CHAPTER I

INTRODUCTION

Every woman deserves the fundamental right to high quality reproductive health care, as it is critical not only to her own well-being, but also to the well-being of her family, community, and our world. Reproductive Health Care is one of main health issues highlighted in the Millennium Development Goals (MDGs) that will lead to healthier women, stronger families, and more stable and prosperous communities. Investing in reproductive health care — in particular family planning and maternal health services — is a cross-cutting and cost-effective strategy to achieve progress on all of the Millennium Development Goals. Access to voluntary family planning saves the lives of women and children, reduces poverty, promotes environmental sustainability, increases security, and allows women to pursue educational and income-generating opportunities (UN).

Currently 215 million women want to have the opportunity to time and space their pregnancies, but lack access to high quality reproductive health and voluntary family planning services. Many people living in developing countries disproportionally lack access to health services and supplies. Fulfilling the unmet need for voluntary family planning alone would cut maternal deaths by a third and reduce infant mortality by 10 to 20 percent (UN Foundation).

In developing countries pregnancy and childbirth-related complications are a leading cause of death among women in their reproductive years. It is estimated that access to family planning services alone would save the lives of 114,000 women. At least 250,000 maternal deaths and as many as 1.7 million newborn deaths could be averted if the need for both family planning and maternal and newborn health services were met (UN).

The maternal mortality ratio in Myanmar is one of the highest in the region. According to official estimates the ratio is 140 maternal deaths per 100,000 live births, while UNICEF estimate this ratio to be 580 deaths per 100,000 live births (Ministry of Health, Union of

Myanmar and UNFPA, 1999). The contraceptive prevalence rate (CPR) for modern FP methods among married women of reproductive age is only 29 per cent. The unmet need for contraception is estimated at 20 percent among married women and would be substantially higher if unmarried women were also included in the calculation. Among the most devastating consequences of the lack of availability of contraception are the high levels of abortion, which is not legal in Myanmar and the number of deaths resulting from unsafe abortions. It is estimated that unsafe abortions account for 50% of maternal deaths (UNFPA, 2001). Public health expenditure in Myanmar is very low. It was found that in 2003 private expenditure on health as a total percentage of total health expenditures was 80.6%. As such households have to make high out-of-pocket payments for treatment of illnesses and thus have to encounter an onerous burden as a result of paying for their own health care (WHO Myanmar, 2008). In summary Myanmar is still far from achieving its targeted MDGs for 2015, with respect to Reproductive Health Care.

Kun Hing Township is one of the conflict-affected areas in Myanmar. This study intends to identify the barriers rural women and families face in accessing Reproductive Health Services in Kun Hing Township, to find out how those barriers operate, and to recommend the kinds of policies and programs that might be useful in helping women to have greater access to Reproductive Health services. The barriers that women face with regard to accessing health care services generally fall into three categories: political, economic, and social. These categories will help guide the design of this study in Kun Hing Township, Shan State, Myanmar.

1.1 Background and Problem Statement

The Shan State is comprised of 3 separate areas commonly known as the Northern, Southern, and Eastern Shan States. These 3 areas represent part of the 18 administrative states and divisions that make up Myanmar. The Shan States, as a whole, is the largest state in Myanmar. Its geographic size is approximately that of the Northeastern Region of Thailand. The Shan State has boundaries with China [to the North], Laos [to the East], Thailand [to the South], the Kayah State [to the Southwest], the Kachin State [to the Northwest], and the Mandalay Division [to the West].

The Shan State is inhabited by many different ethnic groups, that include the Tai speaking Shan as well as smaller numbers of Yunnanese [Chin Haw], Akha [Ekor], Lahu

[Muser], Lisu [Lisor], Kokang, Palaung, Pa-o [Taungso], and Wa. There are also several other "Tai groups" living in many parts of the Shan State that speak other languages/dialects and/or follow different traditions and customs [i.e.Tai Lue]. The Shan, however, are the largest of these groups. They are Theraveda Buddhists who are related to the Thai speaking peoples of Thailand, Laos, southern China, and northern and western Vietnam. Some of the Tai speaking groups, living in parts of Chiang mai and Lamphun [such as the Tai Yong and Tai Khoen], originate from the Shan State.

The population of the Shan State is estimated to be more than 4 million people, but this number may be considerably modified as a result of the recent "Myanmar Census" that took place in March 2014; the first national census undertaken since 1933. The Shan State is organized into 55 Townships. The Eastern Shan State has 11 Townships, the Northern Shan State has 23 Townships, and the Southern Shan State has 21 Townships. At least 33 of these 55 townships were considered, up until relatively recently, to be "conflict areas". During the State Peace Development Council's (SPDC) governance of Burma, they divided the Karen, Karenni, and Shan States into 3 security zone classifications. In the "black zones" local "insurgents" [i.e. the nomenclature given by Burmese government authorities to "rebel fighters", but considered to be "freedom fighters" by much of the local population] maintain nominal control over villages. SPDC troops have orders to shoot civilians on sight in "black zones" on the assumption that they are actively supporting the "insurgents". "Brown zones" are geographic areas where the land is contested by "local insurgents" [or "freedom fighters"] and the Burmese government. "White zones" are areas where SPDC troops [known as "Tatmadaw"] are in total control. One of the "black zones", situated in the Southern Shan States, is Khun Hein or "Kun Hing" [as it is known in Burmese] Township.

Access to reliable demographic and health related data is a major problem when working in Myanmar. The last official census in Burma took place in 1983, when the country supposedly had a population of 35,442,972. However Burma's official census in 1983 failed to count people living in areas where insurgencies were raging. As such one has to question the reliability of these figures? In 2011, the estimated population in Myanmar/Burma had increased to 61.3 million (WHO 2014). In March 2014 the UNFPA assisted the Myanmar/Burmese government to conduct a new census. The results of this huge undertaking will not be known for

at least 6-12 months. In brief some demographers feel that the last credible census for Burma was conducted in 1931 during British rule.

A similar situation concerns the reliability of health data put forth by government officials. There are many government agencies and units responsible for collecting and analyzing demographic "data". International agencies, such as the World Health Organisation (WHO), often report official Myanmar/Burma government health statistics, but at the same time acknowledge that access to information and health services is very limited for some population groups, particularly vulnerable to health problems. This includes people living in rural, remote, and border areas, and low income families in peri-urban areas.

Accordingly one has to be very careful in using/quoting official government figures, not because they are necessarily "doctored" or "designed to deceive", but rather because they are often incomplete. Many key health indicators [or vital events], for example, are primarily based on "hospital records" and limited surveys rather than actual events taking place in rural communities. In brief the vital events [i.e. births and deaths], including miscarriages/induced abortions/stillbirths, infant deaths, early childhood deaths, and maternal deaths, taking place in many rural/remote geographic areas, such as the "survey target area" in Kun Hing Township, go unreported and are not included in official health statistics, although these events may represent the majority of all "vital events" in any given township.

In 2002-2003 a MOH/UNICEF sponsored survey indicated that the Under 5 year Old Death Rate was 66.1 per 1,000 live-births, while the Infant Mortality Rate and Neo-Natal Mortality Rate were respectively 49.7 & 16.3 per 1,000 live-births. It was estimated that two-thirds of all under 5 year old deaths took place among infants, and that one-third all infant deaths took place within the first month or neo-natal period. The estimated Maternal Mortality Rate, in 2000, was 360 per 100,000 live-births, with 2.5 times more maternal deaths taking place in rural areas as compared to urban areas. The survey also estimated that "unsafe abortion" accounted for 50% of maternal deaths. But are these figures accurate or reliable and if so do they only represent a small proportion of all infant, early childhood, and maternal deaths that take place in rural/remote areas of Myanmar (WHO, 2008).

1.2 Research Objective: The proposed thesis exercise contains specific objectives, which include the following topic:

1. To study the factors influencing access to reproductive health services, and their effects on the health status of women of reproductive ages

1.3 Research Scope

The researcher decided to conduct her Reproductive Health Survey in 17 rural communities located in the Ka Li Sub-Township section of Kun Hing Township, the southern Shan State, Burma/Myanmar. According to the map reproduced by local health workers, there are 90 rural villages located in the area south and southwest of Ka Li Sub-Township. As indicated above Kun Hing Township may in fact include as many as 600 villages, but the local health workers-cum-interviewers, assisted by village headmen, only know of the communities in the southern section of Kun Hing Township.

The study's target groups comprised 596 individuals (399 women of reproductive age [15-44 years], 74 village leaders and23 local health service providers) from 17 villages in Kun Hing Township.

1.4 Definition of Terms

The definitions of important terms are given as follows:

Reproductive health: Reproductive health is a state of complete physical and social well-being, and not merely the absence of reproductive disease or infirmity. Reproductive health deals with the reproductive processes, functions and systems at all stages of life in Kun Hing Township.

Access to Reproductive Health Services: Access to Reproductive Health services refers to access to information about places, using the services when they have RH problems or illness as well as barriers to accessing services.

Rural: "Rural" is a relative term as its definition can be quite different in various countries or localities. For this survey "rural" refers to 17 communities located in Kun Hing

Township that are situated far from any urban setting. All or most adult inhabitants, living in rural settings, are generally engaged in agricultural pursuits for their survival, as well as to obtain "cash" or "commodities" to exchange for items used in their households on a daily/regular basis. "Rural", in this study, will also refer to communities where basic "public sector" social services, such as health and education, are non-existent or extremely limited.

Women of Reproductive Age: Women, aged between 15 to 44 years, who are currently living in 17 villages in Kun Hing Township.

Family Planning: In this study refers to modern contraceptive methods as those to "space births" and/or to limit future fertility. This includes Oral Pills, Injectable Contraceptives, Condoms, Intrauterine Devices (IUDs), Implants, and Male and Female Sterilizations.

Reproductive status: Refers to the overall health status of women of reproductive age [i.e. 15-44 years] at the time of data collection exercise.

Antenatal care: Refers to obstetrics care, provided by TBAs, local Auxiliary Midwives as well as skilled health personnel, during a woman's pregnancy.

Skilled health personnel: Refers to trained professional health personnel, such as midwives, doctors, and nurses who have received training to manage normal pregnancies, child birth, and the immediate postnatal period; as well as in the identification, management and referral of complications for women and newborns.

Predisposing factors: Refers to knowledge, beliefs, values, and attitudes of the women of reproductive age.

Enabling factors: Refers to programs, services, availability and accessibility of resources, to support reproductive health and to enable behavior change in women of reproductive age in Kun Hing area.

Reinforcing factors: Refers to social support, peer support, etc which support reproductive health of women in Kun Hing area.