Situation Analysis
of Early Childhood Care and Development
in Myanmar
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Acronyms

ADB  Asian Development Bank
AIDS Acquired Immunodeficiency Syndrome
AMW  Auxiliary Midwife
ARI  Acute Respiratory Infection
ART  Antiretroviral Therapy
ASEAN Association of South East Asian Nations
ATEO Assistant Township Education Officer
BCG  Bacillus Calmette-Guerin
BHS  Basic Health Services
CEDAW Convention on the Elimination of All Forms of Discrimination Against Women
CESR Comprehensive Education Sector Review
CRC  Convention on the Rights of the Child
DEPT Department of Education Planning and Training
DoH  Department of Health
DPT  Diphtheria Pertussis Tetanus
DSW  Department of Social Welfare
ECD Early Childhood Care and Development
ECCE Early Childhood Care and Education
ECI  Early Childhood Intervention
EFA  Education For All
EmOC Emergency Obstetric Care
ENC  Essential Newborn Care
ETWG Education Thematic Working Group
GDP  Gross Domestic Product
GFATM Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV  Human Immunodeficiency Virus
IDD Iodine Deficiency Disorder
IDP  Internally Displaced Person
IMF  International Monetary Fund
IMCI Integrated Management of Childhood Illnesses
IMMCI Integrated Management of Mother and Child Illnesses
IMR  Infant Mortality Rate
JICA Japan International Cooperation Agency
JOIFCP Japanese Organization for International Cooperation in Family Planning
KAP  Knowledge Attitudes and Practices
LBW  Low Birth Weight
MDA  Mid Decade Assessment
MDEP Multi-Donor Education Fund
MDGs  Millennium Development Goals
MEC  Myanmar Education Consortium
MICS Multiple Indicator Cluster Survey
MMGWA Myanmar Mother and Child Welfare Association
MMR  Maternal Mortality Ratio
MoBA Ministry of Border Affairs
MoE  Ministry of Education
MoFR Ministry of Finance and Revenue
MoH  Ministry of Health
MoHA Ministry of Home Affairs
MoI  Ministry of Information
MoL  Ministry of Labour
MoNPED Ministry of National Planning and Economic Development
MoRA Ministry of Religious Affairs
MoSWRR Ministry of Social Welfare, Relief and Resettlement
NGO  Non-Government Organisation
ODA Official Development Assistance
OECD Organisation for Economic Co-operation and Development
ORT  Oral Rehydration Therapy
PMTCT  Prevention of Mother to Child Transmission of HIV/AIDS
SBA  Skilled Birth Attendant
TB  Tuberculosis
TCRC  Township Committee for the Rights of the Child
TEO  Township Education Officer
USMR  Under-5 Mortality Rate
UNAIDS  Joint United Nations Programme on HIV/AIDS
UNDP  United Nations Development Programme
UNESCO  United Nations Educational Scientific and Cultural Organization
UNFPA  United Nations Population Fund
UNICEF  United Nations Children’s Fund
USAID  United States Agency for International Development
UXO  Unexploded Ordnance
VHW  Volunteer Health Worker
WFP  World Food Programme
WHO  World Health Organization
Executive Summary

The most important years for a young child's survival, growth and development are pre-conception through the transition to school, with the fastest period of growth occurring during the first 3 to 4 years of life, when the child's brain is rapidly adapting to the environment. During this period, the developing brain is most sensitive to risks of malnutrition, toxins, stress, and lack of nurturing and brain stimulations. However, because of poverty, undernutrition, micronutrient deficiencies, and learning environments that do not provide enough responsive stimulation, millions of young children around the world are developing more slowly, or failing to develop, critical thinking and learning skills. After their last immunisation, many young children may not be reached by social services until they enter school, resulting in missed opportunities.

For disadvantaged young children, this initial deficit has a multiplying effect: Children raised in poverty, for example, complete far less education than those from middle-income families, due in part to their lowered ability to learn in school. The opportunity to help disadvantaged children have a more equal start in schooling is in the earliest years of life, when young children’s brains are developing most rapidly, and the basis for their cognitive, social and emotional development is being formed. Accumulating global evidence suggests that the most effective interventions to improve human development and break the cycle of poverty occur in children’s earliest years. Thus, to further the commitment to reduce poverty, and to increase the chances of all young children for success, investment in the ECCD is imperative, particularly at the levels of family and community but also in terms of policies, budgets and resource allocations.

The Republic of the Union of Myanmar is developing a Policy on Early Childhood Care and Development (ECCD). This Policy seeks to ensure the provision of comprehensive services for child survival, development, growth and support through the coordination of sectoral, multi-sectoral and integrated services in the fields of education, health, nutrition, sanitation, and child protection.

To provide elements for formulating the ECCD Policy and its Strategic Plan, this Situation Analysis collates knowledge, ideas and evidence-based analysis related to ECCD in Myanmar. It describes the situation of children and families; ECCD resources, including institutions and services, trained specialists, training systems and financial support; and policy and planning documents regarding pregnant women, mothers and children from birth to age 8 years. This study is intended to develop a baseline on information on ECCD and, more broadly, to contribute key elements for future planning, legislation, budgeting and national research in favour of ECCD to ensure the young child's right to survival and development during this most crucial phase of life. The goal will be to have a comprehensive reference document for use in annual reporting on progress and, in the longer term, to prepare this analysis again in four to five years.

Myanmar is estimated to have some 8 million children younger than age 8. Rapid political developments since the new Government assumed power in April 2011 offer hope for mitigating the country's long international isolation, and thus, for improving its social and economic development prospects. Yet because of the serious human development challenges that Myanmar has faced for decades, many young children still live in difficult circumstances that impede their good start in life. Key factors that create vulnerable situations for children include lack of access to education, health and social services; malnutrition; violent conflict and internal/external displacement; natural disasters; and a host of illnesses, including malaria, tuberculosis, and infection with or being affected by HIV/AIDS.

National indicators mask deep disparities in access to basic services, by rural-urban status, region, wealth, ethnicity, gender and other social dimensions such as remoteness, disability, conflict and post-conflict settings, and vulnerability to natural disasters. For example, the percentage of poor people in urban areas totals 24 per cent, while in rural areas it is nearly 43 per cent. Children frequently experience multiple vulnerabilities; a measure of multidimensional child deprivation among children aged 0-4 years in six domains indicates that early childhood education and development represents a particular issue in this age group. Overall, a complex and diverse picture of disadvantage exists across the country, with ethnic minorities frequently experiencing the most disadvantaged situations.
In the context of rapid social, economic and political reform, Myanmar offers many enabling conditions for the effective development of an integrated approach to ECCD. The challenge now is for it to adopt best practices and programme models to ensure that all young children, especially those most disadvantaged, not only survive, but thrive. For impact and efficacy, sectors need to work together where there is potential for real synergy. It is vitally important as well that there be continued and constant efforts to integrate ECCD into the work of all sectors, and for each sector to look at, and programme for, the young child in a holistic manner.

Status of Children and Families

Myanmar is being encouraged to foster an ever-stronger commitment to development of its young children. In so doing, the country can move a long way toward realising its ambitious hopes and vision for national economic and social development. Significant progress on ECCD has been made in a very short period; at the same time, a number of current services for young children are not yet capable of adequately supporting the most disadvantaged children and families in particular. Thus, many young children who are most in need of ECCD services remain unreached. In particular, ECCD services are concentrated in urban areas, where only one-fourth of the population lives.

Strong efforts will be needed to ensure the provision of fully integrated ECCD services that address the holistic development of young children, since many ECCD programmes in the country focus heavily on school readiness and tend to pay less attention to young child health, nutrition and protection. This may require significant strengthening of home- and family-based approaches to address gaps and meet young children’s multiple needs, by further taking into account health, nutrition, sanitation and protection issues as well as psycho-social stimulation. The absence of a recent national census and of reliable and disaggregated data on young children in various sectors remains a key underlying challenge.

With respect to pre-conception planning, more services are required in Myanmar to support preparation for pregnancy and strengthened provision of micronutrients such as folic acid and iron. In this regard, a focus on adolescents will be critical, since actions taken during adolescence, including the potential for unplanned pregnancies, can affect a person’s life opportunities, behavioural patterns and health. Likewise, comprehensive antenatal education services require significant development and expansion. Nutritional issues from the pre-conception period usually carry over into the pregnancy itself, and antenatal health care varies considerably by geographical location.

Achieving Myanmar’s 2015 target of a national Maternal Mortality Ratio of 145 deaths per 100,000 live births remains highly challenging. With regard to child mortality, a particularly rapid downward trend in the 1990s has decelerated subsequently, although the rate continues to decline. The Multiple Indicator Cluster Survey 2009-2010 reported the Infant Mortality Rate stood at 37.5 per 1,000 live births, still high but a notable decrease from the 66.1 in 2006 cited by Government sources. Likewise, the Under-5 Mortality Rate had reduced to 46.1 per 1,000 live births, from 77 in 2006.

Most maternal and young child deaths could be prevented by good-quality antenatal care, as well as properly attended births, prompt access to Emergency Obstetric Care services, and increased attention to postpartum care during the first months and year of life. Pneumonia and diarrhoeal disease as causes of young child deaths represent priority issues.

Postnatal deaths are of particular concern. Some 26,000 children per year who are younger than age 1 month die in Myanmar, and more than two-thirds of these deaths are reported to occur during the first seven days after birth. An overwhelming majority of neonate deaths occur in home births; stronger coverage of postnatal visits within two days after birth and during the first three months is urgently needed.

Trends in ECCD services for children aged 0-3 years cannot be fully assessed because relevant national data are insufficiently available. However, the number of children in this age group who were accessing ECCD programmes in 2011 stood at 37,620 (18,547 males, 19,073 females). Clearer strategies are necessary to support this critically important age group. Overall, access to ECCD services for 0- to 3-year-olds remains underdeveloped.
In addition to the Department of Social Welfare, Ministry of Health, non-governmental organisations, faith-based organisations, community-based organisations, associations and foundations play leading roles in the delivery of ECCD services to the youngest children. A strong need also exists for the development of Early Childhood Intervention services in Myanmar for young children with developmental delays, malnutrition, disabilities, chronic illnesses and atypical behaviours, such as autism. No comprehensive assessment exists of levels of child development at different ages from 3 to 36 months; likewise, data are needed on the incidence of developmental delays or disabilities at birth, while improved identification of Low Birth Weight and pre-term infants is necessary.

Meanwhile, Parenting Education in Myanmar will require more opportunities for parents of children younger than age 3 years. Major challenges remain in obtaining sufficient parental participation, in part because many parents are focusing their efforts on making a living. Parental expectations also may require support to change their participation in additional Parenting Education; many parents do not yet fully understand holistic young child development and its importance in stimulating their children. Positive cultural traditions of good child nurturing in all ethnic groups of Myanmar help to ensure most young children without major vulnerabilities are well-developed emotionally and socially.

Because overall health care-seeking behaviour among adults in the country requires significant strengthening, it is highly probable that more effort also is needed to optimise young children’s use of preventive and basic health care services for their young children. In assuming an important share of overall service provision, private service providers have become an essential part of maternal, postnatal and child health services. However, most are unregulated and many even untrained, offering predominantly curative care of highly variable quality.

Numerous causes contribute to high rates of young child malnutrition in Myanmar. Immediate causes include inadequate intake of nutritious foods; common childhood illnesses, including parasitic worm infestation; poor hygiene and sanitation; limited access to safe drinking water; household food insecurity; inadequate access to health care, particularly in remote areas; and insufficient maternal, infant and young child care and feeding practices. Although breastfeeding is used by most mothers, it does not always begin within 1 hour of birth, and many mothers do not exclusively breastfeed for the first six months. Complementary foods tend not to be fully nutritious, and a balanced diet is often not provided for children from age 6 months onward.

Although malnutrition rates have generally declined modestly, in Myanmar nearly 1 in 4 children younger than age 5 are still moderately underweight, and 5.6 per cent are severely underweight. More than 1 in 3 children are moderately stunted, a slight increase since 2003, and 7.9 per cent are moderately wasted. Micronutrient deficiencies are prevalent, and rates of anaemia in young children are very high. Research has demonstrated that malnourished young children also are developmentally delayed in one or more areas of child development. In addition, young child injury also is a key child health problem in Myanmar, and strengthened attention will need to be given to the issue, with updated and reliable data and expanded injury prevention and safety education within Parenting Education programmes.

The predominance of unhygienic latrines and unimproved water sources are major causes of high rates of diarrhoea in young children. A 2011 study in 6,000 households showed that while 75 per cent of households reported an improved latrine at home, the actual number of hygienic, fly-proof latrines was much smaller. For example, only 36 per cent of all latrines at home had a hygienic floor, with water-pour flush. Numerous schools have latrines that are unsanitary or even unusable for schoolchildren. Open defecation occurs in many areas, particularly in rural communities. In many households, ECCD and preschool centres, and primary schools, child faeces are disposed of improperly, often into the yard or sometimes into surface water. The ECCD Policy will need to include provisions for meeting these needs for improved sanitation, waste management, water and hygiene to strengthen the impact for young children.

Among children aged 37 months to 6 years, what distinguishes ECCD for this age group is their rising access to Early Childhood Care and Education (ECCE) programmes. Preschools can be established by the Department of Social Welfare (Ministry of Social Welfare, Relief and Resettlement), attached as preschool classrooms to basic education primary schools, founded by national or international non-Government, faith-based or community organisations, or run by associations, foundations or private sector groups or individuals. Because of this, it will be important for both the Department of Social
Welfare and Ministry of Education to ensure preschool services are registered, monitored, supervised and supported.

Significantly, more young children in the country are now participating in ECCE programmes (for children aged 3-5 years) than were doing so a decade ago. The percentage of 3- to 5-year-olds attending some form of organised ECCE programme increased from 9 per cent to 22.9 per cent between 2000 and 2009-2010. This represents a doubling in participation, albeit from a very low base. The Education for All National Plan of Action sets an overall target of 25 per cent by 2015, which is likely to be achieved; however, there is a high level of demand for these services and a new target will need to be established. In 2011, 258,235 children aged 3-5 years (109,743 males, 95,006 females) were attending ECCD programmes.

A second Education for All national goal is to increase the percentage of Grade 1 entrants with ECCD experience from 10.69 per cent in 2006 to 20 per cent by 2015. The current percentage stands at 18.50 per cent of boys and 18.73 per cent of girls in 25 disadvantaged townships (2010-2011); Multiple Indicator Cluster Survey data already indicate a far higher percentage nationally, at 39.8 per cent. Gender parity has been achieved in Early Childhood Care and Education programmes. However, comparing the current enrolment rate at this level with others in the region shows Myanmar requires further efforts to match the achievements of its neighbours in the Association of South East Asian Nations.

Wide disparities have been noted between urban preschool attendance, at 39.1 per cent, and rural attendance, at 15.9 per cent. Across states, attendance rates range from 60.7 per cent in Kayah to only 5.4 per cent in Rakhine. Older children are more likely to participate: The participation rate is 32.5 per cent for 4- to 5-year-olds, compared with just 13.8 per cent for 3- to 4-year-olds.

Available data also indicate that the richest quintile benefit most from existing ECCD services for 3- to 5-year-olds (46 per cent), while the poorest quintile benefits least (7.6 per cent). Socially excluded groups such as migrants, as well as those who are remotely located, often related to ethnicity, have enrolled and attended at a lower rate and are more likely to drop out of some ECCD programmes. At the same time, the proportion of schools with an ECCD facility has increased from 10 per cent in 2008-2009 (among 345 sample schools) to 31 per cent in 2010-2011 (among 635 sample schools). An analysis of the impact of higher ECCD coverage also showed that schools with an ECCD facility in 2009-2010 had a significantly higher student attendance rate in Grade 1 than schools without an ECCD facility; in 2010-2011, they recorded higher age-appropriate Grade 1 intakes.

Even so, a 2012 baseline study on the proportion of 181 school-based ECCD facilities that meet minimum quality standards in 15 townships offers an indication of the scale of the quality challenges still to be faced. Results included:

- Only 2 per cent of facilities met all 15 core quality indicators (see Figure 9)
- 54 per cent required urgent attention
- 75 out of 310 ECCD teachers in the facilities (24 per cent) were not trained
- Fewer than one-third of ECCD centres (31 per cent) had sufficient play materials
- Only 1 in 5 teachers recorded children’s developmental progress
- Barely half of communities (51 per cent) recorded parents’ participation
- Fewer than 3 in 5 Mother Circles (56 per cent) were active

Detailed policy guidance with regard to young children remains to be developed in a range of areas, including child-centred learning methods, inclusive education and meeting language needs in bilingual areas. Critically, a national ECCD monitoring and evaluation framework, with appropriate indicators, requires development as part of a comprehensive ECCD management information system that can provide overall accountability.

Related to access, a key issue is how to build up the capacities of governmental, non-governmental, faith-based, community-based and private organisations, as well as associations and foundations, to extend their reach to underserved areas of the country and better meet the needs of the most disadvantaged young children, particularly in under-served ethnic areas. The need to improve awareness of ECCE among various stakeholders likewise has been identified as a key remaining challenge in several studies.
Overall, child protection in Myanmar is generally approached from the perspective of different groups of vulnerable children in need of special protection. However, the systems approach, which focuses on building social welfare and legal systems for all vulnerable children, is being introduced only slowly. Young children belonging to socially or economically marginalised groups, especially ethnic, indigenous, religious and other minority groups, have been found to be particularly at risk.

Meanwhile, a total of 68,521 children younger than 5 years (0.88 per cent) have been identified with disabilities. This appears to be a vast undercount, and major efforts are needed to identify children with disabilities and developmental delays from birth onward. Of those identified thus far, 53,009 have been noted to have various physical disabilities, with 4,263 having sight disabilities, 5,412 with hearing disabilities, and 5,643 with intellectual disabilities. The disabilities of 46,869 young children were attributed to congenital causes; of 16,651 children, to disease prevalence; and of 5,002, to injuries. The Committee on the Rights of the Child has particularly recommended that efforts to facilitate the inclusion of young children with disabilities into the education system and society at large be strengthened in rural and remote areas; inclusive education thus far covers only a small percentage of these children, in both urban and rural areas.

Numerous child residential institutions are run by non-governmental, faith-based, community-based and private organisations, foundations and associations, as well as by the Government. Many of the residential care facilities for young children make their best efforts to fulfil the food, clothing and shelter needs of the children in their care, ensuring the right to survival, but most may not fully understand other basic rights of children, including development, protection and participation. Research also highlights a number of concerns regarding the protection, safety, health and well-being of young children in residential care facilities.

Many facilities are not registered, with young children in these facilities vulnerable to poor standards of care, neglect and abuse. Minimum standards of care have been developed but not yet issued as a directive, nor made mandatory for all residential care facilities in Myanmar. Because children aged 0 to 3 years almost always become developmentally delayed when placed in residential institutions, it is recommended that family placements be provided instead. These should include their own parents, relatives or others who are trained and supported to ensure the young children will be adequately nurtured and develop well.

The number of children in residential care facilities has increased in recent years, from 14,410 (23.4 per cent girls) in 177 registered facilities in 2006 to 17,322 children (22.4 per cent girls) in 217 registered facilities in 2010. A total of 603 children (487 boys, 116 girls) were aged 0-5 years. The number of children in private unregistered institutions across the country is not known.

A key theme is that most young children in private residential care are “social orphans;” they have parents or family members/relatives who could care for them if modest support were provided. Most children are brought to facilities by their parents and relatives, and usually at the start of the school year, suggesting that education and poverty are key reasons why children end up in residential care facilities. Thus, such facilities are not being used as a last resort, but rather, as a type of social safety net by parents who are unaware that their parenting role is essential for their children’s good development. Supporting families to rear their young children well will cost much less than paying for residential care.

A higher priority is now being given to the needs of orphans and vulnerable young children living with and affected by HIV, including psycho-social, nutritional, education and material support, referral and follow-up. In 2009 a total of 5,332 orphans and vulnerable young children affected by HIV were receiving a package of support, with up to half of these children being younger than age 5. More young children will require such support.

More information is needed on child physical, emotional and sexual abuse and general child neglect, although it is known that physical punishment of young children is a common disciplinary measure used by parents, caregivers and teachers. As with issues of child abuse, issues of domestic violence within the family are seldom mentioned publicly. Anecdotal reports indicate sexual abuse of girls and boys occurs in some homes, the community, at work, in institutions and in some schools. It is unclear how many of these are young children. Awareness is low about how to identify and protect children at
risk of domestic violence or child abuse. Very few support services or counselling options exist for victims and their families, even when abuse is reported.

Myanmar has several additional categories of young children who are particularly vulnerable, including those living in severe poverty, involved in child labour, affected by conflict and/or natural disasters, internally displaced and refugee children, children of parents in correctional facilities, children with developmental delays and disabilities, malnourished children, children with diseases including HIV, and others.

**ECCD Resources**

Implementation of ECCD programmes by line Ministries and local authorities is complex. Traditionally ECCD has been seen as a shared responsibility of the Department of Education Planning and Training (DEPT), Ministry of Education, the Department of Social Welfare (DSW), Ministry of Social Welfare, Relief and Resettlement, the Ministry of Health, and the Ministry of Border Affairs. Various other Ministries also are involved in supporting ECCD services, including the Ministry of Home Affairs, Ministry of Labour, Ministry of Religious Affairs, Ministry of National Planning and Economic Development, and Ministry of Finance and Revenue.

Under DEPT, primary schools that have an extra classroom, communities that are able to construct an extra classroom, and those with either an available teacher or the ability to fund a teacher from the community have been encouraged to set up school-based ECCD centres (preschool classes). These are now found in 2,315 schools in 162 townships.

No formal pre-service training for ECCD teachers currently exists in Myanmar. However, the Department of Myanmar Education Research Bureau runs a preschool used as a laboratory for primary school teachers to receive exposure to the preschool atmosphere. DSW also provides preschools and trains their own teachers, many of whom in turn help to train community-based ECCD centres, Parenting Education and Mother Circles for 0-to 3-year-olds that are sponsored and overseen by DSW. Many of these ECCD services under DSW sponsorship are conducted and partially or fully supported by a wide range of national and international NGOs, faith-based and community-based organisations, professional associations, foundations and private sector groups.

The Government now intends to widen preschool education in primary schools and community-based preschools managed or sponsored by DSW in order to greatly expand preschool coverage to the level of, or higher than, that of other countries in the region. This signals the potential for major changes in the approach to ECCD. Policy planning is needed to help ensure strong and appropriate mechanisms are established to coordinate and ensure quality, equity and accountability among these diverse national and international ECCD entities.

A total of 12,254 trained preschool teachers (40 males, 12,214 female) provide ECCD services for children aged 3-5 years, while 25,273 members of Management Committees (6,615 male, 18,658 female) contribute to oversight of community-based ECCD programmes. Trained Parenting Education facilitators total 6,982 (683 males, 6,299 female) and serve 129,255 parents (24,752 male, 104,503 female), while 375 trainers of trainers (10 male, 365 female) also offer ECCD support.

In the recent past, acute human resources constraints among Government and NGOs alike have affected implementation of ECCD programmes. Overall weaknesses in human resources related to ECCD in Myanmar continue to include acute staff shortages; lack of salaries and benefits for full-time personnel; low deployment in geographical and population areas of greatest need, resulting in a lack of equity; some poor service quality; a lack of adequate supervisory and accountability systems and managers; absence of formal ECCD training services at secondary and university levels; inadequate capacity of short-term training institutions; and inadequate attention to preparing ECCD personnel to provide culturally appropriate ECCD services in the mother tongue in minority ethnic regions of Myanmar.

As noted above, no formal pre-service training system exists for ECCD, although some in-service training is provided mainly by the Government, international and national NGOs, faith-based organisations, national associations and foundations. However, many short-term training events require further strengthening, as well as considerable follow-up training and mentoring, to ensure that training and awareness is transformed into positive impact for young children.
In all, it will be necessary to establish a comprehensive, high-quality, and multi-sectoral pre- and in-service ECCD training system. This may include pre-service training at the diploma and university levels, formal certification and re-certification for preschool teachers and other ECCD personnel, and continuous upgrading of the capacities of paraprofessional and volunteer service providers, with a bridging programme for those who wish to pursue further training to achieve professional status.

Overall, a full baseline study on workforce development and training capacity in all ECCD sectors is urgently required to project accurately the needs for expanding and improving training capacity. Development of a comprehensive database for ECCD training could assist in tracking progress in capacity development and provide important information on numbers of trained human resources in the country. In addition, staff in all ECCD-related fields require a broadening of training in other relevant areas, including peace education and Disaster Risk Reduction/Disaster Risk Management.

In Myanmar social sectors historically were secondary to economic sectors in national planning. Budgeting for investments in children, including ECCD, does not have a separate line in most ministerial budgets or the overall national budget. Linkages between national planning and budgeting for the social sectors have been constrained by a lack of resource information during past medium-term (five-year) planning processes; annual plans have been derived from these. A lack of coordination between capital and current budget preparation also may lead to an underestimation of maintenance/running costs of new capital investment. Most ministerial budgets include mainly recurrent expenses and have little left for innovation, training and programme support.

A need for greatly strengthened public resource allocations to health, education and social welfare has been cited as a root cause of suboptimal sector performance. Moreover, these allocations have been highly unbalanced: Education accounted for the majority of the social sector budget in 2009-2010 (78 per cent), with far smaller amounts dedicated to health (20 per cent) and social welfare (2 per cent). It should be noted that all of these budgets, including education, are far below internationally recommended levels. The entire social sector will need to be prioritised in future budgets.

All this has resulted in high out-of-pocket payments by families and communities, so that poor and near-poor households – particularly women, young children, ethnic minorities and the chronically ill within these populations – have difficulty in accessing quality social services. Basically, few social services are even offered in or near some villages and wards. In addition, Official Development Assistance (ODA) to Myanmar has remained very low, at about US$4 per capita, in large part because of international sanctions. While this has improved in the last two years with the change of Government and the influx of humanitarian aid following Cyclone Nargis in 2008, numerous challenges remain in establishing development partnerships.

By mid-2012, however, all this appeared set to change. Following the election of the new Government and encouraging economic and social reforms, nearly all international sanctions were lifted by the United States, European Union and Canada, while the World Bank, International Monetary Fund and Asian Development Bank announced their intended return to Myanmar. Trade and Foreign Direct Investment by members of the Association of South East Asian Nations, particularly Thailand, also offer considerable promise for development investment in the country. Some observers have estimated that the potential exists to upscale ODA by at least a factor of 10, thus potentially raising social sector expenditures. However, it must be cautioned that although ODA may increase, it should not be counted on to replace Government efforts to fund development activities.

The 2012 legislative session witnessed a change with regard to health and education spending, resulting in greater allocations than in previous years. For example, total allocations to the education sector increased from about 0.7 per cent to 1.5 per cent of GDP for 2012-2013. While still very low, spending on education would almost double to 450,000 million kyats from 230,000 kyats in the previous year. The Government’s proposed national budget health would receive about 150,000 million kyats, nearly three times as much as the 55,000 million in the last budget. At the same time, social welfare has received only 3,500 million kyats in 2012-2013. These budgets will need to increase at least sixfold to achieve the levels needed to improve young child development, greatly reduce poverty, meet major needs for health and education, and develop an effective system of social and child protection.
In addition to annual Government budgets, a special Fund for ECCD should be established to fully support all initiatives, services and activities under the new ECCD Policy and its Strategic Plan. This could include support from international development partners; international businesses; various taxes; donations from the private sector and individual benefactors; and other resources.

Policy Analysis

For the Government of Myanmar to recognise that early childhood is a critical period of human development as an area that requires a national policy attention is a major breakthrough. This is a recent development, which has occurred since 2011. Now, however, it is well understood that learning begins at birth and that the early years are when the foundations for subsequent learning and adult values, civic participation and productivity are established. The Government is working to develop the policies, plans and systems for its ECCD system. An ECCD Policy and Strategic Plan are under preparation, as are relevant laws, standards and service regulations. The rapidly evolving context of Myanmar offers new opportunities for accelerating progress, including in the social sectors in general and ECCD in particular, and for addressing widespread systemic constraints.

Myanmar is a party to important international normative instruments, including the Convention on the Rights of the Child (CRC) and the Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW). The Government also has a body of national laws committing the State to the realisation of children’s and women’s rights. At the same time, policy and strategy development require further strengthening in almost all ECCD-related areas. Additional deepening of the decentralisation process will be needed at state, division and district levels alike to propel this progress. Overall, ECCD provides an opportunity to establish a well-functioning system for the decentralisation of services because its work is eminently local, with township, regional/state and national support and technical guidance.

Wide gaps have existed between law and practice at many levels, although many of these are set to be addressed with the revision of the 1993 Child Law now under way to bring it into compliance with the CRC. Many other gaps remain, however, and will require continued attention, including access to and provision of services, greatly expanded financing, improved service management, supervision and accountability, and resource development through the developing of a high-quality and continuous pre- and in-service training system.

Critically, ECCD services are not currently included in several key policy and planning documents, including the Myanmar Health Vision 2030, the 30-Year Basic Education Plan; the Strategic Plan for Child Health Development 2010-2014; or the Rural Development and Poverty Alleviation Plan 2011-2015. ECCD guidelines still require approval, and a comprehensive ECCD database remains to be developed. In particular, a clearer strategy is needed for how to support the holistic development of 0- to 3-year-olds, since much of the policy focus to date has been mainly on 3- to 5-year-olds and their preparation for school.

The education sector is beginning to address many of its critical gaps with regard to ECCD, including policy gaps, through the Comprehensive Education Sector Review begun in mid-2012. At the same time, significant gaps also exist with regard to child protection policies and services, particularly for the most vulnerable and marginalised young children. Health policies will require better targeting to ensure effective services are provided to poor young children and those living in remote and border areas. In particular, malnutrition needs to be considered as an inter-sectoral issue also requiring attention to policies related to food security and livelihoods.

Moreover, in each of these sectors, any disconnect between policies, plans, programmes and resource allocations can make ECCD interventions difficult to implement. A strong ECCD organisational structure will be required to ensure good multi-sectoral coordination, phased service expansion and quality improvement, and service accountability through monitoring, evaluation, and reporting linked to annual planning and budgeting. In the end, if these issues can be addressed, the quality of all social sector services for Myanmar’s youngest children will be significantly improved.
Key recommendations to strengthen ECCD

Pre-conception:
1. Develop and provide pre-conception education for youth and prospective parents in order to help them prepare for conceiving a healthy child and to improve birth outcomes.
2. Expand health education, including through both home visits and group sessions, to promote health-seeking behaviour at the individual level, and to promote the importance of adequate nutrition, as it relates to young children.
3. Expand target groups for Parenting Education, including to adolescents and prospective mothers and fathers; consider including preparation for parenting in Life Skills Education and non-formal education services for youth.
4. Reduce the unmet need for contraception, as well as strengthen delivery of a comprehensive, standardised reproductive health package and essential obstetric care in all geographical areas.
5. Enhance the access of pre-pregnant women to key nutritional supplements, including folic acid and iron.
6. Further encourage the greater involvement of men in reproductive health issues.

Antenatal:
1. Develop a comprehensive package of antenatal education home visits and group sessions, and make it widely available to women, to promote health-seeking behaviour and antenatal health care at the individual level, and explain the importance of adequate nutrition, avoidance of harmful substances and other essential topics with regard to the impact on young children.
2. Expand greatly the provision of antenatal health care visits in health centres and clinics.
3. Enhance the access of pregnant women to key nutritional supplements, including folic acid and iron.
4. Expand/refresh capacity building of Basic Health Services staff, midwives, auxiliary midwives, community health workers and other health care providers to ensure content of antenatal visits is of high quality and standardised.

Delivery:
1. Support expanded capacity building among skilled health care providers covering the delivery and postnatal periods; especially ensure capacity building of management of Emergency Obstetric Care among health care providers involved in home deliveries.
2. Expand delivery services and outreach to help ensure women deliver with skilled medical attendants, preferably in a skilled medical facility.
3. Strengthen community and family awareness of recognition of warning signs of complications during delivery and the postnatal period; of the importance of acquiring Skilled Birth Attendants; and of expediting a rapid referral process in the event of danger signs in childbirth.
4. Encourage institutional delivery for all women, and especially for high-risk pregnant women at Emergency Obstetric Care facilities.
5. Strengthen efforts to ensure birth registration and the provision of a birth certificate for all young children at local health centres.
6. Develop a plan to provide birth registration to all under-18 children who have not yet been registered.
7. Implement specific measures to ensure greater access to birth registry services on the part of children born at home or in remote areas, ethnic minority regions, or displaced/stateless young children.

Postnatal:
1. Ensure that 80 per cent of all newborns receive a community-based Essential Newborn Care package and enhance key family and community practices for neonates.
(2) Ensure that 100 per cent of all Low Birth Weight and pre-term infants receive extra health and nutrition care and development during the newborn period and up to 2 years after birth to ensure they do not develop delays, malnutrition or chronic illnesses.

(3) Expand capacity building for health care providers, including Basic Health Services personnel and community health workers/volunteers, on the importance of provision of quality postnatal care and regularise efforts to obtain data on the quality of Essential Newborn Care.

(4) Increase the proportion of infants receiving breastfeeding within 1 hour of birth to 80 per cent.

(5) Increase the proportion of infants to receive exclusive breastfeeding up to 6 months and appropriate complementary feeding between 6 to 9 months of age, to 80 per cent.

(6) Conduct regular young child death reviews at all levels, including audits in health facilities and hospitals.

Children aged 3 to 36 months:

Child development:

(1) Ensure all parents and young children access regular preventive and basic health, nutrition, water and sanitation, and protection services

(2) Provide quality early care and development services for young children of mothers working outside the home.

(3) Comprehensively map and further expand sustainable ECCD services for 0- to 3-year-olds, including Mother Circles.

(4) Through home visits and centre-based services, expand formal and more integrated Parenting Education and support services to provide a stronger focus on 0- to 3-year-olds and foster awareness of the importance of holistic ECCD.

(5) Identify successful models of services for 0- to 3-year-olds in Myanmar and gather more relevant data on programme coverage.

(6) Identify gaps in curriculum, educational materials and methodologies for services for children aged 0 to 3 years and their parents.

(7) Conduct a comprehensive study/assessment of levels of child development in this age group, including gathering reliable data on developmental delays among the youngest children and disabilities at birth and thereafter.

(8) Establish/strengthen delivery of multi-sectoral Early Childhood Intervention services for very young children identified with developmental delays or disabilities, as well as for very young children with malnutrition or chronic illness.

(9) Strengthen linkages between Mother Circles and Parenting Education with regard to young children, and consider innovative approaches to help establish more sustainable Mother Circles in rural and remote areas.

(10) Ensure programme services for children aged 0 to 3 years and their parents receive greatly increased financial support and other resources.

Health care:

(1) Enhance one sectoral coordination mechanism, through the National Child Health Committee, for greater impact on young children.

(2) Define uniform technical standards for health care provision for young children to be followed by all partners.

(3) Give greater priority to prevention of young child disease and illness rather than curative care, through increased attention to immunisations, regular child checkups and developmental screening, and prevention of diseases such as malaria, tuberculosis and HIV, among other actions.

(4) Improve key family practices with regard to young child health, through effective parent education focused on behavioural change, with reinforcement through communication media.

(5) Conduct a national census to assess health and other indicators, and develop a unified health care monitoring and evaluation system using core indicators, fostering a strong link between evidence/information with planning and programme development.

(6) Address persistent issues of equity and diversity in health care delivery for young children.

(7) Identify gaps in key health care quality assessments and undertake necessary assessments.
(8) Strengthen human resources development, particularly for health education with regard to young children, as well as an efficient system for procurement and logistics.

(9) Conduct gap analysis of additional Parenting Education needs with regard to young child health.

Nutrition:
(1) Strengthen surveillance mechanisms to monitor micronutrient deficiencies in young children.
(2) Increase the proportion of under-3 children with moderate and severe acute malnutrition who receive nutritional rehabilitation treatment and intensive stimulation in order to serve 100 per cent of young children as rapidly as possible.
(3) Increase the proportion of children (aged 6-59) months who receive Vitamin A to 95 per cent.
(4) Ensure all young children with anaemia receive appropriate treatment.
(5) Conduct gap analysis with regard to additional areas of nutrition education needed in Parenting Education and respond to gaps identified to strengthen awareness with regard to appropriate nutritional practices with regard to young children.
(6) Assess the nutritional status of breastfeeding women and provide essential micronutrients and food supplements as needed.
(7) Provide young child feeding services at all Mother Circles and other ECCD centres.

Childhood injuries:
(1) Implement national-level surveillance on childhood injury, disaggregated by age group.
(2) Conduct an in-depth study on the epidemiology of childhood injury in the country.
(3) Strengthen Parenting Education on home, yard and community safety, injury prevention, and first aid with regard to young children.

Sanitation issues:
(1) Formulate a specific water policy and adopt legislation for national drinking water quality standards.
(2) Establish a national water supply and sanitation database to facilitate long-term planning and identify low-coverage townships.
(3) Further strengthen sectoral coordination mechanisms.
(4) Ensure enhanced linkages between awareness/knowledge of recommended safe water and sanitation practices and behaviour change through strengthened behaviour change communication to maximise impact on young children.
(5) Place a strong emphasis on sanitation, water, waste management and hygiene modules for the national Parenting Education programme with regard to young children.
(6) Develop guidelines for homes, ECCD centres, preschools and primary schools with regard to sanitation, water improvement and handling, waste management and hygiene with regard to young children.

Children aged 37 months to 6 years:
Education:
(1) Integrate ECCD into the Basic Education system, through increased attention to Parenting Education and early childhood development; Early Childhood Interventions for 0- to 3-year-olds and preschool for 3- to 4-year-olds; and transition to primary school for 4- to 6-year-olds.
(2) Continue to develop a costed medium-term education strategy and expenditure framework with special attention to ECCD.
(3) Develop a baseline to assess needs for preschools and preschool classes in all communities, as well as a national strategy for ECCD with inclusion strategies/models for poor communities, giving priority to marginalised, ethnic minority, rural and remote communities.
(4) Prioritise the provision of additional financial, human and technical resources for ECCD programmes.
(5) Offer a stronger, integrated health and nutrition package as part of ECCD.
(6) Provide health care services plus nutritionally appropriate and hygienic feeding programmes for preschools.
(7) Particularly provide additional policy guidance on areas related to young children, including child-centred learning methods, inclusive education and meeting language needs in bilingual areas.
(8) Ensure all preschool activities and ECCD services in general are provided in the mother tongue.
(9) Particularly provide additional policy guidance on areas related to young children including child-centred learning methods, inclusive education and meeting language needs in bilingual areas.
(10) Proactively expand Parenting Education to a wider target group of community members, including fathers, grandparents and young people who might become parents in the future.
(11) Improve overall coordination among service providers for young children and strengthen strategic partnerships that offer holistic support based on partners’ comparative advantages, as well as work with partners to undertake further cost-benefit analyses of different types of ECCD in different contexts.
(12) Focus on ensuring the provision of high-quality, culturally and linguistically appropriate preschool education and stimulate further understanding of constraints on quality of ECCD education, while strengthening assessment of young child development.
(13) Provide salaries for full-time community ECCD personnel (e.g., Parenting Education, Mother Circles, preschools, etc.) and explore ways to offer higher salaries to those who already receive stipends or salaries.
(14) Respond to challenges in providing ECCD services in remote areas by means of selecting, training and hiring local teachers and other personnel and offering special incentives.
(15) Establish sustainable pre- and in-service training, monitoring and support systems for ECCD Community Management Committees and caregivers, and strengthen accountability mechanisms.
(16) Undertake a collaborative study to improve analysis and documentation of lessons learned in ECCD.

Children aged 6-8 years

1. Undertake a baseline study of all transitions programmes to identify achievements, challenges, and areas for further development with regard to young children, and foster an even stronger transitions programme to primary school that includes strong parental participation, child-centred approaches, and initial use of the mother tongue in the early primary grades.
2. Systematically implement Child Centred Approach in lower grades of primary schools and upgrade quality of teacher training, particular for multi-grade situations.
3. Give additional attention to improvement of school infrastructure for young children, particularly sanitation facilities for girls.

Vulnerable children with special needs

Children belonging to socially or economically marginalised groups:

1. Develop national strategies to target the poorest and most marginalised young children.
2. Gather additional data relating to young children of ethnic minorities and other marginalised groups to develop policies and programmes that fully ensure implementation of their rights.
3. Ensure appropriateness of language policy in educational situations and expand usage of the mother tongue throughout the early primary school years, with bridging to the national language beginning by Grade 4.
4. Ensure all educational, health, nutrition, sanitation and protection services for young children are culturally and linguistically appropriate through involving members of each ethnic community in the planning, implementation and oversight of all ECCD services.
Children with disabilities or chronic illnesses:

1. Provide strengthened support to early detection of disability and the development of early childhood intervention services, including specific policy guidelines and procedures, screening assessments, individual plans, and home visits with family training services in this regard.
2. Strengthen pre- and in-service capacities of health workers and others to advise parents of young children with disabilities, refer such children to appropriate early intervention and health services and provide quality care and development services.
3. Expand and strengthen inclusive education in preschools and primary schools, especially in rural and remote areas.
4. Deepen the understanding of causes of under-5 disability and existing practices regarding such children, using disaggregated data.
5. Undertake a baseline survey on young children with chronic illnesses and diseases such as malaria, tuberculosis and HIV, and provide recommendations for improving prevention and treatment protocols in specific geographical areas.

Orphans, social orphans, and other children lacking parental guidance:

1. Develop a prevention and de-institutionalisation strategy for young children.
2. Enforce Minimum Standards for Residential Care Facilities as a directive to ensure that compliance becomes mandatory, including for standards of health care and management of young child behaviour.
3. Establish improved registration processes and effective monitoring of residential care facilities, including a clarified monitoring role for Government.
4. Use social mobilisation campaigns to promote a change of public perceptions of residential care and to promote a “family first” approach for young children.
5. Systematically assess the number of young children in street situations.
6. Raise awareness on reunification and reintegration for institutionalised young children through the provision of family preservation and therapy services, financial and material support, Early Childhood Intervention services and other health, nutrition, protection and educational services.
7. Strengthen education, counselling and rehabilitation services for families of young children in difficult circumstances, such as those affected by natural disasters, conflicts or internal displacement, or refugees.

Children affected or infected by HIV/AIDS:

1. Ensure more women and their partners access and use family planning, antenatal, delivery and postpartum services as entry points for HIV testing.
2. Ensure 100 per cent of HIV-positive women receive ART treatment in pregnancy and during and after delivery.
3. Ensure the young children of HIV-positive women receive ART treatment as recommended in PMTCT protocols and Early Childhood Intervention services for them and their parents or caregivers.

Abused and neglected children, including those affected by domestic violence:

1. Conduct baseline studies detailing the extent of abuse and neglect of young children and develop mechanisms for eliminating any forms of young child abuse and discrimination.
2. Proactively raise family and community awareness of young child abuse and neglect and strengthen relevant community-based interventions.
3. Offer enhanced support and rehabilitation services to young children and women suffering as a result of abuse.

Other vulnerable and marginalised children, including issues of child labour:
(1) Develop appropriate services, including counselling and support, to meet the needs of young children living in severe poverty, involved in child labour/street children, affected by conflict and/or natural disasters, internally displaced and refugee children, children in conflict with the law, and young children of parents in correctional facilities.

(2) Strengthen baseline data on other categories of vulnerable and marginalised young children.

(3) Enforce all national laws and standards that have been developed to eradicate abusive child labour and to ensure that all young children are enrolled and participate fully in preschool and primary schooling.

Recommendations for strengthening ECCD with regard to resources:

(1) Ensure adequate and fully transparent funding of ECCD programmes, with a separate budget line for children in national budgeting processes and for the Ministry of Education and Ministry of Health, as is currently found in the Ministry of Social Welfare, Relief and Resettlement.

(2) Strengthen coordination between budgeting for capital investment, development costs and recurrent costs, to ensure greater impact for young children.

(3) To supplement Government budgets, establish a special ECCD Fund to support key initiatives, services and activities presented in the ECCD Policy and its Strategic Plan, with sources including international development partners, international business, various taxes, and private sector donations.

(4) Conduct a baseline study on workforce development needs, establish a high-quality pre- and in-service training system that includes all outstanding training institutions, and develop a systematic and continuous data system on resource capacity issues and issues tied to the training system.

(5) Develop a comprehensive, multi-sectoral quality pre-service ECCD training system, including criteria for certification and periodic re-certification for professional service providers.

(6) Establish an ECCD diploma programme in Colleges of Education as well as bachelor’s, master’s and doctoral programmes at the Institutes of Education, in collaboration with Yangon University.

(7) Upgrade capacities of paraprofessional and volunteer service providers through the provision of pre-service training and regular in-service training; train all ECCD field personnel in areas relevant to ECCD such as peace education and Disaster Risk Reduction/Disaster Risk Management.

(8) Systematically raise awareness of the importance of ECCD as a powerful equaliser, among communities, families and service providers working with and for young children, in all ECCD-related sectors.

(9) Invest in adequately remunerated and accountable staff for ECCD at different levels; particularly examine ways to provide and/or raise salaries among caregivers at community- and school-based ECCD centres and in other full-time work in ECCD activities.

(10) Ensure effective follow-up and practical implementation plans for all ECCD training.

(11) Ensure that duty bearers have the authority, access to and control over resources, as well as motivation to exercise their duties and responsibilities, particularly including oversight.

(12) Strengthen behavioural change communication to translate ECCD knowledge into practice.

Recommendations for strengthened ECCD with regard to policies and planning:

(1) Develop one central entity to oversee ECCD-related development, including development of annual ECCD action plans, and ensure a holistic conceptualisation of ECCD to propel a multi-sectoral and integrated approach to policies, planning, legislation and services.

(2) Consistently establish structures for coordinating ECCD at all levels, including at local, township and regional levels, through a decentralised system for implementation of the ECCD Policy and Strategic Plan.

(3) Promote “bottom-up” planning that ensures that local needs are addressed and strengthened in a cost-effective manner; at the same time, encourage stronger civil society participation, including by young children themselves, as appropriate, in planning processes.
(4) Consolidate and improve the quality, reliability, accuracy and understanding of data, evidence and indicators related to young children through development of a comprehensive, multi-sectoral ECCD management and information system and a monitoring and evaluation framework to strengthen a system of accountability on ECCD. Particularly monitor data on equity, including disaggregated data by age, region, gender, geographic location, rural/urban status, disability, and ethnic and social background to facilitate analysis on the situation of all young children. Prioritise capacity development of both national and sub-national institutions in this regard.

(5) Develop a clear strategy to support the holistic development of 0- to 3-year-olds to better address the needs of the youngest children.

(6) Consider malnutrition among young children as a multi-sectoral issue requiring attention not only to health, nutrition, sanitation and education policies, but also to policies in food security and livelihoods.

(7) Align future and amended long- and medium-term planning documents with the future ECCD Policy and Strategic Plan, and better coordinate various Plans of Action with the objectives of the National Plan of Action for Children 2006-2015.

(8) Ensure special consideration of the most vulnerable and marginalised young children in ECCD-related policies to help provide quality services to those children who have the most to gain, thereby reducing disparities and fostering equity.

(9) Give greater attention to developing a Child Protection Policy focusing on young children as well as older children, and to legislation related to young child protection, especially with regard to child abuse, neglect and exploitation, violence against children, and other children in difficult situations.

(10) Develop a planned approach to social protection that includes clear mechanisms for early detection and identification of vulnerable young children and at-risk families, as well as effective regulation.

(11) Unify the monitoring and evaluation of ECCD services and establish an ECCD Management Information System that includes a Child Tracking System from birth registration to age 18 years.

(12) Ratify remaining international normative instruments that affect young children or their families.

(13) Sufficiently address recommendations of the Committee on the Rights of the Child on the Second, Third and Fourth National Reports on the Implementation of the CRC as they pertain to young children, mothers and their families.

(14) Give greater attention to conducting scientific research and studies with regard to early childhood, to support more informed and evidence-based decisions about effective strategies for improving quality of ECCD services.

Recommendations for strengthened ECCD with regard to legislation:

1. In addition to formulating a national Early Childhood Care and Development Policy and Strategic Plan, adopt and enforce comprehensive legal and regulatory frameworks and standards for ECCD, as needed.

2. Implement and effectively enforce existing laws and policies related to young children.

3. Ensure the revised Child Law fully complies with the CRC and General Comment 7 on ECCD.

4. Specifically incorporate the principle of non-discrimination on the basis of gender, ethnicity, religion or other grounds into all ECCD-related legislation and policies.
Chapter 1: Introduction

Early Childhood Care and Development (ECCD) represents the basis for all human development. Every child has the right to develop to his or her full potential. At the same time, any society has a corresponding obligation to ensure that no single moment of this unique period is lost. In all, investment in young children today is the best guarantee of equitable and sustainable development tomorrow, in Myanmar as well as elsewhere.

1.1 Objectives and methodology of the Situation Analysis

Governments that have ratified the Convention on the Rights of the Child (CRC), as the Republic of the Union of Myanmar has, are responsible for supporting families raising young children to consider their health, nutrition, living environment, social and emotional and cognitive development, and to protect young children from risks. This can not only affect the young child’s performance throughout school, but also her or his eventual success in life. Some 200 million young children in the developing world – more than 1 in 3 children younger than age 5 – are not fulfilling their potential for development. Yet a holistic approach to Early Childhood Care and Development is, first and foremost, the young child’s right, since the CRC guarantees the right to survival and development.

The Republic of the Union of Myanmar is developing a Policy on Early Childhood Care and Development that will integrate with all child development sectors: education, health, nutrition, sanitation, and protection. To provide elements for formulating the ECCD Policy and its Strategic Plan, this Situation Analysis collates knowledge, ideas and evidence-based analysis related to ECCD in Myanmar. It describes the situation of children and families, ECCD resources, and policy and planning documents regarding pregnant women, mothers and children from birth to age 8 years.

This is intended to help develop a baseline on information on ECCD and, more broadly, to contribute key elements for future planning, legislation, budgeting and national research in favour of ECCD to ensure the young child’s right to survival and development during this most crucial phase of life. The goal will be to have a comprehensive reference document for use in annual reporting on progress under the ECCD Policy and Strategic Plan and, in the longer term, to prepare this analysis again in four to five years.

The analysis examines to what extent all children in Myanmar are able to enjoy all their rights as established by the Convention on the Rights of the Child (CRC), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and other key international standards, agreements and Conventions. It not only uses CRC and CEDAW as essential references, but also is guided by basic rights principles of universality, equality and non-discrimination, accountability and participation.

To carry out such an analysis, a wide range of sources was used. Efforts were made to rely on official Government data and analysis, although this was further supplemented by information from other published sources. The aim was to create a comprehensive picture of the situation of young children and ECCD in Myanmar today. The Situation Analysis thus is based on a thorough desk review of existing studies, reports, surveys, statistical data and other information on programmes, policies and legislation.

Critically, a participatory and consultative approach to ECCD policy planning was used from central to community levels to obtain ideas and suggestions from various stakeholders. Two rounds of experience sharing meetings were conducted among members of the Multi-Sector ECCD Policy Development Steering Committee and Multi-Sector ECCD Policy Development Task Force. These were followed by 11 consultation workshops in five capitals of selected states and divisions with ethnic representation (Yangon, Mandalay, Mawlamyine, Monywa and Taunggyi), as well as in six selected townships (Than Phyu Zayet and Than Thon in Mon State, Wyangon and Pinlaung in Shan State, and Kani and Ye U in Sagaing Division).

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*Child development refers to the ordered emergence of interdependent skills of sensory-motor, cognitive, language, and social-emotional functioning. This emergence depends on, and is interlinked with, the child's good nutrition and health. The World Fit for Children document, adopted by the United Nations General Assembly in May 2002, states: “Children should be physically healthy, mentally alert, emotionally secure, socially competent, and ready to learn.”* - UNICEF, State of the World's Children 2003

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Participants included public sector leaders from ECCD-related Ministries, regions and states, townships and communities, as well as parents, teachers, health workers and community leaders; representatives of international and national non-Government organisations, faith-based organisations and community-based organisations; institutes and universities; professional associations; the media; and the private sector. A total of 16 interviews with high-level national leaders also were conducted to secure their views related to ECCD to be included in the policy.

Nonetheless, some limitations and constraints to development of this Situation Analysis must be noted: First, many available data were often inconsistent, dispersed or out of date, reflecting a need for strengthened routine data collection. Other issues were encountered in obtaining some data, with much of it insufficiently disaggregated. Second, Myanmar lacks a recent national census, and for this reason, population-based and reliable regional statistics are unavailable. In spite of some shortcomings, the Multiple Indicator Cluster Survey (MICS) provides useful data on many issues related to young children and mothers. Third, a lack of time and resources to fully identify capacity gaps among duty bearers means that the capacity gaps noted merit further study. Fourth, it was not possible for children themselves to contribute to the Situation Analysis, although many parents participated in regional and national consultation workshops to help prepare the ECCD Policy.

1.2 Structure of the Situation Analysis
Chapter 1 has briefly introduced the purpose of the Situation Analysis, the methodology for preparing this document, and Myanmar’s development context. Chapter 2 presents an analysis of the status of children and families, including a national overview of child and family needs, development trends, and status of children by region, rural/urban status, gender and other dimensions, as available. This covers the pre-conception, antenatal and postnatal phases, as well as children from 3 to 36 months, 37 months to 6 years, and 6 to 8 years of age. Among others, dimensions of childhood development, health, nutrition, water and sanitation, education, and childhood injuries are explored. Attention is given to vulnerable children with special needs. Recommendations are offered for each sub-section.

This leads to the presentation in Chapter 3 of ECCD resources, including institutional resources, trained human resources, pre- and in-service training resources, national financial resources and budgets, and international donor support. Chapter 4 comprises an elaboration of the policy dimensions, including international normative instruments signed, the national policies and laws in ECCD areas, and a comparative analysis. Chapter 5 offers a conclusion.

1.3 Development situation of Myanmar
Myanmar covers 676,578 sq.km. and has a diverse natural environment, including coastal areas, dry plains, and forest, hill and mountain regions. The last census was conducted in 1983, although another is planned for 2014; currently, the country is estimated to have a population of 59 million, with nearly 21 million children younger than age 18. About 8 million children are estimated to be younger than age 8, with under-5 children comprising 11.7 per cent of the total population in 2007. More than two-thirds of the population lives in rural areas, and agriculture remains dominant in economic development. A significant part of the population, particularly in urban areas, is comprised of migrants. Overall life expectancy at birth has risen; for males in 2009, it was 65.5 years (urban) and 64.1 (rural), while for females it was 70.7 (urban) and 67.5 (rural).

A total of 135 officially recognised ethnic groups speak more than 100 languages; many of these ethnic groups are concentrated in the most remote border areas. The country is divided administratively into 14 regions and states, 70 districts, 330 townships, 84 sub-townships, 3,063 wards, 13,618 village tracts and 64,134 villages. Population density varies between 15 per sq.km in Chin State to 666 per sq.km in Yangon Division, with an average density of 86 persons per sq.km. Most people are Buddhist, while the rest are Christian, Muslim and Hindu.

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For decades, Myanmar has faced serious challenges to meet basic human needs. Rapid political developments since late 2010, with a new Government assuming power in April 2011, offer hope for mitigating the country’s long international isolation and for improving its prospects for social and economic development prospects. A series of social and economic reform initiatives have been announced and are under way. ECCD is being prioritised for initial attention through the creation of an ECCD Policy and Strategic Plan with the support of all Ministries that support ECCD services directly or indirectly; most major non-governmental, faith-based, community-based and private organisations; and academic and professional institutions, foundations and international development partners.

In spite of its rich natural diversity and its human potential to achieve sustainable progress, Myanmar is a poor country, with an estimated GDP per capita of US$469 in 2010. Figure 1 below shows that Myanmar’s GDP remains among the lowest in the region.

**Figure 1: Myanmar and the Region, in Terms of Per Capita GDP**

![Graph showing per capita GDP](image)

The country also is significantly behind its neighbours on most socioeconomic indicators, although notable progress has occurred in areas such as poverty rates, at 25.6 per cent in 2010 (urban, 15.7 per cent; rural, 29.2 per cent), and net primary school attendance, at 90.2 per cent. While access to social services is generally expanding, the extent of provision of these services is still very low. The quality of these services represents a major issue in all sectors, reflected, for example, in high repetition and dropout rates in schools. Unification of the exchange rate in early 2012 marks a major step forward in developing national macroeconomic stability. Inflation has dropped dramatically, although this may be imperilled by continuing fiscal deficits and the rapid increase of imports as well as of international companies into Myanmar. Accommodation rates have risen dramatically in recent months.

In the global Human Development Report 2011, Myanmar was ranked 149th out of 187 countries, with a Human Development Index of 0.483, well below the East Asia and Pacific regional average of 0.671. This put Myanmar in the upper ranks of low-human-development countries. The share of the cost of food in total family consumption stands at nearly 70 per cent. Transitory poverty, at 28 percent overall, is larger than the number of chronically poor, at 10 per cent. This means that many

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8 Thematic Analysis 2011, op.cit.
10 UNICEF Myanmar. ‘Budget/Public Finance and Children’s Rights” (PowerPoint presentation), Nay Pyi Taw. 10 August 2012.
people easily fall under the poverty line as a result of numerous factors, including catastrophic health expenditures (see Table 1); for example, some 28.6 per cent of households sampled in 2007 had suffered catastrophic health payments. Women lag behind men on a range of socioeconomic indicators.

**Table 1: The Dynamics of Poverty in Myanmar**

<table>
<thead>
<tr>
<th></th>
<th>Non-poor</th>
<th>Entered into poverty</th>
<th>Escaped from poverty</th>
<th>Chronically poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>76.0</td>
<td>7.4</td>
<td>11.6</td>
<td>5.0</td>
</tr>
<tr>
<td>Rural</td>
<td>57.1</td>
<td>12.7</td>
<td>13.3</td>
<td>11.9</td>
</tr>
</tbody>
</table>

Source: QBEP Programme Document, Annexes to Chapter 1, Multi Donor Education Fund/UNICEF Myanmar

Many young children in Myanmar live under difficult circumstances that constrain fulfilment of their rights and impede their good start in life. Critically, national indicators mask deep disparities in access to basic services, by rural-urban status, region, wealth, gender, ethnicity and other social dimensions such as remoteness, disability, conflict and post-conflict settings, and vulnerability to natural disasters. For example, the percentage of poor people in urban areas totals 24 per cent, while in rural areas it is nearly 43 per cent. The largest number of poor people can be found in Ayeyarwaddy, Mandalay and Rakhine States. A complex and diverse picture of disadvantage exists across the country, with ethnic minorities frequently experiencing the most disadvantaged situations.

Often young children experience multiple vulnerabilities, which are strongly linked with poverty. Drawing on data from the latest Multiple Indicator Cluster Survey (MICS) 2009-2010, a measure of multidimensional child deprivation among children aged 0-4 years in six domains has been formulated. As Figure 2 indicates, early childhood education and development, as well as housing conditions appear to be particular issues in this age group in Myanmar, although significant deprivations are found in all domains.

**Figure 2: Multidimensional Child-Deprivation Situation of Children Aged 0-4 in Myanmar**

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One of the lowest per-capita Official Development Assistance (ODA) rates in Southeast Asia, traditionally low public investments in social services, and major data gaps have also had a combined effect of depriving many of Myanmar’s young children of an adequate education, basic health care, adequate nutrition and other essential social services. Despite initiatives to improve information systems and collect enhanced national-level data on the status of children, a lack of methodological coherence in data collection and the absence of disaggregated data in numerous areas remain underlying challenges.

However, many Myanmar governmental and non-governmental organisations have been addressing young child survival and development to the extent their resources allow, so some important progress has occurred in the last decade. This foundation of institutional and service development will assist with planning for the rapid expansion and improvement of ECCD services from pre-conception to age 8 years. The Government is currently preparing its fifth Five Year National Development Plan 2012-2016, which is focusing not only on new economic investment strategies but also on targeting vulnerable groups for high-priority social services in order to narrow development gaps. The forthcoming Five Year National Development Plan also is expected to focus on achieving the targets of indicators pertaining to the Millennium Development Goals; seven of the eight Goals include indicators and targets relating to ECCD.

### 1.4 Ensuring a Holistic Approach to ECCD

The most important years for a young child’s survival, growth and development are pre-conception through the transition to school, with the fastest period of growth occurring during the first 3 to 4 years of life, when the child’s brain is rapidly growing and adapting to the environment. During this period, the developing brain is most sensitive to risks of malnutrition, toxins, stress, and lack of nurturing and brain stimulations.

However, as noted in Section 1.1, because of poverty, undernutrition, micronutrient deficiencies, and learning environments that do not provide enough responsive stimulation, millions of young children around the world are developing more slowly, or failing to develop, critical thinking and learning skills. After their last immunisation, many young children may not be reached by services until they enter school, resulting in missed opportunities.

For disadvantaged young children, this initial deficit has a multiplying effect: Children raised in poverty, for example, complete far less education than those from middle-income families, due in part
to their lowered ability to learn in school. The opportunity to help disadvantaged children have a more
equal start in schooling is in the earliest years of life, when young children’s brains are developing
most rapidly, and the basis for their cognitive, social and emotional development is being formed.
Accumulating global evidence suggests that the most effective interventions to improve human
development and break the cycle of poverty occur in children’s earliest years. Thus, to further the
commitment to reduce poverty, and to increase the chances of all young children for success,
investment in the ECCD is imperative in order to affect the child’s entire life course (see Figure 3).
This is particularly critical at the levels of family and community but also in terms of policies, budgets
and resource allocations.

Cost-effective investments do exist, and should reach all young children, including the most
disadvantaged: Parenting Education and support, to raise self-confidence and competence of
caregivers; improvement of the home environment through education, supplies and services; access
to clean water and sanitation; health care services, early child care centres with comprehensive
services; and adequate care and feeding practices. In turn, these can help to ensure good nutrition,
particularly iron, iodine, breastfeeding, and adequate growth before birth and in the first 2 years of life.
Figure 3: The Child’s Life Course

Source: UNICEF
The young child needs to be healthy; repeated bouts of illness eventually will reduce learning potential. Young children also need positive and loving interactions with at least one caregiver, and stimulating and responsive environments that provide opportunities for emotional security and early learning. Thus, all areas of survival, growth and development are intimately related and mutually supportive; no aspect of development occurs independently (see Figure 4).

### Figure 4: The Components of Integrated Early Childhood Development

![Integrated Early Childhood Development](image)

**Source:** UNICEF

At the same time, many challenges exist to putting the concept of a holistic or integrated approach to young children’s development into practice. For example, children’s loss of developmental potential is hard to recognise by families or by Government. Decision makers often do not understand the cost of poor early child development for young children and for society. This may be compounded by the fact that expertise tends to be sectoral.

A number of conditions exist under which a holistic approach to ECCD is more likely to be effective, namely, when:

- Decentralisation of resources and responsibilities result in strong local authority and decision making
- The focus is on a particular marginalised population
- Support comes from a level higher than a particular Ministry
- There is interest in supporting child health, education and child development, as well as child survival
- National and local government and civil society have knowledge, experience and capacity in child development programming
- Government officials and international partners understand and can articulate clearly the role of ECCD in poverty reduction
- The family and community are seen as active partners, and there is recognition that a strengthened family or community can have a number of positive effects on young children, given that family relationships are particularly critical for children in the earliest years

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The Government uses the CRC and other rights instruments in making decisions about programming and policies for young children. Service delivery systems are in place and are functioning. Policy development is under way, or there is a policy in place, supporting ECCD.

In the context of rapid social, economic and political reform, Myanmar offers many of these enabling conditions. The challenge now is for it to adopt best practices and programme models to ensure that all young children, especially those most disadvantaged, not only survive, but thrive. For impact and efficacy, sectors need to work together where there is potential for real synergy. It is vitally important as well that there be continued and constant efforts to integrate ECCD into the work of all sectors, and for each sector to look at, and programme for, the young child in a holistic manner.

Chapter 2: Status of Children and Families

For the purposes of this Situation Analysis, Early Childhood Development refers to a comprehensive approach to programmes and policies for children from conception to age 8 years, as well as for their parents and caregivers. Overall, ECCD’s purpose is to ensure good child health, nutrition and hygiene among young children as well as protect the young child’s right to develop his or her full cognitive, emotional, social and physical potential. Multi-sectoral and community-based services that meet the needs of infants and young children are vital to the nation and are intended to include attention to issues of health, nutrition, education, water and sanitation, and child protection in homes and communities.

Myanmar has a long tradition of extended families providing a loving and caring environment for young children. Nonetheless, with longstanding and substantive challenges to the socioeconomic situation of the country, many families now are unable to adequately care for their young children for a variety of reasons, including severe poverty, natural disasters and the impacts of armed conflict.

As a result of traditionally low public expenditures on social services (see Section 3.4), private and non-governmental (NGO), faith-based and community-based organisations, professional associations, foundations and institutions of higher education play a leading role in overall service delivery and support in all sectors related to ECCD; this will be noted throughout the Situation Analysis. Families have borne the vast majority of health costs, which significantly affects both maternal and young child health care. In education, the significant family share of costs has made it difficult for poor families to afford to send their young children to school.

As the sub-sections below will illustrate, largely sectoral services for children younger than age 8 exist in education, health, nutrition, water and sanitation, protection, and prevention of mother to child transmission of HIV (PMTCT) and paediatric HIV care. Despite major challenges, in many geographical areas these have helped prepare young children for school, improved child survival rates and physical development, and provided a more hygienic environment for young children, parents and ECCD facilities.

However, many current services for young children in Myanmar are not yet capable of adequately supporting the most disadvantaged children and families. Thus, many young children who are most in need of ECCD services remain unreached. In particular, ECCD services are concentrated in urban areas, where only one-fourth of the population lives (see Section 2.6.1).

In addition, strong efforts will be needed to ensure the provision of fully integrated and well-coordinated multi-sectoral ECCD services that address the holistic development of young children, as noted in Section 1.4 since many ECCD programmes in the country focus heavily on school readiness and tend to pay less attention to young child health, nutrition, opportunities for early learning and emotional security, psycho-social care, and protection. This may require significant strengthening of home- and family-based approaches to address gaps and meet young children’s multiple needs, by further taking into account health, nutrition, sanitation and protection issues as well as psycho-social stimulation while simultaneously strengthening the environment in which children live.
2.1 Pre-conception
Preparation for pregnancy (pre-conception education and care) is increasingly considered to be essential to avoid poor birth outcomes. Yet with respect to pre-conception planning, more services are needed in Myanmar to support preparation for pregnancy and strengthened provision of micronutrients such as folic acid and iron. In this regard, a focus on adolescents will be critical, since actions taken during adolescence, including birth outcomes and the potential for unplanned pregnancies, can affect a person’s life opportunities, behavioural patterns and health.

ECCD is inextricably linked to women’s health, including before a woman becomes pregnant. In particular, a woman’s nutritional and reproductive health status is crucial during the pre-conception period, as is her readiness to prepare for parenting. Although food is sufficient at the national level, it is not always available when needed at household level because of poverty, transportation and food storage constraints, and poor nutritional knowledge and practices. Inadequate dietary intake contributes to both malnutrition and micronutrient deficiencies throughout many women’s lives.

Appropriate family planning, including for adolescents, is important to the health of women and children by preventing pregnancies that are too early or too late; extending the period between births; and limiting the number of children. The Total Fertility Rate has almost halved as of 2007, dropping to an average of 2.03 births per woman of reproductive age, from 4.7 in 1982-1983. However, because most births take place within marriage and many women are remaining unmarried, the average number of births per married woman actually stands at 4.7. Significant variations are found across states and regions, as well as by rural-urban status and level of education.\(^\text{15}\)

Trends in the contraceptive prevalence rate showed a steady rise between 1991 and 2001, as shown in Figure 53. Yet current use of contraception is still reported by fewer than half of ever-married women in Myanmar (46 per cent), ranging from 58.7 per cent in Yangon to 7.8 per cent in Chin State.\(^\text{16}\) Contraceptive use is associated with women’s higher education level as well as higher wealth quintile. However, the unmet need for contraception is still high, estimated at 17.7 per cent in 2007.\(^\text{17}\) As a result of this unmet need, a large number of unwanted pregnancies occur and result in induced abortions under unsafe conditions, which can lead to complications as well as maternal morbidity and mortality.

**Figure 53: Trends in the Contraceptive Prevalence Rate 1991-2001**

![Figure 53: Trends in the Contraceptive Prevalence Rate 1991-2001](image-url)


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\(^\text{15}\) Situation Analysis of Children 2012, op.cit.
\(^\text{16}\) MICS 2009-2010, op.cit.
\(^\text{17}\) Health in Myanmar 2012, op.cit.
Slow progress toward achievement of Millennium Development Goals (MDGs) 4 and 5, on child and maternal mortality (see Section 2.3), indicate a continuing need to strengthen health system efforts to provide a comprehensive package of quality reproductive health services, particularly in remote and disadvantaged areas. In many rural areas, health centres may have too few basic health staff to meet patients’ needs. In addition, low educational levels of many women, particularly in rural areas, result in low levels of health literacy and poor health-seeking behaviour, as well as a need to encourage healthier lifestyles.

Women in Myanmar also face a number of critical nutrition issues at all stages of life. In particular, adequate levels of iron and folic acid are crucial in the pre-conception phase to prevent severe neural tube defects such as spina bifida and anencephaly, a lack of brain growth. However, the crucial time when a developing foetus needs folic acid is between 22 and 28 days after conception, before many women even know they are pregnant. Especially in unplanned pregnancies, a decision to take folic acid supplements may come too late to provide maximum benefits. Iron folate tablets are reported to be available daily to all pregnant women in the country,18 although it is estimated that about 70 per cent of pregnant women in all 330 townships to receive folic acid supplementation.

Other key nutritional data (see Section 2.5.3) indicate that women’s normal dietary intake in Myanmar does not meet the body’s demands. A 2005 national micronutrient survey found iron deficiency anaemia in 45.2 per cent of women of reproductive age, with anaemia also associated with very high rates of intestinal parasites.19 For both iron and folic acid supplements, however, a key constraint arises from the availability of micronutrient tablets.

Women’s health in Myanmar also may be affected by a relatively high incidence of food poverty, especially in states such as Chin, Shan (East and North), Kachin, Kayah and Rakhine. Most are considered food-deficit regions. In turn, major causes of food insecurity in these regions arise from low agricultural productivity, limited access to productive assets, lack of nutrition education, low wages and income, and high food prices due to high transportation costs.

In addition to women’s low rates of completion of education at primary and secondary school levels, the Life Skills Education curriculum and non-formal, alternative education do not specifically offer Parenting Education for young people. Currently, Parenting Education generally is geared more to women who are already mothers, even as few such education and support programmes are offered. Thus, formal preparations for parenting among adolescents and prospective mothers and fathers are usually minimal.

More broadly, gender equality and empowerment of women are fundamental to achieving all development goals. A requirement of the holistic approach to ECCD is protecting and promoting women’s rights as the first step in securing gains for young children. In Myanmar, gender equality at basic survival level exists, unlike in some of the more high-growth economies in the region. Despite the prevalence of patriarchal cultural norms in Myanmar society, in general deprivations are linked less across gender lines than to the fact of overall deprivation in the society. Nevertheless, patriarchal values still affect hierarchical relationships within the family and community, and by extension, the development status of all women in Myanmar. Traditional beliefs that reinforce attitudes and behaviours that do not favour women remain in some areas, exacerbating regional disparities and constraining awareness and understanding of issues related to empowerment of women. Further attention is needed to strengthen the involvement of men in sensitive gender-related issues, especially in reproductive health issues, pre-conception education, antenatal and postnatal education and care, and all areas of parent education.

Recommendations to strengthen ECCD in the pre-conception period:

- Develop and provide pre-conception education for youth and prospective parents in order to help them preparing for conceiving a healthy child and to improve birth outcomes
- Expand health education, including through both home visits and group sessions, to promote health-seeking behaviour at the individual level, and to promote the importance of adequate nutrition as it relates to the health of young children

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18 Health in Myanmar 2012, op.cit.
19 Situation Analysis of Children 2012, op.cit.
- Expand target groups for Parenting Education, including to adolescents and prospective mothers and fathers; consider including preparation for parenting in Life Skills Education and non-formal education services for youth
- Reduce the unmet need for contraception, as well as strengthen delivery of a comprehensive, standardised reproductive health package and essential obstetric care in all geographical areas
- Enhance the access of pre-pregnant women to key nutritional supplements, including folic acid and iron
- Further encourage the greater involvement of men in reproductive health issues

2.2 Antenatal

Effective antenatal education and professional health and nutrition care before, during and after delivery can improve birth outcomes and make the difference between life and death for both women and their newborns. In Myanmar, comprehensive antenatal education services require significant further strengthening for pregnant women. These will need to include health care, antenatal nutrition and hygiene, preparation for expectant mothers and fathers for positive parenting, non-use of damaging substances (caffeine, alcohol, street drugs, many prescription drugs), use of medically supervised delivery services, preparation for breastfeeding immediately after birth, and postnatal health care and nutrition. Poor birth outcomes can include infant and maternal mortality at birth; Low Birth Weight status; pre-term birth; or specific child health issues such as disability, fragile nutritional status, or disease/illness.

Nutritional issues from the pre-conception period largely carry over into the pregnancy itself. A Government study in 2004 found nearly 3 in 4 pregnant women (71 per cent) were anaemic.20 Anaemia in pregnancy can lead to maternal death, poor birth outcomes (disabilities, Low Birth Weight and pre-term deliveries), and developmental delays in infants and young children.

Antenatal coverage of at least one visit has increased to 83.1 per cent of women in 2009-2010 (95.0 urban, 78.4 rural),21 up from 63.1 per cent reported in another survey just four years earlier.22 The rate of at least four antenatal visits, the number recommended, is similar, at 73.4 per cent.

The content of antenatal care still differs widely between states and regions and between urban and rural areas. For example, 80.1 per cent of women had their blood pressure measured, but this varied between 94.3 per cent in urban areas to 74.4 per cent in rural areas; similarly, 84.5 per cent of urban women had a urine specimen taken, but only 45.8 per cent of rural women received the same service (overall total, 56.9 per cent).23 This indicates that special attention should be placed on serving rural women, who often have lower levels of education. These tests are essential for antenatal care and identifying high-risk pregnancies that require aggressive intervention.

The importance of improving antenatal care, as well as maternal nutrition, is further underscored by high rates of stunting (see Section 2.5.3), given that experts have found that many cases of stunting are already ‘pre-programmed’ in the womb beginning in the first trimester of pregnancy. Few women receive coaching for childbirth, including exercises. Preparation for receiving the baby also is not done in many cases. Many women appear to have no plan for going to a health centre or hospital at the time of birth.

Recommendations to strengthen ECCD in the antenatal period:
- Develop a comprehensive package of antenatal education and make it widely available to women, to promote health-seeking behaviour at the individual level, and explain the importance of adequate nutrition, avoidance of harmful substances and other essential topics with regard to the health of young children
- Expand greatly the provision of antenatal health care visits in health centres and clinics
- Enhance the access of pre-pregnant women to key nutritional supplements, including folic acid and iron

20 Ibid.
21 MICS 2009-2010, op.cit.
22 Situation Analysis of Children 2012, op.cit.
23 MICS 2009-2010, op.cit.
Expand/refresh capacity building of Basic Health Services staff, midwives, auxiliary midwives, community health workers and other health care providers to ensure content of antenatal visits is of high quality and standardised

2.3 Delivery

As in other countries, in Myanmar childbirth represents a particularly vulnerable time for both mother and child. Yet most maternal and child deaths can be prevented by good-quality antenatal care, as well as properly attended births; prompt access to health centres and hospitals and to Emergency Obstetric Care (EmOC) services for high-risk pregnancies and delivery difficulties; and increased attention to postpartum care.

Achieving Myanmar’s 2015 MDG5 target of a national Maternal Mortality Ratio (MMR) of 145 deaths per 100,000 live births appears to be challenging, as shown in Figure 64. The MMR at national level was estimated at 316 per 100,000 live births, according to the 2004-2005 Nationwide Cause-Specific Maternal Mortality Survey, and at a much lower 141 per 100,000 live births in 2009 (113 urban, 152 rural). Using United Nations estimates, the figure in 2008 was 240 maternal deaths per 100,000 live births. Overall, the long-term Myanmar Health Vision sets a target in 2030 of 90 maternal deaths per 100,000 live births. Strongly improved pre-conception and antenatal education and care, along with improved delivery services, will help to achieve this goal well before 2030.

Figure 64: Maternal Mortality Rates in Myanmar

![Figure 64: Maternal Mortality Rates in Myanmar](image)


Again, wide variations in indicators were found by region. In 2005 MMR in the hilly region was 132 per 100,000 live births, while it stood at 264 for the coastal region, 337 for the delta region, and 449 for the central plains. Equally significant, MMR in rural areas stood at about 2.5 times that of urban areas, at 363 per 100,000 live births compared to 140. Generally the older a woman is, the more she is at risk, although teenage mothers also are at particularly high risk.

The main causes of maternal death included postpartum haemorrhage (31 per cent of all maternal deaths), eclampsia (11 per cent), and abortion-related causes (10 per cent), as well as puerperal sepsis, hypertensive disease, prolonged or obstructed labour, antepartum haemorrhage, ruptured uterus and embolism. Indirect causes included heart disease, malaria, tuberculosis and lung

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24 Situation Analysis of Children 2012, op.cit.
26 Ibid.
27 Five-Year Strategic Plan for Child Health Development 2010-2014, op.cit.
29 Ibid.
infections. About 25 per cent of women had to travel more than 4 km to reach the nearest EmOC from home. In addition, a nationally representative study in 2010 found that emergency care services do not exist or were not fully functional in two-thirds of observed facilities.\(^3\) Transport problems, financial constraints and delays in decision making often result in poor use of health care facilities and health care providers.

About 70.6 per cent of births overall are attended by skilled birth attendants (SBAs), although in some parts of the country more than 1 in 10 women delivered without any attendant at all.\(^31\) Significantly, only about one-third of women (36.2 per cent) delivered in a private or Government health facility, with rural-urban differences particularly marked (24.5 per cent vs. 65.2 per cent). Overall, rates also were higher among educated women and in the richest households. As of 2011-2012, 20,044 midwives were providing maternal care throughout the country.\(^32\) In addition, between 2001 and 2007 about 2.37 million clean delivery kits were distributed to ensure clean delivery practices at birth;\(^33\) however, a follow-up study in five townships showed these were used in only about half of births. Tube and mask devices also have been widely distributed for improving the management of birth asphyxia, a condition that, along with intrauterine hypoxia, was responsible for 2.7 per cent of mortality in 2010.\(^34\)

Turning to child mortality, a particularly rapid downward trend between 1990 and 1996 has decelerated subsequently, although the rate continues to decline (see Figure 75). Official statistics indicate Infant Mortality Rates (IMR) of 25.7 per 1,000 live births in urban areas and 27.8 in rural areas in 2009,\(^35\) while the latest MICS survey reported the IMR stood at 37.5 per 1,000 live births in 2009-2010.\(^36\) Although all the figures are still high, they represent a notable decrease from the 66.1 in 2006 cited by official sources. Likewise, the Under-5 Mortality Rate (U5MR) had reduced officially to 36.5 per 1,000 live births overall (36.1 urban, 41.1 rural),\(^37\) or to 46.1 according to the latest MICS, from 77 in 2006. New United Nations inter-Agency estimates in 2011, using improved modelling and data from different surveys, found that U5MR and IMR were 66.2 and 50.4 per 1,000 live births, respectively, in 2010.\(^38\)

Figure 75: Trends in Child Mortality Relative to MDG4

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\(^{30}\) Situation Analysis of Children 2012, op.cit.
\(^{31}\) MICS 2009-2010, op.cit.
\(^{32}\) Health in Myanmar 2012, op.cit.
\(^{33}\) Five-Year Strategic Plan for Child Health Development 2010-2014, op.cit
\(^{34}\) Health in Myanmar 2012, op.cit.
\(^{35}\) Ibid.
\(^{36}\) MICS 2009-2010, op.cit.
\(^{37}\) Health in Myanmar 2012, op.cit.
\(^{38}\) Situation Analysis of Children 2012, op.cit.
Because of differences in sampling and other factors, it is difficult to compare data from different sources. Regardless of source, however, it is clear that about three-quarters of all under-5 deaths occur in infancy (ages 0-11 months), and probably during the first 3 months of life, although data are unavailable regarding neonate death. Table 2 shows the key targets for IMR, U5MR and MMR in the long-term Myanmar Health Vision 2030.

### Table 2: Key Indicators from Myanmar Health Vision 2030

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2001-2002</th>
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<th>2021</th>
<th>2031</th>
</tr>
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<tbody>
<tr>
<td>Life expectancy at birth</td>
<td>60-64</td>
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<td></td>
<td>75-80</td>
</tr>
<tr>
<td>IMR/1,000 LB</td>
<td>59.7</td>
<td>40</td>
<td>30</td>
<td>22</td>
</tr>
<tr>
<td>U5MR/1,000 LB</td>
<td>77.8</td>
<td>52</td>
<td>39</td>
<td>29</td>
</tr>
<tr>
<td>MMR/1,000 LB</td>
<td>2.55</td>
<td>1.7</td>
<td>1.3</td>
<td>0.9</td>
</tr>
</tbody>
</table>

Source: Five-Year Strategic Plan for Child Health Development in Myanmar 2010-2014

According to the Myanmar Nationwide Overall and Cause-Specific Under-5 Mortality Survey 2003, major causes of young child mortality include acute respiratory infection (ARI) or pneumonia (28 per cent); diarrhoea (18 per cent); and brain infections including cerebral malaria (17 per cent). Beriberi (Vitamin B1 deficiency) was a cause of death in 7.1 per cent of cases, although this disease is preventable and easily treatable once recognised. Dengue haemorrhagic fever also was responsible for about 6.3 per cent of U5MR. Significantly, malnutrition was considered a direct cause of death in 1.0 per cent of all deaths investigated, but it was found to be a contributing factor in the vast majority of deaths39 (see Section 2.5.3).

Lastly, another key issue with regard to a child's birth is that of birth registration. In Myanmar birth registration is part of the Modified Vital Registration System. Birth registration stands at 72.4 per cent overall, but again, this is marked by wide rural-urban variations (63.5 vs. 93.5 per cent), as well as by wealth quintile and mother's education. Little difference was found in registration rates between boys and girls. Without birth registration, however, a young child cannot be enrolled in school without a birth certificate.

Overall, birth and death registration have fallen off because of the absence of development committees in many villages to record these statistics; thus, there is little information on how old children are when birth registration actually takes place, and it is generally believed that many newborn births and deaths have gone unrecorded.41 Often, caregivers do not know a birth should be registered.

The Government has carried out advocacy and awareness campaigns for birth registration. It also has reviewed the status of some ethnic minority Rohingya children born of parents unable to obtain marriage authorisation, with a view to regularisation, and its plans to conduct a nationwide census in 2014 may offer important data for overall birth registration.

Concerns still exist with regard to a large number of young children remaining unregistered as a result of insufficient awareness raising on the importance of birth registration. Other constraints may include a lengthy process to obtain birth certificates at township level or unofficial fees associated with registration.

**Recommendations for strengthening ECCD in the delivery period:**

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39 Five-Year Strategic Plan for Child Health Development 2010-2014, op.cit.
40 MICS 2009-2010, op.cit.
41 Ibid
43 Ibid.
Support expanded capacity building among skilled health care providers covering the delivery and postnatal periods; especially ensure capacity building of management of EmOC among health care providers involved in home deliveries.

Expand delivery services and outreach to help ensure women deliver with skilled medical attendants, preferably in a skilled medical facility.

Strengthen community and family awareness of recognition of warning signs of complications during delivery and the postnatal period; of the importance of acquiring SBAs; and of expediting the referral process in the event of danger signs in childbirth.

Encourage institutional delivery for all women, and especially for high-risk pregnant women at EmOC facilities.

Strengthen efforts to ensure birth registration and the provision of a birth certificate for all young children at local health centres.

Develop a plan to provide birth registration to all under-18 children who have not yet been registered.

Implement specific measures to ensure greater access to birth registry services on the part of children born at home or in remote areas, ethnic minority regions, or displaced/stateless young children.

2.4 Postnatal

Some 26,000 children per year who are younger than age 1 month are reported to have died in Myanmar, with more than two-thirds of these deaths reported during the first seven days after birth. These postnatal deaths are of particular concern in reaching the targets of MDG4 on reducing U5MR to 43 per 1,000 live births. An overwhelming majority of neonate deaths occur in home births. Causes of death include prematurity, 30.9 per cent; birth asphyxia, 24.5 per cent; sepsis, including pneumonia, 25.5 per cent; and other causes, 19.1 per cent.

Weight at birth is a good indicator not only of a mother’s health and nutritional status but also of the newborn’s chances of survival, development and long-term growth. About 7.9 per cent of infants in Myanmar were classified in 2000 as Low Birth Weight (LBW, or less than 2,500 grams) by the National Nutrition Centre, although the MICS 2009-2010 reported 8.6 per cent of infants as being LBW. The figures stand at 8.2 per cent in urban areas, 8.8 per cent in rural areas, although wider variations are found between states and regions, with Bago (East) and Kayin having the highest percentage of LBW newborns. Slow fetal growth, fetal malnutrition and disorders related to LBW and short gestation were estimated to cause 3.5 per cent of all mortality in 2010.

It should be noted, however, that in large part because of the high proportion of births at home, only 56.3 per cent of infants are weighed at birth. Therefore, the Low Birth Weight rate may be considerably higher. Nonetheless, all this appears to validate the nutritional issues cited above of pre-pregnant and pregnant women in the country. Furthermore, all Low Birth Weight and pre-term infants (less than 37 months) require intensive and individualised services to ensure they do not become developmentally delayed.

The Expanded Programme of Immunisation (EPI) has demonstrated notable success, offering BCG and DTP, measles, polio and hepatitis B for children, as well as tetanus toxoid for pregnant women. An estimated 91 per cent of newborns have been protected from postnatal tetanus through the two doses of tetanus toxoid given during pregnancy. The MICS 2009-2010 found 88.6 per cent of children to be fully immunised. The programme has been most successful against polio, now eliminated in the country; elimination status for postnatal tetanus was validated in 2010. The EPI programme also has brought about a major decline in measles morbidity and mortality, although measles coverage, at 82.4 per cent, still falls well short of the 95 per cent target; strengthening both first and second doses of measles vaccination is an important part of the Myanmar Immunisation Programme 2012-2016. At the same time, large disparities remain in overall immunisation coverage.

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44 Ibid.
45 Ibid.
46 Five-Year Strategic Plan for Child Health Development 2010-2014, op.cit.
48 Ibid.
49 Health in Myanmar 2012, op.cit.
50 Ibid.
51 Ibid.
by geographic area, which are being addressed by the rollout of a Reaching Every Community strategy in hard-to-reach areas.

Coverage with postnatal visits within two days after birth continues to be low, although exact figures are unavailable. Detailed information on observing signs of illness, care and advice in the postnatal period also is not available to assess the quality of the delivery of Essential Newborn Care (ENC). In its Five-Year Strategic Plan for Child Health Development 2010-2014, the Government is placing a very high priority on the postnatal period, targeting at least two postnatal visits at home during the first week of life to provide ENC; inclusion of neonates in a comprehensive Integrated Management of Childhood Illnesses (IMCI) package; strengthening of referral care for sick newborns; and regular child death reviews at all levels. Mothers with difficult deliveries and high-risk infants require more home visits until both are out of danger and essential postnatal education and support have been provided.

The proportion of mothers initiating breastfeeding within 1 hour of birth has improved substantially, to 75.8 per cent. Nearly 90 per cent of women initiate breastfeeding within 1 day of birth. The exclusive breastfeeding rate up to age 6 months remains very low, however, at 23.6 per cent, with many infants fed with small quantities of water. The exclusive breastfeeding rate is slightly higher among infants aged less than 4 months, at 29.3 per cent. By the end of the sixth month, the percentage of children exclusively breastfed is below 5 per cent. However, most mothers continue to breastfeed for up to 2 to 3 years. The quality of complementary feeding has been the object of considerable concern and nutrition education; food supplements and micronutrients are often needed on the part of malnourished infants and lactating mothers.

No difference was noted in feeding patterns for boys and girls, and there also was little difference in feeding patterns between urban and rural areas. However, regional disparities were marked, from a 1.3 per cent exclusive breastfeeding rate in Rakhine State up to 47 per cent in Mon State. Indications are that many children miss out on adequate complementary food intake, while this may be aggravated by frequent episodes of diarrhoea and acute respiratory infections. Exclusive breastfeeding also may be related to the availability of child care centres attached to mothers’ workplaces; currently working women receive only three months of maternity leave.

Recommendations to strengthen ECCD during the postnatal period:
- Ensure that 80 per cent of all newborns receive a community-based ENC package, and enhance key family and community practices for neonates
- Ensure that 80 per cent of all LBW infants receive extra health and nutrition care and development during the newborn period and up to 2 years after birth to ensure they do not develop delays, malnutrition or chronic illnesses
- Expand capacity building for health care providers, including Basic Health Services personnel and community health workers/volunteers, on the importance of provision of quality postnatal care and regularise efforts to obtain data on the quality of care of ENC
- Increase the proportion of infants receiving breastfeeding within 1 hour of birth to 80 per cent
- Increase the proportion of infants to receive exclusive breastfeeding up to 6 months and appropriate complementary feeding between 6 to 9 months of age, to 80 per cent
- Conduct regular young child death reviews at all levels, including audits in health facilities and hospitals

2.5 Children from 3 months to 36 months of age
The MICS survey 2009-2010 indicated a significant number of young children, including those younger than age 3 years, require greatly improved care and development services during their early years. Most of these children were in rural and remote areas, including especially those from ethnic and linguistic minority groups. In large part, this can be attributed to the poor awareness by parents of the value of ECCD, as well as to the parents’ (particularly mothers’) low level of formal education, and the fact that many adults in Myanmar are preoccupied with earning a living. Yet by the time a child is
3 years old, researchers have found, up to 80 per cent of his or her core brain pathways have been developed.

Trends in ECCD services for children 0-3 years cannot be fully assessed because relevant national data are insufficiently available. However, the number of children in this age group who were reported to be accessing ECCD programmes in 2011 stood at 37,620 (18,547 males, 19,073 females) (see Annex 1, Table A). ECCD for the youngest children currently is provided mainly by the Ministry of Social Welfare, Relief and Resettlement (Department of Social Welfare, or DSW) (see Section 3.1). Support to ECCD services for 0- to 3-year-olds require a clearer strategy, with an effective decentralised system for implementation.

As noted above, in addition to DSW, Ministry of Health, NGOs, faith-based organisations, community-based organisations, associations and foundations play leading roles in delivery of ECCD services to the youngest children from birth to 36 months, as well as to those aged 37 to 60 months. However, nearly all these institutions face significant constraints regarding programme coverage as well as capacity development issues. In addition, women employed in the formal economy often cannot bring their young child to the workplace, and arranging child care can be difficult; child care and development centres are few, and very few accept children younger than 3 years.

Coping mechanisms vary, especially in poor families whose options are limited; as a result, many girls are kept home from school to care for their younger siblings, leading to higher school dropout rates. The provision of quality child care and development services is essential not only for urban women, but also for the majority of rural women who work in the fields.

2.5.1 Child development

In all, access to ECCD services for 0- to 3-year-olds remains underdeveloped. While coverage by Mother Circles appears to be steadily increasing, the total figure of 37,620 children served, noted above, still indicates that only a small percentage of this large population of young children is being served. Furthermore, no data are available regarding the percentage of services for the sub-population of vulnerable children 0 to 3 years of age. At the same time, some ECCD providers for the youngest children have reported the majority of children using their services as being up to two years older than the planned age range (i.e., up to age 5 instead of age 3).

Stronger efforts are needed to significantly expand the coverage of ECCD services for this age group and to gather additional information, while also ensuring sustainability of efforts. Numerous positive effects on very young children with ECCD experience have been noted, including with regard to language development, oral communication skills, cooperative behaviour, development of self-help skills, overcoming shyness or aggression, improved personal hygiene, skills in observation, and skills in listening to and creating stories.

Access to books and toys can be an important indicator of child development, as can engagement of family members with the child. The MICS 2009-2010 showed that 57.9 per cent of households had members who engaged in four or more activities to promote learning in under-5 children, including reading books or looking at picture books, telling stories, singing songs, taking the child outside, playing, or spending time naming, counting and/or drawing people, animals and things. In urban areas this proportion rose to 71.2 per cent, while in rural areas it stood at only 52.4 per cent. However, fathers’ engagement in one or more such activities remained low, at 44.0 per cent overall (48.5 per cent urban, 42.1 per cent rural). Strong variation was seen by region and economic status.

Significantly, the MICS also found that more adults engaged in learning activities with older children than with infants. While adult household members had engaged in learning activities with only 40.5 per cent of children aged 0-23 months, the proportion rose to 70.5 per cent among children aged 24-59 months. This indicates a critical need to raise parents’ awareness of the need for much more stimulation during the earliest years, when rapid brain development is occurring.

56 Based on Government statistics and information provided by 12 ECD partner organisations.
57 Situation Analysis of Children 2012, op. cit.
59 Ibid.
A strong need exists for the development of Early Childhood Intervention (ECI) services in Myanmar. No comprehensive assessment exists of levels of child development at different ages from 3 to 36 months; likewise, data are needed on the incidence of developmental delays or disabilities at birth. The development of reliable statistics in this regard represents an important priority, along with the development of well-planned ECI services for children with developmental delays.

Meanwhile, Parenting Education in Myanmar also requires strengthening to offer more specific opportunities for parents of children younger than age 3 years. Overall, parents of children in ECCD programmes have been found to be highly appreciative and taking a more active interest in their child’s progress. Care provided by ECCD parents was found to have evolved into providing a nurturing and caring home environment for their children.60

Even so, major challenges appear to remain with regard to parental participation. For example, some ECCD service providers have reported that the major challenge in implementation of their programmes was in reaching parents, many of whom were focusing their efforts on making a living.61 Many mothers drop their children off in centre- or home-based services and then go to work in markets, fields or other places. Although it is recognised that parent education is greatly needed, only a small amount is provided at present. A nationwide effort in culturally and linguistically appropriate parent education and support services is necessary, often combined with Mother Circles and other ECCD services.

Parental expectations regarding child development also may require support to change through additional Parenting Education; for example, many parents do not fully understand the concept of holistic child development.62 Instances have been reported of even very young children being taken from ECCD services because they were not being taught reading and writing in the Myanmar language and/or English.

Recommendations to strengthen ECCD (child development) from ages 3 to 36 months:

- Ensure all parents and young children access regular preventive and basic health, nutrition, water and sanitation, and protection services
- Provide quality early care and services for young children of mothers working outside the home
- Comprehensively map and further expand sustainable ECCD services for 0- to 3-year-olds, including Mother Circles
- Through home visits and centre-based services, expand formal and more integrated Parenting Education and support services to provide a stronger focus on 0- to 3-year-olds and foster awareness of the importance of holistic ECCD
- Identify successful models of services for 0- to 3-year-olds in Myanmar and gather more relevant data on programme coverage
- Identify gaps in curriculum, educational materials and methodologies for services for children aged 0 to 3 years and their parents
- Conduct a comprehensive study/assessment of levels of young child development in this age group, including gathering reliable data on developmental delays among the youngest children and disabilities at birth and thereafter
- Establish/strengthen delivery of multi-sectoral Early Childhood Intervention services for very young children identified with developmental delays or disabilities, as well as for very young children with malnutrition or chronic illness
- Strengthen linkages between Mother Circles and Parenting Education, and consider innovative approaches to help establish Mother Circles in rural and remote areas
- Ensure programme services for children aged 0 to 3 years and their parents receive greatly increased financial support and other resources

2.5.2 Health status and services received

61IECD Impact Study, op.cit.
62IECD Impact Study, op.cit.
Despite steady progress in Myanmar, many core young child health and development indicators require further improvement, as noted above, particularly in remote and border areas. Myanmar still faces significant challenges with respect to access to health services, and wide regional variations occur. In some areas no services are available at all.63 Despite recent improvements, a continued need for strengthened public expenditures on health represents a significant challenge to quality services for young children and women alike (see Section 3.4).

Few or no data are currently available on the rate of use of health care services for young children, as well as on their specific needs, scheduled well-child checkups, or inappropriate use of home remedies. However, because overall health care-seeking behaviour among adults in the country requires significant strengthening, it is highly probable that more effort also is needed to optimise young children’s use of health services. Crucially, many of the key health issues raised for children aged 3 to 36 months also apply to children aged 37 months to 6 years (see Section 2.6) and 6 to 8 years (see Section 2.7).

A strong push is under way to develop Universal Health Coverage as part of a comprehensive social security programme, for which strengthening existing Primary Health Care-based approaches and systems will be at the core. Remaining public health system challenges include a need for strengthened sectoral and multi-sectoral coordination, harmonisation of monitoring and evaluation systems, improved efficiency of procurement and logistics, and training and placement of adequate human resources in under-served areas (see Chapter 3). In assuming an important share of overall service provision, private service providers have become an essential part of maternal, postnatal and young child health services. However, strengthening of the training and regulation of these providers is urgently needed, since many offer predominantly curative care of highly variable quality. Universal protocols and regulations continue to be needed to ensure the nation’s mothers and youngest children receive adequate amounts of high-quality health care.

Comparatively fewer people appear to utilise Government services, in part because of inadequate health coverage; health system issues such as perceptions of quality, particularly in rural areas; longer waiting times; physical proximity; staff absences; and drug shortages. For example, 72.2 per cent of 532 household members in a 2007 study by the Department of Health Planning received their health care services from the private sector; nearly 18 per cent of households resorted to self-treatment; and only 5.5 per cent used the public sector.64 Only 13.4 per cent of children with symptoms of pneumonia were taken to Government hospitals in 2009-2010.65 The strengthening of the public health sector is of primary importance to ensure all young children, and most especially vulnerable young children, receive timely and high-quality preventive health care and treatment.

Even so, successful experiences with the EPI programme (see Section 2.4) and de-worming (see Section 2.5.3) have shown that effective outreach programmes can be organised to provide scheduled services that benefit young children. However, this continues to require enhanced capacities for planning, logistics, supervision and monitoring. A nationwide system is needed of continuous health centre services that provide immunisations, de-worming, well-child checkups and developmental screenings.

Overall child mortality data have been provided in Sections 2.3 and 2.4. With regard to young child morbidity, a high prevalence of preventable common illnesses such as acute respiratory infection (ARI), pneumonia, diarrhoea and malaria have been reported. Causes of under-5 morbidity that were treated in the hospital include: diarrhoea and gastroenteritis, 16.9 per cent; ARI, 10.1 per cent; pneumonia, 9.1 per cent; postnatal jaundice, 8.9 per cent; dengue haemorrhagic fever, 6.3 per cent; viral infection, 5.5 per cent; and beriberi, 2.3 per cent.66

However, it should be noted that child morbidity in hospital settings does not fully reflect overall morbidity, since only a small proportion of young children who are sick are treated in public sector hospitals, and many young children are treated at home using traditional medicines and procedures.
In addition, for example, malnutrition is not included in hospital morbidity statistics since it often is not considered a primary health condition.

A comparison of MICS findings between 2003 and 2010 shows that the incidence of diarrhoea among under-5 children in the two weeks prior to the surveys increased by more than 60 per cent (from 4.2 to 6.7 per cent) in just seven years67 (see Section 2.5.5). The Five-Year Child Health Strategic Plan 2010-2014 includes as one of its priorities strengthened community case management of diarrhoea and pneumonia in particular. As a result, it has set targets of 90 per cent each for the proportion of U5 children with diarrhoea who are treated correctly with Oral Rehydration Therapy (ORT), as well as for the proportion of children with pneumonia who are treated correctly with antibiotics.

These are ambitious targets, based upon the current data related to care-seeking behaviour and treatment of these diseases. Use of ORT for young children with diarrhoea has been found to stand at 66.3 per cent (77.1 per cent urban, 61.8 per cent rural), while only 50.3 per cent of young children received ORT or increased fluids and continued feeding (57.3 per cent urban, 47.4 per cent rural).

Care seeking for suspected pneumonia totalled 69.3 per cent (74.4 urban, 67.3 rural), and antibiotic treatment of suspected pneumonia in children was particularly low at 34.2 per cent overall, with little difference between urban and rural rates.68 Significantly, only 6.5 per cent of mothers knew two danger signs of pneumonia, ranging from 0.7 per cent in Sagaing Division, followed by Magwe (1.4 per cent) and Mon (1.5 per cent), to 17 per cent in Kayin State. No variation was found by socioeconomic background or mother’s education.69 With regard to Parenting Education, the specific needs of parents for additional health education will need to be further analysed and then integrated into the curriculum, with special modules prepared for health education.

At the same time, an urgent need has been identified to include children in the National Tuberculosis Treatment Plan, including the response to tuberculosis (TB) and HIV and multi-drug-resistant TB. Gradual implementation of enhanced methods for prevention of child tuberculosis by 2015 also is planned.70 All this will require changing and improving numerous existing practices, such as those relating to diagnosis and contact investigations. About 4,500 children aged 0-4 years were registered and treated for tuberculosis in 2008, and Myanmar is listed among the world’s 22 high-TB-burden countries.

In addition, malaria is re-emerging as a public health issue in part because of climatic and ecological changes, population migration, development of multi-drug-resistant Plasmodium falciparum parasites and insecticide-resistant vectors, and changes in the behaviour of malaria vectors. Although 2009 data indicate malaria mortality has been already reduced to less than half of its level in 2000, malaria morbidity has yet to achieve this objective.

Recommendations for strengthened ECCD (health care) from ages 3 to 36 months:

- Enhance one sectoral coordination mechanism, through the National Child Health Committee
- Define uniform technical standards for health care provision for young children, to be followed by all partners, both public and private
- Give greater priority to prevention of young child disease and illness rather than curative care, through increased attention to immunisations, regular young child checkups and developmental screening, and prevention of diseases such as malaria, tuberculosis and HIV, among other actions
- Improve key family practices with regard to young child health, through effective parent education focused on behavioural change, with reinforcement through communication media
- Conduct a national census to assess health and other indicators, and develop a unified health care monitoring and evaluation system using core indicators, fostering a strong link between evidence/information with planning and programme development
- Address persistent issues of equity and diversity in health care delivery for young children

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67 Situation Analysis of Children 2012, op.cit.
68 MICS 2009-2010, op.cit.
69 Ibid.
70 Ibid.
Identify gaps in key health care quality assessments and undertake necessary assessments.

Strengthen human resources development, particularly for health education, as well as an efficient system for procurement and logistics.

Conduct gap analysis of additional Parenting Education needs with regard to health.

2.5.3 Nutritional status and services received

The critical period of birth to 36 months is of fundamental importance to preventing malnutrition and developmental delays. Nearly all malnourished young children also develop one or more delays in cognitive, physical, language, social or emotional development. Later interventions cannot completely overcome earlier deficits in nutritional status and development, and they are much more costly than early intervention.

Numerous causes contribute to high rates of young child malnutrition in Myanmar. Immediate causes include a need to strengthen nutrition education; inadequate intake of nutritious foods; common childhood illnesses, including parasitic worm infestation; poor hygiene and sanitation; limited access to safe drinking water; household food insecurity; inadequate access to health care, particularly in remote areas; and insufficient maternal, infant and young child care and feeding practices. As with the health issues noted in Section 2.3.4, many of the issues discussed below apply not only to children aged 3 to 36 months, but also to children aged 37 months to 6 years (see Section 2.6) and 6 to 8 years (see Section 2.7).

Although malnutrition rates have generally declined modestly (see Table 3), in Myanmar nearly 1 in 4 children younger than age 5 (22.6 per cent) are still moderately underweight, and 5.6 per cent are severely underweight. More than a third of children (35.1 per cent) are moderately or severely stunted (too short for their age), an apparent slight increase since 2003, and 7.9 per cent are moderately wasted (too thin for their height). Young children with stunting or other forms of malnutrition often have a range of developmental delays that, if not treated rapidly, will have a lifelong impact on mental development and physical health.

Table 3: Nutritional Status of Under-5 Children

<table>
<thead>
<tr>
<th>Nutritional status</th>
<th>1997 (MICS)</th>
<th>2000 (MICS)</th>
<th>2003 (MICS)</th>
<th>2009-2010 (MICS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undernutrition</td>
<td>38.6%</td>
<td>35.3%</td>
<td>31.8%</td>
<td>22.6%</td>
</tr>
<tr>
<td>Stunting</td>
<td>41.6%</td>
<td>33.9%</td>
<td>32.2%</td>
<td>36.1%</td>
</tr>
<tr>
<td>Wasting</td>
<td>8.2%</td>
<td>9.4%</td>
<td>8.6%</td>
<td>7.9%</td>
</tr>
</tbody>
</table>

Source: Five-Year Strategic Plan for Child Health Development in Myanmar 2010-2014 and MICS 2009-2010

No notable difference exists in the nutritional status of male and female young children. Rural children are more likely to be underweight and stunted than children in urban areas. Children in Rakhine and Chin States also are more likely to be undernourished than other young children. While the trend in the prevalence of malnutrition among under-5 children is generally positive, Figure 86 illustrates the extent of the challenges remaining.

Figure 86: Prevalence of Malnutrition Among Under-5 Children, 1997-2010
Those young children whose mothers have secondary or higher education are less likely to be underweight and stunted compared to young children of mothers with primary or no education, whereas variation is smaller for wasting. Distribution across wealth quintiles shows that higher percentages of undernourished children are found in poorer quintiles. For example, among the poorest young children 33.1 per cent are moderately underweight and 9.7 per cent are severely underweight, contrasting with 13.5 per cent of the richest children who are moderately underweight and 2.7 per cent who are severely underweight. Close to 5 out of 10 of the poorest children are stunted, compared to 1 in 5 of the richest. The highest rate of wasting is found in children aged 12-23 months, which is expected as many cease to be breastfed, while the highest coverage of stunting is found in children aged 24-47 months. The highest prevalence of underweight is in older children, aged 48 to 59 months.71

The fact that malnutrition is found in some young children from upper- and middle-income homes reveals that nutrition education and support for behavioural changes in feeding practices are needed in the vast majority of families in Myanmar. Furthermore, nutritional rehabilitation combined with Early Childhood Intervention services is urgently needed to reduce malnutrition rapidly and effectively.

Exclusive breastfeeding rates to age 6 months, which remain low, are noted in detail in Section 2.4. At age 6-9 months, 80.9 per cent of children receive breast milk and solid or semi-solid foods (complementary feeding). By age 12-15 months, 91 per cent of children are still being breastfed, and by age 20-23 months, 65.4 percent continue to be breastfed. The prevalence of continued breastfeeding is far lower for children aged 20-23 months in the richest quintile compared to the poorest, at 48.9 per cent vs. 77.5 per cent.72

As for breastfeeding women, lactation is extremely energy-“expensive” and nutritional requirements at the macro level are even higher for these women than for pregnant women. In addition, lactating women’s requirements increase for vitamins such as Vitamin B1, Vitamin B12 and Vitamin C, as well as for iodine, for proper child growth and development. No data are available on the specific nutritional status of breastfeeding women in Myanmar, although deficiencies are known to be aggravated by poor diet as well as cultural taboos that lead to avoidance of vitamin-rich foods during lactation and pregnancy. Additional analysis is required into needs for enhanced Parenting Education on areas of nutrition, but overall it is critically important that Parenting Education for this age comprises strong knowledge about child nutrition.

In terms of key micronutrients, overall anaemia in under-5 children stood at 75 per cent in 2005, with the highest prevalence (80 per cent) in those aged 6-23 months.73 This is of great concern, given that anaemia in young children usually causes developmental delays, especially with respect to cognitive development. Worm infestation was associated with anaemia, with national estimates of 31 per cent of children infested, rising to 70 per cent of children in coastal areas. De-worming of children aged 2-9 years has a high reported coverage of more than 90 per cent.74

71 Ibid.
72 Ibid.
74 Five-Year Strategic Plan for Child Health Development 2010-2014, op.cit.
Biannual mass campaigns have been conducted in Myanmar to distribute Vitamin A to all children aged 6 months to 5 years. MICS 2009-2010 reported that 55.9 per cent of all targeted children had received at least one Vitamin A supplement in the six months before the survey (51.2 per cent urban, 57.9 per cent rural). Given the prevalence of fruits and vegetables with high levels of Vitamin A, strengthened nutrition education may considerably help improve child status in this regard.

Although no data are available with regard to iodine deficiency disorders (IDD) in young children, a total of 95 per cent of children aged 6-11 years were estimated to live in households using adequately iodised salt in 2008, up from an estimated 60 per cent in 2006.75 Iodine deficiency elimination is expected to be achieved by the end of 2012. Meanwhile, the easy availability of “junk” food, with little nutritional value, is a major issue for very young children in both urban and rural areas.

Indicating the challenges faced in addressing young child nutrition issues, the Five-Year Child Health Strategic Plan 2010-2014 aims to increase the proportion of under-5 children with severe acute malnutrition who received treatment according to national policy to 50 per cent, still a low figure. It also aims to increase the proportion of children aged 6-59 months who received Vitamin A in the preceding six months to 95 per cent.

As with health interventions, numerous NGOs are involved in nutrition interventions for young children. They often promote nutritious food, distribute nutritional supplements and carry out growth and weight monitoring, particularly for under-3 children. In addition, some service providers include a nutrition component in ECCD services for young children, and significant weight gains among the children have been reported (see Section 2.5.2). At the same time, some children who did not like the taste of the food offered had to be fed separately from home-prepared lunch boxes, a time-consuming process that also may undermine the benefits of the nutrition component.76

Lastly, data appear to be lacking on issues of substances affecting young children, including smoking, alcohol, street drugs and toxic substances such as cleaning fluids, insecticides, pharmaceutical drugs and fertilisers. An assessment of such substances should be conducted.

Recommendations for strengthened ECCD (nutrition) for ages 3 to 36 months:

- Strengthen surveillance mechanisms to monitor micronutrient deficiencies in young children
- Increase the proportion of under-3 children with moderate and severe acute malnutrition who receive nutritional rehabilitation treatment and intensive stimulation in order to serve 100 per cent of children as rapidly as possible
- Increase the proportion of children (aged 6-59) months who receive Vitamin A to 95 per cent
- Ensure all young children with anaemia receive appropriate treatment
- Conduct gap analysis with regard to additional areas of nutrition education needed in Parenting Education and respond to gaps identified to strengthen awareness with regard to appropriate nutritional practices for young children
- Assess the nutritional status of breastfeeding women and provide essential micronutrients and food supplements as needed
- Provide young child feeding services at all Mother Circles and other ECCD centres

2.5.4 Childhood injuries and injury prevention

Childhood injuries to young children can include, among others, injuries from falls and sharp objects; road traffic injuries; childhood drowning at home and in rivers and lakes; burns from household fires; injuries from poisoning; injuries due to closeness to roads; and injuries from landmines and unexploded ordnance (UXO). Often these injuries may be caused by parents being unaware of risks; by a young child being at home alone or with inadequate adult supervision; or by an unsafe living environment. Child injury is a key child health problem in Myanmar, and strengthened attention will

75 Ibid.
76 IECD Impact Study, op.cit.
need to be given to the issue, with updated and reliable data. The Government is piloting an injury surveillance system to develop a broader injury information system.77

According to a pilot study conducted at a Yangon General Hospital in 2003, 30.8 per cent of total injured patients reported were children younger than 15 years; no disaggregated data were given for under-5 children. Falls were identified as the major cause of child injury (66 per cent of cases), followed by road traffic accidents (22 per cent). The total number of injured children younger than 15 years was reported to be 976, with the proportion of injured children admitted to hospital to total admission standing at 26.9 per cent. Injuries sustained in the home environment were responsible for 5 per cent of total child injuries. Meanwhile, 5,002 instances of injuries leading to disability in under-5 children were recorded in 2008 and 2009 (prevalence of 0.06 per cent).78

Recommendations for strengthened ECCD (childhood injuries) for ages 3 to 36 months:

- Implement national-level surveillance on childhood injury, disaggregated by age group
- Conduct an in-depth study on the epidemiology of childhood injury in the country
- Strengthen Parenting Education on home, yard and community safety, injury prevention, and first aid for young children

2.5.5 Childhood sanitation issues

Safe drinking water and sanitation are basic conditions for good health, especially for young children. Improved water and sanitation can significantly reduce under-5 mortality, as well as have positive impacts on maternal health, access to education for more girls, and poverty reduction in general. In support of Government efforts, many international organisations, including United Nations Agencies and at least 26 international NGOs, are active in the water and sanitation sector in Myanmar.

A total of 82.3 per cent of the overall population uses an improved source of drinking water (93.2 per cent urban, 77.6 per cent rural). Wide variations also are found by state, from 99 per cent in Shan (East), to 51.1 per cent in Kayin (see Figure 92). By wealth quintile, 66.8 per cent of the poorest households use an improved source of water, while in the richest households the percentage rises to 95.79

Figure 92: Regional disparities in use of improved water sources, 2009-2010

77 World Health Organization Regional Office for South-East Asia, Profiles of Child Injuries in Selected Member States in the Asia-Pacific Region, New Delhi, 2010.
79 MICS 2009-2010, op.cit.
In particular, rural households face challenges in accessing safe water during the “dry” months of March, April and May. Ponds may dry up, forcing people to use less protected sources that often are most distant from the community. In coastal and delta areas, saline water intrusion into groundwater sources has been noted. All this affects the health of young children, who are especially vulnerable to illness arising from issues of water and sanitation.

Only 4.1 per cent of households have water piped into the dwelling, with most using tubewells/boreholes and protected wells; however, as many as 10.9 per cent use unprotected wells. Slightly more than one-third of households use an appropriate water treatment method, with 33.1 per cent boiling their water and only 1.4 per cent using a water filter. As many as 12.2 per cent of households do not use any water treatment method.80

At the same time, access to improved sanitation facilities has reached 84.6 per cent overall, but with wide disparities in coverage between states and regions, and between urban and rural (94.4 per cent urban, 80.4 per cent rural). MICS data showed that between 2003 and 2010, the proportion of the population using sanitary means of excreta disposal increased from 65 per cent to 84.6 per cent. Most widespread was the use of direct or indirect pit latrines with slabs, followed by pour-flush or flush latrines to septic tanks or pits.

Deficiencies in sanitation are directly related to many childhood illnesses, including diarrhoea, parasites and worms. Continued outbreaks of diarrhoeal disease, which significantly contributes to young child mortality, indicate that more attention must being given to ensuring the safety of the water supply chain and to the promotion of good hygiene practices. Monitoring and management of water quality are insufficient. Meanwhile, a 2011 Knowledge, Attitudes and Practices (KAP) study in 6,000 households in 24 townships showed that while 75 per cent of households reported an improved latrine at home, the actual number of hygienic, fly-proof latrines was much smaller. For example, only 36 per cent of all latrines at home had a hygienic floor, such as concrete, with water-pour flush. Numerous

80 Ibid.
schools have latrine facilities that are unsanitary or even unusable for schoolchildren.\textsuperscript{81} The predominance of unhygienic latrines is likely to be a major cause of high rates of diarrhoea in young children.

Open defecation occurs in many areas, particularly in rural communities. Critically, children aged 1-2 years either defecate directly on the ground or into their clothes. In many households, child faeces are disposed of improperly, often into the yard or sometimes into surface water. Disposal into latrines is not common for infant faeces; napkins are usually washed and reused in the same way as clothes.

Many caretakers and young children do not use soap for washing their hands, particularly after the children defecate. Given that 90 per cent of households report eating their meals directly with their fingers, the risk of contamination with germs is substantial. Thus, although studies indicate awareness and knowledge on recommended practices regarding basic sanitation and safe water, this has so far not been translated into appropriate behaviour.\textsuperscript{82}

Most households, especially in rural areas, have been found to use inadequate methods to dispose of their solid waste. Up to 36 per cent of households burned their waste, 17 per cent dumped it in fields, 15 per cent into garbage holes within their compounds, and 16 per cent into streams or ponds or onto the riverbank. An organised form of waste disposal was found only in urban areas.\textsuperscript{83}

Legislation for national drinking water quality standards remains to be developed, although the Government has begun a draft in 2012. Policies also are needed to address the sustainability of water and sanitation infrastructure and to promote equitable access. A national water supply and sanitation database is urgently required to facilitate long-term planning and identify low-coverage townships. Likewise, sectoral coordination mechanisms require further strengthening.

Recommendations for strengthening ECCD (sanitation issues) for ages 3 to 36 months:
\begin{itemize}
  \item Formulate a specific water policy and adopt legislation for national drinking water quality standards
  \item Establish a national water supply and sanitation database to facilitate long-term planning and identify low-coverage townships
  \item Further strengthen sectoral coordination mechanisms
  \item Ensure enhanced linkages between awareness/knowledge of recommended safe water and sanitation practices and behaviour change through strengthened behaviour change communication
  \item Place a strong emphasis on sanitation, water, waste management and hygiene modules with regard to young children for the national Parenting Education programme
  \item Develop guidelines for homes, ECCD centres, preschools and primary schools with regard to sanitation, water improvement and handling, waste management and hygiene
\end{itemize}

2.6 Children aged 37 months to 6 years

Many of the health and nutritional needs of children in Myanmar aged 37 months to 6 years, as well as information on injuries and injury prevention, have already been covered in Sections 2.5.2 and 2.5.3. What distinguishes ECCD for this age group is their rising access to Early Childhood Care and Education (ECCE) programmes, which have largely formed the core of overall ECCD services in the country thus far. This section thus focuses on education needs of these young children and related parent education needs.

2.6.1 Education needs

Traditionally, children and their education are highly valued in Myanmar. Day-care activities for children in Myanmar began in 1949, with the first syllabus for preschool issued in 1977. The current preschool curriculum was issued by the Department of Social Welfare in 2007, along with a teachers’ guide. These set objectives, among others, of attaining “proper development of good character such as physical, intellectual, moral, spiritual, emotional, socialisation and aesthetic enjoying corresponding

\begin{itemize}
  \item \textsuperscript{81} Situation Analysis of Children 2012, op.cit
  \item \textsuperscript{82} Ibid.
  \item \textsuperscript{83} Ibid.
\end{itemize}
Preschools can be established by DSW, attached to basic education primary schools, founded by national or international NGOs, or run by communities, associations, foundations and private individuals or groups. Many of the latter are affiliated with DSW, and some are supported in part by DSW. Standards also are included for school buildings and furniture, daily programmes, teaching methods and working with young children, discipline, keeping student records, and meeting with parents. In addition, some Buddhist monastic education includes services for preschool-aged children; however, because little is known about the contents, methods and results of monastic education for young children, a study is needed.

Significantly, more young children in the country are now participating in ECCE programmes (for children aged 3-5 years) than were doing so a decade ago. The percentage of 3- to 5-year-olds attending some form of organised ECCE programme increased from 9 per cent to 22.9 per cent between 2000 and 2009-2010. This represents a doubling in participation, albeit from a very low base. The Education for All (EFA) National Plan of Action sets an overall target of 25 per cent by 2015, which is likely to be achieved. In 2011, 258,235 children aged 3-5 (109,743 males, 95,006 females) were attending ECCD programmes (see Annex 1, Table A). There is a high level of demand for preschool services and Mother Circles, as many of the latter serve children from 37 to 60 months as well as from approximately 6 to 36 months.

A second EFA national goal is to increase the percentage of Grade 1 entrants with ECCD experience from 10.69 per cent in 2006 to 20 per cent by 2015. The percentage stood at 18.50 per cent of boys and 18.73 per cent of girls in 25 disadvantaged townships in 2010-2011. MICS data indicated a far higher percentage nationally, at 39.8 per cent (see Table 4). Gender parity already has been achieved in ECCE programmes. However, comparing the current enrolment rate at this level with others in the region shows Myanmar requires further efforts to match the achievements of its neighbours. Critically, a comprehensive ECCD database is still needed, a major gap that requires urgent attention.

A strong focus has been accorded to early learning opportunities and strengthening the home-to-school transition, accompanied by a notable expansion of services. For example, in 2011 one major ECCD programme, funded by the Multi-Donor Education Fund and supported by UNICEF, served 306,319 children aged 0-5; the relevant figure in 2007 was 83,137 children. Including programmes by UNICEF-supported NGOs, ECCD has been implemented in a total of 10 per cent of townships in Myanmar and Parenting Education in 18 townships. Direct support to school-based ECCD was provided through short-term training of Township Education Officers (TEOs), Assistant Township Education Officers (ATEOs), cluster heads, head teachers and ECCD teachers.

Nevertheless, in Myanmar it has proved difficult to target the poorest and most marginalised families with ECCD services, in part because of the need for strengthened social data as well as because of the limited reach of NGOs involved in service delivery. More than half of ECCD centres are in urban or peri-urban areas. Thus, young children who have the most access to ECCD are likely to be those who already have a greater chance of completing primary school. Some very successful ECCD programmes have been developed in rural areas with hard-to-reach populations. These have demonstrated that effective rural ECCD services can be developed and made sustainable.

Wide disparities have been noted between urban preschool attendance, at 39.1 per cent, and rural attendance, at 15.9 per cent. Across states, attendance rates also are highly variable, ranging from 60.7 per cent in Kayah to 5.4 per cent in Rakhine. Older children are more likely to participate: The

86 MICS 2009-2010, op.cit.
87 Based on Government statistics and information provided by 12 ECCD partner organisations.
89 MICS 2009-2010, op.cit.
90 MICS 2009-2010, op.cit.
91 MDEF 2007-2011, op.cit.
92 QBEP Annex, op.cit.
93 MDEF 2007-2011, op.cit.
participation rate is 32.5 per cent for 4- to 5-year-olds, compared with just 13.8 per cent for 3- to 4-year-olds.\textsuperscript{94}

Available data also indicate that the richest quintile have a higher attendance rate in existing ECCD services for 3- to 5-year-olds (46 per cent), while the poorest quintile receives the least services (7.6 per cent), as shown in Table 4. Socially excluded groups such as migrants, as well as those who are remotely located (often related to ethnicity), have enrolled and attended at a lower rate and are more likely to drop out of some ECCD programmes.\textsuperscript{95} In 2008 Cyclone Nargis had a severe impact on education overall, damaging about 57 per cent of the total number of schools in affected areas of Ayeyarwaddy and Yangon Divisions. Of these, 1,255 totally collapsed, and 400 ECCD centres were affected.

Table 4: ECCE Data, by Wealth Quintile

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Total</th>
<th>Richest quintile</th>
<th>Middle quintile</th>
<th>Poorest quintile</th>
</tr>
</thead>
<tbody>
<tr>
<td>% children aged 36-59 months attending some form of organised ECCE programme</td>
<td>22.9</td>
<td>46.0</td>
<td>19.5</td>
<td>7.6</td>
</tr>
<tr>
<td>% of first graders who attended pre-school</td>
<td>39.8</td>
<td>51.7</td>
<td>42.1</td>
<td>34.5</td>
</tr>
<tr>
<td>% children of primary school entry age attending Grade 1 – net intake ratio</td>
<td>74.4</td>
<td>80.7</td>
<td>79.3</td>
<td>63.5</td>
</tr>
</tbody>
</table>

Source: MICS 2009-2010

As with health, ECCE in Myanmar depends on a high level of private family resources, especially in urban areas. Family costs of private preschool education have been estimated as averaging 45,000 kyat per year, but can range as high as 75,000 kyat.\textsuperscript{96} In all, there may be direct private costs such as transport; household cash, in-kind and labour contributions; and indirect “opportunity” costs. This further constrains the number of young children in the country who can benefit from development opportunities in early childhood.

Achievements

Multiple impacts from ECCD programmes have been recorded on both the demand and supply sides. In particular, there exists a growing recognition that ECCD plays an important role in preparation for school readiness. This is reflected in part in the proportion of schools with an ECCD facility, which has increased from 10 per cent in 2008-2009 (among 345 sample schools) to 31 per cent in 2010-2011 (among 635 sample schools). An analysis of the impact of higher ECCD coverage also showed that schools with an ECCD facility in 2009-2010 had a significantly higher student attendance rate in Grade 1 than schools without an ECCD facility (44 per cent vs. 30 per cent); in 2010-2011, they recorded higher age-appropriate Grade 1 intakes.\textsuperscript{97}

A 2007 Most Significant Change study revealed a number of important outcomes for children and parents involved in ECCE. The assessment found the five most representative “domains of change” to be (1) knowledge and skills (see Figure 108 below), (2) awareness and appreciation of ECCE, (3) interpersonal skills; (4) value formation; and (5) caregiving practices. A separate tabulation revealed that stakeholders considered the most significant domains to be (1) school readiness; (2) interpersonal skills; (3) knowledge and skills; (4) self-help; and (5) health and hygienic behaviour. A particularly marked improvement was noted in young children’s ability to socialise and better integrate into society at an early age.\textsuperscript{98}

\textbf{Figure 108: Distribution of Parents’ Stories Containing Knowledge and Skills as a Domain of Change, by Sector}

\textsuperscript{94} Ibid.
\textsuperscript{95} Ibid.
\textsuperscript{97} MDEF 2007-2011, op.cit.
\textsuperscript{98} Most Significant Change Study, op.cit.
INGO/FBO sector: preschools operated by international non-governmental organisations and faith-based organisations; DSW sector: preschools operated by Department of Social Welfare; MOE Urban sector: urban preschools operated by Ministry of Education; MOE Rural sector: rural preschools operated by Ministry of Education.

Likewise, a 2011 study by the Metta Development Foundation of community-based ECCD found numerous reports of improvements in children's health and personal hygiene, development of language skills, social skills, skills in controlling emotions, self-help skills, and positive manners and practices. Another study, meanwhile, noted significant and highly significant gains in visual-motor perceptual skills overall, as well as physical development gains (increased average weight and height) for young ethnic minority children.

The Most Significant Change assessment also found that parents of young children in ECCE were highly appreciative of the programme and that their caregiving practices had evolved into providing a nurturing and caring home environment for their children. They feel secure in leaving the children in the care of a preschool and are more productive at work as a result. Communities were found to go to great lengths to support their preschools if provided with the appropriate degree of awareness and appreciation of the programme. Other benefits reported by parents included listening to young children, paying individual attention, and preparing a balanced diet.

A further study by Save the Children in 2010 in three townships found that a significant side effect of children’s enrolment in ECCD programmes was an improvement in families’ livelihoods. Primary carers of young children aged 2 and 6 years have more time to engage in income generating activities or even to resume education themselves. A total of 67 per cent of previous carers of young children now enrolled in ECCD said they now use their available time to support their household livelihood activity, mainly farming. A total of 12 percent have started a remunerated livelihood activity, usually casual farm labour, to complement the income of their household.

Moreover, 72 percent of households stated that their monthly income had increased following the enrolment of children in ECCD; about 34 percent of households stated that they earned as much as an extra 120,000 kyat (US$133) a year, and 26 percent up to a maximum of 240,000 kyat (US$266) a year. These figures show the extent of the impact of ECCD programme on a family’s economic situation, representing 8 and 16 percent of average household income (US$1,867) respectively.

100 Transitions Initiative Midterm Evaluation, op.cit.
101 Ibid.
An opportunity for families and communities to have a voice in determining ways to assess and improve their schools, through the School Self Assessment/School Improvement Plan (SSA/SIP), also may have an impact on school-based ECCD centres. Recent important ECCD initiatives have included not only the approval for development of a multi-sectoral ECCD national policy, but also finding of new entry points (language and literacy groups, Satyamans) to reach the unreached; the mainstreaming of ECCD in theology schools; and review of ECCD delivery models to inform further investments.

**Challenges**

Both a more enabling, pro-poor policy environment and a national strategy for scaling up ECCD interventions particularly remain to be developed. In particular, low public expenditures on education overall, as well as the dispersed nature of State responsibility for ECCD, must be urgently addressed (see Chapter 3). Scope exists for innovative pilots to try out ways of providing more targeted assistance, especially to poor and remote communities. At the same time, various successful ECCD models in several regions/states could be further developed to have the attributes required to take them to scale in their areas, and possibly with adaptation in similar geographic regions/states.

Detailed policy guidance requires strengthening in a range of areas, including child-centred learning methods, inclusive education and meeting the language needs in bilingual areas. Development of the multi-sectoral ECCD national policy thus represents an important step in the right direction. Additional teachers, training and resources to support such initiatives will need to be made available. Critically, a national ECCD monitoring and evaluation framework, with appropriate indicators, will need to be developed as part of a comprehensive ECCD management information system that can provide overall accountability.

In other policy and systemic challenges, the key educational plan to date has a 30-year framework that may be too long for effective planning purposes. The EFA National Plan of Action 2003-2015 requires more attention to costing and sequencing; while it contains a strategy for children aged 0-5 to develop to their fullest potential, there is no budget for ECCE activities to achieve this. Data related to costings for five-year planning cycles generally have not been available.

Several cost studies on ECCD services should be conducted to identify cost per pupil, per cohort and per service site. These data are needed to conduct projections and simulations to maximise investments in ECCD with respect to quality and coverage. In effect, the education sector has lacked a costed medium-term strategy and expenditure framework, a gap that a newly begun, multi-year Comprehensive Education Sector Review (CESR), which includes ECCD, is intended to begin to address.

Related to access, a key issue is how to build up DSW, MoE, MoBA and NGOs’, FBOs’, CBOs’, associations’ and foundations’ capacities to serve all children in areas where they offer services and to extend their reach to under-served areas of the country in order to better meet the needs of the most disadvantaged children. Meanwhile, the need to improve awareness of ECCE among various stakeholders likewise has been identified as a key remaining challenge in several studies. In particular, parents, caregivers and Education Development Management Committees require stronger guidance toward full awareness of the importance of education for young children. Issues of access and equity also remain a priority concern, particularly for border states, as well as for rural areas in general.

An important contribution to the quality of ECCD services has been the publication of user-friendly minimum quality standards in 2009, followed by training for preschool teachers, Government education staff and partner NGOs for monitoring purposes. Core indicators also have been provided for the preschool environment. However, a 2012 baseline study on the proportion of 181 school-based ECCD facilities that actually meet minimum quality standards in 15 townships offers an indication of the scale of the quality challenges still to be faced. Results included:

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Only 2 per cent of facilities met all 15 core quality indicators (see Figure 9)
54 per cent required urgent attention
75 out of 310 ECCD teachers in the facilities (24 per cent) were not trained
Fewer than one-third of ECCD centres (31 per cent) had sufficient play materials
Only 1 in 5 teachers recorded children’s developmental progress
 Barely half of communities (51 per cent) recorded parents’ participation
Fewer than 3 in 5 Mother Circles (56 per cent) were active

Figure 119: Percentage of School-Based ECCDs Based on Quality Scores

Child-to-caregiver ratios are generally around the recommended level of 15:1, but in some centres are too high.105 Strengthened efforts also will need to be made to ensure more inclusive preschools, such as for young children with disabilities, and preschools with expanded bilingual opportunities for young ethnic minority children. Greater attention is needed to develop advocacy materials in ethnic languages, for non-literate community members or for communities without access to video.106 A need for an integrated package of preschool health and nutrition interventions also has been identified.

All this has been compounded by the overall need for strengthened data on early childhood, as well as by previously limited opportunities to support system building through policy reviews and reforms. Likewise, coordination among providers requires further strengthening, and limited attention has been given to the need for communities to use reliable indicators for monitoring and planning improvements.107.

Other major challenges with regard to ECCD include teacher supply and attrition. In part this has been exacerbated in recent years by issues of wide disparities in salary. The salaries of ECCD caregivers have been generally provided by the community; these salaries are usually in the range of 20,000 to 30,000 kyats per month (US$20-$30), which is considerably less than schoolteachers’ salaries, which were raised in January 2010.

Trained teachers thus often prefer to teach other grades, giving them the opportunity for additional income by providing tutoring services for their students. This has become a major source of

105 Ibid.
106 Transitions Initiative Midterm Evaluation, op.cit.
107 Transitions Initiative Midterm Evaluation, op. cit.
ECCD caregivers’ salaries also are less than some caregivers believe they could earn as labourers outside Myanmar, thus encouraging outmigration and mitigating against teacher retention in ECCD programmes.

The quality of the environment provided and effectiveness of management of the centres depends very much on community capacity. An urgent need exists to support development of a more fully-funded and -capacitated system of quality centre-based ECCD, while simultaneously addressing targeting and equity to ensure that ECCD benefits those children for whom it will add most value.109

Management challenges are significant, with preschool Management Committees facing a range of issues including holding regular meetings and formulating appropriate forms of income generation to reduce the use of revolving loans. Only a few have reportedly developed clear plans for sustainability and income generation, although many centres have become sustainable. The major need cited by virtually all studies is to provide salaries for full-time teachers who have no other source of income. Support from Government is needed to cover recurrent expenses of ECCD services, and most especially salaries and benefits for full-time personnel.

A number of caregivers also have been found to believe they require more support from Management Committees in their work. Given that Management Committee members are generally males of high status in the community, while caregivers are young women, there may be both gender and social hierarchy issues involved. In some communities, however, the Committees comprise both men and women, and women do speak up and assist with decision making.

In all, it will be crucial to improve access to the poorest and most disadvantaged children who stand to gain most from ECCD and whose participation will have the most impact on improved primary completion and learning outcomes. It is likely that this can only be achieved through partnerships that will enable holistic support to the poorest communities. This will need to include recognition of vital contributions and expertise in holistic approaches to address poverty, including income generating activities, revolving funds and livelihoods education, as well as facilitation and support to these activities.

On the other hand, it also will be important to support general expansion, improved quality and capacity, in order to further build culturally and linguistically appropriate models that can demonstrate the potential of ECCD and thus support policy dialogue on improved funding strategies in this area (see Section 3.4).

2.6.2 Parenting Education

Parenting Education requires strong advocacy to encourage wider participation by fathers, grandparents and other caregivers. As noted above, major challenges appear to remain with regard to community participation. The percentage of parents with young children in ECCE who met with caregivers to share views decreased sharply between 2009-2010 and 2010-2011, from 38 to 26 per cent. Similarly, the proportion of ECCD centres with an active Management Committee fell over the same period, from 69 to 51 per cent.110 Parents of poor or marginalised children have been found far less likely to attend Parenting Education classes.111

All this again underscores the critical need to raise awareness of the importance of ECCD. Parental awareness on ECCD and positive parenting is also low with children from 3 to 5 years of age. A baseline survey for Parenting Education alternative design, conducted by Save the Children in 27 communities in nine townships, indicated a low level of awareness by parents about child development and positive caring practices. For example, 40.9 per cent of respondents did not know that the important age for young child development is 0 to 5 years, while 9 per cent did not know

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109 To “add value,” ECCD programmes need to provide something that is not already present in the child’s home environment. Programmes are therefore particularly effective if targeted to families where, owing to poverty or low education, there is some lack of support to children’s physical, cognitive or psycho-social development. ECCD programmes are also particularly important for children with a disability or developmental delay that might be mitigated through early intervention, as well as for children who will be entering a school system where the language of instruction is not the home language.
110 MDEF 2007-2011, op.cit
111 Transitions Initiative Midterm Evaluation, op.cit.
understand individual differences in young child development. This often results in parents’ failure to ensure early stimulation for childhood development. Only 36.2 per cent of respondents could express the basic elements of young child rights, i.e., survival, development, protection and participation.

In addition, only 11.2 per cent of respondents felt that young children with disabilities have capacity and skills although they lack in some developmental milestones. Lastly, it appears that many parents treat their children differently according to gender and age, with 42.8 per cent of parents indicating favouritism toward one gender or the other, generally toward sons. A total of 46.8 per cent said they gave more love and care to younger children than older children.

Recommendations for strengthened ECCD (education) for children aged 37 months to 6 years:

- Integrate ECCD into the Basic Education system, through increased attention to Parenting Education and early childhood development; Early Childhood Interventions for 0- to 3-year-olds and preschool for 3- to 4-year-olds; and transition to primary school for 4- to 6-year-olds.
- Continue to develop a costed medium-term education strategy and expenditure framework that provides special attention to ECCD.
- Develop a baseline to assess needs for preschools and preschool classes in all communities, as well as a national strategy for ECCD with inclusion strategies/models for poor communities, giving priority to marginalised, ethnic minority, rural and remote communities.
- Prioritise the provision of additional financial, human and technical resources for ECCD programmes.
- Offer a stronger, integrated health and nutrition package as part of ECCD.
- Provide health care services that are nutritionally appropriate and hygienic feeding programmes for preschools.
- Particularly provide additional policy guidance on areas for young children including child-centred learning methods, inclusive education and meeting language needs in bilingual areas.
- Ensure all preschool activities and ECCD services in general are provided in the mother tongue.
- Strongly enhance awareness among parents, caregivers and other beneficiaries of the importance of ECCD, through the dissemination of up-to-date and internationally recommended information on ECCD, using all media and including information in minority languages.
- Proactively expand Parenting Education to a wider target group of community members, including fathers, grandparents and young people who might become parents in the future.
- Improve overall coordination among service providers and strengthen strategic partnerships that offer holistic support based on partners’ comparative advantages, as well as work with partners to undertake further cost-benefit analyses of different types of ECCD in different contexts.
- Focus on ensuring the provision of high-quality, culturally and linguistically appropriate preschool education and stimulate further understanding of constraints on quality of ECCD education, while strengthening assessment of young child development.
- Provide salaries for full-time community ECCD personnel (e.g., Parenting Education, Mother Circles, preschools, etc.) and explore ways to offer higher salaries to those who already receive stipends or salaries.
- Respond to challenges in providing ECCD services in remote areas by means of selecting, training and hiring local teachers and other personnel and offering special incentives.
- Establish sustainable pre- and in-service training, monitoring and support systems for ECCD Community Management Committees and caregivers, and strengthen accountability mechanisms.
- Undertake a collaborative study to improve analysis and documentation of lessons learned in ECCD.

2.7 Children aged 6-8 years
As with children aged 37 months to 6 years (see Section 2.6.1), much of ECCD for the age group 6-8 years focuses on education, which is examined in more detail below for the early primary grades. At the same time, parents’ support for education may be inadequate as a result of having many children to support, or from the need to use the child in domestic affairs and income-generating activities because of poverty. Other critical issues such as better child nutrition and improved personal hygiene remain, as well as a continuing need to strengthen Parenting Education with regard to children’s developmental needs (see Section 2.6).

2.7.1 Education needs

The percentage of children of primary school age (5-9 years) who are attending primary or secondary school totals 90.2 per cent (93.0 per cent urban, 89.2 per cent rural), according to the MICS 2010. No preferential treatment between genders when enrolling in school has been observed.

In addition, early dropout has fallen considerably from the estimated 45 per cent of children in 2001-2002 who had enrolled but failed to complete Grade 4, with nearly 1 in 5 dropping out at the end of Grade 1 at that time. Between 2009-2010 and 2010-2011 alone, on average the number of students leaving school and no longer attending another school decreased across all grades and genders. Whereas there was an average of 14 students per school leaving education in 2009-2010, a year later that had fallen to 9 students. An overall decrease also occurred between the two years in the number of repeaters, across all grades and genders. All this bodes well for young children in early primary school in Myanmar.

The Transitions Initiative, begun in 2006 by the Ministry of Education and Department of Social Welfare in partnership with Save the Children and UNICEF, places particular emphasis on the smooth transition from home and ECCD centres to the school environment and uses methods derived from Child Centred Approaches. Its overall purpose is to demonstrate the efficacy of community empowerment in this regard, especially the role of parents, children, and Community Based Organisations.

To make the school environment more conducive to learning, the eight-week Transitions Curriculum (TC) supports Grade 1 and 2 teachers to address issues including non-participatory teaching practices, as well as behaviour and classroom management. Thus far, it is in use in 1,991 schools across 25 townships, and served 12,126 children in 200 ECCD centres in poor communities between 2007 and 2010. It also has benefited more than 41,000 trainee teachers from all 20 teacher training institutes.

A recent study of the impact of the Transitions Curriculum on children’s learning has noted that “all stakeholders held that children thrived well academically and socially in primary schools as a result of ECCD experiences and TC exposure.” In particular, the study found that the average rate of children reaching to the highest grade in primary level (Grade 5) rose from 80.55 per cent to 88.17 per cent in selected areas, a significant increase in retention rates The study declared the Transitions Curriculum a feasible and cost-effective alternative to help children without ECCD experience to have a child-friendly learning environment at primary school, especially in areas with limited ECCD service provision. Qualitative evidence of improved learning in Grade 1 also was demonstrated was demonstrated in a mid-term review of the programme, especially for cognitive and language skills, but also for learning and social skills and health/hygiene practices.

Meanwhile, in a positive policy development with regard to the crucial language issue, the education sector is beginning to respond to the needs of non-Myanmar-speaking children by providing ECCD and early grade teaching in mother tongues, with bridging to the national language around Grade 4. Teaching of Myanmar as the national language puts local-language-speaking children on an equal footing with their Myanmar-speaking peers and gives them the competency to continue their later education at secondary and tertiary levels, which are taught only in the Myanmar language.

114 Transitions Initiative Midterm Evaluation, op.cit.
Recent monitoring revealed that about 60 per cent of teachers in primary schools are able to speak the local language. Now, the challenge will be not only to increase the number of local-language-speaking teachers, including in preschool and early primary school classes, but also to assign them to areas where these local languages are being used, to facilitate teaching and learning processes.

Critically, the groundbreaking Language Enrichment Programme under the Multi-Donor Education Fund/UNICEF programme has demonstrated results with major implications for the development of early-grade reading and writing skills, particularly among the nearly 1 in 3 children who have a mother tongue other than the Myanmar language.

In 16 areas of student competency tested in Grades 1 through 3, baseline results had indicated only one competency area (speaking and listening) where more than 50 per cent of all students assessed were competent, with fewer than 10 per cent of all students assessed as competent in eight of the competency areas tested. In contrast, impact study results indicated five competency areas where more than 50 per cent of all students assessed were competent. No competency areas where fewer than 10 per cent of all students are competent were found.

At the same time, numerous education quality issues continue to affect lower primary education. A baseline study on classroom practices shows a high prevalence of teacher-centred methodologies in most schools (80 per cent teacher-directed and only 4 per cent pupil-centred). More than 3 in 5 schools are believed to practice multi-grade teaching, although teachers are generally not adequately prepared with the required knowledge and special skills to effectively manage multi-grade classes; more than 1 in 4 schools still assign teaching responsibilities to general workers employed as support staff, compensating for the shortage of teachers. Key school infrastructure requires further development; for example, the female student-to-latrine ratio, while decreasing remains nearly twice as high as the average ratio across both genders.

More schools also require encouragement to apply the principles learned in the Transitions Curriculum to Grade 1 or other grades. Individual teachers’ attitudes and skills, the degree of support from head teachers, class size and composition (e.g., a multi-grade situation), and degree of linguistic diversity of the community are all factors that have affected progress. To address remaining constraints, it has been recommended that partners work together to conceptualise a holistic model of school improvement and quality development.

Recommendations for strengthened ECCD for children aged 6-8 years:

- Undertake a baseline study of all transitions programmes to identify achievements, challenges, and areas for further development with regard to young children, and foster an even stronger transitions programme to primary school that includes strong parental participation, child-centred approaches, and initial use of the mother tongue in the early primary grades
- Systematically implement Child Centred Approach in lower grades of primary schools and improve quality of teacher training, particularly for multi-grade situations
- Give additional attention to improvement of school infrastructure for young children, particularly sanitation facilities for girls

2.8 Vulnerable children with special needs

Key factors that create vulnerable situations for children include lack of access to education, health and social services; malnutrition; violent conflict and internal/external displacement; natural disasters; and a host of illnesses, including malaria, tuberculosis, and infection with or being affected by HIV/AIDS. Many of these remain highly sensitive issues in Myanmar, both culturally and otherwise.

No specific figures are available with regard to young children living in economic poverty, although overall poverty in the country stands at 25.6 per cent, as noted in Section 1.2. From the sub-sections

116 Ibid.
119 Transitions Initiative Midterm Evaluation, op.cit.
above, however, it is clear that non-income poverty among children remains widespread. Thus, since these factors affect a large number of children in Myanmar, some sources consider all children in the country as potentially vulnerable.\footnote{UNICEF Myanmar. Community-Based Psychosocial Care and Support for Vulnerable Children in Myanmar: A Strategy Paper. Yangon, 2006.} This suggests a need for a holistic approach that ensures that all children have access to basic services, including child protection services; that reduces risk factors; and that builds a protective environment for all children.

Child protection in Myanmar is generally approached from the perspective of different groups of vulnerable children in need of special protection. However, an overall systems approach to the child protection sector, which focuses on building social welfare and legal systems for all vulnerable children, is being introduced only slowly. A unified child protection policy, focusing on early childhood, is urgently needed and is now being developed.

The Government has taken a number of positive steps in policy and systems improvements to promote a protective environment for children, such as developing minimum standards for working children and finalization of a juvenile justice system.

In addition, Cyclone Nargis, while causing so much devastation tragedy and loss of life in 2008, has in the ensuing years provided an opportunity for systems improvements in the area of child protection. An Inter-Agency Child Protection Information Management System initiated after Nargis, for family tracing and reintegration, evolved into a child protection database used to collect and analyse data on child protection. Myanmar is one of 17 countries worldwide, and only one of two in East Asia and the Pacific, using this software from UNICEF, International Red Cross and Save the Children.

Using momentum gained after the Nargis emergency, a particularly important development has occurred with the activation of Township Committees on the Rights of the Child (TCRC). Led by DSW with support from UNICEF, this has built a child protection referral system between more than 500 volunteer-led Community Support Groups and policymakers and multi-sectoral service providers at township level. In turn, these strengthened community-based support mechanisms in education, health, justice, and other sectors in favour of vulnerable children and their families culminate in the TCRCs. Between March 2008 and May 2012, 580 child protection cases (315 boys, 265 girls) had been responded to at TCRC level in 15 townships, particularly including cases of children in contact with the law, sexual abuse/exploitation, neglect, and physical abuse. A total of 39 children involved in the cases were aged 0-5 years, while 103 were aged 6-12 years.

This initiative also has stimulated the leadership of DSW in outlining a National Child Protection Strategy, setting standards, common approaches and training for improving child protection interventions – a milestone for child protection in Myanmar. Moreover, this model of community-/township-based child protection has been replicated by international NGOs such as Save the Children and World Vision.

Current changes in the Myanmar context are providing greater space to address many young child protection issues. Not only does the new decentralised Government structure offer opportunities to expand child protection work at sub-national level, but strengthened working relationships between development partners and newly established Parliamentary Committees on Women and Children, as well as with the Myanmar Human Rights Commission, also hold promise for significant attention in advancing young child rights overall.

Given a need for strengthened and reliable national data on various issues of young child protection and vulnerable young children, it is fundamental to conduct an in-depth analysis to further understand their situation and to map resources and gaps in action. Following such a mapping and analysis, use should be made of the three main pillars of a psycho-social well-being framework for an integrated approach to promote protection and community-based care, particularly for vulnerable young children. These pillars include (1) community activities and capacity building for NGOs, faith-based organisations, community-based organisations, associations and foundations, including a “family first” policy that protects children and prevents institutionalisation; (2) Government policy and capacity building; and (3) development of strengthened coordination and referral mechanisms.\footnote{Ibid.}

\begin{enumerate}
\item \textit{Community-Based Psychosocial Care and Support for Vulnerable Children in Myanmar: A Strategy Paper. Yangon, 2006.}
\item Ibid.
\end{enumerate}
2.8.1 Children belonging to socially or economically marginalised groups

Young children belonging to socially or economically marginalised groups, especially ethnic, indigenous, religious and other minority groups, have been found to be particularly at risk. Issues and achievements in bilingual education already have been raised in Section 2.6.1 and are linked to the need for better targeting of the poorest and most marginalised children. Additional information is needed on all ethnic minorities and other marginalised groups to elaborate policies and programmes to fully ensure implementation of their basic rights, including access to education and primary health care.

Recommendations for strengthened ECCD for children belonging to socially or economically marginalised groups:

- Develop national strategies to target the poorest and most marginalised young children
- Gather additional data relating to ethnic minorities and other marginalised groups to develop policies and programmes that fully ensure implementation of their young children’s rights
- Ensure appropriateness of language policy in educational situations and expand usage of the mother tongue throughout the early primary school years, with bridging to the national language beginning by Grade 4
- Ensure all educational, health, nutrition, sanitation and protection services are culturally and linguistically appropriate through involving members of each ethnic community in the planning, implementation and oversight of all ECCD services

2.8.2 Children with disabilities or chronic illnesses

According to the First Myanmar National Disability Survey 2010, 2.32 per cent of the overall Myanmar population is living with disabilities, translating into a prevalence of 1 person with disabilities in every 10 households.122 The prevalence of persons with disabilities in urban areas was significantly higher than in rural areas (2.49 per cent vs. 2.24 per cent), but with significant variations between states and divisions (see Figure 120). The prevalence of disabilities also was notably higher for males (2.55 per cent) than for females (2.10 per cent). At the same time, these statistics appear to be an undercount because in most low- and middle-income countries, 10 to 12 percent of the population have with one or more disabilities. Given high rates of Low Birth Weight children and child malnutrition in Myanmar, the disability rate may be even higher. A study is needed to ascertain the actual rates of disability and developmental delays in children from 0 to 36 months and above.

Figure 120: Disability by State/Division

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Persons with disabilities and their households are often disadvantaged to a great extent, with little hope for a better future. They are often disproportionately represented among the poor, uneducated, unemployed, living in poor housing, to be landless, to die prematurely, to have food insecurity, to be unable to access public information, to be excluded from public places, and to be unaware of their rights. In the case of Myanmar, detailed statistics on persons with disabilities were not available until very recently, and the extent of inequities for this population has not yet been fully quantified. A law on the rights of persons with disabilities is being developed and is expected to be enacted shortly.

Some 68,521 children younger than 5 years (0.88 per cent) have been identified with disabilities. Of these, 53,009 have been noted to have various physical disabilities, with 4,263 having sight disabilities, 5,412 with hearing disabilities, and 5,643 with intellectual disabilities. This appears to be a serious undercount. The disabilities of 46,869 young children were attributed to congenital causes; of 16,651 children, to disease prevalence; and, as also noted in Section 2.5.4, of 5,002 to injuries. Ayeyarwaddy Division, Yangon Division and Mon State have the highest prevalence on under-5 children with disabilities, at 1.63 per cent, 1.28 per cent and 1.07 per cent respectively.124

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The Committee on the Rights of the Child has particularly recommended that efforts to facilitate the inclusion of children with disabilities into the education system and society at large be strengthened in all areas, but especially in rural and remote areas. It stated that thus far largely only those children with mild impairment in sight, hearing and speaking, particularly those living in cities, have been able to be included in inclusive education programmes.125

Myanmar has one residential facility for children with disabilities, as well as one school for the blind and one school for the deaf. However, overall nearly half of persons with disabilities in the country have never attended school. The country’s Third and Fourth Reports to the Committee on the Rights of the Child noted that in 2006-2007, 11,080 children with disabilities (0-17) were enrolled in formal school, 673 in special schools for the visually- and hearing-impaired, and 9,567 in non-formal learning circles, totaling 21,520 children. Among these, 40.7 per cent were girls. MoE reported that around 600 children with disabilities were enrolled in formal schools in 2010, with 1,450 in special schools.126

Regardless of the figures used, these totals, for all children under 18 years, are far lower than the number of young children with disabilities identified in the first nationwide survey in 2010. It is thus possible to conclude that a very large number of children with disabilities are not yet included in education.

Families’ awareness of the health and nutrition needs of young children with disabilities also is often limited. Many families do not recognise the need to seek extra health care for the child, do not know where to go to seek such care, or are unable to access care even where it is available. Early detection of disabilities and early intervention rarely occur in large part because training for ECI services and developmental paediatrics is unavailable as yet. Without early screening and detection, ECI and rehabilitation services are sought only when children are much older – usually at the age of entering primary school. The important period when many disabilities and developmental delays can be overcome or greatly improved thus is lost. Overall, far fewer young children with disabilities survive beyond age 5: In a 2011 sample of more than 1,100 households, the ratio of children aged 6-18 years to under-5 children among the non-disabled was 3:1, while among children with disabilities it was 1:1.127

Specialised medical services, such as newborn screening and medical-genetic counselling, are very scarce if available at all. Even where early detection and intervention may be practiced, they are not yet linked to early learning programmes or preschools that meet the needs of children with disabilities and help them move smoothly on to school. Capacities of health workers and others in the community likewise require strengthening to provide advice and assistance to parents of children with disabilities, or to refer children with more complex disabilities to more specialised services as they develop. Guidelines and tools for screening, intervention and referral are not yet available to community health care providers. A national system of ECI services has not been developed till now and is urgently needed.

No comprehensive statistics are available on young children with chronic illnesses, but malnutrition is widespread, as noted in Section 2.5.3.

Recommendations for strengthened ECCD for children with disabilities or chronic illnesses:

- Provide strengthened support to early detection of disability and the development of early childhood intervention services, including specific policy guidelines and procedures, screening assessments, individual plans, and home visits with family training services in this regard.
- Strengthen pre- and in-service capacities of health workers and others to advise parents of young children with disabilities, refer such children to appropriate services and provide quality care and development services.
- Expand and strengthen inclusive education in preschools and primary schools, especially in rural and remote areas.

125 CRC Concluding Observations, op.cit.
126 QEBP Annex, op.cit.
127 SPPR Bulletin, op.cit.
Deepen the understanding of causes of under-5 disability and existing practices regarding such children, using disaggregated data. Undertake a baseline survey on young children with chronic illnesses and diseases such as malaria, tuberculosis and HIV, and provide recommendations for improving prevention and treatment protocols in specific geographical areas.

2.8.3 Orphans, social orphans, and other children lacking parental guidance

No specific figures are available for the number of children aged 0-5 years who are orphans. The MICS 2009-2010 found that 5.4 percent of all children aged 0-17 years were not living with a biological parent (6.6 per cent urban, 5.0 per cent rural); about 2 per cent of 0- to 4-year-olds were affected. The prevalence of orphans aged 0-17 years overall was 6.6 per cent total (7.2 per cent urban, 6.4 per cent rural); adoption rates are low. According to a 2004 United Nations publication,128 the estimated number of orphans in 2003 was 1.9 million, or 9 percent of children. Of these, 1.4 million were paternal orphans, 710,000 maternal orphans, and 200,000 double orphans; it was believed that about 7.7 per cent of orphans in Myanmar (146,300) were orphans as a result of the death of parent from AIDS. Given the number of “social orphans,” or those with one or more parents, it is clear that family preservation services and a range of family supports are needed to enable parents to retain and nurture their children well.

Numerous child residential institutions are run by NGOs, faith-based organisations, and private organisations or individuals, as well as by DSW. Despite general agreement that institutional care for children should be a last resort, additional support for orphans, social orphans and vulnerable children is still needed in Myanmar. In practice, residential care is not being used as a last resort.129 Because virtually all young children 0 to 3 years of age become developmentally delayed before or after placement in institutions, family placements should be required for such children, and preferably with their own parents or relatives. Such families will require additional support, but the costs of such services will be greatly less than the cost of residential care.

Many of the residential care facilities for children make their best efforts to fulfil the food, clothing and shelter needs of the young children in their care, ensuring the right to survival, but a number of institutions may not fully understand other basic rights of young children, including development, protection and participation. Research highlights many concerns regarding the protection, safety, health and well-being of young children in residential care facilities.

Major challenges and constraints include a lack of technical expertise, lack of funds, logistical challenges, divergent approaches to programme implementation, and sustainability. Many facilities are not registered, a major cause for concern, with young children in these facilities vulnerable to poor standards of care, neglect and abuse. Minimum standards of care have been developed but not yet issued as a directive, nor made mandatory for all residential care facilities in Myanmar.

The number of children in residential care facilities has increased in recent years, from 14,410 (23.4 per cent girls) in 177 registered facilities in 2006 to 17,322 children (22.4 per cent girls) in 217 registered facilities in 2010.130 Of these 14 of these facilities are run by the Government. A total of 693 children (487 boys, 116 girls) were aged 0-5 years, while 5,785 children (4,639 boys, 1,146 girls) were aged 6-12 years. The number of children in private unregistered institutions across the country is not known. In addition, many children are placed in Buddhist monasteries by their parents, who believe they will be given more food and an education.

As noted above, a key theme is that most young children in private residential care are not full orphans, but have families and relatives who could care for them (see Table 5); in monastic and private institutions, for example, true orphans represent only 20 per cent of total children. Most children are brought to facilities by parents and relatives, and usually at the start of the school year, suggesting that education and poverty are key reasons why children end up in residential care facilities.

130 Ibid.
Table 5: Number of Children in Facilities, by Reason

<table>
<thead>
<tr>
<th>Reason</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both parents are dead</td>
<td>2,748</td>
<td>22.0%</td>
</tr>
<tr>
<td>Only father has died</td>
<td>1,961</td>
<td>15.7%</td>
</tr>
<tr>
<td>Only mother has died</td>
<td>1,612</td>
<td>12.9%</td>
</tr>
<tr>
<td>Both parents alive</td>
<td>5,509</td>
<td>44.1%</td>
</tr>
<tr>
<td>Not known</td>
<td>663</td>
<td>5.3%</td>
</tr>
<tr>
<td>Total</td>
<td>12,493</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: The Situation of Children in Residential Care Facilities in Myanmar, DSW/UNICEF

A general lack of knowledge about reunification and reintegration issues and processes results in little or no planning for the future of these children. For example, fewer than 1 in 5 facilities are reported to be looking for the parents of young children at their facilities, and fewer than 1 in 10 had a budget for children to maintain contact with their family. Less than half of caregivers have received training on young child care and development; they work an average of 60 hours per week and are responsible for an average of 48 children. Admission and recordkeeping are particularly weak, with about half of facilities maintaining a case record (see Table 6).\

Table 6: Documentation Required Upon a Child’s Admission to a Residential Institution

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether parents are living or they are poor or not</td>
<td>49</td>
<td>33.3%</td>
</tr>
<tr>
<td>Recommendation letter from the local authority certifying the child is an orphan</td>
<td>38</td>
<td>25.9%</td>
</tr>
<tr>
<td>A child has to fill out her/her personal profile</td>
<td>31</td>
<td>21.1%</td>
</tr>
<tr>
<td>Health certificate (the children should be free from leprosy)</td>
<td>19</td>
<td>12.9%</td>
</tr>
<tr>
<td>Nothing is needed</td>
<td>18</td>
<td>12.2%</td>
</tr>
<tr>
<td>Birth certificate</td>
<td>13</td>
<td>8.8%</td>
</tr>
<tr>
<td>Not older than 12</td>
<td>11</td>
<td>7.5%</td>
</tr>
<tr>
<td>A child should be free from party politics</td>
<td>10</td>
<td>6.8%</td>
</tr>
<tr>
<td>Letter from the Government authority</td>
<td>6</td>
<td>4.1%</td>
</tr>
<tr>
<td>Household certificate/school leaving certificate</td>
<td>5</td>
<td>3.4%</td>
</tr>
<tr>
<td>Parents should be free from party politics</td>
<td>1</td>
<td>0.7%</td>
</tr>
<tr>
<td>Only the blind are accepted</td>
<td>1</td>
<td>0.7%</td>
</tr>
<tr>
<td>Should stay for two years</td>
<td>1</td>
<td>0.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100.0%</strong></td>
<td></td>
</tr>
</tbody>
</table>

Source: The Situation of Children in Residential Care Facilities in Myanmar, DSW/UNICEF

Health care in the majority of facilities poses a potentially great risk to young children’s well-being. The provision of health services at the facilities requires significant strengthening, with only 36.7 per cent of facilities conducting a medical checkup on the arrival of the child. Fewer than half provide children with regular health checkups, while only 38.8 per cent said children receive routine immunisation. Nearly 3 in 4 do not maintain health records for children. Not all children get three meals a day. Only 8 facilities out of 147 had special nutritional arrangements for children with special needs, such as babies, sick or malnourished children, or children with disabilities.\

\[131\] Ibid.
\[132\] Ibid
Most facilities have rules to manage child behaviour, but punishments are unregulated and may include physical punishment as well as manual labour. Fewer than one-third of caregivers said that children have participated in the development of rules and regulations in a facility."

Lastly, little information exists on the number of young children in street situations in all townships, with further efforts to improve their situations and reintegrate them with their families. Most of these children are older than the group considered under ECCD services. Estimates by various NGOs of the number of children in street situations range from 5,000 to 10,000; however, one 2004 survey found 53 children aged 5-9 years out of a total of 419 surveyed.

Recommendations for strengthened ECCD among orphans, social orphans, and other children lacking parental guidance:

- Develop a prevention and de-institutionalisation strategy for young children
- Enforce Minimum Standards for Residential Care Facilities as a directive to ensure that compliance becomes mandatory, including for standards of health care and management of young child behaviour
- Establish improved registration processes and effective monitoring of residential care facilities, including a clarified monitoring role for Government
- Use social mobilisation campaigns to promote a change of public perceptions of residential care and to promote a “family first” approach for young children
- Systematically assess the number of young children in street situations
- Raise awareness on reunification and reintegration for institutionalised young children through the provision of family preservation and therapy services, financial and material support, ECI services and other health, nutrition, protection and educational services
- Strengthen education, counselling and rehabilitation services for families of young children in difficult circumstances, such as those affected by natural disasters, conflicts or internal displacement, or refugees

2.8.4 Children affected or infected by HIV/AIDS

Although HIV epidemics in Myanmar are declining, the country still has one of the highest HIV prevalence and caseloads in Asia. About one-third of people living with HIV in the country are women, while the HIV sentinel surveillance data from 2009 showed an HIV prevalence of 0.9 per cent among pregnant women aged 15-24, suggesting a large number of infants who could become infected annually through transmission from their mothers. At the same time, a limited amount of information has generally been available for orphans and vulnerable children affected by HIV.

A higher priority is now being given to the needs of orphans and vulnerable children living with and affected by HIV, including psychosocial, nutritional, education and material support, referral and follow-up. In 2009 a total of 5,332 orphans and vulnerable children affected by HIV were receiving a package of support, with up to half of these children being younger than age 5. About 1 per cent of all under-5 deaths in 2007 were due to AIDS.

Significant negative social, economic and psychological effects are common among children affected by HIV/AIDS and their families, including stigma, higher risk of behavioural problems, family dispersion, school dropout, and a smaller proportion with normal height-to-weight ratios than for non-affected children. In particular, a recent study in three townships with high HIV rates found that more than 1 in 4 HIV-affected families had been displaced from their original house, either within the same township or to other townships.

Knowledge of mother-to-child transmission of HIV among women aged 15-49 totalled 65.0 per cent in 2009-2010 (64.5 urban, 65.2 rural), and women who knew where to be tested for HIV was similarly

References:

133 Ibid.
135 Situation Analysis of Children 2012, op.cit.
137 Situation Analysis of Children 2012, op.cit.
high (70.6 per cent total, with urban, 82.1 per cent, and rural, 65.3 per cent). However, the proportion of women who had actually been tested for HIV was sharply lower, at only 17 per cent total, with sharp differences in rural-urban rates (33 per cent urban, 10.5 per cent rural). In 2009, 22 per cent of infants born to HIV-infected mothers were themselves infected.139

Prevention of Mother to Child Transmission services, launched in 2001, were provided by 39 hospitals and 200 townships by 2010.140 According to HIV estimates and projections for 2008-2015 by the National AIDS Programme, 3,879 women need PMTCT services each year. The PMTCT package includes provision of antiretroviral (ART) prophylaxis at 6 weeks of age to babies born to HIV-infected mothers, as well as follow-up HIV testing for infants at 9 months and 18 months. A total of 433 child HIV patients are receiving ART from public hospitals, and Government health personnel in 17 state and division hospitals have been trained on early detection of HIV infection in children. Although there has been a rapid scaling up of PMTCT services in recent years, there exists a perception of a need for strengthened quality of the services. Meanwhile, availability of co-trimoxazole prophylaxis for infants and children aged under 18 months who are exposed to HIV infection is limited in the country (23 per cent in 2009).

Recommendations for strengthened ECCD for children affected or infected by HIV/AIDS:

- Ensure more women and their partners access and use family planning, antenatal, delivery and postpartum services as entry points for HIV testing
- Ensure 100 per cent of HIV-positive women receive ART treatment in pregnancy and during and after delivery
- Ensure the young children of HIV-positive women receive ART treatment as recommended in PMTCT protocols and ECI services for them and their parents or caregivers

2.8.5 Child abuse and neglect, including domestic violence affecting children

A need for stronger information exists on child abuse and neglect overall, although it is known that physical punishment of children is a common disciplinary measure used by parents, caregivers and teachers; this may involve slapping or using implements to beat the child.143 Anecdotal reports indicate sexual abuse of girls and boys occurs in some homes and communities, at work, in institutions and in some schools. It is unclear how many of these are young children.

As with issues of child abuse, domestic violence within the family is seldom mentioned publicly.144 Awareness is low about how to identify and protect children at risk of domestic violence or child abuse. New child-friendly police and court procedures are expected to strengthen the few support services or counselling options that have previously existed for victims and their families.

Similarly, a lack of detailed information is found on child victims of trafficking. The Third and Fourth National Reports to the Committee on the Rights of the Child noted that during 2006, a total of 9 children under 6 years of age were trafficked, mostly to China. Five were eventually repatriated to Myanmar. In the same year, 23 children younger than age 18 were trafficked, with 18 of these returned to Myanmar. Save the Children has reported assisting 155 returnees that were victims of commercial sexual exploitation and trafficking, with some as young as babies.

Recommendations for strengthened ECCD among abused and neglected children, including those affected by domestic violence:

- Conduct baseline studies detailing the extent of abuse and neglect of young children and develop mechanisms for eliminating any forms of child abuse and discrimination
- Proactively raise family and community awareness of young child abuse and neglect and strengthen relevant community-based interventions
- Offer enhanced support and rehabilitation services to young children and women suffering as a result of abuse

139 MICS 2009-2010, op.cit.
140 National Strategic Plan on HIV and AIDS 2011-2015, op.cit.
141 Five-Year Strategic Plan for Child Health Development 2010-2014, op.cit.
142 Situation Analysis of Children 2012, op.cit.
143 Ibid.
144 Community-Based Psychosocial Care and Support for Vulnerable Children, op.cit.
2.8.6 Other vulnerable and marginalised children, including issues of child labour

Myanmar has several additional categories of children who are particularly vulnerable, including those living in severe poverty, involved in child labour/street children, affected by conflict and/or natural disasters, internally displaced and refugee children, children in conflict with the law, and children of parents in correctional facilities.

Although abusive child labour is believed to be widespread overall, no specific information is available on the number of children involved at a very young age. The Committee on the Rights of the Child has expressed concern about child labour at an early age, including in food processing, street vending, refuse collecting and light manufacturing industries, restaurants, tea shops and family agricultural activities, as well as in large-scale development projects in the extractive and energy industries. The minimum legal age for the employment of children is set at 13 years. Minimum standards for the protection of working children have been drafted, including with regard to minimum age certification, working hours, conditions that may pose a risk of physical injury or moral harm, protection and safety, working conditions and welfare facilities, leave/holidays, contact with families, payment and wages, and access to health and education services. However, these remain to be formally implemented and enforced.

Many children in the country are vulnerable to natural disasters and thus are significantly affected when such emergencies occur. Following the devastation of Cyclone Nargis in 2008, emergency preparedness and response in education was expanded, including the outlining of key actions to prevent family separation in emergencies. Child Friendly Spaces guidelines include general standards, play facilities, child participation, activities/curriculum, staffing and ethical guidelines on photography and interviewing children in emergencies.

The Committee on the Rights of the Child has noted several other such groups of vulnerable children, including children of Internally Displaced Persons (IDPs), refugees and others obliged to flee conflict-affected areas. The numbers of children affected by armed conflict are sensitive, but thousands of children remain at risk of being shot in open conflict areas or may be killed or maimed by anti-personnel landmines and UXO, as well as displaced and living in poor economic and social conditions. These children may be recruited as child soldiers or aides. Many lack basic developmental, education and health services, and it appears most become malnourished.

The Committee further noted potentially negative impacts on children of in families that had been evicted from their homes for purposes of extractive industry and large-scale development projects. It expressed particular concern about young children in jails and prisons with their mothers, including the potential detrimental impacts on their social and emotional development through the absence of everyday stimuli and educational materials. Women, many of whom are mothers, constitute about 15 per cent of the total number of people in prisons in Myanmar. Children living in correctional facilities or lacking parental support in the community require a package of special services to develop well.

Recommendations for strengthened ECCD among other vulnerable and marginalised children:

- Develop appropriate services, including counselling and support, to meet the needs of young children living in severe poverty, involved in child labour/street children, affected by conflict and/or natural disasters, internally displaced and refugee children, children in conflict with the law, and young children of parents in correctional facilities
- Strengthen baseline data on these categories of vulnerable and marginalised young children
- Enforce all national laws and standards that have been developed to eradicate abusive child labour and to ensure that all young children are enrolled and participate fully in preschool and primary schooling

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145 CRC Concluding Observations, op.cit.
146 CRC Concluding Observations, op.cit.
147 Situation Analysis of Children 2012, op.cit.
Chapter 3: ECCD Resources

3.1 Institutional resources for ECCD

The main agencies of the State relevant to ECCD include the Department of Social Welfare (DSW), Ministry of Social Welfare, Relief and Resettlement; the Department of Education Planning and Training (DEPT), Ministry of Education; the Department of Health (DoH), Ministry of Health; and the Ministry of Border Affairs. Other Ministries involved in supporting ECCD services include the Ministry of Home Affairs, Ministry of Labour, Ministry of Religious Affairs, Ministry of National Planning and Economic Development, and Ministry of Finance and Revenue.

DEPT and DSW have staff assigned as focal points for ECCD. Currently the two organisations’ services are complementary and non-duplicative. However, implementation of ECCD programmes by line Ministries and local authorities is complex; without careful planning and coordination, unnecessary duplication could occur in the future. Both types of services need to be greatly expanded, building upon the strengths of the programmes in each sector. A strong need exists for ECCD capacity development and strengthening of institutions at different levels, as well as coordination among them. In addition, a greater role for civil society participation in decision making and accountability requires further encouragement.

Overall, ECCD has been seen as a shared responsibility of DEPT and DSW. As in other countries, a distinction exists in Myanmar between centre-based ECCD interventions for 3- to 5-year-old children and more diffuse interventions to support the early development of children aged 0-3 through a combination of health interventions and education of parents and carers. Under DEPT, schools that have an extra classroom, communities that are able to construct an extra classroom, and those with either an available teacher or the ability to fund a teacher from the community have been encouraged to set up school-based ECCD centres (preschool classes). These are now found in 2,315 schools in 162 townships, with such classes serving 74,790 children aged 3-5 years (36,150 boys, 38,640 girls). The Department of Myanmar Education Research Bureau also runs a preschool used as a laboratory for trainees to receive exposure to the preschool atmosphere.

Many community-based ECCD centres, alongside parenting and Mother Circles for 0- to 3-year-olds and for children from 37 to 60 months, are overseen or directly managed by DSW, with a large part of implementation, support and funding from NGOs and faith-based organisations. A 2003 study estimated that there were 270 NGOs and 200,000 community-based organisations in the country. A growing number of local NGOs are formally recognised and are more focused on development interventions, with 82 registered in 2009. Table 7 illustrates the types of interventions of 12 major ECCD partners in Myanmar.

| SN | ECCD Related Activities                                      | K | B | C | E | T | A | S | C | K | B | C | M | S | W | V | D | S | W | Y | N | TH | W | Y | D | B | E | M | R | C | A | D | M | E | R | B |
| 1  | Community-based ECCD programme                             | X | X | X | X | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x |
| 2  | Parenting Education programme                              | X | X | X | X | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x |
| 3  | School-based ECCD programme                                | X | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x |
| 4  | Capacity building of ECCD teachers/ preschool teachers     | X | X | X | X | X | X | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x |

148 QBEP Annex, op.cit.
149 Based on Government statistics provided.
150 Situation Analysis of Children 2012, op.cit.
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<td>34</td>
<td>ECCD materials sale for teachers, trainers, mothers</td>
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Locations of initiatives by these 12 partners are noted in Annex 1, Tables B and C.

Because many staff responsible for ECCD at grassroots level require strengthened relevant professional knowledge and skills, ECCD services are provided largely through voluntary efforts rather than by fully trained, paid professionals. Overall, public-private partnerships with regard to the provision of support for children and women face financial limitations.\(^{151}\)

Extensive education reform is now under way in the country, and a Comprehensive Education Sector Review (CESR) has begun as a follow-up to the Conference on Development of Policy Options on Education and Health, held in February 2012. This multi-year undertaking is intended to include a rapid assessment of education policies, laws, legislation and systems; in-depth analysis of the sector as a whole for reform purposes; and development and implementation of costed sector plans.

Critically, as part of the restructuring of the Basic Education sector it is now intended to include ECCD services, including preschool education, in the Basic Education system and to expand preschool coverage to the level of other countries in the region. This signals the potential for major change in the approach to ECCD. Other planned reform activities include reorganising Basic Education Departments and upgrading Regional/State Education Offices as Regional/State Education Directorates. District Education Offices and Sub-Township Education offices will be established and existing Township Education Offices strengthened. This is expected to address the previously highly centralised nature of education management, with capacity issues considered with respect to participatory policymaking, planning, data management, and monitoring and evaluation.

The National Health Committee is a high-level inter-Ministerial and policymaking body providing guidance for implementation of health programmes and serving as a mechanism for inter-sectoral coordination, with, for example, Ministry of Labour, Ministry of Industry and Ministry of Defense. In line with the National Policy, NGOs such as MMCWA and MRCS also provide services. Health committees have been established down to ward and village tract levels.

By the end of March 2012, there were 987 Government hospitals, with 54,503 hospital beds, along with 87 primary and secondary health centres, 348 Maternal and Child Health Centres, the same number as in 1988-1989. Rural Health Centres numbered 1,565, and Traditional Medicine hospitals stood at 141\(^{152}\) (see Annex 1, Table D). Many more medical personnel are needed, and nurses, midwives and basic health staff especially need to be trained for service in rural areas. Health officers and public health supervisors also are greatly needed.

Relevant Government programmes include the Women and Child Health Development project (previously Integrated Management of Mother and Child Illnesses, or IMMI), which covered 149 townships during 2001-2009 and offers a focus on ENC, community case management of pneumonia and diarrhoea, referral care for sick newborns, improved antenatal, delivery and postpartum care for mothers, and community capacity development and behaviour change communication. Other important programmes include Essential Newborn Care; reproductive health; nutrition; Baby Friendly Hospital Initiative and Baby Friendly Home Delivery; PMTCT services; Central Epidemiological Unit; EPI; malaria, dengue haemorrhagic fever and tuberculosis control; and water and sanitation. Hospital health centres have been established at different levels, and basic and essential supplies are generally available, including vaccines and ORT, although many drugs and supplies are not yet available at Rural and Sub-Rural Health Centres.\(^{153}\) In addition, facilities such as Sub-Rural Health

\(^{151}\) The Singapore International Foundation has set up a Resource Centre for ECE to support ongoing professional development of trainers and other preschool personnel, housing books on child development, child psychology, early childhood current topics, and samples of low-cost teaching aids as well as manuals on how to make them; it also has set up two demonstration centres for trainees.

\(^{152}\) Health in Myanmar 2012, op.cit.

\(^{153}\) Five-Year Strategic Plan for Child Health Development 2010-2014, op.cit.
Centres cover only about two-thirds of townships, while birth spacing programmes, for example, cover about one-third of townships.154

Health programmes are designed to contribute to the continuum of care for young children, and efforts are being made toward programme integration. A health system strengthening programme under the leadership of the Ministry of Health aims to achieve improved service delivery of essential components of immunisation, Maternal and Child Health, nutrition and environmental health by strengthening programme coordination, health planning systems and human resources management and development, in support of MDGs 4 and 5. Through this programme, guidelines for health system assessment at township level have been developed and were conducted in 20 townships at the end of 2011, evaluating planning and management; hard-to-reach mapping; human resources; community participation; infrastructure and transport; essential drugs and logistics systems; finance and financial management; and data quality audit and service quality assessment.155 Mapping of Maternal and Child Health Services also has been conducted in 2011, with the aim to create an inventory of all such services and to share information on service provision among partners and use it to better target delivery of services. At the same time, there still exists a need to address considerable overlaps and insufficient coordination, as well as to apply uniform standards for activities and to strengthen the focus on family and community practices for young children.

Despite recent progress, Myanmar does not yet have a fully efficient social protection system. There is no continuum of services that would provide a comprehensive safety net for all young children, including the most vulnerable, although important models are being developed (see Section 2.8). Instead, the institutional framework for child protection is dispersed and requires strengthened attention. As noted in Section 2.8.3, institutional care is still one of the main forms of substitute care for young children in need of special protection.

Creating a truly protective system for young children thus will be a major task. Among other initiatives, it will require: (a) strengthening Government capacities; (b) promoting the adoption and enforcement of adequate legislation; (c) addressing harmful attitudes, customs and practices; (d) encouraging open discussion of young child protection issues within the media and with political, social, professional and other organisations; (e) developing young children’s life skills, knowledge and participation; (f) building the capacities of families and communities; (g) providing essential services for prevention, recovery and reintegration for young children in special circumstances and those at risk; and (h) establishing and implementing an effective system of monitoring, reporting and oversight.

While there have been sensitivities around external assistance to the education sector in the past, there is now increasing Government openness to dialogue and technical assistance. United Nations Agencies working in multiple sectors related to ECCD include UNICEF, WHO, UNESCO, UNFPA, UNDP, UNHCR WFP and UNAIDS. Major international donors supporting key ECCD service providers are listed in Annex 1, Table D.

In addition to these ECCD partners, major partnerships in child health in Myanmar include those with national and international organisations such as Population Services International, Merlin, Japan International Cooperation Agency (JICA) and Japanese Organization for International Cooperation in Family Planning (JOICFP). With regard to community-based psycho-social care and support of vulnerable children in Myanmar, projects have been launched by additional partners including the Myanmar Nurses Association, Rattana Metta, PACT and CARE.

The Education Thematic Working Group (ETWG), through its ECCD sub-group, provides an important linkage between Government and national and international partners on setting agreed minimum standards and guidance for ECCD centres and ECCD training. It replaced several technical working groups that previously operated independently and is co-led by UNICEF and Save the Children. Key members of the ECCD sub-group include DEPT, DSW and relevant international partners, including NGOs.

Joint achievements of the group have included the development of common minimum ECCD standards (15 indicators), as well as common ECCD training packages and storybooks; however, only

154 Situation Analysis of Children 2012, op.cit.
155 Health in Myanmar 2012, op.cit.
three of the indicators focus directly on children’s learning and development. The group has not yet undertaken a full mapping of ECCD activities and, in the absence of such, has not been able thus far to develop a strategic plan for expansion and improved targeting of services. It is expected that this activity will be included in the ECCD Policy and Strategic Plan.

Until quite recently, Myanmar has received very low levels of Official Development Assistance (ODA) from international donors. It had faced international sanctions from the United States, European Union, and Canada, among others, for many years. There had been no World Bank lending since 1987, no International Monetary Fund (IMF) programme since 1981-82 and no Asian Development Bank (ADB) assistance available, although this is beginning to change (see Section 3.4).

Three major international NGOs in education (Save the Children, World Vision and the Burnett Institute) have now prepared a concept note for development of a Myanmar Education Consortium (MEC), identifying a mechanism by which the consortium in the medium term could evolve to manage grants to national and local NGOs and other bodies, while also supporting capacity development and common monitoring for strengthened impact.

In terms of challenges, coordination mechanisms, particularly at local level, need clarifying. Government officials at central level have had more opportunities than local officials to become sensitised to ECCD areas and issues, and to their responsibilities in this regard through a multi-sectoral, multi-disciplinary approach.

3.2 Trained human resources available in ECCD

To achieve a rights-based approach to ECCD that favours all young children, the following are integral to capacity development: (1) responsibility, motivation, commitment and leadership; (2) authority; and (3) access to and control over resources. Challenges still exist in Myanmar with regard to all three.

Acute human resources constraints among Government and NGOs alike have affected implementation of ECCD programmes. Overall weaknesses in human resources related to ECCD in Myanmar continue to include staff shortages, deployment in areas of greatest need, motivation, and accountability; capacity of training institutions; and capacity of managers to provide supportive supervision. (For details of contents of various ECCD training programmes for village leaders, Management Committees, Parenting Education facilitators, teachers, and toy making workshops, see Annex 2.)

In education, a total of 12,254 trained preschool teachers (40 males, 12,214 female) provide ECCD services for children aged 3-5 years, while 25,273 members of Management Committees (6,615 male, 18,658 female) contribute to oversight of community-based ECCD programmes (see Annex 1, Table F). Generally preschool teachers have received short-term and informal pre-service training and sporadic in-service training; much of this is provided by governmental and non-governmental, faith-based or community-based organisations, associations and foundations, several of which have received considerable support from UNICEF, UNESCO, WHO, UNDP and other international organisations.

A total of 6,982 trained Parenting Education facilitators (683 males, 6,299 female) serve 129,255 parents (24,752 male, 104,503 female) (see Annex 1, Table G), while 375 trainers of trainers (10 male, 365 female) also offer support (see Annex 1, Table H). A high volume of short-term informal training for a range of stakeholders has helped to increase skills, knowledge and motivation among ECCD providers. All this is a notable achievement, although many thousands more preschool teachers and parent educators must be trained in order to assist the Ministry of Education and DSW in providing universal preschool services.

At the same time, teacher competence is directly related to the quality of Colleges of Education and the two national Institutes of Education in Yangon and Mandalay. With respect to ECCD and preschool education, these institutions require a complete developmental process. Both professors and students need new and strengthened skills in pedagogical teaching for ECCD services, preschool

156 MDEF 2007-2011, op.cit.
and primary education. They also need improved facilities, demonstration schools, equipment and information resources. Curricula are overcrowded and require new components and streamlining, especially with respect to developmentally appropriate educational services and teaching methodologies. The training of ECCD planners, supervisors and trainers also is of primary importance. Head teachers have been promoted on the basis of years of service and qualification, and opportunities for teachers to receive training in management, budget, finance and supervision have been few.157

A critical area still to be addressed is the very limited analytical work in the area of supporting capacity development, with an acute lack of systematic data on capacity issues. Data collection and research has thus had limited benefits for management purposes so far, as well as for service delivery to the most vulnerable young children. A need exists to improve multi-sectoral data linkages, including for young child protection, and to enhance life cycle approaches.

Turning to health, it is unclear how many of its trained personnel have specialisation or training specifically related to ECCD, although training teams have been formed at all levels under the Ministry of Health for continuous medical education. In 2011-2012 the total number of doctors stood at 28,077 (11,460 public, 16,617 cooperative and private). The ratio of doctors to nurses was nearly 1:1, with 26,928 nurses found.158 However, the number of doctors and nurses per 1,000 people has not changed significantly since the early 1990s, at 3.8.159 Fewer than half of doctors were in the public sector. Midwives totalled 20,044, as noted in Section II, barely a 10 per cent increase since 1988, with 1,536 Health Assistants, 3,371 Lady Health Visitors, 612 Health Supervisors I and 1,718 Health Supervisors II (see Annex 1, Table J).160 The Health Assistant to population ratio is 1:21,822 and the midwife to population ratio is 1:4,144.161 Midwives, who receive very low salaries, are particularly difficult to retain in more remote, insecure or culturally diverse regions, resulting in significant numbers of unfilled posts.

A total of 52 Mother and Child Health officers were posted at state/division levels to plan, monitor and supervise all MCH activities. Despite Government efforts to strengthen the management effectiveness of township-level managers and health teams in particular, it appears that the total number of health supervisors may be low for effective supervision of the large number of midwives and other personnel, which also include auxiliary midwives (AMWs) and volunteer health workers (VMWs). The Basic Health Services personnel including community health volunteers, provide maternal and child health care, nutrition promotion, school and environmental health education, and immunisation services. It has been noted that time devoted to training in all these categories is insufficient and that a large number of subjects are introduced, often leaving health workers without the requisite skills or competencies desired.162

Currently, 141 trained nutritionists are working in the Ministry of Health Nutrition Team in 15 regions and states in Myanmar. Given the levels of malnutrition, many more nutritionists are needed.

A Social Work Diploma course has been established and a post-graduate curriculum developed. Thus far, 518 students have graduated, with 180 currently enrolled. Two DSW social welfare officers have obtained master’s degrees abroad. In addition, considerable work has been conducted to train juvenile justice officers, police officers and others dealing with child protection.

Meanwhile, the water and sanitation sector is reported to have a fairly well-qualified human resource base, with sanitation engineering being taught in at least one university in Yangon and some senior members of staff studying to postgraduate level in international institutions. However, it appears that technician-level courses in community water supply and sanitation are very limited.

3.3 Pre- and in-service training resources for ECCD

157 Ibid.
158 Health in Myanmar 2012, op.cit.
159 MDEF 2007-2011, op.cit.
160 Health in Myanmar 2012, op.cit.
162 Five-Year Strategic Plan for Child Health Development, op.cit.
No formal pre-service training system exists for ECCD, although some in-service training exists, provided mainly by the Government, international NGOs and national NGOs, faith-based organisations, associations and foundations. However, many training events require further strengthening of follow-up to ensure that training and awareness is transformed into positive impact for young children. “One-off” training programmes have limited impact without immediate follow-up, refresher training, and practical implementation plans.

In all, it will be necessary to establish a comprehensive, high-quality, multi-sectoral pre- and in-service ECCD training system, including formal certification and re-certification, as well as upgrading the capacities of paraprofessional and volunteer service providers. In addition, as noted throughout, a critical need exists to promote awareness of the importance of ECCD at grassroots level, to reinforce parents’ commitment and skills to care for their young children, and to initiate and sustain community-based programmes to respond to the needs of vulnerable young children in particular.

For pre-service training, some engagement with Education Colleges has occurred, such as beginning to support the integration of the Transitions Curriculum into their courses. However, a range of areas that have been introduced into the teacher education curriculum, including ECCD, the Transitions Curriculum, WASH (water, sanitation and hygiene) and others, are still seen as “add-ons,” contributing to overburdening the Education College curriculum. In some cases, the attempt to put in more content without transforming the entire process has resulted in only token coverage, for example, with regard to the incorporation of just one 40-minute period to cover ECCD.163

In health, in-service training has been conducted for staff through the WCHD project in 149 townships and IMCI training in all townships. Since 2006, Basic Health Service providers have been trained comprehensively for ENC in 33 townships; these training courses have been included in pre-service training programmes of doctors, nurses, paramedic students and midwives. Some technical gaps exist in the training of doctors and nurses, although training of these cadres is generally found to be adequate.

As these figures illustrate, however, in-service training does not cover all townships; there also is no consistency in training provided by different partners, and training materials and packages used vary widely. Since training materials are not integrated, staff may receive fragmented training with considerable overlaps. In addition, training may not be based on needs assessments. Follow-up has been conducted with less than 30 per cent of health staff trained.164 In Traditional Medicine, Myanmar offers an innovative programme where basic concepts of Myanmar Traditional Medicine have been introduced into the curriculum of third-year medical students.165

Development of a comprehensive database for ECCD training could assist in tracking progress in capacity development and provide important information on numbers of trained human resources in the country. In addition, staff in all ECCD-related fields also require a broadening of training in other relevant areas, including peace education and Disaster Risk Reduction/Disaster Risk Management.

Overall, baseline studies on workforce development and training capacity in all ECCD sectors are urgently required in order to project accurately the needs for expanding and improving training capacity in Myanmar. Periodic workforce and training studies will be required to meet evolving needs for skilled professionals in all major fields related to ECCD. Based on the workforce and training studies, plans for ECCD workforce development should be established periodically.

3.4 Financial resources and budgets for ECCD

Having adequate Government revenues overall is good for child and family development, especially for the most vulnerable. It makes possible balanced budgets with minimal fiscal deficits and greater
fiscal space, creating greater potential for social sector spending. However, in Myanmar social sectors historically were secondary to economic sectors in national planning. Budgeting for investments in children, including ECCD, does not have a separate line in the national budget. With the exception of child development services within DSW, child budgets are not yet identifiable within sectoral budgets of the Ministries of Education and Health.

Linkages between national planning and budgeting have been insufficient because medium-term (five-year) plans for the social sectors have generally been prepared without resource information; annual plans have been derived from the five-year plans. Frequently, the budget ceiling has not been enough to carry out planned tasks. A need for strengthened coordination between capital and current budget preparation also may lead to an underestimation of recurrent costs and of new capital investments. Overall, the poverty reduction architecture has been fragmented, leading to dispersed impact, difficulty in mainstreaming programmes into regular budgets, complicated monitoring and evaluation, spending inefficiencies and “overcrowding” in some sectors.

Inadequate public resource allocations to health, education and social welfare have been cited as root causes of suboptimal sector performance. In addition, even these low allocations are highly unbalanced: Education accounted for the majority of the social sector budget in 2009-2010 (78 per cent), with far smaller amounts dedicated to health (20 per cent) and very little to social welfare (2 per cent) (see Figure 130).

In large part due to high out-of-pocket payments for education and health, poor and near-poor households – and particularly women, children, ethnic minorities and the chronically ill within these populations – have difficulty in accessing quality social services. For example, a feasibility study on township-based health protection revealed that in 2011 per-capita health expenditures stood at some 30,000 kyat, compared to per-capita Government expenditures of around 1,400 kyat. Although the Ministry of Health has introduced Hospital Trust Funds for the poor, Community Cost Sharing methods for such items as the cost of medicines or X-rays, and Revolving Drug Funds, these interventions have not been sufficient to reduce out-of-pocket expenditures.

| Figure 130: Social Sector Expenditure Within the National Budget, 2009-2010 |

Under the previous Government a strong lack of transparency in the budgeting process made determining overall budget figures, or reconciling conflicting figures, very difficult. Not all Government authorities have applied a strategic approach in formulating development plans, and no specific legal document regulates the integration of child and social development aspects into planning process at local level. If Myanmar is able to allocate adequate financial, human and technical resources to implement its ECCD Policy, this will help to lay a solid foundation for improving the holistic development of children in the country.

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166 UNICEF Myanmar. “Monitoring Social Sector Budgets: What We Know About Social Sector Spending in Myanmar” (PowerPoint presentation), Nay Pyi Taw. August 2012.
167 Ibid.
170 CRC Concluding Observations, op.cit.
For nearly a quarter-century, ODA to Myanmar remained very low, in large part because of the international sanctions noted in Section 3.1 Using data from the Organisation for Economic Cooperation and Development (OECD), the country received about US$247 million in ODA in 2007, compared to US$56 million in 2000. Even so, this was the second-lowest per capita among low-income countries and the lowest per capita in the world, at about US$4 per capita. By contrast, Cambodia received about US$50 per capita and Lao PDR US$80 per capita. The proportion of ODA received by the social sector also was low, at 24 per cent in 2008.

A US$100 million Three Diseases Fund was set up by six donors (Australia, European Community, United Kingdom, Netherlands, Norway, Sweden) in 2006 to respond to the funding gap for HIV, tuberculosis and malaria that had been caused by the temporary withdrawal of the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) in 2005. Both the GFATM and the Three Diseases Fund have provided significant resources over the years, however, while the health system strengthening component of GAVI Alliance assistance has begun to cover 180 townships. The same donor consortium that is behind the Three Diseases Fund plans to start a Three Millennium Development Goals Fund in 2012 to provide external assistance to about 100 townships; this includes a health system strengthening component to support long-term sustainability.

Following Cyclone Nargis in 2008, ODA to Myanmar soared to US$534 million, with about 60 per cent provided as humanitarian assistance. As confidence of the international community increased following successful collaboration, several donors, including Australia, Brazil, the United Kingdom and Switzerland, expanded their presence in the country, and there has been an increased focus on longer-term development assistance. Even so, serious challenges had remained in establishing development partnerships with the country.

By mid-2012, however, all this appeared set to change. Following the election of the new Government and encouraging economic and social reforms, nearly all international sanctions have been progressively lifted by the US, EU and Canada, and the World Bank, IMF and ADB also announced their intended return to the country.

Trade and Foreign Direct Investment (FDI) by members of the Association of South East Asian Nations (ASEAN), particularly Thailand, also offer considerable promise for development investment. Some observers have estimated that the potential exists to upscale ODA by at least a factor of 10. Thus, through appropriate fiscal management and policy reform, Myanmar has the potential to unlock manifold increases in its ODA receipts, in turn raising social sector allocations. However, it must be cautioned that although ODA may increase, it should not be counted on to replace Government efforts to fund development activities. External investments will need to be focused on innovative and developmental activities, training, materials development and capital costs, while recurrent costs of services will need to be borne by the Government to ensure long-term sustainability.

The 2012 legislative session witnessed a change with regard to health and education spending, resulting in greater allocations than in previous years. For example, total allocations to the education sector increased from about 0.7 per cent to 1.5 per cent of GDP for 2012-2013. While still very low, spending on education would almost double to 450,000 million kyats from 230,000 kyats in the previous year. The Government’s proposed national health budget would receive about 150,000 million kyats, nearly three times as much as the 55,000 million in the last budget. At the same time, social welfare has received only 3,500 million kyats in 2012-2013.

Issues regarding the absorptive capacity of each Ministry of the social sector also are arising; too few excellent specialists are trying to do the work of what ordinarily would be a much larger staff. An analysis of ministerial needs at central, regional/state, township and local levels will need to be

171 Thematic Analysis 2011, op.cit.
173 Thematic Analysis 2011, op.cit.
175 Ibid.
176 Thematic Analysis, op.cit.
177 Ibid.
178 “Monitoring Social Sector Budgets: What We Know About Social Sector Spending in Myanmar,” op.cit.
conducted, and additional professional personnel should be trained and put into service as rapidly as possible to meet the needs of each Ministry for programme improvement and growth.

In addition, social sector and human development activities are now being included in socioeconomic Regional Plans, which will be consolidated to form a National Development Plan. Under new planning arrangements, a "bottom-up" process is being established in which planning starts with prioritised submissions from township level, which will then be aggregated and evaluation at district and regional levels.

Data from the recent past indicate the extremely low base from which Myanmar is beginning. Overall Government revenue is still low by regional standards, as is the proportion of social sector expenditures as a percentage of Government spending (see Figures 144 and 152). However, Government revenue is expected to rise to 20 per cent of GDP by 2017 (IMF projections), largely as a result of improvements in taxation and rising revenues from natural gas. Meanwhile, the EFA Mid Decade Assessment (MDA) 2007 suggested that for ECCD there was overall Government funding of only 50.59 per cent, with community funding of 34.17 per cent, and NGO funding of 15.24 per cent.

Figure 144: Social Sector Expenditure in the Region as a Percentage of Government Spending

Figure 152: Social Sector Expenditure to Total Government Expenditure

In absolute terms, Government expenditures for health rose from 464.1 million kyats in 1988-89 (11.8 kyats per capita) to 51,674.9 million kyats in 2008-2009 (885.2 kyats per capita) \(^{179}\) (see Table 8). Figure 163 illustrates the Department of Health current budget vs. the actual current budget from 2007-2008 to 2012-2013, showing the comparatively sharp rise now expected.

As noted in Section II, the importance of developing a comprehensive social security programme, including Universal Health Coverage, has been emphasised. Feasible policy options, including health care financing options, have been identified to accelerate this effort, recognising that a reduction in out-of-pocket payments will be necessary to achieve this goal. In all, social security expenditures on health have accounted for just 1.3 per cent of the total health budget. \(^{180}\) Target indicators to monitor and evaluate overall progress in attaining universal coverage include: (a) out-of-pocket expenditures should not exceed 30 to 40 per cent of total health expenditures; (b) total health expenditures should be at least 4 to 5 per cent of GDP; (c) more than 90 per cent of the population should be covered by pre-payment and risk pooling schemes; and (d) coverage of vulnerable populations with social assistance and safety net programmes should be close to 100 per cent. \(^{181}\) Myanmar also proposes to reduce out-of-pocket payments through not only increasing tax-based financing but also through preparing a new Social Security Law in 2012 to expand coverage of social health insurance by increasing compulsory contributions from the formal sector as well as voluntary contributions from the informal sector and communities. Pilot Maternal and Child Health Voucher Schemes and Township Based Health Protection Schemes are likewise being introduced.

<table>
<thead>
<tr>
<th>Table 8: Government Health Expenditures, 1988-89 and 2006-2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health expenditure (in million)</td>
</tr>
<tr>
<td>- Current</td>
</tr>
<tr>
<td>- Capital</td>
</tr>
<tr>
<td>Total</td>
</tr>
<tr>
<td>Per-capita health expenditure</td>
</tr>
</tbody>
</table>

Source: Five-Year Strategic Plan for Child Health Development in Myanmar 2010-2014

\(^{179}\) Five-Year Strategic Plan for Child Health Development 2010-2014, op.cit.

\(^{180}\) Situation Analysis of Children 2012, op.cit.

\(^{181}\) Health in Myanmar 2012, op.cit.
The Five-Year Strategic Plan for Child Health 2010-2014 reported that Myanmar spends 38 international dollars per capita per year on health, with only about 13 to 14 per cent as Government expenditures and 86 to 87 per cent as out-of-pocket expenses by families. It has been further estimated that about 80 per cent of outpatient expenses and 60 to 66 per cent of inpatient expenses were borne through the use of savings, borrowing or sale of assets. Even an event like pregnancy can become very expensive for households. All this is likely to be catastrophic, especially for the poor.

According to Government sources, national expenditure on education as a proportion of GDP stood at less than 1 percent in 2007-2008, significantly lower than regional and international standards. During the same year, according to these sources, about 5.5 per cent of the annual national budget was spent on education overall, compared to 25 per cent in more affluent neighbouring countries such as Thailand and Malaysia. The 13 Ministries involved in running educational institutions each have their own functional individual budgets; no overall education budget exists. Even within the MoE, each department has its own functional individual budget, making coordination difficult and undermining efficiency and effectiveness. Table 9 indicates MoE expenditure on basic education from 2006-2007 to 2010-2011.\textsuperscript{182}

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Current</th>
<th>Capital</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006/07</td>
<td>125,321,789</td>
<td>3,020,835</td>
<td>128,342,624</td>
</tr>
<tr>
<td>2007/08</td>
<td>132,890,071</td>
<td>5,160,194</td>
<td>138,050,265</td>
</tr>
<tr>
<td>2008/09</td>
<td>135,933,289</td>
<td>9,910,255</td>
<td>145,843,544</td>
</tr>
<tr>
<td>2009/10</td>
<td>157,923,417</td>
<td>25,833,142</td>
<td>183,756,559</td>
</tr>
<tr>
<td>2010/11</td>
<td>222,324,419</td>
<td>9,559,413</td>
<td>231,883,832</td>
</tr>
<tr>
<td>Total</td>
<td>774,392,985</td>
<td>53,483,839</td>
<td>827,876,824</td>
</tr>
</tbody>
</table>

Source: Ministry of Education mimeo (Estimated US$1 = Kyat 1,000)

\textsuperscript{182} QBEP Annex, op.cit.
Estimated public spending in 2008-2009 for primary education stood at about US$13 per student.\(^{183}\)
Assuming that GDP in 2008 was US$28.19 billion, falling to $27.553 billion in 2009, total Government spending on basic education as a whole would have been in the range of only 0.5 per cent of GDP, even lower than the Government figures above.

Although education is highly prized by the citizens of Myanmar, the resources allocated meet only a fraction of the costs, again with the direct consequence of substantial private expenditures at all levels. An increasing amount of cash donations to the formal education sector was recorded by the Ministry of Education, from 290 million kyat in 2002-2003 to 1,123 million kyat in 2009-2010.\(^{184}\) No data were available specific to ECCD.

In 2012-2013 regional grants of 1 billion kyat will be granted for all regions and states except Chin State, which will receive 2 billion. The total of these special allocations thus is 16 billion kyats, an important step in the right direction, but a small amount compared to a total budget of 6.8 trillion kyats. Guidelines for allocations provided by the President have not been widely publicised; in addition, different regions and states have different needs, raising possible concerns regarding equity.\(^{185}\) Nonetheless, this is an important beginning for increasing investment in education and the social sector.

Turning to international financial resources, the second phase of the large MDEF programme has an indicative budget of US$64.9 million for 2012-2015. As shown in Table 10, donor commitment as of mid-January 2012 stood at:\(^{186}\)

**Table 10: MDEF II Donor Commitments 2012-2015**

<table>
<thead>
<tr>
<th>Donor</th>
<th>Amount in national currency</th>
<th>Amount (US$)</th>
<th>Share (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNICEF</td>
<td>US $ 14,156,100</td>
<td>14,156,100</td>
<td>22.8</td>
</tr>
<tr>
<td>Australia</td>
<td>AUD 20,000,000</td>
<td>20,800,918</td>
<td>33.5</td>
</tr>
<tr>
<td>EU</td>
<td>Euro € 13,200,000</td>
<td>16,802,246</td>
<td>27.1</td>
</tr>
<tr>
<td>UK</td>
<td>GBP £ 3,000,000</td>
<td>4,608,354</td>
<td>7.4</td>
</tr>
<tr>
<td>Denmark</td>
<td>DKK 25,000,000</td>
<td>4,277,209</td>
<td>6.9</td>
</tr>
<tr>
<td>Norway</td>
<td>NOK 8,500,000</td>
<td>1,409,538</td>
<td>2.3</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>62,054,365</strong></td>
<td><strong>100.0</strong></td>
<td></td>
</tr>
</tbody>
</table>


Critically, of the total amount committed, the sub-total for ECCD interventions is MDEF US$8,035,330, and UNICEF US$2,624,370, for an overall amount of US$10,659,700, or about 17 per cent of MDEFII resources. Meanwhile, a total of 12 other partner organisations provided some US$13,957,786 between 2008-2009 and 2010-2011 for ECCD (see Annex 1, Table K).\(^{187}\)

Overall, it will be necessary to strengthen the allocation of adequate budget resources in this regard and to foster greater transparency into the budget process, including public dialogue. Pro-child budgeting will need specific budget lines and indicators that will allow monitoring and evaluation of budget allocations for young children at the national and sectoral levels. Strategic budget lines will particularly need to be identified for young children in disadvantaged or vulnerable situations that may require affirmative social measures, especially children living in poverty, children from ethnic and religious minority groups or from remote and border areas, IDP and refugee children, children in street

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\(^{183}\) QBEP Programme Document, op. cit.???

\(^{184}\) Ibid.

\(^{185}\) “Monitoring Social Sector Budgets: What We Know About Social Sector Spending in Myanmar,” op.cit.

\(^{186}\) QBEP Programme Document, op.cit.

\(^{187}\) Some organisations could not provide a specific budget for ECD programmes since the ECD budget was part of the budget for an overall education programme.

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situations, children affected by HIV/AIDS, children with disabilities, orphans and others living in difficult circumstances.

In addition to annual Government budgets, a fund for ECCD should be established to fully support all initiatives, services and activities under the new ECCD Policy and its Strategic Plan. This could include support from international development partners; international businesses; various taxes; donations from the private sector and individual benefactors; and other resources.

Recommendations for strengthened ECCD with regard to resources:

- Ensure adequate and fully transparent funding of ECCD programmes, with a separate budget line for children in national budgeting processes and for the Ministry of Education and Ministry of Health, as is currently found in the Ministry of Social Welfare, Relief and Resettlement
- Strengthen coordination between capital investment, development costs and recurrent costs to ensure greater impact for young children
- To supplement Government budgets, establish a special ECCD Fund to support key initiatives, services and activities presented in the ECCD Policy and its Strategic Plan, with sources including international development partners, international business, various taxes, and private sector donations
- Conduct a baseline study on workforce development needs, establish a high-quality pre- and in-service training system that includes all outstanding training institutions, and develop a systematic and continuous data system on resource capacity issues and issues tied to the training system
- Develop a comprehensive, multi-sectional quality pre-service ECCD training system, including criteria for certification and periodic re-certification for professional service providers
- Establish an ECCD diploma programme in Colleges of Education as well as bachelors, masters and doctoral programmes at the Institutes of Education, in collaboration with Yangon University
- Upgrade capacities of paraprofessional and volunteer service providers through the provision of pre-service training and regular in-service training; train all ECCD field personnel in areas relevant to ECCD such as peace education and Disaster Risk Reduction/Disaster Risk Management
- Systematically raise awareness of the importance of ECCD as a powerful equaliser, among communities, families and service providers working with and for children, in all ECCD-related sectors
- Invest in adequately remunerated and accountable staff for ECCD at different levels; particularly examine ways to provide and/or raise salaries among caregivers at community- and school-based ECCD centres and in other full-time work in ECCD activities
- Ensure effective follow-up and practical implementation plans for all ECCD training
- Ensure that duty bearers have the authority, access to and control over resources, as well as motivation to exercise their duties and responsibilities, particularly including oversight
- Strengthen behavioural change communication to translate ECCD knowledge into practice

Chapter 4: Policy Analysis

4.1 International normative instruments


In recent years it has ratified the Optional Protocol to the CRC on the Sale of Children, Child Prostitution and Child Pornography (2012); the Convention on the Rights of Persons With Disabilities (2011) and the Charter of the Association of South East Asian Nations (ASEAN) (2008). It also has signed the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the Convention Against Transnational Organised Crime; the Protocol Against
the Smuggling of Migrants by Land, Sea and Air, also supplementing the Convention Against Transnational Organised Crime; and the Memorandum on Coordinated Mekong Ministerial Initiative Against Trafficking.

Further, Myanmar signed the Millennium Declaration in 2000 and the World Fit for Children document, an outcome of the 2002 United Nations General Assembly Special Session on Children. It is among States that have adopted: (1) the Vienna Declaration and Programme of Action, at the World Conference on Human Rights in 1993, which included the right to development and made reference to the interdependence and indivisibility of all human rights; (2) the Durban Declaration and Programme of Action, from the World Conference Against Racism 2001; (3) the Universal Declaration on the Eradication of Hunger and Malnutrition, from the World Food Conference 1974; (4) the Dakar Framework for Action for Attaining Education for All, which calls for expansion and improvement of comprehensive early childhood care and education, especially for the most vulnerable and disadvantaged children; and (5) the Declaration of Commitment on HIV/AIDS, from the United Nations General Assembly Special Session on HIV/AIDS in 2001.

Myanmar has yet needs to ratify the following instruments that may affect young children or their families:

- Optional Protocol to the CRC on Involvement of Children in Armed Conflict
- Convention on the Elimination of All Forms of Racial Discrimination
- International Covenant on Economic, Social and Cultural Rights and its Optional Protocol
- International Covenant on Civil and Political Rights and its Optional Protocols
- Optional Protocol to the CEDAW
- Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and its Optional Protocol
- Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families
- Optional Protocol to the Convention on the Rights of Persons With Disabilities
- Convention for the Protection of All Persons From Enforced Disappearance

The Committee on the Rights of the Child, in its Concluding Observations of 3 February 2012 with regard to Myanmar's Third and Fourth Reports on the CRC, has urged the Government to take all necessary measures to address the recommendations from the Concluding Observations of the Second Report that have not yet been implemented, particularly those related to access to health and education. It also urged adequate follow-up to the recommendations on the Third and Fourth Reports.  

4.2 Analysis of Myanmar policies, plans, decrees, laws, legislation, codes, standards, guidelines and regulations in ECCD areas

Young children are rights holders and must be respected as persons in their own right, as noted in General Comment No. 7 to the CRC (2005) (see Annex 2). They need to be recognised as active members of families, communities and societies, with their own concerns, interests and points of view. To achieve their rights, young children have particular requirements for physical nurturance, emotional care and sensitive guidance, as well as for time and space for social play, exploration and learning. These requirements can best be planned for within a framework of national laws, policies and programmes for early childhood.

Many countries, including Myanmar, require a strengthening of attention to this distinct phase of childhood. The Government is in the process of developing the National Development Plan 2012-2016, to which the new ECCD Policy is expected to contribute. In another positive development, the new National Human Rights Commission, established in late 2011, includes a special division on children’s rights. An ECCD Law also is under preparation, to address ECCD services for children that are conducted or sponsored by DSW or conducted separately by other organisations. At the same

188 Ibid.
time, further efforts are needed to apply the CRC holistically in early childhood, taking into account the principles of the universality, indivisibility and interdependence of all basic rights.

4.2.1 Constitution of the Republic of the Union of Myanmar 2008

The 2008 Constitution states, “Mothers, children and expectant women shall enjoy equal rights as prescribed by law.” With regard to education and health, it commits to “earnestly strive to improve education and health of the people; to enact necessary laws to enable national people to participate in matters of their education and health; to implement a free, compulsory primary education system; and to implement a modern education system that will promote all-around correct thinking and a good moral character contributing toward the building of the nation.” Specifically, it also pledges to “care for mothers and children, orphans, fallen Defence Services personnel’s children, the aged and the disabled.” It reiterates the right of every citizen to education and health care. Although there are no explicit references to ECCD services, the general thrust of these sections of the Constitution is supportive of children’s, mothers’ and ethnic minority rights to free education and health services, establishing a foundation for future growth and improvement.

4.2.2 The Child Law 1993

In Myanmar the Child Law 1993 has been adopted to implement the rights of the child recognised in the CRC and to protect the rights of the child overall. The Rules Related to the Child Law were adopted in 2001. However, the CRC can be overridden by national rules and laws.189 Currently the Child Law is under revision to bring it in line with international norms and standards.

The Child Law recognises that every child has a right to survival, development, protection and care, and to achieve active participation within the community. It further states that every child, irrespective of race, religion, status, culture, birth or sex, shall be equal before the law and be given equal opportunities. It defines children in need of protection and care as those who have no parent or guardian, earn a living by begging, are “of so depraved a character that the child is uncontrollable by parents or guardian,” are “in the custody of cruel or wicked parents or guardian,” are “of unsound mind,” are afflicted by a contagious disease, or use narcotic drugs or psychotropic substances.

The Child Law sets up a National Committee on the Rights of the Child, and a National Plan of Action was developed to promote implementation of the CRC, although issues have arisen including weak monitoring. The Law pledges to carry out specifics on freedom of speech, thought and conscience; health; education; language, literature, culture, religion and traditions; information; expression of views; the right to live with and be brought up by parents; citizenship; inherent right to life, including birth registration; adoption; children with disabilities; leisure, play and sports; cultural and artistic activities; and inheritance. It also offers sections on ethics and discipline of children.

The Child Law does not yet fully incorporate all principles and provisions of the CRC; for example, it restricts the definition of the child to age 16 years and sets the age of criminal responsibility at 7 years, both below the recommended international norms. It also offers no explicit legal provision against corporal punishment of children, nor does it have adequate provisions to protect child victims of commercial and sexual exploitation. Some legal provisions contrary to the Convention also remain in force. The Committee on the Rights of the Child has expressed concern about the application of different sources of law (codified and customary laws) that may undermine Myanmar’s efforts to harmonise legislation with the CRC.190

Among other amendments proposed are not only to bring the Law into compliance with the Convention, but also to include best practice treatment of children in line with other laws of countries in the region; to eliminate irregularities between the Law and its Rules and bring in substantive provisions from the Rules into the Law; and to repeal specific sections of other laws that are not in compliance with the Child Law or the CRC. Recommendations have been sought from a range of stakeholders through a series of consultations and with input from international legal experts.

Critically, the proposed changes would:191

- Increase the defined age of a child from 16 years to 18 years old

189 Situation Analysis of Children 2012, op.cit.
190 CRC Concluding Observations, op.cit.
Include a statement of State policy and principles to include the aims of the Law
Commit the State to allocate resources to children in accordance with the "maximum available resources," in compliance with CRC Article 4
Expand the chapter on the rights of the child in accordance with the CRC, including (a) best interests of the child; (b) the right to citizenship to all children born in Myanmar who would otherwise be stateless; (c) free and compulsory education up to and including secondary school level; (d) identification of harmful customs and practices; and (e) setting of a minimum working age of 16
Prohibit "cruel or degrading" treatment, including corporal punishment
Offer new chapters on guardianship and custody; maintenance; adoption and foster care; disability; and children and armed conflict
Strengthen the definition of a child in need of care and protection
Revise the age of criminal responsibility to a minimum of 12 years
Include a chapter on child victims and witnesses

Upon adoption, all these amendments would go a long way toward bringing the revised Child Law into compliance with the CRC.

4.2.3 ECCD in national planning
National planning processes are based on National Plans, sectoral 30-Year Long-Term Plans, Five Year Plans, policies, laws and objectives. However, not all these may be in alignment, as noted throughout this Situation Analysis.

National Plan of Action for Children 2006-2015
The National Plan of Action for Children, which is under revision, formulates a strategy to assist children aged 0-5 years to develop to their fullest potential. Under the current Plan, activities are to include:

- Creating a policy framework and to advocate for ECCD at the highest level
- Raising awareness of ECCD effectively through information, education and communication activities
- Expanding home- and family-based ECCD and providing technical services including Parenting Education
- Supporting the establishment of quality ECCD centres by providing training and helping to coordinate funding and material support
- Creating an ECCD database and multi-sectoral network with the active support of partners
- Increasing the budget to Government departments that are involved in development of pre-primary education and ECCD services
- Improving the nutrition of children while also providing access to basic social services and adequate caring practices
- Promoting physical, mental and emotional health
- Forming a Technical Working Group consisting of experts, policymakers and persons who are involved in ECCD programmes

Many of these targets have already been addressed and progress has been made, as noted throughout this Situation Analysis. Even so, almost all require further attention. The Committee on the Rights of the Child has encouraged appropriate resourcing for the National Plan of Action for Children in human, technical or financial terms, as well as establishment of a system for implementation or monitoring of the Plan.192

Education
The lack of a comprehensive basic education policy thus far in Myanmar has hampered effective planning, management and assessment of education service delivery as well as achievement of the Government’s expressed vision of a knowledge-based society. Guidance has been given most recently by the President’s 10 Points of Education Policy 2011, which prioritises the following:

- To implement free, compulsory primary education
- To increase the enrolment rate in the Basic Education sector

192 Ibid.
To nurture new generations as intellectuals and intelligentsia through human resources development
To improve capacities of teachers in both the Basic and Higher Education sectors
To use teaching aids more effectively
To upgrade the quality and socioeconomic status of educational personnel
To provide scholarships, stipends and awards, both locally and internationally
To promulgate relevant laws for the participation and contribution of the private sector in education services
To collaborate with international and local organisations, including the United Nations, international NGOs and NGOs
To upgrade education standards to international level

The 30-Year Long-Term Basic Education Plan 2001-2031 focuses on:

- Emergence of an education system for modernisation and development
- Completion of basic education by all citizens
- Improvement of the quality of basic education
- Opportunity for pre-vocational and vocational education at all levels of basic education
- Providing facilities for e-education and ICT
- Producing all-around developed citizens
- Capacity building for educational management
- Broader participation of the community in education
- Expansion of non-formal education
- Development of educational research

For its part, the EFA National Plan of Action 2003-2015 highlights ECCD in its six goals, which are:

- Ensuring that significant progress is achieved so that all school-age children have access and complete free and compulsory basic education of good quality
- Improving all aspects of the quality of basic education, including teachers, education personnel and curriculum
- Achieving significant improvement in the levels of functional literacy and continuing education for all
- Ensuring that the learning needs of young people and adults are met through non-formal education, life skills, and preventive education
- Expanding and improving comprehensive Early Childhood Care and Education
- Strengthening the Education Management Information System

Lastly, the Rural Development and Poverty Alleviation Plan 2011-2015 has been developed, although it is unclear how much is being allocated in terms of resources for the Plan. Education activities in this Plan comprise:

- Provision of necessary requirements for all school-going-age children in schools in order to achieve successful implementation of free, compulsory primary education
- Opening of new schools, appointment of teachers, provision for construction of school buildings, and furniture and teaching-learning materials for mobile families and rural areas with low population density
- Fulfilling necessary regional requirements, constructing buildings for boarding students, and establishing a trust fund in order to reduce educational wastage in primary and lower secondary level
- Provision of scholarships in lower and upper secondary levels
- Undertaking a programme to ensure access to higher education for all students who passed matriculation exams
- Provision of necessary requirements for having better school infrastructure, sufficient furniture and teaching-learning materials
- Undertaking activities for getting full capacity/strength of teaching staff, having teacher friendliness and improving the socioeconomic life of teachers, in collaboration with local authorities and local people
- Encouraging the private sector to participate and contribute to education services

Other documents that speak of the Government’s policy on education include the Child Law and the Basic Education Laws of 1966 and 1972. A Preschool Curriculum and Teachers’ Guide were developed by DSW in 2007. As noted in Section 2.6.1, reform strategies for the Basic Education
sector are under way, focusing on a review of relevant laws, enactment of new laws as necessary, and reorganisation of departments within the Ministry of Education in accordance with decentralisation policies.

Overall ECCD guidelines for preschool education have been developed in 2010 but are still awaiting approval.

Health
In health, numerous policies, laws and regulations have been adopted to promote and protect public health. These include the National Health Policy 1993, advocating health for all, the National Reproductive Health Policy 2002, and the Myanmar Health Vision 2030. Five-Year Strategic Plans have been adopted for Child Health 2010-2014, for Reproductive Health 2011-2015 and for HIV/AIDS 2011-2015. A Five-Year Strategic Plan for Water Supply, Sanitation and Hygiene 2012-2016 is being developed, while a National Plan of Action on Food and Nutrition 2011-2015 is being updated.

Specific health-related laws include the Public Health Law 1972; the Law Relating to Private Health Care Services 2007; the Prevention and Control of Communicable Disease Law 1995, which was revised in 2011; the Law Related to the Nurse and Midwife 1990; the National Food Law 1997; the Myanmar Medical Council Law 2000 and the Traditional Medicine Council Law 2000; the National Drug Law 1992 and Traditional Drug Law 1996; the Control of Smoking and Consumption of Tobacco Products Law 2006; and the MMCWA Law 1990 (revised in 2010), establishing this national NGO. National Guidelines for the Clinical Management of HIV Infection in Children were developed in 2004 and revised in 2006. A Code of Marketing of Breast Milk Substitutes is in the process of finalisation.

Social welfare and child protection
The Social Welfare Policy 1975 is currently under revision, with the aim to become a National Child Protection and Social Welfare Policy, in line with the Child Law. This is intended to support a national child protection system through an improved coordination and referral mechanism among the social welfare, health, education and justice sectors, along with civil society organisations.

Plans also are under way to organise a special police force for child protection. In addition, the Directive on Child Friendly Police Procedures was issued by the Myanmar Police Force in 2010, and the Directive on Child Friendly Court Procedures was issued by the Supreme Court in 2012. The national Minimum Re-drafted national Minimum Standards for the Protection of Working Children are being reviewed in 2012 for ministerial approval; Minimum Standards of Care and Protection for Children in Residential Facilities have been in place since 2008. With regard to children with disabilities, Myanmar completed a National Plan of Action for Persons With Disabilities 2010-2012 and is drafting a law to protect the rights of persons with disabilities. A Plan of Action Aimed at Eliminating Child Labour has been announced in 2012, with the aim to end child labour by 2015.

Significant progress has been made to address the issue of trafficking. The Government enacted the Anti-Trafficking in Persons Law 2005 and in 2006 established a Central Body for Suppression of the Trafficking in Persons. Recently a law on anti-trafficking in persons was enacted, along with development of the Second Five-Year National Plan of Action to Combat Human Trafficking (2012-2016). Bilateral agreements with China and Thailand to prevent trafficking also have been signed.

Meanwhile, the Juvenile Justice Inter-Agency Working Group, led by the Government, and the Committee for Prevention Against Recruitment of Under-Aged Children have started addressing issues relating to children in conflict with the law and under-aged recruitment as a grave violation against children. A child reintegration team set up by DSW with an initial focus on family tracing and reintegration of children in residential care may be expanded to assist repatriated trafficking survivors, children living on the street, and former child soldiers.

For the first time, Orphans and Vulnerable Children are the object of a specific strategy in the national HIV/AIDS Strategic Plan 2011-2015. In addition, a Government Working Group on Mine Risk Education has been established, and a Mine Risk Education strategy is being developed. Several official documents deal with disaster preparedness and risk reduction, including the Myanmar Action Plan on Disaster Risk Reduction 2009-2015, the Standing Order on Natural Disaster Management, the Plan of Action for Child Protection in Emergencies: Response to Cyclone Nargis, and the National Plan of Action for Women and Emergencies 2010-2013.
4.2.4 Remaining policy gaps

ECCD has traditionally received insufficient policy and planning attention in Myanmar, although numerous reform efforts are now under way. To strengthen these efforts, several specific policy issues related to ECCD require further attention. Additional deepening of the decentralisation process will be needed at state, division and district levels alike to propel this progress.

Constitutional recognition of Myanmar’s ratification of the Convention on the Rights of the Child would prevent the CRC from being overridden by national laws. Revisions of the Child Law can ensure that all provisions not currently in compliance with the CRC are fully addressed. In particular, strengthened action can be taken to include the principle of the best interests of the young child in all legislation and budgets, to ensure that it is sufficiently applied in judicial and administrative decisions, and to ensure that knowledge of this principle is widespread.

Critically, ECCD services are not currently included in several key policy and planning documents, including the Myanmar Health Vision 2030, the 30-Year Basic Education Plan; the Strategic Plan for Child Health Development 2010-2014; or the Rural Development and Poverty Alleviation Plan 2011-2015. Preschool guidelines still require approval, and a comprehensive ECCD database remains to be developed. In particular, a clearer strategy is needed for how to support the holistic development of 0- to 3-year-olds, since much of the policy focus is on 3- to 5-year-old children and their preparation for school.

Development of a comprehensive basic education policy and inclusion of ECCD in the Basic Education sector is essential, both of which are being undertaken with the new Comprehensive Education Sector Review. Health policies do not as yet promote a holistic approach to patient care, resulting in fragmented and vertical systems of service delivery management, insufficient decentralisation and weak linkages between decisions taken at central and sub-national levels, thereby ultimately affecting the health of under-5 children. In particular, malnutrition is considered mainly as a component of the health sector, rather than an inter-sectoral issue requiring attention in policies related to food security and livelihoods. There is thus no systematic approach as yet to addressing the basic and underlying causes of poor young child health outcomes.

Revision of the Social Welfare Policy requires particular attention to the protection of children, including very young children, from child abuse, exploitation and violence against children. Likewise, an increased focus on children in the HIV control programme agenda is needed. Additional social welfare and child protection gaps are noted in a separate sub-section below.

More broadly, policy and legislative gaps with regard to ECCD in Myanmar can be grouped into the following four areas:

Basic principles and child rights
- Non-discrimination on the basis of gender, ethnicity, language, religion, disability or other grounds has not yet been explicitly incorporated in policies and legislation
- A coherent conceptualisation of inequity for policy dialogue and strategy development requires strengthening
- The National Human Rights Commission requires a mandate and status in compliance with the Paris Principles and assurance of its independence and efficiency. In conjunction with this, the Commission’s special division for children’s rights requires higher visibility to make the institution’s role as strong as possible
- Young children’s access to new technologies and appropriate information needs to be widened, so that they can freely access information and communicate with others. The Government’s lifting of media censorship in August 2012 represents a positive step in this direction

Governance and administrative structures
- As noted throughout this Situation Analysis, significantly increased allocation of financial and human resources to ECCD-related sectors is necessary and urgent. This can be complemented by developing a formal case for “investing in young children”
- Inclusion of ECCD in the Basic Education sector and development of a costed medium-term education strategy will strengthen overall ECCD policy and planning in the education
sector and coordination with other ECCD sectors of health, nutrition, sanitation and protection. The ongoing CESR is intended to be helpful in addressing this critical gap.

- Development is needed of a more comprehensive and inclusive overall poverty reduction strategy, with adequate resources, that in turn can impact on the situation of young children

- The reactivated National Committee on the Rights of the Child will need the mandate and resources for sustainable functioning, as well as the authority to make and follow up on referrals to services for young children with special needs

- The introduction of overall micro-planning at township and community levels can better inform national policy and planning processes, as can the use of reliable demographic data for planning and strengthening of the link between planning and budgeting for social sectors. For this a national census is needed, as well as well structured household surveys and a national study on young child development levels.

- Strengthened coordination among different Ministries implementing various aspects related to the CRC, and ECCD in particular, is critical. Coordination also requires enhancement at various levels (i.e., national, regional/state, district, township and community), as well as between Government, NGOs, faith-based organisations, community-based organisations, the private sector and the informal sector

- Common standards, Standard Operating Procedures and monitoring and evaluation systems remain to be developed for uniform application by all partners in ECCD areas, thereby helping to reduce fragmentation and considerable overlaps

- A systematic periodic review of the quality of ECCD-related programmes can help to inform further development of future ECCD policies

Harmonisation of laws and plans, both internally and with international normative instruments

- The new Child Law, as the basic national legislation with regard to young children, should be fully in compliance with the CRC

- A comprehensive review of domestic legislation (codified and customary laws alike) remains to be undertaken so that all legislation can be harmonised with the CRC and the future ECCD Policy and Strategic Plan

- Specifically, it will be necessary to sufficiently coordinate various Plans of Action related to young children (Child Health Strategic Plan 2010-2014, EFA National Plan of Action 2003-2015 et al.) with the National Plan of Action for Children 2006-2015 and the ECCD Policy and Strategic Plan

Child protection, with particular attention to abuse, exploitation and violence against children:

- The development of further legislation is needed with regard to young child protection, particularly in areas of child physical and sexual abuse, neglect, violence against children, and exploitation. An explicit national legal ban on all forms of violence against young children, in all settings, is necessary.

- A national system of data collection, analysis and dissemination on child protection could be consolidated with the future ECCD management information system to allow coherent and coordinated support to children and parents. This system could feature ancillary services including the establishment of mechanisms for receiving complaints, investigations and prosecutions for child protection issues, including in alternative care settings

- The Minimum Standards on Care and Protection of Children in Residential Care 2008 are awaiting issuance as a formal directive. A strategy for de-institutionalisation of young children remains to be developed, with a clear time frame and budget, including reintegration of children with their families to the degree possible

- Children from 0 to 3 years of age should be placed with trained and nurturing families and not in residential institutions

- Not all private residential institutions are registered, and clear guidelines should be developed to ensure that young children's rights are respected throughout the process of placement in alternative care and during their stay in such institutions

- Child Law provisions are not always consistently applied on adoption, and different forms of customary adoption exist under the 1939 Registration of Kittima Adoptions Act, which only applies to Myanmar Buddhists. No agreed selection, training and monitoring system for adoption exists

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No specific law prohibits corporal punishment for children within the family and alternative care settings or ECCD services, including preschools; corporal punishment is already prohibited in schools, and greater enforcement is needed.

Additional policy support is needed for reducing stigma and discrimination against young children with disabilities, orphans and young children living with or affected by HIV/AIDS.

4.3 Comparative analysis

For Myanmar to recognise that early childhood is a critical period of human development as an area that requires a national policy attention is a major breakthrough. This is a recent development, which has occurred since 2011. Now, however, it is better understood that learning begins at birth, and that the early years provide the foundation for all later learning and development. A good beginning usually results in competent, well-balanced and productive adults. It remains for policies and other legal frameworks to catch up with this shift in approach. Even so, the rapidly evolving context of Myanmar offers new opportunities for accelerating progress in human development, including in the social sectors in general and ECCD in particular, and for addressing and overcoming widespread systemic constraints.

As detailed in Section 4.2, Myanmar has a body of national laws committing the State to the realisation of children’s and women’s rights. Yet while Myanmar has made commitments to national development and to ECCD, and has identified some of the overarching priorities, policy and strategy development that require further strengthening in almost all ECCD-related areas.

Wide gaps exist between law and practice at many levels, although many of these are set to be addressed with the revision of the Child Law now under way. Many other gaps remain, however, and will require continued attention, including with regard to access and provision of services, financing, management, and resource development. The education sector is beginning to address many of its critical gaps with regard to ECCD, including policy gaps, although it remains to be seen how effectively they will be implemented. Significant gaps also exist with regard to child protection policies and services, particularly for the most vulnerable and marginalised young children. Health policies will require better targeting to ensure effective services for poor children and those living in remote and border areas. All of these sectors merit greatly expanded investments in their services and activities to improve young child and family development.

Moreover, in each of these sectors, a disconnect between policies, plans, programmes and resource allocations (see Section 3.4) can make ECCD interventions difficult to implement. A strong ECCD system with an effective organisational development is required to implement the forthcoming ECCD Policy and Strategic Plan. In addition, the monitoring and evaluation of policies, as well as plans and programmes, by State agencies is not yet guided by legal documents. In the end, if these issues can be addressed, they can significantly improve the quality of social sector services for Myanmar’s youngest children.

Recommendations for strengthened ECCD with regard to policies and planning:

- Develop one central entity to oversee ECCD-related development, including development of annual ECCD action plans, and ensure a holistic conceptualisation of ECCD to propel a multi-sectoral and integrated approach to policies, planning, legislation and services

- Consistently establish structures for coordinating ECCD at all levels, including at local, township and regional levels, through a decentralised system for implementation of the ECCD Policy and Strategic Plan

- Promote “bottom-up” planning that ensures that local needs are addressed and strengthened in a cost-effective manner; at the same time, encourage stronger civil society participation, including by young children themselves as appropriate, in planning processes

- Consolidate and improve the quality, reliability, accuracy and understanding of data, evidence and indicators related to young children through development of a comprehensive, multi-sectoral ECCD management and information system and a monitoring and evaluation framework to strengthen a system of accountability on ECCD. Particularly monitor data on equity, including disaggregated data by age, region, gender, geographic location, rural/urban status, disability, and ethnic and social background to facilitate analysis on the situation of all young children. Prioritise capacity development of both national and sub-national institutions in this regard
Develop a clear strategy to support the holistic development of 0- to 3-year-olds to better address the needs of the youngest children

Consider malnutrition among young children as a multi-sectoral issue requiring attention not only to health, nutrition, sanitation and education policies, but also to policies in food security and livelihoods

Align future and amended long- and medium-term planning documents with the future ECCD Policy and Strategic Plan, and better coordinate various Plans of Action with the objectives of the National Plan of Action for Children 2006-2015

Ensure special consideration of the most vulnerable and marginalised children in ECCD-related policies to help provide quality services to those young children who have the most to gain, thereby reducing disparities and fostering equity

Give greater attention to developing a Child Protection Policy focusing on young children as well as older children, and to legislation related to child protection, especially with regard to child abuse, neglect and exploitation, violence against children, and other children in difficult situations

Develop a planned approach to social protection that includes mechanisms for early detection and identification of vulnerable children and at-risk families, as well as effective regulation

Unify the monitoring and evaluation of ECCD services and establish an ECCD Management Information System that includes a Child Tracking System from birth registration to age 18 years

Ratify remaining international normative instruments that affect young children or their families (see Section 4.1)

Sufficiently address recommendations of the Committee on the Rights of the Child on the Second, Third and Fourth National Reports on the Implementation of the CRC as they pertain to young children, mothers and their families

Give greater attention to conducting scientific research and studies with regard to early childhood, to support more informed and evidence-based decisions about effective strategies for improving quality of ECCD services

**Recommendations for strengthened ECCD with regard to legislation:**

- In addition to formulating a national Early Childhood Care and Development Policy and Strategic Plan, adopt and enforce comprehensive legal and regulatory frameworks and standards for ECCD, as needed
- Implement and effectively enforce existing laws and policies related to young children
- Ratify remaining international normative instruments that affect young children or their families (see Section 4.1)
- Ensure the revised Child Law fully complies with the CRC and General Comment 7 on ECCD
- Specifically incorporate the principle of non-discrimination on the basis of gender, ethnicity, religion or other grounds into all ECCD-related legislation and policies

**Chapter 5: Conclusion**

Despite numerous challenges, Myanmar has achieved major improvements in the lives of its young children in recent decades. Maternal, infant and child mortality have declined significantly, while education enrolment and access to water and hygiene have increased. Moreover, the country has managed to achieve these successes for children in the relatively short time of less than 20 years, and with a comparatively low per-capita GDP and small budgets in the social sector.

As General Comment No. 7 to the Convention on the Rights of the Child has noted, young children experience the most rapid period of growth and change during the human lifespan, in terms of their maturing bodies and nervous systems, increasing mobility, communication skills and intellectual capacities, and rapid shifts in their interests and abilities (see Annex 1). Young children’s earliest years are the foundation for their physical and mental health, emotional security, cultural and personal identity, and developing of competencies; they require nurturing, care, stimulation, guidance and protection in ways that are respectful of their growing capacities. During these years, they learn progressively from their activities and interactions with others, although their experiences of growth and development are powerfully shaped by their individual nature as well as their gender, living conditions, family organisation, care arrangements, education systems and cultural beliefs about their needs and proper treatment and upbringing.
Thus, ECCD services should play a fundamental role in helping Myanmar’s young children to be healthy, well-nourished, well-developed and capable of achieving well in school and in life. In short, ECCD is the foundation of human development, and of contributions to family, community and economic productivity.

The basic structural factors influencing the rights of young children are considerable. Specific recommendations already have been offered in Chapter 2 of this Situation Analysis to strengthen ECCD in the country at various stages of a child’s development, from pre-conception to age 8. Based upon the additional analysis presented in Chapters 3 and 4, to further this progress in Myanmar the following overall actions are proposed:

Myanmar’s youngest girls and boys today are generally better off than their peers from a few decades ago. While considerable challenges remain, these are being increasingly recognised and addressed by the Government, communities, parents, families, the international community, and sometimes by children themselves. Myanmar must be encouraged to foster an ever-stronger commitment to development of its young children. In so doing, the country can move a long way toward realising its ambitious hopes and vision.
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## Annexes

### Annex 1: Tables of ECD Beneficiaries and Resources

#### Table A: Number of Children Served by ECD Programmes, 2011

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#### Table B: Location of ECD Services by Six Partner Organisations (1)

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Table C: Location of ECD Services by Six Partner Organisations (2)

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Table C: Location of ECD Services by Six Partner Organisations (2)
Table D: Health Facilities Development

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<td>987</td>
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*Provisional actual
Source: Health in Myanmar 2012

Table E: ECD Service Providers and International Donor Support

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<td>DFID, EC</td>
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### Table G: Trained Parenting Education Facilitators and Parents Served

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### Table H: Trained ECD Trainers from Various ECD Organisations
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Table J: Human Resources for Health

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<td>-Cooperative and private</td>
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<td>1,645</td>
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*Provisional actual
Source: Health in Myanmar 2012.
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Annex 2: Contents of ECD Training for Various Stakeholders

Preparatory ECD Seminar for Village Leaders (4 days)

1. What a child likes to do is what the child needs; children have an innate sense of their needs. This is the cord of ECD.
2. Individual and collective or general understanding of the needs of young children
3. Importance of child development in the early years
4. How are children under-5 developing in the communities?
5. What does the child learn while playing?
6. How are children playing in their communities, and how does this play support their development?
7. Importance of observation in order to identify the developmental stage of a child
8. Awareness of children’s health and nutritional needs and the role of community leaders in promoting good practices
9. Importance of brain development up to age 6 years
10. What is the best foundation for a child to be ready for school and for life?
11. Understanding basic learning theory and encouraging self-expression
12. What is one possibility for an ECD centre in a poor community?
13. What is needed from the community for child development work to be successful?
14. What will you do to get community involvement in child development work?
15. Why do we need an ECD Committee in the community?
16. Who should be on the ECD Committee, and what should be the criteria for selection of ECD Management Committee members?
17. What should be the responsibilities of the committee?
18. Ways children develop as they become involved in their parents’ or daily activities (home-based ECD activities)
19. Different learning styles
20. Practicing categorising skills
21. What should be the characteristics of a child caregiver?
22. What should be the characteristics of an ECD facilitator?
23. What are ECD activities you think would be possible to have in your communities?
24. Development of action plans

Management Committee Training (4 days on management, 2 days on simple accounting)

1. Basic ECD concepts
2. Setting vision, mission and goals relating to ECD programmes
3. Millennium Development Goals and ECD history in Myanmar
4. What do you need to know to manage the project well?
5. What do children need?
6. How do children learn?
7. Why are early years so important?
8. Finding out what participants know about the project
9. Collecting data and information about the communities
10. Importance of play for child development
11. Importance of Management Committee members’ contribution to achieve project success
12. Importance of sharing and learning from each other
13. Understanding the importance of nutrition for the development of young children
14. Understanding management functions
15. Clarifying roles and responsibilities relating to community-based ECD programmes
16. What are the roles and responsibilities of Parenting Education facilitators and preschool teachers?
17. Solving problems encountered and making decisions
18. Developing monitoring and reporting formats
19. Importance of sustainability
20. Financial management
21. Writing action plans

Parenting Education Facilitator Training (6 days)

1. Knowledge of how young children develop, how they learn, and what they need
2. Knowledge of how to support that development through what is available in the community, such as games, stories, play materials, and appropriate child-rearing practices.

3. How to educate parents on how to conduct Focus Group Discussions.

4. Identification of positive child-rearing practices and how to support parents with culturally appropriate Parenting Education.

5. 8 modules of Parenting Education Facilitator Training:
   a. Building self-confidence of caregivers
   b. Supporting children’s development
   c. Relationships: responsive and holistic daily routine
   d. Play and learning: using the human body, home and the environment
   e. Positive discipline with love, from infancy
   f. Learning emotional and social skills
   g. Resilience: overcoming children’s common fears
   h. Keeping our children healthy

**ECD Teacher Training**

1. Holistic definition of young children’s needs

2. Why is observation so important?

3. Why are the early years so important?

4. No development without play, and importance of traditional games

5. What is the best preparation for school?

6. Importance of language enrichment

7. How to write children’s books, how to use storybooks and speech posters with children

8. Health and nutritional needs and their roles in promoting good practices (during pregnancy, after taking baby home, and during early years of children)

9. Why is cleanliness so important for young children (personally, and in the home and environment)?

10. How can we include children with disabilities in the centre?

11. First aid and caring for the environment

12. Family-based activities for child development

13. Community education

14. Working with children

15. How do we use the environment for learning?

16. Creative experience

17. Timetable for the week

18. Learning corners

19. What should an ECD centre look like? What are the indicators of an appropriate ECD centre?

20. Programme planning

21. Excursion to ECD centre

22. How to manage and ECD centre

23. Songs and poems

24. Making games

25. Practical teaching

**Contents of Toy Making Workshop**

1. Importance of play and playthings for child development

2. What do children need?

3. Why do children play?

4. How do children learn?

5. How to make toys for children of various ages at home (infant to 3 years old)

6. Making playthings for children is better than buying costly toys

7. How to get access to toys without having to rely on support from the project
Annex 3: General Comment No. 7 to the Convention on the Rights of the Child

COMMITTEE ON THE RIGHTS OF THE CHILD
Fortieth Session
Geneva, 12-30 September 2005

GENERAL COMMENT No. 7 (2005)
Implementing child rights in early childhood

I. INTRODUCTION
1. This general comment arises out of the Committee’s experiences of reviewing States parties’ reports. In many cases, very little information has been offered about early childhood, with comments limited mainly to child mortality, birth registration and health care. The Committee felt the need for a discussion on the broader implications of the Convention on the Rights of the Child for young children. Accordingly, in 2004, the Committee devoted its day of general discussion to the theme “Implementing child rights in early childhood”. This resulted in a set of recommendations (see CRC/C/143, sect. VII) as well as the decision to prepare a general comment on this important topic. Through this general comment, the Committee wishes to encourage recognition that young children are holders of all rights enshrined in the Convention and that early childhood is a critical period for the realization of these rights. The Committee’s working definition of “early childhood” is all young children: at birth and throughout infancy; during the preschool years; as well as during the transition to school (see paragraph 4 below).

II. OBJECTIVES OF THE GENERAL COMMENT
2. The objectives of the general comment are:

(a) To strengthen understanding of the human rights of all young children and to draw States parties’ attention to their obligations towards young children;

(b) To comment on the specific features of early childhood that impact on the realization of rights;

(c) To encourage recognition of young children as social actors from the beginning of life, with particular interests, capacities and vulnerabilities, and of requirements for protection, guidance and support in the exercise of their rights;

(d) To draw attention to diversities within early childhood that need to be taken into account when implementing the Convention, including diversities in young children’s circumstances, in the quality of their experiences and in the influences shaping their development;

(e) To point to variations in cultural expectations and treatment of children, including local customs and practices that should be respected, except where they contravene the rights of the child;

(f) To emphasize the vulnerability of young children to poverty, discrimination, family breakdown and multiple other adversities that violate their rights and undermine their well-being;

(g) To contribute to the realization of rights for all young children through formulation and promotion of comprehensive policies, laws, programmes, practices, professional training and research specifically focused on rights in early childhood.

III. HUMAN RIGHTS AND YOUNG CHILDREN
3. Young children are rights holders. The Convention on the Rights of the Child defines a child as “every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier” (art. 1). Consequently, young children are holders of all the rights enshrined in the Convention. They are entitled to special protection measures and, in accordance with their evolving capacities, the progressive exercise of their rights. The Committee is concerned that in implementing their obligations under the Convention, States parties have not given sufficient attention to young children as rights holders and to the laws, policies and programmes required to realize their rights during this distinct phase of their childhood. The Committee reaffirms that the Convention on
the Rights of the Child is to be applied holistically in early childhood, taking account of the principle of
the universality, indivisibility and interdependence of all human rights.

4. **Definition of early childhood.** Definitions of early childhood vary in different countries and
regions, according to local traditions and the organization of primary school systems. In some
countries, the transition from preschool to school occurs soon after 4 years old. In other countries, this
transition takes place at around 7 years old. In its consideration of rights in early childhood, the
Committee wishes to include all young children: at birth and throughout infancy; during the preschool
years; as well as during the transition to school. Accordingly, the Committee proposes as an
appropriate working definition of early childhood the period below the age of 8 years; States parties
should review their obligations towards young children in the context of this definition.

5. **A positive agenda for early childhood.** The Committee encourages States parties to construct a
positive agenda for rights in early childhood. A shift away from traditional beliefs that regard early
childhood mainly as a period for the socialization of the immature human being towards mature adult
status is required. The Convention requires that children, including the very youngest children, be
respected as persons in their own right. Young children should be recognized as active members of
families, communities and societies, with their own concerns, interests and points of view. For the
exercise of their rights, young children have particular requirements for physical nurturance, emotional
care and sensitive guidance, as well as for time and space for social play, exploration and learning.
These requirements can best be planned for within a framework of laws, policies and programmes for
early childhood, including a plan for implementation and independent monitoring, for example through
the appointment of a children’s rights commissioner, and through assessments of the impact of laws
and policies on children (see general comment No. 2 (2002) on the role of independent human rights
institutions, para. 19).

6. **Features of early childhood.** Early childhood is a critical period for realizing children’s rights. During this period:

- (a) Young children experience the most rapid period of growth and change during the human lifespan,
in terms of their maturing bodies and nervous systems, increasing mobility, communication skills and
intellectual capacities, and rapid shifts in their interests and abilities;

- (b) Young children form strong emotional attachments to their parents or other caregivers, from whom
they seek and require nurturance, care, guidance and protection, in ways that are respectful of their
individuality and growing capacities;

- (c) Young children establish their own important relationships with children of the same age, as well
as with younger and older children. Through these relationships they learn to negotiate and
coordinate shared activities, resolve conflicts, keep agreements and accept responsibility for others;

- (d) Young children actively make sense of the physical, social and cultural dimensions of the world
they inhabit, learning progressively from their activities and their interactions with others, children as
well as adults;

- (e) Young children’s earliest years are the foundation for their physical and mental health, emotional
security, cultural and personal identity, and developing competencies;

- (f) Young children’s experiences of growth and development vary according to their individual nature,
as well as their gender, living conditions, family organization, care arrangements and education
systems;

- (g) Young children’s experiences of growth and development are powerfully shaped by cultural beliefs
about their needs and proper treatment, and about their active role in family and community.

7. Respecting the distinctive interests, experiences and challenges facing every young child is the
starting point for realizing their rights during this crucial phase of their lives.

8. **Research into early childhood.** The Committee notes the growing body of theory and research
which confirms that young children are best understood as social actors whose survival, well-being
and development are dependent on and built around close relationships. These relationships are normally with a small number of key people, most often parents, members of the extended family and peers, as well as caregivers and other early childhood professionals. At the same time, research into the social and cultural dimensions of early childhood draws attention to the diverse ways in which early development is understood and enacted, including varying expectations of the young child and arrangements for his or her care and education. A feature of modern societies is that increasing numbers of young children are growing up in multicultural communities and in contexts marked by rapid social change, where beliefs and expectations about young children are also changing, including through greater recognition of their rights. States parties are encouraged to draw on beliefs and knowledge about early childhood in ways that are appropriate to local circumstances and changing practices, and respect traditional values, provided these are not discriminatory, (article 2 of the Convention) nor prejudicial to children’s health and well-being (art. 24.3), nor against their best interests (art. 3). Finally, research has highlighted the particular risks to young children from malnutrition, disease, poverty, neglect, social exclusion and a range of other adversities. It shows that proper prevention and intervention strategies during early childhood have the potential to impact positively on young children’s current well-being and future prospects. Implementing child rights in early childhood is thus an effective way to help prevent personal, social and educational difficulties during middle childhood and adolescence (see general comment No. 4 (2003) on adolescent health and development).

III. GENERAL PRINCIPLES AND RIGHTS IN EARLY CHILDHOOD

9. The Committee has identified articles 2, 3, 6 and 12 of the Convention as general principles (see general comment No. 5 (2003) on the general measures of implementation of the Convention). Each principle has implications for rights in early childhood.

10. Right to life, survival and development. Article 6 refers to the child’s inherent right to life and States parties’ obligation to ensure, to the maximum extent possible, the survival and development of the child. States parties are urged to take all possible measures to improve perinatal care for mothers and babies, reduce infant and child mortality, and create conditions that promote the well-being of all young children during this critical phase of their lives. Malnutrition and preventable diseases continue to be major obstacles to realizing rights in early childhood. Ensuring survival and physical health are priorities, but States parties are reminded that article 6 encompasses all aspects of development, and that a young child’s health and psychosocial well-being are in many respects interdependent. Both may be put at risk by adverse living conditions, neglect, insensitive or abusive treatment and restricted opportunities for realizing human potential. Young children growing up in especially difficult circumstances require particular attention (see section VI below). The Committee reminds States parties to the Convention that the right to survival and development can only be implemented in a holistic manner, through the enforcement of all the other provisions of the Convention, including rights to health, adequate nutrition, social security, an adequate standard of living, a healthy and safe environment, education and play (arts. 24, 27, 28, 29 and 31), as well as through respect for the responsibilities of parents and the provision of assistance and quality services (arts. 5 and 18). From an early age, children should themselves be included in activities promoting good nutrition and a healthy and disease-preventing lifestyle.

11. Right to non-discrimination. Article 2 ensures rights to every child, without discrimination of any kind. The Committee urges States parties to identify the implications of this principle for realizing rights in early childhood:

(a) Article 2 means that young children in general must not be discriminated against on any grounds, for example where laws fail to offer equal protection against violence for all children, including young children. Young children are especially at risk of discrimination because they are relatively powerless and depend on others for the realization of their rights;

(b) Article 2 also means that particular groups of young children must not be discriminated against. Discrimination may take the form of reduced levels of nutrition; inadequate care and attention; restricted opportunities for play, learning and education; or inhibition of free expression of feelings and views. Discrimination may also be expressed through harsh treatment and unreasonable expectations, which may be exploitative or abusive. For example:
Discrimination against girl children is a serious violation of rights, affecting their survival and all areas of their young lives as well as restricting their capacity to contribute positively to society. They may be victims of selective abortion, genital mutilation, neglect and infanticide, including through inadequate feeding in infancy. They may be expected to undertake excessive family responsibilities and deprived of opportunities to participate in early childhood and primary education;

Discrimination against children with disabilities reduces survival prospects and quality of life. These children are entitled to the care, nutrition, nurturance and encouragement offered other children. They may also require additional, special assistance in order to ensure their integration and the realization of their rights;

Discrimination against children infected with or affected by HIV/AIDS deprives them of the help and support they most require. Discrimination may be found within public policies, in the provision of and access to services, as well as in everyday practices that violate these children’s rights (see also paragraph 27);

Discrimination related to ethnic origin, class/caste, personal circumstances and lifestyle, or political and religious beliefs (of children or their parents) excludes children from full participation in society. It affects parents’ capacities to fulfill their responsibilities towards their children. It affects children’s opportunities and self-esteem, as well as encouraging resentment and conflict among children and adults;

Young children who suffer multiple discrimination (e.g. related to ethnic origin, social and cultural status, gender and/or disabilities) are especially at risk.

Young children may also suffer the consequences of discrimination against their parents, for example if children have been born out of wedlock or in other circumstances that deviate from traditional values, or if their parents are refugees or asylum-seekers. States parties have a responsibility to monitor and combat discrimination in whatever forms it takes and wherever it occurs - within families, communities, schools or other institutions. Potential discrimination in access to quality services for young children is a particular concern, especially where health, education, welfare and other services are not universally available and are provided through a combination of State, private and charitable organizations. As a first step, the Committee encourages States parties to monitor the availability of and access to quality services that contribute to young children’s survival and development, including through systematic data collection, disaggregated in terms of major variables related to children’s and families’ background and circumstances. As a second step, actions may be required that guarantee that all children have an equal opportunity to benefit from available services. More generally, States parties should raise awareness about discrimination against young children in general, and against vulnerable groups in particular.

Best interests of the child. Article 3 sets out the principle that the best interests of the child are a primary consideration in all actions concerning children. By virtue of their relative immaturity, young children are reliant on responsible authorities to assess and represent their rights and best interests in relation to decisions and actions that affect their well-being, while taking account of their views and evolving capacities. The principle of best interests appears repeatedly within the Convention (including in articles 9, 18, 20 and 21, which are most relevant to early childhood). The principle of best interests applies to all actions concerning children and requires active measures to protect their rights and promote their survival, growth, and well-being, as well as measures to support and assist parents and others who have day-to-day responsibility for realizing children’s rights:

(a) Best interests of individual children. All decision-making concerning a child’s care, health, education, etc. must take account of the best interests principle, including decisions by parents, professionals and others responsible for children. States parties are urged to make provisions for young children to be represented independently in all legal proceedings by someone who acts for the child’s interests, and for children to be heard in all cases where they are capable of expressing their opinions or preferences;

(b) Best interests of young children as a group or constituency. All law and policy development, administrative and judicial decision-making and service provision that affect children must take account of the best interests principle. This includes actions directly affecting children (e.g., related to
14. **Respect for the views and feelings of the young child.** Article 12 states that the child has a right to express his or her views freely in all matters affecting the child, and to have them taken into account. This right reinforces the status of the young child as an active participant in the promotion, protection and monitoring of their rights. Respect for the young child’s agency - as a participant in family, community and society - is frequently overlooked, or rejected as inappropriate on the grounds of age and immaturity. In many countries and regions, traditional beliefs have emphasized young children’s need for training and socialization. They have been regarded as undeveloped, lacking even basic capacities for understanding, communicating and making choices. They have been powerless within their families, and often voiceless and invisible within society. The Committee wishes to emphasize that article 12 applies both to younger and to older children. As holders of rights, even the youngest children are entitled to express their views, which should be “given due weight in accordance with the age and maturity of the child” (art. 12.1). Young children are acutely sensitive to their surroundings and very rapidly acquire understanding of the people, places and routines in their lives, along with awareness of their own unique identity. They make choices and communicate their feelings, ideas and wishes in numerous ways, long before they are able to communicate through the conventions of spoken or written language. In this regard:

(a) The Committee encourages States parties to take all appropriate measures to ensure that the concept of the child as rights holder with freedom to express views and the right to be consulted in matters that affect him or her is implemented from the earliest stage in ways appropriate to the child’s capacities, best interests, and rights to protection from harmful experiences;

(b) The right to express views and feelings should be anchored in the child’s daily life at home (including, when applicable, the extended family) and in his or her community; within the full range of early childhood health, care and education facilities, as well as in legal proceedings; and in the development of policies and services, including through research and consultations;

(c) States parties should take all appropriate measures to promote the active involvement of parents, professionals and responsible authorities in the creation of opportunities for young children to progressively exercise their rights within their everyday activities in all relevant settings, including by providing training in the necessary skills. To achieve the right of participation requires adults to adopt a child-centred attitude, listening to young children and respecting their dignity and their individual points of view. It also requires adults to show patience and creativity by adapting their expectations to a young child’s interests, levels of understanding and preferred ways of communicating.

IV. **PARENTAL RESPONSIBILITIES AND ASSISTANCE FROM STATES PARTIES**

15. **A crucial role for parents and other primary caregivers.** Under normal circumstances, a young child’s parents play a crucial role in the achievement of their rights, along with other members of family, extended family or community, including legal guardians, as appropriate. This is fully recognized within the Convention (especially article 5), along with the obligation on States parties to provide assistance, including quality childcare services (especially article 18). The preamble to the Convention refers to the family as “the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children”. The Committee recognizes that “family” here refers to a variety of arrangements that can provide for young children’s care, nurturance and development, including the nuclear family, the extended family, and other traditional and modern community-based arrangements, provided these are consistent with children’s rights and best interests.

16. **Parents/primary caregivers and children’s best interests.** The responsibility vested in parents and other primary caregivers is linked to the requirement that they act in children’s best interests. Article 5 states that parents’ role is to offer appropriate direction and guidance in “the exercise by the child of the rights in the … Convention”. This applies equally to younger as to older children. Babies and infants are entirely dependent on others, but they are not passive recipients of care, direction and guidance. They are active social agents, who seek protection, nurturance and understanding from parents or other caregivers, which they require for their survival, growth and well-being. Newborn babies are able to recognize their parents (or other caregivers) very soon after birth, and they engage
actively in non-verbal communication. Under normal circumstances, young children form strong mutual attachments with their parents or primary caregivers. These relationships offer children physical and emotional security, as well as consistent care and attention. Through these relationships, children construct a personal identity and acquire culturally valued skills, knowledge and behaviours. In these ways, parents (and other caregivers) are normally the major conduit through which young children are able to realize their rights.

17. Evolving capacities as an enabling principle. Article 5 draws on the concept of “evolving capacities” to refer to processes of maturation and learning whereby children progressively acquire knowledge, competencies and understanding, including acquiring understanding about their rights and about how they can best be realized. Respecting young children’s evolving capacities is crucial for the realization of their rights, and especially significant during early childhood, because of the rapid transformations in children’s physical, cognitive, social and emotional functioning, from earliest infancy to the beginnings of schooling. Article 5 contains the principle that parents (and others) have the responsibility to continually adjust the levels of support and guidance they offer to a child. These adjustments take account of a child’s interests and wishes as well as the child’s capacities for autonomous decision-making and comprehension of his or her best interests. While a young child generally requires more guidance than an older child, it is important to take account of individual variations in the capacities of children of the same age and of their ways of reacting to situations. Evolving capacities should be seen as a positive and enabling process, not an excuse for authoritarian practices that restrict children’s autonomy and self-expression and which have traditionally been justified by pointing to children’s relative immaturity and their need for socialization. Parents (and others) should be encouraged to offer “direction and guidance” in a child-centred way, through dialogue and example, in ways that enhance young children’s capacities to exercise their rights, including their right to participation (art. 12) and their right to freedom of thought, conscience and religion (art. 14).

18. Respecting parental roles. Article 18 of the Convention reaffirms that parents or legal guardians have the primary responsibility for promoting children’s development and well-being, with the child’s best interests as their basic concern (arts. 18.1 and 27.2). States parties should respect the primacy of parents, mothers and fathers. This includes the obligation not to separate children from their parents, unless it is in the child’s best interests (art. 9). Young children are especially vulnerable to adverse consequences of separations because of their physical dependence on and emotional attachment to their parents/primary caregivers. They are also less able to comprehend the circumstances of any separation. Situations which are most likely to impact negatively on young children include neglect and deprivation of adequate parenting; parenting under acute material or psychological stress or impaired mental health; parenting in isolation; parenting which is inconsistent, involves conflict between parents or is abusive towards children; and situations where children experience disrupted relationships (including enforced separations), or where they are provided with low-quality institutional care. The Committee urges States parties to take all necessary steps to ensure that parents are able to take primary responsibility for their children; to support parents in fulfilling their responsibilities, including by reducing harmful deprivations, disruptions and distortions in children’s care; and to take action where young children’s well-being may be at risk. States parties’ overall goals should include reducing the number of young children abandoned or orphaned, as well as minimizing the numbers requiring institutional or other forms of long-term care, except where this is judged to be in a young child’s best interests (see also section VI below).

19. Social trends and the role of the family. The Convention emphasizes that “both parents have common responsibilities for the upbringing and development of the child”, with fathers and mothers recognized as equal caregivers (art. 18.1). The Committee notes that in practice family patterns are variable and changing in many regions, as is the availability of informal networks of support for parents, with an overall trend towards greater diversity in family size, parental roles and arrangements for bringing up children. These trends are especially significant for young children, whose physical, personal and psychological development is best provided for within a small number of consistent, caring relationships. Typically, these relationships are with some combination of mother, father, siblings, grandparents and other members of the extended family, along with professional caregivers specialized in childcare and education. The Committee acknowledges that each of these relationships can make a distinctive contribution to the fulfilment of children’s rights under the Convention and that a range of family patterns may be consistent with promoting children’s well-being. In some countries and regions, shifting social attitudes towards family, marriage and parenting are impacting on young
children’s experiences of early childhood, for example following family separations and reformations. Economic pressures also impact on young children, for example, where parents are forced to work far away from their families and their communities. In other countries and regions, the illness and death of one or both parents or other kin due to HIV/AIDS is now a common feature of early childhood. These and many other factors impact on parents’ capacities to fulfil their responsibilities towards children. More generally, during periods of rapid social change, traditional practices may no longer be viable or relevant to present parental circumstances and lifestyles, but without sufficient time having elapsed for new practices to be assimilated and new parental competencies understood and valued.

20. **Assistance to parents.** States parties are required to render appropriate assistance to parents, legal guardians and extended families in the performance of their child-rearing responsibilities (arts. 18.2 and 18.3), including assisting parents in providing living conditions necessary for the child’s development (art. 27.2) and ensuring that children receive necessary protection and care (art. 3.2). The Committee is concerned that insufficient account is taken of the resources, skills and personal commitment required of parents and others responsible for young children, especially in societies where early marriage and parenthood is still sanctioned as well as in societies with a high incidence of young single parents. Early childhood is the period of most extensive (and intensive) parental responsibilities related to all aspects of children’s well-being covered by the Convention: their survival, health, physical safety and emotional security, standards of living and care, opportunities for play and learning, and freedom of expression. Accordingly, realizing children’s rights is in large measure dependent on the well-being and resources available to those with responsibility for their care. Recognizing these interdependencies is a sound starting point for planning assistance and services to parents, legal guardians and other caregivers. For example:

(a) An integrated approach would include interventions that impact indirectly on parents’ ability to promote the best interests of children (e.g. taxation and benefits, adequate housing, working hours) as well as those that have more immediate consequences (e.g. perinatal health services for mother and baby, parent education, home visitors);

(b) Providing adequate assistance should take account of the new roles and skills required of parents, as well as the ways that demands and pressures shift during early childhood - for example, as children become more mobile, more verbally communicative, more socially competent, and as they begin to participate in programmes of care and education;

(c) Assistance to parents will include provision of parenting education, parent counselling and other quality services for mothers, fathers, siblings, grandparents and others who from time to time may be responsible for promoting the child’s best interests;

(d) Assistance also includes offering support to parents and other family members in ways that encourage positive and sensitive relationships with young children and enhance understanding of children’s rights and best interests.

21. **Appropriate assistance to parents can best be achieved as part of comprehensive policies for early childhood (see section V below), including provision for health, care and education during the early years. States parties should ensure that parents are given appropriate support to enable them to involve young children fully in such programmes, especially the most disadvantaged and vulnerable groups. In particular, article 18.3 acknowledges that many parents are economically active, often in poorly paid occupations which they combine with their parental responsibilities. Article 18.3 requires States parties to take all appropriate measures to ensure that children of working parents have the right to benefit from childcare services, maternity protection and facilities for which they are eligible. In this regard, the Committee recommends that States parties ratify the Maternity Protection Convention, 2000 (No. 183) of the International Labour Organization.**

V. COMPREHENSIVE POLICIES AND PROGRAMMES FOR EARLY CHILDHOOD, ESPECIALLY FOR VULNERABLE CHILDREN

22. **Rights-based, multisectoral strategies.** In many countries and regions, early childhood has received low priority in the development of quality services. These services have often been fragmented. They have frequently been the responsibility of several government departments at central and local levels, and their planning has often been piecemeal and uncoordinated. In some cases, they have also been largely provided by the private and voluntary sector, without adequate
resources, regulation or quality assurance. States parties are urged to develop rights-based, coordinated, multisectoral strategies in order to ensure that children’s best interests are always the starting point for service planning and provision. These should be based around a systematic and integrated approach to law and policy development in relation to all children up to 8 years old. A comprehensive framework for early childhood services, provisions and facilities is required, backed up by information and monitoring systems. Comprehensive services will be coordinated with the assistance provided to parents and will fully respect their responsibilities, as well as their priorities for specific age groups (for example, babies, toddlers, preschool and early primary school groups), and the implications for programme standards and quality criteria. States parties must ensure that the institutions, services and facilities responsible for early childhood conform to quality standards, particularly in the areas of health and safety, and that staff possess the appropriate psychosocial qualities and are suitable, sufficiently numerous and well-trained. Provision of services appropriate to the circumstances, age and individuality of young children requires that all staff be trained to work with this age group. Work with young children should be socially valued and properly paid, in order to attract a highly qualified workforce, men as well as women. It is essential that they are trained to work with this age group. Work with young children should be socially valued and properly paid, in order to attract a highly qualified workforce, men as well as women. It is essential that they are trained to work with this age group.

23. **Programme standards and professional training appropriate to the age range.** The Committee emphasizes that a comprehensive strategy for early childhood must also take account of individual children’s maturity and individuality, in particular recognizing the changing developmental priorities for specific age groups (for example, babies, toddlers, preschool and early primary school groups), and the implications for programme standards and quality criteria. States parties must ensure that the institutions, services and facilities responsible for early childhood conform to quality standards, particularly in the areas of health and safety, and that staff possess the appropriate psychosocial qualities and are suitable, sufficiently numerous and well-trained. Provision of services appropriate to the circumstances, age and individuality of young children requires that all staff be trained to work with this age group. Work with young children should be socially valued and properly paid, in order to attract a highly qualified workforce, men as well as women. It is essential that they are trained to work with this age group. Work with young children should be socially valued and properly paid, in order to attract a highly qualified workforce, men as well as women. It is essential that they are trained to work with this age group.

24. **Access to services, especially for the most vulnerable.** The Committee calls on States parties to ensure that all young children (and those with primary responsibility for their well-being) are guaranteed access to appropriate and effective services, including programmes of health, care and education specifically designed to promote their well-being. Particular attention should be paid to the most vulnerable groups of young children and to those who are at risk of discrimination (art. 2). This includes girls, children living in poverty, children with disabilities, children belonging to indigenous or minority groups, children from migrant families, children who are orphaned or lack parental care for other reasons, children living in institutions, children living with mothers in prison, refugee and asylum-seeking children, children infected with or affected by HIV/AIDS, and children of alcohol- or drug-addicted parents (see also section VI).

25. **Birth registration.** Comprehensive services for early childhood begin at birth. The Committee notes that provision for registration of all children at birth is still a major challenge for many countries and regions. This can impact negatively on a child’s sense of personal identity and children may be denied entitlements to basic health, education and social welfare. As a first step in ensuring the rights to survival, development and access to quality services for all children (art. 6), the Committee recommends that States parties take all necessary measures to ensure that all children are registered at birth. This can be achieved through a universal, well-managed registration system that is accessible to all and free of charge. An effective system must be flexible and responsive to the circumstances of families, for example by providing mobile registration units where appropriate. The Committee notes that children who are sick or disabled are less likely to be registered in some regions and emphasizes that all children should be registered at birth, without discrimination of any kind (art. 2). The Committee also reminds States parties of the importance of facilitating late registration of birth, and ensuring that children who have not been registered have equal access to health care, protection, education and other social services.

26. **Standard of living and social security.** Young children are entitled to a standard of living adequate for their physical, mental, spiritual, moral and social development (art. 27). The Committee notes with concern that even the most basic standard of living is not assured for millions of young children, despite widespread recognition of the adverse consequences of deprivation. Growing up in conditions of absolute poverty has even more serious consequences, threatening children’s survival and their health, as well as undermining
the basic quality of life. States parties are urged to implement systematic strategies to reduce poverty in early childhood as well as combat its negative effects on children’s well-being. All possible means should be employed, including “material assistance and support programmes” for children and families (art. 27.3), in order to assure to young children a basic standard of living consistent with rights. Implementing children’s right to benefit from social security, including social insurance, is an important element of any strategy (art. 26).

27. Health-care provision. States parties should ensure that all children have access to the highest attainable standard of health care and nutrition during their early years, in order to reduce infant mortality and enable children to enjoy a healthy start in life (art. 24). In particular:

(a) States parties have a responsibility to ensure access to clean drinking water, adequate sanitation, appropriate immunization, good nutrition and medical services, which are essential for young children’s health, as is a stress-free environment. Malnutrition and disease have long-term impacts on children’s physical health and development. They affect children’s mental state, inhibiting learning and social participation and reducing prospects for realizing their potential. The same applies to obesity and unhealthy lifestyles;

(b) States parties have a responsibility to implement children’s right to health by encouraging education in child health and development, including about the advantages of breastfeeding, nutrition, hygiene and sanitation. Priority should also be given to the provision of appropriate prenatal and post-natal health care for mothers and infants in order to foster healthy family-child relationships, especially between a child and his or her mother (or other primary caregiver) (art. 24.2). Young children are themselves able to contribute to ensuring their personal health and encouraging healthy lifestyles among their peers, for example through participation in appropriate, child-centred health education programmes;

(c) The Committee wishes to draw States parties’ attention to the particular challenges of HIV/AIDS for early childhood. All necessary steps should be taken to: (i) prevent infection of parents and young children, especially by intervening in chains of transmission, especially between father and mother and from mother to baby; (ii) provide accurate diagnoses, effective treatment and other forms of support for both parents and young children who are infected by the virus (including antiretroviral therapies); and (iii) ensure adequate alternative care for children who have lost parents or other primary caregivers due to HIV/AIDS, including healthy and infected orphans. (See also general comment No. 3 (2003) on HIV/AIDS and the rights of the child.)

28. Early Childhood Education. The Convention recognizes the right of the child to education, and primary education should be made compulsory and available free to all (art. 28). The Committee recognizes with appreciation that some States parties are planning to make one year of preschool education available and free of cost for all children. The Committee interprets the right to education during early childhood as beginning at birth and closely linked to young children’s right to maximum development (art. 6.2). Linking education to development is elaborated in article 29.1: “States parties agree that the education of the child shall be directed to: (a) the development of the child’s personality, talents and mental and physical abilities to their fullest potential”. General comment No. 1 on the aims of education explains that the goal is to “empower the child by developing his or her skills, learning and other capacities, human dignity, self-esteem and self-confidence” and that this must be achieved in ways that are child-centred, child-friendly and reflect the rights and inherent dignity of the child (para. 2). States parties are reminded that children’s right to education include all children, and that girls should be enabled to participate in education, without discrimination of any kind (art. 2).

29. Parental and public responsibilities for Early Childhood Education. The principle that parents (and other primary caregivers) are children’s first educators is well established and endorsed within the Convention’s emphasis on respect for the responsibilities of parents (sect. IV above). They are expected to provide appropriate direction and guidance to young children in the exercise of their rights, and provide an environment of reliable and affectionate relationships based on respect and understanding (art. 5). The Committee invites States parties to make this principle a starting point for planning early education, in two respects:

(a) In providing appropriate assistance to parents in the performance of their child-rearing responsibilities (art. 18.2), States parties should take all appropriate measures to enhance parents’
30. The Committee calls on States parties to ensure that all young children receive education in the broadest sense (as outlined in paragraph 28 above), which acknowledges a key role for parents, wider family and community, as well as the contribution of organized programmes of Early Childhood Education provided by the State, the community or civil society institutions. Research evidence demonstrates the potential for quality education programmes to have a positive impact on young children’s successful transition to primary school, their educational progress and their long-term social adjustment. Many countries and regions now provide comprehensive early education starting at 4 years old, which in some countries is integrated with childcare for working parents. Acknowledging that traditional divisions between “care” and “education” services have not always been in children’s best interests, the concept of “Educare” is sometimes used to signal a shift towards integrated services, and reinforces the recognition of the need for a coordinated, holistic, multisectoral approach to early childhood.

31. Community-based programmes. The Committee recommends that States parties support early childhood development programmes, including home- and community-based preschool programmes, in which the empowerment and education of parents (and other caregivers) are main features. States parties have a key role to play in providing a legislative framework for the provision of quality, adequately resourced services, and for ensuring that standards are tailored to the circumstances of particular groups and individuals and to the developmental priorities of particular age groups, from infancy through to transition into school. They are encouraged to construct high-quality, developmentally appropriate and culturally relevant programmes and to achieve this by working with local communities rather by imposing a standardized approach to early childhood care and education. The Committee also recommends that States parties pay greater attention to, and actively support, a rights-based approach to early childhood programmes, including initiatives surrounding transition to primary school that ensure continuity and progression, in order to build children’s confidence, communication skills and enthusiasm for learning through their active involvement in, among others, planning activities.

32. The private sector as service provider. With reference to its recommendations adopted during its 2002 day of general discussion on “The private sector as service provider and its role in implementing child rights” (see CRC/C/121, paras. 630-653), the Committee recommends that States parties support the activities of the non-governmental sector as a channel for programme implementation. It further calls on all non-State service providers (“for profit” as well as “non-profit” providers) to respect the principles and provisions of the Convention and, in this regard, reminds States parties of their primary obligation to ensure its implementation. Early childhood professionals - in both the State and non-State sectors - should be provided with thorough preparation, ongoing training and adequate remuneration. In this context, States parties are responsible for service provision for early childhood development. The role of civil society should be complementary to - not a substitute for - the role of the State. Where non-State services play a major role, the Committee reminds States parties that they have an obligation to monitor and regulate the quality of provision to ensure that children’s rights are protected and their best interests served.

33. Human rights education in early childhood. In light of article 29 and the Committee’s general comment No. 1 (2001), the Committee also recommends that States parties include human rights education within Early Childhood Education. Such education should be participatory and empowering to children, providing them with practical opportunities to exercise their rights and responsibilities in ways adapted to their interests, concerns and evolving capacities. Human rights education of young children should be anchored in everyday issues at home, in childcare centres, in early education programmes and other community settings with which young children can identify.

34. Right to rest, leisure and play. The Committee notes that insufficient attention has been given by States parties and others to the implementation of the provisions of article 31 of the Convention,
which guarantees “the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts”. Play is one of the most distinctive features of early childhood. Through play, children both enjoy and challenge their current capacities, whether they are playing alone or with others. The value of creative play and exploratory learning is widely recognized in Early Childhood Education. Yet realizing the right to rest, leisure and play is often hindered by a shortage of opportunities for young children to meet, play and interact in child-centred, secure, supportive, stimulating and stress-free environments. Children’s right to play is especially at risk in many urban environments, where the design and density of housing, commercial centres and transport systems combine with noise, pollution and all manner of dangers to create a hazardous environment for young children. Children’s right to play can also be frustrated by excessive domestic chores (especially affecting girls) or by competitive schooling. Accordingly, the Committee appeals to States parties, non-governmental organizations and private actors to identify and remove potential obstacles to the enjoyment of these rights by the youngest children, including as part of poverty reduction strategies. Planning for towns, and leisure and play facilities should take account of children’s right to express their views (art. 12), through appropriate consultations. In all these respects, States parties are encouraged to pay greater attention and allocate adequate resources (human and financial) to the implementation of the right to rest, leisure and play.

35. Modern communications technologies and early childhood. Article 17 recognizes the potential for both traditional print-based media and modern information technology-based mass media to contribute positively to the realization of children’s rights. Early childhood is a specialist market for publishers and media producers, who should be encouraged to disseminate material that is appropriate to the capacities and interests of young children, socially and educationally beneficial to their well-being, and which reflects the national and regional diversities of children’s circumstances, culture and language. Particular attention should be given to the need of minority groups for access to media that promote their recognition and social inclusion. Article 17 (e) also refers to the role of States parties in ensuring that children are protected from inappropriate and potentially harmful material. Rapid increases in the variety and accessibility of modern technologies, including Internet-based media, are a particular cause for concern. Young children are especially at risk if they are exposed to inappropriate or offensive material. States parties are urged to regulate media production and delivery in ways that protect young children, as well as support parents/caregivers to fulfil their child-rearing responsibilities in this regard (art. 18).

VI. YOUNG CHILDREN IN NEED OF SPECIAL PROTECTION

36. Young children’s vulnerability to risks. Throughout this general comment the Committee notes that large numbers of young children grow up in difficult circumstances that are frequently in violation of their rights. Young children are especially vulnerable to the harm caused by unreliable, inconsistent relationships with parents and caregivers, or growing up in extreme poverty and deprivation, or being surrounded by conflict and violence or displaced from their homes as refugees, or any number of other adversities prejudicial to their well-being. Young children are less able to comprehend these adversities or resist harmful effects on their health, or physical, mental, spiritual, moral or social development. They are especially at risk where parents or other caregivers are unable to offer adequate protection, whether due to illness, or death, or due to disruption to families or communities. Whatever the difficult circumstances, young children require particular consideration because of the rapid developmental changes they are experiencing; they are more vulnerable to disease, trauma, and distorted or disturbed development, and they are relatively powerless to avoid or resist difficulties and are dependent on others to offer protection and promote their best interests. In the following paragraphs, the Committee draws States parties’ attention to major difficult circumstances referred to in the Convention that have clear implications for rights in early childhood. This list is not exhaustive, and children may in any case be subject to multiple risks. In general, the goal of States parties should be to ensure that every child, in every circumstance, receives adequate protection in fulfilment of their rights:

(a) Abuse and neglect (art. 19). Young children are frequent victims of neglect, maltreatment and abuse, including physical and mental violence. Abuse very often happens within families, which can be especially destructive. Young children are least able to avoid or resist, least able to comprehend what is happening and least able to seek the protection of others. There is compelling evidence that trauma as a result of neglect and abuse has negative impacts on development, including, for the very youngest children, measurable effects on processes of brain maturation. Bearing in mind the
prevalence of abuse and neglect in early childhood and the evidence that it has long-term repercussions, States parties should take all necessary measures to safeguard young children at risk and offer protection to victims of abuse, taking positive steps to support their recovery from trauma while avoiding stigmatization for the violations they have suffered;

(b) Children without families (art. 20 and 21). Children’s rights to development are at serious risk when they are orphaned, abandoned or deprived of family care or when they suffer long-term disruptions to relationships or separations (e.g. due to natural disasters or other emergencies, epidemics such as HIV/AIDS, parental imprisonment, armed conflicts, wars and forced migration). These adversities will impact on children differently depending on their personal resilience, their age and their circumstances, as well as the availability of wider sources of support and alternative care. Research suggests that low-quality institutional care is unlikely to promote healthy physical and psychological development and can have serious negative consequences for long-term social adjustment, especially for children under 3 but also for children under 5 years old. To the extent that alternative care is required, early placement in family-based or family-like care is more likely to produce positive outcomes for young children. States parties are encouraged to invest in and support forms of alternative care that can ensure security, continuity of care and affection, and the opportunity for young children to form long-term attachments based on mutual trust and respect, for example through fostering, adoption and support for members of extended families. Where adoption is envisaged “the best interests of the child shall be the paramount consideration” (art. 21), not just “a primary consideration” (art. 3), systematically bearing in mind and respecting all relevant rights of the child and obligations of States parties set out elsewhere in the Convention and recalled in the present general comment;

(c) Refugees (art. 22). Young children who are refugees are most likely to be disoriented, having lost much that is familiar in their everyday surroundings and relationships. They and their parents are entitled to equal access to health care, education and other services. Children who are unaccompanied or separated from their families are especially at risk. The Committee offers detailed guidance on the care and protection of these children in general comment No. 6 (2005) on the treatment of unaccompanied and separated children outside their country of origin;

(d) Children with disabilities (art. 23). Early childhood is the period during which disabilities are usually identified and the impact on children’s well-being and development recognized. Young children should never be institutionalized solely on the grounds of disability. It is a priority to ensure that they have equal opportunities to participate fully in education and community life, including by the removal of barriers that impede the realization of their rights. Young disabled children are entitled to appropriate specialist assistance, including support for their parents (or other caregivers). Disabled children should at all times be treated with dignity and in ways that encourage their self-reliance. (See also the recommendations from the Committee’s 1997 day of general discussion on “The rights of children with disabilities” contained in document CRC/C/66.);

(e) Harmful work (art. 32). In some countries and regions, children are socialized to work from an early age, including in activities that are potentially hazardous, exploitative and damaging to their health, education and long-term prospects. For example, young children may be initiated into domestic work or agricultural labour, or assist parents or siblings engaged in hazardous activities. Even very young babies may be vulnerable to economic exploitation, as when they are used or hired out for begging. Exploitation of young children in the entertainment industry, including television, film, advertising and other modern media, is also a cause for concern. States parties have particular responsibilities in relation to extreme forms of hazardous child labour identified in the Worst Forms of Child Labour Convention, 1999 (No. 182) of the ILO;

(f) Substance abuse (art. 33). While very young children are only rarely likely to be substance abusers, they may require specialist health care if born to alcohol- or drug-addicted mothers, and protection where family members are abusers and they are at risk of exposure to drugs. They may also suffer adverse consequences of alcohol or drug abuse on family living standards and quality of care, as well as being at risk of early initiation into substance abuse;

(g) Sexual abuse and exploitation (art. 34). Young children, especially girls, are vulnerable to early sexual abuse and exploitation within and outside families. Young children in difficult circumstances
are at particular risk, for example girl children employed as domestic workers. Young children may also be victims of producers of pornography; this is covered by the Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography of 2002:

(h) Sale, trafficking and abduction of children (art. 35). The Committee has frequently expressed concern about evidence of the sale and trafficking of abandoned and separated children for various purposes. As far as the youngest age groups are concerned, these purposes can include adoption, particularly (though not solely) by foreigners. In addition to the Optional Protocol on the sale of children, child prostitution and child pornography, the 1993 Hague Convention on Protection of Children and Cooperation in Respect of Intercountry Adoption provides a framework and mechanism for preventing abuses in this sphere, and the Committee has therefore always consistently and strongly urged all States parties that recognize and/or permit adoption to ratify or accede to this treaty. Universal birth registration, in addition to international cooperation, can help to combat this violation of rights;

(i) Deviant behaviour and lawbreaking (art. 40). Under no circumstances should young children (defined as under 8 years old; see paragraph 4) be included in legal definitions of minimum age of criminal responsibility. Young children who misbehave or violate laws require sympathetic help and understanding, with the goal of increasing their capacities for personal control, social empathy and conflict resolution. States parties should ensure that parents/caregivers are provided adequate support and training to fulfil their responsibilities (art. 18) and that young children have access to quality Early Childhood Education and care, and (where appropriate) specialist guidance/therapies.

37. In each of these circumstances, and in the case of all other forms of exploitation (art. 36), the Committee urges States parties to incorporate the particular situation of young children into all legislation, policies and interventions to promote physical and psychological recovery and social reintegration within an environment that promotes dignity and self-respect (art. 39).

VII. CAPACITY-BUILDING FOR EARLY CHILDHOOD

38. Resource allocation for early childhood. In order to ensure that young children’s rights are fully realized during this crucial phase of their lives (and bearing in mind the impact of early childhood experiences on their long-term prospects), States parties are urged to adopt comprehensive, strategic and time-bound plans for early childhood within a rights-based framework. This requires an increase in human and financial resource allocations for early childhood services and programmes (art. 4). The Committee acknowledges that States parties implementing child rights in early childhood do so from very different starting points, in terms of existing infrastructures for early childhood policies, services and professional training, as well as levels of resources potentially available to allocate to early childhood. The Committee also acknowledges that States parties may be faced with competing priorities to implement rights throughout childhood, for example where universal health services and primary education have still not been achieved. It is nonetheless important that there be sufficient public investment in services, infrastructure and overall resources specifically allocated to early childhood, for the many reasons set out in this general comment. In this connection, States parties are encouraged to develop strong and equitable partnerships between the Government, public services, non-governmental organizations, the private sector and families to finance comprehensive services in support of young children’s rights. Finally, the Committee emphasizes that where services are decentralized, this should not be to the disadvantage of young children.

39. Data collection and management. The Committee reiterates the importance of comprehensive and up-to-date quantitative and qualitative data on all aspects of early childhood for the formulation, monitoring and evaluation of progress achieved, and for assessment of the impact of policies. The Committee is aware that many States parties lack adequate national data collection systems on early childhood for many areas covered by the Convention, and in particular that specific and disaggregated information on children in the early years is not readily available. The Committee urges all States parties to develop a system of data collection and indicators consistent with the Convention and disaggregated by gender, age, family structure, urban and rural residence, and other relevant categories. This system should cover all children up to the age of 18 years, with specific emphasis on early childhood, particularly children belonging to vulnerable groups.
40. **Capacity-building for research in early childhood.** The Committee noted earlier in this general comment that extensive research has been carried out on aspects of children’s health, growth, and cognitive, social and cultural development, on the influence of both positive and negative factors on their well-being, and on the potential impact of early childhood care and education programmes. Increasingly, research is also being carried out on early childhood from a human rights perspective, notably on ways that children’s participatory rights can be respected, including through their participation in the research process. Theory and evidence from early childhood research has a great deal to offer in the development of policies and practices, as well as in the monitoring and evaluation of initiatives and the education and training of all responsible for the well-being of young children. But the Committee also draws attention to the limitations of current research, through its focus mainly on early childhood in a limited range of contexts and regions of the world. As part of planning for early childhood, the Committee encourages States parties to develop national and local capacities for early childhood research, especially from a rights-based perspective.

41. **Training for rights in early childhood.** Knowledge and expertise about early childhood are not static but change over time. This is due variously to social trends impacting on the lives of young children, their parents and other caregivers, changing policies and priorities for their care and education, innovations in childcare, curricula and pedagogy, as well as the emergence of new research. Implementing child rights in early childhood sets challenges for all those responsible for children, as well as for children themselves as they gain an understanding of their role in their families, schools and communities. States parties are encouraged to undertake systematic child rights training for children and their parents, as well as for all professionals working for and with children, in particular parliamentarians, judges, magistrates, lawyers, law enforcement officials, civil servants, personnel in institutions and places of detention for children, teachers, health personnel, social workers and local leaders. Furthermore, the Committee urges States parties to conduct awareness-raising campaigns for the public at large.

42. **International assistance.** Acknowledging the resource constraints affecting many States parties seeking to implement the comprehensive provisions outlined in this general comment, the Committee recommends that donor institutions, including the World Bank, other United Nations bodies and bilateral donors support early childhood development programmes financially and technically, and that it be one of their main targets in assisting sustainable development in countries receiving international assistance. Effective international cooperation can also strengthen capacity-building for early childhood, in terms of policy development, programme development, research and professional training.

43. **Looking forward.** The Committee urges all States parties, inter-governmental organizations, non-governmental organizations, academics, professional groups and grass-roots communities to continue advocating for the establishment of independent institutions on children’s rights and foster continuous, high-level policy dialogues and research on the crucial importance of quality in early childhood, including dialogues at international, national, regional and local levels.

**Notes**


Committee on the Rights of the Child
Fifty-ninth session
16 January–3 February 2012
Consideration of reports submitted by States parties under article 44 of the Convention
Concluding observations: Myanmar

1. The Committee considered the combined third and fourth periodic report of Myanmar (CRC/C/MMR/3-4) at its 1675th and 1676th meetings (see CRC/C/SR.1675 and CRC/C/SR.1676) held on 19 January 2012, and adopted, at its 1697th meeting, held on 3 February 2012, the following concluding observations.

I. Introduction
2. The Committee welcomes the submission of the combined third and fourth periodic report of the State party (CRC/C/MMR/3-4) and the written replies to its list of issues (CRC/C/MMR/Q/3-4/Add.1). The Committee appreciates the constructive dialogue held with a cross-sectoral delegation of the State party.

II. Follow-up measures undertaken and progress achieved by the State party
3. The Committee notes as positive the adoption of the Anti-Trafficking in Persons Law in 2005.
4. The Committee also welcomes the ratification of or accession to the following international human rights treaties:
   (a) Optional Protocol to the Convention of the Rights of the Child on the sale of children, child prostitution and child pornography, in 2012;
   (b) Convention on the Rights of Persons with Disabilities, in 2011; and (c) Charter of the Association of the Southeast Asian Nations (ASEAN), in 2008.
5. The Committee also notes the following institutional and policy measures:
   (a) The establishment of the Central Body for Suppression of Trafficking in Persons in 2006;
   (b) The establishment of a mechanism by which the National Committee on the Rights of the Child can pursue complaints on acts committed against children; and (c) The development of the National Plan of Action for Children (2006–2015), the National Child Health Strategic Plan (2010–2014), the National Plan of Action for Children (2006–2015), the National Child Health Strategic Plan (2010–2014), the National Plan of Action to Combat Human Trafficking (2007–2011), and the plan to organize a special police force for child protection.
6. The Committee notes as positive the invitation by the State party to the Special Rapporteur on the situation of human rights in Myanmar in 2010 and 2011.

III. Main areas of concerns and recommendations
A. General measures of implementation (arts. 4, 42 and 44, para. 6 of the Convention)
   The Committee’s previous recommendations
7. The Committee, while welcoming the State party’s efforts to address some of the concerns and recommendations made upon consideration of the State party’s second report (CRC/C/15/Add.237), notes with regret that most of its recommendations have been insufficiently addressed or not addressed at all.
8. The Committee urges the State party to take all necessary measures to address the recommendations from the concluding observations of the second periodic report that have not been implemented, particularly those related to children involved in armed conflicts, discrimination and access to health and education. The Committee also urges the State party to, concomitantly, provide adequate follow-up to the recommendations contained in the present concluding observations.

Legislation
9. While noting the indication given by the State party that the 1993 Child Law is being reviewed to integrate some provisions of the Convention, the Committee is concerned that all principles and provisions of the Convention have not yet been fully incorporated into domestic law and that legal provisions contrary to the Convention remain in force. The Committee also expresses its concern about the application of different sources of law, namely codified and customary laws, which may undermine the State party’s efforts to harmonize its legislation with the Convention.

10. The Committee urges the State party to promptly amend the 1993 Child Law and ensure that it incorporates all principles and provisions of the Convention and undertake a comprehensive review of domestic legislation, namely codified and customary laws, in order to ensure that it is brought into compliance with the Convention.

Coordination

11. While noting that the National Committee on the Rights of the Child (NCRC), inactive for a long period, was reactivated recently, the Committee is concerned about its sustainability, its mandate and the resources allocated to its functioning. Furthermore, the Committee is concerned about the lack of collaboration between the different ministries involved in the implementation of activities related to the Convention, which is not yet in place in all states, divisions and districts; and about the small number of operational bodies established at township level.

12. The Committee urges the State party to ensure that NCRC is operational on a sustainable basis and reiterates its recommendation to provide NCRC with the necessary authority and resources to coordinate all activities related to the implementation of the Convention, in an effective manner, both horizontally across ministries and vertically, from the national level down to the divisions, districts and townships.

National Plan of Action

13. While noting the existence of a national strategy expressed in the National Plan of Action for Children (2006–2015), the Committee is concerned that the various existing sectoral plans of action related to children, such as the National Child Health Strategic Plan (2010–2014), the National Strategic Plan for Adolescent Health, and the National Plan of Action (2003–2015) “Education for all”, are not sufficiently coordinated with the National Plan of Action for Children. The Committee is also concerned about reports that the National Plan of Action for Children has not been sufficiently disseminated, that limited human and financial resources are allocated to implement it and that there is no proper mechanism to monitor its implementation.

14. The Committee recommends that the State party take all necessary measures to ensure that the National Plan of Action for children coordinates the various sectoral action plans covering all aspects of the Convention. The Committee also recommends that the National Plan of Action for children be appropriately resourced in human, technical and financial terms. It further recommends that the systems for implementation and monitoring of the plan be put in place.

Independent monitoring

15. The Committee notes the establishment in October 2011 of the National Human Rights Commission, which comprises a special division for children’s rights. However, the Committee is concerned about:

(a) The absence of a law establishing the Commission;
(b) The status of the members of the Commission, who are Government and former Government officials;
(c) The current financial resources of the Commission that do not ensure its independence and efficiency; and
(d) The lack of visibility of the special division for children’s rights.

16. The Committee encourages the State party to:

(a) Adopt a law establishing an independent human rights institution with a status and a mandate in compliance with the Principles relating to the status of national institutions for the promotion and protection of human rights (Paris Principles), taking into account the Committee’s general comment No. 2 (2002) on the role of independent national human rights institutions in the promotion and protection of the rights of the child;
(b) Seek technical assistance from, inter alia, OHCHR National Institutions and Regional Mechanisms Section in this respect;
(c) Ensure that this national mechanism is provided with independent and sufficient human, technical and financial resources; and
(d) Ensure that the independent human rights institution has a special division for children’s rights headed by a commissioner for children in order to make this institution’s role regarding the Convention as visible and as strong as possible.

Allocation of resources
17. The Committee reiterates its deep concern about the extremely low level of resources allocated to the social sectors, in particular education, health and nutrition, at the severe lack of financial resources for the protection and promotion of children’s rights, and conversely at the disproportionately high allocation of public financial resources to the military and State-owned enterprises. Furthermore, the Committee is concerned about the absence of transparency in the budgetary process.
18. In the light of its previous recommendation (CRC/C/15/Add.237, para. 20), the Committee urges the State party to:
(a) Allocate adequate budgetary resources in accordance with article 4 of the Convention for the implementation of the rights of children and in particular increase the budget allocated to the social sectors, including, but not exclusively, education, health and nutrition, and to all areas of child rights;
(b) Introduce a child right’s budget system with specific budget lines and indicators that will allow monitoring and evaluating budget allocations for children;
(c) Define strategic budgetary lines for children in disadvantaged or vulnerable situations that may require affirmative social measures, especially children from ethnic and religious minority groups, children from remote and border areas, internally displaced children, children in street situations, children affected by HIV/AIDS, children with disabilities, orphans and children in situation of poverty, and make sure that those budgetary lines are protected even in situations of economic crisis, natural disasters or other emergencies;
(d) Ensure transparent and participatory budgeting through public dialogue, especially with children and the civil society; and
(e) Take into account the Committee’s recommendations during its day of general discussion in 2007 on “Resources for the Rights of the Child – Responsibility of States”.

Corruption
19. The Committee is concerned that corruption remains pervasive in the State party and that misuse of public resources continues to divert resources that could enhance the implementation of the rights of the child.
20. The Committee urges the State party to take immediate measures to combat corruption, including by developing and implementing an anti-corruption law and policy, carrying out anti-corruption campaigns and building institutional capacities to effectively detect, investigate and prosecute cases of corruption.

Child rights and the business sector
21. While noting aspects of the State party’s legislation regarding labour standards, the Committee notes the absence of a legislative framework regulating the prevention of, protection against and reparation of the adverse impacts of activities by private and State-owned companies, mainly in the extractive and large-scale energy-related sectors. The Committee is especially concerned at the effects of child labour, particularly forced and hazardous labour, living conditions of children, environment degradation, health hazards and barriers to their freedom of movement.
22. The Committee urges the State party to:
(a) Establish the necessary regulatory framework and policies for business and industry, in particular with regard to extractive industry (oil and gas) and large-scale development projects such as dams and pipelines, to ensure that they respect and protect the rights of children; and
(b) Comply with international and domestic standards on corporate social and environmental responsibility with a view to protecting local communities, particularly children, from any adverse effects resulting from business operations, in line with the Guiding Principles on Business and Human Rights: Implementing the United Nations “Protect, Respect and Remedy” Framework and the business and human rights framework that were adopted by the Human Rights Council in 2008 and 2011, respectively.

Data collection
23. While noting some initiatives by the State party to improve interdepartmental information systems and progress made in collecting national level data on the socioeconomic situation and health and education status of the child population, the Committee is concerned at the lack of methodological
coherence in the undertaking of data collection and the absence of disaggregated data on areas covered by the Convention.

24. The Committee encourages the State party to set up a comprehensive data collection system with the support of its partners and to analyse the data collected as a basis for assessing progress achieved in the realization of child rights and for helping design policies and programmes to implement the Convention. The data should be disaggregated by age, sex, geographic location, ethnicity and socio-economic background to facilitate analysis on the situation of children. The Committee also recommends prioritizing capacity development of institutions at the national and subnational levels to be able to design, conduct, analyse and use evidence to monitor, evaluate and influence policies and programmes.

Dissemination and awareness-raising

25. While noting that awareness-raising and training workshops have been conducted and copies of the Convention have been disseminated, the Committee is concerned that the outreach of awareness-raising on the Convention and human rights remains in general limited. The Committee is further concerned about the absence of a system to ensure that the Convention is widely known.

26. The Committee urges the State party to:
(a) Systematically incorporate child rights issues into all curricula of the different education levels and strengthen awareness-raising programmes, including campaigns on the Convention, among children, adolescents, families and communities; and
(b) Develop a national plan of action for human rights education, as recommended in the framework of the World Programme for Human Rights Education.

Training

27. The Committee is concerned that awareness of the Convention remains limited among service providers working with and for children, including in the education, health, social welfare, justice and security sectors, juvenile facilities and in all forms of alternative care.

28. The Committee recommends that all professional groups working for and with children be adequately and systematically trained on children’s rights, in particular judges, lawyers, the police and the army, health personnel, social workers, teachers and personnel working in all forms of alternative care.

Cooperation with civil society

29. While noting the recent progress made in cooperation with the civil society, the Committee is concerned that civil society participation, and in particular children’s participation, remains limited in the formulation of policies and programmes. The Committee is also concerned that insufficient efforts have been made to involve civil society in the implementation of the Convention and that a high level of distrust between civil society and the Government remains. In addition, the Committee expresses its concern about reports that individuals and organizations are punished for carrying out human rights education and engaging with the international human rights mechanisms.

30. The Committee strongly urges the State party to:
(a) Facilitate the participation of civil society organizations and children in all aspects of implementation of the Convention, including policy and programme development, monitoring and evaluation;
(b) Take concrete steps to give legitimate recognition to human rights defenders and their work and to facilitate that work, including those defenders who report child rights violations for appropriate State party action and ensure that nongovernmental organizations (NGOs) can safely carry out their functions, including in remote and border areas, in a manner consistent with the principles of a democratic society; and
(c) Promptly put an end to the repression of human rights defenders, including those carrying out human rights education and ensure that no one is detained in relation to their legitimate and peaceful activities in defence of human rights.

International cooperation

31. Notwithstanding recent positive political developments in the State party, the Committee remains concerned that limited international assistance for the realization of child rights has been provided as a result of, among others, the lack of improvement of the human rights situation in the country.

32. The Committee encourages the State party to make all necessary efforts to improve the human rights situation in the country, including using its resources to the greatest extent for the realization of child rights, thus providing the basis for increased international cooperation.

B. Definition of the child (art. 1 of the Convention)
33. While noting the existence of a draft amendment to the Child Law raising the age of a child, the Committee is concerned about the current distinction between a child (up to the age of 16 years) and a youth (between 16 and 18 years); the absence of a minimum age for marriage for boys; and the legality of the marriage of girls as young as 14 years with parental consent.

34. The Committee reiterates its previous recommendation (CRC/C/15/Add.237, para. 26) that the State party review its legislation to define the child as any person below 18 years of age and establish the minimum legal age for marriage for boys and girls at 18 years.

C. General principles (arts. 2, 3, 6 and 12 of the Convention)

Non-discrimination

35. The Committee reiterates its concern (CRC/C/15/Add.237 para. 27) about the multiple forms of discrimination that persist in the State party, particularly those against girls and children in vulnerable and disadvantaged situations, such as children from ethnic and religious minority groups (including Rohingya children), children from remote and border areas, internally displaced children, children in street situations, children affected by HIV/AIDS, children with disabilities, orphans and children in situation of poverty.

36. The Committee urges the State party to:
(a) Undertake the necessary legislative changes to ensure nondiscrimination on the basis of sex, ethnicity or religion and explicitly incorporate the principle of non-discrimination on any grounds in all newly developed legislation and policies;
(b) Adopt and implement measures to prevent and eliminate discrimination against individual children and specific groups of disadvantaged children;
(c) Carry out public awareness-raising campaigns on the detrimental impacts of discrimination; and
(d) Include information in its next periodic report on measures and programmes relevant to the Declaration and Programme of Action adopted at the 2001 World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance, as well as the outcome document adopted at the 2009 Durban Review Conference.

Best interests of the child

37. While noting that the principle of the best interests of the child is mentioned in article 27 of the Child Law, the Committee is concerned that the knowledge of this principle remains insufficient and no action has been taken by the State party to include it in any other legislation or budgets, or to ensure that it is sufficiently applied in the judicial and administrative decisions.

38. The Committee urges the State party to strengthen its efforts to ensure that the principle of the best interests of the child is appropriately integrated and consistently applied in all legislative, administrative and judicial proceedings and all policies, programmes and projects relevant to and with an impact on children. The legal reasoning of all judicial and administrative judgments and decisions should also be based on this principle.

Respect for the views of the child

39. The Committee reiterates its concern (CRC/C/15/Add.237, para. 32) that traditional attitudes towards children in society continue to limit respect for their views and that the State party has not taken sufficient measures to ensure that the views of the child are given due consideration, especially in courts, schools, relevant administrative and other processes and within the family, other institutions and society at large.

40. In the light of article 12 of the Convention and the Committee’s general comment No. 12 (2009) on the right of the child to be heard and of its previous recommendation (CRC/C/15/Add.237, para. 33), the Committee encourages the State party to ensure that children’s views are given due consideration in courts, schools, relevant administrative and other processes and in the home, other institutions and society at large in all matters concerning them. This may be achieved through, inter alia, the adoption of appropriate legislation, the training of professionals working with and for children and educational information and communication strategies intended to, inter alia, parents, educators, Government administrative officials, the judiciary and society at large on children’s right to have their views taken into account and to be heard in all matters affecting them.

D. Civil rights and freedoms (arts. 7, 8, 13-17, 19 and 37 (a) of the Convention)
Nationality
41. The Committee is concerned about:
   (a) The large number of people without citizenship and the lack of legislation relating nationality to children born in the territory of the State party or to nationals of the State party living abroad, who would otherwise be stateless;
   (b) The very restricted requirement of having both parents as nationals of the country for citizenship, which will render some people stateless;
   (c) The three different categories of citizenship established by the Citizenship Law of 1982, possibly resulting in some categories of children and their parents being discriminated against, stigmatized and/or denied certain rights; and
   (d) The mention of religion and ethnic origin on the identity card.
42. The Committee recommends that the State party:
   (a) Address gaps in the current citizenship legislation, which lead to statelessness;
   (b) Accede to the 1954 Convention relating to the Status of Stateless Persons and the 1961 Convention on the Reduction of Statelessness;
   (c) Abrogate the legal provisions providing for different categories of citizenship; and
   (d) Remove any indication of ethnic origin on identity cards.

Birth registration
43. The Committee notes the establishment of a birth registration system called Modified Vital Registration System; the engagement of the State party to carry out advocacy and awareness for birth registration; the review of the status of a large number of children born of parents who were unable to obtain marriage authorization in the northern Rakhine State, with a view to regularization; and the plan to conduct a nationwide population census in 2014. However, the Committee is concerned that a large number of children, including Rohingya children, remains unregistered as a result of insufficient awareness-raising on the importance of birth registration; a non-user-friendly system; a lengthy process to obtain birth certificates at the township level; unofficial fees associated with the birth registration system; the existence of the local order restricting marriages for Rohingya people; and the practice aimed at reducing the number of their children.
44. The Committee recommends that the State party:
   (a) Strengthen its efforts to ensure effective registration of all children born in the State party, regardless of their origin and without any discrimination;
   (b) Implement special measures for improving the birth registration system, greater access to registry services and sensitization and training for registry officials, with a view to ensuring that all children, including children born in remote areas, and displaced and stateless children, especially Rohingya children, are duly registered at birth and provided with birth certificates and identity cards;
   (c) Develop a plan to provide birth registration to all children up to 18 years of age who have not yet been registered;
   (d) Remove practical restrictions to ensure that all children are registered at birth without discrimination; and
   (e) Abolish the local order restricting marriages for Rohingya people and cease practices which restrict the number of children of Rohingya people.

Freedom of thought, conscience and religion
45. The Committee is concerned that the right of the child to freedom of thought, conscience and religion, although provided by the Child Law, is not respected or protected in practice. The Committee is further concerned about reports that some children are placed in Buddhist monasteries and converted to Buddhism without their parents’ knowledge or consent and that the Government seeks to induce members of the Naga ethnic group, including children, in Sagaing Division to convert to Buddhism.
46. In the light of article 14 of the Convention, the Committee urges the State party to ensure full respect for the right to freedom of thought, conscience and religion for all children. The Committee recommends that the State party cease placing children in Buddhist monasteries and converting them to Buddhism without their parents’ knowledge or consent, and inducing members of the Naga ethnic group, including children, to convert to Buddhism.

Freedom of expression, association and peaceful assembly
47. While welcoming the release of political prisoners, the Committee is concerned about reports that children were kept political prisoners. The Committee is further concerned that the rights to freedom of expression and association, which also affect children, are severely limited in practice and that little
space has been created for children to assemble or form associations outside the framework of Government-controlled NGOs.

48. The Committee urges the State party to:
(a) Ensure that no child is made a political prisoner;
(b) Ensure the full implementation of the rights to freedom of expression and freedom of association and peaceful assembly, in accordance with articles 13, 15 and 17 of the Convention; and
(c) Take measures to encourage children to form associations on their own initiatives outside the framework of Government-controlled NGOs.

Access to appropriate information

49. While noting the recent steps taken to lift censorship, the Committee is concerned about the very limited access of children to internet, new technologies and appropriate information. The Committee is further concerned that young people continue to be prevented from freely accessing information and communicating with others.

50. The Committee recommends that the State party improve children’s access to information, inter alia by providing greater access to newspapers, libraries, radio, television and Internet, and to ensure that children are protected from harmful information. The Committee also urges the State party to ensure that children have the right to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, through any media of the child’s choice.

Torture or other cruel, inhuman or degrading treatment or punishment

51. The Committee is deeply concerned about reported cases of torture of children political prisoners, and cases of children victims of cruel, inhuman or degrading treatment or punishment when arrested.

52. In the light of article 37 (a) of the Convention, the Committee urges the State party to:
(a) Take all necessary measures to prevent, prohibit and protect children from all forms of torture or other cruel, inhuman and degrading treatment or punishment in all settings;
(b) Ensure prompt, independent and effective investigation of all alleged cases of torture or ill-treatment of children and, as appropriate, prosecute offenders;
(c) Provide care, recovery, compensation and rehabilitation for victims; and
(d) Ratify the Optional Protocol to the Convention against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment.

Corporal punishment

53. While noting the legal provisions prohibiting corporal punishment in schools and welcoming the ongoing discussion in the State party with a view to prohibiting corporal punishment in all settings, the Committee is concerned that corporal punishment is still lawful within the family and in alternative care settings and is a disciplinary measure in prisons, including for children under 16 years of age.

54. With reference to the Committee’s general Comment No. 8 (2006) on the right of the child to protection from corporal punishment and other cruel or degrading forms of punishment, the Committee recalls its previous concluding observations (CRC/C/15/Add.237) and urges the State party to:
(a) Ensure that legal provisions prohibiting corporal punishment in school are effectively implemented and that legal proceedings are systematically initiated against those responsible for ill-treating children;
(b) Withdraw provisions of the Child Law and the Penal Code authorizing corporal punishment and prohibit unequivocally by law and without any further delay corporal punishment in all settings, including the family, penal institutions, and alternative care settings;
(c) Strengthen sustained public education, awareness-raising and social mobilization programmes involving children, families, communities and religious leaders on both the physical and psychological harmful effects of corporal punishment with a view to changing the general attitude towards this practice and promote positive, non-violent and participatory forms of child-rearing and discipline as an alternative to corporal punishment; and
(d) Ensure the involvement and participation of the whole society, including children, in the design and implementation of preventive strategies against violence and other forms of abuse.

E. Family environment and alternative care (arts. 5, 18 (paras. 1-2), 9-11, 19-21, 25, 27 (para. 4) and 39 of the Convention)
Children deprived of a family environment
55. While noting that the Department of Social Welfare developed Minimum Standards on Care and Protection of Children in Residential Care (2008), the Committee expresses its concern about the increase in the number of children in residential care facilities; the lack of regulation of private and religious organizations that run residential institutions for children; and reports of physical abuse of children in residential institutions.

56. The Committee recommends that the State party:
(a) Develop a strategy for the deinstitutionalization of children with a clear time frame and budget, which includes the reintegration of children with their families, as far as possible, while taking into account the best interests and the views of the child;
(b) Ensure that all residential institutions for children that are run by private and religious organizations are registered and officially authorized to exert as alternative care institutions;
(c) Develop clear guidelines in order to ensure that children’s rights are respected throughout the entire process of placement in alternative care, with priority given to family-type and community-based measures; in doing so take into account the Guidelines for the Alternative Care of Children;
(d) Ensure systematic periodic review of the quality of care and regular training, including in child rights, of its relevant professionals; and
(e) Establish mechanisms for receiving complaints, investigations and prosecutions for child abuse in alternative care settings and ensure that victims of abuse have access to complaints procedures, counselling, medical care and other recovery assistance as appropriate.

Adoption
57. The Committee is concerned that adoption is regulated by different sources of law, namely codified and customary laws, which may undermine the State party’s efforts to ensure that provisions on adoption conform fully to the principles and provisions of the Convention. The Committee is particularly concerned about the lack of application of the Child Law provisions on adoption and the different forms of customary adoption under the 1939 Registration of Kittima Adoptions Act, which only applies to Myanmar Buddhists. The Committee is further concerned about the absence of a thorough agreed monitoring system of adoptions.

58. The Committee reiterates its recommendation (CRC/C/15/Add. 237, para. 47) that the State party undertake a review of its system of adoption with a view to ensuring that existing legislation on adoption, namely the 1993 Child Law and the 1939 Registration of Kittima Adoptions Act, is brought into compliance with the Convention. The Committee further recommends that the State party set up a monitoring mechanism to ensure that adoption procedures are in accordance with the Convention and are rigorously monitored, and that records are kept. The Committee also recommends that the State party ratify the 1993 Hague Convention on Protection of Children and Cooperation in respect of Intercountry Adoption.

Violence against children, including abuse and neglect
59. While noting that the 1993 Child Law contains various provisions on violence against children, the Committee remains concerned about the widespread violence against and abuse of children, and reiterates its concern (CRC/C/15/Add.237, para. 48) at the lack of appropriate measures, mechanisms and resources to prevent and combat domestic violence, including physical and sexual abuse and the neglect of children; the limited access to services for abused children; and the lack of data on the aforementioned.

60. The Committee recommends that the State party, taking into account the Committee’s general comment No. 13 (2011) on the right of the child to freedom from all forms of violence:
(a) Prioritize the elimination of all forms of violence against children, including by ensuring the implementation of the recommendations of the United Nations study on violence against children (A/61/299), taking into account the outcome and recommendations of the Regional Consultations for South Asia (held in Islamabad, 19-20 May 2005), and paying particular attention to gender aspects;
(b) Provide information concerning the implementation by the State party of the recommendations of the above-mentioned study in its next periodic report, particularly those highlighted by the Special Representative of the Secretary-General on violence against children, namely:
(i) The development in each State of a national comprehensive strategy to prevent and address all forms of violence against children;
(ii) The introduction of an explicit national legal ban on all forms of violence against children in all settings; and
(iii) The consolidation of a national system of data collection, analysis and dissemination, and a research agenda on violence against children;
(c) Ensure that administrative measures reflect Government obligations to establish policies, programmes, monitoring and oversight systems required to protect the child from all forms of violence; and
(d) Cooperate with the Special Representative of the Secretary-General on violence against children and seek technical assistance, inter alia, from the United Nations Children’s Fund (UNICEF), the Office of the United Nations High Commissioner for Human Rights (OHCHR), the World Health Organization (WHO), the International Labour Office (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the Office of the United Nations High Commissioner for Refugees (UNHCR), the United Nations Office on Drugs and Crime (UNODC), and NGO partners.

F. Disability, basic health and welfare (arts. 6, 18 (para. 3), 23, 24, 26, 27 (paras. 1-3) of the Convention)

Children with disabilities
61. The Committee notes with appreciation that the State party ratified the Convention on the Rights of Persons with Disabilities; conducted the National Disability Survey in 2010; completed the National Plan of Action for Persons with Disabilities 2010–2012; and is drafting a law to protect the rights of persons with disability. However, the Committee is concerned about remaining widespread stigma and discrimination against persons with disabilities, the lack of dissemination of the findings of the National Disability Survey; and the lack of adequate resources for the implementation of the National Plan of Action for Persons with Disabilities. The Committee is also concerned that efforts made by the State party to facilitate the inclusion of children with disabilities into the educational system and society at large are insufficient, especially in rural and remote areas, and that only children with mild impairment in sight, hearing and speaking, particularly those living in cities, are included in inclusive education programmes.

62. The Committee recommends that the State party, taking into account the general comment No. 9 (2006) on the rights of children with disabilities, continue to strengthen measures to protect and promote the rights of children with disabilities. The Committee recommends in particular that the State party:
(a) Widely disseminate the findings of the survey and the National Plan of Action for Persons with disabilities to raise public awareness, and include children with disability in these awareness-raising and social change interventions to address widespread stigma and discrimination;
(b) Undertake greater efforts to make available financial resources for the implementation of the National Plan of Action for Persons with Disabilities 2010–2012, especially at the local level;
(c) Pursue efforts to ensure that all children with disabilities exercise their right to education and allocate sufficient resources in order to integrate them, as much as possible, into a system of inclusive education in regular schools; and
(d) Consider ratifying the Optional Protocol to the Convention on the Rights of Persons with Disabilities.

Health and health services
63. The Committee notes that the State party has developed the National Child Health Strategic Plan 2010–2014 and the National Reproductive Health Strategic Plan 2009–2013 and that the maternal mortality rate has declined. However, the Committee remains deeply concerned about the low percentage of the gross domestic product (GDP) spent on health and the lack of human and financial resources for and accessibility to health services, particularly in remote areas. The Committee is further concerned about the high prevalence of preventable common illnesses, such as acute respiratory infections, pneumonia, diarrhoea and malaria; the high under-5 mortality and infant mortality rates; the high number of children chronically malnourished; and the high prevalence of underweight and stunted children under 5 years. The Committee is further concerned that only 15 per cent of infants are exclusively breastfed.

64. The Committee urges the State party to:
(a) Increase the allocation of financial and human resources to the health sector, and in particular:
(i) Allocate adequate resources to fully implement the Health Strategic Plan 2010–2014, in particular with regard to maternal and newborn care and treatment of common illnesses such as acute respiratory infections, pneumonia, diarrhoea and malaria to further reduce infant and child mortality, and (ii) Increase resources for reproductive health, including access to emergency obstetric care;
(b) Strengthen its efforts to reduce infant, child and maternal mortality;
(c) Strengthen its programmes to reduce and eventually eliminate child malnutrition;
(d) Take appropriate steps to ensure free and equal access to primary health care in all areas of its territory, including in remote areas;
(e) Improve access to safe drinking water and sanitation; and
(f) Strengthen its efforts to promote exclusive breastfeeding until 6 months of age by raising the awareness of health personnel and the public of the importance of exclusive breastfeeding.

Adolescent health
65. While welcoming the development of a National Strategic Plan for Adolescent Health, the Committee is concerned about the general lack of knowledge among adolescents of sexual and reproductive health, which has an impact on the number of early pregnancies and abortions among girls below the age of 18. The Committee is further concerned about the limited access by adolescents to contraceptives.
66. Referring to its general comment No. 4 (2003) on adolescent health and development in the context of the Convention, the Committee recommends that the State party raise awareness among adolescents about sexual and reproductive health and the negative impact of early pregnancies and abortion, and provide access to contraceptives.

HIV/AIDS
67. The Committee notes the relatively low HIV infection rate and welcomes the fact that the new national Strategic Plan on HIV/AIDS (2011–2015) includes a strategic priority for orphans and vulnerable children infected and affected by HIV. However, the Committee remains concerned that children are still largely absent from the HIV control programme agenda and by the low antiretroviral therapy availability to children and mothers in need.
68. In the light of its general comment No. 3 (2003) on HIV/AIDS and the rights of the child, the Committee recommends that the State party:
(a) Increase its efforts to prevent the spread of HIV/AIDS, with an emphasis on prevention among young people, provide protection and support for orphans and vulnerable children, and ensure universal and cost-free access to antiretroviral therapy;
(b) Undertake studies and systematic data collection to control the spread of HIV; and
(c) Seek technical assistance from, inter alia, the United Nations Joint Programme on HIV/AIDS (UNAIDS) and UNICEF.

Standard of living
69. While noting the development of the Poverty Alleviation Plan for 2011–2015, the Committee is concerned about the persistently high rate of poverty among children and the lack of information received on the resources allocated to implement this plan. The Committee is further concerned about the significant income disparities between urban and rural areas, which affect the standard of living of children, as well as regional disparities in poverty which result, for example, in the Eastern Shan State having 20 per cent and the Chin State having 40 per cent, respectively, food poverty compared to the national average of 10 per cent. In addition, the Committee expresses concern about serious gaps in the supply of safe drinking water, especially in schools and rural areas, and inadequate sanitation facilities, which affect the health of and the ability to retain children in school.
70. The Committee recommends that the State party:
(a) Ensure that adequate resources are allocated to the fight against poverty, especially child poverty, including by increasing resources to the most disadvantaged families and areas;
(b) Take necessary measures to improve the standard of living for all children within its territory, with particular focus on remote and border areas, and address income disparities between urban and rural areas, which also affect children;
(c) Study and address the root causes of child poverty; and
(d) Develop and implement policies relating to safe drinking water and sanitation, especially in rural areas, and ensure that children in schools have equitable access.

Children in prison with their mothers
71. The Committee is deeply concerned that children detained in jails and prisons with their mothers are denied adequate health care and nutritious food, and their mothers are often denied assistance during childbirth. The Committee is also concerned about the absence, for these children, of everyday stimuli and educational material, which hampers their social and emotional development. The Committee is further concerned about numerous cases of lack of contact between detainees and their families, including their children.
72. The Committee urges the State party to ensure that:
(a) Detained children are provided with enough food and access to health and education services;
(b) The living conditions in detention meet the needs of the children, including access to water and sanitation facilities and access to education, and are compatible with the rights under the Convention; and
(c) Detainees are allowed to see their children on a regular basis.

G. Education, leisure and cultural activities (arts. 28, 29 and 31 of the Convention)

Early childhood development
73. While noting that the National Plan of Action “Education for All” contains a strategy for children aged 0–5 to develop to their fullest potential, the Committee is concerned about the absence of a budget for early childhood development activities and well-planned and comprehensive early childhood care and development programmes.
74. The Committee draws the attention of the State party to the Committee’s general comment No. 7 (2005) on implementing child rights in early childhood and recommends that the State party allocate adequate human, technical and financial resources to the implementation of a policy on early childhood care and development that will lay a solid foundation for the educational development of the children of Myanmar. This policy should involve the parents and include health, nutrition, education and emotional development of children from 0 to school age.

Education, including vocational training and guidance
75. While noting the statement of the delegation that resources allocated to education will increase, the existence of a National Plan of Action (2003–2015) “Education for All”, the Education Activities in the Framework of the Rural Development and Poverty Alleviation Plan (2011–2015) and the construction of schools in the framework of the border-area development programme, the Committee remains concerned about:
(a) The allocation of only 0.9 per cent of GDP on education, which meets only a fraction of the overall costs;
(b) The absence of a ministry in charge of education;
(c) The limited length of compulsory education, which ends at fifth grade;
(d) The low primary school enrolment, the high repetition and dropout rates in the educational system at a very early stage and the disparity in access to education in different states and divisions;
(e) The payment by the families of indirect costs despite the provision for a “fee-free” entitlement and the low salary of teachers;
(f) The shortage of teachers and schools, especially in rural areas and regions affected by armed conflict; and
(g) The absence of teaching in other languages than Myanmar.
76. The Committee recommends that the State party, taking into account the general comment No. 1 (2001) on the aims of education:
(a) Increase the budget allocated to education to reflect regional and international standards;
(b) Ensure leadership in the governance of the education sector, notably by establishing a ministry of education that is well-funded, decentralized and not bureaucratic;
(c) Extend compulsory education to 16 years of age and take all the necessary measures to ensure that children enrol in and complete primary and secondary school, including children living in remote and border areas;
(d) Ensure that primary education is free for all without secondary costs;
(e) Enable teachers to teach by paying them reasonable salaries and provide good-quality teaching and learning materials through a thorough review and reform of the curricula and pedagogy methods involving professional experts in education;  
(f) Increase the number of schools, particularly in remote areas; and  
(g) Adapt the school curriculum to suit the particular situation of the local communities, make use of local teachers to help children who are experiencing language difficulties and revise the language-instruction policy to reflect international standards regarding cultural rights.

H. Special protection measures (arts. 22, 30, 32–36, 38–40 and 37 (b)-(d) of the Convention)

Internally displaced children
77. The Committee is deeply concerned about children and their families obliged to flee conflict-affected areas and also expresses its concern about the negative impact on children of forced evictions of families from their homes for the purpose of extractive industry and large-scale development projects.

78. The Committee urges the State party to:
(a) Acknowledge and address the issues of internally displaced persons, including children, due to conflict or forced evictions;
(b) Prevent situations which force children and their families to be displaced;
(c) Promptly put an end to forced evictions; and
(d) Take all measures to guarantee the rights and well-being of internally displaced children, including by providing access to clean water, adequate sanitation, food and shelter to the internally displaced population, and paying due attention to their needs in terms of health and education.

Children in situations of migration
79. The Committee is deeply concerned about reported serious violations of human rights committed at the borders against deported Myanmar migrants, including girls being sold to brothels or brokers and boys being conscripted; the existence of children aged 15–17 years of age within the workforce of Myanmar migrants; and the prohibition on the return of Rohingya people, including children, who fled the country.

80. The Committee strongly recommends that the State party:
(a) Take the necessary measures to eliminate human rights violations against migrant boys and girls;
(b) Implement comprehensive measures to address the root causes of migration, which include armed conflict, discrimination and deprivation of economic, social and cultural rights; and
(c) Allow Rohingya people, including children, who fled Myanmar to return to the country, and assist them in their reintegration.

Children involved in armed conflict
81. The Committee notes the efforts of the Government of Myanmar and the Committee on the Prevention of Military Recruitment of Underage Children to prevent and halt the recruitment and use of child soldiers. The Committee also notes that the State party cooperated with ILO to return underage recruits. However, the Committee is deeply concerned by:
(a) Reliable reports of the ongoing recruitment of child soldiers, both in the military and by non-State actors, and the estimates of thousands of underage soldiers;
(b) The State party’s responses, which have not reached children reported to be present in the listed non-State armed groups; and
(c) The refusal to allow the international community access to the listed non-State armed groups; and
(d) The use of forced labour of children in support of military garrisons or military operations and of non-State armed groups, in activities such as portering, sentry or guard duty and camp-security-fence construction, in particular in ethnic or religious minority regions.

82. The Committee urges the State party to:
(a) Strengthen its activities aimed at preventing the use of children in armed conflict by the military, releasing and reintegrating existing child soldiers, and extend these activities to non-State ceasefire groups;
(b) Require that a national registration card or original birth certificate be the minimum age verification criteria accepted by the Armed Forces and cease the system of offering incentives to those enlisting new recruits;
(c) Identify all children within the ranks of the Armed Forces, register and demobilize them with full family tracing, reunification and reintegration support from UNICEF and other child protection partners;
(d) Take the appropriate measures to systematize, institutionalize and strengthen disciplinary processes and/or action against those responsible for aiding and abetting the recruitment of child soldiers, in particular ensure that all persons, including senior officials, who have sponsored, planned, incited, financed or participated in military or paramilitary operations using child soldiers are prosecuted by independent and impartial courts;
(e) Facilitate contact between armed groups operating in Myanmar and the United Nations in order to prevent recruitment of children;
(f) Ensure that the protection of children in armed conflicts is included as an important aspect of any comprehensive strategy to negotiate transformation of ceasefire groups to border-guard forces or to resolve conflict with other non-State armed groups;
(g) Take immediate and effective measures to eliminate child labour in support of military garrisons and operations and of non-State armed groups, in activities such as portering, sentry or guard duty and camp-security-fence construction, in particular in ethnic or religious minority regions, and take the appropriate measures to systematize and institutionalize disciplinary processes and/or action against the military officers and civilians responsible for recruiting and using child labour;
(h) Fully implement the recommendations contained in the mission report of the Special Representative of the Secretary-General for Children and Armed Conflict of 23 April 2011; and
(i) Ratify the Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict.

Children affected by the armed conflict

83. The Committee is deeply concerned about the impact of the armed conflict on children, including that children remain at risk of being shot in open conflict areas; access to humanitarian services is obstructed in conflict-affected areas; children are killed and maimed by anti-personnel landmines and unexploded ordinance; they are displaced and live in poor economic and social situation; and schools were attacked during the many years of systematic destruction of entire villages by the military carrying out its “four cuts” policy.

84. The Committee urges the Government to take appropriate measures to:
(a) Strengthen its efforts to end the armed conflict and to ensure that the protection and promotion of children’s rights are given due consideration in any peace negotiations;
(b) Take all necessary measures to protect children against landmines, including by ending the use of landmines and carrying out mine clearance programmes, programmes for mine awareness and physical rehabilitation of child victims;
(c) Take all measures to guarantee the rights and well-being of internally displaced children;
(d) Take all possible measures to protect schools, their personnel and students in a context of conflict;
(e) Ensure that children affected by the conflict can be reintegrated into the education system, including through non-formal education programmes and by prioritizing the restoration of school buildings and facilities and provision of water, sanitation and electricity in conflict-affected areas; and

Economic exploitation, including child labour

85. While noting that a plan of action aimed at eliminating child labour has been developed, the Committee is concerned about:
(a) The widespread use of child labour in unacceptable conditions, including at an early age or in dangerous conditions, in the food-processing, street-vending, refuse collecting and light-manufacturing industries, restaurants, teashops and family agricultural activities, as well as in large-scale development projects in the extractive and energy industries;
(b) The minimum legal age for the employment of children (set at 13 years of age);
(c) The persistence of economic exploitation of children, including low wages, working the same hours as adults and being engaged in dangerous and hazardous forms of work;
(d) The lack of enforcement of the labour laws; and
(e) The absence of systematic labour inspections.

86. The Committee recalls its previous concluding observations (CRC/C/15/Add.237, para. 69) and strongly recommends that the State party:
(a) Take immediate and effective measures to eliminate child labour in unacceptable conditions, including at an early age or in dangerous conditions, in food processing, street-vending, refuse-collecting and light-manufacturing industries, restaurants, teashops and family agricultural activities, as well as in large-scale development projects;
(b) Implement effective measures to address the deep-rooted socio-economic factors that push children into the workforce;
(c) Amend legal provisions to increase the minimum age for the employment of children to 16 years;
(d) Strengthen the enforcement of labour laws and the Child Law to protect children and to ensure prosecution of those who make use of forced labour of children, and provide reparation and sanctions;
(e) Improve labour inspections to ensure that these comprehensively monitor all aspects of the work environment, including the use of child labour;
(f) Continue to seek technical assistance from the ILO International Programme on the Elimination of Child Labour in this regard;
(g) Take the appropriate measures to systematize and institutionalize disciplinary processes and/or action against the military officers and civilians responsible for recruiting and using child labour; and
(h) Ratify the ILO Conventions Nos. 138 (1973) concerning Minimum Age for Admission to Employment and 182 (1999) concerning the Prohibition and Immediate Action for the Elimination of the Worst Forms of Child Labour.

Children in street situations

87. The Committee is concerned about the lack of reliable information on the number of street children in all the townships; the limited acknowledgement by the Government of the issue of children in street situations; and the limited efforts to improve their situations and reintegrate them with their families.

88. The Committee recommends that the State party:
(a) Undertake a systematic assessment of the conditions of children in street situations in order to obtain an accurate picture of its root causes and magnitude and provide information to the Committee in the next report;
(b) Develop and implement, with the active involvement of the children concerned, a comprehensive policy which should address the root causes in order to prevent and reduce this occurrence;
(c) Provide children in street situations with necessary protection, adequate health-care services, education and other social services;
(d) Support family reunification programmes, when it is in the best interests of the child; and
(e) Provide children with adequate information on how they can protect themselves, and on how they can lodge complaints against those who exploit them.

Sexual exploitation and abuse

89. The Committee is deeply concerned about:
(a) Inadequate provisions in the Child Law on the protection of children victims of commercial and sexual exploitation;
(b) Reports of sexual abuse of girls and boys in the home, in the community, at work, in institutions and in some schools, and reports of girls sold for prostitution by their parents;
(c) Information on acts of rape and sexual violence committed by military personnel and police officers against young girls and adolescents over the past years; and
(d) Prosecution of children engaged in prostitution.

90. The Committee strongly recommends that the State party:
(a) Amend the Child Law to protect children from commercial and sexual exploitation;
(b) Strengthen law enforcement and enhance legal aid for abused and exploited children;
(c) Take all necessary measures to prevent and end sexual abuse and exploitation through a comprehensive strategy, notably by prosecuting perpetrators, holding public debates and conducting public educational programmes, including campaigns organized in cooperation with opinion leaders, families and the media;

(d) Conduct proper investigations and provide justice to the victims of rape committed by military personnel and police officers; and

(e) Ensure that victims of sexual abuse and exploitation are not criminalized and have access to appropriate recovery and reintegration programmes and services.

Sale, trafficking and abduction

91. The Committee notes the State party’s overall efforts in combating human trafficking. In particular, the Committee welcomes the accession to the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime; the signature of the Memorandum on Coordinated Mekong Ministerial Initiative against Trafficking; the adoption of the Anti-Trafficking in Persons Law in 2005; the adoption of the Five-Year National Plan of Action to Combat Human Trafficking (2007–2011); the establishment of the Central Body for Suppression of Trafficking in persons in 2006 and the plan to organize a special police force for child protection. It also notes the State party’s significant efforts to combat international sex trafficking of women and girls and to protect repatriated victims of cross-border sex trafficking. However, the Committee remains concerned that:

(a) The State party is a source country for men, women and children who are subjected to trafficking in persons, specifically forced labour, and for women and children in forced prostitution in other countries;

(b) Trafficking and sexual exploitation of women and girls persist in the country for the purpose of prostitution, particularly in urban areas; and

(c) The State party has made limited efforts to prevent and protect victims of internal trafficking and lacks information on the number of children victims of trafficking.

92. In the light of article 34 and other related articles of the Convention, the Committee recommends that the State party:

(a) Strengthen its efforts to combat international and internal child trafficking, including by establishing more rigorous border control;

(b) Increase awareness-raising, in particular among children and young people, on the risks associated with trafficking and migration;

(c) Address the root causes of trafficking;

(d) Ensure that adequate measures are taken to hold perpetrators of child sale, trafficking and abduction accountable for their offences;

(e) Strengthen its efforts to ensure physical and psychological recovery and social reintegration of children victims of exploitation and trafficking; and

(f) Continue to seek assistance from, among others, UNICEF.

Administration of juvenile justice

93. The Committee notes the progress made in the administration of juvenile justice and the issuance in October 2010 of the Protocols on Child Friendly Police Investigations as a national directive by the police force. However, the Committee is concerned about:

(a) The provisions of the Child Law setting the age of criminal responsibility at 7 years, which is at a level well below internationally accepted standards;

(b) The high number of children in pretrial detention;

(c) The prevalence of physical punishment for children in contact or in conflict with the law;

(d) The existence of only two specialized juvenile courts covering limited parts of the country and the lack of training provided to specialized judges;

(e) The conditions of detention in police stations during the arrest and pretrial detention, as well as in the prisons, which are very poor and do not respect strict separation from adults, nor ensure the right to maintain contact with the family; and

(f) The lack of appropriate measures in the juvenile justice system to facilitate the social reintegration of children.

94. The Committee recommends that the State party bring the juvenile justice system fully in line with the Convention, in particular articles 37, 39 and 40, and with other relevant standards, including the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (Beijing Rules), the United Nations Guidelines for the Prevention of Juvenile Delinquency (Riyadh Guidelines), the United Nations Rules for the Protection of Juveniles
Deprived of their Liberty (Havana Rules), the Guidelines for Action on Children in the Criminal Justice System and the Committee’s general comment No. 10 (2007) on children’s rights in juvenile justice. In particular, the Committee urges the State party to:

(a) Amend the Child law to bring it in conformity with the Convention, in particular by raising the legal age of criminal responsibility to an internationally acceptable level, and in no case below the age of 12 years;

(b) Ensure that pretrial detention is used only for serious crimes and that alternative measures are used for other crimes;

(c) Ensure that no child is subject to abuse and ill-treatment when in contact or in conflict with the law;

(d) Establish specialized juvenile courts with adequate human, technical and financial resources throughout the territory of the State party, introduce specialized judges for children in all the regions and ensure that such specialized judges receive appropriate education and training;

(e) Take measures to prevent that children deprived of liberty in police stations or in detention facilities are kept with adults, and that girls are kept with boys, and to ensure that they have a safe, child-sensitive environment, and that they maintain regular contact with their families;

(f) Make use of the technical assistance tools developed by the Interagency Panel on Juvenile Justice and its members, including UNODC, UNICEF, OHCHR and NGOs and seek technical assistance in the area of juvenile justice from members of the Panel.

Child victims and witnesses of crimes
95. The Committee recommends that the State party ensure, through adequate legal provisions and regulations, that all children victims and/or witnesses of crimes, e.g. children victims of abuse, domestic violence, sexual and economic exploitation and trafficking, are provided with the protection required by the Convention and that it take fully into account the Guidelines on Justice in Matters Involving Child Victims and Witnesses of Crime.

Children belonging to minority or indigenous groups
96. The Committee reiterates its concern (CRC/C/15/Add.237, para. 27) that children belonging to ethnic, indigenous, religious and other minority groups, in particular Rohingya children, face multiple restrictions and forms of discrimination and continue to be denied access to basic rights, including the right to food, health care, education, survival and development, as well as the right to enjoy their culture and to be protected from discrimination.

97. The Committee recalls its previous concluding observations (CRC/C/15/Add.237) and urges the State party to gather additional information on all ethnic minorities and other marginalized groups and to elaborate policies and programmes to fully ensure the implementation of their rights without discrimination. The Committee recommends in particular that the State party take effective measures to improve access to education and primary health care for children in the northern Rakhine State. The Committee also recommends that the State party take into account the Committee’s general comment No. 11 (2009) on indigenous children and their rights under the Convention.

I. Ratification of international human rights instruments
98. In order to further strengthen the fulfilment of children’s rights, the Committee urges the State party to ratify all the core United Nations human rights treaties and their Optional Protocols, namely the:

(a) Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict;

(b) International Convention on the Elimination of All Forms of Racial Discrimination;

(c) International Covenant on Economic, Social and Cultural Rights and its Optional Protocol;

(d) International Covenant on Civil and Political Rights and its Optional Protocols;

(e) Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women;

(f) Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and its Optional Protocol;

(g) International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families;

(h) Optional Protocol to the Convention on the Rights of Persons with Disabilities; and the

(i) International Convention for the Protection of All Persons from Enforced Disappearance.
99. It also urges the State party to ratify:
(a) Convention on the Recognition and Enforcement of Decisions relating to Maintenance Obligations; and the

J. Cooperation with regional and international bodies
100. The Committee recommends that the State party cooperate with the Association of Southeast Asian Nations (ASEAN) Commission on the Promotion and Protection of the Rights of Women and Children in the implementation of the Convention and other human rights instruments both in the State party and in other ASEAN member States.

K. Follow-up and dissemination
101. The Committee recommends that the State party take all appropriate measures to ensure that the present recommendations are fully implemented by, inter alia, transmitting them to members of the Government, Parliament, relevant ministries, the Supreme Court and to local authorities for appropriate consideration and further action.
102. The Committee further recommends that the third and fourth periodic report and written replies submitted by the State party and the related recommendations (concluding observations) it adopted be made widely available in several languages of the country, including (but not exclusively) through the Internet, to the public at large, civil society organizations, media, youth groups, professional groups and children, in order to generate debate and awareness of the Convention and its Optional Protocols and of their implementation and monitoring.

L. Next report
103. The Committee invites the State party to submit its combined fifth and sixth periodic report by 13 February 2017 and to include in it information on the implementation of the present concluding observations. The Committee draws attention to its harmonized treaty-specific reporting guidelines adopted on 1 October 2010 (CRC/C/58/Rev.2 and Corr.1) and reminds the State party that future reports should be in compliance with the guidelines and not exceed 60 pages. The Committee urges the State party to submit its report in accordance with the reporting guidelines. In the event a report exceeding the page limitations is submitted, the State party will be asked to review and eventually resubmit the report in accordance with the abovementioned guidelines. The Committee reminds the State party that if it is not in a position to review and resubmit the report, then translation of the report for purposes of examination of the treaty body cannot be guaranteed.
104. The Committee also invites the State party to submit a core document in accordance with the requirements of the common core document in the harmonized guidelines on reporting, approved at the fifth inter-committee meeting of the human rights treaty bodies in June 2006 (HRI/MC/2006/3).