YANGON UNIVERSITY OF ECONOMICS
MASTER OF PUBLIC ADMINISTRATION PROGRAMME

WOMEN'S AWARENESS ON SEXUAL AND REPRODUCTIVE HEALTH

(CASE STUDY: FEMALE STUDENTS AT YANGON UNIVERSITY OF ECONOMICS, KAMAYUT CAMPUS)

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MPA - 26 (18TH BATCH)

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A thesis submitted as a partial fulfilment towards the requirements for
The degree of Master of Public Administration (MPA)

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This is to certify that this thesis entitled "**Women's Awareness on Sexual and Reproductive Health (Case Study: Female Students at Yangon University of Economics)**" submitted as a partial fulfilment towards the requirements for the degree of Master of Public Administration has been accepted by the Board of Examiners.

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ABSTRACT

This paper is designed to determine the women's knowledge on sexual and reproductive health and to identify their opinions and the awareness on how much they understand about sex and reproduction. The objective of the study is realized by the use of the descriptive method. The survey was conducted with the female respondents at Yangon University of Economics. Based on the survey results, parents educate their children regarding puberty. The respondents' awareness on contraceptive methods is at an eligible standard. Not only on contraceptive methods, they have a high level of general knowledge on condom as well. However, they have uncertainty on the workings of a woman's body. It was observed the respondents accept that every woman should be aware of her own sexual and reproductive healthcare and rights. Furthermore, they agree that parents should educate their children about sexual and reproductive health since puberty. The respondents also concur to the statement that all pregnant women and new mothers should be properly taken care of under systematic maternal healthcare services. Ultimately, the respondents agree that the government should supply free contraceptives and maternal healthcare services in both rural and urban areas.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

		Against Women
CEDAW	-	Convention on the Elimination of All Forms of Discrimination
CPR	-	Contraceptive Prevalence Rate
LSE	-	Life Skill Education
MDGs	-	Millennium Development Goals
MOHS	-	Ministry of Health and Sports
MSI	-	Marie Stopes International
PAHO	-	Pan American Health Organization
RH	-	Reproductive Health
RTI	-	Reproductive Tract Infection
SRH	-	Sexual and Reproductive Health
STDs	-	Sexually Transmitted Diseases
STI	-	Sexually Transmitted Infections
TFR	-	Total Fertility Rate
UNFPA	-	United Nations Funds for Population Activities
WHO	-	World Health Organization

CHAPTER I
INTRODUCTION

1.1 Rationale of the Study

Throughout history, the central role of women in society has ensured the stability, progress and long-term development of nations. Women, notably mothers, play the largest role in decision-making about family meal planning and diet. Moreover, women self-report more often their initiative in preserving child health and nutrition. Women are the primary caretakers of children and elders in every country of the world. International studies demonstrate that when the economy and political organization of a society change, women take the lead in helping the family adjust to new realities and challenges. They are likely to be the prime initiator of outside assistance, and play an important role in facilitating changes in family life.

The contribution of women to a society's transition from pre-literate to literate likewise is undeniable. Basic education is key to a nation's ability to develop and achieve sustainability targets. Education can improve productivity, enhance the status of girls and women, reduce population growth rates, enhance environmental protection, and widely raise the standard of living. It is the mother in the family who most often urges children of both genders to attend – and stay – in school. The role of women is at the front end of the chain of improvements leading to the family's welfare and the community's long-term capacity.

Reproductive health is defined as a state of physical, mental, and social well-being in all matters relating to the reproductive system, at all stages of life. Good reproductive health implies that people are able to have a satisfying and safe sex life, the capability to reproduce and the freedom to decide if, when, and how often to do so. Men and women should be informed about and have access to safe, effective, affordable, and acceptable methods of family planning of their choice, and the right to appropriate health-care services that enable women to safely go through pregnancy and childbirth.

The social paradigm has shifted considerably in Myanmar from a time where gender equality was not realized nor acknowledged to a modern age where provision of equal rights and responsibilities to all genders in the society is in the process of being promoted. Consequently, the role of women in the country has been remodeled to be disposed of the discriminations that once held their roots deep inside the society, i.e. in all sectors of the country such as health, education, economics, and jurisdiction, women have come to play an important role and are subject to the duties of a citizen with the rights and responsibilities to participate in the development of the nation.

Myanmar, being a member country of the MDG agreement, has focused on promoting gender equality and empowering women, reducing child mortality rate and improving maternal health care - which are categorized as some of the characteristics of reproductive health care. Myanmar has also acceded to CEDAW, which obligates the government to provide women with equal rights and responsibilities which in turn ensures Myanmar women's entry into the labor market.

Countries now much more invest in reproductive health care services, information services, contraceptive supplies, couples' communication counseling, family planning programmes and postpartum care which significantly make improvements in women's mortality and pregnancy related outcomes. These lead to an increase in labor force participation and productivity of a country.

Unless women aged between 16 and 25 have awareness on sexual and reproductive health, health relating problems can be faced. If a woman has an adequate awareness, health relating risks can be avoided and beneficial to the community. By having awareness, women can properly manage for family planning and improve the community's welfare. That's why it is very important for a woman to understand sexual and reproductive health.

1.2 Objectives of the Study

The objective of this study is to determine the women's knowledge on sexual and reproductive health and to identify their opinions and the awareness on how much they understand about sex and reproduction.

1.3 Method of Study

Descriptive method is used to realize the objectives of the study. In order to explore the women's awareness on sexual and reproductive health, a data collection

was conducted at Yangon University of Economics at Kamayut Campus. The primary data collected are summarized by quantitative method and analyzed by descriptive approach. The secondary data for this study were collected by means of research papers, and publications.

1.4 Scope and Limitations of the Study

There is a total of 734 female students who are taking day classes at Yangon University of Economics at Kamayut Campus in majors such as Applied Economics, Commerce and Statistics. The number of 196 female students are selected as samples and interviewed in this study.

1.5 Organization of the Study

This study is composed of five chapters. The first chapter introduces rationale, objectives, methodology as well as scope and limitations of the study. The second chapter describes the literature review on sexual and reproductive health, their importance and issues and concerns. The third chapter portrays the situation of sexual and reproductive health in Myanmar. The fourth chapter consists of the survey and the analysis of awareness on women's knowledge of sexual and reproductive health. The fifth chapter concludes the study with findings and recommendations.

CHAPTER II
LITERATURE REVIEW

2.1 Importance of Sexual and Reproductive Health

Sexual health is a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. As defined by the World Health Organization (WHO), reproductive health addresses the reproductive processes, functions and system at all stages of life.

The International Conference on Population and Development Programme of Action states that reproductive health implies that 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. Reproductive health is a lifetime concern for both women and men, from infancy to old age. Reproductive health in any of these life stages has a profound effect on one's health later in life. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. (WHO, 2006)

The right of men and women are 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 and provide couples with the best chance of having a healthy infant. Reproductive health includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.

Sexual health is about the well-being, not merely the absence of disease. It involves respect, safety and freedom from discrimination and violence. Sexual health

depends the fulfilment of certain human rights. It is relevant throughout the individual's life span, not only to those in reproductive years, but also to both the young and the elderly. It is also expressed through diverse sexualities and forms of sexual expressions which are critically influenced by gender norms, roles, expectations and power dynamics.

Reproductive health is a crucial part of general health and a central feature of human development. It is a reflection of health during childhood, and crucial during adolescence and adulthood, sets the stage for health beyond the reproductive years for both women and men, and affects the health of the next generation. (Nidhi Kotwal, Neelima Gupta & Rashi Gupta, 2008) The health of the newborn is largely a function of the mother's health and nutrition status and of her access to health care. Reproductive health is a universal concern, but is of special importance for women particularly during the reproductive years.

Although most reproductive health problems arise during the reproductive years, in old age general health continues to reflect earlier reproductive life events. Men too have reproductive health concerns and needs though their general health is affected by reproductive health to a lesser extent than is the case for women. However, men have particular roles and responsibilities in terms of women's reproductive health because of their decision-making powers in reproductive health matters. (Yalley Dolma Chankapa, Ranabir Pal, Dechenla Tsering, 2010)

Sexual health includes far more than avoiding disease or unplanned pregnancy. A sexually transmitted infection or unwanted pregnancy does not prevent someone from being or becoming sexually healthy. Sexual health is the ability to embrace and enjoy sexuality throughout people's lives. It is an important part of physical and emotional health.

Being sexually healthy means: understanding that sexuality is a natural part of life and involves more than sexual behavior, recognizing and respecting the sexual rights, having access to sexual health information, education, and care, making an effort to prevent unintended pregnancies and STDs and seek care and treatment when needed, being able to experience sexual pleasure, satisfaction, and intimacy when desired and being able to communicate about sexual health with others including sexual partners and healthcare providers.

2.2 Issues and Concerns of Sexual Health

Sexual health is a broad area that encompasses many inter-related challenges and problems. Key among the issues and concerns are human rights related to sexual health, sexual pleasure, eroticism, and sexual satisfaction, diseases (HIV/AIDS, STIs, RTIs), violence, female genital mutilation, sexual dysfunction, and mental health related to sexual health. (WHO, 2015)

During a meeting held in Antigua, Guatemala in May 2000, an expert group convened by the Pan American Health Organization and WHO in collaboration with the World Association for Sexology (WAS) compiled an overview of sexual concerns and problems that should be addressed in order to advance sexual health (PAHO/WHO 2000). Sexual health concerns are life situations that can be addressed through education about sexuality and society-wide actions in order to promote the sexual health of individuals. The health sector has a role to play in assessment, and in providing counselling and care.

Sexual health concerns related to body integrity and to sexual safety. It needs for health-promoting behaviours for early identification of sexual problems. It also needs for freedom from all forms of sexual coercion and sexual violence, for freedom from body mutilations, for freedom from contracting or transmitting STIs, for reduction of sexual consequences of physical or mental disabilities and for reduction of impact on sexual life of medical and surgical conditions or treatments.

When sexual health concerns related to eroticism, it is necessary for knowledge about the body, as related to sexual response and pleasure, for recognition of the value of sexual pleasure enjoyed throughout life in safe and responsible manners within a values framework that is respectful of the rights of others, for promotion of sexual relationships practised in safe and responsible manners and to foster the practice and enjoyment of consensual, non-exploitative, honest, mutually pleasurable relationships.

When sexual health concerns related to gender, it focuses on gender equality, freedom of discrimination based on gender and gender differences. When it is related to sexual orientation, it emphasizes on freedom from discrimination based on sexual orientation and freedom to express sexual orientation in safe and responsible manners within a values framework that is respectful of the rights of others.

When sexual health concerns related to emotional attachment, it requires the need for freedom from exploitative, coercive, violent or manipulative relationships, for information regarding choices or family options and lifestyles, for skills, such as

decision-making, communication, assertiveness and negotiation, that enhance personal relationships, and for respectful and responsible expression of love and divorce.

When sexual health concerns related to reproduction, responsible choices about reproduction needs to be informed and responsible, decisions and practices regarding reproductive behavior regardless of age, sex and marital status must be responsible, women must have access to reproductive health care and safe motherhood and prevention of and care for infertility has to be accessible. (WHO, 2000)

2.3 Issues and Concerns of Reproductive Health

Reproductive health means that every baby is wanted and planned for and that every pregnant woman has access to the resources she needs for her own and her baby's robustness. It means putting more effort into improving the survival, health, and development of infants. It also means helping to solve problems of infertility for men and women who want to have a baby and cannot. It means finding more acceptable, safer contraceptive methods and making existing methods more available, with vigorous dissemination of information about contraception and other health matters that affect reproduction. It means increasing support to eliminate or alleviate genetic diseases. Most important, it means developing the view that healthy reproduction is intrinsic to the vitality of the nation and, with it, the commitment to use all possible means, including education, research, ethical inquiry, and political action, to achieve that goal. (K Gemzell-Danielsson, Rabe T, Cheng L, 2013)

Most family-planning programmes and fertility-control policies have traditionally failed to take adequate cognizance of the complex forces influencing the demand for children. In contexts of extreme poverty, for example, lack of resources to meet the rising cost of children are often taken to indicate a decline in demand for children, in such contexts, children are valued as a source of social, economic and political security. The outcome under such conditions may not be increased demand for modern contraceptive services, but changes in the contexts in which children are conceived and in which they grow up. Increased poverty in many parts of the world combined with globalization of capital provide the context for increased entry of children into the workforce as an economic resource to their families and as a cheap source of labour and into economically-based sexual relations. (Neil L. Price and Kirstan Hawkins, 2007)

The United Nations coordinated an International Conference on Population and Development (ICPD) in Cairo, Egypt, in September 1994. Its resulting Programme of Action is the steering document for the United Nations Population Fund (UNFPA). The complex concept of gender and gender mainstreaming is not yet well understood by planners, implementers and providers of health and other services and is sometimes rejected as feminist stridency.

Cultural conditions are mediated by religion, gender and tradition. Religion may influence interpretations about use of certain contraceptives, use of blood or life support systems in emergency obstetrics, etc. Gender influences the low level of male responsibility in use of contraception. Men may also prevent women from using contraceptives of the woman's choice and from limiting family size. Domestic violence and violence against women of all ages is an engendered phenomenon with strong inter-generational links on the part of both men (the right to hit) and women (conditioned to suffer in silence). Gender biased food allocation and exaggerated workload causes malnutrition and increased susceptibility to infectious diseases in girls and women. This bias is culturally acceptable in many societies. Cultural pressures may force girls to marry and bear children at a very young age with serious reproductive health consequences. (Schenker JG, Rabenou V, 1993)

Mental and physical abuse of women blamed for infertility, or poor pregnancy outcomes is a cruel engendered cultural practice. This may contribute to depression and suicide or violence against the woman from the in-laws. There are societies in which women are not allowed to seek health care, even for life-threatening emergency conditions if they are not chaperoned by a male relative. There are also traditional practices where there is a preference to receive care only from female attendants.

At all ages women are more likely to be poorer than men. Women-headed households are more likely to be poorer than those headed by men, irrespective of whether the data come from rural or urban populations or from developed or developing nations. Poor women are likely to live in unsanitary housing, have poor quality meals, and poverty further limits access to even free health care.

Women are forced to tolerate poor quality services, particularly in the public sector because of their lack of personal and social status. Poor women without money for medication or transport are unable to seek alternative services at a private sector clinic. The social distance between providers and poor uneducated women, because of power and knowledge asymmetries, force them to accept low quality services in which

they are treated with little respect. (Munyaradzi Kenneth Dodzo and Marvellous Mhloyi, 2017) Minimal technical information is shared with the client; causing great inconvenience to the patients; and women are often treated with little privacy, confidentiality, respect or dignity. Quality is also compromised when unnecessary administrative programme barriers are placed, e.g. husbands' consent or signature to receive certain services. This affects the woman's right to receive services of choice and to space or limit family size.

The true reproductive and health status of women cannot be measured by the traditional indicators of maternal mortality and contraceptive use. A woman's health status is determined over her lifetime by the gender-based social, political, cultural and economic factors that she has experienced. The lack of access to good nutrition, education and health care for the girl child often starts from infancy. The disadvantages inherent in a lack of educational opportunities and employment and self-esteem increase the risks of adolescence, particularly teen pregnancy, sexual exploitation, and STD/HIV and AIDS. These factors are beginning to affect the male child and male adolescents too. In all countries, this increases their risk of sexual exploitation and diseases. Later, the child bearing years are fraught with obstetric and gynecological emergencies and diseases aggravated by pre-existing anemia, and poor access health care. The ageing woman is faced with shrinking financial resources and personal power and growing personal health care needs related to menopause, systemic diseases, disability and cancers. Throughout her life cycle she may experience physical, sexual and emotional abuse. None of these gender-based cultural and economic experiences are captured in the reproductive health indicators currently in use. (Matthew L., 1995)

2.4 Components of Sexual and Reproductive Health

There are two essential components of sexual and reproductive health care: family planning and maternal health.

2.4.1 Family Planning

Family planning services are defined as "educational, comprehensive medical or social activities which enable individuals, including minors, to determine freely the number and spacing of their children and to select the means by which this may be achieved". Family planning may involve consideration of the number of children a woman wishes to have, including the choice to have no children, as well as the age at

which she wishes to have them. These matters are influenced by external factors such as marital situation, career considerations, financial position, and any disabilities that may affect their ability to have children and raise them, besides many other considerations.

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

By reducing rates of unintended pregnancies, family planning also reduces the need for unsafe abortion. Promotion of family planning – and ensuring access to preferred contraceptive methods for women and couples – is essential to securing the well-being and autonomy of women, while supporting the health and development of communities such as preventing pregnancy-related health risks in women, helping to prevent HIV/AIDS, empowering people and enhancing education, reducing adolescent pregnancies and slowing population growth. (WHO, 2014)

2.4.2 Maternal Health

Maternal health is the health of women during pregnancy, childbirth, and the postpartum period. It encompasses the health of family planning, preconception, prenatal, and postnatal care in order to ensure a positive and fulfilling experience, in most cases, and reduce maternal morbidity and mortality, in other cases. (WHO, 2013)

The United Nations Population Fund (UNFPA) estimated that 289,000 women died of pregnancy or childbirth related causes in 2013. These causes range from severe bleeding to obstructed labor, all of which have highly effective interventions. Both maternal mortality (death) and severe maternal morbidity (illness) are "associated with a high rate of preventability."

Four elements are essential to maternal death prevention. First, prenatal care. It is recommended that expectant mothers receive at least four antenatal visits to check and monitor the health of mother and fetus. Second, skilled birth attendance with emergency backup such as doctors, nurses and midwives who have the skills to manage normal deliveries and recognize the onset of complications. Third, emergency obstetric

care to address the major causes of maternal death which are hemorrhage, sepsis, unsafe abortion, hypertensive disorders and obstructed labor. Lastly, postnatal care which is the six weeks following delivery. During this time bleeding, sepsis and hypertensive disorders can occur and newborns are extremely vulnerable in the immediate aftermath of birth. Therefore, follow-up visits by a health worker is assess the health of both mother and child in the postnatal period is strongly recommended. (WHO, 2016)

(1) Poverty and Access to health care

According to a UNFPA report, social and economic status, culture norms and values, and geographic remoteness all increase a maternal mortality, and the risk for maternal death (during pregnancy or childbirth). Poverty, maternal health, and outcomes for the child are all interconnected. Income is strongly correlated with quality of prenatal care. Sometimes, proximity to healthcare facilities and access to transportation have significant effects on whether or not women have access to prenatal care. (UNFPA, 2012)

(2) HIV/AIDS

Maternal HIV rates vary around the world, ranging from 1% to 40%, in least developed countries having the highest rates. Whilst maternal HIV infection largely has health implications for the child, especially in countries where poverty is high and education levels are low, having HIV/AIDS while pregnant can also cause heightened health risks for the mother. A large concern for HIV-positive pregnant women is the risk of contracting tuberculosis (TB) and/or malaria, in developing countries. (UNFPA, 2012)

(3) Maternal Weight

During pregnancy, women of an average pre-pregnancy weight (BMI 18.5-24.9) should expect to gain between 25-35 pounds over the course of the pregnancy. Increased rates of hypertension, diabetes, respiratory complications, and infections are prevalent in cases of maternal obesity and can have detrimental effects on pregnancy outcomes. Obesity is an extremely strong risk factor for gestational diabetes. Research has found that obese mothers who lose weight (at least 10 pounds or 4.5 kg) in-between pregnancies reduce the risk of gestational diabetes during their next pregnancy, whereas mothers who gain weight actually increase their risk. Women

who are pregnant should aim to exercise for at least 150 minutes per week, including muscle strengthening exercises. (UNFPA, 2012)

(4) Oral Hygiene

Maternal Oral Health has been shown to affect the well-being of both the expectant mother and her unborn fetus. Oral health is especially essential during perinatal period and the future development of the child. Proper management of oral health has benefits to both mother and child. Furthermore, lack of understanding or maintenance of good oral health for pregnant women may have adverse effects on them and their children. Hence, it is imperative to educate mothers regarding the significance of oral health. Moreover, collaboration and support among physicians across various fields, especially among family practitioners and obstetricians, is essential in addressing the concerns for maternal oral health. (Charlene W. J. Africa and Mervyn Turton, 2019)

(5) Prenatal Care

Prenatal care is an important part of basic maternal health care. It is recommended expectant mothers receive at least four antenatal visits, in which a health worker can check for signs of ill health – such as underweight, anemia or infection – and monitor the health of the fetus. During these visits, women are counseled on nutrition and hygiene to improve their health prior to, and following, delivery. They can also develop a birth plan laying out how to reach care and what to do in case of an emergency.

Poverty, malnutrition, and substance abuse may contribute to impaired cognitive, motor, and behavioral problems across childhood. In other words, if a mother is not in optimal health during the prenatal period (the time while she is pregnant), the child is more likely to experience health or developmental difficulties, or death. Cigarette smoking during pregnancy can have a multitude of detrimental effects on the health and development of the offspring. Common results of smoking during pregnancy include pre-term births, low birth weights, fetal and neonatal deaths, respiratory problems, and sudden infant death syndrome (SIDS). (Singer L, Farkas K, Kliegman R., 1992)

Because the fetus's nutrition is based on maternal protein, vitamin, mineral, and total caloric intake, infants born to malnourished mothers are more likely to exhibit malformations. Additionally, maternal stress can affect the fetus both directly and

indirectly. When a mother is under stress, physiological changes occur in the body that could harm the developing fetus. Additionally, the mother is more likely to engage in behaviors that could negatively affect the fetus, such as tobacco smoking, drug use, and alcohol abuse.

(6) Postpartum Period

Globally, more than eight million of the 136 million women giving birth each year suffer from excessive bleeding after childbirth. This condition causes one out of every four maternal deaths that occur annually and accounts for more maternal deaths than any other individual cause. Deaths due to postpartum period disproportionately affect women in developing countries.

For every woman who dies from causes related to pregnancy, an estimated 20 to 30 encounter serious complications. At least 15 per cent of all births are complicated by a potentially fatal condition. Women who survive such complications often require lengthy recovery times and may face lasting physical, psychological, social and economic consequences. Although many of these complications are unpredictable, almost all are treatable.

2.5 Contraceptive Methods

There are two types of contraceptive methods, the modern method and traditional method. Modern method consists of 18 methods. They are: combined oral contraceptives (COCs) or “the pill”, progestogen-only pills (POPs) or “the mini pill”, implants, progestogen only injectables, monthly injectables or combined injectable contraceptives (CIC), combined contraceptive patch and combined contraceptive vaginal ring (CVR), intrauterine device (IUD), intrauterine device (IUD) levonorgestrel, male condoms, female condoms, male sterilization (vasectomy), female sterilization (tubal ligation), lactational amenorrhea method (LAM), emergency contraceptive pills, standard days method or SDM, basal body temperature (BBT) method, two-day method and symptom-thermal method.

The traditional method contains 2 methods. They are: calendar method or rhythm method and withdrawal method.

Contraceptive use has increased in many parts of the world, especially in Asia and Latin America, but continues to be low in sub-Saharan Africa. Globally, use of modern contraception has risen slightly, from 54% in 1990 to 57.4% in 2015. Use of

contraception by men makes up a relatively small subset of the above prevalence rates. The modern contraceptive methods for men are limited to male condoms and sterilization. According to WHO, 214 million women of reproductive age in developing countries who want to avoid pregnancy are not using a modern contraceptive method. Reasons for this include: limited choice of methods, limited access to contraception, particularly among young people, poorer segments of populations, or unmarried people, fear or experience of side-effects, cultural or religious opposition, poor quality of available services, users and providers bias and gender-based barriers. (WHO, 2018)

2.6 Review on Previous Studies

Christine Delagado (2008) studied the undergraduate student awareness of issues related to preconception and pregnancy. In this study, two hundred forty-one students (137 females and 104 males) participated to complete the designed questionnaire. Students demonstrated a low to moderate level of awareness. The study shows that students who had previously taken a course containing information on pregnancy and/or child development correctly answered a greater percentage than those who had not taken such a course. It also says that females had slightly higher awareness scores than males. Students also demonstrated a high level of awareness for substance use, a moderate level of awareness for sexually transmitted diseases and preconception care, and lower levels of awareness for folic acid, prenatal development, health, and pregnancy spacing. Delagado highlighted that efforts to improve preconception health should include increasing awareness of reproductive issues for both males and females. Existing efforts to provide information on reproductive health to students need to be expanded and new strategies developed. She also mentioned that particular attention should be paid to increasing awareness of the benefits of family planning, the early onset and rapid rate of organogenesis, the benefits of folic acid, and the importance of addressing health-related issues.

Maria Wouhabe (2007) studied sexual behavior, knowledge and awareness of related reproductive health issues among single youth in Ethiopia There were a total of 890 male and 3,988 female youth. The study describes that condom is the highest ever-use method to prevent pregnancy while oral contraceptive is the second highest. Although the majority of youth is aware of HIV/AIDS, awareness about other STIs is low. It is also said that male urban youth was more likely to ever have sexual intercourse

than male rural youth. And youth with some form of education were more likely to use prevention method. The author highlighted that socio-demographic factors largely influence youth sexual behaviour.

Maiya Shobha Manandhar and Durga Subedi (2018) studied the awareness regarding preconception care among bachelor level students in Banepa. In this study, a descriptive cross sectional study was carried out with bachelor level students from 4 different colleges of Banepa. Samples were selected using cluster sampling. Data was collected through self-administered questionnaire. The data was analyzed using descriptive and inferential statistics. Results: In the study, 59.9% of the respondents had fair awareness and 20.2% had low awareness and only 18.9% had high awareness regarding preconception care. The authors mentioned that there is significant association between information acquired and level of awareness and source of information and level awareness.

CHAPTER III
SEXUAL AND REPRODUCTIVE HEALTH IN MYANMAR

3.1 Reproductive Health Policy

Ministry of Health and Sports (MOHS) is the major organization that is responsible for raising the health status of the entire people and accomplishes this through the provision of comprehensive health services, via preventive, curative and rehabilitative measures. Myanmar healthcare systems have drastically evolved with the recent changes of political and administrative systems.

As shown in figure in Figure (3.1), there are six departments concerned with Health Service Delivery System in MOHS, which facilitate all aspects of health for the whole population. The Department of Public Health is mainly responsible for primary healthcare and basic health services; nutrition promotion, environmental sanitation, maternal and child health, school health and health education. The Disease Control Division and Central Epidemiology Unit under this Department cover prevention and control of infectious diseases, disease surveillance, outbreak investigation, and capacity building. The Department of Medical Services provides effective treatments and rehabilitation services. Curative services are provided by various categories of health facilities under the control of the Department. The Department of Health Professional Resource Development and Management is mainly responsible for training and production of all categories of health personnel, except for traditional medicine personnel, to attain equitable healthcare for the whole population. The Department of Medical Research conducts national surveys and researches for evidence-based medicine and policy making. The Department of Traditional Medicine is responsible for the provision of healthcare with traditional medicine, as well as training of traditional medicine personnel. The Department of Food and Drug Administration ensures safe food, drugs and medical equipment, and cosmetics. In line with the national health policy, non-governmental organizations such as the Myanmar Maternal and Child Welfare Association and the Myanmar Red Cross Society are taking a share of service provision. Nation-wide non-governmental organizations, as well as locally

acting community-based organizations and religion-based societies, also support and provide healthcare services.

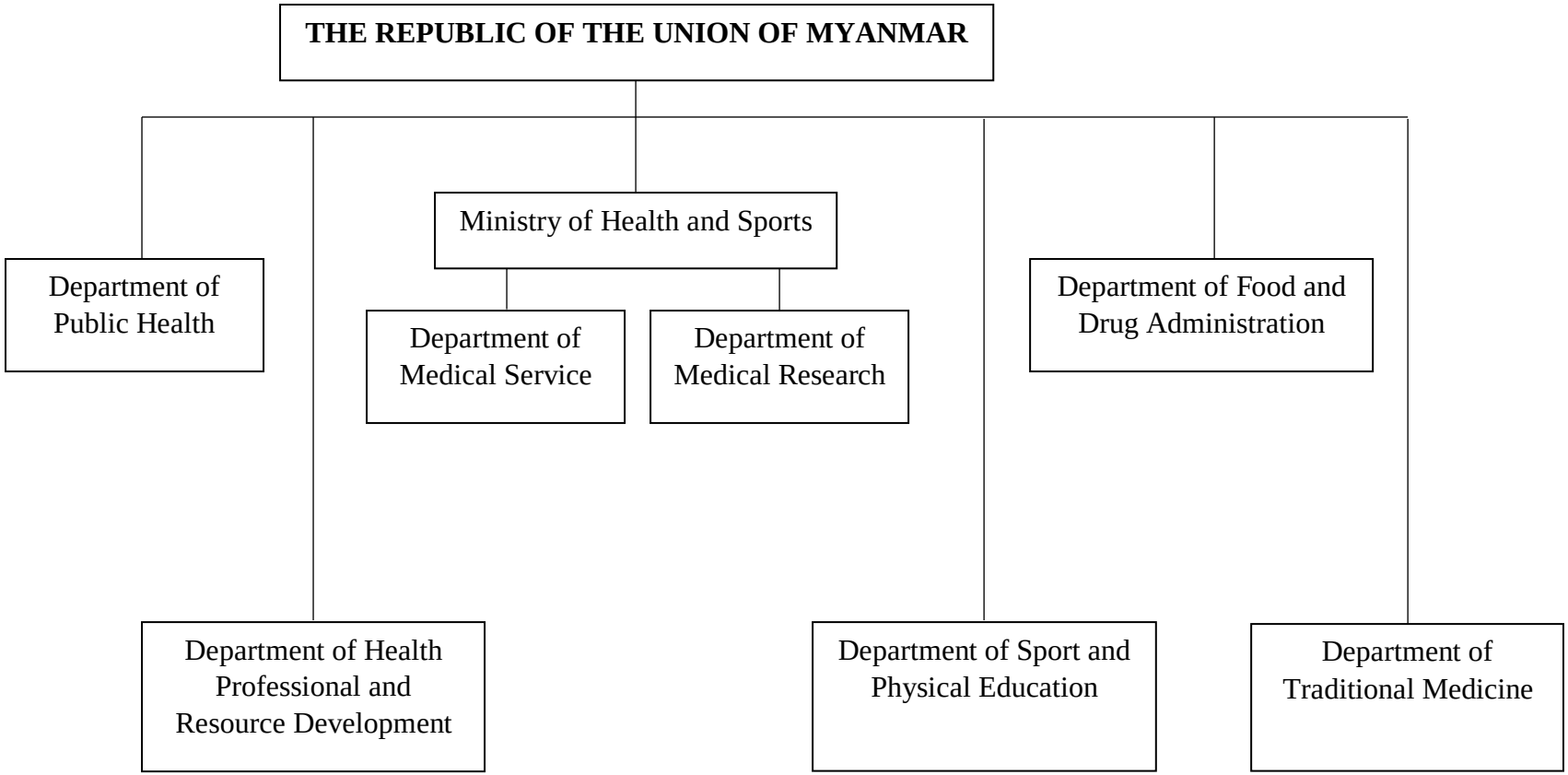
In Myanmar, Ministry of Health and Sports has formulated and implemented the Reproductive Health Policy. Mothers and children constitute 60% of total population and the government has consistently given maternal and child health services as priority in national health plan. Maternal and child health services are provided both in urban and rural settings and have being increasing coverage of quality antenatal services to achieve goals set from the 1994 International Conference on Population and Development (ICPD) and the Millennium Development Goals, to reduce Maternal Mortality Ratio of 1990 to ¾ by 2015.

As early as 1992, the National Population Policy was drafted, with focus on improving the health status of the women and children by ensuring the availability and accessibility of birth-spacing services to all married couples voluntarily seeking such services. It also directed to provide community with information, education and communication measures on birth spacing in advance and providing essential health care using primary health care approach to attain the prevention of diseases and promotion of health life-style. Specific policy directions are provided in the Myanmar Reproductive Health Policy (2002) to attain a better quality of life by improving reproductive health status of women and men, including adolescent through effective and appropriate reproductive health programme undertaken in a life-cycle approach. Policy statements called for operationalizing reproductive health programmes including an integrated and core package of priority interventions for pre-pregnancy, adolescent health, birth spacing, and obstetric care for pregnant women covering antenatal, delivery, neonatal, postnatal and post-abortion care. It also directed for a seeking a sustained political commitment to improve reproductive health status in accordance with the National Health Policy and to promote rules, regulations and laws on reproductive health and also directed that the reproductive health services and activities should be conformed with National Population Policy. It also encouraged for an effective partnership to be strengthened among and between government departments, non-governmental organizations and the private sector in providing reproductive health.

The first Five Year Strategic Plan for Reproductive Health for the period 2004-2008 implemented a set of strategies which aimed at strengthening and expanding the provision of health services and improving performance of the health systems. It

contributed to improved service coverage demonstrated by increased use of modern contraception, increased proportion of births assisted by skilled attendants and higher proportion of pregnant women attending antenatal services. It was then followed with a second Five-year Strategic Plan for Reproductive Health (2009-2013) that defines and promotes the implementation of the essential package of reproductive health services by level of care and sets national targets against selected key reproductive health indicators. The third Five-Year Strategic Plan for Reproductive Health (2014-2018) is to attain a better quality of life of the people by contributing improved reproductive health status of women, men, adolescents and youth. The strategies include: providing a comprehensive package of essential interventions and services; ensuring an integrated care; strengthening health systems for reproductive health; building the health workforce capacity; promoting research and innovations for evidence-based responses; and strengthening community participation.

Figure (3.1) Organogram of Ministry of Health and Sports (MOHS)



Source: http://www.moh.gov.mm/

The goal of the reproductive health policy is to attain a better quality of life by improving reproductive health status of women and men, including adolescents through effective and appropriate reproductive health programmes undertaken in a life-cycle approach.

The policy states as follows.

1. Political commitment should be sustained to improve reproductive health status in accordance with the National Health Policy and to promote rules, regulations and laws on reproductive health.

2. Reproductive health care services and activities should be conformed with National Population Policy.

3. Full respect to laws and religion, ethical and cultural values must be ensured in the implementation of reproductive health services.

4. The concept of integrated reproductive health care must be introduced into existing health services and programmes. Quality reproductive health care must be provided in integrated packages at all levels of the public and private health care systems.

5. Effective partnerships must be strengthened among and between governmental departments, nongovernmental organizations and the private sector in providing reproductive health.

6. Reproductive health services must be accessible, acceptable and affordable to all women and men, especially underserved groups including adolescents and elderly people.

7. Effective referral systems must be developed among and between different levels of services.

8. The development of appropriate information, education and communication material must be strengthened and disseminated down to the grass-root level to enhance the community awareness and participation.

9. Appropriate and effective traditional medicines and socio-cultural practices beneficial for reproductive health must be identified and promoted.

10. Adequate resources must be ensured for sustainability of reproductive health programmes.

The general overview of the national policy is that it is the very high time to encourage, strengthen and intensify the action to be taken for reproductive health for all and it is also important to seize this opportunity by extension of the general health

strategy. And it is also realized that to attain better reproductive health is not limited to interventions by the health sector alone.

3.2 Components of Reproductive Health

The components of reproductive health comprise of

- Maternal and neonatal health
- Abortion
- Birth spacing
- Reproductive health of adolescent and youth

3.2.1 Maternal and Neonatal Health

Approximately 1.3 million women give birth each year in Myanmar. The burden of maternal mortality and newborn mortality and ill-health is considerable. Maternal, child and youth has been accorded as a priority issue since Maternal Mortality Rate, Neonatal Mortality Rate, Infant Mortality Rate and Under-5 Mortality Rate are critical and sensitive indicators of the country's health social and economic status. It has given as a priority issue in the National Health Policy, aiming at reducing the maternal newborn, infant and child morbidity and mortality. The Department of Social Welfare under the Ministry of Social Welfare, Relief and Resettlement is carrying out preventive, protective and rehabilitative measures for vulnerable group such as child, women, youth, disabled persons and elderly. Myanmar National Plan of Action for children is being carried out by focusing in 4 areas: health, nutrition, water and sanitation, and child development and child protection.

3.2.2 Abortion

Under the Penal Code of Myanmar, section 312 states that "whoever , voluntarily causes a woman with child to miscarry shall, if such miscarriage be not caused in good faith for the purpose of saving the life of the women , be punished with imprisonment of either description for a term which may extend to three years, or with fine, or with both; and if the woman be quick with child, shall be punished with imprisonment of either description for a term which may extend to seven years and shall be liable to fine". However, a pregnancy may be legally terminated in good faith to save the life of the pregnant woman. According to the 2007 Fertility and

Reproductive Health Survey, almost 5% of all pregnancies end in abortion. This proportion was higher among urban women (6.89%) than rural (4%) and higher in pregnancies of young women. The abortion rate is positively associated with the level of education; women with a higher education are more likely to choose abortion.

3.2.3 Birth Spacing

The official recognition of birth spacing strategies began in 1992 with UNFPA assistance and has been actively promoted since then. Before that, female sterilization services were common and other methods of contraception were available through private pharmacies. It has been demonstrated a gradual increase in its contraceptive prevalence rate (CPR) reaching 37% in 2001 (32.8% using modern methods and 4.2% - traditional methods) and 41% in 2007 (38.4% for modern methods). The 2009-2013 Reproductive Health Strategic Plan sets the target for CPR of 45% (modern methods) by the year 2013. Government Health Centers provide facilities and manpower for contraceptives provided by UNFPA at subsidized rates in 132 of the county's 325 townships. Marie Stopes International (MSI) has MOU with MOHS and is implementing social marketing of contraceptives in their project townships, approximately 24 townships. MSI opens RH clinics and they reach communities using different approaches providing capacity building for youth through training and supports tertiary hospitals with emergency obstetrics commodities.

3.2.4 Reproductive Health of Adolescent and Youth

Young people are the future of every society and also a great resource of the nation and they constitute one fifth of the total population. Sixteen percent of youth approved of pre-marital sex for boys while only seven percent of youth approved of pre-marital sex for girls. Protection of the youth and adolescents from sexual and reproductive health problems essentially depends on the correct knowledge of the physiology of human reproduction. Reproductive health services and information can improve the health status of adolescents and help them attain the level of understanding required to make responsible decisions. The 2009-2013 National Strategic Plan for Adolescent Health and Development addresses general issues of adolescent health and define strategies for adolescents' reproductive health in particular by supporting adolescent-friendly health services. The latter includes, among others, provision of diagnosis and treatment of sexually-transmitted infections, provision of voluntary

counselling and testing for HIV, provision of counselling and contraceptive services, antenatal, delivery, post-natal and post-abortion care. National AIDS Programme in coordination with Department of Educational Planning and Training (DEPT), Ministry of Education and UNICEF, has introduced School Based Healthy Living and AIDS Prevention Education" (SHAPE) Programme since 1997.

3.3 Five – Year Strategic Plan for Reproductive Health in Myanmar

The strategic plan on reproductive health builds a number of initiatives undertaken to serve the health needs of the population of Myanmar. Recognizing the importance of universal access to reproductive health in achieving MDGs, the National Reproductive Health Policy was developed in 2002. Three consecutive Five-Year Strategic Plans for Reproductive Health (2004-2006), Five-Year Strategic Plans for Reproductive Health (2009-2013) and Five-Year Strategic Plans for Reproductive Health (2014-2018) were developed to ensure coordinated response to the reproductive health needs of women, men, adolescents and youth. The overall goal of strategic plans is to attain a better quality of life of the people by contributing to the improved reproductive health status of women, men, adolescents and youth.

The strategy provides a review of the reproductive health situation and services in Myanmar and set objectives under the following core elements:

1. Improving antennal, delivery, post-partum and newborn care
2. Providing quality services for birth spacing and prevention and management of unsafe abortions
3. Prevention and reducing reproductive tract infections, sexually transmitted infections, including HIV, cervical cancer and other gynecological morbidities
4. Promoting sexual health including adolescent reproductive health and male involvement

The strategy recognizes the centrality of reproductive health and rights in improving maternal and newborn health and achieving internally agreed MDGs. To attain reproductive health targets, the strategy calls for action in the following priority areas:

1. Setting enabling environment
2. Improving information base for decision making
3. Strengthening health systems and capacity for delivery of quality reproductive health services

4. Improving community and family practices

The above actions are led by MOHS and supported by the National Working Committee for Reproductive Health to oversee the implementation of the Strategic Plan, to coordinate the partner's contributions and to advocate for increased mobilization.

The specific objectives of the Five-Year Strategic Plan on Reproductive Health (2014-2018) are:

1. To reduce rates of maternal, perinatal and neonatal morbidity and mortality by increasing equitable access to maternal and newborn services; improving quality, efficiency and effectiveness of service delivery at all levels; and improving responsiveness to the client needs
2. To reduce unmet need for contraception, unplanned births as well as socio-economic disparities in access to and use of contraception
3. To strengthen management of miscarriage and post-abortion care as an integral component of comprehensive reproductive health services
4. To expand access to RTI/STI/HIV services within reproductive health programme, reduce transmission of RTI/STI/HIV including prevention of mother to child transmission of syphilis and HIV
5. To expand reproductive health information and services for adolescents and youth
6. To increase services for screening and treatment of cervical cancer, and
7. To support access to investigate mand management of the infertile couple.

An essential package of reproductive health interventions for provision at health centers and township hospitals and in the community has been defined to provide continuous care across life cycle and from home to hospital. The package includes on-going activities that will be expanded as well as additional services that will be introduced in the basic health services of the public sectors.

The strategic and key activities for the effective and efficient implementation are as follows:

1. Strengthening health systems to enhance the provision of an essential package of reproductive health intervention
2. Increasing access to quality, integrated reproductive health services at all levels of care
3. Engaging the community in promotion and delivery of reproductive health

4. Incorporating gender perspectives in the reproductive health strategic plan, and
5. Integrating reproductive health in humanitarian settings

A broad multi-sectorial approach is adopted in implementing the Strategic Plan. The reproductive health programme collaborates with other departments and divisions under MOHS and partners with other ministries, professional associations, academia, United Nation agencies, bilateral donors and civil society organizations including NGOs.

3.4 Family Planning

Couples can use contraceptive methods to limit or space the number of children they have. The benefits of family planning are not limited to promoting maternal or child health. Family planning can significantly enhance opportunities to attain higher socioeconomic status, education, employment, and empowerment, especially for girls and women. Myanmar committed in 2013 to the Family Planning 2020 (FP2020) global initiative. The goal is to reach more women with lifesaving family planning information and access to contraceptives by the year 2020.

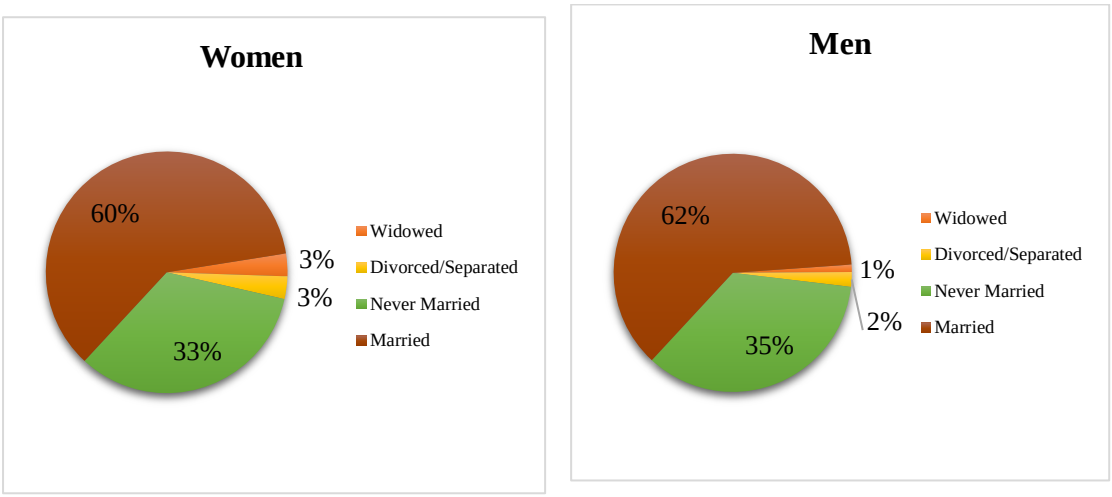
3.4.1 Marriage and Sexual Activity

Marriage and sexual activity help determine the extent to which women are exposed to the risk of pregnancy. Thus, they are important determinants of fertility levels. The median age at first marriage for women is 22.1 while for men is 24.5, which means that women tend to marry 2 years earlier than men.

In Myanmar, 60% of women age 15-49 and 62% of men age 15-49 are married. 3% of women and 2% of men are divorced or separated, and 3% of women and 1% of men are widowed. About one-third of women and men have never married.

Figure (3.2) Marital Status

Percent Distribution of Women and Men Age 15-49



Source: Myanmar Demographic Health Survey 2015- 2016

At age 15-19, the proportion of women who are married is two and a half times that of men. Early marriage increases the risk of teenage pregnancy which can have a profound effect on the health and lives of young women. Child marriage, that is marriage before age 18, is still quite common among Myanmar women: 19% of women age 20-49 were married before age 18. Among men age 20-49, by contrast, only 7% were married before their 18th birthday. Even though marriage before 18 is common, very early marriage (before age 15) is not. The median age at first marriage among rural women is 21.3, 3 years younger than the median age at first marriage among urban women, which is 24.5.

By age 18, 17% of women aged 25-49 have had sexual intercourse. This percentage is lower than that of women who are married by age 18 (19%). Eight percent of men age 25-49 have had sexual intercourse before the age of 18, which is higher than the percentage of men married by age 18 (7%). These suggest that women, on average, first have sexual intercourse after they are married, whereas men, on average, do so before they are married.

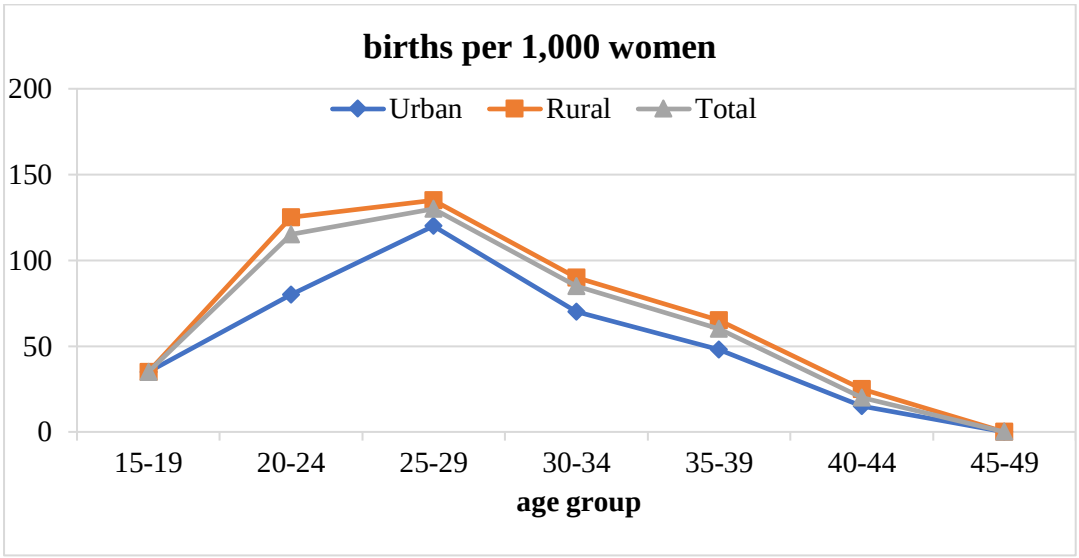
3.4.2 Fertility

The number of children that a woman bears depends on many factors, including the age at which she begins childbearing, how long she waits between births, and her fecundity. Postponing first births and extending the interval between births have reduced fertility levels in many countries. These factors also have positive health

consequences. In contrast, short birth intervals (less than 24 months) can lead to harmful outcomes for both newborns and their mothers, such as preterm birth, low birth weight, and death. Childbearing at a very young age is associated with an increased risk of complications during pregnancy and childbirth and higher rates of neonatal mortality.

The total fertility rate (TFR) in Myanmar is 2.3 children per woman; in urban areas it is 1.9 children, and in rural areas it is 2.4 children. The 2014 Myanmar Census reported the TFR to be 2.5 children (Ministry of Labor, Immigration and Population 2016). Childbearing peaks at age 25-29 when the age-specific fertility rate is 128 (Figure 3.3). It drops sharply thereafter. Age-specific fertility rates (ASFRs) for every age group are lower in urban areas than in rural areas.

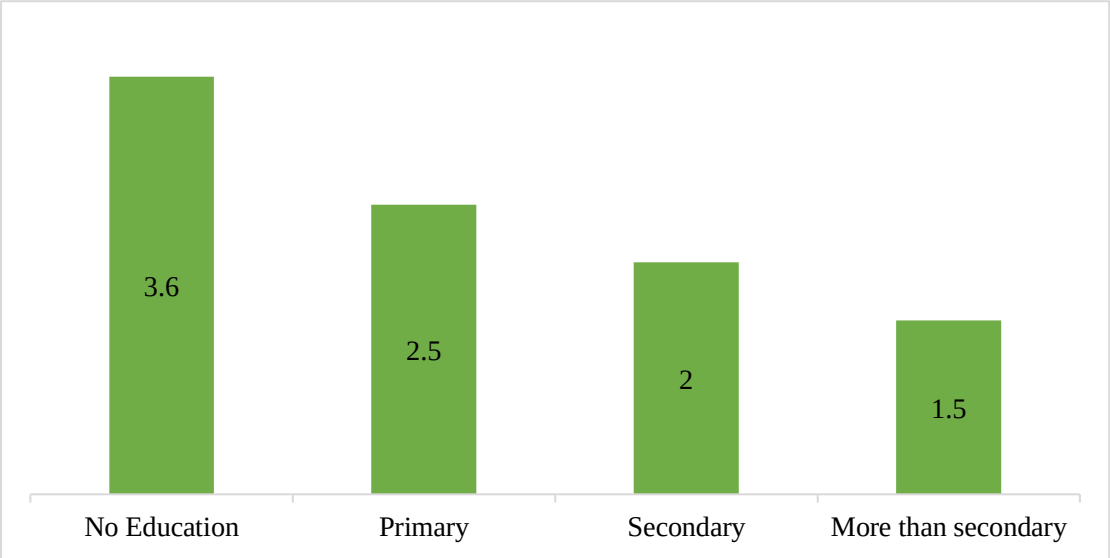
Figure (3.3) Age-Specific Fertility Rates



Source: Myanmar Demographic and Health Survey 2015-2016

Women with no education have a TFR of 3.6 children, two children more than the TFR for women with more than secondary education, 1.5 children (Figure 3.4).

Figure (3.4) Fertility by Mother's Education



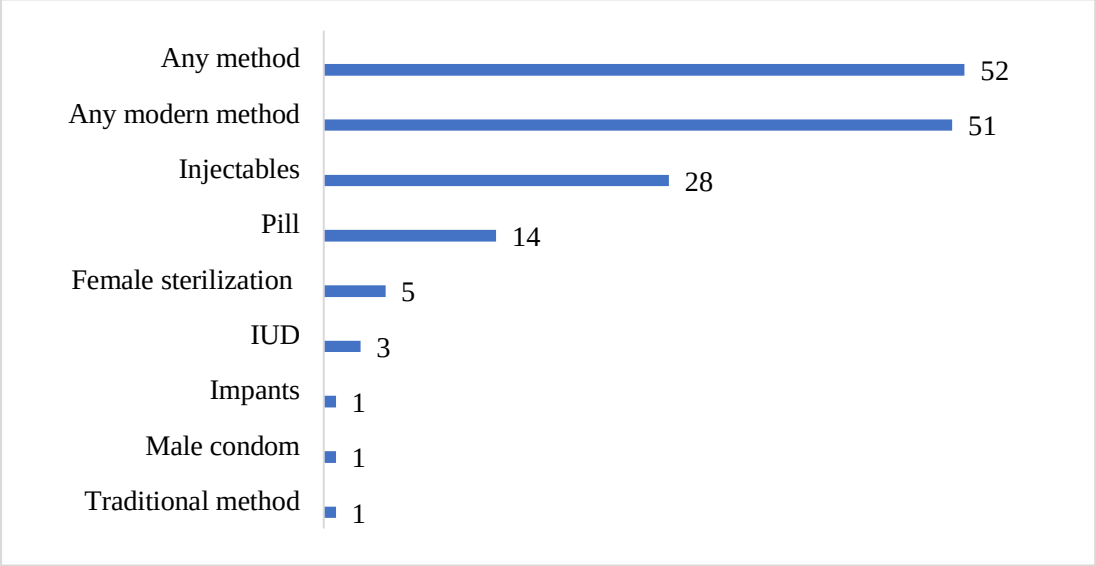
Source: Myanmar Demographic and Health Survey 2015-2016

3.4.3 Contraceptive Knowledge and Use

Knowledge of contraceptive methods is almost universal in Myanmar, with 97% of all women and 95% of all men knowing at least one method of contraception. On average, women have heard of seven methods and men have heard of six methods, with most having heard about modern methods. The most commonly known method among women is injectables (95%), followed by the pill (93%), and female sterilization (84%), while among men, it is the male condom (86%), followed by injectables (85%), and the pill (84%) which is shown in Table (3.2). Knowledge about emergency contraception is relatively poor, with only one in four women and men having heard about it.

The contraceptive prevalence rate among currently married women age 15-49 is 52%, with almost all women using modern methods (51%). This indicates that Myanmar is on track for meeting its commitment to Family Planning 2020, a global partnership for women on reproductive rights. In 2013 Myanmar announced it would increase modern contraceptive use from 41 percent to 50 percent by 2015 and to more than 60 percent by 2020. Among married women, injectables are the most commonly used method (28%), followed by the pill (14%), female sterilization (5%), and the IUD (3%) as shown in Figure 3.5. Modern contraceptive use peaks at 62% among currently married women age 35-39. More than half of currently married adolescents (women age 15-19) (53%) use modern contraceptive methods.

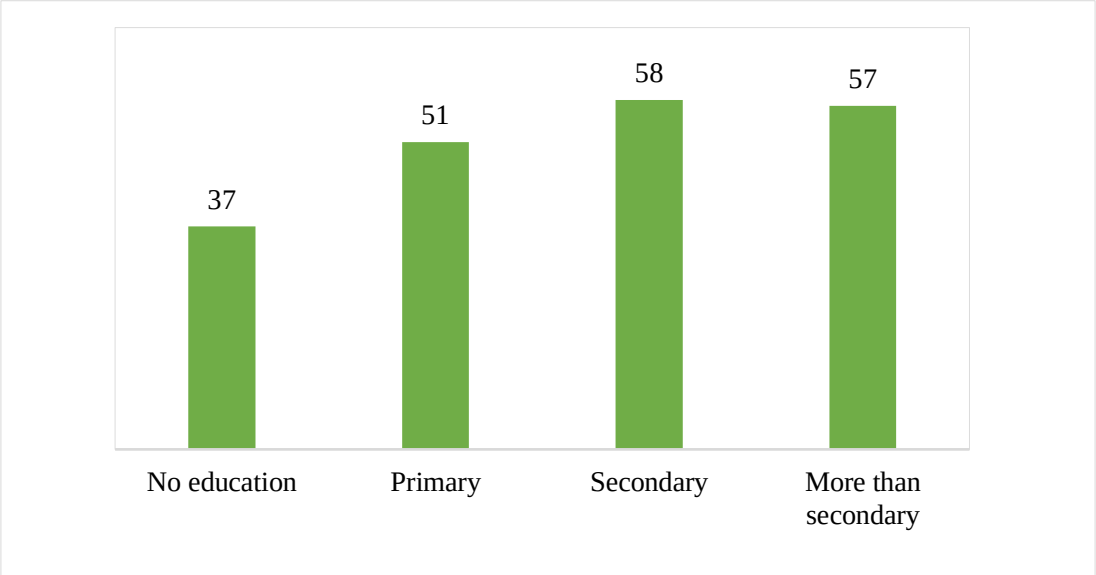
Figure (3.5) Percentage of Currently Married Women Age 15-49 Currently Using a Contraceptive Method



Source: Myanmar Demographic and Health Survey 2015-16

Contraceptive use increases substantially with education. Married women with secondary education or higher are more likely to use modern methods of contraception than those with no education. Women in urban areas are somewhat more likely to use modern contraceptives than those in rural areas.

Figure (3.6) Percentage of Married Women Age 15-49 who Use of Modern Methods by Education



Source: Myanmar Demographic and Health Survey 2015-2016

Table (3.1) Knowledge of Contraceptive Methods

Percentage of all respondents and currently married female respondents age 15-49 who knows any contraceptive method, by specific method

	Women	
Method	**All women**	**Currently married women**
Any method	96.7	98.5
Any modern method	96.6	98.4
Female sterilization	84.4	88.8
Male sterilization	50.7	60.2
Pills	93.0	96.1
IUD	70.5	80.1
Injectables	94.6	97.7
Implants	61.1	70.3
Male condom	73.0	76.8
Female condom	28.4	31.0
Lactational amenorrhea method (LAM)	36.5	43.9
Emergency contraception	25.4	28.7
Other modern method	1.3	1.8
Any traditional method	46.7	58.8
Rhythm	39.7	50.3
Withdrawal	33.9	45.0
Other	0.0	0.0

Source: Myanmar Demographic and Health Survey 2015-2016

3.5 Adolescent Reproductive Health in Myanmar

Adolescence is a critical transition in the life course, during which foundations for health and wellbeing in adulthood, and that of the next generation, are established. This period is defined by rapid biological, cognitive and psychosocial development, encompassing not only the physical changes of puberty but also the development of values, norms and identity related to relationships and gender. Such changes bring new

health needs and risks, and therefore a heighted need for information and services related to reproductive health.

Comprehensive sexual and reproductive health (SRH) education is the cornerstone of improving adolescent reproductive health. In order to make healthy, responsible decisions, young people need accurate information about puberty, reproduction, relationships, the consequences of unsafe sex, and how to avoid HIV, sexually transmitted infections (STIs) and unintended pregnancy. They also need the skills and confidence to be able to deal with peer pressure, negotiate safe and consensual relationships, and navigate the health system to access services. SRH education programs that address these components have demonstrated positive impacts on SRH knowledge, attitudes and safer sexual practices, including delaying onset of sexual activity, reducing the number of partners, and increasing condom and contraceptive use. In Myanmar, national school-based SRH education, known as Life Skills Education (LSE), was added to the core curriculum in primary schools in 2006 and was introduced as a compulsory co-curricular subject for middle schools in 2008. LSE is part of the curriculum in both government and monastic schools and covers topics related to puberty, menstruation, relationships, reproduction, contraception, STIs and HIV.

The adolescent fertility rate is the age-specific birth rate for women of age between 15-19. Adolescent fertility is of interest because births to young women tend to have adverse health consequences for both woman and child. It is to be expected that these health consequences will be more severe for younger adolescents. The adolescent fertility rate for Myanmar during the year prior to 2014 Census was 33 births per 1000 women aged 15-19. Single year rates rise sharply over these ages, from 3 per thousand for 15 years old females to 53 per thousand for 19 years old females and the rate varies substantially between urban and rural areas (22 and 38 per thousand, respectively).

Table (3.2) Adolescent Fertility Rates for Union, Urban and Rural Areas, 2014 Census

Adolescent Fertility Rates (births/1000 women aged 15-19)						
Places	**15-19**	**15**	**16**	**17**	**18**	**19**
Union	33	3	11	21	35	53
Urban	22	2	7	13	21	32
Rural	38	3	12	22	36	55

Source: 2014 Thematic Report on Fertility and Nuptiality

The MOHS has collaborated on a project regarding sexual and reproductive health with UNFPA for the following objectives:

1. To have contributed to meet the reproductive health needs and improving the quality of life of Myanmar people through provision of quality reproductive health services.
2. To have contributed to increase utilization of integrated, quality and gender sensitive reproductive health services by women, men and young people.

The project has strengthened capacities to deliver sexual and reproductive health information and services that reach women, youth, adolescent, minorities and other vulnerable and marginalized groups including those affected by conflicts and disasters.

CHAPTER IV
SURVEY ANALYSIS

4.1 Survey Profile

The Yangon University of Economics is a university which is under the Department of Higher Education (Yangon Region, Myanmar), Ministry of Education. The University was established as a professional institute to train economist, statisticians, accountants, and management personnel, and to do research on economics, business and statistical issues related to the Myanmar Economy.

The University has three Campuses: Kamayut Campus, Hlaing Campus and Ywathagyi Campus. The Kamayut Campus, the Original Campus, is located on the stores of Inya Lake at the corner of Inya Road and Pyay Road. The Hlaing Campus is situated about one mile from the Kamayut Campus. The Ywathagyi Campus, the newly Campus established in 2000, is located 13 miles away from Kamayut Campus.

The University is organized with the Rector, Pro-Rector and Head of Departments forming the Administrative Board and the Academic Board. There are at present a total of 420 full-time staffs, out of which 230 are engaged in teaching and research. The rest are administrative and support personnel.

Courses in Economics, Statistics, Commerce and Management are offered at the Bachelors, Honors, Masters and Diplomas levels. At present, the University is offering the courses for 9 bachelor degrees, 9 master degrees, 11 post graduate diploma degrees and 3 doctoral degrees. The University has nurtured more than 60,000 graduates who specialized in Economics, Statistics, Commerce and Business Studies.

The undergraduate courses are being offered in Ywathagyi Campus and graduate and doctorate courses are being conducted in Kamayut Campus. In Hlaing Campus, Yangon University of Economics has been offering the courses under the Human Resource Development (HRD) programme and has established Myanmar-India Entrepreneurship Development Center since 2009. Also, in 2013, Center of Excellence

for Business Skills Development has been established in Hlaing Campus in cooperation with the United Nations Educational, Scientific and Cultural Organization (UNESCO) and Pepsico.

4.2 Survey Design

The survey was conducted with respondents limited to female students in the Yangon University of Economics (Kamayut Campus) in May 2019. The total female population size of this area is 734. The sample size of the research study is 196. The purpose of choosing this area is to collect the required data specifically from young women on the basis that they play a key role in upholding the standards of sexual and reproductive health of the society.

The survey was implemented in questionnaire format, and questionnaires were implemented in English language. The survey questionnaire consisted of four sections. The first section was to obtain personal information based on demographic data such as gender, age and educational level. The second section was about sources of information on and knowledge of sexual and reproductive health. The third section was about knowledge and use of contraceptive methods such as types of contraceptives, basic knowledge about condoms and STDs. The last or fourth section dealt with sexuality, gender and norms as reproductive health largely depends on society norms and people's point of view on sexuality.

4.2.1 Number of Female Students at Yangon University of Economics (Kamayut)

In 2017 – 2018, the total female population of Yangon University of Economics was 734 and their education levels are stated in the following table (4.1).

Table (4.1) Number of Female Students Attending at Yangon University of Economics (Kamayut) in 2017 – 2018

Year	Female Population
Third Year	77
Fourth Year	70
Honors First Year	24
Honors Second Year	11
Honors Third Year	11
Master First Year	282
Master Second Year	259
Total	**734**

Source: Academic Affairs Office in Yangon University of Economics (2017 – 2018)

4.3 Survey Results

Survey results consisted of three sections: demographic characteristics of the respondents, information on the respondents' level of overall knowledge on sexual and reproductive health and contraceptives, information on the sample-sized public perspective regarding social norms and sexuality.

4.3.1 Demographic Characteristics of Respondents

According to the survey result, total of 196 female respondents participate in this research study. Table (4.2) shows the age segments according to the statistical point of view. And table (4.3) shows the marital status of the respondents.

Table (4.2) Age Segments of the Respondents

Age	Frequency	Percentage
Under 20	60	30.6
20 – 25	110	56.1
25- 30	14	7.1
Above 30	12	6.2
Total	**196**	**100**

Source: Survey Data 2019

When respondents were asked about age segments, (30.6%) of the students are in the age group of under 20 whiles (56.1%) lie in the age group 20 to 25. From the age group of 25 to 30, there is (7.1%) of the student. Only (6.2%) of the students are in the age group above 30 years.

Table (4.3) Marital Status

Marital Status	Frequency	Percentage
Single	189	96.4
Married	7	3.6
Total	**196**	**100**

Source: Survey Data 2019

Out of 196 respondents, (96.4%) is single and only (7%) is married.

4.3.2 Information on the Respondents' Level of Overall Knowledge on Sexual and Reproductive Health and Contraceptives

This section analyzes the respondents' knowledge on sexual and reproductive health and contraceptives by assessing their grasp on puberty, understanding how the reproductive system works, and the contraceptive methods.

(1) Puberty, Sexual and Reproductive Health System and Contraceptive Methods

In the transition to puberty and adolescence, it is important for a girl to have the basic knowledge about puberty, the reproductive health system and the most commonly used contraceptive methods. That is why, the respondents were asked from whom or where they got the knowledge. The questionnaire was designed for the respondents to choose more than one answer since they can obtain the knowledge from more than one place or one person. The following table (4.4) is used to describe the sources of information on puberty, sexual and reproductive health system and contraceptive methods.

Table (4.4) Sources of Information on Puberty, Sexual and Reproductive System and Contraceptive Methods

Source of Information (more than one answer)	Puberty		Sexual and Reproductive Health System		Contraceptive Methods	
	Frequency	%	Frequency	%	Frequency	%
Parents	147	75	27	13.8	37	18.9
Siblings	27	13.8	14	7.1	14	7.1
Teachers	38	19.4	113	57.5	36	18.4
Friends	64	32.7	44	22.4	55	28.1
Other	21	10.7	51	26	93	47.4

Source: Survey Data 2019

According to table (4.4), for the first part "puberty", (75%) of respondents choose their parents where they get the knowledge. (13.8%) of the respondents choose to answer that they obtain the puberty knowledge from their siblings. (19.4%) of the respondents tell that they know about this from teachers and (32.7%) of the respondents get this knowledge from their friends. (21%) get the information from other sources like books and magazines. It can be suggested that respondents who choose teachers and friends gain the knowledge of transition to puberty since in their middle school or high school because puberty starts in a girl between the age of 10 to 14.

For the second part "sexual and reproductive health system", (13.8%) of the respondents know from their parents and only (7.1%) know from their siblings. (57.5%) of the respondents choose their teachers while (22.4%) choose their friends. (26%) of the respondents choose other sources like grade 11 biology text book. Overview of this part can be suggested that respondents may have known how the reproductive system works from schools where they learnt the biology which described the whole chapter of the system.

For the third part "contraceptive methods", (18.9%) of the respondents choose their parents. Only (7.1%) choose their siblings. Those who get the knowledge about contraceptive methods from their teachers is (18.4%) while (28.1%) get it from their friends. (47.4%) of the respondents obtain the knowledge from other sources such as books, magazines, websites and online forums. So, it can be suggested that the respondents acquire the knowledge by discussing it with their friends and finding it on the internet.

(2) Knowledge on Contraceptive Methods

The following table (4.5) presents the most commonly used and other modern contraceptive methods which are known by the respondents.

Table (4.5) Knowledge on Contraceptive Methods

Contraceptive Methods	Yes		No	
	Frequency	%	Frequency	%
Oral pills	103	52.6	93	47.4
Injection	92	46.9	104	53.1
Condom	171	87.2	25	12.8
Withdrawal	27	13.8	169	86.2
Emergency Contraceptive Pills	90	45.9	106	54.1
Calendar Method	75	38.3	121	61.7
IUD	79	40.3	117	59.7
Male Sterilization	54	27.6	142	72.4
Female Sterilization	86	43.9	110	56.1
Female Condom	58	29.6	138	70.4
Implant	34	17.3	162	82.7

Source: Survey Data 2019

In table (4.5), the most known method is condom which is chosen by (87.2%) of the respondents and the least known method is withdrawal method which is chosen by (13.8%) of the respondents. For oral pills, (52.6%) of the respondents choose for this while (46.9%) choose the injection method. (45.9%) of the respondents know the emergency contraceptive pills and (38.3%) know the calendar method. IUD method is known by (40.3%). Male sterilization is claimed to be known by (27.6%) of the respondents while female sterilization is known by (43.9%). Those who know female condom is (29.6%) and who know implant is (17.3%). According to the table, the respondents have well heard of condom and oral contraceptives, both of which are effective to use in family planning and birth spacing.

The above table is linked with the following table (4.6) which shows the safest contraceptive method to avoid pregnancy.

Table (4.6) Safest Method to Avoid Pregnancy

Safest Method to Avoid Pregnancy	Frequency	Percentage
Oral pills	33	16.8
Injection	13	6.6
Condom	110	56.1
Withdrawal	10	5
Emergency Contraceptive Pills	12	6.3
Calendar Method	18	9.2

Source: Survey Data 2019

Among the six methods as shown in table (4.6), (56.1%) of the respondents answer that condom is the safest way to avoid pregnancy. (16.8%) of the respondents choose oral pills and (6.6%) answer injection method. (5%) of the respondents choose withdrawal method and emergency contraceptive pills are chosen by (6.3%) of the respondents. (9.2%) of the respondents choose calendar method. To summarize this table, it is seen that the majority of the respondents consider condom is the safest method in avoiding unwanted pregnancy followed by the oral pills method.

(3) Knowledge on Condom

Table (4.6) describes the respondent's knowledge on condoms.

Table (4.7) Knowledge on Condom

Facts	Yes		No		Maybe/Not sure	
	Frequency	%	Frequency	%	Frequency	%
Condoms can prevent pregnancy and STDs at the same time.	117	59.7	14	7.1	65	33.2
Condoms are the most effective method to prevent HIV/AIDS.	118	60.2	12	6.1	66	33.7
Buying condom in stores is a shameful thing.	30	15.3	85	43.4	81	41.3
If a condom is broken or split, it should be immediately stopped using.	156	79.6	40	20.4	-	-
Have you ever seen a condom?	133	67.9	63	32.1	-	-

Source: Survey Data 2019

According to the table (4.7), (59.7%) of the respondents know that condoms can prevent pregnancy and STDs at the same time. (7.1%) of the respondents do not know this fact and (33.2%) is not sure about this. (60.2%) of the respondents choose to answer "Yes" for the statement that condoms are the most effective method to prevent HIV/AIDS. Only (6.1%) do not know about this and (33.7%) are not sure. For the statement that buying condom in stores is a shameful thing, the survey result shows that (43.4%) of the respondents think that it is not necessary to be shameful. (79.6%) of the respondents think that condoms should be immediately stopped using if it is broken. And (67.9%) have seen what condom looks like. To be summarized for this table, it can be suggested that most of the respondents have the awareness on condoms.

(4) General Knowledge on Sex and Reproduction

The respondents were asked about some statements of sex and reproduction which are mentioned with table (4.8) below.

Table (4.8) Sex and Reproduction

Description	Yes		No		Not Sure	
	Frequency	%	Frequency	%	Frequency	%
A woman can get pregnant on the very time that she has sexual intercourse.	48	24.5	16	8.2	132	67.3
A woman stops growing after having the first intercourse.	7	3.5	114	58.2	75	38.3
A woman is likely to get pregnant if she has had the intercourse half way between her periods.	52	26.5	70	35.7	74	37.8
It is very important for a woman to give birth under the care of an experienced midwife or doctor.	191	97.5	3	1.5	2	1.0
Understanding how menstrual cycle works.	157	80.1	13	6.6	26	13.3

Source: Survey Data 2019

According to table (4.8), (24.5%) of the respondents think that a woman can get pregnant on the very first time of her sexual intercourse while (67.3%) of the respondent are not sure of it. (58.2%) of the respondents do not think that a woman stops growing after having the first intercourse. (37.8%) of the respondents are not sure whether a woman can get pregnant if she has the intercourse halfway between her periods. (97.5%) of the respondents accept that it is very important for a woman to give birth under the care of an experienced midwife or doctor. And (80.1%) of the respondents know how the menstrual works while (6.6%) do not know and (13.3%) are not sure about this.

Table (4.9) shows the respondents' sexual experience they have had before taking this survey.

Table (4.9) Respondents' Sexual Experience

Experience	Frequency	%
Yes	35	17.9
No	161	82.1

Source: Survey Data 2019

Out of 196 students, 35 respondents have had sexual experience in their life, while 161 respondents have never been experienced.

Table (4.10) describes what kind of contraceptive methods the respondents who have experienced sexual intercourse in their life.

Table (4.10) Ever-use Contraceptive Methods

Method (more than one answer)	Frequency	%
Oral Pills	4	2
Injection	4	2
Condom	18	9.2
Withdrawal	4	2
Emergency Contraceptive Pills	1	5
Calendar Method	7	3.6
Other	1	5

Source: Survey Data 2019

According to this table, condom is used the most and emergency contraceptive pill is used the least. Calendar method is used the second most.

4.3.3 Information on the Sample-Sized Public Perspective Regarding Social Norms and Sexuality

This section presents the respondents' perspective regarding social norms and sexuality in areas of premarital sex, gender opinions, knowledge on abortion and opinions on the awareness on sexual and reproductive health.

(1) Premarital Sex

Table (4.11) describes the respondents' point of view on premarital sex.

Table (4.11) The Respondents' Point of View on Premarital Sex

Description	SD (%)	D (%)	N (%)	A (%)	SA (%)	Mean Score
It is all right for unmarried boys and girls to have dates.	7	7.7	23.5	48.0	13.8	3.5
Girls should remain virgins until they get married.	3.1	10.2	30.6	24.0	32.1	3.7
Intimacy before marriage is unacceptable.	5.1	18.4	31.1	24.0	21.4	3.4
There is nothing wrong for unmarried boys and girls to experience sexual intercourse if they love each other.	16.3	20.9	30.6	27.6	4.6	2.8
Girls who lost their virginity for any reasons before marriage should be blamed.	31.6	40.3	19.4	4.6	4.1	2.1

(SD: Strongly Disagree, D: Disagree, N: Neutral, A: Agree, SA: Strongly Agree)
Source: Survey Data 2019

According to table (4.11), the first question is about whether it is okay to have dates for boys and girls and the mean score result shows that it is likely to be agreeable. It can be said that most of the respondents do not think dating is a bad thing. For the

second question, the mean score result is (3.7) which means that girls should remain virgin until she gets married. The third question is about whether intimacy before marriage is unacceptable or not. The students mostly respond neutral. For the fourth question, most of the respondents have neutral answers for this. The fifth question is about that a girl should be blamed if she has lost her virginity for any reason. The mean score result is (2.1) which means that the respondents disagree this. It can be concluded that blaming a girl for this is not a right thing to do.

(2) Gender Opinion

Table (4.12) represents gender opinions of the respondents, which describes how respondents see the male involvement in female's sexual and reproductive health and if a woman should sacrifice everything for the well-being of her own children and husband in a household.

Table (4.12) The Respondents' Gender Opinion

Description	SD (%)	D (%)	N (%)	A (%)	SA (%)	Mean Score
Male involvement in female's sexual and reproductive health is important.	4.6	3.1	15.3	50.0	27.0	3.9
It is mainly the women's responsibility to use the contraceptive methods regularly.	11.7	25.0	20.9	31.6	10.8	3
Women in Myanmar can make their sexual and reproductive life choices freely.	6.6	5.6	18.9	38.8	30.1	3.8
A woman should sacrifice everything for the well-being of her husband and children.	36.7	31.1	18.4	6.6	7.2	2.3

(SD: Strongly Disagree, D: Disagree, N: Neutral, A: Agree, SA: Strongly Agree)
Source: Survey Data 2019

According to table (4.12), for the first statement if male involvement in female's reproductive health is important, (50%) of the respondents agree to it. The mean score

results (3.9) and it can be stated that male participation in women's reproductive health life is very important. The second statement is that the women are the main responsible people to use the contraceptive methods regularly. (31.6%) of the respondents agree to this statement. For the third statement, (38.8%) of the respondents agree that women in Myanmar can make their reproductive life choices freely. The respondents think that women here can decide how many children they want for their families and they can do the family planning and the birth spacing decisions freely. The fourth statement is that a woman should sacrifice everything for the well-being of her own children and husband. (36.7%) of the respondents strongly disagree this while only (6.6%) agrees this. The mean score results show that the respondents are against this statement. It can be analyzed that the respondents have a strong background knowledge of gender equality of a family.

(3) Knowledge on Abortion

Abortion is risky and dangerous. In this section, very basic abortion facts such as having an abortion can bring death, and abortion law should be legalized in Myanmar are asked to the respondents. Table (4.13) shows the respondents' knowledge on abortion.

Table (4.13) The Respondents' Knowledge on Abortion

Description	SD (%)	D (%)	N (%)	A (%)	SA (%)	Mean Score
It is important to use one of the contraceptive methods to avoid unwanted pregnancy.	6.6	2.0	7.7	48.5	35.2	4
Having an abortion is complicated, risky and can even bring death.	6.1	2.0	7.7	33.7	50.5	4.2
Abortion law should be legalized in Myanmar according to the cultural and traditional norms.	6.2	5.1	21.9	39.8	27.0	3.8

(SD: Strongly Disagree, D: Disagree, N: Neutral, A: Agree, SA: Strongly Agree)

Source: Survey Data 2019

According to table (4.13), (48.5%) of the respondents agree that it is important to use contraceptives to avoid unwanted pregnancy. The mean score result shows that the respondents are aware of using contraceptives. (50.5%) of the respondents strongly agree that abortion is complicated, risky and can even bring death. It can be assumed that they have a strong that abortion is very dangerous to women. (39.8%) of the respondents agree to make the abortion law legalized in Myanmar.

(4) Opinion on Awareness

The respondents were asked if women should educate their children at the start of their puberty. Table (4.14) shows their opinions on the awareness of the sexual and reproductive health.

Table (4.14) Opinions on the Awareness of Sexual and Reproductive Health

Description	SD (%)	D (%)	N (%)	A (%)	SA (%)	Mean Score
Every woman should have general knowledge on sexual and reproductive health care and rights.	0.5	4.7	1	21.4	72.4	4.6
A woman's education background can affect her reproductive health life.	8.7	6.6	6.1	38.8	39.8	3.9
Parents or teachers must educate both girls and boys about sexual and reproductive health care and rights at the start of their puberty.	1	1.5	5.7	34.7	57.1	4.4
Maternal health is essential to both mother and child and to the whole family.	0.5	4.1	4.1	47.4	43.9	4.3
Every pregnant mother must take all maternal health services required for the safety of both mother and unborn child.	1.5	2.6	6.6	29.6	59.7	4.4
The government should provide free contraceptives and maternal health services in both rural in urban areas.	5.7	1	10.7	41.8	40.8	4.1
Spending on contraceptives is worth for both men and women.	4.6	3.1	25.5	50	16.8	3.7

(SD: Strongly Disagree, D: Disagree, N: Neutral, A: Agree, SA: Strongly Agree)

Source: Survey Data 2019

According to table (4.14), (72.4%) of the respondents strongly agree to the statement that every woman should have general knowledge on sexual and reproductive health. The mean score (4.4) results for the third statement means that the respondents strongly agree that children need sex education since they are young. For the fourth statement, the mean score is (4.3) which means that the respondents believe that maternal health is essential to both mother and child and to the whole family. (59.7%) of the respondents strongly accept that every pregnant mother must take all maternal health services. The sixth statement shows that the respondents agree that the government should provide contraceptives and maternal services readily accessible in both urban and rural areas.

This survey questionnaire was also designed to conclude to ask the respondents how they would feel after taking this survey. Out of 196 respondents, 34 respondents were shy while they were taking this survey, 47 respondents felt satisfied and 115 respondents felt neutral.

CHAPTER V
CONCLUSION

5.1 Findings

Sexual and reproductive health is important throughout every woman's life. A woman must have enough sexual and reproductive health knowledge depending on her age. If she does not have enough awareness of it, she will not be able to have a happy family life. So, the purpose of this study is, in order to be able to know how much a woman has the overall level of the knowledge on sexual and reproductive health according to her age. This chapter is expressed the finding and some recommendations which are resulted and tracked from data collection.

The survey was conducted with 196 total respondents who lie in four age segments: under 20, 20-25. 25-30 and above 30. Among these segments, (56.1%) of the total respondents are in age between 20-25. Among 196 respondents, 189 students are single while 7 students are married with no children.

Chapter IV is presented with the survey data of the respondents' awareness and opinions on sexual and reproductive health. For a woman to understand sexual and reproductive health, and have awareness on contraceptive methods and uses, a significant factor is the source of information from which they learned about puberty. Many respondents answered they obtained their knowledge on puberty from their parents, from which a conclusion can be drawn: parents educate their children regarding puberty. Moving on, the most frequently mentioned source of information on sexual and reproductive health is teachers, which suggests that this source may either be biology textbooks or the possible existence of special lectures on sexual and reproductive health. In response to the inquiry as to from where they learned about the contraceptive methods and their uses, the most frequent answer is books and internet, followed by friends. This shows that women generally rely on studying online and going to friends for advice when it comes to contraceptive methods.

Many of the respondents have heard about all of the 11 contraceptive methods described which means their awareness on contraceptive methods is at an eligible

standard. When prompted to pick the contraceptive methods they are aware of, 171 in numbers or 87.2% of the respondents mentioned condom as one of the methods they know, rendering it the most popular choice. Subsequently, oral pills take the second place from being chosen by 103 in numbers or 52.6% of the respondents. 92 respondents or 46.9% of the respondents are also aware of injection method, causing it to become the third most known amongst the 11 contraceptive methods. To draw an inference from this data, it may be assumed that survey respondents have general awareness on contraceptive methods.

Oral pills, injection, condom, emergency contraceptive pills, withdrawal and calendar method are listed as options to choose from in terms of safest methods to avoid unintended pregnancy. 110 respondents, or 56.1% of the respondents picked condom as the safest method. Oral pills were regarded as the second safest and calendar method as the third by the respondents. 5% of the respondents answered that withdrawal method is the least safe method of all. From this data, it can be deducted that the respondents' awareness on the safest contraceptive method is at an inadequate level because injection and oral pills are more effective methods than condom. Moreover, calendar method is one of the most unsafe methods. This research suggests that it is required for the respondents to raise the awareness on the safest methods to avoid unintended pregnancy: oral pills and injection.

In order to determine the respondents' level of knowledge regarding condoms, 4 main statements were delivered in the survey questionnaire. The first statement is "Condoms can prevent pregnancy and STDs at the same time." 117 out of 196 respondents claimed this is true, while 14 respondents replied 'false' and 65 respondents were unsure of the answer. Based on this data, since more than 50% of the respondents gave the correct answer, it can be assumed that the awareness on this statement returns positive.

The second statement is "Condoms are the most effective method to prevent HIV/AIDS." 118 respondents agreed with this while 12 respondents disagreed and 66 respondents were uncertain about its accuracy. Factually, condom is the most effective method of protection against AIDS and other STDs in sexual relationships. To conclude, even though the quantity of the respondents aware of this fact outnumbers the remaining, it should be mandatory that the unsure and disagreeing respondents are also well-informed about this particular statement.

The third statement is “Buying condoms in stores is a shameful thing,” with which only 30 out of 196 respondents agreed. 85 respondents believe that it is not shameful while 81 respondents do not express a clear opinion on the case.

The fourth statement, “If a condom is broken or split, it should be immediately stopped using,” received agreement from 156 respondents while the remaining 40 respondents differed in opinion. In fact, a condom should be immediately stopped using if it is broken, split or past its expiry date. The disagreeing respondents should be aware that this statement is entirely true.

Regarding the level of knowledge on sex and reproduction, to the statement “A woman can get pregnant on the very first time that she has sexual intercourse,” 132 respondents answered they are uncertain. 48 respondents agreed with the statement while 16 respondents did not. It may be assumed that the respondents disagreeing with or uncertain about this statement do not understand how a woman’s body functions and only 48 respondents have a grasp on the workings of a woman’s body.

For the statement “A woman stops growing after having her first intercourse,” 114 respondents returned their disagreement. The deduction of this data suggests they are aware that development of a woman’s body is not arrested just because she entered a sexual relationship. When asked whether they understand how menstrual cycle works, 157 respondents answered affirmative and 13 respondents negative while 66 respondents were uncertain. Despite the fact that 80% of the respondents understand the way menstrual cycle works, the remaining 20% should also be aware of the case since they too have grown into adult females.

The respondents’ perspective on premarital sex can be divided into 3 components; the first being their acceptance of unmarried boys and girls dating as a couple. Nevertheless, they believe that a woman should not be sexually experienced before marriage. However, if a woman lost her virginity for some reason before marriage, they do not consider it a valid reason for social condemnation.

From a gender opinion point of view, the respondents accept that male involvement in females’ sexual and reproductive health life is an important factor. They also believe that the women in Myanmar have the right to make their reproductive life choices in an unrestrained manner, and that a woman is not held responsible to sacrifice everything for her family.

Regarding their knowledge on abortion, the respondents accept that it is essential to utilize a contraceptive method to avoid unwanted pregnancy in order to

avert having to weigh abortion as an option. Moreover, they understand that abortion procedures are detrimental and could prove to be fatal.

It was observed the respondents accept that every woman should be aware of her own sexual and reproductive healthcare and rights. Furthermore, they agree that parents should educate their children about sexual and reproductive health since puberty. The respondents also concur to the statement that all pregnant women and new mothers should be properly taken care of under systematic maternal healthcare services. Ultimately, the respondents agree that the government should supply free contraceptives and maternal healthcare services in both rural and urban areas.

5.2 Recommendations

Based on the findings and survey results of the thesis, parents are suggested to educate their children about sexual and reproductive system and contraceptive methods. Being aware of these natural processes and preventive methods will result in the averting of unwanted consequences.

Injection is the cheapest and least demanding method among all contraceptive methods. The respondents' awareness of this method is relatively moderate which should be remedied.

The first step the government should take towards a better understanding of and awareness on sexual and reproductive health should be the incorporation of puberty and sexual and reproductive health knowledge as part of the syllabus or the class schedule by the authorities since middle school. It is a natural process without any reason to be ashamed of, and therefore should be learned by every boy and girl growing up.

It is not adequate to simply educate the youthful. The government should also take measures to interact with the parents by means of social media, panel discussions or organizing exhibitions to further motivate them to ensure their children are properly informed about sexual and reproductive health.

Another measure the government should take is to effectively educate the adult and married women in the rural areas about sexual and reproductive health, contraceptive methods and their uses. Programmes to provide complimentary contraceptives to the indigent in poverty stricken regions should be implemented, with follow-up procedures to sustain a long term operation. Assuming the programmes were efficiently implemented with various respective participants such as nutritionists, economists, policy makers, and international organizations, the women in those regions

would not only acquire awareness on the subject but also be enabled to effectively utilize the expenses as the fertility rate declined.

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Appendix (A)

Questionnaire

Section (1) Background and Family Characteristics

1.1 Age

☐ Under 20 ☐ 20 – 25 ☐ 25 – 30

☐ Above 30

1.2 Specialized subject

_____

1.3 How much income or [1]allowance do you earn per month?

☐ Under 50,000 ☐50,000 – 100,000 ☐ Above 100,000

1.4 What is your religion?

☐ Buddhist ☐ Christian ☐ Hindu

☐ Muslim

1.5 How many family members do you have?

_____

1.6 Who is the [2]breadwinner of your family?

_____

1.7 How much does your family earn per month?

☐ Under 3 lakhs ☐3 to 10 lakhs ☐ 10 to 20 lakhs

☐ Above 20 lakhs

1.8 Please describe your marital status.

☐ Single ☐ Married

1.9 If married, do you have any children?

☐ Yes ☐ No

[1] မုန့်ဖိုး

[2] အိမ်ထောင်ဦးစီး

Section (2) Sources of Information on and Knowledge of Sexual and Reproductive Health

2.1 From whom or where did you learn about [3]puberty? You can choose more than one answer.

☐ Parents ☐ Siblings ☐ Teachers

☐ Friends ☐ Other (please specify) _____

2.2 From whom, or where did you learn about sexual and reproductive systems of men and women (where eggs and sperms are made and how pregnancy occurs)? You can choose more than one answer.

☐ Parents ☐ Siblings ☐ Teachers

☐ Friends ☐ Other (please specify) _____

2.3 Have you ever discussed sex-related matters with one of your family members?

☐ Yes ☐ No

2.4 If YES, please describe who.

_____

Please answer the following statements about sex and reproduction.

2.5 A woman can get pregnant on the very first time that she has sexual intercourse.

☐ True ☐ False ☐ Not Sure

2.6 A woman stops growing after having the first sexual intercourse.

☐ True ☐ False ☐ Not Sure

2.7 A woman is likely to get pregnant if she has had sexual intercourse half way between her periods.

☐ True ☐ False ☐ Not Sure

2.8 Do you think there should be classes on sexual and reproductive health at schools for youths and adolescents?

☐ Yes ☐ No ☐ Not Necessary

2.9 Have you ever heard of any sexually transmitted diseases? If yes, please specify.

_____

2.10 It is very important for a woman to give birth under the care of an experienced midwife or doctor.

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[3] ဆကၠဴးေကာင္ဝင္ျခင္း

☐ Yes ☐ No ☐ Not Necessary

2.11 A woman should have a systematic future family plan before marriage.

☐ Yes ☐ No ☐ Not Necessary

2.12 Would you feel comfortable if you were to seek consultation about sexual and reproductive health care at a clinic?

☐ Yes ☐ No ☐ Not Sure

2.13 Do you understand how menstrual cycle works?

☐ Yes ☐ No ☐ Not Sure

Section (3) Knowledge and Use of Contraceptive Methods

3.1 From whom or where did you learn about [4]contraceptive methods? You can choose more than one answer.

☐ Parents ☐ Siblings ☐ Teachers

☐ Friends ☐ Other (please specify) _____

3.2 The following methods are the most commonly used contraceptive methods to avoid pregnancy. Please choose any method you know.

☐ Oral Pills ☐ Injection

☐ Condom ☐ Withdrawal

☐ Emergency Contraceptive Pills ☐ Calendar Method

3.3 Which method do you think is the safest to avoid pregnancy?

☐ Oral Pills ☐ Injection

☐ Condom ☐ Withdrawal

☐ Emergency Contraceptive Pills ☐ Calendar Method

3.4 There are other methods of contraception which are not mentioned above. What other methods have you heard of? Please choose each method mentioned.

☐ IUD ☐ Male [5]Sterilization

☐ Female Sterilization ☐ Female Condom

☐ Implant ☐ Other (please specify) _____

3.5 Among all methods mentioned above, please describe one method you think is the most suitable for young people? And please give a short reason on your choice.

_____

[4] သေးခဲတားနည်း

[5] သားေယ်ကာျဖတ္ျခင္း

3.6 Have you ever experienced sexual intercourse?

☐ Yes ☐ No (please skip to 3.8)

3.7 Which method of contraception have you or your partner mostly used?

☐ Oral Pills ☐ Injection

☐ Condom ☐ Withdrawal

☐ Emergency Contraceptive Pills ☐ Calendar Method

☐ Other (please specify) ________________________________

3.8 Do you think condoms and pills should be readily accessible?

☐ Yes ☐ No ☐ Maybe

Condom is the only method that can prevent sexually transmitted diseases (STDs). Please answer the following statements about condoms and STDs based on your knowledge.

3.9 Condoms can prevent both pregnancy and sexually transmitted diseases at the same time.

☐ Yes ☐ No ☐ Not Sure

3.10 Condoms are an effective way of protecting against HIV/AIDS.

☐ Yes ☐ No ☐ Not Sure

3.11 Buying condoms in stores is a shameful thing.

☐ Yes ☐ No ☐ Maybe

3.12 If a condom is split or broken, it should be immediately stopped using.

☐ Yes ☐ No ☐ Not Sure

3.13 Have you ever seen a condom?

☐ Yes ☐ No

3.14 Apart from HIV/AIDS, there are other diseases that men and women can catch by having sexual intercourse. Have you heard of any of these diseases?

☐ Yes ☐ No

3.15 What are the signs and symptoms of a sexually transmitted disease in a woman?

☐ Vaginal discharge ☐ Pain during urination

☐ [6]Sores in genital area ☐ Other

____

[6] လိင်အင်္ဂါရောင်ရမ်းခြင်း

Section (4) Sexuality, Gender and Norms

Reproductive health largely depends on society norms and people's point of view on sexuality. The way how women are controlled in accordance with the culture and tradition affects their sexual and reproductive health rights. There are many different views of young people on relationships. Please choose ONLY ONE answer for the following statements.

	Statements	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
4.1	Do you think it is all right for unmarried boys and girls to have dates?					
4.2	Girls should remain virgins until they get married.					
4.3	[7]Intimacy before marriage is unacceptable.					
4.4	There is nothing wrong for unmarried boys and girls to experience sexual intercourse if they love each other.					
4.5	Girls who lost their virginity for any reasons before marriage should be blamed.					
4.6	Male involvement in female's sexual and reproductive health is important.					
4.7	It is mainly the women's responsibility to use the contraceptive methods regularly.					
4.8	It is important to use one of the contraceptive methods to avoid unwanted pregnancy.					

[7] လိင်ဆွဲဆောင်မှု

4.9	Having an [8]abortion is complicated and risky and can even bring death.					
4.10	Do you think abortion law should be legalized in Myanmar according to the cultural and traditional norms?					
4.11	Every woman should have general knowledge on sexual and reproductive health care and rights.					
4.12	Do you think women in Myanmar can make their sexual and reproductive life choices freely? (e.g the number of children she wants)					
4.13	In a household, a woman should sacrifice everything for the well-being of her husband and children.					
4.14	A woman's education background can affect her reproductive health life.					
4.15	Parents or teachers must educate both girls and boys about sexual and reproductive health care and their rights at the start of their puberty.					
4.16	Maternal health is essential to both mother and child and to the whole family.					
4.17	Every pregnant mother must take all maternal health services required for the safety of both mother and unborn child.					

[8] ကိုယ့်ဝန်ဖျက်ချခြင်း

4.18	Do you think the government should provide free contraceptives and maternal health services in both rural and urban areas?					
4.19	Do you think spending on contraceptives is worth for both men and women?					
4.20	It is important to go to a clinic as soon as possible when the symptoms of STDs start to occur.					
4.21	Do you think a family's nutritional status and happiness depend on the household's income?					

4.22 Have you ever been tied by cultural and religious norms in your relationship?

☐ Yes ☐ No

4.23 If YES, state briefly below.

_____

4.24 Have you ever discussed sex-related matters with your partner?

☐ Yes ☐ No

4.25 How do you feel when you take this survey questionnaire?

☐ Shy ☐ Satisfied ☐ Neutral

Appendix (B)

Sample Size Determination

With the total population (N=734), the sample size (n) for estimating population proportion (p) at the 95% confidence level (z=1.96) with 6% marginal error (e=0.06) optimizing precision of the survey results is calculated by using the following formula,

$$n = \frac{z^2.p.q.N}{e^2(N-1)+z^2.p.q}$$

n = sample size	p = sample proportion of success
z = confidence level	q = 1-p
e = marginal error	N = total population

To be safe for any population proportion estimates, p=0.5 is used for the required largest sample for any estimate of population proportion. Therefore, the required total sample level is

$$n = \frac{(1.96)^2 \times 0.5(1-0.5) \times 734}{0.06^2(734-1)+(1.96)^2 \times 0.5 \times (1-0.5)} = 196$$