8th Asia Pacific Conference on Reproductive and Sexual Health and Rights

(Myanmar International Convention Centre – II)

Abstracts and Rapporteurs' Report

Date: 23-26/2/2016

Nay Pyi Taw, Myanmar

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Acknowledgements

Thee Convenor of 8th APCRSHR would like to thank the abstract paper presenters, both oral presentation and poster presentations, from (33) countries of Asia Pacific Region on contributing and sharing their technical expertise, experiences and innovative ideas and research findings. All these contributed to the success of the conference.

All the presentations are very useful, good and applicable in our Asia Pacific Region, the convenor would like to compile those tip top papers in order to organize and keep as valuable souvenirs of the 8th APCRSHR.

Moreover, it is indebted to Dr. Thein Thein Htay (Deputy Minister, Ministry of Health, Myanmar), Dr. Yi Yi Myint (Chair of the Scientific Committee), members of Scientific Committee and International Steering Committee on reviewing and selecting the best papers, and also on the Rapporteur General, Dr. Myint Htwe, lead rapporteurs from National and International and all the rapporteurs for their excellent services.

Most of all, we thank Dr. Dr. Ei Ei Maung, Daw Aye Thiri Myat and Daw Soe San Oo for their dedication and arranging ‘‘Abstracts and Rapporteurs’ Report of the 8th APCRSHR”. In addition, the Convenor would like to thank Xenon Company for printing and providing necessary assistance.

Thank you very much.

Thazin Nwe

Convenor of 8th APCRSHR

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Forced, forbidden or failed: Sex and marriage laws and policies in Asia-Pacific

Lecture Room (1)

a) **Ensuring the Reproductive and Sexual Rights for child brides in Rural India: Looks like a way too far!**

Aparna Mukherjee,India

The Millennium Development Program aims to provide aworld where every woman is free to decide whether and when to have children; where every woman has access to the best reproductive health facility; where every woman can exercise her choices without coercion or discrimination. Unfortunately, for large number of girls in India, this choice is an unrealistic dream. In India 47% of the girls get married below the age of 18 years and in places where other socio-economic indicators are limited for girls; the vulnerabilities may raise by many folds. The lack of power associated with child marriage poses additional reproductive health risks. Unfortunately, these large numbers of girls are ignored in the larger reproductive health policies and therefore, there is a need to understand the ways in which early marriage may compromise young women's lives and their reproductive health and choices and suggest for interventions and targeted programs to ensure them with better choices.

This paper aims to find out the association between the timing of marriage and its association with sexual and reproduction health choices. Also to identify the underlying factors that makes these child brides more vulnerable other than their age at marriage. This paper uses both quantitative and qualitative data collected in Shrawasti district of Uttar Pradesh, where 83% of the girls get married below the age of 18 years. Data is collected from 400 women between the age group 18-25 years who were married below the age of 18 years. In-depth insights from qualitative study on the lived experiences of these young women are also provided in the paper.

Findings show that the younger the age at marriage, girls are3.5 (odds ratio) times more likely to experience forced sex. Those who were married at ages between 16-18 years are more likely to have attempted to stand against physical violence or sexual violence in their marriage as compared to the younger girls. Education of the spouse, economic stabilityof the parental home, mother‘s education, proximity to urban area and health centre were some of the factors that have important role apart from the age at marriage in determiningthe reproductive choices of these young women. Choice of contraceptives to delay the pregnancy (1.5) or decision to have their first birth in the health facility (1.7) were more among women from nuclear families and where husbands have schooling over 12th standard. Qualitative study finds that strong son preference and low status of women have significant impact on her limiting her reproductive and health choices.

Therefore, findings emphasize not only the need to reinforce the laws and programs against child marriage but to address the needs of young women so that they can be guaranteed with larger reproductive choices and sexual rights. It can be done through awareness programs, door-to-door dissemination of information, strengthening the field

health workers to popularize pro-gender attitudes towards family planning that can enable them with better choices and secure a healthy life for themselves and their children.

b) **Preventing child marriages in India: whether financial incentive schemes help in enhancing the age at marriage of girls?**

T.V. Sekher, India

In India, there are about twenty conditional cash transfer (CCT) programs being implemented now in different states aimed at the welfare of girls, mainly for promoting their school education and for enhancing the age at marriage. The ongoing CCT programs in general are complicated with multiple objectives and targeted to specific groups- for poor households, families having girls and families with only girls. The present study, sponsored by UNFPA, attempts to assess one of such financial incentive schemes - Dhanlakshmi- of Government of India being implemented on a pilot basis in seven states since 2008 to understand its implication for preventing child marriages in rural areas.

According to official statistics, 3,36,770 girls have been enrolled into the scheme during 2008 to 2013. In order to assess this scheme, it was decided to conduct a household survey of both beneficiary and non-beneficiary households from the Dhanlakshmi scheme blocks. Accordingly 2150 beneficiary and 1806 non-beneficiary households were interviewed from 5 states (Punjab, Bihar, Odisha, Andhra Pradesh and Jharkhand) during September, 2013 to February, 2014. A beneficiary household is one in which at least one girl is enrolled into Dhanlakshmi scheme at the time of the survey. A non-beneficiary household is one having an eligible girl (1-14 years of age) but not enrolled into the scheme. The beneficiary and non-beneficiary households are similar in terms of socio-economic conditions and have equal access to education and health facilities. Apart from household survey, the qualitative information was collected through key informant interviews, case studies and focus group discussions.

One of the objectives of the Dhanlakshmi scheme is to prevent child marriages and the one condition to receive the terminal benefit of Rs.100,000 (approx. USD 750) is that the girl should remain unmarried till she completes 18 years of age. The study found that this condition had significant impact among the parents of beneficiary girls (comparison to non-beneficiary households) wherein three-fourths of them stated that even if they get a good marriage proposal for their daughter, they will only arrange her marriage after she completes 18 years. The intention and willingness to delay the marriage of the daughter is an indication of the parental preference for receiving the lump sum money, more so among the economically weaker households. The age at marriage of girls may increase not only because of the conditionality under the scheme to receive terminal benefit but also the scheme insists upon the continuation of girl's education up to a certain level, which indirectly delays their marriage. Evidences from all over the world illustrate that ensuring education for girls and their retention in schools is the best and most effective pathway to delay their marriages. It is evident that financial incentives through CCT schemes for girls can drive positive changes in an otherwise resistant social environment prevailing in villages where child marriages are common. The emerging evidence from the study

strongly advocates the continuation of CCT schemes for girls by restructuring the incentives and targeting the socially and economically weaker sections.

c) **Policy Options for Teen Pregnancy Prevention in the Philippines**

Reynaldo Ong Wong, The Philippines

The Commission on Population's Philippine Population Management Program (PPMP) thru its Adolescent Health and Youth Development (AHYD) strand, addresses the concerns of young people to help them achieve their total well-being. Unfortunately, as in any development initiatives, many challenges confront the accomplishment of AHYD's mission. Notable among which is the rising incidence of pregnancy among teenagers. In the Philippines, the reasons for becoming pregnant among teens range from unplanned sexual encounters and peer pressure to lack of information about protected sex, breakdown of family ties, lack of good female role model in the home and the absence of accessible and adolescent-friendly health facilities. Currently, there are no specific and direct laws that address the growing problem of teen pregnancy in the country. In the broadest sense, this body of work attempts to recognize teen pregnancy as a serious societal problem necessitating policy intervention. Specifically, this paper strives to describe and analyze public policy options geared towards teen pregnancy prevention, to wit:

a) policy standards to assess the readiness of pre-service teachers in handling adolescent sexuality and reproductive health education;

b) policy incentives for telecommunication companies which will exercise corporate social responsibility in disseminating messages via social marketing approach to help the government in the campaign against teen pregnancy; and,

c) policy for the establishment of adolescent and youth responsive health service facilities in schools and communities in the country. On the strength of the policy analysis conducted, it appears that the most viable one is the application of standards in gauging the readiness of pre-service teachers in handling sexuality and reproductive health education. Not only it ensures the high quality of sexuality education offered to each and every adolescent in school, the policy also insures the sustainability and comprehensiveness of sexuality education in schools because the teachers are happy knowing that they are fully prepared for the job - academically, affectively and attitudinally.

Improving access for hard to reach populations

Lecture Room (2)

a) **Ethnic Minority Midwife Initiative in Difficult-to-Reach Regions of Vietnam**

Dat Duong, Viet Nam

Background

Over the last two decades, although Viet Nam has attained remarkable achievement in health status of the general population, current data show that reproductive health status of ethnic minorities is relatively low compared to the national average. For instance, the maternal mortality ratio (MMR) amongst ethnic minorities is found to be four times higher than that of the Kinh majority group. Home-delivery rates remain higher among ethnic minorities in northern mountainous provinces, ranging from 40-60% compared with the national average approximating 1.3%. Local customs relating to pregnancy and childbirth preferences, geographical barriers, lack of transportation means, long distance travelling to health facilities and poverty are key factors that contribute to the poor accessibility and utilization of maternal health services. To improve access to and utilization of maternal health services in these regions, UNFPA had technically supported the Ministry of Health to pilot an initiative that builds up an ethnic minority midwife (EMM) network. Local ethnic minority women aged under 35 who have low education level and are nominated by their communities attended a midwifery training course at clinical settings for a duration of 6, 12 or 18 months depending on geographical difficulties, reproductive health needs of the community and capacity of local health staff.

Objective

To document lessons learned in building ethnic minority midwife network in mountainous and difficult-to-reach regions of Vietnam.

Results

To date 1,616 EMMs were trained for 6 months, 42 for 12 months, and 79 for18 months.. During 2006- 2010, more than 100,000 normal deliveries in ethnic minority regions were safely assisted by EMMs and thousands of high-risk pregnancies and obstetric complications were detected and referred to higher level health settings. EMMs who attended 6 month training could provide antenatal care, normal delivery and postnatal care services while those who attend 12-18 month training could provide basic aid for complicated cases. Particularly, those who attended 18 month training acquired 24-26 competencies defined by WHO/ICM, of which 85% were able to perform techniques to manage post-partum hemorrhage. To replicate the initiative in a larger scale, the government should further improve policy frameworks to facilitate their performance of EMM post training including continuing education and technical supervision. In particular, the selection criteria for EMM training and recruitment should be nationally standardized. In addition, actual needs for three options of EMMs training in ethnic minority provinces should be appropriately determined. Moreover, an official mechanism to ensure provincial authorities to allocate adequate local budget to maintain the EMM network should be established.

Conclusions

The ethnic minority midwife initiative shows early positive results and highly appreciated by the Ministry of Health and local authorities. Future operational research should be conducted to generate cost-effectiveness evidence of the EMMs in the different regions. In addition, innovative approaches using ICT should be further explored to facilitate their work and address their learning needs.

b) **Mapping Technique for Assessing Maternal and Child Health Service Coverage**
Kyaw Myint Tun, Myanmar

Background: Migration is dynamic and internal migration is also a growing phenomenon globally including Myanmar. Anecdotal evidence from 2 delta townships suggested that migrant mothers had less access to maternal and child health services than the general population and were overrepresented in cases of maternal mortality. This study aimed to advocate migrant mapping techniques as an important tool for exploration of maternal and child health needs of migrants and investigate how further identification of migrant typologies could be useful for migrant health programming.

Methodology: Participatory migrant mapping was conducted with basic health staff, non-government organization staff, volunteers and local authorities. GPS measurement was made at migrant clusters to develop migrant mappings of Bogale and Mawlamyinegyun Townships with the use of GIS software. Health Management Information System data by rural health center level were taken for health mapping and then matched with migrant mapping. A quantitative survey was conducted to 1,187 migrant households for identification of migrant typologies.

Results: Migrant mapping displayed that migrant clusters were mostly identified in Kyein Chaung Gyi, Kama Kalu, and Kadon Kani areas out of 9 in Bogale and in Kyeik Pi area out of 14 in Mawlamyinegyun Townships' rural health centre coverage areas. Health facilities mapping for Bogale and Mawlamyinegyun Townships revealed that station hospitals were available at Kama Kalu, Kadon Kani and Kyeik Pi among migrant dense areas. Among 1,187 households studied, 552 inbound migrants (47%), 63 hawkers (5%), 467 outbound migrants (39%), and 105 mobile workers (9%) were included. In health mapping, lowest maternal and child health coverage was found at Kyein Chaung Gyi showing ante-natal care 4 times - 23.4%; Skilled Birth Attendants - 30.8%; Penta 3 - 59.7%; and measles 1 - 63.3%. Migration was mainly between villages and townships within Ayeyarwaddy region and high mobility was found among hawkers and mobile workers.

Conclusions: Areas with larger migrant clusters in which no station health facility had lower coverage for maternal and child health service. High mobility related with hawkers and local mobile mothers should be prioritized for approaches to ensure all components of ante-natal care.

c) **Traditions and Current Practices of Emergency Obstetric Care among Chin Ethnics in Myanmar**

Swe Zin Linn, Myanmar

Chin State is located at highland and remote area of north-west of Myanmar. Transportation to and within the State is very difficult. Sparse population, low economic development and high cultural diversity are its peculiarities. Traditional ways of life saving for emergency obstetric problems, current preferences, acceptance and accessibilities of modern life saving methods are questions for health providers. This study was conducted to provide the information aiming to help overcoming challenges and barriers in emergency obstetric care among the ethnics.

It was a cross-sectional descriptive study covering all townships in the State and carried out during January and February 2015. Information were collected by qualitative methods from 15 traditional birth attendants from five townships of south and north part of the State. Quantitative information were collected from government health providers (Lady Health Visitors and Midwives) who are mainly responsible for obstetric care in rural areas. Information were triangulated with facts from 2014 Chin State Annual Evaluation Report.

Traditions that local people highly accepted were birthing baby in sitting position, using locally available edible oil for lubricating birth canal, handling of a rope which is tied at an overhead place for enhancing squeezing action during delivery. Uses of kitchen cooking materials for some emergencies like bleeding and retained placenta were also noted. Many people shy to deliver in lying position that modern practice accepted.

A total of 298 health providers who had average age of 34 years and work service 10 years responded to the self-administered questionnaire. They were carrying out antenatal care for 6 pregnant women and 3 deliveries monthly on average. They were taking care for one to ten pregnancies at the time of assessment. According to their responses, home delivery rate was 62%. Compliance rate for referral was 41%. Common problems for referral at their home delivery practices were ―obstructed/prolong labour‖, ―mal-presentation‖ and ―haemorrhage‖. They reported that fulfilling skills and supplies for oxytocin injection, placental removal for mothers, mucous suction and mouth-to-mouth respiration for babies would reduce referral rate and morbidities.

Common reasons for incompliances of referral were “financial constraints”, “transportation difficulties”, “accommodation difficulties for attendants”, “no attendants”, “insufficient accessories”, “traditional belief”, “disagreement of influential persons at home”, “lack of belief on information of skilled providers” and “afraid of operation procedures at hospital”.

Suggestions for improving their services include; “improving skills of providers”, “collaboration of community in referral”, giving more intensive care on cases”. Providers also pointed out need of improvement of midwife population ratio and good referral network.

Transitioning from policy to practice

Lecture Room (3)

a) **Current legal and policy frame work for Sri Lankan youth on sexual health & HIV infection**

Janaki Vidanapathirana, Sri Lanka

Youth is the transition period of life from childhood to the adulthood, defined by the United Nations for the ages between 15 and 24 years. Sri Lankan youth comprises of one fourth (4.7 million) of total population of 20.6 million. Youth are facing some difficulties to access for sexual health services. Existing Legal and policy frame work on Sexual and reproductive health of youth in Sri Lanka are important for accessing sexual and reproductive health services of youth and treatment for young people by the health care providers. This will existing legal frame work affect the health care providers attitude.

Objective

To review the existing Legal and policy frame work for Sri Lankan youth on sexual health & HIV infection

Methodology

The desk review involved review of existing literature, legal & policies related to field of Sexual and HIV infection for access and getting health services. This study reviewed the existing Legal and policy frame work on Sexual and reproductive health of youth in Sri Lanka to explore the access for sexual and reproductive health services of youth and treatment for young people by the health care providers even in the different punitive laws.

Results

Sri Lankan constitution, health policy, HIV/AIDS policy, National Policy on HIV and AIDS in the World of Work & Migrant policy support for youth to access and get treatment for sexual health. Some of the Legal barriers on Penal Code of Sri Lanka continues the criminalization of homosexuality and the Vagrants Ordinance, which targets soliciting sex in public places as a criminal offence. This provision makes it difficult to reach young commercial sex workers in order to educate them on HIV/AIDS and other STIs as well as on the importance of practicing safe sex. The school curriculum does not include comprehensive sexual education at school including contraceptives. Also legal age of marriage is 18 and consent for sex only at the age of 16 years or above. This 2 year period put them for unsafe without giving sexual health knowledge in standard method. In 2013 youth survey, 80% youth were aware of nearby free general health services, but the knowledge on available sexual and reproductive health and mental health services were poor 55% and 59% respectively. It further revealed that poor accessibility for the services is the cost as indicated by 38% of youth and out of them 50% mentioned the cost was covered by their parents.

Conclusion

Although there are many policies, laws and international conventions in place to support for access and getting treatment for sexual health, several discriminatory laws that undermine for services. Also school curriculum does not include sufficient sexual health content. This also

provided needful information to develop the national strategies by overcome of challenges and plan youth friendly health services.

b) **The Right(s) Evidence: Sex work, violence and HIV in Asia**
Julia Cabassi, Kay Thi Win, Thailand

The Right(s) Evidence: Sex work, violence and HIV in Asia is a multi-country study based on a unique partnership between UN agencies and sex worker organizations conducting research in Indonesia, Myanmar, Nepal and Sri Lanka. The award-winning, community-led process employed peer-interviewers to examine experiences of physical, emotional, sexual and economic violence in domestic, workplace and healthcare settings. Responses revealed significant gendered differences in the circumstances and experiences of male, female and transgender sex workers and that violence critically limits sex workers' ability to negotiate condom use and protect themselves against HIV and other sexually transmitted infections. The report provides an analysis of common protective strategies and risk factors for exposure to violence, finding that laws, law enforcement practices, sex work settings and collectivization significantly impact sex worker safety. Those who commit violence against sex workers continue to enjoy widespread impunity, with police identified as the most common perpetrators. The report recommends: reform to laws, policies and law enforcement practices to decriminalize sex work, protect rights and respond to violations; improved access to justice and knowledge of rights amongst sex workers; better access to services; and promotion of safe work places to reduce sex workers' vulnerability to gender-based violence and HIV infection.

c) **Analysing system's bottlenecks for integration of PMTCT into regular antenatal care services - A case study from West Papua Indonesia**
Nurlely Bethesda Sinaga, Indonesia

Background: West Papua province is considered a low-level generalized HIV/AIDS epidemic area with prevalence of 2.3%, six times the national average. In 2012, the Government of Indonesia, initiated the implementation of the PMTCT strategic action plan incorporating the WHO-recommended Provider Initiated Testing and Counselling (PITC) for HIV and syphilis, towards universal coverage and virtual elimination of mother to child transmission.

Method: This case study is analyzing bottlenecks towards smooth integration of PPTCT and syphilis into routine antenatal care services in Sorong Municipality, West Papua, Indonesia by using Tanahashi approach. Analyzes is conducted by following site assessments (6 Public Health Center and District Health Office), the ANC package, review monthly report (MCH report, logistics report and laboratorium report), including recording and reporting procedures, was adapted to include HIV and syphilis tests for all pregnant women attending their first antenatal care visit.

Results: Between October 2013 - Juni 2014,various bottlenecks were identified during monitoring visits. Low coverage of HIV and/syphilis tested of pregnant women (36%) , stock out of logistics (7 months for HIV reagent and 8 months for syphilis reagent), overlapping of reporting line between MCH and HIV. Adjustments were initiated based on monitoring result such as conducted breakthrough activity (task shifting), provided HIV and Syphilis test at mobile clinic, decentralization of ARV treatment and integrated reporting line. The proportion of 1st ANC visits increased from 79.5% to 95.9% and the number of pregnant women tested for HIV increased from 36% to 57%. A 32% decrease in lost to follow up of ARV treatment was observed. Monitoring data suggests that stock out periods of HIV and syphilis reagents has decreased from 8 to 3 months in a year and is likely a result of improved coordination between HIV and Maternal & Neonatal Health (MNH) programs. However, another bottleneck is found through current monitoring. Result of reporting is still could not recorded harmonizely with national computerized system. It needs intensify approach to resolve it.

Conclusion: Our experience provides a successful model of monitoring based result for the integration of PMTCT services into existing MNH services, utilizing the comparative advantage of the two programmes and improving synergies between them. The increase in uptake of services suggests high community acceptance. This model will provide the basis for the scale up of PMTCT services in this large populous country with a rapidly increasing HIV prevalence.

Overcoming legal challenges to SRHR in Asia-Pacific

Lecture Room (4)

a) **Ready for the Second Child? Beijing's Maternal Health Care Services after Selective Two- children Policy**

Zhuoyan MAO, China

Since the end of 2013, China relaxed its decades-long one-child policy. The couples will be allowed to have two children if either parent is an only child. According to the official announcement, the suggested relaxation of the family planning policy is expected to bring China roughly13 million more babies in five or six years, which may distribute in large and medium-sized cities.

Beijing has implemented comparatively stringent one-child policy for a long time. It brings about a huge population of one child, which further results in a high rate of families composed of at least one only-child parent. In February 2014, Beijing formally enacted the relaxation of fertility policy. And by the end of August 2015, the number of applications for the second child is 50,406 and the number of approval is 46,186. The mothers ranging in age from 31 to 35 account for 56.78% of the applicants, and those aged from 36 to 40 makeup17.32% of the totality. The current Beijing's maternal health care services are designed for the mothers that deliver the first child. Thus these services lack sufficient comprehension and preparation for the demand of the mothers giving birth to a second child. The modification of family planning policy indicates that more families will bear two children. Therefore, comprehending the maternal demand of the mothers giving birth to a second child is more exigent. As Beijing is the capital and one of the megacities of China, this research on Beijing will offer statistical support for relevant departments to adjust original fundamental public health services in time after the relaxation of family planning policy. And it will provide substantial evidence for government to supply more accurate health care to families after the impending implementation of general two-child policy.

This research conducts a survey on the demand of maternal health care services among the women of childbearing age in Beijing. It covers 500 samples from 100 communities in 50 towns based on stratified sampling. The women in samples range in age from 20 to 49 and either husband or wife is an only child with local Hukou. The pregnant women and mothers for the second child make up 50% of the samples separately. The survey content includes basic information of the couple, basic facts of the first child involving delivery methods and details regarding the second child. The details comprise contraception conditions before pregnancy, preparation before pregnancy, prenatal checkup, delivery methods, breast-feeding methods and maternal health care services received after pregnancy. Finally, it investigates the the demand of maternal health care services pre-pregnancy, mid-pregnancy and post-pregnancy of the second child. The research initially discovers that the demand of maternal health care services varies significantly from primiparas to deutiparas. Deutiparas call for consultations regarding looking after the first child during pregnancy and balancing the relationship of the two children and pregnant mental health instruction as well. More findings are under analysis, and the survey report is estimated to be completed by the end of October.

b) **Attitudes of Adults Concerning Induced Abortion and Abortion Law - A Community Based Study in Colombo City of Sri Lanka**

M. Suchira Suranga, Sri Lanka

Introduction and Background:- Abortion is termination of pregnancy, whether spontaneous or induced. Induced abortion is caused intentionally by the administration of drugs or by mechanical means whereas illegal abortion is an induced abortion performed contrary to the laws regulating abortion. Abortion is legally permitted in Sri Lanka, only if it is performed to save the mother's life. Although Sri Lanka has a very restrictive law on abortion, it is estimated that 125,000 to 175,000 induced abortions take place annually. In the year 2010, the percentage contribution from abortion to maternal mortality was 13.5 percent, making it the second most common cause of maternal deaths. Attitudes towards induced abortion in the society can influence not only individual decision-making on the outcome of unwanted pregnancies, but also the health sector policy response towards future changes in the law. This study aims to understand the attitudes of adults towards induced abortion and abortion law in Sri Lanka. Further, it aims to analyze factors associated with attitudes on abortion.

Methodology:- Six Grama Niladhari Divisions (GNDs) and five to eight housing clusters from each GND were selected from Thimbirigasyaya DSD using multi stage stratified random sampling technique. 50 households were systematically selected from each GND. An interview schedule was administrated among 743 residents between 19 to 49 years of age after receiving written informed consent. 12 key informant interviews were conducted among reproductive health professionals and community based service providers.

Results:- Only a small proportion (11 percent) of the respondents were familiar with the situations in which abortion is legal in Sri Lanka. A majority of the respondents stated that induced abortion is against their religious beliefs (70 percent) and cultural and moral values (69 percent) irrespective of their religion and ethnicity. Approximately one tenth of the respondents (11 percent) do not accept the opportunity granted by the current law on abortion to perform induced abortion to save the life of the mother. A majority of the respondents, agreed that it was appropriate to legalize abortion for survivors of rape (65 percent), incest (55 percent) and pregnancies with lethal fetal abnormalities (53 percent). Less than 07 percent of respondents have agreed to legalize induced abortion for other reasons such as contraceptive failure, bad economic conditions and on request. Muslims (and Islam) demonstrated more conservative attitudes towards abortion compared to other ethnic (and religious) groups. Never married respondents below 25 years of age, those who have high level of formal education and a high level of access to different sources of information and less number of living children were more likely to accept a liberal law on abortion.

Conclusion:- Study concludes that respondents demonstrate conservative attitudes towards induced abortion, which highlights the need for more focus interventions to address these issues. Prevention of unwanted pregnancies and sensitization of the society about the issue of illegal abortion through continuous awareness and advocacy programmes, remain as the key strategies to prevent unsafe abortions and their complications.

c) Access to safe abortion for women with unwanted pregnancy: Attitudes of opinion leaders, policy makers and health professionals in Yogyakarta Indonesia.

Mrs. Purwantining Tyas Fitri Kawuri, Indonesia

Introduction

Despite the absence of an accurate figure, unsafe abortion is perceived to contribute to the high maternal mortality rate in Indonesia. In general, abortion practices in Indonesia are considered illegal and against the normative values of Indonesian society. However, safe abortion practices are still being conducted in Indonesia. The 13 clinics that provide safe abortion services, received 32.729 clients accessing their safe abortion services from 2010-2014. Of these clients, 83% are married, 17% are unmarried. Reasons provided by the clients for accessing services had to do with not being ready to have children or not wishing to have more children. The main reason for clients to have ended up with an unwanted pregnancy has to do with the unmet need for contraceptive methods (PKBI DIY, 2015). In August 2014, the government of Indonesia issued a governmental decree (PP 61/2014) regulating the provision of safe abortion services, SRH education for young people and the use of emergency contraception for victims of sexual violence. One year later, there unfortunately has been no follow-up in terms of operationalization of that decree at the provincial and/or district level; resulting in a continuing limitation in terms of access to safe abortion services for those in need.

This study focused on the attitudes of community leaders, policy makers and health professionals when it comes to issues surrounding the governmental decree on provision of safe abortion services and its implication for women with unwanted pregnancies due to sexual violence who would like to access safe abortion services.

Methodology

In the period of December 2014-March 2015, 15 semi structured interviews and 2 Focus Group Discussions (FGD) were conducted with policy makers, opinion leaders and health professionals. The interviews and FGDs were conducted in Bahasa Indonesia and its results were analysed using content analysis according to themes around unwanted pregnancy, sexual violence and access to safe abortion services.

Results

- The provision of sexual and reproductive health education for young people and people living with disability, with emphasis on reproductive health, is fully supported by the respondents. As long as it stays in the realm of the accepted normative value of Indonesian society.
- Contraceptive methods should only be made available for married couples; in the case of women with unwanted pregnancies, adoption is preferred above termination of pregnancy.
- Emergency contraception is not widely known among policy makers, opinion leaders and some of the health professionals; and it is often equated with "killing".

Despite the issuance of the governmental decree in August 2014, the attitudes and opinions of community leaders, policy makers and health professionals in Yogyakarta tend to have remained normative. This may be due to misperception and ignorance regarding the concept of safe abortion, SRH education and emergency contraception. Certain standpoints and/or

positions, for instance pro-life or pro-choice, are not (yet) able to provide workable and acceptable solutions. In conclusion, continuous efforts by all actors are needed to advocate for the (health) benefits that result from the provision of safe abortion services for women with unwanted pregnancies.

Overcoming challenges to SRHR in Asia-Pacific

Lecture Room (5)

a) **No sexual citizenship for a Katoey in the state of Thailand: Problems and needs caused by absence of gender recognition by law**

Ronnapoom samakkeekaro, Thailand

Background : Gender based violence still prevails in Thai society. Victims of such violence are not only women. According to a study on diverse sexuality in family context, it was found that 38.4% of Katoeys (transgenders), 13.8% of gay men, and 11.5% of lesbian women had encountered violence by their family members, academic institutes, and co-workers. Such violence included verbal violence, sexual harassment, and corrective rape, of which major cause was the patriarchal power structure and the ideology of heterosexuality in Thailand.

Method : This mixed-methods study aims to study problems and needs of Katoeys or trans women which are caused by absence of gender recognition by Thai law. Data collection was conducted through multiple tools: qualitative survey (265 Katoeys participated), in-depth interviews and focus group discussion (30 Katoeys participated), from March to August 2014. Data were analyzed using textual analysis.

Result : 50% of Katoeys and trans women in Thai society still encountered problems when applying for jobs because their gender does to conform to their biological sex. 46% struggled to be accepted by family members. 33% and 31% faced difficulty in making legal documents including national ID cards, and in conscription respectively. 40% had been ashamed from being called in public with titles which did not conform to their appearance. The social context where the state of Thailand does not recognize the significance of gender and sexual diversity drove Katoeys to call for changes in social structure for protection and sexual citizenship. Such structural changes could be done through legal mechanisms which acknowledge gender, right to Universal Health Coverage and health care which responsive to Katoeys or trans women's needs. In addition, Katoeys also called for the state to issue certificates to assure legality of genders, and to be able to change one's title regardless of sex reassignment surgery.

Conclusion : State is a social institution which holds power and potential to allow sexual citizenship for people of diverse sexualities and genders, especially for transgender people who are still encountering violence based on their sexuality or gender, which is caused by heterosexual ideology, one of the central ideologies within the state of Thailand. Moreover, sexual citizenship affects rights to health, reproductive health, expression, and stability and security in one's life.

b) **Indonesian LGBT Advocacy and Education through Films and ICT**

Julia Suryakusuma, Indonesia

The use of film and other information communication technologies (ICTs) are becoming an increasingly important and accessible tool in the hands of communities who want to document and share such stories and perspectives to a wider audience. In Indonesia today, one site of struggle where film and ICTs are making a big impact is in building support and acceptance of the rights of LGBT people, including their sexual and reproductive health rights.

Before 2000, the depiction of LGBT people in films has tended to be the target of ridicule and mockery. Nia Dinata's ―Arisan‖ (2003) was the first film showing LGBT in a positive light. Since then more films with LGBT themes - features, documentaries and shorts - have gradually helped shift public attitudes towards LGBT from confusion and hostility to some form of understanding, acceptance and support.

This increased exposure is not however without its downside. In the book ―Queering Internet Governance in Indonesia‖ (2015), the authors point out that the information superhighway is a double-edged sword. It has provided space for the advancement of LGBTIQ rights, but has also made it possible to perpetuate existing discrimination, to incite hatred and inflict abuse through the practice of cyber-bullying. Many LGBT sites have also been closed without prior notification. The existence of cyber-bullying that translates into real-world violence against LGBT people, along with the censorship of LGBT sites is a clear violation of LGBT citizens rights under the Indonesian constitution as well as Indonesia's obligations under international human rights law.

This paper attempts to look at how ICTs – on the one hand, provide a platform for self-expression, a forum to discuss politics, health, sex, relationships as well as to debunk stereotypes, or simply as an arena to engage socially with others. On the other, how ICTs also expose LGBT to greater risks, and how the LGBT members and community can navigate and use ICTs to their advantage. Better understanding how we can foster social conversations and raise the visibility of LGBT issues is crucial to strengthening the political will to implement laws and policies that uphold the principles of non-discrimination, and ensure that sexual health and rights are guaranteed for *all* citizens, regardless of their gender or sexualities.

By exploring case studies as strategies and lessons that can help promote the democratic and human rights of LGBT peoples in Indonesia, this paper aligns with APCRSHR Track 1, Sub-Theme 3: **Overcoming legal challenges to reproductive and SRHR in Asia-Pacific.** This abstract is being submitted to APCRSHR as part of a parallel panel proposal by the Coalition for Sexual and Bodily Rights in Muslim Societies (CSBR).

c) **Social Suffering and Sexual Reproductive Right of Women with Disabilities: A National Study in Thailand**

Penchan Pradubmook, Thailand

In July 2008, Thailand ratified the United Nations Convention on the Rights of Persons with Disabilities. Key pieces of legislation, namely the Persons with Disabilities Empowerment Act, the Persons with Disabilities' Quality of Life Promotion Act and the Persons with Disabilities Education Act, have been enacted during the past few years to serve as comprehensive rights-based laws for persons with disabilities.This paper is part of the first national research project on "A national situation analysis to promote quality of lives of women with disabilities" supported by Ministry of Social Welfare and Health Development, Thailand. This study used quantitative and qualitative methods that included cross-sectional survey and in-depth interviews to explore lives situations and social determinants of health related to sexual and reproductive health right of women with disabilities. The quantitative sample was used national systematic random sampling, consisted of 845 women with disabilities in the communities, while qualitative sample was purposively selected with 10 disabled people.to describe the meanings of women with disability attribute to sexual experiences in the context of a given attitudinal structure.

We found that the majority of women with disabilities was physical impairment (50.2 %) followed by intellectual impairment (20.5%) and communication impairment (18 %). This study we found that most of them living in the vulnerable conditions; 80 % had no education and received primary school level, 56.5% were unemployed. 21.2 % were experienced discrimination in schooling. Disabled women face with discrimination and biased treatment, reflecting double taboo as being disabled and female. Sexual experiences are also gendered and entwined with other forms of oppression and discrimination. Violence against disabled people is prevails. Disabled women tend not to disclose abuse because they fear from not being trusted, and because they fear from the consequences of disclosing such incidents. As women, they perceived motherhood as fulfilling women's role and duty, creating life, being a giver, and challenging obstacles in life and having someone to take care of them when getting old however most of them worried to have family with reasons of "no one truely love me" " will be more burdensome".

This research is a baseline data for national policy and planning strategies on women with disability in Thailand. There are a big gap between the policy given and implementation. Attitudes and practices of practitioners/providers is the main obstacle to sexual health of people with disabilities that violate their right. Raising awareness about SRH for persons with disabilities requires fighting misconceptions, stigma, and discrimination in communities.

Pathways to elimination of gender-based violence

Lecture Room (6)

a) **Connections: Exploring the relationship between intimate partner sexual violence against women in Myanmar, and gendered perceptions of reproductive and sexual health.**

San Shwe, Myanmar

Abstract: In Myanmar there currently exists little sociological evidence on violence against women in the general population, and in particular on women's experiences of sexual violence and abuse. This presentation draws on original findings from the Gender Equality Network's (GEN) qualitative study on women's experiences of partner abuse in Yangon and Mawlamyine , two of the largest urban centres in Myanmar, and on subsequent findings which emerged through a secondary data analysis conducted by a member of the original research team . Whilst the original research focuses on various forms of intimate partner violence, and sexual harassment and assault, further investigation focused in particular on the interconnect between dominant norms and belief around female sexuality and reproductive health, and how women perceive their experiences of intimate partner sexual violence. In particular, social beliefs and norms around women's sexuality hindered women's access to quality information about their reproductive and sexual health rights. This low level of awareness - particularly at sexual debut - resulted in normalization of sexual violence within their intimate partner relationships. This presentation explores GEN's findings, and looks at the importance of this information for the improvement of reproductive and sexual health information, services and rights in Myanmar. The paper concludes with a series of concrete recommendations for policy, programming, and future research.

Key Words: Gender Equality/ Violence against Women/ Intimate partner violence/Sexual Violence/ Women's Rights/ Reproductive and sexual health/ Masculinity/ Norms/ Resarch/ Myanmar

b) **Respectful Relationships: Preventing & addressing gender-based violence in schools**

Justine Sass, Thailand

Introduction Gender-based violence (GBV) is a violation of human rights and a major obstacle to achieving gender equality and safeguarding sexual and reproductive health and rights. This violence often begins early in schools, manifested through physical, emotional, and sexual abuse and followed by cyberbullying. A 2014 UNESCO-UNGEI review found that in 15 Asia-Pacific countries with data, 11 reported bullying rates over 30%, with rates in Pacific countries as high as 68%. Girls were more likely to report emotional and sexual violence, various forms of discrimination and social inclusion than boys, who faced more often physical violence. Being a victim of such violence was found to contribute to early sexual debut, unprotected sex, drug and alcohol abuse, and unsafe sex with multiple partners.

Deeply ingrained gender inequality and rigid gender expectations, and broader societal acceptance of violence were found to be the main drivers of GBV in and around school. To address this, UNESCO, UNICEF, UN Women, Plan International and the

University of Melbourne (UoM) have developed a curriculum resource and training programme to provide practical and evidence-based guidance for school-based interventions to eliminate GBV.

Methods Respectful Relationships: Preventing and addressing Gender-Based Violence in Schools draws on the 2014 UNESCO-UNGEI Asia-Pacific review, the 2013 regional consultation on school GBV, and UoM research and experience in areas of gender discrimination, positive relationships, life-skills and health education, violence prevention and curriculum development. Feedback on concepts, language and implementation practicalities was gained at country-level from stakeholders in Thailand and a pilot of curriculum activities in Papua New Guinea. Initial country-level orientation to the curriculum is scheduled for Q4 2015 in both Fiji and Cambodia, for Ministry of Education officials, teacher educators and teachers, with further countries to be recruited in 2016.

Results The Respectful Relationships resource and training programme is the result of a collaborative process between partners drawing on the strengths of their organisations in gender discrimination and violence, child protection, sexual and reproductive health and life skills education. A school-based setting was selected to build knowledge and capacity as early intervention has been shown to be important in influencing values and attitudes and schools provide access to a large numbers of young people. Evidence further supports the use of participatory learning activities to develop social skills and critical thinking to address social norms which endorse violence.

Challenges of school-based interventions include addressing teacher attitudes and cultural acceptance of violence. In addition, the young person is exposed to many influences beyond the school-gate hence homework activities have been included to encourage discussion of GBV at home.

c) **Why do some women in Viet Nam experience more violence by husbands than others? Risk factors associated with violence by husbands from a cross-sectional national study.**

Henrica Jansen, Thailand

Aim

This research sought to identify risk factors for intimate partner violence (IPV) against women in Viet Nam, to provide evidence for policy and action.

Background

The UN supported National Study on domestic violence against women in Viet Nam was undertaken in 2010, with the aim to measure the prevalence of different types of violence against women, as well as risk factors and consequences. While the report with results of this study was released in 2010, the risk factor analysis was conducted in 2013-2014 as secondary analysis of the dataset produced by the study.

Methods

Data were obtained through face-to-face interviews with 4,838 women 18-60 years using an adaptation of the questionnaire developed for the *WHO Multi-country Study on women"s health and domestic violence*. In addition to the survey component, qualitative interviews were conducted for triangulation and interpretation of findings. Forty variables regarding the women, their husbands, their relationship and their community were used in logistic regression analysis to identify risk factors for partner violence, including socio-demographic characteristics, other experiences with violence, attitudes, husband‘s behaviours, couple characteristics and social capital (support from family and close network).

Findings

Overall, 9% of ever-married women reported to have experienced physical and/or sexual violence by a husband in the past 12 months.

In terms of risk factors for violence by husbands (hereinafter also referred to as ‗partner violence‘), male behaviour that supports male power and gender inequalities, such as having extra-marital relationships and fighting with other men, was strongly associated with violence. Alcohol use by the husband also greatly increased a woman‘s risk of violence. The findings also strongly suggest how violence was learned across generations, as they showed that having experienced violence in childhood was associated with increased likelihood of women experiencing violence by husbands and of men becoming perpetrators of wife abuse. Notable is the strength of the association between relationship variables and partner violence and the lack of relationship between measures of social capital and partner violence.

The findings show that no single underlying factor at individual, relationship or community level explained most of the violence - 15 independent factors were retained in the final multivariate model, each strongly associated with experience of partner violence. This suggests that although stopping one factor, such as alcohol abuse, will reduce the amount of violence, it likely will not stop the problem altogether.

Conclusions

Overall, the findings support existing theories on how underlying gender inequalities and power imbalance between women and men are fundamental causes of violence against women. They suggest that interventions are necessary with families (especially those with young children), schools and communities, with the inclusion of men and boys.

The new evidence is already being by used the UN and the Government of Viet Nam to strengthen prevention measures and services for women who have experienced violence.

Comprehensive sexuality education policies and their implementation

Lecture Room (7)

a) **Abstinence-Only or Comprehensive Sex Education at Myanmar Schools: Preferences among Students, Teachers and Parents**

Phyu Phyu Thin Zaw, Myanmar

Abstract Background School-based sexual health education is already well known for its ability to reach adolescents of diverse backgrounds in prevention of STI/HIV and unwanted pregnancies. In recent years, there has been a debate about the pros and cons of adopting abstinence-only approach as an alternative to a more comprehensive approach of sex education. Studies on both sides indicated the drawbacks of each method. The best solution will depend on the various social and cultural contexts of each country. This study aimed to explore the preferences of type of sex education among students, teachers and parents in Myanmar schools so that current school sex education could be tailored to the special needs of adolescents and the society. Methods This was a school-based, cross-sectional descriptive study which was conducted in all Basic Education High Schools in Pyin Oo Lwin Township, Myanmar by using both qualitative and quantitative methods. A total of 150 students, 150 parents and 120 teachers were randomly selected to answer face-to-face interviews on their preferences between two types of sex education and their RH knowledge. A total of 8 FDG among students, 4 FDGs among parents and 4 FGDs among teachers were done to explore more details on their insights on school sex education for adolescents. Factors associated with main outcomes were determined using multivariate logistic regression. Qualitative data were analyzed by using modified grounded theory approach to content analysis. Results: The preference for type of sex education among students, parents and teachers were contradicted to each other. While 73% of student's preferred comprehensive sex education at schools, only 38% of parents and 41% of teachers preferred such type of sex education. The 11th graders, students from BEHS 2 and 3 were more likely to prefer comprehensive sex education. Students who had a parent with low level of RH knowledge, or a negative behavioral intention were less likely to prefer comprehensive sex education at schools. Conclusion: There are contradictions of preferences for sex education among students, teachers and parents. While more students preferred comprehensive sex education, the teachers and parents preferred abstinence-only sex education. The levels of RH knowledge among all participants were unsatisfactory reflecting the insufficiency of current sex education classes at schools. To make the current school sex education more effective, authors suggested revising the current curriculum more specific and culturally appropriate. Regular trainings for the RH teachers at schools should be constantly provided. Same gender classes should be encouraged.

Key words: Abstinence-only, Comprehensive sex education, reproductive health, students, parents, teachers

b) **Good Practice Guideline for Advocacy Strategies in Conservative and Less Developed Countries**

Sana Zafar Khan, Pakistan

Objective

Aahung is an NGO based in Pakistan that develops the capacity of school teachers to integrate quality Comprehensive Sexuality Education (CSE) into school curriculum's. The intervention aims to empower adolescents by providing them with quality Sexual and Reproductive Health and Rights (SRHR) knowledge, information and skills. Evaluations have revealed that while charter and private schools are able to effectively implement the program, government schools lack adequate decision making power to ensure ownership, institutionalization and sustainability of CSE. Thus, Aahung has taken a number of steps to integrate CSE into the provincial curriculum in Pakistan. The purpose of this paper is to share those successful strategies that enabled Aahung to meet its advocacy goals which in turn can be replicated by other organizations in culturally similar countries with a weak education sector.

Methodology

Aahung has undertaken five successful strategies that have lead to moving CSE curriculum acceptance forward for integration into the Sindh provincial curriculum. First, Aahung set-up a committee where various stakeholders including advocates from the Education Department, reviewed and revised Aahung's CSE modules. This ensured that the content is relevant, appropriate, and acceptable to a wide audience and reduced the chances of resistance that Aahung faced when advocating for CSE integration. Next, Aahung developed the capacity of master trainers working with the government teacher training institutes, on CSE, to serve as advocates and resource personnel. Third, Aahung conducted an extensive national mapping exercise that identified key decision makers, government processes, and advocates for CSE within government departments. This exercise yielded an advocacy roadmap for Aahung to follow and highlighted Sindh Education Department and Curriculum Council as key decision makers. Using these findings, Aahung successfully engaged with strong advocates, "champions", who were able to influence key government decision makers to shape policies and take actions in favour of CSE. Lastly, Aahung hired a curriculum specialist with significant experience of working in the Federal Ministry of Education to develop a Curriculum Framework that outlines where Aahung's CSE modules could be integrated within the secondary school provincial curriculum.

Results

After decades of advocacy efforts, Aahung has engaged in successful dialogue with the Secretary Education, Sindh, and has gained his approval to take forth the process of integration of CSE into the secondary school provincial curriculum. The Secretary Education has also endorsed the pilot testing of Aahung's CSE modules in 25 government schools. Aahung is now at the final stage before integration and is working closely with the Education

Department to review and adopt the Curriculum Framework. Aahung's achievement of integrating the most sensitive part of its content, sexual abuse prevention, into the primary school provincial curriculum, is a testament to the success of its strategies and has paved the way for future CSE module integration.

Conclusion

Aahung is the only organization that has achieved such significant strides in the mainstreaming of CSE in Pakistan. Thus Aahung's advocacy strategies would prove a useful good practice guideline for organizations working in conservative, less developed countries where there is no state sponsored sexuality education.

c) **Advocating for Change: SRHR education among adolescent girls and young women**
May Than Htay, Zin Mar Oo, Myanmar

This research is based on the project implemented by the YWCA of Myanmar which was established in 1900 as a network of women and girls leading change through provision of services and collective engagement with human rights. In partnership with the World YWCA and Department of Foreign Affairs and Trade (DFAT), the YWCA has begun efforts to redress these issues in Myanmar through "Adolescent Girls and Young Women's Leadership Training Institute". The project is designed to empower young women, between the ages of 18 to 30, with knowledge of sexual and reproductive health and rights (SRHR), trafficking, violence against women, advocacy, and the Convention on Elimination of All Forms of Discrimination Against Women (CEDAW) through empowerment trainings. The goal of the project is to promote the role of adolescent girls and young women in society to become change agents. The objectives of this project are to increase knowledge and empower women by equipping them with knowledge and skills necessary for their own and their family lives with special emphasis on SRHR, anti-trafficking and women's rights and advocacy; to equip adolescent girls with skills and knowledge such as sexual and reproductive health and rights, anti-trafficking, life skills, violence against women so that adolescent girls and young women will know their potentials and become adolescent girl champions as well as to promote their status in society. Through this project empowerment trainings were organized in target communities for adolescent girls 10-17 years of age and young women to built skills and knowledge, the Human Rights Based Approach, advocacy, the construction of gender and patriarchy and legal frameworks for protecting women's human rights, as well as increasing their knowledge of SRHR, life skills, VAW, HIV/AIDS and a broad range of leadership skills including training facilitation. With the mentoring approaches the learning circles are to support young women leaders to share their experiences and serve as role models for each other, sharing examples of how young women are leading change and examining ways of addressing barriers in this work. The project has built the capacity of young women and adolescent girls on public speaking, presentation skills and, most importantly, developed advocacy skills to become young woman and adolescent girl leaders. It was found from the research that the project saw successes in empowering young women. Of the women who received new knowledge at the training of trainers, 86% were empowered to become change agents and experienced trainers – these women conducted empowerment peer education

trainings in their areas. Through the trainings, 158 young women, 136 mothers, and 27 men were empowered, with notable changes in both their knowledge and confidence. These changes were evident in the 28 one-on-one video interviews with the young women, which also demonstrated changes in their participation and status in their communities.

1.2 Second Parallel Sessions
Track (2): Governance and accountability
(25-2-2016, Thursday)

	Decentralization and SRHR
Room 1	**Promoting Family Planning by Strengthening Local Government Infrastructure in Bangladesh** Md. Azmal Hossain[1], Waliul Islam[1], Bashir Ahmed[1], *[1]EngenderHealth Bangladesh, Dhaka, Bangladesh*
	Accountability in the provision of contraceptive information and services in a decentralized system of governance Jihan Jacob[1], *[1]Center for Reproductive Rights, Quezon City, Philippines*
	Monitoring government implementation of SRHR policies
Room 2	**Role of community media in monitoring maternal health in India** Sulochana Pednekar[1,2], Nupur Sonar[1], Kayonaaz Kalyanwala[1], *[1]Video Volunteers, Anjuna, Goa, India,[2]Goa University, Taleigao, Goa, India*
	Achieveing RMNCH+A Outcomes through strengthened Health system Governance by colloboration between Government and Development Partners - Experience from the State of Rajasthan,India Sunil Thomas Jacob[1], Venkatesh Srinivasan[1], *[1]UNFPA, UNFPA, India*
	Improvement of Quality Health Services ensured: Lesson Learned from Local Level Monitoring and Advocacy Samia Afrin, Mirza Khaled[1], *[1]Sangkalpa Trust, Patharghata, District Barguna, Bangladesh*
	SRHR in public-private partnership
Room 3	**"Principled Critical Collaboration: Key to GO-NGO Partnership in Advancing Reproductive Health in Davao City"** Romeo Jr Cabarde[1,2], *[1]APILA Center, Davao City Philippines, The Philippines, [2]FPOP, Davao City Philippines, The Philippines*
	Building national resilience for effective sexual reproductive health (SRH) services for the crisis affected population through initial smaller response- A case study of Myanmar Rajrattan Lokhande[1], Tayyaba Shaikh[1], *[1]International Planned Parenthood Federation (IPPF) – SPRINT Initiative, New Delhi, New Delhi, India*
	Engaging the Private Sector in Family Planning Access: The Philippines Experience Vicente Jurlano[1], Klaus Beck[1], Lewelyn Baguyo[1], Rhodora Buenaventura-Snyder[2], *[1]United Nations Population Fund, Makati City, The Philippines, [2]Employers Confederation of the Philippines, Makati City, The Philippines*

Impacts of Global and National SRHR Policies	
Room 4	**Young Women for Change: Voices from Young Women in Nepal** Smriti Thapa[1,2], Pratistha Thapa[2], Kiran Bajracharya[1], *[1]Midwifery Society of Nepal (MIDSON), Kathmandu, Nepal, [2]Young Women For Change, Kathmandu, Nepal*
	Contexts, Realities and Challenges of Sexuality of Forced Bachelor: A Multi-approach Explorative Study in China's Gender Imbalance Governance Yang MENG[1], Shuzhuo LI[1], *[1]Institution for Population and Development Studies, Xi'an Jiaotong University, Xi'an, SHAANXI, China*
	Davao Declaration: Articulating the Rights of Men who have Sex with other Men Jeff Fuentes[1], *[1]City Health Office, Davao City, The Philippines*
Advocacy for Change	
Room 5	**Social Accountability for Adolescents Sexual and Reproductive Health in Nepal** Giri Prasad Panthi[1], Tirtha Man Tamang[2,1], *[1]Singhania University, Rajasthan, India, [2]Tribhuvan University, Kathmandu, Nepal*
	Accountability : Reaching favourable Maternal and newborn health outcomes in Sri Lanka Chithramalee De Silva[1], *[1]Family Health Bureau, Colombo, Sri Lanka*
	"I Decide" petition for empowering young people on sexual and reproductive health and rights Jamuna Devi Sitaula[1], Shweta Bastola[1], Bikash Pokharel[1], *[1]Family Planning Association of Nepal, Kathmandu, South Asia, Nepal*
Rights-based Approach in SRHR	
Room 6	**Comprehensive Gender, Sexuality and Reproductive Health & Rights Education: A Progressive Islamic Approach to the Issues (Best Practices of Center for Women's Studies at Islamic State University Yogyakarta Indonesia)** Alimatul Qibtiyah[1], *[1]Islamic State University, Yogyakarta, Indonesia*
	Social Determinant Approach and Maternal Health Pallavi Saha[1], Sunanda Ganju[2], Renu Khanna[3], Mahima Taparia[3], *[1]SAHAJ, Vadodara, Gujarat, India, [2]SAHAJ, Vadodara, Gujarat, India, [3]SAHAJ, Vadodara, Gujarat, India, [4]SAHAJ, Vadodara, Gujarat, India*
	Looking from another perspectiveGlobal Governance of HIV/AIDS: 'Gender' and Governmentality Nattapat Jatupornpimol[1], *[1]Asian Institute of Technology, Pathumthani,, Thailand*

Decentralization and SRHR

Lecture Room (1)

a) **Promoting Family Planning by Strengthening Local Government Infrastructure in Bangladesh**

Samia Afrin, Md. Azmal Hossain, Bangladesh

Background: The success of Bangladesh's family planning (FP) program can be attributed to its increasing involvement and engagement with locally elected bodies and other key stakeholders at the grassroots level. In 2014, Mayer Hashi-II (MH-II), a USAID-supported FP project implemented by EngenderHealth in Bangladesh, collaborated with another USAID-supported project, Strengthening Democratic Local Governance (SDLG) to explore how local governments and grassroots community groups that are traditonally not involved in health care programs can be involved to influence FP outcomes, especially for long-acting reversible contraceptives (LARCs) and permanent methods (PMs).

Intervention: MH-II developed a simple one-hour FP training module for the SDLG, which was incorporated into their existing training curriculum. MH-II conducted a TOT on effective communication for FP to SDLG partner NGO staff. The trained staff then cascaded the training they received to members of local government bodies, with the expectation that they would integrate FP into their routine work to increase uptake of LARCs and PMs.

Methodology: MH-II implemented the intervention in 73 unions in seven districts over a nine-month period. In addition to mentioned training, FP messages developed in collaboration with all partners were disseminated at the grassroots level through dramas and a FP factsheet. FP information banners and other printed materials were used to decorate the offices of local government bodies. To monitor the progress of the intervention, a number of FP indicators set up by MH-II were incorporated into SDLG's routine monitoring tools.

Results: The intervention succeeded in making local elected bodies and associated stakeholders by creating a more conducive environment for effective dissemination of FP information. FP inspectors regularly participated in monthly meetings at the grassroots level and shared their performance report and obtained inputs from community members on ways to strengthen FP activities at the grassroots level. Creating a linkage between FP facilities/health centers and local governing bodies and other community structures encouraged grassroots ownership of FP program. This linkage also increased the number of FP service center monitoring visits by representatives of the local governing bodies. The increased frequency of these community-led monitoring visits to the facilities led to the construction of connecting roads to health facilities, the renovation of clients' waiting areas (including the donation of chairs and fans), the repair of water-supply points, and improvements in electricity connections. These improvements, in turn, contributed to increased access to FP services at the lowest level of the health service delivery system.

Conclusion: While the intervention has not yet been formally evaluated, lessons learned from this intervention are several. First, local governments and associated stakeholders can be successfully involved in promoting FP if they are adequately supported with the appropriate training and skills and are offered opportunities to harness their skills and strengthen their linkages with both health care facilities and their respective communities. Second, the integration of FP issues with other development-related issues, such as local governance, is a low-cost approach for reaching thousands of community members, as well as for fostering local government accountability to the national FP program.

b) **Accountability in the provision of contraceptive information and services in a decentralized system of governance**
Jihan Jacob, The Philippines

In the Philippines, the responsibility of providing contraceptive information and services (CIS) has been decentralized from the national government to local government units (LGUs). While decentralization only means devolution of specific functions and does not amount to total abdication of governmental powers, a handful of LGUs have acted beyond their authority. For more than a decade, these LGUs have passed discriminatory laws and policies restricting women‘s access to CIS. These restrictions violate women‘s rights to life, health, equality and nondiscrimination, to decide the number and spacing of children, and access to family planning services and information recognized and guaranteed under the Philippine Constitution, national laws and policies, and international agreements.

Reviewing relevant laws and policies and examining international human rights standards, this presentation looks into the two major challenges under the Philippines‘ decentralized structure of governance: (1) ensuring that the national government remains accountable for discriminatory acts committed by LGUs; and (2) ensuring that there is a consistent application of contraceptive-related policies in all LGUs. In the past, the national government claimed non-liability for the issuance and implementation of discriminatory laws and policies by the LGUs because of the decentralization policy. While the government has enacted a national reproductive health law in 2012 that would have guaranteed uniform local laws and policies, LGUs continue to go against the national law and issue discriminatory laws.

Addressing these challenges, the presentation identifies two distinct strategies as applied in the Philippine context. The first strategy is using the inquiry mechanism under the Optional Protocol of Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) to hold the national government accountable. In 2012, an inquiry request was submitted to the Committee on the Elimination of Discrimination Against Women (CEDAW Committee), body tasked to monitor states‘ compliance with CEDAW, to look into the reproductive rights violations in the City of Manila. The violations result from a local executive order effectively banning modern contraceptives. The CEDAW Committee found that the responsibility to ensure women‘s rights lies with the national government and is not affected under a decentralized government. Through the inquiry mechanism, the burden of accountability is reaffirmed on the national government. The second strategy involves establishing monitoring and oversight mechanisms to ensure that LGUs do not overstep the

boundaries of their limited authority. Under the Philippine Local Government Code, the national government exercises the power of supervision over LGUs. To guarantee the effective exercise of this supervisory authority, monitoring and oversight mechanisms have to be put in place. The enactment of a national reproductive health law must be coupled with application of strict safeguards to ensure its full implementation and consistency in contraceptive-related laws and policies in all LGUs.

The presentation concludes that a decentralized system of governance should not pose as a barrier to accountability and this is realizable with the use and establishment of strategic accountability mechanisms.

Monitoring government implementation of SRHR policies

Lecture Room (2)

a) **Role of community media in monitoring maternal health in India**

Sulochana Pednekar, India

Background:

India accounts for the highest number of maternal deaths (289000 in 2013) globally. Despite this, the coverage of this fact has been scant. Now that the uproar after the sterilization deaths in Chhattisgarh (an East Indian state) has died down, the condition of mothers and newborns in India has gone off the radar again.

Video Volunteers, a human rights NGO with the support and partnership of Oxfam India, has launched a project on maternal health reporting. Most maternal deaths can be avoided or prevented like improving access to antenatal care in pregnancy, skilled care during childbirth, and care and support in the weeks after childbirth. The Community Correspondent's (CC's) were working in remote villages and they could monitor the programs in their neighbourhood . CC's will highlight the injustice towards women who died last year, turning them from a statistic into a person whose voice and story matters, even from the grave.

Objective :-

1) To analyze the stories reported on maternal health issues
2) To analyze the violations of health system reported in the stories under different programs etc. 3) To find out the impact of the stories in improving the status
4) To see the overall impact of video monitoring

Methodology:- Video volunteers with Oxfam India, has started a project on Community Monitoring of Maternal Health in India to report the violations , produce stories , take action and devise solutions to improve the state of maternal healthcare in India. Video volunteers has its network of over 180 community journalists from marginalized communities.

Results:- Since 2010, about 50 reports done till date by video volunteers on maternal health issues - including on lack of services for deliveries at night; lack of ambulances in villages; women not being provided medical care at hospitals right after delivery; and the absence of Auxilliary Nurse Midwives or doctors at health centers. Community correspondent, from Rajasthan (a North -west Indian state) through her reporting was successful in bringing about change in her area by providing adequate supply of Iron tablets to pregnant mothers. The stories produced led to bring about change in the community .The stories produced are lived by the community correspondents. Community Correspondent from Madhya Pradesh was able to restart the vaccination which had stopped in the village.

Conclusion:- Community media can play a very important role in monitoring the maternal health. Through the reporting of these stories, Community correspondents have been successfully preventing maternal deaths from taking place in their remote villages. The key to

preventing these deaths lies in our villages where one needs to make sure that fellow villagers get the services and entitlements they deserve. Community correspondents can get great Auxiliary Nurse Midwives working at the villages, and can make Block and District level hospitals deliver the services. Community media can help resolve issues at the ground immediately.

b) **Achieveing RMNCH+A Outcomes through strengthened Health system Governance by collaboration between Government and Development Partners - Experience from the State of Rajasthan, India**

Sunil Thomas Jacob, India

Achieving Reproductive Maternal and Newborn Health outcomes in a State with challenging geography and vulnerable populations can only be possible with the synergising of the efforts of the Government System , Development Partners and Civil Society. RMNCH+A (Reproductive Maternal Newborn Child Health +Adolescents) Programme is an attempt to improve the status of the various Reproductive, Maternal , Newborn health indicators in a State like Rajasthan having a population of 60 million and with high MMR, IMR and TFR.. UNFPA has been designated as the State lead partner of the RMNCH+A to co-ordinate the efforts of the other development partners present in the State and also to work closely with the Government system in those 10 priority districts which are having very adverse Reproductive ,Maternal and Newborn Health indicators. The paper looks at the mechanism of co-ordination and co-operation between the different partners under the RMNCH+A coalition and how this coalition is strengthen the Governance and Accountability system of the State Government to effectively implement the Large Health programmes The strategies adopted under the RMNCH+A included 1) a comprehensive situational/Gap analysis of the infrastructure , human resources , availability of equipment and drugs and the outreach services 2) Capacity Building of the Programme officers in terms of Management capacities 3) Technical capacity building of the Service Providers 4) Strengthening the State and District leadership by providing critical human resources at the State and Districts and 5) most critically the interface between the Development partners and the Government system to bring in corrective measures to strongly implement the National Health mission with the objectives of population , maternal and child health goals. The institutional mechanism of RMNCH+A has brought a better level of Governance and Accountability at the levels of the Blocks , Districts and State. This is done by regular supportive supervision visits to the health institutions in the high priority districts through a system of pre approved checklists covering all the elements of the health institution that is prerequisite to make it functional and providing critical Maternal and newborn health services. The findings of the supportive supervision visits are discussed and action taken at the block level , district level and State level to deliver the reproductive health services with the desired quality. At the state level policy level engagements are being undertaken with the State Government by the Development Partners through a system of State level Task Force where the highest Senior official of the Health Department Chairs the meeting . 16 Score card indicators covering the Reproductive Maternal and Newborn health are developed quarterly which ranks the performance of blocks and districts and shared with the Government .The Development Partner impress upon the State Government to take policy level actions to strengthen the

programme implementation. The Paper provides an insight into the collaboration between the Development partners and Government in terms of strengthening the Health system Governance to achieve RMNCH+A outcomes and bringing an accountability at the various levels of service provision and programme management.

c) **Improvement of Quality Health Services ensured: Lesson Learned from Local Level Monitoring and Advocacy**

Iffat Jahan, Mirza Khaled, Bangladesh

Background: Most governments know what changes need to be made to decrease maternal mortality. In Bangladesh governments have many policies to improve maternal health. However, these policies often fail in implementation and accountability.

It has upgraded 179 Upazila[1] Health Complexes (UHC) among 421 that offer Emergency Obstetrics Care (EmOC[2]) for improve the maternal health. In 2002 Upazila Health Advisory Committees (UHAC) was formed by the Ministry of Health and Family Welfare to monitor the health facilities. In 2009, the new government has reconstructed these committees as Upazila Health Management Committee (UHMC). Whatever the new name is, the implementation is very poor. UHMCs were not active and as well as the EmOC services were not available because of a number of reasons including uncoordinated posting of obstetricians and anaesthetists, high absenteeism rates of doctors, shortage of medical supply and logistic etc.

Bangladesh Maternal Mortality Survey 2010 Maternal Mortality Rate (MMR) is 194 per 100,000 live births which is a 40% decline from 574 in 1990. However, MMR still continues at a high rate due to inadequate antenatal care and unsafe delivery and monitoring.

Sangkalpa Trust, a Community Based Organization (CBO) has focused on the delivery of EmOC services at the local level and their experience highlights the importance of accountably in implementation of policies.

Sankalpa Trust has been working to improve the quality of health services in government health institution and to ensure the accountability of service providers since 2003. It focused on the quality of health services especially on the EmOC services of Patharghata UHC and found that the services were not available because of a number of reasons including uncoordinated posting of obstetricians and anaesthetists, shortage of medical supply etc because the HMCs are not active. There is zero or less monitoring and accountability of existing mechanisms including health care service providers and health authorities.

Objectives: To make the local health authorities & service providers accountable and improve the quality health services at UHCs, specially make the EmOC services available to pregnant women‘s.

Methodology: Regular monitoring and data collection from the UHCs, interview patients and service providers, carry out focus group discussions with women of the community and public representative.

Results:

• Committee members are now more proactive in identifying problems and taking measures to solve them

• 13 out of 16 hospitals hung signboard ―pharmaceutical company representatives restricted during hospital outdoor working hours‖

• Reduction in the collection of illegal fees from patients

• Increased supply: x-ray machine, food, ambulance, medicine, reagents, x-ray flim etc.

• Doctors are more regular in reporting to duty

Conclusion: Activating the Hospital Management Committee can play a critical role for ensuring accountability and improving the quality of health services. Proper monitoring and accountability of the providers are essential for better results in maternal health status of Bangladesh.

[1] Upazila refers to a sub-district.

[2] Comprehensive EmOC includes basic EmOC services plus the provision of caesarean sections and blood transfusions.

SRHR in public-private partnership

Lecture Room (3)

a) **"Principled Critical Collaboration: Key to GO-NGO Partnership in Advancing Reproductive Health in Davao City"**

Romeo Jr Cabarde, The Philippines

At the time when the national debate to legislate a reproductive health law was at its height, Davao City which is an urban hub in Southern Philippines was already gaining grounds in implementing its own reproductive health ordinance enacted three years before the national law was passed. Since the early 80's, advancement in women's health was already strong in the city.

Intrigued by these seemingly unique circumstances, the investigators embarked on a documentation mission of Davao's RH movement history through key informant interviews, focus group dicsussions, document reviews and observations. Its primary goal was to record the narratives of Davao's vibrant movement in the area of SRHR and identify the key element that defined the SRHR landscape of the city. The principal respondents were the pillars of the movement as well as the leaders of various organizations working for SRHR.

The result showed that the key factor in the ability of the city to promote SRHR information and services is because of a strong GO-NGO partnership informed consciously by a work ethic they called ―principled critical collaboration (PCC)). This framework allowed the civil society and the local government unit to work for SRHR in the spirit of state accountability, transparency, participation, empowerment and rule of law. This framework strengthened the claim holders in asserting their rights at the same time capacitating the duty bearer to fulfill its obligation to respect and protect the SRHR of its people.

This led to the creation of a Davao RH Network in 2001 – a network of GO and NGOs contributing in the SRHR research, training, community organizing, campaigns, policy articulation and service delivery in the city.

In conclusion, this template of GO-NGO principled critical collaboration can be used to advance SRHR policies and services in other local settings having similar landscape to Davao City – where there is a vibrant civil society organizations and good governance in local leadership.

b) **Building national resilience for effective sexual reproductive health (SRH) services for the crisis affected population through initial smaller response- A case study of Myanmar**

Rajrattan Lokhande, India

Background:

South Asia and Pacific regions are prone to natural and human induced disasters across the year namely floods, cyclone, landslides, earthquakes, wildfires, droughts, volcanoes and

tsunamis. The Preparatory Stakeholder Analysis report suggests the need for localizing preparedness and response along with implementing integrated models of coordinating and financing humanitarian action and development work. It showed that after the host community, National NGOs were most effective in meeting the needs of the community during crisis. Humanitarian organizations need to work together more intensively to prepare for and respond to conflict in a collaborative way. The Sendai Framework for Disaster Risk Reduction recognizes that the State has the primary role to reduce disaster risk, along with other stakeholders and investing in disaster risk reduction for resilience.

Program Intervention:

SPRINT Initiative supported Myanmar Maternal and Child Welfare Association (MMCWA) to implement short-term project on the minimum initial service package (MISP) for provision of SRH services to internally displaced and vulnerable population in conflict affected Myitkyina and Waing Maw Townships in Kachin State of Myanmar in 2014. This was implemented through their local chapters at Myitkyina and Waing Maw under the overall supervision and guidance from MMCWA based at Nay Pyi Taw.

This involved the MISP assessment, procurement of Reproductive Health (RH) Kits from UNFPA, dignity kits through localize assembly of commodities and hiring community skilled staff for service provision.

Methodology:

A joint review of the initial project was conducted by the IPPF-SPRINT Hub and East and South East Asia & Oceania Regional office in July 2015. This response was assessed with the subsequent response of the MMCWA in August 2015 for the initiation of the emergency project.

Key Findings:

Though MMCWA is a prominent national level NGO but the initiation of the first emergency response took almost three to four months. The process of getting approval from government, organizing the response, arranging for RH kits and capacity building on the MISP together led to delay. The subsequent emergency response for Kale floods in August 2015 was overwhelming and they responded within one week of the crisis. This was mainly due to MMCWA developing good rapport and coordination with the Local Government departments, local chapters of national and international NGOs working for SRH and humanitarian settings. These led to exposure on collaborative efforts for comprehensive and integrated approach for service delivery and avoidance of duplication. Opportunity was taken to build the capacity of MMCWA on responding to crisis through quality SRH service provision. All these factors feed-in for reciprocating to the second emergency. Hence before the award of emergency project by SPRINT, based on the feedback from Government of

Myanmar, MMCWA already deployed funds and skilled manpower with essential commodities at the affected site.

Conclusions:

Building capacity of the national NGO on disaster risk resilience through implementation of small project on the MISP assures effective response to humanitarian crisis subsequently. Implementing the MISP through local chapter, since they understand the needs of the community better, ensures collaborative efforts and effective utilization of resources.

c) **Engaging the Private Sector in Family Planning Access: The Philippines Experience**
Vicente Jurlano, The Philippines

Significance/background

There is a nascent but growing understanding that family planning (FP) is a critical investment for global development with exceptionally high social returns. Despite mounting evidence and the documented importance of FP to achieving sustainable development goals, few private sector companies have prioritized this area of global development.

Local and global companies can be powerful agents for change. They have the power to raise awareness, affect policy, and initiate programs in line with their existing social and business goals.

Merck for Mothers, UN Foundation, Accenture Development Partnerships (ADP) and UNFPA have used their networks, expertise and programs to engage influential companies to expand support for FP. The project was piloted in the Philippines, building on the momentum generated by the recent passage of the controversial Reproductive Health Law and the decades of private sector experience in implementing workplace family planning programs.

Programme intervention: Methodology for the Philippine Pilot Experience

The in-country project is conducted starting February 2015. Activities so far include the following:

• Development and validation of potential approaches for the private sector to encourage greater access to FP, specific to the Philippines;

• Generation of a return on investment template, utilizing the Philippine business context;

• Preparation of high-level and detailed implementation roadmaps for committing companies;

• Conduct of baseline survey involving target clients/beneficiaries as basis for planning and implementation; and

• Targeted support to companies in implementing their commitments, including training of senior management, FP trainors and company-based FP service providers.

The project approach includes a plan to monitor and document progress toward goals.

Results/Key findings

This project has engaged four companies in multi-partner, country-led efforts to expand access to FP. Actionable commitments to FP have been secured from these companies. Commitments include direct in-country work, such as building awareness, policy advocacy, workplace programs, and community outreach.

Garnering interest among companies on an issue that they are aware is socially important but highly-controversial and sensitive especially in a Catholic-country setting, presents certain challenges and risks, as follows:

• Companies feel the area is too controversial and are not interested in aligning their efforts with FP/contraceptive information and services;

• Companies are interested in principle, but few have the capacity or technical ability to implement activities; and

• Companies support the principle but are too concerned about risking their business image (although less public advocacy is possible).

Conclusion

In conclusion, there is very positive response and high ownership of the project by the partner-companies. This has been possible because of the following:

The project presented best practices and even facilitated information exchange with executives from other companies including from other countries which have successfully implemented FP programmes and reaped the benefits.

A national business association with strong experience on workplace FP programs was engaged to provide technical support to companies to design and implement their commitments.

UNFPA tapped existing networks and key business leaders supportive of FP in convincing private sector companies that FP makes good business sense.

Impacts of Global and National SRHR Policies

Lecture Room (4)

a) **Young Women for Change: Voices from Young Women in Nepal**

Smriti Thapa, Nepal

Background: In 2015, with the support from International Women's Health Coalition (IWHC), Midwifery Society of Nepal (MIDSON) implemented a project entitled _Young women for Change‘. The project aimed to engage young women in Nepal in the Beijing +20 process, and in turn strengthen Nepal's positions on sexual and reproductive health and rights at the 59th Session of the Commission on the Status of Women (CSW). As a result of advocacy through the project, Government Officials and CSO Government Delegation from Nepal for CSW 2015 delivered commitment to push for young women's SRHR during the CSW, which subsequently contributed to progressive statement from Nepal at the CSW, 2015.

Objective:

To facilitate the engagement of young women in Nepal in the Beijing +20 process, and in turn strengthen Nepal's positions on sexual and reproductive health and rights at the 59th Session of the Commission on the Status of Women.

Methodology:

Formation of Advisory group which included young women working on diverse movement to help and supervise in the entire project. Qualitative approach was used during the first ever young women consultation process to identity the key issues of young women SRHR in the country context. Various national and international evidences reviewed in the process to triangulate the findings of the consultation to develop a Young Women's Position Paper which highlighted key issues, concerns and recommendations for 59th session of CSW, with a focus on SRHR. The position paper was endorsed through the government delegates attending the CSW through national policy dialogue. Debrief and follow-up conducted for further commitment and direction for young people SRHR in country context.

Outcomes:

Nepal advanced strong position on young people's sexual and reproductive health and rights at the 59th session of the CSW .Links between young Nepalese women activists and key decision-makers involved in the Beijing review process was strengthened. Increased understanding on SRHR advocacy skills and enhanced leadership of young women involved in the project.

Future Directions:

Formation of stronger network of young women working on diverse movement (Human Rights, Environment, Law,Research, technology, media etc.) to work on common ground of sexual and reproductive health and rights. This project also acted as a forum to foreground young women's SRHR issues through social media. The young people involved are motivated

to continue to bring out youth SRHR to the fore of national priority discussion and work with government to build strong national statements in international forums and their effective implementation at national level.

Key words: SRHR, Advocacy, Beijing conference, Young women

b) **Contexts, Realities and Challenges of Sexuality of Forced Bachelor: A Multi-approach Explorative Study in China's Gender Imbalance Governance**

Yang MENG, China

Objective

China's patrilineal culture highlights the importance of son and generates a strong son preference in family fertility, which dominantly causes a gender imbalance society. This tradition also makes sexuality becoming a sensitive topic. While, sexuality is an important thing that the whole society could not ignore, when we talk about health, reproduction, gender, rights and gender imbalance governance. Since most work of our Institute for Population and Development Studies focuses on governmental advocating and policy intervention towards gender imbalance governance, what we want to explore is an effective approach, which reflects the interest of all stakeholders, to practice gender imbalance governance. Besides, the context and reality of sexuality of forced bachelors in rural China are also of great value to discover. As sexuality naturally combines a multi-perspective consideration, the main objective of this paper is to find a potential governance model to reverse gender imbalance, and to uncover the sexuality of forced bachelors, as well as a case study to see how the multi-approach governance model works in one county, which is funded by UNFPA.

Methodology

This study mainly uses qualitative study, including literature analysis about the basic governance model towards gender imbalance and its effectiveness, face to face interview with relevant stakeholders, and a comparative study of conventional governance model and the multi-approach one. It will also introduce a case study to exam the main features of the multi-approach governance model in certain activities.

Results

Based on the analysis of gender imbalance, conventional governance model could be seen as the government-dominated approach. It manly emphasizes controlling sex ratio at birth (SRB), but forget the consequences of gender imbalance, which refers to the sexuality of the forced bachelors and the correction of patrilineal family tradition.

Although conventional governance has a better performance in SRB figure, it lacks rights-protection, the consideration of LGBT groups, and the absent of public stakeholders. The multi-approach governance model is with an interdisciplinary knowledge and adopts multi-methodology, it calls stakeholders, including media, the mass, market, civil society the minority, government and NGOs, working together to promote destigmatization of forced bachelors, mutual respect and equality towards new family institution.

We also find sexuality of forced bachelors has patrilineal representation and without a tangible framing, and thus can be marked as solo (sex of heterosexual marriage and fertility

only), homogenous (monogamous marital heterosexuality) and hegemonic (patrilineal marriage institutions).

In Changfeng's multi-approach governance practice, this trial considers the interests of all relevant stakeholders, and its innovations mainly in four aspects: Toilet Revolution, Surname Revolution, Father's Class, and Revising Village Regulations and Agreement. All these efforts try to weaken son preference tradition, encourage an equal family member status, and change the patrilineal family institutions for the vulnerable groups.

Conclusion

Gender imbalance, gender, sexuality, health and rights share the similar values of equal and protection. Compared with government-dominated governance model, multi-approach gender imbalance governance model combines stakeholders and helps to discover sexuality of forced bachelors, eliminate discrimination, and change patrilineal family institution.

c) **Davao Declaration: Articulating the Rights of Men who have Sex with other Men**
JEFF FUENTES, The Philippines

Recognizing the alarming increase of HIV-AIDS incidence in the Philippines, with the MSM community ranking the highest group at-risk, a nation-wide study was conducted among MSM. The research included a review of local literature on MSM and a mapping of MSM organisations in Visayas and Mindanao. With this, a Visayas-Mindanao Conference of MSM and TG on HIV-AIDS, a first in the country, was held wherein the results of such a research was presented to the MSM and TG community. In this conference, several issues have been raised and lessons were learned.

Foremost among the issues raised in the conference were the human rights abuses suffered by the MSM community, especially those who come from rural areas. Such abuses were perpetrated mostly by the military and the police. It is worth noting that due to such abuses, compounded by the stigma attached to the MSM, negotiation for safer sex practices proved difficult to make, hence resulting to the increase in HIV incidence.

While issues have been raised during the conference, it is also worth noting that best practices have also been celebrated. Among these is the care and support system among MSM in both HIV-positive and non-positive communities. Also, there is MSM representation now in a Barangay Council as in the case of Carcar, Cebu, owing to an organised MSM community. The final output of the conference was the drafting of the MSM Davao Declaration, the first in Southeast Asia, articulating the rights of the MSM.

With these lessons learned from the conference, there is a need to examine the sustainability of ARV program among PLHIV. Finally, a comprehensive package addressing economic, health and social aspects of the MSM community can be drafted based on the lessons learned.

Advocacy for Change
Lecture Room (5)

a) **Social Accountability for Adolescents Sexual and Reproductive Health in Nepal**
Giri Prasad Panthi, India

Adolescent population of Nepal is facing health and social problems related to sexual, reproductive, behavioral and traditional social practices. Adolescent pregnancy, child marriage, unwanted pregnancies, Chhaupadhi (restrictions during mensuration and delivery), sexual- gender based violence, unsafe abortion, HIV/AIDS, drug addiction and suicide are major issues which have severe consequences in the lives of adolescents in Nepal. Addressing such daunting problems that adolescents are facing today needs holistic approach, going beyond health. Wider community support, civic engagement and social mobilizations are required to tackle the problems. Community Based Institutions (CBIs), Community Leaders and citizens have obligations to respond to the problems related with service delivery and ending harmful practice as a social accountability for protection, fulfill and upholding the rights of adolescents. In this context, the objective of this study is assess awareness and engagement capacity of citizens for addressing adolescent sexual and reproductive health problems as a social accountability in Baitadi District of Nepal. Descriptive and analytical research design is used to assess the level of awareness and empowerment from the citizen‘ perspectives. A total of 337 respondents affiliated with community based institutions (CBIs) were interviewed using structured questionnaire for data collection and data analysis was done by using SPSS version 16.0. The preliminary results of the study reveals that majority of citizens were aware and informed about SRH problems of adolescents, citizens perceived that child-marriage (15%) is the main issue of adolescents in the community followed by Gender Based Violence (13.4%) and adolescent pregnancy (12.7%) among others. The study reveals that citizens belonging to rural areas have more actions on preventing child marriage; awareness level was higher among citizens from Non-Dalit communities than in Dalit communities. Further, 59.9 percent citizens feel confident to talk about sexual-reproductive health services related concerns in the meeting whereas 32.6 percent citizens perceived that they are hesitant to speak on SRH issues. Similarly, nearly half of the citizens perceived that they were not capable of deciding freely to talk about SRH related issues in the meeting. Only 61.1 percent citizens feel confident to claim for access to quality health service as their fundamental rights from public health facilities. The study concluded that majority of citizens affiliated with community based institutions were aware about characteristics and SRH issues of adolescent population at their communities. However, still a sizeable citizen felt less confident to use their individual agency to decide freely, speaking up against existing social norms in the group meetings and claiming SRH as rights. The study revealed that citizen‘s accountability capacity is inadequate for tackling adolescent sexual and reproductive health service provision and social behavior change at the community level and therefore this calls for the dire needs to build the capacity of vanguard citizens to contribute to improving adolescents sexual and reproductive health status.

Key words: Adolescent sexual and reproductive health, Community Based Institutions, Citizen Awareness, Citizen Empowerment, Social Accountability, Citizen Engagement, Service delivery, Social Behavior Change,

b) **Accountability : Reaching favourable Maternal and newborn health outcomes in Sri Lanka**

Chithramalee De Silva, Sri Lanka

In Sri Lanka, the last Census, conducted in 2012 recorded a total population of 20.3 million in a land area of 65,610 sq km. The life expectancy at birth, Maternal mortality ration (32/100,000 live births in 2014) and infant mortality rate (8.2/1000 live births in 2013) shows the values in par with developed countries. Health is a fundamental right of the Sri Lankan constitution. Free health service since 1930 ensures cost free and universal health care in both curative and preventive health sectors. From 1944, all citizens are privileged with free education as a result the literacy rate in Sri Lanka is 98%.

The institutional health service delivery system functions at many tiers from rural level up to tertiary care hospitals. The skilled birth attendance at delivery is over 99%. Comprehensive EmOC services are available in 77 hospitals which accounts for 92% of births. The Preventive Health system provides geographical coverage to all citizens based on their place of residence. The Public Health Midwife is the key service provider delivering RH services in a well demarcated area at the grass root level. Community and family education on health promotion and disease prevention make them accountable for some aspects of care.
At national level, Ministry of Health is vested with the provision of policy and strategic direction towards the decentralized health system. Many policies and strategic plans on MNCH provide national guidance and country is moving towards quality assurance in MNCH. Centre is accountable for human resource development, Infrastructure improvement, HMIS and Monitoring and evaluation.

Many approaches are being used to track the achievements. National Health Management Information System provides data to monitor and evaluate the programs. MCH and epidemiological statistics and the surveillance data generated at the grass root level feed into the national data base. Civil registration system originated from the Birth & death Registration act in 1897 provides vital statistics while Research studies/ surveys strengthen the evidence base. Close monitoring though supervision, regular review meetings, feedback reports and programme reviews improved the care provision.

The world renowned Maternal death surveillance and response system in Sri Lanka, conducts a detailed investigation of maternal deaths. This system is moderated by the Ministry of Health in strong collaboration with relevant professional bodies. It includes immediate notification of the maternal deaths, the field and institutional auditing, development of case histories and reviewing by an expert panel to ascertain the cause of death, identifying service deficiencies and making recommendations for further reduction of MDs.

Challenges: Though the national rate in maternal and childhood mortality is low, regional and sector disparity still exists. Tracking resources to reduce newborn mortality which is proportionately higher is a timely need. The gaps in quality of care in MNCH services need to be addressed. The cause specific mortality & morbidity especially medical

diseases complicating pregnancy, Psychological problems in pregnancy & Puperium and Birth defects among infants needs attention. Addressing unmet need of FP among high risk groups and strengthening of contraceptive commodity security need attention of all stakeholders.

c) "**I Decide" petition for empowering young people on sexual and reproductive health and rights**

JAMUNA DEVI SITAULA, Nepal

Background

International Planned Parenthood Federation (IPPF) has launched the ―I Decide‖ campaign globally, to galvanize support on SRHR to build momentum to ensure that Sexual and Reproductive Health and Rights of young people are included in the post -2015 MDG / Development framework. In countries like Nepal, Young people and particularly girls are very vulnerable to suffer sexual and other forms of violence, early marriage, lack of decision-making affecting their own bodies and sexual consent and choices about having children (when and how many). So, as a member association of IPPF, Family Planning Association of Nepal (FPAN) has launched the "I DECIDE" campaign to generate public awareness and lobbing parliamentarians and key policymakers towards youth SRHR. The ―I Decide‖ component (photo frame + signing of the petition) was succeeding to get individual commitment to furthering SRHR. I decide was a very successful campaign where FPAN was successful in giving message I decide…. My Partner, My bodily rights, my family size, my future.

Objective:

To spread the awareness regarding SRHR need of young people in Nepal and to get individual commitment to furthering SRHR and to make government accountability to support Sexual and Reproductive Health and Rights to influence the post -2015 process.

Methodology

First National Population conference, First national Family Planning Day, AFPPD workshop, Annual general meeting, Signature petition, workshop, I decide Innovative Photo frame, / youth mobilization / Vision 2020 workshop / Parliamentarian workshop / engage media/ e-petition etc.

Result

- Realizing the SRHR need of young people in Nepal, the president of Nepal, Rt' Hon. Dr. Ram Baran Yadav has endorsed I Decide by getting photographed with the I Decide photo frame on the occasion of First National Population Country which is a great advocacy achievement itself.
- Deputy prime minister, health minister, 82 Parliamentarians, Policy Makers, Health Secretary, Political leaders, SRH Experts, Donors, Media, Police Personnel, Activists, Stakeholder and civil society leaders has endorsed I Decide by getting photographed with the I Decide photo frame and they agreed to sigh for their commitment.
- FPAN compiled all the signatures and photos of the event and sent it to IPPF, to be presented to the UN secretary General to influence the post -2015 process.

- Amongst the IPPF south Asia‘s member Association, Nepal is the largest number of signature collector (21,254) regarding SRH Rights of young people through I decide Petition.
- I Decide was also the centre of attraction in all the national advocacy events in 2014.

- Some special guests including policymakers, academicians, development practitioners and journalists who invited to the first National Population Conference were oriented on “I decide” by FPAN‘s youths.

Conclusion

Further innovative advocacy approach needs to be conducted to get individual commitment as well as to aware youth, stakeholders, partners, Government, donors, policymakers and Media about to furthering SRH rights of young people and to position SRHR in the top priority of the post -2015 MDG / Development framework.

Rights-based Approach in SRHR

Lecture Room (6)

a) **Comprehensive Gender, Sexuality and Reproductive Health & Rights Education: A Progressive Islamic Approach to the Issues (Best Practices of Center for Women's Studies at Islamic State University Yogyakarta Indonesia)**

Alimatul Qibtiyah, Indonesia

Indonesia is in dire need of a comprehensive gender-sensitive approach to Sexual and Reproductive Health and Rights (SRHR) education. There is clear evidence that the ad-hoc approach to SRHR planning and education implemented to date is failing this generation of Indonesian youth. We see this failure in the high school dropout rate, the number of unwanted pregnancies that result in (unsafe) abortion or early marriage, the number of early marriages that end in divorce, the increasing incidence of STIs and HIV, the ongoing and ever increasing rate of male perpetrated violence against women and girls, and the maternal mortality rate which is higher than both the regional and global averages (220 per 100000 live births). Comprehensive education in the areas of sexual(ity) and reproductive health and rights is requisite to addressing these failures. As a pioneer Islamic tertiary institution in Yogyakarta, UIN prioritizes progressive and moderate Islam. In alignment with this, the mission of the Women's Study Center at UIN is to promote gender equality in Indonesia. Academics and activists at the Center collaborate with Islamic scholars, activists and leaders in society, such as religious judges, Islamic political party leaders, principals of Madrasah (Islamic schools) and heads of a range of Islamic organizations. In carrying out its mission, staff at the PSW promote and generate academic discourse and knowledge on many women's issues employing a progressive Islamic framework that is contextual. In Indonesia, with the largest population of Moslems globally, it is imperative that an Islamic approach is employed to accommodate rapid social and cultural change, change which can be seen as both challenge and threat to Islamic tradition. It is hoped that a progressive approach will, on the one hand, mediate the demands of the modern era, and on the other, be authentically Islamic, since Islamic gender relations are part of contemporary Indonesian life. The values and principles of equitable Islamic gender relations must be systematically promoted in Indonesia. The PSW employs a comprehensive approach to the synthesis of textual Islam and social changes, particularly the inevitable changes in gender relations brought about by extended education and increased access of women to education, employment and politics. This paper explore the best practices that have been done by Center for Women's Studies (PSW) at Islamic State University (UIN) Sunan Kalijaga Yogyakarta to promote and generate academic discourse and knowledge on a range of women's issues focusing on sexuality using a progressive Islamic framework. In addition this paper also discusses the use of knowledge to develop and implement sustainable Gender and SRHR educational programs that lead to increased wellbeing particularly for women and girls. This research is library and field research and employs techniques of documentation and observation to collect data. Data is analyzed by Miles and Huberman. PSW have been collaborated with the community services department through students to disseminate sustainable Gender and SRHR educational programs.

b) **Social Determinant Approach and Maternal Health**

Pallavi Saha, India

Introduction

There has been a decline in India's maternal mortality ratio (MMR) from 254 per 1, 00,000 live births in 2004-06 to 212 in 2007-09, to the latest figures of 178 per 1, 00,000 live births in 2010-12. (1-4) This is, however, far behind the fifth Millennium Development Goal (MDG) target of 109 per 100,000 live births by 2015 (Millennium Development Goals: India country report. New Delhi: Social Statistics Division, Ministry of Statistics and Programme Implementation, Government of India; 2014)

To better understand the underlying causes of persistently high maternal mortality, a civil society initiative led by CommonHealth called Dead Women Talking, was initiated in 2011 to look at maternal mortality in India from a social determinants and human rights perspective. This process has led to the development of a social autopsy tool and a civil society effort across ten states to document maternal deaths. Gujarat is one such state.

Gujarat is one of the better performing states in India with more than 75% institutional deliveries and a maternal mortality ratio of 122. Although, Gujarat is not one of the NRHM high focus states, it has many remote/geographically difficult and poorly served areas and there is a failure to deliver obstetric care at the grass root level despite significant improvements in infrastructure and numerous financial assistance programs.(Obstetric Care Performance: A Situational Analysis of 24x7 Primary Health Centres from Gujarat, India: Sandul Yasobant α, Kranti Suresh Vora σ & Dileep Mavalankar Article : January 2015)

Methodology

Since 2012 ,SAHAJ in collaboration with local NGOs in two tribal blocks each in Dahod and Panchmahal districts in Gujarat has been involved in a project on _Enabling Community Action for Maternal Health' focussing on developing accountability mechanisms to improve maternal health and conducting social autopsies to identify the role of social determinants and quality of care factors in contributing to maternal deaths in the area.

SAHAJ along with a few Jan Swasthya Abhhiyan (Indian chapter of the People's Health Movement) members in Gujarat has been instrumental in documenting 31 deaths that became part of a report based on the analysis of 46 maternal deaths reported from 15 blocks of 11 districts of Gujarat between January 2012 to December 2013(Social Autopsies of Maternal Deaths in Select Areas of Gujarat).

Findings

The above report revealed that apart from health system factors, social, economic, and cultural factors contribute in a compounded way to Maternal Deaths.

Conclusion

By using the social determinants approach, the project has demonstrated that through sangathan women (grass root level collective), it is possible to reach underserved women (including those with severe/sickle cell anaemia and other complications) to attend VHNDs (Village Health and Sanitation Day). The sangathan also demanded weekly Ante Natal Care clinics at the PHCs for migrant/inaccessible women who are unable to attend regular VHNDs. Now, with a provision of a vehicle to ferry women to the PHCs, there is an

increasing demand for iron sucrose and blood availability resulting in a responsive health system.

c) **Looking from another perspective Global Governance of HIV/AIDS: ‘Gender' and Governmentality**

Nattapat Jatupornpimol, Thailand

After first identified in 1981 among male homosexuals in the US, HIV/AID has received so much attention from global community. Why? First, HIV was discovered in the time when the world became so much globalized and the mobility of world population had gradually increased. Second, there has been no medicine to cure HIV yet. With poor health infrastructure governments in the hardest-hit countries, were not able of coping with the epidemic. Lastly, health, economic and social impacts of HIV/AIDS on individuals living with HIV, their families and community threatens human, national and global security. Consequently, the developed countries started to mobilize financial resources, and technical supports to stop the spread of HIV through bilateral and multilateral agreements. Slowly, the epidemic was acknowledged as an urgent global public health problem that required immediate response from global community.

In 1988, the Global Programme on AIDS (GPA), a multilateral initiative, was established. This program is the first coordinated initiative and collective action that the global health governance body established to call for the concern and international cooperation and commitment to fight against HIV/AIDS. In 1994 it was transformed to the Joint United Nations Programme on AIDS or UNAIDS. The limited resources of developing world to cope with the epidemic led to the creation of the transnational network of HIV. In countries affected by the epidemic, experts from developed countries were invited to provide technical advice and assistance. Through different channels, technical knowledge has been transferred from wealthy countries to middle- and low- income countries for better development of HIV initiatives. Stakeholders became aware of social determinants of health and realized that HIV/AIDS is not just a health issue but it is also a gender issue. Thus, they integrate and institutionalize gender into the planning and implementation of HIV-related policies and interventions. Gender became a normative framework of development organizations as a tool to combat HIV/AIDS at its root cause.

The work of the transnational network of HIV/AIDS advocacy has been perceived a good deed because it has successfully cope with the spread of epidemic and providing better access to treatment. Those in the transnational network have been perceived as saviors who come to rescue vulnerable people living with HIV in the Third World and to protect human rights to health and well-being of all. Yet, not much has been researched about this mission of the transnational organizations, which work together with or supported by the powerful First World countries, and their exercise of power in the name of development. It is crucial to critically look at the rationality and their mentality of governance in which some knowledge and norms have been created to govern the way that state and non-state actors within national boundary and people in developing countries act. So, this paper aims to analyze this layer of relationship between the transnational actors and local one and to provide a critical analysis on how gender has become a strategy of the international organizations, in which the Western

power is hegemonic, to direct the development agencies in developing countries to plan and implement their development projects under a certain framework. Borrowing Foucault's concept of governmentality, I argue that governmentality is a mode of government that exists in the global governance of HIV/AIDS, in which _gender' is institutionalized and utilized as a knowledge and tools, and the governmentality allows the exercise of power of the North over the South to exist.

1.3 Third Parallel Sessions
Track (3): Health Justice! Towards Sustainable SRHR Financing
(26-2-2016, Friday)

Universal Access to SRHR	
Room 1	**Sexual and Reproductive Health service in emergency** BIKASH POKHREL[1], Jamuna Devi Sitaula[1], *[1]Family Planning Association Of Nepal, kathmandu, Nepal*
	Women's empowerment and socio-economic disparities in contraceptive use in Cambodia Siow Li Lai[1], Nai Peng Tey[1], *[1]University of Malaya, Kuala Lumpur, Malaysia*
Models for SRHR financing	
Room 2	**Blood, Sweat, Money and Dummy Tummies: Surrogates in India** Jayakant Singh[1], Enu Anand[2], Pallabi Guha[3], Prakash Kumar[4], Raywat Deonandan[5], *[1]Tata Institute of Social Sciences, Mumbai, India, [2]International Institute for Population Sciences, Mumbai, India, [3]Jawaharlal Nehru University, New Delhi, India, [4]International Institute for Population Sciences, Mumbai, India, [5]University of Ottawa, Ottawa, Canada*
	Entitlements for Cash Free Maternal Health Services: Experiences from Gujarat, India Mahima Taparia[1], Renu Khanna[1], Sunanda Ganju[1], Pallavi Saha[1], *[1]SAHAJ, Vadodara, Gujarat, India*
	Reducing unmet need for family planning in Kiribati: A cost-benefit analysis Jacob Daube[1], Eliza Raymond[1], *[1]Family Planning New Zealand, Wellington, New Zealand*
Social marketing for SRH	
Room 3	**Contraceptive Social Marketing in Asian Countries: Achievements and Lessons Learnt** Ulimiri Venkata Somayajulu[1], Tilak Mukherji[1], *[1]Sigma Research and Consulting, New Delhi, Delhi, India*
	Increasing access to quality family planning products and services through private sector in Cambodia Sreymom Em[1], Vichet Am[1], Camille Florence E Tijamo[1], Michelle Phillips[1], *[1]Mariestopes International Cambodia, Phnom Penh, Cambodia*
	Analysis of Financing for Development for Sexual Reproductive Health Issues in Young-Adolescent to Achieve Sustainable Development Goals Isnawati Hidayah[1], *[1]State University of Malang, Malang, Jawa Timur, Indonesia*

SRH commodities security	
Room 4	**Nation-wide Facility assessment for Reproductive Health commodities and services in Myanmar (2014)** Kyaw Oo[1], Theingi Myint[2], Tin Tin Wynn[1], Thi Da[1], Thae Maung Maung[3], Yu Myat Mun[4], *[1]Department of Medical Research (Pyin Oo Lwin Branch), Pyin Oo Lwin, Myanmar, [2]Department of Public Health, Nay Pyi Taw, Myanmar, [3]Department of Medical Research, Yangon, Myanmar, [4]UNFPA, Yangon, Myanmar*
	Stock out of FP and Lifesaving commodities major hindrance of healthy sexuality and sexual rights in Nepal Krishna Prasad Bista[1], *[1]Health 4 Life Logistics, Kathmandu, Nepal*
	Reproductive Health Commodity Security to address Unmet Need for Family Planning in Myanmar Khaing Nwe Tin[1], *[1]Department of Public Health, Nay Pyi Taw, Myanmar*
	Strengthening the Public Health Supply Chain Mechanism below district to improve the health service delivery. Chitra Mahato[1], Ram Bahadur Thapa[1], *[1]UNFPA, Kapilvastu, Nepal*
Financing SRHR in Humanitarian response	
Room 5	**Implementing MISP (Minimum Initial Service Package) for reproductive and sexual health services for the flood affected people in Bangladesh: A case study** Masum Al Jaki[1], Nimisha Goswami[1], *[1]Family Planning Association of Bangladesh, Dhaka, Bangladesh*
	Integration of the Minimum Initial Service Package (MISP) for Reproductive Health by a local NGO with MOH Basic Health Services for Internally Displaced communities in Kachin State Subatra Jayaraj[1], Khin Oo Zin[1], Jayamalar Samuel[1], *[1]International Planned Parenthood Federation -SPRINT ESEAOR, Kuala Lumpur, Malaysia*
	Integrating the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) in National and Local Disaster Risk Reduction and Management Plans: Sharing the Philippine Experience Florence Tayzon[1], *[1]United Nations Population Fund, Makati City, The Philippines*
	Provision of Sexual and Reproductive Health (SRH) Services through MISP in Crises for earthquake affected people of Nepal Nimisha Goswami[1], Anindit Roychowdury[1], *[1]International Planned Parenthood Federation- South Asia Regional Office, New Delhi/ Delhi/South Asia, India*

SRHR in responses	
Room 6	**Antenatal screening of anemia including iron deficiency anemia, haemoglobinopathies and thalassaemia among the pregnant women living in Bago region of Myanmar** Moh Moh Htun[1], Yin Min Htun[1], Zayar Chit[1], Myat Mon Oo[1], Than Than Swe[1], Theingi Myint[2], Mya Ohnmar[1], Hlaing Myat Thu[1] & Kyaw Zin Thant[1] *[1]DMR, Yangon, Myanmar,* [2]DOPH
	Increment of Financial Resources on Sexual and Reproductive Health and Rights in Family Planning Association of Nepal Minita Pant[1], Nabina Maharjan[1] *[1]Family Planning Association of Nepal, Kathmandu, Nepal*
	Positive Changes in Nepal as a result of integration SRH and biodiversity conservation Amu Singh Sijapati[1], Subash Pradhan[1], *[1]Family Planning Association of Nepal, Lalitpur, Nepal*

Universal Access to SRHR

Lecture Room (1)

a) **Sexual and Reproductive Health service in emergency**

BIKASH POKHREL, Nepal

Background

A powerful earthquake of the magnitude of 7.8 struck Nepal on 25 April, 2015, with the epicentre to the West of Kathmandu in Gorkha district. The aftershocks following the earthquake have continued compounding fears of further devastation among the affected population. 39 out of 75 districts are affected by the earthquake and a series of powerful aftershocks. As per Minimum Initial Service Package (MISP) for Reproductive Health and Nepal Health and Demographic survey calculations, there are about 2.0 million women in reproductive age who have been affected by the earthquake in Nepal. Out of which there should be about 126,000 women who are currently pregnant and are in the need of delivery and reproductive health services. Also, there could be an estimated 2,100 women who may be suffering from obstetric complications. UN estimates about 40,000 women are at the increased risk of sexual and gender based violence (SGBV).

Objective

Ensuring access to reproductive health services for the most affected populations in hard-to-reach areas.

Methodologies

1. Reproductive Health (RH) Camps: A total 78(May to August 2015) days RH camp has been executed over 3 month period in 5 districts.
2. Female Friendly Space (FFS): 3 FFS has been tented, one in each Bhaktapur, Lalitpur and Kavre districts.
3. Established Maternity Waiting/Transition homes.
4. Orientation on clinical management of rape (CMR) has been provided to medical team conducting RH camp.
5. Family planning Association of Nepal (FPAN) has provided orientation on RH and dignity kits to staff of government health facilities.
6. Similarly women were oriented on need of dignity kits before distribution of such kits.
7. Women and Children Office notified and information shared on distribution of dignity kits.

Results/Outputs

1)10556 clients were beneficiated by 63311 services regarding family planning, STI, Gynecological, sexual and gender based violence (SGBV) counselling and referral services till the end of august 2015.

2) Over 4000 clients were served by three female friendly space (FFS) centres. 3) 95 lactating as well as pregnant woman were beneficiated by service delivered through maternity waiting/transition homes.

Conclusion

It is a great challenge to address the unmet need of SRH services at the time of emergency but at the same time efforts made by international community and initiation made by Family Planning Association of Nepal (FPAN) has played a great role to ensure access to

reproductive health services for the most affected populations in hard-to-reach areas. Government of Nepal and its people has also trusted in our motto to serve people with care. We seek helping hands in this emergency to ensure people‘s right towards sexual and reproductive health services at any cost.

b) **Women's empowerment and socio-economic disparities in contraceptive use in Cambodia**

Siow Li Lai, Malaysia

Background: Family planning is a fundamental element of reproductive health. Access to contraceptive services is seen as a basic right of women to decide on the timing and frequency of child birth. Making contraceptive methods widely available is one of the commonly used family planning strategies. Contraceptive use is one of the most important proximate determinants of fertility in many developing countries. While many developing countries have launched family planning programs in the 1960s, the government of Cambodia only started the national family planning program in 1994. Since then, the use of contraceptive methods has quickly caught up, with the contraceptive prevalence rate (CPR) climbing rapidly from 12.6% in 1995 to 56.3% in 2014. Contraceptive use varies widely across different sub-groups of the population, partly because family planning services are not free of charge in Cambodia. This study seeks to explain women's empowerment and socio-economic factors influencing the contraceptive use differentials in Cambodia.

Methods: This study used data from the 2010 Cambodian Demographic and Health Survey (CDHS), covering 11,536 currently married women aged 15 to 49 years, including those who were cohabitating. The main dependent variable is the proportion of married women currently using a contraceptive method. A number of women's empowerment and socio-economic variables are selected as predictors of the use of contraception. Women's empowerment is measured in terms of household decision-making autonomy, attitude towards wife beating, media exposure to family planning programs, and respondent's education relative to that of her partner. The socio-economic factors selected are place of residence, respondent's educational level and current working status, and wealth index. Binary logistic regression is used to examine the relationship between various factors and the use of contraception. Respondent's age and age at first marriage are entered as control variables in the multivariate analysis.

Findings: The proportion of married women currently using a contraceptive method has increased from 21.8% in 2000 to 48.8% in 2010. Bivariate analysis showed that all the study variables were significant determinants of contraceptive use in Cambodia. The effects of inter-spousal education difference, respondent's educational level, respondent's current working status and wealth index on current contraceptive use remained significant even after adjusting for other predictors and control variables. In the multivariate context, respondent's education, respondent's current employment and wealth index were positively associated with the use of contraception, and married women that had more education than their partners

were more likely to use a contraceptive method compared to those who married partners with the same educational background.

Conclusion: Findings revealed that both women's empowerment and socio-economic development are fundamental in affecting the use of contraception in Cambodia; however, differentials in contraceptive use are more pronounced across the socio-economic sub-groups. Unemployed women and those from the poorer families are less likely to use a contraceptive method, and this is likely to have an impact on their reproductive health outcomes. Given that women's education is significantly associated with contraceptive use, expanding the educational opportunities for women and improving their access to education could result in higher CPR.

Models for SRHR financing

Lecture Room (2)

a) Blood, Sweat, Money and Dummy Tummies: Surrogates in India

Enu Anand, Jayakant Singh, India

Background: An estimated 15 percent of couples around the world are infertile. Assisted Reproductive Technology (ART) has enabled infertile couples to produce their own, genetically-related children through surrogacy, wherein a third party gestates an ART-produced embryo on behalf of the infertile couple. Paid gestational surrogacy is illegal in many nations, though not in India. As a result, India has become a global leader in providing surrogates for the international ART market. The literature is torn on whether Indian surrogates are treated ethically, while little is known about the demographic profile of these women.

Objectives: We sought to describe the socio-economic and demographic characteristics of Indian surrogates by statistically compiling all data from the published literature. In addition, we qualitatively evaluated the welfare measures proposed for the surrogates in India's draft ART (Regulation) Bill, 2010, in light of our new understanding of surrogates' demographics. Materials and methods: We systematically searched online databases for keywords relating to surrogates in India, restricting our search to English, peer-reviewed studies published between 2000 and 2015. Characteristics of the surrogate mothers described in those studies were summarized, in terms of frequency and distribution of socioeconomic and demographic factors. Relevant aspects of the ART Bill were then assessed in light of this new demographic information. Results: From 17 studies, 67 surrogate mothers were described. One fifth of them were illiterate, and more than half had primary or middle level education. Most were either housewives (44%) or worked in the informal sector (33%). Around one fifth were not of the prescribed legal age (21-35 years) indicating at least one serious gap in the draft ART Bill. We found that the bill is somewhat more favourable to the needs of clients rather than surrogates, suggesting inadequate welfare measures to protect the interest of the surrogates in India.

Conclusion: Publication, availability and selection biases were a potential concern for our meta-analysis of individual participant data. Limited education and information among surrogates may be one of the reasons for ambiguous understanding of surrogacy processes and its potential ill effects. The draft ART Bill of 2010 needs to include a provision for the standard minimum amount to be paid to the surrogates, as well as stricter protections of their autonomy and negotiation power.

b) **Entitlements for Cash Free Maternal Health Services: Experiences from Gujarat, India**

Mahima Taparia, India

This study is about the Janani Shishu Suraksha Yojana, a Government of India initiative to assure free and cashless services to pregnant women for deliveries in public health facilities. The scheme includes: free ante natal care, deliveries and care up to 42 days after delivery, care for sick newborns up to 30 days after birth and for infants up to 1 year of age.

SAHAJ initiated a collaborative project _Enabling Community Action for increasing Accountability for Maternal Health' in 2012 with two partners ANANDI and KSSS in three districts of Gujarat in Western India. The project covers 45 villages and 90,000 population under six Primary Health Centers in Anand, Dahod Panchmahals districts. The main objective of the project is to enable communities to monitor accessibility and quality of maternal healthcare through use of a pictorial monitoring format based on _safe delivery' indicators. The monitoring results in periodic report cards which form the basis of dialogues with healthcare providers and district health officers in order to make the health system more responsive and accountable.

Methodology

All pregnant women in the area are contacted by trained village volunteers twice to get their experiences around quality of maternal health care, once in the 2nd trimester and once around 15 days after delivery. Out of pocket expenditure is one dimension of quality of care from the women's perspective which is recorded. Thus, expenditure data was extracted from the monitoring forms of 500 women between January and June 2015. The analysis of this data was used to assess how well the JSSK is working in the project area.

Findings

Main finding of the study- despite the JSSK more than half the women (51.4%) incurred expenditure for ante natal care, and 48% for deliveries.

Another major finding was that most health care seeking happens from the private sector, where JSSK is not operational. There are various and paradoxical reasons for care seeking from the private sector. In Anand district, which is economically developed, although the public health system is relatively better functioning, the unregulated private sector has managed to capture much of health service provision. In contrast, the backward tribal Panchmahals and Dahod districts, although supposedly high priority districts, the government health system is weak and under resourced/staffed. The impoverished and already vulnerable women are pushed to the private sector. Around 75% of those who went to the private sector incurred expenditures for delivery up to Rs.5000 (USD 80). In Anand District - Pansora PHC,

80% of the women incurred out of pocket expenditure even for ante natal care which is supposed to be provided by the public health system. Even in public facilities, up to 53.4% women (Rasnol PHC) incurred OOPE up to Rs.6000 (USD 100).

Conclusion

JSSK should be expanded to cover maternal health care through the private sector till such time that quality of care is assured in public facilities. Private sector regulation is urgently required. Grievance redressal mechanisms are required and should be implemented in public and private facilities.

c) **Reducing unmet need for family planning in Kiribati: A cost-benefit analysis**
Jacob Daube, New Zealand

Access to family planning is a fundamental human right and is crucial to empowering women and girls to realise their full potential. It is also one of the most cost-effective investments a country can make towards sustainable development. Despite this, progress to ensure universal access to family planning in the Pacific has been inadequate and inequitable. Unmet need for contraception in the Pacific is among the highest in the world. In Kiribati, 28% of married women of reproductive age wish to avoid pregnancy but are not using any form of contraception.

This study models the health, demographic, and economic effects of reducing unmet need in Kiribati and estimates the financial resources required. Three policy models were generated using Spectrum Policy Modelling System, for the period 2010-2050, reflecting three hypothetical family planning scenarios: no change (baseline), where unmet need for family planning remained constant; slow improvement, where all unmet needs were met by 2050; and fast improvement, where all unmet needs were met by 2025. For each scenario, Spectrum was used to project the contraceptive prevalence rate, number of users, family planning commodities and costs, health outcomes for women and children, total fertility rates, population growth, dependency ratio, health and education expenditure and GDP per capita. The resulting data for the period 2010-2025, by year and scenario, were exported for analysis. The impacts of reducing unmet need by 2020 and by 2050 were compared to the baseline scenario for each output of interest. Future costs and health outcomes were discounted at 3% per year.

Results show that meeting unmet would have significant benefits for the health of women and children. Comparing the fast improvement scenario to the baseline, the total contraceptive prevalence rate would rise from 22% to 50% and the contraceptive prevalence rate for modern methods would increase from 18% to 42%. There would be 65% fewer unintended pregnancies each year and 45% fewer high risk births. Subsequently, 18% of maternal deaths would be averted and there would be a 26% reduction in infant deaths. The increasing contraceptive prevalence would also mean that the total fertility rate would decrease from 3.8 to 2.6. Reduced fertility rates would mean that total population in 2025 would be 129,000, compared with 144,000 in the baseline scenario.

Achieving these goals would require AUD$807,000 over a 15 year period to meet all family planning needs, $446,000 more than if unmet need remained unchanged. However, the

population impacts of reducing unmet need would reduce demand for public resources: 23% fewer schools, 19% fewer teachers, 10% fewer health facilities and 10% fewer health workers would be required. This reduction in required human capital and infrastructure would save AUD$18.8 million in government expenditure. Between 2010 and 2025 for every $1 spent on family planning to reduce unmet need by 2020, $23 would be saved in health and education costs.

Social marketing for SRH

Lecture Room (3)

a) **Contraceptive Social Marketing in Asian Countries: Achievements and Lessons Learnt**

Ulimiri Venkata Somayajulu, India

Background

The contraceptive social marketing, conceived by Peter King and his colleagues in 1964, has been embraced by governments, donors and NGOs to deliver health programmes, especially family planning. It makes a product available and affordable while linking it to a communications campaign geared towards behavioural change. Globally, social marketing FP programmes expanded from 23 million participating couples in 2000 to 59 million in 2011. Today, 34% of all couples in the developing world (excluding China) who use contraceptives get them through social marketing.

Objectives and Data Sources

An attempt is made in this paper to have a look at the achievements of contraceptive social marketing programme in terms of health benefits derived by the women in developing countries with focus on south Asian countries. The paper also documents the lessons learnt. The paper is based on the secondary data and publications.

Discussion of results

According to 2013 Contraceptive Social Marketing Statistics published by DKT International, social marketing organizations across the world delivered more impact in 2013 than ever before with 70 million couple years of protection (CYPs), an increase of 6.8% from the 65.5 million CYPs produced in 2012,. The evidence suggests that 93 contraceptive social marketing programmes across 66 countries are providing modern contraception methods at affordable cost and reduce unmet need for family planning among women. Government of India became the first country to initiate contraceptive social marketing programme f in 1968 with the launch of "Nirodh" brand of condoms. The market of family planning products in India has been strengthened with the combined efforts of public, private and non-governmental sectors with social marketing being used now as a key approach for providing accessible and affordable contraceptive products to women from low income families and vulnerable groups. The popular social marketing models adopted include : traditional NGO model, hybrid NGO model and commercial partnership model. The social marketing strategies adopted include behaviour change communication, capacity building, networking, community mobilization, policy advocacy, and mix usage of media (mass media, mid-media and IPC). The countries providing more than one million couple years of protection in 2007 included : Viet Nam - 1,065,000, Ethiopia - 1,467,000, Pakistan- 1,483,000, Philippines - 2,042,000, Nigeria - 2,867,000, Bangladesh - 4,011,000, Indonesia - 4,014,000 and India - 10,263,000. CSM programmes played crucial role in meeting the national public health goals and reduced the load of the hard pressed public sector health services. Evidence based planning was one of the successful strategies adopted by the CSM programmes. Same

approaches and strategies are used to address child survival, HIV/AIDS and reproductive health of the women. Contraceptive social marketing programmes can be further strengthened and scaled up for improving the health status of women, adolescent girls and the children.

b) Increasing access to quality family planning products and services through private sector in Cambodia

Sreymom Em, Cambodia

Background

The Cambodian Demographic and Health Survey in 2010 reported that 56% of men and women of reproductive age preferred to access health services, including family planning (FP) through the private sector. However, private providers are currently not regulated by the government in order to ensure quality of services provided to clients. In July 2014, Marie Stopes International Cambodia (MSIC) worked with the Australian Nongovernment organization Cooperation Program (ANCP) to strengthen the capacity of private service providers to deliver quality FP products and services. This paper summarizes MSIC experience working with private sector to increase access to quality family planning products and services.

Method:

The project was implemented between July 2014 and June 2015 in Kandal province of Cambodia. The activity consisted delivering a comprehensive program of FP training based on a modular curriculum that covered FP methods, counselling, infection prevention, demand creation and stock management. A quality assessment and assurance (QA) was conducted among 100 private sector providers. QA activities include one to one training and mentoring by medical detailers who are also trained midwives. The QA team also reinforced the service delivery concepts with site visits and outbound calling via existing MSIC Hotline.

Result:

Of the 100 providers only 21 had received prior training in FP. Over the life of the project, the number of providers who had started delivering long-term FP services in their private practices increased from 14 to 47, thereby expanding the range of family planning options for their clients. QA team reported that 78 providers demonstrated improved quality of service delivery (Mean QA score increased from 68% to 84%). This contributed to 25% increase in FP product/service delivery by the providers. Reaching to private providers to attend group trainings was a challenge because some providers were unable to take long periods away from their practices. MSIC broke the curriculum into stand-alone modules where appropriate so that the medical detailers can provide on one to one trainings. Recording and reporting of complete data was also a challenge since the providers didn‘t have a system of maintaining client and service records. Our medical detailers then worked closely with the providers in monitoring and recording their product stocks each month, enabling strong estimates of the FP products and services provided.

Conclusion (beyond 2015):
The private sector plays an important role in delivering quality FP products and services. Strengthening support to these providers not only ensures increasing access to FP products and services but also improves quality of services provided to clients. Utilizing the experiences from this project, MSIC will be implementing another similar project in another province of Cambodia to engage private sector in providing quality FP products and services among garment factory workers.

c) Analysis of Financing for Development for Sexual Reproductive Health Issues in Young-Adolescent to Achieve Sustainable Development Goals

Isnawati Hidayah, Indonesia

Sexual Reproductive Health and Right is one of the important issues. SRHR is basic needed of a human being, it has to be fulfilled and get attention. It is important to achieve healthy life for everyone. The 192 UN member states agreed at the Rio+20 summit and started to start a process of designing sustainable development goals, which are "action-oriented, concise and easy to communicate, limited in number, aspirational, global in nature and universally applicable to all countries while taking into account different national realities, capacities and levels of development and respecting national policies and priorities". One of the goals is Ensure healthy lives and promote well-being for all at all ages.

Sexual Reproductive Health as a part of SDGs. The aim is to end poverty and hunger and to achieve sustainable development in its three dimensions through promoting inclusive economic growth, protecting the environment, and promoting social inclusion. United Nations commits to respecting all human rights, including the right to development. UN will ensure gender equality and women's and girls' empowerment. One of women and girl's needed right to get health condition, especially which correlated with Sexual Reproductive Health and Right. To support this cases, UN states Financing for Development which reiterate the need for gender mainstreaming, including targeted actions and investments in the formulation and implementation of all financial, economic, environmental and social policies. As the example, one of the main problems faced by young people is their lack of participation in nation building. This can be traced back to the high rate of early marriage and the high level of poverty in underdeveloped regions. Not only that, but also how they face HIV/AIDS, get knowledge about Reproductive Health, etc., the level of education, an age of marriage, and poverty are interrelated. The lower the education level is, the higher the rate of early marriage will be. Poverty also significantly contributes to early marriage. These ever increasing problems prevent the youth from performing their tasks and functions. World Bank, 2007 explains about Task and Functions of youth which is concluded as Youth Five Life Transitions: continue learning, start working, form families, exercise citizenship, practice healthy life.

This type of research is qualitative while the method used is a qualitative method with a descriptive approach. Most of the data collected through observations and supported by literature studies. The aims of this study determining that Financing Development covers Sexual Reproductive Health and Right for women, young generation and teenagers. The result of this study also shows FfD reaffirms that achieving gender equality, empowering all

women and girls, and the full realization of their human rights are essential to achieve sustained, inclusive and equitable economic growth and sustainable development. Because investing in children and youth is crucial actor and critical to achieving inclusive, equitable and sustainable development for present and future generations, and Ffd mentions recognizing the need to support countries that face particular challenges to make the requisite investments in this area especially which has correlation with SRHR.

SRH commodities security

Lecture Room (4)

a) **Nation-wide Facility assessment for Reproductive Health commodities and services in Myanmar (2014)**

Kyaw Oo, Myanmar

Although Myanmar gave priority to maternal and child health services and considerable inputs have been invested to improve these services, inadequate health resources at different levels and over workload of staff are still challenging for targeted achievements. Most importantly, reproductive health (RH) services must be of quality in all aspects. In this regard, regular supply of medicines for emergency obstetric care (EmOC), infections and contraceptives to meet the needs of facilities is crucial. In this regard, this survey addressed stock-out of RH commodities supply chain (including cold chain); staff training and supervision; availability of guidelines and protocols, availability of information technology, methods of waste disposal and users' fees and finally the views of clients about the services. The survey was conducted in June to August 2014 in collaboration of The Departments of Medical Research and Maternal and Reproductive Health Division (MRH) of the Department of Public Health, with financial support from UNFPA's Supplies Programme, using global standard tools to enhance Reproductive Health Commodity Security. A cross-sectional descriptive design was used to assess a representative sample of 408 health facilities covering three different levels (i.e. tertiary level, district/township level and primary level) from all administratively divided States and Regions. Survey teams were set up with enumerators, team leaders and field supervisors after giving training and pretesting.

Fifty eight percent of health facilities (HFs) could provide at least five modern contraceptive methods. However, one-third of HFs was lacking almost all items of RH medicines mainly due to delay in supply (58%). Availability of at least 7 life-saving RH medicines was 43% in primary level, 75% in secondary level and 89% in tertiary level HFs. Majority of HFs had stock-out for at least one contraceptive method within the last 6 months. Supply system was mostly irregular and inconsistent. One-fourth (24%) and two-third (67%) of HFs had no trained staff for birth spacing and hormonal implant method respectively. Seventeen percent of HFs had received no supervisory visits related to RH during the last one year. Supervision for RH activities was less frequent at tertiary level and secondary level HFs compare to primary level. Supervisions were mostly related to quality of reporting, drug stock-outs and the use of guideline/job aids and less related to staff clinical practice and training. Mobile phones and personal computers were mainly used for communication and for record keeping respectively. Wastes were disposed mostly by burying and burning. Forty-five percent and 42% of tertiary level HFs used municipal system and incineration respectively. Most of clients satisfied with waiting time, cleanliness, privacy and consultation time. Personal relationship and communication of staff were satisfied by more than 90% of clients.

The survey provides evidence-based information for health system strengthening including supply chain management and the provision of quality reproductive health

commodities and services for achieving RH commodity security of the country. The report will be invaluable in the country's continued efforts to reduce Maternal Mortality Rates, Under 5 Mortality Rates and Infant Mortality Rates.

b) **Stock out of FP and Lifesaving commodities major hindrance of healthy sexuality and sexual rights in Nepal**

Krishna Prasad Bista, Nepal

Background: Reproductive health commodities are basic requirement to control unintended child birth and enjoy healthy sexuality. About 80% of Nepal‘s population is rural with 30% below the poverty line. Majority rely on the Government‘s health system for health services, which are obstructed by routine stock-outs of essential live saving drugs such as ORS, condoms, pills, DMPA etc. Despite multiple advances on the country‘s MDGs, for instance, over one-fourth of married women still have an unmet need for family planning and two-thirds of all deliveries still occur at home. Access through reliable supply of contraceptives, medicines and equipment are fundamental to all SRHR programming. The goal of a health logistics system is much larger than simply making it available. It includes assurance of every customer has commodity security. Quality service and drugs as promised by the GON must be received by all irrespective of gender, age, caste, color, status, religion etc.

Objective: To review and to assess the linkages between the RH commodity stock out situation and Sexual Rights of women to healthy sexuality.

Methodology: The assessment consists analysis of secondary data, commodity stock out data from the national Logistic Management Information System, literature reviews and interaction with individuals/organizations, who have been continuously working on these areas.

Findings: Despite significance reduction in the stock-out of FP commodities and tracer drugs since the introduction of LMIS in 1994 (53% - 14%, 80% - 48% respectively), sustained availability of essential and auxiliary commodities at all levels is still an issue. It has taken 10 years since 2000 (62%) to reduce by 16% of stock out of tracer and only 4% reduction of FP commodities (of 23% stock out). NDHS 2011 shows that half of women age 15-49 were sexually active during the four weeks, 18% had been sexually active in the 12 months, and 21% women never had sexual intercourse. The percentage of girls age 15-19 who reported never have had sex increased from 68 percent in the 2006 to 71 percent in the 2011 contribute to the accessibility of affordable contraceptives. Over the last 10 years, LMIS data has demonstrated a reduction in stock-outs of family planning commodities from 53 percent to 14 percent. However, a need to ensure sustained availability of essential commodities at all levels of facility to cater to the most vulnerable and needy population who remain the furthest away with high unmet need. So the rights issue is still far away. Making availability of contraceptives to all has a vicious circle chain from a longer lead time to RH friendly health facilities. Limited understanding on logistic concepts, time, transporting funds, inappropriate planning process, effective inventory control system, capacity of staff, absence or transfer of

trained personnel, policy and procedures and storage space and conditions are key limitation and logistic barriers to provide SRHR.

Conclusion: to come out from high unintended pregnancy and enjoy sexuality it has to be considered making easy availability of quality FP commodities by addressing challenges on commodity management with priority by all partners.

c) **Reproductive Health Commodity Security to address Unmet Need for Family Planning in Myanmar**

Khaing Nwe Tin, Myanmar

ABSTRACT

Reproductive Health Commodity Security (RHCS) is an integral part of Sexual and Reproductive Health and Rights. Without securing the contraceptive commodities, unmet need for family planning cannot be reduced. RHCS exists every person is able to choose, obtain and use of quality contraceptives and other essential RH products when they want.

Background:

Although there is high demand for family planning, the high burden of induced abortions, low CPR, and high unmet need for family planning shows insufficient supply to clients' demand. When demand increases, there is increased pressure on existing service capacity, establishing and maintaining contraceptive security in Myanmar.

Objective:

To review and analyze factors influencing RHCS and to identify ways to improve RHCS aiming to increase contraceptive use and reduce unmet need for family planning in Myanmar.

Study method:

The methodology was literature review of published articles and unpublished documents related to RHCS and family planning in Myanmar. The SPARHCS (Strategic Pathway to RHCS) framework was used for conceptual model and all constraints related to Myanmar context were analyzed.

Findings:

In general, RHCS has not been well addressed, and poor financial commitment, limited knowledge and accessibility of FP services among the underserved populations like adolescents and ethnic groups and in hard-to-reach areas, unavailability of many methods especially implants, the inefficient supply chain, the lack of nationwide LMIS and proper LMU, poor coordination among sectors, and limited capacity and shortage of providers have been recognized.

Conclusions:

Challenges are found in all components of SPARHCS framework that leads to distribution of commodities by a "push" system. It results inadequate or oversupply of commodities in public sectors and financial inaccessibility in private sectors. Clients cannot choose, obtain,

and use contraceptives when they want and RHCS has not been reached in Myanmar. Therefore, RHCS should be given higher priority to achieve its objectives.

Recommendations:
For policy maker level, it is essential to improve enabling environment through priorities actions like prioritization RHCS strategy, strengthening the supply system, setting the Logistic Management Unit and nationwide Logistic Management Information System, coordination among stakeholders and enhancing Public Private Partnership. For the programme level, community based distribution of contraception especially in underserved population, coordination between the procurement committees and monitoring of contraceptive security status and further research to explore the hidden information and gaps should be done. Provision of the quality FP services to all regardless of age and marital status is recommended at the provider level.
Key words: RHCS, contraception, security, unmet need, Myanmar

d) **Strengthening the Public Health Supply Chain Mechanism below district to improve the health service delivery.**
Ram Bahadur Thapa,Chitra Mahato, Nepal

Introduction: Though, Nepal has made significant progress in Reproductive Health indicators, the progress is uneven among the districts. Kapilvastu a Western Terai district of Nepal has low contraceptive prevalence rate (29%), high unmet need of FP methods among young (34%), high in unwanted pregnancy, unsafe abortion, maternal mortality and mobility. One of the major causes responsible for this as spell out by the local communities was stock out situation in the local health facilities below the district. Uninterrupted supply of RH/FP commodities was a pre- requisite for improving the RH/FP for achieving the MDGs, improving the health of women and to realize the constitutional rights of the people as universal access to basic health services. UNFPA, Nepal designed an innovative approach to build the capacity of district and local health facilities for uninterrupted supply of essential health commodities below the district that has very encouraging results.
Purpose: Improving the health service delivery through uninterrupted supply of the RH/FP commodities including essential drugs at local health facilities.
The objectives of the programme: 1. To ensure the timely distribution of medicines, RH commodities in peripheral health facilities. 2. To increase the Logistic Management System (LMIS) reporting.
3. To decrease the stock out situation of medicines & RH commodities.
Methodology:
Involvement of Non-government sector : The local NGO as a service provider selected and contracted to ensure appropriate supply chain management in a scientific way. **Inventory management**: The NGO used an electronic inventory management system that update and maintain the inventory status regularly. **Order tracking and packing:** The service provider prepared the orders and packed the medicines in national standard not compromising the quality of product. **Transportation and Delivery**: The delivery of goods was done in quarterly basis based on tracked order provided by Health faculty. There is the provision of emergency supply in case of emergency also.

Information Services: The NGO maintained the information to monitor stock movements, order status, and invoicing using electronic data management systems.

Results:

• After the intervention, the distribution of medicines and RH commodities is increasingly improved resulting the reduction of district unmet need of FP from 37 % to 27 % among Adolescents.

• Five key commodities are available from 65 % to 90% in health facilities. • The submission of LMIS reporting to district reached at 90 % in comparison to 47%.

• The stock out situation of medicines and RH commodities in peripheral Health faculty was reduced at 10% from 43 %.

Conclusion:

Uninterrupted supply of Health commodities is a prerequisite for effective health services particularly for women and adolescents who have limited time to visit to health facilities. The service must be there when they visit the facilities. It has been very less likely that the women and girls will have repeated visit for the same service particularly in the context of Kapilvastu district. To address this problem and to reach to universal access of basic health services it will be the best module as public - private partnership to below district level lead to significant cost savings and service-level improvements

Financing SRHR in Humanitarian response

Lecture Room (5)

a) Implementing MISP (Minimum Initial Service Package) for reproductive and sexual health services for the flood affected people in Bangladesh: A case study

Masum Al Jaki, Bangladesh

In the late August of 2014, Flash floods were triggered by heavy rain and water from upstream hilly areas across the border inundated the northern part of the country. There was complete shutdown of public health care facilities with zero institutional deliveries. A high need for maternal and child health services engulfed these districts.
Mothers and children were mainly affected due to interrupted health services. Lack of adequate emergency health care services especially family planning services including oral contraceptives and condoms were significant.

The SPRINT Initiative led by the International Planned Parenthood Federation (IPPF) provided an emergency response grant of 32, 661 USD to implement the Minimum Initial Service Package (MISP) among the communities in Districts of Northern Bangladesh affected by the Floods . The project was implemented by IPPF Member Association, Family Planning Association of Bangladesh (FPAB).

This was mainly to provide family planning and sexual and reproductive health (SRH) services to the flood affected people. The interventions included provision of family planning services including pills and condoms, counselling services on how to get follow up of the methods through FPAB team or any other service providers.

A rapid assessment was condcted to assess the reproductive health needs in the flood affected areas before starting the interventions. Several meetings were conducted with different departments of government, and with local community for further liaison. The MISP intervention was carried out from September, 2014 to February, 2015 in Kurigram, Gaibandha, Bogra and Jamalpur districts. The MISP intervention provided services to 48,145 flood affected people (Male: 26,225, Female: 21,920). A total number of 9,885 women of reproductive age (15-49), 2,299 pregnant and lactating women, 426 men and boys and 5153 adolescents of age (10-19) provided with SRH related services.

MISP training for the service providers and other managers of the project was held to implement the MISP. The organisation formed a large number of community awareness group to prevent sexual and gender based violence and conducted several awareness raising campaigns. Through the project, condoms were distributed for prevention of HIV and STI and also as a safe family planning method. Safe and clean delivery kits and midwifery kits were also distributed in local level and pregnant women with complications were referred to tertiary level hospitals to ensure safe deliveries. This is first of its kind in a Muslim country like Bangladesh where female and adolescent girls received condom.

The project activities were implemented in close collaboration with the local leaders, district and national level government representatives, teachers of the local schools, youth

volunteers and the host communities. With IPPF-SARO support, FPAB conducted several preventive and curative SRH interventions both at the camp and government health facilities like community clinics at community level. The condom distribution to female married women and young girls in rural setting had huge implications with regards to their empowerment and negotiation skills on condom use. But mostly it has impacted on the ability of women in decision making process of her reproductive health.

b) Integration of the Minimum Initial Service Package (MISP) for Reproductive Health by a local NGO with MOH Basic Health Services for Internally Displaced communities in Kachin State

Phyo Thandar Aye, Myanmar

The Kachin State Maternal and Child Welfare Supervisory Committee and Myitkyina and Waingmaw Township‘s MCWA, under guidance from Myanmar Maternal and Child Welfare Association (MMCWA) based at Naypyidaw; implemented the MISP for the provision of sexual and reproductive health (SRH) services to the people living in the IDP camps of Myitkyina and Waingmaw Townships Kachin State, Myanmar. The IPPF-SPRINT MISP Emergency Response project targeted 38 IDP camps in two townships and reached a total of 9377 beneficiaries from March to July 2015.

The SPRINT-MMCWA project presented an opportunity to recognize and prioritize SRH services provided to conflict affected populations. It is recognized that local actors‘ best understand the needs of a particular community. This is echoed by the survey done by the World Humanitarian Summit, regional consultation for the South and Central Asia, 2015.

MMCWA has good rapport and coordination with local, national and international NGOs working for SRH and Humanitarian settings. These include Government of Myanmar, Ministry of Health (MOH), UNFPA, UNICEF, MSF, IMC, MRCS, etc.

This joint initiative has resulted in a successful and sustainable model where community leaders, health staff and midwives continued outreach activities and SRH services including awareness program on SGBV and prevention on HIV & STI transmission in camps beyond the project period.

The project was reviewed and evaluated, based on the data collected, by the IPPF-SPRINT National Focal point and SPRINT Regional Team with the support of MMCWA staff.

The integration of MMCWA‘s MISP project into government basic health services complimented for effective use of RH commodities and service provision, while focusing on key MISP objectives. SPRINT-MMCWA provided capacity building by orientating the midwives, MMCWA staff, community leaders and IDP camp coordinators on the MISP. This process allowed focus on key aspects of the MISP, highlighting gender based violence, HIV/STIs and prevention of maternal and newborn mortality and morbidity.

The successful implementation of SRH services in collaboration with the government by a national NGO has shown the positive impact on the project and resulted effective service delivery with accuracy, quality and access to SRH services for IDPs from conflict affected region in Kachin. The capacity building of service providers, project coordinators and local stakeholders on SRH services and MISP to be continued and integrated into Basic Health care services for the IDPs. Engaging local focal person enhanced better communication among project implementers, project coordinators, camp coordinators and local health department staffs which lead to implementation of successful project.

Challenges included limited coverage of IDP camps due to time and budget in addition to the need for attention on SGBV and STI/HIV prevention among adolescents in IDP camps. Nevertheless, the integration of the MISP by a local NGO with MOH Basic Health Services demonstrates a sustainable approach to support SRH services in conflict affected populations.

c) Integrating the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) in National and Local Disaster Risk Reduction and Management Plans: Sharing the Philippine Experience

Florence Tayzon, The Philippines

The Sendai Framework adopted by187 UN member States in March2015 aimed to achieve a substantial reduction of disaster risk and loss in lives, livelihoods and health... in the next 15 years through preparedness and community resilience. Provision of the Minimum Initial Service Package for Sexual and Reproductive Health in emergencies will save the lives of thousands of pregnant and lactating women if MISP was part of the overall government health response.

Objectives: The paper aims to share how the MISP for SRH got integrated into the health emergency package of the Department of Health and how the Department of Health led its integration in the overall National Disaster Response Plan. Likewise, at the local level, the paper aims to show how local government units are integrating the MISP for SRH in their local disaster risk reduction plans.

Methodology: Using the cluster approach, UN and NGO humanitarian partners who have had extensive experience in implementing the MISP in various emergencies particularly Typhoon Haiyan as members of the RH Working Group were effectively mobilized to advocate to the DOH for the passage of a policy issuance integrating the MISP as part of the essential health services to be provided by government during emergencies to address the needs of pregnant and lactating women, adolescents and men. In like manner, LGUs who experienced disasters and had very active local RH Working Groups had a better appreciation of the importance of integrating MISP in their local disaster plans.

Results: As a result of effective evidence-based advocacy, an Administrative Order is about to be issued this October by the Department of Health officially integrating the MISP in its essential health emergency package. More importantly, a Joint Memorandum Circular will be

signed by the Department of Health (for RH), Department of Social Welfare and Development (for GBV) , the Department of Interior and Local Government (for LGU implementation), and with the Office of Civil Defense (for integration in the National disaster Response Plan) for MISP nationwide implementation this November (Both major policy instruments are expected to be signed before the APCRSHR). Meanwhile, a number of LGUs have already integrated MISP in their local disaster risk reduction and management plans.

Conclusions: With MISP for SRH integrated in national and local disaster risk reduction and management plans, there will be a substantial reduction in maternal and infant mortality and morbidity. This will hopefully contribute to the attainment of the Social Development Goal of Good health for everyone!

d) Provision of Sexual and Reproductive Health (SRH) Services through MISP in Crises for earthquake affected people of Nepal.

Nimisha Goswami, India

Background: On 25th April, 2015 a massive earthquake measuring 7.8 in the Richter scale was experienced in Nepal. Barpak VDC in Gorkha district, 80km northwest of Kathmandu was the epicenter. Continued aftershocks followed throughout Nepal. Fourteen districts were hardest hit by the earthquake, while other districts are also reported to be affected. As per MISP calculations, there are about two million women in reproductive age who have been affected by the earthquake in Nepal. Out of which there should be about 126,000 women who were pregnant and were in need of clean delivery and reproductive health kits and 40,000 women at the increased risk of sexual and gender based violence.

Methodology: International Planned Parenthood Federation South Asia Region (IPPF-SAR) and the Department of Foreign Affairs and Trade (DFAT) of the Australian Government through SPRINT Initiative supported its Member Association (MA) Family Planning Association of Nepal (FPAN) to provide Sexual and Reproductive Health and General Healthcare services in the affected areas through its existing clinics and Reproductive Health camps. Aid amounting to USD 100,000 has been allocated for a five month period starting from May, 2015. IPPF established its partnership with the United Nations Population Fund (UNFPA), USAID and Tata Company to provide Reproductive Health Services. Also an Emergency Response Management System (ERMS) was put in place for managing this response effectively.

Salient Findings: The services have been delivered through mobile reproductive health camps, Female Friendly Spaces (FFS), Maternity Transit Homes/ Maternity Care Centre (MTH/MCC). Timely response played an important role and also Coordination with various other partners such as UNFPA, USAID, ECHO, Army and Ministry of Health and Population etc was very beneficial. IPPF/FPAN coordinated with the Ministry of Health and Population, Ministry of Women, Children and Social Welfare and Reproductive Health Sub Cluster. More than 200 camps have been organised by FPAN. Through the medical health camps more than 19000 affected people were provided with SRH services and 450 Dignity Kits

were distributed. More than 3200 people have been provided with STI/HIV services, 5671 Women in Reproductive Age Group and 13000 Young men and boys have been provided with SRH services. Also FPAN has assisted in provision of more than 200 safe deliveries alongwith provision of family planning services like Intra-uterine services, Emergency contraceptives etc.

Timely response can play an important role in such kind of a response and also can save a lot of lives during emergencies. During the Response, Coordination and Communication with various other partners such as UNFPA, USAID, ECHO, Army and Ministry of Health and Population etc have provided tremendous support to this response. It is strongly felt that timely coordination between various partners has all the ingredients to make a response successful for the organization. Also, at the organizational level it was felt that synergy and strong coordination really worked well for the Organization (IPPF) and SPRINT Initiative which is a donor funded project.

SRHR responses

Lecture Room (6)

a) Antenatal screening of anemia including iron deficiency anemia, haemoglobinopathies and thalassaemia among the pregnant women living in Bago region of Myanmar.

Moh Moh Htun, Myanmar

Background: Anemia in pregnancy is a major health problem in many developing countries (33-75%) and is associated with increased rates of maternal and child mortality, premature delivery and low birth weight. The present study was conducted to screen out anemia including iron deficiency anemia, haemoglobinopathies and thalassaemia among pregnant women attending ante-natal clinic of Maternal and Child Health Center (MCH) in Bago region of Myanmar during 2014-2015.

Methods: A cross -sectional descriptive study was carried out in randomly selected 478 pregnant women living in different villages within the age of 18- 43 years and 12-40 weeks of gestation. Anemia was determined by using rapid haemoglobin (Hb) analyzer (Hemocue). Past medical, surgical and obstetric history, social and education status were recorded from the study participants. Red blood cell parameters (Hb %, total red blood cells count, mean corpuscular volume, and red cell width), blood film examination, Osmotic fragility test (OFT), determination of Hb A2%, Hb F % and serum ferritin, H Inclusion test, iso- electric focusing (IEF) were done on pregnant women with Hb less than 11g%in the laboratory at Pathology Research Division, Department of Medical Research.

Results: Anemia (mean Hb 10.2 g %) was detected in 268 pregnant mothers (56%). The most common age group was 20-30 years (63.6%). Most of them were dependent (65%) with primary school level of education (38.1%) and their family income was one hundred to two hundred thousand kyat monthly (71.8%). The commonest gestation of pregnancy was more than 24 weeks (68%) and number of family members was mostly less than 5 (70.7%). The commonest hemoglobin A type (normal Hb) was detected in 195 (76.5%) and other abnormal Hb types (Hb EA, EE and AH) were found in 60 subjects respectively. (21.6%, 1.5% and 0.4) Hemoglobinopathies were detected in 61 pregnant women (28%) and iron deficiency anemia (serum ferritin <30 μg/ml) was found in 89 pregnant mothers (52.5%). Alpha thalassaemia minor was detected in one pregnant mother with anemia and silent beta thalassaemia minor was detected in 28 pregnant women with anemia (12.8%). Hb concentration was significantly different in types of hemoglobin variants. (p=0.008) There were no significant differences between Hb concentration and gestation of pregnancy (p=0.316), education (p=0.711) and family income (p=0.282). Serum ferritin was significantly decreased in more than 24 weeks of pregnancy (p= 0.012) in this study.

Conclusions: In the present research study, iron deficiency anemia is the commonest type of anemia and others are hemoglobinopathies, alpha thalassaemia and silent or minor beta thalassaemia. Anemia is one of the main health problems in pregnant women living in rural areas in Bago region of Myanmar. Prevention and proper treatment of anemia are important

requirements to be included in future health planning for reduction of maternal, child mortality and morbidity. Therefore public health education or information on reproductive health, monitoring the compliances of women towards ante-natal care services and strengthening of their health care seeking behavior are important measures to be practiced in rural communities in Myanmar.

b) Increment of Financial Resources on Sexual and Reproductive Health and Rights in Family Planning Association of Nepal

MINITA PANT,Nabian Maharjan, Nepal

Background:

Family Planning Association of Nepal (FPAN) has been working on the field of sexual and reproductive health and rights (SRHR) with financial and technical support from International Planned Parenthood Federation (IPPF) since its establishment 1959. But recently funding modality has been changed as multi donors prefer to invest in FP/SRH. Investing in SRH/FP has quantifiable benefits such as achieving universal access of FP /SRH, reduce maternal mortality, unwanted pregnancies, unmet need, unsafe abortion, STI/HIV, infertility etc. Due to increment of funding in FPAN, it had provided 48.9 million services especially to youth, poor, marginalized, socially excluded group in remote area which was 33 million in 2010 and FPAN projected to provide 66 million services in 2015.

Objective:

To analyze the value of funding trends of investment and its impact in expanding the services and service centers in FPAN'S remote districts.

Methodology:

Analysis of funding trends on FPAN from 2010 to 2015
Internal / External financial Audit
Data Audit
Annual report of FPAN

Results:

- Increment in FPAN annual budget
- Increment in FP/ SRHR services, in 2010 it was 33 million and in 2014 it was 48.9 million services.
- FPAN succeed to reach in poor, marginalized and socially excluded groups through expanding and strengthening its service centers.
- FPAN received regular annual financial support from IPPF.
- FPAN also has been funding by multi donors such as European Union, USAID, UNFPA, JICA, COICA, WWF, FINDLAND, Danida, Global Fund, BNMT, DFID, Jersey Fund, Bill and Melinda Gates etc.
- Due to FPAN work on SRH /FP and its recognition in country donors were interested and trusted to invest in FPAN for SRH services.
- FPAN was accreditated by IPPF mainly for its financial transparency and strong financial mechanisms.

Conclusion:
Investing in FP /SRH has increased the services in remote area especially to youth, women, and poor, marginalized and socially excluded communities. So more investment in FP / SRH is needed to reach in this community to address unmet need of FP which is still remain 27% amongst women of reproductive age as well as to increase the universal access of SRH services.

c) Positive Changes in Nepal as a result of integration SRH and biodiversity conservation

Amu Singh Sijapati, Nepal

Issue: Population growth coupled with widespread poverty in Nepal's Terai Arc Landscape (TAL) has led to increased dependency on forests leading to degradation of natural resources. Limited livelihood opportunities in these areas, drive adolescents and youth to India and Gulf in search of employment, making them vulnerable to STIs and HIV. Sexual and reproductive health (SRH) is not adequately addressed by the public health system in Nepal in the TAL leading to a high unmet need in these areas. SRH and biodiversity conservation programs have till recently been implemented vertically in the buffer zones and adjoining areas of biological corridors and critical bottlenecks in Nepal. In this context, in a first of its kind initiative in the country, World Wildlife Fund (WWF) Finland, Family Federation of Finland (Väestöliitto), WWF Nepal and Family Planning Association of Nepal implemented a 3-year pilot project on integration of SRH and biodiversity conservation for sustainable management of natural resources. Objectives: To implement and measure, over a three year period, the positive changes as a result of integrated SRH services and biodiversity conservation. In addition, the project aimed to increase involvement of the local population in capacity building related to SRH and biodiversity conservation. The project has sought to contribute towards sustainable management of natural resources and increased access to sexual reproductive health and rights (SRHR) services and improved livelihood conditions in the intervention areas. Methodology: Since January 2011, the integration project is being implemented in 33 Village Development Committees in Chitwan, Dang, Banke, Bardia and Kailali districts of Nepal. Participation and partnerships with local youth in planning, implementation and monitoring and integration of biodiversity conservation and SRH are key approaches adopted by the project. Baseline and end-line surveys were conducted to ascertain the major changes in SRH and biodiversity conservation due to integration. Results: The findings of end-line survey as compared to baseline survey demonstrate the positive changes due to integration of SRH and biodiversity conservation. The comparative analysis shows that the use of biogas increased from 23% to 31%; use of fuel wood in traditional stove decreased from 88% to 82%; local people's involvement in capacity building related to biodiversity conservation and SRH increased from 24% to 43%; youth involvement in biodiversity conservation activities increased from 15% to 50%; the use of family planning service increased from 52% to 63%;awareness about HIV counseling and testing services increased from 42% to 64%. Lessons Learned: Involvement of local youth was key to the success of the project. Capacity building and exposure opportunities as well as a feeling of

ownership motivated the youth to contribute more for SRH and conservation. Biodiversity conservation benefits not only the forests and wildlife, but also the livelihoods of the populations dependent on them. Through an integrated approach to conservation and public health, involvement and empowerment of local communities, the link between SRH and resource use within these communities can be addressed in a sustainable way.

1.4 Fourth Parallel Sessions
Track (4): SRHR integration in Health Systems

	Sex Talk – Exploring Sexuality Education and Communication
Room 1	**Ma Ma Oo Radio Program: A window which every woman can open and feel the experiences of Reproductive Health in Myanmar.** Hnin Kalyar Kyaw[1], Angela Davis[2], Thwe Thwe Win[1], Jo Elsom[2], Aye Aye Myint[1], Tamara Abusham[2], Cheri Mangrai[2], Vipul Khosla[2], Zeyar Myo[3], Phone Myint Win[1], Lia Burns[4], Claire Ryan[1], *[1]Burnet Institute Myanmar, Yangon, Myanmar, [2]Australian Broadcasting Corporation, Victoria, Melbourne, Australia, [3]Myanmar Radio and Television, Yangon, Myanmar, [4]Burnet Institute Melbourne, Victoria, Melbourne, Australia*
	From pilot to program: How a national youth hotline is increasing youth access to quality sexual and reproductive health information and services in Timor-Leste Helen Henderson[1], Deodora Pereira[1], Jaewha Oh[2], *[1]Marie Stopes International Timor-Leste, Dili, Timor-Leste, [2]UNFPA Timor-Leste, Dili, Timor-Leste*
	Effects of Comprehensive Education Service on Sexual and Reproductive Health among Migrant Children in Beijing, China Yue Hu[1,2], Wenli Liu[1,2], *[1]School of Brain and Cognitive Sciences, Beijing Normal University, Beijing, China, [2]Center for Collaboration and Innovation in Brain and Learning Sciences, Beijing Normal University, Beijing, China*
	Integrating HIV in SRHR for Vulnerable Groups
Room 2	***Sexual beliefs and practices associated with sexual transmitted infections among taxi drivers in Hanoi, Vietnam*** La Quang[1], *[1]Hanoi School of Public Health, Hanoi, Viet Nam*
	Engaging communities to address the Sexual Reproductive Health gaps of People Living with HIV through integrated approach Nisha Jagdish Poojary[1], Prashant Saraf[2], Rekha G[3], Uma Patil[3], Sugath Gaikwad[3], Kalpana Apte[1], *[1]Family Planning Association of India(FPA India), Mumbai,Maharashtra,South Asia, India, [2]FPA India, Hyderabad,Solapur, India, [3]FPA India, Bangalore,Belgaum,South Kanara ,Bijapur, India*
	Integrating SRHR in MNCH Services
Room 3	**Understanding blood transfusion management system in public health facilities in selected districts of Bangladesh: A qualitative investigation** Rasheda Khan[1], Sharmin Islam[1], Marzia Sultana[1], Mahbub Elahi Chowdhury[1], *[1]icddr,b, Dhaka, Bangladesh*
	From D&C to Vacuum Aspiration and Misoprostol: Ensuring Quality and Appropriate Use of Technology for Postabortion Care in Myanmar Ni Ni[1], Eva Canoutas[3], Theingi Myint[2], Myint Thu[1], Alison Edelman[3], Tin Lei Lei Aung[1], Cheri Poss[3], *[1]Ipas Myanmar, Yangon, Myanmar, [2]Department of Health, Ministry of Health, Naypyitaw, Myanmar, [3]Ipas, North Carolina, USA*
	Task-sharing incomplete abortion services: decentralizing care by increasing involvement of non-physician and primary care providers with use of misoprostol Laura Frye[1], Rasha Dabash[1], Jill Durocher[1], Beverly Winikoff[1], Pena Melanie[1], *[1]Gynuity Health Projects, NY, NY, USA*

Youth Voices from Myanmar	
Room 4	**Perspectives of youths towards Reproductive Health services in rural and urban areas of Myanmar** Saw Saw[1], Theingi Myint[2], Wai-Wai Han[1], Myo-Myo Mon[2], *[1]Department of Medical Research, Yangon, Myanmar, [2]2. Maternal and Reproductive Health Section, Department of Health, Naypyitaw, Myanmar*
	Need of Formal Sexual and Reproductive Health and Rights education to enhance knowledge and perception of adolescents living in different areas of Yangon City Khine Cho Myat[1], Moe Hnin Phyu Myint Lwin[1], Htet Aung[1], *[1]Myanmar Women and Children Development Foundation, NayPiDaw, Myanmar*
	The potential of rural Youth Centres supporting Myanmar towards the Sustainability Development Goals 2030 - The case of Youth Information Corners in rural Myanmar Hla Hla Aye[1], Yu Myat Mun[1], Sithu Swe[1], Agnethe Ellingsen[2], Aye Nyein Lin[1], Moe Zaw Latt Htun[1], Si Thu Soe Moe[1], *[1]UNFPA Myanmar, Yangon, Myanmar, [2]Queen's University Belfast, Belfast, UK*
Youth Speak- Exploring the Integration of SRHR in Adolescent and Youth Health Services	
Room 5	**Juniors' Responsibilities in Gender and Adolescent Development (JR GAD)** Rolando Borja[1], Honey grace Aguba[1], *[1]Commission on Population Regional Office XI, Davao City, Philippines, The Philippines, [2]Commission on Population Regional Office XI, Davao City, Philippines, The Philippines*
	Menstrual Hygiene Management in Indonesia: Understanding practices, determinants, and impacts among adolescent school girls Jessica Davis[1,2], Alison Macintyre[3], Wayan Suriastini[4], Chelsea Hugget[3], Faiqoh NA[5], Athifa Rahma[5], Bestha Inatsan[5], Claire Quillet[6], Stanley Luchters[1,2], Elissa Kennedy[1,2], *[1]Burnet Institute, Melbourne, Victoria, Australia, [2]Monash University, Melbourne, Victoria, Australia, [3]WaterAid Australia, Melbourne, Victoria, Australia, [4]SurveyMETER, Yogyakarta, Indonesia, [5]Aliansi Remaja Inependen, Jakarta Selatan, Indonesia, [6]UNICEF Indonesia, Jakarta, Indonesia*
	Sexual Reproductive Knowledge, Attitudes and Behavior among Adolescent Akha Females, LuangNamtha province, Lao People's Democratic Republic (PDR): A Qualitative and Quantitative Study Vanphanom Sychareun[1], Kongmany Chaleunvong[1], Visanou Hansana[1], Vathsana Somphet[1], Phouthong Thammavongsa[1], Jo Durham[1], *[1]University of Health Sciences, Vientiane, People's Democratic Republic of Lao, [2]3University of Queensland, School of Public Health, Herston,, Brisbane, Australia*

For Adults Only- Towards Effective SRHR Integration in Adult Health Services	
Room 6	**CARE NEEDS VERSUS CARE SUPPLIED: The Nursing Strategies for Senior Gays and Lesbians** Jed Patrick Catalan[1], *[1]Cebu Normal University, Cebu City, The Philippines*
	Client Satisfaction on Family Planning Services through Mobile Clinics in Rural Areas in Myanmar Authors: Sunshine Aung[1], Phyo Wai Min[2], Okkar Aung[3], Ei Ei Tin[4] Sunshine Aung[1], Phyo Wai Min[1], Okkar Aung[1], Ei Ei Tin[1], *[1]Marie Stopes International, Yangon, Myanmar*
	Integration SRH services in to health system in Sri Lanka Hemantha Senanayake[1], *[1]epartment of Obstetric & Gynecology, Faculty of Medicine, University of Colombo, Sri Lanka, Sri Lanka*
Male Involvement	
Room 7	**Reproductive morbidity and health care utilization among financially capable rural mother in India** Mukesh Ravi Raushan[1], Hemkhothang Lhungdim[1], *[1]International Institute for Population Sciences, Mumbai, Maharashtra, India, [2]International Institute for Population Sciences, Mumbai, Maharashtra, India*
	Decision-making level on Health Care Services Utilization in a Peri-Urban Area of Myanmar Kyi Mar Wai[1], Chiho Watanabe[1], *[1]School of International Health, The University of Tokyo, Tokyo, Japan*
	Does Women's Autonomy Affects Utilization of Maternal and Child Health Care Services in India? Kaushlendra Kumar[1], Shrividya Malviya[2], *[1]Evidence Action, New Delhi, India, [2]All India Institute of Medical Sciences, New Delhi, India*
	Paternal factors are associated with access to institutional delivery utilization in Nepal Dharma Bhatta[1,2], *[1]Pokhara University, Nobel Collge, Sinamangal, Kathmandu, central region, Nepal, [2]Faculty of Medicine, Epidemiology Unit, Prince of Songkla University, HatYai, Songkhla, Thailand*

No Voice Unheard- Speaking out on Timely Issues in SRHR	
Room 8	**Sexual risk behaviors among young men who have sex with men in large cities of Myanmar** Myo-Myo Mon[1], Justine Sass[2], Wai-Wai Myint[3], *[1]Epidemiology Unit, Faculty of Medicine, Prince of Songkla University, Hat Yai, Songkhla, Thailand, [2]UNESCO, Bangkok, Thailand, [3]Department of Medical Research, Ministry of Health, Yangon, Yangon, Myanmar*
	The Need to Improve Counselling Service Quality for Sexual Abuse Survivor in Asia Nur Hidayati Handayani[1], *[1]University of Auckland, Auckland, New Zealand*
	Awareness towards sexual and reproductive health and rights among young people with disability (YPWD) in Nepal Shilpa Lohani[1], Ruchita Rajbhandary[1], Ramchandra Gaihre[2], Sabitri Sapkota[3], *[1]Sunaulo Parivar Nepal, Kathmandu, Nepal, [2]Blind Youth Association of Nepal, Kathmandu, Nepal, [3]Marie Stopes International, London, UK*
Ending Gender Based Violence	
Room 9	**Trafficking of minor girls for commercial sexual exploitation: Exploring the situation of girls in trafficking prone "Source" areas of Bihar, India** Sharmistha Basu[1], Shireen Jejeebhoy[1], K.G Santhya[1], *[1]Population Council, New Delhi, India*
	Domestic violence (DV) in Thai pregnant women and its impact to their sexual and reproductive health Siriwan Grisurapong[1], *[1]Mahidol University, Salaya, Thailand*
	Female Genital Mutilation and venerability of Sexually Transmitted Infections and HIV in Senegal Ramu -[1], *[1]International Institute for Population Sciences, Mumbai, India*

Sex Talk - Exploring Sexuality Education and Communication

Lecture Room (1)

a) Ma Ma Oo Radio Program: A window which every woman can open and feel the experiences of Reproductive Health in Myanmar.

Hnin Kalyar Kyaw, Myanmar

Introduction: Maternal mortality and Infant mortality are high in Myanmar with an estimated 200 deaths per 100,000 live births and 54 children per 1,000 live births respectively. The biggest factors contributing to high mortality rates are critical gaps in health knowledge, low skilled birth attendance rates and financial factors. To reduce the knowledge gaps, innovative tools, such as radio programs are being developed to deliver health messages. In 2014, Myanmar Radio and Television, in collaboration with Australian Broadcasting Corporation and Burnet Institute, developed and delivered a pilot radio program, Ma Ma Oo, which aimed to improve community level reproductive health knowledge. The program was a series of eight episodes, each featuring a different reproductive health theme, in collaboration with Ministry of Health.

Methods: Three intervention and one control villages were selected from Thanlyin Township, in Yangon Region, Myanmar. In intervention villages, listener groups were formed and the eight part radio program was delivered and, each episode being followed by a facilitated discussion of key messages. At the conclusion of this program, a quantitative survey was conducted among 54 women involved in the listener groups, and 40 from control village. Reproductive health knowledge levels were compared between the two groups. Key informants from the intervention villages were chosen for in-depth interviews before and after the program delivery.

Results: Of 54 women exposed to the program, adherence was high with 87% listening to all eight episodes, and 98% listening to at least six episodes. Almost all women (96%) reported enjoying the radio program and their engagement in listener group activities. High knowledge levels existed in both groups regarding recommended breastfeeding practices and basic contraceptive knowledge, but understanding different contraceptive options and the advantages of birth spacing was increased among intervention participants - 96.3% vs. 60% and 85% vs. 72.5% respectively. Significant increases in knowledge for intervention groups were found in antenatal care best practices (79% vs. 45%), cervical cancer prevention and treatment (85.2% vs. 20%), HIV testing and prevention (96.3% vs. 60%) and male involvement in maternal and child health (42.6% vs. 17.5%).

Conclusion: Survey findings indicated that the radio program resulted in improved reproductive health knowledge and the content increased the understanding of and demand for health services, such as HIV testing during pregnancy, skilled birth attendance and cervical cancer screening. Culturally appropriate radio programs like this provide a cost-effective and enjoyable way to increase community health knowledge. As a result of these

findings, the series has since been broadcast across Myanmar, and has been included in health education toolkits. In order to build on the impact of the pilot program, a further series using the Ma Ma Oo brand is currently in the pre-production stages.

b) From pilot to program: How a national youth hotline is increasing youth access to quality sexual and reproductive health information and services in Timor-Leste

Helen Henderson, Timor-Leste

Introduction:

Timor-Leste is a small post-conflict nation with one of the youngest populations in the world: young people (aged 10 – 24 years) comprise 32.5% of the total population. The lack of formal sex education and taboos around sexuality mean that young people‘s understanding of sexuality and reproductive health is severely limited.

As detailed in the 2009-10 Timor-Leste Demographic Health Survey, the adolescent fertility rate is 52. Only 1 in 10 (9.6%) adolescent girls had correct knowledge about their fertile period, two out of three (68.6%) reported being exposed to family planning messages and less than one in four (22.6%) reported their demand for family planning was met. Accurate knowledge about ways HIV can/cannot be transmitted is low with only 11.2% of girls and 14.7% of boys aged 15-19 having comprehensive knowledge about AIDs.

While the majority of the population still live in rural areas, migration to urban areas is increasing. Forty percent of youth now live in urban settings and are increasingly exposed to new environments and technology, including telephone access. Sixty-six percent of the population were mobile phone subscribers in 2013, and the technology market has grown further in the last 2 years.

To increase information and access to services amongst young people, in 2011 Marie Stopes International Timor-Leste (MSTL) launched a national, confidential, free, and easy-to-access telephone hotline to provide young people with quality sexual and reproductive information, and referral to services when required.

Callers can talk with either a male or female operator who is trained, competent and confident. Operators collect demographic, behavioural and call data, and are able to track service referral uptake at the MSTL Dili clinic. The hotline pilot was evaluated in 2013 and now functions as an ongoing MSTL program, the Linha Foin‘sa‘e.

Results:

More than 54,000 calls have been made to the hotline since 2011. Demographic data shows 90.5% of callers were under 25 years of age, and 25.1% were female.

Common reasons for calling include seeking information about: adolescence; sexually transmitted infections; puberty; infertility; and HIV and AIDS.

Eighty-four percent of caller referrals to the MSITL Dili Clinic were redeemed in 2014.

Lessons learnt and going forward: The high number of abusive/prank calls initially recorded when the hotline was launched was reduced by marketing strategies and operator training to better promote the purpose of the hotline.

The number of female callers to the hotline also increased through targeted marketing strategies and messaging.

Partnerships are essential for success. Lina Foin-Sae is supported by national telecommunications companies, enabling young people free access to the hotline. Youth groups and youth serving organisations promote the hotline, conducting essential awareness raising activities.

MSTL plans to open a Lina Foin-sae Facebook page and use WhatsApp messaging to better connect with young people in Timor-Leste.

Conclusion:

The _Lina Foin-Sae‘ hotline is positively contributing to the improvement of young people‘s SRHR in Timor-Leste by using practical, innovative and context-appropriate methods to reach, engage and deliver quality information and referral to available services.

c) Effects of Comprehensive Education Service on Sexual and Reproductive Health among Migrant Children in Beijing, China

Yue Hu, China

Gender inequality, gender-based violence and sexual abuse, high rates of teen pregnancy and STIs are important issues in China. Among the general population, there are 35,810,000 migrant children, of which there are 1060,000 in Beijing. Compared with their local peers, migrant children have to face more challenges in living environment, health conditions and family education. Lack of scientific knowledge and access to formal information source, they may be more disadvantaged and vulnerable. But children have the right to receive sexual and reproductive health (SRH) education, which is a fundamental human right. According to a Chinese national guideline *“China National Program for Child Development (2011-2020)”*, it‘s also said that “Incorporate reproductive and sexual health education into the compulsory education curriculum”. Migrant children‘s needs should be considered; their rights should be protected and realized.

Objectives: The aim of this study was to know sexual health status of migrant children in Beijing and to evaluate effects of SRH education service on migrant children‘s sexual knowledge, sexual information source, attitudes, behaviors and life skills. **Methods:** 605 children of grade five and six in two migrant schools were surveyed by questionnaire and interviews regarding demographics, development of sexual physiology and psychology, information source, knowledge, attitudes, behaviors and skills related to sexuality. One group received 12 class hours of comprehensive SRH education taught by participatory methods, and completed tracking tests and interviews during the 1-year‘s health service. Another control group without any intervention also completed a pre-test and a post-test after one year.

Results : Pre-surveys revealed children‘s development of sexual physiology and psychology; the number of children who enter puberty according to their self-report about menstruation or spermatorrhea was increased significantly during one year. There are gender and grade

differences in physical and psychological development related to sexuality among these children. Lack of sexual knowledge and formal information source were also found. After one year, as compared with the control group, knowledge significantly improved for both grades in the total score and scores of some specific topics such as puberty, HIV/AIDS, reproduction, contraception, etc. Students‘ level of knowledge on the terms of “sexual abuse” and “sexual orientation” has also been improved significantly in the intervention group and the service had a lasting effect. They became view school curricula as the most important sexual information source. Moreover, according to the interviews, more positive attitudes towards sexuality and SRH education were also developed, such as consciousness of gender equality, respecting others ‘ rights and choices, positive attitude towards sexual minorities. And they tended to talk about sexual topics more openly. Children were also armed with useful life skills on contraception, self-protection, communication, negotiation, rejection, decision making and sexual information identification.

Conclusion: More attention should be paid to sexual health of migrant children and their urgent needs of SRH service. The comprehensive SRH education for migrant children, which could be an integral part of health service in all Chinese schools, had a significant impact on increased knowledge, positive attitudes toward sexuality, sexual behaviors and life skills.

Integrating HIV in SRHR for Vulnerable Groups

Lecture Room (2)

a) Sexual beliefs and practices associated with sexual transmitted infections among taxi drivers in Hanoi, Vietnam

La Quang, Viet Nam

Objectives

Risky sexual behaviors are a major contributing factor to the spread of Sexual transmitted infections (STIs). Sexual transmitted infection studies in Vietnam had mainly focused on high-risk groups (e.g. sex workers, drug users) and mainly on women. In order to develop appropriate prevention strategy on STIs for all, there is a need for evidence on sexual practices in other population groups. This research aims to describe the prevalence of risky sexual behaviors among male taxi drivers in Hanoi, Vietnam.

Methods

The cross-sectional design was applied on 1272 male taxi drivers in Hanoi, Vietnam (aged 18–50).

Results

Among 1272 taxi drivers, 50.3% of them were migrant workers and 36.1% were not married yet, 71.2% were living with partners (wife or lover) in Hanoi. With the drivers, who were living with partners, 81.5% of them are currently applying one of contraceptive methods. The percentage of taxi drivers had extramarital sexual behavior was 23% among the sample. Only 21% of taxi drivers reported that they used condom for the most recent of sexual intercourse with partners. When asking drivers about the results of unsafe sex, 51.1% of them reported that the may get STIs, 60.1% reported on the HIV infection, 46.5% reported on the unwanted pregnancy. The univariate analysis revealed that the odds of extramarital sexual behavior were higher in migrant drivers (odds ratio 3.5, $p < 0.05$) and married drivers who were living apart from their spouses (odds ratio 4.7, $p < 0.05$).

Conclusions

This study provided new information for understanding the sexual behavior in among taxi drivers in Hanoi, Vietnam and suggested that the target intervention groups for STIs prevention should be the migrant taxi drivers.

b) Friendly healthcare services for MSM/TG - Fortress in HIV and STIs prevention

Qui Nguyen Lam Duy,Viet Nam

Currently in Ho Chi Minh city, HIV voluntarily counseling and testing services (VCT) and HIV outpatient clinic (OPC) are available in the majority of districts. Despite of its availability, the key groups at high risk of HIV infection such as injecting drug users (IDU), sex workers (SW) and men having sex with men (MSM), transgenders (TG) are still afraid when using these services.

The difference between the estimated number of people infected with HIV and the number of people enrolled in treatment programs shows that there are still many infected people are still unaware of their HIV status or are aware their HIV positive status but still unregistered to the available HIV treatment programs.

MSM, TG are key groups at a high risk of HIV infection. More than the need for confidentiality, not to be stigmatized on their HIV status, these groups also need to access to the friendly services. The "term friendly service" means which is non-stigma and discrimination on sexual orientation, gender identity, gender express and non-judgment about their homosexual or sexual transmitted infections (STIs) and sexual transmitted diseases (STDs) if available.

The overall outcome of the "Friendly Project" is to increase the level of using VCT and OPC among of MSM, TG in HCMC by establishing a ranking of friendly HIV related healthcare services to be referenced and to help them make their appropriate decision in choosing their own service to use. Increasing the number of HIV infected people knowing their HIV status; increasing number of HIV infected people entering treatment program; increasing number of HIV infected people being treated controlling effectively their viral load, these are 3 main aiming goals to end the epidemic according to 90-90-90 goal of The UN. The ranking is established by using the friendly criteria which are assessed by the MSM, TG community groups. These criteria are discussed and addressed by them, and these groups are also take the role in assessing by surveys which is aiming to rank the friendly level of the services. "Friendly Project" through "The Friendly Ranking" also makes recommendations of the users to promote the improvement of the services to be professional and friendly.

The ranking made by the community is also a reliable recognition of the level of satisfaction of the friendliness of the services providing. In the context of foreign fundings in HIV/AIDS prevention are being cut down, in the near future, HIV testing and treatment services will be no longer free. Because of the costly services, absolutely users have their right to choose the service which is rated at high level of quality they are satisfied. Such the ranking will contribute positively to help users make their appropriate choices and to improve others services which is un-rated yet.

(c) Engaging communities to address the Sexual Reproductive Health gaps of People Living with HIV through integrated approach

Nisha Jagdish Poojar, India

Sexual and Reproductive Health needs of People Living with HIV (PLHIV) are not addressed adequately due to stigma and discrimination in the healthcare system. As a result, people do not come forward to know their HIV status and delay in accessing preventive services. The availability of antiretroviral therapy and provision of Prevention of Mother to Child HIV Transmission (PMTCT) related services made it possible for PLHIV to think beyond ART and about marriage and family. Therefore, there is urgent need to provide integrated SRH –HIV information and services to all people especially women and girls in the reproductive age group and PLHIV to help them to fulfil their reproductive right.

Methodology

FPA India implemented a two year project from May 2013-April 2014 at - Bangalore, Belgaum, South Kanara, Bijapur ,Hyderabad and Solapur supported by Japan Trust Fund for HIV and Reproductive Health. The project aimed to supplement and support the national response to eliminate mother to child transmission of HIV by increasing access to integrated SRH-HIV information and services and to mobilize community support for women living with HIV and their children. The project engaged women living with HIV as Mother 2 M other Peer Educators to share their experience of motherhood and to motive women and girls to access range of integrated SRH-HIV services. Health sessions organised in the community increased access and improved health seeking behaviour. Peer Mothers followed up of pregnant women living with HIV to ensure that the child remains HIV negative till 18 months

Results:

The integrated service session at the community camouflaged the status of PLHIV and helped them to access services without any hesitation along with others. During the two year, more than 30,000 men and women received information on SRH and HIV,nearly 60% of them accessed a range of integrated SRH-HIV services like HIV(41%),RTI/STI(6%),Cervical/ Breast cancer screening (17%),contraceptive (10% excluding condom, of which 26% by PLHIV) and Safe abortion(1%) ,Gynae ,ANC/PNC services, general services (25%) etc., Total 6388 pregnant women were seen at project, 59% pregnant women were tested for HIV in FPAI. 9.24% of high-risk pregnant were retested for HIV. 422 pregnant women living with HIV were followed up but 74 PLHIV couples decided to opt abortion services. The remaining 348 pregnant women and their spouses including discordant couples were counselled on safe sex practices, FP,STI and childcare. The continuous support by the peer mothers strengthened empowered couple to make decision about childcare options and FP methods. Till date, 274 women had safe delivery of which, 27 children completed 18 months and tested HIV negative.

Conclusion:

Involvement of PLHIV and peer mother approach helped in improving access to integrated services especially by people living with HIV. The quality non-discriminatory services and satisfied beneficiaries has largely contributed to the achievement of the project. The system of tracking lost to follow up which has been followed in the project could be incorporated into the national program so that there can be efficient tracking of the LFU cases across all projects in all states.

Integrating SRHR in MNCH Services

Lecture Room (3)

a) Understanding blood transfusion management system in public health facilities in selected districts of Bangladesh: A qualitative investigation

Rasheda Khan, Bangladesh

Rational: According to a recent nation-wide survey, hemorrhage was the major causes of deaths in Bangladesh and 35% of all maternal deaths occurred due to this life threatening complications while 73% of them die during anti-partum and post-partum period. The predominance of hemorrhage deaths indicate a need to strengthen access to systematic and proper blood transfusion system in public facilities in Bangladesh where family members face different barriers in collecting and managing blood when needed.

Objective: This study explored how Quality of Care (QOC) is affected by poor blood collection and transfusion system in public health facilities.

Methods: Case observations and exit interviews were carried out with mothers and family members who sought care for maternal complications in different layers of Govt. health facilities in four districts of Bangladesh.

Results: Higher-level public health facilities were equipped for blood transfusion with laboratory technicians and provisions for drawing blood samples, grouping, screening and cross matching. Many facilities had blood banks with refrigerators for storing blood prior to transfusion. However, lack of systematic management, support staff‘s unavailability and huge patient flow often worked as a barrier to use this facility properly and timely. Managing blood was often the responsiblty of patient‘s family members and providers hardly guided them on how and from wehre it collect it. Families usually collected blood from different non-governmental legal blood banks, NGOs, private clinics and unauthorized blood donors. Screening and other testing as part of blood transfusion were usually largely done in private sectors such as diagnostic centres. Family members faced a myriad of barriers while going through all these processes. Often these hassles delayed timely care to mothers who were in dire situation.

Discussion: While higher-level facilities were well epuipped with blood transfusion system, often, lack of proper management system, providers‘ unavailablity and huge patient flow worked as deterrrent factors to ensur timely blood transfusion. To complicate the situaiton, family members often faced severe difficulties as they were unaware of other private sources. All these delayed proper and timely blood transfusion to women who needed it most.

Conclusion: Hemorrhage is one of the major causes of maternal deaths in Bangladesh and managing patietns with such life-threatning complication is still poor in public health facilites. Policies and programmes should focus more on ensuring appropriate use of existing

equipment and availability of technical personals to strengthen the capasity of national health facilities for systematic and timely blood transfusion strategy.

b) From D&C to Vacuum Aspiration and Misoprostol: Ensuring Quality and Appropriate Use of Technology for Post abortion Care in Myanmar

Ni Ni, Myanmar

Background: Despite progress, the maternal mortality ratio in Myanmar remains high at 282 deaths for every 100,000 live births. Abortion-related causes are the third most common cause of MM (~10% of maternal deaths). In an effort to reduce maternal mortality, Ipas is supporting the Myanmar Department of Health, Ministry of Health to improve the quality of postabortion care (PAC) in public facilities. Integral to this intervention is ensuring providers use appropriate technology for uterine evacuation (UE) when a woman presents for PAC. Currently, the most common UE method in Myanmar is dilatation and curettage (D&C), which is considered obsolete by WHO. WHO and FIGO strongly recommend that D&C be replaced by vacuum aspiration and/or medical methods based on safety, acceptability and cost.

Methods: Beginning in 2014, Ipas and the Myanmar Department of Health established an intervention to improve the quality of postabortion care in Myanmar. The intervention involves training providers from teaching, township and stations hospitals in Yangon, Magway and Mandalay divisions. The competency-based training includes manual vacuum aspiration (MVA) and misoprostol for PAC, and a strong emphasis on counseling, infection prevention, contraceptive counseling and services, and monitoring. A _cascade' training approach was used, with teaching hospitals being trained first. Teaching hospital specialists then were trained as trainers and assumed training responsibility and support for the other facilities. For ongoing quality assurance, post-training support is provided to all intervention sites and program data is routinely collected before, during, and after the trainings from logbooks and progress reports.

Results: Data collected from February 2014 to June 2015 show that 84 providers from 38 facilities were trained and 4,267 women received PAC services, of which 81% received a contraceptive method. Overall, appropriate use of technology is still limited among all providers (trained and untrained) at facilities: MVA use is 46% and misoprostol is 2%. However, among trained providers, use is higher at 70% for MVA and marginally higher at 3% for misoprostol. Prior to the intervention, site baseline data estimates show that the vast majority of PAC services (89%) were performed using D&C. The presentation will cover additional updated data (through December 2015) and analysis related to the transition from D&C to MVA/misoprostol, as well as facilitating factors and barriers to the successful uptake of modern PAC technologies in Myanmar.

Conclusion: While the evidence for substituting D&C with safer PAC procedures is well known, Myanmar's early experience with this transition will be useful for future program scale up to other states and divisions. It will also be instructive for countries in the region that are striving to improve the quality of PAC and address maternal mortality.

c) Task-sharing incomplete abortion services: decentralizing care by increasing involvement of non-physician and primary care providers with use of misoprostol
Laura Frye, USA

Introduction: Where abortion is restricted, care for incomplete abortion aims to mitigate the impact of unsafe abortion. In countries like Mexico, Ecuador, Pakistan, and Egypt, PAC services remain highly centralized, often stigmatized, and costly. Treatment is often only available at the district hospital using dilation and curettage (D&C) under general anesthesia. Misoprostol is a safe and effective first-line alternative to D&C that is cheap, widely available, and easy to offer.

Objectives: To understand the potential of misoprostol in reducing reliance on D&C for treatment of incomplete abortion.

Methods: Demonstration projects to integrate misoprostol as first-line treatment of incomplete abortion are underway in select districts and/or states in Mexico, Senegal, Pakistan, and Egypt. Physician and non-physician providers from all levels of care are trained to offer 400 mcg sublingual misoprostol for treatment of incomplete abortion in lieu of referring women for D&C. Women presenting with incomplete abortion are screened for eligibility for treatment of incomplete abortion with misoprostol. If ineligible, women are referred to the hospital for D&C or manual vacuum aspiration (if available). Abortion outcomes, side effects, and women's satisfaction are evaluated after misoprostol treatment.

Results: Findings from these ongoing projects suggest that, among women who present with incomplete abortion at project sites, the majority (~90%) are eligible for misoprostol treatment. Of those treated, most (95-97%) have successful uterine evacuation with misoprostol alone. Side effects are easily tolerable, with 98% of women receiving misoprostol treatment reporting being satisfied.

Conclusion: These demonstration projects show that decentralization of incomplete abortion care, including simple outpatient treatment with misoprostol, is a feasible way to avert approximately 85% of referrals for D&C. In Egypt, an evaluation of services one year after implementation highlighted a sustained reduction in D&C utilization and ongoing acceptability of the decentralized treatment model among both women and providers.

Youth Voices from Myanmar

Lecture Room (4)

a) Perspectives of youths towards Reproductive Health services in rural and urban areas of Myanmar

Saw Saw, Myanmar

Background: In Myanmar, about 24% of total population is youths. According to Fertility and Reproductive Health Survey 2007, about 11.39% of pregnancies in married youths ends in abortion and 20- 30% of maternal deaths found among women<25 years of age. There is limited information on preference of youth for reproductive health (RH) services. **Objectives**: It aimed to describe perceptions and choices of youths for reproductive health services. **Methods**: The operational research was conducted in rural and urban areas of Hinthada, Kyaing Tong and Wun Dwin Townships of Myanmar in 2013. Twenty four Focus Group Discussions (FGDs) and 305 face-to-face interviews were conducted with male and female youths in urban and rural areas. Health facility mapping was also incorporated during FGDs. Most respondents stated that RH services provided at government health facilities were mostly used by married females regardless of age. Most youths from urban areas went to GP clinics and rural youths went to small drug shops and Midwife. Choice of health facility by youths depended on whether they could ensure confidentiality. For Ante natal care, majority of youths went to government health service. For sexually transmitted diseases and post abortion care, majority of youths went to drug shops or GP clinics. Opinion of youths toward government health service was not different among gender, urban-rural and marital status. About 184 (60.3%) of youths viewed RH services at the government sector was good and about 185 (60.7%) thought communication of government health staff was fair. However, during FGD, majority of youths pointed out not keeping confidentiality of their RH problems and communication of health staff towards youth were the main barriers for using government health services. The most common suggestions of youth were creating a warmly and understanding environment for youths and ensuring confidentiality of their RH problems. **Conclusion**: Development of youth friendly RH services is essential. Simultaneously, government health staff should pay attention towards youth while providing regular RH services.

b) Need of Formal Sexual and Reproductive Health and Rights education to enhance knowledge and perception of adolescents living in different areas of Yangon City

Khine Cho Myat, Myanmar

Background: Many adolescents in Myanmar lack the information and resources needed to address their Sexual and Reproductive Health and Rights issues regardless of the existed official curriculum for ―life-skills‖ based education called SHAPE, School-Based Healthy Living and HIV/AIDS Prevention Education. Myanmar is a culturally conservative country thus there are undoubtedly more challenges for Senior High Schools to effectively implement

SHAPE that promotes healthy sexual and reproductive development, maturation and behaviour among adolescents.

Objectives: This study aims to access the level of ―sexual and reproductive health and rights (SRHR)― knowledge and perceptions among adolescents (Grade 9 & 10) at selected Senior High Schools from civilised and suburban areas of Yangon City.

Methods: A cross-sectional comparative questionnaire was surveyed to 447 students from four different Senior High schools, and 440 out of 447 results were reviewed. ―SPSS version 21‖ (Statistical Package for the Social Sciences) software was used for data entry and data analysis. In-Depth Interviews and Key Informant Interviews were also conducted to a total of 20 parents and 8 teachers from the same 4 high schools, to examine parental and guardian perspective qualitatively.

Results: Majority 93% of the students agreed that it is unacceptable to have love relationship at their current age and 91% deemed right that females should keep their virginity until their marriage. Yet, findings showed that 11% of the students; of which most are males, admitted that they already have experienced premarital sexual debut and that 17% of the students have married friend at their age. The study also showed that there is a high level of interest and curiosity in SRHR activities from adolescents yet there are proofs that these adolescents do not have sufficient knowledge on SRHR issues. For instance, 52% of students have heard of contraception yet only 30% have vague knowledge of the contraceptive methods. Data from in-depth interviews revealed that both male and female parents acknowledged their children lack of access to SRHR, and have urged for the right authoritative body to reinforce the existing curriculum. It is generally accepted that by employing the SHAPE in the right way, adolescents have a better chance to avoid risks and dangers associated with sexual experiments. Similarly, the majority of the teachers during Key Informant Interview demonstrated their strong desire for compulsory implementation of SRHR education at government schools to ensure adolescents can make their own right SRHR decisions. A lone surprising outlier among the guardians highlighted that TV drama and Internet were common means leading adolescent to dress in more modernised and revealing manner, resulting in more SRHR issues at their age. Therefore, suggesting restrictions of access to media and choice of clothes as the best way to deduce SRHR risks among Yangon‘s adolescents.

Conclusion: Adolescents‘ high level of interest in SRHR indicate a clear need to intensify the existing curriculum by integrating more cultural components for effective utilisation at every high schools. Training for trainers should also be systematically implemented to enable the teachers to leverage Government's training investment on adolescents's safe future.

c) **The potential of rural Youth Centres supporting Myanmar towards the Sustainability Development Goals 2030 - The case of Youth Information Corners in rural Myanmar**

Agnethe Ellingsen, UK

The Health Promotion and Health Education Division, with the support of UNFPA, operated Youth Information Corners (YICs) since 2002 in 70 townships across the country, in order to respond to the reproductive health needs of rural young people. The YICs are providing information on Reproductive Health (RH), HIV/Aids and other health issues related to young people's health, through library facilities, Behavior Change Communication training and other activities.

In order to increase its efficiency and assess its potential in times of transition, UNFPA and the HPHD conducted a situation analysis of 28 of the YICs through applying the Rapid Assessment Methodology by utilizing both quantitative and qualitative tools. Altogether 28 Focus Group Discussions, 28 Key Informant Interviews with YIC Focals, 26 Key Informant Interviews with Community Support Group Members, in addition to one survey with 347 young respondents, provided evidence based input in the discussion on how to operate and to utilize the potential of youth centers in rural Myanmar.

The key findings are supporting the current efforts of the Myanmar Ministry of Health in integrating an increased youth friendly approach into health systems. For instance, while 80% of the respondents mentioned health workers as their source of health information, only 4% of the interviewed YIC Focals had received any training on youth specific HIV prevention. Other valuable findings such as those related to early marriage and gender based violence (GBV), are further calling for updated and expanded capacity development for rural health staff on young people's health. For example, early marriage was mentioned among the main issues young people are facing in their community by 47% of all young respondents, while 23% of Community Support Group members mentioned GBV as one of the main issues.

Moreover, an untapped potential of youth centres in disaster response was concluded. Given Myanmar's status as high risk country for natural disasters, access to RH services for young people in times of disaster should require special attention. The Flood 2015 occurred simultaneously with this situation analysis, and the role of YICs in flood response received national and international attention through the case of Sarmalauk YIC in Ayeyarwady Region. Their response gave an example on the untapped potential of YICs in disaster response, as their organizational structure opens up for an efficient delivery of the Minimum Initial Service Package (MISP) for RH in crisis situations. That would ensure that young rural people's RH needs are covered during times of disaster and reduce the negative impact of disasters in a cost-efficient way. The fact that 53% of the YICs analysed, engaged 16 active youth volunteers or more, and 99% of all young respondents declared interest in becoming peer educators, are proving an untapped potential of young human resources willing to be mobilized for RH initiatives.

Altogether, the situation analysis provides valuable evidence in a field with still scant data available, on how youth centers could be utilized and become an integrated part in health systems, contributing to Myanmar reaching their part of the Sustainable Development Goals 2030.

Youth Speak- Exploring the Integration of SRHR in Adolescent and Youth Health Services

Lecture Room (5)

a) Juniors' Responsibilities in Gender and Adolescent Development (JR GAD)

Rolando Borja, The Philippines

JR GAD Capability building is a strategy to mainstream and strengthen the support of the youth sector along gender, sexuality, and reproductive health more specifically in reaching adolescent through education that adhere to the principles of adolescent to adolescent approach.

The provision of technical assistance and advocacy were utilized by the Commission on Population Region XI in order to mobilize resources from the LGU partners using their Gender and Development budget in Davao region in the program implementation of JR GAD strategy.

The program aims to provide and acquire the necessary knowledge, attitudes and skills which are necessary to start off initiatives that will strengthen the support and participation of young people and advocates in mainstreaming gender, sexuality and reproductive health in the school and community.

The Regional Population Office R-XI conducted a series of meeting with the Population Officers and Workers assigned in the Province, City, and Municipality regarding the program. Through them, organizing and coordination with the LGU was facilitated. Scheduled of meeting and identification of participants was initiated by the Population Officers and the LGU partners particularly the school guidance counselors and the province, city, and municipality health officers/nurse.

Monitoring and provision of technical assistance through technical expertise and supplies or materials was provided with established teen centers in the community and schools. At present, there are 21 organized teen centers in the Davao region.

JR GAD strategy aims to establish a Teen Center in the school and community that caters the needs of the adolescent while organizing the trained adolescent to become peer education and facilitators in partnership with the guidance office in the school and health centers in the community.

b) Menstrual Hygiene Management in Indonesia: Understanding practices, determinants, and impacts among adolescent school girls

Jessica Davis, Australia

Background:

Menarche is a fundamental part of adolescence, with implications for girls‘ sexuality and sexual and reproductive health (SRH). However menstruation and menstrual hygiene

management (MHM) are largely neglected in policy and programs, despite increasing evidence of the impact that MHM practices can have on SRH, education and psychosocial outcomes for girls. Poor access to information, lack of appropriate facilities to manage menstrual bleeding, inappropriate MHM practices and harmful sociocultural beliefs are common challenges contributing to potential SRH risks, a loss of dignity and behavioural restrictions. Poor MHM and an inability to manage menstruation at school have also been associated with poor school attendance and drop-out, with significant long-term health and socioeconomic implications for girls.

Methods:

A convergent parallel mixed-methods study was conducted in 16 randomly selected secondary schools across four provinces of Indonesia (2 urban and 2 rural schools per province) to examine knowledge, attitudes, practices and impacts of MHM. Girls aged 12-19 years completed self-administered questionnaires. Additionally, eight in-depth interviews with post-menarchal girls, 20 key informant interviews with teachers and health providers, and 24 focus group discussions (FGDs) with girls, boys and mothers were conducted. WASH facilities at participating schools were assessed using structured observation checklists. Descriptive analyses of quantitative data were conducted using Stata 13.1 and qualitative data were analysed thematically.

Results:

In late 2014, 1,159 girls were enrolled. Median age of menarche was 12 years (IQR=12-13). Only 55% felt prepared for menarche and most lacked comprehensive knowledge (median score 9/15 (IQR=7-11). Mothers and teachers were the most common sources of information, however both groups were also a source of misconceptions.

One in seven girls had missed at least one day of school during their last menstruation with pain, feeling unwell, and fear of staining clothes the major reasons for absenteeism. Only 9% of urban school latrines and no rural latrines met minimum standards to support MHM, and most schools lacked physically accessible latrines for girls with disabilities. Sociocultural beliefs and shame associated with menstruation also contributed to poor school participation and unhygienic practices. While most girls reported using disposable sanitary pads, 46% did not change regularly and only 42% of urban girls and 22% of rural girls met international recommendations for MHM. As a result genital itching and discomfort were commonly reported. Menstruation also impacts on girls‘ relationships, particularly with boys and men. Menarche brings new norms and expectations regarding girls‘ interactions with boys, and taboos surrounding menstruation mean that girls are particularly concerned about boys knowing they are menstruating. Notably, misconceptions about reproduction and menstruation may put girls at risk of unintended pregnancy.

Conclusion:

Adolescent girls in Indonesia face substantial challenges that negatively impact on their ability to manage menstruation hygienically and with dignity at school. In addition to

improving school WASH facilities, improved access to quality information about menstruation and MHM as part of comprehensive sexuality education, community interventions to address misconceptions and harmful beliefs, and improved management of associated menstrual symptoms are needed to reduce negative social, health and educational impacts of menstruation.

c) Sexual Reproductive Knowledge, Attitudes and Behavior among Adolescent Akha Females, LuangNamtha province, Lao People's Democratic Republic (PDR): A Qualitative and Quantitative Study

Vathsana Somphet, People's Democratic Republic of LaO

Background: The demographic transition is underway and it has a large youthful population with young people (10-24 years) accounting for 31.2% of the population. In rural areas especially, economic growth and increased road infrastructure are dramatically changing rural lifestyles. For the Akha, who live in the mountainous areas of northern Lao PDR, these changes are profound and are increasing interactions with non-Akha peoples as previously subsistence lifestyles are being integrated into the market economy.

Aim: The purpose of this study was to explore adolescent Akha girls' attitudes, knowledge and behaviours about sex and sexual health.

Methods: This cross sectional survey was undertaken in the communities in LuangNamtha province in Lao PDR, with 409 female adolescents aged 14-19 by using multistage systematic random sampling. In addition, in-depth interview 20 adolescents and 18 key informants were conducted. The questionnaire include socio-demographic characteristic, knowlsge of contraception, STIs/HIV/AIDS, sexual customs, health risk behaviors, attitudes towards premarital sex, and sexual risk behaviors. Qualitative and quantitative data were analysed using thematic and inferential multiple logistic analyses respectively.

Results: In total, 57.7 % (*n*=236) of the participants reported having had sexual intercourse. Mean age at first sexual intercourse was 13.7+1.09. Overall, respondents demonstrated moderate knowledge of reproductive health but poor knowledge of STIs/HIV/AIDS. Translation of this knowledge into practice was reported as moderate at best, in part due to the cultural patterns and logics that pattern sexuality and are deeply embedded in local values, beliefs and practices and what it is to become a healthy woman. Factors related to premarital sexual activities were getting older age (OR=1.2), having experiences of welcome guest (OR=5.7), drinking alcohol (OR=4.2), knowledge of HIV/AIDS/STIs (OR=0.8), high education (OR=0.3). Barriers accessing to adolescent's sexual reproductive health services were lack of money, distance to the health facilities, shyness & embarrassment.

Conclusion: Rapidly changing socio-cultural norms, economic development and changing livelihoods are placing young Akha women increasingly at risk of STIs/HIV. Prevention efforts should include strengthening agency and working at the broader community and societal level to affect change.

For Adults Only- Towards Effective SRHR Integration in Adult Health Services

Lecture Room (6)

a) Care Needs Versus Care Supplied: The Nursing Strategies for Senior Gays and Lesbians

Jed Patrick Catalan, The Philippines

Caring practice has greater impact to patient's health, recovery and well-being. As the population for older gays and lesbians invisibly increases, an emerging challenge for care providers to tailor care according to their unique needs arises. Hence, realism of the notion "Healthy Ageing for All" is within reach when needs are met, regardless of age, culture and gender identity. This study aims to evaluate whether the care strategies provided by nurses are parallel on the wide care needs among elderly gays and lesbians. An exploratory case study was utilized to accurately understand this not clearly-evident-contextual phenomenon. Using a passive snowballing technique, 4 groups of respondents between nurses and senior patients were interviewed. Integrating a multi-level of analysis, data were first examined case by case; cross analyzed and then triangulated using retrieved documents and literatures. Background Knowledge, Attitudes, Caring Roles, Caring Delivered, Caring Gaps, and Culture Rivalry Effects were identified themes. Lags in standard approach turned care outcome to be dependent on how nurses formulate care strategies based on their personal attitudes and biases towards elderly gays and lesbians. This occurrence confirmed that there is unmet or mismatched on the care delivery practices. Data of the study will serve as a useful in nursing education and on its philosophy in coming up a sensitive and well-structured gender care that is equitable, holistic and supportive to these marginalized ageing groups. A replication of the study is recommended to reinforce the analytical generalization of the result.

b) Client Satisfaction on Family Planning Services through Mobile Clinics in Rural Areas in Myanmar Authors:

Sunshine Aung, Myanmar

Background: An International NGO has been providing maternal and child health (MCH) services including family planning through outreach mobile clinics in 8 townships; 7 townships in dry zone and one township in a peri-urban area near Yangon with the aim of increasing accessibility of MCH services for the rural community especially in hard-to-reach areas. Client satisfaction is an important indicator for assurance of the quality of the service and in ensuring clients‘ needs are met.

Purpose: The study was conducted to assess the satisfaction of clients′ receiving family planning services and to elicit clients′ suggestions for improving the services.

Methodology: A descriptive cross-sectional study was conducted at 15 outreach mobile clinics in October and November 2014. A pretested structured questionnaire was administered to conduct client exit interviews with 246 clients. Trained enumerators who

were hired externally interviewed women who received family planning services before an exit from the facility. Epi Info 7 and SPSS was used for data entry and analysis respectively.

Findings: The participants‘ median age were 31 years and 14.6% of women were at or below 24 years of age where 2.0% were teenagers. Of all, 52.3% of clients had education of less than primary level. About one-third (35.4%) of clients‘ main occupation was agriculture while 30.1% were unemployed. Among the respondents, 31.8% were living less than $1.5 per day and 27.0% were below national poverty line.

Majority of clients visiting outreach mobile clinics received 3-monthly injection (75%) followed by oral contraception pills (13%). Almost all (99.6%) of clients reported that they would return for another service in mobile clinic in future and 98.4% would recommend the MSI facility to a friend. Having enough time with provider, advice and information received, treatment procedure were the areas satisfied by 91 to 98% of the clients. About one third of the clients (32.5%) of respondents were less satisfied with the operating hours. Length of waiting time was also less satisfactory for 32.1% of clients.

Of all clients, 97.2% were satisfied with overall experience at mobile clinic. Clients perceived that procedure or treatment, cleanliness of the clinic and friendliness of provider were three most important aspects of care for them. When asked about client motivation to come to MSI clinic, previous good experience at MSI was the most important reason behind choosing MSI service at mobile clinics and low cost and proximity were second and third important reasons.

Conclusion: Family planning services through mobile clinics are meeting the needs of under-served population in the rural areas. Service was satisfactory for the majority of the clients as they had overall good experience at the clinics. While there are specific aspects of care with high client satisfaction level, a few areas did not meet clients‘ expectation well and the organization needs to further improve those areas through communication with the clients as well as adjustment in clinic operations according to the context.

c) Integration SRH services in to health system in Sri Lanka

Hemantha Senanayake, Sri Lanka

Sri Lanka has offered free healthcare and education to its people over half a century. Government invests around 1.4% of GDP (World Bank, 2013) annually on healthcare services, which covers both preventive and curative care. The country has shown good results of its health investment, which places the country above all other South Asian Countries with best health indicators. This is also comparable with lower middle income countries. Integration of reproductive health (RH) care into health system has a long history in Sri Lanka, which has produced great results in terms of low maternal mortality, high CPR and a low adolescent birth rate. RH services are integrated into primary, secondary and tertiary health care services and offered free of charge as noted above. UNFPA in its reproductive rights and SRH framework (2008) identifies following priority areas that need to be integrated into the health system; (a) provision of a basic package of SRH services including family planning; pregnancy-related services, including skilled attendance at delivery and emergency obstetric care; HIV prevention and diagnosis and treatment of STIs; prevention

and early diagnosis of breast and cervical cancers; adolescent sexual and reproductive health (ASRH); and care for survivors of gender-based violence, with reproductive health commodity security (RHCS) for each component of the package (b) the integration of HIV prevention, management and care in SRH services (c) gender sensitive life-skills based SRH education for adolescents and youth; and (d) SRH services in emergencies and humanitarian crises. While acknowledging the fact that Sri Lanka has integrated most of the elements described above, its worth noting that gender sensitive life-skills based SRH education for adolescents and youth, SRH services in emergencies and humanitarian crises and health sector response to GBV has yet to be fully integrated to the health system. There is a wide regional disparity in terms of reproductive health indicators in the country, showing that more targeted and equitable services to ensure uniform access to services. Quality of the services offered is also another challenge, which goes into the issue of the skills/training of the health care providers to the quality of commodities and infrastructure and the services. Respectful care is one of key concepts that need to be introduced under the quality of services, which remains a challenge. Accountability of health personnel and the system is another issue in the RH service delivery system that needs to be highlighted. The system should establish appropriate accountability measures at all levels to ensure that reproductive rights of all citizens of the country are not compromised.

Male Involvement

Lecture Room (7)

a) Reproductive morbidity and health care utilization among financially capable rural mother in India

Mukesh Ravi Raushan, India

Background: Reproductive morbidity (RM) is a major problem associated with birthing which lead to severe disability other than additional burden of reproductive morbidity in developing countries including in India. The District Level Household and Facility Survey reports that rural regions were reported to have one of the higher RM. But there are lack of any literature on association of financial accessibility among mother and health care utilization for RM in rural region of India particularly in Bihar. Data and Methodology: This study explores the extent to which there is a financial accessibility among mother in a village community, and the factors which influence in accessing of health care utilization. Using a quantitative ethnographic approach, 650 mothers were interviewed. The result were presented in form of adjusted predicted probability for ten different groups of RM (WHO-ICD-10) among rural mother of Bihar. We argue that women discuss or interact on their RM if they were financially capable of taking treatment or advice from health care services. This paper hypothesize that financially abled women were better off than their counterpart in backward region of rural India. This dimension on RM is so important as to break the "culture of silence".

Findings: The prevalence of reproductive morbidity such as pain related to female genital organs and menstrual cycle (55 percent) was very high among rural Indian mother followed by maternal disorder predominantly related to pregnancy and childbirth (53 percent). The disorder related to birth weight and neonatal jaundice from preterm delivery was reported to be least prevalent (13 percent). The mother of household with safe water and improved sanitation facility were less at risk of any aforesaid reproductive morbidity ($p<0.001$). The women belonging to scheduled caste were at increased risk and about 56 percent of such women reported to have anyone of such morbidity ($p<0.001$). The factor such as financial accessibility was one of the strongest predictor for motivation among women in deciding health care utilization for maternal morbidity particularly among rural mother in India. The health care utilization were very high among women who discussed RM with their partner and, in turn, partner responded positively ($p<0.001$) as compared to their counterpart whose partner did not. The rural mother with amount of five hundred or more were at 54 percent reduced risk of genital tract disorder than their counterpart from women with no money in hand ($p<0.001$), while, by 60 per cent in case of menstrual disorder and pain related to genital organ and menstrual cycle. The study report that, though statistically insignificant, women reporting their reproductive morbidity were higher if they were financially capable of contacting health care provider.

Conclusion: This study encourage to make women financially capable to reduce RM among mother of rural region in developing countries including in India. On the other hand, husband's support has positive association in contacting health care system. Therefore,

partner support other than financial accessibility may be significant determinant to meet reproductive health needs in developing countries including in India.

b) Decision-making level on Health Care Services Utilization in a Peri-Urban Area of Myanmar

Kyi Mar Wai, Japan

Introduction: Men are solely identified as decision makers in all aspects including the use of health care services of their family members. In many cases, men have economic and social dominance over their spouses, especially in developing countries. Consequently, woman's autonomy which is the ability of a woman to make a decision in a household influences her decision making on utilization of health services. This studied aimed to explore the decision making level in a family regarding health care services utilization in Myanmar. This study also examined how decision making level influence on maternal health care services utilization.

Methods: We conducted a cross-sectional study in Thingangyun Township, Yangon, Myanmar among a total of 433 husbands who were 18 years or above, have at least one child within two years. A structured questionnaire was used for the data collection. Multivariable logistic regressions analysis were developed to determine the correlates of decision-making level and its associations with their spouses' maternal health care services utilization.

Results: Of 433 men, 426 men completed the interview. Regarding the decision-making level in a family, main decision makers were men (58.4%), followed by jointly with spouses (22.2%), spouse alone (13.2%) and the others (5.6%). Men were less likely to be a main decision maker if their spouses were employed (AOR 0.37, 95% CI, 0.21-0.64, $p < 0.000$), if their spouses had higher educational level (AOR 0.40, 95% CI, 0.20-0.78, $p = 0.008$), and if they have more than one child (AOR 0.37, 95% CI, 0.19-0.68, $p = 0.002$). Age was positively associated with men's decision making level (AOR 1.07, 95% CI, 1.00-1.14, $p = 0.036$). Higher spouse' institutional deliveries were found among women who jointly made decision with men regarding receiving health care services (AOR 3.26, 95% CI, 1.02-10.37, $p = 0.045$).

Conclusions: In the Myanmar society, women do not yet have equal status as men in decision-making although equality of men and women has been achieved in the legal aspects. Women's decision-making level showed a significant association with the institutional deliveries. To improve maternal health, targeting only women is not enough. Wider social predicaments should be looked. Encouraging joint decision-making as a mean of women's empowerment could be an important strategy to increase maternal health services utilization in Myanmar.

Keywords: Decision-making, Maternal Health, Gender, Myanmar

c) Does Women's Autonomy Affect Utilization of Maternal and Child Health Care Services in India?

Kaushlendra Kumar, India

Introduction: Women's autonomy and its association with reproductive health and behavior have appeared as a central point of investigations and interventions around the world. Hypothesis: The core hypothesis behind the paper is that, women with low autonomy will be less likely to use maternal and child health care services in India. **Objectives**: The objectives of the study are: (i) to examine the level and differential in the women's autonomy and utilization of maternal and child health care services and (ii) to examine the association between women autonomy and utilization of maternal and child health care services in India. **Data and Methods**: National Family Health Survey-3 (NFHS-3), which has been conducted during 2005-06, is utilized for this study. NFHS-3 has collected information from a nationally representative sample of 124,385 women aged 15-49 years. For analysis purpose kids file has been used, the present study is based on the sample of currently married women who have at least one birth in the preceding five years of the date of survey. This analysis is based on latest birth and also to imprison the child health care children age 12-23 months have been taken for analysis. Utilization of antenatal care services (at least once during the pregnancy), institutional delivery and child immunization for 12-23 months children are considered as dependent variables in this study. The National Family Health survey, 2005-06 posed several questions to women regarding decision making and control over resources. To capture dimension of women autonomy a composite index of women autonomy has been constructed. **Statistical Analysis**: The bi-variate relationship of women's social and demographic variables with the composite index of women autonomy, antenatal care, institutional delivery and child immunization are examined using chi-square test. Binary logistic regression models are used to identify the association between different social and demographic variables with maternal health care services. Further multinomial logistic regression model has been applied to examine the effect of selected socio-economic variables on child immunization. **Findings**: Our study shows that most of socio-economic factors including women autonomy has impact on antenatal care and institutional delivery. Several socio-economic characteristics, particularly women's and husband's education and place of residence, wealth index, women autonomy, regional variation have strong positive association with health-care utilization. The impact of women autonomy is not much on antenatal care visits but very much effect on institution delivery and child immunization. It may be concluded that women with higher autonomy are more likely to use maternal and child health care services as compared to women with low autonomy.

d) Paternal factors are associated with access to institutional delivery utilization in Nepal

Dharma Bhatta,Thailand

Background: Nepal has achieved the target in dropping maternal mortality in the last years. Previous findings however specify that great variations exist among different part of the population. Male are the key decision makers to increase the utilization of institutional delivery in developing countries. We have examined utilization of institutional delivery among Nepalese women in relation to social determinants with the aim to assess the associated paternal factors in access to institutional delivery utilization.

Methods: Data on institutional delivery utilization were resulting from a cross-sectional survey using multistage-cluster sampling among 2178 male in Kathmandu in 2010. Factor analysis was performed to get the male involvement factor. Institutional delivery utilization and associated paternal factor were depicted with path model through structural equation modeling (SEM). Overall goodness of fit of model was based on Root Mean Squared Error of Approximation (RMSEA), Comparative Fit Index (CFI), Tucker-Lewis Index (TFI) and likelihood ratio of chi-square. Overall stability of the model and Wald test were analyzed to ensure the equal affects of the variables.

Results: Low (45.5%) in institutional delivery care utilization endures in this study. Male involvement, income, education, number of children, and age were all significantly associated with institutional delivery utilization, independently and in synergy. Albeit all included structural determinants were closely related to each other or equally affects the utilization for institutional delivery. Analysis revealed a significant effect of income and male involvement in institutional delivery utilization with other determinants.

Conclusions: Age, income, number of children, education of the husband are common factors for the utilization of institutional delivery to their wife. Male involvement is crucial in maternal health service. More structured way to target unlike segments of the population, enchanting synergy effects among several social determinants into deliberations, are required in order to assure maternal health service for all Nepalese women.

No Voice Unheard- Speaking out on Timely Issues in SRHR

Lecture Room (8)

a) Sexual risk behaviors among young men who have sex with men in large cities of Myanmar

Myo-Myo Mon, Thailand

The prevalence of HIV has increased among men who have sex with men (MSM) in recent years, including among younger cohorts under age 25. In Myanmar, HIV prevalence among them was 10.4% although the prevalence among general population was only 0.47%. Risk factors experienced by young men who have sex with men (YMSM) were present at individual, family and school environment. A cross-sectional survey was conducted among YMSM in Yangon and Monywa in 2014 with the aim of determining risk factors in relation to HIV transmission. A total of 200 YMSM in Yangon and 200 YMSM in Monywa were recruited applying respondent driven sampling (RDS). The median age of YMSM was 23 in Yangon and 21 in Monywa. Forty three percent of YMSM in Yangon and 32% in Monywa self-identified as Apwint (feminine). Yangon had a significantly higher percentage of YMSM who reported having a high school education or more compared to Monywa (p=0.00). Most YMSM in both townships reported having a regular job, but a higher percentage of in Monywa reported an estimated monthly income of >100,000 Kyats compared to YMSM in Yangon (p=0.00). Most MSM in both townships currently live with one or both parents. Just over 40% of YMSM reported having problems with family members. One-third (31.8%) in Yangon and 27.4% in Monywa had their first sexual experience at or before 15 years of age, of which over 80% did so with a male partner. Few YMSM in either township reported their first sex being forced. More than three quarters of YMSM were sexually active in the past month with over half reporting having more than one partner. Just over three quarters of YMSM in both townships reported having sex in the past month, among which more than half reported having more than one partner. Fifty three percent in Yangon and 59% in Monywa reported their last sex occurring in the past week. Apwint YMSM had the highest percentages of early sexual debut (compared to Apone or Tha-nge). Being apwint, current age of less than 20, those with less than high school education level, and age of awareness of same-sex preference at aged 10 or below were significant predictors of younger age at first sex. These findings provide useful information upon which to plan new and expand existing services.

b) **The Need to Improve Counselling Service Quality for Sexual Abuse Survivor in Asia**

Nur Hidayati Handayani, New Zealand

Methodology:

Literature review of 28 research journals, reports and textbooks regarding to multicultural counselling issues in adapting the counselling for people of Asian culture and sexual abuse issue.

Result:

Violence against women happens in one of every four women, it increases the probability of many unreported sexual abuse cases. Sexual abuse is considered as part of Sexual Rights abuse and it causes long-term negative impact on the survivors including severe mental health and behavioral issues. Mental health service is still one of the least priorities of country development in most Asian countries. It can be very harmful for the survivors if they had counsellors who were not well trained in this regards. Further, the advocacy of counselling service quality for sexual abuse survivors is still missing in Sexual and Reproductive Health and Rights movement.

Survivors experience various negative feelings, such as anger, great sadness, fear, shame, helplesness, guilt, and depress (Ligiero, et al., 2009; Phanichrat and Townshend, 2010). They also tend to avoid health care treatments that remind them about the trauma feelings or experiences such as regular health care, (Welch, 2013; Postlewaite, 2012). The disturbing experience (of sexual abuse) caused various impacts behavioral or psychological problems such as addiction to drugs, alcohol, food, sex, work, (Landry, 1991); regression, sleep disturbances, eating disorders, acute traumatic response, (Macdonald, Lambie, and Simmonds, 1995); feeling of isolation and stigma, poor self-esteem, difficulty in trusting others, a tendency towards victimization, and sexual maladjustment, (Mold, 2008). However, some of those behavioral issues may be one of their coping mechanisms as a survivor (Asberg and Renk, 2012).

Asian countries are left behind in developing the mental health subject as a comprehensive part of human well-being. As an impact, the stigma and discrimination against people living with mental illness is still high among people of Asian culture. Furthermore, many counsellors face difficulties in dealing with the expectations of counselling practice due to lack of counselling practices. In countries where an individual is influenced by many factors, human rights are still seen as a ‗privilege', not a basic individual need. Therefore, the counsellor's personal norms and values played big role in counselling practice. The sense of safety, trust and control are needed to work with trauma survivors (Trippany, Kress, & Wilcoxon, 2004). The sense of control and power enabled the survivors to finish school, managed fears, and to have small success in a recovery journey (Valentine and Feinauer, 2007). Therefore, using Human Rights and Feminist perspective in delivering counselling service is very important in Asian countries. These perspectives will improve the sense of control over their bodies and body autonomy.

Conclusion:
In Asian countries, good quality of counselling service for sexual abuse is still lack due to cultural and sociological backgrounds. There are many harmful impacts regarding this sexual rights abuse on the survivors. One of the ways to improve the quality is through adding Human Rights and Feminist perspective into counselling approach. Therefore, advocating these approaches is very important in Sexual Reproductive Health and Rights movement.

c) Awareness towards sexual and reproductive health and rights among young people with disability (YPWD) in Nepal

Shilpa Lohani, Nepal

Background: An estimated 2% of the total population in Nepal lives with disability. However, they are barely acknowledged as sexual beings and often face barriers to Sexual and Reproductive Health and Rights (SRHR) information and services. In a country where the median age of first sex is 16 years but less than one-fifth of young women use modern contraception, Young People with Disability (YPWD) are faced with increased vulnerability. But SRHR related programs have often over looked these distinctive needs and issues of YPWDs. Hence, to develop programs catered towards YPWDs, it is essential to understand to what extent YPWDs are aware of their SRHR.

Methodology: A cross-sectional study was conducted in six major districts of Nepal between January and February, 2015. The samples were chosen using multi-stage sampling. The study consisted of 293 participants aged between 15 and 30 years and had either one of the disabilities–hard of hearing/deaf, blind/low vision and physical. Trained Research Assistants with similar disability but in minor degrees administered pre-tested structured questionnaire after obtaining voluntary written informed consent/assent. Ethical approval was obtained from Nepal Health Research Council. Descriptive analyses were performed in SPSS to quantify distributions of discrete and continuous variables.

Results: Of 293 respondents, 45% were female; and mean age was 23.6 (±4) years. Only 25% were married whilst 31% of the unmarried were in a relationship. Interestingly, 61% of the respondent‘s spouse/partner‘s had disability.

Although 76% said they had heard of the key components of SRHR, comprehensive information was still negligent. For example, only 6% had comprehensive knowledge of all modern contraceptives with condoms being the most heard of method (86%). Majority (80%) associated one or more myths and misconception with FP services, and 21% had at least one misconception on STI prevention. Even though 54% agreed pre-marital sex was wrong, 47% were sexually active while 42% had had more than one sexual partner. However, 11% of those who ever had sex reported their first time was forced. Of those sexually active [n=131], 37% were not using any modern contraceptives. Amongst those using contraceptive [n=83], condom was most common (80%). Although, three-fourths said the nearest SRH service center was <30 minutes, only 28% had ever consulted a service provider for SRHR information and right. Nearly one-fifth reported difficulty in communicating with service

providers such as feeling shy or afraid. Respondents stated wanting age appropriate SRHR information highlighting its importance and their preferred mode of communication was inter-personal communication (IPC).

Conclusion: This study highlights lack of adequate awareness on comprehensive SRHR information and services among YPWDs. Therefore, IPC approach should be used to provide comprehensive SRHR information. In addition to increasing awareness and service uptake, this will also provide a platform for YPWD‘s to have open discussions on SRHR.

Ending Gender Based Violence

Lecture Room (9)

a) Trafficking of minor girls for commercial sexual exploitation: Exploring the situation of girls in trafficking prone "Source" areas of Bihar, India

Sharmistha Basu, India

Introduction: Many minor adolescent girls are vulnerable to trafficking for commercial sexual exploitation (CSE) in India. Although an estimated 40% of the approximately three million females in CSE in India are minors, little is known about their situation in trafficking prone ‗source' areas.

Objectives: We explore the situation of girls aged 12-19 years in three trafficking prone districts of Bihar and factors that place some girls at risk of trafficking for CSE.

Methods: A mixed method study was conducted in 35 trafficking prone villages: a survey of 752 girls aged 12-19 and focus group discussions with parents and community leaders.

Results: As expected, only a few girls acknowledged that they, a sister or other family member had been trafficked for CSE. Just 1% of girls aged 12-14 and 7% of girls aged 15-19 reported any such trafficking experience. However, far more girls reported acquaintance with someone in their village/school who had experienced CSE. About 6% of girls aged 12-14 and 20 % of those aged 15-19 were acquainted with a girl who had been trafficked for CSE, for example, within their own or a neighbouring village, as a family tradition, or as a result of false promises of marriage.

A comparison of girls aged 15-19 who did and did not experience trafficking for CSE suggests that those experiencing trafficking were more likely than others to belong to families who had experienced economic shocks, such as loss of livelihood, or serious illness (36% versus 26%), whose family had at least once found it difficult to feed, clothe and provide health care to a family member (57% versus 42%). Differences also emerged in terms of alcohol abuse by family members. Notable were differences in the percentages of girls reporting that they had witnessed a family member being drunk: 75 percent of trafficked girls (that is, all of those who reported alcohol consumption), compared with one-third of other girls (33%).

At individual level, differences were pronounced with regard to girls' own education, economic activity status and gender role attitudes. Economic activity in the 12 months preceding the interview displayed differences: more girls with trafficking experience had worked for wages in the last year than other girls (64% versus 40%), or had ever migrated away from the village for any work (29% versus 9%). Correspondingly, girls with trafficking experience were far more likely to have discontinued their education prematurely than were other girls. These findings were supported by qualitative narratives conducted with parents and community leaders. Gatekeepers highlighted that household poverty, fears about large

dowries for their daughters, parental greed and expectations of financial gain on the one hand, and alcohol abuse on the other were responsible for girls' entry into CSE.

Conclusion: Trafficking of girls for CSE is not a rare event, takes place through deception of many kinds; key protective factors are family access to savings, and girls' agency and retention in school. Findings emphasise the need for prevention programmes that empower families to withstand shocks, and address girls' protection needs.

b) Domestic violence (DV) in Thai pregnant women and its impact to their sexual and reproductive health

Siriwan Grisurapong, Thailand

Four to eight percent of women in this world experienced DV during their pregnancy. It is more common than any other health problems of pregnant women. Most studies related to DV in pregnant women were conducted in developed countries, very few were from Asia and almost none from Thailand. Lack of adequate evidences make it difficult for policies/ programs formulation/ implementation. This study aimed to identify prevalence of DV in Thai pregnant women and its impact to their sexual and reproductive health.

A province in the central part of Thailand was selected to be the site for this study. A random sample of pregnant women who came for Ante Natal Care (ANC) at public hospitals in the province was conducted. In total, 288 women participated in an interviewer-administered survey during October 2010 - March 2011. Interviewers were nurses and social workers who had been trained in interviewing techniques. Data on demographic and socioeconomic characteristics, types and experience of DV and its impact to sexual and reproductive health, attitude towards traditional gender roles, partners having extra marital sexual relations and pleasure in sexual intercourse were collected. Data were analyzed by using Chi-square to compare sexual and reproductive health between women who experienced DV and those without DV experience.

Approximately 16 % of pregnant women in this study experienced DV. Responses of being humiliated, scolded, beaten, pushed, forced sex were 20.5%, 9.3%, 5 %, 10.7% and 3.5% respectively. The demographic and socioeconomic characteristics of women experienced DV and no experience were similar. Women experienced DV had significantly difference self-reported health status and self-pride compared to women without DV experience. They received significantly different support by partners for ANC. For women experienced sexual violence, they had significantly lower sexual pleasure, more depression and difficulty in asking partners to use condoms.

These findings pointed that pregnant women experienced DV had more health problems in general and sexual and reproductive health in particular than those without experience. They are less likely to negotiate for condom uses which can lead to other sexual and reproductive health problems.

c) Female Genital Mutilation and venerability of Sexually Transmitted Infections and HIV in Senegal

Ramu -India

Background- The World Health Organization (WHO) defined female genital mutilation/cutting (FGM/C) as all procedures which involve partial or total removal of the external female genitalia and/or injury to the female genital organs, whether for cultural or any other non-therapeutic reasons. The World Health Organization estimates that between 100 and 140 million women and girls have undergone FGM and that account 2 million or more added to that number each year. Furthermore, those women have undergone FGM they are a more vulnerable group to get a sexual transmitted infection (STI) and HIV as comparable non-FGM women.

Methodology- Main objectives of this study were to understand the female genital mutilation prevalence and its association with venerability of sexually transmitted disease in Senegal. For this study Demographic Health Survey (DHS), 2010-11 data were used. In order to analyze the data set, Bivariate, Chi-squared tests (χ^2) and Binary logistic regression models were used. All analyses of this study were carried out using SPSS 20 software.

Results- The finding shows that the female genital mutilation prevalence significant high among rural area (43%) as compared to their counterpart. These practices were high performed by a traditional circumciser in rural areas (63 %) while in urban area its account about 37 percent only. Knowledge of HIV very poor among rural settings. The results are statistically significant at $P<0.001$ level and with considerable high values of the Chi-square test. However, the FGM practices were remarkably higher among Muslim religion (40.9 %) as compared to non-Muslim religion (18.9%). Likewise, Poular ethnic group was falling in high FGM prevalence (69.4%) zone while Wolof were contributed only 2 percent. The higher prevalence of FGM among no educated women was found along while these practices done by a traditional circumciser also too higher. Sexually transmitted Infections knowledge higher in urban area women along with a high percentage of STIs (68.9%). These trends have been followed by women age group 35-44 years old with knowledge and infected (96.6 & 60.8%). Furthermore, as women education increased the prevalence of STIs also increased, which is a secondary and above category account 74.1 % and primary category women 66.6 percentage respectively. Married women's are about 2 times more likely at $p< 0.01$ to have STIs as compared to their counterpart among FGM category. Similarly, among secondary and above education category women result were found at $p< 0.001$ level of significance.

Conclusion – The overall result shows a significant association between female genital mutilation and sexually transmitted infections among women in Senegal. The percentage of STIs among high educated category women may one cause of high awareness about STIs and high reporting too. The Government should provide free and compulsory education for the women for understanding the basic knowledge and health hazards related to FGM. To prevent STIs government provided free and accessible reproductive health care services to the girls and women.

CHAPTER 2

ABSTRACTS (POSTER PRESENTATION)

Title of Posters at 8th APCRSHR

1	**Family Planning And Abortion** Arumugam Elangovan[1], Mahaboob Munavar Basha[1], *[1]Family Planning Association of India, Chennai, India*
2	**Implementation of Circular on Condom Provision at Hostels and Guesthouses: Lesson-learned on Policy Enforcement in Vietnam** Tu Anh Hoang[1], Son Le Hoang Minh[1], Thao Nguyen Thi[1], Yen Vu Hai[2], *[1]Center for Creative Initiatives in Health and Population, Hanoi, Viet Nam, [2]PATH, Hanoi, Viet Nam, [3]USAID, Hanoi, Viet Nam, [4]T&A Ogilvy, Hanoi, Viet Nam*
3	**Policies Review of Adult Entertainment Sector in Nepal** Binu Lama[1], Sharda Paudyal[1], Rupa Sharma (Neha)[1], *[1]Centre for Awareness Promotion(CAP) Nepal, Kathmandu/Central Nepal, Nepal*
4	**"My life, my choice": the self-transformation in sexuality and reproductive health of Thai women living with physical disabilities** Maliwan Rueankam[1], Penchan Pradubmook[1], *[1]Department of Society and Health, Mahidol University, Nakornprathom, Thailand*
5	**Dialogue with Related Stakeholders about Contraception Policy for Teenangers** I Gusti Ngurah Edi Putra[1], *[1]KISARA IPPA Bali Chapter, Denpasar, Indonesia*
6	**A systems-based approach to optimizing midwifery education in Myanmar** Nwe Nwe Khin[1], Peter Johnson[3], Hnin Wai Hlaing[2], Leah Thayer[2], Su Su Kyi[2], Nay Aung Linn[2], Khine Hay Mar Myint[2], *[1]Department of Health Professional Resource Development and Management, Ministry of Health, Nay Pyi Taw, Myanmar, [2]Jhpiego, Yangon, Myanmar, [3]Jhpiego, Baltimore, USA*
7	**Trafficked into the Sex Industry: Young Nepalese Women and Reproductive Health** Tricia Ong[1], *[1]Deakin University, Melbourne, Victoria, Australia*
8	**Knowledge on Sexual, Reproductive Health and Rights (SRHR) Issues reduce vulnerability towards HIV/AIDS among young pavement dwellers (YPD) in Bangladesh.** Md.Nurul Alom Siddikqe[1], *[1]East West University, Dhaka, Bangladesh, [2]Link Up Bangladesh, Dhaka, Bangladesh*
9	**Employing M-health Platforms to Help Integrate Sexual and Reproductive Health (SRH) into Conventional Healthcare Systems in Less-developed Countries (LDCs)** Swam Saung Oo[1], *[1]University of Leeds, Leeds, West Yorkshire, UK, UK*
10	**Referral pathways for vulnerable groups in four north-eastern provinces of Cambodia** Kun Heng[1], Guechhourng Mao[1], Vichet Am[3], Hemrin Aun[2], Sovann Yim[4], *[1]Partnering to Save Lives, Phnom Penh, Cambodia, [2]CARE Cambodia, Phnom Penh, Cambodia, [3]Marie Stopes International Cambodia, Phnom Penh, Cambodia, [4]Save the Children, Phnom Penh, Cambodia*
11	**Access and Utilization of Prevention of Mother to Child Transmission Services by Female Sex Workers in Selected Townships in Myanmar** Poe Poe Aung[1], Yadana Khin Khin Kyaw[2], Pa Pa Win Htin[3], Than Tun Sein[1], *[1]Burnet Institute, Yangon, Myanmar, [2]UNOPS, Yangon, Myanmar, [3]UNICEF, Yangon, Myanmar*

12	**In or Out? Exclusion of young key populations from national plans as a barrier to SRHR** Justine Sass[1], Karen Humphries-Waa[1], Rebecca Brown[1], Paula Bulancea[2], Annefrida Kisesa-Mkusa[2], Scott McGill[8], Anandita Philipose[3], Ed Ngoksin[7], Shirley Mark Prabhu[4], Nashida Sattar[5], Josephine Sauvarin[3], Bettina T. Schunter[4], Aries Valeriano[6], *[1]UNESCO, Asia-Pacific Regional Bureau, Bangkok, Thailand, [2]UNICEF, Regional Office for South Asia, Kathmandu, Nepal, [3]UNFPA, Asia-Pacific Regional Office, Bangkok, Thailand, [4]UNICEF, East Asia and the Pacific Region, Bangkok, Thailand, [5]UNDP, Regiona Bureau for Asia-Pacific, Bangkok, Thailand, [6]UNAIDS, Asia-Pacific Regional Support Team, Bangkok, Thailand, [7]GNP+, Bangkok, Thailand, [8]Save the Children, Bangkok, Thailand*
13	**Trialling new channels of communication: use of social media to reach adolescents and young people with sexual and reproductive health questions in Laos** Aileen McConnell[1], Dalayvanh Keonakhone[1], Sila Phoummachack[1], *[1]Vientiane Women's Youth Centre for Health and Development, Vientiane, People's Democratic Republic of Lao,*
14	**New Approaches Utilizing Misoprostol for Management of Postpartum Hemorrhage at the Community Level** Laura Frye[1], Rasha Dabash[1], Jill Durocher[1], Holly Anger[1], Dina Abbas[1], *[1]Gynuity Health Projects, New York, NY, USA*
15	**Obstetric and Perinatal Outcomes of Teenagers and Older Women: A Prospective Cohort Study** Ivy Joy Dafielmoto[1], Darleen Estuart[1,2], *[1]Brokenshire Hospital, Davao City, The Philippines, [2]Brokenshire WomanCenter Director, Davao City, The Philippines*
16	**Women's awareness and knowledge of abortion laws: a systematic review** Anisa Assifi[1], Blair Berger[2], Özge Tuncalp[1], Rajat Khosla[1], Bela Ganatra[1], *[1]World Health Organization, Geneva, Switzerland, [2]John Hopkins Bloomberg School of Population Health, Baltimore, USA*
17	**Addressing the SRH needs of Mongolian youth: Participatory approaches to training** Dorjnamjim Ulziikhishig[1], Ganbat Batjargal[1], Bolormaa Norov[2], *[1]Marie Stopes International Mongolia, Ulaanbaatar, Mongolia, [2]Ministry of Health and Sports of Mongolia, Ulaanbaatar, Mongolia*
18	**Importance of thrombocytosis in patients with ovarian cancer at Central Women Hospital, Yangon, Myanmar** Zin Zin Thu[1], Mya Thida[2], Aye Aye Tint[2], Khin Shwe Mar[2], Tin Oo[1], Moh Moh Hlaing[1], Khin Saw Aye[1], *[1]Department of Medical Research, Ministry of Health, Yangon, Myanmar, [2]Department of Medical Services, Ministry of Health, Yangon, Myanmar*
19	**Factors Related to Delayed Antenatal Care among Pregnant Mothers at 300-Bedded General Hospital in Pyin Oo Lwin Township** Thinzar Aung[1], Khay Mar Mya[1], Win Myint Oo[1], *[1]University of Public Health, Yangon, Yangon, Myanmar*
20	**Exploring the perceptions on child marriage among young girls in southern Bangladesh** Shahana Nazneen[1], *[1]Innovations for Poverty Action (IPA), Dhaka, Bangladesh*
21	**Sucessful Model=Upscaling Basic EMOC services in remote areas of Pakistan.** Jamil Ahmed[1], *[1]UNFPA, Punjab, Pakistan*

22	**Gender based violence issues and sexual reproductive health needs of women with disabilities in Jakarta, Indonesia** Asti Widihastuti[1,2], Maulani Rotinsulu[1], Mimi Maryani[1], Risya Kori[2], *[1]Indonesian Association of Women with Disabilities, Jakarta, DKI Jakarta, Indonesia,[2]UNFPA, Jakarta, DKI Jakarta, Indonesia*
23	**Knowledge on Emergency Contraception Among Students Attending University of Distance Education and Staying in the Private Hostels in Pathein Township** Aye Thida Win[1], Thin Myat Han[1], Kyawt Sann Lwin[1], Nay Soe Maung[1], *[1]Pact Myanmar, Yesagyo, Myanmar, [2]University of Public Health, Yangon, Myanmar, [3]University of Public Health, Yangon, Myanmar, [4]University of Public Health, Yangon, Myanmar*
24	**The Join-in Circuit (SangSangai) in Nepal.Opening up choices: An innovative method to support adolescents in fulfilling their sexual and reproductive health needs and rights** Amu Singh Sijapati[1], Rabindra Karki[1], *[1]Family Planning Association of Nepal, Kathamndu, Nepal*
25	**Are courtyard meetings effective in disseminating family planning information? Experiences from Bangladesh** Md. Azmal Hossain[1], Waliul Islam[1], Bashir Ahmed[1], *[1]EngenderHealth Bangladesh, Dhaka, Bangladesh*
26	**Meeting the demands in sexual and reproductive health; progress of an established one stop shop youth-friendly service in Vientiane Capital, Laos** Sila Phoummachack[1], Aileen McConnell[1], Dalayvanh Keonakhone[1], *[1]Vientiane Women's Youth Centre for Health and Development, Vientiane Capital, People's Democratic Republic of Lao*
27	**The effectiveness of home-based HIV counseling and testing in reducing stigma and risky sexual behavior among adults and adolescents: a systematic review and meta-analyses** Garumma Feyissa[1,2], Craig Lockwood[2], Zachary Munn[2], *[1]Jimma University, Jimma, Oromia, Ethiopia, [2]The University of Adelaide, Adelaide, SA, Australia*
28	**Understanding factors influencing unbalanced sex ratios: The situations in two selected districts of Nepal** Mahesh Puri[1], Anand Tamang[1], *[1]Center for Research on Environment Health and Population Activities, Lalitpur, Nepal*
29	**From VCT to Testing: Implementation Early Initiation of ARV Policy - Test and Treatment - in Indonesia** Sisilya Oktaviana Bolilanga[1], *[1]GAYa NUSANTARA, Surabaya, Indonesia*
30	**Contraceptive Knowledge, Perceptions and Practice among Migrant adolescents in Dakhinathiri Township** Ei Ei Maung[1], Myo Myo Mon[2,1], Aye Kyi Kyi[1], *[1]University of Public Health, Yangon, Yangon, Myanmar, [2]Department of Medical Research, Yangon, Yangon, Myanmar*
31	**Oncogenic Human Papillomavirus (HPV) Genotypes among Women with Cervical Pre-cancer and Cancer in Yangon and Mandalay, Myanmar** Mu Mu Shwe[1], Kyi Kyi Nyunt[2], Hla Myat Mo Mo[3], Zin Mon Kay Khine Win[2], Ohnmar Kyaw[1], Khin Than Maw[1], Khin Khin Oo[1], Khin Saw Aye[1], Hlaing Myat Thu[1], Kyaw Zin Thant[1] *[1]Department of Medical Research, Yangon, Myanmar, [2]Central Women Hospital, Mandalay, Myanmar, [3]Sanpya General Hospital, Yangon, Myanmar*

32	**Male Climacteric: An Addition to the Mental Health Burden?** Md. Shafiqur Rahman[1], *[1]Directorate General of Health Services of Bangladesh, Dhaka, Bangladesh*
33	**Contraceptive use among never-married adolescents in Indonesia: Analyzing the effect of region of residence** Sarni Berliana[1], Lia Yuliana[1], Dewi Puspitasari[1], *[1]Sekolah Tinggi Ilmu Statistik, Jakarta, Indonesia*
34	**VSO International Citizens Service (ICS) improving young people's sexual and reproductive health and rights through volunteering and peer education - A case study from Baglung, Nepal** Mahesh Dhungel[1], Georgina Richards[2], Clive Ingleby[2], Bishnu Maya Bhattarai[1], *[1]VSO Nepal, Kathmandu, Central, Nepal, [2]VSO UK, London, UK*
35	**Cervical Cancer Screening: Cytological Pattern of women attending Cervical Cancer Screening Clinic, Department of Medical Research (DMR) (2008 to 2014)** Aye Aye Win[1], Mu Mu Shwe[1], Yin Min Htun[1], Ohnmar Kyaw[1], Thazin Myint[1], Tin Tin Han[1], Khin Saw Aye[1], Kyaw Zin Thant[1], *[1]Department of Medical Research, Yangon, Myanmar*
36	**Integration of adolescent sexual and reproductive health programs in health facilities- what works and what not: evidence from Bangladesh** Sigma Ainul[1], Ubaidur Rob[1], *[1]Population Council, Dhaka, Bangladesh*
37	**How the Indonesian Media Uses Stigamatising and Emotive Language to Discuss Abortion** Kate Walton[1], *[1]Kinerja USAID, Jakarta, Indonesia*
38	**Characteristics of high frequency HIV testers within a population of men who have sex with men reached by an outreach program in Myanmar** Zaw Min Oo[1], Zaw Win Thein[1], Bridget Draper[2], Poe Poe Aung[1], Vanessa Veronese[2,3], Claire Ryan[1], Myo Thant[4], Chad Hughes[2], Mark Stoove[2,3], *[1]Burnet Institute, Yangon, Myanmar, [2]Burnet Institute, Melbourne, Australia, [3]Monash University, Melbourne, Australia, [4]National AIDS Program, Yangon, Myanmar*
39	**"Are we ready to meet all the needs?" - Anticipating the Universal Health Coverage Scheme in Indonesia-** Jesse Brandt[1], Clara Benarto[1], Melania Hidayat[1], *[1]UNFPA, Jakarta, Indonesia*
40	**Review of MISP project implementation in Pakistan and Solomon Islands: Implications for effective SRH emergency responses in Asia and Pacific region** Sinu Chacko[1], Subatra Jayaraj[2], *[1]International Planned Parenthood Federation South Asia Region, New Delhi, India, [2]International Planned Parenthood Federation East and South East Asia and Oceanic Region, Kuala Lumpur, Malaysia*
41	**Use of Social Media: Engaging Youth to Discuss SRH Issues** Shreejana Bajracharya[1], Nilima Raut[1], Satyajit Pradhan[1], *[1]Sunaulo Parivar Nepal, Kathmandu, Nepal*
42	**Access, knowledge and perception of youths towards SRH services in three selected areas in Myanmar.** Thida Kyaw[1], Moe Moe Aung[1], Phyo Wai Min[1], San Shwe[2], Le Le Win[2], *[1]Marie Stopes International - Myanmar, Yangon, Myanmar, [2]Department of Medical Research, Yangon, Myanmar*

43	**Title: Intimate Partner Violence and Symptoms of Sexually Transmitted Infections among Young Indian Women** Jayakant Singh[2], Enu Anand[1], *[1]International Institute for Population Sciences, Mumbai, Maharashtra, India, [2]School of Health Systems and Studies, Tata Institute of Social Sciences, Mumbai, Maharashtra, India*
44	**Impact of policy change introducing nurse provision of safe abortion services in selected government facilities in Bangladesh: An assessment of quality of care and client satisfaction** Kamal Biswas[1], SM Shahidullah[1], Sharmin Sultana[1], Jamie Menzel[1], Rezwana Chowdhury[1], *[1]Ipas Bangladesh, Dhaka, Bangladesh*
45	**Informed, naive or the middle ground: What sexual and reproductive health decisions are being made by women with higher education in contemporary Cambodia?** Jan Moore[1], Melissa Graham[1], Loretta Hoban[1], David Tobin[1], *[1]Deakin University, Burwood, Victoria, Australia*
46	**Redefining "hard to reach": Results from a reproductive health needs assessment in peri-urban Yangon, Myanmar** Grace Sheehy[1,2], Yadanar Aung[1], Angel Foster[1,2], *[1]Cambridge Reproductive Health Consultants, Cambridge, MA, USA, [2]University of Ottawa, Ottawa, ON, Canada*
47	**Unintended Pregnancy and its Relationship with Low Birth Weight in India: What does Data Suggest?** Shrividya Malviya[1], Kaushlendra Kumar[2], Dharmendra Kumar Dubey[3], *[1]All India Institute of Medical Sciences, New Delhi, India, [2]Evidence Action, New Delhi, India, [3]Gauhati University, Guwahati, India*
48	**Knowledge of and Attitude towards HIV/AIDS among Youths of Mandalay Teacher Training College in Myanmar** Aung Ko Oo[1,4], Myo Min Oo[2], Yu Nandar Aung[4], Poe Poe Aung[3], Phyu Phyu Khaing[1], Khin San Hlaing[1], *[1]Department of Psychology, Mandalay University, Mandalay, Myanmar, [2]International Union Against Tuberculosis and Lung Disease, Mandalay, Myanmar, [3]Burnet Institute Myanmar, Yangon, Myanmar, [4]UNOPS Myanmar, Yangon, Myanmar*
49	**Penile fibrosis due to injection of foreign substances** Hla Min Oo[1], Khin Aung Tun[1], Nwe Oo Latt[1], Naing Naing Soe[1], Zaw Win Htay[1], Win Myat Oo[2], *[1]No.(2) Military Hospital (700-Bedded),, Aung-Ban, Southern Shan State,, Myanmar, [2]Defence Services Medical Research Centre, Nay Pyi Taw, Myanmar*
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57	**Sexual and Reproductive Health Assessment on Thai-Burmese Border** Parveen Parmar[2], Payal Modi[1], Mihoko Tanabe[4], Jenn Leigh[3], *[1]University of Massachusetts, Worcester, MA, USA, [2]Brigham and Women's Hospital, Boston, MA, USA, [3]Harvard School of Public Health, Boston, MA, USA, [4]Women's Refugee Commission, New York, NY, USA*
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63	**Comparison of pregnancy exposures and outcomes of women married as a child versus women married as an adult in rural Nepal** Anand Tamang[1], Ashish Lamichhane[1], Dev Maharjan[1], *[1]Center for Research on Environment Health and Population Activities, Kathmandu, Nepal*
64	**Knowledge, Attitude and Practice related to Sexual and Reproductive Health among adolescents living in urban slum areas in Narayanganj City Corporation of Bangladesh** Helee Choudhury[1], Maksud Rahman[1], *[1]EPOS Health Management, Dhaka, Bangladesh*
65	**Transition in Family Planning Behaviour in India: A Retrospective Cohort Analysis** Ajay Gupta[1], *[1]International Institute for Population Sciences, Mumbai, Maharashtra, India*
66	**Greater than the sum of its parts? Effectiveness of a new style of multi-sectoral partnership for improving reproductive, maternal and neonatal health in Cambodia** Julia Battle[1], Abigail Beeson[2], Heidi Brown[3], Naomi Byrne-Soper[4], Ung Kim Heang[1], Luong Soklay[4], Yim Sovann[2], *[1]CARE Cambodia, Phnom Penh, Cambodia, [2]Save the Children, Phnom Penh, Cambodia, [3]Partnering to Save Lives, Phnom Penh, Cambodia, [4]Marie Stopes International Cambodia, Phnom Penh, Cambodia*

1. **Family Planning And Abortion**

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Background:

The Medical Termination of Pregnancy (MTP) Act of 1971 legalized abortions in India. According to statistics brought out by the Union Health Ministry of India, 682,000 induced abortions were recorded in INDIA in 2007. Post abortion Family Planning involves the provision of contraceptive counseling and contraceptive supplies to women after they have had an abortion. However the post abortion contraceptive acceptance is low. Many attribute this to non availability of systematic post abortion family planning counseling. At the individual level, many studies have shown that contraceptive uptake and discontinuation are associated with Socio- Demographic characteristics such as age, Education and Parity. This abstract looked in to the linkage between adoption of Family planning method after abortion and socio demographic characteristics of the clients.

Program Intervention:
The FPA India Chennai has one Reproductive Health and Family Planning Clinic providing safe abortions and family planning contraceptive services . Annually, more than 200 MTPs are performed and Post abortion contraception is also provided. During 2014, a total number of 217 MTPs were performed.

Methodology:
This retrospective study was done by analyzing service statistics of the FPA India static clinic at Chennai. The study focused on two socio-demographic characteristics – Literacy levels and parity of the Family planning acceptors who accepted any one of the Family Planning Methods after undergoing MTP in our clinic during the year 2014. This paper did not violate the confidentiality of MTP acceptors in any way. This abstract used tabulation method to analyze the data.

Key Findings:
During the year 2014 there were 217 MTP clients and among them 7 clients were unmarried. Out of 210 married clients, 117 accepted any one of the F.P methods. The F.P. acceptance percentage is 56. The mean age of the acceptors is 28 years. The study results are given in the following table.
· Strong linkage between literacy of the clients and acceptance to contraceptive methods was seen. The findings of the study show that the literacy level and the Family Planning acceptance are inversely proportionate to each other Therefore it is inferred that, there is a tendency among some highly educated couples to have more than two children.
· The data shows a strong linkage between parity and acceptance to contraception methods. As parity increases the F.P. Acceptance rate also increases.

Lessons Learned:
The findings of the study suggest that the educated women need to be counseled more on family planning methods.
The findings of the study also suggest that most of the MTP clients having less than two children hesitate to adopt Family Planning methods due to various reasons. The lack of proper counseling may be one of the reasons. Evidence has shown that women who are offered a wide range of contraceptive methods are more likely to accept post abortion contraception. Community awareness campaign on MTP laws and Family Planning adoption after MTP should be strengthened.

2. Implementation of Circular on Condom Provision at Hostels and Guesthouses: Lesson-learned on Policy Enforcement in Vietnam

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Background: In 2013, the inter-ministerial circular No.29/2013/TTLT - BYT - BVHTTDL - BCA - BLĐTBXH (condom circular) was issued to strengthen condom provision at hotels and guesthouses nationally by improving inter-sector collaboration and solving persistent gaps and conflicts between HIV prevention programs and other programs on prevention and control of prostitution and drug abuse. This circular hopes to increase access to condoms among key populations (male/ female sex worker, people who injecting drugs...) and also general populations such as young people.

Objectives: A rapid assessment was conducted to (1) assess the implementation of the circular and results and (2) analysis factors that influence the circular enforcement; (3) provide recommendations for improvement in implementation of the circular.

Method: The study method consisted of two components1) Observation at 153 hotels and guesthouses using mystery clients technique and 2) semi-structured interviews with 66 key informants including 48 hotel and guesthouses' managers and 18 government officers in departments related to the circular at provincial level in Ha Noi, Hai Phong and Ho Chi Minh City (HCMC).

Result: While recognizing the importance of the circular, vertical dissemination of the circular in the ministries and to the hotels and guesthouses was low. Only about half of the interviewed government staff in related departments knew about the circular. Health department's staffs seem to be aware of the circular better than their colleagues at other departments. All interviewed guesthouses provided condoms, but this number at hotels was much lower. "normalization" of condom was increasing and contributing to provision of condoms but view on association of condom and sex work among hotels/guesthouses was still prevailed. HIV prevention remained being seen as task of health sector. This was the

main challenge for the implementation of the circular which required the shifting roles of the health and non-health sectors.

Conclusion: The circular was important and relevant for improving HIV/AIDS prevention. However, lack of suitable coordination mechanism, clarity in roles and responsibilities of involved actors and projecting the readiness of sectors, especially non-health sector in taking HIV prevention in their programs has limited the implementation of the circular.

Recommendation: Improving the dissemination of circular from the national to the local level and individuals who directly implement HIV harm reduction and prevention activities as well as to the accommodation establishments. Strengthening the role of the Provincial People's Committee in directing and coordinating the circular planning and evaluation. Discussing and clarifying the roles of "lead" and "supporting" relevant agencies.

Key words: condom provision, circular, hotels, guesthouses, HIV.

The study was done within frame of Healthy Markets Activity funded by USAID and implemented by PATH in collaboration with CCIHP and T&A Ogilvy.

3. Policies Review of Adult Entertainment Sector in Nepal

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Objectives: At present, over 100,000 women and girls are employed either full-time or part-time as employees in the adult entertainment sector (cabin restaurants, dance bars, massage parlor and spa etc) in Kathmandu Valley alone where physical, mental, and sexual abuse is prevalent. Over half of these women are minors (Maiti Nepal: 2010). They are subjected to various forms of violence including physical and sexual abuses from owners, staffs, and customers. 91% of women/girls among 400 women/girls working in the adult entertainment sector (AES) of Kathmandu valley reported that they are forced to perform sexual services ranging from inappropriate touching to non-consensual sex, over 71% of them were deceived, and were not told that their work would involve sexual service prior to recruitment (CAP Nepal:2014). Due to a lack of education, extreme poverty, unemployment, and often times a need to support dependents, these women/girls are tempted into this AES by the lack of qualification required for working in the sector. Often times, they are the most vulnerable, and policy makers overlook their needs.

Methodology: Existing laws and policies regarding controlling exploitations in the AES as well as available literatures have been reviewed.

Findings: The government of Nepal did not have any legal provision to control the risk of violence and sex trafficking in the AES until 2008 when the Supreme Court of Nepal first time recognized that women/girls in the sector are exploited physically, psychologically, sexually and their rights are totally violated. The Supreme Court of Nepal ordered the government for enactment of an act to address their issues, and further issued directives

which would apply as a law until a new act would be brought. The directives prohibited exploitation of women in the AES. It has further forbidden acts of verbal and sexual abuses. This includes the demand for sexual intercourse, inflicting harm upon any employee, or forcing the employee to do anything against her will. The Directives clearly outlines duties of owners that they could not reap financial benefit from the exploitation of these women, or coerce any woman working in the sector to maintain their employ under threat, temptation or punishment. The owners are obligated to guarantee the human rights of women under their employment, the Directives further outlines the code of conduct of customers as well. There is a provision of a Monitoring and Action Committee; unfortunately, this committee is not active and only performed five visits since its inception in 2008. Recently, in 2014, the government of Nepal enacted the Sexual Harassment Act which prohibits sexual harassment of women in the working place. Unfortunately, the Act does not outlaw the issues of exploitation of women/girls working in AES.

Future Direction: a separate act to control exploitation of women/girls working in the AES and to address their issues shall be brought. Till then the Directives shall be properly implemented with follow through the Monitoring Committee to make sure exploitation does not continue to occur. For this, continue advocacy and lobby activities should be done.

4. "My life, my choice": the self-transformation in sexuality and reproductive health of Thai women living with physical disabilities

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Women living with disabilities are facing with social discrimination on the right of sexual being and reproductive health needs. Society devalued them by comparing with the standard of normality and labeled them as "defected object", "the different" or "the other". They are commonly understood to be either asexual, uninterested in sex. Moreover they are predicated as unable to take part in sexual activity, or even unable to be a good mother. Voice of disable women are quite absent in the literatures and interventions design. This study aimed to explore self, subjectivities on their sexuality and reproductive health of women with disabilities in Thailand. Qualitative methodology was applied. Twelve women with physical disabilities with different social contexts and roles in the family and communities were recruited by purposive sampling and snowball technique. Narrative interviews and narrative analysis were used for data collection and analysis.

Most of participants of this study are heterosexual. They transform to be active sexual being through deconstruct asexual myth by build intimacy with lover, decide pattern of intimate relationship by their own such as marry or just cohabit with disabled or non-disabled. However they experienced with negative attitude towards sexual needs and reproductive health needs by dominant medical discourse on their body and patriarchy system on their gender role. They encountered with genetic risk discourse on disabled pregnancy by having determination for a baby. They made their choice to become mother whereas the social norm and societal attitude or belief tends to raise the question whether they have the ability to raise

the child. They can rearing their child and being a wife in their family by their own way. This study showed that women living with physical disabilities were able to transform their self from disable to be able by understanding limitation, relearning new body, and creating new lifestyles. They are negotiating with over power by their power within. Independent living concept, social inclusion opportunities and family support are very important to empower them feel as equal as others.

Recommendations are proposed to promote sexuality and reproductive health right of women with disability. Right based intervention should start at the individual and the family level. We must bring women with disabilities back to be fully human in our society.

5. Dialogue with Related Stakeholders about Contraception Policy for Teenangers

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Introduction:
Reproductive and sexual health rights for teenagers is the right of gaining access to information, youth-friendly health services, and making decisions concerning reproduction free of discrimination, abuse, and violence. Unfortunately, reproductive and sexual issues is taboo in many areas in Indonesia. One of the current problems regarding reproductive and sexual health rights is the draft legislation to criminalize contraception. In the draft legislation, giving information about contraception tools to unmarried teenagers without asked for it will be criminalized, except officers who have authorities. In addition, supermarkets are prohibited to sell contraceptives as condoms freely. If the draft legislation is authorized, it will limit access of teenagers to get information about contraception and access to contraception tools. The result of KISARA IPPA Bali Chapter's research shown that teenagers' need of contraception is very high. Among 384 respondents in Denpasar-Bali, only 19% of them have had sexual intercourse without condom. Therefore, we have conducted event "Dialogue with Related Stakeholders about Contraception Policy for Teenangers" as a form of advocacy to make the government reject the draft legislation.

Objective:
Many pro and cons related the draft legislation to criminalize contraception signifying the government needs to giving special attention about it. Therefore, the aim of this event is to describe behaviour of teenagers related to reproductive and sexual issues in local area and to discuss negative impact of draft legislation if it will be authorized so that the local goverment can give support to reject the draft legislation to criminalize contraception.

Method:
This event have been held in The Indonesian Planned Parenthood (IPPA) Bali Chapter on September 13th 2015. This event was joined by the government of bali Province who have strategic position in support or reject the draft legislation. The method of this activity is firstly giving information to local government about the condition of teenagers' behaviour regarding reproductive and sexual health in Bali and Indonesia, and then the second information is

about the draft legislation to criminalize contraception as condoms. After that, showing testimonial video which is about teenagers' opinion rejecting the draft legislation and continued by dialogue about the impact if the legislation is held by stakeholders.

Result:
The result of this event is a petition containing a rejection of the draft legislation. This event was joined by 17 the government local and 9 who are willing to sign a petition rejection. Therefore, more the government support to reject the draft legislation because they realized that the draft legislation will limit the effort to empower teenagers as peer educator to give information about reproductive and sexual health to other teenagers. The petition that will be referred to the national government.

Conclusion:
The local government realized how important access of teenagers to information about reproductive and sexual health particularly contraception. Most of the government reject the draft legislation to criminalize contraception by their willingness to sign a petition. The petition will soon be referred to the national government for consideration to cancel the draft legislation.

6. **A systems-based approach to optimizing midwifery education in Myanmar**

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Objective: Share evidence-based strategies used to shape critical inputs and influencing factors affecting the competency of graduate midwives

Background: Midwives must be capable of providing safe and effective maternal and newborn care upon graduation and deployment into the Myanmar health system. Jhpiego has been supporting the Ministry of Health to optimize midwifery education in Myanmar with a focus on holistic analysis of, and strategic enhancements to (a) delivery of curriculum; (b) teaching skills; (c) student management; (d) teaching resources; (e) administration and (f) clinical learning sites.

Methods: Eleven of the twenty two schools that prepare midwives for practice in Myanmar were assessed using a rapid assessment tool developed by Jhpiego and reviewed by WHO, UNFPA, ICM and ICN. Analysis of findings resulted in action to support the following optimizations:

- Mapping of national curriculum to ensure consistency with planned revisions to midwifery competencies developed by the Myanmar Nurse & Midwife Council (MNMC). Recommendations to maximize acquisition of essential communication, clinical decision making and psychomotor skills.

- Continued professional development to midwifery tutors focused on clinical skills standardization, effective teaching skills and student performance assessment.

- Procurement and organization of simulators, anatomical models, clinical equipment and supplies within clinical skills labs.

- Support to school principals and school management teams.

- Enhancing performance of health workers providing clinical mentorship to midwifery students.

A sustainable accreditation system is a key factor influencing educational quality. Jhpiego is supporting the MNMC to develop policies and systems needed to accredit providers of midwifery education in Myanmar.

Results: A midwifery faculty development plan has been constructed to update the faculty's skills in clinical standardization, effective teaching skills and performance assessment skills in collaboration with the Ministry. The context specific, competency-based, clinical standardization three-week package was developed and 68 Master Mentors were trained. The Master Mentors are then supported technically to carry out the Low-Dose High Frequency (LDHF) at their working sites. Skills laboratories at midwifery schools are strengthened to develop clinical skills and prepare midwifery students for practice with greater competence in clinical settings. Myanmar Nurse and Midwife Council developed the core competencies standards, code of ethics and accreditation guideline for nurses and midwives with the technical input by Jhpiego.

Conclusion: By strengthening midwifery education in Myanmar with the leadership and guidance of the Ministry of Health, in collaboration with development partners, professional association, regulatory body and other key stakeholders, Myanmar midwives will be prepared to provide consistent, competent and safe clinical care mothers and newborns. These efforts will establish the foundation for a state-of-the-art professional midwifery workforce unmatched in the region.

7. Trafficked into the Sex Industry: Young Nepalese Women and Reproductive Health

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Description of Topic:

Across the globe, adolescent girls have been identified as the most vulnerable population to reproductive health issues. While much of this is due to biological changes in puberty, other issues can include human rights abuses, particularly in relation to sexuality, marriage and childbearing. This study focuses on one of the most highly marginalised and disadvantaged groups to reproductive health in Nepal; adolescent girls have been formerly trafficked into

the sex industry. In Nepali culture, these girls are stigmatised for their former engagement in sex work, having HIV/AID (if they contract it), and, most particularly, if HIV/AIDS is contracted in India. Limited quantitative research reports barriers to reproductive health for trafficked girls; stigmatisation, lack of reproductive health knowledge, and inability of NGOs to provide quality health care. This study is concerned with exploring factors that impact on the reproductive health - perceptions of the reproductive body, hopes and fears around reproduction, and how these aforementioned factors influence reproductive decision-making - of these girls. In addition, it is developing a set of recommendations for reproductive health support and reproductive health education for trafficked girls for Nepal's key health care policy makers, such as, for example, Anti-Trafficking NGOs, Ministry of Education, Ministry of Health, Ministry of Women, Children and Social Welfare, and UNFPA and UNFPA-supported Y-Peer Educators.

Methods:

This study is a qualitative interpretive inquiry. Located in child homes in Kathmandu, Nepal's capital city, it is engaging trafficked girls aged 13-18 - who do not have HIV/AIDS, but are very vulnerable to contracting it due to the risk of being re-trafficked, re-engaging in prostitution, and engaging in ongoing risky sexual behaviours - in a series of processes to gain rich in-depth data about their reproductive health issues. This study is employing a multi-method approach to data collection. The methods are: (Critical Ethnographic) Participant Observation, a Series of 6 Participatory Workshops incorporating the Clay Embodiment Research Method (CERM) and Individual In-Depth Interviews using Photoethnography. The CERM is a new 3-dimensional body mapping technique and method that has been designed for this particular cultural context. Photographs of the clay work are being used to elicit further in-depth data in the individual interviews. Data is being analysed thematically using Applied Thematic Analysis (ATA). ATA enables multiple analytic techniques to be used to analyse qualitative data - inductively - within an interpretivist paradigm.

Salient Findings:

Preliminary findings and/or reflections will be presented at this conference.

Conclusion:

Engaging trafficked girls, exploring a multiplicity of factors, and using innovative methods, this study aims to break new ground to work towards improving reproductive health support and reproductive health education for trafficked girls in Nepal. Although this study is focussed on a group of highly marginalised and disadvantaged adolescent girls to reproductive health in Nepal, the findings are likely to interest lead actors in the Adolescent Sexual and Reproductive Health (ASRH) sectors in South Asia and in other regions across the globe.

8. Knowledge on Sexual, Reproductive Health and Rights (SRHR) Issues reduce vulnerability towards HIV/AIDS among young pavement dwellers (YPD) in Bangladesh.

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Background: The purpose of this intervention was to describe how the YPD's improved their health seeking behaviors and awareness of sexual and reproductive health rights and commodities among 10-24 aged at 3 city corporation those who come from different periphery areas of the country in Bangladesh. The pavement dwellers live at rail stations, bus terminals, parks, boat terminals and various governmental abandon areas. The said YPDs are guardian less, shelter less and guided by the gangs/ pimps where they earn by themselves by stealing, snatching, and pick pocketing for their survive no minimum facilities of toilet and showering. They have no knowledge on how to manage the changes during puberty. Because of the situation in which they live they are habituated to unsafe sex with multiple partners from their early life and being ignorant about sexual diseases access quack and traditional healers for their treatment which results in unwanted pregnancy and unsafe abortion.

Method: The intervention developed mapped the YPDs and gave them eight digits unique identification code (UIC). They were also provided with referral card and form group considering their age, profession and location. The education for creating awareness and enhancing their knowledge was through group, inter personal communication, audio messages through cell phones on sexual and reproductive health rights, sexually transmitted diseases, safe motherhood for young girl, HIV/AIDS, drug use, gender based violence and life skills education; along with more information on family planning, anti natal care (ANC) and post natal care (PNC). No other organization had provided such comprehensive one stop information to them before this. In education sessions the outreach workers promoted practice of safe sex with their sexual partners and also discussed the demerits of multiple sex partners, early marriage, poly marriage and polygamy. The outreach workers referred the YPD's considering their needs to mobile van clinic/ satellite clinic for clinical session where they receive commodities, medicine free of cost and advice for advance treatment if required to reduce their vulnerability. Repeated meeting with local influential elites, government officials and public representatives were also held for creating an enabling environment for them. The outreach workers developed follow up mechanism for transferring knowledge and ensuring health services.

Results: By utilizing the project facilities 80,000 YPDs received information on sexual and reproductive health rights and got access to health services. Increased their knowledge on health, safe sex, safe abortion and safe delivery, ANC, PNC and taken safe delivery services from the clinic. Where previously most of the YPDs were visiting the quacks, traditional healers and hawkers now about 90% of YPDs reached took services and commodities from clinic/hospital including SRH, family planning methods and menstrual regulation services. Through the intervention the YPDs could realize their contribution to society, felt their better self esteem and dignity by themselves.

Conclusion: Indications the YPDs realized the necessity of SRHR information and became conscious about HIV / AIDS and realized the connection to SRHR.

9. Employing M-health Platforms to Help Integrate Sexual and Reproductive Health (SRH) into Conventional Healthcare Systems in Less-developed Countries (LDCs)

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Background

Global mal-distribution and shortages of healthcare workforce and resources are mirrored by hard-to-reach regions where vulnerable populations cannot attract or retain medical professionals, warning ‘universal health coverage'. Gender inequality also mean, girls have limited SRH knowledge and cannot negotiate safe sex. Adolescent females are highly susceptible to sexually-transmitted infections and unplanned pregnancies. Complications of septic abortions kill almost 800 women daily, of which 99% is represented by LDCs.

Information and Communication Technologies (ICT) can act as a catalyst to stimulate LDCs' developmental catch-up plans to leapfrog the intermediate stages of the usual bricks-and-mortar route in other principal industries including healthcare. The world has witnessed how ICT can confront global SRH issues. Commission on Information and Accountability for Women's and Children's Health (2014) recommends, "By 2015, all countries have integrated the use of ICT in their national health information systems and health infrastructure."

Istepanian et al. (2006) define m-health as mobile ICT for healthcare which signifies the evolution of emerging wireless e-health systems via 3rd and 4th Generation mobile networks. M-health can capitalise on core utilities of voice and short messaging service and complex functionalities like Global Positioning System. Affordable mobile devices become ideal communication tools for developing-world populations, who constitute 64% of global mobile phone users. This trend pinpoints mobiles' massively-scalable potential to deliver basic SRH services in resource-constrained settings. Ubiquitous mobiles can offer rural populations remote access to urban healthcare workforce cost-effectively via a real-time information system.

This study proposes m-health as a leapfrogging tool to overcome geographical boundaries and inaccessible healthcare facilities, and fulfil the health needs of poor inhabitants.

Objectives

Primary: To analyse and determine m-health drivers and dimensions in SRH integration in conventional healthcare systems

Secondary: To identify Critical Success Factors (CSFs), barriers to success and sustainability issues

Methods
To collect qualitative data, 37 semi-structured interviews were conducted in Myanmar (a developing country) and the UK (a developed country) from ‘service provider' and ‘user' perspectives, enabling comparative analysis.

Results and analysis

Key discussion substantiated the potential benefits of m-health that could reshape existing SRH delivery approaches. It promises higher efficiency in time and energy, data collection, process improvement and cost-savings that diminish the requirement of physical healthcare resources. Sophisticated SRH applications, information and expertise become accessible virtually everywhere reaching underserved populations.

The majority of participants showed considerable desire to use m-health services. Amongst all m-health initiatives, a health call centre would let them enquire about their private SRH questions and concerns anonymously without being seen by others. Some experts argued that m-health does not replace, but complements traditional face-to-face healthcare as a supportive technique.

Research findings highlighted CSFs (five ‘A's and support or funding from the government and non-governmental organisations like Myanmar Maternal and Child Welfare Association), barriers to success (lack of infrastructure and alternative sources), and sustainability issues (confidentiality and electronic medical records).

Conclusions
Noticing its limitations, a series of practical interventions were recommended to implement m-health project that will help integrate SRH into conventional healthcare systems in LDCs according to the research outcomes.

10. Referral pathways for vulnerable groups in four north-eastern provinces of Cambodia

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Background:
Women of reproductive age (WRA) in the four north-eastern provinces of Cambodia (Kratie, Mondulkiri, Ratanakiri and Stung Treng) face multiple challenges in accessing reproductive maternal and newborn health (RMNH) services. These provinces are home to the majority of Cambodia's ethnic minority groups, who face linguistic and cultural barriers within the formal health sector. Low population density means that health facilities are few and far between, and challenging terrain adds to transport and financial barriers, particularly in the rainy season. These challenges combine to contribute to some of the poorest health indicators in the country.

Objective:
The objective of this study was to identify referral pathways used by WRA to access RMNH services and the barriers that limit this access. The survey included data on particularly vulnerable WRA including the poor, ethnic minorities and those living with a disability.

Methods:
The study involved exit interviews with WRA following uptake of RMNH services (family planning [FP], safe abortion, antenatal care [ANC], safe delivery, postnatal care) at health centres in the four provinces. Following informed consent, interviews were conducted with 138 WRA at 33 health centres in February (dry season) and with 137 WRA at 27 health centres in August 2015 (rainy season).

Results:
The survey populations were similar in the dry and rainy seasons in terms of the proportion of ethnic minorities (17% and 19%, respectively) and holders of the government's ID Poor card (29% and 27%). The most commonly accessed services were ANC (48%/38%) and FP (31%/43%), followed by delivery (16%/13%).

The most common sources of referral from the community to the health facility were through health staff (42%/37%), community health volunteers (31.2%/41.6%), family (35%/27%) and self-referral (23%/18%). Around three quarters of WRA travelled to the health centre with a family member or neighbour and around one quarter came alone. Very few travelled with community health volunteers. More than 80% of WRA in dry and rainy seasons travelled to the health centre by motorbike. While the median distances travelled (4km/3km) and travel times (15 minutes for both) were similar in dry and rainy seasons, the longest distance

travelled was far greater in the rainy season (75km/420 minutes) than the dry season (52km/180 minutes).

The proportion paying entirely from their own pocket for costs relating to accessing RMNH services declined from 85% in February to 69% in August across all WRA, possibly reflecting the ongoing expansion of subsidised services for ID Poor card holders and other health financing support mechanisms for the poor and near-poor.

Discussion:
These results highlight the importance of engaging and building the capacity of health staff in behaviour change communication for RMNH. They also reinforce the need for financial support mechanisms to facilitate uptake of RMNH services by vulnerable rural populations, particularly in the rainy season.

11. Access and Utilization of Prevention of Mother to Child Transmission Services by Female Sex Workers in Selected Townships in Myanmar

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Introduction
There are highly effective interventions to prevent the transmission of HIV from mother to child. Global updates on HIV in 2014 indicated that female sex workers (FSW) are 14 times more likely to have HIV than other women. However, there is still a huge gap in achieving universal access targets for PMTCT for FSW. In Myanmar, while prevention of mother to child transmission (PMTCT) is available, coverage is not universal (WHO, 2014) and only 65% of women access to PMTCT (MOH, NAP, 2014). This study aimed to explore the barriers to access and utilization of PMTCT services among pregnant FSW populations.

Methods
A cross-sectional survey with FSW from four cities (Yangon, Mandalay, Lashio, Muse) was conducted in 2014. Semi-structured interviews with additional qualitative inquiry were carried out using snow ball sampling from FSW network in each township. Questionnaire covered socio-demographic characteristics, knowledge on HIV transmission, information about the last pregnancy, ANC seeking behavior, accessibility to PMTCT services and delivery practice. Barriers to access the PMTCT services were explored in in-depth interview. Descriptive analysis was carried out to explore the proportion of access to PMTCT services.

Findings
Among the 102 FSWs interviewed, only 64% (64/102) could identify mother-to-child-transmission as one of the modes of HIV transmission. Of them, only 15.6% (10/64) could identify correctly all three periods (pregnancy, delivery and breast feeding) which HIV transmission could happen. About 75.5% of women got pregnant with their husbands and

20.6% indicated with casual acquaintance. Qualitative inquiry reported that most of the pregnancies were intended pregnancies. High condom use (98%) was reported with their customers. About 78% (80/102) of women took ANC though majority of them were at a later stage of pregnancy. Regarding access to PMTCT services, (68%, 55/80) received pre-test counseling, (87%, 70/80) received HIV test, (91%, 64/70) informed of their HIV status and (27%, 19/70) received post-test counseling. During qualitative interviews, fourteen of them reported the experience of discrimination in accessing services due to being FSW and their HIV positive status. Ten of those women were currently taking antiretroviral prophylaxis for PMTCT.

Reasons for not seeking ANC indicated travel cost, payment at the health facilities, and being shameful of getting pregnancy without having a husband; for those who conceived with a casual acquaintance. Lack of confidentiality and improper pre- and post-test counseling were also barriers to get HIV test. Half of the women delivered their babies at the health facilities; however traditional birth attendance was still playing the key role due to the financial barrier as well as stigma and discrimination in both community and health facilities against FSW.

Conclusions

Findings reported the high condom use rate, whereas, un-intended pregnancies were found to be less. Less access and late access to ANC and PMTCT services were identified in FSW. Interventions could be focused on reducing in social barriers, financial barriers and enhancing knowledge on HIV transmission to improve PMTCT coverage.

12. In or Out? Exclusion of young key populations from national plans as a barrier to SRHR

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Introduction

Over 620,000 young people are living with HIV in Asia-Pacific, the great majority (>95%) of whom are young key populations (YKPs) including young men who have sex with men, people who inject drugs, sex workers and transgender people. National AIDS strategic plans (NSPs) determine national response to AIDS and guide allocation of funding, resources and human capacity to HIV/SRH programmes. To provide evidence-based priorities, NSPs must address the needs of those most-at-risk. Often marginalized, YKPs are more likely to have: poor understanding of SRHR and HIV, inadequate access to services as well as greater engagement in high-risk behaviours. This review, initiated by the Asia-Pacific Interagency

Task Team on YKP, aimed to identify strengths, weaknesses and gaps in attention to YKP in NSPs and to propose recommendations for future NSP developments and revisions.

Methodology

Inclusion of YKPs was assessed in the NSPs meeting exclusion/inclusion criteria: LIC/MIC, NSP>2013. Excel tool developed, piloted and refined drawing on previous analyses, operational guidance on comprehensive KP packages, and AIDS investment framework. NSP and M&E plans of 19 Asia-Pacific countries, representing all subregions, analysed regarding YKP inclusion 1)Development/review processes; 2)Content e.g. PPTCT, HIV testing, STI prevention, condom promotion; 3) Operationalisation.

Results

NSPs lack attention to young KP; there is limited routine collection of, monitoring and analysis of YKP data; they are not involved in plan development; and there are few plans for research, goals/targets or basic programmes for them. Some exceptions: Nepal specifies STI and PPTCT services for under-age and new-entrant sex workers; Sri Lanka targets ‘beach boys' for prevention services; and the Philippines NSP specifies all YKP for STI prevention, HIV testing, and life-skills education. In most other instances only general youth and children with HIV are targeted and other YKP are neglected.

There is also very little consideration of interventions to provide an enabling environment for YKP such as legal services and literacy, or law and policy reform, and virtually no inclusion of SRHR initiatives. One exception is the Myanmar NSP which targets young people selling sex for GBV prevention, reproductive health services, and drop-in primary health care centres. Age of access to services is rarely, if ever, mentioned. None of the NSPs evaluated included YKPs in operational plans or budgets.

Conclusion

YKP are often invisible in analysis and programming despite being at the frontline of the AIDS epidemic. To ensure the SRHR of young people most at risk, NSPs should include specific targets and goals; accessible programmes including comprehensive SRH services; legal reform and support for SRHR; SRH/life skills and HIV education; family planning; and integrate SRH and other health services for YKP, whilst also clearly articulating age of access to services. Excluding YKP from NSPs effectively denies them of their SRHR.

13. Trialling new channels of communication: use of social media to reach adolescents and young people with sexual and reproductive health questions in Laos

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Geographically Laos is a remote land locked country and travel to the nearest medical service can take days. Reaching adolescents and youth can be challenging for Vientiane Women's Youth Centre for Health and Development (VWYCHD), the only youth-friendly clinic in the country. Cheaper smart phones and improving telecommunications infrastructure suggests more young people are accessing the internet.

The need to include social media and incorporate technology in ways to engage with youth was recognised. We developed an online communication channel to provide STI/ HIV information to youth via our Facebook page 'VWYC Fans'. From February 2015, we piloted a 6 month 'Dr Facebook' project, allowing youth to privately message questions for a confidential response from a specialised Dr.

In 6 months, Dr Facebook received messages from 54 different young people asking questions around STIs, pregnancy, menstruation, genital symptoms and HIV/AIDS. Almost 60% asked how to access the clinic and how to call us. VWYCHD is contributing to limiting the spread of STI/HIV within Laos by addressing the increased demand for innovative service and expanding on our effective communication mediums to continue to engage with youth.

Trialling new and innovative ways to improve communication are paramount to improving our service and reaching those who may be physically out of reach. The service is only available to those who have access to the internet and a Facebook account, which we understand is a barrier. Questions asked by youth help inform us to their needs and enable us to improve our clinic, Facebook page and the information we provide.

14. New Approaches Utilizing Misoprostol for Management of Postpartum Hemorrhage at the Community Level

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Introduction: Treatment options for post-partum haemorrhage (PPH) are urgently needed for women who give birth at the community level and where IV oxytocin (the gold standard) is not feasible. Clinical studies indicate that 800 mcg sublingual misoprostol is comparable to 40 IU IV oxytocin and new community research demonstrates several successful models for its use by non-physician providers in home-births. These new approaches include the use of misoprostol for secondary prevention to preemptively treat women with above-average postpartum bleeding, "first aid" administered immediately upon diagnosis of PPH alongside referral to higher level care, and the use of misoprostol for PPH treatment following its prophylactic use.

Objective: To evaluate the effectiveness and safety of new community-based approaches that utilize misoprostol for PPH management.

Methods: Three community-based randomized placebo-controlled clinical trials were conducted. The first was a implemented at health sub-centres and home deliveries in India wherein Auxiliary Nurse Midwives administered 800 mcg sublingual misoprostol as secondary prevention to women with measured postpartum blood loss of 350 mL or 600 mcg oral misoprostol to all women as universal prophylaxis during the third stage of labor. The second study compared the use of 800 mcg sublingual misoprostol to placebo for PPH first aid among home-births attended by nurse-midwives in rural Egypt. The third study compared the use of 800 mcg sublingual misoprostol to placebo for PPH treatment following use of 600 mcg oral misoprostol for PPH prophylaxis among women giving birth with traditional birth attendants (TBAs) in rural Pakistan.

Results: In the India study a total of 3001 women were analyzed for the primary outcome. The proportion of women with post-partum hemoglobin ≤7.8 g/dL was 5.9% and 8.8% in secondary and primary prevention clusters, respectively (difference = -2.9%, one-sided 95% CI <1.3%). Rates of post-partum transfer and haemorrhage were low (<1%) in both sets of clusters. Of 2011 deliveries enrolled in the Egypt study, PPH was diagnosed in 82 (4.1%) women who received misoprostol (n=34) or placebo (n=48). There was no difference in pre- to post-delivery hemoglobin drop ≥2 g/dL (RR=0.92, 95% CI: 0.32-2.66). Although cessation of active bleeding occurred after treatment administration for slightly more women in the misoprostol group (100% vs. 91.7% in the placebo group) and the two maternal deaths in the study both occurred in the placebo group, these differences were not statistically significant. In the Pakistan study of the 1006 women who enrolled, 703 delivered with a study TBA. 686 (91.7%) participants received prophylaxis and there were 85 PPH cases. Preliminary findings

demonstrate that TBAs can correctly administer the medicine for both indications and there were no adverse events among women who received misoprostol for both PPH prevention and treatment.

Conclusion: Preliminary findings suggest that these non-physician providers (midwives and TBAs) can safely and correctly administer misoprostol, and identify and manage side effects. The results from these trials can inform programs to combat PPH in low-resource settings.

15. Obstetric and Perinatal Outcomes of Teenagers and Older Women: A Prospective Cohort Study

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Teenage pregnancies have long been considered high risk as they are believed to be associated with adverse pregnancy outcomes such as preterm delivery, low birth weight infants, increased incidence of hypertensive disorders, anemia, increased risk of HIV infection and higher rates of perinatal and neonatal mortality. However, several recent studies challenge this long accepted concept, concluding that teenage pregnancy do not present with extra negative perinatal outcome. In this prospective cohort study, we compared the birth and perinatal outcomes of all primiparous teenage mothers with singleton births who delivered from January 1, 2014 to December 31, 2014 in Brokenshire Hospital, a tertiary and teaching hospital in Davao City, Philippines. Pregnancy outcomes of teenage pregnant girls aged 15 to 19 years were compared with those in adult women aged 20 – 34 years who delivered on the same day following each study case with a total of 40 women on each group. The obstetric and perinatal outcomes were compared in the study and control groups using chi-square test. Variables were described using means and standard deviation for the quantitative variables and proportion for the qualitative variables and calculated for p values. A p-value of less than 0.05 was considered statistically significant.

There were 1694 deliveries during the study period, of which 40 (2.36%) were teenage primiparous mothers. A significant proportion of teenage mothers were single and their mean age at delivery was 18.0 years. The rates of gestational age at delivery, fetal presentation at birth, antepartum complications, mode of delivery, type of labor, intrapartum and postpartum complications were not significantly different for both groups. Although not statistically significant, teenage mothers showed higher rates of pre-labor rupture of membranes (37.5% vs 22.5%), urinary tract infection (45.0% vs 32.5%), vaginal delivery (65.0% vs 47.5%) and spontaneous labor (57.5% vs 35%) and a lower incidence of cesarean deliveries (32.5% vs 50.0%). The overall perinatal outcomes also had no significant difference in terms of Ballard scores, birth weights, Apgar scores at 1 minute and 5 minute, incidence of infants requiring admission to NICU and neonatal complications. The results of this study challenge the current thinking and approaches in addressing the problem of teenage pregnancy. Further, this study agrees with recent published reports that with proper care and attention, and access

to basic and emergency obsteric care, birth and perinatal outcomes of teenage pregnancies fare similarly or even better than non-teenage pregnancies.

16. Women's awareness and knowledge of abortion laws: a systematic review

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Introduction

Complications from unsafe abortion cause mortality and morbidities worldwide, placing high strain on limited health system resources and resulting in severe physical, psychological, and financial consequences for women. Barriers to accessing safe abortion exist at multiple levels. The legal context and women's lack of accurate knowledge are two of such barriers women's face in accessing safe abortion services. The objective of this systematic review was to address the gap in evidence synthesis and provide a summary of women's knowledge in two domains: 1) women's awareness of the legal status of abortion in their country, and 2) the accuracy of women's knowledge on the specific legal restrictions outlined in a country's abortion law.

Methods

A comprehensive systematic search across seven databases was carried out in April 2014 and updated in March 2015. The searches were restricted to articles published from 1980 to the end of March 2015, there were no language restrictions. No formal searches for grey literature or conference reports were carried out. Criteria for inclusion included quantitative or mixed-method studies, study objectives related to awareness or knowledge of abortion law, and study sample includes women. For presentation and analysis of the results, the United Nations Population Division (UNPD) abortion policy grounds were adapted to categorise countries into 3 levels based on the legally restrictive context at the time of the study.

Results

Twenty-four studies, published from 1995 to 2015, reported data from 13 countries, majority low- and middle-income countries. Results from 16 studies assessed women's correct understanding of the legal status of abortion in their country, results ranged between 0% and 71%, with knowledge being less than 50% in nine of the 16 studies. In six studies, conducted 4 to 7 years after legalization/liberalisation women who participated in the studies showed very little knowledge of the law change. Thirteen of the studies assessed women's knowledge of the specific legal restrictions on which abortion was permitted. Women's knowledge varied amongst studies, though once again it was generally low.

Conclusion

The provision of information and knowledge about safe, legal abortion is crucial to protect women's health and their human rights. Women have the right to access full information about the likely benefits and potential adverse effects of proposed procedures and available alternatives. The findings from this systematic review illustrated, barring a few exceptions, correct knowledge of the abortion law amongst women who participated in these studies was limited, regardless of the restrictiveness of the abortion legal context. Disparity appears to exist between the legal context and women's knowledge of the abortion context. Additionally, inequality in wealth, level of education, and geographical location was demonstrated in the studies to vary women's level of correct knowledge amongst these subpopulations. As these studies highlighted, many women do not know what the law allows with regards to abortion. Ensuring that women have access to correct knowledge, is one of the barriers that needs to be addressed.

17. Addressing the SRH needs of Mongolian youth: Participatory approaches to training

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Background: Young people (15-24 years of age) account for more than half of Mongolia's population. Yet, their sexual and reproductive health (SRH) issues remain largely neglected. While HIV rates are low, sexually transmitted infections (STIs) are widespread among young people. Many youth are engaging in high-risk sexual behaviour, exposing them to unwanted pregnancy and STIs. Despite their significant SRH needs and the increasing availability and quality of services, young people are not accessing services and rates of condom use are very low. Every year from September to December Marie Stopes International Mongolia (MSIM), in collaboration with the MoH organises condom awareness campaigns. With the commencement of school and public health awareness events such as the National STI prevention and international HIV/AIDS Days, this period represents an opportunity to educate young people on the importance of sexual health. Whilst throughout the year MSIM offers resources for youth to effectively manage their sexual health, one-off condom public awareness days are important to enable subsequent visits to SRH clinics. MSIM has trialled various approaches to youth condom awareness campaigns. The most recent approach, which combines the campaign with learning elements, has been the most successful.

Objectives: To use a station-rotation training during awareness campaign to break barriers preventing young people from asking essential FP/SRH questions and increase subsequent service utilisation.

Methods: Between 300 and 500 people attending condom promotion campaigns were asked to participate in a station rotation learning event. The station-rotation model allows participants to visit various stations, each addressing a specific subject. A total of 5 stations

(each requiring 15 minutes) are set up and participants rotate on a fixed schedule. Short survey and focus group discussions were undertaken amongst participants following the events.

Results: Between 2012 and 2014, station-rotation trainings during condom promotion campaigns were organized in 11 provinces, 3 cities and 13 universities and involved over 9,000 young people. A total of 480 feedbacks were gathered and analysed. Positive mentions on social media and MSIM website and visits to MSIM's clinic increased (by around 10-20%) following the campaigns. Young participants responded that these blended activities were more interesting and fun and allowed equal opportunity for all young people to receive FP/SRH information. The common feedback was that the small groups make it possible for tutors to address the different needs of individual youth and truly engage them in the subject based on their prior knowledge and depth of understanding. In smaller groups youth were more empowered to ask questions and share comments.

Practical significance: The blended participatory approach has significant positive impacts on youth; by providing initial messages and opening up peer-to-peer discussions and learning, increases the acceptability of sexual health education and increases service utilization. Since witnessing the approach's effectiveness, the MoH has expressed an interest in further collaborating with MSIM to continue this approach. MSIM's condom promotion campaign was also visited by various local government and non-government organizations as a learning activity.

18. Importance of thrombocytosis in patients with ovarian cancer at Central Women Hospital, Yangon, Myanmar

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Background: According to WHO report 2012 , ovary cancer is the third most common cause of death from gynecological cancers in Myanmar women, 0.6 in 100,000 population, follow by cervix cancer and Breast cancer. Ultra sonogram, biopsy report, CA 125 level is a widely used method for detection of ovarian cancer, but CA 125 level is not generally available in public healthcare settings. In Myanmar, there have been very limited resources and facilities to perform CA 125 level testing. In this study, we investigated the importance of thrombocytosis in women with ovarian carcinoma and attempt to evaluate its association with other known clinico-pathologic prognostic factors.

Objectives: (1) To describe the proportion of thrombocytosis in patients with ovarian cancer, (2) To examine correlation between pre operative thrombocytosis and CA 12 5 level in patients with ovarian carcinoma, (3) To examine correlation between pre operative thrombocytosis and clinico pathological features

Methodology : This study was approved by the Ethics Review committee at Department of Medical Research, Ministry of Health, Myanmar. The research project was carried out at the Oncology Ward, Yangon Women Hospital, Yangon, Myanmar. A total of 57 newly diagnosed ovarian cancer patients of ages between 13 to 84 years were included in this study. Preoperative platelets count in these patients was analyzed by using automated hematological analyzer (Sysmex) and blood film examination done by pathologist. Pre operative determination of CA 125 level was done at clinical pathology department, CWH. The post operative findings patients was followed up to assess the histology report and other operative finding such as ascites, metastasis.

Results: Out of 57 patients in this study group, 42.1 % (24/57) were reproductive aged women. A total of 49.1% (28/57) were analyzed with normal platelets count and 50.9% (29/57) had high platelets count (thrombocytosis). Among the patients with normal platelets count, 82.1% (23/28) were found with high CA 125 level. Almost all patients with thrombocytosis (100%, 29/29) were found with high CA 125 level (P value= 0.023). According to postoperative reports, metastasis were detected in 60.7% (17/28) patients with normal platelets count, and 89.7% (26/29) patients with thrombocytosis (p vaule= 0.01). Ascites were presented in 64.3% (18/28) patients with normal platelets count, and 86.2% (25/29) patients with thrombocytosis (p vaule= 0.06).

Conclusion: Women who have received a diagnosis of ovarian cancer have thrombocytosis and are substantially increased risk for advanced disease, vascular thromboembolic complications, and compromise disease-specific survival.The outcome of our study will be a great help in patients with ovarian cancer by identification of preoperative biological markers related to cancer aggressiveness and high risk individual who can be targeted for acute treatment.

19. Factors Related to Delayed Antenatal Care among Pregnant Mothers at 300-Bedded General Hospital in Pyin Oo Lwin Township

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A cross sectional analytic study was conducted to find out the factors related to delayed antenatal care (ANC) among pregnant mothers at 300-bedded General Hospital, Pyin Oo Lwin Township. The proportion of delayed ANC, socio-demographic and economic data, obstetric characteristic, knowledge on antenatal care, care during delivery, and contraceptive knowledge of 186 pregnant mothers were collected by face to face interviews. The proportion of delayed ANC (i.e., pregnant mothers who took first ANC visit at >16 weeks of gestation) was 62.4% (95% CI: 55 - 69%). It was 54.1% (95% CI: 45 -64%) from rural area and 74% (95% CI: 64 - 84%) from urban area. Statistically significant associations were found between residence, education, occupation, housing status, parity, history of abortion, knowledge on first ANC visit, occupation of husbands, distance between residence and first ANC clinic and intention of the pregnancy, and delayed ANC. It was found that pregnant mothers who lived in urban area, who had low and middle level education, dependents, who

lived in rented house, who had more than one child, mothers with no history of abortion, who know after 4 months gestation as the most suitable time for first ANC visit, had more delayed ANC. Pregnant mothers with husbands whose were manual workers, who lived in ≤ median distance between residence and first ANC clinic and who answered that their current pregnancy got unintentionally were delayed to take first ANC. These findings indicated that the importance of early ANC and knowledge on first ANC visit yet to be disseminated among all pregnant mothers especially with more than one parity, and unintended pregnancies.

20. Exploring the perceptions on child marriage among young girls in southern Bangladesh

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Despite the enactment of policies, laws and programs, child marriage is a persistent problem in Bangladesh like many developing countries. In Bangladesh, the marriage prevalence rate is 64% which makes this country first in Asia and third in the world in child marriage prevalence. Girls who are forced into marriage early often have to abandon their education, limiting their future economic security and social well-being and increasing the risk of maternal and child mortality and morbidity. In this study we ask whether these negative outcomes can be averted by developing girls' knowledge of the risks of child marriage and strategies for preventing child marriage.

Objective:

To explore the perceptions of young girls of southern Bangladesh regarding child marriage.

Method:

One hundred young girls from 28 villages in 3 districts in southern Bangladesh were interviewed during May to August 2015. Themes were identified from common girls' empowerment indicators. Girls were selected based on criteria including marital status, age of marriage, migration status, and income generating activity. Trained female field researchers interviewed them at parental and in-laws houses using an interview guidelines and mini recorder. The guideline was extensively pretested. Girls' and guardians' consents were taken first before building rapport with them for 15-20 minutes. All interviews were translated into English, checked twice, analyzed, and categorized into themes.

Salient findings on marriage attitudes:

Girls' age between 15 to 27 years, both married (66%) and unmarried (34%) were asked their perceptions regarding child marriage. Nineteen percent refused to answer while the rest fell into three categories: 15% condemned child marriage as risky but said girls should obey their parent's decision and should not try to resist or negotiate with parents to delay marriage; 47% condemned child marriage and thought girls should protest and stop child marriage; 19% understood the risks of child marriage but thought that these risks were warranted if early

marriage helped secure a better groom. Interestingly the majority of married girls thought girls should obey their parents whereas the majority of unmarried girls thought it was possible to negotiate with parents. Nearly all girls understood the risks of early marriage, unmarried girls were more optimistic of their ability to influence their parents' decisions on marriage than married girls. The research also raised important questions about the perceived tradeoff between the timing of marriage and the quality of the groom.

Conclusion:

Girls and parents understand the dangers of early marriage. Girls find it hard to go against the will of their parents and parents are not simply ignoring the needs of their daughters. Proposals only come intermittently and parents have to weigh the risks of early marriage against the risk of not finding another high quality groom. Information to girls isn't enough, reduced child marriage requires multiple interventions for girls, parents of girls and parents of grooms and the community along with the reinforcement of laws/policies against child marriage.

21. Successful Model=Upscaling Basic EMOC services in remote areas of Pakistan.

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Goals and targets,

Overall goal of the project was to contribute in the improvement of MDG 4&5.

Targets

1. Increase # of institutional deliveries from 1 to 20/month.
2. Increase # of ANC from 25 to 200/month.
3. Increase # of PNC from 2 to 40/month
4. Increase # of FP clients from 3 to 25/months.

Implementation Strategy

The program was being implemented in close collaboration and coordination with all the national priority health programs to ensure efficient and effective utilization of public resources.
The program was designed as a support and extension of the existing district health system and therefore it should ultimately be adopted as the new district health system

Strengthening the BHUs and RHCs

• Provision of additional HR for round the clock services

• Top up salary for existing staff who is willing to work during the evening/night shifts

• Improvement of the utilization of health facilities by bridging the gap between the community and health services by promoting referrals by the LHWs.

• Creation of an efficient supply system on a continuing basis in order to assure the regular delivery of essential drugs, vaccines and family planning materials.

• Strengthening Monitoring and Evaluation mechanisms to monitor implementation progress of the program.

• Expansion of the program into poor and underserved areas to target the most vulnerable populations based on geographical distances.

Achievements.

The progress shown by converting the almost nonfunctional BHUs to round the clock maternal and child care centers has been remarkably astonishing and the community feedback to these services is extremely positive.

BHUs which caters the needs of 30000-40000 population,where no more than one delivery was conducted every month now boast of an average of over 40 verifiable deliveries per BHU. The ANC improved to around 200/month,PNC to around 80/month and Family Planning Clients jumped to 35 /months.

Why it is best practice.

• As it was planned and implemented with the ownership of Health Department and development partners it showed excellent results.

• Monitoring system was very strong based on E monitoring and reporting.

• Ownership by the community was very evident.

• This is cast effective model, and cast benefit analysis showed us that with provision of additional 850 $/month we can coverts health facility to run 24/7 for the provision of BOC services.

• There was dedicated staff to support the smooth operations in the field.

• UNFPA provided regular feedback and support during implementation of this project.

• A team who was responsible for program and operations worked with dedication.

• There were no audit observations in last 2 years just because of day to day interaction with implementing partner and provision of technical inputs along with the capacity of partner agency.

Scope for the scalability.

As this was implemented successfully in the remote areas of Punjab with excellent results, policy advocacy campaign was launched by us to show cased this model to policy makers and donors community.

Looking it cast effectiveness Govt of Punjab has upscale it in to the entire province of Punjab.PC-1 has been approved for starting this model in all 36 districts of Punjab.

22. Gender based violence issues and sexual reproductive health needs of women with disabilities in Jakarta, Indonesia

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Key Words
Women with Disabilities, HIV, Gender based violence, Indonesia

Purpose
To explore reproductive health knowledge, attitude, sexual behaviors, and gender based violence issues among women with disabilities in Jakarta, Indonesia.

Methodology
Data collection conducted through structured questionnaire; in depth interview; focused group discussion and field observation. Informants are 102 women with disabilities (hearing, speech, sight, physical and intellectual disabilities), aged 13 to 59 from in Jakarta.
Data were collected by trained enumerators who are also women with disabilities.

Findings

Although half of respondent had heard about HIV, their comprehensive knowledge are low. Knowledge of contraceptive were only 15 %. 5% of women with hearing disabilities and 15 % of women with physical disabilities sub groups were sexual active. Only 5% of women with hearing disabilities who were sexual active were using condoms during sexual intercourse. 75% of respondents did not have health insurance and did not know where they could access sexual and reproductive health services. Expressed needs of sexual desire and marriage were reported ignored by parents, caregiver, and family. There were reported cases of rape and other forms of sexual violence within various settings such as school, private residence, workplace and public place.

Conclusion

Sexual reproductive health needs of women with disabilities are overlooked. There is therefore recommended to develop tailored responses of Sexual Reproductive Health issues of women with disabilities regarding reproductive health, HIV, and gender based violence.

23 Knowledge on Emergency Contraception Among Students Attending University of Distance Education and Staying in the Private Hostels in Pathein Township

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Background: The emergency contraception is a useful method of family planning method after unprotected intercourse to reduce the chance of unwanted or unplanned pregnancies. Unwanted pregnancy which may lead to unsafe abortion is common among young women. Emergency contraception adds an important option for helping sexually active adolescents avoid unintended pregnancy. The prevention of unintended pregnancy in turn prevents the risks that adolescent pregnancy poses for mother and child, including abortions.

Aim: The aim of this study is to assess the knowledge on emergency contraception among the students attending University of Distance Education and staying in the Private hostels.

Methods: A cross-sectional descriptive study was conducted among 295 students attending University of Distance Education and staying in the private hostels. Study participants were selected by simple random sampling. The respondents who gave informed consent were provided with questionnaires. Data was collected by pre-tested and self-administered questionnaires.

Results: The findings of the study revealed that 239 respondents (81%) had ever heard about EC. The forty-three point five percent of the respondents got the general information about emergency contraception from medical sources and forty-six point four percent could mention the trade name or brand name of emergency contraceptive pills. Only one point six percent of the respondents could describe the different method of emergency contraception apart from the emergency contraceptive pills. In this study, more than half of the respondents answered important time to use emergency contraceptive pills was unprotected sexual exposure. Although combined oral contraceptive pills can be used as emergency contraception in alternative ways when emergency contraceptive pills are not easily available, (19.3%) reported that the oral contraceptive pills cannot be used as emergency contraception. The correct timing of effectiveness of post coital pills (up to 120 hours after unprotected intercourse) was identified by majority of the respondents. The recommended hours between the two doses of emergency contraceptive pills for taking (12 hours apart) was correctly identified by the (23.8%) of the respondents. Showing the answers of respondents (32.2%) on emergency contraceptive pills is a method of early abortion; the respondents had having false beliefs on emergency contraceptive pills. And (17.2%) of the respondents believed that the emergency contraceptive pills can protect STIs. Among socio-demographic characteristics, race was significantly associated with knowledge level ($p<0.05$). Although there was no satistically significant association, (16 to 20 years) age group had 2.5 times higher knowledge than other age groups. And also, there were (1.6) time higher knowledge level in male respondents than the female respondents. Opportunely, the first year students had higher

knowledge level than other academic years. Among the 239 subjects, (42.7%) of the respondents had high knowledge about the emergency contraception.

Conclusion: There were low level of awareness about emergency contraception and some misbelieves and misconceptions about emergency contraceptive pills and oral contraceptive pills. With better education through Audio-Visual media and University lecture adding with reproductive health issues and discussion among students with medical personnel, more effort should be exerted towards improving the awareness of emergency contraception among the University students.

24 The Join-in Circuit (SangSangai) in Nepal.Opening up choices: An innovative method to support adolescents in fulfilling their sexual and reproductive health needs and rights

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SangSangai is an entertaining, adolescent-friendly education tool addressing HIV and related issues.It consists of 6 thematic stations with various activities. It uses games, role plays, discussions & exhibitions to share knowledge and change attitudes and behavior. Participatory Methods, no lecturing by facilitators: and verbally active .There are 2 trained facilitators for each station. It is a time-efficient tool: up to 90 adolescents can participate at the same time (6 groups)

OBJECTIVES OF SANGSANGAI

1. Enhanced utilization of health services through reinforcement of health-seeking behavior:
• Increased use of family planning services
• Increased use of counseling and care services for STIs incl. HIV
2. Enhanced communication among peers as well as with parents, teachers and service providers
3. Increased motivation to look after and respect the sexual and reproductive health and rights of oneself and others

Findings

SangSangai is already covering a substantial part of ASRH topics (i.e. HIV, STIs, Gender, Contraception) as outlined in (draft) National ASRH Communication Strategy. However:
1. It needs to broaden its focus from HIV to SRHR to address adolescents' needs and rights
2. Have clear and simple messages that adolescents understand (and improve the activities to bring these across)
3. Use a stronger gender-sensitive approach

Strengths

- Better Communication skills:
  - Self-reported improved ability to speak about SRH issues, to ask someone for information , to visit youth-friendly health services

- More reporting of medical doctors(43%) , parents (46%) and relatives (64%) as a source of information for HIV and STIs

- Better condom negotiation:
  - Self-reported ability to talk about condoms with opposite sex higher

Evaluation: main recommendations

Thematic broadening of Join-In-Circuit:

From HIV □Sexual and reproductive health and rights

Consequences:

- Need for identification of alternative government entity to ensure ownership (Family Health Division)
- Need for revision of stations (content and messages) to focus on SRHR (Adaptation Workshop)
- Improved institutional arrangements to ensure sustainability (larger NGOs such as FPAN, NRCS, Save the Children etc.)
- Align more with the sex education efforts in schools (Min of Education) as schools are most used setting
- Improve transport and logistics: reduce weight and size of stations (produce stations on the floor)

The SangSangai approach has been highly appreciated by the adolescent target group. It has also gained wide acceptance and support from the Nepalese Government (Ministry of Youth and Sports), European Commission, United Nation Volunteers and youth organisations. The high potential of the field-tested and well-proven Sang-Sangai method for the improvement of SRHR in Nepal will hopefully receive further investment in future by the Ministry of Health and Population, bilateral and multilat-eral external development partners and NGOs.

25. **Are courtyard meetings effective in disseminating family planning information? Experiences from Bangladesh**

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Background: Courtyard meeting (CYM) is one of the tried and tested methods of disseminating Family Planning (FP) meesages in Bangladesh FP program. In recent years it has had a limited impact for several reasons, such as the retirement of government fieldworkers, nonuse of any information, education, and communication (IEC) materials. The Directorate General of Family Planning (DGFP) requested Mayer Hashi-II (MH-II)-a USAID-supported FP project implemented by EngenderHealth Bangladesh provided technical support to increase the effectiveness of CYMs, ensuring full community participation and increasing uptake of FP, particularly long-acting reversible contraceptives (LARCs) and permanent methods (PMs).

Intervention: Along with the DGFP, MH-II targeted CYMs at the community level in two districts for six months. 150 field workers were trained on the effective dissemination of FP messages and were provided with IEC materials, such as hanging wall charts with FP discussion points, LARC and PM leaflets, and an FP flipchart. CYMs were organized twice a month by FWAs after training; in these CYMs, the hanging chart was displayed, and IEC materials were used for FP discussion. CYMs ended with distribution of LARC and PM leaflets.

The CYMs were closely monitored and followed up by local DGFP managers and MH-II staff. At the end of six-months, a mixed-method approach was used to explore the performance of CYMs. The LARC and PM performance of the pre- and post-intervention areas of the same period (June-November 2014) was compared. The assessment team observed 17 CYMs, and conducted 34 exit interviews with CYM participants to solicit their views on the meetings' effectiveness.

Results: Couple-years of FP protection increased by 6% at the end of the six-month analysis period. Uptake of injectables in CYM intervention areas increased by 58%, versus 4% in non-intervention areas. IUD uptake at CYM intervention areas rose by 26%, versus 21% in non-intervention areas, and implant acceptance climbed by 94% in intervention areas versus 60% in non-intervention areas. A significant decline was observed for no-scalpel vasectomy (NSV): It dropped by 3% in CYM intervention areas, while it rose by 24% in non-intervention areas. A similar trend was observed for tubectomy (down 7% in intervention areas, but up 7% in non-intervention areas).

Conclusions: CYM reinvigoration has provided several insights that should be considered before scaling up: the use of IEC materials enhanced the learning experience, for example, use of the hanging chart during CYMs prompted participants to remember the discussion points and ask questions on a particular issue; all CYM participants were women-this therefore facilitated a comprehensive discussion on female contraception, ultimately increasing the uptake of implants and intrauterine devices (IUDs); male participation in CYMs was nil, possibly because of their timing, which was invariably from 10 am to 12 noon, when most men are at work; CYM participants' average age was below 30, while PM users' median age was 28 years, according to the Bangladesh Demographic and Health Survey 2011. This then raises the question of why PM acceptance declined in the intervention areas; this issue should be further explored.

26. Meeting the demands in sexual and reproductive health; progress of an established one stop shop youth-friendly service in Vientiane Capital, Laos

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As Laos opens up to the world, more entertainment places open where youth gather to drink, meet friends and come into contact with international tourists with many different attitudes to relationships, drugs, alcohol and sex. This creates greater risks of STI/ HIV infection for Lao youth.

In 2001, evidence of increasing STI/HIV rates led to the establishment of Vientiane Women's and Youth Centre for Health and Development (VWYCHD) and a confidential sexual health clinic. The only youth-friendly clinic within Laos, it has grown from a basic counsel and treat service to a one stop shop concept, to support young people who have STI/HIV concerns, reproductive health needs, non-STI genital conditions and those affected by drug or alcohol issues.

In 2007, the clinic extended its opening times to 7 days per week to cope with increasing demands and be more accessible to youth who live further out of Vientiane Capital. We are currently trialling use of social media as a platform to address needs and increase information provision. In 2013, VWYCHD were successful in funds to purchase a microscope. This allows accurate diagnosis of symptoms and as a result better treatment and care, reducing reinfections and further transmission of STIs. This year we acquired an ultrasound machine and are undergoing training to better support young women in our ability to diagnose gynaecological abnormalities such as ovarian cysts, endometriosis, pelvic inflammatory disease, and support in pregnancy choices. Our female Dr is trained in Implanon insertion to offer a broader range of longer-acting higher-efficacy contraceptive options. Needs of migrant youth living in urban garment factory dormitories are addressed via a mobile clinic. The mobile clinic allows our one stop shop to deliver services to the community within their community. Our daily life-skills based radio programme and country-wide free call hotline also reaches youth far and wide. In 2014, the clinic saw almost 30% increase in client attendance compared to 2013. 80% were single, 19% married and 9% divorced which highlights our service is also engaging well with Lao unmarried youth and they represent the majority using the clinic (89%). In 2013, 54 MSM attended VYCHD clinic and this number rose 81% to 98 MSM consultations in 2014. In 2014, 70% of clients attending were tested and treated for STIs. We work in partnership with the Referral Care Network (RCN), a network of 12 health providers to ensure clients receive continuity in preventive and curative services, and adequate follow up, according to their needs. The clinic is contributing to limiting the spread of HIV within Laos and increase in attendance shows us that our one stop shop service is meeting the demand.Staff must be non-judgmental regarding client relationship status and sexual history. 'Word of mouth' friend referral, radio and social media are a reliable means of one stop shop promotion. Integrated training for our clinical staff across clinical specialties to meet our individual client holistic need in one consultation is a more realistic way forward in achieving best outcomes for Lao youth.

27. The effectiveness of home-based HIV counseling and testing in reducing stigma and risky sexual behavior among adults and adolescents: a systematic review and meta-analyses

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Background
Human immunodeficiency virus (HIV) counseling and testing (HCT) is a critical and essential gateway to HIV prevention, treatment and support services. This review aimed determine the effectiveness of home-based HCT in reducing HIV-related stigma and risky sexual behavior among adults and adolescents.

Methods
We searched for studies reported in English Language from 2001 to 2014 in MEDLINE, Web of Science, EMBASE, Scopus and CINAHL. Papers were assessed by two independent reviewers for methodological validity prior to inclusion in the review using standardized critical appraisal instruments from the Joanna Briggs Institute (JBI). Data were analyzed using the software provided by JBI.

Results
Nine studies were included in this review, five of them reporting on stigma and related outcomes, three of them on sexual behavior and four of them on clinical outcomes. The risk of observing any stigmatizing behavior in the community was 16% lower among the participants exposed to home-based HCT when compared to the risk among participants in the control arm. The risk of experiencing any stigmatizing behavior by HIV positive patients was 37% lower among the intervention population compared to the risk among the control population. The risk of intimate partner violence was 34% lower among participants exposed to home-based HCT. The risk of reporting more than one sexual partner was 58% lower among participants exposed to home-based HCT. The risk of having any casual sexual partner in the past three months was 51% lower among participants exposed to home-based HCT.

Conclusions

Home-based HCT is protective against stigma and risky sexual behaviors.

28. Understanding factors influencing unbalanced sex ratios: The situations in two selected districts of Nepal

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Introduction: Gender biased sex selection is an emerging issue in Nepal. Nepal has legalised abortion in 2002 and service started from 2004. Unlike in India and China, the use of sex-selective abortion has not received much attention in either the research or policy context. However, Nepal has begun showing signs of skewed or disturbed child sex ratios (CSR) in some districts of the terai and hill regions. This paper explores the underlying factors influencing adverse sex ratios in two selected districts of Nepal.

Data and Method: A population-based cross-sectional study of 1000 married women with at least two children, one of whom was aged 0-5 years in two hill districts namely, Kaski (where CSR is adverse) and Tanahun (where CSR is normal) was conducted in 2014. Descriptive analysis was out to compare factors underlying difference between two districts (one with adverse CSR and another balance sex CSR) of Nepal.

Results: Though small family size is prevalent in both districts, son preference was slightly stronger among women in Kaski than in Tanahun. For example, 72% of women in Kaski thought that a son is essential to continue the family lineage compared with 63% women in Tanahun. More women in Kaski than Tanahun reported the use of ultrasound (82% vs 52%). About 42% of women in Kaski compared with 32% women in Tanahun reported seeking information on the sex of the foetus at least for one pregnancy. More women from urban than rural areas reported seeking information on the sex of the foetus in both districts. Misuse of technology was reported by a higher proportion of women in Kaski than in Tanahun. For example, 37% of women in Kaski, compared with 27% in Tanahun reported that their provider had disclosed the sex of foetus to them. In addition, there was a fairly systematic increase in percentage of women reporting disclosure of the sex of the foetus by parity. Thirteen percent of women from Kaski compared to about 10% of those in Tanahun reported life time experiences of an induced abortion. Of them, 13% of women reported sex selection was the reasons for an abortion.

Conclusions: Our findings suggest that despite some commonalities in son preference, the practice of undergoing ultrasound tests and discloser of the sex of the foetus was higher in Kaski than in Tanahun. High CSR in Kaski was attributed to the above practice, accentuated by couples in Kaski desiring fewer children. The underlying factors for normal or “balanced” CSR in Tanahun are its dominant rural population, poverty and poor access to diagnostic clinics performing sex determination tests and relatively better community-based gender-focused programmes. In the absence of direct interventions, there is a possibility of worsening CRS in Nepal as access to prenatal diagnostic techniques proliferates to districts beyond Kaksi. Therefore, there is a need to implement national policies and programmes that aim to empower girls, promote gender equality and improve girls’ overall situation.

29. From VCT to Testing: Implementation Early Initiation of ARV Policy - Test and Treatment - in Indonesia

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On March 2013, new policy for HIV-AIDS and STI Control Program in Indonesia recommended the early initiation of ARV (Decree MoH 129/2013). The new policy recommends to have treatment initiation for adults PLHIV patient with CD4 cell count 500 cells/mm3 or below, include patient with co-infected TB, Hepatitis B and C, MSM, WSW, IDU, PLWHA to all children with HIV under 5 years of age, all pregnant and breastfeeding women with HIV, to all HIV-positive partners where one partner in the relationship is uninfected. Objective of this research is to describe the implementation of early initiation ARV and explore factors that facilitate or inhibit early initiation of ARV therapy in PLHIV patients in Bandung, Semarang and Yogyakarta. Data collected by doing FGD and in-depth interview with PLHIV patients from September 2013 to February 2014. Eligible informant appropriate with Decree MoH 129/2013 criteria who did not consuming ARV at least 3 months, age 18 years old, voluntary participated and provide informed consents. Case studies from three locations showed there is lack of understanding the early initiation of ARV. The majority of patients still did not understand what early initiation of ARV is**.** Only patients who were active in the organization has received explanation about the early initiation of ARV during a meeting orginized by a peer support group or organization. This fact correlated with the socialization of this policy in all level, locally and nationally. Respondent who understand about early initiation of ARV therapy is defined as the provision of ART without assessing CD4 counts. After patient's received a short explanation about early initiation of ARV, many patient refused to accept it because fear of side effects and fear of status disclosure. Some other patients clearly stated that they will accept it because they believed that early initation of ARV will prevent deterioration of their immunity system and to suppress virus growth. Some respondent said that the Decree from MoH was not appropriate. CD4 level is not one standard for ARV treatment, because the ARV the drugs should be taken for life and had many side effects. Doctors should also look at PLHIV patient's psychological condition and the readiness to accept ARV treatment. In the other hand, the new policy for early initiation of ARV will directly increase burden of clinic. HIV program will have to strive to offer efficient service to reach better adherence rate and better clinical outcome. Maximising HIV testing uptake and ensuring early diagnosis if PLHIV will require much stronger leadership on HIV testing, strategic combination of acceptable and high yield testing modalities, policy changes to decentralize and democratize HIV testing and fully embracing innovations including HIV self-testing and incidence testing.

30. Contraceptive Knowledge, Perceptions and Practice among Migrant adolescents in Dakhinathiri Township

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A cross-sectional descriptive study was carried out in Datkhina Thiri Township aiming to describe contraceptive knowledge, perceptions and practice among migrant adolescents. Face-to-face interviews were carried out among 160 male and female unmarried migrant adolescents of age 15-19 years who currently stayed at construction sites by using a pretested semi-structured questionnaire. Participatory sex census (paper slips method) was also used to describe sexual behavior among 28 adolescents. Findings revealed that sex distribution was equal and mean age of respondents was 17.39 years. Among the respondents, most adolescents (95.0%) had history of schooling. Of which who had history of schooling, only few (7.9%) were in-school and majority (92.1%) was out-of-school at the time of study. Nearly half of adolescents (45.4%) had middle level education. Majority (90.0%) were employed. Only half of respondents (50.0%) lived with both parents. TV and radio were common media utilized among respondents. Over three-fourth of respondents (77.5%) awared of pubertal changes while over half (55.0%) knew how pregnancy is conceived. About one-third of adolescents (36.2%) were in the category of having high knowledge of contraception while nearly half (47.5%) had positive perceptions towards contraception. Some adolescents (7.5%) stated that they had premarital sexual experiences during interview. Of which, all were male adolescents and (41.6%) had history of using contraception. Condom was commonly used method. During participatory sex census sessions, 2 out of 14 male and 4 out of 14 female were found to have premarital sexual experiences. Factors significantly associated with knowledge of contraception were respondent's educational status, family monthly income, respondents' current living condition, experience of having boy/girl friend in the past and current, exposure to printed media, receiving information from siblings, from health personals and from media. However, only family monthly income was found to have statistically significant association with perceptions towards contraception. These findings suggested that proper and timely information on contraception should be expanded to reach migrant adolescents in order to prevent adolescent pregnancy and reproductive health risks among them.

31. Oncogenic Human Papillomavirus (HPV) Genotypes among Women with Cervical Pre- cancer and Cancer in Yangon and Mandalay, Myanmar

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Persistent infection with oncogenic types of human papillomavirus (HPV) is the most important risk factor associated with cervical cancer. Therefore detection of HPV genotypes may have prognostic significance for women who are at risk of disease progression. The objectives of the study are to determine the HPV DNA and genotypes among women with cervical pre-cancer and cancer in Myanmar. A cross-sectional descriptive study was performed in 169 women with cervical neoplasia during 2012 to 2014. After obtaining the informed consent, cervical cells were collected from 134 women with cervical intraepithelial neoplasia (CIN) and 35 with squamous cell carcinoma (SCC) of the cervix (median age 45 years; range 20-78) attending Sanpya General Hospital, Yangon and Central Women Hospital, Mandalay. HPV DNA testing and genotyping was performed by polymerase chain reaction and restriction fragment length polymorphism (PCR-RFLP) method. Consensus sequence primer pairs within the E6 andE7 open reading were used to amplify oncogenic HPV genotypes (HPV-16,-18,-31,-33,-35,-52b,-58). HPV were identified in CINI 33/84 (39.3%), CINII 17/29 (58.6%), CINIII 14/21 (66.7%), and squamous cell carcinoma (SCC) 27/35 (77.1%). Overall, the most common genotypes were HPV-16 (68.1%), followed by HPV-31 (16.5%), HPV-18 (7.7%), HPV-58 (6.6%), and HPV-35 (1.1%). Among SCC, HPV-16 was the most common genotype (66.7%) followed by HPV-18 (14.8%), HPV-31 (11.1%), HPV-35 (3.7%), and HPV-58 (3.7%). In CINI, the most common genotype were HPV-16 (69.7%) followed by HPV-31 (21.2%), HPV-18 (6.1%) and HPV-58 (3.0%). In CINII, HPV-16 was most commonly determined (52.9%) followed by HPV-31 (23.5%), HPV-58 (17.6%), and HPV-18 (5.9%). In CINIII, HPV-16 was also the most common genotype (85.7%) followed by HPV-31 (7.1%) and HPV-58 (7.1%). Vaccine preventable genotype, HPV 16 was the most common genotype in both Yangon and Mandalay, Myanmar. In Mandalay, HPV-35 was detected but not in Yangon. Information on HPV genotypes distribution in cervical intraepithelial neoplasia and invasive cervical cancer is crucial to predict the future impact of HPV16/18 vaccines and screening programmes and to establish an appropriate post-vaccinal virologic surveillance.

32. Male Climacteric: An Addition to the Mental Health Burden?

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Background and Objective: This article attempts to summarize some of the research findings to give an insight into the psychological changes that occur in men at climacteric in order to help the concerned to come up with suggestions to reduce the additional mental health burden among male in advanced years.

Methods: Content analysis of data collected from recoded electronic communication has been done for etic interpretation.

Results: Unlike female perimenopausal syndrome, male climacteric syndrome is not inevitable. About 30 percent male aged between 40 - 79 years experience male climacteric syndrome because of multifaceted conditions. Those experiencing male climacteric syndrome have decreased quality of life, and increased risk of many diseases of aging leading to shorter lifespan. Symptoms usually associated with male climacteric syndrome include depression, nervousness, hot flushes, decrease in libido, erectile dysfunction, easy fatigability, and poor concentration and memory. These symptoms collectively cause break in mental health. Currently there is surge of scientific and commercial interest in promoting the male climacteric syndrome, which probably is not taking into consideration past futile experience with hormonal replacement therapy in post-menopausal females.

Conclusion: Shifting cultural perceptions rather than any new scientific ‘discoveries' have fostered the (re)medicalization of the male climacteric syndrome by pharmaceutical and other business concerns. Psyche of aging men are exploited by promises of remaining ‘forever functional' to the extent that men can demonstrate their virility and stave off old age. Broken promises lead to mental disorders. These disorders have to be recognized by mainstream health services.

33. Contraceptive use among never-married adolescents in Indonesia: Analyzing the effect of region of residence

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Background

The aim of this study is to examine individual and contextual factors on contraceptive use at first sexual intercourse among never-married adolescents in Indonesia. We restrict our study on sexual intercourse for the first time because we were interested in examining the initiation of risky behavior. The 2012 Indonesia Demographic and Health Survey (IDHS) data showed that about 7.6% of never-married adolescents have engaged in sexual intercourse. Currently, the family planning program in Indonesia is not intended for never-married adolescents but the 2012 IDHS showed that there is substantial proportion of adolescents who think that family planning services, particularly contraceptive methods should be available to them, with inter-provincial range about 20% to 65%.

Methodology

This study used Adolescent Reproductive Health (ARH) data from the 2012 IDHS, focusing on never-married adolescents age 15-24 years in Indonesia. A multilevel logistic regression is applied in this study for adolescents who have engaged in sexual intercourse (level 1) nested with 33 provinces in Indonesia (level 2). Individual-level factors as control variables are sex (male or female), residence area type (urban or rural), age at first sexual intercourse (numeric), number of contraceptive methods known ($\leq$ 3 methods or $\geq$ 4 methods), knowledge of avoiding pregnancy (yes or no) and comprehensive knowledge of HIV/AIDS (low, moderate, or high). Province-level variables reflecting openness-level are percentage of adolescents who agree that contraceptive method should be available to them and population density (persons per km^2). We constructed 3 models: an empty model (without any independent variables), model contained individual-level variables, and extended model including province-level variables.

Results

Among the 1,511 respondents, 37% reported using a contraceptive method at first sexual intercourse. This means more than half of the respondents who were sexually active engaged in unprotected sexual intercourse (63%). Based on the null two-level model, we found that there is strong evidence that between-province variance is non-zero but approximately only 4% of the variance in the log odds of contaceptive use could be attributed to the province level (σ_u^2, p-value=0.000). Adding individual-level and province-level explanatory variables lead to a reduction in the province-level variance. Adolescents who are male, live in urban area, know at least 4 contraceptive methods, know how to avoid pregnancy, and have higher knowledge of HIV/AIDS tend more likely to use contraceptive method at first time sexual intercourse than their counterparts. Province variance in the proportion of using contraceptive use among adolescents is not significant associated with the province level of opennes.

Conclusion

Our findings indicate that adolescents should be provided with better knowledge about reproductive and sexual health that are suitable for their needs as a young individual. This study shows that the propensity of contraceptive use is mainly determined by individual variation although community variation has statistically significant contribution to it. Hence, in order to avoid the potential for unwanted pregnancies and the possibility of contracting STIs and HIV/AIDS among never-married adolescents, policy makers and authorized agencies need to consider the needs of this population and ensure their access to family planning services.

34. VSO International Citizens Service (ICS) improving young people's sexual and reproductive health and rights through volunteering and peer education - A case study from Baglung, Nepal

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The intervention mobilised 4 teams of Nepalese and UK youth volunteers between the age of 18 and 25. Over 18 months, 77 ICS volunteers engaged and mobilised young adolescents and their families in school and community settings in six rural areas, to improve sexual and reproductive health and rights (SRHR) outcomes through the development of a system of peer education.

Developing the case study involved a desk review and field research using semi structured interviews, focus group discussions and a participatory workshop. 127 participants (beneficiaries, peer educators and stakeholders) were included

Findings:

- Youth volunteers lived in host homes throughout the time they were in the community, which helped them to integrate, build relationships and engage in and out of school young people and community members in SRHR education.
- Youth volunteers mobilised 39 local youths (65% female) to become peer educators in 6 schools and organised specialist training from health professionals. They provided ongoing mentoring and training for the peer educators, helping them to develop their leadership and communication skills. Those mobilised continued to educate their peers in schools on SRH issues after the ICS volunteers left
- Young people were shown to be approachable, innovative, and empathetic, able to create a safe, interactive learning environment for other youth. This approach is more participatory and yields a higher response from students. Given the sensitive nature of some of the topics covered, this rapport was important for building both students' confidence and their ability to take ownership of their sexual health.

- Peer educators, students and community members have become better informed on a range of SRH topics and young people have become more confident discussing these. Some early signs of improved health practices have been reported.

Conclusions:

- Youth mobilisation and engagement through volunteering and peer education is an effective methodology for delivering SRHR education.
- A holistic approach to adolescent and youth SRHR programming is required where young people can increase demand for health services, while other interventions address the supply of appropriate SRH services and the wider socio, economic and cultural barriers to accessing SRH education that exist.
- Effective peer education systems require both technical training for peer educators on SRH topics by health professionals, but also ‘soft skills' development (e.g. facilitation, communication and leadership skills) to build the confidence and effectiveness of peer educators to speak about SRHR topics. Young people can effectively train their peers in these skills.
- School and community ownership of any peer education system is essential to enable sustainability of the intervention and ICS projects should be integrated as part of wider relevant education, livelihoods and health programme interventions

Learning from our experience in Nepal, we plan to scale up our approach to Bangladesh, using the energy youth volunteers bring as peer educators to challenge traditional practices around child marriage whilst also generating increased demand for SRH services. We propose to work in partnership with Marie Stopes International to ensure that these services are appropriate, accessible and of suitable quality.

35. Cervical Cancer Screening: Cytological Pattern of women attending Cervical Cancer Screening Clinic, Department of Medical Research (DMR) (2008 to 2014)

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Cervical cancer is one of the most common female malignancies with high mortality rate in developing countries. In Myanmar, it ranks the second most frequent cancer in women and currently, (Papanicolaou) Pap smear is accepted as most appropriate test for cervical cancer screening because it is a simple, non invasive and a cost effective method for the diagnosis of cervical and vaginal precancerous lesions. With the aim of early detection of cervical cancer in any women having awareness of cancer cervix, cervical cancer screening clinic at DMR was established at July 2008. The purpose of this study is to determine the prevalence of different cervical cytology patterns of women attending the clinic. A total of 4885 conventional Pap smear findings of women attending the clinic from July 2008 to July 2014 with their clinical records were retrospectively analyzed. The numbers and rates of cervical cytology findings were as follows: Unsatisfactory 17/4885(0.3%), Inflammation

2295/4885(47.0%), Normal 2184/4885(44.7%), Atypical squamous lesion 210/4885(4.3%), Precancerous lesions (mild, moderate and severe dyskaryosis) 167/4885 (3.4%) and Cancer cervix 12/4885(0.2%). Majority of Pap smears in this study were evaluated as inflammation that pointed out vaginal infections are important that should receive more attention as public health problem. The low frequency of precancerous lesion and carcinoma cervix could be due to represented cases taken only in women at low risk. Although there was some limitation in screening population which did not cover the general population, we believed the present study revealed some important issues and also suggested that more prospective studies with larger numbers are needed to determine the real prevalence of the cervical epithelial abnormalities in our country to generate more reliable policies. Furthermore, screening program should be planned nation-wide like Pap smear testing as a routine screening at primary health care unit in order to achieve early detection of precancerous and cancerous lesions thus help in effective management of the cancer.

36. Integration of adolescent sexual and reproductive health programs in health facilities- what works and what not: evidence from Bangladesh

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Background and Objectives

Traditionally, sexual and reproductive health (SRH) information is taboo in Bangladesh. Adolescents are often kept deprived of essential information about their bodies and access to sexual and reproductive health services. Adolescent girls are extremely vulnerable, especially in the context of high child marriage and early childbearing taking place in Bangladesh. Adolescent girls enter sexual life poorly informed about protection from pregnancy, infection and their circumstances do not allow them to assert their preferences and exercise their reproductive choices. Unmarried adolescents are another vulnerable group who has far less access to information and services on SRH compared to their married counterparts, as it is not culturally accepted here. Identifying proper channel to access to adolescents with appropriate information and services is necessary to instill positive norms around contraceptive behaviors and to enjoy safe and satisfing sexual and reproductive life.

The paper reviews adolescent sexual and reproductive health (ASRH) programs in Bangladesh, synthesize lessons learned and suggest ways to integrate SRH programs in the health facilities.

Methodology

Using secondary data, reviewing research reports, publications and project documentation on ASRH programs and interventions implemented in the last ten years, this paper critically analyze ASRH programs in Bangladesh and identifies best practices. Thirty-three programs have been identified and reviewed in this process. Apart from the desk review,

communication with program implementer and project site visits has been conducted to better understand the program strategies, challenges and to identify the component that works.

Findings

The result suggests that integrated intervention work well rather than stand-alone intervention. Awareness raising program on sensitive issues like SRH works best when coupled with skill building program- most popular among them are computer training. Older adolescents, unmarried and adolescents continuing education mostly attend these awareness programs; young adolescents (10-14) and married are largely missing in adolescent and youth programs.

In the SRH service delivery, situation is reverse. SRH service delivery still revolves around married. Married adolescents and women are the main clients, largely because of antenatal checkup, delivery and family planning. Sexual and reproductive health services for unmarried adolescents are still missing. Few NGO programs that claim to provide SRH services to unmarried adolescents are limited to counseling on pubertal changes, advice on relationship problems with family, friends or intimate partner. None of these counselors employed are professional; on the best they have some short training on issues of SRH.

SRH service delivery coupled with nutrition and general health services (blood grouping, weighting, vitamin supplements and TT vaccines) work in favor of making unmarried adolescents visit the health centers. Offering these general health services also removes the tagging a health facility as "FP clinic" which are traditionally thought to be visited by married people only.

Conclusions:

Services for unmarried adolescents need to be institutionalized by setting up adolescent corners in existing Govt. health facilities and SRH services coupled with general health and nutrition can be a great strategy to sidetrack the associated taboo. Building capacity on professional counselor on SRH is any area of priority.

37. H**ow the Indonesian Media Uses Stigamatising and Emotive Language to Discuss Abortion**

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Sexual and reproductive health is closely linked with morality in Indonesia. Sex is seen as something that only married couples should do, and even then, it should primarily be done with the aim of producing children. Sexual relationships that occur outside of marriage are believed by the majority of Indonesians to be immoral and sinful.

Abortion is largely illegal in Indonesia. It is permitted only in cases of rape or where the pregnancy poses a health risk to the mother or foetus. Despite this, it is estimated that up to 2

million abortions are performed in Indonesia every year. Most are illegal and unsafe, and annually, 130 out of every 1,000 Indonesian women undergoing unsafe abortions are hospitalised due to complications.

Mass media plays a hugely influential role in shaping public opinion. Newspapers and news websites offer readers the opportunity to develop and strengthen their worldview by presenting information on local, national and global events. In theory, news should be objective and factual, with no allegations or gossip put forward. In practice, however, this is not always the case, particularly in countries such as Indonesia where a free press is a relatively new development.

Articles on sex and morality appear in Indonesian newspapers virtually every day. But how does the Indonesian media talk about these issues in the twenty-first century? Specifically, how does the media talk about abortion?

My research covers only cases of abortion or suspected abortion that occur in Indonesia itself. While some international cases were also reported in Indonesian newspapers, the reports were often short and objective due to their originating from international wire sources. Their inclusion in this research would have thus skewed the results. Articles that referred to cases where babies were born at full term and then killed or abandoned were not included, as these were not cases of abortion. All articles in this study are available online.

I identified 44 cases of abortion or suspected abortion reported in 2014 and 2015 on news websites such as Kompas, Fajar, Merdeka, Detik.com, Okezone, and Tribun. These 44 cases were covered in 53 different articles. Of the 44 cases, 26 (59%) were reported using negative, sensationalist and emotive language. This language is used to encourage the reader to think that abortion is an immoral act. Abortion The worst offenders were local newspapers, such as Fajar (71% of cases used sensationalist or emotive language). National newspapers such as Kompas use sensationalist or emotive language less frequently when reporting on abortion (33% of cases).

The type of language used generally centres around shame and morality. Unmarried couples were consistently referred to as having affairs (hubungan gelap) or living in sin (kumpul kebo). The word malu (shame or embarrassment) appeared in 18% of articles. Many articles also attempt to shame the women involved by naming them. 25% (11 articles) of the articles identified the women by name; another 39% (17 articles) identified the women by their initials.

38. Characteristics of high frequency HIV testers within a population of men who have sex with men reached by an outreach program in Myanmar

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It is estimated that there are 240,000 men who have sex with men (MSM) in Myanmar and that this population is one of the three key populations highly affected by HIV, with prevalence of 6.6 % in 2014. Heightened transmission risk is due to condomless anal sex, and having multiple sexual partners. Vulnerability is also increased by reluctance to access HIV related health care due to a fear of stigma/discrimination and potentially low self-perceived risk. Although prevention efforts have been scaled up in recent years, programmatic gaps still exist and are evidenced, in part, by the fact that in 2013 only 39% of MSM had a HIV test. Frequent HIV testing is an important component of HIV prevention strategies, as early diagnosis, treatment and behavioral change can help prevent the onward transmission of HIV. This study aims to explore the characteristics of a group of MSM who test frequently for HIV in Yangon and Mandalay to inform how to adapt promotion of HIV testing in real practice.

MSM respondents were recruited in Yangon and Mandalay through convenience and snow-ball sampling with time-venue-based strategy. Quantitative, cross-sectional interviewer-administered surveys were completed by trained peer educators, using a password protected electronic tablet. Descriptive statistics and uni - and multivariable analysis were used to identify association between theoretically important variables. High frequency testers were defined as participants who typically self reported testing for HIV at least every three months.

A total of 520 MSM were recruited across Yangon and Mandalay. Mean age of respondents was 26.5 years. Of those who were recruited, 444 respondents were either HIV negative or undiagnosed. Of these, 83.45% had ever tested for HIV, with 60.34% reporting testing every three months.

A number of factors emerged as significantly ($p<0.05$) associated with high frequency testing on a univariable level. In multivariate analysis, those who reported being versatile in sexual positioning with their regular male partner(s), compared to those with no regular male partners, remained significantly more likely to test frequently for HIV (AOR =1.94, 95%CI: 1.03 - 3.67) . Those who reported being exclusively the insertive partner with their casual male partners, compared to those with no casual male partners, were significantly less likely to test frequently for HIV (AOR= 0.50, 95%CI: 0.25 - 0.98).

High frequency testers were more commonly reported inconsistent condom use, not being the exclusively insertive partner, and not knowing the status of their partner compared to non high frequent testers.

Targeted promotion of frequent HIV counseling and testing should be encouraged among high-risk MSM including those in sero discordant relationships, MSM with multiple male

partners and inconsistent condom users. Novel HIV testing service models should be explored as a way to improve accessibility and increase the proportion of those who test frequently. Regular and frequent testing among high-risk MSM can serve as an entry point into strategic use of anti-retroviral drugs, including Test and Treat and Pre Exposure Prophylaxis (PrEP).

39. Greater than the sum of its parts? Effectiveness of a new style of multi-sectoral partnership for improving reproductive, maternal and neonatal health in Cambodia

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Cambodia has made impressive progress in improving reproductive, maternal and neonatal health (RMNH) in the first 15 years of the 21st century. However, these significant gains have not reached some of the most vulnerable population groups. In 2010, the Cambodian Ministry of Health (MoH) launched the Fast-Track Initiative Roadmap to Reduce Maternal and Newborn Mortality 2010-2015 (FTI) to accelerate progress towards Millennium Development Goals 4 and 5.

In 2013, to support achievement of the FTI objectives, the Australian Government's Department of Foreign Affairs and Trade (DFAT) funded Partnering to Save Lives (PSL), a five-year program to improve RMNH, with a particular focus on vulnerable groups: ethnic minorities, garment factory workers and people living with a disability. The program works to improve RMNH service delivery, strengthen and engage communities on RMNH issues, and translate learning and knowledge into improved RMNH policies and practices.

PSL is a unique partnership, aiming to combine the different strengths of government (Cambodian MoH and Australian DFAT) and implementing non-governmental organisations (NGOs: CARE, Marie Stopes International Cambodia and Save the Children) as five equal partners. Planning, research and learning, monitoring and evaluation, reporting, advocacy, and inclusion are conducted jointly, in line with cross-partnership program design and annual planning documents.

Halfway through PSL's five-year program, the partners are conducting a qualitative assessment to address the following questions:

• How effectively has PSL leveraged and combined the different strengths of the five partners to achieve RMNH outcomes?

• How could the effectiveness of the partnership be improved in the second half of the program?

The assessment, which is due to be completed by the end of 2015, involves a combination of qualitative methods, including document review, key informant interviews across the five partners and with external stakeholders, and participatory exercises with management and field staff from the three NGO partners.

The results are expected to cover concepts such as:

• technical harmonisation across the partnership, including the development of innovative midwife capacity building and behaviour change communication (BCC) approaches

• implementation of cross-partnership learning on priority issues such as addressing financial barriers to accessing RMNH services and improving community referral pathways

• impact of joint advocacy on RMNH issues in relation to vulnerable groups (e.g., participation in development of national guidelines for garment factory infirmaries).

The results will be used to formulate improved processes and approaches to maximise synergy across the partnership. This might include strengthening the roles of cross-partnership working groups on clinical quality and BCC, and revising the annual learning and review cycle. Recommendations will also be shared with other organisations and stakeholders considering similar partnership structures.

40. "Are we ready to meet all the needs?" - Anticipating the Universal Health Coverage Scheme in Indonesia-

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Background

The Government of Indonesia launched its National Health Insurance Programme (*Jaminan Kesehatan National = JKN*) in January 2014, aiming for total coverage of all Indonesian population by 2019. Family Planning is included in the packages offered in the scheme, and as inidcated in the policy, the Government will be in charge in meeting all the contraceptive needs for the population through the scheme.

Anticipating the above, UNFPA conducted an assessment of the country's current effectiveness and efficiency in the management of the national contraceptive supply chain and its preparedness to assume a greater national responsibility for forecasting long-term contraceptive requirements, estimating annual procurement needs for, and procurement and distribution of, contraceptives throughout the country.

Objectives

To provide information and develop comprehensive understanding on the BKKBN's[1] current supply chain situation and to consider future options for ensuring that its supply chain system can handle the increased spatial volumetric demand for its products.

Methodolgy

The exercise used as a reference the manual titled Logistics System Assessment Tool (LAST)[2] as the framework in designing the central data collection instrument. It employes key informant interviews, document analysis, field visits, and group consultative processes as key tools.

Analysis were based on the data collected from the F/II/KB data base obtained from computer files at central administration of BKKBN covering the period of January 2012 - March 2013. It involves 19,000 service delivery points from 497 districts located in 34 provinces.

Site visits were conducted to 6 districts in 3 provinces to collect information from key informants through indep interviews and FGDs, including assessment of the province and district warehouses

Results

- On average, the provinces maintain stocks of injectable contraceptives between 14 million to around 14 million vials per month. While the districts maintain around 4.8 million to 5.3 million vials per month.
- Consumption rate appears to be stable at 2 million doses per month.
- Around 1-2 government facilities and 3-4 private facilities experience stock zero per month.
- Percentage of contraceptive stock outs at district warehouse is around 16-34% (Jun 2012 - Jan 2013; n=497 districts)
- In the new JKN scheme, BKKBN has to manage as many as 60,000 service delivery points; almost trhreefold of the current number (current: 23,500)
- Issues of capacity in anticipating the increasing needs: resources, storage, personel (soft skills)
- As the scheme is so new, the policy and guide is not yet comprehensively developed. Gaps in policies and guidelines creates confusion and poses people to risks of missmanagement.

Conclussion

- The supply chain system is operating normally at the provincial stock level (7-8 months of stock); but bellow normal at the district level.
- Challenges in meeting the increasing needs of contraceptives in around 60,000 SDPs by only relying on the 'traditional' supply chain system.
- Innovative yet effective supply chain management needs to be operated to meet the increaisng needs.
- More work at policy table are needed.

41. Review of MISP project implementation in Pakistan and Solomon Islands: Implications for effective SRH emergency responses in Asia and Pacific region

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Asia and the Pacific together witness more than 80% of the world's natural disasters annually. While efforts to reduce the pre and post- crisis vulnerability and risk are progressively been addressed, there are a rising number of people needing humanitarian assistance in the aftermath of disaster events. SPRINT is a global SRH initiative by International Planned Parenthood Federation (IPPF) which addresses life threatening SRH needs during disasters through the implementation of the Minimum Initial Service Package (MISP). Under this initiative, SPRINT implemented MISP projects in response to earthquake and drought in Pakistan (2013-14) and floods in Solomon Islands (2014). In 2014, two Post Emergency Review exercises were conducted to evaluate the implementation of the projects. This paper studies the overall project strategy adopted during the response to understand the best practices and challenges for MISP implementation. The study provides recommendations for practitioners and policy makers to address gaps in SRH service delivery during emergencies.

Key findings- The two projects were timely implemented by identifying the existing gaps in humanitarian response. SRH issues like sexual and gender based violence, maternal and newborn care, HIV and other STIs, and family planning, were addressed through various activities, benefiting 86,599 and 20,000 people in Pakistan and Solomon Islands respectively. SPRINT provided the necessary surge in capacity and resources in addition to technical guidance implementing partners; the response was well coordinated by establishing partnerships with Government and Health Clusters; Benefit-Cost ratio was high; collaborations were developed with other partners/agencies for comprehensive service delivery and sustainability. While the implementation of the MISP via local CSO partners (IPPF Member Associations) effectively address community level SRH information and service provision, service provision at health center and hospital levels are very dependent on services provided by the government or other medical service providers. As both Member Associations had previously implemented small scale responses, they were able to build on their previous experience to improve the MISP response.

Challenges/ Barriers- Initial delay in response due to availability of resources; lack of comprehensive understanding of SRH needs among key stakeholders responsible for humanitarian aid provision; Inadequate trained staff for service delivery; barriers to provide comprehensive SRH services due to social, cultural and political conditions.

Recommendations- Support country coordination teams/inter agency groups to ensure prioritization of SRH needs during crisis; integrate SRH with other sectors of humanitarian response like protection, shelter, WASH, food and security; build capacity of service providers to ensure SRH friendly services; Preposition RH commodities strategically, and if

distributed to Central Medical Stores, facilitate access to the commodities for local CSO service providers as MISP Implementation partners; IEC- design innovative awareness campaigns with the community to achieve behaviour change; strengthen the coordination and collaboration mechanisms at national and regional level to ensure provision of comprehensive services and sustainability; build partnerships with private health and CSR collaborations, and advocate for SRH in emergencies to ensure adequate funding.

42. Use of Social Media: Engaging Youth to Discuss SRH Issues

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Background:

Youth constitute of almost 33% of the total population of Nepal (NDHS-2011). Unmet need for family planning remains high amongst youth. There is poor communication among youth when it comes to discuss about sexual health. The unmet need for spacing is higher among younger women compared to older women, this result in a high prevalence of unintended pregnancy. 96% of youth have access to mobile phone and 34% have access to computer or internet (INCITE STUDY, MSI 2014). There is great opportunity to use social media as Behavior Change Communication medium.

To engage youth in social media like FACEBOOK, “ROCKETS & SPACE” page was created in March 2014. The FB page provided a platform for youth to discuss on SRH issues. This FB page is linked with our Helpline as it was found that 87% of youth are interested to get information through Helpline on FP (INCITE STUDY, MSI 2014). Although social media is a prominent part of daily life among youth, we are still not able to disseminate accurate information on SRH. Therefore, social media like FB should be utilized properly.

Methodology

Rockets & Space FB page is a youth-centric SPN/MSIN initiative. The objective is to establish a platform where sex can be demystified and safe sex promoted. It is an interactive approach to communicate with youth. R&S characters were also developed to disseminate relevant SRH information to youth. The R&S character depicts the character of Nepali youth and plays a role model to motivate youngster to use modern contraceptive. Facebook posts are developed using characters with key message on SRH issues. They are posted regularly. The page creates event on international day celebration like “Photo Contest on WCD-2015”. This had encouraged youth to brainstorm about importance of contraceptive and post their photo with the message. We received nearly 50 entries for the event.

Results:

The page received 35,000+ likes.The weekly post reach is 29,000+, post engagement is 2500+, response rate is 90% and 1500+ newly likes every week. Helpline receives 20% of its caller from the page on monthly basis. R&S characters are getting popular.Characters are used in all IEC materials and informative advertisment in papers.

We receive approximately on average of 5 messages every day from youth regarding their SRH issues and queries. Most commonly asked question are related to adolescent bodily changes such as penis size, breast size, wet dreams,menstruation, masturbation, etc. The messages are replied instantly and referred to our service centres and helpline.

Knowledge contribution:

It is observed that youths are engaged in our page. This has provided important insight on effectiveness of social media to communicate on SRH to youth. These observations and insight report of page have encouraged developing youth friendly messages for youth on SRH and their engagement without hesitation. The FB page has provided a safe platform to youth to seek safe behavior and use contraceptive.It has motivated youth to visit our youth friendly services centres. Social media is important for youth friendly communication on SRH for behavior change.

43. Access, knowledge and perception of youths towards SRH services in three selected areas in Myanmar.

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In Myanmar, many INGOs deliver Sexual and Reproductive health (SRH) interventions to address SRH needs and rights of Myanmar communities in different parts of the country. Young people are a particularly important group to target as they are at a critical point of their lives; the choices they have and the decisions they make during this period - especially with regards to SRH - are key determinants for their futures. This study was conducted to explore the access, knowledge and perceptions of youth towards SRH services and to enhance the greater understanding of the needs of the existing and potential consumers aiming to provide SRH services by one INGO in most effective ways. Ethical approval was obtained. A total of 36 In Depth Interviews were carried out, 24 sessions for youth, aged between 15 years and 19 years (12 for male and 12 for female). 12 sessions were for married youths, including newly wedded ones. Most of youths were students, few were daily waged workers. Urban, peri-urban and rural areas were selected; Thingangyune, Mandalay and Thanlyin respectively. Youth expressed that accessibility is important to utilize SRH services. They understand reproductive health as birth spacing. Most of female youth were reluctant to speak up about sex. Contraception is mainly required based on economics situation of the family and the status of men; whether they have jobs or stable income.

Regarding knowledge, majority of youth know what is birth spacing. Family Planning (FP) is another confused term for them since majority were not aware of family planning before marriage. Knowledge on contraceptive methods were explored as oral pills, injections and IUD. One of the long lasting methods (implant) was also known by those who utilize FP service. Knowledge on SRH was found to be satisfactory and there were also positive perception towards utilization of SRH services rendered by clinics. Most of the youth visited drop in centre, youth centre and from there they gained some knowledge and they are aware what those centres are providing for the community. Male youths visited for HIV VCCT and for getting condoms. For females, unlike male youths, they do not visit youth centres or drop in centres except those who are relatives of the centre staff. Main reasons for utilization of SRH services were quality of services provided, good social dealing by the staff and affordability for modern contraceptives. However, knowledge on family planning was not found to be related to education or residence. For improving services youth suggested that information should be given to the community by their peer. In conclusion, youths and newly wedded couples should be focused as potential consumers for SRH .We have to find out better picture of the needs and problems of adolescents in different levels, including out of school youth.

44. Title: Intimate Partner Violence and Symptoms of Sexually Transmitted Infections among Young Indian Women

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Objective: To assess the association of three different types of violence i.e. physical, emotional and sexual with self-reported symptoms or presence of genital sore, genital discharge and sexually transmitted diseases (STD's) among young married women in India. Methods: A cross sectional analysis of population based data based on National Family and Health Survey-3, India was conducted. The sample consisted of 13426 young women in the age group 15-24. The association between different types of IPV and women's reported symptoms of STI was checked using bi-variate and multi-variate analyses.

Results: Overall 23, 7 and 13 percent of women experienced physical, sexual and emotional violence respectively. The symptomatic prevalence of genital discharge, genital sore and any STD was 9, 2 and 1.2 percent respectively. There were steep differentials in the reporting of gynecologic morbidity among women who experienced violence and those who didn't. Sexual violence has emerged as the most prominent type of violence which increases the risk of genital discharge/Sore. Results indicate that only 8 percent of women who didn't face sexual violence reported genital discharge whereas the percentage elevated to 20 percent for women who experienced sexual violence. The results of Logistic regression showed that STI is significantly higher among women who suffered from physical violence, sexual violence or any violence when controlled for socio-demographic and gynecologic background of women.

Conclusion: Young women are at risk of both intimate partner violence and STI's, and the study further strengthens the association between IPV and increased risk of genital morbidities. All types of violence contributed in the risk of STI's, thus indicating several pathways that link IPV to the sexual health of young women. It should be the state's responsibility to establish a link between healthcare providers and services with IPV victims. The inclusion of counselling services is also proposed to screen the IPV victims and their health. The integration of Sexual and Reproductive healthcare with the health providers is call of the time.

45. Impact of policy change introducing nurse provision of safe abortion services in selected government facilities in Bangladesh: An assessment of quality of care and client satisfaction

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Objectives:
More than 600,000 unsafe abortions take place in Bangladesh each year. One of the barriers to women accessing safe abortion care is an inadequate number of qualified service providers. A key strategy in addressing this barrier was to advance policy changes that would expand the provider base from doctors to midlevel providers. As part of a 18-month pilot project to integrate menstrual regulation (MR), postabortion care (PAC), and family planning services at select government facilities, nurses in addition to doctors were trained on safe abortion services. Due in part to the findings from the pilot and additional advocacy efforts of Ipas Bangladesh, the Ministry of Health and Family Welfare (MOH&FW) issued an order stating that any Senior Staff Nurse/Staff Nurse who receives training can provide safe abortion services. In 2013, nurses began providing direct abortion and postabortion care services in 2013 due, in part, to the policy advocacy efforts of Ipas Bangladesh. This study aims to assess the impact of nurse provision of safe abortion services on overall safe abortion care, and to evaluate the quality of those services.

Method:
A secondary analysis of Ipas Bangladesh's service delivery and client exit interview routine monitoring data was conducted. Service delivery data were collected from 159 nurses and 115 doctors at 75 facilities from 7 divisions in Bangladesh. Key service delivery indicators were analyzed and compared by provider cadre. Differences were assessed using a chi-square test. Statistical significance was assessed at an alpha level of 0.05 for all analyses. Service quality data from 87 exit interviews with women who received abortion services from nurses were analyzed, and proportions are presented.

Results:
The analysis of service delivery data showed that the services provided by nurses and doctors differed significantly. Nurses provided 50% induced abortion services and 48% postabortion

care (PAC) services while doctors provided 10% induced and 81% PAC ($p<0.001$). Significantly higher post-abortion contraceptive uptake was seen among women served by nurses (82%), compared with doctors (68%) ($p<0.001$). The client exit interview data revealed that 93% of women who received care from nurses rated the quality of those services as either "excellent" or "good", and 98% would recommend the facility to family and friends.

Conclusions:
Abortion services provided by trained nurses are of high quality, and are associated with high levels of client satisfaction. Policy change enabling the expansion of services to this new cadre of providers has allowed greater access to safe abortion care in Bangladesh. Ipas Bangladesh will continue to work with the government in improving the provision of services from nurses and other mid-level providers.

46. Informed, naive or the middle ground: What sexual and reproductive health decisions are being made by women with higher education in contemporary Cambodia?

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Introduction

Research regarding sexual and reproductive health (SRH) knowledge and behaviour in Cambodia has tended to focus on women with little or low literacy levels. Little is known about the sexual and reproductive knowledge, behaviours and decision-making processes of Cambodian women with tertiary education. However, data from the 2014 Cambodian Demographic Health Survey highlights the use of traditional contraception methods (rhythm and withdrawal) increases with higher educational attainment. Investigating the preferred contraceptive methods used by this cohort and what influences or informs their reproductive health decision-making is essential as without this information it can be easy to assume educated women have the knowledge and capacity to make informed decisions about their SRH. Such assumptions fail to meet the requirements of SRH rights ... *to have access to the information, education and means to enable them to exercise these rights (UN 2015).* The aim of this study was to explore SRH practices among Cambodian women with post-secondary education.

Methods

The study employed a sequential mixed methods approach. The SRH practices of 238 women (recruited using convenience sampling) were collected using an online questionnaire. Twenty in-depth interviews were conducted with purposefully selected questionnaire respondents. Body mapping formed part of the interview process to both generate conversation and to help explain key concepts around contraceptive use and decision-making. The interview data were used to explain the findings from the questionnaire to provide a better understanding of the women's SRH practices.

Findings

The median age of the women was 29 years (IQR = 24-33). Education levels varied with 55% of women having a bachelor degree. Fifty one percent (n=122) of the women were sexually active, of which 61.5% (n=75) were taking action to avoid pregnancy. Of those who were sexually active 42.8% (n=102) were married, 6.6% (n=16) were in a relationship and 1.6% (n=4) were single. The male condom was the preferred contraceptive method (16%; n=38), with traditional methods being used by 13% (n=31) of the women. Few women used the daily pill (4.6%; n=11), however, 2.9% (n=7) of women were using the emergency pill as a precautionary measure. The use of the male condom as the preferred contraception was echoed in the interviews with women indicating this was the preferred precautionary method for planning pregnancies and birth spacing. Decision-making regarding condom use, withdrawal or the rhythm method in the child bearing years suggested concerns and misconceptions of modern hormone based contraceptives. These methods were viewed as medicine and promoted anxieties around infertility and maternal health, and as such explain the low uptake of these effective contraceptive methods.

Conclusion

The findings highlight that women with post-secondary education are not naïve, nor well informed about SRH matters. They appear suspended in the middle ground having implications for SRH programs going forward. The cultural myths and misconceptions of modern hormone based contraceptives have the potential to leave educated women in this study disempowered in regard to their SRH rights.

47. Redefining "hard to reach": Results from a reproductive health needs assessment in peri-urban Yangon, Myanmar

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

Objectives: The purpose of this needs assessment was to identify and document the reproductive health needs of women of reproductive age living in the peri-urban townships of Yangon, as well as the availability and accessibility of reproductive health services in the

townships, and potential avenues for improving services. The study focused on a range of sexual and reproductive health issues including maternal health and delivery care, contraception, abortion, and post-abortion care. This presentation focuses specifically on the dynamics shaping access to sexual and reproductive health care, services, and products in peri-urban Yangon.

Methods: We collected data over 10 weeks in Yangon in 2014. We interviewed 18 key informants representing a range of reproductive health organizations. We held seven focus group discussions, including five with adult women residing in peri-urban Yangon, and two with doctors and midwives working in peri-urban townships. We also conducted a service mapping exercise, which included administering facility surveys at 27 hospitals and clinics, and administered a general reproductive health survey to 147 adult women. We used standard qualitative analytic techniques to interpret these data.

Findings: Our findings highlight significant unmet reproductive health needs in peri-urban Yangon, including significant barriers to accessing reproductive health services. Rural and urban barriers to access converge in peri-urban townships; major barriers to access include geographic distance, inadequate transportation infrastructure, fear of judgment and harassment from providers (especially surrounding stigmatized services like post-abortion care), and rampant misinformation, myths and rumours around sexual and reproductive health issues and products. We also identified a gap in reproductive health services and resources tailored toward young and unmarried populations.

Conclusions: There is an overarching need for comprehensive information and resources in peri-urban Yangon. The peri-urban population requires a unique and tailored service delivery approach to meet their complex and varied reproductive health needs. More reproductive health services and resources for young and unmarried populations also appear warranted.

48. Unintended Pregnancy and its Relationship with Low Birth Weight in India: What does Data Suggest?

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Introduction: Little information is available on relationship between unintended pregnancy and low birth weight in India. **Hypothesis**: We hypothesise that unintended pregnancies are more likely to be delivered as low birth weight baby as compared to intended pregnancies. Objective: This paper examines the relationship between unintended pregnancy and risk of low birth weight in India. **Data:** The National Family Health Survey (NFHS-3) data conducted during 2005-06 was used for analysis. It provides a comprehensive picture of the population and health conditions in India. Analysis of the data is restricted to sub-sample of women interviewed in the state of Odisha. Birth weight was recorded on the NFHS-3 questionnaire for births in the five years preceding the survey either from a written record or the mother's memory recall. Since birth weight may not be known for many babies, the mother's estimate of the baby's size at birth was obtained for all births. **Methods**: For the purpose of analysis mothers perception of birth size was categorized in two groups (i) normal birth weight = (average + large + larger than average) and (ii) low birth weight = (small size + smaller than average). Further, information on intention of last pregnancy/births is also available in NFHS-3 data set that provides us opportunity to relate with birth weight. An unintended pregnancy is classified as mistimed (not intended at that time) or unwanted (not desired at any time). To fulfil the objective of the paper frequency distribution, cross tabulation analysis is done. Chi-square test was applied to test the association between pregnancy intention and low birth weight in the state. Logistic regression analysis is also used to assess the relationship between pregnancy intention and low birth weight in the state after control for other important social and demographic covariates. Birth weight in dichotomous form is used as dependent variable and selected socio-economic and demographic variables were used as explanatory variables. These covariates include place of residence, education of mothers, economic status, nutritional status of mothers measured in terms of body mass index, caste, religion, birth order, age of mothers, place of delivery including intention of pregnancy (intended, mistimed and unwanted births). **Findings**: Analysis reveals that around one-fourth births in the state of Odisha were below the standard normal weight, more than national average of one-fifth. This varies significantly by status of pregnancy intention. There were significantly increased odds of low birth weight among unintended pregnancies ending into a live birth. Within the unintended category, mistimed and unwanted pregnancies were associated with low birth weight. There were statistically significantly increased odds of low birth weight among mistimed pregnancies (odds ratio = 1.69, 95% confidence interval = 1.05, 2.71) and unwanted pregnancies (odds ratio = 1.82, 95% confidence interval = 1.10, 3.01). Unwanted and mistimed pregnancies ending into a live birth are significantly associated with an increased risk of low birth weight in the state of Odisha, India.

49. Knowledge of and Attitude towards HIV/AIDS among Youths of Mandalay Teacher Training College in Myanmar

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Background: Young college students are susceptible to HIV because of their curiosity, vulnerability and lack of accurate HIV/AIDS information. Moreover, they will later become school teachers taking key roles in spreading HIV/AIDS-related knowledge to students. With limited data among young college students in Myanmar, this study aimed to assess their knowledge of and attitudes towards HIV/AIDS.

Methods: A quantitative, cross-sectional study on 249 students aged between 15 and 24 years who joined teacher training programme at Mandalay Education College in Myanmar was conducted between October and November, 2014 by using self-administered questionnaires through systematic random sampling. Association between knowledge and attitude was assessed by correlation analysis.

Results: Findings were mean age 21 (±0.9) years, 66% female, 96% unmarried and 46% rural resident and the response rate was 95.4%. The mean knowledge score was 30 (±4.3) [IQR: 27 to 33] out of maximum 42 scores but there were no significant differences in scores by sex, age, marital status and residence. Although the overall level of HIV/AIDS-related knowledge was 71%, some misconceptions about non-transmissible routes of HIV still reported; 44.2% on through mosquitoes bite. However, 70.2% responded that condom can prevent HIV, STI and unwanted pregnancy and 74.7% were aware that HIV/AIDS is no longer a death sentence. The knowledge on where free HIV testing and treatment available was very low; 9.2% and 3.2% respectively. Additionally, 43.4% of students believed that youths are among key populations for contracting HIV/AIDS. Nearly two-third of students showed positive attitudes towards HIV/AIDS and 87.4% responded that they agreed HIV-positive students to continue studying or maintain their friendship. Statistically significant correlation was found between knowledge level and attitude ($r=0.248$, $p< 0.001$). Television and newspaper were the commonest sources of HIV/AIDS information while family and internet were least common.

Conclusions: Misconceptions on modes of HIV transmission, low level of self-awareness on being in high risk group to contract HIV and very low level of knowledge on availability of free HIV testing and treatment are relevant data in this study and addressing these findings with specific training curriculum will help students improve their knowledge of and attitude towards HIV/AIDS.

50. Penile fibrosis due to injection of foreign substances

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Background High-viscosity fluids like paraffin, mineral oils, vaseline and polydimethyl siloxane have been used for more than 100 years to improve body contour. Vaseline injections have been reported for penile augmentation as early as 1899. These substances are harmful when injected subcutaneously. A sclerosing chronic inflammation frequently leads to functional impairment. We encountered patients with acquired penile fibrosis due to injection of foreign substances into the penis in our military medical practice, but the clinical characteristics, treatments and their outcomes have not been studied.

Objectives The aim of this study was to highlight the detrimental effect of this problem in military persons and their clinical profiles.

Methods Twenty-six patients with symptomatic penile fibrosis resulting from injection of foreign substance, who had attended to No. (2) Military Hospital (700- Bedded) within January 2013 to January 2015 were studied retrospectively. All data required were collected from patient's medical records, operating theatre records and personnel interview with individual patient by single investigator.

Results The age of peak incidence was 37.3 years. The youngest patient was 20 years and eldest one was 58 years. All of the patients had penile fibrosis resulting from injection of fatty substances (paraffin contained hair cream) by non professional persons. Most of them had lower educational level, only two of 26 patients had university education. None of them were officers and mostly were private in rank (10 of 26, 38.5%).The motivation of 18 (18 of 26, 69.2%) patients was spirit of imitation and 7 patients (7 of 26 , 26.9%) was to enlarge the penile size. Only one patient wanted to increase the feeling of sexual partner. Seventeen (17 of 26, 65.4%) patients needed multiple surgical interventions and 16 (16 of 23, 69.6%) encountered complications. Two patients had to transfer to urology for urethral fistula repair. The average hospital stay was 10.4 weeks ranging from one to 27 weeks.

Conclusion The present study showed harmful consequences of injection of foreign substances into the penis. They also demended the high cost of health care services. We should improve their health education and belief to prevent these dangerous behaviors.

51. Stigma, discrimination and violence among young men who have sex with men in Myanmar

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Introduction

Men who have sex with men (MSM) are one of the key populations affected by HIV worldwide. In Myanmar, homosexuality is still illegal and MSM often remain hesitant to disclose their MSM status to families, communities, health service providers and their female partners. Non-disclosure can increase vulnerability to risky behaviours and impede access to sexual and reproductive health services. This analysis aimed to further explore the extent of stigma, discrimination and sexual violence experienced by young MSM in Myanmar, and to characterise the impact that these issues have on their access to sexual health services.

Methods

In 2015, as part of the Link Up project, a global consortium led by the International HIV/AIDS Alliance, a cross-sectional survey was conducted among MSM aged 18-24 years across six townships in Myanmar. Respondent driven sampling was utilised to recruit MSM participants who underwent a face-to-face interview using electronic tablets. The questionnaire collected information on socio-demographic characteristics, health service access and their experience of stigma, discrimination and violence during health service access or in other aspects of their lives. Focus group discussions were also conducted among 54 MSM. Descriptive analysis was carried out to investigate negative experiences among MSM.

Findings

Among 585 participants, 13.5% were hidden, 28.9% were open, and 57% were masculine type MSM. The proportion of participants who had been refused health services, education services and employment because of their sexual behaviour were 0.2%, 2.7% and 2.2% respectively. Almost one-fifth of all participants (18.8%) had been verbally insulted, and 6.3% had been hit or beaten at least once within the past 12 months because of their sexual orientation. The mean age for sexual debut with a male partner was 16.6 years, which is younger than the legal age of consent, and 18.2% of all participants reported having been forced or coerced into their first sexual experience. Sexual assault and rape was reported by 11.8% (69/585) of MSM, and in most cases this occurred more than once (median=2, IQR=1-3) in the past 12 months. The perpetrator of the assault was usually someone they know (57%), and mostly a social acquaintance (44%) or another MSM (31%). Among those

reporting sexual assault, only 16% sought medical treatment after being forced to have sex and only 3% reported the event to the police.

Conclusion

Stigma, discrimination and sexual violence are still experienced by MSM in Myanmar. Despite such a strikingly high prevalence of sexual violence, only a small proportion of participants felt comfortable reporting the incident to the police and seeking health services, thus indicating that the stigma, discrimination and fear of violence from authorities continues to be a challenge in Myanmar. A greater level of health education, and sexual health and rights training for young MSM including mitigating the impact of sexual violence among MSM where it occurs. Moreover, integrated health care network with trusted health service providers and members of the community who can enhance in providing stigma-free services should be warranted in Myanmar.

52 "Operational Research for the Introduction of the Combination Package of Mifepristone and Misoprostol into the Thai Health Service Systems"

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An operational research for the introduction of the combination package of mifepristone and misoprostol to terminate pregnancy up to 63 days was conducted in Thailand during 2012-2015. This study intended to obtain evidences on the safety, efficacy and acceptability of the combination package of mifepristone and misoprostol performed by trained government providers. Also, it envisioned to assess acceptability of both providers and participants on medical termination of pregnancy (MTP) management and utilization. In addition, it intended to develop service delivery model and strategies for scaling up the availability and accessibility of the combination package of mifepristone and misoprostol in Thailand. This study had been conducted at obstetrics and gynecology department of 9 pilot hospitals located in the central, northern, northeastern and southern regions of Thailand. These hospitals included 5 university hospitals, 1-health promotion hospital and 3- provincial hospitals. All of these selected sites are currently providing safe abortion services using both MTP and surgical methods within the context of the Thai law and Medical Council's

regulations. Total of 430 participants were enrolled in these studies. All women received mifepristone 200 mg at admission. 24 - 48 hours later, women had choices to choose whether they preferred to receive misoprostol 800 µg, administered either sublingually or vaginally at home or at clinics. The outcome of the treatment was assessed at follow - up visits on days 10-14. Non - participants observation and in-depth interview to assess participants and providers perspectives and experiences with MTP were also conducted at the 9 hospitals. Around 30 key informants were in-depth interviewed. The results revealed that the combine package of mifepristone and misoprostol had more than 93 percent effectiveness to terminate pregnancy up to 63 days gestation. More than 98 percent of Thai health care providers and participants felt satisfied with the methods. More than 80 percent of participants thought that side effects of the method were as expected or less than expected. Participants felt that the method was more natural and had less invasive than surgical abortion. Around 89 percent of participants reported that the method provided more privacy than surgical abortion. More than 65 percent of the participants preferred to use misoprostol at home rather than at clinic. More than 95 percent of the participants preferred to have MTP services available in Thailand. Both providers and participants suggested that this method should be widely available as a routine service at all level of health care facilities that had surgical method back up. Even though more than 150 providers were trained and networked by the Bureau of Reproductive Health to provide MTP services in Thailand, more trained providers are still needed. Long term service systems for making the combination package available and accessible in Thailand need to be set up and strengthening.

53. Innovative approaches to Services and culture barriers.

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The area of Program Management office Rahnuma-FPAP is hub of anti- NGOs elements. The mobility of women is strongly restricted with the permission of wen. Child marriage, force marriage and custom of Swara are common practice in male dominated society. Various innovative approaches have been adopted to provide a congenial atmosphere for access to service. Socio-culture bearers are main hindrance in access to women, men, and young people providing services them including diverse groups to SRH services through static and mobile units.

Reduction in socio-cultural barriers to the access to SRHR information education and services is to be achieved by enhanced awareness about SRHR needs among people, creation of an enabling environment leading to increased usage of SRH services and improvement in participation of men and youth in SRHR programs. The team is conducting different kinds of activities with diverse marginalized groups on SRHR and gender issues around service delivery points that would include sessions, street theatres etc., dialogue with opinion/religious leaders and involvement of other stakeholders.

Objectives

- To reduce socio-cultural barriers to access the SRH information, education and services by men, women and youth.
- To strengthen political commitment and support for SRH programs.
- To empower women to exercise their choice and rights in regard to their sexual and Reproductive lives.
- To increase male commitment to SRH.
- To improve access to SRH information and sexuality education using a right-based approach.

Challenges:

Pathan custom has extremely rigid application of female seclusion than other ethnic groups in Pakistan. Women status under Pathan Customary Law or Pashtunwali supersedes both religious and national laws. It is a great challenge to work for women in strong male dominating society where the concept of honour is attached with women and they have very limited or restricted visibility and mobility. Women don't have access to their basic needs without proper permission of males. Women related issues are not discussed openly. The unstable and conflict ridden environment, widely pervasive anti NGO sentiments, and fundamentalism in project area are other immense challenges which confined staff at various stages in implementation of scheduled project activities.

Results of Three years (2012 t 2014):

• About 103 religious local leaders sensitized. Resource persons of religious leader have been formed on RH. A group of Swara girls and child marriage survivors have been formed. Three hundred Jirga members and Influential of community have been sensitized.

• Achieved 55780 CYP, SRH services 114096, Abortion and its related care 4273, SGBV 16062, safe mother hood services 12254, Family Planning, STI/HIVs package to Swara,

Future Directions:

The thematic area would be increased to provide SRHR and abortion services to Swara girls, child marriage survivors and women. PMO would try its best to create congenial atmosphere to women folk where they would access to their SRHR service without any resistance. It will intensify advocacy and lobbying with different stakeholders including federal and provincial governments for laws and practices conducive of protecting women against all kinds of violence and discrimination.

54. Exploring Impact of BALIKA program on Adolescent Sexual and Reproductive Health Knowledge and Behavior among Girls in Rural Bangladesh

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Background: In Bangladesh, girls are married and become sexually active without the benefit of sexual and reproductive health and rights (SRHR) education. Adolescents constitute one-fourth of the population of Bangladesh and BDHS (Bangladesh Demographic and Health Survey) 2014 suggests that 31 percent of adolescents aged 15-19 in Bangladesh have begun childbearing. Inadequate knowledge enhances their risks to get exposed towards STIs, HIV/AIDS, early marriage, higher maternal mortality rate which are also associated with unwanted pregnancies. The BALIKA (Bangladeshi Association for Life skills, Income and Knowledge for Adolescents: *Generating Evidence to Delay marriage in Bangladesh*) project has been designed as multifaceted interventions to generate evidence on what works to delay marriage and improve life opportunities for girls in rural Bangladesh. The project offered three distinct interventions and assessed their impact relative to a control population.

Objectives: This paper examines the impact of a skill building program BALIKA to improve the knowledge of sexual and reproductive health, awareness and use of family planning methods of adolescents girls in three rural districts of Bangladesh

Data & Methodology: The sample for this study comprises 11609 adolescents of 12-18 years old from the baseline survey which was drawn from Khulna, Satkhira and Narail the three districts of southern Bangladesh using randomize control trial (RCT) design. At the endline survey same respondents of baseline survey have been followed up after 18 months, So far we have collected information of 3,615 respondents with plans to reinterview all remaining respondents by November 2015. We have performed t-test to examine the changes in different indicators in intervention arms relative to control arm in endline. The analysis assesses impact of programs, not just on program participants but on an intent to treat sample. Thus program impact is measured at a village level where all adolescents were invited and given the opportunity to attend, but about 35% actually attended. In further analysis, we will use more rigorous statistical techniques to explore the program impact accounting for attrition over the period.

Results: The intervention increased the awareness about STI and the level of knowledge about at least three routes of transmission of HIV/AIDS significantly in all intervention arms over control at the endline. However, the change in the knowledge about STI was more dominant in education arm with 9.6 percentage points (16.2% vs 6.6%) higher than control compared to 5.4 and 7.1 percentage points increase in gender and livelihood arms, respectively. The contraceptive awareness was found to be significantly higher in the endline compared to the baseline survey across intervention arms while comparing the changes in the endline over the control arm, it reveals that gender and education arm demonstrated significantly greater improvement (Education arm: 91.0% , Gender arm: 91.2% , Control arm: 84.3%). Use of modern contraceptives among married adolescents increased

significantly and specifically for the injectable and condom method by nearly 10 percentage points relative to the control arm.

Conclusion: The intervention substantially improved the knowledge on sexual and reproductive health and use of modern contraceptives among married adolescents.

55. **Knowledge, Attitude and Practice of Exclusive Breastfeeding Among Infants Mothers in Tharkata Township**

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A community based cross-sectional study was carried out aiming to explore knowledge, attitude and practice of exclusive breastfeeding up to six months in Tharkata Township, Yangon in 2012. Face to face interviewed using pretested questionnaires were done among 157 mothers of infants (6 - 12 months old).

Nearly 100% of mothers knew that breastfeeding should start within half hour, honey and formula milk are not needed before six months. All mothers knew that colostrums should feed within 30 minutes after delivery and animal milk are not needed before six months. There were 95.5% of mothers who knew starting time of weaning diet. Majority of mothers 98.1% responded that they did not know EBF up to six months can space next pregnancy. Seventy nine (50.32%) of mothers were included in low knowledge group.

There were 100% of mothers agreed about that EBF can save money, EBF can make bonding between mother and baby, EBF can prevent infections for baby, colostrums is needed to feed baby and EBF can benefit for country. One fifty six (99.4%) of mothers agreed that EBF can prevent PPH for mother. The statements "Water should be given before six months' was agreed by 82.2%," "BF should stop when baby is sick" was disagreed by 98.1%, "Early weaning diet is good for baby (before 6 months)" was agreed by 45.2%. There were 51% of mothers who had negative attitude for EBF up to six months in this study.

The breastfeeding initiation time within half hour was found in 78.3% and sustained EBF up to six months without any supplements was only 8.3%. There were 72.6% of mothers who exclusively breastfed their baby up to four months. All 157 mothers (100%) were still breastfeeding now. There was a high prevalence of colostrums feeding 100% and there were 17.8% of mothers who started weaning diet at four months. There were only 12% of mothers who gave mix feeding to their baby.

It was found that low educated mothers were less knowledgeable (P=0.002), more negative attitude ($p<0.01$) and less practiced of EBF up to six months ($p<0.01$). There was no association between current occupation status of mothers and knowledge, attitude towards EBF. But in practice of EBF up to six months, working mothers did EBF up to six months (P=0.049*). There was no association between AN frequency, PN frequency and PN care providers and knowledge of EBF. But mothers who delivered their babies in hospitals had high knowledge (P=0.029). Mothers who had more than one child had more negative attitude

(P=0.003) and who took AN care less than or four times had negative attitude (P=0.015). Mothers who delivered their babies by NSVD were breastfed to their babies within half hour (p<0.01). Mothers whose infants were 1st ordered had less negative attitude (P=0.005). It was observed that low knowledge mothers were less practiced EBF up to six months (P=0.001) and had more negative attitude (p=0.031). And then mothers who had negative attitude towards EBF did not practice EBF up to six months in this study (P<0.01).

56. MATERNAL HEALTH-SEEKING BEHAVIORS OF YOUNG WOMEN IN THE PHILIPPINES

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This study describes and assesses the levels of maternal health-seeking behaviors of young Filipino women 15-24 years old as well as the factors influencing them and the extent to which they compare with that of their older counterparts (i.e. women 25-49 years old). This paper examines the variations in the care seeking behaviors of women during pregnancy, childbirth and postpartum period using specific maternal health indicators.

Using data from the 2008 National Demographic and Health Survey (2008 NDHS), results reveal that in terms of the levels of maternal health-seeking behaviors, young women show significantly different behavior in only one indicator of antenatal care compared to their older counterparts. Particularly, a significantly lower proportion of young Filipino women have their first antenatal care check-up within the first semester of their last pregnancy. In terms of delivery and postnatal care no significant variation is demonstrated.

Bivariate analyses show that maternal health-seeking behaviors of young women vary across selected background characteristics such as parity, household wealth status, education and type of place of residence. The same holds true for older women. Consistent with earlier studies, the proportion of women who have better maternal health-seeking behaviors decreases with increasing parity. Whereas, having a higher level of education, belonging to households of upper wealth status and urban residence are associated with better maternal health-seeking behaviors.

Multivariate analyses reveal that parity, household wealth status, and education significantly influence antenatal care seeking behaviors of young women, but place of residence did not have a significant effect. The same finding holds for their older counterparts. Antenatal care seeking behavior impinges positively on delivery care seeking behavior, and better antenatal and delivery care seeking behaviors redound to improvements in the postnatal care seeking behaviors of both young and older women.

57. Policy Change for Service Provision: Abortion Care by Midlevel Providers

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Introduction: Public health care services in Bangladesh are provided through two separate directorates under the Ministry of Health and Family Welfare (MoHFW). Before 2011, only the Directorate General of Family Planning (DGFP) provided the full range of menstrual regulation (MR), abortion, postabortion care (PAC), and family planning (FP) services; the Directorate General of Health Services' (DGHS) role was limited to the provision of postabortion care. Doctors and Family Welfare Visitors (FWV) of DGFP have been both authorized and trained to provide MR, PAC and FP services, while only DGHS doctors could provide PAC services. This limited and disjointed provision of abortion-related services is likely the reason why a survey in 2010 found that of the estimated 647,000 incidences of induced abortions in Bangladesh, the majority were unsafe (Singh et al. 2012).

Action: Following its inception in 2011, Ipas Bangladesh undertook several initiatives in coordination with the Obstetrical and Gynecological Society of Bangladesh (OGSB) and Ministry of Health and Family Welfare (MoHFW) to increase the role of the nurse cadre of DGHS in abortion-related service provision through task shifting and task sharing. Ipas Bangladesh organized series of meetings with DGFP, DGHS, the Directorate of Nursing Services, and the Bangladesh Nursing Council. As a result of Ipas Bangladesh's and OGSB's advocacy efforts, nurses have been granted permission for having training and subsequently provide MR, PAC and FP services. The MoHFW, in partnership with the Directorate of Nursing Services and DGHS, issued a circular to incorporate MR, PAC and FP services into the nurse job description.

Outcome: Task shifting and task sharing around MR, PAC and FP services in public facilities has supported the government's efforts to improve access to and availability of these essential sexual and reproductive health services in a cost-effective manner. Service data shows that, following the change in job description, nurses have dramatically increased access to MR, PAC and FP services in Bangladesh. Within Ipas-supported primary and secondary level DGHS facilities, nurses are now providing 94% of the abortion-related services and are consistently using appropriate technology. It is hoped that, as nurse trainings are scaled up, the resulting increase in service provision will improve maternal health in Bangladesh.

Discussion and Recommendation: The positive impact of Ipas Bangladesh's successful advocacy efforts on abortion-related service provision adds to a growing body of research around the effectiveness of task sharing and task shifting in increasing access to and availability of high-quality services. When mid-level providers such as nurses are effectively trained and supported post-training, they are equally capable as doctors of providing high-quality MR, PAC and FP services. Organizations working in the health arena should consider advocating, whenever appropriate, for widened scopes of work for mid-level providers. By

supporting task shifting and task sharing, organizations can contribute public health systems in improving their quality of care.

58. Sexual and Reproductive Health Assessment on Thai-Burmese Border

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Background: With the political changes in Myanmar/Burma, access and aid have dramatically increased to the region. However, reproductive health care on the Thai-Burmese border remains in crisis with communities having among the highest maternal mortality rates in the world.

Objective: This study aims to understand areas for intervention to improve access to community-based sexual reproductive health (SRH) services and thereby, reduce maternal mortality. More specifically, we aim to identify key barriers related to access and quality of SRH services among rural border communities.

Methods: Trained health workers conducted qualitative interviews with community members and stakeholders to assess SRH services on the border. Twelve focus group discussions were conducted with local Burmese women of reproductive age with children under five who were likely to have accessed reproductive health services in four townships in Karen/Kachins tate. Additionally, twelve key informant interviews were conducted in the townships with healthcare personnel practicing in each community. Finally, key informant interviews were conducted with stakeholders from 20 community-based organizations to understand the leadership and organizational perspective.

Results: The main barrier to access identified by women included parameters related to cost. Transport, medicines, contraceptives, and consultations costs were prohibitive and limited healthcare seeking behavior. Efforts by the Mobile Obstetric Maternal Health Workers (MOM) Project and others have helped improve pregnancy and delivery care which continues to remain community-based by local midwifes and Traditional Birth Attendants. Access to farther, tertiary facilities remains a challenge due to cost and transportation when complications arise. Family planning has mixed acceptance rates in communities, with no services for unmarried adolescents and women. Finally, other previously reported barriers such as security have improved with peace agreements and political change

Conclusion: Despite many advances, innovative strategies need to be embraced to improve access to sexual reproductive health along the border. Essential public health services need to be community-based and affordable to improve SRH healthcare in the region.

59. "Nothing is lacking in Medicine": Medical Teachers' perceptions on Integration of Gender in Medicine in Medical Colleges of Maharashtra, India

Ameerah Hasnain
CEHAT, Mumbai, India

Gender orientation in medicine has been discussed world over in a number of studies that are suggestive of not only gender bias in doctor-patient relationships (doctors perceiving women's complaints mostly in terms of psycho-somatic disorder, fibromyalgia or reproductive issues) but also how the medical curriculum is devoid of any insights into social dogmas which affect health-seeking behaviours and its outcomes on the health of men and women across communities.

This study emanates from a larger study namely, **Integration of Gender in Medical Education (GME)** undertaken by CEHAT in the year 2011.

Aim of the study is to understand the perspectives of the doctors on whether gender should be integrated in medical education as an important social determinant of health. It is a qualitative study, the data of which was elicited with the help of semi-structured interviews. A total of 60 doctors who are faculty members of Forensic medicine and Toxicology, General Medicine, Obstetrics & Gynecology, Preventive and Social medicine and Psychiatry disciplines in these colleges have been interviewed for the study. The data has been analyzed using the qualitative data analysis software Atlas.ti.

The findings of the study indicate that considerable variation can be observed among departments with regard to doctor's perceptions on gender as a social determinant of health. Firstly, gender was equated to only sex-differentials in health of men and women. For instance, during their pre-service training as doctors, respondents claimed that gender was taught in terms of female-specific (biological) diseases in Social medicine. Secondly, It was largely understood that gender or any other social determinant of health falls within the ambit of Obstetrics & Gynecology and Social medicine, not any other discipline. This understanding also extended to their perception of integration of gender in medical education. So, doctors from Obstetrics & Gynecology and Social medicine could associate more to the idea of having gender in their curriculum than the respondents from Forensics, who claimed that there is no relation of gender with their subject.

The above findings are significant as they reflect the lack of understanding of gender inequities among medical professionals who are educators as well. This lack of understanding is transferred through their teaching to the students who would become the health professionals of the future

60. A Perspective on Gender Equality in Bangladesh: An Urban and Rural Scenario

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Background: Gender discrimination is considered as a tremendous constraint towards the development process. Gender situation in Bangladesh has been changing over last two decades due to considerable economic transition and social change. Although progress has been made in many spheres of social life of women, they still receive less investment for health care and education. This paper has made an attempt to explore the root causes of different perception towards gender in Bangladesh.

Methodology: The paper used the data from a primary survey conducted in both urban and rural areas of two study districts of Bangladesh used a multistage random sampling method. A total 1,037 married women aged 18-49 years were interviewed using a structured questionnaire in order to estimate their gender biasness in family composition. Age of respondents, living children, education, wealth index, exposure to mass media, mobility, self-efficacy, asset ownership and decision-making were considered as independent variables. Both bi-variate and multivariate analyses were used where perspective on gender equality is considered as dependent variable. In this paper the perspective on equal rights and opportunities of gender is exhibited in four dimensions: education, self-esteem, decision-making, freedom of mobility, and control of material resources.

Result: Findings reveal that 54 percent women were gender equitable in urban area and 38 percent in rural area. From bivariate analysis it is found that education, wealth index, number of living children, husband's occupation, exposure to media, mobility, ownership of asset and self-efficacy were strongly associated with perception on gender equality of women in both urban and rural areas. Logistic regression analysis was used to examine the odds of gender equality for each of the potential factors controlling for the others. The results of the regression analysis indicated that the overall model was supported for urban area (R Square = .115, p<.004) and for rural area (R Square = .185, p<.000). Analysis of the significance levels indicated that women who completed primary had a more than three times odds (b = 3.186, p<.01) of equal perception on gender compared to women who never attended school in urban area and in rural area it was more than five times odds (b = 5.377, p<.05). The odds (b = 2.106, p<.05) of gender equality were two times higher among the women who were exposed to media than women who were not exposed. Exposed to media (b = 2.106, p<.05) and Self-efficacy (b = 1.77, p<.01) are significantly associated in urban area. On the other hand besides education and exposed to media, mobility (b = 2.28, p<.00) and husband's occupation (b = 2.49, p<.05) also had significant association with perspective of gender equality in rural area.

Conclusion: The study concludes that education, exposure to information through media have the impact on perspective of gender equality of women in both urban and rural areas. Therefore, effective initiatives undertaken by the concerned govt./non-govt. agencies in

improving women`s education and access to information could enhance women's perception in order to achieve gender equality and development at all levels in Bangladesh.

61. Review of Curricula in the Context of Comprehensive Sexuality Education (CSE) in Nepal, 2014

Manju Karmacharya[1], Latika Maskey Pradhan[2], Josephine Sauvarin[3], Anandita Philipose[4]
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Background: Nepal is a signatory of the International Conference on Population and Development (ICPD) and has endorsed the ICPD beyond 2014 review document, where the need for CSE is highlighted because CSE provides a full range of information, skills and values to enable adolescents to informed choices about their health and sexuality. The rights-based, age appropriate and gender-sensitive sexuality education in a meaningful way, can lead to a decrease in unintended pregnancies and sexually transmitted infections and does not encourage adolescents to initiate sexual activity earlier.

Objectives of the study was to review the status of CSE in Nepal against 6 key concepts of International Technical Guidance on Sexuality Education (ITGSE) –II (2009), UNESCO.

Methodology: This study used mixed approach with an in-depth desk review of the existing curriculum, text books and teachers' guides for Grade 1-10 formal and non-formal education curriculum, and teaching materials for pre-service training (Bachelor Degree in Education) and consultative meetings with experts.

Findings: CSE in Curriculum: The study shows that the inclusion of CSE topics in lower secondary and secondary levels in the formal school system in Nepal is encouraging though it is not as comprehensive as given in the ITGSE. There are notable gaps at the primary school level and inconsistencies in the CSE topics and their links to each grade/age appropriateness, in the six major areas assessed: i. relationships; ii. values, attitudes and skills; iii. culture, society and human rights; iv. human development; v. sexual behavior and; vi. sexual and reproductive health.

CSE coverage in In-service and Pre-Service Training: The most concerning gap in CSE implementation is the lack of trained teachers delivering CSE. Teachers with relevant academic qualification majors (Health and Physical Education; Population Studies by Tribhuvan University) are decreasing in number. This is because of lack of opportunities and absence of compulsory quotas for CSE teachers in public schools.

Out-of School Program: CSE topics are rarely included in out-of-school programs.

Recommendations: There is a need for curriculum revision to ensure consistency of the CSE topics linking each grade with age appropriate and culturally accepted information at the grades specified by the ITGSE during regular 5 years revision cycle. Textbooks and teachers' guides of formal education as well as out of schools' children's curriculum should also be revised in-line with revision of curriculum of CSE.

NCED requires introducing provision of in-service training on CSE as a supply subject to ensure teachers who are teaching CSE without having any pre-service training are trained. Prioritize hiring qualified teachers in Health and Physical education (who have received pre-service training/degree) to teach the subject.

Conclusion: Well-trained teachers with pre-service or in-service training play a key role to deliver good quality sexuality education. Clear sectoral, school policies and revised curricula on CSE help teachers as CSE equips adolescents with communication and negotiation skills that contribute to strengthen overall academic progress and empowers young people to advocate for their own rights.

62. Trend and correlates of modern contraceptive use among married women (age 15-24) in Nepal: An Evidence from Nepal Demographic and Health Surveys

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It is evident that young people (age 10-24), which comprise almost one-third (33%) of Nepal's population faces unique physical and emotional challenges. Early age at marriage and childbearing, sexually transmitted infection and HIV Aids are some problems faced by this group. These problems are considered to be driven by poverty, low literacy level, low level of condom use, cultural and religious factors, and stigma and discriminations. Use of modern contraceptives can prevent unintended pregnancy, early child bearing and their consequences. However, use of modern contraceptive among young people in Nepal is relatively low and least researched. This paper aims to analyze the level, trends and correlates of modern contraceptive use in Nepal. We used data from the three Demographic and Health Survey (DHS) conducted in Nepal in 2001, 2006 and 2011. Non-pregnant young married women age 15-24 were included in the analysis for sample size of 2116 in 2001, 2047 in 2006 and 2060 in 2011. Stata12 was used to run the multilevel logistic regression models to examine the trend and correlates of modern contraceptive use. Modern contraceptive use among young married women increased from 18% in 2001 to 23% in 2006 and slightly decreased to 22% in 2011. The unadjusted logistic regression coefficient indicated that young women were significantly more likely to use modern contraceptive in 2006 (uaOR=1.37) and in 2011 (uaOR=1.33) than in 2001. When we added the individual, household, media exposure and community level variables in the model, the adjusted odds ratio for year was substantially decreased and no longer significant. This result indicated that individual, household and community level variables mediated the effect of year on modern contraceptive use. The adjusted odds ratios further indicated that young women living in urban areas (aOR=1.38), achieving secondary education (aOR=1.29), engaged in business or service (aOR=1.57) and

manual (aOR=2.34) occupation, family planning worker's visit (aOR=2.48) and exposure to family planning information through radio (aOR=1.22) were significantly more likely to use modern contraceptive then their counterparts. Number of living children also increased odds of using modern contraceptive. Although none of the community-level variales (derived from individual characteristics within primary sampling unit) were significantly associated with modern contraceptive use, significant community-level variance remained un-explained in final model, suggesting that community-level variables are also important in predicting modern contraceptive use in Nepal. the model also indicates that 28% of the variation in modern contraceptive use among young married women in Nepal is attributed to commmunity factors. It is therefore concluded that focused family planning program and awareness activities tageting to illeterate women living in rural and underserved areas will help to improve the trend of modern contraceptive use among young women in Nepal.

63. Coverage and compliance to antenatal care services among pregnant mothers in Sri Lanka

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Introduction: Family Health Bureau of the Ministry of Health revised the maternal care package in 2012, based on the external review and to address the gaps in service provision. The findings of this study would enable to identify the level of implementation of the revised package on the service provision of antenatal care, efficiency of service delivery, quality of care and the practices of the clients.

Objective: To assess the coverage and compliance to the antenatal care services according to the revised maternal care package in Sri Lanka.

Methods: Cross sectional descriptive study was conducted among a national sample of 840 antenatal mothers with the period of gestation of 36 weeks or more. Multistage random cluster sampling method was used to identify the sample. A cluster was an obstetric unit in a specialist care hospital and the sampling frame was the ward admission register. A pre tested interviewer administered questionnaire and a data extraction checklist was used to collect data. The study period was from April to June 2015.

Results: The response rate was 99.1% (n=832). The mean age of participants was 28.5 years. Public health midwives had registered 92.4% (n=769) of the pregnant mothers. The average number of clinic visits was 10.3 while 4.0% (n= 34) had not attended any antenatal clinic. The average number of home visits by public health midwife per mother was 3.1 while 13.3% (n=111) had not received even a single home visit. The registration and clinic attendance before 8 weeks of gestation was 47.7% and 35.1% respectively. Majority of the mothers (92.1%) reported that the booking visit was to a field clinic or primary care hospital while 3.7% reported attending to a private clinic.

Referral for specialist care was done for 75.7% (n=630) of mothers and 86.8% (n=547) complied with the reference. Pre pregnancy folic acid was reported by 61.5% (n=512) while 92.8% (n=772) and 90.3% (n= 751) of mothers reported taking iron and calcium tablets during the previous one week. Only 74.0% (n= 616) of mothers and 45.0% (n=374) of spouses had attended at least one antenatal classes.

Record keeping in the pregnancy record, correct management of blood pressure chart and fundal height chart was done only in 73.7% (n=613) and 37.4% (n=311) of pregnancy records respectively. Among the participants 89.7% (n=746) and 88.0% (n=732) had at least a single measure of blood sugar and haemoglobin respectively. Ultra sound scan before 20 weeks of gestation was done among 87.5% of mothers. However, breast examination was done only in 52.3% of mothers.

Conclusion: The national study highlights that the peripheral clinics are still being used as the first contact of antenatal care. The standard antenatal care practices should be further strengthened. The attendance for antenatal classes was low and antenatal record maintenance needs improvement.

Recommendations: Programmatic approach needs to be followed to improve the coverage of interventions. Further, close supervision and monitoring is required to improve the record maintenance.

Key words: Maternal care package, coverage, service delivery

64. Comparison of pregnancy exposures and outcomes of women married as a child versus women married as an adult in rural Nepal

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Introduction
Child marriage has grave consequences for girls' reproductive and sexual health, impeding their overall development and wellbeing. It makes girls vulnerable to sexual and other forms of physical violence and abuse. Despite these adverse consequences, child marriage is particularly pervasive across South Asia including in Nepal where 50-70 percent of girls are married before the age of 18. This paper compares the pregnancy outcomes of girls married as a child i.e. below the age of 18 with those married as an adult i.e. 18 years and above.

Method
Data for this paper is derived from a large scale formative study conducted in six high child marriage prevalent districts of Nepal. Using a cluster sampling technique, 1200 married women aged 24 years and below were sampled from 48 clusters representing the six districts. The clusters were identified through social mapping of communities highly vulnerable to child marriage practices. From each cluster (approximately 100 households per cluster) we

sampled 25 households using systematic random sampling and from each sampled household we interviewed one married women aged below 25 years.We analysed the results using combination of descriptive analysis and logistic regression to compare outcomes that included mean number of pregnancies, exposure to unintended pregnancies, abortion and fetal wastage between women who married as children and who married as adults.

Results

792 women (66.6 percent) were married before 18 years of age. A strong statistical association was found between age at marriage and age at first pregnancy (r=0.642). More than half (58 %) of the respondents marrying as a child reported being pregnant before completing 18 years of age. Mean age at first pregnancy was 17 years for respondents marrying as a child and 20 years for respondents marrying as adults.On average, respondents marrying as a child conceived one additional child compared to women of same age group marrying as an adult. The odds of respondents being a high multipara was 6 times higher in those who married as a child than their counterpart (OR=6.32, 95% CI 1.92,20.8) Nearly a third (30%) of the respondents married as a child reported their first pregnancy as unintended and they were twice as likely to experience such pregnancy than their counterpart (17%)(OR=2.13, 95% CI 1.5,3.03) . Similarly they were also four times as likely than those married as an adult to be pressured into conceiving their first child(OR=3.88, 95% CI 2.13,7.08). Girls from rural areas were more vulnerable to experiencing unexpected first pregnancy and to be pressurised into conceiving their first child. Experience of abortion, still birth and current use of contraceptive however were not siginificantly associated with the age at marriage.

Conclusion

The findings suggest that child marriage is strongly associated with girl's age at first pregnancy, high multi parity, experince of pressure to conceive and adverse pregnancy outcomes. Apart from enforcement of marriage laws, expansion of comprehensive reproductive and sexual health information and services including contraceptives and safe abortion services for child marriage survivors is vital to protect their health and well being.

65. Knowledge, Attitude and Practice related to Sexual and Reproductive Health among adolescents living in urban slum areas in Narayanganj City Corporation of Bangladesh

Helee Choudhury, Maksud Rahman
EPOS Health Management, Dhaka, Bangladesh

Objective: The KAP study has been implemented under the project "Addressing Bangladesh's Demographic Challenges"(ABDC), which focuses on the improvement of Sexual Reproductive Health (SRH) services provided within the Narayanganj City Corporation in Bangladesh. As part of a multiple situation analysis, the KAP survey was designed to enable collection of the baseline information on adolescents' knowledge about

their SRHR and to highlight critical points where action for behavior change of adolescents is needed.

Methodology: The study was a cross-sectional design and used both qualitative and quantitative data collection techniques. The qualitative assessment was among adolescents and gatekeepers.

Findings: A total of 911 adolescents were interviewed. Majority (55.9%) were from the age-group 14-16 years. About 45.4% of the boys and 60.8% of the girls were found to be studying in schools/ colleges.35.5% were found to be working, 77.8% of girls spending their earnings for their parents' family. Less than a quarter of the adolescents were able to identify the common physical changes that occur during puberty. Only 21.2% of boys and 38.1% of girls had heard about contraceptives, among them, the pill and injection were the most commonly cited methods. 17.3% of boys and 11.3% of girls claimed to have ever seen a condom.81.2% were aware of the legal age of marriage for females. 52.5% were aware of the potential risk to the life of young pregnant girls and their babies if married off at an early age.58.2% of adolescents had heard about HIV/AIDS and most of them were aware of the ways of HIV transmission. At the same time, 25.6% had misconceptions related to HIV transmission. Only 2.4% of the respondents claimed to have heard of STIs. Most of the adolescents showed positive attitudes towards sexuality and expressed the view that both married and unmarried adolescents need to know about SRH in order to protect themselves from unwanted pregnancies and STIs including HIV/AIDS. 94.3% of the girl had experienced menstruation; most of them used cloth for menstrual protection which they washed with soap and water and then dried inside the room. Among the boys, 63.3% had ever experienced a wet dream. About 11.1% of the boys had ever had sexual intercourse, among them only 48% used protection during sex.

The analysis of the interviews with the gatekeepers demonstrated that most gatekeepers had misperceptions about adolescents' SRH, although almost all gave the subject much importance. Some gatekeepers agreed that they had limited knowledge about ASRH. They agreed that adolescents should have the right to get information and services related to SRH, also agreed to the need for contraceptives.

Conclusions: The study revealed that majority of the adolescents in the study area did not have adequate knowledge related to SRH. Comprehensive culturally sensitive interventions are therefore deemed necessary in order to ensure ASRH rights and access to information and services.
The results and recommendations of the study are meant to contribute to planning and implementation the interventions and to increase 25% knowledge under the ABDC project of GIZ/EPOS by 2017.

66. Transition in Family Planning Behaviour in India: A Retrospective Cohort Analysis

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International Institute for Population Sciences, Mumbai, Maharashtra, India

India is the first country to adopt the family program in 1952, since after government tried to decrease the fertility levels but still it is the second largest populous country in world today. . The present paper describes in detail one major aspect of the Indian fertility transition: the spread of family planning behavior between 1983 and 2006. We have conceptualize the transition in the control of marital fertility as a process that begins with minimal levels of birth control. Further, this transition takes place both within and across marriage cohorts. Thus, we will be concerned with the cohorts in which given behaviors first occur and both the stage in the marriage history and the period in India history at which they take place. Examination of change over time allows us to look for both period effects and cohort effects. So, We have examined changes in levels of ever- use of FP(contraception, abortion and sterilization) over time and assess impact of martial behaviour. The data from three rounds of National-Family-Health-Survey(NFHS), India conducted in 1992-93,1998-2000 and 2005-06, was pooled to construct marriage cohorts. Six consecutive marriage cohorts were made from 1983 to 2006 which constitute a sample of 1,68,530 ever married women of ages 15-44 years. A trend analysis was performed using Cochran-Mantel-Haentzel (CMH) test on cohorts married. Bivariate and multivariate analysis is done to understand the FP behaviour by marital cohorts.

We have found that ever use of contraception has decreased across the marital cohorts. It is probably most of the women had not completed the reproductive span. While terminated pregnancy and Sterilization has decreased significantly. Ever- use of contraception ranged from 77 percent in the 1983-1986 cohorts after 20-24 years of marriage to 60.3 percent in the 1999-2002 cohorts after less than 15 years of marriage. It is unlikely that the youngest cohort (2003-2006), which just reached 31.6 percent contraception (as opposed to family planning). Ever-use of sterilization ranged from 67.9 percent for the 1983-1986 cohorts to 19 percent for the 1999-2002 cohorts. Very little sterilization occurred before women completed five years of marriage.Results from logistic shows that Contraceptive ever-use has increased significantly, also terminated pregnancy and sterilization has reduced significantly over the period.It was also found that women had started using the contraception when they already had more the two living children and increased as the marital duration increases. As indicated by the ever-use rates, the practice of family planning has almost totally under class barriers. Each cohort adopted FP at a slower rate than the cohorts before it. Succeeding cohorts also began family planning earlier, both in terms of duration of marriage and in terms of number of living children.The cohort trends in adoption rates probably reflect qualitatively different cohort experiences.Period effects were clearly evident in the FP behavior of Indian couples and appear to be stronger than differences among cohorts.The period effect in India was probably produced by the rapid introduction of several modern methods of family planning by a national family planning program.

CHAPTER 3

LIST OF RAPPORTEURS

3.1. List of Rapporteurs

A. Rapporteur General

Dr. Myint Htwe

Chair, Ethics Review Committee, Department of Medical Research, Ministry of Health

President, Preventive & Social Medicine Society,
Myanmar Medical Association

B. Lead Rapporteur Team

National

1.	Dr. Myint Htwe	Chair, Ethics Review Committee, Department of Medical Research (DMR), Ministry of Health President, Preventive & Social Medicine Society, Myanmar Medical Association
2.	Dr. Saw Saw	Deputy Director/Head, Health Systems Research Division, DMR
3.	Dr. Moh Moh Hlaing	Deputy Director, DMR
4.	Dr. Myo Myo Mon	Deputy Director, DMR
5.	Dr. Thida	Deputy Director, DMR
6.	Dr. San Hone	Deputy Director, NAP, Department of Public Health
7.	Dr. Phyu Phyu Thin Zaw	Research Scientist, DMR

International

1.	Prof. Terence Hull	Emeritus Professor, Australian National University
2.	Dr. Rena Dona	Assistant Representative, UNFPA

C. Session Rapporteurs

National

1. Dr. Soe Min Oo	Deputy Director, Central Epidemiology Unit, Department of Public Health
2. Dr. Phyu Phyu Aye	Deputy Director, Maternal and Reproductive Health Division, Department of Public Health
3. Dr. Toe Thiri Aung	Deputy Director, Expended Program Immunization (EPI), Department of Public Health
4. Dr. Khaing Nwe Tin	Assistant Director, Maternal and Reproductive Health Division, Department of Public Health
5. Dr. Myo Myo Mon	Assistant Director, Maternal and Reproductive Health Division, Department of Public Health
6. Dr. Thida Win	Assistant Director, Child Health Division, Department of Public Health
7. Dr. Su Mon Myat	Assistant Director, School Health, Department of Public Health
8. Dr. Win Lae Htut	Assistant Director, School Health, Department of Public Health
9. Dr. Aye Mya Chan Thar	Assistant Director, Expended Program Immunization, Department of Public Health
10. Dr. Nang Cho Nwe Mon	Research Officer, DMR
11. Dr. Kyaw Thu Soe	Research Officer, DMR
12. Dr. Aung Thu	Research Officer, DMR
13. Dr. Yadanar Aung	Research Officer, DMR
14. Dr. Kay Thwe Thwe Mg	Research Officer, DMR
15. Dr. Myo Moh Moh	Lecturer, Department of Preventive and Social Medicine, University of Medicine (1), Yangon
16. Dr. Phyo Maung Maung	Medical Officer, Department of Obstetrics and Gynecology, University of Medicine, Mandalay
17. Dr. Aye Mya Aung	Lecturer, University of Public Health, Yangon
18. Dr. Thiri Win	Assistant Director, Child Health Division, Department of Public Health
19. Dr. Lwin Lwin Aye	Assistant Director, NCD Control Program, Department of Public Health
20. Dr. Thinzar Aung	Medical Officer, Central Epidemiology Unit, Department of Public Health
21. Dr. Ei Ei Maung	Assistant Director, MMCWA
22. Dr.Sein Aung Sein Myint	Program Analyst(Gender), UNFPA Myanmar
23. Dr Sithu Swe	National Program Officer (young people), UNFPA Myanmar
24. Daw Yu Myat Mun	Prgram Analyst (RH/ARH), UNFPA Myanmar
25. Dr. Hlaing Htaik Hta Khin	Coordinator, UNFPA Myanmar

International

1. Ms. Rasheda Khan	Senior Research Investigator, Bangladesh
2. Ms. Enu Anand	Doctoral Student, International Institute for Population Sciences (IIPS),India
3. Mr. Mukesh Ravi Raushan	Doctoral Fellow, International Institute for Population Sciences (IIPS), India
4. Ms. Siow Li Lai	Lecturer, University of Malaya, Malaysia
5. Mr. Jed Patrick Catalan	Doctoral Student, Cebu Normal University, The Philippines
6. Ms. Smriti Thapa	Coordinator, Youth Champions Advocacy Network Nepal (YCANN), Nepal
7. Ms. Shilpa Lohani	Monitoring, Evaluation and Research Officer, Sunaulo Parivar Nepal/Marie Stopes International, Nepal
8. Ms. Sille Jansen	Advocacy, Human Rights &Communication Consultant, UNFPA
9. Mr. Jake Lucchi	Programme Analyst- Adolescents and Youth Asia Pacific Regional Office, UNFPA
10. Ms. Nur Hidayati Handayani	Coordinator, Gue Tau, DKI Jakarta, Indonesia

Coordinators

1. Dr. Phyu Phyu Thin Zaw	Research Scientist, DMR
2. Dr. Ei Ei Maung	Assistant Director, MMCWA
3. Dr. Thinzar Aung	Medical Officer, Department of Public Health

3.2 Guideline for Rapporteur Team

To synthesize issues raised and their suggested solutions in the conferences together with record policy recommendations to be further call for action, rapporteur team are a key function of 8th APCRSHR. There are two team of rapporteurs, including lead (conference) rapporteur team and (session) rapporteur team. The lead rapporteur team will finalize summary of the conference gathering from all conference sessions.

Each session rapporteur team is composed of three rapporteurs. One of them will be a focal point compiling abstracts of session and summary records from the team and sending the final version to lead rapporteur team. Expected deliverables, action, flow chart of activities and templates for session abstract and summary records are provided below.

A. Lead Rapporteur Team

Expected Deliverables

1. Synthesize and reach consensus among the team on the final text focusing on issues arose, solutions and recommendations from all sessions of the Conference (Plenary, Parallel session) to be reported in the Conference Session.
2. Synthesize and finalize the rapporteurs' report for 8th APCRSHR 2016.

B. apporteur Team

The Rapporteur Team consists of one international and two Myanmar colleagues. The team of three has to produce (1) abstract of the session and (2) summary record. Each team needs to select the focal point. The focal point is responsible for compiling deliverables.

Expected Deliverable

Abstract of the session - in electronic file, word document format, not more than 500 words. This abstract should include the following topics:

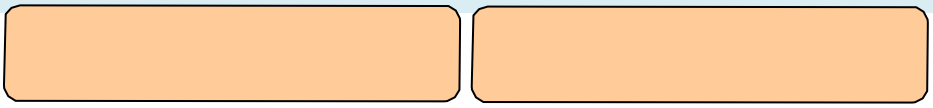
- Key messages from the presentations
- Major problem and issues raised / discussed by participants
- Suggested solutions which should reflect from both pro and con

The template of the abstract is provided [see Template]. This abstract will facilitate the preparation of the conference synthesis on. The electronic file of the abstract should be saved in word file (MS Word). The file should be named as follows: **Abstract Plenary Session xx, Abstract PL No., Room No.**

The focal point of each rapporteur team is requested to submit their expected deliverables to Lead rapporteur team at email by 19:00 hrs of the first and second day and 14:30 hrs of the last day. Please avoid submission by handy drive as computer virus could be spread widely.

Flow Chart Responsibilities of Session Rapporteurs and the Lead Rapporteur Team of 8th APCRSHR

Session type	no. of session	room	total	all sessions	Rapporteur team (Trio)
Plenary	**4**	**1**	**4**	**4**	**32 (X3)**
Parallel Sessions					**(Inter = 10)**
1st PL		**7**		**7**	**(Myanmar = 25)**
2nd PL		**6**		**6**	
3rd PL		**6**		**6**	
4th PL		**9**		**9**	



Session Rapporteur Team

(Rappoteur 1, 2, 3)

Abstract (≤500 words)

Focal point of each session to submit the abstract record to the Lead Rapporteur Team via email by **19.00 hrs** of the first and second day and **14.30 hrs** of the last day

Lead Rapporteur Team of 8th APCRSHR 2016

at email: rappteam.8apcrshr@gmail.com

2. ppt file of the synthesis to be presented on Day 4 (4th PL: 14:00-15:30 hrs

Template

Abstract Plenary Session xx, Abstract PL,No., Room,No.

Title

……..……
……

Session Rapporteurs

1. ……[Focal Point]
2. ……..…..
3. ……..…..

Guidelines

- This abstract will facilitate the preparation of the conference declaration on 26th February 2016.
- The abstract should not greater than **500 words**
- Please use word document, kindly save word2007 version
- naming file: Abstract Plenary Session xx, or Abstract PL,No., Room,No.
- The abstract should include three following topics:
  A. Key messages from the presentations
  B. Major problem and issues raised / discussed by participants which should reflect both pro and con
  C. Suggested solutions which should reflect from both pro and con

  Other important issues could be noted for example the involvement of stakeholders.

-Not later than ---- hrs of the first and second day and ---- hrs of the last day; the focal point of each session should submit the abstract to the Lead Rapporteur Team of 8th APCRSHR 1……2……3……

Word count: ……

A. The Key Messages from the Presentation

B. Issues raised or discussed by participants

C. Suggested solutions

3.3 Rapporteurs Trainings

1. **Number of Trainings : Two**
2. **Training schedule**
   a) **First Time Training**
   Date : 16.2.2016
   Time : 9:00 am to 12:00 Noon
   Place : CEC Function Hall, MMCWA, Nay Pyi Taw

   All Myanmar rapporteurs attended this training.

   b) **Second Time Training**
   Date : 23.2.2016
   Time : 1:00 pm to 2:00 pm
   Place : Rapporteurs' Room, MICC II, Naypyitaw

   All Myanmar and International rapporteurs attended this training.

3. **Training agenda**

Item 1.	Welcome speech	H.E. Dr. Thein Thein Htay, Deputy Minister, MOH
Item 2.	Welcome Address and Conference Overview	Daw Thazin Nwe, President, MMCWA
Item 3.	Opening Remarks	Dr. Yi Yi Myint, Chair, Scientific Committee
Item 2.	Background and Objectives of 8th APCRSHR	Dr. Saw Saw Lead Rapporteur/Deputy Director, DMR
Item 2.	Introduction • Role of Rapporteur • Expected Deliverables	Dr. Phyu Phyu Thin Zaw Lead Rapporteur/Research Scientist, DMR
Item 3.	Walk through 8th APCRSHR conference program • YOUTH CONFERENCE • DAY 1 • DAY 2 • DAY 3	Dr. Ei Ei Maung Coordinator
Item 4.	• Proposed content of conference proceeding • Preparation for the second meeting • Nay pyi Taw Declaration	Dr. Phyu Phyu Thin Zaw Lead Rapporteur/Research Scientist, DMR
Item 5.	General Discussion	

Chapter 4

RAPPORTUERS' REPORTS

4.1. Rapporteur General's Report

Rapporteur General's Report reading at the closing ceremony of 8th APCRSHR (26/2/2016)

After an excellent entertainment, what I'm going to do is another spectrum. I hope you will not be disappointed because you've enjoyed a lot.

The reason why we had invested so much money, manpower and technician for this conference, we deserved to declare the report. I would like to request all the attendees from Asia and the Pacific region to take serious consideration on this report as well as the commitment that we are going to presented after my report.

On behalf of the rapporteur group, I would like to thank the Patrons and Chair of MMCWA, Daw Thazin Nwe, National Advisory Group, Dr. Thein Thein Htay and patrons, National Steering Committee (NSC) members and also the chair of the scientific committee, Dr. Yi Yi Myint, Organizers of the conference, International Scientific Committee (ISC) members. I'd also like to thank to international and national rapporteurs who give so much time and seriousness in preparing this report. I hope you will bear with me when I read this report. I think it is not much time. Here I also would like to mention the fact that the seriousness of our young rapporteurs, Doctors and research scientists from Department of Medical Research (DMR) and also the professionals from Department of Public Health (DoPH). They are really the people who will lead the MOH in the years later. On top of that, the young children you've just seen, this conference is especially for them. SRHR when they grown up, so in fact, we are working for the young children.

This report is just the short synthesis of the salient points of the conference. I would like to mention one factor that the number of participants are so many and that they may not be able to attend each and every session. Therefore, this report will be of sum use to them.

The 8th Asia Pacific Conference on Reproductive and Sexual Health and Rights was conducted in this MICC –II, Nay Pyi Taw from 23rd to 26th 2016. It was opened by the Vice President of the Republic of the Union of Myanmar followed by key note addressed by the Executive Director of UNFPA and also by the President of Malaysia AIDS Council. The technical sessions started with the welcome speech by the president of MMCWA and the key note address by WHO representative in Myanmar. The theme of the conference was "**Ensuring universal access to SRHR for sustainable development in Asia and the Pacific**"

The conference was sponsored by 13 Implementing Partners as mentioned in the last page of the conference book. The conference was conducted with the following objectives;

(i) To provide a platform for SRHR stakeholders to share successes and lessons learned to identify and agree on priority actions to advance universal access to SRHR for sustainable development;
(ii) To review cutting-edge research findings on SRHR;

(iii) To share evidence-based practices in advocacy, policy, financing, governance & accountability, SRHR program integration in health systems; and

(iv) To strengthen partnerships and open opportunities for new alliances in SRHR.

The conference methodology consists of plenary sessions, parallel sessions, satellite sessions, skill workshops, symposia, poster presentations, field trips and learning booths.

A. PLENARY SESSIONS.

There were 4 plenary sessions and 13 presentations were made. Three presentations were made under the rubric of Health Rights for all: Towards enabling Laws and Policies and SRHR. **The key messages of this plenary session are**

- Many countries have mismatches between SRHR policies and their implementation
- Poor knowledge of community & family members on SRHR issues is a barrier for young people to access SRHR services
- Many countries have signed several international treaties like CEDAW, ICPD & BPFA. However, there had not been much changes in terms of national policies, laws, regulations & practice in real situation.
- Women rarely have rights on their own bodies.
- Inter-sectional, equitable & life cycle approach focusing on family will automatically ensure SRHR for all.
- Any developmental work related to SRHR in any country should not be hampered by natural disasters, conflicts, & change of government.
- Ensure meaningful engagement & empowerment of young people & women so that they value themselves & can aspire their dreams.
- Participation of all actors including, religious & community leaders, policy makers & law enforcement bodies rather than health sector alone is required to ensure SRHR.
- Collaboration among all stakeholders including local & international NGOs & CSOs (public private partnerships) is important for sustainability of the achievements.
- Policy advocacy & policy dialogues should be in place appropriately to ensure SRHR.

Three presentations were made under the rubric of **Governance and Accountability**.

The key messages of the session are

- Making political leaders accountable to SRHR by way of feeding evidence- based information, especial economic and health benefits
- Leadership transformation of local parliamentarians to influence on the local health system must be encouraged
- Generate or reinforce strong political will to parliamentarians for promoting SRHR as they are key persons in our endeavor to advocate SRHR
- Multi-prong strategies involving multi-disciplinary, multi-institutional, multi-sectoral, multi-party, multi-ethnic approaches may be considered to propagandize SRHR
- Leadership transformation of parliamentarian members & creating sense of ownership, co-ownership and co-creation for SHRH activities must be promoted.
- Special programs for rural poor aiming for obtaining better health outcomes especially for maternal & reproductive health may be considered
- Role of Regional Health Directors is key in promoting SRHR issues
- Members of local women associations must advocate their respective duty bearer husbands (local authorities) for SRHR issues
- Men or husbands must play a proactive role in SRHR issues & they should listen to their wives' ideas on SRHR

Then, three presentations were made under the rubric of **Health Justice: Towards Sustainable SHRH Financing .**

The key messages of the session are

- FP is a universal value to human development
- Revenues from taxes to finance different insurance models can address needs of poor and vulnerable
- Increase the fiscal space for RMNCAH
    - Increase government revenue
    - Re-prioritization
    - Health sector specific resources
    - Development assistance
    - Efficiency gains: better use of existing funding
- Empower people & strengthen institutions & engage stakeholders in ASEAN processes
- Require solid enduring foundation of funding sources (not subject to political disruption; not subject to rescission as a human right; not marginalized by shifting health priorities)

The final plenary session had four presentations were made under the rubric of "**SRHR Integration in Health Systems**".

The key messages of the session are

- Policy, financing and service delivery should be service centered, not system centered, not just combining services under one roof
- Most policy are in place but not acted upon
- Advocacy must be strongly evidence based
- Vertical funding of development partners need to be readjusted so that resource allocation becomes rational & equitable
- Task shifting is one option for consideration while integrating SRHR into the health system
- How should SRHR be integrated into each stage of the life course is important in order to achieve continuum of care

B. PARALLEL SESSIONS

After the plenary sessions, there were parallel sessions. A total of 83 papers unbelievable were presented under the 26 rubrics during four parallel sessions.

Parallel Session I. Track 1, Health Rights for All: Towards Enabling Laws and Policies for SRHR.

Highlights of the sessions

Twenty-one parallel papers covered a wide range of topics to demonstrate that rights go beyond issues of law and regulation to include the geographic and financial challenges that governments face.

Ministries of Health, Home Affairs, and Family Welfare need to ensure that their citizens have access to quality, respectful services.

Changing laws regarding marriage age, accessible RH services, and protection of vulnerable groups may be vital, but they will only be effective if they are accompanied by investments to achieve implementation, and supervision to guarantee respectful administration.

Key issues raised from the floor included

- Concern over growing intolerance in some countries to the detriment of sexually active, young unmarried people, and people identified as LGBTQI.
- It is the duty of government to protect their rights, but instead moralizers use the instruments of government to persecute them.
- Gender based violence is widely understood to be a threat to the rights, and the safety, of women and children, but in most Asian and Pacific societies the persistence of patriarchy undermines efforts to prevent domestic violence.

- At times, the authorities charged with protecting women are themselves perpetrators of violations of existing laws, and are tacitly protected by patriarchal legal institutions.

In summary, the discussions carried out in the seven parallel sessions highlighted the importance of national recognition of SRHR as explicit, and universal rights in modern societies.

Parallel Session II, Track 2, Governance and Accountability

The second parallel session is **"Governance and Accountability**".

Highlights of the sessions

- The structures and functioning of the governments have a crucial impact on the reach and success of sexual and reproductive health strategies
- The plenary speakers and 17 parallel papers reminding participants that non-governmental and private organization can be a catalytic role in expanding and improving SRHR
- The experience to date of the impact of such initiatives has been mixed.
- On the one hand energized and focused activities of strong businesses and NGOs can offer efficient service, while on the other hand decentralized government structures can prevent consistent implementation of central government policies. Governments and business appear to work most effectively in addressing a common goal during the time of natural disasters; so that point the immediacy of need outweighs any sense of competition.
- For effective collaboration in normal times there must be effective, mutually respectful communication between government officials and members of civil society. The voices of service consumers are influential in the design and monitoring of SRHR service provision. The cornerstone of human rights is tolerance.
- All these highlights and the facts are based on the research findings presented by all the papers presented by very experienced researchers.

Parallel Session III, Track 3, Health Justice: Towards Sustainable SRHR Financing

Highlights of the sessions

- For large portions of the population SRHR services are beyond reach because of cost, distance or social marginalization. Twenty presentations reviewing the experiences of programs grappling with these challenges were able to identify a range of interventions that draw services closer to people, and empower people to access services.
- Workers at the vanguard of these efforts include logisticians, whose task it is to ensure that equipment, drugs, and supplies are delivered in a timely and safe fashion. Their responsibilities are often undervalued.
- This is why it is vital to carry out routine logistical mapping, continuous up-skilling of logistical staff and comprehensive cost-benefit analysis of all corners of the health services system.
- Case studies of service provision in times of natural disaster serve as timely reminders of the importance of building strong financial-logistical systems during times of normality.

Parallel Session IV, Track 4, SHRH Integration in Health systems

Highlights of the sessions

- Information and education are the bricks and mortar integrating different elements of health systems.
- The 28 parallel papers show how across the Asia Pacific region innovative practitioners are using schools, radio, television and direct training to promote healthy practices and effective cures for a range of SRHR problems.
- Interestingly, despite a common reference to "tradition" to justify limiting access of young people to SRHR and stigmatizing LGBTQI people, the religious, cultural and economic scenarios across nations are remarkably heterogeneous.
- It appears that the common denominator blocking better health is fear of change.
- The SRHR agenda, like other key elements of promoting welfare, demands that governments and communities work to move from fear of change to effective management of change for better health systems.

I would like to mention that two symposia were conducted. One on **"Advocating for youth SRHR and access to FP: Report from Bali and the road to SDGs".** Second symposium is on "**Moving from MDGs to SDGs for improving maternal and child health".**

Eight satellite sessions were held. The titles of satellite sessions are

1. Skills Marketplace
2. Breaking barriers: Advocating Sexual and Reproductive Health and Rights in Myanmar

3. Engaging “Su Su”: Using social marketing and social franchising to expand access to family planning in Myanmar
4. The Link Up program: addressing the sexual reproductive health and rights(SRHR) needs of young key populations in Myanmar
5. Saving the lives of Mothers and Newborns through Support to Emergency Referral Services across 5 States/Regions in Myanmar
6. FP 2020: Tune in to Myanmar’s Action Plan to deliver as promised
7. It’s Worth Doing Right: Quality of Care in Contraceptive Service Provision
8. AY Leadership is learned: A Staged and Systematic Training using Blended Learning Modalities

A total of 90 posters were shown by 17 countries. Six Field visits were made. One official Gala Dinner was organized by the organizer. The participants were entertained one Myanmar National Costume Show.

Conclusion

In conclusion, the conference can be regarded as a successful one and the achievement of objectives is an acceptable level of satisfaction. This is due to the following factors:

- Active participation of distinguished participants
- Sense of ownership of the conference by the participants
- Evidence based discussion points and presentations, research findings are real beneficent to Asia-Pacific Region
- Researchers are appeared to be technically of very very high quality
- Sessions are well run by experienced moderators and chair persons
- Well reporting national and international rapporteurs
- Efficient logistics and administrative support by the organizers

I would like to thank you for your attention. Thank you very much.

4.2. Sessions Rapporteurs' Reports

First Plenary Session

"Health Rights for All: Towards enabling laws and Policies for SRHR"

Date - 24-2-2016

Venue - Plenary Hall, MICC 2, Nay Pyi Taw

1. Title of Session: **"Health Rights for All: Towards enabling laws and Policies for SRHR"**
2. Presentations and presenters:
   a) Young people and the law – Looking at the legal and policy barriers for young peoples' SRHR in the region: Ms. Justine Sass
   b) Rights and empowerment in SRHR – The timeliness of this conference in terms of reflecting and evaluating the progress/achievements in fulfilling SRHR dreams and goals: Ms. Ninuk Widyantoro
   c) Reproductive health and policy and FP2020 with special focus on Myanmar Experience: Her Excellency Dr. Thein Thein Htay
3. Moderator: Mx. Mario Balibago
4. Rapporteurs
   (1) Dr. Khaing Nwe Tin (Focal Point: Maternal and Reproductive Health Unit, Department of Public Health, Myanmar)
   (2) Dr. Myo Myo Mon (Maternal and Reproductive Health Unit, Department of Public Health, Myanmar)
   (3) Rasheda Khan (icddr,b, Bangladesh)

A) The Key Messages from the Presentation

Several key messages came from the plenary session to enhance the SRHR issues. It is mentioned that many countries have mismatched SRHR policies and their implementations along with community/family members' poor knowledge on SRHR issues work as barriers for young people to access SRHR services. They also mentioned that many countries have signed different international treaties like CEDAW, ICPD & BPFA, however, there has not been much changes in terms of national policy, laws, regulations and practice in real situation. Last but not the least, they also think that women rarely have rights on their own bodies. Sadly, worldwide political and social issues strategize women's biological and mental health which are hugely violating/manipulating women's SRHR needs and rights.

B) Major Problems and issue raised

One of the major issues raised towards the speakers was that while the core idea of 'Health Rights for All', why do we keep on suggesting focusing on women, girls and young people(certain groups). The responses were that nobody should be leaving behind in terms of accessing SRHR services, however, focus should be more on vulnerable/underserved groups i.e. women, young people and children who have been neglected for years. The speakers mentioned about inter-sectional, equitable and life cycle approach focusing on family which will automatically ensure the SRHR for all.

Another major issue was about the sustainability in advancing and gaining the goals of SRHR for all and the contributions of UN organizations in this respect. The speakers think that UN should be careful so that any developmental works related to SRHR in any countries do not get hindered by natural disasters, conflicts, Govt. change and so on.

C) Suggested solutions

It is now paramount to focus even more on women, girls and young people to ensure their health rights especially SRHR. It is also important to recognize the capacities of young people and continue the fighting to ensure meaningful engagement and empowerment of young people and women so that they value themselves and aspires their dreams. To make all these to happen, it is needed to strengthen the participation of all actors including, religious and community leaders, policy makers and law enforcement bodies rather than health sectors alone to ensure SRHR. In addition to this, collaboration among all stakeholders including NGOs and CSOs (public private partnerships) is important for sustainability of the achievements. Last but not the least, policy Advocacy/Dialogue should be placed appropriately to ensure SRHR.

First Parallel Sessions:

Track (1): Health rights for all: Towards enabling laws and policies for SRHR

Room 1

1. **Title : " Forced, Forbidden or failed: Sex and marriage laws in Asia-Pacific"**

2. Papers and presenters:

a) Ensuring the Reproductive and Sexual Rights for child brides in Rural India: Looks like a way too far!
Aparna Mukherjee, India

b) Preventing child marriages in India: whether financial incentive schemes help in enhancing the age at marriage of girls?
T.V. Sekher, India

c) Policy Options for Teen Pregnancy Prevention in the Philippines
Reynaldo Ong Wong, The Philippines

3. Session Rapporteurs

(1) Dr. Thida Win
(2) Dr. Su Mon Myat
(3) Ms. Enu Anand

A) Key Messages:

In India, there are child brides problems and there should be targeted programs by the state for this specific sub-population. Women can have better Reproductive health if there is any nearby health facility, better educated and non-alcoholic husband, and she herself is financially empowered. There is a need to re-inforce laws and programs against child marriage. To address the needs of young women they should be provided with larger reproductive choices and sexual rights.

Financial incentive schemes prove to be beneficial in prolonging the education and age at marriage of girls. Beneficiary girls whose parents got financial incentives were better in education and had delayed marriage age than the non-beneficiary girls whose parents were not enrolled in any financial incentive scheme.

Teenage pregnancy is a government failure to make policy intervention.

B) Issues and Problems raised:

In-spite of legal marriage age laws, there is high prevalence of child marriages in rural India; may be due to non-reporting and inadequate punishment. Adolescent mothers are not specifically addressed in major schemes.

Due to unequal gender norms, government started providing financial incentives to the parents of the girl child at various stages with certain criteria and it proved out beneficial for the girl child. But we are unsure how long this conditional cash transfers can sustain.

Teenage have limited information on ASRH due to inadequate sexuality education and they have no information on how and where to get ASRH information. Teenage are unable to

obtain lifesaving SRH services due to strict laws in Philippines. Due to accessibility to cellphones and internet teenagers are actively seeing sex-videos.

C) Suggested Solutions:

Child brides should have proper accessibility to health services and should be economic empowered. Social support to the child brides can ensure better SRH. Promoting education and gender norms in the society is suggested for their welfare. The needs of young women can be fulfilled through awareness programs, door-to-door dissemination of information, strengthening the field health workers to popularize pro-gender attitudes towards Sexual and reproductive health and rights which can enable them with better choices and secure a healthy life for themselves and their children.

These type of programs cannot sustain if policymakers are not well informed about the benefits of the scheme. Incentives can play an important role in girl's initial years of age. Better design, better targeting, proper implementation of the scheme required at the society level to remove gender barriers.

Teenagers can be reached through multi-modal means like responsive school, clinics, and technology mediated services. And the service should be accessible to the teenagers easily and conveniently.

Room (2)

1. **Title : "Improving access for hard to reach populations"**
2. **Papers and Presenters**
   a) Ethnic Minority Midwife Initiative in Difficult-to-Reach Regions of Vietnam
   Dat Duong, Viet Nam
   b) Mapping Technique for Assessing Maternal and Child Health Service Coverage
   Kyaw Myint Tun, Myanmar
   c) Traditions and Current Practices of Emergency Obstetric Care among Chin Ethnics in Myanmar
   Swe Zin Linn, Myanmar
3. **Session Rapporteurs**
   (1) Dr Win Lae Htut [Focal Point]
   (2) Dr Aye Mya Chan Thar
   (3) Mr. Mukesh Ravi Raushan

A. Key Messages from the presentations

During last decades, health sectors can reduce MMR and try to reach MDGs target by health system strengthening. However, there is still gap in healthcare access between ethnic minority in hard to reach area and major ethnic population. Most frequent barriers for healthcare assess among those population are difficulties in reaching health centers and cultural constraints. Hence, recruitment and retention of locally acceptable village based ethnic minority basic health staffs by initiating training programs for them. Political commitment for long-term investment and evidence-based advocacy are needed for sustainable development of EMM in hard to reach area.

One of the hard to reach population is migrant people. Evidences show health care access among migrant population is much less than other. Hence, health care access among migrant population is a major consideration for universal health coverage. Therefore, there is need for comprehensive techniques to investigate the geographical location and health care coverage among risky population such as migrant population so that we can provide evidence based information to policy maker for appropriate mobilization of scare resources in the most effective way.

In hard to reach area, traditional ways of health care is very common due to difficulty in access to modern health services. Especially, in child delivery, traditionally birth attendant are very common and accepted by local people in hard to reach are. Although, government strengthened emergency obstetric care services to reduce MMR, most of the deliveries in hard to reach area are attended by TBAs and treated by traditional ways. Hence, in order to provide evidence based information of such practices more research and investigation should be encouraged. Therefore, TBAs should be integrated into modern medical practices by incorporating skilled training and good communication practices.

B. **Major problem and Issues raised/discussed by participants**

1. In order to improve the maternal health not only quantitative achievement in health outcomes but also qualitative improvement should be taken into account in general especially in hard to reach area. Therefore, as a methodology is concern for the qualitative assessment for maternal health services, there is a need to develop a measurement technique.
2. How to assess and measure the distribution and healthcare access of migrant/mobile population especially for maternal health?
3. There is a need standardized selection criteria for ethnic minority midwives for better long term outcome.
4. There is urgent need for new healthcare strategy for specific population such as mobile population.

C. Suggested Solutions:

1. Encourage qualitative studies on maternal health care services.
2. Planning of special healthcare programs for specific population.
3. Review, monitor and evaluate the studies related to maternal health services for population at risk such as in hard to reach area population.
4. Possible and feasible policies for implementation of maternal health services in particular setting such as migrant population.
5. Special training on safe delivery for TBA especially in hard to reach area.

Room (3)

1. Title**: "Transitioning from policy to practice"**
2. **Papers and Presenters**
   a) Current legal and policy frame work for Sri Lankan youth on sexual health & HIV infection
   Janaki Vidanapathirana, Sri Lanka
   b) The Right(s) Evidence: Sex work, violence and HIV in Asia
   Julia Cabassi, Kay Thi Win, Thailand
   c) Analysing system's bottlenecks for integration of PMTCT into regular antenatal care services - A case study from West Papua Indonesia
   Nurlely Bethesda Sinaga, Indonesia
3. **Session Rapporteurs** :

   (1) Dr Kyaw Thu Soe (focal point)

   (2) Dr Nang Cho New Mon

   (3) Ms. Siow Li Lai

A. The key messages from the presentation

- There are legal barriers to accessing RH services in Sri Lanka especially homosexuality, LGBT community, brothels and vagrants ordinance issues. Comprehensive sexual education is not included in school curriculum. Among the youths, there is poor knowledge on RH and cost barriers to access RH services
- The four countries (Indonesia, Myanmar, Nepal, and Sri Lanka) multi-centered studies show violence are done mainly by police and clients to the sex workers. It critically limits sex workers ability to negotiate condom use in Asia. Factors to decrease violence involve making laws, law enforcement practices, safe sex work setting, and collectivization impact sex workers' safety in Asia. It recommends to reform laws, policies and law enforcement practices in Asia. The speaker wants the audience read the reports which is published online. Challenges are to advocate the evidence to change. Results are pain of the sex workers, life of the sex workers. Sex workers have the rights to free from violence like other human being. Challenges of the research are the priorities of sex workers, and reading the quality of interviews for four countries. The purpose is to understand the solutions, the risk factors, and the protective factors on how to prevent violence on sex workers.
- Bottle necks analysis show low coverage of HIV tested pregnant women in Indonesia, the stock out of logistic supplies, overlapping of reporting line. Solved by a model "breakthrough activity, provision of test kids in remote areas, decentralization of ARV treatment, integrated reporting line". This model (research-based monitoring) will help cities with large populations with rapidly increasing HIV prevalence. Lesson from the studies: need efforts to give protection to mother and child.

B. Issues raised or discussed by participants

1. What are the best laws and policies for young people (by UNFPA)?
   Majority laws have no linkage between governments and youth sectors especially education sectors. Therefore there is a need to develop the linkage.
2. Among 4 countries, what actions are taken after the researches (violence among sex workers) (by UNFPA)?
   Sri Lanka: There are lots of discussions after the research, and basically there is a good support. Develop many programs to train the police. Myanmar: Develop action plan including legal counseling for sex workers with the help of NGOs. Indonesia: provides legal services (hotlines) and legal counseling.
3. Different types violence on sex workers?
   Types of violence include economic, physical, sexual, and mental violence. Street sex workers are the ones who are most vulnerable to violence.
4. What types of sex workers according to the studies?
   Generally there are street based, brothel based, Karaoke, and massage bars, and freelance sex workers.
5. What are the factors related to not having comprehensive sexual education in Sri Lanka?
   It is the optional subject, and the curriculum includes being faithful to the partners. There is a need to produce culturally appropriate sex education.
6. What are the reasons not using the HIV (PCR) tests?
   Due to the complexity of the diagnostics tests. No agreement between policy makers, problems of ownerships, starting only at the age of 18 months (for babies), and cannot conduct properly (cannot collect blood samples properly).
7. What are the implications for de-criminalization's of sex work (prostitutions)?
   Eg. in New Zealand , there is de-criminalization of prostitutions. It has much impact on reduction of violence. Policy makers afraid that there will be increasing in sex work. But there is no evidence. Legal approach eg. Red light areas don't work to reduce violence because the sex industries are outside those areas.
8. Is that provision of condoms safe to the young in Sri Lanka?
   Not prohibited to use condoms. They are provided. But they are afraid to use because police will take action. Proportion aged 15-24 getting HIV is increasing due to cultural norms (not using condoms).

C. Suggested solutions

1. Chair suggested initiation of legislative bodies to protect the sex workers, and the law to prevent violence against sex workers. There is a need to understand from the government's side what to resist and to concern to get the right results.
2. The conference should invite the legislative bodies to obtain good suggestions from them.
3. There is a need to improve PMCT coverage.
4. National HIV strategic plan, Sri Lanka, has free health services to everyone (no discrimination). However, no sexual education in the country. Information on transgender is not collected because it is restricted in schools. Between age 16 and 18, they cannot use condoms, because the legal age of marriage is 18.The condom use differentials is large across educational groups.

5. There is a case that brothels are breaking down. The sex workers are driven into the street.
6. There is a challenge to transform policy into practices. We've learnt a lot of ways. The government will benefits from the UN's contributions. There is a need of government to concern, and to ensure.

Room (4)

1. **Title: "Health rights for all: Towards enabling laws and policies for SRHR"**
2. **Papers and Presenters**
   a) Ready for the Second Child? Beijing's Maternal Health Care Services after Selective Two-children Policy
   Zhuoyan MAO, China
   b) Attitudes of Adults Concerning Induced Abortion and Abortion Law - A Community Based Study in Colombo City of Sri Lanka
   M. Suchira Suranga, Sri Lanka
   c) Access to safe abortion for women with unwanted pregnancy: Attitudes of opinion leaders, policy makers and health professionals in Yogyakarta Indonesia.
   Mrs. Purwantining Tyas Fitri Kawuri, Indonesia
3. **Session Rapporteurs**:

(1) Dr Yadanar Aung (focal point)

(2) Dr Aung Thu

(3) Mr. Jed Patrick Montero Catalan

(4) Ms NH Handayani

Chairs Remarks:

- The Chinese government should welcome the second child's policy
- Abortion laws and policies need to reform, different countries have different concepts, criteria setting, and priorities which not same in the global. We need to consider our own setting and good platforms.

A. The key messages from the presentation

1st speaker:

- 60% caesarian for the first child impacted the decision of having the natural delivery for the second child which increases the factor of maternal mortality
- The people eligible for the 2nd child policy did not access the free service from the government
- 90 million people are eligible for the 2nd child policy

2nd speaker:

- The rank of abortion acceptance attitude from the highest to the lowest: save live of mother, rape, incest, fatal abnormalities lethal condition, fetes may survive, contraceptive failure, and economic condition, on the request of cope, on the request of women.
- Ethnicity, religion, age, years of formal education, marital status and number of living children were identified as the factors associated with respondent's attitude on induced abortion

3rd speaker:

- No follow up after the decree of PP no. 61/2014 such as operational at provincial and district level

- Emergency contraceptive is similar to abortion (policy maker and community leader's view)
- Adoption is more preferable than abortion

B. Issues raised or discussed by participants

- Unmarried couple's access of contraceptives and abortion is limited in Indonesia and Sri Lanka
- Abortion is looked as a shameful act by the women who had abortion in China
- 80% married couple used condom but the failure of contraceptive is high in China
- Despite of the numbers of related studies existing on abortion in Sri Lanka, there was no clear action plan done by the government
- Suggested the legal safe abortion policy in Indonesia

C. Suggested solutions

- Provision of maternal health care services pre-pregnancy, mid-pregnancy and post-pregnancy: Need to have examination and health counselling (before delivery) and need to have the consultation on the procedure of reproductive service certification (after deliver) in China
- Provision of space for breast feeding in public in China
- Prevention of unwanted pregnancies and sensitization of the society about the issue of illegal abortion through continuous awareness and advocacy programmes, remain as the key strategies to prevent unsafe abortions and their complications in Sri Lanka
- Follow up PP 61/2014 on the ministerial level and at the level of local regulations need to be drafted; synchronization between the existing rule with PP for the definition of rape and rules that allow abortion; Increased knowledge, sensitivity and the ability for police officers and medical staffs; Strengthening of networking of institutions and activists to advocate SRHR education and services in a comprehensive and integrated SRHR for youth and people with disabilities in Indonesia

Room (5)

1. Title **: "Overcoming challenges to SRHR in Asia –Pacific"**
2. Papers and Presenters
   a) No sexual citizenship for a Katoey in the state of Thailand: Problems and needs caused by absence of gender recognition by law
   Ronnapoom samakkeekaro, Thailand
   b) Indonesian LGBT Advocacy and Education through Films and ICT
   Julia Suryakusuma, Indonesia
   c) Social Suffering and Sexual Reproductive Right of Women with Disabilities: A National Study in Thailand
   Penchan Pradubmook, Thailand

3. **Session Rapporteurs**

   1) Dr. Kay ThweThweMaung [Focal Point]
   2) Dr. Myo Moh Moh
   3) Ms. Smriti Thapa

A. The Key Messages from the Presentation

- People living with disability are the most oppressed and/or minority group whose needs and rights are often neglected from the larger developmental agendas including the sexual and reproductive health and rights. Societal myths and attitudes plays a large role as contributing factor to this which is further reflected in the attitudes and practices of practitioners/providers which is more disabling than actual disability. Raising awareness and utilization of existing policies and pushing for the new policies that will help people living with disability access full range of SRHR and enjoy their human right with dignity.
- The phobia and fear surrounding the LGBT community still exist in the Asia pacific region. The most pertinent example is the recent media scrutiny and hateful statement coming g from the leaders in the position in Indonesia. The state in turn should be able to protect the rights of all the minorities living in the nation including that of different gender identities. It is only though gender mainstreaming and inclusion is that where each individual will be able to enjoy the rights fully.
- The people with different gender identities should be addressed legally and their demand wide a range of social security, identity, right to marriage, nondisclosure and range of other basic human rights . It cannot be achieve singly with the effort of civil societies and needs to be integrated in the programs of government through increased awareness and funding.

B. Issues raised or discussed by participants Transgender people are still encountering violence based on their sexuality or gender. We all face the challenges concerning the sexual citizenship that affect right to reproductive health, expression, stability and security in Katoey's life.

- How the social media become a tool for advantages of LGBT to overcome the challenges?
- How can we foster social conversations ontothe visibility of LGBT issues?

C. Suggested Solution

- It is necssary to implement political laws to uphold the principles of non-descrimination and regardless of their gender and disabilities.
- We should lobby government to rethink an abuse of human rights and discriminatory against homosexual.
- Special attention should be given to health needs and rights of women belonging to vulnerable and disadvantaged group such as women with physical and mental disbilities

Room (6)

1. **Title : "Pathways to elimination of gender-based violence"**
2. **Papers and Presenters**
   a) Connections: Exploring the relationship between intimate partner sexual violence against women in Myanmar, and gendered perceptions of reproductive and sexual health.
   San Shwe, Myanmar
   b) Respectful Relationships: Preventing & addressing gender-based violence in schools
   Justine Sass, Thailand
   c) Why do some women in Viet Nam experience more violence by husbands than others? Risk factors associated with violence by husbands from a cross-sectional national study.
   Henrica Jansen, Thailand

3. **Session Rapporteurs**
   1. Dr. Seng Aung Sein Myint ……..[Focal Point]
   2. Dr. Phyo Maung Maung
   3. Ms Shilpa Lohani

A. Key Message

- Dr San Shwe from Gender Equality Network presented the finding of the qualitative survey conducted in Myanmar. The study explored the types, patterns, consequences and coping strategies among women who experienced violence. Physical violence was most common with more than half who experience physical violence requiring hospitalization. However, many women internalize violence, and box them into the categories of 'wifely duties'.
- Justine Sass from UNESCO Bangkok, talked about the school related GBV (SRGBV). Based on the report, Education for All' published by UNESCO it highlighted that there is limited evidence on SRGBV. Even though LGBTI are significantly vulnerable, there is no data. It stressed that school curriculum often ignore or stigmatize LGBTI. The infrastructure in most schools are not LGBTI friendly. The SRGBV is not limited to peers but also the teachers.
- Henirca Jansen from UNFPA APRO Bangkok, presented the risk factors leading to IPV from the secondary analysis of the National VAW survey in Vietnam 2009 – 2010. Using an ecological model, the study highlighted that risk factors such as alcoholism, abuse as a child, having children, extra marital affair of husband etc. contributed towards GBV by husbands.

B. Issue Raised

The major issued raised during first presentation were on pathways to mitigate negative social norms such as "male sexual entitlement, internalization of GBV by women, negotiation power of women" in Myanmar. The role of health providers in GBV was also questioned in the discussion session. The participant questioned how the study planned to disseminate among the general public. The SRGBV stressed the problem of misunderstanding of language and concepts around gender among school children and even teachers. The third presentation focused on reduction of risk factors to intimate partner violence, and stressed the urgency to start the gender sensitization at an early age. The

participants raised question on how the study had addressed the relationship of GBV at an early age and trafficking as a consequence of GBV. Also, the best ways to eliminate GBV had not been clearly highlighted by any of the presentation and created a mismatch with the session title.

C. Suggested Solution

The first presentation study recommends legal policies surrounding GBV to protect women and enable the victims of GBV to access support. GEN plans to have a documentary screened at an international festival in June and take it local with a mobile cinema. The second presentation mentioned that a low-resource tool developed by University of Melbourne is being launched next week in the region that seeks to strengthen the school curriculum and build skills around gender among both students and teachers. The third session stressed to eliminate GBV, the key is to start from earliest possible, with the positive parenting and preventing child abuse, and the child has degree of copying behavior from their parents' the domestic violence . Henrica from UNFPA also pointed that the preventing of GBV should be a focus, working closely with the communities to address the negative norms.It is also very important to note that integration GBV module to the health care practioner curriculum, where WHO have the policy and technical guideline.

Room (7)

1. **Title: "Comprehensive sexuality education policies and their implementation"**
2. **Papers and Presenters**
   a) Abstinence-Only or Comprehensive Sex Education at Myanmar Schools: Preferences among Students, Teachers and Parents
   Phyu Phyu Thin Zaw, Myanmar
   b) Good Practice Guideline for Advocacy Strategies in Conservative and Less Developed Countries
   Sana Zafar Khan, Pakistan
   c) Advocating for Change: SRHR education among adolescent girls and young women
   May Than Htay, Zin Mar Oo, *Myanmar*
3. **Session Rapporteurs**

   1. Dr. Sithu Swe [Focal Point]

   2. Daw Yu Myat Mun

   3. Dr. Aye Mya Aung

A. The Key Messages from the Presentation

- Lesson learnt from the Aahung's achievement of integrating the most sensitive part of its content, sexual abuse prevention, into the primary school curriculum, is a testament to the success of its strategies and has paved the way for future CSE module integration. A standardized school-based sex education programs across all levels of basic education high schools is needed to integrate in core curriculum.
- Conducting a situational analysis of the policy environment, stakeholders as well as identifying strong advocates (champion) is critical for CSE development.
- Importance of policy and advocacy strategies for the development of CSE especially in conservative and less developed countries
- There are contradictions of preferences for sex education among students, teachers and parents. While more students preferred comprehensive sex education, the teachers and parents preferred abstinence-only sex education. The multiplier and scale-up trainings should be conducted timely and consistently to update the knowledge and the skill of parents and teachers
- It is essential to use a participatory approach and include a diverse range of stakeholders to review the CSE modules and ensure that the content and language is age relevant, age appropriate and culturally sensitive.

B. Issues raised or discussed by participants and suggested solutions

- The sexuality education is context sensitive. The choice of language in sex education and advocacy is a major issue.
- How would you measure the outcome and output of the SRH programs in term of behavior?
- The contents and technical jargons are challenging for the understanding and absorption by the audience.
- Can CSE trigger the early engagement of sexual activities?
- Can it prevent teenage pregnancy and how?

C. Suggested solutions which should reflect from both pro and con

- The nation-wide consultation with stakeholders and young people (participatory method) from different backgrounds should be undertaken to develop a cultural and locally acceptable CSE.
- The safe space (youth friendly environment) can desensitize young people with SRH information. As a result, the community acceptance on SRH increases among young people and their parents.
- For the better understanding and effectiveness of the CSE, the non-technical (layman terms) should be applied and the youth peer educators should lead the awareness raising activities.
- According to the global and regional research, evaluation and scientific paper, CSE can delay the early initiation of sexual exposure and reduce the frequency of sexual intercourse, reduce number of sexual partners, increased proper condom and conceptive use, and reduce STI and pregnancy rates.
- Supportive supervision and monitoring should be implemented to deliver the quality CSE programs.
- Further studies should be conducted to know deeper insight of CSE in wider population in the resources (figures) limited countries like Myanmar.

Second Plenary Session

"Governance and Accountability"

Date - 25/2/2016

Venue - Plenary Hall, MICC II, Nay Pyi Taw

1. **Title: " Governance and Accountability"**
2. **Presentations and presenters:**
   a) Bridging leadership in local Governance for maternal & child health and family.
   Mr. Ernesto Garilao, Executive Director, Zuellig Family Foundation, Philippines
   b) Advocacy, action and challenges in Papua New Guinea to implementing the SRHR aspects of the SDGs from an HLTF perspective
   Mr. John Hyde, Chair, GOPAC
   c) Building capacity for governance and accountability for women's right.
   Ms Shireen Hug, Founder, Women Right Organization Bangladesh
3. **Moderator**: Dr Myint Htwe, Retired Director Program Management, WHO

4. **Rapporteurs**

1. Dr. Thida [Focal Point]

2. Dr. Hlaing Htike Hta Khin

3. Ms. Rasheda Khan

A. The Key Messages from the Presentation

Speaker 1: Bridging leadership in local governance for Maternal and child health and family

Ernesto from Philippine presented that by using health change model mentioning on how local government & NGO involves in leadership and governance in order to provide health outcome. In 2008, there is fragmentation of health services in Philippine, disparity of health outcome between rich urban and poor rural and high MMR and IMR. In the health change model, it includes Local health system that provides Basic health services, addressing inequities in local setting, capacity building on leadership. After piloting, result showed zero MMR, reduced IMR, increased CPR and improved health outcomes. Ministry spent USD 70 million dollars for the intervention. It is found that regional director plays important role in

producing good results. Country where local health system in weak, limited resources and high maternal and U5 mortality needs that kind of political transformation.

- NGOs, CBOs, and developmental partners should be working together.
- Regional director is important to complete a programme through improved leadership role
- Managerial skills and strong financing system at local government and health department is essential
-

Speaker 2: Experiences of PNG

John Hyde presented on the role of Governance and accountability in PNG and highlighted that it is most important to have political will of government in SRHR. In 2013, there was enormous change in PNG after the 7th APCRSHR and Moana statement. In that workshop, PNG committed the transformation of political will for SRHR goal, for instance, women involvement in parliament, civil society working group collaboration towards SRHR human right. SMALL PNG function as the Secretariat to Parliamentary group for awareness raising and for some financial assistance. Gender neutral financing, investing in women and child which in turns help income generating for them and result in positive economic benefit/outcome of country. Making sure that our department, parliament, government is committed to form SDG committee by using national sensitive tools to champion in achieving the SDG.

- Integrating political will to change the system and resources allocation.
- SRHR should be inbuilt within the local system (regardless of donors' interest)

Speaker 3: Claiming accountability for the fulfillment of women's right

She highlighted that Mission statement is advancement of women's right to bodily integrity which involve a multi-pronged approach. Engagement with duty bearer, mobilization of rights holder is needed (voice, alliances, knowledge, monitoring duty bearers in terms of service provider). District level alliance including all CSO activists will present to local community member, local government and local service providers for sustainable outcome. International women day etc. also influence changes in attitude and behavior of right holders. Advocacy with guardian institutions, parliamentary committee and capacity building of local partner organization is to be carried out to accomplish the successful results.

No matter how much we focus on these issues, it is ultimately the govt. support to enhance this.

B. Issues raised or discussed by participants and suggested solutions

Q &A

Q: How financing go under SDG goal and how do u ensure for financing system?

A: Challenges and opportunities in PNG to advocate parliamentarian body. (John)

By investing in women, ARH demonstrated financial advantage. (ie Lower hospital intervention cost, higher economic productivity.)

Suggestion by UPPER house parliamentarian, INDIA: It focus is on national SDG, focus on specific target (not necessary 169 targets). We need to be a lot smarter than before

Q: mayors changing in every 3 yers – how we talk about sustainability? How are you addressing the sustainability with local government?
A: Ernesto:– reinforcing mayor that to take the program is the good of the community health looking into it as 9 years program instead of tenure of his job which is 3 years and institutionalize into the local program.

Q: How can u do for awareness raising of women in Myanmar to claim their right? How do you do it in Bengladesh?
A: Bangladesh government integrated lots of program to raise awareness of women which is still not enough, women often have to fight for claiming their right with people they love.… So idea is to provide enabling mechanism for women who wish to play her rights. This is not an overnight process and. This is for long term effort to assure women to claim their right.

Q: How much we can influence the religious leadres and **how hard do you rate religious leader involvement in Philippines**? –
A: Religious leaders give the acknowledgement of the rights based educations in the secular country. Involving religious leaders in the program is required. Limited capacity for local government (duty bearer), faith based leader/indigenous leader is totally new with SRHR. Denying CSE for primary school education was later convinced by FBO.

Q: Abstinence of service provider is problem, how do you reduce in your program?
A: It was hard for organization but it was possible because being a small program. She ensured it through oversight mechanism which includes regular meetings with hospital management committee to enforce them to work in the duty ours. But this is still a big problem in the country.

Q: Responsibility of mother looking after children and emphasize their role outside the house?
A: it is not sustain result yet, if women choose to be at home and care taking of family, it is their right. Women have to right to be everywhere. The question should be more of whether the men need to spend and take more responsible in the family matter as good father.

"India parliamentarian woman quoted that why the question is on women? Men should take responsibility and take commitment in the task shifting role of women in family matters."

Q: How do you organize to set up monitoring system in police station and hospital?
Different meeting with different bodies are made and getting permission saying that we will not be the trouble makers. Many steps and months convincing government duty bearers, sharing experience in term of dialogue by meeting rather than publishing on the media. It has to be renegotiated.

Q: The previous decentralization programe failed and did you consider this while initiating the programme again and consider centralizing it again?
A: It was considered and decided that whatever was already started should be tried to make it work.

Q: How much the Banking of the poor (GRameen Bank/Dr.Yunus) influenced the empowerment of women, if that has changed the position of women.
A: it's a very complex issue, it will take some time to assess. It has changed women's position in economic and social status but whether it has changed the political involvement of the women is a big question. Not the time to reassess this but kept an eye on this issue

Q: Which other building block to address the SRHR outcome?
A: architecture of health system, additional intervention is needed. Referral hospital

Summary

- Generating political will, Parliamentarian are the key person.
- Leadership transformation of local leader, ownership, co-ownership
- Special program for rural poor, regional director role,
- Local MMCWA members to advocate their duty bearer husbands (local authorities)
- Men should not be trouble maker by all means.

2nd Parallel Sessions

Track (2): Governance and accountability

Room (1)

1. **Title : " Decentralization & SRHR"**
2. **Papers and Presenters**
   a) Promoting Family Planning by Strengthening Local Government Infrastructure in Bangladesh
   Md. Azmal Hossain, Bangladesh
   b) Accountability in the provision of contraceptive information and services in a decentralized system of governance
   Jihan Jacob, The Philippines
3. **Session Rapporteurs**
   (1) Dr. Thida Win
   (2) Dr. Su Mon Myat
   (3) Ms. Enu Anand

A. Key Messages:

Every pregnancy should be planned, every child should be wanted, and every mother should have the best chance at survival. Community involvement in the national FP program can create opportunities to make health and FP interventions viable and sustainable. Build capacity of grassroots-level community members and leaders for quality FP service provision as a linkage between facility and community. There is conflict between national and local laws in Philippines.

B. Issues and Problems raised:

Involvement of local governance bodies to become responsible for monitoring and supervision, including motivating and disseminating FP messages related to LARCs and PMs within their communities.

In Philippines, conflict between national and local laws and policies is issue to promote FP services. Accountability of national government for acts of the Local Government Unit,

C. Suggested Solutions:

The interventions for FP promotion should be focused on **Training and Capacity Building, Direct Technical Assistance, and Policy Advocacy.** In Bangladesh context, local government and stakeholders can be successfully involved in the promotion of FP if: they are adequately supported with the appropriate training and skills. They are offered opportunities to harness their skills and strengthen their linkages with both health care facilities and their

respective communities. A low-cost can be developed approach to reaching thousands of community members. A key element in fostering local government accountability to the national FP program

Partnerships with local stakeholders can be made possible due to: Shared vision and clearly defined objectives regarding FP, commitment to the shared vision from among key partners with necessary expertise and engagement and participation of partners at all levels (grassroots, community, local government…).

In Philippines, National monitoring and oversight mechanisms to ensure that LGUs do not overstep the boundaries of their limited authority.

Male involvement should be emphasized in family planning services. Engagement with the religious leaders and local government units and community is ensured through Faith Based Organization and Community Support Organization. All women have the rights to access full range of FP services.

Issues raised by audience:

Some of the audience raised the issues of access to family planning services as the fundamental right of women but in Myanmar context, these rights are not in the hands of women instead in the hands of their husbands and mother-in-laws. Male involvement in family planning is very important issue.

Sterilization law is important issue in Bangladesh context. Before sterilization procedure spouse agreement and at least two alive children is essential. It is similar in Myanmar context.

Access to family planning services by unmarried people is also a problem. In Bangladesh, public (state) FP services are only available for legally married women. Unmarried women can only access the information on FP. In Philippines, no distinction for marriage but minors can access to information and modern contraception but with parental consent.

Regarding safe abortion, in Bangladesh it is only for life threatening conditions but in phillippines no reason to abort though access to post abortion care is the rights of women if complications arises after abortion.

Room (2)

1. **Title: "Monitoring government implementation of SRHR policies"**
2. **Papers and presenters**
   a) Role of community media in monitoring maternal health in India
   Sulochana Pednekar, India
   b) Achieveing RMNCH+A Outcomes through strengthened Health system Governance by collaboration between Government and Development Partners - Experience from the State of Rajasthan, India
   Sunil Thomas Jacob, India
   c) Improvement of Quality Health Services ensured: Lesson Learned from Local Level Monitoring and Advocacy
   Samia Afrin, Bangladesh

3. **Session Rapporteurs**

   (1) Dr Win Lae Htut [Focal Point]
   (2) Dr Aye Mya Chan Thar
   (3) Mr. Mukesh Ravi Raushan

A. Key Messages from the presentations

Monitoring of the health services given at different levels (community, provincial and state levels) can improve government accountability and quality of services provided by the government health centers.

Community is empowered by making them participate actively in the monitoring of existing government programmes by volunteers (community correspondents) videos recording. Those videos help in reducing violations of health systems and increase quality of maternal health services and ensure the availability of those services in the areas where they are needed most.

Government accountability can be improved by co-operation and collaboration between development partners and government authorities. MMR, IMR and other indicators are still high in the high priority districts in the intervention areas although marked improvements can be made at the national level in India. Therefore, the supportive supervisions and monitoring activities can be strengthened to achieve better health outcomes.

Despite the good policy, the implementation is poor without proper monitoring. Therefore, in the case of Bangladesh, reactivation and strengthening of health management committees at local level improves the quality of services by means of monitoring the services given and advocating to the local authorities.

B. **Major problems and Issues raised/discussed by participants**

Ethical issues concerning the video recordings of the local people and officials might be a problem especially when they are used for the purposes other than advocating the local authorities and policy makers.

Problems should be identified properly in video documentation.

Assurance of data quality could be a problem in identifying high priority districts in the intervention areas.

How to define illegal fees for services and any way to monitor those fees should also be considered.

C. Suggested Solutions:

Informed consent was taken before taking videos with the local communities and the identities was hidden by a number of ways such as blurring of faces in order to conduct video taking video ethically.

Community voices were taken into account to identify and prioritize the problems in accessing and utilizing the health services and the concerned authority was informed to improve the quality, availability and accountability of services.

Local authorities have to make sure the quality of data for identifying the high priority districts. In addition with PPP, the pre approved checklists covering reproductive, maternal and child health to make it functional.
Any fees to be given for the services at the public health facilities is free of charge and should be monitored for reduction and elimination of those illegal fees.

Room (3)

1. **Title: "SRHR in public-private partnership"**
2. **Papers and presenters**
   a) "Principled Critical Collaboration: Key to GO-NGO Partnership in Advancing Reproductive Health in Davao City"
   Romeo Jr Cabarde, The Philippines
   b) Building national resilience for effective sexual reproductive health (SRH) services for the crisis affected population through initial smaller response- A case study of Myanmar
   Rajrattan Lokhande, India
   c) Engaging the Private Sector in Family Planning Access: The Philippines Experience
   Vicente Jurlano, The Philippines

3. **Session Rapporteurs** :
   (1) Dr Kyaw Thu Soe (focal point)
   (2) Dr Nang Cho New Mon
   (3) Ms. Siow Li Lai

A. The key messages from the presentation

- This study was done in the city located at the southern part of Philippines (Davao province) to find out the key elements that defined SRHR landscape. The basic idea is "Moving the few TO Move the many". There is a very strong GO-NGO partnership by PCC (principled critical collaboration): state accountability, transparency, participation, empowerment, rule of law- respect and protect the SRHR of its people. PCC GO-NGO can be used to advance SRHR policies and services at the cities where there is a vibrant civil society organizations and good governance in local leadership. He concluded that RH is a check-balance between government and public.
- Research is about SPRINT project. The purpose of the project is to improve coordination, prevent violence, reduce STI, reduce maternal mortality, and provide comprehensive SRH services, addressing the resilience, and increase access to and quality of SRH services after disasters. Delay in emergency response by MMCWA because of delay in process of approval from governance, arranging for RH kits and capacity building. Good response in some place where there is good rapport and coordination with local government departments, local chapters of national and INGOs, humanitarian settings. Implementation of MISP ensures collaborative effects and utilization of resources.
- Four private companies in multi-partner, country led efforts to expand to access family planning: FP/RH study is important to reduce maternal mortality, reduce replacement cost, reduce unwanted pregnancies, and empower and promote rights of women. Direct-in country work. Challenges include controversial areas, capacity or technical ability, risking their business. Very positive response and high ownership of the project by partner-companies. Lessons learned from the BAFP project include interest in FP came after approach in their local context, company interest in FP but lack of ability, initiation of FP requires slow process of awareness and commitment, and prefer apolitical in FP initiatives.

B. Issues raised or discussed by participants

General: all presentations have no relation to public-private partnership. Discuss. What is the real definition of public-private partnership? Why it doesn't work in Asia Pacific's health sectors? There is no good example of good PPP.

First presenter:

- How the public-private collaboration in improving SRH? How far they succeed in SRH, and MCH?

Second presenter

- Is there any plan to provide trainings to MMCWA members in Myanmar regarding response to disaster affected populations?

Third presenter:

- What are the mechanisms for service provision and commodity supply?
- How to overcome resistance from government factories?
- How is private companies contributing budget for the project?
- Is there any plan to conduct family planning trainings in private companies?

C. Suggested solutions

General: Second presenter gives an example of Nepal earthquake; private companies provide ground support and food. In terms of capacity building, they already provide 5 trainings since 2015. The third presenter said that the nurses are well trained and they have in-house FP provision.

First presenter:

- Women access to free SRH services provide by government through legislation. Women started to come out to fight against violence. Partnership with 911 (hotline) to report violence against women.
- Challenges faced: strong opposition from Catholic Church, misconception of FP/SRH (it is due to strong influence of Catholic society), financial sustainability issue
- Solution: teach women empowerment
- It doesn't need to have INGOs for a long time to support government, government has to stand on their own, and take responsibilities to deliver safe SRHR services to communities.

Third presenter:

- Strengthening in-house provision, lookup to service provided, identify companies that can access services for free
- Solutions for resistance of government's factories: Case to case study, understand reasons why there is resistance, position FP during break time,

distribute through TV, browse through the ROI, and let the private companies know how much to invest and their return from the investment

- Eg. 80 million pesos to reach out to the public – slow process
- The companies contribute certain amount of budget (they wouldn't like to express in exact amount), and some sort of commodities procurement, and conduct trainings, and even hiring O&G.

Room (4)

1. **Title: "Impacts of Global and National SRHR Policies"**
2. **Papers and Presenters**
   a) Young Women for Change: Voices from Young Women in Nepal
   Smriti Thapa, Nepal
   b) Contexts, Realities and Challenges of Sexuality of Forced Bachelor: A Multi-approach Explorative Study in China's Gender Imbalance Governance
   Yang MENG, Shuzhou Li, China
   c) Davao Declaration: Articulating the Rights of Men who have Sex with other Men
   JEFF FUENTES, The Philippines
3. **Session Rapporteurs** :
   (1) Dr. Kay Thwe Thwe Maung (Focal Point)
   (2) Daw Yu Myat Mun
   (3) Mr. Jed Patrick Montero Catalan
   (4) Ms NH Handayani

Chairs Remarks:

- We should be vigilant and continue to become an activist so no man will be behind.

A. The key messages from the presentation

1st speaker:

- There is lack of involvement of young women in the decision making process from national to international level
- Create the strong link between Sexual and Reproductive Health to Human Rights
- Nepal has signed several human rights laws, but there is lack of accountability of the government
- There was a release of regressive constitutional draft regarding women's rights in Nepal
- The training has increased understanding on SRHR advocacy skills and enhanced leadership of young women involved in the project

2nd speaker:

- The imbalance sex ratio at birth which male is higher than female caused forced bachelor
- The government-oriented governance modell is still lack lacks rights-protection, the consideration of LGBT groups, and the absent of public stakeholders.
- Forced bachelors is a vulnerable group and caused by gender imbalance

3rd speaker:

- The HIV case increased by 25% annually in the Philippines while Davao City ranked the 5th in the country. The MSM group is the highest group at risk.

- Human rights violation among MSM and transgender as inflicted by the national police and military especially in the rural areas
- The Anti-discrimination ordinance in Davao City was drafted and guided by the Davao Declaration

B. Issues raised or discussed by participants

- Using the clear gender campaign & researches in government and NGO to address gender issues
- Nepal championing the decreased number of maternal mortality through the decriminalization of abortion in the policy, will Nepal decriminalize the sex workers to improve SRHR?
- LGBT rights has been politically threatened, there should strategic advocacy in the parliamentary and the government, working with media, and create solidarity message to support the LGBT rights in Indonesia

C. Suggested solutions

- Create link between young women activists and key decision-makers in national and international
- Using multi-perspective governance model, which calls stakeholders: media, the mass, market, civil society, and the minority; working together to promote destigmatization of forced bachelors, mutual respect and equality towards new family institution in China
- To examine the sustainability of ARV program among PLHIV; and create the comprehensive package addressing economic, health and social aspects among these groups in Davao City

Room 5

1. **Title: "Advocacy for change"**
2. **Papers and Presenters**
   a) Social Accountability for Adolescents Sexual and Reproductive Health in Nepal
   Giri Prasad Panthi, Nepal
   b) Accountability : Reaching favourable Maternal and newborn health outcomes in Sri Lanka
   Chithramalee De Silva, Sri Lanka
   c) "I Decide" petition for empowering young people on sexual and reproductive health and rights
   JAMUNA DEVI SITAULA, Nepal
3. **Session Rapporteurs** :
   (1) Dr Yadanar Aung (focal point)
   (2) Dr Aung Thu

A. The key messages from the presentation

- Need to access (close monitoring through supervision, regular reviews, feed back reports, short programme reviews)
- There is no evidence in Nepal, how demand side governance is functioning to fulfill unmet need for SRHR and how to seek advocacy meeting taking into account in young population for adolescent health, unsafe abortion, child marriage, median age at first marriage (17.5 years). High-risk behaviors in culturally sensitive issues are still rising. Although National program on adolescent health and SRHR are set up since 2009, there are no such studies carried out for effectiveness and role of social accountability in Nepal.
- In Sri Lanka, free health since 1930 / free education since 1944
- Health is a fundamental right (Article 27- Constitution of Sri Lanka) ensures free and universal health care services
- Facilitate the continuum of care, data generation and accountability
- Adolescent pregnancy (12.7%), Sexual violence (7.2%) and unsafe abortion (7.7%) perceived prevalence of ASRH issues by Citizens

B. Issues raised or discussed by participants

- Quality of care improvement
- Human resources issues
- Changing pattern of cause of obstetric morbidities and maternal deaths directly/ indirectly
- Neonatal deaths
- Difficulties and procedures in social accountability
- Better performance of minority and disabilities apart from youth population in "I Decide" programme
- When the Socio-economic status change, the people want more children in Sri Lanka

C. Suggested solutions

- Addressing unmet need of family planning among high-risk groups and strengthening of contraceptive commodity security might need attention of all stakeholders.
- Further innovative advocacy approach needs to be conducted to get individual commitment as well as to aware youth, stakeholders, policy makers to strengthening SRHR rights of young population
- To position SRHR in the top priority of the post 2015 MDG development framework
- Community empowerment, social accountability should be revolved at all levels after decentralization
- High demanding greater accountability and impacts on adolescents behaviors by parents, partners, communities and civil society organizations
- Impact of decentralization, only administrative powers over local affairs delegated to political subdivisions.
- Policy setting for the entire country still lies in the President and Congress. Need strong empowerment of Parliament.

Room (6)

1. **Title : "Rights based Approach in SRHR"**
2. **Papers and presenters**
   a) Comprehensive Gender, Sexuality and Reproductive Health & Rights Education: A Progressive Islamic Approach to the Issues (Best Practices of Center for Women's Studies at Islamic State University Yogyakarta Indonesia)
   Alimatul Qibtiyah, Indonesia
   b) Social Determinant Approach and Maternal Health
   Pallavi Saha, India
   c) Looking from another perspective Global Governance of HIV/AIDS: 'Gender' and Governmentality
   Nattapat Jatupornpimol, Thailand
3. **Session Rapporteurs**
   (1) Dr. Seng Aung Sein Myint ……..[Focal Point]
   (2) Dr. Phyo Maung Maung
   (3) Ms Shilpa Lohani

A. Key message

Dr Alimatul Qibtiyah, from Indonesia, presented the organization philosophical framework that family is not the source of patriarchal culture rather as a goal to create gender equality and equity "rights from home". The program strategies include enlightening, facilitating, advocacy and conduct research with the religious leader using progressive approach. She also demonstrated the impact of this approach by giving examples of shift in Islamic judges' gender equality perspective during rulings at the court after receiving the training.

Pallavi Saha, India, talked about the social determinant approach towards maternal mortality. She stressed that to reduce maternal mortality the paradigm should shift from institutionalize delivery to safe delivery. She presented her organization's program that analyzed data from maternal deaths and engaged community women/leaders to create a collaborative program that used pictorial tools to increase the knowledge of the community in safe delivery and engaged community leaders to develop an accountability mechanism in reporting of deaths (e.g. SMS reporting). She urged that maternal death is not just bio-medical but has social causes. Major cause of maternal mortality is PPH in public health institutes, but PPH has its roots in the social determinants of the women's health.

Nattapat Jatupornpimol, Researcher from AIT, Bangkok, Global governance of HIV

Govern + Mentality = Governmentality (Govern the mind of people) is not limited to politician and state, but also the community. e.g., parenting. Governmentality is an act that influences the population to conform for e.g. conformity to sexual and reproductive conduct, through various policy. She mentioned that the Gender as Human Rights approach is the accepted norm in development field, and it impact on the how HIV programs are implement (e.g. Discrimination of people living with HIV should be eliminated, as the discrimination faced by PLHIV is compounded by their gender identity such as LGBTQI, sex workers etc.

B. Issued raised and solution

Dr Alimatu Qibitiyah, is providing different categories of the progressive, mostly progressive and highly progressive, in the context of Islamic society away from textual Islamic approach, to monitor the progress of the gender equity work. The major issue raised during floor discussion was that the study did not provide any meaningful impact in the SRHR such as reduction in unwanted pregnancy or unsafe abortion.

Pallavi Saha, the monitoring mechanism at the community level has a positive impact on the service delivery. The new approach for safe delivery should integrate social determinants that impact the maternal health into medicalized service delivery. Community engagement and collaboration with the community leaders is a must for achieving better maternal health. However, the floor raised some issues that even though the study talks about social determinants it mostly ignore the social determinants but focuses on regular ANC checkups and monitoring of maternal deaths only.

Nattapat Jatupornpimol, when HIV had just been discovered the immediate action was taken through bio-medical approach. Later there was a shift with human rights, discrimination perspective coming in, from public health and medical approach to a development issues. Gender is now mainstreamed as women and SRHR, women empowerment, and SDG are all integrated. Because of these changes from different level of political impact, there has been the national laws, policies, guideline, and technology changes. Hence, the gender approach is a tool for development programs to think and rethink the power dynamic between different stakeholders and taking into account the community engagement as well as integrate bottom up approach from community to national, to supranational level.

Third Plenary Session

Health Justice! Towards Sustainable SRHR Financing

Date - 26/2/2016

Venue - Plenary Hall, MICC II, Nay Pyi Taw

1. **Title: "Health Justice! Towards Sustainable SRHR Financing"**
2. **Presentations and presenters**

   a) Sustainability FP Financing: By and For Whom?
   Amy O. Tsui, Professor
   Johns Hopkins Bloomberg School of Public Health

   b) Financing for rights-based universal access to sexual and reproductive health care
   Caryn Bredenkamp, PhD
   Senior Economist

   c) ASEAN Post 2015 Health Development Agenda (2016 to 2020): Opportunities of Partnership
   Dr. Ferdinal M. Fernando, MD, MDM
   Assistant Director & Head of Health
   ASEAN Cross Sectoral Cooperation Directorate
   ASEAN Socio-Cultural Community Departmen

3. **Moderator :** Dr. Phone Myint, Secretary, People's Health Foundation
   Public Health Professional, Health Economist,
   Retired Deputy Director General

4. **Session Rapporteurs**
   (1) Dr. Myo Myo Mon [Focal Point]
   (2) Dr. Moh Moh Hlaing
   (3) Ms. Sille Jansen

A. Key Messages:

Presentation on Sustainability FP Financing pointed out that who bears the financial responsibility and what we should do when if external assistance for family planninghad not been or was no longer available?

Second presentation highlighted that there is needed to increase the fiscal space for RMNCAH by Increasing government revenue, to re-prioritize, to find Health sector specific resource ,to do development assistance, to practice better use of existing funding (Efficiency gains)

ASEAN Post 2015 Health Development Agenda presentation pointed out that people empowerment, strengthening of institutions and engagement of stakeholders in ASEAN process and requirement of solid enduring foundation of funding sources (not subject to political disruption; not subject to rescission as a human right; not marginalized by shifting health priorities.

B. Suggested Solutions:

Professor Tsui concluded :the FP field has never been at a more robust moment in its history of global acceptance, rising middle class is a key source of sustainable demand to be met by private sector, revenues from taxes to finance different insurance models can address needs of poor and vulnerable.

Dr. Caryn Bredenkamp concluded that scaling-up RMNCAH coverage to adequate levels will require significant additional resources, external resources can be mobilized, but are not going to fill the gap, what is needed is sustained commitments to prioritizing health in the budget, while ensuring fiscal sustainability.

Key result areas for ASEAN Post 2015 Health Development Agenda were engaged Stakeholders in ASEAN processes ,empowered People and Strengthened Institutions,
inclusive of all people by educing Barriers, equitable Access for All , sustainable management of biodiversity and natural resources, ssustainable cities and climate, a disaster resilient ASEAN, towards an open ,adaptive, creative, innovative and responsive ASEAN

Third Parallel Sessions

Track 3: Health Justice! Towards Sustainable SRHR Financing

Room (1)

1. **Title : "Universal Access to SRHR"**
2. **Papers and presenters**
   a) Sexual and Reproductive Health services in Emergency (BIKASH POKHREL, Nepal)
   b) Women's empowerment and Socio Economic disparities in contraceptive use in Cambodia (Siow Li Lai, Malaysia)

3. **Session Rapporteurs**

   (1) Dr Sithu Swe [Focal Point]
   (2) Dr. Hlaing Htike Hta Khin
   (3) Dr. Soe Min Oo

A. The Key Messages from the Presentation

Speaker 1: BIKASH

Mr Bikash presented on the tremendous & powerful earthquake that shock the Nepal on 25 April 2015 and intervention made for women of RH aged aftermath of disaster. It involved the distribution of RH kits, medicine, food and delivery of clinical & counselling services, general health checkup and capacity building in term of MISP package. Government of Nepal should Replicate Emergency response model adopted by FPAN in every emergency response.

- The international community should sincerely focus on the issues regarding the SRH in emergency.
- Short term, Mid term and Long term plan should be made by government of Nepal to address the every upcoming disasters so as to ensure the access to reproductive health services for the most affected populations in hard-to-reach areas in emergency.

In conclude, for People facing disaster, it is important to consider how the health services can be reached to them.

Speaker 2: Siow Li

Researcher mentioned that with launching of NFP program in 1993, the data show increasing trend of CPR and decreasing TFR. Studied on the Independent variables of Socio economic factors relationship with dependent variable of proportion of contraceptive use. Women who exposed to media, who disagreed to use because of beaten by husband, significant relationship with wealth index, educational status of both women. It is presented on how socio economic status of women influence on the CPR.

B. Issues raised or discussed by participants and suggested solutions

Q &A

Q: How do you define traditional method?

A: withdrawal, another unknown method stated by speaker

Q: Why rural area use modern method than urban?

A: Strong family planning in country for rural area being accessible and supported by government especially for the poor.

Q: How do you control bias in multivariate analysis? From Prince Songklar University

A: used previous secondary data, there will be confounding factors.

Comment: Since the result differ than other countries, how this research will prove to government of Cambodia to readdress the issue?

>>Those with tertiary education are less likely to use Modern method than less educated.

Q: During emergency response, How ART treatment for HIV positive population have effect on receiving services aftermath of disaster?

A: Answer is vague on providing direct answer.

Q: Responding to earthquake, any depression cases in emergency setting? A: there is complete package of referral which include psychosocial support.

Q:What type of GBV is common and how do you prepare for it?

Provide GVB counselling services to 1-2% of rape case among the disaster victims.

Room (2)

1. **Title: "Models for SRHR financing"**
2. **Papers and Presenters**
   a) Blood, Sweat, Money and Dummy Tummies: Surrogates in India
   Enu Anand, India
   b) Reducing unmet need for family planning in Kiribati: A cost-benefit analysis
   Jacob Daube, New Zealand
3. **Session Rapporteurs**
   (1) Dr. Thida Win
   (2) Dr. Su Mon Myat
   (3) Dr. Toe Thiri Aung
   (4)

A. Key Messages:

Surrogacy is legal in India resulting the international market and the cost is cheap and no laws but guidelines present. Surrogates were from poor socio economic status and not of the prescribed legal age. India draft ART Regulation Bill, 2010 was drafted with the gap of age and protection of welfare for surrogates.
Kiribati has rapidly growing population and by using Spectrum Policy Modelling system, the effects of reducing unmet need is rejected. The health of women and children will be improved significantly together with impact on socio economic and environment.

B. Issues and Problems raised:

Most of the surrogate mothers belonged to poor-socio-economic backgrounds. Most of the surrogate mothers were Hindu, may be due to the fact that Hindu religion allows for surrogacy. Rights and information of surrogate mothers are not well informed and it is exploitation of human rights.
Family planning is a fundamental human right and is crucial to empowering women and girls to realise their full potential. Family planning is cost-effective investment and evidence showed maternal and infant death could be averted. Moreover, reducing social and economic impact for reducing demand for public resources, human capital requirement and infrastructure requirement.

C. Suggested Solutions:

Further research is required for surrogacy. If the revised Act for Surrogacy is passed, there will be restrictions like it is only for Indian couples, married, only one surrogate, etc
Spectrum Policy Modelling system can be used for the small country or a specific area of the country for policy advocacy with evidence for RH in setting the targets. An increased and long term financial commitment and prioritization for FP is needed. HMIS should be urgently strengthened and also different source of data is required.

D. Issues raised by audience:

The population of Kiribati is mainly due to Adolescent Fertility Rate and the access to contraceptives is only for oral. The contribution for Family Planning is spilt like Ministry of Health, UNFPA, INGOs, etc.
Poverty makes the women lend their body and no social support as they hide from the neighbors so that they should be protected with the law.

Room (3)

1. **Title: "Social marketing for SRH"**
2. **Papers and Presenters**
   a) Contraceptive Social Marketing in Asian Countries: Achievements and Lessons Learnt
   Ulimiri Venkata Somayajulu, India
   b) Increasing access to quality family planning products and services through private sector in Cambodia
   Sreymom Em, Cambodia
   c) Analysis of Financing for Development for Sexual Reproductive Health Issues in Young-Adolescent to Achieve Sustainable Development Goals
   Isnawati Hidayah, Indonesia
3. **Session Rapporteurs**

   (1) Dr Win Lae Htut [Focal Point]
   (2) Dr Aye Mya Chan Thar
   (3) Dr Lwin Lwin Aye

A. Key Messages from the presentations

- Social marketing tools are used to improve family planning services in terms of coverage and quality and they can help to achieve behavioral change in the community. Significant improvements in utilization of FP services have been made in recent years partly as a result of social marketing in those services.
- Strengthening support to and training of private providers in family planning services can improve coverage and quality of those services in the case of Cambodia. About half of the people receive family planning services from the private providers but the quality of the private sector has not been regulated before.
- Although MDGs and SDGs focus on well being of community, investment in adolescent health is still lagging. Therefore, health planners should aware of filling the gaps in SDGs by adding financing policies for adolescent and youth reproductive health. This could be better done through innovative technologies such as investment in social media education.

B. **Major problem and Issues raised/discussed by participants**

- The issue raised first was if there is any pricing strategy for better use of contraceptive social marketing (CSM), any challenges and solutions in implementing CSM.
- For recruiting the private providers to provide FP services to community, any selection criteria to identify the eligible providers to be included in the project were discussed.
- The continuation and maintenance of quality of services provided would be an issue after cessation of support from MSI in the case of Cambodia. Any training to staff from MSI such as TOT was provided or not to work with private providers was clarified.
- Payment methods to get the FP services from private providers such as FOC, cost sharing should be fixed.

C. Suggested Solutions:

- Market scenarios should be analyzed and then, depending on the availability, affordability and accessibility of population and health services, the price can be fixed accordingly.
- Sustainability of quality FP services from private sector can be maintained by alternative ways such as using hotline services to get help on technical assistance when needed.
- Proper TOT was given to MSI staffs to assure the quality of trainers.
- Partnership and networking are important for successful social marketing in family planning services.
- Acceptable costs for private FP services should be negotiated.

Room (4)

1. **Title: "SRH commodities security"**
2. **Papers and Presenters**
   a) Nation-wide Facility assessment for Reproductive Health commodities and services in Myanmar (2014)
   Kyaw Oo, Myanmar
   b) Stock out of FP and Lifesaving commodities major hindrance of healthy sexuality and sexual rights in Nepal
   Krishna Prasad Bista, Nepal
   c) Reproductive Health Commodity Security to address Unmet Need for Family Planning in Myanmar
   Khaing Nwe Tin, Myanmar
   d) Strengthening the Public Health Supply Chain Mechanism below district to improve the health service delivery
   Ram Bahadur Thapa, Chitra Mahato, Nepal
3. **Session Rapporteurs** :
   (1) Dr. Kyaw Thu Soe (Focal Point)
   (2) Dr. Nang Cho Nwe Mon
   (3) Dr. San Hone

Four papers were presented in this parallel session where the first 3 papers emphasized on the assessment of current SRH commodities security status from the perspective of supply chain management system, availability of skilled service providers, and the last paper showed the success story of employing public private partnership model for supply chain management at the service delivery level.

A. The key messages from the presentation

- Despite improvement in achieving MDG target, sustained availability of essential and auxiliary health related commodities at all level is still a challenging issue in most countries in the Asia and Pacific including Nepal.
- Limited availability of skilled service providers, essential commodities, and logistics management skill are major concerns threaten the RHCS in Myanmar. In addition, under-established and weaknesses of LMIS in term of both geographic coverage and functioning status has leads to frequent shortage of essential and lifesaving RH medicines and commodities and thus unmet need for family planning and quality SHR services.
- Rural facility, and Marginalized people (rural poor) suffered more from shortage of RH commodities, and skilled service providers than urban facilities
- Health system strengthening including supply chain management and the provision of quality RH commodities and services is of URGENT NEED for achieving RH commodities security

- Ensuring the sustained availability of essential RH commodities is usually a forgotten issue which actually is the key to secure catering of quality RH services to the most vulnerable and most in need population
- A costed National Strategic Plan for RH commodities supply change management is required to ensure the RHCS
- Web based real time logistic management system need to be employed to have timely information and necessary management
- Any SRH plan should take into the consideration of all 6 main components for RHCS rather than just logistic management
- The model of public-private partnership for RH commodities management at below district level worked well in Nepal

B. Issues raised or discussed by participants

- Timely dissemination of study findings to those who need to know such as policy makers, planners, implementing partners, and communities need to be done. This can ensure the timely modification/ correction of any weakness in the cascade of services that ensure quality SRHCS (sexual and reproductive health commodity security).
- Any measures taken to improve the SRHCS should tailored to the context of each level.
    - ✓ For most vulnerable primary health facility that need timely reporting mechanism should be emphasize with making good use of available technology at different level
- Advocacy for increasing demand and commodities supply for long term family planning methods should be carried out.
- How do you address the stock out in marginalized commodities (hard to reach) including providing information to the commodities?
    - o All health facilities including in hard to reach areas are involved in the quantification exercise
    - o PPP model can be helpful :
    - o Recruitment of community peers for hard to reach areas is also an alternative solution
- Strong supply chain system alone will not guaranteed the SRHS. Policy, regulation, coordination with all stakeholders, service delivery in right based approach are all essential components.

C. Suggested solutions

- The issue of under achieved RHCS status need to be addressed URGENTLY:
    - Develop National Strategic Plan for procurement and supply chain management
    - Strengthen Procurement and supply chain management system at national and sub-national levels; and for all implementing partners working for SRH

    - Replicate the success story of Private-Public-Partnership model for logistic management
    - Establish web-based real time reporting for logistic management system
    - Integrate SRH services quality assessment and assurance process in routine monitoring, supervision, and evaluation processes
- A regional network for RH commodities security should be establish in order to
    - ensure continuous security assurance
    - get technical assistance and share experiences (success and failed stories) in RHCS issues
    - use standardized RH commodities in the regions so that timely and necessary logistic management can be carried out to manage the crisis of RH commodities stock out especially under any emergency/ natural disaster conditions

Room (5)

1. **Title: Financing SRHR in Humanitarian response**
2. **Papers and Presenters**
   a) Implementing MISP (Minimum Initial Service Package) for reproductive and sexual health services for the flood affected people in Bangladesh: A case study
   Masum Al Jaki, Bangladesh
   b) Integration of the Minimum Initial Service Package (MISP) for Reproductive Health by a local NGO with MOH Basic Health Services for Internally Displaced communities in Kachin State
   Phyo Thandar Aye, Myanmar
   c) Integrating the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) in National and Local Disaster Risk Reduction and Management Plans: Sharing the Philippine Experience
   Florence Tayzon, The Philippines
   d) Provision of Sexual and Reproductive Health (SRH) Services through MISP in Crises for earthquake affected people of Nepal.
   Nimisha Goswami, India

3. **Session Rapporteurs**
   (1) Dr Kay Thwe Thwe Maung [Focal Point]
   (2) Dr Myo Moh Moh

A. The Key Messages from the Presentation

Key SRH interventions during emergency and disaster include:

- Family planning (all methods - including long-term and permanent, as well as emergency contraception)
- Safe abortion care to the full extent of the law and post-abortion care
- Pregnancy care
- Childbirth care (including emergency obstetric care)
- Postnatal care (mother and newborn)
- Prevention and management of sexually transmitted infections and HIV, including mother-to-child transmission of HIV and syphilis
- Prevention and management of gender-based violence

Challenges in intervention services during disaster and emergency

- Timeliness (communication, approval, procurement of supplies) especially remote area, Limited recourses due to time and budget , cultural barriers (Christian community, ethnic misconceptions, youngsters were shy to attend SRH activities), geographical barriers , Language barrier , Limited financed projects have difficult to recruit top brain, Limited appropriate personnel for managerial level (prior education/ experience)
- Services such as condom distribution to women and girls in rural areas largely affected their empowerment and negotiation skills.

B. Issues raised or discussed by participants and suggested solutions

Issues raised or discussed by participants

- How is solution in emergency labor complication during disaster.
- How to collect resources
- Do you give training how to use first-aid-kit

C. Suggested solutions

- Addressing the dilemma of limited resources vs difficult communities
- Suggest to include management courses for administrative/ management team in addition to task-oriented for service providers
- More international assistance to national and local CSOs in overall development areas
- Make many training how to solve emergency first aid kit
- Preparedness plays an important role during response.
- Coordination with the Government at all the stages and at all the levels is extremely important to ensure government buy in and ownership.
- Funding for Preparedness and Mitigation is a must especially for SRHR in emergencies.
- Collection of Humanitarian Stories can play a very important role in creating awareness and advocating for the organizational cause. However, Ethical Issues need to be considered and adequate confidentiality norms must be maintained.
- Capacity Building of the Government Service providers on MISP and Sexual and Reproductive Health Service Provision is also very important. This is from the purview of Preparedness and making the Government aware of SRH needs during crises.

Room (6)

1. **Title: SRHR responses**
2. **Papers and presenters**
   a) Antenatal screening of anemia including iron deficiency anemia, haemoglobinopathies and thalassaemia among the pregnant women living in Bago region of Myanmar.
   MOH MOH HTUN, Myanmar
   b) Increment of Financial Resources on Sexual and Reproductive Health and Rights in Family Planning Association of Nepal
   Nabina Maharjan, Nepal
   c) Positive Changes in Nepal as a result of integration SRH and biodiversity conservation
   Amu Singh Sijapati, Nepal
3. **Session Rapporteurs** :
   (1) Dr Yadanar Aung (focal point)
   (2) Dr Aung Thu

A. The key messages from the presentation

First Speaker

- In Myanmar, alpha thalassaemia was 13% (varies on ethic group)
- Comprehensive antenatal care
- The most common age for anemia in pregnant women in Myanmar was 20-30 years of age (younger age group). Most of the mother in this study (Educational status - in Primary school level)
- Low income family is high risk
- Screening of anemia in AN care is one of the important functions for MCH

Second Speaker

- Investing in SRH/FP has quantifiable benefits such as achieving universal access of FP /SRH, reduce maternal mortality, unwanted pregnancies, unmet need, unsafe abortion, STI/HIV, infertility etc.
- FPAN provided funding increased annual financial support
- The more investment in SRHR, the better outcomes in universal access of SRHR services
- Equity of funding distribution from multi donors is effective especially to youth, women, and poor, marginalized and socially excluded communities

Third Speaker

- Early marriage high in most of the communities
- Poor access to sexual and reproductive health and family planning services
- Strengthening of environmental health especially in safe drinking water supply
- Social, cultural and economic barriers (SRHR and biodiversity linkage)
- Nepal is land lost area and most of the population depends on agriculture

- To improve livelihood, sustainable of natural resources
- Youth involvement in biodiversity conservation activities increased from 15% to 50%

B. Issues raised or discussed by participants

- The method of blood sample from venous and haemoglobin color scale methods are cheap (Availability of tests in different level of healthcare) rural and urban area also
- Geographical constraints to get blood samples
- How to motivate Youth participation in current SRHR services and biodiversity
- They can attract foreigner to visit the sites (to more facility, to support) very difficult to role of new opportunities
- What's about incentives? Depends on funded by projects
- Youth working in diversity networking with HIV projects
- A lot of challenging to link between FP/Biodiversity that funded by WWF
- Multi-sectorial approach (Linkage of environmental health, FP, SRHR and HIV is very high (Advocate the volunteers and youth generations)

C. Suggested solutions

- Youth engagement and motivation is crucial in both SRHR services and FP/
- The integration of health with NRM institutions is an opportunity for health institutions to strengthen and sustain
- Increased investment in FP / SRH is needed to reach in this community to address unmet need of FP which is still remain 27% amongst women of reproductive age as well as to increase the universal access of SRH services.

Chair comments:

- Governance and Accountability and financial management
- There is population and environmental health to strengthen the SRHR services

Fourth Plenary Session

SRHR Integration in Health

Date - 26/2/2016

Venue - Plenary Hall, MICC II, Nay Pyi Taw

1. **Title**…SRHR Integration in Health
2. Presentation and presenters
   a) Integrating SRHR into the Life Course - The Opportunities and the Challenges
      Dato Narimah Awin
      Retired WHO Regional Advisor
   b) Integration of SRHR in HIV
      Ms. Jet Riparip
      Regional Representative for Asia and the Pacific, International HIV/AIDS Alliance
   c) Milestone of Reproductive Health services in Myanmar
      Dr. Theingi Myint
      Former Director, Maternal and Reproductive Health, Dept. of Public Health, MOH
   d) Program Approaches to Improving Access and Equity for Reproductive and Sexual Health Interventions
      Jeffrey Smith
      Vice President for Technical Leadership
      Assistant Professor of Gynecology and Obstetrics and International Health at the Johns Hopkins University, JHPIEGO
3. **Moderator:** Ms. Janet Jackson, Country Representative UNFPA Myanmar
4. **Session Rapporteurs**

   (1) Dr. Phyu Phyu Thin Zaw [Focal Point]

   (2) Dr. Thinzar Aung

   (3) Ms. Sille Jensen

A. **Key Messages**

Integrating SRHR in health systems requires attention to policy, financing and service delivery. All these areas should be “people-centered” and “family-centered” and “women-centered” not “system-centered”. It is not just combining services under one roof. Integration is needed throughout the system. There are myths concerning SRHR integration. Despite strong political commitment to integrate SRHR in health systems by governments, INGOS and UN agencies, most policies are just mentioned in National Health Plans and not really acted upon. There are horizontal and vertical integrations. Only few UHC covers both. In Service delivery, the traditional clients and “most at risk” clients differ greatly. At the service delivery stage, some NGOs could integrate more compared to some government services.

B. Discussions and Issues Raised

Each country has challenges in integration of SRHR. Looking at the examples of Bangladesh, Myanmar and Malaysia, SRHR needs are differ and specific, some are sensitive during one's life course, from newborn to old age. In Malaysia, there are controversies that where is integration actually happening. Financing goes to different parts of RH services. The government and other RH organizations need to integrate those budgets by themselves. Many INGOS have very limited funds. In terms of service delivery, there are gaps in current referral systems. Limited facilities discouraged the integration process. Malaysia was also able to integrate SRHR rights into it's health system. The marginalized people were taken as priority in the country. Gender perspectives, integrating SRHR are some strategies of Myanmar SRHR integration. In terms of India, family planning was considered as part of the overall health system. Within just five years, many family planning facilities were successfully established in India. Government commitment is essential and working inside the system is more effective when integrate SRHR is integrated in health systems. The needs and wants of the clients should be directly asked and those needs and wants should be addressed in implementation. Multichannel approach is essential to suit the needs of different communities. Ensuring accountability of services during integration process is very essential.

C. Solutions

Solutions: Integration is a solution to make sure smooth access to services, it is about putting the woman at the centre – it should facilitate that woman to get the care she wants.

- If we want services to be integrated, policies are needed to support integration and these policies need to be funded.
- If a woman goes to the clinic she should be able to access all services that she needs in one visit, this is horizontal integration.
- Where integration is not possible we need to make linkages, for example between primary, secondary and tertiary care – this is vertical integration.
- We also need to look at linking of information across a lifetime so that when a doctor sees your records he knows your medical history.
- Other factors to integrate are non-medical: integrating a gender perspective, for example.

Enabling factors for integration are:

- Policies and Plans, these should not just exist on paper but should be implemented. If integration is in a policy or plan, it is an enabling factor for integration but will only work is there is follow up.
- Donors, governments and NGOs, need to integrate their own funding and programmes.
- **Training for service delivery so that they can sensitively and adequately respond to youth and key populations including LGBTQ, sex workers, people who inject drugs is necessary so that youth and key populations can access services. We**

need to consult key populations to ask what they need so that the health care services can respond.

Examples of successful integration:

- the CCM in Myanmar, integrating work on HIV, TB and Malaria under MDG6 and because the system is working well, other health issues are now also brought under this coordination mechanism leading to more integration.
- Traditional clients and most at HIV risk/key populations have other needs, is a myth. Link UP in Bangladesh and Myanmar are linking services for young key populations to general youth friendly services. Training on delivering youth friendly services as well as key population – the principles on non-judgmental attitude and privacy are the same, so there is no need to have separate services for young people in general and young key population because they both suffer from discrimination and stigma when accessing services.

  However, integration of services may not be beneficial for young key populations as the services they need to access, if part of the general system, may have service providers that are not sensitized enough to the issues of LGBT, sex workers, people who inject drugs etc.

Other solutions:

- Task shifting
- **De-medicalization for example, peer-to-peer education and training of sellers of drugs to provide information, for example on contraceptive choice.**
- **Lay health workers could do more. For example sex workers are already doing HIV testing, they could also be trained to do injections for family planning and implants. This could be very effective because sex workers have high incidences of unwanted pregnancy and abortion and we are only approaching them as vectors for transmission, not as women with reproductive health needs. Integrating these would have many health benefits.**
- **Continuum of care: Life course integration of SRHR: each life stage (from new born to old age) has SRHR needs, so these need to be addressed for people from all ages. We should also broaden our span from 'reproductive' for adult women, they are not just 'reproductive' they are also 'productive' so reproductive health is too limited, if you look at violence against women alone, that is a huge health issue that needs to be integrated.**
- Evidence-based advocacy:
  - Internationally agreed indicators to measure progress
  - Universal Health Coverage
  - 'Sin tax' on tobacco & alcohol

Fourth Parallel Sessions
Track (4): SRHR integrating in Health System

Room (1)

1. **Title: "Exploring Sexuality Education and Communication"**
2. **Papers and Presenters**
   - *a)* Ma Ma Oo Radio Program: A window which every woman can open and feel the experiences of Reproductive Health in Myanmar.
     Hnin Kalyar Kyaw, Myanmar
   - *b)* From pilot to program: How a national youth hotline is increasing youth access to quality sexual and reproductive health information and services in Timor-Leste
     Helen Henderson, Timor-Leste
   - *c)* Effects of Comprehensive Education Service on Sexual and Reproductive Health among Migrant Children in Beijing, China
     Yue Hu, China
3. **Session Rapporteurs**
   1. Dr. Seng Aung Sein Myint ……..[Focal Point]
   2. Dr. Phyo Maung Maung

A. Key Message

Hnin Kalyar Kyaw, Burnet Institute Myanmar, presented about the piloted radio program about sexuality education program together with Myanmar State Own radio program. The evaluation was done, comparing between intervention and control villages, and the program has shown that significant increase of knowledge of the different key areas of SRH. MRTV is going to broadcast based on the piloted radio program.

Helen Henderson, talked about National Youth Hotline in Timor-Leste. The hotline project is to respond the Timor-Leste has high fertility and high maternal mortality rate. The hotline name is changed from Kiss to Youth Hotline, after consultation with the Youth. The common topics are adolescent health, HIV, STD, infertility.

Yue Hu from China presented about CSE in migrant children in Beijing. The pilot migrant education project started in 15 migrant's school using UNESCO and WHO guidelines, in addition to the local policy guideline. The textbook are produce integrated gender, development, rights and life skills together with teacher/volunteer capacity building. The project is also used social media to reach the parent about CSE. The evaluation showed the significant improvement of knowledge on Sexual abuse, sexual orientation as well as the other areas such as HIV/AIDS, puberty and so on. In addition, this pilot project was the only source of information that most migrant student received. The attitude regarding the sexual orientation was improve, such as gender equality in job search, and parenting of homosexual. The teach even said that their teaching methods are also improved.

B. Issue Raised and Solution

The radio program increase demand but the needs cannot be fulfilled.

Regarding the National Youth Hotline in Timor-Lester, they find out that more than 80% of the phone call are not answered, because the hotline number is busy. So that, they expand the hour and more counsellor on the hotline. Now the National Youth Hotline pilot is MSI program in Timor-Leste and working closely with MOH. The telecommunication company is giving free hotline call. The whats-app account is also created so that people with hearing disability can access the counseling services. If the minor call the hotline or , the sexual abuses cases call the hotline? What are the common questions?

Young people can call the hotline, and if they need referral, the counselor refer to the available services. The common questions are like menstruation and puberty. The counselor will refer to VAW cases to GBV services, and that service is available throughout the country.

The CSE program policy advocacy with the Chinese government to incorporate into the public education curriculum.

What are the resistance seen in CSE program? Particularly regarding LGBT?
In China, there are cases about sexual abuse and misunderstanding in the news, so the teachers and parents want their children to have CSE. On the other hand, they are worried about misuse of CSE. There is no direct referring of LGBT, but the curriculum guided about relationship, gender, rights and family.

Room (2)

1. Title: "Integrating HIV in SRHR for vulnerable group"

2. Papers and presenters:

a) Sexual beliefs and practices associated with sexual transmitted infections among taxi drivers in Hanoi, Vietnam,
Dr. La Ngoc Quang, Viet Nam

b) Engaging communities to address the Sexual Reproductive Health gaps of People Living with HIV through integrated approach
Mrs. Nisha Jagdish Poojar, India

3. Rapporteurs

(1) Dr. Khaing Nwe Tin *(Focal Point: Maternal and Reproductive Health Unit, Department of Public Health, Myanmar)*

(2) Dr. Myo Myo Mon *(Maternal and Reproductive Health Unit, Department of Public Health, Myanmar)*

(3) Dr. Moh Moh Hlaing *(Deputy Director, Department of Medical Research)*

A. The Key Messages from the Presentation

There is limited knowledge on risky sexual behavior among the migrant taxi drivers in Vietnam and they practice risky sexual behaviour, so these groups should be focused as a target vulnerable group.

Currently, SRH needs of PLHIV are not well addressed in programs. They are limited accessibility for SRH services due to stigma and discrimination and SRH Rights of them are violated.

Integration of HIV in SRH services through community engagement can improve service coverage, results the positive outcomes and more efficient use of resources especially in pregnant women, vulnerable groups.

B. Major Problems and issue raised

- What are the experiences/ how to link between HIV and family planning services for PLHIV women especially at primary/grass root level?
-

C. Suggested solutions

It should be included the migrant taxi drivers in vulnerable groups and provided the SRHR information and services to them as a target group.

It is needed to improve access to integrated, duality and non-discriminatory services especially by PLHIV through community based approach: involving of PLHIV and peer mother.

Room (3)

1. **Title: "Integrating SRHR in MNCH Services"**
2. **Papers and Presenters**

a) Understanding blood transfusion management system in public health facilities in selected districts of Bangladesh: A qualitative investigation
Rasheda Khan, Bangladesh

b) From D&C to Vacuum Aspiration and Misoprostol: Ensuring Quality and Appropriate Use of Technology for Post abortion Care in Myanmar
Ni Ni, Myanmar

c) Task-sharing incomplete abortion services: decentralizing care by increasing involvement of non-physician and primary care providers with use of misoprostol
Laura Frye, USA

3. Session Rapporteurs

(1) Dr. Thida Win
(2) Dr. Su Mon Myat
(3) Dr. Thinzar Aung

A. Key messages

While higher-level facilities were well equipped with blood transfusion system, lack of proper management system, providers' unavailability and huge patient flow worked as deterrent factors. Managing blood was often the responsibility of patient's family members and providers to ensure timely blood transfusion.

Most of family members did not know the blood group of their patients. To complicate the situaiton, family members often faced severe difficulties as they were unaware of other private sources. Family members' low knowledge act as barrier. All these delayed proper and timely blood transfusion to women who needed it most.

Decentralization of incomplete abortion care, including simple outpatient treatment with misoprostol, is a feasible way to avert approximately 85% of referrals for D&C. training providers from teaching, township and stations hospitals in Yangon, Magway and Mandalay divisions. The competency-based training includes manual vacuum aspiration (MVA) and misoprostol for PAC, and a strong emphasis on counseling, infection prevention, contraceptive counseling and services, and monitoring.

B. Issues raised

Hemorrhage is one of the major causes of maternal deaths in Bangladesh and managing patietns with such life-threatening complication is still poor in public health facilites.

No woman should lose her life while giving birth to life.

Expanded service delivery model of Cascade approach training model was used.

On job training is important for rapid diffusion of the skill. Supportive leadership is important. Task sharing of incomplete abortion services to non-physician and primary care providers with use of misoprostol has great benefits of increase accessibility and less cost and more focus on counseling and option to avoid surgical procedure. Health care system get the benefit of better use of resources, increase care , reduce workload and reduce cost.

C. Suggested Solution

Policies and programmes should focus more on ensuring appropriate use of existing equipment and availability of technical personals to strengthen the capacity of national health facilities for systematic and timely blood transfusion strategy.

While the evidence for substituting D&C with safer PAC procedures is well known, Myanmar's early experience with this transition will be useful for future program scale up to other states and divisions. It will also be instructive for countries in the region that are striving to improve the quality of PAC and address maternal mortality. Scaling up of Post abortion care is proposed solution.

An evaluation of services one year after implementation highlighted a sustained reduction in D&C utilization and ongoing acceptability of the decentralized treatment model among both women and providers. Scaling up of task sharing is proposed solution.

Room (4)

1. **Title: "Youth Voices from Myanmar"**
2. **Papers and Presenters**

a) Perspectives of youths towards Reproductive Health services in Rural and urban areas of Myanmar
Saw Saw, *Myanmar*

b) Need of Formal Sexual and Reproductive Health and Rights education to enhance knowledge and perception of adolescents living in different areas of Yangon City
Khine Cho Myat, Myanmar

c) The potential of rural Youth Centres supporting Myanmar towards the Sustainability Development Goals 2030 - The case of Youth Information Corners in rural Myanmar
Agnethe Ellingsen, *UK*

3. Session Rapporteurs

(1) Dr Win Lae Htut [Focal Point]
(2) Dr Aye Mya Chan Thar
(3) Dr Swam Saung Oo

A. Key Messages from the presentations

Although significant proportion of total population are youth in Myanmar, there is no enough information for why and how young people choose adolescent health services. According to study, confidentiality and communication of healthcare providers are most common barriers for utilization of reproductive health services utilization among young people. Therefore, we need to create a warmly and understanding youth friendly reproductive health services for young people and ensure their confidentiality for effective utilization of health services among adolescents.

Many adolescent have low level of knowledge related to reproductive health even though reproductive health education is existed as official school curriculum. The major constraints for implementation of life skill education are cultural barrier among parents and teachers. And the study proved that curiosity and interest in sexuality among young people is high. Therefore, there is need to develop new strategies for comprehensive sexual health education (CSE) for young people such as training of trainers and including CSE in school curriculum with methodologies which can overcome cultural constraints.

Implementation of Youth Information Center (YIC) was poor due to many limitations such as lack of data and information, confidentiality and updated IEC materials. Therefore, skill training for basic health staffs especially in rural area for developing comprehensive adolescent health services is very essential for quality and coverage of adolescent health services.

B. **Major problem and Issues raised/discussed by participants**

According to the study, young people perceived that adolescent health services are mainly for married people. So that, most of the adolescents should be educated about reproductive

health services in order to increase their awareness. Moreover, special programs and contraceptive services for unmarried youth should be developed in Myanmar.

Nowadays, healthcare services are facing with over workload of health care providers. Therefore, there is no confidentiality and good communication between healthcare providers and young people.

In Myanmar, most of the parents and teachers accept comprehensive sexual education is inappropriate for young age. Hence, reproductive health education in life skill curriculum cannot be effective for the adolescents.

C. Suggested Solution

Reproductive health services should include a warmly and understanding reproductive health services for young people and ensure their confidentiality. These services should also protect health and sexual rights of youth population.

New strategies for comprehensive sexual health education (CSE) for young people such as training of trainers and including CSE in school curriculum in order to overcome cultural constraints should be developed.

In order to provide evidence based information, research has to be encourages and findings should be disseminated to policy makers related to youth friendly services.

Develop sufficient and equitable youth friendly health services and increasing healthcare manpower and enough infrastructures for youth friendly services.

Provide skill training for basic health staffs especially in rural area for developing comprehensive adolescent health services including comprehensive sexual education and reproductive health services.

Room (5)

1. **Title: "Youth Speak-Exploring the Integration of SRHR in Adolescent and Youth Health Services"**

2. Papers and presenters

a) Juniors' Responsibilities in Gender and Adolescent Development (JR GAD)
Rolando Borja, The Philippines

b) Menstrual Hygiene Management in Indonesia: Understanding practices, determinants, and impacts among adolescent school girls
Jessica Davis, Australia

c) Sexual Reproductive Knowledge, Attitudes and Behavior among Adolescent Akha Females, LuangNamtha province, Lao People's Democratic Republic (PDR): A Qualitative and Quantitative Study
Visanou Hansana, People's Democratic Republic of LaO

3. Session Rapporteurs:

(1) Dr Kyaw Thu Soe (focal point)
(2) Dr Nang Cho New Mon
(3) Mr. Jake Lucchi

A. The key messages from the presentation

- JR GAD capability building is a strategy to mainstream and strength the support of the youth sector along gender, sexuality and reproductive health more specifically in reaching adolescent through education that adhere to the principles of adolescent to adolescent approach. This study was done to provide and acquire the necessary knowledge, attitudes and skills which are necessary to start off initiatives, strengthen the support and participation of young people and advocates in mainstreaming gender, sexuality and reproductive health in the school and community. In the Davao region, there are 21 organized teen centers. JR GAD strategy aims to a Teen Center in the school and community that caters the needs of adolescent while organizing the trained adolescent to become peer education and facilitators in partnership with the guidance office in the school and health centers in the community.
- Menstruation and menstrual hygiene management (MHM) are largely neglected in policy and programs. Poor access to information, lack of facilities to manage menstrual bleeding, inappropriate practices and harmful sociocultural beliefs are common challenges. Misconceptions about reproduction and menstruation may put girls at risk of unintended pregnancy.
- Economic growth and increased road infrastructure are dramatically changing rural lifestyles. For the Akha people, these changes are profound and are increasing interactions with non-Akha peoples as previously subsistence lifestyles are being integrated into the market economy. The purpose of the study was to explore adolescent Akha girl's attitudes, knowledge and behavior about sex and sexual health. Rapidly changing sociocultural norms, economic development and changing live hoods are placing young Akha women at risk of STIs/HIV.

B. Issues raised or discussed by participants

First presenter:

- What do you expect from these generated data of study for policy maker level?

Second presenter

- From point of ethical issue, the researcher gets the ethical consent from whom? How religion effects on menstruations and MHM and how to handle it?

C. Suggested solutions

General: Chair gives comment, that there is no study yet on sexual activities research on ethnic group in Myanmar. He encouraged to do research about sexual activities on ethnic group in Myanmar.

First presenter:

- We have to change the culture of the government. Peer to peer approach is effective with mentoring adult who is expert on ASRHR. Young people need opportunities to practice their knowledge. Timing and alignment of strategies to government practices and strengths improved implementation.

Second presenter:

- Taken consent from Principal, Parents if the girl is under 15 years old. Above 15 years of age can give consent herself.
- Burnet partnered with Water Aid for the program on menstrual hygiene management. Global data shows that menstruation management has a major impact on adolescent girls' health.
- The study found a range of attitudes and beliefs about menstruation, some harmful and some construction. On the knowledge section, there was poor knowledge and many misconceptions. School WASH facilities were insufficient.
- Key recommendations were to manage menstruation education in school; provide menstrual hygiene materials in school; address misconceptions about pain relief medication; health checks should include menstrual health; improving latrines.

Third presenter.

- Lack of money and distance to facilities were barriers to accessing services, as well as embarrassment and communication barriers.
- Key recommendations were targeted preventive interventions to delay sexual debut, out of school CSE programs, working to keep adolescents in schools, and providing youth friendly services at the district level.

Room (6)

1. **Title:** "**Adults Only- Towards Effective SRHR Integration in Adult in Adult Health Services"**
2. **Papers and presenters**
   a) Care Needs Versus Care Supplied: The Nursing Strategies for Senior Gays and Lesbians
   Jed Patrick Catalan, The Philippines
   b) Client Satisfaction on Family Planning Services through Mobile Clinics in Rural Areas in Myanmar Authors:
   Sunshine Aung, Myanmar
   c) Integration SRH services in to health system in Sri Lanka
   Hemantha Senanayake, Sri Lanka

3. **Session Rapporteurs**
   (1) Dr. Toe Thiri Aung
   (2) Dr. Myo Moh Moh
   (3) Dr. Sithu Swe [Focal Point]

A. **The Key Messages from the Presentation**

- **N**on-discrimination with confidentially health services and nursing care should be provided for the senior gays and lesbians.
- Health is human rights. It must be holistic and equitable regardless of age, culture and even gender identity.
- Family planning services through mobile clinics are meeting the needs of under-served population in the rural areas.
- Integration of reproductive health (RH) care into health system has produced great results in terms of low maternal mortality, high CPR and a low adolescent birth rate.
- Women reproductive health rights are essential to realizing wide range of fundamental human rights.
- GBV is important thing and think about that as global problem.
- A rights-based approach is essential for progress.
- The perception, attitude and cultural belief of the health care providers can trigger the patients to engage in unmet needs for the reproductive health services.

B. Issues raised or discussed by participants and suggested solutions

- Any findings about unmet need for the other groups rather than old gays and lesbians?
- Any mechanism to take account on those who are not satisfied with the services provided by the mobile clinics?
- How do you operate the mobile clinic in Myanmar?
- Any criteria like the number of children and minimum age to do the sterilization?

C. Suggested solutions which should reflect from both pro and con

- The safety, comfortable and respectful care and health services should be provided for the elderly people including LGBDI groups. Caring system should be readdressed. Re-engineering gender care strategies in the nursing curriculum.

- The capacity building trainings for the health care providers to provide proper health care and services for elderly Gays and Lesbians groups.

- The reproductive health care and services should be integrated into national health care system to achieve a sort of tangible positive outcomes in terms of low MMR, high contraceptive prevalence rate and low adolescent birth rate.

- The feedback mechanism from the community should be provided in every health care centers.

Room (7)

1. **Title: "Male Involvement"**
2. **Papers and Presenters**
   a) Reproductive morbidity and health care utilization among financially capable rural mother in India
   Mukesh Ravi Raushan, India
   b) Decision-making level on Health Care Services Utilization in a Peri-Urban Area of Myanmar
   Kyi Mar Wai, Myanmar
   c) Does Women's Autonomy Affect Utilization of Maternal and Child Health Care Services in India?
   Kaushlendra Kumar, India
   d) Paternal factors are associated with access to institutional delivery utilization in Nepal
   Dharma Bhatta, Thailand

3. **Session Rapporteurs**
   (1) Dr. Thida [Focal Point]

   (2) Dr. Win Min Oo

   (3) Dr. Phyu Phyu Thin Zaw

A. **Key Messages**

Among four studies, most of them mainly assess how the male involvement, socio-economic status and women autonomy affect the RH service utilization in India, Nepal and Myanmar. In India the education, household economy, facilities at household level such as sanitation and source of water were reported to be highly associated with maternal morbidity among women in India. In Myanmar, men were solely decision makers regarding the utilization of health care services of their family members, however; families with female decision makers had a higher utilization of maternal care services. The same finding was seen in the Indian study where women autonomy is strongly associated with RH service delivery. Another study in Nepal also supported these finding in which male participation and income is important in institutional delivery utilization.

B. Discussions and Issues Raised

In Myanmar Society, women do not yet have equal status as men in decision making although equality of men and women had been achieved in the legal aspect. However, In India is facing some difficulties. There are obviously some needs to look beyond individual level factors when examining the health seeking behaviors of women. This issue is also indirectly obvious in Myanmar setting. Myanmar women usually comply with their husbands' predetermined decisions about healthcare.

C. Solutions

In Asia Pacific Region, a wider scope of social predicaments along with integration of SRHR polices which encourage women empowerment into the health systems is essential to improve the health system as a whole. The influence of women's autonomy should be considered as important as other known social determinants at policy maker levels. Integrated and practical policies are needed to establish women-oriented services, not system-oriented services in these countries**.**

Room (8)

1. **Title: "No Voice Unheard- Speaking out on Timely Issues in SRHR"**
2. **Papers and presenters**
   a) Sexual risk behaviors among young men who have sex with men in large cities of Myanmar
   Myo Myo Mon, Myanmar
   b) The Need to Improve Counseling Service Quality for Sexual Abuse Survivor in Asia
   Nur Hidayati Handayani, New Zealand
   c) Awareness towards sexual and reproductive health and rights among young people with disability (YPWD) in Nepal
   Shilpa Lohani, Nepal

1. **Session Rapporteurs**
   (1) Dr. Lwin Lwin Aye [Focal Point]
   (2) Dr. Ei Ei Maung
   (3) Dr. Kay Thwe Thwe Maung

A. Key Messages from the presentations

In recent years, prevalence of HIV has increased among MSM and this prevalence was higher than in general population in Myanmar. Risk factors for transmission of HIV in young men who sex with men(YMSM) are younger age at first sex, sexually activeness and having more than one partner, and, low education level, age under 20 years, awareness of same-sex preference at aged 10 or below are significant risk factors for younger age at first sex.

In Asian countries, cultural and social barriers, lack of proper training and missing advocacy for service quality in counseling service for sexual abuse are making survivors of it suffering from harmful impacts, so adding Human Rights and Feminist perspective into counseling approach is need to improve quality of counseling service and advocacy of this approach is also very important for reducing harmful impacts in survivors of sexual abuse.

Young people with Disability (YPWD) are more vulnerable than normal ones because they often faced with barriers to get comprehensive SRHR information and services than normal ones, and also had difficulties in communicating with service providers due to feelings such as shy or afraid. Therefore, giving comprehensive SRHR information in their preferred delivery mode named Inter-personal communication (IPC) and SRHR services to YPWD are very important to improve their awareness on SRHR and to increase utilization of services.

B. **Major problem and Issues raised/discussed by participants**

1. In order to improve the maternal health not only quantitative achievement in health outcomes but also qualitative improvement should be taken into account in general especially in hard to reach area. Therefore, as a methodology is concern for the qualitative assessment for maternal health services, there is a need to develop a measurement technique.

2. How to assess and measure the distribution and healthcare access of migrant/mobile population especially for maternal health?
3. There is a need standardized selection criteria for ethnic minority midwives for better long term outcome.
4. There is urgent need for new healthcare strategy for specific population such as mobile population.

C. Suggested Solution:

1. Encourage qualitative studies on maternal health care services.
2. Planning of special healthcare programs for specific population.
3. Review, monitor and evaluate the studies related to maternal health services for population at risk such as in hard to reach area population.
4. Possible and feasible policies for implementation of maternal health services in particular setting such as migrant population.
5. Special training on safe delivery for TBA especially in hard to reach area.

Room (9)

1. **Title: "Ending Gender based violence"**
2. **Papers and presenters**
   a) Trafficking of minor girls for commercial sexual exploitation: Exploring the situation of girls in trafficking prone "Source" areas of Bihar, India
   Sharmistha Basu, India
   b) Domestic violence (DV) in Thai pregnant women and its impact to their sexual and reproductive health
   Siriwan Grisurapong, Thailand
   c) Female Genital Mutilation and venerability of Sexually Transmitted Infections and HIV in Senegal
   Ramu, India

3. Session Rapporteurs :
(1) Dr Yadanar Aung (focal point)
(2) Dr Aung Thu
(3) Dr San Hone (lead rapporteur)

A. The key messages from the presentation

First Speaker

- Traffickers encompass: Agents and outsiders who are involved in the recruitment, transport, sale of girls; those profiting in any way from girls in CSE
- Household distress factors (difficulty in feeding, clothing, providing health care to family member) that caused distress and more likely the girls experiencing trafficking of CSE
- Women education, household debts are alternative perceived to CSE

Second Speaker

- Domestic Violence during pregnancy have a severe negative consequence to women and their unborn baby
- Established intimate partner violence by MOPH in Thai
- A few of pregnant women are earning money by themselves. In generally, most of the women who experienced DV are totally dependent to their partners
- Forced to unwanted sex acts (oral, anal and stand)

Third Speaker

- FGM cause fertility problems can suffer immediate and long-term health complication and lead medical burdens.
- In study, rural women are more likely to do FGM than urban women (Level of person who performed circumcision by place of residence in Senegal, 2010-11 were common in rural area)

- FGM is currently being practiced in several African countries since of the community ritual, traditional and cultural believes, which is deeply rooted in the society

B. Issues raised or discussed by participants

- How to solve the forced sex problems because DV mention from husband (violated by own husband)
- Strongly correlation with DV and menstrual cycle in Bangladesh
- How to make sure is that child labor, trafficking
- How will be change the policy affected for Africa after study

C. Suggested solutions

- Public campaign is solution for DV
- Screening in AN clinics is not enough (participation of private sector as well)
- Understanding how we design the prevention program for trafficking
- There are a lot of harmful practices in communities (Local level policy recommendation)

Chair comments: For trafficking, poverty is the root cause. Now DV is coming to public violence and nobody dare to hurt (video clips) was humiliated by husband in public area.
FGM since 2000, US conference make awareness to stop FGM but still gaps exists. As voice issued for gender based now is the time to broadcast. DV not to be worsen as Public violence at all.

8th APCRSHR