

MAM	Medical Action Myanmar
MCH Center	Maternal and Child health Center
mCPR	Contraceptive Prevalence Rate (Modern Method)
MDHS	Myanmar Demographic and Health Survey
MMA	Myanmar Medical Association
MMCWA	Myanmar Maternal and Child Welfare Association
MMK	Myanmar Kyat (currency)
MPA	Master of Public Health
MoHS	Ministry of Health and Sports
MRH	Maternal and Reproductive Health Division
MSI	Marie Stopes International
NASA	National HIV/AIDS Spending Assessment
NGOs	Non-government Organizations
OCP	Oral Contraceptive Pill
OOP	Out-of-Pocket
PATH	Program for Appropriate Technology in Health
PSI	Population Services International
RHC	Rural Health Center
RHC-LMS	Reproductive Health Commodity- Logistics Management System
RI	Relief International
SC DMPA	Sub-cutaneous Depot Methoxy Progesterone Acetate
SIDA	Sweden International Development Agency
Sub RHC	Sub Rural Health Center
TFR	Total Fertility Rate
UNICEF	United Nations Children Fund
UNF	United Nations Foundation
UNFPA	United Nations Population Fund
UNOPS	United Nations Office for Project Services
UoPH	University of Public Health
USAID	United States Aids for International Development
USD	United States Dollar
VHV	Village Health Volunteers
WHO	World Health Organization

Executive Summary

Contraceptive prevalence rate (mCPR for MW) in Myanmar is improving from 46 percent in 2012 to 54 percent in 2019, and unmet need for family planning decreased from 20 to 16 per cent for the same period.

The specific objectives of the FP Spending Assessment were to determine the total expenditures on FP in 2018 from different sources including, determining the FP expenditures by different spending categories, and establish who are the providers of FP services and analyze spending by each provider ownership and type. There were four basic questions that were answered by the assessment including who pays for FP services at the county level, who manages the FP funds and up to what level, who provides FP services, and what FP services were provided.

The results showed that total FP spending was US$ 24,362,558 in 2018, including out-of-pocket expenditure for FP. In 2018, financing of FP commodities and other activities comes mainly from the households out of pocket spending (26.44%), National Government (18.17%) and development partners (United Nations Population Fund - 16.05%, pooled Three MDG Fund {Australia, Denmark, The European Union, Sweden, Switzerland, the United Kingdom and the United States of America} - 14.84%). Financing agents included Ministry of Health and Sports, Department of Medical Research, UNFPA, WHO, UNOPS, Myanmar Medical Association, Myanmar Maternal and Child Welfare Association, Marie Stopes International, Population Services International, Relief International, Community Partners International, John Snow's Inc., DKT International, PATH, Clinton Health Access Initiatives, International Rescue Committee, Medical Action Myanmar and JHPIEGO.

Myanmar Government started to procure FP commodities 5 years ago, and the level of funding sharply increased in the first few years, but now decreasing within the last three years. Before, FP commodities (all items) for public health facilities solely relied on UNFPA supplies. For the last few years, UNFPA funding for FP commodities and FP activities was also significantly declined, and only long term reversible methods and emergency pills are supported by UNFPA in 2018.

international NGOs (36%) are the main financing agents in the provision of FP services in the country. The second largest share is managed by FP users for their out-of-pocket (household) expenditure. Ministry of Health and Sports and UN agencies accounted for 18.53% and 17.77% respectively. Among international NGOs, Marie Stopes International, Population Services International and DKT International are key entities as financing agents. Among UN agencies, UNFPA is the key agent channeling funds for FP activities and services.

In terms of FP service providers, the INGOs (36.50%) accounted for the highest expenditure on FP services followed by private sector (26.44%) and public health facilities (25.59%). Among international NGOs, Marie Stopes International accounted for nearly half of the expenditure of INGOs at 17.80%.

In terms of expenditure by FP Service Categories (FPSC), spending on provision of FP services (67.24%) made the highest share of FPSC. The second largest share goes to programme management (26.87%) while the spending on training (4.26%), advocacy (1.35%) and research (0.19%) are comparatively low. Among the service provision cost, injectables and pills are significantly higher than other methods, as it includes out-of-pocket expenditure.

In terms of expenditure by FP Production Factor (FPPF), staff cost (direct and indirect service provision, programme management and consultancy) for FP services (44.21%) took the largest amount of expenditure, followed by FP commodities, consumables, procurement and distribution (21.84%), while operational expenses (rent, utilities, repair, travel, admin, etc.) (20.45%) and expenditure on training (7.62%) are third and fourth largest share of spending for FP production factors. Recurrent cost (99.4%) is obviously much higher than capital cost.

Since the total health budget is low is Myanmar and there are competing priorities, public sector funding for contraceptive is not adequate to meet the demand of the health facilities. Some methods are not popular among the clients and there are over-stocks. Injectables and implants are highly demanded but pills, ECP and IUD are on low demand in some areas. Retention of health staff and inefficient supply chain management, especially in remote areas, is also a major problem in Myanmar. Government funding is not available yet for FP training, M&E or organizational arrangement. There are limited number of staff at central level to manage the FP programme for the whole country.

Conclusion

Significantly high level of out-of-pocket expenditure for FP highlighted the importance of private sector in FP service provision. Although the government expenditure on FP commodities has increased in recent years, the trend is not stable and it has decreased in 2018 due to competing priorities for health budget. Financing of FP services is heavily depended on international funds, which is not sustainable. Share of FP service provision by NGOs is also noticeably high.

The findings in this study provide comprehensive picture of FP resource flow to the national government, regional governments, donor agencies and NGOs working in reproductive health, and raise awareness on the need for advocacy and resource mobilization to address the unmet FP needs.

Recommendations

1. Although there are stock-out of FP commodities at the public health facilities, and it is allowed to procure FP commodities at state/regional level and at hospital level, only one region, out of 14, procured some contraceptives in 2018. Need based procurement should be encouraged by central level to avoid stock-outs. The national

and regional governments should have clear policy on financing strategies and public spending on for FP.

2. The coverage of RHC-MIS (Reproductive Health Commodity – Management Information System) supported by UNFPA and JSI should be expanded to all state/regions, in order to promote PULL system of distribution.
3. The focus of the support should be prioritized for poor, marginalized communities. Longer term methods should be promoted for those who has difficult access to the health facilities.
4. New methods should be introduced to expand the choice of methods, including post-partum IUD for multi-parous women.
5. Advocacy on relaxing regulations for female sterilization, and revising law which prohibit male sterilization should also be implemented.
6. Resource tracking of FP services should be employed to inform policy, planning and budgeting of FP commodities, and to ensure political commitment at both national and state/regional level. Financial tracking of FP services can also inform alternative financing approaches. The national and state/regional governments should explore new health financing strategies and increase public spending on for FP.
7. Public Private Partnerships should be explored to expands services availability and quality.

1. Introduction

1.1 Country Context

Myanmar is one of the countries in South East Asia. It borders Lao PDR and Thailand to the east, China to the North, India and Bangladesh to the West, and bounded by Bay of Bengal to the west and Andaman Sea to the south. The country is divided administratively, into Nay Pyi Taw Union Territory and 14 states and regions (Shan State is divided into three areas; northern, eastern and southern Shan State). Myanmar is comprised of 74 districts, 330 townships, 3,065 wards, 13,619 village tracts and 64,134 villages. The main features of the country are the delta region (consisting of Ayeyawady and Yangon Regions) and the central plain (Mandalay, Magwe, Sagaing and Bago regions) surrounded by mountains which are mainly composed of ethnic States (Kachin, Kayah, Kayin, Chin, Shan, Mon and Rakhine States). There are two coastal areas (Rakhine State and Tanintharyi Region). The results of the 2014 Myanmar Population and Housing Census indicated that the population of Myanmar on the 29th March 2014 was 51,419,420 persons. And estimated population for 2018 is about 53 million. The 2014 Census data show that the population density in Myanmar is 76 persons per square kilometre. About 30 per cent of the population reside in urban areas.

1.2 Overview of FP in Myanmar

FP2020/Track20 estimated that there are 4,920,000 women who are using a modern contraceptive method in Myanmar in 2019. As a result of modern contraceptive use, 1,865,000 unintended pregnancies are prevented (Indicator #6), 440,000 unsafe abortions and 1,500 maternal deaths are averted (Indicator #7 & #8). Following table showed Myanmar country data of FP2020 2019 Core Indicators 1 to 4.

	Indicator	Current estimate for 2019	Projection in 2020
#1	Additional Users of Modern Contraception	979,000	1,075,000
#2	Modern Contraceptive Prevalence Rate (mCPR AW)	32.8%	33.3%
#3	Unmet Need for Modern Contraceptive (MW)	16.3%	16%
#4	Demand Satisfied for Modern Contraceptive (MW)	76.8%	77.4%

According to 2015-16 Myanmar Demographic and Health Survey, 60% of women age 15-49 are married. The current total fertility rate in Myanmar is 2.3 children per woman (1.9 in urban and 2.4 in rural). The median age at first marriage is 22.1 for women. Among rural women, it is 21.3, i.e., 3 years younger than urban women. The median birth interval is 49 months. Thirty-two percent of births occur within 3 years of a previous birth, and only 13%

occur within 24 months. The median age of a woman at her first birth is 24.7 years, and only 7% of women give birth before they are 18.

Overall 13% of currently married women age 15-49 want to have another child soon, 18% want to wait at least 2 years, and 61% want no more children or are sterilized. Overall, 52% of currently married women use a method of family planning (CPR), with 51% using a modern method (mCPR) and 1% using a traditional method. Among modern methods, injectables are most commonly used (28%), followed by the pill (14%), female sterilization (5%), and the IUD (3%). At the time of MDHS survey, implants were not widely used in public sector. For public sector, training and commodity support for Implant and subcutaneous depo injection were introduced phase by phase.

Over half of modern contraceptive users (54%) receive their method from public sector sources—government hospitals, health centers, and clinics. There are disparities across states/regions.

Overall, 16% of married women in Myanmar have an unmet need for family planning, 5% for spacing births and 11% for limiting births, but are not currently using contraception. The total demand for family planning constitutes 69% of married women, of which three-quarters is satisfied by the use of modern methods. 40% of women use pills that are promoted through social marketing, while 84% of women who use male condoms use the Ahphaw brand of PSI social marketing.

1.3 Overview of Assessment

Track20 is a Gates Foundation funded project to track progress in FP towards the goals of FP2020. One of its activities is to track FP expenditures, namely “Family Planning Spending Assessment (FPSA)”, managed by Avenir Health. The first round included four countries, i.e., Bangladesh, Indonesia, Kenya and Senegal. The second round (2018) is conducted in 6 counties including Myanmar. Tracking of FP expenditure considered resource flow of both financial and non-financial resources from their origin to the end point of service delivery, among the different institutions involved. Tracking was done from financing sources whether public, private or foreign and among the different providers of services. In summary, the tracking sought to answer the following questions:

- Who pays for FP in the county?
- Who manages the funds and up to what level?
- Who provides the FP services?
- What FP services were provided?

In general, FP tracking was aimed at obtaining the overall picture of the total spending on FP and FP services provided in the country and in the counties by the various stakeholders. The

specific objectives of the FP Spending Assessment in Myanmar were to determine the total expenditures on FP in Calendar Year 2018 from different sources including, determining the FP expenditures on different spending categories, and establish who are the providers of FP services and analyze spending by each provider type.

The results of the study provide estimates of expenditures on FP from government essential to: i) inform global monitoring of spending on FP, especially government contribution, ii) inform the resource gap analysis by comparing available resources and resource needs based on the strategic and operational plans; iii) provide financial information that will inform policy dialogue, iv) help in planning and budgeting in order to strengthen the case for family planning within the National development agenda ; v) be used to advocate for increased funding for FP resources in counties, and vii) be used to monitor progress of polices in place by assessing whether expenditure is per priority areas.

2. Methodology

2.1 Overall Scope

Scope of this study was calendar year 2018. In Myanmar, government fiscal year began from 1st April to 31st March of following year, but in 2018, it was changed to a period from 1st October to 31st September. Consequently, there was a mini-fiscal period of 6 months in 2018, i.e., from 1st April 2018 to 31 September 2018, and the overall fiscal year was 18 months from 1st April 2018 to 31st September 2019. Therefore, it was difficult to collect data for the fiscal year. However, other sources of FP resources used different years, mainly calendar year, running from January to December. To harmonize the financial years, attempts were made to estimate expenditure based on the calendar year 2018.

2.2 Classifications used to build the FP spending Accounts

This study adopted NASA classifications, but customized them to FP spending tracking. Following the NASA classifications, FP spending assessments classifies three sets of entities in the flow of funds for FP as financing sources, financial agents and service providers.

i. Financing Sources: Financing sources are defined as entities which ultimately bear the expenses of financing FP services and related activities.

ii. Financial Agents: Financial agents are defined as entities which pass funds from financing sources to other financial agents or service providers in order to pay for the provision FP services. They determine how funds are allocated to finance the different FP services.

iii. Service providers: Providers are defined as entities that produce and provide health care goods and services as they relate to FP.

In addition to the three entities, the other classifications consist of family planning service categories and categorization of budgetary items in the production of FP services. (See Annex 1)

2.3 Approach

In this adapted methodology, the resource tracking is a comprehensive and systematic methodology used to determine the flow of resources intended to support the provision of family planning services in a country. The tool tracks actual expenditure from public, private and international sources for all FP related interventions, services and activities. By adapting the NASA methodology, this assessment follows the national health accounts framework and principles. It applies standard accounting methods to reconstruct all transactions in a given country, 'following the money' from the funding sources to agents and providers and services provided.

2.4 Sampling

For the financing agents and service providers, the assessment included almost all key organizations working for FP in Myanmar, which are also service providers. A listing frame of key financing agents in provision of FP services in Myanmar was developed by the research team and the MRH Division. Financing agents included Ministry of Health and Sports, Department of Medical Research, UNFPA, WHO, UNOPS, Myanmar Medical Association, Myanmar Maternal and Child Welfare Association, Marie Stopes International, Population Services International, Relief International, Community Partners International, John Snow's Inc., DKT International, PATH, Clinton Health Access Initiatives, International Rescue Committee, Medical Action Myanmar and JHPIEGO.

Furthermore, a sample of townships was also selected by MRH Division to collect data from public health facilities. These were Myeik, Tanintharyu and Kyun Su Townships in Tanintharyi Region, Lewe Township in NayPyiTaw Region, Thasi, Wundwin and Meikhtilar Townships in Mandalay Region, Thabaung Township in Ayeyarwady Region, Hpa-an, Kawkareik and Hlaingbwe Townships in Kayin State. In these Townships, 2 to 7 health facilities were sampled.

2.5 Data Collection

Data collection was mainly from financing agents and service providers. MRH Division provided support for data collection by providing letters to the organizations about the assessment. Research team sent the letters and follow with phone call to the selected agents. The standard questionnaires were used to collect data. However, not all of them were able to fill the forms but they provided financial data based on their report formats. A few organizations were not able to provide disaggregated data due to human resource and time constraint.

The sources for funds FP commodities and activities were Government of Myanmar, one national NGO, 8 multilateral funds or development funds, 8 international not-for-profit organizations, 4 foundations and one anonymous donor. Contribution from USAID was not shown in the list but its contribution is included in multilateral funds (3MDG Fund). The financial agents and service providers are almost similar and included 18 entities.

The data collecting team also visited the townships and collected data from service providers using standardized tools. The data were collected from public health facilities. The data collected included human resource and workload statistics for FP services, operational expenditure for FP and all other service, and FP commodities received in 2018. The expenditure data on FP at the facility level were not generally available since the services are integrated. This necessitated the use of costing methods to estimate amount spent for FP at that level. Similarly, expenditure on FP specific activities by the state/region

government was not available for the same reason as the state/region do not have FP specific line item.

The total amount of household out-of-pocket expenditure was obtained from Commodity Gap Analysis (CGA) 2019.

2.6 Data Analysis

Data entry and analysis were facilitated by use of Excel Spreadsheet. The data entry and data processing sheet was provided by Avenir Health based on Kenya FPSA team's creation. The data were entered by identifying the expenditure by a given FP service provider, and tracing back to a financing agent and one financing source at a time. This was done to ensure no double counting. One entry in one row in Excel comprised a financing source, a financing agent, a service provider, FP service categories, and FP production factors.

Estimation of Public Sector State/Regional level Expenditure

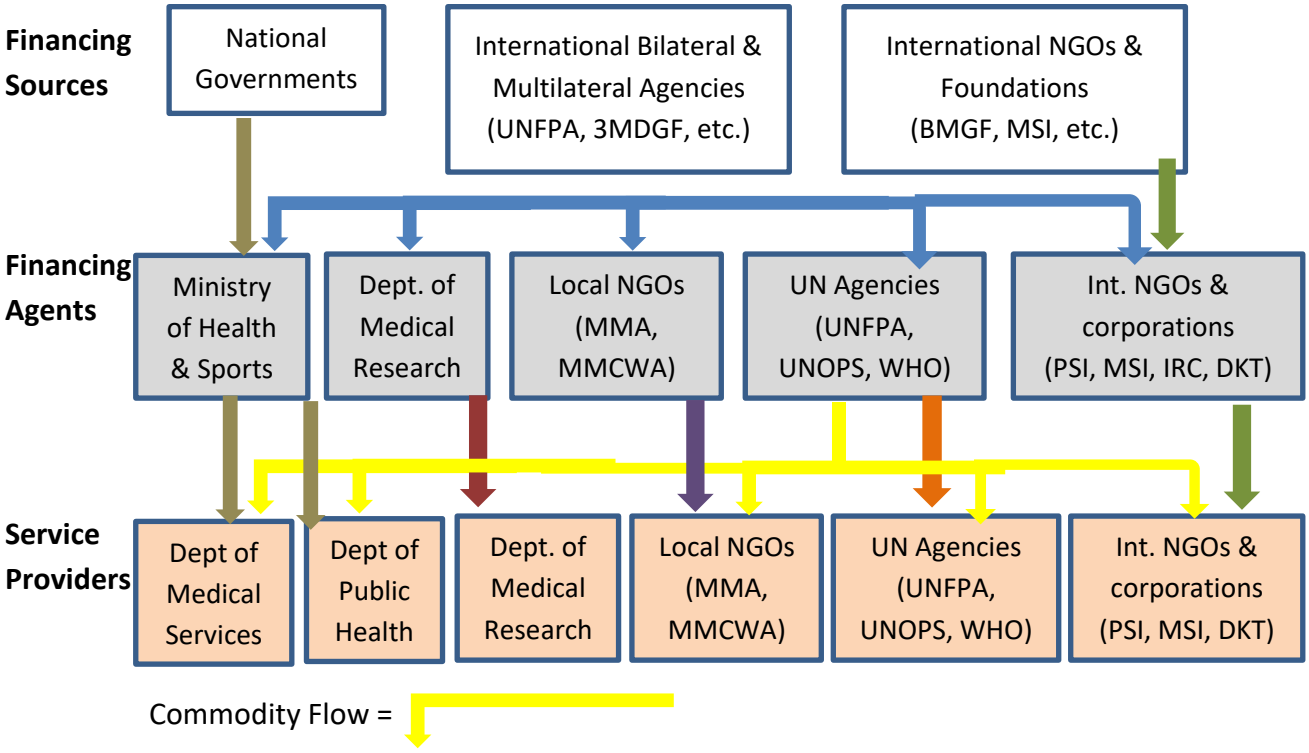
Although there are State/Regional level governments, the health sector budget is managed at the central level. Therefore, staff cost and procurement cost were mainly provided by MRH Division in collaboration with relevant units. Some State/Regions also procured commodities in addition to the central supplies. MRH Division sent letters to all state/ regional health department to obtain the expenditure on FP commodities. Operational cost was obtained from the field data collection and calculated for FP based on FP related workload. Direct service provision staff cost for FP is calculated based on findings of a research conducted by MPH students of the University of Public Health, Yangon.

3. FP Expenditure Findings

3.1 Financing of FP in Myanmar

In Myanmar, financing of FP commodities and activities are undertaken by different stakeholders. The stakeholders consist of sources of funds, financing agents, and the providers of FP services. Figure 1. presents diagrammatic view of the flows of funds for FP.

Figure 1. Flows of funds for FP



3.2 Total Expenditure of FP in Myanmar

Total spending in 2018 in terms of the US dollars is 24,362,558.

3.3 FP Expenditure by Financing Sources

Table 1 and Figure 2 show the results of FP spending analyzed by key financing sources.

Table 1. FP spending by key financing sources

FS	Fund Source	USD	%
Domestic			
F.S.1.1.1.5	Government of Myanmar Ministry of Planning and Finance	4,425,635	18.17%

F.S.2.3	Not for Profit organization - Myanmar Maternal and Child Welfare Association	128,674	0.53%
F.S.2.2	FP service users (Household OOP expenditure) Household's fund	6,440,555	26.44%
Sub-total		**10,994,864**	**45.13%**
International			
Multilateral funds or development funds			
F.S. 3.2.07	United Nations Population Fund	3,909,535	16.05%
F.S. 3.2.16	UNFPA Supplies Project (GPRHCS)	1,617,946	6.64%
F.S.3.2.02	World Health Organization	21,000	0.09%
F.S. 3.2.16	United Nations Foundation	74,436	0.31%
F.S.3.2.99	Maternal Health Fund	24,459	0.10%
F.S.3.2.99	3MDG Fund	3,616,189	14.84%
F.S.3.2.99	Global Fund for HIV/AIDS, TB, Malaria	562,405	2.31%
F.S. 3.2.16	FP2020	107,420	0.44%
Sub-total		**9,933,390**	**40.77%**
International not-for-profit organizations and foundations			
F.S.3.3.13	Bill and Melinda Gates Foundation	427,884	1.76%
F.S.3.3.99	Martin Fabert Foundation	63,132	0.26%
F.S.3.3.99	Marie Stopes International	420,210	1.72%
F.S.3.3.99	International Planned Parenthood Federation	77,279	0.32%
F.S.3.3.99	Packard Foundation	153,038	0.63%
F.S.3.3.99	Community Partners International (CPI)	13,369	0.05%
F.S.3.3.99	International Rescue Committee (IRC)	407,142	1.67%
F.S.3.3.99	John Snow Research and Training Institute (JSI)	11,812	0.05%
F.S.3.3.99	Save the Children	96,985	0.40%
F.S.3.3.99	Medical Action Myanmar Private Donation	171,540	0.70%
F.S.3.3.99	Children's Investment Fund Foundation (CIFF)	181,023	0.74%
F.S.3.3.99	Large Annonymous Donor	130,430	0.54%
F.S.3.3.09	Population Services International (PSI)	83,677	0.34%
	Sub-total	**2,237,521**	**9.18%**

Foreign Governments			
F.S.3.1.01	Government of Australia	118,118	0.48%
F.S.3.1.16	Government of Norway	404,274	1.66%
F.S.3.1.21	Government of United Kingdom	101,008	0.41%
F.S.3.1.20	Swiss Agency for Development and Cooperation	60,358	0.25%
F.S.3.1.19	Sweden International Development Agency (SIDA)	513,025	2.11%
	Sub-total	**1,196,783**	**4.91%**
	Total	**24,362,558**	

Figure 2. FP spending by categories of financing sources

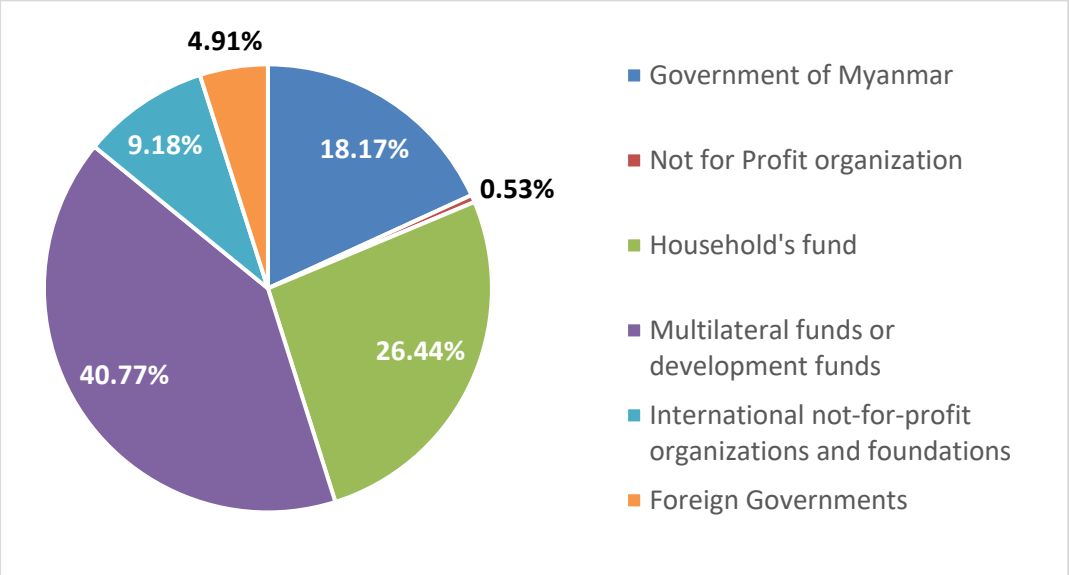


Table 1 and Figure 2 show that the largest contribution to total FP expenditure is from household fund (26.44%), and the second, third and fourth largest contribution is from National Government (18.17%), United Nations Population Fund (16.05%) and the Three MDG Fund {Australia, Denmark, The European Union, Sweden, Switzerland, the United Kingdom and the United States of America} (14.84%).

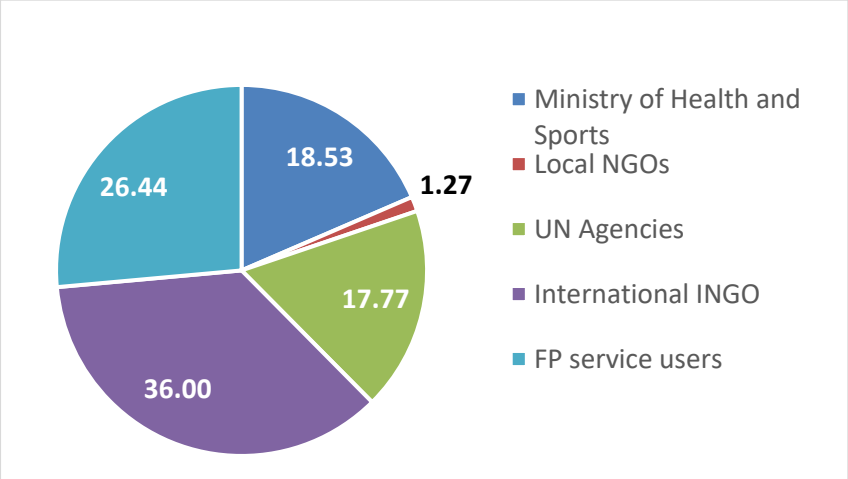
3.4 FP Expenditure by Financing Agents

Financing agents refer to entities that manage and use the funds for payment or purchase of FP services, FP commodities and other FP related activities. The financing agents also decide the type of activity fund. Table 2 and Figure 3 show the results of FP spending by financing agents.

Table 2. FP spending by financing agents

FA	Financing Agent	USD	%
	Government of Myanmar	**4,513,379.26**	18.53
F.A.1.1.1.1	Ministry of Health and Sports	4,425,635.26	
F.A.1.1.1.1	Department of Medical Research	87,744.00	
	Local NGOs	**310,337.46**	1.274
F.A. 2.4	Myanmar Maternal and Child Welfare Association	205,952.22	
F.A. 2.4	Myanmar Medical Association	104,385.24	
	UN Agencies	**4,328,679.75**	17.77
F.A.3.2.07	United Nations Population Fund	3,665,778.75	
F.A.3.2.16	United Nations Office for Project Services (UNOPS)	641,901.00	
F.A.3.2.02	World Health Organization	21,000.00	
	International INGO	**8,769,606.75**	36.00
F.A.3.3.99	Marie Stopes International (MSI)	4,225,986.00	
F.A.3.3.99	Population Services International (PSI)	1,348,278.00	
F.A.3.3.99	Relief International (RI)	108,416.35	
F.A.3.3.99	Community Partners International (CPI)	86,505.00	
F.A.3.3.99	John Snow International (JSI)	983,333.09	
F.A.3.3.99	International Rescue Committee (IRC)	407,142.00	
F.A.3.3.99	Medical Action Myanmar (MAM)	171,540.31	
F.A.3.3.99	Clinton Health Access Initiative (CHAI)	54,854.00	
F.A.3.3.99	Program for Appropriate Technology in Health (PATH)	63,132.00	
F.A.3.3.99	JHPIEGO	107,420.00	
F.A.3.4	DKT International	1,213,000.00	
	Household's fund		
F.A.2.3	FP service users (Household OOP expenditure)	**6,440,555.00**	26.44
	Total	**24,362,558.22**	

Figure 3. FP Spending by categories of Financing Agents



The table 2 and Figure 3 show that international NGOs (36%) are the main financing agents in the provision of FP services in the country. The second largest share is managed by FP users for their out-of-pocket (household) expenditure. Ministry of Health and Sports and UN agencies accounted for 18.53% and 17.77% respectively. Among international NGOs, Marie Stopes International, Population Services International and DKT International are key entities as financing agents. Among UN agencies, UNFPA is the key agent channeling funds for FP activities and services.

3.5 FP Expenditure by Service Providers

Service Providers are entities that engage directly in the production, provision and delivery of FP services against a payment for their contribution. FP services and interventions are provided by a number of providers that include the public entities, private for profit and non-profit domestic organizations and international entities. Table 3 and Figure 4 provide broad picture of the main providers of FP services during 2018.

Table 3. FP Spending by Service Providers

PS	Service Providers	Amount in USD	%
	Government of Myanmar		
P.S. 1.1.1	Public General Hospitals	1,197,615	4.92%
P.S.1.2.1	Public Outpatient care centres	4,307,335	17.68%
P.S.1.12	Department of Medical Research	87,744	0.36%
P.S.2.99	Village Health Volunteers (AMW/CHW)	79,496	0.33%
P.S.1.2.1	National AIDS Programme & other recipients	562,405	2.31%
	Local NGOs		
P.S.2.11	Myanmar Maternal and Child Welfare Association	209,452	0.86%
P.S.2.12	Myanmar Medical Association	104,385	0.43%
	UN Agencies		
P.S. 4.2	United Nations Population Fund	2,461,380	10.10%
P.S. 4.2	World Health Organization	21,000	0.09%
	International INGO		
P.S.2.11	Marie Stopes International (MSI)	4,335,870	17.80%
P.S.2.11	Population Services International (PSI)	1,431,378	5.88%
P.S.2.11	Relief International (RI)	108,416	0.45%
P.S.2.11	Community Partners International (CPI)	86,505	0.36%
P.S.2.11	John Snow International (JSI)	983,333	4.04%
P.S.2.11	International Rescue Committee (IRC)	311,283	1.28%
P.S.2.11	Medical Action Myanmar (MAM)	171,540	0.70%
P.S.2.11	Clinton Health Access Initiative (CHAI)	54,854	0.23%
P.S.2.11	Program for Appropriate Technology in Health (PATH)	63,132	0.26%

P.S.2.11	JHPIEGO	107,420	0.44%
P.S.2.11	DKT International	1,213,000	4.98%
P.S.2.11	Various Service providers (public hospitals and NGOs)	24,459	0.10%
	Private for profit out-patient care centers		
P.S.3.2.1	Private for profit out-patient care centers	**6,440,555**	26.44%
	Total	**24,362,558**	

Figure 4. FP Spending by categories of Service Providers

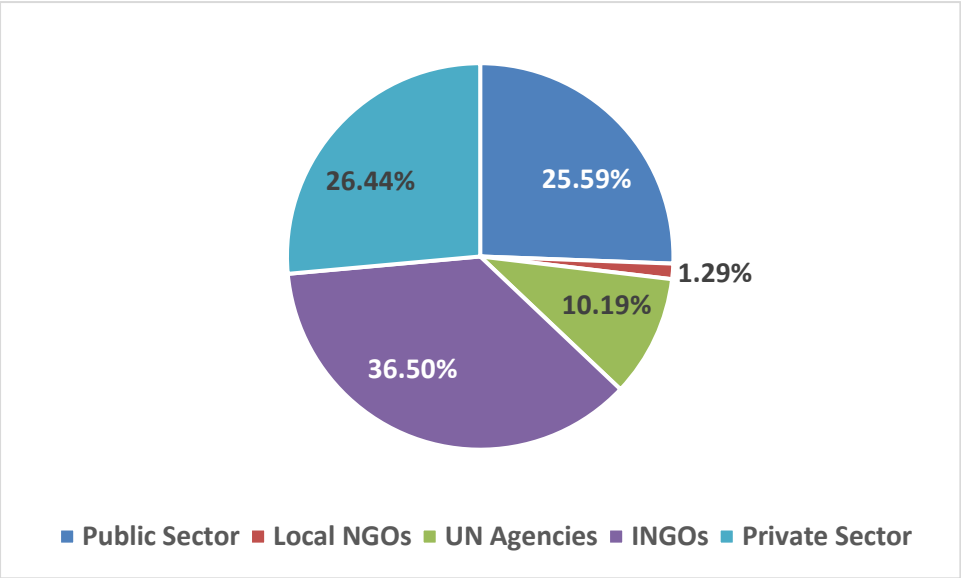


Table 3 and Figure 4 show that the INGOs (36.50%) accounted for the highest expenditure on FP services followed by private sector (26.44%) and public health facilities (25.59%). Among international NGOs, Marie Stopes International accounted for nearly half of the expenditure of INGOs at 17.80%.

3.6 Expenditure by FP Service Categories (FPSC)

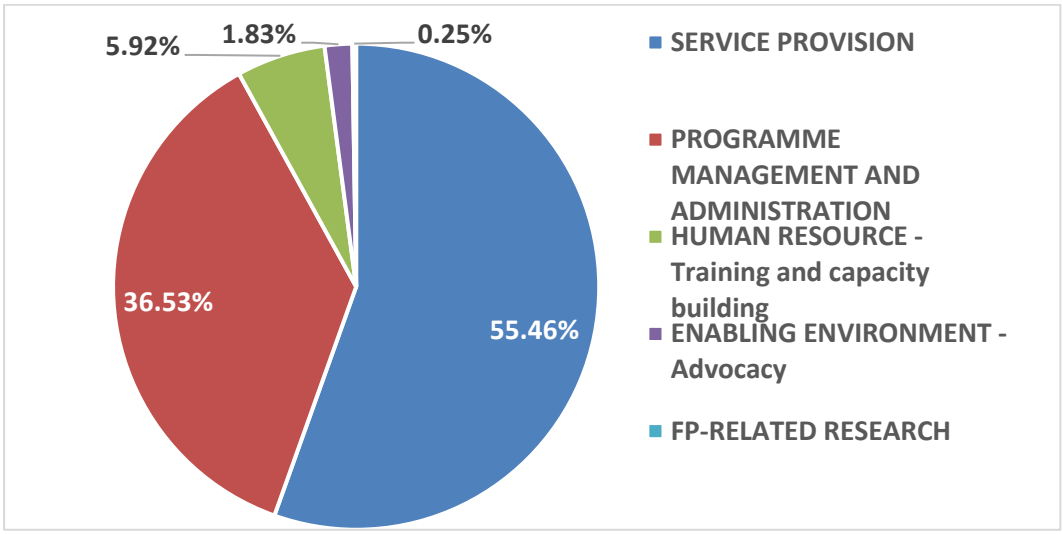
The expenditure in the provision of any FP services in this section consisted of FP services including demand creation, programme coordination and management, human resource development focusing on capacity building, enabling environment including advocacy, and research services. Table 4 and Figure 5 show FP spending on FP service according to detailed classifications that were developed.

Table 4. Expenditure by FP Service Categories (FPSC) excluding Private (for-profit) Sector

FP Service Categories		Amount	%
	SERVICE PROVISION		

FPSC 1.1:	Counselling on contraceptive methods and any other FP advice	7,748	0.04%
FPSC 1.23:	Information, education and communication for FP	1,367,381	7.63%
FPSC 1.4:	Prescription and provision of male condoms for FP	576,939	3.22%
FPSC 1.6:	Provision of Pills	402,151	2.24%
FPSC 1.7:	Provision of Injectables	1,344,527	7.50%
FPSC 1.8:	Provision of IUDs	21,716	0.12%
FPSC 1.9:	Provision of Implants	186,862	1.04%
FPSC 1.98:	FP services not disaggregated by type	6,032,555	33.66%
	PROGRAMME MANAGEMENT AND ADMINISTRATION		
FPSC 2.0:	PROGRAMME MANAGEMENT AND ADMINISTRATION	3,018,089	16.84%
FPSC 2.1:	Planning, coordination, and programme management	1,688,886	9.42%
FPSC 2.2:	Administration and transaction costs associated with managing & disbursing funds	66,575	0.37%
FPSC 2.3:	Monitoring and evaluation	632,058	3.53%
FPSC 2.4:	Operations research	87,744	0.49%
FPSC 2.5:	Drug supply systems	983,333	5.49%
FPSC 2.7:	Upgrading and provision FP medical equipment	14,447	0.08%
FPSC 2.9:	Upgrading and construction of infrastructure	12,094	0.07%
FPSC 2.98:	Programme management and administration not broken down by type	43,551	0.24%
FPSC 3.2:	**HUMAN RESOURCE - Training and capacity building**	**1,061,692**	**5.92%**
FPSC 4.1:	**Advocacy**	**328,547**	**1.83%**
FPSC 5.0:	**FP-RELATED RESEARCH**	**45,108**	**0.25%**
		17,922,003	

Figure 5. Expenditure by FP Service Categories (FPSC) excluding Private (for-profit) Sector

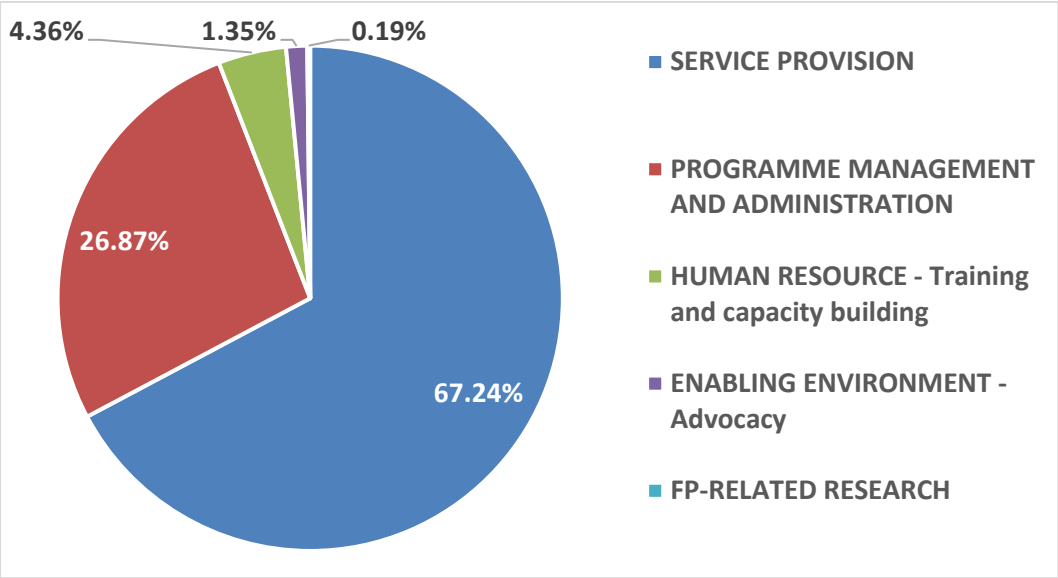


The table 4 and Figure 5 show the Expenditure by FP Service Categories (FPSC) excluding Private Sector (for-profit Sector – household fund). Spending on provision of FP services (55.46%) made the highest share of FPSC. The second largest share goes to programme management (36.53%) while the spending on training (5.92%), advocacy (1.83%) and research (0.25%) are comparatively low. Among the service provision cost, injectables is significantly higher than other methods.

Table 5. Expenditure by FP Service Categories (FPSC) including Private Sector (for-profit Sector – household fund)

FP Service Categories		Amount	%
	SERVICE PROVISION		
FPSC 1.1:	Counselling on contraceptive methods and any other FP advice	7,748	0.03%
FPSC 1.23:	Information, education and communication for FP	1,367,381	5.61%
FPSC 1.4:	Prescription and provision of male condoms for FP	776,311	3.19%
FPSC 1.6:	Provision of Pills	3,390,236	13.92%
FPSC 1.7:	Provision of Injectables	4,267,887	17.52%
FPSC 1.8:	Provision of IUDs	98,999	0.41%
FPSC 1.9:	Provision of Implants	336,375	1.38%
FPSC 121:	Female Sterilization	101,182	0.42%
FPSC 1.98:	FP services not disaggregated by type	6,032,555	24.76%
FPSC 1.99:	FP services not elsewhere classified	1,760	0.01%
	PROGRAMME MANAGEMENT AND ADMINISTRATION		
FPSC 2.0:	PROGRAMME MANAGEMENT AND ADMINISTRATION	3,018,089	12.39%
FPSC 2.1:	Planning, coordination, and programme management	1,688,886	6.93%
FPSC 2.2:	Administration and transaction costs associated with managing & disbursing funds	66,575	0.27%
FPSC 2.3:	Monitoring and evaluation	632,058	2.59%
FPSC 2.4:	Operations research	87,744	0.36%
FPSC 2.5:	Drug supply systems	983,333	4.04%
FPSC 2.7:	Upgrading and provision FP medical equipment	14,447	0.06%
FPSC 2.9:	Upgrading and construction of infrastructure	12,094	0.05%
FPSC 2.98:	Programme management and administration not broken down by type	43,551	0.18%
FPSC 3.2:	**HUMAN RESOURCE - Training and capacity building**	**1,061,692**	**4.36%**
FPSC 4.1:	**Advocacy**	**328,547**	**1.35%**
FPSC 5.0:	**FP-RELATED RESEARCH**	**45,108**	**0.19%**
		24,362,558	100.00%

Figure 6. Expenditure by FP Service Categories (FPSC) including Private Sector (for-profit Sector – household fund)



The table 5 and Figure 6 show the Expenditure by FP Service Categories (FPSC) including Private Sector (for-profit Sector – household fund). Similarly, spending on provision of FP services (67.24%) made the highest share of FPSC. The second largest share goes to programme management (26.87%) while the spending on training (4.26%), advocacy (1.35%) and research (0.19%) are comparatively low. Among the service provision cost, injectables and pills are significantly higher than other methods, as it includes out-of-pocket expenditure.

3.7. Expenditure by Production Factors

The Production factors classified the FP spending by budget items and Table 6 showed the detailed expenditure on each Production Factor and Table 7 shows recurrent and capital costs in total.

Table 6. Expenditure by Production Factors

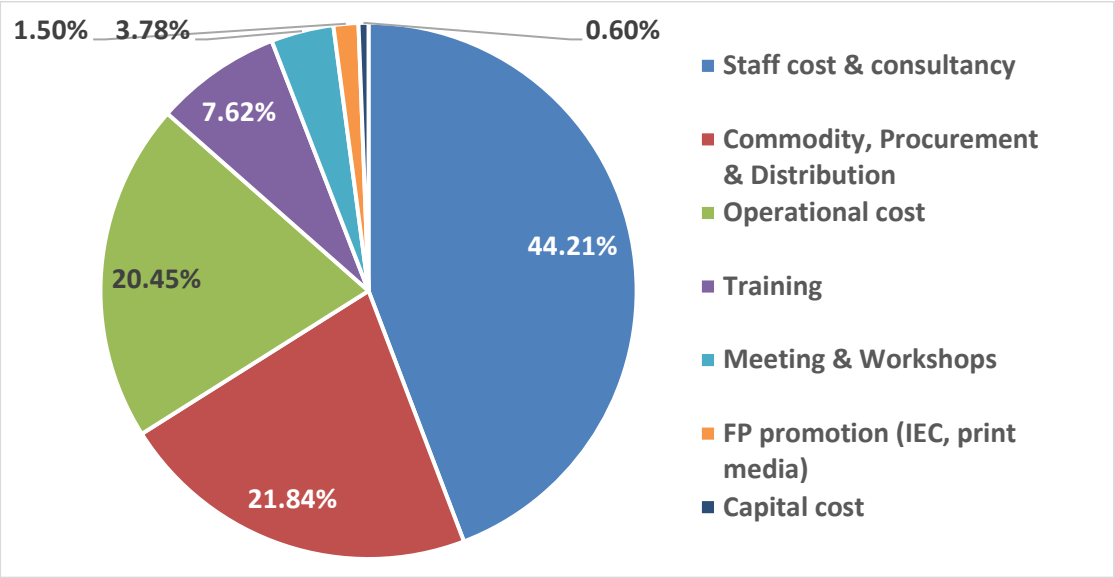
Production Factors	Amount	%
FPPF 1.1.1: Direct FP service provision staff cost.	3,830,880	21.38%
FPPF 1.1.2: Indirect FP service provision staff cost.	712,195	3.97%
FPPF 1.1.3: Management staff cost.	3,237,366	18.06%
FPPF 1.2.1: Pills.	463,681	2.59%

FPPF 1.2.2: Injectables and related consumables.	2,303,404	12.85%
FPPF 1.2.3: IUD and related consumables.	22,359	0.12%
FPPF 1.2.4: Implants and related consumables.	198,758	1.11%
FPPF 1.2.7: Male condoms for FP.	594,309	3.32%
FPPF 1.2.98: Contraceptives and consumables not disaggregated by type.	46,498	0.26%
FPPF 1.3: Reagents and materials	120,031	0.67%
FPPF 1.4.1: Information, education and communication (IEC) materials	259,069	1.45%
FPPF 1.4.2: Print media	9,328	0.05%
FPPF 1.5.1: Rent.	342,807	1.91%
FPPF 1.5.2: Utilities – water, electricity, communication, and related.	662,282	3.70%
FPPF 1.5.3: Repairs and maintenance.	56,822	0.32%
FPPF 1.5.4: Transportation and travel expenses.	1,147,963	6.41%
FPPF 1.5.98: Administrative costs not disaggregated by type.	1,455,823	8.12%
FPPF 1.6: Consulting services	142,037	0.79%
FPPF 1.7: Meetings and workshops	677,130	3.78%
FPPF 1.9: Training	1,365,870	7.62%
FPPF 1.20: Procurement services	33,675	0.19%
FPPF 1.22: Transportation, and distribution	131,455	0.73%
FPPF 2.1.1 Upgrading of health facilities for FP provision.	12,094	0.07%
FPPF 2.2.2: Information technology (hardware and software)	75,113	0.42%
FPPF 2.2.3: Medical equipment for FP	21,054	0.12%
	17,922,003	

Table 7. Share of Recurrent and Capital cost on Production Factors

Production Factors	Amount	%
Recurrent cost Total	17,813,742	99.4%
Capital cost Total	108,261	0.6%
	17,922,003	

Figure 7. Expenditure by group of Production Factors



Above tables show that staff cost (direct and indirect service provision, programme management and consultancy) for FP services (44.21%) took the largest amount of expenditure, followed by FP commodities, consumables, procurement and distribution (21.84%), while operational expenses (rent, utilities, repair, travel, admin, etc.) (20.45%) and expenditure on training (7.62%) are third and fourth largest share of spending for FP production factors. Recurrent cost (99.4%) is obviously much higher than capital cost.

4. Government Financing on Family Planning in Myanmar (2018)

Ministry of Health and Sports (MoHS) (Financing Agent FA 1.1.1.1 - Ministry of Health) received funding from the Ministry of Finance (Financing Source FS.1.1.1.1.5) for health services. However, there is no separate budget line for reproductive health or family planning services because health facilities are providing all health services and there is no separate RH for FP facilities under MoHS.

MoHS is providing FP services through its two departments — Department of Public Health (DoPH) and Department of Medical Services (DMS).

Maternal and Reproductive Health (MRH) Division, under the DoPH, is the focal unit for FP services of MoHS. Its main functions for FP related activities include advocacy, coordination with various agencies and organizations, capacity development of health staff, technical assistance, distribution of FP commodities, data management, monitoring and supervision, etc. There is no focal unit for FP under the DMS.

Procurement of FP commodities is done by procurement unit of DoPH, State/regional health departments and sometimes by hospitals, which are 200 bedded and above. MoHS also received FP commodities from development agencies.

Under the DoPH, Lady Health Visitors (LHV), Midwives (MW) and small number of medical officers are the main 'FP direct service providers' especially for the short term methods. In 2018, (2,018) LHVs and (13,737) MWs provided health services, based in static clinics such as MCH centers, urban health centers and rural and sub-rural health centers, and also through mobile services. The direct service provision cost for FP is estimated at 7% of their workload, based on a study "Workload and spending time on Reproductive Health Services among Midwives in two selected Districts" conducted by MPH candidates of the University of Public Health, Yangon in 2018.

(Note: The number of LHV increased from (1,887) in 2017 to (2,018) in 2018 (6.9%) and the number of MW increased from 13,295 in 2017 to 13,737 in 2018 (3.3%). The salary of LHV increased from 175,000 in 2017 to 198,000MMK in 2018, and salary of MW increased from 160,000 to 180,000MMK.)

Table 8. Service provision staff cost (Lady Health Visitors)

Sr	State/Region	# of LHV	Unit cost/month	For 1 Year	Total salary of LHV in 2018	7% for FP
1	NayPyiTaw	39	198,000	12	92,664,000	6,486,480

2	Kachin State	70	198,000	12	166,320,000	11,642,400
3	Kayah State	44	198,000	12	104,544,000	7,318,080
4	Kayin State	65	198,000	12	154,440,000	10,810,800
5	Chin State	71	198,000	12	168,696,000	11,808,720
6	Sagaing Region	200	198,000	12	475,200,000	33,264,000
7	Tanintharyi Region	65	198,000	12	154,440,000	10,810,800
8	Bago Region	218	198,000	12	517,968,000	36,257,760
9	Magwe Region	201	198,000	12	477,576,000	33,430,320
10	Mandalay Region	199	198,000	12	472,824,000	33,097,680
11	Mon State	89	198,000	12	211,464,000	14,802,480
12	Rakhine State	115	198,000	12	273,240,000	19,126,800
13	Yangon Region	192	198,000	12	456,192,000	31,933,440
14	Shan State (South)	121	198,000	12	287,496,000	20,124,720
15	Shan State (North)	84	198,000	12	199,584,000	13,970,880
16	Shan State (East)	41	198,000	12	97,416,000	6,819,120

17	Ayeyarwady Region	204	198,000	12	484,704,000	33,929,280
		2018			**4,794,768,000**	**335,633,760**

Table 9. Service provision staff cost (Midwives) by State /Region

Sr	State/Region	# of MW	Unit cost/month	For 1 Year	Total salary of MW in 2018	7% for FP
1	NayPyiTaw	296	180,000	12	639,360,000	44,755,200
2	Kachin State	503	180,000	12	1,086,480,000	76,053,600
3	Kayah State	203	180,000	12	438,480,000	30,693,600
4	Kayin State	414	180,000	12	894,240,000	62,596,800
5	Chin State	468	180,000	12	1,010,880,000	70,761,600
6	Sagaing Region	1,754	180,000	12	3,788,640,000	265,204,800
7	Tanintharyi Region	383	180,000	12	827,280,000	57,909,600
8	Bago Region	1,391	180,000	12	3,004,560,000	210,319,200
9	Magwe Region	1,379	180,000	12	2,978,640,000	208,504,800
10	Mandalay Region	1,293	180,000	12	2,792,880,000	195,501,600
11	Mon State	523	180,000	12	1,129,680,000	79,077,600

12	Rakhine State	846	180,000	12	1,827,360,000	127,915,200
13	Yangon Region	913	180,000	12	1,972,080,000	138,045,600
14	Shan State (South)	640	180,000	12	1,382,400,000	96,768,000
15	Shan State (North)	574	180,000	12	1,239,840,000	86,788,800
16	Shan State (East)	264	180,000	12	570,240,000	39,916,800
17	Ayeyarwady Region	1,893	180,000	12	4,088,880,000	286,221,600
	Total MW	**13,737**			**29,671,920,000**	**2,077,034,400**
	Total LHV and MW	**15,755**			**34,466,688,000**	**2,412,668,160**

In government health care services, long term FP methods such as female sterilization, IUD and Implant insertions are mainly provided by medical doctors at the hospital level with the assistance of nurses. They also provide short term methods but the number is insignificant. Service provision staff cost for long term methods is estimated by using average hour needed for one client (counseling and providing method) and estimated number of clients receiving those services in 2018. (Note: Male sterilization is illegal in Myanmar, except for very rare cases when board approved female client cannot undergo surgery {tubal ligation} due to her health condition).

Table 10. Working hour of hospital staff and average salary per month

	Working hour per month	**One month salary (MMK)**
One Medical doctor	160	275,000
One Nurse	160	216,000
2 providers (doctor + nurse)	160	**491,000**

Table 11. Long Term Method service provision staff cost

Long Term Method Staff cost	Working Hour for one client	Staff cost for one client	Estimated # of clients	Total staff cost
Implant counseling & provision	3	6,138	12013	73,735,794
IUD counseling & provision	3	6,138	40876	250,896,888
Female sterilization	8	24,550	45089	1,106,934,950
Total				**1,431,567,632**

MRH Division plays the key role in Myanmar FP programme management. It has 18 staff in 2018, and total amount of salary is as follows -

Table 12. Government Programme Management Staff Cost (Central)

MRH Division	# of staff	Unit cost/month	For 1 Year	Total salary of PM staff in 2018
Director	1	374,000	12	4,488,000
Deputy Director	3	341,000	12	12,276,000
Assistant Director	2	308,000	12	7,392,000
Medical Officer & Staff Officer	5	275,000	12	16,500,000
Branch Clerk	2	216,000	12	5,184,000
Upper Division Clerk	1	198,000	12	2,376,000
Lower Division Clerk	1	180,000	12	2,160,000

Support staff	3	130,000	12	4,680,000
Total	**18**			**55,056,000**
			40% for FP	**22,022,400**

Table 13. Total Government staff cost for FP services

		Amount in MMK	**%**
1	Short term methods service providers	2,412,668,160	62.40%
2	Long term methods service providers	1,431,567,632	37.03%
3	Programme management staff	22,022,400	0.57%
	Total	**3,866,258,192**	

Figure 8. Government Staff cost for FP services

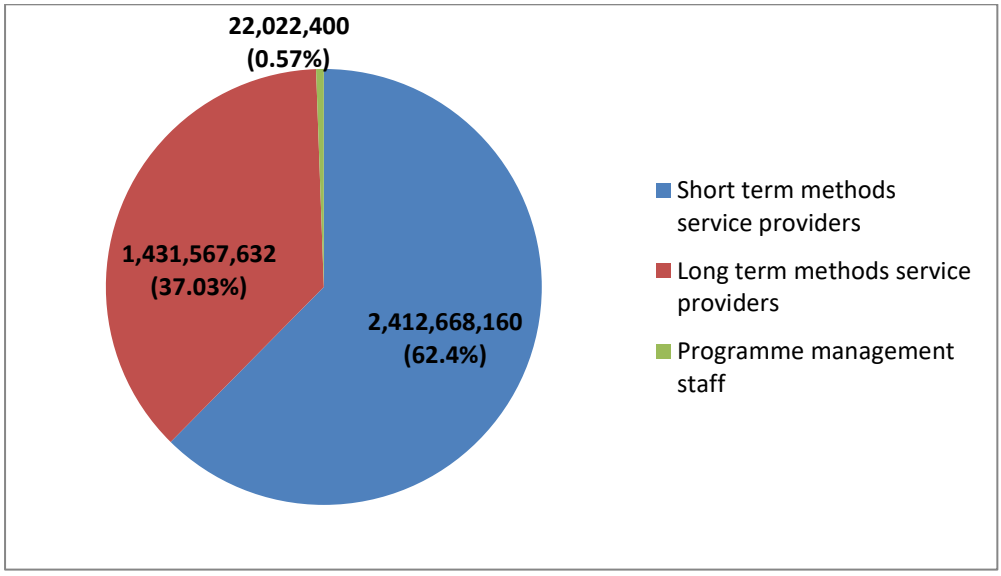


Table 14. Government procurement cost of family planning commodities in 2018

	Item	Qty	Unit Cost (MMK)	Total amount (MMK)	Procured by
1	Inj Depo	2,000,000	780	1,560,000,000	Central
2	OCP	500,000	295	147,500,000	Central
3	Inj Depo	7,000	665	4,655,000	Ayeyarwady Region
				1,712,155,000	

Health centers under the Department of Public Health received **operational cost** to run the clinics in a fixed amount. Rural Health centers (and equivalent health centers) received MMK 250,000 per month and Sub-rural health centers received MMK 96,000 per month for travel cost, labour charges, rental cost, transportation, office utilities, fuel, phone charges, printing, equipment, building repair, training, etc.

Table 15. Public health centers' operational cost total and for FP

	Per month		Per year	# of facilities	Total amount	4% for FP
Support cost for 1 RHC	250,000	12	3,000,000	1,650	4,950,000,000	198,000,000
Support cost for 1 SRHC	96,000	12	1,152,000	8,250	9,504,000,000	380,180,000
						578,180,000

Table 16. Government funding for FP by type of Providers (PS) and Family Planning Spending Categories (FPSC)

	Expenses	Total amount (MMK)	%

PS.1.1.1. Public General Hospitals and PS 1.1.2. Public Special Hospitals FPSC 1.8, 1.9, 1.21 Long term methods	FPPF 1.1.1 Service provision staff cost 303,830,800 (commodities provided by DPs)	1,431,567,632	22.62%
PS 1.2.1. Public Out-patient care centers (MCH centers, RHC, Sub-RHCs) FPSC 1.4, 1.6, 1.7, Short term methods	FPPF 1.1.1 Service provision staff cost = 2,412,668,160	4,703,003,160	74.32%
	FPPF 1.2 FP Commodities – Short term methods 1,712,155,000		
	FPPF 1.5 - Internal Administrative cost 578,180,000		
PS 1.13.2. Department inside Ministry of Health FPSC 2.98 Programme Management	FPPF 1.1.3 Programme Management staff cost 22,022,400	193,237,900	3.05%
	FPPF 1.22 transportation and distribution 171,215,500		
Total		6,327,808,692	
Equivalent USD	(Exchange rate 2018 IMF)	**4,425,635.25**	

Figure 9. Government funding for FP by type of Providers (PS) and Family Planning Spending Categories (FPSC)

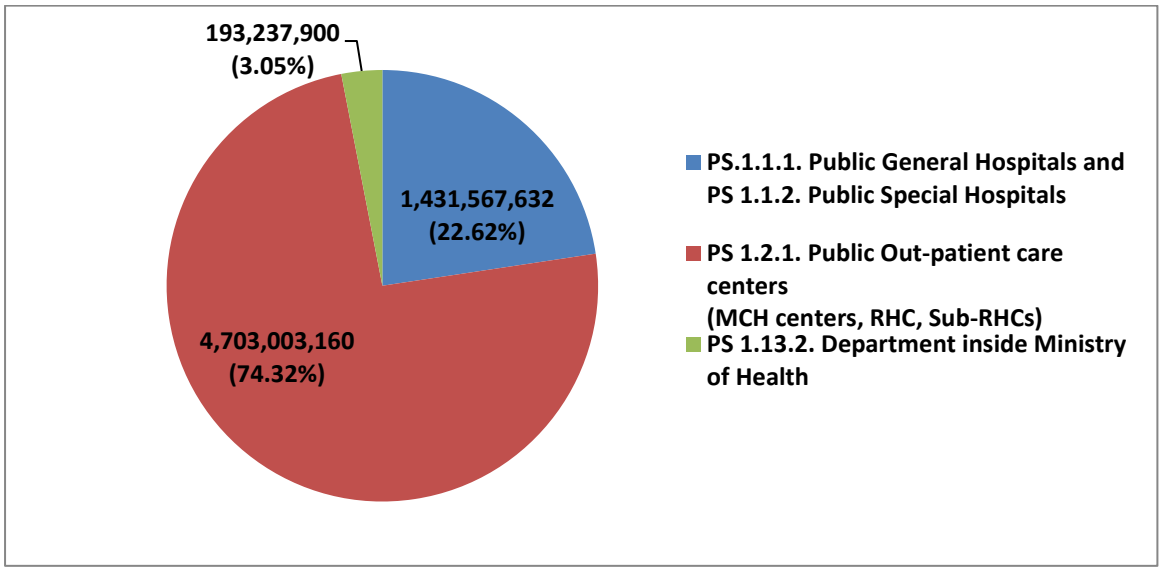
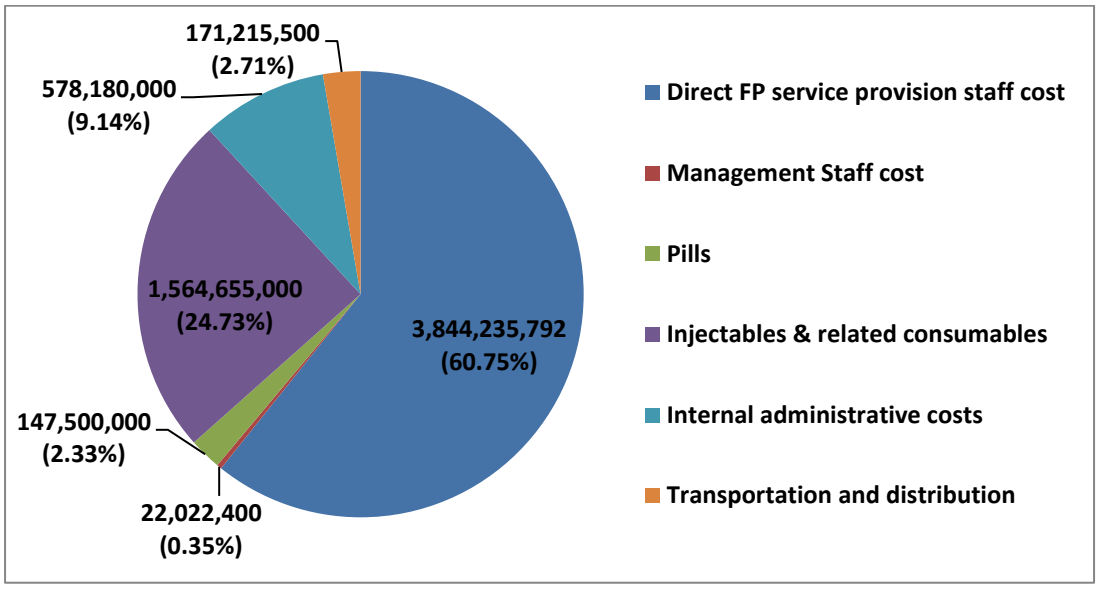


Table 17. Government funding for FP by Production Factor (FPPF)

		Total amount (MMK)	%
FPPF 1.1.1	Direct FP service provision staff cost	3,844,235,792	60.75%
FPPF 1.1.3	Management Staff cost	22,022,400	0.35%
FPPF 1.2.1	Pills	147,500,000	2.33%
FPPF 1.2.2	Injectables & related consumables	1,564,655,000	24.73%
FPPF 1.5.98	Internal administrative costs	578,180,000	9.14%
FPPF 1.22	Transportation and distribution	171,215,500	2.71%
		6,327,808,692	
Equivalent USD		4,425,635.25	

Figure 10. Government funding for FP by Production Factor (FPPF)



For FP commodity procurement, MRH Division estimates the requirement based on various information (including population, CPR, method mix, MDHS survey and RHC-LMS system data, etc.), and requests to the MoHS administrative body. MRH Division also consults with UNFPA for joint plan of procurement. For the distribution of commodities to all state/regions, breakdown lists of the commodities are prepared by MRH using the consumption data of the RHC-LMS system and in consultation with personnel from state/regional health departments. RHC-LMS system was established in 14 out of 17 state/regions, and health centers receiving FP commodities need to report back to township health departments and then to MRH Division through online RHC-LMS system. MoHS started to use DHIS2 system, but FP client number is not included in the system yet.

UNFPA supplies for MoHS - MoHS received Sub-cutaneous depo injection (SC-DMPA - Sayana Press) and long term contraceptive commodities (Jadelle and Implanon implants) from UNFPA in 2018, distributed to the state/regions as per the list mentioned below.

Table 18. UNFPA supplies for MoHS by State/Region

Sr	State/Region	SC DMPA (0.85$)	Amount	Jadelle ($8.5)	Amount	Implanon ($8.5)	Amount
1	Kachin State	3,400	19,890	1,000	8,500	504	4,284
2	Kayah State		0	300	2,550	216	1,836
3	Kayin State		0	1,800	15,300		0
4	Chin State		0	300	2,550	504	4284

5	Sagaing Region	3,200	62,220		0		0
6	Tanintharyi Region	19,400	16,490		0		0
7	Bago Region	67,600	57,460	1,000	8,500		0
8	Magwe Region		0	1,000	8,500	1,008	8,568
9	Mandalay Region	84,800	72,080	1,500	12,750	1,008	8,568
10	Mon State	28,600	24,310	1,000	8,500	504	4,284
11	Rakhine State	44,200	37,570	1,000	8,500	1,008	8,568
12	Yangon Region	102,200	86,870	1,000	8,500	1,008	8,568
13	Shan State (South)	33,000	28,050		0		0
14	Shan State (North)		0	1,000	8,500	1,008	8,568
15	Shan State (East)	10,000	8,500		0		0
16	Ayeyarwady Region	85,000	72,250	1,000	8,500	1,008	8,568
17	NayPyiTaw (Council)	16,000	13,600	1,000	8,500	1,008	8,568
18	Central (MRH)	5,000	4,250	700	5,950	720	6,120
19	Training use	7,200	6,120		0		0
		599,600	**509,660**	13,600	**115,600**	9,504	**80,784**
	Total Amount						**706,044**

Key difficulties faced by state/regional health departments and health centers include insufficient quantity of FP commodities due to low investment on family planning and inefficient supply chain management, as well as IEC materials available for them. However, some methods are not popular among the clients and there are over-stocks. Choice of method mix varies among state/regions as well as among health facilities. Although push system of

distribution was used before, the pull system is being initiated by using RH-LMS system. Reallocating the commodities from over-stock to under-stock township/facilities is also practiced now. Injectables and implants are highly demanded but pills, ECP and IUD are on low demand in some areas.

Since the total health budget is low is Myanmar and there are competing priorities, funding for contraceptive is not adequate to meet the demand of the health facilities. Similarly, staff salaries are low compared to other countries or to household expenditure. Therefore, retention of health staff, especially for remote areas, is a major problem in Myanmar.

Government funding is only accessible by government health departments, but it is only for FP commodities and government funding is not available yet for training, M&E or organizational arrangement. Government started to procure FP commodities 5 years ago, and the level of funding sharply increased in the first few years, but now decreasing within the last three years. Before, FP commodities (all items) for public health facilities solely relied on UNFPA supplies. For the last few years, UNFPA funding for FP commodities and FP activities was also significantly declined, and only long term reversible methods and emergency pills are supported by UNFPA in 2018.

Key challenges in implementing FP services include inadequate and insecure funding and human resources for FP commodities and activities (training, monitoring & supervision, RHC-LMS, etc.). There are limited number of staff at central level to manage the FP programme for the whole country, and there is no specific focal person at state/regional level although focal persons for maternal health are taking care of family planning component.

5. Summary, Conclusion and Recommendations

5.7. Summary, Conclusion

Significantly high level of out-of-pocket expenditure for FP highlighted the importance of private sector in FP service provision. Although the government expenditure on FP commodities has increased in recent years, the trend is not stable and it has decreased in 2018 due to competing priorities for health budget. Financing of FP services is heavily depended on international funds, which is not sustainable. Share of FP service provision by NGOs is also noticeably high.

The findings in this study provide comprehensive picture of FP resource flow to the national government, regional governments, donor agencies and NGOs working in reproductive health, and raise awareness on the need for advocacy and resource mobilization to address the unmet FP needs.

5.8. Recommendations

1. Although there are stock-out of FP commodities at the public health facilities, and it is allowed to procure FP commodities at state/regional level and at hospital level, only one region, out of 14, procured some contraceptives in 2018. Need based procurement should be encouraged by central level to avoid stock-outs. The national and regional governments should have clear policy on financing strategies and public spending on for FP.
2. The coverage of RHC-MIS (Reproductive Health Commodity – Management Information System) supported by UNFPA and JSI should be expanded to all state/regions, in order to promote PULL system of distribution.
3. The focus of the support should be prioritized for poor, marginalized communities. Longer term methods should be promoted for those who has difficult access to the health facilities.
4. New methods should be introduced to expand the choice of methods, including post-partum IUD for multi-parous women.
5. Advocacy on relaxing regulations for female sterilization, and revising law which prohibit male sterilization should also be implemented.
6. Resource tracking of FP services should be employed to inform policy, planning and budgeting of FP commodities, and to ensure political commitment at both national and state/regional level. Financial tracking of FP services can also inform alternative financing approaches. The national and state/regional governments should explore new health financing strategies and increase public spending on for FP.
7. Public Private Partnerships should be explored to expands services availability and quality.

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FP2020/Track20 data (online)

Appendix

Appendix 1. Classification used for financing sources, financing agents, service providers, FP service categories and FP factors of production

FS: Financing sources		Where funding originates from.
FS.01	Public funds	This is further broken into National Government, regional government, County Government.
FS.02	Private funds	Include households, private for-profit and not-for-profit organizations.
FS.03	International funds	Include wide range of entities such as bilateral, multilateral, foundations such BMGF, and international private organizations.

FA: Financing agents		Channels for funding.
FA.01	Public sector	Includes ministries and departments at national and regional government, state corporations
FA.02	Private sector	Include households, private insurance firms, private employers, for-profit and not-for-profit organizations, national NGOs.
FA.03	International purchasing organizations	Include wide range of entities such as bilateral, multilateral, foundations such BMGF, and international NGOs.

PS: FP service providers		Actors engaged in the production and delivery of Services.
PS.01	Public sector providers	Providers that are integrated in government. This would also include government agencies (such as Ministries, hospitals, schools, etc.)
PS.02	Private sector providers	Not-for-profit and for-profit organizations including private health facilities and national NGOs.
PS.03	Bilateral and multilateral entities – in country offices	Bilateral and multilateral agencies.

FPSC: FP service categories		Activities or programs to that result in effective provision of FP to those who need them.
FPSC.01	Family planning services	Further classified into provision of different FP methods, demand creation activities among others.
FPSC.02	Program management and administration	Program expenditures are defined as expenses incurred at administrative levels outside the point of health care delivery. These include planning and administration, monitoring and evaluation (M&E), operation research, supply systems support among others.
FPSC.03	Human resources	This category refers to services of the workforce through approaches for training, recruitment, retention, deployment, and rewarding of quality performance of health care workers and managers for work in the FP. Cost of human resources for provision of FP methods is already covered under the FP services and was excluded from human resource classification. Training and capacity building is the main category under this classification.
FPSC.04	Enabling environment	Mainly advocacy and institutional development expenditure
FPSC	FP related research	Classified into different types of research excluding operational research.

FPPF: FP factors of production		They consist of budgetary items in terms of recurrent and capital expenditure.
FPPF.01	Recurrent expenditure	Further classified into budget items such salaries, FP commodities, IEC, materials, administrative expenses such utilities, transport and travel expenses, meeting and workshops expenses etc. Provision of different FP methods, demand creation activities among others.
FPPF.02	Capital expenditure	The main categories of the classification features are buildings, capital equipment, and capital transfers. These categories may include major renovation and reconstruction or enlargement of existing fixed assets, as these interventions can improve and extend the previously expected service life of the asset.

Annex 2 – Map of Myanmar


INDIA
CHINA
KACHIN
Myitkyina
SAGAING
Hakha
CHIN
Sagaing
Mandalay
SHAN
MANDALAY
Taunggyi
MAGWE
Magwe
Sittwe
Nay Pyi Taw
Loikaw
RAKHINE
KAYAH
BAGO
Bago
KAYIN
AYEYARWADY
Pathein
Yangon
Hpa-an
YANGON
Mawlamyine
MON
THAILAND
Dawei
TANINTHARYI
Andaman
Sea
Gulf of
Thailand