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MYANMAR/BURMA

BREAKING BARRIERS:

Advocating Sexual and Reproductive
Health and Rights

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BREAKING BARRIERS:

Advocating Sexual and Reproductive Health and Rights

ARROW COUNTRY STUDIES

ISBN 978-967-0339-23-8

2016



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A close-up, low-angle photograph of a woman in Myanmar. She is wearing a traditional headscarf and a patterned shawl. A woven basket is balanced on her head. The image is overlaid with a semi-transparent orange filter. The text is positioned in the lower right quadrant of the image.

MYANMAR/BURMA

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LIST OF ACRONYMS

ACWC	ASEAN Commission on the Promotion and the Protection of the Rights of Women and Children	GEN	Gender Equality Network
AFPPD	Asian Forum of Parliamentarians on Population and Development	GEWESWG	Enhancing Gender Equality and Women's Empowerment Sector Working Group
AHMM	ASEAN Health Ministers Meeting	GII	Gender Inequality Index
AICHR	ASEAN Intergovernmental Commission on Human Rights	GONGO	Government-owned Non-government Organisation
AMA	AIDS Myanmar Alliance	HCCG	Health Convergence Core Group
AMW	Auxiliary Midwives	HPWG	Humanitarian Protection Working Group
ANC	Antenatal Care	HRH	Human Resource for Health
APF	ASEAN People's Forum	HSCC	Health Sector Coordinating Committee
APN+	Asia Pacific Network of People Living with HIV and AIDS	ICPD	International Conference on Population and Development
ARHN	Adolescent Reproductive Health Network	ICPD POA	International Conference on Population and Development Programme of Action
ARHRZ	Adolescent Reproductive Health Rights Zone	IDP	Internally Displaced Persons
ARROW	Asian-Pacific Resource and Research Centre for Women	ILO	International Labour Organization
ART	Antiretroviral Treatment	INGO	International Non-government Organisation
ARV	Antiretroviral drugs	IOM	International Organization for Migration
ASEAN	Association of Southeast Asian Nations	JI-MNCH	Joint Initiative on Maternal Newborn Child Health
ASIR	Age-specific Incidence Rate	KDHW	Karen Department of Health and Welfare
AVAW	Anti-Violence Against Women	KIO	Kachin Independence Organisation
BI-MM	Burnet Institute Myanmar	KnMHC	Karenni Mobile Health Committee
BMA	Burma Medical Association	KWAT	Kachin Women's Association Thailand
BPHWT	Back Pack Health Worker Team	KWEG	Karen Women's Empowerment Group
BRC	Burma Relief Centre	KWHRO	Kuki Women's Human Rights Organisation
BWU	Burmese Women's Union	KWO	Karen Women's Organisation
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women	KYO	Karen Youth Organisation
COIA	Commission on Information and Accountability for Women's and Children's Health	KYWO	Kayan Women's Organisation
COM	Charity Oriented Myanmar	LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, or Questioning
CPI	Community Partners International	LWO	Lahu Women's Organisation
CRC	Convention on the Rights of the Child	MANA	Myanmar Anti-Narcotics Association
CSE	Comprehensive Sexuality Education	MAP	Migrant Assistant Programme Foundation
CSO	Civil Society Organisation	MDG	Millennium Development Goals
DFID	Department for International Development	MDM	Médecins Du Monde
DSW	Department of Social Welfare	MDR	Maternal Death Review
EHO	Ethnic Health Organisations	MDSR	Maternal Death Surveillance and Response
ENAP	Every Newborn Action Plan	MINA	Myanmar Interfaith Network on AIDS
GBV	Gender-based Violence	MMA	Myanmar Medical Association
		MMCWA	Myanmar Maternal and Child Welfare Association

MNCWA	Myanmar National Committee for Women's Affairs	TWU	Tavoy Women's Union
MNHC	Mon National Health Committee	UHC	Universal Health Coverage
MOE	Ministry of Education	ULYO	United Lahu Youth Organisation
MOH	Ministry of Health	UNAIDS	Joint United Nations Programme on HIV/AIDS
MPG	Myanmar Positive Group	UNDP	United Nations Development Programme
MPWN	Myanmar Positive Women Network	UNFPA	United Nations Population Fund
MSF	Médecins Sans Frontières	UNGTG	UN Gender Theme Group
MSI	Marie Stopes International	UNHCR	United Nations High Commissioner for Refugees
MSM	Men Who Have Sex with Men	UNHRC	United Nations Human Rights Council
MSWRR	Ministry of Social Welfare, Relief and Resettlement	UNICEF	United Nations Children's Fund
MTC	Mae Tao Clinic	UNTOC	United Nations Convention against Transnational Organized Crime
MWAF	Myanmar Women's Affairs Federation	VAW	Violence Against Women
MWEA	Myanmar Women Entrepreneurs' Association	VCT	Voluntary Counselling and Testing
NCDP	National Comprehensive Development Plan	WASH	Water, Sanitation and Hygiene
NGO	Non-government Organisation	WHO	World Health Organization
NGO-GG	NGO Gender Group	WLB	Women's League of Burma
NHEC	National Health and Education Committee	WON	Women's Organisations Network
NLD	National League for Democracy	WPNA	Women's Peace Network Arakan
NSPAW	National Strategic Plan on the Advancement of Women	WRWAB	Women's Rights and Welfare Association of Burma
PGK	Pyi Gyi Khin	YDP	Youth Development Programme
PLHIV	People Living with HIV	YIC	Youth Information Corners
PMTCT	Prevention of Mother-to-Child Transmission	YWCA	Young Women's Christian Association
PSI	Population Services International		
PTE	Phan Tee Eain		
PWID	People Who Inject Drugs		
PWO	Palaung Women's Organisation		
PWU	Pa-O Women's Union		
RH	Reproductive Health		
RHS	Reproductive Health Services		
RMNCAH	Reproductive Maternal Newborn Child and Adolescent Health		
RWU	Rakhaing Women's Union		
SAW	Social Action for Women		
SHAPE	School-based Healthy Living and HIV/AIDS Prevention Education		
SLS	Secondary Life Skills		
SPDC	State Peace and Development Council		
SRH	Sexual and Reproductive Health		
SRHR	Sexual and Reproductive Health and Rights		
SRR	Sexual and Reproductive Rights		
SSDF	Shan State Development Foundation		
STI	Sexually Transmitted Infection		
SWAN	Shan Women's Action Network		
SWIM	Sex Workers in Myanmar		
SYP	Shan Youth Power		
TBA	Traditional Birth Attendant		
TBC	The Border Consortium/Thai Burma Consortium		

BACKGROUND

Political developments in Myanmar/Burma¹ prompted the Asian-Pacific Resource and Research Centre for Women (ARROW) in 2013 to undertake a small-scale scoping study to re-evaluate and refine its advocacy strategies for sexual and reproductive health and rights (SRHR), and to strengthen partnerships for advocacy with civil society organisations (CSO) working on SRHR in the country. The study aimed to identify the status of and the potential for SRHR advocacy by CSOs in Central Myanmar/Burma and in Eastern states along the Thai-Myanmar/Burma border, and increase the current knowledge base on SRHR issues, gaps, and challenges. The study was reviewed in 2015 to include an overview of key progress made on SRHR goals by civil society, government and other non-government stakeholders in the country. This report presents the results of the scoping study.

ARROW is a regional non-profit women's NGO based in Kuala Lumpur, Malaysia, that has consultative status with the Economic and Social Council of the United Nations. Since it was established in 1993, it has been working to advance women's health, affirmative sexuality and rights, and to empower women through information and knowledge, engagement, advocacy and mobilisation. ARROW works with local partner organisations across 19 countries in Asia, Pacific, Middle East, and North Africa, and has a priority focus on SRHR of women and youth, challenging the impact of religious fundamentalisms on sexual and reproductive rights, and building knowledge and alliances around the intersections of SRHR with development issues, such as climate change, food security, migration, and poverty.

In July 2010, ARROW began working in partnership with CSOs working on SRHR in Myanmar/Burma, including organisations operating in Thailand and in the borders between the two countries. ARROW organised two regional dialogues, in 2010 and 2011, with CSOs from inside and

the border areas of the country to identify key issues and advocacy strategies for women's and youth SRHR issues in Myanmar/Burma and strategies to support CSO partners to participate in regional and international advocacy partnerships and events. Through these dialogues, ARROW developed advocacy projects with these partner organisations.

This report contains an overview and analysis of government policies and services that were implemented under the Thein Sein Administration—the Government of Myanmar from 2011 to 2015. At the time of writing, a new government-in-waiting led by the winners of the 2015 elections—the National League for Democracy (NLD)—took administrative power in February 2016. It is hoped that the new government will take steps towards making progress on key SRHR policy areas outlined in this report.

DEFINITIONS

■ **Reproductive Health** implies that people are able to have a responsible, satisfying, and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this definition is the right of women and men to be informed of, and to have access to safe, effective, affordable, and acceptable methods of fertility regulation of their choice, and to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth, and provide couples with the best chance of having a healthy infant.²

■ **Reproductive Rights** embrace certain human rights that are already recognised in national laws, international human rights documents, and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children, to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.³

■ **Sexual Health** implies a positive approach to human sexuality. The purpose of sexual healthcare should be the enhancement of life and personal relations, as well as counselling and care related to reproduction and sexually transmitted diseases.⁴

■ **Sexual Rights** embrace human rights that are already recognised in national laws, international human rights documents, and other consensus documents. These include the right of all persons, free of coercion, discrimination and violence, to the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive healthcare services; right to seek, receive and impart information in relation to sexuality; right to sexuality education; respect for bodily integrity; choice of partner; right to decide to be sexually active or not; consensual sexual relations; consensual marriage; right to decide whether or not, and when to have children; and right to pursue a satisfying, safe and pleasurable sexual life.⁵

Source: Sivananthi Thanenthiran, Sai Jyothirmai Racherla, and Suloshini Jahanath, *Reclaiming and Redefining Rights: ICPD+20 Status of Sexual and Reproductive Health and Rights in Asia Pacific* (Kuala Lumpur: ARROW, 2013), 22.

PURPOSE OF THE REPORT

This report is aimed at highlighting that ALL WOMEN in Myanmar/Burma—regardless of ethnicity, citizenship, refugee or internally displaced person (IDP) status, race, religion, occupation, or sexual orientation and gender identity and expression—are deserving of full recognition, fulfilment and respect of their human rights, including their sexual and reproductive health and rights.

The report summarises the key findings of a scoping study commissioned by ARROW in 2014 and undertaken by a team of experts with deep understanding of the context and stakeholders in Myanmar/Burma. It aims to provide:

- An overview of the status of sexual and reproductive health and rights (SRHR) in Myanmar/Burma in 2014–15;
- An overview of key stakeholders working in SRHR, including government, NGOs, CSOs, and networks in Myanmar/Burma and the areas bordering Thailand; and
- An analysis and summary of key gaps, challenges, and opportunities for SRHR advocacy in the country.

The report is intended for use as a resource for civil society, activists, government, and non-government actors working to improve access to SRHR in Myanmar/Burma. There remains a significant lack of information on the status of SRHR in the country, especially those that include rights-based analyses and highlight the voices of human rights activists, ethnic nationality groups, women, and young people. Myanmar/Burma has been a closed country for decades and the previous military dictatorship severely restricted independent qualitative and quantitative research, and community-based consultation.

Nevertheless, CSOs have made significant progress in advocacy on SRHR, despite the restrictive and challenging political environment for the last three decades. However, there has been limited opportunity for CSOs to promote their work, achievements, challenges, and issues. It is hoped that this report will provide an opportunity to

share information on SRHR more widely among multiple stakeholders, to promote transparent and evidence-based development, and to recognise the challenges and achievements of civil society actors in Myanmar/Burma and border areas.

At this critical time of increased donor interest and investment in Myanmar/Burma, the report also aims to promote transparency, information sharing, accountability,⁶ and good practice within the government and donor community. The information is also intended to support CSOs to:

- Develop a coordinated advocacy approach to SRHR issues at the national level, with a particular focus on marginalised, difficult and disadvantaged segments of the population (Eastern and Western States);
- Secure much-needed donor support for SRHR programming and advocacy; and
- Advocate for improvements in state-funded sexual and reproductive health (SRH) services and SRHR programmes.

The report is available in English edition and a Burmese translation is forthcoming.

EXECUTIVE SUMMARY

Myanmar/Burma is in a unique democratic and political transition with rapidly developing and emerging civil society activism at the national level, increasing donor interest and funding, and strong advocacy experience and activism from previously exiled and border-based activists and organisations.

However, there are severe challenges to women, especially regarding sexual and reproductive health and rights. It remains one of the poorest countries in Asia, with drastically underfunded health services, and women's sexual and reproductive health and rights (SRHR) outcomes are among the worst in the Asia-Pacific region. The country has not met many of the Millennium Development Goals (MDGs), or the International Convention on Population and Development (ICPD) targets and reports, despite making progress. Maternal mortality is estimated at 200 deaths in every 100,000 births; there is less than 50% contraceptive coverage, and a severe lack of access to even basic maternal healthcare; and more than 76% of births occur in the home without skilled birth attendants. Women from ethnic states and conflict areas are in dire need of sexual and reproductive health (SRH) services, with maternal mortality rates more than three times higher than the national rate.

Sexual rights are constrained by restrictive laws, a constitution that discriminates against women and minority groups, widespread conservative attitudes, and lack of knowledge of SRHR within communities. Young people have extremely limited access to contraception, while comprehensive sexuality education is yet to be implemented in the education systems. Growing religious fundamentalism and nationalism centred on ethnic-religious identities also threaten the rights of women to freedom of religion, independent marriage choices, and access to SRH services, including the lack of safe abortion services due to restrictive law and religious conservatism. Sexual and

gender-based violence are widespread and perpetrated by state forces and the military, and within homes and communities, with limited options for protection or redress from these crimes. The prevalence of HIV remains high with inadequate prevention and treatment services, and people who are at high risk of HIV, including sex workers, transgender people, and drug users face high levels of stigma and discrimination and are criminalised by the laws of the country.

There is an urgent need for a significant increase in health investment by the government to improve access to SRH. There is also a need for investment and funding to adequately support the vital role of civil society organisations—both in the implementation of SRH programming and in their essential role as advocates for SRHR.

National level CSO advocacy is growing within a new, fast changing, and challenging advocacy environment as many activists, including women, sex workers, LGBTIQ,⁷ and young people, are embracing newly emerging advocacy opportunities. CSO advocacy for women has been focused on women's leadership, political participation, law reform and constitutional change, and gender-based violence (GBV). Two central women's advocacy networks and a border-based ethnic women's network have been leading CSO advocacy, and these are increasingly collaborating for advocacy on key women's human rights issues at the national level. Women's networks have in the past three years focused on law reform to combat gender-based violence and the development of a national strategic plan for women, with women's health as a key focus area. Sex worker and LGBTIQ advocates have worked on raising awareness and building partnerships with national level parliamentarians to advocate for law reform, using a human rights framework to challenge laws that criminalise same-sex behaviours, and sex work. A number of key national

level and border area youth organisations and networks are working in the programme area on SRH for young people that aim to build advocacy capacity and leaderships skills, and increase SRHR knowledge through sexuality and sexual and reproductive health education for young people.

Organisations that work in the border areas and Eastern Myanmar/Burma are also key players in SRHR advocacy. Border-based ethnic health organisations and ethnic women's groups have strong skills and nearly 20 years of experience in international level advocacy work. Border-based ethnic women's groups continue to implement successful international advocacy campaigns on sexual rights for women highlighting the issues of GBV and systematic sexual violence against women and girls in conflict zones, internally displaced persons (IDP) camps, and refugee areas. Border-based health service providers are working on health programme delivery and advocacy with donors and governments to ensure that vital maternal, child, and reproductive health services are accessible for ethnic, IDP, and refugee communities in Eastern Myanmar/Burma. They are also working on cross-border advocacy to ensure that the border-based health workforce can effectively converge and collaborate with the state health system in the future.

With the high demand and urgent need for advocacy on SRHR, the capacity of CSOs and networks in Myanmar/Burma and border areas is stretched and challenged. In addition, the current political transition brings many competing advocacy agendas and priorities for CSOs. SRHR advocacy is often not prioritised, and issues such as political participation, the ethnic peace process, and constitutional reform take precedence over women's and girls' SRHR at this stage. For SRHR, there are also limits to the capacity for national level advocacy due to a lack of knowledge of SRHR-specific advocacy and a lack of absorptive capacity (i.e., activists have limited time or human resources to commit to SRHR advocacy due to a focus on organisational development or programmatic activities).

In all of the CSO networks, there is yet to be a coordinated national level advocacy strategy and position on SRHR, which includes a comprehensive policy or advocacy position across the broad spectrum of issues. Abortion, contraception, comprehensive sexuality education, and rights for sexual minorities are highly contentious issues both culturally and politically, and remain challenges for public-level advocacy. Conservative cultural and religious beliefs shape public attitudes towards girls' and women's sexuality, and sexual behaviour. This then determines what is moral and acceptable for girls and women, thus making it difficult to advocate for safe sex, use of contraception and condoms, sexual rights, rights of sex workers, and for the acceptance of same-sex relationships. The lack of research and data collection led by national and local level CSOs and international non-government organisations (INGOs) has been a barrier to the implementation of SRHR programmes and activities and the development of effective evidence-based responses, especially in ethnic and conflict-affected communities. Arrests of human rights activists continue to take place. Rising nationalism, religious fundamentalism, and on-going armed conflicts in ethnic states also severely impact the SRHR of women from ethnic nationalities and religious minorities. Therefore, CSOs operating in a complicated political and security environment need to adopt highly sensitive and strategic advocacy approaches.

Given these challenges, the support and development of national level SRHR advocacy by civil society is urgent and a matter of priority. SRHR is recognised as an issue across multiple organisations and populations. This calls for effective collaboration and coordination for national level advocacy between networks, including border-based and Central Burma-based organisations and across multiple groups including women, youth, sex workers, LGBTIQ, and ethnic groups. International support by donors and other partners, including CSOs such as ARROW, could assist in forwarding the advocacy agenda. Given the political history and environment of the country, there is a need to consider unique ways of working in the country, to support emerging national movements, and to build CSOs capacity.

SECTION 1:

METHODOLOGY

The scoping study was undertaken by a team of researchers commissioned by ARROW from November 2013 to April 2014. A desk review of literature on the health data and research related to SRHR in Myanmar/Burma was undertaken in November 2013, updated in April 2014 and again in December 2015.⁸ Key indicators for analysis of progress in SRHR were based on international frameworks used in the MDGs and in the ICPD frameworks. A list of key stakeholders working on SRHR in Central Myanmar/Burma, and the Thai-Myanmar/Burma border areas was compiled, and feedback was sought on the major SRHR issues and advocacy challenges they faced. Stakeholders were interviewed in Myanmar/Burma in December 2013, and in Thailand in January 2014.

A two-phased methodology was used for the consultation with stakeholders. In the first phase, a broad list of key agencies and individuals were identified, based on a review of current information directories from the Local Resource Centre Myanmar, a project funded by the European Union aimed at supporting civil society development in the country, which has a comprehensive database listing key local NGOs, INGOs, UN agencies, and networks in Myanmar/Burma. Recommendations were also sought from key border-based organisations in Thailand for organisations in Myanmar/Burma; from the ARROW programme staff; and from one of the consultants who has established links with women's human rights activists and organisations in the country via her work with the women's movement. From these sources, a list of stakeholders was compiled which was expanded with recommendations from groups in Myanmar/Burma.

In phase two, interviews were conducted with 33 organisations and individuals (see Appendix 1), in Yangon (Rangoon) on 15-24 December 2013, and interviews with border-based groups in January 2014. Selection criteria

for organisations to interview included at least two of the following criteria:

1. Organisational objectives include a rights-based approach and advocacy goals on gender, youth, women, or human rights;
2. Organisations that implement SRHR programmes or advocacy at the national level;
3. Organisations that were identified as leaders in SRHR advocacy by other activists or organisations; and
4. Organisations that work on SRHR in Eastern Myanmar/Burma and border areas.

The assessment process aimed for representation from CSOs working across key priority target groups, such as women, religious communities, youth, LGBTIQ, and sex worker communities. Face-to-face consultations were held with a broad range of stakeholders. This included: two INGO SRHR service providers; two UN agencies; two media representatives; two sex workers organisations; one LGBT representative; three religious representatives (Muslim, Christian, and Buddhist); five youth representatives; eight women's organisations representatives; and seven border-based organisations identified as key actors working in Eastern Myanmar/Burma and border areas on SRHR services and advocacy. For individuals, an interview was conducted to gain insight into key SRHR issues such as abortion, contraception, cultural and religious attitudes, and media role and representation. The findings of the interviews have been included in the report sections below.

LIMITATIONS

Since this was not intended as a comprehensive mapping study, it does not claim to include all stakeholders working on SRHR in Myanmar/Burma, and may invariably have omitted many organisations working in this area. The scope of the consultation was limited at the time of the study to Yangon (Rangoon)-based organisations and a selection of Thai-Myanmar/Burma based organisations that work in Eastern Myanmar/Burma and had previous links working with ARROW. The priority focus was on CSOs that were recommended as leading advocates for women and young people's SRHR. Due to the limited timeframes of the assessment, it was not possible to meet with some leading UN, INGO, government services, and national government-owned non-government organisations (GONGO), and for these agencies, a desk review was conducted to give an overview of their work on SRHR (see Appendix 1).

In addition, the interviews with leading CSOs and networks also included specific questions on current perspectives, working relationships, and advocacy potential with the Myanmar Maternal and Child Health Welfare Association (MMCWA), as the leading national non-government stakeholder and service provider of SRHR, and these findings are also included in the report.

It should be noted that while the Republic of the Union of Myanmar (Burma) consists of seven regions and seven states, this report focuses only on two states: Eastern and Western. The report does not claim to cover all issues within the country; nor does it cover situations of all communities and ethnic groups.

SECTION 2:

SRHR STATUS AND OVERVIEW

The information in the following section is based on a data and literature review of health statistics and studies on SRHR in Myanmar/Burma, aside from additional information gained from interviews with key women, LGBTIQ, sex workers, and civil society activists (see Appendix 1).

2.1 OVERVIEW: CURRENT POLITICAL CONTEXT

After more than 60 years of military dictatorship, the country has undertaken a period of political transition with political space in the country opening up in 2012; the suspension of international sanctions in 2013; and the first national elections held in November 2015. The previous military government—the State Peace and Development Council (SPDC)—adopted a highly contested Constitution in 2008, and held a tightly controlled election in November 2010. This resulted in the election of the reformist President Thein Sein, a former military general who was a key player in the previous regime. The Thein Sein administration oversaw the release of former political prisoner Aung San Suu Kyi, who went on to successfully contest by-elections with the opposition National League for Democracy (NLD) in April 2012, and become a member of the parliament. The NLD has had representatives working at the national, regional, and state levels since this time.

Under the Thein Sein government, a number of reforms were undertaken, including financial sector reform, easing of media censorship, release of political prisoners, steps towards law reform, plans to reform the health and education systems, and ceasefire agreements signed with eight ethnic armed groups. These reforms revived Myanmar/Burma's relations with the international community, resulting in the lifting of sanctions, increased investment and development aid, and being granted the role as ASEAN Chair in 2014. In November 2015, Aung San Suu Kyi led the NLD to an election victory, winning an absolute majority in both Houses of Parliament.⁹ The

NLD government took up their administrative position on February 1, 2016.

While the political situation has improved over the last three years, there remain significant challenges. It is one of the poorest countries in Southeast Asia with 22.7% of the estimated 62 million people living in poverty. Poverty level is up to 1.8 times higher in rural areas and worse in some ethnic states. It is widespread in remote border areas, ethnic states,¹⁰ and conflict-affected areas. Myanmar/Burma ranks 150 out of 187 countries on the UN Human Development Index¹¹ and has not met many of the MDGs. Government spending on health in Myanmar/Burma is still one of the lowest in the world,¹² resulting in health outcomes that are among the worst in Asia with large numbers of people dying from easily preventable illnesses and diseases.

The legal system remains essentially dysfunctional with most of the laws from the previous military regime and laws from colonial days still in place. An independent judiciary is not yet functioning and government agencies, organisations, and security forces are plagued by corruption, bias, and lack of accountability.¹³

The country's democratic transition has been challenged by tensions between reformist and hard-liner elements in the current parliament and the unpredictable role of the military, which retains majority control of parliament and whose command lies outside of the President. The 2008 Constitution is not democratic, and gives the military a dominant role in all levels of government. The current system of governance does not allow for equitable representation for ethnic nationalities who are calling for a federal system which guarantees equality of all ethnic nationalities. While the Thein Sein government has supported a national peace process, a nationwide ceasefire and an effective process for political dialogue with ethnic

communities that will include constitutional change and electoral reform is yet to be realised. Moreover, in some areas in Eastern Myanmar/Burma, the military continues to engage in armed conflict with ethnic Shan and Kachin armed groups. The peace process, constitutional reform, and return of refugees and IDPs are sensitive issues that threaten to derail national progress towards democratic reform. Moreover, the recent national elections has resulted in only minimal representation of ethnic parties in the parliament, which may limit the capacity for inclusive political participation and from ethnic communities at the national and regional levels.

In the past three years, there has been an increase in sectarian violence and inter-religious tensions across the country as a result of rising religious fundamentalism, Buddhist nationalism, and tensions between Muslim and Buddhist groups. The fundamentalist Buddhist movement led by high-profile Buddhist monks (known as “969”) promotes a radical form of anti-Islamic Buddhist nationalism, which has inflamed conflict across the country, especially in Rakhine State. Over the course of the 2015 election campaign, these inter-religious tensions were politicised to the point where Muslims were excluded from the election process under various election rulings, resulting in the current situation where there are no Muslims in the future parliament.¹⁴ Moreover, the nationalist Buddhist monks have also driven the enactment of controversial legislations that could further discriminate women from ethnic nationalities and religious minorities and undermine their sexual and reproductive rights.¹⁵ Activists who spoke out against these bills have “faced intimidation, public humiliation and even death threats,” and have been branded as “national traitors.”¹⁶

Gender discrimination is systemic and poses a threat to the reform process and a significant barrier to the realisation of human rights for women and girls across the country. In the 2014 *Human Development Report*, Myanmar/Burma ranks 83 out of 187 countries in the Gender Inequality Index (GII).¹⁷ The 2008 Constitution of Myanmar/Burma does not meet the standards of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) to which Myanmar/Burma acceded in 1997, and fails to ensure

COMPOSITION OF SEXUAL AND REPRODUCTIVE HEALTH

Sexual and reproductive health includes the following:

- Contraceptive services and safe abortion services within the parameters of the country’s laws;
- Pregnancy-related services, including skilled attendance at delivery, emergency obstetric care, and post-abortion care;
- Infertility diagnosis and treatment;
- Sexually transmitted infections and prevention, diagnosis, treatment, and care;
- Early diagnosis of, treatment, care, and support for reproductive cancers, including breast and cervical cancers;
- Prevention of gender-based violence and care of survivors;
- Sexuality education; and
- Adolescent sexual and reproductive health.

This definition is derived from the ICPD Programme of Action and subsequent interpretations. From: TK Sundari Ravindran, *An Advocate’s Guide: Strategic Indicators for Universal Access to SRHR* (Kuala Lumpur: ARROW, 2013), 21, accessed December 2, 2015, http://arrow.org.my/wp-content/uploads/2015/04/Advocates-Guide_SRHR-Indicators_2013.pdf.

substantive equality for women. Key issues of concern for women’s sexual and reproductive health include high maternal mortality and morbidity; lack of reproductive and basic health services; and high HIV levels among some groups of women. Political participation in public decision-making is low with only 4.6% of women in the Thein Sein era parliament, and women are underrepresented in the labour market (50.5% female labour force participation compared to 85.2% male).¹⁸ Access to education is a key issue for both genders—only 18% of girls and 17.6% of boys access secondary education.¹⁹ In all States and regions, males generally have slightly higher literacy levels than females, and there is gender discrimination in education policy, which restricts women’s participation in some areas of higher education.

Gender-based violence is a serious concern, and affects women at all levels of society and in all social, ethnic, and religious groups. Women and girls in rural areas and among ethnic groups, especially in Eastern Myanmar/Burma and Rakhine State, are severely affected by gender-based violence, religious fundamentalism, armed conflict, and poor access to SRHR services. People from sexual and gender minorities also face huge challenges in addressing the systematic discrimination within the country's laws and institutions, and in effectively challenging the high levels of violence and discrimination they face in every-day life.

While there is considerable expectation that the new NLD government will undertake significant steps to further democratic reform, it is unclear what their policy stance will be in regards to SRHR, gender equality, and towards the more entrenched challenges related to religious and ethnic conflicts in the country. In this challenging environment, however, there is a growing voice and strength from the civil society movement, which has taken significant steps forward to advocate for gender equality and SRHR and embrace the steps towards political change in the country.

2.2 GOVERNMENT POLICY AND SERVICES

The following section provides a summary of the government policies that impact on SRHR, including international conventions, regional agreements, and national policies on health, population, women, and young people. It also provides an overview of Myanmar/Burma's sexual and reproductive health services system.

2.2.1 International Human Rights Commitments by the Government

The government has signed a number of key international human rights treaties that provide obligations of due diligence towards the protection and promotion of human rights, including SRHR for the people of Myanmar/Burma. These include the following:

- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW):²⁰ The government acceded in 1997, but has not signed the Optional Protocol (2000) to establish an inquiry

procedure and investigation mandate for women's human rights violations. The Government of Myanmar has expressed reservation on Article 29 and does not consider itself bound by the provision set forth in the said article.

- Convention on the Rights of the Child (CRC):²¹ The government acceded in 1991.
- United Nations Convention against Transnational Organised Crime²² (including the protocols on trafficking and smuggling of persons): The government signed in 2004.
- Geneva Conventions and the Protocols:²³ Myanmar/Burma ratified in 1992.
- Convention 87 Freedom of Association/Protection of the Right to Organise,²⁴ and Convention 29 Forced Labour Convention, 1930:²⁵ Myanmar/Burma has only signed two of the nine core international labour rights treaties.

Regional agreements and treaties have also been signed by Myanmar/Burma in the ASEAN region, with state commitment to the protection and promotion of human rights, in relation to migration, health, and trafficking. These are articulated in the following agreements:

- ASEAN Declaration Against Trafficking in Persons Particularly Women and Children (2004);²⁶
- ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers (2007);²⁷ and
- ASEAN Declaration on the Elimination of Violence Against Women in the ASEAN Region (2004).²⁸

2.2.2 Key Government Health Policies and Plans

Myanmar/Burma has a number of policies aimed at improving the health of the population. Some of the key policies targeting or linked to SRHR are outlined below.

The Constitution of the Republic of the Union of Myanmar 2008

guarantees women's equality, but it does not satisfy CEDAW requirements to define and prohibit direct and indirect discrimination against women. The Constitution primarily focuses on women's role as mothers rather than guaranteeing the fundamental human rights of

all women, including health, gender equality, and the right to citizenship for some groups. Moreover, the Constitution legitimises all of the current laws in the country, including the repressive laws introduced by past dictatorships, which do not meet international human rights standards.

The Constitution includes a clause granting the right to healthcare for all citizens (Article 367); clauses obligating state responsibility to “care for mothers, children, orphans, the aged and the disabled” (Article 32) and guaranteeing “mothers, children, and expectant women” equal rights before the law (Article 351). However, it does not recognise the right to health per se, and specifically limits healthcare and healthcare rights to the “national people” or “citizens.”

Myanmar’s National Health Plan 2011-2016 is aligned with the National Comprehensive Development Plan (NCDP) Health Sector, a 20-year visionary plan. The National Health Plan focuses on 11 programme areas and aims to improve health for mothers, neonates, children, adolescent and elderly as a life cycle approach; and to expand healthcare coverage in rural, peri-urban and border areas. The plan aims to strengthen primary healthcare systems, including a priority for the development of health facilities in the underserved border areas. In 2012, Myanmar/Burma amended its 1954 Social Security Act in order to expand the coverage of social health insurance, keeping with its long-term plan for universal health coverage. There is a parallel five-year Strategic Plan (2011-2016) to improve Health Information Systems in population health, public health, hospitals, and reporting systems for private health sectors.

The National Reproductive Health Policy and Reproductive Health Strategic Plan, developed by the National Health Committee of the Ministry of Health (MOH), has been in place since 2002. The objectives of the policy are to improve the health status of mothers and children; and reduce maternal, neonatal and child mortality, and morbidity, based on MDG goals 4 and 5. Interventions, which aim to reach MDG targets, particularly for 70% of the population in rural areas, include: antenatal care (four visits), skilled and institutional delivery at 80%, increased postnatal care, post-abortion care, quality birth spacing services, emergency obstetric care, essential newborn

care, adolescent reproductive health, male involvement in reproductive healthcare, cervical cancer screening and treatment, community health volunteer training, and development of community-based-referral systems.²⁹ The plan covers human resources for maternal and newborn health, focusing on increasing capacity of medical personnel, although it has no specific targets for increasing the midwifery workforce.³⁰

The Costed Implementation Plan to Meet FP2020 Commitments aims to improve the reproductive health of men, women, and adolescents; reduce maternal and infant mortality; and scale up the provision of quality integrated birth spacing services. The government has pledged to increase the health budget to cover nearly 30 million couples by 2010 and increase resources for family planning in state budgets. The Plan complements the National Strategic Plan for Reproductive, and aims to create an enabling environment for birth spacing, generating demand and sustaining behaviour change among clients and providers, and increasing supply of good quality birth spacing services via health workforce development and reliable contraceptive supplies. The government pledged to reduce unmet needs for contraception and increase contraceptive prevalence rates to 50% by 2015, aiming to reach 900,000 women of reproductive age in the next seven years with family planning services.³¹

These policies are accompanied by five-year national strategic plans for Reproductive Health, Child Health and Adolescent Health, which uses the life course and continuum-of-care approach, as follows:

- **The Five Year National Reproductive Health Strategic Plan (2009-2013)** has been updated and replaced by the 2014-2018 Plan. The scope of this plan has maintained the essential package of services contained in the previous five-year plan, and has expanded it to include emerging issues, such as RH services in humanitarian settings; controlling gynaecological problems, especially cervical cancer; and applying gender-sensitive approaches such as including a stronger focus on the role of men in women’s reproductive health. Though lower on the current priority list, a gradual

introduction of services for infertile couples, RH needs of the elderly, and RH services for disabled persons is planned. In addition, the plan is costed using a robust methodology.

- **The National Child Health Plan (2010-2014)** covers the five-year period and is currently being reviewed and updated. The new plan (2015-2019) shall have a significant component for newborn health, in line with the priority accorded by the World Health Assembly 2014 that endorsed the “Every Newborn Action Plan (ENAP).” This plan will also undergo a robust costing exercise. There is also ongoing discussion between the four UN agencies (UNICEF, UNFPA, UNAIDS and WHO) and the Ministry of Health to merge the Newborn and Child Health Plan with the Reproductive Health Plan.
- **The National Five-year Adolescent Health and Development Strategic Plan (2014-2018)** is currently being developed; concrete plans for the launch and implementation have not yet been announced as of the time of publication. The previous Adolescent Health Plan focused on school and youth health programmes aimed to promote student health, but did not include comprehensive sexuality education. The School-based Healthy Living and HIV/AIDS Prevention Education Programme (SHAPE), was implemented in collaboration with the National AIDS Programme under the Department of Health, Department of Education Planning and Training, and UNICEF since 1998. The National Life Skills Curriculum was also introduced in 2000 and expanded nationwide. Youth-friendly health services were also implemented in 28 townships, including 10 new townships in 2012. The country’s Ministry of Health released the National Service Standards and Guidelines on Adolescent and Youth Healthcare in July 2013, providing broad standards for youth health programmes. However, these do not mention SRHR specifically. A new legislation is currently being drafted to replace the Juvenile Law, which will raise the age of a “minor” from under 16 to under 18 years, and set a minimum age for marriage and employment.³²

It is noteworthy that in these plans, approaches have been identified for community engagement, including of

civil society in several activities such as advocacy for reproductive, maternal, newborn, child, and adolescent health (RMNCAH).

- **Myanmar’s National Strategic Plan on HIV and AIDS 2011-2016**³³ aims for population-based HIV prevention and treatment targeting men, women, and youth across the country. The plan also targets HIV prevention for key affected population groups, including sex workers, men who have sex with men, and injecting drug users, with targets for 80% condom use, expansion of antiretroviral treatment (ART), and prevention of mother-to-child transmission (PMTCT) across all population groups. These are based on the latest treatment guidelines from WHO, and guided by the Asia Pacific Framework for the Elimination of New Paediatric HIV Infections and Congenital Syphilis (2010).
- **The Health Workforce Strategic Plan 2012-2017**, developed with extensive consultation with stakeholders, is to guide the development of human resources for health to meet the challenges facing the country’s health system. The principles, strategies and approaches are for health in general, and are applicable to SRH.

Policy Challenges

Feedback from CSOs and INGOs indicate that it is difficult to access official government policies easily. Often, there are no hard copies or electronic copies available for community stakeholders. The government has now developed strong skills in developing policies, which appear to meet international standards and benchmarks. However, in the implementation of policy, there are often major shortfalls.

CSO activists have observed that the government has also tended to announce major policies at international forums in order to showcase their newly developed reputation as a reformist government, however, often there is no clear implementation plan announced with the policy. For policies related to SRHR, the government maintains a conservative approach to wording. For example, the government reportedly is reluctant to use words like

“sexual health” or “sexual rights” in laws or policies, and prefers to focus instead on areas such as maternal and child health. Thus, the lack of public recognition of the sexual rights framework makes it challenging to advocate on sexual rights issues.

2.2.3 Nationwide Reproductive and Sexual Health Services by the Government

Sexual and reproductive health services by the government are guided by the National Reproductive Health Policy and the related Strategic Plans for Reproductive Health, Child and Newborn Health, and Adolescent Health, mentioned earlier. While there are numerous policies and plans in place for health development, in reality, Myanmar/Burma’s health indicators for maternal mortality continue to rank amongst the worst in Asia. It has not met the MDG and ICPD targets set for 2014 and 2015.

The poor health outcomes for women are directly related to the lack of investment in health, under the previous military regime of the SPDC, as well as the Thein Sein government. There are several challenges and constraints that make it extremely difficult for the services contained in these plans to be implemented optimally.

The general healthcare system has limited national coverage, and universal access to primary healthcare remains a challenge, especially in rural and border areas. In 2013, government health expenditure covered only 27.2% of the total health expenditure with the remainder being covered by private expenditure or externally funded services delivered by non-government organisations.³⁴ In the same year, public health expenditure as a percentage of GDP was only 0.5%, the lowest amongst ASEAN countries.³⁵ However, increased spending on health planned to reach 3.38% of the budget in 2014,³⁶ and in the 2015/16 budget, a total of USD592.3m was allocated for health spending—a nearly 7% increase over the previous budget.³⁷ Nevertheless, big challenges remain. Some of the current challenges to maternal and child health delivery (which includes reproductive health) are: inadequate workforce, health expenditure and infrastructure, over-worked health staff especially midwives, and significant geographical and

ADOLESCENT SRHR SERVICES

Adolescent SRH services include “at a minimum... gender-sensitive life-skills-based SRH education and a package of social protection services for adolescents and youth, including psychosocial counseling, contraception, prevention, STI prevention/treatment and maternal health services.”

Source: UNFPA, *Making Reproductive Rights and Sexual and Reproductive Health a Reality for All: Reproductive Rights and Sexual and Reproductive Health Framework* (New York: UNFPA, 2008), in TK Sundari Ravindran, *An Advocate’s Guide: Strategic Indicators for Universal Access to SRHR* (Kuala Lumpur: ARROW, 2013), 23, accessed December 2, 2015, http://arrow.org.my/wp-content/uploads/2015/04/Advocates-Guide_SRHR-Indicators_2013.pdf.

coverage gaps.³⁸ In addition, adequate data, especially sex-disaggregated data, is not available to inform gender-sensitive programming, analysis, and planning for gender-specific targets.

There has been no functioning health insurance system, with the state-run Myanmar Insurance company being the only insurance provider in the country until 2013. Since 2014, however, the government has allowed private insurance firms to operate and sell health insurance.³⁹ This and the low government expenditure results in high out-of-pocket expenditures, which at 93.7% is amongst the highest in the world.⁴⁰ Patients face long queues and “cost-share” at government health facilities, i.e., pay for all medical tests, food, treatments, medicines, dressings, and must even bring their own bedding. This impacts those poor and most marginalised, as studies have shown that the ability to pay becomes the key determinant for accessing health care.⁴¹ Moreover, it has been observed that high out-of-pocket expenses is a barrier to the ability to access sexual and reproductive health services.⁴²

Reproductive and sexual health services are provided by a mix of government, international and national/

Central Myanmar/Burma-based NGOs, private providers, community-based organisations, and ethnic health organisations (including women and youth groups) (see section 3.2 for more details). Government SRH services include HIV prevention and treatment, STI treatment and prevention, and maternal and child health services. Family planning has not previously been included in the government's health budget. In November 2013, the government pledged to create a budget line for contraceptives. It allocated USD1.29 million for 2012-2013, and pledged to reduce unmet need for contraception, and increase contraceptive prevalence rates to 50% by 2015.⁴³⁻⁴⁴

Skilled healthcare professionals are extremely limited. Government medical facilities are renowned for having inadequate number of staff, most of whom are low-paid and unskilled. Government-trained midwives often prefer to do private, community-level work where they provide home-based care or set up as pharmacists, rather than work in government healthcare facilities where they have low pay and poor working conditions. Even so, there is a lack of trained midwives in communities. The Government estimates that there were 20,617 midwives working in 2012, with an estimated 22,757 auxiliary midwives (AMWs)⁴⁵ providing maternal care with the ratio of midwifery skilled providers (including AMWs) to village is 1:1.3.⁴⁶ There are less than 350 maternal and child health centres run by the Ministry of Health. The UNFPA in 2013, allocated USD300,000 to upgrade maternity wards and delivery rooms in ten locations across the country, including Shan State and the divisions of Yangon (Rangoon), Magway, and Ayeyarwady (Irrawaddy).⁴⁷

Government health services that are “youth-friendly” are limited. Adolescent health and HIV services that are currently available are not user-friendly with concerns expressed by young people about the lack of confidentiality and privacy when accessing health services.⁴⁸ As mentioned earlier, the Ministry of Education's sex education curriculum provides basic health information about sex and HIV prevention for students aged 10-16 as part of the “secondary life skills” (SLS) curriculum. Reproductive and sexual health are introduced in sixth grade, with lessons on

physical growth and emotional changes due to puberty, as well as HIV; seventh graders are asked to consider boy-girl relationships to determine an age-appropriate level of closeness; and in 10th and 11th grades, students learn how to prevent unplanned pregnancies and STIs, with abstinence promoted as the most effective method.

While HIV prevention and treatment services have expanded over the past five years, the coverage of voluntary counselling and testing (VCT) is very low at only 9% and the majority of people living with HIV cannot yet access antiretroviral treatment (ART). The number of persons receiving ART at the end of 2014 was 85,626 (GARP indicator 4.1), representing 40% of all persons estimated to be living with HIV.⁴⁹ Access to ART in government health clinics is currently restricted by residency requirements (i.e., evidence of house registration), which makes it difficult for HIV-positive people in highly mobile groups, such as sex workers and migrants, to access treatment.⁵⁰ While prevention of mother-to-child transmission of HIV (PMTCT) services has been scaled up in health services across the country, there is low attendance to antenatal care (ANC) services in rural areas and a considerable loss to follow up before and after birth.⁵¹ Drugs and medication supply and quality is reportedly low and limited in hard-to-reach areas, with drugs in remote areas often expired.

The majority of healthcare is provided through private practitioners registered as general practitioners with the Myanmar Medical Association (MMA), which has branches in townships nationwide. The MMA is an NGO founded in 1949, which operates on its own budget generated from its activities and membership fees and is the only professional body of medically qualified doctors in Myanmar/Burma. There are however large numbers of ‘quack’ or unqualified doctors (colloquially known as “Dr. Yaan Gu”), who have only partial knowledge of SRHR issues or medical procedures, but offer spurious medical services and treatments to patients for a fee. Some practices are particularly harmful, such as the reportedly widespread use of intravenous treatments for a variety of illness, which results in risk of unclean needles, contamination, and spread of HIV.

In Eastern Myanmar/Burma, community-based organisations, ethnic health organisations (EHOs), and women's groups are the main SRH service providers. In ethnic areas such as Karen, Karenni, Mon, Kachin, and Shan states, comprehensive SRH care is only available at district level government hospitals. However, most people cannot access these services due to lack of transport and roads, inability to pay for treatment, substandard services, inadequate medical supplies, discrimination, and language barriers. In addition, the government health system does not reach conflict-affected areas or areas controlled by ethnic armed groups in Eastern Myanmar/Burma, where there are no government midwives or government health services operating. Community organisations, including women's, health, and youth organisations based on the Thai-Myanmar/Burma border, provide SRHR programmes in these areas. In addition, there are EHO health department programmes run by ethnic armed groups; health projects run by ethnic political groups; and health programmes run by ethnic CSOs working in the Thai border and Eastern Myanmar/Burma.

All of these organisations work in an extremely challenging environment, with limited funding and resources, to provide mobile and community-based SRHR services. They use a primary healthcare approach, which utilises community-based trained traditional birth attendants, medics, village and community health workers, and health volunteers to provide health services to communities (see section 3.4 below).

2.2.4 Policies and Machinery for Women: Sexual and Reproductive Rights

Since the early nineties, Myanmar/Burma has established national machinery for advancing women's equality.

The Ministry of Social Welfare, Relief and Resettlement (MSWRR) is the line ministry, with its Department of Social Welfare (DSW) as focal point to address gender issues and implementation of CEDAW commitments. The key government departments, committees, and organisations which are government-funded and staffed and sit under the DSW are summarised below.

Myanmar National Committee for Women's Affairs (MNCWA), which was formed in 1996, is the national mechanism and focal organisation for the advancement of women in Myanmar/Burma, and works in line with the Beijing Platform for Action to carry out women's protection and development tasks.

Myanmar Women's Affairs Federation (MWAFF), formed on 20 December 2003, is the key implementation body of CEDAW commitments. MWAFF is responsible for organising at the grassroots level and for the implementation of the National Strategic Plan for Advancement of Women drawn from, but not including, all 12 action areas from the Beijing Platform of Action. MWAFF has undertaken awareness raising to protect women from violence and trafficking in persons, established violence against women subgroups at central and grassroots level, established counselling centres in each township for victims of violence against women, provided GBV training since 2008 for police, judiciary, health and welfare staff, and developed protocols for reporting and follow up of GBV.

Myanmar Maternal and Child Welfare Association: Under the National Health Policy, government-organised NGOs, such as Myanmar Maternal and Child Welfare Association (MMCWA), play a role in health service provision. For national implementation of reproductive health strategies, the Ministry of Health and the Myanmar Women Entrepreneurs' Association (MWEA) oversees the MMCWA. Established in 1991 under the Act (21/90), MMCWA is a voluntary organisation dedicated to promoting the health and wellbeing of mothers and children. MMCWA is funded by the government and "contributes complementary assistance in service provision in healthcare delivery as a leading NGO of Ministry of Health."⁵² It operates under

a hierarchical structure with a central committee (35 members) and executive committee (15 members) at the national level; plus state and regional supervisory councils, supervisory committees at the district level, branches in townships, and association in wards and villages. MMCWA claims to have 14 million volunteer members as of December 2011 from all walks of life with no gender and racial discrimination.

MMCWA runs the national diagnostic centre and maternity clinic called Myittar Sanyay, which provides a maternal health programme, and diagnostic services and treatment referrals for reproductive cancers. They also run 133 maternity homes throughout the country, staffed by trained medical staff who provide antenatal, delivery, and postnatal care, in addition to breastfeeding and birth spacing (family planning) counselling, and immunisation. Eleven Maternity Waiting Homes have also been established to provide a shelter for women with high-risk pregnancies from remote areas.

MMCWA works with MOH staff in projects on HIV prevention using a community-based model to train volunteers for HIV prevention and awareness raising activities. It integrates PMTCT programmes into maternity home services, and promotes HIV awareness in an adolescent reproductive health programme.

The MMCWA has wide geographical coverage, and some note a genuine commitment and eagerness to try and improve women's health. However, in the past, its previous links with the military has caused some ethnic communities and civil society activists to be wary. It is also widely seen as under-resourced with a management style that is very bureaucratic, and as the organisation answers directly to government officials—the Director of Health, the regional medical authority, or local civil administrators—its independent advocacy capacity is limited. In practical service delivery, stakeholders note that the MMCWA needs further improvement in its professional standards and practices, especially in providing information on SRHR including HIV.

The MMCWA is a key stakeholder in the area of SRHR. It was also seen as likely to receive a significant funding boost in 2014 as one of the key implementing organisations in women's health within the National Strategic Plan for the Advancement of Women (NSPAW).

National Strategic Plan for Advancement of Women

2013–2022: The Ministry of Social Welfare, Relief, and Resettlement has launched the National Strategic Plan for Women Advancement 2013–2022. The Plan outlines a

comprehensive approach for the government to improve the situation of women and girls. It identifies 12 priority areas to achieve gender equality, aligned with CEDAW and the Beijing Declaration and its Platform for Action. The plan was developed by the Myanmar National Committee for Women's Affairs, with terms of reference and annual operational plans developed by a management committee. Implementation is expected to be undertaken via government, UN, INGOs, and CSOs partners.

The priority areas laid out in the plan are livelihoods and poverty reduction, education and training, health, violence against women, emergencies, economy, decision-making, institutional mechanisms, human rights, media, environment, and the girl child. It aims to strengthen laws, systems, structures, and practices to promote, protect, and fulfil women and girls right to quality and affordable healthcare, including SRH. The plan emphasises “health” rather than “rights” with a focus on increasing access to “basic health, SRH, HIV and STI treatment care and support, and community-based initiatives with women's organisations.” The plan aims to combat GBV via law reform, training for judiciary and police, awareness-raising, and legal/psychosocial support for survivors of GBV. There is also a section on women's human rights, which aims for the protection promotion and fulfilment of economic, social, cultural, civil, and political rights of women and girls. There is no comprehensive definition of SRHR in the plan, but this may be further articulated in action plan indicators.

The government has no specific policies that promote the rights of sexual or gender minorities. In fact, it actively supports laws that criminalise same-sex behaviours. While sexual rights issues are increasingly being articulated via civil society networks, and in some forums supported by international organisations and UN bodies, there is yet to be any significant development towards protection and promotion of sexual rights for LGBTIQ people in Myanmar/Burma.

2.3 KEY SRHR INDICATORS AND STATUS

While there is a lack of credible and accessible data on many of the common indicators for SRHR in Myanmar/

Burma, the following section provides an overview of the current status against key indicator areas based on available data and feedback from interview participants.

It covers issues of reproductive health and then focuses on SRHR for different population groups.

2.3.1 Reproductive Rights Indicators

Maternal Health

Women's health in Myanmar/Burma is among the worst in the Asia-Pacific region. While it has seen a reduction in maternal mortality rate from 453 in 1990 to 178 in 2015, the number of maternal deaths continues to be as high as 1,700 deaths, with the lifetime risk of maternal deaths for women being one in 260 women.⁵³ The 2014 Census data estimates maternal mortality ratio at 200 per 100,000 live births, above all countries in South East Asia.⁵⁴

More than two-thirds (70%) of the population live in remote areas where 90% of maternal deaths occur. Most women deliver their babies without trained assistance or access to emergency obstetric services with 76% of deliveries taking place at home.⁵⁵ Myanmar/Burma continues to rank second highest among the countries in the Southeast Asia, only behind Laos.⁵⁶ Women in Eastern Myanmar/Burma, especially in conflict-affected areas, face enormous risks having children; one in 12 women are at risk of death as a result of pregnancy or childbirth, a rate three times higher than the national average.⁵⁷ It is common practice nationwide for women to pay for maternal healthcare, accessed mostly via private health providers. Women often use an instalment system to pay midwives for antenatal, delivery, and postnatal care, which can amount to more than 30,000 kyat (USD23). Women living in remote areas and ethnic states sometimes face up to five hours of travel by boat just to access maternal health services. Given the high level of poverty in these areas, many women cannot afford either the travel or healthcare costs, and tend to use traditional medicines and local traditional birth attendants. In rural areas, especially the Delta region, women tend to have large families of eight to ten children, have limited knowledge of and access to contraception, and mothers die

during delivery due to unsafe birthing practices and lack of services. In some areas, there is growing awareness of birth spacing practices due to education and awareness-raising by NGO community-based programmes, but there remains a high level of unmet need in birthing services and pre- and postnatal care.

Data on mortality and morbidity⁵⁸ show that maternal deaths are highest in women aged 45-49 years, followed by young women (15-19 year old), with the leading cause of death as postpartum haemorrhage (31.0%), hypertensive disorders of pregnancy, including eclampsia (16.9%), and abortion-related causes (9.9%). The government estimates that 89% of women received antenatal care coverage at least one visit; but less than half (43%) of women are covered for at least four visits.⁵⁹ In rural areas, there is an extreme shortage of trained midwives with local CSOs estimating government coverage at only one midwife for up to 15 villages that cannot meet the maternal healthcare needs of women in these areas. The availability of skilled birth attendants is far below the level recommended by the WHO: an additional 7,000 additional midwives are needed in the country.⁶⁰

Abortion

Abortion is illegal, except when the pregnancy threatens the life of the mother, and both women and health practitioners can face fines and imprisonment from 3-10 years.⁶¹ The public health service does not provide safe abortion services; effectively the only approach to address unwanted pregnancy is primary prevention by contraception. The national reproductive health (RH) policy does provide for post-abortion care, which is a tertiary prevention for preventing complications and deaths, an intervention that is clearly too late to meet the needs of women. Therefore, in reality, women are forced to turn to abortion as a means of fertility control due to their lack of access to contraception and conservative cultural attitudes that limit women's decision making over their own reproductive health.⁶² Women access abortion primarily through traditional birth attendants (TBAs); however, unsafe conditions and delays in seeking qualified care increases the likelihood of complications.⁶³

Abortion practices vary widely, and women access services according to what they can afford. TBAs offer the cheapest services, often using traditional medicines, but also dangerous practices including use of bicycle spokes, sticks, and herbs inserted in the vagina. Women who can afford to pay more will seek out the services of retired midwives or nurses who run informal private practices and offer women a higher standard of service than untrained TBAs. There is a system of payment for women who can pay off their debt over time. However, this can be difficult for many women who are living in poverty. Many women do not understand about the risks of abortion and have no access to information on safe abortion practices. In some areas, safe abortion is available in private clinics, but many women cannot afford to pay for these services.

Unmarried and young women often cannot access family planning services, which are targeted to married women only, leaving young, single women at greater risk of unwanted pregnancies. A 2007 survey⁶⁴ showed that abortion was most common among younger women (15-19 years old), women living in urban areas, and women who had a university education.

More recent data from SRHR providers in Myanmar/Burma, however, show that young, poor women make up a large part of their clientele accessing SRH services.⁶⁵ Compared to other Southeast Asian countries, the government reports low numbers of teenage births (adolescent birth rates at 17.4 per 100,000 women aged 15-19 years) and the age at marriage is relatively high.⁶⁶

Buddhism teaches that abortion is prohibited and women who are pregnant outside of marriage are stigmatised. Even women who are pregnant due to rape are expected to keep the child to show their strength, morality, and innocence. Abortion is also not permitted in Christianity, and while it is permissible in Islam depending on factors such as time and extenuating circumstances,^{67,68} it is widely regarded as forbidden. Muslim women in Rakhine State live within restrictive policy and legal regimes, which make them vulnerable to coercive family planning practices. In 2011, an estimated 14.3% of women who identify as Rohingya

in northern Rakhine State had undergone at least one abortion and 26% of those had multiple abortions, due to the restriction on childbirth.⁶⁹ Many Muslim women in Rakhine State also face severe gender discrimination under the guise of cultural and Islamic religious norms, which prohibit women (apart from widows) from going outside the house unless accompanied by their fathers, guardians, or husbands. Many women also cannot access healthcare services without permission from their husband or other male family members, and make independent choices regarding their bodies and contraception. This is even more heightened in an environment where there is lack of rule of law and security, and restrictions on movement by the government.

The medical profession is also divided on the issue of abortion. Many older doctors tend to be conservative and adhere to cultural norms, and use medical ethics, such as “do no harm,” to justify an anti-abortion stance. Younger doctors must rely on their own research and exposure to international systems to be able to challenge these attitudes and systems.

Contraception

Many women cannot access family planning services. Contraceptive prevalence in Myanmar/Burma is only 48.7% and unmet need for contraception for married women in 2015 is estimated at 16.3% and that of modern methods is 19.6%. Some 1.53 million married or in-union women aged 15 to 49 want to stop or delay pregnancy but are not using a modern method of contraception.⁷⁰

There are limited choices in family planning services, with injectable birth control methods being the most common for women. An estimated 27.5% of women use injectables, 11.5% use the pill, 3.6% use female sterilisation, and only 2.1% use the IUD.⁷¹ Women bear the burden of responsibility for contraception, with low levels of male condom use (estimated at only 0.4%), on par with male sterilisation and other traditional contraceptive methods.⁷² Antenatal screening for syphilis is not part of routine treatment services.⁷³

There has been a decline in total fertility rate, now fewer than 2% and below replacement level. However, this is not likely to be due to effective contraception, but rather may be related to factors, such as the high levels of migration and the prolonged conflict across many states.⁷⁴

There is a high level of stigma and shame around women using contraception. Often husbands do not want or allow their wives to use contraception or to undergo checks for sexually transmitted infections, so many women do so secretly. Most women have limited knowledge about their bodies, sex education, or contraceptive choices. Condom use is not common as men often refuse to use them, and condoms are widely seen as an indication of 'bad,' immoral or promiscuous women and men. The contraceptive pill and injection is relatively easy for women to buy at public or private health clinics in urban centres, but at the township hospitals there is sometimes limited supply. Sterilisation is strictly controlled by law, and is difficult and expensive to access—women must go through three to four levels of bureaucracy requiring state level permission for each procedure, and costs can amount up to USD250.

Reproductive Cancers

Reproductive cancers are rising in the country. The Globocan 2012 report estimated in 2015 that there are 6,575 women newly diagnosed of breast cancers compared to 5,648 in 2012; 6,137 diagnosed of cervical cancers compared to 5,286 in 2012; and 1,618 diagnosed of ovarian cancers compared to 1,396 in 2012. An estimated 7,996 women are dying of these cancers in 2015 compared to 6,830 in 2012.⁷⁵ The 2014 report by the HPV Information Centre states that cervical cancer is the second most frequent cancer among women, with about an estimated 5,286 women being diagnosed, and 2,998 deaths from cervical cancer every year.⁷⁶

Cervical cancer is largely preventable with effective screening and treatment, either by visual inspection or by cervical cytology, which is not well developed in Myanmar/Burma. Currently, screening is carried out by an INGO (PSI), but is limited to a few townships. However, plans are underway to introduce national screening using visual

inspection in a phased manner. The country is not ready for primary prevention by the administration of the efficacious but costly HPV vaccine.

Breast cancer survival rates can also be greatly reduced through early detection and treatment. However, these services are extremely limited and many patients do not access medical help until the late stage of illness, leading to high numbers of preventable deaths.

HIV and AIDS

While HIV prevalence has been declining, there remains high HIV prevalence for women who are sex workers, people who inject drugs, some migrant women, and pregnant women in border areas. Myanmar/Burma has a concentrated HIV epidemic, with elevated HIV rates for injecting drug users (23.1%) and sex workers (6.3%),⁷⁷ and some pregnant women in Thai-Myanmar/Burma border areas (up to 1.5%).⁷⁸ There was an estimated 70,000 adult women with HIV in 2014, with only 79% of HIV-positive pregnant women receiving WHO-recommended regimen for prevention and parent-to-child transmission.⁷⁹ Most new HIV infections are among women considered 'low risk' (27% of new infections in 2014), which indicates increasing transmission between intimate partners.⁸⁰ Women acquire HIV through their male partners, as there are significant proportions of male STI clients and PWID who are married, and condom use among regular partners is very low. Infection in young key populations is also showing declining trends since 2000, with data for men who have sex with men (MSM) (3.8%), the lowest compared to female sex workers (FSW) (6.2%) and people who inject drugs (PWID) (16.8%).⁸¹ The age limit for independent, voluntary counselling and testing (VCT) is 16 years, and those under 16 years require parental consent. This means that young people who use drugs, MSM, those who are not living with parents, who are homeless, or migrant workers have limited independent access to VCT.

Women can face higher HIV risk due to the social norms and unequal gender roles in the family, which makes it difficult to negotiate condom use and demand that sexual partners use condoms. Women also have high levels of responsibility

for care of children and other family members, including orphaned relatives and those living with HIV and AIDS. Approximately 212,000 people in Myanmar/Burma were living with HIV in 2014, 34% of whom were females.⁸²

There is currently no law prohibiting discrimination on the grounds of HIV status in the workplace or community settings, and the Penal Code Art 269 criminalises negligent or malignant acts which are likely to spread life-threatening infectious diseases.⁸³

Myanmar/Burma has implemented an improved treatment regime for HIV and AIDS using the most recent guidelines from WHO released in 2010, including a clear policy and programme for the prevention of mother-to-child transmission, with support from UN agencies and international donors. Nevertheless, there remain many barriers to access. It is reported that women who are HIV-positive face high levels of discrimination from private health providers who often refuse to provide them with healthcare and refer them to the under-resourced government hospitals or to NGO services. Government hospital staff members often charge women and children who are HIV-positive double the amount than other patients. For reproductive health services, HIV-positive women are reportedly forced to pay an extra fee of up to 45,000 kyat (USD34.67) in some areas. Staff at government and private hospitals reportedly have limited knowledge on HIV transmission and prevention and often misadvise patients. Government staff members commonly have no respect for patient confidentiality, treat women rudely, and blame them for HIV status, especially if they are sex workers. HIV-positive women who are pregnant are often vilified and shamed by doctors and reportedly face forced sterilisation, whereby doctors perform sterilisation at the time of birth often without the permission of women.

2.3.2 Sexual Rights Indicators

Recognition of sexual rights is extremely limited; both the law and judiciary fail to recognise gender equality and there are weak protections for the rights of women, ethnic, religious, or sexual minorities. Women's access to justice is

limited due to their unequal status in society, and there is a lack of protection and redress for violation of human rights for women, ethnic, gender, and sexual minorities.

The following section will cover key issues on sexual rights, including gender-based violence, rights for sexual and gender minorities, rights of young women, and religious and cultural barriers to sexual rights.

Gender-based Violence

Violence against women and girls has been highlighted as a key human rights issue for the past two decades in Myanmar/Burma, both in terms of domestic violence and the high levels of sexual violence, including rape used as a weapon of war against ethnic women in conflict zones. As far back as 2008, the CEDAW Committee expressed concern about domestic violence and sexual violence, including rape in Myanmar/Burma which appears to be “accompanied by a culture of silence and impunity, [and] that cases of violence are thus underreported and that those that are reported are settled out of court.”⁸⁴ The UN Security Council Resolution in August 2013 expressed “concern about remaining human rights violations, including arbitrary arrests and detentions of political activists and human rights defenders, forced displacement, land confiscations, rape and other forms of sexual violence and torture and cruel, inhuman, and degrading treatment.”

Domestic Violence

Domestic violence is widespread in both mainstream and ethnic communities. Myanmar/Burma has no law to combat domestic violence and no mechanisms for restraining orders to protect women from violent spouses, relatives, or boyfriends. While limited official information on the level of domestic violence is available, there are however, standard operational protocols for survivors of domestic violence. At the township level, incidences of domestic violence against women are reported to the Myanmar Women's Affairs Federation (MWAFF), which takes up the case on behalf of the victim after investigation. The MWAFF Domestic Violence Procedures, however, have reportedly not resulted in many convictions, and the majority of cases are resolved by

out-of-court settlement or divorce procedures. Breaches of confidentiality are also common in this system, making women reluctant to come forward due to both safety and privacy concerns.

There are also very limited social support systems or services available to women who have experienced violence. In the last two years, women's civil society groups and activists have been able to utilise public space for domestic violence campaigns and have undertaken successful advocacy with the Ministry of Social Welfare, Relief and Resettlement to draft a law that would criminalise domestic violence, expected to be in accord with CEDAW. This law is currently in the final development phase and the bill is due to be submitted to parliament in 2016. At the current time, there is a government-led process, with UN and CSOs input to develop this comprehensive Anti-Violence against Women (AVAW) law (see section below).

Sexual Violence

Myanmar/Burma has a law against rape in the Penal Code, Section 375, which prohibits rape with punishment up to 10 years imprisonment. However, the law is problematic in many areas. In cases of rape and sexual assault, government hospitals must obtain permission from the local police before they are permitted to examine and treat patients, in order that "evidence is not destroyed." This means that women must report the crime to the police before receiving medical treatment, which can discourage women from seeking help and fails to ensure women's basic right to health treatment. The law also does not have adequate legal protections relating to evidence and prosecution for victims of rape, including basic protections for privacy and legal representation.⁸⁵

In December 2013, civil society activists noted that police data recorded a rise in reported rapes and that rape was the second most commonly reported serious crime, behind murder. A total of 654 rapes of women and children were reported in 2012, and during 2013, up to 85% of rape cases nationwide had been reported in Yangon (Rangoon) Division, the country's most populous city and the commercial capital.⁸⁶ The arrest of rape suspects is often

reported in state-run newspapers, but perpetrators are rarely convicted to jail terms. Cultural attitudes, which are reflected in media reporting, often blame the victims of rape—for their behaviour, clothing, or for being out in public places.

The legal system of Myanmar/Burma does not have effective legal protections for sexual harassment, either in the workplace or in public. The Penal Code (Sections 354 and 509) contains vaguely worded clauses around offending women's morality but provides no clear definition of what this entails. Sexual harassment of women and girls is common in buses and crowded public areas, where women are touched and groped by men. However, women activists have challenged this widespread practice with public whistle blowing campaigns on public transportation.⁸⁷

Rape and sexual assault of women and children, both boys and girls, is reportedly widespread according to CSO activists, but are rarely reported to the police. There are limited legal services or support for rape victims and no child-specific support services. In most cases, the victims and victim's families will settle out-of-court, as they do not have effective representation in the legal system (most just get a government-appointed lawyer), and many cannot afford legal fees and do not want the shame of a public court case.

While accurate data on rape cases are limited, in 2015, almost 60% of rapes reported to police in Yangon (Rangoon) Region in the first half of the year involved a victim under 16 years.⁸⁸ Over the past two years, a Member of Parliament from the opposition National League for Democracy (NLD)—U Thein Nyunt—twice submitted a proposal to introduce the death penalty for sexual abuse of children, citing the growing number of cases.⁸⁹ However, there was limited consultation on this law with women, child rights activists, or CSOs and it did not pass parliament. The AVAW law currently being drafted offers opportunity for law reform for greater protection for women and child rape victims and survivors.

Sexual Violence by the State and Military

Women who are imprisoned, either arbitrarily or as political prisoners, are also vulnerable to gender-based violence, including sexual violence by authorities. Despite the Thein Sein government releasing several rounds of political prisoners, over the past three years, there has been continued use of restrictive laws to imprison activists, journalists, and human rights defenders working for a range of political causes, such as land reform, farmer rights, environmentalists, social media activists, students, and more. As of November 2015, activists have documented 116 political prisoners, including 17 women imprisoned, with 477 people facing trial on charges under laws aimed at restricting political activism in the country.⁹⁰ The government however contests this with official figures indicating that 27 political prisoners remained in prison.⁹¹

The on-going armed conflict and militarisation of border areas and conflict zones in ethnic states has resulted in high levels of violence against ethnic women, perpetrated by the military with no legal redress for victims. Military rape is rarely investigated, and even when investigations do occur, they are undertaken by military tribunals with no process of transparency.

For decades, ethnic women and girls have been subject to widespread and systematic sexual violence by soldiers of the Burmese military, including rape, torture, and sexual slavery as a means of terrorising and subjugating ethnic nationalities. Women and girls are also routinely subject to rape, sexual violence and torture, while being forced by the military to perform compulsory labour, including forced-portering.⁹²

Despite the current ceasefire and peace process in the country over the last three years, ethnic states and border areas remain highly militarised, and human rights and women's groups in Shan, Kachin, Mon, Karen, Karenni, Rakhine, and Chin states continue to document cases of sexual violence perpetrated by the military. The Women's League of Burma released a report in January 2014,⁹³ documenting multiple instances of sexual violence against women over the past three years when the ceasefire

process was being implemented. The report, which involved over 100 women, with seven gang rapes and victims as young as eight years old, showed that a widespread and systematic pattern of sexual violence continues. In January 2014, allegations of the rape of a 13-year-old girl by a Burmese Army soldier have again been reported in Mon State, indicating that there is still no change in military practices and reports of sexual abuse continue in areas where troops are stationed.⁹⁴ In 2015, the Shan Human Rights Foundation documented eight cases of sexual violence since April, including a 32-year-old woman gang-raped by ten soldiers on November 5, three days before national elections.⁹⁵

The UN General Secretary has called on the Thein Sein government to fully investigate and respond to current and historical human rights violations and abuses, including conflict-related crimes of sexual violence. The Special Rapporteur on the Situation of Human Rights in Myanmar also recommended the amendment of constitutional provisions to provide better accountability and civilian oversight over military tribunals.⁹⁶ These crimes have been recognised internationally with more than 30 UN resolutions by the UN General Assembly (UNGA) and UN Human Rights Council (UNHRC) on the situation of human rights in Myanmar/Burma, including sexual violence, and reports submitted by the UN Special Rapporteur on the Situation of Human Rights in Myanmar and reports by the UN Special Rapporteur on Violence against Women.⁹⁷ Despite this situation, there is currently no option for legal redress through government or national courts, and the government continues to ignore calls for justice. Moreover, there is a constitutional guarantee to protect all military personnel and leaders with a blanket amnesty from accountability for war crimes, including sexual violence against women in ethnic states.⁹⁸

Ethnic and border-based women's groups have pursued a strong international advocacy agenda to document, expose, and highlight the ongoing sexual violence against women in conflict areas. The current AVAW law reform process occurring at the national level should in principle offer some legal solutions and protections for women in these situations. However, there is concern that the law may not

include strong enough protections for women, especially its capacity to provide adequate protection and redress for GBV in armed conflict situations. It appears that it will not be able to include adequate mechanisms to cover state obligation to pursue and prosecute perpetrators of war crimes, including against state and military actors, due to the limits in the 2008 Constitution. Advocacy by CSO and opposition political parties called for changes to the Constitution in 2014. However, any constitutional changes must be approved by more than 75% majority vote in the parliament where the military holds a 25% representation, followed by a national referendum.

Eastern Myanmar/Burma: Internally Displaced Persons, Refugees, and Conflict-Affected Communities

Women in Eastern Myanmar/Burma's ethnic states face extreme barriers to access sexual and reproductive health services, due to their remote location, lack of infrastructure and healthcare services, language barriers, costs, discrimination against ethnic women, high levels of corruption, and under-resourcing of government hospitals and clinics.

Many communities therefore rely on traditional birth attendants (TBAs) for maternal healthcare. However, these women are often untrained, use unsafe birthing practices and unsterile equipment, and lack knowledge of basic hygiene. While increasingly TBAs have been able to access training and support from border-based and ethnic health actors,⁹⁹ there is a severe lack of safe delivery equipment, with only limited number of safe birth or hygiene kits provided by donor-funded programmes. In some areas, such as Shan state, traditional healers are used for maternal health and delivery even though they have no training in this. These factors lead to extremely high rates of maternal mortality, where with one in 12 women are at risk of death from pregnancy or childbirth.

Cultural and community beliefs often discourage contraception and prohibit abortion. In ethnic communities facing conflict, military and community leaders often discourage any form of birth control, and instead promote childbirth and population increase to support ethnic culture

and autonomy and future military recruitment. Similarly, young people are discouraged from using contraception and there is limited opportunity for SRH education in community schools or institutions. In this environment, unwanted pregnancy and unsafe abortion is common, and traders in border areas sell imported, outdated, unsafe abortifacient or contraceptive medicine, which result in unwanted pregnancies and, often, maternal death.

Internally Displaced People and Communities

Over the past three years, despite the national state-led ceasefire process, there has been continued armed conflict in northern Shan State and Kachin State, displacing hundreds of thousands of people. The UN estimates that there are 230,000 internally displaced people (IDP) in ethnic states and border zones of Eastern Myanmar/Burma.¹⁰⁰ In areas controlled by the Kachin Independence Organisation (KIO), there are recorded data on 67 IDP camps with at least 78,000 people.¹⁰¹ Reasons for displacement include armed conflict between ethnic armies and the Burmese army, and land confiscation due to development projects undertaken by civil, military, state, ethnic groups, and private investors.

Women and girls living in internally displaced communities face grave threats to their sexual and reproductive rights. They live under constant threat of armed and community conflict and instability. Gendered division of labour see women and girls as the primary caregivers and in these circumstances, they often struggle to ensure personal and family survival, are vulnerable to gender-based violence, and have limited access to SRH services.

Basic hygiene is a big challenge in IDP camps due to the location and insecurity of camps, with lack of access to clean water in many areas. STI and TB are widespread in some camps; there is limited access to contraception and RH services, and a huge need for awareness-raising on contraception and STI prevention.

HIV prevention and treatment in mobile and conflict-affected IDP communities are difficult with limited diagnosis services and limited access to antiretroviral (ARV) treatment for people who do test positive. People do not

have information about family planning in remote areas and access to contraception is extremely limited (provided only in some camp areas or by mobile health teams). Even in camps, however, the lack of privacy and high levels of stigma prevent women, men and young people from using contraception.

Most women in IDP camps or other areas in Eastern Myanmar/Burma have no access to government hospitals, clinics, or midwives, and either give birth at home or make the journey across borders to China or Thailand to access healthcare at border clinics. Lack of official referral processes and identity documents mean that those entering China and Thailand are vulnerable to arrest and extortion by authorities. In addition, health treatment, especially in the China border, is often expensive and for both Thailand and China-based health services, language barriers can mean that patients often do not understand the treatment, costs, or diagnoses.

There is limited infrastructure, roads, and transport in Eastern Myanmar/Burma, which means women often die from birth complications on the journey to seek maternal healthcare. Most women rely on TBAs, many of whom are untrained and do not have clinical supplies.

In some areas, the conflict has reduced over the past few years and this has seen increased access for mobile health teams and ethnic health organisations to reach displaced communities. However, in Shan, Kachin, and Karen states, there remain areas of conflict or “black zones,” where conflict continues to prevent health workers’ access to villages and prevents people from leaving the village if they need emergency healthcare.

Refugee Camps

There are ten refugee camps for displaced people from Myanmar/Burma based along the border of Thailand and Myanmar/Burma, with a total population of 106,787 in October 2015.¹⁰² Despite donor support, SRHR services in camps are often inadequate and the situational and cultural issues resulting from closed camp communities can amplify risks and problems for women and girls. In some camps,

there are high numbers of underage pregnancies and marriage of teenage girls. This is caused by the lack of SRHR curriculum in the camps’ education system, limited supplies of contraception, a lack of privacy in accessing SRHR services, and high levels of stigma preventing young people from accessing contraception.

Limited maternal health services in Thai-based refugee camps mean that women with birth complications must be transferred to Thai health clinics, sometimes up to four hours away. The limited transport options and camp curfews discourage women from leaving early enough to get medical help, which greatly increases risk of serious complications or death on the way to hospital. In some border area camps, Shan women must travel to Thai hospitals to give birth in order to ensure that their children have birth registration documents.

In some refugee camps, there are high levels of sexual violence and women often do not feel secure. In Shan camps on the Thai side of the border, rape is not commonly reported but domestic violence is a problem for many women in the community. For Karen refugee border camps, there has been a documented increase in sexual violence against women and girls in these camps over the recent years. INGOs have provided legal support for women to seek justice via an internal refugee camp justice system or to prosecute perpetrators through the Thai legal system. However, many women do not feel secure enough in the camp to pursue these options.

Moreover a recent study¹⁰³ has highlighted the complete failure of these justice systems for women who do report GBV with over 80% of reported cases in Karen refugee camps ending in inadequate outcomes for victims of violence. The study examined 289 cases of Sexual and Gender-Based Violence (SGBV) against women in Mae Ra Ma Luang, Mae La Oon, Mae La, Umpiem Mai, Noh Poe, Ban Don Yang and Htam Hin refugee camps from 2011 to 2013 to determine the factors contributing to official reporting of crimes, as well as the justice system’s response to such crimes. The largest number of SGBV cases in the seven camps was cases of physical violence; among those, 92% were domestic violence cases. In addition 60 cases of

sexual violence were analysed. The study found that in most cases of reported SGBV, the justice outcome did not protect the woman from further violence and did not attempt to support behaviour change in the male perpetrator. These weak justice systems have in fact failed to protect women and girls from further violence and allowed perpetrators impunity.

Western Myanmar/Burma: IDPs, Refugees, and Conflict-Affected Communities

In Western Myanmar/Burma, women have also been severely impacted by conflict in both Chin and Rakhine states.

In Chin State, the poorest state of Myanmar/Burma, women have been victims of armed conflict and religious persecution. Despite a ceasefire agreement signed in 2012 by the ethnic armed group in Chin State, human rights groups have documented extra-judicial killings and sexual violence in 2012. There has also been armed conflict between the Burmese and Arakan armies in 2015 causing 350 people now internally displaced in Southern Chin state.¹⁰⁴ On-going, institutionalised, religious persecution has also been documented. This includes widespread discrimination against Chin Christian communities in terms of restricted access to places of worship, and discrimination within government-supported educational institutions. Coercion from local government officials, Buddhist monks, and state-run institutions for Chin Christians to renounce their religion and convert to Buddhism has also occurred, often with serious threats to individuals and communities who do not comply.¹⁰⁵

This on-going religious discrimination and conflict has forced the predominantly Christian ethnic Chin communities to flee across the border to Mizoram in Northeast India, and to the capital New Delhi. Myanmar/Burma's refugee organisations have documented more than 200 violent attacks over the past three years on Chin refugees in New Delhi, over half of those being sexual assaults against Chin women and children.¹⁰⁶ There are inadequate protections or redress mechanism for these crimes, with limited services for refugees, or survivors of sexual and gender-based

violence, as the Indian government is not a party to the UN Refugee Convention.

In Rakhine State, women have been affected by the long history of communal conflict between the majority Rakhine Buddhist population and Muslim communities, which has resulted in barriers to reproductive healthcare and a dire humanitarian situation in the state. In some areas of Rakhine State, local level discriminatory government policies and procedures have also had severe impact on the rights of women.

Women and girls who are from Muslim communities in northern Rakhine State face severe and crosscutting discrimination based on gender, race and religion, which impact severely on their human rights, including SRHR. The communal violence between Buddhist and Muslims in some areas has also been sparked by incidents of gender-based violence, reports, rumours or allegations of the sexual assault and/or murder of Buddhist women by Muslim men. This has resulted in widespread displacement, death, and injury of men, women and children, with the majority of victims being Muslim. A respondent also noted that internally displaced women and other Rohingya women are reportedly facing a lot of discrimination from medical staff in hospitals in Sittwe and other locations after the conflict in 2012.

The UN estimates that in Rakhine State, 416,600 people are affected by conflict or inter-communal violence, including 140,000 people in Rakhine state IDP camps, as well as others with restricted freedom of movement.¹⁰⁷ As of September 2015, more than 98,000 people were living in 21 IDP sites in Sittwe township (Rakhine state) alone. Women in camps and displaced communities in Rakhine do not have adequate access to SRH services with limited UN and INGO operations in the area, providing basic healthcare, but no specialist medical care, limited SRHR education, and limited access to contraception. Access by INGO to communities across the broader Rakhine State is restricted by local government authorities and regulations due to widespread public mistrust by the majority Buddhist population. Protests against international aid agencies in 2014 for alleged cultural and religious insensitivity and bias towards

the Muslim community led to the shutdown of INGO operations in the area, the evacuation of 170 aid workers, and left most of the 140,000 IDPs and over 700,000 vulnerable people outside camps with limited humanitarian support, including healthcare access.¹⁰⁸

Rakhine State has become highly militarised since the sectarian violence began, with state security forces, military, and police personnel living close to villages and communities. In many communities, men are often absent from households due to fear of being harassed, arrested, or forced into labour by the military. In addition, state police forces have been criticised for failing to protect people in conflict situations, and in some cases being accused of perpetrating violence themselves. The Nasaka, a state-sponsored security force in Rakhine, have been accused of widespread rape and sexual assault of Muslim women and girls, and were disbanded in July 2013 to be replaced by state police and immigration officers.¹⁰⁹ Freedom of movement for women in Rakhine state is also impacted by government restrictions and a lack of security and rule of law, which again impacts negatively on access to health care.

Given these dire conditions, countless people have fled Rakhine State in the last two years, either by sea or overland, to neighboring countries such as Bangladesh and Thailand. The UNHCR estimates that in the first six months of 2015, 31,000 people left the Bay of Bengal on irregular journeys by boat.¹¹⁰ In May 2015, a regional trafficking network was uncovered in Southern Thailand, with trafficking camps and mass graves found along the Thai-Malaysia border—a key destination for Muslims from Rakhine State and Bangladesh who are fleeing persecution and poverty. Investigations by Amnesty International revealed a practice whereby people from Myanmar/Burma and Bangladesh had been trafficked and held captive and abused until their families could pay a ransom for their release, with many dying of starvation, disease, or beatings while waiting for their relatives to pay.¹¹¹ The ASEAN, hampered by its policy of non-interference in a member country's affairs, has faced wide criticism for its delayed and inadequate response with regards the Rohingya refugee

crises.^{112,113} Migration between countries is a highly political issue amongst ASEAN members.

Citizenship Rights

The classification of ethnicity within the country is a highly contested issue that is directly linked to citizenship and ethnic rights and autonomy. The Citizenship Law (1982) proclaims ethnic groups of the Kachin, Karenni, Karen, Chin, Burman, Mon, Rakhine, or Shan to be Burmese citizens, and mandates the Council of State with the power to decide whether any ethnic group is national or not.¹¹⁴ The government also uses a controversial classification system, developed under the previous military regime of recognising “135 national races,” which was developed by the previous military regime and based on government data that is more than 25 years old.¹¹⁵

The citizenship for Muslim communities that identify as Rohingya is a highly sensitive and contested issue. The Thein Sein Union level government and the Rakhine state government do not recognise the Rohingya as an ethnic group of Myanmar/Burma, and consider them to be “Bengali” migrants from Bangladesh, and as such are only entitled to limited rights as temporary migrants and non-citizens.¹¹⁶ The National League for Democracy (NLD) is silent on this issue. Rohingya groups, advocates, and human rights activists, however, claim that the Rohingya have lived in Myanmar/Burma for centuries and are a distinct ethnic group of the country, and as such are entitled to citizenship.^{117,118} This has left an estimated 810,000 men, women, and children stateless and living in IDP camps in northern Myanmar/Burma with limited human rights protections.¹¹⁹

In March 2014, the government, with support from UNFPA, conducted the first nationwide population census since 1983. The census was contested by some ethnic groups and stateless minorities who voiced concern about the potential for the census to further endorse exclusion from citizenship and restrict ethnic autonomy for some population groups. The issue of citizenship for communities who identify as Rohingya was particularly contentious. Despite the

Rohingyas being included in previous censuses, and despite initial government assurances that all respondents would have the option to self-identify their ethnicity, people were prohibited by the government from self-identifying as Rohingya during the census implementation.¹²⁰ In addition, some ethnic armed groups boycotted the census and did not allow census administrators in conflict-affected and contested areas. The census data and report was published in May 2015.¹²¹

In addition to women who are stateless, many women in rural areas have limited access to or cannot afford to acquire citizenship documents, such as identity cards or passports. Women who are in conflict zones, refugee camps, or those who are internally displaced also have limited access to a national registration card (identity card) or citizenship documentation, either because it has never been granted to begin with, or because they have lost documents in the process of fleeing conflict. Those without citizenship can be excluded from certain rights within the Constitution, including healthcare and a lack of a national registration card can exclude women and children from accessing formal health services. This is a major issue for millions of women from Myanmar/Burma who live as undocumented migrants in neighbouring Thailand. They face limited health service access, and exploitation in informal sector industries, such as agriculture, sex work, and domestic work, where there are no labour rights protections. It also creates barriers to healthcare access for sex workers, and women who migrate from rural to urban areas within Myanmar/Burma.¹²² Women who do not have identity documents cannot register their children's births, either in Myanmar/Burma or Thailand, which may affect their children's access to health, education and other vital services. For Muslim Rohingya women, the lack of citizenship affects both themselves and their children. The prohibition against having more than two children (imposed on Muslims in Northern Rakhine State)¹²³ means that registration of third and subsequent births is difficult if not impossible, and results in increased levels of statelessness for the community.

Discriminatory Population Control Law and Policy

On February 2015, the Union level government approved a new law that also promotes potentially coercive population control practices for designated population groups in Myanmar/Burma. The new Population Control Law allows for the government in any designated region found to have a high birth rate, to activate and deliver health and population control measures, including potentially requiring 36-month birth spacing between two pregnancies. This essentially allows the government to enforce family planning measures on designated population groups. The law has been criticised by women's activists in Myanmar/Burma and the international community as an illegitimate interference by the State in the right of a woman to determine the number and spacing of her children, as stipulated in the Convention on the Elimination of All Forms of Discrimination Against Women, to which Myanmar/Burma is a party.¹²⁴

Marriage Rights

Marriage laws in Myanmar/Burma differ according to religious norms and practices, many of which discriminate against women. Currently, a plethora of laws and customary practices exist to control women's sexual rights, including age of marriage, divorce, and inheritance. The age of marriage is set at 18 for Buddhist women; however, customary law allows for marriage at 15 years, and the current Penal Code appears to condone marriage for girls at 12 years old.¹²⁵ Various laws also restrict a women's ability to divorce her husband, to access property rights in divorces, and to marry foreigners. Hindu women cannot divorce their husband. Muslim women are governed by separate legislation and customary law, have unequal divorce rights compared to the husband, and are subject to polygamy, which is legal and practiced in some communities.

The 2008 CEDAW Committee's Concluding Observations¹²⁶ states that discriminatory customary practices persist in Myanmar/Burma, especially in ethnic communities, with regard to marriage and its dissolution, as well as family relations, including inheritance. The Committee expressed

concern about the persistence of bigamy and polygamy in Myanmar/Burma's laws, and recommended revising the laws to eliminate these practices.

In 2015, a series of new laws—the Protection of Race and Religion Laws—were approved by parliament. The laws were initiated by a fundamentalist radical Buddhist monk-led movement and approved by the Supreme Council of Monks. They were strongly promoted by the nationalist Buddhist 969 movement who in 2014, called for a boycott of Muslim-owned businesses, and claimed that Buddhism was under threat from Islam. The monk-led Organisation for the Protection of Race, Religion, and Belief (Ma Ba Tha) submitted a petition of four million signatures to parliament and campaigned nationwide to build public support for the laws, which were passed in 2015. Moreover, the issue of race and religion was highly politicised throughout the 2015 election campaign. The Ma Ba Tha movement and various political parties and candidates promoted the laws as a key strategy in protecting Buddhist religion and culture, while vilifying Muslims which were excluded from running for parliament. A summary of the laws as outlined by FIDH¹²⁷ is provided below:

The Religious Conversion Law requires anyone wishing to convert to another religion to file an application to a state-governed body. Anyone found guilty of violating provisions of the law could face six months to two years in prison.

The Monogamy Law criminalises extra-marital relations for a man or woman who remarries or lives “unofficially” with another person before an existing union is dissolved. Punishments include a seven-year prison sentence and a fine under Article 494 of the Criminal Code.

The Interfaith Marriage Law requires Buddhist women and men of other faiths who wish to marry to apply for permission from local authorities. Violators of the law could face prison terms and/or fines.

The Population Control Healthcare Law allows the government to designate areas, based on socio-

economic indicators, in which they can impose restrictions on “birth spacing” for women, requiring a 36-month interval between pregnancies. Designation criteria, enforcement, and punishment for those who violate the law have not been specified.

These laws have been widely criticised by local, regional, and international human rights activists and the UN Special Rapporteur^{128,129} as being restrictive, discriminatory, and divisive. At the national level, representatives of Central Myanmar/Burma women's groups, the Gender Equality Network (GEN) and Women's Organisations Network (WON), have advocated against the laws in public forums and by lobbying Members of Parliament and government officials, with some activists receiving death threats and ongoing harassment due to their opposition against the laws.

The law in Myanmar/Burma does not allow same-sex marriage. In 2013, a man and a transgender woman in Moulmein, Mon State held a marriage ceremony according to a report in newspapers, but the act drew harsh criticism and threats in the local community and from authorities.¹³⁰

Rights for Women with Disabilities

There are an estimated 1.3 million persons living with disability in Myanmar/Burma, the majority being visually impaired persons and mine victims. The socioeconomic status of people living with disabilities is considerably lower than the national average, with only 15% reporting any current livelihood, and less than 10% attending high school or having access to healthcare.¹³¹ People living with disability also have limited opportunities to participate in community life and activities, and are excluded from the benefits of programmes which could improve their quality of life.

Women with disabilities face severe challenges with a lack of access to SRHR services, and are vulnerable to violence including sexual violence.¹³² Currently, activists are calling for a comprehensive rights framework for women with disabilities, and are advocating for improved protection from violence for women with disabilities. Activists have

been advocating for a law to promote and protect the rights of people with disabilities, which was enacted in Myanmar/Burma in June 2015. The drafting of by-laws is now in progress, led by the Ministry of Social Welfare, Relief and Resettlement, in collaboration with organisations for people with disabilities and related institutes.¹³³

Rights for Sexual and Gender Minorities

Myanmar/Burma has a highly prohibitive legal and social environment for sexual and gender minorities. Same-sex sexual relations (both male to male, and female to female) are illegal and criminalised within Section 377 of the Penal Code with punishment up to ten years in prison.¹³⁴ LGBTIQ people are regularly victimised by authorities, or discriminated against by public officials, including the police. Sexual minorities often suffer violence and harassment by police. The Yangon (Rangoon)-based LGBT Rights Network, an alliance of 19 CSOs, is advocating for the removal of articles in the Penal Code that discriminate against LGBTIQ and criminalise same sex behaviours.

Transgender people face the most extreme levels of discrimination out of all gender identities, which impacts on their health status. Doctors often refuse to treat, or sometimes even touch transgender patients. They often abuse them, withhold subscribing medicine, and fail to give appropriate information and medical advice. Because of this massive stigma, transgender people tend to self-medicate with poor consequences for their health, and prefer to stay away from health services.

In 2013, 12 gay and transgender people were arrested in the city of Mandalay and subjected to verbal, physical, and sexual abuse by police officials while being detained.¹³⁵ This resulted in a subsequent discussion in the Mandalay Regional Parliament in 2015, where parliamentarians advocated for 'education' and punishment of transgender people as a priority response. The LGBT Rights Network strongly condemned these actions toward members of the LGBT community. In a more positive move, Daw Aung San Suu Kyi called for the decriminalisation of homosexuality in Myanmar/Burma while speaking at the International Congress on AIDS in Asia and the Pacific in November 2013.

Rights for Young People

Deeply rooted cultural norms, in both mainstream and ethnic communities, promote a conservative and discriminatory attitude toward women and girls, placing them in a submissive and secondary position to men and boys.¹³⁶

Conservative attitudes towards sexuality within the society see premarital sex as social deviance, and there is a reluctance to endorse sexuality education for girls and boys in school due to a fear of encouraging sexual promiscuity. These social attitudes are reinforced in the Penal Code, which includes a number of clauses aimed at outlawing extramarital sex, with punishment for adultery, for "outraging a woman's modesty," and men who deceive women into extramarital sex, with sentences up to 10 years in prison.¹³⁷

While there is no specific law regarding the legal age of consent, the provisions in the Penal Code statute against rape sets the age of consent for consensual sex and marriage for girls at 14 years old, with no age of consent defined for boys. The rape statute is confusing, however, with punishment for marital rape when the wife is 12 or 13 years old set at two years, but if the wife is younger than 12, the act is considered rape and subject to 10 years' sentence.

Young women also have limited knowledge of SRHR, with past surveys showing that young women had limited understanding of links between pregnancy, sex, and contraception.¹³⁸ A 2007 survey¹³⁹ showed gaps in knowledge among young people, with only 37.7% of those surveyed knowing about three methods of HIV prevention and only 47.5% of youth able to correctly reject common misconceptions about HIV prevention. The large numbers of young people that are out of the school system and unemployed also show low knowledge about sex, reproductive health, and STI, and have limited access to information education and services. In a 2008 behavioural survey, conducted among out-of-school youth, 54% of female respondents had never seen a condom and only 30% of female respondents knew where to obtain a condom.¹⁴⁰

Less than half of these young women and men aged 15-24 (47.5%) correctly identified ways of preventing sexual transmission of HIV and rejected major misconceptions about HIV transmission.

As Myanmar/Burma opens up, the role of young people is changing with more freedom, mobility, independence, and for some, increased opportunity for sexual relations. However, young people still have very low knowledge on HIV and there is high level of stigma against condom use. Government family planning services target only married couples, whereas the reality is that many young people are sexually active and not married or in partnership and need access to contraception.

The Ministry of Education's sex education curriculum in schools provides basic health information about sex and HIV prevention for students aged 10-16 as part of the "secondary life skills" (SLS) curriculum. However, the SLS curriculum does not meet standards for comprehensive sexuality education (CSE) and is not widely implemented, as school teachers often refuse or are reluctant to deliver any programme that concerns sex education, due to their lack of capacity in SRHR knowledge and a fear of backlash from parents and communities. It is a widespread belief that if parents, school teachers, or officials talk about sex or condoms, it will promote promiscuity among young people. Some INGOs and CSOs have successfully developed and implemented small-scale adolescent reproductive health programmes, working closely with progressive school leaders and communities. In other areas, local medical practitioners may attend the school to talk about HIV. However, even these programmes are challenged to deliver CSE due to strong, conservative values within communities.

Rights for Sex Workers

Sex workers face numerous violations of their sexual and labour rights due to the criminalisation of prostitution, lack of adequate access to HIV prevention and treatment, and high levels of police violence and harassment against all sex workers (female, male, and transgender sex workers). Sex work is criminalised under the Myanmar Suppression of Prostitution Act, 1949, including sex work in private or

SEX EDUCATION VS. SEXUALITY EDUCATION

Sex education is defined as the "basic education about reproductive processes, puberty and sexual behaviour. Sex education may include other information, for example, about contraception, protection from sexually transmitted infections, and parenthood."

Source: "Sex Education," Glossary, International Planned Parenthood (IPPF), accessed 2 December 2015, <http://www.ippf.org/resources/media-press/glossary/s>.

Comprehensive sexuality education is defined as "education about all matters relating to sexuality and its expression. Comprehensive sexuality education covers the same topics as sex education, but also includes issues such as relationships, attitudes towards sexuality, sexual roles, gender relations and the social pressures to be sexually active, and it provides information about sexual and reproductive health services. It may also include training in communication and decision-making skills."

Source: "Comprehensive Sexuality Education," Glossary, International Planned Parenthood (IPPF), accessed 2 December 2015, <http://www.ippf.org/resources/media-press/glossary/c>.

in brothels, and soliciting with punishment of five years imprisonment. There are also several other laws under which sex workers are frequently arrested. According to Order 1048 (1/2000), condoms are not to be used as evidence to prosecute people under the Act. However, sex workers still report being arrested for possessing condoms and sex work venues such as some KTV and massage parlours do not allow condoms on the premises.

Sex worker organisations have led strong advocacy campaigns for law reform over the past three years, working closely with progressive parliamentarians to amend the law and decriminalise sex work, which has resulted in a number of debates in parliament.¹⁴¹ In 2013, National League for Democracy MP Daw Sandar Min

proposed decriminalising sex work,¹⁴² but her motion was overwhelmingly rejected by the lower house. A more conservative bill was introduced by the Ministry of Home Affairs in July 2015 with the Suppression of Prostitution Act proposing punishment of sex workers and caning of their clients.¹⁴³ The Ministry of Social Welfare, Relief and Resettlement, however, recommended the punishment be changed to a prison term of up to one year with hard labour, and a fine. In November 2015, the law had been sent back to the Bill Committee after an upper house MP objected and argued that the law should be amended to protect, rather than punish, sex workers.

Programmes for female sex workers have expanded over the last few years under HIV prevention initiatives. The targeted prevention programmes operate through drop-in centres and outreach programmes, providing access to information and services including condoms, STI screening, HIV counselling and testing. There are some INGOs that provide reproductive health services for sex workers, including contraception, cervical cancer screening, STI treatment, and VCT. However, many women cannot access these services as they cannot get to the clinics due to lack of transport or do not know about them.

Sex workers are often discriminated against by healthcare staff in private and public health facilities if they seek post abortion care, and are sometimes even refused service by medical staff. This is especially bad in government hospitals where doctors reportedly bully, harass, and yell abuse at sex workers. Private clinics reportedly are a little better because women pay for the service. Sex workers who are pregnant also face high levels of discrimination if medical staff know of their profession, and in some cases they are refused maternal health services due to their work.

Sex workers are highly mobile and this can also cause difficulty in accessing health services, when moving for international work or from rural to urban areas. Lack of appropriate citizenship documents, visa, or work permits can lead to exclusion from health service access both inside and outside the country.

SECTION 3:

KEY SRHR STAKEHOLDERS

3.1 UN ORGANISATIONS

The four main UN agencies working on SRHR in Myanmar/Burma are the United Nations Populations Fund (UNFPA), the United Nations Development Programme (UNDP), the Joint United Nations Programme on HIV/AIDS (UNAIDS), and the United Nations Children's Fund (UNICEF). The United Nations Office for Project Services (UNOPS) and the World Health Organization (WHO) are also key agencies providing technical support for work on SRHR in Myanmar/Burma.

UNFPA has had a presence in the country since 1970, and is the lead UN agency on SRHR. It has established the National Working Committee for Reproductive Health, and provides funding and technical assistance for SRHR activities aligned to ICPD and MDG targets. UNFPA funds SRHR activities in 89 townships and seven states and regions. They work closely with the government MOH and MMCWA, the Myanmar Medical Association (MMA), and INGO service providers, such as Marie Stopes International (MSI) and Population Services International (PSI). UNFPA's priority areas include SHR, maternal health, adolescent health, HIV and AIDS prevention, youth development, humanitarian relief to crisis areas, and gender equality, including GBV.

UNFPA is a member of the National Task Force for Youth Policy, and is working with the government to develop the National Adolescent Strategic Action Plan. UNFPA advocates for gender-sensitive SRH education for young people, and universal, equitable access to comprehensive health services for youth. They currently support the development of Adolescent Reproductive Health services via pilot services in programme areas and training of health personnel using the new national Adolescent Health Standards released in mid-2013. UNFPA has supported over 400,000 youth to access information, education and communication on RH and HIV with their most recent

educational resources on SRHR in the Burmese language released in December 2013.¹⁴⁴ UNFPA has also supported youth centres, youth peer education, and youth information corners/centres (YIC) in the country since 2000, with a focus on HIV prevention and awareness-raising on SRHR for young people.

UNFPA activities on HIV are streamlined under the government National AIDS Plan which target key affected population groups and UNFPA supports one third of current contraceptive needs in the country. UNFPA is implementing pilot programmes for linked HIV and RH services in programme areas, including STI screening within antenatal care services and promoting male involvement in RH and HIV programmes.

UNFPA has conducted fertility and reproductive health surveys in Myanmar/Burma since 2001, including data collection on access to SRHR services and youth SRHR issues. It is currently implementing a research project on girl-child health needs, including for sex education and GBV issues for girls, to be carried out in targeted townships. UNFPA was the leading agency providing technical assistance for the government to implement a nationwide population census in March 2014, and supported a review of Myanmar/Burma's progress towards the ICPD Programme of Action and the MDGs.¹⁴⁵

UNFPA Myanmar's country office, in cooperation with the Asian Forum of Parliamentarians on Population and Development (AFPPD), has been supporting parliamentarians on issues related to population, reproductive health, HIV, and gender. They do this via the Parliamentary Committee on Population and Social Development, formed in 2011, which includes lawmakers from various political parties and ethnic groups. UNFPA has worked with the government in the ICPD national review process, which has included a national forum held

in 2012 with multi-stakeholder input into a standardised questionnaire that measures the results and promises kept against ICPD commitments. Findings of this process were reported by the government to the UN General Assembly in September 2014.

As a member of the Humanitarian Working Group, UNFPA has supported GBV interventions in IDP and refugee camps in Rakhine and Kachin States. It also supports reproductive health services and supplies in three clinics run by the Myanmar Medical Association (MMA) in Rakhine State and community-based service providers in Kachin State to prevent STI, unwanted pregnancies, and HIV.

UNFPA is a member of the UN Gender Theme Group (UNGTG) with a mandate to work across gender issues with different Ministries, and has been involved in the development of the national strategic plan for women. They are also working with other UN agencies in the Enhancing Gender Equality and Women's Empowerment Sector Working Group (GEWESWG), chaired by the Ministry of Social Welfare and the French Embassy, along with CSO representatives from women's networks and INGOs. UNFPA has been a key driver in the Anti-Violence Against Women (AVAW) law reform, the 16 Days Activism campaign, and is planning a nationwide qualitative research study into GBV in 2014. UNFPA also works via the UNGTG on developing a national action plan for UN Security Council Resolution 1325 with the Ministry of Home Affairs, MAAF and CSOs to ensure women's involvement in the peace process.

In terms of SRHR, **UNDP** works primarily on HIV prevention, law reform, and promotion of human rights for sex workers, MSM, transgender, and disabled persons, with advocacy targeting the Attorney General Office, the Ministry of Justice, Parliamentary sub-committees, and CSO members.

UNAIDS works with key population groups affected by HIV and AIDS, including sex workers, MSM, transgender, youth, and mobile populations. They implement HIV prevention and intervention activities streamlined under the government National Aids Plan, and advocate for improved HIV prevention and treatment services with the MOH.

UNICEF supports health programme interventions in conflict-affected communities in Rakhine and Kachin states; works with women, youth, and vulnerable populations on HIV prevention; and is currently working with the government to have a life skills curriculum (including sexual health and HIV education) embedded in the national education law reform and school systems. UNICEF has also supported initiatives to promote interfaith dialogue, and work with religious leaders from Buddhist, Christian, Hindu, and Muslim communities to address child development and protection.

Additionally, **WHO** provides technical support in many areas in reproductive, maternal, newborn, child, and adolescent health (RMNCAH), especially in formulating evidence-based policy, providing standards and guidelines, health system strengthening, and human resource development. WHO does not directly provide services. Since February 2013, WHO is actively engaged with the Ministry of Health in developing and implementing the national roadmap on the recommendations of the Commission on Information and Accountability (COIA). These are under seven thematic areas, and two of these are (i) Maternal Death Surveillance and Response (MDSR), which is an enhancement of the current Maternal Death Review (MDR), and (ii) Advocacy and outreach (for which the target groups are parliamentarians, the media and civil society organisations).¹⁴⁶

Since 2012, **UNOPS** has been involved by being the managing agency for the three MDG Fund (by donors) for three major areas of work—RMNCH, Health System Strengthening, and the three diseases (malaria, TB, and HIV). The Fund is an extension of the Joint Initiative on Maternal, Newborn and Child Health (JI-MNCH), which started in 2010 for the six districts in Ayeryarwaddy Region affected by the Nargis cyclone, and has since then been extended to 42 poor and hard-to-reach townships.

The UN agencies clearly have a strong rights-based mandate and are actively working with government and CSOs on key issues of sexual rights, law reform, GBV, and youth reproductive health. However, they are constrained in

their advocacy due to government restrictions on their role. UN agencies, like other INGOs, are restricted in their access to certain populations, especially in ethnic states and conflict areas, which are where there is often the most urgent need for SRHR services. In addition, the UN and other humanitarian agencies are increasingly impacted by the religious conflict in Burma. The suspension of UN humanitarian operations in March 2014 in Rakhine State that has been mentioned earlier in the report, due to attacks on INGO and UN offices by groups of demonstrators in Sittwe (an area that has seen waves of violence between Buddhists and Muslims), highlights the sensitive environment that UN staff are working in. The issues with the March 2014 Census, where the government backtracked on its agreement with UNFPA to allow people to self-identify as Rohingya in the census count, also demonstrates the limits and challenges for the UN in advocating around sensitive issues.

Regardless of these challenges and limitations however, UN agencies are well placed to work collaboratively with CSOs to forward a national SRHR agenda and are key players in national SRHR advocacy.

3.2 INTERNATIONAL NON-GOVERNMENT ORGANISATIONS

International non-government organisations (INGOs) have expanded their work in Myanmar/Burma since 2008, with some having implemented programmes in the country for much longer. INGOs are key SRHR service providers, especially in remote and rural areas, and provide vital health services to underserved communities. INGOs cover different regions and target groups according to their programme priorities and work through partnerships with local communities, CSOs, and local NGOs in their target communities.

The leading service providers for SRHR working at the national level include Marie Stopes International, Population Services International, Médecine Sans Frontières (MSF), Medicine Du Mon, Malteser International, Burnett Institute, and Alliance Myanmar (International HIV/AIDS Alliance).

INGOs must operate according to the terms and conditions outlined in a Memorandum of Understanding (MOU) with the government. Their capacity for advocacy is often linked to and restricted by the specific terms stipulated in the MOU. INGOs are also constrained in their SRHR advocacy and often are not able or willing to risk their legal status and service provision activities to push controversial or sensitive advocacy agendas in public or with the government.

The shutdown of INGOs in Rakhine State in March 2014 demonstrates the reality of these restrictions and sensitivities in Myanmar/Burma. In March 2014, all INGOs were forced to shut down operations in Rakhine State due to attacks on their offices by local demonstrators. The attacks were sparked by rumours that staff from the INGO Malteser International had removed and mishandled a Buddhist flag from office premises, which was widely interpreted as being insensitive and showing partisan support for the Rohingya Muslim population.¹⁴⁷ This inflamed an already sensitive situation in the divided community and resulted in mass protests and suspension of aid operations in the area. These events demonstrate the precarious position that many INGOs must operate within, and the difficulty for advocacy activities especially around sensitive SRHR and population issues.

Given these serious challenges, INGOs in Myanmar/Burma have used different strategies to promote advocacy via partnerships with CSOs and international stakeholders and the use of research where possible. Activities for research and data collection were initially tightly controlled by the Thein Sein government. Many INGOs have limited capacity for research activities and are restricted to work only on data collection related to their service provision. They have established data collection on service provision and monitoring and evaluation systems that can be useful to inform CSOs advocacy efforts and can provide an important partnership and research-based opportunity. Some organisations have been able to informally share data and statistics with local activists for advocacy purposes on specific issues, which can support more effective, evidence-based advocacy. Other agencies have more recently successfully negotiated research partnerships with

key government agencies, such as the MOH and MMCWA, or external research partners working in ethnic and border regions. These research projects can provide advocacy opportunity via training and capacity for project staff and partners, and in the analysis of outcomes to identify gaps and challenges in SRHR.

INGOs also utilise international human rights frameworks and partnerships with other international stakeholders to promote improvements in SRHR, working with community-based CSOs to forward these agendas.

3.3 CIVIL SOCIETY ORGANISATIONS

Civil society organisations (CSOs), including faith-based, youth, women, ethnic, sex worker, LGBTIQ organisations, have an increasing role in SRHR advocacy and programme implementation in Myanmar/Burma. However, in the challenging political context, CSOs face both constraints and emerging opportunities. CSOs have been active in Myanmar/Burma for decades, despite restrictions in advocacy and operations imposed by the previous military regime. The mix of CSOs now include local level organisations, district and national level groups and networks, and organisations and networks that work in and along Myanmar/Burma border areas, some with offices in neighbouring countries. There are a wide range of interest groups represented by CSOs, including youth, ethnic communities, women, labour, political, and religious organisations, with an estimated 10,000 organisations registered with the General Administration Department under the Ministry of Home Affairs in 2014. This includes over 300 local NGOs registered since the beginning of 2012.¹⁴⁸ Roughly 10% of active groups are implementing programme activities with the support of international or local donors, while most of the remaining groups are charitable groups that rely on local funding.¹⁴⁹

In the last three years, there has been an influx of donor funding from the international community. This has provided opportunity to expand SRHR work, but also threaten to overwhelm smaller CSOs who have yet to build capacity to manage the financial reporting and oversight procedures required by international donors. In addition, the weak

financial infrastructure in Myanmar/Burma, which has only recently moved from a cash-based economy, after the lifting of international sanctions on national banks, means that many CSOs still have limited access to efficient financial infrastructure.

Legally, CSOs cannot open an organisational bank account unless they are a registered organisation. However, the legal framework for CSOs has been highly restrictive in the past. CSOs have been operating under the Law on Associations, enacted in 1988 by the SPDC to control student associations and political parties. This law is exceedingly limiting and applies criminal penalties of up to five years jail time for unregistered organisations. The process of registration in itself was inefficient and expensive. The Act was used by the military junta to punish any group or individual who has connections, support for, or participation with associations deemed illegal by the government, including ethnic groups and political organisations.

However, in March 2014, after a year of activism from CSOs, a more progressive Association Registration Bill began to be considered in Parliament to replace the 1988 law; the bill was subsequently enacted in June 2014. Under the new law, registration will be voluntary and there will be no criminal penalty for unregistered organisations, i.e., smaller organisations do not need to pay a registration fee and can choose not to register at all; and the registration application process can occur at the township-level. The new law will enable many CSOs to register formally under the Act. However, activists have criticised the by-law issued on June 5 by the Ministry of Home Affairs, for including provisions that could potentially be used to restrict NGO registration and activities. These include requiring NGOs that are registering to have a recommendation letter from a government department related to their programme.¹⁵⁰ Moreover, monitoring needs to be done to ensure that local authorities are aware of these changes, and smaller NGOs are not forced to register.

There is increasing competition for funding among CSOs, and an overinvestment in funding support for Yangon (Rangoon)-based urban programmes, compared to projects in rural, remote, and ethnic states. Smaller CSOs must

compete with larger INGOs, or join their programmes as partners. There is also unfair advantage and special privileges for registered GONGO that were set up by, and have close professional or family links with members of the previous military and current government. These organisations have privileged access to resources, including funding and political links, but generally promote highly conservative agendas aligned with government priorities.

Public advocacy and street-based activism has been highly restricted in Myanmar/Burma. Section 505 (b) of the Penal Code and the Peaceful Assembly and Peaceful Procession Law (2011) Article 18, requires activists to register and obtain government permission for any public protest. An estimated 130 activists have been charged under the protest law from 2011-2013, with 57 activists jailed for protesting without permission.¹⁵¹ As of November 2015, activists have documented 116 political prisoners including 17 women imprisoned, with 477 people facing trial on charges under laws aimed at restricting political activism in the country.¹⁵²

In 2014, CSO activists continued to report high levels of government harassment and antagonism from officials at the state, division, and township levels. President Thein Sein met CSO representatives to address some of these issues early in 2014, and a draft bill on amending the Peaceful Assembly and Peaceful Procession Law was discussed in the March Upper House Parliamentary session to consider relaxing restrictions and reducing jail terms in the Act.¹⁵³ The law has been amended on June 24, 2014. However, some civil society groups have expressed concern that the reforms have “introduce[d] greater ambiguity to the legislation and do not bring it into compliance with international human rights law.”^{154,155} Moreover, human rights groups report that arrests of peaceful protesters continue.¹⁵⁶ If genuine change does not happen, this will continue to force civil society to be conservative and risk-averse in advocacy.

3.4 ETHNIC HEALTH AND COMMUNITY-BASED ORGANISATIONS IN EASTERN MYANMAR/BURMA

In Eastern Myanmar/Burma, community-based organisations and ethnic health organisations are the main SRHR service

providers and the leading activists for SRHR advocacy. Community-based organisations include women’s, health, and youth organisations working in the border areas of Thailand and Myanmar/Burma. Ethnic health organisations include health department programmes from ethnic armed groups, health projects run by ethnic political groups, and health programmes run by ethnic CSOs working in the border areas and Eastern Myanmar/Burma.

These organisations have significant experience and expertise in delivery of primary healthcare to conflict-affected communities, including provision of medical care (both curative and preventative), community health education, and maternal and child healthcare. They use a strong participatory and community-based approach; have developed relationships of trust with local communities; and work with local community members for health service delivery (community and village health volunteers, trained traditional birth attendants, and mobile medics). Their combined programmes reach almost 500,000 people and include a health workforce of over 2,650 health assistants, medics, community health workers, maternal and child health workers, trained village health workers, and trained traditional birth attendants. In a 2013 survey of five states in Eastern Myanmar/Burma, 70% of respondents reported that they accessed ethnic-led health services, compared to only 8% that accessed government health services within the last 12 months.¹⁵⁷

Ethnic and community-based health providers rely on external donor funding, and work closely with international health partners to provide health training and outreach to communities in Eastern Myanmar/Burma. They have developed health information systems, disease surveillance and monitoring systems, and have high level of expertise in community-based health service delivery. Despite these skills, they are not recognised officially by the government in Myanmar/Burma, and are forced to work from the Thai side of the border with unofficial mobile teams and clinics based in Myanmar/Burma’s Eastern states.

Organisations working on the Thai-Myanmar/Burma border and in Eastern Myanmar/Burma face unique challenges to their SRHR work and advocacy. The peace process

over the last three years has seen some improvement in the ease of movement for local health organisations, and increased INGO programmes opening in some areas of Eastern Myanmar/Burma. However, there remain conflict areas, ethnic-controlled areas, and IDP communities that INGOs and government health providers cannot access. INGOs need to have government permission and local area permission to work in conflict zones and ethnic-controlled areas. However, the communities in these areas often do not trust either the INGOs or the government officials that they come with, and often will not grant permission for access due to safety and security concerns. This means that border-based groups and ethnic health organisations are the only health providers in these communities.

On June 25, 2014 the Association Registration Law was enacted and came to force on July 14, 2014. This law, which replaced the 1988 Association Act, is aimed at registering the organisations and INGOs. The law calls for voluntary registration of NGOs. Registration bodies at the national, regional, state, district, and township levels, have decision-making powers on the registration of an organisation, and the issue and change of registration certificates.¹⁵⁸ There is no mention of a process for registering Thai-Myanmar/Burma border-based NGOs, and it is not clear if these NGOs can formally register their organisations.

During the military regime, most border-based NGOs, including women's groups, were seen as a "threat to the state" and therefore branded as "illegal organisations." This has meant that they are unable to work legally and openly within their own communities. It is not clear how the new laws apply to these organisations, and if they will be recognised as legal organisation by the new NLD government. In the past, some applications were fast-tracked especially for INGOs with large budgets, while other CSOs found the application process bureaucratic with their applications being stalled by government for no reason. Many organisations remain reluctant to officially register with the government due to the high level of mistrust and the fact that the peace process and political reform is not yet guaranteed in ethnic states. In addition, it appears that the old Associations Law is still being used in some conflict-affected areas, and the people communicating with ethnic

armed groups and ethnic political organisations continue to face harassments, arrests, and detention—despite the fact that these groups are part of the government-led peace-process and ceasefire agreement.^{159,160}

There is concern that the new Registration Law will likely put pressure on organisations working in Eastern Myanmar/Burma to register with the government in order to legally receive donor funds, and many donors are already moving towards this model. Many large international donors have now changed their funding guidelines to exclude non-registered organisations. International donors are tending to move towards funding support for organisations based in Central Myanmar/Burma that are approved and registered with the government, rather than border-based agencies. This has resulted in a significant drop in funding support to border-based and ethnic organisations, which are as yet unable to register in Myanmar/Burma, yet in many areas are the only health providers for conflict affected, ethnic communities in Eastern Myanmar/Burma. It also threatens the sustainability of effective community-based health interventions which have developed over two decades and now have significant capacity to service communities in Eastern Myanmar/Burma, via their skilled health practitioners, health information systems, and community-based programming.

For SRHR, this shift in donor priorities is of major concern for communities in Eastern Myanmar/Burma. For example, one of the largest funders of SRHR, the MDG Fund, now prefers projects that are government-endorsed, that work via registered CSOs, and are often vertical, top-down programmes supporting government health service systems, rather than supporting a primary healthcare approach, which is proven to be vital in remote areas. INGO programmes that do aim to target remote areas and ethnic states often employ urban-based staff; often fail to ensure that local ethnic language is used within their programmes; and most programmes have no links to community-based organisations or individuals. They are also required to operate according to their MOU with the government, require government permission to enter any remote areas, and have limited capacity for rights-based advocacy around SRHR issues.

3.5 MEDIA

Women's empowerment and SRHR issues are generally not well-covered by the Burmese media. The government does not regularly communicate policy-level decisions or plans for health service development to the media. In addition, CSOs also need support to build up their skills to use media effectively for advocacy on SRHR issues.

The media itself tends to reflect conservative cultural attitudes towards sexual rights. Popular media tends to promote conservative perspectives around sexuality and gender, and sex education and discussions of sexuality is still widely considered taboo. Media often report negatively on women, using gender stereotypes. While this is starting to change, the majority of journalists have little experience on reporting on gender issues, and often lack comprehensive understanding of gender and human rights frameworks. Moreover, the media sector has been working under strict government censorship, and there is a need for training and capacity building to ensure media can be an effective partner for advocacy.

Sexual and reproductive health and rights are not widely covered in media as they are not seen as important issues, but rather perceived as an everyday factor of women's lives, and often not important enough for public discussion. SRHR issues are thus mainly featured in newsletters and publications by women's groups and CSOs, alternative blog postings, and by some returning exiled media (mainly Mizzima, and sometimes Irrawaddy and DVB). There has been some recent media coverage of GBV issues on television and in print media, due to proactive advocacy by CSOs in the 16 Days of Activism Against Violence Against Women Campaign, and the government's launch of the NSPAW. The media market however is a competitive business, so media will publish popular news and issues that sell well.

Social media is of growing importance and is now a key forum for young people and urban-based people. Political activism occurs on Facebook, but a pattern of using Facebook for negative attacks and abuse is also increasing. This has resulted in online harassment against women who

are activists for women's rights, and widespread online abuse and hate speech between Buddhist and Rohingya or Muslim supporters.

To support more effective media advocacy, CSOs have identified a need for capacity building for the wider community on how to use social media effectively in a way that does not create further conflict and division, but promotes debate and insight. There is also a need for training and education of the media sector, including development of strong ethics-based reporting. Women's organisations have also identified the need for strategic level training on how to use the media effectively, especially over this reform period, to formulate strategies for SRHR advocacy with government and parliamentarians.

SECTION 4:

SRHR ADVOCACY CAPACITY, CHALLENGES, AND OPPORTUNITIES

This section includes a summary of key challenges and advocacy capacity in 2014 for organisations and networks working on SRHR in Myanmar/Burma. The information is based on feedback from the interviews and assessment visits with 33 organisations and individuals in Myanmar/Burma and border areas (see Appendix 1). A summary of key opportunities, forums, and mechanisms for national level SRHR advocacy in the future, as identified by stakeholders is also included.

4.1 KEY STAKEHOLDERS, CHALLENGES, AND OPPORTUNITIES FOR SRHR ADVOCACY

4.1.1 Youth Organisations

There is no identified CSO that is currently doing coordinated comprehensive national level advocacy for SRHR for youth in Myanmar/Burma. Most organisations tend to focus on their individual SRHR programme areas, including SRH education, HIV and AIDS, and support for young people who are survivors of sexual abuse and rape. There has been some successful advocacy by youth organisations, who have worked at the local level with education authorities and community or religious leaders to support the implementation of SRH education programmes in some schools and communities.

Youth organisations have had limited research capacity for extensive national or local-level research activities. Some organisations have developed links with research-based INGOs to conduct joint SRHR projects, which may develop their capacity for research work in the future.

Abortion and contraception are sensitive issues culturally, especially for young women, making these challenging areas for advocacy. Many youth organisations do not yet have a clearly established rights-based advocacy position around issues such as young people and CSE, abortion,

sex work, and LGBTIQ. Some youth organisations are also members of national women's networks providing opportunity for collaborative advocacy on SRHR issues for women and girls.

4.1.2 Women's Organisations

Women's organisations have been strongly involved in the CSO movement at the national and local levels. Many women who are leading human rights activists have founded and now manage their own organisations in Myanmar/Burma and in the Thai-Myanmar/Burma border areas. Most national/Central Myanmar/Burma-based women's organisations advocacy work focus on the right to political participation and women's leadership. This is in response to the opening of the political space, the possibility of constitutional reform, and the national elections in 2015.

For SRHR issues, there exists strong, coordinated, and successful advocacy around gender-based violence, with advocacy led primarily by the Gender Equality Network (GEN) in partnership with the Women's Organisation Network (WON). This has led to high-level collaborative work and relationship building with the Ministry of Social Welfare and Development, the launch of the national women's development plan NSPAW (noted above), and the development of strong advocacy partnerships between UN, INGO and CSOs on the issue of GBV. Individual women's organisations have developed advocacy links with some progressive Members of Parliament and some government officials, mainly via donor-funded political participation and women's leadership projects.

However, women's health, especially their SRH, is not a priority advocacy issue, even though many organisations have identified it as a key priority for women nationwide. Women's organisations have not yet been able to do

any comprehensive research on SRHR, though some organisations have funding and programme links with leading INGOs who provide SRHR programmes. Many organisations do not yet have a clearly established rights-based advocacy position around issues, such as young people and CSE, abortion, sex work, and LGBTIQ. Some individual organisations work at the programme level with government-owned NGOs (MWAF and MMCAW) and have developed strategic national level advocacy on SRHR with the Ministry of Health and the Ministry of Social Welfare in the future.

4.1.3 Religious Organisations

Most women's and civil society organisations in Myanmar/Burma operate primarily from within a Buddhist cultural and religious background. However, other faith-based organisations, including Muslim, Christian, and Hindu organisations are active members of the national/Central Myanmar/Burma women's networks, and are working to challenge religious fundamentalism.

WON has effectively mobilised member organisations, both faith- and non-faith based, through a public campaign and individual level engagements with religious leaders, against the discriminatory marriage bill proposed by the fundamentalist Buddhist groups. GEN, another national network, has recently published research into cultural and social practices, which may provide the basis for future advocacy around SRHR and religious fundamentalism. The study did not cover a thorough review of individual faith-based organisations. However, some possible barriers to SRHR advocacy in terms of religious groups were identified, especially for contentious issues such as abortion, contraception, sex work, and LGBTIQ.

4.1.4 Ethnic Women's Organisations

There is a large number of ethnic women's organisations in Myanmar/Burma, but ethnic women's representation is not yet comprehensive in national women's networks, like GEN and WON. It is worth noting, however, that one of the leading ethnic women's organisations nationally, the Karen Women's Empowerment Group (KWE), chaired WON

for two years and is active in national advocacy for legal reforms around AVAW and the NSPAW.

Ethnic women's organisations based outside of Yangon (Rangoon) tend to focus on state or regional level advocacy, implementation of SRHR services, and are linked to regional level peace processes calling for protection of women in armed conflict and in IDP areas.

Ethnic women's organisations that are members of the Women's League of Burma (WLB) and based in Myanmar/Burma's border areas, such as the Kachin Women's Association Thailand (KWAT), Karen Women's Organisation (KWO), and Shan Women's Action Network (SWAN), have conducted their own research and documentation of sexual and GBV by the military, and effectively use media for regional and international level advocacy. Five WLB members are working extensively on SRHR programmes and advocacy in Eastern Myanmar/Burma, but are not yet able to operate legally or openly in their respective ethnic areas inside the country. Border-based and ethnic women's groups, however, continue to effectively implement SRHR advocacy programmes in conflict-affected and remote areas. They also work closely with ethnic political leaders and community leaders in their respective states in Eastern Myanmar/Burma on SRHR of the women in their communities.

4.1.5 Border-Based Health Organisations

Border-based groups working on SRHR for migrant, refugee, and IDP communities have high-level advocacy skills and experience. In the Thai-Myanmar/Burma border, ethnic women's groups, ethnic health, and community-based service providers have collaborated for nearly 20 years on research, monitoring, and data collection and advocacy campaigns to highlight the urgent SRHR issues in Eastern Myanmar/Burma.

One of the key advocacy groups for health issues (including SRHR) is the Health Convergence Core Group (HCCG). Membership of the HCCG includes Chin, Karen, Karenni, Mon, and Shan ethnic health organisations, as well as community-based health organisations such as the Back Pack Health Worker Team (BPHWT), Mae Tao Clinic (MTC),

the National Health and Education Committee (NHEC), and the Burma Medical Association (BMA).

Formed in May 2012, the HCCG regularly holds coordination meetings, and has organised multi-stakeholder convergence seminars with participation from Central Myanmar/Burma-based health implementers, ethnic area-based health groups, and INGOs; one of these seminars highlighted maternal and child healthcare. In April 2014, HCCG members co-hosted the Health System Development Seminar, and its more than 95 participants included state level health authorities, as well as representatives from the NLD health network, Myanmar Medical Association, and the Myanmar Health Assistant Association. At this seminar, participants discussed the importance of a decentralised healthcare system that devolves political, financial, and administrative decision-making processes to the state and local levels. It also highlighted the need to support, strengthen, and expand existing healthcare structures in ethnic areas to ensure sustainable healthcare delivery, in particular for vulnerable community members like pregnant mothers and children.

The HCCG has developed models describing the possible convergence process at health programme, system, policy, and structural levels, and provides a forum for discussion and sharing of related health information. The HCCG's main purpose, in addition to creating a safe space for dialogue between relevant stakeholders, is to provide guidance for its members and associated networks on convergence preparatory steps and to explore policy options for achieving the convergence of ethnic, community-based, state, and government health systems through political dialogue. This is aimed at primarily the health programme level, where coordination of activities for health workforce members, such as community-based auxiliary midwives has begun.

Challenges remain in moving towards policy level convergence, as this is dependent on a negotiated political settlement between government and ethnic organisations, including explicit agreement on a health policy that incorporates primary healthcare principles, especially community participation and ownership.

4.1.6 Networks

The study identified a number of national level networks in Myanmar/Burma that currently focus in some way on SRHR issues, including three national women's networks, one sex worker network, and one LGBT Rights network, plus a number of HIV prevention networks. It also identified two border-based youth networks that work on SRHR.

Networks can offer substantive and wide-ranging representation; can forward broad and participatory advocacy agendas; and have an increasingly effective voice with donors and government. There are many effective CSO networks working at the local, national, and international levels. Some networks' strength lie in their access to international and regional level advocacy partners, strong leadership, funding support, and English language fluency. Other networks have strengths in their knowledge and experience in working at the local and national levels, navigating the challenging domestic political environment, and having established strong links with local communities and leaders.

Some key challenges that were identified for national civil society networks include engaging with many vibrant, emerging, and sometimes overlapping networks of CSOs, sometimes having multiple representations for key groups. The issue of national representation can also be further exacerbated by donor priorities and the promise of donor funding, which sees donors supporting one network over another. This can lead to competition between networks for both funding support and legitimacy to claim national representation. Another challenge is that most CSO leaders and activists are overstretched at the moment due to the pressure to respond and participate in such a large number of network activities and multiple advocacy agendas that are highly important (e.g., constitutional reform, GBV, law reform for sex workers and MSM, and ethnic peace process, among other issues). There is also an identified need to support network development via training and capacity building in developing advocacy strategies and leadership, funding/financial planning strategies for networks and CSOs, and organisational development support.

The section below provides a summary of the different networks that are working on SRHR, and aims to provide an overview and mapping of key leading networks for SRHR advocacy.

Gender Equality Network (GEN) started as an inter-agency coordination mechanism in response to Cyclone Nargis in 2008, and has developed into a strong advocacy network with a six-person coordination unit, international donor support, and has access to high-level skills and networks for policy level advocacy. GEN currently includes more than 100 members: women's organisations, CSOs, NGOs, INGOs, UN representatives, and technical resource persons. Representation includes organisations working on gender, women's rights, livelihoods, HIV, health, violence against women, women's leadership and participation in public life, and policy development. SRH, HIV, and women's health have been identified as key issues for the network to consider.

Current advocacy and research is focused on women's participation in public life, VAW, law and policy reform, and social and cultural practices. GEN has been a key driver in successful efforts to draft an AVAW law, and in working with the government to develop the national strategic plan for the advancement of women. It has high-level research capacity, and has gained government approval for research into two key areas in 2014: GBV and other gender issues, and social practices and cultural norms.

Women's Organisation Network (WON) is a non-government civil society network of women's organisations formed in 2008, with 34 member organisations including ethnic, faith-based (Buddhist, Christian, Muslim, and Hindu), youth, and women's organisations. The membership does not currently include sex worker organisations, but some members of WON work with sex workers in HIV prevention and SRHR.

There is no coordinated comprehensive SRHR advocacy strategy within WON and no formal position developed yet on SRHR issues such as abortion, contraception, and youth SRHR. However, some members of WON work directly on SRHR at the programme level, and also play an active role

in WON activities and strategic planning. WON has been a strong advocate for sexual rights in terms of GBV and sexual violence. The network has worked on the national NSPAW, AVAW law on rape, domestic violence, and have strongly campaigned against discrimination and rising religious fundamentalism that restrict the rights of women in the proposed marriage law.

WON is now in a new term of leadership with a Steering Committee made up of ten member organisations with strong advocacy commitment, plus a three-person secretariat.

Women's League of Burma (WLB) is a coalition of 13 women's organisations representing Myanmar/Burma's main ethnic groups: Burmese Women's Union, Kachin Women's Association-Thailand (KWAT), Karen Women's Organisation (KWO), Karenni National Women's Organisation (KNWO), Women's Rights and Welfare Association of Burma (WRWAB), Kayan Women's Organisation (KYWO), Kuki Women's Human Rights Organisation (KWHRO), Lahu Women's Organisation (LWO), Palaung Women's Organisation (PWO), Pa-O Women's Union (PWU), Rakhaing Women's Union (RWU), Shan Women's Action Network (SWAN), and Tavoy Women's Union (TWU). It was established in 1999 with the aim of increasing the participation of women in the struggle for democracy and human rights, promoting women's participation in the national peace and reconciliation process, and enhancing the role of the women of Myanmar/Burma at the national and international level. WLB has strong skills and experience at international and regional level advocacy on sexual rights, especially in highlighting GBV and systematic sexual violence against women and girls in conflict zones, and IDP and refugee areas. WLB released a report on sexual violence by the military in Eastern Myanmar/Burma in January 2014.

There is growing collaboration on advocacy between border-based women's groups and Central Myanmar/Burma-based women's groups, with the first National Women's Forum of Burma, jointly organised by the Women's Organisations Network (WON) and the Women's League of Burma (WLB), held in Yangon (Rangoon) in September 2013.

The forum hosted over 400 participants from ethnic, state, and regionally based women's organisations, international, and border-based women's organisations, political parties, women parliamentarians, CSOs, and individuals. Key outcomes included advocacy agendas focused on legal protection for women; women and decision-making; women and peace; the constitution, federalism and women; and gender equality. One of the main advocacy goals was to amend the current 2008 Constitution in accordance with CEDAW.

There is also increased coordination and communication on advocacy linked to GBV, with the launch of the WLB research report on sexual violence by the military in 2014; and the drafting of recommendations for constitutional reforms, and the AVAW law reform processes. At this stage, there is no comprehensive SRHR advocacy strategy yet developed between border-based, ethnic, and other mainstream Central Myanmar/Burma women's networks and organisations to forward a comprehensive SRHR advocacy agenda. There is yet to be an identified and agreed position between these groups on issues such as abortion, contraception, sex work, and LGBTIQ.

Sex Workers in Myanmar (SWIM) is a sex worker-led national organisation started in 2009, whose community includes women who are sex workers (not transgender or male sex workers). In 2013, SWIM ran self-help groups in all of the 14 states and divisions in Myanmar/Burma. It has more than 1,000 members, and holds regular workshops for sex workers, and monthly and quarterly meetings. SWIM has worked closely with UN partners on advocacy for law reform to decriminalise sex work and to combat discrimination against HIV positive sex workers. SWIM is part of the alliance of seven HIV networks, has worked with WON on VAW forums and advocacy, and with UN and INGO partners on HIV and AIDS prevention and awareness-raising.

Myanmar LGBT Rights Network was formed on 26 November 2012, with support and capacity building from Colors Rainbow. The Network has representation nationally in ten divisions and has members from organisations, individuals, and INGOs. The Network aims to work for

the rights of LGBT; to stop all discrimination and forms of oppression against LGBT; and to ensure LGBT have fair and equal treatment, recognition, respect, legal protection, and recognition of their capacity.

Advocacy has included surveys and data collection in Myanmar/Burma to document violence against LGBT, including police violence; advocacy against of police harassment, discrimination and arbitrary detention of transgender people; and advocacy for law change to decriminalise homosexuality. The Network has also campaigned strongly via the justice system, courts, police, National Human Rights Commission, and Members of the Parliament for legal redress in a case of police discrimination against a transgender HIV-positive woman. The Network has representation from lesbian women in GBV research, and works with lesbian women's groups nationwide.

Myanmar Positive Women Network (MPWN) remains the leading women-specific network on HIV and AIDs prevention with national representation. MPWN is involved at the national level for SRHR advocacy and has more than 2,500 members from 12 regions nationwide. MPWN was formed in 2008 during a self-help group meeting in Yangon. It aims to establish an independent network represented by women living with HIV. MPWN was formed with funding support from UNAIDS and technical support from the Asia Pacific Network of People Living with HIV and AIDS (APN+). Its activities focus on HIV prevention, education and advocacy on the rights of HIV-positive women, including rights to access ART, VCT, SRH health services, and for introducing anti-discriminatory laws. MPWN is a member of GEN, and one of the key members of the alliance of seven HIV networks, and regularly joins advocacy events with other CSOs. These include the International Women's Day meeting with the Vice President in Nay Pyi Taw, UNDP Legal Review Workshop advocating for maternal health services for HIV positive women, and law reform for anti-discrimination.

There are in fact seven national level networks focused on advocacy for HIV and AIDS issues for different populations and target groups. The Networks are supported by UNAIDS

and Pyoe Pin (DFID) to advocate on their own issues related to HIV and AIDS. The Networks include representation from the following groups:

- Men who have sex with men (MSM)—Myanmar MSM Network
- Sex workers—Sex Workers in Myanmar Network (SWIM)
- People Who Inject Drugs (PWID)—Myanmar Anti-Narcotics Association (MANA)
- People Living with HIV (PLHIV)—Myanmar Positive Group (MPG)
- Positive women—Myanmar Positive Women’s Network MPWN
- National network—National Network of NGOs (3 N)
- Interfaith network—Myanmar Interfaith Network on AIDS (MINA)

4.1.7 Youth Networks

There is no national youth network specially focused on SRHR issues. However, one Central Myanmar/Burma youth programme and two border-based youth networks are active in SRHR education for youth.

The Youth Development Programme (YDP) of the Myanmar Medical Association (MMA) is a nationwide youth programme funded by the UNFPA with a specific focus on SRHR. The YDP runs a Youth Development Centre in Yangon (Rangoon), and other activities and centres in other parts of Myanmar/Burma. It targets youth aged 14-25 years, and holds monthly meetings in Yangon (Rangoon) and other centres, plus week-long youth education training programmes aimed to increase young people’s knowledge of basic SRH issues and to motivate them to adopt healthier lifestyles.

YDP is youth-run and supports programme participants to become volunteer peer-educators. YDP also holds youth awareness-raising events around HIV and SRHR, including a World AIDS Day event in December 2013, attended by more than 3,000 youth, families, and members of the general public in Yangon (Rangoon). They also hosted a visit from HRH Crown Princess Mary of Denmark, patron of UNFPA in January 2014.

The Adolescent Reproductive Health Network (ARHN), formed in 2003, has worked for 10 years, based in Mae Sot in Thailand. It is providing SRHR services, education and advocacy for migrant and displaced communities from and within Myanmar/Burma. ARHN members include the following: Burma Medical Association (BMA), Burmese Women’s Union (BWU), Karen Youth Organisation (KYO), Mae Tao Clinic (MTC), Palaung Women’s Organisation (PWO), Social Action for Women (SAW), Tavoy Women’s Union (TWU), and United Lahu Youth Organisation (ULYO).

Since 2008, ARHN members have collectively operated a youth centre, where workshops for adolescents are held to cover the reproductive anatomy; physical and emotional changes during adolescence; family planning; sex and gender; HIV and STI transmission and prevention; and consequences of unsafe abortion. AHRN has developed a standard curriculum to be used for peer education trainings among migrant workers and students. Participants aged 12-24 are trained as peer educators and family planning supplies are distributed through these peer educators.

The Adolescent Reproductive Health Zone (ARHZ) is another youth network formed in 2006 with six member organisations. AHRZ works on adolescent reproductive health and conducts reproductive health awareness trainings among migrant workers and along Thai-Myanmar/Burma border areas. ARHZ has 12 representatives from these six organisations: Migrant Assistant Program Foundation (MAP), Burmese Women’s Union (BWU), Lahu Women’s Organisation (LWO), Kachin Women’s Association Thailand (KWAT), United Lahu Youth Organisation (ULYO), and Shan Youth Power (SYP).

The goal of the AHRZ is to promote sexual and reproductive health among young people from Myanmar/Burma between the ages 12-24. The network has trained youth focal points and peers; conducted awareness-raising activities in the community on the issues of adolescent reproductive health, sexual and reproductive rights, gender, HIV and AIDS, and family planning; and has distributed condoms and oral contraceptive pills to prevent unintended teenage pregnancy. It currently runs annual SRHR training workshops. However, ARHZ has limited advocacy capacity due to limited funding support.

4.2 KEY SRHR ADVOCACY OPPORTUNITIES AND RECOMMENDATIONS

The following section provides a synthesis of recommendations and opportunities for SRHR advocacy at the national level, drawn from feedback from participants who were consulted in Myanmar/Burma and border-based groups.

At this stage, there is no coordinated, comprehensive, national level advocacy approach for SRHR. There is a gap in national level advocacy particularly around universal access to SRHR, which includes young people among other marginalised women. However, there has been strong national level advocacy around sexual rights including GBV, law reform for sex workers and LGBTIQ; and strong responsive advocacy to challenge the rising religious fundamentalism and restrictions imposed on women under marriage laws.

Key advocacy opportunities identified by CSOs and activists in Myanmar/Burma and border areas are summarised below under these themes: (i) the government's commitment towards Universal Health Coverage (UHC); (ii) legal reforms to alleviate the plight of marginalised groups and GBV; (iii) legal, policy and other reforms for young people; (iv) optimising regional platforms; (v) the COIA Roadmap; and (vi) existence of advocacy guidelines and tools.

OPPORTUNITY #1: Government's Commitment to Universal Access to Sexual and Reproductive Health

- There is opportunity for advocacy around reproductive health issues with the Ministry of Health, which is currently reviewing and developing new policies in key areas, and receiving technical support from donors. CSOs can support this change by input and awareness-raising on SRHR issues and current gaps.
- UNFPA Myanmar has supported a review of Myanmar/Burma's progress towards the ICPD Programme of Action and the MDGs, the findings of which was reported by the government to the UN General Assembly in September 2014.¹⁶¹ The government's National Forum led the review: the National

Commission on Population and Development and the Parliamentary Committee on Population and Social Development, which includes lawmakers from various political parties and ethnic groups. Other stakeholders involved in the review included: UNFPA, Ministry of Planning and Economic Development, Ministry of Immigration and Population, Ministry of Health, Ministry of Social Welfare, Relief and Resettlement, Ministry of Border Affairs, Ministry of Education, Attorney General's Office, Myanmar Maternal and Child Welfare Association (MMCWA), Myanmar Women Affairs Federation (MWAFF), Myanmar Red Cross Society (MRCS), and other CSOs that were consulted during the 2012 validation workshop. Governments around the world had agreed to extend the scope of ICPD POA beyond 2014, and in September 2014, agreed to an ambitious development agenda, the 2030 Agenda for Sustainable Development, which includes targets related to SRHR. The report would be useful in terms of highlighting gaps and advocating for universal SRHR in the follow up to both the ICPD POA and the 2030 Agenda.

- The Health Sector Coordinating Committee (HSCC) serves as the main convener for health partners and includes representation of government MOH, INGOs, UN, and some community-based organisations. The mandate of the HSCC has been extended its scope beyond HIV, TB, and malaria to cover all health issues, including reproductive health. This committee is broad-based but has not been seen as an effective SRHR platform in the past, but may provide a forum for advocacy in the future using a health service system approach.
- MOH representatives sit on the Committee for the National Strategic Plan for the Advancement of Women (NSPAW), which has a key priority focus on Women's Health. It is expected that CSOs will be consulted in the development of the NSPAW implementation action plan and this will provide opportunity for SRHR advocacy.
- It is expected that the MMCWA will receive a significant boost in funding and will play a key role in NSPAW implementation so advocacy and collaboration with MMCWA is vital.

- Some INGO and CSOs representatives sit on various health-related working groups with the government that could be used for SRHR advocacy, including the Myanmar Health Services Coordination Committee (previously focused on HIV, TB, and malaria, but now has expanded to cover all health including RH) and the National HIV Technical and Strategic Working Group on HIV.
 - Key technical working groups on gender issues include: the UN Gender Theme Group (UNGTG) with a mandate to work across gender issues with different ministries; and the Enhancing Gender Equality and Women's Empowerment Sector Working Group (GEWESWG), chaired by the Ministry of Social Welfare and co-chaired by the French Embassy, along with CSOs representatives from women's networks and INGOs.
 - The results of the 2015 elections may provide opportunity to push for a women's health platform. The opposition NLD party, which has won the majority, has prioritised healthcare reform since joining Parliament in 2012, has a health committee, and is working on renovation of one of the best-known public hospitals in Yangon (Rangoon). Developing an advocacy plan or package to improve SRHR aimed at politicians may be useful. Members of Parliament and politicians need knowledge on SRHR, some SRHR issues are considered too sensitive (e.g. abortion, contraception), and there are other competing policy agendas (e.g. constitutional reform, land grabbing, and peace process). Given these issues, CSO will need to take the lead on advocacy on SRHR in the post-election period.
 - The GEN network has developed a successful relationship with the Ministry of Social Welfare, which could also provide a key entry point to influence the Ministry of Health to work in a more proactive way on SRHR. The MOH has been involved in consultation and development of NSPAW and AVAW.
- OPPORTUNITY # 2: Law Reform to Deal With Gender-biased Violence**
- Advocacy around issues of violation of sex workers' rights are moving forward and getting more media attention, and support from some UN agencies' programmes such as UNAIDS and UNDP. Sex workers have been able to secure support for law reform from some parliamentarians for the legalisation of sex work, and non-discrimination of sex workers, which may be carried forward in the future parliament.
 - Advocacy around issues of violation of LGBTIQ rights are moving forward and getting more attention from the media, and support from some UN programmes such as UNAIDS. Activists are currently advocating for law reform and for LGBTIQ rights through the ASEAN People's Forum, National MPs, and the National Human Rights Commission.
 - The GEN and WON networks are now working with key UN and government representatives to draft a national Anti-Violence Against Women Law. It is expected that the law will meet international standards aligned with CEDAW. Problems are anticipated in dealing with the accountability of state and military for sexual crimes, and the implementation of the law. This will require monitoring and advocacy with key players, including the Ministry of Justice and MMWAF.
 - The government submitted its 4th and 5th combined periodic report to the CEDAW Committee, in 2015. The leading agency for this report is the Myanmar National Committee for Women's Affairs, of the Ministry of Social Welfare, Relief and Resettlement. Women's networks are currently undergoing planning consultations to develop a shadow report. The CEDAW Committee will consider the government's report and the shadow reports at its 64th session in Geneva in July 2016.¹⁶²
 - Advocacy for women in conflict areas, including in Kachin and Rakhine states, can also be forwarded via GEN members who have links to national level working groups such as the Humanitarian Protection Working Groups (HPWG). The HPWG includes UNICEF, UNFPA, OCHA, DRC, NRC, World Vision, Save the Children, and several other organisations.
 - UNHCR participates in the monitoring and reporting mechanism under the UN Security Council Resolution 1612 on Children in Armed Conflict. UNFPA is working via the UNGTG on developing a national action plan for UN Security Council Resolution 1325: with the

government Ministry of Home Affairs, MAAF, and CSOs to ensure women's involvement in the peace process.

- GEN is also involved in the development of the National Action Plan for UN Security Council Resolution 1325 working with the UNRC, UNGTC, MAAF, and Ministry of Home Affairs.
- GEN has called for law reform to set a common minimum age (preferably 18) and standard for consent by both parties, to eliminate parental consent, and require registration of all marriages to further women's equality and autonomy in marriage.

OPPORTUNITY #3: Law Reform for Youth Development

- The MOH is currently drafting the Adolescent Health Policy. UNFPA, UNICEF, WHO and the National Task Force for Youth Policy are working with the government to develop the National Adolescent Strategic Action Plan.
- The Ministry of Education (MOE) is currently looking at curriculum reform and development, which can provide an entry point for advocacy on CSE in schools. The MOE, however, is seen to be unsupportive of CSE, and their understanding of its importance needs to be built. Key UN agencies to forward adolescent health issues include UNICEF and UNFPA.
- The issue of child sexual assault has been raised in parliament in 2013-14, and an opportunity may exist for law reform via the AVAW law development to ensure that adequate protections are in place for child victims of sexual assault, including legal representation, confidential video interviews, and a child advocate.

OPPORTUNITY #4: Optimising Regional Platforms

- Myanmar/Burma's role as ASEAN Chair in 2014 provided key opportunities for advocacy at the ASEAN People's Forum (APF), via the South East Asian Women's Caucus and advocacy to government sitting on the ASEAN Commission on the Promotion and the Protection of the Rights of Women and Children (ACWC), ASEAN Intergovernmental Commission on Human Rights (AICHR), the ASEAN Health Ministers

Meeting (AHMM), and the ASEAN HIV-AIDS Working Group. Follow up is necessary.

- The ASEAN People's Forum held in March 2014 provided key advocacy opportunities for SRHR for women, youth, sex workers, LGBTIQ, women with disabilities, HIV positive groups, and ethnic nationalities. The APF Statement from the March 2014 forum included SRHR as a key issue for these diverse groups. There is a further opportunity to advocate on these issues in the follow up to the forum and in key ASEAN events and meetings.
- UNFPA works with the Asian Forum of Parliamentarians on Population and Development (AFPPD), to support and Social Development. AFPPD was formed in 2011 and includes lawmakers from various political parties and parliamentarians in Myanmar/Burma working on SRH, HIV and gender, via the Parliamentary Committee on Population and Social Development.
- The Asia Pacific Forum on Sustainable Development is organised by UN ESCAP annually in Bangkok, and will be the key regional follow-up and review mechanism for the 2030 Agenda on Sustainable Development. This is an opportunity for local and national civil society groups to connect with regional networks working on SRHR, such as ARROW, and advocate for addressing gaps on SRHR.

OPPORTUNITY # 5: The COIA Roadmap

- The road map to implement the recommendations of COIA has seven thematic areas, including advocacy and outreach targeting three constituencies (parliamentarians, media, and civil society). WHO has included workshops for these activities in its workplan.
- The following is amended from the roadmap developed at the national workshop in February 2013. The catalytic funding of USD12,000 for advocacy has been used by the MOH to organise meetings and workshops on advocacy for health staff. In this roadmap, advocacy is defined as "an organised, deliberate, systematic and strategic processes intended to bring about a positive change." It is about increasing the voice, access and influence of vulnerable individuals and groups in the decision-making process. It also states that advocacy

approaches must be evidence-based. The activities planned are as follows:

- » Establish coalition with participation of all stakeholders by forming electronic linkages and networks; develop website for RMNCH Myanmar;
- » Parliamentarians sit on the national committee with other stakeholders on a regular basis (quarterly);
- » Organise public forum for information sharing by parliamentarians at national, regional and state levels;
- » Support capacity of CSOs to utilise the RMNCH website to disseminate messages;
- » Work with the media to strengthen technical area capacity to report on RMNCH issues; Conduct workshops for the media communication to health personnel and assign media focal point in each;
- » Work with media to strengthen media capacity to report commitment to Global Strategy for Women's and Children's Health; and
- » Improve information flow to media, by press conferences biannually, encouragement of the use of the Myanmar MOH website, and wide dissemination of MOH publications.

OPPORTUNITY # 6: Existence of Guidelines and Tools on Advocacy

It can be assumed that the constituencies, including NGOs and CSOs that will implement these activities, have knowledge, expertise and experience in advocacy work, especially in RMNCAH. Nonetheless, it is pertinent to suggest here to refer to some guidelines and toolkits on this subject that have been developed by many organisations, including UN agencies (particularly WHO and UNFPA) that offer opportunities. There are generic guidelines for advocacy and for advocacy in health, but more importantly, there are guidelines on advocacy for specific areas of RMNCAH, such as family planning, RH supplies, adolescent health, safe abortion, and other issues.

ENDNOTES

- 1 In this report, "Myanmar/Burma" are both used, the latter in deference to the Burma democracy movement. For the same reason, the terms "Yangon/Rangoon" are both used. The term "women and young people of Myanmar/Burma" is used rather than "Burmese women and Burmese youth" to recognise equality across all ethnicities, including Burmese and Burmans. Likewise, "Myanmar/Burma's democracy" and "Myanmar/Burma's society" are used instead of the term "Burmese democracy" and "Burmese society."
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- 7 Stands for Lesbian, Gay, Bisexual, Transgender, Intersex, Queer or Questioning.
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 - 21 Includes obligations to protect children and young people from sexual rights violations.
 - 22 Adopted in 2000, the Convention includes the protocol to prevent, suppress and punish trafficking in persons, especially women and children; and the protocol against the smuggling of migrants by land, sea and air. These protocols aim to provide protection for women and children against trafficking for forced labour and sexual exploitation. However, the government has reservations on Article 16 relating to extradition and does not consider itself bound by the same, and on Article 35 referring to disputes relating to the interpretation or application of this Convention to the International Court of Justice.
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APPENDIX 1:

LIST OF INDIVIDUALS AND ORGANISATIONS CONSULTED

Note: Some interviewees chose to remain anonymous.

1. AIDS Myanmar Alliance (AMA)
2. Akhaya Women
3. Aye Aye Thar
4. Badei Dha Moe – Civil Society Organization
5. Burma Relief Centre (BRC)
6. Charity-Oriented Myanmar
7. Colorful Girls/Girl Determined
8. Colors Rainbow
9. Community Partners International (CPI)
10. Gender Equality Network (GEN)
11. Alliance Myanmar, International HIV/AIDS Alliance in Myanmar
12. Kachin Women's Association Thailand
13. Karen Women's Empowerment Group
14. Karen Women Organisation (KWO)
15. Lahu Women's Organisation
16. MAP Foundation
17. Marie Stopes International Myanmar
18. Myanmar Positive Women's Network
19. NGO Gender Group
20. Paung Ku
21. Phan Tee Eain
22. Phyo Let Than, Independent journalist
23. Pyi Gyi Khin
24. Sex Workers in Myanmar (SWIM)
25. Shan Women's Action Network (SWAN)
26. The Thai Burma Consortium (TTBC)
27. Thin Thin Aung, Journalist and media company owner
28. Triangle Women's Support Group
29. United Nations Development Programme (UNDP)
30. United Nations Population Fund (UNFPA)
31. Women's Organisation Network of Myanmar (WON)
32. Women's Peace Network—Arakan
33. Young Women's Christian Association (YMCA) of Myanmar

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ISBN 9789670339238



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ARROW is a regional non-profit women's NGO based in Kuala Lumpur, Malaysia, and has consultative status with the Economic and Social Council of the United Nations. Since it was established in 1993, it has been working to advance women's health, affirmative sexuality and rights, and to empower women through information and knowledge, evidence generation, advocacy, capacity building, partnership building, and organisational development.

ARROW envisions an equal, just, and equitable world, where every woman enjoys her full sexual and reproductive rights. ARROW promotes and defends women's rights and needs, particularly in the areas of health and sexuality, and to reaffirm their agency to claim these rights.

This publication has been produced through the core funding support of



ARROW also receives institutional support from the **Ford Foundation**.

The content of this publication does not necessarily reflect the views and positions of these donors.