



FPWATCH RESEARCH BRIEF

Myanmar 2016 FPwatch Survey:
Findings from a contraceptive
commodity and service assessment
among private sector outlets

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Suggested Citation: Myanmar 2016 Outlet Survey Findings. (2016). FPwatch Research Brief. Population Services International and FPwatch. Washington DC: USA.

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Cover page photo credit: Sai Moe Kyaw, PSI

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Background

Myanmar aims to exceed a modern contraceptive prevalence rate (mCPR) of 60% by 2020, reduce unmet need to 10% and to improve method mix through increased use of long-acting and permanent methods (LARC/PMs) and decentralization to the districts.

FAMILY PLANNING ENVIRONMENT IN MYANMAR

Myanmar has made steady and important gains in availability of and access to modern contraceptive methods in recent years. The modern contraceptive prevalence rate (mCPR) has increased from 32.8% in 2001 to 51.3% in 2015.^{1,2} However, unmet need for modern family planning methods remains higher than national goals at 16.3% and regional disparities and inequities in access between urban and rural and rich and poor populations persist.³

The most common modern family planning methods reportedly used in Myanmar are contraceptive injections and oral contraceptives, used by 27.6% and 13.8% of currently married women, respectively. Less than 9% of currently married women use long-acting reversible contraceptives or permanent methods (LARC/PMs). There is an ongoing opportunity to increase contraceptive access for women of reproductive age, which make up 30% of Myanmar's population.⁴

SECTOR ROLES IN CONTRACEPTIVE PROVISION

Family planning services and commodities provided through the public sector are augmented by private for-profit and not-for-profit providers, especially clinics and pharmacies. In addition, there are a large number of trained health workers acting in a private capacity, as well as general retailers and untrained providers known to be providing family planning commodities and services. A small majority of modern family planning methods are provided by the private sector (51.8%) compared to the public sector (42.2%), but the large majority of LARC/PMs are provided by the public sector.⁵

From 2014-15, the Myanmar government completed a health facility survey looking at the availability of family planning and reproductive health commodities in the public sector.⁶ However, high quality evidence related to the private sector provision of modern family planning methods remains limited.

NATIONAL FP2020 COMMITMENTS

The Myanmar government plays an active leadership role in national efforts to improve reproductive health. **In 2013, Myanmar committed to the London Summit on Family Planning's FP2020 Initiative goals.**^{7,8} As part of this, Myanmar pledged to reach a mCPR above 60% by 2020 and committed to improving method mix with use of long-acting and permanent methods and decentralization to the districts. In addition, the national government has pledged to reduce unmet need for family planning to under 10% and increase demand satisfaction to 80% by 2015. Myanmar also committed to increase the use of monitoring and evaluation data to improve quality, address regional disparities, dedicate funding to cover almost 30 million couples by 2020, boost public-private partnerships to expand service delivery and strengthen the reproductive health commodity supply chain.

KEY POLICIES AND INTERVENTIONS

Myanmar has implemented several initiatives to address its high unmet need for family planning and to improve contraceptive access, including:⁸

- Encouraging task-sharing for Auxiliary Midwives
- A Nationwide Implant Training for providers and a planned post-training assessment
- Implementing an RH Commodity Logistic System in 12 townships
- Building capacity of monitoring and evaluation officers
- Increasing provision of post-partum IUCD services
- Creating a Lead Working Group on Family Planning
- Increasing state budgets for family planning

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FPwatch at a glance

WHAT IS FPWATCH?

FPwatch is a multi-country research project implemented by Population Services International (PSI) with funding from the Bill and Melinda Gates Foundation (BMGF) and the Three Millennium Development Goal (3MDG) Fund. Standardized tools and approaches are employed to provide comparable data across countries and over time. FPwatch is a response to the Family Planning 2020 (FP2020) goal to **enable 120 million additional women and girls to have informed choice and access to family planning information and a range of modern contraceptive methods.**⁹ Launched in 2015, FPwatch is designed to provide timely, relevant and high-quality FP market information. Research methods implemented include outlet surveys and interviews with national FP experts.

GOAL

The FPwatch project aims to inform and monitor national and global policy, strategy and funding decisions for improving informed choice and access to FP information and a range of modern contraceptive methods.

RELEVANCE

FPwatch is an expansion of PSI's ACTwatch research initiative¹⁰ and is designed to deliver high-quality evidence on modern contraceptive availability, price and relative market share and contraceptive service availability and readiness through outlet surveys in the proposed countries. FPwatch market evidence will complement other FP research and monitoring that is heavily reliant on population-based studies and modeling. The data gathered and analyzed through FPwatch will provide the FP community with

relevant evidence to support the strategic decision making necessary for reaching women and girls who are in need of FP information, services and contraceptives.

The 2016 baseline FPwatch Myanmar survey complements concurrent data collection focused on tracking FP2020 progress, including surveys conducted among Myanmar's public sector outlets by the Government of Myanmar. The 2016 Myanmar FPwatch survey supplements and builds upon these surveys by conducting a full contraceptive commodity audit and service provider questionnaire with information on contraceptive commodity and service availability, price, volume and service readiness for all private outlets.

FPwatch market monitoring in Myanmar in 2016 was implemented in the context of national strategies designed to improve access to and choice of modern contraceptive methods.

OUTLET SURVEYS

Outlet surveys are the core component of the FPwatch project. The outlet survey conducted by The Myanmar Marketing Research and Development Co., Ltd. under supervision of PSI-Myanmar and in partnership with the MOHS, was designed to monitor and provide estimates for key FP market indicators at the national level and to provide estimates specific to metropolitan, urban and rural settings in Myanmar.

This summary report presents cross sectional data from the 2016 outlet survey.

5

Number of FPwatch outlet surveys implemented internationally from 2015 – 2016

+80,000

Total number of outlets screened in 2015-2016 outlet surveys

+18,000

Number of outlets interviewed in 2015-2016 outlet surveys

What questions are answered by the outlet survey?



What types of outlets in the public and private sectors are carrying modern contraceptive methods?



What proportion of public and private sector outlets are stocking selected modern contraceptive commodities and providing a range of methods?



What is the relative market share for each contraceptive method and for each outlet type?



What is the consumer price of modern contraceptive methods among private sector outlets?



What proportion of public and private sector outlets are providing selected modern contraceptive services, and what is the readiness of selected outlet types for performing contraceptive services?

The FPwatch Countries, 2015 – 16



Methods

FPwatch implements standardized methods and questionnaires that allow for comparisons within and between countries. Together, a full census of all outlets providing contraceptive methods, a full audit of all available contraceptive commodities and a provider interview on contraceptive services give a complete picture of the FP commodity and services market.

HOW IS THE SAMPLING CONDUCTED?

In Myanmar, one-stage sampling was conducted for the metro stratum and two-stage sampling was conducted for urban and rural strata. In urban and rural strata, the primary sampling unit used was the township and secondary sampling unit was urban wards for the urban stratum and village tracts for the rural stratum. In the metro stratum, the sampling unit was the metro ward. A representative sample of these wards and village tracts was selected from the 272 townships (58 were excluded for security reasons), covering 14 states and divisions, for urban and rural strata and from all metro-designated wards for the metro stratum. A multi-stage, cluster design using probability-proportional-to-size (PPS) sampling was employed to select clusters within each stratum, with cluster population serving as the measure of size. A representative sample of private outlets providing contraceptive methods directly to consumers was selected.

WHAT TYPES OF OUTLETS ARE SAMPLED?

Unlike other FPwatch countries, only private sector outlets were considered for inclusion. The main types of private outlets sampled included private (community) health workers, not-for-profit outlets, private facilities, pharmacies, general retailers and itinerant drug vendors (IDVs). A further explanation of outlet type definitions and categories is given on page 12.

HOW ARE THE OUTLETS IDENTIFIED?

The FPwatch outlet survey included all private outlets in selected clusters with the potential to sell modern contraceptive commodities or offering contraceptive services. As many of these outlets are unregistered, mobile or recently opened, official listings of these outlets and their locations were not available. A census approach was therefore implemented, supported by local informants, maps and lists of registered outlets where available.

WHAT IS AN OUTLET CENSUS?

This involves a team of data collectors moving systematically through a defined area to identify all private outlets that have the potential to sell or distribute contraceptive methods.

WHAT HAPPENS AFTER AN OUTLET IS IDENTIFIED?

The outlet is screened for availability of modern contraceptive methods or services. Outlets were eligible for the full survey if they had modern contraceptive commodities including oral contraceptives, emergency contraceptive pills, contraceptive injectables, contraceptive implants and/or intrauterine devices (IUDs) in stock at the time of survey or in the previous three months, or offer contraceptive services including contraceptive injections, implant or IUD insertions, and/or male or female sterilizations. Some information on brands, prices and distribution of condoms was collected from all outlets screened if condoms were available. Other commodities were considered but not found in outlets surveyed. Permission to conduct the interview was obtained from the main provider.

HOW IS INFORMATION ON CONTRACEPTIVE COMMODITIES AND SERVICES CAPTURED?

Full contraceptive audits were conducted among outlets with eligible contraceptive commodities in stock. Information was recorded for each unique contraceptive identified in the outlet. Among outlets offering eligible contraceptive services, providers were interviewed to provide information for each type of service.

WHAT INFORMATION IS RECORDED ON THE AUDITS AND PROVIDER INTERVIEWS?

An audit sheet is completed for each unique modern contraceptive commodity in stock. The audit sheet captures product information from the product package including the brand name, manufacturer, country of manufacturer and formulation/strength (if applicable). The audit sheet also captures information from the provider including the amount sold in the last one month, retail price and stock-outs in the previous three months. The provider interview captures the number of services performed, price, provider credentials and the availability of a minimum set of essential equipment.

Comprehensive product information and provider reports on amount distributed and retail price allow for calculating estimates of contraceptive method availability, price and relative market share. Comprehensive service and provider information allows for calculating estimates of readiness for contraceptive services.



Photo credit: Sai Moe Kyaw, PSI

Sample

Outlet types providing modern contraceptive methods

HOW MANY OUTLETS WERE INCLUDED IN THE SAMPLE AND SCREENED?

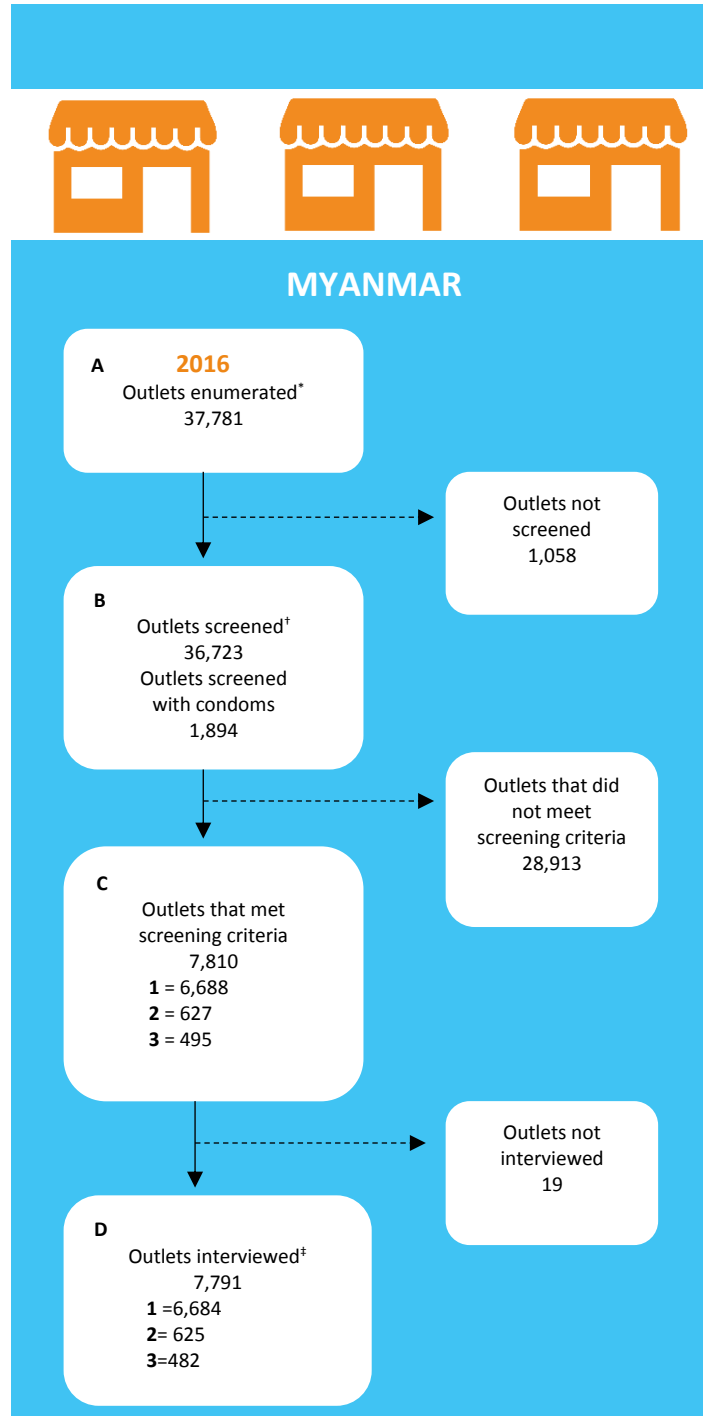
More than 37,000 private outlets across 670 wards and village tracts (clusters) were enumerated (i.e. identified as outlets with potential to sell or provide modern contraceptive commodities and services) during the full census activity. Among those that were screened, over one-fifth met at least one of the three eligibility criteria in that they had at least one brand of modern contraceptive commodity including oral contraceptives, emergency contraceptive pills, contraceptive injectables, implants and/or IUDs, in stock in the previous three months or provided contraceptive services. A total of 7,791 private outlets were interviewed by the FPwatch study in 2016.

1 in 5

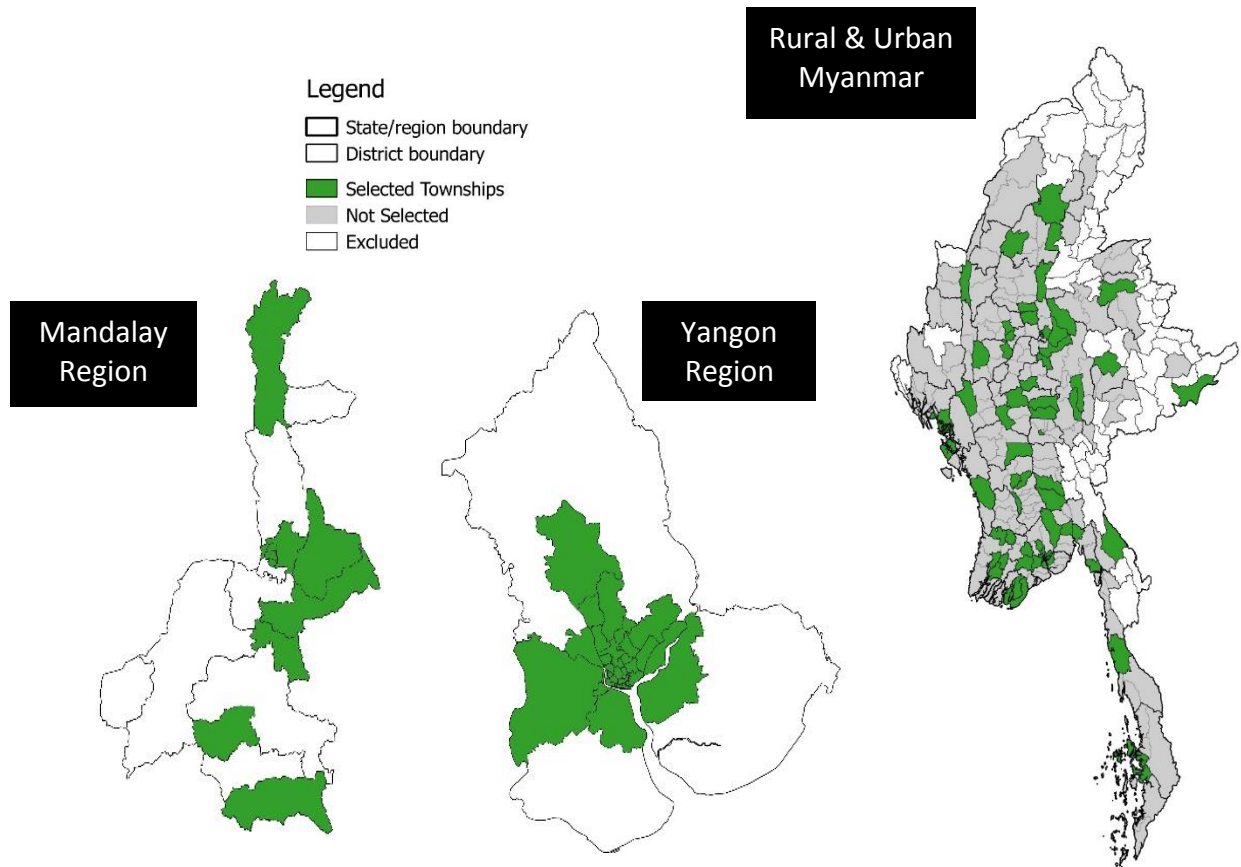
Number of outlets screened that met eligibility for full interview

Key:

- 1: Modern contraceptive commodities (includes oral contraceptives, emergency contraceptives, injectables, implants or IUDs) in stock on day of visit
 - 2: Modern contraceptive commodities reportedly in stock during the previous three months but not on the day of the visit
 - 3: Contraceptive services (including contraceptive injections, implant insertions, IUD insertions, male sterilizations or female sterilizations) available but no modern contraceptive commodities in stock (commodities purchased elsewhere and brought for service)
- * Outlets enumerated: Identified as outlets with potential to sell or distribute modern contraceptive commodities (male condoms, female condoms, oral contraceptives, emergency contraceptives, injectables, implants, IUDs) and/or provide contraceptive services (injections, implants, IUDs, male/female sterilizations) during the census
 - † Outlets screened: Administered questions to assess current or recent (previous three months) availability of modern contraceptive commodities or services
 - ‡ Outlets interviewed: A partial or complete interview was conducted with an outlet representative (health facility provider or staff)



Myanmar Study Area



Strata	# Selected Townships	# Wards/		# Outlets Enumerated	# Outlets Interviewed
		Village Tracts			
Metro	39	95		7,653	1,436
Urban	55	256		14,871	2,652
Rural	55	319		15,257	3,703
Total	94	670		37,781	7,791

Private contraceptive market composition

WHAT IS CONTRACEPTIVE MARKET COMPOSITION?

Contraceptive market composition illustrates the *distribution of all outlets that were found to have at least one modern contraceptive commodity in stock on the day of survey*. Outlets stocking only male condoms and no other modern contraceptives were not considered for these charts. The pie chart below illustrates the distribution of these outlet types by each private outlet type for all of Myanmar. On the following page, charts for market composition for metro, urban and rural strata are given.

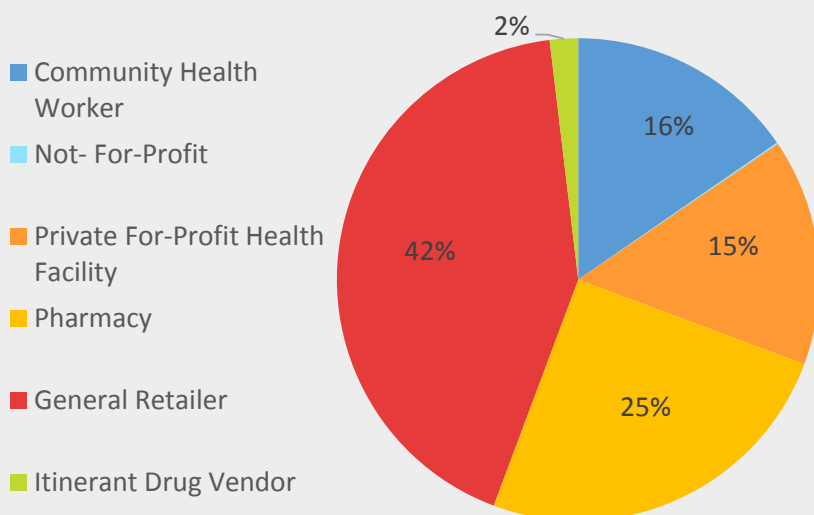
WHAT IS THE 2015 MODERN CONTRACEPTIVE MARKET COMPOSITION IN THE PRIVATE SECTOR?

Looking only at the contraceptive market composition of the private sector in Myanmar, the majority of the composition was accounted for by general retailers (42 percent) of those private outlets stocking modern contraceptives (excluding condoms only outlets). One-quarter of the private market composition consisted of pharmacies, 16 percent consisted of private CHWs and 15 percent of private facilities. In addition to these outlets and providers, 2 percent of the composition consisted of IDVs.

42%

The private market composition accounted for by general retailers in 2016, the most common outlet type stocking modern contraceptives.

NATIONAL CONTRACEPTIVE MARKET COMPOSITION FOR THE PRIVATE SECTOR OF MYANMAR, BY OUTLET TYPE, 2016



N= 6,680

Total number of contraceptive-stocking and/or service-providing outlets by type in 2016: CHW N=987; Not-for profit N=5; Private for-profit health facility N=993; Pharmacy N=1,528; General retailer N=3,035; **Itinerant** drug vendor N=132.

This chart excludes outlets that only provided male condoms and did not stock any other modern contraceptive methods.

OUTLET TYPES

CHWs are formally trained health workers offering non-facility based and/or community-based services. These providers may practice within government health facilities and see patients privately outside of working hours. They typically are midwives, health assistants, nurses, auxiliary nurse midwives, village malaria volunteers, community health services providers (CHSPs), etc.

Not-for-profits consist of non-governmental health centers and non-governmental organization (NGO) clinics. **Private health facilities** consist of hospitals, clinics and polyclinics and facility-based medical doctors acting in a private capacity. **Pharmacies** consist of registered and unregistered retail pharmacies or wholesale pharmacies providing some retail services. **General retailers** consist of general stores and village shops. **Itinerant drug vendors** consist of traditional/indigenous practitioners and other providers of health services without formal health training. **Private medical outlets** combine CHWs, not-for-profits private health facilities and pharmacies. **Private other outlets** combine general retailers and IDVs.

HOW DOES CONTRACEPTIVE MARKET COMPOSITION DIFFER AMONG GEOGRAPHIC STRATA?

It is important to consider the private market composition according to geographic differences.

In Metro Myanmar, the most common outlet type comprising the private sector market composition was pharmacies (41 percent). Both private facilities (29 percent) and general retailers (27 percent) were also strongly represented among those outlets or providers stocking any modern contraceptive other than those stocking only male condoms. The only other outlet type with an appreciable portion of the market composition were CHWs (3 percent).

The private market composition of urban Myanmar was relatively similar to metro areas, but with higher proportions of the private market composition for general retailers (37 percent) and lower for pharmacies (34 percent) and private facilities (18 percent). CHWs were also a higher proportion of the private market composition (10 percent) compared to metro areas.

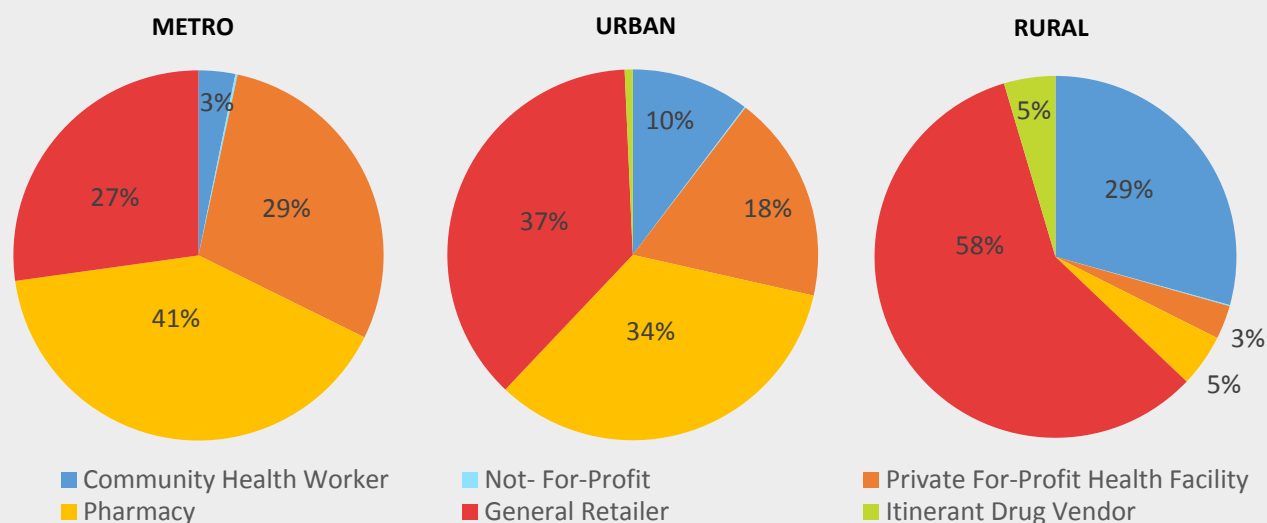
In rural Myanmar, the majority of the private market composition was accounted for by general retailers (58 percent), significantly higher compared to metro and urban areas. There was also significantly higher proportions of IDVs (5 percent) and CHWs (29 percent) of those providing contraceptive commodities in rural areas compared to metro and urban areas. Finally, pharmacies (5 percent) and private facilities (3 percent) comprised only a small share of the private market composition in rural areas.

These findings show diversity in the market landscape composition according to location. The findings are indicative of the types of outlets that may be ready to provide access to modern contraceptive methods in Myanmar and across geographical zones.

The regional market landscapes vary. However, general retailers consisted of a significant portion (one-quarter to nearly 60 percent) of the market composition across strata.

Over-the-counter outlet types dominated the private sector accounting for about two-thirds of the market composition across strata.

CONTRACEPTIVE MARKET COMPOSITION FOR THE PRIVATE SECTOR OF METRO, URBAN AND RURAL MYANMAR



Metro N=1,368; Urban N=2,382; Rural N=2,930

These charts exclude outlets that only provided male condoms and did not stock any other modern contraceptive methods.



Photo credit: Sai Moe Kyaw, PSI

Availability of a diversity of methods in the private sector

WHAT IS THE AVAILABILITY OF SELECTED RANGES OF CONTRACEPTIVE METHODS AMONG ELIGIBLE OUTLETS?

Access and choice of contraceptive method are integral components of the FP2020 Initiative and the Myanmar’s national FP2020 commitments. This section reports on the availability of any modern contraceptive method, three or more methods, three or more methods with at least one LARC/PM and five or more methods among all outlets of a particular type that were screened in the full census activity. *Availability indicators are given among outlets screened.* The chart below illustrates the availability by outlet type for all of Myanmar. On the following page, charts for availability for metro, urban and rural strata are given.

Over half of CHWs screened had at least one modern method available though less than ten percent had three or more methods available. Only a handful of CHWs screened had five or more methods available on the day of the survey.

Nearly three-quarters of private facilities surveyed had at least one modern method available, with about one-fifth of those screened stocking three or more methods. Less than 5 percent of private facilities screened had three or more methods including at least one LARC/PM available and only about 1 percent had five or more methods available.

Among pharmacies, nearly all of those screened had at least one modern method available and nearly half had three or more methods available on the day of the survey. Only a handful had a LARC/PM method available or five or more modern methods.

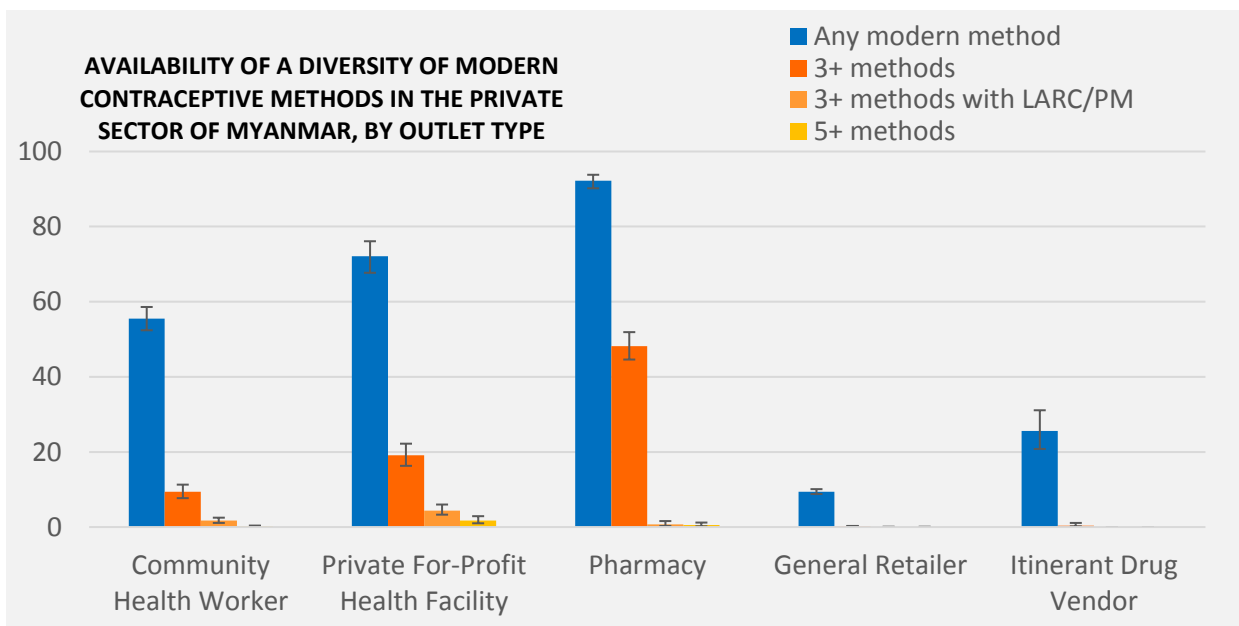
General retailers, one of the most common outlet types providing modern methods, were, nonetheless, not often stocking modern contraceptives (about 10%) and about one-quarter of IDVs offered at least one method of modern contraceptive. However, very few of these outlets or providers offered three or more methods on the day of the survey.

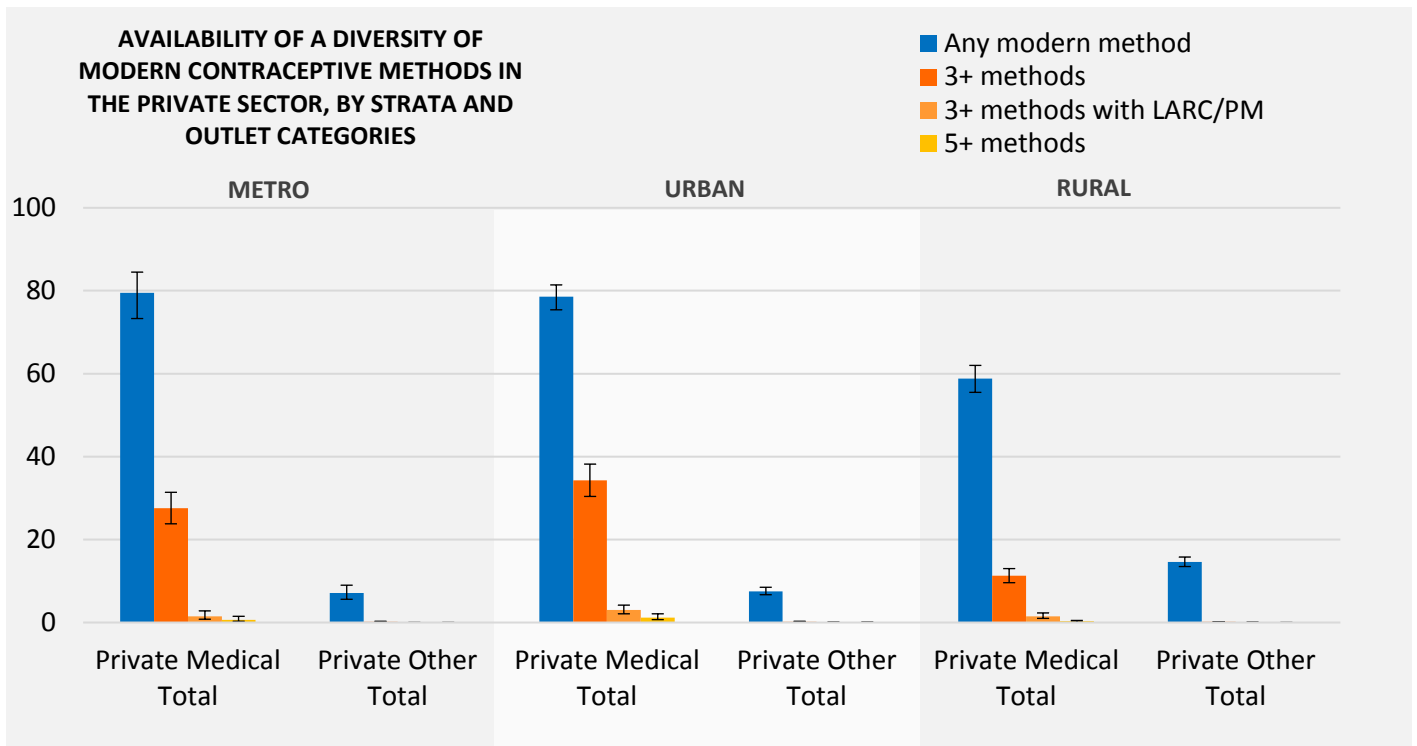
Percent of private outlets screened with any modern FP methods available

9% vs. **26%**
of general retailers vs. of IDVs

Percent of private outlets screened with 3+ modern FP methods available

9% vs. **19%** vs. **48%**
of CHWs vs. of private health facilities vs. of pharmacies





HOW DOES AVAILABILITY OF SELECTED RANGES OF CONTRACEPTIVE METHODS AMONG ELIGIBLE OUTLETS DIFFER AMONG GEOGRAPHIC STRATA?

There were a few differences in the availability of selected method mixes across geographic strata. Looking at private medical outlets (CHWs, private facilities, pharmacies), slightly fewer of these outlets screened in rural areas stocked any modern method (almost 60 percent) compared to metro areas (about 80 percent each). Private medical outlets were also more likely to have three or more methods available in metro (about one-quarter) and urban areas (about one-third) compared to rural areas (about 10 percent). Other private outlet types (general retailers and IDVs) in rural areas were slightly more likely to stock at least one modern method compared to metro and urban areas.

28%

Percent of metro private medical outlets with 3+ methods

34%

Percent of urban private medical outlets with 3+ methods

11%

Percent of rural private medical outlets with 3+ methods



Photo Credit: Sai Moe Kyaw, PSI



Photo credit: Sai Moe Kyaw, PSI

Contraceptive commodity availability in the private sector

WHAT IS THE AVAILABILITY OF CONTRACEPTIVE METHODS AMONG ELIGIBLE OUTLETS IN THE PRIVATE SECTOR?

The census approach involved a search for all outlets that had the potential to provide modern contraceptive methods in each selected cluster. The following graphs on page 19 show the percentage of outlets found to have selected non-hormonal short-acting contraceptives, hormonal short-acting contraceptives and LARCs among outlets of that type screened. The graphs on page 20 give availability by broad outlet categories for each of the three geographic strata.

WHAT IS THE AVAILABILITY OF SELECTED CONTRACEPTIVE METHODS AMONG ELIGIBLE OUTLETS?

In Myanmar about one-fifth of CHWs and private facilities and 60 percent of pharmacies had at least one brand of male condom in stock on the day of the survey. Only small proportions of general retailers and IDVs screened stocked male condoms. Female condoms were rarely stocked across outlet types.

About one-quarter of CHWs, one-third of private facilities and 85 percent of pharmacies screened stocked at least one brand of oral contraceptive. Less than 10 percent of general retailers and less than 5 percent of IDVs stocked oral contraceptives. Most oral contraceptives were combined oral contraceptives (COCs) and progestin only pills (POPs) were rarely stocked except in pharmacies (about one-third). Emergency contraceptive pills were also rarely stocked except in pharmacies (40 percent). Contraceptive injectables were commonly stocked by CHWs (almost half), private facilities (almost two-thirds) and pharmacies (almost half). Injectables were also commonly available with IDVs with almost one-quarter of those screened found to be stocking at least one brand of injectable. All injectables were depot medroxyprogesterone acetate (DMPA) injectables. The majority were three month injectables with a small amount of one month injectables available.

Brands of LARCs were only found among CHWs, private facilities and pharmacies (IUDs only). Less than 1 percent of private facilities screened stocked contraceptive implants (Implanon® and Jadelle®), which were not found in other facility types. Less than 5 percent of private facilities, less than 2 percent of CHWs and less than 1 percent of pharmacies screened stocked IUDs (all Copper T).

HOW DOES AVAILABILITY OF SELECTED CONTRACEPTIVE METHODS AMONG ELIGIBLE OUTLETS DIFFER AMONG GEOGRAPHIC STRATA?

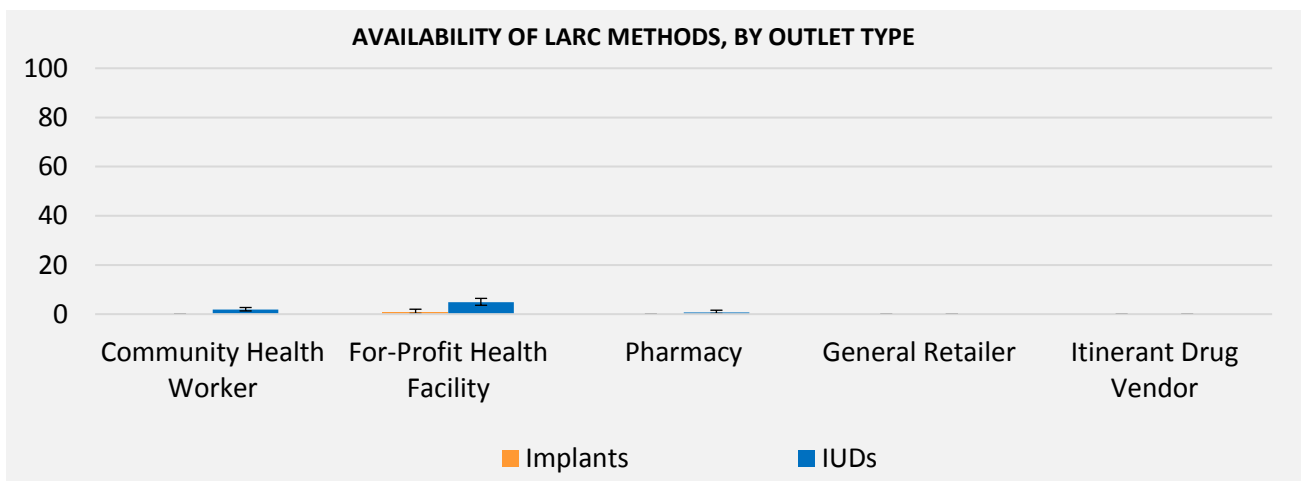
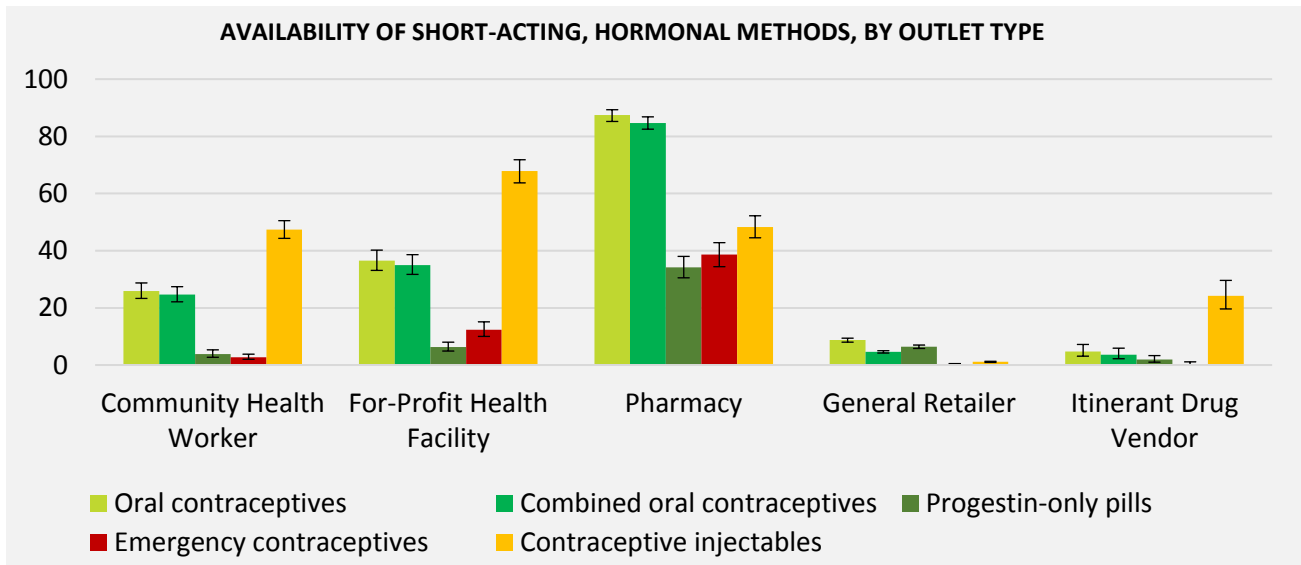
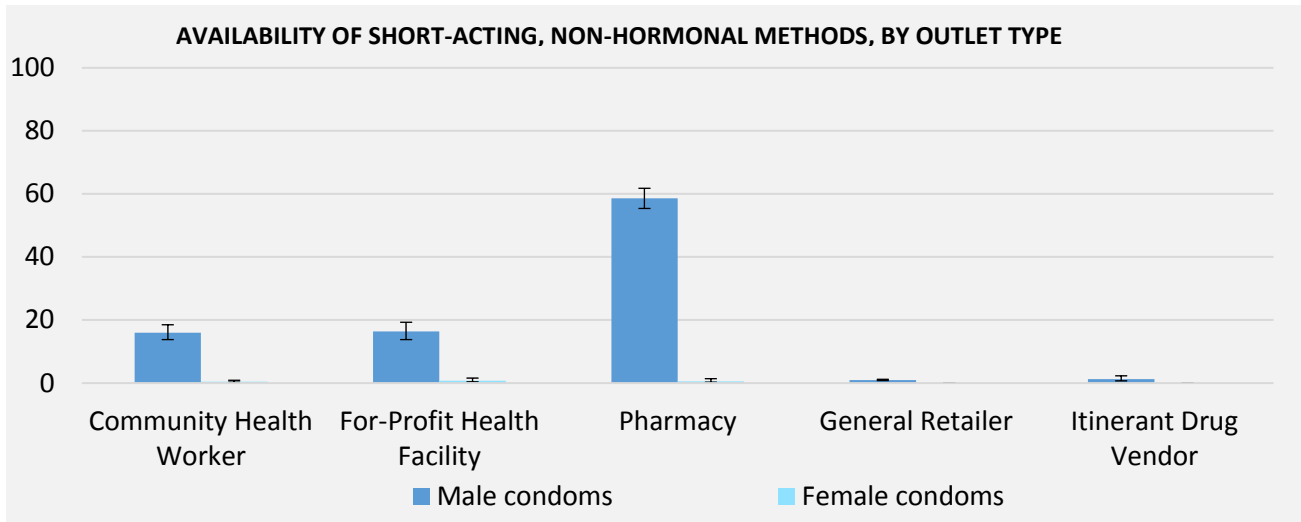
In general, private medical outlets in rural areas were less likely to stock all short-acting methods compared to those in metro and urban areas and significantly less likely for all short-acting methods except contraceptive injectables. However, the highly numerous general retailers as well as IDVs were more likely to stock oral contraceptives and contraceptive injectables compared to those in metro and urban areas.

Availability of LARC methods was uniformly low across all strata and outlet types.

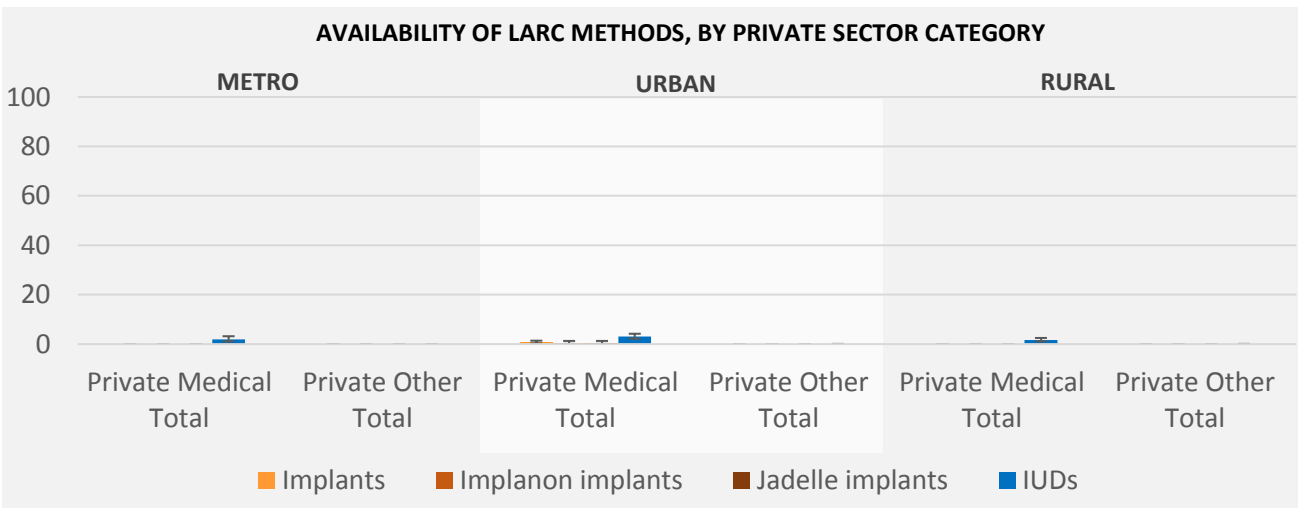
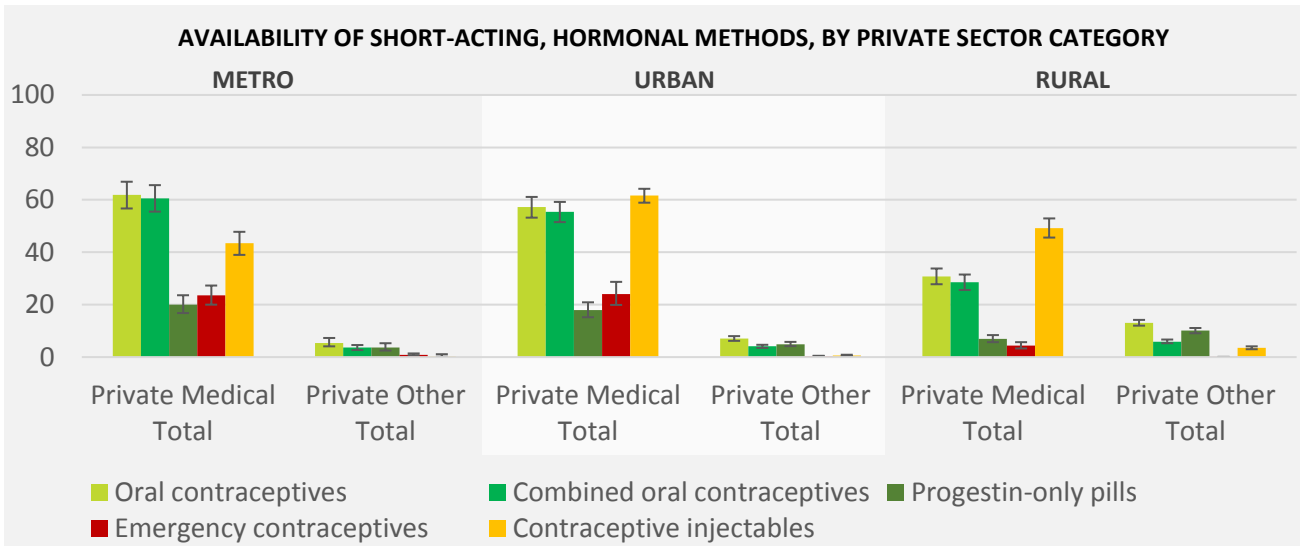
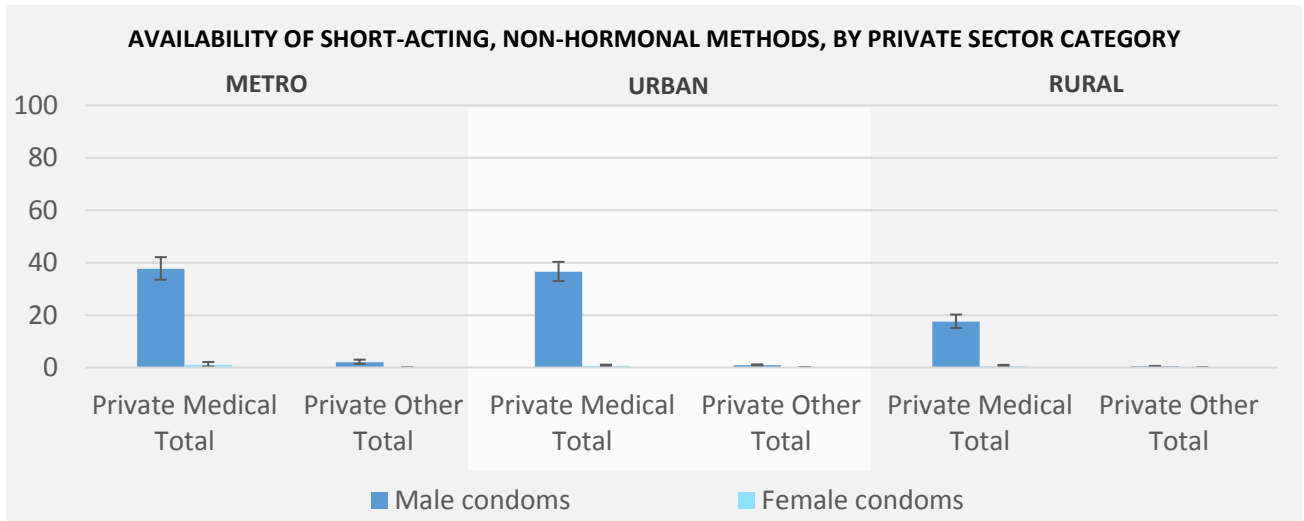


Photo Credit: Sai Moe Kyaw, PSI

ALL MYANMAR



MYANMAR GEOGRAPHIC STRATA



Stock-outs

WHAT ARE STOCK-OUTS?

The graphs below present data for *point-in-time stock-outs* or the percentage of outlets stocked out on the day of the survey of all brands of a method, *among outlets reportedly stocking at least one brand of the method in the previous three months*. Graphs are only presented for the national sample.

WHAT CONTRACEPTIVE METHODS ARE OUT OF STOCK AMONG OUTLETS TYPICALLY STOCKING THE METHOD?

Among CHWs, approximately one-fifth of CHWs reportedly stocking oral contraceptives in the previous three months were currently stocked out of all brands of the method. Approximately one-quarter were stocked out of emergency contraceptive pills, 15 percent injectables and one-fifth IUDs, although few stocked IUDs currently or in the previous three months. Among private facilities, only about 10 percent of those stocking the method in the previous three months were currently stocked out of oral contraceptives and or emergency contraceptive pills and less than 5 percent were stocked out of injectables. For LARC methods, although few stocked implants in the previous three months, of those that did, one-quarter were currently stocked out of all brands. Less than 5 percent of private facilities were stocked out of IUDs. In pharmacies, less than 5 percent of those reportedly stocking the method in the previous three months were currently stocked out of oral contraceptives, about 10 percent of emergency contraceptive pills and less than 10 percent of injectables. Although few pharmacies stocked

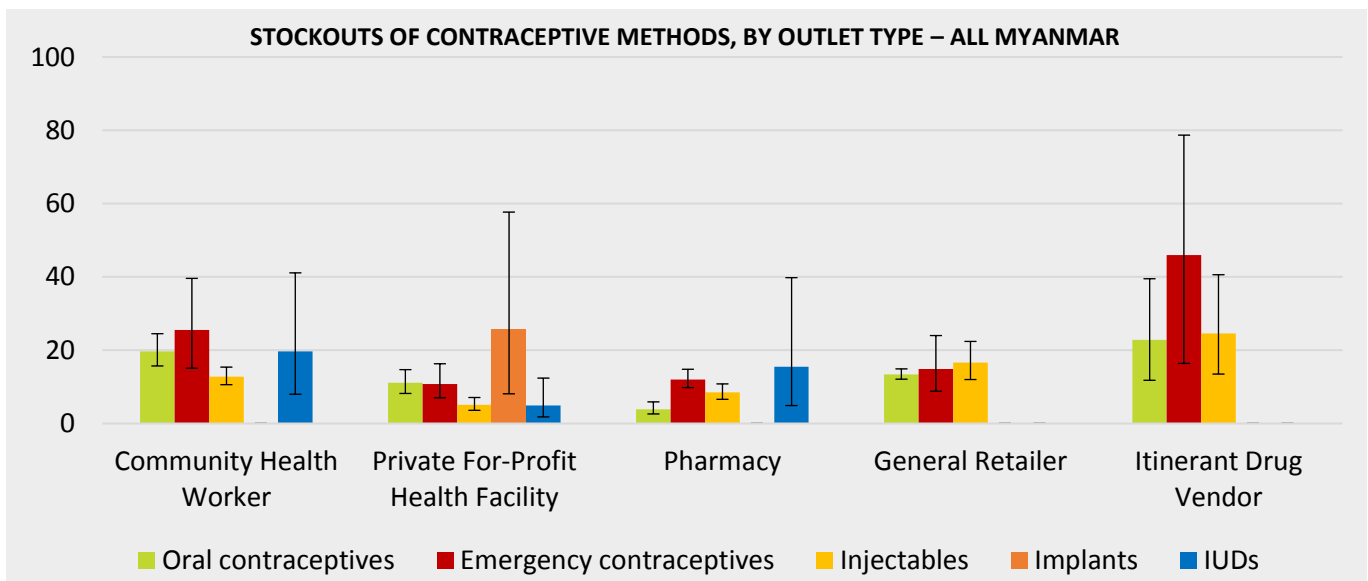
IUDs in the previous three months, of those that did, over 15 percent were currently stocked out.

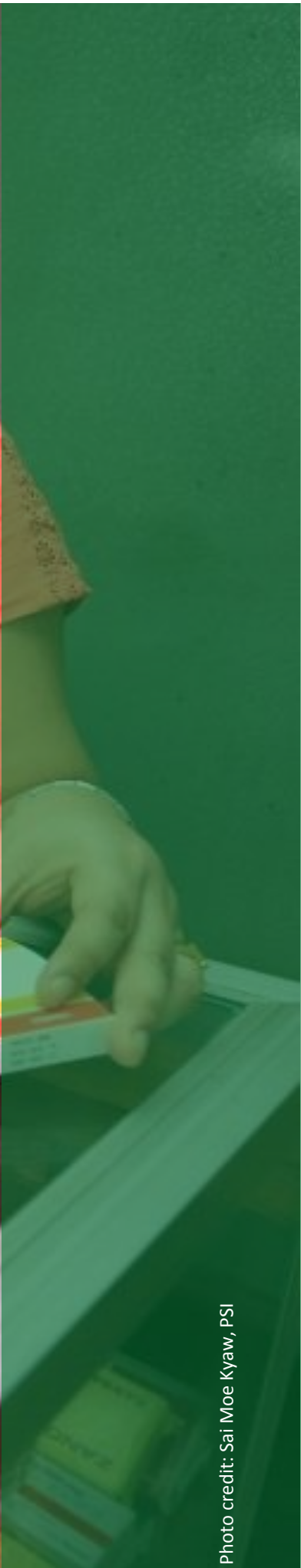
Among other private outlet types, about 15 percent of general retailers reportedly stocking the method were currently stocked out of oral contraceptives, emergency contraceptive pills and injectables. For IDVs, almost one-quarter of those reportedly stocking the method in the previous three months were currently stocked out of oral contraceptives and injectables, methods more commonly stocked by IDVs.

There were some differences in stock outs by strata. Generally, stock outs were about twice as common in urban areas for oral contraceptives and injectables among those outlets stocking them in the previous three months and four times as common compared to private outlets in metro areas.



Photo Credit: PSI





Private sector contraceptive market share

Market share by method and private outlet types

WHAT IS CONTRACEPTIVE MARKET SHARE?

Market share of modern contraceptive methods, or the relative share of distribution by outlet type and method type of the total volume distributed directly to the individual consumer, is estimated using information about reported distribution of each commodity sold during the one-month period preceding the survey. Market share is reported in couple years of protection (CYP). **CYP is the estimated protection provided by contraceptive methods during a one-year period.** Volume distributed for each method type is converted to CYP by a conversion factor specific to each method.¹⁰ The graphs on this and the following page show contraceptive market share as a proportion of the total CYP by outlet and method types for all Myanmar and by strata, respectively. The second graph on page 24 and graph on page 25 present market share as a proportion of the total CYP within outlet types by method for all Myanmar and by strata, respectively.

The CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor.

For example, 1 sterilization service equals:
 139.5 Oral contraceptives
 37.2 Injectables
 ~3.7 Implanon implants
 ~2.0 IUDs

UNPACKING THE PRIVATE SECTOR CONTRACEPTIVE MARKET SHARE

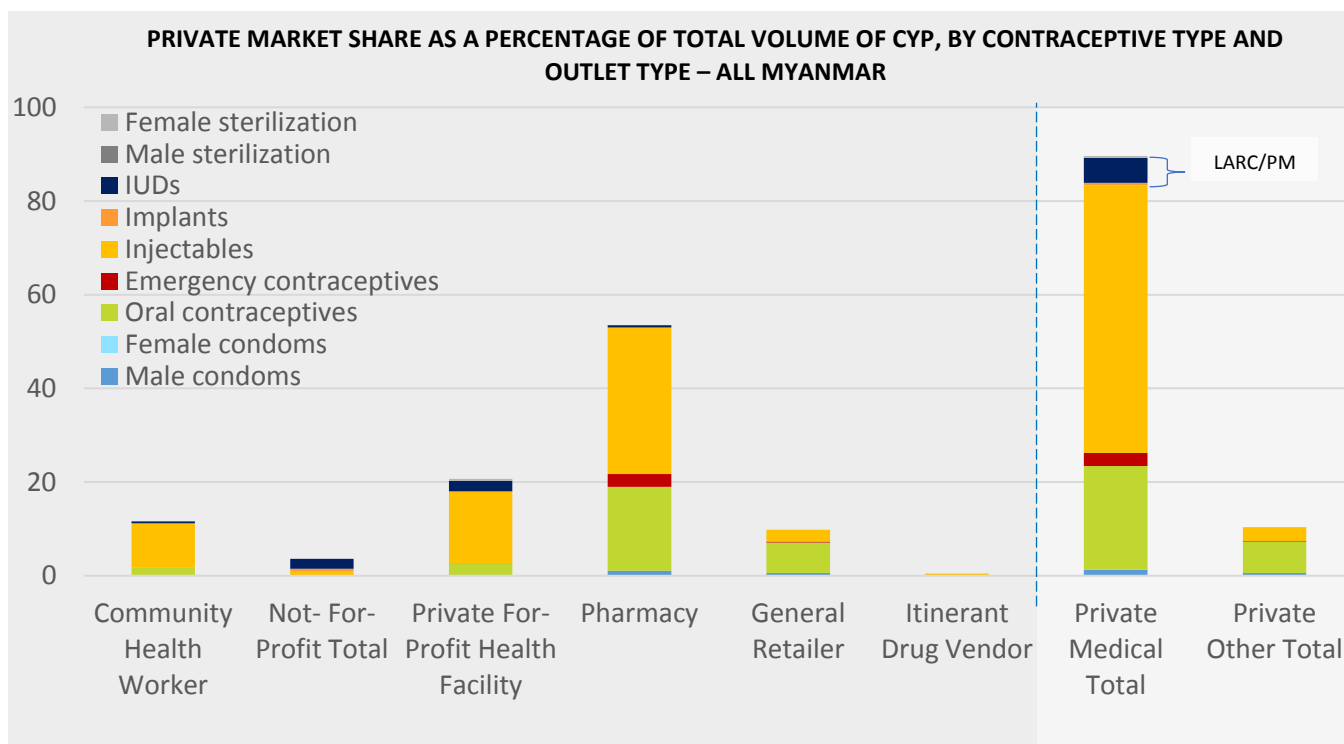
The majority of the private sector market share (54 percent) was from pharmacies, followed by 21 percent from private facilities and 12 percent from CHWs. In particular, injectables distributed by pharmacies accounted for almost one-third of the entire market share for Myanmar and oral contraceptives from pharmacies, nearly another 20 percent. An additional 10 percent of the market share was from general retailers. Not-for-profits and IDVs accounted for 4 percent and 1 percent of the total private market share, respectively. Most of the private sector market share was accounted for by contraceptive injectables (60 percent), followed by

54%

Pharmacy contribution to contraceptive market share of total CYP in the private sector

6%

Percent of CYPs, across outlets, accounted for by LARC/PMs



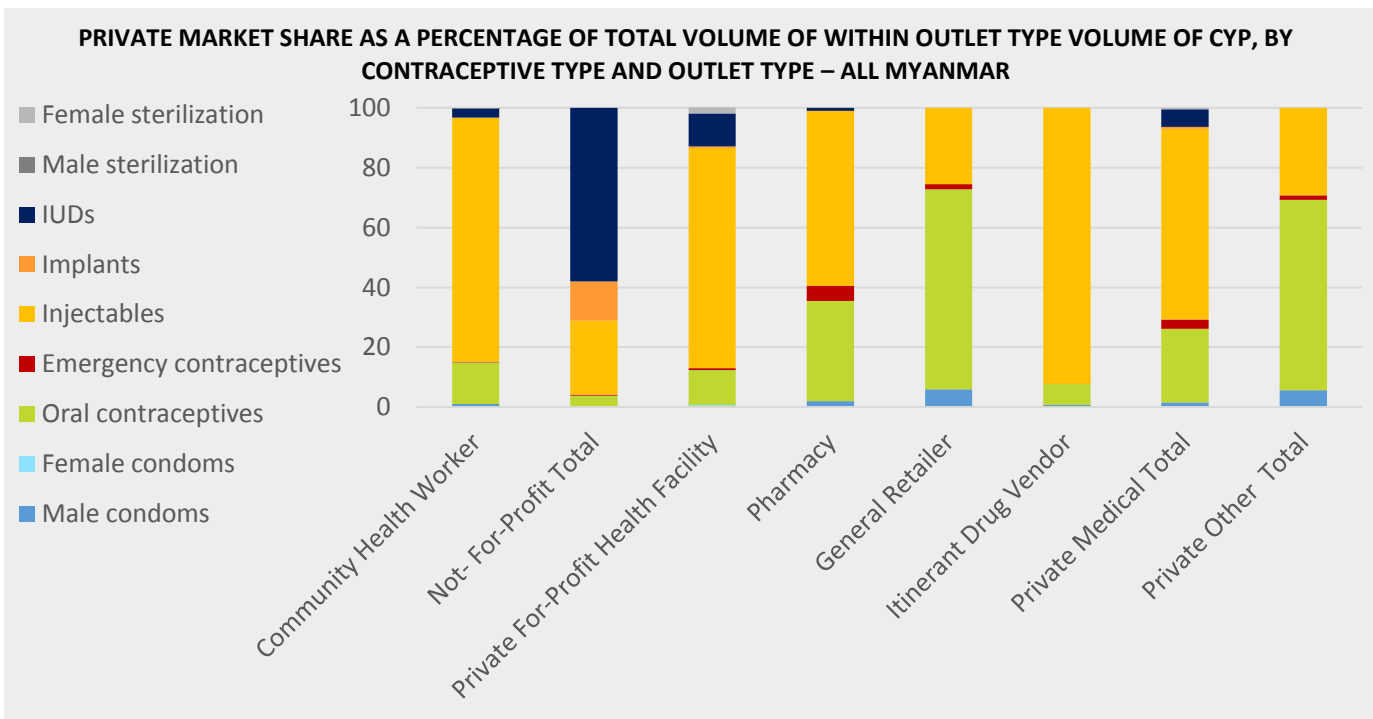
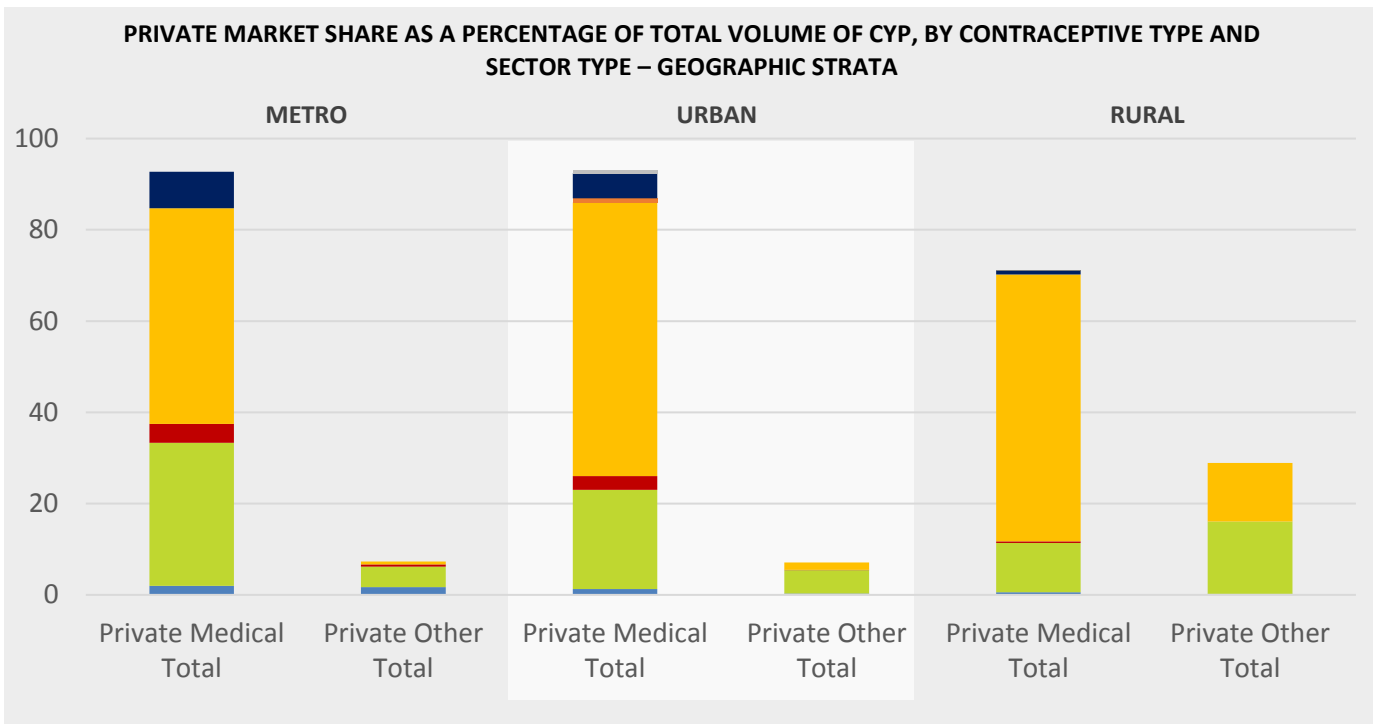
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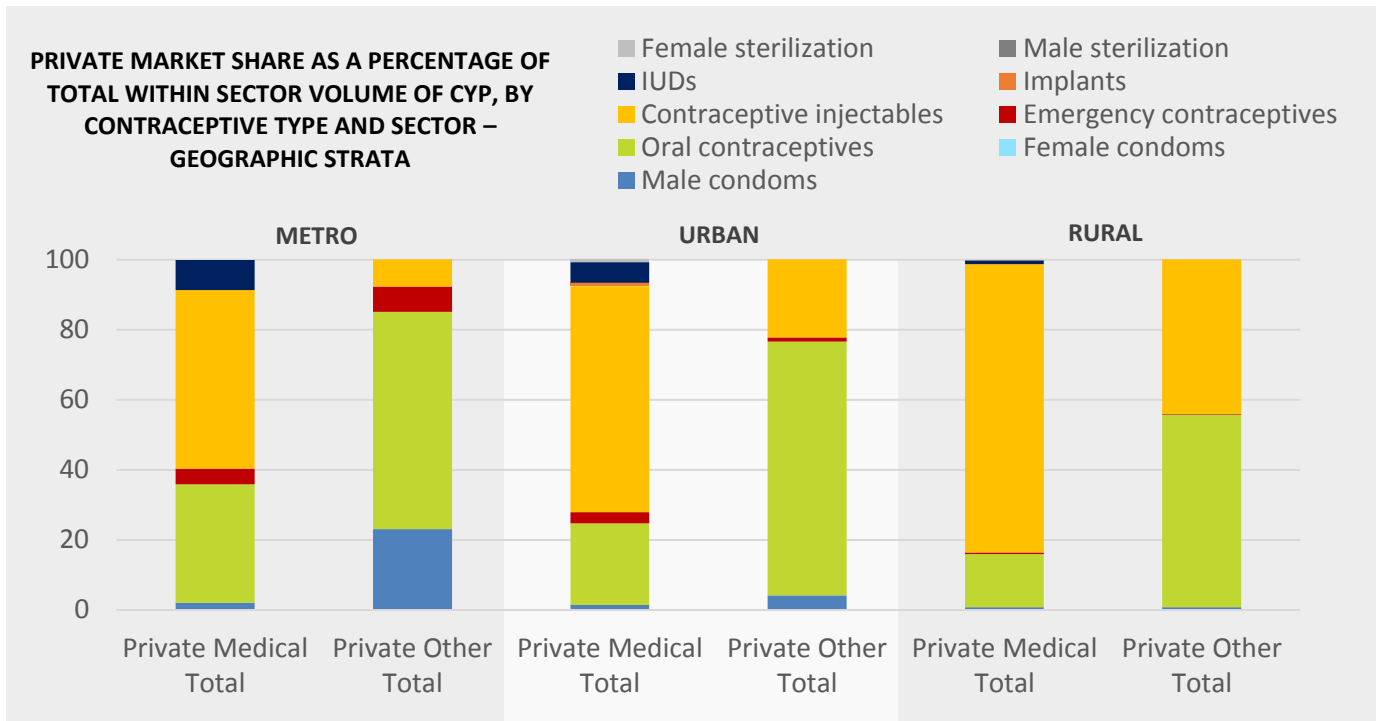
11. The RESPOND Project technical meeting, 2011. *New Developments in the Calculation and Use of CYP and Their Implications for Evaluation of Family Planning Programs*. Accessed via: http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/fp/cyp on September 8, 2015.

- Female sterilization
- Male sterilization
- IUDs
- Implants
- Contraceptive injectables
- Emergency contraceptives
- Oral contraceptives
- Female condoms
- Male condoms

Injectables account for about **60%** of the private sector market share; ranging from 48% in metro areas to 62% in urban areas and highest in rural areas at 71%

Oral contraceptives account for **29%** of the private sector market share; ranging from 27% each in urban and rural areas and highest in metro areas at 36%





LARC/PMs account for only:
8% of metro private market share
8% of urban private market share
1% of rural private market share

oral contraceptives (29 percent). LARC/PMs accounted for 6 percent of the private market share, primarily from distribution of IUDs (5 percent). Emergency contraceptive pills and male condoms accounted for less than 3 percent of the market each. Within private facility market share private facilities was largely from injectables across outlet types, except for general retailers, where oral contraceptives accounted for a larger share of the general retailer CYP volume.

HOW DOES PRIVATE MARKET SHARE DIFFER AMONG GEOGRAPHIC ZONES?

Among the strata, there were significant differences in market share comparing metro, urban and rural strata. Specific private outlet types are not distinguished, but estimates can be found in the Myanmar FPwatch reference report. In metro areas, 80 percent of the total CYP volume coming from this stratum was accounted for by private facilities and pharmacies (40 percent each). In the urban stratum, 84 percent came from private facilities and pharmacies (18 percent and 66 percent, respectively). However, in rural areas, nearly half the market share

comes from private CHWs (46 percent) with an additional 26 percent from general retailers and 19 percent from pharmacies. CHWs and general retailers account for significantly less market share in rural and urban areas (about 5 percent and 7 percent each, respectively). In addition, a larger share of the market is accounted for by not-for-profit outlets in metro areas (8 percent) in metro areas and IDVs (3 percent) in rural areas, compared to other strata.

Comparing method contributions to the market share by geographic strata, 84 percent of the private market share in metro areas comes from injectables (48 percent) and oral contraceptives (36 percent). LARC/PMs account for 8 percent of the metro market share (all from IUDs). In urban areas, an equally high proportion of the market share (89 percent) is accounted for by injectables (62 percent) and oral contraceptives (27 percent), with 8 percent from LARC/PMs (6 percent from IUDs and 1 percent each from implants and female sterilizations). Rural areas show the highest proportion of the market share accounted for by injectables (71 percent) of the three strata, with an additional 27 percent from oral contraceptives. These two methods alone account for 98 percent of the rural market share in the private sector. IUDs are the only LARC/PM with 1 percent or more of the market share (at 1 percent).



Photo credit: Sai Moe Kyaw, PSI

Readiness to provide contraceptive services in the private sector

This section addresses the private sector readiness to offer provider-dependent contraceptive services (or procedures) according to Myanmar family planning guidelines. It addresses availability and service readiness to provide contraceptive services.

WHAT PROVIDER-DEPENDENT CONTRACEPTIVE SERVICES ARE OFFERED AND WHERE?

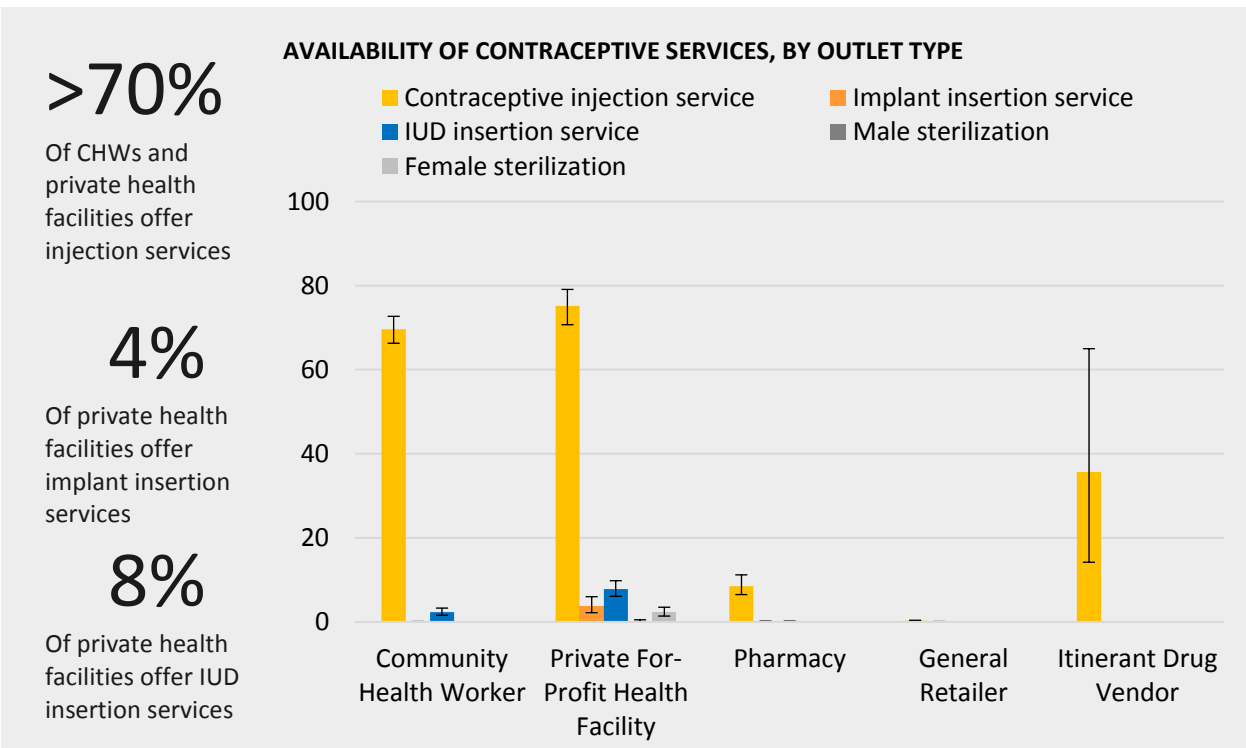
This graph shows the percentage of outlets with selected provider-dependent procedures available among all screened outlets of the outlet type.

Relatively low percentages of all private outlet types screened offered services other than contraceptive injections. For this service, over two-thirds of CHWs and over three-quarters of private facilities offered contraceptive injection services. In addition, about one-third of IDVs (predominantly in rural areas) and about 10 percent of pharmacies offered injections.

Other procedures were rarely offered in private outlet types among outlets screened, except for small proportions of private facilities offering implant insertions (4 percent), IUD insertions (8 percent) and/or female sterilizations (2 percent). An additional 2 percent of CHWs reportedly offered IUD insertion services.



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ARE OUTLETS MEETING QUALITY STANDARDS TO DELIVER PROVIDER-DEPENDENT CONTRACEPTIVE SERVICES?

In the service readiness graphs on the following page, overall *service readiness* is given for contraceptive injection, implant insertion, IUD insertion and female sterilization procedures among outlets reportedly offering the selected service. With the exception of contraceptive injections, service readiness estimated for all outlet types should be considered in the context of small sample sizes given low offering of the services and the compounding of missing data from one or more of the three criteria. Readiness to provide contraceptive services is a composite indicator combining: 1. Availability of the contraceptive on-site on the day of the survey; 2. Availability of a credentialed and trained provider, on current staff; and 3. Availability of a sentinel set of equipment needed for the service*

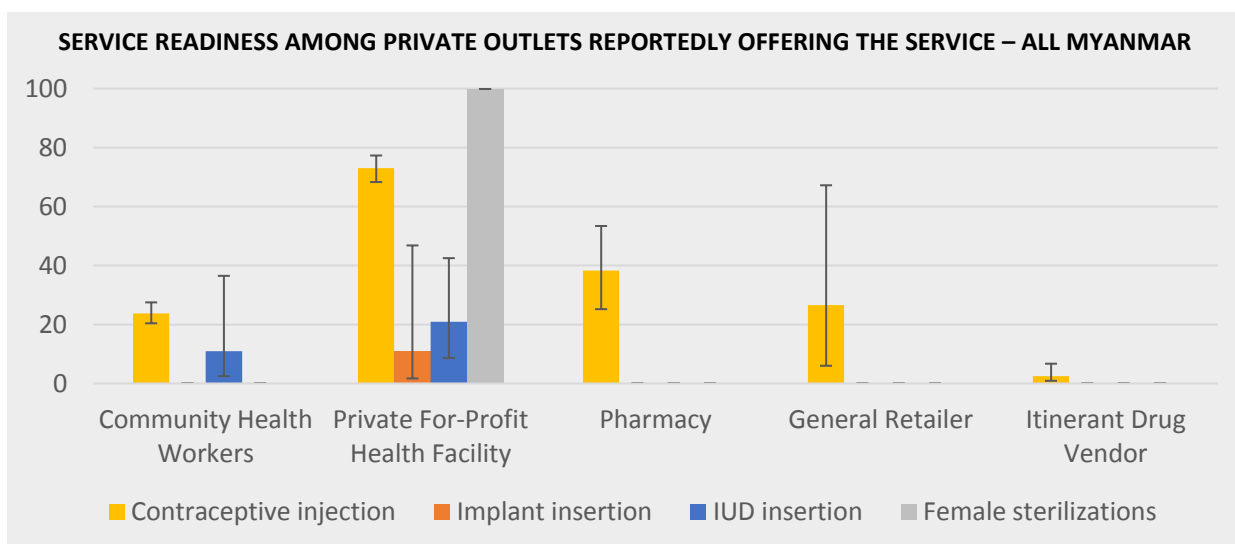
For injection services, only about one-quarter of CHWs and nearly three-quarters of private facilities met criteria for service readiness. For CHWs, about 30 percent did not stock the commodity, 60 percent did not have credentials/training to provide the service and 30 did not have necessary equipment. For facilities, the lack of the physical commodity was the most common criteria lacking for meeting full service readiness. In pharmacies, about 40 percent of those reportedly offering the service were service ready whereas it was only about one-quarter of general retailers and less than 5 percent of IDVs. Low service readiness was predominantly due to lacking credentials/training to perform the service.

Few private outlets offered LARC/PM services, but among those that did (predominantly private facilities), service readiness was generally low, often due to lack of availability of the commodity. For female sterilizations, while nearly all private facilities met the three criteria for service readiness, there was significant missing data for these services in facilities.

Readiness to provide contraceptive services is a composite indicator combining:

1. Availability of contraceptive on-site (not applicable to sterilizations);
2. Availability of a trained/credentialed providers; and
3. A sentinel, minimum set of equipment needed for the service.

If an outlet meets all 3 conditions, it is classified as service-ready.



* Full service readiness is defined as having available: 1. The commodity (not applicable for male/female sterilization); 2. A provider with credentials and/or training to perform the service (per correspondence with Myanmar Government Ministry of Health and Sports and other FP stakeholders); and 3. A minimum set of sentinel equipment (http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/long-acting-permanent-methods/percent-of-facilities-with-appropriate) for providing the service.



Modern contraceptive private market prices

WHAT IS THE COST PER CYP IN USD, FOR CONTRACEPTIVE METHODS IN THE PRIVATE SECTOR?

Prices for contraceptive methods were standardized across methods by converting into price per CYP. The following graphs report *median USD price and price per CYP with interquartile ranges* for all brands of a method in the private sector outlets. The prices listed are those incurred by the end-user and do not necessarily reflect any subsidy that may be provided. Prices for commodities with a service component may reflect cost of the service as well.

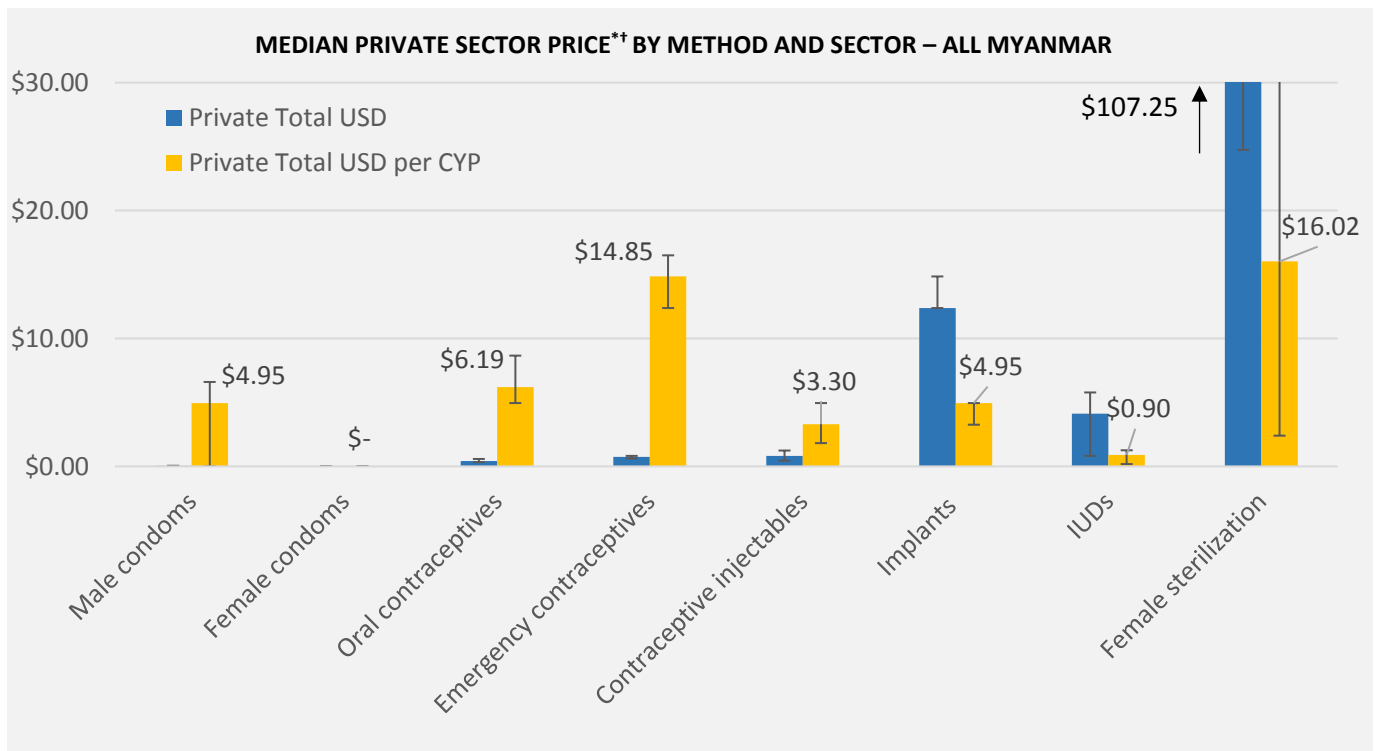
The median price per CYP in private outlets for injectables and oral contraceptives, the largest market share contributors in Myanmar, was \$3.30 USD per CYP and \$6.19 USD per CYP, respectively. Median price for emergency contraceptive pills, male condoms and implants were higher compared to the most common methods. Median price for female sterilization was considerably higher in the private sector at \$16.02 USD per CYP. The most cost-efficient method in the private sector was IUDs at \$0.90 USD per CYP. Prices did not vary much between strata and specific outlet types.



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3x

The increase in price of one CYP for injectables (largest market share) compared to IUDs in Myanmar's private sector



* Price may include a service charge in those outlets offering both the commodity and service.

† Based on the average rate of exchange from February 26th to May 19th, 2016 of 1,212.121 Myanmar Kyat per 1 USD.



Summary

While Myanmar is making strides toward achieving its ambitious FP2020 goals for CPR and reaching additional women with modern contraceptive methods, FPwatch findings on the private sector family planning market suggest that there is potential to expedite progress toward FP2020 commitments, leveraging the private sector to provide increased access and choice to women and men in Myanmar.

This 2016 FPwatch study was conducted in 14 states and divisions, covering 670 fully-censused, representative wards and village tracts. It was conducted among 7,791 private outlets with modern contraceptives and/or services and they survey provides total market data for the total contraceptive-supply environment in the Myanmar private sector. Together, with the 2014 – 16 reproductive health commodities and services facility assessments conducted by the Myanmar government and the United Nations Population Fund (UNFPA), these surveys provide a picture of the total contraceptive market in Myanmar.

The data is relevant for monitoring and informing the Myanmar's FP2020 commitments, recent public and private initiatives and investments and as part of the market development approach for understanding the Myanmar's contraceptive environment. The FP2020 commitment is critical to Myanmar's long-term goals. Reducing unmet need to 10% and increasing mCPR to over 60% are seen as key steps towards Myanmar's development path.



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An integral part of Myanmar's commitment to FP2020 in 2013 is to boost partnerships with the private sector with the aim to increase family planning services and commodities on a wider scale. The FPwatch study conducted among the private sector demonstrates considerable potential for achieving this aim. The FPwatch survey found nearly 7,800 private outlets delivering family planning commodities and services (over one-fifth of outlets approached). These outlets and providers ranged from mobile itinerant drug vendors and stationary general retailers to large private metro hospitals.

As demonstrated by FPwatch findings, a significant portion of outlets (>40%) consisted of general retailers, often stocking oral contraceptives and accounting for almost 10% of the total private market share. With IDVs, these, often untrained health providers, comprised nearly two-thirds of private outlets delivering family planning commodities and services and accounted for over one-quarter of the market share in rural areas. General retailers also experienced higher rates of stock outs compared to other outlet types, with about 15% of general retailers stocking the method in the previous three months being currently stocked out of oral contraceptives and nearly one-fifth of contraceptive injectables. Stock outs for these methods among general retailers also tended to be highest in rural areas.

A significant portion of these private outlets providing commodities and services also consisted of pharmacies (one-quarter) which was higher in metro and urban areas (over one-third) and accounted for over half of the total market share for all of Myanmar and two-thirds in urban Myanmar. Pharmacies were the most likely outlet type to offer a diversity of methods with nearly half of those screened offering three or more methods, primarily oral contraceptives, contraceptive injectables and another method. In addition, about 10% of pharmacies offered injection services, but these pharmacies did not often have trained staff to deliver injection services.

Community health workers or trained health workers (non-doctors) were also significant actors providing contraceptive commodities and services in the private sector within their communities. They accounted for 16 percent of the total market composition and an equal proportion of the total volume of private sector volume in CYP. CHWs were much better represented in rural areas, with nearly one-third of providers or facilities stocking a modern contraceptive, and responsible for almost half of the total share of rural area private sector CYP volume. A small portion (about 10%) also were found to be offering three or more methods, predominantly oral contraceptives (about one-quarter of CHWs screened), injectables (almost half) and one other method. Over two-thirds of CHWs offered contraceptive injection services but only about one-quarter of those were found to be service ready, often lacking training, credentials, and commodities to provide this service. A handful of CHWs also reportedly offered IUD insertion services. CHWs experienced higher rates of stock outs compared to other outlet types, with about 20% of CHWs stocking the method in the previous three months being currently stocked out of oral contraceptives and 15% being stocked out of contraceptive injectables. Stock outs for these methods among general retailers also tended to be highest in rural areas.

Private facilities, comprised of large hospitals, polyclinics and GP clinics, comprised 15% of the total market composition ranging from nearly one-third in metro areas to one-fifth in urban areas and only 3% in rural areas. Private facilities, which also accounted for one-fifth of the total private market share of CYP, were highest in metro areas (40%). Approximately one-fifth of private facilities screened stocked three or more methods and a handful stocked five or more methods on the day of the survey. Private facilities were the



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most likely private outlet type to offer LARC/PM services, but these commodities and services were still rarely provided in the private sector. Less than 5% of private facilities stocked an IUD or provided an IUD insertion service. Only a handful of private facilities stocked a contraceptive implant or provided an implant insertion service and less than 3% offered female sterilization services. For LARC/PM services, few private facilities met service readiness criteria for offering the service, with the exception of female sterilizations, which were challenging to estimate due to low sample size. Availability of services tended to be highest in urban areas compared to metro and rural areas.

In addition to these private outlet types, not-for-profit outlets and IDVs also played minor roles in the private contraceptive market. Although their numbers were small in metro areas, not-for-profits accounted for 8% of metro market share, were very likely to have three or more methods and to stock or provide LARC/PM commodities and services. IDVs largely played a role in rural areas, accounting for 5% of that stratum's market composition and 3% of the rural area volume of commodities and services in CYP. Most of this share was from contraceptive injectables, with over one-third offering the associated service but few of these meeting service readiness criteria for contraceptive injections. Also, almost one-quarter of IDVs stocking oral contraceptives or injectables in the previous three months were currently stocked out of one or both methods.

There were several challenges associated with disparities in access to trained providers between regions, high proportions of stock outs of common methods and low service readiness for contraceptive injections. In addition, the FPwatch data indicate several challenges with meeting Myanmar's FP2020 objective to improve method



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mix with increased use of LARC/PMs, especially in relation to the private sector's role in meeting this objective. As demonstrated by the FPwatch survey, there is a large reliance on just two methods (contraceptive injectables and oral contraceptives) in the private sector. Only pharmacies were found to have large proportions of those screened with three or more methods offered and very few outlets had five or more methods or a LARC/PMs offered. Even trained providers were not likely to have implant or IUDs in stock or to provide implant insertion, IUD insertion or female sterilization services. Only 6% of the total private market share was accounted for by LARC/PMs, which was only 1% in rural areas. Moreover, IUDs are considerably more affordable per CYP (three times) compared to the commonly used oral contraceptives and injectables. Overall, the FPwatch survey demonstrates significant room for improvement

in engaging the private sector to improve method mix and increase use of LARC/PMs.

Assessing progress toward FP2020 goals and national Myanmar policies

The contraceptive market findings in the private sector of Myanmar demonstrate a significant role for the private sector in meeting FP2020 goals and national objectives. They also demonstrate significant potential for public-private partnerships and for leveraging the private sector to improve access to a choice of modern contraceptives for the women and men of Myanmar. There are challenges in improving upon geographic disparities of access, improving choice and improving access to quality family planning services and procedures. However, there also appear to be some successes. For example, the large absolute number of private providers (significantly larger than other FPwatch countries) with the capability to offer family planning commodities and services highlights the large untapped potential of the private sector to contribute toward FP2020 goals and national objectives. Overall, the FPwatch survey in Myanmar provides key data to inform and supplement contraceptive market monitoring and highlights key action points toward the Myanmar's FP2020 goals.

Acknowledgements

We would like to acknowledge:

The 3MDG Fund for their generous support, UNFPA for their technical insights, the Myanmar Marketing Research and Development Co., Ltd. team for their conduct of the survey and the government of Myanmar for their generous support throughout all phases of the research.

Dr. Tin Aung, Daniel Crapper, Saw Pa Pa Naing, Dr. Swai Mon Oo, Dr. Aye Kyawt Paing, Leah Mari-Richards, Dr. May Me Thet, Barry Whittle, Dr. Myint Myint Win from PSI-Myanmar;

Dr. Katie Bates, Dr. Nirali Chakraborty, Keith Esch, Catharine Hurley, Danielle Garfinkel, Tarryn Haslam, Tabeth Jiri, Aliza Lailari, Dr. Megan Littrell, Julius Ngigi, Jen Pope, Justin Raharainiaina, Mac Shoen, Dr. Bryan Shaw and Kate Thanel from the ACT/FPwatch team;

Dr. Jane Bertrand, Veronique Dupont, Janine Hum, Amy Lin, Dr. Scott Radloff and Dr. Prashant Yadav from our Technical Advisory Group.

Lastly, we would like to thank the members of the quality control team, the supervisors, members of the questionnaire traffic control team, the enumerators and all of the providers who participated in these surveys. Your contributions are invaluable.

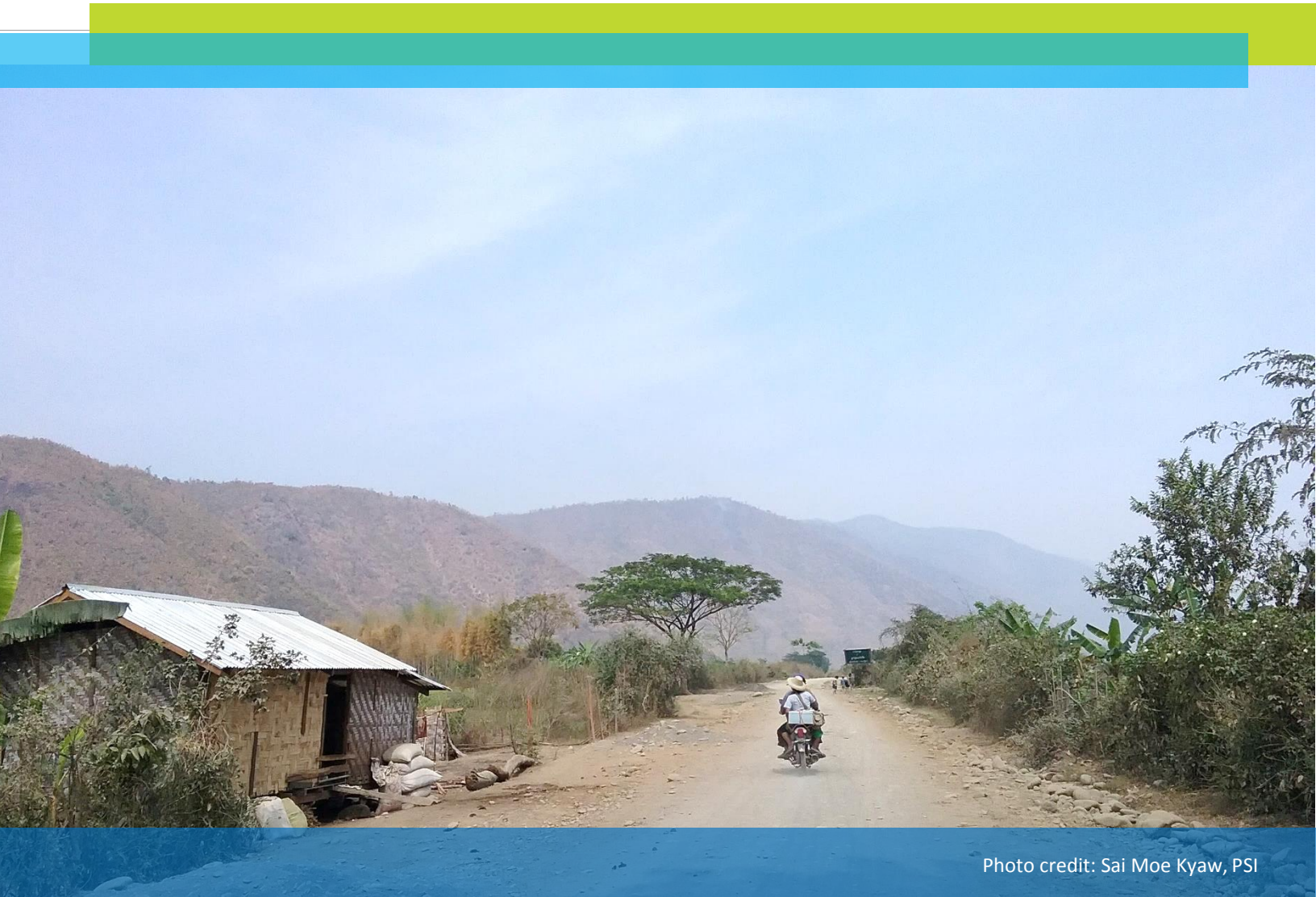


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FPwatch is a multi-country research project designed to provide timely, relevant and high quality contraceptive market evidence. Launched in 2015 with funding from the Bill and Melinda Gates Foundation, it is currently implemented in 5 countries with additional funding from the Three Millennium Development Goal Fund in Myanmar. Standardized tools and approaches are employed to provide comparable data across countries and over time.

The project will inform FP market strategies and priorities for national Ministries of Health and their partners. Additional resources are available on the website (www.fpwatch.info).

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