NEAR THE CITY
BUT HARD TO REACH

A REPRODUCTIVE HEALTH NEEDS ASSESSMENT IN PERI-URBAN YANGON, MYANMAR

FEBRUARY 2015

uOttawa
Faculté des sciences de la santé
Faculty of Health Sciences

Cambridge Reproductive Health Consultants

Y.W.C.A

NEAR THE CITY BUT HARD TO REACH

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

AUTHORS

Grace Sheehy, MSc(c)

Yadanar Aung, MBBS

Cari Sietstra, JD

Angel M. Foster, DPhil, MD, AM

ACKNOWLEDGEMENTS

This project was supported by a number of scholarships and grants, including a trainee grant from the Society of Family Planning, an Ontario Graduate Scholarship, and a travel scholarship from the University of Ottawa. Ms. Sheehy also received a grant from the Centre for Global and Community Engagement to support the development of this report. Dr. Foster's Endowed Chair is funded by the Ministry of Health and Long-Term Care in Ontario and we appreciate the general support for her time that made this project possible. Finally, Cambridge Reproductive Health Consultants' work in Thailand and Myanmar has long been supported by an anonymous donor to whom we are grateful.

The study team thanks all of the organizations and individuals who participated in the interviews, focus group discussions, and surveys. We would like to express our gratitude to the National YWCA of Myanmar, as well as the Yangon YWCA, for their support of the project and assistance with recruitment, facilitation, and translation.

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

Graphic Design & Photographs by Nancy Chuang

Suggested citation

Sheehy G, Aung Y, Sietstra C, Foster A. Near the city but hard to reach: A reproductive health needs assessment in peri-urban Yangon. Cambridge, MA: CRHC, 2015.

For additional information or copies of this report, please contact: angel.foster@uottawa.ca.

TABLE OF CONTENTS

LIST OF ABBREVIATIONS, ACRONYMS & KEY TERMS

ANC	Ante-natal care
ARH	Adolescent reproductive health
CBO	Community-based organization
CPR	Contraceptive prevalence rate
CRHC	Cambridge Reproductive Health Consultants
EC	Emergency contraception
ECPs	Emergency contraceptive pills
FGD	Focus group discussion
IUD	Intrauterine device
LARC	Long-acting reversible contraception
MMR	Maternal mortality ratio
NGO	Non-governmental organization
OCPs	Oral contraceptive pills
PAC	Post-abortion care
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
TBA	Traditional birth attendant
YWCA	Young Women's Christian Association

Commuting in North Okkalapa.

EXECUTIVE SUMMARY

BACKGROUND & CONTEXT

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

PROJECT AIMS & OBJECTIVES

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

METHODS

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

SETTING

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

Housing in Thin Gan Gyun.

FINDINGS

Reproductive health services are often available but inaccessible

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

Misinformation about sexual and reproductive health issues is widespread

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

Institutional deliveries are increasingly common, but harmful traditional practices persist

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

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

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

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

Unsafe abortion care is widely available in the peri-urban townships and demand is considerable, despite widespread awareness of the associated morbidity and mortality. TBAs remain the primary providers and employ a variety of mechanical, medical, and traditional methods. Although misoprostol is available from drug shops, dosage and administration is often incorrect, leading to incomplete abortions. Post-abortion care (PAC) is available from the public sector, a fact that is either unknown or serves as a deterrent, and many

women fear harassment and judgment from providers. Given the distances to public hospitals and lack of information about when and where to access PAC, many women seek PAC dangerously late.

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

DISCUSSION & RECOMMENDATIONS

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

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

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

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

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

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

CONCLUSION

The study findings highlight inaccessible reproductive health services, considerable misinformation, common and unsafe practices surrounding delivery and abortion, and an overarching need for comprehensive information and resources in peri-urban Yangon. A unique and tailored service delivery approach is needed to meet the complex and varied needs of this population. Many organizations are doing important work to improve reproductive health in peri-urban Yangon, but more data and resources are needed to inform their funding and programming efforts. Collaboration between these organizations, and support from the reproductive health community more broadly, could help facilitate these efforts.

BACKGROUND & CONTEXT

Myanmar has been in a period of rapid change since the military officially ceded power to a civilian government in 2011. However, the long history of military rule, characterized by forced labor, displacement, rape, and imprisonment, has led to poor health outcomes across the country [1,2]. Although spending on health has increased substantially in recent years, through foreign aid, private sector investment, and expanded public sector budget allocations, health outcomes across the country are varied and in many regions remain poor. Historically, health outcomes have been better in urban centers, like Yangon, than in rural settings (see Figure 1 for a map of the country).

Consistent with overarching health dynamics, reproductive health indicators are generally poor and reflect significant regional and geographic disparities. Information about reproductive health in Myanmar is spotty; reliable national statistics are difficult to access and conflict affected areas have long been omitted from most "national" datasets. Indeed, the results of the 2014 national census and the 2015 demographic and health survey, while still flawed, are eagerly anticipated by a range of stakeholders and will provide more robust and accurate information about the Myanmar population overall and reproductive health in particular. Until the government opening in 2011 international academics were generally prohibited from conducting research in government-controlled areas of Myanmar.

However, the best available evidence strongly suggests that there are significant unmet reproductive health needs throughout the country. The age of marriage for women and the total fertility rate have steadily increased and decreased, respectively, in recent years, a remarkable feat given the lack of government intervention in those domains. Other reproductive health indicators have witnessed far less improvement. The national maternal mortality ratio [MMR] is currently estimated at 200 deaths per 100,000 live births [3] and the MMR is estimated to be four or five times higher in conflict affected regions [4,5]. Deliveries attended by a skilled birth attendant have increased considerably, reaching 64% in 2007 [6]. In urban settings, women are increasingly choosing institutional deliveries over home deliveries; about half of all urban women experienced their last delivery in a health facility [6]. In Myanmar, abortion is severely legally restricted such that the procedure can only be performed to save the life of the woman and this exception is narrowly interpreted

Figure 1: Map of Myanmar

[7]. While the leading cause of maternal mortality at the national level is post-partum hemorrhage, at least 10% of maternal deaths are directly attributable to unsafe abortion; in conflict-affected parts of the country, as many as half of maternal deaths are due to unsafe abortion [8,9]. A range of contraceptive methods, including emergency contraceptive pills (ECPs), are available in Myanmar. In 2010, the country's contraceptive prevalence rate (CPR) was 46%, a substantial increase from the early 1990s [10]. The most recent studies suggest that the majority of contracepting women use modern methods of contraception and one third of all contraceptive users use Depo-Provera (hormonal injection) [10].

Although these studies present an overall picture of reproductive health in Myanmar, the need for more data to inform policies, programs, and funding priorities is pressing. In addition to the shortage of information about specific populations (including those living in conflict-affected areas), information about women's experiences and perceptions of reproductive health is lacking. Further, very little is known about reproductive health among internal migrant communities, a rapidly growing population in the country.

In line with global trends, rural populations in Myanmar are increasingly moving to urban centers in the hope of finding better economic opportunities. Nearly 30% of the country's population currently resides in urban settings [11] and this rate is expected to continue growing. As economic opportunities and foreign investment in cities expand, so do rents, making city life increasingly unaffordable for many Burmese. Those who cannot afford to live near the city center often settle in more affordable townships on the edges of town. The growth of these peri-urban areas is changing the face of Yangon, Myanmar's largest city and former capital. The peri-urban region of Yangon encompasses a series of townships and houses several million people, many of whom hail from rural areas and distant regions of the country. Located on the peripheries of the city and characterized by poor infrastructure, slum settlements, and a mobile, migrant population, this dynamic peri-urban area is forcing a redefinition of the concept "hard to reach." While donors and government agencies are increasingly interested in working and investing in these townships, there remains a lack of data to guide these efforts.

North Okkalapa.

PROJECT AIMS & 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, 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 report presents major findings and is intended to serve as a resource for researchers, organizations, and potential donors working on the reproductive health needs of this population.

METHODS

In the summer of 2014, our multi-disciplinary project team conducted a multi-methods study to assess a number of core elements of reproductive health in peri-urban Yangon. We modeled the assessment after the approach used in "Separated by Borders, United in Need: An assessment of reproductive health on the Thailand-Burma border" [9]. The goal of this needs assessment was to integrate data from a range of sources to present an overall picture of the reproductive health needs and service availability in the peri-urban townships of Yangon.

DATA COLLECTION

There were several components to this needs assessment. We conducted 18 key informant interviews with representatives from non-governmental organizations (NGOs), community-based organizations (CBOs), and governmental agencies working in the field of reproductive health in Yangon. We identified participants through the study team's networks, word-of-mouth, and internet searches. Topics discussed included organizational scope, perceptions of reproductive health, and potential avenues for improving health outcomes.

Of the nine townships defined as peri-urban (next page), we used the 2013 Yangon Directory to identify 575 facilities. In order to gain a more in-depth understanding of the service delivery dynamics in the peri-urban Yangon region, we conducted a service mapping exercise in two townships, North Okkalapa and Hlaing Thar Yar. We chose these two townships because they differ considerably in infrastructure and location and we hoped they would provide an idea of the varied nature of peri-urban Yangon. In addition to identifying the physical location of service delivery points in these two townships, we also conducted surveys with representatives from 27 facilities, including private clinics (n=16) and hospitals (n=9). These surveys allowed us to capture information about facilities, affiliated health service providers, catchment areas, and patient populations, as well as available reproductive health services and their costs.

We also conducted a series of focus group discussions (FGDs) with both health care providers and women from peri-urban Yangon. We held two FGDs with providers: one with midwives, and one with doctors. Both FGDs were recruited with the help of the Yangon Young Women's Christian Association (YWCA) and explored participants' experiences working in the field of reproductive health in peri-urban Yangon. We also held five FGDs with women currently residing in peri-urban Yangon. Participants came from six peri-urban townships and were recruited with the assistance of the Yangon and National YWCAs, the Burnet Institute, and Marie Stopes International. We explored women's perceptions of reproductive health in their townships, their opinions on service accessibility, and their recommendations for improving information and services.

Finally, we conducted a brief reproductive health survey with 147 women residing in peri-urban Yangon. The survey asked women who were affiliated with the National YWCA's Microfinance Program general reproductive health questions, including those centered on contraceptive use, pregnancy history, and abortion experiences. Our participants resided in six peri-urban townships.

DATA ANALYSIS

We analyzed interview and FGD data using prevailing qualitative analytic techniques and managed our data using ATLAS.ti. We developed codes, categories, and themes both prior to and during the data collection and analysis process. We entered survey responses into Microsoft Excel and analyzed these data using descriptive statistics.

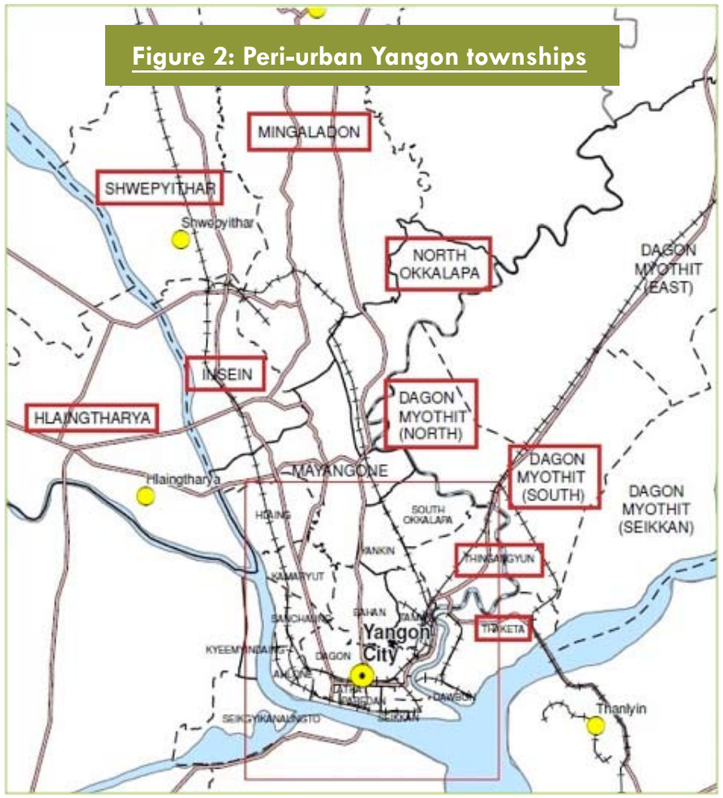
ETHICS STATEMENT

We received approval for this study from the Health Sciences and Sciences Research Ethics Board (REB) of the Office of Research and Integrity at the University of Ottawa (File #H02-14-03). The Board of Directors of the National YWCA Myanmar also reviewed and approved the protocol. We obtained verbal consent from participants at the beginning of each interview and/or FGD; participants could end their participation at any time without penalty. In order to protect the confidentiality of our participants we have removed or masked all personally identifying information in this report.

DESCRIPTION OF THE SETTING

In Myanmar, there is no widely agreed-upon definition of what constitutes a peri-urban area. In Yangon, as in the rest of the country, there is uncertainty as to which townships are peri-urban, as these spaces often encompass aspects of both rural and urban areas. While a proximity to an urban center is somewhat implied, peri-urban spaces comprise a unique set of demographic and socioeconomic characteristics which distinguish them beyond geographic location [12]. In the context of peri-urban Yangon, the study team identified four characteristics that could broadly categorize townships as peri-urban: poor infrastructure (including inadequate roads, sanitation, transportation and electricity); many informal, slum settlements; a highly mobile population; and a population that is largely engaged in daily wage labor. Using this set of criteria and informed by extensive discussions with local stakeholders and key informants, we identified nine townships that could be broadly categorized as peri-urban: Hlaing Thar Yar, Insein, Mingaladone, North Dagon, North Okkalapa, Shwe Pyi Thar, South Dagon, Thar Gay Ta, and Thin Gan Gyun.

Figure 2: Peri-urban Yangon townships



Mingaladone, near the train tracks.

Although we have classified these nine townships as peri-urban, we recognize that significant variation exists both within and between each township. Indeed, there are disparities in infrastructure and population diversity within each township. However, these nine townships sufficiently embody our identified characteristics so as to be classified as "peri-urban." Together, these townships comprise a population of approximately three million [11].

Our FGD participants and survey respondents came from a total of six of these nine peri-urban townships, while the scope of work of the key informants spanned all nine townships. The service mapping exercise also examined all nine townships, however two (North Okkalapa and Hlaing Thar Yar) were chosen for more in-depth examination. The two townships demonstrate the range in infrastructure and socioeconomic status across peri-urban Yangon. While both were unanimously considered peri-urban by stakeholders, Hlaing Thar Yar has significantly poorer infrastructure, is more geographically inaccessible, and has a higher number of migrants than North Okkalapa.

FINDINGS

REPRODUCTIVE HEALTH SERVICES ARE OFTEN AVAILABLE BUT INACCESSIBLE

Patients at MSI Thin Gan Gyun Centre.

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

Given the proximity of most peri-urban townships to the urban center of Yangon, available services are plentiful compared to rural parts of the country. Private clinics and drug shops are widespread and most townships have one or two public hospitals. However, participants repeatedly reported that access to hospitals was limited due to transportation and financial constraints. Although residents of peri-urban Yangon may be geographically proximate to donors or providers, socioeconomic factors, including their long work hours, daily and seasonal mobility, and overall lack of prioritization of health, impact access. As one key informant noted, "The government [provides] antenatal care. [Peri-urban women] don't have time to go there, because if they go there they won't get their daily wages."

Our service-mapping exercise in Hlaing Thar Yar and North Okkalapa found that although private clinics were abundant their hours of operation varied widely, thus reducing access. Of the 16 private clinics surveyed, 15 were open during some evening hours and only five were open throughout the entire day. All hospitals included in the survey were open 24 hours, but there were only three public hospitals in the two townships, serving a combined population of more than one million people [11].

The availability of sexual and reproductive health (SRH) services varied widely and was unpredictable. Most facilities stocked Depo-Provera but less than half offered condoms or EC and methods of long acting reversible contraception (LARC), such as the intrauterine device (IUD) or the hormonal implant, were rarely available. Testing and treatment for sexually transmitted infections (STIs) and HIV was also available sporadically; less than half of all facilities offering treatment and only one-quarter offering testing. Private and public hospitals offered the majority of SRH services but the cost varied tremendously; the limited number of public hospitals offered free services whereas private facilities charged significant fees for consultation and medications/devices. Several NGOs operate in the townships and offer a range of low-cost or free services.

Participants in our FGDs repeatedly discussed geographic and economic barriers to accessing services. Limited transportation options make hospitals difficult and expensive to reach, even if services are free. Private clinics, which are often more geographically accessible, require high out-of-pocket expenditures. NGOs provide a range of affordable or free services but do not operate in every township. Women reported that drug shops remain the most accessible and affordable option and thus were most frequented. Women overwhelmingly reported a preference for receiving care from private clinics and NGOs, which were perceived as being less judgmental. Women's decision-making whether, when, and where to seek SRH

care was also influenced by prevailing gender norms, their role in the household, marital status, and traditional beliefs and practices.

MISINFORMATION ABOUT SEXUAL AND REPRODUCTIVE HEALTH ISSUES IS WIDESPREAD

> **Some of the young women, they're afraid [to] use the Depo injection…[They ask] "Will I become fat? Will people notice I am using the contraception by looking at my figure?"**
>
> *(Key informant interview, June 2014)*

One of the most pressing reproductive health issues in peri-urban Yangon is the lack of information, and rampant misinformation, about SRH issues. Women's decision-making is influenced by what they hear from other women in their communities. Although many FGD participants had a basic level of knowledge of some sexual and reproductive health issues, they lacked more in-depth knowledge and many held medically-inaccurate beliefs. Effective and continuous contraceptive use appears to be hindered by lack of information about which contraceptives are available and where, misinformation about the proper dosage, administration, and timing of different methods, and non-evidence based fear of side effects. Concern that use of Depo-Provera would result in visible weight gain such that others would be able to detect use based on weight distribution was common and stressful for participants.

Although only half of the participants in our FGDs and survey had heard of emergency contraception (EC), those who were aware of EC were plagued with misinformation. FGD participants reportedly received inaccurate information from friends, media outlets, and even doctors. Several participants confused EC with abortifacients and knowledge about dosage, timing, and administration varied widely. Few knew that EC could be taken up to five days after unprotected intercourse; the majority assumed ECPs had to be taken within a few hours to have any efficacy. Rumors about the potential risks associated with EC, particularly if used multiple times, were rampant and included concerns about organ damage, infertility, and death.

Many participants identified expanding comprehensive and accessible reproductive health information in the peri-urban townships as a priority. Although FGD participants obtained much of their health information from friends and family, they cited NGOs and CBOs, magazine/journals, TV, radio, and township medical departments as their primary sources of reliable information.

INSTITUTIONAL DELIVERIES ARE INCREASINGLY COMMON, BUT HARMFUL TRADITIONAL PRACTICES PERSIST

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

Women are generally aware that hospital-based deliveries and deliveries with a trained health care provider have better health outcomes than home deliveries, especially those without a skilled attendant. Many of our FGD participants discussed cases where a relative or friend had given birth at home with a traditional birth attendant (TBA) and had a negative outcome, including complications leading to hospitalization and death of the baby or the mother. This knowledge was reflected in the practices of our FGD and survey participants, the majority of whom reported that their last delivery took place in a hospital.

Yet home deliveries remain common. Transportation and financial constraints that shape access to SRH services, in general, also appear to impact both utilization of ante-natal care (ANC) and hospital maternity services. Rather than give up the limited but critical income associated with daily labor, many women in peri-urban areas forgo ANC. Women who are unable to afford the transportation, consultation, medication, or other costs associated with a hospital delivery, and women who would prefer to give birth with a family member in attendance who would otherwise not be able to afford to travel to the facility, often given birth at home. Although some of these deliveries take place with a skilled midwife, FGD participants reported that women in their townships often used a TBA, despite known risks.

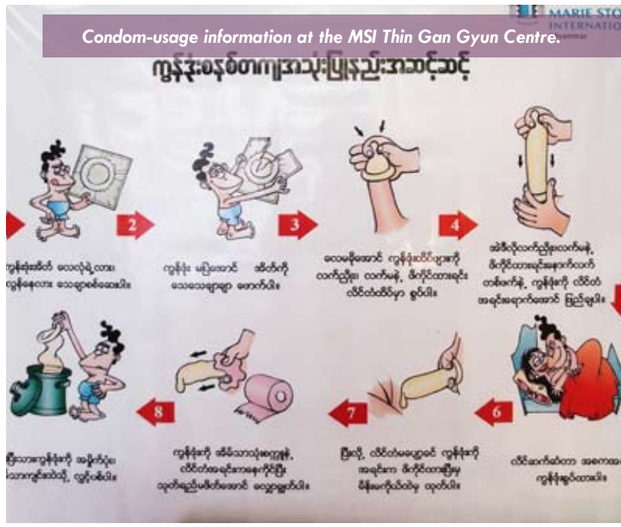
The high costs associated with an institutional delivery are not the only factors influencing women's decisions to use the services of TBAs. Many women residing in peri-urban regions of Yangon have longstanding relationships with TBAs, who have often provided services to other women in their current community or from their community of origin. Further, TBAs offer an affordable home-based delivery "package" that includes cooking, cleaning, assistance with the newborn, and child care for siblings, services that support post-partum women. That women are able to give birth surrounded by friends and family was also repeatedly reported as comforting in contrast with the solitary experience of giving birth in a hospital. Finally, TBAs often support birthing and postpartum practices that are culturally resonant.

However, these practices often carry risks. Participants reported that common practices associated with TBAs include pressing bricks on a woman's abdomen after delivery in order to remove "bad blood," encouraging women to go on restrictive diets in the postpartum period, and discouraging women from using water or soap for up to a month postpartum. These practices are often reinforced by community elders and older women relatives and stem from practices in communities of origin. As one medical doctor and FGD participant working in Insein township explained, "Burmese people have this superstition that during the puerperium period the mother has to eat only fried fish and soup…They just listen to the words of their neighbors and their mothers; they do not listen to the words of health care providers."

A VARIETY OF CONTRACEPTIVES ARE AVAILABLE, BUT MANY BARRIERS TO CONSISTENT USE EXIST

> **[A neighbor in peri-urban Yangon] was recommended to adopt contraception, but she can't give her time for that because she is busy with her jobs. She cannot go very often to get the injection, the pill she is always forgetting, and the [hormonal implant] is expensive, which she cannot afford…That is why she just keeps delivering babies.**
>
> *(23-year old FGD participant, resident of North Okkalapa)*

Within peri-urban Yangon a variety of contraceptive methods are available and the overwhelming majority of facilities that participated in our service mapping exercise offer contraceptive counseling. Our results suggest a robust methods mix that includes male condoms, oral contraceptive pills (OCPs), hormonal injections, ECPs, and LARC methods. However, reports from key informants and FGD participants confirmed the findings from our service mapping exercise; availability of contraception is highly variable and inconsistent, due to both different facility practices and temporary stock outs. For women who struggle to get to a health facility or work long hours and have minimal time to seek services, the unpredictability of contraceptive availability is an impediment to consistent use of ongoing methods. Further, our FGD participants evinced little knowledge as to where free or low-cost contraceptives could be obtained. Women often reported obtaining contraceptives at drug shops, but were concerned about the risk of purchasing expired products.



Condom-usage information at the MSI Thin Gan Gyun Centre.

Consistent with national statistics, Depo-Provera was the most commonly used contraceptive method among our survey and FGD participants (40%). Women were especially appreciative of the affordability, accessibility, and relative ease of use but had concerns about weight gain. OCPs were the second most widely used contraceptive method. However, women explained that consistent use was difficult; many day laborers lacked a consistent and predictable schedule which interfered with their ability to take a daily medication. Few women (less than 5%) had ever used a LARC method. In addition to the limited availability of IUDs, widespread misinformation about costs, side effects, and complications exists. Further, women consistently expressed concern about having to expose their genitals to a doctor, having a "foreign body" inside them, and damaging the uterus. In contrast, there appears to be growing interest in the contraceptive implant, despite an overarching lack of availability. Insertion of the implant in the arm is differentiated from, and preferable to, vaginal insertion of an IUD, which is perceived as a "surgery." Sterilization is rarely used and difficult to access due to rigid government inclusion criteria, that has long been motivated by pronatalist aims.

ECPs are widely available from pharmacies, drug shops, and betel shops and are inexpensive. However, knowledge of ECPs is limited and misinformation abounds. FGD participants reported increased use of ECPs in recent years, particularly by young women, unmarried women, and woman engaged in

extramarital sex. Although use of ECPs may indeed be preferable for these populations, given the lack of services dedicated to unmarried populations, the medication itself is stigmatized and associated with sexual behaviors that are culturally taboo. Similarly, condom use is not widespread; key informants and FGD participants reported that stigma and shame surround the purchase of condoms, especially by women, and that women rely on male partners to purchase condoms for them.

Finally, traditional contraceptive methods, particularly the herbal preparation kay thi pan, are considered by many women to be effective. Some women use it after sex or weekly in order to prevent pregnancy. Other women use it monthly to "purify" their blood and "induce" menstruation.

UNSAFE ABORTION IS COMMON AND PAC IS DIFFICULT TO ACCESS

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

The severe legal restrictions on abortion in Myanmar have resulted in considerable stigma, shame, and secrecy surrounding the procedure. Key informants estimated that rates of unsafe abortion in peri-urban Yangon are high, likely comparable to those in rural areas. However, the stigmatized nature of the procedure likely impedes data collection. Even in our anonymous survey, many women were unwilling to disclose their abortion history; one-third of respondents did not answer the question "Have you ever had an abortion?" Of those who did respond, approximately 11% said yes. However, FGD participants had many stories of neighbors, friends, and relatives having abortions, suggesting the practice is more widespread than our survey results suggest.

According to both key informants and FGD participants, abortion is widely available from untrained, community-based providers, and is most commonly performed by TBAs. Skilled midwives seeking extra income may also provide abortions. Some women first try to self-induce and then seek out a TBA or midwife. Despite local availability, women often travel outside their townships to access abortions away from the gaze of their community. Some TBAs charge per month of pregnancy, for example 5,000 kyat (USD5) per month, while others set a single price. Participants in the assessment reported knowing of unsafe abortions through seven months gestation.

Figure 3: Reported abortion methods

- **Mechanical**
  - Insertion of branches, pipes, hands into the uterus
  - Abdominal massage with hot bricks, fists, pipes, feet
- **Medical**
  - Use of misoprostol (many regimens)
  - Consumption of antimalarials
- **Traditional**
  - Use of kay thi pan (herbal mix) to "bring on" a period

Participants unanimously believed that having an abortion was dangerous and associated with significant risk of morbidity and mortality. Many participants shared stories of local women who had died from an unsafe abortion and none of our FGD participants shared a story of a woman who had experienced a safe and legal induced abortion in Myanmar. Reported abortion practices included "mechanical methods" (insertion of sharp objects into the vagina, abdominal massage), "medical methods" (use of misoprostol, consumption of anti-malarial medications), and "traditional" methods (kay thi pan). Mechanical, medical, and traditional methods are often used in combination, for example kay thi pan may be used in conjunction with insertion of a sharp branch. TBAs often lack information about the signs and symptoms of complications and are sometimes reticent to refer women to a hospital for post-abortion care (PAC). According to key informants, even those TBAs who have long and well-known histories of providing especially dangerous abortion care continue to provide services; demand in peri-urban areas is simply sufficiently high.

Unsafe abortion is a significant contributor to maternal mortality in Myanmar. Some of the limited evidence suggests that as much as half of maternal deaths in some Yangon hospitals are due to unsafe abortion [13]. Key informants in our study confirm that much of this mortality is due to lack of timely access to PAC. In peri-urban Yangon, PAC is provided by the public sector in hospitals. However, due to stigma, shame, and fear of criminal repercussions, many women are unaware of where to obtain safe PAC services or too scared to seek services when needed. According to one key informant, "People don't know they can get PAC in these areas… They know that if you have had an abortion, this is criminal. So if it's criminal, it's better not to go to the public sector…So a lot of maternal deaths are resulting from septic abortion…They still don't know hospitals provide PAC." Although some women reportedly lie to providers and state that they are having a miscarriage, fear of harassment or questioning by doctors and nurses leads some women to avoid PAC altogether or until it is dangerously too late.

REPRODUCTIVE HEALTH SERVICES FOR ADOLESCENT AND UNMARRIED POPULATIONS ARE LIMITED

> **I am single so I don't know much about the reproductive health.**
>
> *(21 year-old FGD participant, resident of Insein)*

Due to the stigma surrounding pre- and extra-marital sex, unmarried women are often met with judgment when accessing reproductive health care. Indeed, all components of our assessment confirm that there is an absence of SRH services tailored towards unmarried women. As a consequence, many young and unmarried women appear to bypass the health system entirely, obtaining products from unlicensed drug shops or having male partners purchase contraceptives for them.

There is a dearth of Information and educational resources for young and unmarried women. Indeed, according to our key informants and FGD participants some parents actively hinder their daughters' access to SRH information for fear this knowledge will encourage sexual activity. Further, FGD participants reported that health service providers are often hostile toward unmarried women who ask SRH questions or evince knowledge about issues related to reproductive health. As a consequence, many young, unmarried women feel that reproductive health has nothing to do with them and our unmarried FGD participants explained that because of their marital status they did not know anything about SRH issues. Our study participants acknowledged that the lack of tailored information and services and overall cultural taboos surrounding sex outside of marriage hindered the ability of women to access contraception and adequately prevent the transmission of STIs.

Young women coming off the circular train line in Mingaladone.

DISCUSSION & RECOMMENDATIONS

Market vendors traveling on Yangon's "circular" (suburban) train.

Although in recent years there has been increased attention paid to the needs of peri-urban populations, our assessment reveals that there continues to be significant unmet need for comprehensive reproductive health services and that women face many barriers to accessing existing services. The peri-urban population in Yangon is comprised of migrants from both distant states and regions and rural areas in geographically proximate areas. Highly mobile and economically vulnerable, this population reflects both national geographic health disparities and the health disparities within major urban centers. Indeed, the population of peri-urban Yangon is forcing a redefinition of the concept of "hard-to-reach." Traditionally, "hard-to-reach" areas have referred to remote regions that are geographically inaccessible. While peri-urban Yangon is geographically proximate to the city center, socioeconomic factors (e.g. poverty, long work hours, inability to prioritize health, and reliance on traditional practices) make this area hard-to-reach in a less geographic or spatial way.

Below we outline a series of recommendations; some center on the expansion of existing programs and projects while others focus on priorities for new efforts and structural reform. This list is not comprehensive but reflects a range of recommendations generated by participants in the assessment. Implementing these recommendations will require support from local communities, organizations, and donors.

ESTABLISH TAILORED HEALTH EDUCATION AND SERVICE DELIVERY EFFORTS

Study participants overwhelmingly agreed that the need for tailored health education tools and services in the peri-urban townships is pressing. Health information is largely shared through word-of-mouth and the advice of medical professionals is disregarded in favor of guidance from community elders. Tailored health education tools geared towards low-literacy populations, that tie health into broader lifestyle issues, are presented in culturally-relevant and resonant ways, and are made widely available, could be useful in improving knowledge in peri-urban Yangon. The use of media, including print and TV advertising, journals, and radio, provides great potential for spreading health information.

A lack of affordable and accessible transportation keeps many women from accessing reproductive health care. Many participants specifically referenced transportation costs as a significant, and prohibitive, health-related expenditure. Public transportation is limited, and taking a taxi can cost several thousand kyats—a day's wages for daily laborers. FGD participants also expressed appreciation of NGOs that bring services to their townships and provide transportation to bring women to their services. The improvement of transportation options and infrastructure could greatly improve women's access to reproductive health services. Transportation barriers could be reduced by expanding current efforts to bring services to the townships and by investing in ferry transportation systems, which eliminate costly transportation expenses by bringing groups to distant, otherwise inaccessible service delivery points. Additionally, expanding the provision of healthcare and education at workplaces, such as garment factories, could also help reach the peri-urban population.

IMPROVE TRAINING ON SEXUAL AND REPRODUCTIVE HEALTH FOR HEALTHCARE PROVIDERS

Women are often deterred from seeking care due to judgmental providers who they feel shame them for seeking reproductive health information or services. This is particularly true for young and unmarried women and for women seeking PAC. General practitioners lack training on reproductive health counselling and service delivery and few providers are able to specialize in the reproductive health field. Gaps in the provision of reproductive health services in peri-urban Yangon could be mitigated by improving the SRH training given to health care providers, either by updating curricula or expanding continuing education programs.

IMPROVE TASK-SHIFTING BETWEEN PROVIDERS AND PATIENTS

Key informants in particular highlighted the need for task-shifting, both among providers and between providers and patients, to expand access to SRH care and services. Increasing the number of trained midwives is critical, as is providing more comprehensive, long-term training to auxiliary midwives. Currently, treatments that require a single visit in neighboring countries require multiple visits to different providers in Myanmar owing to providers' limited service delivery capabilities. Expanding the service delivery capabilities of midwives and auxiliary midwives could greatly increase their ability to meet women's reproductive health needs, such as allowing midwives to provide oxytocin for postpartum hemorrhage management.

Several key informants also raised the possibility of task-shifting between providers and patients, particularly through the provision of self-injectable contraceptives. As stakeholders continue to explore the feasibility of introducing self-injectable contraceptives, their benefits for peri-urban, migrant, and daily wage working populations should be explored, as these populations may all face difficulties reaching a health facility in time for their injection every three months.

ENGAGE COMMUNITY MEMBERS IN DESIGNING PROGRAMS AND INITIATIVES

When making decisions about their reproductive health women are often guided by the experiences and advice of their elders or "aunties." This information can be valued over that shared by a medical professional. While this support in decision-making can be beneficial, it can also be harmful if aunties are promoting ineffective, misleading, or dangerous information or practices. Respected community elders should be engaged and empowered to provide their communities with comprehensive and accurate information about SRH issues through targeted trainings, workshops, and resources.

HIV information in MSI Thin Gan Gyun Centre's youth drop-in area.

Many key informants discussed the need for a set of standards to guide reproductive health programming, to ensure quality and consistency across the field. Such guidelines could ensure a minimum standard of care and quality, integrate monitoring and evaluation mechanisms, and embed community priorities, derived from consultation and collaboration.

IDENTIFY AVENUES FOR EXPANDING ACCESS TO SAFE ABORTION AND POST-ABORTION CARE

Harm from unsafe abortion continues to be a significant factor in maternal morbidity and mortality in peri-urban Yangon. Although there are limitations to any efforts to improve access to safe or safe(r) abortion care due to the legal status of abortion in Myanmar, there is a need to begin a comprehensive dialogue about unsafe abortion among migrant and peri-urban populations and to identify and institutionalize mechanisms to increase women's timely access to safe and legal services. Discussions about unsafe abortion among this population could include information about the legal status of abortion in Myanmar and the possibility of looking to the example of neighboring countries (e.g. Thailand, Bangladesh) for expanding legal services or developing a menstrual regulation program. Discussions could also focus on the health consequences of unsafe abortion and the possibilities for expanding access to safe(r) services and harm reduction strategies, including provision of evidence-based information about the use of misoprostol for early pregnancy termination. These discussions and initiatives could be undertaken through the framework of a policy forum, through conferences,

workshops and trainings, for local communities, providers, and service-delivery organizations. Finally, identifying avenues for increasing awareness about PAC services and improving the quality of care and the reception that women receive is critical. Efforts to expand the use of manual vacuum aspiration for post-abortion care and incomplete abortion management warrant additional attention.

EXPAND EFFORTS TO IMPROVE ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

Adolescents are increasingly being prioritized in health programming around the world. In Myanmar, several organizations are beginning to engage youth and develop youth-friendly programs and services. Efforts to improve reproductive health services geared toward adolescents and unmarried populations should be developed in collaboration and consultation with the target populations and rooted in evidence of their needs. Service providers must be trained on how to be non-judgmental and respectful of adolescents seeking their care or advice. Development of tailored health education efforts is especially important.

Figure 4: List of recommendations

- **Establish tailored health education and service delivery efforts**
- **Improve training on sexual and reproductive health for healthcare providers**
- **Improve task-shifting between providers and patients**
- **Engage community members in designing programs and initiatives**
- **Identify avenues for expanding access to safe abortion and post-abortion care**
- **Expand efforts to improve adolescent and unmarried sexual and reproductive health**

LIMITATIONS

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

CONCLUSIONS

The findings from this assessment highlight the inaccessibility of existing reproductive health services, considerable misinformation, common and unsafe practices surrounding delivery and abortion, and an overarching need for comprehensive information and resources in peri-urban Yangon. The peri-urban population requires a unique and tailored service delivery approach to meet their complex and varied health needs. Countless organizations are working tirelessly to improve reproductive health across Myanmar, including in peri-urban Yangon. This dynamic, rapidly evolving space provides unique challenges to providing comprehensive and accessible reproductive health services. Resources are needed for peri-urban women, service providers, organizations, and donors to best inform the delivery of reproductive health care. As more rural migrants seek economic opportunities in Yangon the peri-urban population will continue to grow. Initiatives dedicated to creating targeted health education and service delivery programs, removing transportation barriers, improving training opportunities for providers, and expanding efforts to work with adolescents, community elders, and the broader peri-urban population are just some of the efforts that could contribute to improved reproductive health.

REFERENCES

1. Sietstra C. "The Thailand-Burma border: Addressing needs in long-term conflict settings." In: Foster A, Wynn L, editors. *Emergency Contraception: The story of a global reproductive health technology*. New York: Palgrave MacMillan; 2012. p. 239-53.

2. Mullany L, Lee C, Yone L, Paw P, Oo E, Maung C, Lee T, Beryer C. "Access to essential maternal health interventions and human rights violations among vulnerable communities in eastern Burma." *PLoS Medicine*. 2008;5(12):1689(10). Available at: http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.0050242

3. World Bank. "Maternal mortality ratio (modeled estimate per 100,000 live births): Myanmar." In *WHO, UNICEF, UNFPA, The World Bank, and the United Nations Population Division. Trends in Maternal Mortality: 1990 to 2013*. Geneva, Switzerland: World Health Organization, 2014. Available at: http://data.worldbank.org/indicator/SH.STA.MMRT

4. Burma Medical Association, National Health and Education Committee, Back Pack Health Worker Team. "Diagnosis: Critical." 2010. Available at: http://www.jhsph.edu/research/centers-and-institutes/center-for-public-health-and-human-rights/_pdf/Burma_DiagCritical_19Oct10.pdf

5. Back Pack Health Worker Team. "Chronic emergency: Health and human rights in Eastern Burma." Thailand: BPHWT, 2006. Available at: http://www.jhsph.edu/research/centers-and-institutes/center-for-public-health-and-human-rights/_pdf/ChronicEmergency_BPHWT_Report2005.pdf

6. Ministry of Immigration and Population, UNFPA. "Country report on 2007 Fertility and Reproductive Health Survey." Nay Pyi Taw, Myanmar: Ministry of Immigration and Population, Myanmar, 2009.

7. Ba Thike K. "Abortion: A public health problem in Myanmar." *Reproductive Health Matters 1997*;9:94-100. Available at: http://www.cwds.ac.in/library/collection/elib/abortion/ab_abortion_a.pdf

8. UNFPA. "Report on situation analysis of population and development, reproductive health and gender in Myanmar." Myanmar: UNFPA, 2010. Available at: http://yangon.sites.unicnetwork.org/files/2013/05/july-2010-Report-on-Situation-Analysis-UNFPA.pdf

9. Hobstetter M, Walsh M, Leigh J, Lee C, Siestra C, Foster A. "Separated by borders, united in need: An assessment of reproductive health on the Thailand-Burma border." Cambridge, MA: Ibis Reproductive Health, 2012. Available at: http://media.wix.com/ugd/26bef0_c545278fc18448bfa81a500bc897fc08.pdf

10. Ministry of Health, UNICEF. "Myanmar multiple indicator cluster survey 2009-2010." Nay Pyi Taw, Myanmar: Ministry of National Planning and Economic Development and Ministry of Health, Myanmar, 2011. Available at: http://www.childinfo.org/files/MICS3_Myanmar_FinalReport.pdf

11. Department of Population. "Population and housing census of Myanmar, 2014: Provisional results." Nay Pyi Taw, Myanmar. Available at: http://unstats.un.org/unsd/demographic/sources/census/2010_phc/Myanmar/MMR-2014-08-28-provres.pdf

12. Iaquinta DL, Drescher AW. "Defining periurban: Understanding rural-urban linkages and their connection to institutional contexts." Paper presented at the Tenth World Congress of the International Rural Sociology Association, Rio de Janeiro, 2000. Available at: http://www.ruaf.org/sites/default/files/econf1_submittedpapers_11iaquinta.doc

13. Ministry of Health, Myanmar. *Five-year strategic plan for reproductive health in Myanmar, 2014-2018*. 2014.

BIOGRAPHIES OF KEY STUDY PERSONNEL

Grace Sheehy, MSc(c), is a Master's student in Interdisciplinary Health Sciences at the University of Ottawa, Canada. She is studying reproductive health in Myanmar for her thesis research. Her research interests include sexual and reproductive health and rights (SRHR) in Canada and Southeast Asia, particularly assessing access to abortion and contraception and young women's health-seeking behaviors. Ms. Sheehy led all components of the study, including study design, data collection and analysis, and dissemination of the findings.

Yadanar Aung, MBBS, is the Young Women's Coordinator at the National YWCA of Myanmar. Her research interests include the SRHR of adolescent girls, young women, and women in Myanmar. A medical doctor based in Yangon, Myanmar, Dr. Yadanar's work focuses on promoting SRHR among adolescent girls and young women, ending violence against women, and achieving gender equality. Dr. Yadanar facilitated logistical aspects of the fieldwork and contributed to the conceptualization of the study, data collection and analysis, and interpretation and dissemination of the findings.

Cari Sietstra, JD, is a specialist in reproductive health and justice issues and non-profit organization management. She is a Co-Founder and Principal of Cambridge Reproductive Health Consultants. She earned her JD from Stanford University and her BA from Harvard College. Her current projects focus on decreasing maternal mortality and harm from unsafe abortion among vulnerable Burmese populations living on both sides of the Thailand-Myanmar border. She was the founder and first Executive Director of Law Students for Choice (now Law Students for Reproductive Justice). As a Senior Co-Investigator on this project, Ms. Sietstra contributed to the conceptualization of the study, analysis of the results, and dissemination of the findings.

Angel M. Foster, DPhil, MD, AM holds an Endowed Chair in Women's Health Research at the University of Ottawa where she is an Associate Professor in the Faculty of Health Sciences. She is also a Co-Founder and Principal of Cambridge Reproductive Health Consultants and an Affiliated Scholar at Ibis Reproductive Health (Cambridge, MA). She received her DPhil in Middle Eastern studies from the University of Oxford, attending as a Rhodes Scholar, her MD from Harvard Medical School, and both a Master's degree (AM) and a Bachelor's degree (BAS) from Stanford University. Dr. Foster has conducted social science and health policy research in Canada, Egypt, Jordan, Lebanon, Morocco, Myanmar, Palestine, Thailand, Tunisia, and the US. Her research portfolio focuses on contraception and abortion, young women's sexual behaviors and practices, and health professions education. Dr. Foster has authored or co-authored over fifty articles, book chapters, and reports on sexual and reproductive health; her first book, Emergency contraception: The story of a global reproductive health technology (A Foster & L Wynn Eds.), was published by Palgrave MacMillan in 2012. She is currently the Chair of the Population, Reproductive, and Sexual Health Section of the American Public Health Association. Dr. Foster supervised the overall project and contributed to the conceptualization of the project, study design and implementation, analysis and interpretation of the results, and dissemination of the findings.

ABOUT CAMBRIDGE REPRODUCTIVE HEALTH CONSULTANTS

Cambridge Reproductive Health Consultants (CRHC) is a non-profit organization dedicated to improving reproductive health and fostering reproductive justice worldwide. By leveraging the skills of professionals from a variety of fields, CRHC focuses on increasing access to safe, legal, high quality, and affordable abortion care, reducing harm from unsafe abortion, increasing access to emergency contraception and long-acting reversible contraceptive methods, and advancing new reproductive health technologies in low resource and protracted refugee and conflict settings. CRHC accomplishes its mission by conducting action- and intervention-oriented research, creating and incubating new and innovative programs, and developing and delivering evidence-based reproductive health information, resources, and trainings.

CRHC • 1770 Massachusetts Avenue, Suite 181 • Cambridge, MA 02140 • USA
www.cambridgereproductivehealthconsultants.org • CRHCgeneral@gmail.com

Cambridge Reproductive Health Consultants