2017 Health Facility Assessment for Reproductive Health Commodities and Services

November 2019

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Department of Medical Research
Department of Public Health
Department of Medical Services and
UNFPA

November 2019

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Foreword

The Ministry of Health and Sports has been tracking to enhance equitable health coverage according to Universal Health Coverage, which meets the needs and rights of all, particular of key and vulnerable populations. Moreover, The Ministry of Health and Sports has made efforts as per Sustainable Development goals, to ensure healthy lives and promote well-being for all at all ages through reducing the maternal mortality ratio and ending preventable deaths of newborns to reduce neonatal mortality. These concerted efforts in Myanmar by the Government, the United Nations, NGOs and other actors, 50% of married women in Myanmar are now able to practice family planning. However, one in six women has an unmet need for contraception. This leads to unintended pregnancies, unsafe abortions, and maternal and neonatal death. Access to family planning is fundamental human right and is crucial to empowering women and girls to realize their full potentials. It is also one of the most cost-effective investments a country can make towards sustainable development. Although Myanmar gave priority to maternal and child health services and considerable inputs have been invested to improve these services, inadequate health resources at different levels and over workload of staff are still challenging for targeted achievements.

In line with National Health Plan, the Ministry of Health and Sports has been planning and implementing the interventions to improve the health status of mothers, newborns and children. In the area of maternal and reproductive health, progress was made for maternal and newborn health and birth spacing with a reduction in maternal mortality and increase in contraceptive prevalence rate. Although services for family planning and reproductive medicine at different level health facility are made effectively both by public and private sector, customer's satisfaction is key factor for efficient utilization. Nation-wide Health Facility Assessment for Reproductive Health Commodities and Services was strenuous effort of Department of Medical Research (Pyin Oo Lwin Branch) in collaboration with Maternal & Reproductive Health Division, Department of Public Health and Department of Medical Services. Well-organized and trained teams actively participated in data collection over the country during May and September 2017. As the assessment is a continuation of 2014, 2015 and 2016 assessment activities, this report is a result of successful forth mission. We aim to provide the information and understanding needed for the country's Reproductive Health Security. The current situation on availability of birth spacing services, life-saving reproductive health medicines, stock-out situation, and logistic management system, availability of skilled staff for reproductive health care services, information & communication facilities, cold chain facilities, and clients' satisfaction are provided in this report. Comparisons of some important parameters in four years are also included. As a difference from previous reports, qualitative finding regarding feeling and satisfaction of clients on family planning and reproductive health care services are included in this report.

We would like to thank all concerned persons without whose relentless efforts and dedication this undertaking would not have been successful. In particular, we would like to express our heartfelt thanks to Ms. Janet E. Jackson, UNFPA Representative for Myanmar for her keen interest and support for this undertaking. Thanks are also due to Dr. Hla Hla Aye (UNFPA, Assistant Representative, Retired), Dr. Yin Yin Htun Ngwe(UNFPA, Assistant Representative), Dr. Aung Thu Tun (UNFPA, Project Specialist) and other concerned staff of UNFPA for their continuous support along the implementation process.

Professor Dr. Zaw Wai Soe,
Acting Director General
Department of Medical Research

Acronyms

BEmOC	Basic Emergency Obstetric Care
CEmOC	Comprehensive Emergency Obstetric Care
CMSD	Central Medical Store Depot
COC	Combined Oral Contraceptive Pill
CPR	Contraceptive Prevalence Rate
DMO	District Medical Officer
DMR-POLB	Department of Medical Research (Pyin Oo Lwin Branch)
DMS	Department of Medical Services
DoPH	Department of Public Health
DPMA	Depo Medroxyprogesterone Acetate
ECP	Emergency Contraceptive Pill
EmOC	Emergency Obstetric Care
FP	Family Planning
GPRHCS	Global Programme to Enhance Reproductive Health Commodity Security
HA	Health Assistant
HF	Health Facility (Service Delivery Point)
ICT	Information and Communications Technology
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IUD	Intrauterine Device
LHV	Lady Health Visitor
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MIMU	Myanmar Information Management Unit
MMR	Maternal Mortality Ratio
MO	Medical Officer
MRH	Maternal and Reproductive Health
MS	Medical Superintendent
NO	Nursing Officer
ObGy	Obstetrics and Gynaecology
OCPs	Oral Contraceptive Pills
PMTCT	Prevention of Mother-to-Child Transmission
RH	Reproductive Health
RHC	Rural Health Centre
RHCS	Reproductive Health Commodity Security

SDGs	Sustainable Development Goals
SDP	Service Delivery Point (Health Facility)
SRHR	Sexual and Reproductive Health and Rights
THO	Township Health Officer
THN	Township Health Nurse
TMO	Township Medical Officer
UHC	Urban Health Centre
VCT	Voluntary Counselling and Testing

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Executive summary

Myanmar is one of 46 countries that receives pivotal support from the UNFPA Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS). This includes essential supplies of contraceptives, condoms, medicines and equipment for voluntary family planning and the prevention of sexually transmitted infection (STI), including HIV, and maternal health as well as support to build the capacity of national health systems to deliver quality services that underpin good reproductive health programmes. This is the fourth assessment and is a continuation of the assessments implemented in 2014, 2015 and 2016, and analyses comparative findings.

A cross-sectional descriptive design was used in all states and regions of the country. A representative sample size was surveyed in order to generalize results to the target population and standardized sampling methods were applied. A standardized questionnaire was used. The Department of Medical Research (Pyin Oo Lwin Branch) was primarily responsible for data collection activities in collaboration with the Maternal and Reproductive Health Division and with the assistance of the Department of Public Health and Department of Medical Services.

A total of 383 health facilities were surveyed; this included 181 facilities at the primary level, 161 at the secondary level, 22 at the tertiary level and 19 facilities at private hospitals. Out of the 383 facilities surveyed, 166 were located in urban areas and 217 were in rural areas.

The survey findings show that 82.3 per cent of service delivery points/health facilities at the primary level offered at least three modern methods of contraceptives. For secondary and tertiary level facilities and private hospitals, 34 per cent, 77 per cent, and 63 per cent, respectively, offered at least five modern methods of contraceptives.

Overall, 49 per cent of health facilities could provide (by the time of the survey) all of the seven maternal and reproductive health (RH) medicines, including the two essential life-saving maternal and RH drugs. The percentage was highest at tertiary level facilities (72 per cent) and lowest at primary level facilities (46 per cent), and higher in urban compared to rural facilities (54 per cent vs. 47 per cent). The availability of life-saving maternal and

reproductive health (MRH) medicines was higher in health facilities in the private sector compared to the government sector (53 per cent vs. 50 per cent). 'M-dopa" had the highest stock-outs of all MRH medicines at 69 per cent.

The incidence of "no stock-outs" of modern contraceptive methods was 51 per cent at all health facilities, higher than the level recorded in 2016. A stock of oral contraceptive pills (OCPs) and injectable methods was reported at more than 75 per cent of health facilities at all levels. There was a notable increase in "no-stock-outs" for all methods compared to 2016, particularly for male condoms, OCPs and injectable methods.

Pharmacists and assigned medical officers (MOs) were primarily responsible for drug indents and ordering. Pharmacists were the most frequently assigned focal person in all states and regions. Supplies for the majority of primary and secondary level health facilities were quantified by the supplier (57.8 per cent and 65.7 per cent, respectively). The main source of supplies for health facilities at all levels was the State/Region Health Department at 36 per cent. Township Health Departments (THDs) were the main source of supply at 66 per cent of rural health facilities. In urban areas the main suppliers were State/Region Health Departments and THDs at 37 per cent and 66 per cent, respectively. Most health facilities (>75 per cent) at all levels and in all states/regions had their own arrangements for the transportation of drug supplies to their health facilities. Government made transportation arrangements in 22 per cent of tertiary and 13 per cent of secondary level health facilities, respectively.

Most health facilities, especially at the primary and secondary levels, stated that the interval between the indent and supply was irregular (64 per cent and 76 per cent, respectively); this was higher than reported in 2016. Fourteen per cent of health facilities at the tertiary level estimated the interval to be less than 2 weeks. An irregularity between the indent and supply was more pronounced in primary and secondary level health facilities, where two-thirds of health facilities stated that the interval was irregular; this was more pronounced compared to the assessment findings in 2016.

The availability of a cold chain system was highest at tertiary and secondary level health facilities at 100 per cent and 83 per cent, respectively, and lowest at primary level health facilities at 43 per cent. The overall availability of a cold chain system was approximately 66 per cent with marked urban and rural disparities (79 per cent vs. 56 per cent). Of those health facilities with a cold chain system, more than 90 per cent used electrical power. Most tertiary level health facilities used a power source from the national grid. Nearly 40 per cent of health facilities at the primary level used solar power. The difference between urban and rural health facilities' usage of the national grid as a power source was significant (92 per cent in urban areas vs. 59 per cent in rural areas).

Staff had been trained in voluntary family planning and how to insert an implant at 50 per cent and 21 per cent of health facilities, respectively. At all levels of health facilities, the percentages were higher compared to 2016. In the majority of states/regions less than 20 per cent of health facilities at all levels had trained staff to insert the implant. The urban/rural difference in health facilities with trained staff to insert the implant was still significant (30 per cent vs. 14 per cent).

The percentage of health facilities that had not received supervision for the provision of reproductive health services was 37 per cent (similar to 2016). This was highest in secondary level health facilities at 45 per cent, but there was an urban/rural disparity. About 40 per cent of health facilities had received supervision at irregular intervals.

Guidelines of any sort were available at 36 per cent of health facilities. Based on all of the 383 health facilities assessed, the most frequently available guidelines were the: "Job Aid for Antenatal Care" (25 per cent) and the "Guidebook for Antenatal Care" (23 per cent). Sixteen per cent of health facilities had the "Checklist for Birth Spacing", while the "National Guidebook for Birth Spacing" was only available at 7 per cent of health facilities and the "Guide for Waste Disposal" at 5 per cent of health facilities.

Almost all health facilities had at least one communications device with smart phones (82 per cent), mobile phones, 47 per cent, and computers at 31 per cent ranked as the top three

communication devices. The availability of these three devices was lowest in primary level health facilities.

All health facilities had a waste disposal management system. The most frequently used methods were burying (62 per cent) and burning (57 per cent). An incineration method was only used by 10 per cent of health facilities.

Respondents from 38 per cent of health facilities stated that there was user-fees especially for medicines (62 per cent) and specialty services (30 per cent).

Most of the respondents surveyed were able to access the family planning (FP) method of their choice. In regard to the services they received, respondents reported that they received little information from providers about the side-effects of contraceptives; about how to manage the side effects of contraceptives; and about the need to follow up with the provider if they were experiencing side-effects. This was particularly true at tertiary level health facilities. Less than 10 per cent of respondents reported long waiting times at their health facility, this was lower than the figure recorded in 2016 that was "less than 15 per cent". Long waiting times were reported more frequently by clients at tertiary level health facilities (17 per cent), which was considerably lower than the figure recorded in 2016 (33.3 per cent).

About one-third (28 per cent) of clients responded they had to pay for services at health facilities. The response was highest at the tertiary level (36 per cent) and lowest at the primary level (27 per cent). The urban/rural difference was significant. Out of 313 clients (28 per cent) who reported the need to pay for clinic visits, the average amount paid for various items was not more than 600 kyats (about $US0.50). The highest costs incurred were for the purchase of medicines both within and outside of the clinic (1000 kyats for each item). The amounts paid for various services were highest at the tertiary level than at any other level.

1. Introduction

1.1 Background to the report

Access to safe, voluntary family planning is a human right. Family planning is central to gender equality and women's empowerment and is a key factor in reducing poverty. Yet in developing regions, some 214 million women who want to avoid pregnancy are not using safe and effective family planning methods, for reasons ranging from a lack of access to information or services to a lack of support from their partners or communities.[1] This threatens their ability to build a better future for themselves, their families, their communities and ultimately their countries.

UNFPA works to support family planning by: ensuring a steady, reliable supply of quality contraceptives; strengthening national health systems; advocating for policies supportive of family planning; and gathering data to support this work. UNFPA also provides global leadership in increasing access to family planning, by convening partners – including governments – to develop evidence and policies, and by offering programmatic, technical and financial assistance in developing countries.

Access to contraceptive information is central to achieving gender equality. When women and couples are empowered to plan whether and when to have children, women are better enabled to complete their education; women's autonomy within their households is increased; and their earning power is improved. This strengthens their economic security and well-being and that of their families.[2]

Reproductive health supplies should be considered a vital aspect of reproductive health systems, programmes and services. A systematic supply of contraceptives enables couples to plan their families; basic medications prevent obstetric emergencies and save the lives of mothers; and condoms protect people from HIV and sexually transmitted infections. There are clear economic benefits to reap from investing in family planning. For every additional dollar that is invested in contraception, the cost of pregnancy-related care is reduced by $2.22.[3] In terms of socioeconomic benefits, achieving universal access to quality sexual and reproductive health services is estimated to yield returns of $120 for every dollar invested.[4]

[1] https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception
[2] https://www.unfpa.org/resources/population-and-poverty
[3] https://www.unfpa.org/press/family-planning-empowering-people-developing-nations
[4] https://www.who.int/pmnch/media/events/2015/gs_2016_30.pdf

Family planning can also help countries realize a 'demographic dividend', a boost in economic productivity[5] that occurs when there are growing numbers of people in the workforce and falling numbers of dependents. There are a number of challenges to improving access to family planning information and services. Women in the lowest wealth quintile, those in rural areas and marginalized groups – including adolescents, unmarried people, the urban poor, rural populations, sex workers and people living with HIV – often have less access to family planning services. Efforts to increase access must be sensitive to cultural and national contexts, and must consider economic, geographic and age disparities within countries. It is increasingly recognized that economic development is not sufficient to reduce poverty if it is not inclusive and that barriers to accessing family planning services – whether economic, social or institutional – must be dismantled to allow free and informed choice.[6]

UNFPA advocates for sustainable resources to be allocated for the procurement of family planning supplies and the provision of high quality services, recognizing that the realization of reproductive health and rights is a specific target under one of the 17 Sustainable Development Goals (SDGs), and is integral to realizing all of the goals. UNFPA supports countries in their efforts to increase access to reproductive health commodities and to integrate UNFPA's global Reproductive Health and Commodity Security strategy into their national action plans.[7]

1.2 Country profile of Myanmar

Myanmar, located in South-East Asia, is approximately 676,600 square kilometres, extending about 2,050 kilometres (1,270 miles) from north to south and 930 kilometres (580 miles) from east to west. It is slightly larger than Afghanistan and slightly smaller than the United States of America's state of Texas.[8] Myanmar has approximately 1,930 kilometres of coastline on the Bay of Bengal and Andaman Sea. Elsewhere it shares approximately 6,500 kilometres (4,000 miles) of land borders with five neighbouring countries: Bangladesh to the west; India to the north-west; China to the north and north-east; Lao PDR to the east; and Thailand to the east and south-east. Based on geographic variations in relief, soils, drainage patterns and climate, Myanmar can be divided into five distinct physiographic regions: the

[5] http://www.healthpolicyproject.com
[6] https://tanzania.unfpa.org/sites/default/files/pub-pdf/familyplanning_A5_13nov_highres.pdf
7 Countries Must Ensure Access to Reproductive Health Supplies, Experts Stress. Available at: https://www.unfpa.org/fr/node/7282. (Accessed: 25.6.2018).
[8] https://www.nationsonline.org/oneworld/myanmar.htm

northern mountains, the western ranges, the eastern plateau, the central basin and lowlands, and the coastal plains and deltas.

Myanmar is divided for administrative purposes into 15 states/regions, 74 districts, 330 townships and 83 subtownships, 3,065 wards, 13,619 village tracts and 64,134 villages. As a large state, Shan State is divided into three: Northern, Eastern and Southern Shan States, according to health administrative areas. The main features of the country are the delta region (consisting of the Ayeyawady and Yangon Region) and the central plain surrounded by mountains mainly composed of ethnic states.[9] The 2014 Myanmar Census estimated the total population of the country at 51,486,253. The population of Myanmar is most heavily concentrated in the central part of the country, along a corridor connecting the cities of Yangon, Nay Pyi Taw and Mandalay. Geographical information system (GIS) analysis shows that approximately 50 per cent of the total population lives within 100 kilometres of these three urban centres. The remaining half of the population is distributed relatively sparsely in largely rural areas to the north, south, east and west, although there are smaller urban concentrations in all of these areas.[10]

Between the 1983 and 2014 censuses, Myanmar's population increased by almost 16.2 million people, or approximately 46 per cent. This means that, on average, the population of the country increased by more than half a million people in each of the 31 years between the two censuses. The average annual growth rate during this period was 0.9 per cent, making Myanmar one of the slowest growing countries in South-East Asia (Department of Population, 2017a).[11] The most striking features of the age distribution are that Myanmar is a relatively young country (in terms of its age profile), with more than half of the population younger than 30. Myanmar is still a predominantly rural country, with only about 30 per of the population living in urban areas.[12]

The proportion of urban dwellers in three quarters' of the country's townships is less than the Union proportion because 50 per cent of the country's urban population live in Myanmar's three major cities; Yangon (5.21 million), Mandalay (1.22 million), and Nay Pyi Taw (1.16 million). In the 2014 Census, the total fertility rate for the Union was estimated to be 2.5. The

9 Health in Myanmar, 2015. Ministry of Health and Sports, Myanmar.
10 Department of Population. 2015. *2014 Myanmar Population and Housing Census: Union Report.* Ministry of Immigration and Population, Department of Population, Nay Pyi Taw, Myanmar.
11 https://myanmar.unfpa.org/en/news/census-report-projects-population-growth-over-35-years-and-supports-long-term-planning
12 https://myanmar.unfpa.org/en/country-profile

adolescent fertility rate is 33.2 births per thousand women aged 15-19 years. The World Bank estimated the Gross Domestic Product (GDP) per capita in Myanmar at $US1,420.50 in 2016. The GDP per Capita in Myanmar is equivalent to 11 per cent of the world's average GDP.[13]

1.3 Rationale

The unmet need for contraceptives remains high in many areas of Myanmar, and is highest among the most vulnerable in society: adolescents, those in the lowest wealth quintile, those living in rural areas and urban slums, people living with HIV, and internally displaced people. The latest estimates are that 222 million women have an unmet need for modern methods of contraception, and the need is greatest where the risks of maternal mortality are the highest.[14]

In Myanmar, according to the estimates of the Maternal Mortality Estimation Inter-Agency Group (MMEIG), Myanmar's maternal mortality ratio (MMR) stood at 520 per 100,000 live births in 1990 and decreased to 200 (interval range 120-330) per 100,000 live births in 2010. This estimate is consistent with the figure of 192 per 100,000 live births as reported by the Health Management Information System (HMIS) in 2011.

Post-partum haemmorhage (31 per cent), eclampsia (11.2 per cent) and abortion-related mortality (9.9 per cent) remain the major causes of maternal deaths in Myanmar.[15] Three-quarters of all maternal deaths occur during delivery and the immediate post-partum period. A weak health system infrastructure; a lack of accessibility to health services; and limited access to accurate sexual and reproductive health information further contribute to maternal mortality.

UNFPA implemented its first Programme of Assistance in Myanmar in 2002 and continues to provide financial and technical assistance to government to implement activities that contribute to the strategic priorities of promoting good governance and strengthening democratic institutions and rights under the United Nations Strategic Framework prepared by United Nations agencies and government. UNFPA continues to strengthen and build its

[13] https://tradingeconomics.com/myanmar/gdp-per-capita
14 World Health Oorganization. Ensuring human rights in the provision of contraceptive information and services: guidance and recommendations. 2014
15Nationwide Cause-specific Maternal Mortality Survey (2004-2005). UNICEF and Department of Health.

partnerships across Departments of Government to strengthen national capacities in the management and accountability of funding with a view to transitioning to the use of national systems to execute development assistance.

1.4 Objectives

1.4.1 General objective

To assess the reproductive health commodities security (RHCS) status of the country.

1.4.2 Specific objectives

1. To assess the availability, utilization and supply chain management system for reproductive health (RH) commodities at different levels of health facilities.

2. To assess the quality of RH services, particularly the emphasis on family planning in terms of training, supervision, the use of guidelines and information and communications technology (ICT).

3. To determine accessibility to RH services at different levels of health facilities.

1.5 Research methodology

1.5.1 Study design

As a standardized consistent methodology was used for the previous assessment, this assessment used a cross-sectional descriptive study design that covered all states/regions. Three levels of health facilities that provide reproductive health (RH) services, including voluntary family planning, maternal care and the treatment of reproductive tract infections, were included. The clients of respective facilities were interviewed using both quantitative and sub-sample qualitative approaches. Data collection activities were carried out during May and September of 2017.

1.5.2 Sampling procedure

Health facilities (HFs) that provide modern methods of contraceptives and maternal/RH services were stratified into three broad categories:

a) Primary level HFs (rural health centre, urban health centre and maternal and child health centre).[16]

[16] In Myanmar, there are two levels of primary health facilities (Rural Health Centres (RHC) and Sub-RHCs). There are about five to six Sub-RHCs under the administration of one RHC; one midwife is posted at each Sub-RHC. Sub-RHCs are closely supervised by the RHC in terms of commodity supplies and services provided. Due to this clustering effect, the situation at the RHC is representative of the situation at the Sub-RHCs under its administration. One Sub-RHC is attached to

b) Secondary level HFs/hospitals (station or township hospital without obstetrician-gynaecologist (ObGy) specialists).
c) Tertiary level hospitals/state/region/district hospitals and hospitals with ObGy specialists).

The list of all service delivery points (providing family planning and maternal health services) in each of the administrative units of the country was taken from the Health Management Information System (Department of Public Health) and was used as the sample frame for the selection of health facilities.[17] Health facilities (HFs), which provided modern methods of contraceptives, were then summarized by area and level. This was used for the determination of the sample size (number of HFs by state/region).

Table 1.1 Service delivery points providing family planning and maternal health services by state/region

State/Region	Number of tertiary hospitals	Number of secondary level HFs	Number of primary level HFs
Kachin	4	47	87
Kayah	2	14	34
Kayin	4	29	69
Chin	3	21	68
Sagaing	9	97	239
Tanintheri	3	29	58
Bago	4	96	187
Magway	6	70	204
Mandalay	11	67	154
Mon	2	29	85
Rakhine	3	49	132
Yangon	11	54	154
Shan South	3	54	104
Shan North	5	56	92
Shan East	4	23	39
Ayeyawady	6	95	266
Nay Pyi Taw	1	16	31
Total	**81**	**860**	**2003**

All HFs were listed and assigned a unique number. This list was used for the sampling frame.

To ensure the total sample contained a minimum number of health facilities at each level and that the parameters were characteristic of the population, the following formula was used:

$$n = \frac{Z^2 p(1-p)}{d^2}$$

Where n = *minimum sample size for each domain*

Z = *Z score that corresponds to a confidence interval*

[17] Annual Hospital Statistics Report 2013. Department of Health Planning, Ministry of Health.

The formula was adopted to give large (tertiary and secondary) health facilities a higher probability of inclusion in the survey because of their smaller numbers, which acted as a guide to choose the sample of primary level HFs.

The following steps were taken to determine the distribution of the sample size by administrative area and health facility.

Step 1) Calculate relative proportion for the types of service delivery points (SDPs).

The relative proportion for tertiary level SDPs was calculated as follows:

[Total number of tertiary SPDs]÷[Total number of SDPs on the sample frame].

	Tertiary level HFs	Secondary level HFs	Primary level HFs	Total
Number of SDPs	81	860	2003	2944
Relative proportion	0.027514	0.29212	0.680367	

Step 2) The formula above was applied to obtain the minimum sample size for each type of HF.

The confidence interval was set at Z-score = 95 per cent and 5 per cent confidence limit.

$$n = \frac{Z^2 p(1-p)}{d^2}$$

p = relative proportion

d =0.07[18], Z=1.96

Confidence Interval and Confidence Limit	Minimum sample size of service delivery point			
	Tertiary level	Secondary level	Primary level	Total
[95% confidence interval (Z = 1.96) and 10% confidence limit (d = 0.07)	23	160	172	355

Step 3: Correction for abnormal-oversized samples

[18]Due to a reduction in the total budget for 2017 activities, the number of health facilities for the field survey (sample size requirement) was adjusted accordingly. So as not to adversely affect the sample size representation, the precision (D) in the calculation was adjusted from the routine value (0.05) to (0.07). Due to this adjustment, the precision of every calculated proportion (percentages) was less precise than the 2016 report.

There was no abnormal sample size larger than the actual existing total number in each category. Thus, the calculated numbers were set as minimum requirements.

Step 4: Distribution of sample sizes by administrative unit

To distribute the total sample size for each category of HF by state/region, the relative proportions for each domain were made from the calculation whereby the total state/region-wide and health system level-wide HFs were divided mathematically by the total number of level-wide HFs. These proportions were multiplied with the required number of total HFs at each level.

Table 1.2 Required number of HFs for sample size

State/Region	Tertiary	Secondary	Primary	Private[19]	Total
Kachin	1	9	7	1	18
Kayah	1	3	3	1	8
Kayin	1	6	6	1	14
Chin	1	4	6	1	12
Sagaing	2	18	20	2	42
Tanintheri	1	5	5	1	12
Bago	1	18	16	1	36
Magway	2	13	17	2	34
Mandalay	3	13	13	3	32
Mon	1	6	8	1	16
Rakhine	1	9	11	1	22
Yangon	3	10	13	3	29
Shan (South)	1	10	9	1	21
Shan (North)	1	11	8	1	21
Shan (East)	1	4	4	1	10
Ayeyawady	2	18	23	2	45
Nay Pyi Taw	0	3	3	0	6
Total	**23**	**160**	**172**	**23**	**378**

As a final step, a systematic sampling method was used to select the HFs based on the list (sampling frame). The list of sample HFs was discussed in the coordination meeting with local regional health authorities to obtain any necessary security clearance. Where there were security concerns, HFs in these areas were replaced with the second HF from the list, after discussions with and getting the agreement of the concerned UNFPA National Programme Officer. Replacement was less than 5 per cent of the total sample size and the representativeness was not severely affected.

1.5.3 Questionnaire

A generic standardized questionnaire from the 2016 survey was translated and reformatted for convenience and ease of use by the survey team of the Department of Medical Research, Pyin Oo Lwin Branch (DMR-POLB). The questionnaire had two parts. Some of the information provided by the respondent was verified by the interviewer using observation of relevant evidence and records available at the facility. To ensure a robust comparison between successive years, the same questionnaire was used as in the previous assessments. See Annex 1.

[19] Private HFs were included in this year's assessment after discussions with stakeholders and after obtaining the permission of the Deputy Minister of Health. It was decided that the number of private HFs would be the same as the number of tertiary level HFs and the same sampling method was used.

1.5.4 Fieldwork/data collection

DMR-POLB organized a one-day coordination meeting in March 2017 with health authorities from all state/region health departments to gain buy-in for the assessment, to discuss the sample requirements of the assessment, to form teams to undertake the survey, and to draw up a timeline with activities to implement the survey. In addition, ways to ensure quality was maintained during face-to-face interviews using a structured questionnaire and qualitative in-depth interview guide were discussed. It was finalized that 23 tertiary, 160 secondary, and 172 primary level HFs, totalling 355, would be included in the assessment. Additionally, 23 private hospitals were included in the study, having total number of HF to be 378.

Enumerator training was conducted over two days in May 2017 and research assistants from the DMR-POLB were recruited. Fifty-two field enumerators, 14 technical supervisors (team leaders) and five investigators, attended the training. A pilot test of the field activities was carried out at five HFs (including one district hospital, one station hospital, one Maternal and Child Health centre and two rural health centres covering three levels of HFs) in Pyin Oo Lwin Township. Household visits with a randomly selected sample of clients from the register list at health facilities took place in most states/regions. Interviews were conducted using both a quantitative and qualitative approach. Qualitative in-depth interviews were only conducted with a sub-sample of respondents using six different modern methods of contraceptives in each state/region. Tertiary hospitals in one township, secondary level HFs in two townships and primary level HFs in four rural areas were visited in most states/regions.

Data collection began simultaneously in May 2017 in all states/regions under the close supervision of local administrative supervisors and DMR-POLB technical supervisors. Data collection activities were completed in September 2017.

1.5.5 Data analysis

Data entry was completed using EpiData software. Data analysis was conducted in SPSS after the EpiData record file had been exported into SPSS format. Descriptive analysis was mainly used. Frequency tables were primarily generated in accordance with the list of dummy tables outlined in the guideline document. Disaggregates by urban/rural, state/region, level of HF and location were mainly calculated. Tables and graphs were produced for presentations. Qualitative data were analysed manually. A content analysis method was used for qualitative data from the client in-depth interviews.

1.5.6 Ethical considerations

Permission from central authorities to undertake the assessment was requested as a first step as the final report would disclose the weaknesses in health service provision across the country, although not disclose information on individual HFs. Local authorities of health facilities were asked for their informed consent to be included in the survey according to the guidelines of the Department of Medical Research Ethics Review Committee. Permission for the dissemination and printing of the report was requested from the Ministry of Health and Sports.

Sharing of the findings of the assessment and dissemination of the report more broadly will be beneficial for service providers, programme managers, policymakers and donor agencies who can use the findings for evidence-based and informed decision-making in the provision of relevant implementation activities in the respective areas covered by the assessment.

1.5.7 Successes and challenges of the study

Successes

1. Experiences and lessons learned from the 2016 assessment were shared and discussed in the coordination meeting in which local health authorities and research teams participated.
2. All most all of the health facilities compiled through the systematic random sampling could be accessed across the country as preparations were made for survey activities in hard-to-reach areas well in advance at the coordination meeting.
3. The standardized questionnaire tool to assess RH commodities was administered by experienced and well-trained researchers who had experience from the assessments implemented in previous years.
4. Pretesting improved the interviewing techniques of research staff, including field enumerators.
5. Although client exit interviews were not carried out and the mobile sampling technique for client selection was not applicable in some areas, clients who had recently used RH services were interviewed to reflect their satisfaction with RH facilities.
6. The direct observation method, using the checklist question form, was used to determine the expiration dates of RH medicines.

7. Local teams were used to reduce any misunderstandings by respondents when the questionnaire was being administered. A lack of language barriers had an impact on the validity and reliability of data collected.
8. In addition to quantitative data on commodities and services, qualitative assessments of clients' satisfaction with the services they received was recorded in this year's survey.

Challenges

1. Although preparations were made in advance for HFs in hard-to-reach areas, some HFs were replaced with a different HF due to security issues e.g. in Mantong Township (Ta'ang National Liberation Army (TNLA) ethnic group) in Northern Shan State and Monghsat Township (United Wa State Army (UWSA) ethnic group) in Eastern Shan State. Transportation difficulties were also experienced in Mindone Township, Magway Region, and Tongzang, Thantlang and Tiddim Townships, Chin State.
2. Although private hospitals with obstetrician-gynaecologist (OBGY) specialists were assessed in every state/region, general practitioners' clinics in townships were not assessed as they were private paying services and supposed to be providing effective and efficient RH care for communities.
3. The standard questionnaire for the RHCS study was developed for health facilities in the public sector. It was not, however, appropriate for private sector HFs.
4. Seasonal variations in the supply of RH commodities may be an issue and the assessment was carried out during the rainy season. However, it is hypothesized that RH commodities should be secured regardless of seasonal factors, and that an assessment can be carried out in any conditions.

2. Summary of national protocols

2.1 Universal health coverage

Universal Health Coverage (UHC) – when all people have access to the health services they need without experiencing financial hardship – has become a global health priority. Under the Sustainable Development Goals (SDGs), all United Nations Member States have agreed to strive to achieve UHC by 2030. To achieve the goals and targets of the 2030 Agenda, health systems must be strengthened so that they provide equitable and inclusive universal coverage. To achieve these aspirational goals, and in light of the current challenges, core strategies are to ensure the availability of quality, efficacious and low cost essential medicines; improve the infrastructure of the health system, including equipment and modern technology; and strengthen the supply chain management. Basic health staff (BHS), down to the grassroots level, are providing promotive, preventive, curative and rehabilitative services using a primary health care approach. The infrastructure for service delivery is sub-rural health centres and rural health centres where midwives, lady health visitors and health assistants are assigned to provide primary health care services to the rural community.

2.2 Maternal and reproductive health in Myanmar

Myanmar is in transition, rapidly realizing the importance of promoting reproductive health at the national level, attracting donor interest and funding, and undertaking advocacy with health-related organizations. Challenges, however, remain for women in regard to their reproductive health status. Although progress has been made, Myanmar has not met many of the Millennium Development Goals (MDGs) or the International Conference on Population and Development (ICPD) targets. Pregnancy-related mortality is estimated at 227 deaths for every 100,000 births. Demand for family planning is estimated at 69 per cent among currently married women of reproductive age (aged 15 to 49), and three-quarters of this demand is satisfied, with a contraceptive prevalence rate of 51 per cent for modern methods. There are, however, some limitations in access to basic maternal healthcare. About 63 per cent of births occur at home without the presence of a skilled birth attendant. Women who live in hard-to-reach areas are in need of sexual and reproductive health (SRH) services.[20]

[20] Myanmar Demographic and Health Survey 2015-2016.

The National Reproductive Health Policy was developed in 2002 and has been supported by three consecutive Reproductive Health Strategic Plans. To improve the health status of mothers and children, including newborns, by reducing maternal, newborn and child mortality and morbidity, four core strategies have been developed. These emphasize:

• Creating an enabling environment for access to health

• Improving the evidence base for decision-making

• Strengthening health systems and the capacity for the delivery of reproductive health services

• Improving community and family practices.

Myanmar has committed to Family Planning 2020 (FP2020), a global partnership. A Costed Implementation Plan to meet Myanmar's FP2020 commitments was developed in 2014, which complements the Five-Year Strategic Plan for Reproductive Health. Myanmar also endorsed the Sustainable Development Goals (SDGs) in 2015, including targets on universal access to sexual and reproductive health care services and the realization of reproductive rights.

The Ministry of Health and Sports recognizes that more needs to be done to achieve national and international targets in maternal, newborn and child health. Specific interventions to strengthen maternal, newborn and child health and to achieve the related targets of Millennium Development Goals 4 and 5 include an emphasis on:

•Providing antenatal care

•Promoting skilled and institutional delivery and postnatal care

•Expanding post-abortion care and providing quality family planning services

•Ensuring the provision of Emergency Obstetric Care

•Providing Essential Newborn Care

•Strengthening adolescent reproductive health

•Promoting male involvement in sexual and reproductive health

•Promoting cervical cancer screening, early diagnosis and treatment

•Strengthening referral systems for pregnant women using community volunteers.

Aligned with these strategies, antenatal care, provided by skilled birth attendants, is standardized for all pregnant mothers who should have at least four check-ups prior to delivery. Facility-based deliveries and postnatal care are encouraged at primary health care

settings. Quality voluntary family planning services have a major role to play in improving maternal health outcomes and services need to be expanded in all townships. Emergency obstetric care, both comprehensive (CEmOC) and basic (BEmOC), must be strengthened. While progress is being made to achieve the target of assigning one midwife in every village,[12] village-based health workers will have strengthened capacity to fulfil this role through trainings, refresher trainings, and monitoring and supervision under the guidance and coordination of Township Medical Officers in villages where there is currently no midwife.[21] On the demand side, the sexual and reproductive health knowledge of clients of reproductive health services, as well as their families, will be improved and the lack of affordable, good quality services will be addressed.

To achieve these goals, financing to improve the quality of midwifery services; the strengthening of supervision and monitoring of services by township health departments; on-the-job training and capacity building of basic health staff; and strengthening linkages between skilled midwives and village-based health workers to enhance the quality and strengthen the continuum of care are mandatory activities of the Ministry of Health and Sports.[22]

2.3 National Health Plan for Maternal and Reproductive Health

As a long-term goal to achieve universal health coverage (UHC), the National Health Plan (2011-2016) aims to reduce morbidity, disability and mortality, including for mothers, newborns and children by providing high quality services, improving the coverage and accessibility of services, integrating services, and improving community participation. The first step was the provision of an available and accessible package of quality services, known as the essential package of health services (EPHS), a major component of which is maternal and reproductive health services.

Most of the targeted activities have centred around building the skills of basic health staff in townships with regular year-by-year expansion of training sessions across townships. Training focused on obstetric care, including emergency and newborn care, the insertion of the intrauterine device, and post-abortion care.[23]

[21]Health in Myanmar 2015. The Ministry of Health and Sports, Myanmar.
[22]Service Quality Improvement for MNCH. Avilable at http://www.3mdg.org/what-we-do/maternal-newborn-and-child-health/programme-areas/item/673-service-quality-improvement-for-mnch (Accessed: 20.11.16)
[23] National Health Plan (2011-2016). Ministry of Health, Myanmar.

2.4 Policy development around sexual and reproductive health and rights

Access to family planning is one of the most cost-effective investments a country can make, a fundamental human right, and a crucial step to empower women and girls to realize their full potential. It can bolster a country's sustainable and inclusive development. Although family planning has been a priority for Myanmar since the 1994 International Conference on Population and Development, and significant progress has been made in increasing access to voluntary family planning, challenges remain. Overall 16 per cent of married women of reproductive age (aged 15 to 49) have an unmet need for modern contraceptive methods, 5 per cent of women want to space births, while 11 per cent of women want to limit births.[24] Regional disparities in the unmet need for contraceptives are evident in Myanmar, ranging from a high of 23 per cent in Rakhine and Chin State to a low of 12 per cent in Yangon Region and Nay Pyi Taw.[25]

2018 marks a policy shift in sexual and reproductive health and rights (SRHR) in Myanmar within the context of its changing needs and morbidity patterns. Myanmar's strong policy foundation in the area of SRHR and its sustained political commitment provide a unique opportunity for government to redefine a common vision and mission, revisit goals and objectives, and establish a wider evidence-based policy framework grounded in human rights. The National SRHR Policy addresses SRHR challenges faced by the people of Myanmar and calls for strengthening the health sector by increasing sustainable resource allocation to improve access to SRH services. The policy is based on an assessment of emerging issues in Myanmar, as well as lessons learned and best practices from other countries.

The draft of the SRHR Policy states that all individuals of reproductive age, including marginalized groups, regardless of their marital status, will have equitable access to quality and inclusive family planning information, commodities, and services, and will have the freedom to decide on the desired number of children and to determine the healthy timing and spacing of pregnancies.

[24] Ministry of Health and Sports (MoHS) and ICF. Myanmar Demographic and Health Survey 2015-16. Nay Pyi Taw, Myanmar, and Rockville, Maryland USA: Ministry of Health and Sports and ICF, 2017.

[25] Ministry of Social welfare, Relief and Resettlement. *National Strategic Plan for Early Childhood Intervention 2017-2021.*Nay Pyi Taw, 2017.

3. Findings

3.1 Sample health facilities

Table 3.1 Sample health facilities by level, by state/region

		Level of health facility				
		Tertiary	Secondary	Primary	Private	Total
State/Region	Kachin	1	10	8	0	19
	Kayah	1	2	5	0	8
	Kayin	1	6	6	1	14
	Chin	1	4	6	0	11
	Sagaing	2	18	20	2	42
	Tanintheri	1	5	5	1	12
	Bago	1	18	17	1	37
	Magway	3	13	18	0	34
	Mandalay	3	13	14	3	33
	Mon	1	6	8	1	16
	Rakhine	2	8	11	1	22
	Yangon	1	11	15	5	32
	Shan (South)	1	10	10	1	22
	Shan (North)	2	10	8	1	21
	Shan (East)	0	5	4	0	9
	Ayeyawady	1	19	23	1	44
	Nay Pyi Taw	0	3	3	1	7
Total		**22**	**161**	**181**	**19**	**383**

The number of sample HFs was distributed proportionately to the level of facilities and states/regions. A total of 383 health facilities, including 19 private hospitals, were assessed. Although the number of private hospitals listed is the same as the number of tertiary facilities, data from three hospitals were excluded during analysis due to insufficient information.

Table 3.2 Sample health facilities by state/region, and urban/rural area

		Urban/Rural		
		Urban	Rural	Total
State/Region	Kachin	12	7	19
	Kayah	4	4	8
	Kayin	5	9	14
	Chin	3	8	11
	Sagaing	16	26	42
	Tanintheri	6	6	12
	Bago	20	17	37
	Magway	14	20	34
	Mandalay	11	22	33
	Mon	6	10	16
	Rakhine	7	15	22
	Yangon	22	10	32
	Shan (South)	12	10	22
	Shan (North)	7	14	21
	Shan (East)	3	6	9
	Ayeyawady	13	31	44
	Nay Pyi Taw	5	2	7
	Total	**166**	**217**	**383**

Selected HFs in Yangon Region included urban health centres and maternal and child health clinics as well as primary level HFs. Some station hospitals were located in urban rather than rural areas. All selected secondary level HFs in Kachin, Bago, Shan (South) and Nay Pyi Taw were mainly township hospitals and located in urban settings. The proportion of HFs in urban areas was higher than in rural areas in these two regions.

Figure 3.1 Distance to nearest medical depot from health facility by state/region

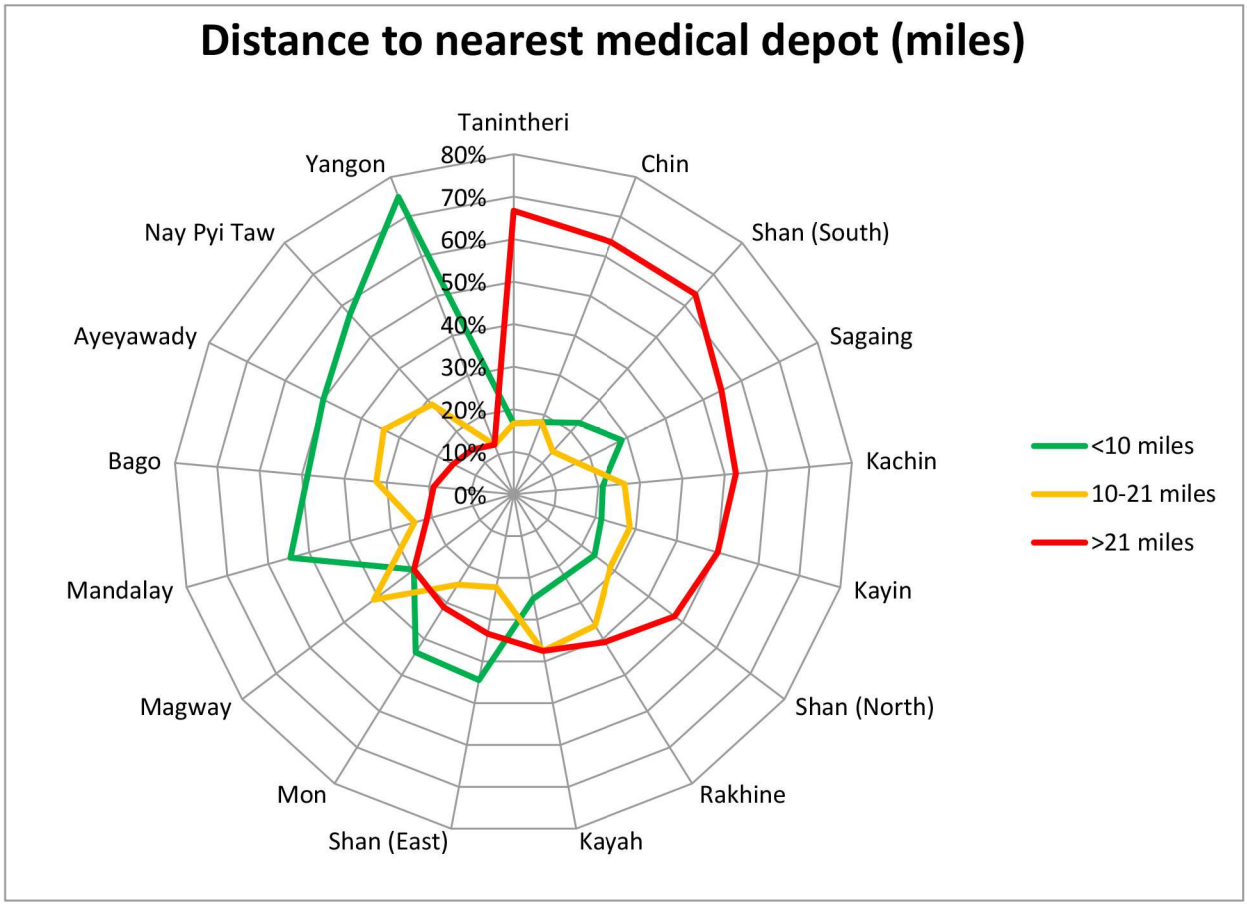


Figure 3.1 shows that more HFs in Yangon, Nay Pyi Taw, and Ayeyawady were located less than 10 miles away from the nearest medical depot. A higher proportion of HFs in Tanintheri, Kachin, Chin, Shan (South), Sagaing, Kachin, and Kayin were located more than 21 miles away from the nearest medical depot.

3.2 Modern contraceptives offered by primary health facilities

Table 3.2 Percentage distribution of primary level health facilities offering at least three modern contraceptive methods by type of facility

			Providing minimum family planning services		
			Providing	Not providing	Total
Level of Health Facility	Primary	Freq	32	149	181
		%	17.7%	82.3%	100.0%

It was considered essential that primary level HFs could provide three modern methods of contraceptives rather than five, which was required of secondary and tertiary level HFs. Out of the total 181 primary level HFs, 82.3 per cent (compared to 81.4 per cent in 2016) were providing at least three modern methods of contraceptives, and the majority were providing the minimum required family planning services.

Table 3.3 Percentage distribution of primary level health facilities offering at least three modern contraceptive methods by state/region

			Providing minimum family planning services		
			Providing	Not providing	Total
State/Region	Kachin	Freq	1	7	8
		%	12.5%	87.5%	100.0%
	Kayah	Freq	0	5	5
		%	.0%	100.0%	100.0%
	Kayin	Freq	2	4	6
		%	33.3%	66.7%	100.0%
	Chin	Freq	3	3	6
		%	50.0%	50.0%	100.0%
	Sagaing	Freq	2	18	20
		%	10.0%	90.0%	100.0%
	Tanintheri	Freq	1	4	5
		%	20.0%	80.0%	100.0%
	Bago	Freq	6	11	17
		%	35.3%	64.7%	100.0%
	Magway	Freq	5	13	18
		%	27.8%	72.2%	100.0%
	Mandalay	Freq	1	13	14
		%	7.1%	92.9%	100.0%
	Mon	Freq	2	6	8
		%	25.0%	75.0%	100.0%
	Rakhine	Freq	5	6	11
		%	45.5%	54.5%	100.0%
	Yangon	Freq	3	12	15
		%	20.0%	80.0%	100.0%
	Shan (South)	Freq	0	10	10
		%	.0%	100.0%	100.0%
	Shan (North)	Freq	0	8	8
		%	.0%	100.0%	100.0%
	Shan (East)	Freq	0	4	4
		%	.0%	100.0%	100.0%
	Ayeyawady	Freq	1	22	23
		%	4.3%	95.7%	100.0%
	Nay Pyi Taw	Freq	0	3	3
		%	.0%	100.0%	100.0%
	Total	**Freq**	**32**	**149**	**181**
		%	**17.7%**	**82.3%**	**100.0%**

More than 80 per cent of primary level HFs in 11 states/regions could provide at least three modern contraceptive methods. In Mon, Magway, Kayin and Bago States/Regions less than

80 per cent of primary level HFs could provide at least three modern contraceptive methods, while in Chin and Rakhine States the figure was less than 60 per cent.

Table 3.5 Percentage distribution of primary level health facilities offering at least three modern contraceptive methods, urban/rural area

			Providing minimum family planning services		
			Providing	Not providing	Total
Urban/Rural	Urban	Freq	5	39	44
		%	11.4%	88.6%	100.0%
	Rural	Freq	27	110	137
		%	19.7%	80.3%	100.0%
	Total	**Freq**	**32**	**149**	**181**
		%	**17.7%**	**82.3%**	**100.0%**

More than 80 per cent of primary level HFs in rural areas were providing at least three modern contraceptive methods, while in urban areas this figure was 88.6 per cent. The difference between urban and rural areas (88.6 per cent vs. 80.3 per cent) was not statistically significant The difference was less than observed in the 2016 assessment.

Table 3.6 Percentage distribution of primary level health facilities offering at least three modern contraceptive methods by management of facility

			Providing minimum family planning services		
			Providing	Not providing	Total
Type of administration	Govt	Freq	32	149	181
		%	17.8%	82.3%	100.0%
	Total	Freq	32	149	181
		%	17.7%	82.3%	100.0%

All primary level HFs are under government administration, and 82.3 per cent were providing at least three modern methods of contraceptives.

Table 3.7 Percentage distribution of primary level health facilities offering at least three modern contraceptive methods by distance from nearest warehouse/source of supply

			Providing minimum family planning services		
			Providing	Not providing	Total
Distance to nearest medical depot	<10 miles	Freq	12	73	85
		%	14.1%	85.9%	100.0%
	10-21 miles	Freq	11	41	52
		%	21.2%	78.8%	100.0%
	>21 miles	Freq	9	35	44
		%	20.5%	79.5%	100.0%
Travel duration to nearest med. depot	Within a day	Freq	32	146	178
		%	18.0%	82.0%	100.0%
	Within a week	Freq	0	3	3
		%	.0%	100.0%	100.0%
Route to travel to nearest med. depot	Road	Freq	32	137	169
		%	18.9%	81.1%	100.0%
	Water	Freq	0	12	12
		%	.0%	100.0%	100.0%
	Total	**Freq**	**32**	**149**	**181**
		%	**17.7%**	**82.3%**	**100.0%**

The availability of at least three modern contraceptive methods in primary level HFs was not significantly associated with distance or travel duration to the nearest medical depot or the mode of travel.

3.3 Modern contraceptives offered by secondary and tertiary health facilities

Table 3.8 Percentage distribution of primary level health facilities offering at least five modern contraceptive methods by type of facility

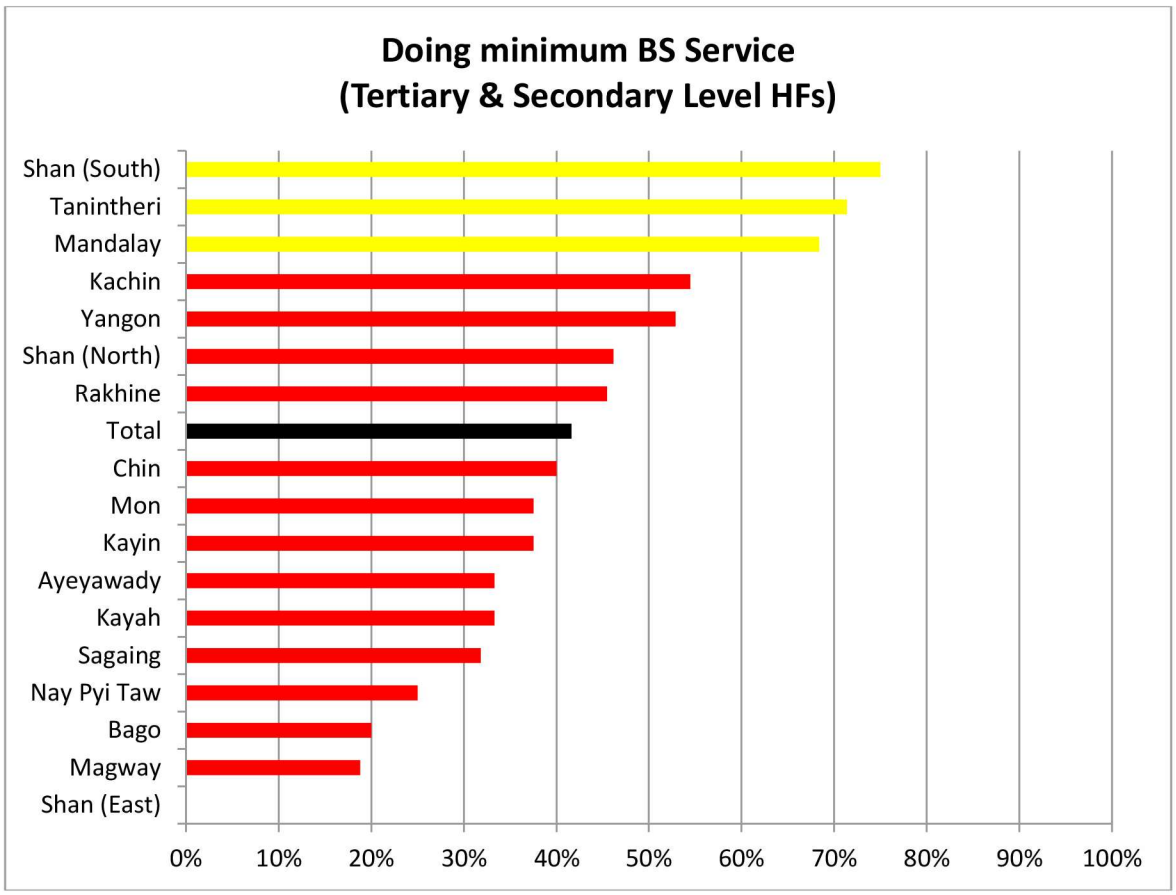
			Providing minimum family planning services		
			Providing	Not providing	Total
Level of Health Facility	Tertiary	Freq	5	17	22
		%	22.7%	77.3%	100.0%
	Secondary	Freq	106	55	161
		%	65.8%	34.2%	100.0%
	Private	Freq	7	12	19
		%	36.8%	63.2%	100.0%
	Total	**Freq**	**118**	**84**	**202**
		%	**58.4%**	**41.6%**	**100.0%**

Thirty four per cent of secondary level HFs had at least five modern contraceptive methods available, which was significantly lower than the 77.3 per cent of tertiary level HFs and 63.2 per cent of private HFs. The highest percentage reported in tertiary level HFs was lower than the figure reported in the 2016 assessment (91.3 per cent).

Table 3.9 Percentage distribution of primary level health facilities offering at least five modern contraceptive methods by state/region

			Providing minimum family planning services		
			Not providing	Providing	Total
State/Region	Kachin	Freq	5	6	11
		%	45.5%	54.5%	100.0%
	Kayah	Freq	2	1	3
		%	66.7%	33.3%	100.0%
	Kayin	Freq	5	3	8
		%	62.5%	37.5%	100.0%
	Chin	Freq	3	2	5
		%	60.0%	40.0%	100.0%
	Sagaing	Freq	15	7	22
		%	68.2%	31.8%	100.0%
	Tanintheri	Freq	2	5	7
		%	28.6%	71.4%	100.0%
	Bago	Freq	16	4	20
		%	80.0%	20.0%	100.0%
	Magway	Freq	13	3	16
		%	81.2%	18.8%	100.0%
	Mandalay	Freq	6	13	19
		%	31.6%	68.4%	100.0%
	Mon	Freq	5	3	8
		%	62.5%	37.5%	100.0%
	Rakhine	Freq	6	5	11
		%	54.5%	45.5%	100.0%
	Yangon	Freq	8	9	17
		%	47.1%	52.9%	100.0%
	Shan (South)	Freq	3	9	12
		%	25.0%	75.0%	100.0%
	Shan (North)	Freq	7	6	13
		%	53.8%	46.2%	100.0%
	Shan (East)	Freq	5	0	5
		%	100.0%	.0%	100.0%
	Ayeyawady	Freq	14	7	21
		%	66.7%	33.3%	100.0%
	Nay Pyi Taw	Freq	3	1	4
		%	75.0%	25.0%	100.0%
	Total	**Freq**	**118**	**84**	**202**
		%	**58.4%**	**41.6%**	**100.0%**

Figure 3.2 Percentage of tertiary and secondary level health facilities providing five modern contraceptives by state/region



In 13 out of 17 states/regions less than 60 per cent of tertiary/secondary level and private HFs were providing five modern methods of contraceptives.

Table 3.10 Percentage distribution of primary level health facilities offering at least five modern contraceptive methods, urban/rural area

			Providing minimum family planning services		
			Providing	Not providing	Total
Urban/Rural	Urban	Freq	58	64	122
		%	47.5%	52.5%	100.0%
	Rural	Freq	60	20	80
		%	75.0%	25.0%	100.0%
	Total	**Freq**	**118**	**84**	**202**
		%	**58.4%**	**41.6%**	**100.0%**

The urban/rural difference in the percentage of primary level HFs providing at least five modern methods of contraceptives (52.5 per cent vs. 25 per cent) was noted to be statistically significant.

Table 3.11 Percentage distribution of primary level health facilities offering at least five modern contraceptive methods by management of facility

			Providing minimum family planning services		
			Providing	Not providing	Total
Type of administration	Govt	Freq	111	72	183
		%	59.7%	40.3%	100.0%
	Private	Freq	7	12	19
		%	36.8%	63.2%	100.0%
	Total	Freq	118	84	202
		%	58.4%	41.6%	100.0%

The proportion of primary HFs in the public and private sector that were providing five modern methods of contraceptives was 40.3 per cent and 63.2 per cent, respectively, which was statistically significant.

Table 3.12 Percentage distribution of primary level health facilities offering at least five modern contraceptive methods by distance from nearest warehouse/source of supply

			Providing minimum family planning services		
			Providing	Not providing	Total
Distance to nearest medical depot	<10 miles	Freq	36	26	62
		%	58.1%	41.9%	100.0%
	10-21 miles	Freq	35	14	49
		%	71.4%	28.6%	100.0%
	>21 miles	Freq	47	44	91
		%	51.6%	48.4%	100.0%
Travel duration to nearest medical depot	Within a day	Freq	115	78	193
		%	59.6%	40.4%	100.0%
	Within a week	Freq	3	6	9
		%	33.3%	66.7%	100.0%
Route to travel to nearest medical depot	Road	Freq	111	83	194
		%	57.2%	42.8%	100.0%
	Water	Freq	7	1	8
		%	87.5%	12.5%	100.0%
	Total	**Freq**	**118**	**84**	**202**
		%	**58.4%**	**41.6%**	**100.0%**

There was no significant association between the distance to medical depots or travel duration and the availability of five modern methods of contraceptives at secondary and tertiary level HFs. The mode of transport, however, did impact on the number of HFs providing five methods of contraceptives; 42.3 per cent of HFs that travelled by road could provide five modern methods while the figure was 12.5 per cent for HFs that had to travel by water.

3.4 Availability of maternal and reproductive health medicines

Table 3.13 Percentage distribution of health facilities with seven (including two essential) life-saving maternal/reproductive health medicines available by type of facility

			Could provide at least 7 types of life-saving medicines		
			Could not provide	Could provide	Total
Level of health facility	Tertiary	Freq	6	16	22
		%	27.3%	72.7%	100.0%
	Secondary	Freq	80	81	161
		%	49.7%	50.3%	100.0%
	Primary	Freq	97	84	181
		%	53.6%	46.4%	100.0%
	Private	Freq	9	10	19
		%	47.4%	52.6%	100.0%
	Total	**Freq**	**192**	**191**	**383**
		%	**50.1%**	**49.9%**	**100.0%**

Essential life-saving maternal and reproductive health medicines were available in 49.9 per cent of all HFs, but there was a significant difference in availability at different levels. The availability was highest at the tertiary level (72.7 per cent) and lowest at the primary level (46.4 per cent). Availability at the primary level was higher than in 2016, when it stood at 39.5 per cent.

Table 3.14 Percentage distribution of health facilities with seven (including two essential) life-saving maternal/reproductive health medicines available by type of facility by year of assessment

Level of health facility	Could provide at least 7 types of life-saving medication			
	2014	2015	2016	2017
Tertiary level HF	88.7%	82.6%	65.2%	72.7%
Secondary level HF	75.0%	58.4%	63.1%	50.3%
Primary level HF	43.4%	34.9%	39.5%	46.4%
Private HF	NA	NA	69.6%	52.6%
Total	**61.8%**	**48.6%**	**52.9%**	**49.9%**

A comparison at all levels of HFs of the availability of the seven essential RH medicines with data from the last three assessments shows a fluctuating trend. In 2014 the figure for all HFs was 62 per cent, dropping to 49 per cent in 2015, and then rising to 53 per cent in 2016 before decreasing again to 50 per cent in 2017. It was observed that at primary level HFs, availability had fluctuated over the past four surveys but increased above 2014 levels in 2017.

Table 3.15 Percentage distribution of health facilities with seven (including two essential) life-saving maternal/reproductive health medicines available by state/region

			Could provide at least 7 types of life-saving medication		
			Could not provide	Could provide	Total
State/Region	Kachin	Freq	8	11	19
		%	42.1%	57.9%	100.0%
	Kayah	Freq	2	6	8
		%	25.0%	75.0%	100.0%
	Kayin	Freq	6	8	14
		%	42.9%	57.1%	100.0%
	Chin	Freq	10	1	11
		%	90.9%	9.1%	100.0%
	Sagaing	Freq	30	12	42
		%	71.4%	28.6%	100.0%
	Tanintheri	Freq	5	7	12
		%	41.7%	58.3%	100.0%
	Bago	Freq	31	6	37
		%	83.8%	16.2%	100.0%
	Magway	Freq	17	17	34
		%	50.0%	50.0%	100.0%
	Mandalay	Freq	10	23	33
		%	30.3%	69.7%	100.0%
	Mon	Freq	4	12	16
		%	25.0%	75.0%	100.0%
	Rakhine	Freq	14	8	22
		%	63.6%	36.4%	100.0%
	Yangon	Freq	19	13	32
		%	59.4%	40.6%	100.0%
	Shan (South)	Freq	7	15	22
		%	31.8%	68.2%	100.0%
	Shan (North)	Freq	8	13	21
		%	38.1%	61.9%	100.0%
	Shan (East)	Freq	3	6	9
		%	33.3%	66.7%	100.0%
	Ayeyawady	Freq	16	28	44
		%	36.4%	63.6%	100.0%
	Nay Pyi Taw	Freq	2	5	7
		%	28.6%	71.4%	100.0%
	Total	**Freq**	**192**	**191**	**383**
		%	**50.1%**	**49.9%**	**100.0%**

The percentage of HFs which had seven life-saving maternal/reproductive health medicines was nearly 50 per cent in total. The lowest percentages were found in Chin, Bago, Sagaing and Rakhine, all at less than 40 per cent, while the highest percentages were found in Mon and Kayah at more than 70 per cent.

Figure 3.3 Percentage of health facilities that could provide seven life-saving maternal/reproductive health medicines by state/region

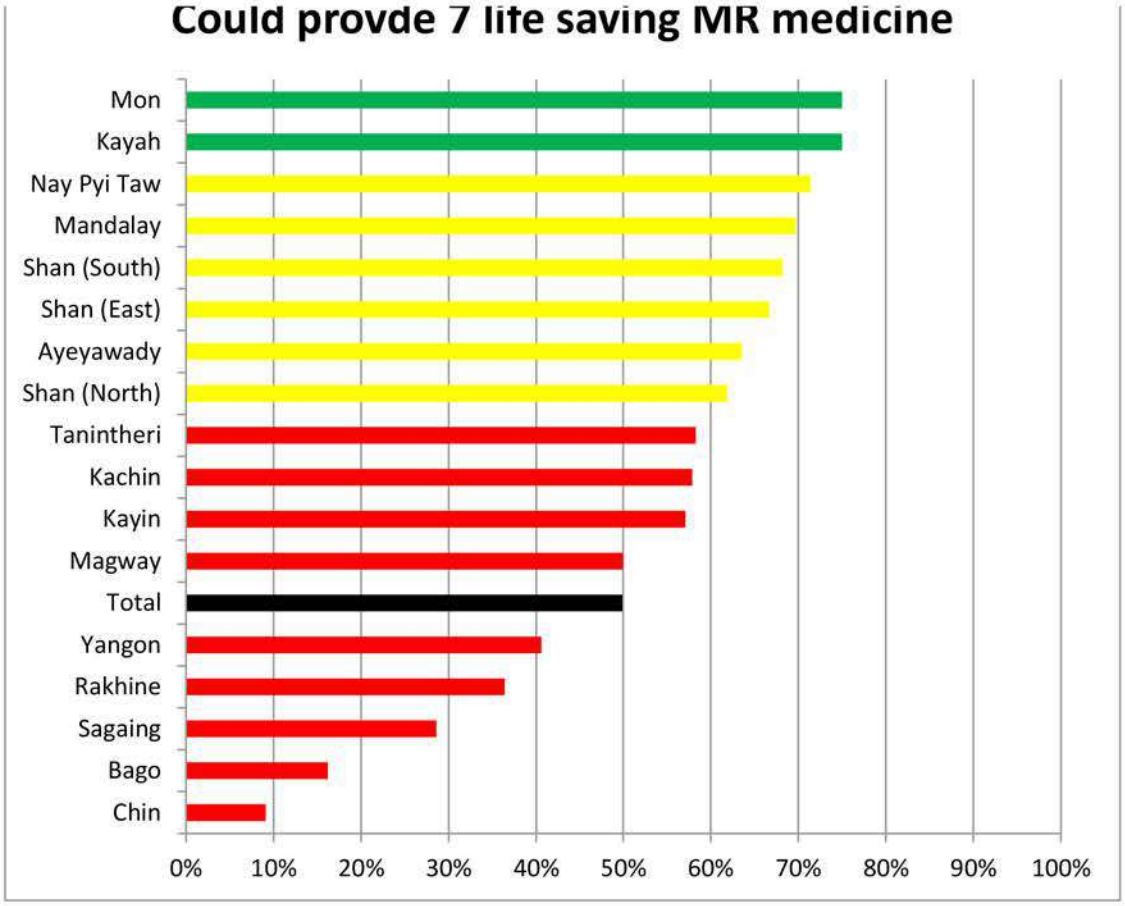


Table 3.16 Percentage distribution of health facilities with seven (including 2 essential) life-saving maternal/reproductive health medicines available, urban/rural area

			Could provide at least 7 types of life-saving medication		
			Could not provide	Could provide	Total
Urban/Rural	Urban	Freq	76	90	166
		%	45.8%	54.2%	100.0%
	Rural	Freq	116	101	217
		%	53.5%	46.5%	100.0%
	Total	**Freq**	**192**	**191**	**383**
		%	**50.1%**	**49.9%**	**100.0%**

The availability of seven life-saving maternal/reproductive health medicines was higher, but not significantly higher, at HFs in urban compared to rural areas (54.2 per cent vs. 46.5 per cent).

Table 3.17 Percentage distribution of health facilities with seven (including 2 essential) life-saving maternal/reproductive health medicines available by management of facility

			Could provide at least 7 types of life-saving medication		
			Could not provide	Could provide	Total
Type of administration	Govt	Freq	183	180	363
		%	50.4%	49.6%	100.0%
	Private	Freq	9	10	19
		%	47.4%	52.6%	100.0%
	Total	**Freq**	**192**	**191**	**383**
		%	**50.1%**	**49.9%**	**100.0%**

The availability of seven life-saving maternal/reproductive health medicines was higher in HFs in the government sector compared to those in the private sector (49.6 per cent vs. 52.6 per cent).

Table 3.18 Percentage distribution of health facilities with seven (including 2 essential) life-saving maternal/reproductive health medicines available by distance from nearest warehouse/source of supply

			Could provide at least 7 types of life-saving medication		
			Could not provide	Could provide	Total
Distance to nearest medical depot	<10 miles	Freq	77	70	147
		%	52.4%	47.6%	100.0%
	10-21 miles	Freq	55	46	101
		%	54.5%	45.5%	100.0%
	>21 miles	Freq	60	75	135
		%	44.4%	55.6%	100.0%
Travel duration to nearest med. depot	Within a day	Freq	184	187	371
		%	49.6%	50.4%	100.0%
	Within a week	Freq	8	4	12
		%	66.7%	33.3%	100.0%
Route to travel to nearest med. depot	Road	Freq	179	184	363
		%	49.3%	50.7%	100.0%
	Water	Freq	13	7	20
		%	65.0%	35.0%	100.0%
	Total	Freq	192	191	383
		%	50.1%	49.9%	100.0%

The availability of seven maternal/reproductive health medicines at HFs was not significantly associated with distance, travel duration or mode of transport to the nearest medical depot.

Table 3.19 Percentage of total health facilities reporting stocks-outs of reproductive health medicines by year of assessment

RH medicine	Percentage of HFs with stock-outs					
	2014	2015	2016 (Both govt + private sector)	2016 (Govt sector only)	2017 (Both govt + private sector)	2017 (Govt sector only)
Inj ampicillin	39.7%	39.7%	31.8%	32.1%	49.1%	50.8%
Inj azithro	40.2%	49.6%	31.2%	32.4%	37.3%	39.3%
Inj benz penicillin	38.0%	45.1%	46.8%	47.7%	49.6%	51.9%
Inj dexa	31.1%	37.2%	30.6%	31.5%	38.4%	40.4%
Inj cal gluconate	34.6%	49.6%	34.4%	35.7%	44.6%	46.7%
Oral cefixime	32.8%	46.5%	35.0%	36.3%	46.2%	48.6%
Inj gentamycin	31.4%	36.1%	21.1%	21.9%	32.6%	34.3%
Oral hydralazine	57.4%	89.3%	64.7%	64.6%	78.1%	79.4%
Inj MgSO4	28.2%	43.1%	27.7%	27.3%	21.7%	21.7%
Oral M-Dopa	52.9%	80.8%	58.1%	59.2%	67.6%	69.5%
Inj metro	5.9%	10.4%	4.0%	3.9%	13.3%	14.0%
Oral misoprostol	31.1%	25.4%	25.4%	26.1%	27.4%	28.8%
Oral nifedipine	30.6%	46.2%	28.6%	29.7%	29.0%	30.5%
Inj oxytocin	24.5%	27.9%	23.7%	24.0%	13.3%	14.0%
Inj Na Lactate	11.5%	22.3%	14.7%	15.0%	13.6%	14.3%
Inj TT	35.3%	58.0%	39.3%	40.8%	32.9%	34.6%

With the exception of the medicines MgSO4, oxytocin, Na Lactate and TT, for all other maternal and reproductive health medicines stock-outs had increased in 2017 compared to 2016.

3.5 Incidence of 'no stock-outs' of modern contraceptives in the last three months

According to information requirement of UNFPA (Myanmar) and Maternal and Reproductive Health Division (MRH), DoPH, "no-stock-outs" are defined in this report when modern methods of contraception are available for a period of three months. For primary level HFs, modern methods of contraceptives include: i) male condoms; ii) oral contraception; iii) injectables; iv) emergency contraception; and v) IUDs. For tertiary and secondary level HFs, modern methods include: i) male condoms; ii) oral contraception; iii) injectables; iv) emergency contraception; v) IUDs; vi) implants; and vii) female sterilization.

Table 3.20 Percentage distribution of health facilities with 'no stock-outs' of a modern contraceptive method in the last three months by type of facility

			At least one modern contraceptive method "stock-out" within last 3 months		
			No stock-out	Stock-out	Total
Level of health facility	Tertiary	Freq	11	11	22
		%	50.0%	50.0%	100.0%
	Secondary	Freq	44	117	161
		%	27.3%	72.7%	100.0%
	Primary	Freq	74	107	181
		%	40.9%	59.1%	100.0%
	Private	Freq	19	0	19
		%	100.0%	.0%	100.0%
	Total	**Freq**	**148**	**235**	**383**
		%	**38.6%**	**61.4%**	**100.0%**

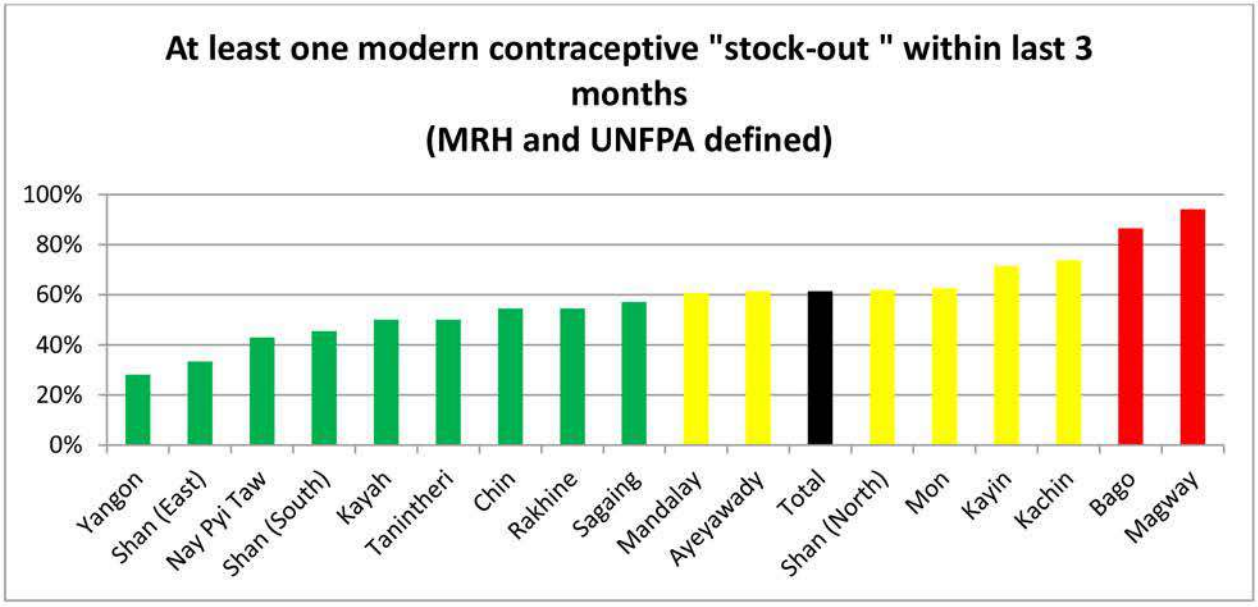
According to the above criteria, 38.6 per cent of HFs assessed were able to provide at least one modern method of contraceptive over the last three months. There was no obvious disparity between different levels of HFs. At 50 per cent of tertiary level HFs there were "no stock-outs" of a modern contraceptive method in the last three months.

Table 3.21 Percentage distribution of health facilities with 'no stock-outs' of a modern contraceptive method in the last three months by state/region

			At least one modern contraceptive stock-out within last 3 months		
			No stock-out	Stock-out	Total
State/Region	Kachin	Freq	5	14	19
		%	26.3%	73.7%	100.0%
	Kayah	Freq	4	4	8
		%	50.0%	50.0%	100.0%
	Kayin	Freq	4	10	14
		%	28.6%	71.4%	100.0%
	Chin	Freq	5	6	11
		%	45.5%	54.5%	100.0%
	Sagaing	Freq	18	24	42
		%	42.9%	57.1%	100.0%
	Tanintheri	Freq	6	6	12
		%	50.0%	50.0%	100.0%

Bago	Freq	5	32	37
	%	13.5%	86.5%	100.0%
Magway	Freq	2	32	34
	%	5.9%	94.1%	100.0%
Mandalay	Freq	13	20	33
	%	39.4%	60.6%	100.0%
Mon	Freq	6	10	16
	%	37.5%	62.5%	100.0%
Rakhine	Freq	10	12	22
	%	45.5%	54.5%	100.0%
Yangon	Freq	23	9	32
	%	71.9%	28.1%	100.0%
Shan (South)	Freq	12	10	22
	%	54.5%	45.5%	100.0%
Shan (North)	Freq	8	13	21
	%	38.1%	61.9%	100.0%
Shan (East)	Freq	6	3	9
	%	66.7%	33.3%	100.0%
Ayeyawady	Freq	17	27	44
	%	38.6%	61.4%	100.0%
Nay Pyi Taw	Freq	4	3	7
	%	57.1%	42.9%	100.0%
Total	**Freq**	**148**	**235**	**383**
	%	**38.6%**	**61.4%**	**100.0%**

Figure 3.4 Percentage of health facilities reporting "no stock-out" of modern contraceptives in last three months



Comparing different states/regions Yangon and Shan (East) reported the lowest percentage of "stock-outs" at less than 30 per cent.

Table 3.22 Percentage distribution of health facilities with 'no stock-outs' of a modern contraceptive method in the last three months, by urban/rural area

			At least one modern contraceptive stock-out within last 3 months		
			No stock-out	Stock-out	Total
Urban/Rural	Urban	Freq	83	83	166
		%	50.0%	50.0%	100.0%
	Rural	Freq	65	152	217
		%	30.0%	70.0%	100.0%
	Total	**Freq**	**148**	**235**	**383**
		%	**38.6%**	**61.4%**	**100.0%**

Urban and rural stock-outs of at least one modern method of contraceptive were 50 per cent and 70 per cent respectively, and the disparity was striking.

Table 3.23 Percentage distribution of health facilities with 'no stock-outs' of a modern contraceptive method in the last three months by management of facility

			At least one modern contraceptive stock-out within last 3 months		
			No stock-out	Stock-out	Total
Type of administration	Govt	Freq	129	235	364
		%	35.4%	64.6%	100.0%
	Private	Freq	19	0	19
		%	100.0%	.0%	100.0%
	Total	**Freq**	**148**	**235**	**383**
		%	**38.6%**	**61.4%**	**100.0%**

A comparison between 'stock-outs' in government and private sector HFs revealed that "no stock-outs" were much higher in private sector HFs (100 per cent vs. 35.4 per cent).

Table 3.24 Percentage distribution of health facilities with 'no stock-outs' of a modern contraceptive method in the last three months by distance from nearest warehouse/source of supply

			At least one modern contraceptive stock-out within last 3 months		
			No stock-out	Stock-out	Total
Distance to nearest medical depot	<10 miles	Freq	73	74	147
		%	49.7%	50.3%	100.0%
	10-21 miles	Freq	28	73	101
		%	27.7%	72.3%	100.0%
	>21 miles	Freq	47	88	135
		%	34.8%	65.2%	100.0%
Travel duration to nearest med depot	Within a day	Freq	142	229	371
		%	38.3%	61.7%	100.0%
	Within a week	Freq	6	6	12
		%	50.0%	50.0%	100.0%
Route to travel to nearest med. depot	Road	Freq	139	224	363
		%	38.3%	61.7%	100.0%
	Water	Freq	9	11	20
		%	45.0%	55.0%	100.0%
	Total	**Freq**	**148**	**235**	**383**
		%	**38.6%**	**61.4%**	**100.0%**

The location of HFs to the nearest medical depot was not associated with the percentage of "no stock-outs".

	%	18.2%	6.6%	6.0%	12.5%
OCP	Freq	15	127	144	15
	%	68.2%	84.1%	85.7%	93.8%
Injectable contraceptive	Freq	19	111	135	16
	%	86.4%	73.5%	80.4%	100.0%
ECP	Freq	7	43	88	13
	%	31.8%	28.5%	52.4%	81.2%
IUD	Freq	18	63	40	14
	%	81.8%	41.7%	23.8%	87.5%
Implant	Freq	10	40	4	10
	%	45.5%	26.5%	2.4%	62.5%
Female sterilization	Freq	16	63	0	7
	%	**72.7%**	**41.7%**	**.0%**	**43.8%**

*Multiple response table.

There was a comparatively higher percentage of "no stock-outs" across all levels of HFs for OCPs and injectables (more than 70 per cent at all levels). The contraceptive method with the lowest "no stock-outs" at all HFs was the female condom at less than 6 per cent. Implant availability was higher at tertiary and secondary level HFs. Implant methods were available at 62.5 per cent of private HFs.

Table 3.26 "No stock-out" status in the last six month for each modern contraceptive method by state/region

State/ Region		No stock-out of modern contraceptives in within last 3 months*								
		Male condom	Female condom	OCP	Injectable contraceptive	ECP	IUD	Implant	Female sterilization	Total
Kachin	Freq	7	2	19	17	12	10	1	8	19
	%	36.8%	10.5%	100.0%	89.5%	63.2%	52.6%	5.3%	42.1%	
Kayah	Freq	6	0	8	8	5	4	0	0	8
	%	75.0%	.0%	100.0%	100.0%	62.5%	50.0%	.0%	.0%	
Kayin	Freq	4	0	12	13	4	5	6	5	13
	%	30.8%	.0%	92.3%	100.0%	30.8%	38.5%	46.2%	38.5%	
Chin	Freq	4	1	10	10	1	3	1	2	11
	%	36.4%	9.1%	90.9%	90.9%	9.1%	27.3%	9.1%	18.2%	
Sagaing	Freq	11	1	33	27	11	6	1	12	39
	%	28.2%	2.6%	84.6%	69.2%	28.2%	15.4%	2.6%	30.8%	
Tanintheri	Freq	5	1	12	12	7	6	1	5	12
	%	41.7%	8.3%	100.0%	100.0%	58.3%	50.0%	8.3%	41.7%	
Bago	Freq	3	2	25	16	10	15	3	8	34
	%	8.8%	5.9%	73.5%	47.1%	29.4%	44.1%	8.8%	23.5%	
Magway	Freq	9	0	29	26	3	6	9	8	33
	%	27.3%	.0%	87.9%	78.8%	9.1%	18.2%	27.3%	24.2%	
Mandalay	Freq	12	1	23	17	11	15	12	7	30
	%	40.0%	3.3%	76.7%	56.7%	36.7%	50.0%	40.0%	23.3%	
Mon	Freq	10	1	12	12	6	8	0	7	15
	%	66.7%	6.7%	80.0%	80.0%	40.0%	53.3%	.0%	46.7%	
Rakhine	Freq	10	5	15	15	9	7	0	2	17
	%	58.8%	29.4%	88.2%	88.2%	52.9%	41.2%	.0%	11.8%	
Yangon	Freq	14	1	22	27	20	12	11	4	29
	%	48.3%	3.4%	75.9%	93.1%	69.0%	41.4%	37.9%	13.8%	
Shan (South)	Freq	15	3	21	21	11	12	9	7	21
	%	71.4%	14.3%	100.0%	100.0%	52.4%	57.1%	42.9%	33.3%	
Shan (North)	Freq	15	0	18	17	10	5	4	3	21
	%	71.4%	.0%	85.7%	81.0%	47.6%	23.8%	19.0%	14.3%	
Shan (East)	Freq	7	0	8	8	2	0	0	0	8
	%	87.5%	.0%	100.0%	100.0%	25.0%	.0%	.0%	.0%	
Ayeyawady	Freq	24	7	28	30	23	17	6	6	40
	%	60.0%	17.5%	70.0%	75.0%	57.5%	42.5%	15.0%	15.0%	
Nay Pyi Taw	Freq	6	1	6	5	6	4	0	2	7
	%	85.7%	14.3%	85.7%	71.4%	85.7%	57.1%	.0%	28.6%	
Total	Freq	162	26	301	281	151	135	64	86	357

*Multiple response table.

The most common reason for stock-outs (within the last three months) were untimely supplies, no users and no skilled staff.

3.6 Incidence of 'no stock-outs' of modern contraceptives on the day of the survey

Table 3.27 Percentage distribution of health facilities with 'no stock-outs' of modern contraceptive methods at the time of the survey by type of facility

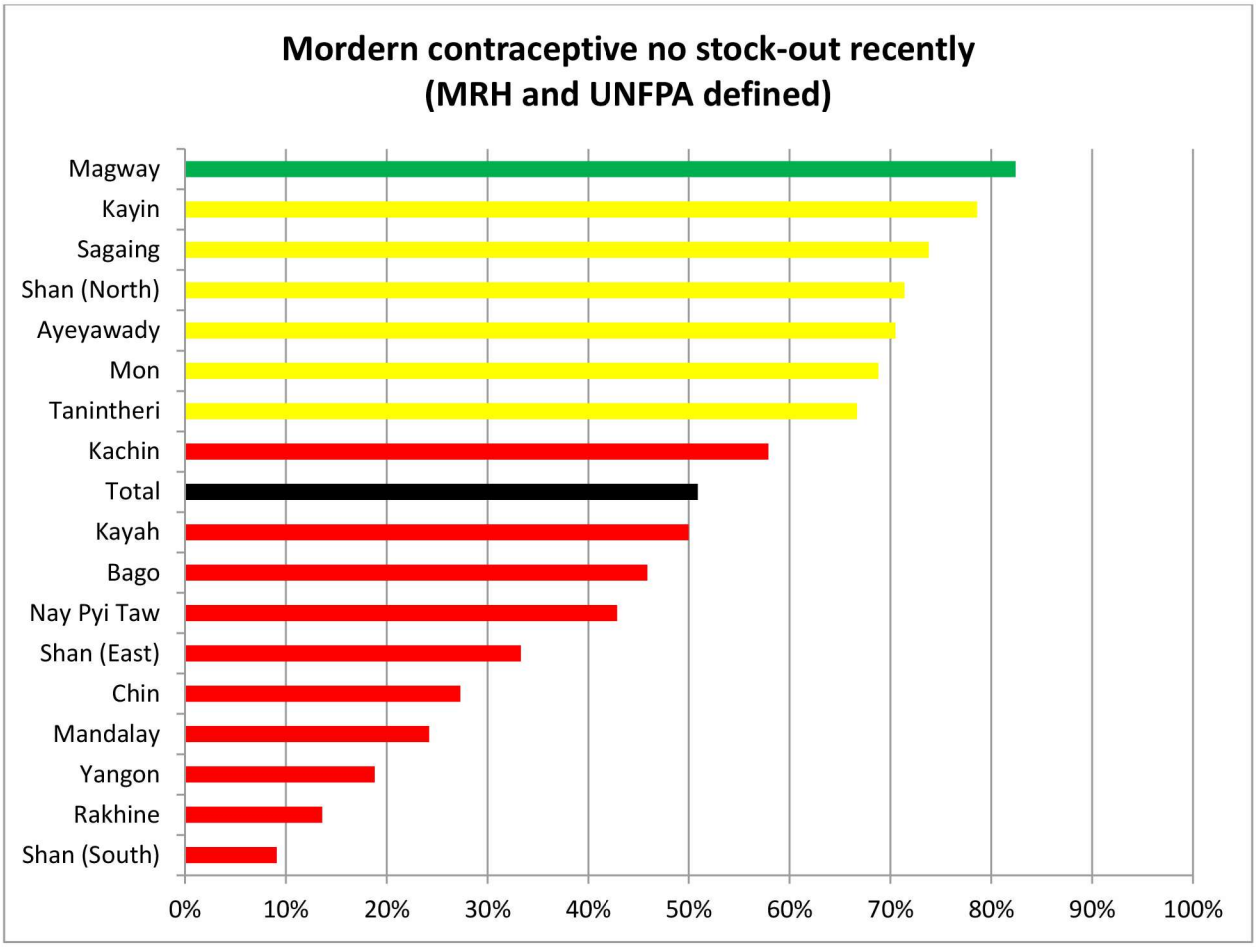
			Modern contraceptive No stock-out recently		
			Stock-out	No stock-out	Total
Level of Health Facility	Tertiary	Freq	11	11	22
		%	50.0%	50.0%	100.0%
	Secondary	Freq	58	103	161
		%	36.0%	64.0%	100.0%
	Primary	Freq	119	62	181
		%	65.7%	34.3%	100.0%
	Private	Freq	0	19	19
		%	.0%	100.0%	100.0%
	Total	**Freq**	**188**	**195**	**383**
		%	**49.1%**	**50.9%**	**100.0%**

A recent "no-stock-out" of a modern contraceptive was found in 50.9 per cent of all HFs. Primary level HFs and private sector HFs recorded much lower percentages (34 per cent) of recent "no stock-outs" compared to higher level HFs (more than 50 per cent).

Table 3.28 Percentage distribution of health facilities with 'no stock-outs' of modern contraceptive methods at the time of the survey by state/region

			Modern contraceptive No stock-out recently		
			Stock-out	No stock-out	Total
State/Region	Kachin	Freq	8	11	19
		%	42.1%	57.9%	100.0%
	Kayah	Freq	4	4	8
		%	50.0%	50.0%	100.0%
	Kayin	Freq	3	11	14
		%	21.4%	78.6%	100.0%
	Chin	Freq	8	3	11
		%	72.7%	27.3%	100.0%
	Sagaing	Freq	11	31	42
		%	26.2%	73.8%	100.0%
	Tanintheri	Freq	4	8	12
		%	33.3%	66.7%	100.0%
	Bago	Freq	20	17	37
		%	54.1%	45.9%	100.0%
	Magway	Freq	6	28	34
		%	17.6%	82.4%	100.0%
	Mandalay	Freq	25	8	33
		%	75.8%	24.2%	100.0%
	Mon	Freq	5	11	16
		%	31.2%	68.8%	100.0%
	Rakhine	Freq	19	3	22
		%	86.4%	13.6%	100.0%
	Yangon	Freq	26	6	32
		%	81.2%	18.8%	100.0%
	Shan (South)	Freq	20	2	22
		%	90.9%	9.1%	100.0%
	Shan (North)	Freq	6	15	21
		%	28.6%	71.4%	100.0%
	Shan (East)	Freq	6	3	9
		%	66.7%	33.3%	100.0%
	Ayeyawady	Freq	13	31	44
		%	29.5%	70.5%	100.0%
	Nay Pyi Taw	Freq	4	3	7
		%	57.1%	42.9%	100.0%
	Total	**Freq**	**188**	**195**	**383**
		%	**49.1%**	**50.9%**	**100.0%**

Figure 3.5 Percentage of health facilities with recent "no stock-outs" of a modern contraceptive by state/region



At the Union level, HFs with recent "no stock-outs" of a modern contraceptive method was 51 per cent. States/regions where recent "no stock-outs" were lowest, at less than 20 per cent, were Shan (S), Rakhine and Yangon. States/regions where recent "no stock-outs" were highest included Magway at more than 70 per cent.

Table 3.29 Percentage distribution of health facilities with 'no stock-outs' of modern contraceptive methods at the time of the survey by urban/rural area

			Modern contraceptive No recent stock-out		
			Stock-out	No stock-out	Total
Urban/Rural	Urban	Freq	75	91	166
		%	45.2%	54.8%	100.0%
	Rural	Freq	113	104	217
		%	52.1%	47.9%	100.0%
	Total	**Freq**	**188**	**195**	**383**
		%	49.1%	50.9%	100.0%

Urban HFs had a higher percentage of recent "no-stock-outs" of a modern method of contraception compared to rural HFs (54.8 per cent vs. 47.9 per cent).

Table 3.30 Percentage distribution of health facilities with 'no stock-outs' of modern contraceptive methods at the time of the survey by management of facility

			Modern contraceptive No recent stock-out		
			Stock-out	No stock-out	Total
Type of administration	Govt	Freq	188	176	366
		%	51.3%	48.7%	100.0%
	Private	Freq	0	19	19
		%	.0%	100.0%	100.0%
	Total	**Freq**	**188**	**195**	**383**
		%	**49.1%**	**50.9%**	**100.0%**

The difference between government and private sector HFs in terms of recent "no stock-outs" was significant (49 per cent vs. 100 per cent).

Table 3.31 Percentage distribution of health facilities with 'no stock-outs' of modern contraceptive methods at the time of the survey by distance from nearest warehouse/source of supply

			Modern contraceptive No recent stock-out		
			Stock-out	No stock-out	Total
Distance to nearest medical depot	<10 miles	Freq	79	68	147
		%	53.7%	46.3%	100.0%
	10-21 miles	Freq	46	55	101
		%	45.5%	54.5%	100.0%
	>21 miles	Freq	63	72	135
		%	46.7%	53.3%	100.0%
Travel duration to nearest med. depot	Within a day	Freq	182	189	371
		%	49.1%	50.9%	100.0%
	Within a week	Freq	6	6	12
		%	50.0%	50.0%	100.0%
Route to travel to nearest med. depot	Road	Freq	178	185	363
		%	49.0%	51.0%	100.0%
	Water	Freq	10	10	20
		%	50.0%	50.0%	100.0%
	Total	Freq	188	195	383
		%	49.1%	50.9%	100.0%

There was no association between recent "no stock-outs" and the location of HFs.

Table 3.32 Incidence of 'no stock-outs' of modern contraceptives by level of health facility

Incidence of 'no stock-outs' of modern contraceptives on the day of the survey*		Level of health facility			
		Tertiary	Secondary	Primary	Private
Male condom	Freq	17	56	91	8
	%	81.0%	36.8%	52.9%	66.7%
Female condom	Freq	4	21	12	0
	%	19.0%	13.8%	7.0%	.0%
OCP	Freq	16	124	155	11
	%	76.2%	81.6%	90.1%	91.7%
Injectable contraceptives	Freq	19	117	149	12
	%	90.5%	77.0%	86.6%	100.0%
ECP	Freq	8	53	91	8
	%	38.1%	34.9%	52.9%	66.7%
IUD	Freq	17	61	46	9
	%	81.0%	40.1%	26.7%	75.0%
Implant	Freq	9	45	6	10
	%	42.9%	29.6%	3.5%	83.3%
Female sterilization	Freq	5	21	0	4
	%	23.8%	13.8%	.0%	33.3%

*Multiple response table.

At the time of the survey, the percentage of HFs with stocks of OCPs and injectable methods was high at all levels at more than 75 per cent. A stock of female condoms was lowest at all levels of HFs at less than 5 per cent. Stock availability of implants was lower at secondary level HFs compared to tertiary level HFs (29.6 per cent vs. 42.9 per cent). The stock rate for implants at private sector HFs was quite high at 83.3 per cent.

Table 3.33 Incidence of 'no stock-outs' of modern contraceptives by state/region

State/Region		Incidence of 'no stock-out' of modern contraceptives on the day of the survey								
		Male condom	Female condom	OCP	Injectable	ECP	IUD	Implant	Female sterilization	Total
Kachin	Freq	8	3	19	18	12	10	2	1	19
	%	42.1%	15.8%	100.0%	94.7%	63.2%	52.6%	10.5%	5.3%	
Kayah	Freq	6	0	8	8	3	4	0	0	8
	%	75.0%	.0%	100.0%	100.0%	37.5%	50.0%	.0%	.0%	
Kayin	Freq	4	0	11	13	4	6	6	0	13
	%	30.8%	.0%	84.6%	100.0%	30.8%	46.2%	46.2%	.0%	
Chin	Freq	4	1	6	6	3	3	1	1	7
	%	57.1%	14.3%	85.7%	85.7%	42.9%	42.9%	14.3%	14.3%	
Sagaing	Freq	17	3	31	31	19	11	2	6	37
	%	45.9%	8.1%	83.8%	83.8%	51.4%	29.7%	5.4%	16.2%	
Tanintheri	Freq	4	1	11	11	6	5	1	1	11
	%	36.4%	9.1%	100.0%	100.0%	54.5%	45.5%	9.1%	9.1%	
Bago	Freq	9	4	28	25	13	10	3	2	36
	%	25.0%	11.1%	77.8%	69.4%	36.1%	27.8%	8.3%	5.6%	
Magway	Freq	11	0	31	26	5	3	6	0	34
	%	32.4%	.0%	91.2%	76.5%	14.7%	8.8%	17.6%	.0%	
Mandalay	Freq	14	4	26	19	15	18	14	3	33
	%	42.4%	12.1%	78.8%	57.6%	45.5%	54.5%	42.4%	9.1%	
Mon	Freq	8	0	14	12	4	9	0	2	15
	%	53.3%	.0%	93.3%	80.0%	26.7%	60.0%	.0%	13.3%	
Rakhine	Freq	10	5	15	17	7	5	1	1	19
	%	52.6%	26.3%	78.9%	89.5%	36.8%	26.3%	5.3%	5.3%	
Yangon	Freq	11	2	25	28	18	12	13	3	31
	%	35.5%	6.5%	80.6%	90.3%	58.1%	38.7%	41.9%	9.7%	
Shan (South)	Freq	11	3	14	15	8	8	7	4	15
	%	73.3%	20.0%	93.3%	100.0%	53.3%	53.3%	46.7%	26.7%	
Shan (North)	Freq	16	0	19	19	7	4	4	0	21
	%	76.2%	.0%	90.5%	90.5%	33.3%	19.0%	19.0%	.0%	
Shan (East)	Freq	8	1	9	9	3	1	1	0	9
	%	88.9%	11.1%	100.0%	100.0%	33.3%	11.1%	11.1%	.0%	
Ayeyawady	Freq	24	10	32	33	27	20	8	5	42
	%	57.1%	23.8%	76.2%	78.6%	64.3%	47.6%	19.0%	11.9%	
Nay Pyi Taw	Freq	7	0	7	7	6	4	1	1	7
	%	100.0%	.0%	100.0%	100.0%	85.7%	57.1%	14.3%	14.3%	
Total	**Freq**	**172**	**37**	**306**	**297**	**160**	**133**	**70**	**30**	**357**

*Multiple response table.

Four modern methods of contraceptives (OCPs, the male condom, injectables and the ECP) were available across all states/regions. Although IUD availability was lower than the other three methods, it was available in all states/regions. The stock of ECP was lowest in Magway Region. Implants and female sterilization were not available in many states/regions.

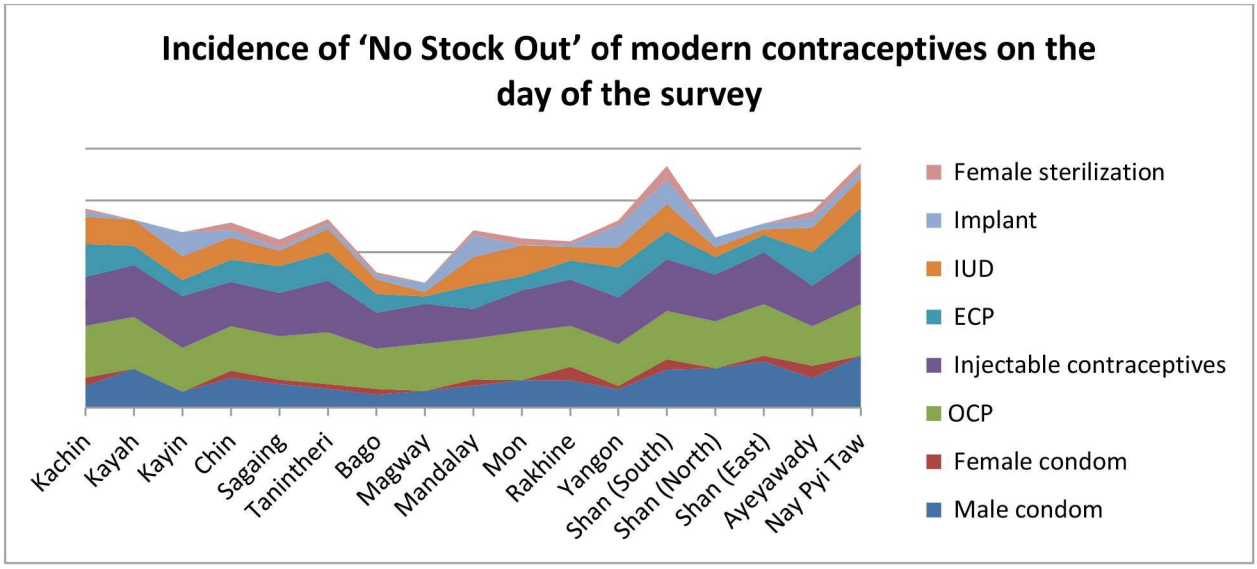


Table 3.34 Incidence of 'no stock-out' of modern contraceptives by urban/rural area

Incidence of 'no stock-out ' of modern contraceptives on the day of the survey*		Urban/Rural	
		Urban	Rural
Male condom	Freq	76	96
	%	50.0%	46.8%
Female condom	Freq	19	18
	%	12.5%	8.8%
OCP	Freq	124	182
	%	81.6%	88.8%
Injectable contraceptives	Freq	132	165
	%	86.8%	80.5%
ECP	Freq	80	80
	%	52.6%	39.0%
IUD	Freq	75	58
	%	49.3%	28.3%
Implant	Freq	50	20
	%	32.9%	9.8%
Female sterilization	Freq	21	9
	%	13.8%	4.4%

*Multiple response table.

Apart from the implant, ECP, IUD, and female sterilization where there were higher incidences of "no stock-outs" on the day of the survey in urban HFs, there were no differences in the "no stock-out" status on the day of the survey for other methods in urban and rural HFs.

Table 3.35 Incidence of 'no stock-outs' of modern contraceptives by location of health facility

			Distance to nearest medical depot (miles)		
			<10 miles	10-21 miles	>21 miles
Incidence of 'no stock-out' of modern contraceptives on the day of the survey*	Male condom	Freq	70	41	61
		%	50.7%	41.4%	50.8%
	Female condom	Freq	17	7	13
		%	12.3%	7.1%	10.8%
	OCP	Freq	119	82	105
		%	86.2%	82.8%	87.5%
	Injectable contraceptives	Freq	115	78	104
		%	83.3%	78.8%	86.7%
	ECP	Freq	78	34	48
		%	56.5%	34.3%	40.0%

IUD	Freq	55	30	48
	%	39.9%	30.3%	40.0%
Implant	Freq	30	15	25
	%	21.7%	15.2%	20.8%
Female sterilization	Freq	13	6	11
	%	9.4%	6.1%	9.2%

*Multiple response table.

Table 3.36 Incidence of 'no stock-outs' of modern contraceptives by distance of health facility to medical depot

Incidence of 'no stock-outs' of modern contraceptives on the day of the survey		Travel duration to nearest med. depot	
		Within a day	Within a week
Male condom	Freq	167	5
	%	48.1%	50.0%
Female condom	Freq	34	3
	%	9.8%	30.0%
OCP	Freq	297	9
	%	85.6%	90.0%
injectable contraceptives	Freq	288	9
	%	83.0%	90.0%
ECP	Freq	156	4
	%	45.0%	40.0%
IUD	Freq	127	6
	%	36.6%	60.0%
Implant	Freq	68	2
	%	19.6%	20.0%
Female sterilization	Freq	28	2
	%	8.1%	20.0%
Total	**Freq**	**347**	**10**

*Multiple response table.

Table 3.37 Incidence of 'no stock-outs' of modern contraceptives by mode of transport from health facility to medical depot

Incidence of 'no stock-outs 'of modern contraceptives on the day of the survey*		Mode of travel to nearest med. depot	
		Road	Water
Male condom	Freq	161	11
	%	47.8%	55.0%
Female condom	Freq	37	0
	%	11.0%	.0%
OCP	Freq	291	15
	%	86.4%	75.0%
Injectable contraceptives	Freq	279	18
	%	82.8%	90.0%
ECP	Freq	150	10
	%	44.5%	50.0%
IUD	Freq	129	4
	%	38.3%	20.0%
Implant	Freq	69	1
	%	20.5%	5.0%
Female sterilization	Freq	29	1
	%	8.6%	5.0%

*Multiple response table.

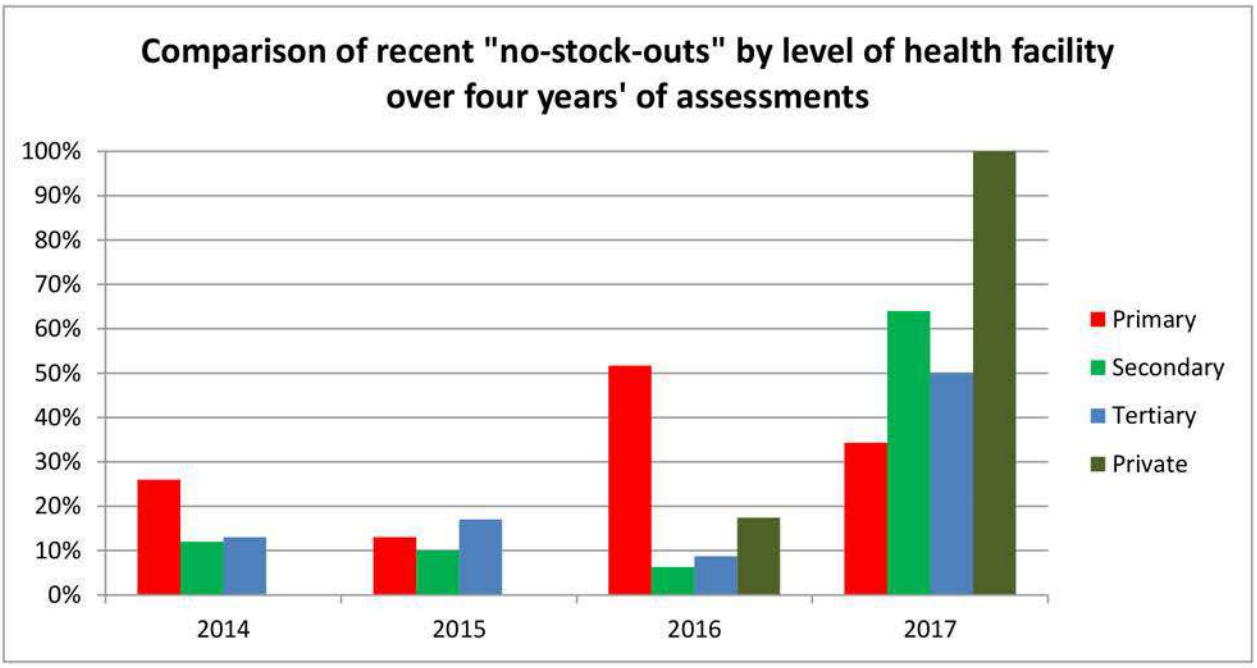
There was no significant association between the distance of HFs to the nearest medical depot and the recent stock status for each modern contraceptive.

The most common reasons for stock-outs (on the day of survey) were untimely supplies, no users and no skilled staff. These reasons were reported more frequently at secondary and primary level HFs.

Table 3.38 Level-wide comparison of recent stock-outs for at least one method between 2014, 2015, 2016 and 2017

Health facility level		2014			2015			2016			2017		
		Not at all	Stock-out of at least one method	Total	No stock-	Stock-out of at least one method	Total	No stock	Stock-out of at least one method	Total	No stock	Stock-out of at least one	Total
Tertiary	Freq	8	54	62	4	19	23	2	21	23	11	11	22
	%	13%	87%	100.00%	17%	83%	100.0%	8.7%	91.3%	100.0%	50.0%	50.0%	100.0%
Secondary	Freq	18	130	148	16	145	161	10	150	160	103	58	161
	%	12%	88%	100.00%	10%	90%	100.0%	6.3%	93.8%	100.0%	64.0%	36.0%	100.0%
Primary	Freq	52	146	198	22	150	172	89	83	172	62	119	181
	%	26%	74%	100.00%	13%	87%	100.0%	51.7%	48.3%	100.0%	34.3%	65.7%	100.0%
Private	Freq	-	-	-	-	-	-	4	19	23	19	0	19
	%	-	-	-	-	-	-	17.4%	82.6%	100.0%	100.0%	.0%	100.0%
Total	Freq	78	330	408	42	314	356	105	273	378	195	188	383
	%	19%	81%	100.00%	12%	88%	100.0%	27.8%	72.2%	100.0%	50.9%	49.1%	100.0%

Figure 3.7 Comparison of recent "no-stock-outs" by level of health facility over four years' of assessments



Private, tertiary level and secondary level HFs reported an increase in "no stock-out" rates. A comparison in trends for primary levels HFs over the four assessments showed that the percentage of "no stock-outs" had decreased in 2017.

Table 3.39 Comparison of stock-outs of specific methods between the 2017 assessment and the previous assessments in 2014, 2015, and 2016

Specific method	Specific method		Specific method		Specific method		Specific method	
	Specific method	Specific method	Specific method	Specific method	Specific method	Specific method	Specific method	Specific method
Long-acting and permanent methods								
Implant*	232	57%	124	67%	109	28.8%	124	67.8%
IUD	252	62%	171	48%	215	56.9%	129	33.7%
Male sterilization	NR	NR	NR	NR	NR	NR	NR	NR
Female sterilization*	29	14%	26	14%	90	49.2%	15	8.2
Short-term methods								
Male condom	183	45%	155	44%	153	40.5%	123	32.1%
Female condom	387	95%	174	49%	147	38.90%	149	38.9%
Prescribing injectables	122	30%	69	19%	59	15.6%	45	11.7%
OCP	116	28%	50	14%	53	14.0%	35	9.1%
ECP	399	98%	188	53%	164	43.4%	136	35.5%

*Calculation was made only for tertiary and secondary levels HFs.

A comparison of stock-outs for specific methods over the four years of assessments showed that there has been a reduction in stock-outs for male condoms, OCPs and injectable methods.

3.7 Supply chain, including cold chain

3.7.1 Person responsible for reordering supplies

Table 3.40 Percentage distribution of health facilities by persons responsible for ordering medical supplies by type of health facility

		Main person responsible for drug indent							
Level of Health Facility		MS/Head	Specialist/ Assigned MO	Pharmacist	Other	HA/LHV/ Sister	DMO	TMO	Total
Tertiary	Freq	12	6	0	1	1	2	0	22
	%	54.5%	27.3%	.0%	4.5%	4.5%	9.1%	.0%	100.0%
Secondary	Freq	23	93	11	13	8	0	13	161
	%	14.3%	57.8%	6.8%	8.1%	5.0%	.0%	8.1%	100.0%
Primary	Freq	0	13	146	5	15	0	2	181
	%	.0%	7.2%	80.7%	2.8%	8.3%	.0%	1.1%	100.0%
Private	Freq	9	1	1	0	7	0	1	19
	%	47.4%	5.3%	5.3%	.0%	36.8%	.0%	5.3%	100.0%
Total	**Freq**	**44**	**113**	**158**	**19**	**31**	**2**	**16**	**383**
	%	**11.5%**	**29.5%**	**41.3%**	**5.0%**	**8.1%**	**.5%**	**4.2%**	**100.0%**

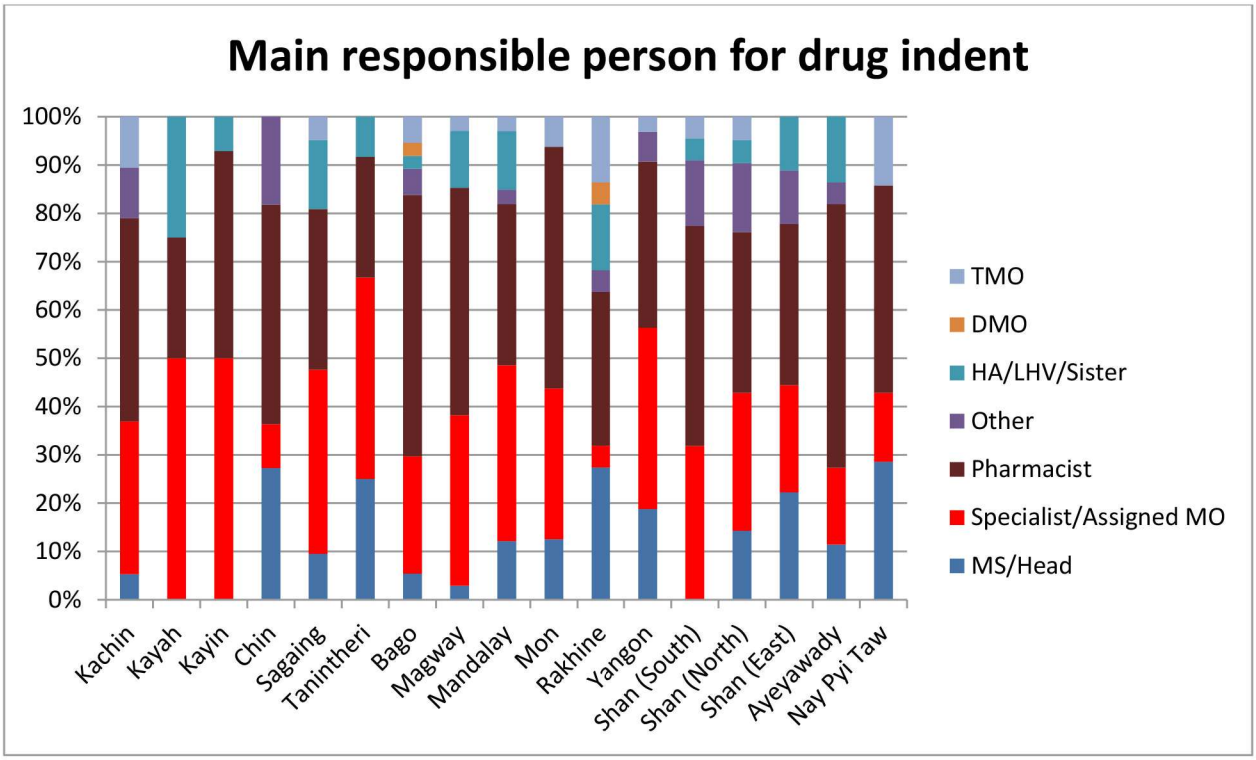
For all health facilities a pharmacist or assigned MO were the people primarily responsible for ordering medical supplies.

Table 3.41 Percentage distribution of health facilities by persons responsible for ordering medical supplies by state/region

		Main person responsible for drug indent							
State/Region		MS/Head	Specialist/ Assigned MO	Pharmacist	Other	HA/LHV/ Sister	DMO	TMO	Total
Kachin	Freq	1	6	8	2	0	0	2	19
	%	5.3%	31.6%	42.1%	10.5%	.0%	.0%	10.5%	100.0%
Kayah	Freq	0	4	2	0	2	0	0	8
	%	.0%	50.0%	25.0%	.0%	25.0%	.0%	.0%	100.0%
Kayin	Freq	0	7	6	0	1	0	0	14
	%	.0%	50.0%	42.9%	.0%	7.1%	.0%	.0%	100.0%
Chin	Freq	3	1	5	2	0	0	0	11
	%	27.3%	9.1%	45.5%	18.2%	.0%	.0%	.0%	100.0%
Sagaing	Freq	4	16	14	0	6	0	2	42
	%	9.5%	38.1%	33.3%	.0%	14.3%	.0%	4.8%	100.0%
Tanintheri	Freq	3	5	3	0	1	0	0	12
	%	25.0%	41.7%	25.0%	.0%	8.3%	.0%	.0%	100.0%
Bago	Freq	2	9	20	2	1	1	2	37
	%	5.4%	24.3%	54.1%	5.4%	2.7%	2.7%	5.4%	100.0%
Magway	Freq	1	12	16	0	4	0	1	34
	%	2.9%	35.3%	47.1%	.0%	11.8%	.0%	2.9%	100.0%
Mandalay	Freq	4	12	11	1	4	0	1	33
	%	12.1%	36.4%	33.3%	3.0%	12.1%	.0%	3.0%	100.0%
Mon	Freq	2	5	8	0	0	0	1	16
	%	12.5%	31.2%	50.0%	.0%	.0%	.0%	6.2%	100.0%
Rakhine	Freq	6	1	7	1	3	1	3	22
	%	27.3%	4.5%	31.8%	4.5%	13.6%	4.5%	13.6%	100.0%
Yangon	Freq	6	12	11	2	0	0	1	32
	%	18.8%	37.5%	34.4%	6.2%	.0%	.0%	3.1%	100.0%
Shan (South)	Freq	0	7	10	3	1	0	1	22
	%	.0%	31.8%	45.5%	13.6%	4.5%	.0%	4.5%	100.0%
Shan (North)	Freq	3	6	7	3	1	0	1	21
	%	14.3%	28.6%	33.3%	14.3%	4.8%	.0%	4.8%	100.0%
Shan (East)	Freq	2	2	3	1	1	0	0	9
	%	22.2%	22.2%	33.3%	11.1%	11.1%	.0%	.0%	100.0%
Ayeyawady	Freq	5	7	24	2	6	0	0	44
	%	11.4%	15.9%	54.5%	4.5%	13.6%	.0%	.0%	100.0%
Nay Pyi Taw	Freq	2	1	3	0	0	0	1	7
	%	28.6%	14.3%	42.9%	.0%	.0%	.0%	14.3%	100.0%
Total	**Freq**	**44**	**113**	**158**	**19**	**31**	**2**	**16**	**383**
	%	**11.5%**	**29.5%**	**41.3%**	**5.0%**	**8.1%**	**.5%**	**4.2%**	**100.0%**

By state/region a pharmacist or MO were primarily responsible for ordering medical supplies. The percentages for all persons responsible for ordering medical supplies by state/region are shown at Figure 3.9.

Figure 3.8 Percentage distribution of health facilities by person responsible for ordering medical supplies by state/region



The person responsible for ordering medical supplies did not vary significantly by state/region. Pharmacists were most frequently assigned in all states/regions.

Table 3.42 Percentage distribution of health facilities by person responsible for ordering medical supplies by urban/rural area

		Main person responsible for drug indent							
Urban/Rural		MS/Head	Specialist/ Assigned MO	Pharmacist	Other	HA/LHV/ Sister	DMO	TMO	Total
Urban	Freq	37	52	33	11	18	2	13	166
	%	22.3%	31.3%	19.9%	6.6%	10.8%	1.2%	7.8%	100.0%
Rural	Freq	7	61	125	8	13	0	3	217
	%	3.2%	28.1%	57.6%	3.7%	6.0%	.0%	1.4%	100.0%
Total	**Freq**	**44**	**113**	**158**	**19**	**31**	**2**	**16**	**383**
	%	**11.5%**	**29.5%**	**41.3%**	**5.0%**	**8.1%**	**.5%**	**4.2%**	**100.0%**

In urban HFs, the Medical Superintendent/Head, assigned MO and Pharmacist took responsibility for ordering medical supplies, while in rural HFs the Pharmacist, and assigned

MO were primarily responsible. This was a change from the findings of 2016 that inclusion of HAs were found among responsible persons in urban.

Table 3.43 Percentage distribution of health facilities by person responsible for ordering medical supplies by management of facility

		Main person responsible for drug indent							
Type of administration		MS/Head	Specialist/ Assigned MO	Pharmacist	Other	HA/LHV/ Sister	DMO	TMO	Total
Govt	Freq	36	113	158	18	23	2	16	366
	%	9.9%	30.7%	43.3%	4.9%	6.3%	.5%	4.4%	100.0%
Private	Freq	8	0	0	1	8	0	0	17
	%	47.1%	.0%	.0%	5.9%	47.1%	.0%	.0%	100.0%
Total	**Freq**	**44**	**113**	**158**	**19**	**31**	**2**	**16**	**383**
	%	**11.5%**	**29.5%**	**41.3%**	**5.0%**	**8.1%**	**.5%**	**4.2%**	**100.0%**

Private HFs more frequently assigned the responsibility for ordering medical supplies to the Sister and Head of the HF.

3.7.2 Quantifying resupplies

Table 3.44 How resupply is quantified by type of health facility

			How resupply is quantified*			
			(By calculation and indent)	(By supply depot)	(By other)	Total
Level of Health Facility	Tertiary	Freq	16	9	2	22
		%	72.7%	40.9%	9.1%	
	Secondary	Freq	89	93	9	161
		%	55.3%	57.8%	5.6%	
	Primary	Freq	78	119	4	181
		%	43.1%	65.7%	2.2%	
	Private	Freq	14	2	5	19
		%	73.7%	10.5%	26.3%	

*Multiple response table.

Supplies for the majority of primary and secondary level HFs were quantified by the medical depot (65.7 per cent and 57.8 per cent, respectively). Tertiary level HFs quantified supplies more by calculation (72.7 per cent).

Table 3.45 How resupply is quantified by state/region

			How resupply is quantified*			
			(By calculation and indent)	(By supply depot)	(By other)	Total
State/Region	Kachin	Freq	10	12	0	19
		%	52.6%	63.2%	.0%	
	Kayah	Freq	4	5	0	8
		%	50.0%	62.5%	.0%	
	Kayin	Freq	2	12	0	14
		%	14.3%	85.7%	.0%	
	Chin	Freq	3	8	0	11
		%	27.3%	72.7%	.0%	
	Sagaing	Freq	14	34	1	42
		%	33.3%	81.0%	2.4%	
	Tanintheri	Freq	9	8	0	12
		%	75.0%	66.7%	.0%	
	Bago	Freq	16	28	2	37
		%	43.2%	75.7%	5.4%	
	Magway	Freq	19	23	0	34
		%	55.9%	67.6%	.0%	
	Mandalay	Freq	20	15	6	33
		%	60.6%	45.5%	18.2%	

	Mon	Freq	3	13	0	16
		%	18.8%	81.2%	.0%	
	Rakhine	Freq	4	20	1	22
		%	18.2%	90.9%	4.5%	
	Yangon	Freq	27	2	4	32
		%	84.4%	6.2%	12.5%	
	Shan (South)	Freq	17	3	2	22
		%	77.3%	13.6%	9.1%	
	Shan (North)	Freq	8	13	1	21
		%	38.1%	61.9%	4.8%	
	Shan (East)	Freq	6	3	0	9
		%	66.7%	33.3%	.0%	
	Ayeyawady	Freq	30	20	2	44
		%	68.2%	45.5%	4.5%	
	Nay Pyi Taw	Freq	5	4	1	7
		%	71.4%	57.1%	14.3%	
Total		**Freq**	**197**	**223**	**20**	**383**

*Multiple response table.

Table 3.46 How resupply is quantified by urban/rural area

			How resupply is quantified*			
			(By calculation and indent)	(By supply depot)	(By other)	Total
Urban/Rural	Urban	Freq	106	76	13	106
		%	63.9%	45.8%	7.8%	63.9%
	Rural	Freq	91	147	7	91
		%	41.9%	67.7%	3.2%	41.9%
Total		**Freq**	**197**	**223**	**20**	**197**

*Multiple response table.

The supply needs of the majority of HFs both in urban and areas were calculated/estimated by the HFs themselves, while in rural HFs they were calculated by the depot. "Other" means the use of a facility stock report or form that is created by a higher level HF.

Table 3.47 How re-supply is quantified by management of facility

		How resupply is quantified*			
Type of administration		(By calculation and indent)	(By supply depot)	(By other)	Total
Govt	Freq	185	221	15	364
	%	48.3%	57.7%	3.9%	95.0%
Private	Freq	14	2	5	19
	%	73.7%	10.5%	26.3%	5.0%
Total	**Freq**	**197**	**223**	**20**	**383**

*Multiple response question.

Private sector HFs mainly quantified supply needs by calculation (73.7 per cent). Many HFs were using a computer-generated system.

Table 3.48 How re-supply is quantified by distance to depot from health facility

			How resupply is quantified*			
			(By calculation and indent)	(By supply depot)	(By other)	Total
Distance to nearest medical depot	<10 miles	Freq	89	71	11	147
		%	60.5%	48.3%	7.5%	
	10-21 miles	Freq	38	74	2	101
		%	37.6%	73.3%	2.0%	
	>21 miles	Freq	70	78	7	135
		%	51.9%	57.8%	5.2%	
Travel duration to nearest med. depot	Within a day	Freq	190	216	20	371
		%	51.2%	58.2%	5.4%	
	Within a week	Freq	7	7	0	12
		%	58.3%	58.3%	.0%	
Route to travel to nearest med. depot	Road	Freq	185	211	19	363
		%	51.0%	58.1%	5.2%	
	Water	Freq	12	12	1	20
		%	60.0%	60.0%	5.0%	
	Total	**Freq**	**197**	**223**	**20**	**383**

*Multiple response table.

3.7.3 Source of supplies

Table 3.49 Main source of supplies by type of health facility

			CMSD	State/Region Health Department	District Health Department	Township Health Department	Private Pharmacy/ Company	Total
Level of Health Facility	Tertiary	Freq	4	8	6	0	4	22
		%	18.2%	36.4%	27.3%	.0%	18.2%	100.0%
	Secondary	Freq	6	45	12	96	2	161
		%	3.7%	28.0%	7.5%	59.6%	1.2%	100.0%
	Primary	Freq	0	16	7	156	2	181
		%	.0%	8.8%	3.9%	86.2%	1.1%	100.0%
	Private	Freq	0	1	0	0	18	19
		%	.0%	5.3%	.0%	.0%	94.8%	100.0%
Total		**Freq**	**10**	**70**	**25**	**252**	**26**	**383**
		%	**2.6%**	**18.3%**	**6.5%**	**66.1%**	**6.5%**	**100.0%**

The main suppliers for HFs at all levels were the Township Health Departments and State/Region Health Departments at 66.1 per cent and 18.3 per cent, respectively. However, the suppliers for the majority of tertiary level HFs were the Central Medical Store Depot (CMDS) and the State/Region Health Depot (18.2 per cent and 36.4 per cent, respectively).

Table 3.50 Main source of supplies by state/region

			CMSD	State/Region Health Department	District Health Department	Township Health Department	Private Pharmacy/ Company	Total
State/Region	Kachin	Freq	1	7	1	9	1	19
		%	5.3%	36.8%	5.3%	47.4%	5.3%	100.0%
	Kayah	Freq	0	7	0	0	1	8
		%	.0%	87.5%	.0%	.0%	12.5%	100.0%
	Kayin	Freq	0	1	3	9	1	14
		%	.0%	7.1%	21.4%	64.3%	7.1%	100.0%
	Chin	Freq	1	1	1	8	0	11
		%	9.1%	9.1%	9.1%	72.7%	.0%	100.0%
	Sagaing	Freq	1	7	4	28	2	42
		%	2.4%	16.7%	9.5%	66.7%	4.8%	100.0%
	Tanintheri	Freq	1	2	1	7	1	12
		%	8.3%	16.7%	8.3%	58.3%	8.3%	100.0%
	Bago	Freq	0	6	2	28	1	37
		%	.0%	16.2%	5.4%	75.7%	2.7%	100.0%
	Magway	Freq	1	4	4	23	2	34
		%	2.9%	11.8%	11.8%	67.6%	5.9%	100.0%
	Mandalay	Freq	0	4	3	23	3	33
		%	.0%	12.1%	9.1%	69.7%	9.1%	100.0%
	Mon	Freq	0	1	0	13	2	16
		%	.0%	6.2%	.0%	81.2%	12.5%	100.0%
	Rakhine	Freq	1	4	0	16	1	22
		%	4.5%	18.2%	.0%	72.7%	4.5%	100.0%
	Yangon	Freq	0	12	0	16	4	32
		%	.0%	37.5%	.0%	50.0%	12.5%	100.0%
	Shan (South)	Freq	0	3	2	16	1	22
		%	.0%	13.6%	9.1%	72.7%	4.5%	100.0%
	Shan (North)	Freq	0	3	3	14	1	21
		%	.0%	14.3%	14.3%	66.7%	4.8%	100.0%
	Shan (East)	Freq	2	3	0	4	0	9
		%	22.2%	33.3%	.0%	44.4%	.0%	100.0%
	Ayeyawady	Freq	2	4	1	35	2	44
		%	4.5%	9.1%	2.3%	79.5%	4.5%	100.0%
	Nay Pyi Taw	Freq	0	1	0	4	2	7
		%	.0%	14.3%	.0%	57.1%	28.6%	100.0%
Total		**Freq**	**10**	**70**	**25**	**253**	**25**	**383**
		%	**2.6%**	**18.3%**	**6.5%**	**66.1%**	**6.5%**	**100.0%**

Table 3.51 Main source of supplies by management of facility

			CMSD	State/Region Health Department	District Health Department	Township Health Department	Private Pharmacy/ Company	Total
Type of administration	Govt	Freq	10	69	25	252	8	364
		%	2.7%	19.2%	6.8%	69.3%	1.9%	100.0%
	Private	Freq	0	1	0	0	17	19
		%	.0%	5.3%	.0%	.0%	94.8%	100.0%
Total		**Freq**	**10**	**70**	**25**	**253**	**26**	**383**
		%	**2.6%**	**18.3%**	**6.5%**	**66.1%**	**6.5%**	**100.0%**

The main source of supplies for private sector HFs was private pharmacies and companies.

Table 3.52 Main source of supplies by urban/rural area

			CMSD	State/Region Health Department	District Health Department	Township Health Department	Private Pharmacy/ Company	
Urban/Rural	Urban	Freq	8	57	15	61	25	166
		%	4.8%	34.3%	9.0%	36.7%	15.1%	100.0%
	Rural	Freq	2	13	10	192	0	217
		%	.9%	6.0%	4.6%	88.5%	.0%	100.0%
Total		Freq	10	70	25	253	25	383
		%	2.6%	18.3%	6.5%	66.1%	6.5%	100.0%

The main suppliers for HFs in urban areas were State/Region Health Departments and Township Heath Departments (36.7 per cent and 34.3 per cent, respectively). The main suppliers for HFs in rural areas were Township Health Departments (88.5 per cent).

3.7.4 Transportation of supplies

Table 3.53 Responsibility for transportation of supplies by type of health facility

			Responsibility for transportation of supplies				
			(Government)	(State/Region Health Department)	(Own arrangement)	(Other)	Total
Level of Health Facility	Tertiary	Freq	5	2	17	4	22
		%	22.7%	9.1%	77.3%	18.2%	
	Secondary	Freq	21	14	135	11	161
		%	13.0%	8.7%	83.9%	6.8%	
	Primary	Freq	7	1	167	10	181
		%	3.9%	.6%	92.3%	5.5%	
	Private	Freq	0	0	5	15	19
		%	.0%	.0%	26.3%	78.9%	
	Total	**Freq**	**33**	**17**	**324**	**40**	**383**

Most HFs (more than 75 per cent) at all levels made their own arrangements for transportation of supplies to their HFs. Government arrangements for transportation of supplies for tertiary and secondary level HFs were only 22.7 per cent and 13 per cent, respectively.

Table 3.54 Responsibility for transportation of supplies by state/region

			Responsibility for transportation of supplies				
			(Government)	(State/Region Health Department)	(Own arrangement)	(Other)	Total
State/Region	Kachin	Freq	3	4	9	3	19
		%	15.8%	21.1%	47.4%	15.8%	
	Kayah	Freq	0	0	8	0	8
		%	.0%	.0%	100.0%	.0%	
	Kayin	Freq	1	0	12	1	14
		%	7.1%	.0%	85.7%	7.1%	
	Chin	Freq	4	0	7	1	11
		%	36.4%	.0%	63.6%	9.1%	
	Sagaing	Freq	5	0	37	1	42
		%	11.9%	.0%	88.1%	2.4%	
	Tanintheri	Freq	1	0	11	2	12
		%	8.3%	.0%	91.7%	16.7%	
	Bago	Freq	4	2	34	3	37
		%	10.8%	5.4%	91.9%	8.1%	
	Magway	Freq	3	1	29	1	34
		%	8.8%	2.9%	85.3%	2.9%	
	Mandalay	Freq	0	4	31	2	33
		%	.0%	12.1%	93.9%	6.1%	
	Mon	Freq	2	0	13	1	16
		%	12.5%	.0%	81.2%	6.2%	
	Rakhine	Freq	5	2	18	2	22
		%	22.7%	9.1%	81.8%	9.1%	
	Yangon	Freq	1	0	27	10	32
		%	3.1%	.0%	84.4%	31.2%	
	Shan (South)	Freq	2	0	17	5	22
		%	9.1%	.0%	77.3%	22.7%	
	Shan (North)	Freq	1	1	19	2	21
		%	4.8%	4.8%	90.5%	9.5%	
	Shan (East)	Freq	0	0	9	0	9
		%	.0%	.0%	100.0%	.0%	
	Ayeyawady	Freq	1	3	38	4	44
		%	2.3%	6.8%	86.4%	9.1%	
	Nay Pyi Taw	Freq	0	0	5	2	7
		%	.0%	.0%	71.4%	28.6%	
Total		**Freq**	**33**	**17**	**324**	**40**	**383**

Table 3.54 shows that most HFs arranged the transportation of supplies themselves in all states/regions. States/region arrangements were identified in some HFs in Kachin, Mandalay and Rakhine.

Table 3.55 Responsibility for transportation of supplies by urban/rural area

			Responsibility for transportation of supplies				
			(Government)	(State/Region Health Department)	(Own arrangement)	(Other)	Total
Urban/Rural	Urban	Freq	22	14	123	32	166
		%	13.3%	8.4%	74.1%	19.3%	
	Rural	Freq	11	3	201	8	217
		%	5.1%	1.4%	92.6%	3.7%	
	Total	**Freq**	**33**	**17**	**324**	**40**	**383**

An urban/rural difference for transportation by HFs themselves was noted (74.1 per cent vs. 92.6 per cent). Government arranged transportation in 13.3 per cent of HFs in urban areas and 5.1 per cent of HFs in rural areas.

Table 3.56 Responsibility for transportation of supplies by management of facility

			Responsibility for transportation of supplies				
			(Government)	(State/Region Health Department)	(Own arrangement)	(Other)	Total
Type of administration	Govt	Freq	33	17	319	25	364
		%	9.0%	4.7%	87.4%	6.8%	
	Private	Freq	0	0	5	15	19
		%	.0%	.0%	26.3%	78.9%	
	Total	**Freq**	**33**	**17**	**324**	**40**	**383**

3.7.5 Length of time between ordering and receiving supplies

Table 3.57 Estimated length of time between ordering and receiving supplies by type of health facility

			Interval between indent and arrival							
			<2 weeks	2 weeks-1 month	1-2 months	2-4 months	4-6 months	>6 months	No regular interval	Total
Level of Health Facility	Tertiary	Freq	3	3	1	0	2	1	12	22
		%	13.6%	13.6%	4.5%	.0%	9.1%	4.5%	54.5%	100.0%
	Secondary	Freq	10	10	8	13	11	6	103	161
		%	6.2%	6.2%	5.0%	8.1%	6.8%	3.7%	64.0%	100.0%
	Primary	Freq	15	8	4	5	5	6	138	181
		%	8.3%	4.4%	2.2%	2.8%	2.8%	3.3%	76.2%	100.0%
	Private	Freq	5	1	1	1	0	0	11	19
		%	26.3%	5.3%	5.3%	5.3%	.0%	.0%	57.9%	100.0%
Total		**Freq**	**33**	**22**	**14**	**19**	**18**	**13**	**264**	**383**
		%	**8.6%**	**5.7%**	**3.7%**	**5.0%**	**4.7%**	**3.4%**	**68.9%**	**100.0%**

The majority of HFs, especially secondary and primary level HFs, stated that the interval between the order and receipt of supplies was irregular (64 per cent and 76 per cent, respectively). At 13.6 per cent of HFs at the tertiary level the interval was estimated as less than two weeks. About two-thirds of HFs at all levels said that the interval was irregular.

Table 3.58 Estimated length of time between ordering and receiving supplies by state/region

			Interval between indent and arrival							
			<2 weeks	2 weeks-1 month	1-2 months	2-4 months	4-6 months	> 6months	No regular interval	Total
State/Region	Kachin	Freq	0	1	0	4	3	1	10	19
		%	.0%	5.3%	.0%	21.1%	15.8%	5.3%	52.6%	100.0%
	Kayah	Freq	1	0	1	0	0	0	6	8
		%	12.5%	.0%	12.5%	.0%	.0%	.0%	75.0%	100.0%
	Kayin	Freq	0	0	1	0	0	0	13	14
		%	.0%	.0%	7.1%	.0%	.0%	.0%	92.9%	100.0%
	Chin	Freq	0	0	0	1	1	0	9	11
		%	.0%	.0%	.0%	9.1%	9.1%	.0%	81.8%	100.0%
	Sagaing	Freq	1	0	0	0	0	2	39	42
		%	2.4%	.0%	.0%	.0%	.0%	4.8%	92.9%	100.0%
	Tanintheri	Freq	0	1	0	3	1	0	7	12
		%	.0%	8.3%	.0%	25.0%	8.3%	.0%	58.3%	100.0%
	Bago	Freq	0	1	0	2	2	0	32	37
		%	.0%	2.7%	.0%	5.4%	5.4%	.0%	86.5%	100.0%
	Magway	Freq	2	0	2	0	6	2	22	34
		%	5.9%	.0%	5.9%	.0%	17.6%	5.9%	64.7%	100.0%
	Mandalay	Freq	3	1	1	0	0	1	27	33
		%	9.1%	3.0%	3.0%	.0%	.0%	3.0%	81.8%	100.0%
	Mon	Freq	1	0	1	0	2	1	11	16
		%	6.2%	.0%	6.2%	.0%	12.5%	6.2%	68.8%	100.0%
	Rakhine	Freq	0	0	0	0	1	1	20	22
		%	.0%	.0%	.0%	.0%	4.5%	4.5%	90.9%	100.0%
	Yangon	Freq	3	9	3	2	1	0	14	32
		%	9.4%	28.1%	9.4%	6.2%	3.1%	.0%	43.8%	100.0%
	Shan (South)	Freq	12	2	1	2	1	0	4	22
		%	54.5%	9.1%	4.5%	9.1%	4.5%	.0%	18.2%	100.0%
	Shan (North)	Freq	2	2	0	0	0	2	15	21
		%	9.5%	9.5%	.0%	.0%	.0%	9.5%	71.4%	100.0%
	Shan (East)	Freq	0	0	1	3	0	1	4	9
		%	.0%	.0%	11.1%	33.3%	.0%	11.1%	44.4%	100.0%
	Ayeyawady	Freq	8	4	3	2	0	2	25	44
		%	18.2%	9.1%	6.8%	4.5%	.0%	4.5%	56.8%	100.0%
	Nay Pyi Taw	Freq	0	1	0	0	0	0	6	7
		%	.0%	14.3%	.0%	.0%	.0%	.0%	85.7%	100.0%
Total		**Freq**	**33**	**22**	**14**	**19**	**18**	**13**	**264**	**383**
		%	**8.6%**	**5.7%**	**3.7%**	**5.0%**	**4.7%**	**3.4%**	**68.9%**	**100.0%**

Table 3.59 Estimated length of time between ordering and receiving supplies by urban/rural area

			Interval between indent and arrival							
			<2 weeks	2 weeks-1 month	1-2 months	2-4 months	4-6 months	>6 months	No regular interval	Total
Urban/Rural	Urban	Freq	19	11	8	12	11	7	98	166
		%	11.4%	6.6%	4.8%	7.2%	6.6%	4.2%	59.0%	100.0%
	Rural	Freq	14	11	6	7	7	6	166	217
		%	6.5%	5.1%	2.8%	3.2%	3.2%	2.8%	76.5%	100.0%
Total		**Freq**	**33**	**22**	**14**	**19**	**18**	**13**	**264**	**383**
		%	**8.6%**	**5.7%**	**3.7%**	**5.0%**	**4.7%**	**3.4%**	**68.9%**	**100.0%**

The percentage of HFs with an irregular interval significantly differed between HFs in urban and rural areas (59 per cent urban vs. 76.5 per cent rural).

Table 3.60 Estimated length of time between ordering and receiving supplies by management of health facility

			Interval between indent and arrival							
			<2 weeks	2 weeks-1 month	1-2 months	2-4 months	4-6 months	>6 months	No regular interval	Total
Type of administration	Govt	Freq	28	21	13	18	18	13	253	364
		%	7.7%	5.8%	3.6%	5.2%	4.9%	3.6%	69.5%	100.0%
	Private	Freq	5	1	1	1	0	0	11	19
		%	26.3%	5.3%	5.3%	5.3%	.0%	.0%	57.9%	100.0%
	Total	**Freq**	**33**	**22**	**14**	**19**	**18**	**13**	**264**	**383**
		%	**8.6%**	**5.7%**	**3.7%**	**5.0%**	**4.7%**	**3.4%**	**68.9%**	**100.0%**

In private HFs 26.3 per cent received drug supplies over a relatively short interval (less than two weeks).

3.7.6 Frequency of resupply

Table 3.61 Frequency of resupply by type of health facility

			Interval between indents						
			Every 2 weeks	Once a month	Every 3 months	Every 6 months	Once a year	Irregular	Total
Level of Health Facility	Tertiary	Freq	1	3	0	10	1	7	22
		%	4.5%	13.6%	.0%	45.5%	4.5%	31.8%	100.0%
	Secondary	Freq	0	14	13	58	6	70	161
		%	.0%	8.7%	8.1%	36.0%	3.7%	43.5%	100.0%
	Primary	Freq	0	27	22	46	11	75	181
		%	.0%	14.9%	12.2%	25.4%	6.1%	41.4%	100.0%
	Private	Freq	5	3	0	1	0	10	19
		%	26.3%	15.8%	.0%	5.3%	.0%	52.6%	100.0%
	Total	**Freq**	**6**	**47**	**35**	**115**	**18**	**162**	**383**
		%	**1.6%**	**12.3%**	**9.1%**	**30.0%**	**4.7%**	**42.3%**	**100.0%**

Forty-two per cent of HFs described the interval between indents and supplies as irregular. This irregularity was more pronounced in private HFs (52.6 per cent). An irregular resupply at HFs in the government sector at all levels of HFs was observed (around 35 per cent).

Table 3.62 Frequency of resupply by state/region

			Interval between indents						
			Every 2 weeks	Once a month	Every 3 months	Every 6 months	Once a year	Irregular	Total
State/Region	Kachin	Freq	0	0	8	8	2	1	19
		%	.0%	.0%	42.1%	42.1%	10.5%	5.3%	100.0%
	Kayah	Freq	0	1	1	2	0	4	8
		%	.0%	12.5%	12.5%	25.0%	.0%	50.0%	100.0%
	Kayin	Freq	0	5	1	0	0	8	14
		%	.0%	35.7%	7.1%	.0%	.0%	57.1%	100.0%
	Chin	Freq	0	0	1	3	1	6	11
		%	.0%	.0%	9.1%	27.3%	9.1%	54.5%	100.0%
	Sagaing	Freq	0	2	2	24	1	13	42
		%	.0%	4.8%	4.8%	57.1%	2.4%	31.0%	100.0%
	Tanintheri	Freq	1	1	1	4	0	5	12
		%	8.3%	8.3%	8.3%	33.3%	.0%	41.7%	100.0%
	Bago	Freq	1	0	5	12	0	19	37
		%	2.7%	.0%	13.5%	32.4%	.0%	51.4%	100.0%
	Magway	Freq	0	2	1	19	4	8	34
		%	.0%	5.9%	2.9%	55.9%	11.8%	23.5%	100.0%
	Mandalay	Freq	0	2	0	11	2	18	33
		%	.0%	6.1%	.0%	33.3%	6.1%	54.5%	100.0%
	Mon	Freq	1	2	2	5	0	6	16
		%	6.2%	12.5%	12.5%	31.2%	.0%	37.5%	100.0%
	Rakhine	Freq	0	0	0	2	0	20	22
		%	.0%	.0%	.0%	9.1%	.0%	90.9%	100.0%
	Yangon	Freq	1	2	2	8	6	13	32
		%	3.1%	6.2%	6.2%	25.0%	18.8%	40.6%	100.0%
	Shan (South)	Freq	0	12	2	3	1	4	22
		%	.0%	54.5%	9.1%	13.6%	4.5%	18.2%	100.0%
	Shan (North)	Freq	1	2	1	9	1	7	21
		%	4.8%	9.5%	4.8%	42.9%	4.8%	33.3%	100.0%
	Shan (East)	Freq	0	0	4	2	0	3	9
		%	.0%	.0%	44.4%	22.2%	.0%	33.3%	100.0%
	Ayeyawady	Freq	0	14	4	3	0	23	44
		%	.0%	31.8%	9.1%	6.8%	.0%	52.3%	100.0%
	Nay Pyi Taw	Freq	1	2	0	0	0	4	7
		%	14.3%	28.6%	.0%	.0%	.0%	57.1%	100.0%
Total		**Freq**	**6**	**47**	**35**	**115**	**18**	**162**	**383**
		%	**1.6%**	**12.3%**	**9.1%**	**30.0%**	**4.7%**	**42.3%**	**100.0%**

Table 3.63 Frequency of resupply by urban/rural area

			Interval between indents						
			Every 2 weeks	Once a month	Every 3 months	Every 6 months	Once a year	Irregular	Total
Urban/Rural	Urban	Freq	6	17	14	51	10	68	166
		%	3.6%	10.2%	8.4%	30.7%	6.0%	41.0%	100.0%
	Rural	Freq	0	30	21	64	8	94	217
		%	.0%	13.8%	9.7%	29.5%	3.7%	43.3%	100.0%
	Total	**Freq**	**6**	**47**	**35**	**115**	**18**	**162**	**383**
		%	**1.6%**	**12.3%**	**9.1%**	**30.0%**	**4.7%**	**42.3%**	**100.0%**

An irregular interval between indents and supplies was observed in HFs in urban and rural areas (41per cent vs. 43.3 per cent), with no notable differences.

Table 3.64 Frequency of resupply by management of facility

			Interval between indents						
			Every 2 weeks	Once a month	Every 3 months	Every 6 months	Once a year	Irregular	Total
Type of administration	Govt	Freq	1	44	35	114	17	152	364
		%	.3%	12.1%	9.6%	31.3%	4.7%	41.7%	100.0%
	Private	Freq	5	3	0	1	0	10	19
		%	26.3%	15.8%	.0%	5.3%	.0%	52.6%	100.0%
	Total	**Freq**	**6**	**47**	**35**	**115**	**18**	**162**	**383**
		%	**1.6%**	**12.3%**	**9.1%**	**30.0%**	**4.7%**	**42.3%**	**100.0%**

Irregularity in the frequency of resupply was more pronounced in private HFs than HFs in the government sector (52.6 per cent vs. 41.7 per cent).

3.7.7 Availability of a cold chain

Table 3.65 Availability of cold chain by type of health facility

			Have cold chain system		
			Yes	No	Total
Level of Health Facility	Tertiary	Freq	22	0	22
		%	100.0%	.0%	100.0%
	Secondary	Freq	134	27	161
		%	83.2%	16.8%	100.0%
	Primary	Freq	78	103	181
		%	43.1%	56.9%	100.0%
	Private	Freq	18	1	19
		%	94.7%	5.3%	100.0%
Total		**Freq**	**252**	**131**	**383**
		%	**65.8%**	**34.2%**	**100.0%**

The availability of a cold chain at all HFs was 65.8 per cent. The percentage was higher in tertiary and secondary level HFs at 100 per cent and 83.2 per cent, respectively, and much lower in primary level HFs at 43.1 per cent. The difference was statistically significant. Almost all private HFs had a cold chain system.

Table 3.66 Availability of a cold chain by state/region

			Have cold chain system		
			Yes	No	Total
State/Region	Kachin	Freq	13	6	19
		%	68.4%	31.6%	100.0%
	Kayah	Freq	5	3	8
		%	62.5%	37.5%	100.0%
	Kayin	Freq	11	3	14
		%	78.6%	21.4%	100.0%
	Chin	Freq	6	5	11
		%	54.5%	45.5%	100.0%
	Sagaing	Freq	33	9	42
		%	78.6%	21.4%	100.0%
	Tanintheri	Freq	7	5	12
		%	58.3%	41.7%	100.0%
	Bago	Freq	21	16	37
		%	56.8%	43.2%	100.0%
	Magway	Freq	20	14	34
		%	58.8%	41.2%	100.0%
	Mandalay	Freq	25	8	33
		%	75.8%	24.2%	100.0%
	Mon	Freq	11	5	16
		%	68.8%	31.2%	100.0%
	Rakhine	Freq	10	12	22
		%	45.5%	54.5%	100.0%
	Yangon	Freq	24	8	32
		%	75.0%	25.0%	100.0%
	Shan (South)	Freq	13	9	22
		%	59.1%	40.9%	100.0%
	Shan (North)	Freq	15	6	21
		%	71.4%	28.6%	100.0%
	Shan (East)	Freq	7	2	9
		%	77.8%	22.2%	100.0%
	Ayeyawady	Freq	26	18	44
		%	59.1%	40.9%	100.0%
	Nay Pyi Taw	Freq	5	2	7
		%	71.4%	28.6%	100.0%
Total		**Freq**	**252**	**131**	**383**
		%	**65.8%**	**34.2%**	**100.0%**

The overall availability of a cold chain system at all HFs was 65.8 per cent, with variations among states/regions observed. In Rakhine, Chin, Bago, Tanintheri, Magway, Shan (S), and

Ayayawady States/Regions availability was less than 60 per cent. In Sagaing Region and Kayin State more than 70 per cent of HFs had a cold chain system.

Figure 3.9 Percentage of health facilities with a cold chain system by state/region

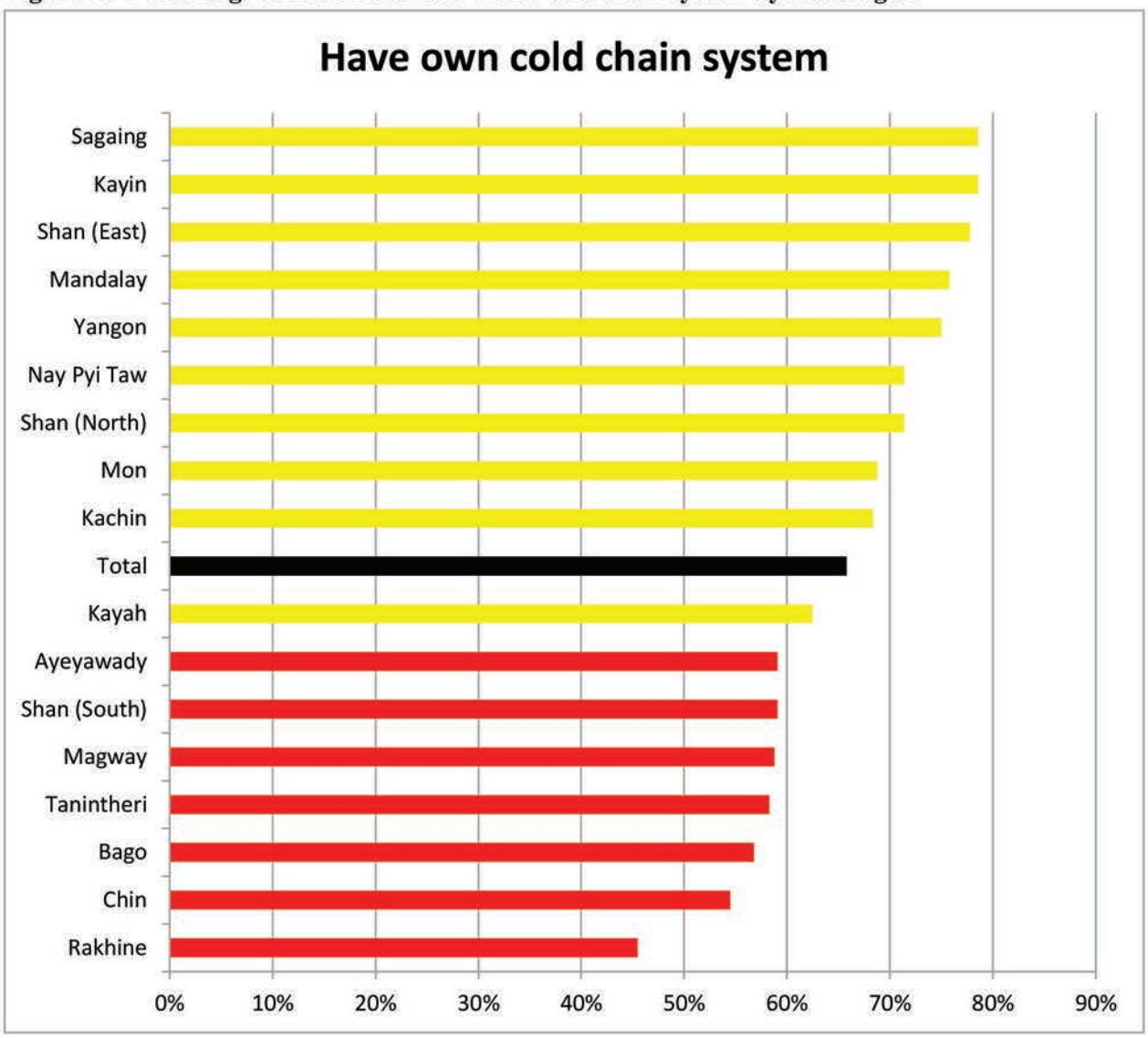


Table 3.67 Availability of a cold chain by urban/rural area

			Have cold chain system		
			Yes	No	Total
Urban/Rural	Urban	Freq	131	35	166
		%	78.9%	21.1%	100.0%
	Rural	Freq	121	96	217
		%	55.8%	44.2%	100.0%
Total		**Freq**	**252**	**131**	**383**
		%	**65.8%**	**34.2%**	**100.0%**

The urban/rural difference in the availability of a cold chain system was apparent (78.9 per cent vs. 55.8 per cent).

Table 3.68 Availability of a cold chain by management of facility

			Have cold chain system		
			Yes	No	Total
Type of administration	Govt	Freq	234	130	364
		%	64.3%	35.7%	100.0%
	Private	Freq	18	1	19
		%	94.7%	5.3%	100.0%
	Total	**Freq**	**252**	**131**	**383**
		%	**65.8%**	**34.2%**	**100.0%**

In the government sector 64.3 per cent of HFs had a cold chain system, compared to 95 per cent of HFs in the private sector.

Table 3.69 Type of cold chain by level of health facility, by state/region, by urban/rural area

			Type of cold chain*			
			(Fridge)	(Refillable icebox)	(Other)	Total
Level of Health Facility	Tertiary	Freq	22	1	0	22
		%	100.0%	4.5%	.0%	
	Secondary	Freq	132	5	3	134
		%	98.5%	3.7%	2.2%	
	Primary	Freq	71	11	2	78
		%	91.0%	14.1%	2.6%	
	Private	Freq	17	3	2	18
		%	94.4%	16.7%	11.1%	
State/Region	Kachin	Freq	13	0	0	13
		%	100.0%	.0%	.0%	
	Kayah	Freq	5	0	0	5
		%	100.0%	.0%	.0%	
	Kayin	Freq	11	0	0	11
		%	100.0%	.0%	.0%	
	Chin	Freq	4	3	0	6
		%	66.7%	50.0%	.0%	
	Sagaing	Freq	31	10	0	33
		%	93.9%	30.3%	.0%	
	Tanintheri	Freq	7	1	0	7
		%	100.0%	14.3%	.0%	
	Bago	Freq	20	2	1	21
		%	95.2%	9.5%	4.8%	
	Magway	Freq	19	1	0	20
		%	95.0%	5.0%	.0%	
	Mandalay	Freq	23	0	5	25
		%	92.0%	.0%	20.0%	
	Mon	Freq	11	0	0	11
		%	100.0%	.0%	.0%	
	Rakhine	Freq	9	2	0	10
		%	90.0%	20.0%	.0%	
	Yangon	Freq	23	1	1	24
		%	95.8%	4.2%	4.2%	
	Shan (South)	Freq	13	0	0	13
		%	100.0%	.0%	.0%	
	Shan (North)	Freq	15	0	0	15
		%	100.0%	.0%	.0%	
	Shan (East)	Freq	7	0	0	7
		%	100.0%	.0%	.0%	
	Ayeyawady	Freq	26	0	0	26
		%	100.0%	.0%	.0%	
	Nay Pyi Taw	Freq	5	0	0	5
		%	100.0%	.0%	.0%	
Urban/Rural	Urban	Freq	128	8	4	131
		%	97.7%	6.1%	3.1%	
	Rural	Freq	114	12	3	121
		%	94.2%	9.9%	2.5%	
Type of administration	Govt	Freq	226	17	5	234
		%	96.2%	7.3%	2.1%	
	Private	Freq	17	3	2	18
		%	94.4%	16.7%	11.1%	
Total		**Freq**	**242**	**20**	**7**	**252**

*Multiple response table.

Of those HFs that had a cold chain system, more than 90 per cent used an electrical system and less than 7 per cent used an ice box. The difference in the percentages of HFs using an electrical system at the secondary and tertiary levels and the primary level was not

significant. There was no obvious urban/rural difference in the percentages of HFs using an electric type cold chain (97 per cent vs. 94 per cent). Difference between government and private HFs was also not apparent.

Table 3.70 Source of power for fridge used for cold chain by type of health facility

			Source of power for fridge*						
			Electricity from grid	Electricity from generator	Electricity from mobile generator	Electricity from kerosene system	Electricity from solar system	Electricity from hydro-power generator	Total
Level of Health Facility	Tertiary	Freq	21	5	0	0	1	0	22
		%	95.5%	22.7%	.0%	.0%	4.5%	.0%	
	Secondary	Freq	106	45	3	1	35	3	134
		%	79.1%	33.6%	2.2%	.7%	26.1%	2.2%	
	Primary	Freq	43	4	1	1	28	1	71
		%	60.6%	5.6%	1.4%	1.4%	39.4%	1.4%	
	Private	Freq	16	6	0	0	0	0	16
		%	100.0%	37.5%	.0%	.0%	.0%	.0%	
	Total	**Freq**	**186**	**60**	**4**	**2**	**64**	**4**	**243**

*Multiple response table.

The power supply for the majority of cold chain systems was a regular supply system. Some tertiary and secondary level and private HFs had their own generators (22.7 per cent, 33.6 per cent and 37.5 per cent, respectively). About 26 per cent of secondary level HFs and 39 per cent of primary level HFs used solar power.

Table 3.71 Source of power for fridge used for cold chain by state/region

			Source of power for fridge						
			Electricity from grid	Electricity from generator	Electricity from mobile generator	Electricity from kerosene system	Electricity from solar system	Electricity from hydro-power generator	Total
State/Region	Kachin	Freq	9	2	0	0	3	1	13
		%	69.2%	15.4%	.0%	.0%	23.1%	7.7%	
	Kayah	Freq	5	1	0	0	0	0	5
		%	100.0%	20.0%	.0%	.0%	.0%	.0%	
	Kayin	Freq	7	2	0	0	4	0	11
		%	63.6%	18.2%	.0%	.0%	36.4%	.0%	
	Chin	Freq	3	1	0	0	1	0	4
		%	75.0%	25.0%	.0%	.0%	25.0%	.0%	
	Sagaing	Freq	21	0	0	1	10	0	31
		%	67.7%	.0%	.0%	3.2%	32.3%	.0%	
	Tanintheri	Freq	6	1	0	0	0	0	6
		%	100.0%	16.7%	.0%	.0%	.0%	.0%	
	Bago	Freq	18	10	2	0	4	0	20
		%	90.0%	50.0%	10.0%	.0%	20.0%	.0%	
	Magway	Freq	14	3	0	0	6	0	20
		%	70.0%	15.0%	.0%	.0%	30.0%	.0%	
	Mandalay	Freq	23	0	0	0	2	0	25
		%	92.0%	.0%	.0%	.0%	8.0%	.0%	
	Mon	Freq	9	2	1	0	2	1	11
		%	81.8%	18.2%	9.1%	.0%	18.2%	9.1%	
	Rakhine	Freq	4	6	0	0	5	1	8
		%	50.0%	75.0%	.0%	.0%	62.5%	12.5%	
	Yangon	Freq	23	11	0	0	1	0	23
		%	100.0%	47.8%	.0%	.0%	4.3%	.0%	
	Shan (South)	Freq	10	5	0	1	5	0	13
		%	76.9%	38.5%	.0%	7.7%	38.5%	.0%	
	Shan (North)	Freq	11	4	0	0	5	0	15
		%	73.3%	26.7%	.0%	.0%	33.3%	.0%	
	Shan (East)	Freq	4	0	0	0	4	0	7
		%	57.1%	.0%	.0%	.0%	57.1%	.0%	
	Ayeyawady	Freq	14	9	1	0	12	1	26
		%	53.8%	34.6%	3.8%	.0%	46.2%	3.8%	
	Nay Pyi	Freq	5	3	0	0	0	0	5
	Taw	%	100.0%	60.0%	.0%	.0%	.0%	.0%	
Total		**Freq**	**186**	**60**	**4**	**2**	**64**	**4**	**243**

Table 3.72 Source of power for fridge used for cold chain by urban/rural area

			Source of power for fridge						
			Electricity from grid	Electricity from generator	Electricity from mobile generator	Electricity from kerosene system	Electricity from solar system	Electricity from hydro-power generator	Total
Urban/Rural	Urban	Freq	118	40	3	2	14	1	128
		%	92.2%	31.2%	2.3%	1.6%	10.9%	.8%	
	Rural	Freq	68	20	1	0	50	3	115
		%	59.1%	17.4%	.9%	.0%	43.5%	2.6%	
Total		**Freq**	**186**	**60**	**4**	**2**	**64**	**4**	**243**

The urban/rural difference in the use of the national grid as a power supply was markedly significant (92 per cent in urban areas vs. 59 per cent in rural areas). The use of solar power was much higher in rural areas compared to urban areas (43.5 per cent vs. 10.9 per cent).

Table 3.73 Source of power for fridge used for cold chain by management of facility

			Source of power for fridge						
			Electricity from grid	Electricity from generator	Electricity from mobile generator	Electricity from kerosene system	Electricity from solar system	Electricity from hydro-power generator	Total
Type of administration	Govt	Freq	171	55	4	2	64	4	228
		%	74.9%	24.2%	1.8%	.9%	28.2%	1.8%	
	Private	Freq	15	4	0	0	0	0	15
		%	100.0%	26.7%	.0%	.0%	.0%	.0%	
Total		**Freq**	**186**	**60**	**4**	**2**	**64**	**4**	**243**

There was no significant difference between the use of generators at private and government HFs.

3.7.8 Staff training and supervision

Table 3.74 Percentage of health facilities with staff trained to provide family planning services and to insert and remove implants

		Frequency	Per cent
Family planning services	Provide	193	50.4
	Do not provide	190	49.6
Implant	Provide	81	21.1
	Do not provide	302	78.9
	Total	**378**	**100.0**

About 50.4 per cent of HFs had trained staff in the provision of family planning services; this figure was lower than in 2016 (55 per cent). Similarly, HFs that had trained staff to insert and remove implants was still low at 21.1 per cent, but higher than in 2016 (15.6 per cent).

Table 3.75 Percentage distribution of staff trained to provide family planning services and to insert and remove implants by type of health facility

			Have trained staff for family planning services		Have trained staff on implant		
			Yes	No	Yes	No	Total
Level of Health Facility	Tertiary	Freq	10	12	8	14	22
		%	45.5%	54.5%	36.4%	63.6%	100.0%
	Secondary	Freq	72	89	50	111	161
		%	44.7%	55.3%	31.1%	68.9%	100.0%
	Primary	Freq	100	81	14	167	181
		%	55.2%	44.8%	7.7%	92.3%	100.0%
	Private	Freq	11	8	9	10	19
		%	57.9%	42.1%	47.4%	52.6%	100.0%
	Total	**Freq**	**193**	**190**	**81**	**302**	**383**
		%	**50.4%**	**49.6%**	**21.1%**	**78.9%**	**100.0%**

The percentage of HF that had trained staff on family planning was lowest in secondary level HFs (44.7 per cent) compared to tertiary and primary level HFs (45.5 per cent and 55.2 per cent, respectively). The difference was not statistically significant. At all levels of HFs, the percentage of staff trained was higher than in 2016.

In tertiary level HFs 36.4 per cent had trained staff to insert and remove the implant and these percentages were lower among all government sector HFs than in private sector HFs (47.4 per cent). At the primary level 7.7 per cent of HFs had trained staff to insert and remove the implant.

Table 3.76 Percentage distribution of staff trained to provide family planning services and to insert and remove implants by state/region

			Have trained staff on family planning services		Have trained staff on implant		Total
			Yes	No	Yes	No	
State/Region	Kachin	Freq	14	5	3	16	19
		%	73.7%	26.3%	15.8%	84.2%	100.0%
	Kayah	Freq	2	6	0	8	8
		%	25.0%	75.0%	.0%	100.0%	100.0%
	Kayin	Freq	11	3	2	12	14
		%	78.6%	21.4%	14.3%	85.7%	100.0%
	Chin	Freq	4	7	1	10	11
		%	36.4%	63.6%	9.1%	90.9%	100.0%
	Sagaing	Freq	23	19	8	34	42
		%	54.8%	45.2%	19.0%	81.0%	100.0%
	Tanintheri	Freq	6	6	3	9	12
		%	50.0%	50.0%	25.0%	75.0%	100.0%
	Bago	Freq	14	23	5	32	37
		%	37.8%	62.2%	13.5%	86.5%	100.0%
	Magway	Freq	12	22	8	26	34
		%	35.3%	64.7%	23.5%	76.5%	100.0%
	Mandalay	Freq	25	8	12	21	33
		%	75.8%	24.2%	36.4%	63.6%	100.0%
	Mon	Freq	12	4	3	13	16
		%	75.0%	25.0%	18.8%	81.2%	100.0%
	Rakhine	Freq	5	17	2	20	22
		%	22.7%	77.3%	9.1%	90.9%	100.0%
	Yangon	Freq	24	8	17	15	32
		%	75.0%	25.0%	53.1%	46.9%	100.0%
	Shan (South)	Freq	11	11	9	13	22
		%	50.0%	50.0%	40.9%	59.1%	100.0%
	Shan (North)	Freq	4	17	3	18	21
		%	19.0%	81.0%	14.3%	85.7%	100.0%
	Shan (East)	Freq	4	5	2	7	9
		%	44.4%	55.6%	22.2%	77.8%	100.0%
	Ayeyawady	Freq	18	26	2	42	44
		%	40.9%	59.1%	4.5%	95.5%	100.0%
	Nay Pyi Taw	Freq	4	3	1	6	7
		%	57.1%	42.9%	14.3%	85.7%	100.0%
Total		**Freq**	**193**	**190**	**81**	**302**	**383**
		%	**50.4%**	**49.6%**	**21.1%**	**78.9%**	**100.0%**

In the majority of states/regions less than 20 per cent of HFs had trained staff to insert and remove the implant. Kayin, Yangon, Mandalay, Mon and Kachin had the highest levels of HFs that had trained staff in the provision of family planning services at more than 60 per cent.

Figure 3.10 Percentage of HFs that had trained staff on family planning and implant

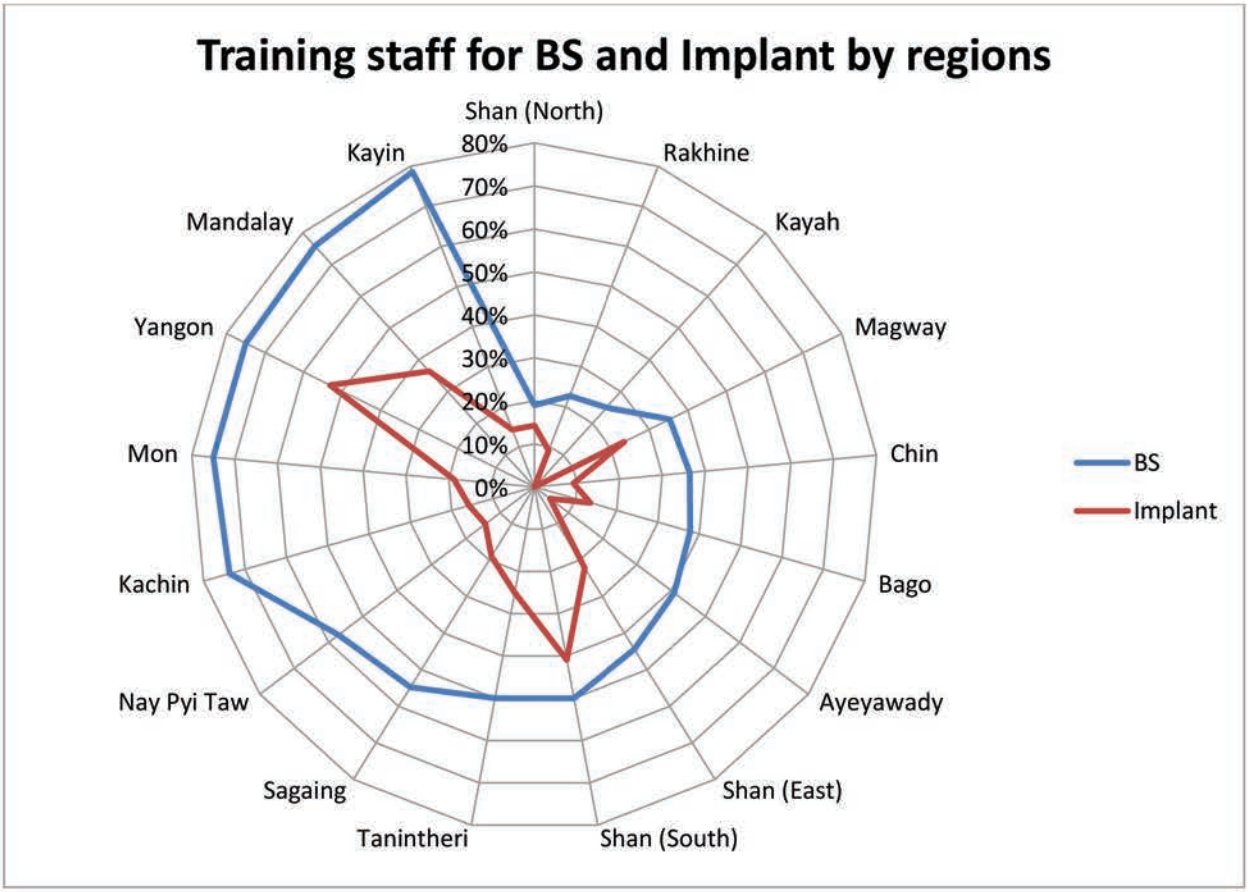


Table 3.77 Percentage distribution of staff trained to provide family planning services and to insert and remove the implant by urban/rural area

			Have trained staff for family planning services		Have trained staff for implant		
			Yes	No	Yes	No	Total
Urban/Rural	Urban	Freq	85	81	51	115	166
		%	51.2%	48.8%	30.7%	69.3%	100.0%
	Rural	Freq	108	109	30	187	217
		%	49.8%	50.2%	13.8%	86.2%	100.0%
	Total	**Freq**	**193**	**190**	**81**	**302**	**383**
		%	**50.4%**	**49.6%**	**21.1%**	**78.9%**	**100.0%**

The urban/rural difference in the percentage of HFs that had trained staff on family planning was not significant (51 per cent and 50 per cent, respectively). But a difference was noted in the presence of trained staff to insert and remove the implant (31 per cent for urban HFs and 14 per cent for rural HFs). This urban/rural difference was significantly less pronounced than in 2016 (29 per cent vs. 6 per cent).

Table 3.78 Percentage distribution of staff trained to provide family planning services and to insert and remove the implant by management of facility

			Have trained staff for family planning services		Have trained staff for implant		
			Yes	No	Yes	No	Total
Type of administration	Govt	Freq	182	182	72	292	364
		%	50.0%	50.0%	19.8%	80.2%	100.0%
	Private	Freq	11	8	9	10	19
		%	57.9%	42.1%	47.4%	52.6%	100.0%
Total		**Freq**	**193**	**190**	**81**	**302**	**383**
		%	**50.4%**	**49.6%**	**21.1%**	**78.9%**	**100.0%**

The private sector had more HFs with trained staff for the insertion and removal of implants than HFs in the government sector (47 per cent vs. 20 per cent).

Table 3.79 Percentage distribution of the last time staff received training for family planning including for the provision of implants by type of health facility

			Last time trained				
			Last 2 months	2-6 months ago	6-12 months ago	>1year ago	Total
Level of Health Facility	Tertiary	Freq	2	1	3	4	10
		%	20.0%	10.0%	30.0%	40.0%	100.0%
	Secondary	Freq	3	8	24	37	72
		%	4.2%	11.1%	33.3%	51.4%	100.0%
	Primary	Freq	2	3	17	78	100
		%	2.0%	3.0%	17.0%	78.0%	100.0%
	Private	Freq	0	1	2	8	11
		%	.0%	9.1%	18.2%	72.7%	100.0%
Total		**Freq**	**7**	**13**	**46**	**127**	**193**
		%	**3.6%**	**6.7%**	**23.8%**	**65.8%**	**100.0%**

Most staff who had been trained in family planning received the training more than one year ago (66 per cent). This longer duration was more marked at private and primary level HFs (73 per cent and 78 per cent respectively).

Table 3.80 Percentage distribution of the last time staff received training for family planning including for the provision of implant, by state/region

			Last time trained				
			Last 2 months	2-6 months ago	6-12 months ago	> 1year ago	Total
State/Region	Kachin	Freq	1	0	0	13	14
		%	7.1%	.0%	.0%	92.9%	100.0%
	Kayah	Freq	0	0	2	0	2
		%	.0%	.0%	100.0%	.0%	100.0%
	Kayin	Freq	1	2	2	6	11
		%	9.1%	18.2%	18.2%	54.5%	100.0%
	Chin	Freq	0	0	1	3	4
		%	.0%	.0%	25.0%	75.0%	100.0%
	Sagaing	Freq	4	0	1	18	23
		%	17.4%	.0%	4.3%	78.3%	100.0%
	Tanintheri	Freq	0	0	0	6	6
		%	.0%	.0%	.0%	100.0%	100.0%
	Bago	Freq	0	0	0	14	14
		%	.0%	.0%	.0%	100.0%	100.0%
	Magway	Freq	0	1	6	5	12
		%	.0%	8.3%	50.0%	41.7%	100.0%
	Mandalay	Freq	0	0	11	14	25
		%	.0%	.0%	44.0%	56.0%	100.0%
	Mon	Freq	0	2	3	7	12
		%	.0%	16.7%	25.0%	58.3%	100.0%
	Rakhine	Freq	0	0	0	5	5
		%	.0%	.0%	.0%	100.0%	100.0%
	Yangon	Freq	0	4	10	10	24
		%	.0%	16.7%	41.7%	41.7%	100.0%
	Shan (South)	Freq	0	4	5	2	11
		%	.0%	36.4%	45.5%	18.2%	100.0%
	Shan (North)	Freq	0	0	3	1	4
		%	.0%	.0%	75.0%	25.0%	100.0%
	Shan (East)	Freq	0	0	0	4	4
		%	.0%	.0%	.0%	100.0%	100.0%
	Ayeyawady	Freq	0	0	2	16	18
		%	.0%	.0%	11.1%	88.9%	100.0%
	Nay Pyi Taw	Freq	1	0	0	3	4
		%	25.0%	.0%	.0%	75.0%	100.0%
Total		**Freq**	**7**	**13**	**46**	**127**	**193**
		%	**3.6%**	**6.7%**	**23.8%**	**65.8%**	**100.0%**

The percentage of HFs with staff trained in family planning, including in the provision of implant services, who had received training more than a year ago was high in Tanintheri, Shan (E), Bago, and Rakhine compared to other states/regions.

Figure 3.11 Percentage of health facilities that had trained staff more than one year ago

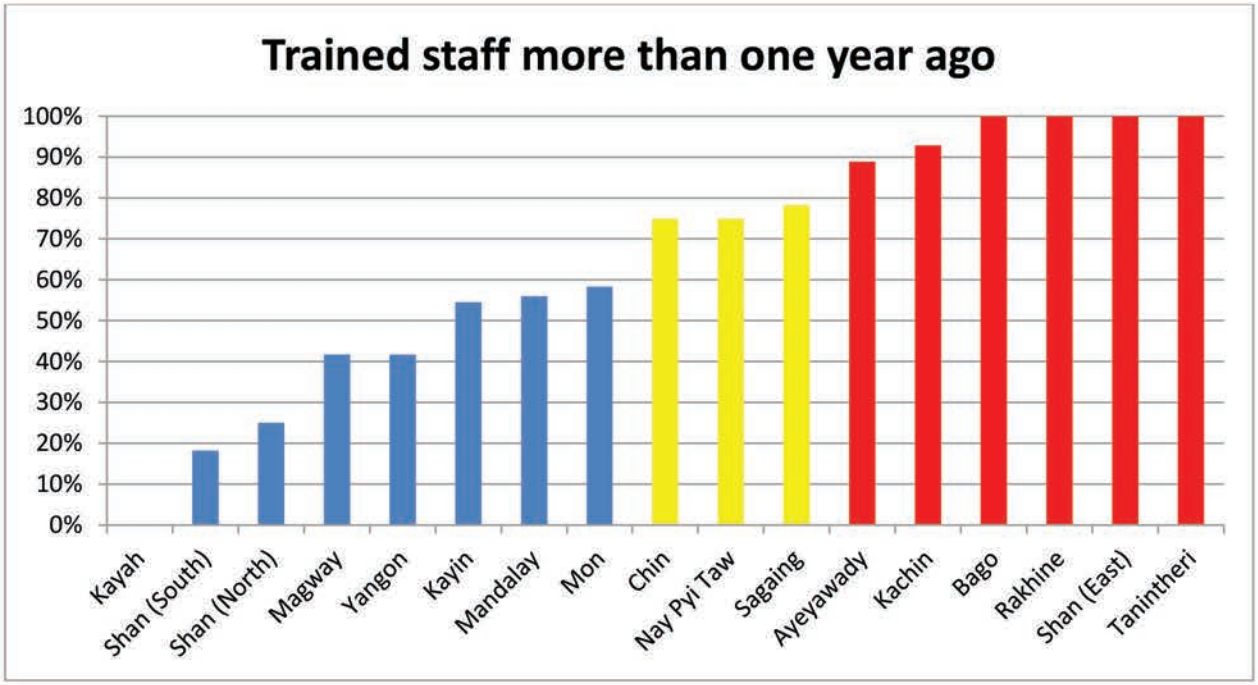


Table 3.81 Percentage distribution of the last time staff received training for family planning including in the provision of implant by urban/rural area

			Last time trained				
			Last 2 months	2-6 months ago	6-12 months ago	>1year ago	Total
Urban/Rural	Urban	Freq	4	10	24	47	85
		%	4.7%	11.8%	28.2%	55.3%	100.0%
	Rural	Freq	3	3	22	80	108
		%	2.8%	2.8%	20.4%	74.1%	100.0%
Total		**Freq**	**7**	**13**	**46**	**127**	**193**
		%	**3.6%**	**6.7%**	**23.8%**	**65.8%**	**100.0%**

The percentage of staff trained more than one year ago was much higher in rural than in urban HFs (74 per cent vs. 55 per cent).

Table 3.82 Percentage distribution of the last time staff received training for family planning including in the provision of implant by management of facility

			Last time trained				
			Last 2 months	2-6 months ago	6-12 months ago	>1 year ago	Total
Type of administration	Govt	Freq	7	12	44	119	182
		%	3.8%	6.6%	24.2%	65.4%	100.0%
	Private	Freq	0	1	2	8	11
		%	.0%	9.1%	18.2%	72.7%	100.0%
Total		**Freq**	**7**	**13**	**46**	**127**	**193**
		%	**3.6%**	**6.7%**	**23.8%**	**65.8%**	**100.0%**

			<1 month	1-3 months	3-6 months	6-12 months	Never	
Level of Health Facility	Tertiary	Freq	6	3	3	4	6	22
		%	27.3%	13.6%	13.6%	18.2%	27.3%	100.0%
	Secondary	Freq	15	20	30	24	72	161
		%	9.3%	12.4%	18.6%	14.9%	44.7%	100.0%
	Primary	Freq	28	45	26	24	58	181
		%	15.5%	24.9%	14.4%	13.3%	32.0%	100.0%
	Private	Freq	5	3	0	4	7	19
		%	26.3%	15.8%	.0%	21.1%	36.8%	100.0%
Total		**Freq**	**54**	**71**	**59**	**56**	**143**	**383**
		%	**14.1%**	**18.5%**	**15.4%**	**14.6%**	**37.3%**	**100.0%**

The percentage of HFs that had not received supervision in reproductive health was 37 per cent and this was highest at secondary level HFs at 45 per cent.

Table 3.84 Percentage distribution of the last time health facility was supervised in the past 12 months by state/region

			Last supervision visit					
			<1 month	1-3 months	3-6 months	6-12 months	Never	Total
State/Region	Kachin	Freq	4	7	4	4	0	19
		%	21.1%	36.8%	21.1%	21.1%	.0%	100.0%
	Kayah	Freq	0	1	2	3	2	8
		%	.0%	12.5%	25.0%	37.5%	25.0%	100.0%
	Kayin	Freq	7	3	4	0	0	14
		%	50.0%	21.4%	28.6%	.0%	.0%	100.0%
	Chin	Freq	2	1	4	2	2	11
		%	18.2%	9.1%	36.4%	18.2%	18.2%	100.0%
	Sagaing	Freq	2	4	2	5	29	42
		%	4.8%	9.5%	4.8%	11.9%	69.0%	100.0%
	Tanintheri	Freq	1	2	1	0	8	12
		%	8.3%	16.7%	8.3%	.0%	66.7%	100.0%
	Bago	Freq	1	4	6	7	19	37
		%	2.7%	10.8%	16.2%	18.9%	51.4%	100.0%
	Magway	Freq	4	9	10	3	8	34
		%	11.8%	26.5%	29.4%	8.8%	23.5%	100.0%
	Mandalay	Freq	0	3	2	6	22	33
		%	.0%	9.1%	6.1%	18.2%	66.7%	100.0%
	Mon	Freq	6	6	3	1	0	16
		%	37.5%	37.5%	18.8%	6.2%	.0%	100.0%
	Rakhine	Freq	2	10	5	2	3	22
		%	9.1%	45.5%	22.7%	9.1%	13.6%	100.0%
	Yangon	Freq	12	10	5	3	2	32
		%	37.5%	31.2%	15.6%	9.4%	6.2%	100.0%
	Shan (South)	Freq	3	3	4	3	9	22
		%	13.6%	13.6%	18.2%	13.6%	40.9%	100.0%
	Shan (North)	Freq	8	3	6	4	0	21
		%	38.1%	14.3%	28.6%	19.0%	.0%	100.0%
	Shan (East)	Freq	0	2	0	2	5	9
		%	.0%	22.2%	.0%	22.2%	55.6%	100.0%
	Ayeyawady	Freq	0	1	1	8	34	44
		%	.0%	2.3%	2.3%	18.2%	77.3%	100.0%
	Nay Pyi Taw	Freq	2	2	0	3	0	7
		%	28.6%	28.6%	.0%	42.9%	.0%	100.0%
Total		**Freq**	**54**	**71**	**59**	**56**	**143**	**383**
		%	**14.1%**	**18.5%**	**15.4%**	**14.6%**	**37.3%**	**100.0%**

It was evident that Ayeyawady, Sagaing, Tanintheri and Mandalay had the highest proportion of HFs (more than 60 per cent) that had not received reproductive health (RH) supervision. There were no HFs in Shan (N), Nay Pyi Taw, Mon, Kayin and Kachin that had not been supervised for RH.

Figure 3.12 Percentage of health facilities that have never received reproductive health supervision

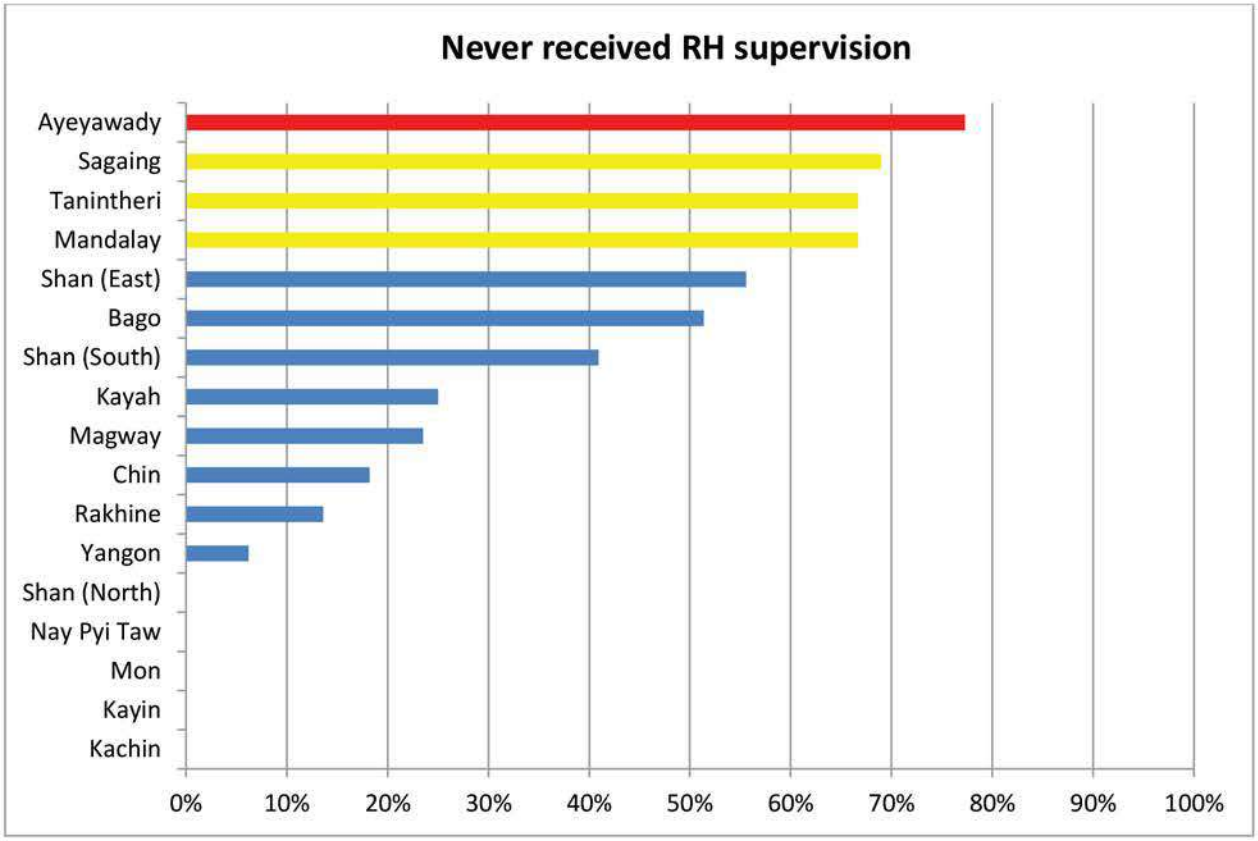


Table 3.85 Percentage distribution of the last time health facility was supervised in the past 12 months by urban/rural area

			Last supervision visit					
			<1 month	1-3 months	3-6 months	6-12 months	Never	Total
Urban/Rural	Urban	Freq	30	29	21	26	60	166
		%	18.1%	17.5%	12.7%	15.7%	36.1%	100.0%
	Rural	Freq	24	42	38	30	83	217
		%	11.1%	19.4%	17.5%	13.8%	38.2%	100.0%
Total		**Freq**	**54**	**71**	**59**	**56**	**143**	**383**
		%	**14.1%**	**18.5%**	**15.4%**	**14.6%**	**37.3%**	**100.0%**

There was no significant difference between the percentage of HFs that had never received RH supervision between urban and rural areas.

Table 3.86 Percentage distribution of the last time health facility was supervised in the past 12 months by management of facility

			Last supervision visit					
			<1 month	1-3 months	3-6 months	6-12 months	Never	Total
Type of administration	Govt	Freq	49	68	59	52	136	364
		%	13.5%	18.7%	16.2%	14.0%	37.4%	100.0%
	Private	Freq	5	3	0	4	7	19
		%	26.3%	15.8%	.0%	21.1%	36.8%	100.0%
	Total	**Freq**	**54**	**71**	**59**	**56**	**143**	**383**
		%	**14.1%**	**18.5%**	**15.4%**	**14.6%**	**37.3%**	**100.0%**

There was no significant difference in the number of HFs that had received RH supervision in the private and government sector.

Table 3.87 Percentage distribution of the frequency of supervisory visits by type of health facility

			Weekly	Monthly	Every 3 months	Every 6 months	Once a year	Not regularly	Total
Level of Health Facility	Tertiary	Freq	2	3	0	4	2	5	16
		%	12.5%	18.8%	.0%	25.0%	12.5%	31.2%	100.0%
	Secondary	Freq	0	7	22	9	10	41	89
		%	.0%	7.9%	24.7%	10.1%	11.2%	46.1%	100.0%
	Primary	Freq	1	17	35	22	7	41	123
		%	.8%	13.8%	28.5%	17.9%	5.7%	33.3%	100.0%
	Private	Freq	1	0	1	1	1	8	12
		%	8.3%	.0%	8.3%	8.3%	8.3%	66.7%	100.0%
Total		**Freq**	**4**	**27**	**58**	**36**	**20**	**95**	**240**
		%	**1.7%**	**11.2%**	**24.2%**	**15.0%**	**8.3%**	**39.6%**	**100.0%**

Most supervisory visits were at irregular intervals (40 per cent) and there was no notable difference between levels of HFs. The second most frequent interval was "every 3 months" (24 per cent). The frequency of supervisory visits was comparatively shorter in tertiary and primary level HFs.

Table 3.88 Percentage distribution of the frequency of supervisory visits by state/region

			Weekly	Monthly	Every 3 months	Every 6 months	Once a year	Not regularly	Total
State/Region	Kachin	Freq	1	1	8	3	1	5	19
		%	5.3%	5.3%	42.1%	15.8%	5.3%	26.3%	100.0%
	Kayah	Freq	0	0	2	2	1	1	6
		%	.0%	.0%	33.3%	33.3%	16.7%	16.7%	100.0%
	Kayin	Freq	1	3	4	2	0	4	14
		%	7.1%	21.4%	28.6%	14.3%	.0%	28.6%	100.0%
	Chin	Freq	0	1	1	4	0	3	9
		%	.0%	11.1%	11.1%	44.4%	.0%	33.3%	100.0%
	Sagaing	Freq	0	1	3	2	1	6	13
		%	.0%	7.7%	23.1%	15.4%	7.7%	46.2%	100.0%
	Tanintheri	Freq	0	0	1	0	0	3	4
		%	.0%	.0%	25.0%	.0%	.0%	75.0%	100.0%
	Bago	Freq	0	0	2	3	2	11	18
		%	.0%	.0%	11.1%	16.7%	11.1%	61.1%	100.0%
	Magway	Freq	0	2	13	8	1	2	26
		%	.0%	7.7%	50.0%	30.8%	3.8%	7.7%	100.0%
	Mandalay	Freq	1	0	1	0	2	7	11
		%	9.1%	.0%	9.1%	.0%	18.2%	63.6%	100.0%
	Mon	Freq	0	8	6	0	1	1	16
		%	.0%	50.0%	37.5%	.0%	6.2%	6.2%	100.0%
	Rakhine	Freq	0	0	4	0	0	15	19
		%	.0%	.0%	21.1%	.0%	.0%	78.9%	100.0%
	Yangon	Freq	0	3	3	4	1	19	30
		%	.0%	10.0%	10.0%	13.3%	3.3%	63.3%	100.0%
	Shan (South)	Freq	0	0	3	4	1	5	13
		%	.0%	.0%	23.1%	30.8%	7.7%	38.5%	100.0%
	Shan (North)	Freq	1	3	5	2	5	5	21
		%	4.8%	14.3%	23.8%	9.5%	23.8%	23.8%	100.0%
	Shan (East)	Freq	0	0	1	0	1	2	4
		%	.0%	.0%	25.0%	.0%	25.0%	50.0%	100.0%
	Ayeyawady	Freq	0	1	0	2	3	4	10
		%	.0%	10.0%	.0%	20.0%	30.0%	40.0%	100.0%
	Nay Pyi Taw	Freq	0	4	1	0	0	2	7
		%	.0%	57.1%	14.3%	.0%	.0%	28.6%	100.0%
Total		**Freq**	**4**	**27**	**58**	**36**	**20**	**95**	**240**
		%	**1.7%**	**11.2%**	**24.2%**	**15.0%**	**8.3%**	**39.6%**	**100.0%**

Table 3.89 Percentage distribution of the frequency of supervisory visits by urban/rural area

			Weekly	Monthly	Every 3 months	Every 6 months	Once a year	Not regularly	Total
Urban/Rural	Urban	Freq	3	15	18	13	6	51	106
		%	2.8%	14.2%	17.0%	12.3%	5.7%	48.1%	100.0%
	Rural	Freq	1	12	40	23	14	44	134
		%	.7%	9.0%	29.9%	17.2%	10.4%	32.8%	100.0%
Total		**Freq**	**4**	**27**	**58**	**36**	**20**	**95**	**240**
		%	**1.7%**	**11.2%**	**24.2%**	**15.0%**	**8.3%**	**39.6%**	**100.0%**

The percentage of HFs that had been more frequently visited was higher at rural HFs. Annual visits were higher in urban HFs. The pattern was the same as 2016.

Table 3.90 Percentage distribution of the frequency of supervisory visits by management of facility

			Weekly	Monthly	Every 3 months	Every 6 months	Once a year	Not regularly	Total
Type of administration	Govt	Freq	3	27	57	35	19	88	228
		%	1.3%	11.8%	24.9%	15.7%	7.9%	38.4%	100.0%
	Private	Freq	1	0	1	1	1	8	12
		%	8.3%	.0%	8.3%	8.3%	8.3%	66.7%	100.0%
Total		**Freq**	**4**	**27**	**58**	**36**	**20**	**95**	**240**
		%	**1.7%**	**11.2%**	**24.2%**	**15.0%**	**8.3%**	**39.6%**	**100.0%**

As in 2016, supervision for RH was more apparent and frequent in the government sector than in the private sector.

Table 3.91 Percentage of health facilities with issues included in supervisory visits by type of health facility

			Issues included in supervisory visits*						
			Supervised for treatment	Supervised for logistics	Supervised for staffing and training	Supervised for reporting	Supervised for a biding guideline and instruction	Supervised for other	Total
Level of Health Facility	Tertiary	Freq	10	10	8	6	5	4	16
		%	62.5%	62.5%	50.0%	37.5%	31.2%	25.0%	
	Secondary	Freq	62	62	49	49	41	23	89
		%	69.7%	69.7%	55.1%	55.1%	46.1%	25.8%	
	Primary	Freq	67	78	64	80	59	26	123
		%	54.5%	63.4%	52.0%	65.0%	48.0%	21.1%	
	Private	Freq	7	3	3	4	3	5	12
		%	58.3%	25.0%	25.0%	33.3%	25.0%	41.7%	
Total		**Freq**	**146**	**153**	**124**	**139**	**108**	**58**	**240**

**Multiple response table.*

Issues encountered during supervisory visits were described. The most frequently identified issue was logistics. The second most frequent issues were clinical management and reporting. The occurrences of issues were not different between levels of HFs. Supervision for abiding guideline and instruction was also apparent in this year's assessment.

Table 3.92 Percentage of health facilities with issues included in supervisory visits by state/region

			Issues included in supervisory visits						
			Supervised for treatment	Supervised for logistics	Supervised for staffing and training	Supervised for reporting	Supervised for a biding guideline and instruction	Supervised for other	Total
State/Region	Kachin	Freq	18	15	18	18	19	1	19
		%	94.7%	78.9%	94.7%	94.7%	100.0%	5.3%	
	Kayah	Freq	5	5	4	3	2	0	6
		%	83.3%	83.3%	66.7%	50.0%	33.3%	.0%	
	Kayin	Freq	14	14	14	14	14	1	14
		%	100.0%	100.0%	100.0%	100.0%	100.0%	7.1%	
	Chin	Freq	2	4	2	6	3	0	9
		%	22.2%	44.4%	22.2%	66.7%	33.3%	.0%	
	Sagaing	Freq	6	8	7	10	8	0	13
		%	46.2%	61.5%	53.8%	76.9%	61.5%	.0%	
	Tanintheri	Freq	2	2	0	0	0	1	4
		%	50.0%	50.0%	.0%	.0%	.0%	25.0%	
	Bago	Freq	7	6	4	8	4	11	18
		%	38.9%	33.3%	22.2%	44.4%	22.2%	61.1%	
	Magway	Freq	19	19	17	16	6	2	26
		%	73.1%	73.1%	65.4%	61.5%	23.1%	7.7%	
	Mandalay	Freq	4	7	5	5	6	4	11
		%	36.4%	63.6%	45.5%	45.5%	54.5%	36.4%	
	Mon	Freq	16	15	15	15	15	2	16

	Rakhine	%	100.0%	93.8%	93.8%	93.8%	93.8%	12.5%	
		Freq	10	9	7	6	4	10	19
	Yangon	%	52.6%	47.4%	36.8%	31.6%	21.1%	52.6%	
		Freq	7	11	1	8	9	17	30
	Shan (South)	%	23.3%	36.7%	3.3%	26.7%	30.0%	56.7%	
		Freq	7	8	5	10	5	2	13
	Shan (North)	%	53.8%	61.5%	38.5%	76.9%	38.5%	15.4%	
		Freq	18	16	14	6	1	3	21
	Shan (East)	%	85.7%	76.2%	66.7%	28.6%	4.8%	14.3%	
		Freq	1	4	2	2	2	1	4
	Ayeyawady	%	25.0%	100.0%	50.0%	50.0%	50.0%	25.0%	
		Freq	8	8	7	7	6	0	10
	Nay Pyi Taw	%	80.0%	80.0%	70.0%	70.0%	60.0%	.0%	
		Freq	2	2	2	5	4	3	7
		%	28.6%	28.6%	28.6%	71.4%	57.1%	42.9%	
Total		**Freq**	**146**	**153**	**124**	**139**	**108**	**58**	**240**

Overall, issues with guidelines were observed in all states/regions although this was less pronounced in Kachin, Mon, Kayin, and Ayeyawady than in other states/regions, in particular Kachin, Kayin, Shan (E) and Mon.

Figure 3.13 Percentage of health facilities supervised for different issues

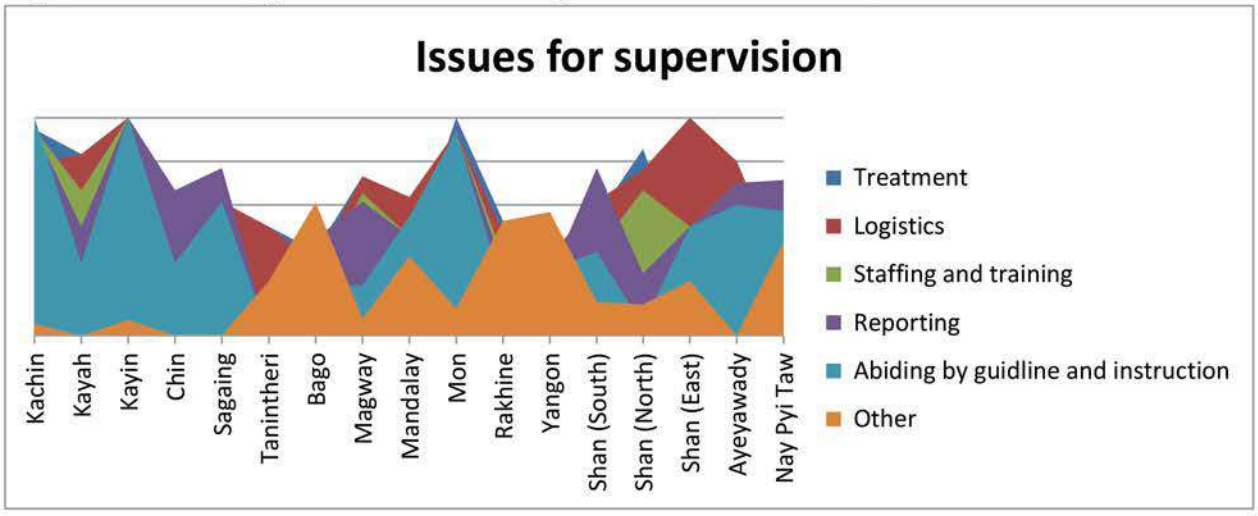


Table 3.93 Percentage of health facilities with issues included in supervisory visits by urban/rural area

			Issues included in supervisory visits						
			Supervised for treatment	Supervised for logistics	Supervised for staffing and training	Supervised for reporting	Supervised for a biding guideline and instruction	Supervised for other	Total
Urban/Rural	Urban	Freq	63	60	47	52	43	33	106
		%	59.4%	56.6%	44.3%	49.1%	40.6%	31.1%	
	Rural	Freq	83	93	77	87	65	25	134
		%	61.9%	69.4%	57.5%	64.9%	48.5%	18.7%	
Total		**Freq**	**146**	**153**	**124**	**139**	**108**	**58**	**240**

The differences in issues included in supervision visits did not differ between urban/rural HFs.

Table 3.94 Percentage of issues included in supervisory visits by management of facility

			Issues included in supervisory visits						
			Supervised for treatment	Supervised for logistics	Supervised for staffing and training	Supervised for reporting	Supervised for a biding guideline and instruction	Supervised for other	Total
Type of administration	Govt	Freq	139	150	121	135	105	53	229
		%	60.7%	65.1%	52.4%	59.0%	45.8%	23.1%	
	Private	Freq	7	3	3	4	3	5	12
		%	58.3%	25.0%	25.0%	33.3%	25.0%	41.7%	
Total		**Freq**	**146**	**153**	**124**	**139**	**108**	**58**	**240**

Supervision for reporting, staff training and logistics at private sector HFs was lower than at government sector HFs.

3.7.9 Availability of guidelines, check-lists and job aids

Table 3.95 Percentage of health facilities with guidelines, check-lists and job aids

Use of guidelines, checklists and job aids*	Responses N	Responses Per cent
Have Guidebook for National Birth Spacing	26	6.8%
Have Checklist for Birth Spacing	61	15.9%
Have ANC Guidelines (National/WHO)	88	23.0%
Have Checklist/Job Aid for AN care	95	24.8%
Have Guidebook for Waste Disposal	19	5.0%

* Multiple response table.

Guidelines of any variety were available at 36 per cent of HFs. Based on all 383 HFs assessed, the most frequently available guidebook was the "Job Aid for Antenatal Care" (25 per cent) and the "Guidebook for Antenatal Care" (23 per cent). Regarding the Guide for Birth Spacing, 16 per cent of HFs had the "Checklist for Birth Spacing". The "National Guidebook for Birth Spacing " was only available at 7 per cent of HFs. The "Guide for Waste Disposal" was the least available at only 5 per cent of HFs. The availability of all guidelines was less than in 2016.

Table 3.96 Have Guidebook for National Birth Spacing by health facility level, by state/region, by urban/rural area

			Have Guidebook for National Birth Spacing			
			Have (shown)	Have (not shown)	Do not have	Total
Level of Health Facility	Tertiary	Freq	1	3	18	22
		%	4.5%	13.6%	81.8%	100.0%
	Secondary	Freq	6	6	149	161
		%	3.7%	3.7%	92.5%	100.0%
	Primary	Freq	19	20	142	181
		%	10.5%	11.0%	78.5%	100.0%
	Private	Freq	0	1	18	19
		%	.0%	5.3%	94.7%	100.0%
State/Region	Kachin	Freq	3	1	15	19
		%	15.8%	5.3%	78.9%	100.0%
	Kayah	Freq	0	0	8	8
		%	.0%	.0%	100.0%	100.0%
	Kayin	Freq	0	0	14	14
		%	.0%	.0%	100.0%	100.0%
	Chin	Freq	1	0	10	11
		%	9.1%	.0%	90.9%	100.0%
	Sagaing	Freq	1	3	38	42
		%	2.4%	7.1%	90.5%	100.0%
	Tanintheri	Freq	2	0	10	12
		%	16.7%	.0%	83.3%	100.0%
	Bago	Freq	2	5	30	37
		%	5.4%	13.5%	81.1%	100.0%
	Magway	Freq	3	3	28	34
		%	8.8%	8.8%	82.4%	100.0%
	Mandalay	Freq	3	3	27	33
		%	9.1%	9.1%	81.8%	100.0%
	Mon	Freq	0	1	15	16
		%	.0%	6.2%	93.8%	100.0%
	Rakhine	Freq	0	0	22	22
		%	.0%	.0%	100.0%	100.0%
	Yangon	Freq	1	2	29	32
		%	3.1%	6.2%	90.6%	100.0%
	Shan (South)	Freq	1	1	20	22
		%	4.5%	4.5%	90.9%	100.0%
	Shan (North)	Freq	1	2	18	21
		%	4.8%	9.5%	85.7%	100.0%
	Shan (East)	Freq	1	0	8	9
		%	11.1%	.0%	88.9%	100.0%
	Ayeyawady	Freq	7	8	29	44
		%	15.9%	18.2%	65.9%	100.0%
	Nay Pyi Taw	Freq	0	1	6	7

		%	.0%	14.3%	85.7%	100.0%
Urban/Rural	Urban	Freq	5	12	149	166
		%	3.0%	7.2%	89.8%	100.0%
	Rural	Freq	21	18	178	217
		%	9.7%	8.3%	82.0%	100.0%
Type of administration	Govt	Freq	26	29	309	364
		%	7.1%	7.9%	85.0%	100.0%
	Private	Freq	0	1	18	19
		%	.0%	5.3%	94.7%	100.0%
Total		**Freq**	**26**	**30**	**327**	**383**
		%	**6.8%**	**7.8%**	**85.4%**	**100.0%**

Table 3.97 Have Checklist for Birth Spacing by health facility level, by state/region, by urban/rural area

			Have Checklist for Birth Spacing			
			Have (form)	Have (no form)	Do not have	Total
Level of Health Facility	Tertiary	Freq	9	4	9	22
		%	40.9%	18.2%	40.9%	100.0%
	Secondary	Freq	14	16	131	161
		%	8.7%	9.9%	81.4%	100.0%
	Primary	Freq	36	43	102	181
		%	19.9%	23.8%	56.4%	100.0%
	Private	Freq	2	1	16	19
		%	10.5%	5.3%	84.2%	100.0%
State/Region	Kachin	Freq	4	0	15	19
		%	21.1%	.0%	78.9%	100.0%
	Kayah	Freq	0	0	8	8
		%	.0%	.0%	100.0%	100.0%
	Kayin	Freq	1	7	6	14
		%	7.1%	50.0%	42.9%	100.0%
	Chin	Freq	3	0	8	11
		%	27.3%	.0%	72.7%	100.0%
	Sagaing	Freq	3	6	33	42
		%	7.1%	14.3%	78.6%	100.0%
	Tanintheri	Freq	2	0	10	12
		%	16.7%	.0%	83.3%	100.0%
	Bago	Freq	9	11	17	37
		%	24.3%	29.7%	45.9%	100.0%
	Magway	Freq	7	7	20	34
		%	20.6%	20.6%	58.8%	100.0%
	Mandalay	Freq	8	6	19	33
		%	24.2%	18.2%	57.6%	100.0%
	Mon	Freq	1	3	12	16
		%	6.2%	18.8%	75.0%	100.0%
	Rakhine	Freq	0	1	21	22
		%	.0%	4.5%	95.5%	100.0%
	Yangon	Freq	1	8	23	32
		%	3.1%	25.0%	71.9%	100.0%
	Shan (South)	Freq	8	5	9	22
		%	36.4%	22.7%	40.9%	100.0%
	Shan (North)	Freq	1	2	18	21
		%	4.8%	9.5%	85.7%	100.0%
	Shan (East)	Freq	2	0	7	9
		%	22.2%	.0%	77.8%	100.0%
	Ayeyawady	Freq	11	7	26	44
		%	25.0%	15.9%	59.1%	100.0%
	Nay Pyi Taw	Freq	0	1	6	7
		%	.0%	14.3%	85.7%	100.0%
Urban/Rural	Urban	Freq	28	25	113	166
		%	16.9%	15.1%	68.1%	100.0%
	Rural	Freq	33	39	145	217
		%	15.2%	18.0%	66.8%	100.0%
Type of administration	Govt	Freq	59	63	242	364
		%	15.9%	17.5%	66.6%	100.0%
	Private	Freq	2	1	16	19
		%	10.5%	5.3%	84.2%	100.0%
Total		**Freq**	**61**	**64**	**258**	**383**
		%	**15.9%**	**16.7%**	**67.4%**	**100.0%**

Table 3.98 Have Antenatal Care Guidelines (National/WHO) by health facility level, by state/region, by urban/rural area

			Have ANC Guidelines (National/WHO)			
			Have (form)	Have (no form)	Do not have	Total
Level of Health Facility	Tertiary	Freq	3	6	13	22
		%	13.6%	27.3%	59.1%	100.0%
	Secondary	Freq	16	21	123	160
		%	10.0%	13.1%	76.9%	100.0%
	Primary	Freq	69	55	56	180
		%	38.3%	30.6%	31.1%	100.0%
	Private	Freq	0	4	15	19
		%	.0%	21.1%	78.9%	100.0%
State/Region	Kachin	Freq	7	1	10	18
		%	38.9%	5.6%	55.6%	100.0%
	Kayah	Freq	2	0	6	8
		%	25.0%	.0%	75.0%	100.0%
	Kayin	Freq	0	7	7	14
		%	.0%	50.0%	50.0%	100.0%
	Chin	Freq	5	2	4	11
		%	45.5%	18.2%	36.4%	100.0%
	Sagaing	Freq	4	12	25	41
		%	9.8%	29.3%	61.0%	100.0%
	Tanintheri	Freq	3	3	6	12
		%	25.0%	25.0%	50.0%	100.0%
	Bago	Freq	10	10	17	37
		%	27.0%	27.0%	45.9%	100.0%
	Magway	Freq	6	12	16	34
		%	17.6%	35.3%	47.1%	100.0%
	Mandalay	Freq	11	4	18	33
		%	33.3%	12.1%	54.5%	100.0%
	Mon	Freq	0	5	11	16
		%	.0%	31.2%	68.8%	100.0%
	Rakhine	Freq	0	3	19	22
		%	.0%	13.6%	86.4%	100.0%
	Yangon	Freq	11	7	14	32
		%	34.4%	21.9%	43.8%	100.0%
	Shan (South)	Freq	7	5	10	22
		%	31.8%	22.7%	45.5%	100.0%
	Shan (North)	Freq	5	4	12	21
		%	23.8%	19.0%	57.1%	100.0%
	Shan (East)	Freq	5	0	4	9
		%	55.6%	.0%	44.4%	100.0%
	Ayeyawady	Freq	10	10	24	44
		%	22.7%	22.7%	54.5%	100.0%
	Nay Pyi Taw	Freq	2	1	4	7
		%	28.6%	14.3%	57.1%	100.0%
Urban/Rural	Urban	Freq	33	33	100	166
		%	19.9%	19.9%	60.2%	100.0%
	Rural	Freq	55	53	107	215
		%	25.6%	24.7%	49.8%	100.0%
Type of administration	Govt	Freq	88	82	192	364
		%	24.2%	22.5%	52.6%	100.0%
	Private	Freq	0	4	15	19
		%	.0%	21.1%	78.9%	100.0%
Total		**Freq**	**88**	**86**	**207**	**381**
		%	**23.1%**	**22.6%**	**54.3%**	**100.0%**

Table 3.99 Have Checklist/Job Aid for Antenatal Care by health facility level, by state/region, by urban/rural area

			Have Checklist/Job Aid for AN Care			
			Have (form)	Have (no form)	Do not have	Total
Level of Health Facility	Tertiary	Freq	2	5	15	22
		%	9.1%	22.7%	68.2%	100.0%
	Secondary	Freq	27	12	122	161
		%	16.8%	7.5%	75.8%	100.0%
	Primary	Freq	66	60	54	180
		%	36.7%	33.3%	30.0%	100.0%
	Private	Freq	0	4	15	19
		%	.0%	21.1%	78.9%	100.0%
State/Region	Kachin	Freq	7	2	10	19
		%	36.8%	10.5%	52.6%	100.0%
	Kayah	Freq	2	0	6	8
		%	25.0%	.0%	75.0%	100.0%
	Kayin	Freq	0	7	7	14
		%	.0%	50.0%	50.0%	100.0%
	Chin	Freq	5	2	4	11
		%	45.5%	18.2%	36.4%	100.0%
	Sagaing	Freq	7	7	27	41
		%	17.1%	17.1%	65.9%	100.0%
	Tanintheri	Freq	2	2	8	12
		%	16.7%	16.7%	66.7%	100.0%
	Bago	Freq	12	10	15	37
		%	32.4%	27.0%	40.5%	100.0%
	Magway	Freq	8	9	17	34
		%	23.5%	26.5%	50.0%	100.0%
	Mandalay	Freq	7	5	21	33
		%	21.2%	15.2%	63.6%	100.0%
	Mon	Freq	1	8	7	16
		%	6.2%	50.0%	43.8%	100.0%
	Rakhine	Freq	2	3	17	22
		%	9.1%	13.6%	77.3%	100.0%
	Yangon	Freq	11	7	14	32
		%	34.4%	21.9%	43.8%	100.0%
	Shan (South)	Freq	3	6	13	22
		%	13.6%	27.3%	59.1%	100.0%
	Shan (North)	Freq	4	3	14	21
		%	19.0%	14.3%	66.7%	100.0%
	Shan(East)	Freq	4	0	5	9
		%	44.4%	.0%	55.6%	100.0%
	Ayeyawady	Freq	17	9	18	44
		%	38.6%	20.5%	40.9%	100.0%
	Nay Pyi Taw	Freq	3	1	3	7
		%	42.9%	14.3%	42.9%	100.0%
Urban/Rural	Urban	Freq	34	31	101	166
		%	20.5%	18.7%	60.8%	100.0%
	Rural	Freq	61	50	105	216
		%	28.2%	23.1%	48.6%	100.0%
Type of administration	Govt	Freq	95	77	191	364
		%	26.1%	21.1%	52.5%	100.0%
	Private	Freq	0	4	15	19
		%	.0%	21.1%	78.9%	100.0%
Total		**Freq**	**95**	**81**	**206**	**382**
		%	**24.9%**	**21.2%**	**53.9%**	**100.0%**

Table 3.100 Have Guidebook for Waste Disposal by health facility level, by state/region, by urban/ rural area

			Have Guidebook for Waste Disposal			
			Have (form)	Have (no form)	Do not have	Total
Level of Health Facility	Tertiary	Freq	2	2	18	22
		%	9.1%	9.1%	81.8%	100.0%
	Secondary	Freq	10	16	134	160
		%	6.2%	10.0%	83.8%	100.0%
	Primary	Freq	7	13	160	180
		%	3.9%	7.2%	88.9%	100.0%
	Private	Freq	0	5	14	19
		%	.0%	26.3%	73.7%	100.0%
State/Region	Kachin	Freq	1	3	15	19
		%	5.3%	15.8%	78.9%	100.0%
	Kayah	Freq	0	0	8	8
		%	.0%	.0%	100.0%	100.0%
	Kayin	Freq	0	0	14	14
		%	.0%	.0%	100.0%	100.0%
	Chin	Freq	1	0	10	11
		%	9.1%	.0%	90.9%	100.0%
	Sagaing	Freq	2	5	35	42
		%	4.8%	11.9%	83.3%	100.0%
	Tanintheri	Freq	1	1	10	12
		%	8.3%	8.3%	83.3%	100.0%
	Bago	Freq	1	7	29	37
		%	2.7%	18.9%	78.4%	100.0%
	Magway	Freq	3	2	29	34
		%	8.8%	5.9%	85.3%	100.0%
	Mandalay	Freq	1	2	30	33
		%	3.0%	6.1%	90.9%	100.0%
	Mon	Freq	0	1	15	16
		%	.0%	6.2%	93.8%	100.0%
	Rakhine	Freq	1	1	20	22
		%	4.5%	4.5%	90.9%	100.0%
	Yangon	Freq	1	7	24	32
		%	3.1%	21.9%	75.0%	100.0%
	Shan (South)	Freq	0	2	20	22
		%	.0%	9.1%	90.9%	100.0%
	Shan (North)	Freq	0	2	19	21
		%	.0%	9.5%	90.5%	100.0%
	Shan (East)	Freq	1	0	7	8
		%	12.5%	.0%	87.5%	100.0%
	Ayeyawady	Freq	6	1	36	43
		%	14.0%	2.3%	83.7%	100.0%
	Nay Pyi Taw	Freq	0	2	5	7
		%	.0%	28.6%	71.4%	100.0%
Urban/Rural	Urban	Freq	10	22	132	164
		%	6.1%	13.4%	80.5%	100.0%
	Rural	Freq	9	14	194	217
		%	4.1%	6.5%	89.4%	100.0%
Type of administration	Govt	Freq	19	31	312	362
		%	5.2%	9.1%	85.7%	100.0%
	Private	Freq	0	5	14	19
		%	.0%	26.3%	73.7%	100.0%
Total		**Freq**	**19**	**36**	**326**	**381**
		%	**5.0%**	**9.4%**	**85.6%**	**100.0%**

3.7.10 Use of information and communications technology (ICT)

Table 3.101 Percentage of health facilities by type of information and communications technology (ICT) available

Type of information and communications technology available*	Response	
	N	Per cent
Use of computer	118	30.8%
Use of mobile phone	179	46.7%
Use of smartphone	313	81.7%
Use of tablet	28	7.3%
Use of internet facilities (LAN)	62	16.2%
Use of internet facilities (Wi-Fi)	19	5.0%
Use of other ICT (Wi-Fi)	8	2.1%

*Multiple response table.

Almost all HFs had one ICT appliance, much higher than in 2016. The three most frequently used ICT appliances were smartphones (82 per cent), mobile phones (47 per cent) and computers (31 per cent).

Table 3.102 Type of ICT available by level of health facility, by state/region, by urban/rural area

			Type of ICT available*							
			Computer	Mobile phone	Smartphone	Tablet	LAN	Wi-Fi	Other ICT	Total
Level of Health Facility	Tertiary	Freq	15	15	18	3	3	0	0	22
		%	68.2%	68.2%	81.8%	13.6%	13.6%	.0%	.0%	
	Secondary	Freq	55	82	137	19	27	6	4	161
		%	34.2%	50.9%	85.1%	11.8%	16.8%	3.7%	2.5%	
	Primary	Freq	32	70	144	5	26	11	4	178
		%	18.0%	39.3%	80.9%	2.8%	14.6%	6.2%	2.2%	
	Private	Freq	16	12	14	1	6	2	0	19
		%	84.2%	63.2%	73.7%	5.3%	31.6%	10.5%	.0%	
State/Region	Kachin	Freq	10	17	11	2	0	0	4	19
		%	52.6%	89.5%	57.9%	10.5%	.0%	.0%	21.1%	
	Kayah	Freq	2	8	3	0	1	0	0	8
		%	25.0%	100.0%	37.5%	.0%	12.5%	.0%	.0%	
	Kayin	Freq	1	6	11	0	0	0	0	12
		%	8.3%	50.0%	91.7%	.0%	.0%	.0%	.0%	
	Chin	Freq	1	8	4	0	0	0	0	11
		%	9.1%	72.7%	36.4%	.0%	.0%	.0%	.0%	
	Sagaing	Freq	19	29	28	4	20	3	0	42
		%	45.2%	69.0%	66.7%	9.5%	47.6%	7.1%	.0%	
	Tanintheri	Freq	4	7	10	1	6	1	0	12
		%	33.3%	58.3%	83.3%	8.3%	50.0%	8.3%	.0%	
	Bago	Freq	8	13	34	4	1	0	0	37
		%	21.6%	35.1%	91.9%	10.8%	2.7%	.0%	.0%	
	Magway	Freq	3	10	34	0	0	1	0	34
		%	8.8%	29.4%	100.0%	.0%	.0%	2.9%	.0%	
	Mandalay	Freq	13	10	33	2	0	0	0	33
		%	39.4%	30.3%	100.0%	6.1%	.0%	.0%	.0%	
	Mon	Freq	4	4	15	0	1	0	0	16
		%	25.0%	25.0%	93.8%	.0%	6.2%	.0%	.0%	
	Rakhine	Freq	3	9	19	3	2	0	0	21
		%	14.3%	42.9%	90.5%	14.3%	9.5%	.0%	.0%	
	Yangon	Freq	17	11	30	1	2	3	0	32
		%	53.1%	34.4%	93.8%	3.1%	6.2%	9.4%	.0%	
	Shan (South)	Freq	9	14	9	2	1	0	0	22
		%	40.9%	63.6%	40.9%	9.1%	4.5%	.0%	.0%	
	Shan (North)	Freq	6	5	21	1	0	1	2	21
		%	28.6%	23.8%	100.0%	4.8%	.0%	4.8%	9.5%	
	Shan (East)	Freq	3	8	5	3	0	0	0	9
		%	33.3%	88.9%	55.6%	33.3%	.0%	.0%	.0%	
	Ayeyawady	Freq	12	13	39	2	26	9	2	44
		%	27.3%	29.5%	88.6%	4.5%	59.1%	20.5%	4.5%	
	Nay Pyi Taw	Freq	3	7	7	3	2	1	0	7
		%	42.9%	100.0%	100.0%	42.9%	28.6%	14.3%	.0%	
Urban/Rural	Urban	Freq	79	96	130	19	25	8	3	166
		%	47.6%	57.8%	78.3%	11.4%	15.1%	4.8%	1.8%	

	Rural	Freq	39	83	183	9	37	11	5	214
		%	18.2%	38.8%	85.5%	4.2%	17.3%	5.1%	2.3%	
Type of administration	Govt	Freq	102	167	299	27	56	17	8	361
		%	27.9%	46.1%	82.6%	7.2%	15.7%	4.4%	2.2%	
	Private	Freq	16	12	14	1	6	2	0	19
		%	84.2%	63.2%	73.7%	5.3%	31.6%	10.5%	.0%	
Total		**Freq**	**118**	**179**	**313**	**28**	**62**	**19**	**8**	**380**

*Multiple response table.

For all types of ICT equipment, availability was lowest at primary level HFs. An urban/rural difference was also apparent. Private sector HFs more frequently had ICT equipment. The pattern had not changed from 2016.

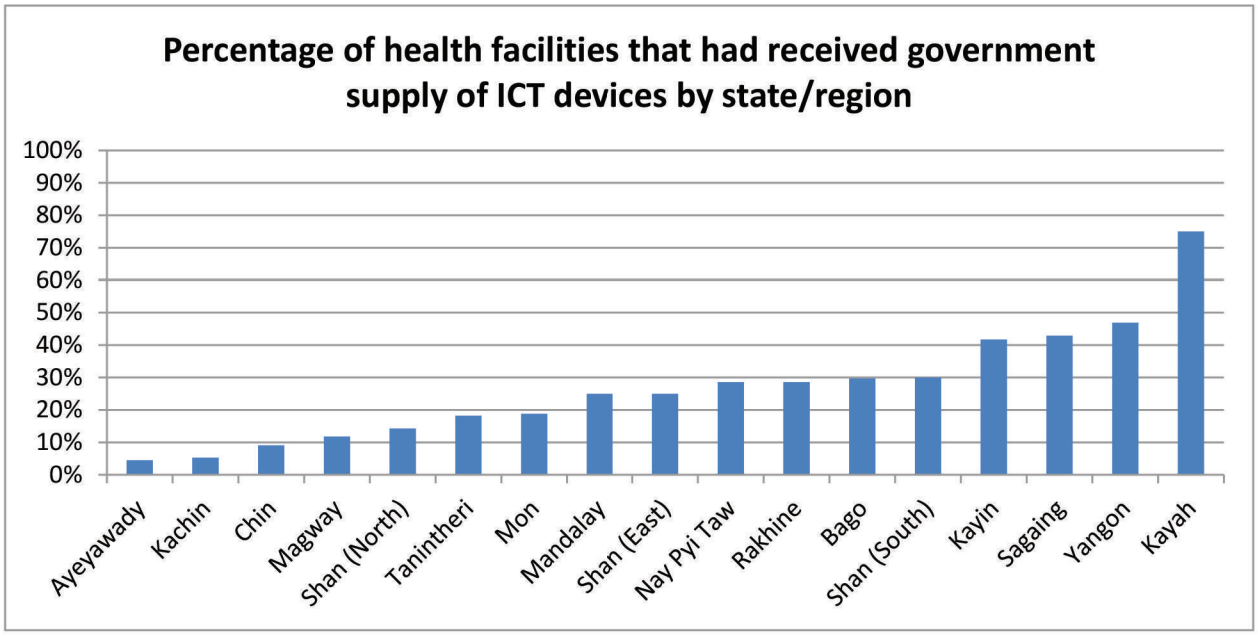
Table 3.103 Percentage of health facilities by how ICT was acquired

			Supplier of ICT*				
			Own	Govt.	Owner of HC.	Donor	Other
Level of Health Facility	Tertiary	Freq	30	22	0	1	0
		%	56.6%	41.5%	0.0%	1.9%	0.0%
	Secondary	Freq	238	57	0	22	2
		%	74.6%	17.9%	0.0%	6.9%	0.6%
	Primary	Freq	259	16	1	9	7
		%	88.7%	5.5%	0.3%	3.1%	2.4%
	Private	Freq	47	0	2	0	0
		%	96%	0%	4%	0%	0%
Urban/Rural	Urban	Freq	258	75	2	15	2
		%	73.3%	21.3%	0.6%	4.3%	0.6%
	Rural	Freq	316	20	1	17	7
		%	87.5%	5.5%	0.3%	4.7%	1.9%
Type of administration	Govt	Freq	525	95	1	32	9
		%	79.3%	14.4%	0.2%	4.8%	1.4%
	Private	Freq	49	0	2	0	0
		%	96.1%	0.0%	3.9%	0.0%	0.0%

*Total = Summation of Numbers of HFs which had all types of ICT

The most frequent response for the source of ICT at HFs was "own", followed by government. ICT supplied by government was lowest at primary level HFs compared to tertiary and secondary level HFs.

Figure 3.14 Percentage of HFs that had received a government supply of ICT devices by state/region



HFs that had received ICT devices from government were mostly observed in Kayah, Yangon, Sagaing and Kayin compared to other states/regions.

Table 3.104 Percentage distribution of health facilities by main purpose for which ICT is used by level of health facility, by state/region and urban/rural area

			Use of IT*										
			Patient register	Hospital record	Patient records	Insurance	Phone billing	Communications	HE	Indent	Training	Consultation	Other	Total
Level of Health Facility	Tertiary	Freq	3	5	1	0	0	5	2	2	1	1	5	15
		%	20.0%	33.3%	6.7%	.0%	.0%	33.3%	13.3%	13.3%	6.7%	6.7%	33.3%	
	Secondary	Freq	10	15	4	1	1	3	9	12	8	1	26	53
		%	18.9%	28.3%	7.5%	1.9%	1.9%	5.7%	17.0%	22.6%	15.1%	1.9%	49.1%	
	Primary	Freq	3	12	2	0	0	2	6	3	2	0	21	32
		%	9.4%	37.5%	6.2%	.0%	.0%	6.2%	18.8%	9.4%	6.2%	.0%	65.6%	
	Private	Freq	5	6	3	0	2	2	0	6	0	1	3	14
		%	35.7%	42.9%	21.4%	.0%	14.3%	14.3%	.0%	42.9%	.0%	7.1%	21.4%	
State/ Region	Kachin	Freq	7	6	2	1	1	1	6	3	4	1	0	7
		%	70.0%	60.0%	20.0%	10.0%	10.0%	10.0%	60.0%	30.0%	40.0%	10.0%	.0%	70.0%
	Kayah	Freq	1	2	0	0	0	1	0	1	0	1	0	1
		%	50.0%	100.0%	.0%	.0%	.0%	50.0%	.0%	50.0%	.0%	50.0%	.0%	50.0%
	Kayin	Freq	0	0	0	0	1	1	0	1	0	0	0	0
		%	.0%	.0%	.0%	.0%	100.0%	100.0%	.0%	100.0%	.0%	.0%	.0%	.0%
	Chin	Freq	0	0	0	0	0	0	0	0	0	0	1	0
		%	.0%	.0%	.0%	.0%	.0%	.0%	.0%	.0%	.0%	.0%	100.0%	.0%
	Sagaing	Freq	2	3	1	0	0	2	0	3	0	0	13	2
		%	10.5%	15.8%	5.3%	.0%	.0%	10.5%	.0%	15.8%	.0%	.0%	68.4%	10.5%
	Tanintheri	Freq	0	2	0	0	0	0	1	0	1	0	1	0
		%	.0%	66.7%	.0%	.0%	.0%	.0%	33.3%	.0%	33.3%	.0%	33.3%	.0%
	Bago	Freq	0	3	0	0	0	0	1	1	1	1	3	0
		%	.0%	37.5%	.0%	.0%	.0%	.0%	12.5%	12.5%	12.5%	12.5%	37.5%	.0%
	Magway	Freq	2	1	1	0	0	1	1	1	1	0	0	2
		%	66.7%	33.3%	33.3%	.0%	.0%	33.3%	33.3%	33.3%	33.3%	.0%	.0%	66.7%
	Mandalay	Freq	3	4	2	0	0	1	3	5	1	0	10	3
		%	23.1%	30.8%	15.4%	.0%	.0%	7.7%	23.1%	38.5%	7.7%	.0%	76.9%	23.1%
	Mon	Freq	0	0	0	0	0	1	0	1	0	0	0	0
		%	.0%	.0%	.0%	.0%	.0%	50.0%	.0%	50.0%	.0%	.0%	.0%	.0%
	Rakhine	Freq	0	1	0	0	0	0	0	0	0	0	2	0
		%	.0%	33.3%	.0%	.0%	.0%	.0%	.0%	.0%	.0%	.0%	66.7%	.0%
	Yangon	Freq	1	0	2	0	0	0	2	3	0	0	16	1
		%	6.2%	.0%	12.5%	.0%	.0%	.0%	12.5%	18.8%	.0%	.0%	100.0%	6.2%
	Shan (South)	Freq	2	3	1	0	0	1	0	1	0	0	4	2
		%	22.2%	33.3%	11.1%	.0%	.0%	11.1%	.0%	11.1%	.0%	.0%	44.4%	22.2%
	Shan (North)	Freq	1	1	0	0	1	2	1	0	0	0	2	1
		%	16.7%	16.7%	.0%	.0%	16.7%	33.3%	16.7%	.0%	.0%	.0%	33.3%	16.7%
	Shan (East)	Freq	1	1	0	0	0	0	0	0	1	0	1	1
		%	33.3%	33.3%	.0%	.0%	.0%	.0%	.0%	.0%	33.3%	.0%	33.3%	33.3%
	Ayeyawady	Freq	0	9	0	0	0	1	2	2	1	0	1	0
		%	.0%	75.0%	.0%	.0%	.0%	8.3%	16.7%	16.7%	8.3%	.0%	8.3%	.0%
	Nay Pyi Taw	Freq	1	2	1	0	0	0	0	1	1	0	1	1
		%	33.3%	66.7%	33.3%	.0%	.0%	.0%	.0%	33.3%	33.3%	.0%	33.3%	33.3%
Urban/Rural	Urban	Freq	17	24	9	1	3	9	9	19	7	3	33	76
		%	22.4%	31.6%	11.8%	1.3%	3.9%	11.8%	11.8%	25.0%	9.2%	3.9%	43.4%	
	Rural	Freq	4	14	1	0	0	3	8	4	4	0	22	38
		%	10.5%	36.8%	2.6%	.0%	.0%	7.9%	21.1%	10.5%	10.5%	.0%	57.9%	
Type of administration	Govt	Freq	15	31	5	0	0	8	15	16	9	1	53	99
		%	15.2%	31.3%	5.1%	.0%	.0%	8.1%	15.2%	16.2%	9.1%	1.0%	53.5%	
	Private	Freq	6	7	5	1	3	4	2	7	2	2	1	14
		%	42.9%	50.0%	35.7%	7.1%	21.4%	28.6%	14.3%	50.0%	14.3%	14.3%	7.1%	

ICT was most frequently used for routine communication, consultations, medical indents and health education.

3.7.11 Waste disposal

Table 3.105 Percentage distribution of health facilities by waste disposal method by level of health facility, by state/region and urban/rural area

			Method of waste disposal*					
			Burning	Burying	Incineration	Municipal system	Waste bins	Total
Level of Health Facility	Tertiary	Freq	7	9	7	10	0	22
		%	31.8%	40.9%	31.8%	45.5%	.0%	
	Secondary	Freq	96	104	25	28	5	161
		%	59.6%	64.6%	15.5%	17.4%	3.1%	
	Primary	Freq	112	121	6	12	3	181
		%	61.9%	66.9%	3.3%	6.6%	1.7%	
	Private	Freq	5	3	1	15	2	19
		%	26.3%	15.8%	5.3%	78.9%	10.5%	
State/Region	Kachin	Freq	9	14	2	4	2	19
		%	47.4%	73.7%	10.5%	21.1%	10.5%	
	Kayah	Freq	7	7	0	1	1	8
		%	87.5%	87.5%	.0%	12.5%	12.5%	
	Kayin	Freq	4	9	2	2	0	14
		%	28.6%	64.3%	14.3%	14.3%	.0%	
	Chin	Freq	7	10	2	1	0	11
		%	63.6%	90.9%	18.2%	9.1%	.0%	
	Sagaing	Freq	28	25	2	4	1	42
		%	66.7%	59.5%	4.8%	9.5%	2.4%	
	Tanintheri	Freq	7	7	1	2	0	12
		%	58.3%	58.3%	8.3%	16.7%	.0%	
	Bago	Freq	27	21	2	9	0	37
		%	73.0%	56.8%	5.4%	24.3%	.0%	
	Magway	Freq	26	26	4	2	0	34
		%	76.5%	76.5%	11.8%	5.9%	.0%	
	Mandalay	Freq	24	15	3	7	0	33
		%	72.7%	45.5%	9.1%	21.2%	.0%	
	Mon	Freq	4	7	3	4	0	16
		%	25.0%	43.8%	18.8%	25.0%	.0%	
	Rakhine	Freq	14	12	1	3	0	22
		%	63.6%	54.5%	4.5%	13.6%	.0%	
	Yangon	Freq	2	14	7	15	1	32
		%	6.2%	43.8%	21.9%	46.9%	3.1%	
	Shan (South)	Freq	17	11	1	1	0	22
		%	77.3%	50.0%	4.5%	4.5%	.0%	
	Shan (North)	Freq	12	19	1	2	0	21
		%	57.1%	90.5%	4.8%	9.5%	.0%	
	Shan (East)	Freq	8	9	0	1	2	9
		%	88.9%	100.0%	.0%	11.1%	22.2%	
	Ayeyawady	Freq	19	29	8	5	2	44
		%	43.2%	65.9%	18.2%	11.4%	4.5%	
	Nay Pyi Taw	Freq	5	2	0	2	1	7
		%	71.4%	28.6%	.0%	28.6%	14.3%	
Urban/Rural	Urban	Freq	82	81	19	61	7	166
		%	49.4%	48.8%	11.4%	36.7%	4.2%	
	Rural	Freq	138	156	20	4	3	217
		%	63.6%	71.9%	9.2%	1.8%	1.4%	
Type of administration	Govt	Freq	215	234	38	50	8	365
		%	58.6%	64.1%	10.4%	14.0%	2.5%	
	Private	Freq	5	3	1	15	2	19
		%	26.3%	15.8%	5.3%	78.9%	10.5%	
Total		**Freq**	**220**	**237**	**39**	**65**	**10**	**383**
		%	**57.4%**	**61.9%**	**10.2%**	**16.2%**	**2.6%**	**100%**

* Multiple response table.

Burying and burning were the most frequently used methods for waste disposal. However, 46 per cent of tertiary level HFs and 79 per cent of private HFs used a municipal disposal system.

3.7.12 Charges for user fees

Table 3.106 Types of users charges

Service or which user fee is charged*	Responses N	Responses Percent	Percent of Cases (N=145) (37.9%)	Percent of all HFs (N=383)
Charging for consultation	20	9.2%	13.8%	5.2%
Charging for medication	134	61.5%	92.4%	35.0%
Charging for specialty services	64	29.4%	44.1%	16.7%

* Multiple response table.

User charges were recorded at 38 per cent of HFs. Respondents from 35 per cent of HFs stated there were user fees especially for medicines and specialty services (17 per cent). HFs that charged for consultation fees only constituted 5 per cent. This comparatively higher number was due to the inclusion of private sector HFs in this analysis. Private sector HFs had no services that were free of charge.

Table 3.107 Percentage distribution of health facilities by type of service for which user fee is charged for consultation by level of health facility, by state/region, and urban/rural area

			For family planning	For ANC	For delivery services	For perinatal care services	For neonatal care services	For under-five childcare services	For HIV (ART) services	Total
Level of HF	Primary	Freq	2	1	2	2	2	2	2	2
		%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	Private	Freq	8	9	9	10	9	9	11	11
		%	72.7%	81.8%	81.8%	90.9%	81.8%	81.8%	100.0%	
State/ Region	Kayah	Freq	1	1	1	1	1	1	1	1
		%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	Sagaing	Freq	1	1	1	1	1	1	1	1
		%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	Bago	Freq	1	0	1	2	1	1	2	2
		%	50.0%	.0%	50.0%	100.0%	50.0%	50.0%	100.0%	
	Mandalay	Freq	3	3	3	3	3	3	3	3
		%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	Mon	Freq	0	1	1	1	1	1	1	1
		%	.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	Rakhine	Freq	0	0	0	0	0	0	1	1
		%	.0%	.0%	.0%	.0%	.0%	.0%	100.0%	
	Yangon	Freq	2	2	2	2	2	2	2	2
		%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	Shan (S)	Freq	1	1	1	1	1	1	1	1
		%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	Shan (N)	Freq	1	1	1	1	1	1	1	1
		%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Urban/Rural	Urban	Freq	9	10	10	11	10	10	12	12
		%	75.0%	83.3%	83.3%	91.7%	83.3%	83.3%	100.0%	
	Rural	Freq	1	0	1	1	1	1	1	1
		%	100.0%	.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Type of administration	Govt	Freq	2	1	2	2	2	2	2	2
		%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	Private	Freq	8	9	9	10	9	9	11	11
		%	72.7%	81.8%	81.8%	90.9%	81.8%	81.8%	100.0%	
Total		**Freq**	**10**	**10**	**11**	**12**	**11**	**11**	**13**	**13**

Table 3.108 Percentage distribution of health facilities by service for which user fee is charged for medication by level of health facility, by state/region, and urban/rural area

			For family planning	For ANC medication	For childcare medication	Total
Level of Health Facility	Tertiary	Freq	1	2	2	2
		%	50.0%	100.0%	100.0%	
	Secondary	Freq	14	18	25	27
		%	51.9%	66.7%	92.6%	
	Primary	Freq	10	17	19	21
		%	47.6%	81.0%	90.5%	
	Private	Freq	7	7	7	7
		%	100.0%	100.0%	100.0%	
State/Region	Kachin	Freq	0	1	2	2
		%	.0%	50.0%	100.0%	
	Kayah	Freq	1	0	1	1
		%	100.0%	.0%	100.0%	
	Kayin	Freq	1	0	0	1
		%	100.0%	.0%	.0%	
	Chin	Freq	2	2	2	2
		%	100.0%	100.0%	100.0%	
	Sagaing	Freq	0	10	11	11
		%	.0%	90.9%	100.0%	
	Tanintheri	Freq	1	1	1	1
		%	100.0%	100.0%	100.0%	
	Bago	Freq	16	16	16	16
		%	100.0%	100.0%	100.0%	
	Magway	Freq	2	1	2	2
		%	100.0%	50.0%	100.0%	
	Mandalay	Freq	0	3	4	5
		%	.0%	60.0%	80.0%	
	Mon	Freq	2	2	2	2
		%	100.0%	100.0%	100.0%	
	Rakhine	Freq	2	1	2	2
		%	100.0%	50.0%	100.0%	
	Yangon	Freq	0	1	1	1
		%	.0%	100.0%	100.0%	
	Shan (South)	Freq	0	1	0	1
		%	.0%	100.0%	.0%	
	Shan (North)	Freq	3	4	5	6
		%	50.0%	66.7%	83.3%	
	Shan (East)	Freq	2	1	4	4
		%	50.0%	25.0%	100.0%	
	Ayeyawady	Freq	0	1	2	2
		%	.0%	50.0%	100.0%	
	Nay Pyi Taw	Freq	1	0	1	1
		%	100.0%	.0%	100.0%	
Urban/Rural	Urban	Freq	17	21	24	27
		%	63.0%	77.8%	88.9%	
	Rural	Freq	15	23	29	30
		%	50.0%	76.7%	96.7%	
Type of administration	Govt	Freq	25	37	46	50
		%	51.0%	74.5%	92.2%	
	Private	Freq	7	7	7	7
		%	100.0%	100.0%	100.0%	
Total		**Freq**	**32**	**44**	**53**	**57**

User fees for medication were most frequently charged at HFs at the tertiary level and charges were also more apparent in urban HFs.

Table 3.109 Percentage distribution of health facilities by service provided by a qualified healthcare provider for which user fee is charged by level of health facility, by state/region, and urban/rural area

			For family planning	For ANC	For delivery	For postnatal care	For newborn care	For under-five child care	For HIV (ART)	Total
Level of Health Facility	Tertiary	Freq	0	0	0	0	0	1	1	1
		%	.0%	.0%	.0%	.0%	.0%	100.0%	100.0%	
	Secondary	Freq	0	1	2	1	4	6	6	8
		%	.0%	12.5%	25.0%	12.5%	50.0%	75.0%	75.0%	
	Primary	Freq	3	4	4	4	4	5	7	7
		%	42.9%	57.1%	57.1%	57.1%	57.1%	71.4%	100.0%	
	Private	Freq	8	8	8	8	8	8	8	9
		%	88.9%	88.9%	88.9%	88.9%	88.9%	88.9%	88.9%	
State/Region	Kayah	Freq	0	1	1	1	1	1	1	1
		%	.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
		%	1	1	1	1	1	1	1	1
	Sagaing	Freq	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
		%	0	0	0	0	0	0	1	1
	Bago	Freq	.0%	.0%	.0%	.0%	.0%	.0%	100.0%	
		%	0	0	0	0	1	2	1	2
	Magway	Freq	.0%	.0%	.0%	.0%	50.0%	100.0%	50.0%	
		%	4	4	4	4	4	4	4	4
	Mandalay	Freq	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
		%	2	2	2	2	2	2	2	2
	Yangon	Freq	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
		%	2	1	1	1	2	2	4	5
	Shan (South)	Freq	40.0%	20.0%	20.0%	20.0%	40.0%	40.0%	80.0%	
		%	1	1	2	1	2	4	4	5
	Shan (North)	Freq	20.0%	20.0%	40.0%	20.0%	40.0%	80.0%	80.0%	
		%	1	2	2	2	2	3	3	3
	Shan (East)	Freq	33.3%	66.7%	66.7%	66.7%	66.7%	100.0%	100.0%	
		%	0	1	1	1	1	1	1	1
	Ayeyawady	Freq	.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
		%	0	1	1	1	1	1	1	1
Urban/Rural	Urban	Freq	8	8	8	8	9	11	11	13
		%	61.5%	61.5%	61.5%	61.5%	69.2%	84.6%	84.6%	
	Rural	Freq	3	5	6	5	7	9	11	12
		%	25.0%	41.7%	50.0%	41.7%	58.3%	75.0%	91.7%	
Type of administration	Govt	Freq	3	5	6	7	8	12	14	16
		%	23.5%	35.3%	41.2%	35.3%	52.9%	76.5%	88.2%	
	Private	Freq	8	8	8	8	8	8	8	9
		%	88.9%	88.9%	88.9%	88.9%	88.9%	88.9%	88.9%	
Total		**Freq**	**11**	**13**	**14**	**13**	**16**	**20**	**22**	**25**

Table 3.110 Percentage distribution of health facilities offering modern contraceptive methods by level of health facility, by state/region, and urban/rural area

			Offering modern contraceptive method*								
			Male condom	Female condom	OCP	Injectable	ECP	IUD	Implant	Female sterilization	Total
Level of Health Facility	Tertiary	Freq	15	3	17	21	9	21	14	21	22
		%	68.2%	13.6%	77.3%	95.5%	40.9%	95.5%	63.6%	95.5%	
	Secondary	Freq	69	8	143	145	50	82	59	86	159
		%	43.4%	5.0%	89.9%	91.2%	31.4%	51.6%	37.1%	54.1%	
	Primary	Freq	123	11	173	175	112	41	5	1	180
		%	68.3%	6.1%	96.1%	97.2%	62.2%	22.8%	2.8%	.6%	
	Private	Freq	9	1	15	15	10	13	10	15	18
		%	50.0%	5.6%	83.3%	83.3%	55.6%	72.2%	55.6%	83.3%	
State/Region	Kachin	Freq	8	2	19	19	13	10	3	7	19
		%	42.1%	10.5%	100.0%	100.0%	68.4%	52.6%	15.8%	36.8%	
	Kayah	Freq	7	0	8	8	5	2	0	2	8
		%	87.5%	.0%	100.0%	100.0%	62.5%	25.0%	.0%	25.0%	
	Kayin	Freq	4	0	13	14	4	6	7	5	14
		%	28.6%	.0%	92.9%	100.0%	28.6%	42.9%	50.0%	35.7%	
	Chin	Freq	6	1	11	10	2	3	2	2	11
		%	54.5%	9.1%	100.0%	90.9%	18.2%	27.3%	18.2%	18.2%	
	Sagaing	Freq	23	1	39	39	15	12	4	13	42
		%	54.8%	2.4%	92.9%	92.9%	35.7%	28.6%	9.5%	31.0%	
	Tanintheri	Freq	7	0	12	12	8	8	4	6	12
		%	58.3%	.0%	100.0%	100.0%	66.7%	66.7%	33.3%	50.0%	
	Bago	Freq	8	5	30	29	15	14	1	10	37
		%	21.6%	13.5%	81.1%	78.4%	40.5%	37.8%	2.7%	27.0%	
	Magway	Freq	13	0	32	33	4	12	12	7	34
		%	38.2%	.0%	94.1%	97.1%	11.8%	35.3%	35.3%	20.6%	
	Mandalay	Freq	22	1	31	30	21	23	18	15	33
		%	66.7%	3.0%	93.9%	90.9%	63.6%	69.7%	54.5%	45.5%	
	Mon	Freq	11	1	14	15	7	8	0	8	16
		%	68.8%	6.2%	87.5%	93.8%	43.8%	50.0%	.0%	50.0%	
	Rakhine	Freq	14	4	17	19	8	4	1	6	19
		%	73.7%	21.1%	89.5%	100.0%	42.1%	21.1%	5.3%	31.6%	
	Yangon	Freq	14	2	25	29	19	12	12	9	31
		%	45.2%	6.5%	80.6%	93.5%	61.3%	38.7%	38.7%	29.0%	
	Shan (South)	Freq	17	2	22	22	13	16	10	7	22
		%	77.3%	9.1%	100.0%	100.0%	59.1%	72.7%	45.5%	31.8%	
	Shan (North)	Freq	17	0	20	21	11	6	5	7	21
		%	81.0%	.0%	95.2%	100.0%	52.4%	28.6%	23.8%	33.3%	
	Shan (East)	Freq	8	0	9	9	2	0	0	1	9
		%	88.9%	.0%	100.0%	100.0%	22.2%	.0%	.0%	11.1%	
	Ayeyawady	Freq	31	2	40	41	28	19	9	15	44
		%	70.5%	4.5%	90.9%	93.2%	63.6%	43.2%	20.5%	34.1%	
	Nay Pyi Taw	Freq	6	2	6	6	6	2	0	3	7
		%	85.7%	28.6%	85.7%	85.7%	85.7%	28.6%	.0%	42.9%	
Urban/Rural	Urban	Freq	93	12	141	156	79	93	59	86	164
		%	56.7%	7.3%	86.0%	95.1%	48.2%	56.7%	36.0%	52.4%	
	Rural	Freq	123	11	207	200	102	64	29	37	215
		%	57.2%	5.1%	96.3%	93.0%	47.4%	29.8%	13.5%	17.2%	
Type of administration	Govt	Freq	207	22	333	341	171	144	78	106	361
		%	57.7%	6.1%	92.3%	94.2%	47.5%	39.2%	21.5%	29.6%	
	Private	Freq	9	1	15	15	10	13	10	15	18
		%	50.0%	5.6%	83.3%	83.3%	55.6%	72.2%	55.6%	83.3%	
Total		**Freq**	**216**	**23**	**348**	**356**	**181**	**157**	**88**	**123**	**379**

* Multiple response table.

The OCP and injectable contraceptives were the most commonly provided family planning methods at all levels of HFs. The majority of tertiary level HFs provided male condoms, OCPs, injectables, IUDs and female sterilization. Commonly available family planning methods at primary level HFs were OCPs, injectables, ECP and male condoms. Female condoms, ECP, IUDs and implants were not as available at all levels of HFs. An urban/rural difference was evident for IUDs, implants and female sterilization. The pattern was similar to 2016.

Table 3.111 Percentage distribution of health facilities with any maternal/reproductive health medicine available by level of health facility, by state/region, and urban/rural area

			Available MRH Medicine																
			Ampicillin	Azithromycin	Penicillin	Beta dexa	Calcium gluconate	Cefixime	Gentamycin	Hydralazine	MgSO4	M-Dopa	Metro	Misoprostol	Nifedipine	Oxytocin	NaLactate	TT	Total
Level of Health Facility	Tertiary	Freq	14	18	14	20	18	18	13	11	22	11	18	15	14	19	20	20	22
		%	63.6%	81.8%	63.6%	90.9%	81.8%	81.8%	59.1%	50.0%	100.0%	50.0%	81.8%	68.2%	63.6%	86.4%	90.9%	90.9%	
	Secondary	Freq	88	107	115	120	114	106	121	29	115	63	141	105	112	138	139	117	161
		%	54.7%	66.5%	71.4%	74.5%	70.8%	65.8%	75.2%	18.0%	71.4%	39.1%	87.6%	65.2%	69.6%	85.7%	86.3%	72.7%	
	Primary	Freq	77	94	46	78	61	62	105	19	149	31	154	139	127	157	151	99	181
		%	42.5%	51.9%	25.4%	43.1%	33.7%	34.3%	58.0%	10.5%	82.3%	17.1%	85.1%	76.8%	70.2%	86.7%	83.4%	54.7%	
	Private	Freq	15	18	16	18	17	18	18	9	14	13	19	16	19	17	19	19	19
		%	78.9%	94.7%	84.2%	94.7%	89.5%	94.7%	94.7%	47.4%	73.7%	68.4%	100.0%	84.2%	100.0%	89.5%	100.0%	100.0%	
State/Region	Kachin	Freq	11	16	14	17	15	15	19	6	13	8	19	19	18	17	19	16	19
		%	57.9%	84.2%	73.7%	89.5%	78.9%	78.9%	100.0%	31.6%	68.4%	42.1%	100.0%	100.0%	94.7%	89.5%	100.0%	84.2%	
	Kayah	Freq	3	6	4	5	5	6	8	0	7	0	5	4	5	6	7	8	8
		%	37.5%	75.0%	50.0%	62.5%	62.5%	75.0%	100.0%	.0%	87.5%	.0%	62.5%	50.0%	62.5%	75.0%	87.5%	100.0%	
	Kayin	Freq	11	13	6	11	9	6	13	4	9	4	14	9	11	14	10	12	14
		%	78.6%	92.9%	42.9%	78.6%	64.3%	42.9%	92.9%	28.6%	64.3%	28.6%	100.0%	64.3%	78.6%	100.0%	71.4%	85.7%	
	Chin	Freq	5	2	3	2	1	1	4	1	3	0	10	4	9	4	4	3	11
		%	45.5%	18.2%	27.3%	18.2%	9.1%	9.1%	36.4%	9.1%	27.3%	.0%	90.9%	36.4%	81.8%	36.4%	36.4%	27.3%	
	Sagaing	Freq	12	34	22	24	29	23	29	4	33	13	32	27	26	34	30	17	42
		%	28.6%	81.0%	52.4%	57.1%	69.0%	54.8%	69.0%	9.5%	78.6%	31.0%	76.2%	64.3%	61.9%	81.0%	71.4%	40.5%	
	Tanintheri	Freq	4	6	9	6	7	7	10	1	10	3	11	10	10	11	11	6	12
		%	33.3%	50.0%	75.0%	50.0%	58.3%	58.3%	83.3%	8.3%	83.3%	25.0%	91.7%	83.3%	83.3%	91.7%	91.7%	50.0%	
	Bago	Freq	5	10	8	10	12	12	6	2	26	3	26	19	13	28	31	15	37
		%	13.5%	27.0%	21.6%	27.0%	32.4%	32.4%	16.2%	5.4%	70.3%	8.1%	70.3%	51.4%	35.1%	75.7%	83.8%	40.5%	
	Magway	Freq	21	20	15	15	13	10	19	5	24	4	29	20	18	34	31	23	34
		%	61.8%	58.8%	44.1%	44.1%	38.2%	29.4%	55.9%	14.7%	70.6%	11.8%	85.3%	58.8%	52.9%	100.0%	91.2%	67.6%	
	Mandalay	Freq	17	22	13	18	19	24	21	8	28	10	31	29	18	32	33	15	33
		%	51.5%	66.7%	39.4%	54.5%	57.6%	72.7%	63.6%	24.2%	84.8%	30.3%	93.9%	87.9%	54.5%	97.0%	100.0%	45.5%	
	Mon	Freq	5	9	7	13	12	8	10	5	16	11	15	15	14	13	8	13	16
		%	31.2%	56.2%	43.8%	81.2%	75.0%	50.0%	62.5%	31.2%	100.0%	68.8%	93.8%	93.8%	87.5%	81.2%	50.0%	81.2%	
	Rakhine	Freq	11	11	9	10	9	14	12	5	14	7	19	13	17	20	20	17	22
		%	50.0%	50.0%	40.9%	45.5%	40.9%	63.6%	54.5%	22.7%	63.6%	31.8%	86.4%	59.1%	77.3%	90.9%	90.9%	77.3%	
	Yangon	Freq	16	24	15	26	19	22	24	3	29	7	28	18	30	19	29	27	32
		%	50.0%	75.0%	46.9%	81.2%	59.4%	68.8%	75.0%	9.4%	90.6%	21.9%	87.5%	56.2%	93.8%	59.4%	90.6%	84.4%	
	Shan (South)	Freq	15	11	9	19	12	13	20	2	16	5	21	18	12	21	22	12	22
		%	68.2%	50.0%	40.9%	86.4%	54.5%	59.1%	90.9%	9.1%	72.7%	22.7%	95.5%	81.8%	54.5%	95.5%	100.0%	54.5%	
	Shan (North)	Freq	12	15	13	15	11	12	17	3	16	8	17	15	19	20	19	15	21
		%	57.1%	71.4%	61.9%	71.4%	52.4%	57.1%	81.0%	14.3%	76.2%	38.1%	81.0%	71.4%	90.5%	95.2%	90.5%	71.4%	
	Shan (East)	Freq	5	7	5	7	5	6	9	1	7	3	8	4	5	9	9	8	9
		%	55.6%	77.8%	55.6%	77.8%	55.6%	66.7%	100.0%	11.1%	77.8%	33.3%	88.9%	44.4%	55.6%	100.0%	100.0%	88.9%	
	Ayeyawady	Freq	35	28	33	36	29	22	34	17	44	31	41	44	41	42	40	42	44

		%	79.5%	63.6%	75.0%	81.8%	65.9%	50.0%	77.3%	38.6%	100.0%	70.5%	93.2%	100.0%	93.2%	95.5%	90.9%	95.5%	
	Nay Pyi Taw	Freq	6	3	6	2	3	3	2	1	5	1	6	7	6	7	6	6	7
		%	85.7%	42.9%	85.7%	28.6%	42.9%	42.9%	28.6%	14.3%	71.4%	14.3%	85.7%	100.0%	85.7%	100.0%	85.7%	85.7%	
Urban/Rural	Urban	Freq	98	119	102	120	111	110	118	43	128	60	146	122	129	142	150	129	166
		%	59.0%	71.7%	61.4%	72.3%	66.9%	66.3%	71.1%	25.9%	77.1%	36.1%	88.0%	73.5%	77.7%	85.5%	90.4%	77.7%	
	Rural	Freq	96	118	89	116	99	94	139	25	172	58	186	153	143	189	179	126	217
		%	44.2%	54.4%	41.0%	53.5%	45.6%	43.3%	64.1%	11.5%	79.3%	26.7%	85.7%	70.5%	65.9%	87.1%	82.5%	58.1%	
Type of administration	Govt	Count	179	219	175	218	193	186	239	59	286	105	313	257	253	314	310	236	364
		%	49.0%	60.0%	47.7%	59.7%	52.9%	51.0%	65.8%	16.4%	78.4%	29.0%	86.0%	70.7%	69.6%	86.0%	85.2%	64.9%	
	Private	Count	15	18	16	18	17	18	18	9	14	13	19	16	19	17	19	19	19
		%	78.9%	94.7%	84.2%	94.7%	89.5%	94.7%	94.7%	47.4%	73.7%	68.4%	100.0%	84.2%	100.0%	89.5%	100.0%	100.0%	
Total		**Count**	**194**	**237**	**191**	**236**	**210**	**204**	**257**	**68**	**300**	**118**	**332**	**275**	**272**	**331**	**329**	**255**	**383**

Table 3.112 Percentage distribution of health facilities with any modern contraceptive method in-stock (no stock-out) in last three months by level of health facility, by state/region, and urban/rural area

			Male condom	Female condom	OCP	Injectable	ECP	IUD	Implant	Female sterilization
Level of Health Facility	Tertiary	Freq	14	4	15	19	7	18	10	16
		%	63.6%	18.2%	68.2%	86.4%	31.8%	81.8%	45.5%	72.7%
	Secondary	Freq	48	10	127	111	43	63	40	63
		%	31.8%	6.6%	84.1%	73.5%	28.5%	41.7%	26.5%	41.7%
	Primary	Freq	89	10	144	135	88	40	4	0
		%	53.0%	6.0%	85.7%	80.4%	52.4%	23.8%	2.4%	.0%
	Private	Freq	11	2	15	16	13	14	10	7
		%	68.8%	12.5%	93.8%	100.0%	81.2%	87.5%	62.5%	43.8%
State/Region	Kachin	Freq	7	2	19	17	12	10	1	8
		%	36.8%	10.5%	100.0%	89.5%	63.2%	52.6%	5.3%	42.1%
	Kayah	Freq	6	0	8	8	5	4	0	0
		%	75.0%	.0%	100.0%	100.0%	62.5%	50.0%	.0%	.0%
	Kayin	Freq	4	0	12	13	4	5	6	5
		%	30.8%	.0%	92.3%	100.0%	30.8%	38.5%	46.2%	38.5%
	Chin	Freq	4	1	10	10	1	3	1	2
		%	36.4%	9.1%	90.9%	90.9%	9.1%	27.3%	9.1%	18.2%
	Sagaing	Freq	11	1	33	27	11	6	1	12
		%	28.2%	2.6%	84.6%	69.2%	28.2%	15.4%	2.6%	30.8%
	Tanintheri	Freq	5	1	12	12	7	6	1	5
		%	41.7%	8.3%	100.0%	100.0%	58.3%	50.0%	8.3%	41.7%
	Bago	Freq	3	2	25	16	10	15	3	8
		%	8.8%	5.9%	73.5%	47.1%	29.4%	44.1%	8.8%	23.5%
	Magway	Freq	9	0	29	26	3	6	9	8
		%	27.3%	.0%	87.9%	78.8%	9.1%	18.2%	27.3%	24.2%
	Mandalay	Freq	12	1	23	17	11	15	12	7
		%	40.0%	3.3%	76.7%	56.7%	36.7%	50.0%	40.0%	23.3%
	Mon	Freq	10	1	12	12	6	8	0	7
		%	66.7%	6.7%	80.0%	80.0%	40.0%	53.3%	.0%	46.7%
	Rakhine	Freq	10	5	15	15	9	7	0	2
		%	58.8%	29.4%	88.2%	88.2%	52.9%	41.2%	.0%	11.8%
	Yangon	Freq	14	1	22	27	20	12	11	4
		%	48.3%	3.4%	75.9%	93.1%	69.0%	41.4%	37.9%	13.8%
	Shan (South)	Freq	15	3	21	21	11	12	9	7
		%	71.4%	14.3%	100.0%	100.0%	52.4%	57.1%	42.9%	33.3%
	Shan (North)	Freq	15	0	18	17	10	5	4	3
		%	71.4%	.0%	85.7%	81.0%	47.6%	23.8%	19.0%	14.3%
	Shan (East)	Freq	7	0	8	8	2	0	0	0
		%	87.5%	.0%	100.0%	100.0%	25.0%	.0%	.0%	.0%
	Ayeyawady	Freq	24	7	28	30	23	17	6	6
		%	60.0%	17.5%	70.0%	75.0%	57.5%	42.5%	15.0%	15.0%
	Nay Pyi Taw	Freq	6	1	6	5	6	4	0	2
		%	85.7%	14.3%	85.7%	71.4%	85.7%	57.1%	.0%	28.6%
Urban/Rural	Urban	Freq	71	13	129	132	72	85	46	55
		%	46.1%	8.4%	83.8%	85.7%	46.8%	55.2%	29.9%	35.7%
	Rural	Freq	91	13	172	149	79	50	18	31
		%	44.8%	6.4%	84.7%	73.4%	38.9%	24.6%	8.9%	15.3%

No stocks-outs of contraceptive methods over the last three months were only observed for OCPs and injectables at all levels of HFs (more than 70 per cent). No stock-outs for female condoms were lowest at all levels of HFs (less than 20 per cent). Implant 'no stock-outs' had improved since 2016 (at more than 20 per cent) for government sector HFs at all levels. IUDs and female sterilization 'no stock-outs' were moderately observed at all levels of government HFs except at primary level HFs (20 to 40 per cent).

Table 3.113 Percentage distribution of health facilities with a modern contraceptive method in stock (no stock-out) at the time of the survey by level of health facility, by state/region, and urban/rural area

			Contraceptive no recent stock-out*							
			Male condom	Female condom	OCP	Injectables	ECP	IUD	Implant	Female sterilization
Level of Health Facility	Tertiary	Freq	17	4	16	19	8	17	9	5
		%	81.0%	19.0%	76.2%	90.5%	38.1%	81.0%	42.9%	23.8%
	Secondary	Freq	56	21	124	117	53	61	45	21
		%	36.8%	13.8%	81.6%	77.0%	34.9%	40.1%	29.6%	13.8%
	Primary	Freq	91	12	155	149	91	46	6	0
		%	52.9%	7.0%	90.1%	86.6%	52.9%	26.7%	3.5%	.0%
	Private	Freq	8	0	11	12	8	9	10	4
		%	66.7%	.0%	91.7%	100.0%	66.7%	75.0%	83.3%	33.3%
State/Region	Kachin	Freq	8	3	19	18	12	10	2	1
		%	42.1%	15.8%	100.0%	94.7%	63.2%	52.6%	10.5%	5.3%
	Kayah	Freq	6	0	8	8	3	4	0	0
		%	75.0%	.0%	100.0%	100.0%	37.5%	50.0%	.0%	.0%
	Kayin	Freq	4	0	11	13	4	6	6	0
		%	30.8%	.0%	84.6%	100.0%	30.8%	46.2%	46.2%	.0%
	Chin	Freq	4	1	6	6	3	3	1	1
		%	57.1%	14.3%	85.7%	85.7%	42.9%	42.9%	14.3%	14.3%
	Sagaing	Freq	17	3	31	31	19	11	2	6
		%	45.9%	8.1%	83.8%	83.8%	51.4%	29.7%	5.4%	16.2%
	Tanintheri	Freq	4	1	11	11	6	5	1	1
		%	36.4%	9.1%	100.0%	100.0%	54.5%	45.5%	9.1%	9.1%
	Bago	Freq	9	4	28	25	13	10	3	2
		%	25.0%	11.1%	77.8%	69.4%	36.1%	27.8%	8.3%	5.6%
	Magway	Freq	11	0	31	26	5	3	6	0
		%	32.4%	.0%	91.2%	76.5%	14.7%	8.8%	17.6%	.0%
	Mandalay	Freq	14	4	26	19	15	18	14	3
		%	42.4%	12.1%	78.8%	57.6%	45.5%	54.5%	42.4%	9.1%
	Mon	Freq	8	0	14	12	4	9	0	2
		%	53.3%	.0%	93.3%	80.0%	26.7%	60.0%	.0%	13.3%
	Rakhine	Freq	10	5	15	17	7	5	1	1
		%	52.6%	26.3%	78.9%	89.5%	36.8%	26.3%	5.3%	5.3%
	Yangon	Freq	11	2	25	28	18	12	13	3
		%	35.5%	6.5%	80.6%	90.3%	58.1%	38.7%	41.9%	9.7%
	Shan (South)	Freq	11	3	14	15	8	8	7	4
		%	73.3%	20.0%	93.3%	100.0%	53.3%	53.3%	46.7%	26.7%
	Shan (North)	Freq	16	0	19	19	7	4	4	0
		%	76.2%	.0%	90.5%	90.5%	33.3%	19.0%	19.0%	.0%
	Shan (East)	Freq	8	1	9	9	3	1	1	0
		%	88.9%	11.1%	100.0%	100.0%	33.3%	11.1%	11.1%	.0%
	Ayeyawady	Freq	24	10	32	33	27	20	8	5
		%	57.1%	23.8%	76.2%	78.6%	64.3%	47.6%	19.0%	11.9%
	Nay Pyi Taw	Freq	7	0	7	7	6	4	1	1
		%	100.0%	.0%	100.0%	100.0%	85.7%	57.1%	14.3%	14.3%
Urban/Rural	Urban	Freq	76	19	124	132	80	75	50	21
		%	50.0%	12.5%	81.6%	86.8%	52.6%	49.3%	32.9%	13.8%
	Rural	Freq	96	18	182	165	80	58	20	9
		%	46.8%	8.8%	88.8%	80.5%	39.0%	28.3%	9.8%	4.4%

*Multiple response table.

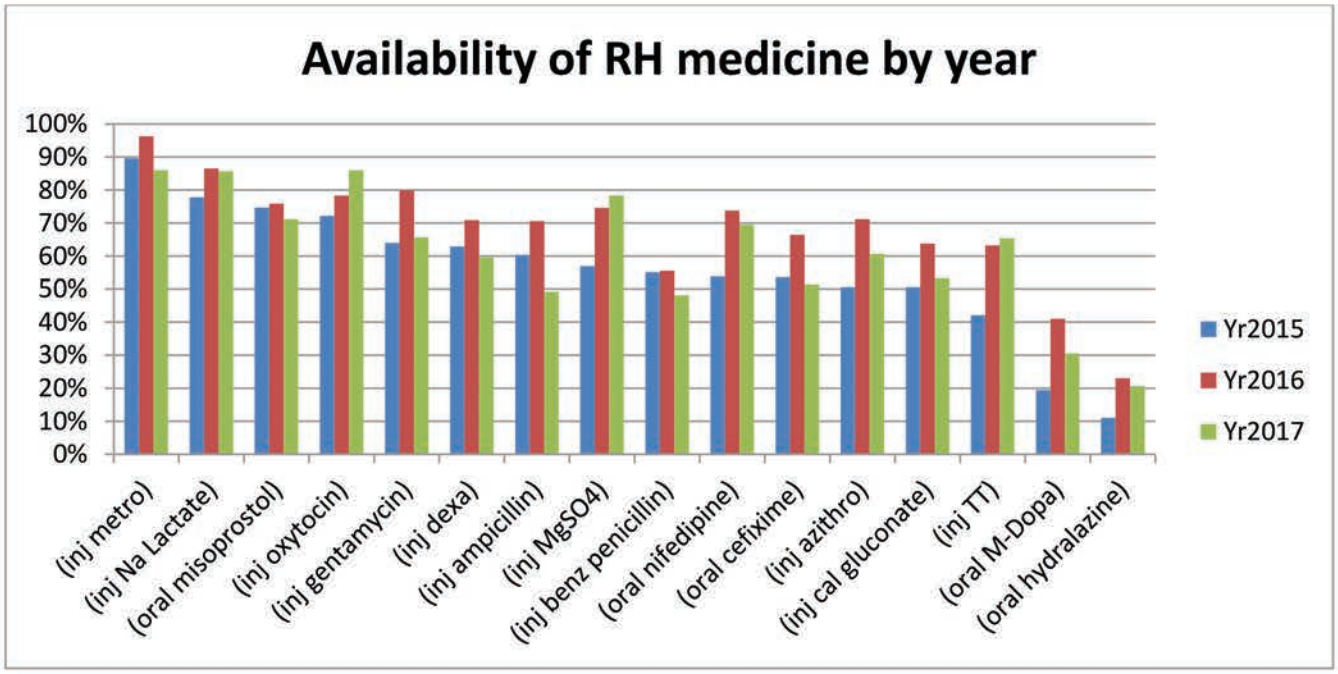
A recent "no stock-out" rate was very low for female condoms at all levels of HFs (less than 20 per cent). The highest "no stock-out" rate at HFs at all levels was for the OCP and injectable methods (more than 75 per cent). No stock-outs for other family planning methods were apparent (20 to 50 per cent). A significant urban/rural discrepancy was noted for implants and female sterilization.

Table 3.114 Availability of life-saving maternal and reproductive health medicines, 2015 to 2017

RH Medicine	2015	2016	2017
(Inj metro)	89.6%	96.3%	86.0%
(Inj Na Lactate)	77.8%	86.5%	85.7%
(Oral misoprostol)	74.7%	75.9%	71.2%
(Inj oxytocin)	72.2%	78.3%	86.0%
(Inj gentamycin)	64.0%	79.9%	65.7%
(Inj dexa)	62.9%	70.9%	59.6%
(Inj ampicillin)	60.4%	70.6%	49.2%
(Inj MgSO4)	57.0%	74.6%	78.3%
(Inj benz penicillin)	55.1%	55.6%	48.1%
(Oral nifedipine)	53.9%	73.8%	69.5%
(Oral cefixime)	53.7%	66.4%	51.4%
(Inj azithro)	50.6%	71.2%	60.7%
(Inj cal gluconate)	50.6%	63.8%	53.3%
(Inj TT)	42.1%	63.2%	65.4%
(Oral M-Dopa)	19.4%	41.0%	30.5%
(Oral hydralazine)	11.0%	23.0%	20.6%

The four most common reproductive health life-saving medicines in 2017 were Inj. Metronidazole (86 per cent), Na Lactate (86 per cent), Oral misoprostol (71 per cent) and Inj. Oxytocin (86 per cent). Inj Meg Sulph. was available at 78 per cent of all HFs. The least frequently available medicines were M-dopa (31 per cent) and Hydralazine (21 per cent). Sixty-five per cent of HFs at all levels had injectable TT. It was not relevant to include primary level HFs in this analysis as most HFs had no continuous cold chain to keep the TT injection at their facility at all times. The availability of some type of reproductive health medicine (metro, misoprostol, genta,dexa, MgSO4, penicillin, cefixime, nifedipine, azithro, and calcium) was lower in the 2017 assessment compared to 2016.

Figure 3.15 Availability of RH medicine by year



4. Findings from client interviews

Table 4.1 Background characteristics of clients by state/region, by level of health facility, urban/rural area

State/Region	Frequency	Per cent
Kachin	66	6
Kayah	65	6
Kayin	65	6
Chin	64	6
Sagaing	65	6
Tanintheri	64	6
Bago	65	6
Magway	65	6
Mandalay	58	5
Mon	66	6
Rakhine	64	6
Yangon	67	6
Shan (South)	73	7
Shan (North)	64	6
Shan (East)	65	6
Ayeyawady	65	6
Nay Pyi Taw	69	6
Tertiary	86	8
Secondary	327	30
Primary	697	63
Urban	370	33
Rural	740	67
Total	**1110**	**100.0**

The distribution of clients who responded to the client exit interview by state/region, level of HF and urban/rural are described in table 4.1. This year's assessment planned to recruit sample clients in equal number in all states regions. In each state/region, five clients from one tertiary HF, 20 from two secondary HFs and 40 from four primary HFs were included in the assessment selected from HFs' client registers. No clients from private sector HFs were included. Most clients were interviewed at home, rather than at clinics, by specifically recruited and trained enumerators from State/Region Public Health Departments. Client recruitment was also proportionately in accordance with the level of facility and urban/rural status. The proportion of clients in rural areas was nearly twice that of urban areas.

Table 4.2 Background characteristics of clients, by level of health facility, urban/rural area

		Urban/Rural		
		Urban	Rural	Total
Health Facility Level	Tertiary	86	0	86
	Secondary	149	178	327
	Primary	135	562	697
Total		**370**	**740**	**1110**

Table 4.3 Percentage distribution of clients by level of health facility, by sex

			Sex		
			Male	Female	Total
Health Facility Level	Tertiary	Freq	0	86	86
		%	.0%	100.0%	100.0%
	Secondary	Freq	0	327	327
		%	.0%	100.0%	100.0%
	Primary	Freq	2	695	697
		%	.3%	99.7%	100.0%
	Total	**Freq**	**2**	**1108**	**1110**
		%	**.2%**	**99.8%**	**100.0%**

Table 4.4 Percentage distribution of clients by five-year age group, by level of health facility, by state/region, and urban/rural area

			Age group (year)								
			15-19	20-24	25-29	30-34	35-39	40–44	45-49	50+	Total
Health Facility Level	Tertiary	Freq	5	17	26	14	15	6	3	0	86
		%	5.8%	19.8%	30.2%	16.3%	17.4%	7.0%	3.5%	.0%	100.0%
	Secondary	Freq	12	54	62	82	61	40	13	3	327
		%	3.7%	16.5%	19.0%	25.1%	18.7%	12.2%	4.0%	.9%	100.0%
	Primary	Freq	19	113	152	169	128	79	33	4	697
		%	2.7%	16.2%	21.8%	24.2%	18.4%	11.3%	4.7%	.6%	100.0%
State/Region	Kachin	Freq	0	16	17	19	7	7	0	0	66
		%	.0%	24.2%	25.8%	28.8%	10.6%	10.6%	.0%	.0%	100.0%
	Kayah	Freq	3	13	17	14	15	3	0	0	65
		%	4.6%	20.0%	26.2%	21.5%	23.1%	4.6%	.0%	.0%	100.0%
	Kayin	Freq	2	12	13	18	9	7	4	0	65
		%	3.1%	18.5%	20.0%	27.7%	13.8%	10.8%	6.2%	.0%	100.0%
	Chin	Freq	0	4	9	23	15	9	4	0	64
		%	.0%	6.2%	14.1%	35.9%	23.4%	14.1%	6.2%	.0%	100.0%
	Sagaing	Freq	2	8	11	15	17	9	3	0	65
		%	3.1%	12.3%	16.9%	23.1%	26.2%	13.8%	4.6%	.0%	100.0%
	Tanintheri	Freq	1	5	6	16	15	13	7	1	64
		%	1.6%	7.8%	9.4%	25.0%	23.4%	20.3%	10.9%	1.6%	100.0%
	Bago	Freq	3	10	11	16	12	12	1	0	65
		%	4.6%	15.4%	16.9%	24.6%	18.5%	18.5%	1.5%	.0%	100.0%
	Magway	Freq	3	9	24	13	9	4	2	1	65
		%	4.6%	13.8%	36.9%	20.0%	13.8%	6.2%	3.1%	1.5%	100.0%
	Mandalay	Freq	1	11	10	15	6	10	5	0	58
		%	1.7%	19.0%	17.2%	25.9%	10.3%	17.2%	8.6%	.0%	100.0%
	Mon	Freq	2	12	10	18	14	7	2	1	66
		%	3.0%	18.2%	15.2%	27.3%	21.2%	10.6%	3.0%	1.5%	100.0%
	Rakhine	Freq	2	12	11	20	8	9	2	0	64
		%	3.1%	18.8%	17.2%	31.2%	12.5%	14.1%	3.1%	.0%	100.0%
	Yangon	Freq	2	8	11	11	15	12	5	3	67
		%	3.0%	11.9%	16.4%	16.4%	22.4%	17.9%	7.5%	4.5%	100.0%
	Shan (South)	Freq	2	9	24	13	21	3	1	0	73
		%	2.7%	12.3%	32.9%	17.8%	28.8%	4.1%	1.4%	.0%	100.0%
	Shan (North)	Freq	5	12	16	14	10	5	1	1	64
		%	7.8%	18.8%	25.0%	21.9%	15.6%	7.8%	1.6%	1.6%	100.0%
	Shan (East)	Freq	6	21	17	8	6	2	5	0	65
		%	9.2%	32.3%	26.2%	12.3%	9.2%	3.1%	7.7%	.0%	100.0%
	Ayeyawady	Freq	1	12	13	16	13	5	5	0	65
		%	1.5%	18.5%	20.0%	24.6%	20.0%	7.7%	7.7%	.0%	100.0%
	Nay Pyi Taw	Freq	1	10	20	16	12	8	2	0	69
		%	1.4%	14.5%	29.0%	23.2%	17.4%	11.6%	2.9%	.0%	100.0%
Urban/Rural	Urban	Freq	15	66	82	91	63	40	12	1	370
		%	4.1%	17.8%	22.2%	24.6%	17.0%	10.8%	3.2%	.3%	100.0%
	Rural	Freq	21	118	158	174	141	85	37	6	740
		%	2.8%	15.9%	21.4%	23.5%	19.1%	11.5%	5.0%	.8%	100.0%
	Total	**Freq**	**36**	**184**	**240**	**265**	**204**	**125**	**49**	**7**	**1110**
		%	**3.2%**	**16.6%**	**21.6%**	**23.9%**	**18.4%**	**11.3%**	**4.4%**	**.6%**	**100.0%**

More than 90 per cent of clients were aged between 20 to 49 years.

Table 4.5 Percentage distribution of clients by marital status, by level of health facility, by state/region, and urban/rural area

			Marital status			
			Unmarried/ live together	Married/ live together	Divorce/ separated/ widow	Total
Health Facility Level	Tertiary	Freq	1	84	1	86
		%	1.2%	97.7%	1.2%	100.0%
	Secondary	Freq	8	316	3	327
		%	2.4%	96.6%	.9%	100.0%
	Primary	Freq	4	689	4	697
		%	.6%	98.9%	.6%	100.0%
State/Region	Kachin	Freq	0	65	1	66
		%	.0%	98.5%	1.5%	100.0%
	Kayah	Freq	1	62	2	65
		%	1.5%	95.4%	3.1%	100.0%
	Kayin	Freq	0	65	0	65
		%	.0%	100.0%	.0%	100.0%
	Chin	Freq	4	60	0	64
		%	6.2%	93.8%	.0%	100.0%
	Sagaing	Freq	1	64	0	65
		%	1.5%	98.5%	.0%	100.0%
	Tanintheri	Freq	0	64	0	64
		%	.0%	100.0%	.0%	100.0%
	Bago	Freq	2	62	1	65
		%	3.1%	95.4%	1.5%	100.0%
	Magway	Freq	0	65	0	65
		%	.0%	100.0%	.0%	100.0%
	Mandalay	Freq	0	58	0	58
		%	.0%	100.0%	.0%	100.0%
	Mon	Freq	0	65	1	66
		%	.0%	98.5%	1.5%	100.0%
	Rakhine	Freq	0	63	1	64
		%	.0%	98.4%	1.6%	100.0%
	Yangon	Freq	0	67	0	67
		%	.0%	100.0%	.0%	100.0%
	Shan (South)	Freq	0	73	0	73
		%	.0%	100.0%	.0%	100.0%
	Shan(North)	Freq	0	63	1	64
		%	.0%	98.4%	1.6%	100.0%
	Shan(East)	Freq	1	63	1	65
		%	1.5%	96.9%	1.5%	100.0%
	Ayeyawady	Freq	4	61	0	65
		%	6.2%	93.8%	.0%	100.0%
	Nay Pyi Taw	Freq	0	69	0	69
		%	.0%	100.0%	.0%	100.0%
Urban/Rural	Urban	Freq	6	362	2	370
		%	1.6%	97.8%	.5%	100.0%
	Rural	Freq	7	727	6	740
		%	.9%	98.2%	.8%	100.0%
Total		**Freq**	**13**	**1089**	**8**	**1110**
		%	**1.2%**	**98.1%**	**.7%**	**100.0%**

The majority of clients were married (98.1 per cent). There was no differential between level of HFs, state/region and urban/rural area.

Table 4.6 Percentage distribution of clients by education level, by level of health facility, by state/region, and urban/rural area

			Education level			
			No schooling	Primary	Above primary	Total
Health Facility Level	Tertiary	Freq	3	22	61	86
		%	3.5%	25.6%	70.9%	100.0%
	Secondary	Freq	25	100	202	327
		%	7.6%	30.6%	61.8%	100.0%
	Primary	Freq	60	242	395	697
		%	8.6%	34.7%	56.7%	100.0%
State/Region	Kachin	Freq	1	10	55	66
		%	1.5%	15.2%	83.3%	100.0%
	Kayah	Freq	8	29	28	65
		%	12.3%	44.6%	43.1%	100.0%
	Kayin	Freq	3	13	49	65
		%	4.6%	20.0%	75.4%	100.0%
	Chin	Freq	6	13	45	64
		%	9.4%	20.3%	70.3%	100.0%
	Sagaing	Freq	2	32	31	65
		%	3.1%	49.2%	47.7%	100.0%
	Tanintheri	Freq	6	28	30	64
		%	9.4%	43.8%	46.9%	100.0%
	Bago	Freq	5	25	35	65
		%	7.7%	38.5%	53.8%	100.0%
	Magway	Freq	3	23	39	65
		%	4.6%	35.4%	60.0%	100.0%
	Mandalay	Freq	3	19	36	58
		%	5.2%	32.8%	62.1%	100.0%
	Mon	Freq	4	26	36	66
		%	6.1%	39.4%	54.5%	100.0%
	Rakhine	Freq	10	17	37	64
		%	15.6%	26.6%	57.8%	100.0%
	Yangon	Freq	10	27	30	67
		%	14.9%	40.3%	44.8%	100.0%
	Shan (South)	Freq	4	25	44	73
		%	5.5%	34.2%	60.3%	100.0%
	Shan (North)	Freq	7	9	48	64
		%	10.9%	14.1%	75.0%	100.0%
	Shan (East)	Freq	9	21	35	65
		%	13.8%	32.3%	53.8%	100.0%
	Ayeyawady	Freq	4	23	38	65
		%	6.2%	35.4%	58.5%	100.0%
	Nay Pyi Taw	Freq	3	24	42	69
		%	4.3%	34.8%	60.9%	100.0%
Urban/Rural	Urban	Freq	12	107	251	370
		%	3.2%	28.9%	67.8%	100.0%
	Rural	Freq	76	257	407	740
		%	10.3%	34.7%	55.0%	100.0%
Total		**Freq**	**88**	**364**	**658**	**1110**
		%	**7.9%**	**32.8%**	**59.3%**	**100.0%**

More than 50 per cent of clients had attained above primary level education. One-third of clients had attained primary level education only. Attained levels of education were marginally higher in urban areas as well as at tertiary level HFs. Respondents from Kachin, Chin, Sagaing and Shan (N) were noted to have relatively higher levels of education.

Table 4.7 Percentage distribution of clients by frequency of visit to health facilities for family planning services, by level of health facility, by state/region, and urban/rural area

			Frequency of visits to family planning clinic				
			Monthly	Bi-monthly	Tri-monthly	Irregularly	Total
Health Facility Level	Tertiary	Freq	24	2	48	12	86
		%	27.9%	2.3%	55.8%	14.0%	100.0%
	Secondary	Freq	62	2	231	32	327
		%	19.0%	.6%	70.6%	9.8%	100.0%
	Primary	Freq	150	13	480	54	697
		%	21.5%	1.9%	68.9%	7.7%	100.0%
State/Region	Kachin	Freq	21	2	39	4	66
		%	31.8%	3.0%	59.1%	6.1%	100.0%
	Kayah	Freq	2	3	52	8	65
		%	3.1%	4.6%	80.0%	12.3%	100.0%
	Kayin	Freq	24	0	39	2	65
		%	36.9%	.0%	60.0%	3.1%	100.0%
	Chin	Freq	12	2	36	14	64
		%	18.8%	3.1%	56.2%	21.9%	100.0%
	Sagaing	Freq	12	1	48	4	65
		%	18.5%	1.5%	73.8%	6.2%	100.0%
	Tanintheri	Freq	7	0	56	1	64
		%	10.9%	.0%	87.5%	1.6%	100.0%
	Bago	Freq	21	0	43	1	65
		%	32.3%	.0%	66.2%	1.5%	100.0%
	Magway	Freq	20	2	42	1	65
		%	30.8%	3.1%	64.6%	1.5%	100.0%
	Mandalay	Freq	12	1	40	5	58
		%	20.7%	1.7%	69.0%	8.6%	100.0%
	Mon	Freq	20	0	45	1	66
		%	30.3%	.0%	68.2%	1.5%	100.0%
	Rakhine	Freq	19	1	40	4	64
		%	29.7%	1.6%	62.5%	6.2%	100.0%
	Yangon	Freq	7	1	54	5	67
		%	10.4%	1.5%	80.6%	7.5%	100.0%
	Shan (South)	Freq	15	0	43	15	73
		%	20.5%	.0%	58.9%	20.5%	100.0%
	Shan (North)	Freq	13	3	39	9	64
		%	20.3%	4.7%	60.9%	14.1%	100.0%
	Shan (East)	Freq	13	0	46	6	65
		%	20.0%	.0%	70.8%	9.2%	100.0%
	Ayeyawady	Freq	7	0	51	7	65
		%	10.8%	.0%	78.5%	10.8%	100.0%
	Nay Pyi Taw	Freq	11	1	46	11	69
		%	15.9%	1.4%	66.7%	15.9%	100.0%
Urban/Rural	Urban	Freq	83	9	241	37	370
		%	22.4%	2.4%	65.1%	10.0%	100.0%
	Rural	Freq	153	8	518	61	740
		%	20.7%	1.1%	70.0%	8.2%	100.0%
Total		**Freq**	**236**	**17**	**759**	**98**	**1110**
		%	**21.3%**	**1.5%**	**68.4%**	**8.8%**	**100.0%**

About 90 per cent of clients interviewed visited clinics monthly or every three months. Two-thirds of all clients (68 per cent) visited family planning clinics every three months, while 8.8 per cent of clients made irregular visits. Irregular visits were more apparent at tertiary level HFs, and in Kayah, Chin State and Shan (N), but there was no obvious differences between urban and rural areas. Clients making visits to clinics every three months was more frequent at lower level HFs.

5. Clients' perception of family planning service provision

Table 5.1 Percentage distribution of clients' perspective of family planning service providers' adherence to technical issues by level of health facility, by state/region, and urban/rural area

			Clients' perspective of family planning service providers' adherence to technical issues*						
			Got preferred method	Informed on how to use	Informed of side effects	Informed how to manage side effects	Informed of side effects that need follow-up	Informed of next appointment	Total
Health Facility Level	Tertiary	Freq	73	62	55	52	51	62	80
		%	91.2%	77.5%	68.8%	65.0%	63.8%	77.5%	
	Secondary	Freq	294	265	232	219	237	277	323
		%	91.0%	82.0%	71.8%	67.8%	73.4%	85.8%	
	Primary	Freq	640	600	526	517	538	618	686
		%	93.3%	87.5%	76.7%	75.4%	78.4%	90.1%	
State/Region	Kachin	Freq	66	62	55	55	58	62	66
		%	100.0%	93.9%	83.3%	83.3%	87.9%	93.9%	
	Kayah	Freq	49	54	47	37	43	58	64
		%	76.6%	84.4%	73.4%	57.8%	67.2%	90.6%	
	Kayin	Freq	65	61	61	61	60	64	65
		%	100.0%	93.8%	93.8%	93.8%	92.3%	98.5%	
	Chin	Freq	59	52	50	48	51	47	63
		%	93.7%	82.5%	79.4%	76.2%	81.0%	74.6%	
	Sagaing	Freq	61	56	47	51	50	56	65
		%	93.8%	86.2%	72.3%	78.5%	76.9%	86.2%	
	Tanintheri	Freq	62	50	43	44	46	54	64
		%	96.9%	78.1%	67.2%	68.8%	71.9%	84.4%	
	Bago	Freq	57	53	31	30	34	53	63
		%	90.5%	84.1%	49.2%	47.6%	54.0%	84.1%	
	Magway	Freq	58	59	54	55	56	58	62
		%	93.5%	95.2%	87.1%	88.7%	90.3%	93.5%	
	Mandalay	Freq	55	52	50	51	50	48	57
		%	96.5%	91.2%	87.7%	89.5%	87.7%	84.2%	
	Mon	Freq	65	55	51	53	54	66	66
		%	98.5%	83.3%	77.3%	80.3%	81.8%	100.0%	
	Rakhine	Freq	56	45	31	28	31	45	59
		%	94.9%	76.3%	52.5%	47.5%	52.5%	76.3%	
	Yangon	Freq	62	60	58	55	60	61	67
		%	92.5%	89.6%	86.6%	82.1%	89.6%	91.0%	
	Shan (South)	Freq	68	68	61	62	63	56	70
		%	97.1%	97.1%	87.1%	88.6%	90.0%	80.0%	
	Shan(North)	Freq	52	50	39	34	35	47	60
		%	86.7%	83.3%	65.0%	56.7%	58.3%	78.3%	
	Shan (East)	Freq	49	53	49	50	51	64	65
		%	75.4%	81.5%	75.4%	76.9%	78.5%	98.5%	
	Ayeyawady	Freq	54	45	43	37	44	57	64
		%	84.4%	70.3%	67.2%	57.8%	68.8%	89.1%	
	Nay Pyi Taw	Freq	69	52	43	37	40	61	69
		%	100.0%	75.4%	62.3%	53.6%	58.0%	88.4%	
Urban/Rural	Urban	Freq	330	307	278	260	272	311	362
		%	91.2%	84.8%	76.8%	71.8%	75.1%	85.9%	
	Rural	Freq	677	620	535	528	554	646	727
		%	93.1%	85.3%	73.6%	72.6%	76.2%	88.9%	
Total		**Freq**	**1007**	**927**	**813**	**788**	**826**	**957**	**1089**

* Multiple response question.

Most clients interviewed received their preferred family planning method. They received the least information from healthcare providers about side-effects, about how to manage side effects and about the need to follow up for side-effects, especially at tertiary level HFs.

Clients' responses about receiving their preferred contraceptive method was considerably lower in Kayah (77 per cent) and Shan (E) (75 per cent) compared to other states/regions where this figure was more than 80 per cent. However, the rates reported were an improvement on 2016.

Clients were relatively less informed about side effects in Nay Pyi Taw, Ayeyawady, Shan (N), Bago and Magway. An urban/rural difference in the information received was not noted.

Table 5.2 Percentage distribution of clients' perspective on family planning service's organizational aspects by level of health facility, by state/region, and urban/rural area

			Clients' perspective on service organizational aspects*			
			Waiting time before consultation was too long	**Satisfied with cleanliness of HC**	**Satisfied with privacy at HC**	**Total**
HealthFacilityLevel	Tertiary	Freq	14	80	81	82
		%	17.1%	97.6%	98.8%	
	Secondary	Freq	45	322	321	324
		%	13.9%	99.4%	99.1%	
	Primary	Freq	72	680	677	688
		%	10.5%	98.8%	98.4%	
State/Region	Kachin	Freq	3	65	65	65
		%	4.6%	100.0%	100.0%	
	Kayah	Freq	14	62	64	65
		%	21.5%	95.4%	98.5%	
	Kayin	Freq	2	65	65	65
		%	3.1%	100.0%	100.0%	
	Chin	Freq	8	57	57	57
		%	14.0%	100.0%	100.0%	
	Sagaing	Freq	3	64	64	65
		%	4.6%	98.5%	98.5%	
	Tanintheri	Freq	8	64	64	64
		%	12.5%	100.0%	100.0%	
	Bago	Freq	4	64	65	65
		%	6.2%	98.5%	100.0%	
	Magway	Freq	8	63	63	65
		%	12.3%	96.9%	96.9%	
	Mandalay	Freq	5	57	56	57
		%	8.8%	100.0%	98.2%	
	Mon	Freq	17	65	66	66
		%	25.8%	98.5%	100.0%	
	Rakhine	Freq	14	62	61	63
		%	22.2%	98.4%	96.8%	
	Yangon	Freq	10	62	58	64
		%	15.6%	96.9%	90.6%	
	Shan (South)	Freq	5	73	73	73
		%	6.8%	100.0%	100.0%	
	Shan (North)	Freq	5	64	64	64
		%	7.8%	100.0%	100.0%	
	Shan (East)	Freq	7	65	64	65
		%	10.8%	100.0%	98.5%	
	Ayeyawady	Freq	6	62	62	63
		%	9.5%	98.4%	98.4%	
	Nay Pyi Taw	Freq	12	68	68	68
		%	17.6%	100.0%	100.0%	
Urban/Rural	Urban	Freq	40	357	355	363
		%	11.0%	98.3%	97.8%	
	Rural	Freq	91	725	724	731
		%	12.4%	99.2%	99.0%	
Total		**Freq**	**131**	**1082**	**1079**	**1094**

Favourable responses about the organizational aspects of the clinic were high (more than 95 per cent). Most clients were satisfied with the cleanliness and privacy at the health centre. Less than 10 per cent of clients complained about long waiting times at HFs, which was lower than the less than 15 per cent that was recorded in 2016. Clients at tertiary level HFs complained more

frequently about long waiting times (17 per cent), which was significantly lower than in 2016 (33.3 per cent). A significantly higher percentage of clients complained about long waiting times in Nay Pyi Taw, Rakhine, Kayah and Mon. There was no urban rural difference in the response about long waiting times.

Table 5.3 Percentage distribution of clients' perspective on inter-personal aspects of family planning services by level of health facility, by state/region, and urban/rural area

			Clients' perspective on inter-personal aspects*			
			Took enough time for consultation	Gave regards and warm welcome	Insisted/urged to accept the method given	Total
HealthFacilityLevel	Tertiary	Freq	82	82	10	86
		%	95.3%	95.3%	11.6%	
	Secondary	Freq	309	319	29	324
		%	95.4%	98.5%	9.0%	
	Primary	Freq	680	681	44	690
		%	98.6%	98.7%	6.4%	
State/Region	Kachin	Freq	65	65	3	66
		%	98.5%	98.5%	4.5%	
	Kayah	Freq	64	65	1	65
		%	98.5%	100.0%	1.5%	
	Kayin	Freq	65	65	1	65
		%	100.0%	100.0%	1.5%	
	Chin	Freq	56	56	6	59
		%	94.9%	94.9%	10.2%	
	Sagaing	Freq	61	61	7	65
		%	93.8%	93.8%	10.8%	
	Tanintheri	Freq	63	64	1	64
		%	98.4%	100.0%	1.6%	
	Bago	Freq	63	62	3	65
		%	96.9%	95.4%	4.6%	
	Magway	Freq	65	64	4	65
		%	100.0%	98.5%	6.2%	
	Mandalay	Freq	56	58	6	58
		%	96.6%	100.0%	10.3%	
	Mon	Freq	62	66	17	66
		%	93.9%	100.0%	25.8%	
	Rakhine	Freq	54	62	4	62
		%	87.1%	100.0%	6.5%	
	Yangon	Freq	63	63	7	64
		%	98.4%	98.4%	10.9%	
	Shan (South)	Freq	73	72	10	73
		%	100.0%	98.6%	13.7%	
	Shan (North)	Freq	64	63	2	64
		%	100.0%	98.4%	3.1%	
	Shan (East)	Freq	65	63	7	65
		%	100.0%	96.9%	10.8%	
	Ayeyawady	Freq	65	65	0	65
		%	100.0%	100.0%	.0%	
	Nay Pyi Taw	Freq	67	68	4	69
		%	97.1%	98.6%	5.8%	
Urban/Rural	Urban	Freq	356	359	28	368
		%	96.7%	97.6%	7.6%	
	Rural	Freq	715	723	55	732
		%	97.7%	98.8%	7.5%	
Total		**Freq**	**1071**	**1082**	**83**	**1100**

* Multiple response question.

Regarding their inter-personal relationship with service providers during clinic visits, almost all respondents gave a favourable response. Less than 10 per cent of respondents stated they had

been urged to accept a family planning method by a healthcare provider. This was more frequently observed in Rakhine and Shan (S).

Table 5.4 Percentage distribution of clients' perspective on family planning service outcomes by level of health facility, by state/region, and urban/rural area

			Clients' perspective on outcome aspects*				
			Satisfied with attitude of staff	Satisfied with service/ treatment	Will visit HC in future	Will encourage friends/ relatives to use HC	Total
Health Facility Level	Tertiary	Freq	82	83	80	83	86
		%	95.3%	96.5%	93.0%	96.5%	
	Secondary	Freq	318	322	313	311	324
		%	98.1%	99.4%	96.6%	96.0%	
	Primary	Freq	683	691	675	671	692
		%	98.7%	99.9%	97.5%	97.0%	
State/Region	Kachin	Freq	65	66	66	66	66
		%	98.5%	100.0%	100.0%	100.0%	
	Kayah	Freq	64	65	65	65	65
		%	98.5%	100.0%	100.0%	100.0%	
	Kayin	Freq	65	65	65	65	65
		%	100.0%	100.0%	100.0%	100.0%	
	Chin	Freq	56	58	47	50	58
		%	96.6%	100.0%	81.0%	86.2%	
	Sagaing	Freq	63	65	64	65	65
		%	96.9%	100.0%	98.5%	100.0%	
	Tanintheri	Freq	64	64	64	64	64
		%	100.0%	100.0%	100.0%	100.0%	
	Bago	Freq	65	62	64	63	65
		%	100.0%	95.4%	98.5%	96.9%	
	Magway	Freq	64	64	64	65	65
		%	98.5%	98.5%	98.5%	100.0%	
	Mandalay	Freq	58	58	56	56	58
		%	100.0%	100.0%	96.6%	96.6%	
	Mon	Freq	65	66	66	65	66
		%	98.5%	100.0%	100.0%	98.5%	
	Rakhine	Freq	62	63	58	56	63
		%	98.4%	100.0%	92.1%	88.9%	
	Yangon	Freq	63	66	62	64	66
		%	95.5%	100.0%	93.9%	97.0%	
	Shan (South)	Freq	72	73	71	71	73
		%	98.6%	100.0%	97.3%	97.3%	
	Shan (North)	Freq	64	63	64	64	64
		%	100.0%	98.4%	100.0%	100.0%	
	Shan (East)	Freq	62	65	64	63	65
		%	95.4%	100.0%	98.5%	96.9%	
	Ayeyawady	Freq	64	64	60	64	65
		%	98.5%	98.5%	92.3%	98.5%	
	Nay Pyi Taw	Freq	67	69	68	59	69
		%	97.1%	100.0%	98.6%	85.5%	
Urban/Rural	Urban	Freq	356	366	352	353	369
		%	96.5%	99.2%	95.4%	95.7%	
	Rural	Freq	727	730	716	712	733
		%	99.2%	99.6%	97.7%	97.1%	
Total		**Freq**	**1083**	**1096**	**1068**	**1065**	**1102**

*Multiple response table.

Almost all responses pointed to the clients' satisfaction with the outcomes of their clinic visit. A few respondents from Chin State stated that they would be less willing to visit the HF in the future, while a few respondents from Nay Pyi Taw stated that they would be less willing to encourage friends to visit the HF.

6. Clients' appraisal of family planning service costs

Table 6.1 Percentage of clients reporting paying for services and average amount paid by level of health facility, by state/region, and urban/rural area

			Needed to pay for last visit for family planning services		
			Yes	No	Total
Health Facility Level	Tertiary	Freq	31	55	86
		%	36.0%	64.0%	100.0%
	Secondary	Freq	95	232	327
		%	29.1%	70.9%	100.0%
	Primary	Freq	187	510	697
		%	26.8%	73.2%	100.0%
State/Region	Kachin	Freq	17	49	66
		%	25.8%	74.2%	100.0%
	Kayah	Freq	18	47	65
		%	27.7%	72.3%	100.0%
	Kayin	Freq	1	64	65
		%	1.5%	98.5%	100.0%
	Chin	Freq	13	51	64
		%	20.3%	79.7%	100.0%
	Sagaing	Freq	29	36	65
		%	44.6%	55.4%	100.0%
	Tanintheri	Freq	6	58	64
		%	9.4%	90.6%	100.0%
	Bago	Freq	38	27	65
		%	58.5%	41.5%	100.0%
	Magway	Freq	13	52	65
		%	20.0%	80.0%	100.0%
	Mandalay	Freq	12	46	58
		%	20.7%	79.3%	100.0%
	Mon	Freq	6	60	66
		%	9.1%	90.9%	100.0%
	Rakhine	Freq	29	35	64
		%	45.3%	54.7%	100.0%
	Yangon	Freq	23	44	67
		%	34.3%	65.7%	100.0%
	Shan (South)	Freq	1	72	73
		%	1.4%	98.6%	100.0%
	Shan (North)	Freq	45	19	64
		%	70.3%	29.7%	100.0%
	Shan (East)	Freq	19	46	65
		%	29.2%	70.8%	100.0%
	Ayeyawady	Freq	15	50	65
		%	23.1%	76.9%	100.0%
	Nay Pyi Taw	Freq	28	41	69
		%	40.6%	59.4%	100.0%
Urban/Rural	Urban	Freq	88	282	370
		%	23.8%	76.2%	100.0%
	Rural	Freq	225	515	740
		%	30.4%	69.6%	100.0%
Total		**Freq**	**313**	**797**	**1110**
		%	**28.2%**	**71.8%**	**100.0%**

About one-third (28 per cent) of clients responded they had to pay for services at HFs. The response was highest at tertiary level HFs (36 per cent) and lowest at primary level HFs (27 per cent). The rate was also highest in Shan (N) (70 per cent). Around 40 per cent of clients reported that they had to pay for services in Rakhine State, Nay Pyi Taw, and Magway and Sagaing Regions, with this figure being lowest in Mon State (9.1 per cent). The urban/rural difference was significant (23 per cent vs. 30 per cent).

Figure 6.1 Percentage of clients reporting paying for services by level of health facility

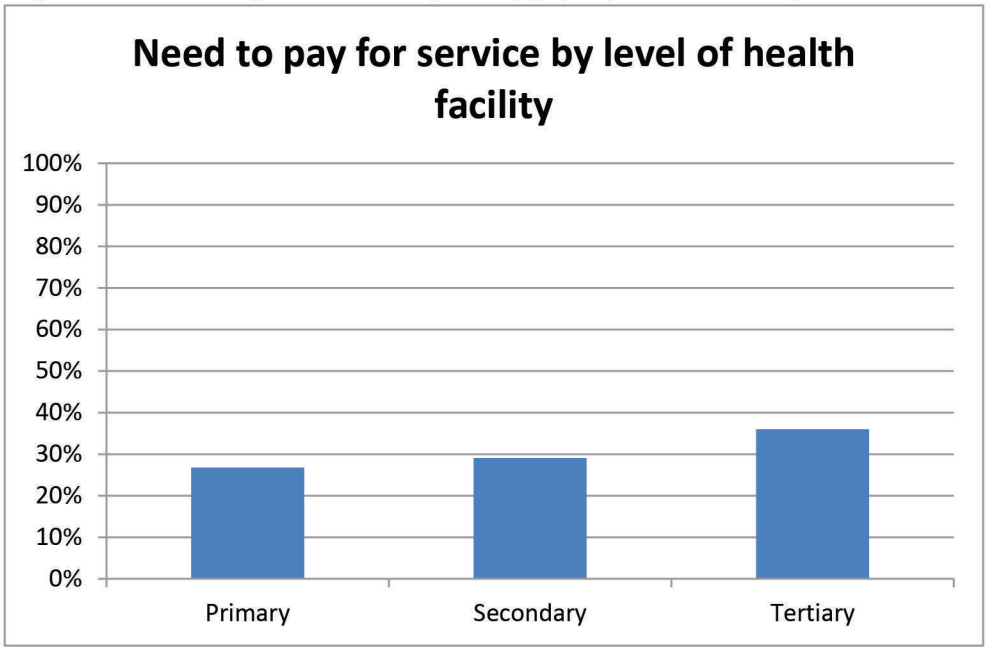


Table 6.2 Percentage of clients reporting paying for services and average amount paid per visit by management of facility

Health Facility Level		For registration	For Lab/X-ray procedure	Medicine from clinic	Medicine from outside pharmacy	Examination fees
Tertiary	N	6	2	20	7	2
	Median	500	1250	2000	4800	3000
	Mean	783	1250	6040	19043	3000
	Std.Deviation	567	1061	10383	25048	2828
Secondary	N	18	7	46	34	14
	Median	500	0	1350	1500	1250
	Mean	561	5929	2709	1991	1821
	Std.Deviation	316	13046	7345	2719	3856
Primary	N	48	14	97	64	20
	Median	500	0	1000	1000	0
	Mean	773	157	2627	5678	550
	Std.Deviation	783	533	12316	13422	826
Total	**N**	**72**	**23**	**163**	**105**	**36**
	Median	**500**	**0**	**1000**	**1000**	**250**
	Mean	**721**	**2009**	**3069**	**5375**	**1181**
	Std.Deviation	**679**	**7332**	**10897**	**12808**	**2589**

Out of the 313 clients (28 per cent) who reported they had to pay for clinic visits, the average amount paid for various items was not more than 600 kyats (about $US0.50). The highest cost was for medicine, either bought at or outside the clinic, at 1000 kyats per item. The amount paid per clinic visit was highest at tertiary level HFs than at any other level.

Table 6.3 Percentage of clients reporting paying for services and average amount paid by state/region

			Needed to pay for last visit to clinic for family planning services		
			Yes	No	Total
State/Region	Kachin	Freq	17	49	66
		%	25.8%	74.2%	100.0%
	Kayah	Freq	18	47	65
		%	27.7%	72.3%	100.0%
	Kayin	Freq	1	64	65
		%	1.5%	98.5%	100.0%
	Chin	Freq	13	51	64
		%	20.3%	79.7%	100.0%
	Sagaing	Freq	29	36	65
		%	44.6%	55.4%	100.0%
	Tanintheri	Freq	6	58	64
		%	9.4%	90.6%	100.0%
	Bago	Freq	38	27	65
		%	58.5%	41.5%	100.0%
	Magway	Freq	13	52	65
		%	20.0%	80.0%	100.0%
	Mandalay	Freq	12	46	58
		%	20.7%	79.3%	100.0%
	Mon	Freq	6	60	66
		%	9.1%	90.9%	100.0%
	Rakhine	Freq	29	35	64
		%	45.3%	54.7%	100.0%
	Yangon	Freq	23	44	67
		%	34.3%	65.7%	100.0%
	Shan (South)	Freq	1	72	73
		%	1.4%	98.6%	100.0%
	Shan (North)	Freq	45	19	64
		%	70.3%	29.7%	100.0%
	Shan (East)	Freq	19	46	65
		%	29.2%	70.8%	100.0%
	Ayeyawady	Freq	15	50	65
		%	23.1%	76.9%	100.0%
	Nay Pyi Taw	Freq	28	41	69
		%	40.6%	59.4%	100.0%
Total		**Freq**	**313**	**797**	**1110**
		%	**28.2%**	**71.8%**	**100.0%**

Table 6.4 Services for which client paid by state/region

State/Region		For registration	For Lab/ X-ray procedure	Medicine from clinic	Medicine from outside pharmacy	Examination fees
Kachin	N			13	4	
	Mean			1154	3875	
	SD			427	2213	
Kayah	N	1		3	13	1
	Mean	500		8633	5231	500
	SD	.		7149	9075	.
Kayin	N	1	1	1	1	1
	Mean	0	0	0	10000	0
	SD	.	.	.	.	.
Chin	N	13	13	13	13	13
	Mean	538	154	1885	2077	0
	SD	519	555	5482	5511	0
Sagaing	N	16	1	9	2	1
	Mean	906	35000	2056	10500	1000
	SD	375	.	1286	6364	.
Tanintheri	N	6				
	Mean	1317				
	SD	1840				
Bago	N	9		26	3	
	Mean	889		904	1167	

	SD	333		382	289	
Magway	N	2	1	7	7	
	Mean	350	500	1286	1029	
	SD	212	.	809	236	
Mandalay	N	3		7	1	2
	Mean	1500		1143	1500	1500
	SD	0		244	.	0
Mon	N	2		3	1	
	Mean	500		2500	13000	
	SD	0		2179	.	
Rakhine	N	2		7	13	7
	Mean	300		1457	881	3929
	SD	283		113	629	5062
Yangon	N	11	2	16	4	
	Mean	564	3350	1013	1088	
	SD	234	4455	510	681	
Shan (South)	N	1	1	1	1	1
	Mean	0	0	5000	0	0
	SD	.	.	.	.	.
Shan (North)	N			22	23	
	Mean			1114	7339	
	SD			576	17948	
Shan (East)	N			11	5	
	Mean			2382	17100	
	SD			1692	20968	
Ayeyawady	N	2		4	4	6
	Mean	500		2325	1500	1583
	SD	0		13500	408	492
Nay Pyi Taw	N	3	4	20	10	4
	Mean	0	500	7410	12160	250
	SD	0	1000	26580	22744	500
Total	**N**	**72**	**23**	**163**	**105**	**36**
	Mean	**721**	**2009**	**3069**	**5375**	**1181**
	SD	**679**	**7332**	**10897**	**12808**	**2589**

There were high variations in amounts paid by respondents for their visits to HFs for family planning services.

Table 6.5 Percentage of clients reporting paying for services and average amount paid by urban/rural residence

			Needed to pay for last visit to family planning services		
			Yes	No	Total
Urban/Rural	Urban	Freq	88	282	370
		%	23.8%	76.2%	100.0%
	Rural	Freq	225	515	740
		%	30.4%	69.6%	100.0%
Total		**Freq**	**313**	**797**	**1110**
		%	**28.2%**	**71.8%**	**100.0%**

Table 6.6 Service for which clients paid by urban/rural residence

Urban/Rural		For registration	For Lab/X-ray procedure	Medicine from clinic	Medicine from outside pharmacy	Examination fees
Urban	N	26	12	47	33	10
	Mean	688	3683	7268	5695	700
	SD	510	10040	19546	13385	1567
Rural	N	46	11	116	72	26
	Mean	739	182	1367	5228	1365
	SD	763	603	2083	12628	2893
Total	**N**	**72**	**23**	**163**	**105**	**36**
	Mean	**721**	**2009**	**3069**	**5375**	**1181**
	SD	**679**	**7332**	**10897**	**12808**	**2589**

An urban rural difference for the amount paid for medicine was apparent and was much higher in urban areas. Table 6.3 cannot be explained exclusively by the inclusion of private HFs in the assessment.

Table 6.7 Percentage distribution of clients by mode of transportation, distance travelled and cost of transportation

		Frequency	Per cent
Main route to reach the clinic	On foot	742	67
	Bicycle	63	6
	Motorbike	249	22
	Bus/Taxi	32	3
	Own vehicle	16	1
	Other	8	1
Distance to clinic from home (mile)	<=.0	6	1
	1.0-1.9	834	84
	2.0+	150	15
Cost of clinic visit	<=.00	69	18
	1.00-1000.00	267	69
	1001.00-2000.00	18	5
	2001.00-3000.00	13	3
	3001.00-4000.00	0	0
	4001.00+	18	5

Motor bike and on foot were the most frequent modes of transport to clinics at 22 per cent and 67 per cent, respectively. The majority of clients (85 per cent) lived less than two miles from their nearest HF. Most of them (84.3 per cent) spent no more than 1000 kyats (nearly one $US1) per clinic visit. This finding was consistent with the 2016 assessment.

Table 6.8 Percentage distribution of clients by mode of transportation by level of health facility, by state/region, and urban/rural area

			Main mode of transport to reach clinic						Total
			On foot	Bicycle	Motorbike	Bus/Taxi	Own vehicle	Other	
Health Facility Level	Tertiary	Freq	39	4	22	15	3	3	86
		%	45.3%	4.7%	25.6%	17.4%	3.5%	3.5%	100.0%
	Secondary	Freq	205	16	87	8	9	2	327
		%	62.7%	4.9%	26.6%	2.4%	2.8%	.6%	100.0%
	Primary	Freq	498	43	140	9	4	3	697
		%	71.4%	6.2%	20.1%	1.3%	.6%	.4%	100.0%
State/Region	Kachin	Freq	31	8	21	4	2	0	66
		%	47.0%	12.1%	31.8%	6.1%	3.0%	.0%	100.0%
	Kayah	Freq	51	1	12	0	1	0	65
		%	78.5%	1.5%	18.5%	.0%	1.5%	.0%	100.0%
	Kayin	Freq	33	3	19	7	2	1	65
		%	50.8%	4.6%	29.2%	10.8%	3.1%	1.5%	100.0%
	Chin	Freq	38	1	25	0	0	0	64
		%	59.4%	1.6%	39.1%	.0%	.0%	.0%	100.0%
	Sagaing	Freq	50	2	11	0	1	1	65
		%	76.9%	3.1%	16.9%	.0%	1.5%	1.5%	100.0%
	Tanintheri	Freq	43	9	5	1	6	0	64
		%	67.2%	14.1%	7.8%	1.6%	9.4%	.0%	100.0%
	Bago	Freq	33	12	20	0	0	0	65
		%	50.8%	18.5%	30.8%	.0%	.0%	.0%	100.0%
	Magway	Freq	50	1	11	0	0	3	65
		%	76.9%	1.5%	16.9%	.0%	.0%	4.6%	100.0%
	Mandalay	Freq	31	1	21	4	1	0	58
		%	53.4%	1.7%	36.2%	6.9%	1.7%	.0%	100.0%
	Mon	Freq	42	7	12	5	0	0	66
		%	63.6%	10.6%	18.2%	7.6%	.0%	.0%	100.0%
	Rakhine	Freq	52	0	9	2	0	1	64
		%	81.2%	.0%	14.1%	3.1%	.0%	1.6%	100.0%
	Yangon	Freq	53	3	8	2	1	0	67
		%	79.1%	4.5%	11.9%	3.0%	1.5%	.0%	100.0%
	Shan (South)	Freq	48	6	18	0	1	0	73
		%	65.8%	8.2%	24.7%	.0%	1.4%	.0%	100.0%
	Shan (North)	Freq	43	0	20	0	1	0	64
		%	67.2%	.0%	31.2%	.0%	1.6%	.0%	100.0%
	Shan (East)	Freq	46	3	14	2	0	0	65
		%	70.8%	4.6%	21.5%	3.1%	.0%	.0%	100.0%
	Ayeyawady	Freq	56	0	4	4	0	1	65
		%	86.2%	.0%	6.2%	6.2%	.0%	1.5%	100.0%
	Nay Pyi Taw	Freq	42	6	19	1	0	1	69
		%	60.9%	8.7%	27.5%	1.4%	.0%	1.4%	100.0%
Urban/Rural	Urban	Freq	211	29	92	22	9	7	370
		%	57.0%	7.8%	24.9%	5.9%	2.4%	1.9%	100.0%
	Rural	Freq	531	34	157	10	7	1	740
		%	71.8%	4.6%	21.2%	1.4%	.9%	.1%	100.0%
Total		**Freq**	**742**	**63**	**249**	**32**	**16**	**8**	**1110**
		%	**66.8%**	**5.7%**	**22.4%**	**2.9%**	**1.4%**	**.7%**	**100.0%**

Table 6.9 Percentage distribution of clients by distance travelled, by level of health facility, by state/region and urban/rural area

			Distance to clinic from home (miles)			Total
			<=.0	1.0-1.0	2.0+	
Health Facility Level	Tertiary	Freq	2	56	25	83
		%	2.4%	67.5%	30.1%	100.0%
	Secondary	Freq	0	229	60	289
		%	.0%	79.2%	20.8%	100.0%
	Primary	Freq	4	549	65	618
		%	.6%	88.8%	10.5%	100.0%
State/Region	Kachin	Freq	0	61	5	66
		%	.0%	92.4%	7.6%	100.0%
	Kayah	Freq	0	63	2	65
		%	.0%	96.9%	3.1%	100.0%
	Kayin	Freq	0	9	15	24
		%	.0%	37.5%	62.5%	100.0%
	Chin	Freq	0	36	21	57
		%	.0%	63.2%	36.8%	100.0%
	Sagaing	Freq	0	58	6	64
		%	.0%	90.6%	9.4%	100.0%
	Tanintheri	Freq	1	59	4	64
		%	1.6%	92.2%	6.2%	100.0%
	Bago	Freq	0	52	12	64
		%	.0%	81.2%	18.8%	100.0%
	Magway	Freq	0	60	3	63
		%	.0%	95.2%	4.8%	100.0%
	Mandalay	Freq	0	17	10	27
		%	.0%	63.0%	37.0%	100.0%
	Mon	Freq	0	59	7	66
		%	.0%	89.4%	10.6%	100.0%
	Rakhine	Freq	0	49	10	59
		%	.0%	83.1%	16.9%	100.0%
	Yangon	Freq	0	43	4	47
		%	.0%	91.5%	8.5%	100.0%
	Shan (South)	Freq	1	66	5	72
		%	1.4%	91.7%	6.9%	100.0%
	Shan (North)	Freq	0	61	3	64
		%	.0%	95.3%	4.7%	100.0%
	Shan (East)	Freq	0	53	12	65
		%	.0%	81.5%	18.5%	100.0%
	Ayeyawady	Freq	1	49	4	54
		%	1.9%	90.7%	7.4%	100.0%
	Nay Pyi Taw	Freq	3	39	27	69
		%	4.3%	56.5%	39.1%	100.0%
Urban/Rural	Urban	Freq	2	259	69	330
		%	.6%	78.5%	20.9%	100.0%
	Rural	Freq	4	575	81	660
		%	.6%	87.1%	12.3%	100.0%
Total		**Freq**	**6**	**834**	**150**	**990**
		%	**.6%**	**84.2%**	**15.2%**	**100.0%**

Table 6.10 Percentage distribution of clients by cost of transportation (kyat), by level of health facility, by state/region and urban/rural area

			Cost of clinic visit					Total
			<=.00	1-1000	1001-2000	2001-3000	4001+	
Health Facility Level	Tertiary	Freq	6	26	4	4	10	50
		%	12.0%	52.0%	8.0%	8.0%	20.0%	100.0%
	Secondary	Freq	35	78	7	5	5	130
		%	26.9%	60.0%	5.4%	3.8%	3.8%	100.0%
	Primary	Freq	28	163	7	4	3	205
		%	13.7%	79.5%	3.4%	2.0%	1.5%	100.0%
State/Region	Kachin	Freq	0	26	3	0	2	31
		%	.0%	83.9%	9.7%	.0%	6.5%	100.0%
	Kayah	Freq	0	12	1	1	0	14
		%	.0%	85.7%	7.1%	7.1%	.0%	100.0%
	Kayin	Freq	33	27	1	2	0	63
		%	52.4%	42.9%	1.6%	3.2%	.0%	100.0%
	Chin	Freq	1	21	1	0	1	24
		%	4.2%	87.5%	4.2%	.0%	4.2%	100.0%
	Sagaing	Freq	9	8	1	0	1	19
		%	47.4%	42.1%	5.3%	.0%	5.3%	100.0%
	Tanintheri	Freq	0	16	0	5	0	21
		%	.0%	76.2%	.0%	23.8%	.0%	100.0%
	Bago	Freq	3	16	0	0	0	19
		%	15.8%	84.2%	.0%	.0%	.0%	100.0%
	Magway	Freq	0	5	0	0	1	6
		%	.0%	83.3%	.0%	.0%	16.7%	100.0%
	Mandalay	Freq	0	13	2	2	2	19
		%	.0%	68.4%	10.5%	10.5%	10.5%	100.0%
	Mon	Freq	0	18	1	0	4	23
		%	.0%	78.3%	4.3%	.0%	17.4%	100.0%
	Rakhine	Freq	0	7	1	1	0	9
		%	.0%	77.8%	11.1%	11.1%	.0%	100.0%
	Yangon	Freq	0	8	0	1	0	9
		%	.0%	88.9%	.0%	11.1%	.0%	100.0%
	Shan (South)	Freq	0	22	0	0	1	23
		%	.0%	95.7%	.0%	.0%	4.3%	100.0%
	Shan (North)	Freq	0	18	1	0	0	19
		%	.0%	94.7%	5.3%	.0%	.0%	100.0%
	Shan (East)	Freq	8	5	1	0	2	16
		%	50.0%	31.2%	6.2%	.0%	12.5%	100.0%
	Ayeyawady	Freq	0	17	1	1	3	22
		%	.0%	77.3%	4.5%	4.5%	13.6%	100.0%
	Nay Pyi Taw	Freq	15	28	4	0	1	48
		%	31.2%	58.3%	8.3%	.0%	2.1%	100.0%
Urban/Rural	Urban	Freq	34	108	6	7	13	168
		%	20.2%	64.3%	3.6%	4.2%	7.7%	100.0%
	Rural	Freq	35	159	12	6	5	217
		%	16.1%	73.3%	5.5%	2.8%	2.3%	100.0%
Total		**Freq**	**69**	**267**	**18**	**13**	**18**	**385**
		%	**17.9%**	**69.4%**	**4.7%**	**3.4%**	**4.7%**	**100.0%**

Table 6.11 Average time spent by client accessing family planning services by level of health facility, by state/region and urban/rural area

		Travel to clinic (minutes)	Waiting time at clinic (minutes)	Travel back to home (minutes)	Total time spent (minutes)
Level	Tertiary	15	13	15	43
	Secondary	13	8	13	34
	Primary	11	7	11	28
Region	Kachin	14	6	14	35
	Kayah	20	10	20	50
	Kayin	13	3	13	29
	Chin	0	0	1	1
	Sagaing	12	7	12	32
	Tanintheri	9	3	9	20
	Bago	11	8	11	29
	Magway	8	12	8	28
	Mandalay	18	18	17	53
	Mon	1	1	1	3
	Rakhine	14	8	14	35
	Yangon	16	10	16	41
	Shan (South)	14	18	17	49
	Shan (North)	9	6	10	25
	Shan (East)	11	7	12	29
	Ayeyawady	18	10	18	45
	Nay Pyi Taw	14	6	14	35
Urban/Rural	Urban	13	8	13	35
	Rural	11	7	11	30
Total		**12**	**8**	**12**	**31**

The total time spent per clinic visit for family planning services was, on average, about 31 minutes. This included 12 minutes travel each way, and eight minutes waiting time.

Table 6.12 Percentage distribution of clients by activities they would have engaged in during the time spent accessing family planning services by sex, by five-year age group, by marital status, by education

			Activities would have engaged in during time spent accessing family planning services*							
			(Regular house chores)	(Farm work)	(Selling)	(Manual labour)	(Skilled labour)	(Professional job)	(Other)	Total
Sex	Male	Freq	0	0	1	0	1	0	0	2
		%	0.00%	0.00%	50.00%	0.00%	50.00%	0.00%	0.00%	
	Female	Freq	718	152	137	41	41	26	33	1104
		%	65.00%	13.80%	12.40%	3.70%	3.70%	2.40%	3.00%	
Age	15-19	Freq	29	1	3	1	1	1	1	36
		%	80.60%	2.80%	8.30%	2.80%	2.80%	2.80%	2.80%	
	20-24	Freq	118	24	18	11	9	3	4	184
		%	64.10%	13.00%	9.80%	6.00%	4.90%	1.60%	2.20%	
	25-29	Freq	156	36	25	7	13	5	8	240
		%	65.00%	15.00%	10.40%	2.90%	5.40%	2.10%	3.30%	
	30-34	Freq	172	30	38	7	7	8	10	263
		%	65.40%	11.40%	14.40%	2.70%	2.70%	3.00%	3.80%	
	35-39	Freq	126	34	28	8	9	6	7	202
		%	62.40%	16.80%	13.90%	4.00%	4.50%	3.00%	3.50%	
	40-44	Freq	80	21	17	2	2	3	2	125
		%	64.00%	16.80%	13.60%	1.60%	1.60%	2.40%	1.60%	
	45-49	Freq	33	6	8	4	1	0	0	49
		%	67.30%	12.20%	16.30%	8.20%	2.00%	0.00%	0.00%	
	50+	Freq	4	0	1	1	0	0	1	7
		%	57.10%	0.00%	14.30%	14.30%	0.00%	0.00%	14.30%	
Marital status	Unmarried/ live together	Freq	6	4	2	1	0	0	0	13
		%	46.2%	30.8%	15.4%	7.7%	.0%	.0%	.0%	
	Married/live together	Freq	706	145	136	40	42	26	33	1085
		%	65.1%	13.4%	12.5%	3.7%	3.9%	2.4%	3.0%	
	Divorced/separated/widowed	Freq	6	3	0	0	0	0	0	8

		%	75.0%	37.5%	.0%	.0%	.0%	.0%	.0%	
Education level	No schooling	Freq	59	17	9	4	0	0	5	87
		%	67.8%	19.5%	10.3%	4.6%	.0%	.0%	5.7%	
	Primary	Freq	243	43	36	18	15	4	9	363
		%	66.9%	11.8%	9.9%	5.0%	4.1%	1.1%	2.5%	
	Above primary	Freq	416	92	93	19	27	22	19	656
		%	63.4%	14.0%	14.2%	2.9%	4.1%	3.4%	2.9%	
Total		**Freq**	**718**	**152**	**138**	**41**	**42**	**26**	**33**	**1106**

* Multiple response table.

About two-thirds of clients missed household chores to attend the clinic. About 20 per cent of clients stated they left farm jobs where they earned money or their jobs as vendors. There were no apparent differentials observed in activities missed between clients with different background characteristics, except unmarried women who cited missing household chores less than married women.

Table 6.13 Percentage distribution of clients by persons indicated to have performed activities on their behalf while they were at clinic by sex, by five-year age group, by marital status, by education

			To whom assigned task while at clinic				
			Family member	Working partner	Nobody	Other	Total
Sex	Male	Freq	1	1	0	0	2
		%	50.0%	50.0%	.0%	.0%	100.0%
	Female	Freq	490	19	586	5	1100
		%	44.5%	1.7%	53.3%	.5%	100.0%
Age	15-19	Freq	14	0	21	1	36
		%	38.9%	.0%	58.3%	2.8%	100.0%
	20-24	Freq	74	5	103	0	182
		%	40.7%	2.7%	56.6%	.0%	100.0%
	25-29	Freq	102	3	133	2	240
		%	42.5%	1.2%	55.4%	.8%	100.0%
	30-34	Freq	118	7	136	1	262
		%	45.0%	2.7%	51.9%	.4%	100.0%
	35-39	Freq	91	3	109	0	203
		%	44.8%	1.5%	53.7%	.0%	100.0%
	40-44	Freq	63	2	59	0	124
		%	50.8%	1.6%	47.6%	.0%	100.0%
	45-49	Freq	27	0	22	0	49
		%	55.1%	.0%	44.9%	.0%	100.0%
	50+	Freq	2	0	3	1	6
		%	33.3%	.0%	50.0%	16.7%	100.0%
Marital status	Unmarried/ live together	Freq	4	0	9	0	13
		%	30.8%	.0%	69.2%	.0%	100.0%
	Married/ live together	Freq	483	20	573	5	1081
		%	44.7%	1.9%	53.0%	.5%	100.0%
	Divorced/separated/widowed	Freq	4	0	4	0	8
		%	50.0%	.0%	50.0%	.0%	100.0%
Education level	No schooling	Freq	45	0	41	0	86
		%	52.3%	.0%	47.7%	.0%	100.0%
	Primary	Freq	165	5	188	3	361
		%	45.7%	1.4%	52.1%	.8%	100.0%
	Above primary	Freq	281	15	357	2	655
		%	42.9%	2.3%	54.5%	.3%	100.0%
Total		**Freq**	**491**	**20**	**586**	**5**	**1102**
		%	**44.6%**	**1.8%**	**53.2%**	**.5%**	**100.0%**

About 47 per cent of clients did not delegate their duties to others during their clinic visit. Some 46 per cent of clients stated they delegated their duties to family members during their clinic

visit. Differentials in delegation of duties to family members were not apparent among different backgrounds.

Table 6.14 Average amount paid to person who performed activities on behalf of client by activities performed while client was accessing family planning services

Background occupation status	Family member	Working partner	Total average
Regular HH Chores	2750	8000	2710
Farm work	3500	3000	3250
Selling	3000	4000	3500

Of those clients who delegated activities during their clinic visit, 47 per cent paid about 2700 kyats for regular house work and 3250 kyats for farm work.

Table 6.15 Percentage distribution of clients by source of funds used to pay for family planning services by sex, by five-year age group, by marital status, by education

			Client by source of funds used to pay for family planning services*			
			Client themselves	Spouse	Family member	Total
Sex	Male	Freq	1	0	0	1
		%	100.0%	.0%	.0%	
	Female	Freq	223	317	9	549
		%	40.6%	57.7%	1.6%	
Age	15-19	Freq	7	9	1	17
		%	41.2%	52.9%	5.9%	
	20-24	Freq	38	59	1	98
		%	38.8%	60.2%	1.0%	
	25-29	Freq	44	70	1	115
		%	38.3%	60.9%	.9%	
	30-34	Freq	63	71	3	137
		%	46.0%	51.8%	2.2%	
	35-39	Freq	39	61	2	102
		%	38.2%	59.8%	2.0%	
	40-44	Freq	22	36	1	59
		%	37.3%	61.0%	1.7%	
	45-49	Freq	11	10	0	21
		%	52.4%	47.6%	.0%	
	50+	Freq	0	1	0	1
		%	.0%	100.0%	.0%	
Marital status	Unmarried/live together	Freq	5	1	1	7
		%	71.4%	14.3%	14.3%	
	Married/live together	Freq	216	314	8	538
		%	40.1%	58.4%	1.5%	
	Divorced/separated/widowed	Freq	3	2	0	5
		%	60.0%	40.0%	.0%	
Education level	No schooling	Freq	20	24	1	45
		%	44.4%	53.3%	2.2%	
	Primary	Freq	54	98	1	153
		%	35.3%	64.1%	.7%	
	Above primary	Freq	150	195	7	352
		%	42.6%	55.4%	2.0%	
Total		**Freq**	**224**	**317**	**9**	**550**

* Multiple response table.

The source of funds for clients to access family planning services was mainly their spouse (57 per cent) or themselves (41 per cent).

Table 6.16 Average amount paid by each source for family planning services by background characteristics of clients

Sex	Client themselves	Spouse	Family member
Male	1000		
Female	2230	3686	1200
Age			
15-19	5286	1167	5000
20-24	2868	3381	500
25-29	1849	2335	500
30-34	1542	5363	1900
35-39	2698	3266	1000
40-44	2698	5032	1000
45-49	836	3040	
50+		500	
Marital status			
Unmarried/live together	280	1000	5500
Married/live together	2284	3665	3125
Divorced/separated/widowed	1167	8250	
Education level			
No schooling	3815	2302	
Primary	1773	2605	500
Above primary	2179	4399	3250
Total	**2225**	**3686**	**2500**

The average amount paid by each source for family planning services was around 2500 kyats.

7. Summary of findings

7.1 Summary of findings about health facilities

7.1.1 Modern contraceptives offered by primary level health facilities

Since 82.3 per cent of primary level HFs were providing at least three modern methods of contraceptives, the majority of primary level HFs were fulfilling basic voluntary family planning services. There was not much variation from 2016.

7.1.2 Modern contraceptives offered by secondary and tertiary level and private health facilities

The availability of at least five modern methods of contraceptives at secondary and tertiary level and private HFs was 34 per cent, 77 per cent and 63 per cent, respectively. An urban rural differential was noted, while HFs providing five methods of contraceptives was lowest at secondary level HFs.

7.1.3 Availability of maternal and reproductive health essential medicines

Nationwide availability of essential life-saving MRH medicines was 49 per cent, lower than the figure of 53 per cent in the 2016 assessment. The percentage was highest at tertiary level HFs at 72 per cent and lowest at primary level HFs at 46 per cent. The percentage was higher in urban compared to rural area HFs; 54 vs. 47 per cent. The availability of life-saving MRH medicine was higher in HFs in the private sector compared to those in the government sector (53 per cent vs. 50 per cent).

RH medicines with the lowest stock-outs were Metro Inj (14 per cent), Inj Oxytocin (14 per cent) and Na Lactate (14 per cent). Inj Meg Sulph was stocked-out at 22 per cent of HFs. The medicine with the highest stock-out rate was M-dopa (69 per cent).

7.1.4 Incidence of 'no stock outs' of modern contraceptives in the last three months

Some 39 per cent of HFs were able to provide a choice of modern contraceptive methods in the three months prior to the survey; higher than in 2016. The availability of a range of contraceptives was lowest at secondary level HFs compared to tertiary and primary levels of HFs (27 per cent vs. 50 per cent and 41 per cent respectively). "No stock-outs" for OCPs and

injectables was 70 per cent at all levels of HFs. "No stock-outs" for female condoms was less than 20 per cent at all levels. Implant "no stock-outs" was 46 per cent at tertiary level HFs.

7.1.5 Incidence of 'no stock outs' of modern contraceptives on the day of the survey

"No stock-outs" on the day of the survey was 51 per cent for all HFs; much higher than in 2016. Stocks for OCPs and injectable methods were more than 75 per cent at all levels of HFs. There was an obvious increase in "no-stock-outs" for all methods compared to 2016, particularly for male condoms, OCPs and injectable methods.

7.1.6 Supply chain, including cold chain

Responsible person: Pharmacists and assigned MOs were primarily responsible for drug indents and ordering. Pharmacists were most frequently assigned in all states/regions.

Calculation of needs: Supplies for the majority of secondary and primary levels HFs were quantified by the supplier (57.8 per cent and 65.7 per cent, respectively). HFs in rural areas were less likely to calculate needs themselves than in urban areas (42 per cent vs. 64 per cent).

Supply: Some 36 per cent of tertiary level HFs were mainly supplied by State/Region Health Departments; a change from 2016. Some 86 per cent of primary level HFs were supplied by Township Health Departments. The assessment observed that THDs were taking more responsibility as a major supply source (66 per cent). Major suppliers for HFs in urban areas were State/Region Health Departments and Township Health Department (37 per cent and 66 per cent respectively).

Transportation: Most HFs (more than 75 per cent) at all levels and in all states/regions had their own arrangements for transportation of drug supplies. Government arrangements for transportation were found in tertiary and secondary level HFs (22.7 per cent and 13 per cent). HFs making their own arrangements was more obvious in rural than in urban areas (93 per cent vs. 74 per cent). Compared to the 2016 assessment, HFs making their own arrangements in both urban and rural HFs had increased.

Interval: Most HFs, especially secondary and primary level HFs, stated that the interval between the indent and supply was irregular (64 per cent and 76 per cent, respectively); higher than in 2016. Some 14 per cent of HFs at the tertiary level estimated the interval as less than two weeks. Irregularity was more pronounced in secondary and primary level HFs. Two-thirds of

HFs stated that the interval was irregular. Irregularity of interval was more pronounced in this assessment than in 2016.

Cold chain: The availability of a cold chain was highest at tertiary and secondary level HFs (100 per cent and 83 per cent) and lowest at primary level HFs (43 per cent). The overall percentage availability of a cold chain system was about 66 per cent with obvious urban rural differences (79 per cent vs. 56 per cent). Of those HFs with available cold chain units, more than 90 per cent used an electrical power supply system. Most tertiary level HFs used a power source from the national grid. Nearly 40 per cent of HFs at the primary level used solar power. The difference between urban and rural HFs in the usage of the national grid was significant (92 per cent in urban vs. 59 per cent in rural). The usage of solar power was much higher in rural compared to urban HFs (44 per cent vs. 11 per cent).

7.1.7 Staff trained for family planning and implant services

Some 50 per cent and 21 per cent of HFs had trained staff in family planning and implant services, respectively. At all levels of HFs, the percentages were higher than in 2016. In most states/regions, less than 20 per cent of HFs had trained staff in the provision of implant services. The urban rural difference in the presence of trained staff to provide implant services was significant (30 per cent vs. 14 per cent). The private sector had much higher percentages of implant trained staff than the government sector (47 per cent vs. 20 per cent). Most staff who had been trained to provide family planning services had been trained more than one year ago (66 per cent).

7.1.8 Supervision

The percentage of HFs that had not received supervision for reproductive health was 37 per cent (similar to 2016) and this was highest at secondary level HFs (45 per cent) with no differentials between urban and rural HFs. About 40 per cent of HFs received supervision at irregular intervals. The most frequent interval was “every 3 months” (24 per cent). The percentage of HFs that had been more frequently supervised was higher in rural areas. The most frequent supervisory issue was logistics. The second most frequent issues were reporting and clinical treatment.

7.1.9 Availability of guidelines, check-lists and job aids

Availability of any guidelines at all HFs was 36 per cent. Based on all 383 HFs assessed, the most frequently available guidebook was the "Job Aid for Antenatal Care" (25 per cent) and the "Guidebook for Antenatal Care" (23 per cent). Only 16 per cent of HFs had the "Checklist for Birth Spacing". The "National Guidebook for Birth Spacing" was available at only 7 per cent of HFs while the "Guide for Waste Disposal" was the least available guideline (5 per cent).

7.1.10 Use of information and communications technology

Almost all HFs had one ICT appliance. Smart phones (82 per cent), mobile phones (47 per cent) and computers (31 per cent) were the top three ICT appliances available. All ICT appliances were least available in primary level HFs. The most frequent use of ICT devices was for routine communication, medical indents, health education and consultations.

7.1.11 Waste disposal

All HFs had their own waste disposal management system. The most frequently used methods were burying (62 per cent) and burning (57 per cent). An incineration method was only used by 10 per cent of HFs.

7.1.12 Charges for user fees

Respondents from 38 per cent of HFs stated that there were user fees especially for medicines (62 per cent) and speciality services (30 per cent).

7.2 Summary of findings about clients

7.2.1 Characteristics

The urban rural ratio of clients was 1:2. More than 90 per cent of clients were aged between 20 to 49 years. Very few (0.7 per cent) were divorced/widowed at the time of the interview. More than 50 per cent of clients had attained 'above primary' level education. About 90 per cent of clients visited health facilities monthly or every three months.

7.2.2 Clients' perception of family planning service provision

Most clients received their preferred family planning method. They reported receiving relatively little information from healthcare providers about side-effects of contraceptives, about how to manage side effects and about the need to follow up for side-effects, especially at tertiary level HFs. This was lower in Kayah (77 per cent) and Shan (E) (75 per cent) compared to other states/regions where the figure was more than 80 per cent. Less than 10 per cent of clients complained about long waiting times at HFs (this figure was less than 15 per cent in 2016) and this was more evident among clients at tertiary level HFs (17 per cent) although this was lower than the 2016 figure of 33.3 per cent.

7.2.3 Clients' appraisal of the costs of family planning services

About one-third (28 per cent) of clients responded they had to pay for services at HFs. The response was highest at tertiary level HFs (36 per cent) and lowest at primary level HFs (27 per cent). Urban rural differences were significant. Out of 313 clients (28 per cent) who reported they had to pay for clinic visits, the average amount paid for various items was not more than 600 kyats ($US0.50). The highest cost incurred was for medicine, purchased both in and outside the clinic (1000 kyats per item). Costs incurred were highest at tertiary level HFs than at other levels. The total time spent on family planning clinic visits was, on average, 31 minutes. This included 12 minutes traveling to and from the clinic and eight minutes waiting time at the clinic.

8. Findings of in-depth interviews with contraceptive users

In 2017, user's perceptions on the reproductive health services they received at HFs were also assessed through in-depth interviews with clients using different contraceptive methods. The qualitative data was collected by interviewing six clients in each state/region who were using six different contraceptive methods: sterilization, oral contraceptive pills, depo injection, male condoms, implants and IUDs. A total of 102 users (six different users for each contraceptive method in most of states/regions) participated in in-depth interviews conducted by well-trained interviewers. Data was gathered on users' perception of reproductive health care services, including the cost of services.

8.1 Respondents who had undergone female sterilization

8.1.1 Background characteristics of clients

A total of 16 women who had undergone female sterilization were interviewed by trained interviewers in all states/regions except Ayeyawady Region. The average age of respondents was 39; the youngest was 31 and the eldest was 49. Eleven underwent sterilization at tertiary level hospitals and the remainder underwent the procedure at secondary level hospitals.

8.1.2 Clients' perception of reproductive health services

Most of the clients stated that before undergoing sterilization, they didn't receive counselling on the procedure from healthcare providers at the hospital.

One respondent said:

> *"I didn't receive an explanation on the nature of the sterilization method, its side effects and the consequences of undergoing the procedure."*

However, clients who had undergone sterilization in Mon and Kayin State knew that this method was a lifelong or permanent contraceptive.

> *"The healthcare provider from the hospital explained that I could not become pregnant after I had undergone sterilization."*

All respondents said that they received information on sterilization during their follow-up visit to the hospital for post-operative care, but not within the context of family planning.

Respondents waited some months for official and legal permission to proceed with female sterilization.

8.1.3 Clients' perception of health care costs

Regarding the perception of contraception service costs, some respondents said they had not been charged for the operation or other services. They said they received the operation free of charge at hospital. One respondent from Kachin State responded favourably about the health facility:

> *"I was very satisfied with the doctors and nurses during my stay in hospital and they didn't charge me for the operation."*

However, some respondents reported costs for travel, drugs, and clinical examinations and investigations. Some interviewees stated that they had spent a lot of money on being sterilized. A respondent from northern Shan State said:

> *"I spent a lot of money, around two hundred thousand Kyats, on the operation and I had to pay off that debt for a long time."*

Nevertheless, respondents said they were satisfied with the health facilities and the attitude of healthcare providers.

8.1.4 Clients' reasons for undergoing sterilization

All of the respondents had switched contraceptive methods. Some of them said they had used both oral and injectable contraceptive methods before sterilization. One of the respondents said:

> *"I had used both oral and Depo injection but I kept becoming pregnant until I had five children, then I decided to be sterilized."*

A 49-year-old woman from Bago Region revealed her reason for being sterilized:

> *"I am getting old; I have three children and because I am afraid of the side effects of other contraceptives such as hypertension and obesity, I decided to be sterilized."*

8.2.Implant users

8.2.1 Background characteristics of clients

A total of 15 clients using the implant from all states/regions except Mon State and Bago Region were interviewed by trained interviewers. Their mean age was 29; the youngest was 20 and the eldest was 41. Five respondents had attended tertiary level hospitals for the insertion of their implant, eight had visited secondary and the remaining women had received the service at primary level health facilities.

8.2.2 Clients' perception of reproductive health services

Respondents who were using the implant were mainly satisfied with family planning services. The respondents said they had received detailed information from healthcare providers at their respective health facilities on their contraceptive method including side effects, usage, contraindications, indications and the need for follow-up visits. However, a 20-year-old mother from Eastern Shan State said:

> *"I didn't receive any information on the need to make a follow up visit after the insertion of the implant."*

Most of the clients responded favourably about the services; they had a good relationship with the healthcare provider and were satisfied with the clinic environment. Some clients, however, were dissatisfied with the long waiting times at clinics or hospitals for implant insertion services in some areas including Eastern Shan State, Rakhine State and Yangon Region. However, all respondents were very happy with the provider's services relating to the provision of the implant.

8.2.3 Clients' perception of health care costs

Clients reported that they had spent money on traveling to health facilities, but they didn't pay for examinations or other investigations. However, clients who had the implant inserted at a private clinic had to pay for the implant, but not the insertion. A mother who had an implant inserted at a private clinic in Northern Shan State said:

> *"I paid 60000 kyats for the implant only, it is cheaper than other contraceptives".*

8.2.4 Reasons for using the implant

All of the implant users had used one or more contraceptive methods before. Primarily respondents were afraid of the side effects of oral contraception including hypertension, and were worried that they would forget to take the pill daily. Others disliked the side effects of

injectables such as weight gain and amenorrhoea. Clients from Chin State and Mandalay Region said that they wanted to have an implant inserted because they had heard good things about it from others. An implant user from Chin State, however, disliked the method as she had experienced continuous bleeding since its insertion and wanted it removed.

8.3 Male condom users

8.3.1 Background characteristics of clients

A total of 13 clients using condoms were interviewed by trained interviewers. Their mean age was 34.1 years. The youngest was 20 and the eldest was 42. Seven of them accessed condoms at secondary level HFs and three went to primary level health facilities.

8.3.2 Clients' perception of reproductive health services

Most participants reported that healthcare providers explained the correct use of condoms. Information included the possibilities of condoms tearing; what to do if condoms tore; the side effects; a need to return to health centres if clients were experiencing any difficulties using condoms; and that condoms can prevent the transmission of sexually transmitted infections.

They stated that healthcare providers explained the side effects of this method before they first used it. One client experienced pain and a burning sensation when she used condoms and she discussed this with her doctor.

Almost all participants were satisfied with the services they received. The communication between them and healthcare providers was warm and friendly. They were also satisfied with the cleanliness and waiting times at the health centre.

Health centres could provide condoms as needed by participants. However, if there was a stock-out, clients purchased condoms at pharmacies. One participant spoke about the availability of condoms at their health facility:

> *"Previously, I could get as many condoms as I needed from the health centre. But now I don't get them at the health centre as there are none there. I have to buy them at vendor shops".*

8.3.3 Clients' perception of health care costs

Most participants received condoms from rural health centres; and some bought condoms from pharmacies. At rural health centres, they were free of charge. At least one to two strips of six pieces were given by midwives to clients at any one time. When they bought condoms from pharmacies, they cost 100 kyats to 350 kyats per condom.

8.3.4 Reasons for using male condoms

Most participants had used injectable contraceptive methods before switching to condoms. The main reason for switching was because of the side effects of the injection method. One participant responded that she switched to using condoms because her husband has Hepatitis C, and she would like to prevent the transmission of the virus. Most participants responded that they had decided themselves to use condoms after counselling from healthcare providers.

8.4 Oral contraceptive pill users

8.4.1 Clients' perception of reproductive health services

Respondents reported that healthcare providers explained about the various methods of contraception but did not provide details about side effects or the management of side effects. Healthcare providers reminded clients about the need to make a follow-up appointment. Respondents said that there was good communication between healthcare providers and clients and were satisfied that health facilities were clean. Clients felt secure and said they had adequate time for examination. Of the 23 clients currently using the OCP, 11 respondents said clinics were clean. Other clients mentioned that there were not enough toilets at hospitals and that the sanitation was poor.

> "*Take one pill per day. If you miss a pill, take two pills as soon as you remember. That is what the midwife at the hospital I went to for family planning told me".*
> *(30 year-old-woman, Shan-South)*

Most clients didn't complain about the waiting time at clinics. The waiting time varied from 15 minutes to 2 hours. One-third of clients responded that the waiting time was long but the rest found the wait acceptable. They reported that healthcare providers treated them well and were kind.

"There is a good relationship between contraceptive users and providers. The providers treat us like family members."

8.4.2 Clients' perception of health care costs

Some methods of contraception (implants and sterilization at rural health centres and maternal and child health clinics) were not available; there was also a stock-out of injectables and pills. During stock-outs clients had to buy commodities from shops and some were not affordable. They expected to be able to access free government family planning services. Most respondents said there were no charges at clinics for treatment but they paid 200-500 kyats for their registration books. When OCPs were not provided by health facilities, they bought them at pharmacies.

8.4.3 Reasons for using the current method

Twenty-one out of 23 current OCP users had switched methods as they did not like using one method for a long time. Their decisions were not related to services provided. Reasons given for switching methods included weight gain, irregular bleeding, headaches, and dizziness. If clients did not want any more children, they preferred sterilization. But as this procedure needed to be officially approved they decided to use IUD or implants. At the rural health centre level, long-term contraceptive methods were not accessible. Sexually active women who lived in rural areas perceived that the IUD/implant insertion was a permanent method. Most women could not afford to seek modern contraception methods. Even though contraceptives are provided free of charge, costs incurred for traveling to health facilities were still too high.

8.5 Users of injectable methods

A total of 18 clients using the injectable method were interviewed. Most clients decided to use the injectable themselves. They knew about other contraceptive methods, especially the oral contraceptive pill, the implant and intrauterine device. Their source of information about contraception was from healthcare providers, their peers and mothers.

8.5.1 Clients' perception of reproductive health services

Healthcare providers explained the side effects of injectable contraceptives before administration. The most common concerns that healthcare providers addressed were that clients

must return to the clinic if they suffered spotting after the injection They also explained to clients about the delay in menstruation when using injectables. Other common side effects explained by healthcare providers included dizziness and headaches.

Most clients reported that healthcare providers answered any queries on the contraception in detail. Some providers explained to clients that they should not have sexual relationships for at least seven days after the injection. They also explained about existing medical conditions that could be exacerbated by the injectable and what contraception might be more appropriate.

Most providers generally mentioned that the injectable had to be administered every three months, but did not give clients the exact date of their follow-up visit. Some providers noted down the follow-up date on their clinic book and clients made a follow-up visit one day before they were due. Only a few providers, however, reminded clients to have another injection. In some cases, three months after the injection, clients waited to menstruate before they had their next dose as they thought they were pregnant.

> *"I did not go to the clinic if I had not menstruated within three months of having the injection as I thought this must be because I was pregnant".*

Almost all clients said that the clinic was clean. They also preferred this situation of the clinic Moreover, clients reported that some providers disposed of waste in selected areas and if the clients did not follow their rule, they shouted at them. There was a privacy room in the clinic for examinations, counselling and treatment. A curtain at the door of the room increased the feeling of privacy and confidentiality for clients.

Some patients said that if there were many patients at the clinic, they had to wait for some hours. Or sometimes, they had to return to the clinic on another day. If the provider was attending a meeting, they had to wait for some hours. They reported that the nearby presence of a healthcare provider was very convenient not only for contraception but also for other health care matters.

Clients reported that they were treated in a friendly manner and spoken to politely.

> *"Healthcare providers never shout or discriminate".*

> *"Healthcare providers are always friendly, and speak gently and have a good outlook".*

But a few clients reported that when providers had a heavy workload, especially when there were many patients, that they might be shouted at.

8.5.2 Clients' perception of health care costs

Respondents mainly went to the clinic on foot and by motorbike. It did not take long to get there and the cost for traveling was negligible. In addition, no charges were incurred at the clinic. Some clients mentioned that they did not have to pay for anything even when the healthcare provider made a home visit. But sometimes, they donated money to the clinic – 500-1000 Kyats – or as much as they could afford. It could cost 1000-2000 Kyats for contraception when there was a shortage of contraceptives at the clinic.

8.5.3 Reasons for using current method

Clients gave several reasons for choosing injectables, one of which was that it was the most available method in their area. Other reasons included the side effects of oral contraception such as dizziness and nausea, and that they would forget to take it daily. In some cases, OCPs were not suitable for clients due to existing medical conditions. In some areas clients chose the injectable due to a lack of availability of other contraceptives.

"I went to a private clinic to have an implant inserted as I had become overweight using the injectable. However, there were no implants, so I had to use the injection as usual."

"I know about contraception that prevents pregnancy for at least five years. I don't want to go to hospital, however, but I would choose it if it was available here."

"I hope to have an implant inserted. Here in my village there is only a choice of two methods, oral and injectable contraceptives".

A lack of confidence about the effectiveness of other contraception methods, especially the IUD and oral contraceptive pill, was another reason for choosing the injectable.

> *"I heard that even while using the intrauterine contraception, some women became pregnant. Therefore, I do not want to use it."*
>
> *"I used the oral contraception pill but still became pregnant."*

8.6 IUD method users

The age range of IUD users was between 26 to 43-years-old. A total of 17 IUD users were interviewed. Some, but not all participants, had heard about the IUD, pills, injection and implant although they were not using.

8.6.1 Clients' perception of reproductive health services

Most participants reported that healthcare providers did not inform them about the range of contraceptive methods available. Half of the participants reported that the side effects of the IUD were explained to them. One respondent said that she only knew that she would have regular menstruation with the IUD, but did not know of other side effects. The need for a follow-up visit was not mentioned by almost all healthcare providers except in the case of two participants.

8.6.2 Client satisfaction with clinic

Only a few participants said they had sufficient time for examination. Most participants were satisfied with the clinic, which was clean, allowed privacy and had a separate room where the IUD was inserted. Almost all participants reported that they did not need wait long to have their IUD inserted. While one participant complained that they had to wait for the healthcare provider who was at a meeting.

8.6.3 Clients' perception of health care costs

No cost for the IUD was mentioned by participants except in the case of two clients. One had to make a donation of 2000 Kyats and another had to pay 10,000 Kyats, although both said that this did not cause a financial burden.

8.6.4 Reasons for using current method

Clients made their own decision to have the IUD inserted, also receiving advice from midwifes, NGOs and others. One reason for choosing the IUD was that clients would still menstruate regularly. Some did not want to use the implant because they did not like the idea of it being inserted under the skin and were afraid that there would be difficulties with removal. Clients did not choose the injectable due to delays in menstruation and weight gain.

Almost all participants had a history of using OCPs and/or injections. The main reasons for the cessation of OCPs were that participants had experienced palpitations, dizziness and fatigue, while reasons for abandoning injectables were fear of weight gain, experience of weight gain or loss and the need for a repeated dose.

9. Discussion

In Myanmar, health sector policies and programmes, especially voluntary family planning programmes, focus on the prevention of unwanted pregnancies and abortion and other pregnancy-related morbidities by strengthening the health system to meet the reproductive health needs of communities. Myanmar's unmet need for modern contraceptives among married women of reproductive age stands at 16 per cent with regional disparities. A number of factors drive this unmet need including: limited the reproductive health knowledge of clients; a shortage of skilled health care providers; shortages and stock-outs of critical contraceptive methods; limitations in the provision of long-acting contraceptives; geographical challenges, especially in areas affected by conflict; and a sizeable funding shortfall for family planning commodities and services. To meet contraceptive needs, the health system's capacity to provide user-friendly reproductive health services, including contraception, must be increased. Timely, reliable and quality data on family planning programming is critical to ensure that future programme interventions are evidence-based. As a fourth consecutive assessment, this report provides valuable RH commodity data for stakeholders' effective utilization in improving family planning and RH services.

As a country of the Global Programme for RHCS, Myanmar has an existing functional coordination mechanism for RHCS in place led by government with the involvement of relevant stakeholders. This mechanism has strengthened national leadership and ownership and ensures a more coordinated approach to activities in-country.

9.1 Awareness raising

It is important for clients to make the right decision about which contraceptive is appropriate for them and to have access to a range of contraceptive methods. Family planning programmes should be rights-based with providers equipped with the appropriate skills to counsel clients on the family planning method mix so that they can make an informed decision. The findings reveal that users of the most common contraceptive methods – the OCP and injectables – do not get sufficient information about side effects or the management of these. Misunderstandings about long term methods such as the IUD and implants are also prevalent. In order to improve the contraceptive prevalence rate, misconceptions need to be addressed.

9.2 Training of health staff

The assessment noted that in about half of HFs surveyed, staff had been trained in the provision of family planning. Far fewer HFs had trained staff in the provision of the implant method and urban rural disparities were apparent. High staff turnover impacts on the number of trained staff at health facilities. Refresher training is costly and time consuming and programme managers also face challenges in recruiting skilled trained staff to their HFs. To address these challenges, the provision of comprehensive, quality, and rights-based family planning and SRHR counselling should be integrated into the pre-service curriculum.

9.3 Improving reproductive health commodity security and the contraceptive method mix

Logistics management information systems need to be bolstered so that the family planning method mix is available at all health facilities all of the time and RHCS is achieved. In this survey, 82.3 per cent of primary level HFs, 34 per cent of secondary level HFs, 77 per cent of tertiary level HFs and 63 per cent of private sector HFs were providing the minimum number of modern contraceptives. Only 39 per cent of HFs reported 'no stock-outs' over the last three months, 51 per cent of which were on the day of assessment. Regarding MRH medicine, the availability of essential life-saving MRH medicine was noted to be 49 per cent for all HFs. A push system for quantifying supply needs is still dominant in HFs. Regular and consistent supply systems have not yet been established. A lack of a consistent cold chain for RH medicine was evident at more than 50 per cent of HFs at the primary level. There was also a lack of regular supervision for RH at many HFs. Overall, a comparison with findings from the assessments over the last four years showed there was some improvement in RH commodity security. Counselling clients on long acting reversible methods and creating demand, while improving their availability, will contribute to the security status of these commodities.

9.4 Strengthening coordination between the public and private sector

More than 60 per cent of private HFs could provide family planning services, which was slightly lower than tertiary level HFs (73 per cent). All private HFs were also found to have rates of 100 per cent of "no stock-outs of a modern method" in the last three months while only 19 per cent of private HFs were found to have "no stock-outs of a modern method" on the day of the

assessment. Availability of life-saving MRH medicine was higher in HFs in the private sector compared to the government sector (53 per cent vs. 50 per cent). The private sector also had much higher percentages of trained staff to insert the implant than the government sector (47 per cent vs. 20 per cent). The findings show the potential of the private sector's contribution to RHCS. Government health sectors have to consider how to engage with the private sector to build a private-public partnership for RHCS. RHCS is a dynamic and complex process that depends on changes in policy; changes in the activities of key stakeholders in the public sector; changes in donor funding commitments; increased demand for contraceptives; changes in the procurement and manufacturing cycle; and the emergence of new contraceptive methods.

The government supply chain, as well as financial management for capacity building of service providers, both in the public and private sector, are facilitated by a variety of partners who offer quality family planning services. This assistance will certainly help reduce the unmet need for contraceptives, unwanted pregnancies, abortions, as well as maternal morbidity and mortality among women of reproductive age.[26] UNFPA, together with the MOHS, is supporting public-private partnerships in contraceptive distribution to achieve commitments made under FP2020, which include increasing the contraceptive prevalence rate to 50 per cent and reducing the unmet need to 10 per cent. Thus, the active involvement of the private sector and aligned partners in contraceptive procurement mechanisms and the development and revision of projections for reproductive health supplies, including contraceptives and RH medicines, will assist in achieving RHCS. It will enable the efficient use of resources and promote equitable and sustainable access to family planning.

9.5 Dynamics of reproductive health commodity security

After several years of intensive efforts to create RHCS in the country, some challenges still remain: 1) There needs to be a shift from a push to a pull system in the forecasting of commodities; 2) Supply chain management needs to be reviewed to align with the reorganization of departments under the Ministry; and 3) Logistic management information systems need to be integrated into the government's HMIS. Addressing these challenges will help to address the discrepancies between urban and rural health facilities in terms of RH life-saving medicines and the range of available contraceptive methods. Irregularities of stock and stock imbalances also

[26]http://myanmar.unfpa.org/news/unfpa-introduces-contraceptive-implant-first-time-myanmar

remain a challenge. Strengthening distribution systems and stock adjustments based on stock data using a computerized reporting system is needed.

Health facilities should have ownership in logistics management, especially for essential items: quantifying minimum needs and ordering and reporting rationality of use. Medicine requisition should be a bottom-up approach. Quantifying supplies of commodities should be concurrent with logistics management skills training. Various donor agencies and governments need to promote better logistics management, rather than investing in the purchase of newer commodities, and focus on facilities meeting contraceptive needs and robust human resources for health. Capacity development is required at the district, state/region and national level to manage commodities in the health system.

The monitoring and evaluation of commodity security concurrently with programme performance, and making necessary adjustments (if new constraints emerge or outcomes do not meet work plan targets) is necessary. This function should be the responsibility of the working group, which must routinely monitor stock status reports, the procurement pipeline status, existing funding and future commitments, and the quality and reach of service delivery.[27] A new Reproductive Health Commodity Logistic System (RHC-LS), has been established, designed to ensure product availability is on-going. But there are challenges in the implementation of the RHC-LS. The RHC-LS, will in time, as it is developed, adapt to meet this challenges until it becomes fully functional.[28]

[27] Sarley, David, Raja Rao, Carolyn Hart, Leslie Patykewich, Paul Dowling, Wendy Abramson, Chris Wright, Nadia Olson, and Marie Tien. October 2006. Contraceptive Security: Practical Experience in Improving Global, Regional, National, and Local Product Availability. Arlington, Va.: DELIVER, for the U.S. Agency for International Development.

[28] http://myanmar.unfpa.org/news/improving-availability-reproductive-health-commodities-connecting-demand-and-supply#sthash.ZR9wLjk5.dpuf

10. Conclusion

This report provides four years' trends of RH Commodity and Services at a representative sample of urban and rural, state/region, government and private sector HFs across the country. It provides an overview of RHCS activities in recent years, reflecting political, economic and administrative changes. There have been improvements in the stock-out situation in states/regions reflecting the LMIS and Supply System that was established in 2014. RHCS activities could be sustained and improved in the future if policy, systems and development activities are synchronized with each other.

11. Recommendations

11.1 Commodity security

11.1.1 Contraceptives

HFs in Chin and Rakhine States should focus on strengthening their capacity to offer a minimum level of family planning services.

Secondary Level HFs in Magway, Bago, Nay Pyi Taw, Sagaing, Kayah and Ayeyawady still have little capacity to provide a minimum level of family planning services. These HFs should focus on procuring a sufficient quantity of contraceptives to meet demand as well as a range of contraceptives.

11.1.2 Reproductive health medicines

The availability of seven essential RH medicines at secondary level HFs, especially Chin, Bago, Sagaing and Rakhine, has decreased over the four years' of assessments. These areas should be prioritized for supplies of RH medicine, mainly antibiotic injections such as cefixime, benzyl penicillin and ampicillin.

11.1.3 Supply chain

No stock-out rates were lower in primary level HFs in 2017 compared to 2016. This indicates the supply system has become weaker at this level. There was an increasing trend of stock-outs for implants. The availability of this method was also linked with the availability of trained staff.

Primary level HFs still need to improve their management especially in quantifying demand. New distribution methods should be investigated to ensure a shorter interval in transporting supplies from townships to HFs. A country-wide quantification of need should begin.

11.2 Contraceptive services

The implant stock rate, which might relate to the presence of trained staff, was very low at secondary level HFs and indicates a need to improve both the supplies and range of contraceptives at secondary level HFs, with the presence of more trained staff.

At the tertiary level, which has a high clinic attendance, there was a low rate of family planning counselling except in the provision of follow-up appointments and on admission to hospital.

Doctors didn't counsel clients effectively so that they had sufficient information to make an informed choice about their contraceptives. Building capacity at tertiary level HFs to improve family planning services needs to be investigated.

11.3 Logistics and supply chain management systems

11.3.1 Training

Overall data for logistics management show that pharmacists and assigned MOs are the main person responsible for drug indents. Not every secondary level HFs has a pharmacist post. The role of pharmacists at hospitals is not consistently described as being a logistics management role. A job description, as well as the skills needed, for the medicine and commodity supply chain post at HFs should be clearly described. The task of logistics management should be shifted to reduce an unnecessary work burden on administrative staff and clinical staff at HFs. Skills training for them and other appropriate staff at HFs (if there is no pharmacist) in logistics management must be expanded based on infrastructure and programme needs in terms of geographical area and level of HF. Areas which have higher stock-out status such as Bago, Magway, Chin, Rakhine, Yangon and Mandalay should be prioritized for training sessions.

Effective training for implants should be emphasized at secondary level HFs (especially at station hospitals in Kayah, Chin, Bago, Ayeyawady) to narrow down urban rural differences. Vacancies for trained skilled person should be filled.

11.3.2 Supply system

Responsibility for the supply chain and logistics management are assumed at the central level as well as at the state/region level. The linkages between the two levels of management should be harmonized for itemization, quantification, and procurement and distribution by using computerized mechanisms, and effective communication and monitoring system. The needs of commodities and supplies should be quantified locally. Supply needs should transition from a pull to a push system. Regularity of quantification, ordering and distribution should be maintained.

To reduce stock-outs at all levels of HFs, there should be a good channel of reporting and communication of real time stock status using modern ICT technology. The feasibility of mobile phone technology for real time reporting of RH logistics should be studied. Standard operating

procedures for the national LMIS system should be developed. Guides for procurement, quantification, and distribution should reach all levels of HFs across the country.

The integration of supplies at NGOs, INGOs and in the private sector should be coordinated by the government sector to harmonize proper distribution based on local needs. There should be clear guidelines for storing RH medicines in cold chain systems.

11.4 Monitoring and evaluation

Central level monitoring systems that reach primary level HFs should be reinforced. The monitoring of RHCS should be integrated into existing monitoring activities such as immunization, disease control and infrastructure development. RHCS monitoring information systems should be reconsidered in light of the recent revision of the HMIS, particularly the need for information to develop linkages between the HMIS and the RHLMIS and this should be discussed among stakeholders. Key tracer variables for RHCS insecurity should be identified from existing data sources through more detailed analysis.

Every supervision visit to lower levels of HFs should be made using a checklist system that includes RH commodities and services issues. Every supervision visit should be recorded and reported to higher level authorities and the relevant immediate supervision level, including feedback given to the HFs.

Ad-hoc supervisions should be replaced with planned supervisory visits that should be more regular and have greater coverage, including HFs in hard-to-reach areas.

11.5 Waste disposal

Waste disposal guidelines and standard operating procedures should be systematically distributed to secondary and primary level HFs. There should be a dedicated budget line with sufficient resources for the establishment and maintenance of waste disposal systems at all level of HFs. Uniformity in implementing waste disposal at all level of HFs should be monitored.

11.6 Methodology for assessment

Future assessments should include HFs at INGOs, since INGOs working in reproductive health are providing contraceptives in townships without hospitalization; these HFs should be considered as primary level.

A qualitative approach, especially in-depth interviews with clients and key informants, was included in this year's assessment to gather more robust data from clients to triangulate with information from the questionnaire survey. This qualitative approach was helpful to avoid selection bias in client interviews. The questionnaire should be modified to "whether RH medicine are stored in existing cold chain or not".

Annex 1.

GPRHCS Survey Questionnaire ENGLISH

Commodity Security Branch, Technical Division, UNFPA
Global Programme to Enhance Reproductive Health Commodity Security

SURVEY QUESTIONNAIRE

2017 FACILITY ASSESSMENT FOR REPRODUCTIVE HEALTH COMMODITIES AND SERVICES

INFORMATION ABOUT THE INTERVIEW
Country .....
Date of the Survey (year and month) .....
Name of Interviewer .....Date of Interview.....
Time Interview Started..... Time Interview Ended.....
Questionnaire checked and attested to be properly completed
Name of Supervisor.....
Signature ..... Date) .....

The questionnaire is in two parts; Module 1 (sections 1 to 13) is for the health facility/SDP; and, module 2 (sections 14 and 15) is for exit interview of clients visiting the SDP.

To administer Module 1, the interviewer should find the person in charge of the facility or the most senior worker who is present at the facility on that day. It is recommended that the interviewer should greet the interviewee; introduce himself herself; and, explain the purpose of the visit.

To ensure informed consent to the interview it is necessary to read the following statement to the interviewee:

- Your facility was selected to participate in this study. We will be asking you questions about aspects of RH commodities and services in your facility including family planning. The information obtained from your facility and from other facilities will be used by the MOH and other partners to understand the situation and for better planning to improve on service provision.
- The survey is in two parts: The first part will be answered by you the service provider and the second part will be answered by the clients who are visiting the facility for family planning services. We will require your permission to carry on with the exit at the appropriate time.
- You are assured that your name or that of any other health worker who will be designated to respond to this questions or the name of any client WILL NOT be mentioned or included in the dataset or in any report of this survey.
- You may refuse to answer any question or choose to stop the interview at any time. However, we hope you will answer the questions, which will be of benefit to strengthening national efforts to provide RH services including family planning.
- If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate if you introduce us to that person to help us collect that information.
- At this point, do you have any questions about the study? Do I have your agreement to proceed?

The interviewer can proceed with the interview once the consent of the interviewee has been obtained. At the end of the interview for the SDP [Sections 1 to 13]; please thank the interviewee for his/her time and the information provided; and, obtain his/her permission or the permission of the relevant authorities before carrying on with the Exit Interview of Family planning clients [Sections 14 and 15]

(Rev – August 2014)

Commodity Security Branch, Technical Division, UNFPA

Global Programme to Enhance Reproductive Health Commodity Security

MODULE 1:

AVAILABILITY OF COMMODITIES

(Rev – August 2014)

Commodity Security Branch, Technical Division, UNFPA
Global Programme to Enhance Reproductive Health Commodity Security

SECTION 1: FACILITY IDENTIFICATION (Name, Location and Distance)	
SN^{o}	**ITEMS**
001	Name of Service Delivery Point.....
002	A) Location (Name of Settlement)..... B) Location (Name of Administrative Unit).....
003	Indicate geographic coordinates of the SDP if any system Global Positioning System (GPS) is used; /_____/_____/
004	SDP is located in an urban area or a rural settlement (as per your country's classification; 1 Urban☐ 2 ☐Rural
005	A) What is the distance between the location of the health facility and the nearest warehouse or store or facility which this SDP receives its regular supplies? /__/___/ B) Please indicate distance is in; 1 Kilometers ☐ 2 Mile ☐

SECTION 2: SDP TYPE AND SERVICES PROVIDED	
006	Level of Service Delivery Point(**Tick the option that is applicable to your country)** Primary Level Care SDPs/facilities (or equivalent to country context) 1 ☐ Secondary level care SDPs/facilities/hospitals (or equivalent) 2 ☐ Tertiary level care SDPs/facilities/hospitals (or equivalent) 3 ☐
007	Management of Service Delivery Point: 1 Government ☐ 2 Private ☐ 3 NGO ☐ 4 Others (please specify.....) ☐
008	Does this facility provide family planning services? 1 Yes ☐ 2 No ☐ (If No, then items in Section 3 and 5 (that is 011 to 014 and 019 to 024) should NOT be administered)
009	Does this facility provide maternal health including delivery services (e. g. with a maternity unit or section for delivery)? 1 Yes ☐ 2 No ☐ (If No, then items in Section 4 (that is 015 to 018) should NOT be administered)
010	Does this facility provide any HIV/AIDS services (e.g. VCT, PMTCT, ART, etc.)? 1 Yes ☐ 2 No ☐

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Global Programme to Enhance Reproductive Health Commodity Security

SECTION 3: MODERN CONTRACEPTIVE METHODS OFFERED AT SDP Please note that for the SDP to respond to items in this section, it should have indicated in Item 008 above that 'Yes' it provides family planning services									
Item	(1) Male condoms	(2) Female Condoms	(3) Oral Contraception	(4) Injectables	(5) IUDs	(6) Implants	(7) Sterilisation for Females	(8) Sterilisation for Male	(9) Emergency contraception
011 With respect to each of the contraceptive methods, please state whether the SDP is supposed/ expected to offer it, **in line with the current national protocols, guidelines and/or laws specific for this level* of service delivery.** Please discuss with the respondent and then record your conclusion before proceeding.	**1 Yes,** this SDP is expected /supposed to provide this method ☐ **2 No,** this SDP is NOT expected/ supposed to provide this method ☐ *(Tick only one option)*	**Yes,** this SDP is expected /supposed to provide this method ☐ **2 No,** this SDP is NOT expected/ supposed to provide this method ☐ *(Tick only one option)*	**Yes,** this SDP is expected /supposed to provide this method ☐ **2 No,** this SDP is NOT expected/ supposed to provide this method ☐ *(Tick only one option)*	**Yes,** this SDP is expected /supposed to provide this method ☐ **2 No,** this SDP is NOT expected/ supposed to provide this method ☐ *(Tick only one option)*	**Yes,** this SDP is expected /supposed to provide this method ☐ **2 No,** this SDP is NOT expected/ supposed to provide this method ☐ *(Tick only one option)*	**Yes,** this SDP is expected /supposed to provide this method ☐ **2 No,** this SDP is NOT expected/ supposed to provide this method ☐ *(Tick only one option)*	**Yes,** this SDP is expected /supposed to provide this method ☐ **2 No,** this SDP is NOT expected/ supposed to provide this method ☐ *(Tick only one option)*	**Yes,** this SDP is expected /supposed to provide this method ☐ **2 No,** this SDP is NOT expected/ supposed to provide this method ☐ *(Tick only one option)*	**Yes,** this SDP is expected /supposed to provide this method ☐ **2 No,** this SDP is NOT expected/ supposed to provide this method ☐ *(Tick only one option)*
(Please recall SDP level as recorded in item 006 above)* **012** **If 'Yes' in item 011** (i.e., this SDP is supposed/ expected to offer this method), please state whether the SDP actually **offer it to clients** on a regular basis	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 011) ☐ *(Tick only one option)*	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 011) ☐ *(Tick only one option)*	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 01) ☐ *(Tick only one option)*	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 01) ☐ *(Tick only one option)*	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 01) ☐ *(Tick only one option)*	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 01) ☐ *(Tick only one option)*	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 01) ☐ *(Tick only one option)*	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 01) ☐ *(Tick only one option)*	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 01) ☐ *(Tick only one option)*
	NOTE, FOR EACH OF THE METHODS - If this SDP is **actually supposed/expected to <u>OFFERS</u>** the contraceptive method but it is currently out of stock or not available at the time of the survey, please record as "Yes" (i.e.; the method is actually offered, although it is not currently in stock or available)								

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Item	(1) Male condoms	(2) Female Condoms	(3) Oral Contraception	(4) Injectables	(5) Emergency contraception	(6) IUDs	(7) Implants	(8) Sterilisation for Females	(9) Sterilisation for Male
013 If this SDP is supposed/expected to offer this method to clients (in line with current national guidelines, etc.) but the response to 010 is "No", please indicate the main reason *(Tick only one option [as the main reason] for each contraceptive)*	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐
	2 Delays by this SDP to request for supply of the contraceptive ☐	**2** Delays by this SDP to request for supply of the contraceptive ☐	**2** Delays by this SDP to request for supply of the contraceptive ☐	**2** Delays by this SDP to request for supply of the contraceptive ☐	**2** Delays by this SDP to request for supply of the contraceptive ☐	**2** Delays by this SDP to request for supply of the contraceptive ☐	**2** Delays by this SDP to request for supply of the contraceptive ☐	**2** Delays by this SDP to request for supply of the contraceptive ☐	**2** Delays by this SDP to request for supply of the contraceptive ☐
	3 The contraceptive is not available in the market for the SDP to procure ☐	**3** The contraceptive is not available in the market for the SDP to procure ☐	**3** The contraceptive is not available in the market for the SDP to procure ☐	**3** The contraceptive is not available in the market for the SDP to procure ☐	**3** The contraceptive is not available in the market for the SDP to procure ☐	**3** The contraceptive is not available in the market for the SDP to procure ☐	**3** The contraceptive is not available in the market for the SDP to procure ☐	**3** The contraceptive is not available in the market for the SDP to procure ☐	**3** The contraceptive is not available in the market for the SDP to procure ☐
	4 Low or no client demand for the contraceptive ☐	4 Low or no client demand for the contraceptive ☐	4 Low or no client demand for the contraceptive ☐	4 Low or no client demand for the contraceptive ☐	4 Low or no client demand for the contraceptive ☐	4 Low or no client demand for the contraceptive ☐	4 Low or no client demand for the contraceptive ☐	4 Low or no client demand for the contraceptive ☐	4 Low or no client demand for the contraceptive ☐
						5 No train staff to provide this contraceptive at the SDP ☐	**5** No train staff to provide this contraceptive at the SDP ☐	**5** No train staff to provide this contraceptive at the SDP ☐	**5** No train staff to provide this contraceptive at the SDP ☐
						6. Lack of equipment for the provision of this contraceptive ☐	**6.** Lack of equipment for the provision of this contraceptive ☐	**6.** Lack of equipment for the provision of this contraceptive ☐	**6.** Lack of equipment for the provision of this contraceptive ☐
	7. Any other Reason (please specify)……. ………………………	7. Any other Reason (please specify)……. ………………………	7. Any other Reason (please specify)……. ………………………	7. Any other Reason (please specify)……. ………………………	7. Any other Reason (please specify)……. ………………………	7. Any other Reason (please specify)……. ………………………	7. Any other Reason (please specify)……. ………………………	7. Any other Reason (please specify)……. ………………………	7. Any other Reason (please specify)……. ………………………
014 From responses provided to Item 012, discuss with the respondent and record the conclusion by ticking one of the following statements	**IF THIS IS A PRIMARY SDPS (AS NOTED IN ITEMS 06)** 1 This SDP **offers** up to two modern contraceptive methods ☐ 2 This SDP **offers** three and more (at least three) modern contraceptive methods ☐				**IF THIS IS A SECONDARY OR TERTIARY SDPS (AS NOTED IN ITEM 06)** 3 This SDP **offers** up to four modern contraceptive methods ☐ 4 This SDP **offers** FIVE and more (at least three) modern contraceptive methods ☐				

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SECTION 4: AVAILABILITY OF MATERNAL/RH MEDICINES									
Items	**Maternal/RH Medicines** **Please note that for the SDP to respond to items in this section, it should have indicated in Item 009 above that 'Yes' it provides maternal health including delivery services**								
	(1) **Ampicillin**	**(2)** **Azithromycin**	**(3)** **Benzathine benzylpenicillin**	**(4)** ***Either*** **Betamethasone** ***Or*** **Dexamethasone** ***Or Both of these medicines***	**(5)** **Calcium gluconate**	**(6)** **Cefixime**	**(7)** **Gentamicin**	**(8)** **Hydralazine**	**(9)** **Magnesium sulfate**
015 With respect to each of the maternal/ RH Medicines, please state whether the SDP is supposed have it available; **in line with the current national protocols, guidelines and/or laws specific for this level* of service delivery.** Please discuss with the respondent and then record your conclusion before proceeding *(* Please recall SDP level as recorded in item 006 above)*	**1 Yes,** this SDP is expected /supposed to have available this Maternal /RH Medicine ☐ **2 No,** this SDP is NOT expected/ supposed to have available this Maternal /RH Medicine ☐ *(Tick only one option)*	**1 Yes,** this SDP is expected /supposed to have available this Maternal /RH Medicine ☐ **2 No,** this SDP is NOT expected/ supposed to have available this Maternal /RH Medicine ☐ *(Tick only one option)*	**1 Yes,** this SDP is expected /supposed to have available this Maternal /RH Medicine ☐ **2 No,** this SDP is NOT expected/ supposed to have available this Maternal /RH Medicine ☐ *(Tick only one option)*	**1 Yes,** this SDP is expected /supposed to have available any or both of these Maternal /RH Medicines ☐ **2 No,** this SDP is NOT expected/ supposed to have available any or both of these Maternal /RH Medicine ☐ *(Tick only one option)*	**1 Yes,** this SDP is expected /supposed to have available this Maternal /RH Medicine ☐ **2 No,** this SDP is NOT expected/ supposed to have available this Maternal /RH Medicine ☐ *(Tick only one option)*	**1 Yes,** this SDP is expected /supposed to have available this Maternal /RH Medicine ☐ **2 No,** this SDP is NOT expected/ supposed to have available this Maternal /RH Medicine ☐ *(Tick only one option)*	**1 Yes,** this SDP is expected /supposed to have available this Maternal /RH Medicine ☐ **2 No,** this SDP is NOT expected/ supposed to have available this Maternal /RH Medicine ☐ *(Tick only one option)*	**1 Yes,** this SDP is expected /supposed to have available this Maternal /RH Medicine ☐ **2 No,** this SDP is NOT expected/ supposed to have available this Maternal /RH Medicine ☐ *(Tick only one option)*	**1 Yes,** this SDP is expected /supposed to have available this Maternal /RH Medicine ☐ **2 No,** this SDP is NOT expected/ supposed to have available this Maternal /RH Medicine ☐ *(Tick only one option)*
016 **If 'Yes' in item 015** (i.e., this SDP is expected/ supposed to have available the maternal /RH medicine) please state whether the medicine is currently available at the SDP	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 015) ☐	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 015) ☐	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 015) ☐	**1 Yes (for any or both)** ☐ **2 No (for any or both)** ☐ **3 Not Applicable** (because "No" to item 015) ☐	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 015) ☐	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 015) ☐	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 015) ☐	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 015) ☐	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 015) ☐

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	(Tick only one option)	*(Tick only one option)*	*(Tick only one option)*	*(Tick only one option)*	*(Tick only one option)*	*(Tick only one option)*	*(Tick only one option)*	*(Tick only one option)*	*(Tick only one option)*
017 If this SDP is supposed/ expected to have available this medicine (in line with current national guidelines, etc.) but the response to 015 is "No", please indicate the main reason *(Tick only one option [as the main reason] for each medicine)*	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐ **3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5 No** train staff to provide this medicine at the SDP ☐ 7. Any other Reason (please specify)……. ……………………	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this **2** Delays by this SDP to request for supply of the medicine ☐ **3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5 No** train staff to provide this medicine at the SDP ☐ 7. Any other Reason (please specify)……. ……………………	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐ **3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5 No** train staff to provide this medicine at the SDP ☐ 7. Any other Reason (please specify)……. ……………………	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐ **3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5 No** train staff to provide this medicine at the SDP ☐ 7. Any other Reason (please specify)……. ……………………	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐ **3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5 No** train staff to provide this medicine at the SDP ☐ 7. Any other Reason (please specify)……. ……………………	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐ **3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5 No** train staff to provide this medicine at the SDP ☐ 7. Any other Reason (please specify)……. ……………………	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐ **3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5 No** train staff to provide this medicine at the SDP ☐ 7. Any other Reason (please specify)……. ……………………	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐ **3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5 No** train staff to provide this medicine at the SDP ☐ 7. Any other Reason (please specify)……. ……………………	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐ **3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5 No** train staff to provide this medicine at the SDP ☐ 7. Any other Reason (please specify)……. ……………………

INTERVIEWER VERIFICATION for ITEM 016

Medicines	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**	**(8)**	**(9)**
	Ampicillin	**Azithromycin**	**Benzathine benzylpenicillin**	***Either*** **Betamethasone** ***Or*** **Dexamethasone**	**Calcium gluconate**	**Cefixime**	**Gentamicin**	**Hydralazine**	**Magnesium sulfate**

				Or Both of these medicines					
For each response provided for **item 016**, the interviewer should validate the response by a physical Inventory and note the appropriate finding	☐ Inventory taken, Medicine is in stock ☐ Inventory taken, Medicine is NOT in stock	☐ Inventory taken, Medicine is in stock ☐ Inventory taken, Medicine is NOT in stock	☐ Inventory taken, Medicine is in stock ☐ Inventory taken, Medicine is NOT in stock	☐ Inventory taken, any or both of the medicine(s) is/are in stock ☐ Inventory taken, any or both of the medicine(s) is/are NOT in stock	☐ Inventory taken, Medicine is in stock ☐ Inventory taken, Medicine is NOT in stock	☐ Inventory taken, Medicine is in stock ☐ Inventory taken, Medicine is NOT in stock	☐ Inventory taken, Medicine is in stock ☐ Inventory taken, Medicine is NOT in stock	☐ Inventory taken, Medicine is in stock ☐ Inventory taken, Medicine is NOT in stock	☐ Inventory taken, Medicine is in stock ☐ Inventory taken, Medicine is NOT in stock

SECTION 4 continues on the next page

SECTION 4 - continues: AVAILABILITY OF MATERNAL/RH MEDICINES								
Items	**Maternal/RH Medicines** **Please note that for the SDP to respond to items in this section, it should have indicated in Item 007 above that 'Yes' it provides delivery services**							
	(10) **Methyldopa**	**(11)** **Metronidazole**	**(12)** **Mifepristone**	**(13)** **Misoprostol**	**(14)** **Nifedipine**	**(15)** **Oxytocin**	**(16)** ***Either*** **Sodium lactate compound solution** ***Or*** **Sodium chloride** ***Or Both of these medicines***	**(17)** **Tetanus toxoid**
015-*continues* With respect to each of the maternal/ RH Medicines, please state whether the SDP is supposed have it available; **in line with the current national protocols, guidelines and/or laws specific for this level* of service delivery.** Please discuss with the respondent and then record your conclusion before proceeding *(* Please recall SDP level as recorded in in item 006 above)*	**1 Yes,** this SDP is expected /supposed to have available this Maternal /RH Medicine ☐ **2 No,** this SDP is NOT expected/ supposed to have available this Maternal /RH Medicine ☐ *(Tick only one option)*	**1 Yes,** this SDP is expected /supposed to have available this Maternal /RH Medicine ☐ **2 No,** this SDP is NOT expected/ supposed to have available this Maternal /RH Medicine ☐ *(Tick only one option)*	**1 Yes,** this SDP is expected /supposed to have available this Maternal /RH Medicine ☐ **2 No,** this SDP is NOT expected/ supposed to have available this Maternal /RH Medicine ☐ *(Tick only one option)*	**1 Yes,** this SDP is expected /supposed to have available this Maternal /RH Medicine ☐ **2 No,** this SDP is NOT expected/ supposed to have available this Maternal /RH Medicine ☐ *(Tick only one option)*	**1 Yes,** this SDP is expected /supposed to have available this Maternal /RH Medicine ☐ **2 No,** this SDP is NOT expected/ supposed to have available this Maternal /RH Medicine ☐ *(Tick only one option)*	**1 Yes,** this SDP is expected /supposed to have available this Maternal /RH Medicine ☐ **2 No,** this SDP is NOT expected/ supposed to have available this Maternal /RH Medicine ☐ *(Tick only one option)*	**1 Yes,** this SDP is expected /supposed to have available any or both of these Maternal /RH Medicines ☐ **2 No,** this SDP is NOT expected/ supposed to have available any or both of these Maternal /RH Medicine ☐ *(Tick only one option)*	**1 Yes,** this SDP is expected /supposed to have available this Maternal /RH Medicine ☐ **2 No,** this SDP is NOT expected/ supposed to have available this Maternal /RH Medicine ☐ *(Tick only one option)*

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016-*continues* **If 'Yes' in item 015** (i.e., this SDP is expected/ supposed to have available the maternal /RH medicine) please state whether each medicine is currently available at the SDP	1 Yes ☐ 2 No ☐ **3 Not Applicable** (because "No" to item 016) ☐ *(Tick only one option)*	1 Yes ☐ 2 No ☐ **3 Not Applicable** (because "No" to item 016) ☐ *(Tick only one option)*	1 Yes ☐ 2 No ☐ **3 Not Applicable** (because "No" to item 016) ☐ *(Tick only one option)*	1 Yes ☐ 2 No ☐ **3 Not Applicable** (because "No" to item 016) ☐ *(Tick only one option)*	1 Yes ☐ 2 No ☐ **3 Not Applicable** (because "No" to item 016) ☐ *(Tick only one option)*	1 Yes ☐ 2 No ☐ **3 Not Applicable** (because "No" to item 016) ☐ *(Tick only one option)*	1 Yes <u>(for any or both)</u> ☐ 2 No <u>(for any or both)</u> ☐ **3 Not Applicable** (because "No" to item 016) ☐ *(Tick only one option)*	1 Yes ☐ 2 No ☐ **3 Not Applicable** (because "No" to item 016) ☐ *(Tick only one option)*
017-*continues* If this SDP is supposed/ expected to have available this medicine (in line with current national guidelines, etc.) but the response to 013 is "No", please indicate the main reason *(Tick only one option [as the main reason] for each medicine)*	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐ **3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5 No** train staff to provide this medicine at the SDP ☐ 7. Any other Reason (please specify)……. ……………………………	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐ **3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5 No** train staff to provide this medicine at the SDP ☐ 7. Any other Reason (please specify)……. ……………………………	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐ **3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5 No** train staff to provide this medicine at the SDP ☐ 7. Any other Reason (please specify)……. ……………………………	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐ **3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5 No** train staff to provide this medicine at the SDP ☐ 7. Any other Reason (please specify)……. ……………………………	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐ **3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5 No** train staff to provide this medicine at the SDP ☐ 7. Any other Reason (please specify)……. ……………………………	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐ **3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5 No** train staff to provide this medicine at the SDP ☐ **6** The SDP does not have a cold chain to store the medicine ☐ 7. Any other Reason (please specify)……. ……………………………	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐ **3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5 No** train staff to provide this medicine at the SDP ☐ 7. Any other Reason (please specify)……. ……………………………	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐ **3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5 No** train staff to provide this medicine at the SDP ☐ 7. Any other Reason (please specify)……. ……………………………
018 From responses provided to Item 016 above, please discuss with respondent and record the conclusion by ticking one of the following statements	**1 Yes** - this SDP has available the seven (7) lifesaving maternal/RH medicines *(which included the two mandatory medicines [Magnesium Sulfate and Oxytocin] and any other five of the remaining medicines on the list - <u>bearing in mind that; a) Sodium chloride and Sodium lactate compound solution are alternate; and b) Dexamethasone is an alternate to Betamethasone</u>* ☐				**2 No-** this SDP does not have available the seven (7) lifesaving maternal/RH medicines *(which included the two mandatory medicines [Magnesium Sulfate and Oxytocin) and any other five of the remaining medicines on the list <u>- bearing in mind that; a) Sodium chloride and Sodium lactate compound solution are alternate; and b) Dexamethasone is an alternate to Betamethasone</u>* ☐			

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INTERVIEWER VERIFICATION for ITEM 016								
Medicines	**(10)** **Methyldopa**	**(11)** **Metronidazole**	**(12)** **Mifepristone**	**(13)** **Misoprostol**	**(14)** **Nifedipine**	**(15)** **Oxytocin**	**(16)** ***Either*** **Sodium chloride** *Or* **Sodium lactate compound solution**	**(17** **Tetanus toxoid**
For each response provided for **item 016**, the interviewer should validate the response by a physical Inventory and note the appropriate finding	☐ Inventory taken, Medicine is in stock ☐ Inventory taken, Medicine is NOT in stock	☐ Inventory taken, Medicine is in stock ☐ Inventory taken, Medicine is NOT in stock	☐ Inventory taken, Medicine is in stock ☐ Inventory taken, Medicine is NOT in stock	☐ Inventory taken, Medicine is in stock ☐ Inventory taken, Medicine is NOT in stock	☐ Inventory taken, Medicine is in stock ☐ Inventory taken, Medicine is NOT in stock	☐ Inventory taken, Medicine is in stock ☐ Inventory taken, Medicine is NOT in stock	☐ Inventory taken, any or both of the medicine(s) is/are in stock ☐ Inventory taken, any or both of the medicine(s) is/are NOT in stock	☐ Inventory taken, Medicine is in stock ☐ Inventory taken, Medicine is NOT in stock

SECTION 5: NO STOCK OUT OF MODERN CONTRACEPTIVE METHODS AT SDP Please note that for the SDP to respond to items in this section, it should have indicated in Item 008 above that 'Yes' it provides family planning services									
Item	**(1)** **Male condoms**	**(2)** **Female Condoms**	**(3)** **Oral Contraception**	**(4)** **Injectables**	**(5)** **Emergency contraception**	**(6)** **IUDs**	**(7)** **Implants**	**(8)** **Sterilisation for Females**	**(9)** **Sterilisation for Male**
(i): NO STOCK-OUT IN THE LAST SIX MONTHS BEFORE THE SURVEY									
	1 Yes; this method has been out-of-stock (STOCK-OUT) on a given day at this SDP in the last **six** months ☐ **2 No;** this method has not been out-of-stock **(NO STOCK OUT)** on any given day at this SDP in the last **six** months ☐ *(Tick only one option)*	**1 Yes;** this method has been out-of-stock (STOCK-OUT) on a given day at this SDP in the last **six** months ☐ **2 No;** this method has not been out-of-stock **(NO STOCK OUT)** on any given day at this SDP in the last **six** months ☐ *(Tick only one option)*	**1 Yes;** this method has been out-of-stock (STOCK-OUT) on a given day at this SDP in the last **six** months ☐ **2 No;** this method has not been out-of-stock **(NO STOCK OUT)** on any given day at this SDP in the last **six** months ☐ *(Tick only one option)*	**1 Yes;** this method has been out-of-stock (STOCK-OUT) on a given day at this SDP in the last **six** months ☐ **2 No;** this method has not been out-of-stock **(NO STOCK OUT)** on any given day at this SDP in the last **six** months ☐ *(Tick only one option)*	**1 Yes;** this method has been out-of-stock (STOCK-OUT) on a given day at this SDP in the last **six** months ☐ **2 No;** this method has not been out-of-stock **(NO STOCK OUT)** on any given day at this SDP in the last **six** months ☐ *(Tick only one option)*	**1 Yes;** this method has been out-of-stock (STOCK-OUT) on a given day at this SDP in the last **six** months ☐ **2 No;** this method has not been out-of-stock **(NO STOCK OUT)** on any given day at this SDP in the last **six** months ☐ *(Tick only one option)*	**1 Yes;** this method has been out-of-stock (STOCK-OUT) on a given day at this SDP in the last **six** months ☐ **2 No;** this method has not been out-of-stock **(NO STOCK OUT)** on any given day at this SDP in the last **six** months ☐ *(Tick only one option)*	**1 Yes;** this method has been out-of-stock (STOCK-OUT) on a given day at this SDP in the last **six** months ☐ **2 No;** this method has not been out-of-stock **(NO STOCK OUT)** on any given day at this SDP in the last **six** months ☐ *(Tick only one option)*	**1 Yes;** this method has been out-of-stock (STOCK-OUT) on a given day at this SDP in the last **six** months ☐ **2 No;** this method has not been out-of-stock **(NO STOCK OUT)** on any given day at this SDP in the last **six** months ☐ *(Tick only one option)*

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019 With respect to each of the contraceptive methods that the SDP is supposed/expected to provide **in line with the current national protocols, guidelines and/or laws specific for this level* of service delivery** (as indicated in Item 011 above); please indicate whether it has been **out of stock at this SDP on any given day, within the last six months preceding the survey, and therefore the contraceptive method was not available to give/provide to clients at this SDP** *(* Please recall SDP level as recorded in in item 006 above)***020** From responses provided to Item 019 above, please discuss with respondent and record the conclusion by ticking one of the following statements		One or more of the contraceptive methods offered by this SDP has been out-of- stock on a given day in the last six months preceding the survey. Therefore, **this <u>SDP experienced stock out in the last six months [STOCK-OUT WITHIN THE LAST SIX MONTHS]</u>** ☐				All contraceptive method offered by this SDP has been available/ in-stock on all days in the last six months preceding the survey. Therefore, **this <u>SDP did not experience stock out in the last six months [NO-STOCK-OUT WITHIN THE LAST SIX MONTHS]</u>** ☐			
021 If "Yes" to Item 019 (that this method has been out of stock **<u>(STOCK OUT)</u>** at this SDP on any given day within **<u>the last six</u>** months (in line with current national guidelines, etc.) please **indicate the main reason**	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ **4** Low or no client demand for the contraceptive ☐ 7. Any other Reason (please specify).......	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ **4** Low or no client demand for the contraceptive ☐ 7. Any other Reason (please specify).......	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ **4** Low or no client demand for the contraceptive ☐ 7. Any other Reason (please specify).......	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ **4** Low or no client demand for the contraceptive ☐ 7. Any other Reason (please specify).......	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ **4** Low or no client demand for the contraceptive ☐ 7. Any other Reason (please specify).......	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ **4** Low or no client demand for the contraceptive ☐ **5** No train staff to provide this contraceptive at the SDP ☐ **6.** Lack of equipment for the provision of this contraceptive ☐ 7. Any other Reason (please specify).......	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ **4** Low or no client demand for the contraceptive ☐ **5** No train staff to provide this contraceptive at the SDP ☐ **6.** Lack of equipment for the provision of this contraceptive ☐ 7. Any other Reason (please specify).......	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ **4** Low or no client demand for the contraceptive ☐ **5** No train staff to provide this contraceptive at the SDP ☐ **6.** Lack of equipment for the provision of this contraceptive ☐ 7. Any other Reason (please specify).......	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ **4** Low or no client demand for the contraceptive ☐ **5** No train staff to provide this contraceptive at the SDP ☐ **6.** Lack of equipment for the provision of this contraceptive ☐ 7. Any other Reason (please specify)....... ....
(ii): <u>NO STOCK-OUT AT THE TIME OF THE SURVEY</u>									

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022 With respect to each of the contraceptive methods that the SDP is supposed/expected to **provide in line with the current national protocols, guidelines and/or laws specific for this level*** **of service delivery (as indicated in Item 011 above)**; please indicate whether it is currently **out of stock at this SDP and therefore the contraceptive method was not available to give/provide to clients at this SDP** *(* Please recall SDP level as recorded in in item 006 above)*	**1 Yes;** this method is currently out-of-stock (STOCK-OUT) at this SDP ☐ **2 No;** this method is currently not out-of-stock (**NO STOCK OUT)** at this SDP ☐ *(Tick only one option)*	**1 Yes;** this method is currently out-of-stock (STOCK-OUT) at this SDP ☐ **2 No;** this method is currently not out-of-stock (**NO STOCK OUT)** at this SDP ☐ *(Tick only one option)*	**1 Yes;** this method is currently out-of-stock (STOCK-OUT) at this SDP ☐ **2 No;** this method is currently not out-of-stock (**NO STOCK OUT)** at this SDP ☐ *(Tick only one option)*	**1 Yes;** this method is currently out-of-stock (STOCK-OUT) at this SDP ☐ **2 No;** this method is currently not out-of-stock (**NO STOCK OUT)** at this SDP ☐ *(Tick only one option)*	**1 Yes;** this method is currently out-of-stock (STOCK-OUT) at this SDP ☐ **2 No;** this method is currently not out-of-stock (**NO STOCK OUT)** at this SDP ☐ *(Tick only one option)*	**1 Yes;** this method is currently out-of-stock (STOCK-OUT) at this SDP ☐ **2 No;** this method is currently not out-of-stock (**NO STOCK OUT)** at this SDP ☐ *(Tick only one option)*	**1 Yes;** this method is currently out-of-stock (STOCK-OUT) at this SDP ☐ **2 No;** this method is currently not out-of-stock (**NO STOCK OUT)** at this SDP ☐ *(Tick only one option)*	**1 Yes;** this method is currently out-of-stock (STOCK-OUT) at this SDP ☐ **2 No;** this method is currently not out-of-stock (**NO STOCK OUT)** at this SDP ☐ *(Tick only one option)*	**1 Yes;** this method is currently out-of-stock (STOCK-OUT) at this SDP ☐ **2 No;** this method is currently not out-of-stock (**NO STOCK OUT)** at this SDP ☐ *(Tick only one option)*
023 From responses provided to Item 019 above, please discuss with respondent and record the conclusion by ticking one of the following statements		One or more of the contraceptive methods offered by this SDP is currently out-of- stock at this SDP. Therefore, **this SDP is experiencing stock out on the day the survey [STOCK-OUT ON DAY OF SYRVEY]** ☐			ALL contraceptive method offered by this SDP are currently in-stock/available at this SDP. Therefore, **this SDP did not experiencing stock out on the day of the survey [NO-STOCK-OUT ON DAY OF SYRVEY]** ☐				
024 If "Yes" to Item 22 (that this method is out-of-stock**(STOCK OUT)** at this SDP (in line with current national guidelines, etc.) please **indicate the main reason** *(Tick only one option [as the main reason] for each contraceptive)*	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ **4** Low or no client demand for the contraceptive ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ **4** Low or no client demand for the contraceptive ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ **4** Low or no client demand for the contraceptive ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ **4** Low or no client demand for the contraceptive ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ **4** Low or no client demand for the contraceptive ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ **4** Low or no client demand for the contraceptive ☐ **5** No train staff to provide this contraceptive at the SDP ☐ **6.** Lack of	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ **4** Low or no client demand for the contraceptive ☐ **5** No train staff to provide this contraceptive at the SDP ☐ **6.** Lack of	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ **4** Low or no client demand for the contraceptive ☐ **5** No train staff to provide this contraceptive at the SDP ☐ **6.** Lack of	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ **4** Low or no client demand for the contraceptive ☐ **5** No train staff to provide this contraceptive at the SDP ☐ **6.** Lack of

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						equipment for the provision of this contraceptive ☐	equipment for the provision of this contraceptive ☐	equipment for the provision of this contraceptive ☐	equipment for the provision of this contraceptive ☐
	7. Any other Reason (please specify)……. …………………………	7. Any other Reason (please specify)……. …………………………	7. Any other Reason (please specify)……. …………………………	7. Any other Reason (please specify)……. …………………………	7. Any other Reason (please specify)……. …………………………	7. Any other Reason (please specify)……. …………………………	7. Any other Reason (please specify)……. …………………………	7. Any other Reason (please specify)……. …………………………	7. Any other Reason (please specify)……. …………………………

INTERVIEWER VERIFICATION for ITEM 022									
Contraceptive	**(1) Male condoms**	**(2) Oral Contraception**	**(3) IUDs**	**(4) Implants**	**(5) Injectables**	**(6) Female Condoms**	**(7) Sterilisation for Male**	**(8) Sterilisation for Females**	**(9) Emergency contraception**
For each response provided for **item 022**, the interviewer should validate the response by a physical Inventory and note the appropriate finding	☐ Inventory taken, contraceptive is in stock ☐ Inventory taken, contraceptive is NOT in stock	☐ Inventory taken, contraceptive is in stock ☐ Inventory taken, contraceptive is NOT in stock	☐ Inventory taken, contraceptive is in stock ☐ Inventory taken, contraceptive is NOT in stock	☐ Inventory taken, contraceptive is in stock ☐ Inventory taken, contraceptive is NOT in stock	☐ Inventory taken, contraceptive is in stock ☐ Inventory taken, contraceptive is NOT in stock	☐ Inventory taken, contraceptive is in stock ☐ Inventory taken, contraceptive is NOT in stock	☐ Inventory taken, contraceptive is in stock ☐ Inventory taken, contraceptive is NOT in stock	☐ Inventory taken, contraceptive is in stock ☐ Inventory taken, contraceptive is NOT in stock	☐ Inventory taken, contraceptive is in stock ☐ Inventory taken, contraceptive is NOT in stock

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MODULE 2:

FACILITY RESOURCES

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SECTION 6: SUPPLY CHAIN *[To be responded to by all SDPs]*	
025 Who is the main person responsible for ordering medical supplies at this facility? *(Tick only one option)*	Medical Doctor 1☐ Clinical Officer 2☐ Pharmacist 3☐ Nurse 4☐ Other (specify) _____ 5☐
026 How are the resupplies for contraceptives for this facility determined? *(Tick only one option)*	Staff member(s) of this facility makes request based on calculation of quantity needed using a formula1☐ Quantity is determined by the institution/warehouse responsible for supplying this SDP 2☐ Any other method used (please specify) .....3☐
027 Does this SDP use any logistics forms for reporting and ordering supplies? *(Tick only one option)*	Yes *(enumerator verifies the availability of forms)* 1☐ Yes *(but availability not observed by enumerator)* 2☐ No; there are no logistics forms in use 3☐
028 What is the **main source** of your routine medicines and supplies? *(Tick only one option)*	Central Medical Stores 1☐ Regional/district Warehouse or institution 2☐ Local medical store on the same site 3☐ NGO 4☐ Donors 5☐ Private Sources 6☐
029 Who is responsible for transporting products to your facility? *(Tick only one option)*	National/central government 2☐ Local/District administration 1☐ This Facility Collects 3☐ Other(Specify) _____4☐
030 On average, approximately how long does it take between ordering and receiving products? *(Tick only one option)*	Less than two weeks 1☐ More than two weeks but not up to one month 2☐ More than one month but not up to two months 3☐ More than two months but not up to four months 4☐ More than four months but not up to six months 5☐ More than six months 6☐
031 On average, how frequently is the facility resupplied? *(Tick only one option)*	Once every two weeks 1☐ Once every month 2☐ Once every three months 3☐ Once every six months 4☐ Once a year 5☐

SECTION 7: EXISTENCE OF COLD CHAIN AT SDP *[To be responded to by all SDPs]*	
032 Does this SDP have its own cold chain to store medicines or items? *(Tick only one option)*	Yes 1☐ No 2☐ Not Applicable (no to 032 above) 3☐
033 If yes to 032, please give a list of the reproductive/ maternal health medicines or items that this SDP stores in cold chain?	_____ _____
034 If yes to 032; what type of cold chain does the SDP have? *(Tick only one option)*	Electric Fridge 1☐ Ice box (SDP have to regularly replenish ice supply 2☐ Other (specify) _____ 3☐ Not Applicable (no to 032 above) 4☐
035 If the type of cold chain (in 034) is a fridge please indicate the source of power for this *(Tick only one option)*	Electricity from national grid 1☐ Generator plant at the SDP 2☐ Portable generator at the SDP 3☐ Kerosene/paraffin fuel 1☐ Any Other (specify) _____ 3☐ Not Applicable (no to 030 above) 4☐
036 If the SDP does not have its own cold chain, how does it preserve items that are supposed to be in cold chain?	_____ _____

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SECTION 8: STAFF TRAINING FAMILY PLANNING *[To be responded to by all SDPs]*	
037 Are there staff working at this SDP who are trained to provide family planning services? *(Tick only one option)*	Yes 1☐ No 2☐
038 If yes; please indicate how many staff members are trained in provision of family planning services	[.....]
039 Is any staff member trained for the insertion and removal of implant contraceptive, specifically? *(Tick only one option)*	Yes 1☐ No 2☐
040 If yes; please indicate how many staff members are trained for the insertion and removal of implant contraceptive	[.....]
041 Are the trained staff actually providing FP services *(Tick only one option)*	Yes 1☐ No 2☐
042 If no to item 041 please indicate the reason why the staff is NOT actually providing FP services *(Tick only one option)*	Yes 1☐ No 2☐
043 When last did any staff at this SDP receive training in provision of family planning services *(Tick only one option)*	In the last two months 1☐ Between two and six months ago 2☐ Between six month and one year ago 3☐ More than one year ago 4☐
044 Did the training exercise include the insertion and removal of implant contraceptive *(Tick only one option)*	Yes 1☐ No 2☐

SECTION 9: STAFF SUPERVISION FOR REPRODUCTIVE HEALTH INCLUDING FAMILY PLANNING *[To be responded to by all SDPs]*	
045 When was the last time this facility was visited by a supervisory authority in the past 12 months? *(Tick only one option)*	In less than one Month 1☐ between one and three Months ago2☐ Between three and six months ago 3☐ Between six month and one year ago 4☐ Not supervised in the past 12 month 5☐
046 How frequently does this facility receive visits from supervisory authorities? *(Tick only one option)*	Weekly 1☐ Monthly 2☐ Every three months3☐ Every six months 4☐ Once a year 5☐ Never 6☐
047 Which of the following were included in the supervision *(Tick only one option)*	Staff clinical practices 1 ☐ Drug stock out and expiry 2 ☐ Staff availability and training 3 ☐ Data completeness, quality, and timely reporting 4☐ Review use of specific guideline or job aid for reproductive health 5☐ Any other please specify..... 6☐

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SECTION 10: AVAILABILITY OF GUIDELINES, check-lists and Job aid *[To be responded to by all SDPs]*	
048 This facility has available any family planning guidelines (national or WHO)? *(Tick only one option)*	Yes (enumerator verifies the availability of guidelines 1☐ Yes availability of guideline not verified 2☐ Not available 3☐
049 This facility has available any family planning check-lists and/or job-aids? *(Tick only one option)*	Yes (enumerator verifies the availability of guidelines 1☐ Yes availability of guideline not verified 2☐ Not available 3☐
050 This facility has available any ANC guidelines (national or WHO)? *(Tick only one option)*	Yes (enumerator verifies the availability of guidelines 1☐ Yes availability of guideline not verified 2☐ Not available 3☐
051 This facility has available any ANC check-lists and/or job-aids? *(Tick only one option)*	Yes (enumerator verifies the availability of guidelines 1☐ Yes availability of guideline not verified 2☐ Not available 3☐
052 This facility has available any Waste disposal guideline? *(Tick only one option)*	Yes (enumerator verifies the availability of guidelines 1☐ Yes availability of guideline not verified 2☐ Not available 3☐

SECTION 11: AVAILABILITY AND USE OF INFORMATION COMMUNICATION TECHNOLOGY (ICT) *[To be responded to by all SDPs]*	
053 Does this facility use any form of Information Communication Technologies (ICT) System *(see list in 054 below) - (Tick only one option*	Yes (enumerator verifies availability) 1☐ Yes (availability not verified) 2☐ No ICT is not used 3☐
054 If Yes; which of the following types ICTs are used in the SDP *(Tick ALL the options that apply)*	Computer 1☐ Mobile phones - basic handsets 2☐ Mobile phones - smart phones 3☐ Tablets 4☐ Internet facilities – LAN 5☐ Internet facilities - Wi-Fi 6☐ Other…….(specify) 7☐
055 How did the SDP acquire the ICT? *(Tick ALL the options that apply)*	Staff members personal item 1☐ Provided by government 2☐ Provided by proprietor of SDP 3☐ Received as Donation 4☐ Other…….(specify5☐
056 What is the main purpose for which the SDP uses the? *(Tick ALL the options that apply)*	Patient registration 1☐ Facility record keeping 2☐ Individual patient records/Electronic Medical Record 3☐ Health Insurance Claims and Reimbursement System 4☐ Mobile money cash transfers and payments 5☐ Routine communication 6☐ Awareness and demand creation activities 8☐ Supply chain management/stock control 9☐ Health worker training 10☐ Clinical consultation (long distance communication with experts) 7☐ Other (specify)…… 11☐

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SECTION 12: WASTE DISPOSAL *[To be responded to by all SDPs]*	
057 How does the SDP dispose of health waste? *(Tick only one option)*	Burning on the grounds of the SDP 1☐ Bury in special dump pits on the grounds of the SDP 2☐ Use of Incinerators 3☐ Centrally collected by specific agency for disposal away from the SDP 4☐ Disposed with regular garbage 5☐

SECTION 13: CHARGING FOR USER FEE *[To be responded to by all SDPs]*			
058 Does this facility charge patients for consultation *(Tick only one option)*	Yes 1☐	No 2☐	
059 If Yes; are there exemptions for any of the following services *(Tick ALL the options that apply)*	Family planning services 1☐ Delivery services 3☐ Newborn care services 5☐ HIV care (e.g. HTC and ART) 7☐	Antenatal care services 2☐ Post natal care services 4☐ Care of sick children under 5 years 6☐ Other (specify)..... **8**☐	
060 Does this facility charge patients for any medication *(Tick only one option)*	Yes 1☐	No 2☐	
061 If Yes; are there exemptions for any of the following services *(Tick ALL the options that apply)*	Family planning commodities 1☐ Child health medicines 3☐	Maternal Health medicines 2☐ Other (specify)..... 4☐	
062 Does this facility charge patients for any service provided by a qualified health care provider *(Tick only one option)*	Yes 1☐	No 2☐	
063 If Yes; are there exemptions for the following services *(Tick ALL the options that apply)*	Family planning services 1☐ Post natal care services 4☐ HIV care 7☐	Antenatal care services 2☐ Newborn care services 5☐ Caesarean Section 8☐	Delivery services 3☐ Care of sick children under 5 years 6☐ Other (specify)..... 9☐

NOTE:
At this stage;

1) **Thank the interviewer for his/her time and for the information provided**
2) **Inform him/her that for the next part of the survey, as you informed him/her earlier, you would interview family planning clients who are visiting the SDP**
3) **Assure him/her that the responses of the clients will not be used against anybody or the SDP but will be used for a general understanding of the views of clients and for better service provision**
4) **Specifically ask for permission from the relevant authority of the SDP for you to carry on with the exit interview**

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MODULE 3:

EXIT INTERVIEW - CLIENTS' PERCEPTION AND APPRAISAL OF COST FOR FP SERVICES

NOTE
Please inform the respondent that;

- **You are not a staff member of the SDP but here to talk to ask their opinion about the services they have just received**
- **Although the staff of the SDP have been informed about, and have given permission for the exercise; they will not be told anything that the respondent says**
- **The questions are not personal and his/her name or particulars will not be recorded**
- **His/her response will not be used against anybody**
- **He/she may refuse to answer any question or choose to stop the interview at any time. However, you hope he/she will answer the questions, which will be useful to improve on the services that are provided.**
- **If he/she has any questions about the study he/she can ask at this stage**

The interviewer can then ask client, if he/she agrees to proceed with the interview. Once the consent of the interviewee has been obtained, then the interviewer can proceed with the interview.

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SECTION 14: EXIT INTERVIEW - CLIENTS' PERCEPTION *[To be administered to clients at SDPs offering FP services (indicating 'Yes' to Item 008 above)]*		
14.1 Respondents Background		
064 Age	/__/__/	
065 Sex *(Tick only one option)*	Male 1 ☐ Female 2 ☐	
066 Marital status *(Tick only one option)*	Never Married or in union 1☐ Currently Married or in Union 2 ☐ Formerly Married (Divorced/separated/widowed) 3 ☐	
067 Level of Education *(Tick only one option)*	No Education 1 ☐ Primary 2 ☐ Secondary and higher level 3☐	
068 How often do you visit this SDP for FP services? *(Tick only one option)*	Once a month 1☐ Once every 2 months 2☐ Once every 3 months 3☐ Others (please specify) 4☐	
14.2 Provider adherence to technical aspects		
069 Were you provided with the family planning method of your choice at this SDP? *(Tick only one option)*	Yes 1☐	No 2 ☐
070 Did the family service provider take your preference and wishes into consideration in deciding on the family planning method you received? *(Tick only one option)*	Yes 1☐	No 2 ☐
071 Did the health worker teach you how to use the family planning method? *(Tick only one option)*	Yes 1☐	No 2 ☐
072 Were you told about the common side effects of the family planning method? *(Tick only one option)*	Yes 1☐	No 2 ☐
073 Did the health worker inform you about what you can do regarding the side effects of the family planning method should they occur? *(Tick only one option)*	Yes 1☐	No 2 ☐
074 Did the health worker inform you about any serious complications that can occur, as a result of using the family planning method, for which you should come back to the SDP should such occur? *(Tick only one option)*	Yes 1☐	No 2 ☐
075 Were you given any date when you should come back for check-up and/or additional supplies? *(Tick only one option)*	Yes 1☐	No 2 ☐
14.3 Organizational aspect		
076 In your opinion did you wait too long for the service to be provided to you? *(Tick only one option)*	Yes 1☐	No 2 ☐
077 Are you satisfied with the cleanliness of the health facility? *(Tick only one option)*	Yes 1☐	No 2 ☐
078 Are you satisfied with the privacy at the exam room? *(Tick only one option)*	Yes 1☐	No 2 ☐
079 Are you satisfied with the time that was allotted to your case by the health care provider? *(Tick only one option)*	Yes 1☐	No 2 ☐
14.4 Interpersonal aspect		
080 Did staff at the health facility treat you with courtesy and respect *(Tick only one option)*	Yes 1☐	No 2 ☐
081 Did any of the health service providers force you to accept or insisted that you should accept the family planning method that you received	Yes 1☐	No 2 ☐

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today? *(Tick only one option)*	
082 Are you satisfied with the attitude of the health provider towards you generally? *(Tick only one option)*	Yes 1☐ No 2 ☐
14.5 Outcome aspect	
083 Are you satisfied with the service you received? *(Tick only one option)*	Yes 1☐ No 2 ☐
084 Will you continue visiting this SDP in future? *(Tick only one option)*	Yes 1☐ No 2 ☐
085 Would you recommend your relatives or friends to come to this clinic *(Tick only one option)*	Yes 1☐ No 2 ☐

SECTION 15: EXIT INTERVIEW – CLIENTS' APPRAISAL OF COST FOR FP SERVICES
[To be administered to clients at SDPs offering FP services (indicating 'Yes' to Item 008 above)]

15.1 Family Planning service payment

086
For today's visit did you pay to receive any family planning service? *(Tick only one option) - (If yes then continue with 087, but if no please skip to 088)* Yes 1☐ No 2 ☐

087
If you paid for anything today please how much did you pay for the following method (amount in local currency)? *(Indicate for ALL that apply)*

Card 1☐ /_____/ Laboratory test/x-ray 2☐ /_____/ Contraceptive received from service provider 3☐ /_____/
Contraceptive purchased from pharmacy 4☐ /_____/ Consultation fee 5☐ /_____/ Others (please specify) 6☐..... /_____/

15.2 Travel cost

088
What was the main mode of transportation for you to travel from your place of residence to this SDP *(Tick only one option)*

Walked 1☐ *(if this is selected then skip to 091)* Bicycle 2☐ Motorcycle 3☐
Bus/taxi 4 ☐ Private vehicle 5☐ Others (please specify) 6☐..... /_____/

089
What distance did you travel from your place of residence to this SDP /_____/ 1 Kilometers ☐ 2 Mile ☐ *(Tick only one option)*

090
How much did it cost you to travel from your residence to this SDP /_____/ (amount in local currency)

091
How much will it cost you to travel from your this SDP back to your residence /_____/(amount in local currency)

15.3 Family Planning time spent and cost

092
How long did it take for you to travel from your place of residence to this SDP today /_____/ Hours ; /_____/ Minutes

093
How long did it take for you to get the service at this SDP (time it took between your arrival at this SDP and the time you got the service today) /_____/ Hours ; /_____/ Minutes

094
How long will it take you to travel back to your place of residence /_____/ Hours ; /_____/ Minutes

095
What is the main thing you would have been doing during the time you have been here receiving FP services at this SDP today *(Tick only one option)*

Household chores 1☐	Working on household farm 2☐	Selling in the market/trading 3☐	Employed as unskilled labourer 4☐
Employed as killed labourer 5☐	Clerical or professional work 6☐	Others (please specify) 7☐.....	

0096
From the activity you referred to in 095, who took over this activity? *(Tick only one option)*

Family member 1☐	Co-worker 2☐	Nobody 3☐	Other (please specify) 4☐.....

097
Did you have to pay the person who took over the activity on your behalf *(Tick only one option)* Yes 1☐ No 2 ☐

098
If yes please indicate or estimate the monetary value of the payment *(Tick only one option)* /_____/ (amount in local currency)

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15.4 Financing for FP			
099			
Please indicate the where you obtain the resources to pay for the cost of FP services you have received today? *(Tick ALL the options that apply) - Please refer only to payments mentioned under 087 -(service payment)*			
Paid for by myself 1	Spouse (husband or wife) 2☐	Family Members other than spouse (husband or wife) 3☐	Others (please specify) 4☐.....
0100			
Please indicate the amount for each of the sources mentioned in 099 for payment for the cost of FP services you have received today? *(Indicate for ALL the options that apply) – Indicate with reference to payments mentione under 087 - service payment*			
Paid for by myself 1☐ /_____/(amount in local currency)	Spouse (husband or wife) 2☐ /_____/(amount in local currency)	Family Members other than spouse (husband or wife) 3☐ /_____/(amount in local currency)	Others (please specify) 4☐..... /_____/(amount in local currency)

NOTE:
At this stage;

1) **Inform him/her that the interview has ended, and**
2) **Thank the interviewer for his/her time and for the information provided**

Annex 2.

GPRHCS Survey Questionnaire MYANMAR

၂၀၁၇ ခုနှစ်အတွင်းကျန်းမာရေးဌာနများ၏မျိုးဆက်ပွားကျန်းမာရေးဆိုင်ရာဆေးပစ္စည်းနှင့်
ကျန်းမာရေးစောင့်ရှောက်မှုလုပ်ငန်းများဆန်းစစ်လေ့လာခြင်း
သုတေသနမေးခွန်းလွှာ

မေးမြန်းမှုမှတ်တမ်း

စဉ်	အကြောင်းအရာ	မှတ်တမ်း
၁။	မေးခွန်းလွှာမှတ်ပုံတင်အမှတ်	|__|__|__|__|__|
၂။	မေးမြန်းသောရက်စွဲ	|__|__|/|__|__|/|__|__|__|__|
၃။	မေးမြန်းသူအမည်	_____
၄။	မေးမြန်းမှုစတင်ချိန်	|__|__|း|__|__| နာရီ
၅။	မေးမြန်းမှုပြီးဆုံးချိန်	|__|__|း|__|__| နာရီ
၆။	မေးခွန်းလွှာမှတ်တမ်းများစစ်ဆေးပြီးခြင်းသက်သေခံချက် ကြီးကြပ်သူအမည် လက်မှတ် ရက်စွဲ (ရက်/လ/နှစ်)	_____ _____ |__|__|/|__|__|/|__|__|__|__|

အခန်း ၁။ ကျန်းမာရေးဌာန၏အကြောင်းအချက်များ

စဉ်	အကြောင်းအချက်	ဖြေဆိုချက်
၁။	ကျန်းမာရေးဌာန၏အမည်	
၂။	တည်နေရာ (က)ပြည်နယ်/တိုင်း (ခ)မြို့နယ် (ဂ)ကျေးလက်ကျန်းမာရေးဌာန	 _____ _____ _____
၃။	GPS စနစ်အသုံးပြုသောနေရာဖြစ်လျှင်ကိုဩဒိနိတ်	N---------- E----------
၄။	မြို့ပေါ်/ကျေးလက်	၁။မြို့ပေါ် ၂။ကျေးလက်
၅။(၅.၁)	ကျန်းမာရေးဌာနနှင့်ယင်းဌာနအတွက်လိုအပ်သောဆေးဝါး ပစ္စည်းများထုတ်ယူရာအနီးဆုံးဆေးသိုလှောင်ဌာန အကွာအဝေး	|__|__| မိုင်
(၅.၂)	ယင်းဌာနသို့ သွားရောက်ရန် ကြာမြင့်သောအချိန်	|__|ရက် |__|__|နာရီ|__|__|မိနစ်
(၅.၃)	ယင်းဌာနသို့ သွားရောက်ရန် အသုံးပြုသောလမ်းကြောင်း	၁။ ကုန်းလမ်း ၂။ ရေလမ်း

အခန်း ၂။ ကျန်းမာရေးဌာနအမျိုးအစားနှင့်ကျန်းမာရေးစောင့်ရှောက်မှုအမျိုးအစား

၆။(၆.၁)	ကျန်းမာရေးဌာနအမျိုးအစား	၁။ကျန်းမာရေးဌာန(RHC/UHC/MCH) ၂။တိုက်နယ်ဆေးရုံ(Station Hospital) ၃။မြို့နယ်ဆေးရုံ(ကုတင် ---------) ၄။ခရိုင်ဆေးရုံ (ကုတင် ---------) ၅။ပြည်နယ်/တိုင်း အဆင့်ဆေးရုံ (ကုတင်------) ၆။ဗဟိုအဆင့်ဆေးရုံကြီး ၇။ အခြားဝန်ကြီးဌာန
(၆.၂)	ယခု ကျန်းမာရေးဌာနရှိရာမြို့နယ်သည် မျိုးဆက်ပွား ကျန်းမာရေး စီမံချက်တွင် ပါဝင်သော မြို့နယ် ဟုတ်ပါသလား	၁။ဟုတ် ၂။မဟုတ်
၇။	ကျန်းမာရေးဌာနစီမံခန့်ခွဲမှုအမျိုးအစား	၁။အစိုးရဆေးရုံ ၂။ပုဂ္ဂလိကဆေးရုံ ၃။အဖွဲ့အစည်း(NGO) ၄။အခြား(ဖေါ်ပြပါ_____)
၈။	သားဆက်ခြားလုပ်ငန်းများဆောင်ရွက်ခြင်းရှိ/မရှိ	၁။ရှိ ၂။မရှိ
၉။	ကလေးမွေးဖွားခြင်းအပါအဝင်မိခင်စောင့်ရှောက် ရေးလုပ်ငန်းများဆောင်ရွက်ခြင်း	၁။ရှိ ၂။မရှိ
၁၀။	HIV/AIDS ဆိုင်ရာကျန်းမာရေးစောင့်ရှောက်မှု လုပ်ငန်းများဆောင်ရွက်ခြင်း(VCT,PMTCT,ARTစသည်)	၁။ရှိ ၂။မရှိ

အခန်း၃။ ခေတ်မီ သားဆက်ခြားနည်းလမ်းများဆောင်ရွက်ပေးမှု

(မေးခွန်းအမှတ်စဉ် ၅ ရှိ ဟုဖြေထားမှသာဤအခန်း ၃ နှင့် အကျုံးဝင်သည်)

စဉ်	အကြောင်းအရာ	ဆောင်ရွက်ပေးနိုင်မှုအခြေအနေ	
	လက်ရှိဌာန၏ဖွဲ့စည်းပုံနှင့်လုပ်ငန်းတာဝန်ပေးအပ် မှုစီမံချက်လုပ်ငန်းပြဌာန်းဆောင်ရွက်မှုအခြေအနေ များအရအောက်ဖေါ်ပြပါနည်းလမ်းများကို ဆောင်ရွက်ပေးရန်သတ်မှတ်ထားပါသလား။	**၁၁။**သတ်မှတ်ထားမှု ၁။သတ်မှတ် ၂။မသတ်မှတ်	**၁၂။**ဆောင်ရွက်ပေးနေမှု ၁။ဆောင်ရွက်နေ ၂။မဆောင်ရွက် ၃။အကျုံးမဝင် (မသတ်မှတ်ဟု ရွေးအကွက်တွင် ဖြည့်ထားလျှင်)
	(က)အမျိုးသားသုံးကွန်ဒုံး	__	__
	(ခ)အမျိုးသမီးသုံးကွန်ဒုံး	__	__
	(ဂ)တားဆေးကဒ်(တစ်နေ့တစ်လုံးသောက်ရန်)	__	__
	(ဃ) သန္ဓေတားထိုးဆေး	__	__
	(င)အရေးပေါ်သန္ဓေတားဆေး	__	__
	(စ)သားအိမ်တွင်းထည့်ပစ္စည်း(IUD)	__	__
	(ဆ)အရေပြားအောက်သန္ဓေတားဆေး(Implant)	__	__
	(ဇ)အမျိုးသမီး သားကြောဖြတ်ခြင်း	__	__
	(ဈ)အမျိုးသား သားကြောဖြတ်ခြင်း	__	__

မှတ်ချက်။ သားဆက်ခြားနည်းလမ်းတစ်ခုချင်းစီအတွက် ဤဌာနသို့ ဆောင်ရွက်ပေးရန် သတ်မှတ်ထားပြီး ပုံမှန်ဆောင်ရွက်ပေး နေသော်လည်း ပေးမြန်းကာလအတွင်း ပစ္စည်းပြတ်လပ်မှုကြောင့် လတ်တလောဆောင်ရွက်နိုင်ခြင်းမရှိပါလျှင် ဒုတိယကော်လံတွင် **"ဆောင်ရွက်နေ"** ဟုသာဖြည့်သွင်းပါ။

စဉ်	အကြောင်းအရာ	ဖြေဆိုချက်
၁၃။	မေးခွန်းနံပါတ်(၁၂)တွင် **မဆောင်ရွက်နိုင်**ဟုဆိုပါလျှင် မည်သည့်အတွက်ကြောင့်ဆိုသည်ကိုဖေါ်ပြပါ။	၁။ထောက်ပံ့ပစ္စည်းများအခါခါမိမရောက်သဖြင့် ၂။ထောက်ပံ့ပစ္စည်းအခါခါမိမတောင်းခံနိုင်သဖြင့် ၃။စွေးကွက်ပစ္စည်းပြတ်လပ်မှုကြောင့် ၄။သုံးစွဲမည့်သူမရှိ၍(သို့)အလွန်နည်း၍ **မှတ်ချက်။ ။ အောက်ပါနံပါတ်(၅)နှင့်(၆) သည် (စ)မှ (ဈ)ကို ဖြေဆိုလျှင် ကိုးကားရန်** ၅။ဤနည်းလမ်းကိုဆောင်ရွက်ပေးနိုင်မည့် ဝန်ထမ်းမရှိ၍ ၆။ဤနည်းလမ်းကိုဆောင်ရွက်ပေးနိုင်မည့် ပစ္စည်းကိရိယာမရှိ၍ ၇။အခြား(ဖော်ပြပါ____)
	(က)အမျိုးသားကွန်ဒုံး	|__| _____
	(ခ)အမျိုးသမီးကွန်ဒုံး	|__| _____
	(ဂ)တားဆေးကဒ် (တစ်နေ့တစ်လုံးသောက်ရန်)	|__| _____
	(ဃ)သန္ဓေတားထိုးဆေး	|__| _____
	(င) အရေးပေါ်သန္ဓေတားဆေး	|__| _____
	(စ)သားအိမ်တွင်းထည့်ပစ္စည်း(IUD)	|__| _____
	(ဆ)အရေပြားအောက်ထည့်ပစ္စည်း (Implant)	|__| _____
	(ဇ)အမျိုးသမီး သားကြောဖြတ်ခြင်း	|__| _____
	(ဈ)အမျိုးသား သားကြောဖြတ်ခြင်း	|__| _____
၁၄။	မေးခွန်းနံပါတ် (၁၂)၏အဖြေကိုမူတည်၍ဤကျန်းမာရေးဌာနတွင်သားဆက်ခြားနည်းလမ်းများဆောင်ရွက်ပေးနိုင်မှုအခြေအနေကိုသုံးသပ်ပါ။	*မေးခွန်းနံပါတ် (၆) အရ ကျန်းမာရေးဌာန (RHC/ UHC/ MCH) ဖြစ်ပါက ၁။ ယခုကျန်းမာရေးဌာနသည် **ခေတ်မီ** သားဆက်ခြားနည်းလမ်း(၂) ခုအထိ ဆောင်ရွက်ပေးနိုင်သည်။ ☐ ၂။ ယခုကျန်းမာရေးဌာနသည် **ခေတ်မီ** သားဆက်ခြားနည်းလမ်း အနည်းဆုံး (၃) ခုနှင့်အထက်ဆောင်ရွက် ပေးနိုင်သည်။ ☐ *မေးခွန်းနံပါတ် (၆) အရ (တိုက်နယ်ဆေးရုံ နှင့်အထက်) ဖြစ်လျှင် ၁။ ယခုကျန်းမာရေးဌာနသည် **ခေတ်မီ** သားဆက်ခြားနည်းလမ်း(၄) ခုအထိ ဆောင်ရွက်ပေးနိုင်သည်။ ☐ ၂။ ယခုကျန်းမာရေးဌာနသည် **ခေတ်မီ** သားဆက်ခြားနည်းလမ်းအနည်းဆုံး(၅) ခုနှင့်အထက် ဆောင်ရွက် ပေးနိုင်သည်။ ☐

အခန်း၄။ သန္ဓေတားဆေးများပြတ်လပ်မှု

(မေးခွန်းအမှတ် ၈ ၌ ရှိ ဟုဖြေထားမှသာဤအခန်း ၄ နှင့် အကျုံးဝင်သည်)

အကြောင်းအရာ	မေးခွန်းနံပါတ် (၁၉)	မေးခွန်းနံပါတ် (၂၀)
မေးခွန်းနံပါတ် (၆)အရသတ်မှတ်အဆင့်ရှိ ဆေးရုံ/ဆေးခန်းအနေဖြင့်ပြဋ္ဌာန်းချက်တာဝန်ပေးချက်(သို့)စီမံချက်တစ်ခုခုအရအောက်ပါသန္ဓေတားဆေးနှင့်ပစ္စည်းများရှိသင့်ပါလျက် လွန်ခဲ့သော (၃)လအတွင်းပြတ်လပ်ခြင်း ကြောင့်သန္ဓေတားရန်ဆောင်ရွက်ပေးနိုင်ခဲ့ခြင်းမရှိသည်မျိုးဖြစ်ခဲ့ပါသလား။	၁။ပြတ်လပ်ခဲ့ဘူး ၂။မပြတ်လပ်ခဲ့ဘူး	အဘယ့်ကြောင့်ပြတ်လပ်ခဲ့ကြောင်းအဓိကအချက်ကိုဖော်ပြပါ ၁။ထောက်ပံ့မှုကြန့်ကြာ၍ ၂။တောင်းခံမှုနှောင့်နှေး၍ ၃။ဈေးကွက်၌ပစ္စည်းပြတ်လပ်၍ ၄။အသုံးမရှိ၍(သို့)အသုံးအလွန်နည်း၍ **မှတ်ချက်။ ။ အောက်ပါနံပါတ်(၅)နှင့်(၆) သည် (စ)မှ (ဈ)ကို ဖြေဆိုလျှင် ကိုးကားရန်** ၅။ကျွမ်းကျင်ဝန်ထမ်းမရှိ၍ ၆။ပစ္စည်းကိရိယာမစုံလင်၍ ၇။အခြား(ဖော်ပြပါ____)
(က)အမျိုးသားကွန်ဒုံး	__	__ _____
(ခ)အမျိုးသမီးကွန်ဒုံး	__	__ _____
(ဂ)တားဆေးကဒ် (တစ်နေ့တစ်လုံးသောက်ရန်)	__	__ _____
(ဃ)သန္ဓေတားထိုးဆေး	__	__ _____
(င) အရေးပေါ်သန္ဓေတားဆေး	__	__ _____
(စ)သားအိမ်တွင်းထည့်ပစ္စည်း(IUD)	__	__ _____
(ဆ)အရေပြားအောက်ထည့်ပစ္စည်း (Implant)	__	__ _____
(ဇ)အမျိုးသမီးသားကြောဖြတ်ခြင်း	__	__ _____
(ဈ)အမျိုးသား သားကြောဖြတ်ခြင်း	__	__ _____
၂၀။မေးခွန်း (၁၉) ၏အဖြေကိုမူတည်၍တဘက်ပါအချက်တစ်ခုခုဖြင့်မှတ်ချက်ပြုပါ။	၁။တစ်မျိုးနှင့်အထက်လွန်ခဲ့သော(၃)လအတွင်းအနည်းဆုံးတစ်ကြိမ်ပြတ်လပ်ခဲ့ဘူးသည်။	၂။ဆေးအမည်အားလုံးတစ်ခါမျှပြတ်လပ်ခဲ့ဘူးခြင်းမရှိ။

အကြောင်းအရာ	မေးခွန်းနံပါတ် (၂၂)	မေးခွန်းနံပါတ် (၂၄)	ဆေးလက်ကျန်စာရင်းနှင့်တိုက်ဆိုင်စစ်ဆေးပါ
မေးခွန်းနံပါတ် (၆)အရ သတ်မှတ် အဆင့်ရှိ ဆေးရုံ/ဆေးခန်းအနေဖြင့် ပြဋ္ဌာန်းချက်တာဝန်ပေးချက် (သို့) စီမံချက်တစ်ခုခုအရအောက်ပါ သန္ဓေတားဆေးနှင့် ပစ္စည်းများရှိသင့်ပါလျှက်ယခုလက်ရှိအချိန်တွင် ဆေးပြတ်လပ်နေသဖြင့်သန္ဓေတားရန် ဆောင်ရွက်ပေးနိုင်မှု ရှိနေပါသလား။	၁။ယခုပြတ်လပ်နေသည် ၂။ယခုမပြတ်လပ်နေပါ	အဘယ့်ကြောင့်ပြတ်လပ်ခဲ့ကြောင်း အဓိကအချက်ကိုဖော်ပြပါ ၁။ထောက်ပံ့မှုကြန့်ကြာ၍ ၂။တောင်းခံမှုနှောင့်နှေး၍ ၃။ဈေးကွက်၌ပစ္စည်းပြတ်လပ်၍ ၄။အသုံးမရှိ၍ (သို့) အသုံးအလွန်နည်း၍ **မှတ်ချက်။ ။ အောက်ပါနံပါတ်(၅) နှင့် (၆) သည် (စ)မှ (ဈ)ကို ဖြေဆိုလျှင် ကိုးကားရန်** ၅။ကျွမ်းကျင်ဝန်ထမ်းမရှိ၍ ၆။ပစ္စည်းကိရိယာမစုံလင်၍ ၇။အခြား(ဖော်ပြပါ____)	၁။လက်ကျန်ရှိ ၂။လက်ကျန်မရှိ
(က)အမျိုးသားကွန်ဒုံး	__	__ _____	__
(ခ)အမျိုးသမီးကွန်ဒုံး	__	__ _____	__
(ဂ)တားဆေးကဒ် (တစ်နေ့တစ်လုံးသောက်ရန်)	__	__ _____	__
(ဃ)သန္ဓေတားထိုးဆေး	__	__ _____	__
(င) အရေးပေါ်သန္ဓေတားဆေး	__	__ _____	__
(စ)သားအိမ်တွင်းထည့်ပစ္စည်း (IUD)	__	__ _____	__
(ဆ)အရေပြားအောက်ထည့်သားဆက်ခြားပစ္စည်း (Implant)	__	__ _____	__
(ဇ)အမျိုးသမီး သားကြောဖြတ်ခြင်း	__	__ _____	__
(ဈ)အမျိုးသား သားကြောဖြတ်ခြင်း	__	__ _____	__
၂၃။ မေးခွန်း (၂၂) ပေါ်မူတည်၍ တာဘက်ပါအချက်အလက်တစ်ခုခုကို မှတ်ချက်ပြုပါ။	**၁။**တစ်မျိုးနှင့်အထက် ယခုလက်ရှိအချိန်တွင်ပြတ်လပ်နေသည်။	**၂။** ဆေးအမည်အားလုံးလက်ရှိအချိန်တွင်မပြတ်လပ်ပါ။	

အခန်း၅။ မိခင်စောင့်ရှောက်ရေးနှင့်မျိုးဆက်ပွားကျန်းမာရေးဆေးဝါးများအခြေအနေ

(မေးခွန်းအမှတ် ၉ ၌ ရှိ ဟုဖြေထားမှသာဤအခန်း ၅ နှင့်အကျုံးဝင်သည်)

ဆေးအမည်	မေးခွန်းအမှတ် (၁၅) ပွဲ့စည်းပုံ/တာဝန်ခံမှု/စီမံချက်များအရ အောက်ပါဆေးဝါးများသုံးစွဲခွင့် ရှိပါသလား။ ၁။သုံးစွဲခွင့်ရှိ ၂။သုံးစွဲခွင့်မရှိ	မေးခွန်း အမှတ် (၁၆) မေးခွန်း (၁၅) ၌သုံးစွဲခွင့်ရှိဟုဖြေဆိုလျှင်အဆိုပါဆေးဝါးများလက်ရှိတွင်ဤဌာနတွင်ရရှိနိုင်ပါ သလား။ ၁။ရရှိနိုင် ၂။မရရှိနိုင် ၃။အကြုံးမဝင် (မေးခွန်း (၁၅) တွင်သုံးစွဲခွင့်မရှိဖြစ်၍)	မေးခွန်း အမှတ် (၁၇) မေးခွန်း (၁၅) တွင် (၁) ဖြစ်၍ မေးခွန်း (၁၆) တွင် (၂) ဖြစ်လျှင်မည်သည့်အတွက်ကြောင့်ဆိုသည်ကိုဖြေပေးပါ။ ၁။ထောက်ပံ့ဆေးဝါးများရရှိရန်ကြန့်ကြာနေသဖြင့် ၂။ဆေးဝါးများတောင်းခံရန်ကြန့်ကြာနေသဖြင့် ၃။စွဲးကွက်၌ဆေးဝါးများပြတ်လပ်နေသဖြင့် ၄။အသုံးလုံးဝမရှိ၍(သို့)သုံးစွဲမှုအလွန်နည်းပါး၍ ၅။ဆေးဝါးသုံးစွဲပေးနိုင်မည့်ကျွမ်းကျင်ဝန်ထမ်းမရှိ၍ ၆။Oxytocin ဆေးအတွက် အအေးလမ်းကြောင်းမရှိ၍ ၇။အခြား (ဖေါ်ပြပါ_____)	*မေးခွန်း(၁၆)တွင်ဖြေဆိုချက်နှင့်ပတ်သက်၍မေးမြန်းသူကဆေးလက်ကျန်စာရင်းစာအုပ်နှင့်တိုက်ဆိုင်စစ်ဆေးချက် ၁။ဆေးလက်ကျန်စာရင်းကြည့်ရာတွင်လက်ကျန်ရှိ ၂။ဆေးလက်ကျန်စာရင်းကြည့်ရာတွင်လက်ကျန်မရှိ
(က)Ampicillin	__	__	__	__
(ခ)Azithromycin	__	__	__	__
(ဂ)Benzithine BenzylPenicillin	__	__	__	__
(ဃ)Betamethasone(သို့)Dexamethasone(သို့)နှစ်မျိုးလုံး	__	__	__	__
(c)Calcium gluconate	__	__	__	__
(စ)Cefixime	__	__	__	__
(ဆ)Gentamycin	__	__	__	__
(ဇ)Hydralazine	__	__	__	__
(ဈ)Megnesium Sulphate	__	__	__	__
(ည)Methyldopa	__	__	__	__
(ဋ)Metronidazol	__	__	__	__
(ဌ)Misoprostol	__	__	__	__
(ဍ) Mifepristone	__	__	__	__
(ဎ)Nifedipine	__	__	__	__
(ဏ) Oxytocin	__	__	__	__
(တ) Sodium lactate or Sodium chloride or both	__	__	__	__
(ထ) Tetanus toxoid	__	__	__	__
၁၈။မေးခွန်း(၁၆)၏ဖြေဆိုချက်အရ၊မူတည်၍ ဖြေဆိုသူနှင့်ဆွေးနွေးရှင်းလင်းပြီပါ	၁။Magnesium sulphateနှင့် Oxytocin အပါအဝင်စုစုပေါင်းမွေးဖွား မိခင်စောင့်ရှောက်ရေးနှင့်မျိုးဆက်ပွားကျန်းမာရေးဆိုင်ရာ အသက်ကယ်ဆေးအမည်စုစုပေါင်း(၇)မျိုးခန့်ရရှိနိုင်သည်။	၂။အထက်ပါတဲ့သို့ဆေးအမည်(၇).မျိုးခန့်မထောက်ပံ့နိုင်ပါ။ မှတ်ချက်။ က) sodium chloride နှင့် sodium lactate compound တို့ကိုအတူတူကဲ့သို့မှတ်ယူပါ။ ခ) Dexamethazone နှင့် Betamethazonတို့ကိုအတူတူကဲ့သို့မှတ်ယူပါ။	

အခန်း(၆)။ ပစ္စည်းထောက်ပံ့ရေးလမ်းကြောင်း(ကျန်းမာရေးဌာနအမျိုးအစားအားလုံးအားမေးရန်)

စဉ်	အကြောင်းအရာ	ဖြေဆိုချက်
၂၅။	ဤဌာန၏ဆေးနှင့်ဆေးပစ္စည်းများမှာယူရန်အဓိကတာဝန်ခံသူ	၁။ဆေးရုံအုပ်ကြီး/ဆေးရုံအုပ် ၂။အထူးကုဆရာဝန်/ဆေးရုံတာဝန်ခံဆရာဝန် ၃။ဆေးဝါးကျွမ်းကျင်/HA/LHV ၄။သူနာပြု ၅။အခြား(ဖော်ပြပါ_____) ၆။ခရိုင်ဆရာဝန်ကြီး ၇။မြို့နယ်ဆရာဝန်ကြီး
၂၆။	ဤဌာနအတွက်သန္ဓေတားဆေးပြန်လည်ဖြည့်တင်းရေးကိုမည်သို့လုပ်ဆောင်ပါသလဲ။ *(တစ်ခုမကဖြေဆိုနိုင်သည်။)*	၁။ဌာနဝန်ထမ်းကသတ်မှတ်ဖော်မြူလာကိုသုံး၍လိုအပ်သောပမာဏကိုတွက်ချက်တောင်းခံသည် ၂။ထောက်ပံ့ရေးဌာနကတွက်ချက်ဆုံးဖြတ်သည် ၃။အခြားနည်းလမ်းသုံးသည်(ဖော်ပြပါ_____)
၂၇။	အစီအရင်ခံခြင်းနှင့်မှာယူခြင်းအတွက်သတ်မှတ်သောပုံစံကိုအသုံးပြုပါသလား။	၁။သုံးသည်(ပုံစံကိုပြနိုင်သည်) ၂။သုံးသည်(ပုံစံကိုမပြနိုင်) ၃။မသုံးပါ
၂၈။	ဆေးနှင့်ဆေးပစ္စည်းများ**အဓိက**ထောက်ပံ့ရာကိုဖော်ပြပါ။	၁။ဗဟိုဆေးသိုလှောင်ရေးဌာန ၂။ပြည်နယ်/တိုင်းကျန်းမာရေးဌာန ၃။ခရိုင်ကျန်းမာရေးဌာန ၄။မြို့နယ်ကျန်းမာရေးဌာန ၅။ကျေးလက်ကျန်းမာရေးဌာန ၆။NGO ၇။အလှူရှင် ၈။ပြင်ပဆေးဆိုင်/ကုမ္ပဏီ
၂၉။	ဆေးနှင့်ဆေးပစ္စည်းသယ်ဆောင်ပေးသူ *(တစ်ခုမကဖြေဆိုနိုင်သည်။)*	၁။အစိုးရ ၂။ပြည်နယ်တိုင်း/ခရိုင်ကျန်းမာရေးဦးစီးဌာန ၃။မိမိအစီအစဉ် ၄။အခြား(ဖော်ပြပါ_____)
၃၀။	(မှာယူရလျှင်)မှာယူခြိုန်နှင့်ရောက်ရှိခြိုန်ကြားကာလမည်မျှရှိသလဲ။ မေးခွန်းနံပါတ်(၂၆) ကို (၁)ဟုဖြေဆိုလျှင်	၁။နှစ်ပတ်အောက် ၂။၂ပတ်မှ၁လအထိ ၃။၁လမှ၂လအထိ ၄။၂လမှ၃လအထိ ၅။၃လမှ၆လအထိ ၆။၆လကျော်ကြာ ၇။ပုံမှန်မရှိ
၃၁။	ဆေးဝါးအထောက်အပံ့ရရှိမှုတစ်ကြိမ်နှင့်တစ်ကြိမ် မည်မျှခြားသလဲ။	၁။၂ပတ်တစ်ခါ ၂။တစ်လတစ်ခါ ၃။၃လတစ်ခါ ၄။၆လတစ်ခါ ၅။၁နှစ်တစ်ခါ ၆။ပုံမှန်မရှိ

အခန်း(၇)အအေးလမ်းကြောင်း(ကျန်းမာရေးဌာနအမျိုးအစားအားလုံးမေးရန်)

စဉ်	အကြောင်းအရာ	ဖြေဆိုချက်
၃၂။	ကိုယ်ပိုင်အအေးလမ်းကြောင်းစနစ်ရှိ/မရှိ။ (စဉ်ဆက်မပျက် အအေးခံသိမ်းဆည်းနိုင်သောစနစ်)	၁။ရှိ ၂။မရှိ (နံပါတ် ၃၆ သို့)
၃၃။	ရှိခဲ့လျှင်အအေးခံစနစ်ဖြင့် ထားရှိသော မိခင်စောင့်ရှောက်ရေးနှင့် မျိုးဆက်ပွားကျန်းမာရေးဆေး အမည်စာရင်း ပေးပါ။	_____ _____ _____ _____ _____
၃၄။	ရှိခဲ့လျှင်အအေးခံစနစ်အမျိုးအစားဖော်ပြပါ။ *(တစ်ခုမကဖြေဆိုနိုင်သည်။)*	၁။ရေခဲသေတ္တာ ၂။ရေခဲဗူး(ရေခဲပြန်လည်ဖြည့်တင်းရသော) ၃။အခြား (ဖော်ပြပါ----------)
၃၅။	ရေခဲသေတ္တာဖြစ်လျှင်လျှပ်စစ်မဟုတ်အားရရှိသောနေရာ။ *(တစ်ခုမကဖြေဆိုနိုင်သည်။)*	၁။ ၂၄နာရီမဟုတ်အားပို့လွှတ်စနစ် ၂။ကိုယ်ပိုင်မီးစက်(အထိုင်) ၃။ကိုယ်ပိုင်မီးစက်(ရွှေ့ပြောင်းနိုင်) ၄။ရေနှံဆီသုံးစနစ် ၅။ဆိုလာစနစ် ၆။တပိုင်တနိုင်ရေအားလျှပ်စစ်စနစ် ၇။ကျေးရွာသုံးဘုံမဟုတ်အားပေးစနစ်
၃၆။	အအေးခံစနစ်မရှိလျှင်အအေးခံစနစ်ဖြင့်ထားရန်လိုသောဆေးမျှားကိုမည်သို့ထားရှိသလဲ။	_____ _____ _____

အခန်း(၈) ။ သားဆက်ခြားစီမံကိန်းသင်တန်းတက်ရောက်ပြီးစီးမှု(ဌာနအမျိုးအစားအားလုံးမေးရန်)
Example: Quality RH, IUD, Implant etc

စဉ်	အကြောင်းအရာ	ဖြေဆိုချက်
၃၇။	သားဆက်ခြားလုပ်ငန်းဆောင်ရွက်ရန်သင်တန်းတက်ရောက်ပြီးသောဝန်ထမ်းရှိ/မရှိ။	၁။ ရှိ ၂။မရှိ (နံပါတ် ၄၅ သို့)
၃၈။	ရှိခဲ့လျှင်လက်ရှိကျန်းမာရေးဌာနတွင် တာဝန်ထမ်းဆောင်ဆဲအရေအတွက်	_____ဦး
၃၉။	အရေပြားအောက်ထည့်သားဆက်ခြားပစ္စည်းထည့်သွင်းရန်/ပြန်ထုတ်ရန်လေ့ကျင့်ပေးပြီးသောဝန်ထမ်းရှိ/မရှိ။	၁။ရှိ ၂။မရှိ
၄၀။	ရှိခဲ့လျှင်အရေအတွက်	_____ဦး
၄၁။	သင်တန်းတက်ရောက်ပြီးဝန်ထမ်းသည်အမှန်တကယ်ဝန်ဆောင်မှုပေးနေပါသလား။	၁။ပေး ၂။မပေး
၄၂။	မပေးနေလျှင်အဘယ်ကြောင့်နည်း။	_____
၄၃။	နောက်ဆုံးသင်တန်းတက်ရောက်ပြီးစီးသောကာလ	၁။လွန်ခဲ့သော ၂လ ၂။ ၂လနှင့်၆လကြား ၃။၆လနှင့်၁နှစ်ကြား ၄။တနှစ်ကျော်ကာလ
၄၄။	အရေပြားအောက်ထည့်သားဆက်ခြားပစ္စည်း ထည့်သွင်းခြင်း၊ ပြန်ထုတ်ခြင်းကို သင်တန်းတွင် လေ့ကျင့်သင်ကြားပေးမှုရှိပါသလား	၁။ရှိပါသည် ၂။မရှိပါ

အခန်း(၉) သားဆက်ခြားဝန်ဆောင်မှု အပါအဝင် မျိုးဆက်ပွားကျန်းမာရေး စောင့်ရှောက်မှုအတွက် ကြိုးကြပ်ခြင်း(ဌာနအမျိုးအစားအားလုံးမေးရန်)

စဉ်	အကြောင်းအရာ	ဖြေဆိုချက်
၄၅။	လွန်ခဲ့သောတစ်နှစ်အတွင်းကြိုးကြပ်သူတစ်ဦးဦး ရောက်ရှိခဲ့သောနောက်ဆုံးကာလ (သားဆက်ခြား ကျန်းမာရေးစောင့်ရှောက်မှု ပါဝင်သော ကြိုးကြပ်မှု)	၁။၁လမရှိသေး ၂။၁လမှ၃လအတွင်း ၃။၃လမှ၆လအတွင်း ၄။၆လမှတစ်နှစ်အတွင်း ၅။လုံး၀မလာရောက်ခဲ့ဘူး
၄၆။	(အထက်ပါ) ကြိုးကြပ်မှုတစ်ကြိမ်နှင့်တစ်ကြိမ်မည်မျှကြာပါသလဲ။	၁။အပတ်စဉ် ၂။လစဉ် ၃။၃လတစ်ခါ ၄။၆လတစ်ခါ ၅။တစ်နှစ်တခါ ၆။လုံး၀မရှိ ၇။ပုံမှန်မရှိ
၄၇။	(အထက်ပါ)ကြိုးကြပ်မှုတွင်ဘာတွေလုပ်လေ့ရှိသလဲ။ *(တစ်ခုမကဖြေဆိုနိုင်သည်။)*	၁။ကုသမှုလုပ်ငန်းစဉ် ၂။ဆေးပြတ်လပ်မှုနှင့်သက်တမ်းလွန်မှုစီစစ် ၃။၀န်ထမ်းအင်အားနှင့်သင်တန်းတက်ရောက်ပြီးမှုစီစစ် ၄။အချက်အလက်ပြည့်စုံမှုမှန်ကန်မှုနှင့်အချိန်မီအစီအရင်ခံနိုင်မှုစီစစ် ၅။မျိုးဆက်ပွားကျန်းမာရေးစောင့်ရှောက်မှုလုပ်ငန်းလမ်းညွှန်များအတိုင်းလိုက်နာဆောင်ရွက်မှုစီစစ် ၆။အခြား(ဖေါ်ပြပါ_____)

အခန်း(၁၀)။ လုပ်ငန်းလမ်းညွှန်များရရှိမှု(ဌာနအမျိုးအစားအားလုံးမေးရန်)

စဉ်	အကြောင်းအရာ	ဖြေဆိုချက်
၄၈။	သားဆက်ခြားလုပ်ငန်းလမ်းညွှန် (Family planning guidelines (National/WHO)	၁။ရရှိ(ထုတ်ပြနိုင်) ၂။ရရှိ(ထုတ်မပြနိုင်) ၃။မရရှိ
၄၉။	သားဆက်ခြား(ပညာပေး)အထောက်အကူပြုပစ္စည်း (Family planning checklist and or job-aids)	၁။ရရှိ(ထုတ်ပြနိုင်) ၂။ရရှိ(ထုတ်မပြနိုင်) ၃။မရရှိ
၅၀။	ကိုယ်ဝန်စောင့်ရှောက်မှုလုပ်ငန်းလမ်းညွှန် ANC guidelines (National/WHO)	၁။ရရှိ(ထုတ်ပြနိုင်) ၂။ရရှိ(ထုတ်မပြနိုင်) ၃။မရရှိ
၅၁။	ကိုယ်ဝန်စောင့်ရှောက်မှုလုပ်ငန်းအထောက်အကူပြုပစ္စည်း (AN checklist and or job-aids)	၁။ရရှိ(ထုတ်ပြနိုင်) ၂။ရရှိ(ထုတ်မပြနိုင်) ၃။မရရှိ
၅၂။	စွန့်ပစ်ပစ္စည်းများသိမ်းဆည်းစွန့်ပစ်ရေးလုပ်ငန်းလမ်းညွှန် (Waste disposal guideline (National/WHO)	၁။ရရှိ(ထုတ်ပြနိုင်) ၂။ရရှိ(ထုတ်မပြနိုင်) ၃။မရရှိ

အခန်း(၁၁)။ သတင်းအချက်အလက်နှင့်ဆက်သွယ်ရေးနည်းပညာရရှိမှု(ဌာနအမျိုးအစားအားလုံးမေးရန်)

စဉ်	အကြောင်းအရာ	ဖြေဆိုချက်
၅၃။	သတင်းအချက်အလက်နှင့်ဆက်သွယ်ရေးနည်းပညာသုံးစွဲမှု	၁။သုံး(တွေ့ရသည်) ၂။သုံး(မတွေ့ရ) ၃။မသုံး

စဉ်	အကြောင်းအရာ	ဖြေဆိုချက်
၅၄။ ဆက်သွယ်ရေးနည်းစနစ်(အောက်ဖော်ပြပါအချက်များမှအဖြေမှန်များကို ဝိုင်းပေးရန်)	၅၅။ ထောက်ပံ့သူ ၁။ကိုယ်ပိုင် ၂။အစိုးရ ၃။ဆေးခန်းပိုင်ရှင် ၄။အလှူရှင် ၅။အခြား(ဖေါ်ပြပါ_____)	၅၆။ အဓိကအသုံးပြုရခြင်းအကြောင်းရင်း *(တစ်ခုမကဖြေဆိုနိုင်သည်။)* ၁။လူနာမှတ်ပုံတင်ခြင်း ၂။မှတ်တမ်းထိမ်းခြင်း ၃။လူနာတစ်ဦးခြင်းမှတ်တမ်းထိမ်းခြင်း ၄။ကျန်းမာရေးအာမခံ ၅။ဖုန်းဖြင့်ဘီလ်ဆောင်ခြင်း ၆။ပုံမှန်ဆက်သွယ်ပြောဆိုခြင်း ၇။ကျန်းမာရေးပညာပေး ၈။ဆေးနှင့်ဆေးပစ္စည်းများမှာယူခြင်း ၉။သင်တန်းပေးခြင်း ၁၀။လူနာပြုစုကုသမှုအကြံဥာဏ်တောင်းခံခြင်း ၁၁။အခြား(ဖေါ်ပြပါ_____)
၁။ကွန်ပျူတာ	၁__၁ _____	၁၀၊၁၁၊၁၂၊၁၃၊၁၄၊၁၅၊၁၆၊၁၇၊၁၈ ၁၉၊၂၀၊၂၁၊_____
၂။မိုဘိုင်းဖုန်း(ရိုးရိုးဟန်းစက်)	၁__၁ _____	၁၀၊၁၁၊၁၂၊၁၃၊၁၄၊၁၅၊၁၆၊၁၇၊၁၈ ၁၉၊၂၀၊၂၁၊_____
၃။မိုဘိုင်းဖုန်း(smart phone)	၁__၁ _____	၁၀၊၁၁၊၁၂၊၁၃၊၁၄၊၁၅၊၁၆၊၁၇၊၁၈ ၁၉၊၂၀၊၂၁၊_____
၄။သင်ပုန်းကွန်ပျူတာ	၁__၁ _____	၁၀၊၁၁၊၁၂၊၁၃၊၁၄၊၁၅၊၁၆၊၁၇၊၁၈ ၁၉၊၂၀၊၂၁၊_____
၅။အင်တာနက်(LAN)	၁__၁ _____	၁၀၊၁၁၊၁၂၊၁၃၊၁၄၊၁၅၊၁၆၊၁၇၊၁၈ ၁၉၊၂၀၊၂၁၊_____
၆။အင်တာနက်(Wi-Fi)	၁__၁ _____	၁၀၊၁၁၊၁၂၊၁၃၊၁၄၊၁၅၊၁၆၊၁၇၊၁၈ ၁၉၊၂၀၊၂၁၊_____
၇။အခြား(ဖေါ်ပြပါ_____)	၁__၁ _____	၁၀၊၁၁၊၁၂၊၁၃၊၁၄၊၁၅၊၁၆၊၁၇၊၁၈ ၁၉၊၂၀၊၂၁၊_____

အခန်း(၁၂)။စွန့်ပစ်ပစ္စည်းများကို စီမံခန့်ခွဲမှု(waste disposal)

စဉ်	အကြောင်းအရာ	ဖြေဆိုချက်
၅၇။	ဆေးရုံဆေးခန်းစွန့်ပစ်ပစ္စည်းများကိုမည်သို့စီမံသလဲ။ *(အဖြေတစ်ခုမက ဖြေဆိုနိုင်ပါသည်)*	၁။မြေပေါ်ပုံ၍မီးရို့ ၂။သတ်မှတ်နေရာတွင်ကျင်းတူး၍မြှုပ် ၃။မီးရို့စက်သုံး၍ရို့ ၄။စည်ပင်အမှိုက်သိမ်းစနစ်ဖြင့်ဆက်သွယ်ဆောင်ရွက် ၅။ပုံမှန်အမှိုက်ပုံးများဖြင့်စွန့်ပစ်

အခန်း(၁၃)ကုသမှုစရိတ်ကျခံခြင်း(ဌာနအမျိုးအစားအားလုံးကိုမေးရန်)

စဉ်	အကြောင်းအရာ	ဖြေဆိုချက်
၅၈။	ယခု ဆေးရုံဆေးခန်းတွင် ပုံမှန်အားဖြင့် စမ်းသပ်ခ ယူလေ့ရှိပါသလား။	၁။ယူ ၂။မယူ(နံပါတ် ၆၀ သို့)
၅၉။	စမ်းသပ်ခယူလျှင်တဘက်ပါအကြောင်းအရာတို့အတွက်ကင်းလွတ်ခွင့်ပြုပါသလား။	၁။သားဆက်ခြားခြင်း။ ၂။ကိုယ်ဝန်စောင့်ရှောက်မှု ၃။ကလေးမွေးဖွားမှု ၄။မီးတွင်းကာလစောင့်ရှောက်မှု ၅။မွေးကင်းစကလေးစောင့်ရှောက်မှု ၆။၅နှစ်အောက်ကလေးစောင့်ရှောက်မှု ၇။HIV(ART နှင့် HTC)/PMCT ၈။အခြား(ဖော်ပြပါ________)
၆၀။	ပုံမှန်အားဖြင့် ဆေးဖိုးကို လူနာများက ကျခံရပါသလား။	၁။ ကျခံရပါသည် ၂။ မကျခံရပါ (နံပါတ် ၆၂ သို့)
၆၁။	ကျခံရလျှင်တဘက်ပါဆေးများအတွက်ကင်းလွတ်ခွင့်ပြုပါသလား။	၁။သားဆက်ခြားခြင်း။ ၂။မိခင်ကျန်းမာရေးဆိုင်ရာဆေးများ ၃။ကလေးဆိုင်ရာဆေးများ ၄။အခြား(ဖော်ပြပါ________)
၆၂။	ကျန်းမာရေး ဝန်ထမ်းဖြင့် ပြသမှုအတွက် လူနာက ကုန်ကျစရိတ် ရှိပါသလား။	၁။ရှိ ၂။မရှိ (အပိုင်း ၁၄ သို့)
၆၃။	ရှိလျှင်တဘက်ပါတို့အတွက်ကင်းလွတ်ခွင့်ရှိပါသလား။ *(တစ်ခုမကဖြေဆိုနိုင်သည်)*	၁။သားဆက်ခြားခြင်း ၂။ကိုယ်ဝန်စောင့်ရှောက်မှု ၃။ကလေးမွေးဖွားမှု ၄။မီးတွင်းကာလစောင့်ရှောက်မှု ၅။မွေးကင်းစကလေးစောင့်ရှောက်မှု ၆။၅နှစ်အောက်ကလေးစောင့်ရှောက်မှု ၇။HIV (ART နှင့် HTC) /PMCT ၈။အခြား(ဖော်ပြပါ________)

၁။ကျေးဇူးတင်ကြောင်းပြောပါ။
၂။လူနာတစ်ဦးဦးကိုဆက်လက်မေးမြန်းမည့်အကြောင်းပြောပါ။
၃။လူနာ၏ဖြေဆိုချက်များကို ဤဆေးခန်းနှင့်ဆေးဝန်ထမ်းတစ်ဦးဦးကို အပြစ်ပေးအရေးယူရေးအတွက် သုံးမည်မဟုတ်ဘဲလုပ်ငန်းနှင့်ဝန်ဆောင်မှုများတိုးတက်မှုအတွက်သုံးမည်ဖြစ်ကြောင်းပြောပါ။
၄။တာဝန်ရှိသူတစ်ဦးဦးထံမှခွင့်ပြုချက်တောင်းပြီးမှဆက်မေးပါ။

ဆေးခန်းပြသူများ၏ထင်မြင်ယူဆချက်များနှင့်သားဆက်ခြားစီမံကိန်းလုပ်ငန်းများအတွက်ကုန်ကျစရိတ်

ခန့်မှန်းဖော်ထုတ်ခြင်း

	ကျန်းမာရေးဌာန၏အမည်	
	တည်နေရာ (က)ပြည်နယ်/တိုင်း (ခ)မြို့နယ် (ဂ)ကျေးလက်ကျန်းမာရေးဌာန	 _____ _____ _____

အပိုင်း(၁၄)။ ဆေးခန်းပြသူ၏ထင်မြင်ယူဆချက်များ

၁၄.၁ ဖြေဆိုသူ၏နောက်ခံအကြောင်းအချက်

စဉ်	အကြောင်းအရာ	ဖြေဆိုချက်
၆၄။	ပြည့်ပြီးအသက်	၊__၊__၊ နှစ်
၆၅။	ကျား/မ	၁။ကျား ၂။မ
၆၆။	အိမ်ထောင်ရေး	၁။လက်မထပ်ရသေး/အတူနေ ၂။လက်ထပ်ထား/အတူနေ ၃။ကွာရှင်း/ကွဲကွာ/မုဆိုးမ/မုဆိုးဖို
၆၇။	ပညာရေး	၁။ကျောင်းမနေ ၂။မူလတန်း ၃။အလယ်တန်း/အထက်တန်းနှင့်အထက်
၆၈။	သားဆက်ခြားနိုင်ရန်အတွက်ဆေးခန်း ဘယ်နှစ်ကြိမ်လာရသလဲ။	၁။လစဉ် ၂။၂လတစ်ကြိမ် ၃။၃လတစ်ကြိမ် ၄။အခြား(ဖော်ပြပါ_____)

၁၄.၂ ။ဝန်ထမ်း၏လိုက်နာဆောင်ရွက်မှု

စဉ်	အကြောင်းအရာ	ဖြေဆိုချက်
၆၉။	သင်ရွေးချယ်သောသားဆက်ခြားနည်းလမ်းကိုရရှိပါသလား။ ရလျှင် မည်သည့်သားဆက်ခြားနည်းလမ်းကို ရရှိပါသလဲ။	၁။ရ _____ ၂။မရ
၇၀။	နည်းလမ်းရွေးချယ်ရာတွင် သင်နှစ်သက်သောဆန္ဒရှိသောနည်းလမ်းကို ထည့်သွင်းဆွေးနွေး ခဲ့ပါသလား။	၁။ဖြစ် ၂။မဖြစ်
၇၁။	မည်သို့သုံးစွဲရမည်ကိုကျန်းမာရေးဝန်ထမ်းကသင်ပေးပါသလား။	၁။သင် ၂။မသင်
၇၂။	ဘေးထွက်ဆိုးကျိုးများကိုရှောပြောပြပါသလား။	၁။ပြော ၂။မပြော
၇၃	ဘေးထွက်ဆိုးကျိုးများဖြစ်လာလျှင်မည်သို့ဆောင်ရွက်ရမည်ကိုပြောပြပါသလား။	၁။ပြော ၂။မပြော
၇၄။	ဆေးခန်းသို့ပြန်လာပြရန်လိုအပ်သောနောက်ဆက်တွဲပြဿနာများအကြောင်းပြော ပြပါသလား။	၁။ပြော ၂။မပြော
၇၅ ။	ထပ်မံလာပြရန်(သို့)ဆေးထပ်ယူရန်ရက်ချိန်းပေးလိုက်သလား။	၁။ပေး ၂။မပေး

၁၄.၃ ဆေးခန်းနှင့်ဆိုင်သောအကြောင်းအရာများ

စဉ်	အကြောင်းအရာ	ဖြေဆိုချက်
၇၆။	ဆေးခန်းမပြသမီစောင့်ဆိုင်းရတာအတော်ကြာပါသလား။	၁။ကြာ ၂။မကြာ
၇၇။	ဆေးခန်းသန့်ရှင်းမှုအနေအထားကိုစိတ်ကျေနပ်ပါသလား။	၁။ကျေနပ် ၂။မကျေနပ်
၇၈။	စမ်းသပ်ခန်း၏လုံခြုံမှုအပေါ်စိတ်ကျေနပ်မှုရှိရဲ့လား။	၁။ကျေနပ် ၂။မကျေနပ်
၇၉။	သင့်ကိုစမ်းသပ်ကုသမှုပြုရာတွင်အချိန်လုံလောက်စွာပေးရဲ့လား။	၁။ပေး ၂။မပေး

၁၄.၄။ ပြောဆိုဆက်ဆံရေး

စဉ်	အကြောင်းအရာ	ဖြေဆိုချက်
၈၀။	သင့်အပေါ်လေးစားပြုဂုဏ်စွာဆက်ဆံရဲ့လား။	၁။ဆက်ဆံ ၂။မဆက်ဆံ
၈၁။	သင်ရခဲ့သောသားဆက်ခြားနည်းလမ်းအပေါ် လက်ခံအောင်အတင်းအကြပ် တိုက်တွန်းခဲ့သလား။	၁။တိုက်တွန်း ၂။မတိုက်တွန်း
၈၂။	ခြုံ၍ပြောရလျှင်ဝန်ထမ်းကသင့်အပေါ်ထားရှိသောစိတ်ဓါတ်ကိုနှစ်သက်ရဲ့လား။	၁။နှစ်သက် ၂။မနှစ်သက်

၁၄.၅။ ရလဒ်

စဉ်	အကြောင်းအရာ	ဖြေဆိုချက်
၈၃။	သင်ရရှိသောဝန်ဆောင်မှုအပေါ်စိတ်ကျေနပ်မှုရှိရဲ့လား။	၁။ကျေနပ် ၂။မကျေနပ်
၈၄။	နောက်တစ်ကြိမ်ထပ်လာဖို့စိတ်ကူးရှိရဲ့လား။	၁။ရှိ ၂။မရှိ
၈၅။	မိသားစုဆွေမျိုးမိတ်ဆွေများကိုဤဆေးခန်းသို့လာပြရန် လမ်းညွှန်ပေးမှာလား။	၁။ပေး ၂။မပေး

အခန်း(၁၅) ဝန်ဆောင်မှုကုန်ကျစရိတ်အပေါ်သုံးသပ်ချက်

(မေးခွန်းနံပါတ်၈၆၊ (ဟုတ်) ဟုဖြေထားသောဆေးခန်းအတွက်သာ)

၁၅.၁။ သားဆက်ခြားစီမံကိန်းဝန်ဆောင်မှုကုန်ကျစရိတ်

စဉ်	အကြောင်းအရာ	ဖြေဆိုချက်
၈၆။	ယခုပြဿသည့်အခေါက်သားဆက်ခြားခြင်း အတွက်ကုန်ကျမှုရှိပါသလား။	၁။ကုန်ကျ ၂။မကုန်ကျ (နံပါတ် ၈၈ သို့)
၈၇။	ကုန်ကျမှုရှိသည်ဆိုလျှင်မည်မျှရှိပါသလဲ။	မှတ်ပုံတင်စာအုပ်ပြုလုပ်ရန် |__|__|__|__|__| ကျပ် ဓါတ်ခွဲ/ဓါတ်မှန် |__|__|__|__|__| ကျပ် ဆေးခန်းမှသားဆက်ခြားဆေး/ပစ္စည်း |__|__|__|__|__| ကျပ် ပြင်ပမှ သားဆက်ခြားဆေး/ ပစ္စည်း |__|__|__|__|__| ကျပ် စမ်းသပ်ခ |__|__|__|__|__| ကျပ်

၁၅.၂ ။ခရီးစရိတ်

စဉ်	အကြောင်းအရာ	ဖြေဆိုချက်
၈၈။	ဆေးခန်းသို့လာရန်ခရီးစသွားလာရသောအဓိကနည်းလမ်း	၁။လမ်းလျှောက် ၂။ဘိုင်စကယ် ၃။မော်တော်ဆိုင်ကယ် ၄။ဘတ်(စ်)/တက္ကစီ ၅။ကိုယ်ပိုင်ယာဉ် ၆။အခြား(ဖော်ပြပါ_____)
၈၉။	ဆေးခန်းနှင့်အိမ်အကွာအဝေး	၊__၊__၊မိုင်
၉၀။	ဆေးခန်းသို့လာရန်စုစုပေါင်းကုန်ကျစရိတ်	၊__၊__၊__၊__၊ကျပ်
၉၁။	အိမ်သို့ပြန်လာရန်ကုန်ကျစရိတ်	၊__၊__၊__၊__၊ကျပ်

၁၅.၃။ အချိန်ကုန်မှု

စဉ်	အကြောင်းအရာ	ဖြေဆိုချက်
၉၂။	ဆေးခန်းသို့လာရန်အချိန်မည်မျှကုန်သလဲ။	၊__၊__၊နာရီ၊__၊___၊မိနစ်
၉၃။	ဆေးခန်း၌မပြသမီစောင့်ဆိုင်းနေရချိန်	၊__၊__၊နာရီ၊__၊___၊မိနစ်
၉၄။	အိမ်သို့ပြန်ရန်အချိန်မည်မျှကုန်သလဲ။	၊__၊__၊နာရီ၊__၊___၊မိနစ်
၉၅။	ဆေးခန်းလာပြသည့်ကာလအတွင်းအိမ်တွင်အဓိကလုပ်စရာ ဘာတွေရှိသလဲ။	၁။ပုံမှန်အိမ်အလုပ် ၂။စိုက်ခင်းအလုပ် ၃။စျေးရောင်းအလုပ် ၄။လက်ခစားအလုပ် ၅။ကျွမ်းကျင်လက်ခစားအလုပ် ၆။စာရေး(သို့)Professional အလုပ် ၇။အခြား(ဖော်ပြပါ_____)
၉၆။	ဤကျန်ခဲ့သောအလုပ်ကိုမည်သူ့ကိုလွှဲခဲ့သလဲ။	၁။မိသားစု ၂။လုပ်ဖော်ကိုင်ဘက် ၃။ဘယ်သူ့မှမလွှဲခဲ့ရ ၄။အခြား(ဖော်ပြပါ___)
၉၇။	လွှဲခဲ့သည့်အတွက်အခကြေးငွေပေးခဲ့ရသလား။	၁။ပေး ၂။မပေး
၉၈။	ပေးခဲ့လျှင်မည်မျှနည်း။	၊__၊__၊__၊__၊ကျပ်

၁၅.၄။ ငွေကြေးစီမံမှု

စဉ်	အကြောင်းအရာ	ဖြေဆိုချက်
၉၉။	ယနေ့ကုန်ကျစရိတ်အတွက်မည်သို့ဖြေရှင်းခဲ့ပါသလဲ။	၁။မိမိဘာသာ ၂။ခင်ပွန်း/ဇနီး ၃။အခြားမိသားစု ၄။အခြားနည်း(ဖော်ပြပါ_____)
၁၀၀။	ယနေ့ကုန်ကျစရိတ်အတွက်မည်သူကမည်မျှကျခဲ့ပါသလဲ။	၁။မိမိဘာသာ၊__၊__၊__၊__၊ကျပ် ၂။ခင်ပွန်း/ဇနီး၊__၊__၊__၊__၊ကျပ် ၃။အခြားမိသားစုဝင်၊__၊__၊__၊__၊ကျပ် ၄။အခြားနည်း(ဖော်ပြပါ_____)

ကျေးဇူးတင်ပါသည်။