2015 Health Facility Assessment for Reproductive Health Commodities and Services

May 2016

2015 Health Facility Assessment for Reproductive Health Commodities and Services

Department of Medical Research

Department of Public Health

Department of Medical Services

UNFPA

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Contents

Foreword

In Myanmar, emphasis has been placed and a lot of inputs have been invested for improving maternal and child health services. Under the leadership and guidance of the National Health Committee, the Ministry of Health has been planning and implementing the interventions to improve the health status of mothers, newborns and children. The Ministry of Health has made efforts to reach the Millennium Development Goals, especially reducing maternal mortality and child mortality by providing quality services covering the whole country. The Ministry of Health is the major player in the health sector as a governing agency as well as a provider of comprehensive health care. However, many key players played increasing roles with evolving political and administrative circumstances. In the area of reproductive health, progress was made for maternal and newborn health and birth spacing with a reduction in maternal mortality and increase in contraceptive prevalence rate. To build on these accomplishments, health systems need to be strengthened and programmes targeted for the most vulnerable populations.

The mission of Facility Assessment for Reproductive Health Commodities and Services is to provide the information and understanding needed for the country's Reproductive Health Security. Inherent in this survey is the responsibility to collect data that accurately describe the current situation on availability of birth spacing services, life-saving reproductive health medicines, stock-out situation, logistic management system, availability of skilled staff for reproductive health care services, information & communication facilities, cold chain facilities, and clients' satisfaction. The data will be useful for country's effort to grant universal access to RH services at all level of care covering the whole country. Reliable and objective data are essential to the credibility and impartiality of reproductive health resources mobilization carried out by government and various organizations in the country. The development of an effective logistic management system is necessary to achieve equitable and timely distribution of commodities and quality RH services which is well responsive to client's need.

This report on 2015 Facility Assessment for RH Commodities and Services was prepared by the Department of Medical Research (Pyin Oo Lwin Branch) in collaboration with Maternal & Reproductive Health Division, DOPH and Department of Medical Services. The report is based on comprehensive information collected at representative sample health facilities all over the country by well-organized and trained teams during May and August 2015. This is a continuation of 2014 Assessment activities and findings also reflect comparison between two consecutive years.

We would like to thank all concerned persons without whose relentless efforts and dedication this undertaking would not have been successful. In particular, we would like to express our heartfelt thanks to Ms. Janet E. Jackson, UNFPA Representative for Myanmar for her keen interest and support for this undertaking. Thanks are also due to Dr. Hla Hla Aye, Assistant Representative, Daw Yu Myat Mun, Programme Analyst, U Moe Zaw Latt Tun, Project Assistant and other concerned staff of UNFPA for their continuous support along the implementation process.

Dr. Kyaw Zin Thant

Director General

Department of Medical Research

Acknowledgement

UNFPA is honoured to be in partnership with the Department of Medical Research for a second year to conduct the country's second health facility survey for reproductive health commodities and services during 2015. The survey aims at pinpointing areas for strengthening the health system to improve availability of high quality and equitable sexual and reproductive health information and services.

This health facility survey is part of UNFPA's support to MOH for increasing access to and use of quality maternal and newborn health services, including family planning. These services are part of an integrated MNCH service package to improve the quality of health facilities, increase capacities to build and maintain a competent health workforce, establish a Logistics Management Information System, improve RH/FP Supply Chain Management System, and ensure the availability of essential RH/FP commodities and equipment. In order to improve birth spacing/family planning program strategically and to promote resource allocation and enhanced programming efficiency to reduce high unmet needs for contraceptives, it is essential to ensure that facilities have the commodities, services and contraceptive choices that women need.

UNFPA acknowledges the kind support of health authorities from each State/Regional Department of Medical Services, Department of Public Health, and the Maternal and Reproductive Health Division of Department of Public Health. Our grateful thanks also go to the Department of Medical Research for the leadership, technical support, and managerial and supervisory role in field data collection activities, without which this facility assessment would not have been completed within a very limited time frame. Assistance and support of field enumerators and technical supervisors recruited from the Department of Medical Research (Pyin Oo Lwin Branch) were invaluable. This report was based on the quality information they provided. Gratitude is also expressed to staff from the Department of Medical Research (Pyin Oo Lwin Branch) who participated actively in field supervision during activities of various teams across the country, including remote and hard-to-reach areas. Special thanks are due to health staff from hard-to-reach areas for their kind arrangement for local transportation to help the survey team in completing the survey in a timely manner.

Janet E. Jackson

UNFPA Representative for Myanmar

Abbreviations

BEmOC	Basic Emergency Obstetric Care
BS	Birth Spacing
CEmOC	Comprehensive Emergency Obstetric Care
CMSD	Central Medical Store Depot
COC	Combined Oral Contraceptive Pill
CPR	Contraceptive Prevalence Rate
DMO	District Medical Officer
DMR-POLB	Department of Medical Research (Pyin Oo Lwin Branch)
DoPH	Department of Public Health
DMS	Department of Medical Services
DPMA	Depo Medroxyprogesterone Acetate
ECP	Emergency Contraceptive Pill
EmOC	Emergency Obstetric Care
FOC	Free-of-charge
FP	Family Planning
GPRHCS	Global Programme to Enhance Reproductive Health Commodity Security
HA	Health Assistant
HF	Health Facility (Service Deliver Point)
ICT	Information and Communication Technology
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IUD	Intrauterine Device
LHV	Lady Health Visitor
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MIMU	Myanmar Information Management Unit
MMR	Maternal Mortality Ratio
MO	Medical Officer
MS	Medical Superintendent
NO	Nursing Officer
ObGy	Obstetrics and Gynaecology
PMTCT	Prevention of Mother to Child Transmission
RH	Reproductive Health
RHC	Rural Health Center
RHCS	Reproductive Health Commodity Security
SDP	Service Delivery Point (Health Facility)
THO	Township Health Officer
THN	Township Health Nurse
TMO	Township Medical Officer
UHC	Urban Health Center
VCT	Voluntary Counselling and Testing

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Executive summary

Introduction: From 2010 to 2012 UNFPA, through the UNFPA Supplies Programme, formerly the Global Programme to enhance Reproductive Health Commodity Security (GPRHCS), has supported the conduct of an annual survey on the availability and stock-out of contraceptives and maternal health medicines in 12 GPRHCS Stream 1 countries. In 2013, Myanmar received support from UNFPA Supplies Programme to assist the Ministry of Health to secure RH commodities. Linking to the programme, a nation-wide survey across public health services with a representative sample of health facilities over all states and regions was undertaken since 2014 to track RHCS indicators, such as the availability of RH commodities, supply chain (including cold chain) systems, staff training and supervision; availability of guidelines and protocols, Information Communication Technology, method of waste disposal and user fees. The survey also obtained the views of clients about the quality and cost of services through exit interviews. This is the second report for Myanmar assessed the situation of 2015.

Method: A cross-sectional descriptive design covering all regions with a representative sample size and sampling methods was used. The standardized questionnaire adapted in translation and formatting was used. Department of Medical Research (Pyin Oo Lwin Branch) mainly carried out data collection activities with assistance of Department of Public Health and Department of Medical Services. A total of 356 health facilities were surveyed and this included 172 at primary level, 161 at secondary level, and 23 at tertiary level. Out of the 356 facilities surveyed; 131 were located at urban and 225 were at rural areas.

Offering Modern contraceptives: Survey findings revealed that at primary service delivery points/health facilities (HF), 84.3% offered at least three modern contraceptive methods. For secondary and tertiary level HFs, 62.5% could offer at least five modern contraceptives. Most frequently available method was OCP (90%). Second method was “Injection” was 84%.

Availability of Maternal and RH medicines: Overall 48.6% of the HFs had available (by the time of the survey) all the seven including the two essential lifesaving maternal and RH drugs. Urban rural difference was significant (63% vs. 40%, P<0.001). Significant reduction of percentages of HFs which were available of seven essential RH medicine was noted (from 62% to 49%, P<0.001). Urban had more HFs which could provide & RH medicines than rual (63% vs. 40%, P<0.001). Two years comparison showed availabilities of all types of RH medicine (except misoprostol) were less in 2015 than 2014.

Incidence of No stock-out of the modern contraceptive methods: "No stock-out of a modern contraceptive" was defined in this study as a HF if it was situation of stock all modern methods (excluding male sterilization which is not legally authorized to HF for contraceptive purpose). If one HF was found stock-out (or not available to provide) of any one modern method (such as male/female condom, OCP, Injectable, ECP, IUD, Implant, Female sterilization) during the last six months, it was recognized as 'Stock-out". The findings show that 34.6% of HFs in this study was able to provide at least one modern contraceptive method during last six month. There was no obvious differential among different level of HFs.

Stock situation at the day of assessment showed that OCP, M condom, injectable and ECP were available at all regions. Implant and ECP were highrest stock-out (at the day of assessment) contraceptive methods. The rate for "at least one method stock-out" was higher for primary level HFs and total HFs in 2015 compared to 2014. Method specific stock-out rate comparisons showed that significant reduction for all methods except implant, F-sterilization and male condom.

Supply chain including Cold chain: "Pharmacist", "TMO" and "assigned MO" were main responsible person for drug indent. Quantifying the needs of 48% of tertiary HFs was made by medical depot. The main source of supplies of contraceptives was the Township Health Departments (48.9%), followed by the Central Medical Store (22.8%), State/Region Health Department (20.8%). 68% of the facilities in the rural area used the Township Health Department compared to 40.5% of the urban facilities used State/Region Health Departments. Most of HFs (>74%) at all levels had their own arrangement for transportation of supplies to their HFs. Government arrangement for the transportation for tertiary and secondary level HFs were only 26% and 11% respectively. Most of HFs especially secondary and primary levels stated that the interval between order and receipt was irregular (42% and 41% respectively). 40% HFs at tertiary level was estimated the interval as "1-2 months". Thirty-six percent of HFs described the interval of between-indents of supplies was "irregular". The irregularity was more pronounced in secondary and primary level HFs. (37% vs. 17%) One-third of HFs stated that the interval was "six-month" duration. Statement of six-month interval was higher in tertiary level HFs than secondary and primary level HFs (52% vs. 39% & 27% respectively). The SDPs with no cold chain included 39% in total. Availability of cold chain was higher in tertiary and secondary level HFs (100% & 84%) and too much less in primary level HFs (34%). The difference was statistically significant ($P<0.05$). Urban rural

difference of the availability of cold chain system was also markedly obvious (90% vs. 44%, P<0.001). More than 80% was electric system and less than 25% was ice box.

Staff training and supervision: About two third (66%) of HFs had trained staff for birth spacing services. However, HFs which had trained staff for implant was only 17%. Out of all HFs assessed, 58.7% had received supportive supervision. The HFs received the overall supervisory visits directly from the authorities, 23.3% of HFs received at every six to twelve months. Issues encountered during supervisory visits were described. Most frequent issue was identified as 'logistic". Second most-frequent issues were "reporting" and 'clinical treatment". The occurrences of issues were not different between levels of HFs.

Availability of Guidelines, checklists and job aids: Availability of guidelines was not more than 78%. Most frequently available guidebook was "Job aid for antenatal care" (77%) and "Guidebook for antenatal care" (68%). Regarding the guide for BS, 57% of HFs had "Checklist for BS". "National guidebook for BS" was available at 33% of HFs only. "Guide for waste disposal" was least available at only 21% of HFs.

Use of information Communication technology (ICT) and waste disposal: Ninety eight percent of HFs had ICT appliances. Three most frequently used ICT appliance were "Smart phone" (71%), "mobile phone" (64%) and "computer" (37%). Most frequent uses of ICT were "routine communication' (91%), "consultation" (66%) and "medical indent" (55%). For those three types of use, mobile phone and smart phone were utilized commonly.

Waste disposal: All HFs had their own arrangement for waste disposal. Among the various methods, most frequently used method was "burying" (44%). Secondly, it was "burning" (33%). Incineration method was used only by 8% of HFs.

Charges for user fees: Respondents from 23% of HFs stated there was user fees especially for "medicine" (92%) and "specialty services" (26%). Results show that majority of SDPs charge user fees for services provided by a qualified health care provider for Family Planning services, antenatal care services, delivery services, postnatal care services, newborn care services, HIV care, and caesarean section. Most of these fees are charged at primary and secondary SDPs.

Client's perception of family planning service provision: Clients were generally satisfied with the quality of services from FP providers. Favourable response for situation of clinic was in high rates. Most of visitors expressed that they were satisfied about cleanliness and privacy at the health center. Long waiting time at the health center was complained only by 8% of respondents.

Client's appraisal of cost of family planning services: About 11% said that they had spent some amount for medicine from the clinic (about 1500 kyats) and 7% had spent for to buy medicine from outside (about 1000 kyats). Charge for registration (median amount=500 kyats) was stated by 5% of clients. Total time spent for clinic visit for BS was about 25 minutes. These were ten minutes each for travel go and back, 5 minutes for waiting time. Of those clients who had assigned for their work during the clinic visit (55%) had to spend about 2000 kyats for the assignment. The payment was made mostly by their spouse (66%) and by themselves (31%).

Recommendations

A. Commodities supply

A1. Contraceptives

To decrease number of primary level HFs with stock-out short-term contraceptives, male condom, female condom and ECP should be distributed to the primary level HFs in the regions which have lowest availability of three modern methods (i.e. Kayah, Kayin and Rakkhine States)

Implant, IUD and male condom supplies should be more emphasized to secondary level HFs especially at rural (i.e. Station Hospitals) at Chin, Magway, Kachin and Mon to combat low percentage of availability of at least five modern methods. Implant method should be promoted to be available at all regions.

ECP shortage at Kayin, Chin, Bago, Magway and Naypyitaw was high. Supplies should be prioritized toward those areas.

Male condom shortage at tertiary level HFs should be reduced by continuum of supplies towards the areas (Kayin, Magway, Naypyitaw and Bago).

IUD supplies should focus to Kayin, Bago, Mon and Magway Regions which had high stock-out rate.

A2. RH Medicine

RH medicines with high stock-out rate were hydralazine, M-dopa, azithromycin, cefixime, nifedipine and Ca Gluconate. Ayeyarwaddy, Rakkhine, Shan (south) and Kayah areas which were low available for 7 essential life-saving RH medicine should be prioritized. Focus should be made to secondary and primary level HFs.

A3. Cold Chain

Health care providers should be informed about oxytocin injection should be kept in cold chain together with TT injection and a policy brief should be used by MOH to all levels of health facilities.

Availability of cold chain was low in primary and secondary level HFs especially at rural areas. Ayayarwaddy, Kayah and Chin were lowest available area for cold chain. Cold chain equipments supplementation should be considered giving priority to the specified. Type of cold chain system should be in line with source of electricity available in the area.

A4. Waste Disposal

Mini-incinerators should be supplied for station hospitals, primary level HFs.

B. Logistic and Supply Chain Management System

B1. Training

Logistic management skill training should be enhanced and expanded its coverage based on availability of infrastructure and programme needs in terms of geographical area and level of HFs.

For future SC management trainings Pharmacists should be prioritized to attend since they are taking responsibility for drug indent. Quantifying amount and items should be based on HFs' utilization data rather than medical depot's stock status. Standard form for indent including identifying and quantification of amount need should be developed and distributed toward all areas and all levels of HF (special emphasis on Station Hospitals and primary level HFs) for improving need-based supply system.

Training, staff assignment, service availability and commodities supplies should be harmonized. BS and implant training sessions should be conducted more in Sagaing, Shan (east), Tanintheri, Shan (north) and Rakkhine especially at secondary and primary level HFs. Guidebooks for birth spacing should be distributed more to secondary and primary level HFs especially to Sagaing, Tanintheri, Magway, Shan East and Kachin).

B2. Sypply system

Commodities sypply system should be developed efficiently for timely distribution of commodities at targeted sites.. Development of a system should be in coordination with multi-level and multi-dimensional stakeholders from different regions and it should be specified about route, frequency, transportation, time schedule.

B3. Policy advocacy

Service availability for female sterilization at secondary level HF was relatively low level than tertiary level HFs.

Implant method provision at secondary level HFs should be promoted simultaneously with supplies and skilled training and community awareness raising activities.

Strengthening supply chain and logistic management to be more comprehensive and considering sustainability and self-reliance of State/Regions Health Department

Enforcement for commodities supplies system to be more systematic in calculation, distribution and monitoring based on needs synchronizing different levels

Nationwide LMIS system should be developed with advanced information and communication technology. Unexpensive Smart phone and Tablets, specially developed user friendly software for LMIS are appropriate for HFs at rural and hard-to-reach areas.

Standard operating procedure for national LMIS system should be developed and trained BHS to be applied

To improve policy and regulatory environment that contributes to enhancement of Reproductive Health Commodity Security

To ensure that more than one staff has the ability to make the orders to cater for periods when another staff is either on leave, sick or when they leave the facility.

C. Monitoring and Evaluation

Matters related to RH medicine, contraceptive commodities stock and resupply should be a priority agenda item for all regular supervisory and monitoring visits of regional and township health authorities.

RH medicine and Contraceptive commodities tracking information gathering should be combined into existing HMIS system. Key tracer variables should be identified from existing data source by more detail analysis.

There should be systematic expansion of RHCS in a phased manner to cover the whole nation. Significant changes in the reproductive health commodity security can only be seen when segmented efforts are harmonized and logically sequenced.

The collection, analysis, availability, use and distribution of logistics data for evidence-based decision making at all levels should be strengthened.

Module II (Client's Interview) should be modified in some portions like sample size and sampling and data collection procedure without much affecting the result in linking to Module I (Facility assessment) results.

PART I

Introduction

Background of the assessment

Improving maternal and child health is a global priority. An estimated 1 000 women – most of them in developing countries– die every day due to complications related to pregnancy or childbirth. In Myanmar according to the Census 2014 8 women die every day due to child birth. Many of these deaths are preventable or treatable if there should be access to quality services, contraceptives and medicines. The access and availability of medicines at public health facilities are limited in many areas. In this case, exact information about the limitations in terms of geographical areas, types of services and logistic items are essential. From 2010 to 2012 UNFPA, through the UNFPA Supplies Programme, formerly the Global Programme to enhance Reproductive Health Commodity Security (GPRHCS), has supported the conduct of an annual survey on the availability and stock-out of contraceptives and maternal health medicines in 12 GPRHCS Stream 1 countries. Myanmar became one of the 46 GPRHCS focus countries in 2013. In 2014, a nation-wide survey across public health services with a representative sample of 408 health facilities over all states and regions was undertaken to: 1) To assess availability, utilization and supply chain management system for RH commodities at different levels of health facilities, 2) To assess quality of RH services with emphasis on family planning in terms of training, supervision, use of guidelines and ICT, and 3) To determine clients' accessibility to RH services provided at different level of facilities. The focus of the past survey was on three outcome indicators in the monitoring and evaluation framework of the GPRHCS which focused on a) Service Delivery Points (SDPs) offering at least three modern methods of contraceptives; b) 7 life-saving maternal/RH medicines (Magnesium Sulphate and Oxytocin plus any other five) from the WHO list available in all facilities providing delivery services; c) 'no stock outs' of contraceptives within last 6 months. The assessment has revealed that while most health facilities have access to supplies,

they have experienced stock-outs in the past six months.[1] This current 2015 survey was conducted to identify any changes or improvement during the period of implementation and to monitor the enforcement of logistic management of various partners and to identify other key issues especially for family planning service delivery.

Country background information

Myanmar is also one of the world's most diverse countries, with a rich history and a wealth of cultural and religious traditions, and as many as 135 different ethnic groups. The population of Myanmar on 29th March was 51,419,420 persons. The population density is 76 persons per square kilometer and about 30% resides in urban areas. The larger urban populations concentrated in Yangon and Mandalay. Administratively, Myanmar is divided into seven states, seven regions and one union territory (Nay Pyi Taw). The states - Chin, Kachin, Kayah, Kayin, Mon, Rakhine, and Shan - cover mainly the upland areas and are largely populated by national races/ethnic communities. The regions - Ayeyarwady, Bago, Magway, Mandalay, Sagaing, Tanintharyi, and Yangon - are situated mainly on the plains with a population of predominantly Bamar origin.[2] It consists of 74 Districts, 330 Townships, 398 Towns, 3065 Wards, 13,619 Village Tracts and 64,134 Villages. Great diversity exists between the regions due to the rugged terrain in the hilly north which makes communication extremely difficult. In the southern plains and swampy marshlands, there are numerous rivers and tributaries of these revers criss-crossing the land in many places. About (89.4%) of the population, mainly Bamar, Shan, Mon, Rakhine and some Kayin are Buddhists. The rest are Christians (4.9%), Muslims (3.9%) Hindus (0.5%) and Animists (1.2%).[3] Development of social sector has kept pace with economic development. Expansion of schools and institutes of higher education has been considerable especially in the Regions and States. Expenditures for health and education have raised considerably, equity and access to education and health and social services have been ensured all over the country. Twenty four special development regions have been designated in the whole country where health and education facilities are developed or upgraded along with other development activities.[3] The Ministry of Health is the key player in promoting and maintaining health of people while some ministries are also involving in improving health of population by establishing social security scheme and producing medicines and therapeutic agents. Considerable achievements have been made in

[1] 2014 Facility Assessment for RH Commodities and Services in Myanmar. Department of Medical Research/Department of Public Health/UNFPA
[2] The MIMU. http://www.themimu.info
[3] Health in Myanmar, 2014. MOH

the health sector with the guidance and support of the State, efforts of health professional and workforce and collaboration of national and international partners. Social and voluntary organizations in the country have invested much of their time and efforts to collaborate with the Ministry of Health.

Rationale

The UN General Assembly's special session on the ICPD pledged the member States "to protect people—especially women and girls—to eradicate extreme poverty, protect the rights and dignity of all people and secure the future of our planet for generations to come." Women, girls and children have access to sexual and reproductive health services, including family planning, with significant overall impacts on their health in the 20 years since the historic Programme of Action. By 2014, 84 countries had logistics management systems for supplies and distribution of contraceptives, enabling more women to gain access to them. 2014 has shown much progress but many global challenges still remain in collecting the data needed for evaluation.[4]

Maternal deaths have fallen by nearly half over the past 20 years but approximately 800 women still die every day from childbirth and the complications of pregnancy, and more than 220 million women still have unmet needs for modern contraception. As a result, Millennium Development Goal (MDG) 5 on maternal health is currently the farthest from attainment, and is unlikely to be met. Economic growth has lifted millions from poverty but has not reduced inequality, and the disparities are stark. Gender inequality remains one of the most pronounced forms of inequality, with the female half of the world's population owning only 1 per cent of the world's wealth.[5]

Most maternal and child deaths occur in low- and middle-income countries. Effective interventions exist for improving reproductive, maternal, newborn and child health and preventing those deaths. The challenges are to implement and expand those interventions, making them accessible to all who need them before and during pregnancy, childbirth and the early years of life, and to ensure the quality of care. Investing in women's and children's health will not only reduce mortality, but will also generate high health, social, and economic returns. These returns include greater gross domestic product growth through improved productivity, and prevention by 2035 of the needless deaths of 147 million children and five million women, as well as 32 million stillbirths. Ending preventable maternal and child

[4] Annual Report 2014. UNFPA
[5] The UNFPA Strategic Plan, 2014-2017

deaths shapes the ambitious agenda and challenge for the programme area. International partners continue support countries in meeting existing commitments made in global and regional initiatives to end preventable maternal and child death. They include, to end preventable deaths of newborn", to end preventable maternal mortality.[6]

Progress has been made in reducing maternal and child mortality. Between 1990 and 2012, maternal and child mortality was almost halved, with the greatest reductions occurring in the second half of that period. But each day about 800 women still die from pregnancy- or childbirth-related events. Each year, 6.6 million children die before their fifth birthday, about 44% of them during their first four weeks of life. Unmet sexual and reproductive health needs persist, with an estimated 222 million women having unmet needs for contraception and 499 million new cases of curable sexually transmitted infections occurring every year.

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

Post-partum haemmorhage (31%), eclampsia (11.2%) and abortion-related mortality (9.9%) remain the major causes of maternal deaths in Myanmar.[7] Three quarters of all maternal deaths occur during delivery and the immediate post-partum period. In addition to these direct causes of maternal mortality, a number of household and community level factors as well as social factors such as the nutrition of girls and women and women's educational levels; underpin the high levels of maternal mortality. Further contributing to maternal mortality are weak infrastructure, poor reach of health services and limited access to information.

At the end of 2015, UNFPA and its partners have joined forces to accelerate progress on MDG 5: to improve maternal health. MDG 5, the central focus of the work of UNFPA, calls for steep reductions in maternal mortality and universal access to reproductive health. UNFPA is the lead UN agency supporting the achievement of MDG 5. Given the slow progress in improving maternal health and a growing global commitment to the human rights of women and girls, achievement of MDG 5 has galvanized an outpouring of support– in the form of global, regional and country partnerships and initiatives, as. It emphasizes care

[6] SIXTY-EIGHTH WORLD HEALTH ASSEMBLY. A68/7. Provisional Agenda. WHO. 30-4-2015

[7] Nation-wide cause specific maternal mortality survey (2004-2005) UNICEF and Department of Health

during the 48 hours surrounding childbirth, when the lives of mothers and their newborns are at greatest risk, through four high-impact approaches: 1) Taking life-saving measures during and after birth; 2) Optimizing service delivery mechanisms that are already in place. 3) Increasing access to a choice of modern contraceptive methods, 4) Focusing on countries, places and circumstances where deaths are highest.[8]

UNFPA has provided it's Programme of Assistance to Myanmar since 2012 and UNFPA has used modify assistance to the government departments to implement the activities that contribute to the strategic priorities of promoting good governance and strengthening democratic institutions and rights under the United Nations Strategic Framework prepared by UN agencies and the Government. UNFPA is making its continued effort to strengthen and build its partnership with the departments in the area of strengthening national capacities for management and accountability of funds in order to increase the possibility of gradually and eventually shifting more towards utilizing national systems in the execution of development assistance.

The assessment focused on both the availability of RH commodities and salient aspects of service delivery facilities that underpin good RH programmes. In addition to assessing the availability and stock out of RH commodities, the survey addressed supply chain (including cold chain); staff training and supervision; availability of guidelines and protocols, Information Communication Technology (ICT), method of waste disposal and user fee. In addition, the survey also obtained the views of clients about the services. Information obtained from the survey could be useful for the country's endeavor towards better access to reproductive health commodities and for achieving universal access to reproductive health and improved maternal health.

[8] http://www.unfpa.org/millennium-development-goal-5-improve-maternal-health

Objective

General objective

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

Specific objectives

1. To assess availability, utilization and supply chain management system for RH commodities at different level of health facilities
2. To assess quality of RH services emphasis on family planning in terms of training, supervision, use of guidelines and ICT
3. To determine clients' accessibility to RH services providing at different level of facilities

Research Methodology

Study design

Cross-sectional descriptive study design was used. All states and regions (administrative areas) were covered. Three levels of health facilities which were providing reproductive health services including family planning, maternal care and treatment of reproductive tract infections were included. The clients of the respective facilities were also interviewed. Data collection activities were carried out during May and August of 2015.

Sampling procedure,

The survey considered the following broad categories of Service Delivery Points (Health Facilities) that provide modern methods of contraceptives and maternal/RH services as stratums:

a) Primary Level Facilities (Rural Health Centre, Urban Health Center and Maternal & Child Health Center)[9]
b) Secondary level Facilities/Hospitals (Station or Township Hospital without ObGy Specialist)
c) Tertiary level Hospitals (District/State/Region Hospitals and Hospitals with ObGy Specialist)

The list of all service delivery points (providing Family Planning and Maternal Health services) in each of the administrative units of the country was taken from MRH/DoPH. This list served as a frame for the selection of samples.[10] Then, Health facilities (HFs) that could provide modern contraceptives were summarized by area and level. This was used for determination of sample size (number of HFs by administrative regions).

State/Region	Number of Tertiary Hospitals	Number of secondary level HFs	Number of primary level HFs
Kachin	4	47	87
Kayar	2	14	34
Kayin	4	29	69
Chin	3	21	68
Sagaing	9	97	239
Tanintheri	3	29	58
Bago	4	96	187
Magwe	6	70	204

[9] In Myanmar, there were two levels in the primary HF (i.e. Rural Health Center and sub-RHC). Under the administration of one RHC, there was about 5-6 sub-RHCs in which one midwife for each is posted. Sub-RHCs are closely supervised by RHC for commodities and services to be in same fashion. Due to this clustering effect, situation of the RHC was representative to the situation of sub-RHCs under its administration. In every RHC, one sub-RHC was attached and providing services to the main villages covered by the RHC. Regarding to these reasons, sub-RHCs were not included in the sampling methodology as another level (4th Level sampling).
[10] Annual Hospital Statistics Report 2013, DHP, MOH

Mandalay	11	67	154
Mon	2	29	85
Rakkhine	3	49	132
Yangon	11	54	154
Shan South	3	54	104
Shan North	5	56	92
Shan East	4	23	39
Ayeyarwaddy	6	95	266
Nay Pyi Taw	1	16	31
Total	81	846	2003

Again, all HFs were listed and unique number was assigned and this list was used for sampling frame.

The total sample should contain a minimal number of each level of facility to support good estimation of the parameters of the population. The following formula is used:

The formula adopts an approach that gives large (tertiary and secondary) facilities a higher probability of inclusion in the survey because of their small number and provides a guide for choosing a sample of the primary facilities.

Step 1) Calculate relative proportion for the types of SDPs

The relative proportion for Tertiary level SDPs is calculated as follows:

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

	Tertiary level HFs	Secondary level HFs	Primary Level HFs	Total
Number of SDPs	81	846	2003	2930
Relative Proportion	0.027645	0.288737	0.683618	0.027645

Step 2) Apply the formula above to obtain the minimal sample size for each Type of HFs

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

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

P= relative proportion

D=0.07[11], Z=1.96

Confidence Interval and Confidence Limit	Minimal Sample Size of Service Delivery Point			
	Tertiary level	Secondary level	Primary Level	Total
[95% confidence interval (Z = 1.96) and 10% confidence limit (d = 0.07)	23	161	172	356

Step 3: Correction for abnormal-oversize samples

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

Step 4: Distribution of Sample Sizes for Administrative Units

To distribute total sample size for each category of HFs among the administrative units, the relative proportions for each domain was made from the calculation where the region-wise and level-wise total HFs was divided mathematically by level-wise total HFs. Then these proportions were multiplied with required number of total HFs in each level.

Required numbers of HFs were as in the following table;

Administrative Sub Region	Category of Service Delivery Point			
	Tertiary level	Secondary level	Primary Level	Total
Kachin	1	9	7	17
Kayar	1	3	3	7
Kayin	1	5	6	12
Chin	1	4	6	11
Sagaing	2	18	20	40
Tanintheri	1	6	5	12
Bago	1	19	18	38
Magwe	2	13	17	32
Mandalay	3	13	13	29
Mon	1	5	7	13
Rakkhine	1	9	11	21
Yangon	3	10	13	26
Shan South	1	11	9	21
Shan North	1	11	8	20
Shan East	1	4	3	8
Ayeyarwaddy	2	18	23	43
Nay Pyi Taw	0	3	3	6
Total	**23**	**161**	**172**	**356**

Finally, systematic sampling method was used to select the HFs based on the list (sampling frame). The list of sample HFs was described in the coordination meeting with local regional

[11] Due to reduction of total budget for 2015 activities, the number of health facilities for field survey (sample size requirement) was adjusted accordingly. Not to severely affected the representativeness of the sample size, the precision (D) in the calculation was adjusted from routine value (0.05) to (0.07). Due to this adjustment, the precision of every calculated proportion (percentages) are less précised than last year (2014) report.

health authorities for security assurance. In case of security concern, some HFs in their areas were replaced with second HF from the list, after discussion and getting agreement of concerned UNFPA National Programme Officer. Replacement was less than 5% of total sample size and thus the representativeness was not severely affected.

Questionnaire

There is a generic standardized questionnaire for the survey version 2014 and it was translated and re-formatted for convenience and easy understanding of survey team of DMR-POLB. Questionnaire has two parts. Some of the information given by interviewee was verified by interviewer using observation of relevant evidences and records available in the facility. See Annex 1&2.

Field work/data collection

Face-to-face interview using structured questionnaire was used to collect data. DMR-POLB organized a one-day coordination meeting at DMR-POLB in Mar 2015 with health authorities from state/regional health departments as the survey covered all states and regions. The objectives of the meeting were to advocate local health authorities on the survey, to discuss on the recruitment of local field supervisors, to draw field data collection schedule and to determine the roles and responsibilities of local authorities in the supervision process. Emphasis was placed on the quality of the survey and participants actively discussed on the level and number of supervisors to be assigned at state/regions, service delivery points to be surveyed, financial issues and timeline for field works and supervision. It was confirmed that 23 tertiary, 161 secondary, 172 primary level HFs, totaling 356 were covered.

Enumerator training was conducted in May 2015 for two days duration. Since the survey is a nation-wide survey, research assistants recruited from DMR-POLB attended the training. Twenty-five field enumerators, (15) technical supervisors (team leader) and (4) investigators attended the training sessions. Pilot testing on field activities was carried out at five HFs (including one district hospital, one station hospital, one MCH and two RHC covering three levels of HFs) in Pyin Oo Lwin Township. The data collection started in May 2015 simultaneously in all state/regions under close supervision of local administrative supervisors and DMR-POLB technical supervisors. Data collection activities for the last area (Ayeyarwaddy delayed due to flood disaster) were completed in Aug 2015.

During the interview process in most health facilities, an informant for all aspects about commodities (who was assigned by authorized person), mainly responded. However, if some

information were needed to be verified or if the person could not answer clearly, another informant was invited and requested to respond. So, there were more than one respondent in the interview at most of HFs.

Data analysis

Data entry was made using EpiData software. Data analysis was done in SPSS after transfer of the EpiData record file into SPSS format. Descriptive analysis was mainly used. Frequency tables were mainly described in accordance with the list of dummy tables described in the guideline document. Proportions and percentage were described in combination with graphical display appropriately.

Ethical consideration

Prior permission from central authorities was taken first because the report would disclose the country's situation and weaknesses in the health services provision. Informed consent from local authorities of the facility was made according to the guidelines of Department of Medical Research Ethics Review Committee. Report did not uncover individual facility's information. Permission for dissemination and printing of report from MOH was taken properly. Sharing of information and dissemination of the report would be beneficial for service providers, programme manager, policy makers and donor agencies as the findings can be utilized for evidence based and informed decision making in provision of relevant implementation activities in the respective areas.

Success and challenges of the study

According to the last year experience, we expend the data collection period across two quarters (Q2&Q3). Since we have more time for; arrangement, survey duration, recollection and checking of forms and expenditure statements, there were quite convenient and less administrative constraints. We used DMR staff as survey enumerators, they were easier to train and were supervised closely. All recruited persons from States/Regions are assigned as field supervisors. They are more efficient in arrangement of field travel, coordination with providers of selected health facilities. Thus the data collection activities are smoother and could be finished as plan period.

Field works in Rakkhine State were carried out in difficult situation due to heavy rain and storm alert. Thus, travel plan in some areas were rearranged with permission of DMR supervisor and local supervisors resulting travel days and travel routes to be longer duration. Similar situation was also faced in Ayeyarwaddy Region as there was flood disaster during

the trip causing travel constraint for passing affected area to reach target health facilities. Although the trip plan was changed, the team did not alter the sample HFs to another one. Field visit to that HFs were finished after the disaster situation became stable. Given the time required to complete all administrative and financial procedures, the data collection activities could be started only in mid-2015 although it was aimed to be a 2014 survey.

For the clients' interview, there was weakness in selection due to limitation of time. Selection bias caused the results showing much satisfactory for existing service provision. Modified methods of data collection for Module II of this assessment methodology should be considered not to disturbing facility assessment (Module I) and its time schedule.

PART II

Summary of the national protocols

Maternal and Reproductive Health in Myanmar

The Ministry of Health has been planning and implementing the interventions to improve the health status of mothers, newborns and children by reducing maternal, neonatal and child mortality and morbidity. Core strategies include; 1) Setting enabling environment; 2) Improving information base for decision making; 3) Strengthening health systems and capacity for delivery of reproductive health services; and 4) Improving community and family practices. Along with past years of implementation, MoH recognized many things to do more for targeted achievements in MNCH.

Standard frequency of antenatal care for all pregnant mothers is at least four visits with quality care by skilled birth attendants and targeted antenatal care interventions need to be strengthened. The standard skill and attitude towards good antenatal, intra-natal and postnatal care is mandatory in both facility-based and primary health care setting. To prevent unsafe abortion, quality birth spacing services plays a major important role and it needs to be expanded in all townships. It points out that Emergency Obstetric Care facilities and activities including Comprehensive and Basic Emergency Obstetrics Care (CEmOC and BEmOC) are needed to be strengthened. The Ministry of Health aims to assign one midwife in one village.[12] But, there is scarcity of resources and DOH will train auxiliary midwife to assign them in the village with absence of midwife. Maternal and Child Health care will be improved by giving the trainings, refresher trainings, provision of supply, monitoring and supervision of health volunteer under the guidance and coordination of Township Medical Officer. It is a real challenge that limited access of the people to the Maternal and Child Health (MCH) services and information especially in rural remote areas. Delay referral of mothers and newborn need to be overcome by community based or innovative interventions. Volunteers namely: Maternal and Child Health Promoters (MCHPs) were developed at the community level to enhance community initiative for the maternal and child health promotion with defining their roles as “Bridging mothers to health care providers”.[12]

In 2007, delivery by skilled birth attendants was estimated at 67% with regional disparities. It increased to 71% in 2010. The content and quality of service provision assessed in national or local surveys indicate that; 73% antenatal care coverage, 84% measles immunization

[12] Health in Myanmar 2014. The Ministry of Health, Myanmar

coverage and 66% demand for FP satisfied.[13] Although training of service providers mainly midwives, has taken place extensively, the other components that contribute to quality in service delivery need strengthening: supplies and logistics, equipment and infrastructure, monitoring and supervision and incentives to retain health staff in under-served areas. On the demand side, the knowledge of clients and families and affordable good quality services need to be addressed.

The Ministry of Health has to focus on improving quality within the health sector as an explicit area of work. This will build upon work already being undertaken. Such work include: 1) Financing to improve quality of midwifery services, 2) Strengthening of township health department supervision and monitoring of services across areas where 3MDG is providing financing support, 3) On-the-job training and capacity building of basic health staff, and 4)Strengthening linkages between skilled midwives and auxiliary midwives to enhance quality and strengthen the continuum of care.[14]

National Health Plan for Maternal and Reproductive Health

National Health Plan (2011-2016) aims to reduce morbidity, disability and mortality through the life span including those of mothers, neonates and children and improvement in overall health status by providing services, improving coverage and accessibility, integrating services and community participation. Since NHP prioritized for maternal health in strengthening services and quality, most of targeted activities were skill training for basic health staff in townships with regular year-by-year expansion of training sessions to townships. Training included obstetric care including emergency care, neonatal care, IUD insertion and post-abortion care. Within the last five years, some training sessions targeted 100-200 townships, but some sessions could cover only less than 100 townships. Regarding to BS, IUD insertion training targeted for less than 15 townships only. Documented formal training for other contraceptives especially implants and logistic management were not found.[15]

Strategic Plan for Reproductive Health[16]

The Strategic Plan on Reproductive Health laid down based on the National Population Policy (1992), the National Health Policy (1993), which was followed by formulation of the Myanmar Reproductive health Policy (2002). The National Comprehensive Development

[13] Myanmar Country Profile 2014
[14] http://www.3mdg.org/what-we-do/maternal-newborn-and-child-health/programme-areas/item/673-service-quality-improvement-for-mnch (retreived at 8-11-15)
[15] National Health Plan (2011-2016). Ministry of Health, Myanmar
[16] Five-Year Strategic Plan for Reproductive Health (2014-2018). Department of health, Ministry of Health, Myanmar

Plan – Health Sector (2010-2011 to 2030-2031) and the National Health Plan (2011-2016) are the overarching frameworks for the Strategic Plan on Reproductive Health (RH). The Policy and Strategic Plan of the Ministry of Health are national response to the ICPD PoA and the United Nations MDGs. Building on the momemtum, the 2014-2018 Strategic Plan also responds to the UN Secretary General's Global Strategy for Women and Children's Health (2010).

The essential package of RH interventions at all levels of health facilities provides continuous care across life cycle and from home to hospital. On-going activities are expanded and additional services are introduced in the Basic Health services of the public sector. The strategies and key activities for effective implementation are as follows: 1) Strengthening health systems to enhance the provision of an essential package of RH interventions, 2) Increasing access to quality, integrated RH services at all levels of care, 3) Engaging the community in promotion and delivery of RH, 4) Incorporating gender perspectives in the RH Strategic Plan, and 5) Integrating RH in humanitarian settings. With a broad muilti-sectoral approach, the RH Programme is collaborating with other departments and divisions under MoH and partnering with other ministries, professional associations, academia, United Nations Agencies, bilateral donors and civil society organizations including NGOs.

Guidelines and laws which underline the provision of contraceptive and maternal/RH commodities

Policy guidelines for health service provision and development have also been provided in the Constitutions of different administrative period. In Article 18, it described as the Union shall enact the necessary law to enable National people to participate in matters of their education and health. In Article 32, it described that the Union shall care for mothers and children.

As part of fulfilling the responsibility to improve and protect health of the citizens the government has enacted some health laws. Majority of current health laws are found to be related to the public health law promulgated in 1972. Existing health laws may be categorized as; health laws for promoting or protecting health of the people, health laws concerned with standard, quality and safety of care and laws relating to social organization.

The National Health Committee (NHC) which was formed on 28 December 1989 as part of the policy reforms, is a high level inter-ministerial and policy making body for health matters. The NHC takes the leadership role and gives guidance in implementing the health

programmes systematically and efficiently. The high level policy making body is instrumental in providing the mechanism for intersectoral collaboration and coordination, guidance and direction for all health activities. The National Health Policy was developed with the initiation and guidance of the NHC in 1993 and it has placed the *Health For All* goal as a prime objective using Primary Health Care approach.

Considering the rapid changes in demographic, epidemiological and economic trends both nationally and globally, a long-term 30 years health development plan had been drawn up to meet the future health challenges. Since 1991, the Government of Myanmar has adopted a policy of making contraceptives available in the public sector. By early 1996, birth spacing activities were taking place in 33 townships, provided COCs, DPMA and condoms at primary level HFs. IUD insertions are undertaken at township hospitals, maternal and child health centers and some rural health centers. Contraceptive users paid a user charge as part of a cost recovery scheme previously. The birth spacing services expanded with intensive training and refresher training among providers, implementation of birth spacing management information system, collaboration with partner organizations and development of IEC materials. Female sterilization was provided in most township hospitals only if prior official approval has been obtained. Male sterilization is legally available only to those whose wives cannot undergo female sterilization because of possible adverse health consequences. Injectable contraceptive can be purchased at most drug stores by health staff as well as clients without any prescription.[17]

[17]UNDP/UNFPA/WHO-HRP/World Bank. An Assessment of Contraceptive Method Mix in Myanmar. 1997

PART III

Findings

Sample Health Facilities (HFs) in the study

Table A. Sample HFs by Regions

		Health Facility Level			
		Tertiary	Secondary	Primary	Total
State/Region	Kachin	1	9	7	17
	Kayah	1	3	3	7
	Kayin	1	5	6	12
	Chin	1	4	6	11
	Sagaing	2	18	20	40
	Tanintheri	1	6	5	12
	Bago	1	19	18	38
	Magway	2	13	17	32
	Mandalay	3	13	13	29
	Mon	1	5	7	13
	Rakkhine	1	9	11	21
	Yangon	3	10	13	26
	Shan (South)	1	11	9	21
	Shan (North)	1	11	8	20
	Shan (East)	1	4	3	8
	Ayeyarwaddy	2	18	23	43
	Naypyitaw	0	3	3	6
Total		23	161	172	356

As described in the previous section for sampling and sample size, numbers of HFs were distributed proportionately to the level of facilities and administrative regions.

Table B. Sample HFs by Urban/Rural

		Urban/Rural		
		Urban	Rural	Total
State/Region	Kachin	6	11	17
	Kayah	2	5	7
	Kayin	6	6	12
	Chin	2	9	11
	Sagaing	15	25	40
	Tanintheri	4	8	12
	Bago	8	30	38
	Magway	8	24	32
	Mandalay	8	21	29
	Mon	5	8	13
	Rakkhine	10	11	21
	Yangon	19	7	26
	Shan (South)	13	8	21
	Shan (North)	9	11	20
	Shan (East)	5	3	8
	Ayeyarwaddy	8	35	43
	Naypyitaw	3	3	6
Total		131	225	356

Selected HFs in Yangon Regions included Urban Health Centers and MCH clinics as primary level HFs. Some of Station Hospitals were also located at urban rather than rural context. Similarly, all selected secondary level HFs in Shan (East) were located in urban setting. Thus, the proportion of HFs at urban was higher than that of rural in those two regions.

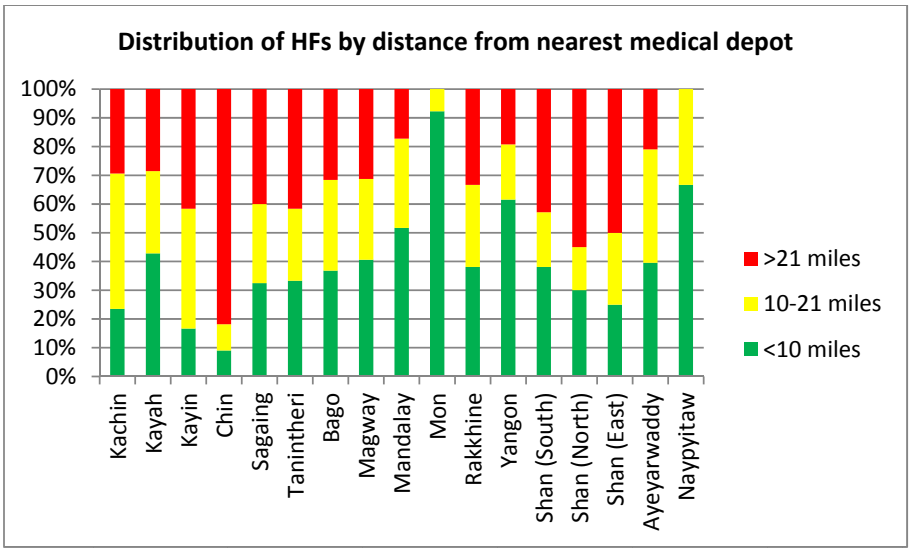


Figure 1. Sample HFs by Distance to nearest medical depot (mile)

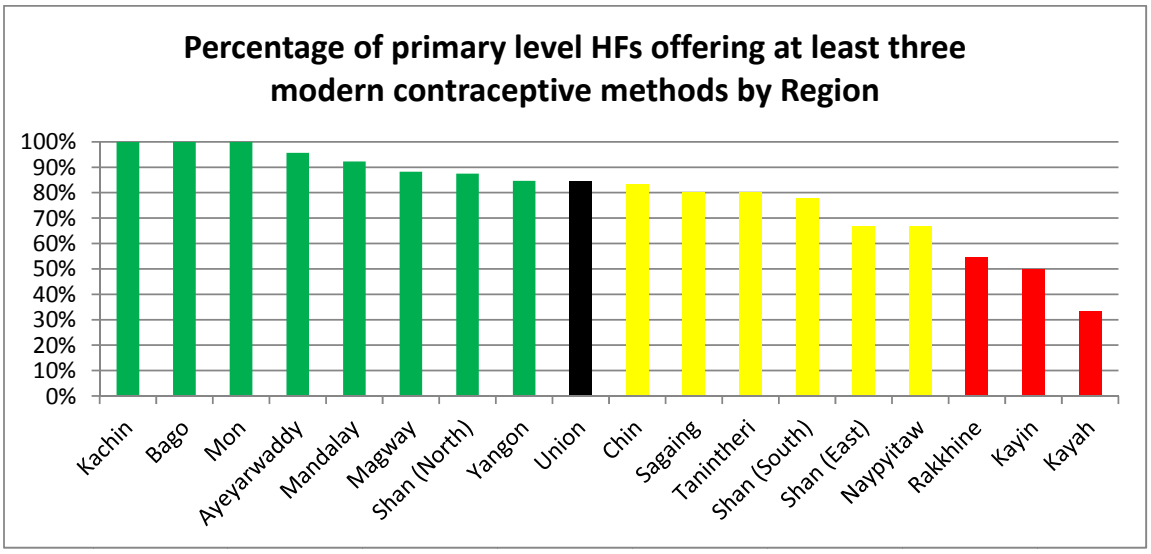
Figure shows majority of HFs in Mon, Yangon, Mandalay and Nay Pyi Taw were located at less than 10 miles away from nearest medical depot. Majority of HFs at Chin, Shan (N) and Shan (E) were located at more than 21 miles away from the nearest medical depot.

Section A1. Modern contraceptives offered by primary facilities

Table 1a. Percentage distribution of service delivery points offering at least three modern contraceptive methods by primary HFs

			Providing at least three modern contraceptive methods		
			No	Yes	Total
Type of Health Facility	MCH	Freq	2	4	6
		%	33.3%	66.7%	100.0%
	RHC	Freq	24	138	162
		%	14.8%	85.2%	100.0%
	UHC	Freq	1	3	4
		%	25.0%	75.0%	100.0%
Total		Freq	27	145	172
		%	15.7%	84.3%	100.0%

Primary level HFs were considered as be essential to have “three” modern contraceptives rather “five” which was especially essential for secondary and tertiary level HFs. Out of total 172 primary level HFs, 84% were providing at least three modern contraceptive and majority was fulfilling basically required services for birth spacing. Proportion for providing 3 modern contraceptive methods in RHCs was less than that of UHC/MCHs, but it was not statistically significant (P>0.05).



Green colored areas are higher than Union percentage. Yellow and red colors indicate areas lower than Union percentage.

Figure 2. Percentage distribution of primary level HFs offering at least three modern contraceptive methods by Region

It was noted that 84% of all primary level HFs could provide at least three modern contraceptive methods. Rakkhine, Kayin and Kayah areas were identified as least percentage of primary level HFs which could provide at least three modern contraceptive methods.

Table 3a. Percentage distribution of service delivery points offering at least three modern contraceptive methods by urban/rural

			Providing at least three modern contraceptive methods		
			No	Yes	Total
Urban/Rural	Urban	Freq	3	13	16
		%	18.8%	81.3%	100.0%
	Rural	Freq	24	132	156
		%	15.4%	84.6%	100.0%
Total		Freq	27	145	172
		%	15.7%	84.3%	100.0%

More than 80% of primary level HFs in both urban and rural strata, was providing at least three modern contraceptive methods. The differences between urban and rural (81% vs. 85%) was not statistically significance (Chi2 test P=0.725).

Table 5a. Percentage distribution of HFs offering at least three modern contraceptive methods by distance from nearest medical depot

			Providing at least three modern contraceptive methods		
			No	Yes	Total
Distance to nearest medical depot (mile) (group)	<10 miles	Freq	12	87	99
		%	12.1%	87.9%	100.0%
	10-21 miles	Freq	9	39	48
		%	18.8%	81.3%	100.0%
	>21 miles	Freq	6	19	25
		%	24.0%	76.0%	100.0%
Travel duration to nearest med depot	Within a day	Freq	27	144	171
		%	15.8%	84.2%	100.0%
	Within a week	Freq	0	1	1
		%	0.0%	100.0%	100.0%
Route to travel to nearest med depot	Road	Freq	26	136	162
		%	16.0%	84.0%	100.0%
	Water	Freq	1	9	10
		%	10.0%	90.0%	100.0%
Total		Freq	27	145	172
		%	15.7%	84.3%	100.0%

Availability of at least three modern contraceptive methods in primary level HFs was not associating with distance, travel duration and route to travel to nearest medical depot from the HF.

Section A2. Modern contraceptives offered by secondary and tertiary facilities

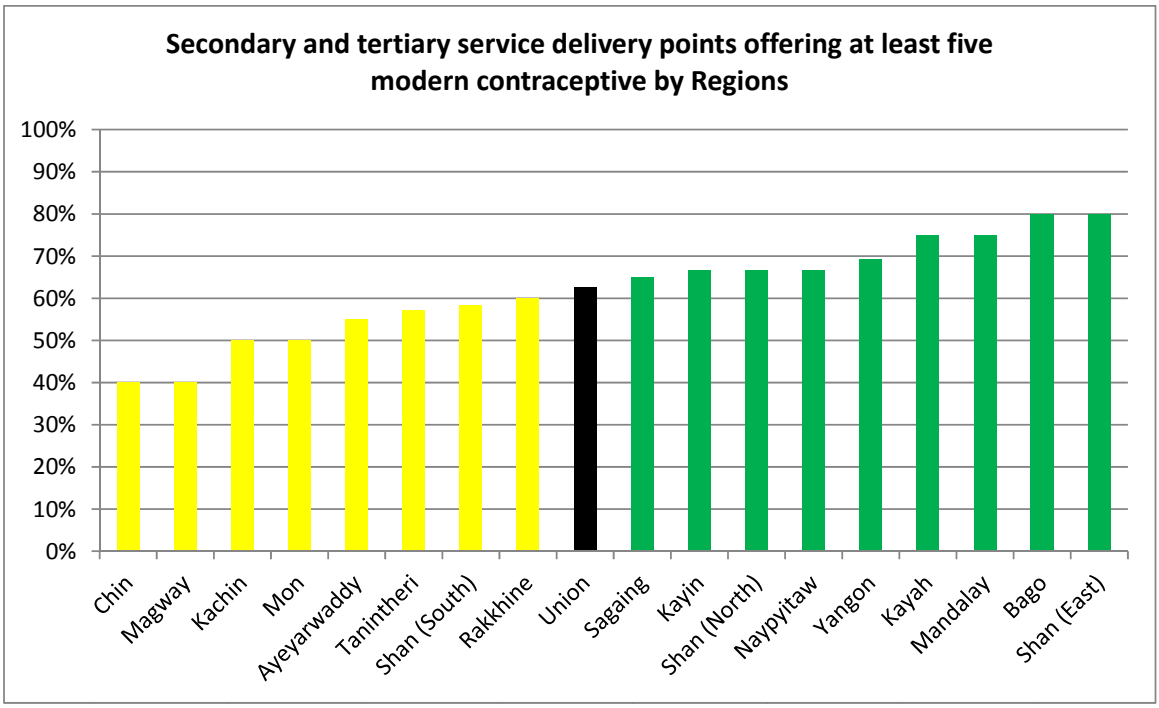
Table 1b. Percentage distribution of secondary and tertiary service delivery points offering at least five modern contraceptive by level of HFs

			Providing at least five modern contraceptive methods		
			No	Yes	
Type of Health Facility	Tertiary	Freq	5	18	23
		%	21.7%	78.3%	100.0%
	Secondary	Freq	64	97	161
		%	39.8%	60.2%	100.0%
Total		Freq	69	115	184
		%	37.5%	62.5%	100.0%

Not like in primary level HFs, lower percentage (63%) of availability of at least "five" modern contraceptive methods was found in secondary and tertiary level HFs (63% vs. 84%, P<0.001). When these two levels of HFs were stratified, lowest percentage was found in Secondary level HFs (62.5%). The higher percentage was in Tertiary Level HFs (78.3%).

Table 2b. Percentage distribution of secondary and tertiary service delivery points offering at least five modern contraceptive by Regions

			Providing at least five modern contraceptive methods		
			No	Yes	Total
State/Region	Kachin	Freq	5	5	10
		%	50.0%	50.0%	100.0%
	Kayah	Freq	1	3	4
		%	25.0%	75.0%	100.0%
	Kayin	Freq	2	4	6
		%	33.3%	66.7%	100.0%
	Chin	Freq	3	2	5
		%	60.0%	40.0%	100.0%
	Sagaing	Freq	7	13	20
		%	35.0%	65.0%	100.0%
	Tanintheri	Freq	3	4	7
		%	42.9%	57.1%	100.0%
	Bago	Freq	4	16	20
		%	20.0%	80.0%	100.0%
	Magway	Freq	9	6	15
		%	60.0%	40.0%	100.0%
	Mandalay	Freq	4	12	16
		%	25.0%	75.0%	100.0%
	Mon	Freq	3	3	6
		%	50.0%	50.0%	100.0%
	Rakkhine	Freq	4	6	10
		%	40.0%	60.0%	100.0%
	Yangon	Freq	4	9	13
		%	30.8%	69.2%	100.0%
	Shan (South)	Freq	5	7	12
		%	41.7%	58.3%	100.0%
	Shan (North)	Freq	4	8	12
		%	33.3%	66.7%	100.0%
	Shan (East)	Freq	1	4	5
		%	20.0%	80.0%	100.0%
	Ayeyarwaddy	Freq	9	11	20
		%	45.0%	55.0%	100.0%
	Naypyitaw	Freq	1	2	3
		%	33.3%	66.7%	100.0%
Total		Freq	69	115	184
		%	37.5%	62.5%	100.0%



Green colored areas are higher than Union percentage. Yellow and red colors indicate areas lower than Union percentage.

Figure 3. Percentage distribution of secondary and tertiary service delivery points offering at least five modern contraceptive by Regions

Table 3b. Percentage distribution of secondary and tertiary service delivery points offering at least five modern contraceptive by Urban/Rural

			Providing at least three modern contraceptive methods		
			No	Yes	Total
Urban/Rural	Urban	Freq	36	79	115
		%	31.3%	68.7%	100.0%
	Rural	Freq	33	36	69
		%	47.8%	52.2%	100.0%
Total		Freq	69	115	184
		%	37.5%	62.5%	100.0%

Urban rural difference (69% vs. 52%) was noted to be statistically significant (P=0.025).

Table 5b. Percentage distribution of secondary and tertiary service delivery points offering at least five modern contraceptive by distance to nearest medical depot

			Providing at least three modern contraceptive methods		
			No	Yes	Total
Distance to nearest medical depot (mile)	<10 miles	Freq	19	24	43
		%	44.2%	55.8%	100.0%
	10-21 miles	Freq	23	29	52
		%	44.2%	55.8%	100.0%
	>21 miles	Freq	27	62	89
		%	30.3%	69.7%	100.0%
Travel duration to nearest med depot	Within a day	Freq	68	110	178
		%	38.2%	61.8%	100.0%
	Within a week	Freq	1	5	6
		%	16.7%	83.3%	100.0%
Route to travel to nearest med depot	Road	Freq	65	104	169
		%	38.5%	61.5%	100.0%
	Water	Freq	4	11	15
		%	26.7%	73.3%	100.0%
Total		Freq	69	115	184
		%	37.5%	62.5%	100.0%

There was no significant association between geographical location and availability of five modern contraceptive methods in secondary/tertiary level HFs.

Section B. Availability of Maternal and RH Medicines

Table 6. Percentage distribution of service delivery points with seven (including 2 essential) life-saving maternal/reproductive by level of HFs

			Available 7 life-saving MR medicine (including MgSO4 & oxytocin)		
			No	Yes	Total
Health Facility Level	Tertiary	Freq	4	19	23
		%	17.4%	82.6%	100.0%
	Secondary	Freq	67	94	161
		%	41.6%	58.4%	100.0%
	Primary	Freq	112	60	172
		%	65.1%	34.9%	100.0%
Total		Freq	183	173	356
		%	51.4%	48.6%	100.0%

Availability of essential life-saving maternal and reproductive health medicine was 49% in total. And there was a significant difference among different levels of HFs (Chi2 P<0.001). The availability was highest in tertiary level (83%) and lowest in primary level (35%).

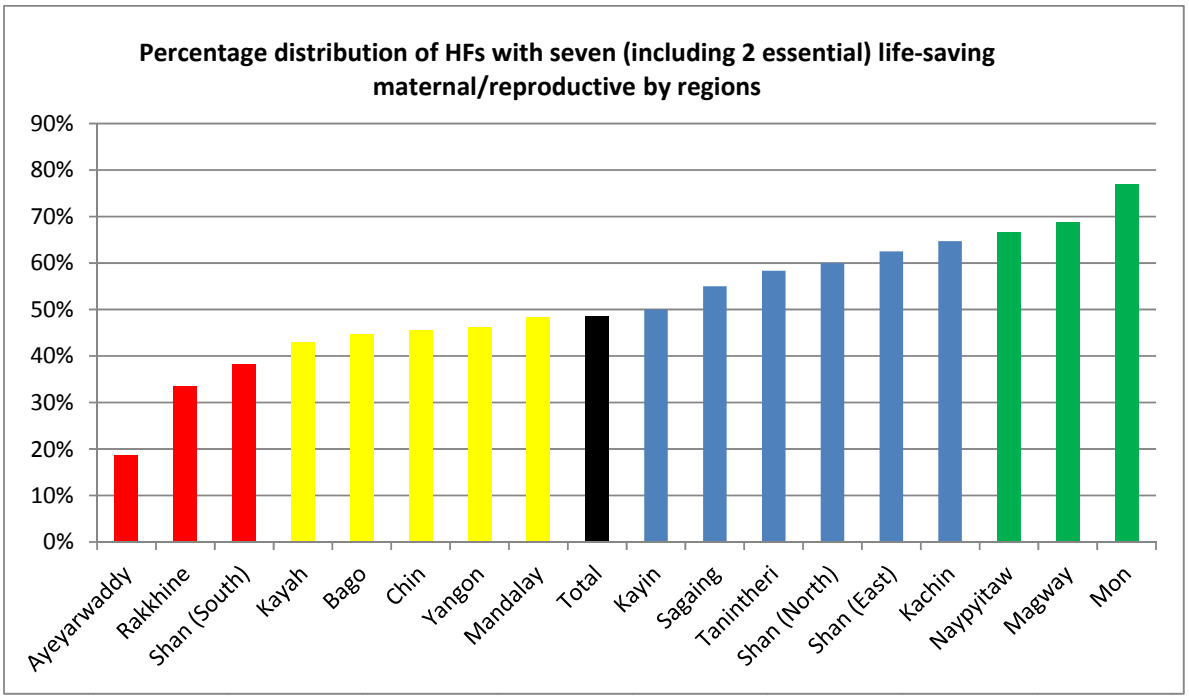
Table 6a. Comparison of RH medicine availability by level of HFs between two years' assessment

Level of health facility	Could provide at least 7 types of life saving medication		Chi-squared test P value
	2014	2015	
Tertiary/District Hospital	88.7%	82.6%	0.457
Township/Station Hospital	75.0%	58.4%	0.002
UHC/RHC/MCH	43.4%	34.9%	0.093
Total	61.8%	48.6%	<0.001

Comparison for all levels between two years showed significant reduction of percentages for availability of seven essential RH medicine (from 62% to 49%, P<0.001). Significant reduction was found in secondary and primary levels.

Table 7. Percentage distribution of HFs with seven (including 2 essential) life-saving maternal/reproductive by regions

			Available 7 life-saving MR medicine (including MgSO4 & oxytocin)		
			No	Yes	Total
State/Region	Kachin	Freq	6	11	17
		%	35.3%	64.7%	100.0%
	Kayah	Freq	4	3	7
		%	57.1%	42.9%	100.0%
	Kayin	Freq	6	6	12
		%	50.0%	50.0%	100.0%
	Chin	Freq	6	5	11
		%	54.5%	45.5%	100.0%
	Sagaing	Freq	18	22	40
		%	45.0%	55.0%	100.0%
	Tanintheri	Freq	5	7	12
		%	41.7%	58.3%	100.0%
	Bago	Freq	21	17	38
		%	55.3%	44.7%	100.0%
	Magway	Freq	10	22	32
		%	31.3%	68.8%	100.0%
	Mandalay	Freq	15	14	29
		%	51.7%	48.3%	100.0%
	Mon	Freq	3	10	13
		%	23.1%	76.9%	100.0%
	Rakkhine	Freq	14	7	21
		%	66.7%	33.3%	100.0%
	Yangon	Freq	14	12	26
		%	53.8%	46.2%	100.0%
	Shan (South)	Freq	13	8	21
		%	61.9%	38.1%	100.0%
	Shan (North)	Freq	8	12	20
		%	40.0%	60.0%	100.0%
	Shan (East)	Freq	3	5	8
		%	37.5%	62.5%	100.0%
	Ayeyarwaddy	Freq	35	8	43
		%	81.4%	18.6%	100.0%
	Naypyitaw	Freq	2	4	6
		%	33.3%	66.7%	100.0%
Total		Freq	183	173	356
		%	51.4%	48.6%	100.0%



Green and blue colored areas are higher than Union percentage. Yellow and red colors indicate areas lower than Union percentage.

Figure 4. Percentage distribution of HFs with seven (including 2 essential) life-saving maternal/reproductive by regions

Percentage of HFs which have seven life-saving MR medicine was less than 50% in total. Least percentage was found in Ayeyarwaddy, Rakkhine and Shan (S) (<40%). Highest percentage was found in Mon, Magway and Nay Pyi Taw (>65%).

Table 8. Percentage distribution of HFs with seven (including 2 essential) life-saving maternal/reproductive by urban/rural

			Available 7 life-saving MR medicine (including MgSO4 & oxytocin)		
			No	Yes	Total
Urban/Rural	Urban	Freq	48	83	131
		%	36.6%	63.4%	100.0%
	Rural	Freq	135	90	225
		%	60.0%	40.0%	100.0%
Total		Freq	183	173	356
		%	51.4%	48.6%	100.0%

Availability of life-saving MRH medicine was higher in HFs at urban compare to that of rural (63% vs. 40%, P<0.001).

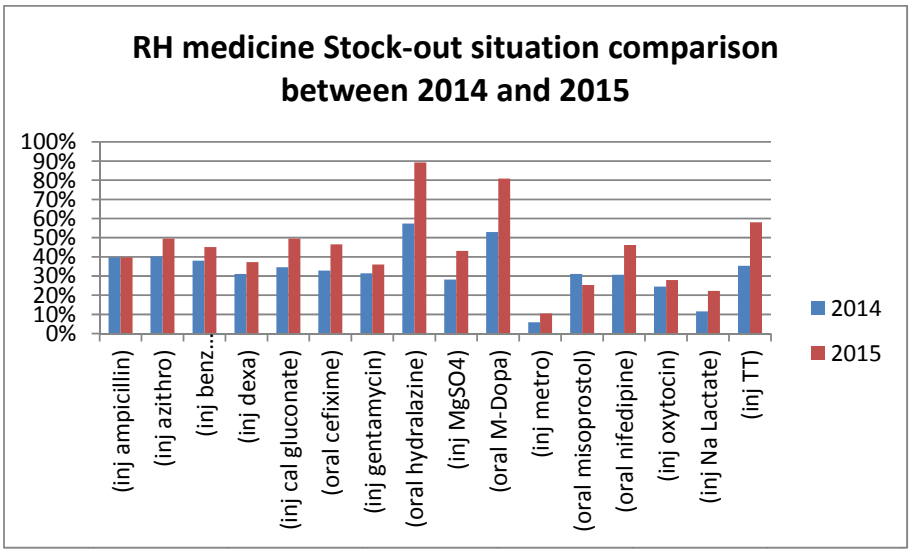
Table 10a. Percentage distribution of service delivery points with seven (including 2 essential) life-saving maternal/reproductive by distance to nearest medical depot

			Available 7 life-saving MR medicine (including MgSO4 & oxytocin)		
			No	Yes	Total
Distance to nearest medical depot (mile) (group)	<10 miles	Freq	81	61	142
		%	57.0%	43.0%	100.0%
	10-21 miles	Freq	58	42	100
		%	58.0%	42.0%	100.0%
	>21 miles	Freq	44	70	114
		%	38.6%	61.4%	100.0%
Travel duration to nearest med depot	Within a day	Freq	182	167	349
		%	52.1%	47.9%	100.0%
	Within a week	Freq	1	6	7
		%	14.3%	85.7%	100.0%
Route to travel to nearest med depot	Road	Freq	167	164	331
		%	50.5%	49.5%	100.0%
	Water	Freq	16	9	25
		%	64.0%	36.0%	100.0%
Total		Freq	183	173	356
		%	51.4%	48.6%	100.0%

Availability of MRH medicine among HFs located at different distances from medical depot were statistically significant. HFs at farer the location from depot had higher availability ($P<0.05$).

Table 10b. Comparison of RH medicine stock-out between 2014 and 2015

RH medicine	Percentage of HF with stock-out	
	2014	2015
inj ampicillin	39.7%	39.7%
inj azithro	40.2%	49.6%
inj benz penicillin	38.0%	45.1%
inj dexa	31.1%	37.2%
inj cal gluconate	34.6%	49.6%
oral cefixime	32.8%	46.5%
inj gentamycin	31.4%	36.1%
oral hydralazine	57.4%	89.3%
inj MgSO4	28.2%	43.1%
oral M-Dopa	52.9%	80.8%
inj metro	5.9%	10.4%
oral misoprostol	31.1%	25.4%
oral nifedipine	30.6%	46.2%
inj oxytocin	24.5%	27.9%
inj Na Lactate	11.5%	22.3%
inj TT	35.3%	58.0%



Except oral misoprostol, all other RH medicines stock-out situation increased at 2015.

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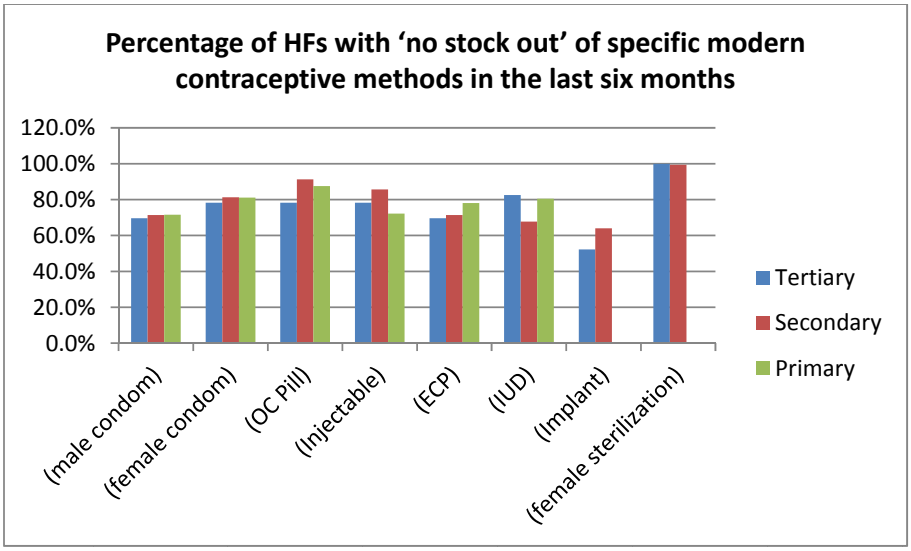
Section C. Incidence of 'No Stock Out' of modern contraceptives in the last six months

Table 11. Percentage distribution of service delivery points with 'no stock out' of a modern contraceptive method in the last six months by level of HFs

			"No stock-out" a modern contraceptive within last 6 months		
			No stock-out	Stock-out	Total
Health Facility Level	Tertiary	Freq	7	16	23
		%	30.4%	69.6%	100.0%
	Secondary	Freq	53	108	161
		%	32.9%	67.1%	100.0%
	Primary	Freq	63	109	172
		%	36.6%	63.4%	100.0%
Total		Freq	123	233	356
		%	34.6%	65.4%	100.0%

"No stock-out of a modern contraceptive" was defined in this study as a HF if it was situation of without stock-out any one of modern methods within the last six month of the assessment period. Male sterilization was not taken into account because it is not authorized to perform in all level in all regions in the country. Any performance of this method in the country was illegal. If one HF was found stock-out (or not available to provide) of any one modern method such as male/female condom, OCP, Injectable, ECP, IUD, Implant, Female sterilization (F sterilization and implant wre not accounted for primary level HFs) during the last six months, it was recognized as 'Stock-out".

According to the defined criteria, 34.6% of HFs in this study was able to provide at least one modern contraceptive method during last six month. There was no obvious differential among different level of HFs. All tertiary level HFs was also found 100% "No stock-out a modern method" in last six months.



**Implant and F sterilization are calculated only for tertiary and secondary levels*

Figure 5. Percentage distribution of HFs with 'no stock out' of specific modern contraceptive methods in the last six months by level of HFs

Comparatively higher percentages of no stock-out situation across all levels of HFs were for "OCP" and "Injectable" (more than 70% for all levels). Similarly, the method which was lowest for HFs was for "implant" about 55% for tertiary and secondary level HFs). Stock of ECP was about 75%.

Table 12. Percentage distribution of service delivery points with 'no stock out' of a modern contraceptive method in the last six by regions

State/Region		At least one mordern contraceptive stock-out within last 6 months (MRH and UNFPA defined)		Total
		No stock-out	Stock-out	
Kachin	Freq	12	5	17
	%	70.6%	29.4%	100.0%
Kayah	Freq	7	0	7
	%	100.0%	0.0%	100.0%
Kayin	Freq	5	7	12
	%	41.7%	58.3%	100.0%
Chin	Freq	8	3	11
	%	72.7%	27.3%	100.0%
Sagaing	Freq	12	28	40
	%	30.0%	70.0%	100.0%
Tanintheri	Freq	5	7	12
	%	41.7%	58.3%	100.0%
Bago	Freq	6	32	38
	%	15.8%	84.2%	100.0%
Magway	Freq	4	28	32
	%	12.5%	87.5%	100.0%
Mandalay	Freq	15	14	29
	%	51.7%	48.3%	100.0%
Mon	Freq	6	7	13
	%	46.2%	53.8%	100.0%
Rakkhine	Freq	3	18	21
	%	14.3%	85.7%	100.0%
Yangon	Freq	12	14	26
	%	46.2%	53.8%	100.0%
Shan (South)	Freq	6	15	21
	%	28.6%	71.4%	100.0%
Shan (North)	Freq	4	16	20
	%	20.0%	80.0%	100.0%
Shan (East)	Freq	5	3	8
	%	62.5%	37.5%	100.0%
Ayeyarwaddy	Freq	16	27	43
	%	37.2%	62.8%	100.0%
Naypyitaw	Freq	1	5	6
	%	16.7%	83.3%	100.0%
Total	Freq	127	229	356
	%	35.7%	64.3%	100.0%

Comparing different regions for the "no stock-out", Kayah, Kachin, Chin and Shan (E) were lowest having less than 40%.

Table 13. Percentage distribution of service delivery points with 'no stock out' of a modern contraceptive method in the last six by urban/rural

			At least one mordern contraceptive stock-out within last 6 months (MRH and UNFPA defined)		Total
			No stock-out	Stock-out	
Urban/Rural	Urban	Freq	37	94	131
		%	28.2%	71.8%	100.0%
	Rural	Freq	90	135	225
		%	40.0%	60.0%	100.0%
Total		Freq	127	229	356
		%	35.7%	64.3%	100.0%

Both urban and rural, more than 60% of HFs was "stock-out a modern method". Urban percentage was higher than rural (71.8% vs. 60%), it was statistically significant. (Chi2 test P=0.017)

Table 14. Percentage distribution of service delivery points with 'no stock out' of a modern contraceptive method in the last six by Distance to nearest medical depot

			At least one mordern contraceptive stock-out within last 6 months (MRH and UNFPA defined)		Total
			No Stock-out	Stock-out	
Distance to nearest medical depot (mile) (group)	<10 miles	Freq	50	92	142
		%	35.2%	64.8%	100.0%
	10-21 miles	Freq	39	61	100
		%	39.0%	61.0%	100.0%
	>21 miles	Freq	38	76	114
		%	33.3%	66.7%	100.0%
Travel duration to nearest med depot	Within a day	Freq	124	225	349
		%	35.5%	64.5%	100.0%
	Within a week	Freq	3	4	7
		%	42.9%	57.1%	100.0%
Route to travel to nearest med depot	Road	Freq	122	209	331
		%	36.9%	63.1%	100.0%
	Water	Freq	5	20	25
		%	20.0%	80.0%	100.0%
Total			127	229	356
		%	35.7%	64.3%	100.0%

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

Table 12b. Percentage distribution of HFs with 'no stock out' of specific modern contraceptive methods in the last six months by regions

			No stock-out of modern contraceptives in last 6 months[a]								
			(M condom)	(F condom)	(OCP)	(Inj)	(ECP)	(IUD)	(Implant)	(F steri)	Total
State/Region	Kachin	Freq	14	16	17	17	15	15	8	10	17
		%	82.4%	94.1%	100.0%	100.0%	88.2%	88.2%	47.1%	58.8%	
	Kayah	Freq	7	7	7	7	7	7	4	4	7
		%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	57.1%	57.1%	
	Kayin	Freq	8	12	10	8	12	9	6	6	12
		%	66.7%	100.0%	83.3%	66.7%	100.0%	75.0%	50.0%	50.0%	
	Chin	Freq	11	11	10	10	10	10	3	5	11
		%	100.0%	100.0%	90.9%	90.9%	90.9%	90.9%	27.3%	45.5%	
	Sagaing	Freq	26	39	38	32	24	23	10	20	40
		%	65.0%	97.5%	95.0%	80.0%	60.0%	57.5%	25.0%	50.0%	
	Tanintheri	Freq	9	12	7	6	12	12	6	7	12
		%	75.0%	100.0%	58.3%	50.0%	100.0%	100.0%	50.0%	58.3%	
	Bago	Freq	20	17	32	27	23	23	8	20	38
		%	57.1%	48.6%	91.4%	77.1%	65.7%	65.7%	22.9%	57.1%	
	Magway	Freq	14	7	30	21	12	18	5	15	32
		%	43.8%	21.9%	93.8%	65.6%	37.5%	56.3%	15.6%	46.9%	
	Mandalay	Freq	25	22	28	26	26	25	14	16	29
		%	86.2%	75.9%	96.6%	89.7%	89.7%	86.2%	48.3%	55.2%	
	Mon	Freq	9	8	12	13	9	11	5	6	13
		%	69.2%	61.5%	92.3%	100.0%	69.2%	84.6%	38.5%	46.2%	
	Rakkhine	Freq	13	13	13	12	17	19	6	9	21
		%	61.9%	61.9%	61.9%	57.1%	81.0%	90.5%	28.6%	42.9%	
	Yangon	Freq	21	24	23	23	20	21	10	13	26
		%	80.8%	92.3%	88.5%	88.5%	76.9%	80.8%	38.5%	50.0%	
	Shan (South)	Freq	18	21	20	14	20	16	6	12	21
		%	85.7%	100.0%	95.2%	66.7%	95.2%	76.2%	28.6%	57.1%	
	Shan (North)	Freq	12	20	18	16	13	14	3	12	20
		%	60.0%	100.0%	90.0%	80.0%	65.0%	70.0%	15.0%	60.0%	
	Shan (East)	Freq	7	8	6	8	6	8	5	5	8
		%	87.5%	100.0%	75.0%	100.0%	75.0%	100.0%	62.5%	62.5%	
	Ayeyarwaddy	Freq	34	43	37	35	32	28	14	20	43
		%	79.1%	100.0%	86.0%	81.4%	74.4%	65.1%	32.6%	46.5%	
	Naypyitaw	Freq	4	6	5	3	5	5	2	3	6
		%	66.7%	100.0%	83.3%	50.0%	83.3%	83.3%	33.3%	50.0%	
Total		Freq	252	286	313	278	263	264	115	183	356

Table 13b. Percentage distribution of HFs with 'no stock out' of specific modern contraceptive methods in the last six months by urban/rural

			Urban/Rural		
			Urban	Rural	Total
No stock-out of modern contraceptives in last 6 months[a]	(male condom)	Freq	94	158	252
		%	71.8%	71.2%	
	(female condom)	Freq	107	179	286
		%	81.7%	80.6%	
	(OC Pill)	Freq	114	199	313
		%	87.0%	89.6%	
	(Injectable)	Freq	109	169	278
		%	83.2%	76.1%	
	(ECP)	Freq	93	170	263
		%	71.0%	76.6%	
	(IUD)	Freq	93	171	264
		%	71.0%	77.0%	
	(Implant)	Freq	62	53	115
		%	47.3%	23.9%	
	(female sterilization)	Freq	114	69	183
		%	87.0%	31.1%	
Total		Freq	131	225	356

There were significant differences between urban and rural for percentages of stock of injectable, implant and F Sterilization within the last six months. In all those methods, percentages were higher in urban.

Table 15Ab. Percentage distribution of HFs with 'no stock out' of specific modern contraceptive methods in the last six months by Distance

			Distance to nearest medical depot (mile) (group)			
			<10 miles	10-21 miles	>21 miles	Total
No stock-out of modern contraceptives in last 6 months[a]	(male condom)	Freq	94	75	83	252
		%	67.6%	75.0%	72.8%	
	(female condom)	Freq	107	83	96	286
		%	77.0%	83.0%	84.2%	
	(OC Pill)	Freq	121	88	104	313
		%	87.1%	88.0%	91.2%	
	(Injectable)	Freq	105	77	96	278
		%	75.5%	77.0%	84.2%	
	(ECP)	Freq	106	78	79	263
		%	76.3%	78.0%	69.3%	
	(IUD)	Freq	111	72	81	264
		%	79.9%	72.0%	71.1%	
	(Implant)	Freq	29	39	47	115
		%	20.9%	39.0%	41.2%	
	(female sterilization)	Freq	42	52	89	183
		%	30.2%	52.0%	78.1%	
Total		Freq	142	100	114	356

Table 15Bb. Percentage distribution of HFs with 'no stock out' of specific modern contraceptive methods in the last six months by Duration

			Travel duration to nearest med depot		
			Within a day	Within a week	Total
No stock-out of modern contraceptives in last 6 months[a]	(male condom)	Freq	245	7	252
		%	70.8%	100.0%	
	(female condom)	Freq	279	7	286
		%	80.6%	100.0%	
	(OC Pill)	Freq	308	5	313
		%	89.0%	71.4%	
	(Injectable)	Freq	272	6	278
		%	78.6%	85.7%	
	(ECP)	Freq	257	6	263
		%	74.3%	85.7%	
	(IUD)	Freq	258	6	264
		%	74.6%	85.7%	
	(Implant)	Freq	111	4	115
		%	32.1%	57.1%	
	(female sterilization)	Freq	177	6	183
		%	51.2%	85.7%	
Total		Freq	349	7	356

Table 15Cb. Percentage distribution of HFs with 'no stock out' of specific modern contraceptive methods in the last six by Route

			Route to travel to nearest med depot		
			Road	Water	Total
No stock-out of modern contraceptives in last 6 months[a]	(male condom)	Freq	236	16	252
		%	72.0%	64.0%	
	(female condom)	Freq	266	20	286
		%	81.1%	80.0%	
	(OC Pill)	Freq	294	19	313
		%	89.6%	76.0%	
	(Injectable)	Freq	258	20	278
		%	78.7%	80.0%	
	(ECP)	Freq	245	18	263
		%	74.7%	72.0%	
	(IUD)	Freq	249	15	264
		%	75.9%	60.0%	
	(Implant)	Freq	105	10	115
		%	32.0%	40.0%	
	(female sterilization)	Freq	168	15	183
		%	51.2%	60.0%	
Total		Freq	331	25	356

"No stock-out" rates for each contraceptive methods were compared and described in the above three tables. Although female sterilization is a modern method, it should be considered differently from other methods because it needs equipment capitalized rather than need of

commodities by regular supplies and refilling. There was no pattern of association between rates of "no stock-out" and differential of distance, travel duration and travel route.

Section D. Incidence of 'No Stock Out' of modern contraceptives on the day of the survey

Table 16. Percentage distribution of HFs with 'no stock out' of each modern contraceptive method at the time of the survey by level of HFs

			Health Facility Level			Total
			Tertiary	Secondary	Primary	
Incidence of 'No Stock Out' of modern contraceptives on the day of the survey[a]	(male condom)	Freq	8	86	107	201
		%	34.8%	53.4%	62.2%	
	(female condom)	Freq	9	84	89	182
		%	39.1%	52.2%	51.7%	
	(OC Pill)	Freq	16	139	151	306
		%	69.6%	86.3%	87.8%	
	(Injectable)	Freq	18	134	135	287
		%	78.3%	83.2%	78.5%	
	(ECP)	Freq	13	71	84	168
		%	56.5%	44.1%	48.8%	
	(IUD)	Freq	15	77	93	185
		%	65.2%	47.8%	54.1%	
	(Implant)	Freq	10	50	-	60
		%	43.5%	31.1%	-	
	(Female sterilization)	Freq	23	135	-	158
		%	100.0%	83.9%	-	
Total		Count	23	161	172	356

"No stock-out' situation *at the time of survey* was summarized for each modern contraceptive method. Percentages of HFs with stock for "OCP" and "Injectable" methods were high in all levels (>70%). These two methods were comparatively higher for "no stock-out rate" in secondary and primary levels HFs than tertiary level HFs. Male and female condom stock was lowest in tertiary level HFs compare to secondary and primary level HFs (<40% vs. >50%). Reversely, percentages for ECP stock were lower in secondary and primary level HFs compare to tertiary level HFs (44% & 49% vs. 56%).

Table 17. Percentage distribution of HFs with 'no stock out' of each modern contraceptive method at the time of the survey by regions

			Incidence of 'No Stock Out' of modern contraceptives on the day of the survey[a]								Total
			male condom	female condom	OC Pill	Injectable	ECP	IUD	Implant	Female sterilization	
State/Region	Kachin	Freq	14	10	16	14	12	11	6	9	17
		%	82.4%	58.8%	94.1%	82.4%	70.6%	64.7%	35.3%	52.9%	
	Kayah	Freq	5	-	7	6	3	3	-	3	7
		%	71.4%	-	100.0%	85.7%	42.9%	42.9%	-	42.9%	
	Kayin	Freq	4	-	11	8	2	4	1	6	12
		%	33.3%	-	91.7%	66.7%	16.7%	33.3%	8.3%	50.0%	
	Chin	Freq	8	5	11	11	3	5	-	2	11
		%	72.7%	45.5%	100.0%	100.0%	27.3%	45.5%	-	18.2%	
	Sagaing	Freq	23	39	36	33	20	21	7	19	40
		%	57.5%	97.5%	90.0%	82.5%	50.0%	52.5%	17.5%	47.5%	
	Tanintheri	Freq	10	12	11	9	12	12	6	7	12
		%	83.3%	100.0%	91.7%	75.0%	100.0%	100.0%	50.0%	58.3%	
	Bago	Freq	16	7	35	29	14	14	4	15	38
		%	42.1%	18.4%	92.1%	76.3%	36.8%	36.8%	10.5%	39.5%	
	Magway	Freq	10	-	28	26	7	13	2	15	32
		%	31.3%	-	87.5%	81.3%	21.9%	40.6%	6.3%	46.9%	
	Mandalay	Freq	15	3	26	22	12	15	1	12	29
		%	51.7%	10.3%	89.7%	75.9%	41.4%	51.7%	3.4%	41.4%	
	Mon	Freq	9	1	11	13	6	5	1	3	13
		%	69.2%	7.7%	84.6%	100.0%	46.2%	38.5%	7.7%	23.1%	
	Rakkhine	Freq	14	12	15	12	14	17	5	9	21
		%	66.7%	57.1%	71.4%	57.1%	66.7%	81.0%	23.8%	42.9%	
	Yangon	Freq	12	2	22	23	11	15	3	11	26
		%	46.2%	7.7%	84.6%	88.5%	42.3%	57.7%	11.5%	42.3%	
	Shan (South)	Freq	16	19	19	16	13	12	4	11	21
		%	76.2%	90.5%	90.5%	76.2%	61.9%	57.1%	19.0%	52.4%	
	Shan (North)	Freq	12	20	16	18	10	11	3	12	20
		%	60.0%	100.0%	80.0%	90.0%	50.0%	55.0%	15.0%	60.0%	
	Shan (East)	Freq	7	8	6	8	6	7	5	5	8
		%	87.5%	100.0%	75.0%	100.0%	75.0%	87.5%	62.5%	62.5%	
	Ayeyarwaddy	Freq	24	43	32	33	21	18	12	19	43
		%	55.8%	100.0%	74.4%	76.7%	48.8%	41.9%	27.9%	44.2%	
	Naypyitaw	Freq	2	1	4	6	2	2	-	-	6
		%	33.3%	16.7%	66.7%	100.0%	33.3%	33.3%	-	-	
Total		Freq	201	201	182	306	287	168	185	60	158

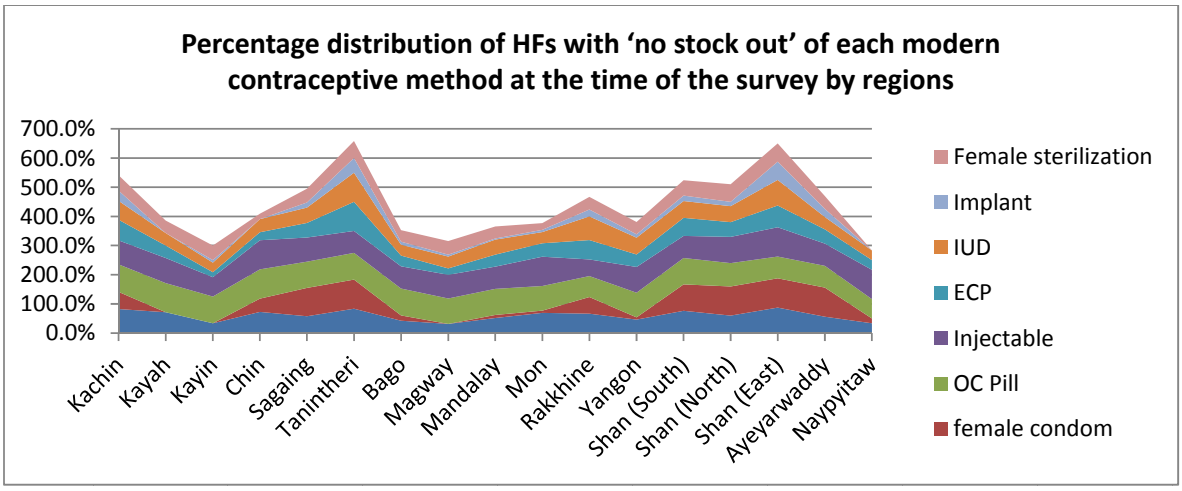


Figure 6. Percentage distribution of HFs with 'no stock out' of each modern contraceptive method at the time of the survey by regions

Three common modern methods (OCP, M condom and Injectable) were available across all regions. Although IUD availability was lower than those three methods, it was also found stock in all regions. Stock of ECP was low in Chin, Sagaing, Tanintheri and Nay Pyi Taw Regions. Implant method was not stock in many Regions.

Table 18. Percentage distribution of HFs with 'no stock out' of each modern contraceptive method at the time of the survey by urban/rural

			Urban/Rural		
			Urban	Rural	Total
Incidence of 'No Stock Out' of modern contraceptives on the day of the survey[a]	(male condom)	Freq	72	129	201
		%	55.0%	57.3%	
	(female condom)	Freq	63	119	182
		%	48.1%	52.9%	
	(OC Pill)	Freq	107	199	306
		%	81.7%	88.4%	
	(Injectable)	Freq	110	177	287
		%	84.0%	78.7%	
	(ECP)	Freq	63	105	168
		%	48.1%	46.7%	
	(IUD)	Freq	70	115	185
		%	53.4%	51.1%	
	(Implant)	Freq	35	25	60
		%	26.7%	11.1%	
	(Female sterilization)	Freq	105	53	158
		%	80.2%	23.6%	
Total		Freq	131	225	356

Recent IUD, Implant and F sterilization stock status were different between urban and rural HFs. Percentages for recent stock for those methods were higher in urban compare to rural.

Table 20a. Percentage distribution of HFs with 'no stock out' of each modern contraceptive method at the time of the survey by Distance

			Distance to nearest medical depot (mile) (group)			
			<10 miles	10-21 miles	>21 miles	Total
Incidence of 'No Stock Out' of modern contraceptives on the day of the survey[a]	(male condom)	Freq	81	48	72	201
		%	57.0%	48.0%	63.2%	
	(female condom)	Freq	59	54	69	182
		%	41.5%	54.0%	60.5%	
	(OC Pill)	Freq	119	88	99	306
		%	83.8%	88.0%	86.8%	
	(Injectable)	Freq	111	79	97	287
		%	78.2%	79.0%	85.1%	
	(ECP)	Freq	70	43	55	168
		%	49.3%	43.0%	48.2%	
	(IUD)	Freq	80	51	54	185
		%	56.3%	51.0%	47.4%	
	(Implant)	Freq	16	22	22	60
		%	11.3%	22.0%	19.3%	
	(Female sterilization)	Freq	36	44	78	158
		%	25.4%	44.0%	68.4%	
Total		Freq	142	100	114	356

Table 20b. Percentage distribution of HFs with 'no stock out' of each modern contraceptive method at the time of the survey by Duration

			Travel duration to nearest med depot		
			Within a day	Within a week	Total
Incidence of 'No Stock Out' of modern contraceptives on the day of the survey[a]	(male condom)	Freq	195	6	201
		%	55.9%	85.7%	
	(female condom)	Freq	176	6	182
		%	50.4%	85.7%	
	(OC Pill)	Freq	299	7	306
		%	85.7%	100.0%	
	(Injectable)	Freq	280	7	287
		%	80.2%	100.0%	
	(ECP)	Freq	164	4	168
		%	47.0%	57.1%	
	(IUD)	Freq	182	3	185
		%	52.1%	42.9%	
	(Implant)	Freq	58	2	60
		%	16.6%	28.6%	
	(Female sterilization)	Freq	153	5	158
		%	43.8%	71.4%	
Total		Freq	349	7	356

Table 20c. Percentage distribution of HFs with 'no stock out' of each modern contraceptive method at the time of the survey by Route

			Route to travel to nearest med depot		
			Road	Water	Total
Incidence of 'No Stock Out' of modern contraceptives on the day of the survey[a]	(male condom)	Freq	186	15	201
		%	56.2%	60.0%	
	(female condom)	Freq	163	19	182
		%	49.2%	76.0%	
	(OC Pill)	Freq	285	21	306
		%	86.1%	84.0%	
	(Injectable)	Freq	268	19	287
		%	81.0%	76.0%	
	(ECP)	Freq	155	13	168
		%	46.8%	52.0%	
	(IUD)	Freq	174	11	185
		%	52.6%	44.0%	
	(Implant)	Freq	54	6	60
		%	16.3%	24.0%	
	(Female sterilization)	Freq	146	12	158
		%	44.1%	48.0%	
Total		Freq	331	25	356

There were no significant associations between geographical distances of HFs to nearest medical depot and recent stock status for each modern contraceptive.

Section Da. Recent stock-out situation and reasons for stock-out by specific contraceptive methods

Table 20d. Stock-out situation and reasons for stock-out by specific methods of contraception

Recent stock-out by methods[a]	N	Percent (N=356)	Reasons for stock-out							
			Untimely supply	Untimely indent	No users	No supply	No skilled staff	No equipment	Stock-out at market	Total
M condom	155	43.5%	68%	3%	15%	13%	0%	0%	1%	100%
F condom	174	48.9%	39%	0%	39%	21%	1%	0%	0%	100%
OCP	50	14.0%	77%	3%	13%	7%	0%	0%	0%	100%
Inj	69	19.4%	85%	10%	0%	3%	0%	0%	2%	100%
ECP	188	52.8%	56%	3%	28%	10%	2%	0%	1%	100%
IUD	171	48.0%	53%	3%	21%	5%	14%	3%	1%	100%
Implant *	124	67.4%	43%	2%	9%	10%	29%	5%	2%	100%
F sterilization*	26	14.1%	2%	0%	7%	0%	84%	7%	0%	100%

*(for tertiary and secondary level only)

Recent stock-out of specific modern contraceptive methods showed that being highest for implant (67%) and ECP (53%). Second highest methods for stock-out were IUD, male condom and female condom (48%, 43% and 49% respectively). Implant and female sterilization (67% and 14% unavailability of service) was calculated only for tertiary and secondary level HFs only because primary level HFs are not relevant to offer the services.

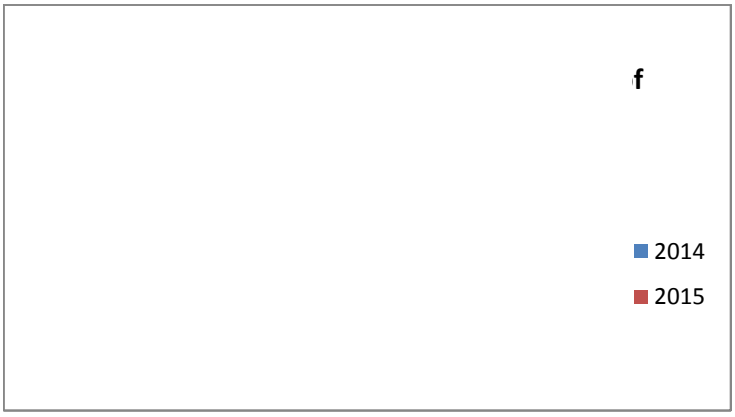
The reasons for stock-out could be summarized as untimely supply was most frequent for all methods. Secondly, it was untimely indent. Most common reasons for the highest stock-out method “female condom” were “no users” (39%) and “untimely supply” (39%). Most common reasons for stock-out of implant were “untimely supply” (43%) and “no skilled staff” (29%). ECP stock-out was mainly due to “untimely supply” (56%). Main reason for male condom stock-out was also “untimely supply” (68%). Unavailability of female sterilization services was mainly due to lack of skilled staff (84%).

Section Db. Comparison of recent stock-out situation between 2014 and 2015

In the previous section, tables and figures showed stock-out situation in each specific methods. In 2014 assessment, stock-out situation for HFs was defined as whether a HF could provide all modern contraceptive methods or not. If one HF could provide all methods, it was categorized to be a HF with "no stock-out". If it could not provide all methods, it was categorized as "stock-out". To be able to compare the situation of stock-out between two assessments, 2015 data were analysed in same fashion regarding to the stock. Since "male sterilization" was not permitted to provide in all levels, it was principally excluded in setting out the criteria of stock-out. Secondly, 'female sterilization" was only relevant for secondary and tertiary level HFs. It could not be justified for primary level HFs to be categorized as "stock-out" because every primary level HF have not authorized to provide the female sterilization.

Table 20e. Level-wise comparison of recent stock-out for at least one method between 2014 and 2015

Health facility level		2014			2015			Chi-squared test P value
		Not at all	At least one stock-out	Total	No stock-out at all	Stock-out at least one	Total	
Tertiary	Freq	8	54	62	4	19	23	0.598
	%	13%	87%	100.00%	17%	83%	100.0%	
Secondary	Freq	18	130	148	16	145	161	0.533
	%	12%	88%	100.00%	10%	90%	100.0%	
Primary	Freq	52	146	198	22	150	172	0.001
	%	26%	74%	100.00%	13%	87%	100.0%	
Total	Freq	78	330	408	42	314	356	0.006
	%	19%	81%	100.00%	12%	88%	100.0%	



Insignificant reduction of percentage for at least one method stock-out at time of assessment was observed at tertiary level only (87% at 2014 and 83% at 2015, P=0.598). Comparison for secondary and primary levels showed the percentages were increasing. Statistical significances were noted for primary level (P=0.001) and for total (P=0.006).

Table 20f. Comparison of method specific stock-out at the time of assessment between 2014 and 2015

Method	2014		2015		Chi-squared test P value
	Number of HF with recent stock-out for service	% stock-out for all (N=408)	Number of HF with recent stock-out for service	% stock-out for all (N=356)	
Long-acting and permanent methods					
prescribing implant*	232	57%	124	67%	0.015
prescribing IUD	252	62%	171	48%	<0.001
male sterilization	NR	NR	NR	NR	
female sterilization*	29	14%	26	14%	0.927
Short-term method					
male condom distribution	183	45%	155	44%	0.715
female condom distribution	387	95%	174	49%	<0.001
prescribing injectable	122	30%	69	19%	0.001
OC pill prescribing	116	28%	50	14%	<0.001
ECP prescribing	399	98%	188	53%	<0.001

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

Comparison for specific methods between two years was found reduction of stock-out for all methods except female sterilization. Significant reductions for method specific stock-out were observed all short-term methods except male condom. For the long-term methods, significant reduction was observed for IUD.

Section E. Supply Chain, including cold chain

E1. Persons responsible for ordering medical supplies

Table 21. Percentage distribution of HFs with persons responsible for ordering medical supplies by level of HFs

			Health Facility Level			
			Tertiary	Secondary	Primary	Total
Main responsible person for drug indent	MS/Head	Freq	19	32	3	54
		%	82.6%	19.9%	1.7%	15.2%
	Specialist/ Assigned MO	Freq	3	54	4	61
		%	13.0%	33.5%	2.3%	17.1%
	Pharmacist	Freq	-	8	137	145
		%	-	5.0%	79.7%	40.7%
	Other	Freq	-	8	3	11
		%	-	5.0%	1.7%	3.1%
	HA/LHV/Sister	Freq	-	13	10	23
		%	-	8.1%	5.8%	6.5%
	DMO	Freq	1	3	-	4
		%	4.3%	1.9%	-	1.1%
	TMO	Freq	-	43	15	58
		%	-	26.7%	8.7%	16.3%
Total		Freq	23	161	172	356
		%	100.0%	100.0%	100.0%	100.0%

Overall condition shows, “pharmacist”, “TMO” and “assigned MO” were main responsible person for drug indent.

Table 22. Percentage distribution of HFs with persons responsible for ordering medical supplies by regions

			Main responsible person for drug indent							
			MS/ Head	Specialist/ Assigned MO	Pharmacist	Other	HA/LHV/ Sister	DMO	TMO	Total
State/ Region	Kachin	Freq	2	5	6	2	-	-	2	17
		%	11.8%	29.4%	35.3%	11.8%	-	-	11.8%	100.0%
	Kayah	Freq	1	2	2	1	1	-	-	7
		%	14.3%	28.6%	28.6%	14.3%	14.3%	-	-	100.0%
	Kayin	Freq	1	6	4	1	-	-	-	12
		%	8.3%	50.0%	33.3%	8.3%	-	-	-	100.0%
	Chin	Freq	3	-	7	-	1	-	-	11
		%	27.3%	-	63.6%	-	9.1%	-	-	100.0%
	Sagaing	Freq	2	-	11	1	2	-	24	40
		%	5.0%	-	27.5%	2.5%	5.0%	-	60.0%	100.0%
	Tanintheri	Freq	1	1	6	-	1	1	2	12
		%	8.3%	8.3%	50.0%	-	8.3%	8.3%	16.7%	100.0%
	Bago	Freq	6	11	17	3	-	-	1	38
		%	15.8%	28.9%	44.7%	7.9%	-	-	2.6%	100.0%
	Magway	Freq	4	10	17	-	-	-	1	32
		%	12.5%	31.3%	53.1%	-	-	-	3.1%	100.0%
	Mandalay	Freq	6	2	7	3	1	-	10	29
		%	20.7%	6.9%	24.1%	10.3%	3.4%	-	34.5%	100.0%
	Mon	Freq	-	5	7	-	-	-	1	13
		%	-	38.5%	53.8%	-	-	-	7.7%	100.0%
	Rakkhine	Freq	10	-	11	-	-	-	-	21
		%	47.6%	-	52.4%	-	-	-	-	100.0%
	Yangon	Freq	3	1	11	-	5	-	6	26
		%	11.5%	3.8%	42.3%	-	19.2%	-	23.1%	100.0%
	Shan (S)	Freq	10	2	9	-	-	-	0	21
		%	47.6%	9.5%	42.9%	-	-	-	0.0%	100.0%
	Shan (N)	Freq	-	2	5	-	5	3	5	20
		%	-	10.0%	25.0%	-	25.0%	15.0%	25.0%	100.0%
	Shan (E)	Freq	2	1	-	-	3	-	2	8
		%	25.0%	12.5%	-	-	37.5%	-	25.0%	100.0%
	Ayeyar	Freq	1	13	21	-	4	-	4	43
		%	2.3%	30.2%	48.8%	-	9.3%	-	9.3%	100.0%
	Naypyitaw	Freq	2	-	4	-	-	-	-	6
		%	33.3%	-	66.7%	-	-	-	-	100.0%
Total		Freq	54	61	145	11	23	4	58	356
		%	15.2%	17.1%	40.7%	3.1%	6.5%	1.1%	16.3%	100.0%

There were mainly four persons who took responsibility for ordering supplies. These were pharmacist, assigned MO, TMO and MS in order of percentage. For those four categories, region-wise distribution of percentages was described below.

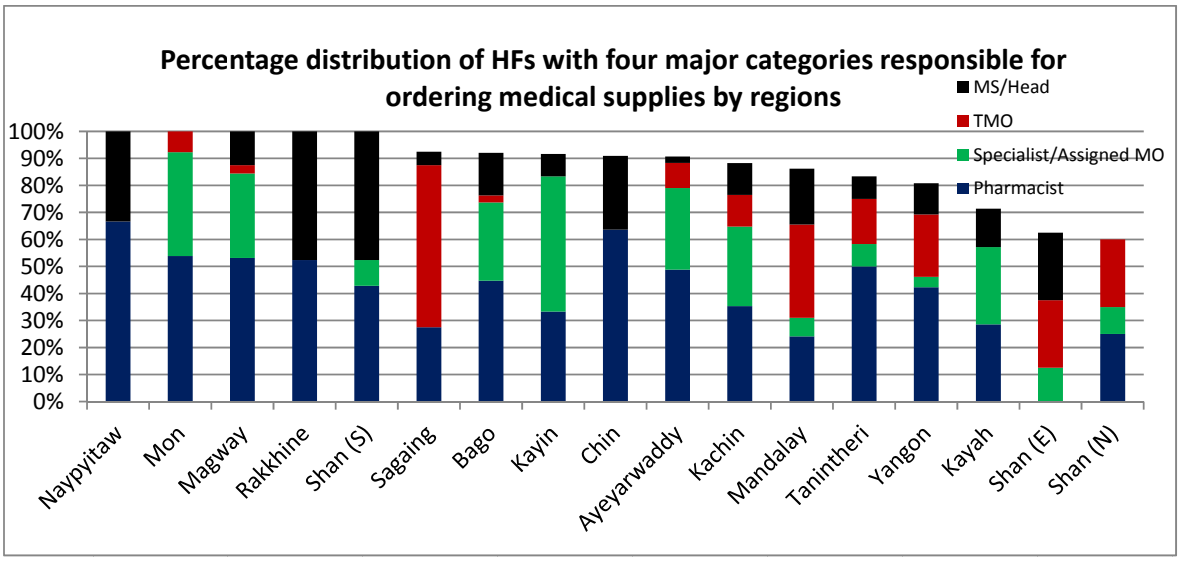


Figure 7. Percentage distribution of HFs with four major categories responsible for ordering medical supplies by regions

Those four categories were taking full responsibility at five regions (Nay Pyi Taw, Mon, Magway, Rakkhine and Shan (S). Of those areas, Nay Pyi Taw and Rakkhine were found MS and Pharmacists only took responsibilities. Role of TMOs was obvious in Sagaing, Mandalay and Yangon areas.

Table 23. Percentage distribution of HFs with persons responsible for ordering medical supplies by urban/rural residence

			Urban/Rural		
			Urban	Rural	Total
Main responsible person for drug indent	MS/Head*	Freq	48	6	54
		%	36.6%	2.7%	15.2%
	Specialist/Assigned MO	Freq	19	42	61
		%	14.5%	18.7%	17.1%
	Pharmacist*	Freq	15	130	145
		%	11.5%	57.8%	40.7%
	Other*	Freq	2	9	11
		%	1.5%	4.0%	3.1%
	HA/LHV/Sister*	Freq	5	18	23
		%	3.8%	8.0%	6.5%
	DMO*	Freq	4	-	4
		%	3.1%	-	1.1%
	TMO*	Freq	38	20	58
		%	29.0%	8.9%	16.3%
Total		Freq	131	225	356
		%	100.0%	100.0%	100.0%

*Statistically significant differences of percentages between urban and rural. (P<0.05)

In urban HFs, MS/Head, DMO and TMO were taking responsibility for ordering medical supplies more while in rural HFs Pharmacist, HA/LHV/Sister were taking responsibility more. Since many HFs at rural area are primary level and medical supplies for many of those

HFs would be taken action by pharmacist at respective township health department which was attached to township hospital.

E2. Quantifying resupply

Table 25. How re-supply is quantified by type of HFs

			How resupply is quantified?[a]			
			(by calculation and indent)	(by supply depot)	(by other way)	Total
Health Facility Level	Tertiary	Freq	14	11	2	23
		%	60.9%	47.8%	8.7%	
	Secondary	Freq	57	121	4	161
		%	35.4%	75.2%	2.5%	
	Primary	Freq	39	139	6	172
		%	22.7%	80.8%	3.5%	

Percentages and totals are based on respondents.

a. Dichotomy group tabulated at value 1.

The majority of tertiary level HFs (61%) quantified the need by themselves. However, calculation of 48% of tertiary HFs was made by medical depot. Supplies for majority secondary and primary levels HFs were also quantified by medical depot only (75% and 81% respectively).

Table 26. How re-supply is quantified by Administrative Unit (Region)

			How resupply is quantified?[a]			
			(by calculation and indent)	(by supply depot)	(by other way)	Total
State/Region	Kachin	Freq	9	8	0	17
		%	52.9%	47.1%	0.0%	
	Kayah	Freq	5	2	0	7
		%	71.4%	28.6%	0.0%	
	Kayin	Freq	4	12	0	12
		%	33.3%	100.0%	0.0%	
	Chin	Freq	4	8	0	11
		%	36.4%	72.7%	0.0%	
	Sagaing	Freq	7	35	0	40
		%	17.5%	87.5%	0.0%	
	Tanintheri	Freq	7	5	0	12
		%	58.3%	41.7%	0.0%	
	Bago	Freq	8	29	2	38
		%	21.1%	76.3%	5.3%	
	Magway	Freq	7	29	0	32
		%	21.9%	90.6%	0.0%	
	Mandalay	Freq	17	17	1	29
		%	58.6%	58.6%	3.4%	
	Mon	Freq	8	6	0	13
		%	61.5%	46.2%	0.0%	
	Rakkhine	Freq	1	20	0	21
		%	4.8%	95.2%	0.0%	
	Yangon	Freq	18	21	1	26
		%	69.2%	80.8%	3.8%	
	Shan (South)	Freq	9	14	1	21
		%	42.9%	66.7%	4.8%	
	Shan (North)	Freq	4	16	0	20
		%	20.0%	80.0%	0.0%	
	Shan (East)	Freq	1	7	0	8
		%	12.5%	87.5%	0.0%	
	Ayeyarwaddy	Freq	1	39	4	43
		%	2.3%	90.7%	9.3%	
	Naypyitaw	Freq	0	3	3	6
		%	0.0%	50.0%	50.0%	
Total		Freq	110	271	12	356

Percentages and totals are based on respondents.

a. Dichotomy group tabulated at value 1.

Table 27. How re-supply is quantified by urban/rural residence

			How resupply is quantified?[a]			
			(by calculation and indent)	(by supply depot)	(by other way)	Total
Urban/Rural	Urban	Freq	60	90	4	131
		%	45.8%	68.7%	3.1%	
	Rural	Freq	50	181	8	225
		%	22.2%	80.4%	3.6%	

Percentages and totals are based on respondents.

a. Dichotomy group tabulated at value 1.

Needs of majority of HFs both in urban and rural areas were calculated/estimated by depot rather than themselves. Calculation of needs of HFs in rural areas were less in practicing by themselves than HFs in urban area (22% vs. 46%, P<0.001). “Other” means “use of facility stock report or form that created by higher level HF”.

E3. Use of standard form for medicinal indent

Table 25a . Use of standard form for indent by level of HFs

			Use of standard form for indent			
			Use (have form)	Use (not have form)	Not use	Total
Health Facility Level	Tertiary	Freq	16	0	7	23
		%	69.6%	0.0%	30.4%	100.0%
	Secondary	Freq	60	18	83	161
		%	37.3%	11.2%	51.6%	100.0%
	Primary	Freq	42	16	114	172
		%	24.4%	9.3%	66.3%	100.0%
Total		Freq	118	34	204	356
		%	33.1%	9.6%	57.3%	100.0%

Of all HFs, 33% were using standard forms for indent the supplies. Respondents of 10% of HFs were using the standard forms but they could not show the form. Thus, 43% of HFs might be using the standard forms for medicinal indent. Percentage of HFs which were using of standard form was much less in primary level HFs and highest in tertiary level HFs (24% vs. 70%).

Table 26a . Use of standard form for indent by regions

			Use of standard form for indent			
			Use (have form)	Use (not have form)	Not use	Total
State/Region	Kachin	Freq	13	3	1	17
		%	76.5%	17.6%	5.9%	100.0%
	Kayah	Freq	1	1	5	7
		%	14.3%	14.3%	71.4%	100.0%
	Kayin	Freq	6	1	5	12
		%	50.0%	8.3%	41.7%	100.0%
	Chin	Freq	1	2	8	11
		%	9.1%	18.2%	72.7%	100.0%
	Sagaing	Freq	16	1	23	40
		%	40.0%	2.5%	57.5%	100.0%
	Tanintheri	Freq	7	3	2	12
		%	58.3%	25.0%	16.7%	100.0%
	Bago	Freq	11	1	26	38
		%	28.9%	2.6%	68.4%	100.0%
	Magway	Freq	4	7	21	32
		%	12.5%	21.9%	65.6%	100.0%
	Mandalay	Freq	14	0	15	29
		%	48.3%	0.0%	51.7%	100.0%
	Mon	Freq	6	0	7	13
		%	46.2%	0.0%	53.8%	100.0%
	Rakkhine	Freq	0	1	20	21
		%	0.0%	4.8%	95.2%	100.0%
	Yangon	Freq	14	2	10	26
		%	53.8%	7.7%	38.5%	100.0%
	Shan (South)	Freq	10	1	10	21
		%	47.6%	4.8%	47.6%	100.0%
	Shan (North)	Freq	2	9	9	20
		%	10.0%	45.0%	45.0%	100.0%
	Shan (East)	Freq	3	0	5	8
		%	37.5%	0.0%	62.5%	100.0%
	Ayeyarwaddy	Freq	6	2	35	43
		%	14.0%	4.7%	81.4%	100.0%
	Naypyitaw	Freq	4	0	2	6
		%	66.7%	0.0%	33.3%	100.0%
Total		Freq	118	34	204	356
		%	33.1%	9.6%	57.3%	100.0%

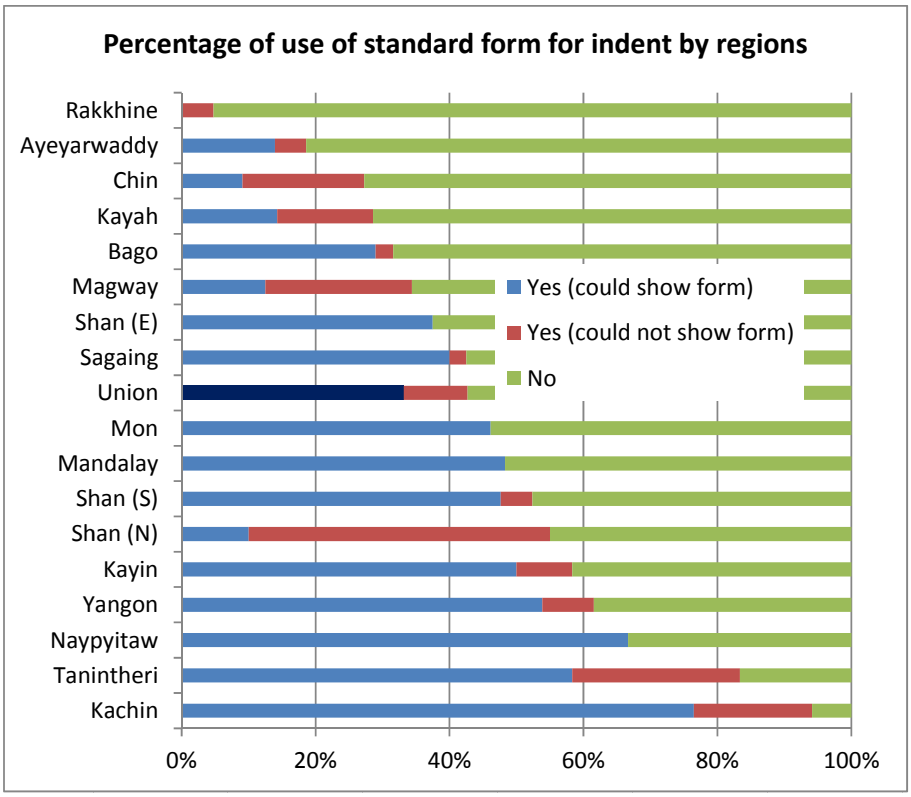


Figure 8. Percentage of use of standard form for indent by regions

The graph shows that “level of use of standard forms for indent the supplies” was quite low in Rakkhing and Ayeyarwaddy Regions. Although not too low, the rates of Chin, Kayah, Bago, Magway, Shan (E) and Sagaing Regions were lower than that of Union level. The best areas were Kachin, Tanintheri, Naypyitaw and Yangon.

Table 27a . Use of standard form for indent by urban/rural

			Use of standard form for indent			
			Use (have form)	Use (not have form)	Not use	Total
Urban/Rural	Urban	Freq	66	13	52	131
		%	50.4%	9.9%	39.7%	100.0%
	Rural	Freq	52	21	152	225
		%	23.1%	9.3%	67.6%	100.0%
Total		Freq	118	34	204	356
		%	33.1%	9.6%	57.3%	100.0%

Urban rural difference of percentage of HFs using standard form for medicinal indent was also statistically significant. The percentage was about two time higher in urban compare to rural (50% vs. 23%, Chi2 P<0.05).

E4. Source of supplies

Table 29. Main source of supplies by type of HFs

			Health Facility Level			
			Tertiary	Secondary	Primary	Total
Main source of supplier	CMSD	Freq	18	37	26	1
		%	78.3%	23.0%	15.1%	22.8%
	State/Region Health Department	Freq	4	53	17	74
		%	17.4%	32.9%	9.9%	20.8%
	District Health Department	Freq	1	10	13	24
		%	4.3%	6.2%	7.6%	6.7%
	Township Health Department	Freq	-	59	115	174
		%	-	36.6%	66.9%	48.9%
	NGO	Freq	-	1	-	1
		%	-	.6%	-	.3%
	Private Pharmacy/Company	Freq	-	1	1	2
		%	-	.6%	.6%	.6%
Total		Freq	23	161	172	356
		%	100.0%	100.0%	100.0%	100.0%

Main source of supplies for tertiary level HFs was Central Medical Store (78%). However, supplies for majority of secondary and primary level HFs were from Township Health Department (37% and 67% respectively). Many of secondary level HFs were also noted to be supplied by Central Store and Region/State Health Department (23% and 33% respectively).

Table 30. Main source of supplies by Administrative Unit (Region)

			Main source of supplier						
			CMSD	State/Region Health Department	District Health Department	Township Health Department	NGO	Private Pharmacy/Company	Total
State/Region	Kachin	Freq	2	5	2	8	-	-	17
		%	11.8%	29.4%	11.8%	47.1%	-	-	100.0%
	Kayah	Freq	1	1	-	5	-	-	7
		%	14.3%	14.3%	-	71.4%	-	-	100.0%
	Kayin	Freq	5	3	2	2	-	-	12
		%	41.7%	25.0%	16.7%	16.7%	-	-	100.0%
	Chin	Freq	2	1	2	6	-	-	11
		%	18.2%	9.1%	18.2%	54.5%	-	-	100.0%
	Sagaing	Freq	23	8	1	8	-	-	40
		%	57.5%	20.0%	2.5%	20.0%	-	-	100.0%
	Tanintheri	Freq	2	4	1	5	-	-	12
		%	16.7%	33.3%	8.3%	41.7%	-	-	100.0%
	Bago	Freq	9	1	-	27	-	1	38
		%	23.7%	2.6%	-	71.1%	-	2.6%	100.0%
	Magway	Freq	3	7	6	16	-	-	32
		%	9.4%	21.9%	18.8%	50.0%	-	-	100.0%
	Mandalay	Freq	12	3	2	12	-	-	29
		%	41.4%	10.3%	6.9%	41.4%	-	-	100.0%
	Mon	Freq	2	3	-	8	-	-	13
		%	15.4%	23.1%	-	61.5%	-	-	100.0%
	Rakkhine	Freq	2	7	-	11	1	-	21
		%	9.5%	33.3%	-	52.4%	4.8%	-	100.0%
	Yangon	Freq	5	7	-	14	-	-	26
		%	19.2%	26.9%	-	53.8%	-	-	100.0%
	Shan (South)	Freq	4	12	1	4	-	-	21
		%	19.0%	57.1%	4.8%	19.0%	-	-	100.0%
	Shan (North)	Freq	2	7	-	11	-	-	20
		%	10.0%	35.0%	-	55.0%	-	-	100.0%
	Shan (East)	Freq	1	3	2	2	-	-	8
		%	12.5%	37.5%	25.0%	25.0%	-	-	100.0%
	Ayeyarwaddy	Freq	3	1	5	33	-	1	43
		%	7.0%	2.3%	11.6%	76.7%	-	2.3%	100.0%
	Naypyitaw	Freq	3	1	-	2	-	-	6
		%	50.0%	16.7%	-	33.3%	-	-	100.0%
Total		Freq	81	74	24	174	1	2	356
		%	22.8%	20.8%	6.7%	48.9%	.3%	.6%	100.0%

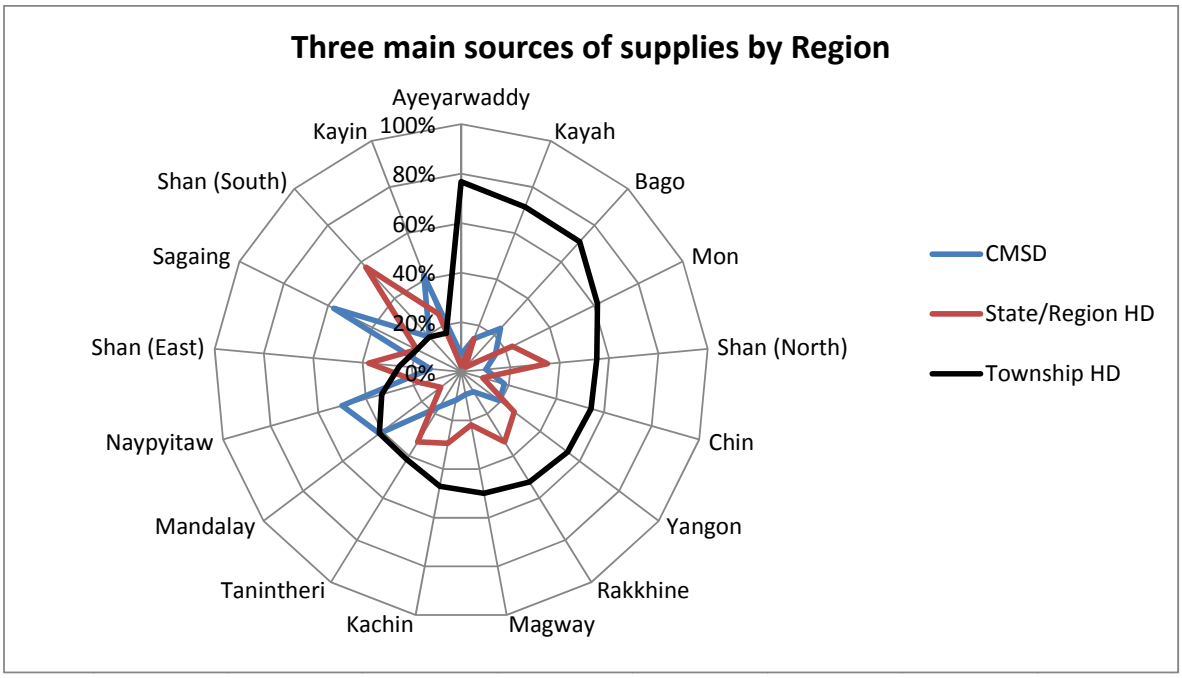


Figure 9. Percentage distribution of three main sources of medicine supplies by region

Township Health Departments were identified as most frequent source of supplies for overall taking nearly 50% of total sources described by HFs. Other sources such as "State/Region HD" and "CMSD" were more frequent described as main sources for HFs in Nay Pyi Taw, Mandalay, Shan (E), Sagaing, Shan (S) and Kayin.

Table 31. Main source of supplies by urban/rural residence

			Urban/Rural		
			Urban	Rural	Total
Main source of supplier	CMSD	Freq	48	33	81
		%	36.6%	14.7%	22.8%
	State/Region Health Department	Freq	53	21	74
		%	40.5%	9.3%	20.8%
	District Health Department	Freq	8	16	24
		%	6.1%	7.1%	6.7%
	Township Health Department	Freq	21	153	174
		%	16.0%	68.0%	48.9%
	NGO	Freq	1	0	1
		%	.8%	0.0%	.3%
	Private Pharmacy/Company	Freq	0	2	2
		%	0.0%	.9%	.6%
Total		Freq	131	225	356
		%	100.0%	100.0%	100.0%

Major suppliers for HFs at urban area were CMSD and State/Region Health Department (37% and 41% respectively. Major supplier for HFs from rural area was Township Health Department (68%).

E5. Transportation of supplies

Table 33. Responsibility for transportation of supplies by type of HFs

			Responsibility for transportation of supplies[a]				
			(Government)	(State/Region Health Department)	(Own arrangement)	(Other)	Total
Health Facility Level	Tertiary	Freq	6	2	17	4	23
		%	26.1%	8.7%	73.9%	17.4%	
	Secondary	Freq	17	15	143	3	161
		%	10.6%	9.3%	88.8%	1.9%	
	Primary	Freq	5	1	167	0	172
		%	2.9%	.6%	97.1%	0.0%	
Total		Freq	28	18	327	7	356

Percentages and totals are based on respondents.

a. Dichotomy group tabulated at value 1.

Most of HFs (>74%) at all levels had their own arrangement for transportation of supplies to their HFs. Government arrangement for the transportation for tertiary and secondary level HFs were only 26% and 11% respectively.

Table 34. Responsibility for transportation of supplies by Administrative Unit (Region)

			Responsibility for transportation of supplies[a]				Total
			(Government)	(State/Region Health Department)	(Own arrangement)	Distributir (Other)	
State/Region	Kachin	Freq	4	2	10	1	17
		%	23.5%	11.8%	58.8%	5.9%	
	Kayah	Freq	-	2	5	-	7
		%	-	28.6%	71.4%	-	
	Kayin	Freq	-	1	11	-	12
		%	-	8.3%	91.7%	-	
	Chin	Freq	1	-	11	1	11
		%	9.1%	-	100.0%	9.1%	
	Sagaing	Freq	7	-	35	-	40
		%	17.5%	-	87.5%	-	
	Tanintheri	Freq	3	1	10	-	12
		%	25.0%	8.3%	83.3%	-	
	Bago	Freq	4	1	36	1	38
		%	10.5%	2.6%	94.7%	2.6%	
	Magway	Freq	2	1	29	-	32
		%	6.3%	3.1%	90.6%	-	
	Mandalay	Freq	1	1	29	-	29
		%	3.4%	3.4%	100.0%	-	
	Mon	Freq	-	-	13	-	13
		%	-	-	100.0%	-	
	Rakkhine	Freq	3	4	19	2	21
		%	14.3%	19.0%	90.5%	9.5%	
	Yangon	Freq	-	-	26	1	26
		%	-	-	100.0%	3.8%	
	Shan (South)	Freq	1	4	19	1	21
		%	4.8%	19.0%	90.5%	4.8%	
	Shan (North)	Freq	1	1	18	-	20
		%	5.0%	5.0%	90.0%	-	
	Shan (East)	Freq	1	-	7	-	8
		%	12.5%	-	87.5%	-	
	Ayeyarwady	Freq	-	-	43	-	43
		%	-	-	100.0%	-	
	Naypyitaw	Freq	-	-	6	-	6
		%	-	-	100.0%	-	
Total		Freq	28	18	327	7	356

Percentages and totals are based on respondents.

a. Dichotomy group tabulated at value 1.

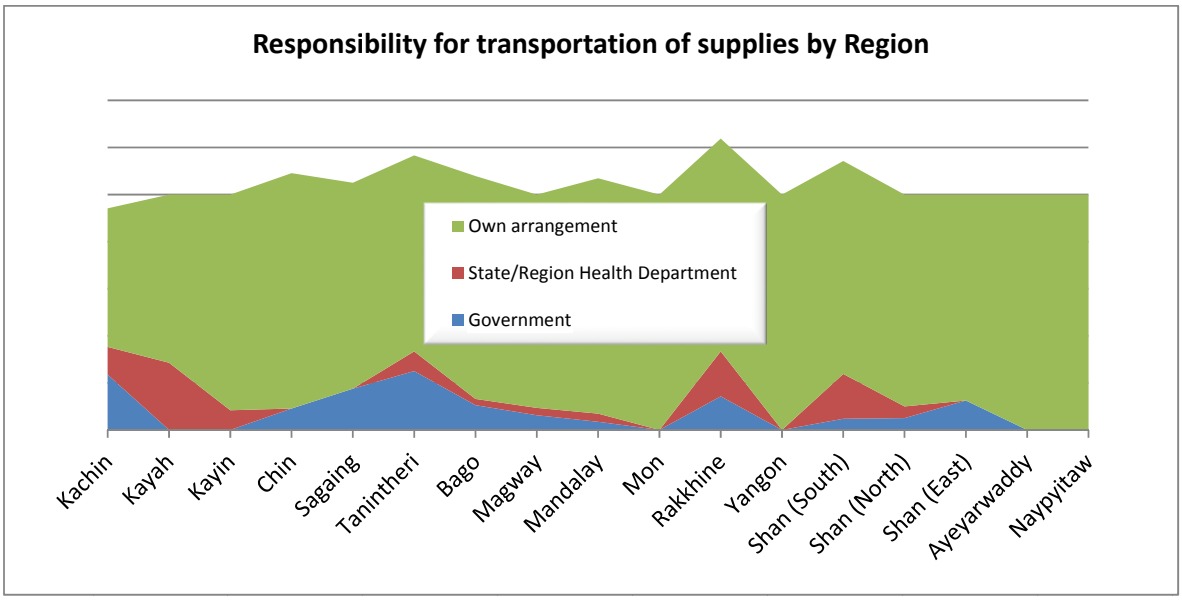


Figure 10. Responsibility for transportation of supplies by Administrative Unit (Region)

The figure shows most of HFs were arranging the transportation for supplies themselves in all areas. Government arrangement was identified in some HFs at Tanintheri, Sagaing, Kachin and Bago. State/Region arrangement was noted in Kachin, Kayah, Kayin, Rakkhine and Shan (S).

Table 35. Responsibility for transportation of supplies by urban/rural residence

			Responsibility for transportation of supplies[a]				
			(Government)	(State/Region Health Department)	(Own arrangement)	Distributor (Other*)	Total
Urban/Rural	Urban	Freq	20	16	110	7	131
		%	15.3%	12.2%	84.0%	5.3%	
	Rural	Freq	8	2	217	0	225
		%	3.6%	.9%	96.4%	0.0%	
Total		Freq	28	18	327	7	356

Percentages and totals are based on respondents.

a. Dichotomy group tabulated at value 1.

*Others= Supply contract company, UNFPA

Urban rural difference for transportation by own arrangement was noted (84% vs. 96%, P<0.001). However, 15% of HFs in urban and 4% at rural had government arrangement (P<0.001).

E6. Length of time between order and receipt

Table 37. Estimated length of time between order and receiving of supplies by type of HFs

			Health Facility Level			
			Tertiary	Secondary	Primary	Total
Interval between indent and arrival	< 2 weeks	Freq	4	12	15	31
		%	22.2%	14.6%	21.7%	18.3%
	2 weeks - 1 month	Freq	-	11	9	20
		%	-	13.4%	13.0%	11.8%
	1 - 2 months	Freq	7	11	4	22
		%	38.9%	13.4%	5.8%	13.0%
	2 - 4 months	Freq	-	2	2	4
		%	-	2.4%	2.9%	2.4%
	4 - 6 months	Freq	1	9	5	15
		%	5.6%	11.0%	7.2%	8.9%
	> 6 months	Freq	1	3	6	10
		%	5.6%	3.7%	8.7%	5.9%
	no regular interval	Freq	5	34	28	67
		%	27.8%	41.5%	40.6%	39.6%
Total		Freq	18	82	69	169
		%	100.0%	100.0%	100.0%	100.0%

Most of HFs especially secondary and primary levels stated that the interval between order and receipt was irregular (42% and 41% respectively). 40% HFs at tertiary level was estimated the interval as “1-2 months”.

Table 38. Estimated length of time between order and receiving of supplies by Administrative Unit (Region)

			Interval between indent and arrival							
			< 2 weeks	2 weeks - 1 month	1 - 2 months	2 - 4 months	4 - 6 months	> 6 months	no regular interval	Total
State/Region	Kachin	Freq	-	2	-	1	3	1	3	10
		%	-	20.0%	-	10.0%	30.0%	10.0%	30.0%	100.0%
	Kayah	Freq	5	1	-	-	1	-	-	7
		%	71.4%	14.3%	-	-	14.3%	-	-	100.0%
	Kayin	Freq	1	-	1	1	5	4	-	12
		%	8.3%	-	8.3%	8.3%	41.7%	33.3%	-	100.0%
	Chin	Freq	2	1	1	-	-	-	-	4
		%	50.0%	25.0%	25.0%	-	-	-	-	100.0%
	Sagaing	Freq	3	1	2	-	-	-	10	16
		%	18.8%	6.3%	12.5%	-	-	-	62.5%	100.0%
	Tanintheri	Freq	1	1	2	-	-	-	3	7
		%	14.3%	14.3%	28.6%	-	-	-	42.9%	100.0%
	Bago	Freq	-	3	1	-	2	1	27	34
		%	-	8.8%	2.9%	-	5.9%	2.9%	79.4%	100.0%
	Magway	Freq	3	1	3	-	-	1	3	11
		%	27.3%	9.1%	27.3%	-	-	9.1%	27.3%	100.0%
	Mandalay	Freq	2	2	5	-	1	-	7	17
		%	11.8%	11.8%	29.4%	-	5.9%	-	41.2%	100.0%
	Mon	Freq	3	1	1	2	3	-	2	12
		%	25.0%	8.3%	8.3%	16.7%	25.0%	-	16.7%	100.0%
	Rakkhine	Freq	-	-	-	-	-	-	1	1
		%	-	-	-	-	-	-	100.0%	100.0%
	Yangon	Freq	7	3	4	-	-	-	5	19
		%	36.8%	15.8%	21.1%	-	-	-	26.3%	100.0%
	Shan (South)	Freq	2	2	1	-	-	1	3	9
		%	22.2%	22.2%	11.1%	-	-	11.1%	33.3%	100.0%
	Shan (North)	Freq	2	-	1	-	-	1	2	6
		%	33.3%	-	16.7%	-	-	16.7%	33.3%	100.0%
	Shan (East)	Freq	-	-	-	-	-	-	1	1
		%	-	-	-	-	-	-	100.0%	100.0%
	Ayeyarwaddy	Freq	-	2	-	-	-	1	-	3
		%	-	66.7%	-	-	-	33.3%	-	100.0%
Total		Freq	31	20	22	4	15	10	67	169
		%	18.3%	11.8%	13.0%	2.4%	8.9%	5.9%	39.6%	100.0%

Table 39. Estimated length of time between order and receiving of supplies by urban/rural residence

			Urban/Rural		
			Urban	Rural	Total
Interval between indent and arrival	< 2 weeks	Freq	13	18	31
		%	16.5%	20.0%	18.3%
	2 weeks - 1 month	Freq	12	8	20
		%	15.2%	8.9%	11.8%
	1 - 2 months*	Freq	17	5	22
		%	21.5%	5.6%	13.0%
	2 - 4 months	Freq	3	1	4
		%	3.8%	1.1%	2.4%
	4 - 6 months	Freq	6	9	15
		%	7.6%	10.0%	8.9%
	> 6 months	Freq	4	6	10
		%	5.1%	6.7%	5.9%
	no regular interval*	Freq	24	43	67
		%	30.4%	47.8%	39.6%
Total		Freq	79	90	169
		%	100.0%	100.0%	100.0%

Percentages of HFs with "irregularity of the interval" was significantly different between HFs of urban and rural areas (30% in urban vs. 48% in rural, P<0.05). Inversely, estimation of "1-2 month" interval was higher in urban compare to rural (22% vs. 6%, P<0.05).

E7. Frequency of resupply

Table 41. Frequency of resupply by type of HFs

			Health Facility Level			
			Tertiary	Secondary	Primary	Total
Interval between indents	every 2 weeks	Freq	0	2	1	3
		%	0.0%	1.2%	.6%	.8%
	once a month	Freq	4	16	23	43
		%	17.4%	9.9%	13.4%	12.1%
	every 3 months	Freq	2	14	30	46
		%	8.7%	8.7%	17.4%	12.9%
	every 6 months	Freq	12	62	47	121
		%	52.2%	38.5%	27.3%	34.0%
	once a year	Freq	1	8	7	16
		%	4.3%	5.0%	4.1%	4.5%
	Irregular	Freq	4	59	64	127
		%	17.4%	36.6%	37.2%	35.7%
Total		Freq	23	161	172	356
		%	100.0%	100.0%	100.0%	100.0%

Thirty-six percent of HFs described the interval of between-indents of supplies was "irregular". The irregularity was more pronounced in secondary and primary level HFs. (37% vs. 17%) One-third of HFs stated that the interval was "six-month" duration. Statement of

six-month interval was higher in tertiary level HFs than secondary and primary level HFs (52% vs. 39% & 27% respectively).

Table 42. Frequency of resupply by Administrative Unit (Region)

			Interval between indents						
			every 2 weeks	once a month	every 3 months	every 6 months	once a year	Irregular	Total
State/Region	Kachin	Freq	1	-	1	7	1	7	17
		%	5.9%	-	5.9%	41.2%	5.9%	41.2%	100.0%
	Kayah	Freq	-	2	1	3	-	1	7
		%	-	28.6%	14.3%	42.9%	-	14.3%	100.0%
	Kayin	Freq	-	2	1	8	1	-	12
		%	-	16.7%	8.3%	66.7%	8.3%	-	100.0%
	Chin	Freq	-	-	-	7	2	2	11
		%	-	-	-	63.6%	18.2%	18.2%	100.0%
	Sagaing	Freq	-	2	8	23	-	7	40
		%	-	5.0%	20.0%	57.5%	-	17.5%	100.0%
	Tanintheri	Freq	-	5	-	-	-	7	12
		%	-	41.7%	-	-	-	58.3%	100.0%
	Bago	Freq	-	2	1	5	-	30	38
		%	-	5.3%	2.6%	13.2%	-	78.9%	100.0%
	Magway	Freq	1	5	8	6	1	11	32
		%	3.1%	15.6%	25.0%	18.8%	3.1%	34.4%	100.0%
	Mandalay	Freq	-	3	2	15	-	9	29
		%	-	10.3%	6.9%	51.7%	-	31.0%	100.0%
	Mon	Freq	-	4	2	5	-	2	13
		%	-	30.8%	15.4%	38.5%	-	15.4%	100.0%
	Rakkhine	Freq	-	4	1	11	1	4	21
		%	-	19.0%	4.8%	52.4%	4.8%	19.0%	100.0%
	Yangon	Freq	-	4	1	5	3	13	26
		%	-	15.4%	3.8%	19.2%	11.5%	50.0%	100.0%
	Shan (South)	Freq	1	2	1	9	3	5	21
		%	4.8%	9.5%	4.8%	42.9%	14.3%	23.8%	100.0%
	Shan (North)	Freq	-	1	7	6	2	4	20
		%	-	5.0%	35.0%	30.0%	10.0%	20.0%	100.0%
	Shan (East)	Freq	-	-	2	4	1	1	8
		%	-	-	25.0%	50.0%	12.5%	12.5%	100.0%
	Ayeyarwaddy	Freq	-	7	8	4	-	24	43
		%	-	16.3%	18.6%	9.3%	-	55.8%	100.0%
	Naypyitaw	Freq	-	-	2	3	1	-	6
		%	-	-	33.3%	50.0%	16.7%	-	100.0%
Total		Freq	3	43	46	121	16	127	356
		%	.8%	12.1%	12.9%	34.0%	4.5%	35.7%	100.0%

Table 43. Frequency of resupply by urban/rural residence

			Urban/Rural		
			Urban	Rural	Total
Interval between indents	every 2 weeks	Freq	1	2	3
		%	.8%	.9%	.8%
	once a month	Freq	17	26	43
		%	13.0%	11.6%	12.1%
	every 3 months	Freq	11	35	46
		%	8.4%	15.6%	12.9%
	every 6 months	Freq	59	62	121
		%	45.0%	27.6%	34.0%
	once a year	Freq	11	5	16
		%	8.4%	2.2%	4.5%
	irregular	Freq	32	95	127
		%	24.4%	42.2%	35.7%
Total		Freq	131	225	356
		%	100.0%	100.0%	100.0%

Irregularity of interval was more frequently stated in HFs at rural than HFs at urban (42% vs. 24%). Six-month interval was more in urban than rural (45% vs. 28%).

E8. Availability of cold chain

Table 45. Availability of cold chain by type of HFs

			Have own cold chain system		
			Yes	No	Total
Health Facility Level	Tertiary	Freq	23	0	23
		%	100.0%	0.0%	100.0%
	Secondary	Freq	135	26	161
		%	83.9%	16.1%	100.0%
	Primary	Freq	59	113	172
		%	34.3%	65.7%	100.0%
Total		Freq	217	139	356
		%	61.0%	39.0%	100.0%

Availability of cold chain was higher in tertiary and secondary level HFs (100% & 84%) and too much less in primary level HFs (34%). The difference was statistically significant ($P<0.05$).

Table 46. Availability of cold chain by Administrative Unit (Region)

			Have own cold chain system		
			Yes	No	Total
State/Region	Kachin	Freq	10	7	17
		%	58.8%	41.2%	100.0%
	Kayah	Freq	3	4	7
		%	42.9%	57.1%	100.0%
	Kayin	Freq	8	4	12
		%	66.7%	33.3%	100.0%
	Chin	Freq	4	7	11
		%	36.4%	63.6%	100.0%
	Sagaing	Freq	31	9	40
		%	77.5%	22.5%	100.0%
	Tanintheri	Freq	7	5	12
		%	58.3%	41.7%	100.0%
	Bago	Freq	19	19	38
		%	50.0%	50.0%	100.0%
	Magway	Freq	20	12	32
		%	62.5%	37.5%	100.0%
	Mandalay	Freq	17	12	29
		%	58.6%	41.4%	100.0%
	Mon	Freq	8	5	13
		%	61.5%	38.5%	100.0%
	Rakkhine	Freq	15	6	21
		%	71.4%	28.6%	100.0%
	Yangon	Freq	16	10	26
		%	61.5%	38.5%	100.0%
	Shan (South)	Freq	18	3	21
		%	85.7%	14.3%	100.0%
	Shan (North)	Freq	10	10	20
		%	50.0%	50.0%	100.0%
	Shan (East)	Freq	6	2	8
		%	75.0%	25.0%	100.0%
	Ayeyarwaddy	Freq	20	23	43
		%	46.5%	53.5%	100.0%
	Naypyitaw	Freq	5	1	6
		%	83.3%	16.7%	100.0%
Total		Freq	217	139	356
		%	61.0%	39.0%	100.0%

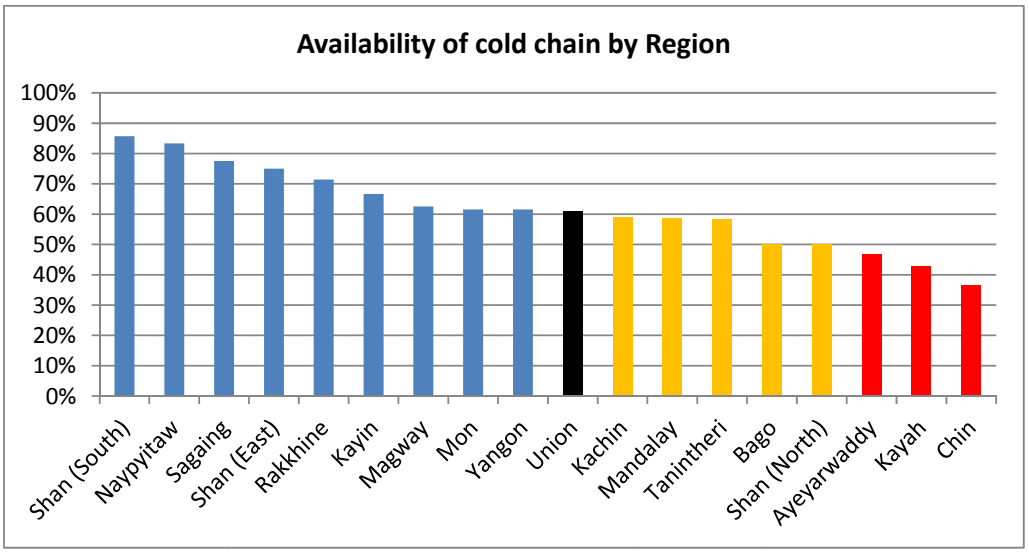


Figure 11. Availability of cold chain system by region

Overall percent of availability of cold chain system was about 60% and it was much less in Chin, Kayah and Ayayarwaddy Regions (<less than50%). The availability was high in Shan (S) and Nay Pyi Taw Regions having more than 80%.

Table 47. Availability of cold chain by urban/rural residence

			Have own cold chain system		
			Yes	No	Total
Urban/Rural	Urban	Freq	118	13	131
		%	90.1%	9.9%	100.0%
	Rural	Freq	99	126	225
		%	44.0%	56.0%	100.0%
Total		Freq	217	139	356
		%	61.0%	39.0%	100.0%

Urban rural difference of the availability of cold chain system was also markedly obvious (90% vs. 44%, P<0.001).

Table 45a. Type of cold chain by type of HFs

			Type of cold chain (N=217, 61%)			
			(electric)	(refillable ice box)	(other)	Total
Health Facility Level	Tertiary	Freq	22	4	2	23
		%	95.7%	17.4%	8.7%	
	Secondary	Freq	128	6	10	135
		%	94.8%	4.4%	7.4%	
	Primary	Freq	48	13	2	59
		%	81.4%	22.0%	3.4%	
Total		Freq	198	23	14	217

Percentages and totals are based on respondents.
a. Dichotomy group tabulated at value 1.

Of those HFs which had cold chain system, more than 80% was electric system and less than 25% was ice box. The difference among percentages of being electric system between primary and other two levels (<94% vs. 81%) was statistically significant (P<0.001).

Table 46a. Type of cold chain by Administrative Unit (Region)

			Type of cold chain (N=217, 61%)			
			(electric)	(refillable ice box)	(other)	Total
State/Region	Kachin	Freq	10	1	-	10
		%	100.0%	10.0%	-	
	Kayah	Freq	3	-	-	3
		%	100.0%	-	-	
	Kayin	Freq	7	1	-	8
		%	87.5%	12.5%	-	
	Chin	Freq	4	-	-	4
		%	100.0%	-	-	
	Sagaing	Freq	31	-	-	31
		%	100.0%	-	-	
	Tanintheri	Freq	5	-	3	7
		%	71.4%	-	42.9%	
	Bago	Freq	18	2	-	19
		%	94.7%	10.5%	-	
	Magway	Freq	18	2	-	20
		%	90.0%	10.0%	-	
	Mandalay	Freq	14	7	2	17
		%	82.4%	41.2%	11.8%	
	Mon	Freq	7	1	-	8
		%	87.5%	12.5%	-	
	Rakkhine	Freq	15	-	1	15
		%	100.0%	-	6.7%	
	Yangon	Freq	14	4	-	16
		%	87.5%	25.0%	-	
	Shan (South)	Freq	14	-	6	18
		%	77.8%	-	33.3%	
	Shan (North)	Freq	10	-	-	10
		%	100.0%	-	-	
	Shan (East)	Freq	6	1	-	6
		%	100.0%	16.7%	-	
	Ayeyarwaddy	Freq	18	3	-	20
		%	90.0%	15.0%	-	
	Naypyitaw	Freq	4	1	2	5
		%	80.0%	20.0%	40.0%	
Total		Freq	198	23	14	217

Percentages and totals are based on respondents.

a. Dichotomy group tabulated at value 1.

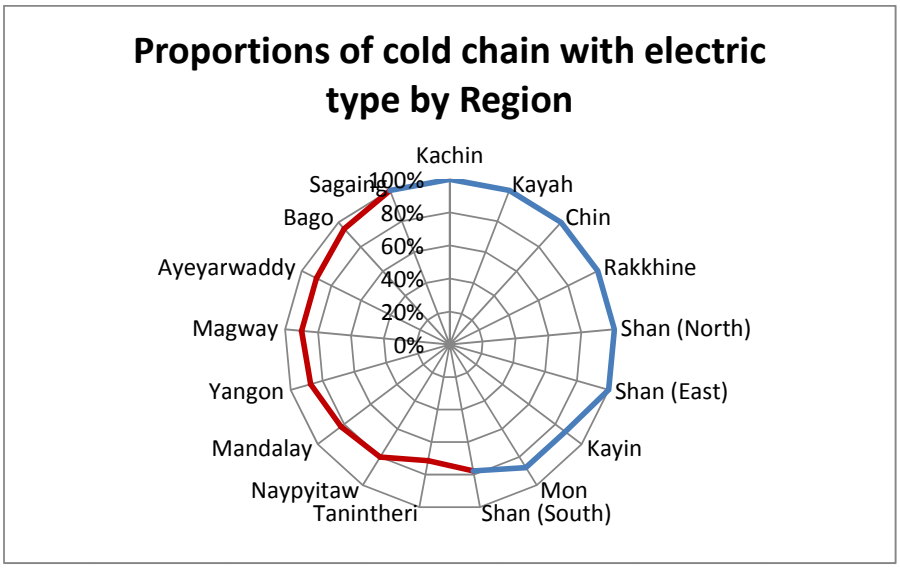


Figure 12. Proportions of cold chain with electric type by regions

HFs in States had more electric type cold chain than Regions.

Table 47a. Type of cold chain by urban/rural residence

			Type of cold chain (N=217, 61%)			
			(electric)	(refillable ice box)	(other)	Total
Urban/Rural	Urban	Freq	108	15	11	118
		%	91.5%	12.7%	9.3%	
	Rural	Freq	90	8	3	99
		%	90.9%	8.1%	3.0%	
Total		Freq	198	23	14	217

There was no obvious urban rural difference of percentages of electric type cold chain (92% vs. 91%).

Table 49. Source of power for Fridges used for cold chain by type of SDP

			Health Facility Level			
			Tertiary	Secondary	Primary	Total
Source of power for Fridges (N=207, 58%)	from grid	Freq	21	93	28	142
		%	91.3%	68.9%	57.1%	
	from own generator	Freq	7	30	1	38
		%	30.4%	22.2%	2.0%	
	from mobile generator	Freq	3	10	1	14
		%	13.0%	7.4%	2.0%	
	from solar system	Freq	3	40	21	64
		%	13.0%	29.6%	42.9%	
	from own hydro-power generator	Freq	-	2	1	3
		%	-	1.5%	2.0%	
	from village common generator	Freq	-	4	-	4
		%	-	3.0%	-	
Total		Freq	23	135	49	207

Some of HFs had more than one source of power supply for their electric cold chain system. Most of tertiary HFs which had electric type cold chain, the power source was from the national grid. However, nearly half of HFs in primary level (43%) used solar power source.

Use of power from national grid among different levels of HFs was significantly different (92%, 69% and 57% respectively, P=0.014).

Table 50. Source of power for Fridges used for cold chain by Administrative Unit (Region)

			Source of power for Fridges (N=207, 58%)						
			from grid	from own generator	from mobile generator	from solar system	from own hydro-power generator	from village common generator	Total
State/Region	Kachin	Freq	3	1	-	6	-	1	10
		%	30.0%	10.0%	-	60.0%	-	10.0%	
	Kayah	Freq	2	-	-	1	-	-	3
		%	66.7%	-	-	33.3%	-	-	
	Kayin	Freq	4	1	-	2	-	1	7
		%	57.1%	14.3%	-	28.6%	-	14.3%	
	Chin	Freq	1	-	-	4	1	-	4
		%	25.0%	-	-	100.0%	25.0%	-	
	Sagaing	Freq	24	9	1	9	-	-	31
		%	77.4%	29.0%	3.2%	29.0%	-	-	
	Tanintheri	Freq	4	3	-	5	-	-	7
		%	57.1%	42.9%	-	71.4%	-	-	
	Bago	Freq	13	-	-	4	-	-	17
		%	76.5%	-	-	23.5%	-	-	
	Magway	Freq	14	-	-	3	-	1	18
		%	77.8%	-	-	16.7%	-	5.6%	
	Mandalay	Freq	16	11	8	1	-	-	17
		%	94.1%	64.7%	47.1%	5.9%	-	-	
	Mon	Freq	5	-	1	3	-	-	7
		%	71.4%	-	14.3%	42.9%	-	-	
	Rakkhine	Freq	2	1	-	13	-	-	15
		%	13.3%	6.7%	-	86.7%	-	-	
	Yangon	Freq	14	7	3	-	1	-	15
		%	93.3%	46.7%	20.0%	-	6.7%	-	
	Shan (South)	Freq	13	-	-	5	-	-	18
		%	72.2%	-	-	27.8%	-	-	
	Shan (North)	Freq	9	-	-	2	1	-	10
		%	90.0%	-	-	20.0%	10.0%	-	
	Shan (East)	Freq	2	-	-	4	-	-	6
		%	33.3%	-	0.0%	66.7%	-	-	
	Ayeyarwaddy	Freq	12	5	1	2	-	1	18
		%	66.7%	27.8%	5.6%	11.1%	-	5.6%	
	Naypyitaw	Freq	4	-	-	-	-	-	4
		%	100.0%	-	-	-	-	-	
Total		Freq	142	38	14	64	3	4	207

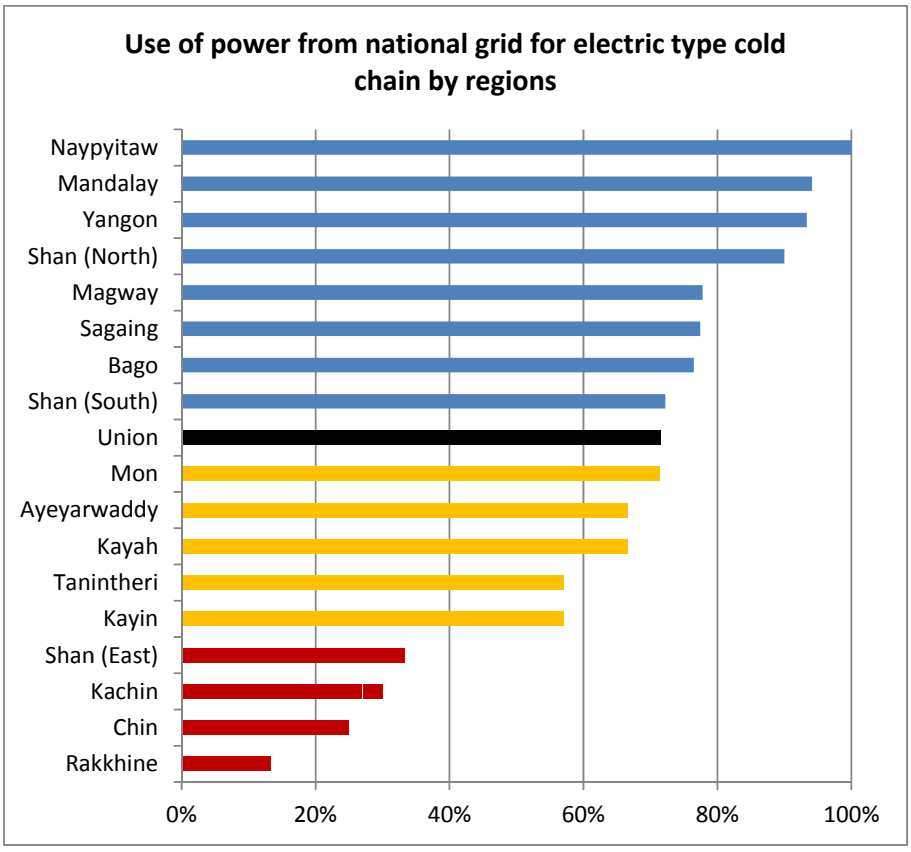


Figure 13. Use of power from national grip for electric type cold chain by regions

Use of power from national grid was quite low in Shan €, Kachin, Chin and Rakkhine areas (<40%). Overall calculation shows, 72% of electric type cold chain in HFs were using national grid as power source.

Table 51. Source of power for Fridges used for cold chain by urban/rural residence

			Urban/Rural		
			Urban	Rural	Total
Source of power for Fridges (N=207, 58%)	from grid	Freq	97	45	142
		%	84.3%	48.9%	
	from own generator	Freq	26	12	38
		%	22.6%	13.0%	
	from mobile generator	Freq	9	5	14
		%	7.8%	5.4%	
	from solar system	Freq	24	40	64
		%	20.9%	43.5%	
	from own hydro-power generator	Freq	1	2	3
		%	.9%	2.2%	
	from village common generator	Freq	-	4	4
		%	-	4.3%	
Total		Freq	115	92	207

Urban rural difference of use of national grid as power supply was also markedly significant (84% in urban vs. 49% in rural, P<0.001). Similarly, use of solar power was much higher in rural compare to urban (43% in rural vs. 21% in urban, P<0.001).

Section F. Staff training and supervision

F1. FP Services

Table 53. Percentage of HFs with staff trained to provide FP services and for the insertion and removal of Implants

Method	HF with trained staff (N=356)	Percent
BS	234	65.7
Implant	60	16.9

About two third (66%) of HFs had trained staff for birth spacing services. However, HFs which had trained staff for implant was only 17%.

Table 54a. Percentage of HFs with staff trained to provide FP services by level of HFs

			Have staff trained for birth spacing services		
			Have	Not have	Total
Health Facility Level	Tertiary	Freq	20	3	23
		%	87.0%	13.0%	100.0%
	Secondary	Freq	85	76	161
		%	52.8%	47.2%	100.0%
	Primary	Freq	129	43	172
		%	75.0%	25.0%	100.0%
Total		Freq	234	122	356
		%	65.7%	34.3%	100.0%

Percentages of having trained staff for BS was lowest in secondary level (53%) compare to tertiary and primary levels (87% and 75% respectively). The difference was statistically significant (P<0.001).

Table 55a. Percentage distribution of staff trained to provide FP services by regions

			Have staff trained for birth spacing services		
			Have	Not have	Total
State/Region	Kachin	Freq	12	5	17
		%	70.6%	29.4%	100.0%
	Kayah	Freq	4	3	7
		%	57.1%	42.9%	100.0%
	Kayin	Freq	9	3	12
		%	75.0%	25.0%	100.0%
	Chin	Freq	2	9	11
		%	18.2%	81.8%	100.0%
	Sagaing	Freq	19	21	40
		%	47.5%	52.5%	100.0%
	Tanintheri	Freq	6	6	12
		%	50.0%	50.0%	100.0%
	Bago	Freq	32	6	38
		%	84.2%	15.8%	100.0%
	Magway	Freq	23	9	32
		%	71.9%	28.1%	100.0%
	Mandalay	Freq	22	7	29
		%	75.9%	24.1%	100.0%
	Mon	Freq	9	4	13
		%	69.2%	30.8%	100.0%
	Rakkhine	Freq	12	9	21
		%	57.1%	42.9%	100.0%
	Yangon	Freq	19	7	26
		%	73.1%	26.9%	100.0%
	Shan (South)	Freq	16	5	21
		%	76.2%	23.8%	100.0%
	Shan (North)	Freq	11	9	20
		%	55.0%	45.0%	100.0%
	Shan (East)	Freq	4	4	8
		%	50.0%	50.0%	100.0%
	Ayeyarwaddy	Freq	28	15	43
		%	65.1%	34.9%	100.0%
	Naypyitaw	Freq	6	0	6
		%	100.0%	0.0%	100.0%
Total		Freq	234	122	356
		%	65.7%	34.3%	100.0%

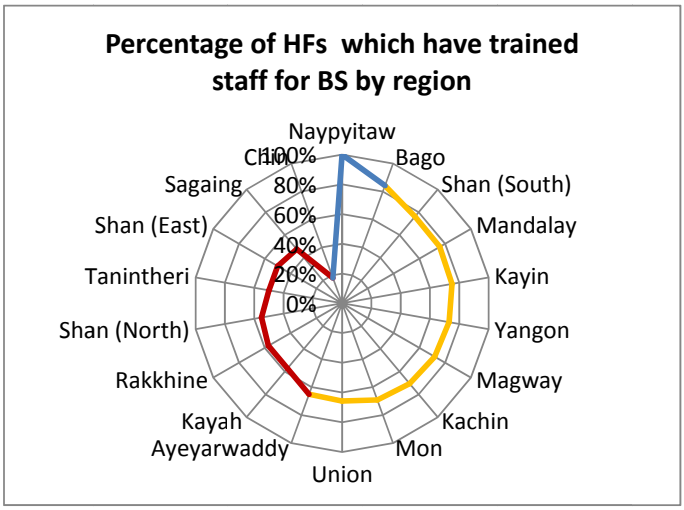


Figure 14. Percentage of HFs with trained staff for BS by regions

The graph shows that Chin, Sagaing, Shan (E), Tanintheri, Shan (N), Rakkhine and Kayah were low level of HFs which had trained staff for BS.

Table 56a. Percentage distribution of staff trained to provide FP services by urban/rural

			Have staff trained for birth spacing services		
			Have	Not have	Total
Urban/Rural	Urban	Freq	88	43	131
		%	67.2%	32.8%	100.0%
	Rural	Freq	146	79	225
		%	64.9%	35.1%	100.0%
Total		Freq	234	122	356
		%	65.7%	34.3%	100.0%

Urban rural difference of percentage of HFs with trained staff for BS was not much obvious (67% and 65% respectively).

F2. Implant

Table 54b. Percentage of HFs (which was providing implant) with staff trained to provide Implant by level of HFs

			Have staff trained for implant		
			Have	Not have	Total
Health Facility Level	Tertiary	Freq	16	3	19
		%	84.2%	15.8%	100.0%
	Secondary	Freq	38	59	97
		%	39.2%	60.8%	100.0%
	Primary	Freq	6	127	133
		%	4.5%	95.5%	100.0%
Total		Freq	60	189	249
		%	24.1%	75.9%	100.0%

84% of tertiary level HF had trained staff for implant and it was highest among three levels of HFs. 5% of primary level of HF had trained staff for implant.

Table 55b. Percentage distribution of HFs (which was providing implant) staff trained to provide Implant by regions

			Have staff trained for implant		
			Have	Not have	Total
State/Region	Kachin	Freq	2	10	12
		%	16.7%	83.3%	100.0%
	Kayah	Freq	2	2	4
		%	50.0%	50.0%	100.0%
	Kayin	Freq	1	9	10
		%	10.0%	90.0%	100.0%
	Chin	Freq	-	2	2
		%	-	100.0%	100.0%
	Sagaing	Freq	10	14	24
		%	41.7%	58.3%	100.0%
	Tanintheri	Freq	4	2	6
		%	66.7%	33.3%	100.0%
	Bago	Freq	5	31	36
		%	13.9%	86.1%	100.0%
	Magway	Freq	5	20	25
		%	20.0%	80.0%	100.0%
	Mandalay	Freq	7	15	22
		%	31.8%	68.2%	100.0%
	Mon	Freq	3	6	9
		%	33.3%	66.7%	100.0%
	Rakkhine	Freq	4	8	12
		%	33.3%	66.7%	100.0%
	Yangon	Freq	7	12	19

		%	36.8%	63.2%	100.0%
	Shan (South)	Freq	3	13	16
		%	18.8%	81.3%	100.0%
	Shan (North)	Freq	2	12	14
		%	14.3%	85.7%	100.0%
	Shan (East)	Freq	2	2	4
		%	50.0%	50.0%	100.0%
	Ayeyarwaddy	Freq	1	27	28
		%	3.6%	96.4%	100.0%
	Naypyitaw	Freq	2	4	6
		%	33.3%	66.7%	100.0%
Total		Freq	60	189	249
		%	24.1%	75.9%	100.0%

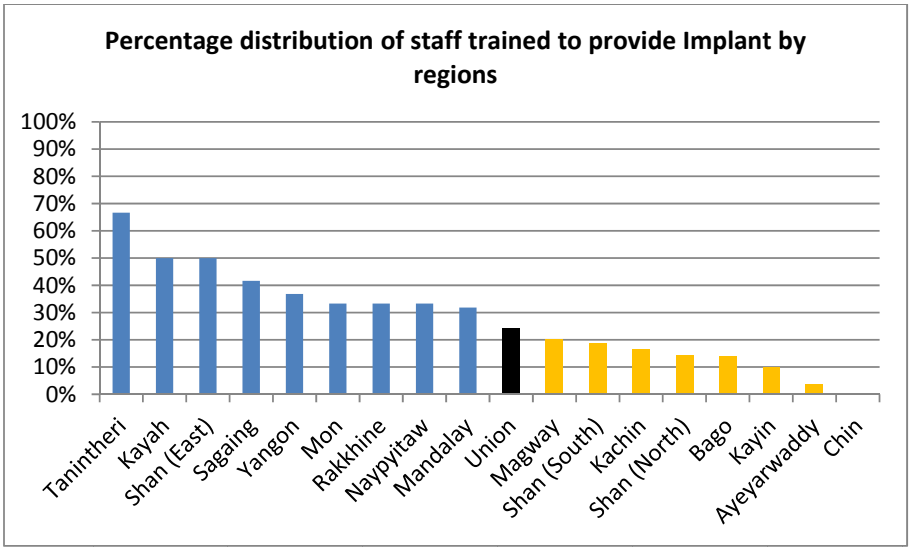


Figure 15. Percentage distribution of staff trained to provide Implant by regions

Union level percentage of HFs with trained staff for implant was very low having 24% only. Magwe, Shan (S) Kachin, Shan (N), Bago, Kayin, Ayeyarwaddy and Chin were lower than that of Union level percentage. Tanintheri was the highest of all having 67%.

Table 56b. Percentage distribution of HFs (which was providing implant) with staff trained to provide Implant by urban/rural

			Have staff trained for implant		
			Have	Not have	Total
Urban/Rural	Urban	Freq	43	49	92
		%	46.7%	53.3%	100.0%
	Rural	Freq	17	140	157
		%	10.8%	89.2%	100.0%
Total		Freq	60	189	249
		%	24.1%	75.9%	100.0%

Urban rural difference of having trained staff for implant was quite significant (47% vs. 11%, P<0.001).

Table 58. Percentage distribution of HF with the trained staff for FP including for provision of implants by type of HFs

			Last time training				
			Last 2 months Ago	2 - 6 months ago	6 - 12 months ago	> 1 year Ago	Total
Health Facility Level	Tertiary	Freq	3	2	3	12	20
		%	15.0%	10.0%	15.0%	60.0%	100.0%
	Secondary	Freq	2	4	5	77	88
		%	2.3%	4.5%	5.7%	87.5%	100.0%
	Primary	Freq	2	1	18	108	129
		%	1.6%	.8%	14.0%	83.7%	100.0%
Total		Freq	7	7	26	197	237
		%	3.0%	3.0%	11.0%	83.1%	100.0%

Most of trained staff for BS got the training more than one year ago (83%). This longer duration was more marked at secondary and primary level HFs (88% and 84% respectively).

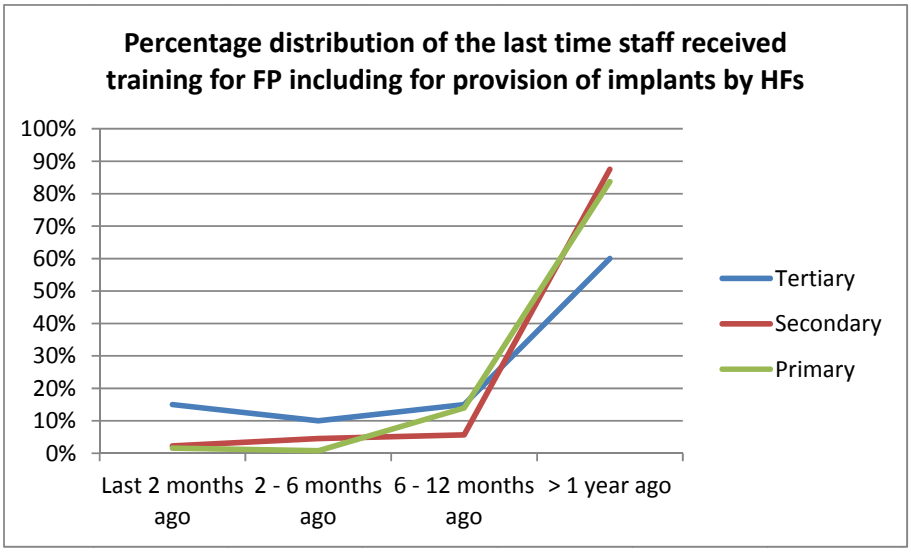


Figure 16. Percentage distribution of the last time staff received training for FP including for provision of implants by HFs

The graph shows that, among trained staff for implant, percentage of HFs with more recently trained staff (i.e. last two months ago) was higher in tertiary level compare to other two levels of HFs.

Table 59. Percentage distribution of HF with trained staff for FP including for provision of implants by regions

			Last time training				
			Last 2 months ago	2 - 6 months ago	6 - 12 months ago	> 1 year ago	Total
State/Region	Kachin	Freq	-	-	1	11	12
		%	-	-	8.3%	91.7%	100.0%
	Kayah	Freq	-	-	2	2	4
		%	-	-	50.0%	50.0%	100.0%
	Kayin	Freq	-	1	1	7	9
		%	-	11.1%	11.1%	77.8%	100.0%
	Chin	Freq	-	-	-	2	2
		%	-	-	-	100.0%	100.0%
	Sagaing	Freq	-	-	1	19	20
		%	-	-	5.0%	95.0%	100.0%
	Tanintheri	Freq	-	-	2	4	6
		%	-	-	33.3%	66.7%	100.0%
	Bago	Freq	1	-	1	31	33
		%	3.0%	-	3.0%	93.9%	100.0%
	Magway	Freq	-	1	5	17	23
		%	-	4.3%	21.7%	73.9%	100.0%
	Mandalay	Freq	2	2	2	16	22
		%	9.1%	9.1%	9.1%	72.7%	100.0%
	Mon	Freq	1	1	5	2	9
		%	11.1%	11.1%	55.6%	22.2%	100.0%
	Rakkhine	Freq	-	-	1	11	12
		%	-	-	8.3%	91.7%	100.0%
	Yangon	Freq	1	1	3	14	19
		%	5.3%	5.3%	15.8%	73.7%	100.0%
	Shan (South)	Freq	1	-	1	14	16
		%	6.3%	-	6.3%	87.5%	100.0%
	Shan (North)	Freq	-	-	-	12	12
		%	-	-	-	100.0%	100.0%
	Shan (East)	Freq	-	-	-	4	4
		%	-	-	-	100.0%	100.0%
	Ayeyarwaddy	Freq	-	1	1	26	28
		%	-	3.6%	3.6%	92.9%	100.0%
	Naypyitaw	Freq	1	-	-	5	6
		%	16.7%	-	-	83.3%	100.0%
Total		Freq	7	7	26	197	237
		%	3.0%	3.0%	11.0%	83.1%	100.0%

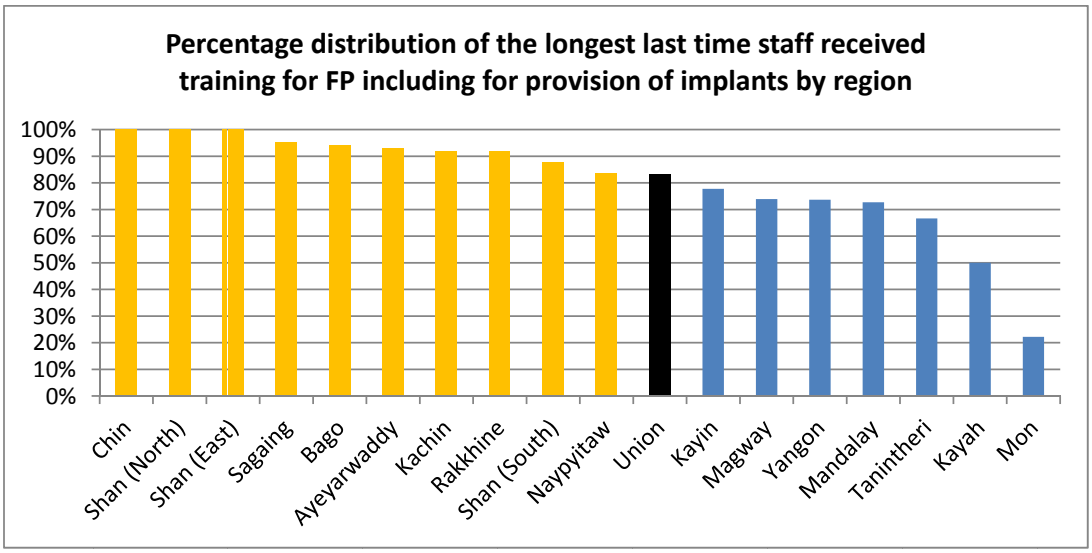


Figure 17. Percentage distribution of the longest last time staff received training for FP including for provision of implants by region

Percentage of HFs with staff trained for BS including "implant" service received more than one year ago was high in Chin, Shan, Sagaing, Bago and Ayeyarwaddy compare to other regions.

Table 60. Percentage distribution of HF with trained staff for FP including for provision of implants by urban/rural

			Last time training				
			Last 2 months ago	2 - 6 months ago	6 - 12 months ago	> 1 year ago	Total
Urban/Rural	Urban	Freq	5	3	9	73	90
		%	5.6%	3.3%	10.0%	81.1%	100.0%
	Rural	Freq	2	4	17	124	147
		%	1.4%	2.7%	11.6%	84.4%	100.0%
Total		Freq	7	7	26	197	237
		%	3.0%	3.0%	11.0%	83.1%	100.0%

The percentage was not much different between urban and rural (81% and 84%).

Table 62. Percentage distribution of the last time the facility was supervised in the past 12 months by type of HFs

			Last reach of a supervision visit					
			< 1 month	1 - 3 month	3 - 6 month	6 - 12 months	never	Total
Health Facility Level	Tertiary	Freq	5	2	1	4	11	23
		%	21.7%	8.7%	4.3%	17.4%	47.8%	100.0%
	Secondary	Freq	12	24	16	34	75	161
		%	7.5%	14.9%	9.9%	21.1%	46.6%	100.0%
	Primary	Freq	19	27	20	45	61	172
		%	11.0%	15.7%	11.6%	26.2%	35.5%	100.0%
Total		Freq	36	53	37	83	147	356
		%	10.1%	14.9%	10.4%	23.3%	41.3%	100.0%

Percent of HFs which had not received supervision for RH matters was 41% (209 out of 356) and it was highest in tertiary level (48%).

Table 63. Percentage distribution of the last time the facility was supervised in the past 12 months by Administrative Unit (Region)

			Last reach of a supervision visit					
			< 1 month	1 - 3 month	3 - 6 month	6 - 12 months	never	Total
State/Region	Kachin	Freq	-	1	5	8	3	17
		%	-	5.9%	29.4%	47.1%	17.6%	100.0%
	Kayah	Freq	2	4	-	1	-	7
		%	28.6%	57.1%	-	14.3%	-	100.0%
	Kayin	Freq	8	1	1	2	-	12
		%	66.7%	8.3%	8.3%	16.7%	-	100.0%
	Chin	Freq	1	-	1	2	7	11
		%	9.1%	-	9.1%	18.2%	63.6%	100.0%
	Sagaing	Freq	1	8	5	15	11	40
		%	2.5%	20.0%	12.5%	37.5%	27.5%	100.0%
	Tanintheri	Freq	1	5	2	3	1	12
		%	8.3%	41.7%	16.7%	25.0%	8.3%	100.0%
	Bago	Freq	1	1	1	9	26	38
		%	2.6%	2.6%	2.6%	23.7%	68.4%	100.0%
	Magway	Freq	7	10	6	7	2	32
		%	21.9%	31.3%	18.8%	21.9%	6.3%	100.0%
	Mandalay	Freq	2	2	-	9	16	29
		%	6.9%	6.9%	-	31.0%	55.2%	100.0%
	Mon	Freq	5	1	3	2	2	13
		%	38.5%	7.7%	23.1%	15.4%	15.4%	100.0%
	Rakkhine	Freq	-	-	-	1	20	21
		%	-	-	-	4.8%	95.2%	100.0%
	Yangon	Freq	-	2	3	4	17	26
		%	-	7.7%	11.5%	15.4%	65.4%	100.0%
	Shan (South)	Freq	2	4	1	4	10	21
		%	9.5%	19.0%	4.8%	19.0%	47.6%	100.0%
	Shan (North)	Freq	4	10	3	3	-	20
		%	20.0%	50.0%	15.0%	15.0%	-	100.0%
	Shan (East)	Freq	1	1	4	2	-	8

		%	12.5%	12.5%	50.0%	25.0%	-	100.0%
	Ayeyarwaddy	Freq	-	2	2	9	30	43
		%	-	4.7%	4.7%	20.9%	69.8%	100.0%
	Naypyitaw	Freq	1	1	-	2	2	6
		%	16.7%	16.7%	-	33.3%	33.3%	100.0%
Total		Freq	36	53	37	83	147	356
		%	10.1%	14.9%	10.4%	23.3%	41.3%	100.0%

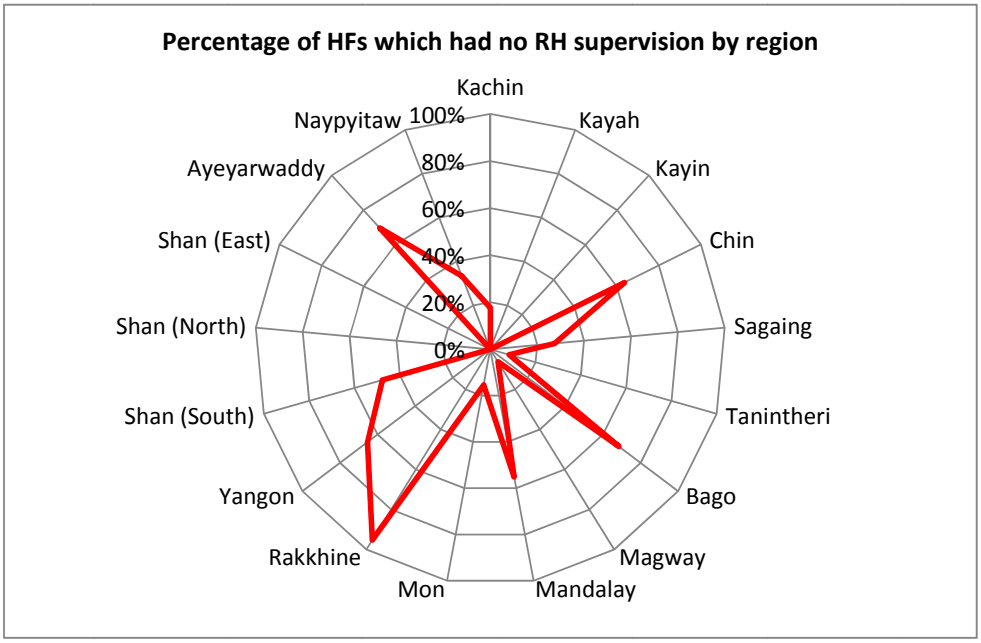


Figure 18. Percentage of HFs which had no RH supervision by region

It was obvious that Rakkhine, Chin, Bago, Ayeyarwaddy and Mandalay Regions had higher proportion of HFs which had not received RH supervision.

Table 64. Percentage distribution of the last time the facility was supervised in the past 12 months by urban/rural residence

			Last reach of a supervision visit					
			< 1 month	1 - 3 month	3 - 6 month	6 - 12 months	Never	Total
Urban/Rural	Urban	Freq	16	20	12	29	54	131
		%	12.2%	15.3%	9.2%	22.1%	41.2%	100.0%
	Rural	Freq	20	33	25	54	93	225
		%	8.9%	14.7%	11.1%	24.0%	41.3%	100.0%
Total		Freq	36	53	37	83	147	356
		%	10.1%	14.9%	10.4%	23.3%	41.3%	100.0%

The percentages of HFs which had no RH supervision were not much different between urban and rural.

Table 66. Percentage distribution HFs (whch had supervision) by the frequency of supervisory visits by type of HFs

			Health Facility Level			
			Tertiary	Secondary	Primary	Total
Interval between supervision visits	weekly	Freq	-	-	2	2
		%	-	-	1.8%	1.0%
	monthly	Freq	3	6	14	23
		%	25.0%	7.0%	12.6%	11.0%
	every 3 months	Freq	2	19	31	52
		%	16.2%	22.1%	27.9%	24.9%
	every 6 months	Freq	1	15	10	26
		%	8.1%	17.4%	9.0%	12.4%
	once a year	Freq	1	11	14	26
		%	8.1%	12.8%	12.6%	12.4%
	not regularly	Freq	5	35	40	80
		%	41.6%	40.7%	36.0%	38.3%
Total		Freq	12	86	111	209
		%	100.0%	100.0%	100.0%	100.0%

Most of supervision was in irregular interval (37%) and no obvious difference among levels of HFs. Second most frequent interval was “every 3 months” (24%). Frequency of supervisory visits was comparatively shorter in tertiary and primary level HFs.

Table 67. Percentage distribution HFs (which ahd supervision) by the frequency of supervisory visits by Administrative Unit (Region)

			Interval between supervision visits						
			weekly	monthly	every 3 months	every 6 months	once a year	not regularly	Total
State/Region	Kachin	Freq	-	-	3	2	1	8	14
		%	-	-	21.4%	14.3%	7.1%	57.1%	100.0%
	Kayah	Freq	-	3	3	-	-	1	7
		%	-	42.9%	42.9%	-	-	14.3%	100.0%
	Kayin	Freq	2	2	3	1	-	4	12
		%	16.7%	16.7%	25.0%	8.3%	-	33.3%	100.0%
	Chin	Freq	-	-	-	1	2	1	4
		%	-	-	-	25.0%	50.0%	25.0%	100.0%
	Sagaing	Freq	-	3	7	5	9	5	29
		%	-	10.3%	24.1%	17.2%	31.0%	17.2%	100.0%
	Tanintheri	Freq	-	-	4	1	1	5	11
		%	-	-	36.4%	9.1%	9.1%	45.5%	100.0%
	Bago	Freq	-	-	-	2	1	9	12
		%	-	-	-	16.7%	8.3%	75.0%	100.0%
	Magway	Freq	-	1	13	3	3	10	30
		%	-	3.3%	43.3%	10.0%	10.0%	33.3%	100.0%
	Mandalay	Freq	-	2	3	1	2	5	13
		%	-	15.4%	23.1%	7.7%	15.4%	38.5%	100.0%
	Mon	Freq	-	3	3	-	1	4	11
		%	-	27.3%	27.3%	-	9.1%	36.4%	100.0%
	Rakkhine	Freq	-	-	-	-	-	1	1
		%	-	-	-	-	-	100.0%	100.0%
	Yangon	Freq	-	-	2	1	3	3	9
		%	-	-	22.2%	11.1%	33.3%	33.3%	100.0%
	Shan (South)	Freq	-	-	1	1	3	6	11
		%	-	-	9.1%	9.1%	27.3%	54.5%	100.0%
	Shan (North)	Freq	-	5	6	5	0	4	20
		%	-	25.0%	30.0%	25.0%	0.0%	20.0%	100.0%
	Shan (East)	Freq	-	3	4	-	-	1	8
		%	-	37.5%	50.0%	-	-	12.5%	100.0%
	Ayeyarwaddy	Freq	-	-	-	2	-	11	13
		%	-	-	-	15.4%	-	84.6%	100.0%
	Naypyitaw	Freq	-	1	-	1	-	2	4
		%	-	25.0%	-	25.0%	-	50.0%	100.0%
Total		Freq	2	23	52	26	26	80	209
		%	1.0%	11.0%	24.9%	12.4%	12.4%	38.3%	100.0%

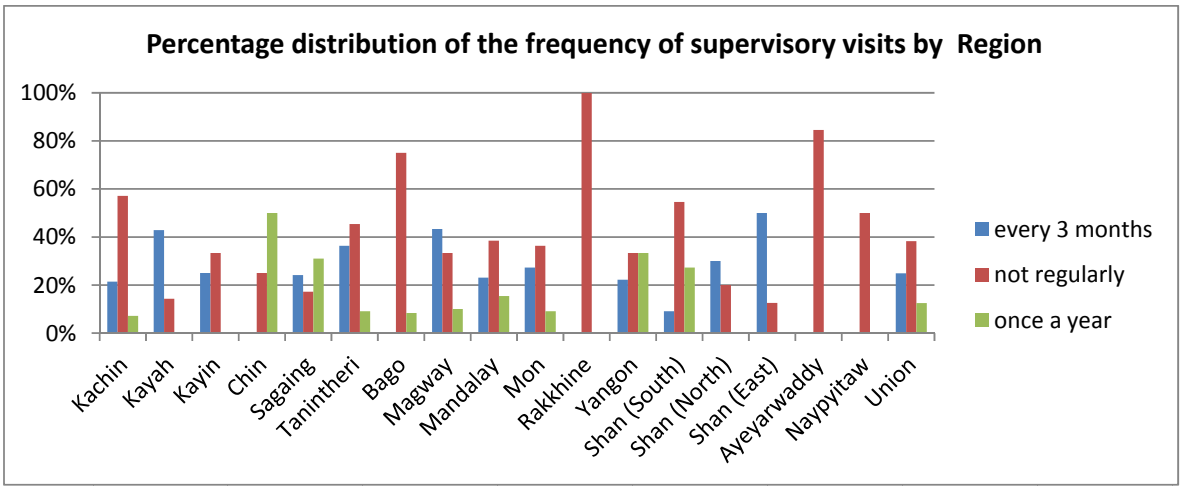


Figure 19. Percentage distribution of the frequency of supervisory visits by Region

Irregularity of supervisory visit was more frequent in Rakkhine, Ayeyarwaddy, Bago and Kachin. More than 40% of supervisory visit in Chin State was once a year. Three-monthly visit was frequent in Shan(E), Magway and Kayah (>40%).

Table 68. Percentage distribution of HFs (which ahad supervision) by frequency of supervisory visits by urban/rural residence

			Urban/Rural		
			Urban	Rural	Total
Interval between supervision visits	weekly	Freq	1	1	2
		%	1.3%	.8%	1.0%
	monthly	Freq	8	15	23
		%	10.4%	11.4%	11.0%
	every 3 months	Freq	14	38	52
		%	18.2%	28.8%	24.9%
	every 6 months	Freq	8	18	26
		%	10.4%	13.6%	12.4%
	once a year	Freq	15	11	26
		%	19.5%	8.3%	12.4%
	not regularly	Freq	31	49	80
		%	40.3%	37.1%	38.3%
Total		Freq	77	132	209
		%	100.0%	100.0%	100.0%

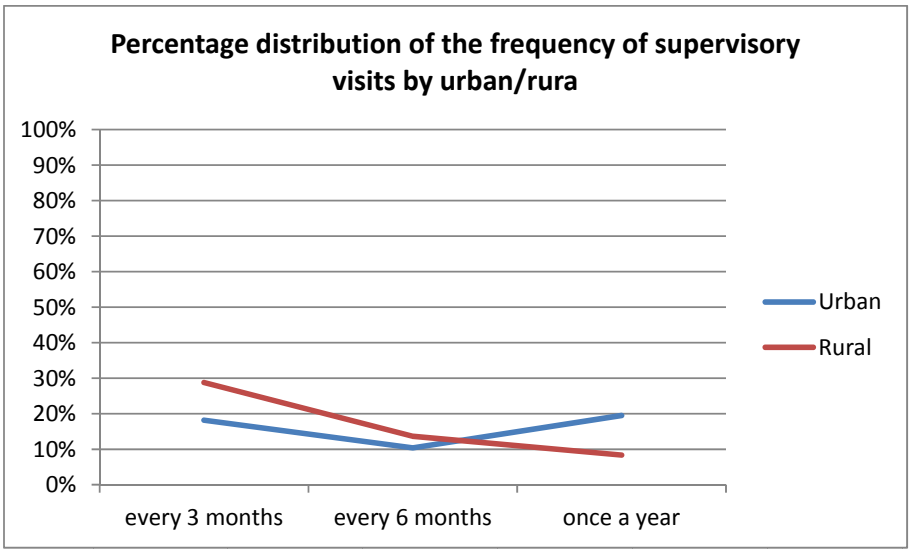


Figure 20. Comparison of frequency of supervisory visit by urban rural

Percentage of HFs which had been more frequently visited was higher in rural. One-a-year visit was higher in urban.

Table 70. Percentage of HFs (which had supervision) by issues included in supervisory visits by type of HFs

			Health Facility Level			
			Tertiary	Secondary	Primary	Total
Issues included in supervisory visits (N=209, 58%)	for treatment	Freq	9	66	75	150
		%	75.0%	76.7%	67.6%	
	for logistics	Freq	10	68	92	170
		%	83.3%	79.1%	82.9%	
	for staffing and training	Freq	8	57	61	126
		%	66.7%	66.3%	55.0%	
	for reporting	Freq	9	55	86	150
		%	75.0%	64.0%	77.5%	
	for abiding guideline and instruction	Freq	6	42	70	118
		%	50.0%	48.8%	63.1%	
	for other	Freq	0	2	3	5
		%	0.0%	2.3%	2.7%	
Total		Freq	12	86	111	209

Percentages and totals are based on respondents.

a. Dichotomy group tabulated at value 1.

Issues encountered in the supervisions were described. Most frequent issue was identified as ‘logistic”. Second most-frequent issues were “reporting” and ‘clinical treatment”. The occurrences of issues were not different between levels of HFs.

Table 71. Percentage of HFs (which had supervision) with issues included in supervisory visits by Administrative Unit (Region)

			Issues included in supervisory visits (N=209, 58%)						
			for treatment	for logistics	for staffing and training	for reporting	for abiding guideline and instruction	for other	Total
State/Region	Kachin	Freq	12	12	6	11	6	-	14
		%	85.7%	85.7%	42.9%	78.6%	42.9%	-	100%
	Kayah	Freq	7	7	7	7	6	-	7
		%	100.0%	100.0%	100.0%	100.0%	85.7%	-	100%
	Kayin	Freq	10	4	7	8	11	-	12
		%	83.3%	33.3%	58.3%	66.7%	91.7%	-	100%
	Chin	Freq	1	4	2	1	3	-	4
		%	25.0%	100.0%	50.0%	25.0%	75.0%	-	100%
	Sagaing	Freq	25	25	23	26	5	1	29
		%	86.2%	86.2%	79.3%	89.7%	17.2%	3.4%	100%
	Tanintheri	Freq	8	6	5	4	4	-	11
		%	72.7%	54.5%	45.5%	36.4%	36.4%	-	100%
	Bago	Freq	6	8	10	9	8	-	12
		%	50.0%	66.7%	83.3%	75.0%	66.7%	-	100%
	Magway	Freq	23	26	19	27	24	-	30
		%	76.7%	86.7%	63.3%	90.0%	80.0%	-	100%
	Mandalay	Freq	10	12	2	3	10	-	13
		%	76.9%	92.3%	15.4%	23.1%	76.9%	-	100%
	Mon	Freq	8	9	7	9	8	-	11
		%	72.7%	81.8%	63.6%	81.8%	72.7%	-	100%
	Rakkhine	Freq	1	1	1	1	1	-	1
		%	100.0%	100.0%	100.0%	100.0%	100.0%	-	100%
	Yangon	Freq	7	9	7	5	6	-	9
		%	77.8%	100.0%	77.8%	55.6%	66.7%	-	100%
	Shan (South)	Freq	3	10	9	7	6	-	11
		%	27.3%	90.9%	81.8%	63.6%	54.5%	-	100%
	Shan (North)	Freq	17	16	12	18	8	1	20
		%	85.0%	80.0%	60.0%	90.0%	40.0%	5.0%	100%
	Shan (East)	Freq	6	8	7	7	2	-	8
		%	75.0%	100.0%	87.5%	87.5%	25.0%	-	100%
	Ayeyarwaddy	Freq	3	9	2	7	9	1	13
		%	23.1%	69.2%	15.4%	53.8%	69.2%	7.7%	100%
	Naypyitaw	Freq	3	4	-	-	1	2	4
		%	75.0%	100.0%	-	-	25.0%	50.0%	100%
Total		Freq	150	170	126	150	118	5	209

Percentages and totals are based on respondents.

a. Dichotomy group tabulated at value 1.

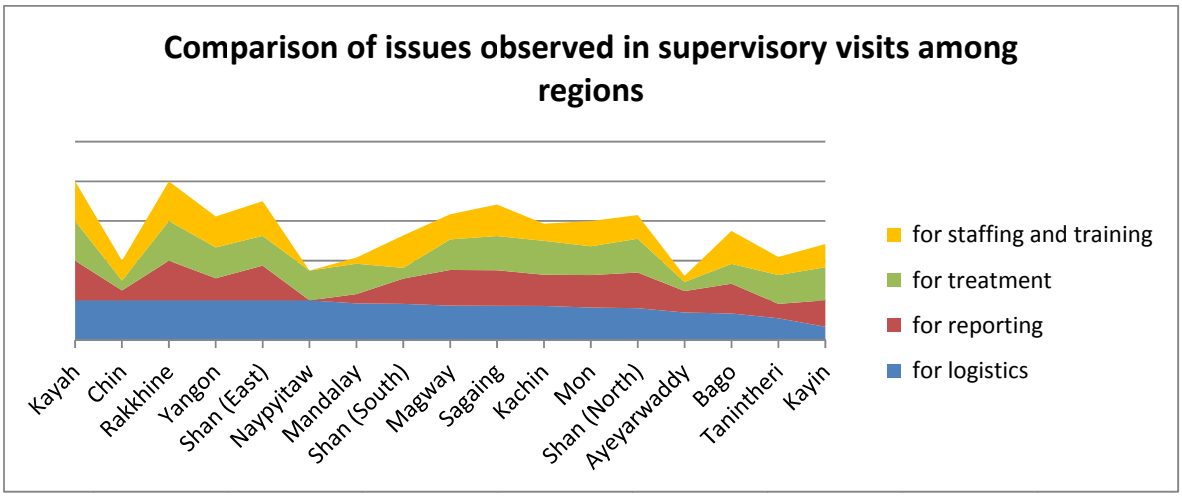


Figure 21. Comparison of issues observed in supervisory visits among regions

In overall, logistic problems were observed in all areas although less pronounced in Kayin and Tanintheri than other areas. Cumulative percentages of HFs which had issues were least in Chin, Nay Pyi Taw and Ayeyarwaddy. The highest peaks were observed in Kayah, Rakkhine, Shan (E) and Sagaing.

Table 72. Percentage of HFs (which had supervision) with issues included in supervisory visits by urban/rural residence

			Urban/Rural		
			Urban	Rural	Total
Issues included in supervisory visits[a]	for treatment	Freq	56	94	150
		%	72.7%	71.2%	
	for logistics	Freq	59	111	170
		%	76.6%	84.1%	
	for staffing and training	Freq	49	77	126
		%	63.6%	58.3%	
	for reporting	Freq	50	100	150
		%	64.9%	75.8%	
	for abiding guideline and instruction	Freq	37	81	118
		%	48.1%	61.4%	
	for other	Freq	1	4	5
		%	1.3%	3.0%	
Total		Freq	77	132	209

Percentages and totals are based on respondents.
a. Dichotomy group tabulated at value 1.

Urban rural differences of issues were found for logistic, reporting and ‘following guideline and instruction”. In those issues, the percentages of HFs were higher in rural area.

Section G. Availability of guidelines, check-lists and job aids

Table 74. Percentage of HFs with guidelines, check-lists and job aids

		Responses	
		N	Percent
Use of guidelines, check list and jobaid (could show) (N=227, 64%)	Guidebook for national birth spacing	75	33.0%
	Checklist for birth spacing	129	56.8%
	guidebook for AN care	154	67.8%
	Checklist/job aid for AN care	176	77.5%
	Guidebook for waste disposal	47	20.7%

Availability of guidelines was not more than 78%. Most frequently available guidebook was "Job aid for antenatal care" (77%) and "Guidebook for antenatal care" (68%). Regarding the guide for BS, 57% of HFs had "Checklist for BS". "National guidebook for BS" was available at 33% of HFs only. "Guide for waste disposal" was least available at only 21% of HFs.

Table 74a. Percentage of HFs with guidelines, check-lists and job aids by level of HFs

			Guidelines, check-lists and job aids (could show) (N=227, 64%)					
			guidebook for national birth spacing	checklist for birth spacing	guidebook for AN care	checklist/job aid for AN care	guidebook for waste disposal	Total
Health Facility Level	Tertiary	Freq	6	7	7	9	5	11
		%	54.5%	63.6%	63.6%	81.8%	45.5%	
	Secondary	Freq	29	50	61	60	19	87
		%	33.3%	57.5%	70.1%	69.0%	21.8%	
	Primary	Freq	40	72	86	107	23	129
		%	31.0%	55.8%	66.7%	82.9%	17.8%	
Total		Freq	75	129	154	176	47	227

Distribution of availability of various guidebooks was not much different among different level of HFs.

Table 74b. Percentage of HFs with guidelines, check-lists and job aids by regions

			Guidelines, check-lists and job aids (could show) (N=227, 64%)					
			guidebook for national birth spacing	checklist for birth spacing	guidebook for AN care	checklist/job aid for AN care	guidebook for waste disposal	Total
State/Region	Kachin	Freq	3	3	6	6	5	11
		%	27.3%	27.3%	54.5%	54.5%	45.5%	
	Kayah	Freq	0	3	3	4	1	5
		%	0.0%	60.0%	60.0%	80.0%	20.0%	
	Kayin	Freq	3	5	5	8	4	9
		%	33.3%	55.6%	55.6%	88.9%	44.4%	
	Chin	Freq	2	4	4	5	0	5
		%	40.0%	80.0%	80.0%	100.0%	0.0%	
	Sagaing	Freq	6	14	17	25	2	27
		%	22.2%	51.9%	63.0%	92.6%	7.4%	
	Tanintheri	Freq	1	4	5	6	1	10
		%	10.0%	40.0%	50.0%	60.0%	10.0%	
	Bago	Freq	5	12	19	18	5	25
		%	20.0%	48.0%	76.0%	72.0%	20.0%	
	Magway	Freq	7	11	10	14	12	20
		%	35.0%	55.0%	50.0%	70.0%	60.0%	
	Mandalay	Freq	5	11	12	20	3	21
		%	23.8%	52.4%	57.1%	95.2%	14.3%	
	Mon	Freq	7	10	10	10	5	10
		%	70.0%	100.0%	100.0%	100.0%	50.0%	
	Rakkhine	Freq	5	7	10	8	2	13
		%	38.5%	53.8%	76.9%	61.5%	15.4%	
	Yangon	Freq	6	13	16	19	4	22
		%	27.3%	59.1%	72.7%	86.4%	18.2%	
	Shan (South)	Freq	7	8	10	3	0	10
		%	70.0%	80.0%	100.0%	30.0%	0.0%	
	Shan (North)	Freq	10	10	14	11	0	15
		%	66.7%	66.7%	93.3%	73.3%	0.0%	
	Shan (East)	Freq	2	3	3	5	0	7
		%	28.6%	42.9%	42.9%	71.4%	0.0%	
	Ayeyarwaddy	Freq	5	6	5	9	0	11
		%	45.5%	54.5%	45.5%	81.8%	0.0%	
	Naypyitaw	Freq	1	5	5	5	3	6
		%	16.7%	83.3%	83.3%	83.3%	50.0%	
Total		Freq	75	129	154	176	47	227

Percentages and totals are based on respondents.

a. Dichotomy group tabulated at value 1.

The percentage distribution of HFs of which guides was recently available was more frequent "for ANC" than that "for BS". Guides for antenatal care were observed in all areas. However, observed percentage of HF which observed with guides for BS was not much. Mon, Shan (S), Shan (N), Chin and Ayeyarwaddy Regions were observed as highest percentage of HFs with one or more BS Guides. The areas with least frequently observed HFs with one of BS Guides were Kayah, Kachin and Tanintheri.

Table 74c. Percentage of HFs with guidelines, check-lists and job aids by urban/rural

			Guidelines, check-lists and job aids (could show) (N=227, 64%)					
			Have guidebook for national birth spacing	Have checklist for birth spacing	Have guidebook for AN care	Have checklist/job aid for AN care	Have guidebook for waste disposal	Total
Urban/Rural	Urban	Freq	36	55	66	64	21	89
		%	40.4%	61.8%	74.2%	71.9%	23.6%	
	Rural	Freq	39	74	88	112	26	138
		%	28.3%	53.6%	63.8%	81.2%	18.8%	
Total		Freq	75	129	154	176	47	227

Percentages and totals are based on respondents.

a. Dichotomy group tabulated at value 1.

Urban rural discrepancies for availability of various kinds of guide books were not much obvious.

Section H. Use of Information Communication Technology (ICT)

Table 75. Percentage of HFs with types of Information Communication Technology available

		Responses	
		N	Percent
Types of Information Communication Technology available (N=350, 98%)	Computer	128	36.6%
	Mobile phone	224	64.0%
	Smart phone	249	71.1%
	Tablet	27	7.7%
	Internet facilities (LAN)	39	11.1%
	Internet facilities (Wi-Fi)	12	3.4%
	Other ICT (Wi-Fi)	36	10.3%

Ninety eight percent of HFs had ICT appliances. Three most frequently used ICT appliance were “Smart phone” (71%), “mobile phone” (64%) and “computer” (37%).

Table 76. Percentage of HFs by how ICT was acquired

		Responses	
		N	Percent
Supplier of ICT (N=342, 96%)	Own	463	77.3%
	Govt.	118	19.7%
	Donor	14	2.3%
	Other	4	.7%
Total		599	100.0%

Most frequent response for source of the ICTs at HFs was “own” (77%). Secondly, it was “government” (20%).

Table 77. Percentage of HFs by main purpose for which ICT is used

Use for	N	%	Computer	Mobile	Smart phone	Tablet	Internet
Routine communication	323	91%	1.9%	41.7%	47.7%	1.5%	1.5%
Consultation	234	66%	.6%	43.7%	51.1%	1.2%	.9%
Medical indent	196	55%	6.5%	42.8%	44.9%	.4%	-
Health education	107	30%	15.4%	28.2%	47.0%	2.0%	2.7%
Hospital record	70	20%	82.7%	2.7%	9.3%	4.0%	-
On-job training	66	19%	28.1%	26.0%	34.4%	3.1%	-
Patient register	42	12%	57.8%	11.1%	26.7%	4.4%	-
Phone billing	13	4%	5.6%	44.4%	44.4%	5.6%	-
Health Insurance	4	1%	50.0%	25.0%	-	-	25.0%

Most frequent uses of ICT were “routine communication’ (91%), “consultation” (66%) and “medical indent” (55%). For those three types of use, mobile phone and smart phone were utilized commonly.

Section I. Waste disposal

Table 78. Percentage distribution of HFs by how health wastes are disposed

		Responses	
		N	Percent
Method of waste disposal (N=356, 100%)	burning	196	33.1%
	burying	263	44.4%
	incineration	47	7.9%
	municipal system	37	6.3%
	waste bans	49	8.3%
Total		592	100.0%

All HFs had their own arrangement for waste disposal. Usually, wastes from hospitals were not disaggregated according to their source wards in the hospital. It means that MRH wastes were not treated separately. Among the various methods, most frequently used method was “burying” (44%). Secondly, it was “burning” (33%). Incineration[18] method was used only by 8% of HFs.

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[18] Incinerators were not standardized in most of hospitals.

Section J. Charges for user fees

Table 79. Percent distribution of HFs by issues for which user fee is charged for counsultation

	Frequency	Percent
Yes	5	1.4
No	351	98.6
Total	356	100.0

Table 80. Percent distribution of HFs by issues for which user fee is charged for medication

	Frequency	Percent
Yes	75	21.1
No	279	78.4
No response	2	.6
Total	356	100.0

Table 81. Percent distribution of HFs by issues for which user fee is charged for speciality services

	Frequency	Percent
Yes	21	5.9
No	334	93.8
No response	1	.3
Total	356	100.0

Respondents from 23% of HFs stated there was user fees especially for “medicine” (21.1%%) and “specialty services” (5.9%%). HFs wihich charged for consultation fees was only 1.4%.

Table 102. Percentage distribution of HFs offering modern contraceptive method

	Methods	N	Percent
Recently available modern contraceptives[a]	M condom	198	55.6%
	F condom	22	6.2%
	OCP	322	90.4%
	Inj	299	84.0%
	ECP	120	33.7%
	IUD	143	40.2%
	Implant	32	9.0%
	F sterilization	106	29.8%

Most frequently available method was OCP (90%). Second method was “Injection” was 84%.

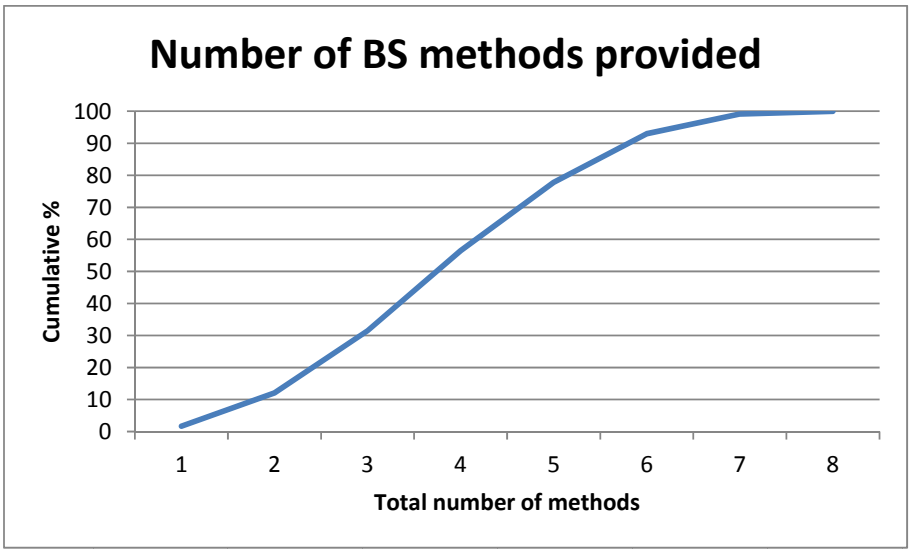

Figure 22. Cumulative number of BS methods could be provided in HFs

It could be seen that most of HFs could provide three to six modern methods of contraception.

Table 103. Percentage distribution of service delivery points with any Maternal/RH Medicine Available (e16totalnew)

RH medicine	N	Percent
(inj metro)	319	89.6%
(inj Na Lactate)	277	77.8%
(oral misoprostol)	266	74.7%
(inj oxytocin)	257	72.2%
(inj gentamycin)	228	64.0%
(inj dexa)	224	62.9%
(inj ampicillin)	215	60.4%
(inj MgSO4)	203	57.0%
(inj benz penicillin)	196	55.1%
(oral nifedipine)	192	53.9%
(oral cefixime)	191	53.7%
(inj azithro)	180	50.6%
(inj cal gluconate)	180	50.6%
(inj TT)	150	42.1%
(oral M-Dopa)	69	19.4%
(oral hydralazine)	39	11.0%

Four most common RH life-saving medicines were “Inj Metronidazole” (90%), “Na Lactate” (78%), “Oral misoprostol” (75%) and “Inj Oxytocin” (72%). “Inj Meg Sulph” was available at 57% of all HFs. Least frequently available medicine were ‘M-dopa” (19%) and

"Hydralazine" (11%). 42% of HFs of all levels had injection TT. Primary-level HFs were not relevant in this availability because most of those HFs had no continuous cold chain to keep TT injection all the time in their facility.

Table 104. Percentage distribution of service delivery points with modern contraceptive method in stock (NO STOCK OUT) in the last six months

	Frequency	Percent
No stock-out	127	35.7
Stock-out	229	64.3
Total	356	100.0

Table 105. Percentage distribution of service delivery points with modern contraceptive methods in stock (NO STOCK-OUT) at the time of survey

	Frequency	Percent
No stock-out	122	34.3
Stock-out	234	65.7
Total	356	100.0

More than 30% of HFs had stocked least number of contraceptives (three methods for primary level HFs and five methods for secondary and tertiary level HFs) recently and during the last six months.

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Stock Information for Myanmar FP2020 Core Indicator

11a: **Percentage** of tertiary and secondary level service delivery points [SDPs) offering at least five modern methods of contraceptives

Tertiary	Secondary	Urban	Rural	Total
84	63	68.7	52.2	62.5

11b: **Percent** of primary level service delivery points [SDPs) offering at least three methods

Primary	Urban	Rural
84.3	81.3	84.6

PART IV

Findings from clients interview

Characteristics

Table D. Distribution of clients by region

Sample clients		Frequency	Percent
Regions	Kachin	51	4.7
	Kayah	21	1.9
	Kayin	36	3.3
	Chin	33	3.0
	Sagaing	124	11.4
	Tanintheri	36	3.3
	Bago	115	10.6
	Magway	98	9.0
	Mandalay	102	9.4
	Mon	39	3.6
	Rakkhine	64	5.9
	Yangon	75	6.9
	Shan (South)	63	5.8
	Shan (North)	60	5.5
	Shan (East)	24	2.2
	Ayeyarwaddy	130	11.9
	Naypyitaw	18	1.7
Level	Tertiary	68	6.2
	Secondary	501	46.0
	Primary	520	47.8
Urban/Rural	Urban	384	35.3
	Rural	705	64.7

Distribution of clients who had responded to the client exit interview by region, level of HFs and urban/rural residence were described in the table above. Since at least three clients for each HF was recruited, the percentage distributions were approximated to that of HFs. The survey teams could not wait till to the clinic opening days at field. Some of HFs had no regular BS Clinic days. These constraints lead the team to recruit the BS clients not exactly at clinic exit situation. Instead, the enumerators recruited the clients from most recently visited clients from the registers.

Table E. Recruitment of clients by level of HFs and urban/rural

		Urban/Rural		
		Urban	Rural	Total
Health Facility Level	Tertiary	68	0	68
	Secondary	277	224	501
	Primary	39	481	520
Total		384	705	1089

Client recruitment was also proportionately in accordance with level of facility and urban/rural status. Proportion of clients in rural was nearly twice of urban.

Table 82-85. Socio-demographic characteristics of clients

Characteristics	Age groups (total number of clients)								
	10-14 age	15-19 age	20-24 age	25-29 age	30-34	35-39	40-44	45-49	50+
Type of facility									
Primary level	0	6	70	114	128	108	76	17	1
Secondary level	0	13	84	115	119	99	51	17	3
Tertiary level	0	6	70	114	128	108	76	17	1
Residence									
Urban	1	11	68	74	104	65	48	12	1
Rural	0	10	97	168	160	153	89	25	3
Total	1	21	165	242	264	218	137	37	4

		Frequency	Percent
Marital status	Married/live together	1083	99.4
	Divorce/separated/ widow	6	.6
Education level	No schooling	39	3.6
	Primary	341	31.3
	Above primary	709	65.1

More than 80% of clients were aged between 21 and 50 years. Six clients (0.6%) had divorced/widower at the time of interview. Two-third of clients were ‘above primary’ level education.

Table 86. Percentage distribution of clients by frequency of visit to the HF for BS services

		Frequency	Percent
Frequency of ever visit to birth spacing clinic	Monthly	300	27.5
	two-monthly	14	1.3
	three-monthly	692	63.5
	Irregularly	40	3.7
	Just once (for implant)	16	1.5
	Irregular (to take condom)	3	.3
	Just once (for IUD)	22	2.0
	Six monthly	2	.2
	Total	1089	100.0

More than 90% of clients in the interview were monthly or three-monthly visitors.

Clients' perception of family planning service provision

Table 87. Percentage distribution of clients' perspective of FP service provider's adherence to technical issues

Clients' perspective on Technical issues (n=1079)	Percent of Cases
The method you got is that you like	90.9%
Staff informed you how to use the method	89.5%
Staff informed you side effects of the method	80.4%
Staff informed you how to manage side effects of the method	78.9%
Staff informed you side effects of the method that need to follow up	85.0%
Staff informed next appointment	92.8%

a. Dichotomy group tabulated at value 1.

According to the response of clients, information they received less from providers was "about how to manage side effects of the contraceptives".

Table 87b. Percentage distribution of client's perception of FP service provider's adherence to technical issues

Characteristics	Percentage		
	Provided with method of choice	Informed about common side effects of the method	client given date to return to SDP for check-up and/or additional supplies
Type of facility			
Primary level	99.6	82.6	94
Secondary level	99.4	77.6	90.4
Tertiary level	100	73.5	86.8
Residence			
Urban	99.7	76.6	89.3
Rural	99.4	81.5	93.3
Total	99.5	79.8	91.9

Table 88. Percentage distribution of clients' perspective of FP service organizational aspects

Clients' perspective on service organizational aspects (N=1087)	Percent of Cases
Waiting time before consultation was too long	8.2%
Satisfy the cleanliness of HC	98.4%
Satisfy privacy status of HC	99.2%

Favourable response for situation of clinic was in high rates. Most of visitors satisfied about cleanliness and privacy at the health center. Long waiting time at the health center was complained only by 8% of respondents.

Table 89. Percentage distribution of client's perspective of FP service inter-personal aspects

Clients' perspective on inter-personal aspects (N=1089)	Percent of Cases
Took enough time for consultation	99.0%
Gave regards and warm welcome	99.4%
Insisted/urged to accept the method you got	8.0%

a. Dichotomy group tabulated at value 1.

Regarding the inter-personal relationship with service providers during the clinic visit, almost all of respondents gave favorable response. Only 8% of respondents stated they have been insisted to accept the BS method that they have from the HF.

Table 89b. Percentage distribution of client's perspective of FP service inter-personal aspects

Characteristics	Percentage of Client indicated he/she was forced by the health service providers to accept or insisted he/she should accept FP method
Type of facility	
Primary level	8.1
Secondary level	8
Tertiary level	7.4
Residence	
Urban	6.5
Rural	8.8
Total	8

Table 90. Percentage distribution of clients' perspective of FP service outcome aspects

Clients' perspective on outcome aspects (N=1089)	Percent of Cases
Satisfied with the attitude of staff on you	98.7%
Satisfy the service/treatment you received	99.7%
Have idea to visit the HC in future	97.2%
Have idea to encourage friends/relatives to use this HC	98.3%

a. Dichotomy group tabulated at value 1.

On the outcome aspect, almost all statements pointed clients satisfied the result of the clinic visit.

Clients' appraisal of cost of BS services

Clients' appraisal on cost	N	Percent
Charged for registration	49	4.5%
Charged for Lab/X Ray procedure	4	.4%
Medicine from clinic	121	11.1%
Medicine from outside pharmacy	73	6.7%
Examination fees	3	.3%

There were few issues about costing at the clinic visit. About 11% had spent some amount for medicine from the clinic (about 1500 kyats) and 7% had spent for to buy medicine from outside (about 1000 kyats). Charge for registration (median amount=500 kyats) was stated by 5% of clients. There were no obvious differences of expenses of clients among areas, urban/rural status and different transportation status.

Table 91. Percentage of clients reporting paying for service and average amount paid by type of HF

Health Facility Level		Registration	Lab/X Ray procedure	Medicine from clinic	Medicine from outside	Examination fees
Tertiary	N	4	3	3	7	-
	Median	500	5000	1500	1000	-
	Mean	700	6000	1833	1279	-
	SD	542	1732	577	571	-
Secondary	N	23	1	57	30	1
	Median	500	2000	1000	950	500
	Mean	587	2000	2184	1587	500
	SD	246	-	4311	2299	
Primary	N	22	-	61	36	2
	Median	500	-	1500	900	600
	Mean	452	-	2961	1282	600
	SD	376	-	7321	1838	566
Total	N	49	4	121	73	3
	Median	500	5000	1500	1000	500
	Mean	536	5000	2567	1407	567
	SD	339	2449	5970	1955	404

Table 92. Percentage of clients reporting paying for service and average amount paid by Administrative Unit (Region)

State/Region		registration	Lab/X Ray procedure	Medicine from clinic	Medicine from outside pharmacy	Examination fees
Kachin	N	-	3	1	3	-
	Median	-	5000	1000	3000	-
	Mean	-	5000	1000	3667	-
Kayah	N	-	-	1		-
	Median	-	-	150		-
	Mean	-	-	150		-
Kayin	N	2	-	3	9	-
	Median	400	-	1000	500	-
	Mean	400	-	1000	711	-
Chin	N	1	-	2	1	1
	Median	200	-	600	600	200
	Mean	200	-	600	600	200
Sagaing	N	6	-	10	18	-
	Median	500	-	1000	900	-
	Mean	633	-	7400	1283	-
Tanintheri	N	-	-	2	4	-
	Median	-	-	1500	750	-
	Mean	-	-	1500	663	-
Bago	N	5	-	17	11	-
	Median	500	-	1500	900	-
	Mean	600	-	2815	759	-
Magway	N	7	-	-	7	1
	Median	500	-	-	1000	500
	Mean	486	-	-	1214	500
Mandalay	N	16	-	28	2	-
	Median	500	-	1250	1000	-
	Mean	519	-	1393	1000	-
Mon	N	1	-	1	2	-
	Median	500	-	1000	1500	-
	Mean	500	-	1000	1500	-
Rakkhine	N	-	-	18	1	-
	Median	-	-	1500	1200	-
	Mean	-	-	1311	1200	-

Yangon	N	7	1	1	4	-
	Median	500	5000	150	975	-
	Mean	350	5000	150	1113	-
Shan (South)	N	-	-	5	1	1
	Median	-	-	500	500	1000
	Mean	-	-	900	500	1000
Shan (North)	N	-	-	15	2	-
	Median	-	-	1500	750	-
	Mean	-	-	6433	750	-
Ayeyarwaddy	N	3	-	17	8	-
	Median	500	-	1000	750	-
	Mean	500	-	924	1094	-
Naypyitaw	N	1	-	-	-	-
	Median	500	-	-	-	-
	Mean	500	-	-	-	-
Total	N	49	4	121	73	3
	Median	500	5000	1500	1000	500
	Mean	536	5000	2560	1400	560

Table 93. Percentage of clients reporting paying for service and average amount paid by urban/rural residence

Unban/Rural		Charged for registration	Charged for Lab/X Ray procedure	Medicine from clinic	Medicine from outside pharmacy	Examination fees
Urban	N	20	3	38	23	-
	Median	500	5000	1500	1000	-
	Mean	538	6000	2820	1689	-
	SD	316	1732	5182	2527	-
Rural	N	29	1	83	50	3
	Median	500	2000	1000	950	500
	Mean	534	2000	2452	1277	567
	SD	359		6324	1641	404
Total	N	49	4	121	73	3
	Median	500	5000	1500	1000	500
	Mean	536	5000	2567	1407	567
	SD	339	2449	5970	1955	404

Table 95. Percentage of clients by Cost of transportation and travel route

Main route to reach the clinic	N	Cost for transportation (43% response rate)		
		Median	Mean	Std. Deviation
On-foot	208	0	82	330
Bicycle	22	1000	1045	950
Motorbike	178	500	1037	1800
Bus/Taxi	41	4000	5816	6660
Own vehicle	3	1000	3667	4619
Other	19	600	1453	2258
Total	471	300	1065	2796

Table 95b. Percentage of clients by Cost of transportation and Distance to clinic from home

Distance to clinic from home (mile) (group)	N	Cost for transportation (41% response rate)		
		Median	Mean	Std. Deviation
<=0 .2 mile	217	0	74	189
0.3 -0.5 mile	56	500	609	654
0.6 mile and above	174	1000	2419	4212
Total	447	200	1054	2859

Table 96. Average time spent by client for FP services

	travel to clinic (total minute)	waiting at clinic (total minute)	return to home (total minute)
N	1089	1089	1089
Median	10	5	10
Mean	13	7	14
Std. Deviation	18	23	27

Total time spent for clinic visit for BS was about 25 minutes. These were ten minutes each for travel go and back, 5 minutes for waiting time.

Table 96a. Time spent by client for BS services

		Frequency	Percent
Duration for travel to clinic (total minute)	<= 10	720	66.1
	11 - 30	316	29.0
	31 - 60	34	3.1
	61 - 120	16	1.5
	121+	3	.3
	Total	1089	100.0
Duration for waiting at clinic (total minute)	<= 10	894	82.1
	11 - 30	176	16.2
	31 - 60	13	1.2
	61 - 120	3	.3
	121+	3	.3
	Total	1089	100.0
Duration for return to home (total minute)	<= 10	721	66.2
	11 - 30	314	28.8
	31 - 60	33	3.0
	61 - 120	15	1.4
	121+	6	.6
	Total	1089	100.0

More than 90% of clients have to spend <30 minutes for travel time to and from the clinic and waiting time at clinic.

Table 97. Percentage distribution of clients by activities they would have engaged in during the time spent receiving BS services

Activities they would have engaged in during the time spent receiving FP services (N=1083, 99%)	Percent of Cases
Regular house chores	63.6%
Farm works	13.9%
Selling	13.3%
Manual labour	4.0%
Skill labour	3.5%
Professional job	3.2%
Others	1.8%

a. Dichotomy group tabulated at value 1.

Other main task at home left during the clinic visit (specified)=Breed, CD lend, feed the goat, feed the pig, Feed the pig, livestock(duck), livestock(pig), sewing, tea maker, teacher

Nearly two-third of clients they spared the time for household works during the clinic visit. About one-third stated they spared time for earning works/duties.

Table 98. Percentage distribution of clients by persons indicated to have performed activities on their behalf while they were away receiving FP Services and the estimated average payment

		Frequency	Percent
To whom assigned the task left at home	Family member	560	51.4
	Working partner	27	2.5
	Nobody	489	44.9
	Other (friend/neighbor/laborers)	13	1.2
	Total	1089	100.0

About 45% of clients did not delegate the duties to others for absence of works during the clinic visit.

Table 99. Average amount paid to persons who performed activities on behalf of clients by activities performed while client was away receiving FP services

		Frequency	Percent
To whom assigned the task left at home	Family member	560	51.4
Average amount paid (MMK)	Working partner	27	2.5
Mean (SD)=2225(1974)	Nobody	489	44.9
Median=2000	Other	13	1.2
	Total	1089	100.0

Of those clients who had assigned for their work during the clinic visit (55%) had to spend about 2000 kyats for the assignment. The payment was made mostly by their spouse (66%) and by themselves (31%).

Table 100. Percentage distribution of clients by source of funds used to pay for FP services

Clients by source of funds used to pay for FP services (N=566, 52%)	Percent of Cases	Mean (SD) MMK
by myself	31.3%	2100 (6600)
by spouse	66.6%	2700 (6200)
by family members	1.8%	1670 (1400)
by others	.7%	350 (475)

a. Dichotomy group tabulated at value 1.

PART V

Summary of findings

Summary for findings about HFs

Modern contraceptives available: Most frequently available contraceptive methods were OCP (90%) and "Injection" (84%). It could be seen that most of HFs could provide three to six modern methods of contraception to the clients.

Modern contraceptives offered by primary facilities: 84% of primary-level HFs were providing at least three modern contraceptive and majority was fulfilling basic birth spacing services.

Modern contraceptives offered by secondary and tertiary facilities: Percentage of availability of at least five modern contraceptive methods found in secondary and tertiary level HFs were (63% vs. 84%, P<0.001). The lowest percentage was in Station Hospitals (50%) and the highest percentage was in District Hospitals (91%).

Availability of Maternal and RH essential medicine: Nation-wide availability of essential life-saving MRH medicine was 49%. The percentage was highest in tertiary level (83%) and lowest in primary level (35%).The percentage was higher in urban compared to rural (63% vs. 40%) facilities. The HFs located farer from medical depots had higher percentage of availability.

Four lowest stock-out RH medicines were "Metronidazole" (10%), "Na Lactate" (22%), "Oral misoprostol" (25%) and "Inj Oxytocin" (28%). "Inj Meg Sulph" was stocked-out at 43% of HFs. Highest stock-out medicine were 'M-dopa" (81%) and "Hydralazine" (89%). 58% of HFs of all levels had Anti Tetanus toxoids (TT). Primary-level HFs were not relevant in this availability assessment because most of those HFs had no continuous cold chain system to keep TT injection at their facility.

Incidence of 'No Stock Out' of modern contraceptives in the last six months: 36.5% of HFs was able to provide choice of modern contraceptive method during last six month. The availability was not different among different level of HFs. No stock-out for OCP and Injectable were 70% for all levels of HFs. No stock-out for female condom" was about 80% for all levels. Implant stock-out was also high in secondary level HFs. Stock of ECP was 75% for all levels of HFs.

Incidence of 'No Stock Out' of modern contraceptives on the day of the survey: Stocks for OCP and Injectable methods were more than 70% in all levels. Percentage of male and female condom stock was lowest in tertiary level HFs than primary (<40% vs. >50%). ECP stock was lower in secondary and primary level HFs than tertiary level HFs (44% & 49% vs. 56%).

Supply Chain, including cold chain:

Responsible person: Pharmacists, TMO and assigned MO were main responsible person for drug indent and ordering. They were taking full responsibilities at five regions (Nay Pyi Taw, Mon, Magway, Rakkhine and Shan (S). Of those areas, Nay Pyi Taw and Rakkhine were found MS and Pharmacists only took responsibilities. Role of TMOs was obvious in Sagaing, Mandalay and Yangon Regions.

Calculation of needs: Sixty one percent of tertiary level HFs calculated the needs of contraceptions. Calculation of 48% of tertiary HFs was made by central medical depot (CMSD). Supply needs for majority of other two levels HFs were quantified by medical depot only (75% and 81% respectively). HFs in rural areas were less in practicing calculation by themselves than in urban area (22% vs. 46%, P<0.001).

Indent: Only 33% of HFs were using standard forms for indent the supplies. Using of standard form was much less in primary level HFs compare to tertiary level HFs (24% vs. 70%).The standard form use rate was quite low in Rakkhing and Ayeyarwaddy Regions. The areas with high use rates were Kachin, Tanintheri, Naypyitaw and Yangon.The rate was about two times higher in urban than rural (50% vs. 23%).

Supply: 78% of tertiary level HFs was mainly supplied by Central Medical Store. 37% of secondary and 67% of primary level HFs was supplied by Township Health Departments. Major suppliers for HFs of urban area were CMSD and State/Region Health Department (37% and 41% respectively).

Transportation: Most of HFs (>74%) at all levels and all regions had their own arrangement for transportation of drug supplies to their HFs. Government arrangement for the transportation was found in tertiary and secondary level HFs (26% and 11%). Government arrangement was identified in Tanintheri, Sagaing, Kachin and Bago. Own arrangement was more obvious in rural than urban (96% vs. 84%, P<0.001).

Interval: Most of HFs especially secondary and primary levels stated that the interval between indent and supply was irregular (42% and 41% respectively). 40% HFs at tertiary level was estimated the interval as 1-2 months. Irregularity was more pronounced in

secondary and primary level HFs. (37% vs. 17%) One-third of HFs stated that the interval was six-month duration. Irregularity of interval was more in rural than urban (42% vs. 24%). Six-month interval was more in urban than rural (45% vs. 28%).

Cold chain: Availability of cold chain was the highest in tertiary and secondary level HFs (100% & 84%) and the least in primary level HFs (34%). Overall percent of availability of cold chain system was about 60% with obvious urban rural difference (90% vs. 44%, P<0.001). It was much less in Chin, Kayah and Ayayarwaddy Regions (<less than50%). Shan (S) and Nay Pyi Taw Regions had more than 80%.Of those available cold chain units, more than 80% used electrical power supply system. This type of cold chain was found more in States than Regions. Most of tertiary HFs used power source from the "national grid". Nearly half of HFs in primary level (43%) used solar power. The difference between urban and rural for the usage of national grid was also significant (84% in urban vs. 49% in rural, P<0.001). The usage for the solar power was much higher in rural compare to urban (43% in rural vs. 21% in urban, P<0.001).

Staff trained for BS and Implant: There were 66% and 17% of HFs which had trained staff for birth spacing and implant respectively. Presence of trained staff for BS was lowest in secondary level (53%) compare to tertiary and primary levels (87% and 75%). Chin, Sagaing, Shan (E), Tanintheri, Shan (N), Rakkhine and Kayah had low level of presence of trained staff for BS. The presence of trained staff for implant was only at 24% in the whole Union, and that of tertiary level HF was 84% and primary level was (5%). Magwe, Shan (S) Kachin, Shan (N), Bago, Kayin, Ayeyarwaddy and Chin had lower in percentage of having trained staff compared to the Union level. Urban rural difference for presence of trained staff for implant was quite significant (47% vs. 11%, P<0.001). Most of trained staff for BS got the training more than one year ago (83%). Percentage of HFs with more freshly trained staff (i.e. last two months ago) was higher in tertiary level compare to other two types of HFs.

Supervision: Percent of HFs which had not received supervision for RH was 41% and it was highest in tertiary level (48%). Rakkhine, Chin, Bago, Ayeyarwaddy and Mandalay Regions received lower percentage of RH supervision compare to the union level. Most of RH supervision was in irregular interval (37%). Second most frequent interval was "every 3 months" (24%). Frequency of supervisory visits was comparatively low in tertiary and primary level HFs. Irregularity of supervisory visit was more frequent in Rakkhine, Ayeyarwaddy, Bago and Kachin. Percentage of HFs which had been more frequently visited

was higher in rural. Most frequent issue in supervision was identified as 'logistic". Second most frequent issues were "reporting" and 'clinical treatment".

Availability of guidelines, check-lists and job aids: Availability of guidelines were found not more than 78% of all health facilities Most frequently available guidebook was "Job aid for antenatal care" (77%) and "Guidebook for antenatal care" (68%). Regarding the guide for BS, 57% of HFs had "Checklist for BS". "National guidebook for BS" was available at 33% of HFs only. "Guide for waste disposal" was least available (21% of HFs). Distribution of availability of various guidebooks was not much different among different level of HFs. Guides for antenatal care were more available than that of BS. Guides for antenatal care were observed in all areas and that for BS was not observed much. HFs at Mon, Shan (S), Shan (N), Chin and Ayeyarwaddy Regions had more BS Guides. The least frequently observed HFs with one of BS Guides were Kayah, Kachin and Tanintheri.

Use of Information Communication Technology (ICT): Ninety eight percent of HFs had ICT appliances. "Smart phone" (71%), "mobile phone" (64%) and "computer" (37%) were top three ICT appliances. Most frequent response for source of the ICTs at HFs was "own" (77%). Most frequent uses of ICT were for "routine communication' (91%), "consultation" (66%) and "medical indent" (55%). For those three types of use, mobile phone and smart phone were utilized commonly.

Waste disposal: All HFs had their waste disposal management system. Most frequently used methods were "burying" (44%) and "burning" (33%). Incineration method was used only by 8% of HFs.

Charges for user fees: Respondents from 23% of HFs stated that there was user-fees especially for "medicine" (92%) and "specialty services" (26%).

Summary of findings about clients

Characteristics: Proportion of clients in rural was nearly twice of urban. More than 80% of clients were aged between 21 and 50 years. Very few (0.6%) were divorced/widower at the time of interview. Two-third of clients were 'above primary' level education. More than 90% of clients in the interview visited the health facilities monthly or three-monthly.

Clients' perception of family planning service provision: According to the response of clients, the information they received less from providers was "how to manage side effects of the contraceptives". Very high percentage of the clients had favorable response for situation of clinic. Most of visitors satisfied with cleanliness and privacy at the health center. Long waiting time at the health center was complained only by 8% of respondents. Almost all of respondents gave favorable response regarding provider-clients relationship. Only 8% of respondents stated that they were insisted to accept the BS method that they received from the HF. According to the results, almost all statements pointed clients were satisfied with services of the health care facilities.

Clients' appraisal of cost of BS services: About 11% had had to pay for medicine at the clinic (1500 kyats in median) and 7% had to buy medicine from outside (1000 kyats in median). Only five percent of clients stated that they had to pay registration fees (median amount=500 kyats) Total time spent for clinic visit for BS was about 25 minutes. More than 90% of clients had to spend <30 minutes for travel time to and from the clinic and waiting time at clinic. Nearly two-third of clients they lost the time for household chores during the clinic visit. About one-third stated that they had productivity lost. About 45% of clients replace any person to do their chores during their visit to the clinic. Out of them (55%) had to pay around 2000 kyats for hiring people to help them. The payment was contributed mostly by their spouse (66%) and by themselves (31%).

Discussion and conclusion

In 2014, more than 90% of HFs could provide at least one of three types of modern contraceptive, most of which were injectables, OC pills and male condoms. The most available method was OCP in this year while injectable was the most in last year. Availability of five modern contraceptive methods in secondary and tertiary levels HFs was noted less than those of last year. However, further detail analysis showed that comparison of proportion of availability of contraceptive methods in tertiary level HFs for 2014 and 2015 (i.e. 81% vs. 80%, P=0.945), in primary level HFs for 2014 and 2015 (i.e. 87% vs. 84%, P=0.405) were not statistically significant. The difference in secondary level HFs for 2014 and 2015 (76% vs. 60%) was obvious and noted as that of 2015 was less than that of 2014 (P=0.003). High stock-out rate contraceptive methods were implant, ECP, IUD and condoms. At least one method stock-out rate was higher in 2015. It may be due to types of contraceptives supplies during the years more focus on coverage of HFs in terms of number and regions rather than on variety of methods.

Improvement of contraceptive method availability was obvious in method specific comparison analysis. Significant reductions of stock-out were found for all short-term method except male condom distribution. IUD stock-out also significantly decreased from 62% to 48%.

Female sterilization and implant insertion service availability was considered only for tertiary level and secondary level HFs because the methods need presence of a medical doctor and enough equipments. These requirements were not available at primary level HFs. Government do not allow this service to provide at primary level. Tertiary and secondary level availability was high and community demand is also high for this type of service.

Implant stock-out rate was still high having 51% because of untimely supply and lack of skilled staff. Some studies reported awareness of users and in public about the implant method. However, there was risk of misinformation on side effects and unfavourable effects of long acting contraceptives by untrained providers. Some service providers who were not trained yet received implant supply and they did implant insertions and then it make problems to patients such as infection, deep insertion and difficulty in removal. It suggests providing training for service providers, proper distribution, awareness raising and demand creation for implant should be carried out simultaneously with systematic supply of implant to the HFs.

Regarding to RH medicine, the items of most widely available (such as metronidazole, Sodium lactate, misoprostol, oxytocin and megnium sulphate) were similar to those of 2014

survey. The percentages of availability were also significantly different between two survey findings in all items. It means there were no obvious changes in supply chain mechanism during these two years to achieve more availability of RH medicines. Availability of 7 essential RH medicines was 49% in 2015 and it was less than that of 2014 figure 62%. The decrease was obvious in secondary level only (75% in 2014 and 42% in 2015). The percentages in primary level for two survey findings were 43% in 2015 and 35% in 2014. So, it could be interpreted that the improvement within one year was apparent only in primary level and reasons for the reduction in secondary level HFs should be considered. In comparison of urban rural percentages of contraceptives availability between the two years, there was no difference between rural HFs (44% in 2014 and 40% in 2015) but the difference between urban HFs was significant (74% in 2014 and 63% in 2015). So it could be interpreted that high proportion of secondary level HFs in rural areas (i.e. Station Hospitals) in 2015 survey (43%) compare to that of 2014 (4%) should be considered as the reason. And also, it should be considered that RH medicine supply should emphasize more towards secondary level HFs especially Station Hospitals.

"No stock-out" situation was found improved for this year (94% vs. 82%). Regarding the different type of contraceptives, the percentages of stock of contraceptives were found highest for OCP and injectable. However, percentages for implant, ECP and IUD were still low (about 50%). Percentage of stock for implant was very low having about 20% in tertiary and less than 10% in other two levels of HFs. ECP was the method of low demand. IUD and implant were methods which need skilled staff. Demand for these two methods was also relatively low compare to OCP and injectable in the country. Client demand for IUD and implant could not increase without skilled staff in the HFs. There was an apparent number of training sessions during these years for IUD and implant. For more option and better choice of contraceptive methods for client, IUD and implant method promotion are appropriate but it needs long-term strategy since high cost and more time for skill training across the country. Promoting use of IUD and Implants also need clear policy and guidelines for provision of these methods by BHS in rural setting HFs. However, male condom stock was also found not reach to 100%. Since it was a less-cost contraceptive method, supply of male condom should be planned for 100% coverage in all levels of HFs. Contraceptive prevalence rate was increasing in the last decade and unmet need was slowly decreasing. In 2014 the Government spent 1.29 million USD for purchasing contraceptives. UNFPA also covered 50% of townships all over the country for support for RH. However, there were many challenges in

securing reproductive health commodities and services. Wide necessities in LMIS, delayed shipments of procured commodities, need of efficient distribution infrastructure and low demand coupled with less skill staff for BS are identified.[19] To overcome these challenges, actionable strategies which were laid down in 2014 in the "Costed Implementation Plan to meet FP2020 commitments-Myanmar" need to be implemented, more emphasis and investment need to be directed towards supply chain stregthening. There are still gaps in funding for contraceptives procurement which need to be addressed.

Since May 2013, John Snow Inc (JSI), with the support of UNFPA, is working with MOH to strengthen RH supply chain in Myanmar – Assessment and designing of RH commodity Logistics System (RHCLS), development of SOP, conducting TOT, followed by Multiplier trainings in 12 Pilot Townships at four states and regions (Yangon, Mandalay, Ayeyarwaddy Regions and southern Shan State) in 2014. After evaluation of RHCLS project in 2015, RH LMIS was starting to set up in 12 townships of 4 States and Regions. According to JSI report, stock adequacy in the programme regions was varying about 11%-44% of HFs in 2015. Stock-out situation was also found 15%-46%.[20] This situation reflects logistic management system has to carry out for significant period to reach RH commodities security. LMIS training could cover small fraction only. To expand the training and launching the LMIS system towards more regions, there are many things to fulfill the necessities. Infrastructural developments such as information technology and communication networks are causing major limitation for development of the system. Consequently, these limitations make area expansion of LMIS to be not need-based. Finally, supply chain of commodities covering all levels of HFs might be still in challenging to reduce stock-out situation.

Procurement, distribution and other complementary inputs like training, infrastructure renovation (site preparation) etc. have to carefully planned to get well harmonization and fully effective for best provision of services. Commodities arriving much earlier or later than the other inputs can lead to non-provision of services and consequently wastage of resources. Health facilities should have ownership in logistic management especially on essential items, quantifying minimum needs, ordering and reporting rationality of use. The medicines requisition should be bottom up approach. Moreover, the equal distribution among health facilities should not be done but equitable distribution. Logistic management needs skill. Thus supplies of commodities should go concurrently with logistic management skill training. Various donor agencies and governments need to promote better logistic

[19] Costed Implementation Plan to meet FP2020 Commitments Myanmar 2014. MOH/UNFPA
[20] Updated reprot: Reproductive Health Commodity Logistics System. MOH, UNFPA, JSI, RI. Jun 2015

management rather than invest in the purchase of newer supplies when most facilities have need and skilled staff. Capacity development is required at district, regional and national level to manage commodities in the health system.

One of biggest partner of MOH, UNFPA developed and printed out: "FP 2020 Costed Plan", "National Midwifery Standards" as per ASEAN-WHO guidelines, "RH Strategic Costed Plan 2014-2018". Budgetary allocation and resource mobilization for RH interventions, FP TWG and commodities management meeting were conducted. Social mobilization activities on FP were also implemented. Regarding the RH LMIS, office automation, meeting for National Harmonization for RH supply chain management, monitoring township LMIS activities and establishment of RH commodity tracking system were conducted. However, the coverage is low to make apparent achievement for improvement of outcome parameters. Since Myanmar become one of 46 countries in 2013 to be supported by the UNFPA Supplies Programme as part of the aiming to achieve goal of FP 2020. With this program, UNFPA support 5.2 million USD worth of contraceptives (mainly male & female condom, injectable, ECP, IUD and implant) and critical medicines (mainly magnesium sulphate, misoprostol and oxytocin) for maternal health in 2014 and 2.7 million worth of contraceptives to MOH for public facilities and also to the other sectors via the three major partners: IPPF through 135 maternity homes, MSI through 50 project sites and PSI through 3500 SDPs across the country. Logistic supply system was accomplished with various activities through training, logistic and technical support, and monitoring. MOH was supported for automated logistic management system for RH commodities. The RH commodities supported by UNFPA are tracked monthly by respective IPs with batch numbers. In order to avoid the overstock and under-stock facilities, UNFPA and JSI are encouraging to mobilize the RH commodities in township level, RHC and Sub-center level. Since 2015, the Quality Improvement Team (QIT) were set up in Township level as well as State and Regional level and regularly organized the QIT meeting to review the stock balance and to facilitate the stock reallocation of FP and RH commodities from overstock townships to understock or stock out townships.

Midwives are key to reducing maternal and newborn deaths especially in rural areas where 70% of the population[21]. Evidence shows that MWs who are educated and regulated to international standards can provide 87% of essential care needed by women and their newborns and can prevent up to 60% of maternal deaths. In order for MWs to provide high

[21] The 2014 Myanmar Population and Housing Census

quality care they also need adequate infrastructure, readily available drugs and supplies, water and sanitation, communication, and a functioning referral system if complications arise during childbirth. UNFPA supports midwifery in Myanmar by contributing to research, building the capacity of midwives and traditional birth attendants, and providing medicines and materials. Midwifery workforce was assessed for future projection and policy options, workforce planning for a resilient health system. Decision making training for midwives with required skill were set and deployed in right numbers to regions in need. UNFPA together with the MOH is supporting public-private partnerships in contraceptives distribution to achieve commitments of FP2020 which include increasing CPR to 50% and to reduce unmet need to 10%.

To build the capacity and strengthen the health system, UNFPA together with JSI and all other development partners works with the MOH to improve the procurement planning, forecasting and supply planning for uninterrupted supplies of RH commodities at service delivery points so that women will have right commodities at the right time and right quantity at their choice for birth spacing.

Health facility survey 2015 highlighted the fact that there is much more investment of capacity building to train Basic health staff on long acting reversible contraceptives (LARC). Presence of trained staff for BS was lowest in secondary level (53%) compare to tertiary and primary levels (87% and 75%). Chin, Sagaing, Shan (E), Tanintheri, Shan (N), Rakkhine and Kayah had low level of presence of trained staff for BS. Thus, these regions need to be focused when 2016 trainings are planned.

The presence of trained staff for implant was only at 24% in the whole Union, and that of tertiary level HF was 84% and primary level was (5%). Magwe, Shan (S) Kachin, Shan (N), Bago, Kayin, Ayeyarwaddy and Chin had lower in percentage of having trained staff compared to the Union level.

Although improvemtns were evident in preventiong stock outs, there is still descripencies between urban and rural health facilities in terms of RH life saving medicines and choice of contraceptive methods. Irregularities of stock replenishment and addressing stock imbalances remain as challenges which need strengthened distribution system and stock adjustments based on stock data using computerized reporting system.

In conclusion, recent survey findings do provide further information to policy makers and implementers for evidence-based decision making for family planning and safe-motherhood. Although there was not much difference of findings between two consecutive surveys

because many planned activities related to LMIS and supplies were started in 2014. However, success will be achieved in coming few years. The regular assessments will also be a form of close monitoring rather than evaluation. It could help programme with timely information about any deviations, challenges and needs to help timely adjustment of the implementation.

The report covers the situation (including the modern contraceptives and life-saving critical maternal medicines) and the evidences on tracking the achievement of recent implementation of strategic plan. Together, these findings constitute a package that will increase the effectiveness and efficiency of the implementation, enabling the MOH to have a more significant impact on the lives of women in Myanmar. A review of the serial health facility survey findings with implementing partners, stakeholders and program managers need to take place to find the most strategic solution for Reproductive Health Comodity Security in Myanmar.

Recommendations

A. Commodities supply

A1. Contraceptives

To decrease number of primary level HFs with stock-out short-term contraceptives, male condom, female condom and ECP should be distributed to the primary level HFs in the regions which have lowest availability of three modern methods (i.e. Kayah, Kayin and Rakkhine States)

Implant, IUD and male condom supplies should be more emphasized to secondary level HFs especially at rural (i.e. Station Hospitals) at Chin, Magway, Kachin and Mon to combat low percentage of availability of at least five modern methods. Implant method should be promoted to be available at all regions.

ECP shortage at Kayin, Chin, Bago, Magway and Naypyitaw was high. Supplies should be prioritized toward those areas.

Male condom shortage at tertiary level HFs should be reduced by continuum of supplies towards the areas (Kayin, Magway, Naypyitaw and Bago).

IUD supplies should focus to Kayin, Bago, Mon and Magway Regions which had high stock-out rate.

A2. RH Medicine

RH medicines with high stock-out rate were hydralazine, M-dopa, azithromycin, cefixime, nifedipine and Ca Gluconate. Ayeyarwaddy, Rakkhine, Shan (south) and Kayah areas which were low available for 7 essential life-saving RH medicine should be prioritized. Focus should be made to secondary and primary level HFs. UNFPA supplies have started to limit itself to contraceptives, thus MOH procurement will need to take over this portion.

A3. Cold Chain

Health care providers should be informed about oxytocin injection should be kept in cold chain together with TT injection and a policy brief should be published by MOH to all levels of health facilities.

Availability of cold chain was low in primary and secondary level HFs especially at rural areas. Ayayarwaddy, Kayah and Chin were lowest available area for cold chain. Cold chain equipments supplementation should be considered giving priority to the specified. Type of cold chain system should be in line with source of electricity available in the area.

A4. Waste Disposal

Gudilines for waste disposal have been developed in present; however, there is need for specific guidelines for RH commodities. Mini-incinerators should be supplied for station hospitals, primary level HFs.

B. Logistic and Supply Chain Management System

B1. Training

Logistic management skill training should be enhanced and expanded its coverage based on availability of infrastructure and programme needs in terms of geographical area and level of HFs.

Pharmacists should be prioritized to attend more training since they are majority for taking responsibility for drug indent. Quantifying amount and items should be based from HFs' need rather than medical depot's stock status. Standard form for indent including identifying and quantification of amount need should be developed and distributed toward all areas and all levels of HF (special emphasis on Station Hospitals and primary level HFs) for improving need-based supply system.

Training, staff assignment, service availability and commodities supplies should be harmonized. BS and implant training sessions should be conducted more in Sagaing, Shan (east), Tanintheri, Shan (north) and Rakkhine especially at secondary and primary level HFs. Guidebooks for birth spacing should be distributed more to secondary and primary level HFs especially to Sagaing, Tanintheri, Magway, Shan East and Kachin).

B2. Sypply system

Commodities sypply system should be developed to be efficient enough to have timeliness to reach the target site. Development of a system should be in coordination with multi-level and multi-dimensional stakeholders from different regions and it should be specified about route, frequency, transportation, time schedule.

B3. Policy advocacy

Service availability for female sterilization at secondary level HF was relatively low level than tertiary level HFs.

Implant method provision at secondary level HFs should be promoted simultaneously with supplies and skilled training and community awareness raising activities.

Strengthening supply chain and logistic management to be more comprehensive and considering sustainability and self-reliance of State/Regions Health Department

Enforcement for commodities supplies system to be more systematic in calculation, distribution and monitoring based on needs synchronizing different levels

Nationwide LMIS system should be developed with advanced information and communication technology. Unexpensive Smart phone and Tablets, specially developed user friendly software for LMIS are appropriate for HFs at rural and hard-to-reach areas.

Standard operating procedure for national LMIS system should be developed and trained BHS to be applied

To improve policy and regulatory environment that contributes to enhancement of Reproductive Health Commodity Security

To ensure that more than one staff has the ability to make the orders to cater for periods when another staff is either on leave, sick or when they leave the facility.

C. Monitoring and evaluation

All regular supervision of regional and township health authorities should have included with matter about RH medicine, contraceptive commodities stock and resupply. Inventory management focal point at central, state and region level and township level need to be identified as the LMU (Logistic management unit) with one or two designated trained staff to manage inventory control, manage stock imbalances and transaction of stock so that commodities are available in the right place and at right time for the people who need to use them.

RH medicine and Contraceptive commodities tracking information gathering should be combined into existing HMIS system. Key tracer variables should be identified from existing data source by more detail analysis.

There should be systematic continuum in continuation of year-wise programme for RHCS. Including various segments should be harmonized and logical to make significant changes.

A review of the serial health facility survey findings and other studies on the supply chain, commodity inventory management mechnisms inviting implementing partners, stakeholders and program managers need to take place to find the most strategic solution for Reproductive Health Comodity Security in Myanmar. The collection, analysis, availability, use and distribution of logistics data for evidence-based decision making at all levels should be strengthened.

Module II (Client's Interview) should be modified in some portions like sample size and sampling and data collection procedure without much affecting the result in linking to Module I (Facility assessment) results.

Annex 1. GPRHCS Survey Questionnaire ENGLISH

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

SURVEY QUESTIONNAIRE

2014 FACILITY ASSESSMENT FOR REPRODUCTIVE HEALTH COMMODITIES AND SERVICES

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

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

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

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

- Your facility was selected to participate in this study. We will be asking you questions about aspects of RH commodities and services in your facility including family planning. The information obtained from your facility and from other facilities will be used by the MOH and other partners to understand the situation and for better planning to improve on service provision

MODULE 1:

AVAILABILITY OF COMMODITIES

SECTION 1: FACILITY IDENTIFICATION (Name, Location and Distance)

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

SECTION 2: SDP TYPE AND SERVICES PROVIDED	
006	Level of Service Delivery Point(**Tick the option that is applicable to your country)** Primary Level Care SDPs/facilities (or equivalent to country context) 1 ☐ Secondary level care SDPs/facilities/hospitals (or equivalent) 2 ☐ Tertiary level care SDPs/facilities/hospitals (or equivalent) 3 ☐
007	Management of Service Delivery Point: 1 Government ☐ 2 Private ☐ 3 NGO ☐ 4 Others (please specify……) ☐
008	Does this facility provide family planning services? 1 Yes ☐ 2 No ☐ (If No, then items in Section 3 and 5 (that is 011 to 014 and 019 to 024) should NOT be administered)

009	Does this facility provide maternal health including delivery services (e. g. with a maternity unit or section for delivery)? 1 Yes ☐ 2 No ☐ (If No, then items in Section 4 (that is 015 to 018) should NOT be administered)
010	Does this facility provide any HIV/AIDS services (e.g. VCT, PMTCT, ART, etc.)? 1 Yes ☐ 2 No ☐

SECTION 3: MODERN CONTRACEPTIVE METHODS OFFERED AT SDP

Please note that for the SDP to respond to items in this section, it should have indicated in Item 008 above that 'Yes' it provides family planning services

Item	(1) Male condoms	(2) Female Condoms	(3) Oral Contraception	(4) Injectables	(5) IUDs	(6) Implants	(7) Sterilisation for Females	(8) Sterilisation for Male	(9) Emergency contraception
011 With respect to each of the contraceptive methods, please state whether the SDP is supposed/ expected to offer it, **in line with the current national protocols, guidelines and/or laws specific for this level* of service delivery**. Please discuss with the respondent and then record your conclusion before proceeding.	**1 Yes,** this SDP is expected /supposed to provide this method ☐ **2 No,** this SDP is NOT expected/ supposed to provide this method ☐ *(Tick only one option)*	**Yes,** this SDP is expected /supposed to provide this method ☐ **2 No,** this SDP is NOT expected/ supposed to provide this method ☐ *(Tick only one option)*	**Yes,** this SDP is expected /supposed to provide this method ☐ **2 No,** this SDP is NOT expected/ supposed to provide this method ☐ *(Tick only one option)*	**Yes,** this SDP is expected /supposed to provide this method ☐ **2 No,** this SDP is NOT expected/ supposed to provide this method ☐ *(Tick only one option)*	**Yes,** this SDP is expected /supposed to provide this method ☐ **2 No,** this SDP is NOT expected/ supposed to provide this method ☐ *(Tick only one option)*	**Yes,** this SDP is expected /supposed to provide this method ☐ **2 No,** this SDP is NOT expected/ supposed to provide this method ☐ *(Tick only one option)*	**Yes,** this SDP is expected /supposed to provide this method ☐ **2 No,** this SDP is NOT expected/ supposed to provide this method ☐ *(Tick only one option)*	**Yes,** this SDP is expected /supposed to provide this method ☐ **2 No,** this SDP is NOT expected/ supposed to provide this method ☐ *(Tick only one option)*	**Yes,** this SDP is expected /supposed to provide this method ☐ **2 No,** this SDP is NOT expected/ supposed to provide this method ☐ *(Tick only one option)*

(Please recall SDP level as recorded in item 006 above)* **012** **<u>If 'Yes' in item 011</u>** (i.e., this SDP is supposed/ expected to offer this method), please state whether the SDP actually **<u>offer it to clients</u>** on a regular basis	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 011) ☐ *(Tick only one option)*	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 011) ☐ *(Tick only one option)*	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 01) ☐ *(Tick only one option)*	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 01) ☐ *(Tick only one option)*	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 01) ☐ *(Tick only one option)*	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 01) ☐ *(Tick only one option)*	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 01) ☐ *(Tick only one option)*	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 01) ☐ *(Tick only one option)*	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 01) ☐ *(Tick only one option)*
	NOTE, FOR EACH OF THE METHODS - If this SDP is **actually supposed/expected to <u>OFFERS</u>** the contraceptive method but it is currently out of stock or not available at the time of the survey, please record as "Yes" (i.e.; the method is actually offered, although it is not currently in stock or available)								

Item	(1) Male condoms	(2) Female Condoms	(3) Oral Contraception	(4) Injectables	(5) Emergency contraception	(6) IUDs	(7) Implants	(8) Sterilisation for Females	(9) Sterilisation for Male
013 If this SDP is supposed/expected to offer this method to clients (in line with current national guidelines, etc.) but the response to 010 is "No", please indicate the main reason *(Tick only one option [as the main reason] for each contraceptive)*	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ 4 Low or no client demand for the contraceptive ☐ 7. Any other Reason (please specify)……. ……………………………	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ 4 Low or no client demand for the contraceptive ☐ 7. Any other Reason (please specify)……. ……………………………	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ 4 Low or no client demand for the contraceptive ☐ 7. Any other Reason (please specify)……. ……………………………	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ 4 Low or no client demand for the contraceptive ☐ 7. Any other Reason (please specify)……. ……………………………	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ 4 Low or no client demand for the contraceptive ☐ 7. Any other Reason (please specify)……. ……………………………	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ 4 Low or no client demand for the contraceptive ☐ **5** No train staff to provide this contraceptive at the SDP ☐ **6.** Lack of equipment for the provision of this contraceptive ☐ 7. Any other Reason (please specify)……. ……………………………	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ 4 Low or no client demand for the contraceptive ☐ **5** No train staff to provide this contraceptive at the SDP ☐ **6.** Lack of equipment for the provision of this contraceptive ☐ 7. Any other Reason (please specify)……. ……………………………	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ 4 Low or no client demand for the contraceptive ☐ **5** No train staff to provide this contraceptive at the SDP ☐ **6.** Lack of equipment for the provision of this contraceptive ☐ 7. Any other Reason (please specify)……. ……………………………	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ 4 Low or no client demand for the contraceptive ☐ **5** No train staff to provide this contraceptive at the SDP ☐ **6.** Lack of equipment for the provision of this contraceptive ☐ 7. Any other Reason (please specify)……. ……………………………

014	IF THIS IS A PRIMARY SDPS (AS NOTED IN ITEMS 06)	IF THIS IS A SECONDARY OR TERTIARY SDPS (AS NOTED IN ITEM 06)
From responses provided to Item 012, discuss with the respondent and record the conclusion by ticking one of the following statements	1 This SDP **offers** up to two modern contraceptive methods ☐ 2 This SDP **offers** three and more (at least three) modern contraceptive methods ☐	3 This SDP **offers** up to four modern contraceptive methods ☐ 4 This SDP **offers** FIVE and more (at least three) modern contraceptive methods ☐

SECTION 4: AVAILABILITY OF MATERNAL/RH MEDICINES									
Items	**Maternal/RH Medicines** **Please note that for the SDP to respond to items in this section, it should have indicated in Item 009 above that 'Yes' it provides maternal health including delivery services**								
	(1) **Ampicillin**	**(2)** **Azithromycin**	**(3)** **Benzathine benzylpenicillin**	**(4)** ***Either*** **Betamethasone** ***Or*** **Dexamethasone** ***Or Both of these medicines***	**(5)** **Calcium gluconate**	**(6)** **Cefixime**	**(7)** **Gentamicin**	**(8)** **Hydralazine**	**(9)** **Magnesium sulfate**

015 With respect to each of the maternal/ RH Medicines, please state whether the SDP is supposed have it available; **in line with the current national protocols, guidelines and/or laws specific for this level[*] of service delivery.** Please discuss with the respondent and then record your conclusion before proceeding *(* Please recall SDP level as recorded in item 006 above)*	**1 Yes,** this SDP is expected /supposed to have available this Maternal /RH Medicine ☐ **2 No,** this SDP is NOT expected/ supposed to have available this Maternal /RH Medicine ☐ *(Tick only one option)*	**1 Yes,** this SDP is expected /supposed to have available this Maternal /RH Medicine ☐ **2 No,** this SDP is NOT expected/ supposed to have available this Maternal /RH Medicine ☐ *(Tick only one option)*	**1 Yes,** this SDP is expected /supposed to have available this Maternal /RH Medicine ☐ **2 No,** this SDP is NOT expected/ supposed to have available this Maternal /RH Medicine ☐ *(Tick only one option)*	**1 Yes,** this SDP is expected /supposed to have available <u>any or both of these</u> Maternal /RH Medicines ☐ **2 No,** this SDP is NOT expected/ supposed to have available <u>any or both of these</u> Maternal /RH Medicine ☐ *(Tick only one option)*	**1 Yes,** this SDP is expected /supposed to have available this Maternal /RH Medicine ☐ **2 No,** this SDP is NOT expected/ supposed to have available this Maternal /RH Medicine ☐ *(Tick only one option)*	**1 Yes,** this SDP is expected /supposed to have available this Maternal /RH Medicine ☐ **2 No,** this SDP is NOT expected/ supposed to have available this Maternal /RH Medicine ☐ *(Tick only one option)*	**1 Yes,** this SDP is expected /supposed to have available this Maternal /RH Medicine ☐ **2 No,** this SDP is NOT expected/ supposed to have available this Maternal /RH Medicine ☐ *(Tick only one option)*	**1 Yes,** this SDP is expected /supposed to have available this Maternal /RH Medicine ☐ **2 No,** this SDP is NOT expected/ supposed to have available this Maternal /RH Medicine ☐ *(Tick only one option)*	**1 Yes,** this SDP is expected /supposed to have available this Maternal /RH Medicine ☐ **2 No,** this SDP is NOT expected/ supposed to have available this Maternal /RH Medicine ☐ *(Tick only one option)*
016 **If 'Yes' in item 015** (i.e., this SDP is expected/ supposed to have available the maternal /RH medicine) please state whether the medicine is currently available at the SDP	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 015) ☐ *(Tick only one option)*	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 015) ☐ *(Tick only one option)*	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 015) ☐ *(Tick only one option)*	**1 Yes <u>(for any or both)</u>** ☐ **2 No <u>(for any or both)</u>** ☐ **3 Not Applicable** (because "No" to item 015) ☐ *(Tick only one option)*	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 015) ☐ *(Tick only one option)*	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 015) ☐ *(Tick only one option)*	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 015) ☐ *(Tick only one option)*	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 015) ☐ *(Tick only one option)*	**1 Yes** ☐ **2 No** ☐ **3 Not Applicable** (because "No" to item 015) ☐ *(Tick only one option)*
017 If this SDP is supposed/ expected to have available this medicine (in line with current national guidelines, etc.) but the response to 015 is "No", please indicate the main reason *(Tick only one option [as the main reason] for each medicine)*	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this **2** Delays by this SDP to request for supply of the medicine ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐

	3 The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5** **No** train staff to provide this medicine at the SDP ☐ 7. Any other Reason (please specify)……. …………………………….	**3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5** **No** train staff to provide this medicine at the SDP ☐ 7. Any other Reason (please specify)……. …………………………….	**3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5** **No** train staff to provide this medicine at the SDP ☐ 7. Any other Reason (please specify)……. …………………………….	**3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5** **No** train staff to provide this medicine at the SDP ☐ 7. Any other Reason (please specify)……. …………………………….	**3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5** **No** train staff to provide this medicine at the SDP ☐ 7. Any other Reason (please specify)……. …………………………….	**3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5** **No** train staff to provide this medicine at the SDP ☐ 7. Any other Reason (please specify)……. …………………………….	**3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5** **No** train staff to provide this medicine at the SDP ☐ 7. Any other Reason (please specify)……. …………………………….	**3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5** **No** train staff to provide this medicine at the SDP ☐ 7. Any other Reason (please specify)……. …………………………….	**3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5** **No** train staff to provide this medicine at the SDP ☐ 7. Any other Reason (please specify)……. …………………………….

INTERVIEWER VERIFICATION for ITEM 016									
Medicines	**(1)** **Ampicillin**	**(2)** **Azithromycin**	**(3)** **Benzathine benzylpenicillin**	**(4)** ***Either*** **Betamethasone** *Or* **Dexamethasone** ***Or Both of these medicines***	**(5)** **Calcium gluconate**	**(6)** **Cefixime**	**(7)** **Gentamicin**	**(8)** **Hydralazine**	**(9)** **Magnesium sulfate**
For each response provided for **item 016**, the interviewer should validate the response by a physical Inventory and	☐ Inventory taken, Medicine is in stock	☐ Inventory taken, Medicine is in stock	☐ Inventory taken, Medicine is in stock	☐ Inventory taken, any or both of the medicine(s) is/are in stock	☐ Inventory taken, Medicine is in stock	☐ Inventory taken, Medicine is in stock	☐ Inventory taken, Medicine is in stock	☐ Inventory taken, Medicine is in stock	☐ Inventory taken, Medicine is in stock

note the appropriate finding	☐ Inventory taken, Medicine is NOT in stock	☐ Inventory taken, Medicine is NOT in stock	☐ Inventory taken, Medicine is NOT in stock	☐ Inventory taken, any or both of the medicine(s) is/are NOT in stock	☐ Inventory taken, Medicine is NOT in stock	☐ Inventory taken, Medicine is NOT in stock	☐ Inventory taken, Medicine is NOT in stock	☐ Inventory taken, Medicine is NOT in stock	☐ Inventory taken, Medicine is NOT in stock

SECTION 4 continues on the next page

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

recorded in in item 006 above)								
016-*continues* **If 'Yes' in item 015** (i.e., this SDP is expected/ supposed to have available the maternal /RH medicine) please state whether each medicine is currently available at the SDP	1 Yes ☐ 2 No ☐ **3 Not Applicable** (because "No" to item 016) ☐ *(Tick only one option)*	1 Yes ☐ 2 No ☐ **3 Not Applicable** (because "No" to item 016) ☐ *(Tick only one option)*	1 Yes ☐ 2 No ☐ **3 Not Applicable** (because "No" to item 016) ☐ *(Tick only one option)*	1 Yes ☐ 2 No ☐ **3 Not Applicable** (because "No" to item 016) ☐ *(Tick only one option)*	1 Yes ☐ 2 No ☐ **3 Not Applicable** (because "No" to item 016) ☐ *(Tick only one option)*	1 Yes ☐ 2 No ☐ **3 Not Applicable** (because "No" to item 016) ☐ *(Tick only one option)*	1 Yes <u>(for any or both)</u> ☐ 2 No <u>(for any or both)</u> ☐ **3 Not Applicable** (because "No" to item 016) ☐ *(Tick only one option)*	1 Yes ☐ 2 No ☐ **3 Not Applicable** (because "No" to item 016) ☐ *(Tick only one option)*
017-*continues* If this SDP is supposed/ expected to have available this medicine (in line with current national guidelines, etc.) but the response to 013 is "No", please indicate the main reason *(Tick only one option [as the main reason] for each medicine)*	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐ **3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5 No** train staff to provide this medicine at the SDP ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐ **3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5 No** train staff to provide this medicine at the SDP ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐ **3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5 No** train staff to provide this medicine at the SDP ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐ **3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5 No** train staff to provide this medicine at the SDP ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐ **3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5 No** train staff to provide this medicine at the SDP ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐ **3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5 No** train staff to provide this medicine at the SDP ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐ **3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5 No** train staff to provide this medicine at the SDP ☐	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this medicine ☐ **2** Delays by this SDP to request for supply of the medicine ☐ **3** The medicine is not available in the market for the SDP to procure ☐ **4** Low or no demand/need for the medicine at this SDP ☐ **5 No** train staff to provide this medicine at the SDP ☐

	7. Any other Reason (please specify)……. ……	7. Any other Reason (please specify)……. ……	7. Any other Reason (please specify)……. ……	7. Any other Reason (please specify)……. ……	7. Any other Reason (please specify)……. ……	**6** The SDP does not have a cold chain to store the medicine ☐ 7. Any other Reason (please specify)……. ……	7. Any other Reason (please specify)……. ……	7. Any other Reason (please specify)……. ……
018 From responses provided to Item 016 above, please discuss with respondent and record the conclusion by ticking one of the following statements	**1 Yes** - this SDP has available the seven (7) lifesaving maternal/RH medicines *(which included the two mandatory medicines [Magnesium Sulfate and Oxytocin] and any other five of the remaining medicines on the list - bearing in mind that; a) Sodium chloride and Sodium lactate compound solution are alternate; and b) Dexamethasone is an alternate to Betamethasone* ☐					**2 No-** this SDP does not have available the seven (7) lifesaving maternal/RH medicines *(which included the two mandatory medicines (Magnesium Sulfate and Oxytocin) and any other five of the remaining medicines on the list - bearing in mind that; a) Sodium chloride and Sodium lactate compound solution are alternate; and b) Dexamethasone is an alternate to Betamethasone* ☐		

INTERVIEWER VERIFICATION for ITEM 016

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

SECTION 5: NO STOCK OUT OF MODERN CONTRACEPTIVE METHODS AT SDP **Please note that for the SDP to respond to items in this section, it should have indicated in Item 008 above that 'Yes' it provides family planning services**									
Item	**(1)** **Male condoms**	**(2)** **Female Condoms**	**(3)** **Oral Contraception**	**(4)** **Injectables**	**(5)** **Emergency contraception**	**(6)** **IUDs**	**(7)** **Implants**	**(8)** **Sterilisation for Females**	**(9)** **Sterilisation for Male**
(i): <u>NO STOCK-OUT IN THE LAST SIX MONTHS BEFORE THE SURVEY</u>									
	1 Yes; this method has been out-of-stock (STOCK-OUT) on a given day at this SDP in the last **six** months ☐ **2 No;** this method has not been out-of-stock **(NO STOCK OUT)** on any given day at this SDP in the last **six** months ☐ *(Tick only one option)*	**1 Yes;** this method has been out-of-stock (STOCK-OUT) on a given day at this SDP in the last **six** months ☐ **2 No;** this method has not been out-of-stock **(NO STOCK OUT)** on any given day at this SDP in the last **six** months ☐ *(Tick only one option)*	**1 Yes;** this method has been out-of-stock (STOCK-OUT) on a given day at this SDP in the last **six** months ☐ **2 No;** this method has not been out-of-stock **(NO STOCK OUT)** on any given day at this SDP in the last **six** months ☐ *(Tick only one option)*	**1 Yes;** this method has been out-of-stock (STOCK-OUT) on a given day at this SDP in the last **six** months ☐ **2 No;** this method has not been out-of-stock **(NO STOCK OUT)** on any given day at this SDP in the last **six** months ☐ *(Tick only one option)*	**1 Yes;** this method has been out-of-stock (STOCK-OUT) on a given day at this SDP in the last **six** months ☐ **2 No;** this method has not been out-of-stock **(NO STOCK OUT)** on any given day at this SDP in the last **six** months ☐ *(Tick only one option)*	**1 Yes;** this method has been out-of-stock (STOCK-OUT) on a given day at this SDP in the last **six** months ☐ **2 No;** this method has not been out-of-stock **(NO STOCK OUT)** on any given day at this SDP in the last **six** months ☐ *(Tick only one option)*	**1 Yes;** this method has been out-of-stock (STOCK-OUT) on a given day at this SDP in the last **six** months ☐ **2 No;** this method has not been out-of-stock **(NO STOCK OUT)** on any given day at this SDP in the last **six** months ☐ *(Tick only one option)*	**1 Yes;** this method has been out-of-stock (STOCK-OUT) on a given day at this SDP in the last **six** months ☐ **2 No;** this method has not been out-of-stock **(NO STOCK OUT)** on any given day at this SDP in the last **six** months ☐ *(Tick only one option)*	**1 Yes;** this method has been out-of-stock (STOCK-OUT) on a given day at this SDP in the last **six** months ☐ **2 No;** this method has not been out-of-stock **(NO STOCK OUT)** on any given day at this SDP in the last **six** months ☐ *(Tick only one option)*
019 With respect to each of the contraceptive methods that the SDP is supposed/expected to provide **in line with the current national protocols, guidelines and/or laws specific for this level* of service delivery** (as indicated in Item 011 above); please indicate whether it has been **out of stock at this SDP on any given day, within the last six months preceding the survey, and therefore the contraceptive method was not available to give/provide to clients at this SDP** *(* Please recall SDP level as recorded in in item 006 above)***020** From responses provided to Item 019 above, please discuss with respondent and record the conclusion by ticking one of the following statements			One or more of the contraceptive methods offered by this SDP has been out-of- stock on a given day in the last six months preceding the survey. Therefore, **this <u>SDP experienced stock out in the last six months [STOCK-OUT WITHIN THE LAST SIX MONTHS]</u>** ☐			All contraceptive method offered by this SDP has been available/ in-stock on all days in the last six months preceding the survey. Therefore, **this <u>SDP did not experience stock out in the last six months [NO-STOCK-OUT WITHIN THE LAST SIX MONTHS]</u>** ☐			

021 If "Yes" to Item 019 (that this method has been out of stock **(STOCK OUT)** at this SDP on any given day within **the last six** months (in line with current national guidelines, etc.) please **indicate the main reason**	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ 4 Low or no client demand for the contraceptive ☐ 7. Any other Reason (please specify)……. ……………………………	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ 4 Low or no client demand for the contraceptive ☐ 7. Any other Reason (please specify)……. ……………………………	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ 4 Low or no client demand for the contraceptive ☐ 7. Any other Reason (please specify)……. ……………………………	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ 4 Low or no client demand for the contraceptive ☐ 7. Any other Reason (please specify)……. ……………………………	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ 4 Low or no client demand for the contraceptive ☐ 7. Any other Reason (please specify)……. ……………………………	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ 4 Low or no client demand for the contraceptive ☐ **5** No train staff to provide this contraceptive at the SDP ☐ **6.** Lack of equipment for the provision of this contraceptive ☐ 7. Any other Reason (please specify)……. ……………………………	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ 4 Low or no client demand for the contraceptive ☐ **5** No train staff to provide this contraceptive at the SDP ☐ **6.** Lack of equipment for the provision of this contraceptive ☐ 7. Any other Reason (please specify)……. ……………………………	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ 4 Low or no client demand for the contraceptive ☐ **5** No train staff to provide this contraceptive at the SDP ☐ **6.** Lack of equipment for the provision of this contraceptive ☐ 7. Any other Reason (please specify)……. ……………………………	**1** Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive ☐ **2** Delays by this SDP to request for supply of the contraceptive ☐ **3** The contraceptive is not available in the market for the SDP to procure ☐ 4 Low or no client demand for the contraceptive ☐ **5** No train staff to provide this contraceptive at the SDP ☐ **6.** Lack of equipment for the provision of this contraceptive ☐ 7. Any other Reason (please specify)……. ……………………………
(ii): NO STOCK-OUT AT THE TIME OF THE SURVEY									

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

	4 Low or no client demand for the contraceptive ☐ 7. Any other Reason (please specify)……. …………………………….	4 Low or no client demand for the contraceptive ☐ 7. Any other Reason (please specify)……. …………………………….	4 Low or no client demand for the contraceptive ☐ 7. Any other Reason (please specify)……. …………………………….	4 Low or no client demand for the contraceptive ☐ 7. Any other Reason (please specify)……. …………………………….	4 Low or no client demand for the contraceptive ☐ 7. Any other Reason (please specify)……. …………………………….	4 Low or no client demand for the contraceptive ☐ **5** No train staff to provide this contraceptive at the SDP ☐ **6.** Lack of equipment for the provision of this contraceptive ☐ 7. Any other Reason (please specify)……. …………………………….	4 Low or no client demand for the contraceptive ☐ **5** No train staff to provide this contraceptive at the SDP ☐ **6.** Lack of equipment for the provision of this contraceptive ☐ 7. Any other Reason (please specify)……. …………………………….	4 Low or no client demand for the contraceptive ☐ **5** No train staff to provide this contraceptive at the SDP ☐ **6.** Lack of equipment for the provision of this contraceptive ☐ 7. Any other Reason (please specify)……. …………………………….	4 Low or no client demand for the contraceptive ☐ **5** No train staff to provide this contraceptive at the SDP ☐ **6.** Lack of equipment for the provision of this contraceptive ☐ 7. Any other Reason (please specify)……. …………………………….

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

MODULE 2:

FACILITY RESOURCES

SECTION 6: SUPPLY CHAIN *[To be responded to by all SDPs]*	
025 Who is the main person responsible for ordering medical supplies at this facility? *(Tick only one option)*	Medical Doctor 1☐ Clinical Officer 2☐ Pharmacist 3☐ Nurse 4☐ Other (specify) _____ 5 ☐
026 How are the resupplies for contraceptives for this facility determined? *(Tick only one option)*	Staff member(s) of this facility makes request based on calculation of quantity needed using a formula1☐ Quantity is determined by the institution/warehouse responsible for supplying this SDP 2☐ Any other method used (please specify) ……3☐
027 Does this SDP use any logistics forms for reporting and ordering	Yes *(enumerator verifies the availability of forms)* 1☐ Yes *(but availability not observed by enumerator)* 2☐ No; there are no logistics forms in use 3☐

supplies? *(Tick only one option)*	
028 What is the **main source** of your routine medicines and supplies? *(Tick only one option)*	Central Medical Stores 1☐ Regional/district Warehouse or institution 2☐ Local medical store on the same site 3☐ NGO 4 ☐ Donors 5 ☐ Private Sources 6 ☐
029 Who is responsible for transporting products to your facility? *(Tick only one option)*	National/central government 2☐ Local/District administration 1 ☐ This Facility Collects 3☐ Other(Specify) _____4 ☐
030 On average, approximately how long does it take between ordering and receiving products? *(Tick only one option)*	Less than two weeks 1 ☐ More than two weeks but not up to one month 2 ☐ More than one month but not up to two months 3 ☐ More than two months but not up to four months 4 ☐ More than four months but not up to six months 5 ☐ More than six months 6 ☐
031 On average, how frequently is the facility resupplied? *(Tick only one option)*	Once every two weeks 1 ☐ Once every month 2 ☐ Once every three months 3 ☐ Once every six months 4 ☐ Once a year 5 ☐

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

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

SECTION 9: STAFF SUPERVISION FOR REPRODUCTIVE HEALTH INCLUDING FAMILY PLANNING *[To be responded to by all SDPs]*

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

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

only one option)	

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

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

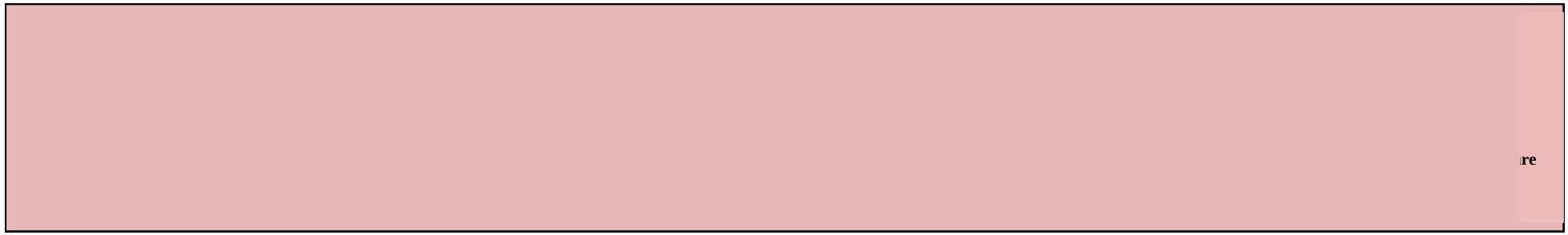
SECTION 13: CHARGING FOR USER FEE *[To be responded to by all SDPs]*			
058 Does this facility charge patients for consultation *(Tick only one option)*	Yes 1☐	No 2 ☐	
059 If Yes; are there exemptions for any of the following services *(Tick ALL the options that apply)*	Family planning services 1☐ Delivery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

NOTE:
At this stage;

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

MODULE 3:

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



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

In your opinion did you wait too long for the service to be provided to you? *(Tick only one option)*	Yes 1☐	No 2 ☐
077 Are you satisfied with the cleanliness of the health facility? *(Tick only one option)*	Yes 1☐	No 2 ☐
078 Are you satisfied with the privacy at the exam room? *(Tick only one option)*	Yes 1☐	No 2 ☐
079 Are you satisfied with the time that was allotted to your case by the health care provider? *(Tick only one option)*	Yes 1☐	No 2 ☐
14.4 Interpersonal aspect		
080 Did staff at the health facility treat you with courtesy and respect *(Tick only one option)*	Yes 1☐	No 2 ☐
081 Did any of the health service providers force you to accept or insisted that you should accept the family planning method that you received today? *(Tick only one option)*	Yes 1☐	No 2 ☐
082 Are you satisfied with the attitude of the health provider towards you generally? *(Tick only one option)*	Yes 1☐	No 2 ☐
14.5 Outcome aspect		
083 Are you satisfied with the service you received? *(Tick only one option)*	Yes 1☐	No 2 ☐
084 Will you continue visiting this SDP in future? *(Tick only one option)*	Yes 1☐	No 2 ☐
085 Would you recommend your relatives or friends to come to this clinic *(Tick only one option)*	Yes 1☐	No 2 ☐

SECTION 15: EXIT INTERVIEW – CLIENTS' APPRAISAL OF COST FOR FP SERVICES

[To be administered to clients at SDPs offering FP services (indicating 'Yes' to Item 008' above)]

15.1 Family Planning service payment

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

087

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

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

15.2 Travel cost

088

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

Walked 1☐ *(if this is selected then skip to 091)* | Bicycle 2☐ | Motorcycle 3☐

Bus/taxi 4 ☐ | Private vehicle 5☐ | Others (please specify) 6☐…….……. /_____/

089

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

090

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

091

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

15.3 Family Planning time spent and cost

092

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

093

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

094

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

095

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

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

0096

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

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

097 Did you have to pay the person who took over the activity on your behalf *(Tick only one option)*	Yes 1☐ No 2 ☐
098 If yes please indicate or estimate the monetary value of the payment *(Tick only one option)*	/_____/ (amount in local currency)

15.4 Financing for FP

099

Please indicate the where you obtain the resources to pay for the cost of FP services you have received today? *(Tick ALL the options that apply) - Please refer only to payments mentioned under 087 -(service payment)*

Paid for by myself 1	Spouse (husband or wife) 2☐	Family Members other than spouse (husband or wife) 3☐	Others (please specify) 4☐…….....

0100

Please indicate the amount for each of the sources mentioned in 099 for payment for the cost of FP services you have received today? *(Indicate for ALL the options that apply) – Indicate with reference to payments mentione under 087 - service payment*

Paid for by myself 1☐ /_____/(amount in local currency)	Spouse (husband or wife) 2☐ /_____/(amount in local currency)	Family Members other than spouse (husband or wife) 3☐ /_____/(amount in local currency)	Others (please specify) 4☐……..... /_____/(amount in local currency)

NOTE:

At this stage;

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

Annex 2. GPRHCS Survey Questionnaire MYANMAR

၂၀၁၅ ခုနှစ်အတွင်းကျန်းမာရေးဌာနများ၏ မျိုးဆက်ပွားကျန်းမာရေးဆိုင်ရာဆေးပစ္စည်းနှင့်

ကျန်းမာရေးစောင့်ရှောက်မှုလုပ်ငန်းများဆန်းစစ်လေ့လာခြင်းသုတေသန

သဘောတူညီချက်ပုံစံ

၁။ရှင်းလင်းပြောကြားချက်

ကျွန်တော်/ကျွန်မသည် ဆေးသုတေသနဦးစီးဌာနမှ ခန့်အပ်တာဝန်ပေးထားသော ယခုသုတေသန အတွက် ဝန်ထမ်းတစ်ဦး ဖြစ်ပါသည်။ ယခုသုတေသနလုပ်ငန်းသည် ကျွန်ုပ်တို့ဌာနနှင့် ကျန်းမာရေးဦးစီးဌာန (မိခင်နှင့်မျိုးဆက်ပွားကျန်းမာရေးဌာနခွဲ) တို့ပူးပေါင်းလျက် မြန်မာနိုင်ငံတွင်းရှိ ကျန်းမာရေးဌာန အလွှာအသီးသီး၏ သားဆက်ခြားလုပ်ငန်းနှင့် မျိုးဆက်ပွားကျန်းမာရေးဝန်ဆောင်မှုများ ဆောင်ရွက် နေမှုအပေါ်တွင် ဆေးဝါးပစ္စည်းနှင့် ဝန်ဆောင်မှုအရည်အသွေးစံနှုန်းများကို လေ့လာဆန်းစစ်ရန် ဖြစ်ပါသည်။ ရရှိသောအချက်အလက်များအရ လက်ရှိလုပ်ငန်းများအနေဖြင့် အနာဂါတ်တွင် ဆက်လက် ဆောင်ရွက်ရန် လိုအပ်ချက်များနှင့် ထောက်ပံ့ပစ္စည်းများကိုတိကျစွာ ဖေါ်ထုတ်သိရှိရမည်ဖြစ်ပြီး ဝန်ဆောင်မှုလုပ်ငန်းများ အဆက်မပြတ်ရေးနှင့် တိုးတက်ဖွံ့ဖြိုးရေးအတွက် အထောက်အပံ့ဖြစ်စေမည် ဖြစ်ပါသည်။ ယခုသုတေသနလုပ်ငန်းတွင် ပါဝင်ရန်သင်၏ ခွင့်ပြုချက်ကို ကျွန်ုပ်တို့ရလိုပါသည်။

ကျွန်ုပ်တို့၏ အလွှာအလိုက်ကျဘန်းရွေးချယ်မှုစနစ်အရ ဤဆေးခန်းကိုရွေးချယ်ရခြင်း ဖြစ်ပါသည်။ သင့်ကို မျိုးဆက်ပွားကျန်းမာရေးနှင့် ပစ္စည်းများအကြောင်း၊ ဝန်ဆောင်မှုများအကြောင်းမေးမြန်းမည် ဖြစ်ပါသည်။ မေးမြန်းရရှိသော အချက်များကိုကျန်းမာရေးဝန်ကြီးဌာနနှင့် အခြားဆက်စပ်အဖွဲ့အစည်းများအတွက် စီမံခန့်ခွဲမှုနှင့် ဝန်ဆောင်မှုများ ပိုမိုတိုးတက်ကောင်းမွန်စေရေးအတွက် အသုံးပြုပါမည်။

ဤသုတေသနတွင်အပိုင်း ၂ ပိုင်းပါရှိပါသည်။ ပထမပိုင်းတွင် ဝန်ထမ်းများကဖြေဆိုရန်ဖြစ်ပြီး ဒုတိယပိုင်းကိုမူ ဆေးခန်းသို့သားဆက်ခြားအတွက်လာရောက်ပြသသော သူသုံးဦးက ဖြေဆိုရန် ဖြစ်ပါသည်။ ယင်းအတွက်လည်း သင်၏ခွင့်ပြုချက်ကိုကျွန်ုပ်တို့ရလိုပါသည်။ သင်၏ အမည်သော်၎င်း၊ သင်ကတာဝန်ပေးဖြေဆိုခိုင်းသူ အမည် သော်ပ်၎င်း၊ ဆေးခန်းပြသူအမည်သော်၎င်း ကျွန်ုပ်တို့၏ အချက်အလက်သိမ်းဆည်းမှုစနစ်နှင့် အစီရင်ခံစာတွင် လုံးဝဖော်ပြမည်မဟုတ်ပါ။

သင့်အနေဖြင့်မည်သည့်မေးခွန်းကိုမဆို မဖြေဆိုလိုကငြင်းဆိုနိုင်ခွင့်ရှိပါသည်။ မေးနေစဉ်မည်သည့် အချိန်တွင်မဆို မဖြေဆိုလိုတော့ပါက ရပ်ဆိုင်းနိုင်သည်။ သို့သော်သင်၏ဖြေဆိုချက်များက နိုင်ငံ၏ မျိုးဆက်ပွားကျန်းမာရေးစောင့်ရှောက်မှုလုပ်ငန်းဖွံ့ဖြိုးလာစေရန် အထောက်အပံ့ဖြစ်စေနိုင်သဖြင့် ပြည့်စုံစွာ ဖြေဆိုလိမ့်မည်ဟုမျှော်လင့်ပါသည်။ တချို့မေးခွန်းများကို သင့်ထက်ပိုမိုပြည့်စုံမှန်ကန်စွာ ဖြေဆိုနိုင်မည့်သူ ရှိသည်ဆိုလျှင် ထိုသူနှင့် ကျွန်ုပ်တို့အား မိတ်ဆက်ပေးလိုပါသည်။ ကျွန်ုပ်ယခုပြောပြသမျှအပေါ်တွင် မရှင်းလင်းသည်များရှိပါသလား။ ရှိပါလျှင် ယခုပြန်လည်မေးမြန်းနိုင်ပါသည်။ နောင်အချိန်မှ မေးမြန်းလိုပါက လည်း ဒေါက်တာကျော်ဦး ညွှန်ကြားရေးမှူး (လူမှုဆေးသုတေသန) ဖုန်း ၀၈၅-၂၀၅၀၂၅၀ သို့ ဖုန်းဖြင့်ဖြစ်စေ၊ လူကိုယ်တိုင်လာရောက်၍ဖြစ်စေ ဆက်သွယ်မေးမြန်းနိုင်ပါသည်။ ယခုကျွန်ုပ်တို့ဆက်လက်ဆောင်ရွက်ရန် သင်၏ ခွင့်ပြုချက်ကိုရရှိလိုပါသည်။

၂။သဘောတူညီခွင့်ပြုချက်ပုံစံ

ကျွန်တော်/ကျွန်မသည် ယခုသုတေသနလုပ်ငန်းသည် ကျန်းမာရေးဌာနအလွှာအသီးသီး၏ သားဆက်ခြား လုပ်ငန်းနှင့် မျိုးဆက်ပွားကျန်းမာရေးဝန်ဆောင်မှုများ ဆောင်ရွက်နေမှုအပေါ်တွင် ဆေးဝါးပစ္စည်းနှင့် ဝန်ဆောင်မှုအရည်အသွေးစံနှုန်းများကို လေ့လာဆန်းစစ်ရန်ဖြစ်ပြီး ရရှိသောအချက်အလက်များဖြင့် ဝန်ဆောင်မှု လုပ်ငန်းများအဆက်မပြတ်ရေးနှင့် တိုးတက်ဖွံ့ဖြိုးရေးအတွက် အထောက်အပံ့ဖြစ်စေမည်ဖြစ်ကြောင်း သိရှိပါသည်။ ကျဘန်းရွေးချယ်မှုစနစ်အရ ဤဆေးခန်းကိုရွေးချယ်ရခြင်းဖြစ်ကြောင်း သိရှိပါသည်။ ပထမပိုင်းတွင် ဝန်ထမ်းများကဖြေဆိုရန်ဖြစ်ပြီး ဒုတိယပိုင်းကိုမူ ဆေးခန်းသို့သားဆက်ခြားနိုင်ရေးအတွက် လာရောက်ပြသသော သူထဲမှသုံးဦးက ဖြေဆိုရန်ဖြစ်ကြောင်း သိရှိပါသည်။ မည်သည့်မေးခွန်းကိုမဆို မဖြေဆိုလိုကငြင်းဆိုနိုင်ခွင့်ရှိကြောင်း သိရှိပါသည်။ မရှင်းလင်းသည်များရှိပါလျှင် ယခုပြန်လည် မေးမြန်းနိုင်ကြောင်းနှင့် ကျေနပ်သည်အထိ ပြန်လည်ဖြေကြားပေးမည်ကိုသိရှိပါသည်။ ကျွန်ုပ်က ယခုသုတေသနလုပ်ငန်းတွင် ပါဝင်ရန်နှင့် ဆေးခန်းလာလူနာသုံးဦးကို ဆွေးနွေးမေးမြန်းရန် ကိစ္စအား သဘောတူ ခွင့်ပြုပါသည်။

လက်မှတ်_____ မေးမြန်းသူလက်မှတ်_____

အမည်_____ အမည်_____

ရက်စွဲ_____ ရက်စွဲ_____

၂၀၁၅ခုနှစ်အတွင်းကျန်းမာရေးဌာနများ၏မျိုးဆက်ပွားကျန်းမာရေးဆိုင်ရာဆေးပစ္စည်းနှင့်

ကျန်းမာရေးစောင့်ရေတွက်မှုလုပ်ငန်းများဆန်းစစ်လေ့လာခြင်း

သုတေသနမေးခွန်းလွှာ

မေးမြန်းမှုမှတ်တမ်း

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

အခန်း ၁။ ကျန်းမာရေးဌာန၏အကြောင်းအချက်များ

စဉ်ပ	အကြောင်းအချက်	ဖြေဆိုချက်
၁။	ကျန်းမာရေးဌာန၏အမည်	
၂။	တည်နေရာ (က)ပြည်နယ်/တိုင်း (ခ)မြို့နယ် (ဂ)ကျေးလက်ကျန်းမာရေးဌာန	 _____ _____ _____

၃။	GPS စနစ်အသုံးပြုသောနေရာဖြစ်လျှင်ကိုဩဒိနိတ်	N---------- E----------
၄။	မြို့ပေါ်/ကျေးလက်	၁။မြို့ပေါ် ၂။ကျေးလက်
၅။(၅.၁)	ကျန်းမာရေးဌာနနှင့်ယင်းဌာနအတွက်လိုအပ်သောဆေးဝါး ပစ္စည်းများထုတ်ယူရာအနီးဆုံးဆေးသိုလှောင်ဌာန အကွာအဝေး	|___|___| မိုင်
(၅.၂)	ယင်းဌာနသို့ သွားရောက်ရန် ကြာမြင့်သောအချိန်	|__|ရက် |__|__|နာရီ|__|__|မိနစ်
(၅.၃)	ယင်းဌာနသို့ သွားရောက်ရန် အသုံးပြုသောလမ်းကြောင်း	၁။ ကုန်းလမ်း ၂။ ရေလမ်း

အခန်း ၂။ ကျန်းမာရေးဌာနအမျိုးအစားနှင့်ကျန်းမာရေးစောင့်ရှောက်မှုအမျိုးအစား

၆။(၆.၁)	ကျန်းမာရေးဌာနအမျိုးအစား	၁။ကျန်းမာရေးဌာန(RHC/UHC/MCH) ၂။တိုက်နယ်ဆေးရုံ(Station Hospital) ၃။မြို့နယ်ဆေးရုံ(ကုတင် ----------) ၄။ခရိုင်ဆေးရုံ (ကုတင် ----------) ၅။ပြည်နယ်/တိုင်း အဆင့်ဆေးရုံ (ကုတင်-------) ၆။ဗဟိုအဆင့်ဆေးရုံကြီး ၇။ အခြားဝန်ကြီးဌာန

(၆.၂)	ယခု ကျန်းမာရေးဌာနရှိရာမြို့နယ်သည် မျိုးဆက်ပွား ကျန်းမာရေး စီမံချက်တွင် ပါဝင်သော မြို့နယ် ဟုတ်ပါသလား	၁။ဟုတ် ၂။မဟုတ်
၇။	ကျန်းမာရေးဌာနစီမံခန့်ခွဲမှုအမျိုးအစား	၁။အစိုးရဆေးရုံ ၂။ပုဂ္ဂလိကဆေးရုံ ၃။အဖွဲ့အစည်း(NGO) ၄။အခြား(ဖေါ်ပြပါ_____)
၈။	သားဆက်ခြားလုပ်ငန်းများဆောင်ရွက်ခြင်းရှိ/မရှိ	၁။ရှိ ၂။မရှိ
၉။	ကလေးမွေးဖွားခြင်းအပါအဝင်မိခင်စောင့်ရှောက်ရေးလုပ်ငန်းများဆောင်ရွက်ခြင်း	၁။ရှိ ၂။မရှိ
၁၀။	HIV/AIDS ဆိုင်ရာကျန်းမာရေးစောင့်ရှောက်မှုလုပ်ငန်းများဆောင်ရွက်ခြင်း(VCT,PMTCT,ART စသည်)	၁။ရှိ ၂။မရှိ

အခန်း၃။ ဆေတ်မီ သားဆက်ခြားနည်းလမ်းများဆောင်ရွက်ပေးမှု
(မေးခွန်းအမှတ်**၈** ၌ **ရှိ** ဟုဖြေထားမှသာဤအခန်း **၃** နှင့် အကျုံးဝင်သည်)

စဉ်	**အကြောင်းအရာ**	**ဆောင်ရွက်ပေးနိုင်မှုအခြေအနေ**	
	လက်ရှိဌာန၏ဖွဲ့စည်းပုံနှင့်လုပ်ငန်းတာဝန်ပေးအပ်မှုစီမံချက်လုပ်ငန်းပြဋ္ဌာန်းဆောင်ရွက်မှုအခြေအနေများအရအောက်ဖေါ်ပြပါနည်းလမ်းများကို ဆောင်ရွက်ပေးရန်သတ်မှတ်ထားပါသလား။	**၁၁။**သတ်မှတ်ထားမှု ၁။သတ်မှတ် ၂။မသတ်မှတ်	**၁၂။**ဆောင်ရွက်ပေးနေမှု ၁။ဆောင်ရွက်နေ ၂။မဆောင်ရွက် ၃။အကျုံးမဝင် (မသတ်မှတ်ဟု ရှေ့အကွက်တွင် ဖြည့်ထားလျှင်)
	(က)အမျိုးသားသုံးကွန်ဒုံး	__|	__|

	(ခ)အမျိုးသမီးသုံးကွန်ဒုံး	__|	__|
	(ဂ)တားဆေးကဒ်(တစ်နေ့တစ်လုံးသောက်ရန်)	__|	__|
	(ဃ) သန္ဓေတားထိုးဆေး	__|	__|
	(င)အရေးပေါ်သန္ဓေတားဆေး	__|	__|
	(စ)သားအိမ်တွင်းထည့်ပစ္စည်း(IUD)	__|	__|
	(ဆ)အရေပြားအောက်သန္ဓေတားဆေး(Implant)	__|	__|
	(ဇ)အမျိုးသမီး သားကြောဖြတ်ခြင်း	__|	__|
	(ဈ)အမျိုးသား သားကြောဖြတ်ခြင်း	__|	__|

မှတ်ချက်။ သားဆက်ခြားနည်းလမ်းတစ်ခုချင်းစီအတွက် ဤဌာနမှ ဆောင်ရွက်ပေးရန်၊ သတ်မှတ်ထားပြီး ပုံမှန်ဆောင်ရွက်ပေး နေသော်လည်း ဝေမးမြန်းကာလအတွင်း ပစ္စည်းပြတ်လပ်မှုကြောင့် လတ်တလောဆောင်ရွက်နိုင်ခြင်းမရှိပါလျှင် ဒုတိယကော်လံတွင် "**ဆောင်ရွက်နေ**" ဟုသာဖြည့်သွင်းပါ။

စဉ်	**အကြောင်းအရာ**	**ဖြေဆိုချက်**
၁၃။	မေးခွန်းနံပါတ်(၁၂)တွင်**မဆောင်ရွက်နိုင်**၊ဟုဆိုပါလျှင် မည်သည့်အတွက်ကြောင့်ဆိုသည်ကိုဖေါ်ပြပါ။	၁။ထောက်ပံ့ပစ္စည်းများအချိန်မီမရောက်သဖြင့် ၂။ထောက်ပံ့ပစ္စည်းအချိန်မီမတောင်းခံနိုင်သဖြင့် ၃။ဈေးကွက်ပစ္စည်းပြတ်လပ်မှုကြောင့် ၄။သုံးစွဲမည့်သူမရှိ၍(သို့)အလွန်နည်း၍ **မှတ်ချက်။ ။ အောက်ပါနံပါတ်(၅)နှင့်(၆) သည် (စ)မှ (ဈ)ကို ဖြေဆိုလှုပ်ရှား ကိုးကားရန်** ၅။ဤနည်းလမ်းကိုဆောင်ရွက်ပေးနိုင်မည့် ဝန်ထမ်းမရှိ၍ ၆။ဤနည်းလမ်းကိုဆောင်ရွက်ပေးနိုင်မည့် ပစ္စည်းကိရိယာမရှိ၍ ၇။အခြား(ဖော်ပြပါ____)
	(က)အမျိုးသားကွန်ဒုံး	__| _____

	(ခ)အမျိုးသမီးကွန်ဒုံး	|__| ____________________
	(ဂ)တားဆေးကဒ် (တစ်နေ့တစ်လုံးသောက်ရန်)	|__| ____________________
	(ဃ)သန္ဓေတားထိုးဆေး	|__| ____________________
	(င) အရေးပေါ်သန္ဓေတားဆေး	|__| ____________________
	(စ)သားအိမ်တွင်းထည့်ပစ္စည်း(IUD)	|__| ____________________
	(ဆ)အရေပြားအောက်ထည့်ပစ္စည်း (Implant)	|__| ____________________
	(ဇ)အမျိုးသမီး သားကြောဖြတ်ခြင်း	|__| ____________________
	(ဈ)အမျိုးသား သားကြောဖြတ်ခြင်း	|__| ____________________
၁၄။	မေးခွန်းနံပါတ် (၁၂)၏အဖြေကိုမူတည်၍ဤကျန်းမာရေးဌာနတွင်သားဆက်ခြားနည်းလမ်းများဆောင်ရွက်ပေးနိုင်မှုအခြေအနေကိုသုံးသပ်ပါ။	နည်းလမ်း|__|ခုဆောင်ရွက်ပေးနိုင်သည်။

အခန်း၄။ သန္ဓေတားဆေးများပြတ်လပ်မှု

(မေးခွန်းအမှတ် ၈ ၌ **ရှိ** ဟုဖြေထားမှသာဤအခန်း ၄ နှင့် အကျုံးဝင်သည်)

အကြောင်းအရာ	မေးခွန်းနံပါတ် (၁၉)	မေးခွန်းနံပါတ် (၂၁)
မေးခွန်းနံပါတ် (၆)အရသတ်မှတ်အဆင့်ရှိဆေးရုံ/ဆေးခန်းအနေဖြင့်ပြဌာန်းချက်တာဝန်ပေးချက်(သို့)စီမံချက်တစ်ခုခုအရအောက် [illegible]	၁။ပြတ်လပ်ခဲ့ဘူး ၂။မပြတ်လပ်ခဲ့ဘူး	အဘယ့်ကြောင့်ပြတ်လပ်ခဲ့ကြောင်းအဓိကအချက်ကိုဖော်ပြပါ ၁။ထောက်ပံ့မှုကြန့်ကြာ၍ ၂။တောင်းခံမှုနှောင့်နှေး၍
(က)အမျိုးသားကွန်ဒုံး	|__|	|__| ____________________
(ခ)အမျိုးသမီးကွန်ဒုံး	|__|	|__| ____________________
(ဂ)တားဆေးကဒ် (တစ်နေ့တစ်လုံးသောက်ရန်)	|__|	|__| ____________________
(ဃ)သန္ဓေတားထိုးဆေး	|__|	|__| ____________________
(င) အရေးပေါ်သန္ဓေတားဆေး	|__|	|__| ____________________

(စ)သားအိမ်တွင်းထည့်ပစ္စည်း(IUD)	|__|	|__| _____
(ဆ)အရေပြားအောက်ထည့်ပစ္စည်း (Implant)	|__|	|__| _____
(ဇ)အမျိုးသမီးသားကြောဖြတ်ခြင်း	|__|	|__| _____
(ဈ)အမျိုးသား သားကြောဖြတ်ခြင်း	|__|	|__| _____
၂၀။မေးခွန်း (၁၉) ၏အဖြေကိုမူတည်၍တဘက်ပါအချက်တစ်ခုခုဖြင့်မှတ်ချက်ပြုပါ။	၁။တစ်မျိုးနှင့်အထက်လွန်ခဲ့သော(၆)လအတွင်းအနည်းဆုံးတစ်ကြိမ်ပြတ်လပ်ခဲ့ဘူးသည်။	၂။ဆေးအမည်အားလုံးတစ်ခါမျှပြတ်လပ်ခဲ့ဘူးခြင်းမရှိ။

အကြောင်းအရာ	မေးခွန်းနံပါတ် (၂၂)	မေးခွန်းနံပါတ် (၂၄)	ဆေးလက်ကျန်စာရင်းနှင့်တိုက်ဆိုင်စစ်ဆေးပါ
မေးခွန်းနံပါတ် (၆)အရ သတ်မှတ် အဆင့်ရှိ ဆေးရုံ/ဆေးခန်းအနေဖြင့် ပြဋ္ဌာန်းချက်တာဝန်ပေးချက်(သို့)စီမံချက်တစ်ခုခုအရအောက်ပါ သန္ဓေတားဆေးနှင့်ပစ္စည်းများရှိသင့်ပါလျှက်ယခုလက်ရှိအချိန်တွင် ဆေးပြတ်လပ်နေသဖြင့်သန္ဓေတားရန် ဆောင်ရွက်ပေးနိုင်မှု ရှိနေပါသလား။	၁။ယခုပြတ်လပ် နေသည် ၂။ယခုမပြတ်လပ်နေပါ	အဘယ့်ကြောင့်ပြတ်လပ်ခဲ့ကြောင်း အဓိကအချက်ကိုဖော်ပြပါ ၁။ထောက်ပံ့မှုကြန့်ကြာ၍ ၂။တောင်းခံမှုနှောင့်နှေး၍ ၃။ဈေးကွက်၌ပစ္စည်းပြတ်လပ်၍ ၄။အသုံးမရှိ၍(သို့)အသုံးအလွန်နည်း၍ **မှတ်ချက်။ ။ အောက်ပါနံပါတ်(၅)နှင့် (၆) သည် (စ)မှ (ဈ)ကို ဖြေဆိုလျှင် ကိုးကားရန်** ၅။ကျွမ်းကျင်ဝန်ထမ်းမရှိ၍ ၆။ပစ္စည်းကိရိယာမစုံလင်၍ ၇။အခြား(ဖော်ပြပါ_____)	၁။လက်ကျန်ရှိ ၂။လက်ကျန်မရှိ
(က)အမျိုးသားကွန်ဒုံး	__	__ _____	__
(ခ)အမျိုးသမီးကွန်ဒုံး	__	__ _____	__
(ဂ)တားဆေးကဒ်(တစ်နေ့တစ်လုံးသောက်ရန်)	__	__ _____	__
(ဃ)သန္ဓေတားထိုးဆေး	__	__ _____	__
(င) အရေးပေါ်သန္ဓေတားဆေး	__	__ _____	__
(စ)သားအိမ်တွင်းထည့်ပစ္စည်း(IUD)	__	__ _____	__

(ဆ)အရေပြားအောက်ထည့်သား ဆက်ငြခဲဘားပစ္စည်း (Implant)	__|	__| _____	__|
(ဇ)အမျိုးသမီး သားကြောဖြတ်ခြင်း	__|	__| _____	__|
(ဈ)အမျိုးသား သားကြောဖြတ်ခြင်း	__|	__| _____	__|
၂၃။ မေးခွန်း (၂၂) ပေါ်မူတည်၍ တဘက်ပါအချက်အလက်တစ်ခုခုကို မှတ်ချက်ပြုပါ။	**၁။**တစ်မျိုးနှင့်အထက်ယခုလက်ရှိအချိန်တွင်ပြတ်လပ်နေသည်။	**၂။** ဆေးအမည်အားလုံးလက်ရှိအချိန်တွင်မပြတ်လပ်ပါ။	

အခန်း၅။ မိခင်စောင့်ရှောက်ရေးနှင့်မျိုးဆက်ပွားကျန်းမာရေးဆေးဝါးများအခြေအနေ

(မေးခွန်းအမှတ် **၉ ၌ ရှိ** ဟုဖြေထားမှသာဤအခန်း **၅** နှင့်အကျုံးဝင်သည်)

	မေးခွန်းအမှတ် (၁၅)	**မေးခွန် အမှတ် (၁၆)**	**မေးခွန်း အမှတ် (၁၇)**	*မေးခွန်း(၁၆)တွင် ဖြေဆိုချက်နှင့်ပတ်သက်၍မေးမြန်းသူက ဝေဆေးလက်ကျန်စာရင်း စာအုပ်နှင့်တိုက်ဆိုင်စစ်ဆေးချက်
ဆေးအမည်	ဖွဲ့စည်းပုံ/တာဝန်ခံမှု/ စီမံချက်များအရ အောက်ပါဆေးဝါးမျာားသုံးစွဲခွင့်ရှိပါသလား။	မေးခွန်း (၁၅) ၌သုံးစွဲခွင့်ရှိဟုဖြေဆိုလျှင်အဆိုပါ ဆေးဝါးများလက်ရှိတွင်ဤဌာန၌ရရှိနိုင်ပါသလား။	မေးခွန်း (၁၅) တွင် (၁) ဖြစ်၍ မေးခွန်း (၁၆) တွင် (၂) ဖြစ်လျှင်မည်သည့်အတွက်ကြောင့်ဆိုသည်ကိုဖြေပေးပါ။ ၁။ထောက်ပံ့ဆေးဝါး	၁။ဆေးလက်ကျန်စာရင်းကြည့်ရာတွင်လက်ကျန်ရှိ

	၁။သုံးစွဲခွင့်ရှိ ၂။သုံးစွဲခွင့်မရှိ	၁။ရရှိနိုင် ၂။မရရှိနိုင် ၃။အကြိုးမဝင် (မေးခွန်း (၁၅) တွင်သုံးစွဲခွင့်မရှိဖြစ်၍)	များ ရရှိရန်ကြန့်ကြာနေသဖြင့် ၂။ဆေးဝါးများတောင်းခံရန်ကြန့်ကြာနေသဖြင့် ၃။ဈေးကွက်၌ဆေးဝါး များပြတ်လပ်နေသဖြင့် ၄။အသုံးလုံးဝမရှိ၍(သို့)သုံးစွဲမှုအလွန်နည်းပါး၍ ၅။ဆေးဝါးသုံးစွဲပေးနိုင် မည့်ကျွမ်းကျင်ဝန်ထမ်းမရှိ၍ ၆။Oxytocin ဆေး အတွက် အအေးလမ်း ကြောင်းမရှိ၍ ၇။အခြား (ဖေါ်ပြပါ_____)	၂။ဆေးလက်ကျန်စာရင်းကြည့်ရာတွင်လက်ကျန်မရှိ
(က)Ampicillin	|__|	|__|	|__|	|__|
(ခ)Azithromycin	|__|	|__|	|__|	|__|
(ဂ)Benzithine BenzylPenicillin	|__|	|__|	|__|	|__|

(ဃ)Betamethasone(သို့)Dexamethasone(သို့)နှစ်မျိုးလုံး	|__|	|__|	|__|	|__|
(င)Calcium gluconate	|__|	|__|	|__|	|__|
(စ)Cefixime	|__|	|__|	|__|	|__|
(ဆ)Gentamycin	|__|	|__|	|__|	|__|
(ဇ)Hydralazine	|__|	|__|	|__|	|__|
(ဈ)Megnesium Sulphate	|__|	|__|	|__|	|__|
(ည)Methyldopa	|__|	|__|	|__|	|__|
(ဋ)Metronidazol	|__|	|__|	|__|	|__|
(ဌ)Misoprostol	|__|	|__|	|__|	|__|
(ဍ) Mifepristone	|__|	|__|	|__|	|__|
(ဎ)Nifedipine	|__|	|__|	|__|	|__|
(ဏ) Oxytocin	|__|	|__|	|__|	|__|
(တ) Sodium lactate or Sodium chloride or both	|__|	|__|	|__|	|__|
(ထ) Tetanus toxoid	|__|	|__|	|__|	|__|
၁၈။မေးခွန်း(၁၆)၏ဖြေဆိုချက်အပေါ်မူတည်၍ဖြေဆိုသူနှင့်ဆွေးနွေး၍မှတ်ချက်ပြုပါ	၁။Magnesium sulphateနှင့်Oxytocinအပါအဝင်စုစုပေါင်း မွေးဖွား မိခင်စောင့်ရှောက်ရေးနှင့်မျိုးဆက်ပွားကျန်းမာရေးဆိုင်ရာ အသက်ကယ်ဆေးအမည်စုစုပေါင်း(၇)မျိုးခန့်		၂။အထက်ပါကဲ့သို့ဆေးအမည်(၇).မျိုးခန့်မဝေ တောက်ပံ့နိုင် ပါ ။ မှတ်ချက်။ က) sodium chloride နှင့် sodium Lactate compound	

	ရရှိနိုင်သည်	တို့ကိုအတူတူကဲ့သို့မှတ်ယူပါ။ ခ) Dexamethazone နှင့် Betamethazonတို့ကိုအတူတူကဲ့သို့မှတ်ယူပါ။

အခန်း(၆)။ ပစ္စည်းထောက်ပံ့ရေးလမ်းကြောင်း(ကျန်းမာရေးဌာနအမျိုးအစားအားလုံးအားမေးရန်)

စဉ်ဝ်	အကြောင်းအရာ	ဖြေဆိုချက်
၂၅။	ဤဌာန၏ဆေးနှင့်ဆေးပစ္စည်းများမှာယူရန်အဓိကတာဝန်ခံသူ	၁။ဆေးရုံအုပ်ကြီး/ဆေးရုံအုပ် ၂။အထူးကုဆရာဝန်/ဆေးရုံတာဝန်ခံဆရာဝန် ၃။ဆေးဝါးကျွမ်းကျင်/HA/LHV ၄။သူနာပြု ၅။အခြား(ဖော်ပြပါ_____) ၆။ခရိုင်ဆရာဝန်ကြီး ၇။မြို့နယ်ဆရာဝန်ကြီး
၂၆။	ဤဌာနအတွက်သန္ဓေတားဆေးပြန်လည်ဖြည့်တင်းရေးကိုမည်သို့လုပ်ဆောင်ပါသလဲ။ *(တစ်ခုမကဖြေဆိုနိုင်သည်။)*	၁။ဌာနဝန်ထမ်းကသတ်မှတ်ဖော်မြူလာကိုသုံး၍လိုအပ်သောပမာဏကိုတွက်ချက်တောင်းခံသည် ၂။ထောက်ပံ့ရေးဌာနကတွက်ချက်ဆုံးဖြတ်သည် ၃။အခြားနည်းလမ်းသုံးသည်(ဖော်ပြပါ_____)
၂၇။	အစီအရင်ခံခြင်းနှင့်မှာယူခြင်းအတွက်သတ်မှတ်သောပုံစံကိုအသုံးပြုပါသလား။	၁။သုံးသည်(ပုံစံကိုပြနိုင်သည်) ၂။သုံးသည်(ပုံစံကိုမပြနိုင်)

		၃။မသုံးပါ
၂၈။	ဆေးနှင့်ဆေးပစ္စည်းများ**အဓိက**ထောက်ပံ့ရာ ကိုဖော်ပြပါ။	၁။ဗဟိုဆေးသိုလှောင်ရေးဌာန ၂။ပြည်နယ်/တိုင်းကျန်းမာရေးဌာန ၃။ခရိုင်ကျန်းမာရေးဌာန ၄။မြို့နယ်ကျန်းမာရေးဌာန ၅။ကျေးလက်ကျန်းမာရေးဌာန ၆။NGO ၇။အလှူရှင် ၈။ပြင်ပဆေးဆိုင်/ကုမ္ပဏီ
၂၉။	ဆေးနှင့်ဆေးပစ္စည်းသယ်ဆောင်ပေးသူ *(တစ်ခုမကဖြေဆိုနိုင်သည်။)*	၁။အစိုးရ ၂။ပြည်နယ်တိုင်း/ခရိုင်ကျန်းမာရေးဦးစီးဌာန ၃။မိမိအစီအစဉ် ၄။အခြား(ဖော်ပြပါ_____)
၃၀။	(မှာယူရလျှင်)မှာယူချိန်နှင့်ရောက်ရှိချိန်ကြားကာလ မည်မျှရှိသလဲ။ မေးခွန်းနံပါတ်(၂၆) ကို (၁)ဟုဖြေဆိုလျှင်	၁။နှစ်ပတ်အောက် ၂။၂ပတ်မှ၁လအထိ ၃။၁လမှ၂လအထိ ၄။၂လမှ၄လအထိ ၅။၄လမှ၆လအထိ ၆။၆လကျော်ကြာ ၇။ပုံမှန်မရှိ
၃၁။	ဆေးဝါးအထောက်အပံ့ရရှိမှု တစ်ကြိမ်နှင့် တစ်ကြိမ် မည်မျှခြားသလဲ။	၁။၂ပတ်တစ်ခါ ၂။တစ်လတစ်ခါ ၃။၃လတစ်ခါ ၄။၆လတစ်ခါ ၅။၁နှစ်တစ်ခါ

		၆။ပုံမှန်မရှိ

အခန်း(၇)အအေးလမ်းကြောင်း(ကျန်းမာရေးဌာနအမျိုးအစားအားလုံးမေးရန်)

စဉ်ဝ	အကြောင်းအရာ	ဖြေဆိုချက်
၃၂။	ကိုယ်ပိုင်အအေးလမ်းကြောင်းစနစ်ရှိ/မရှိ။ (စဉ်ဆက်မပျက် အအေးခံသိမ်းဆည်းနိုင်သောစနစ်)	၁။ရှိ ၂။မရှိ (နံပါတ် ၃၆ သို့)
၃၃။	ရှိခဲ့လျှင်အအေးခံစနစ်ဖြင့် ထားရှိသော မိခင်စောင့်ရှောက်ရေးနှင့်ဝဲ့မျိုးဆက်ပွားကျန်းမာရေးဆေး အမည်စာရင်း ပေးပါ။	_____ _____ _____ _____ _____
၃၄။	ရှိခဲ့ဝဲလျှင်အအေးခံစနစ်အမျိုးအစားဖော်ပြပါ။ *(တစ်ခုမကဖြေဆိုနိုင်သည်။)*	၁။ရေခဲသေတ္တာ ၂။ရေခဲဗူး(ရေခဲပြန်လည်ဖြည့်တင်းရသော) ၃။အခြား (ဖော်ပြပါ----------)
၃၅။	ရေခဲသေတ္တာဖြစ်လျှင်လျှပ်စစ်ဓါတ်အားရရှိသောနေရာ။ *(တစ်ခုမကဖြေဆိုနိုင်သည်။)*	၁။၂၄နာရီဓါတ်အားပို့လွှတ်စနစ် ၂။ကိုယ်ပိုင်မီးစက်(အထိုင်)

		၃။ကိုယ်ပိုင်မီးစက်(ရွှေ့ပြောင်းနိုင်) ၄။ရေနုံဆီသုံးစနစ် ၅။ဆိုလာစနစ် ၆။တပိုင်တနိုင်ရေအားလှုပ်စစ်စနစ် ၇။ကျေးရွာသုံးဘုံခါတ်အားပေး စနစ်
၃၆။	အအေးခံစနစ်မရှိလျှင်အအေးခံစနစ်ဖြင့်ထားရန်လိုသောဆေးများကိုမည်သို့ထားရှိသလဲ။	_____ _____ _____

အခန်း(၈) ။ သားဆက်ခြားစီမံကိန်းသင်တန်းတက်ရောက်ပြီးစီးမှု(ဌာနအမျိုးအစားအားလုံးမေးရန်)

Example: Quality RH, IUD, Implant etc

စဉ်ဝ	အကြောင်းအရာ	ဖြေဆိုချက်
၃၇။	သားဆက်ခြားလုပ်ငန်းဆောင်ရွက်ရန်သင်တန်းတက်ရောက်ပြီးသောဝန်ထမ်းရှိ/မရှိ။	၁။ ရှိ ၂။မရှိ (နံပါတ် ၄၅ သို့)
၃၈။	ရှိခဲ့လျှင်လက်ရှိကျန်းမာရေးဌာနတွင် တာဝန်ထမ်းဆောင်ဆဲအရေအတွက်	_____ဦး
၃၉။	အရေပြားအောက်ထည့်သားဆက်ငြခားပစ္စည်းထည့်သွင်းရန်/ပြန်ထုတ်ရန်လေ့ကျင့်ပေးပြီးသောဝန်ထမ်းရှိ/မရှိ။	၁။ရှိ ၂။မရှိ
၄၀။	ရှိခဲ့လျှင်အရေအတွက်	_____ဦး
၄၁။	သင်တန်းတက်ရောက်ပြီးဝန်ထမ်းသည်အမှန်တကယ်ဝန်ဆောင်မှုပေးနေပါသလား။	၁။ပေး ၂။မပေး
၄၂။	မပေးနေလျှင်အဘယ်ကြောင့်နည်း။	_____
၄၃။	နောက်ဆုံးသင်တန်းတက်ရောက်ပြီးစီးသောကာလ	၁။လွန်ခဲ့သော၂လ ၂။၂လနှင့်ဖြလကြား

		၃။ဖြေနှင့်၁နှစ်ကြား ၄။တနှစ်ကျော်ကာလ
၄၄။	အရေပြားအောက်ထည့်သားဆက်ပြုခြင်းပစ္စည်း ထည့်သွင်းခြင်း၊ ပြန်ထုတ်ခြင်းကို သင်တန်းတွင် လေ့ကျင့်သင်ကြားပေးမှု ရှိပါသလား	၁။ရှိပါသည် ၂။မရှိပါ

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

စဉ်ပ	အကြောင်းအရာ	ဖြေဆိုချက်
၄၅။	လွန်ခဲ့သောတစ်နှစ်အတွင်းကြီးကြပ်သူတစ်ဦးဦး ရောက်ရှိခဲ့သောနောက်ဆုံးကာလ (သားဆက်ခြား ကျန်းမာရေးစောင့်ရှောက်မှု ပါဝင်သော ကြီးကြပ်မှု)	၁။၁လမရှိသေး ၂။၁လမှ၃လအတွင်း ၃။၃လမှ၆လအတွင်း ၄။၆လမှတစ်နှစ်အတွင်း ၅။လုံးဝမလာရောက်ခဲ့ဘူး
၄၆။	(အထက်ပါ) ကြီးကြပ်မှုတစ်ကြိမ်နှင့်တစ်ကြိမ်မည်မျှကြာပါသလဲ။	၁။အပတ်စဉ် ၂။လစဉ် ၃။၃လတစ်ခါ ၄။၆လတစ်ခါ ၅။တစ်နှစ်တခါ ၆။လုံးဝမရှိ ၇။ပုံမှန်မရှိ
၄၇။	(အထက်ပါ)ကြီးကြပ်မှုတွင်ဘာတွေလုပ်လေ့ရှိသလဲ။ *(တစ်ခုမကဖြေဆိုနိုင်သည်။)*	၁။ကုသမှုလုပ်ငန်းစဉ် ၂။ဆေးပြတ်လပ်မှုနှင့်သက်တမ်းလွန်မှုစီစစ် ၃။ဝန်ထမ်းအင်အားနှင့်သင်တန်းတက်

		ရောက်ပြီးမှုစီစစ် ၄။အချက်အလက်ပြည့်စုံမှုမှန်ကန်မှုနှင့် အချိန်မီအစီအရင်ခံနိုင်မှုစီစစ် ၅။မျိုးဆက်ပွားကျန်းမာရေးစောင့်ရှောက်မှုလုပ် ငန်းလမ်းညွှန်များအတိုင်းလိုက်နာဆောင် ရွက်မှုစီစစ် ၆။အခြား(ဖေါ်ပြပါ_____)

အခန်း(၁၀)။ လုပ်ငန်းလမ်းညွှန်များရရှိမှု(ဌာနအဆိုးအစားအားလုံးမေးရန်)

စဉ်ဝ	အကြောင်းအရာ	ဖြေဆိုချက်
၄၈။	သားဆက်ခြားလုပ်ငန်းလမ်းညွှန် (Family planning guidelines (National/WHO)	၁။ရရှိ(ထုတ်ပြန်ိုင်) ၂။ရရှိ(ထုတ်မပြနိုင်) ၃။မရရှိ
၄၉။	သားဆက်ခြား(ပညာပေး)အထောက်အကူပြုပစ္စည်း (Family planning checklist and or job-aids)	၁။ရရှိ(ထုတ်ပြန်ိုင်) ၂။ရရှိ(ထုတ်မပြနိုင်) ၃။မရရှိ
၅၀။	ကိုယ်ဝန်စောင့်ရှောက်မှုလုပ်ငန်းလမ်းညွှန် ANC guidelines (National/WHO)	၁။ရရှိ(ထုတ်ပြန်ိုင်) ၂။ရရှိ(ထုတ်မပြနိုင်) ၃။မရရှိ
၅၁။	ကိုယ်ဝန်စောင့်ရှောက်မှုလုပ်ငန်းအထောက်အကူပြု ပစ္စည်း (AN checklist and or job-aids)	၁။ရရှိ(ထုတ်ပြန်ိုင်) ၂။ရရှိ(ထုတ်မပြနိုင်) ၃။မရရှိ

၅၂။	စွန့်ပစ်ပစ္စည်းများသိမ်းဆည်းစွန့်ပစ်ရေးလုပ်ငန်းလမ်းညွှန် (Waste disposal guideline (National/WHO)	၁။ရရှိ(ထုတ်ပြနိုင်) ၂။ရရှိ(ထုတ်မပြနိုင်) ၃။မရရှိ

အခန်း(၁၁)။ သတင်းအချက်အလက်နှင့်ဆက်သွယ်ရေးနည်းပညာရရှိမှု(ဌာနအမျိုးအစားအားလုံးမေးရန်)

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

စဉ်ဝ	အကြောင်းအရာ	ဖြေဆိုချက်
၅၄။ ဆက်သွယ်ရေးနည်းစနစ် **(အောက်ဖော်ပြပါအချက်များမှအဖြေမှန်များကိုဝိုင်းပေးရန်)**	**၅၅။ ထောက်ပံ့သူ** ၁။ကိုယ်ပိုင် ၂။အစိုးရ ၃။ဆေးခန်းပိုင်ရှင် ၄။အလှူရှင် ၅။အခြား (ဖေါ်ပြပါ_____)	**၅၆။ အဓိကအသုံးပြုရခြင်းအကြောင်းရင်း** *(တစ်ခုမကဖြေဆိုနိုင်သည်။)* ၁။လူနာမှတ်ပုံတင်ခြင်း ၂။မှတ်တမ်းထိမ်းခြင်း ၃။လူနာတစ်ဦးခြင်းမှတ်တမ်းထိမ်းခြင်း ၄။ကျန်းမာရေးအာမခံ ၅။ဖုန်းဖြင့်ဘီလ်ဆောင်ခြင်း ၆။ပုံမှန်ဆက်သွယ်ပြောဆိုခြင်း ၇။ကျန်းမာရေးပညာပေး ၈။ဆေးနှင့်ဆေးပစ္စည်းများမှာယူခြင်း ၉။သင်တန်းပေးခြင်း ၁၀။လူနာပြုစုကုသမှုအကြံဉာဏ်တောင်းခံခြင်း ၁၁။အခြား(ဖေါ်ပြပါ_____)

၁။ကွန်ပျူတာ	__ _____ _	၁၂၃၄၅၆၇၈ ၉၀၁၁ _____
၂။မိုဘိုင်းဖုန်း(ရိုးရိုးဟန်းစက်)	__ _____ _	၁၂၃၄၅၆၇၈ ၉၀၁၁ _____
၃။မိုဘိုင်းဖုန်း(smart phone)	__ _____ _	၁၂၃၄၅၆၇၈ ၉၀၁၁ _____
၄။သင်ပုန်းကွန်ပျူတာ	__ _____ _	၁၂၃၄၅၆၇၈ ၉၀၁၁ _____
၅။အင်တာနက်(LAN)	__ _____ _	၁၂၃၄၅၆၇၈ ၉၀၁၁ _____
၆။အင်တာနက်(Wi-Fi)	__ _____ _	၁၂၃၄၅၆၇၈ ၉၀၁၁ _____
၇။အခြား(ဖေါ်ပြပါ_____)	__ _____ _	၁၂၃၄၅၆၇၈ ၉၀၁၁ _____

အခန်း(၁၂)။စွန့်ပစ်ပစ္စည်းများကို စီမံခန့်ခွဲမှု(waste disposal)

စဉ် ၀	အကြောင်းအရာ	ဖြေဆိုချက်
၅၇။	ဆေးရုံဆေးခန်းစွန့်ပစ်ပစ္စည်းများကိုမည်သို့	၁။မြေပေါ်ပုံ၍မီးရှို့

	စီမံသလဲ။ *(အဖြေတစ်ခုမက ဖြေဆိုနိုင်ပါသည်)*	၂။သတ်မှတ်နေရာတွင်ကျင်းတူး၍မြှုပ် ၃။မီးရှို့စက်သုံး၍ရှို့ ၄။စည်ပင်အမှိုက်သိမ်းစနစ်ဖြင့်ဆက်သွယ် ဆောင်ရွက် ၅။ပုံမှန်အမှိုက်ပုံးများဖြင့်စွန့်ပစ်

အခန်း(၁၃)ကုသမှုစရိတ်ကျခံခြင်း(ဌာနအမျိုးအစားအားလုံးကိုမေးရန်)

စဉ်ဝ	အကြောင်းအရာ	ဖြေဆိုချက်
၅၈။	ယခု ဆေးရုံဆေးခန်းတွင် ပုံမှန်အားဖြင့် စမ်းသပ်ခ ယူလေ့ရှိပါသလား။	၁။ယူ ၂။မယူ(နံပါတ် ၆၀ သို့)
၅၉။	စမ်းသပ်ခယူလျှင်တဘက်ပါအကြောင်း အရာတို့အတွက်ကင်းလွတ်ခွင့်ပြုပါသလား။	၁။သားဆက်ခြားခြင်း။ ၂။ကိုယ်ဝန်စောင့်ရှောက်မှု ၃။ကလေးမွေးဖွားမှု ၄။မီးတွင်းကာလစောင့်ရှောက်မှု ၅။မွေးကင်းစကလေးစောင့်ရှောက်မှု ၆။၅နှစ်အောက်ကလေးစောင့်ရေ့ှာက်မှု ၇။HIV(ART နှင့် HTC)/PMCT ၈။အခြား(ဖော်ပြပါ_____)
၆၀။	ပုံမှန်အားဖြင့် ဆေးဖိုးကို လူနာများက ကျခံရပါ သလား။	၁။ ကျခံရပါသည် ၂။ မကျခံရပါ (နံပါတ် ၆၂ သို့)
၆၁။	ကျခံရလျှင်တဘက်ပါဆေးများအတွက်ကင်းလွတ်ခွင့် ပြုပါသလား။	၁။သားဆက်ခြားခြင်း။ ၂။မိခင်ကျန်းမာရေးဆိုင်ရာဆေးများ ၃။ကလေးဆိုင်ရာဆေးများ

		၄။အခြား(ဖော်ပြပါ_____)
၆၂။	ကျန်းမာရေး ဝန်ထမ်းဖြင့် ပြသမှုအတွက် လူနာက ကုန်ကျစရိတ် ရှိပါသလား။	၁။ရှိ ၂။မရှိ (အပိုင်း ၁၄ သို့)
၆၃။	ရှိလျှင်တဘက်ပါတို့အတွက်ကင်းလွတ်ခွင့်ရှိပါသလား။ *(တစ်ခုမကဖြေဆိုနိုင်သည်)*	၁။သားဆက်ခြားခြင်း ၂။ကိုယ်ဝန်စောင့်ရှောက်မှု ၃။ကလေးမွေးဖွားမှု ၄။မီးတွင်းကာလစောင့်ရှောက်မှု ၅။မွေးကင်းစကလေးစောင့်ရှောက်မှု ၆။၅နှစ်အောက်ကလေးစောင့်ရေှာက်မှု ၇။HIV (ART နှင့် HTC) /PMCT ၈။အခြား(ဖော်ပြပါ_____)

၁။ကျေးဇူးတင်ကြောင်းပြောပါ။

၂။လူနာတစ်ဦးဦးကိုဆက်လက်မေးမြန်းမည့်အကြောင်းပြောပါ။

၃။လူနာ၏ဖြေဆိုချက်များကို ဤဆေးခန်းနှင့်ဆေးဝန်ထမ်းတစ်ဦးဦးကို အပြစ်ပေးအရေးယူရေးအတွက် သုံးမည်မဟုတ်ဘဲလုပ်ငန်းနှင့်ဝန်ဆောင်မှုများတိုးတက်မှုအတွက်သုံးမည်ဖြစ်ကြောင်းပြောပါ။

၄။တာဝန်ရှိသူတစ်ဦးဦးထံမှခွင့်ပြုချက်တောင်းပြီးမှဆက်မေးပါ။

၃။ဆေးခန်းလာလူနာ၏သဘောတူညီခွင့်ပြုချက်ပုံစံ

ကျွန်တော်/ကျွန်မသည် ယခုသုတေသနလုပ်ငန်းသည် ကျန်းမာရေးဌာနအလွှာအသီးသီး၏ သားဆက်ခြားလုပ်ငန်းနှင့်မျိုးဆက်ပွားကျန်းမာရေးဝန်ဆောင်မှုများ ဆောင်ရွက်နေမှုအပေါ်တွင် ဆေးဝါးပစ္စည်းနှင့် ဝန်ဆောင်မှုအရည်အသွေးစံနှုန်းများကို လေ့လာဆန်းစစ်ရန်ဖြစ်ပြီး ရရှိသောအချက်အလက်များဖြင့် ဝန်ဆောင်မှုလုပ်ငန်းများအဆက်မပြတ်ရေးနှင့် တိုးတက်ဖွံ့ဖြိုးရေးအတွက် အထောက်အပံ့ဖြစ်စေမည် ဖြစ်ကြောင်း သိရှိပါသည်။ ကျဘန်းရွေးချယ်မှုစနစ်အရဤဆေးခန်းကိုရွေးချယ်ရခြင်းဖြစ်ကြောင်းနှင့် ကျွန်တော်/ကျွန်မသည် ဤဆေးခန်းသို့ သားဆက်ခြားနိုင်ရေးအတွက် လာရောက်ပြသသော သူတစ်ဦးလူနာတစ်ဦးဖြစ်၍ ဆွေးနွေးမေးမြန်းရန် ရွေးချယ်ရခြင်းဖြစ်ကြောင်း သိရှိပါသည်။ မည်သည့်မေးခွန်းကိုမဆိုမဖြေဆိုလိုက ငြင်းဆိုနိုင်ခွင့်ရှိကြောင်း သိရှိပါသည်။ မရှင်းလင်းသည်များရှိပါလျှင်ယခုပြန်လည်မေးမြန်းနိုင်ကြောင်းနှင့် ကျေနပ်သည်အထိ ပြန်လည် ဖြေကြားပေးမည်ကို သိရှိပါသည်။ ကျွန်ုပ်က ယခုသုတေသနလုပ်ငန်းတွင် ပါဝင်ရန်နှင့် ဆွေးနွေးမေးမြန်းရန် ကိစ္စအား သဘောတူခွင့်ပြုပါသည်။

လက်မှတ်_____ မေးမြန်းသူလက်မှတ်_____

အမည်_____ အမည်_____

ရက်စွဲ_____ ရက်စွဲ_____

ဆေးခန်းပြသူများ၏ထင်မြင်ယူဆချက်များနှင့်ဝန်သားဆက်ခြားစီမံကိန်းလုပ်ငန်းများအတွက်ကုန်ကျစရိတ်ခန့်မှန်းဖော်ထုတ်ခြင်း

အပိုင်း(၁၄)။ ဆေးခန်းပြသူ၏ထင်မြင်ယူဆချက်များ

၁၄.၁ ဖြေဆိုသူ၏နောက်ခံအကြောင်းအချက်

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

၁၄.၂ ။ဝန်ထမ်း၏လိုက်နာဆောင်ရွက်မှု

စဉ်ဝ်	အကြောင်းအရာ	ဖြေဆိုချက်
၆၉။	သင်ရွေးချယ်သောသားဆက်ခြားနည်းလမ်းကိုရရှိပါသလား။ ရလျှင် မည်သည့်သားဆက်ခြားနည်းလမ်းကို ရရှိပါသလဲ။	၁။ရ ---------- ၂။မရ
၇၀။	နည်းလမ်းရွေးချယ်ရာတွင် သင်နှစ်သက်သောဆန္ဒရှိသောနည်းလမ်းကို ထည့်သွင်းဆွေးနွေးခဲ့ပါသလား။	၁။ဖြစ် ၂။မဖြစ်

၇၁။	မည်သို့သုံးစွဲရမည်ကိုကျန်းမာရေးဝန်ထမ်းကသင်ပေးပါသလား။	၁။သင် ၂။မသင်
၇၂။	ဘေးထွက်ဆိုးကျိုးများကိုရောပြောပြပါသလား။	၁။ပြော ၂။မပြော
၇၃	ဘေးထွက်ဆိုးကျိုးများဖြစ်လာလျှင်မည်သို့ဆောင်ရွက်ရမည်ကိုပြောပြပါသလား။	၁။ပြော ၂။မပြော
၇၄။	ဆေးခန်းသို့ပြန်လာပြရန်လိုအပ်သောနောက်ဆက်တွဲပြဿနာများအကြောင်းပြောပြပါသလား။	၁။ပြော ၂။မပြော
၇၅ ။	ထပ်မံလာပြရန်(သို့)ဆေးထပ်ယူရန်ရက်ချိန်းပေးလိုက်သလား။	၁။ပေး ၂။မပေး

၁၄.၃ ဆေးခန်းနှင့်ဆိုင်သောအကြောင်းအရာများ

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

၁၄.၄။ ပြောဆိုဆက်ဆံရေး

စဉ်ဝ်	အကြောင်းအရာ	ဖြေဆိုချက်
၈၀။	သင့်အပေါ်လေးစားပြုဂုဏ်စွာဆက်ဆံရဲ့လား။	၁။ဆက်ဆံ ၂။မဆက်ဆံ
၈၁။	သင်ရခဲ့သောသားဆက်ပြခြင်းနည်းလမ်းအပေါ် လက်ခံအောင်အတင်းအကြပ်တိုက်တွန်းခဲ့သလား။	၁။တိုက်တွန်း ၂။မတိုက်တွန်း
၈၂။	ခြုံ၍ပြောရလျှင်ဝန်ထမ်းကသင့်အပေါ်ထားရှိသောစိတ်ဓါတ်ကိုနှစ်သက်ရဲ့လား။	၁။နှစ်သက် ၂။မနှစ်သက်

၁၄.၅။ ရလဒ်

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

အခန်း(၁၅) ဝန်ဆောင်မှုကုန်ကျစရိတ်အပေါ်သုံးသပ်ချက်

(မေးခွန်းနံပါတ်**၈၈**၏ **(ဟုတ်)** ဟုဖြေထားသောဆေးခန်းအတွက်သာ)

၁၅.၁။ သားဆက်ခြားစီမံကိန်းဝန်ဆောင်မှုကုန်ကျစရိတ်

စဉ်ပ	အကြောင်းအရာ	ဖြေဆိုချက်
၈၆။	ယခုပြသသည့်အခေါက်သားဆက်ခြားခြင်း အတွက်ကုန်ကျမှုရှိပါသလား။	၁။ကုန်ကျ ၂။မကုန်ကျ (နံပါတ် ၈၈ သို့)
၈၇။	ကုန်ကျမှုရှိသည်ဆိုလျှင်မည်မျှရှိပါသလဲ။	မှတ်ပုံတင်စာအုပ်ပြုလုပ်ရန်|__|__|__|__|__|ကျပ် ခါတ်ခွဲ/ခါတ်မှန်|__|__|__|__|__|ကျပ် ဆေးခန်းမှသားဆက်ခြားဆေး/ပစ္စည်း|__|__|__|__|__|ကျပ် ပြင်ပမှ သားဆက်ခြားဆေး/ ပစ္စည်း |__|__|__|__|__|ကျပ် စမ်းသပ်ခ|__|__|__|__|__|ကျပ်

၁၅.၂ ။ခရီးစရိတ်

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

၁၅.၃။ အချိန်ကုန်မှု

စဉ်ဝ်	အကြောင်းအရာ	ဖြေဆိုချက်
၉၂။	ဆေးခန်းသို့လာရန်အချိန်မည်မျှကုန်သလဲ။	|__|__|နာရီ|__|__|မိနစ်
၉၃။	ဆေးခန်း၌မပြသမီစောင့်ဆိုင်းနေရချိန်	|__|__|နာရီ|__|__|မိနစ်
၉၄။	အိမ်သို့ပြန်ရန်အချိန်မည်မျှကုန်သလဲ။	|__|__|နာရီ|__|__|မိနစ်
၉၅။	ဆေးခန်းလာပြသည့်ကာလအတွင်းအိမ်တွင်အဓိကလုပ်စရာ ဘာတွေရှိသလဲ။	၁။ပုံမှန်အိမ်အလုပ် ၂။စိုက်ခင်းအလုပ် ၃။ဈေးရောင်းအလုပ် ၄။လက်ခစားအလုပ် ၅။ကျွမ်းကျင်လက်ခစားအလုပ် ၆။စာရေး(သို့)Professional အလုပ် ၇။အခြား(ဖော်ပြပါ_____)

၉၆။	ဤကျန်ခဲ့သောအလုပ်ကိုမည်သူကိုလွှဲခဲ့သလဲ။	၁။မိသားစု ၂။လုပ်ဖော်ကိုင်ဘက် ၃။ဘယ်သူမှမလွှဲခဲ့ရ ၄။အခြား(ဖော်ပြပါ_____)
၉၇။	လွှဲခဲ့သည့်အတွက်အခကြေးငွေပေးခဲ့ရသလား။	၁။ပေး ၂။မပေး
၉၈။	ပေးခဲ့လျှင်မည်မျှနည်း။	|__|__|__|__|ကျပ်

၁၅.၄။ ငွေကြေးစီမံမှု

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

ကျေးဇူးတင်ပါသည်။