

Situation Analysis of Children in Myanmar

July 2012



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Ministry of National Planning and Economic Development

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Abbreviations and acronyms

ACT	artemisinin combination therapy
ADRA	Adventist Development and Relief Agency
ARI	acute respiratory infections
ART	antiretroviral therapy
ASEAN	Association of Southeast Asian Nations
BHS	basic health staff
CBO	community-based organization
CCA	child-centred approach
CCM	Country Coordinating Mechanism
CEA	cost-effectiveness ratio
CEDAW	Convention on the Elimination of Discrimination Against Women
CFS	child-friendly school
CLTS	community-led total sanitation
COMMIT	Coordinated Mekong Ministerial Initiative Against Trafficking
CRC	Convention on the Rights of the Child
CSG	community-based support group
CWBO	child well-being and opportunities
DALY	disability adjusted life year
DANIDA	Danish International Development Agency
DDA	Department of Developmental Affairs
DSW	Department of Social Welfare
EBF	exclusive breastfeeding
ECCE	early childhood care and education
ECD	early childhood development
EFA	Education for All
EPI	expanded programme of immunization
FBO	faith-based organization
FHAM	Fund for HIV/AIDS in Myanmar
GDP	gross domestic product
GER	gross enrolment rate
GPI	Gender Parity Index
IDA	iron deficiency anaemia
IDD	iodine deficiency disorder
IDP	internally displaced person
IDU	injecting-drug user
IHLCA	Integrated Household Living Conditions Assessment
ILO	International Labour Organization
IMR	infant mortality rate
IOM	International Organization for Migration
ITN	insecticide-treated bed nets
IYCF	infant and young child feeding

JICA	Japan International Cooperation Agency
KAP	knowledge, attitudes and practice
LSE	life skills education
MBPND	Ministry of Progress of Border Areas and National Races and Development Affairs
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MMCWA	Myanmar Maternal and Child Welfare Association
MMR	maternal mortality rate
MNCH	maternal, newborn and child health
MoE	Ministry of Education
MoH	Ministry of Health
MoL	Ministry of Labour
MoRA	Ministry of Religious Affairs
NAP	National Aids Programme
NFPE	non-formal primary education
NGO	non-government organization
NPA	National Plan of Action for Children
NRC	National Registration Card
NSW	National Sanitation Week
ODA	overseas development assistance
OVC	orphans and vulnerable children
PLHA	people living with HIV or AIDS
PMCT	prevention of mother-to-child transmission
PTA	parent-teacher association
PTR	pupil-teacher ratio
RHC	rural health centre
SBA	skilled birth attendant
SPDC	State Peace and Development Council
SRH	sexual and reproductive health
STD	sexually transmitted disease
TBA	traditional birth attendant
TCRC	Township CRC Committee
TFR	total fertility rate
UIE	urinary iodine excretion
UN	United Nations
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNHCR	United Nations High Commissioner for Refugees
UNIAP	United Nations Inter-Agency Project on Human Trafficking
UNICEF	United Nations Children's Fund
UPE	universal primary education
VCT	voluntary counselling and testing
WASH	water, sanitation and hygiene
WFP	World Food Programme
WHO	World Health Organization

Foreword

UNICEF and Government of Myanmar have started the basic relation since 1950 by signing the basic agreement. UNICEF is supporting financial and technical assistance to protect children, to improve rural health services, basic education for children, community water supply, sanitation, HIV/AIDS prevention, early childhood development as well as immunization programmes.

The Situation Analysis of Children (SITAN) in Myanmar was developed by various departments including Ministry of National Planning and Economic Development and UNICEF based on the results of the Multiple Indicator Cluster Survey (2009-2010) and other international as well as national publications. The purpose of this report is to provide information and identify the country's priority, challenges for future policy direction, programmes and actions. This Situation Analysis can contribute to work more effectively towards the achievement of both children's rights and the Millennium Development Goals. SITAN analyzes socio-economic challenges for women and children.

This report set out the key areas where action is urgently required to enhance financing and strengthen policy. Poverty is still challenging in Myanmar so public and private sectors, institutions, UN organizations, NGOs and INGOs need collective efforts to carry out activities for the wellbeing of women and children as well as poverty eradication in Myanmar. Thus, I encourage all stakeholders to support the national efforts of achieving MDGs, international commitments and to be balanced and proportionate development among States and Regions.

I am very grateful to UNICEF for technical and financial support for publication of this report and also to concerned officials from various ministries who provide valuable inputs in preparing this report. Without their interest and involvement, the SITAN would not be materialized.

I hope that this report will contribute for the necessary arrangements and programmes to improve the situation of the women and children in Myanmar.



His Excellency U Tin Naing Thein
Union Minister for National Planning and Economic Development

Message from UNICEF Myanmar Representative

The Situation Analysis of Children is the product of close collaboration between the Ministry of National Planning and Economic Development, the SITAN Technical Working Group, consisting of representatives of various government departments working in the social sector, and UNICEF.

This publication analyses the current situation of children and women in Myanmar in terms of realising the rights of children, based on the best available data from various surveys, routine reporting and information available from various sources. In line with a human-rights based approach, the report highlights the immediate, underlying, structure causes of non-realisation of children's rights. It also maps the capacity of various duty bearers, such families, communities, local and national governments to work for the realisation of children's rights.

Myanmar has made steady progress on many fronts related to millennium development goals. There is improvement in primary school enrolment, and steady decline in infant, child and maternal mortality. These could not have been achieved without extension and improvement in quality and provision of social services. The report shows, however, that there are wide disparities in the country, due to geographic location, urban/rural residence, socio-economic status and education level. As Myanmar's population continues to grow, concentrated efforts need to be directed towards improving the equity of children, to give all children the same chances in life. Especially, more needs to be done to realise the rights of women and children who reside in remote areas. The data available from the recently completed Multiple Indicator Cluster Survey 2009-2010, some of which is quoted in this publication, would be of special interest in planning interventions in those areas.

UNICEF hopes that the information available in this publication will be of use to various planners, programmers, and policy makers interested in the realisation of women and children's rights and the situation of equity and disparities in Myanmar. UNICEF welcomes any suggestions and feedback on this publication so that we could improve the next round of situation analysis to be conducted while designing the next country programme.



Ramesh Shrestha
UNICEF Representative

Special note on the Situation Analysis of Children and recent events in Myanmar

The present Situation Analysis (SITAN) report is based on the most recent available data for the areas of health and nutrition; water, sanitation and hygiene; education; HIV/AIDS and child protection. Where available, estimates are quoted for several years to present a trend. The SITAN draws on data provided in the Multiple Indicator Cluster Survey (MICS) and Integrated Household Living Condition Assessment (IHLCA) conducted in 2009/2010. Some topics show less recent data as they were not included in the MICS and IHLCA. They are dated and referenced as such.

In March 2011, Myanmar ushered in a democratically elected civilian government. The country has since experienced rapid social, economic and political change, including reforms of key legislation such as the Child Law, and lifting censorship on media. Political and economic sanctions have also been eased. Budget allocations to the social sector have increased, with higher allocations made to education and health.

As the SITAN uses MICS and IHLCA data that was collected in 2009/2010, it does not fully capture changes in the lives of children brought about by the most recent economic and social developments in Myanmar. While SITANs are typically conducted every five years to allow sufficient time for change in child development indicators, given the pace of change in Myanmar, a SITAN will be conducted in three years to analyse changes in the realisation of children's rights in the context of democratisation and decentralisation in Myanmar.

Acknowledgements

The Myanmar Situation Analysis of Children (SITAN) has been produced through a collaborative process under the guidance of the SITAN Technical Working Group, comprised of representatives of government departments working in the social sector and the Social Policy, Monitoring and Evaluation section (SPME) of UNICEF Myanmar. UNICEF would like to thank all members of the Technical Working Group for dedicating their time and efforts to this task, including their participation in group discussion and their contributions to the analysis since October 2010. Special thanks are extended to His Excellency U Tin Naing Thein and His Excellency Dr. Kan Zaw, Minister and Deputy Minister for the Ministry of National Planning and Economic Development. We also thank to Daw Lai Lai Thein, Director General of the Planning Department, for her leadership of the Technical Working Group and her coordination of the SITAN process.

The SPME team of UNICEF Myanmar (Yoshimi Nishino, chief of SPME, Christian Stoff, M&E specialist, Mona Korsgard, M&E specialist, Khaing Soe, M&E specialist Gillian San San Aye, knowledge management officer, and Pwint Mon Swe Win, programme assistant) worked closely with the technical working group from the initiation from the study, through analysing the data, drafting, commenting, and finalization of the draft.

Many UNICEF staff members as well as international and national consultants also contributed to the analysis and writing process. Although not possible to mention everybody by name, we would like to express our sincere thanks to all of these individuals. Every consultant made unique and valuable contributions to this report. We would like to specifically express our thanks to Marinus Gotink, chief of Young Child Survival and Development section (YCSD), Siddharth Nirupam, Jeannette Wijnants, chief of child protection section, Niki Abrishamian, chief of education section, Dara Johnston chief of WASH, and Maharajan Muthu, chief of HIV and children section for their revising and improving their chapters many times.

Finally, we also would like to thank our representative, Ramesh Shrestha and the deputy representative, Juanita Vasquez, for their constant support for the realization of this SITAN.



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Executive summary

The Situation Analysis of Children in Myanmar provides an overview of the situation regarding children's and women's rights to health and nutrition; water, sanitation and hygiene; education; be free of HIV; and protection. The analysis identifies the basic structural factors as well as the immediate and underlying factors influencing the realization of all children's rights in Myanmar. This report includes analysis of the roles and capacities of duty bearers – those with responsibility for ensuring that children's rights are realized. The primary purpose of this situation analysis is to consolidate relevant information and analysis to identify the country's priority challenges to fulfilling children's rights and to make corresponding recommendations for future policy direction, programmes and actions.

Basic structural factors impacting the realization of children's rights in Myanmar

The realization of children's rights in Myanmar is influenced by the overall country context and, specifically, by a number of basic structural factors:

Constitutional and legal framework – Although Myanmar became a State Party to the Convention on the Rights of the Child (CRC) in 1991, constitutional status did not follow it and therefore it can be overridden by national rules and laws. Various provisions of the CRC manifest mainly through the framework of the 1993 Child Law; however, there are some areas in which the law diverges from the CRC (such as defining a child as up to 16 years rather than 18 years). A National Plan of Action was developed to promote the implementing of the CRC, but there are issues, such as weak monitoring. Myanmar ratified the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) in 1997, but, again, there are areas (marriage, inheritance) in which national legislation and customary laws discriminate against women. The 2008 Constitution reaffirms the state's responsibility to provide free basic education and health care for all and to care for mothers and children, the disabled and orphans. Myanmar is fully committed to the Millennium Declaration and to achieving the Millennium Development Goals by 2015.

Quality of governance and economic performance – Following the national elections in November 2010, a new civilian government took office on 1 April 2011. The new government has been implementing a wide-ranging programme of reforms and moving to a decentralized system of governance. Myanmar remains a low-income country in South-East Asia; per capita gross domestic product was \$1,093 in 2009, while inflation averaged 24.9 per cent per year between 2000 and 2008¹. Growth is hampered by limited transport and other infrastructure and by energy shortages. The economy is dominated by agriculture, followed by services; industry accounts for just 15 per cent of GDP. Myanmar has made moves towards becoming a market economy, but its trade volume per capita is low. Remittances from workers abroad have been estimated at \$300 million annually.² The economy was badly hit by Cyclone Nargis (May 2008) as well as the recent global financial crises. Children, especially from poor families, face more severe risks (death, malnutrition, dropping out of school permanently) than adults owing to the economic crises.

Spending in the social sector is very low: health and education combined for 1.5 per cent of GDP between 2000 and 2007 (far short of other ASEAN countries), with the bulk of spending on education (78 per cent).

1 U Myint, *Myanmar Economy: A comparative view*, Institute for Security and Development Policy, Stockholm, 2009.

2 Turnell, S. et al., *Migrant Worker Remittances and Burma: An economic analysis of survey results*, Macquarie University, Sydney, Australia, 2008.

The low public resource allocation for the social sector impacts on service delivery, leading to, for example: services not being available (particularly in remote areas) or not being of adequate standard; insufficient personnel, especially trained service providers; low salary levels and low investment in capacity development. There are additional issues in relation to planning and coordination, organization and management, and monitoring and accountability.

Demographic profile and trends – The population of Myanmar was estimated to be 58 million in 2008³ and is expected to reach 66 million by 2020.⁴ The vast majority of people live in the central regions, with far fewer in outlying areas. The urban population has grown from 25 per cent in 1990 to 34 per cent in 2009.⁵ Significant reductions in fertility rates and, to a lesser extent, mortality have led to a shift in the population age profile towards more working-age people. More than half of the working population is employed in agriculture. Myanmar has 135 ethnic groups clustered into eight main groups (the Bamar are the largest, forming 69 per cent of the total population), and more than 100 languages and dialects are spoken across the country. Levels of population migration are significant, both in-country and to Thailand, China and India. Migration is mostly for economic reasons, but there are also large numbers of people displaced by natural disasters and conflict. The wide ethno-linguistic diversity and highly mobile population pose particular challenges for service delivery and access to development opportunities.

Socio-cultural values and norms – Children in Myanmar are expected to study hard and/or work hard (including domestic chores). Attitudes towards children make little allowance for the need for play and recreation. There is widespread acceptance of working children and little evidence of children's participation in decisions affecting them in service provision (such as in schools). Myanmar society is generally patriarchal: men are the main bread-earners and the main decision-makers. Attitudes to women are strongly underpinned by religious beliefs; moreover, personal affairs such as marriage, divorce and inheritance tend to be governed by Customary Law.

Poverty – The proportion of people living in poverty in terms of household expenditure fell from 32 per cent in 2004–2005 to 26 per cent in 2009–2010. Poverty dynamics in Myanmar are characterized by major rural-urban and regional disparities, and by a larger proportion of transitory (28 per cent households) than chronic (10 per cent) poverty. Rural households are poorer than urban households. The highest levels of poverty incidence are found in Chin State (73 per cent), followed by Rakhine State (44 per cent). In Myanmar, poverty contributes to a situation in which children typically do not enrol in or drop out of school, many children work, there is increased vulnerability to exploitation and households are unable to access health services.

Humanitarian issues – Throughout its existence as an independent State, Myanmar has experienced a complex set of conflicts between the central Government and ethnic nationalities seeking autonomy. The new civilian Government has made moves towards reconciliation with the ethnic nationalities. Myanmar is prone to natural disasters; the worst was Cyclone Nargis in 2008, which caused the loss of more than 138,000 lives and \$10 billion worth of damage; but there have been many smaller-scale disasters (cyclones, floods and earthquakes).

3 Ministry of National Planning and Economic Development, Central Statistical Organization, *Statistical Profile of Children and Women in Myanmar 2009*, Nay Pyi Taw, Myanmar, 2010.

4 United Nations Population Fund, *Report on Situation Analysis of Population and Development, Reproductive Health and Gender in Myanmar*, Nay Pyi Taw, 2010.

5 United Nations Development Programme, *Human Development Report 2009*, UNDP, New York 2009

Conflicts and natural disasters have had detrimental impact on the people of Myanmar, particularly women and children, causing loss of life, insecurity, psychological distress and displacement while undermining access to services, affecting livelihoods and pushing people (deeper) into poverty. Both make it far harder for duty bearers to carry out their roles and ensure the realization of children's rights.

Children's right to health and nutrition

Each year, around 56,000 children under five die in Myanmar – 43,000 of them younger than 1 month. Despite improvements, the country's under-5 and infant mortality rates are the highest among ASEAN member countries⁶, and many of these deaths are preventable. Child mortality rates are higher in the central plains, in rural areas, among families without formal education and among children from the poorest families.

Maternal and child mortality – Severe postpartum haemorrhage is the main direct obstetric cause of maternal deaths, followed by hypertensive disorders of pregnancy, including eclampsia and abortion-related complications. The principal causes of neonatal mortality (within 28 days of age) are prematurity, birth asphyxia and sepsis, including pneumonia. Deaths are most common in home-delivered babies in rural areas. The main direct causes of deaths among children under-5 continue to be acute respiratory infections, diarrhoea and malaria, exacerbated by underlying malnutrition, which contributes to around 50 per cent of these deaths. The expanded programme of immunization has led to the virtual elimination of polio but has been less successful against measles. There are significant disparities in disease prevalence, morbidity and mortality across the country.

Malnutrition – Child malnutrition greatly increases the risks of morbidity and mortality and adversely affects intellectual and physical development. Micronutrient deficiencies affecting children in Myanmar include iron deficiency anaemia and infantile beriberi due to vitamin B1 deficiency. Vitamin A supplementation has been effective, and progress has also been made in addressing iodine deficiency disorders.

Reproductive health care – Problems related to reproductive health are another immediate causal factor hampering children in Myanmar from realizing their right to health. Immediate and effective professional care before, during and after delivery can make the difference between life and death for both women and their newborns. Antenatal coverage and deliveries by skilled birth attendants have increased, but most births still take place outside health facilities. Although there has been a marked increase in contraceptive prevalence rate in Myanmar and the total fertility rate has fallen considerably, there is still much scope for improvement in birth spacing.

Key underlying factors influencing maternal and child health in Myanmar are household dietary intake, access to safe water and sanitation and access to and quality of health services. Although food is sufficient at the national level, it is not always available when needed at the household level; low-income levels and poor nutritional knowledge and practices (milk is available but not widely drunk, for example) are two reasons for this.

Health care system – Myanmar's health care system continues to grapple with significant problems in terms of access, quality, human resources, management and organization. The levels of public expenditure on health services are very low, and inefficiencies in the health system mean that what little is spent does not achieve maximum results. Many health facilities lack basic equipment and supplies and do not have sufficient and/

or appropriate health staff. The health assistant to population ratio in Myanmar is 1:21,822, and the mid-wife population ratio is 1:4,144⁷. Service delivery is particularly weak in rural, remote and border areas: as a result, children and women in such areas and those from poorer families tend to have substantially worse health and survival outcomes. The private sector provides the majority of health care services, particularly for the poor; however, users are vulnerable to financial exploitation and low-quality (sometimes even harmful) treatment.

There is inadequate focus on maternal health, neonatal and under-5 mortality or family and community practices; as well, there is no systematic approach to addressing underlying causes of poor health outcomes. Many families lack the knowledge and skills for appropriate family care practices as well as the financial resources to meet the costs involved. Approximately 87 per cent of the overall expenditure on health care is incurred by consumers in out-of-pocket expenses – the highest in the region. The high level of private financing of health expenditures promotes an emphasis on income-generating curative care, with less attention to prevention.

Children's right to water, sanitation and hygiene

Access to clean water – There has been an increase in households' access to improved water sources over the past several years, but there are significant disparities: access to clean water is less in rural than urban areas, in the poorest households, and in some regions (lowest levels in Kayin and Rakhine states). Additionally, there are large seasonal variations, with access greater in the rainy than dry season. Only around one third of households have their water source on their premises; the rest have to fetch water. The most common water sources used are tube wells or bore holes, followed by protected dug wells.

Improved sanitation – Access to improved sanitary facilities has also increased substantially, to 84.6 per cent of the population in 2009–2010⁸. Most widespread is the use of direct or indirect pit latrines with slabs, followed by pour-flush or flush latrines (one survey⁹ found flush latrines to be most common). Almost 15 per cent of households used unsanitary ways of excreta disposal. Use of improved latrines is much higher in urban and richer households compared with rural and poorer households. Again, there are large regional disparities, with Rakhine State having the lowest level of access (48 per cent). Access at home does not mean universal access. Many schools have latrine facilities but their condition is often poor, leaving many of them unsanitary or even unusable for school children. Similarly, latrines are rarely available in the field, where many people work, and they thus have to resort to open defecation.

Hygiene – Awareness and knowledge in Myanmar about recommended practices with respect to safe water and basic sanitation has so far not been translated into appropriate behaviour. Hand washing is prevalent among the population, but the use of soap is not. Surveyed households are usually aware of the need for proper hygiene in water fetching and storage, although the extent to which the former is acted upon is unclear. In many households, child faeces are disposed improperly.

In addition to water source type, fetching and storage, two other factors have an immediate impact on the

7 Ministry of Health, *National Health Plan, 2006-2011*, Myanmar

8 Ministry of National Planning and Economic Development, Ministry of Health and UNICEF, *Myanmar Multiple Indicator Cluster Survey 2009-2010*, Nay Pyi Taw, 2011.

9 Ministry of Health and UNICEF. 'Knowledge, Attitude and Practice Study into Water, Sanitation and Hygiene in 24 townships of Myanmar'. Yangon 2011.

fulfilment of the right to safe water: water source quality and water treatment. A water-quality assessment found that many of the dug wells – protected or not – contained water contaminated with faecal coliform.¹⁰ Contamination is also caused in many households by having animals and/or latrines close to the water source. Arsenic contamination is a problem in some areas, notably Ayeyarwaddy Region. Only around one third of households use an appropriate water treatment method to make their water safe to drink; use of a proper treatment is less widespread among the poor, in rural households and in some states/regions (with the lowest rates in Bago (West), Rakhine and Ayeyarwaddy).

The immediate causal factors impacting access to improved sanitation are design and maintenance of improved facilities and the manner in which solid waste is disposed of. Many latrines designated as ‘improved’ by households are in fact unhygienic; even where genuinely improved, poor maintenance means they may be only partially or not functional at all. These problems are more widespread in rural areas. Most households use inadequate methods to dispose of their solid waste: burning or dumping in fields, in garbage holes within their residential compound or into a stream or along a river bank. The underlying factors impacting access to clean water and sanitation in Myanmar include: the ‘disconnect’ between awareness about safe water and sanitation and actual practice; resource constraints; and challenges posed by the varied terrain as well as the frequent natural disasters.

The responsibility for protecting water from contamination, ensuring proper sanitation practices and following good hygiene behaviour begins in the home. Families in Myanmar are hampered by a lack of knowledge and/or failure to translate this into practice and by resource constraints. Two tools that have proved effective in improving the safe water, sanitation and hygiene (WASH) situation in Myanmar – water safety planning and community-led total sanitation – both centre on the collective realization by communities that they must solve their own problems.

Public sector service delivery for WASH is hampered by resource constraints, the involvement of multiple agencies and limited coordination, and an insufficient focus on safe water and sanitation in policies. The country has no specific water policy and no national drinking water standard, both of which are critical to ensure safe water. Policies are also needed to promote equitable access, which ensures affordable safe water and sanitation for the poorest. However, the annual National Sanitation Week has been effective in promoting extensive latrine coverage.

Children’s right to education

Early childhood development – Participation in early childhood development (ECD) programmes (for children aged 3–5 years) has more than doubled compared with 10 years ago (up from 10 per cent in 2002 to 22.9 per cent in 2009–2010).¹¹ However, there are significant disparities: children from the richest households, with educated mothers, and those living in urban areas are more likely to participate. Regional disparities are particularly marked. Core indicators for minimum quality standards for ECD have been developed, but a national ECD monitoring and evaluation framework is lacking. An evaluation of the community-based Mothers’ Circles (home-based play groups of parents and children), however, found they benefitted both children and their families. Pre-school programmes are increasingly used to pay attention to mother tongue learning and

10 Ministry of Agriculture and Irrigation and UNICEF, *Drinking Water Quality Surveillance and Monitoring: Analysis of drinking water quality in selected areas of Myanmar*, Yangon, April 2002.

11 Ministry of National Planning and Economic Development, Ministry of Health and UNICEF, *Myanmar Multiple Indicator Cluster Survey 2009-2010*, Nay Pyi Taw, 2011.

prepare speakers of other languages for the transition to Myanmar language in primary education.

Primary education – The majority of primary school-aged children (5–9 years) in Myanmar are attending school. Improved coverage at the primary level has come about through increased numbers of schools as well as the establishment of many schools with multi-grade teaching. However, regional, urban–rural (enrolment is slightly higher in urban areas) and wealth (highest for rich households) disparities exist. The enrolment of disabled children is particularly low. Children are expected to enrol in primary school at the age of 5, but late enrolment is common, leading to many overaged children in primary education. Again, there are regional, urban-rural and income-related disparities in both enrolment and completion rates. The net completion rate for primary school is only 54.2 per cent.¹²

The quality of primary education service delivery is low, and learning needs to be improved. Despite moves to introduce child-centred approaches, rote learning remains the dominant form of instruction. The traditional primary school classroom is an unfriendly environment for most children, and use of corporal punishment is widespread. There are no standardized achievement tests to assess learning progress in a systemic manner. However, a Myanmar language learning achievement test revealed that fewer than 25 per cent of students had achieved a minimum level of competency; Myanmar language and mathematics scores were found to be significantly correlated.¹³ During the early years, children are automatically promoted, and the transition rate to lower secondary education is high (albeit lower among the poorest than the richest children).

Secondary education – Participation rates in secondary education are increasing but still low and inequitable. MICS 2009–2010 found that only 58.3 per cent of children of secondary school age were attending secondary school – the remainder were either out of school or attending primary school. The rural–urban difference in attendance is far more pronounced for secondary than primary schools; so too are the disparities based on socio-economic status and regional disparities. Mothers' education is again a significant positive factor. As with primary education, teachers generally maintain traditional didactic practices and an emphasis on rote learning. Application of the child-centred approaches is made harder by increasing class sizes. An overwhelming majority of children fail to complete a basic education (primary and secondary) as defined by the Government of Myanmar.

There is considerable education provision outside the public sector. Monastic schools operate all over the country; registered schools serve around 180,000 children, but the total number of children in the system is estimated to be around 200,000. Most monastic schools are primary; they use the official school curricula but also teach about Buddhist culture and way of life. Because no fees are charged and food is provided, these schools are able to reach some of the poorest children.

The immediate causal factors hampering children in Myanmar from realizing their right to education are the limited quality of education services and the high actual and opportunity costs of education. Quality is impaired by insufficient infrastructure, insufficient teachers, outdated teaching methodologies and large teacher-pupil ratios. Although no fees are levied in primary education, there are multiple charges that families must pay in order for their children to access it. This burden is heaviest for the poorest families. Tuition fees are charged for both middle and higher secondary schools. Nearly 30 per cent of school-aged children not attending school in 2009 did not do so because of the cost burden.¹⁴ Parents also have to consider the

12 *ibid*

13 UNICEF, *Baseline of 1,000 Schools in the Child-Friendly Schools Programme in Myanmar in 2007*, Vol., Yangon, 2008.

14 Tripartite Core Group, *Post-Nargis Periodic Report II*, Yangon, 2009.

opportunity cost of keeping their children in education, both for themselves and their children; many feel work is a better option for them than education. Parents' appreciation of the value of education and their willingness to support it for their children is strongly linked to their own educational experience (or lack of it). But even where children do attend school, parental involvement in their education is limited.

Underlying causes for the failure of children in Myanmar to realize their right to education include structural factors undermining service delivery, a lack of options in non-formal basic education and language barriers. The former includes lack of funding for the education sector as well as limited policy development and planning, limited quality of teacher training, sector-level management failings and inadequate monitoring and assessment. The current provision of non-formal or alternative primary education for children who have dropped out of school is very limited in coverage. Despite the country's very complex linguistic diversity, Myanmar language is the sole language of government, public affairs and public education. The 'language barrier' is a significant factor for children from non-Myanmar ethnic groups dropping out of school. Three focus areas of education reform in Myanmar are quality, equity and sector capacity.

Children's right to be free of HIV

HIV prevalence among the adult population was estimated to be 0.61 per cent in 2009.¹⁵ The overall epidemic in Myanmar is still a concentrated one, with most infections reported in large urban areas, northern and north-eastern parts of the country and among the most-at risk groups. HIV prevalence among high-risk population groups, particularly female sex workers, is declining; but it has been quite steady among low-risk population groups such as pregnant women, blood donors and new TB patients.

Prevalence among women – About one third of people living with HIV in the country are women.¹⁶ The male-to-female ratio of reported HIV cases is decreasing, showing a steady increase in the proportion of women infected. These women are largely the sexual partners of men linked to high-risk groups. This pattern of the epidemic increasingly puts children at greater risk through mother-to-child transmission. Sentinel surveillance data from 2009 showed HIV prevalence of 0.95 per cent among pregnant women aged 15–24, suggesting a high number of infants who could become infected.

Prevalence among children – To date there has not been much information on the prevalence and situation of children affected by HIV in Myanmar. In 2009, 4,650 children younger than 15 years were HIV positive, with half under five years of age. Similar numbers of boys and girls were infected across all age groups. Although the number of people 14 years or older living with HIV or AIDS is predicted to decrease between 2009 and 2012, the number of 10- to 14-year-olds with HIV or AIDS is forecast to increase over the same period. The numbers of children orphaned by AIDS in Myanmar is increasing; many more continue to live with one parent who may or may not be infected. Affected or orphaned children tend to be taken care of by their extended family, or failing that, monasteries or government- and faith-based organization-run institutions. Negative socio-economic implications are common among such children: stigma; higher risk of behavioural problems and a smaller proportion with normal height-to-weight ratios than non-affected children.

There are three immediate factors impacting HIV prevalence in Myanmar: i) the low level of HIV knowledge, ii) high-risk behaviour and iii) lack of preventive care and treatment services (voluntary counselling and test-

15 MOH, WHO and UNAIDS, *HIV estimates and projections, Myanmar 2008-2015*, Myanmar

16 Joint United Nations Programme on HIV/AIDS (UNAIDS), *UNAIDS Report on the Global AIDS Report, 2010*, Geneva

ing and prevention of mother-to-child transmission (PMCT) services). Less than one third of women of reproductive age have appropriate knowledge of HIV transmission and prevention methods. However, increased coverage of the PMCT programme has led to almost two thirds of women being aware of all three methods of mother-to-child transmission. Regional and other disparities in knowledge about HIV are quite marked. Safe sex practices (notably condom use) have increased among high-risk groups, such as female sex workers, but among the general population the practice of unsafe sexual behaviour is still an alarming issue.

Underlying causes of HIV prevalence and impact in Myanmar are threefold: stigma and discrimination, low quality in the services for people with HIV or AIDS and increased migration. Stigma and discrimination prevent people from testing for HIV, openly discussing prevention and seeking treatment services. Although there has been a rapid scaling up of PMCT services in recent years, the focus has been on quantity; this has resulted in a perceived compromise on quality of the services. Data on HIV in relation to migration is limited, but studies show low levels of HIV knowledge and condom use and relatively high STI and HIV prevalence in some Myanmar migrant groups.¹⁷

The capacity of families to care for children affected by HIV is often undermined by the fact that one or both parents will also be infected or even dead. Orphaned children are often taken care of by extended family members or taken into institutions. People and children affected by HIV face stigma and discrimination within their extended families as well as in the wider community.

There has been considerable expansion in the number, role and capacity of community-based organizations and of self-help groups composed of people living with HIV and those from high-risk groups. However, their capacity is limited by poverty, illness, lack of training, and discrimination.¹⁸ Myanmar's current health plan ranks AIDS as one of the top-three priority diseases (alongside malaria and tuberculosis) due to its public health, political and socio-economic importance. However, children remain the missing face in the HIV and AIDS response, with inadequate attention to their situation and needs.

Children's right to protection

Children have the right to protection from violence, neglect, exploitation and abuse.

Birth registration – Birth registration coverage has considerably increased in the past several years, according to MICS 2009–2010 – although some care has to be exercised when interpreting this data. There is no difference between boys and girls in their likelihood of being registered at birth, but there are wide rural–urban, regional and rich–poor disparities. Children with educated mothers are also more likely to have their births registered.

Exploitation of children – The labour force participation of children aged 10–14 years is 18 per cent among the poor; it appears that many working children are unpaid family helpers. Even where the tasks undertaken by children are not dangerous, work is damaging in that it prevents them from going to school or engaging in recreation and play, and places them under stress. Despite legal restrictions, commercial sex of women is available in Myanmar. Children exploited for commercial sex are most often girls, but there are also some

17 International Organization for Migration Thailand, 2008. *Migration and HIV/AIDS in Thailand: A desk review of migrant labour sectors*, Bangkok 2008. *Migration and HIV/AIDS in Thailand: Triangulation of biological, behavioural and programmatic response data in selected provinces*, IOM Thailand, Bangkok 2010.

18 *Myanmar National Strategic Plan on HIV and AIDS, 2011–2015*

boys. Children form a considerable proportion of trafficked persons, both within and outside Myanmar: most international trafficking of Myanmar women and girls to China is for forced marriage; other common reasons for trafficking of women and children are for labour purposes (domestic work, factories, fishing industry, begging, and street vending) and commercial sex work.

Children without parental care – Around 5 per cent of children aged 0–17 years in Myanmar are not living with their biological parents, most notably in border areas with high levels of migration. The overall prevalence is certainly higher, considering this data does not include those living in residential facilities or on the street. Parental death is not the main reason for children being without parental care: Two thirds of those in residential care have one or both parents alive. The extended family traditionally cares for children without primary caregivers but not for strangers. Adoption rates are low, leaving many children under the care of various types of institutions.

Government-run facilities for children are far fewer in number than monastic or other faith-based/NGO-run facilities. The total number of children in private unregistered institutions across the country is not known. Residential facilities generally just meet the basic needs of children in their care. There is limited understanding and prioritizing of reunification and reintegration of children into the family environment.

Children in contact with the law – Children coming into contact with the law in Myanmar are often seen as offenders and delinquents rather than as needing special protection. Most are boys, with theft the most common offence; in contrast, cases of juvenile prostitution always involve girls.¹⁹ Many of the children in contact with the law come from broken families or have no parents or guardians. The most common sentences issued to young offenders are bonds and admonition. There is weak capacity and familiarity in child-friendly justice approaches and little provision of legal aid or other services.

Other vulnerable groups – These include children with disabilities, children affected by armed conflict or natural disasters and victims of violence, neglect and abuse. A survey²⁰ found that around 318,000 Myanmar children younger than 15 years were disabled, 249,000 of them of school-age (6–15 years). Disability is often a result of preventable causes, such as polio and iodine deficiency. Persons with disability are socially, economically and educationally disadvantaged; almost half of them have never attended school.

There are two immediate factors hampering children in Myanmar from securing their right to protection: poverty and family breakdown or tensions. Poverty in particular forces children to work; both poverty and family breakdown increase children's vulnerability to commercial sexual exploitation and trafficking. Lack of awareness about child protection is also a factor in the denial of some children's rights, notably birth registration. Underlying causes are again twofold: weaknesses in state protection systems and services, and social attitudes regarding children and women. The latter promote the acceptance of working children, domestic violence and child marriage in certain parts of the country.

Families and communities in Myanmar have limited knowledge and skills related to children's rights and protection. Unlike health and education, social welfare does not attract private sector engagement other than in the form of occasional donations. Government protection services in Myanmar are hampered by such issues

19 Institute of Economics, Sandar Hmwe, *Juvenile Justice System in Myanmar*, Research Paper, EMPA Programme, Yangon, 2009.

20 Ministry of Social Welfare, Relief and Resettlement and The Leprosy Mission International, *Myanmar National Disability Survey, 2010*, Nay Pyi Taw.

as underfunding, lack of staff and weak coordination. There are also serious shortcomings in the legal and policy framework for child protection; for example, Myanmar has not ratified the International Labour Organization conventions on child labour and is not a signatory to the UN Convention on People with Disabilities; provisions in the Child Law allow for physical punishment.

Key Recommendations

Basic structural factors influencing children's rights – Legislation upholding the rights of children should be enforced. Investment on children, especially spending in the social sector, needs to be greatly increased through the effective and efficient allocation of government funds and public sector governance strengthened. Effective social protection mechanisms linked with poverty reduction strategies should be established to protect the poor and vulnerable, to help them meet their basic needs, to prevent them from falling into poverty and to develop livelihood skills and human capital that can lift them out of poverty. Advocacy and social mobilization should be carried out to tackle the societal values and norms that hamper the realization of children's rights. Peace-building processes and disaster risk reduction need to be promoted.

Children's right to health and nutrition – Investment in the health sector needs to be increased by both government and international partners to provide an equitable, high-quality health system. There is a need to prioritize key interventions that can reduce neonatal and child mortality, to extend the full continuum of care to all townships and to improve the health practices and health-seeking behaviour of families and communities. Health service planning needs to be strengthened at all levels.

Children's right to water, sanitation and hygiene – A holistic approach needs to be taken, in which issues related to water supply and sanitation and promoting good hygiene practice are tackled together. Greater coordination is needed among government departments at all levels. In this regard, a WASH task force could be created for planning, budget allocation, monitoring and data analysis. Cost-effective solutions need to be found and proper impact assessment of interventions carried out. Efforts are needed to translate awareness about the importance of proper WASH among families and communities into actual practice.

Children's right to education – Education reform in Myanmar needs to focus on quality, equity and sector capacity. Efforts should be made on a priority basis to improve the quality of education in primary schools through, for example, better teacher training, curriculum reform, provision of infrastructure and supplies and proper student assessment. Primary education needs to be made completely free of cost. Targeted interventions are needed to ensure access to education in remote areas, for the poor, for the disabled and for non-Myanmar-speaking ethnic nationalities. The education sector capacity needs to be built through decentralized education management, evidence-based planning and enhanced community participation.

Children's right to be free of HIV – Greater focus is needed on children in HIV policy-making and programming. Support and services for orphans and vulnerable children need to be improved. Prevention efforts need to target females and young drug users and focus on reducing new infections in the 10–14 years age group. Access and quality of PMCT services need to be improved.

Children's right to protection – The legal framework for child protection needs to be strengthened and enforcement promoted. Mechanisms need to be established for regular collection of disaggregated information on women and children affected by specific protection problems, thereby enabling effective solutions to be developed. Increased resources are needed for social welfare, and coordination between different agencies

needs to be strengthened. Minimum standards of care in residential facilities need to be enforced. Attitudinal change needs to be promoted, in particular towards working children, domestic violence, corporal punishment, children with disabilities, birth registration and child marriage.



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Introduction

UNICEF is committed to helping build a world in which the rights of every child to survival, development, participation and protection are fully realized. Children's rights and women's rights are closely linked. UNICEF Myanmar has been working to promote the realization of both in the country. Myanmar is a signatory to the Convention on the Rights of the Child (CRC), the Convention on the Elimination of Discrimination Against Women (CEDAW) and is committed to achieving the Millennium Development Goals (MDGs).

The *Situation Analysis of Children in Myanmar* is a comprehensive examination of children's rights within a specific country context. It entails a detailed review of the status of children as right holders – to safe water and sanitation, to education, to health, to freedom from HIV and to protection. The situation analysis presented in this report is holistic in its outlook: it covers the level of access to rights as well as the factors influencing (or hampering) the realization of rights – both immediate and underlying, and the roles and capacities of duty-bearers. It thus covers the socio-economic, financial and policy issues related to the situation of children. It pays special attention to the most vulnerable groups of children, pointing out disparities and analysing causes of inequalities.

The primary purpose of the situation analysis of children is to identify the country's challenges to fulfilling children's rights through the consolidation of useful information and analysis and to make corresponding recommendations for future policy direction, programmes and actions. Specifically, the recommendations provide a basis for decision-making and the selection of appropriate courses of action by UNICEF as well as by the Government on issues relevant to children. The situation analysis is also to be used as a resource for various parties working to promote children's and women's rights. It provides a baseline for measuring future progress in the realizing of children's rights.

The previous situation analysis for Myanmar was published in 1999. This 2012 situation analysis was prepared by UNICEF Myanmar in collaboration with Myanmar government partners over a period of more than one year, starting from October 2010.

The report draws on available data from the two most recent national surveys, the Multiple Indicator Cluster Survey (MICS) 2009–2010²¹ and the Integrated Household Living Conditions Assessment (IHLCA) 2009–2010²², along with published reports from government departments, United Nations agencies and NGOs. Anecdotal information corroborated from a number of sources has been included. Interviews and consultations were conducted with a wide variety of government and non-government actors. Finally, valuable direction and technical inputs were provided by a Technical Working Group, convened under the Ministry of National Planning and Economic Development, with representation from 25 government departments and offices.

The limitations of this situation analysis stem largely from data constraints in terms of reliability, availability and timeliness, although updated data is increasingly available from such national surveys as MICS and IHLCA. MICS in particular is the best source for the situation analysis because it provides data for children disaggregated by sex, region, household wealth level and educational level of the household head. It does not,

21 Ministry of National Planning and Economic Development, Ministry of Health and UNICEF, *Myanmar Multiple Indicator Cluster Survey 2009-2010*, Nay Pyi Taw, 2011.

22 Ministry of National Planning and Economic Development, UNDP, UNICEF, and SIDA, *Integrated Household Living Conditions Assessment, 2009-2010*, Nay Pyi Taw, 2011.

however, contain sufficient information on child protection or on adolescents and women. Another methodological constraint of the situation analysis is that the research process did not include specific consultations with women and children; instead, the analysis draws on available information on women's and children's perspectives and views from consultations conducted for other reports and analyses, some of which have not been published. Thus this report focuses mainly on children's rights. As noted, UNICEF is concerned about both children's and women's rights, and the two are closely connected. But due to limitations of space and information, women's issues are only discussed in the context of children's rights.

This situation analysis report comprises two parts. Part One examines children's rights in the Myanmar context. It looks at the core or structural factors influencing the fulfilment of children's rights such as the country's legal and policy framework, quality governance and poverty. Part Two focuses on specific children's rights: to health and nutrition; the right to water, sanitation and hygiene; to education; to be free of HIV; and to protection. Each chapter in Part Two begins with an overview of the situation in terms of rights (including trends), followed by a causality analysis (looking at both immediate and underlying causes) and duty-bearers' role and capacity analysis; it concludes with recommendations.

PART ONE: BASIC STRUCTURAL FACTOR IMPACTING THE REALIZATION OF CHILDREN'S RIGHTS IN MYANMAR

This section of the situation analysis report provides an overview of the Myanmar context for children as right holders while the duty bearers are responsible for the realization and protection of children's rights. The basic structural factors influencing the realization of children's rights include the general legal and policy framework for children's rights, quality of governance and economic performance, the country's demographic profile and trends, socio-cultural values and norms, poverty and humanitarian issues. These factors are common to all children's rights. Part Two examines in detail the individual rights – to health and nutrition, to water and sanitation, to education, to freedom from HIV and to protection.



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1. Constitutional and legal framework

Myanmar became a State Party to the Convention on the Rights of the Child (CRC) in 1991. However, the CRC does not have constitutional status in Myanmar, which means its provisions can be overridden in court by existing national rules and laws. This makes revision of all national instruments to ensure conformity with the CRC an important step to enable Myanmar to meet its obligations as a State Party.

The CRC has been manifested largely through the framework of Myanmar's Child Law and a National Plan of Action specifically developed around the CRC requirements. CRC implementation is overseen by the Ministry for Social Welfare, Relief and Resettlement. Myanmar's Second Periodic Report on progress in CRC implementation was submitted in 2004 and the combined Third and Fourth Periodic Reports were submitted in July 2009. The Child Law was developed as a step towards meeting Myanmar's obligations as a State Party to the CRC and enacted in July 1993, with additional Rules Related to the Child Law enacted in 2001 to strengthen compliance with the CRC. The Child Law affirms the State's recognition that "every child has the right to survival, development, protection and care and to achieve active participation within the community"²³. Implementation of the CRC and Child Law is overseen by a series of Committees on the Rights of the Child at national, state/region, district and township levels. However, the UN Committee on the Rights of the Child has noted concern that these committees are not fully operational.²⁴ Challenges include a lack of clear roles, responsibilities and awareness among committee members.

Additionally, there are areas of disagreement between the Child Law and the CRC. These include the restricted definition of the child (up to age 16 rather than 18), the minimal age of criminal responsibility (7 years of age with conditional judgement and based on maturity up to 12 years), no specific legal provision for minimum age of marriage and no explicit legal provision against corporal punishment of children (it allows for "admonition by a parent, teacher or other person having the right to control the child, which is for the benefit of the child"). The combined Third and Fourth CRC Periodic Report states the intention to change the age of childhood as up to 18 years, the minimum age of criminal responsibility to 10 years and of employment to 15 years,²⁵ but these changes have yet to be enacted.

The National Plan of Action for Children (2006–2015) was developed by the National Committee on the Rights of the Child to support commitments to the CRC, the MDGs and those outlined by the World Fit for Children initiative.²⁶ It covers key actions to be undertaken in health and nutrition, water and sanitation, education and child development, and child protection. However, the National Plan of Action has no dedicated resources to monitor progress and the extent to which it is achieving its aims has yet to be reviewed. The National Plan of Action is currently being revised, and the new draft is expected to include a social protection aspect reflecting the country's new commitment to poverty reduction.

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) was ratified by Myanmar in 1997. The First Periodic Report was submitted to the CEDAW Committee in 1999, followed by a combined Second and Third Report in 2006. The Ministry of Social Welfare, Relief and Resettlement, with the support of the Myanmar Women's Affairs Federation, leads in the implementation of the CEDAW. Myanmar's

23 *Convention on the Rights of the Child*, (Article 8, Chapter V).

24 Concluding Observations and Recommendations, 2004.

25 Union of Myanmar, *Third and Fourth National Report on the Implementation of the CRC*, Myanmar

26 *The National Plan of Action for Children (2006-2015)*

legal system is based on statutory laws but also customary law, case law and common law. Areas in which national legislation and customary laws may still discriminate against women include particular practices involving marriage, family relations, inheritance and citizenship.²⁷

Other international conventions relating to women and children acceded by Myanmar are the Convention Against Transnational Organized Crime, the Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children and the Protocol Against the Smuggling of Migrants by Land, Sea and Air.

Myanmar is fully committed to the Millennium Declaration and its eight Millennium Development Goals (MDGs), with targets set for 2015. MDG progress reports were provided in 2005 and 2006, and strategies for achievement of the MDG targets have been incorporated in the various national development plans prepared over the past five years. The most recent IHLCA report (2009–2010) also includes a publication dedicated to measuring progress towards the MDGs.

The 2008 Constitution of the Republic of the Union of Myanmar entered into force in late 2010 and reaffirms the state's responsibility to "promote socio-economic development including health and education" (Article 22) and strive for better living standards for its people with free basic education, health care, care for mothers and children, the disabled and orphans.²⁸ The Constitution guarantees the welfare of mothers and children: Article 32(a) provides that "the Union shall care for mothers and children, orphans, fallen Defence Services personnel's children, the aged and the disabled"; and section 351 states that "mothers, children and expectant women shall enjoy equal rights as prescribed by law".

²⁷ Concluding Observations of the Committee on the Elimination of Discrimination against Women, 7 November 2008.

²⁸ Article 345, Chapter VIII. Specified as those having parents who are both nationals or had obtained citizenship at the time the Constitution entered into force.

2. Quality of governance and economic performance

The political, economic and social objectives that guide Myanmar's development include the aim to build a developed nation with a market-oriented economy and to improve health and education standards.

a) Administrative and political set-up

Administratively, the country is divided into seven regions and seven states, which are further subdivided into 69 districts, 330 townships, 82 subtownships, 3,044 wards, 13,627 village tracts and 64,168 villages. The states lie around the country's perimeter and the regions are more centrally located. A total of 67 townships are designated as "border areas" and come under the administration of the Ministry for Progress of Border Areas and National Races. Special development assistance is allocated for these, mostly in the form of infrastructure projects. Many of these border townships are in 'special regions', which tend to have lower income levels, health status and access to services than other areas.

The State Law and Order Restoration Council assumed power in 1988 and was subsequently renamed the State Peace and Development Council (SPDC). Following national elections in November 2010, a new civilian government took office on 1 April 2011. The new government has been implementing a wide-ranging programme of reforms. The three branches of government – executive, judiciary and legislature – have been granted independence and a decentralized structure has been introduced. Subnational legislative and executive structures have been established. The ongoing changes towards decentralization offers the potential for improvement in women's and children's lives by ensuring that development plans and programmes reflect local needs and by addressing specific issues, such as land allocation and microfinance.

b) Economic performance

Myanmar's macro-economic performance is characterized by low GDP growth, high inflation rates, underdeveloped foreign exchange policy and limited fiscal space (public revenue collection), especially in comparison with other countries in the region. This macro-economic performance impacts directly on household economic well-being, which in turn has a direct impact on children's access to nutrition, health care, opportunities for education and access to safe water and good sanitation and their ability to fulfil their development potential.

Myanmar officially belongs to the group of 49 countries designated as 'least developed' by the United Nations due to its low socio-economic development indicators;²⁹ it is the lowest placed among the South-East Asian countries listed in the 2011 Human Development Index (149 of 179 listed countries). Myanmar's per capita gross domestic product of \$1,093 in 2009 was also the lowest among the ASEAN countries, trailing that of Cambodia (at \$1,802) and Lao People's Democratic Republic (at \$2,431).

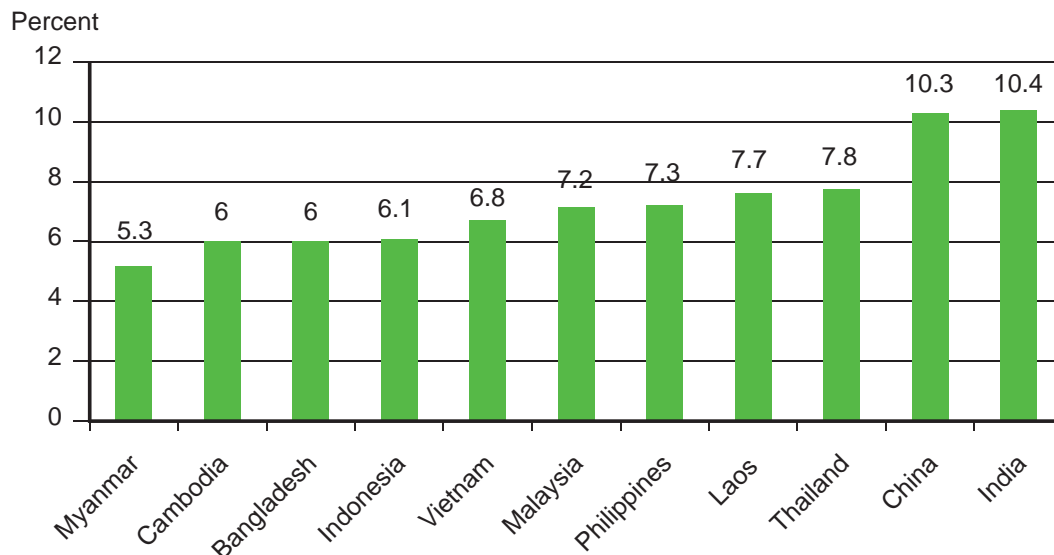
The latest available data, for 2010, projected economic growth of 5.3 per cent per year.³⁰ That put Myanmar

29 Key indicators are low-income, human resource weakness (based on indicators of nutrition, health, education and adult literacy) and economic vulnerability.

30 International Monetary Fund, *World Economic Outlook*, IMF, Washington D.C., USA, April 2011.

lowest among its neighbours in terms of economic performance (figure 1). Apart from low levels of GDP, the Myanmar economy is adversely affected by high inflation: the average annual rate of inflation from 2000 to 2008 was 24.9 per cent – more than five times higher than the average 4.5 per cent for 18 other Asian countries. High inflation places an additional burden on women and children. Growth is also hampered by limited transport and other infrastructure and by energy shortages.

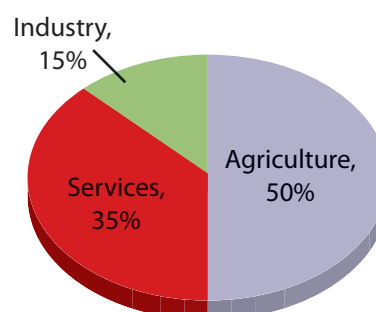
Figure 1: Comparison of growth of real GDP of Myanmar and its neighbours, 2010



Source: International Monetary Fund, World Economic Outlook. IMF. Washington D.C, USA, April 2011.

In terms of sectors, agriculture has retained a consistently large share of the economy for more than 50 years; by contrast, other countries in South-East Asia have experienced growth in industrial sectors.³¹ Some 17 per cent of the total land area is cultivated mainly for rice but also some export crops.³² Yields and long-term sustainability of the agricultural sector are threatened by degradation of land and decreasing soil fertility. As illustrated in figure 2, the second-largest sector in the Myanmar economy is services, accounting for around one third of GDP. These are mostly low-end services, such as trade, repairs and household-based activities. Tourism is a potential source of revenue and, after many years of stagnation, the number of foreign visitors recently increased.

Figure 2: GDP composition, by sector



Source: Organisation for Economic Co-operation and Development, Aid for Trade 2009, OECD, Paris, France

31 U Myint, *Myanmar Economy: A comparative view*, Asia Paper, Institute for Security and Development Policy, Stockholm, December 2009.

32 Ministry of National Planning and Economic Development, Central Statistics Organization, *Statistical Yearbook 2008*, Myanmar 2009

Industry accounts for only 15 per cent of GDP, and 6 per cent of employment, despite the Government's efforts to promote industrialization. These shares have increased only marginally over the past 60 years, confirming that the structural transformation from agriculture to manufacturing and services experienced in neighbouring countries has not yet occurred in Myanmar.³³ In terms of international trade, Myanmar has made moves towards becoming a market economy and is a member of ASEAN and the World Trade Organization. However, its trade volume per capita is still lower than those of other ASEAN members, which launched their drive towards market economies at almost the same time as Myanmar.³⁴ Exports are mostly to Thailand (44 per cent of export earnings in 2006), with smaller amounts to China and India.³⁵ The estimated 2 million migrant workers living outside Myanmar also contribute to the economy. Official registered remittances reached \$125 million in 2007,³⁶ while unofficial remittance flows have been estimated at \$300 million annually.³⁷

Due to international sanctions, overall levels of foreign direct investment, including overseas development assistance (ODA) have remained modest. Sanctions have hampered the kind of foreign direct investment that could boost manufacturing productivity and employment – and contributed indirectly to the reliance on unsustainable extraction of natural resources (including forests, fisheries and minerals) and the exploitation of offshore oil and gas.

Despite its relatively limited external trade and low external investment, Myanmar has not been completely immune to the impact of global downturns. Investment fell sharply between 1998 and 2004 due largely to the impact of the Asian financial crisis on investors,³⁸ while the 2008–2009 global financial crisis led to a decrease in natural gas exports and remittance inflows due to the lower economic activity in migrant-receiving countries.³⁹ Crises such as natural disasters also have had a major impact on the economy, particularly given its heavy emphasis on agriculture. Cyclone Nargis, which devastated large tracts of agricultural land in 2008, resulted in economic losses estimated at about 2.7 per cent of GDP⁴⁰ (see Chapter 6: Humanitarian issues). A survey in 2006–2007 found more than two thirds of the population older than 15 years to be economically active, with higher rates among males than females (84 per cent compared with 60 per cent).⁴¹ The IHLCA 2009–2010 found that relatively more poor household members were economically active than non-poor household members, suggesting that poverty was not due to economic inactivity but to low returns on economic activities. This was true even for poor households in urban areas.

In terms of type of economic activity, more than half of the working population is employed in agriculture. Rural women are most likely to be working in the agriculture sector, whereas the services sectors are the main employers of women in urban areas. Some 54 per cent of the poor and 40 per cent of the non-poor were engaged in agricultural activities. However, the poor whose primary economic activity was agriculture

33 U Myint, Myanmar Economy: A comparative view, Asia Paper, Institute for Security and Development Policy, Stockholm, December 2009.

34 Kudo, T. et al., Institute of Developing Economies, *Trade, Foreign Investment and Myanmar's Economic Development During the Transition to an Open Economy, Discussion Paper No. 116*, Japan, August 2007.

35 U Myint, Myanmar Economy: A comparative view, Asia Paper, Institute for Security and Development Policy, Stockholm, December 2009.

36 United Nations Development Programme, *Human Development Report 2009*, UNDP, New York, 2009.

37 Turnell, S. et al., *Migrant Worker Remittances and Burma: An economic analysis of survey results*, Macquarie University, Sydney, Australia, 2008.

38 Kudo, T. et al., *Trade, Foreign Investment and Myanmar's Economic Development During the Transition to an Open Economy, Discussion Paper No. 116*, Institute of Developing Economies, Japan 2007.

39 *Country report of the ASEAN Assessment of the Social Impact of the Global Financial Crisis*, 2010

40 Asian Development Bank and Government of Myanmar, *'Fact Sheet'*, ADB, Manila, 31 December 2009.

41 In focusing on income-based activities, this particular index does not reflect those engaged full time in home-based domestic activities (generally women), or voluntary engagement in charitable and religious services.

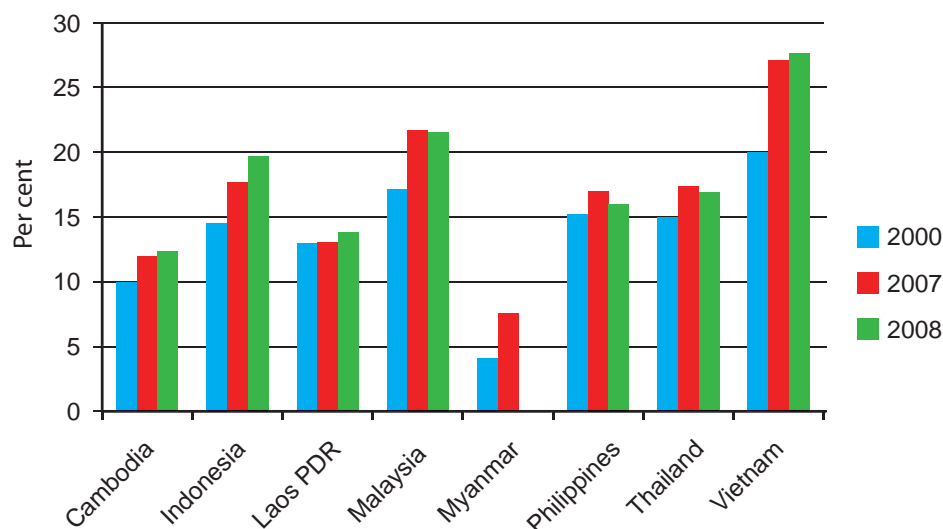
(32 per cent) were more likely to be landless compared with the same group among the non-poor (19 per cent); if they owned land, the average holding (4.4 acres) was smaller than those of non-poor households (7.3 acres).⁴²

Casual labour, which has an adverse impact on household vulnerability, increased for the poor, from 23 per cent in 2005 to 28 per cent in 2010, suggesting that their employment had become less stable, organized and secure. Moreover, total debt levels among the poor were high, at 14 per cent of total consumption expenditures; food expenditure accounted for up to 74 per cent.

c) Social sector spending

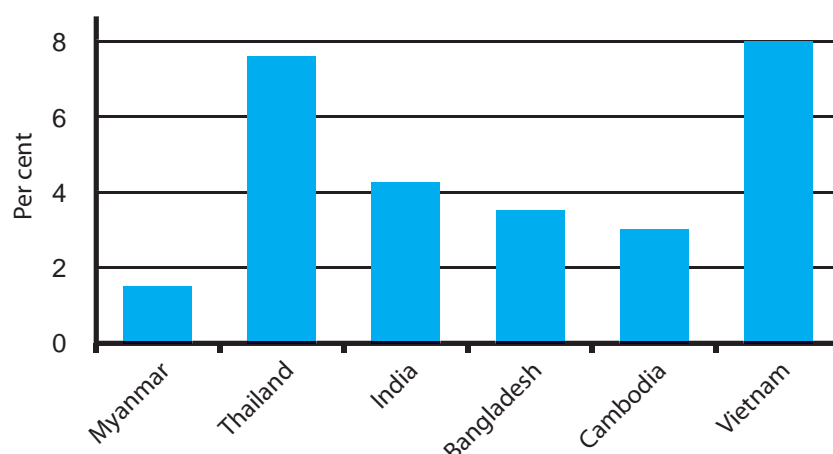
The achievement of women's and children's rights is critically dependent on the allocation of resources for social services and other sectors promoting development and opportunities. As discussed in the previous section and highlighted in figure 3, Myanmar has very limited fiscal space (despite increasing revenues from increased gas exports in the past few years). This in turn is reflected in the public social sector spending; in terms of GDP, this is currently the lowest among the ASEAN nations (figure 4). An estimated 1.5 per cent of GDP was devoted to health and education between 2000 and 2007. This was far short of the 8.1 per cent of GDP spent on those sectors in Viet Nam and even less than the 3.1 per cent expenditure in Cambodia. Despite an almost doubling of the amount allocated to the social sectors in the state budget between 2003–2004 and 2008–2009, inflation over this period discounted any real gains.

Figure 3: Comparison of government revenue as a percentage of GDP



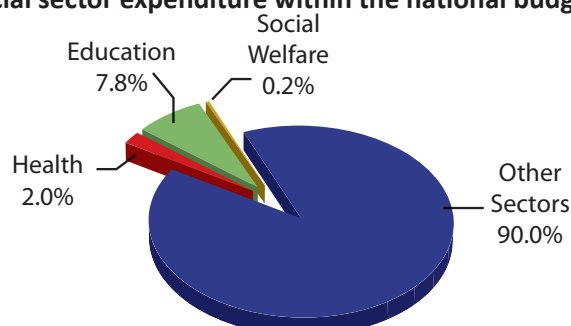
Source: UNESCAP, 2009.

42 Ministry of National Planning and Economic Development, UNICEF, UNDP and SIDA, *Integrated Household Living Conditions Assessment, 2009-2010*, Yangon, 2011.

Figure 4: Health and education expenditure in select ASEAN countries as % of GDP, 2000–2007⁴³

Source: The Real Wealth of Nations: Pathways to human development, Human Development Report, UNDP, New York 2010.

Public social sector allocations (health, education and social welfare) formed 10 per cent of the 2009–2010 state budget (figure 5). Education accounted for the majority (78 per cent) of the budget, with far smaller amounts dedicated to health (20 per cent) and very little to social welfare (2 per cent).⁴⁴ The public expenditure allocation for health meets only around 10 per cent of the overall health needs and is not sufficient for staffing the Department of Social Welfare.

Figure 5: Social sector expenditure within the national budget, 2009–2010

Source: Public expenditure data provided by the Planning Department, November 2010

Another factor contributing to the limited fiscal space for social sector spending is that Myanmar receives very low levels of overseas development assistance. Its per capita ODA in 2007, at \$4, was the lowest in South-East Asia. The input grew dramatically in 2008 with the humanitarian response to Cyclone Nargis (\$533 million)⁴⁵ but has since dropped and appears to be returning to pre-Nargis levels as the projects come to a close. The main contributing countries in 2006–2007 were Australia, Japan and Republic of Korea.⁴⁶ In 2008, the social sector received 24 per cent of the country's ODA.

There is discussion ongoing on increasing the overall social sector budget among policymakers. However, without substantial improvement in the overall economy and government revenues, resource allocations for social sectors will remain small. Option to increase fiscal space include a more effective taxation system and increased revenue from natural resources extractions.

⁴³ United Nations Development Programme, *The Real Wealth of Nations: Pathways to human development, Human Development Report*, New York 2010.

⁴⁴ Public expenditure data provided by the Planning Department, November 2010.

⁴⁵ World Bank, 'World Development Indicators', Washington, D.C., last updated 19 November 2010.

⁴⁶ OECD DAC. *Aid for Trade at a Glance Myanmar 2009* <http://www.oecd.org/dataoecd/23/25/43195110.pdf>

d) Service delivery challenges

The relatively low public resource allocation for the social sectors has an impact on the availability and quality of services in Myanmar.

In terms of service facilities or infrastructure (such as buildings, equipment and supplies), there are areas in the country where these are either not available, or are not of adequate standard. The number of schools, for example, is insufficient for the population's needs. Schools rely extensively on community contributions for primary school buildings and maintenance – meaning that poorer communities face great difficulty in ensuring quality facilities for their children. Financial constraints are frequently cited by Township Education Officers as barriers to the adequate provision of functioning latrines and clean drinking water in schools. There are no social welfare offices below township level, – and these are in only a fraction of the country's townships. There are scant services for women and children in need of social welfare services.

Regarding personnel, there are small numbers of providers – and even fewer trained providers. Social welfare, in particular, traditionally has not been a priority, and there were less than 10 university-trained social workers in the country in 2005. The number of doctors and nurses per thousand people has not changed significantly since the early 1990s.⁴⁷ Capacity development requires investment in staff training – something made difficult by scant resources. Thus township education officers, for example, have broad responsibilities for educational planning and management but have limited skills in planning, budgeting and monitoring. Salary levels in the public sector are also poor, providing little incentive to perform well.

In addition to limited resources, social sector service delivery in Myanmar is hampered by a number of factors. In many sectors, implementation responsibility is disbursed among multiple agencies; coordination among them needs to be improved. For example, there are 13 ministries involved in running educational institutions. Each has its own budget and programmes, but there is no overall education budget. Even within the Ministry of Education, each department has its own functionally independent budget. Such wide distribution of responsibility makes coordinated action difficult, in turn undermining efficiency and effectiveness. Effective policymaking, planning and management requires accurate, updated data on development indicators, needs, service facilities and human resources in different parts of the country. The mechanisms for regular administrative data collection and analysis, however, are weak. Although there is a national information management system in various sectors reporting regularly, the quality and utilization of data can be significantly improved.⁴⁸ The Multiple Indicator Cluster Survey (MICS) 2009–2010 and the Integrated Household Living Conditions Assessment (IHLCA) 2009–2010 have provided very useful survey data, both on overall trends (as compared with the previous MICS and IHLCA rounds) and on regional, urban–rural, gender-based and other disparities. But there remains considerable scope for improvement in this area.

Effective planning also requires a long-term perspective, aligning short- and medium-term goals and programmes with a broader strategic vision. This long-term outlook is not always evident in Myanmar. A key education goal of the government, for example, is to expand quality ECD, but ECD services are not included in either the Strategic Plan for Child Health Development 2010–2014, the Myanmar Health Vision 2030 or the 30-Year Basic Education Plan.

⁴⁷ See levels of human resources for 1990–1991 and 2007–2008 in the health section.

⁴⁸ MOH/UNICEF, the data dictionary for Health Management Information System.

All these factors contribute to poor organization and management of service delivery. In the health sector, for example, production and procurement sources for essential drugs are variable but inconsistent, and the distribution of those drugs and the management systems are too centralized to be effective. A general challenge in the public sector is that accountability mechanisms are weak, so officials face little scrutiny over how they perform (or fail to perform) their duties.

Box 1: Role of non-state providers in service delivery

The capacity of the public sector service delivery to ensure children's rights, such as access to health and education, is limited to some extent, due to the limited public spending on such services. In this context, non-state providers are seen as having the potential to have a significant role in filling the gap in delivery in basic services, especially for poor and marginalized children.⁴⁹ Non-state providers are major contributors to service provision in health – greatly outweighing state-supported services – and in establishing safe water sources (mainly through private donations), proper sanitation (providing affordable materials for latrines) and education (providing private schools and tuition). Despite this, there are only limited public–private partnerships relating to the provision of support for women and children. Non-state providers also have an important role in the realization of the rights of women and children by generating employment and monitoring the availability and pricing of essential commodities.

A 2003⁵⁰ study found that an estimated 270 national NGOs and 200,000 community-based organizations were operating throughout the country, providing services and safety nets for the most vulnerable. Local NGOs were mainly implementing welfare and charity-type initiatives, while the community-based organizations were more likely to be faith-based and supporting religious, welfare and education activities. Some ceasefire groups and their affiliates have also formed NGOs to deliver development services in their areas. Civil society groups and the private sector contributed a major role in the provision of relief and ongoing support following Cyclone Nargis⁵¹ (see Chapter 6: Humanitarian issues).

Civil society organizations in Myanmar tend to be localized and issue-based, with strong commitment but limited skills, knowledge and experience. The quality of services provided varies widely, with often poorly trained voluntary workers and outdated methods.⁵² There is a growing number of formally recognized local NGOs – 82 were registered in 2009,⁵³ which tend to be more developmental in approach. These include a number of organizations created by the Government to implement particular activities, such as the Myanmar Women's Affairs Federation and the Myanmar Maternal and Child Welfare Association. There are far fewer international NGOs in Myanmar, although the numbers of them grew significantly in response to Cyclone Nargis as well as the opening up of the country. Strategic partnerships with NSPs are essential to reach poor and marginalized children in effective and efficient ways, and thereby ensure equity and quality. This can reduce the logistical and financial burden on the public sector. However, a legal and regulatory framework needs to be developed to assure the responsibilities and roles of the state.

49 UNICEF East Asia and Pacific Regional Office and Asian Development Bank, *The Role of Non-State Providers in Delivering Basic Social Services for Children, Workshop Report*, Philippines, April 2010.

50 Heidel, Brian, *The Growth of Civil Society in Myanmar*, Save the Children, 2006

51 Government of Myanmar/UN/ASEAN, *Post-Nargis Joint Assessment Report*, Yangon, 21 July 2008.

52 Lorch, Jasmin, Myanmar's Civil Society, *The Emergence of Civil Society in Areas of State Weakness*, E Press 2007

53 LNGO in Myanmar and Save the Children. *Local Non-Government Organization (LNGO) Directory 2009*, Yangon 2009

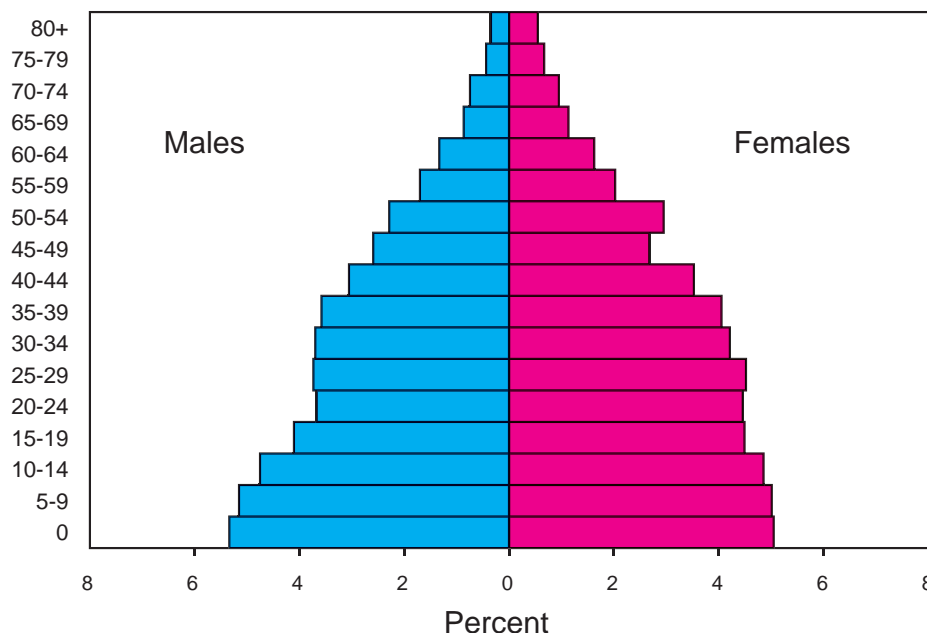
3. Demographic profile and trends

Key demographic traits in Myanmar – falling fertility rates, ethno-linguistic heterogeneity and high levels of migration – all influence the realization of children’s and women’s rights in the country.

a) Population size and growth

The population of Myanmar was estimated to be 58.38 million in 2008, of which about 35–40 per cent was between 0 and 18 years old⁵⁴ – an increase of 65 per cent since the last census in 1983.⁵⁵ The population is expected to reach 66 million by 2020.⁵⁶ The vast majority of people live in the central regions, with significantly fewer in outlying areas. The urban population is limited compared with neighbouring countries but has grown from 25 per cent in 1990 to 34 per cent in 2009⁵⁷, the result of natural population growth, net immigration and also the reclassification of 64 heavily populated rural areas as sub-townships.

Figure 6: Age and sex distribution of household population, 2009–2010



Source: MICS, 2009–2010

In terms of age profile, Myanmar is seeing a trend towards an older population, with fewer children and more people of working age. Close to a third of the population is younger than 15 years (18.9 million, or 32.2 per cent),⁵⁸ and a quarter are women and girls of reproductive age (14.8 million)⁵⁹ (figure 6). The shift in popula-

⁵⁴ The estimation of number of children (0–18) is based on data of the Statistical Yearbook 2009, Ministry of National Planning and Economic Development, Central Statistical Organization, Nay Pyi Taw, 2010 and Township Health Profile, 2008.

⁵⁵ The Government plans to conduct a census in 2014.

⁵⁶ United Nations Population Fund, Report on Situation Analysis of Population and Development, Reproductive Health and Gender in Myanmar, UNFPA, Bangkok, 2010.

⁵⁷ United Nations Development Programme, *Human Development Report 2009*, USA, 2009

⁵⁸ Data provided by the Central Statistical Organization, November 2010. *The 2007 Fertility and Reproductive Health Survey* estimates the number of children under 15 years at 28.3 million.

⁵⁹ Around 50 per cent of the female population, of 29.4 million, in 2008 were aged 15–49 years. Statistical Profile of Children and Women in Myanmar 2009, Central Statistical Organization, Ministry of National Planning and Economic Development, Nay Pyi Taw, 2010.

tion age profile is due to significant reductions in fertility rates and, to a lesser extent, mortality. Fertility rates almost halved as of 2007, dropping to an average of 2.03 births per woman of reproductive age⁶⁰ from 4.7 in 1982–1983.⁶¹ However, because most births take place within marriage and many women remain unmarried, the average number of births per married woman is actually 4.7.⁶² Furthermore, there are significant variations across states and regions.⁶³ Women in rural areas and with limited education consistently have more children on average than those in urban areas and with higher education. The highest number of births are to women aged 25–29 years, although there are still significant numbers of births among girls younger than 18 years (10 per cent), and 1.5 per cent of women have had a child before the age of 15 years.⁶⁴ Life expectancy for men and women increased from 57 years and 61 years, respectively, in 1991 to 63 years and 66 years, respectively, in 2007.⁶⁵

b) Ethno-linguistic diversity

Myanmar is one of the most ethnically diverse countries in Asia. The country's 135 ethnic groups are clustered into eight main groups, the largest of which are the Bamar (69 per cent of the total population), who are situated mainly in the plains and river valleys of the central and delta regions and lower parts of the country. Among the others: the Shan (8.5 per cent) live mainly around the Shan plateau in the frontier states bordering Thailand, Lao PDR, China; the Kayin (6.2 per cent) live mainly in the south-east and Ayeyarwaddy Delta; the Rakhine people (4.5 per cent) are found mainly in the western coastal region; the Mon (2.4 per cent) live in the southern part of the country; the Chin (2.2 per cent) live in the western mountainous regions; the Kachin (1.4 per cent) in the upper north; and the Kayah (0.4 per cent) live in the eastern hilly region.⁶⁶ Each group has its own language or dialect and observes particular customs and traditions.⁶⁷

In all, more than 100 languages and dialects are spoken across Myanmar. Myanmar (Burmese) is the most widely spoken language, with approximately 32 million native speakers, and is a second language for a further 10 million people.⁶⁸ Language does not equate to ethnic identity, however, and several languages may be spoken within a single ethnic group. In terms of religious belief, the population is predominantly Buddhist (89 per cent), with around 5 per cent Christian, 4 per cent Muslim and the remainder from animist and other religions.⁶⁹

The wide diversity of ethno-linguistic groups in Myanmar poses particular challenges for service delivery and access to development opportunities. This is exacerbated by long-standing ethnic conflicts (see Chapter 6: Humanitarian issues).

60 United Nations Population Fund, *Report on Situation Analysis of Population and Development, Reproductive Health and Gender in Myanmar*, Bangkok, 2010.

61 Ministry of National Planning and Economic Development, Central Statistical Organization, *Statistical Yearbook (2009)*, Nay Pyi Taw

62 United Nations Population Fund, *Report on Situation Analysis of Population and Development, Reproductive Health and Gender in Myanmar*, Bangkok, 2010.

63 The highest was in Rakhine State (2.87) and the lowest was in Mandalay Region (1.69)

64 Ministry of Immigration and Population and United Nations Population Fund, *Country Report on 2007 Fertility and Reproductive Health Survey*, Yangon, 2009.

65 Ministry of Immigration and Population and United Nations Population Fund, *Country Report on 2007 Fertility and Reproductive Health Survey*, Yangon, 2009.

66 1983 Population Census.

67 Myanmar's colonial inheritance and its myriad ethnic groups have resulted in a prolonged conflict in some border areas with armed insurgent groups. Myanmar's government has entered into ceasefire agreements with 17 insurgent groups, allowing them to resettle and self-administer their respective areas.

68 Lewis Paul, *Ethnologue: Languages of the World*, 16th ed., SIL International, USA, 2009.

69 1983 Population Census.

c) Migration

The levels of population migration in Myanmar are substantial, mostly for economic reasons. This is despite restrictions on movement even within the country (stemming from the requirement for registration cards to access long-distance transport services). A 2001 survey indicated that 17 per cent of the population were migrants, concentrated more in urban than rural areas (38 per cent and 9 per cent, respectively).⁷⁰ This does not include the large numbers of seasonal workers and sometimes entire families who leave their villages in periods where there is no agricultural income to work in gem, gold or jade mines or to collect non-timber forest products, such as rattan and bamboo. There is also movement among people displaced from their homes by natural disasters, conflict and relocation to make way for large-scale development and infrastructure projects.

Internal migration tends to be highest among young adults of both sexes who move to larger centres for employment opportunities. Patterns of movement vary with the opening of new projects and opportunities. A study in 2004⁷¹ found a third of such migration to be rural–rural, seeking seasonal agricultural or industrial work, while a further third was from towns to larger urban centres. Movement from rural to urban environments accounted for just 22 per cent of total migration, although in-migration to Yangon continues to be significant; in 2001, there were more than 220,000 registered new migrants, with likely many more unregistered.⁷² Overall, there is little detailed data on changing internal migration patterns and none on migration patterns of children. Anecdotal information indicates that numbers may be increasing.

Unknown thousands more, including women and children, have migrated across the country's porous borders to China, India and Thailand, with many sending remittances to support struggling families in Myanmar. Thailand was home to an estimated 2 million Myanmar migrants in 2008,⁷³ although only 486,000 workers were formally registered with the Thai authorities.⁷⁴ On average, migrants were found to be sending home 38 per cent of their foreign earnings, with 96 per cent of receiving families reportedly using this income for basic survival needs.⁷⁵

Such a highly mobile population has immense repercussions on, among others, women and children's access to health services, nutrition and exposure to potential abuse. Similarly, children's welfare and development opportunities are likely to be compromised due to separation from migrating family members and/or their own migratory patterns.

70 Ministry of Immigration and Population and United Nations Population Fund *Myanmar Fertility and Reproductive Health Survey 2001*, Yangon 2002

71 As drawn from the 2004 Family and Youth Survey; see United Nations Population Fund, *Report on Situation Analysis of Population and Development, Reproductive Health and Gender in Myanmar*, UNFPA, Bangkok, 2010.

72 Government of Myanmar and UNFPA, *Myanmar Fertility and Reproductive Health Survey 2001*, Yangon 2002

73 IOM Regional Thematic Working Group on International Migration, Including Human Trafficking Situation Report on International Migration in East and South East Asia, Bangkok, 2008.

74 *ibid*

75 Turnell, S. et al., *Migrant Worker Remittances and Burma: An economic analysis of survey results*, Macquarie University, Sydney, Australia, 2008.

4. Socio-cultural values and norms

As in other countries, many social and cultural norms and values in Myanmar influence the realization of children's rights. Attitudes towards children, for example, make little allowance for the need for play and recreation. Children are expected to study hard and/or work hard (including domestic chores). This is reflected in traditional teaching methodologies in schools, which stress learning by rote and discipline. There is widespread acceptance of working children, fostered in large part by poverty and the need for extra income. Many poor families, in which parents lack education themselves, value work above education for their children. There is little evidence of children's participation in decisions affecting them, in service provision (such as in schools), in their communities or in the wider policy domain.

Myanmar society is generally patriarchal; men are the main income-earners and the main decision-makers. A qualitative study⁷⁶ across five regions found that both men and women believed the man should be the family breadwinner. Women were expected to maintain the household and care for children and the elderly whether or not they also work outside the home, although men were found to provide extra support to cooking and child care when their wives were ill or pregnant. Women's involvement and consultation in household decision-making was found to be limited, particularly in rural environments, with most women having to request their husband's permission to vary their daily routines. There was an expectation among men and women that a husband's needs and wants should come first.⁷⁷

Attitudes to women are strongly underpinned by religious beliefs. Myanmar's Buddhists believe that males have religious superiority over females, in turn influencing social norms, cultural traditions and opportunities accorded to women and girls. Similarly, the Christians and Muslims see men and women as having different roles, with the wife generally obeying the husband as the head of the family. Some groups are considerably more conservative; for example, among some Muslim groups in Rakhine State, women cannot leave the house without a male relative.

Personal affairs such as marriage, divorce and inheritance tend to be governed by customary law. The traditional and legal system allows men to take more than one wife although this appears to be rarely practised. Customary law allows a woman aged 18 or older to marry without parental permission, while girls younger than 18 years require the consent of parents/guardians. Interpretations of this vary across the ethnic and religious groups. Buddhist law allows boys from puberty to marry without parental consent, while the Christian Marriage Act allows the marriage of girls from 13 years and boys from 16. In practice, it is relatively common for girls to marry in their teens. The practice is more common among some cultures than others: MICS 2009–2010 indicates that 7 per cent of young women and girls aged 15–19 are married, with the percentage reaching 22 per cent in Shan (East).⁷⁸

76 Smith, R. *The Hen is Crowing: A Gender Impact Study of two UNDP Myanmar Community Development Programmes*. 2006

77 However, analysis of cyclone-affected households in the Delta region found decision-making to be largely divided by sphere, with decisions regarding children's schooling, off farm work and borrowing made jointly by the husband and wife, whereas women often controlled household finances and men controlled the larger farm expenditures.

78 There are other disparities in early marriage. Girls and young women in rural areas are slightly more likely to be married than their counterparts in urban areas. Likewise, young women with primary education only (12 per cent) are more than twice as likely to be married as young women with secondary or higher education (5 per cent), although the difference in educational level could also be a consequence of the early marriage. Girls and young women in the poorest households (9 per cent) are also more likely to be married than their peers in the richest households (4 per cent). See MICS, 2009–2010.

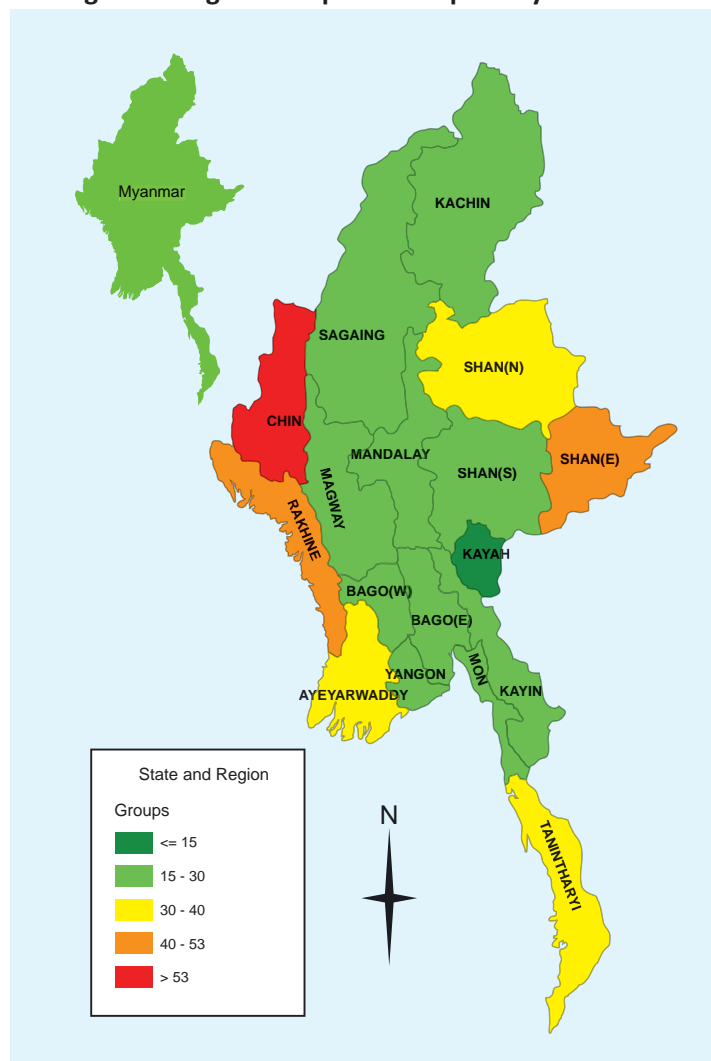
Similar variation is seen in relation to ownership and inheritance. Rights to property ownership, bank loans and inheritance are equal for women under Buddhist law, but this is not always the case among other ethnic groups: Chin women, for example, are unable to inherit property. In the event of divorce, custody of boys is commonly awarded to the father and of girls to the mother whereas very young children, regardless of sex, are usually placed in their mother's care. One fifth of Myanmar's households are headed by women, more so in urban than rural areas. This seems to be due to children tending to remain with the mother after separation or divorce whereas widowed or separated men are more likely to remarry quickly or leave their children with relatives. Men are also more likely than women to migrate to other areas for work, leaving their wives to care for the family.

5. Poverty

a) Household expenditure poverty

Data from the IHLCA 2004–2005 and 2009–2010 show that the proportion of people living in poverty in terms of household expenditure fell from 32 per cent to 26 per cent. The proportion of food-poor fell 6 percentage points, to 5 per cent, meaning they had insufficient income at the household level to cover their basic food needs.⁷⁹

Figure 7: Regional disparities in poverty incidence



Source: IHLCA, 2009-2010

Although an overall drop in poverty is reported, there are huge regional and other disparities in both poverty rates and trends; indeed, there are some regions in which poverty rates increased (figure 7). Rural households were poorer in terms of both household expenditure and food. In terms of regions, the highest levels of poverty incidence were found in Chin (73 per cent) followed by Rakhine (44 per cent), Tanintharyi (33 per cent), Shan (33 per cent) and Ayeyarwaddy (32 per cent). When considered by population share, Ayeyarwaddy accounted for 19 per cent of the overall poverty incidence in Myanmar, followed by Mandalay (15 per cent), Rakhine (12 per cent) and Shan (11 per cent).

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The food poverty line represents the amount of food required to meet the typical caloric requirements and it assumes that all household income is spent on food.

As well as major regional disparities, poverty dynamics in Myanmar are characterized by a higher proportion of transitory than chronic poverty – 28 per cent and 10 per cent of households, respectively. This means that while some households escaped poverty between 2005 and 2010, others fell into poverty or remained poor. When those escaping poverty between 2005 and 2010 are taken into account, the two IHLCA survey rounds found that 38 per cent of the population were poor in 2005 and/or in 2010. There is no formal coordinated social protection mechanism to protect poor children and families, to prevent families from falling into poverty or to help move them out of poverty. Only a small proportion of government workers are covered by the current formal social security system. Although the inter-agency working group for social protection of children has been actively advocating a social protection policy as well as social protection strategies since 2009, no concrete action has been suggested by the Government yet. Following the establishment of the poverty reduction and rural development strategies unit under the President's Office, it is expected that social protection will be linked with poverty-reduction strategies.

b) Poverty and development outcomes

Poverty often results in people being deprived of access to basic goods and services. It is directly correlated with low levels of health and education, limited access to clean water and sanitation, inadequate physical security, lack of voice and insufficient capacity and opportunity to better one's life. Because of children's higher dependence and vulnerability, poverty affects them more adversely than adults. Poverty in childhood can cause lifelong cognitive and physical impairment. The impact of poverty in childhood can be irreversible, leading to children becoming permanently disadvantaged and thereby perpetuating the cycle of poverty across generations.

Children from poor households in Myanmar grow up in a different socio-economic environment to those from non-poor households. The average number of members in poor households was 6 compared with 4.7 people in non-poor households as of 2009-2010. Housing conditions were worse for the poor; just 32 per cent of poor households had a roof of adequate quality, compared with 59 per cent of non-poor households, and they were less likely to use clean water or have an improved sanitation facility. Particularly pronounced were differences in access to electricity: 28 per cent among poor households versus 55 per cent in non-poor.⁸⁰

Both IHLCA (2009–2010) and MICS (2009–2010) data show a clear correlation between poverty and MDG outcomes. For example, according to the IHLCA, children and youth from poorer households fared markedly worse than those from richer households. According to MICS, 33.1 per cent of the poorest children are underweight compared with only 13.5 per cent of the richest children. Women from the poorest households were less likely to have their births attended by skilled health personnel than those from the richest households (51 per cent versus 96.1 per cent) and to have their babies delivered in a health facility (12.4 per cent versus 77.5 per cent). Children and women in poor households are disadvantaged in health status as well as access to essential services.

There is ample further evidence that poverty undermines children's development, contributing to their not enrolling in or dropping out of school, the preponderance of them working, their inability to access health services and their increased vulnerability to exploitation. Primary education in Myanmar is supposed to be free, but in practice there are multiple charges that parents must pay (enrolment fees, textbooks, stationery,

80 Ministry of National Planning and Economic Development, UNDP, UNICEF, and SIDA, *Integrated Household Living Conditions Assessment 2009-2010*, Yangon, 2011.

uniforms, exam fees, etc.). Nearly 30 per cent of school-aged children in 2009 did not attend school at all because of the cost burden.⁸¹ In many areas, health facilities are not available; but even where they are, most families are expected to pay for medicines, surgical supplies and laboratory tests in addition to the high cost of transportation. The costs involved are a barrier to timely referral and appropriate care, particularly for the rural poor. Families experiencing catastrophic health payments have a high risk of falling into poverty as they resort to informal coping mechanisms, such as borrowing from money lenders, selling assets, cutting food intake or even withdrawing children from school. This highlights the need to establish formal social protection mechanisms to protect children and families.

A 2006 UNICEF/Department of Social Welfare study of working children found they were generally from poor families who relied on poorly paid and unstable casual, seasonal or unskilled jobs; and many were from households that had migrated from their home towns in search of work. The children's income was often a critical support for the family's survival – 60 per cent of children considered that their families would have less food without their work, whereas the removal of a single child's income would mean no food at all for one in 10 households. Children's work also was found to often contribute to repaying the high levels of daily interest accrued because of the family debts. Most of the working children had started school but dropped out before completing the primary level due to an emergency or event in the family that required extra cash, and they rarely resumed their schooling.

81 U Tin Nyo, Education and Vocational Training Issues and Strategies, Myanmar, Background paper for policy options, Yangon, 2011.

6. Humanitarian issues

The humanitarian situation remains dire for many children and women across Myanmar. The underlying cause is the high level of poverty among primarily the rural population. A number of factors accentuate their vulnerability, including the low coverage of basic services in the hard-to-reach and typically mountainous and remote areas of the country; the long-standing conflicts in border areas inhabited by ethnic minorities and the frequency and intensity of natural hazards.

a) Hard-to-reach areas

Some of the most vulnerable women and children in Myanmar with the greatest humanitarian needs are those living in the hard-to-reach areas, which are remote, inhabited by ethnic minority groups, often affected by protracted conflict (since the country's independence in 1948) and have poor coverage of basic social services, including education and health.

The recently published MICS shows that basic services coverage (antenatal care, institutional deliveries, pre-school and primary school) in states/regions with significant hard-to-reach areas, such as Chin, Sagaing, Kayah and Northern Rakhine State, are considerably lower than in other parts of the country, resulting in a higher illiteracy rate and higher infant, child and maternal mortality rates.⁸²

The low standard of social service delivery is a result of both access and quality issues. Access is made difficult due to geographic remoteness and the mountainous nature of the border areas, combined with security and infrastructural challenges caused by the protracted conflict in many of the areas. Quality of social services suffers in the hard-to-reach areas because of the limited resources (both human and financial) allocated to them, difficulties in attracting and maintaining quality service providers to areas of hardship as well as the disruption of social services due to conflict/security concerns.

The humanitarian needs in the hard-to-reach and conflict-affected areas are compounded by the very limited humanitarian access granted to the international humanitarian community. It is hoped that the recent access granted to areas controlled by the Kachin Independence Organization in the conflict-affected Kachin State will set a precedent to the international humanitarian community – under its humanitarian principles – to be allowed increased access to affected civilians in any conflict-affected area.

As in other situations, children in displacement are particularly vulnerable, having few or no means to sustain their livelihood over time. They are particularly vulnerable to illnesses and diseases caused by temporary and substandard living conditions and their lack of access to basic social services, while children in displacement are often at risk of missing out on education. Women and children displaced may also lack the basic protection mechanism that the social ties in a local community typically offer. Although their conditions are not well documented, due to reasons of access, it is generally understood that their heightened vulnerability exposes them to a range of protection-related risks, including abuse and human trafficking. The short-term humanitarian assistance to conflict-affected ethnic civilians would need to be combined with longer-term development support in these areas.

⁸² The discrepancy between the actual hard-to-reach areas and the national average may yet be greater than the survey suggest because many of the most remote areas could not be included in the survey precisely due to reasons of access and remoteness.

As for the stateless Muslim population in the northern Rakhine State, there has been limited social investment and protection for this group over time, making them one of the most vulnerable people with the greatest humanitarian needs in the country. They face unique challenges that undermine the well-being of children and women, including the deprivation of citizenship and the restriction of mobility to pursue education or economic opportunities.

b) Natural disasters

Myanmar is prone to natural disasters on a frequent and increasing basis and is vulnerable to the effects of climate change, which affects socio-economic progress. The coastal regions are exposed to cyclones, tropical storms and tsunamis, while the hilly regions are exposed to landslides. Rainfall-induced flooding is a recurring phenomenon across the country, and except for Tanintharyi Region the whole country is at risk from earthquakes.

Cyclone Nargis, which hit the Ayeyarwaddy Delta in May 2008 and left 138,370 people dead and affected a further 2.4 million people, was by far the largest natural disaster in the recent history of Myanmar. There have since been frequent small- to medium-scale natural hazards, including floods, landslides, rat infestations, heat waves and earthquakes; with Cyclone Giri that hit Rakhine State in October 2010 having the most devastating impact, destroying more than 21,000 houses and affecting at least 224,000 people.

Natural disasters and the negative effects of climate change hit the poorest and the most vulnerable the hardest, partly because they are often residing in locations and in shelter that are most vulnerable to natural disasters. Their limited assets and sources of livelihoods are damaged or lost, forcing them to borrow at high interest rates that they cannot afford to recover. They are more vulnerable to disease outbreak and poor health due to lower levels of nutrition and hygiene and because their inadequate community health infrastructure and their supplies may be at greater risk of destruction.

c) Addressing the humanitarian situation of children and women

Following the inauguration of the new civilian government on 30 March 2011, a number of initial moves were made towards reconciliation: Peace talks were restarted with some armed groups; a 'peace committee' was established to resolve ethnic issues and ensure lasting peace; a Human Rights Commission was formed to safeguard the rights of citizens; and the Government committed to improve services in border areas and create economic and job opportunities there.

The responses to Cyclone Giri (October 2010) and to the earthquake that hit Shan State (March 2011) have reflected the many lessons learned from the experience of Cyclone Nargis and are a testament to the capacities developed in the areas of early warning, emergency preparedness and response at both the central and regional levels. The Department of Relief and Resettlement under Ministry of Social Welfare and Relief and Resettlement is now taking the leading role in drafting the Disaster Management Law. The formulation of policy documents and action plans, such as the Myanmar Action Plan on Disaster Risk Reduction (MAPDRR) and the Standing Order on Disaster Management, have been achieved due to the high level of political will, commitment and institutional arrangements put in place by the Government, with the support of the international community.

Myanmar has clearly expressed its commitment to reducing vulnerability to natural disasters and climate change through community-level interventions as well as capacity building of local institutions on service delivery to the vulnerable populations. Significant investment by the Government will be required, with the support of the international community, for implementing the plans.

There are a range of initiatives with special attention on children, spurred by the experience of Cyclone Nargis, that set an example for the future. The various cyclone-resistant schools built back after the cyclone serve as models for safe schools along the long coastline that is susceptible to the Bay of Bengal's volatility. The life skills curriculum developed to complement core subjects now includes a disaster risk and emergency behaviour component for all primary and secondary students across the country. It is widely recognized within the disaster risk reduction community that the most effective way to address society's costs for future hazards is to invest in expanding the knowledge of children.

7. Basic structural factors impacting children's rights: Key Recommendations

The analysis of basic structural factors impacting children's rights in Myanmar shows that these are both numerous and wide-ranging. A full list of recommendations to address these factors would be correspondingly long. Instead, the following identifies key areas where improvements are needed and could have a substantial impact on the realization of children's rights in the country:

- Legislation upholding the rights of children should be enforced, and necessary amendments carried out to address any shortcomings in laws and policies.
- To enable higher levels of public spending and revenue, macro-economic growth has to be promoted through infrastructure development, sustainable exploitation of natural resources, development of industry and manufacturing, tourism and other sectors and facilitation of foreign investment. Other options to expand the fiscal space to improve the distribution of wealth need to be considered – pro-poor taxation, such as value-added taxes (VAT) or increased ODA, could be ways to increase government revenue.
- Public investment in human development, especially in the social sectors, needs to be greatly enhanced. At the same time, reforms are needed to promote the efficient and effective use of the limited public financial resources. These could include increased transparency of the public budget and promoting bottom-up planning to ensure that local needs are addressed and strengthened.
- Public sector governance has to be strengthened through evidence-based decision-making and planning, streamlined implementation arrangements and greater coordination between different agencies, greater investment in service delivery facilities and personnel (including capacity building), modern management techniques and robust monitoring and accountability mechanisms.
- Effective social protection policies and mechanisms should be established in linkage with the newly proposed poverty reduction and rural development strategies to help poor and vulnerable families meet their basic needs, to prevent them from falling into poverty and to reduce their economic risks. As well, strategies are needed to develop the human capital (including, for example, investment in children's education, especially early childhood development) and livelihood skills that can lift people out of poverty. Innovative and appropriate social protection strategies for Myanmar children and families should be suggested.
- As a part of the social protection debate, efforts to promote economic growth should be inclusive and geared towards job creation and equitable distribution of growth dividends across all strata of society – in particular to benefit the poor and vulnerable groups.
- Advocacy and social mobilization should be carried out to promote children's participation and the empowerment of women and to tackle the societal values and norms that hamper the realization of children's rights. Access to information needs to be improved.

- Peace-building processes need to be encouraged in all parts of the country affected by conflict to promote the inclusion of ethnic minorities in all aspects of national life (politics, decision-making, education and culture), and to address regional disparities in economic and human development indicators, thereby improving the fulfilment of children's rights in these areas.
- Disaster risk reduction and management should be promoted to lessen the impact of natural disasters and enable quicker and more effective recovery from them.



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PART TWO: SITUATION ANALYSIS OF SPECIFIC CHILDREN'S RIGHTS

This part of the situation analysis report looks at what is happening in Myanmar in relation to specific children's rights: to health and nutrition; to water, sanitation and hygiene; to education; to be free of HIV; and to protection.

Each chapter begins with an assessment of the extent to which each right is realized in Myanmar; for example, in the case of education, looking at levels of school enrolment. This is followed by a causality analysis, examining both the immediate and underlying factors impacting the realization of the respective right. The duty bearers role and capacity analysis looks at what each of the key duty bearers – families, communities, civil society groups, the private sector, government and international development partners – are doing in relation to that right. Finally, each chapter concludes with a list of key recommendations to promote the full realization of the right.



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8. Children's Right to Health and Nutrition

Article 24 of the Convention on the Rights of the Child states that all children have the right “to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health”. The CRC commits States Parties to taking measures to diminish infant and child mortality, to ensuring the provision of healthcare to all children, to combating disease and malnutrition and to ensuring appropriate prenatal and postnatal healthcare for mothers. This chapter explores the extent to which the children of Myanmar are able to realize their right to health, the causes of violations of this right, and the roles of the duty bearers who are responsible for children's health and nutrition.

8.1 Situation overview

a) Maternal mortality

According to UN estimates, the maternal mortality ratio (MMR) in 1990 was 420 maternal deaths per 100,000 live births; in 1995 it was estimated at 350 maternal deaths per 100,000 live births, in 2000 at 290 maternal deaths per 100,000 live births, in 2005 at 250 maternal deaths per 100,000 live births and in 2008 at 240 maternal deaths per 100,000 live births.⁸³ The 2004–2005 Nationwide Cause-Specific Maternal Mortality Survey estimated the MMR to be 316 per 100,000 live births.⁸⁴ Based on this trend, achieving the national MDG 5 MMR target of 145 per 100,000 live births by 2015⁸⁵ remains a challenge.

The 2004–2005 Nationwide Cause-Specific Maternal Mortality Survey also reported significant variations in MMR based on age, type of delivery, urban–rural locality and region. MMR was highest in the 45–49 age group, but younger women aged 15–19 years also showed higher risks compared with other age groups. The majority of maternal deaths (88 per cent) occurred at home, but also in public hospitals (10 per cent) or on the way to a healthcare facility. The same study found that MMR was 140 per 100,000 live births in urban populations but 363 per 100,000 live births in rural populations.

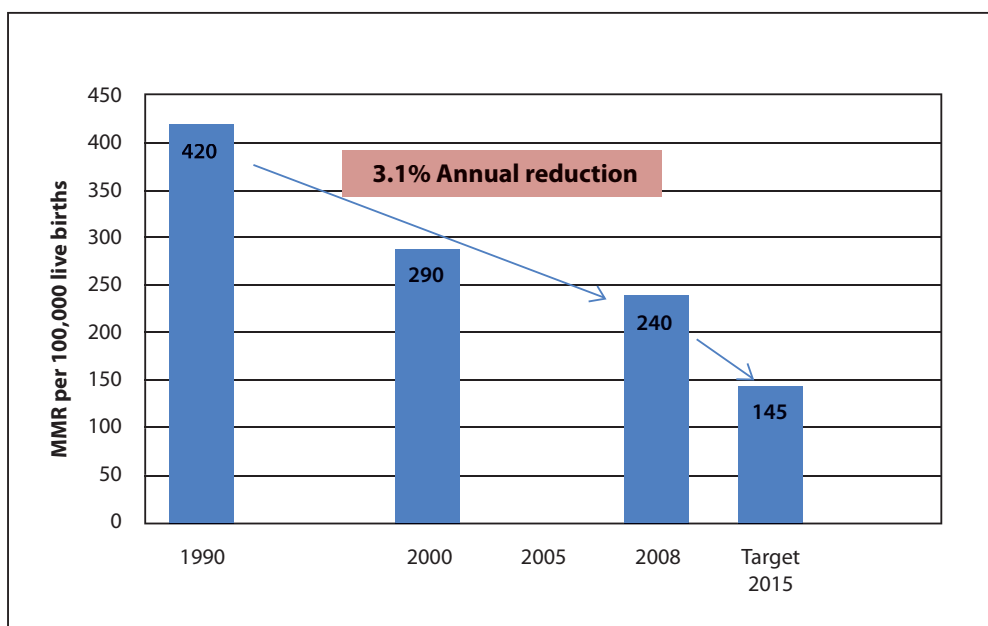
Subnational figures show MMR to be lowest in the hilly region (132 per 100,000 live births, ranging from 47 to 216) and highest in the central plains (449 per 100,000 live births, ranging from 317 to 581), with MMR of 264 (range: 52–477) and 337 (range: 266–409) per 100,000 live births in the coastal region and the delta, respectively. Among the states and regions, the lowest estimate was 136 and the highest 527 per 100,000 live births.

83 World Health Organization, UNICEF, United Nations Population Fund and The World Bank, Trends in Maternal Mortality: 1990 to 2008, Geneva, 2010.

84 95 per cent confidence interval: 177–451

85 United Nations, *Millennium Development Goals Report 2006*, New York 2006

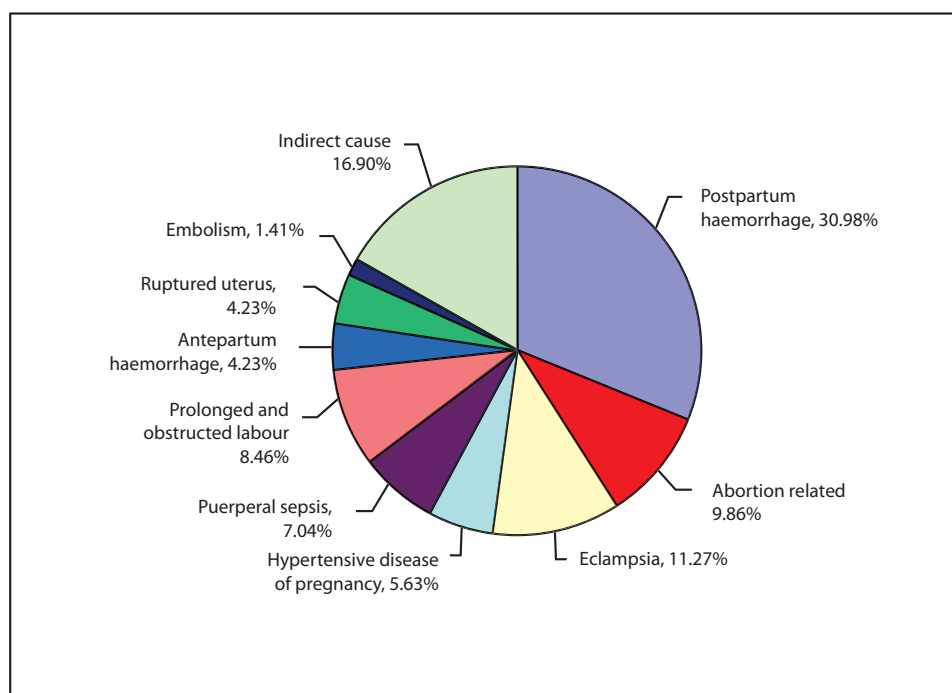
Figure 8: Maternal mortality rates in Myanmar



Source: Trends in Maternal Mortality: 1990 to 2008, WHO, UNICEF, UNFPA and World Bank, Yangon, 2010.

Severe postpartum haemorrhage was the main direct obstetric cause of maternal deaths (31 per cent), followed by hypertensive disorders of pregnancy including eclampsia (11.3 per cent) and abortion-related causes (9.9 per cent).

Figure 9: Main causes of maternal death in Myanmar



Source: Nationwide Cause-Specific Maternal Mortality Survey (2004-2005), Department of Health and UNICEF

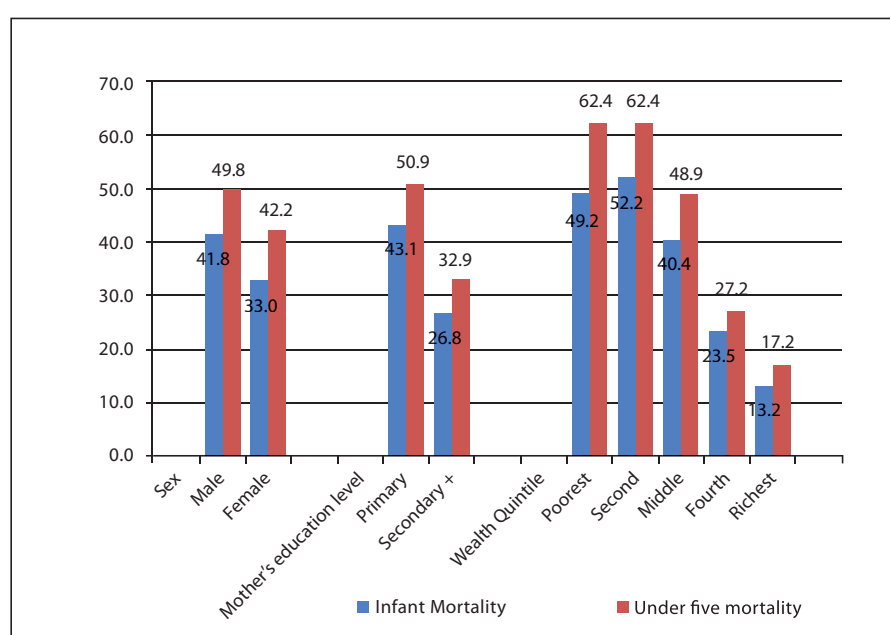
b) Child mortality

Each year, around 56,000 children under-five die in Myanmar – 26,000 of them younger than 1 month.⁸⁶ The country's under-five and infant mortality rates are the highest among ASEAN member countries,⁸⁷ and many of the deaths are preventable.

Neonatal mortality rates for 1990 are not available. Under-five mortality fell from 83.7 per 1,000 live births in 1996 to 77 per 1,000 live births in 2006,⁸⁸ and the infant mortality rate (IMR) fell from 70.3 per 1,000 live births to 66.1 per 1,000 live births in the same period. MICS 2009–2010 reports under-five mortality at 46.1 per 1,000 live births and infant mortality at 37.5 per 1,000 live births. There were large variations in the child mortality rates: they were substantially higher in rural (42.8 per 1,000 live births infant and 52.9 per 1,000 live births under-five mortality) as compared with urban areas (24.5 per 1,000 live births and 29.1 per 1,000 live births respectively), higher among the children whose mother had primary education only and among children from families in the poorest quintile.

New UN interagency estimates, using improved modelling and data from different surveys, were released in 2011 and indicate that under-five and infant mortality were 66.2 and 50.4 per 1,000 live births, respectively, in 2010.

Figure 10: Infant mortality and under-five mortality rates, by sex, mother's education level and wealth quintile, 2009–2010



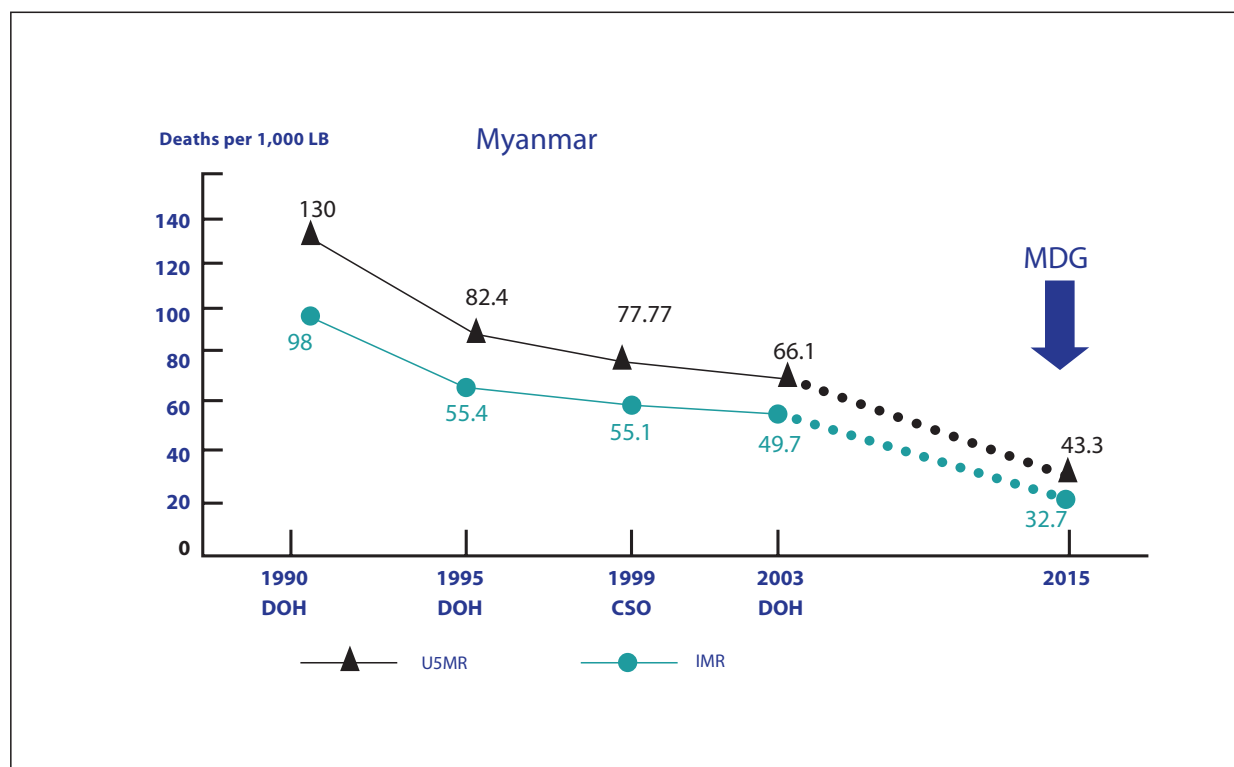
Source: MICS, 2009–2010

86 United Nations Inter-agency Group for Child Mortality Estimation, Levels and Trends in Child Mortality 2011, New York, 2011

87 ibid

88 Ministry of Immigration and Population and United Nations Population Fund. *Country Report on 2007 Fertility and Reproductive Health Survey*, Yangon, 2009.

Figure 11: Trends in child mortality relative to MDG4



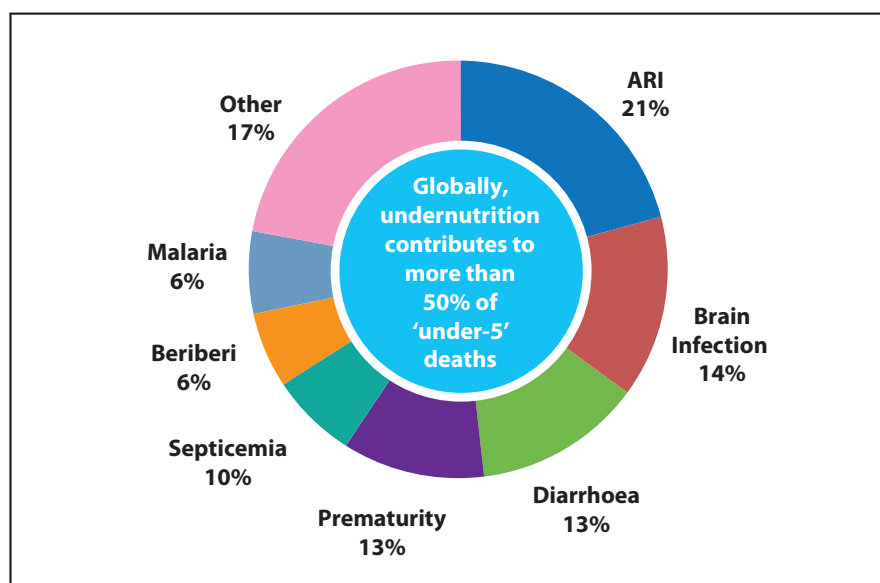
Source: National Child Health Strategic Plan, 2010–2014

Despite differences in sampling and other factors among the various sources, it is clear that the rates for infant and under-five mortality have been declining over the past two decades. However, the rates of decline may have slowed during the decade 2001–2010 in comparison with the earlier periods between 1981–1990 and 1991–2000.

A 2002–2003 nationwide study⁸⁹ carried out in 126,000 households across 120 townships found that about 73 per cent of all under-five deaths occurred in infancy (0–11 months) and 27 per cent in the 1–4 years age group. During infancy, 34 per cent of the deaths occurred in the neonatal period. Among the neonate deaths, more than two thirds occurred during the first seven days after birth, most within three to four days of the onset of the first signs of illness – with delay in care seeking due to failure to recognize its seriousness. In rural areas, 89.9 per cent of the neonatal deaths occurred in home-delivered babies, while in urban areas 75.8 per cent of neonatal deaths were among babies delivered at home. Neonatal deaths were twice as common if the baby was delivered by a non-skilled birth attendant as compared to a midwife or a doctor.

The principal causes of neonatal mortality (under 28 days of age) in 2002–2003 were prematurity (30.9 per cent), birth asphyxia (24.5 per cent) and sepsis, including pneumonia (25.5 per cent).⁹⁰ More than 90 per cent of the deaths during the post-neonatal period were attributed to a single cause.

89 Ministry of Health and UNICEF. *Overall and Cause-Specific Under-Five Mortality Survey*, Yangon 2002–2003.
90 *ibid*

Figure 12: Causes of deaths among children younger than 5 years, 2002–2003

Source: Overall and Cause-Specific Under-Five Mortality Survey, 2002–2003, Ministry of Health and UNICEF.

The main direct causes of deaths among children under-five continue to be diarrhoea, acute respiratory infections and malaria, exacerbated by underlying malnutrition, which contributes to around 50 per cent of these deaths.

Acute respiratory infections – Morbidity and mortality among children due to severe respiratory infections, particularly pneumonia, continues to be high at 21 per cent of under-five deaths and 27.6 per cent of deaths among children aged between one month and five years.⁹¹ Care is sought for suspected pneumonia in around 66 per cent of cases,⁹² but it is not clear what proportion received appropriate treatment.

Diarrhoea – Diarrhoea is the second leading cause of child death in Myanmar, causing 13 per cent of deaths of children under five and 17.6 per cent of those among children aged between one month and five years.⁹³ However, the increased use of the new formula oral rehydration salts with zinc supplementation has been a positive development in treating diarrhoea. MICS 2009–2010 indicates that 50 per cent of children under five with diarrhoea in the two weeks prior to the survey received oral rehydration therapy (ORT) or increased fluid and continued feeding. A 2007 survey reported that 49 per cent of under-five children received oral rehydration salts (ORS) after diarrhoea, and 51 per cent were taken to a health facility or health care provider.⁹⁴

Malaria – Malaria is the fourth leading cause of death in under-five children in Myanmar, accounting for 7.6 per cent of deaths in children aged between 1 month and 5 years.⁹⁵ Myanmar sees more than 600,000 clinical cases each year,⁹⁶ constituting an estimated 10 per cent of outpatients and 15 per cent of patients in hospitals. Some 30 per cent of the reported malaria cases are in children under 15 years of age (the total malaria burden and mortality are likely to be much higher than reported, given poor access to and utilization

91 Ministry of Health and UNICEF. *Overall and Cause-Specific Under-Five Mortality Survey*, Yangon 2002–2003.

92 UNICEF, *State of the World's Children Report 2009*, as quoted in the Five-year Strategic Plan for Child Health Development in Myanmar (2010–2014).

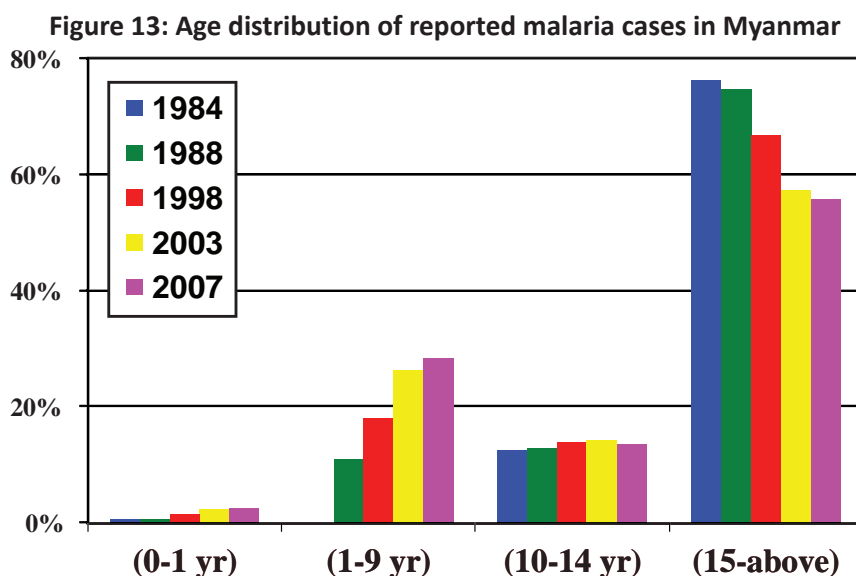
93 Ministry of Health and UNICEF. *Overall and Cause-Specific Under-Five Mortality Survey*, Yangon 2002–2003.

94 Ministry of Immigration and Population and United Nations Population Fund, *Country Report on 2007 Fertility and Reproductive Health Survey*, Yangon, 2009.

95 Ministry of Health and UNICEF. *Overall and Cause-Specific Under-Five Mortality Survey*, Yangon 2002–2003.

96 Ministry of Health, *National Malaria Control Programme Report*, Yangon, 2005.

of health care in remote areas where most cases originate and that malaria reporting does not include cases treated in the private sector or through traditional medicine practices).



Source: Vector-Borne Disease Control, Ministry of Health, 2009.

The National Malaria Control Programme aimed to reduce malaria morbidity in 2010 to 50 per cent of the 2000 level. According to the National Malaria Control Programme Report 2010, malaria mortality fell from 5.50 per 100,000 population in 2000 to 1.64 per 100,000 population in 2009;⁹⁷ malaria mortality had already been reduced to less than 50 per cent of the level in 2000 but malaria morbidity had yet to reach this goal.

Immunization – Myanmar's Expanded Programme of Immunization (EPI) was launched in the 1980s and quickly raised immunization coverage, dramatically reducing the incidence of vaccine-preventable diseases. Coverage declined to some extent between 1998 and 2005, from 89 per cent to around 77 per cent,⁹⁸ due mainly to the change from a vertical programme to one which is integrated in primary health care support. According to MICS 2009–2010, 88.6 per cent of children were fully immunized.

The programme has been most successful against polio, now virtually eliminated from Myanmar. It also has been instrumental in bringing about a major decline in measles morbidity and mortality; in 2007, measles caused 11 deaths per 100,000 children under-five (around 725 deaths). However, the 2010 target of a 95 per cent reduction of the 2000 levels of measles mortality and morbidity was not achieved. Measles immunization was reported to be 82.4 per cent in the IHLCA 2009–2010 (slightly up from 80 per cent in 2005) and 83.8 per cent in the Health Management Information System (HMIS) 2009. But there are considerable differences in coverage between poor and non-poor children– 76 per cent and 86 per cent, respectively – and between rural (80 per cent) and urban (92 per cent) dwellers.⁹⁹ There are also moderate regional variations, with coverage particularly low in Rakhine State (68 per cent).

Coverage of routine immunization of pregnant women with at least two doses of tetanus toxoid increased, from 64 per cent in 1999 to 87 per cent in 2009. MICS 2009–2010 reported a 91.8 per cent rate of neonatal tetanus protection. These routine and supplementary immunization activities were complemented by efforts

⁹⁷ Ministry of Health, *National Malaria Control Programme Report*, Yangon, 2010.

⁹⁸ WHO vaccine-preventable diseases: monitoring system, 2010 global summary

⁹⁹ Ministry of National Planning and Economic Development, United Nations Development Programme, UNICEF and SIDA. *Integrated Household Living Conditions Assessment 2009-2010*, Yangon, 2011

to improve maternal health and ensure delivery by skilled birth attendants. As a result, the number of reported neonatal tetanus cases fell from 190 per 1,000 births in 1991 to 41 per 1,000 births in 2000 and then to 34 per 1,000 births in 2009. In May 2010, the elimination status was validated by national and international experts through a data review focusing on key maternal and neonatal tetanus criteria. This was followed by a survey in three select townships using the World Health Organization's LQA-CS¹⁰⁰ protocol.

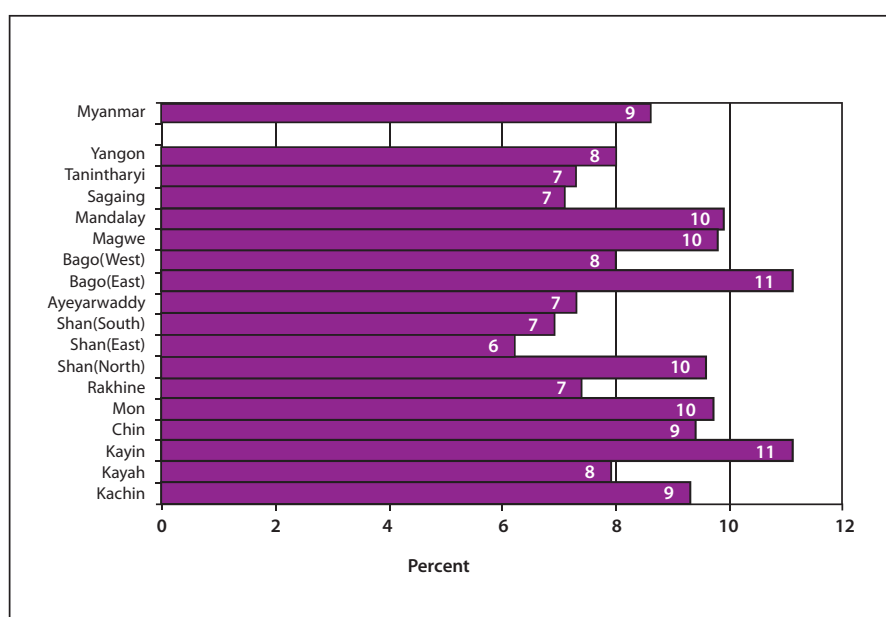
However, there are large disparities in immunization coverage. In general, it is weaker in states than in regions, and vaccine-preventable diseases are also more prevalent in the states. The lowest coverage in 2007, for example, was in Shan (East) at 58.9 per cent and then in Kayin State, while the highest coverage was achieved in Tanintharyi at 93.5 per cent, followed by Bago (East) at 89.1 per cent and then Yangon.¹⁰¹

c) Malnutrition among children and women

Malnutrition continues to severely affect the survival and development of children and women in Myanmar. Child malnutrition greatly increases the risks of morbidity and mortality, as well as adversely affecting intellectual and physical development.

Low birth weight – Malnutrition transfers from one generation to the next through undernourished mothers who bear low birth weight babies. The World Health Organization estimates that low birth weight babies have a three to four times greater risk of dying from diarrhoeal diseases and acute respiratory infections as well as measles if they are not immunized; they are also more likely to be malnourished by the time they reach their third birthday. The MICS 2009–2010 reported low birth weight prevalence of 8.6 percent. It may be higher because many babies are born at home and not weighed after birth (56.3 per cent infants were weighed at birth, according to the MICS 2009–2010). Low birth weight is a common cause of death in neonates. As seen in figure 14, there are significant variations by region or state, with Bago (East) and Kayin having the highest percentage of underweight newborns.

Figure 14: Percentage of infants weighing less than 2,500 grams at birth, 2009–2010



Source: MICS, 2009–2010

100 Lot Quality Assurance and Cluster Sampling

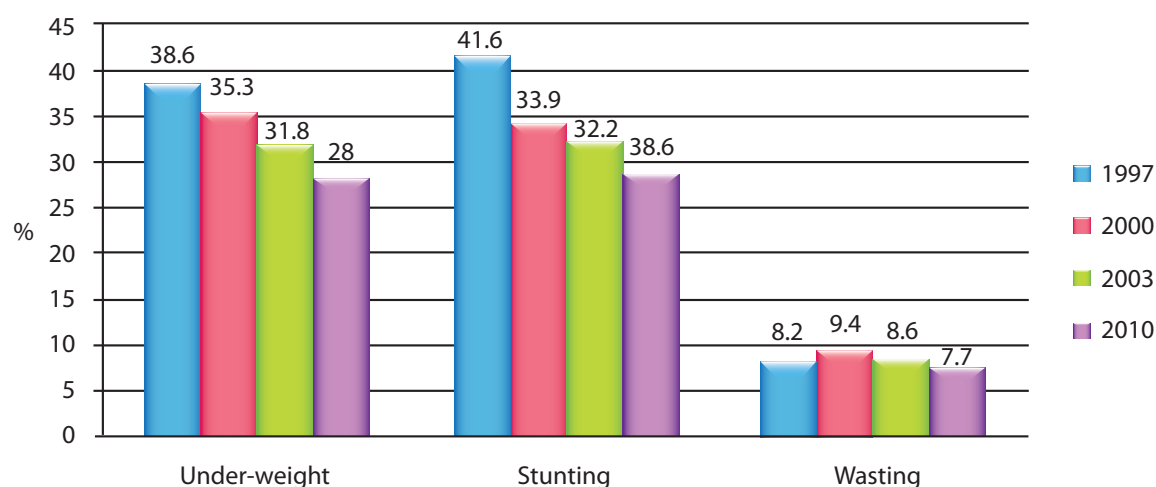
101 Ministry of Health, *Annual Public Health Statistics Report*, Yangon, 2009.

Infant and young child feeding – MICS 2009–2010 reveals that early initiation of breastfeeding (within one hour of birth) occurred in 75.8 per cent of cases; the exclusive breastfeeding (EBF) rate (0–6 months) was 23.6 per cent, the rate of children aged 12–15 months breastfed was 91 per cent and the rate of children aged 20–23 months breastfed was 65.4 per cent. Only 23.6 per cent of children were exclusively breastfed for the first six months; this could be rapidly increased if infants were not fed with small quantities of water.

The prevalence of exclusive breastfeeding is slightly higher in rural than in urban areas, but regional disparities are far greater: from a 1.3 per cent exclusive breastfeeding rate in Rakhine up to 40.6 per cent in Kachin. The indications are that many children miss out on adequate complementary food intake because they are weaned by their mothers, while this may be aggravated by frequent episodes of diarrhoea and acute respiratory infections.

Stunting, wasting, underweight children – Although rates for stunting (as an indicator of chronic malnutrition) fell during the period 1997–2000, there was no change in wasting (an indicator of acute malnutrition). The MICS 2003 survey revealed that prevalence of wasting was 8.6 per cent and stunting was 32.2 per cent. The prevalence of underweight children was 31.8 per cent. The MICS 2009–2010 survey found the prevalence of wasting to be 7.7 per cent, stunting 28.6 per cent and underweight children at 28 per cent¹⁰² indicating a decline between 1997 and 2003. These figures clearly show that even though there have been improvements in terms of malnutrition, vigorous efforts are needed to attain the MDG targets.

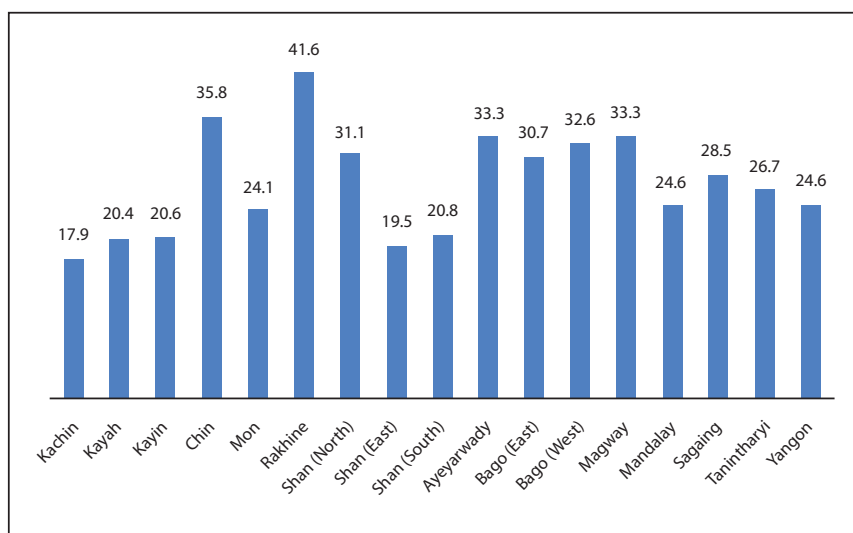
Figure 15: Prevalence of malnutrition among under-5 Children, 1997–2010



Source: MICS, 1997–2010

Children in rural areas appear more likely to be underweight and stunted than children in urban areas, but there is little difference in the level of wasting. About one third of rural children were moderately or severely underweight (29.9 per cent), and moderately or severely stunted (31.6 per cent) in the recent MICS findings. But prevalence was nearly equal among both sexes.

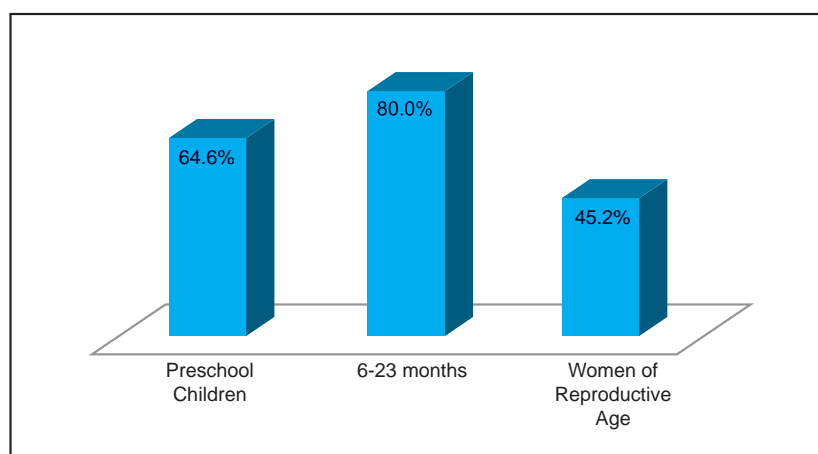
¹⁰² These estimates are based on the NCHS-standard approach, which was also applied in 2003; applying the WHO-standard, the figures become 7.9 per cent, 35.1 per cent and 22.6 per cent, respectively.

Figure 16: Percentage of underweight, by states and regions, 2009–2010

Source: MICS, 2009–2010

In terms of regional disparities, children in Rakhine and Chin states are more likely to be undernourished than other children. In Rakhine, a total of 41.6 per cent of children were either moderately or severely underweight, according to the recent MICS, whereas the underweight prevalence was 35.8 per cent in Chin. Also in Ayeyarwaddy and Magwe regions and Shan (North), around one in three children were underweight. Severe or moderate stunting was as high as 51.8 per cent in Chin, 42.9 per cent in Rakhine and 42.5 per cent in Shan (North). Similarly, there was higher prevalence of stunting in Rakhine, Chin, Kayah, and Shan (North and South) states when compared with other regions and states.

Iron deficiency anaemia – Poor maternal nutritional status and iron and folic deficiency anaemia adversely influence pregnancy outcomes. In children younger than 2 years, anaemia can result in learning problems even if the iron deficiency and resulting anaemia are corrected. A 1994 study conducted by the Department of Medical Research (Lower Myanmar) found that 58 per cent of pregnant women were anaemic, while a study by the Nutrition Section of the Department of Health in 2004 found 71 per cent of pregnant mothers were anaemic. A 2005 nationwide survey¹⁰³ found iron deficiency anaemia (IDA) in 64.6 per cent of pre-school children, more than 80 per cent of children aged 6–23 months and 45.2 per cent in women of reproductive age.

Figure 17: Prevalence of iron deficiency anaemia among children and women, 2005

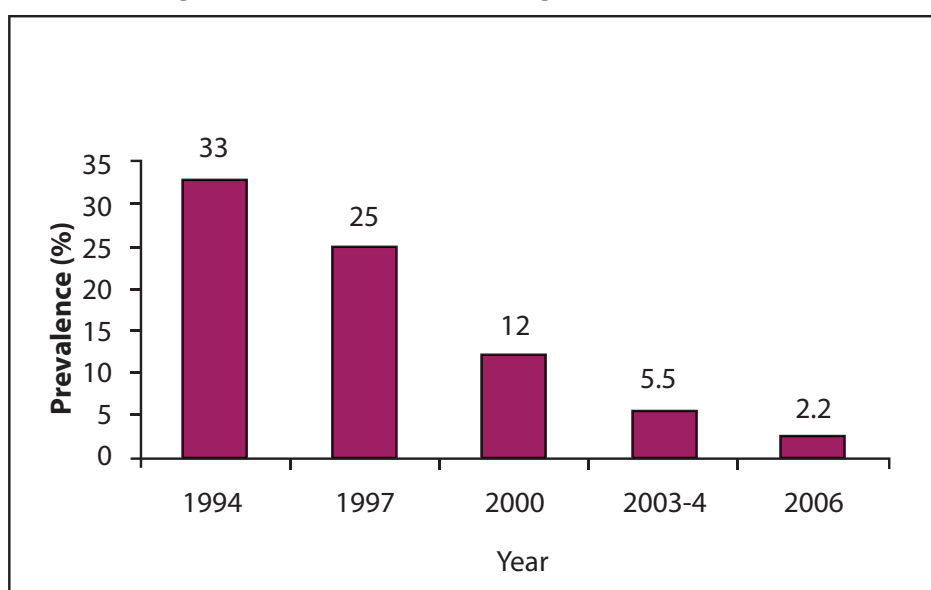
Source: 2005 Multiple Micronutrient Survey, Ministry of Health and UNICEF

Iron deficiency is exacerbated by the presence of intestinal parasites. The same National Nutrition Centre/ UNICEF 2005 survey found worm infestation to be associated with anaemia in all groups. Levels of infestation were particularly high in coastal areas: 92 per cent of pregnant women and 70 per cent of children were found to have one or more of three common worm types (*Ascaris*, *Trichuris* and hookworm), compared with national estimates of 45 per cent and 31 per cent, respectively.

Iodine deficiency disorders – Iodine deficiency is the single most important cause of preventable brain damage and mental disability. During pregnancy, iodine deficiency can lead to irreversible brain damage in the foetus as well as a greater number of stillbirths, spontaneous abortions and congenital abnormalities. The prevalence of goitre, the most visible form of iodine deficiency, fell from 33 per cent in 1994 to 2.2 per cent in 2006. This shows that there has been huge progress over the years in the control of iodine deficiency disorders (IDD).

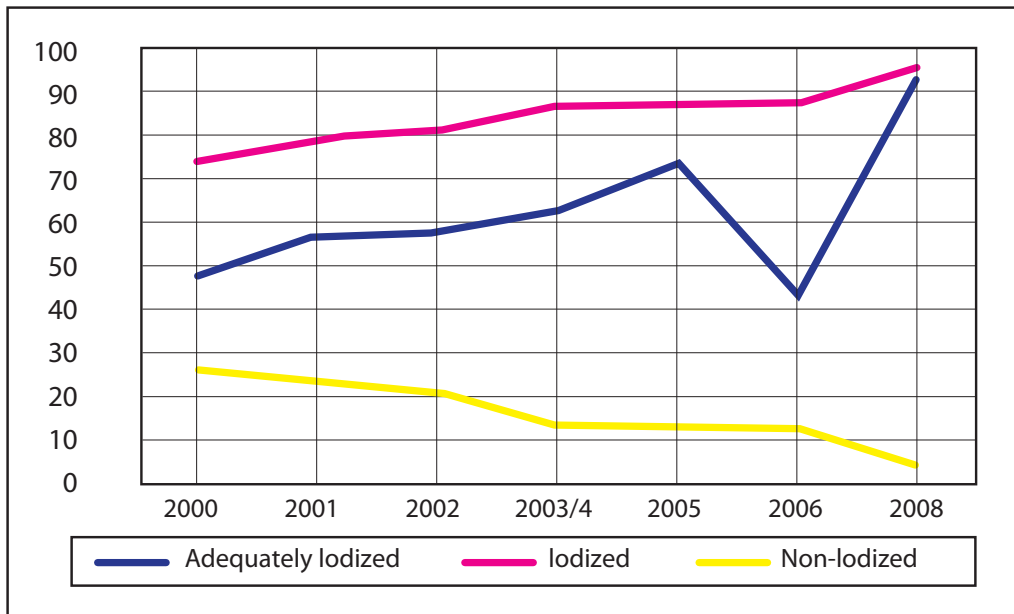
Myanmar aims to eliminate IDD by 2012. This requires the use of adequately iodized salt by more than 90 per cent of households and a median urinary iodine excretion (UIE) between 100 and 200 µg per litre. According to the National Nutrition Centre, consumption of iodized salt was 10.8 per cent in 1994. While production of iodized salt has increased, a 2006 survey found consumption of this averaging 43.4 per cent and that the national median UIE had decreased to 123.5 µg per litre. According to a school-based survey of household iodized salt consumption conducted in 2008, more than 80 townships of a total of 325 had less than a 90 per cent adequately iodized salt consumption rate.

Figure 18: Prevalence of visible goitres, 1994–2006



Source: National Nutrition Centre, Department of Health.

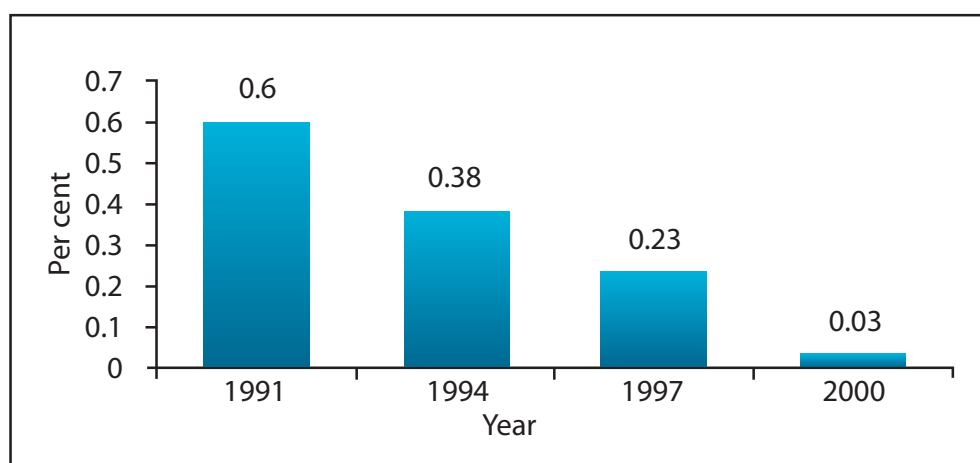
Figure 19: Iodized salt consumption rate, 2000–2008



Source: National Nutrition Centre, Department of Health.

Vitamin A deficiency – Vitamin A is fundamental to all stages of body development and functioning. Children with vitamin A deficiency are 23 per cent more likely to die from measles and 50 per cent more likely to suffer acute measles.¹⁰⁴ Biannual mass campaigns have been conducted in Myanmar to distribute vitamin A to all children aged 6 months to 5 years. MICS 2009–2010 reported that 55.9 per cent of all targeted children had received at least one vitamin A supplement in the six months prior to the survey. The prevalence of Bitot's spots (on the eyes) among under-five children reduced, from 0.6 per cent in 1991 to 0.03 per cent in 2000, showing sustained virtual elimination of vitamin A deficiency. Manifestations of vitamin A deficiency have become very rare events in clinical settings. However, a problem remains if subclinical deficiencies are considered, which are frequently associated with the high prevalence of under-five mortality, diarrhoea, measles and acute respiratory infections.

Figure 20: Prevalence of Bitot's spots among children under 5, 1991–2000



Source: National Nutrition Centre, Department of Health.

Infantile beriberi – Vitamin B1 deficiency during infancy, known as infantile beriberi, is the fifth leading cause of death among babies between 1 month and 1 year of age, accounting for 7 per cent of all infant deaths.¹⁰⁵ Beriberi can occur in breastfed infants when the mother's body is lacking in vitamin B1 and can be fatal within 24 hours of the symptoms becoming apparent, if not treated. Vitamin B1 deficiency in women is aggravated by poor diet as well as cultural taboos that lead to avoidance of vitamin B1 rich foods during pregnancy and lactation.

Box 2: Disparities in children's right to health¹⁰⁶

Rural-urban disparities:

- In rural areas, one fourth (25 per cent) of children are delivered in a health facility; in urban areas 65 per cent of children are delivered in a health facility.
- In rural areas, 63 per cent of births are attended by skilled personnel; compared with 90 per cent in urban areas.
- In rural areas, the proportion of children with diarrhoea treated with oral rehydration treatment is 62 per cent, compared with 77 per cent in urban areas.

Disparities based on mother's education:

- Among mothers with primary education, 25 per cent of births take place in a health facility, compared with 54 per cent among mothers with secondary or higher education.
- Among mothers with primary education, 62 per cent give birth with the assistance of a skilled birth attendant, compared with 85 per cent among mothers who have secondary or higher education.

Regional disparities:

- In Chin State 6 per cent of children are delivered in a health facility; in Yangon 69 per cent of births take place in a health facility
- In Shan (North) 28 per cent of under-five children with diarrhoea are treated with oral rehydration treatment, compared with 90 per cent of children in Tanintharyi.

Socio-economic disparities

- Among children in the poorest households, 58 per cent of diarrhoea cases are treated with oral rehydration treatment, compared with 79 per cent among children in the richest households.
- Among mothers in the poorest households 51 per cent give birth with the assistance of a skilled birth attendant; compared with 96 per cent in the richest households.

8.2 Causality analysis

a) Immediate causes

Problems or failings in one aspect of a woman's or child's health care have knock-on effects on other issues. Thus the immediate causal factors hampering children in Myanmar from realizing their right to health are weaknesses in disease prevention and treatment, persistent protein-energy and micronutrient malnutrition and problems related to the delivery of health care and family planning services.

¹⁰⁵ Ministry of Health and UNICEF, *Overall and Cause-Specific Under-Five Mortality Survey, 2003*, Yangon.

¹⁰⁶ Ministry of National Planning and Economic Development, Ministry of Health and UNICEF, Myanmar, *Multiple Indicator Cluster Survey 2009-2010*, Nay Pyi Taw, 2011.

As seen in this chapter communicable, parasitic and preventable childhood diseases, including acute respiratory infections, diarrhoeal diseases and malaria, are among the leading causes of infant and child mortality. Many of them could be prevented through immunization or other preventive interventions (such as insecticide-treated bed nets). Many are also easily treatable, such as diarrhoea; even acute respiratory infections respond well to early care. Community case management of pneumonia through community health workers, for example, has been shown to promote better care-seeking and treatment practices and so reduce the fatality rate.¹⁰⁷ The persistence of easily preventable or treatable diseases in Myanmar is related directly to failure or delay in seeking care, limited availability of services (discussed further on) and inequities in coverage leading to significant disparities in disease prevalence, morbidity and mortality across the country.

Malaria is the leading cause of morbidity and mortality and is re-emerging as a public health problem due to climatic and ecological changes, uncontrolled population migration, multidrug-resistant parasites and insecticide-resistant vectors. A total of 284 of Myanmar's 325 townships are endemic for malaria (particularly in forested areas), which account for 60 per cent of reported malaria cases. About 3.6 million children under 5 and 800,000 pregnant women live in areas at high or moderate risk of malaria transmission.

As the analysis in this chapter indicates, a major challenge for Myanmar is the widespread malnutrition among children as well as women. Child malnutrition greatly increases the risks of morbidity and mortality and adversely affects intellectual and physical development. The low exclusive breastfeeding rate, the inappropriate introduction of complementary foods and micronutrient deficiencies have a well-known synergistic effect, fuelling malnutrition and thereby vulnerability to other illnesses.

Women's reproductive health

Immediate and effective professional care before, during and after delivery can make the difference between life and death for both women and their newborns. Nearly three quarters of all neonatal deaths and stillbirths could be prevented if women were adequately nourished and received appropriate care during pregnancy, childbirth and the postnatal period.

Antenatal and delivery care – Between 2005 and 2009, antenatal coverage increased from 63.1 per cent to 70.6 per cent, and the proportion of deliveries attended by skilled birth attendants grew from 57.9 per cent to 64.4 per cent. However, the majority (90 per cent) of deliveries still take place at home, particularly in rural areas.

Table 1: Reproductive health care

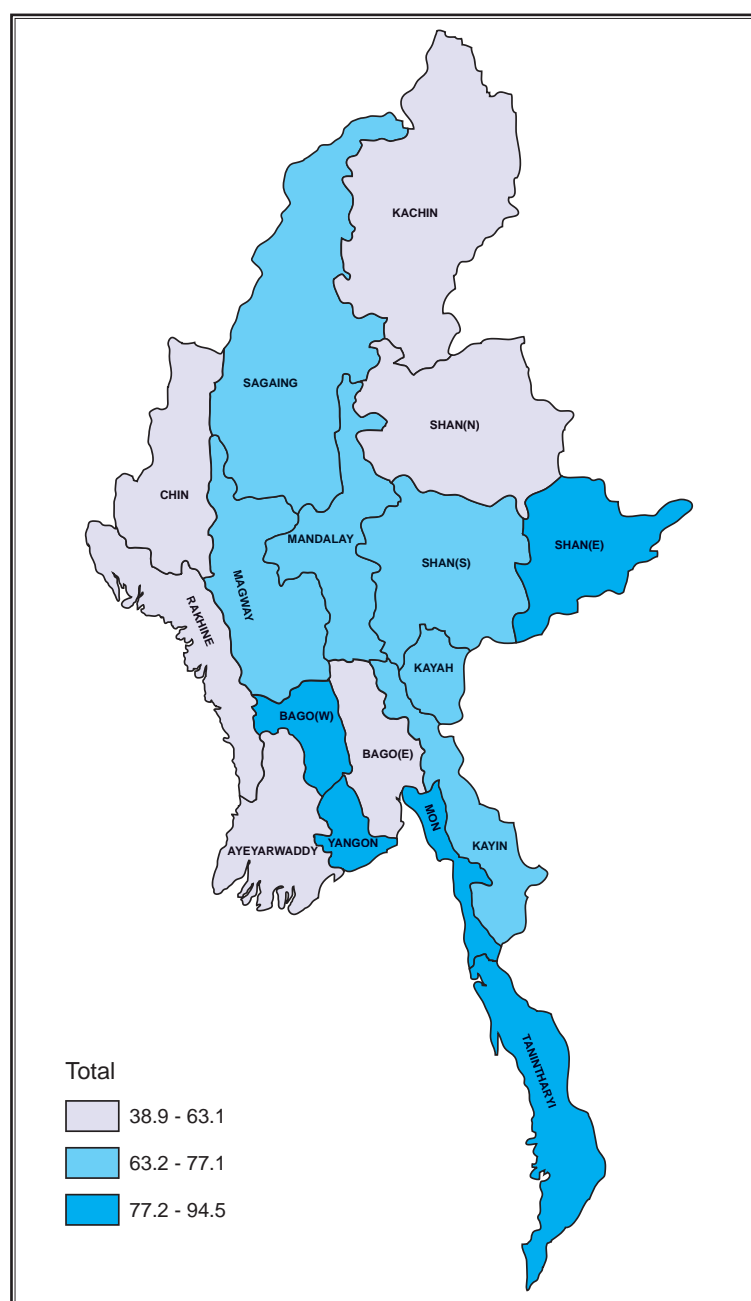
Indicator	2005	2006	2007	2009*	2010
Antenatal care coverage, one visit (%)	63.1	63.9	64.6	70.6	73
Proportion of birth assisted by skilled birth attendant (%)	57.9	63.5	64.16	64.4	64.8
Delivered by auxiliary midwife (%)	13.3	14.2	13.7	13.0	
Delivered by traditional birth attendant (%)	8.8	9.0	8.6	8.2	
Frequency of postnatal visits (average number)	4.8	4.9	5.4	6	

Source: HMIS; * Reproductive Health Statistic Report 2008 and Public Health Statistic Report 2009, Department of Health Planning, Yangon (these reports do not include data from the private sector).

107 Ministry of Health and UNICEF, *Evaluation of Community Case Management of Pneumonia and Diarrhoea in Dawei Township*, Nay Pyi Taw 2011

Table 1 provides facility-based data. MICS 2009–2010 reported that, overall, 93.1 per cent of women received antenatal care at least once during their pregnancy, from any type of provider. A total of 83.1 per cent of ever-married women received antenatal care from a skilled provider (95 per cent in urban areas and 78.4 per cent in rural areas). But the content of antenatal care differed widely between states and regions and between urban and rural locations. In total, 70.6 per cent of births were attended by skilled birth attendants. It is notable that in certain locations of the country (Chin and Shan (North) states), more than one in 10 women delivered without any attendant at all. More than one third (36.2 per cent) of women delivered in a health facility, either government or private. In all cases – antenatal care, assistance by skilled birth attendant, institutional delivery – rates were higher in urban than rural areas, among educated women and in the richest households.

Figure 21: Regional disparities in skilled birth attendant at delivery, 2009-2010

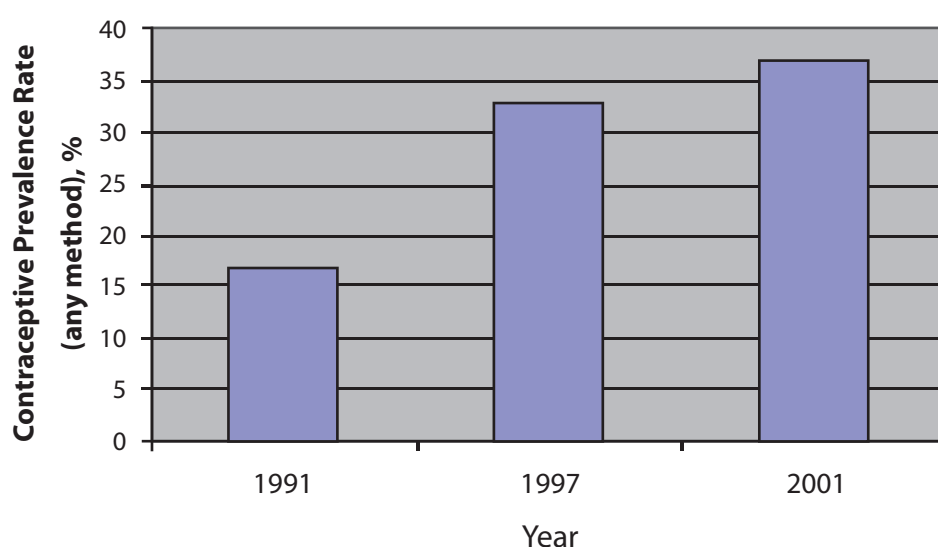


Source: MICS 2009-2010

With so many births taking place at home, postpartum care often receives little or no attention through the service delivery system. In the event of complications, the outcomes for the mother and newborn thus depend on the capacity of communities to recognize danger signs and seek timely professional care and on the established community-based health services. A nationally representative study in 2010¹⁰⁸ found that emergency care services were not fully functional in two thirds of the observed facilities for reasons such as lack of medical doctors, low staff motivation and low demand. Two thirds of the deliveries had been referred, most often by the basic health staff, and the median total time to reach a facility after initiation of labour pains was three hours. The average waiting time for service after reaching a facility was 30 minutes.

Birth spacing and contraceptive prevalence – The total fertility rate (TFR) in Myanmar dropped, from 3.4 in 1990 to 2.0 in 2007, according to the 2007 Fertility and Reproductive Health Survey. Although the rural TFR fell drastically, from 3.28 in 1997 to 2.2 in 2007, urban fertility remained substantially lower (1.97 in 2001, 1.7 in 2007). Fertility performance was essentially concentrated among women aged 25–29, with minimal contribution from women younger than 20 or older than 40; women aged 15–19 contributed only 4–5 percent of the overall fertility. The decline in fertility levels could be attributed to delays in the age of marriage and first birth, an increase in the proportion of women who never married,¹⁰⁹ decline in fertility preferences and increased use of modern methods of contraception among women.

Figure 22: Trends in the contraceptive prevalence rate, 1991–2001



Source: Ministry of Immigration and Population and United Nations Population Fund, Detailed Analysis on Fertility and Reproductive Health Survey, Yangon, 2001.

There has been a marked increase in the contraceptive prevalence rate in Myanmar, reaching 37 per cent in 2001 (32.8 per cent using modern methods and 4.2 per cent traditional methods) and 41 per cent in 2007 (38 per cent modern methods, 3 per cent traditional methods). MICS 2009–2010 reported that 46 per cent of ever-married women used contraception, with injection the most commonly used method. Contraceptive use is highest among women in urban areas, those with secondary or higher education, and among the wealthiest women.

¹⁰⁸ Ministry of Health and UNICEF, *Assessment of Emergency Obstetric Care in Myanmar*, Nay Pyi Taw, 2010.

¹⁰⁹ Ministry of Immigration and Population and United Nations Population Fund, *Detailed Analysis on Fertility and Reproductive Health Survey*, Yangon, 2004.

Nationally, however, the unmet need for contraception is still high, estimated at 19.1 per cent in 1997, 17.8 per cent in 2001 and 17.7 per cent in 2007 of all currently married women of reproductive age (4.9 per cent unmet need for spacing purposes and 12.8 per cent for limiting pregnancies)¹¹⁰. The most widely used methods of contraception are the three-monthly injectable contraceptives (14.9 per cent) and daily combined oral pills (8.6 per cent). There is negligible use of IUDs and male methods for contraception, such as condoms. Women in urban areas have been found to be more likely to use contraceptive methods than their rural counterparts, and the prevalence of modern contraception is lowest among women with no schooling and increases with the level of educational attainment.¹¹¹

Guaranteeing access to birth spacing alone could reduce the number of maternal deaths by an estimated 25 per cent and child mortality by up to 20 per cent.¹¹² Although there has been progress in reducing overall fertility and contraceptive use has increased, there is much scope for improvement in both these areas.

One consequence of the high unmet need for birth spacing services is that a significant proportion of unwanted pregnancies in Myanmar result in induced abortions under unsafe conditions, leading to complications, maternal morbidity and mortality,¹¹³ which are exacerbated by delays in seeking qualified care. Abortion is legally restricted and permitted only to save a woman's life, but the 2004–2005 Maternal Mortality Survey found abortion-related causes to be responsible for 9.8 per cent of all maternal deaths.¹¹⁴ The traditional birth attendant's home was found to be the most common place for inducing abortion.¹¹⁵

b) Underlying causes

The underlying factors influencing reproductive and child health in Myanmar are complex, including socio-economic status, cultural values and norms, demographic and geographic indicators (age, ethnicity and location). However, the key factors are access to safe water and sanitation, household food security and access to quality health services.

Global studies have demonstrated a clear impact in the reduction of morbidity and mortality in children as a result of improvements in water and sanitation.¹¹⁶ Chapter 9 of this report examines issues related to WASH in Myanmar and the link between them and health impacts (such as diarrhoeal disease).

Household food security—Myanmar is self-sufficient in food production with thick forests that ensure monsoon rains and the potential to bring vast stretches of arable land under crops. Rice is the staple food of the nation and the principal agricultural product. Although food is sufficient at the national level, it is not always available when needed at household level due to low income levels, variation in food production, transport and food storage constraints, marketing systems and nutritional knowledge and practices. The production of

110 Ministry of Immigration and Population and the United Nations Population Fund, *Detailed Analysis on Fertility and Reproductive Health Survey*, Yangon, 2004.

111 Ministry of Immigration and Population and United Nations Population Fund, *Country Report on 2007 Fertility and Reproductive Health Survey*, Yangon, 2009.

112 Maternal and Neonatal Health in East and South-East Asia, UNFPA, *Country Technical Services Team for East and South-East Asia*, Thailand, March 2006

113 World Health Organization, 'Myanmar and Birth Spacing: An Overview,' 2005, New Delhi.

114 Ministry of Health and UNICEF, *Nationwide Cause Specific Maternal Mortality Survey 2004–2005*, Yangon, 2006.

115 Ministry of Immigration and Population and United Nations Population Fund, *Family and Youth Survey 2004: Country Report*, Yangon, October 2006.

116 Fewtrell, L. et al., 'Water, Sanitation and Hygiene Interventions to Reduce Diarrhoea in Less Developed Countries: A systematic review and meta-analysis', *The Lancet Infectious Diseases*, Vol. 5 No. 1, 2005, pp. 42-52.

meat and eggs has increased over the decade, from 1995–1996, but remains insufficient;¹¹⁷ and per capita intake of protein from animal sources differs widely between regions. A Household Food Security Survey in 1997¹¹⁸ found inadequate consumption in rural areas other than in rice and oil; milk was found to be available at the national level, but the respondents were not in the habit of drinking it. The average household in 2007 spent an estimated 72 per cent of its income on food¹¹⁹ and as a result, many households were particularly vulnerable to price increases. Inadequate dietary intake directly contributes to malnutrition as well as to deficiency disorders related to iron, iodine, vitamin A and vitamin B1.

Basic health service access and quality – Health services were discussed in Part One in the context of ‘quality of governance’ in Myanmar, but a number of issues specific to the health sector are explored here.

Over the past decade, Myanmar has seen the addition of 293 allopathic hospitals, almost 18,480 beds and 221 new rural health centres (taking the total to 1,558 rural health centres). The number of maternal and child health centres has remained unchanged, at 348 in the urban areas. In total, the country’s 924 hospitals provide 43,789 beds, and there are some 26,435 doctors, 25,644 nurses and 19,556 midwives.¹²⁰ Despite this progress, Myanmar still has significant problems with access to health services. The above figures mask wide regional variations in access to services. The remote and border areas of Myanmar have traditionally had fewer health facilities, primarily due to problems with access and security. As a result, children and women in rural, remote and outlying areas and those from poorer families tend to have substantially worse health and survival outcomes.

The challenges of remote locations, armed insurgencies and so on have led to some areas in Myanmar being classified as ‘hard to reach’ (including at least 82 of Myanmar’s 325 townships within the national EPI). Coupled with scarcity of resources, this has led to growing pressure on the most peripheral parts of the health system to focus on a targeted or essential group of minimum maternal and child health interventions in their catchment areas. Moreover, in many areas, no services are available at all: Medicines and trained providers for such common childhood illnesses as pneumonia and diarrhoea at the subrural health centre level cover around two thirds of the townships. Similarly, the birth spacing programme meets the needs of only one third of the country’s townships.

Many health facilities lack basic equipment and supplies. A major problem, again affecting the most peripheral levels of the health system the most, is lack of sufficient and/or appropriate health staff. The number of medical graduates has doubled since 1988, but the same period saw an increase of only 10 per cent in the number of midwives. According to international estimates, 2.28 health care providers (doctors, nurses and midwives) per 1,000 population is a threshold to achieve 80 per cent coverage for skilled attendance during deliveries.¹²¹ In Myanmar, the health assistant ratio is 1:21,822 and the midwife population ratio is 1:4,144.¹²² In 2007–2008, there were 3.8 doctors per 10,000 population, less than half of whom were in the public sector, and 3.8 nurses and 3.1 midwives per 10,000 population.

117 Department of Health, *National Plan of Action for Food and Nutrition*, Nay Pyi Taw, 2006–2010.

118 Ministry of Health, National Nutrition Center, 1997.

119 Ministry of National Planning and Economic Development and UNDP, *Integrated Household Living Conditions Assessment*, Nay Pyi Taw, 2007.

120 Ministry of Health, *Health in Myanmar*, Nay Pyi Taw, 2011.

121 World Health Organization, *World Health Report 2006*, Geneva, 2007.

122 Ministry of Health, *National Health Plan (2006-2011)*, Nay Pyi Taw.

Moreover, midwives are overloaded with multiple administrative responsibilities,¹²³ and there is confusion and conflict in their roles and that of the public health supervisors. Midwives are also difficult to retain in more remote, insecure and culturally diverse regions, resulting in significant numbers of unfilled posts and consequent lack of access to services. The motivation of health staff generally can become a problem due to insufficient training, irregular supervision and low salaries. The average midwife's salary is approximately \$2 per day. Such low levels do not encourage or reward good performance and outcomes at the personal or institutional level – a problem made worse by weak overall accountability.

Table 2: Comparative health human resources, 1990–1991 to 2007–2008

	1990–1991 (population 40.78 million)		1995–1996 (population 44.74million)		2007–2008 (population 57.50 million)	
	Number of providers	Providers per 10,000 population	Number of providers	Providers per 10,000 population	Number of providers	Providers per 10,000 population
Doctors (public and private)	12,268	3.0	13,202	3.0	21,799	3.8
Doctors (public sector)	4,418	1.1	5,229	1.2	7,976	1.4
Nurses	8,558	2.1	9,876	2.2	22,027	3.8
Midwives	8,334	2.0	8,454	1.9	18,098	3.1

Source: Statistical Yearbook 2008, Central Statistical Organization

The referral system for emergency obstetric and neonatal care services is weak, and there is a lack of integration between reproductive health and other health programmes and services such as maternal nutrition, anaemia and prevention and treatment of malaria. This is due in part to the vertical flow of funding dedicated to specific programmes. Maternal health does not receive adequate resources and is not seen as a priority in terms of financial commitments. Similarly, there is inadequate focus on neonatal and under-five mortality or on family and community practices. The high level of private financing of health expenditures promotes an emphasis on income-generating curative care, with less attention to prevention.

There are a number of issues with health financing in Myanmar:

Low public expenditure on health – Levels of public expenditure on health are low. The Government of Myanmar has greatly increased health spending over the last decade: overall health spending went up from 20,849 million kyat in 2005–2006 to 64,001.2 million kyat in 2009–2010, while per capita health expenditure rose from 376 kyat in 2005–2006 to 1,0824 kyat in 2009–2010.¹²⁴ In GDP terms, health spending increased, from 1.8 per cent of per capita GDP in 1998 to 2.0 per cent in 2007.¹²⁵ Despite these increases, the level of public spending remains far too low to guarantee results for all segments of the population. Kerala in India, Malaysia and Sri Lanka have all shown that maternal, newborn and child health outcomes can improve significantly for relatively little public expenditure in well-designed health systems; but the analysis of those experiences indicates that there is a minimum level of public expenditure below which progress stalls.

Inefficient expenditure – Inefficiencies in the health system mean that what little is spent on health does not achieve maximum results or even value for money. Acute respiratory infections, for example, attract around 5

123 Ministry of Health, 'Health System Working Paper: Health Systems Barriers to Improving Immunization and MCH coverage in Myanmar', Nay Pyi Taw, 8 January, 2008

124 Ministry of Health, *Health in Myanmar 2008*, Nay Pyi Taw, 2009

125 Ministry of Health, *Myanmar Health Statistics*, 2010.

per cent of direct aid globally, whereas they cause more than 19 per cent of child mortality. Meanwhile, other diseases receive larger funding than their share of the disease burden.¹²⁶ Inefficiency also occurs because scarce resources are directed to high-end tertiary services rather than to primary or secondary levels of care which could achieve the same outcome at a lower per unit cost. A further advantage of primary and secondary levels of care is that they are potentially more equitable, in that they are more available to the rural and urban poor. As well, the focus on curative diseases rather than preventive interventions promotes inefficiency. In 2001, 29.57 per cent of government health expenditure in Myanmar was devoted to curative and rehabilitative care and only 9.45 per cent for prevention and public health services.¹²⁷

Burden on users – Approximately 87 per cent of the overall expenditure on health in Myanmar is incurred by consumers in out-of-pocket expenses – the highest in the region.¹²⁸ The need to pay even relatively small sums is a barrier to health care for poor people, exacerbating poverty and inequality. A study in 2007¹²⁹ estimated the incidence of catastrophic payments as the proportion of households for whom health care costs were more than 40 per cent of their non-food expenditure. Overall, 136 (28.6 per cent) of 476 sampled households, had suffered catastrophic health payments. The degree to which health costs are passed on to the consumer is a marker of inequity and poor social safety nets. Social security expenditure on health accounts for just 1.3 per cent of the total health budget.

126 Schiffman, 2006 quoted in UNICEF, A Country Specific Strategic Analysis for reaching the health-related MDGs in Myanmar, Asia and Pacific Representatives Meetings, Cha-am Thailand.

127 Myanmar National Health Accounts, 1998-2001.

128 Countdown 2015 and WHO National Health Account Series.

129 Ministry of Health Department of Health and World Health Organization, *Health Care Financing Methods and Access to Health Care in Myanmar*, Nay Pyi Taw, 2008.

Box 3: Cost of treating a sick child¹³⁰

A boy, 2 years old, suffered from fever, cough, and tightness of chest. Daw Thida, the 47-year-old mother of the child, whose husband is a manual worker at the Kyauktaga Township Railways Department, bought sat-hsay (a combination of drugs) from a drug shop in Kauktaga town for 200 kyat per day, for four days. After the fourth day, the tightness of chest had improved, but the boy's fever did not subside. The grandmother of the child, trying to cure the illness in the Myanmar traditional approach, applied oak-hsay (literally meaning a drug for covering) to the body of the child to bring down the body temperature.

Five minutes after applying the oak-hsay, the child lapsed into fits. The mother rushed him to the private clinic of a medical doctor who works at Kyauktaga hospital, by a trishaw. The doctor referred the baby to the hospital, and the mother had to rush him there by trishaw. The doctor accompanied them. The baby was hospitalized for six days. During that time, the mother had to spend about 12,500 kyat on the needed medicines. The parents stayed at the hospital with the child till he was discharged.

Recalls Daw Thida, "My husband could take only three days leave and his salary was cut 500 kyat per day for the other days he was absent ... my husband borrowed money from a friend ... about 30,000 kyat, at an interest rate of 30 per cent. We cannot think of whether the interest rate is high or low ... to save our baby is important. We paid it back from my husband's salary ... 6,000 kyat per month, which is equivalent to three or four days' expenses for the meals of our whole family [there are eight children]. We reduced how much we ate. My eldest daughter found work as a manual labourer."

Inequities in health financing are especially noticeable with respect to maternal, neonatal and child health whereby a 'normal' event like pregnancy can become very expensive for households. A 2010 nationwide study found that the median total cost for delivery at a hospital was about 95,000 kyat, mainly covering the provider's fees and medicine, which averaged 35,000 and 30,000 kyat, respectively. In the study, almost all women reported that medicines were easily available but only 12 per cent of clients received all medicines free of charge from a hospital.¹³¹

8.3 Duty bearers: Role and capacity analysis

a) Family

Families are the duty bearers with the most immediate impact on maternal and child health and nutrition. They are responsible to maintain proper family care practices, such as infant and young child feeding, good hygiene and the care and treatment of sick children. In Myanmar, many families lack the knowledge and skills for appropriate family care practices as well as the financial resources to meet the costs involved.

Many deaths could be avoided if serious complications were recognized by caregivers and patients were referred to a health facility without delay. MICS 2009–2010 found that only 6.5 per cent of mothers or

¹³⁰ Ministry of Health and UNICEF, *Feasibility Study on Township Based Micro Health Protection, Myanmar: Qualitative Exploration*, Nay Pyi Taw, October 2011.

¹³¹ Ministry of Health and UNICEF, *Assessment of Emergency Obstetric Care in Myanmar*, Nay Pyi Taw, 2010.

caregivers of children under-five knew of the two danger signs of pneumonia – fast and difficult breathing. Families' awareness of the danger signs during pregnancy and delivery is also often low. In addition, there are some inappropriate beliefs and practices regarding diet for pregnant and lactating women. Families require more knowledge and skills and also the motivation to make and sustain additional efforts through social, educational and material support.

Adolescents tend to have limited information and understanding of reproductive health issues. A study in urban Yangon Region indicated that 76 per cent of 12- to 18-year-olds had heard of reproductive health, but 20 per cent knew nothing about it.¹³² Another study looking at communication between parents and adolescents on reproductive health¹³³ found parents reluctant to initiate such discussions due to the sensitivity of the subject and also because their own knowledge was sometimes poor. There are no projects dealing specifically with the reproductive health needs of adolescent internal migrants in Myanmar, even though these young people are at greater risk of HIV infection and other problems affecting their reproductive health.

Low government expenditure means that around 85 per cent of health expenditures are covered by household out-of-pocket spending.¹³⁴ This makes health care a significant expense for poor families and leads to delays in seeking health care.¹³⁵ In a 2006 study, households devoted about 1.3 per cent of their income to health care,¹³⁶ mostly for medicines and medical goods (54 per cent) and to curative services (30 per cent).¹³⁷

b) Communities

Strong and coherent communities have a main supportive function to households in strengthening family members' health outcomes. Since the 1978 Alma Ata conference, the primary health care strategy has been promoted in many parts of the world, including Myanmar. However, since the model was first introduced there has emerged awareness that primary health care is not entirely free because it is vital to provide strong supervisory links to primary health care workers; this supervision is to be provided by the township health system and requires considerable resources.

c) Civil society and the private sector

Civil society can play an important role in mobilizing community demand for health care services, training health workers, supporting national monitoring and evaluation of quality and access, and contributing to dialogue on policy development. They have duties to ensure that their activities serve to complement and strengthen national systems and to strive for sustainability in their service delivery initiatives.

The Myanmar Maternal and Child Welfare Association (MMCWA), an NGO established by the Government, with presence in all townships, has the widest engagement through activities related to health and awareness-raising as well as education and economic assistance. Civil society organizations have also been pivotal in establishing community-based care for HIV- or AIDS-affected families, but have remained small-scale local

132 Ministry of Health Medical Statistics Research Division, *Annual Report 2008*, Yangon, 2008.

133 'Reproductive health communication between parents and adolescents in North Okkalapa Township', Myanmar Health Sciences Research Journal, Vol. 21, No. 1, 2009.

134 Ministry of Health and WHO National Health Accounts, Myanmar (2006–2007).

135 MNPED, UNDP 2006. Poverty Profile: *Integrated Household Living Conditions Survey in Myanmar*, 2006, Nay Pyi Taw.

136 Based on monthly household expenditure data, 2006. *Statistical Yearbook 2008*, Central Statistical Organization, Nay Pyi Taw, 2009.

137 Ministry of Health and WHO. National Health Accounts, Myanmar (2006–2007),

initiatives. The Myanmar Red Cross Society provides community assistance in times of distress and disaster. Relatively few international NGOs are engaged in the health sector. Through the Three Diseases Fund (3DF) and the Global Fund, organizations such as PSI, Marie Stopes International and Save the Children Fund have been awarded contracts that are either disease specific or township specific and often concentrate on working outside the government health system. Other organizations, such as Doctors Without Borders (MSF), have been working in the country for more than 10 years and maintain health programmes, especially in the regions and states.

The role of private providers and the incentives that drive them is important because so many people turn to the private sector. A 2007 study by the Department of Health Planning found that 72.2 per cent of 532 household members received their health care services from the private sector; nearly 18 per cent of the households resorted to self-treatment and only 5.5 per cent used the public sector. Private providers are used especially by the poor due to physical proximity, shorter waiting times, no staff absences or drug shortages as in the public sector and perceptions of quality.¹³⁸ Private providers are thus an essential and important part of maternal, neonatal and child health services. However, most are unregulated and many even untrained – making the poor, in particular, vulnerable to low-quality and potentially even harmful treatment as well as financial exploitation.

d) Government

Myanmar's government holds the main responsibility for providing appropriate and accessible health care support for children and women.

Health policy and guidelines – In 1993, the National Health Policy was developed with the initiation and guidance of the National Health Committee. Under the policy, the 'health for all' goal was placed as a prime objective, to be achieved using a primary healthcare approach. Specific elements of the policy included provision of sufficient local level human resources, exploration of alternative health financing systems and expansion of health service activities to rural and to border areas.

The overarching policy framework for health development is the Myanmar Health Vision 2030, aiming to achieve universal coverage of health services, capacity building of human resources, medical research, modernization and more extensive utilisation of Myanmar traditional medicine. The five-year National Health Plan (2006–2011) seeks to accelerate efforts to realize the longer-term vision as well as the health-related MDGs and includes a focus on accelerating rural health development activities. Additional five-year strategic plans have been prepared around child health development, reproductive health, adolescent health and development and HIV and AIDS.

There are some key issues that are not being addressed at policy level, leading in turn to shortfalls in funding and implementation. Despite the overwhelming scientific and economic justification for investing in nutrition, for example, it is often overlooked and underfunded. Similarly, the maternal, newborn and child health 'continuum of care' approach requires access to care at different levels (families and communities, outreach services, and clinical services) and at critical time periods (pre-pregnancy, pregnancy, peri- and postnatal and neonatal periods and childhood). These requirements are not being adequately addressed, perpetuating

138 Ministry of Health, Department of Health Planning, *Health Care Financing Methods and Access to Health Care in Myanmar 2007*, Nay Pyi Taw, 2008.

morbidity, inequity and reduced productivity through the generations.

A further problem is that the health policies in place do not as yet promote a holistic approach to patient care, resulting instead in fragmented and vertical systems of service delivery management, weak decentralization and insufficient connection between decisions taken at central and subnational levels. Malnutrition, for example, is considered mainly as a component of the health sector rather than an inter-sectoral issue requiring attention in policies related to food security and livelihoods. Thus there is no systematic approach as yet to addressing the basic and underlying causes of poor child health outcomes.

A health system strengthening initiative adopted in 2008 is focused on improving the delivery of essential components of immunization, maternal and child health and nutrition and environmental health, with specific attention to promoting equity, responsiveness and the efficiency of health care services. Priority has also been accorded to the development of health services in underserved border areas. Capacity building and empowerment of community health workers to deliver life-saving interventions at the community level is the most important technical shift in the Myanmar context. This policy shift would be successful if community health workers were adequately trained and provided with appropriate supervision and monitoring.

Institutional framework – The inter-ministerial National Health Committee (NHC), formed in 1989, coordinates and facilitates inter-sector collaboration and provides guidance, direction and policy for all public health activities in line with the National Health Plan. The Department of Health (DOH) within the Ministry of Health is responsible for the delivery of preventive and curative health services. All technical programming functions are through states, and regions and townships. Although there is a district level to the health system, it is for administrative purposes only.

Townships have a catchment area of 100,000–200,000 people and are responsible for managing all secondary and primary care services, including one to two station hospitals and four to seven rural health centres. Each rural health centre has four sub-centres at the village level, covered by a midwife and public health supervisor (grade 2). Voluntary health workers (community health workers and auxiliary midwives) provide outreach services to village hamlets.

Birth spacing services in Myanmar are provided through the public sector in 132 of the country's 325 townships as well as through the private sector. Female sterilization is available through the public sector in all townships, but subject to permission from the state/region-level board. Effective implementing of a pro-poor cost-sharing policy for contraceptive supplies to ensure availability of modern contraceptive methods free of cost or at subsidized rate remains a challenge. There are also problems in terms of a sound logistic-management system for reproductive health commodities.

e) International development partners

International development partners have duties to ensure that the technical and financial assistance they provide for the health sector are well coordinated, sustainable and locally relevant.

In recent years, external assistance in health care has provided limited support to improve the quality of and access to preventive, promotive and curative health services for mothers and children. After the general destruction in the wake of Cyclone Nargis, the attention of most external partners was directed to preventing

further loss of life and rebuilding health infrastructure and services, especially in the Ayeyarwaddy Delta. The Global Fund and the Three Diseases Fund have provided significant resources over recent years, but activities have been disease focused and have only marginally contributed to strengthening of township health plans. In 2011, the health systems strengthening component of the GAVI assistance has started to cover incrementally over the next four years up to 180 townships. The same donor consortium plans to start a 3 Millennium Development Goals Fund in 2012 to provide external assistance to about 100 townships; this includes a health system strengthening component to support long-term sustainability.

8.4 Key recommendations

Financial resources for effective township health plans – The health sector in Myanmar has suffered for decades from low investment in creating an equitable health system, both from the Government as well as international partners. Because national resources will continue to be limited, even with substantial national budget increases, significant outside assistance will be needed to ensure the building of an equitable health system that is capable of providing high-quality and low-cost preventive, promotive and curative health care to the entire population.

Policy gaps and prioritization of effective strategies – A systematic approach to policy-making for the health sector is needed so that a holistic, integrated strategy can be adopted to health care of children and women and cross-sectoral issues like malnutrition can be effectively addressed. Greater attention needs to be paid to key interventions that reduce neonatal and child mortality and maternal mortality and to changing behaviours of families and communities to prevent malnutrition, diarrhoea and pneumonia. Overall, much greater priority (and resources) should be given to prevention of disease and illness. It is the family and community level which are most important for the health of children. Consequently, improvement of key family practices and health outreach services that can be taken to families and communities need to be prioritized. Research should be conducted to develop effective behaviour change communication strategies. Comprehensive and community-oriented primary health care as a key element of the health system needs to be re-emphasised, with strengthening of the link between community health activities and the township health system.

Effective planning – Planning at all levels and by all stakeholders needs to be made more effective. To bring this about, state and region health departments should be involved in township health planning exercises, and vertical health programmes supported by international development partners should be aligned with township health plans. State and region health departments should also be supported to develop meso health plans, to minimize overlapping of services.

Effective coordination – The coordination of health services provision needs to be strengthened: with international development partners for resource mobilization; among different entities/programmes involved in health care (child health, nutrition, EPI, malaria) to contribute to the required continuum of care; at all levels of the health system (national, state/region, district and township); and across service providers (public sector, private sector, NGOs, informal sector). The regulation of private health providers should be strengthened.

Promoting equity – Inequities in access to and quality of services should be addressed. One option would be to implement the scenario-based approach adopted in the national Child Health Strategic Plan. This is

based on the principle that simple interventions, if implemented widely, are likely to create the greatest improvement in child survival. Consistent with this, population/areas could be stratified according to risk factors, poverty and so on, and different intervention packages be applied – basic for those where health service coverage is low, intermediate in areas where coverage is better and a complete package where it is high. An additional measure needed to reduce the cost burden of health care on the poor is greater provision of social security support (social safety nets and health insurance).

Increase of demand side – through focused communication for development (C4D) and quality of services strategies, including exploration of demand side health financing options.



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9. Children's right to water and sanitation

Access to safe water and basic sanitation are essential for child survival, health and development; but they also are critical to the realization of all children's rights in Myanmar. The United Nations General Assembly 2010 resolution "Declares the right to safe and clean drinking water and sanitation as a human right that is essential for the full enjoyment of life and all human rights".¹³⁹

This chapter provides an overview of the situation regarding women's and children's right to safe water, sanitation and hygiene in Myanmar. It then analyses the factors influencing the realization of this right, and the roles and capacities of relevant duty bearers, ending with key recommendations for the realization of this right.

Box 4: WASH and diarrhoea – Critical Link

Globally, nearly one in five child deaths is due to diarrhoea; it is the second leading cause of death among children under-five globally and kills more young children than AIDS, malaria and measles combined.¹⁴⁰

It has been estimated that 88 per cent of diarrhoeal deaths worldwide are attributable to unsafe water, inadequate sanitation and poor hygiene.¹⁴¹ The burden of diarrhoea disease can be reduced by up to an estimated 25 per cent through improving the water supply, 32 per cent through improving sanitation, 45 per cent through handwashing and by 39 per cent through appropriate household water treatment and safe storage.¹⁴² Handwashing at critical times, including before eating or preparing food and after using the toilet, can reduce diarrhoea rates by almost 40 per cent.¹⁴³

Given that in Myanmar diarrhoea is the second leading cause of deaths among children under-five, accounting for as much as 18 per cent of child mortality,¹⁴⁴ there is a particular need for the country to prioritize further improvements to access and use of clean water and basic sanitation. MICS 2009/10 reported that 6.7 per cent of under-5 children had diarrhoea in the two weeks preceding the survey.

9.1 Situation overview

While on the surface substantial improvements have been made in Myanmar with regard to access to safe water and improved sanitation, a comparison of the MICS findings between 2003 and 2010 show that the incidence of diarrhoea among under-five children increased by more than 60 per cent (from 4.2 to 6.7 per cent) in the past seven years.

139 Article 1, Human Right to Water and Sanitation, United Nations General Assembly Resolution A/64/L.63/Rev.1, 26 July 2010.

140 Bartram, J. and Cairncross, S., 'Hygiene, Sanitation and Water: Forgotten foundations of health', PLoS Medicine, November 2010, Volume 7, Issue 11

141 Black, R.E., Morris, S. and Bryce, J., 'Where and Why are 10 Million Children Dying Every Year?', The Lancet, vol. 361, no. 9376, 28 June 2003, pp. 2226-2234.

142 World Health Organization, Combating water-borne disease at the household level. The International Network to Promote Household Water Treatment and Safe Storage.

143 Waddington, H. et al., International Initiative for Impact Evaluation: Synthetic review 001 –Water, sanitation and hygiene interventions to combat childhood diarrhoea in developing countries, 3IE, 2009.

144 Ministry of Health and UNICEF, *Overall and Cause-Specific Under-Five Mortality Survey*, Yangon, 2003

With respect to the use of improved water sources at household level, the MICS estimated an increase from 60 per cent in 1995 to 78.8 per cent in 2003 and 82 per cent in 2010.¹⁴⁵ With respect to basic sanitation, the MICS estimated that between 1997 and 2010, the population proportion usually using sanitary means of excreta disposal increased from 65 per cent in 2003 to 84.6 per cent in 2010.¹⁴⁶ Most widespread was the use of direct or indirect pit latrines with slabs, followed by pour-flush or flush latrines to septic tanks or pits, both of which are improved latrine types. Unsanitary ways of excreta disposal using direct or indirect pit latrines without slabs and other or no facilities were mentioned by 6.4 per cent and 7.5 per cent households, respectively.

In early 2011, UNICEF conducted a WASH knowledge, attitudes and practice (KAP) study in 6,000 households in 24 townships. The study discovered the reasons for the apparent high physical coverage of improved sanitation but low impact on the incidence of child diarrhoea. Although the findings show comparable access figures to the IHLCA and MICS findings, the KAP probes to a greater degree of detail, which allows for much deeper analysis.

In the KAP study, 83 per cent of the community households reported that they had a latrine at home, about 14 per cent did not have access to improved latrines and more than 8 per cent defecated openly. However, a closer look at the condition of these latrines, 75 per cent of which are claimed to be improved, shows that the actual number of hygienic, fly proof latrines is very small.

Table 3: Comparison of child mortality and sanitation figures in eight ASEAN countries, 1990–2009

Country	Under-5 mortality rank	Under-5 mortality rate		Infant mortality rate (under 1)		Neonatal mortality rate 2009	Life expectancy at birth (years) 2009	% of population using improved sanitation facilities 2008		
		1990	2009	1990	2009			total	urban	urban
Malaysia	157	18	6	16	6	3	75	96	96	95
Thailand	125	32	14	27	12	8	69	89	92	82
Viet Nam	93	55	24	39	20	12	75	75	94	67
Philippines	77	59	33	41	26	15	72	76	80	69
Indonesia	66	86	39	56	30	19	71	52	67	36
Myanmar	44	118	71	84	54	33	62	81	86	79
Cambodia	36	117	88	85	68	30	62	29	67	18
Laos PDR	52	157	59	108	46	22	65	53	86	38
Singapore	184	8	3	6	2	1	81	100	100	

Source: State Of the World Children. UNICEF (2011)

Designation of flush or pour flush in the Myanmar context must be understood: Most latrines of this type refer to the HDPE¹⁴⁷ 'pan and pipe', which is neither water sealed nor fly proof. Some 72 per cent of the

¹⁴⁵ The IHLCA estimated an increase from 62.6 per cent in 2004–2005 to 69.4 per cent in 2010–2011. However, the definition used in the IHLCA is not in accordance with the international definition used in the MICS. Adjusting for differences in the definition, the IHLCA estimate fell between 75 and 80 per cent in 2010.

¹⁴⁶ This is similar to the results from the two IHLCA surveys that estimated an increase from 67.3 per cent in 2005 to 79 per cent in 2010.

¹⁴⁷ High density polyethylene, a polyethylene thermoplastic made from petroleum.

improved latrines were labelled as 'flush/pour flush to pit latrine', which indicates the use of the HDPE pan and pipe. More than 8 per cent of households with children under-5 said their children had suffered from diarrhoea during the two weeks preceding the survey. The predominance of unhygienic latrines was most likely a major cause of the diarrhoea.

The KAP study also found that 68 per cent of households had access to improved water sources; however, the survey further showed that at the point of consumption, the water is probably being contaminated because only 17 per cent of households had a safe way to extract drinking water from its storage. Additionally, there are many possibilities for source contamination in between, with almost one third of latrines too close to water sources and many other poor hygienic practices creating a risk of contamination.

The issue is further highlighted when comparing water, sanitation and under-five mortality rates in neighbouring countries. In Table 3, selected indicators from socio-economically similar ASEAN countries have been extracted from UNICEF 2010 State of the World's Children. Myanmar's sanitation coverage is reported as comparable to Thailand or Malaysia, but the infant mortality rate is similar to Lao PDR or Cambodia.

Indicators for WASH also vary across regions and income levels. MICS 2009–2010 showed that large disparities exist in terms of safe water and improved sanitation. With respect to safe water, the MICS 2009–2010 estimated that 77.6 per cent population in rural areas used improved water sources, while it was 93.2 per cent in urban areas. These figures hide the fact that there are significant seasonal variations. The smallest population proportions using improved water sources were found in Kayin and Rakhine states, at 51.1 per cent and 57.7 per cent, respectively (figure 23). Rural households face particular challenges in accessing safe water during the 'dry' months of March, April and May. Disparities in the use of improved water sources were also found with respect to a household's wealth level. MICS 2009–2010 estimated that among households in the poorest wealth quintile, 66.8 per cent used an improved source of water, compared with 95 per cent in the richest wealth quintile.

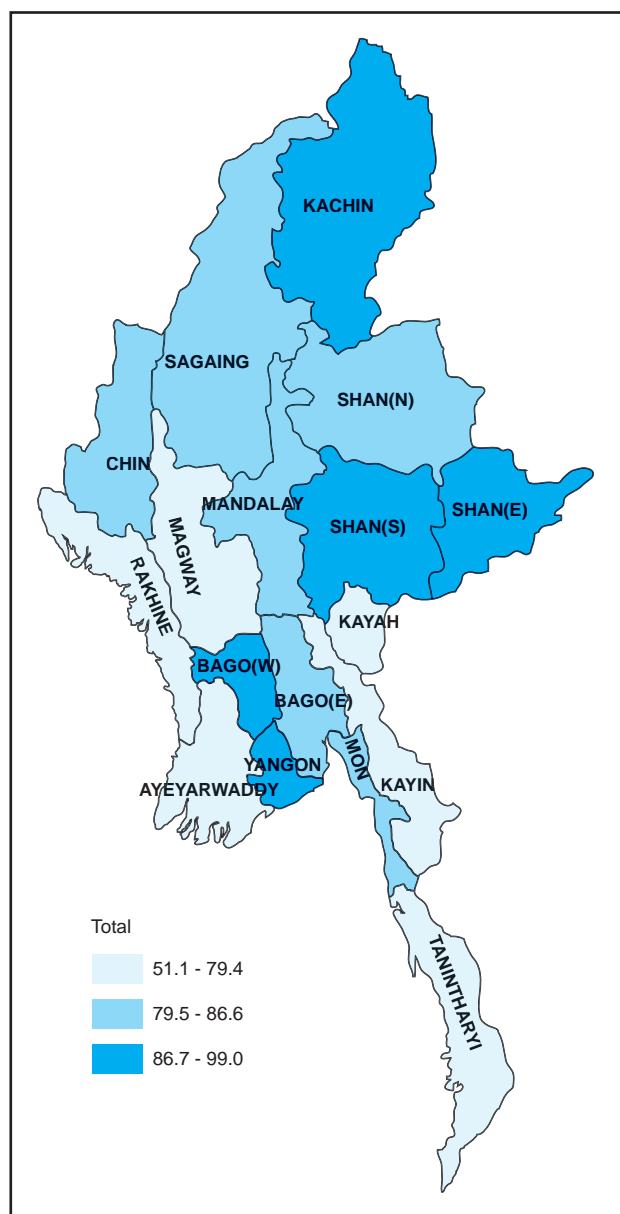
Use of improved latrines is much higher in urban and richer households compared with rural and poorer households. In urban areas, MICS estimated that 94.4 per cent population usually used latrines of an improved type, compared with 80.4 per cent in rural areas. Large disparities were also found between states and regions. In particular, Rakhine (48 per cent) and Shan (North) (68.3 per cent) were among the states and regions where relatively fewer households used improved sanitation facilities. In terms of wealth, 59.8 per cent population in the poorest quintile usually used improved sanitation facilities, compared with 98.2 per cent among the richest quintile.

Awareness and knowledge on recommended practices regarding safe water and basic sanitation has so far not been translated into appropriate behaviour. Almost all people are aware that open defecation should be avoided. Still, open defecation has been found to occur in many areas throughout the country, but particularly in rural communities. Similarly, people are aware of the importance of using soap when washing hands. However, few people actually use soap even when it comes to hand washing after defecation.

a) Access to clean water

In Myanmar, a number of surveys over the past decade all showed an increase in households' access to improved water sources; MICS reported a jump from 60 per cent in 1995 to 78.8 per cent in 2003 to 82 per cent in 2009-2010. The IHLCA estimated an increase from 62.6 per cent in 2004–2005 to 69.4 per cent in 2010. However, the definition used in IHLCA is not in accordance with the international definition used in MICS; adjusting for the differences, the IHLCA estimate comes to 75–80 per cent in 2010.¹⁴⁸

Figure 23: Regional disparities in use of improved water sources, 2009-2010



Source: MICS (2009-2010)

148 Unlike the international definition used in MICS, the IHLCA classified all bottled water as unimproved, which makes up for almost 20 per cent population in urban areas and 6.4 per cent overall. Moreover, IHLCA used a more stringent definition, classifying only water sources within 30 minutes location from a residence as improved. The MICS estimated that 4 per cent households had to travel more than 30 minutes to collect the water and return. However, the IHLCA included protected ponds in its definition of improved water sources, which, according to the international definition (also used in MICS) is an unimproved water source. Adjusting the IHLCA estimate to the international definition places the estimate at between 75 and 80 per cent of the population with access to an improved water source.

Box 5: Improved water sources and sanitation

Access of households to clean water is determined by assessing the proportions of households using improved ‘clean’ water sources, such as water piped into dwellings or yards, water from public standpipes, tube wells/boreholes, protected wells or protected springs or bottled water, if used in combination with water for purposes other than drinking from improved water sources. Unimproved water sources, such as surface water from rivers, ponds or lakes or from unprotected dug wells or springs, are known to more likely contain unclean water that is hazardous to human health.

The UN Joint Monitoring Programme for water supply and sanitation (JMP) defines improved sanitation as a “sanitation system in which excreta are disposed of in such a way that they reduce the risk of faecal-oral transmission to its users and the environment”. Facilities that hygienically separate human excreta from human contact can thus be regarded as sanitary. With respect to latrines, the following are categorized as ‘improved’: pour-/flush toilets connected to a sewerage system, septic tank or pit latrine; ventilated improved pit (VIP) latrines; pit latrines with slabs or composting toilets. By contrast, pour-/flush toilets connected to elsewhere, that is, no sewerage system, septic tank or pit latrine; open pit latrines without slabs; and buckets or hanging latrines, are all categorized as ‘unimproved’. Any facility, whether improved or not, that is shared with other households is considered unimproved. Finally, any form of open defecation in the bush, field, river or lake that is, without using any facility is considered unimproved.

While access to latrines is a prerequisite for ensuring the sanitary disposal of faeces, evidence from other countries suggests that it does not guarantee that people are actually using them. Problems in latrine maintenance, latrine construction as well as local customs may prevent people from using their latrines. Internationally sponsored household surveys, such as the Demographic and Health Survey (DHS) or MICS, thus ask respondents what kind of toilet facility they and other household members usually use.

Box 6: Access to water leaves children free to study¹⁴⁹

Gant Gaw village in Myebon Township was badly hit by Cyclone Giri in October 2010. The spring where the villagers collected water, located on a hill some 3 miles from the village, was contaminated by debris. According to U Maung Thar, a villager, before Cyclone Giri he had to spend half a day every day to fetch 40 litres of water for drinking purposes and household use. Climbing up and down the steep hill with no proper road and reaching the spring was extremely strenuous. The situation was even worse for the elderly in the village, who were unable to reach the spring on their own and had to depend on neighbours for water for everyday use.

“When we spent all that time fetching water, we had to rely on our children for much of the chores at home. Children had too much responsibility at home to be able to focus on school and studies. School absenteeism had become common, causing many to drop out during the school years,” said U MaungThar.

Construction of a gravity flow system from the spring brought water within close reach of the villagers. Children of Gant Gaw village nowadays are allowed time they need for education, social activities and play, largely made possible by the gravity flow system.

Water source type – According to the most recent MICS, the most common water sources used in Myanmar were tube wells or bore holes (31.5 per cent), followed by protected dug wells (27.2 per cent), unprotected dug wells (10.9 per cent), surface water (5.1 per cent), protected springs (3.1 per cent) and unprotected springs (0.9 per cent). Hilly regions, like Shan and Chin states, were found to be more dependent on gravity-fed water systems, while use of surface water was more prevalent in the delta region (9.3 per cent in Ayeyarwaddy) and dry zone (10.6 per cent in Magwe). Approximately 60 per cent of the urban population in the city of Yangon had piped water. The remaining city population took water from wells, ponds and rainwater harvesting.¹⁵⁰

When reporting on water access in Myanmar, it is important to recognize the impact of the different seasons on the use of ‘safe’ water. The surveys cited here did not take the seasonal variations into account, reporting only a single estimate for the whole year. Several recently conducted surveys found a strong seasonal component with households switching from the use of a surface water source in the drier seasons to the use of rainwater during the rainy season. For example, the 2011 WASH KAP study¹⁵¹ estimated that, while during the rainy season, up to 82 per cent of households used water from improved sources, only 70 per cent used the source during the drier summer and winter seasons. A large number of households were found to switch from rainwater collection (16 per cent to 2 per cent) to fetching surface water (12 per cent to 21 per cent) at the end of the rainy season. The months in which households had difficulties in getting water were March, April and May, when many of the water sources were depleted.

Water fetching – MICS 2009–2010 found that only 35 per cent of households had their water source on their premises; the remaining 65 per cent had to fetch water. Water was more accessible for urban households;

149 UNICEF Newsletter, Vol. 5 No. 1, June 2011.

150 Than M.M., ‘Water and Waste Water Management in Yangon, Myanmar’, in Proceedings of Water Environment Partnership in Asia First International Workshop, Irrigation Department, Ministry of Agriculture and Irrigation, March 2010.

151 Ministry of Health and UNICEF. ‘Knowledge, Attitude and Practice Study into Water, Sanitation and Hygiene in 24 townships of Myanmar’. Yangon 2011.

64 per cent had water on their premises, compared with rural households, in which only 24 per cent had it. Similarly, water was more accessible for wealthier households. Adult females were the household member who usually fetched the water. While these gender differences were common throughout the country, the use of children for collecting water was found to be low. Very few households reported having to spend more than one hour for a round trip to fetch water.

b) Access to basic sanitation

MICS 2009–2010 estimated that the proportion of the population with access to sanitary means of excreta disposal increased from 65 per cent in 2003 to 84.6 per cent in 2010.¹⁵² Most widespread was the use of direct or indirect pit latrines with slabs (64.9 per cent), followed by pour-/flush latrines linked to septic tanks or pits (13.9 per cent), both of which are improved latrine types. Unsanitary ways of excreta disposal using direct or indirect pit latrines without slabs and other or no facilities were mentioned by 6.4 per cent and 7.5 per cent households, respectively.

The MICS findings were echoed by the 2011 KAP study, which found that 69 per cent of households had an improved latrine, 16 per cent were without any latrine and 6.3 per cent shared their latrine with other households. According to the KAP study, rural households were less likely to have improved sanitation facilities. However, a closer look at the data and from analysis of the observation check list, many of the latrines reported as improved were in fact unhygienic. For example, only 36 per cent of all latrines at home had a hygienic floor, such as concrete, with water-pour flush.

While home access to sanitary latrines is crucial, this is not sufficient to ensure that every person has adequate access to sanitary facilities at all times. The WASH in Schools survey 2010 found that many schools have latrine facilities but their condition is often poor, leaving many of them unsanitary or even unusable for school children. In the KAP study, a large number of households (62 per cent) reported that at least one of their household members worked in the field. Among the households, 85 per cent reported that no latrine was available in the field – meaning they had to resort to open defecation. Hence, it is important to note that information about the ‘usual’ means of excreta disposal at home can only be a rough proxy for whether the practice of open defecation had been completely eradicated.

c) Hygiene practices

Awareness and knowledge in Myanmar about recommended practices regarding safe water and improved sanitation has so far not been translated into appropriate behaviour.

Open defecation—Almost all people are aware that open defecation should be avoided. Despite this, open defecation has been found to occur in many areas throughout the country, particularly in rural communities.

Hand washing – Hand washing at critical times reduces faecal–oral transmission and plays an important role in preventing disease. The critical times include after defecation or cleaning child faeces, before eating or feeding a child, and before cooking. To achieve an adequate hygienic level, hand washing with water alone is not sufficient. The real benefit of hand washing is achieved only when done with soap rather than with water alone.

¹⁵² This is similar to the results from the two IHLCA surveys, which estimated an increase, from 67.3 per cent in 2005 to 79 per cent in 2010.

Although hand washing has been found to be prevalent among the population, the use of soap is not. According to the 2011 KAP study, almost all respondents washed their hands before meals, but up to 60 per cent did not do so with soap. Given that 90 per cent of households – 93 per cent in rural and 78 per cent in urban areas – reported eating their meals with their fingers directly, the risk of contamination with germs is thus substantial. Similarly, most adult household members reported washing their hands after defecating, but up to 30 per cent used only water without soap. While water was available in 82 per cent of toilet facilities, soap was available in only 15 per cent.

Water fetching – Improper handling practices during water fetching from the water point to the household can lead to water contamination.¹⁵³ The KAP study found that people were aware of this hazard, pointing out that water fetching using dirty water containers or containers without covers can affect the water quality. However, a dedicated study is needed to assess whether this awareness translates into appropriate practices of water fetching that prevent water contamination.

Water storage – The manner in which households store their water can impact water quality. Using lids for water containers, cleaning containers regularly and keeping containers elevated from the ground are measures to prevent contamination. Most households in the 2011 KAP study were found to be aware of these measures. The majority of households kept their water container elevated, covered and clean. The use of earthen pots of two or more gallons was most common, followed by plastic containers and tin/metal containers in a few households. Water taps and the use of cups with handles that are cleaned regularly are additional measures to keep water safe. According to the KAP study, only a few households had water containers with taps, or poured water from containers into cups. Most of the households were found to dip their water cups – most of them with handles – into the container.

Defecation practices of children – The use of napkins is widespread for children up to the age of 1 year; from the age of 2 years, a large number of children switch to using latrines. The critical group of children are thus those aged 1–2 years. Many of them defecate either directly on the ground or into their clothes; use of a pot is low, at about one in five cases. In many households, child faeces are disposed of improperly, often into the yard or sometimes into surface water. Disposal into latrines is not common for infant faeces; up to 81 per cent of caretakers reported that they used other means for disposing of the faeces. Napkins are usually washed and re-used in the same way as clothes.¹⁵⁴

Another problem is that many caretakers and children do not use soap for washing their hands or cleaning a child's bottom, particularly after the children defecate. Focus group discussions revealed that a number of individuals perceived child faeces as less harmful than adult faeces.¹⁵⁵

153 Action Contre La Faim. *External Final Report on Water and Sanitation, Hygiene Disaster Risk Assessment*, February 2008.

154 Ministry of Health and UNICEF. *Knowledge, Attitude and Practice Study into Water, Sanitation and Hygiene in 24 townships of Myanmar*. Yangon 2011.

155 Ibid

Box 7: Disparities in children's right to water, sanitation and hygiene

Rural–urban disparities:¹⁵⁶

- In rural areas, 66 per cent of the population have access to an improved source¹⁵⁷ of drinking water in all seasons; compared with 86 per cent in urban areas.
- The urban population is nearly twice as likely to wash their hands with soap before eating compared with the rural population (59 per cent in urban areas versus 36 per cent in rural areas).
- The rural population is six times as likely to defecate in the open compared with the urban population (19 per cent in rural areas versus 3 per cent in urban areas).
- In urban areas 64 per cent of latrines have 'bricks/concrete & plastic pan, and wood' flooring, compared with 40 per cent of rural latrines.

Socio-economic disparities:¹⁵⁸

- Among the poorest quintile, 25 per cent treat their drinking water with an appropriate method, compared with 41 per cent in the richest households.
- Among the poorest quintile 26 per cent have no access to sanitary facilities, while nobody in the richest quintile lack sanitation facilities.

Gender disparities:

- In 72 per cent of households an adult woman is the person who usually collects the household's drinking water. An adult man collects the water in 24 per cent of households.¹⁵⁹
- In Rakhine state women collect water in 93 per cent of households.¹⁶⁰
- Open defecation is less common among women than among men – 40 per cent of women said they had not defecated in the open in the last year, compared with 27 per cent of men.¹⁶¹

Geographic disparities.

- The proportion of the population reporting difficulty in getting water is 82 per cent in Rathedaung Township in Rakhine State compared to 23% in Chang Oo Township, Sagaing Region.¹⁶²
- In Rakhine State 41 per cent of the population is without access to sanitation facilities, compared with 0.3 per cent in Yangon.¹⁶³

156 Ministry of Health and UNICEF. 'Knowledge, Attitude and Practice Study into Water, Sanitation and Hygiene in 24 townships of Myanmar'. Yangon 2011.

157 Although having access to an improved water source, contamination of the water happens between the time of fetching and drinking, so that far fewer actually drink clean water.

158 Ministry of National Planning and Economic Development, Ministry of Health and UNICEF, *Myanmar Multiple Indicator Cluster Survey 2009-2010*, Nay Pyi Taw, 2011.

159 Ibid

160 Ibid

161 Ministry of Health and UNICEF. 'Knowledge, Attitude and Practice Study into Water, Sanitation and Hygiene in 24 townships of Myanmar'. Yangon 2011.

162 Ibid

163 Ministry of National Planning and Economic Development, Ministry of Health and UNICEF, *Myanmar Multiple Indicator Cluster Survey 2009-2010*, Nay Pyi Taw, 2011.



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9.2 Causality analysis

a) Immediate factors

Five factors have an immediate impact on fulfilment of the right to safe water: i) water source type, ii) water source quality, iii) water fetching, iv) water storage and v) water treatment. Water source type, fetching and storage were discussed previously in the situation overview; the other factors are discussed below. Access to sanitation, type of facilities and defecation practices were also discussed previously. Equally important are proper design and maintenance of improved facilities, and the manner in which solid waste is disposed of – these are discussed below.

Water source quality –The type of water source used by households can only be a rough proxy for water quality: Water from an improved source may still be compromised by chemical or faecal contamination. A water quality assessment in 2001 found that many of the dug wells – protected or not – contained water contaminated with faecal coliform.¹⁶⁴ The same study showed that even sources taking water from lower water tables such as tube wells, were not entirely free of contamination. Least safe for drinking were gravity-flow systems, ponds, lakes and reservoirs.

Human behaviour that can lead to contaminated water includes bathing, defecating or washing clothes in the proximity of a water source. The 2011 WASH KAP study found that about one in three households bathed and washed clothes close to the water source outside their compounds with proper water drainage systems, and one in two households with animals had them fed close to a water source. Moreover, many of the latrines were found to be located less than 50 feet from a water source. Given that most latrines in rural areas have pits with permissible lining, often using bamboo or wood, the risk of contamination of the ground water and thus the water source can be substantial.

With regard to chemical contamination, arsenic levels exceeding the recommended levels were found in 47 townships in 2006, with the most serious problems encountered in the Ayeyarwaddy Region, where more than half of drinking water wells were contaminated.¹⁶⁵ The only sources found to be safe from arsenic contamination were gravity-flow systems and springs. Fluoride is another potentially hazardous substance in water; while low levels can be beneficial for the human body, when they exceed a certain threshold they can cause considerable damage to teeth and bone structure. A study in 2001 found no fluoride in the water sources serving up to 2.5 million people (particularly in Magway and Ayeyarwaddy regions), while 2 million were at risk of too-high levels of fluoride, particularly in Sagaing, Mandalay and Bago regions.¹⁶⁶

Water treatment – Water treatment can be crucial for ensuring clean drinking water, particularly in countries where many households obtain their water from unimproved water sources, such as surface water or unprotected wells. Boiling, adding bleach or chlorine, using a water filter and using solar disinfection are all capable of removing most types of bacteria and thus can make water even from unimproved water sources safe to drink.

164 Ministry of Agriculture and Irrigation and UNICEF, *Drinking Water Quality Surveillance and Monitoring, Analysis of Drinking Water Quality in Selected Areas of Myanmar*, Yangon, April 2002.

165 UNICEF, *Arsenic Mitigation in Myanmar, Final progress and utilization report presented to the Australian Agency for International Development (AusAID)*, Yangon, April 2006.

166 Reconnaissance survey conducted by the Water Resources Utilisation Department, 2001.

According to MICS 2009–2010, 12 per cent of households in Myanmar did not use any water treatment method, and 10 per cent just let their water stand and settle. The most common way of treating water was to strain it through a cloth, a practice that does not make water sufficiently safe for drinking. Only 35 per cent of the population used an appropriate water treatment method to make their water safe to drink; one in three households boiled their water, while very few used water filters or added bleach or chlorine. The proportion of households using appropriate treatment methods were almost the same for those obtaining water from improved water sources (35.5 per cent) and unimproved sources (31 per cent), even though the latter carry far greater risks of contamination.

There were significant disparities in the use of appropriate water treatment. Despite the fact that the rural population was more likely to use water from unimproved sources, fewer households treated water appropriately (32.6 per cent) compared with urban households (39 per cent). With regard to regional differences, the lowest percentage of population treating water appropriately was found in Bago (West) with 9 per cent, followed by Rakhine State (18 per cent) and Ayeyarwaddy (19 per cent). The highest prevalence of appropriate household water treatment was found in Kayah (84 per cent) and Chin (83 per cent), where the most common treatment method was boiling the water. Among the poorest households, 25 per cent used an appropriate water treatment method, while 41 per cent did so among the richest households.

Designation and maintenance of sanitary facilities – Latrines designated as ‘improved’ are not always so in practice. In the 2011 WASH KAP study, 83 per cent of the community households reported that they had a latrine at home (14 per cent did not have access to improved latrines and more than 8 per cent defecated openly). However, a closer look at the condition of the latrines – 75 per cent of which were claimed to be improved – showed that the actual number of hygienic, fly-proof latrines was very small. Designation of flush or pour flush in the Myanmar context must be understood. Most latrines of this type refer to the HDPE¹⁶⁷ ‘pan and pipe’. Some 72 per cent of the improved latrines were labelled as ‘flush/pour flush to pit latrine’, which indicates the use of the HDPE pan and pipe and which is neither water sealed nor fly proof. More than 8 per cent of the households with children under 5 said their children had suffered from diarrhoea during the two weeks preceding the survey. The predominance of unhygienic latrines was most likely a major cause of this diarrhoea.

Even where facilities are genuinely ‘improved’, a further issue is maintenance of them. Most widespread in Myanmar are latrines made of bamboo and wood.¹⁶⁸ These types of latrines often become unusable after a few years unless repaired and maintained properly. Hence many latrines – even improved ones – may be available but either only partially or not at all functional. According to the 2011 KAP study, up to 35 per cent latrines were of limited functionality and unclean. These problems were more widespread in rural areas.

Solid waste disposal – Waste disposal, both wastewater and solid, is subsumed under sanitation. In Myanmar the majority of the solid waste produced by households consists of solid or semi-solid refuse from food, which is decomposable. However, the amount of non-decomposable waste, either combustible (such as paper, wood and cloth) or non-combustible (such as metal, glass and plastics) is on the rise. If disposed of inadequately, the gases and non-decomposable remains can pollute land, water or air and can serve as a breeding ground for disease-carrying insects and rodents. Adequate solid waste disposal methods include burying the waste in the yard, composting, collection by scavengers or a neighbourhood collection mechanism with local disposal.

167 High density polyethylene, a polyethylene thermoplastic made from petroleum.

168 Ministry of Health and UNICEF. ‘*Knowledge, Attitude and Practice Study into Water, Sanitation and Hygiene in 24 townships of Myanmar*’. Yangon 2011.

Inadequate methods include burning and open dumping in the yard, in the street or in bodies of water.

According to the 2011 WASH KAP study, most households used inadequate methods to dispose of their solid waste, with rural households more prone to do so. Up to 36 per cent of households burned their waste, 17 per cent dumped it in fields, 15 per cent into garbage holes within their compounds and 16 per cent into streams or ponds or on the river bank. Although most of these methods were used in rural as well as urban areas, dumping waste in the field was much more common in rural areas (up to 20 per cent) compared with urban areas (6 per cent). Disposal at unofficial garbage sites was also common, with 11.1 per cent in urban and 15.6 per cent in rural areas. An organized form of waste disposal was only found in urban areas, where households either disposed of their garbage at a disposal site specified by the municipality (7.8 per cent) or had their garbage collected by private (2.9 per cent) or public (6.5 per cent) garbage collectors.

b) Underlying factors

Underlying factors impacting access to clean water and sanitation in Myanmar include: a 'disconnect' between awareness about safe water and sanitation and actual practice; resource constraints; and challenges posed by Myanmar's varied terrain and frequent natural disasters.

Disconnect between awareness and behaviour – The KAP study found that households in Myanmar are generally aware of the importance of having clean water, maintaining basic sanitation and hygiene levels. However, this awareness has not yet translated into the corresponding appropriate behaviour. For example, up to 88 per cent individuals could cite an appropriate water treatment method among multiple answers, and 83 per cent mentioned boiling water; yet the same survey found that only 66 per cent actually treated their water appropriately and only 61 per cent boiled it. Similarly, bathing, washing clothes, trash disposal and defecation close to the water source were mentioned by about 47 per cent, 33 per cent, 30 per cent and 26 per cent, respectively, creating a high risk of human waste contaminating improved water sources. Despite this, many latrines were located close to a water source, and many household respondents reported disposing of waste and child faeces into surface water sources.

In some cases, despite awareness, there may be cultural practices and attitudes that prevent individuals from acting appropriately. A survey in 2002, for example, found that up to one third of households without latrines also thought that it is not customary to use them, particularly in the Delta and coastal areas.¹⁶⁹ In other cases, it is lack of knowledge that prevents appropriate actions. Regarding the water supply, for example, households and communities have a number of options to improve the safety (covering dug wells, ensuring proper drainage to prevent surface water seeping back into the ground near the well and so on), but they need more knowledge as well as skills and resources to put them into practice. When the skills and resources are provided, change is seen: 65 per cent households reported that increased knowledge on the beneficial health impacts of using toilets led them to build and use latrines at home.

Resource constraints – Even with awareness and the right attitude, clean water and basic sanitation may not be affordable for poorer households. The cost of installing water sources can be a major constraint and varies considerably across different areas and types of terrain. Shallow tube wells with hand pumps and improved wells and ponds are the cheapest water sources (\$0.73–\$1.65 per person). Deep tube wells, needed to reach the low water tables in the dry zone and arid areas, cost around \$4.54 per capita, while the gravity flow

169 UNICEF/MMRD. 'KAP Survey on Water, Sanitation and Hygiene in Myanmar' Yangon 2002

systems used in hilly terrain cost over \$16 per capita.¹⁷⁰ With respect to basic sanitation, 72 per cent of households in the 2011 KAP study reported that they built their own latrine at an average cost of 41,742 kyat. The average lifetime of a latrine was reported to be about three years, meaning the additional cost for repairing or building a new one would arise within a short time span.

Funding for the provision of safe water and sanitation comes from a variety of sources, notably private donations (discussed in section 10.3 further on). Government resources for water supply are generated from tax revenues, with the Department of Development Affairs allocating 3 per cent of each township's revenue to urban water supplies (generally provided as piped supply) and 5 per cent to rural systems. The Department of Development Affairs also receives limited funding for water supply from a central budget. The result is that water systems in better-off regions and townships tend to be better resourced than those in poorer and more remote townships.

Environmental factors and natural disasters – Myanmar has abundant water resources in much of the country, including both surface and underground sources. However, different parts of the country experience a variety of challenges in availability of safe water. The delta and coastal areas have to deal with flooding and saltwater intrusion (also brought on by events such as cyclones), while dry areas are constrained by low water tables and frequent drought. In the hilly areas, the problem can be both inadequate water sources and water retention; it can be difficult to maintain water supplies on sloping lands. The increasing levels of agriculture, population growth, migration and urbanization and the development of new urban centres all pose challenges to water availability and quality as well as to environmental degradation.

Many areas of Myanmar are subject to annual flooding, which, along with periodic disasters, can have a major negative impact on the safe water and sanitation facilities that have been established. The damage caused by Cyclone Nargis to the water supply systems alone amounted to an estimated \$7.7 million,¹⁷¹ with 60 per cent of the affected population reporting inadequate access to clean water.¹⁷² The rise in salinity caused by such events can take as long as two to three years to clear from water sources, forcing the affected communities to find other solutions. The impact of climate change, particularly the greater frequency and severity of these events in different and sometimes new locations, means that large swathes of the population are at much greater risk of water shortages.

Sustainable domestic water supplies depend upon the availability of renewable water sources that can be developed easily. Myanmar's rainfall ranges from 750 millimetres to more than 4,300 millimetres per annum; but 95 per cent of this falls in the months of May to October.¹⁷³ Additionally, fresh water resources are not spread evenly across the country; large areas of the central plains, known as the 'dry zone', are dependent on deep wells for most of the year. Many of these wells (more than 10,000 in the dry zone) were developed with international assistance, but are now 10–30 years old and at risk of failure as they become older.

170 Based on 1998 estimates. Report on Country-level Assessment of Water Supply and Sanitation 2000 in Myanmar, Department of Health, WHO and UNICEF, 2002.

171 Data provided by the Department of Relief and Resettlement, November 2010.

172 Tripartite Core Group, *Post-Nargis Joint Assessment*, July 2008.

173 Ministry of National Planning and Economic Development, Central Statistics Organization, *Statistical Yearbook 2009*, Nay Pyi Taw, 2010.

9.3 Duty bearers: Role and capacity analysis

Box 8: Cost effectiveness of WASH interventions

Measuring the cost benefit of WASH interventions or investments is not practically possible in monetary units, but rather in natural units such as healthy life years gained or disability adjusted life years¹⁷⁴ (DALYs) averted or in time saved. A cost-effective analysis is the method of choice for deciding how to allocate resources in the health sector.¹⁷⁵

Interventions against diarrhoeal disease (\$ per DALY averted) ⁸⁸	Cost-effectiveness ratio
Cholera immunizations	1,658–8,274
Rotavirus immunization	1,402–8,357
Measles immunization	257–4,565
Oral rehydration therapy	132–2,570
Breastfeeding promotion programme	527–2,001
Latrine construction and promotion	≤270.00
House connection water supply	223
Hand pump or stand post	94
Water sector regulation and advocacy	47
Latrine promotion	11.15
Hygiene promotion (including hand washing)	3.35

A cost-effectiveness study on interventions addressing high-burden diseases in low- and middle-income countries and on WASH interventions in particular published in 2006 demonstrates some WASH interventions are among the top-most cost-effective approaches for averting DALYs related to diarrhoeal disease. It also demonstrates that the differences in costs per DALY averted among the intervention types are considerable.

a) Family and communities

The responsibility for protecting water from contamination, ensuring proper sanitation practices and following good hygiene behaviour begins in the home. As seen in this chapter, families are hampered by lack of knowledge and/or failure to translate this into practice and by resource constraints.

Regarding hygiene practice, many families have at least some awareness of good behaviour, such as washing hands, using soap, avoiding open defecation and treating water to make it safe to drink. While awareness

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- 174 The disability adjusted life year, or DALY, is a health gap measure that extends the concept of potential years of life lost due to premature death to include equivalent years of 'healthy' life lost by virtue of being in states of poor health or disability. The DALY combines in one measure the time lived with disability and the time lost due to premature mortality. One DALY can be thought of as one lost year of 'healthy' life and the burden of disease as a measurement of the gap between current health status and an ideal situation where everyone lives into old age free of disease and disability.
- 175 Haller, L., Hutton G. and Bartram, J., 'Estimating the Costs and Health Benefits of Water and Sanitation Improvements at the Global Level', in *Journal of Water and Health*, 5 April 2007.
- 176 Laxminarayan R., Chow, J. and Shahid-Salles S, *Intervention Cost-Effectiveness: Overview of Main Messages*, Chapter 2. *Disease Control Priorities in Developing Countries*. Second Edition. Jameson et al., Oxford University Press, New York, 2006.

levels are high, practice is not, leading to many preventable problems, not least of which is the high prevalence of diarrhoea. Proper drainage around a house can reduce breeding sites for vectors that carry disease, such as rats, flies and mosquitoes, thereby preventing the transmission of malaria, which is the leading killer of under-five children in Myanmar.

Regarding resource constraints and social services, there is an increasing tendency for families to expect others to provide for them, especially in areas supported by aid agencies in the wake of disasters such as Cyclone Nargis. Although it is true that constructed water supply (drilled well or piped system) often calls for substantial investment beyond the resources of a single family, sanitation does not require much investment, as demonstrated by the initial trials for community-led total sanitation (CLTS) (see below). The success of this tool is not based on funding but rather the realization by every family that even if one member of the community defecates in the open, everyone is at risk.

Resource constraints could also be addressed through the use of less costly options. The 2011 WASH KAP study found that most latrines cost more than 40,000 kyat. This cost is for prescribed technology, often imposed by external projects, but based on best practices from outside the community. Naturally the better the latrine the more hygienic it will be, but the first goal should be achieving a basic standard of sanitation. What is required is a more attainable facility, within the community's budget. In the recent CLTS training, the cost of a basic latrine was only 3,000 kyat, using locally available material and a 2,000 kyat pan and pipe. Locally manufactured ceramic pans (of good quality) cost less than 6,000 kyat.

The collective realization of the community that it must solve its own problems is at the core of the two main tools used for improving WASH in Myanmar: water safety planning and CLTS. Both entail creating awareness of the need for every individual in the community to play a part in protecting water sources from contamination and preventing pathogens from re-entering the human body. In many communities, in Myanmar the water supply systems have been built through the collective effort of the whole village. More than 30 rural villages have sustainable piped systems; meters record water use and payments are made accordingly. CLTS has only been introduced in 10 villages so far, but the results are promising, and the communities involved have shown a great willingness to become open-defecation free.

b) Civil society and private sector

Private donors in Myanmar provide a major financial contribution for rural water supply, based on the Buddhist belief that donating water returns ten-fold blessings. This resource has been recognized as a major factor which can expand population coverage, and the Government held eight nationwide campaigns between 2001 and 2004 to raise funds from local sources. In terms of basic sanitation, 5 per cent of households in the 2011 WASH KAP study reported that their latrines had been built and/or donated by NGOs. The private sector also contributes an important role through the manufacturing of water supply and sanitation materials.

c) Government

Policies and legislation – The Convention on the Rights of the Child highlights children's right to the highest attainable standard of health; this includes provision of clean drinking water, promotion of hygiene and environmental sanitation and addressing the dangers and risks of environmental pollution.¹⁷⁷ MDG 7, which

177 Article 24 of the *Convention on the Rights of the Child*, Yangon

focuses on environmental sustainability, includes targets on access to safe water and improved sanitation; this right is also implicit in MDG 4 because without clean water and protection from poor sanitation, other health interventions cannot succeed. Myanmar's Constitution (2008) highlights water as a resource for the major development sectors and pays particular attention to the protection of the natural environment.

Various laws are related to water, specifically those around urban water utilisation, health, environment, irrigation water supply and livestock and fisheries. The Public Health Law (1972) includes a focus on environmental sanitation, control of epidemic disease and attention to the quality and cleanliness of food as means of protecting people's health. The Development Committee Law (1993) clarifies the responsibility of these bodies in relation to water supply, sanitation and sewerage disposal in urban areas. Issues around water and sanitation are also referred to in various other pieces of legislation; for example, the Myanmar Investment Commission Guideline (1994), which specifies that new projects from both foreign and local private investments must have wastewater treatment plans or systems. In all, the statutory laws are more relevant to issues of urban water supply.

Two national policies have been developed which are relevant to water and environmental sanitation. The National Environmental Policy (1994) focuses on water as a natural resource and on ensuring attention to environmental considerations (including preserving natural resources) in the development process. In 1995 the Government established a National Health Policy that resolved to achieve 'sanitation for all' by 2000, making sanitation a priority at every level of government.¹⁷⁸ The National Health Policy expands environmental health activities to include prevention and control of air and water pollution and allows for the development of new rules and regulations to address prevailing health-related conditions, as necessary. The Government's policy on hygiene promotion (including hand washing) also comes under the prevention and control of environmental health project outlined in the National Health Plan (2001–2006).¹⁷⁹

A national policy on waste management was established in 2003, again under the National Health Plan. Systems are in place in the major cities: Yangon's City Development Committee reportedly collected 80 per cent of solid waste in 2007.¹⁸⁰ They tend to be less developed in many towns, however, and at the village level they are very limited or non-existent. Waste management therefore remains a serious problem.

Safe water supply and environmental sanitation are an important focus of Myanmar's National Plan of Action for Children (2006–2015), which highlights the link between unsafe water supplies and improper sanitation and ill-health of women and children. It also notes the need for safe water supply and sanitation in some underdeveloped urban areas and most rural areas. The National Plan of Action defines a range of strategies to improve safe water and basic sanitation coverage, including strengthening government infrastructure and effective deployment in appropriate sectors, awareness-raising at the grass-roots level, promoting private sector engagement in the water sector, quality surveillance of drinking water and strengthened cooperation between relevant departments.

Overall, the policies in place include positive steps towards prevention and control of water and environmental pollution, but there is insufficient focus on safe water and sanitation. Myanmar has no specific water policy and no national drinking water standards, both of which are critical to ensure safe water for health. Additional

178 Bajracharya, D., 2003. Myanmar experiences in sanitation and hygiene promotion: lessons learned and future directions. *International Journal of Environmental Health Research* 13. S141-S152.

179 Myanmar, *National Health Profile 2008*, Nay Pyi Taw

180 *ibid.*

gaps are the lack of legislation on rural water supply for domestic use, the quality assurance of drinking water,¹⁸¹ regulation of drinking water provided by other sources and supply systems, protection of rivers and lakes from pollution by sewage, industrial as well as solid waste disposal and environmental pollution. Policies are also needed to address the sustainability of water and sanitation infrastructure and promote equitable access, which ensures affordable safe water and sanitation for the poorest.

Institutional framework – The Government's mandate in terms of water supply has been to provide at least one drinking water source for every village in rural areas throughout the country. There is no specifically designated lead or coordinating body for the provision, maintenance and regulation of this. Responsibility is fragmented among a number of ministries and departments including: the Environmental Sanitation Division, the Central Health Education Bureau and the Occupational Health Division of the Ministry of Health, the Department of Development Affairs of the Ministry of Border Area Affairs, and the Department of Educational Planning and Training of the Ministry of Education.

In rural areas, the Department of Development Affairs oversees construction, operation and maintenance of water supply systems and construction and inspection of sanitation arrangements. In peri-urban areas, the Department of Development Affairs has most WASH responsibilities, although there tends to be less attention to sewerage disposal. In Yangon, Mandalay and Nay Pyi Taw, WASH is the remit of the respective city development committees, but the Ministries of Health and Education also have some responsibilities. No specific agency is responsible for disposal of solid waste and sewerage in rural areas; much therefore depends on the commitment, available resources and hygiene awareness of the communities.

National Sanitation Week – The annual Government-led National Sanitation Week has been carried out since 1998 and provides a major push to promote rural sanitation coverage by raising public awareness of sanitation issues and promoting cooperation and working partnerships with communities. The National Sanitation Week has undoubtedly been the reason for the extensive coverage of latrines across the country. People know why they should have a latrine and want to use one; however, many believe that they cannot afford to maintain the infrastructure unless further subsidy is provided, which is resulting in damaged and unused facilities.

The National Sanitation Week has recently been focussing on disadvantaged townships. In 2002, for example, special emphasis was directed to 73 townships in which more than half of households had no access to a sanitary latrine;¹⁸² – with the aim of upgrading households' sanitary facilities and providing information on hygiene. In select townships, the National Sanitation Week activities are followed up with intensive mobilization of hard-to-reach households and school-based sanitation and hygiene education activities.

d) International development partners

Among aid agencies and donors, UNICEF takes the lead for WASH in Myanmar. Before cyclone Nargis, only JICA, Save the Children, ADRA and UNICEF had WASH activities within their programmes. During and following the disaster, the number of international and national partners implementing WASH programmes increased many-fold; however, this is reducing as funding declines and these agencies concentrate their health budgets on curative programmes. AusAID have been the most generous of the donors for WASH interventions. Other major WASH donors include Danida and JICA.

¹⁸¹ Other than bottled drinking water, which is the focus of a specific law.

¹⁸² Bajracharya, D., 2003. Myanmar experiences in sanitation and hygiene promotion: lessons learned and future directions. International Journal of Environmental Health Research 13. S141-S152

9.4 Key Recommendations

Improved coordination – Developing sustainable WASH systems and practices in every village tract in Myanmar will require responsible departments in the government to work together at national, state or region, and township levels to ensure a convergent approach to achieve common goals together. Establishment of a WASH task force is recommended for planning, budget allocation, monitoring and data analysis. GAD might be considered as a core agency of the Task Force.

Holistic approach to WASH – Issues related to water supply and sanitation (promoting access to improved water sources and sanitation and reducing risks) and promoting good hygiene practice (translating awareness into action) need to be tackled together. The impact of an improved water supply is lessened if the improvement in sanitation and hygiene do not come at the same time. Equally, improved sanitation is rarely possible if safe water is not available, and good hygiene practices are not in place. The recent pilots in water safety planning and community-led total sanitation in Myanmar show the impact such a holistic approach can have. In addition, WASH in School initiatives can add to this combined effect, educating children on proper water, sanitation and hygiene practices, thereby reinforcing the message at home. As part of a holistic approach, there is a need for planning at all levels.

Proper impact assessment – Proper impact assessment requires clear definitions and the setting of clear targets. Thus, in the case of sanitation, the success of such programmes should not be based on the number of latrines that are built, functioning or clean, but instead the number of communities that have achieved the goal of being “open-defecation free, defined as follows: the household has a functioning latrine, which everyone uses and is fly proof, and everyone washes their hands with soap after use. Equally, the provision of water supply should not just be counted as a community with a system but rather as a community in which every member has sufficient quantity of safe water all year round. The target for this could be defined as ‘adequate, sustained water supply for all year around’ or ‘robust, sustainable and appropriate technology’.

Translating WASH awareness into behaviour change – The innovative Four Cleans awareness programme that Myanmar has implemented over the past two decades has clearly had an impact on people’s knowledge. The challenge now is finding the next steps to ensure that this knowledge is translated into practice, through an attitudinal change. This could be done through CLTS initiatives.

Cost-effective solutions – Using such tools as CLTS, locally developed solutions to improved sanitation that are maintainable within community’s budgets are possible. This can be combined with water-safety planning to create both an awareness of the problem of open defecation and other poor hygiene practices as well as an attitudinal change towards people believing that avoiding the risks is within their power.



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10. Children's right to education

The Convention on the Rights of the Child commits States Parties to making primary education compulsory and free, making secondary education and vocational guidance available and accessible to all children and taking measures to encourage regular school attendance and reduce the drop-out rates. With its full endorsement of the Millennium Declaration, Myanmar has committed to achieving universal primary education (MDG 2) and equality at all levels (MDG 3) by 2015.

This chapter looks at the extent to which children in Myanmar are able to realize their right to education (disaggregated into early childhood development, primary and secondary education and focusing on issues of participation, completion and quality), the causes of violations of this right and the roles and capacities of the duty bearers who are responsible for ensuring children's education.

10.1 Situation overview

There has been considerable expansion in education provision in Myanmar over the past two decades. Most schools, except for a small number of proprietary vocational schools, are operated or supervised by the central Government. While the Ministry of Education (MoE) is the primary provider of educational services, other government departments have important roles, including the Department of Social Welfare, which oversees community-based early childhood development (ECD) programmes, the Ministry of Religious Affairs, which oversees monastic schools, and the Ministry of Border Affairs, which builds schools in some border areas. NGO participation is mainly in the non-formal sector, monastic education and ECD.

The formal education system entails 11 years of schooling beginning at age 5. Increasingly, younger children are participating in pre-primary education through pre-schools (operated by the Ministry of Education and attached to primary schools) or community-based early childhood centres (operated by the Department of Social Welfare, NGOs or community groups).

According to the Ministry of Education, there are currently 35,548 primary and post-primary schools, 3,022 middle (lower secondary) schools and 2,306 high (upper secondary) schools. Some 5.2 million students are enrolled in primary schools (grade 1–grade 5), 2.3 million students in middle schools (grade 6–grade 9) and 0.7 million students in high schools (grade 10–grade 11). The number of schools in the border areas has increased annually, reaching 1,074 in 2010. The average distance a child has to travel to school is 1.43 miles.

The table below spotlights the progress against the MDGs, the Education for All (EFA) and the 30-Year Basic Education Development Plan¹⁸³ targets.

183 Ministry of Education, *Education for All in Myanmar*, Nay Pyi Taw, October 2010.

Table 4: Progress against education goals

Millennium Development Goals	Progress
<ul style="list-style-type: none"> Goal 2: Achieve universal primary education Target 3: Ensure that by 2015, children everywhere, boys and girls alike, can complete a full course of primary schooling 	Current net enrolment rate is 84% in primary education, with 16% of 5- to 9-year-olds not in school. Completion rate according to MICS (2009–2010) is only 54%.
<ul style="list-style-type: none"> Goal 3: Promote gender equality and empower women Target 4: Eliminate gender disparity in primary and secondary education, preferably by 2005, and to all levels of education no later than 2015 	Gender parity has been achieved at the primary level. Female secondary net attendance is slightly higher in urban and rural areas according to MICS (2009–2010).
Dakar Framework for Action: Education for All (EFA) – From the World Education Forum 2000	
<ul style="list-style-type: none"> Expand and improve comprehensive early childhood care and education, especially for the most vulnerable and disadvantaged children 	Participation in ECCE has increased though still low compare to the region. Number of pre-school classes increased from 496 in 2001 to 2,567, covering almost 7.3% of primary schools. ¹⁸⁴
<ul style="list-style-type: none"> Ensure that by 2015 all children, particularly girls, children in difficult circumstances and those belonging to ethnic minorities, have access to and complete primary education of good quality 	Girls' enrolment in primary school is 84%. There is no overarching strategy or disaggregated data on children in difficult circumstance and ethnic minorities.
<ul style="list-style-type: none"> Ensure that the learning needs of all young people and adults are met through equitable access to appropriate learning and life skills programmes Achieve a 50% improvement in levels of adult literacy by 2015, especially for women, and equitable access to basic and continuing education for all adults 	Life skills-based education for primary level has been introduced in all schools. Currently, secondary life skills education is being expanded to all secondary schools in phases, and young female literacy rate is estimated at 87.8, according to MICS (2009–2010)
<ul style="list-style-type: none"> Eliminate gender disparities in primary and secondary education by 2005 and achieve gender equality in education by 2015, with focus on ensuring girls' full and equal access to and achievement in basic education of good quality 	See above MDG progress.
<ul style="list-style-type: none"> Improve all aspects of quality education and ensure excellence so that recognized and measurable learning outcomes are achieved by all, especially in literacy and numeracy and essential life skills 	Standardized tests have been developed to measure Myanmar language and mathematics learning competencies and have been administered in targeted townships and not yet scaled up as a national standard for measuring learning achievement.

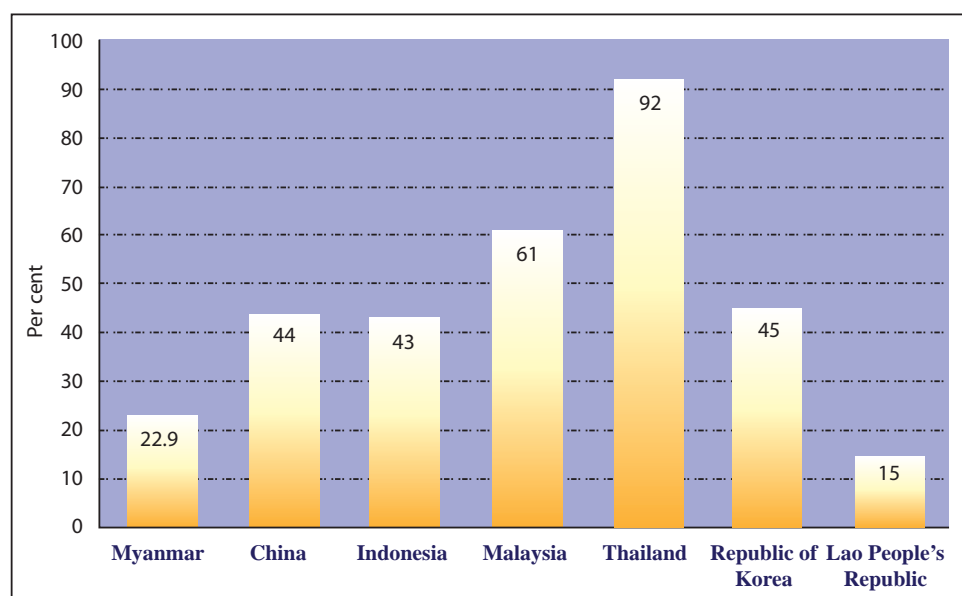
Myanmar Long-Term Basic Education Development Plan: Programme 2: Completion of basic education by all citizens	
<ul style="list-style-type: none"> Universal primary education by the end of the first five-year medium-term plan 	<p>Even though the grade 1 intake rate in primary education is 98.37% in 2010–2011, the retention and completion of primary education remain challenging. Achievement of these targets will depend on further investment in the basic education sector, especially in terms of increasing access and improving quality.</p>
<ul style="list-style-type: none"> Universal lower secondary education by the end of the third-five year medium-term plan 	
<ul style="list-style-type: none"> Universal basic education by the end of the long-term plan 	

a) Early childhood development

Early childhood is now internationally recognized as a critical period of human development, when the foundations for subsequent learning and adult life are established, and an area that requires national policy attention.

Significantly more children are participating in early childhood care and education (ECCE) programmes (for children aged 3–5 years) than 10 years ago (trends on early childhood development (ECD) services for children up to 3 years old cannot be assessed because relevant national data is not available). The percentage of children aged 3–5 years attending some form of organized early childhood education programme increased from 9 per cent to 22.9 per cent between 2000 and 2009–2010.¹⁸⁵ This represents a doubling in participation, albeit from a low base. The EFA National Plan of Action sets the target of 25 per cent by 2015, which (on current trends) is likely to be achieved. Gender parity has been achieved. However, comparison of the current rate with the gross enrolment rate (GER) in pre-primary and early childhood care and education with other countries in the region finds Myanmar still lags behind its neighbours.

Figure 24: Gross enrolment ration in pre-primary and other ECCE programmes in the region

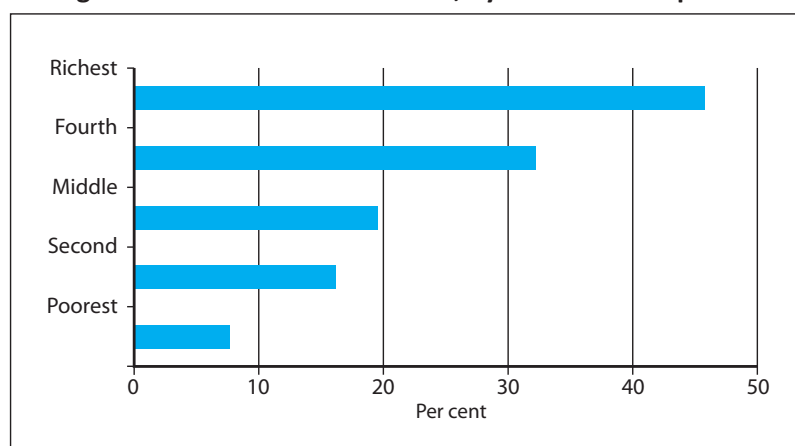


Source: Education for All Global Monitoring Report 2011 and MICS 2009–2010.

185 Ministry of National Planning and Economic Development, Ministry of Health and UNICEF, *Myanmar Multiple Indicator Cluster Survey 2009–2010*, Nay Pyi Taw, 2011.

Although the overall rise is impressive, there are significant disparities. Available data indicates that the richest quintile benefit most from existing ECCE services (46 per cent) and the poorest quintile the least (7.6 per cent) ¹⁸⁶ (figure 25).

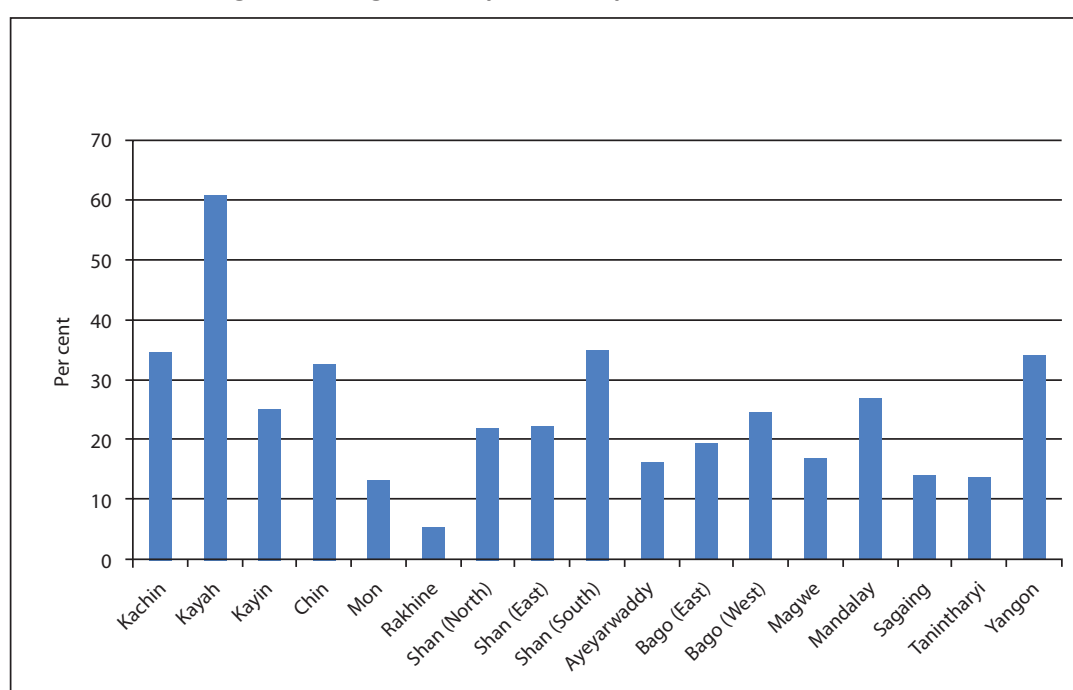
Figure 25: Pre-school attendance, by wealth index quintiles



Source: MICS 2009-2010

There are similar findings for children whose mothers have at least secondary education (35.7 per cent participating in early childhood development), compared with those with only primary education (15.8 per cent). There is a bias towards urban settings: 39.1 per cent ECD participation compared with 15.9 per cent in rural areas. Older children are more likely to participate: the rate is 32.9 per cent for 4- to 5-year-olds, compared with 13.8 per cent for 3- to 4-year-olds. Regional disparities are particularly marked: rates range from 60.7 per cent in Kayah State to 5.4 per cent in Rakhine State (figure 26). Other factors such as ethnicity and language, place of residence and disability, can exacerbate the disadvantages arising from household poverty.

Figure 26: Regional disparities in pre-school attendance



Source: MICS 2009-2010

Ensuring the quality of ECD services is a work in progress. Core indicators for minimum quality standards for ECD have been developed and are being progressively implemented with support from UNICEF. These cover areas such as the pre-school environment, learning corners, the role of caregivers, child participation, parental and community participation and ECD management. However, a national monitoring and evaluation framework for ECD services is currently lacking.

In the community-based Mothers' Circles (for children aged 0–3 years), the caregivers were found¹⁸⁷ to have acquired a good knowledge of families and their situation and developed key skills, leading to children feeling at home in the Circles. The Mothers' Circles help build social recognition, community trust and a safe and secure environment for young children. As a result of the holistic interventions, the participating children gained weight, malnutrition was addressed and they had a better health status. Parents became more patient and gentle with children, paid more attention to hygiene and had a better understanding of how children learn. There was more interest in their development and a lessening of the parental care burden, which was helpful for poor working families.

These findings were corroborated by a 2007 study on the impact on livelihoods of ECD programmes,¹⁸⁸ which found strong community satisfaction with the educational aspect of the programme. Children enrolled in the ECCE centres were reported to be consistently more active, curious and clean than those not enrolled. Overall, children's enrolment in the programme allowed parents to work with the security that their children were being well cared for, thus promoting an improvement in families' livelihoods.

Pre-school programmes are increasingly being used to pay attention to mother tongue learning as well as to preparing speakers of other languages for the transition to Myanmar language in primary education. (Developmentally appropriate children's books and learning materials have been developed by MoE and other partners to promote bilingual development in targeted ECD centres.)

Research has shown that children who have participated in early childhood development programmes are more likely to enrol in primary education and less likely to drop out, with children from disadvantaged families benefiting disproportionately. In the MICS 2009–2010 survey, 39.8 per cent of children attending first grade in Myanmar had attended pre-school in the previous year. The figure was higher in urban areas (52.8 per cent) than in rural areas (34.4 per cent). Mothers' education consistently is a strong influence in determining children's enrolment in pre-school. Some 44.5 per cent of first graders whose mothers had secondary or higher education attended pre-school in the previous year, compared with 39.7 per cent of those whose mothers had primary education only. There are also differences according to socio-economic status, with 34.5 per cent of first graders in the poorest households having had the opportunity to attend pre-school, compared with 51.7 per cent of the richest children.

b) Primary education

The majority (84 per cent) of primary school-aged children (5–9 years) in Myanmar were attending school in 2010.¹⁸⁹ Improved coverage at the primary level has been achieved, as confirmed by the expansion in the

187 UNICEF programme monitoring.

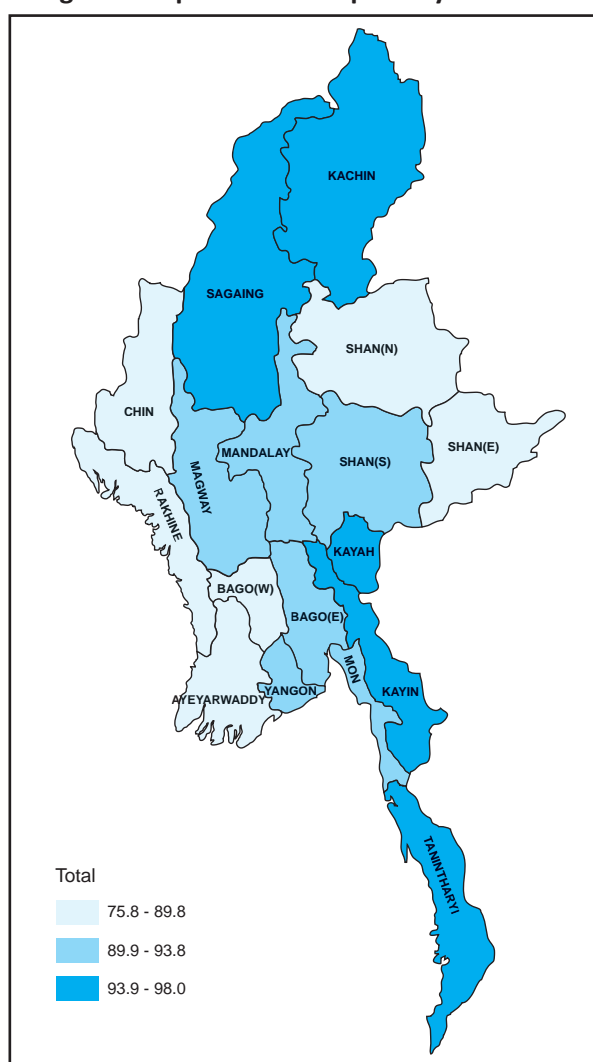
188 UNICEF Assessment of Early Childhood Development and its impact on Children, Parents and Communities in Myanmar. The Most Significant Change Approach Yangon. 2007

189 Ministry of Education (MoE) Department of Educational Planning and Training, Basic Education Indicators for HRDI (Labour), memo (1), Nay Pyi Taw, 2010.

school numbers cited in the previous section as well as by the establishment of many schools teaching multi-grade; these account for up to 60 per cent of total provision, and even in less remote areas they constitute an estimated 20–30 per cent of schools.

The gender parity index for primary school net attendance in 2009–2010 was 1.01.¹⁹⁰ At the national level, there were no significant differences between the attendance of boys and girls in primary education. However, other disparities exist: in terms of regions (figure 27), Tanintharyi (98 per cent) had the highest rate of primary education participation and Rakhine (75.8 per cent) the lowest; there was a slight bias towards urban schooling – 93 per cent compared with 89.2 per cent in rural schools; it was much higher for children from the richest quintile (94.9 per cent) than those from the poorest (81.4 per cent).¹⁹¹ Enrolment of disabled children is particularly low (as discussed in Chapter 12).

Figure 27: Regional disparities in net primary school attendance rate



Source: MICS 2009-2010

Children are expected to enrol in primary school at the age of 5, but late enrolment is common. Despite official whole township enrolment drives undertaken since 1999–2000, the MICS 2009–2010 data show that

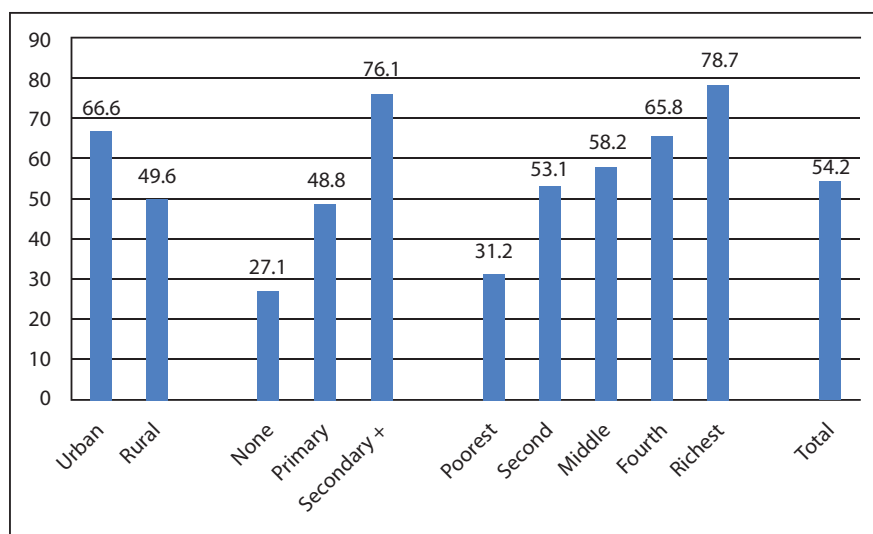
190 Ministry of National Planning and Economic Development, Ministry of Health and UNICEF, *Myanmar Multiple Indicator Cluster Survey 2009–2010*, Nay Pyi Taw, 2011.

191 Ministry of National Planning and Economic Development, Ministry of Health and UNICEF, *Myanmar Multiple Indicator Cluster Survey 2009–2010*, Nay Pyi Taw, 2011.

only 77.3 per cent of 5-year-olds attended school. This increased to 95 per cent for 7- and 8-year olds. Given the 117 per cent gross enrolment rate in primary education in 2008¹⁹² and that 11.9 per cent of children aged 10–15 in 2009–2010 were attending primary school, these figures indicate that many overaged children are enrolled in primary education.

Again, there are significant disparities. As much as 19 per cent of 10-15 year old children from the poorest households were still in primary school, but only 5 per cent from the richest. The rich–poor contrast is more marked when the status of 9-year-olds is assessed: only 31.2 per cent of 9-year-olds from the poorest households were in the last year of primary school, compared with 78.7 per cent of those from the richest. Regional disparities are prominent: just 31.7 per cent of 9-year olds were in the last year of primary school in Rakhine State, compared with 72.3 per cent in Tanintharyi.

Figure 28: Net primary school completion rate, by urban–rural residence, mother’s education level and wealth quintile



Source: MICS 2009-2010

The net completion rate for primary school was only 54.2 per cent (children of primary school completion age attending the last year of primary school) in 2009-2010.¹⁹³ The same significant disparities are seen based on socio-economic status (78.7 per cent richest quintile, compared with 31.2 per cent poorest quintile), rural–urban division (49.6 per cent, compared with 66.6 per cent); mother’s education level and geographic area. The overall rate was very low, which means that (on current trends) Myanmar will not achieve MDG 2 for primary completion. The most recent MoE estimates (2008–2009) indicate a survival rate until grade 5 of 76 per cent, implying a high drop-out rate.

The quality of primary education service delivery is low and learning outcomes are poor. However, child-centred approaches (CCA) to teaching and learning are being introduced in basic education schools, especially at primary level. Teacher trainings for CCA will be conducted nationwide from the 2012–2013 academic year to the 2015–2016 academic year, in accord with the National Plan. The primary curriculum too remains rigid, subject-driven, inflexible to adaptation to different contexts and backgrounds, and devoid of a developmental approach.

192 UNESCO, *The Hidden Crisis: Armed conflict and education*. EFA Global Monitoring Report, Paris, 2011.

193 Ministry of National Planning and Economic Development, Ministry of Health and UNICEF, *Myanmar Multiple Indicator Cluster Survey 2009–2010*, Nay Pyi Taw, 2011.

The traditional primary school classroom is an unfriendly environment for most children. The child-friendly school (CFS) baseline study in 2007 revealed the very widespread use of corporal punishment to maintain classroom discipline. Some 62 per cent of teachers told their students that they would be beaten if they did not perform well in a test, and 82 per cent of students reported being beaten if they had done something wrong. Over 40 per cent of teachers reported having to use the cane more than once a week. Some 55 per cent of students claimed that they had been victims of physical bullying. At the end of the child-friendly schools intervention, 3 of the 20 townships targeted registered an improvement in teachers practising positive, non-aggressive and alternative discipline. Declining rates of teachers using corporal punishment were reported from 2007–2008 to 2008–2009. Nonetheless, 50 per cent of schools in the targeted townships still used physical punishment¹⁹⁴ (albeit with reduced frequency), and reports of students being bullied by fellow students had increased. This may reflect greater sensitivity to the issue and/or an actual increase in violence in schools.

In 2007, the MoE developed a standardized learning achievement test in Myanmar language and mathematics through a regional initiative. These tests, however, have not been institutionalized in terms of a national assessment process. At the primary school level, assessment is based solely on teacher-created 'end of chapter' tests, providing no comparable data on learning achievement trends overall or on possible disparities (by region, socio-economic status and gender). However, the Myanmar language and mathematics learning achievement tests, which were administered as part of the child-friendly school baseline study, revealed that fewer than 25 per cent of students had achieved a minimum level of competency in Myanmar language.¹⁹⁵ There were substantial variations between schools within townships. The average level of learning achievement is far from satisfactory: The majority of students would have failed if the pass mark was 50 per cent. Myanmar language and mathematics scores were found to be significantly correlated. The mathematics test was too difficult for most students even though it was based on the curriculum; only 21 per cent of students achieved at least 50 per cent of the competencies. Around 50 per cent of the students had an ability level to answer only 8 of the 40 questions, meaning that very few will be adequately prepared for secondary school level mathematics.

During the early years, children are automatically promoted. Official data from 2008 suggests that the policy of automatic promotion is being followed in most schools. The transition rate to lower secondary education is high: 95.3 per cent of the children who successfully completed the last grade of primary school were found to be attending the first year of secondary school.¹⁹⁶ However, among the poorest households, the transition rate was lower (87.2 per cent) than among the richest (99.6 per cent).

c) Secondary education

Participation rates in secondary education are increasing but still low and inequitable. The gross enrolment rate for secondary education was estimated to be 53 per cent in 2008, a significant increase from 34 per cent in 1999.¹⁹⁷ According to official data, there were 1,193,000 out of school adolescents at the end of the school year in 2008, with more than 50 per cent of them boys. This represents a massive waste of human capital

194 UNICEF, Progress in Implementation of the Child-Friendly Schools Programme in Myanmar Over the Three-Year Period from 2007 to 2009, Yangon, 2010.

195 UNICEF, Baseline of 1,000 Schools in the Child-Friendly Schools Programme in Myanmar in 2007, Vol. 1, Yangon, 2008.

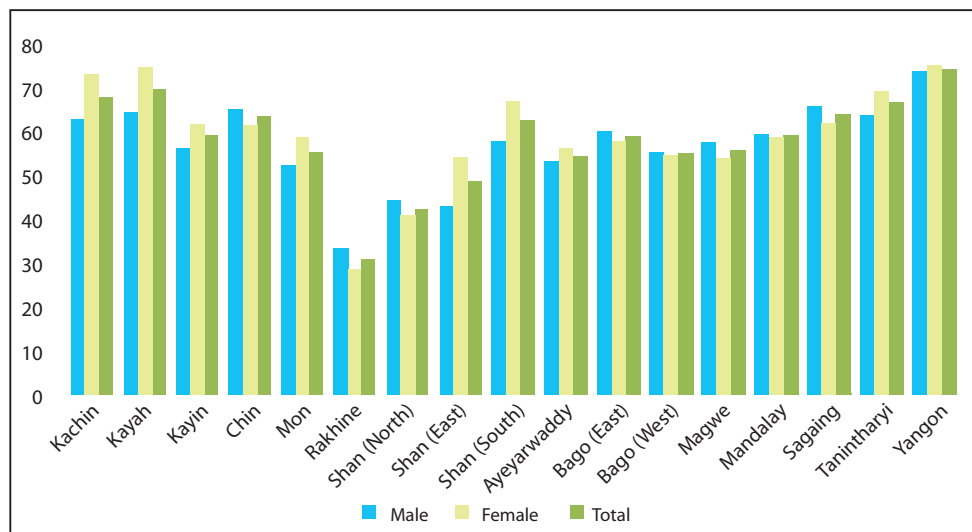
196 Ministry of National Planning and Economic Development, Ministry of Health and UNICEF, *Myanmar Multiple Indicator Cluster Survey 2009–2010*, Nay Pyi Taw, 2011.

197 UNESCO, *The Hidden Crisis: Armed conflict and education*, EFA Global Monitoring Report, Paris, 2011.

and a shortfall in the fulfilment of the right to education. MICS 2009–2010 found that only 58.3 per cent of children of secondary school age were attending secondary school – the remainder were either out of school or attending primary school.

The recent MICS also found that the rural–urban difference in secondary school attendance (76 per cent versus 52 per cent) was far more pronounced than for primary school attendance. So too were the disparities based on socio-economic status: only 28.2 per cent of children from the poorest households were in secondary school, compared with 85.5 per cent from the richest households. Regional disparities were also greater (figure 29): the secondary school attendance rate was 74.7 per cent in Yangon but only 30.9 per cent in Rakhine low rates were also found in Shan State.

Figure 29: Regional disparities in net secondary school attendance rate, by state and division



Source: MICS 2009-2010

Mothers' education was again a significant factor in the recent MICS; 83.9 per cent of children whose mothers had secondary or higher education attended secondary school, compared with 54.1 per cent for those with mothers who had only primary education and 31.2 per cent for those whose mother had no education. Interestingly, secondary school attendance varied with age: only half of the 10-year-olds were in secondary school, rising to 67.4 per cent for 11- and 12-year-olds, but dropping to 45.2 per cent of 15-year-olds.

The gender parity index for primary school remains close to the national average, regardless of socio-economic status and geographic location, but the value for secondary education varies more. In Shan (East), the primary school gender parity index (GPI) was 1.11, but for secondary school it was 1.26. This means that more girls than boys attended primary school; the disparity became even more pronounced after reaching secondary school. Secondary school-aged girls were at a disadvantage in Rakhine (GPI 0.84) and Shan (North) (GPI 0.83).

Participation in upper secondary education (grades 9–11) is very low. The most recent official data for gross enrolment in upper secondary education is 38 per cent (2008). Disaggregated data are not available. This means that the overwhelming majority of children fail to complete a basic education as defined by the Government of Myanmar (primary and secondary); for many, the highest level of school completion will be lower secondary school (grades 6–8). This provides a very low base for equipping young people with the skills needed to participate fully in social and economic development.

Only 18 per cent of females and 17.6 per cent of males (older than 25) had attained at least secondary education in 2010. Although typical of low human development countries, these rates still compare poorly with other countries in the region: Bangladesh (30.8 percent of females and 39.3 per cent of males), Lao PDR (22.9 per cent of females and 36.8 per cent of males), Thailand (25.6 per cent of females and 33.7 per cent of males) and Vietnam (24.7 percent of females and 28 percent of males).¹⁹⁸

There is very little research available on secondary education performance. The expansion of primary schools into post-primary schools has enabled an expansion of lower secondary participation. However, the conditions that have to be met to open a post-primary school, which include the readiness of the community to contribute to infrastructure improvements, may not be met in the poorest and most remote localities. Ensuring that quality post-primary schooling is offered to all primary school completers is now a major challenge for secondary education development.

As with primary education, teachers generally maintain traditional didactic practices and an emphasis on rote learning. Application of the child-centred approach is made harder by increasing class sizes: In 1999, the pupil–teacher ratio (PTR) in middle schools was 28:1, but had risen to 36:1 in 2008. Similarly, in upper schools the PTR was 30:1 in 1999 and 34:1 in 2008.¹⁹⁹ These figures almost certainly mask a context in which some schools have smaller ratios and some have larger classes.

Special topics: Life skills-based education and disaster risk reduction

Life skills-based education, with a focus on health promotion and HIV prevention is a co-curricular activity at primary level and is currently being rolled out in secondary education. Life skills-based education has a relatively long development history in Myanmar, dating back to the late 1990s. The original impetus to introduce life skills came from the perceived need to educate children about HIV and AIDS. As a result, the country probably has the highest coverage rate in primary education in the region. This is a major achievement.

However, there are several issues in the teaching of life skills-based education. Some teachers do not follow the steps in the teachers' guides, preferring to use traditional teacher-centric methods, which mean that students may not be able to practise skills in the classroom. Some teachers have difficulty with sensitive topics, such as sexuality, and they may not give life skills high priority.

The primary life skills curriculum, covering five thematic areas, has relevant content. The lower secondary curriculum has recently been revised and implementation has started in the regions, with plans to cover all schools by 2014. Revision of the higher secondary level curriculum is still underway. Overall at secondary level, there needs to be a strong focus on gender, sexual and reproductive health and drug abuse education as part of preparation for adulthood. There also needs to be stronger linkages between the child-friendly schools approach, which includes school health issues, and life skills-based education.

Cyclone Nargis in May 2008 highlighted the vulnerability of the education system in low-lying delta areas to the effects of a powerful cyclone. The ever-present risk of natural disaster in Myanmar, compounded by climate change, means that all school children and staff need to participate in disaster risk reduction (DRR) education. DRR is now included in the primary life skills curriculum, but will need to be monitored to see if it is being implemented effectively.

198 United Nations Development Programme, *Human Development Report*, New York, 2010.

199 UNESCO, *The Hidden Crisis: Armed conflict and education*, EFA Global Monitoring Report, Paris, 2011.

10.2 Causality analysis

a) Immediate factors

The immediate causal factors hampering children in Myanmar from realizing their right to education are the poor quality of education services and the costs involved, both actual and opportunity costs.

Poor quality of education services – In general, the quality of education is affected by teacher qualifications and experience as well as by the curriculum, textbook quality and availability, infrastructure and student–teacher ratio.

The lack of qualified and/or poorly trained teachers seriously affects the quality of education delivery. A considerable number of primary teachers, middle school teachers and high school teachers are not certified to teach at the appropriate level. At the same time, the nation's more than 226,000 teachers, like other civil servants, are poorly paid. Public service salaries were drastically increased in January 2010; nevertheless, according to MOE data, a primary school teacher's pay still averages only 47,000 kyat (\$58) per month, a secondary school teacher's pay averages 53,000 kyat (\$66) per month and a high school teacher's pay (upper secondary) averages 59,000 kyat (\$73) per month. This low pay compels many teachers to take second jobs or offer private after-school tutorials for a fee.²⁰⁰ Many rural families provide supplementary support to teachers in order to retain them, including additional salary, food, living quarters, water and firewood. The teacher promotion system means that experienced primary and secondary teachers are lost to other sectors in education.

A related issue is the use of outdated teaching methodologies. Teachers generally rely on traditional didactic teaching methods supported by encouragement of rote learning for tests and examinations. The current curricula, teachers' guides and resource books have not been assessed in terms of quality of content, gender sensitivities, age and developmental appropriateness. Although the MoE is trying to introduce the child-centred approach, teachers have been unable or resistant to adopting the change. The low salaries as well as the low status of teachers means there are few incentives for them to develop specialism and expertise or to work in challenging and remote schools.

Many, if not most, of the schools in Myanmar are in poor physical condition and lack basic infrastructure, such as water and sanitation facilities. Schools rely extensively on community contributions for primary school building and maintenance; as a result, the quality of primary school infrastructure can be poor. Space for learning may be inadequate or lacking in partitions, so several teachers have to share the same classroom. Schools may lack usable blackboards and teaching aids, sufficient desks and chairs, clean water and basic sanitation.

The classroom – pupil ratio also influences the teaching–learning environment. While the average class size at primary level is 34 students per classroom disparities are large, with up to 60 students per class in some rural schools.²⁰¹ About 50 per cent of primary schools are multi-grade, where a teacher is responsible for teaching two or three grades simultaneously in the same classroom. But the current teacher training does not include this component, thus leaving multi-grade teachers poorly equipped to carry out their tasks.

200 According to interviews carried out in some of Myanmar's border areas, the attrition rate of trained teachers is at times as high as 90 percent.

201 Ministry of Education, *Education for All National Action Plan 2003*(p. 20), Yangon.

Both schools and teachers are not equipped to meet the learning needs of children with disabilities, and very few children with disabilities are mainstreamed into the government schools. There are very few education facilities for children with disabilities, and many depend on private contribution to sustain their programme. Data on the number of children with disabilities and type of disabilities are limited.

Education costs: Actual and opportunity – Although no fees are levied in primary education, there are multiple charges that families must pay in order for their children to access school. These include: i) direct private costs: admission related costs; instruction-related costs (for example textbooks) and non-instruction related costs (for example uniforms); ii) household contributions, such as for school maintenance; and iii) indirect private or opportunity costs, which refer to foregone earnings associated with time spent by the child in school. The average private cost of education per child in primary school are estimated to be \$46 per child in grades 1–3 and \$56 per child in grades 4–5, equivalent to between 4.5 per cent and 5.9 per cent of annual household income (\$1,136).²⁰² This burden is heaviest for the poorest families.

Tuition fees are charged for both middle and higher secondary schools, at 500–800 kyat and 900–1,000 kyat per month, respectively.²⁰³ In addition, parent–teacher association fees of 500 kyat per annum are also required. Private tuition is a common phenomenon at secondary level, especially in urban areas (students rely heavily on these classes to achieve higher marks in examinations, while for teachers it is a source of additional income).

The cost of education in Myanmar has a direct impact on participation in education. Nearly 30 per cent of school-aged children not attending school in 2009 did not attend because of the cost burden.²⁰⁴

As well as actual costs, there are opportunity costs to educating children. Parents have to weigh up the relative costs and benefits of keeping their child in the education system with those from having the child engage in alternative activities (notably work and domestic chores). Families gain in the short-term from children's income (for working children) or from children looking after younger siblings and doing domestic chores, thus freeing their parents to work. Many parents think work is also a better long-term option for their children than education, a view aggravated by the problems with quality of education delivery in Myanmar. When parents see their children making slow progress through the system – or if they fail to see clear improved learning outcomes - this will likely undermine the perception that their child is benefitting.

Opportunity cost applies to parents as well, particularly in the case of young children whose schools are a long distance from their home. Children cannot walk alone to distant schools and parents often will not have the time to take and bring them back daily, so they keep the children at home. This is one of the reasons for the relatively high proportion of overaged children in schools, particularly in rural areas.

b) Underlying causes

Underlying causes for the failure of children in Myanmar to realize their right to education include language barriers, and limited options in non-formal basic education. The current provision of non-formal or alternative primary education for children who have dropped out of school is very limited in coverage. Second-chance non-formal primary education is currently provided by MoE and selected NGOs (see 10.3 below).

202 U Tin Nyo Education and Vocational Training Issues and Strategies, Background paper for policy options, Yangon, 2011.

203 ibid

204 Tripartite Core Group, Post-Nargis Periodic Report II, Yangon, 2009.

Language barriers – Myanmar has very complex linguistic diversity. While it is not specified in the Myanmar Constitution or 30-Year Plan, in practice Myanmar language is the sole language of government, public affairs and public education, seen as a vehicle to promote national unity and ensure political stability. The ‘language barrier’ is widely perceived as a significant factor in the drop out of children from non- Myanmar speaking ethnic groups. The MoE recognizes this and accepts the need to provide different kinds of methodologies and materials for children who do not speak Myanmar at home. However, the restrictive policy context has constrained the development of expertise in bilingual language and learning issues as well as of educationally sound strategies for addressing the range of bilingual and multilingual contexts that exist in Myanmar.

Access to alternative education – With only 54 per cent of children completing their full course of primary education, there is a great need for a much stronger non-formal education (NFE) system to provide alternative education for the large population of primary school drop outs as well as ensure that vulnerable out-of-school teenagers can develop life and livelihood skills. As yet, there is no NFE budget or dedicated department within the MoE. The importance of NFE, however, has recently been given greater recognition by the MoE through its publication, NFPE: A Helping Hand, Department of Basic Education 1, February 2011.

Non-formal primary education is currently being implemented in 40 townships only, in partnership with MoE, UNICEF and the private sector where a simplified curriculum covering four subjects (Myanmar language, English, mathematics and general studies) has been prepared for children aged 10–14. A total of 2,130 children (with close to gender parity) participated in 2010–2011 at level one (up from 799 in 2008–2009), and 1,932 at level 2 (up from 295 in 2008–2009).²⁰⁵ The Extended and Continuous Education and Learning (EXCEL) programme supported by the MoE and UNICEF and implemented by local NGOs, reached more than 75,000 children in 2006–2010; nonetheless, coverage is small compared with the need and the demand. This is largely due to the limited number of local NGOs and their capacity to implement EXCEL at a large scale.

Structural factors are already described in the first chapter. There is limited investment in the education sector as well as weak policy development and planning. Public sector spending in 2008–2009 on primary education was estimated at \$13 per student and on secondary education at \$30 per student. Based on total GDP in 2008 of \$28.19 billion and in 2009 of \$27.553 billion, this amounts to spending on basic education of around 0.5 per cent of GDP. The resources allocated for education in Myanmar meet only a fraction of the overall costs. This will be further discussed.

Other problems encountered in the education sector also stem from basic structural factors. Lack of investment in early childhood development as a key strategy to increase school readiness and retention has put the education system at a disadvantage. Teacher competence is directly related to the quality of Education Colleges. These institutions struggle with such challenges as: inadequate skills in pedagogical teaching; poor facilities, equipment and information resources; overcrowded curricula; and lack of supervision. School management is insufficiently geared towards achieving quality in teaching and learning. Head teachers are promoted on the basis of years of service and qualification. Some secondary head teachers receive specific training in management, budget, finance and supervision, but most primary head teachers have no training and very limited opportunity to learn and develop in their role.

Since the education system is highly centralized, townships and schools are unable to develop activities and programmes to meet local needs. Poor communication between the central and local levels contributes

205 Ministry of Education, NFPE: A Helping Hand, Nay Pyi Taw, 2011.

to confusion regarding rules and regulations, thus weakening policy implementation, service delivery and monitoring. Similarly, the absence of an effective system for disbursing funds directly to schools undermines the school administration. Little capacity exists to provide extra services to any child or group of children, irrespective of how needy or well justified. Officials, especially at the subnational levels, would benefit from capacity building in management skills that can strengthen their abilities to increasingly target services towards the needs of the poor.

Box 9: Diary of an ethnic Pao boy's dream²⁰⁶

"I have a dream. I want to learn and grow up as an educated person. My dream may seem simple but it is not so easy to come true for me. I am a 15 year old and belong to the Pao ethnic group. I live in Hsaung Pho village of Kyauk Ta Lone Gyi Township, Taunggyi District of Myanmar's Shan State. I completed my lower secondary education in the local middle school. I never failed to do my studies when in school. But I had to drop out anyway. My parents have very limited income to support our family of six children. My elder brother, sister and I had to leave school and start working in my parents' farm before it was time for us to go to the High School. Some of my friends had to do the same. Nevertheless a glimmer of hope remained in my mind. I still wanted to learn more ... only I did not know how.

One afternoon last year when I was working on the vegetable plantation, Ko Khun Myo Thu from our village visited our home and spoke with my parents about the life skills course that was going to be offered for out-of-school children just like me. He is the facilitator and monitor of that project, and he advised my parents to let me join the course. The unexpected opportunity felt almost like a dream come true. My parents readily agreed and I joined the one-year life skills education course.

The course covered a number of topics. I learned many new things. Lessons on 'Each with their own beauty' and 'What is most important in life' were my favourites. I also enjoyed the games we played. 'Each with their own beauty' was about everyone having at least one strength or a special ability. 'What is most important in life' helped us to understand the importance of good health. We cannot study or work or eat, live and earn money without good health. The course also taught us to have better understanding among peers.

I became more tolerant. I could not believe that I learned to take part in discussions and expressed my opinions and thoughts. Nothing felt as good as sharing what is on my mind. People in the village said the training changed the way we walked and talked. I became recognized by the people in the village. I started feeling like I had a significant existence. I stopped feeling small because of my education or family status. I became knowledgeable on many things. My communication with my parents also improved.

I was living my dream. My thirst for knowledge grew. The more I learned, more I wanted to learn. My idea of learning has also changed. Before I thought schools were the only place where one could learn. Now I read books in my leisure time and learn all the time."

10.3 Duty bearers: Role and capacity analysis

a) Family and communities

Parents' appreciation of the value of education in Myanmar, and their willingness to support it for their children is strongly linked to their own educational experience (or lack of it). The majority of parents have not been exposed to early childhood development opportunities, for example, and thus have limited understanding of the benefits for their children and the family. This undermines not only their willingness to send their children to early childhood development programmes but also their own capacity to promote early childhood development within the household. Many parents in Myanmar may not actively play or converse with their children because they are unaware of the importance of these actions for optimizing children's development. Most households have few age-specific development-oriented toys and limited access to safe, child-centred play environments.

A repeated factor influencing education indicators in Myanmar (enrolment in primary school, overaged children in primary school, enrolment in secondary school, etc.) is the education level of mothers: Those who have had educational opportunities themselves are far more likely to ensure them for their children than those with little or no education.

In many cultures in Myanmar, childcare is perceived as a woman's responsibility, with the father viewed as the breadwinner. As such, many fathers are only peripherally involved in the care and stimulation of their children.²⁰⁷ Mothers engaged in agriculture and the informal economy may take their young child to work. However, for women employed in the formal economy who cannot bring their child to the workplace, arranging childcare can be difficult; childcare centres are few and very few accept children younger than 3 years. Coping mechanisms vary, especially in poor families whose options are limited. While older members of the extended family traditionally cared for children while parents worked, the increasing mobility of Myanmar society means this is no longer an option for many households. Older children may have their schooling disrupted if they are required to look after younger siblings.

For children who do attend school, parental involvement is limited. Parents have the most direct interest in improvements in quality and affordability of education, but they generally have little voice in the education of their children: 'client power' in primary education is weak, particularly for the poorest households. In the 2010 child-friendly schools baseline survey, 75 per cent of schools reported that they had a School Council, but 80 per cent of parents reported that they had no contact with the school. Very small numbers of parents attended the School Council or PTA. Most schools are only loosely connected with the communities they serve, and accountability is highly constrained.

Families and communities are expected to play an important role in the provision of public sector education, being responsible for maintenance of the primary school building (and sometimes construction or expansion of facilities). This places a significant financial burden on families, in particular the poorest households, in turn impacting the quality of education their children receive. Private expenditure on education at all levels is substantial. The Ministry of Education has recorded a rise in the amount of cash donations received, from 290 million kyat in 2002–2003 to 1,123 million kyat in 2009–2010.²⁰⁸ Without such private contributions, the

207 Sternin, M, Report on the Study of Child Care Practices in Selected Communities of Hlaing Tha Yar, North Okkalapa and Thongwa, UNICEF, Yangon, 1999.

208 Ministry of Education, *Education for All Country Progress Report 2010*, Nay Pyi Taw, 2010.



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functioning of the education system would be further impaired.

b) Civil society and private sector

Until the mid-twentieth century, most children in Myanmar obtained their basic education in Buddhist monastic schools. Beginning with independence in 1948, public schools were expanded and gradually supplanted the monastic education system in most areas. The monastic schools, however, continue to provide valuable education services.

Monastic schools operate in all states and regions, in an estimated 230 townships. There are around 1,400 schools registered with the Ministry of Religious Affairs (MoRA), serving around 180,000 children. Because many more schools are not registered, the total numbers in the system are estimated at around 200,000. Most monastic schools are primary but some cover the middle and high school grades. They use the official primary and middle school curricula, but also teach about Buddhist culture and way of life. Because no fees are charged and food is provided, these schools are able to reach some of the poorest children. They cater primarily to poor children in the communities in which monasteries are located, including orphans, children of migrant workers and those sent away from remote areas. In addition, there are an unknown number of self-help community schools in Myanmar which are not registered or recognized. These are reportedly more common in remote and conflict-affected areas.

Early childhood development (ECD), in particular, is mainly implemented by local NGOs and faith-based organisations (FBOs) largely through community-based ECD centres. In recent years, NGOs have helped communities to add many new centres, some linked to schools or churches. Expansion of early childhood development has been strongly dependent on external support and the capacity of local NGOs. UNICEF, Save the Children and World Vision have played important roles in the expansion. NGOs and community financing represented about 50 per cent of budget allocations to early childhood development in 2006–2007.²⁰⁹

Because of the rising participation by NGOs and communities, the Department of Social Welfare has changed its strategy from that of direct provision of childcare services to one of community support. NGOs are thus important partners in expanding the coverage and improving the quality of ECD service provision. However, a major capacity constraint is the limited number of local NGOs with ECD expertise and their limited geographical reach; a key issue is how to build up local NGO capacity to extend their reach to underserved areas of the country and better meet the needs of the most disadvantaged children.

The private sector is slowly emerging in support of the education sector. The most significant of this participation is private sector support for non-formal primary education, which has resulted in expanding the coverage from 23 townships to 40 townships.

²⁰⁹ Ministry of Education, EFA Mid-Decade Assessment Report, Yangon, 2007.

c) Government

Policy framework – Education is a priority on Myanmar’s national agenda, and there is a high demand for education among the general population. Section 28 of the Constitution of the Government of Myanmar guarantees “free and compulsory primary education”. It also acknowledges the equal rights of men and women to access all levels of education. As a State Party to the CRC, Myanmar is committed to not only provide access to education but also to eliminate discrimination at all levels, set minimum standards and improve quality. This is echoed in its commitment to achieve MDGs 2 and 3, such as universal primary education and parity in education, and to the Education for All goals.²¹⁰

Several documents speak of the Government’s policy on education, including: i) the Child Law of 1993; ii) the Basic Education Laws of 1966 and 1973; iii) the Thirty-Year Long-Term Education Plan 2001–2031;²¹¹ and iv) the Education for All Plans of 1993 and 2003. Each of these policy documents (discussed below) embraces the concept of universal basic education and lifelong learning. However, there is no comprehensive basic education policy in Myanmar. Lack of such a policy hampers effective planning, management and assessment of education service delivery.

The Child Law (1993) is specific about the obligations of the state regarding provision of basic education. It includes reference to free and compulsory education, special measures to reduce drop-out rates and special arrangements for children who are unable to attend State schools. The law further states that “every child shall have the right to maintain his or her own cherished language, literature and culture....”²¹²

The education sector planning is framed by the overarching Ministry of Education 30-Year Long-Term Basic Education Plan (FY 2001–2002 to FY 2030–2031) and by the EFA National Action Plan (2003). The 30-Year Long-Term Basic Education Plan commits to “transform subject-centred approach into child-centred approach, traditional teaching approach into participatory and active learning approach, rote learning into learning based on applicability, and the examination system into a system of progress measurement through continuous assessment.” The EFA National Action Plan sets out six main objectives that are congruent with the Long Term Plan (box 10). The 30-Year Long-Term Basic Education Plan 2001–2031 sets out goals and strategies to achieve universal primary education by 2006, universal middle education by 2016 and universal secondary education by 2031. Its 10 programmes include completion of basic education, education quality, vocational education, education management, community participation in education and education research.

210 The six international EFA goals have been slightly re-worked into four Myanmar EFA Goals by combining the literacy and lifelong learning goals, combining the access and quality goals, addressing of gender as a cross-cutting issue rather than a separate goal and the addition of a specific goal on education management and EMIS. However, internationally, Myanmar reports on all six global goals.

211 No details are available on how the Government will implement the 30-year programme, nor on the costs and financing of the plan.

212 Ministry of Social Welfare, Relief and Resettlement, *Child Law*, 1993.

Box 10: Education for All: Myanmar EFA for 2015

1. All school-aged children will have access to and complete free and compulsory basic education of good quality.
2. The quality of basic education will be improved in all aspects (teachers, educational personnel and curriculum).
3. Levels of functional literacy and access to continuing education will be significantly improved.
4. The learning needs of young people and adults will be met through non-formal education, life skills and preventive education programmes.
5. Comprehensive early childhood care and education programmes will be expanded and improved.
6. Education management and management information systems will be improved.

Source: Education for All Plan, 2003

The Government of Myanmar has set the target of achieving universal primary education by 2015. National EFA-related strategies include the adoption of a child-friendly schools approach to improve the quality of primary school education.

Although commitments for education in Myanmar are strong, there are serious issues in policy-making. Policy development for basic education, backed by evidence and analytical work to guide decision-making and education reform, is weak. The database on practically every aspect of education in Myanmar requires significant improvement. Due to lack of reliable information, programme planning and management has been severely constrained.²¹³ Weak information systems make it difficult to accurately assess changes over time or to examine internal variations. There is no policy to ensure that as many children as possible achieve minimum standards in basic skills. There is also a lack of clear national policy on ensuring equity in primary as well as secondary education. The Government has plans to expand non-formal primary education, but no specific department for it exists within the Ministry of Education; and there is currently no clear strategy for out-of-school adolescents' education.

Institutional framework – The structure of the education system and the core responsibilities of the MoE are laid out in the Basic Education Law (1973). All schools are operated by the central Government with support from regional, district and township-level education authorities. Basic education consists of 11 years' education comprising primary, middle and high schools in a 5-4-2 structure. Entry to primary school is at age 5. In practice, however, there is both under-aged and over-aged enrolment, especially in rural schools. Middle schools (lower secondary) comprise four grades (6–9). High school (upper secondary) comprises grades 10–11. Thus post-basic education begins with higher education. Early childhood development services are provided through NGO-supported Mothers' Circles (0–3 years), centre-based pre-schools (3–5 years) and school-based pre-schools (3–5 years).

The Ministry of Education is the primary provider and duty bearer of educational services, but several other government departments play important roles. The Ministry of Border Affairs (MoBA) is responsible for

²¹³ Although an overview of the national situation can be derived by extrapolating from surveys and area-specific statistics, the resulting analyses lack statistical rigor. For example, data on school participation according to age, gender and family income are available only from MICS surveys. In most regional education assessments and reports carried out by the Asian Development Bank, UNESCO and the World Bank, the education data on Myanmar are consistently missing.

education and social services in the border and ceasefire areas. A national-level coordinating body, the National Education Committee, determines national education policies and plans, thereby highly centralizing decision-making in the sector. The Ministry of Religious Affairs (Department of Promotion and Propagation of the Sasana) runs a parallel system of monastic schools. Overall responsibility for early childhood development rests with the Department of Social Welfare, although there are multiple agencies involved (MoE, MoH and MoBA). A critical issue is effective inter-ministerial coordination; institutional cultures are highly sectoral; early childhood development, for example, is neither included in the Strategic Plan for Child Health Development for 2010–2014,²¹⁴ the Myanmar Health Vision 2030 nor the 30-Year Long-Term Basic Education Development Plan.

d) International development partners

Unlike in other countries, external engagement in education in Myanmar is very limited. UNICEF and some other UN agencies, such as the World Food Programme and UNESCO, along with JICA, are the only major players in the formal sector. A number of international and local NGOs support early childhood development, monastic education and non-formal education, but none of them has a Memorandum of Understanding to work directly with the Ministry of Education in the formal sector.

10.4 Key Recommendations

Four key priorities emerge from this situation analysis of the basic education sector: i) increasing financial investment and governmental budgetary allocation in the basic education sector, ii) strengthening national policies and systems for greater accountability, iii) improving the quality of the basic education sector and iv) increasing capacity and expertise of the Ministry of Education in key education areas.

Increasing financial investment in the basic education sector – There is an urgent need for greater allocation to education as a share of GDP and specifically for greater investment in the basic education sector. Improvements in basic education should feed into and be supported by improvements in higher education. It is also critical that future public expenditures to the education section are targeted strategically and efficiently. Targeted investments, such as capitation funds at the school level, will allow each school to manage its own budget and develop a support mechanism for disadvantaged or vulnerable children who are at risk of dropping out. Additional public sector funds will also need to be strategically targeted to meet the needs of communities and households that are especially disadvantaged as the result of poverty or other factors. Stress in advocacy efforts should be placed on the fact that investment in education will, in the long-term, reap rich benefits in terms of increased economic productivity.

Strengthening national policies and systems for greater accountability – Education is a fundamental strategy for human development, poverty alleviation and ultimately, for peace and security. Strengthening the national education policies for improving the education sector will require: i) development of relevant policy options that are costed and have demonstrated impact for improving education quality, particularly for the poor and disadvantaged learners in making the linkage with poverty reduction and rural development strategies; ii) undertaking policy-relevant research to enable and support policy-makers and key stakeholders at all levels of the system to make informed and evidence-based decisions about effective strategies for im-

214 Ministry of Health, *Five-Year Strategic Plan for Child Health Development (2010-2014)*, Nay Pyi Taw, 2010.

proving education quality; ii) engagement in evidence-informed policy dialogue processes among different stakeholders, to share and disseminate information and ideas about good practice to improve the quality of education through improved knowledge management mechanisms; and 4) facilitating the exchange of local and international experts and decision-makers working in the field of education system building and education quality. Policy development should be linked to clear implementation plans.

Improving the quality of basic education sector – The last Education Sector Review in Myanmar was carried out in 1993. Conducting a comprehensive sector review and analysis will help strengthen the capacities of education leaders and education systems so as to enable them to formulate and implement educational reforms in an informed manner, facilitate decision-making, contribute to policy implementation, participate in reform programme reviews and to identify national priorities.

Improving the quality of education is particularly critical to ensuring that the learning needs of the disadvantaged are met, thereby providing pathways out of poverty for families and communities. To enhance the quality of the sector, systems need to be strengthened in all aspects, including curriculum development, teacher education and development, assessment and monitoring of learning achievements, a non-formal education system and an institutional and human capacity development structure.

Increasing capacity and expertise of the Ministry of Education in key education areas – A human resource capacity analysis of the Ministry of Education will enable the identification of capacity gaps and better inform the design of a systematic plan to build and strengthen national capacities, particularly in such areas as education policy, planning and management, education financing, teacher education development, curriculum design, examination and assessment, special education, inspection system, education research, early childhood education and EMIS. Capacity could also be built through the provision of scholarships for further study and skills building, including through South-South exposure and interaction, and through specific targeted training in-country.



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11. Children's right to be free of HIV

Children have the right to live free of HIV. AIDS is ranked as the top priority in the Myanmar national health plan, and the National Strategic Plan on HIV/AIDS includes a commitment to the prevention of mother-to-child transmission (PMCT). This chapter looks at the extent to which the right of children in Myanmar to be free of HIV is realized, the causes of violations of this right and the roles and capacities of the duty bearers who are responsible for ensuring children are free of HIV.

11.1 Situation overview

a) Overall prevalence of HIV

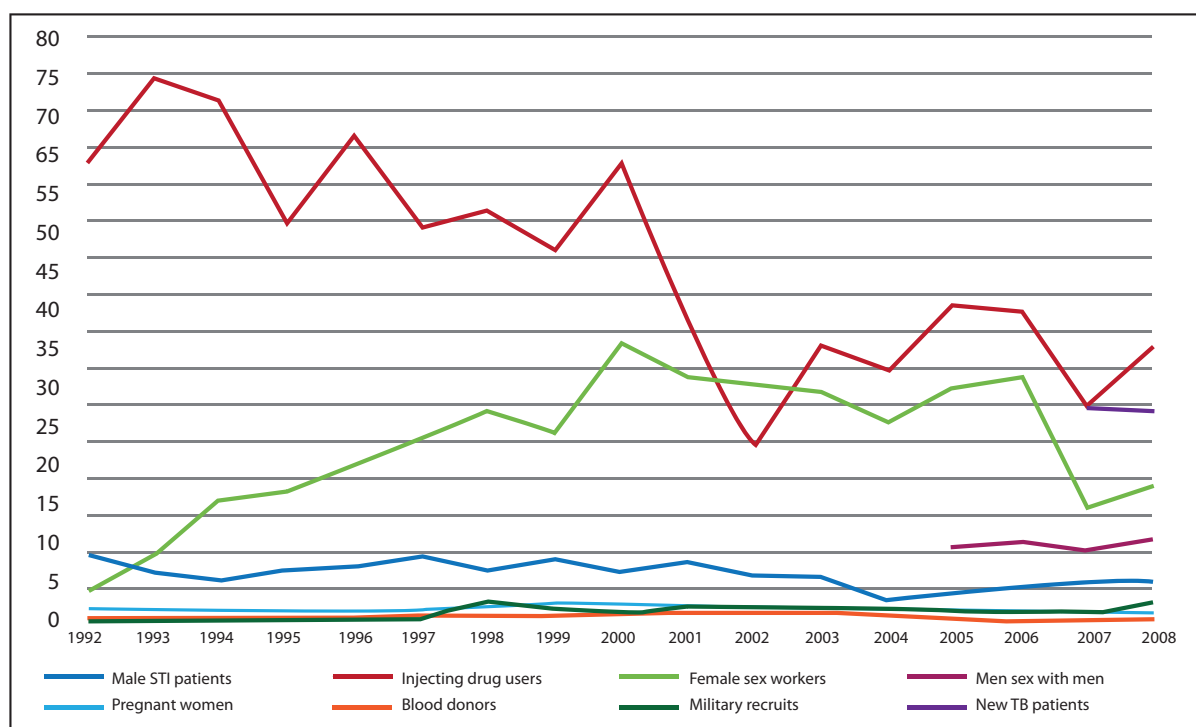
General population –The very first HIV infection in Myanmar was identified in 1988. Overall HIV prevalence among the adult population (aged 15–49) was estimated to be 0.61 per cent (238,000 people) in 2009.²¹⁵

The overall epidemic in Myanmar is still a concentrated one. The majority of HIV infections are reported from large urban areas and from the northern and north-eastern parts of the country, while the lowest rates are reported from the western part. In terms of population groups, HIV infection is largely concentrated among most-at risk groups, namely female sex workers and their clients, men who have sex with men and injecting drug users. In the past HIV infection has been concentrated mainly in men in Myanmar, but the number of women affected is increasing (see discussion below).

The National AIDS Programme (NAP) has been conducting HIV sentinel surveillance of select populations groups on a yearly basis since 1992. Estimation and modelling based on surveillance data indicates that overall HIV prevalence peaked in 2000 and has been slowly declining since then. From 2009 to 2010, there was an overall drop in the projected numbers of HIV infections among adults. However, in some age groups, notably those under 15 years, the number of HIV infections is projected to increase over the same period; the annual increase is substantial – more than 10 per cent. This requires intensive focus on interventions for prevention, as well as care and treatment for that particular age group.

Among high-risk groups – HIV prevalence among high-risk population groups, particularly female sex workers, is declining probably as a result of awareness raising and behavioural change interventions targeting such groups (figure 30). The most recent data (HIV sentinel surveillance 2010) indicated that HIV prevalence was 11.4 per cent in female sex workers, 11 per cent in men who have sex with men and 28.1 per cent in male injecting drug users. These figures show that, despite the fall in overall prevalence, HIV is still an alarming public health issue.

215 National AIDS Programme, WHO and UNAIDS, HIV estimates and projections in Myanmar, 2008-2015, Nay Pyi Taw.

Figure 30: HIV prevalence among high-risk and low-risk groups, 1992–2008

Source: Ministry of Health, UNGASS Country Progress Report, Nay Pyi Taw, 2010

Among low-risk groups –Although HIV prevalence has been falling among high-risk groups, it has been quite steady among the low-risk population groups, including pregnant women, blood donors, military recruits and new TB patients.

A 2010 study estimated that 35 per cent (81,000) of people living with HIV in the country were women.²¹⁶ The male-to-female ratio of reported HIV cases has changed, from almost 8:1 in 1994 to 1.9:1 in 2009, and is projected to be 1.6:1 by 2015, highlighting a steady increase in the proportion of women being infected over the past few years. These women are largely the sexual partners of men linked to high-risk groups. (Women in Myanmar culture face greater risk of infection partly because they have less freedom and authority than men, including in matters involving sexual relations.) This pattern of the epidemic increasingly puts children at greater risk through mother-to-child transmission.

UNGASS²¹⁷ indicator 22, the percentage of young women and men aged 15–24 who are HIV infected, is assessed through the proxy indicator of HIV prevalence among pregnant women attending antenatal clinics. The HIV sentinel surveillance data from 2009 showed HIV prevalence of 0.9 per cent among pregnant women aged 15–24 (suggesting a large number of infants who could become infected annually through transmission from their mothers). An estimated 4,300 pregnant women were living with HIV in 2009,²¹⁸ of whom 2,398 had received antiretroviral (ARV) prophylaxis.²¹⁹

b) HIV prevalence among children

To date, there has not been much information on the prevalence and situation of children affected by HIV in

216 Joint United Nations Programme on HIV/AIDS (UNAIDS), *UNAIDS Report on the Global AIDS Report, 2010*, Geneva
 217 United Nations General Assembly 26th Special Session
 218 Myanmar National Strategic Plan on HIV and AIDS, 2011–2015.
 219 Universal Access Report, UNAIDS, Geneva, 2010.

Myanmar. In 2009, 4,650 children under the age of 15 years were HIV-positive, with half aged under 5, and a further 33 per cent aged between 5 and 9 years. A similar number of boys and girls were infected across all age groups. In 2007, 1 per cent of all deaths in children aged under 5 was due to AIDS, and 560 children under 15 years were expected to have died as a result of AIDS in 2009.

A 2011 study conducted in three urban townships among 600 children (300 affected by HIV and AIDS and 300 not affected) estimated the prevalence of HIV infection among children aged under 18 to be 0.6–0.8 per cent.²²⁰ Although this finding cannot be generalized to other townships in the country, it gives some indication of the scale of the problem. In addition, only 40 per cent of HIV-infected children were receiving ART.

The issue of orphans and vulnerable children due to HIV and AIDS is an increasing problem, especially in high prevalence townships. The numbers of children orphaned by AIDS in Myanmar is increasing, from an estimated 2.9 per cent in 2001 to 7.7 per cent in 2005; the 2010 study of three townships found that 17 per cent of children affected by HIV and AIDS were orphans, while 39 per cent had just one parent living. Many more continue to live with one parent who may or may not be infected.

Affected and orphaned children tend to be taken care of by their extended family, generally by their grandparents and sometimes by aunts and uncles. Where no-one from the extended family has the capacity to care for a child, they are commonly sent to monasteries or to institutions run by the Department of Social Welfare or faith-based organizations. Around 15,000 orphaned and vulnerable children are being supported in some way through programmes run by various organizations,²²¹ although the level of support may be minimal for many of these children.

The small-scale studies conducted to date report that negative socio-economic implications are common among orphans and vulnerable children affected by HIV and AIDS. In the 2010 study²²², significant differences between children affected by HIV and AIDS and those not affected were identified in relation to social conditions, such as family displacement from original house (27 per cent versus 1 per cent), child/sibling displacement (20 per cent versus 2.7 per cent) and family dispersion (20.3 per cent versus 1.3 per cent).

The same study also revealed that a larger proportion of children not affected by HIV or AIDS participated in social, festival or sports activities compared with affected children (60.1 per cent versus 51.3 per cent). Children affected by HIV and AIDS had a higher risk of behavioural problems (8.1 per cent versus 3.7 per cent); and a higher proportion of them were in the abnormal category regarding hyperactivity and pro-social behaviour compared with children who were not affected (18.4 per cent vs. 12.8 per cent).

Also in the 2010 study, 73 per cent of children affected by HIV and AIDS had normal weight for their height compared with 90 per cent of unaffected children. A qualitative assessment within the same study revealed that although the service providers reported reducing stigma, children affected by HIV and AIDS and adults living with HIV reported experiencing a higher degree of stigma, especially among extended family members, neighbours and friends.

220 National AIDS Programme and Department of Medical Research, *Situation Analysis of Orphans and Vulnerable Children Due to HIV/AIDS in Three Selected Townships*, Nay Pyi Taw, 2011.

221 Department of Social Welfare, National AIDS Programme and UNICEF, *Children Affected by HIV and AIDS in Myanmar: Progress and the way forward*, Nay Pyi Taw, May 2010.

222 National AIDS Programme and Department of Medical Research, *Situation Analysis of Orphans and Vulnerable Children Due to HIV/AIDS in Three Selected Townships*, Nay Pyi Taw, 2011.

Box 11: Disparities in children's right to be free of HIV

Disparities by population groups:

HIV prevalence in 2010 was 11.4 per cent in female sex workers, 11 per cent in men who have sex with men, 28.1 per cent in injecting drug users and 0.9 per cent in pregnant women aged 15–45²²³. Comprehensive knowledge of HIV/AIDS was lower in women from rural areas (25 per cent), poorest households (17.3 per cent) and with only primary education (20.2 per cent) compared to those from urban areas (64.5 per cent), richest households (42.2 per cent) and with secondary or higher education (41.7 per cent). Similar trend was also observed for women who have been tested for HIV.²²⁴

Disparities between children affected by HIV and AIDS and non-affected peers:

Among children affected by HIV and AIDS, family displacement from original house is 27 per cent, child/sibling displacement is 20 per cent, family dispersion is 20.3 per cent, participation in social/sports activities is 51.3 per cent, and behavioural problems prevalence is 8.1 per cent, and proportion of children with normal weight for height is 73 per cent.

Among non-affected peers family displacement from original house is 1 per cent, child/sibling displacement is 2.7 per cent, family dispersion is 1.3 per cent, participation in social/sports activities is 60.1 per cent, and behavioural problems prevalence is 3.7 per cent, and proportion of children with normal weight for height is 90 per cent.²²⁵

11.2 Causality analysis

a) Immediate factors

There are three immediate factors causing problems with regard to HIV infection in Myanmar: lack of HIV knowledge, high-risk behaviour and lack of preventive, care and treatment services.

HIV-related knowledge – According to the recent MICS data,²²⁶ comprehensive and correct knowledge of HIV prevention methods and transmission²²⁷ among women of reproductive age group was only 30.1 per cent, pointing to a lack of appropriate knowledge among two-thirds of reproductive-age women. The findings indicate that knowledge levels about identifying correct methods to prevent HIV transmission are quite high (60.1 per cent), but only 40.8 per cent of respondents rejected misconceptions about HIV transmission. This shows the prevalence of incorrect information about HIV in Myanmar society.

223 HIV Sentinel Sero-surveillance 2010 Myanmar, National AIDS Programme, Department of Health, Ministry of Health, June 2011.

224 Ministry of National Planning and Economic Development, Ministry of Health and UNICEF, *Myanmar Multiple Indicator Cluster Survey 2009–2010*, Nay Pyi Taw, 2011.

225 National AIDS Programme, Department of Medical Research and UNICEF, *Situation Analysis of Orphans and Vulnerable Children Due to HIV/AIDS in Three Selected Townships*, Nay Pyi Taw, 2011.

226 Ministry of National Planning and Economic Development, Ministry of Health and UNICEF, *Myanmar Multiple Indicator Cluster Survey 2009–2010*, Nay Pyi Taw, 2011.

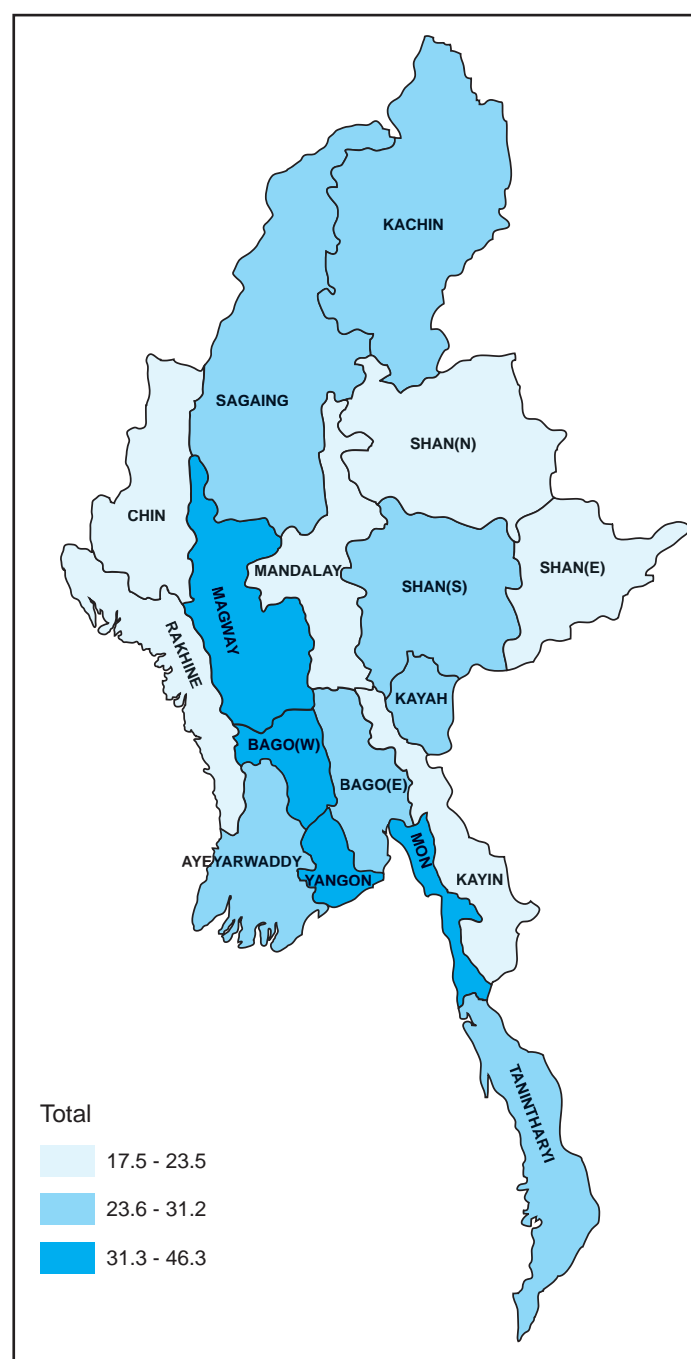
227 Knowledge of two ways of preventing HIV transmission and rejecting three common misconceptions.



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The MICS survey also indicated that knowledge of all three methods of mother-to-child transmission (during pregnancy, delivery and breastfeeding) among Myanmar women was 65 per cent. This higher figure, as compared with the figure for comprehensive and correct HIV knowledge, is the result of increased coverage of the PMCT programme.

Figure 31: Regional disparities in comprehensive knowledge about HIV prevention among women 15–49 years

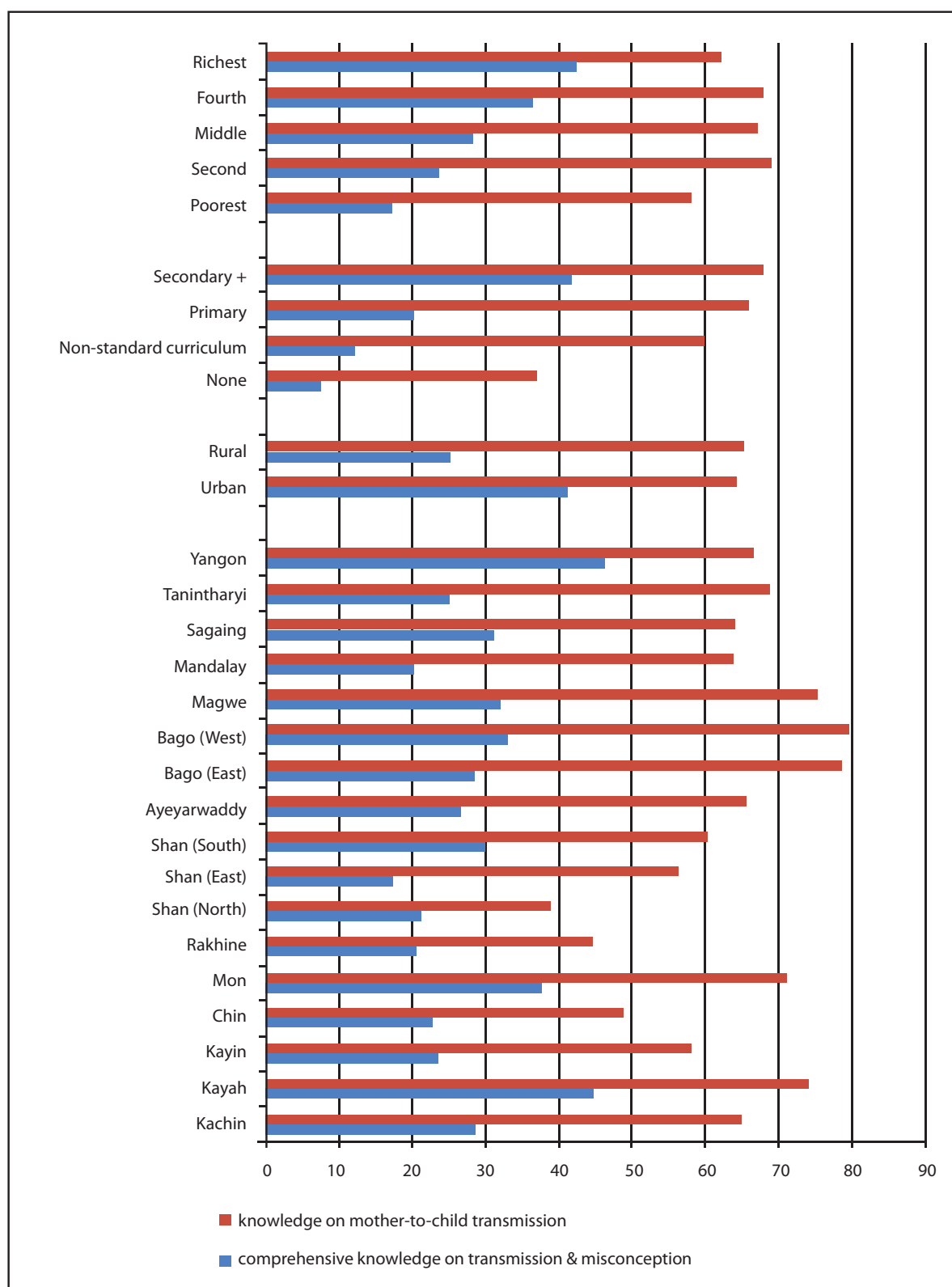


Source: MICS 2009-2010

Regional and other disparities in knowledge about HIV are quite marked (figures 31 and 32). Although the level of comprehensive HIV knowledge was higher in urban than rural areas, no such variation was seen in level of knowledge related to mother-to-child transmission (MCT). In terms of geographic area, Shan (North), Shan (East) and Rakhine were found to be lowest in both knowledge categories. The proportion of women with comprehensive knowledge increased with the level of education and wealth status. Comprehensive

knowledge of HIV transmission among young women aged 15–24 was found to be 31.8 per cent.

Figure 32: Comprehensive and correct HIV knowledge compared with knowledge on mother-to-child transmission



Source: MICS 2009-2010

Out-of-school youth are exposed to more risk than young people in school; as well as the obvious greater free time, this is especially due to migration and disposable cash income. Only 48 per cent of out-of-school youth surveyed in 2008 were able to correctly identify ways of preventing the sexual transmission of HIV and could reject major misconceptions about HIV transmission.²²⁸

Knowledge of and access to places for voluntary counselling and testing (VCT), uptake of VCT services as well as knowledge of HIV test results are also important aspects in the response to and control of HIV and AIDS epidemics. The recent MICS data indicated that 70.6 per cent of women aged 15–49 years knew where they could be tested for HIV, but again, there were regional disparities. Some 17.6 per cent of the respondents had actually been tested for HIV, of which 91.5 per cent knew the test results. Among women respondents this figure can largely be attributed to their access to and use of the PMCT programme. According to the 2007 Behaviour Surveillance Survey,²²⁹ a total of 11 per cent of the adult population, both men and women, had had HIV testing in the 12 months prior to the survey.

High-risk HIV-related practices – Another immediate cause of HIV problems is increasing high risk behaviour. Among the general population, the practice of unsafe sexual behaviour is still an alarming issue. According to the 2007 Behaviour Surveillance Survey, conducted among the general population, 17 per cent of youth and 70 per cent of adults were sexually active. Of them, 27.4 per cent of young men and 8.8 per cent of adult men reported having had sex with a commercial sex worker in the past year; 51.1 per cent of men aged 15–49 reported using condoms during their last sexual intercourse (UNGASS indicator).

In the same study, 85 per cent of youth reported using condoms consistently when having sex with sex workers, but only 23 per cent used condoms with casual acquaintances. Reported condom use was higher in the most-at-risk population groups than in the low-risk groups. Among female sex workers, condom use was very high in Mandalay (97 per cent reported always using condoms) and moderately high in Yangon (83 per cent). This highlights the need to focus on the lower level of safe sex practice among low-risk groups.

Limited access to preventive HIV services – In 2008, 21 national and international agencies reported providing VCT in the country (most agencies do pre-test counselling and post-test counselling with follow-up services, while they refer clients for HIV testing to other providers). The uptake of VCT services has been increasing in recent years in both the most-at-risk population groups and the general population.²³⁰ However, the number of people with access to VCT services is still low compared with the overall population. Key barriers to better uptake of HIV counselling and testing include: the fear of stigma and discrimination associated with attending AIDS/STD clinics and being identified as a person living with HIV; the limited number of VCT services; lack of adequate financial support for transportation to the services; and issues related to consent and confidentiality.

PMCT services are similarly limited. According to HIV estimates and projections for 2008–2015 by the National AIDS Programme, 3,679 women need PMCT services each year. The National AIDS Programme PMCT services have been expanding to meet this demand. Community- and hospital-based prevention of mother-to-child transmission is now available in about 200 townships and 38 specialized hospitals. The average post-test return rate of pregnant women who received pre-test counselling was 50 per cent in 2010 compared with 27 per cent in 2007. The proportion of HIV-positive pregnant women who received anti-retroviral

228 Ministry of Health, Behaviour Surveillance Survey in 2008 Targeting Out of School Youth, Nay Pyi Taw, 2009.

229 Ministry of Health, National AIDS Programme, *Behaviour Surveillance Survey 2007 Targeting General Population*, Nay Pyi Taw, 2008.

230 Ministry of Health, *UNGASS Country Progress Report*, Nay Pyi Taw, 2010.

therapy increased from 24 per cent in 2005 to 60 per cent in 2010. Still, coverage of PMCT services needs to be expanded further.

b) Underlying causes

Underlying causes of HIV prevalence and impact in Myanmar are threefold: stigma and discrimination, lack of quality in the services for people with HIV and AIDS and increased migration.

Stigma and discrimination – Stigma and discrimination prevent people from testing for HIV, openly discussing prevention and seeking treatment services. Several studies and reviews conducted in the country²³¹ report that stigma and discrimination towards people living with HIV and AIDS is still high among extended family members, neighbours and friends in the community as well as in the school environment.

When HIV-related attitudes and perceptions were assessed by presenting four different scenarios to respondents,²³² the MICS 2009–2010 survey found positive attitudes towards people living with HIV or AIDS in only one third of women of reproductive age. Among out-of-school youth, only 41 per cent were willing to buy food from an HIV-infected vendor, and 69 per cent were willing to eat with an HIV-infected person.²³³

Discriminatory attitudes towards HIV were more prevalent among women than men.²³⁴ The level of stigma and discrimination also differed from place to place: a 2007 study found that in places such as Dawei, Myeik and Tachileik it seemed lower, while it was higher in Mandalay and central Myanmar.²³⁵ The recent MICS data confirmed that Mandalay, Sagaing, Bago (East) and Rakhine were among the states and regions with the highest level of discriminatory attitudes towards people living with HIV or AIDS. Interestingly, the first three of these regions (Mandalay, Sagaing and Bago (East)) also had high levels of knowledge on ways of transmission and prevention methods. More in-depth study is needed to better understand the level and extent of stigma and discrimination among Myanmar communities.

The level of access to HIV treatment services tends to be inversely related to the level of stigma and discrimination (high levels of stigma lead to low access). With regard to children, the impact of stigma and discrimination on their psychosocial well-being resulted in limited participation by HIV-affected children in various social and school-related activities (less than their non-affected peers).²³⁶ Discrimination against children in school and in the community is a concern for HIV-affected families. Stigma in the workplaces is also high and has negative implications for people living with HIV and AIDS. Disclosure of HIV status was found to have affected the working opportunity and environment for single parents.²³⁷

Migration – Data related to HIV risks and vulnerabilities among mobile and migrant population groups in Myanmar is limited. Some studies showed low level of HIV knowledge, low level of condom acceptance and

231 Situation Analysis of Orphans and Vulnerable Children Due to HIV/AIDS in Selected Townships, Department of Medical Research and National AIDS Programme, Nay Pyi Taw, 2011; Behavioral Surveillance Survey of General Population, National AIDS Programme, 2007; Review of Myanmar National AIDS Programme, National AIDS Programme, 2006.

232 Four scenarios: i) caring for a family member sick with AIDS; ii) keeping HIV status of a family member secret; iii) a teacher with HIV should not be allowed to work; and iv) buying food from a person with HIV or AIDS.

233 Myanmar National Strategic Plan on HIV and AIDS, 2011–2015.

234 Behavioral Surveillance Survey of General Population, National AIDS Programme, 2007.

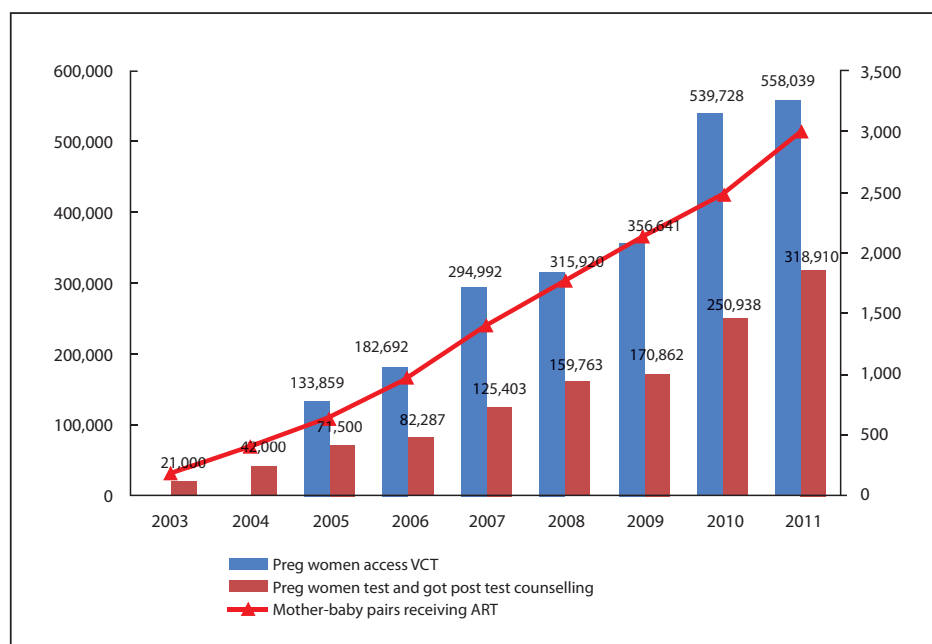
235 Review of Myanmar National AIDS Programme, National AIDS Programme, 2006.

236 Situation Analysis of Orphans and Vulnerable Children Due to HIV/AIDS in Selected Townships, Department of Medical Research and National AIDS Programme, Nay Pyi Taw, 2011.

237 Medical Statistics Division, Annual Report 2009, Ministry of Health, Nay Pyi Taw, 2010.

use (especially with casual sex partners) and relatively high STI and HIV prevalence in some Myanmar migrant groups in Thailand, such as seafarers and sex workers.²³⁸

Figure 33: Achievements of PMCT programme, 2003–2010



Source: Ministry of Health, National AIDS Programme, Global AIDS Response Progress Report Myanmar, Nay Pyi Taw, 2011

Parts of Chin State and Sagaing Region of Myanmar border with a region in India that has a high prevalence of HIV, and cross-border migration between these areas is common.²³⁹ These regions are highly vulnerable to HIV infection and need additional focus in terms of generating evidence as well implementing prevention, care, support and treatment services.

Quality of services – There has been a rapid scale-up of PMCT services in recent years, but the focus has been on quantity. This has resulted in a perceived compromise on quality of the services. Although a comprehensive assessment of quality of services has not been done in the country, parameters such as the only 50 per cent of pregnant women tested for HIV who come for post-test counselling (figure 33) indicate a compromise in the quality of services.

11.3 Duty bearers: Role and capacity analysis

a) Family and community

The dominant status of men in Myanmar society means they have the final say in matters of sexual relations. In the case of men in high-risk groups, this exposes women to greater risk of infection. People and children affected by HIV experience stigma and discrimination within their extended families as well as in the wider community.

²³⁸ International Organization for Migration Thailand, Migration and HIV/AIDS in Thailand: A desk review of migrant labour sectors, Bangkok, 2008; International Organization for Migration Thailand, Migration and HIV/AIDS in Thailand: Triangulation of biological, behavioural and programmatic response data in selected provinces, Bangkok, 2010.

²³⁹ National AIDS Control Programme, National AIDS Control Organisation, India.

The capacity of families to care for children affected by HIV is often undermined by the fact that one or both parents will also be infected or even dead. The discrimination experienced in the workplace means many affected families struggle to earn enough to meet their basic needs, let alone to care for someone with HIV. Orphaned children are often taken care of by extended family members (though they are not treated as well as non-affected children) or taken into institutions (monasteries, charitable institutions, Department of Social Welfare facilities). Clearly, such children will struggle to access their rights and realize their potential.

b) Civil society and private sector

There has been considerable expansion in the number, role and capacity of community-based organizations and of self-help groups composed of people living with HIV and those from high-risk groups. Viable self-help groups of people living with HIV have been developed. In 2010 there were more than 200 groups with about 10,000 members. These groups meet regularly to provide services and support to group members and other people living with HIV. They participate in AIDS coordination committees and also advocate for those who do not receive services. However, their capacity is limited by poverty, illness, lack of training and discrimination.²⁴⁰

Many international and national NGOs are working for prevention of HIV infection among the most-at-risk populations as well as providing care and treatment services for people living with HIV in various geographic regions. Although the quality of services offered by many of these NGOs is exceptionally good, major challenges they face are that the interventions are limited to particular locations and do not reach the wider population, and they have limited funds, in turn threatening the sustainability of the services. It should be noted that there are no large international NGOs working on PMCT in Myanmar.

In Shan State (Lashio and Muse townships), several NGOs are complementing the life skills curriculum with in-school peer education projects, with attention towards reducing HIV-related stigma and discrimination.

c) Government

Myanmar's current health plan ranks AIDS as one of the top three priority diseases (alongside malaria and tuberculosis) due to its public health, political and socio-economic importance.

Policy framework –The National AIDS Committee was established in 1989 and a short-term plan for HIV prevention was launched in the same year. The first national medium-term plan for the prevention and control of HIV and AIDS was formulated in 1991. In line with priorities set forth by the National Health Plan, a National Strategic Plan for Expansion and Upgrading of HIV and AIDS Activities in Myanmar 2001–2005, aimed at enhancing HIV prevention and care efforts through a countrywide collaboration across sectors.

In 2003 the Country Coordinating Mechanism was established. Several departments from the Ministry of Health (MOH), United Nations organizations and national and international NGOs were represented in the Country Coordinating Mechanism. The Ministry of Health also participated in the United Nations Expanded Thematic Group on AIDS, which oversaw the development and implementation of the UN Joint Programme for HIV and AIDS and the associated Fund for HIV and AIDS in Myanmar (FHAM).

The National AIDS Programme of MoH provides for coordination at national and subnational levels. It has a

²⁴⁰ National Strategic Plan of HIV/AIDS 2011 – 2015.

direct presence in 45 priority townships in the form of AIDS/STD teams. In these townships, the National AIDS Programme is able to actively coordinate the work of partners and supports the functioning of AIDS Committees at different administrative levels.

In 2005, the Ministry of Health led the development of the National Strategic Plan on HIV and AIDS 2006–2010, with full involvement of all partners and multiple ministries. The National Strategic Plan and its Operational Plans (2006–2009, subsequently updated to 2008–2010) became key reference documents for partners working on HIV, providing the strategic framework of action, including priority setting for resource allocation. In 2010 both the National Strategic Plan and the Operational Plan were reviewed and the National Strategic Plan 2011–2015 was developed (table 5)

Table 5: Strategic priorities of the National Strategic Plan (2011–2015)

Strategic priority I: Prevention of the transmission of HIV through unsafe behaviour in sexual contacts and injecting drug use	
Interventions	
I.1	Female sex workers and their sexual partners; clients of female sex workers and their sexual partners
I.2	Men who have sex with men, male sex workers, clients of male sex workers and the sexual partners of all groups
I.3	Injecting drug users, drug users and their sexual partners
I.4	Prison or rehabilitation facility populations
I.5	Mobile and migrant populations and communities affected by population movement
I.6	Uniformed services personnel (military and police).
I.7	Young people
I.8	Workplace
Strategic priority II: Provision of a comprehensive continuum of care for people living with HIV	
Interventions	
II.1	VCCT, ART, community-based care, hospitals for adults and children
II.2	PMCT and reproductive health
Strategic priority III: Mitigation of the impact of HIV on people living with HIV and their families	
Interventions	
III.1	Psychological, economic and nutritional support for people living with HIV and their families
III.2	Orphans and vulnerable children infected and affected by HIV
IV. Cross-cutting interventions	
IV.1	Health (including private health sector), non-health and community systems strengthening.
IV.2	Favourable environment for reducing stigma and discrimination
IV.3	Strategic information, monitoring and evaluation, and research

Although there is a commitment to address issues related to children under the National Strategic Plan 2011–2015, strategies to identify and address the issues related to children need to be clearly defined. The situation analysis of orphans and vulnerable children due to HIV or AIDS in three townships that was conducted by the Department of Medical Research and the National AIDS Programme in 2011, with support from UNICEF, generated some information about the needs of children affected by HIV. Due to the limited coverage and limitations in the design of the study, estimates of children affected by HIV and information on how specific groups of children affected or infected by HIV are impacted for the country as a whole are still not available. Most of the other available statistics also consider only the 15 years and older age groups.

Box 12: Recommendations from children's consultation on HIV and AIDS²⁴¹**To their families:**

- We would like our parents to be more mindful of our health needs.
- Please give us your lovingkindness, care and security. We thrive when being cared by our parents, brothers and sisters.
- We would like our parents to listen to us more.

To international and national NGOs working on HIV and AIDS:

- Please ensure children's rights without discrimination.
- Please organize for us more vocational training that will help us to get good jobs when we are ready.
- Please provide us health care services and medicines as needed.
- We need more clinics with ARV facilities.
- NGOs are requested to continue their current support.

To local authorities:

- We want the local authorities to have more awareness and knowledge of HIV and AIDS.
- Please ensure children's participation in activities that relate to children.
- No discrimination against children.
- Adequate security and protection to be for ALL children.
- Local authorities should be well aware of children's rights and help realize them.

To the government in dealing with HIV and AIDS:

- ARV and nutrition support must be given to children who are infected with HIV.
- Hospitals do not discriminate against HIV infected mothers and allow them to deliver their babies in hospitals.
- Educational support for children who cannot afford to go to school.
- School teachers must not discriminate against children with HIV.
- Teachers should not beat children.
- Children's recommendations must be considered

Programme implementation –The reach and effectiveness of HIV prevention, treatment and care in Myanmar are constrained by the large population spread, poorly developed communication and transport infrastructure, limitations within the health system and widespread poverty, which forces people to engage in unsafe behaviour in situations of high risk. Nevertheless, significant progress has been made in scaling up targeted prevention services for specific high-risk groups (female sex workers and men who have sex with men). There has also been an increase in the provision of treatment for increased numbers of people living with HIV, although ART availability remains well below the needs.

High-risk groups – Services provided to sex workers and their clients include: peer education and outreach for behaviour change, ; promotion of male and female condoms and lubricants, STD services and voluntary counselling and testing (VCT services. Services provided to injecting drug users encompass establishing drop-in centres, promoting access to sterile needles and syringes, peer education and outreach work, methadone

maintenance therapy and condom promotion. Service utilisation records over recent years indicate an increasing trend among most-at-risk population groups to access these services.²⁴²

The current total number of drop-in centres by geographical distribution is still limited, and there is a need to expand these in new locations within the priority townships. HIV testing services are available only in 140 out of the 325 townships. Only 6 per cent of the IDUs who were reached through outreach services were female. There is a lack of concrete knowledge on the clients of sex workers and their intimate partners and ways to best reach them with HIV prevention and awareness-raising activities.

PMCT – Myanmar was one of the first countries in Asia to introduce activities related to prevention of mother-to-child transmission of HIV (PMCT) in 2000 and the first to begin at the level of the rural health centre. PMCT services cover more than a third of Myanmar's townships and are integrated within the routine maternal and child health and antenatal care services. These services provide basic information on HIV to pregnant women, offer HIV testing and anti-retroviral prophylaxis, safer delivery care, safer infant feeding counselling, follow-up care, support and treatment.

The National AIDS Programme estimates that 4,300 women need PMCT services each year. Currently, community and hospital-based PMCT services are available in about 200 townships and 38 specialized hospitals. However, only 18 per cent of the estimated pregnant women in the country have been tested for HIV. By the end of 2009, a total of 21,138 people were receiving ART; 43 per cent of them were women. The total number of people in need of ART was estimated to be 74,000; hence, coverage equates to only one-fourth of the estimated need. HIV pregnant women who received anti-retroviral therapy increased from 24 per cent in 2005 to 60 per cent in 2010. The PMCT programme is dependent on antenatal care coverage. While this is relatively high, in order to achieve the MDG targets, the programme needs to develop strategies to reach pregnant women who do not have access to antenatal care services.

Treatment of children with HIV – Testing facilities for diagnosing HIV infection in children under 18 months of age have been recently introduced in the country and have a long way to go in terms of access to all children in need. Availability of co-trimoxazole prophylaxis for infants and children aged under 18 months who are exposed to HIV infection is limited in the country (23 per cent in 2009).²⁴³

Life skills – The Ministry of Education has incorporated HIV-related messages into the existing Life Skills curriculum of primary and secondary education. Out of school youth were also targeted through non-formal education.

Orphans and vulnerable children – Provision of care and support for orphans and vulnerable children continued to be one of the more severely under-funded interventions. In the National Strategic Plan 2006–2010, only 25 per cent of projected activities were carried out in this area in 2008. Although coverage of orphans and vulnerable children has been increasing, efforts are still needed to provide better support in different dimensions in this area.

242 Ministry of Health, UNGASS Country Progress Report, Nay Pyi Taw, 2010.

243 UNAIDS, *Universal Access Report*, Geneva, 2010.

d) International development partners

UNICEF programming in Myanmar includes a focus on HIV, with four priority areas: i) reducing new HIV infections among adolescents and young adults; ii) eliminating new HIV infections among children; iii) ensuring children living with HIV have access to care and treatment services; and iv) ensuring children affected by HIV and AIDS have access to support systems. It has programmes in all these areas, some in partnership with UNFPA, UNAIDS and WHO.

In addition, UNODC, UNOPS, IOM and WFP are all working on issues related to HIV and AIDS.

11.4 Key Recommendations

Focus on children – Much greater focus has to be placed on children in HIV and AIDS policy-making and programming. This entails in-depth study of both the prevalence of HIV among different age groups and of the situation of children affected or infected by HIV.

Prevention of new infections among adolescents – In view of the forecasted rise in HIV prevalence among 10- to 14-year-olds between 2009 and 2012, strategies must be developed to reduce new HIV infections in this age group. These should be devised and implemented in collaboration with reproductive health and education systems.

PMCT expansion – PMCT coverage in government institutions should be expanded to 100 per cent, and PMCT should be established in townships that do not have this. PMCT and other services should be made readily available to all pregnant women. Operational research should be conducted to understand needs in relation to PMCT among pregnant women and to ensure they can access government services. In this regard there should be greater collaboration with maternal and child health services. Prevention efforts should also target women (in particular, the partners of people in high-risk groups and those of reproductive age) and young drug users.

Services for orphans and vulnerable children – Support for orphaned and vulnerable children must be improved. To this end, coordination between NGOs, faith-based organizations and civil society groups working with children affected by HIV and relevant government departments (health, education and social welfare) should be strengthened.

The overall quality of services in relation to HIV and AIDS should be improved.



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12. Children's right to protection

The Convention on the Rights of the Child commits State Parties to protecting children from “all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse”. This chapter looks at the extent to which children in Myanmar realize their right to protection, the causes of violations of their right to protection and the roles and capacities of the duty bearers who are responsible for child protection.

12.1 Situation overview

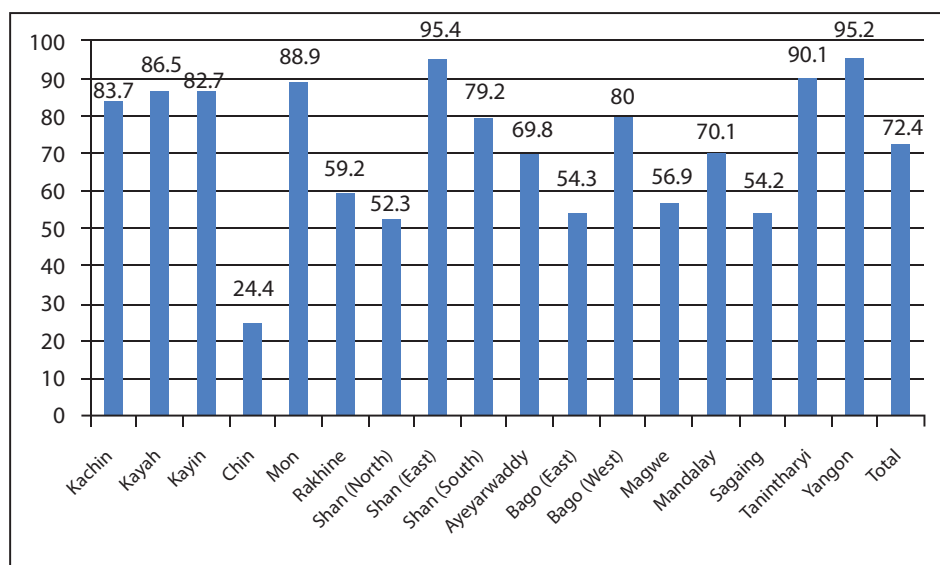
a) Birth registration

The MICS study in 2003 showed a significant gap in birth registration, in Myanmar with 35 per cent of births of children under-5 years unregistered. According to MICS 2009–2010, 72 per cent of children were registered at birth, indicating increased coverage of birth registration. However, some caution should be shown in interpreting the strength of this increase because the topic can potentially confuse, and it is thought that some respondents reported other types of registration and identity documents. It should also be noted that this indicator refers to both children who hold a birth certificate and children whose mother or caregiver reports that the birth has been registered.

The recent MICS data show that there was no difference between boys and girls in their likelihood of being registered at birth. There were, however, wide rural–urban and regional disparities. In urban areas, 94 per cent of births were registered, compared with 64 per cent in rural areas. Figures 39 and 40 illustrate birth registration figures for states and regions: as seen, Shan (East) and Yangon had the highest rates (95.4 per cent and 95.2 per cent, respectively), while the rate in Chin State was just 24.4 per cent. In several states and regions, just over half of children's births were registered.

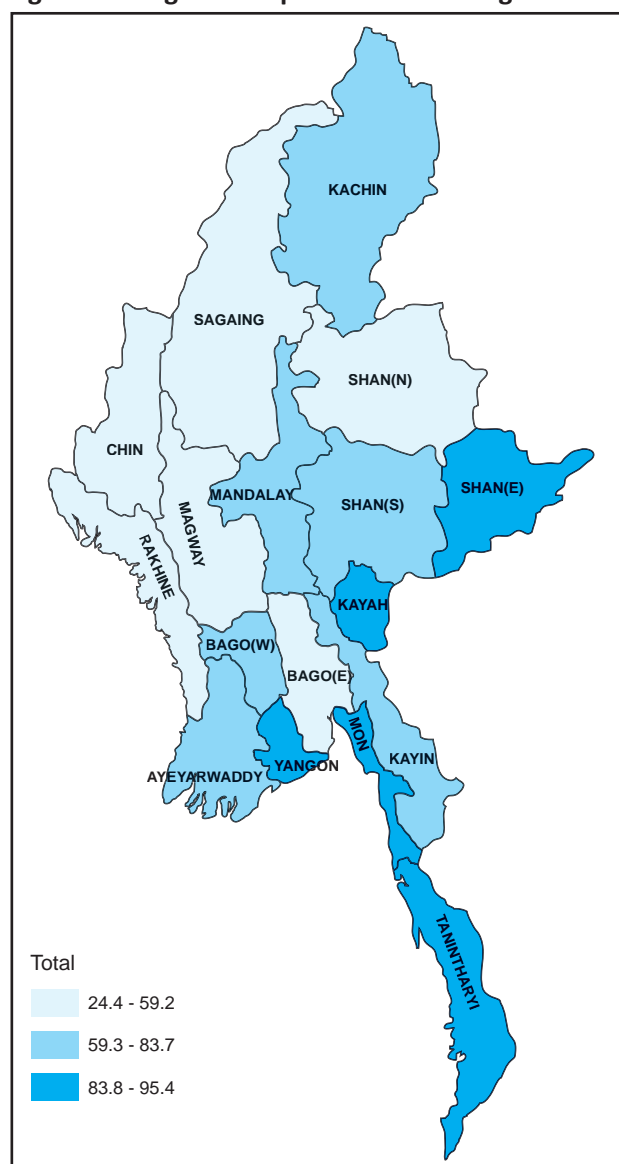
The education level of the mother or caregiver of the child is shown to influence the likelihood of the child being registered at birth. While just over half (52 per cent) of under-five children whose mother had no education were registered at birth, the coverage increased to 66 per cent for children whose mother had primary education, and 85 per cent for children whose mother had secondary or higher education. Primary caregivers from lower socio-economic groups were found to be less likely to register births. Among children from the poorest households, 50 per cent were registered at birth, while nearly all (96 per cent) births among children from the richest households were registered.

Figure 34: Birth registration of children under 5, by state or region



Source: MICS 2009-2010

Figure 35: Regional disparities in birth registration



Source: MICS 2009-2010

Box 13: Disparities in children's right to protection²⁴⁴

Rural--urban disparities:

In rural areas 64 per cent of children under five are registered, compared with 94 per cent in urban areas.

Socio-economic disparities:

- Among children in the poorest households, 50 per cent are registered, while 96 per cent of children in the richest households are registered.
- Among 15-19 year-old girls in the poorest households 9 per cent are married, compared with 4 per cent among girls in the richest households.

Regional disparities:

- Less than one fourth (24 per cent) of under-five children in Chin State are registered, while 95 per cent of children in Yangon are registered.
- In Shan (East) 22 per cent of girls aged 15-19 are married, compared with Sagaing where 5 per cent of 15- to 19-year-old girls are married.

Gender disparities:

- Boys constitute 81 per cent, and girls constitute 19 per cent of children coming into contact with the law.²⁴⁵
- A study of residential care facilities found 9,458 boys and 3,053 girls in residential care.²⁴⁶

Disparities between working and non-working children:

The school enrolment rate for 10- to 14-year-olds in the general population is 78 per cent, but among 10-- to -14-year-olds participating in the labour force it is 11.6 per cent.²⁴⁷

b) Exploitation of children

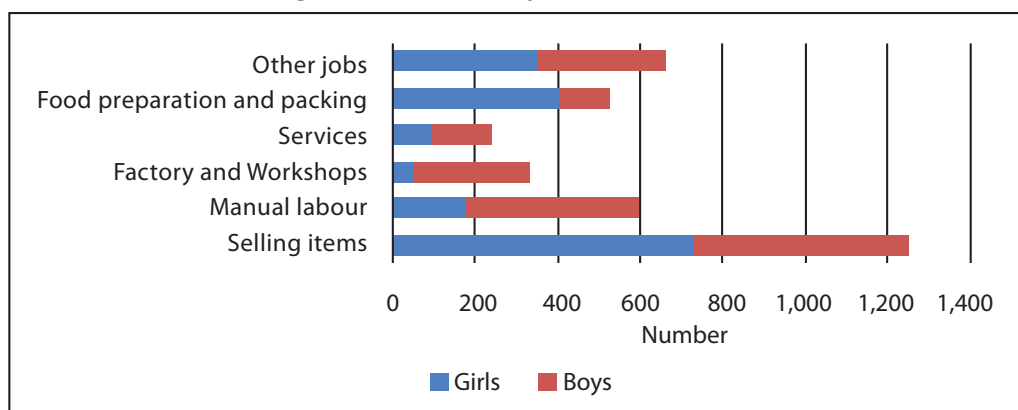
Working children – The IHLCA 2009–2010 reports the labour force participation of children aged 10–14 years as 18 per cent among the poor and 10 per cent even among the non-poor. Although there is a lack of data, it appears that many working children are unpaid family helpers, carrying out small tasks in farms and agriculture, family businesses or domestic tasks at home. Even where the tasks undertaken by children are not dangerous, work is damaging in that it prevents them from going to school or engaging in recreation and play and places them under stress. IHLCA 2009–2010 reports a far lower school enrolment rate (11.6 per cent) among children aged 10–14 years participating in the labour force than the general school enrolment for children of that age in Myanmar (78 per cent).

244 Ministry of National Planning and Economic Development, Ministry of Health and UNICEF, *Myanmar Multiple Indicator Cluster Survey 2009-2010*, Nay Pyi Taw, 2011. - unless otherwise stated

245 Third and Fourth National Report on the Implementation of the Convention of the Rights of the Child, 2001-2006, Government of Myanmar, Yangon

246 Ministry of Social Welfare and Relief & Resettlement and UNICEF. *Assessment of the Situation of Children in Residential Care Facilities in Myanmar, 2010–2011*, Yangon, 2011.

247 Ministry of National Planning and Economic Development, United Nations Development Programme, UNICEF and SIDA. *Integrated Household Living Conditions Assessment 2009-2010*. Yangon. 2011

Figure 36: Children's paid work activities

Source: Compass Research, Working Children in Myanmar: Child protection, Department of Social Welfare and UNICEF, 2006.

A 2006 study of 5,000 children across 14 townships in 6 of Myanmar's regions²⁴⁸ found that over a third of those aged 7–16 years were working, with similar numbers of boys and girls. Children were earning low and irregular incomes. Younger children had the fewest work options and were more likely to take on lower-paid work or begging. The main types of work undertaken are summarized in figure 36.

More than a third of these children were selling basic food and snacks, vegetables and simple commodities. Other common areas of work were manual labour (agriculture, fishing, cutting rock, carpentry, painting, small electrical jobs), food preparation and packing, factories and workshops (repairing cars, working with metal or paper factories) and services (work in tea shops and restaurants, domestic work and delivering snacks). 'Other jobs' included the collection of plastic and used wrapping material from rubbish bins and dumps and washing, cutting and melting the plastic for recycling (especially among children aged 7–9 years) and girls' employment in sewing, knotting and weaving (which could eventually allow them to own a small business and work independently).

Children who live on the street in Myanmar are often working as beggars, domestic workers, waste pickers, or are exploited for commercial sex. With no protective adult, they are especially vulnerable to abuse by adults as well as older children, including harassment and exploitation, beatings and robbery, stigma, rape and risky sexual behaviour.²⁴⁹

Commercial and sexual exploitation – Despite legal restrictions (see section 12.3), commercial sex is available in Myanmar, particularly in larger cities and border towns and dispersed among many types of establishments. Brothels are illegal in Myanmar, but female staff are available for sex in many pubs and karaoke bars, restaurants, massage parlours and nightclubs. Estimates place the number of female sex workers in Myanmar at around 60,000, 18.4 per cent of whom are thought to be HIV-positive.²⁵⁰ Children exploited for commercial sex are most often girls, but there are also some boys.

An assessment of 58 female sex workers under 25 years of age in three cities in 2010²⁵¹ found 12 per cent to be aged 10–14 years and another 33 per cent to be aged 15–19. Some reportedly used contraceptives, though most

248 Conducted in Sagaing, Mandalay, Magwe, Bago, Ayeyarwaddy and Yangon. See Compass Research, Working Children in Myanmar: Child protection, Department of Social Welfare and UNICEF, Yangon, 2006.

249 Working Children in Myanmar: Child protection, Department of Social Welfare and UNICEF, Yangon 2006.

250 Ministry of Health, National AIDS Programme, *National Strategic Plan for HIV and AIDS in Myanmar, Progress Report 2009*, Nay Pyi Taw, 2010.

251 United Nations Population Fund and Save the Children, *Assessment of Young Female Sex Workers*, Yangon, 2010.

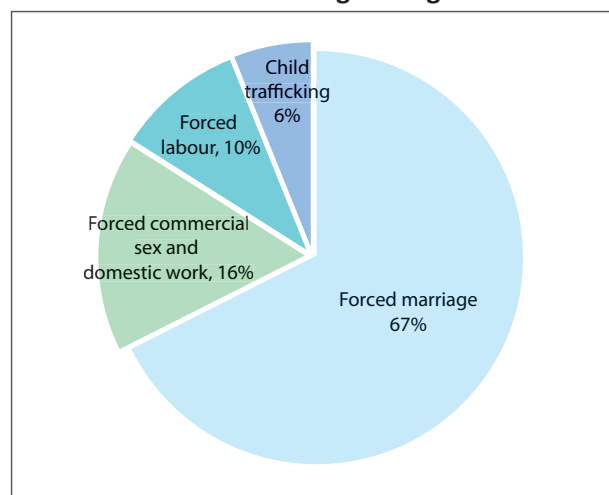
knew little about contraception or the dangers of HIV. These sex workers reported verbal, physical, sexual and financial abuse from their clients, pimps and others as well as stigma, discrimination and verbal abuse from others in their communities, which could isolate them from social networks. The illegal nature of their work means that they are also at risk of being put into detention centres for periods ranging from 15 days to 3 years.

Trafficking and abduction of women and children –The Anti-Trafficking in Persons Law defines trafficking as involving the recruitment, transportation, transfer, sale, purchase, lending, hiring, harbouring or receipt of persons for the purpose of exploitation with or without the person’s consent.²⁵² The existence of widespread migration over short and long distances and for different periods of time provides a context and cover for trafficking, both within Myanmar and across its land and sea borders, most often to Thailand or China.

The vast majority of internal as well as international trafficking cases go unreported and unaddressed, but Myanmar’s efforts in recent years have identified increasing numbers of trafficked people as well as traffickers. Most reported cases prior to 2004 were to Thailand, but numbers to China have since increased. This might indicate changes in trafficking routes, source communities and reasons for trafficking; but given the large number of unreported cases, great caution should be shown in drawing conclusions to this effect. Of the 613 trafficking cases registered in Myanmar between 2006 and 2010 (involving 1,070 victims), most had been trafficked to China (79 per cent) but also to local destinations (11 per cent) and to Thailand (10 per cent).²⁵³ Traffickers could be men or women. Two thirds of the trafficking victims identified in 2009 came from source communities in Yangon, Mandalay, Shan (North) and Kachin.²⁵⁴

With regard to reasons (figure 35), the vast majority of cases of trafficking to international destinations identified in 2009 were for the purposes of forced marriage, often involving sending young girls to China. Other reasons for trafficking were found to be forced commercial sex and domestic work, forced labour (generally to work on fishing boats and in seafood factories) and child trafficking, which includes cases of forced adoption, again mainly to China but also to Thailand.²⁵⁵

Figure 37: Reasons for trafficking among cases found in 2009



Source: 2009 Annual Progress Report, Myanmar Five-Year National Plan of Action to Combating Human Trafficking.

252 Article 3, Anti-trafficking in Persons Law 2005.

253 Ministry of Home Affairs, ‘Statistics on Trafficking Cases for SITAN’, No. 1096(2)/210/ Oo 4, Nay Pyi Taw, November 2010.

254 The Union of Myanmar, Ministry of Home Affairs, The Central Body for Suppression of Trafficking in person, 2009 Annual Progress Report, Myanmar Five-Year National Plan of Action to Combating Human Trafficking, Nay Pyi Taw, 2009

255 ibid

Children form a considerable proportion of trafficked persons both within and outside Myanmar: 21 per cent of those rescued in 2009 and 10 per cent of those repatriated were children. Some victims of internal trafficking are boys, but the majority appear to be girls and women who are trafficked for domestic work and commercial sex work. Overall, however there is little data on children, the situation in their source communities or factors increasing children's risks of being trafficked.

c) Children without parental care

Prevalence of children without parental care –The MICS 2009–2010 found that 5.4 per cent of children aged 0–17 years in Myanmar were not living with their biological parents, most notably in border areas with high levels of migration. The largest numbers were found in Mon (19 per cent), Kayin (12 per cent) and Tanintharyi (12 per cent). A further 10 per cent of children in Mon State live with their mother only, although their father is alive. The overall prevalence of children who are without parental care in Myanmar is certainly higher, considering the MICS data only captures children who are still found living within a household, and does not include children who live in residential facilities or on the street. Of those in residential care, two thirds had one or both parents alive – 44.1 per cent with both parents and 28.6 per cent with one parent.

The recent MICS data do not give reasons for children living without their parents, although it is clear that it is not due to the death of the parent. (The same data set showed that one or both parents of 6.6 per cent of Myanmar children aged 0–17 had died; the proportion was 2 per cent for children aged 0–4, but 13.5 per cent for those aged 15–17.) It is also not known to what extent parents of these children continue to keep in touch with them through letters, telephone calls or visits. Some of the parents might eventually return to live with their children, meaning that these children are not permanently left without parental care.

The likelihood of children being away from their parents was highest in the 15–17 age group (8 per cent), but children of all ages across Myanmar were affected, with 2 per cent of 0- to 4-year-olds, 6 per cent of 5- to 9-year-olds and 9 per cent of 10- to 14-year-olds living without their biological parents. The data indicates that more children in the richest households (7 per cent) live without their parents than in the poorest households (3 per cent). This could reflect parents being away for economic reasons and sending remittances back to family members.

It is not possible from the MICS data to say how the children without parental care are faring compared with other children. States and regions with high proportions of children without parental care show high coverage rates on indicators pertaining to education, nutrition and child health, but no information is available on the quality of care from the primary caregiver.

Adoption –The extended family in Myanmar traditionally cares for children without primary caregivers, but not necessarily the children of strangers. Although widely practised, such informal fostering is not regulated by government or social service agencies.

Regarding longer-term solutions for children who are permanently without parental care, there are three forms of in-country adoption in Myanmar (see section 12.1), but adoption rates are low. According to the combined Third and Fourth Periodic Report on CRC Implementation, between 2001 and 2006 a total of 48 orphans were adopted through procedures within the Department of Social Welfare and 44 through the Ministry of Health rules and regulations.

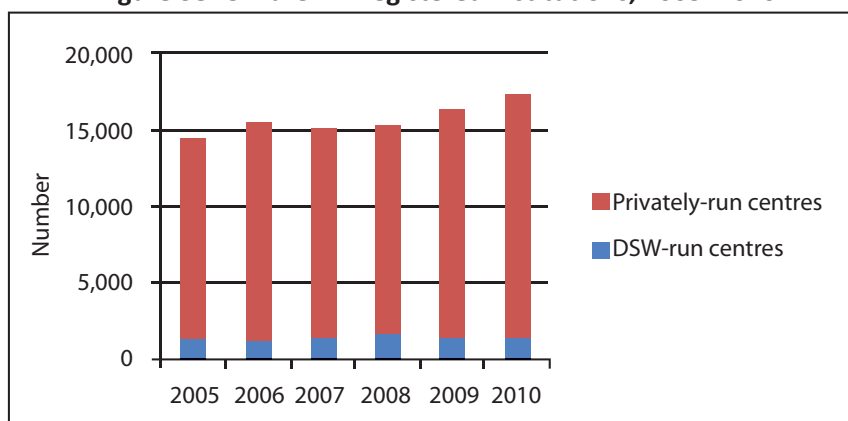
Children in residential facilities – The low rate of adoption and lack of alternative forms of family-based care leaves many children under the care of various types of institutions. It should be noted that many residential facilities do not primarily cater to orphans.

A 2010–2011 Assessment of the Situation of Children in Residential Care Facilities in Myanmar²⁵⁶ found 12,511 children (1,085 of them aged over 18) in the 147 institutions covered in the assessment. These included government, private, registered and unregistered institutions. Boys vastly outnumbered girls (9,458 boys and 3,053 girls). Some 44.1 per cent of these children were reported to have both parents alive, challenging theories on the reasons why children are sent to institutions. Around 264 per cent of facilities reported that children were brought to them by parents, often at the beginning of the school year, while 31.8 per cent of children were admitted after being brought to the institutions by strangers (including the police and authorities). The high percentage of former children in the street and children in contact with the law indicates the practice of taking children from the street to institutions.

Government-run facilities for children are far fewer in number than monastic or other faith-based or NGO-run facilities. Across the country, government institutions include: six residential nurseries caring for 237 children up to age 5; nine training schools for boys and girls aged 6–18; two schools for the blind; one for the deaf; and one institute for mentally disabled children. The training schools accommodate a mix of children who are orphaned, wards of the state, children with disabilities, juvenile offenders, victims of abuse and exploitation, those with behavioural problems and street children. Children who have been trafficked to other countries are also required to stay in these facilities for two weeks on their return to Myanmar for vocational training and psychological support.

The small number of children in government-run residential care was echoed by the Department of Social Welfare/UNICEF study, showing that in 2010 17,322 children were living in 217 registered residential care facilities, of whom 1,414 were in government centres (figure 38). A total of 92 per cent were living in institutions run mainly by monastic and other faith-based groups (these facilities come under the mandate of the Ministry of Religious Affairs). In addition several non-residential facilities, such as drop-in centres, are operated by national and international agencies. Registration requirements in Myanmar are not clear, not enforced by government agencies, and many people are likely to not know about the existence of them. The total number of children in private unregistered institutions across the country is not known.

Figure 38: Children in registered institutions, 2005–2010



Source: Department of Social Welfare, 2010.

Residential facilities generally just meet the basic needs of children in their care, often through the donations of well-wishers. The institutions covered in the 2010–2011 assessment tended to be overcrowded with insufficient funding, clothing, bedding and caregivers.²⁵⁷ Government-run institutions have a managerial board, but this is not the case for religious institutions, and there is limited accountability and oversight of the way in which children are treated. Although several of the institutions included in the assessment of residential facilities said they had a code of conduct, this was rarely known by the children and rarely displayed. Very few facilities kept records of the children in their care; in some of the facilities where records were kept, they were not confidential. Children had very limited opportunity to influence decisions relating to the running of the facilities.²⁵⁸

The majority of staff (80 per cent) in the institutions covered by the 2010–2011 assessment were found to be committed to caring for children in difficult circumstances, but there was little understanding of children's psychosocial needs and how best to meet these (only 41 per cent of staff had received training in child care and development). Play was neither valued nor encouraged (although most institutions allowed one hour for play each day) and the main emphasis was on good behaviour, doing well in school and following religious instruction. In most of the facilities studied, children had daily chores they had to carry out, such as fetching water, sweeping, cleaning and preparing meals. Failure to carry out these duties could result in punishment. In 2007, the Department of Social Welfare, UNICEF and partners jointly developed the Minimum Standards of Care and Protection of Children in Residential Care (completed in 2009). Though approved by the Department of Social Welfare, the standards have not yet been issued as a directive or disseminated widely.

In general, children tend to have little contact with their families once placed in residential care. Families are not encouraged to visit, and parents tend to be confident in the level of care provided as well as unable to visit due to distance and financial constraints. This is significant given that residential care should be a last and temporary resort, and the goal should be to reintegrate children back into the family environment. The situation in Myanmar indicates limited understanding and prioritization of reunification and reintegration of children into the family environment. The 2010–2011 assessment found that 46.3 per cent of the institutions covered actively encouraged or engaged in reintegration activities. Moreover only 20 per cent of children who knew the whereabouts of their families were reported to be allowed to visit them.

Reintegration of children from government-run institutions comes under the Department of Social Welfare. For children in contact with the law (alleged offenders, victims and witnesses) who have completed one year in residential care and behaved well during that period, probation officers make field visits to wards, townships and families to facilitate reintegration. Between 2005 and 2010, 3,273 children were reintegrated with parents and guardians after a year of residential care.²⁵⁹ For other children in residential care, reintegration is usually only instigated at the request of a child's parents, and proactive tracing and reintegration rarely occurs. The documentation and process required for parents to be reunified with their children is also complex and often unclear, thereby further complicating, delaying or preventing reintegration.

There is little preparation of children for the time when they will leave residential care. When children do leave institutions, they have few links to their own communities, and many reportedly remain in the cities to find a job, take on religious work or join the military.²⁶⁰

257 Department of Social Welfare and UNICEF, *Assessment of the Situation of Children in Residential Care Facilities in Myanmar, 2010–2011*, Yangon, 2011.

258 *ibid*

259 Information provided by DSW 2010, Nay Pyi Taw.

260 Department of Social Welfare and UNICEF, *Assessment of the Situation of Children in Residential Care Facilities in Myanmar, 2010–2011*, Yangon, 2011.

d) Children in contact with the law

Children coming into contact with the law in Myanmar are often seen as offenders and juvenile delinquents rather than as victims, witnesses and those needing special protection.

Between 2001 and 2006, 7,650 juvenile offenders passed through Myanmar's courts, mainly in Yangon and Mandalay Divisions. The overall incidence of juvenile offending appears low (0.006 percent of the under-14 population in 2005) and has been decreasing.²⁶¹ Most children coming into contact with the law were boys (81 per cent).²⁶² In 2003-2008, 91 per cent of theft cases – the most common offence – involved boys. Boys were also more likely to be involved in assault and gambling-related offences (more than 80 per cent of cases); by contrast all cases of juvenile prostitution involved girls.²⁶³

Many of the children in contact with the law come from broken families or have no parents or guardians. They come into contact with the law for committing minor offences for survival purposes or through being found on the streets. The high incidence of theft and juvenile prostitution-related offences reflect poverty as an underlying factor.

From 2003 to 2006, the most common sentences issued to young offenders were bonds (2,076 children, or 44 per cent) and admonition (36 per cent), with considerably fewer sentenced to DSW-run training schools. Only 46 children (1 per cent) were sentenced to the supervision of a probation officer and 23 to imprisonment.²⁶⁴ However, between 2003 and 2008, the Yangon Juvenile Court sentenced 238 young offenders to prison, 427 to bonds and only 282 to admonition.²⁶⁵ No information is available on the number of children in prisons or the conditions of their detention.

Also found within the prison system are the children of women prisoners; these children can remain with their mothers in prison up to the age of 4 and possibly 6 years if there is no-one outside to take care of them. Women constituted around 15 per cent (8,771 women) of the total number of people in prison in Myanmar in 2007.²⁶⁶ In 2006, 25 children were reported to be living with their mothers in prison.²⁶⁷ Pre-schools have been established in the prisons to teach the children poems and basic language skills.

Services and specific support for children in contact with the law as well as those returning to their family environment are limited. There is weak capacity and familiarity in child-friendly justice approaches and little provision of legal aid.

261 Hmwe, Sandar, Statistical Year Book and Supreme Court, Juvenile Justice System in Myanmar, Research Paper, EMPA Programme, Institute of Economics, Yangon, March 2009.

262 Government of Myanmar, *Third and Fourth National Report on the Implementation of the Convention of the Rights of the Child, 2001-2006*, Yangon.

263 Hmwe, Sandar, Statistical Year Book and Supreme Court, Juvenile Justice System in Myanmar, Research Paper, EMPA Programme, Institute of Economics, Yangon, March 2009.

264 Data from the juvenile courts in Yangon and Mandalay. (A 'Bond' is a conditional release upon issuance for a good behaviour undertaking and for a monetary sum. 'Admonition' is a reprimand by the Judge in lieu of detention.

265 1,755 juvenile cases in Yangon in from 2003 to 2008; see Hmwe, Sandar, Statistical Year Book and Supreme Court, Juvenile Justice System in Myanmar, Research Paper, EMPA Programme, Institute of Economics, Yangon, March 2009, p. 45.

266 Statistical Year Book 2008, Central Statistical Organization, 2009.

267 Government of Myanmar, *Third and Fourth National Report on the Implementation of the Convention of the Rights of the Child, 2001-2006*, Yangon.

e) Other vulnerable groups

Children with disability – Myanmar's first ever survey on persons with disability²⁶⁸ found a prevalence of 2.32 per cent across the Union in 2008–2009, or one person with disability in every nine households. In total, around 318,000 children aged under-15 were disabled, 249,000 of them of schoolage (6–15 years) and close to 480,000 women and girls older than 15. The rates of disability among males and females were similar at the national level, but there were regional disparities: Some areas had higher rates of disability among children than others, notably Mon and Kayin States and in Ayeyarwaddy and Tanintharyi Divisions. As much as 60 per cent of childhood disability was found to be due to congenital factors, with children most likely to be affected by intellectual or hearing impairment, often as a result of preventable causes such as anoxic birth injury, polio and micronutrient deficiencies.

Persons with disability in Myanmar were found to be economically, socially and educationally disadvantaged. Almost half the people with a disability never attended school compared with the national average enrolment rate of 84 per cent, and only 2.2 per cent of people with disability had completed university qualifications, as compared with 12 per cent of the non-disabled population.²⁶⁹ (Note that while disabled persons can enrol in higher education, current regulations exclude them from entering Education Colleges.) Although this information refers primarily to adults, it is a strong indication of the future opportunities of children with disabilities.

Families were the primary caregivers for people with disability in 95 per cent of cases in the 2008–2009 disability survey. There are very few residential facilities in Myanmar catering to children with disabilities. A 2010–2011 Residential Facility Assessment included two facilities for blind children and one for deaf children; all three facilities had around 100–150 children, but it was not noted whether staff had appropriate training to address the special learning needs of these children or whether they could access appropriate learning materials. A little more than a third of the facilities in the assessment accepted children with disabilities, but the study did not address whether there was any special programme for these children.²⁷⁰

According to the Ministry of Education, in 2010 around 800 disabled children were enrolled in formal schools, a further 1,450 in special schools which cater mainly for blind and deaf children and 36 in higher education. In the absence of more comprehensive data it is reasonable to conclude that a very large number of disabled children are not yet included in education.

Children affected by HIV – Children affected by HIV include those who have one or both parents with HIV or AIDS, those who have lost one or both parents to AIDS, those living with extended family or in residential institutions because their parents cannot care for them, children infected with HIV and those suffering from AIDS (the situation of these children is discussed in Chapter 11).

Children affected by armed conflict – Conflict in some of Myanmar's border areas continues to have a direct and damaging impact on large numbers of children. Many children have been recruited into the armed forces (the Tatmadaw) and armed groups, unknown numbers of families have been displaced, and some areas remain affected by anti-personnel mines and unexploded ordnance.

268 Department of Social Welfare and Leprosy Mission International, *Myanmar National Disability Survey*, 2010, Nay Pyi Taw
 269 ibid
 270 Department of Social Welfare and UNICEF, *Assessment of the Situation of Children in Residential Care Facilities in Myanmar, 2010–2011*, Yangon, 2011.

The exact numbers of children serving in the military or various armed groups in Myanmar is not known, and estimates vary greatly. The Government itself reports that since 2002 it has released 440 underage recruits (these include Tatmadaw releases).²⁷¹ The Government has informed the country's Task Force on Monitoring and Reporting Grave Violations Against Children that 395 underaged recruits – all male – were discharged between 2006 and 2010, the majority of them recruited between the ages of 15 and 17. A total of 196 of these children received support for tracing and reintegration with their families through international organizations.

Post-release interviews conducted among the boys released indicate that some had volunteered to join the army through a sense of duty and patriotism, the lack of alternative livelihood opportunities or the desire to join peers. Others had been forcibly recruited into the armed forces by either civilian brokers/recruiters or soldiers from other battalions. Some had been persuaded by civilian brokers to leave their villages with the promise of paid work. Others were brought to the armed forces by a relative or someone that they knew. Poverty and locality are factors increasing the likelihood of underage recruitment; patterns of recruitment include working and unaccompanied children being picked up from the streets, railway stations, Buddhist pagodas or other public places.

Most of Myanmar's non-state armed groups, including those that have ceasefire agreements with the Government, are reported to have at least some children in their ranks. These are mostly located in Tanintharyi Region and Mon, Kayin, Kayah, Shan, Kachin and Chin states. Practices within these armed groups differ, with under-age children recruited through a variety of methods, including village lotteries, forced recruitment and coercion. The United Wa State Army, for example, was reported in 2008²⁷² to have a visible presence of uniformed children drawn from villages on the basis of recruitment quotas. Younger children (6–11 years) were reportedly sent to military-run schools and later recruited, while children aged 12–18 underwent direct military training and were seen manning checkpoints. Where a household had no boys, girls were reportedly taken in their place.²⁷³

271 United Nations General Assembly- A/HRC/17/9, *Report of the Working Group on the Universal Periodic Review, Myanmar*, 24 March 2011.

272 United Nations Security Council, *Report of the Secretary-General on Children and Armed Conflict in Myanmar*, S/2009/278, 1 June 2009.

273 *ibid.*

Box 14: Story of a child soldier

Maung Aung is 21 years old and lives in Hlaing Thar Yar, a peri-urban area of Yangon with his parents and younger sister. He helps his mother at the family's grocery shop. When Maung Aung was 17, he was convinced by an army sergeant to take a job in Thanlyin. In December 2007 he was sent to Tat Ma 33 at Than Lyet Swan, and could not get back home. Even though he knows children younger than 18 could not enter the army, he was forced to join. At that time he was in grade 10. "Though it is a long time ago, I remember it very well because I was very scared at the time," he recalled.

After two days in Than Lyet Swan, he was sent to No.1 Training School and attended 16 weeks training. After the training, he was assigned as a private in Thanlyin (Ya La Kha). Following a formal complaint issued by Maung Aung's parents to the Ministry of Defence, he was released from the army on 28 May 2008, with a ceremony attended by local authorities and defence officers, and received all release documents. After returning from the army, he was working as a night guard at Dagon Center and struggling to support his family. An international development agency was made aware of his case by notification of the Ministry of Foreign Affairs; it offered psychosocial support to Maung Aung and his family along with some cash to start up a grocery store to generate income to support the schooling of his younger sister.

A case worker from a local partner NGO visited Maung Aung and his family to listen and ease Maung Aung's experience of distress that he suffered from the military training school.

"We sorted out together what would be the best way to start my life again," he said. Maung Aung now earns some income from the shop and feels proud that he is helping his family. "I share my experience with young boys in our area," he explained. "I don't want the same thing happen to them."

Another legacy of the conflicts is the presence of landmines – primarily anti-personnel mines, which are concentrated along Myanmar's borders with Bangladesh and Thailand, and in eastern parts of the country. Kayin State and Bago Region are suspected to contain the heaviest mine contamination and have the highest number of recorded victims.²⁷⁴ In addition, there are reports of landmines being laid in Kachin State by the Kachin Independence Army since the end of the ceasefire arrangements with the Government in June 2011. Few mined areas are marked, increasing the threat to villagers and internally displaced persons. Marking and fencing of mined areas has reportedly increased but does not occur consistently. Knowledge tends to be passed primarily by word of mouth among villagers or due to casualties occurring.

There are an estimated 42 conflict-related fatalities (killed by mines, during armed conflict, etc.) per million inhabitants annually in Myanmar.²⁷⁵ In 2009, there were reportedly at least 262 new mine or explosive remnants of war casualties, based on state and media reports and information provided by organizations. Of these, 259 casualties were reportedly civilian, although it is not clear how many were children. In 2008, at least 213 civilian casualties were reported through similar sources.²⁷⁶ In 2010, there were a number of reports of children being killed and maimed during skirmishes or by landmines and unexploded ordnance.

274 Mine Action Canada, Landmine Monitor, October 2010

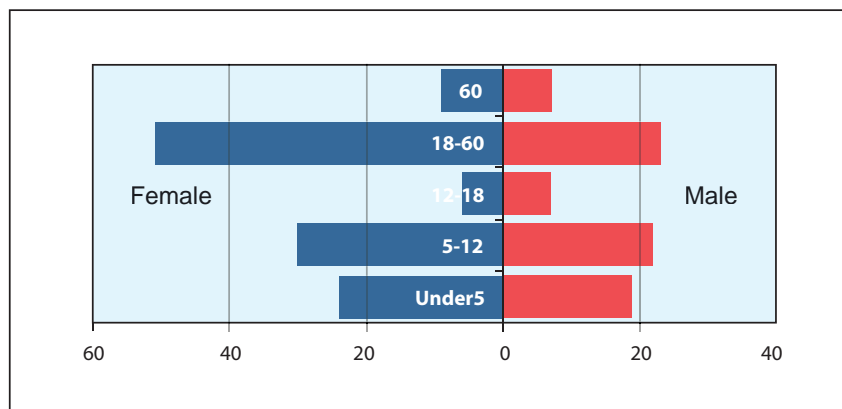
275 United Nations Development Programme, *Human Development Report*, New York, 2010.

276 Landmine Monitor 2010 notes that the bulk of the 721 mine and explosive remnants of war accidents (508) reported in 2008 were military casualties.

As of 2010, Myanmar had people internally displaced by armed conflict, mainly in the rural areas of eastern Myanmar.²⁷⁷ There were also unknown but significant numbers of internally displaced persons in other parts of the country, including in urban areas. Internally displaced persons live with physical insecurity due to their forced displacement and relocation, have less access to basic necessities, and face a higher risk of exploitation. Because the areas most affected by conflict tend to be inhabited largely by minority nationalities, it is thought most of the internally displaced persons in eastern Myanmar likely belong to such groups.

Children affected by emergencies and natural disasters – Globally, children typically represent 50–60 per cent of those affected by disaster and have often been found to be affected more severely and in greater numbers than adults.²⁷⁸ This was also the case in Myanmar, with women and children disproportionately affected by Cyclone Nargis (figure 37). The cyclone struck 37 townships across Yangon and Ayeyarwaddy regions in 2008, severely affecting 2.4 million people or onethird of the local population. Around 61 per cent of the 140,000 people killed in the initial event were women and girls, with even higher numbers of female deaths in some villages.²⁷⁹

Figure 39: Indicative age–sex pyramid of the deaths due to Cyclone Nargis in 10 severely affected villages



Source: Tripartite Core Group, Post-Nargis Joint Assessment, Yangon July 2008.

The disaster also had wide-ranging longer-term impacts on women and children. The cyclone compounded an already food-insecure environment, causing the loss of some or all food stocks in threequarters of households.²⁸⁰ Affected households were found to have reduced food intake, with somewhat higher levels of child malnutrition and high levels of child morbidity six months after the event.²⁸¹ Many households had adopted children or accepted homeless neighbours into their home, meaning that more people were sharing fewer resources.

Finally, children were found to be at greater risk of violence, abuse, exploitation and neglect, with families facing difficulties in continuing their education as they struggled to rebuild livelihoods.²⁸² Women were also negatively impacted: levels of debt, alcoholism and domestic violence were suspected to have increased in areas affected by Cyclone Nargis, with as many as 39 per cent of women in some areas indicated that there was often or sometimes violence against women in their community,²⁸³ occurring most often in the home but

²⁷⁷ www.internal-displacement.org (Internal Displacement Monitoring Centre)

²⁷⁸ Children are directly affected by death and injuries and by diseases related to malnutrition, poor water and sanitation – conditions that are exacerbated by disasters. In addition, disasters disrupt education and can cause psychological trauma.

²⁷⁹ Government of Myanmar, United Nations and ASEAN, *Post-Nargis Joint Assessment Report*, Yangon, July 2008.

²⁸⁰ *ibid*

²⁸¹ Save the Children, *Nutrition Assessment Report: Ayeyarwaddy Division, Mawlamyinegyun and Ngapudaw*, Yangon, November–December 2008.

²⁸² Save the Children, *Household Economy Approach Report, for Pakkoku*, Yangon, 2008.

²⁸³ Tripartite Core Group, *Post-Nargis Periodic Review IV*, Yangon, 2010.

also while travelling alone or working outside the home.²⁸⁴

Victims of violence, abuse and neglect – There is little data on child victims of violence and abuse in Myanmar, but consultations with children and women indicate the problem is very widespread.²⁸⁵

Physical punishment of children is a common disciplinary measure used by parents, caregivers and teachers, and may involve slapping but also the use of implements to beat the child.²⁸⁶ The 2006 Department of Social Welfare/UNICEF study of working children found that violence was reported to be common in these children's homes, due to arguments about alcohol, money and the struggle to provide the basic needs of the family and often involved physical beating and sometimes hitting with objects.

With regard to gender-based violence, 150 cases of rape of women and girls were reported in Yangon in 2004–2005, half of whom were younger than 15 years of age.²⁸⁷ Discussion of gender-based violence is quite sensitive in Myanmar. Women are often reluctant to talk about instances of marital violence due to the cultural preference on the appearance of harmony and the shame associated with conflict at home.²⁸⁸ Despite this, around one fourth of interviewees in a 2006 study described at least one instance in their household, although only a few portrayed the incident as serious. Indeed, several women would describe two people fighting with each other, rather than a passive woman being hit by a man.²⁸⁹ Interviewees told of some families in which violence was regular. Most of the female respondents in the study linked serious violence to men's alcohol consumption.

As seen below, natural disasters and major crises can also increase the risks to women and children. Each round of the Post-Nargis Periodic Review reported a higher incidence of gender-based violence, with 7 per cent in second review and 20 per cent in the third review. Although this seems to indicate a growing problem of domestic violence, conclusions should be drawn with some caution. The increased reporting of this could be a sign of increased awareness and willingness to overcome social taboos.²⁹⁰

12.2 Causality analysis

a) Immediate factors

There are two immediate factors hampering children in Myanmar from securing their right to protection: poverty and family breakdown or tensions. The first of these was discussed in Part One of this report: Poverty forces children to work and increases their vulnerability to commercial sexual exploitation and trafficking.

Family breakdown and tensions are intimately connected to exploitation and abuse of children and women in Myanmar. According to the Myanmar Women's Affairs Federation, the most common causes of marital

284 Tripartite Core Group, Post Nargis Periodic Review II, Yangon, 2009.

285 Department of Social Welfare and UNICEF, *Working Children in Myanmar*, Yangon, 2006.

286 *ibid*

287 Ni Hla, Nwe, Psychological Trauma of Rape Victims, Ph.D. dissertation, 2006, cited in the Report on the Situation Analysis of Population and Development, Reproductive Health and Gender in Myanmar, United Nations Population Fund, Bangkok, 2010.

288 Smith, Reid, A Hen is Crowing: A gender impact study of two UNDP Myanmar community development programmes, Yangon, 2006.

289 *ibid*

290 Post-Nargis assessment carried out by the Women's Protection Working Group, cited in Report on Situation Analysis of Population and Development, Reproductive Health and gender in Myanmar, United Nations Population Fund, Bangkok, 2010.

violence against women in Myanmar tend to be financial difficulties, alcohol consumption and incompatibility with in-laws.²⁹¹

The 2006 Department of Social Welfare/UNICEF study of working children found that, while the primary reason they were working was economic necessity, a web of factors had helped to create the situation in which they needed to work: unemployment, debt, gambling, alcoholism, illness and accidents, broken marriages and remarriages, domestic violence, neglect and abandonment, and migration.²⁹² Many of the working children came from broken marriages or less stable families, often following departure of the father. Where mothers remarried, children were not always well accepted by the step-parent and sometimes abused, sent to live with relatives and made to leave school to start work. As a result, some children preferred to be out working rather than living at home.

Lack of guardians has also been a factor increasing the number of early marriages in some areas.²⁹³ Similarly, the 2010 assessment of 58 sex workers found that about half had lost one parent or were orphaned. The young women and children in the commercial sex trade were often from broken families and very poor backgrounds. Some were found to have been trafficked, but others entered the sex trade voluntarily to escape abuse and difficult family environments or to earn more than they could in factory or other unskilled work.

Lack of awareness is also a factor in the denial of some children's rights. Awareness of the importance of having a birth certificate tends to be low in Myanmar. In MICS 2009–2010, mothers or caregivers of children without birth registration were asked why the birth was not registered; the most common reason given was that the caregiver did not know the birth should be registered. Awareness of services for persons with disabilities in Myanmar is also very low – only 27 per cent of those affected were aware of social services and just a third of these had ever used the services.²⁹⁴

b) Underlying causes

Underlying causes for denial of children's right to protection in Myanmar are twofold: i) weaknesses in state protection systems and services and ii) social attitudes to children and women. Generic issues relating to the former – lack of investment, limited facilities and personnel, lack of capacity, poor planning and coordination between different responsible agencies – were discussed in the context of 'Quality of governance' in Part One. Specific issues related to the legal, policy and institutional structures for child protection in Myanmar are examined in the following analysis of duty bearers.

Social attitudes in Myanmar promote the acceptance of working children, domestic violence and teenage marriage. Many see the role of children as to study hard and/or work hard: the notion of children needing a lot of time for recreation and play is an alien one. Furthermore, tolerance of working children is linked to the value (or lack of it) attached to education. The 2006 Department of Social Welfare/UNICEF study found a widespread belief among parents that work affords better opportunities for their children than education in the longer term, with it being more advantageous to enter the workforce at a young age so as to acquire skills and promotion as early as possible.

291 Myanmar Women's Affairs Federation, *Gender Statistics in Myanmar*, 2006, Yangon.

292 Department of Social Welfare and UNICEF, *Working Children in Myanmar*, Nay Pyi Taw, 2006.

293 'Delta Protection Sector Update, September 2010: Bogale, Pyapon and Labutta Hub', United Nations Development Programme, Yangon, 2010.

294 Department of Social Welfare and Leprosy Mission International, *Myanmar National Disability Survey, 2010*, Yangon, 2011.

Tolerance of violence against women and children is related to the dominant role of men in Myanmar society – discussed in Part One. Incidents of domestic violence are considered a family matter and rarely reported, even though they may be widely known within the community. (There are very few support services or counselling options available to victims and their families, even where abuse is reported.) Harsh disciplinary punishment of children occurring in some school and work environments, which causes humiliation and sometimes injury, is rarely considered by parents or others as a cause for concern or an issue to be reported.

12.3 Duty bearers: Role and capacity analysis

a) Family and community

Families are the primary duty bearers for children and carry the most immediate responsibilities for ensuring their rights to protection. Communities have responsibilities to mobilize for child protection in the community and to demand accountability and redress where rights are violated. Communities also play an important role in supporting families to care for their children as well as the reintegration of children who have been separated from their families when trafficked or taken as under-aged military recruits or who were orphaned.

Myanmar's various cultures traditionally value children and are motivated to fulfil their needs and protect them from exploitation. However, families and communities in Myanmar have limited knowledge and skills related to children's rights and protection, and some prevalent practices, particularly related to verbal and physical violence against women and children go unreported and unaddressed as a result (see section 12.1). Attitudes towards disabled people, among both affected families and communities, undermine the status of the disabled and prevent them realizing their potential. In most families (67.5 per cent), the overwhelming attitude towards the disabled was one of pity.

The economic and other hardships endured by many families can often lead to decisions that are directly damaging to their children's protection. These include withdrawing children from education to work in occupations and environments that may be harmful, placing children in residential care or allowing the recruitment of children into armed forces or armed groups.

The practice of sending children away to work is based largely on economic necessity. The 2006 Department of Social Welfare/UNICEF study of working children noted that some parents thought their child would eat better food more regularly when this was provided by an employer in a working situation. Parents were also able to reduce their expenses at home and gained additional revenue through their child's wages; some could also take an advance on wages when delivering the child to employers, which rendered the child more vulnerable because he or she would have to stay on even when conditions were very poor. Employers preferred the practice of children being with them 'round the clock' because they would be free to work anytime. At work, the children worried about abuse and salary deductions and about illnesses, accidents or other situations that could cause them to lose their jobs. But they tended to be reluctant to tell their parents of ill-treatment at work, not wanting to further burden them.

In the 2006 study, working children's parents, community leaders and employers saw little they could do to

protect and provide adequately for these children.²⁹⁵ The few apprenticeship and vocational training programmes were welcomed by parents and working children; however, with no shortage of new potential workers in their communities, employers had little incentive to develop such solutions. Working children, their parents and communities did not expect their circumstances to improve in the near future and did not see how they could earn more or find better jobs.

A similar reasoning applies to the practice of sending children to the monastery for shorter or longer periods of time, although this is also a tradition that is valued in Myanmar. In poor communities, the monastery has traditionally taken on the role of social safety net, providing education and caring for the sick; and monks enjoy great respect in their communities. This tradition is carried forward through the monastic schools. Many parents, particularly those who cannot afford education for their children, still value the opportunity to send their children to the monastery where they can learn Buddhist teachings, acquire some education and receive better meals than the parents can afford to give them.

The failure of families to register the birth of their children stems from both lack of knowledge as well as financial and other constraints. As seen in section 12.1, the most common reason cited by mothers/caregivers for non-registration of their children's birth was that they did not know the birth should be registered. However, other reasons commonly cited were the cost, the distance to travel and lack of knowledge of where to register.²⁹⁶ Given that the birth certificate is not required for many purposes (education, health care, etc.) and that there is some cost incurred to obtain it, it follows that for many it might not be a prioritized document.

The central role of health personnel in the birth registration process suggests that women who come into contact with them through antenatal care or delivery will be more likely to register the birth of their child. Conversely, women from poorer families and in rural areas who often deliver at home with the aid of a traditional birth attendant²⁹⁷ are less likely to register their children.

Trafficking can sometimes involve family members of trafficked persons, especially children. In the 2007 Fertility and Reproductive Health Survey, several women identified parents and friends as being involved in trafficking; with the main causes for trafficking cited as poverty, illiteracy and hope for a better life elsewhere (as well as entrapment). As noted previously, communities can play a role in supporting reintegration of people who have been trafficked. But while half the women interviewed in the Fertility and Reproductive Health Survey said the community would support women or girls who were trafficking survivors and treat them normally, an equal proportion said the girl would be looked down on as a bad girl, that they would be an outcast in society and could not get married.²⁹⁸

Even with limited resources, communities can be supported to strengthen the protective environment in their area. This was demonstrated by the initiative to set up community-based protection support groups across nine townships, with links to the Township Child Rights Committees (TCRC). By giving interested and influential community members the authority and skills to promote child protection, the support groups initiative was able to show significant results: Over a period of one year, 206 cases of children in need of protection were reported to the nine Township Child Rights Committees (Figure 40).

295 Department of Social Welfare and UNICEF, *Working Children in Myanmar*, Nay Pyi Taw, 2006.

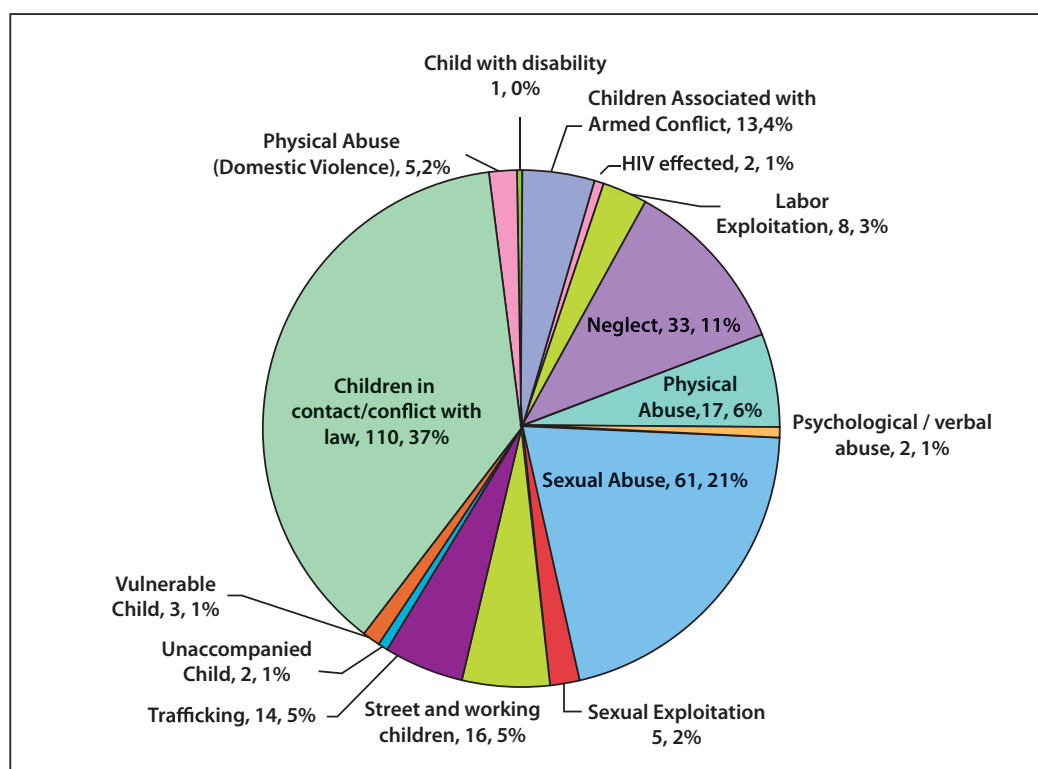
296 Ministry of National Planning and Economic Development, Ministry of Health and UNICEF, *Myanmar Multiple Indicator Cluster Survey 2009-2010*, Nay Pyi Taw, 2011.

297 Ibid

298 Ministry of Immigration and Population and United Nations Population Fund. *Country Report on 2007 Fertility and Reproductive Health Survey*, Yangon, 2009.

Protection issues which are being effectively addressed by many community support groups include: beating and other forms of violence in families; sending children to alcohol shops; resolving cases of petty crime; and supporting the care and protection of orphans and vulnerable children. Some children are also being protected from harmful work. In some areas, especially border areas, community support groups are raising awareness about safe migration and the risks of trafficking.²⁹⁹ However, it must be stressed that this is a very small-scale initiative, and the vast majority of townships and communities are not covered.

Figure 40: Child protection cases referred to township CRC Committees by community-based support groups



Source: UNICEF Child Protection Mid-Year Report, 2011

Box 15: Impact of civil society groups, as reported by children³⁰⁰

Children reported the following changes in their lives after the establishment of a child protection community support group in their village:

“There is more awareness and knowledge of children’s rights and child protection our community.”

“There is less violence in our homes.”

“Parents speak more kindly to us.”

“Our parents don’t let us go to risky places anymore, like playing on the riverbank or going to the shop to buy liquor for them.”

“We do less hard work.”

“More children receive support.”

“There is more prevention and response to child sexual abuse.”

“We feel happier and more confident.”

b) Civil society and private sector

Religious institutions, faith-based organizations and civil society groups provide support for certain affected groups, most notably through the provision of residential care facilities for disadvantaged, abandoned or orphaned children. They also provide adhoc support to struggling families. Unlike the health and education sectors, social welfare does not attract private sector engagement other than in the form of occasional donations and, in some cases, regular support for residential care institutions. There are around 26 national NGOs focused on protection-related issues.

Support from non-governmental organizations (national and international) is often focused on specific protection issues through localized and vertical pilot programmes. Examples include programmes supporting children affected by HIV and AIDS, trafficked women and children, street and working children and children recruited into the armed forces or armed groups.

c) Government

The Government holds the ultimate responsibility for ensuring the rights of all citizens, including children’s right to protection. This section reviews the policy and institutional aspects of the Government’s role in ensuring child protection in Myanmar; the analysis follows the issues discussed in section 12.1.

The Ministry of Social Welfare, Relief and Resettlement has the lead responsibility to provide for children, women, youth, persons with disability and the elderly, primarily through the Department of Social Welfare. Child Rights Committees have been established at the national, regional/state, district and township levels to coordinate CRC implementation among government departments. Protection services in Myanmar are hampered by the ‘quality of governance’ issues discussed in Part One, notably: under funding, lack of staff as well as of trained staff, weak coordination between different social sectors, as well as poor integration of protection within the key social sectors (health, education, etc.) and the lack of basic quantitative and qualitative information on common protection problems, which in turn hamper effective programme development.

300 From participatory exercises with more than 200 boys and girls as part of the UNICEF Township/Community-Based Child Protection Systems-Building Evaluation, June 2011.

Government role in relation to working children – Myanmar has not ratified the International Labour Organization conventions on child labour (the 1973 Minimum Age Convention or the 1999 Convention on the Worst Forms of Child Labour) but has various laws governing the employment of children. Employment of children younger than 13 years is prohibited in line with the Shops and Establishments Act (1951). Children aged 13–15 are permitted to work up to four hours a day if they have a certificate of fitness,³⁰¹ while a 15-year-old child can work as an adult. Workers at government-owned factories and oil fields can be employed officially only after 18 years of age. Myanmar’s combined third and fourth Periodic Report on the CRC (2006) noted the intention to change the minimum age of employment from 13 to 15 years, but it has yet to be enacted.³⁰² Working hours, leave of absence, holidays and other entitlements for working children are mentioned in the Factories Act and Shops and Establishments Act.

Article 24 of the Child Law (1993) specifies that every child has “the right to work of his own volition” and “the right to hours of employment, rest and leisure and other reliefs prescribed by law,” but it also prohibits children from earning a livelihood from some types of work, such as begging, being exploited for commercial sex or work that may be hazardous to “their life or moral character”.

Since the Constitution was approved in 2008, existing laws, including The Factories Act and Shops and Establishments Act, are reviewed and amended to be in line with international instruments in advance, and it is planned to submit these amended laws to Hluttaw’s Bill Committee. The Ministry of Labour is responsible to protect and safeguard the safety of child employees in the workplace and to prevent infringement and loss of their rights. The issue of working children (and children in the street) has not been fully acknowledged in policies to date, and the Myanmar National Plan of Action for Children, 2006–2015 notes that the issue is “not common in Myanmar as compared to other developing countries.”³⁰³ Even so, a set of Minimum Standards for Working Children was developed in 2007 in a process led by the Ministry of Labour and UNICEF and involving other ministries and civil society groups. The Minimum Standards were slated for redrafting as of mid-2011. Once approved, issued as a directive and linked to a clear monitoring mechanism, the Minimum Standards will have the potential to reduce exploitive child labour and to better protect the rights of working children (such as minimum age, maximum working hours, minimum pay, no hazardous work, combined with provision of education opportunities)

Government role in relation to commercial and sexual exploitation – Myanmar’s Penal Code has a number of articles that deal with sexual exploitation and abuse. Sexual intercourse is considered to be rape where involving a child under 14 years, except in the case of married girls who have attained 13 years. Over 14 years of age, any intercourse without consent is considered rape. The Suppression of Prostitution Act (1949) makes it illegal to entice a woman into commercial sex, to live off the earnings of commercial sex, to run a brothel or to solicit in public. It is also illegal for parents or guardians of children younger than 16 years to knowingly allow them to be exploited for commercial sex.

Myanmar’s Penal Code prohibits the sale, trafficking and abduction of children; a number of active measures have been taken to address trafficking issues over the past decade. The Anti-Trafficking in Persons Law (2005) entitles trafficked women and children to special protection, including repatriation, reintegration and rehabilitation support, and penalties against perpetrators. A Central Body for Suppression of Trafficking in Persons was formed to implement this law in 2006, along with similar bodies at the regional, district and

301 As per the Factories Act (1951).

302 Government of Myanmar, *Third and Fourth Periodic Reports on the Implementation of the CRC (2001-2006)*, Yangon..

303 Article 81 of part 4, Child Protection, Myanmar National Plan of Action for Children, 2006-2015.

township levels. A Five-Year National Plan of Action to Combat Human Trafficking was adopted in 2007. An Anti-Trafficking Unit has been established within the Myanmar Police Force under the Ministry of Home Affairs, and several in-country task forces and working groups involving the government, international and local agencies are also focused on the issue. In addition, a border liaison office has been established in the border towns of Lwei Je and Muse. A data collection system is in place for trafficking, but it needs to be strengthened. Myanmar is party to various regional agreements on trafficking,³⁰⁴ including the COMMIT initiative, together with five other countries in the Greater Mekong sub region.

Government role in relation to children without parental care – While the current legislation does include a number of regulations concerning provision of residential care for children for different reasons, there is no national system for fostering. Myanmar has three forms of in-country adoption: under the Department of Social Welfare, the Department of Health and the Supreme Court. These are governed by separate procedures and have no common legal framework. Adoption procedures tend to be complex and are seldom used in practice. Moreover, while the different procedures provide varying degrees of recognition of inheritance rights,³⁰⁵ even the ‘full adoption’ practice of Kittima does not consider the adopted child to be fully equal to a biological child.³⁰⁶ The adoption law remains highly discriminatory in that adoption is possible only for those of Buddhist religion, and its implementation is insufficiently monitored.

Government role in relation to children in contact with the law – Children who come into contact with the law may be alleged offenders, victims, or witnesses. Myanmar’s Child Law (1993) and Penal Code (1861) set a very low minimum age of criminal responsibility at 7 years, although allowance is made for the immaturity of children younger than 12 who have “not attained sufficient maturity of understanding to judge the nature and consequences of his conduct”. Myanmar’s combined third and four CRC Periodic Report (2006) notes the intention to change the minimum age of criminal responsibility to 10 years.³⁰⁷

Sentencing provisions for children include admonition (and release), a bond, a fine, supervision of a probation officer or for more serious infringements, being sent to training school or to prison. These differ from those of adults in that children cannot be sentenced to death, transportation for life or whipping,³⁰⁸ and are not ordinarily sentenced to imprisonment unless for an offence which would have been punishable with these harsher sentences.

In such cases, the child may be sentenced to imprisonment for up to seven years if aged under 16, and up to 10 years’ imprisonment if aged 16–18. A child may be released after due admonition. For children over 14 years, a fine may be imposed on the child if they have an income or on the parent. These children can also be subject to up to three years’ probationary supervision or sent to a training centre for a minimum of two years or until the age of 18. Children younger than 16 years may be tried in one of two juvenile courts (in Mandalay and Yangon) as well as in other areas where township judges are empowered to handle juvenile cases in their respective townships.

304 A bilateral Myanmar-Thailand MOU, bilateral Myanmar-China MOU and SOPs on repatriation and reintegration between Myanmar and Thailand are underway.

305 Under Buddhist law, full adoption (Kittima) allows inheritance; adoption by compassion (Apatittha) may or may not entitle the child to inheritance; and Chatta-batta (literally meaning ‘pick up the child’) which does not allow the child any inheritance rights.

306 Alternative Care for Children without Primary Caregivers in Tsunami-Affected Countries, Indonesia, Malaysia, Myanmar and Thailand, UNICEF, July 2006.

307 Third and Fourth Periodic Reports on the Implementation of the CRC (2001-2006), Government of Myanmar, Yangon.

308 Child Law (1993), section 45.

Government role in relation to children affected by disability – Myanmar is not a signatory to the United Nations Convention on People with Disabilities (under which State Parties should ensure that children with disabilities can access an inclusive, quality and free education),³⁰⁹ and it has not adopted the WHO classificatory system for disability. The country's 2008 Constitution notes the state's responsibility to care for persons with disabilities, and a National Plan of Action on Persons with Disabilities 2010–2012 has been developed which seeks to provide persons with disability with increased opportunities to participate in society as equal members and to contribute to the country's social and economic goals.

In practice, there are no tools, procedures or trained staff to diagnose disability in the early years, no support for families of disabled children and no training for teachers and head teachers to support inclusion. This situation represents not only the exclusion of a large group of children from their right to education but also a missed opportunity to reduce the social and economic costs to society of disability and social exclusion through early intervention, mitigation and though active steps to include disabled children and their families in education, the community and society.

Government role in relation to children affected by armed conflict – Under Myanmar's Defence Services Act (1959) and the Defence Council Directive 13/73 of 1974, a person cannot enlist in the armed forces if younger than 18 years. The Government has not signed the Optional Protocol on the involvement of children in armed conflict,³¹⁰ but a National Plan of Action to Prevent Under-Age Recruitment was developed by a high-level Government Committee for the Prevention of Military Recruitment of Under-Age Children, which was set up in 2004. Government efforts have focused on preventing recruitment through tighter controls and awareness-raising among recruitment units as well as the release of underaged recruits. The high-level Government Committee continues to report regular activities under its auspices, and some initiatives have been undertaken alongside international and national organizations to provide reintegration support to children who are released and training on preventing underaged recruitment to military and government personnel.

Evidence indicates that underaged recruitment by recruitment units has fallen since the formation of the Government Committee, but there has been less change where recruitment procedures are led by soldiers from other battalions. A complication is the common lack of appropriate birth certificates or identity documents to prove a child's age; and sometimes the use of falsified documents are not (or cannot be) adequately checked during the recruitment process. As of May 2010, disciplinary action had been taken against 108 military personnel found to have aided the recruitment of underaged children since 2002.³¹¹

Discharges of under-aged children so far have been in response to complaints lodged either directly by parents or through international organizations. Released children have noted the presence of other children in their units, indicating the need for more proactive efforts to identify and release underaged children.

The Union of Myanmar has not acceded to the Mine Ban Treaty but did participate in the Ottawa Convention Implementation and Universalization Workshop held in Indonesia in 2008. Currently, there are no state-run mine-risk education activities, no humanitarian mine clearing or official victim assistance programmes or strategy.

309 In September 2011, at the 18th Session of the Human Rights Council in Geneva, the Myanmar Foreign Minister stated that the Government planned to ratify the Disabilities Convention this year.

310 The Optional Protocol of the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict came into force in 2002 and stipulates that State Parties "shall take all feasible measures to ensure that persons below the age of 18 do not take a direct part in hostilities and that they are not compulsorily recruited into their armed forces".

311 Report received by UNICEF from the Judge Advocate General's Department of the Ministry of Defence in June 2010.

Government role in relation to children affected by natural disasters and emergencies – Myanmar has made global, regional and national commitments to promote effective disaster management and disaster risk reduction. Institutional arrangements and plans for disaster management extend to state/region, district and township levels³¹² and include preparedness and response activities for the various hazards which can affect different areas of the country. But although children typically represent 50–60 per cent of those affected by disasters globally,³¹³ specific arrangements related to children or women in Myanmar’s action plans are limited. A clear finding after Cyclone Nargis was that it impacted children and women differently.³¹⁴ This underscores the importance of ensuring the collection of disaggregated data, which can reflect how different groups of children and women are affected by the disaster and whether their specific needs as far as relief, rehabilitation and recovery are being met. This remains an area that needs to be strengthened in Myanmar.

Government role in relation to violence against children – Provisions in the Child Law allow for “admonition by a parent, teacher, or other person having the right to control the child, which is for the benefit of the child”. Although the Department of Social Welfare (in collaboration with UNFPA and the Women’s Protection Technical Working Group) is working on the advancement of women in Myanmar, including addressing gender-based violence, no specific work is being done to address violence against children.

Government role in relation to birth registration – Birth registration enables the legal recognition of children’s identity and nationality and ensures they are not excluded from opportunities and protection accorded to a country’s citizens. In ratifying the CRC, Myanmar confirmed its commitment to the right of all the country’s children to a name and nationality, to ensure registration and to redress the situation of any child who is stateless for some reason.

Birth registration is required by law in Myanmar,³¹⁵ although there is no punishment for those who do not register the birth of their children. The Modified Vital Registration System was established in 1999 and was expected to cover the entire country by early 2006. Under this system, children are to be registered in the place they are born rather than the place in which their parents are registered as living, thus limiting problems relating to long distances to travel for birth registration.³¹⁶

For children up to 1 year old, the midwife is the person who initiates the birth registration procedure; she fills in the relevant form to send to the Township Medical Officer, who signs the birth certificate. The process becomes more complicated after the first year of the child’s life. The Township Medical Officer must request approval from the Health Office at the state or region level to issue a birth certificate for children aged 1–5 years. Children older than 5 years cannot receive a birth certificate, requiring instead a court-issued affidavit to affirm their birth details.

Immediate consequences of not having birth registration are limited. Children can be included in the household registration listing, which serves most purposes; they can still access health care and have been able to enrol in primary schools without a birth certificate since the 2003 All Children in School initiative under

312 ‘Institutional Arrangements for Disaster Management in Myanmar, 2009’ and ‘Action Plan on Disaster Risk Reduction, Preparedness, Relief and Rehabilitation’, NDPCC, Union of Myanmar, Nay Pyi Taw.

313 Children are directly affected by death and injuries as well as from diseases related to malnutrition, poor water and sanitation – conditions that are exacerbated by disasters. In addition, disasters disrupt education and can cause psychological distress

314 Tripartite Core Group, *Post-Nargis Periodic Review*, Yangon, 2008–2010.

315 Article 9(b) of the Child Law (1993) and Article 24 of the Rules relating to the Child Law require the birth registration of children by parents or guardians.

316 Muzzi, Mariana, UNICEF Good Practices in Integrating Birth Registration into Health Systems (2000–2009), Working paper, UNICEF, 2010.

the Ministry of Education. Lack of a birth certificate or other official document attesting to a child's age and identity becomes more problematic as a child grows older, increasing their vulnerability to under-aged recruitment and exploitation. In general, repatriation of child survivors of trafficking becomes more difficult with children who do not have a birth certificate. For children who come into contact with the law, a birth certificate is important to avoid the child being treated as an adult in court. It also becomes more difficult to undertake study outside of Myanmar as foreign institutions generally require a birth certificate.

The most important identity document for administrative purposes in Myanmar is the National Registration Card (NRC), which can be issued to children from the age of 10 years. The NRC is required to enter higher education, formal employment, to legalize marriage or purchase land, to conduct bank transfers, to obtain a passport and as proof of identity during travel between states and divisions.³¹⁷ A birth certificate is not required to obtain an NRC, but applications do require the NRC details of parents, grandparents and some information concerning the registration of great-grandparents. The current system can exclude children born in Myanmar if both parents were not born in the country or if they cannot provide documentation proving they were (in line with the Citizenship Act (1982)).

d) International development partners

The international community providing support for the protection of women and children in Myanmar includes NGOs, UN agencies and donors. There are seven international NGOs engaged in protection-related activities. Although international NGOs working in Myanmar increased in the wake of Cyclone Nargis, relatively few of them were working on protection.

The activities of international development partners are often centred on specific protection issues: children in the street, support to children affected by HIV, trafficking and underage recruitment. However, a small number of the larger INGOs have been developing community-based child protection systems.

A number of UN agencies, with quite diverse mandates, are focused on the protection of women and children. UNICEF works to ensure protective environments for women and children across Myanmar and child-friendly social services. Its recently established legal aid programme has benefitted more than 2,752 children, including 1,798 boys. The ILO works to eliminate forced labour, including underaged recruitment into the military and armed groups. Both the IOM and the United Nations Inter-Agency Project on Human Trafficking (UNIAP) work for migrant protection and to counter trafficking (with UNIAP having a regional outlook).

12.4 Key Recommendations

Strengthen the legal framework – Efforts are needed to bring about ratification of relevant international conventions (such as the UN Convention on People with Disabilities) and to make amendments to Myanmar law to bring them in line with international conventions. The Child Law, in particular, needs to be amended to bring its definition of the child in line with international definitions and to remove scope for allowing physical punishment of children. Equally important, strong efforts are needed to promote the enforcement of laws and policies related to child protection.

317 Tripartite Core Group, Post-Nargis Periodic Review IV, Yangon, 2010.

Data collection – Mechanisms need to be strengthened for the regular collection of disaggregated information on women and children affected by specific protection problems (such as victims of trafficking, exploitation for commercial sex, children in the labour force, children affected by HIV). Data collection could be disaggregated by the types of children who need special protection mentioned in the rules related to the Child Law, thereby enabling effective solutions to be developed.

Improve the quality of services – Increased resources need to be allocated for social welfare services and the quality of them improved. In addition, coordination between different agencies involved in protection, especially government entities, needs to be strengthened to promote an integrated, holistic approach to addressing child protection issues. Furthermore, the national capacity for social work needs to be strengthened, including through training on social work.

Engage communities – Greater efforts should be made at the community level to create protective environments for children and women. This will entail efforts to promote attitudinal change in Myanmar society to reduce tolerance of, for example, working children, domestic violence, corporal punishment and child marriage, and to promote birth registration and a positive outlook on children with disabilities.

Regulate residential facilities – Increased attention should be paid to preventing the institutionalization of children, and more efforts are needed to avoid the separation of children from their families. Regulation of residential facilities for children needs to be strengthened, and the minimum standards of care should be enforced. Greater efforts need to be made to reintegrate children now in residential facilities with their families, where appropriate and in the best interests of the child.

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Annex A. Member list of SITAN Technical Working Group

Chair: Daw Lai Lai Thein

Director General

Planning Department

Daw Thway Thway Chit

Director

Planning Department

Daw Lwin Lwin Than

Deputy Director

Office of Attorney General

U Zaw Zaw Oo

Assistant Director

General Administrative Department

Daw Omma Rangmi (Police Major)

Dy. Head of Anti-Trafficking Unit

Department Against Transnational Crime
Myanmar Police Force

Daw Khin May Nu

Deputy Director

Department of Social Welfare

U Than Htut Swe

Director

Department of Relief & Resettlement

U Tun Than

Dy. General Manager

Social Security Board

Daw Tin Mar Htwe

Deputy Director

Department of Labour

Daw Malar Aung

Director

Central Statistical Organization

Daw Yu Lay Cho

Deputy Director

Department of Development Affairs

Dr. U Tin Win Kyaw

Director (Public Health)

Department of Health

Dr. Thet Thet Mu

Director

Department of Health Planning

Dr. Khin May Oo

Director

Department of Medical Research
(Lower Myanmar)

Dr. Khin Wai

Director, Department of Medical Research
(Upper Myanmar)

Dr. Aye Moe Moe Lwin

Director

Department of Medical Research
(Central Myanmar)

U Min Kyaw Wai

Deputy Director

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U Aung Chain

Director

Department of Basic Education No. 2

U Kyaw Win Myint

Deputy Director

Department of Basic Education No. 3

Dr. Aung Myat Kyaw Sein

Professor, Head, University of Yangon
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Daw Yee Yee Than

Professor, Head
Yangon Institute of Economics,
Department of Commerce

Daw Kyi Kyi Thein

Director, Department of Higher Education
(Upper Myanmar)

U Ko Lay Win

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Daw Nwe Nwe Win

Director
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