

**YANGON UNIVERSITY OF ECONOMICS
MASTER OF PUBLIC ADMINISTRATION PROGRAMME**

**BARRIERS TO CONTRACEPTIVE METHOD SWITCHING
AMONG WOMEN OF REPRODUCTIVE AGE GROUP
(Case Study: Selected Villages in Kalay Township)**

**HTET WAI MAUNG
EMPA – 13 (16th Batch)**

DECEMBER, 2019

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This thesis is submitted as a partial fulfillment towards the requirements for the degree of Master of Public Administration (MPA)

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YANGON UNIVERSITY OF ECONOMICS
MASTER OF PUBLIC ADMINISTRATION PROGRAMME

This is to certify that this thesis paper entitled “**Barriers to Contraceptive Method Switching among Women of Reproductive Age Group (Case Study: Selected Villages in Kalay Township)**” submitted as a partial fulfilment of the requirement for the Degree of Master of Public Administration, has been accepted by the Board of Examiners.

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ABSTRACT

World Health Organization (WHO) defined maternal health as the health of women during pregnancy, childbirth, and the postpartum period (WHO, 2016). Maternal health is a very important determinant of familial, educational, economic, and environmental development. One key to maternal health is family planning, which can empower women to fulfill their familial and community roles. Family planning through contraception offers women the opportunity to gain time between childbirths by deciding when to get pregnant in relation to their other life obligations. Having fewer children and spacing out births offers women and children a better quality of life and an opportunity to be more productive members of their communities. The use of long acting reversible methods of contraception (LARCs) has not kept step with that of short-acting methods such as oral pills and injectable in Myanmar. Despite its wider benefits and access at the community level, long-acting reversible and permanent methods of contraception are among the underutilized services and are thought to be influenced by misconceptions and socio-cultural values. This study aimed to explore awareness, attitudes, perceptions, myths, misconceptions of women and barriers to using long-acting reversible contraception in users of short-term methods, to inform those responsible for implementing the program such as policy makers and planners to develop and/or improve appropriate interventions to increase contraceptive use which ultimately improve women's health.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ASEAN	Association of Southeast Asian Nations
BHS	Basic Health Staff
CBHW	Community-based Health Workers
COCs	Combined Oral Contraceptive Pills
CPR	Contraceptive Prevalence Rate
DMPA	Depomedroxyprogesterone Acetate injection
DMR	Department of Medical Research
DOP	Department of Population
DoPH	Department of Public Health
EC	Emergency Contraceptive Pills
FP	Family Planning
HA	Health Assistant
HIV	Human Immunodeficiency Virus
INGOs	International Non-government Organizations
IUD	Intrauterine Devices
Jhpiego	Johns Hopkins Program for International Education in Gynecology and Obstetrics
LAM	Lactational Amenorrhea Method
LAPM	Long-acting Permanent Methods of Contraception
LARC	Long-acting Reversible Methods of Contraception
LMIS	Logistic Management and Information System
LNGIUD	Levonorgestrel Releasing Intrauterine Devices
MMCWA	Myanmar Maternal and Child Welfare Association
MMR	Maternal Mortality Ratio
MOIP	Ministry of Labour, Immigration and Population
MSI	Marie Stopes International
NGOs	Non-government Organizations
Ob/gyn	Obstetrics and Gynecology
OPD	Out-patient Department
PHS	Public Health Supervisor

PID	Pelvic inflammatory disease
PSI	Population Service International
RHC	Rural Health Center
SDG	Sustainable Development Goals
SRHC	Sub-Rural Health Center
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
UNFPA	United Nation Population Assistant Fund
U5MR	Under-five mortality rate
WHO	World Health Organization
WRA	Women of Reproductive Age

CHAPTER 1

INTRODUCTION

1.1 Rationale of the Study

In Myanmar, although the use of contraceptives has increased in recent decades, the contraceptive prevalence rate (modern methods) is 51% among married women. The use of permanent and long-acting reversible methods of contraception (LAPM and LARCs) (not greater than 3.7%) has not followed that of short-acting methods such as oral and injectable pills. Usage varies according to wealth, with 46% among poor women compared to 55% among wealthy women using modern contraceptives, and by level of education; among uneducated women, only 38% use a modern method, compared to 57% of women who have passed secondary school.

Unmet need for family planning (FP) in Myanmar is 16% (spacing and limiting). The unmet need is lower for women with secondary or higher education (12.7%) than for those without education or primary education (18.4%). In addition, it is also lower in urban areas (12.8%) than in rural areas (17.4%).

The use of contraception and family planning has many advantages. By reducing rate of unintended pregnancy, it reduces the number of unsafe abortions. Family planning and contraception prevents health risks related to pregnancy and child birth in women by spacing of pregnancies at increased risk of health problems and death from childbearing.

Family planning and contraception enables women who wish to reduce the size of their family. Evidence suggests that women who have more than 4 children are at risk of maternal death. Family planning can prevent closely spaced and ill-timed pregnancies and birth, which contribute to infant death. Infants of mothers who die as a result of giving birth also have a greater risk of death and poor health.

Family planning reduces the risk of unintended pregnancies among women living with HIV, resulting in fewer infected babies and orphans. Family planning enables people to make informed choices about their sexual and reproductive health. Family planning represents an opportunity for women to pursue additional education and participate in public health including paid employment in non-family organizations.

Additionally, having smaller families allow parents to invest more in each child. Children with fewer siblings tend to stay in school longer than those with many siblings. Pregnant adolescents are more likely to have preterm or low birth-weight babies. Babies born to adolescents have higher rate of death. Many adolescent girls who become pregnant have to leave school. This has long-term impact for them as individuals, their families and communities. Family planning slows unsustainable population growth resulting negative impact on the economy, environment and national development efforts.

If the most effective LAPMs were used, the number of unwanted births and induced abortions could have been substantially reduced to help families and countries reach their health goals. In addition, avoiding barriers to contraceptive use and increasing the demand for family planning could prevent unwanted pregnancies, maternal deaths and infant deaths each year.

In the study area, Kalay, half of the population are Chin and according to 2014 population and housing census report, total fertility rate among Chin was 5.0 which is the highest among all States and Regions in Myanmar. Moreover, the contraceptive prevalence rate of Chin State by 2015 demographic and health survey was 25% which is the lowest among all States and Regions. Despite its wider benefits and access made at community level, contraceptive methods are one of underutilized services in study area and it is believed to be influenced by misconceptions and socio-cultural values. Therefore, this study questions focused on exploring barriers to inform program managers. The structured questions were asked to married women respondents who are not using long acting and permanent method of contractions focused on their and community view on contraceptive methods, desire for more children, methods preference and reason for preference, fear of side effects and misconceptions about contraceptive utilization and possible solution/s to address challenges. All participants were encouraged to openly answer their opinions.

1.2 Objectives of the Study

This study aimed to explore awareness, attitudes, perceptions, myths, misconceptions facing by women and other barriers to using long-acting reversible contraception in users of short-term methods, to inform those responsible for implementing the program such as policy makers and planners to develop and/or improve appropriate interventions to increase contraceptive use which ultimately improve women's health.

1.3 Method of Study

A cross-sectional study design using quantitative methods was conducted in two Chin villages and two Bamar villages in the Kalay Township area of Myanmar in May, 2019. Two Chin villages and two Bamar villages were randomly selected to collect samples.

The quantitative data were collected by using structured interviewer administered questionnaires. The structured questionnaire was developed in Myanmar language by reviewing different literatures considering the local situation. Married women respondents who were using short-term contraceptive methods were randomly selected as study population ($n = 197$). The study population was calculated based on 27,556 total women of reproductive age, WRA, in Kalay Township by using 95% confident interval and 7% margin of error.

Five data collectors and one supervisor were trained for proper interview, data collection and quality assurance. Firstly, ten samples were collected for pretest to identify reliability of the questionnaires. Reliability test was done by using IBM SPSS Statistics version 25 and revised the questionnaires as necessary. All the data collectors went to the selected villages during May, 2019. They randomly selected respondent married women of reproductive age who had been using short-term contraceptive methods (such as injection Depo or combined oral contraceptive pill) or respondent women of reproductive age who are not currently using any kind of modern contraceptive methods. After that they collected the required data from those respondents by using structured questionnaire provided. All the data were entered into Microsoft Excel and exported to IBM SPSS Statistics version 25 for analysis. The binary logistic regression model along with 95% confidence interval were used.

1.4 Scope and Limitations of the Study

This study was conducted at selected villages in Kalay Township. The study period is during May, 2019. Samples were taken from respondent married women who are living in selected villages and currently using short-term contraceptive methods or who are not using any kind of modern contraceptive methods. This study sample had limited coverage to married women who are living very hard to reach villages where the health facility coverage is also limited.

1.5 Organization of the Study

This study is organized into five chapters. The first chapter is introduction with rationale, objectives, method, scope and limitation, and organization of the study. The second chapter presents the literature review and phenomenological perception of married women on family planning. The third chapter, then presents overview of the family planning, contraceptive service provision and needs of Myanmar. The fourth chapter is the analysis on barriers for contraceptive method switching among married women of reproductive age group at selected villages in Kalay. The last chapter explores in the finding of the study, conclusion and recommendation.

CHAPTER 2

LITERATURE REVIEW

2.1 Family Planning and Contraception

The World Health Organization definition is this: “Family planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility. A woman’s ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy” (WHO, 2010).

Promotion of family planning and ensuring access to preferred contraceptive methods for women and couples is essential to securing the well-being and autonomy of women, while supporting the health and development of communities.

Even though contraceptive use has increased worldwide over the last decade, more than 350 million couples worldwide have limited or no access to effective and affordable family planning services, especially to long acting reversible contraceptive methods. Yet, Myanmar like many other regions of the developing world continues to have a high unmet need for family planning. Among those who are using contraception, most are using short-acting methods, such as oral contraceptives and injectables. Myanmar has median contraceptive prevalence rate, 51.3% with highly dependent on short-term family planning methods, and high unmet need. Chin State is the lowest in contraceptive prevalence rate, with only 25% CPR.

2.2 Benefits of Family Planning and Contraception

Promotion of family planning and ensuring access to preferred contraceptive methods for women and couples is essential to securing the well-being and autonomy of women, while supporting the health and development of communities.

2.2.1 Preventing pregnancy-related health risks in women

A woman's ability to choose if and when to become pregnant has a direct impact on her health and well-being. Family planning allows spacing of pregnancies and can delay pregnancies in young women at increased risk of health problems and death from early childbearing. It prevents unintended pregnancies, including those of older women who face increased risks related to pregnancy. Family planning enables women who wish to limit the size of their families to do so. Evidence suggests that women who have more than 4 children are at increased risk of maternal mortality. By reducing rates of unintended pregnancies, family planning also reduces the need for unsafe abortion.

2.2.2 Reducing infant mortality

Family planning can prevent closely spaced and ill-timed pregnancies and births, which contribute to some of the world's highest infant mortality rates. Infants of mothers who die as a result of giving birth also have a greater risk of death and poor health.

2.2.3 Helping to prevent HIV/AIDS

Family planning reduces the risk of unintended pregnancies among women living with HIV, resulting in fewer infected babies and orphans. In addition, male and female condoms provide dual protection against unintended pregnancies and against STIs including HIV.

2.2.4 Empowering people and enhancing education

Family planning enables people to make informed choices about their sexual and reproductive health. Family planning represents an opportunity for women to pursue additional education and participate in public life, including paid employment in non-family organizations. Additionally, having smaller families allows parents to invest more in each child. Children with fewer siblings tend to stay in school longer than those with many siblings.

2.2.5 Reducing adolescent pregnancies

Pregnant adolescents are more likely to have preterm or low birth-weight babies. Babies born to adolescents have higher rates of neonatal mortality. Many

adolescent girls who become pregnant have to leave school. This has long-term implications for them as individuals, their families and communities.

2.2.6 Slowing population growth

Family planning is key to slowing unsustainable population growth and the resulting negative impacts on the economy, environment, and national and regional development efforts.

2.3 Modern Contraceptive Methods

Modern contraceptive methods can be classified under 3 broad groups: (1) long-acting reversible contraceptives (LARC), i.e., intrauterine devices (IUD) and hormonal implants; (2) short-acting contraceptives (i.e., oral contraceptive (COC) pills, condoms, spermicides, and injectable hormones; and (3) permanent methods (i.e., sterilization via tubal-ligation or vasectomy).

Table 2.1 Effectiveness of Contraceptive Methods

		First-Year Pregnancy Rate	12-Month Pregnancy Rate
Family planning method	Consistent / correct use	As commonly used	As commonly used
Implants	0.1	0.1	0.6
Vasectomy	0.1	0.15	
Female sterilization	0.5	0.5	
Levonorgestrel IUD	0.5	0.7	
Copper-bearing IUD	0.6	0.8	1.4
LAM (for 6 months)	0.9	2	
Monthly injectable	0.05	3	
Progestin-only injectable	0.2	4	1.7
Combined oral contraceptives	0.3	7	5.5

		First-Year Pregnancy Rate	12-Month Pregnancy Rate
Family planning method	Consistent / correct use	As commonly used	As commonly used
Progestin-only pills	0.3	7	
Combined patch	0.3	7	
Combined vaginal ring	0.3	7	
Male condoms	2	13	5.4
Standard Days Method	5	12	
Two Day Method	4	14	
Ovulation Method	3	23	
Fertility awareness methods		15	
Diaphragms with spermicide	16	17	
Withdrawal	4	20	13.4
Female condoms	5	21	
Spermicide	16	21	
Cervical cap	26	32	
No method	85	85	

Source; Family Planning – Global Handbook for Providers, 2018

2.4 Attributes of Long-Acting and Permanent Methods

Long-acting and permanent methods are by far the most effective (99 percent or greater) methods of contraception available and are very safe and convenient. They all are clinical methods and thus must be provided by trained doctors, nurses, and/or midwives in health facilities. Only by one client and provider attachment results in years of protection against unintended pregnancy. The desirability of these methods is due to their long-life span; unlike pills, condoms & injectables has higher continuation and effectiveness rates.

The American College of Obstetricians and Gynecologists and American Academy of Pediatrics endorse long-acting reversible contraceptives (LARCs) as the first-line contraceptive option because of these agents' efficacy and safety profiles.

2.5 Determinants of long acting reversible contraceptive use

2.5.1 Socio-demographic determinants

A number of factors could contribute to the lack of availability and access to long acting reversible contraceptive methods. Evidences from other countries and within Myanmar showed that many factors including fertility related reason, opposition to use, lack of knowledge, method related reason could act as barriers to choose long acting reversible contraceptive methods as a method.

A cross sectional community-based survey conducted to assess factors associated with utilization of long acting and permanent contraceptive methods among married women in Mekelle town, 2011. Alemayehu (2012) found that, the majority of the married women for not using long acting reversible contraceptive methods (LARCs) were using another method of contraception 360 (93.3%), Mothers who had high knowledge were 8 times more likely to use long acting contraceptive methods as compared with those who had low knowledge, mothers who had two or more pregnancies were 3 times more likely to use long acting contraceptive methods as compared with those who had one pregnancy & more than half (53.6%) of married women had negative attitude towards practicing of LARCs.

Mekonnen (2011) revealed that married women who attained primary and secondary plus level of education have about 2 times more likely to use contraception than women who have no formal education.

2.5.2 Access to information and services factors

In Sub-Saharan Africa and Asia, 22–25% of married women have reason for not using contraceptive methods due to lack of access to information and services. Even when trained providers are available, providers may not provide LARCs to their clients because of unnecessary or outdated restrictions, such as age or the number of children a woman has. They may not be familiar with the latest evidence and so may unintentionally deny a client an LARCs for inappropriate medical reasons. Or, they

may not offer comprehensive information about all methods during counseling, which limits the ability of a client to make an informed contraceptive choice.

Alemayehu (2012) examined that married women general awareness about Long acting permanent methods (LAPMs), 63.9% had heard about LAPMs in general, out of this, 80.7%, 55.3% and 39.8% had heard about implants, IUD and female sterilization, respectively. Only 15.6% of the married women heard about vasectomy and 23.8% named more than two contraceptives. Moreover, 124 (44.1%) had awareness about more than one advantage of long acting contraceptive methods.

2.5.3 Religion and Cultural Norms

In Nigeria, implant services have been maintained, but no attempt has been made to report the response of this largely in Hausa and Muslim community where contraceptive use is generally low. In Jordan, nearly 40% of married men do not believe in practicing contraception and more than half believe that family size should be left up to God. Sexuality is not openly discussed because of taboos. Additionally, son preference and the need for children in the workforce are barriers to contraceptive use even within the context of marriage.

Mekonnen (2011) found out that about 22.2% of family planning users expected rejections by religious leaders and their community to practice it.

2.5.4 Myths and misconceptions, Knowledge and attitude as determinant

A third of the population had felt that the prolonged use of hormonal contraceptives would lead to future infertility (Hobago, 2009).

With regard to attitudes about LAPMs, 15.5% and 26.8% married women agreed that implant can result in irregular bleeding and cause severe pain during insertion and removal respectively (Alemayehu, 2012). Above one fourth (29.7%) of the married women agreed that insertion of IUD can result in shame while it inserted to cervix by health professional. About 19.6% agreed that IUD prevents from doing normal activities and 34.4% agreed that undergoing an operation for female sterilization was dangerous. Asked on their attitudes about the side effects of LAPMs, they agreed that irregular bleeding due to the use of implant is severe (28.9%), insertion and removal of implant is highly pain full (33.1%), losing privacy during IUD insertion is shameful (65.3%).

Some reasons for the unmet need are socio-cultural values and norms that deter the use of family planning in the community (Mekonnen, 2011). The majority (43.1%) replied they could not get the method they prefer in the nearby health facility unless they walk a long distance, in some instances up to 18 kilometers. Another 12.6% reported absence of all contraceptives or the ones they preferred in facilities. About 4.8% mentioned lower level service providers' incompetence. Whereas, about 16.8% of married women reported reasons related to the side effect and contraindications of available contraceptive methods in the area such as heart burn, excessive bleeding and their presumption of requirement of balanced diet and optimum work load.

2.5.5 Husband-wife discussion as determinant of contraceptive use

Nearly 59% were married and 25.5% were using modern methods. Nearly 75% of contraceptive users had at least one living child Ghana. More than 82% of women had discussed family planning with someone, but only 48.3% had discussed contraception with their partners. In Yemen, about 42% of women said they had not talked to their husbands about family planning in the year preceding the survey while 26% had discussed it once or twice and 32% had discussed it more often (Omar, 2009).

There was a positive association between partner's educational status of women and contraception (Mekonnen, 2011). The odds of contraception was 1.32 and 1.50 times higher among married women whose partners have primary and secondary plus level of education respectively compared to those who have uneducated partners & women.

2.6 Perceptions about long acting reversible contraceptive

2.6.1 Patient Perceptions

A survey of women aged 15 to 49 years showed their low overall knowledge about LARCs. Of those studied, 53.9% had heard of the implant, 59.8% the LNGIUD, and 46.1% the IUD. Half of those surveyed did not know LARCs were the most efficacious contraceptives and thought incorrectly that LARCs negatively affect fertility. Women gain most of their knowledge about contraception from personal anecdotes they are informed about a particular contraceptive based on acquaintances' experiences, whether positive or negative. A qualitative survey revealed that women recalled negative contraceptive experiences from friends and family more so than

positive experiences. This finding is significant because women may be given incorrect or exaggerated information from peers that could affect their impression of LARCs. However, in an additional qualitative study, many women did report that information given to them by providers could potentially counteract acquaintances' anecdotes. One study found that, if women were introduced to the IUD from a health care provider, they were 2.7 times more likely to choose them, which suggests that, even if adolescents are first gaining information on contraception from peers, they still have a tendency to trust health care providers' recommendations. If providers are able to educate adolescents with correct and up-to-date information, women may subsequently relay this accurate information to their peers.

2.6.2 Provider Perceptions

Medical providers who provide contraception for women are typically those who practice in the specialties of family medicine and obstetrics-gynecology. Providers account for most adolescent primary care, placing them in a unique position to be the first to introduce LARCs to this age group. A survey of pediatricians regarding practices concerning LARCs showed a misunderstanding of the safety of IUDs in adolescents. In a survey of 53 New York pediatricians, more than 80% reported initiating contraception, but only 35.8% reported counseling about IUD use. Lack of awareness of guidelines for LARC use is not only evident for providers but also for obstetrician-gynecologists (OBGYNs).

A survey of more than 1500 OBGYNs revealed that more than half disagreed with IUDs being the first-line choice of contraception for women. This survey also showed that OBGYNs who had recently completed continuing medical education were more likely to insert an IUD in a nulliparous woman. Although this survey reveals that many OBGYNs are not up to date with current guidelines, it also suggests that education can help practitioners update their practices.

One survey of family medicine residents found that most residents thought that an IUD was appropriate for a woman less than 20 years old, but only 51.8% of all residents thought that an IUD was appropriate for a woman who had contracted a sexually transmitted infection (STI) in the past 6 months, and nearly a third thought IUDs increase long-term risk of pelvic inflammatory disease. Although the residents surveyed showed enthusiasm for IUDs, only 55.7% of first-year through third-year

residents had inserted at least one LNGIUD and only 31% had inserted at least one IUD. In order for LARCs, and in particular IUDs, to be more available to adolescents, it is important to give resident physicians more opportunities to acquire the skills to perform insertions.

2.7 Risks, barriers, and misconception of LARCs

2.7.1 Risk of pelvic inflammatory disease with intrauterine devices

Pelvic inflammatory disease (PID) is an infection of the upper genital tract caused by the spread of bacteria (most commonly *Neisseria gonorrhoeae* and *Chlamydia trachomatis*) from the vagina or cervix to the uterus. PID can lead to serious medical consequences such as tubo-ovarian abscess, ectopic pregnancy, and infertility. The risk for PID is of concern for women because they have greater rates of STIs, which, if left untreated, predispose these patients to PID.

One study of OBGYNs showed that 1 in 7 of those surveyed thought that PID is a major risk of IUDs. This association most likely stems from the chronicles surrounding the Dalkon Shield, an IUD that was shown in the 1970s to be associated with PID but has now been off the market for decades.

There is also concern among some providers that insertion of an IUD for a woman already at increased risk for STIs may further increase the risk for acquiring PID. Evidence shows that the small risk for PID after insertion is mildly increased for the 20 days after insertion but then returns to baseline. It is thought that the likely cause of infection is contamination during the insertion procedure, not the IUD itself.

An analysis of 6 studies investigating the relationship between IUD insertion and PID found that those women who had a cervical infection at the time of IUD insertion had a 0% to 5% risk of PID and those without a cervical infection at insertion had a 0% to 2% risk. Although there seems to be a minimally increased risk of acquiring PID with IUD insertion in patients with a concurrent infection, one study showed there was no significant difference of PID after IUD insertion in adolescents who were screened for an STI within 1 year before IUD insertion compared with those who were not screened. In addition, patients who were screened on the day of insertion, including those less than 26 years old, had similar rates of PID to those who were previously screened. Therefore, an extra appointment for STI screening before IUD insertion is not

necessary and is likely to lead to increased costs for the patient. Adolescents should be screened for STIs at the time of IUD insertion. They should be counseled about the small risk for infection and, in the case of infection, the patient can be safely treated with the IUD in place.

2.7.2 Infertility

Another reservation about IUD use in adolescents is the fear that an IUD could lead to infertility. Many women are fearful the IUD will become permanently fixed in the body and unable to be removed. A case control study of women showed that CuT380A did not increase risk for tubal occlusion but that infection with *C trachomatis* did increase this risk. An additional prospective study showed a quick return to fertility after IUD removal. Providers should help dispel patients' fears that IUDs negatively affect future plans for pregnancy.

2.7.3 Expulsion of intrauterine devices

Historically, IUDs were marketed for parous women and this legacy may be a barrier to use in women, who are likely to be nulliparous. OBGYNs are less likely to provide IUDs to nulliparous women. Avoiding IUDs in nulliparous women may also be rooted in fear of difficulty of IUD placement and increased expulsion rates. In addition, women express fear that an IUD expulsion would leave them susceptible to pregnancy.

A study of IUD insertions in young women showed high success rates (>90%) for the insertion process. In addition, the CHOICE study investigated IUD expulsions in thousands of women and found no increased expulsion rate in nulliparous women. The study, however, did find an increased rate of expulsion in women less than 20 years of age, regardless of parity. Although the rate was increased in this age group, their expulsion rate was low, at less than 3%. Expulsion of IUDs is highest for immediately postpartum women (within 10 minutes of placental delivery). Despite this higher rate, American College of Obstetricians and Gynecologists recommends IUD and implant insertion in postpartum women before leaving the hospital. Immediate insertion of LARCs is promoted given that postpartum women are motivated to begin contraception and may not return for their postpartum visits. Regardless of parity, women should be counseled by their providers on the signs of an IUD expulsion and to do a monthly self-check of IUD placement to monitor themselves for expulsion.

2.7.4 Menstrual cycle disturbance with LARCs

Menstrual cycle disturbance is a common reason of women decide to have their LARCs removed. Each LARC method has a unique bleeding profile. Bleeding can be unpredictable for implant users and this change is the most common reason women discontinue the implant. Around 22% of women with the implant experience amenorrhea, 33% infrequent bleeding, 6.7% frequent bleeding, and 17.7% prolonged bleeding. Dysmenorrhea and heavy bleeding often increase in the first few months after CuT380A insertion but usually decrease over time. In addition, irregular and increased bleeding is common in the first 3 months following insertion of LNGIUDs but also usually decreases over time and may lead to amenorrhea. LNGIUDs with higher doses of levonorgestrel usually result in less bleeding over time. The Mirena LNGIUD is US Food and Drug Administration approved to treat heavy menstrual bleeding and results in a 70% to 95% reduction in menstrual bleeding. The use of nonsteroidal anti-inflammatory medications is shown to improve dysmenorrhea and irregular/prolonged bleeding with all LARC methods.

The CHOICE project surveyed women who experienced changes in menstrual flow and frequency of menses regarding their satisfaction with their contraception. At 6 months postinsertion, more than 90% of LARC users (95% of LNGIUD users, 93% of IUD users, and 90% of implant users) were satisfied with their form of birth control regardless of changes in bleeding. Between 45% and 62% of LARC users report lighter bleeding and infrequent menses, which can be considered a benefit to LARC use. Young women should be counseled regarding the unique bleeding changes associated with their chosen LARC.

2.8 Long-acting reversible contraceptives discontinuation

When compared with older women, younger women have been found to have a slightly higher discontinuation rate of LARCs. Although adolescents are slightly more likely to discontinue a LARC method, the rate of discontinuation is significantly lower than that of women discontinuing non-LARC contraceptives. An analysis of more than 10 studies showed a continuation rate of 84% for all LARC methods in adolescents. Proper counseling about potential menstrual disturbances and coping mechanisms may reduce the discontinuation rate. Specifically, with the implant, women should be

counseled to promptly return to the office to discuss bleeding concerns, because this earlier consultation may improve continuation rates.

2.9 Fear, pain and uterine perforation with intrauterine device insertion

Women express concern that IUDs may cause harm to their bodies. Uterine perforation is a potential adverse event, but it is uncommon. A review of the safety of IUDs found that perforation rates of LNGIUD and IUD were both very low, ranging from 0% to 0.1%, irrespective of age. Women at the highest risk for perforation are those who are breast feeding and those who are postpartum (<36 weeks from last delivery). Breastfeeding and postpartum state are independently associated with higher rates of IUD perforation. Although uterine perforation is a serious adverse event of IUD insertion, the outcomes of perforations in one study of more than 60,000 women were neither serious nor life threatening. Providers should counsel their patients on the low risk for uterine perforation.

Women who have heard of the IUD, but who have not had an IUD themselves, express a fear of the insertion process. Furthermore, women's fear not being in control during the procedure. From the providers' perspective, some express concern that, if a young woman's first contraceptive is one that induces pain, she may be left with a negative impression of contraception and pelvic examinations. In order to reduce pain and increase ease of insertion, some providers administer misoprostol to nulliparous patients before IUD insertion. A randomized study of nulliparous women showed no reduction in pain or ease of insertion with prophylactic misoprostol. The women pretreated with misoprostol experienced more adverse side effects like cramping and nausea before IUD insertion. Routinely giving patients misoprostol before IUD insertion could worsen the IUD insertion experience and should be avoided. Some providers require patients to be menstruating at the time of IUD insertion in order to definitively rule out pregnancy and because of the belief that insertion at this time may reduce pain and increase ease of the procedure. A review of 8 studies showed no reduction of pain with IUD insertion while the patient was menstruating. Because of the difficulty of scheduling appointments and arranging transportation, requiring a woman to return while on her menses adds an unnecessary barrier to IUD use.

A 2017 randomized trial investigated the use of 10-mL 1% lidocaine paracervical nerve blocks in reducing pain of the 13-mg LNGIUD in young women.

Those women who received a paracervical block rather than a sham block reported less pain with insertion. In addition, a comparison of LNGIUDs found that the models of LNGIUD that contain a smaller frame caused less pain with insertion and were easier to insert in younger women. To reduce pain during IUD insertion, providers may offer a smaller IUD, such as Kyleena 19.5-mg LNGIUD or Skyla 13.5-mg LNGIUD, as well as administration of a paracervical block. IUDs may be safely and effectively inserted at any point in the menstrual cycle as long as pregnancy can be excluded. In order for an adolescent to feel in control of the insertion process, providers should reassure the patient that she may request discontinuation at any point during the procedure.

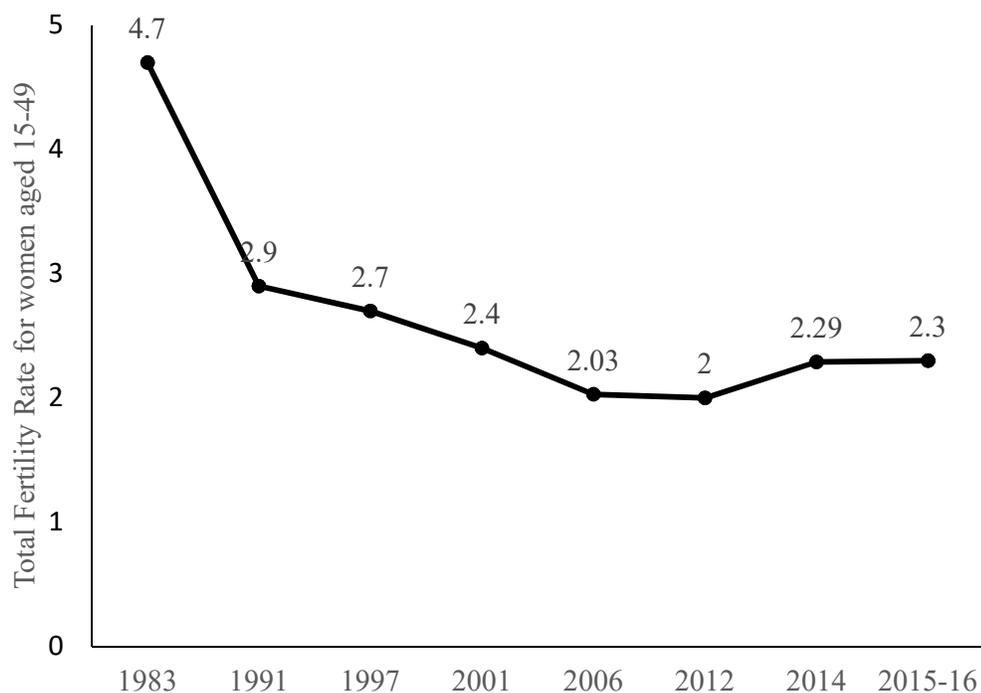
CHAPTER 3

CONTRACEPTIVE SERVICES, KNOWLEDGE AND USE IN MYANMAR

3.1 Fertility in Myanmar

The 2014 population and housing census reported that the total fertility rate is 2.5 children per woman at the Union level, 1.9 children per woman for urban areas, and 2.8 children per woman for rural areas. Total fertility of States and Regions varies from a high of 5.0 children per woman for Chin State to a low of 1.8 children per woman for Yangon Region. The total fertility rate (TFR) in Myanmar has decreased from 4.7 to 2.3 in the last 33 years. The TFR was 2.3 for all women in 2015 and 4.03 for ever-married women in 2014. The TFR for all women ages 15 to 49 in Myanmar was slightly lower than the average TFR of other countries in the South East Asia region, at 2.5 children per woman. The TFR differs according to population location; fertility is higher among rural women than among urban women at 2.4 and 1.9, respectively. The age specific fertility rate is higher in rural women ages 20 to 24 than the 25 to 29 age group.

Figure 3.1 Trends in TFR for women (aged 15-49), 1983-2016



Source: Jhpiego FP2020 Landscape Analysis Report

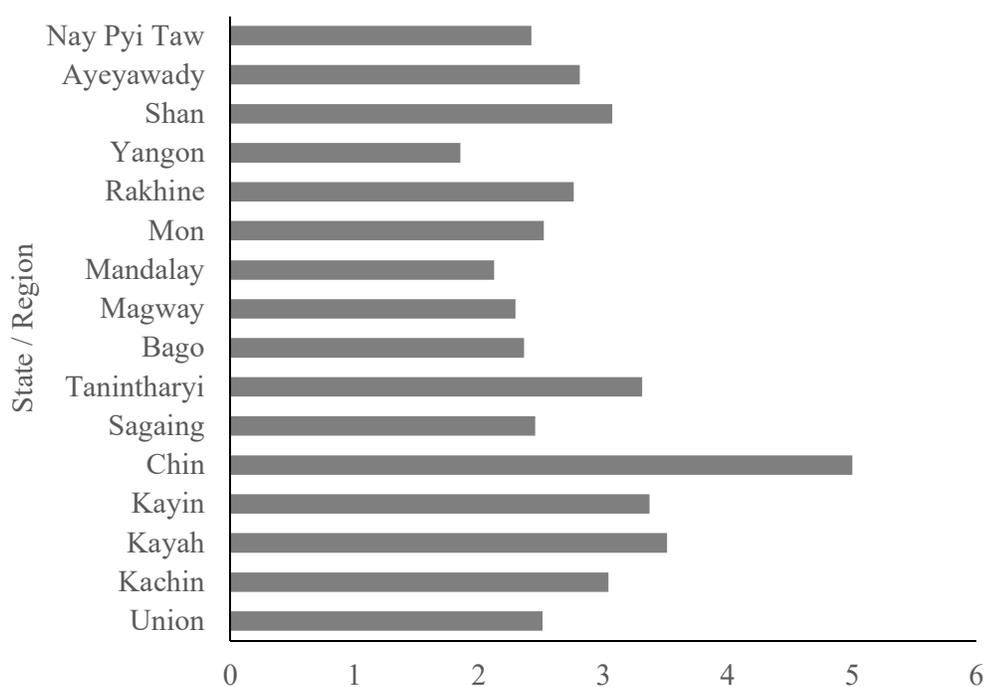
Table 3.1 Total fertility rates for Union and States/Regions

State/Region	Unadjusted	Adjusted
Union	2.29	2.51
Kachin	2.81	3.04
Kayah	3.33	3.51
Kayin	3.41	3.37
Chin	4.35	5.00
Sagaing	2.31	2.45
Tanintharyi	2.97	3.31
Bago	2.19	2.36
Magway	2.07	2.29

State/Region	Unadjusted	Adjusted
Mandalay	1.94	2.12
Mon	2.43	2.52
Rakhine	2.23	2.76
Yangon	1.72	1.85
Shan	2.67	3.07
Ayeyawady	2.58	2.81
Nay Pyi Taw	2.15	2.42

Source: Census Report Volume (4-A) - Thematic Report on Fertility and Nuptiality

Figure 3.2 Total fertility rates for Union and States/Regions



Source: Table 3.1 Total fertility rates for Union and States/Regions

3.2 Overview of contraceptive knowledge

According to Demographic and Health Survey in Myanmar (2015-16), knowledge of contraceptive methods among married women is almost universal, with 98.5% knowing at least one method of contraception. On average, women have heard of seven methods, with most having heard about modern methods. The most commonly known method among married women is injectables (97.7%), followed by the pill (96.1%), and female sterilization (88.8%). Knowledge about emergency contraception is relatively poor, with only one in four married women having heard about it.

Table 3.2 Knowledge on contraceptive methods

Method	All Women (%)	Married Women (%)
Any method	96.7	98.5
Any modern method	96.6	98.4
Female sterilization	84.4	88.8
Male sterilization	50.7	60.2
Pill	93.0	96.1
IUD	70.5	80.1
Injectables	94.6	97.7
Implants	61.1	70.3
Male condom	73.0	76.8
Female condom	28.4	31.0
Lactational amenorrhea method (LAM)	36.5	43.9
Emergency contraception	25.4	28.7
Other modern method	1.3	1.8

Source: Myanmar Demographic and Health Survey 2015-16

3.3 Use of modern contraceptive methods

Modern contraceptive methods include male and female sterilization, injectables, intrauterine devices (IUDs), contraceptive pills, implants, male condoms, and the lactational amenorrhea method (LAM).

According to Myanmar Demographic and Health Survey (2015-16), among married women, injectables are the most commonly used method (28%), followed by the pill (14%), female sterilization (5%), and the IUD (3%).

Modern contraceptive use peaks at 62% among currently married women age 35-39. More than half of currently married adolescents (women age 15-19) (53%) use modern contraceptive methods.

3.4 Use of modern contraceptive methods by background characteristics

Myanmar Demographic and Health Survey (2015-16) said that modern contraceptive use is highest among married women with 1-2 living children (58%) and generally declines as the number of living children goes up. Women in urban areas are somewhat more likely to use modern contraceptives than those in rural areas (57% versus 49%). Contraceptive use increases substantially with education. Married women with secondary education or higher are more likely to use modern methods of contraception than those with no education (57-58% versus 38%). There are big differences in contraceptive use among currently married women across states and regions. The use of modern contraception ranges from a low of 25% in Chin State to a high of 60% in Bago Region and Yangon Region.

3.5 Family planning service provision and service range

The Government of Myanmar implemented a policy which has made contraceptives available in the public sector since 1991. Birth spacing activities have taken place in townships; since 1996, combined oral contraceptive (COCs) pills, depomedroxyprogesterone acetate (DMPA) injection and condoms have been available at primary level health facilities. Women have access to intrauterine devices (IUD) at township hospitals, maternal and child health centers and some rural health centers. Previously, contraceptive users needed to pay a user charge as part of a cost recovery scheme, however currently there is no charge. Female sterilization can be done in most township hospitals only after prior official approval has been obtained. Male

sterilization is legally available only to those whose wives cannot undergo female sterilization due to possible adverse health consequences. Male sterilization is restricted by law to those men whose wives have been approved for, but are not able to undergo sterilization. Injectable contraceptives can be purchased at most drug stores by health staff as well as clients without any prescription.

3.6 Source of modern contraceptive methods

United Nation Population Assistant Fund (UNFPA) provides family planning commodities (oral contraceptive (COCs) pills, injectables, condoms, and implants) to the Maternal and Reproductive Health Division, Department of Public Health (DoPH) and family planning implementing partners (INGOs, NGOs). Marie Stopes International (MSI)/Myanmar's clinics, mobile outreach activities, and Sun Quality Health Network, franchise network of Population Services International (PSI)/Myanmar, provide a broad range of family planning services (COC pills, injectables, condoms, implants, IUD). MSI and PSI distribute family planning commodities in a social marketing approach to pharmacies and clinics. Local non-governmental organization such as maternity clinics of the MMCWA, provide family planning services as well.

3.7 Family planning service readiness of health facilities

Health facility assessment for reproductive health commodities and services (2016) stated that health staff or service providers in government health facilities were assigned to conduct FP counseling/education. However, more than 50 percent of the health facilities did not have job aids or visual aids, for counselling during family planning service provision. Almost all of the tertiary level hospitals have a high load of clients for antenatal care and postnatal care in the out-patient department (OPD). OPD space is very limited for OPD day of Ob/gyn ward admittance in all tertiary level hospitals; nursing station, examination bed for clients/patients, and doctor station were in the trolley way in one of the health facilities. Healthcare providers (midwives, nurses and doctors) were available at the health facilities and provided FP service with supporting staff (Nurse Aid, Public Health Supervisor (PHS) II, Health Assistant (HA) and cleaner).

More than 80 percent of health facilities have the necessary facilities, instruments/kits and materials needed to support the provision of FP service. More than

80 percent of health facilities which provide IUD services have almost all of instruments except alligator forceps. More than 80 percent of health facilities providing contraceptive implants have all necessary instruments and materials, except scalpel since most of providers use the disposable trocar for implant (Jadelle) insertion (Jadelle implants and disposable trocars were supplied by UNFPA through the Maternal Reproductive Health Division, Department of Public Health, Ministry of Health and Sports).

More than 80 percent of the health facilities offered at least three modern contraceptives; oral contraceptives, injectables, male condom/emergency contraceptives. There was no difference between urban and rural or among levels of health facilities on the availability of at least three modern contraceptives. However, IUD insertion and removal services were available in 60 percent of health facilities, followed by 33 percent for implants and permanent methods. None of the health facilities were able to offer female condoms as a method of choice in FP service provision due to a lack of commodity/supply and lack of awareness.

3.8 Family planning trainings for service providers

According to the 2016 health facility assessment for reproductive health commodities and services, the percentage of facilities with trained staff for birth spacing was lowest in the secondary level (40.65) compared to tertiary and primary levels (61 percent and 69 percent, respectively). In all health facility levels, the percentage was less than that of the previous year. Fifty two percent of tertiary level health facilities had trained staff for implant insertion and removal, which was highest among the three levels of health facilities. Nearly six percent of primary level health facilities trained staff for implant insertion and removal. The private sector also had low levels of trained staff for both birth-spacing and implant (48 percent and 52 percent, respectively).

3.9 Quality assurance of service providers

Capacity building of national level monitoring and evaluation officers was carried out with the support of the Track 20 team to improve the monitoring system for family planning. Moreover, consensus building workshops for FP 2020 indicators have been conducted since 2016 to get agreement among stakeholders while discussing data utilization, data monitoring, private sector involvement, and other monitoring issues. The reproductive health logistic management and information system (LMIS) was

implemented in selected project townships starting in 2014 to ensure reproductive health commodity security

3.10 Role of private sector

FPwatch Study Reference Document (2016) reported that the majority of the private sector contraceptive market is comprised of general retailers (42 percent). Outside of general retailers, the private outlets stocking modern contraceptives (excluding condoms only outlets) are made up of 25 percent pharmacies, 15 percent private facilities, 16 percent private community health providers (village health volunteers, midwives, nurses, retired health workers), and 2 percent itinerant drug vendors.

The pharmacy contribution to contraceptive market share in the private sector was 54 percent, followed by 21 percent from private facilities, and 12 percent from community health workers and health providers in the community. General retailers and non-profits accounted for about 10 percent and 4 percent of the total private market share, respectively. Less than 1 percent was from itinerant drug vendors.

3.11 Health status of mothers and children

The maternal mortality ratio (MMR) in Myanmar is the second highest among ASEAN countries at 282 deaths per 100,000 live births, compared to 161 in Cambodia and 20 in Thailand. Every year, approximately 2,800 women die during pregnancy or child birth. The under-five mortality rate (U5MR) is 72 deaths per 1,000 live births, compared to 29 in Cambodia and 12 in Thailand. The infant mortality rate is 62 per 1,000 live births compared to 25 in Cambodia and 11 in Thailand. The adolescent fertility rate is 36 births per thousand women aged 15-19 years (Jhpiego, 2017).

3.12 National family planning program

Improving access to sexual and reproductive health services such as family planning (FP) is fundamental to achieving the Sustainable Development Goals (SDG) because this access is strongly interrelated with women's and children's health, as well as poverty, education, gender equality, and human rights. Access to FP contributes up to a 44% reduction in maternal deaths and a 21% reduction of deaths in children under five year of age. Access enhances opportunities for women and girls to attain greater

socioeconomic status through education, employment, and empowerment, and accelerates the development of the country by reducing healthcare costs.

Myanmar has the second highest maternal mortality ratio (MMR) (178/100,000 live births) among the Association of Southeast Asian Nations (ASEAN) countries. Abortion-related complications were the second leading cause of maternal death. In the 2014 Myanmar Population and Housing Census, the MMR in Myanmar was 282 deaths per 100,000 live births. The pregnancy-related mortality ratio was 227 deaths per 100,000 live births in the 2015-16 Myanmar Demographic and Health Survey. Given these statistics, Myanmar has been working to improve accessibility to modern FP methods and to improve maternal and newborn health. Reproductive, maternal, newborn, child, and adolescent health are priority public health issues in the Myanmar National Health Plan. In 2013, Myanmar strongly committed to Family Planning 2020, a global initiative focused on reaching more women with life-saving information and access to contraceptives by the year 2020.

The Government of Myanmar views family planning as critical to save lives, by protecting mothers and children from death, ill health, disability and under development. It views access to family planning information, commodities, and services as a fundamental right for every woman and community if they are to develop to their full potential. In order to improve the life of women and girls through access to quality birth spacing services without any social and regional disparities, Myanmar has committed to Family Planning 2020 with the aim to (1) Increase Contraceptive Prevalence Rate (CPR) from 41 percent to above 60 percent by 2020, (2) Reduce unmet need to less than 10 percent, (3) Increase demand satisfaction from 67 percent to 80 percent, and (4) Improve method mix with increased use of long acting methods and decentralization to districts. Myanmar's commitment includes policy, financial and service delivery perspectives that are critical to increasing access for more women and girls.

Myanmar's FP program began in 1991 as a pilot in one township. Since 2012, the government has increased the health budget, invested additional resources in the FP program, and increased the accessibility of contraceptives at the community level. Myanmar has been working to increase contraceptive use by married couples and unmarried individuals through informed choice. National surveys conducted in

Myanmar showed an increasing trend in the modern contraceptive prevalence rate (CPR) from 38% in 2007 to 51% in 2016, and a decreased trend in the unmet need for FP from 19% in 2007 to 16% in 2016. However, the CPR and the unmet need for FP are not adequate for achieving the FP2020 targets of greater than 60% CPR and less than 10% of unmet need.

In addition, there is much disparity in unmet need for FP among Myanmar's states and regions. Although the best approach to reducing unintended pregnancies is contraception, the high rate of unsafe abortion shows that women in Myanmar continue to experience challenges in contraceptive accessibility and use. Since the majority of unplanned pregnancies and abortions occur in women who were not using birth control or were not using it consistently, greater access to and consistent use of contraception are crucial in the reduction of unplanned pregnancies and abortions. Furthermore, unplanned pregnancies can lead to poor maternal and child health outcomes, which affect the development of the country.

CHAPTER 4

SURVEY ANALYSIS

4.1 Survey Profile

This study was conducted in selected villages (two Bamar villages and two Chin villages) in Kalay Township from 15 April 2019 to 31 May 2019. Kalay is a historical area. Kalay situated at North West part of Sagaing Region. There are 157 villages and 19 wards in Kalay Township. According to 2014-population census, total population in Kalay Township is 338,079. Bamar and Chin are the major population living in Kalay Township (53% and 46%). Among the total population, 64% are living in rural area and 36% are living in urban area. In addition, among total population, male proportion is 48% and female proportion is 52%. Buddhist and Christian are major religion among population (53% and 46%).

According to Township Profile from General Administrative Department (2017), there are 5 public hospital, 5 private hospital, 8 rural health centers (RHC) and 47 sub-rural health centers (SRHC) which are providing general medical care including reproductive health services in Kalay Township. In those health facility, 81 medical doctors (doctor and population ratio = 1:4173), 136 nurses (nurse and population ratio = 1:2485) and 8 health assistants (HA and population ratio = 1:42259) are providing medical care services including reproductive health care.

Non-government organization (NGO) such as Population Service International (PSI) and Marie Stopes International (MSI) were major private service providers for family planning services. Now, because of limitation in donor funding availabilities, Marie Stopes International (MSI) ended their project activities in Kalay Township for reproductive health services therefore Population Service International (PSI) only is major private service provider for family planning services.

4.2 Survey Design

This study was the cross-sectional study design using quantitative methods. Study population is the married women of reproductive age group who were using short-term contraceptive methods and residing in rural area of Kalay Township.

The questionnaire was divided into three parts: (1) Socio-demographic conditions of respondents, (2) Contraceptive knowledge and usage history and (3) Questions relating to long-term reversible contraceptive methods. The questionnaire had multiple-choice questions in which choice of answer and respondents were asked to select one or more of the alternatives and dichotomous questions that had only two response alternatives, Yes or No and demographic questions. Collected data were tabulated, analyzed and interpreted in the light of objective of the study by applying descriptive statistics.

Survey finding are categorized into (3) parts. The first part, Part (A) is Socio-demographic conditions of respondents. The second part, Part (B) is showing reproductive and contraceptive history of the respondent. The final part, Part (C) is finding about knowledge, attitude of respondents and service requirement for long-term and reversible contraceptives.

4.3 Demographic Characteristics of the Respondents

In this study, total 210 married women respondents were interviewed and 197 valid responses were included to give some findings regarding the barriers for contraceptive method switching from short-term contraceptive methods to long-term reversible contraceptive methods. Below tables describe the socio-demographic conditions of respondents.

Table 4.1 Race and religion of the respondents

Race	Frequency	Percent	Valid Percent	Cumulative Percent
Bamar	92	46.7	46.7	46.7
Chin	105	53.3	53.3	100.0
Religion	Frequency	Percent	Valid Percent	Cumulative Percent
Buddhist	91	46.2	46.2	46.2
Christian	106	53.8	53.8	100.0

Source: Survey Data, 2019

53.3% of the respondents were Chin and 46.7% were Bamar. 46.2% of the respondents were Buddhist and 53.8% were Christian.

Table 4.2 Age of respondents and number of children

	Minimum	Maximum	Mean	Std. Deviation
Age	19	49	34.54	6.759
Women's age of marriage	16	35	22.11	4.086
Number of children	0	9	2.55	1.912
Number of Children	Bamar	Chin	Total	Percentage
0	10	0	10	5
1	57	11	68	35
2	22	15	37	19
3	2	27	29	15
4 and above	1	52	53	27

Source: Survey Data, 2019

The youngest women among respondents is 19 year and the oldest women is 49 year. The mean age is 34.54. The earliest age of marriage among respondents is at 16 year and the latest age is at 35 year. The mean age of marriage is 22.11. Among the respondents, the number of children is range from 0 to 9 (mean number of children is 2.55). All the Chin respondents have at least one child. Among the all respondents, 27% have four and above children. In those respondents who have four and above children, 98% are Chin respondents meaning that Chin respondents desire to have many children in their family.

Table 4.3 Education status of husband and wife

Women's Education	Frequency	Percent	Valid Percent	Cumulative Percent
Read and Write	10	5.1	5.1	5.1
Primary School	30	15.2	15.2	20.3
Middle School	50	25.4	25.4	45.7
High School	44	22.3	22.3	68.0
University Graduate	63	32.0	32.0	100.0
Number of Children	Low Education	Under Graduate Education	Post Graduate Education	Percentage
0	2	6	2	5
1	2	40	26	35
2	3	18	16	18.5
3	1	17	11	14.5
4 and above	4	41	8	27
Husband's Education	Frequency	Percent	Valid Percent	Cumulative Percent
Read and Write	20	10.2	10.2	10.2
Primary School	38	19.3	19.3	29.4

Middle School	53	26.9	26.9	56.3
High School	27	13.7	13.7	70.1
University Graduate	59	29.9	29.9	100.0
Number of Children	Low Education	Under Graduate Education	Post Graduate Education	Percentage
0	1	9	4	5
1	5	37	26	34.5
2	3	19	15	19
3	5	18	6	14.5
4 and above	6	39	8	27

Source: Survey Data, 2019

Among respondent women, 45.7% have up to middle school education level and the other 54.3% have high school and university graduate level. Among husbands of the respondent women, 56.3% have up to middle school education level and the left 43.7% have high school and university graduate level.

After categorizing the education level of respondent women as (1) respondents who can do read and write only as low education level (2) respondents who have at least primary education and up to high school level education as under graduate education level and (3) respondents who are attending for university degree or who already had university degree as post graduate education level, the respondents who are under the education level of under graduate level have 4 and above children.

Moreover, after doing the same categorization to the education level of respondents' husbands, the result was similar to the education level of respondent women that families with husbands who are under the education level of under graduate level have 4 and above children.

4.4 Contraceptive knowledge and usage history of the respondents

Table 4.4 Knowledge on contraceptive methods

Knowledge on contraceptive methods	Frequency	Percent	Valid Percent
Pill	197	100.0	100.0
Injectables	195	99.0	99.0
EC Pill	44	22.3	22.3
Condom	136	69.0	69.0
IUD	194	98.5	98.5
Implants	193	98.0	98.0
Source of knowledge	Frequency	Percent	Valid Percent
BHS	26	13.2	13.2
CBHW	54	27.4	27.4
NGO Staffs	117	59.4	59.4
Husband	2	1.0	1.0
Parents	1	0.5	0.5
Friends/Relatives	192	97.5	97.5
Magazine/Books/Newspaper	64	32.5	32.5
Internet	23	11.7	11.7

Source: Survey Data, 2019

Almost all the women know about combined oral contraceptive pills (100%), injectables (99%), intra-uterine device (98.5%) and implants (98%). Over half of women (69%) answered that they know about condom. Women who have knowledge about emergency contraceptive pill were very small portion and only 22.3% of the respondents know about that.

Almost all the women said they got contraceptive knowledge from their friends and relatives (97.5%). More than half of the respondents (59.4%) said that they know contraceptive methods from awareness raising session by NGO staffs. Some of the respondents said they also got contraceptive knowledge from community-based health workers (CBHW) (27.4%) and magazine, books and newspapers. Very few respondents said that basic health staffs also gave knowledge about contraceptive methods (13.2%) and also some found about contraception from internet (11.7%). Almost all of the women said they never got contraceptive knowledge from parents and from their husbands.

Table 4.5 History of first-time contraception

	Minimum	Maximum	Mean	Std. Deviation
Age of first-time contraception	18.0	40.0	26.929	4.8619
First-time contraceptive method	Frequency	Percent	Valid Percent	Cumulative Percent
Pill	61	31.0	31.0	31.0
Injectables	53	26.9	26.9	57.9
EC Pill	8	4.1	4.1	61.9
Condom	21	10.7	10.7	72.6
IUD	37	18.8	18.8	91.4
Implants	13	6.6	6.6	98.0
Calendar Method	4	2.0	2.0	100.0
Who give decision for first-time contraception	Frequency	Percent	Valid Percent	Cumulative Percent
BHS	28	14.2	14.2	14.2

CBHW	27	13.7	13.7	27.9
NGO Staffs	47	23.9	23.9	51.8
Husband	2	1.0	1.0	52.8
Who give decision for first-time contraception	Frequency	Percent	Valid Percent	Cumulative Percent
Friends, Relatives	63	32.0	32.0	84.8
Own decided	30	15.2	15.2	100.0
Provider of first-time contraception	Frequency	Percent	Valid Percent	Cumulative Percent
BHS	18	9.1	9.2	9.2
CBHW	39	19.8	19.9	29.1
NGO Clinic	54	27.4	27.6	56.6
Provider of first-time contraception	Frequency	Percent	Valid Percent	Cumulative Percent
Private Clinic	2	1.0	1.0	57.7
Private Hospital	9	4.6	4.6	62.2
Pharmacy	74	37.6	37.8	100.0

Source: Survey Data, 2019

Most of the first-time contraceptive methods of the respondents were pill (31%) and injectables (26.9%). Some of the respondents used IUD for their first-time contraceptive method (18.8%). The respondent's decision for first-time contraception was mostly because of friends and relatives (32%) and because of NGO staffs counseling (23.9%). Basic health staffs (BHS) (14.2%) and community-based health workers (CBHW) (13.7%) also encouraged to use first-time contraception. Some of the respondents (15.2%) decided by their own to use contraception for first-time.

The biggest provider of contraception is pharmacy (37.6%) and NGO clinic (27.4%). Community based health workers also provided contraceptive methods to some respondents (19.8%).

4.5 Knowledge, attitude and service requirement for LARC

Table 4.6 Knowledge about long-term contraceptive methods

Knowledge on LARCs	Frequency	Percent	Valid Percent
Female sterilization	90	45.7	45.7
Male sterilization	79	40.1	40.1
IUD	197	100.0	100.0
Implants	197	100.0	100.0

Source: Survey Data, 2019

All of the respondents answered that they know long-term reversible contraceptive methods very well.

Table 4.7 Accessibility of long-term contraceptive methods

Accessibility of long-term contraceptive methods	Frequency	Percent	Valid Percent
Yes	87	44.2	44.2
No	77	39.1	39.1
Not know	33	16.8	16.8

Source: Survey Data, 2019

Among the respondents, 44.2% said that they have easy accessibility to long-term contraceptive methods however, 39.1% said they are not and 16.8% said they do not know where to get service.

Table 4.8 Service providers for long-term contraceptive methods

Service provider for long-term contraception	Frequency	Percent	Valid Percent
BHS	19	9.6	9.6
CBHW	1	0.5	0.5
NGO Clinic	91	46.2	46.2
Private clinic	74	37.6	37.6
Private hospital	77	39.1	39.1
Not know	33	16.8	16.8

Source: Survey Data, 2019

Most of the respondents said that women could get long-term contraceptive services from NGO clinics (46.2%), private clinics (37.6%) and private hospital (39.1%). Only 9.6% of respondents said women could get long-term contraceptive services from basic health staffs from government hospital and public health facilities. Some of the respondents (16.8%) do not know the service providers who could give services for long-term contraceptive methods because some of the respondents said in there are only NGO clinic visited to their village and gave service for long-term contraceptive methods. However now, the clinic was closed last year and they do not know where to go to get service for long-term contraceptive methods.

Table 4.9 Knowledge on advantages of using long-term contraceptive methods

Know advantages of using LARCs	Frequency	Percent	Valid Percent
Yes	172	87.3	87.3
No	25	12.7	12.7
Advantages of using LARCs	Frequency	Percent	Valid Percent

No need to go frequently to service provider	126	64.0	70.4
One-time expenditure is enough	15	7.6	8.4
Has long-term effect for contraception	167	84.8	93.3
Easy to get baby after removal	18	9.1	10.1
Effectively prevent unwanted pregnancy	138	70.1	77.1

Source: Survey Data, 2019

Most of the respondents said they have knowledge on using of long-term contraceptive methods and what they mostly said is that using long-term contraceptive methods makes (1) No need to go frequently to service provider (2) has long-term effect for contraception and (3) effectively prevent unwanted pregnancy.

Table 4.10 Knowledge on disadvantages of using long-term contraceptive methods

Know disadvantages of using LARCs	Frequency	Percent	Valid Percent
Yes	124	62.9	62.9
No	73	37.1	37.1
Disadvantages of using LARCs	Frequency	Percent	Valid Percent
Irregular menstrual cycle	120	60.9	88.2
Headache	48	24.4	35.3
Disadvantages of using LARCs	Frequency	Percent	Valid Percent
Lower abdominal pain	78	39.6	57.4
Acne	5	2.5	3.7

Weight changes	120	60.9	88.2
Vertigo	42	21.3	30.9
Breast tenderness	2	1.0	1.5
Mode changes	2	1.0	1.5

Source: Survey Data, 2019

Most of the respondents said they have knowledge on disadvantages of using long-term contraceptive methods and what they mostly said is that using long-term contraceptive methods makes (1) irregular menstrual cycle (2) weight changes and (3) lower abdominal pain. Some of the respondents said long-term contraceptive methods makes headache and vertigo.

Table 4.11 Negative feeling on long-term contraceptive methods

Negative feeling on LARCs	Frequency	Percent	Valid Percent
Cause hypertension	10	5.1	5.1
Can move other part of the body	97	49.2	49.2
Can lost in the body	41	20.8	20.8
Can cause health problems	171	86.8	86.8
Can cause anemia	14	7.1	7.1
Can cause unavailability to have baby	118	59.9	59.9

Source: Survey Data, 2019

Most of the respondents said they have negative feeling on using long-term contraceptive methods such as long-term contraceptive methods can cause health problems, can cause unavailability to have baby and can move other part of the body. Moreover, some of the respondents said long-term contraceptive methods could lost in the body as well as they could cause anemia.

Table 4.12 Reason for still do not use long-term contraceptive methods

Still do not use LARCs because	Frequency	Percent	Valid Percent
Fear of side effects	65	33.0	33.0
Fear of moving other part of the body	4	2.0	2.0
Plan to do sterilization	22	11.2	11.2
Want to have baby	81	41.1	41.1
Fear to insert in the body	106	53.8	53.8
No service provider	25	12.7	12.7

Source: Survey Data, 2019

Most of the respondents said they still do not use long-term contraceptive methods because they fear to insert in their body, they have plan to have more babies in their future and also, they fear to side effects. Some of the respondents said there is no service provider nearby their villages.

Table 4.13 Requirements for women to use LARCs

Requirement for women to use LARCs	Frequency	Percent	Valid Percent
Service facility should not too far away	179	90.9	90.9
Easy to go to the service facility	171	86.8	86.8
Need to get the service with cheap prize	195	99.0	99.0
Need to have good reputation of the service provider	103	52.3	52.3
Need to have good relationship with service provider	3	1.5	1.5

Source: Survey Data, 2019

Most of the respondents said (1) service facility should not too far away from their villages, (2) easy to go to the service facility from their villages, (3) need to get the service with cheap prize, and (4) need to have good reputation of the service provider are requirement for women to use long-term contraceptive methods easily. Only very few respondents said good relationship with service provider is required for women to use long-term contraceptive methods.

CHAPTER 5

CONCLUSION

5.1 Findings

Married women of reproductive age (15-49) are aware of the various modern contraceptive methods that are being provided at various service facilities thus; male condoms (69%), injectable (99%), pills (100%), implants (98%), intrauterine device (96%) and (22%) knew of emergency contraceptive pills. Only 44% of the respondents knew where to obtain family planning methods from. Moreover, only 35% of the respondents got proper counseling for family planning. The most important source of information in regards to Family planning was reported to be from NGO clinic, private hospital and private clinic so that family planning education from public sector is very little.

Among several factors that would affect use of long acting reversible contraceptive methods, age of women, race, education and occupation of the respondents and husband-wife discussion were found determinants of long-acting reversible contraceptive method use. Significant association between women's age, race, education and occupation of the respondents and use of long acting reversible contraception methods was observed. Those women having discussion with their husbands on contraceptive methods were found more likely to use LARCs than who did not have.

Health concerns was the most commonly cited reasons for not using. Second, opposition to use either is because of taboos that says those devices can cause unavailability to have baby in the future. Thirdly, women cited fear to insert in the body or think that the device can move other part of the body. Lack of contraceptive supplies and logistic problems in getting the contraceptives to the public provider continue to be a challenge in the health facilities, a few women stated that lack of access (distance or costs) was the reason for not using.

5.2 Recommendations

Focus on reducing the top barriers to family planning uptake through improving counseling services to reduce health concerns and fear of side effects, educating women about their bodies and when they are most at risk of getting pregnant, and breaking down cultural and social barriers to contraceptive use.

Ensure that women have access to a full range of contraceptive methods (short-term, long term, and permanent) to satisfy their reproductive needs at different life stages. Health workers who are working in the study area should offer all options of contraceptive methods with their advantage and disadvantage, risk and benefits as to enable the clients utilize safe and convenient methods using proper counseling technique by considering the occupation and age of the women.

Take advantage of all opportunities! With so many women experiencing unplanned pregnancies, providers need to integrate family planning counseling, services, and follow-up into postpartum programs as well as other services that offer an opportunity to reach women- post abortion care, community health programs like children immunization.

Reach out to women and their partners at multiple stages in their reproductive lives to better satisfy changing needs from adolescents and young women and men, to middle-aged and older couples.

Further study (qualitative) need to be conducted to address some crosscutting issues like health provider and health facility associated with utilization of long-acting reversible contraceptive methods.

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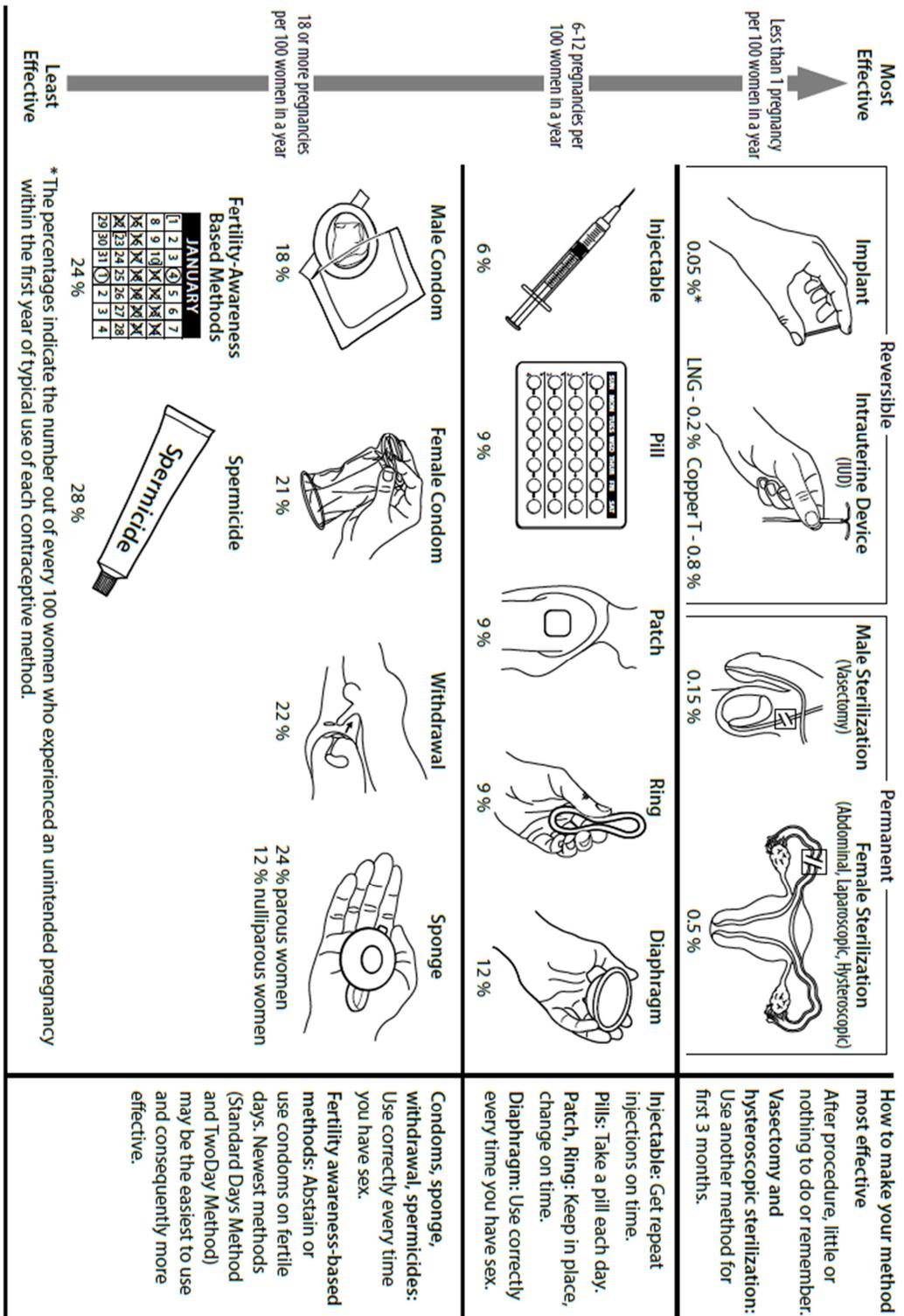
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Appendix 1 Use of modern contraceptive methods by states and regions



Source: Myanmar Demographic and Health Survey 2015-16

Appendix 2 Effectiveness of Family Planning Methods



Source: Family Planning – Global Handbook for Providers

မြန်မာနိုင်ငံ၊ စစ်ကိုင်းတိုင်းဒေသကြီး၊ ကလေးမြို့နယ်အတွင်းရှိ အမျိုးသမီးများ၏
သားဆက်ခြားနည်းလမ်းများ ပြောင်းလဲအသုံးပြုခြင်းနှင့် ပတ်သက်သော အကြောင်းအရာများကို
လေ့လာခြင်း မေးခွန်းလွှာ

အမှတ်စဉ် |__|__|__|

ရပ်ကွက်/ကျေးရွာအမည် မေးမြန်းသူအမည်

ကျန်းမာရေးဌာန/ဌာနခွဲ ရက်စွဲ

အပိုင်း (က) - လူမှုရေးနှင့်လူဦးရေအပိုင်းအခြားဆိုင်ရာ ပိသေသများ

စဉ်	မေးမြန်းချက်	ဖြေကြားချက်/တုံ့ပြန်ချက်	ကုဒ်အမှတ်
A1	ပြည်ပြီးအသက် နှစ်	__ __
A2	လူမျိုး	၁။ ဗမာ ၂။ ချင်း ၃။ အခြား (ဖော်ပြရန်)	__
A3	ကိုးကွယ်သည့်ဘာသာ	၁။ ဗုဒ္ဓဘာသာ ၂။ ခရစ်ယာန်ဘာသာ ၃။ အစ္စလာမ်ဘာသာ ၄။ ဟိန္ဒူဘာသာ ၅။ အခြား (ဖော်ပြရန်)	__
A4	အမျိုးသမီး၏ အမြင့်ဆုံးအောင်မြင်ခဲ့သော အတန်းပညာ	၁။ စာမတတ် / ရေးတတ်၊ ဖတ်တတ် ၂။ မူလတန်းနှင့်မူလတန်းအောင် ၃။ အလယ်တန်းနှင့်အလယ်တန်းအောင် ၄။ အထက်တန်းနှင့်အထက်တန်းအောင် ၅။ တက္ကသိုလ်၊ ကောလိပ် နှင့် ဘွဲ့ရ	__
A5	ခင်ပွန်း၏ အမြင့်ဆုံးအောင်မြင်ခဲ့သော အတန်းပညာ	၁။ စာမတတ် / ရေးတတ်၊ ဖတ်တတ် ၂။ မူလတန်းနှင့်မူလတန်းအောင် ၃။ အလယ်တန်းနှင့်အလယ်တန်းအောင် ၄။ အထက်တန်းနှင့်အထက်တန်းအောင် ၅။ တက္ကသိုလ်၊ ကောလိပ် နှင့် ဘွဲ့ရ	__
A6	အမျိုးသမီး၏ အလုပ်အကိုင် (အဓိကအားဖြင့် ဘာအလုပ် လုပ်ပါသလဲ)	၁။ အလုပ်မလုပ်ပါ / အိမ်ရှင်မ ၂။ တောင်သူ (စိုက်ပျိုးမွေးမြူရေး) ၃။ ကာယလုပ်သား / ကျပန်းအလုပ် ၄။ ကျွမ်းကျင်လုပ်သား ၅။ အရောင်းအဝယ် ၆။ စာရေးစာချီနှင့်ဆိုင်သော ၇။ ပညာရှင် (နည်းပညာ / အုပ်ချုပ်မှု) ၈။ ကျောင်းသူ ၉။ မဖြေပါ	__
A7	ခင်ပွန်း၏ အလုပ်အကိုင် (အဓိကအားဖြင့် ဘာအလုပ် လုပ်ပါသလဲ)	၁။ အလုပ်မလုပ်ပါ ၂။ တောင်သူ (စိုက်ပျိုးမွေးမြူရေး) ၃။ ကာယလုပ်သား / ကျပန်းအလုပ် ၄။ ကျွမ်းကျင်လုပ်သား ၅။ အရောင်းအဝယ် ၆။ စာရေးစာချီနှင့်ဆိုင်သော ၇။ ပညာရှင် (နည်းပညာ / အုပ်ချုပ်မှု) ၈။ ကျောင်းသား ၉။ မဖြေပါ	__
A8	အမျိုးသမီး အိမ်ထောင်ပြုချိန်က အသက် နှစ်	__ __
A9	ကလေးအရေအတွက် (ကလေးမရှိလျှင် '0' ဟုရေးရန်) ယောက်	__ __

အပိုင်း (ခ) သားဆက်ခြားနည်းလမ်းများသုံးစွဲမှုဆိုင်ရာမေးခွန်းများ

ပထမဆုံးအကြိမ် သားဆက်ခြားနည်းလမ်း အသုံးပြုခြင်း			
B1	သင်သိသောသားဆက်ခြားနည်းလမ်းများကိုဖော်ပြပါ (အဖြေ တစ်မျိုးထက် ပိုနိုင်သည်)	၁။ နေ့စဉ်သောက်ဆေးကတ် ၂။ သုံးလခံထိုးဆေး ၃။ အရေးပေါ်သောက်ဆေး ၄။ ကွန်ဒုံး ၅။ သားအိမ်တွင်းထည့်ပစ္စည်း ၆။ လက်မောင်းတွင်းထည့်ပစ္စည်း ၉၉။ အခြား (ဖော်ပြရန်)	___ ___ ___ ___ ___ ___ ___
B2	သားဆက်ခြားနည်းလမ်းများအကြောင်း ဘယ်သူက ပြောပြခဲ့ပါသလဲ (အဖြေ တစ်မျိုးထက် ပိုနိုင်သည်)	၁။ ကျန်းမာရေးဝန်ထမ်းများ (ဥပမာ-သားဖွားဆရာမ) ၂။ ကျန်းမာရေးလုပ်သား / အရန်သားဖွားဆရာမ ၃။ NGO ဝန်ထမ်းများ ၄။ မိမိခင်ပွန်း ၅။ မိဘများ ၆။ ဆွေမျိုး / သူငယ်ချင်း ၇။ မဂ္ဂဇင်း၊ စာအုပ်၊ သတင်းစာ ၈။ အင်တာနက် ၉။ ရေဒီယို ၉၉။ အခြား (ဖော်ပြရန်)	___ ___ ___ ___ ___ ___ ___ ___ ___
B3	ပထမဆုံး သားဆက်ခြားနည်းလမ်းကို ဘယ်အသက်အရွယ်မှာ စပြီးသုံးခဲ့ပါသလဲ နှစ်	___
B4	ပထမဆုံးအသုံးပြုခဲ့သောသားဆက်ခြားနည်းလမ်းက ဘာပါလဲ	၁။ နေ့စဉ်သောက်ဆေးကတ် ၂။ သုံးလခံထိုးဆေး ၃။ အရေးပေါ်သောက်ဆေး ၄။ ကွန်ဒုံး ၅။ သားအိမ်တွင်းထည့်ပစ္စည်း ၆။ လက်မောင်းတွင်းထည့်ပစ္စည်း ၉၉။ အခြား (ဖော်ပြရန်)	___
B5	ပထမဆုံးအကြိမ် သားဆက်ခြားနည်းလမ်းအသုံးပြုရန် ဘယ်သူက ဆုံးဖြတ်ပေးခဲ့ပါသလဲ	၁။ ကျန်းမာရေးဝန်ထမ်းများ (ဥပမာ-သားဖွားဆရာမ) ၂။ ကျန်းမာရေးလုပ်သား / အရန်သားဖွားဆရာမ ၃။ NGO ဝန်ထမ်းများ ၄။ မိမိခင်ပွန်း ၅။ မိဘများ ၆။ ဆွေမျိုး / သူငယ်ချင်း ၇။ မိမိကိုယ်တိုင် ၉၉။ အခြား (ဖော်ပြရန်)	___
B6	ပထမဆုံးအကြိမ် သားဆက်ခြားနည်းလမ်းအသုံးပြုရန် မည်သူမှ ဝန်ဆောင်မှုပေးခဲ့ပါသလဲ	၁။ ကျန်းမာရေးဝန်ထမ်း (ဥပမာ-သားဖွားဆရာမ) ၂။ အရန်သားဖွားဆရာမ ၃။ NGO ဆေးခန်း ၄။ ပုဂ္ဂလိက ဆေးခန်း ၅။ ပုဂ္ဂလိက အထူးကု ဆေးခန်း ၆။ ဆေးဆိုင် (B10 သို့ ကျော်၍မေးပါ) ၉၉။ အခြား (ဖော်ပြရန်)	___
B7	ဝန်ဆောင်မှုပေးသူက သားဆက်ခြား နည်းလမ်းများအကြောင်း ပြောပြဆွေးနွေးပေးပါသလား	၁။ ဆွေးနွေးပေးခဲ့ပါသည် ၂။ ဆွေးနွေးမပေးခဲ့ပါ ၉၉။ မသိပါ	___
B8	ဝန်ဆောင်မှုပေးသူက သားဆက်ခြား နည်းလမ်းကြောင့် ဘေးထွက်ဆိုးကျိုး/ ပြဿနာ တစ်ခုခုဖြစ်ခဲ့လျှင် ဘာလုပ်ရမလဲဆိုတာ သေချာရှင်းပြခဲ့သလား	၁။ ရှင်းပြခဲ့ပါတယ် ၂။ ရှင်းမပြခဲ့ပါ ၉၉။ မသိပါ	___
B9	ဝန်ဆောင်မှုပေးသူထံ မိမိသိချင်တာတွေ မေးရတာ အဆင်ပြေရဲ့လား	၁။ အဆင်ပြေပါတယ် ၂။ အဆင်မပြေပါ	___

		၉၉။ မသိပါ	
B10	သားဆက်ခြားနည်းလမ်းကြောင့် ဘေးထွက်ဆိုးကျိုး / ပြဿနာ တွေ ကြုံတွေ့ခဲ့ရပါသလား (ဥပမာ- ရာသီသွေးမမှန်တာ)	၁။ ကြုံတွေ့ခဲ့ပါသည် ၂။ မကြုံတွေ့ခဲ့ပါ ၉၉။ မသိပါ	_
B11	အခြားသားဆက်ခြားနည်းလမ်းသို့ပြောင်းလဲ အသုံး ပြုခဲ့ပါသလား	၁။ အသုံးပြုခဲ့ပါသည် ၂။ အသုံးမပြုခဲ့ပါ (အပိုင်း (ဂ) C1 သို့ကျော်၍မေးပါ)	_
B12	သားဆက်ခြားနည်းလမ်းများကို ဘယ်နှစ်ကြိမ် ပြောင်းလဲ အသုံးပြုခဲ့ပါသလဲ ကြိမ်	_
B13	ပြောင်းလဲအသုံးပြုခဲ့သော သားဆက်ခြားနည်းလမ်းတွေက ဘာတွေလဲ (အဖြေ တစ်မျိုးထက် ပိုနိုင်သည်)	၁။ နေ့စဉ်သောက်ဆေးကတ် ၂။ သုံးလခံထိုးဆေး ၃။ ကွန်ဒုံး ၄။ သားအိမ်တွင်းထည့်ပစ္စည်း ၅။ လက်မောင်းအရေပြားအောက်ထည့်ပစ္စည်း ၉၉။ အခြား (ဖော်ပြရန်)	_ _ _ _ _ _
ယခုလက်ရှိအသုံးပြုနေသော သားဆက်ခြားနည်းလမ်း			
B14	ယခုလက်ရှိအသုံးပြုနေသော သားဆက်ခြားနည်းလမ်း မှာ ဘယ်နည်းလမ်းပါလဲ	၁။ နေ့စဉ်သောက်ဆေးကတ် ၂။ သုံးလခံထိုးဆေး ၃။ ကွန်ဒုံး ၄။ သားအိမ်တွင်းထည့်ပစ္စည်း ၅။ လက်မောင်းအရေပြားအောက်ထည့်ပစ္စည်း ၉၉။ အခြား (ဖော်ပြရန်)	_
B15	ယခုလက်ရှိ အသုံးပြုနေသော သားဆက်ခြားနည်းလမ်း အသုံးပြုရန် ဘယ်သူက ဆုံးဖြတ်ပေးခဲ့ပါသလဲ	၁။ ကျန်းမာရေးဝန်ထမ်းများ (ဥပမာ-သားဖွားဆရာမ) ၂။ ကျန်းမာရေးလုပ်သား / အရန်သားဖွားဆရာမ ၃။ NGO ဝန်ထမ်းများ ၄။ မိမိခင်ပွန်း ၅။ မိဘများ ၆။ ဓေ့မျိုး / သူငယ်ချင်း ၇။ မိမိကိုယ်တိုင် ၉၉။ အခြား (ဖော်ပြရန်)	_
B16	ယခုလက်ရှိ အသုံးပြုနေသော သားဆက်ခြားနည်းလမ်းအတွက် မည်သူမှ ဝန်ဆောင်မှုပေးခဲ့ပါသလဲ	၁။ ကျန်းမာရေးဝန်ထမ်း (ဥပမာ-သားဖွားဆရာမ) ၂။ အရန်သားဖွားဆရာမ ၃။ NGO ဆေးခန်း ၄။ ပုဂ္ဂလိက ဆေးခန်း ၅။ ပုဂ္ဂလိက အထူးကု ဆေးခန်း ၆။ ဆေးဆိုင် (B19 သို့ ကျော်၍မေးပါ) ၉၉။ အခြား (ဖော်ပြရန်)	_
B17	ဝန်ဆောင်မှုပေးသူက ယခုလက်ရှိ အသုံးပြုနေသော သားဆက်ခြားနည်းလမ်း အကြောင်း ပြောပြ ဆွေးနွေး ပေးပါသလား	၁။ ဆွေးနွေးပေးခဲ့ပါသည် ၂။ ဆွေးနွေးမပေးခဲ့ပါ ၉၉။ မသိပါ	_
B18	ဝန်ဆောင်မှုပေးသူက လက်ရှိအသုံးပြုသော သားဆက်ခြားနည်းလမ်းကြောင့် ဘေးထွက်ဆိုးကျိုး / ပြဿနာ တစ်ခုခုဖြစ်ခဲ့လျှင် ဘာလုပ်ရမလဲဆိုတာ သေချာရှင်းပြခဲ့သလား	၁။ ရှင်းပြခဲ့ပါတယ် ၂။ ရှင်းမပြခဲ့ပါ ၉၉။ မသိပါ	_
B19	ယခုလက်ရှိအသုံးပြုနေသော သားဆက်ခြား နည်းလမ်းကြောင့် ဘေးထွက်ဆိုးကျိုး / ပြဿနာတွေ ကြုံတွေ့ရပါသလား	၁။ ကြုံတွေ့ခဲ့ပါသည် ၂။ မကြုံတွေ့ခဲ့ပါ ၉၉။ မသိပါ	_
B20	ဘာကြောင့် ယခုလက်ရှိအသုံးပြုသော သားဆက်ခြားနည်းလမ်းသို့ ပြောင်းလဲ အသုံးပြုတာပါလဲ (အဖြေ တစ်မျိုးထက် ပိုနိုင်သည်)	၁။ ဘေးထွက်ဆိုးကျိုးတွေ ခံစားရလို့ ၂။ မိသားစု / ယောက်ျားမကြိုက်လို့ ၃။ ပို၍အဆင်ပြေမယ်ထင်လို့ ၄။ ယခင်နည်းလမ်းကို ဝန်ဆောင်မှုပေးမည့်သူမရှိတော့လို့	_ _ _ _

		၅။ ငွေကြေးမတတ်နိုင်တော့လို့ ၉၉။ အခြား (ဖော်ပြရန်)	၂။
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အပိုင်း (ဂ) နှစ်ရှည်ခံ သားဆက်ခြားနည်းလမ်းများနှင့်သက်ဆိုင်သော မေးခွန်းများ

C1	နှစ်ရှည်ခံ သားဆက်ခြားနည်းလမ်းများကို သိပါသလား	၁။ သိပါသည် (C2 ကို ဆက်မေးပါ) ၂။ မသိပါ (C4 ကို ဆက်မေးပါ)	၂။
C2	သင်သိသော နှစ်ရှည်ခံ သားဆက်ခြားနည်းလမ်းများကို ပြောပြပေးပါ (အဖြေ တစ်မျိုးထက် ပိုနိုင်သည်)	၁။ အမျိုးသမီး သားကြောဖြတ်ခြင်း ၂။ အမျိုးသား သားကြောဖြတ်ခြင်း ၃။ သားအိမ်တွင်းထည့် သားဆက်ခြားပစ္စည်း ၄။ လက်မောင်းတွင်းထည့် သားဆက်ခြားပစ္စည်း ၉၉။ အခြား (ဖော်ပြရန်)	၂။ ၂။ ၂။ ၂။ ၂။
C3	နှစ်ရှည်ခံ သားဆက်ခြားနည်းလမ်းများအကြောင်း ဘယ်သူက ပြောပြခဲ့ပါသလဲ (အဖြေ တစ်မျိုးထက် ပိုနိုင်သည်)	၁။ ကျန်းမာရေးဝန်ထမ်းများ (ဥပမာ-သားဖွားဆရာမ) ၂။ ကျန်းမာရေးလုပ်သား / အရန်သားဖွားဆရာမ ၃။ NGO ဝန်ထမ်းများ ၄။ မိမိခင်ပွန်း ၅။ မိဘများ ၆။ ဆွေမျိုး / သူငယ်ချင်း ၇။ မဂ္ဂဇင်း၊ စာအုပ်၊ သတင်းစာ ၈။ အင်တာနက် ၉။ ရေဒီယို ၉၉။ အခြား (ဖော်ပြရန်)	၂။ ၂။ ၂။ ၂။ ၂။ ၂။ ၂။ ၂။ ၂။
C4	မိမိနေထိုင်သော ရပ်ကွက်/ကျေးရွာတွင် နှစ်ရှည်ခံ သားဆက်ခြား နည်းလမ်းများကို ဝန်ဆောင်မှု အလွယ်တကူ ရယူနိုင်ပါသလား	၁။ ရယူနိုင်ပါသည် ၂။ မရယူနိုင်ပါ ၉၉။ မသိပါ	၂။ ၂။ ၂။
C5	မိမိနေထိုင်သော ရပ်ကွက်/ကျေးရွာတွင် မည်သူက နှစ်ရှည်ခံ သားဆက်ခြားနည်းလမ်းများကို ဝန်ဆောင်မှု ပေးပါသလဲ (အဖြေ တစ်မျိုးထက် ပိုနိုင်သည်)	၁။ ကျန်းမာရေးဝန်ထမ်း (ဥပမာ-သားဖွားဆရာမ) ၂။ အရန်သားဖွားဆရာမ ၃။ NGO ဆေးခန်း ၄။ ပုဂ္ဂလိက ဆေးခန်း ၅။ ပုဂ္ဂလိက အထူးကု ဆေးခန်း ၆။ မသိပါ ၉၉။ အခြား (ဖော်ပြရန်)	၂။ ၂။ ၂။ ၂။ ၂။ ၂။ ၂။
C6	နှစ်ရှည်ခံ သားဆက်ခြားနည်းလမ်းများကို အသုံးပြုခြင်း၏ ကောင်းကျိုးများကို သိပါသလား	၁။ သိပါသည် (C7 ကို ဆက်မေးပါ) ၂။ မသိပါ (C8 ကို ဆက်မေးပါ)	၂။ ၂။
C7	သင်သိသော နှစ်ရှည်ခံ သားဆက်ခြားနည်းလမ်းများကို အသုံးပြုခြင်း၏ ကောင်းကျိုးများကို ပြောပြပါ (အဖြေ တစ်မျိုးထက် ပိုနိုင်သည်)	၁။ ဝန်ဆောင်မှုပေးသူထံ ခဏခဏ သွားစရာ မလိုခြင်း ၂။ တစ်ကြိမ်တစ်ခါသာ ကုန်ကျစရိတ်ရှိခြင်း ၃။ နှစ်ရှည်ခံခြင်း ၄။ ကလေးပြန်ရဖို့ လွယ်ကူခြင်း ၅။ ကိုယ်ဝန်မရအောင် အလွန်ထိရောက်စွာ ကာကွယ်ခြင်း ၉၉။ အခြား (ဖော်ပြရန်)	၂။ ၂။ ၂။ ၂။ ၂။ ၂။
C8	နှစ်ရှည်ခံ သားဆက်ခြားနည်းလမ်း၏ ဘေးထွက်ဆိုး ကျိုးများကို သိပါသလား	၁။ သိပါသည် (C9 ကို ဆက်မေးပါ) ၂။ မသိပါ (C10 ကို ဆက်မေးပါ)	၂။ ၂။
C9	သင်သိသော နှစ်ရှည်ခံ သားဆက်ခြားနည်းလမ်း၏ ဘေးထွက်ဆိုးကျိုး များကို ပြောပြပါ (အဖြေ တစ်မျိုးထက် ပိုနိုင်သည်)	၁။ ရာသီသွေးမမှန်ခြင်း ၂။ ခေါင်းကိုက်ခြင်း ၃။ ဝမ်းဗိုက်အောက်ပိုင်းနာခြင်း ၄။ ဝက်ခြံထွက်ခြင်း ၅။ ကိုယ်အလေးချိန်ပြောင်းလဲခြင်း (ပိန်သွား/ဝသွား) ၆။ မအီမသာဖြစ်ခြင်း ၇။ ရင်သားများ နာကျင်ခြင်း ၈။ စိတ်ပိုင်းဆိုင်ရာပြောင်းလဲခြင်းများ ၉၉။ အခြား (ဖော်ပြရန်)	၂။ ၂။ ၂။ ၂။ ၂။ ၂။ ၂။ ၂။ ၂။

C10	<p>မိမိနှင့် မိမိကျေးရွာတွင်ရှိသော အမျိုးသမီးများ၏ နှစ်ရှည်ခံ သားဆက်ခြားနည်းလမ်းများအပေါ် ဆိုးကျိုးအမြင်ကို ပြောပြပါ</p> <p>(အဖြေ တစ်မျိုးထက် ပိုနိုင်သည်)</p>	<p>၁။ သွေးတိုးရောဂါ ဖြစ်စေသည်။ ၂။ ထည့်ထားသောပစ္စည်းသည် ခန္ဓာကိုယ်အတွင်း အခြားနေရာများသို့ ရောက်သွားနိုင်သည်။ ၃။ ထည့်ထားသောပစ္စည်းသည် ခန္ဓာကိုယ်အတွင်း ပျောက်သွားနိုင်သည်။ ၄။ ပစ္စည်းထည့်ထားခြင်းကြောင့် ရောဂါရသည်။ ၅။ သွေးအားနည်းရောဂါကို ဖြစ်စေနိုင်သည်။ ၆။ ကလေးမရဘဲ ဖြစ်နိုင်သည်။ ၉၉။ အခြား (ဖော်ပြရန်)</p>	<p>___ ___ ___ ___ ___ ___ ___ ___</p>
C11	<p>ဘာကြောင့် နှစ်ရှည်ခံ သားဆက်ခြားနည်းလမ်းတစ်ခုခုကို ပြောင်းလဲ အသုံးမပြုတာလဲ</p> <p>(အဖြေ တစ်မျိုးထက် ပိုနိုင်သည်)</p>	<p>၁။ ဘေးထွက်ဆိုးကျိုးတွေခံစားရမှာစိုးလို့ ၂။ ခန္ဓာကိုယ်ရဲ့အခြားနေရာတွေကို ရောက်သွားမှာစိုးလို့ ၃။ မိသားစု / ယောက်ျားက ခွင့်မပြုလို့ ၄။ သားကြောဖြတ်ဖို့အစီအစဉ်ရှိလို့ ၅။ ကလေးလိုချင်လို့ ၆။ ကြောက်လို့ ၉၉။ အခြား (ဖော်ပြရန်)</p>	<p>___</p>
C12	<p>နှစ်ရှည်ခံ သားဆက်ခြားနည်းလမ်းတွေကို အမျိုးသမီးတွေ အသုံးပြုရန် လွယ်ကူအဆင်ပြေဖို့ ဘာတွေလိုအပ်ပါသလဲ</p> <p>(အဖြေ တစ်မျိုးထက် ပိုနိုင်သည်)</p>	<p>၁။ ဝန်ဆောင်မှုပေးသူနှင့် နီးဖို့လို ၂။ ဝန်ဆောင်မှုပေးသူထံသွားဖို့အဆင်ပြေဖို့လို ၃။ ဈေးသက်သာဖို့လို ၄။ ဝန်ဆောင်မှုပေးသူက နာမည်ကောင်းဖို့လို ၅။ ဝန်ဆောင်မှုပေးသူနှင့် ရင်းနှီးဖို့လို ၆။ ဆေးခန်းဖွင့်ချိန်တွေ အဆင်ပြေဖို့လို ၇။ မိမိယူသော ဝန်ဆောင်မှုကို လျှို့ဝှက်ထားဖို့လို ၉၉။ အခြား (ဖော်ပြရန်)</p>	<p>___ ___ ___ ___ ___ ___ ___</p>

ယခုလိုအချိန်ပေးဖြေကြားပေးတဲ့အတွက် ကျေးဇူးအများကြီးတင်ပါတယ်။