YANGON UNIVERSITY OF ECONOMICS
DEPARTMENT OF APPLIED ECONOMICS
MASTER OF PUBLIC ADMINISTRATION PROGRAMME

A STUDY ON FAMILY PLANNING KNOWLEDGE, ATTITUDE AND PRACTICE AMONG MARRIED WOMEN (CASE STUDY - KAWKAREIK TOWNSHIP, KAYIN STATE)

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A thesis submitted in partial fulfillment of the requirements for the degree of
Master of Public Administration (MPA)

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This is to certify that this thesis entitled "**A STUDY ON FAMILY PLANNING KNOWLEDGE, ATTITUDE AND PRACTICE AMONG MARRIED WOMEN (CASE STUDY - KAWKAREIK TOWNSHIP, KAYIN STATE)**", submitted in partial fulfilment towards the requirements for the degree of Master of Public Administration (MPA) has been accepted by the Board of Examiners.

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ABSTRACT

Family planning, utilizing contraception, provides women with the ability to space out childbirths by choosing the timing of pregnancy in alignment with their other life responsibilities. This study aims to examine the family planning situation, specifically focusing on the knowledge, attitudes, and practices (KAP) regarding family planning methods among married women in Kawkareik Township, Kayin State, and to assess the KAP of married women regarding family planning in selected villages. The study uses descriptive and quantitative survey method. A sample of 200 respondents were selected from 6 villages in Kawkareik Township. Many women in the study area are aware of family planning, although only just over half of the women had a broader knowledge of its benefits of birth control. The two-thirds of women in the study area use contraceptive methods, and positive attitudes persist despite religious and cultural contradictions. These findings recommended the need for accessible contraceptive supplies and expanded education, in addition to common methods, linking family planning to broader socio-economic development.

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LIST OF ABBREVIATIONS

AMW	Auxiliary midwife
COCs	Combined Oral Contraceptive Pills
FP	Family Planning
IEC	Information, Education, and Communication
IUCDs	Intrauterine Devices
KAP	Knowledge, Attitudes, and Practices
LAM	Lactational Amenorrhea Method
LARC	Long-Acting Reversible Contraceptive
MMR	Maternal Mortality Ratio
MOHS	Ministry of Health and Sports
MW	Midwives
NGOs	Non-Governmental Organizations
OCPs	Oral Contraceptive Pills
SDGs	Sustainable Development Goals
SRHR	Sexual and Reproductive Health and Rights
STIs	Sexually Transmitted Infections
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
WHO	World Health Organization

CHAPTER I
INTRODUCTION

1.1. Rationale of the Study

The larger family sizes can place significant economic pressure on households. Parents may struggle to provide for their children's basic needs, such as food, education, and healthcare (Adolesc, 2021). In many cases, limited financial resources must be stretched thin, leading to inadequate living conditions. Larger family sizes can lead to limited resources for education, overcrowded classrooms, insufficient materials, and lower quality. In poor families, older children may leave school to support financially. Additionally, larger family sizes can impact social and cultural norms, leading to high birth rates.

Women have a lifelong maternal mortality risk (Gazeley, et al., 2023). It may die during pregnancy. The risk of pregnancy and delivery problems killing a woman. It evaluates pregnancy opportunities across a woman's lifespan. Knowledge of family planning among married women can prevent pregnancy-related deaths.

Myanmar's government promotes family planning information, attitude, and practice among married women by advocating for legislation reforms and greater financing. Various projects and initiatives by Government and NGOs are being implemented to improve rural livelihoods, infrastructure, and social services by reducing larger family's size. Non-Governmental Organizations (NGOs) work with government agencies and other stakeholders to prioritize reproductive health in national health agendas.

There are significant health risks among married women in poor areas of Myanmar. Population explosions within families are the rapid increases in family size due to high birth rates. Population explosions within families in Myanmar are seem to be the crucial intention especially for under developed regions out of the major cities (Jirapongsuwan, et al., 2016).

By studying these three aspects of knowledge, attitude, and practice, researchers and policy makers can gain insights into the effectiveness of family planning programs in Myanmar, identify gaps in knowledge or services, and develop strategies to improve family planning education and access to contraceptive methods. In rural areas of Myanmar, there is a need for better coverage of healthcare facilities.

Due to natural barriers and transportation, healthcare services are often inaccessible. It is crucial to provide safe childbirth and post-natal care for pregnant mothers who cannot easily reach healthcare facilities.

Understanding the knowledge, attitudes, and practices (KAP) related to family planning among married women can significantly impact maternal and child health. This study focuses on understanding how married women in some villages in Kawkareik township, Kayin State.The participants are in their reproductive years, perceive and engage in family planning. It is essential to examine how married women perceived family planning. Well knowledge of the married women would help people health and well-being, and it leads to social-economic development with better resource allocation, and it could lead to improve the overall quality of life by reducing poverty in the rural regions. The effective family planning can reduce unwanted pregnancies, lower maternal and infant mortality rates, promote healthier family dynamics, and closely linked to socio-economic development, it is to examine the level of education and knowledge of the married women in rural area like Kayin state. The findings from such a study also can inform policymakers and healthcare providers, aiding in the design and implementation of targeted interventions.

1.2. Objectives of the Study

The objective of the study is:

To assess the knowledge, attitudes and practices of family planning among married women in Kawkareik Township.

1.3. Methods of Study

Descriptive method is used in examining the knowledge, attitudes, and practices (KAP) related to family planning among married women from six villages of Kawkareik Township, Kayin State. The study surveyed 200 randomly selected married women in six villages using the "KoboCollect" survey tool, ensuring one married

woman was surveyed per household. Data collection was done face-to-face interview method with informed using structured questionnaires. The study collects both quantitative and qualitative data.

1.4. Scope and Limitations of the Study

This study is mainly focus analyze to the family planning knowledge, attitude and practice among married women. The study involved 6 numbers of villages in the Kawkareik township, Kayin State. The study involves 200 numbers of women as sample respondents in the study of the family planning knowledge, attitude and practice among Married women in Kawkareik Township, Kayin State. The study population scopes in married women who live in villages situated in these Kawkareik Township.

1.5. Organization of the Study

In examining the Level of Knowledge about different family planning among Married women in Kayin state, the study organizes with total five chapters. Chapter one is the introduction. Chapter two is the literature reviews. The chapter three is overview of family planning in Myanmar. Chapter four presents survey analysis of the study. Chapter five is the conclusion with discussions of findings, recommendations and suggestions, and the needs for further studies.

CHAPTER II
LITERATURE REVIEW

2.1. Family Planning and Economic Development

The ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births" is the definition of family planning (UNFPA, 2022). It is accomplished by treating involuntary infertility and using contraceptive methods. This comprises a variety of contraceptive treatments, such as tablets, injectables, implants, intrauterine devices, fertility-limiting surgeries, barrier techniques like condoms, and non-invasive techniques like abstinence and the calendar method. Infertility therapy and instructions on how to conceive when it is desirable are also included in family planning (UNFPA, 2022). Family planning is essential to enabling women and girls to reach their full potential and is a fundamental human right. Additionally, it is among the most economical investments a nation can undertake in the direction of sustainable development (UNFPA, 2022).

Family planning and economic development are closely linked, as effective family planning contributes to economic growth and improved living standards in various ways. It enhances workforce participation, enabling women to pursue education and careers, contributing to a skilled and productive workforce, and allowing families to invest more time and resources into professional and economic activities.

Family planning helps reduce poverty by enabling families to have fewer children, reducing economic strain and allowing better resource allocation for food, education, and healthcare, leading to improved quality of life and breaking poverty cycles (Marianne, 2024).

Slower population growth reduces pressure on public resources like healthcare, education, and infrastructure, allowing governments to allocate funds more effectively and promote sustainable economic development.

Families with fewer children can invest more in education and health, resulting in a more capable and innovative workforce. This, in turn, drives economic development by promoting entrepreneurship and technological advancements.

Family planning empowers women by allowing them to make reproductive health decisions, promoting gender equality and promoting diverse economic growth. It also manages population growth, resulting in a favorable age structure with more working-age individuals and fewer dependents, accelerating economic growth. Family planning is not just a health initiative; it's a key driver for sustainable economic progress.

Some notable quotes from prominent experts regarding the relationship between family planning and economic development, along with the years they were made. Thant (1967), no other problem is more crucial to the future of peace and all humanity than the problem of population control. This quote highlights the early recognition of population's significance on global well-being, which inherently links to economic stability. Obaid (2004), when women are empowered, the whole society benefits, and reproductive health is fundamental to women's empowerment. This emphasizes the link between family planning (a core part of reproductive health) and women's empowerment, which in turn significantly contributes to economic development through increased participation in the workforce and improved family well-being.

According to Osotimehin (2012), access to family planning is a human right, and it is also one of the smartest investments a country can make to reduce poverty and improve health. This quote directly connects family planning to poverty reduction and improved health, both critical aspects of economic development. They emphasize that empowering individuals, especially women, to make informed choices about their family size not only improves individual well-being but also promotes broader social and economic prosperity.

2.2. Family Planning Practices and Methods

Family planning refers to the strategies and practices that individuals or couples use to control the number and spacing of their children. It encompasses a variety of methods and considerations. Family planning practices vary depending on cultural, social, and economic factors, as well as individual preferences and access to healthcare services (WHO, 2012). These practices play a critical role in promoting the health and well-being of families, reducing maternal and infant mortality, and improving overall quality of life.

Family planning, as a formal public health initiative with national scope, primarily emerged in response to global concerns about rapid population growth in the mid-20th century, particularly after World War II. India led the way by establishing the world's first national family planning program in 1952. This pioneering effort in India, which included a mass media campaign to promote contraceptive use, aimed to address the challenges posed by high fertility rates and population expansion (Seltzer, 2002).

Following India's lead, the 1960s saw a significant expansion of such programs across various developing countries. This era was characterized by a shared concern among governments and international agencies regarding the potential negative effects of rapid population growth on economic development, resource availability, and overall societal well-being. Notable nations that began implementing their own family planning programs during this decade included Pakistan, South Korea, Cuba, Chile, and Costa Rica (ANDERSON, 2018). These countries adopted policies focused on fertility regulation and enabling individuals and couples to make informed choices about family size and spacing, signifying a critical shift in public health policy towards recognizing reproductive health and individual rights in family planning. This global spread in the 1960s laid the groundwork for the more widespread adoption of family planning initiatives that would continue to evolve in scope and reach over the subsequent decades, with 179 governments supporting access to contraception by 1998 (Seltzer, 2002).

Family planning practices among married women involve a range of behaviors and decisions aimed at controlling the number and timing of children they have. These practices involve various behaviors and decisions to control the number and timing of children (WHO, 2012). Additionally, spacing children between pregnancies is crucial for ensuring the health of both the mother and child. Health and counseling services are available to provide prenatal and postnatal care, as well as professional advice on family planning options and reproductive health. Family planning offers numerous benefits, including healthier mothers and babies, smaller families, more money and food for each child, more time for parents, and allowing young people to stay in school (WHO, 2012). However, contraceptives are often needed to delay pregnancy, and it is recommended that young women and men wait until at least 18 years or have completed studies before having children. After having a child, it is healthier to wait at least 2 years before trying to re-pregnant. Family planning practices among married couples are crucial for improving reproductive health, ensuring adequate birth spacing, and preventing

unintended pregnancies. Studies have shown that knowledge and attitudes towards family planning vary widely across regions and cultures (WHO, 2012).

Family planning practices encompass a variety of methods to help individuals or couples control the timing and number of pregnancies. These methods can be broadly categorized into natural and artificial approaches.

Artificial methods for sperm control include barrier methods like condoms, hormonal contraception like pills and implants, A long-acting reversible contraceptive like intrauterine devices (non-hormonal IUCDs), chemical barriers like spermicides and vaginal gels, and surgical solutions like vasectomy for men and tubal ligation for women (WHO, 2018). Depending on individual preferences, health conditions, and lifestyle of married women, some methods are reversible, allowing for future pregnancy, while others, like surgical methods, are permanent.

Most commonly used natural methods for fertility include abstinence, calendar method, withdrawal method and lactational amenorrhea method. Abstinence involves avoiding sexual intercourse, calendar method tracks menstrual cycles, Withdrawal method involves the male withdrawing his penis from the vagina before ejaculation to prevent pregnancy and lactational amenorrhea method uses breastfeeding as a temporary contraceptive (WHO, 2012).

(i) Hormonal Contraception

Combined oral contraceptive pills (COCs) are a convenient contraceptive option containing estrogen and progesterone, used to prevent pregnancy by inhibiting ovulation and altering tubal motility (Jain & Muralidhar, 2011). They require daily administration and a medical prescription after a thorough health examination. COCs have certain contraindications, such as maternal age over 35 or family history of conditions like heart disease, liver disease, hypertension, or diabetes. When used correctly, they have a 93% to 99% success rate.

The contraceptive injection, administered every 12 weeks, works by inhibiting ovulation and increasing cervical secretion viscosity, creating a barrier to sperm. It has a high efficacy rate of 94% to 99.8% in preventing pregnancy. It is suitable for lactating mothers and can help recession ovarian cysts or breast lumps. However, it can cause menstrual patterns changes, weight gain, and delay the return to fertility after discontinuing he method, which can take several months (Jain & Muralidhar, 2011).

The Subdermal implant, often referred to as "the rod" or "the implant," is a highly effective long-acting reversible contraceptive (LARC) method. It consists of a small, flexible rod subcutaneously inserted into the upper arm by a healthcare professional. This device continuously releases a low dose of progestogen into the bloodstream, which primarily prevents ovulation, thickens cervical mucus to impede sperm passage, and may also thin the uterine lining to inhibit implantation. Offering 99.9% effectiveness in pregnancy prevention, implants provide reliable contraception for up to three years, though they can be removed sooner if desired (Jain & Muralidhar, 2011).

(ii) Barrier Method

Condoms offer a unique dual protection against both pregnancy and most sexually transmitted infections (STIs), distinguishing them from other contraceptive methods (Jain & Muralidhar, 2011). They are hormone-free and can be used on demand, with both external (male) and internal (female) varieties available. Their widespread availability in various forms and at numerous retail locations makes them easily accessible without a prescription. When used correctly, condoms are highly effective, demonstrating an 82% to 98% success rate in preventing pregnancy, and they can be combined with other contraceptive methods for enhanced protection. This method provides comprehensive and accessible reproductive health benefits for a diverse range of individuals (Jain & Muralidhar, 2011).

(iii) A long-acting reversible contraceptive

The copper intrauterine device (IUCD) is a non-hormonal contraceptive method that uses a small T-shaped plastic device with copper components. Its primary mechanism involves the continuous release of copper ions, which affect sperm motility and viability. The device also alters the uterine lining, preventing fertilized egg implantation. Despite its high efficacy rate of 95-99% and protection for up to 10 years, potential disadvantages include heavier menstrual bleeding, pelvic inflammation, and increased risk of ectopic pregnancy. Regular checks are necessary to prevent dislodgement (Jain & Muralidhar, 2011).

(iv) Natural Method

The calendar method of birth control requires significant preparation, starting with monitoring your menstrual cycle for six to twelve months. You then use this historical data to calculate your fertile window. To find your first fertile day, subtract

18 from your shortest cycle length. For your last fertile day, subtract 11 from your longest cycle length. This method demands high tracking proficiency, and its effectiveness can be challenging due to natural fluctuations in cycle length.

The withdrawal method, also known as "pulling out," aims to prevent pregnancy by having the male partner remove their penis from the vagina before ejaculation. This method demands significant self-control from the male. Due to the difficulty of consistent and perfect execution, there is a 22% chance of pregnancy when relying on this tactic. Furthermore, even if withdrawal is successful, pregnancy can still occur. This is because pre-ejaculate fluid, which may contain small amounts of sperm, can be discharged from the penis before full ejaculation.

The Lactational Amenorrhea Method (LAM) is a temporary contraceptive option specifically for the first six months after childbirth. It's effective only if the mother is exclusively breastfeeding, has not yet resumed menstruation, and is feeding frequently (at least every four hours during the day and six hours at night). This consistent nursing prevents the body from releasing an egg. It's important to note that ovulation occurs before the first period, so fertility can return unexpectedly. When strictly adhered to, research suggests LAM can be up to 98% effective in preventing pregnancy.

(v) Surgical Methods/ Permanent Methods

Tubal ligation is a permanent surgical method of female sterilization, as described by Jain and Muralidhar (2011). This procedure involves the severing and tying of the fallopian tubes, effectively preventing sperm from reaching the eggs and thus inhibiting fertilization. While considered a highly reliable contraceptive method, requiring only a single day of hospitalization, its permanence necessitates a firm decision from the couple prior to the procedure. Although surgical reversal is possible, its success is not guaranteed, and fertility may not always be restored. Therefore, individuals considering tubal ligation should be fully committed to permanent contraception (Jain & Muralidhar, 2011).

2.3. Sustainable Development Goals (SDG) and Reproductive Health

Target 3.7 of SDG 3 seeks universal access to sexual and reproductive health-care services, family planning, education, and integration into national policies by 2030 (Otu, et al., 2021). This emphasizes reproductive health as a public health and human

rights priority for everyone's health and well-being. Contraception, trained birth attendants, and emergency obstetrics minimize mother and newborn mortality. Empowering women and girls, reducing teenage pregnancies, and integrating reproductive health into national health programs increases service delivery and equity (Tohit & Mainul, 2024).

Family planning strongly influences health, education, gender equality, and economic growth, making it essential to meet the Sustainable Development Goals (SDGs). The following circumstances link family planning and SDGs. Good Health and Wellness Family planning reduces mother and child mortality by providing sexual and reproductive health care. It helps people make reproductive health decisions.

Figure (2.1) Sustainable Development Goals 3

Source: https://jointsdgfund.org

Reproductive health—family planning, maternal and child health, and STD prevention—affects human capital development (UNFPA, 2022). Individuals and couples who may freely and responsibly choose the number, spacing, and timing of their children have healthier families, lower maternal and child mortality, and better educational and economic possibilities, especially for women. This empowerment of

women, through their ability to participate more fully in education and the workforce, contributes significantly to household income, reduced poverty, and overall economic growth (UNFPA, 2022). Conversely, unmet needs for family planning can lead to higher fertility rates, increased strain on healthcare systems, larger family sizes that may hinder educational attainment and resource allocation, and a slower demographic transition, all of which can impede national economic progress. Therefore, investing in comprehensive reproductive health services, including accessible family planning, is not merely a health intervention but a fundamental strategy for fostering sustainable economic development (UNFPA, 2022).

2.4. Review on Previous Studies

Ahmed, et al, (2025) studied knowledge, attitude and practice of family planning Among married couples living in Farah Omar District, Burao. The study involved participants of among 134 married couples in the Farah Omar district of Burao. Survey instrument is the use of structured questionnaires and collected data was analyzed through statistical software. The study found that most couples had a high level of awareness and a positive attitude toward family planning descriptive statistics. Ahmed, et al, 2025 also found that although they have positive view and preference, actual usage of family planning methods was low, possibly due to educational levels.

Tilahun, et al., (2013) conducted a study relating to family planning knowledge, attitude and practice among married couples. The study was conducted in different countries. It also presents the roles of roles of community healthcare workers in educating to be higher attitude on family planning knowledge and awareness, as well as the accessibility and supports relating to family planning (Tilahun, et al., 2013).

Tilahun, et al., (2013) studied examines knowledge, attitudes, and contraceptive practice in the Jimma zone, Ethiopia, revealing that only 29% of married women use contraceptives, with 20% having unmet needs. Thor study found that family planning was well-known, with women having better knowledge of long-term contraceptive methods and men having better knowledge of traditional methods. Research revealed that while knowledge of contraceptive methods was high, actual usage was significantly lower. Factors like formal education and counseling about side effects played a role in increasing contraceptive use. These findings emphasize the importance of education, access to resources, and mutual understanding between partners in promoting effective family planning practices.

Ali, et al. (2020) examined Egyptian married couples' family planning knowledge and practice. The investigation took place at Minet Sandob village's medical family center and all obstetric private clinics. The purposive sample included 176 married couples who satisfied inclusion criteria. According to Ali, et al. (2020), 69.9% of wives had inadequate family planning knowledge, whereas 40.3% and 38.1% of husbands were happy with health unit information. The study found that marital communication and male family planning engagement improved contraceptive usage and fertility decisions.

May Myo Myint Khaing (2022) studied contraceptive knowledge, attitude, and practice among reproductive-aged married women in Hmawbi Township. The study employed cross-sectional descriptive methodologies on married couples using structured survey questionnaires. The survey indicated that all participants understood contraception for family planning. 74% used contrcetives. The study indicated that age of married women and their husbands, total number of children, and attitude toward contraception directly affect contraception use (Khaing, 2022).

Thida Win, (2015) studied that Myanmar has established policies and regulations concerning family planning (FP), with the public sector serving as the primary service provider. International and local organizations, alongside the private sector, also play a significant role. However, notable gaps persist in FP service provision, particularly for sexually active unmarried individuals, and to a lesser extent for married couples. These disparities primarily stem from a scarcity of human and financial resources across both public and private sectors, a lack of targeted programs for unmarried populations, and deeply entrenched cultural norms within the country. Consequently, current barriers to FP use in Myanmar are largely attributable to supply-side resource deficiencies, compounded by influential cultural factors (Thida, 2015). To address these challenges, it is crucial to review existing programs and approaches to ensure inclusivity for all individuals requiring FP services. Furthermore, an assessment of the current workload of service providers is warranted, necessitating an increase in both human and financial resources. Future program design could also benefit from additional research into FP-related cultural norms to develop more effective and culturally sensitive approaches (Thida, 2015).

CHAPTER III
OVERVIEW OF FAMILY PLANNING IN MYANMAR

3.1 Overview of Reproductive Health Sector in Myanmar

Complete physical, mental, and social well-being in all reproductive concerns is reproductive health. Safe and pleasant sexual life, ability to reproduce and freedom to determine whether, when, and how often, and access to appropriate health care services, including prenatal and postnatal care, safe delivery, and reproductive tract infection treatment, comprise reproductive health.

Recent years have seen reproductive health progress in Myanmar, but many obstacles persist. Under the National Sexual and Reproductive Health and Rights Policy (2022), the government seeks equal access to excellent reproductive health care for all areas and people. Despite these efforts, maternal mortality in Southeast Asia is 282 per 100,000 live births, twice the norm. Lack of qualified birth attendants, especially in rural regions, and a scarcity of nearly 7,000 certified midwives are problems.

While most pregnant women receive prenatal care, only 37% of births take place in medical institutions, and 63% of deliveries happen at home. In Myanmar, qualified healthcare professionals such as nurses, midwives, and doctors assist with 60% of deliveries (MOHS, 2017). Traditional birth attendants and auxiliary midwives assist with 29% and 6% of births, respectively. With a 52.2% contraceptive prevalence rate, family planning services have grown, yet 16% of people still lack access to them. Women's health is still at danger from unsafe abortions and issues resulting from restricted access to birth spacing treatments. Service delivery is further hampered by geographic limitations, poverty, and cultural restrictions. One of the numerous reasons for the high number of home births is the inadequate National Sexual and Reproductive Health and Rights Policy (MOHS, 2017).

Myanmar is working with international organizations like UNFPA to improve midwifery education, emergency obstetric care, and family planning plans. Future efforts include sustained investment, community engagement, and culturally sensitive

outreach to achieve universal reproductive health coverage and reduce preventable maternal deaths. Myanmar's reproductive health practices are influenced by progress, cultural norms, and systemic challenges. The country is expanding access to services through the National Sexual and Reproductive Health and Rights Policy, promoting equitable, quality care. Family planning is a major focus, with a 52.2% contraceptive prevalence and 16% unmet need, despite widespread use and misconceptions, particularly in rural areas.

Table (3.1) Myanmar’s Fertility rate and infant mortality rate (2014~2024)

Year	Fertility Rate (births per woman)	Infant Mortality Rate (deaths per 1,000 live births)
2014	2.5	46.3
2015	2.3	41.4
2016	2.21	40.1
2017	2.17	39.5
2018	2.19	38.9
2019	2.18	38.9
2020	2.15	37.6
2021	2.12	36.4
2022	2.13	35.2
2023	2.12	34.1
2024	2.06	33

Source: MOHS, 2024

In Table (3.1), Myanmar's fertility rate has shown a consistent downward trend over the decade from 2014 to 2024. Starting at 2.50 births per woman in 2014, it gradually decreased to 2.30 in 2015, then to 2.21 in 2016, and continued its decline, reaching 2.06 births per woman by 2024. This sustained reduction indicates a significant demographic shift, moving towards a lower birth rate within the country (MOHS, 2017).

Concurrently, Myanmar's Infant Mortality Rate, measured as deaths per 1,000 live births, notably declined from 46.3 in 2014 to 33.0 in 2024. This substantial decrease

signifies improved infant survival rates, reflecting advancements in healthcare and living conditions (MOHS, 2017).

These positive demographic shifts, namely the decline in both fertility and infant mortality rates in Myanmar, are attributed to comprehensive improvements in maternal health services, an increase in access to contraception, and effective child health interventions. The expansion of maternal health services has likely led to safer deliveries and better prenatal and postnatal care for mothers (MOHS, 2017). Increased access to contraception empowers women and couples to make informed decisions about family planning, thereby influencing birth spacing and overall fertility. Furthermore, child health interventions, such as immunization programs and improved nutrition, have played a crucial role in reducing infant mortality (MOHS, 2017).

These combined factors contribute significantly to better health outcomes for both mothers and children across the nation. The result is a healthier population, which is a key indicator of societal development, and a more managed demographic transition, leading to a more stable population structure over time. This trend suggests a growing awareness and adoption of modern healthcare practices and family planning methods among the population (MOHS, 2017).

3.2 Family Planning Practices in Myanmar

Family planning in Myanmar is shaped by various factors, including cultural beliefs, accessibility of contraceptive methods, and awareness campaigns. Studies indicate that over 90% of women in certain regions are aware of contraceptive options for birth spacing. There are about one million women give birth each year in Myanmar. for every 100,000 live births were an estimated 316 maternal deaths in 2004-2005. And thus, the material mortality ratio (MMR) is high. According to 2019 Myanmar’s Inter-census survey, the population of women is 53.2% of total population. Teen-age fertility rate is 20.3 births per 1,000 women aged 15-19 while total fertility rate (TFR) is 2 children per women aged 15 to 49.

Family planning knowledge, attitude and practices among married couples are required in Myanmar. It is a kind of a control for a rapid growth of population in Myanmar. For that, family planning practices are needed to be effective. Proper family planning reduces unintended pregnancies, lowers maternal mortality rates, and improves child health outcomes by allowing adequate birth spacing.

Well-planned smaller family sizes tend to be better financial stability as parents can allocate resources more effectively for education, healthcare, and overall well-being. Women can become confident by the accessing to family planning methods. By controlling their reproductive health, that leads to be a greater participation in education in education and the workforce (Lwin, 2013).

Family planning services are being improved through counseling, accessibility, and education. Guidelines emphasize healthy pregnancy timing and spacing, quality care, and informed decision-making. Displaced populations face social barriers and myths affecting contraceptive use. Community sensitization and male involvement are crucial steps for improved practices. Family planning in Myanmar utilizes various contraceptive methods, influenced by accessibility, cultural beliefs, and regional disparities.

3.2.1 Family Planning Policies Implementation by Department of Public Health in Myanmar

The Department of Public Health (DOPH) within Myanmar's Ministry of Health (MOH) is undertaking a crucial effort to accelerate progress towards national maternal and child health goals, Sustainable Development Goals (SDGs), and other global health targets. This initiative is primarily guided by the Myanmar National Strategic Plan for Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health (NSP-SRMNCAH) for 2021-2025. This NSP-SRMNCAH represents the country's inaugural comprehensive strategic document for sexual, maternal, reproductive, newborn, child, and adolescent health (MOHS, 2022).

The vision underpinning this strategy is to "make Myanmar a country where every woman, newborn, child and adolescent will achieve optimal health and development through best evidence-based interventions during Pre-Pregnancy, Pregnancy, delivery, Post-Partum, newborn, child and adolescent periods that will allow them to realize their full potential, and contribute to the development and prosperity of the nation (MOHS, 2022)." The general objective of this five-year strategy is "to end preventable deaths of mothers, newborns, children and adolescents, to improve their health, well-being and development; to ensure their rights through equitable, efficient and accountable health systems." This document outlines five broad specific objectives and targets, aligning with both Myanmar's sustainable development targets and global health commitments.

To achieve these goals and objectives, the NSP-SRMNCAH identifies four key implementation strategies: (i) Strengthening Health Systems, (ii) Ensuring availability, accessibility and continuity of quality SRMNCAH service provision in humanitarian settings, (iii) Empowerment through community engagement, and (iv) Forging and strengthening partnerships. These strategies collectively aim to enhance the implementation of family planning policies by the Department of Public Health, contributing to improved reproductive health outcomes across Myanmar (MOHS, 2022).

The Department of Public Health in Myanmar is implementing strategies to improve family planning and reproductive health, including public awareness, healthcare provider training, commodity security, and legal reform, to ensure equitable and sustainable access to family planning services. Myanmar's Department of Public Health policy states, "All individuals of reproductive age, regardless of marital status, ability or special entity, will have equitable access to quality and inclusive FP information, commodities, and services and will have the freedom to decide on the desired number of children and determine the healthy timing and spacing of pregnancies." Strategies are listed in the table below (MOHS, 2022).

Table (3.2) Strategies for Policy Implementation of Family Planning in Myanmar

Strategy - 1 **Awareness & Education**	Raise awareness and provide life-stage appropriate health education on family planning, using locally appropriate strategies, to all individuals who could benefit from access to contraception.
Strategy - 2 **Service Provider Training**	Incorporate trainings for all cadres of service providers in the pre-service and in-service training curriculum on how to offer comprehensive, quality, inclusive and voluntary right-based family planning and SRHR counseling and services for women, men and adolescents.
Strategy - 3 **Commodity Security**	Improve reproductive health commodity security, especially in places where stock-outs and unmet need for contraception are high, through approaches such as strengthening the capacity of the Logistics Information Management System and conducting implementation research on commodity availability.

Strategy 4 **Method Mix Availability**	Promote availability and accessibility of a wide contraceptive method mix, including new as well as long-acting contraceptive methods, at all levels of the health system.
Strategy - 5 **Innovative Outreach**	Pursue innovative ways to reach the socially and geographically hard-to-reach with modern family planning, including task-shifting, community-based distribution, self-administered methods of contraception, door-to-door sales as well as social marketing.
Strategy - 6 **Total Market Approach**	Implement a total market approach to family planning, which involves strengthening coordination between public and private sector actors to enable efficient use of resources and promote equitable inclusive and sustainable access to family planning.
Strategy - 7 **Policy and Legal Reform**	Review and revise existing laws, policies and procedures that limit access to family planning methods including emergency contraception, female and male sterilization, and injectable contraceptives, as well as laws, policies and procedures that limit access to accurate information and quality services by adolescents.
Strategy - 8 **Male Involvement**	Encourage greater male involvement in reproductive health and family planning by advocating with opinion leaders; disseminating messages and materials on men's shared responsibility in parenthood and sexual and reproductive behavior; and training health providers and the wider community on how to engage men as partners in addressing gender inequality.
Strategy - 9 **Stakeholder Advocacy**	Advocate the importance of SRHR and family planning among various stakeholders including decision makers, community leaders, and media.
Strategy - 10 **Data & Research Enhancement**	Enhance data collection on family planning and sexual and reproductive health by integrating operational and implementation research into existing and new programs.
Strategy - 11 **Commercial Sector Quality Monitoring**	Monitor the quality of contraceptives sold in the commercial sector and take corrective action as needed and ensure the provision of correct information and appropriate counseling on the chosen methods by different outlets.

Source: MOHS,2023

The Department of Public Health in Myanmar uses a comprehensive framework for family planning policy implementation, aiming to ensure equitable access to quality information, commodities, and services for all reproductive age individuals. The framework includes eleven key strategies: raising health literacy on family planning, integrating rights-based counseling into health curricula, improving commodity security, and promoting method mix availability to ensure wide accessibility of various contraceptive methods across all health system levels (MOHS, 2023). The strategies include Innovative Outreach, a Total Market Approach, Policy and Legal Reform, Male Involvement in reproductive health and family planning, Stakeholder Advocacy, Data & Research Enhancement, and Commercial Sector Quality Monitoring. These strategies aim to reach hard-to-reach populations, enhance public and private sector coordination, review and revise laws limiting access to family planning methods, and ensure accurate information for adolescents (MOHS, 2023).

The Ministry of Health and Sports (MOHS) utilizes basic health staff like midwives and auxiliary midwives to provide door-to-door sales, counseling, and information to women in rural areas. Community-based health workers (CBHWs) also bridge health systems and communities, engaging community, religious, and ethnic leaders, women, and youth groups in advocacy and social mobilization. MOHS collaborates with UN agencies, INGOs, and local NGOs to implement family planning strategies in Myanmar. Key partners include UNFPA, PATH, and JICA, providing technical support, financial assistance, and program implementation to reach underserved populations and improve commodity security (MOHS, 2023).

3.3 Family Planning Practices in Kayin State

Kayin State is situated between latitudes 15° 45' north and 19° 25' north, and longitudes 96° 10' east and 98° 28' east. Its temperature is hot and humid, owing to mountain ranges and its proximity to the sea in the tropics. The eastern mountain regions have temperatures that never drop below 22.2 °C (71.9 °F) in the hottest month, while the lowlands in the west and south enjoy a tropical monsoon climate. The annual rainfall ranges from 3,000 millimeters (120 in) to 4,800 millimeters (190 in), with the majority falling in the summer. Thanlwin River, Thaungyin River), Gyaing, and Attaran are some of the most important rivers. Administratively, Kayin State consists of one city, nine towns, four districts, seven townships, and 4092 villages. Its population

has increased significantly, from 858,429 in the 1973 Census to 1,055,359 in 1983, and then to 1,574,079 in 2014. This indicates a about 49% rise between the 1983 and 2014 censuses. Kayin State has the eleventh largest population among Myanmar's states and regions, trailing only Tanintharyi Region, Nay Pyi Taw Territory, and Chin State. Its share of the total national population increased somewhat, from 3.0% in 1983 to 3.1% in 2014.

Kawkareik is a townshihp within Kayin state. Kawkareik is also administrative division. In this town, the culture of people is rich, diverse, and deeply rooted in tradition, language, and spirituality. Mostly of the people are Karen people, including Sgaw and Poe Kayin, each with distinct dialects and customs. The major dominant religious are Buddhism and Christianity. Religion in this Kawkareik township is complex role in shaping attitudes towards family planning.

Depending on the community and belief system involved, religion affects how people think about family planning. For some, it helps support family planning. For others, it creates challenges. It depends on their beliefs and community. While the Sgaw Karen are predominantly Christian and often live in the hills, the Pwo Karen are mostly live in flat region. Buddhist and reside in the lowlands. conservative interpretations of both Buddhism and Christianity in rural areas can discourage contraceptive use. Some religious leaders and elders view family planning as interfering with natural or divine processes. They think using family planning is wrong because it goes against nature or what they believe God wants.

Family planning practices in rural areas like Kawkareik township often reflect a mix of culture norms, access to healthcare, people education levels, and local government policies. Both Kawkereik and Hpa- An town have trained local women. Many of the trained women are religiously active to promote safe pregnancies and birth spacing through community outreach. In this region. the low- and middle-income people are seeking a shift in reproductive behavior because of increased education and awareness as well as availability of contraceptive methods. Family planning practices in Kawkareik reflect a mix of progress and ongoing challenges. It depends on the accessibility of modern family planning services.

3.4 NGOs' Activities and Contributions in Kawkareik Township

In Kawkareik Township, Kayin State, a significant number of non-governmental organizations are actively involved in providing vital support and implementing various development initiatives. These include KBC-SM Social Mission, Save the Children, Premiere Urgence Internationale, Karen Department of Health and Welfare, Karen Environmental and Humanitarian Organization, Norwegian Refugee Council, International Rescue Committee, Handicap International - Humanity & Inclusion, and Population Services International. Their collective presence underscores a concerted effort to address the multifaceted challenges faced by the local communities, ranging from essential services to more specialized assistance (MIMU, 2025).

These organizations engage in a broad spectrum of activities tailored to the specific needs of Kawkareik Township. For instance, Population Services International and Karen Department of Health and Welfare are crucial in delivering health services, including reproductive health and family planning, while Save the Children focuses on child protection and welfare (MIMU, 2025). Humanitarian aid and support for displaced populations are often provided by groups such as Norwegian Refugee Council and International Rescue Committee, given the region's context. Furthermore, Karen Environmental and Humanitarian Organization addresses environmental concerns, and Handicap International - Humanity & Inclusion works to support individuals with disabilities. Through their diverse programs, these NGOs play an indispensable role in strengthening community resilience, improving access to vital services, and fostering sustainable development across Kawkareik Township (MIMU, 2025).

Table (3.3) Name of NGOs within Kawkareik Township

No.	Name of NGOs within Kawkareik Township
1	KBC-SM (Karen Baptist Convention) Social Mission
2	SCI (Save the Children)
3	PUI (Premiere Urgence Internationale)
4	KDHW (Karen Department of Health and Welfare)
5	KEHOC (Karen Environmental and Humanitarian Organization)
6	NRC (Norwegian Refugee Council)
7	IRC (International Rescue Committee)
8	HI (Handicap International- Humanity & Inclusion)
9	PSI (Population Services International)

Source: KBC-SM, 2025

The diverse mandates and collaborative spirit among these non-governmental organizations foster a holistic approach to development in Kawkareik. By coordinating their efforts, they not only fill critical gaps in basic service provision, such as healthcare and education, but also address complex humanitarian and environmental issues that are crucial for long-term stability (MIMU, 2025). This integrated strategy helps to maximize the reach and effectiveness of their programs, ensuring that even the most vulnerable and hard-to-reach populations benefit from improved access to essential resources and specialized support. Ultimately, the combined strength of these NGOs significantly contributes to building a more resilient and self-sufficient community capable of navigating ongoing challenges and progressing towards sustainable well-being in Kayin State (MIMU, 2025).

CHAPTER IV
SURVEY ANALYSIS

4.1.1 Survey Area

Kawkareik Township, situated in Kawkareik District of Kayin State, Myanmar, is the principal town and second most populated township in the state. It is the only township in Kawkareik District, one of the four districts in Kayin State. The state has faced numerous challenges, including decades of conflict, which have led to large-scale population displacement and long-term tension. NGOs in that region are working directly with communities to increase family planning knowledge, attitude and practice among married women. According to the 2019 Myanmar Information Management Unit, the township had a total population of 292,942, with a population density of 164 people per square kilometer. The sex ratio stood at 98 males for every 100 females. The MIMU reported 54,066 households in Kawkareik Township, with an average household size of 5 members. The majority (81.61%) live in rural areas, with 18.39% in urban areas. The Township comprises 53 village tracts and 260 villages. Kawkareik Township has been chosen as the survey area due to its notably higher Total Fertility Rate (TFR) of 2.9 children per woman (15–49 years) according to the 2014 population census compared to the national average of 2.5. This disparity necessitates an investigation into the influencing factors and the need for fertility regulation.

Rural women in Kayin State are less likely to use modern contraception due to poor family planning services, limited contraceptive methods, limited infrastructure, disconnected social services, and lower literacy rates compared to urban women. These socioeconomic barriers hinder health-seeking behaviors and contribute to the overall socioeconomic disparity. All selected villages within Kawkareik Township are currently accessible for travel, and necessary permissions for the survey have been obtained from local authorities.

Table (4.1) Sample of the Study Area

Sr No.	Name of Village	Male	Female	Total Population	Number of samples	%
1	Paing Yat	572	622	1,194	40	20
2	Moke Seik Kone	250	450	700	32	16
3	Kawt Gu	468	508	976	32	16
4	Naung Khit	192	208	400	32	16
5	Kyar Inn Su	495	456	951	32	16
6	Naung Li	308	355	663	32	16
	Total	2,285	2,599	4,884	200	100

Source: Survey Data (2025)

4.2 Survey Design

This study examines family planning knowledge, attitude, and practices among married women in Kawkareik township, Kayin state. A survey questionnaire is the chosen survey tool. Data collection will include both quantitative and qualitative data. For data collection, the researcher will use an interviewing method with a total of 200 respondents, who are chosen from six villages named Paing Yat, Moke Seik Kone, Kawt Gu, Naung Khit, Kyar Inn Su, and Naung Li villages in Kawkareik township. The questionnaire is divided into four main parts: Section (A) focuses on the socio-demographic characteristics of the respondents, Section (B) assesses knowledge on family planning, Section (C) investigates into attitudes towards family planning. Finally, Section (D) examines the current practice of family planning among married women in these townships, including current method use, reasons for non-use, and future intentions regarding family planning. The questionnaire is specifically prepared for collecting information from married women of reproductive age. The findings and results derived from this research will be used exclusively for academic research purposes. The questionnaire set is attached in the appendix.

4.3 Survey Result

Survey results included the components on profile of respondents, knowledge on family planning, attitudes on family planning, and the current practice on family planning method.

4.4 Profile of Respondents

The first part is the analysis on the profiles of the participant respondents. Table (4.2) illustrates the profile of respondents in terms of total frequency and percentage on gender, ethnicity, religion, age, education, occupation, income, age of first marriage, number of year(s) of marriage, number of children, and being a child who died in childhood are analyzed.

Table (4.2) Profile of Respondents (n=200)

Sr. No.	Profile of Respondents	Total Frequency	Percentage
		200	**100**
1	**Religion**		
	Buddhist	181	90.5
	Christian	10	5
	Islam	9	4.5
2	**Ethnicity**		
	Karen	118	59
	Mon	57	29
	Burma	11	6
	Pakistani descent	14	7
3	**Age**		
	19 to 25 years	30	15
	26 to 30 years	34	17
	31 to 35 years	34	17
	36 to 40 years	38	19
	41 to 45 years	44	22
	Above 45years	20	10
4	**Education**		
	No education	15	7.5
	Read and write	27	13.5
	Primary	71	35.5
	Middle	46	23
	Secondary /High school student	29	14.5
	University student	2	1
	Graduate and above	10	5

5	**Occupation**		
	Dependent	72	36
	Daily labor	24	12
	Farmer/ Gardener	37	18.5
	Skilled worker	26	13
	Government staff	8	4
	Merchant	15	7.5
	Others (AD HOC Labor)	18	9
6	**Family Incomes**		
	Less than 500,000 Kyat	123	61.5
	Between 500,001 to 1,000,000 kyat	63	31.5
	Between 1,000,001 to 1,500,000 kyat	9	4.5
	Between 1,500,001-kyat 2,000,000 kyat	4	2
	Above 2,000,0000 kyat	1	0.5
7	**Age at first marriage**		
	Under 18 years	23	11.5
	19 to 25 years	116	58
	26 to 30 years	52	26
	31 to 35 years	6	3
	36 to 40 years	2	1
	Above 40 years	1	0.5
8	**Number of Years in Marriage**		
	Less than 1 Year	12	6
	2-3 Years	25	13
	3-5 Years	56	28
	More than 5 Years	107	53
9	**Number of children**		
	No child	22	11
	1 Child	53	27
	2 Children	55	28
	3 children	41	21
	4 children	20	10
	5 children	9	5
10	**Ever had a child who died in childhood?**		
	Yes	27	13.5
	No	173	86.5

Source: survey data, 2025

Table (4.2) illustrates that the participants were 200 number of wives by 100%. Analyzing the religious, 91 % (181 out of a total of 200) respondents are Buddhism, 5% (10 respondents) are Christian, and the rest 9 respondents are Islam religion. The majority of participants are Buddhists.

In the ethnicity analysis, 59% (118 of a total of 200) respondents were Karen, Mon with 28%, Burmese with 8%, and the other 7%, respectively. Karens were the most participants and followed by Mon, as second major participants in that study.

Age analysis reveals that 15% (30 out of a total of 200) of participants fall in the age group of 19 to 25 years, (17%) fall in the age group of 26 to 30 years, (17%) fall in the age group of 31 to 35 years, (19%) fall in the age group of 36 to 40 years, (22%) fall in the age group of 41 to 45 years, and (10%) are above 45 years. In terms of percentage, respondents in the age group 19 to 30 years made up 32%; the age group 31 to 40 years was composed of the major ages, at (36%) and those above 41 years composed the second most, at (32%), respectively.

The educational level of the respondents was found as (7%) had no education, (18%) respondents were read and write level , (35%) respondents had primary school level of education, (23%) respondents had middle school level of education, (15%) were high school level, (1%) respondent possess university student, (5%) respondents were graduate and above level of education. By the analysis, majority of respondents' education are primary by 35%, followed by primary level education by 22% and read and write level by 18%. Only very few or 6% of a total respondent have university student and above level of education.

By the Table (4.2) the occupation analysis result shows that 36% (72 out of total of 200) respondents were dependents, (12%) were daily labors, (18%) by farmer/ gardeners, (13%) were skilled workers, (4%) were government staff, (37%) were merchants, (9%) were other occupations (Ad Hoc work) by 9%.

Respondent income levels analysis result shows that (61.2%) respondents earn less than 500,000 Kyat, (31%) respondents earn between 500,001 to 1,000,000 kyat, (4.5%) respondents earn between 1,000,001 to 1,500,000 kyat, and 4 respondents by 2% earn between 1,500,001 to 2,000,000 kyat, and (1%) respondent earn above 2,000,0000 kyats. The majority of respondents are found as earn less than 500,000 kyats per month.

In examining the age at first marriage, study describes that 23 respondents are under 18 years of age when first marriage, 116 and majority of respondents are first

marriage in the age between 19 to 25 years, 52 are 26 to 30 years, 6 are 31 to 35 years, 2 are 36 to 40 years, and first marriage of 1 respondent is above 40 years. In term of percentage, ages of first marriage are found mostly in the age between 19 to 25 years by 58.2%, followed by age between 26 to 30 years by 25.9%, and few of them are under 18 years (11.4%) for their ages at first marriage.

Analysis of the numbers of years in marriage life, study finds that 6% respondents have less than 1 year, 13% have 2-3 years, 28% have 3 to 5 years, and 53% respondents have more than 5 years of marriage life. In this marriage period analysis, majority of participants have more than five years of marriage life by 53%, and 3 to 5 years contribute second most participants by 28%.

By the analysis result of the Table (4.2), 11% (22 out of a total of 200) respondents out of have no child, (27%) respondents have 1 Child, (28%) respondents have 2 children, (21%) respondents have 3 children, (10%) respondents have 4 children, and (5%) have 5 children, respectively. In term of percentage, women respondents with 2 children by 28%with the most participants, while similarity of couples with 1 child by 27%. It is followed by families with 3 children by 20%, no child by 11%, and five children by 5%, respectively.

In examining the respondents by "Ever had a child who died in childhood?", (13.5%) respondents out of 200 respondents replied they had, and (86.5%) or majority of respondents did not have a child who died in childhood.

4.5 Knowledge on Family Planning

Respondents' knowledge on family planning and contraceptive methods were analyzed. The total frequency and percentage value relating to the knowledge are shown in Table (4.3), as follows:

Table (4.3) Knowledge on Family Planning

Awareness on family planning (n=200)	Frequency	Percentage
Yes No	104 96	52 48
Total	**200**	**100**
Source of knowledge for family planning) (n=104)		
Doctor	17	16
M.W	87	84
A.M. W	38	37
Neighbors	70	67
Husband	10	10
Relative	45	43
Self	8	8
IEC/Action program	55	53
Knowledge of the place where to get contraceptives (n=200)		
Drug shops	70	35
Hospital	6	3
Township Health Center	12	6
Private clinic	48	24
Midwife	65	33
Auxiliary Midwife	40	20
Knowledge on the different types of Contraceptives (n=200)		
Yes No	200 0	100 0
Awareness on the contraceptive methods (n=200)		
OC Pill	176	88
Injectable Contraceptives	166	83
IUCD	22	11
Condom	42	21
Calendar method	18	9
Withdrawal	56	28
Subdermal Contraceptive Implant	85	43
Male Sterilization	8	4
Female Sterilization	68	34

Source: survey data, 2025

By the Table (4.3), 52% (104) out of a total of (200) wives' respondents replied they have heard about family planning, while 48% respondents have not ever heard.

The 52% respondents who have aware family planning are further asked their knowledge on the source of knowledge for family planning. The table shows that 16% (of the 104) get information from doctor, 84% respondents heard from midwives (MW), 37% get from auxiliary midwife (AMW), 67% of respondents heard from their neighbors, 10% of respondents from their husband, 43% heard from their relatives, 8% from their self-knowledge, and 53% from IEC/Action program. Majority of respondents who have heard about family plannings are majorly from midwives by 84%, followed by neighbors by 67%, and IEC/Action program by 53%, and poorly received by self-knowledge.

The knowledge of a total of the 200 respondents regarding the place where to get contraceptives, the study finds that 35% of the wives have knowledge of drug shops at where to get contraceptives, 3% of the respondents answered they get from hospital, 6% of answer the rural health center, 24% answer private clinic, 33% of the total of 200 answer the midwife and 20% of answered the auxiliary midwife at where they can get contraceptives. By the study, major place is the drug shops by 35%, followed by midwife by 32%, and auxiliary midwife by 20%, can get to get contraceptives, respectively.

Regarding the awareness of different types of contraceptives among total 200 respondents, the study finds that all 100% gave strong awareness of contraceptives methods. The all the wives clearly understand the contraceptives although they are not clearly family planning contraceptives.

They are asked with the 9 questions related to different contraceptive methods. It is to organize the methods and their frequency, covering options like oral contraceptive pills (OCPs), injectable contraceptives, intrauterine devices (IUDs), condoms, calendar-based methods, withdrawal methods, subdermal implants, male and female sterilization.

According to Table (4.3), 88% (176 out of a total of 200) respondents have aware OC Pill as contraceptives, with the high awareness, 83% of respondents aware injectable contraceptives, with the second most high aware, IUCD as a contraceptives which is aware by 11%, and another 21% of the respondents have aware the use of condom for contraceptives, 9% of respondents aware on calendar-based method, 28%

aware on withdrawal contraceptive method, 43% aware subdermal contraceptive implant, 4% of the respondents have aware on male sterilization, and the rest 34% aware on female sterilization. By the study of all contraceptive methods, “OC Pill” and “Injectable Contraceptives” across multiple rows suggests that these are commonly used or recognized methods among the respondents.

4.6 Attitudes on Family Planning

In examining the attitude of family planning of the wives in that Kawkareik Township, respondents are asked to reveal their options on that of the family planning is good thing for mother and family, good things for mothers and children, is good for improving the standard of living, and with contradicts my religion and culture. In this analysis, respondents reveal their options based on the Five-point Likert scale measure of 1 is strongly disagree to 5 is strongly agree level. The interpretation of Five-point scale is as follows: the mean value between 1 to 1.8 is strongly disagree, between 1.81 to 2,6 is disagree, the value falls between 0.61 to 3.4 is neutral or moderate agreement, 3.41 to 4.2 is agree, and between 4.21 to 5.0 is strongly agree option.

4.6.1 Attitude on Family planning as a Good Thing for Wife and Family.

The first analysis of married couples’ attitudes (wife’s view) on the family planning practices is conducted on their views on relationship of family planning as a good thing for housewives and their families. The numbers of total respondents, and percentage for different degree of views, and mean value with standard deviation value, which are presented in Table (4.4), as follows:

Table (4.4) Attitude on Family planning as a Good Thing for Wife and Family

Agreement Level	Frequency	Percent
Strongly disagree	5	2.5
Disagree	17	8.5
Neutral	36	18
Agree	74	37
Strongly agree	68	34
Total	200	100

Source: Survey Data, 2025

Based on that Table (4.4), 34% (68 out of a total of the 200 participants) gave strongly agree option. Of the 200 participants, 37% also gave agree option, 18% respondents gave moderately agree option. A few or 9% (17 respondents) were not favor, and 3% (5 respondents) gave strongly disagree option. The overall mean value of 3.92 falls in agree mean range of 3.41 to 4.20, indicating majority of respondents are in favor of family planning which is good thing for married women and their family.

4.6.2 Attitude on Family Planning as good for Health of the mothers and their Children.

Table (4.5) reports the respondents' attitude on family planning as a good for health of the mothers and children. The total numbers of respondents, and percentage for different degree of views, along with mean value and standard deviation value, which are presented in Table (4.5), as follows:

Table (4.5) Attitude on Family planning as a Good for Health of the Mother and their Children

Agreement Level	Frequency	Percent
Strongly disagree	4	2
Disagree	31	15.5
Neutral	48	24
Agree	67	33.5
Strongly agree	50	25
Total	200	100

Source: Survey Data, 2025

Based on that Table (4.5), 25% (50 out of a total of the 200 participants) gave strongly agree option. Of the 200 participants, 34% also gave agree option, 24% respondents gave moderately agree option. A few or 16% of respondents were not favor, and 2% of respondents gave strongly disagree option. The overall mean value of 3.64 falls in agree mean range of 3.41 to 4.20, indicating majority of respondents are in favor of family planning which is good thing for mother and children. Majority of wives have positive attitude on family planning by its good for health mothers and children.

4.6.3 Family planning is good for Improving the Standard of Living

Table (4.6) reports on respondent attitude on family planning as a good thing for improving the standard of living. Total frequency, percentage, mean value and standard deviation value are stated in Table (4.6).

Table (4.6) Attitude on Family Planning as Improving the Standard of Living

Agreement Level	Frequency	Percent
Strongly disagree	5	2.5
Disagree	21	10.5
Neutral	78	39
Agree	56	28
Strongly agree	40	20
Total	200	100

Source: Survey Data, 2025

By the Table (4.6), Strongly agree 20% (40 out of a total of the 200) respondents gave strongly agree option, 28% gave agree option, 11% gave neutral or moderately agree option, 11% gave disagree option, and 3% gave strongly disagree option. The mean of 3.53 falls in agree mean range, indicating the mean value is a generally positive perception among most of respondents and strong believe that family contributes to improve the standard of living.

4.6.4 Family Planning with Contradicts Religion and Culture

Table (4.7) illustrates the respondents' attitude on family planning with contradicts at their religion and culture. Respondents' views relating to the influence of religion as culture in their region is as follows:

Table (4.7) Attitude on Family Planning as Contradicts with Religion and Culture

Agreement Level	Frequency	Percent
Strongly disagree	6	3
Disagree	26	13
Neutral	38	19
Agree	72	36
Strongly agree	58	29
Total	200	100

Source: Survey Data, 2025

By the Table (4.7) illustrates that Strongly agree 13% (26 out of a total of the 200) gave strong agree options, 19% gave agree option, 36% of respondents gave moderate agree option, and 25% of respondents gave disagree option, and 8% of a total respondents gave strongly disagree option. The mean value 3.75 falls in the agree mean range of 3.41 to 4.20, indicating significant opposition on that of perceive family planning which views as contradicting their religion and culture. However, 25% disagree and 8% gave strongly disagree indicates they do not view family planning as contradicting their religion and culture.

4.7 The Current Practice on Family Planning Methods

Table (4.8) presents the current practices on family planning method among the wives' participants in that Kawkareik Township, as follows:

Table (4.8) Current Practice on Family Planning Methods

Sr. No	**Current Practice on Family Planning Methods**	**Total respondent**	**%**
1	Yes	153	77%
2	No	47	23%
	Total	**200**	**100%**
Sr. No	**Current Use Family Planning Method (n=153)**	**Total Response**	**%**
1	**OC Pills**	**48**	**31**
2	**Injection**	**43**	**28**
3	**IUCD**	**2**	**1**
4	**Condom**	**8**	**5**
5	**Calendar method**	**4**	**3**
6	**Withdrawal**	**10**	**7**
7	**Implants**	**27**	**18**
8	**Male Sterilization**	**0**	**0**
9	**Female Sterilization**	**20**	**13**

Source: Survey Data, 2025

By the study, the 77% out of a total of the 200 respondents replied that they were currently practice on family planning method, while 23% respondents did not use at present.

Further study is conducted among 153 respondents who have currently used family planning method, Table (4.8) reports that 31% uses OC Pills, 28% use injection, IUCD, 5% use Condom, 3% used Calendar method, 7% used Withdrawal method, 18% used Implants, 13% used female sterilization, and no one male used sterilization method.

The study further extends to examine why respondents do not use any family planning method at present. It involves 47 respondents who replied they do not use contraceptives in current. Table (4.9) presents the reason for not using any family planning method in current period.

Table (4.9) Reason for not using any Family Planning Method in current period (n=47)

Sr. No.	Reason for stopping contraceptives	Frequency	%
1	I might not be able to get pregnant anymore.	8	17
2	Uterine Suspension or Uterine Lifting Surgery	2	4
3	It has been paused because pregnancy is planned	17	36
4	Husband does not allow to use	1	2
5	Pregnant period	9	19
6	Becoming older and lower chance for pregnancy	1	2
7	It has been paused because pregnancy is planned	2	4
9	Still no children in the family	3	6
10	Becoming fatter and stopped temporarily	2	4
11	Live in two different regions	1	2
12	Although injectable method is used, we do not get any child	1	2

Source: Survey Data, 2025

According to Table (4.9), 17% gave reason that they might not be able to get pregnant anymore, and another 4% gave reason of uterine Suspension or Uterine Lifting

Surgery, 36% of respondents gave reason about it has been paused because pregnancy is planned, and with the most given reasons, 2% of respondent gave reason husband does not allow to use, 19% gave reason of pregnant period, 2% gave reason as becoming older and lower chance for pregnancy, 4% gave reason of it has been paused because pregnancy is planned, 6% gave reason of still no children in the family and they are trying to get child, and 4% gave reason of becoming fatter and thus stopped temporarily. The most given reason is It has been paused because pregnancy is planned by the 36% of a total of the 47 respondents, followed by pregnant period, and difficult to get pregnant anymore.

Respondent intention to use contraceptives is analyzed. Respondents have to answer the question of "Do you prefer to use family planning methods in the future?". Of the total 200, their intention of contraceptives use is shown as follows:

Table (4.10) Intention to Use Family Planning Method in the Future

Sr. No	Preference to use family planning methods in the future (n=200)	Total	Percentage
1	Yes	172	86
2	No	28	14
	Total	200	100

Source: Survey Data, 2025

By the Table (4.10), it finds that 86% (172 out of a total of 200 respondents) indicating a "Yes" or intending to use family planning methods, while 14% of the respondent would not be use any more. The preference of the majority of respondents suggests a strong awareness and acceptance of family planning methods among the surveyed population.

CHAPTER V

CONCLUSIONS

In this chapter, it is the conclusion of the research findings of knowledge, attitude, and practices of the married women who are living in Kawkareik Township in Kayin State. It discusses of the details of the research findings, gives suggestions and recommendations, as well as the highlighting the needs for further studies for its limitation of times and budget in conducting the research study.

5.1. Findings

In examining the family planning knowledge, attitude, and practices among married couples, the study involved 200 married women from six villages in Kawkareik, Kayin State. The study mainly focused on quantitative research study. The qualitative research approach is also applied to examine the respondents' options because they do not use contraceptive method at present days. Of the 200 married women, the 91% or majority of the respondents are Buddhism, and they are mostly Karen ethnics. In that study, the age distribution of the married women reveals that 68% or majority of married women were age more that 31-years. Education level analysis 6% or very few have university level education. The majority of women have no education and school level education. The occupational status reveals that majorly of respondents are dependents, and followed by farm land workers or gardeners and skilled workers. Their monthly household income levels find that majority of their families earns less than 500,000 kyats, and the second most income level is found as less than 1,000,000 kyats in these villages. Age at first marriage of 200 married women is found between 19 to 25 years by 70% of the total respondents. Analyzing their years of marriage, the majority of the married women have more than five years of married life, and some have 3 to 5 years of married life. Having children in their families, the study involves similar contributions of the numbers of children of 1 child, 2 children, 3

children, 4 children, and very few families have 5 children in their families. Among these 200 married women, about 14% have every had a child who died in childhood.

In the analysis of the married women's knowledge on family planning, the 104 numbers are found as aware on family planning, while 48% did not. Based on their knowledge on family planning, the study conducts to examine source of knowledge among these 104 who aware on family planning. By the study, majority got information from Midwife and IEC/Action program. They also received information from their neighbors and relatives, also form auxiliary midwife. It is very rare getting self-knowledge on family planning.

In the analysis of the knowledge of contraceptives, all the participants have well understood contraceptives used although they do not realize family planning contraceptives. Majority aware OC pills and injectable contraceptives as contraceptives methods. Some of married women practices Subdermal Contraceptive Implant, female sterilization, use of condom and withdrawal practices to prevent pregnancy. The study finds that use of IUCD, calendar method, and male sterilization which are very rare contraceptive methods among these married women in Kawkareik township.

Married women in these villages know well about specific methods available to prevent pregnancy. However, a few more than 50% of respondents have broader understanding of family planning how to make informed decisions about reproductive health like spacing and limiting children, for the benefits on maternal and child health, economic well-being, and so on.

In the examining the attitudes on family planning, descriptive research method was conducted. Based on the Likert scale measure, married women attitudes on family planning contraceptives which is good things for wife and family, for mother and children, for improving standard of living, and examine their views of contraceptives used relating to their religion and culture.

In the analysis of married women attitudes on family planning contraceptives which is good things for wife and family, majority of women views as positive views on family planning contraceptives that is a good thing for wife and family. Only a few 13.5% of the total respondent's view as not good for wife and family. In analyzing the attitude on the effect on mother and children, the descriptive analysis reveals that the majority of women are positive views and in favor of family planning which is good thing for married women and their family. Further, it analyzes women attitude relating

to standing of living. The study also finds that well interconnection between family planning and standard of living with positive impact such as economic well-being and household financial security. In the views of married women on family planning with respect to religion and culture, most of respondents were agreed with the contradictions at their religion and culture. Although there is a significant opposition on that of perceive family planning, majority of respondent's view family planning contraceptives used as good thing for themselves, for family and for kids, as well as increasing socio-economic well-being.

Viewing positively on family planning contraceptives use, 77% or majority of respondents are found as practicing contraceptives at present days. The study finds that use of OC pills, injection, implants, female sterilization are the most popular contraceptives among all other methods for preventing pregnancy. In analyzing the reasons for not using any contraceptives presently, study finds that planning for getting pregnant, pregnant period, which are found as major reasons, and the intention behavior analysis is found as majority of the married women will intend to family planning contraceptives for future.

5.2. Suggestions

Being the strong awareness and knowledge, as well as positive attitude of the 200 numbers of married women in the villages of Kawkareik township, Kayin State, the following recommendation and suggestions could be made. Being the lower education level of the women in these villages, it has to find easy way to educate people about growing use of contraceptives methods, not only for limitation of birth, but also for reducing maternal mortality and infant mortality rate.

Regarding the knowledge on the family planning, the study finds that nearly half of the participants do not realize the family planning practices. This seems majority of women thought out birth control better than family planning or broader socio-economic development like education, careers, financial stability and personal growth, and even ensure well-being of existing children. Currently, they got information from midwife, auxiliary midwife, neighbors, relatives, and IEC/Action plan. It could be suggested that women getting education and counselling from healthcare providers, community health workers (midwife and auxiliary midwife), peer educators, are not enough. It is needed to organized engaging sessions in community centers, schools,

workplace, and places of pubic area for family planning education. TV, radio, and social media are also good place of communication by culturally appropriate information to increase high aware on family planning. It could be suggested the needs of more discussion the benefits of spacing or limiting the birth with related to family planning.

In this study, although women are not fully aware on family planning, these women are highly aware of various contraceptives for birth control, especially the use of OC pills, injections, implants, female sterilization, and the use of condom. Because of the OC Pill (Oral Contraceptive Pill) and injectable contraceptives are commonly used or recognized methods among respondents, it strongly suggests and necessitates that these contraceptives must be in full stock and readily available and accessible in these villages.

Regarding attitude on family planning, the study finds that this practice is a good thing for wife and family. Family planning is also good things for mothers and their children. It could be recommended that it needs to share the success of existing positive attitudes. That is, it is to identify the women in the villages who are successfully practicing family planning and are thriving. This real-life information is more powerful than giving education in semesters. For some villages, there are contradicts with religion and culture, it is suggested that the needs of partnerships with local women groups, religious leaders, local authorities, respected leaders, and community leaders, who captured positive attitude on family planning. are required with local women's growth and improving standard of living,

Married women know well about contraceptives for preventing pregnancy. However, there are the lack of knowledge on family planning. It could be the reasons that the married women in these villages in Kawkareik township might hear about contraceptives through advertising, friends, or general conversations, giving them basic method knowledge without deeper context. It is strongly suggested that healthcare educations are needed to provide to women to enhance the knowledge that family planning is associated with sustainable development goal (SDG) and economic development

Regarding the high awareness of these 200 participant women's contraceptive practices for limitation of birth rate, it is strongly recommended to advocate, and to speak about these benefits of contraceptives used in their own networks and to talk about benefits of family planning rather than just talk about limiting births by contraceptives.

The study finds that many of married women participants in this study are encouraging and intend to use contraceptives. However, as women reproductive needs evolve through their lives, relying solely on popular contraceptives of OC pills and injectables, is not sufficient for their long-term health. For that, it could be suggested that family planning educations should be expanded beyond just the most common methods, offering a wider range of suitable contraceptive choices (IUCD, implants, male sterilization, female sterilization) that can adapt to women's changing circumstances and health needs over time.

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Appendix

Survey Questionnaire

Section (A) Demographic Profile of Respondents

1.Religion	☐ Buddhist ☐ Christian ☐ Islam ☐ Other -----------------
2.Ethnicity	☐ Karen ☐ Mon ☐ Burma ☐ Pakistani descent
3.Age	☐ Under 18 years ☐ 18 to 25 years ☐ 25 to 30 years ☐ 30 to 35 years ☐ 35 to 40 years ☐ 40 to 45 years ☐ Above 45years
4.Education	☐ No education ☐ Read and write ☐ Primary ☐ Middle ☐ Secondary /High school student ☐ University student ☐ Graduate and above

5.Occupation	☐ Dependent ☐ Daily labor ☐ Farmer/ Gardener ☐ Skilled worker ☐ Government staff ☐ Merchant ☐ Others---------------------
6.Family Incomes	☐ Less than 500,000 Kyat ☐ Between 500,001 to 1,000,000 Kyat ☐ Between 1,000,001 to 1,500,000 kyat ☐ Between 1,500,001 to 2,000,000 Kyat
7.Age at first marriage	☐ Under 18 years ☐ 18 to 25 years ☐ 25 to 30 years ☐ 30 to 35 years ☐ 35 to 40 years ☐ Above 40 years
8.Number of Years in Marriage	☐ Less than 1 Year ☐ 2-3 Years ☐ 3-5 Years ☐ More than 5 Years

9.Number of children	☐ 1 Child ☐ 2-3 Children ☐ 3-5 Children ☐ More than 5 Children
10.Ever had a child who died in childhood?	☐ Yes ☐ No

Section (B) Knowledge on Family Planning

11.Have you ever heard about family planning?	☐ Yes ☐ N0
12.Sources of knowledge for family planning are….	☐ Doctor ☐ M.W ☐ A.M.W ☐ Neighbors ☐ Husband ☐ Relative ☐ Self ☐ IEC/Action program
13.Do you know the place where you can get contraceptive?	☐ Drug shops ☐ Hospital ☐ Rural Health Center ☐ Private clinic ☐ Midwife ☐ Auxiliary Midwife

14. Are you aware of family planning and its importance?	☐ Yes ☐ No
15. Have you ever heard different types of Contraceptive?	☐ Yes ☐ No
16. If say "Yes", what methods have you heard?	☐ O.C Pills ☐ Injection ☐ IUCD ☐ Condom ☐ Calendar method ☐ Withdrawal ☐ Implants ☐ Male Sterilization ☐ Female Sterilization

Section (C) Attitude on Family Planning

Please rate in an accordance with your agreement ranging from 1 is strongly disagree to 5 is strongly agree.

Sr. No.	Description	Agreeable Level				
17.	I believe that family planning is a good thing for me and my family.	1	2	3	4	5
18.	Family Planning is good for health of the mothers and their children.	1	2	3	4	5
19.	Family planning is good for improving the standard of living.	1	2	3	4	5
20.	Family Planning with contradicts my religion and culture.	1	2	3	4	5

Section (D) The Current Practice on Family Planning Method

21.Are you using any type of Family Planning method now?	□ Yes □ No
22.If say "Yes", which method was that?	□ OC Pills □ Injection □ IUCD □ Condom □ Calendar method □ Withdrawal □ Implants □ Male Sterilization □ Female Sterilization

	□ Other ----------------
23.If say “No”, Explain why it was not used" is:	□ ……………………………………
24.Do you prefer to use family planning methods in the future?	□ Yes □ No

Figure 2: Map of Kayin State by Districts and Townships