



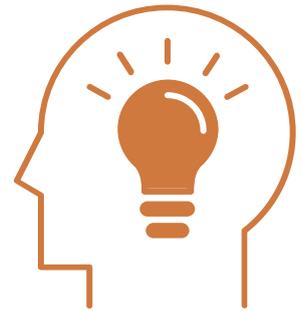
**Bloomberg  
Philanthropies**  **DATA FOR  
HEALTH INITIATIVE**

## **CRVS best-practice and advocacy**

Advocating for change: How advocacy contributed to strengthened civil registration and vital statistics in Myanmar

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August 2020





## Resources available from the University of Melbourne, Bloomberg Philanthropies Data for Health Initiative

### *CRVS course prospectuses*

These resources outline the context, training approach, course content and course objectives for the suite of CRVS trainings delivered through the Bloomberg Philanthropies Data for Health Initiative. Each course focuses on a specific CRVS intervention or concept, and is designed to support countries to strengthen their CRVS systems and data.

### *CRVS Fellowship reports and profiles*

The CRVS Fellowship Program aims to build technical capacity in both individuals and institutions to enhance the quality, sustainability and health policy utility of CRVS systems in Fellows' home countries. *Fellowship reports* are written by Fellows as a component of the program, and document, in detail, the research outcomes of their Fellowship. *Fellowship profiles* provide a summary of Fellows' country context in relation to CRVS, an overview of the Fellowship experiences, the research topic and the projected impact of findings.

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Generated through the Initiative, CRVS best-practice and advocacy resources are based on a combination of technical knowledge, country experiences and scientific literature. These resources are intended to stimulate debate and ideas for in-country CRVS policy, planning, and capacity building, and promote the adoption of best-practice to strengthen CRVS systems worldwide.

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CRVS country reports describe the capacity-building experiences and successes of strengthening CRVS systems in partner countries. These resources describe the state of CRVS systems-improvement and lessons learnt, and provide a baseline for comparison over time and between countries.

### *CRVS technical guides*

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### *CRVS tools*

Interactive and practical resources designed to influence and align CRVS processes with established international or best-practice standards. These resources, which are used extensively in the Initiative's training courses, aim to change practice and ensure countries benefit from such changes by developing critical CRVS capacity among technical officers and ministries.

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Melbourne School of Population and Global Health  
Building 379  
207 Bouverie Street  
Carlton, VIC 3053  
Australia

CRVS-info@unimelb.edu.au  
[www.mspgh.unimelb.edu.au/dataforhealth](http://www.mspgh.unimelb.edu.au/dataforhealth)

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# Advocating for change: How advocacy contributed to strengthened civil registration and vital statistics in Myanmar

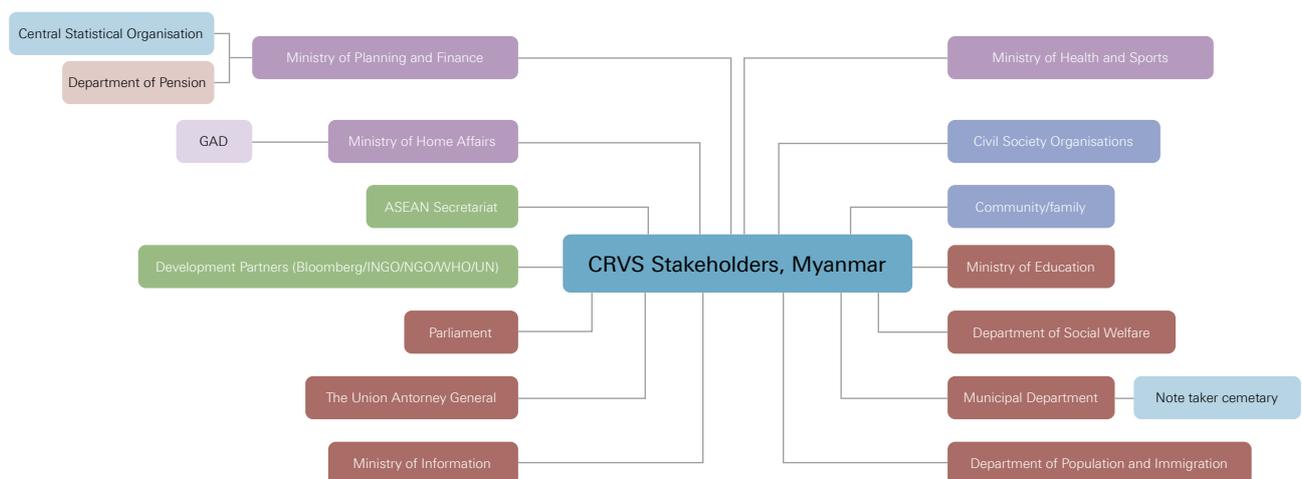
In 2016, the government of Myanmar partnered with the Bloomberg Philanthropies Data for Health Initiative to strengthen death registration practices in hospitals and communities. This report discusses the role of advocacy in the planning and delivery of this civil registration and vital statistics-strengthening intervention, focusing on the strategies and methods used, and outcomes produced.

## Introduction

Advocacy can be used to raise awareness and persuade government and civil society stakeholders involved in a process or system of the benefits of pursuing a specific intervention or policy direction. For civil registration and vital statistics (CRVS), the role and importance of the system in collecting information on births, deaths and causes of death on a continuous basis for policy and planning purposes is not always clear to the wide range of stakeholders involved. CRVS stakeholders often have different responsibilities, perspectives and agendas. Government stakeholders, in particular, may have multiple budget demands, and require convincing of the benefits of CRVS strengthening over other, perhaps to them more obvious, interventions to improve the health and wellbeing of populations. **Advocacy aimed at strengthening CRVS systems is necessary to fill gaps in knowledge, modify attitudes on the importance of data for policymaking, and to change CRVS stakeholder practice.**

In 2016 the government of Myanmar, a country with low death registration completeness despite a strong political commitment to CRVS, partnered with the Bloomberg Philanthropies Data for Health (D4H) Initiative to introduce interventions to strengthen death registration practices in both hospitals and the community. These CRVS improvement strategies were based on proven interventions, introduced in consultation with country stakeholders and in synergy with existing systems. In Myanmar, however, as in many other countries, the CRVS system is complicated and involves a myriad of actors (see **Figure 1**). Convincing these stakeholders of the need for specific CRVS improvements at both national and local levels (where the data collection occurs) required sustained and focused advocacy efforts. It also necessitated a staged process that generated evidence to advocate for a scale-up of interventions throughout the country, across the project cycle.

**Figure 1: CRVS stakeholders in Myanmar**





Key stakeholders across all levels of government, administration and health service provision were identified and involved in the planning from an early stage, ensuring the types of system-level changes required to implement the interventions could occur. Additionally, community members were identified as key stakeholders, with their increased knowledge of the importance of CRVS understood to be a key driver of improvements in death registration completeness rates for community deaths. To effectively engage these key stakeholders and ensure sustainability of the interventions, a strong need for advocacy related to several key areas was identified, including:

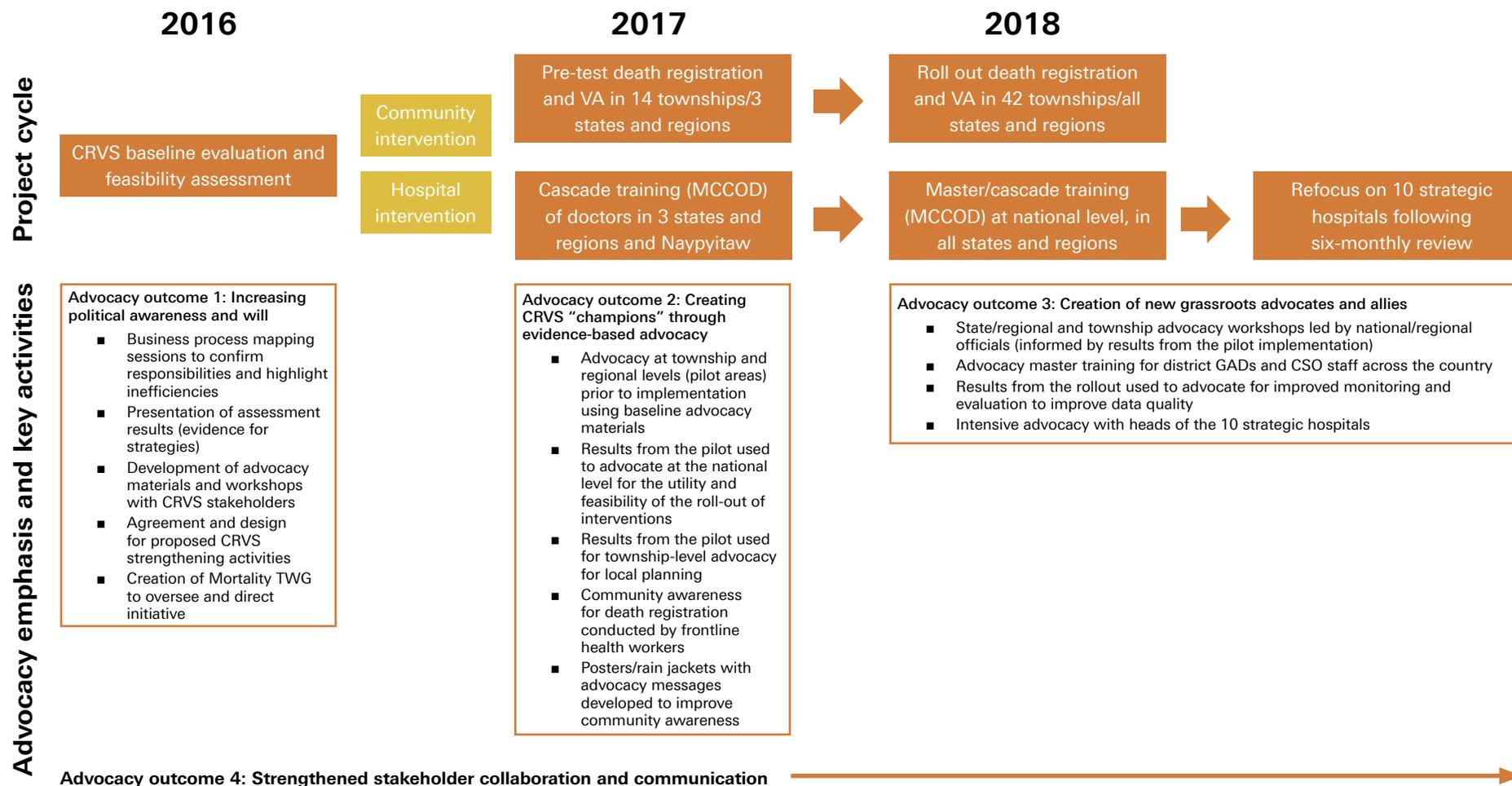
- A lack of understanding within government and amongst other stakeholders about CRVS processes and agencies responsible for different aspects of the system
- A lack of knowledge within government and amongst other stakeholders on how birth and death information (including cause of death) could be used for health planning, policy and other government services
- An absence of community knowledge about the need for birth and death certificates and associated data to improve population health
- A lack of monitoring and evaluation mechanisms within the CRVS system to ensure good quality data to produce vital statistics
- Weaknesses in CRVS data utilisation in planning and policymaking.

To address the identified challenges, advocacy efforts were directed towards achieving four core outcomes:

1. Increasing political awareness and will
2. Creation of new CRVS “champions” through evidence-based advocacy
3. Creation of new grassroots advocates and allies
4. Strengthened stakeholder collaboration and communication.

The relative emphasis towards these advocacy outcomes during the implementation of the interventions is illustrated in **Figure 2**. Efforts towards these outcomes were often simultaneous over the course of the intervention.

Figure 2: Stages of the project cycle and advocacy emphasis at each stage





## Advocacy outcome 1: Increasing political awareness and will

To influence stakeholders at the national level, evidence needed to be generated to identify the core issues within Myanmar's CRVS system, the impact and extent of these issues, and viable solutions. This evidence was presented in the form of a baseline assessment report, compiled at the beginning of the initiative. Existing systems and national CRVS data were reviewed by the D4H team and Myanmar government officials, with this information providing the foundation for the baseline report. A subsequent in-depth feasibility assessment was conducted to explore existing knowledge; attitudes and practices among key stakeholders regarding birth and death registration processes; understand how vital data were being used for health planning and policymaking, and; identify barriers within the existing vital registration process. **Without a baseline evaluation to present evidence of prevailing issues and suggested solutions, it would have been difficult to garner political interest or engagement in the proposed intervention.** The dissemination of results from the baseline evaluation and subsequent feasibility assessment, were key milestones which provided evidence for, and legitimacy to, the proposed CRVS interventions to be implemented under the D4H Initiative.

The development of advocacy presentations based on the findings from these initial assessments stressed the benefits of complete, accurate and timely vital statistics for planning and policymaking, and highlighted weaknesses within the existing system. Stakeholder and business process mapping workshops were conducted to help CRVS decisionmakers understand agency responsibility at different levels within the system, uncover inefficiencies in CRVS processes, and discuss potential solutions. The strategy for implementation of D4H interventions were developed and a Mortality Technical Working Group (TWG), comprising representatives from all agencies responsible for CRVS, was created and tasked with overseeing the process. The strategy and TWG provided a strong foundation on which to move forward with implementation. The multi-stakeholder composition of the advocacy activities and resultant TWG fostered collaboration in this initiative between the General Administration Department (GAD), Central Statistical Organisation (CSO) and the Ministry of Health and Sports (MOHS): key stakeholders in the process. Additionally, at the state/region level, advocacy meetings were organised with relevant government stakeholders to ensure their support for the townships involved in implementation.

Business process mapping sessions were useful to agree on the different responsibilities of agencies and on some of the existing problems within the system, particularly at the township level. They also assisted to understand how new interventions such as VA might be integrated into the CRVS system. Importantly, suggestions for system changes during these workshops needed to be based on best-practice evidence, and any proposed new activity needed to demonstrate utility and feasibility before it would be accepted by CRVS stakeholders.

## Advocacy outcome 2: Creation of new CRVS "champions" through evidence-based advocacy

The baseline evaluation and feasibility assessment, along with advocacy efforts at the national and state/region level with the key CRVS stakeholders, paved the way for a pilot implementation of proposed CRVS strengthening activities. **Whilst a pilot was the first step in the implementation of these activities, it also played a critical advocacy role by producing contextual evidence to demonstrate the utility and feasibility of the new CRVS strengthening interventions in Myanmar.**

Two main interventions were proposed to improve death registration completeness and cause of death assignment - the primary problems identified through the baseline assessment:

1. Introduction of medical certification of cause of death (MCCOD) training in hospitals to improve mortality and cause of death information
2. Introduction of verbal autopsy (VA) and improved death registration processes to improve mortality and cause of death information for community deaths (which constitute around 84 per cent of all deaths in the country<sup>1</sup>).

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<sup>1</sup> Department of Medical Research (Lower Myanmar) Department of Health Planning. *Assessment of Routine Public Health Information System by Basic Health Staff at Township Level, Myanmar*. Nay Pyi Daw: Ministry of Health, World Health Organization; 2011 September 2011.

For the pilot implementation, it was decided that MCCOD training in hospitals, improved death registration processes, and introduction of VA for community deaths would be conducted in 14 townships across three states and regions. Advocacy materials developed from the baseline assessment were tailored to the 14 participating townships, where advocacy meetings were held prior to implementation. These meetings were held to convince frontline CRVS stakeholders at the state/region and township levels of the critical importance of a strengthened CRVS system, and the need for the proposed interventions to achieve this. **The success of the initiative was largely dependent on the appreciation, understanding and collaboration amongst the CRVS stakeholders at this local level.** These frontline staff were also responsible for advocating to the community to improve their acceptance of procedures, including VA (a new process) to understand the cause of community deaths.

The pilot demonstrated that the interventions could rapidly improve death registration completeness and community cause of death assignment from VA in townships, as well as improve the information on medical death certificates for mortality coding of hospital deaths. This evidence was then used to advocate at two levels: to national CRVS stakeholders to support further roll-out of interventions and integration into the national CRVS system, and to regional and township level staff to use the information in local planning and continue to improve the completeness and quality of the death data. Advocacy meetings were held with key stakeholders, including the existing national Coordination Committee of Birth and Death Registration (CCBDR), hospital heads, and township medical officers (TMOs) to demonstrate the utility and feasibility of the D4H interventions.

“Champions” of the intervention emerged at both national and township levels, with senior officials from the MOHS and CSO in particular providing essential political support to mobilise and roll-out to a further 28 townships (42 in total) across all states and regions in the subsequent scale-up phase. In the case of VA, this provided a nationally representative sample to understand patterns and trends in community mortality and cause of death across the country. As noted in the project evaluation report, the strong political support *‘inarguably contributed to the achievements at the output level’*.<sup>2</sup> (p.40)

The implications of engaging key advocates or champions can be seen in the intervention’s setbacks as well as in its achievements. The results from the project evaluation highlighted how varied political support at the township level, in particular, contributed to the function and sustainability of implemented activities.<sup>3</sup> Where greater political support existed, with individuals willing to push for change and engage meaningfully with the initiative, the best outcomes were observed.

Given the importance of individual support for the interventions, staff turnover was considered to be a significant challenge, as with every new staff member, a new advocacy effort was needed. To address this issue in a sustainable manner, a process of frequent progress evaluation meetings was established to drive implicit advocacy and ensure new staff understood the benefits of the initiative. Staff movements were not always a loss to the intervention, however. In one instance a national level “champion” of CRVS moved to a state office and then became a “champion” for CRVS in that state.

Advocacy efforts need to be well targeted and timed. In the pilot phase of VA implementation, an attempt to cost the intervention led to high costs “per VA” due to high initial set up expenses and relatively low numbers of VAs at that stage of the initiative. A reframing of the issue was necessary to alleviate concerns that the VA intervention would not be affordable or sustainable in the long term. This involved cultivating a better understanding of ongoing costs, economies of scale and the impact of increasing levels of VA on the cost “per VA”, as well as the substantial benefits and potential cost-savings that could result from interventions better targeted at the health issues identified through VA.

### Advocacy outcome 3: Creation of new grassroots advocates and allies

As done during the pilot implementation, advocacy meetings were held in each of the new townships during the scale-up phase. The importance of CRVS and the utility of the new interventions as evidenced from the pilot were a focus of these meetings. Importantly, each of these meetings was attended by senior officials who provided opening remarks to emphasise the importance of CRVS as a national priority. Such endorsement from high level officials was instrumental in engaging grassroots advocates and allies who need to report to their superiors. Workshops were arranged to allow for discussion, and informational pamphlets on MCCOD and VA in the Myanmar language were provided to cement the concepts.

<sup>2</sup> Naing. *End of project evaluation of Data for Health Initiative*. Empower Consultancy; 2019. Available at: <https://crvsgateway.info/file/11681/3295>

<sup>3</sup> Ibid.

**Image 1: Township advocacy meeting**



Through these regional and township meetings, early support for, and an understanding of the aims of the initiative was seeded. This support built steadily following implementation as health workers began to see the benefits of improved registration and certification practices. In addition, death registration in hospitals – previously assumed to be complete – had increased, with key hospital staff now appreciating the importance of registering these deaths, along with improved MCCOD. This was unexpected but welcome progress to improvements in the recording of hospital deaths.

*'In the old days, we thought that a person was dead already, and why did we have to care for eliciting cause of death. It was such a waste of resources. Now, we know that finding out the cause of death can derive benefits for those who are still alive. We did not do it [investigation of cause of death] thoroughly before, but now we pay attention to it.'*<sup>44</sup> (p.6) – Township health staff

At the same time, frontline health staff in townships were advocating for death registration within the community. As well as distributing posters and pamphlets at rural health centres, rain jackets embossed with messages about death registration in the Myanmar language were distributed to basic health staff who wore them when visiting the villages (see **Image 2**). As VA became more familiar to the community, and frontline workers continued to promote the importance of the new practice, the community accepted this new data collection method and were increasingly willing to provide the necessary information.

4 Naing. *End of project evaluation of Data for Health Initiative*. Empower Consultancy; 2019. Available at: <https://crvsgateway.info/file/11681/3295>

**Image 2: BHS wearing the promotional rain jackets**



**Image 3: Graphic used on the rain jackets. The text reads: ‘When people register deaths properly, health staff can find a way to prevent as well as treat illness. Shall we participate together to improve the country’s health system?’**



The information generated from the scale-up of interventions was used to advocate for more robust data monitoring practices. Townships were able to see their results alongside those of other townships, generating healthy competition, valuable discussions on the challenges of implementation, and motivation to improve results. Standard Operating Procedures for death registration and VA were developed to facilitate the data exchange between the TMOs and CSOs to ensure data quality and linkage.

For the MCCOD training strategy, however, the success of this intervention during the pilot and the apparent ease with which this short training could be delivered to doctors resulted in an overly ambitious scale-up of this intervention to all hospitals in the country. Whilst MCCOD training can appear relatively easy to implement, the importance of effective advocacy to instil strong support from hospital management responsible for ongoing monitoring and data quality was not fully appreciated. Such advocacy, feasible for the relatively small number of target hospitals included in the pilot, was not possible to conduct prior to the training when scaled-up to all of Myanmar’s hospitals. When the mid-term evaluation showed poorer than expected results, the TWG subsequently changed the strategy and focused initially on staff training, including key hospital management staff, in 10 strategically important hospitals. The training included a strong emphasis on advocacy, with this strategy proving successful and, thereby, demonstrating the importance of a whole-of-system approach to advocacy efforts.

### **Advocacy outcome 4: Strengthened stakeholder collaboration and communication**

Improving the collaboration and communication among stakeholders across all levels of Myanmar’s CRVS system was a core outcome on which the achievement of all other advocacy outcomes hinged. Greater collaboration and communication were understood to be crucial to accomplish the desired outcomes of the intervention as a whole – particularly if sustainability was to be achieved.

Increasing political awareness and generating political will, creating CRVS “champions”, generating grassroots advocates and allies - including community engagement - all involved substantial input and coordination across various ministries, national and regional governmental departments, district and township GADs, township medical offices and hospitals, medical personnel, and independent agencies.

**To strengthen collaboration and communication, the D4H team followed advice from lead national-level stakeholders and ensured meetings and workshops engaged and empowered all relevant officials and other individuals at every stage of the project cycle.** Continual education and awareness-raising were critical success factors for this outcome, particularly in an environment with high staff turnover. Without a shared understanding of the core issues, public health implications and viable solutions, a strong foundation for meaningful collaboration would not have existed.



Regular TWG meetings, CCBDR meetings, and monitoring and evaluation workshops at both national and local levels were held to further strengthen and improve implementation. In addition, a CRVS advocacy master training session was held for district GAD and CSO staff who could then continue this advocacy to the stakeholders at the township level.

Given the large number of stakeholders from a variety of agencies involved at different levels of the system, a comprehensive advocacy package was difficult to achieve, and gaps in communication gaps did arise. For hospitals, a letter sent from the national Medical Service Department to all hospitals mandating the implementation of death registration and correct MCCOD practices was only a first step in ensuring procedural compliance by busy hospital doctors. At a township level, variable collaboration between stakeholders as a result of key staff changes threatened to jeopardise interventions relying on implementational consistency to provide nationally representative, good quality data on which to base local health planning. Many of these gaps were also a result of the rapid roll-out strategy across Myanmar that saw the country up-scale from 14 townships in three states and regions in the pilot (covering around three per cent of the population), to 42 townships across all states and regions (covering around 16 per cent of the population). Moving forward, efforts to close communication gaps and standardise data collection across all sites will require sustained advocacy efforts and strong national leadership.

## Conclusion

When compared with early data on mortality, substantial gains have been made to strengthen Myanmar's death registration system. With more deaths counted, and more usable, representative cause of death data now available to the CSO, Myanmar has begun to build a more comprehensive and reliable picture of the health of its citizens. This very substantial achievement, whereby the policy utility of routine mortality data has increased enormously, will undoubtedly support further advocacy efforts to sustain and improve the implementation of current interventions and ensure they are fully embedded within the CRVS system.

### **Meaningful engagement and collaboration with grassroots stakeholders all the way to the highest levels of government has required a sustained advocacy effort for all stakeholders and at each stage of the process.**

As demonstrated through this intervention, advocacy materials and approaches need to be tailored to the interests of the particular stakeholder so that each agency appreciates the benefits, establishes ownership and takes responsibility for their part in the process. This is not easy to achieve in a system with so many important actors all contributing to the success of the implementation.

For now, political support has been largely cemented at the national level. Even so, ongoing advocacy will be necessary to counter staff turnover or an unforeseen change in the political landscape. The D4H team and government partners will continue to seize all opportunities to demonstrate progress on strengthening CRVS through the D4H interventions. Displaying data from death registration activities, and distributing pamphlets and technical guidance books at the national statistical forum, the information technology forum and ethnicity day events have proved to be highly successful ways of advocating to the Vice President, Ministers and Parliamentarians. These methods will continue to be utilised as the initiative continues, ensuring key decisionmakers understand the function of the CRVS system, the leading causes of death in Myanmar, and the importance of using mortality data for planning and policymaking.

Further progress is needed to engage a handful of participating townships more completely and create further CRVS "champions" and grassroots allies to improve the system. A particular emphasis will be placed on the ongoing training and monitoring of relevant health personnel, ensuring frontline staff are equipped with the necessary skills and knowledge to perform their responsibilities to a high level, and remain committed to and engaged with the intervention.

Challenges and barriers are inevitable in any advocacy effort, with the success of such efforts largely contingent on both the receptibility of the target stakeholders and the advocacy approach itself. For CRVS interventions, the Myanmar case highlights the importance of an approach that is both participatory and evidence-based, as well as feasible and scalable. Any CRVS intervention must also align with national priorities, and following system changes, there must be both the resources and an imperative to act on information generated through improvements to national mortality data. As death registration procedures implemented through D4H are further integrated, utilisation of the improved mortality data for public health policy changes will be a challenge the government needs to address.

The program partners on this initiative include: The University of Melbourne, Australia; CDC Foundation, USA; Vital Strategies, USA; Johns Hopkins Bloomberg School of Public Health, USA; World Health Organization, Switzerland.

Civil Registration and Vital Statistics partners:



## For more information contact:

CRVS-info@unimelb.edu.au  
crvsgateway.info

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