

# **A reproductive health needs assessment in peri-urban Yangon, Myanmar**

## **Thesis**

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## **Abstract**

The 2010 elections in Myanmar installed the country's first civilian-elected government in more than 50 years, and subsequent growth and change have been rapid. However, reproductive health indicators are generally poor and reflect significant regional and geographic disparities. Rural populations are increasingly migrating to urban centers, like Yangon, in search of better economic opportunities and in response to persistent conflict. Many are settling in peri-urban Yangon, a dynamic series of townships characterized by poor infrastructure, slums, and a highly mobile population. However, very little is known about the reproductive health needs of this population. This study was designed to identify the reproductive health needs of women in peri-urban Yangon, and to understand better current practices, available services, and potential avenues for improvement. My research focused on delivery care, contraception, abortion, and post-abortion care. Using a multi-methods approach, and standard qualitative analytic techniques, I identified significant unmet reproductive health needs in peri-urban Yangon. The findings suggest that reproductive health services are often available but inaccessible. Findings demonstrate considerable misinformation, common and unsafe practices surrounding abortion and delivery, and a dearth of comprehensive sexual and reproductive health services for adolescent and unmarried populations.

## **Résumé**

Les élections de 2010 au Myanmar ont installés le premier gouvernement civil élu depuis 50 ans, et les changements subséquents ont été rapides. Toutefois, les indicateurs de santé reproductive de la population sont généralement pauvres et reflètent les disparités régionales et géographiques. De plus en plus, les populations rurales migres vers les centres urbains, comme la ville de Yangon, à la recherche de meilleures opportunités économiques et pour fuir des conflits. De nombreux immigrés s'installent dans la région "péri-urbaine" de Yangon, une série de cantons dynamique, caractérisé par l'insuffisance des infrastructures, les bidonvilles, et une population très mobile. Cependant, on sait très peu des besoins de santé reproductive de cette population. Cette étude a été conçue pour identifier les besoins de santé reproductive des femmes dans les zones péri-urbaines de Yangon, et de mieux comprendre leurs pratiques, les services disponibles, et les avenues d'amélioration potentiels. Ma recherche a porté comme sujet les soins de la livraison, la contraception, l'avortement et les soins post-avortement. En utilisant une approche multi-méthodes et des techniques standards d'analyse qualitative, j'ai identifié des besoins non-satisfaits de santé reproductive dans péri-urbaine Yangon. Mes résultats suggèrent que les services de santé reproductive sont souvent disponibles, mais inaccessibles. Les résultats démontrent beaucoup de désinformation, des pratiques dangereuses entourant l'avortement et l'accouchement, et une manque de services complets de santé sexuelle et reproductive pour les populations adolescentes et célibataires.

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## Acronyms and Abbreviations

ANC	Antenatal care
CBO	Community-based organization
CPR	Contraceptive prevalence rate
EC	Emergency contraception
ECPs	Emergency contraceptive pills
FGD	Focus group discussion
FP2020	Family Planning 2020
GHAP	Global Health Access Program
Ibis	Ibis Reproductive Health
IUD	Intrauterine device
MMR	Maternal mortality ratio
NGO	Non-governmental organization
OCPs	Oral contraceptive pills
PAC	Post-abortion care
PI	Principal Investigator
PPH	Post-partum hemorrhage
REB	Research Ethics Board
TBA	Traditional birth attendant
TFR	Total fertility rate
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
YWCA	Young Women’s Christian Association

## **CHAPTER 1: Background**

### **1.1 The Context in Myanmar**

#### *1.1.1 Brief history and recent political changes*

Myanmar's history is rich and complex. The country formerly known as Burma<sup>1</sup> has seen the rise and fall of many kingdoms, thrived as a hub for international trade, experienced British colonization, and been invaded by Japan. Myanmar finally achieved independence in 1948, only to be overtaken by a military junta in 1962, which dominated the country until 2011 (Hlaing, 2012; Myint-U, 2006). For nearly half a century, the country remained isolated from the global community, and the violent practices of the military – including forced labour, displacement, sexual violence, imprisonment and murder – went largely unnoticed by much of the world (Back Pack Health Worker Team, 2006; Mullany, Lee, Yone, et al., 2008; Sietstra, 2012). In eastern Myanmar, the military destroyed entire villages and withheld access to funding and relief efforts (Mullany, Lee, Palae Paw, et al., 2008; Mullany, Lee, Yone, et al., 2008). In western Rakhine state, the long history of abuse against the Rohingya – one of 135 ethnic minority groups in the country (Ministry of Health, 2014a) – remains ongoing, through the denial of citizenship, “economic marginalisation, human rights abuses, and restrictions on language and cultural expression”(International Crisis Group, 2014, p. 14). Further, the isolationist policies of the military hindered data collection in the country during its rule, and there remains a dearth of evidence to inform policy and programming, particularly around health. Conflict-affected and ethnic minority areas have been omitted from most otherwise national datasets, meaning the available data is not representative of the population as a whole.

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<sup>1</sup> For the purposes of this research, the name Myanmar has been purposely used to align with the language used inside the country by the local population and major bodies, including United Nations agencies. However, populations in Eastern Myanmar and Thailand often use the name Burma instead, to dispute the military's decision to change the country's name.

The military also actively worked to hinder international aid and humanitarian efforts during its long rule; most notably during Cyclone Nargis in 2008 when the military government refused to accept desperately needed humanitarian assistance (Larkin, 2010). However, local activists and organizations have long worked to counter the military rule, demand democracy, and provide access to services to the Burmese population both within and outside the country (Hlaing, 2012). Many Burmese fled to neighbouring Thailand to escape ongoing violence and conflict. There are nine refugee camps in Thailand and the country is home to more than 1.5 million undocumented migrants and refugees from Myanmar (Sietstra, 2012). Within the country, Aung San Suu Kyi – daughter of Aung San, considered the father of Burmese independence – has remained a symbol of hope to many Burmese. Optimism blossomed in 1990, when her party, the National League for Democracy (NLD), won the legislative elections. However, the victory was short-lived – the military ignored the election results and placed Aung San Suu Kyi under house arrest, which continued for most of the next two decades (CIA, 2010; Hlaing, 2012). The following years saw continued human rights abuses, isolation, and violent crackdown on protests, among other atrocities.

Yet in 2010, the ruling leaders held a parliamentary election for reasons that remain largely unknown. Some experts have suggested that the elections were an attempt for the military regime to legitimize their rule (e.g. Steinberg, 2011) or deflect criticism and pressure from the international community, while government officials claim they were solely motivated by benefit to the country (Hlaing, 2012). To the surprise of many, the military lost the election and the results were upheld; the country's first civilian-elected government in more than half a century came to power. The new president, former Prime Minister Thein Sein, has been criticized for his close military ties, and the military remains powerful in the country (CIA, 2010; Steinberg, 2011). However, the change in government has initiated a series of political reforms, including eased media restrictions, release of political prisoners, ceasefire agreements to end long-standing civil wars between ethnic minority groups,

and opening the country to investment (Hlaing, 2012). The government's miniscule health budget has also increased recently, although remains the lowest in the region as a percentage of Gross Domestic Product (Back Pack Health Worker Team, 2006; UNICEF, 2013). These political reforms have been publicly supported by major global powers, like the United States, who began lifting economic sanctions on the country in 2012 (U.S. Department of the Treasury, 2014).

Both within and outside the country, the reforms have been met by many with cautious optimism coupled with considerable skepticism. This distrust is largely owing to the fact that the military remains powerful and maintains veto power in parliamentary decision-making, holding one-quarter of seats in parliament (CIA, 2010; Hlaing, 2012; Steinberg, 2011). Further, violence, displacement and imprisonment at the hands of military personnel continue in parts of the country (Mullany, Lee, Yone, et al., 2008; Sietstra, 2012). In addition, despite the promising political reforms, the past year has seen multiple journalists jailed and sentenced to hard labour for "defaming" politicians or reporting on the activities of the government; violent response to national protests; and a refusal to amend a constitutional stipulation that bars Aung San Suu Kyi from running for president in the upcoming election (e.g. Fuller, 2014; Hla Tun, Petty, & Macfie, 2014; Min Min, 2015; The Economist, 2015). While the international community supports the ongoing political reforms in the country, the government of Myanmar continues to face intense pressure and scrutiny for its halting progress toward democracy.

### *1.1.2. Reproductive health trends in Myanmar*

The available data on health in Myanmar is limited; on reproductive health it is particularly sparse. In certain regions – especially those affected by conflict, inhabited predominantly by ethnic minority groups, or those that are growing rapidly – evidence on health is essentially non-existent. That these regions are often excluded from most otherwise national datasets suggests that most population-

wide data are not representative of the country as a whole. The limited available evidence suggests significant unmet reproductive health needs across the country. In this section, I will explore the currently available data on a variety of reproductive health indicators, including maternal mortality, unsafe abortion, contraception, and pregnancy and delivery care.

### *1.1.3. Available reproductive health indicators*

The available evidence on reproductive health in Myanmar is largely consistent with the overarching health dynamics in the country, in that there are significant regional and geographic disparities in health outcomes and access to health services. Despite the lack of government funding to improve reproductive health, certain indicators have improved considerably in recent years (UNFPA, 2010). The age of marriage for women has steadily increased from 21.2 in 1973, to 26.1 in 2006; approximately half of women of reproductive age (15-49) are unmarried (UNFPA, 2010). The delayed age of marriage is likely a contributing factor to the steady decrease in the total fertility rate (TFR) in the country, which has declined steadily from 4.7 in 1983 to 2.0 in 2006 (UNFPA, 2010). However, the TFR is higher in rural regions (2.18) than in urban regions (1.68) (UNFPA, 2010).

There are also significant geographic disparities in fertility rates, with the highest rates in conflict-affected Rakhine State (2.87), and the lowest rates in the more stable Yangon Division (1.69) (UNFPA, 2010). However, any decline in fertility represents a remarkable feat in Myanmar, given the pro-natalist policies of the government (Hla Hla Aye & Tin Tin Nyunt, 2010), who have actively sought to increase the population of the country, and particularly of the Burmese ethnic majority. Although it is difficult to determine the exact causes of the country's delayed marriage and decreased fertility, increased access to education and employment, increases in the number of people never-married, and increased use of modern contraceptive methods, coupled with declining fertility preferences, could all

be underlying factors (UNFPA, 2010). Further, the country's long history of violence, displacement, and economic strife may all be correlated to a decreased interest in marriage and fertility, although this has not been the case in other countries with similar histories. In the case of Myanmar specifically, however, these factors may intersect with the reverence placed on celibacy in both Buddhist and Burmese tradition to contribute to a decreased interest in marriage and reproduction (Jones, 2007).

Other reproductive health indicators in the country have experienced far less improvement. The national maternal mortality rate (MMR) remains one of the highest in the region, estimated at 200 deaths per 100,000 live births (World Bank, 2013). In the country's conflict-affected and border regions, the MMR is estimated to be four or five times higher (Hobstetter et al., 2012), and one in twelve women are at risk of dying from pregnancy-related complications (Back Pack Health Worker Team, 2006). The primary cause of maternal death in the country is post-partum hemorrhage (PPH), followed by hypertensive pregnancy disorders, like eclampsia. Unsafe abortion is the third most common cause of maternal death (UNFPA, 2010).

Abortion in Myanmar is legally restricted, and permissible only to save a woman's life; however, this condition is narrowly interpreted such that few women are able to obtain safe, legal abortion care (Ba-Thike, 1997). Providers can face three years in jail and/or a fine if they are caught providing an abortion (Ba-Thike, 1997). Further, abortion is heavily stigmatized, in part due to fear of criminal repercussions, and a Buddhist belief in avoiding harm or ending life (Ba-Thike, 1997). However, abortion rates are high, as are related morbidity and mortality; across the country, at least 10% of maternal deaths are directly attributable to unsafe abortion complications (UNFPA, 2010). In conflict-affected parts of the country, and even in some of Yangon's hospitals, this rate is four to five times higher, with up to half of maternal deaths attributable to unsafe abortion complications (Hobstetter et al., 2012; Ministry of Health, 2014b). The 2007 Fertility and Reproductive Health Survey reported that at least

4.7% of pregnancies in the country are terminated (Ministry of Immigration and Population & UNFPA, 2009). Given the legal restrictions on the procedure, the stigma and shame surrounding it, and difficulties collecting data on abortion-related morbidity and mortality, this is likely an underestimate.

Largely due to the extensive efforts of international non-governmental organizations (NGOs), contraceptive prevalence has increased significantly, and knowledge of contraceptive methods is widespread (Ministry of Immigration and Population & UNFPA, 2009). Although the overall contraceptive prevalence rate (CPR)<sup>2</sup> remains low at 46% (Ministry of Health & UNICEF, 2011), the use of contraceptives among married women has more than doubled in the last three decades, and women are increasingly choosing more effective modern methods of contraception over less effective traditional methods<sup>3</sup> (Ministry of Immigration and Population & UNFPA, 2009). The unmet contraceptive need in the country<sup>4</sup> has decreased, although remains high at 17.7% in 2007 (Ministry of Immigration and Population & UNFPA, 2009).

As with other reproductive health indicators, stark regional and geographic disparities surrounding contraceptive prevalence exist. The CPR is highest in Yangon Division, at 58.7%, in sharp contrast to the rate of 7.8% in Chin state (Ministry of Health & UNICEF, 2011). The most commonly used contraceptives in the country are the hormonal injection, used by 27% of women, followed by the oral contraceptive pill (OCP), used by 11.5% of women (Ministry of Health & UNICEF, 2011; Ministry of Immigration and Population & UNFPA, 2009). Use of long-acting reversible contraceptives, particularly the intrauterine device (IUD) is currently low, at 2% (Ministry of Health & UNICEF, 2011). The majority of

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<sup>2</sup> The contraceptive prevalence rate is defined as the percentage of married women who are currently using (or whose partner is using) a method of contraception (WHO, 2006).

<sup>3</sup> Use of the terms "modern" and "traditional" to describe contraceptive methods requires some additional comment. The term modern is often used in contrast to a pejorative descriptor, such as "pre-modern" or "traditional." Scholars have argued that this language reinforces other binaries that reflect unequal power relations, such as East/West, Global North/Global South, or developed country/developing country. However, these descriptors for contraceptive methods are well established in medicine and public health and have defined meaning. As there are no other widely accepted classifications of contraception in English, throughout this thesis I will use the standard descriptors. However, I do so cognizant of the power and importance of language.

<sup>4</sup> Unmet contraceptive need is defined as the percentage of women of reproductive age who do not currently want to become pregnant but are not currently using any method of contraception (Ministry of Immigration and Population & UNFPA, 2009).

women who use modern contraceptive methods obtain them primarily from the private sector (Ministry of Immigration and Population & UNFPA, 2009). However stock-outs are common across the country, which impacts women's ability to continuously and consistently access contraception (UNFPA, 2010). Contraceptive use is closely tied to education level, number of children, and location, with use increasing with every level of educational attainment, among women with more children, and among those living in urban centers (UNFPA, 2010).

Little data exists on the use of emergency contraception (EC) in Myanmar. Although emergency contraceptive pills (ECPs) are widely available from pharmacies, many ECPs are low-quality or counterfeit (UNFPA, 2010). Thus, the efficacy of these pills is likely reduced. Since most ECPs are obtained from the private sector, and data from private pharmacies is not included in national health statistics, there is little data on the quality and use of ECPs in the country.

Pregnancy and delivery care have seen some improvement in Myanmar in recent years, however issues pertaining to quality and quantity of care persist. In 2007, approximately 80% of pregnant women had received antenatal care (ANC) from a medical professional in the last five years, while 16% had not (Ministry of Immigration and Population & UNFPA, 2009). Other studies have found that 93% of women received at least one ANC visit, 83% of which were with a skilled provider, most commonly a midwife (Ministry of Health & UNICEF, 2011). The quality of care is significantly higher in urban areas, with 95% of women receiving ANC from a skilled provider, compared to rural areas where 78% of women received ANC from a skilled provider (Ministry of Health & UNICEF, 2011). Women in rural areas rarely receive all components of comprehensive ANC, including measuring blood pressure, testing urine and blood, and measuring weight and height (Ministry of Health & UNICEF, 2011).

Every year in Myanmar, more than one million women give birth, and the majority of these births occur at home (UNFPA, 2010). However, women are increasingly choosing to give birth in

hospitals and clinics, or to be accompanied by a skilled birth attendant during a home delivery (Ministry of Immigration and Population & UNFPA, 2009). The number of births attended by a skilled birth attendant increased from 56% in 1997, to 70.6% in 2010 (Ministry of Immigration and Population & UNFPA, 2009; Ministry of Health & UNICEF, 2011). More than one-third of births across the country are attended by a midwife, often the most accessible skilled provider (Ministry of Health & UNICEF, 2011). In Yangon, the most common birth attendant is now a doctor (Ministry of Health & UNICEF, 2011). In 2010, approximately 36% of deliveries occurred in a public or private facility (Ministry of Health & UNICEF, 2011); however, significant regional and economic disparities in delivery care exist. The more education and wealth a woman has, the more likely she is to give birth with a skilled birth attendant, and in a health facility (Ministry of Health & UNICEF, 2011). While approximately half of poor women give birth with a skilled birth attendant, this figure rises to 96% for the wealthy (Ministry of Health & UNICEF, 2011). In addition, nearly two-thirds of babies in urban settings are born in a health facility, compared to just one-quarter of babies in rural settings (Ministry of Health & UNICEF, 2011).

Three-quarters of maternal deaths occur during delivery or in the immediate post-partum period (Ministry of Health & UNICEF, 2011). In Myanmar, less than one-quarter of women with pregnancy complications reach a hospital, and 90% of maternal deaths occur at home or on route to a hospital or clinic (UNFPA, 2010). Several delays keep women from timely access to post-partum care, including lack of financial resources, delayed decision-making in the home, inadequate transportation infrastructure, and poor quality of care at the health facility (UNFPA, 2010). The high number of maternal deaths across Myanmar suggests that these delays may all be hindering access to care.

In sum, although reproductive health outcomes remain poor in much of the country, Myanmar has seen considerable and surprising improvements in reproductive health in recent decades. However, significant regional, geographic, and socioeconomic disparities in reproductive health outcomes and

service accessibility persist, and the legal restrictions on abortion continue to lead to high rates of morbidity and mortality across the country. The government has committed to improving reproductive health in their National Strategic Plans on Reproductive Health, and has made commitments to international efforts to improve reproductive health, such as the Family Planning 2020 (FP2020) global partnership, which aims to support women around the world to decide their own fertility desires (FamilyPlanning2020.org). Significant investment and collaboration are required to improve reproductive health in Myanmar, and further research is needed to inform these efforts.

#### *1.1.4 Rural to urban migration patterns in Myanmar*

In Myanmar, ongoing conflict has forced many to move from their communities of origin to seek safety and better opportunities both within and outside the country. More than three million people have migrated to neighbouring countries, “for economic, social and political reasons” (UNFPA, 2010, p. 55). The country has also seen considerable migration internally. Older estimates of internal migration (e.g. the 1991 Population Changes and Fertility Survey) estimated that one in ten people in Myanmar move to another state or division at least once in their lifetimes (UNFPA, 2010), although an updated estimate is currently unavailable. Currently, the majority of Myanmar’s population resides in rural regions. However, in line with overarching global migration trends, rural populations in Myanmar are increasingly migrating to urban centers, like Yangon, seeking better economic opportunities.

Despite ongoing rural-urban migration, the urban population remains relatively small, with just 29.6% of the population residing in cities in 2014 (Department of Population, 2014). This represents a slight increase from 1991 when the percentage was 24.9% (UNFPA, 2010). The limited available evidence on migration in the country suggests that the predominant migration flows are from rural regions to urban settings and from smaller urban centers to larger urban centers (UNFPA, 2010). Yangon

is the country's most populous urban center, with a population of 7.35 million (Department of Population, 2014), and receives the majority of internal migrants in the country (UNFPA, 2010). In 2001, Yangon received the most internal migrants across the country, with 221,000 people moving to the city (UNFPA, 2010). In the same year, Yangon had the country's lowest number of out-migrants (UNFPA, 2010). The city is expected to grow rapidly in the coming years.

Myriad factors, including internal and international migration to Yangon, the city's status as the country's economic hub, and a lack of affordable housing, have resulted in Yangon becoming an increasingly unaffordable place to reside. Recent news coverage on rents in Yangon have compared the city to major metropolises like New York City with respect to rental costs (e.g. Vallikappen & Thakur, 2013), and highlighted the already stretched resources and infrastructure, suggesting the city may be unable to accommodate continued migration without major structural investments (e.g. Khine Kyaw, 2014). As rents continue to increase exponentially across Yangon, the city's poor are settling in underdeveloped, slum settlements on the city's outskirts: an area locally known as peri-urban Yangon, and the setting of this study. The study area will be discussed in more detail in Chapter 2.

## 1.2. Rationale

In 2013, Ibis Reproductive Health (Ibis) and the Global Health Access Program (GHAP) researched and wrote a report on reproductive health along the Thailand-Myanmar border, entitled *Separated by Borders, United in Need: An assessment of reproductive health on the Thailand-Burma border* (Hobstetter et al., 2012). The study assessed reproductive health needs among Burmese migrants living in Thailand, and focused on contraception, maternal mortality, and unsafe abortion. The report was enthusiastically received by stakeholders on both sides of the border. Stakeholders attending a dissemination meeting in Yangon in September 2013, held by my supervisor, Dr. Angel M. Foster and her

colleagues, discussed a need for a similar project assessing reproductive health in the peri-urban townships of Yangon, where there is a lack of data to inform the programming of donors and service delivery organizations. Dr. Foster assessed the feasibility of conducting a similar needs assessment in this area, and determined it would be suitable for a Master's-level thesis. When Dr. Foster asked if I would be interested in leading this study, I enthusiastically accepted. This study has been designed to address this need for evidence, and utilizes similar methods as Hobstetter et al.'s report.

### 1.3. Specific Objectives

This thesis aimed to address the current gap in research surrounding reproductive health in peri-urban Yangon. The goal of this research was to use a range of methods to collect data from a variety of actors and stakeholders to create a comprehensive picture of reproductive health in peri-urban Yangon. Specifically, this multi-methods study aimed to:

1. Understand the current reproductive health status of women of reproductive age (16-49) in the peri-urban areas surrounding Yangon;
2. Determine the reproductive health care and services available in peri-urban Yangon;
3. Document women's perceptions of available services, utilization of services, and perceptions of how services and access to services can be improved; and
4. Identify avenues for advocacy/ policy work to improve service delivery and accessibility

### 1.4. Considerations of Reproductive Justice

Conducting reproductive health work and research in international settings requires conscious and ongoing engagement with the fraught history of reproductive health abuses that have plagued

relationships between the Global North and Global South and the legacy of these dynamics. In particular, the use of coercive practices by dominant powers against racial and ethnic minority groups, as well as other marginalized groups in the Global North, must be acknowledged when exploring access to contraception and safe abortion care. A reproductive justice framework provides an important lens for conducting this work in a just, respectful, and ethical way. Reproductive justice is defined as “the complete physical, mental, spiritual, political, social and economic well-being of women and girls, based on the full achievement and protection of women’s human rights” (Ross, 2006, p.14). Conceptualized by women of colour and Indigenous women in the United States, the concept encompasses both a theoretical framework and a social movement. Reproductive justice links reproductive rights and social justice and moves beyond the pro-choice movement’s historical focus on abortion to also include women’s rights to have a child, to not have a child, and to parent their children (Ross, 2006). Reproductive justice arose in response to the pro-choice movement’s lack of acknowledgement of the myriad factors that may impact women’s abilities to make choices about their reproductive health (Sillman, Fried, Gutierrez & Ross, 2004; Fried, 1990). The reproductive justice movement is built on a foundation of intersectionality, which illustrates the interlocking forms of oppression that shape women’s lives and access to opportunities (Crenshaw, 1991). In the context of reproductive health, this can include a focus on the historical, political, cultural, social, and economic factors that influence women’s reproductive health outcomes, access to services, and interactions with health care providers and the state.

This framework is particularly important given North America’s long history of attempting to hinder the reproduction of non-white populations; as Dorothy Roberts writes: “America has always viewed unregulated Black reproduction as dangerous,” in part due to enduring stereotypes regarding who is “fit” to be a mother (1997, p. 8). The concept of scientific racism is rooted in the belief that race has a biological basis and that some races are biologically inferior to others; the reproduction of

“inferior” races is thus seen as needing to be controlled. Because of this, reproductive politics have long been inextricable from race politics (Roberts, 1997). While the legalization of contraception was a pivotal moment in women’s reproductive freedom in North America, its benefits were enjoyed primarily by white, middle-class women (Roberts, 1997). The success of the “birth control” movement was based in part on support among eugenicists for the control of marginalized populations, including women of colour, poor women, and women with disabilities (Roberts, 1997; Nelson, 2003; Eig, 2014). Government-funded programs in the United States deemed these women “unfit” to be mothers, and coerced many into using contraceptives like the Norplant or to be sterilized (Roberts, 1997). Outside the United States, foreign aid was used to facilitate the distribution, promotion and – at times – coercion of contraceptives and sterilization in the Global South. Contraceptive use was incentivized through employment, cash, government benefits, and even food aid in countries including Indonesia, China, India and Bangladesh (Roberts, 1997). This history of contraceptive coercion continues to influence women’s decision-making in some of these contexts.

Reproductive justice has provided an important framework for the research and writing of this thesis. In the context of Myanmar, the government has made minimal effort to provide access to contraception or safe abortion care, and international organizations have played an important role in bringing contraceptives into the country. Although contraceptive coercion is not represented in the literature on reproductive health in Myanmar, acknowledging the history of contraceptive coercion in the Global South and North, as well as the many factors that affect women’s reproductive health is important when conducting research in this setting. This project also sought to move beyond focusing just on access to contraception and abortion – a historical critique of reproductive health work – to also include a focus on safe delivery care, which encompasses women’s right to have children.

Reproductive justice activists have ensured that women of colour and their experiences are at the foreground of the movement (Sillman, Fried, Gutierrez & Ross, 2004). In this thesis, I have attempted to position our participants and their experiences at the foreground, and have included quotes from peri-urban women to illustrate key themes whenever possible. Further, this thesis was informed by a theoretical foundation of practical action research. The study aims were identified by the community itself, and consistent with the principles of action research, the study was designed not only to acquire knowledge, but also to empower participants and affect positive change in their communities (Grundy, 1982; Masters, 1995). In order to ensure our research has impact locally and beyond, we have been actively disseminating the findings from this research to audiences both within and outside Myanmar; the dissemination plan is outlined in detail in Chapter 6.

### 1.5. Thesis Outline

This thesis is structured as a “thesis by articles.” This type of thesis involves a series of academic articles prepared during the student’s enrolment (University of Ottawa & Faculty of Graduate and Postdoctoral Studies, 2012). Per these requirements, my thesis begins with an introductory chapter, followed by three research articles prepared for submission to peer reviewed journals, and a discussion section that synthesizes and analyzes the major themes, places them in a broader context, and provides concluding thoughts.

In this first Chapter, I provided an overview of the context in Myanmar, the currently available reproductive health indicators in the country, and rural-to-urban migration patterns. This is followed by a discussion of the rationale of the study and the study aims, and I end with a discussion of reproductive justice and the theoretical model for this project. In Chapter 2, I begin by exploring the study area.

Following this, I describe the multi-methods approach used to collect data, as well as the analytic approach.

Chapter 3 is comprised of my first academic article, entitled “Sex in the almost city: Dynamics shaping access to reproductive health services in peri-urban Yangon, Myanmar,” submitted to *Studies in Family Planning* in March 2015. This article explores the accessibility of reproductive health services in peri-urban Yangon, and focuses specifically on misinformation and barriers for unmarried populations. Chapter 4 is comprised of my second academic article, entitled “‘We can lose our life for the abortion’: Exploring dynamics shaping abortion care in peri-urban Yangon, Myanmar,” submitted to *Contraception* in May 2015. This article explores the dynamics surrounding unsafe abortion in peri-urban Yangon, including the legality of the procedure, common providers and methods, and stories shared by focus group participants. Chapter 5 is comprised of my third academic article, entitled “‘She learned it from her mother and grandmother’: Women’s experiences of delivery and post-partum practices in peri-urban Yangon, Myanmar,” submitted to the *Maternal and Child Health Journal* in May 2015. This article explores women’s experiences giving birth and engaging in post-partum practices in peri-urban Yangon. These articles have all been formatted according to the requirements of the respective journal.

I conclude the thesis with Chapter 6, which offers a discussion of the articles, synthesizing their content and relating them to the broader reproductive health context in the country and beyond. I also offer a series of recommendations and next steps for moving forward to improve reproductive health outcomes and service delivery in the study area. This chapter also includes a discussion of the significance, implications, and limitations of the study, as well as a reflection on my own positionality in relation to the research and a statement of contribution. The chapter ends with concluding thoughts and suggestions for future research. The bibliography and appendices follow this chapter.

## CHAPTER 2: Methods

### 2.1. Study Area

Yangon is the largest city in Myanmar, and the country's former capital. The city is rapidly expanding, as people from around the country seek better economic opportunities and escape from conflict, and foreign nationals pursue investment opportunities and aid work. As the city becomes increasingly unaffordable, many poor residents, and particularly poor migrants, are settling in cheaper townships on Yangon's periphery. Although the government of Myanmar does not have official criteria to classify townships as distinctly "urban", "peri-urban", or "rural", this set of townships is locally known as "peri-urban Yangon." The limited available literature on peri-urban spaces describes them as inhabiting a continuum between distinctly urban and rural settings (Jaquinta & Drescher, 2000; Marshall et al., 2009). Although the term implies proximity to an urban center, peri-urban spaces also comprise a range of demographic and socioeconomic characteristics which distinguish them, and the populations who live in them, beyond mere location. In Yangon, the peri-urban population straddles multiple worlds – neither fully urban nor rural, this population poses evolving challenges for service delivery organizations, donors, and governmental agencies. While rural migrants may bring with them traditions, beliefs, and practices from their communities of origin that impact their behaviours and lifestyles, their urban proximity provides them better access to information and services than their rural counterparts. These factors make this population unique, and uniquely hard-to-reach.

To define our study area, our study team had to determine which of Yangon's townships could be considered distinctly "peri-urban." We developed a set of criteria based on the international literature, anecdotal evidence, and conversations with local stakeholders to formally classify Yangon's townships. We classified a township as peri-urban if it is characterized by poor infrastructure, a large number of slum settlements, and a highly mobile population that engages in daily wage labour. These

criteria were not quantitatively measured, due to the limited available data in Myanmar on population characteristics, infrastructure, and migration. Rather, townships were categorized based on anecdotal and observational evidence. Once we had created our list of peri-urban townships, we shared it with local stakeholders, to validate our assumptions and ensure we had categorized townships accurately. Recognizing that these criteria do not necessarily define an entire township and that disparities exist both within and between townships, we identified nine townships that could be broadly categorized as peri-urban: Hlaing Thar Yar, Insein, Mingaladone, North Dagon, North Okkalapa, Shwe Pyi Thar, South Dagon, Thar Gay Ta, and Thin Gan Gyun. These townships have a combined population of roughly three million people (Department of Population, 2014).

## 2.2. Methodology

The methods used in this multi-methods study are based on a study design created by researchers at Ibis and GHAP, and used in Ibis' 2012 report: *Separated by Borders, United in Need: An assessment of reproductive health on the Thailand-Burma border*, authored by Hobstetter et al. Ibis and GHAP collected data through in-depth interviews with stakeholder organizations, review and synthesis of local data and statistics, service mapping, and focus group discussions (FGDs) with migrants and healthcare workers (Hobstetter et al., 2012). My study utilized similar methods, with slight modifications. In addition to the aforementioned data collection techniques, my thesis also includes general reproductive health data from a survey conducted by the National YWCA of Myanmar with women in peri-urban Yangon.

The use of qualitative methodology is important to this study for several reasons. Qualitative research seeks to document and understand social phenomena, particularly in light of the meanings people ascribe to them (Kitzinger, 2013). The limited available data in Myanmar are predominantly

quantitative; however, these datasets are sparse, often out-of-date, and omit large parts of the country, although this may change in the coming months when the results of the 2014 Census are made public. Data produced by the government (for instance, population estimates), have often been inaccurate due to a failure to account for changes in fertility rates and emigration (Spoorenberg, 2013) – indeed, the provisional results of the 2014 Census have already highlighted discrepancies from previous official sources, documenting a population nine million smaller than the previous government estimate (Department of Population, 2014; The Economist, 2014). Evidently, quantitative data has never told the whole story of reproductive health in Myanmar. Thus, there is a need for research on women’s reproductive health experiences, to fill significant knowledge gaps and inform policy and programming. In this study, the use of qualitative methods offers an opportunity to add nuance to the currently available figures, while the use of survey data provides a slightly broader picture of reproductive health.

By using qualitative research methods, the study participants were positioned as the experts of their own experiences, knowledge, and opinions. This was particularly important given my own positionality as a white, Western researcher seeking their stories. As much as possible, I attempted to position myself as a collector of stories, rather than an expert on them. Although this thesis was designed to be as practical as possible, the research is underpinned by my own theoretical grounding in feminism and reproductive justice. These theoretical underpinnings helped me to frequently reassess and evaluate my position as a white woman conducting research in a developing country in the Global South, and acknowledge the potential power dynamics inherent to this research process. My reflections on this process are covered in more depth in Chapter 6.

### 2.3. Data Collection

Data were collected in Yangon between June and August 2014. The following section describes the methods used: key informant interviews, FGDs, surveys, and review of available data.

### *2.3.1. Key Informant Interviews*

#### Sampling

In the month leading up to my fieldwork, I began using purposive sampling to identify experts working in the field of reproductive health in Yangon. By combining contacts in Dr. Foster's network with extensive online searches, I was able to identify most organizations working in the field of reproductive health in Yangon. Two weeks prior to my fieldwork, I sent introductory emails to all potential key informants, which included a brief overview of the study. I ultimately contacted a total of 28 potential participants. Key informants were eligible to participate if they were currently working in the field of reproductive health in Yangon, and were sufficiently fluent in either English or Burmese to participate in an interview. Upon arriving in Yangon, I validated and expanded my list of key informants with Dr. Yadanar of the National YWCA of Myanmar, and sent follow-up emails to each potential participant to schedule a meeting. I was able to ultimately interview 18 key informants representing 15 different organizations. Key informants worked at a range of community-based organizations (CBOs), non-governmental organizations (NGOs), and governmental agencies. Key informants were predominantly high-level representatives of their respective organizations who specialized in reproductive, maternal, and/or sexual health. The majority of key informants (n=17) were Burmese, however all were sufficiently fluent in English such that an interpreter was not required.

#### Data collection

I interviewed all key informants in-person in Yangon, predominantly at the office or place of work of the participant. Two key informants met with me on the weekend, and three interviews took place outside their place of employment. Prior to each interview, I emailed a copy of the consent form to the key informant, and at the beginning of each interview I went over the consent form and obtained verbal consent. The majority of participants consented to being audio-recorded (n=14); during unrecorded interviews, I took copious notes and typed extensive memos and summaries immediately after. Each interview followed a semi-structured interview guide designed specifically for this study. I asked key informants about the scope of their organization's work, their perceptions of reproductive health in peri-urban Yangon, and their opinions on how service delivery could be improved. Interviews lasted an average of 60 minutes.

Immediately following each interview, I uploaded audio-files to my personal, password-protected laptop. I would then write a short memo reflecting on the interview content and experience, and began identifying emergent themes. As much as possible, I transcribed interviews verbatim within one week of completion. I used ATLAS.ti 7.5.2 to organize and manage the data.

### *2.3.2. Focus Group Discussions*

Focus group discussions (FGDs) are used by researchers to explore group interactions to elicit data (Kitzinger, 2013), and to understand the different ways communities talk about a specific topic. FGDs also allow for an understanding of social and community norms as well as outlying experiences and behaviours. FGDs were important to this study because they allowed us to explore the experiences and perceptions of women residing in the peri-urban townships, and providers working in the peri-urban townships, and to observe the interactions and dialogues among these groups. Given the mobile nature

of this population, key informants were especially excited about our FGDs as they had had few opportunities to hear from peri-urban women themselves.

In the context of international research, FGDs are particularly important because they can shift the dynamic between researcher and research subject by ensuring participants are positioned as the experts of their own experiences. The emphasis is on the interactions between participants, not between the researcher and participants; the facilitator must encourage discussion without leading, interrupting, or influencing the flow of conversation. Feminist research methods scholars have noted the applicability of FGDs as a feminist research method, as they can allow “for a more egalitarian and less exploitative dynamic than other methods” (Montell, 1999, p. 44). FGDs are especially important in the field of health research, for their uses in documenting experiences of health and illness.

### Sampling

My initial plan was to recruit FGD participants upon arriving in Yangon using flyers, word-of-mouth, and social media posts. However, after discussing this plan with Dr. Yadanar, it became evident that these strategies would be ineffective in this context; few people would be receptive to calls for participation in a study, due to a lack of familiarity with research. Further, the mobility of non-Myanmar citizens is restricted in parts of the city, including in some of the peri-urban townships; this meant I would not be able to travel freely in these areas, further inhibiting recruitment. Instead, Dr. Yadanar suggested we reach out to NGOs operating in the peri-urban townships and ask them to recruit participants. With the help of three NGOs, we recruited participants from six of the nine peri-urban townships, and hosted our FGDs in their offices and facilities.

We conducted five FGDs with women of reproductive age (16-49) (n=27) who currently reside in peri-urban Yangon, and two FGDs with healthcare providers (doctors: n=5; midwives: n=4) who currently work in peri-urban Yangon, for a total of 36 participants. Although I had hoped to recruit

comparable numbers of women in different age groups (under 30 and over 30), and of different marital statuses (unmarried and married), in the interest of having relatively homogeneous groups by age and marital status, my ability to do so was limited by my reliance on others to recruit. Ultimately, we had slightly more unmarried participants (n=15) than married participants (n=12), and more participants over 30 (n=18) than under 30 (n=9). Three of our FGDs were homogeneous in both age and marital status (single and over 30; single and under 30; married and over 30). We did not have a group comprised solely of married women under the age of 30, although we had one group of women who were all under 30 and half of whom were married, and one group that had an age range of 21-42, including both married and unmarried women.

For our FGDs of providers we were able to recruit five doctors working in three peri-urban townships for our first FGD, and four midwives working at a hospital in Insein township for our second FGD with the help of the Yangon and National YWCAs. Our providers represented six different organizations working in the peri-urban townships of Insein, North Okkalapa, and Hlaing Thar Yar. The doctors were attending a YWCA training, and stayed for an extra hour to do an English-language FGD with me. The midwives at an Insein hospital were recruited with the help of the Yangon YWCA. With permission, we held the Burmese-language FGD at the hospital.

### Data collection

Dr. Yadanar and I co-led all FGDs, and held them during the workday at the offices, clinics, or facilities of the respective NGOs, with the exception of the FGD with doctors. We informed participants in our FGDs of local women that they would be compensated monetarily (5,000 kyat or CAD5) for their travel and time, and given lunch. The provision of money to cover the transportation costs of participants also helped facilitate the participation of women who otherwise would not have been able to afford the travel to join us. We provided lunch and drinks to all of our provider participants.

FGDs were hosted at organizational head offices (n=4), a peri-urban reproductive health clinic (n=2), and a peri-urban hospital (n=1). At the beginning of each FGD, Dr. Yadanar would introduce us, and read a copy of the consent form aloud, obtaining verbal consent from each participant. The FGDs followed a discussion guide designed for this study. FGDs were interpreted for me by YWCA staff or Dr. Yadanar, who provided me a summary of the discussion following each question. At this time, I would ask probing questions which she would translate to the participants, and would take extensive notes of what had been translated for me. For the most part, our FGD participants actively participated in the discussions and were eager to share their thoughts and stories. FGDs lasted for an average of 90 minutes.

We audio-recorded all FGDs with the consent of participants. Following each FGD, I would type a summary of the discussions, based on the interpretations I had received. I would also write a reflective memo. All Burmese-language FGDs were transcribed and translated to English by a research assistant based in Mae Sot, Thailand, to whom I was introduced through a colleague. I used ATLAS.ti 7.5.2 to organize and manage the data.

### *2.3.3. Service Mapping and Facility Survey*

The service mapping component of the study was designed to identify the available service delivery points in Yangon's peri-urban townships and document which reproductive health services were available at different types of facilities. Due to a dearth of detailed maps and addresses in the country, as well as the considerable expanse of both the study area and the number of service delivery points (at least 575), creation of a physical map of all service delivery points in peri-urban Yangon proved not to be feasible. Further, due to the opacity of the public sector, I could not obtain in-depth information about services provided by the public sector. Thus, the service mapping component of this

study offers a narrative overview of the available services in the study area, rather than a visual representation.

In order to document the availability of services in the peri-urban townships, I consulted the 2013 Yangon Directory (the most recent online directory at the time of my fieldwork). The Directory provides a listing of public and private clinics and hospitals in each township. I identified 575 public and private service delivery points across the nine peri-urban townships. Private clinics were relatively plentiful in the townships, ranging from 31 in Mingaladone to 99 in North Okkalapa. Most townships had one or two public hospitals, and up to five private hospitals. In addition, through conversations with key informants, I identified three organizations delivering reproductive health services in peri-urban Yangon: Marie Stopes International, Population Services International, and the YWCA.

Although the number of service delivery points in peri-urban Yangon is considerable, not all facilities offer a comprehensive range of reproductive health services and products. Thus, the facility survey was developed to understand better which services and products are available from different types of facilities. The facility survey explored the availability and cost of various products and services, including contraception, delivery, and post-abortion care. The survey was orally administered in Burmese by Dr. Yadanar to representatives from hospitals and clinics in two peri-urban townships, Hlaing Thar Yar and North Okkalapa. We chose these two townships to highlight the range of infrastructure in the peri-urban townships: Hlaing Thar Yar is widely considered to have some of the poorest infrastructure in Yangon, is geographically distant from the city centre, and has a significant mobile, migrant population. Conversely, North Okkalapa is closer to the city, has better infrastructure, and a less mobile population.

Dr. Yadanar and I spent one full day in each township, and administered the survey to as many service delivery points as we could locate within that time. Several of the clinics we surveyed were not

listed in the Yangon Directory, suggesting that the total number of service delivery points could be significantly larger than the figure presented suggests. We administered the surveys to a total of 27 service delivery points in Hlaing Thar Yar (n=11) and North Okkalapa (n=16). We surveyed private clinics (n=14), private hospitals (n= 7), and public sector facilities (n=3), including one public hospital, and two township health departments. The public sector facilities were unwilling to be recorded and often refused to answer questions, so our data from them is limited. We entered all survey data into Microsoft Excel.

#### *2.3.4. Reproductive Health Survey*

The National YWCA hosted a week-long training for members of its Microfinance Program in July 2014. Dr. Yadanar proposed having the YWCA conduct a general health reproductive survey with participants from peri-urban Yangon townships. The survey collected basic demographic information, as well as more specific information about reproductive health, including contraception, abortion, and pregnancy histories. YWCA staff distributed the survey over two days and emphasized that participation was voluntary and confidential; participants were provided with refreshments. Dr. Yadanar and the YWCA granted Dr. Foster and her study team permission to work with the anonymized dataset which was provided as a Microsoft Excel file. A total of 147 women completed the survey. Respondents came from six of the nine peri-urban townships: North Okkalapa (n=73); Hlaing Thar Yar (n=49); Insein (n=5); North Dagon (n=2); South Dagon (n=1), Thin Gan Gyun (n=1), and unspecified or no response (n=14).

#### *2.3.5. Review and Synthesis of Available Data*

Prior to, throughout, and following the data collection process, I searched for all publicly available publications and datasets about reproductive health in peri-urban Yangon. Any quantitative data sets on health in the peri-urban townships are available exclusively through the public health departments in each township, and they were unable to share these with me. Thus, the data I reviewed was largely based on national datasets, or qualitative studies in other parts of the country. This data is presented in Chapter 1 of this thesis, and in the introductions to the articles in Chapters 3, 4 and 5.

#### 2.4. Data Analysis

Qualitative data from the study was analyzed iteratively, such that it began during fieldwork through the preliminary identification of themes and patterns. This process was facilitated by the use of reflective memos, summaries of interviews and FGDs, and regular discussions with Dr. Yadanar and Dr. Foster about emerging findings. This preliminary analysis helped me to familiarize myself with the data, and allowed me to draw early findings from the study, which were presented to stakeholders in Yangon at an invited talk in August 2014. I hired a research assistant in Mae Sot, Thailand to transcribe and translate all Burmese-language FGDs, so I could analyze the transcripts once I was back in Ottawa.

Upon returning from my fieldwork, I began to formally analyze my data using content and thematic analysis. I used *a priori* (pre-determined) codes and categories derived from the study aims and research questions, as well as inductive analytic techniques as new findings emerged from the data. I began my content analysis by developing a code book, where I listed and carefully defined all codes for internal consistency. I then analyzed all transcripts using these codes and categories, as well as new categories that emerged throughout. This data was managed using the qualitative data management software ATLAS.ti 7.5.2. After I finished coding my data, I carefully read through all categories and codes to identify emergent themes and patterns. Thematic analysis is the process by which patterns and

themes are identified and analyzed (Braun & Clarke, 2006). This process allowed me to refine the themes I had initially identified in my preliminary analysis; the formal analysis allowed me to distinguish and expand upon themes I had previously overlooked. I looked closely for concordant and discordant themes, particularly between age and marital groups, migrant and non-migrant populations, and between participants in FGDs and key informant interviews. For both the facility and reproductive health surveys, I calculated descriptive statistics, such as frequencies and cross-tabulations, using Microsoft Excel and PSPP 0.8.4<sup>5</sup>.

## 2.5. Ethics

We received approval for this study from the Health Sciences and Sciences Research Ethics Board (REB) at the University of Ottawa (File H02-14-03) on April 28<sup>th</sup>, 2014. The approval letter is included as Appendix A. The Board of Directors of the National YWCA of Myanmar also reviewed and approved the study protocol. We obtained verbal consent from participants at the beginning of each interview and/or FGD; participants could end their participation at any time without penalty. In order to protect the confidentiality of our participants we have removed or masked all personally identifying information throughout all reports, articles, and documents emerging from this research. Finally, as data from reproductive health survey with peri-urban women was collected by the YWCA for their own purposes and fully anonymized, the Office of Research Ethics and Integrity determined in September 2014 that we did not need REB approval to work with these data.

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<sup>5</sup> PSPP is a statistical analysis program and free replacement for SPSS.

## **CHAPTER 3: Article 1**

**Submitted to:** *Studies in Family Planning*

**Title:** Sex in the almost city: Dynamics shaping access to reproductive health services in peri-urban Yangon, Myanmar

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The study team thanks all of the organizations and individuals who participated in the interviews, focus group discussions, and surveys. We would like to express our gratitude to the National YWCA of Myanmar, as well as the Yangon YWCA, for their support of the project and assistance with recruitment, facilitation, and translation. Finally, we thank Drs. Raywat Deonandan and Shoshana Magnet for their feedback on earlier phases of this project.

## **Abstract**

Myanmar experienced rapid growth and change since the 2010 elections installed the country's first civilian-elected government in half a century. However, reproductive health indicators remain poor and reflect significant regional disparities. Rural populations are increasingly migrating to urban centers. Many are settling in peri-urban Yangon, a dynamic series of townships characterized by poor infrastructure, slums, and a highly mobile population. However, very little is known about reproductive health in this population. Our study explored the reproductive health needs of women in peri-urban Yangon, through interviews (n=18), focus group discussions (n=7), facility surveys (n=27) and a reproductive health survey (n=147). Study findings suggest that although reproductive health services are often available a number of factors are shaping access to care, including high and "hidden" costs, misinformation, and an absence of programs targeting young and unmarried women. Exploring efforts to expand access to affordable, evidence-based, and tailored information and services appears warranted.

## **Introduction**

For decades, Myanmar was a mystery to much of the world. Ruled by an isolationist military dictatorship, ongoing violence, oppression and human rights abuses were veiled under a shroud of secrecy for nearly half a century (Back Pack Health Worker Team 2006). The elections in 2010 installed the country's first civilian-elected government in more than 50 years and subsequent growth and change has been rapid (Hlaing 2012). Foreign aid and investment are entering Myanmar in unprecedented numbers and the world is opening up to this long-isolated country for the first time in recent history. The ceding of military power has been accompanied by a series of reforms, including the release of political prisoners, increased investment in infrastructure, and eased media restrictions (Hlaing 2012). However, the military remains powerful and the long history of violence, forced labor,

displacement, rape, and imprisonment is still recent and remains ongoing in parts of the country (Sietstra 2012; Mullany et al. 2008a) Although spending on health has increased substantially in recent years, health outcomes across the country are varied and in many regions remain poor.

Reproductive health indicators are consistent with these overarching health dynamics and reflect significant regional and geographic disparities. Information about reproductive health is limited; reliable national statistics are difficult to access and conflict-affected areas have long been omitted from most otherwise national datasets (Ministry of Immigration and Population & UNFPA 2009; Ministry of Health & UNICEF 2011; Department of Population 2014). The isolationist policies of the military hindered data collection in the country for nearly half a century and thus there is little evidence to inform policy, programs, and donor spending. However, the best available evidence suggests that there are significant unmet reproductive health needs throughout the country.

The age of marriage for women and the total fertility rate have steadily increased and decreased, respectively, in recent years, a remarkable feat given the lack of government intervention in those domains. Other reproductive health indicators have witnessed far less improvement. The national maternal mortality ratio (MMR) is currently one of the highest in Southeast Asia, estimated at 200 deaths per 100,000 live births (World Bank 2013), and the MMR is estimated to be four to five times higher in conflict affected regions (Back Pack Health Worker Team 2006; Burma Medical Association, National Health and Education Committee & Back Pack Health Worker Team 2010). Deliveries attended by a skilled birth attendant have increased considerably, reaching 70.6% in 2010 (Ministry of Immigration and Population & UNFPA 2009; Ministry of Health & UNICEF, 2011). In urban settings, women are increasingly choosing institutional deliveries over home deliveries; about half of all urban women experienced their last delivery in a health facility (Ministry of Immigration and Population & UNFPA 2009).

In Myanmar, abortion is severely legally restricted such that the procedure can only be performed to save the life of the woman and this exception is narrowly interpreted (Ba Thike 1997). While the leading cause of maternal mortality at the national level is post-partum hemorrhage, at least 10% of maternal deaths are directly attributable to unsafe abortion; in conflict-affected parts of the country, as many as half of maternal deaths are due to unsafe abortion (Hobstetter et al. 2012; UNFPA 2010). A range of contraceptive methods, including progestin-only emergency contraceptive pills (ECPs) and long acting reversible contraception (LARC), are available in Myanmar. In 2010, the country's contraceptive prevalence rate was 46%, a substantial increase from the early 1990s (Ministry of Health & UNICEF 2011). The most recent studies suggest that the majority of contracepting women use modern methods of contraception<sup>1</sup> and one third of all contraceptive users use the hormonal injection (Ministry of Health & UNICEF 2011). Studies in eastern Myanmar and Mandalay have highlighted significant barriers to accessing reproductive health services, particularly for conflict-affected populations and adolescents (Hobstetter et al. 2012; Thin Zaw et al. 2013; Thin Zaw et al. 2012). Previous studies have also identified the challenges in providing services for mobile, migrant, and conflict-affected populations in various parts of the country and the considerable unmet reproductive health needs of internally displaced populations (Mullany et al. 2008a; Mullany et al. 2008b; Hobstetter et al. 2012; Gedeon et al. 2015).

Although these studies present an overall picture of reproductive health in Myanmar, the need for more data to inform policy, programs, and funding priorities is pressing. In addition to the shortage of information about specific populations, a dearth of information exists about women's experiences with and perceptions of reproductive health services. Further, very little is known about reproductive health among migrant communities, a rapidly growing population in the country. Rural populations are

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<sup>1</sup> Scholars have argued that the use of binaries like "modern" and "traditional" can reflect and reinforce unequal power relations, such as East/West or developed/developing country. However, these descriptors for contraceptive methods are well established in medicine and have a defined meaning, and as such I use them throughout this piece, while remaining cognizant of the power and importance of language.

increasingly migrating to urban centers, like Yangon, in the hope of finding better economic opportunities. Rents in Yangon are increasing exponentially, making the city unaffordable, especially for the poor (Vallikappen & Thakur 2013; Brook 2014; Tun 2014). As a result, migrants are concentrated in growing slum settlements on the periphery of the city. Donors, policy-makers, and government agencies are increasingly interested in working and investing in these townships, but lack evidence to guide these efforts.

Motivated by this context, the purpose of our study was to explore and identify the reproductive health needs of women of reproductive age (16-49) residing in the townships of peri-urban Yangon. We also wanted to identify the availability and accessibility of reproductive health services and products, as well as potential avenues for improving the delivery and accessibility of reproductive health services. The overall study focused on maternal health and delivery care, contraception, including emergency contraception and LARC, abortion, and post-abortion care. In this paper we focus specifically on the dynamics shaping access to services.

### **Study area**

Yangon is Myanmar's largest city and former capital and has a population of approximately 7.35 million (Department of Population 2014). The city is divided into more than 30 townships that extend into the surrounding countryside and is rapidly expanding, largely due to an influx of rural migrants. Many migrants – often poor, separated from families and social networks, and with inconsistent, unreliable wages – are increasingly settling in the cheaper townships on the periphery of the city. Although the government of Myanmar does not have official criteria to classify townships as either urban or rural, this set of townships is locally known as “peri-urban Yangon.” Generally, peri-urban spaces inhabit a continuum between urban and rural spaces. While a proximity to an urban center is somewhat implied,

peri-urban spaces comprise a unique set of demographic and socioeconomic characteristics which distinguish them beyond geographic location (Iaquinta & Drescher 2000).

To clearly define the study area and more formally classify Yangon's townships, we developed a set of criteria based on the international literature, anecdotal evidence, and extensive conversation with stakeholders. We classified a township as peri-urban if it is characterized by poor infrastructure, a large number of slum settlements, and a highly mobile population that largely engages in daily wage labor. Recognizing that these criteria do not necessarily define an entire township and that differences exist both within and between townships, we identified nine townships that could be broadly categorized as peri-urban: Hlaing Thar Yar, Insein, Mingaladone, North Dagon, North Okkalapa, Shwe Pyi Thar, South Dagon, Thar Gay Ta, and Thin Gan Gyun (Figure 1). These townships were the focus of our study and, according to the Yangon Directory (2013), contain a total of 575 health service delivery points, as presented in Figure 2.

## **Methods**

### *Data collection*

Our study design is based on a multi-methods assessment reported in *Separated by Borders, United in Need: An assessment of reproductive health on the Thailand-Burma border* (Hobstetter et al. 2012). Our multi-disciplinary project team conducted data collection in the summer of 2014 in Yangon. We conducted 18 key informant interviews with representatives from non-governmental organizations (NGOs), community-based organizations (CBOs), and governmental agencies working in the field of sexual and reproductive health in all nine peri-urban townships. We identified key informants through the study team's networks, internet searches, and referrals from early participants. Using a guide developed specifically for this study, our domains of inquiry included organizational scope, perceptions

of reproductive health in peri-urban Yangon, and potential avenues for improving reproductive health outcomes. We conducted all semi-structured interviews, which averaged 60 minutes, in English.

We also conducted seven focus group discussions (FGDs). We held two FGDs with providers working in peri-urban Yangon: one with hospital-based midwives in Insein township (n=4) and one with doctors working in a variety of clinical settings (n=5). We recruited participants with the help of a local CBO and providers represented six different organizations working in the peri-urban townships of Insein, North Okkalapa, and Hlaing Thar Yar. Our health service provider FGDs explored participants' experiences working in the field of reproductive health in peri-urban Yangon and averaged one hour. We also held five FGDs with women (n=27) currently residing in peri-urban Yangon who we recruited with the assistance of three NGOs and CBOs. Our Burmese-language discussions explored women's perceptions of reproductive health in their townships, opinions regarding service accessibility, and recommendations for improving information and services. We offered participants lunch and 5,000 kyat (USD5) to cover travel and other costs.

In order to gain a more in-depth understanding of the service delivery dynamics in the peri-urban Yangon region, we conducted a service mapping exercise in North Okkalapa and Hlaing Thar Yar, two peri-urban townships that differed considerably in infrastructure and location. In addition to mapping the physical location of service delivery points, we also conducted on-site surveys with representatives from 27 facilities, including private clinics (n=16) and hospitals (n=9). These orally-administered surveys allowed us to capture information about the facility, affiliated health service providers, catchment area, and patient population, as well the availability and cost of reproductive health services.

Finally, we conducted a short reproductive health survey with 147 women residing in peri-urban Yangon. The survey asked women affiliated with the National YWCA's Microfinance Program general

reproductive health questions, including those centered on contraceptive use, pregnancy history, and abortion experiences. We provided refreshments to respondents.

### *Data analysis*

Using transcripts (translated to English), notes, and memos, we analyzed the key informant interviews and FGDs for content and themes, using both *a priori* (pre-determined) categories and codes based on the research questions and inductive codes that emerged from the data. This was an iterative process in that analysis occurred simultaneous to data collection. We used ATLAS.ti to manage our qualitative data. Regular team meetings guided the identification of themes and interpretation of the findings and we resolved differences by discussion. We entered survey responses into Microsoft Excel and analyzed these data with descriptive statistics. We analyzed each component of the project separately and in the final analytic phase we combined the findings, with specific attention to concordant and discordant results. This triangulation of multiple data sources allowed us to identify prominent themes which we present in the results section.

### *Ethics*

We received approval for this study from the Research Ethics Board (REB) at the University of Ottawa. The Board of Directors of the National YWCA of Myanmar also reviewed and approved the study protocol. In order to protect the confidentiality of our participants we have removed or masked all personally identifying information throughout this article.

## **Results**

### *Study participants*

Women in the FGDs came from six of the nine peri-urban townships, ranged in age from 21 to 45, and included both unmarried (n=15) and married (n=12) women. Participants worked as daily laborers, street-side vendors, tailors, and housewives and many worked from dawn until dusk, making wages they frequently characterized as extremely low. In some FGDs, as many as half of participants had migrated from rural villages to their current township.

Survey participants resided in six peri-urban townships, with the majority living in North Okkalapa (50%) and Hlaing Thar Yar (33%). One-quarter identified as hailing from a rural area of Myanmar. Survey respondents were older on average than FGD participants; just over half were 40 or above. Three-quarters of respondents were married and roughly the same number (77%) had children. More than half (59%) were employed and the majority (78%) had completed some middle school or high school. Survey respondents were all members of the National YWCA's Microfinance program and receive health education and resources as part of their membership.

*Inconsistency, geography, and cost impede access to available services*

*They have to travel; they have to walk one hour...and they have no proper transportation...So it is very difficult to travel for the health services. It is one of the constraints for them. (Key informant, June 2014)*

Given the proximity of most peri-urban townships to the urban center of Yangon, available services are plentiful compared to rural parts of the country. Most townships have one or two public hospitals and private clinics and drug shops (informal pharmacies staffed by shopkeepers without medical training) are widespread. However, our service mapping exercise highlighted disparities in service availability between facilities. While most hospitals are open 24 hours a day, they are few in number. In contrast, hours of operation of clinics varied widely; most were open into the evening (n=15 out of 16), but few remained open throughout the entire day (n=5). Further, the overall availability of services appears varied and unpredictable. Most facilities stock Depo-Provera injections (n=26 out of 27), but less than

half offer condoms or ECPs, and LARC methods, such as the IUD or the hormonal implant, are rarely available. Compared to clinics, hospitals offer a more comprehensive range of sexual and reproductive health services but costs vary tremendously; the limited number of public hospitals offered nominally free-of-charge services, whereas private hospitals charged significant fees for consultation and medications/devices.

Despite an overarching availability of reproductive health services, our participants highlighted the myriad barriers to access women continue to face; geographic and socioeconomic barriers in particular were commonly referenced by our FGD participants as prohibitive. For instance, although public hospitals offer “free” services, our participants characterized the public sector as inaccessible; geographic distance to public hospitals coupled with considerable transportation expenses make these facilities costly and time-consuming to access. Women are also deterred by the long wait times at overcrowded, understaffed public hospitals, and feared experiencing judgment, harassment, and/or pressure to buy expensive medicines. Fear of incurring significant expenses, often through hidden costs, was a significant deterrent to seeking care from the public sector.

*The services available are a little distant from this area. Some go to the hospital, but they are afraid to go there because it may cost 10-20,000 kyat [USD10-20], and they will have to buy extra medicine every day...That is why they don't go to the hospital too much. They're afraid of the hospital. (30-year old resident of Insein township, FGD participant)*

Despite the free services advertised by the public sector, many of our FGD participants preferred seeking care from private sector facilities, including clinics and informal shops, despite the associated out-of-pocket expenses. Private sector facilities were characterized as being more geographically and economically accessible. For women who do not have the time or money to access the formal health care system, drug shops in particular offer the most affordable and convenient option.

*Most of the people have big economic problems, so most cannot go to the hospital. People there wait for a long time. And in the private clinics, they have to give a lot of their money; even if it's not a lot of money, they cannot afford to go to the clinic. So they just seek health services from the drug shops. (Doctor working in Hlaing Thar Yar township, FGD participant)*

However, key informants told us that shopkeepers lack medical or pharmaceutical training and often give incorrect information about the dose and administration of medications. Further, they described how a reliance on informal providers is changing the willingness of some to seek more formal care.

*Because of the low level of education and income, people cannot spend money or are not willing to spend money on providers...they just want to go out and buy drugs from the shops and they will get prescriptions and advice from them. Only when they cannot treat or heal themselves with those drugs will they seek out something else. (Key informant, July 2014)*

Several NGOs also operate in some peri-urban townships and offer a range of affordable or free services. Our FGD participants often preferred receiving reproductive health care from these facilities due to their accessibility, minimal cost, and non-judgmental services. Access to services is also impacted by the livelihoods of many peri-urban residents, who work long hours, have little interest in prioritizing health, and engage in work that requires daily and/or seasonal mobility. FGD and survey participants suggested that decision-making around health is also influenced by socialized gender roles, the influence of a woman's husband or mother-in-law, religious considerations, the weight given to traditional beliefs and practices, and the advice of community elders.

*Misinformation about reproductive health is widespread and shapes access*

*The major issue is that due to lack of knowledge and information, they are afraid to use the contraception. (Key informant, June 2014)*

Rampant misinformation, myths, and rumors appear to be one of the most significant barriers to service accessibility in peri-urban Yangon. Although many FGD participants had a basic level knowledge of some sexual and reproductive health issues, they lacked more in-depth knowledge and many held medically-inaccurate beliefs. Accordingly to key informants and women who participated in the FGDs and the survey, women's decision-making is influenced by what they hear from other women in their communities, particularly their aunties (respected older women). Effective and continuous

contraceptive use appears to be especially hindered by lack of information about which methods are available and where, misinformation about correct protocol for use, and non-evidence based fear of side effects. As one key informant explained, “Some of the young women, they’re afraid [to] use the Depo injection...[They ask] “Will I become fat? Will people notice I am using [this method] by looking at my figure?” This concern about weight gain and distribution was echoed by women in our FGDs. Lack of information and fear of side effects also leads some women to be quick to attribute any illness or ailment to their contraceptive method, which can deter them from consistent and ongoing use.

*Some women believe that whenever they suffer some minor illness, it is due to taking oral contraceptive pills, or taking Depo, or inserting the IUD. (Doctor working in North Okkalapa township, FGD participant)*

Emergency contraception appears to be especially plagued by misinformation. Only half of the participants in both the FGDs and survey had heard of ECPs. However, those who were aware of ECPs often confused them with abortifacients and knowledge about dose and timeframe for use was poor. Rumors about the potential risks associated with ECPs, particularly if used multiple times, appear rampant and included concerns about organ damage, infertility, and death.

*You can only take it [ECPs] six times – if more than six times, there will be negative consequences, because that pill is so strong it can affect the uterus and you cannot have kids anymore. (29 year-old resident of North Okkalapa township, FGD participant)*

The need to expand access to comprehensive and reliable contraceptive information was unanimously identified as a priority among our FGD participants.

#### *Youth-targeted reproductive health services and information are limited*

*Here, when you see reproductive health, it’s meant for married women...The young women think “it’s not for me”, so most of them just buy drugs over the counter. (Key informant, July 2014)*

All components of our study confirm that there is an absence of sexual and reproductive health services targeting unmarried women and adolescents as most existing services are geared exclusively to married

women. Further, our participants reported that both unmarried and young women are met with discrimination, judgment, and shame when they attempt to access care. As one key informant noted, “It’s still very hard for a young woman to get a condom at the pharmacy. They will look down on you and surely talk behind your back like you’re a bad girl.” As a consequence, many unmarried and young women appear to bypass the health system entirely, obtaining products from drug shops or through male partners or married peers.

*As I am married, I just go and buy it [emergency contraception] for her, because she is single. Single women don’t buy it, just their boyfriends will buy it for them, or they will ask somebody they know. (26 year-old resident of North Okkalapa, FGD participant)*

Many of our FGD participants who had heard of ECPs believed them to be exclusively used by young and unmarried women. Key informants explained that young and unmarried women may be more likely to use ECPs, because they can more easily access it from drug shops without visiting a clinic or healthcare providers.

*Going to the reproductive health clinic and asking for contraceptives is something only married women will do in our country. So unmarried, young women, they just use short-term methods like emergency contraception. (Key informant, June 2014)*

Information and educational resources for unmarried and young women are also lacking. According to our participants, health service providers and community members are often hostile toward unmarried women who ask questions or evince knowledge of reproductive health. Key informants who try to reach young women through their programming highlighted the barriers presented by family members, who often do not want their daughters to know about reproductive health.

*We organized an awareness training on sexual and reproductive health, but mothers don’t want their daughters to attend, because they’re worried that if they know about contraceptives, they will...have sex. So it’s because of cultural and social issues that young women don’t know about contraception. (Key informant interview, June 2014)*

Our participants repeatedly reported that the lack of information and services hinders the ability of young and/or unmarried women to access contraception, among other reproductive health services. However, there appears to be a growing interest, discussed both by key informants and FGD participants, to develop reproductive health services and programs tailored toward adolescents.

## **Discussion**

Neither fully urban nor fully rural, peri-urban populations straddle multiple worlds. In Yangon, the peri-urban population is significantly comprised of rural migrants; of our study participants, approximately one-third had migrated to peri-urban Yangon in recent years. The traditions, cultures, and practices brought with them from their area of origin must contend with their new urban proximity, which brings with it better access to information, services, and technologies. Together, these factors contribute to a dynamic set of circumstances that make this population unique – and uniquely hard to reach. A concept historically used to describe geographically remote regions, peri-urban populations are forcing a redefinition of the concept of “hard to reach”. While most peri-urban townships are geographically proximate to Yangon’s city center, socioeconomic factors, including poverty, long work hours, inability to prioritize health, and reliance on traditional practices, make this area hard-to-reach in a less geographic or spatial way. Indeed, peri-urban populations in Yangon face multiple layers of challenges in accessing health services, and donors, providers, and policy-makers face their own challenges in reaching this population.

Given the unique circumstances surrounding the peri-urban townships of Yangon, our findings suggest that a tailored approach is required to meet the diverse reproductive health needs of this population. Our study reveals that, even when services are available, this population faces continued and significant barriers to access. Expanding ferry transportation systems, which regularly bring groups

to distant, otherwise inaccessible service delivery points, could significantly improve women's access to reproductive health care.

Further, expanding access to information about the location and hours of facilities, as well as the services they provide, could mitigate the barriers that inconsistent opening hours present and ensure women are aware of where and when they can access care within their townships. Additional resources on the correct use of medicines like ECPs could help counteract the inaccurate advice given by ill-informed drug shop staff. Initiatives to increase access to information and create new programs should be developed in close consultation with community members to ensure they are culturally resonant and locally appropriate.

In addition to expanding information on service availability, there is a need for targeted, comprehensive reproductive health education resources for unmarried and young women, as well as low-literacy peri-urban populations. The stigma surrounding pre-marital sex, and the fact that reproductive health services, information, and resources are all exclusively targeted toward married women, means that unmarried women lack access to reliable and comprehensive reproductive health resources. The development of resources tailored toward adolescents and unmarried populations could help ensure they have accurate, comprehensive, and non-judgmental sources of information.

FGD participants received much of their health information by word-of-mouth, and based their decisions on the experiences and stories of family, friends, and neighbors. The advice of community elders is often prioritized over that of medical professionals, even when that advice is medically inaccurate. Low levels of literacy may impede peri-urban women from seeking out alternate sources of information. Culturally appropriate resources, tailored toward community elders, could help ensure that the advice they share is accurate and comprehensive. Similarly, low-literacy materials, including graphic or pictorial handouts and radio broadcasts, could provide alternate sources of information for women who may otherwise depend on receiving health information from friends and family.

In contrast, the recent expansion in access to mobile phones and the internet in the country (World Bank 2014; Forbes Asia 2014) could also provide new opportunities for disseminating health information, especially to youth. Burmese-language resources developed for mobile or internet platforms have the potential to have reach across the country and provide accurate and comprehensive reproductive health information in an anonymous forum. Thus a two-tiered health education approach that focuses on developing both low-literacy and high(er) tech resources appears warranted.

### **Limitations**

Our study has several limitations. Perspectives from some peri-urban populations have not been reflected in our findings due to time, financial, and logistical constraints such that participants in our FGDs and surveys resided in only six of the nine peri-urban townships. Further, although qualitative research is not meant to be representative or generalizable, our survey and FGD participants were recruited with assistance from a number of NGOs and CBOs operating in peri-urban Yangon. As such, it is possible that our participants were more familiar with available services than the broader population. Finally, although our multi-disciplinary, multi-national team collaborated extensively on this project, working in multiple languages can present challenges. We appreciate that some nuance may have been lost in translation but we are confident that through team discussions and collaborative efforts we were able to accurately capture the perspectives of our participants.

### **Conclusion**

Our study findings illustrate that, despite an overarching availability of reproductive health services in peri-urban Yangon, a variety of geographic, socio-economic, information, and socio-cultural barriers to access persist and there remains a dearth of services tailored to young and unmarried women. This population requires a unique and tailored service delivery approach to meet their complex and varied

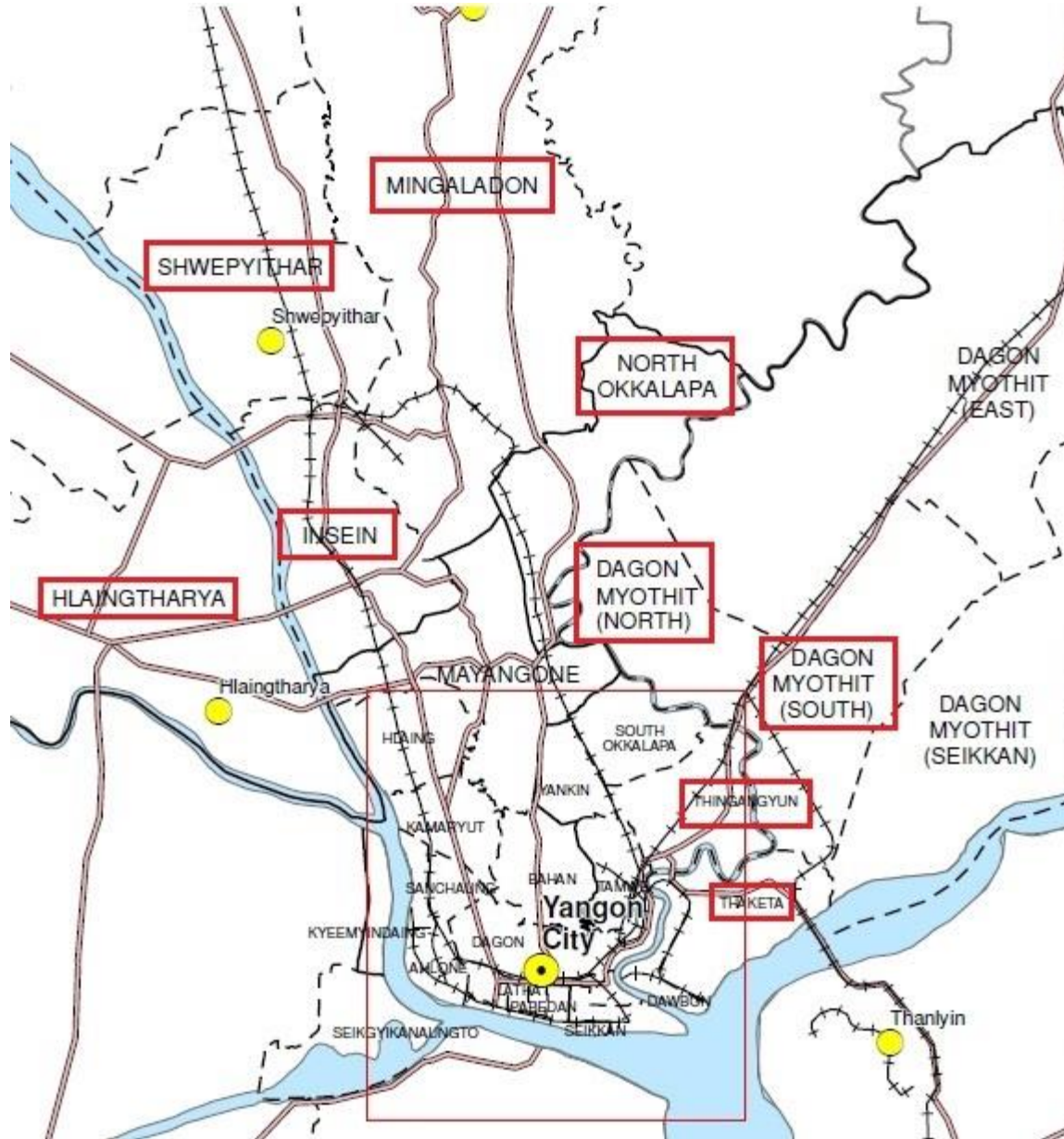
reproductive health needs. As the peri-urban population in Yangon continues to expand the need for sound evidence will grow. The findings of this study may resonate with peri-urban populations in other large cities within Myanmar, as well as in other Asian countries. Future research should continue to explore the reproductive health needs and health outcomes of peri-urban populations, within Myanmar and beyond.

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Figure 1: Map of Yangon, Myanmar, with peri-urban townships indicated



Source: Myanmar Information Management Unit 2012.

**Figure 2: Health service delivery points in peri-urban Yangon townships**

<b>Township</b>	<b>Population (2014)</b>	<b>Public Hospitals</b>	<b>Private Hospitals</b>	<b>Private Clinics</b>	<b>Township Health Departments</b>
Hlaing Thar Yar	686,827	1	2	88	1
Insein	305,670	3	3	77	1
Mingaladone	332,520	2	1	31	2
North Dagon	203,883	0	4	43	1
North Okkala	332,869	2	5	99	1
Shwe Pyi Thar	343,270	1	0	33	0
South Dagon	371,579	1	0	50	0
Thar Gay Ta	220,447	1	0	69	1
Thin Gan Gyun	209,301	1	2	48	1
<b>Total</b>	<b>3,006,366</b>	<b>12</b>	<b>17</b>	<b>538</b>	<b>8</b>

Sources: Yangon Directory Group 2013; Department of Population 2014.

## **CHAPTER 4: Article 2**

**Submitted to:** *Contraception*

**Title:** “We can lose our life for the abortion”: Exploring the dynamics shaping abortion care in peri-urban Yangon, Myanmar

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## **Abstract**

**Objectives:** Abortion in Myanmar is severally legally restricted and permissible only to save a woman's life. As a result, unsafe abortion is common and contributes significantly to maternal mortality. Our overall study aimed to explore women's reproductive health needs in peri-urban Yangon, a dynamic series of townships on the periphery of the country's largest city characterized by poor infrastructure, slum settlements, and a mobile, migrant population. In this paper, we focus specifically on the perceptions, opinions, and experiences of both adult women and key informants with respect to unsafe abortion and post-abortion care in peri-urban Yangon.

**Study design:** In 2014 we conducted 18 key informant interviews with individuals working in reproductive health in peri-urban Yangon and seven focus group discussions with health service providers (n=2) and adult women (n=5). We analyzed these data for content and themes using a multi-phased iterative approach.

**Results:** In peri-urban Yangon, unsafe abortion appears to be common and is largely provided by traditional birth attendants. Women use a range of mechanical, medication, and traditional methods, often in combination. Post-abortion care is available but misinformation and fear of harassment keep many women from accessing timely care.

**Conclusion:** Efforts to reform the highly restrictive abortion law in Myanmar combined with implementation of harm reduction strategies have the potential to greatly improve a neglected area of women's health. Future research on the cost of unsafe abortion to the public sector could be instrumental in achieving legal and service delivery reform.

**Implications:** Measures to increase access to safe, legal abortion care and reduce harm from unsafe abortion need to be expanded. Developing strategies to liberalize Myanmar's abortion law, raising awareness about misoprostol, training clinicians to provide woman-centered post-abortion care, and documenting the cost of unsafe abortion to the public sector appear warranted.

## Introduction

In Myanmar, induced abortion is severely legally restricted. The Penal Code of 1860 prohibits abortion unless the procedure is performed to save the life of the woman. Punishment for providing an induced abortion can include a prison sentence of up to three years and/or a fine [1]. However, rates of unsafe abortion are high and contribute to at least 10% of maternal deaths across the country and up to half of maternal deaths in conflict-affected regions [1,2,3]. Even in the urban center of Yangon, the country's largest city and former capital, where health outcomes are generally better than in rural parts of the country, the limited available evidence suggests that up to half of maternal deaths in some of the city's hospitals are attributable to unsafe abortion complications [4]. Fear of criminal repercussions, coupled with a religious and cultural valorization of life, keep many providers from offering abortion care, even in cases that are legally permissible, and have contributed to a shroud of shame, secrecy, and stigma surrounding the procedure [1,5]. These dynamics have also hindered data collection on the practices, patterns, and impact of unsafe abortion in the country.

The rapidly expanding city of Yangon is home to approximately 7.35 million people [6], and is divided into townships that extend into the surrounding countryside. As rural migrants pour into the city seeking economic opportunities, they are increasingly residing in the cheaper townships on the city's periphery, locally known as "peri-urban Yangon." Peri-urban spaces inhabit a continuum between urban and rural spaces, distinguished by a unique set of demographic and socioeconomic characteristics [7,8,9]. Although data are limited, the population residing in these areas is widely believed to have poor reproductive health outcomes, reflecting a confluence of economic, educational, geographic, and cultural-ethnic disparities [5,8,9].

In 2014, we conducted a multi-methods study to explore and identify the reproductive health needs of women of reproductive age (16-49) residing in the townships of peri-urban Yangon. The overall project aimed to shed much needed light on the reproductive health experiences of a highly

marginalized population and provide information for service delivery organizations and other local stakeholders. In this paper, we focus specifically on the perceptions, opinions, and experiences of both adult women and key informants with respect to induced abortion and post-abortion care in peri-urban Yangon.

## **Methods**

Our multi-disciplinary project team conducted a multi-methods needs assessment in the summer of 2014. We modeled our design after *Separated by borders, united in need: An assessment of reproductive health on the Thailand-Burma border* [3] and we have provided a detailed description of the methods elsewhere [5]. In brief, our assessment included a systematic review of published articles, grey literature, and data provided by local service delivery organizations, interviews with 18 key informants, a service mapping exercise that included orally administered surveys with representatives from 27 facilities, a survey of 147 peri-urban women participating in a microfinance program, and seven focus group discussions (FGDs) with health care providers (n=2) and women (n=5). Although the government of Myanmar does not have official criteria to classify townships, our study centered on nine townships that can be broadly characterized as peri-urban. We provide a map of the study area as Figure 1. In this article we draw from our key informant interviews and FGDs and detail these methods and our analytic approach.

### *Data collection: Key informant interviews*

We identified key informants through our study team's networks and online searches. We recruited participants using purposive sampling through emails and phone calls where we explained the purpose of the study. GS conducted interviews with 18 key informants who represented a variety of non-governmental organizations, community-based organizations, and government agencies, working in

the field of reproductive health in peri-urban Yangon. GS recorded interviews when the participant consented, took notes throughout, and wrote reflective memos afterwards. Interviews lasted an average of 60 minutes and explored organizational scope and both organizational and individual experiences working in this sector.

#### *Data collection: Focus group discussions*

We also held a series of FGDs with people who live and work in peri-urban Yangon. We recruited participants with the help of several local organizations that used their organizational networks and programming to advertise the study. We used multi-modal recruitment techniques including announcements, handouts, and participant referrals. The Burmese-language FGDs were co-led by GS and YA, a Burmese medical doctor with extensive facilitation experience. We conducted seven FGDs, five with women residing in peri-urban Yangon (n=27) and two with health care providers working in peri-urban Yangon (n=9). We present basic participant demographics on Table 1. We compensated participants for their time and travel and provided lunch and refreshments. All FGD participants consented for the discussion to be audio-recorded and GS wrote notes throughout and reflective memos following each FGD. We held the FGDs at the headquarters and clinics of the local organizations that assisted in recruitment. FGDs lasted 60-90 minutes and explored participants' experiences living and working in the peri-urban townships.

#### *Data analysis*

Using transcripts, notes, and memos, we analyzed both the interviews and FGDs for content and themes, using both *a priori* (pre-determined) categories and codes based on the research questions, as well as inductive codes that emerged from the data [10,11]. We managed our data using ATLAS.ti and GS served as the primary coder. We used an iterative approach such that analysis occurred

simultaneously with data collection. Regular team meetings guided the interpretation of the findings and we resolved differences through discussion. We analyzed each component of the project separately and in the final analytic phase we combined the findings, with specific attention to concordant and discordant results. In February 2015, our study team presented our preliminary findings to stakeholders in Yangon; we incorporated the feedback we received into our final analysis. Triangulation of multiple data sources allowed us to identify prominent themes which we present in the results section.

### *Ethics*

We received ethics approval from the Health Sciences and Sciences Research Ethics Board at the University of Ottawa (File #H02-14-03). The Board of Directors of the National YWCA of Myanmar also reviewed and approved the study protocol. To protect participant confidentiality we have removed or masked all personally identifying information throughout this article.

### **Results**

#### *Abortion is unsafe and common*

*There is a woman who got pregnant...She had an abortion by doing a lot of heavy work...She [then] bought a medicine from the pharmacy and took two packages with hot water...She suffered pain, could not work, and seemed to be bleeding. Then her sister stepped on her waist and it dropped down. (26 year-old FGD participant, Insein township)*

Our key informants and FGD participants shared many stories of women in their communities having unsafe abortions. On Figure 2 we share several of these accounts. Although induced abortion is permitted to save a woman's life none of our FGD participants knew someone who had procured a safe, legal procedure. Women in our FGDs were well aware of the risks associated with unsafe abortion. As one 34 year-old FGD participant from Insein township explained, "When we get pregnant we should just

give birth, because we can lose our life for the abortion.” However, much of our FGDs centered on women who had suffered abortion-related injury and death.

Participants spoke in great detail about these women – describing age, marital status, family composition, occupation – suggesting that they were personally familiar with the women and their abortion experiences. Some of our participants also shared the stories of family members and mothers in particular. However, our participants were reticent to disclose their own abortion histories, possibly due to the stigma and shame surrounding the procedure.

#### *Traditional birth attendants are the most common providers*

*[In peri-urban Yangon] those who can [perform an abortion] safely will not touch it, because it's illegal. Those who have something to lose – license, prestige, or image – will not touch it. But those who have nothing to lose...they are doing it. Even with the mortality, they can just disappear for a day or two and come back and always work in the same area, because the demand is there. (Key informant interview, July 2014)*

According to both our key informants and FGD participants, abortion is widely available in peri-urban Yangon and most commonly performed by untrained, community-based providers, particularly traditional birth attendants (TBAs). TBAs use a range of techniques to induce abortions, as described by a 26 year-old FGD participant from North Okkalapa whose mother is a TBA:

*My mother uses the pill when she provides an abortion, the pill that is inserted in the uterus...My mother doesn't like to insert other substances and stir the uterus, but some TBAs do...She also uses Burmese traditional medicine, like boiling the ginger and letting women drink it.*

FGD participants were widely aware that TBAs were associated with both ineffective and dangerous abortion techniques and that TBAs lacked information about when to refer women for post-abortion care. However, demand for abortion in the peri-urban townships is sufficiently high that even TBAs with long histories of poorly performed, dangerous abortion care continue to provide services. The fees

charged by TBAs reportedly range from 5,000 kyat (USD 5) per month of pregnancy up to seven months' gestation to a fixed price of 20,000-30,000 kyat (USD 20-30).

Although abortions are primarily provided by TBAs in peri-urban Yangon, we did hear about trained midwives who offer abortion services using misoprostol. Our key informants speculated that these providers, whose wages are generally low, are motivated by the extra income. We were also repeatedly told that few doctors are willing to provide abortion care, even in cases where the woman meets the eligibility requirements and a medical board authorizes the procedure. Key informants attributed this reluctance to a deep seated fear of criminal repercussion combined with Buddhist and Burmese socio-cultural values. As one key informant explained:

*[In] the Burmese tradition, they really value life. They say that if you perform the abortion you will be punished 500 lives, the next lives. So they really don't want to perform abortion.*

*Women use a range of methods, often in combination*

*More women are using [misoprostol] to induce abortion. But they are not using the correct dose. They are taking suboptimal doses, so it triggers some bleeding, and then they take a little bit more again. (Key informant interview, August 2014)*

Abortion practices in peri-urban Yangon involve a range of mechanical, medication, and traditional methods. On Figure 3 we present the range of methods described by study participants. Both key informants and FGD participants explained that women often use multiple methods over the course of an unwanted pregnancy (see Figure 2). For example, a woman might first attempt to induce an abortion herself, using traditional herbal preparations such as *kay thi pan*. When this method is unsuccessful, she may engage in additional self-induction practices, such as consumption of alcohol or self-injury, or visit a TBA. TBAs typically begin with herbal preparations before advancing to more effective, but also more dangerous, methods, such as sharp stick insertion or stomping on the belly.

Among our key informants there was a common perception that women are increasingly using misoprostol for early pregnancy termination. Misoprostol is widely available in pharmacies and drug

shops and relatively inexpensive. However, our key informants reported that knowledge of the optimal regimen [12] is limited and few women understand the timing of the abortion process. As a result, even after misoprostol use, women are reportedly resorting to mechanical methods. This dynamic was echoed by our FGD participants, many of whom were vaguely aware of “a pill” but knew little about how and when it was used. Efforts to provide accurate and comprehensive information about misoprostol by providers and NGOs have been hampered by concerns about legal risks.

*Post-abortion care is available, but often inaccessible*

*People don't know they can get PAC [post-abortion care] in these areas...They know that if you have had an abortion, this is criminal. So if it's criminal, it's better not to go to the public sector...So a lot of maternal deaths are resulting from septic abortion...[Women and providers] still don't know hospitals provide PAC. (Key informant interview, July 2014)*

Post-abortion care is available in most hospitals in peri-urban Yangon. But despite the overarching availability of PAC, lack of information about where services can be accessed combined with poor advice from untrained, community-based abortion providers keep many peri-urban women from accessing timely PAC. According to both our key informants and FGD participants, women will often first try to treat complications with antibiotics they procure from drug shops or from follow-up care with a TBA.

A further deterrent to accessing PAC appears to be the reception women receive when they present at hospitals with post-abortion complications. Key informants and FGD participants reported that women presenting for PAC at hospitals are often met with harassment and judgment from doctors and nurses, who may scold them for procuring an abortion, or pressure them to reveal their provider. One key informant described the reception women seeking PAC may receive upon presenting at a hospital, “The nurses shout. They are angry, so they shout at the girls. So the girls aren't happy at the hospital.” This was reiterated in the stories of FGD participants, who also emphasized the financial cost of PAC. As we heard from a 30-year-old participant from Insein township:

*Some [women] go to the hospital, but they are afraid to go to the hospital because it may cost 10,000-20,000 kyat [USD 10-20] and it is time-consuming...They're [also] afraid of the hospital because of the interrogations there...the doctors ask about the abortion history.*

## **Discussion**

Myanmar has undergone rapid growth and change since the 2010 elections installed a nominally-civilian elected government [13]. Although spending on health has increased considerably, health outcomes, and particularly reproductive health outcomes, largely remain poor. The maternal mortality ratio remains high, at 200 per 100,000 live births [14], and unsafe abortion is a major cause of maternal death and disability. Our findings related to unsafe abortion practices are consistent with the findings of studies conducted in Eastern Burma and with women from Burma residing in Thailand [3,15,16]. However, initiatives to improve access to safe or safe(r) abortion are limited by the severe legal restrictions and the culture of fear that surrounds abortion.

The need for legal reform on the status of abortion is pressing. Since 2011, the Myanmar government has instituted a series of political reforms, including easing media restrictions and releasing political prisoners [13,17]. These reforms have been met with cautious optimism and suggest there may be a window of opportunity to push for the liberalization of the current abortion law. Myanmar has long been isolated from much of the global community. Thus, creating opportunities for advocates of reform to learn about the experiences of other countries in the region with a shared legal tradition, such as India and Bangladesh [18,19], could be valuable.

However, even in the absence of legal reform there is considerable need to improve access to safe and safe(r) abortion care. Misoprostol is available from a variety of service delivery points in peri-urban Yangon. Misoprostol can be used as a single abortifacient in the first nine weeks of pregnancy at 70%-90% efficacy [12]. Although not as effective as the gold standard mifepristone/misoprostol regimen, our results suggest that use of misoprostol-alone would be much safer and more effective than many of the abortion methods currently being used by women. Identifying avenues for expanding

access to information about evidence-based misoprostol protocols to health care workers, traditional birth attendants, and individual women and supporting community-based distribution efforts may serve to reduce harm from unsafe abortion, as has been documented in other contexts [20].

Finally, the reported lack of access to timely, non-judgmental PAC is concerning. Our findings demonstrate that many women do not know where or when to access PAC and are fearful of the reception they will receive at the hospital. Redoubling efforts to raise awareness about women's rights with respect to PAC as well as about the indications for accessing services appears warranted. Further, our results suggest that nurses and doctors working in PAC-providing facilities need additional training on how to provide non-judgmental, woman-friendly care. Research on the cost of unsafe abortion to the public health system would likely serve a critical role in galvanizing support for all of these efforts.

### *Limitations*

As is true of qualitative research in general, this study is not meant to be representative or generalizable. Rather, this study aimed to explore a particular phenomenon in-depth from the perspective of a range of participants. As we were only able to recruit participants from six peri-urban townships, perspectives from residents of other regions may not be reflected in our findings. Further, we conducted our study in Burmese and English; migrants who hail from regions with other dominant languages were not able to participate. Finally, we conducted this study in 2014 and thus more recent service delivery reforms would not be reflected in our findings.

### **Conclusion**

Our findings suggest that unsafe abortion is common in peri-urban Yangon. Efforts to reform the highly restrictive abortion law in Myanmar combined with implementation of harm reduction strategies have

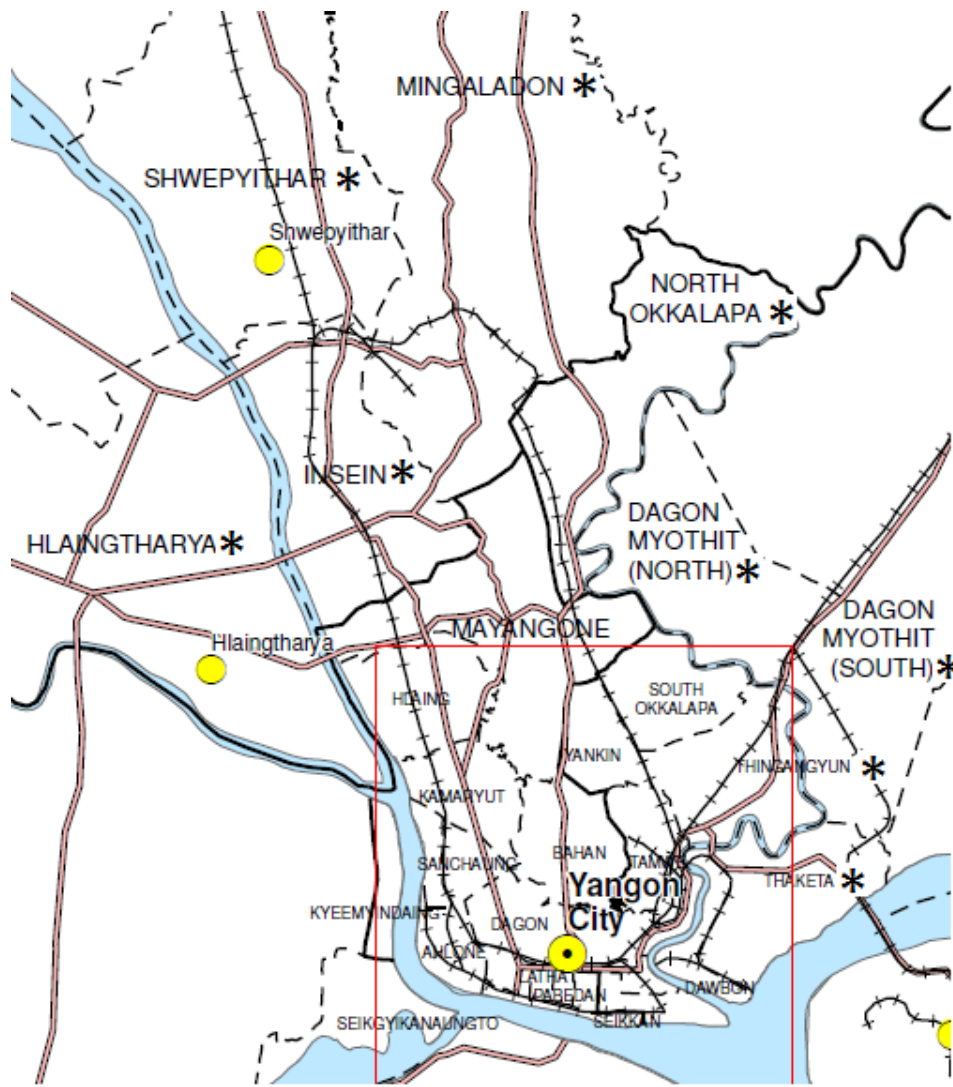
the potential to greatly improve a neglected area of women's health. Future research on the costs of unsafe abortion to the public sector could be instrumental in achieving legal and service delivery reform.

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Figure 1: Map of peri-urban Yangon/Yangon, study sites marked with an “\*”



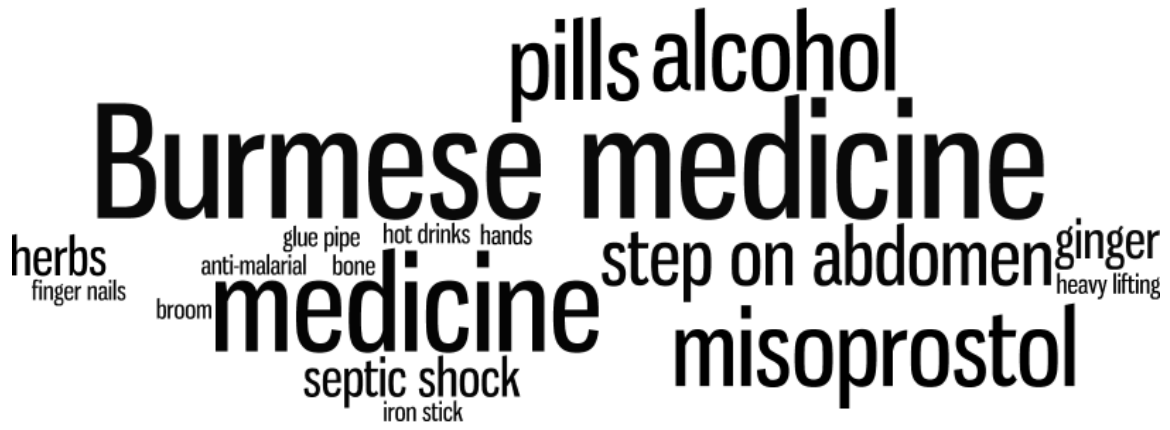
**Table 1: Composition of FGDs**

<b>FGD</b>	<b>Location</b>	<b>Type</b>	<b>Number of participants</b>	<b>Description</b>
1	Yangon	Adult women	6	Married and single women from North Okkalapa township, age 25-29.
2	Yangon	Adult women	5	Single women from North Okkalapa and Hlaing Thar Yar townships, age 21-30
3	Yangon	Adult women	6	Married and single women from Insein township, age 21-42
4	Yangon	Adult women	5	Single women from South Dagon, North Okkalapa, South Okkalapa, and North Dagon, age 30-38
5	Yangon	Adult women	5	Married women from South Dagon, North Dagon, Thin Gan Gyun, age 30-45
6	Yangon	Doctors	5	Doctors working or volunteering in a range of facilities, including a private hospital, a private clinic, a public hospital, and NGO facilities in three peri-urban townships
7	Yangon	Midwives	4	Midwives working in a private hospital in Insein township

**Figure 2: Stories of unsafe abortion**

<p>One girl...was taken by another friend to the midwife's house. [When she] went back home, she had a fever, and then something coming out of her vagina – it's her intestine...so we had to cut it off. And then we had to do [an operative procedure]. (Key informant interview, August 2014)</p>	<p>My mother had cancer when I was young...When she got the disease, there was a ball in her uterus that kept growing. She had it tested by a traditional birth attendant [TBA], who told her it was a baby. My mother didn't know what to do so she decided to try to abort it with the TBA. The TBA had my mother drink pounded ginger with the medicine she made which is very hot. My mom has to drink it three times per day. When the TBA tried to abort the baby my mom was getting worse, since the source was actually her cancer...Then the TBA brought the iron stick to stir her insides, but my mom decided not to do it anymore. (29 year-old FGD participant, North Okkalapa)</p>
<p>At first, she tried by herself. Based on rumors she had heard, she took Burmese medicine with alcohol. After she took the medicine, she let [the traditional birth attendant] step on [her abdomen]. (30 year-old FGD participant, Insein)</p>	
<p>They raised [her] lower body up and put a basin under the body, and inserted the glue pipe in her vagina. (45 year-old FGD participant, North Dagon)</p>	

Figure 3: Reported abortion methods



## **CHAPTER 5: Article 3**

**Title:** “She learned it from her mother and grandmother”: Women’s experiences of delivery and post-partum practices in peri-urban Yangon, Myanmar

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## **Abstract**

**Introduction:** Every year in Myanmar more than one million women give birth. Although births in hospitals and those attended by skilled birth attendants have increased considerably, the majority of women continue to give birth at home. Our needs assessment aimed to explore women's reproductive health in peri-urban Yangon, a rapidly growing area characterized by poor infrastructure, slum settlements and a mobile, migrant population. In this article, we focus specifically on the perceptions and experiences of adult women, key informants, and health care providers regarding delivery and post-partum care.

**Methods:** Our study team conducted a systematic literature review, 18 key informant interviews, 27 facility surveys, a survey with 147 adult women, and seven focus group discussions with women and health care providers over the summer of 2014. We analyzed these data for content and themes using deductive and inductive techniques and used descriptive statistics to analyze the survey results.

**Results:** Women in peri-urban Yangon are increasingly choosing to give birth in hospitals; however public hospitals are often inaccessible due to financial constraints and lack of transportation. Further, sociocultural and financial considerations continue to make deliveries with a traditional birth attendant an appealing option for some women and potentially harmful traditional post-partum practices remain common.

**Discussion:** Peri-urban populations face many competing influences that guide decision-making surrounding delivery. Efforts to address the barriers to accessing hospital-based maternity services appear warranted. The development of culturally-relevant resources that seek to raise awareness on the potential risks of traditional post-partum practices may also be of use.

**Significance:** Understanding the barriers women face to accessing safe delivery care is vital to efforts to improve access to facility-based maternity services. Improving access to hospital-based delivery care and

increasing access to information about unsafe post-partum practices could help women more safely navigate the delivery and post-partum period.

## Introduction

Globally, the majority of maternal deaths occur in the period surrounding delivery (Singh, Darroch & Ashford, 2014). Maternal mortality ratios remain high in a number of developing countries, particularly when a large proportion of women give birth at home (Montagu et al., 2011). Home deliveries remain a more affordable and accessible option for many of the world's poor whereas wealthy women are increasingly choosing facility-based deliveries (Montagu et al., 2011). Countless traditions, practices, beliefs and rituals surround the delivery and post-partum period, many with the intention of improving the health of a woman and/or her infant (Dennis et al, 2007). Although these practices vary considerably between and across countries, globally women engage in food-, behavior- and hygiene-related rituals and traditions in the wake of childbirth (Dennis et al., 2007).

Each year in Myanmar more than one million women give birth and the majority of these births take place at home (UNFPA, 2010). Despite recent reforms, Myanmar's long history of conflict, violence, and isolation continues to have lasting impacts on population health and the country's health budget remains the lowest in the region (Back Pack Health Worker Team, 2006; UNICEF, 2013). The national maternal mortality ratio is relatively high – at 200 deaths per 100,000 live births – and post-partum hemorrhage is the leading cause of maternal death (WHO et al., 2014; Ministry of Health & UNICEF, 2011). Maternal mortality ratios are significantly higher in conflict-affected and rural regions, although data are spotty (Hobstetter et al., 2012). Traditional post-partum practices, including food avoidance and behavior restrictions, are observed by many women across the country, especially among rural populations (Sein, 2013).

Despite the high number of home births and the prevalence of traditional practices, Myanmar women are increasingly choosing to give birth in hospitals and clinics or deliver at home with a skilled birth attendant (Ministry of Immigration and Population & UNFPA, 2009). The 2009-2010 Multiple Indicator Cluster Survey found that 70.6% of deliveries were attended by a skilled birth attendant, and

36.2% of women had given birth in a hospital or clinic (Ministry of Health & UNICEF, 2011). Women in Yangon are the most likely to choose an institutional delivery, with 68.9% of women giving birth in a facility (Ministry of Health & UNICEF, 2011), and 85% giving birth with either a doctor, nurse, or midwife (Ministry of Immigration and Population & UNFPA, 2009). However, significant regional and economic disparities persist (UNFPA, 2010). Wealthy women and women with a secondary school education or above are more likely to give birth in a health facility (Ministry of Health & UNICEF, 2011). In urban settings, nearly two-thirds of babies are born in a health facility, compared to just one-quarter in rural settings (Ministry of Health & UNICEF, 2011). As rural populations are increasingly migrating to urban centers, these figures may begin to shift.

Globally, rural populations are migrating to cities at an unprecedented scale (UNFPA, 2007). Myanmar has seen significant urban growth in recent years, with the majority of internal migrants moving to Yangon, the country's largest city and former capital, and the city is expanding rapidly. Many migrants are settling in underdeveloped townships on the city's periphery, locally known as "peri-urban Yangon." There remains a lack of data on the needs and experiences of Yangon's peri-urban residents to inform local programming.

Our study focused specifically on reproductive health in peri-urban Yangon. Home to more than three million people (Department of Population, 2014), the nine townships we identified as "peri-urban" are characterized by informal slum settlements, poor infrastructure, and a mobile, migrant population (Sheehy et al., 2015a).<sup>1</sup> In 2014, our study team conducted a needs assessment among women of reproductive age (16-49) in peri-urban Yangon and centered on contraception, abortion care, and delivery care. Our project aimed to provide much needed data on the reproductive health experiences of a mobile, migrant population to help inform the work of local organizations. This article explores women's delivery and post-partum practices in peri-urban Yangon.

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<sup>1</sup> Our nine study townships included Hlaing Thar Yar, Insein, Mingaladone, North Dagon, North Okkalapa, Shwe Pyi Thar, South Dagon, Thar Gay Ta, and Thin Gan Gyun.

## Methods

### *Study design and data collection*

Our multi-disciplinary, multi-national study team collected data in the summer of 2014. We modeled our study design after the multi-methods needs assessment reported in *Separated by Borders, United in Need: An assessment of reproductive health on the Thailand-Burma border* (Hobstetter et al., 2012). Our assessment included a systematic review of the grey and published literature, interviews with 18 key informants, a service mapping exercise involving in-person orally administered surveys at 27 service delivery points, a survey with 147 peri-urban women participants in a microfinance program, and seven focus group discussions (FGDs) with health care providers (n=2) and adult women (n=5). We have detailed these methods in other publications (Sheehy et al., 2015a; Sheehy et al., 2015b). In summary, our key informant interviews explored organizational and individual experiences working in the field of reproductive health in peri-urban Yangon, and key informants represented a range of non-governmental organizations, community-based organizations, and government agencies. Our facility surveys collected information on the availability of services at various hospitals and clinics, as well as some data on costs and fees. Our reproductive health survey asked general questions about reproductive health, including contraceptive, pregnancy, and abortion histories. Finally, our FGDs explored experiences and perceptions of those who live and work in peri-urban Yangon. We obtained verbal consent from all participants prior to beginning data collection, and reminded them that their participation was both voluntary and confidential.

### *Data analysis*

We transcribed and translated (if needed) all recordings from interviews and FGDs. Using our transcripts, notes and memos, we analyzed both the interviews and FGDs for content and themes, using both *a priori* (pre-determined) categories and codes based on the research questions, as well as

inductive codes that emerged from the data. We managed our data using the software ATLAS.ti. We generated descriptive statistics from both our facilities survey and our survey with women in peri-urban Yangon through Microsoft Excel®. We analyzed data iteratively and team meetings guided our interpretation; we resolved differences through discussion. We analyzed each study component separately and combined the findings at the end of our analysis, paying specific attention to concordant and discordant results. In February 2015, we presented our preliminary findings to stakeholders in Yangon; we incorporated the feedback we received into our final analysis. Triangulation of multiple data sources allowed us to identify prominent themes which we present in the results section.

### *Participant characteristics*

Our participants represented a range of backgrounds and experiences. Our FGD and survey participants resided in six of the nine peri-urban townships, while the scope of work of our key informants spanned all nine townships. Our FGDs included women ranging in age from 21 to 45, slightly more of whom were unmarried (n=15) than married (n=12). Our survey participants were largely older than our FGD participants, with more than half aged 40 or above, and three-quarters were married. Almost all FGD participants and more than half of survey respondents were employed, working as daily wage workers, tailors, housewives and vendors. Our FGD participants often characterized their wages as low and their workdays as long. Our survey respondents were all members of the microfinance program of the National YWCA, and receive health education through their membership.

### *Ethics*

The Research Ethics Board at the University of Ottawa approved this study (File #H02-12-03) as did the Board of Directors of the National YWCA of Myanmar. We have removed or masked all personally identifying information throughout this article.

## Results

### *Women are increasingly choosing institutional deliveries*

*Before, people were afraid of the hospital and that is why they gave birth in the community [at home]. But when you give birth at the hospital you get knowledge as well...and it doesn't cost for the service (29 year-old FGD participant, North Okkalapa township).*

Historically, the majority of women in Myanmar have given birth at home. Yet consistent with national trends (UNFPA, 2010), participants in all components of our study reported that women in peri-urban Yangon are increasingly delivering at hospitals. Indeed, 68% of our survey participants and the majority of our FGD participants delivered their last child in a facility. Both our key informants and our FGD participants repeatedly highlighted the changing landscape of delivery care in peri-urban Yangon; many explained that there is a growing awareness that facility-based deliveries are safer. Yet socioeconomic dynamics shape decision-making about delivery location; one midwife reflected a near universal, if not somewhat hyperbolic, sentiment when she explained, “Only very poor women give birth at home.” However, these changes appear to be recent and very much in flux. As explained by a 38 year-old FGD participant from North Dagon: “In the past, around two years ago, people gave birth at home with a traditional birth attendant. But now people don't give birth at home.” Several women in our FGDs and many of our key informants explained that this transition was slower to take root in certain townships. One key informant explained: “Even in one township where the general hospital is quite near, they use the TBA [traditional birth attendant]...The TBAs look after the babies, they cook for them, so [women] rely more on the TBA.”

### *Public hospitals are often inaccessible as a delivery venue*

*For some people it is easy to get delivery service at the hospital but for the poor people like us, we have to work so we just give birth at home. (42 year-old FGD participant, South Dagon township)*

Although public hospitals offer nominally free-of-charge delivery services, our participants repeatedly reported that the costs of delivering in a facility were often prohibitive. Some FGD participants explained that public hospitals are geographically distant from their communities and that the limited transportation infrastructure means that travel to a hospital is expensive, with a taxi easily costing a day's wages. As a 30-year old FGD participant from South Dagon explained: "The delivery doesn't cost much, it's just the transportation that is costly." In addition, hospital visits were characterized by many as replete with high and hidden costs in the form of requested "donations" or the requirement to purchase expensive medicines.

Our survey of a sub-set of facilities in two peri-urban townships confirmed this finding. Delivery care was available at all of the hospitals we surveyed, including both public (n=2) and private (n=8); the private clinics we surveyed were small, most with under 10 staff, and none provided delivery care. Delivery services were offered free-of-charge at public hospitals, but they were distant from one another. Conversely, private hospitals were more plentiful, but prices for delivery care varied widely, ranging from USD50 to USD1,100 for vaginal deliveries and from USD400 to USD1,300 for Cesarean-sections.

*Socioeconomic and cultural considerations strongly influence decision-making*

*They want to deliver at home where you can have many visitors and relatives around, so they don't deliver with the skilled birth attendants. They deliver with TBAs – "lethe"– she learned it from her mother and grandmother. And she stays in the home one month, and helps with the household work, so they like it very much. But they [TBAs] are not skilled. (Key informant interview, August 2014)*

Our FGD participants widely considered giving birth in a hospital to be safer than giving birth at home. They also discussed a growing awareness in their communities of the potential consequences of home-based deliveries that take place in the absence of a skilled birth attendant; several participants

shared stories of women they knew dying following delivery with a traditional birth attendant (TBA), including this one, shared by a 34-year old resident of Insein:

*She gave birth with the TBA. After her delivery, she ate Burmese noodles and drank ice water. She then got bleeding because of the complication, and she died...The TBA said it was because she ate noodles and ice water which are unmatched foods and that is why she died. There are two to three women who died after delivering with that TBA.*

This awareness was reflected in the delivery practices of our participants, who are now predominantly choosing hospital-based deliveries.

Despite the knowledge of the relative risks associated with different delivery sites, 14% of our survey participants and several of our FGD participants reported having given birth at home with the assistance of a TBA. Although FGD participants largely lacked confidence in the skills of TBAs, they also highlighted the complex relationships women have with their TBAs which influence their decision-making. Our key informants echoed this sentiment and one explained, “The TBAs and the women are like relatives, and long-time neighbors. So they usually go to the TBA for the delivery.” According to both our key informants and our FGD participants a combination of economic and sociocultural factors continue to make home births with TBAs a more affordable and appealing option for peri-urban women. As one 30-year old FGD participant from Insein township explained: “Most people in my community rely on TBAs, because they don’t have to pay them a big amount.” TBAs offer an affordable home-based delivery care package, which involves ongoing physical and social support following delivery.

Delivering with a TBA also allows women to remain at home with family, rather than alone in a hospital which many found unappealing. The high costs associated with reaching a public hospital make it costly for women’s families to join them for the delivery, as do the long wait times which may lead to missed wages. Women who were unable to afford the costs associated with hospital delivery, and women who preferred giving birth with their family, often choose to give birth at home. As one FGD

participant explained: “When they [female relatives] deliver in hospital it makes us busy with the transportation and we can’t give our time for that, so they just deliver at home.”

For women who want to safely give birth at home, delivering with a skilled birth attendant like a midwife could present an appealing option. However, midwives were seen as inaccessible, especially compared to community-based TBAs. Key informants discussed the midwife shortage in the country, explaining that midwives often have to serve several villages and are overworked: “A big issue is the mobility of midwives...their coverage is too much, and the transportation support is very limited for them.” Another key informant explained that midwives may need to travel “30-40 km to provide service,” despite a lack of transportation support, suggesting that their availability as birth attendants is limited.

#### *Traditional post-partum practices are common and potentially harmful*

*Burmese people have this superstition that during the puerperium period the mother has to eat only fried fish and soup...They just listen to the words of their neighbors and their mothers; they do not listen to the word of health care providers. (Physician working in Insein township)*

Women in peri-urban Yangon appear to engage in a wide range of traditional post-partum practices, including food and hygiene restrictions and behavioral and physical rituals and practices. These practices are also often promoted by TBAs and respected elder women in a community, known as “aunties.” With respect to food, many women are encouraged to eat restricted diets comprised primarily of fried fish and rice; one key informant highlighted the potential harms of this: “[Due to] the nutrition restriction, they have [vitamin] B1 deficiency, both the mother and the baby.” Post-partum food restrictions appear to be commonly practiced, regardless of delivery venue.

Behavioral- and hygiene-related restrictions and practices include the promotion of excessive sweating, spreading turmeric on the body, and the avoidance of touching soap and/or water for more

than a month post-partum. One FGD participant explained the perceived benefits of sweating in particular, also illustrating that these practices are potentially more common among women who give birth at home: “This method helps them let the pain and numbness go away. In the hospital this could not be done.”

Physical practices include manipulation of the abdomen to remove post-delivery blood from the uterus, which is seen by many as unhealthy; one midwife explained, also illustrating the potential consequences: “Some massage the abdomen to take out the bad blood. Some put hot bricks over the abdomen. They think that if there is a lot of blood coming out of the uterus, bad blood will go out of their body. Some of them come back with secondary post-partum hemorrhage.” These consequences were expanded upon by a key informant: “They massage the abdomen after delivery to take out all the “bad blood.” And then they have the pelvic abscess and need unnecessary operations.” Despite these potential harms, traditional post-partum practices appear to be commonly used.

## **Discussion**

The experiences and perceptions of delivery and post-partum care among our participants highlight the competing influences peri-urban women face, between the traditions, beliefs, and practices they may inherit from their communities of origin, and their urban proximity which allows for better access to information and services. Peri-urban populations straddle multiple worlds; that they are neither fully urban nor fully rural with respect to demographics and setting makes for unique considerations and constraints in providing services to this dynamic population.

A range of strategies are required to meet the complex and varied delivery-related needs of women in peri-urban Yangon. Our findings suggest that women in peri-urban Yangon are increasingly aware that hospital-based deliveries are safer than home-based deliveries; knowledge that is reflected in their delivery practices. However, women’s abilities to access a hospital for delivery care are often

hindered by financial and transportation-related constraints. Efforts to make hospital-based delivery care a more accessible option appear warranted. Improving transportation options for women and their families to travel to geographically inaccessible public hospitals could be an important step in improving access. Investing in public transportation or subsidizing taxi services for pregnant women could help women in labor reach the hospital in a timely manner, while ferry transportation systems that regularly bring groups to health facilities could be used to facilitate family visits to hospitals.

Although knowledge of safer delivery venues appears common, there appears to be a lack of awareness of the negatives outcomes associated with traditional post-partum practices and rituals. While some of these rituals, especially those in the immediate post-partum period, are associated more closely with home births, post-partum restrictions on food in particular appear to be widely practiced irrespective of delivery venue. While our key informants and midwives explained the risks associated with some practices, our FGD participants more often explained the perceived benefits, particularly for food- and hygiene-related practices. Recognizing the importance of traditional beliefs and practices surrounding reproductive events is important; however, addressing potentially dangerous practices could prevent unnecessary post-partum mortality and morbidity. Thus, increasing access to comprehensive information about the risks associated with many of the widely practiced post-partum rituals is vital. Culturally resonant resources that provide information through stories and narratives could help address this identified need. Since women receive much health information from respected elder women, developing resources that include or are tailored toward aunties may be useful in helping them provide accurate information.

Further, efforts to expand access to skilled birth attendants so that women who prefer to give birth at home can do so safely have the potential to meet an identified need. The shortage of midwives across the country presents a prohibitive barrier to access, as does the lack of transportation infrastructure to facilitate their travel between villages and townships. Increasing the number of

midwives trained and their transportation support is vital to improving the accessibility of skilled birth attendants. Improving training for other community-based providers who can support the work of midwives by providing basic care and referrals, such as community health workers and auxiliary midwives, also appears warranted.

### *Limitations*

Our study is qualitative and is thus not meant to be representative or generalizable. Further, as our study team was only able to recruit participants from six peri-urban townships the perspectives of women living in other areas of peri-urban Yangon are not reflected in our findings. Our survey participants are all members of the National YWCA's microfinance program; thus, their knowledge of the available services is likely more in-depth than that of non-members. Finally, as our study was conducted in Burmese and English, peri-urban migrants with another dominant language were not eligible to participate.

### **Conclusion**

The findings from our study highlight the constraints and considerations peri-urban women face when deciding where to give birth, and the ongoing use of traditional post-partum practices. Efforts to improve access to public hospitals for safe delivery appear warranted, as does the development of culturally resonant resources on the potential harms associated with common traditional post-partum practices. Increasing the number of midwives trained, and the training given to other community-based providers, may also be valuable.

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## CHAPTER 6: Discussion

The final chapter of this thesis includes a discussion of the findings, and their significance and implications, including an overview of my return to Yangon to share the findings in early 2015. From there, I explore possible next steps and recommendations for future efforts to improve reproductive health in peri-urban Yangon. Per the suggestion of stakeholders in Yangon, these recommendations have been broken into sections pertaining specifically to *policy, service delivery, programming, and future research*. Following this, I speak more specifically of my future work following the completion of this thesis in the form of a fellowship that will allow me to return to Yangon for nine months in 2015-2016. I will conclude this final chapter by discussing my own positionality and reflexivity throughout this research process, the limitations of the study, the contributions of different members of the study team, and concluding thoughts.

### 5.1. Integration of Findings

The three articles presented in this thesis provide an overview of the major reproductive health needs in peri-urban Yangon, focusing specifically on issues of access, misinformation, and unsafe abortion and barriers to safe delivery care. Social, economic, and geographic barriers all shape access to reproductive health services in peri-urban Yangon, and these dynamics are explored in-depth in the first article. Similar dynamics shape access to abortion and safe delivery care. However, the legal status of abortion negatively impacts the sociocultural context surrounding abortion, making it incredibly stigmatized. This stigma exacerbates barriers to access, and makes it more difficult for women to seek care and counseling following an unsafe abortion. There is much misinformation surrounding the termination of pregnancy, particularly the efficacy of dangerous, non-medical methods. Similarly, lack of

information surrounding the potential harms of some traditional post-partum practices is leading to unnecessary mortality among peri-urban women. Further, as with other reproductive health events, young and unmarried women face particular stigma when looking to prevent or terminate a pregnancy. The majority of study participants emphasized the need for more health education efforts on the dangers of harmful practices surrounding reproductive health events like abortion and delivery.

Taken together, the study findings highlight significant unmet reproductive health needs in peri-urban Yangon, as well as the unique experiences and characteristics of the peri-urban population. This population is highly mobile and economically vulnerable, reflecting both national and geographic health disparities, as well as health disparities present within major urban centers. The population is reshaping our definition of “hard-to-reach” – a term historically used to describe geographically remote populations. Yangon’s peri-urban population is “hard-to-reach” despite being geographically proximate to the city centre, largely due to socioeconomic factors. Poverty, long work hours, an inability to prioritize health, poor transportation infrastructure, misinformation, and reliance on traditional practices and beliefs are just some of the factors that shape the dynamics of service delivery and accessibility in peri-urban Yangon, and pose challenges to service delivery organizations, donors, and governmental agencies attempting to reach this population.

As global urbanization trends continue, with increasing numbers of rural populations migrating to urban centers like Yangon in the pursuit of better economic opportunities, peri-urban populations will likely continue to grow – as will their health needs. Thus, it is imperative to understand the needs, experiences, and dynamics of these populations to inform future efforts to provide them with services and resources. Yangon’s peri-urban population has complex and evolving reproductive health needs, and requires a tailored service delivery approach. Our participants consistently identified the need for

comprehensive reproductive health information, resources, and services in the peri-urban townships. Further recommendations are covered more in-depth later in this chapter.

## 5.2. Significance and Implications of Findings

In early 2015, I received a grant from the University of Ottawa's Centre for Global and Community Engagement to return to Southeast Asia for nearly one month to disseminate the findings of this research in the form of a report of top-level findings, and through a series of meetings and presentations. Since this research was requested to inform the work of local stakeholders working in the field of reproductive health in Yangon, active and rigorous dissemination of the study findings was imperative. During my return to Yangon, I distributed more than 40 copies of the report of key findings, entitled: *Near the city but hard to reach: A reproductive health needs assessment in peri-urban Yangon, Myanmar* (Sheehy, Aung, Sietstra, & Foster, 2015). I include the Executive Summary as Appendix B. I also met individually with representatives of eight different organizations working to improve reproductive health in peri-urban Yangon to discuss the implications of the study findings.

I also co-led presentations with Dr. Foster and Dr. Yadanar in Yangon and Mae Sot, Thailand to share and discuss our findings. These were attended by a total of 40 people from a range of NGOs, CBOs and governmental agencies. The discussions that emerged highlighted the need for comprehensive recommendations in the fields of policy, service delivery, research and programming, to inform future efforts to improve reproductive health outcomes in peri-urban Yangon. The recommendations we provided in our report offered a guide for a more complete set of recommendations, which are discussed in more detail below. Given the widespread enthusiasm and support for this project among NGOs, CBOs and governmental agencies, I believe that the findings have the possibility to influence future initiatives to improve reproductive health in peri-urban Yangon.

Finally, the findings from this study have been submitted to three peer-reviewed academic journals, found in Chapters 3, 4, and 5. These articles promise to fill a significant gap in the academic literature on reproductive health needs and experiences in peri-urban Yangon. The findings will also be presented at a series of local and regional conferences over the next year; I have submitted or will submit abstracts to present at the International Conference on Family Planning in late 2015 in Indonesia, and at the 8th Asia Pacific Conference on Reproductive and Sexual Health and Rights in Nay Pyi Taw, Myanmar in early 2016. I will continue to explore opportunities to share the findings of this research through peer-reviewed publications, book chapters, community engagement opportunities, conference presentations, and future research opportunities in the coming years.

### 5.3. Recommendations

A range of approaches are needed to address the reproductive health challenges in peri-urban Yangon. During the discussions following my presentation of findings in Yangon, stakeholders had many recommendations for future efforts to improve reproductive health in peri-urban Yangon. I have incorporated recommendations from these discussions, as well as from informal conversations with stakeholders, our study team, and from best practices and lessons learned presented in the international literature, in this section. I explore mechanisms to improve reproductive health outcomes in peri-urban Yangon that pertain specifically to *policy, service delivery, research and programming* below. Ideally, through collaboration across fields and organizations, these efforts could be undertaken in conjunction. Many organizations are already working to improve reproductive health in Yangon, and some are working on similar initiatives as those suggested here; these efforts should be expanded and supported, to maximize their impact and ensure their sustainability.

### 5.3.1. Policy

The coming years represent a timely and exciting opportunity to affect policy change in Myanmar. Stakeholders I met in Yangon expressed optimism about the possibility of health policy reform in the country and were eager for recommendations and best practice suggestions from other countries, particularly for policies pertaining to the provision of safe, legal abortion care. Although the population of peri-urban Yangon has unique experiences and needs, the population is similar to populations around the world in that they require and deserve access to safe, legal abortion services. Population-level policies intended to improve access to reproductive health care and services will have positive impacts on women across the country, including women in peri-urban Yangon. Thus, the policy suggestions included in this section are intended for country-level policy reform, and are not specific to peri-urban Yangon.

A change to existing policy that could have a substantial impact on women's lives would be to reform the legal status of abortion in the country. Abortion was made illegal in Myanmar during British colonial rule, and the current law banning abortion except in cases of life endangerment is a remnant of colonial law (Ba-Thike, 1997). However, unsafe abortion remains a significant contributor to maternal mortality across the country. The government of Myanmar has made several national and international commitments to improving maternal health, specifically by reducing maternal mortality. However, as the experiences of other countries in the region have illustrated, mechanisms to reduce maternal mortality must include access to safe abortion care to be most effective.

For example, in neighbouring Bangladesh, efforts to increase contraceptive uptake and promote menstrual regulation<sup>6</sup> have contributed to improved maternal health. However, abortion remains illegal

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<sup>6</sup> Bangladesh's menstrual regulation provides early termination of pregnancies up to 10 weeks gestation, prior to a pregnancy test being administered to confirm the pregnancy. The procedure is framed as "regulating" a late menses rather than terminating an established pregnancy.

and unsafe abortion contributes to significant maternal morbidity and mortality across the country; each year, approximately 500,000 women are hospitalized for abortion-related complications (Hossain, Maddow-Simet, Singh, & Remez, 2012). Conversely, in neighbouring Thailand, abortion is legally permitted to preserve a woman's life, physical health or mental health and if the pregnancy resulted from rape or incest (Guttmacher Institute, 2012), and the country's maternal mortality rate is much lower than Myanmar's, at 26 per 100,000 live births (World Bank, 2013). Although the Myanmar government may be unwilling to make abortion legal without restrictions, adding exceptions to the law for cases of rape, incest, minors, and threats to physical and mental health could have significant impacts on women's health and well-being across the country. Further, there is a need for the development of protocols to ensure high quality post-abortion care is provided across the public health sector that includes manual vacuum aspiration, counseling, and non-judgmental treatment and care.

In terms of broader policy reform that could improve reproductive health outcomes in Myanmar, an increased health budget, and within it an increased allotment for reproductive health expenditures, is an essential first step. The government now funds health care through the public sector, however hospitals are understaffed and overcrowded. Despite this, many doctors in the country are unable to find work. Expanding the health budget would allow the hiring of more doctors, which could increase the availability of health care providers across the country. This could also allow more opportunities for general practitioners to specialize in family planning and reproductive health care, which could help fill significant gaps in health care provision.

### *5.3.2 Service delivery*

Our study participants overwhelmingly agreed that there is a pressing need for tailored reproductive health service delivery efforts in peri-urban Yangon. Myriad barriers keep women from

accessing the available services in their townships, including overlapping sociocultural, socioeconomic, financial, and information-related barriers. In particular, a lack of affordable and accessible transportation options serves as a prohibitive barrier to access. Most peri-urban townships have one public hospital, which must serve a population of hundreds of thousands of people spread across large areas, connected by inadequate roads, and with limited public transportation options. Thus, women may be required to take an expensive taxi to a public hospital; somewhat negating the free services the hospital offers, as a taxi can easily cost a day's wages (1,000-5,000 kyat, or CAD 1-5). Many of our participants specifically referenced transportation costs as a significant, and prohibitive, health-related expenditure, and a primary barrier to accessing care, particularly delivery care. Our FGD participants also expressed gratitude towards organizations that provide transportation to bring women to their services and clinics, or to bring service providers into the townships. Stakeholders interested in addressing these barriers could increase investments in ferry transportation systems, which regularly bring groups of people to distant, otherwise inaccessible service delivery points. Additionally, regularly bringing service providers into the peri-urban townships through satellite clinics could mitigate geographic barriers to access. Finally, expanding the provision of health care in workplaces, especially garment factories which employ many peri-urban women, could help peri-urban women regularly access reproductive health services and products.

Service delivery initiatives could also be improved by increasing the training on sexual and reproductive health that healthcare providers receive, to ensure that the services they offer are comprehensive and the information they provide is medically accurate. General practitioners lack training on reproductive health counselling and service delivery, and few providers are able or willing to specialize in reproductive health. Women in our FGDs reported receiving inaccurate information from healthcare providers, as well as experiencing judgment and harassment when asking questions or seeking care for reproductive health issues. This judgment and harassment was particularly experienced

by young and unmarried women, who are often deterred from seeking care due to provider biases. Existing gaps in the provision of reproductive health services could be mitigated by improving the training on sexual and reproductive health that health care providers receive; for instance, by updating medical school curricula to include a more comprehensive and updated focus on reproductive health and the currently available technologies and gold standards, or by expanding continuing medical education programs offered to doctors and midwives, to allow them to specialize or update their knowledge.

Finally, given the intense harassment and judgment faced by young and unmarried women when they attempt to access reproductive health services and information, there is a need to expand service delivery efforts that are tailored toward these groups. Efforts to meet the needs of this population should be developed and implemented in close collaboration and consultation with young and unmarried women, and designed based on evidence of their needs. As adolescent health is increasingly prioritized around the world, organizations and agencies operating in Myanmar can look to best practices and lessons learned from neighbouring countries to inform these efforts, such as the Adolescent Reproductive Health Network in Thailand, which is a collaborative effort among eight CBOs to address the reproductive health needs of young migrants from ethnic communities in Myanmar (Women's Refugee Commission, Save the Children, UNHCR, & UNFPA, 2012).

### *5.3.3. Research*

Myanmar's long history of isolation and flawed data collection efforts have contributed to an overall lack of evidence to inform policy and programming in the country. With respect to reproductive health, more qualitative research is needed on women, men, and adolescents' experiences, and more quantitative, nationally-representative data is needed on a range of reproductive health indicators.

Quantitative data collection efforts should attempt to include conflict-affected and ethnic minority inhabited regions of the country as much as possible, as these populations have long been excluded from most otherwise national datasets.

In considering specific reproductive health indicators, and evaluating which research could have maximum impact in the country, there emerges a clear need for more evidence on the social and economic costs of unsafe abortion. Unsafe abortion has high costs on women's lives, health and well-being; it also burdens the health care system. Myanmar's government has a negligible health budget, and may be responsive to opportunities to more effectively allocate public health resources. Given the lack of information about when and where to access post-abortion care, and women's well-founded fears of harassment and judgement from public sector doctors, it appears many women do not obtain post-abortion care (PAC) until their complications are dangerously late. This care is thus much more resource-intensive, requiring medications, surgeries, and extended hospital stays. The Myanmar government is aware of the high rates of maternal mortality in the country, but has not stated any intention to reform the abortion law in their most recent National Strategic Plan on Reproductive Health (Ministry of Health, 2014b). Rigorous research on the financial burden of unsafe abortion to the public health care system could provide important evidence for reshaping the government's policy on unsafe abortion. Research on this topic in other settings has estimated the costs of unsafe abortion by estimating post-abortion care costs based on empirical studies, and using results from costing models, such as the WHO's Mother-Baby Package (Vlassoff, Walker, Shearer, Newlands, & Singh, 2009). Further, research on the experiences of women accessing PAC could also provide important evidence to inform the development of new protocols to ensure PAC is delivered in a comprehensive, cost-effective way.

Finally, evidence on the specific reproductive health experiences and needs of particular population subgroups would be beneficial in informing programming efforts. Research on the

reproductive health needs of ethnic minority groups, remote and rural populations, the urban poor and peri-urban populations, men, female sex workers, adolescents, and unmarried women is needed to inform efforts to meet the needs of these complex and varied groups. Studies should be developed in consultation with representatives of these communities, and look at lessons learned from similar studies in the Southeast Asian region to ensure studies are designed in a culturally appropriate manner.

#### *5.3.4 Programming*

In order to improve reproductive health outcomes in peri-urban Yangon, there is a need for tailored, innovative, and replicable programming efforts that focus specifically on the needs of mobile, migrant populations. Our study participants consistently highlighted the need for more opportunities to learn about sexual and reproductive health in their townships, but explained that they often lacked the free time or interest to attend the trainings that were occasionally made available to them. Thus, future programming that aims to improve knowledge of sexual and reproductive health issues must be designed with the lifestyles and experiences of peri-urban populations in mind, particularly accounting for their long work hours, minimal free time, and overarching disinterest in health. Educational efforts should be developed in close consultation with community members, be culturally resonant, accessibly written, and tie health into broader lifestyle issues.

Specific education resources should be developed for young and unmarried women, to provide non-judgmental information tailored to their needs. There is also a need for resources that are tailored toward community elders, or “aunties”, who comprise a significant source of health information for peri-urban women, and whose opinion is often more highly regarded than that of medical professionals. Sexual and reproductive health resources and programs tailored towards men would also be useful, to improve their own health and well-being, and to help them understand better the reproductive health

experiences of women in their lives. Stakeholders are increasingly recognizing the importance of involving men in reproductive health education and training. The WHO has published a guide to programming for male involvement in reproductive health (World Health Organization, 2011), while other organizations and researchers have explored policies that could encourage male involvement (e.g. Greene et al., 2004); barriers to male involvement, such as perceiving reproductive health as solely women's responsibility (Kabagenyi et al., 2014); and opportunities for including men, such as through community outreach efforts (Walston, 2005). Programming efforts to involve men in reproductive health should be cognizant of lessons learned from other settings, including barriers and opportunities, and should be developed and expanded in a Myanmar-appropriate context. These efforts could focus on understanding women's rights, the harms of intimate partner violence, prevention of pregnancy, and prevention and treatment of STIs and HIV.

Paramount to ensuring that the suggested programming efforts are culturally-appropriate and have community value is the effective engagement of community members in the design, implementation and evaluation of reproductive health programs. Identifying mechanisms for successfully engaging community members is an essential first step, and can include community outreach, collaboration with community-based organizations, and working to utilize and expand locally-available assets and resources.

#### 5.4. Future Work

##### *5.4.1 OceanPath fellowship 2015-2016*

Through the process of collecting and analyzing data for this thesis a finding stood out to both me and Dr. Yadanar that seemed not only pressing, but something that could potentially be addressed

with simple, cost-effective measures: the rampant misinformation, myths and rumours surrounding sexual and reproductive health issues in peri-urban Yangon. We discussed the implications of this finding on women's access to and use of services, and explored both the ways women were receiving this misinformation, and the avenues women identified as their preferred means of receiving health information. We also studied the currently available reproductive health education resources, to determine what was available and what could be built upon.

Together, we developed a project that would provide comprehensive reproductive health education to peri-urban women – particularly to adolescents and unmarried women who currently lack access to resources and services, and face discrimination when seeking this information – through a set of tailored health education resources and trainings. In early 2015, I was granted an OceanPath fellowship, funded by a private family foundation and administered through the Coady Institute, which provides me with the resources to develop this project over nine months in Yangon beginning in September 2015. Working closely with the National YWCA of Myanmar and affiliated with Cambridge Reproductive Health Consultants, I plan to develop the following resources: a mobile app or website, with comprehensive and accurate information about a range of sexual and reproductive health issues, all available in Burmese; a comic book, or series of comic books, tailored to low-literacy women in peri-urban Yangon that provides comprehensive information about specific reproductive health issues or events (for instance, choosing a contraceptive, or giving birth) through culturally resonant stories about women navigating similar experiences; and finally, a peer education training workshop, that provides comprehensive reproductive health education to adolescents and their teachers to bring back to their communities. My goal for this project is to improve women's access to reproductive health information and resources in peri-urban Yangon, so they are equipped to make informed, evidence-based decisions for their own health. This fellowship provides an exciting opportunity for me to continue my work in Yangon, and to bring my research into practice.

## 5.5. Reflexivity

Reflexivity is an important component of qualitative research; as the researcher cannot hold a completely neutral, objective role in the process of collecting and analyzing data, reflexivity allows us to maintain self-awareness, and acknowledge our role in the research process and the potential effects our role has on the research process and outcomes (Finlay, 2002; Anderson, 2008). Being aware of the effect one has on one's own research is of particular importance when conducting cross-cultural research; the researcher is inherently an "outsider" but cannot remain "outside" the research process, and must engage with this dynamic.

As a Canadian researcher conducting interviews and focus group discussions in Yangon, I was an outsider looking in on a community; however, my role also influenced my perceptions of the content of interviews and focus groups, and possibly the process of collecting data using these methods. The extensive training I have received on qualitative research under the mentorship of my supervisor, Dr. Foster, was imperative in my navigating this process in a reflective, respectful, and ethical way. Using my training, I was able to be cognizant of my role, and continuously reflect on my positionality throughout the research process. My reflexivity was facilitated by the use of memos – short write-ups I completed following each interview and focus group, where I reflected on the process, the emergent themes and findings, and on my own perceptions of and relations to the research process. These memos were useful for many reasons – not only did they facilitate the data analysis process by allowing ongoing identification of themes and patterns, but they also allowed me to continuously engage with my role in the research process, and forced me to identify and evaluate my perceptions of the community I was working with.

Working closely with Dr. Yadanar also helped me navigate some of the complex dynamics of conducting cross-cultural research. As a white woman from the Global North collecting data from

Burmese women who were often low-income and from diverse ethnic backgrounds, there were inherent power dynamics present. I was especially aware of these dynamics due to my academic grounding in feminist theory and reproductive justice; together this background provided me with a better understanding of the structural and historical constructs that impact women's lives and decision-making, and the complex ways social, economic, religious, and political factors, among others, influence women's health and well-being (Ross, 2006).

As discussed in Chapter 1, reproductive justice is a framework I believe strongly in, and influences all of my work around reproductive health. This project marked the first time I was able to actively engage with this framework in the field, which was both exciting and challenging. While engaging with a reproductive justice framework helped broaden my understanding of our participants' lives and experiences, and be especially cognizant of my position and privilege throughout the research process, it was also a challenge in a setting where the term is largely unknown, and the focus of the field locally is on reproductive rights. My collaborator worked hard to include a rights-based perspective in her work, and values it strongly. Although reproductive justice advocates may suggest moving beyond the concept of rights to strive toward broader societal change, in this context women asserting their right to reproductive health care is incredibly powerful, and still relatively new, and I respect this position.

With respect to my role in the research process, while I sought to create an inviting, respectful environment it is possible that some FGD participants would have been less comfortable sharing personal details about their lives with me. Dr. Yadanar and I worked closely together to mitigate any discomfort by co-leading the FGDs; Dr. Yadanar would lead the Burmese-language discussion using the discussion guide I created, and interpret probing questions that I had. Dr. Yadanar and I agreed that our

participants seemed to feel comfortable in the FGDs – this was evidenced by relaxed postures, laughter and banter during the discussions, and a fairly even distribution of talking among participants.

Frequent debriefs with Dr. Yadanar and Dr. Foster also helped me to be reflective of my role and position in this research. Dr. Yadanar was very honest with me about how she perceived my impact on the process. In our debriefs after each FGD, I would ask what she thought of the participation, and whether she noticed if anyone was uncomfortable. We noticed that participants enjoyed when I introduced myself at the beginning, tried to speak a bit of Burmese, and asked if they had questions for me. I began doing this at the beginning of each FGD, answering questions about my research, my school, and my family, to put the participants at ease. Dr. Yadanar was also honest about when my role might hinder data collection – for instance, we attempted to plan an interview with a traditional birth attendant (this ultimately proved unsuccessful, as she eventually declined to participate). Dr. Yadanar explained that the TBA might feel uncomfortable discussing the sensitive nature of her work (i.e. providing abortion care illegally) around a foreigner, so we decided I would not attend the interview, but would debrief extensively with Dr. Yadanar following it. Taking measures such as these helped me to recognize how I might have an effect on the research process and outcomes, and helped ensure that participants were as comfortable as possible in sharing their insights and experiences with us.

## 5.6. Limitations

This study has several limitations. Due to time, financial and logistical constraints, we could not include perspectives from residents of each of the nine peri-urban townships; participants in our FGDs and surveys reside in only six of the nine peri-urban townships. As this research was qualitative, the findings are not meant to be generalizable across the entire peri-urban population, or beyond. Although this research is not meant to be representative or generalizable, we acknowledge that our recruitment

mechanisms may have further impacted the sample, as our participants were recruited by several NGOs and CBOs operating in peri-urban Yangon. Thus, our participants may have been more familiar with reproductive health issues, and the available services in their townships, compared to the broader peri-urban population. Finally, working in several languages can present challenges. I worked closely on this study with Dr. Yadanar and Dr. Foster, and had extensive conversations about the study findings as they emerged. Although some nuance may have been lost in translation, I am confident that the extensive debriefs, memos, and field notes taken throughout the data collection process helped ensure that the perspectives of our participants were accurately captured.

#### 5.7. Statement of Contribution

I completed this study in partial fulfillment of the requirements for the Master of Science in Interdisciplinary Health Sciences at the University of Ottawa. As the Principal Investigator (PI), I conceptualized this study, designed the study instruments, collected and analyzed the data, and led the development of all three manuscripts. I also managed the local study team and coordinated local dissemination efforts.

However, several other individuals contributed substantially to this project. My supervisor, Dr. Foster, was the Senior Investigator on the *Separated by Borders* project and assessed the initial feasibility of the overall needs assessment in peri-urban Yangon. Dr. Foster helped orient me to the context, the project, relevant stakeholders and data collection techniques, and worked closely with me to design a study that was both rigorous and feasible given our time and financial parameters. Dr. Foster guided me throughout the research process, including developing the proposal, getting REB approval, identifying a local collaborator, and providing feedback and guidance on the study instruments. Dr. Foster read my memos and transcripts, and we held regular meetings during my fieldwork to discuss

emerging findings and interpret the results. She also contributed to all dissemination activities associated with this project.

Dr. Yadanar served as a Co-Investigator on this project. Dr. Yadanar worked closely with me throughout my fieldwork; she navigated the logistics of scheduling and holding FGDs, including finding a venue and recruiting participants, and facilitated and interpreted the Burmese-language discussions for me. She also developed the general reproductive health survey. Dr. Yadanar also assisted with recruitment, data collection, and dissemination efforts by introducing me to her extensive network and helping me navigate various challenges that emerged during my fieldwork. She contributed to the overarching analytic process as well as all dissemination activities.

Cari Sietstra, JD, also contributed to this project. She was a Co-Investigator on the *Separated by Borders* project. She contributed to the conceptualization, design, implementation and administration of this project.

As the PI of this project I led the writing of all three manuscripts. All listed authors for each article met the criteria for authorship as outlined by the individual journal. We determined authorship, authorship order, and corresponding author based on team discussions. The listed co-authors of each manuscript reviewed early drafts and provided substantive and editorial feedback. All co-authors have approved the manuscripts included in this thesis.

## 5.8. Conclusion

Myanmar has seen remarkable growth and change since the 2010 elections, and the coming years represent an exciting time, as aid and investment enter the country in unprecedented amounts, and political reform appears more promising than ever. However, the need for increased efforts to

improve population health remains important, as does the need for evidence to inform these efforts. The findings from this thesis highlight significant unmet reproductive health needs in peri-urban Yangon, despite an overarching availability of reproductive health services in the area. A variety of barriers to access persist, including geographic, socio-economic, and socio-cultural barriers, and there remains a lack of services and resources for young and unmarried women. A unique and tailored approach is required to meet the complex and diverse reproductive health needs in peri-urban Yangon, especially as this population continues to grow. Efforts to improve reproductive health must take place at the policy-level, through service delivery efforts, continued research, and innovative programming. Collaboration across fields and organizations, as well as support from the broader reproductive health community is required to undertake these efforts.

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## Appendix A: Ethics Approval Letter

File Number: H02-14-03

Date (mm/dd/yyyy): 04/28/2014



**Université d'Ottawa**      **University of Ottawa**  
Bureau d'éthique et d'intégrité de la recherche      Office of Research Ethics and Integrity

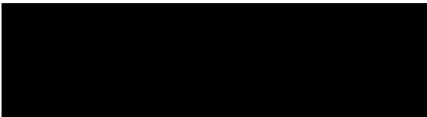
This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement (2010) and other applicable laws and regulations in Ontario, has examined and approved the ethics application for the above named research project. Ethics approval is valid for the period indicated above and subject to the conditions listed in the section entitled "Special Conditions / Comments".

During the course of the project, the protocol may not be modified without prior written approval from the REB except when necessary to remove participants from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the project (e.g., change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, including consent and recruitment documentation, should be submitted to the Ethics Office for approval using the "Modification to research project" form available at: <http://www.research.uottawa.ca/ethics/forms.html>.

Please submit an annual report to the Ethics Office four weeks before the above-referenced expiry date to request a renewal of this ethics approval. To close the file, a final report must be submitted. These documents can be found at: <http://www.research.uottawa.ca/ethics/forms.html>.

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5387 or by e-mail at: [ethics@uOttawa.ca](mailto:ethics@uOttawa.ca).

### **Signature:**



Protocol Officer for Ethics in Research  
For Daniel Lagarec, Chair of the Sciences and Health Sciences REB

# Near the city but hard to reach

## A reproductive health needs assessment in peri-urban Yangon, Myanmar

### *Executive Summary*

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The conclusions and opinions expressed in this report are those of the authors and do not necessarily represent the views of the organizations with which the authors are affiliated, the individuals and organizations acknowledged in this report, or the funders.

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## Executive summary

### Background & context

Recent political reforms in Myanmar have resulted in rapid changes throughout the country. Spending on health has increased significantly, through both foreign aid and government spending, but reproductive health outcomes remain poor in much of the country. Although urban-rural health disparities have historically been pronounced, the influx of rural migrants seeking economic opportunities in major urban areas has complicated this previously established distinction. Peri-urban Yangon is a dynamic series of townships characterized by poor infrastructure, slums, and a highly mobile population. Although donors are increasingly interested in investing in this region, there remains a lack of data and resources to guide these efforts.

### Project aims & objectives

This needs assessment identifies the reproductive health needs of women living in peri-urban Yangon and seeks to understand better current practices, available services, and potential avenues for improvement. This study focused on delivery care, contraception, abortion, and post-abortion care. This report is intended to serve as a resource for researchers, organizations, and potential donors working on reproductive health in peri-urban Yangon.

### Methods

A multi-disciplinary study team from the University of Ottawa (Canada), the National YWCA (Myanmar), and Cambridge Reproductive Health Consultants (US) employed a multi-methods study design to complete this project. We conducted interviews with 18 key informants, held seven focus group discussions with 27 women and nine healthcare providers, completed a service mapping exercise that included surveys of 27 facilities, and administered a survey with 147 women participants in the National YWCA's microfinance program. We also conducted a systematic review of published and unpublished sources of information regarding reproductive health in peri-urban Yangon. We used standard qualitative analytic techniques to interpret these data and formulate our recommendations.

### Setting

Although some of Yangon's townships are widely considered peri-urban, there is no consistent definition for this setting in Myanmar. At the outset of the project we established classification criteria including a township characterized by the existence of poor infrastructure, a large number of slum settlements, and a mobile population largely engaged in daily wage labor. Based on these criteria and extensive consultation with local stakeholders, we identified nine Yangon townships as peri-urban: Hlaing Thar Yar, Insein, Mingaladone, North Dagon, North Okkala, Shwe Pyi Thar, South Dagon, Thar Gay Ta, and Thin Gan Gyun.

### Findings

#### **Reproductive health services are often available but inaccessible**

Although many service delivery points exist in the nine peri-urban townships, geographic and socioeconomic factors limit affordable access. Despite providing nominally free services, public hospitals are associated with long travel and wait times, crowded facilities, and hidden costs. The lack of adequate transportation infrastructure in peri-urban settings impacts the accessibility of public sector facilities, which women typically only use in emergencies. When choosing a provider, women overwhelmingly prefer private clinics and non-governmental organizations as they are often closer, more affordable, and perceived as offering non-judgmental services. Poverty, coupled with high out-of-pocket expenses and

transportation costs, deters many women from seeking care. Women's health-seeking behaviors are also influenced by gender norms, marital status, and traditional beliefs and practices.

### **Misinformation about sexual and reproductive health issues is widespread**

Misinformation and rumors hinder women's access to and use of reproductive health and family planning products and services. In particular, fear of contraceptive side effects, including weight gain, infertility, and even death, keep many women from choosing effective and long-term methods. Misinformation is propagated by word-of-mouth, from neighbors, friends and family, as well as by poorly informed providers, shopkeepers, and media outlets.

### **Institutional deliveries are increasingly common, but harmful traditional practices persist**

There is a growing awareness that institutional deliveries are safer than home deliveries and many women reported that their most recent delivery took place in a hospital. However, traditional and cultural factors, as well as women's relationships with traditional birth attendants (TBAs), still strongly influence decision-making. TBAs offer women an affordable home-based delivery care package that provides both physical and social support. However, TBAs also promote harmful post-partum practices, including restricted diets and unhygienic cleansing rituals.

### **A variety of contraceptives are available, but many barriers to consistent use exist**

Contraceptive injections are overwhelmingly preferred but women remain anxious about perceived side effects. Although interest exists in long-acting reversible contraception (LARC), particularly the implant, women fear the insertion procedure and perceive LARCs as expensive and inaccessible. Traditional methods (i.e. kay thi pan) continue to be used to "purify" blood and induce menstruation. Emergency contraception (EC) is inexpensive and readily available at drug and betel shops. However, awareness of the method is limited and misinformation abounds. A small number of women appear to use EC as their primary contraceptive method and EC is perceived as being particularly appropriate for young and unmarried women.

### **Unsafe abortion is common and post-abortion care is difficult to access**

Unsafe abortion care is widely available in the peri-urban townships and demand is considerable, despite widespread awareness of the associated morbidity and mortality. TBAs remain the primary providers and employ a variety of mechanical, medical, and traditional methods. Although misoprostol is available from drug shops, dosage and administration is often incorrect, leading to incomplete abortions. Post-abortion care (PAC) is available exclusively from the public sector, a fact that is either unknown or serves as a deterrent, and many women fear harassment and judgment from providers. Given the distances to public hospitals and lack of information about when and where to access PAC, many women seek PAC dangerously late.

### **Reproductive health services for adolescent and unmarried populations are limited**

A lack of tailored services for young and unmarried women, as well as discrimination from providers, mean few reproductive health services are available for this group. Unmarried women lack accessible, tailored health education resources and face judgment when they are perceived as knowing too much about reproductive health. These factors hinder unmarried women's ability to continuously access contraceptives, leading some to rely on EC as their primary method.

## **Discussion & recommendations**

### **Establish tailored health education and service delivery efforts**

The need for tailored health education and service delivery efforts is pressing. Health education resources should be tailored toward low-literacy populations and tie health to broader lifestyle issues in culturally-relevant ways. Adolescents and unmarried women in particular would benefit from tailored, non-judgmental resources. Service delivery efforts should aim to diminish transportation-related barriers. Bringing services to peri-urban townships and using ferry transportation systems could reduce existing barriers. Health education and service delivery efforts should also be expanded into workplaces when possible.

### **Improve training on sexual and reproductive health for healthcare providers**

Healthcare providers have few opportunities to learn about sexual and reproductive health, either in medical school or continuing medical education programs. Young and/or unmarried women continue to face judgment and discrimination when accessing reproductive health care. Resources for providers should be expanded, particularly those relating to contraceptive methods and counselling, emergency contraception, post-abortion care, and youth-friendly services.

### **Improve task-shifting between providers and patients**

Expanding the service delivery capabilities of midwives and auxiliary midwives could meet women's reproductive health needs and eliminate the need for multiple facility visits for treatment or care. The feasibility of introducing injectable contraceptives that patients can self-administer should be explored, noting the potential benefits for peri-urban populations who may struggle to reach a health facility every three months. Providing women with correct information about timing, dosage, and administration of medications, such as EC, should also be prioritized.

### **Engage community members in designing programs and initiatives**

The advice of community elders often takes precedence over that of healthcare providers. Thus, it is imperative that community elders have accurate information about reproductive health to share with local women. Further, to maximize impact and reach community members, elders and women in peri-urban areas should be closely involved in the development of reproductive health projects and programs in their townships.

### **Identify avenues for expanding access to safe abortion and post-abortion care**

Harm from unsafe abortion is a significant contributor to maternal morbidity in peri-urban Yangon. Without increased access to safe and legal care, unsafe abortion will continue in the region. There is a significant need to identify and institutionalize mechanisms to increase women's timely access to safe and legal services. The accessibility of PAC, and information about where it can be accessed, should also be expanded.

### **Expand efforts to improve adolescent sexual and reproductive health**

Efforts to improve adolescent reproductive health and youth-friendly service delivery should be developed in collaboration and consultation with adolescents, and rooted in evidence of their needs. Providers should be trained in offering non-judgmental and accessible services to adolescents. More research on adolescent reproductive health is needed to inform these efforts.

### **Conclusion**

The study findings highlight inaccessible reproductive health services, considerable misinformation, common and unsafe practices surrounding delivery and abortion, and an overarching need for comprehensive information and resources in peri-urban Yangon. A unique and tailored service delivery approach is needed to meet the complex and varied needs of this population. Many organizations are

doing important work to improve reproductive health in peri-urban Yangon, but more data and resources are needed to inform their funding and programming efforts. Collaboration between these organizations, and support from the reproductive health community more broadly, could help facilitate these efforts.