

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

**A STUDY ON REPRODUCTIVE HEALTH LITERACY
AMONG YOUTH WORKERS IN INDUSTRIAL ZONE
(Case Study in South Dagon Township)**

**HTIN LIN AUNG
EMPA – 15 (16th BATCH)**

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AMONG YOUTH WORKERS IN INDUSTRIAL ZONE
(Case Study in South Dagon Township)

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Administration (MPA) Degree

Supervised by

Dr. Phyu Phyu Ei
Professor, Head
Department of Applied Economics
Yangon University of Economics

Submitted by

Htin Lin Aung
Roll Number- 15
EMPA 16th Batch
(2017 – 2019)

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This thesis entitled “**A Study on Reproductive Health Literacy among Youth Workers in Industrial Zone**” was submitted as a partial fulfillment towards the requirements for the degree of Master of Public Administration and it has been accepted by the Board of Examiners.

BOARD OF EXAMINERS

1. Professor Dr. Tin Win
Rector
Yangon University of Economics
2. Professor Dr. Ni Lar Myint Htoo
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Professor and Head of Department
Department of Applied Economics
Yangon University of Economics
4. Dr. Khin Chaw Myint
Associate Professor (Retd.)
Yangon University of Economics
5. U Thein Naing
Associate Professor
Department of Applied Economics
Yangon University of Economics
6. U Thein Ko
Lecturer
Department of Applied Economics
Yangon University of Economics

September, 2019

ABSTRACT

Most of the people in many cultures are reluctant to discuss about reproductive health and sexual education. These may lead to increased incidence of sexually transmitted infections, adolescent pregnancy, unsafe abortion, child marriages.

Objective of this study is to assess the knowledge and attitude of reproductive health among youth Industrial workers of South Dagon Township, Yangon Region. Cross-sectional descriptive study was done among 197 youth industrial workers in South Dagon Township. The respondents were between 15-24 year and most of them were high school level and female workers. Most of the youths knew the contraceptive methods and took that service from clinic. According to the knowledge level, most of the male respondents (74.9%) and female (76.9%) had poor knowledge level. According to the attitude level, most of the male respondents (87.0%) and female (64.7%) had poor attitude level. There was a significant association between sex of the respondents and attitudes on sex education and reproductive health and female respondents had better attitude score. Another statistical significant association was found between occupation and attitudes on sexual education, the dependent respondents had better attitude score. No significant association between other socio-demographic characteristics of parents and knowledge of sexual education was seen.

Most of the youth agreed to develop easily accessible reproductive health services and knowledge for youths. Most of them concurred to teach sexual education in school curriculum. Improving sexual and reproductive health status for youth requires a multi-sectoral approach that not only addresses young people's need for their knowledge, practice and quality services, but also important to have supportive and enabling environment. Thus, pilot projects to promote youth's reproductive health literacy is needed.

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LIST OF ABBREVIATIONS

ABR	- Adolescent Birth Rate
AIDS	- Acquired Immunodeficiency Syndrome
AH	- Adolescent Health
ARH	- Adolescent Reproductive Health
ASRH	- Adolescent Sexual and Reproductive Health
CHEB	- Central Health Education Bureau
CPR	- Contraceptive Prevalence Rate
CSE	- Comprehensive Sex Education
DALY	- Disability Adjusted Life Year
DHS	- Demographic Health Survey
DOH	- Department of Health
EC pills	- Emergency Contraceptive Pills
FGM	- Female Genital Mutilation
FP	- Family Planning
GBV	- Gender-Based Violence
HICs	- High-Income Countries
HIV	- Human Immunodeficiency Virus
HLPU	- Health Literacy Promotion Unit
IREC	- Institutional Research and Ethics Committee
IUD/IUCD	- Intrauterine Contraceptive Device
LAM	- Lactational Amenorrhea Method
LB	- Live Births
LMICs	- Low- and middle-income countries
MCT	- Mother to Child Transmission
MDGs	- Millennium Development Goals
MMR	- Maternal Mortality Ratio
MOHS	- Ministry of Health and Sports
MPHC	- Myanmar Population and Housing Census
MRH	- Maternal and Reproductive Health
NAFCI	- National Adolescent Friendly Clinic Initiative
NHP	- National Health Plan

OC	- Oral Contraceptive
RH	- Reproductive Health
RHC	- Rural Health Center
RMNCAH	- Reproductive, Maternal, Newborn, Child and Adolescent Health
SDGs	- Sustainable Development Goals
SOGIE	- Sexual orientation, gender identity and expression
SRHC	- Sub Rural Health Centre
SRH	- Sexual and Reproductive Health
SRHR	- Sexual, Reproductive Health and Rights
STDs	- Sexually Transmitted Diseases
STI	- Sexually Transmitted Infection
UN	- United Nations
UNAIDS	- United Nations Programme on HIV/AIDS
UNDP	- United Nations Development Programme
UNESCO	- United Nations Educational, Scientific and Cultural Organization
UNFPA	- United Nations Population Fund
UNICEF	- United Nations International Children's Emergency Fund
UHC	- Universal Health Coverage
WHO	- World Health Organization
WIA	- Workforce Investment Act

CHAPTER I

INTRODUCTION

1.1 Rationale of the study

Universal Health Coverage (UHC) is a really important theme towards sustainable development and to reduce the poverty, and is an essential component in protection of financial hardship and in reducing social inequalities. It is also an expression of the right to health. Reproductive sexual health and the right to the core of the right to health and sustainable development, a prerequisite for achieving gender equality and non-discrimination. Therefore, SRHR is a main component to achieve UHC.

Adolescent and adolescent reproductive health is important in the prevention of sexually transmitted diseases (STI), HIV, unwanted pregnancy and pregnancy-related death. Adolescents are one sixth of the world's population. They account for 6% of the world's global burden of disease and injury. About 1.2 million of adolescents died in 2015 due to overall diseases. Adolescent deaths occurred mostly in low- and middle-income countries especially in the Africa, which was about 45% and in South-East Asia regions, 26% (WHO, 2017).

Management of reproductive health related problems in adolescent is a must and could be integrated with school health policy, because children and youth population groups comprised 23.4 million persons, 46.5 % of total population in Myanmar (Department of Population, 2017). In developing countries, it was found that nearly one-half of people with HIV infection are female with the age of less than 25 years and there were more than 13 million teenaged girls who had unwanted pregnancies and gave births in every year. Young women have chance twice to be infected HIV as young men with the same age group. In 2017, approximately 7,000 adolescent girls and young women were found HIV-positive. HIV disproportionately affects women and adolescent girls because of vulnerabilities created by unequal cultural, social and economic status. Young women are particularly vulnerable to abuse as a result of gender power imbalances. Early childbearing continues to be an

impediment to improvements in the educational, economic and social status of women (Avert.Org, 2019).

Adolescents have particular health needs for their rapid physical, sexual, social and emotional development. Adolescence is the period when many risky (or protective) behaviors start or are consolidated, having a major impact on health as adults. E.g. diet, physical activity, substance use and sexual risk behaviors.

Inadequate access to youth-friendly health services is a major barrier for young people and adolescents. Health systems in most countries, particularly in Asia, generally do not specifically address adolescent needs at the work places. There were few statement and finding regarding youth SRHR, and their effectiveness has not been seen documented. Nowadays, sexual and reproductive health could not be taught by own parents or even in the school curriculum, leaving the adolescent and youth to be unable to pass on crucial knowledge. There is a great need for reproductive health information and services targeted at adolescents and youth sector regarding Information on the risks and prevention of pregnancy, STDs and HIV/AIDS, as well as on the consequences of unplanned pregnancy and abortion. A more holistic approach of Youth Reproductive Health to occupational health and education sectors need more legislative action or policy to influence risk taking behavior.

Since youth is a period of changes in physical, emotional, sexual and social things in life, it is an appropriate period to set up foundations for healthy adult life. The future of a country lies in the hands of the youths. They are fulfilling with large of ambitions and hope for the futures. If these youth were not able to have chance for their talent, it will be sure a great loss for a country (Mya, 2016). Reproductive health problems such as unwanted pregnancy and STIs and other social problems can occur in youths if they don't have proper and adequate reproductive behavior, awareness and perceptions of premarital sex issues.

Moreover, adolescent marriages and pregnancies is a challenge in many countries. Early pregnant girls are not physically and emotionally mature enough to achieve mature mother life and they face a higher risk of pregnancy and delivery complications. Dropout rate of school could be increased, which are reducing their future opportunities for education and occupations. Adolescents face difficulties in obtaining family planning services and are therefore at risk of unintended and unwanted pregnancies and experienced unsafe abortions. Pregnancies during the adolescent lives are more likely to have chance of abortion (UNFPA, 2014).

In addition, the Sustainable Development Goals offer an extraordinary opportunity for young people to learn about and act on issues in society and the world. Young people have been pronounced as the ‘torch bearers’ by United Nations leaders and that they have a central role to play in the successful implementation of the Goals. Children, young women and men are critical agents of changes and their unlimited capacities for involvement is essential to create a better world (Valerie, 2015).

Moreover, findings of this study would provide valuable information for policy makers and project managers in RMNCAH "Reproductive, Maternal, Newborn, Child and Adolescent Health" so that culturally sensitive, need-based and appropriate intervention plans, strategies and educational messages might be supported for youth workers. As the consequences, it might reduce HIV transmission, unsafe abortions, pregnancy related deaths and obstacles to attain higher education and earning capacity which would contribute to achieve safer sex and to reduce maternal and infant mortality. In addition, it would partly contribute to achieve some goals and objectives of Sustainable Development Goals (SDGs), Universal Health Coverage (UHC) and National Health Plan (NHP) regarding reproductive, maternal, youth, child and family health. Knowing reproductive health literacy among youth industrial workers could lead to advocate policy makers and MOHS about the ways to enhance and promote health care services on specified population.

1.2 Objective of the study

Objective of this study is to assess the knowledge and attitude of reproductive health among youth Industrial workers of South Dagon Township, Yangon Region.

1.3 Method of study

This study focuses on 15 to 24 years old youth industrial workers in South Dagon Township, Yangon. Descriptive method is used in this study. Secondary data was used as a reference from demographic data of Township Profile (2017) by general administrative department, South Dagon Township. In order to collect the primary data, the survey was conducted with structured questionnaire among the 15 to 24 years old youth industrial workers in South Dagon Township by random sampling.

South Dagon Township is selected because there was 314 MMR per 100, 000 live birth in the same year. There were 3.4% of ABR in South Dagon Township in 2017. Abortion rate was 2.6%, total 118 numbers of abortion was found. Number of live birth

by 15-19 years old mother is 37 in 2017. Contraceptive Prevalence Rate (Modern Method) is 70.7 % in 2017 (MOHS, 2018). Most of people in South Dagon Township are migrant workers from many rural areas of Myanmar and there is much opportunities to practice and expose to sexual risk behaviors.

1.4 Scopes and limitation of study

The study population in this study will be comprised; Male and female youths in industrial zone of South Dagon Township, Yangon Region. All youth workers (both male and female) between aged 15 and 24 years old in an industry of South Dagon Township, Yangon Region are included. Youth workers who had been absent on that days of interview, youth workers who had mental disorders, youth workers who cannot read and write well in Myanmar language, other workers who are not in the range of Youth age group: 15 – 24 years are excluded in accordance with the study criteria. Apart from reproductive health related information, other health problems are not designated in this study.

1.5 Organization of the study

This thesis is organized into five chapters. Chapters 1 is an introductory one that presents rationale of the objective, method of the study, scope and limited of the study and organization of the study. Chapter 2 presents with literature review of RH literacy among youth workers and related studies. It describes concept and importance of RH literacy and government policies related to RH as well. Chapter 3 describes the current situation of reproductive health status in Myanmar; overview of reproductive health in Myanmar, RH policies and practices in Myanmar and RH situations of Myanmar. Chapter 4 consists of the survey analysis. Chapter 5 compromises the part of conclusion, discussion, suggestions, and needs for future research.

CHAPTER II

LITERATURE REVIEW

This chapter presents the literature review for the following topics, (a) concept of reproductive health in youth workers, (b) Importance of reproductive health literacy for youth workers, (c) government policies related to reproductive health (d) barriers against RH literacy and (e) previous studies.

2.1 Concept of Youth and Reproductive Health Literacy

In Cairo definition; “*Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes*”. Reproductive Health mentions that to be satisfy and safety sex in their lives and that to freely decide, what, where, when and how often. These facts are the right for men, women, boys and girls to know well and to access safe, efficient methods of birth spacing through their choice, and other methods to regulate fertility in accordance with the law, and to access appropriate health-care services provision which enable women to be safer pregnancy and childbirth and for the family, the best option to get a healthy baby life.

In regards to statistical purposes, the UN defines ‘youth’, “*as those persons between the ages of 15 and 24 years, without prejudice to other definitions by Member States*” (UN, 2001).

Migration for social wellbeing has highly influenced the transfer of people in Asia-pacific areas. As a result, total of 4.4 million contract workers of the Philippines has moved to other countries. From Indonesia, according to the latest data, total estimated 4 million migrant employees, of which significantly 75% are women. There were 3.14 million migrant from Myanmar, Cambodia and Laos in Thailand each year and 50% are unregistered people. However, not all countries have done the same for providing health and rights information and education to those workers (Bondad, 2013). Currently, even in those countries, they have no sustainable plan to examine pre-departure, after-arrival and reintegration programs to address SRHR issues for adolescent and youth workers. There is a need to advocate to States of origin and of

employment to develop and implement comprehensive policies and programs that address the health of youth workers and members of their families, including their sexual and reproductive health.

“Sexual health is a state of physical, emotional, mental, and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity” (WHO, 2006). The sexual rights must be valued, protected, and happy so that to have healthy sexual practices. Sexuality is a kind of aspect of humanity and incorporated sex, gender identities and stereotypes, sexual education, pleasure, tenderness, and reproduction, Sexuality is influenced by the spiritual factors such as interaction of genetic, psychological, social, ecological, political, cultural, ethical, historical and religious. (Glasier, 2006).

The definition of reproductive health clearly be informed that ‘health’ does not only refer to the absence of disease, deformity and physical impairment, but also to the power to enjoy ‘welfare’ in any sense, leading to a biologically, spiritually, socially and economically better life. Men and women are applied with an equal chance.

Reproductive Rights: There are two important statements concerning reproductive rights: (1) *“people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so “ and (2) “the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth* (WHO, 2008).

Enshrines the equal right of men and women to the enjoyment of all economic, social and cultural rights including the right to “just and favorable” conditions of work, social security, protection and assistance to the family and to women before, during and after childbirth, and the right to the enjoyment of the highest attainable standard of physical and mental health. SRH is indivisible from other human rights. Highlights the right to make free and responsible decisions, free of violence, coercion and discrimination, about one’s own body and SRH. Includes underlying determinants of health e.g. safe and healthy working conditions, health related education and information, and protection from all forms of violence. (Committee on Economics, 2016)

2.2 Policies of Reproductive Health for youth workers

Specific statement about reproductive health and rights to youth workers are not found in national laws, human rights documents and other consensus. However being recognized to sexual rights embrace human rights. They include the right of all individuals, free from harassment and discrimination to: attain the highest methods of sexual health, which includes SRH services, sexual health promotion; respect for physically integrity; decide on their friends and partners; select active of sexuality; consensual relationship; consensual matrimony; decide how, where and when to have children; pursue a happy sexual life. Human rights also require to respect the rights of others.

Agenda 2030 and the Universal Coverage of SRH Services consists of; *“Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care, number of countries with laws and regulations that guarantee women aged 15-49 years access to sexual and reproductive health care, information and education, proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods, Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group.”* (UN, 2015)

2030 Sustainable Development Agenda calls for universal coverage of SRH services include that; *“By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births. By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs and achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.”* (UN, 2015)

SRH related interventions are needed to advocate by the national laws, regulations, policies and institutional parameters. These policies and regulations are main component to conduct SRH related activities and in promoting rights for sexual health as well. These include national laws and policies governing the supporting of health care deliveries, criminal, civil and administrative laws applicable to gender issues to improve sexual and reproductive health (WHO, 2017)

2.2.1 Collaboration of Government, NGO, INGOs for youth workers

In USA, more than 9 million individuals received training and related services supported under Title I of WIA, an increase of nearly 250 percent in just two years, and more than half of these individuals found employment in a tough labor market. Over one millions of workers well received trainings and other support from government such as sexual education to youth and adult, vocational training for rehabilitation and veterans' rehabilitation. Congress has separated the funding for theses program although demand for workforce services are increasing and critical employment and training programs have to release extra funding under current proposals which are to cover the deficit of federal. (National Association of Counties, 2013)

In Thailand, Ministry of Public Health has developed 350 Health Promoting Hospitals committed to health promotion and making health services more user-friendly especially for youth workers. Thailand Ministry of Health launched "Friend Corners" services to be in shopping malls and public areas in 2001. Adolescent peers are the focal persons to contact and to have counselling. Health staff provide counselling or basic primary care, or refer adolescents to specialized services. The Friend Corner web site combines music, fashion and health information. It has been praised for making information accessible in an attractive way.

National Adolescent Friendly Clinic Initiative (NAFCI) are introduced in South Africa. Need assessment and awards are used to improve the quality of health services to youth workers at government health facilities: which planned as a national health program. After a pilot period of 18 months, there were 350 clinics functioning, with 171 associated clinics by end of 2005. Part of the Love-Life Initiative, initiated through the DOH to improve the sexual health of adolescents through various strategies (to ensure sustainability). Positive legislation on youth wellbeing helped make the release simpler. The majority of clinics assessed externally met 80% to 90% of NAFCI requirements.

Inadequate financial resources to expand youth-related programs; education programs not meeting the needs for RH of young people; limited capacity of human resources. E.g. limited trained personals. Turnover of trained peers affect the reach and sustainability of programs to ensure that adolescents and youth have accurate knowledge of sexual and reproductive health and access to reproductive health services. (Department of Health, 2014)

2.3 Importance of reproductive health literacy for youth workers

In the world's poorest populations, unsafe sex is the second most important risk factor for disability and death and the ninth most important factor among developed countries. There are cheap effective methods available to prevent unintended pregnancy, provide safe abortion, help women navigate pregnancy and childbirth safely, and prevent and manage sexually transmitted infections. Every year, however, more than 120 million couples have an unmet need for contraceptives, 80 million women have unintended pregnancies (45 million of which result in abortion), more than half a million women die from pregnancy, childbirth and postpartum complications, and 340 million people acquire new infections of gonorrhea, syphilis, chlamydia or trichomonas. Sexual and reproductive ill-health mostly affects women, adolescents and youths.

In many developed countries, women are disempowered, and youth are disempowered everywhere, possibly. Sexual and reproductive health facilities are unavailable or of poor quality and are underused in many countries because it makes people feel awkward about topics such as sexual intercourse and sexuality. The growing influence of conservative political religious and cultural forces around the world threatens to undermine progress since 1994, and is arguably the best example of the negative interference of politics into public health (Glasier, 2006).

In every years worldwide, 23 million unsafe abortions are taking place. Nearly one in three women worldwide experience gender-based violence in the form of intimate partner violence or non-partner sexual violence. In developing countries, approximately 16 million girls aged 15 to 19 years and 2.5 million girls under 16 years give birth each year. Complications during pregnancy and childbirth are the world's leading cause of death for girls aged 15 to 19. In Africa, Middle East and Asia, where female genital mutilation is concentrated, more than 200 million girls and women alive today have been cut, nearly 266,000 have been removed. For one of the four curable sexually transmitted infections, more than 350 million women and men require care. There are almost two million new patients diagnosed with HIV. Infertility is also a global issue, affecting more than 10% of women of reproductive age. (Commission, 2018)

According to the Global AIDS Response Progress Report, the prevalence of HIV among young people worldwide is the maximum 15-24 years. In addition, among teenage girls and young women aged 15-24 years, new HIV infections occur

worldwide. (UNAIDS, 2016) In addition to the HIV sentinel report, the Magway region has a high HIV burden and premarital sex is also one of the problems of reproductive health among Myanmar's youth. On the other hand, HIV/AIDS is one of the principal epidemic diseases in Myanmar (MOHS, 2015).

The lives of young people will be adversely affected without knowledge of sexual and reproductive health (SRH). Likewise, if they lack access to training, participating, and exploring reproductive health services, adolescent and youth development negative outcomes such as unwanted pregnancy, early marriage, and sexual violence may occur (UNFPA, 2014a).

Adolescents make up one sixth of the population of the world. We constitute 6 percent of the global disease and disability burden in the world. 1.2 million teenagers died in 2015. In African (45%) and South-East Asia (26%) areas, over two-thirds of teenage deaths occurred in low-and middle-income countries. Most illnesses and accidents in teenagers can be avoided or treated. However, there are more than 3000 adolescents die every day due to different reasons. (WHO, 2017)

Contraception is the intentional avoidance by mechanical or natural means of childbirth. A variety of modern contraceptive methods, materials, and facilities should be usable, appropriate, available, and affordable, and delivered by qualified professionals in environments that meet quality of care requirements without coercion. Contraception is one of the most cost-effective health-care interventions, preventing unintended pregnancies and abortions (as well as related complications of unsafe abortions) while also contributing to reducing maternal and neonatal mortality, and enhancing newborn and child health. Prevention of unintended pregnancy through contraception also opens up more educational opportunities for girls, thereby improving their socioeconomic status and overall well-being. (WHO, Sexual health and its linkages to reproductive health: an operational approach, 2017)

Intension for the youth workers, Thailand Ministry of Public Health announced that any migrant, regardless of documentation status, could register for healthcare; this policy includes such benefits as family planning; Health tests and treatment of pregnant women, together with aftercare services; neonate care from birth to 28 days of age; prevention of mother-to-child transmission of HIV (PMTCT); and antiretroviral (ARV) medicines for the first time. (Das, 2016).

Reproductive health is a critical part of overall health and a key characteristic of human development. It reflects health in childhood, and is crucial in adolescence and

adulthood, sets the stage for health for both male and female beyond reproductive years, and can determine next-generation health. Reproductive health is an important component of general health, and it is a basic requirement for social, economic and human development (United Nations D. o., 1995)

2.4 Impact of Reproductive Health on youth workers

In South East Asia Region, about 6 million adolescent girls (15-19 yrs) are giving birth each year. The Adolescent Birth Rate among 15–19 year old girls in the Region is 33.9/1000 (the global average- 44.1). Wide variation are found between countries within the Region. Since the year 2000, there has been a decline in the adolescent birth rate (ABR) in all countries in the Region except Myanmar, Sri Lanka and Thailand.

Where data are available, indicate that a significant percentage of adolescent births are “unwanted” (Maldives- 28%, Nepal – 25%, Timor-Leste – 12%, Indonesia – 10%). The Demand for Contraception among 15–19 year old girls is above 50% in all countries for which data are available, except India, Timor-Leste, Bangladesh and Sri Lanka. There also remains a significant unmet need for contraception is 42% in Nepal, 36% in Maldives, 27% in Bhutan. Sources of Information about SRH for youth from countries in Region vary significantly (mainly from parents, friends and the media/ few from schools and health workers). Comprehensive SRH Knowledge among young people is below 40% in all countries except Thailand, where the figure is 56%. (WHO, Strategic directions for improving adolescent health in South-East Asia Region., 2011)

There is a low level of knowledge among teenagers about human sexuality and reproductive health. The Sexual and Reproductive Health curriculum established by the Myanmar Ministry of Education in the National Life Skills curriculum was implemented as a co-curricular subject in 2013 into middle school (10 years and above on average). However, according to a UNICEF study conducted in Myanmar, an assessment of Life Skill Education in middle schools revealed that knowledge about reproductive health was the lowest of all included topics in the Life Skill Curriculum. Over 40% of students do not know about contraceptive knowledge. Only half knows that a woman can get pregnant the first time she has sexual intercourse. Only one third had accurate information on HIV transmission. Reproductive health knowledge, HIV and STI knowledge were low with below (50%) of middle school adolescents.

Possible causes of poor sexual and reproductive health among middle school adolescents were lack of cultural sensitive teaching methods on SRHR and lack of proper training among middle school teachers. Teachers were unable to convey information in a reliable and appealing manner to the target group. Few high school teachers are willing to deliver messages that contain even plain, concise, and relevant information on issues of sexual and reproductive health. Most teachers have not addressed sexual topics with students, particularly teenagers, because they lack the skills of sex education. In 2017, seven out of ten children (71%) were enrolled in middle schools. In the context of increasing middle school enrollment rate, it is very important to promote Life Skill Education especially on sexual and reproductive health among middle school going adolescents in Myanmar. (School Health Department, 2017)

2.5 Barriers of Reproductive Health for youth

Significant barriers still present and disturb accessing SRH information and services, affecting adolescents and youth and leading to higher rates of unintended pregnancies and abortions, as well as a growing incidence of sexually transmitted infections (STIs) and HIV infection. Because of limited access to youth-friendly SRH resources and data, unsafe abortions among adolescent girls make a significant contribution to lasting SRH problems and even maternal deaths. If the obstacles to comprehensive sexuality education and youth-oriented family planning services were eliminated, then the growing prevalence of STIs could be avoided, including HIV. (UNFPA, 2014a).

There are a number of factors that affect the sexual health of a person operating at multiple levels. The achievement of sexual health, guided by an ecological approach, therefore involves interventions not only at the level of the individual, but also at family and peer levels; society (social, organizational); and law, policy and other structural factors; since these ever-widening circles of influence can affect an individual's sexual health.

Barriers indicate that there are high rates of child marriage in the region, premarital sexual activity is increasing, and adolescent birth rates remain high. There is high unmet need for family planning. Many women still cannot make their own informed decisions. Violence against women is widely prevalent including in the Asia Pacific region. Access to safe abortion where legal remains limited. Labour force participation of women are still decreased. (United Nations, 2017)

Despite the fact that, with the exception of HIV and AIDS, sexual and reproductive ill-health is a major cause of morbidity and mortality, large donor group support has not been identified. Others point out that decisions to use insufficient funds are focused on the risk of death and disability due to a particular disorder in the current climate of health sector change. Sexual and reproductive health is not just about disease, it is also about a collection of related issues of health and human rights, and many people are still confused about what it is. In fact, it is not sufficient to use DALYs to measure the total burden of sexual and reproductive disease. Pregnancy is not a disease and associated complications are rarely counted until they lead to death; a stillbirth does not even contribute one DALY; reproductive morbidity is often inadequately assessed and is usually under-reported due to associated stigma. Furthermore, DALYs only assess death, illness and disability without attributing any importance to preventive measures, such as family planning, which prevent ill health and promote well-being, including in sexual matters. (Glasier, 2006)

2.5.1. Cultural and social norms around sexuality

Social norms are shared expectations or informal rules among a group of people how people should behave. Norms are reflections of values or ideas about sexuality (e.g. men have the right to control women's bodies, or a woman's place is in the home); Norms also means behaviors that are suggested acceptable or unacceptable (e.g. heterosexual relationships are acceptable, but not other sex relationships); and they are also forms of behavior that are regarded as "normal" (e.g. having unprotected sex, multiple concurrent sexual relationships or transactional sex; sexual abuse and sexual harassment; child, early and forced marriage; female genital mutilation). Access to sexual health care services can be affected by existing cultural and social norms. (WHO, Sexual health and its linkages to reproductive health: an operational approach, 2017)

2.5.2. Gender and socioeconomic inequalities

Gender inequality occurs due to gender norms and roles, cultural or institutional practices, policies and laws, and economic factors maintaining unequal power relations between male and female. Socioeconomic inequality means unequal distribution of access to and control over resources, social status, and power depending on social factors (e.g. race, ethnicity, gender, religion, age) and economic factors (poverty or wealth). These inequalities influence in decision-making process for sexual relations.

They can also disturb access to services and resources. (WHO, Sexual health and its linkages to reproductive health: an operational approach, 2017)

2.5.3. Peer Pressure Influence

Key Sexual and Reproductive health issues that affect young people are pubertal changes: boys and girls, conflicting messages: cultural practices especially for menstruation, pregnancy: adolescent fertility rate, initiation of sexual activity, unsafe sex practices, unwanted and unplanned pregnancy, adolescent pregnancy and impacts on health. Besides, access to contraception: stigma and discrimination in accessing information and services, unsafe abortion which leads to maternal mortality rate, MMR (third leading cause of high MMR), and violence including gender based violence: child sexual abuse, forced intercourse, sexual harassment, bullying, violence based on SOGIE, pregnancy related GBV are included. Other key factors influence of information and communication technologies on sexual behaviors are misuse of information and images relating to sexual activity (cyberbullying, sexting, poor mental/emotional health, alcohol, tobacco and drugs).

A study in Japan describe peer pressure can influence sexual behavior of youth. The presence of friends with sexual experience can affect attitudes toward sexual activity. The study found that having sexually experienced friends is associated with sexual behavior of the respondents (Nagamatsu, 2012)

2.6 Benefits of investing in youth SRHR

Implementing in youth SRH could allow people following benefits for their better lives. Health benefits: (1) Fewer unintended pregnancies and complications therefore, with savings in terms of less ill health (2) Less maternal death (3) Less complications of pregnancy and delivery (4) Less neonatal and child death (5) Less malnutrition and ill health among mothers and infants (6) Fewer adolescent pregnancies, with fewer complications therefore, fewer school drop-outs and better economic outcomes with better education (Health, Economic and Social Benefits) (7) Less HIV/AIDS and STIs. Economic benefits: (8) Less health expenditure, reduction of healthcare costs (9) Economic gains with less poverty when girls and adolescents are able to increase their education and contribute to the economy, including prosperity of the family. Social benefits: (10) Promotes gender equality with ensuing chain of benefits. (Susheela Singh, 2014)

A basic, overarching justification for investing in adolescent health is that, like all adults, teenagers have fundamental rights to life, growth, the highest achievable health standards, and access to health services. These are sponsored by international conventions of human rights, which are signed by almost all nations. More specifically, it becomes increasingly clear that promoting and protecting adolescent health will bring great benefits to public health, the economy and demographics. Adolescent health investments bring a triple health benefit dividend.

Investing in adolescent health preserves and improves positive preventive measures that helped children in early childhood, and rectifies earlier disparities in education. On the other hand, gains made by substantial investment in maternal and child health services over recent decades are at risk of being reversed if today's adolescent health programming lacks sufficient investment. Moreover, improved health for teenagers offers financial and greater benefits to society. It occurs through higher productivity, lower health costs and increased social capital.

In low-and middle-income (LMICs) countries, investment in adolescent health is likely to lead to reductions in mortality and fertility levels, which can contribute to increased economic growth. Despite fewer births each year, a country's youth-dependent population is growing smaller than the working-age population (age 15–64), creating a window of opportunity for rapid economic growth. In high-income countries, improvements in low-income youth's health and well-being, including those with high birth rates and more vulnerable to risk factors for ill-health, will also help break the transmission of poverty and disadvantage across generations.

Adolescent health commitment is also vital to meeting the 17 SDGs and their 169 targets, each of which is directly or indirectly linked to adolescent growth, health or well-being. Many SDGs, such as those dealing with health and food safety, narrowly cover adolescents' health and well-being within their wider population goals. (WHO, Global Accelerated Action for the Health of Adolescents, AA-HA!: Guidance to Support Country Implementation, 2017)

2.7 Review on Previous Studies

A study of unmet needs for reproductive health knowledge among unmarried youth workers showed that lack of formal sexual education and the special social status were deep reason for their low knowledge. Very few of them had received sex education in school. The knowledge they have usually come first from peer communication and

are full of mistakes. As growing up, mass media, like TV and magazines begin to be their major knowledge sources. Working long hours each day, with little leisure time and living isolated in cities, migrant people rarely benefit from the ongoing education activities in cities (Shuang-ling, 2008)

A study about sexual health behavior of young adolescent Taiwanese girls stated that sexual health knowledge and normative beliefs were significantly associated with sexual health behaviors. Moreover, sexual self-concept mediated the association between sexual health knowledge and normative beliefs with sexual health behavior. The influence of sexual self-concept was explained by the increase in variance (total effect), from 14–58% (Pai, 2012)

A study in Ambo, central Ethiopia about Sexual and reproductive health experience, knowledge and problems among university students describes mean age during first sex is $17.29 \pm SD 2.21$. The quantitative data showed unwanted pregnancy among 5% of the students and abortion prevalence is 2.5% of the respondents. But high rates of unwanted pregnancy and unsafe abortion were reported in the qualitative data. (Abenezer, 2017)

Based on the results of a 2005 survey by the Japanese Association for Sex Education (2007), it was noted that there is a prominent increase in the rate of teenage Japanese males and females with sexual experience from 3.6% and 4.2%, respectively, among early adolescents (aged 13-15 years) to 26.6% and 30.0%, respectively, among late adolescents (aged 16-18 years). So, sexuality is an important area of early adolescent health. Sexual behavior is significantly influenced by attitudes toward and intention to engage in sexual activity. The study by the Japan Family Planning Association (2008), the average age of first intercourse is 19 years. So, studying about attitudes toward sexual activity is more important than investigating sexual behavior for young adolescents in Japan. Based on the results of national and international studies conducted on adolescents, the factors influencing the sexual activity of early adolescents include the social factors and individual factors. Adolescents who have had risky behaviors would tend to have a more attitude toward sexual activity than those who have not had risky experiences. (Nagamatsu, 2012)

A survey performed in Thai-Myanmar border showed that adolescent pregnancy is associated with traditional views and stigma on sexual and reproductive health issues, resulting in a knowledge gap on contraception and life skills necessary to negotiate sexual and reproductive choices, in particular for unmarried adolescents.

While adolescent girls worried mostly about physical difficulties in childbirth and financial hardship, adolescent boys thought that missed educational opportunities and social consequences could make the future difficult. Most adolescents received information on contraception from mothers, sisters, aunties, neighbors and friends. Many adolescents had heard about contraceptives, but did not know how to use them correctly. Adolescents are hesitant to use clinic services because of the associated stigma and social control on premarital sex: a clinic visit in itself could show the community that the adolescent is sexually active or interested in premarital sex (Asnong C, 2018).

CHAPTER III

GENERAL SITUATION OF REPRODUCTIVE HEALTH IN MYANMAR

This chapter describes (a) overview of reproductive health in Myanmar, (b) RH policies and practices in Myanmar and (c) RH situations of Myanmar.

3.1 Overview of reproductive health in Myanmar

In Myanmar, school-based programs for life skills are carried out by Ministry of Education, and NGOs have conducted educational activities on adolescent reproductive health (ARH) at township and community levels. In addition, life skills and training on reproductive health issues are provided at Youth Training Schools that are under the Department of Social Welfare. The Central Health Education Bureau (CHEB, Now- Health literacy promotion unit, HLPU) and the reproductive Health Program have established Youth Information Corners in Rural Health Centers in 67 townships and Youth friendly health services in 28 townships.

Adolescent account for almost 20% of Myanmar's population (an estimated 10 million adolescents aged 10-19 years). Young people are at risk of risky sexual behaviors. Adolescent pregnancies become doubled in the last decade. 33 of every 1,000 girls aged 15-19 give birth in every year and Adolescent Birth Rate is 36 per 1000 women according to Myanmar Demographic Health Survey 2015-2016). 9% of adolescents (aged between 15-19 years) who ever had sexual intercourse had STI/symptoms of Sexually Transmitted Infections. Fifteen percent of adolescent girls (15-19 years of age) and six percent of adolescent boys (15-19 years of age) had early sex (before 18 years of age). 7% of youth maternal death are due to abortion or unwanted pregnancy and 27% of abortion related death occur in the age group of 15-24 year. 20% of all maternal deaths are among youths (15-24 years). In 2016 Myanmar Maternal Death Surveillance Report, 174 deaths in youth (15 – 24 year) out of total 815. According to MDHS 2015-16, education level and attainment of sexual and reproductive health education significantly reduces adolescent pregnancies. Teens with poor sexual and reproductive health education are 4 times more likely to have teen pregnancies than those with higher education. (Htun Win Latt, 2018)

According to Myanmar Demographic Health Survey (2015-2016), over half (52%) of married women are currently using a method of contraception: 51% use a modern method and 1% use traditional method. Injectable are the most common method, used by 28% of married women, followed by the contraceptive pill (14%), and female sterilization (Ministry of Health and Sport and ICF, 2016).

Table 3.1. Adolescent Birth Rate in Demographic Health Survey, Myanmar (2016)

(Source: Demographic Health Survey, Myanmar, 2016)

3.2 Reproductive Health situation in Myanmar

In Myanmar, 2,800 women die from preventable causes of pregnancy and

Background Characteristics	Percentage of Women age 15-19 who:		Percentage who have begun childbearing
	Have had a live birth	Are pregnant with first child	
Age			
15	0.7	0.1	0.8
16	1.0	0.8	1.8
17	1.9	1.3	3.2
18	4.4	1.2	6.5
19	16.1	1.4	17.5
Residence			
Urban	3.7	0.7	4.3
Rural	4.6	1.1	6.7

childbirth each year. The 2014 census revealed that 282 per 100,000 live births, Myanmar's Maternal Mortality Ratio (MMR) is the second highest in the region, and significantly higher than the ASEAN average of 140. In Myanmar, 52.2% of married women practice family planning. The vast majority of these, 51.3% of married women, use modern contraceptives. The target is to increase the modern contraceptive prevalence rate for all women to 60%, and to reduce the unmet need for family planning from 16% to below 10% by 2020. These are critical milestones to achieving Sustainable Development Goal #3, which includes universal access to sexual and reproductive health services and rights by 2030 (UNFPA, 2016).

In Multiple Indicators Cluster Survey (2010) showed that contraceptive prevalence rate of ever-married women is 46%. The most popular method is the injection, which is used by nearly one in three (27.5%) of ever married women in Myanmar. The next most popular method is the pill, which is used by 11.5% of the ever-married women. Only 2.1% use IUD and 3.6% of women reported female sterilization. Male condoms, male sterilization, lactational amenorrhea (LAM) process, abstinence, implants and removal are used by less than one percent. (Ministry of National Planning and Economic Development and Ministry of Health Myanmar, 2011).

According to a study in University of Magway, 45% of the distance education of university students engaged into premarital sex (Htike, 2017). One of the study in Myanmar in 2010 established that 10% of the youth adored the premarital sex. The respondents were medical students and youth from the community. About 40% of male respondents and 28% of female respondents had positive attitude of premarital sex (Kay Khine, 2016).

In a study among medical students in University of Medicine II, Yangon, over half of the students 67.1% live with biological parents and 14.3% live with friends. Concerning reproductive health risk predictors, there was significant relation between gender, age group and communication with family members and friends. Male respondents 16.5% and 3.2% of female respondents have risky sexual behavior. (Hnin Wai Lwin Myo, 2004)

A study of youth in rural area of Mon state found that most of the respondents 74.9% had low knowledge level and only 24.1% of the respondents had higher knowledge level. Forty two persons 27.5% of elder age group (20-24) had a high knowledge level and 12 persons 19.4% of the younger group (15-19) had high level. But there is no statistically significant association between the two groups. Females had a higher level of knowledge than males. Graduate respondents had a higher level of knowledge than undergraduate persons. Education and reproductive health knowledge level is associated. But, there is no association between occupation and total knowledge score and there is also no association between family members and total score of reproductive health and risk behaviors. Nearly 50% of the respondents did not know that a woman can get pregnant on the very first time of intercourse that she has sexual intercourse and if she had sex only once (Min Myo Kyi, 2016).

In a study among commercial motorcycle drivers in Meikhtila Township, most respondents (74%) were from urban and the rest of respondents were rural area of Meikhtila Township. Their major source of information was mostly from medical doctor (24.5%) and Basic health staffs (16.5%). Commonest type of media in receiving reproductive health information was internet. This study found that respondents who living with family has lower sexual risk behavior than living with non-family (28% vs 58%). Higher proportion of respondents who received information from parents were in the low risk group (69.3% vs 42.9%, $p < 0.5$). On the other side, higher proportion of respondents who received information from friends were in the high-risk group (61.1% vs 30.8, $p < 0.5$). The study showed no association between newspaper, journal, media, and internet with risk behavior and also explain there were no significant association between age, race, religion, residence, education and, average income per month and reproductive health and sexual behavior. There was no significant association of information receive from medical doctor, BHS, friends, spouse and sexual behavior. (Pyae Phy Chain, 2017)

In a study entitled "Equity of access to reproductive health services among youth in Mandalay City, Myanmar resource-limited suburban communities," two-thirds of young people used some kind of RH services at least once in the past. Levels of unmet needs were 62.6 percent, 31.9 percent, 38.7 percent and 56.2 percent respectively for sexual RH data, family planning, maternal care and HIV testing. Less likely to receive RH programs are young people living in the southern or southwestern suburbs, having a deceased parent, never being married or never exposed to mass media. Being a young adult, a current student, being employed as a waste recycler, having sexual relations, being married, being exposed to mass media, having a high level of knowledge of HR tools and suppliers, or having a high level of exposure to RH services has significantly increased the likelihood of using these services. In addition to youth socio-demographic characteristics, exposure to mass media, traditional peer engagement, and knowledge of provider types and programs significantly influenced the unmet needs of youth for RH services. Conclusion: the availability and use of these resources by young people, despite the availability of RH services, was unsatisfactory. (Phyu Phyu Thin, 2012)

3.3 Reproductive Health policies and objectives in Myanmar

Two overall objectives of the National SRHR Policy include: (a) to inform decision-makers, development/implementing partners, health providers, and beneficiaries about the policy and ensure that they use the policy in their work and/or lives and (b) to aid in the reform of existing laws, regulations, and definitions that restrict access to essential SRHR information and services, especially among adolescents, youth, and marginalized and vulnerable groups.

In Myanmar, family planning policy states that “all individuals of reproductive age, regardless of marital status, ability or special entity, will have equitable access to quality and inclusive family planning 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”. Adolescent sexual and reproductive health and rights policy states that “the highest achievable standard of sexual and reproductive health for adolescents will be pursued by protecting and fulfilling adolescents’ rights to information and quality services, in addition to promoting enabling environments and opportunities to develop life skills”.

Gender and gender-based violence policy statement says that “Gender-sensitive approaches will be mainstreamed throughout all levels of the health system, and individuals affected by gender-based violence (GBV) will have ready access to quality, comprehensive sexual and reproductive health services”. Special groups (Inclusivity) policy statement includes “All individuals, regardless of age, sex, sexual orientation, gender identity, ability, disease status, behaviors, work and social movement, will have their dignity and rights upheld, including their right to health.” And reproductive health morbidities policy statement comprise “All women, men, and young people will have access to information, prevention, early diagnosis, and care for reproductive health morbidities”.

In 1992, Myanmar introduced the National Policy on Population. The Ministry of Health's Reproductive Health Policy and Strategic Plans on Reproductive Health (2004-2008, 2009-2013 and 2014-2018) are continuing contributions to the Program of Action of the United Nations Millennium Development Goals (MDG) International Conference on Population and Development, the Millennium Development Goals of the United Nations (MDG) and the Global Strategy for Women and Children's Health of the UN Secretary-General (2010). Myanmar also made a commitment to the Global Partnership Initiative, Family Planning 2020 (FP 2020) in Addis Ababa, Ethiopia, in

November 2013. Myanmar's government considers family planning to be crucial to saving lives and securing mothers and children's well-being. Access to information, goods and resources for family planning is a fundamental right for all women and individuals in the community if they are to develop to their full potential. (Department of Public Health, 2015)

The Government of Myanmar has committed to FP2020: (a) to strengthen the policy of providing training / skilled nurses, midwives and volunteers with medical contraceptive methods through better coordination among multi-stakeholders under the Nay Pyi Taw Agreement. (b) To implement people-centered policies to address regional disparity and inequity between urban and rural and rich and poor. (c) to expand the forum of family planning under the umbrella of the Health Sector Coordinating Committee and to create a Working Group on Family Planning as a branch of the MNCH Technical Strategy Group. Myanmar pledged to increase the health budget to cover nearly 30 million couples by 2020 and committed (d) to increase the resources allocated to family planning in state budgets. The government will also ensure results-based management by new initiatives for efficient frameworks for fund distribution and internal auditing. Other operational strategies include continued reinforcement of the information system for logistics management. (Department of Public Health, 2015).

CHAPTER IV

SURVEY ANALYSIS

This chapter includes (a) Survey Profile, (b) Survey Design and (c) Survey result of Reproductive Health Literature amongst industrial workers.

4.1 Survey Profile

Yangon Region is highest population density among any other States and Regions. Meanwhile, adolescent birth rate of Yangon Region in 2017 is 10.6%. Number of live birth by 15-19 years old mother is 2926 in 2017. There was 2.7 % of abortion rate; total 2935 numbers of abortion in 2017 and 4046 abortion cases in 2018. During 2017, 117 maternal deaths occurred in Yangon Region (MMR per 100,000 LB is 112.7). Contraceptive prevalence rate for modern methods is 72.6% used.

Among Yangon Region, South Dagon Township is selected because there was 314 MMR per 100, 000 live birth in the same year. There were 3.4% of ABR in South Dagon Township in 2017. Abortion rate was 2.6%, total 118 numbers of abortion was found. Number of live birth by 15-19 years old mother is 37 in 2017. Contraceptive Prevalence Rate (Modern Method) is 70.7 % in 2017 (MOHS, 2018). The indicators were merely tips of ice berg. South Dagon Township is situated in Yangon Region where both urban and rural setting exists. Since South Dagon Township had been developed industrial zones with other area in Yangon Region in recent year, there will be more opportunities to learn and expose to sexual and reproductive health issues and risk behaviors of industrial workers. Furthermore, most people in South Dagon Township are migrant workers from many rural areas of Myanmar and there is much opportunities to practice and expose to sexual risk behaviors.

4.2 Survey Design

Working age group population (15-64 years) was 31126534 and among them, youth population was 8182866 (Department of Labour, 2015). Primary data was used for this descriptive study. The survey was conducted with structured questionnaire among the 15 to 24 years old youth industrial workers in South Dagon Township by

simple random sampling. In accordance with the Township profile of GAD, total Industrial Workers in South Dagon Township was 182622 in 2017 (General Administrative Department, 2017). There are total 3 industrial zones in South Dagon Township and “Zone 2” was selected by using simple random sampling.

In “Zone 2”, there are 820 industries which are functioning at the end of 2017. Among them, the empirical data was collected during July to the youth industrial workers from Global Textile Industry by using simple random sampling. 197 respondents were selected by using sample size calculator based on 182622 sample population (AAPOR, 2015). After collecting the data, analysis was done by using SPSS V-16 Software. Survey questionnaires were organized and structured by the reference with illustrative questionnaires for young people (Cleland, 2001).

4.3 Survey Results

In this study, total 197 industrial workers who had age from 15 to 24 year were participated. 62 males and 135 females were selected proportionately.

4.3.1 Characteristics of the Respondents

Table (4.1) Socio-demographic characteristic of respondents (n=197)

Gender of Respondent	Number of Respondents	Percent
Male	62	31.5
Female	135	68.5
Total	197	100.0
Marital Status	Number of Respondents	Percent
Single	61	31.0
Marriage	126	64.0
Divorced	10	5.1
Total	197	100.0
Educational Status	Number of Respondents	Percent
Can Read and Write	17	8.6
Primary School passed	19	9.6
Middle School passed	85	43.1
High School passed	76	38.6
Total	197	100.0

Table (4.1) Socio-demographic characteristic of respondents (Contd.)

Presence of Relationship	Number of Respondents	Percent
Yes	111	56.3
No	86	43.7
Total	197	100.0
Gender of Relationship	Number of Respondents	Percent
Not applicable	67	34.0
Boy Friend	88	44.7
Girl Friend	42	21.3
Total	197	100.0

Source: “A Study on Reproductive Health Literacy among Youth Workers in Industrial Zone”, Survey data (2019)

4.3.2 Knowledges about Reproductive Health

Table (4.2) knowledge of youth workers on physical changes during puberty for boys and girls

Knowledge on Puberty	Number of Respondents	Percent
Starting menarche	121	61.4
Semen Production	31	15.7
Above 15 years old	20	10.2
Don't Know	25	12.7
Total	197	100.0

Source: “A Study on Reproductive Health Literacy among Youth Workers in Industrial Zone”, Survey data (2019)

Table (4.2) shows knowledge of youth workers on physical changes during puberty for boys and girls. Most of the respondents (63% of male respondent and 54.6% of female) knew about growth spurt and 27.8% of male and 14.8% of female knew about external genital growth and 29.6% of male and 54.6% of female knew about hoarseness of voice as physical changes during puberty for boys. Most respondents (58.3 % of male and 72.2% of female) knew about breast nodule development, 39.8% of male and 69.4% of female knew about menarche and 20.4% of male and 19.4% of female knew about external genital growth as physical changes during puberty for girls.

Table (4.3) Distribution of sources of knowledge about contraception (n=197)

Source of Knowledge	Number of Respondents			
	Yes	%	No	%
Information from Books	120	60.9	77	39.1
Information from Newspaper	86	43.7	111	56.3
Information from Magazine	29	14.7	168	85.3
Information from TV/Radio	103	52.3	94	47.7
Information from Family	40	20.3	157	79.7
Information from Peer	45	22.8	152	77.2
Information source is from parent	44	22.3	153	77.7
Information source is from husband	21	10.7	176	89.3
Information source is from friend	64	32.5	133	67.5
Information source is from health staff	121	61.4	76	38.6
Information source is from mass media	43	21.8	154	78.2
Information source is from IEC materials	94	47.7	103	52.3

Source: “A Study on Reproductive Health Literacy among Youth Workers in Industrial Zone”, Survey data (2019)

Among respondents, 197 respondents (81.4%) knew sources of knowledge about contraception. These were parents (22.3%), friends (32.5%), health staffs (61.4%), husband (10.7%), from IEC materials (47.7%) respectively.

Table (4.4) Knowledge of youth workers concerning contraceptive methods**(n=197) *(Multiple Responses)**

Variables	Male n (%)	Female n (%)
Knowing methods of contraceptive methods		
Yes	53 (86.1)	126(93.5)
No	9 (13.9)	9 (6.5)
Known contraceptive methods *		
OC pills	43 (81.7)	113 (90.1)
Injection	45 (84.9)	117 (93.1)
IUCD	7 (14.1)	60 (48.5)
Condom	23 (42.5)	39 (30.7)
Implant	2 (4.3)	44 (34.6)

Source: “A Study on Reproductive Health Literacy among Youth Workers in Industrial Zone”, Survey data (2019)

This table (4.4) shows most of the respondents (86.1% male and 93.5% female) knew about methods of contraceptive methods. Most common known sources of methods of contraceptive methods for both sexes were injections (84.9% male and 93.1% female) and Oral contraceptive pills (81.7% male and 90.1% female).

Table (4.5) Knowledge of youth workers on consequences of premarital sex**(n=197) *(Multiple Responses)**

Knowledge on STD	Number of Respondents	Percent
No	27	13.7
Yes	170	86.3
Knowledge about unwanted Pregnancy	Number of Respondents	Percent
No	57	28.9
Yes	140	71.1
Knowledge on Social Distress	Number of Respondents	Percent
No	104	52.8
Yes	93	47.2
Total	197	100.0

Source: “A Study on Reproductive Health Literacy among Youth Workers in Industrial Zone”, Survey data (2019)

This table (4.5) shows most respondents (82.4% male and 89.8%) knew the consequences of premarital sex. Among them, unwanted pregnancy (76.4% male and 90.7% female) and sexually transmitted infections (23.6% and 24.7% female) were the most well-known consequences of premarital sex for both respondents.

Table (4.6) Knowledge of youth workers concerning on chance of getting pregnancy in adolescent female (n=197)

Knowledge on getting Pregnancy		
Description	Number of Respondents	Percent
First time of intercourse	22	11.2
By coitus of every time	31	15.7
If she had coitus in mid cycle of menstrual period	106	53.8
Don't Know	38	19.3
Total	197	100.0

Source: “A Study on Reproductive Health Literacy among Youth Workers in Industrial Zone”, Survey data (2019)

This table (4.6) shows that most of respondents (44.4% male and 53.7% female) thought that an adolescent girl can get pregnant at every time of sexual intercourse. Only 44.4% male and 34.3% female knew it is not. Most of respondents (50.0% male and 60.2% female) knew that an adolescent girl can get pregnant if she had sexual intercourse at the mid time of menstrual cycle but 25.0% male and 17.6% female did not know about it. Most of respondents (69.4% male and 70.4% female) knew that an adolescent girl can get pregnant at the first sexual intercourse but 19.4% male and 20.4% female did not know about it.

Table (4.7) Knowledge of youth workers concerning start of reproductive functions (n=197)

Knowledge on Boy	Number of Respondents	Percent
Yes	141	71.6
No	7	3.6
Don't Know	49	24.9
Total	197	100.0
Knowledge on Girl	Number of Respondents	Percent
Yes	158	80.2
No	7	3.6
Don't Know	32	16.2
Total	197	100.0

Source: “A Study on Reproductive Health Literacy among Youth Workers in Industrial Zone”, Survey data (2019)

This table (4.7) shows most of male respondents (74.1%) and half of female respondents (53.7%) knew the starting time of male reproductive function. Among them, only 42.5% of male respondents and 34.5% of female respondents could say that ejaculation of semen was the starting time of male reproductive functions. Most of respondents (80.6% male and 87.0% female) knew the starting time of female reproductive function. Among them, 79.3% of male respondents and 74.5% of female respondents could say that menarche was the starting time of female reproductive functions.

Table (4.8) Level of knowledge on sexual practice and contraceptive methods among youth workers (n=197)

Knowledge Level on Sexual Practice	Number of Respondents	Percent
Low	120	60.9
High	77	39.1
Total	197	100.0
Knowledge Level on Contraception	Number of Respondents	Percent
Low	105	53.3
High	92	46.7
Total	197	100.0

Source: “A Study on Reproductive Health Literacy among Youth Workers in Industrial Zone”, Survey data (2019)

Knowledge level on sexual education and reproductive health were classified into four levels of knowledge using different cut-off points (25%= 7 points, 50%= 14 points, 75%= 21 points and 100%= 29 points of total knowledge score) according to the given marks. According to figure, 86.6% youth workers could answer 25% of total knowledge questions, very few (8.8%) could answer 75% of total knowledge questions and no one could answer 100% of total knowledge questions.

4.3.3 Attitude of Youth Workers on Reproductive Health

Table (4.9) Attitudes concerning giving sexual education to youth (n=197)

Youth should be provided sexual education	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
Number of Respondents	138	50	6	0	3
Percent (%)	70.1	25.4	3.0	.0	1.5
RH education to youth can promote to test sex earlier					
Number of Respondents	31	42	34	72	18
Percent (%)	15.7	21.3	17.3	36.5	9.1
RH education to under eighteen years old is not suitable					
Number of Respondents	65	58	6	30	38
Percent (%)	33.0	29.4	3.0	15.2	19.3
Mass media are appropriate to use in RH education					
Number of Respondents	66	60	65	3	3
Percent (%)	33.5	30.5	33.0	1.5	1.5
RH education should be included in School Curriculum					
Number of Respondents	9	47	8	63	70
Percent (%)	4.6	23.9	4.1	32.0	35.5

Source: "A Study on Reproductive Health Literacy among Youth Workers in Industrial Zone", Survey data (2019)

Table (4.9) shows the attitude of the youth workers towards teaching sex education to their adolescent children. Only 41.2% youth workers strongly agreed and 32.9% youth workers agreed (which were overall 74.1% of total youth workers) with the statement of talking about sexual health with children only when they reach sexual maturity (puberty). Most of total youth workers (62.5%) expressed (38.4% disagreed 24.1% strongly disagreed) with the statement of embarrassing to talk about sexual health with their children and 36.6% and 19.0% were also not thinking that sex education induced adolescents to have sexual experiment.

Among respondents, 77.3% (39.8% strongly agree and 37.5% agree) of youth workers believed that adolescents should not have a boyfriend or girlfriend and 68.9% agreed (33.3% strongly agreed and 34.6% agreed) to punish their children if they have sexual relations. However, 82% of youth workers (44% strongly agree and 38% agree) were willing to be the first person to teach their children about sex and relationships and then, 176 youth workers (81.5%) accepted that their children could talk and discuss all matters including sex related matters anytime with them.

Among respondent youth workers, 88% (43.1% strongly agree and 44.9% agree) believed that there should be reproductive health services which were easily available to adolescents and 81.9% (52.3% strongly agree and 29.6% agree) accepted that sex education program should be added in school curriculum.

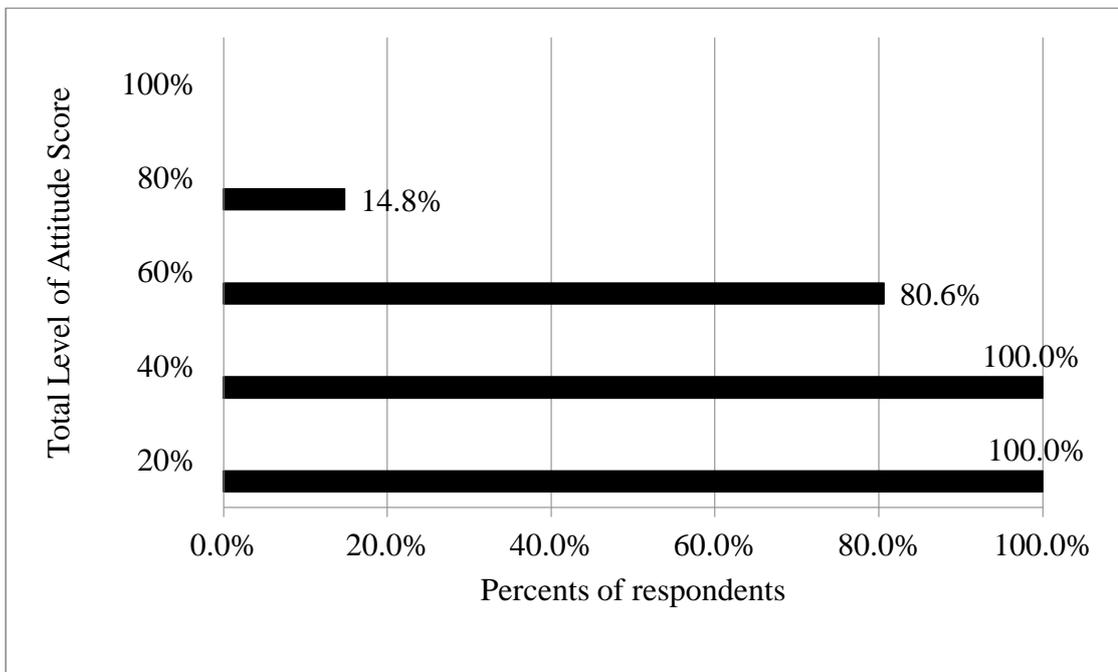
Table (4.10) Level of Attitude on RH education and Premarital sex of respondents (n=197)

Level Of Attitude on RH education	Number of Respondents	Percent
Poor	116	58.9
Good	81	41.1
Level of Attitude on Premarital Sex	Number of Respondents	Percent
Poor	53	26.9
Good	144	73.1
Total	197	100.0

Source: “A Study on Reproductive Health Literacy among Youth Workers in Industrial Zone”, Survey data (2019)

As shown in Table (4.10), only 41% good attitude on sexual health and reproductive health education. However, 73.1% good attitude on premarital sexual practice. Mean attitude score (SD) was 44.3 (6.2). Minimum and maximum attitude scores were 32 and 63 respectively.

Table (4.11) Level of attitude on sexual education and reproductive health among youth workers according to the giving marks (n=197)



Source: “A Study on Reproductive Health Literacy among Youth Workers in Industrial Zone”, Survey data (2019)

Attitude level of respondents concerning sexual education and reproductive health were classified into five levels using different cut-off points (20%=13 points, 40%=26 points, 60%=39 points, 80%=52 points and 100%=65 points of total attitude score). Figure (4.3) indicates that all (100%) youth workers could give right answered to 20% and 40% of total attitude questions while most (80.6%) could answer 60% of total attitude questions and very few (14.8%) could answer 80% of attitude questions and no one could answer 100% of attitude questions .

4.3.4 Relationship/ Association on Reproductive Health Literacy

Table (4.12) Association between Presence of Relationship and Gender of respondents (n=197)

Variables	Gender of Respondent		Total	x ² value	p value	Odd Ratio	95% CI
	Male n (%)	Female n (%)					
Presence of Relationship							
Yes (Ref.)	27 (43.5)	84 (62.2) 51 (37.8)	111 86	6.023	0.014	0.468	- 0.25, 0.86
No	35 (56.5)						

Source: “A Study on Reproductive Health Literacy among Youth Workers in Industrial Zone”, Survey data (2019)

The table (4.12) shows that there is significant association between gender and presence of relationship. The larger proportion of female respondents (62.2%) was found to have presence of relationship when compared to that of male respondents (43.5.0%).

Table (4.13) Association between Socio demographic characteristic and attitude level of respondents (n=197)

Variables	Attitude Level		Total	x ² value	p value	Odd Ratio	95% CI
	Good n (%)	Poor n (%)					
Sex							
Male (Ref.)	9(13.0) 42(34.3)	53 (87.0) 93 (64.7)	62 135	13.579	<0.001*	1.0 3.5	- 1.8 , 7.0
Female							
Highest level of education							
Below high school (Ref.)	40(74.4)	110(24.6)	150	1.155	0.282	1.0	- 0.7 ,
High school and above	21(86.1)	26 (13.9)	47			1.5	3.4

Source: “A Study on Reproductive Health Literacy among Youth Workers in Industrial Zone”, Survey data (2019)

The larger proportion of female respondents (34.3%) was found to have good attitude levels when compared to that of male respondents (13.0%). There was statistically significant association between attitude level of respondents and sex of respondents ($p=0.000$) (Odds ratio = 3.5, 95% CI = 1.8, 7.0). The larger proportion of respondents who were dependents (37.8%) was found to have good attitude levels when compared to that of respondents who were not dependents (20.8%).

Table (4.14) Association between knowledge level and attitude level of respondents (n=197)

Variables	Attitude Level		Total	χ^2 value	<i>p</i> value	Odd Ratio	95% CI
	Good n (%)	Poor n (%)					
Knowledge level	17	34					
Low	(33.3)	(66.7)	51	3.499	0.061	1.9	0.9, 3.9
(Ref.)	25	121	146				
High	(20.6)	(79.4)					

Source: “A Study on Reproductive Health Literacy among Youth Workers in Industrial Zone”, Survey data (2019)

Table (4.14) shows that there was no statistically significant association between attitude level and knowledge level of youth workers ($p>0.05$)

Table (4.15) Association between Knowledge level of Sexual Practice and Knowledge level on Contraception (n=197) (Continued)

Variables	Knowledge level on Contraception		Total	x ² value	p value	Odd Ratio	95% CI
	Low n (%)	High n (%)					
Knowledge level of Sexual Practice Low (Ref.) High	88(83.8) 17(16.2)	32 (34.8) 60 (65.2)	120 77	49.5	<0.001*	9.7	- 4.95, 19.0

Source: “A Study on Reproductive Health Literacy among Youth Workers in Industrial Zone”, Survey data (2019)

Knowledge level of Sexual Practice is lower than knowledge level of contraceptive methods (83.8%) and (16.2%). There was statistically significant association between knowledge level of respondents on sexual practice and knowledge level of respondents on contraception (p=0.000) (Odds ratio = 49.5, 95% CI = 4.95, 19.0).

Table (4.16) Association between Knowledge level on Contraception and Attitude level of Reproductive Health (n=197) (Continued)

Variables	Knowledge level on Contraception		Total	x ² value	p value	Odd Ratio	95% CI
	Low n (%)	High n (%)					
Attitude level of Reproductive Health Poor (Ref.) Good	52(49.5) 53(50.5)	64 (69.6) 28 (30.4)	116 81	8.14	0.004	0.29	- 0.24, 0.77

Source: “A Study on Reproductive Health Literacy among Youth Workers in Industrial Zone”, Survey data (2019)

There was significant association between knowledge level of contraception and attitude level of reproductive health ($p=0.000$) (Odds ratio = 0.29, 95% CI = 0.24, 0.77).

Table (4.17) Association between Attitude level of Premarital Sex and Knowledge level of Sexual Practice (n=197) (Continued)

Variables	Knowledge level of Sexual Practice		Total	χ^2 value	<i>p</i> value	Odd Ratio	95% CI
	Low n (%)	High n (%)					
Attitude level of Premarital Sex							
Poor (Ref.)	26(21.7)	27 (35.1)	53	4.28	0.039	0.512	- 0.27, 0.97
Good	94(78.3)	50 (64.9)	144				

Source: “A Study on Reproductive Health Literacy among Youth Workers in Industrial Zone”, Survey data (2019)

There was significant association between attitude level of premarital sex and knowledge level of sexual practice ($p=0.000$) (Odds ratio = 0.512, 95% CI = 0.27, 0.97). There is negative association between them as odds ratio is less than 1. Thus, though attitude level of premarital sex is poor, there may be high in knowledge level of sexual practice.

CHAPTER V

CONCLUSION

This chapter describes (a) Findings and discussion on reproductive health literacy among youth workers (b) Recommendations which are based on the findings of this study.

5.1 Findings

In the quantitative study, total 197 industrial workers who had age from 15 to 24 year were participated. Among them 30 males and 62 females were from plastic industrial of South Dagon township and 32 males and 73 females were from another textile industrial of that township. Self-Administered-Interview was done to assess youths' knowledge, attitude and ways to overcome the barriers on giving sexual health education to youth workers.

5.1.1 Socio-demographic status of the respondents

Regarding socio-demographic characteristics of the respondents, the largest age group was between 18-24 years of age (68.5% male and 54.6% female). Regarding with education, 8.6% of respondents were "can read and write". 9.6% of total respondents passed primary school. Majority of the respondent (43.1%) passed middle school and 38.6% passed high school. Most of the respondents (64%) got married at their age between 15-24 years, 31% were single and 4.1% were divorced. More than half of female(52.0%) got knowledge of sexual health from health staff and hearsay, 44.9% and 40.2% respectively, in the meanwhile, males got sexual health knowledge from friends, Facebook (social media) and hearsay, regardless of these information were correct or not.

5.1.2 Knowledge of respondents on reproductive health

According to the knowledge regarding puberty of the respondents on reproductive health 12.7% of the respondent didn't know when puberty started. 19.3% did not know about how a pregnancy got by. Most of the participants in this study knew about reproductive physiology of male and female adolescents although their

knowledge concerning on the chances of getting pregnancy in female adolescent was not high enough.

By the knowledge on consequences of unprotected sex, 13.7% of the respondent did not know that it may transmitted by sexually transmitted diseases. 28.9% did not know that it may happen unwanted pregnancies and 47.2% answered it may cause social distress. Consequences of premarital sex (especially unwanted pregnancy) were known by majority of respondents. It might be probably due to unacceptable perception of premarital sex in Myanmar culture. In a study done in lower primary school in Ghana in 2014, it was found that (77.6%) of interviewed mothers knew that their sons/daughters, regardless of their gender, had concern about sexuality; their main horror was adolescent pregnancy (KingsleyNyarko, 2014).

Among STIs, HIV/AIDS was well known by most of respondents and majority of respondents knew these diseases can be transmitted sexually than any other diseases. Only 16.2% and 12.7% answered that Hepatitis B and Hepatitis C could be transmitted sexually. Majority of the respondents (84.3%) answered that using condom could prevent STDs.

82.5% of males knew condom, over 78% of males knew OC pills and injection methods. On the other hand, over 92% of female's answers were OC pills and injection and 30% knew implant method for contraception. Most of both males and females knew place of sexual health services, especially contraceptive services, were provided.

In a study done in Ghana among lower primary school in 2014, stated that 54% of fathers and 38% of mothers have never talked to their children about sexual health. Again, 46.7% of fathers and 51.7% of mothers said they were comfortable talking to their children about it (KingsleyNyarko, 2014). This study also showed knowledge about information sources described that respondent can get RH information from family members are 20.3%. However, 62.9% of the respondents heard about premarital sex practice from friends and 44.7% also knew from internet.

The constraint from the respondents mostly found was inadequate knowledge of reproductive health. It may be probably because they felt shy to discuss sexual health with their friends and family members. There were no health educations sessions and reproductive health information sources were not available in their work places. On the other hand, the study conducted in lower primary school of Ghana, 2014 found that 53.3% of fathers and 48.3% of mothers admitted discomfort in talking to their children about sexual health (KingsleyNyarko, 2014)

5.1.3 Attitude towards respondents on reproductive health

In that study, it was found that 8.3% of respondents strongly agreed and 26.4% agreed that sex education could induce adolescents to have sexual experiments and then, 11.6% of respondents strongly agreed and 29.6% agreed that teaching about contraception could increase the likelihood of sexual relations in adolescents.

5.1.4 Association between socio-demographic characteristics and knowledge and attitudes among respondents

According to the statistical calculations, there were no significant associations between the knowledge level on RH and socio-demographic characteristics of the respondents. The study done in Ghana (Baku, 2017) stated that, 20.5% of the youth workers in the pre-intervention group had little knowledge about adolescent sexuality topics while 18.1% in the control group had also poor knowledge about it. There were no significant association in very good knowledge levels of youth workers in both groups at pre-intervention (37.0% vs. 27.7%, p-value = 0.351). After the intervention, significantly more youth workers in the intervention group displayed very good knowledge levels (60.0% vs. 34.7%, p-value = 0.001). Therefore, there should be an intervention for reproductive health education to youth workers.

In this study, there was association between occupation and sex and attitude levels of respondents, it may be due to that the dependent mothers who lived at home with their adolescent children could understand their adolescents' natures than father who worked outside. Thus, that study showed that nearly 25% of respondents had high attitude level in which females (72.5%) were more than males (27.5%). In other study, it was found that occupation of youth workers were might engage to the barriers for youth workers in discussing about sexual health with their children as they had little time to stay with their children (M. Svodziwa, 2016). In that study, there was no significant association between knowledge levels and attitude levels of respondents. Knowledge level of respondents regarding sexual health education and had no effect on their attitude level on sexual health education.

5.1.5. Perception and barrier of youth workers on sexual Health Education

Concerning on the perception of youth workers of adolescents, most of the respondents did not understand the reproductive health. Some thought that it meant the

relationship between men and women and process of conception and some youth workers viewed reproductive health from socioeconomic aspect. Concerning on the advantages on giving sexual health education to adolescents, most of the youth workers accepted that giving sexual health education to their adolescents is needed to do. They thought that sexual health education can prevent some risky sexual behaviours and sexually transmitted diseases.

Almost all youth workers thought that teaching sexual health education at school is relevant, but most of them thought it should be started only when the children reach the age of adolescents. Most of youth workers thought their families and neighbors would have positive opinion on teaching sexual education to their adolescents but some youth workers thought their neighbors might blame them of teaching it.

In this study, most common barriers for youth workers on giving sexual health education were gender difference and not discussing about RH with parents. These results were similar to another qualitative study among youth workers with pre-teenage children from United States in 2007 (Wilson, 2007). Concerning on the response of children, some youths willingly accepted sexual health education but some youths thought it as embarrassment. Some youth workers taught their adolescent children about sexual health by giving examples. Some taught it wisely and gently to make their children listen well.

Some youth workers wanted to give sex education to them in order to prevent risky sexual behaviors but very few participants thought that sexual health should not be taught to school level because it might be harmful to them.

Improving the knowledge of youth workers on sexual and reproductive health is important so that they can teach their adolescent children sexual and reproductive health education. Disseminating comprehensive information about reproductive health to community is also important. Findings on this study showed that some participants with low attitude scores on qualitative research accepted that sex education should be given to youths but not all of them are capable of teaching it because of their incomplete knowledge on reproductive health. Almost all of the youth workers did not accept teaching sexual health education at school is relevant.

5.2 Recommendations

The study was done in 2019 among 197 youth industrial workers in industrial zone of South Dagon Township, Yangon Region to explore their reproductive health literacy. RH knowledge is important for the youths to stay safe in their lives and for their environment so that to reduce reproductive health problems. In this study, most of the respondents are high school level. Most of the respondents are female and have relationship. About two-third of the respondents had low level of knowledge and attitude. There was no statistically significant association between the level of knowledge and socio-demographic factors. However, there was statistically significant association between the level of attitude and sex of respondents. Female respondents had better attitude level than the males. There was statistically significant association between attitude on reproductive health and occupation of respondents. The level of attitude of the dependent respondents had higher level than that of the independent respondents.

Based on the findings, the following are recommended.

Training and education programs for youth industrial workers concerning reproductive health should be provided because in this study most of the respondent had low knowledge level on sexual and reproductive health.

It needs to give more capacity building about reproductive health education to health staff because in this study, most of the respondents got their knowledge from health staff.

Youth Health Corners or mobile clinic plan for industrial workers should be planned by coordination with Industrial Zone Administrative Committee because most of the respondents were low knowledge about general reproductive health knowledge and in knowledge about contraceptive methods.

Mass media education concerning sexual and reproductive health to the community should be promoted because getting sexual health knowledge from mass media among the youths was low in this study.

Further studies to assess the perceptions and practices of adolescents on Sexual and reproductive education among youth in any other regions are recommended because this study was done only in South Dagon Township in Yangon region and only among the industrial workers.

Improving sexual and reproductive health status for youth requires a multi-sectoral approach that not only addresses young people's need for their knowledge,

practice and quality services, but also important to have supportive and enabling environment. Thus, pilot projects to promote youth's reproductive health literacy is recommended.

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APPENDIX 1: QUESTIONNAIRES

(ENGLISH VERSION)

Awareness and Perceptions Related to Reproductive Health

Among 15-24 Years Industrial Workers

In South Dagon Township, Yangon Region

SECTION (1)

Background and Family Characteristics

Respondent ID.....

No.	Questions	Code
Background Characteristics		
1.	Age in completed yearsyears	
2.	Sex (1) Male (2) Female	
3.	Marital status (1) Single (2) Marriage (3) Divorce (4) NA	
4.	Education (1) Can read and write (2) Primary school passed (3) Middle school passed (4) High school passes (5) Graduate	
5.	Occupation (1) Students (4) Nongovernment staff (2) Dependent (5) Others (3) Government staff	
6.	Presence of relationship 1. Yes 2. No <i>If No, skip to Q10.</i>	
7.	If Yes (1) Boyfriend (2) Girlfriend	

SECTION (2)

Knowledge on Reproductive Health and Sexually Transmitted Diseases

No.	Questions	Code
General Knowledge on Reproductive Health		
8..	What do you understand by puberty? (1) Starting menarche (2) Semen production (3) Above 15 years old (4) Don't know	
Knowledge on Reproductive Health Anatomy		
9.	Boys can reproduce when they start ejaculation. (1) Yes (2) No (3) Don't know	
10.	Girls can be pregnant when they start menstruation. (1) Yes (2) No (3) Don't know	
11.	Can pregnancy be got by (1) First time of intercourse? (2) By coitus of every time? (3) If she had coitus in mid cycle of menstrual period? (4) Don't know	
Knowledge about Reproductive Health Problems		
12.	Do you know consequences of unprotected sex? If Yes, consequences of unprotected sex are (1) STI (2) Unwanted pregnancy (3) Social Distress (4) Others (5) Don't know	
Knowledge on Sources Reproductive Health Services		

13.	<p>From where have you obtained information about RH knowledge?</p> <p>(1) Books (4) TV / Radio (2) Newspaper (5) Family members (3) Magazine (6) Friends (7)Others</p>	
Knowledge on Sexual practice		
14.	<p>Have you heard of Premarital sexual practice? If Yes, from what source?</p> <p>1. Friends 4. Film 2. Internet 5. Others 3. Magazine Journal/Pamphlets 6. No/ never been heard</p>	
15.	<p>Can get diseases from sexual partners? If yes, which diseases you can get from sexual intercourse?</p> <p>1. HIV/AIDS 4. Hepatitis C 2. Sexually Transmitted Infections 5. Others 3. Hepatitis B 6. No/ Never</p>	
16.	<p>Do you know preventive methods of sexually transmitted diseases? If yes, describe the preventive methods of sexually transmitted diseases.</p> <p>1. Abstinence 3. Use condom 2. Be faithful to one partner 4. Others 5. No</p>	
17.	<p>What are the side effects of premarital sexual practice?</p> <p>(1) Unwanted pregnancy (2) Induced abortion (3) Maternal death (4) STIs (5) Others (.....)</p>	

18.	Who should know about contraception methods to avoid pregnancy after sex? (1) Only boys (2) Only girls (3) Both																																					
Knowledge on Contraception																																						
19.	Which kind of contraceptive methods have you heard? (Multiple responses, not probe) <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Oral contraceptive pills</td> <td style="width: 20%;">Yes ()</td> <td style="width: 30%;">No ()</td> </tr> <tr> <td>Injection medroxyprogesterone</td> <td>Yes ()</td> <td>No ()</td> </tr> <tr> <td>Female condom</td> <td>Yes ()</td> <td>No ()</td> </tr> <tr> <td>Male condom</td> <td>Yes ()</td> <td>No ()</td> </tr> <tr> <td>IUD</td> <td>Yes ()</td> <td>No ()</td> </tr> <tr> <td>Female sterilization</td> <td>Yes ()</td> <td>No ()</td> </tr> <tr> <td>Implant</td> <td>Yes ()</td> <td>No ()</td> </tr> <tr> <td>Emergency contraceptive pill</td> <td>Yes ()</td> <td>No ()</td> </tr> <tr> <td>Withdrawal</td> <td>Yes ()</td> <td>No ()</td> </tr> <tr> <td>Abstinence</td> <td>Yes ()</td> <td>No ()</td> </tr> <tr> <td>Calendar method</td> <td>Yes ()</td> <td>No ()</td> </tr> <tr> <td colspan="3">Other specify.....</td> </tr> </table>	Oral contraceptive pills	Yes ()	No ()	Injection medroxyprogesterone	Yes ()	No ()	Female condom	Yes ()	No ()	Male condom	Yes ()	No ()	IUD	Yes ()	No ()	Female sterilization	Yes ()	No ()	Implant	Yes ()	No ()	Emergency contraceptive pill	Yes ()	No ()	Withdrawal	Yes ()	No ()	Abstinence	Yes ()	No ()	Calendar method	Yes ()	No ()	Other specify.....			
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Calendar method	Yes ()	No ()																																				
Other specify.....																																						
20.	Where did you get the information about contraceptive methods? (Multiple responses) <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Parents</td> <td style="width: 20%;">Yes ()</td> <td style="width: 30%;">No ()</td> </tr> <tr> <td>Husband</td> <td>Yes ()</td> <td>No ()</td> </tr> <tr> <td>Friends</td> <td>Yes ()</td> <td>No ()</td> </tr> <tr> <td>Medical professionals</td> <td>Yes ()</td> <td>No ()</td> </tr> <tr> <td>From mass media (TV, radio, journal, magazine)</td> <td>Yes ()</td> <td>No ()</td> </tr> <tr> <td>From IEC materials (pamphlets, posters)</td> <td>Yes ()</td> <td>No ()</td> </tr> <tr> <td colspan="3">Others specify.....</td> </tr> </table>	Parents	Yes ()	No ()	Husband	Yes ()	No ()	Friends	Yes ()	No ()	Medical professionals	Yes ()	No ()	From mass media (TV, radio, journal, magazine)	Yes ()	No ()	From IEC materials (pamphlets, posters)	Yes ()	No ()	Others specify.....																		
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21.	<p>Can contraceptive reduce unwanted pregnancies and unintended pregnancies?</p> <p>1. Yes 2.No 3.Don't know</p>	
22.	<p>Do you think using condom can protect against STD infection including HIV/AIDS?</p> <p>1. Yes 2. No 3. Don't know</p>	
23.	<p>Do you know the side effects of emergency contraceptive pill? (Multiple responses, not probe)</p> <p>(1) Menorrhagia Yes () No ()</p> <p>(2) Nausea & vomiting Yes () No ()</p> <p>(3) Dizziness Yes () No ()</p> <p>(4) Others specify.....</p>	

SECTION (3)

Attitudes on Reproductive Health

No.	Questions	Code
Attitudes on Reproductive Health		
24.	It is advisable to give knowledge concerning nature of sexual maturation to youth. SA <input type="checkbox"/> A <input type="checkbox"/> DK <input type="checkbox"/> DA <input type="checkbox"/> SDA <input type="checkbox"/>	
25.	Giving health education to youths will promote them to test sex earlier. SA <input type="checkbox"/> A <input type="checkbox"/> DK <input type="checkbox"/> DA <input type="checkbox"/> SDA <input type="checkbox"/>	
26.	It is not suitable to give sex education to youths under 18 years because young. SA <input type="checkbox"/> A <input type="checkbox"/> DK <input type="checkbox"/> DA <input type="checkbox"/> SDA <input type="checkbox"/>	
27.	Mass media are appropriate for dissemination of sex education and reproductive health for youths. SA <input type="checkbox"/> A <input type="checkbox"/> DK <input type="checkbox"/> DA <input type="checkbox"/> SDA <input type="checkbox"/>	
28.	Sex education should be included in school curriculum. SA <input type="checkbox"/> A <input type="checkbox"/> DK <input type="checkbox"/> DA <input type="checkbox"/> SDA <input type="checkbox"/>	
29.	It is embarrassing to discuss about reproductive knowledge. SA <input type="checkbox"/> A <input type="checkbox"/> DK <input type="checkbox"/> DA <input type="checkbox"/> SDA <input type="checkbox"/>	
Attitudes on Premarital Sex		
30.	Youths can practice premarital sex if their partners have desire. SA <input type="checkbox"/> A <input type="checkbox"/> DK <input type="checkbox"/> DA <input type="checkbox"/> SDA <input type="checkbox"/>	
31.	Youths should know about contraception before marriage. SA <input type="checkbox"/> A <input type="checkbox"/> DK <input type="checkbox"/> DA <input type="checkbox"/> SDA <input type="checkbox"/>	
32.	Youth can practice sex with prostitute to reduce their sexual desire. SA <input type="checkbox"/> A <input type="checkbox"/> DK <input type="checkbox"/> DA <input type="checkbox"/> SDA <input type="checkbox"/>	
33.	Youth should discuss with friends to make premarital sex. SA <input type="checkbox"/> A <input type="checkbox"/> DK <input type="checkbox"/> DA <input type="checkbox"/> SDA <input type="checkbox"/>	

SECTION (4)

Behavior Questions

No.	Questions	Code
34.	Have you ever had sex before marriage? (1) Yes 2. No <i>If No, skip to Q40.</i>	
35.	Age at the first experience of sex is years	
36.	With whom did you have sex? (1) Boy friends (2) Girl friends (3) Fiancée (4) CSWs/Prostitute (5) Others (Please specify)	
37.	Did you use any contraceptives after sex? 1. Yes 2. No <i>If No, skip to Q39.</i>	
38.	Which type of contraception did you use then? (1) Injection Depo (2) Oral pills (3) Morning after pills (4) Traditional medicine (5) Safe period (6) Hormonal implant (7) Don't know (8) Others (Please specify)	
39.	If you didn't use any contraceptive, why? (1) We don't think it will lead to pregnancy (2) Not easily available (3) No wish to use (4) Shame (5) Partner did not accept it (6) Used condom instead of drugs (7) No knowledge of how to use (8) Others (Please specify)	

40.	Do you accept premarital sex? 1. Yes 2. No <i>If No, skip to Q109.</i>	
41.	If yes, give your reasons.	
42.	If no, give your reasons.	
43.	Please provide your suggestion to policy makers about youth reproductive health.	

Many thanks for your answers to complete this Researches

APPENDIX 2: MYANMAR'S COMMITMENTS TO FP 2020

The Government of Myanmar views family planning as critical to saving lives, 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.

Objectives

- 2 Increase CPR from 41 per cent to 50 per cent by 2015 and above 60 per cent by 2020
- 3 Reduce unmet need to less than 10 per cent by 2015 (from 12 per cent in 2013)
- 4 Increase demand satisfaction from 67 per cent to 80 per cent by 2015
- 5 Improve method mix with increased use of long acting permanent methods (LAPMs) and decentralization to districts

Policy and Political Commitments

Myanmar aims to strengthen the policy of providing clinical contraceptive methods by trained/skilled nurses, midwives and volunteers through better collaboration among multi-stakeholders within the context of Nay Pyi Taw Accord. The government of Myanmar also pledges to implement people-centered policies to address regional disparity and inequity between urban and rural and rich and poor populations. In addition, Myanmar commits to expanding the forum of family planning under the umbrella of the Health Sector Coordinating Committee and to creating an Executive Working Group on Family Planning as a branch of the Maternal Newborn and Child Health Technical Strategic Group.

Financial Commitments

In fiscal year 2011-2012, Myanmar committed USD \$1.29 million for the purchase of contraceptives during the 2012-2013 financial period. Myanmar pledges to increase the health budget to cover nearly 30 million couples by 2020. The Myanmar Ministry of Health commits to working toward increasing the resources allocated to family planning in state budgets. The government is also committed to ensuring results-based management through new initiatives for effective fund flow mechanisms and internal auditing.

Programme and Service Delivery Commitments

Myanmar seeks to boost partnership with the private sector, civil society organizations, and other development partners for expanded service delivery. The

government of Myanmar will continue to strengthen the logistics management information system to ensure reproductive health commodity security through improved projection, forecasting, procurement, supply, storage, systematic distribution, and inventory control. In addition, Myanmar will implement a monitoring system to strengthen quality of care and ensure women have a full range of contraceptive options.

The Government of Myanmar will review and develop a five-year strategic plan for reproductive health through a consultative process, and Myanmar's family plan will address regional disparities and inequalities. The government also commits to improving the method mix with increased use of long-acting methods. Myanmar will host a national conference focused on family planning and reproductive health best practices in 2014 and the 8th Asia Pacific Conference on Reproductive and Sexual Health and Rights in 2016. <http://www.familyplanning2020.org/reaching-thegoal/commitments/allcommitments/commitment/40> (accessed 11 September 2014)

Annex 3: SRHR policies brief

ANNEX 4: CHARACTERISTICS OF YOUTH FIRENDLY HEALTH SERVICES

EQUITABLE: All adolescents, not just certain groups, are able to obtain the health services they need.

ACCESSIBLE: Adolescents are able to obtain the health services that are provided

- policies or procedures are in place that ensure that services are free or affordable to adolescents.

- the point of health service delivery has convenient hours of operation.

- adolescents are well-informed about the range of available reproductive health services and how to obtain them.

- Community members understand the benefits that adolescents will gain by obtaining the health services they need, and support their provision.

ACCEPTABLE: Health services are provided in ways that meet the expectations of adolescent clients

- Policies and procedures are in place that guarantee client confidentiality.

- The point of health service delivery ensures privacy.

- Health-care providers are non-judgmental, considerate, and easy to relate to.

- Adolescents are actively involved in designing, assessing and providing health services.

APPROPRIATE: The health services that adolescents need are provided either at the

point of health service delivery or through referral linkages.

EFFECTIVE: The right health services are provided in the right way and make a positive contribution to the health of adolescents.