

Factors affecting utilization of family planning services among
married women of reproductive age living in the rural area of
Kayin State, Myanmar



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ปัจจัยที่มีผลต่อการใช้บริการวางแผนครอบครัวในผู้หญิงวัยเจริญพันธุ์ ที่อยู่ในชนบทรัฐกะฮีน
ประเทศเมียนมา



วิทยานิพนธ์นี้เป็นส่วนหนึ่งของการศึกษาตามหลักสูตรปริญญาสาธาณสุขศาสตรมหาบัณฑิต
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ชาไป๋ ดูน : ปัจจัยที่มีผลต่อการใช้บริการวางแผนครอบครัวในผู้หญิงวัยเจริญพันธุ์ ที่อยู่ในชนบทรัฐกะฮีน ประเทศเมียนมา. (Factors affecting utilization of family planning services among married women of reproductive age living in the rural area of Kayin State, Myanmar) อ.ที่ปรึกษาหลัก : อุษณีย์ พึ่งปาน

ผลตอบแทนของการส่งเสริมการวางแผนครอบครัว ไม่เพียงแต่จะสามารถพัฒนาสุขภาพของแม่หรือเด็ก แต่ ยัง เ พื่ ม โ อ ก า ส ท า ง ก า ร ศึ ก ษ า การจ้างงานและการส่งเสริมสถานะทางเศรษฐกิจและสังคมที่ดีขึ้น โดยเฉพาะสำหรับสตรีทั้งเด็กและผู้ใหญ่ วัตถุประสงค์ของงานวิจัยครั้งนี้ คือ เพื่อประเมินสัดส่วนการใช้การวางแผนครอบครัวเพื่อการคุมกำเนิดและเพื่อหาปัจจัยที่มีผลต่อการใช้บริการคุมกำเนิดในสตรีวัยเจริญพันธุ์ที่แต่งงานแล้ว จำนวน 388 คน ที่อาศัยในชนบทเมืองพะอัน รัฐกะฮีน ประเทศเมียนมา เก็บข้อมูลด้วยการสัมภาษณ์ตัวต่อตัว เป็นการวิจัยภาคตัดขวาง เชิงพรรณนา ผลการศึกษา พบว่า สตรีวัยเจริญพันธุ์ที่แต่งงานแล้ว ร้อยละ 87.1 คุมกำเนิด โดยส่วนใหญ่ใช้ยาฉีด และยาเม็ดคุมกำเนิด ปัจจัยที่ส่งผลต่อการคุมกำเนิด จากการวิเคราะห์ด้วยวิธี **bivariate analysis** คือ อายุ ระดับการศึกษา จำนวนบุตร ระดับความรู้เกี่ยวกับ การคุมกำเนิด ค่าใช้จ่ายที่สามารถรับได้ ระยะทางการเดินทางมายังจุดให้บริการ ความพึงพอใจต่อบริการคุมกำเนิด สถานภาพความรู้ในการ รับบริการ และจำนวนชนิดที่ให้บริการ แต่เมื่อนำปัจจัยที่เกี่ยวข้องทั้งหมดมาวิเคราะห์ด้วย **multivariate analysis** หลังจากควบคุม ตัวแปรอิสระอื่นแล้ว พบว่า ปัจจัยที่ส่งผลต่อการใช้อายุคุมกำเนิดแบบมีนัยสำคัญทางสถิติ คือ อายุ ระดับการศึกษา ระดับความรู้ และ สถานภาพความรู้ในการรับบริการ การศึกษานี้ยังพบว่าการมีการศึกษาสูงและมีความรู้ เรื่องการคุมกำเนิดมากจะเป็นตัวชี้วัดการคุมกำเนิด ถึงแม้ว่า สตรี ที่ แต่งงาน เหล่า นี้ จะ ได้ รับ ข้อมูล ด้าน สุข ภาพ แต่บางคนก็ยังคงต้องการได้รับข้อมูลเพิ่มเติมรวมถึงความรู้ด้านสุขภาพที่เกี่ยวกับการคุมกำเนิด



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Sabai Tun : Factors affecting utilization of family planning services among married women of reproductive age living in the rural area of Kayin State, Myanmar. Advisor: Asst. Prof. USANEYA PERNGPARN, Ph.D.

The rewards of promoting family planning services not only restricted to improving maternal or child health but also significantly advanced the fitting occasion to gain higher educational status, better employment, empowerment and greater socioeconomic status especially for girls and women. The main purpose of this study was to assess the utilization proportion of family planning services for contraception and to determine the factors affecting the utilization of contraception among 388 married women of reproductive age living in the rural area of Hpa-an Township, Kayin state, Myanmar. The data was collected by face to face interview in this quantitative cross-sectional descriptive study. This study revealed that the proportion of married reproductive aged women who consume contraception was (87.1%). The most common used methods were injectable and oral contraceptive pills. The key factors affecting the usage of contraception were women age, level of education, number of living children, knowledge level about contraception, affordability for contraceptive cost, distance and transportation to the service point, satisfaction on the services, receiving status of health education about contraception and the number of type of health education they received in bivariate analysis. In multivariate analysis, only women age, level of education, knowledge level and receiving status of health education about contraception are significant after controlling other independent variables. The study also revealed that high education level and high knowledge are the indicators. Though married women received health information up to a certain level, some still want to get more information and health education about contraception.

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TABLE OF CONTENTS

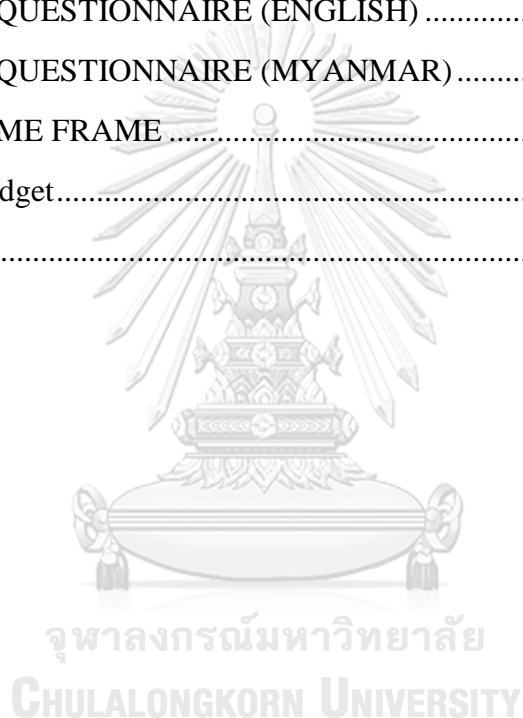
	Page
ABSTRACT (THAI)	iii
ABSTRACT (ENGLISH).....	iv
ACKNOWLEDGEMENTS.....	v
TABLE OF CONTENTS.....	vi
CHAPTER I.....	1
INTRODUCTION	1
1.1. Background and rationale of the study.....	1
1.2. Research questions of the study	4
1.3. Research objectives	5
1.3.1. General objective.....	5
1.3.2. Specific objectives.....	5
1.4. Variables.....	5
1.4.1. Independent variables	5
1.4.2. Dependent variables	6
1.5. Conceptual framework	7
1.6. Operational definitions	7
1.6.1. Predisposing factors.....	7
1.6.2. Enabling factors	8
1.6.3. Need factors	8
1.6.4. Utilization of contraction.....	9
CHAPTER II.....	11
LITERATURE REVIEW	11
2.1. Reproductive health.....	11
2.2. Why family planning is important among reproductive health care services ...	11
2.3. Contraception methods in Myanmar	12

2.4. Utilization of contraception being critical	13
2.5. Maternal deaths averted by contraceptive use	14
2.6. Trends in contraceptive prevalence globally	15
2.7. Trends of contraceptive prevalence in Myanmar	16
2.8. Current conditions of Kayin State	17
2.9. Current effort for family planning services in Myanmar	18
2.10. Challenges and opportunities	19
2.11. Studies done on utilization of contraception	20
Age	20
Ethnicity	20
Religion	20
Level of education	21
Occupation	21
No. of living children	22
Family income	22
Knowledge of contraception	23
Decision maker	23
Service provider	23
Need for information	24
Availability of family planning services for contraception	24
Accessibility of family planning services for contraception	24
2.12. Anderson model of health care utilization	24
CHAPTER III	27
RESEARCH METHODOLOGY	27
3.1. Study design	27
3.2. Study Population	27
3.3. Study Area	27
3.4. Sample Size	28
3.5. Sampling Technique	28

3.5.1.	Selection Criteria	30
3.6.	Measurement Tool.....	31
3.6.1.	Data Validity and Reliability	31
3.6.1.2.	Validity.....	31
3.6.1.2.	Translation.....	31
3.6.1.2.	Pre-test and Reliability	32
3.6.2.	Components of Measurement Tool	32
3.6.2.1.	Part 1 – Predisposing Factors.....	32
3.6.2.2.	Part 2 – Enabling Factors	32
3.6.2.3.	Part 3 – Need Factors	34
3.7.	Data Collection	34
3.8.	Data Entry and Data Analysis	35
3.9.	Ethical Consideration	35
3.10.	Expected Benefit & Application	36
3.11.	Limitation	36
3.12.	Obstacles and strategies to solve them	36
Chapter IV.....		38
Results.....		38
4.1.	Socio-demographic characteristics of respondents	38
Age	38	
Ethnicity		38
Religion		39
Level of education		39
Occupation.....		39
No. of living children		39
Family income		39
4.2.	Contraception utilization status	41
4.3.	Knowledge about contraceptive methods and use (Enabling factors).....	43
4.4.	Attitude towards contraception utilization (Enabling factors)	50

4.5. Service providers' conditions and decision makers of respondents (Enabling factors).....	52
4.6. Need factors for services	54
Place to get contraception.....	54
Affordable for the costs of contraceptive utilization.....	54
Distance from home	54
Transportation condition	55
Method availability.....	56
Satisfaction for that services.....	57
4.7. Need factors for information (Need for information).....	58
4.8. The association between the independent variables and the utilization of contraceptives (Bivariate analysis).....	61
4.8.1. Association between socio-demographic characteristics (Predisposing Factors) and utilization of contraception.....	61
4.8.2. Association between enabling factors and utilization of contraception	64
4.8.3. Association between need factors and utilization of contraception	67
4.8.3.1. Need for services.....	67
4.8.3.2. Need for information.....	68
4.9. Results from multivariate analysis	70
Chapter V	72
Discussion, Conclusion and Recommendation.....	72
5.1. Discussion.....	72
5.1.1. What proportion of married women of reproductive age living in the rural area of Kayin state, Myanmar utilizing family planning services for contraception	72
5.2. What are the factors affecting the contraception utilization and what relationships are statistically significant in affecting the contraception usage?	73
5.2.1. Predisposing factors/socio-demographic characteristics.....	73
5.2.2. Enabling factors.....	75

5.2.3. Need factors.....	76
5.3. Conclusion.....	79
5.4. Recommendation.....	80
REFERENCES	81
APPENDIX A. INFORMED CONSENT FORM WITH PERSONAL INFORMAITON (ENGLISAH).....	82
APPENDIX B. INFORMED CONSENT FORM WITH PERSONAL INFORMAITON (MYANMAR).....	85
APPENDIX C. A QUESTIONNAIRE (ENGLISH)	88
APPENDIX C. A QUESTIONNAIRE (MYANMAR).....	99
APPENDIX D. TIME FRAME	110
APPENDIX E. Budget.....	112
VITA.....	113



CHAPTER I

INTRODUCTION

1.1. Background and rationale of the study

Family planning can help people to get their desired number of children and able to space between the pregnancies. Family planning includes the utilization of contraception and the infertility treatment. The advantages of the utilization of contraception are prevention of unwanted pregnancies and related risk factors, prevention of HIV/AIDS, decreasing the infant mortality, empowering the literacy rate of people especially women, reducing adolescent pregnancies, slowing population growth[1]. The utilization of contraception has got many good benefits. Prevention of unintended pregnancies, reducing the number of abortions, and lowering the incidence of death and disability related to complications of pregnancy and childbirth can be gained by utilization of family planning. The long-term benefits range from increased education for women and better child health to greater family savings and stronger national economies[2].

The result will be very spectacular if all women who want to avoid a pregnancy used modern contraceptives and all pregnant women and their newborns received care at the standards recommended by WHO. Compared with the current situations, the unintended pregnancies would be reduced by 70 percent, from 74 million to 22 million per year; maternal deaths would fall 67 percent, from 290,000 to 96,000; newborn deaths would decline 77 percent, from 2.9 million to 660,000; the burden of disability related to pregnancy and delivery experienced by women and newborns would decrease by two-thirds and transmission of HIV from mothers to newborns would be nearly eliminated—achieving a 93 percent reduction to 9,000 cases annually[3]. The utilization of contraception is mostly by women in the reproductive age who are married or in a union in the various regions of the world. Globally, in 2017 63 percent of these women were using some contraception[4].

In addition, the utilization rate of contraception is *varied* as in Europe, Latin America and the Caribbean, and Northern America are above 70 percent, while being below 25 percent are in Middle and Western Africa. Unmet need for family planning means that the women affirm that they want to stop or delay childbearing but are not using any method of contraception to prevent pregnancy. There are more than one in

ten married or in a union women are having unmet need all over the world. Globally in 2017, the utilization of modern contraceptive methods was 58 per cent of married or in-union women of reproductive age with 92 per cent of all contraceptive users and the proportion of the demand for family planning that was satisfied by modern contraceptive methods (the proportion of women currently using a modern method among all women who have a need for family planning) was 78 per cent. However, the utilization rate of modern contraceptive methods by couples who want to prevent pregnancy remains low in some countries. In 2017, less than half of the total demand for family planning was being met with modern methods in 45 countries (including 32 in Africa). In an additional 64 countries, more than half but less than 75 per cent of the total demand was being met by the use of modern methods. However, the unmet need for family planning is projected to remain above 10 per cent worldwide between now and 2030 despite the reductions anticipated for some regions. The number of married or in-union women using contraception is projected to rise by 15 million globally, from 778 million in 2017 to 793 million in 2030, according to the median projection variant of the United Nations. The growth in the number of contraceptive users is projected to be especially fast in Africa and Southern Asia. Globally, the number of married or in-union women with an unmet need for family planning is projected to decline slightly, from 142 million in 2017 to 139 million in 2030. Living up to the commitment of the international community to achieve universal access to reproductive health by 2030 will require intensified support for family planning, including the implementation of effective government policies and programs. Access to health care services and the realization of reproductive rights for all people will be essential to fulfil the pledge of the 2030 Agenda for Sustainable Development that “no one will be left behind”[5].

In developing countries, women of reproductive age who want to avoid pregnancy not using a modern contraceptive method are 214 million. While some family planning methods like condoms, *help to prevent* the transmission of HIV and other sexually transmitted infections. Family planning / contraception not only reduces the need for abortion (especially unsafe one) but also reinforces people’s rights (example: determination of the number and spacing of their children) and prevents deaths of mothers and children[6]. As the result of Landon summit on Family Planning in 2012, there was a momentum about FP2020 enforcing the countries to take steps to accelerate

the expanding progresses towards the family planning accessibility for 120 million women and girls from the poorest countries in the world by the year 2020. The rights of women and girls to decide whether, when, and how many children they want to have are being reinforced and supported by new political, financial and service delivery commitments. For better child health, increased education for women, greater family savings, and stronger national economies, these important investments will be contributed and important.

According to Myanmar Demographic Health Survey (2015-2016), overall, 52 percent of married women who are living together with husband use a method of family planning. Among them, 51 percent of them are using a modern method and one percent are with a traditional method. *Injections* are most commonly used method among modern methods (28 percent) with the pill (14 percent), female sterilization (five percent), and the IUD (three percent). Women in urban areas are somewhat more likely to use modern contraceptives than those in rural areas. The 57 percent of urban women use *contraception* while rural ones being 49 percent. More than a half of modern contraceptive users receive the contraceptive services from public health care center such as government hospitals, health centers, and clinics[6].

In Myanmar, Kayin State is one of the least utilization percentage of modern contraceptive methods among states and regions (25 percent-40 percent) and also one of the highest unmet needs for contraception among states and regions of Myanmar. In Kayin State, maternal mortality rate is 276 for every one hundred thousand live births. Maternal mortality rate count for women dying while during pregnancy/delivery or 42days within after pregnancy termination. The infant mortality rate and Under 5 mortality rate of Hpa-an township is 39 and 45 per one thousand live births each. The total fertility rate is 2.9 children per woman of (15-49 years) and is slightly higher than the total fertility rate of 2.5 at the National level[6].

The available primary data and secondary sources suggest that Kayin State faces an extensive array of socioeconomic challenges as it embarks on a new era of peace building, including limited infrastructure, a fractured economy, and rudimentary and disconnected social services, owing not only to decades of conflict and displacement, but the division of territory between the government and several NSAs (*Non-State Actors*), primarily the KNU and DKBA. Moreover, only 17.8 percent of total

population live in urban area and the left 82.2 percent live in rural area of Hpa-an Township[7]. Government facilities for reproductive health services has much effect upon the women for slum area too. (Slum mean limited access to services)[8]. The utilization of contraception is still low especially in the developing world although the benefits of family planning are dramatic. On average, the highest level of contraceptive use usually found out with women in the highest economic conditions. Likewise rural women are less likely to use modern contraception than urban women for having poor quality of family planning services and limited choice of contraceptive methods[9].

Maternal mortality is a serious public health issue in many less developed countries. Myanmar faces a challenge with respect to maternal health and mortality. The MMR for Myanmar is two times higher than the MMR ratio in South-East Asian countries, and is higher than the global and developing country averages[10]. There are four pillars to reduce that high in maternal mortality in developing countries and family planning compromises as one the important role. The burden of maternal health system and 25 percent of maternal death can be reduced by boosting the contraceptive prevalence in developing countries[11]. However contraception acts as an important role in reducing the mortality and morbidity of mother and infant, Myanmar is relatively lower in the prevalence of modern contraceptive than the other countries, comparing with neighbors in Asia[12].

Therefore, in the conclusion my study is going to state the baseline knowledge providing the factors affecting the utilization of family planning services for contraception among married women of reproductive age (18-49 years) from the rural area in Hpa-an Township, Kayin State, Myanmar. The finding of this study will not only increase the availability of data necessary to support by will providing baseline information on factors affecting the utilization of family planning services for contraception but also guide effective strategy and implementation plan for FP2020 commitment and policy making and health system strengthening for improving maternal and child health.

1.2. Research questions of the study

1.2.1. What proportion of married women of reproductive age living in the rural area of Kayin state, Myanmar utilize family planning services for contraception?

1.2.2. What are the factors affecting utilization of family planning services for contraception among married women of reproductive age living in the rural areas of Kayin State, Myanmar?

1.2.3. Are there any associations between these factors and the utilization of family planning services for contraception among married women of reproductive age living in the rural areas of Kayin State, Myanmar?

1.3. Research objectives

1.3.1. General objective

To assess the utilization of family planning services for contraception and factors affecting upon that contraceptive usage among married reproductive aged women in rural areas, Kayin State, Myanmar.

1.3.2. Specific objectives

1.3.2.1. To assess the utilization of family planning services for contraception among married reproductive aged women in rural areas, Kayin State, Myanmar.

1.3.2.2. To determine the factors affecting the utilization of contraception among married women of reproductive age living in the rural area of Kayin State, Myanmar comparing between users and non-users.

1.4. Variables

1.4.1. Independent variables

❖ Predisposing Factors

- Age
- Ethnicity
- Religion
- Level of education
- Occupation
- No. of living children

❖ Enabling Factors

- Family income
- Knowledge
- Attitude
- Services provider
- Decision maker

- ❖ Need Factors
 - Need of services
 - Need of information

1.4.2. Dependent variables

- ❖ Utilization of family planning services for contraception

The use of health service is influenced by many factors, the best-known conceptual framework for understanding the utilization of health services has been presented by the Andersen revised model of (1995). Anderson model has been referred to frequently in utilization research as the behavioral model. Anderson says that use of health services is dependent upon the predisposing factor (age, gender, marital status, social class), the enabling components (income, health insurance, access to a source of care), and the need components (presence of symptoms or disease, morbidity). The enabling component indicates that though the individual may be predisposed to use health service, the individual must also have some means of obtaining them. These may remote or hinder the use of health services. Predisposing and enabling components, however, are not sufficient to affect the use of health services. What ultimately required is an individual perception of some illness need before health care is sought. This is the most crucial factor that affects choice of health service utilization[13].

1.5. Conceptual framework

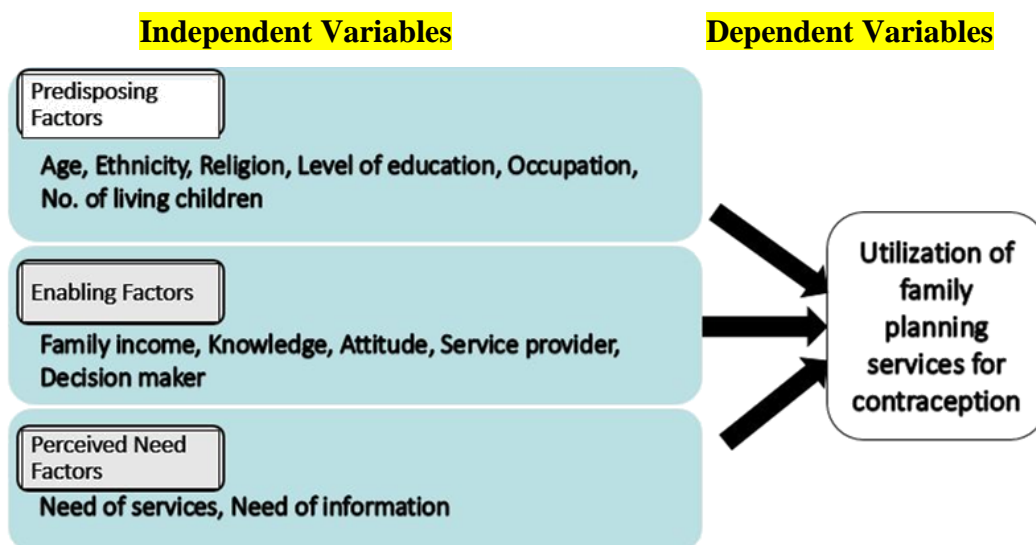


Figure-1 Conceptual Framework (Modified from kim and Lee, 2016)

1.6. Operational definitions

1.6.1. Predisposing factors

1.6.1.1. Age refers to the self-reported completed age of respondents at the time of last birthday.

1.6.1.2. Ethnicity means the original ethnic group of self-reported answer that the respondents belonged to and classified into Kayin, Pao, Burmeses and others.

1.6.1.3. Religion means the religions of respondent differentiated into Buddhist, Island, Christian and others.

1.6.1.4. Level of education directs the highest education level at the time of interview which has been self-reported by the respondents. It is classified as illiterate, able to read and write or basic monastery school, primary school level (equivalent to Grade 1 to Grade 5), middle school level (equivalent to Grade 6 to Grade 9), high school level (equivalent to Grade 10 to Grade 11) and higher than high school level (any level higher than high school like university or master or PHD).

1.6.1.5. Occupation commits the self-reported their current occupation status which they work mainly at the time of interview and classified into eight types. They are employee, own business, self-employee (Daily paid worker), housewife, farmer, unemployed, students and others.

1.6.1.6.No. of living children brings up the total number of living children that the respondents have.

1.6.2. Enabling factors

1.6.2.1.Family income here means the total monthly income by the whole family under same household. The results will be self-reported by respondents.

1.6.2.2.Knowledge of contraception refers to the level of knowledge of respondents on contraception related with the type of contraception, how to use contraception and side effects of contraception. The score for the correct answer is 1 and for incorrect answer is 0. There will be 20 questions related with the contraceptive methods. The highest score will be 20 and lowest will be 0. The level of knowledge will be classified into three groups; Low level, Fair, High level of knowledge. Cut off points and other details will be mentioned in methodology part.

1.6.2.3.Attitude towards contraception indicates the way how the women act on contraception and the opinion whether agree or disagree the statement concerning contraception. Attitude will be measured in three groups; negative, moderate and positive attitude. The cutoff points and details will be mentioned in methodology part.

1.6.2.4.Service provider represents the service provider concerns for cultural appropriateness whether the providing services are culturally appropriate to the women or not. It includes gender preferences of the service providers and condition of service provision.

1.6.2.5.Decision maker denotes a person who is making the decision for the women utilization of contraception, mostly and mainly which can be husband, herself, mother /mother in law, peers, health workers and others.

1.6.3. Need factors

1.6.3.1.Need for services involves availability and accessibility of family planning services for contraception.

Availability of family planning services for contraception expresses that the availability of contraceptive services (the presence of health organization or personnel to consult with contraceptive usage matters and any health service

centers such as public clinics or health centers or private clinics) and affordability for the cost of utilization.

Accessibility of family planning services for contraception implies to address the distance and time of clients have to travel to get contraception, transportation from home and satisfaction for that services.

1.6.3.2 Need for information intends of need for receiving family planning services for contraception in terms of informative materials like media, journals or things related with the information, education, communication materials such as pamphlets, posters, vinyl or brochure. It includes whether the respondents received or not received the health education about contraception, in what way they received and what information they want to receive if they have not received any information about contraception.

1.6.4. Utilization of contraction

It refers to any one method utilization by the woman or by the partner, including natural method such as fertility awareness method, withdrawal and abstinence or any modern method such as short-term, long term and permanent methods.

“Current user” directs that a woman who uses contraceptive methods 3 months before the time of interview.

“Ever-user” refers to the woman who ever used contraception and stopped using for more than or almost 3 months prior to interview.

“Never user” mean that the women had never used contraception in her lifetime.

1.6.5. General

1.6.5.1. Reproductive age

Women of reproductive age here means all women aged 18-49 years.

1.6.5.2. Unmet need

Unmet need for family planning is defined as the percentage of women of reproductive age, either married or in a union, who have an unmet need for family planning. Women with unmet need are those who are want to stop or delay childbearing but are not using any method of contraception.

1.6.5.3. Infertility

Infertility is defined as “a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse.”

1.6.5.4. Family planning

Family planning services here focus only on the services related with the contraceptive methods.

1.6.5.5. Contraception includes any type of modern contraceptive methods listed as follow:Modern Methods Short Termed Methods

Pills	➤ Combined oral contraceptives (COCs)
	➤ Progestogen-only pills (POPs)
	➤ Emergency Contraceptive Pills
Injection	➤ Progestogen only injectable
	➤ Monthly injectable or combined injectable contraceptives (CIC)
Condom	➤ Male Condom

Long termed Methods

Implant	➤ Jadelle
	➤ Implanon
Intrauterine device (IUD)	➤ Intrauterine device (IUD): copper containing
	➤ Intrauterine device (IUD) levonorgestrel

Permanent Methods

Sterilization	➤ Male Sterilization
	➤ Female Sterilization

Natural Methods

➤ Fertility Awareness Method
➤ Lactational Amenorrhea Method (LAM)
➤ Withdrawal

1.6.5.6. Rural Health Center (RHC)

RHC is a clinic located in a rural, providing health care services for the community living in that rural area and around.

CHAPTER II

LITERATURE REVIEW

2.1. Reproductive health

Reproductive health is defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes[14]. This definition has been adopted by the 1994 Programmed of Action of the International Conference on Population Development (ICPD). Reproductive health consists of the following health cares:

- Family-planning counselling, information, education, communication and services, including access to
- safe and effective contraceptive methods;
- Education and services for prenatal care, safe delivery and post-natal care, especially breast-feeding and
- infant and women's health care;
- Prevention and appropriate treatment of infertility;
- Prevention of unsafe abortion¹ and management of the consequences of abortion;
- Prevention and treatment of reproductive tract infections, sexually transmitted diseases and other
- reproductive health conditions;
- Prevention of harmful practices, such as female genital mutilation; and
- Information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood[15].

2.2. Why family planning is important among reproductive health care services

Family planning can help people to get their desired number of children and able to space between the pregnancies. Family planning can be accomplished through the promoting the utilization of contraception and the infertility treatment. The well-being and autonomy of women, and supporting the health and development of communities can be improved by empowering the family planning accessibility and

availability of every contraceptive method among reproductive aged women and couples. The advantages of the utilization of contraception are prevention of unwanted pregnancies and related risk factors, prevention of HIV/AIDS, decreasing the infant mortality, empowering the literacy rate of people especially women, reducing adolescent pregnancies, slowing population growth[1]. Enabling individuals to determine freely the number and spacing of their children can be achieved by an educational, comprehensive medical or social activities like family planning services[16].

Preventive health services that provide quality, low cost and easily accessible to reproductive health care for women and men during their reproductive years are family planning services. Family planning is often limited to the use of contraception. It aims to promote a positive view of sexuality and enable people to make informed choices about their sexual and reproductive health and well-being however providing a holistic service. It also ensures that resources are available for raising a child in significant amount, which include time, finance and social environment at intervals mutually determined by both partners to have their desired number of children[17]. Access to safe, voluntary family planning can help couples and individuals realize their basic right to decide freely and responsibly if, when and how many children to have[15]. In addition, contraceptive prevalence and the unmet need for family planning are key indicators for measuring improvements in access to reproductive health[18]. In family planning, contraception is a constitutional part of reproductive health while also being one of the most important determinant of maternal mortality rate and infant mortality rate[19]. Therefore, contraception plays the main role to achieve family planning in developing countries with low contraceptive prevalence rate.

2.3. Contraception methods in Myanmar

According to Family Planning guideline for service providers by Maternal and Reproductive Health Unit, Ministry of Health and Sports, Myanmar, contraceptive methods in that guidelines are as follow:

(1) Modern Methods

Short termed Methods

Pills	Combined oral contraceptives (COCs)
	Progestogen-only pills (POPs)
	Emergency Contraceptive Pills
Injection	Progestogen only injectable
	Monthly injectable or combined injectable contraceptives (CIC)
Condom	Male Condom
	Female Condom

Long termed Methods

Implant	Jadelle
	Implanon
Intrauterine device (IUD)	Intrauterine device (IUD): copper containing
	Intrauterine device (IUD) levonorgestrel

Permanent Methods

Sterilization	Female Sterilization
	Male Sterilization

(2) Traditional Methods

- (1) Calendar method or rhythm method
- (2) Withdrawal (coitus interrupts)
- (3) Lactational amenorrhea method (LAM)

2.4. Utilization of contraception being critical

The utilization of contraception has got many good benefits which substantial. Prevention of unintended pregnancies, reducing the number of abortions, and lowering the incidence of death and disability related to complications of pregnancy and childbirth can be gained by utilization of family planning. The long-term benefits range from increased education for women and better child health to greater family savings and stronger national economies[2]. The result will be very spectacular if all women who want to avoid a pregnancy used modern contraceptives and all pregnant women and their newborns received care at the standards recommended by WHO. Compared

with the current situations, the unintended pregnancies would be reduced by 70 percent, from 74 million to 22 million per year; maternal deaths would fall 67 percent, from 290,000 to 96,000; newborn deaths would decline 77 percent, from 2.9 million to 660,000; the burden of disability related to pregnancy and delivery experienced by women and newborns would decrease by two-thirds and transmission of HIV from mothers to newborns would be nearly eliminated—achieving a 93 percent reduction to 9,000 cases annually[3].

2.5. Maternal deaths averted by contraceptive use

Maternal mortality is a serious public health issue in many less developed countries. It refers to deaths among women while pregnant, during delivery, or within 42 days of delivery from any cause arising from the pregnancy or its management. The improvement of maternal health is recognized as an international development goal. One of the important target of the Sustainable Development Goals (SDGs) is to reduce the MMR by 70 per 100,000 live births in 2030. Myanmar faces a challenge with respect to maternal health and mortality. The MMR for Myanmar is two times higher than the MMR ratio in South-East Asian countries. Similarly the MMR of Myanmar is higher than not only for globally but also among developing country averages[10].

There are four pillars to reduce that high in maternal mortality in developing countries and family planning compromises as one the important role. In terms of maternal mortality reduction, the number of maternal deaths would be almost 266,000 higher than the current level with the absence of contraceptive use and with the contraceptive utilization MMR can be reduced by almost 44 percent. The burden of maternal health system and 25 percent of maternal death can be reduced by boosting the contraceptive prevalence in developing countries[11]. Compare to the average maternal mortality ration of 140 for Southeast Asian countries, the maternal mortality ratio of 282 for Myanmar is high[20]. However contraception acts as an important role in reducing the mortality and morbidity of mother and infant, Myanmar is relatively lower in the prevalence of modern contraceptive than the other countries, comparing with neighbors in Asia[12].

2.6. Trends in contraceptive prevalence globally

The utilization of contraception is mostly by women in the reproductive age who are married or in a union in the various regions of the world. Globally, in 2017 63 percent of these women were using some contraception[4]. In addition, the utilization rate of contraception is various as in Europe, Latin America and the Caribbean, and Northern America were above 70 percent, while being below 25 per cent in Middle and Western Africa. Unmet need for family planning means that the women affirm that they want to stop or delay childbearing but are not using any method of contraception to prevent pregnancy. There are more than one in ten married or in a union women are having unmet need all over the world. Globally in 2017, the utilization of modern contraceptive methods was 58 per cent of married or in-union women of reproductive age with 92 per cent of all contraceptive users and the proportion of the demand for family planning that was satisfied by modern contraceptive methods (the proportion of women currently using a modern method among all women who have a need for family planning) was 78 per cent. However, the utilization rate of modern contraceptive methods by couples who want to prevent pregnancy remains low in some countries. In 2017, less than half of the total demand for family planning was being met with modern methods in 45 countries (including 32 in Africa). In an additional 64 countries, more than half but less than 75 per cent of the total demand was being met by the use of modern methods. However, the unmet need for family planning is projected to remain above 10 per cent worldwide between now and 2030 despite the reductions anticipated for some regions. The number of married or in-union women using contraception is projected to rise by 15 million globally, from 778 million in 2017 to 793 million in 2030, according to the median projection variant of the United Nations. The growth in the number of contraceptive users is projected to be especially fast in Africa and Southern Asia. Globally, the number of married or in-union women with an unmet need for family planning is projected to decline slightly, from 142 million in 2017 to 139 million in 2030. Living up to the commitment of the international community to achieve universal access to reproductive health by 2030 will require intensified support for family planning, including through the implementation of effective government policies and programs. Access to health care services and the realization of reproductive

rights for all people will be essential to fulfil the pledge of the 2030 Agenda for Sustainable Development that “no one will be left behind”[5].

In developing countries, women of reproductive age who want to avoid pregnancy are not using a modern contraceptive method are 214 million. While some family planning methods like condoms, help prevent the transmission of HIV and other sexually transmitted infections. Family planning / contraception not only reduces the need for abortion (especially unsafe one) but also reinforces people’s rights (example: determination of the number and spacing of their children) and prevents deaths of mothers and children[1]. As the result of Landon summit on Family Planning in 2012, there was a momentum about FP2020 enforcing the countries to take steps to accelerate the expanding progresses towards the family planning accessibility for 120 million women and girls from the poorest countries in the world by the year 2020. The rights of women and girls to decide whether, when, and how many children they want to have are being reinforced and supported by new political, financial and service delivery commitments. For better child health, increased education for women, greater family savings, and stronger national economies, these important investments will be contributed and important.

2.7. Trends of contraceptive prevalence in Myanmar

The utilization of contraception had increased in 1997 with the increase utilization especially injectable and the pills while the utilization of permanent contraceptive methods is low with the difficulty and taking much time for getting approval. Furthermore, the law restricts for the male sterilization who is with the approval from wives but the female sterilization can undergo with the sterilization board approval. In 2007, the utilization rate of contraception had been increased to 40.9 percent from 16.8 percent in 1991. Among them, the 3-monthly injection was the favorite method of choice which had been used by 19.3 percent of reproductive aged women[21]. According to Myanmar Demographic Health Survey (2015-2016), overall, 52 percent of married women who are living together with husband use a method of family planning. Among them, 51 percent of them are using a modern method and one percent are with a traditional method. Injectable are most commonly used method among modern methods (28 percent) with the pill (14 percent), female sterilization (five percent), and the IUD (three percent). Women in urban areas are somewhat more likely

to use modern contraceptives than those in rural areas. The 57 percent of urban women use while rural ones being 49 percent. More than a half of modern contraceptive users receive the contraceptive services from public health care center such as government hospitals, health centers, and clinics[6].

2.8. Current conditions of Kayin State

In Myanmar, Kayin State is one of the least utilization percentage of modern contraceptive methods among states and regions (25 percent-40 percent) and also one of the highest unmet needs for contraception among states and regions of Myanmar[6]. In Kayin State, maternal mortality rate is 276 for every one hundred thousand live births. Maternal mortality rate count for women dying while during pregnancy/delivery or 42days within after pregnancy termination. The infant mortality rate and Under 5 mortality rate of Hpa-an township is 39 and 45 per one thousand live births each. The total fertility rate is 2.9 children per woman of (15-49 years) and is slightly higher than the total fertility rate of 2.5 at the National level[20].

Kayin State is located in eastern part of Myanmar. Its population is **1.5** million. Kayin State has 4 districts (Hpa-an, Pharpon, Myawady and Kawkareik). Among 4 districts, Hpa-an occupies over half of the total population (783,510) and also has highest female population among Kayin State[22]. Moreover, only 17.8 percent of total population live in urban area and the left 82.2 percent live in rural area of Hpa-an Township. Kayin State is located in southeastern Myanmar, Kayin State is bounded by Mandalay Region and Shan State to the north, Kayah State to the northeast, Mon State and Bago Region to the West, and Thailand to the East. Previously known as Karen State, the territory is inhabited primarily by the Karen people, a broad umbrella identity that includes a multiplicity of ethnic groups such as the Sgaw, Pwo and Pao, many with unique cultures and mutually unintelligible languages. The available primary data and secondary sources suggest that Kayin State faces an extensive array of socioeconomic challenges as it embarks on a new era of peace building, including limited infrastructure, a fractured economy, and rudimentary and disconnected social services, owing not only to decades of conflict and displacement, but the division of territory between the government and several NSAs, primarily the KNU and DKBA[7].

The utilization of contraception is still low especially in the developing world although the benefits of family planning are dramatic. On average, the highest level of

contraceptive use usually found out with women in the highest economic conditions. Likewise rural women are less likely to use modern contraception than urban women for having poor quality of family planning services and limited choice of contraceptive methods[10]. There are many other reasons for underutilization of contraception apart from the accessibility to contraception like lack of knowledge about contraception, cultural acceptance, personal perception, religious suggestions, misbelieves with the health concerns and myths about side effects[23].

Moreover, only 17.8 percent of total population live in urban area and the left 82.2 percent live in rural area of Hpa-an Township. Government facilities for reproductive health services has much effect upon the women for slum area too. (Slum mean limited access to services)[8]. Most of rural area characterized by deteriorated or poorly structured houses crowded together, poor environmental managements such as deficient access to safe drinking water and sanitation, stagnation of water, and poor drainage with excessive open sewers, excessive amount of uncollected rubbish, severe overcrowding, flies, and poor lighting. There are still that the inequity of access to RH services between the rich and the poor, and those living in urban and rural areas and which has been highly prioritized as a global equity issue[24].

2.9. Current effort for family planning services in Myanmar

The government of Myanmar views that family planning accessibility such as information, commodities, and services are the fundamental human right for all women and in the community and enforcing them has been prioritized. The government of Myanmar also consider the availability and accessibility of family planning services are critical for saving lives, mother and child protections, reduction of disability and poor quality of life and under development. Also, the government of Myanmar made the commitment a momentum of FP2020 in 2012 at London Summit on family planning. The government reinforced the implementation plan to meet FP2020 commitments and then the third Strategic Plan for Reproductive Health for the fulfillment of increasing demand for birth spacing by improving access to and use of birth spacing. The Objectives are as follow:

- ❖ To increase CPR from 41 percent to 50 percent by 2015 and above 60 percent by 2020
- ❖ To reduce unmet need to less than 10 percent by 2015 (from 12 percent in 2013)

- ❖ To increase demand satisfied from 67 percent to 80 percent by 2015
- ❖ To improve method mix with increased use of long acting reversible methods (LARM)
- ❖ To reduce adolescent pregnancy rate from 16.9 per 1,000 to 10 per 1,000 (2018) and
- ❖ To improve access by decentralization the management of reproductive health programs including birth spacing programs to districts and townships [25].

As in MDHS (2015-2016), the CPR is 52 percent, with the 51 percent of modern contraceptive methods utilization. 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. Three-quarters of the total demand for family planning is satisfied by modern methods (75 percent)[26].

2.10. Challenges and opportunities

Limited data and resources is main weakness of Myanmar. There are also poor data management and official statistics are inaccurate and often dated. Moreover, strong cultural norms about sexual behavior making difficulties for some researchers to find out for the prioritization. As Myanmar is one of the conservative country, social and cultural values can serve as barriers, particularly for young women, in accessing reproductive health services including those for birth spacing.

During empowering the family planning services accessibility and availability, many nongovernmental organizations are playing as an important role. Shortage in funding is also a common problem for nongovernmental organizations and limited resources with the shortage of funding being one of the main challenges for the government in implementation the action plans.

Being Myanmar's policy as a pro-natalist, some permanent methods are not easy to get approval. Moreover, there are also provider bias as a barrier for women in the utilization of informed choice methods and most suitable ones. Some of the providers refuse some practices like provision of contraception to unmarried women mixing with the sensitive cultural and religious conditions. Furthermore is there is

insecurity in commodities in the family planning services commodities in the public sector[27].

2.11. Studies done on utilization of contraception

Age

Age is the important as it has much influence in the contraceptive use. The study showing the significant difference between age and contraceptive utilization (p-value= 0.001) done among married women of reproductive age in Myanmar, Mandalay. The utilized percent was highest among 21-30 years and lowest among 18-20. In Ethiopia, the study show that the age of 20-39 years uses contraception more than those of 15-19 years old. There was a significant association with the p-values of 0.000 between the women of age 20-39 years and the current utilization of contraception[28]. Similarly, the study done among Myanmar migrant showed that the contraception utilization is lowest among 18-24 years old age group and therefore the association between them show statistically significant with p-values=0.005[29]. The study from Southern Ethiopia was controversy with the study done in Ethiopia as showing the age range of 15-19 use more contraception than those of 35-49 with the 95 percent significant level[30].

However the study done in Phang-Nga Province, Thailand among Myanmar migrant women found out that there is no significant association between age and the utilization of contraception[31]. Likewise, the study done among the women of child bearing age in Nigeria revealed that age did not have a significant association with the utilization of contraception[17].

Ethnicity

The study done in Ghana revealed that there is no significant effect of ethnicity on contraceptive use[32]. The study done in Ethiopia was arguing that, whether a woman experiences higher education, economics, family planning knowledge and accessible, the diversity in ethnicity has a significant effect on her current utilization of contraception[28].

Religion

Religion is one of the determinants for the utilization of contraception. A study from Finland for Somali refugee women living in Finland found out that the utilization of

contraception is related to the religious belief[33]. The study done in among Myanmar women of reproductive age showing there was no significant association between religion and most of the respondents were Buddhist and only few of them were Muslim, Hindu and Christian[19].

Level of education

There were many studies showing that level of education has a significant effect on the utilization of contraception and the women who has got better educated are expected that late to marry and use more family planning after getting married as they can have discussed freely about that. *The study revealed that the education plays major role in sexual reproductive health. Reinforcing the collaboration with other non-health sectors, especially education sector is needed. Information, education and communication activities concerning reproductive health should be expanded* [34]. The studies through reproductive age women from Ethiopia North Zone and Kenya approved the significant association between utilization of contraception and education with the p-value <0.001 [35, 36].

Similarly, the study through reproductive aged women from Bauchi state revealed that there was an association between level of education and utilization of family planning with the p-value <0.05 [17] and those done in Ethiopia showing that the contraceptive prevalence rate increased with the higher level of education[28]. Nevertheless, the study done in among married women of reproductive age living in Mandalay, Myanmar revealed no significant association between education and contraception usage[19]. In the similar way, the study done in Phang-Nga Province, Thailand among Myanmar migrant women found out that the level of education had positive relationship with the usage of contraception. The women with lower education level were less likely to use contraception than who has secondary education, however, this association was not significant for those having higher education level[31].

Occupation

Occupation often shape the decision for practicing contraceptives among women. The employment factor increases the status of women and gives them a higher sense of independence. The study done in among Myanmar reproductive aged women from Mandalay revealed that there is no association between occupation and contraception usage[19]. Similarly, the study done in Phang-Nga Province, Thailand among

Myanmar migrant women found out that the occupation was not significantly associated with the usage of contraception[31]. The studies done in Northern Zone of Ethiopia and Kenya exposed that occupational status of women was significant with p -value <0.2 in bivariate analysis while in multiple logistic regression mode not statistically significant with the utilization of contraception[35, 36]. In addition, the study done in Northwest Ethiopia discovered that the occupational status had significant association with the demand for utilization of contraception[37].

No. of living children

Number of living children is the important factor in contraceptive use. It provides information on actual family size and influences on the decision to use contraception and the intention to have additional births. The study done in among Myanmar women of reproductive age in Mandalay revealed that there is significant association between number of living children and contraception usage[19]. The study done in Nairobi, Kenya showed that the number of living children increase, the use of contraception increase[36].

The study done in Phang-Nga Province, Thailand among Myanmar migrant women found out that the number of living children had significant positive effect on the contraception usage as the use of contraception increase with increasing number of living children. It was possibly because the women who reached the desired family size use contraception to avoid pregnancy. However, the use declined slightly in women who had ≥ 3 children because they were older, less fertile or more likely to have secondary infertility[31]. Likewise, the findings from the study done in Northern Ethiopia and Kenya showing that the number of living children was significantly associated with utilization of contraception as women who want another child are more likely to use contraception[35, 36].

Family income

Income which is in term of economic factor also influences on the decision to use contraception. The study done in among Myanmar women of reproductive age in Mandalay revealed that there is no significant association between monthly family income and utilization of contraception[19]. The study done in Phang-Nga Province, Thailand among Myanmar migrant women found out that the income was not significantly associated with the usage of contraception[31].

Knowledge of contraception

Knowledge and use of contraceptives are the most fundamental indicators which are most frequently used by national and international organization to assess the success of family planning programs. Regarding the knowledge level of contraceptives, it indicated noticeably that women with a good or fair knowledge will participate in more practicing family planning than those who have poor knowledge. This is because they know well about the benefit of contraceptive use and understand the real information of side-effects of contraceptive method; they feel confidently and use more[31]. Regarding the knowledge level of the respondents, it indicated there was a significant association between knowledge and contraception usage at p-value of 0.014[19].

Likewise, the study done in Nigeria showed that there was a significant association between contraceptive utilization at p-value of 0.03[17]. The study done in Phang-Nga Province, Thailand among Myanmar migrant women found out that the knowledge was not significantly associated with the usage of contraception[31]. *Regarding total knowledge score of respondents about contraception, 58.4% had good knowledge score. Moreover, 81.2% of patients had high attitude score. About 76.2% of respondents were current users. Among current user, half of the respondents used 3 monthly injections. Among never users, the commonest reason for non-use was they wanted child. Among current users, they got pregnant mainly because they stopped contraception due to desire to get next child[38].*

Decision maker

Main mediating in utilization of contraception is decision maker for women using contraception or not. Spouse's attitudes also shape the use of contraception for a women[39]. Moreover, Sangi-Haghpeykar and et al. proved that the spouses are influential in contraceptive decision and Hispanic women cannot use contraception without the spouse approval.

Service provider

The utilization of modern contraception in sub-Saharan African, however is influenced by individualized financial capacity, cultural appropriateness like the gender of service providers by the community also had been adversely affecting[40].

Need for information

Need for information also has an important role in the utilization of family planning. The study through Myanmar migrant women in Thailand recommend that to fulfill the gap between low contraception utilization and knowledge by providing the adequate and effective information about all available contraceptive methods to the community[19]. *Regarding source of information, 55.2% of patients had noticed about contraception from relatives and friends[38].*

Availability of family planning services for contraception

The study from Kenya mentioned that the most choice of contraceptive method is injectable type and this could be due to convenience and having comfortable ways for the availability of this methods than others[36].

Accessibility of family planning services for contraception

The study done in Phang-Nga Province, Thailand among Myanmar migrant women found out that the accessibility to health services was not significantly associated with the usage of contraception[31]. In most of the developing countries, women cannot easily access to all modern contraceptive methods [41, 42].

2.12. Anderson model of health care utilization

The Andersen's Behavioral model is constructed as predisposing characteristics, enabling resources, Need and Use of Health care services. Among the predisposing characteristics, demographic factors such as age and gender represent biological imperatives suggesting the likelihood that people will need health service. Traditional measures used to assess social structure include education, occupation, and ethnicity. Health beliefs are attitudes, values, and knowledge that people have about health and health services that might influence their subsequent perceptions of need and use of health services. Both community and personal enabling resources must be present for use to take place. First, health personnel and facilities must be available where people live and work. Then, people must have the means and know-how to get to those services and make use of them.

The use of health service is influenced by many factors, the best-known conceptual framework for understanding the utilization of health services has been presented by the Andersen revised model of (1995) which includes, the national health policy, the

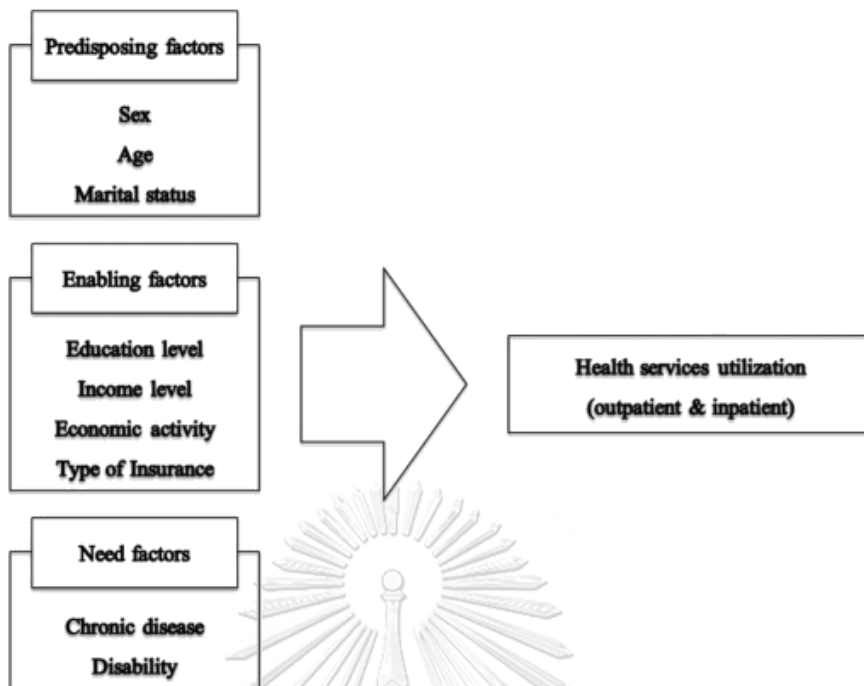
resources, and their organization in the health system as important determinants of the population's use of services. This model also shows the multiple influences on health services use and subsequently, on health status. It includes feedback loops showing the outcome, in turn affects subsequent predisposing factors and perceived need for services[43].

Anderson model has been referred to frequently in utilization research as the behavioral model. Anderson says that use of health services is dependent upon the predisposing factor (age, gender, marital status, social class), the enabling components (income, health insurance, access to a source of care), and the need components (presence of symptoms or disease, morbidity). The enabling component indicates that though the individual may be predisposed to use health service, the individual must also have some means of obtaining them. These may remote or hinder the use of health services. Predisposing and enabling components, however, are not sufficient to affect the use of health services. What ultimately required is an individual perception of some illness need before health care is sought. This is the most crucial factor that affects choice of health service utilization[13].

A behavioral model of health services uses for understanding access to medical care



This model is also aforementioned as the theoretical framework to examine the predisposing, enabling, and need factors that determine the overall health-services-utilization experiences of outpatients and inpatients[44].



CHAPTER III RESEARCH METHODOLOGY

3.1. Study design

This study was a quantitative cross-sectional study.

3.2. Study Population

The population of the study was married women of reproductive age between 18-49 years who living in the rural area of Hpa-an Township, Kayin State, Myanmar.

3.3. Study Area

This study was carried out in the rural area of Hpa-an townships, Kayin State which is one of the least utilization percentage of modern contraceptive methods (25 percent-40 percent) and also one of the highest unmet needs for family planning among states and regions of Myanmar[6].

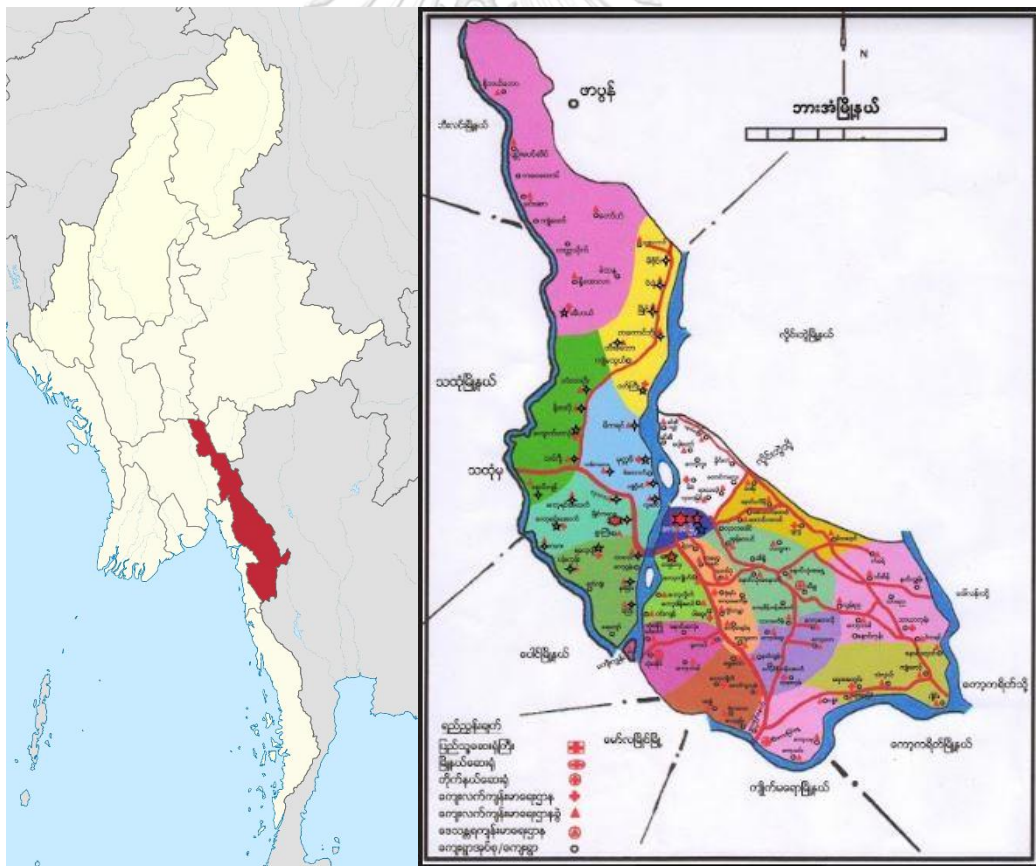


Figure-2 The Study area, Hpa-an Township (Source: MOHS 2016)

3.4. Sample Size

According to Cochran's formula[45],

$$n = \frac{Z^2 pq}{d^2}$$

$$n = \frac{(1.96)^2 \times 0.55 \times 0.45}{(0.05)^2}$$

$$n = 380$$

n = sample size

Z = standard value for 95 percent confidence interval (Z=1.96)

d = error allowance = 0.05

p = the proportion of targeted population who expected to use contraception

p = 55 percent = 0.55 (Contraceptive Prevalence Rate of Hpa-an Township is 55 percent according to Hpa-an Health profile from Department of Public Health, Hpa-an, in 2017)

q = 1-p = 1-0.55 = 0.45

3.5. Sampling Technique

Multistage sampling technique was used according to the following figure of sampling flow chart.

Step 1 – Kayin State was purposively selected as which is one of the least utilization percentage of modern contraceptive methods (25 percent-40 percent) and also one of the highest unmet needs for family planning services among fifteen states and regions of Myanmar[6].

Step 2 – There are four districts (Hpa-an, Pharpon, Myawady and Kawkareik) in Kayin State with the total population of 1,504,326 and the total female population is 765,199. Among them, Hpa-an District was purposively selected as its total population 783,510 which occupies over the half of the total population of Kayin State and also having 401,183 of total female population representing over the half of total female population of Kayin State[22]. Moreover, Hpa-an district has the highest female population among that four districts of Kayin State.

Step 3 – Hpa-an District has seven townships (Hpa-an, Hlaingbwe, Thandaunggyi, Paingkyon, Shan Ywathit, Leiktho and Bawgali). Among that seven

townships, Hpa-an Township was purposively selected for possessing 421,575 of total population with total female population of 217,665 covering over the half of Hpa-an District population[22]. Step 4 – In Myanmar, only 70 percent of total population inhabit in the rural area. Similarly, Hpa-an Township, only 17.8 percent of total population live in urban area and the left 82.2 percent live in rural area. Therefore, the study area was done in the rural area purposively. For the rural area, there are total 91 village tracts under cover of 17 Rural Health Centers. There are 6 Rural Health Centers in Western part and 11 Rural Health Centers in Eastern part of Hpa-an Townships crossing by Than Lwin River.

Step 5 – Depend on the desired sample size, three Rural Health Centers from total 17 Rural Health was enough to choose to represent the study area. But for the result to represent for the proposed regions (West and East part of Hpa-an Township), the three Rural Health Centers was chosen proportionately based on the number of existing Rural Health Centers in the Western and Eastern part of Hpa-an Township.

Step 6 – For the purpose of three Rural Health Centers and to be proportionately chosen, one from six Rural Health Centers from West part and two from eleven Rural Health Centers from East part of Hpa-an Township was selected by using excel based Computerized Randomly. The list of Rural Health Centers was from Department of Public Health, Hpa-an Township. (Kyauk Ta Lone Rural Health Center from the West part was selected. Htone Aing and Done Yin Rural Health Centers was resulted from the East part.)

Step 7 – Two villages under cover of selected Rural Health Center was selected by using the following criteria:

- Nearest Village from the Rural Health Center
- Farthest Village from the Rural Health Center

According to mapping data, Kyauk Ta Lone and Paw Taw Mu villages under cover of Kyauk Ta Lone RHC, Htone Aing and Phar Lin villages under Htone Aing RHC and Kawt Hta Ma Lain and Htee Htar Pha Lo villages under Done Yin RHC was selected to conduct survey. Systematic sampling of households was done for data collection. For systematic sampling of households, the total household numbers and the community mapping from each selected villages was obtained from the village administer team which has been updated quarterly. If the woman of the house you

randomly pick up refuses to participate in your study, our research team moved to another household beside it with the priority of household in which married reproductive age women are living. From each selected villages, 65 reproductive aged of married women were selected for interview after systemic sampling of households in each selected villages to get the sample size of 390 married reproductive age women.

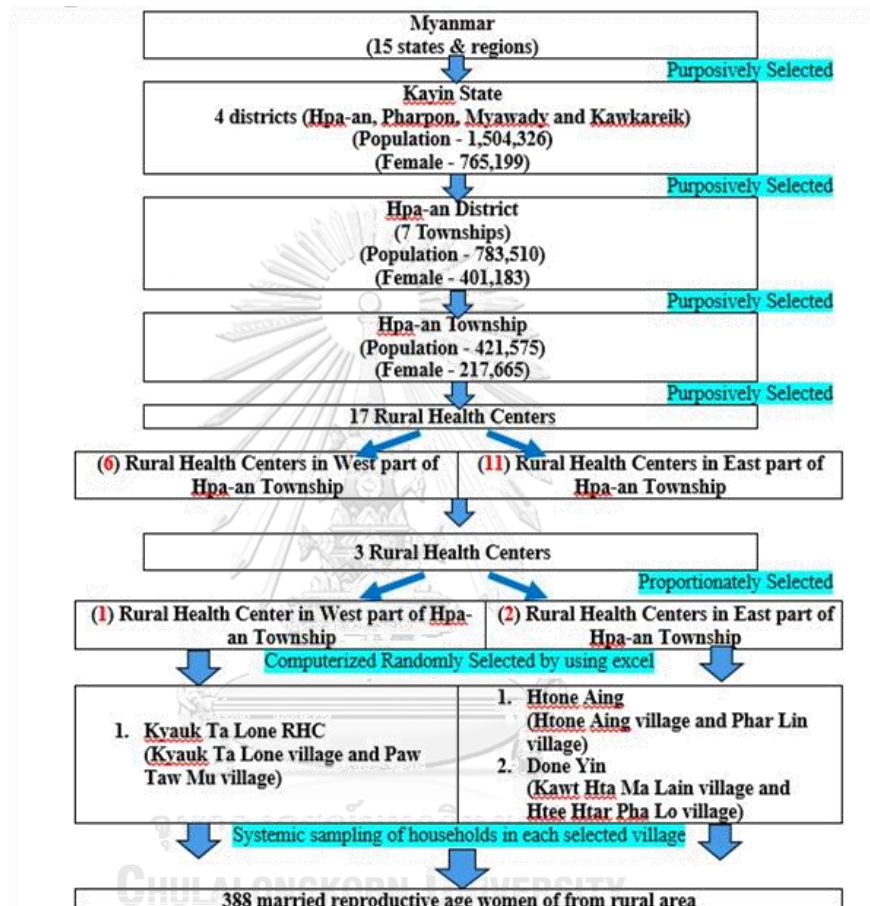


Figure-3 Sampling Flow Chart

3.5.1. Selection Criteria

➤ Inclusion Criteria

- Married women who are in reproductive age of 18-49 years.
- Married women who are mentally sound and willing to participate.

➤ Exclusion Criteria

- Women who widowed, divorced, separated or never married.
- Married women who are pregnant at the time of interview
- Married women who are hysterectomized or infertile.

3.6. Measurement Tool

The data collection was face to face interview to participants by using a questionnaire.

3.6.1. Data Validity and Reliability

3.6.1.2. Validity

The structured questionnaire in English language was produced and reviewed for content validity by three external expertise members (1. Dr. Myo Myo Mon, Deputy Director Epidemiology Research Division Department of Medical Research, 2. Dr. Sein Hlaing, National Health Director, International Rescue Committee, and 3. Dr. Aung Kyaw Kyaw, Senior Health Coordinator, Family Planning-Post abortion care in emergencies, International Rescue Committee. The Index of Item-Objective Congruence (IOC) was conducted. The questionnaire was revised according to exam committee members' comments and experts' comments. IOC value is 0.95.

3.6.1.2. Translation

After validating, the questionnaire was translated into Myanmar Language by expert of Family Planning Community team working in the Family Planning and Post Abortion Care in Emergencies, IRC/Myanmar who has expert skills in Family Planning with the competency of English and Myanmar language. Then, translated Myanmar questionnaire will be translated back to English questionnaire by another Family Planning expert, Senior Health Service Quality Team Leader from International Rescue Committee (Family Planning and Post Abortion Care in Emergencies Project), who do not know original English questionnaire with the competency of both language, Myanmar and English. If there is any discrepancy between two translations, two translators will meet together to agree on a final wording and solve the problem of the discrepancy. If they do not agree with each other in discussion and third person with the competency of both Myanmar and English Language and expert skills in family planning will facilitate their discussion firstly to get the final wording. If the agreement is not yet achieved for final wording, the third person will decide final wording of the questionnaire and choose the right translation with the agreement by at least one translator.

3.6.1.2. Pre-test and Reliability

Pre-test (pilot test) for the questionnaire were conducted in another rural area (Kwat Yin Village) in Hpa-an Township of Kayin State with similar characteristics and similar geographical location to the selected study areas. Moreover, respondents from pretest area did not participate in the study. The pretest was done by principal researcher among ten percent of sample size 380, 38 married women of reproductive age.

The purpose of pretest is to know the process of conducting research including the respondents' comprehension regarding each question in the questionnaire, the flow of questionnaire and duration of interview time, whether the contents of the questionnaire is relevant for respondents to answer or not and to check the internal consistency of the questionnaire.

The Cronbach's Alpha was used to test the internal consistency of scale data and in SPSS software. Cronbach's Alpha level with above cutoff point of 0.70[46] will be accepted because it means more than 70 percent of the measured variance is reliable and the remaining less than 30 percent is due to random error. For internal consistency of binary data, Kuder-Richardson formula 21, or *KR-21* with cutoff points of 0.7 was calculated in SPSS software[47]. The results from *KR-21* for pre-test showed 0.74 for knowledge and from 0.76 for Cronbach's alpha showed 0.89 for perceptions.

3.6.2. Components of Measurement Tool

The questionnaire was divided into three components and these are predisposing factors, enabling factors and perceived need factors.

3.6.2.1. Part 1 – Predisposing Factors

This part will include age, ethnicity, and religion, level of education, occupation, and number of living children.

3.6.2.2. Part 2 – Enabling Factors

This part is comprised of with the family income, knowledge on contraception, attitude towards contraception, and service provider and decision maker for utilization of contraception.

Knowledge about contraception

This part included 20 questions which are prepared and modified by literature[45] and using Family planning guidelines[48]. The negative statements were (Question no. 3, 5, 8, 9, 10, 15 and 20). The questions were validated by experts. The answers were

True, False and don't know. Only one correct answer got 1 and others got 0. The score range from 0-20 questions and categorized into three levels as follow by using Benjamine Bloom's criteria[45].

Low level of knowledge (<60 percent) - <12 scores

Fair level of knowledge (60-80 percent) – 12-16 scores

High level of knowledge (>80 percent) - >16 scores

Attitude towards contraception

The attitude towards contraception was measured with 10 questions with the scale used for the statement was Likert's Scale. The questions were prepared and modified by literature[31] and using Family planning guidelines[48]. The negative statements were (Question no. 2, 4, 7, 8, 9 and 10). The questions are structured by researcher and will be validated with experts. For scoring of perception on contraception, responds to statements are ranged from strongly agree to strongly disagree and will be scored using 5 point Likert's scale as mentioned below.

Positive statements		Negative statements	
Choice	Scores	Choice	Scores
Strongly agree	5	Strongly agree	1
Agree	4	Agree	2
Not Sure	3	Not Sure	3
Disagree	2	Disagree	4
Strongly disagree	1	Strongly disagree	5

For calculating scores of perception on contraception, the cut-off point was mean scores \pm standard deviation. All individual's answers for perception on contraception was summed up and calculated mean and standard deviations. The score range from 10-50. The level of perception on contraception will be classified as follow[31];

Negative attitude - Scores \leq mean - standard deviations

Moderate attitude - Scores between Poor and Good attitudes

Positive attitude - Scores \geq mean scores + standard deviations

3.6.2.3.Part 3 – Need Factors

Need factors was conducted for the need for services (accessibility and availability) and need for the need for information.

3.7. Data Collection

Data was collected by face to face interviews of the studied population by *principal* researcher and five research assistants. The selected five research assistants were trained for one-day prior data collection to reduce interviewer's bias. In the respect of the dignity of respondent women, all of the recruited research assistants were female basic health staff who can speak local language very fluently and all are from the urban area. Training topics were purpose of research (research objectives), research methodology and detailed information about the questionnaire and ethics about conducting research. Principle researcher explained about all training topics to research assistants with the related documents. At the end of training, research assistants asked the questions to the principal researcher what they were unclear or wanted to know more. After question sections, research assistants had to do role-play section as interviewer and interviewee to each other to assess their understanding about training as well as research conducting procedures and performance of research assistants. Every researcher had to practice as interviewer with different interviewees at least two times in a role play to be familiar and to minimize interviewer's bias. At the end of training sections, they had to do field testing with married women of reproductive age by using the questionnaire on account of assessing their performance. The research assistants provided research participant with the correct answer. Their performance was observed and correct by principal researcher during their practices.

All the respondents were asked the same questionnaire. After completion of interview, the interviewer had to check the error or the omission of interviewer and the questionnaire were checked by the principle researcher immediately after interview. The screener to select research participants according to your inclusion and exclusion criteria was the Lady Health visitors from each selected area who are taking responsible

for that area and having the updated data about population and household mapping of that area.

3.8. Data Entry and Data Analysis

Principle researcher checked the data and the questionnaire will be coded before entering data to the computer. After that, data entry was done by double entry process. Data analysis was processed by using SPSS software version 22 (licensed from Chulalongkorn University) for windows. The descriptive statistical analysis was performed as below:

Categorical data -frequency and percentage

Continuous data -Mean and standard deviation and frequency and percentage

Categorization of continuous independent factors for data analysis will be mentioned in detailed in the result chapter. In order to determine the relationship between independent and dependent variables, bivariate analysis will be used. For categorical variables, Person's Chi-square test was used and if the data did not meet the assumption Fisher's exact test was used (if the cells frequencies are less than 5, 20 percent with P value level of 0.05. For continuous variables, Mann-Whitney U test was used. Moreover, multivariate logistic regression model was also used to identify the determinants of contraceptive utilization. Odds ratio (OR) with its 95% confidence interval (CI) and P value were described. All tests were two-sided and the level of significance was set at 0.05.

3.9. Ethical Consideration

The study on title "Factors affecting Utilization of family planning services among married women of reproductive age living in the rural area of Kayin State, Myanmar" was reviewed and approved by the Research Ethics Review Committee for Research Involving Human Research Participants, Health Science Group, Chulalongkorn University (CoA No. 282/2018) and Department of Medical Research, Myanmar (Ethics/DMR/2019/033). Permission from the selected township and village leaders from the selected villages were also attained. Moreover, the participation of the respondents was voluntary and the decision to participate in the study or not was not being disclosed to any authority. The interviewer explained the objectives of the study

and obtained informed consent from each respondents. All answer sheets and data reports were kept in locked cabinet. The collected data were put into the database and then all the answer sheets will be destroyed by burning.

3.10. Expected Benefit & Application

This study provides base line information of utilization of family planning services among Myanmar married women living in rural area to health authorities for further promoting contraceptive usage and family planning knowledge to Myanmar married women.

3.11. Limitation

There was some limitation as this study will be only made in married women of reproductive age (18-49 years) living in rural area of Kayin State so that the findings cannot be generalized to the whole Myanmar married women population. This study could not reveal that which methods of contraception are available from which service points. Since this study had limited by time constraint, the unsecured environment and language barrier, the variables were quantitative and choses upon the thoughts to affect the non-users among Myanmar married women. However, in order to know more in-depth about more social norms and qualitative research should be explored. And the another township of Kayin state should also be studied in order to determine which area is causing Kayin state as one of the least utilization percentage of modern contraceptive methods among states and regions (*25 percent-40 percent*) and also one of the highest unmet needs for contraception among states and regions of Myanmar. Further comprehensive study is recommended to assess supply related factors, competency of service providers and considering private facilities, non-users preferably community based study and husbands' perception and acceptance toward contraceptive use.

3.12. Obstacles and strategies to solve them

In October, in Myanmar especially Kayin State (having Than Lwin River across) there is the risk of flooding as while the monsoon is leaving. The road to villages will be difficult to access to reach to the selected villages. For this obstacles, data is going to be collected in November/December and prepare to rent a suitable type of vehicles with the road conditions. However, there is also unstable political condition making unsecured environment, advocacy with township authorities and ethnic group

and the approval from these groups will have to be obtained. Language barriers is also a big challenge. The local health staff who can say the local languages are mandatory to recruit for data collection and interview.



Chapter IV

Results

The descriptive portion of the variables and the results showing the association between the variables assessing the factors affecting the utilization of the contraceptive service among married women of reproductive age living in the rural area of Kayin State, Myanmar will be prescribed in this chapter. A cross-sectional descriptive and analytic study was conducted in the six villages of Hpa-an township, Kayin State, Myanmar (Kyauk Ta Lone, Paw Taw Mu, Htone Aing, Phar Lin, Kawt Hta Ma Lain and Htee Htar Pha Lo villages). A total of 388 married reproductive aged women were interviewed in this study. This study was carried out in February 2019. The result of this study are mentioned according to the following:

1. Findings of exploratory analysis on independent and dependent variables among respondents are presented in frequencies, percentage, means, standard deviation (SD), and Median and range accordingly.
2. Association between the dependent and independent variables are disclosed in tables showing the statistical significance, with the p-value set up at 0.05.

4.1. Socio-demographic characteristics of respondents

The frequency distribution of selected variables describing characteristics of the respondents representing predisposing factors and enabling factors are stated in this part. Table – 1 brings out that socio-demographic characteristics such as age, ethnicity, religion, level of education, occupation, number of living children and family income.

Age

All respondents were in reproductive age of 18-49 years old. The bulk of respondents (75.3%) were in the age of 25 to 44 years. Only 5.3% of respondents were younger than 20 years while 9.3% and 10.1% of them were 20 to 24 years and 45 to 49 years respectively. The mean age was 33.31 with SD 7.74.

Ethnicity

Mostly of the respondents (84%) were Kayin with only 6.6% Burmese and 10% of Tamil people.

Religion

Almost all of the respondents (90.2%) were Buddhist and the others were Christian.

Level of education

The majority of respondents (64.4%) attended primary school level, and 10.6% of respondents attended middle school level while 9.6% and 4.6% attended high school and higher high school level each. Only few of (9.8%) were illiterate with one percent able to read and write.

Occupation

In term of occupation, 71.7% were housewives, and 10% of them were self-employee (Daily paid worker). Nine percent of respondents were working on own business with five percent farming. Only few of 3.4% compromised employee (Government) and the others were unemployed.

No. of living children

The number of living children of respondents ranged from 0 to 7. The median number of living children was 2 ranged between 0 and 7 and half of the women (58.5%) had 1 to 2 children. Nearly one third of women (36.3%) had 3 to 4 children and only few 3.7% had 5 to 7 children. Only 1.5% had no children.

Family income

The economic status of recruited married women had been assessed on the basic of monthly family income. Total family income varied from 5,000 to 500,000 Kyat (3 to 300 USD). Half of the respondents (53.6%) had monthly family income of 20,000 to 100,000 Kyat (13 to 67 USD) and one third of them (36.9%) had more than 100,000 Kyat (67 USD). Few of respondents (9.5%) had monthly family income of lower than 20,000 Kyat (13 USD).

Table-1 Socio-demographic Characteristics of Respondents (Predisposing and enabling factors)

Variables	Frequency	Percentage
Age (n=388)		
<20	21	5.3
20-24	36	9.3
25-29	74	19.1
30-34	74	19.1
35-39	93	24.0
40-44	51	13.1
45-49	39	10.1
Total	388	100.0
Median=34, Range=18-49, Mean=33.31, SD=7.74		
Ethnicity (n=388)		
Kayin	326	84.0
Burmese	25	6.0
Tamil	37	10.0
Total	388	100.0
Religion (n=388)		
Buddhist	350	90.2
Christian	38	9.8
Total	388	100.0
Level of Education (n=388)		
Illiterate	38	9.8
Able to read and write or basic monastery school	4	1.0
Primary school level	250	64.4
Middle school level	41	10.6
High school level	37	9.6
Higher than high school level (Graduate)	18	4.6

Total	388	100.0
Occupation (n=388)		
Employee(Government)	13	3.4
Housewife	276	71.1
Farmer	22	5.7
Unemployed	3	0.8
Own business	35	9.0
Self-employee (Daily paid worker)	39	10.0
Total	388	100.0
No. of living children (n=388)		
0	6	1.5
1 to 2	227	58.5
3 to 4	141	36.3
5 to 7	14	3.7
Total	388	100.0
Median=2.00, Range=0-7		
Family Income (n=388)		
<20,000 Kyat (<13 USD)	37	9.5
20,000-100,000 Kyat (13 to 67 USD)	208	53.6
>100,000 Kyat (>67 USD)	143	36.9
Total	388	100.0
Median=100000, Range=5000-500000, Mean=132525.77, SD=267663.229		

4.2. Contraception utilization status

Proportion of married women of reproductive age living in the rural area of Kayin state, Myanmar utilizing family planning services for contraception was measured by the percentage of married women in the reproductive age using contraception by herself or her husband. Table – 2 showed that proportion in details.

The contraceptive utilization rate among the recruited married women in Hpa-an was 87.1% and the rest were not using any form of contraception at the time of study. Ten percent of respondents had ever used of contraceptive methods and only few 2.3% had never used of contraception throughout their life.

The contraceptive methods used by current users had also mentioned in Table – 2. Among the 338 current users, injection methods were the most commonly used (60.1%). Nearly one third of current users (28.1%) answered for the utilization of OC pills while very few of four percent and three percent of them chose IUD and Implant respectively. The utilization percent of condoms and Female sterilization among common users are the same with about two percent.

Table-2 Frequencies and Percentages of current contraceptive utilization status and its methods

Contraceptive Utilization Status	Frequency	Percentage
Contraceptive Usage (n=388)		
Current use	338	87.1
Ever used	41	10.6
Never used	9	2.3
Total	388	100.0
Methods (n=338)		
Injection	203	60.1
OC pills	95	28.1
IUD	14	4.0
Implant	10	3.0
Condoms	8	2.4
Female Sterilization	8	2.4
Total	338	100.0

Table - 3 showed the reasons for using contraception by current users and not using reasons of non-users. The reasons for using contraception among current users in which half of them used contraception to prevent pregnancy while 16.0% for providing better life for their children, 4.1% was to improve financial conditions, 1.5% was to maintain their health, 1.3% was to regulate menstruation.

For those of non-users, one third of respondents (34.0%) didn't use contraception as they want to get pregnant. After that 26.0% who are not using contraception currently didn't use contraception as they afraid of side effects while 18.0% of non-users thought that they could not get pregnant as they had less sexual activity, 10.0% responded as they were far from home to get contraception and eight percent of respondents answered they don't like contraception and four percent replied as contraception are expensive.

Table-3 Frequencies and Percentages of Reasons for Use and Non-use of contraceptives

Reason- Use and Non-use	Frequency	Percentage
For current users (n=338)		
Prevent Pregnancy	248	73.4
Provide Better life for my children	62	18.3
Improve financial conditions of my family	16	4.7
Maintain my health	6	1.8
Regulate menstruation	5	1.5
Others	1	0.3
Total	338	100.0
For non-users (n=50)		
Want more children	17	34.0
Afraid of side effects	13	26.0
Less sexual activity	9	18.0
Far from Home	5	10.0
I don't like contraception	4	8.0
Contraception are expensive	2	4.0
Total	50	100.0

4.3. Knowledge about contraceptive methods and use (Enabling factors)

The respondents' knowledge about contraception was scrutinized by asking a series of structured questions. In the beginning, all of the respondents were asked whether they had heard of contraceptive methods or not. After that they were questioned about how to use contraception and side effects of contraception.

Table – 4 disclosed the number and percentage of respondents who had heard of each contraceptive methods. For the short-termed contraceptive methods like combined oral contraceptives (COCs), emergency pills (EC pills), progestrogen only injections and male condoms were well known among current users with 84.6%, 80.5%, 98.2% and 98.5% respectively. Among non-users, these short termed methods were not as much known as in current users except progestrogen only injections 96.0% and male condoms 96.0% which were well heard by non-users too.

For the long-termed methods, both jadelle and implanon were well heard (95.9% for Jadelle by current users and 84.0% by non-users) and (93.5% for Implanon by current-users and 76.0% by non-users). Moreover, 86.1% of current users heard about IUD while only 56.0% of non-users heard about that. Among permanent methods, the majority of respondents (current users and non-users) were known about female sterilization (98.2% and 96.0%).

Traditional contraceptive methods are more known among current users (80.2% for calendar methods, 73.4% for withdrawal methods and 70.1% for Lactational amenorrhea methods-LAM) compared with non-users (66.0% for calendar methods, 70.0% for withdarwal methods and 76.0% for Lactational amenorrhea methods-LAM).

Table-4 Frequencies and Percentages of married women who had heard of contraception (n=388)

Method ever heard	Current users (n=338)		Non-users (n=50)	
	Frequency	Percentage	Frequency	Percentage
Combined oral contraceptives (COCs)	286	84.6	23	46.0
Progestogen-only pills (POPs)	124	36.7	13	26.0
Emergency Contraceptive Pills	272	80.5	28	56.0
Progestogen only injectable	332	98.2	48	96.0
Monthly injectable or combined injectable contraceptives (CIC)	145	42.9	27	54.0
Male Condom	333	98.5	48	96.0
Female Condom	191	56.5	27	54.0
Jadelle	324	95.9	42	84.0

Implanon	316	93.5	38	76.0
Intrauterine device (IUD): copper containing	291	86.1	28	56.0
Intrauterine device (IUD) levonorgestrel	114	33.7	8	16.0
Female Sterilization	332	98.2	48	96.0
Male Sterilization	158	46.7	25	50.0
Calendar method or rhythm method	271	80.2	33	66.0
Withdrawal (coitus interrupts)	248	73.4	35	70.0
Lactational amenorrhea method (LAM)	237	70.1	38	76.0

Multiple responses allowed

The knowledge about contraception comprised with 20 questions and the score was 1 for correct answer and 0 for incorrect or don't know. Total knowledge score was categorized into three levels as follow by using Benjamine Bloom's criteria[45] .

Low level of knowledge (<60 percent) ≤ 12 scores

Fair level of knowledge (60-80 percent) 12-16 scores

High level of knowledge (>80 percent) ≥ 16 scores

The number and percentage of current users and non-users who responded correctly to each question concerning how to use contraception and side effects of contraception was presented in Table – 5.

Among the respondents, the statements for the proper use of OC pills, Depo injection and female sterilization were correctly answered by the majority of the respondents (98.5% of current users and 98.0% of non-users for OC pills), (98.5% of current users and 90.0% of non-users) and (91.1% for current users and 82.0% of non-users). Nevertheless, the use of emergency contraceptive pills was responded the true answers on (70.1% of current users) but only (36.0% of non-users). The statement about the side effects of OC pills and depo injection were correctly responded by the over half of the current users (65.4% for OC pills, 52.4% for depo injection) and less than half of non-users (46.0%) for OC pills and over the half of non-users (60.0%) for depo injection. However, the side effects of IUD and implants were correctly answered by one third of the current users (38.5% for IUD,33.4% for implant) but the non-user

correctness rate is less than that of users (28.0% for IUD and 22.0% for implant). Most of the current users (71.3%) and one third of (38.0%) non-users stated the right answer for the incorrect statement about OC pills can protect the STDs including HIV/AIDS. Besides, the statements about HIV/AIDS, induced abortion and contraception were correctly responded by most of the respondents; (97.9% users and 88.0% non-users for women can have children again by stopping to take pill or injection), (72.8% users and 72.0% non-users for you have more chance to suffer from STI if you have unprotected sex with many partners), (98.8% users and 88.0% non-users for improper use of contraception can cause unplanned pregnancy), (99.7% users and 98.0% non-users for induced abortion can sometimes threaten a woman's life) and (70.1% users and 68.0% non-users for when you are suffering from STI, you have more chance to be infected by HIV). The negative sentences about condom can make men impotence was replied the truth by half of current users (55.3%) while only 24.0% of non-users got that. Moreover, the negative statements about male sterilization was correctly by 28.4% of users and 14.0% of non-users. There was also the nearly same correct rate between users and non-users for the statement about IUD protective factors (33.4% users and 32.0% non-users) and negative sentence about implant side effects (32.5% users and 32.0% non-users). The negative statements that women cannot get pregnant if having sex during monthly bleeding was corrected among more non-users 50.0% and 30.0% of current users. The last negative sentences about STI can be prevented by all contraceptive methods was correctly answered by over half 63.3% of current user and one third of non-users (32.0%).

Table-5 Frequencies and Percentages of respondents who achieved the correct answer to each question (n=388)

No.	Statement	Current users (n=338)		Non-users (n=50)	
		Frequency	Percentage	Frequency	Percentage
1	Women who take oral contraceptive (pill) should take a pill every day to avoid becoming pregnant.	333	98.5	49	98.0
2	Oral pill can cause dizziness and nausea.	221	65.4	23	46.0
3*	Using oral contraceptive pill can protect against sexually transmitted infections (STIs) including HIV/AIDS.	241	71.3	19	38.0
4	Depo injection should be taken once in 3 months to prevent pregnancy.	333	98.5	45	90.0
5*	Injection can cause cessation of breast milk.	177	52.4	30	60.0
6	Women can have children again by stopping to take pill or injection.	331	97.9	44	88.0
7	If the women do not want the children anymore, female	308	91.1	41	82.0

No.	Statement	Current users (n=338)		Non-users (n=50)	
		Frequency	Percentage	Frequency	Percentage
	sterilization should be used.				
8*	Condom can make men impotent or weak.	187	55.3	12	24.0
9*	Male sterilization can reduce sexual desire and it can cause weakness to men.	96	28.4	7	14.0
10*	Woman cannot get pregnant if she has sex during monthly bleeding.	104	30.8	25	50.0
11	Emergency contraception have to take within 72 hours after unprotected sex.	239	70.7	18	36.0
12	You have more chance to suffer from STI if you have unprotected sex with many partners.	246	72.8	36	72.0
13	IUD can change in bleeding patterns (especially in the first 3 to 6 months)	130	38.5	14	28.0
14	IUD can protect against cancer of the lining of the uterus (endometrial cancer) and cervical cancer	113	33.4	16	32.0

No.	Statement	Current users (n=338)		Non-users (n=50)	
		Frequency	Percentage	Frequency	Percentage
15*	Implant cannot get infrequent bleeding, prolonged bleeding, no monthly bleeding, or irregular bleeding.	110	32.5	16	32.0
16	Implant can sometimes be expelled out.	113	33.4	11	22.0
17	Improper use of contraception can cause unplanned pregnancy.	334	98.8	44	88.0
18	Induced abortion can sometimes threaten a woman's life.	337	99.7	49	98.0
19	When you are suffering from STI, you have more chance to be infected by HIV.	237	70.1	34	68.0
20*	All contraceptive methods can prevent both STIs and pregnancy if used properly	214	63.3	16	32.0

* Negative statements

Table - 6 displayed the summary of knowledge about contraception depending on the total knowledge score about contraception among the participants. The majority of non-users (76.0%) got less than sixty percent and categorized as low level of

knowledge while 22.0% for non-users gained the fair level and only few of two percent of non-users were in high level of knowledge. Half of the respondents who were currently using contraception (55.6%) attained the fair level 60-80% of total knowledge scores. Likewise, one third of current users (34.3%) included in low level and 10.1% of them were in high level of knowledge.

Table-6 Total knowledge score level of respondents for the knowledge about contraception (n=388)

Knowledge level	Current users (n=338)		Non-users (n=50)	
	Frequency	Percentage	Frequency	Percentage
Low level of knowledge (<60%)	116	34.3	38	76.0
Fair level of knowledge (60-80%)	188	55.6	11	22.0
High Level of knowledge (>80%)	34	10.1	1	2.0

Mean = 12.85, SD = 2.70, Range = 6-19

4.4. Attitude towards contraception utilization (Enabling factors)

The attitude towards contraception indicates the way how the women act on contraception and the opinion whether agree or disagree the statement concerning contraception which was assessed by asking these to the married women. The attitude towards contraception will be measured by 10 questions of both positive and negative aspects and used the Likert's Scale for these statements. Furthermore, the scores for positive questions, was given 5 for strongly agree, 4 for agree, 3 for not sure, 2 for disagree and 1 for strongly disagree while the negative ones in opposite scoring with positive ones. Attitude will be measured in three groups; negative, moderate and positive attitude. For calculating scores of perception on contraception, the cut-off point will be mean scores \pm standard deviation. All individual's answers for perception on contraception will be summed up and calculated mean and standard deviations. The score range from 10-50. The level of perception on contraception will be classified as follow [31];

Negative attitude - Scores \leq mean - standard deviations

Moderate attitude - Scores between Poor and Good attitudes

Positive attitude - Scores \geq mean scores + standard deviations

The respondents' attitude level was disclosed in table – 7. Mean score of the attitude was 32.73 and the standard deviation was 2.72 with the lowest score 26 and the highest 44. Most of the respondents, 60.4% of current users and 70.0% of non-users had moderate attitude level for contraception.

Table-7 Level of attitude towards contraception (n=388)

Attitude level	Current users (n=338)		Non-users (n=50)	
	Frequency	Percentage	Frequency	Percentage
Negative attitude (≤ 30.0)	76	22.5	8	16.0
Moderate attitude (30.1-35.5)	204	60.4	35	70.0
Good attitude (≥ 35.6)	58	17.2	7	14.0

Mean = 32.73, SD = 2.72, Range = 26-44

Table - 8 shows the percentage of married women's attitude towards each question regarding contraception. Majority of respondents agree (70.7% for users and 74.0% of non-users) agreed that the family planning can improve mother's life. Over half of respondents (64.8% of users and 56.0% of non-users) agreed upon the negative sentence that using oral contraceptive is bad because it can get overweight. For the positive sentences of decision making on children number, teaching about contraception at school and both women and men know about contraception were agreed (73.1% users and 64.0% non-users), (57.7% users and 50.0% non-users) and (86.7% users and 74.0% non-users) respectively. In contrast with above the negative sentences about using condom can interfere with sexual activity was responded (46.4% users and 70.0% non-users) as not sure. Moreover, the negative statement of belief to stop using Depo injection if she has no menstrual bleeding for a month was agreed by half of current users (50.3%) and responded not sure by 44.0% of non-users. The negative aspect structured question of discussion on using contraception is ashamed among couples was disagreed by 48.5% of users and 52.0% of non-users. Majority of respondents (54.4% users and 70.0% of non-users) responded not sure for the negative statement of uncomfortable sexual intercourse with IUD. Similarly, female sterilization can affect the woman's good health in negative sentence was replied for not sure answer by 54.1% of user and 60.0% of non-users.

Table-8 PERCENTAGES OF ATTITUDE TOWARDS CONTRACEPTION AMONG MARRIED WOMEN (n=388)

No.	Method ever heard		Strongly agree	Agree	Not Sure	Disagree	Strongly disagree
1	I believe that family planning can improve mother's life.	Current Users	21.6%	70.7%	2.4%	5.3%	0.0%
		Non-users	18.0%	74.0%	6.0%	0.0%	2.0%
2*	Using oral contraceptive is bad because it can get overweight.	Current Users	9.8%	64.8%	17.8%	7.4%	0.3%
		Non-users	0.0%	56.0%	36.0%	8.0%	0.0%
3	Husband and wife should decide number of children.	Current Users	23.1%	73.1%	2.4%	1.5%	0.0%
		Non-users	32.0%	64.0%	0.0%	4.0%	0.0%
4*	Using condom can interfere with sexual activity.	Current Users	0.6%	46.2%	46.4%	6.8%	0.0%
		Non-users	6.0%	18.0%	72.0%	4.0%	0.0%
5	Contraceptive utilization should be taught in the school.	Current Users	0.9%	57.7%	32.2%	8.6%	0.6%
		Non-users	2.0%	36.0%	50.0%	8.0%	4.0%
6	I believe that both men and women should have some knowledge about using contraception.	Current Users	9.8%	86.7%	2.4%	1.2%	0.0%
		Non-users	18.0%	74.0%	8.0%	0.0%	0.0%
7*	I believe that women should stop using Depo injection if she has no menstrual bleeding for a month.	Current Users	0.9%	50.3%	15.1%	32.0%	1.8%
		Non-users	2.0%	24.0%	44.0%	28.0%	2.0%
8*	Discussion on using contraception is ashamed among couples.	Current Users	2.1%	30.5%	10.1%	48.5%	8.9%
		Non-users	6.0%	24.0%	12.0%	52.0%	6.0%
9*	IUD methods disturbs sexual intercourse.	Current Users	0.3%	26.6%	54.4%	18.0%	0.6%
		Non-users	4.0%	14.0%	70.0%	12.0%	0.0%
10*	Female sterilization can affect the woman's good health.	Current Users	2.1%	22.5%	54.1%	20.4%	0.9%
		Non-users	2.0%	26.0%	60.0%	10.0%	2.0%

* Negative statements

4.5. Service providers' conditions and decision makers of respondents (Enabling factors)

In term of service provider, the 92.0% of current users received the services from female health workers, 0.9% form male and 7.1% from both male and female health workers while 90.2% of ever used women received from female, none from male

and the rest 9.8% from both male and female were disclosed in table - 9. This is only counted for the respondents who had ever used contraception and those of currently using. For the gender preferences, the majority of respondents, 99.4% of current users and 98.0% of non-users responded the preference of same gender service providers.

As shown in Table - 9, half 56.5% of current users' decision makers were their husbands and the rest 42.3% and 1.2% were by self and by mother or mother in law respectively. For non-users, 50.0% were by self while 48.0% were by husband and the other 2.0% were by mother or mother in law.

Table-9 Frequencies and Percentages of service providers Conditions and decision makers of respondents (Enabling factors) (n=388)

Enabling factors	Current users (n=338)		Ever used women (n=41)	
	Frequency	Percentage	Frequency	Percentage
Service Provider Gender condition				
Male	3	0.9	0	0.0
Female	311	92.0	37	90.2
Both	24	7.1	4	9.8
Never used			(9)	(18.0)
Total	338	100.0	41	100.0

Table-9 cont. Frequencies and Percentages of service providers Conditions and decision makers of respondents (Enabling factors) (n=388)

Enabling factors	Current users (n=338)		Non-users (n=50)	
	Frequency	Percentage	Frequency	Percentage
Service Provider (Same Gender Preferences)				
Yes	336	99.4	49	98.0
No	2	0.6	1	2.0
Total	338	100.0	50	100.0

**Decision Maker for utilization of
contraception**

Self	143	42.3	25	50.0
Husband	191	56.5	24	48.0
Mother/Mother in Law	4	1.2	1	2.0
Total	338	100.0	50	100.0

4.6. Need factors for services

Need for services involves availability and accessibility of family planning services for contraception. **Availability of family planning services for contraception** expresses that the places to get contraception services (Where can you get the service for contraception), method availability and affordability for the cost of utilization. **Accessibility of family planning services for contraception** implies to address the distance and time of clients have to travel to get contraception, transportation from home and satisfaction for that services.

Place to get contraception

As shown in Table - 10, this is only counted for the respondents who had ever used contraception and those of currently using. The half of current-users (58.9%) and 56.1% of ever-used women mentioned that rural health centers (RHC) for receiving contraception. One third of ever-used women (34.1%) and (28.7% of current users) thought hospital as service point for contraception. Only a few 12.1% of current-users and five percent of ever-used women replied the drug stores as the service point for contraception. More than four percent of ever-used women and less than one percent of current-users stated the private clinics as place to get contraception.

Affordable for the costs of contraceptive utilization

Most respondents (99.7% of current users and 90.0% of ever-used women) said that they could afford for the cost while less than one percent of current-users and ten percent of ever-used women responded as they could not afford. This is also calculated upon the respondents who had ever used contraception and those of currently using.

Distance from home

The majority of married women participated in the study (92.3% of current users and 92.7% of ever-used women) said that it took half an hour to one-hour from their

home to the place to get contraception while (five percent of users and two percent of ever-used women) and (two percent of users and five percent of ever-used women) responded that it took two hours and one hour respectively. The respondents who had ever used contraception and those of currently using are only calculated.

Transportation condition

Half of the respondents (69.5% of users) said that they used private vehicle to go to place for getting contraception while the another user 16.6% and 8.6% used walking and public vehicle respectively. The rest 5.3% of users asked someone to buy the contraception for them. Similarly, the half ever-used women (63.4%) responded that they could use their private vehicle to go to the health center and 17.1% of each could use walking and public vehicle. The only two percent of non-users said that they used to ask someone to buy contraception for them. This variable is brought to think for the respondents who had ever used contraception and those of currently using only.

Table-10 Frequencies and Percentages on Need Factors (for services) of Respondents

Variables	Current users (n=338)		Ever used (n=41)	
	Frequency	Percentage	Frequency	Percentage
Place to get contraception (n=388)				
RHC	199	58.9	23	56.1
Hospital	97	28.7	14	34.1
Drug Store	41	12.1	2	4.9
Private clinics	1	0.3	2	4.9
Total	338	100.0	41	100.0

Affordability for the cost**(n=388)**

Yes	337	99.7	37	90.0
No	1	0.3	4	10.0
Total	338	100.0	41	100.0

Distance from home (n=388)

Half an hour to one-hour	312	92.3	38	92.7
One hour	8	2.4	1	2.4
Two hours	18	5.3	2	4.9
Total	338	100.0	41	100.0

Transportation condition**(n=388)**

Private vehicle	235	69.5	26	63.4
Walking	56	16.6	7	17.1
Public vehicle	29	8.6	7	17.1
Ask someone to buy	18	5.3	1	2.4
Total	338	100.0	41	100.0

Method availability

As stated in table - 11, most of the injectable users (69.5%) got the services from RHC while 29.6% from hospital and one percent from drug store. However, for OC pills users half of (50.5%) received from RHC, one third (36.8%) from Drug store and 12.6% from hospital. Half of (50.0%) condom users obtained from drug store, 12.5% from hospital and 37.5% from RHC. For IUD users, 50.5% went to hospital, 42.9% in RHC and 7.1% in private clinic. For the implant services, most of them (90%) got from hospital. Female sterilization is available only in hospital.

Table 11 FREQUENCIES AND PERCENTAGE OF METHOD AVAILABILITY RESPONDED BY CURRENT USERS UPON THE PLACE TO GET CONTRACEPTION METHODS (n=338)

	Injection		OC pills		Condoms		IUD		Implant		Female Sterilization	
	n	%	n	%	n	%	n	%	n	%	n	%
Hospital	60	29.6	12	12.6	1	12.5	7	50.0	9	90.0	8	100.0
RHC	14	69.5	48	50.5	3	37.5	6	42.9	1	10.0	0	0.0
Drug Store	1											
Private clinics	2	1.0	35	36.8	4	50.0	0	0.0	0	0.0	0	0.0
	0	0.0	0	0.0	0	0.0	1	7.1	0	0	0	0.0

*n=Frequency, %=Percentage

Satisfaction for that services

The satisfaction status for the services were mentioned in the table-12. The hundred percent of current-users replied that they were satisfied upon the contraception services they received. In addition, the reasons for satisfaction were mentioned in table - 13. Nearly half of the respondents (45.4%) who satisfied upon the contraception services were due to low cost or free of charge for services. The other reasons were no time to wait to get the services 34.6%, having privacy and confidentiality 12.4%, friendly service providers 5.7%, near from home 1.6% and the left 0.3% was due to maintain the health of respondents.

Table-12 Frequencies and Percentages on Need Factors (for services) of Respondents (n=388)

Satisfaction status for services	Current users (n=338)	
	Frequency	Percentage
Yes	338	100.0
No	0	0.0
Total	338	100.0

Table-13 Frequencies and Percentage of Reasons for satisfaction and non-satisfaction upon services for contraception (n=388)

Reasons	Frequency	Percentage
Reason for Satisfaction (n=370)		
Low cost or free	155	45.8
No time to wait	124	36.7
Privacy and Confidentiality	36	10.7
Friendly Service Provider	17	5.0
Near from Home	5	1.5
Others	1	0.3
Total	338	100.0

4.7. Need factors for information (Need for information)

Need for information intends of receiving family planning services for contraception in terms of informative materials like media, journals or things related with the information, education, communication materials such as pamphlets, posters, vinyl or brochure. It includes whether the respondents received or not received the health education about contraception, in what way they received and what information they want to receive if they have not received any information about contraception. Table - 14 was revealed with this information.

Receiving of health education about contraception

Most of current users (87.6%) and half of non-users (68.0%) said that they had received the health education about contraception while the other (12.4% of users) and (32.0% of non-users) have not received yet.

The number of Health Education types

The number of type of health education asked in the questionnaire were health talk as one type - type number one, pamphlets/brochure/leaflet as one type - type number two, cartoon booklet as one type - type number three, group training/workshop as one type - type number four, video as one type - type number five, wall sheet/poster as one type - type number six and total six types of health education which were supposed to common in Myanmar were assessed. Among the married women who had ever received health education session, only one type of health education receivers were (for health talk, 61.5% users and 79.5% non-users; for pamphlets/brochure/leaflet,

18.9% users and 5.9% non-users; for cartoon booklet, 11.8% users and 2.9% non-users; for group training/workshop, 6.1% users and 2.9% non-users; for video, only 0.3% users and none of both users and non-users for wall sheet/ poster) while there were none of users for receiving two types of health education but 5.9% of non-users. For three types or more health education types receivers show 1.4 among users and 2.9 among non-users.

What they want by Non-receiver for Health Education about Contraception

The respondents who have not received any information yet replied that they wanted to get the information on different methods of contraceptive methods (64.3% of current-users and 50% of non-users), 4.7% of current users wanted to know more about the available services and (31.0% of current users and 50% of non-users) wanted to know about the adverse effects for contraception.

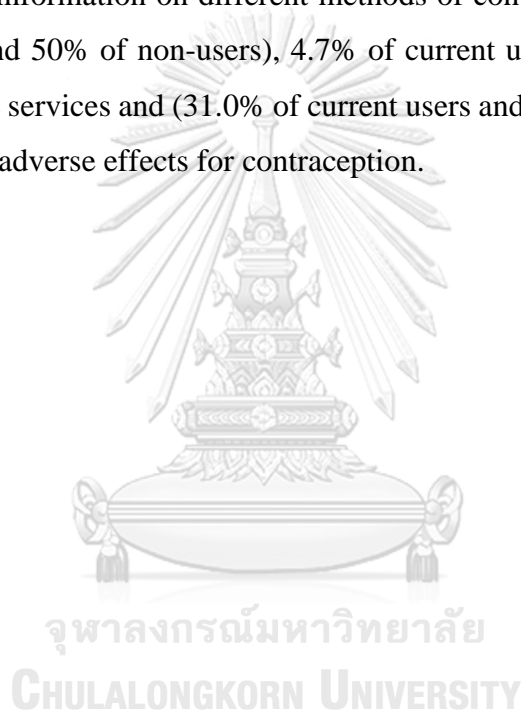


Table-14 Frequencies and Percentages on Need Factors (for information) of Respondents

Need factors (for information)	Current users (n=338)		Non-users (n=50)	
	Frequency	Percentage	Frequency	Percentage
Receiving of health education about contraception				
Yes	296	87.6	34	68.0
No	42	12.4	16	32.0
Total	338	100.0	50	100.0
The type of information they had received (n=330)				
Received Health talk	182	61.5	27	79.5
Received Pamphlets/brochure/leaflet	56	18.9	2	5.9
Received Cartoon booklet	35	11.8	1	2.9
Received Group training/workshop	18	6.1	1	2.9
Received Video	1	0.3	0	0.0
Received two types	0	0.0	2	5.9
Received ≥3 types	4	1.4	1	2.9
Total	296	100.0	34	100.0
Multiple responses allowed				
What they want by non-receiver for health education about contraception (n=58)				
I want to get the information on different methods of contraceptive methods.	27	64.3	8	50.0
I want to know what services are available.	2	4.7	0	0.0
I want to know about the adverse effects of contraceptives.	13	31.0	8	50.0
Total	42	100.0	16	100.0

4.8. The association between the independent variables and the utilization of contraceptives (Bivariate analysis)

The association between the predisposing factors, enabling factors, need factors and contraception utilization was tested by using Chi-square and Fisher's exact test. The level of significance for the association between these independent and dependent variables was set at $p\text{-value} \leq 0.05$. [13, 19].

4.8.1. Association between socio-demographic characteristics (Predisposing Factors) and utilization of contraception

Table – 15 shows the association between socio-demographic characteristics (Predisposing Factors) and utilization of contraception.

Age

The utilization of contraception (current users and non-users) was compared among the respondent's age. There was a significant difference between age group and utilization of contraception ($p\text{-values} < 0.05$). The average age of married women who are current contraceptive users was 33.67 ± 7.67 years old, while that of non-users was 30.88 ± 7.90 . Range of age are 18-49 for current users and 19-43 for non-users.

Ethnicity

The association between ethnicity and contraceptive utilization was not significantly differences ($p\text{-value} > 0.05$). The majority of current users (84.9%) and non-users (78%) were Kayin and 5.3% users were Burmese and 9.8% were Tamil. For the non-users 14% were Burmese and 8% were Tamil.

Religion

The respondents' religion was compared with the utilization of contraception and showing no significant difference ($p\text{-value} > 0.05$) between them. Majority of current users were Buddhist while the rest were Christian.

Level of education

The contraceptive usage and respondents' education level were compared and a statistically significant difference was found out in this study ($p\text{-value} < 0.05$). The proportion of contraception utilization was highest among literate married women (93.5%).

Occupation

To determine the association between contraceptive utilization and occupation, the occupation was categorized into dependents and working women. There was no significant difference between these two (p -value > 0.05). The majority of dependents (71.9%) use contraception while the others 28.1% were working women.

No. of living children

There was a statistical significant difference between contraception utilization and number of living children (p -value < 0.05). The contraception utilization was highest 84.9% among women who has 1- 3 children followed by 4 or more than that number of children 13.9% and least utilization among nonporous married women.

Table - 15 Association between socio-demographic characteristics (Predisposing Factors) and utilization of contraception (n=388)

Variables	Current users (n=338)		Non-users (n=50)		p-value
	Frequency	Percentage	Frequency	Percentage	
Age					
Mean (\pm Std. Deviation)	33.67(\pm 7.67)		30.88(\pm 7.90)		0.038 ^c
Min-Max	18-49		19-43		
Median	34		30.5		
Ethnicity					
Kayin	287	84.9	39	78.0	0.213 ^a
Non-Kayin	51	15.1	11	22.0	
Total	338	100.0	50	100.0	
Religion					
Buddhist	305	90.2	45	90.0	1.000 _b
Christian	33	9.8	5	10.0	
Total	338	100.0	50	100.0	
Level of Education					
Illiterate	22	6.5	20	40.0	0.000 ^a
Literate	316	93.5	30	60.0	
Total	338	100.0	50	100.0	
Occupation					
Dependent	243	71.9	36	72.0	1.000 _a

Working women	95	28.1	14	28.0
Total	338	100.0	50	100.0

No. of living children

0	4	1.2	2	4.0	0.016 ^b
1 - 3	287	84.9	35	70.0	
≥4	47	13.9	13	26.0	
Total	338	100.0	50	100.0	

a)Chi-Square Test, b) Fisher's Exact Test c)Mann Whitney U Test
Significant association at $p \leq 0.05$



4.8.2. Association between enabling factors and utilization of contraception

Table – 16 shows the association between enabling factors and utilization of contraception.

Family Income (Kyat)

A comparison between contraception utilization and respondents' monthly family income was presented in table - 17. The income was categorized into ≤ 130000 and >130000 Kyat (≤ 87 and > 87 USD). There was no significance difference between contraception utilization and income group (p-value > 0.05), 62.1% of current users had income ≤ 130000 kyats (≤ 87 USD) while the rest of current users earned higher.

Knowledge level

The knowledge about contraception was compared with the contraception usage and there was a statistically significant difference between these two variables with (p-value < 0.01). The use of contraception was highest (55.6%) among fair knowledge level while decrease to 34.35% among low level and (10.1%) of high level.

Attitude level

The association between attitude towards contraception and utilization was tested and no significant difference was found out (p-value > 0.05). Similarly, with the knowledge level the contraception utilization is high among moderate attitude (604%) and lowest (17.1%) among good attitude.

Service Providers

Regarding service provider, the majority 92.0% of users received services from female health workers while both of the gender 7.1% and least from male health workers 0.9%. There was no statistical significant (p-value > 0.05) between gender of service providers and contraception usage. There is also no significant difference between the gender of service providers with p-value < 0.05 . The majority of current users prefer same gender preferences (99.4%) while the rest current user replied for no preference.

Decision Maker for utilization of contraception

There was no statically significant difference between the decision makers and contraception utilization (p-value >0.05). The half 57.7% of current users' decision makers were their family members (husband, mother in law and mothers) and for non-users 50% of them decide by themselves while the rest by their family members.



Table - 16 Association between Enabling Factors and utilization of contraception (n=388)

Variables	Current users (n=338)		Non-users (n=50)		p-value
	Frequency	Percentage	Frequency	Percentage	
Family Income					
(Kyat)					
≤ 130000 (≤87 USD)	210	62.1	36	72.0	0.209 ^a
>130000 (>87USD)	128	37.9	14	28.0	
Total	338	100.0	50	100.0	
Knowledge level					
Low level of knowledge (<60%)	116	34.3	38	76.0	0.000 ^b
Fair level of knowledge (60-80%)	188	55.6	11	22.0	
High Level of knowledge (>80%)	34	10.1	1	2.0	
Total	338	100.0	50	100.0	
Attitude level					
Negative attitude (≤30.0)	76	22.5	8	16.0	0.439 ^b
Moderate attitude (30.1-35.5)	204	60.4	35	70.0	
Good attitude (≥35.6)	58	17.1	7	14.0	
Total	338	100.0	50	100.0	

Usually who provide you the service when you visit to health center

Male	3	0.9	1	10.0	0.350 ^b
Female	311	92.0	44	88.0	
Both	24	7.1	5	2.0	
Total	338	100.0	50	100.0	

Service Provider (Same Gender Preferences)

Yes	336	99.4	49	98.0	0.340 ^b
No	2	0.6	1	2	
Total	338	100.0	50	100.0	

Decision Maker for utilization of contraception

Self	143	42.3	25	50.0	.306 ^a
Family (Husband/Mother/M other in Law)	195	57.7	25	50.0	
Total	338	100.0	50	100.0	

a) Chi-Square Test, b) Fisher's Exact Test

Significant association at $p \leq 0.05$

4.8.3. Association between need factors and utilization of contraception

Table – 17 shows the association between need factors and utilization of contraception.

4.8.3.1. Need for services

Need for services implied for availability and accessibility to family planning services. **Availability of family planning services for contraception** expresses that the places to get contraception services (Where can you get the service for contraception), method availability and affordability for the cost of utilization. **Accessibility of family planning services for contraception** implies to address the distance and time of clients have to travel to get contraception, transportation from home and satisfaction for that services. All of these above variables were only counted for the respondents who had ever used contraception and those of currently using for the reason with the women who had experiences in using contraception. Therefore the results for these were prescribed only with percentage and frequencies and compared.

4.8.3.2. Need for information

Receiving of health education about contraception and number of health education types they had received

Assessment of the association between source of information (receiving health education about contraception) and utilization of contraception found out that there is a significant difference between these two variable with p-value <0.05. The current users 87.6% had received health education about contraception while the rest (12.4%) had not yet. There was significant difference between the number of health education types received by married women and contraception utilization (p-value <0.05). . Type of health education asked in the questionnaire were health talk as one type, pamphlets/brochure/leaflet as one type, cartoon booklet as one type, group training/workshop as one type, video as one type, wall sheet/poster as one type and total six types of health education which were supposed to common in Myanmar were assessed. Among the married women who had ever received health education session, most of them (86.4%) of users had received in only type of health education while 62.0% of non-users either. Responders who had received more than one type of health education about contraception were 1.2% among users and six percent among non-users.

Table – 17 Association between Need Factors and utilization of contraception (n=388)

Variables	Current users (n=338)		Non-users (n=50)		p-value
	Frequency	Percentage	Frequency	Percentage	
Need for information					
Receiving of Health Education about Contraception					
Yes	296	87.6	34	68.0	0.001 ^a
No	42	12.4	16	32.0	
Total	338	100.0	50	100.0	

Number of Health Education types

One type receiver	292	86.4	31	62.0	.000 ^b
Never Received	42	12.4	16	32.0	
More than one type receiver	4	1.2	3	6.0	
Total	338	100.0	50	100.0	

a) Chi-Square Test, b) Fisher's Exact Test

Significant association at $p \leq 0.05$



4.9. Results from multivariate analysis

In order to review the variables which were significant at bivariate level and to clear the association picture between these variables, the logistic regression was performed in table – 18. In bivariate analysis, ten variables were found to be significantly associated but in multivariate analysis, only three variables (age, level of education and level of knowledge) were found out to be statistically significant where number of living children, distance, transportation, affordability on cost for contraception, satisfaction upon services, receiving health education about contraception and number of types of health education had been received were turned out to be insignificant.

Respondent age was found statistically significant ($p\text{-value} \leq 0.05$) even after controlling other variables in multivariate analysis. The B coefficient value represented that the age of respondents has negative effect on utilization of contraception meaning the older women were less likely to use contraception than the younger age groups.

For educational level, the literate married women had 5.318 times higher contraception utilization rate than illiterate (AOR=5.318, 95% CI: 2.348, 12.043). The level of education still had effect on contraception usage in multivariate analysis with $p\text{-value} < 0.001$.

For number of living children, the AOR of married women having (1-3) living children and 4 or more living children are AOR < 1 even though statistical not achieved. This is possible to reduce the non-usage of contraception 0.974-fold odd for having (1-3) living children (AOR=0.974, 95% CI: 0.092,10.315) and having 4 or more living children by 0.509 (AOR=0.509, 95% CI: 0.200,1.298).

For knowledge level about contraception, high level of knowledge about contraception had 1.694 times higher utilization of contraception rate than other lower level and fair level of knowledge had 6.083 times higher. Among the level of knowledge, high level of knowledge still had effect on contraception usage in multivariate analysis with $p\text{-value} < 0.05$.

For receiving health education session about contraception, there was no statistical achievement. The B coefficient values representing not being not receiving health education session had negative effect on utilization of contraception meaning the women who are not receiving health education are less likely to use contraception than

opposite groups. And the last one is number of type of health education received OR <1, receiving more than one type of health education session is the possible to lower 0.243-fold odd of non-utilization of contraception (AOR= 0.243; 95% CI: 0.043,1.370) compared to receiving one type of health education session.

TABLE - 18 LOGISTIC REGRESSION ANALYSIS OF VARIABLES THAT MAINTAIN SIGNIFICANT STATISTICAL ASSOCIATION

Variables	B	Odd Ratio	95% CI		p-value
			Lower	Upper	
Respondent Age	-0.068	0.934	0.888	0.983	0.009*
Level of Education					
Illiterate	1 (Reference)				
Literate	1.671	5.318	2.348	12.043	0.000*
No. of living children					
0	1 (Reference)				
1 - 3	-0.026	0.974	0.092	10.315	0.983
≥4	-0.676	0.509	0.200	1.298	0.157
Knowledge level					
Low level of knowledge (<60%)	1 (Reference)				
Fair level of knowledge (60-80%)	1.805	6.083	0.780	47.425	0.085
High Level of knowledge (>80%)	0.527	1.694	0.208	13.805	0.026*
Receiving of Health Education about Contraception					
Yes	1 (Reference)				
No	-1.414	0.243	0.043	1.370	0.109
Number of Health Education types					
One type receiver	1 (Reference)				
Never Received					
More than one type receiver	-1.414	0.243	0.043	1.370	0.109

*Significant at $p \leq 0.05$

Chapter V

Discussion, Conclusion and Recommendation

The main purpose of this study was to assess the proportion of married women of reproductive age living in the rural area of Kayin state, Myanmar utilizing family planning services for contraception and to determine the factors affecting the utilization of contraception among these women from rural area of Kayin state, Myanmar.

The expectation of this study is that the outcome could be useful as the base line information of utilization of family planning services among Myanmar married women living in rural area to health authorities for further promoting contraceptive usage and family planning knowledge to Myanmar married women.

This discussion part covers the research questions with the description of the association between results and places it in context of the literature for conclusion and further recommendations.

5.1. Discussion

5.1.1. What proportion of married women of reproductive age living in the rural area of Kayin state, Myanmar utilizing family planning services for contraception

Proportion of married women of reproductive age living in the rural area of Kayin state, Myanmar utilizing family planning services for contraception was measured by the percentage of married women in the reproductive age using contraception by herself or her husband. The contraceptive utilization rate among the recruited married women in Hpa-an was 87.1% out of which 90.6% uses short-termed contraceptives, seven percent applies to long-termed methods and the rest two percent consumes the permanent method of female sterilization. It was higher than the contraceptive prevalence rate described in the [6, 19] and Hpa-an township profile data in 2017. This showing that the contraceptive utilization proportion was not equal among the states in the country. Hpa-an townships is developing during these days and the proper roads which is connected to every major villages are setting up. Therefore, the accessibility to the contraceptive services is within the reach of rural community even though they have to travel for some hours.

For the contraceptive methods choice, over the half of respondents consumes injection (60.1%) followed by 28.1% pills and then by four percent IUD these result

trend is consistent with the statistic results from Myanmar Demographic Health survey data done in 2017[6]. In this study, the main reasons for not using contraception were that 34.0% they wanted more children as half of the respondents have 1-2 living children, while 26% of respondents replied as they afraid of side effects with the results most of the non-users (76%) has low level of knowledge of contraception, 18% thought that they cannot conceive as they have less sexual activity consistent with the results older women are less likely to use contraception and ten percent far from home though Majority of respondents responded as half an hour or one hour from home and they mostly use their private vehicle to go to the health care facility. Moreover, a few number of respondents eight percent replied that they don't like contraception and four percent perceived that contraception are expensive.

5.2. What are the factors affecting the contraception utilization and what relationships are statistically significant in affecting the contraception usage?

5.2.1. Predisposing factors/socio-demographic characteristics

Regarding the age, all the participants were reproductive age women within the age group of 18-49 years old in the study. The bulk of respondents (75.3%) were in the age of 25 to 44 years. Only five percent of respondents were younger than 20 years while nine percent and ten percent of them were 20 to 24 years and 45 to 49 years respectively. The mean age was 33.31 with SD 7.74.

There was a statistically significant difference between respondent age and contraception usage with (p-values < 0.05) in bivariate analysis. The average age of married women who are current contraceptive users was 33.67 ± 7.67 years old, while that of non-users was 30.88 ± 7.90 . This finding is similar with the study done in Mandalay, Myanmar[19].

In multivariate analysis, age was found statistically significant (p-value ≤ 0.05) even after controlling other variables same with the study [31]. Respondents age was found statistically significant (p-value ≤ 0.05) even after controlling other variables in multivariate analysis. The B coefficient value represented that the age of respondents has negative effect on utilization of contraception meaning the older women were less likely to use contraception than the younger age groups. It seems to be that the younger

generation women more likely to use compared to the older age group, as the older women may have less sexual activity and they perceived lower chance to get conceived.

Ethnicity and religion were found no significant affect upon contraception utilization. This has similar agreement with the study done in Ghana[32] for ethnicity while for religion similar with [19]. Among the respondents, the majority of current users (84.9%) were Kayin and five percent users were Burmese and more than nine percent were Tamil. Similarly, most of the current users were Buddhist while the rest were Christian. This is because there were not much different ethnic and religious groups among the respondents.

The contraceptive usage and respondents' education level were compared and a statistically significant difference was found out in this study (p -value <0.05) in bivariate analysis. This result is same with the study done in Ethiopia and Myanmar, Mon state [17, 34]. The proportion of contraception utilization was lowest among women who never go to primary school level 0.9% and illiterate 5.7%. Generally, education is like a vehicle to learn about the health knowledge in family planning and may lead to small family size.

However, after controlling the other independent variables in multivariate analysis, education still had an influence upon contraception usage. The literate married women had 5.786 times higher contraception utilization rate than illiterate (AOR=5.786, 95% CI: 2.224, 15.055). The level of education still had effect on contraception usage in multivariate analysis with p -value <0.001 . This finding is in contrast with the study done among Myanmar migrant women from Thailand[31]. Therefore, literate women are expected to consume more contraception.

The majority of the women who use contraception currently were dependents (71.9%) use contraception while the others 28.1% were working women. There was no significant difference between occupation and contraception usage (p -value > 0.05) in bivariate analysis. The results are consistent with the studies done in Phang-Nga Province, Thailand and Mandalay, Myanmar [19, 31]. As the dependents women are more likely to use contraception, those who had not worked might not have enough money for raising children compared to the working mother who can support the family and children.

The number of living children is also one of the important factor which can affect the contraception utilization. The contraception utilization was highest 86.1% among women who has less than or equal 3 children followed by 4 or more than that number of children 13.9%. In bivariate analysis, there was a statistical significant difference between contraception utilization and number of living children (p-value < 0.05). In multivariate analysis, the number of living children has no longer significant difference upon utilization of contraception. The married women having (1-3) living children- OR>1 and having 4 or more living children- OR<1, even though statistical not achieved. This is possible to increase the non-usage of contraception 1.230-fold odd for having (1-3) living children (AOR=1.230, 95% CI: 0.089, 17.087) and having 4 or more living children is possible to reduce the non-utilization rate 0.484 (AOR=0.484, 95% CI: 0.155, 1.510). The results is controversial with the study done in Phang-Nga Province, Thailand[31]. The married women with more living children are more likely to use contraception than those of less number of living children.

5.2.2. Enabling factors

Average family income was 132525 Kyat (about 90 USD) which is almost the same with the average income of each person had been prescribed for a year of (2016-2017) as 1,337,319 in Hpa-an township GAD profile. In bivariate analysis, there was no significance difference between contraception utilization and income group (p-value > 0.05), (62.1%) of current users had income \leq 130000 kyats (\leq 87 USD) while the rest of current users earned higher same with the married women of reproductive women from Mandalay, Myanmar [19].

Regarding the knowledge about contraception, the majority of women heard of 3 months' injections, OC pills, female sterilization, male condoms, IUD, implant and traditional methods. The knowledge about contraception was compared with the contraception usage and there was a statistically significant difference between these two variables with (p-value <0.01). Likewise with the studies from Ethiopia, Thailand and Myanmar [17, 19, 31, 38]. Moreover, the association between the knowledge about contraception and contraceptive utilization were statistical achieved in multivariate analysis. High level of knowledge about contraception had 2.28 times higher utilization of contraception rate than other lower level and fair level of knowledge. Among the level of knowledge, high level of knowledge still had effect on contraception usage in

multivariate analysis with p -value <0.001 . It is possible to assume that poor level of knowledge about contraception is the indicators which can lead to misuse and unwanted pregnancies.

For the attitude towards the contraception, no significant difference was found out (p -value > 0.05) between the attitude and contraception utilization in bivariate analysis which is consistent with the study among Myanmar migrant women from Thailand [31]. Similarly, with the knowledge level the contraception utilization is high among moderate attitude 604% and lowest 17.1% among good attitude. However, attitude scores are high among current-users but there was not much different attitude level among respondents (users and non-users).

Regarding service provider, the majority of (92.0%) of users received services from female health workers while both of the gender seven percent and least from male health workers less than one percent 0.9%. In bivariate analysis, there was no statistical significant (p -value >0.05) between gender of service providers and contraception usage same with the study from Butan [13]. There is also no significant difference between the same gender preference with p -value <0.05 . The majority of current users prefer same gender preferences (99.4%) while the rest current user replied for no preference. It is showing the community prefer the same gender service provider even though they are not statistically significant and it is possible to assume that there was not much significant perception upon the gender of services providers as most of the service providers were female for RH services.

Main mediating in utilization of contraception is decision maker for women using contraception or not. There was no statically significant difference between the decision makers and contraception utilization (p -value >0.05) in bivariate analysis. The result is polemical with the study from Butan [13]. The half (56.5%) of current users' decision makers were their husbands and 42.3% of them were by themselves while the rest 1.2% was by mother/mother in law.

5.2.3. Need factors

Availability, accessibility and health education about contraception are important factors in contraceptive usage among rural people. The rural community suffer more from geographical, time, economic and cultural challenges than those from

urban. In term of place to get contraception, the half of current-users (58.9%) and 56.1% of ever-used women mentioned that rural health centers (RHC) for receiving contraception. One third of ever-used women (34.1%) and (28.7% of current users) thought hospital as service point for contraception. [19].

Continuing in Table 11, most of the injectable users (69.5%) got the services from RHC while 29.6% from hospital and one percent from drug store. However, for OC pills users half of (50.5%) received from RHC, one third (36.8%) from Drug store and 12.6% from hospital. Half of (50.0%) condom users obtained from drug store, (12.5%) from hospital and 37.5% from RHC. For IUD users, 50.5% went to hospital, 42.9% in RHC and seven percent in private clinic. For the implant services, most of them (90%) got from hospital. Female sterilization is available only in hospital. It was assumed that the method availability of long-termed methods is found out to be still low in the places where most of respondents receive the contraception (RHC and Hospital) and there was also some missed information available in a certain level.

Regarding the perception upon the cost Most respondents (99.7% of current users and 90.0% of ever-used women) said that they could afford for the cost while less than one percent of current-users and ten percent of ever-used women responded as they could not afford which is a controversial results done in Thailand [45].

Majority of women participated in the study (92.3% of current users and 92.7% of ever-used women) said that it took half an hour to one-hour from their home to the place to get contraception while (five percent of users and two percent of ever-used women) and (two percent of users and five percent of ever-used women) responded that it took two hours and one hour respectively.

This variable is brought to think for the respondents who had ever used contraception and those of currently using only.

Half of the respondents (69.5% of users) said that they used private vehicle to go to place for getting contraception while the another user 16.6% and 8.6% used walking and public vehicle respectively. The rest 5.3% of users asked someone to buy the contraception for them. Similarly, the half ever-used women (63.4%) responded that they could use their private vehicle to go to the health center and 17.1% of each could use walking and public vehicle. The only two percent of non-users said that they used to ask someone to buy contraception for them. It is possible to assume that walking

could be due to near to service point and some reasons of non-users are too far to the service point.

For the satisfaction on upon services, the hundred percent of current-users replied that they were satisfied upon the contraception services they received. In addition, the reasons for satisfaction were mentioned in table - 13. Nearly half of the respondents (45.4%) who satisfied upon the contraception services were due to low cost or free of charge for services. The other reasons were no time to wait to get the services 34.6%, having privacy and confidentiality 12.4%, friendly service providers 5.7%, near from home 1.6% and the left 0.3% was due to maintain the health of respondents. The percentage were reflecting that the women who are not satisfied upon services are less likely to use contraception than opposite groups.

Likewise, health information availability was found to be significant statistically for current users in bivariate analysis (p-value <0.05). Women who received health information would like to use contraception 87.6%. In multivariate analysis it has no longer effect upon significant. The B coefficient values representing women who hadn't received health education about contraception had negative effect on utilization of contraception meaning that women are less likely to use contraception than opposite groups.

For the received numbers about types of health education, there was significant difference between the number of health education types received by married women and contraception utilization (p-value <0.05). The mentioned typed of types of health educations had been received by current users (range 0-6) and for that of the non-users had received up to only three types of health education about contraception showing the more types of health education about contraception they received the more rate of contraception usage. However, there was no longer significant in multivariate analysis, is the possible to increase 1.161-fold odd of non-utilization of contraception (AOR= 1.161; 95% CI: 0.468, 1.427). The number of health education types is assumed to have less effect upon contraceptive utilizations as some of the health education types cannot be easily absorbed by community and the way of providing health education to influence the community is sometimes difficult.

5.3. Conclusion

Although, Kayin State is one of the least utilization percentage of modern contraceptive methods among states and regions (25 percent-40 percent) and also one of the highest unmet needs for contraception among states and regions of Myanmar, there is no previous community-based study upon contraception utilization for rural area of Hpa-an township. This study will provide the base line information of utilization of family planning services among Myanmar married women living in rural area to health authorities for further promoting contraceptive usage and family planning knowledge to Myanmar married women.

The data were collected from the six villages of Hpa-an township, Kayin State, Myanmar (Kyauk Ta Lone, Paw Taw Mu, Htone Aing, Phar Lin, Kawt Hta Ma Lain and Htee Htar Pha Lo villages). A total of 388 married reproductive aged women were interviewed in this study.

The main purpose of this study is to assess the utilization of family planning services for contraception and factors affecting upon that contraceptive usage among married reproductive aged women in rural areas, Kayin State, Myanmar.

Data analysis was processed by using SPSS software version 22 (licensed from Chulalongkorn University) for windows. Person's Chi-square test was used and results did not meet the assumption Fisher's exact test was used (if the cells frequencies are less than 5, 20 percent with P value level of 0.05. After that, multiple logistic regression was used in order to find out the associations between multiple independent variables and a dichotomous dependent variable.

This study revealed that the proportion of married reproductive aged women who consume contraception was 87.1%. The most common used methods were injectable and OC pills. The common reasons for not utilizing the contraception were want to get pregnant, afraid of side effect and another Health reasons as being old to get conceived and less sexual activity. The key factors affecting the usage of contraception were age, level of education, number of living children, knowledge about contraception, receiving health education about contraception and number of health education type received in bivariate analysis.

In multivariate analysis, only women age, level of education, knowledge level and receiving status of health education about contraception are significant after

controlling other independent variables. The study also revealed that high education level and high knowledge is the indicators which can prevent the menses and unwanted pregnancies. Though married women received health information up to a certain level, some still want to get more information and health education about contraception.

5.4. Recommendation

The proportion of contraception in this study 87.1% is satisfactory; however, the remaining 20% should also be encouraged by providing proper information. The utilization rate of short-termed methods 90.6% is enormously high compared to long termed methods, to promote the long termed contraception utilization, method-based health education and information sections should be developed.

The method availability of long-termed methods is found out to be still low in the places where most of respondents receive the contraception (RHC and Hospital), the availability of long-termed methods should be promoted and encourage to share the available methods at these service points. Health service programs and strategies of the country at each level of health care delivery system need to consider the involvement of males for modern contraceptives utilization.

In this study, most of the respondents were older age of 35 years and older but these groups is highest proportion among the non-users. In addition, the multivariate revealed that older women were less likely to use contraception than the younger, specific age-group targeting health education should be innovated and implemented among community for this area.

The education plays major role in sexual reproductive health. Reinforcing the collaboration with other non-health sectors, especially education sector is needed. Information, education and communication activities concerning reproductive health should be expanded.

REFERENCES



จุฬาลงกรณ์มหาวิทยาลัย
CHULALONGKORN UNIVERSITY

**APPENDIX A. INFORMED CONSENT FORM WITH PERSONAL
INFORMAITON (ENGLISAH)**

**Ethics Review Committee
Department of Medical Research
Ministry of Health and Sports
The Republic of the Union of Myanmar
Informed Consent Form**

This informed consent is for the married women of reproductive age living in the rural area of Kayin State, Myanmar who are invited to participate in the research **“FACTORS AFFECTING UTILIZATION OF FAMILY PLANNING SERVICES AMONG MARRIED WOMEN OF REPRODUCTIVE AGE LIVING IN THE RURAL AREA OF KAYIN STATE, MYANMAR”**.

Name of Principal Investigator : Dr Sabai Tun
Name of Organization : Master of Public Health student, College of Public Health Science, Chulalongkorn University, Thailand.
Name of Sponsor : Self
Tittle of the Study :“FACTORS AFFECTING UTILIZATION OF FAMILY PLANNING SERVICES AMONG MARRIED WOMEN OF REPRODUCTIVE AGE LIVING IN THE RURAL AREA OF KAYIN STATE, MYANMAR”

**PART I: Information Sheet
Introduction**

I am Dr Sabai Tun, Master of Public Health student, College of Public Health Science, Chulalongkorn University, Thailand. We are doing research on **“FACTORS AFFECTING UTILIZATION OF FAMILY PLANNING SERVICES AMONG MARRIED WOMEN OF REPRODUCTIVE AGE LIVING IN THE RURAL AREA OF KAYIN STATE, MYANMAR”**. I am going to give you information and **invite you** to participate in this research. There may be some words that you do not understand. If you do not understand any word, you can ask me or other research team members at any time.

Purpose

The purpose of this study is to find out the prevalence of utilization of family planning services for contraception and its associated/ influencing/ underlying factors among married reproductive aged women in rural areas, Kayin State, Myanmar. It will help married reproductive aged women to improve health care.

Type of Research Intervention

Married reproductive aged women will be interviewed by applying the structured questionnaire. Face-to-face interview will be conducted and it will take about 15 minutes.

Participant selection

You are being invited to take part in this research because you are a married women of reproductive age between 18-49 years living in the rural area of Hpa-an Township, Kayin State, Myanmar.

Voluntary Participation

Your participation in this research is entirely voluntary. It is your choice whether to participate or not. It will not affect any medical care even if you choose not to participate. You may change your mind later and stop participating even if you agreed earlier.

Procedures and Protocol

We would like to invite you for interview. Interview will take about 15 minutes. Anonymity and confidentiality of the information will be ensured and only researchers will have accessed to the information.

Duration

The research will take place about *15 minutes* and you are invited once to participate in the study.

Risks and discomfort

You may refuse to answer any question or not take part in a portion of the interview if you feel the question(s) are personal or if talking about them makes you uncomfortable.

Confidentiality

The research being done in the community may draw attention and you may be asked questions by other people in the community. However, we will inform the community that the research is related to some health activities. Hence, the community will not know the entire purpose of the study. We will not be sharing information about you to anyone outside of the research team. The information that we collect from this research project will be kept private. Any information about you will have a number on it instead of the name. Only the researchers will know what your number is and we will lock that information up with a lock and key. It will not be shared with or given to anyone except the investigators.

Sharing the Results

The knowledge that we get from this research will be shared with you and will also be published so that other interested people may learn from the research.

Who to Contact

If you have any questions, you can ask me or the research team members now or later. If you wish to ask questions, you may contact **Dr. Sabai Tun**, Principal *Researcher*, Master of Public Health student, at College of Public Health Sciences, Chulalongkorn University, Tel:+959-5173440, No.(294), *KhayMarThi Road, North Okkalapa, Yangon*, Email: sabaitun16@gmail.com.

This proposal has been reviewed and approved by the Ethics Review Committee, Department of Medical Research which is a committee whose task is to make sure that research participants are protected from harm. If you wish to find out more about the Committee, contact the secretary of the committee at the Department of Medical Research, No.5, Ziwaka Road, Dagon PO, Yangon, 11191, phone 01- 375457- ext: 118 (during office hours)

PART II: Certificate of Consent

I have been invited to participate in research about **“FACTORS AFFECTING UTILIZATION OF FAMILY PLANNING SERVICES AMONG MARRIED WOMEN OF REPRODUCTIVE AGE LIVING IN THE RURAL AREA OF KAYIN STATE, MYANMAR”** I have been informed that there is no risk from the research. I am aware that there may be benefit personally by learning mindfulness practice and knowledge on reproductive health. I have been provided with the name and address of a researcher who can be easily contacted.

“I have read the forgoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study and understand that I have the right to withdraw from the study at any time without in any way affecting my medical care.”

Name of participant _____

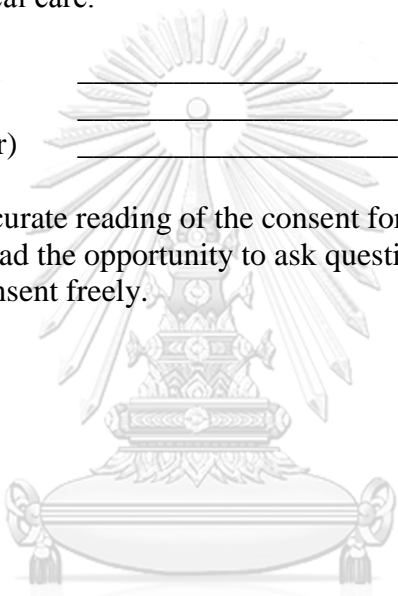
Signature of participant _____

Date (Day/ Month/ Year) _____

If illiterate

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Thumb print of a participant



If illiterate

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Name of witness _____

Signature of witness _____

Date (Day/ Month/ Year) _____

I have read or witnessed the accurate reading of the consent form of the potential participant and the individual has had the opportunity to ask questions.

I confirm that the individual has given consent freely.

Name of Researcher _____

Signature of Researcher _____

Date (Day/ Month/ Year) _____

A copy of this Informed Consent Form has been provided to participant _____
(initialed by the researcher/assistant)

APPENDIX B. INFORMED CONSENT FORM WITH PERSONAL INFORMATION (MYANMAR)

လူပုဂ္ဂိုလ်များအပေါ် သုတေသနစမ်းသပ်မှုဆိုင်ရာကျင့်ဝတ်ကော်မတီ

ဆေးသုတေသနဦးစီးဌာန

ကျန်းမာရေးနှင့် အားကစားဝန်ကြီးဌာန

ပြည်ထောက်စုသမ္မတမြန်မာနိုင်ငံတော်

သုတေသနလုပ်ငန်းတွင် ပါဝင်ဆောင်ရွက်ရန် သဘောတူညီချက်တောင်းခံခြင်း

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သုတေသနပြုသူအမည် ဒေါက်တာ စံပယ်ထွန်း
ရာထူး ပြည်သူ့ကျန်းမာရေးပညာ မဟာဘွဲ့ကျောင်းသူ
ထောက်ပံ့သောအဖွဲ့ ကိုယ်တိုင်
သုတေသနစာတမ်းခေါင်းစဉ် “ကရင်ပြည်နယ်/ ဘားအံမြို့နယ်၏ ကျေးလက်ဒေသနေရာများတွင် နေထိုင်လျက်ရှိသော မျိုးဆက်ပွားနိုင်သည့် သက်အရွယ်အတွင်းရှိ အိမ်ထောင်သည် အမျိုးသမီးများ အကြား မိသားစုစီမံကိန်းနှင့် သားဆက်ခြားနည်းလမ်းများ အသုံးပြုခြင်းနှင့် ပတ်သက်၍ ကျန်းမာရေးစောင့်ရှောက်မှုရယူခြင်း ဆိုင်ရာ အမူအကျင့်များကို လေ့လာသော သုတေသန”

အပိုင်း (၁) သုတေသန အချက်အလက်များ နှုတ်ခွန်းဆက်

ကျွန်မသည် ပြည်သူ့ကျန်းမာရေးသိပ္ပံဌာန၊ ချူလာလောင်ကွန်း တက္ကသိုလ်တွင် ပြည်သူ့ကျန်းမာရေး မဟာဘွဲ့အတွက် တက်ရောက်လေ့လာနေသူဖြစ်ပါသည်။ ကျွန်မသည် “ကရင်ပြည်နယ်/ ဘားအံမြို့နယ်၏ ကျေးလက်ဒေသနေရာများတွင် နေထိုင်လျက်ရှိသော မျိုးဆက်ပွားနိုင်သည့် အသက်အရွယ်အတွင်းရှိ အိမ်ထောင်သည် အမျိုးသမီးများ အကြား မိသားစုစီမံကိန်းနှင့် သားဆက်ခြားနည်းလမ်းများ အသုံးပြုခြင်းနှင့် ပတ်သက်၍ ကျန်းမာရေးစောင့်ရှောက်မှုရယူခြင်း ဆိုင်ရာ အမူအကျင့်များကို လေ့လာသော သုတေသန” ကို လုပ်ဆောင်မည် ဖြစ်ပါသည်။ သင့်ကို ကျွန်မ၏ သုတေသနတွင် ပါဝင်ရန်

ဖိတ်ခေါ်အပ်ပါသည်။ နားမလည်သော စကားရပ်များ ရှိပါက ကျွန်ုပ် (သို့မဟုတ်) သုတေသနတွင် ပါဝင်သော ဝန်ထမ်းတစ်ဦးဦးအား အချိန်မရွေး မေးမြန်းနိုင်ပါသည်။

သုတေသနလုပ်ခြင်းရည်ရွယ်ချက်

ဤသုတေသနရည်ရွယ်ချက်မှာ “ကရင်ပြည်နယ်၊ ဘားအံမြို့နယ်၏ ကျေးလက်ဒေသနေရာများတွင် နေထိုင်လျက်ရှိသော မျိုးဆက်ပွားနိုင်သည့် အသက်အရွယ်အတွင်းရှိ အိမ်ထောင်သည် အမျိုးသမီးများ အကြား မိသားစုစီမံကိန်းနှင့် သားဆက်ခြားနည်းလမ်းများ အသုံးပြုခြင်းနှင့် ပတ်သက်၍ ကျန်းမာရေးစောင့်ရှောက်မှုရယူခြင်း ဆိုင်ရာ အမူအကျင့်များ နှင့် ယင်းတို့နှင့် သက်ဆိုင်သည့် အချက်အလက်များကို လေ့လာဖော်ထုတ်ခြင်းဖြင့် အိမ်ထောင်သည် အမျိုးသမီးများ အတွက် ကျန်းမာရေးစောင့်ရှောက်မှု ပိုမိုတိုးတက်ကောင်းမွန်လာစေရန် ရည်ရွယ်ပါသည်။

သုတေသန အတွင်းလုပ်ဆောင်မှု အမျိုးအစား

ဤသုတေသနတွင် မျိုးဆက်ပွားနိုင်သော အသက်အရွယ်အတွင်းရှိ အိမ်ထောင်သည် အမျိုးသမီးများ အားတွေ့ဆုံ၍ မေးခွန်းလွှာဖြင့် မေးမြန်းခြင်းကို ပြုလုပ်မည် ဖြစ်ပါသည်။ မေးခွန်းလွှာဖြင့် မေးမြန်းခြင်းမှာ ၁၅-မိနစ်ခန့် ကြာမြင့်မည်ဖြစ်ပါသည်။

သုတေသနတွင် ပါဝင်မည့်သူများကို ရွေးချယ်ခြင်း

သင်သည် အသက် ၁၈ နှစ်မှ ၄၉ နှစ် အတွင်းရှိ အိမ်ထောင်သည် အမျိုးသမီးတစ်ဦး ဖြစ်သည့် အတွက် သုတေသနတွင် ပါဝင်ရန် ဖိတ်ခေါ်ခြင်း ဖြစ်ပါသည်။

မိမိဆန္ဒအရ သုတေသနတွင် ပါဝင်ခြင်း

ဤသုတေသနတွင် ပါဝင်ခြင်းမှာ သင်၏လွတ်လပ်သော သဘောဆန္ဒ အရ သာ ဖြစ်ပါသည်။ ပါဝင်ခြင်းမရှိပါကလည်း သင့်၏ ကျန်းမာရေးစောင့်ရှောက်မှုကို မည်သို့မှ ထိခိုက်စေမည်မဟုတ်ပါ။ ဤသုတေသနတွင် ပါဝင်ရန် သဘောတူခဲ့သော်လည်း အချိန်မရွေး အကြောင်းပြချက်မလိုဘဲ နှုတ်ထွက်ခွင့် ရှိပါသည်။

သုတေသနလုပ်ငန်းလုပ်ဆောင်ချက်

သင့်ကို မိသားစုစီမံကိန်းနှင့် သားဆက်ခြားနည်းလမ်းများ အသုံးပြုခြင်းနှင့် ပတ်သက်၍ ကျန်းမာရေးစောင့်ရှောက်မှုရယူခြင်း ဆိုင်ရာ အမူအကျင့်များ နှင့် ယင်းတို့နှင့် သက်ဆိုင်သည့် အချက်အလက်များကို မေးခွန်းလွှာဖြင့် မေးမြန်းခြင်းတွင် ပါဝင်ရန် ဖိတ်ခေါ်ပါမည်။ ထိုသို့ မေးမြန်းခြင်းမှာ ၁၅-မိနစ်ခန့် ကြာမြင့်မည်ဖြစ်ပါသည်။ သင်ဖြေဆိုသည့် အကြောင်းအရာများကို လျှို့ဝှက်စွာ စောင့်ထိန်းမည် ဖြစ်ပြီး သုတေသနအဖွဲ့ဝင်များမှလွဲ၍ အခြားသူများကို သိရှိခွင့်ပေးမည်မဟုတ်ပါ။

အချိန်အပိုင်းအခြား

သုတေသနအတွက် မေးမြန်းချိန်မှာ (၁၅) မိနစ်သာ ကြာမြင့်မည် ဖြစ်ပြီး၊ သင့်ကို တစ်ကြိမ်သာ မေးမြန်းမည် ဖြစ်ပါသည်။

ကိုယ်စိတ်အနှောင့်အယှက်ဖြစ်စေခြင်း

မေးခွန်းများဖြေဆိုရာတွင်လည်း သင့်အနေနှင့် မဖြေချင်သော မေးခွန်းများရှိပါက မဖြေဘဲနေနိုင်ပါသည်။ သင့်အနေနှင့် ဖြေဆိုရန် အခက်အခဲရှိပါက (သို့မဟုတ်) မေးခွန်းများသည် ပုဂ္ဂိုလ်ရေးဆန်လွန်းပါက ထိုမေးခွန်းများကို ဖြေဆိုရန် မလိုပါ။

လျှို့ဝှက်ထားရှိမှု

ဤသုတေသနဆောင်ရွက်ခြင်းကို အခြားသူများက သတိပြုမိကောင်းပြုမိနိုင်ပြီး မေးမြန်းခြင်းမျိုးရှိနိုင်ပါသည်။ ကျန်းမာရေးနှင့်ဆိုင်သော လုပ်ငန်းတစ်ခုအဖြစ်သာ အသိပေးမည်ဖြစ်ပါသည်။ သုတေသန လုပ်ငန်းတစ်ခုလုံးအကြောင်းကို သိရှိကြမည်မဟုတ်ပါ။ သင်ဖြေကြားပေးလိုက်သော အကြောင်းအရာများကိုလည်း သုတေသနအဖွဲ့ဝင်များမှလွဲ၍ အခြားမည်သူမျှသိရှိကြမည်မဟုတ်ပါ။ အကြောင်းအရာအချက်အလက်များကိုလည်း သုတေသနအဖွဲ့ဝင်များမှလွဲ၍ အခြားမည်သူနှင့်မျှပြောဆိုခြင်း ပြုမည်မဟုတ်ပါ။ အကြောင်းအရာအချက်အလက်များကို အမည်ဖြင့်မမှတ်ဘဲ ဂဏန်းအမှတ်အသားဖြင့်သာ မှတ်ပါမည်။ ယင်းဂဏန်းအမှတ်အသားကိုလည်း သုတေသနအဖွဲ့ဝင်များကသာ သိကြမည်ဖြစ်ပြီး အကြောင်းအရာများကို လုံခြုံစွာသော့ခတ် သိမ်းဆည်းထားမည် ဖြစ်ပါသည်။

အဖြေများကိုမျှဝေခြင်း

ဤသုတေသနမှ ရရှိသောအဖြေများကို သုတေသန တွင် ပါဝင်သူများအား ပြန်လည် အသိပေးမည်ဖြစ်ပါသည်။ အခြား စိတ်ဝင်စားသောသူများ အတွက် သုတေသနစာတမ်းထုတ်ဝေခြင်းကိုလည်း ပြုလုပ်မည်ဖြစ်ပါသည်။

ဆက်သွယ်ရန်

အကယ်၍ သင့်၌မေးစရာမေးခွန်းများ ရှိနေပါက အချိန်မရွေးမေးမြန်းနိုင်ပါသည်။ မေးစရာရှိလျှင် ဒေါက်တာစံပယ်ထွန်း ဖုန်းနံပါတ် ၀၉ ၅၁၇၃၄၄၀၊ အမှတ် (၂၄၉)၊ ခေမာသီလမ်းမကြီး၊ မြောက်ဥက္ကလာပမြို့နယ်၊ ရန်ကုန်မြို့၊ သို့ဆက်သွယ်နိုင်ပါသည်။ ဤသုတေသန အဆိုပြုလွှာကို လူပုဂ္ဂိုလ်များအပေါ် သုတေသနစမ်းသပ်မှုဆိုင်ရာ ကျင့်ဝတ်ကော်မတီ၊ ဆေးသုတေသနဦးစီးဌာန ၏ သဘောတူညီချက်ရယူပြီးဖြစ်ပါသည်။ သင့်အနေဖြင့် ဤကော်မတီအကြောင်းကို စုံစမ်းလိုပါက အတွင်းရေးမှူး(ကော်မတီ)၊ ဆေးသုတေသနဦးစီးဌာန၊ အမှတ်(၅)၊ ဇီဝကလမ်း၊ ဒဂုံမြို့နယ်၊ ရန်ကုန်မြို့။ စာတိုက်သေတ္တာအမှတ် - ၁၁၁၉၁၊ ဖုန်း- ၀၁- ၃၇၅၄၅၇၊ လိုင်းခွဲ-၁၁၈ သို့ ရုံးချိန်အတွင်းဆက်သွယ်မေးမြန်းနိုင်ပါသည်။

APPENDIX C. A QUESTIONNAIRE (ENGLISH)

The questionnaire on “Factors affecting utilization of family planning services among married women of reproductive age (18-49 years) living in the rural area of Kayin State, Myanmar”

Instruction: Please tick in [] or fill in

Study No

Date/...../.....

Address

1. How old are you? Age Years

2. What is your ethnicity?

a. Kayin

b. Pao

c. Burmese

d. Others (specify)

3. What is your religion? (Tick one only)

a. Buddhist

b. Christian

c. Islam

d. Others (specify)

4. What is your highest educational level completed? (Tick one only)

a. Illiterate

b. able to read and write or basic monastery school

c. primary school level
(equivalent to Grade 1 to Grade 5)

d. middle school level
(equivalent to Grade 6 to Grade 9)

e. high school level (equivalent to Grade 10 to Grade 11)

f. higher than high school level (any level higher than high school like university or master or PHD)

5. What is your main occupation(Tick one only)

a. Employee (Government)

b. Housewife

c. Farmer/Fisherman

d. Unemployed

e. Own business

f. Self-employee (Daily paid worker)

g. Students

h. Others (specify)

6. **How many living children do you have now?**
person
7. **How many total family members in the respondent's family?**
person
8. **How many working family members in the respondent's family?**
person
9. **Estimated total family income per month of respondent**
MMK

10. Do you or your partner even use contraception?

<input type="checkbox"/> A. Yes and currently used.	<input type="checkbox"/> B. Ever use and stopped	<input type="checkbox"/> C. Never use
<input type="checkbox"/> i). Which method are you or your partner using now? (Answer only one method)	<input type="checkbox"/> i). How long have you been stop using the contraceptive method? days/months/years	<input type="checkbox"/> i).Never use contraception before
If yes, what is the most important reason of using of contraception?	What is the main reason that you stopped using contraception? Explain	What is the most important reason for not using of contraception?
<input type="checkbox"/> a. Prevent Pregnancy	-----	-----
<input type="checkbox"/> b. Provide better life for my children	-----	-----
<input type="checkbox"/> c. Maintain my health	If ever use or never use, go to Question no. 10.1	
<input type="checkbox"/> d. Regulate menstruation	10.1	Can you explain more reason for not using contraception?
<input type="checkbox"/> e. Improve financial conditions of my family	<input type="checkbox"/>	Availability
<input type="checkbox"/> f. Others (specificity)	<input type="checkbox"/>	Accessibility

Go to Question no. 11	<input type="checkbox"/>	Family concern
	<input type="checkbox"/>	Cultural concern
	<input type="checkbox"/>	Knowledge/Attitude concern

11. Who decides family planning for you? (Tick one only)

- | | |
|--|---|
| <input type="checkbox"/> a. Self | <input type="checkbox"/> b. Peer |
| <input type="checkbox"/> c. Husband | <input type="checkbox"/> e. Health worker |
| <input type="checkbox"/> d. Mother/mother-in-law | <input type="checkbox"/> f. Others..... |

12. Where can you get the services for contraception? (Tick one only)

- | | |
|---|---|
| <input type="checkbox"/> a. Hospital | <input type="checkbox"/> b. Rural Health Centre |
| <input type="checkbox"/> c. Drug store | <input type="checkbox"/> d. Private clinics |
| <input type="checkbox"/> e. NGO/INGO clinic | <input type="checkbox"/> f. Others..... |

13. How can you go to get contraceptives? (Tick one only)

- | | |
|---|--|
| <input type="checkbox"/> a. walking | <input type="checkbox"/> b. public vehicle |
| <input type="checkbox"/> c. private vehicle | <input type="checkbox"/> d. ask someone to buy |
| <input type="checkbox"/> e. not affordable | <input type="checkbox"/> f. Others..... |

How long does it take for you to reach the health center for

14. contraception?

- | | |
|--|---|
| <input type="checkbox"/> a. Half an hour to one-hour | <input type="checkbox"/> b. One hour |
| <input type="checkbox"/> c. Two hours | <input type="checkbox"/> d. More than two hours |
| <input type="checkbox"/> e. not affordable | <input type="checkbox"/> f. Others..... |

15. How many contraceptive methods can be obtained where you getting the services for contraception? (Can Tick more than one)

- | | |
|--|---|
| <input type="checkbox"/> a. Injection | <input type="checkbox"/> b. Pills |
| <input type="checkbox"/> c. Emergency pills | <input type="checkbox"/> d. Condom |
| <input type="checkbox"/> e. IUD | <input type="checkbox"/> f. Implants |
| <input type="checkbox"/> g. Female Sterilization | <input type="checkbox"/> h. Others..... |

16. How much can it cost of the contraceptives?

Cost..... (per dose)

17. How do you think about the cost of contraceptives?

- | | |
|--|--|
| <input type="checkbox"/> a. affordable | <input type="checkbox"/> b. Not affordable |
|--|--|

18. Which gender is the health worker who more frequently provides you when you visit to health center?

- | | |
|----------------------------------|------------------------------------|
| <input type="checkbox"/> a. Male | <input type="checkbox"/> b. Female |
| <input type="checkbox"/> c. Both | |

19. Do you have any preference of same gender service provider?

(note: female preference of female service provider and male preference of male service provider)

- | | |
|---------------------------------|--------------------------------|
| <input type="checkbox"/> a. Yes | <input type="checkbox"/> b. No |
|---------------------------------|--------------------------------|

20. Have you ever received any health education materials or health education on contraception?

- a. Yes b. No

➤ If yes, what types of health education materials or health education about contraception have you received?

➤ If no, what information about contraception do you need?

- | | |
|--|--|
| <input type="checkbox"/> a. Pamphlets/Brochure/Leaflet | <input type="checkbox"/> a. I want to get the information on different methods of contraceptive methods. |
| <input type="checkbox"/> b. Cartoon booklet | <input type="checkbox"/> b. I want to know what services are available. |
| <input type="checkbox"/> c. Wall sheet/Poster | <input type="checkbox"/> c. I want to know about the adverse effects of contraceptives. |
| <input type="checkbox"/> d. Group training/Workshop | <input type="checkbox"/> d. Other information's (specificity) |
| <input type="checkbox"/> e. Health talk | <input type="checkbox"/> g. Other (specify) |
| <input type="checkbox"/> f. Video | |

21. Are you satisfied with the family planning services?

- a. Yes b. No

➤ If yes, why do you satisfy?

➤ If no, why don't you satisfy?

- | | |
|---|--|
| <input type="checkbox"/> a. Friendly Service Provider | <input type="checkbox"/> a. No friendly service provider |
| <input type="checkbox"/> b. No time to wait | <input type="checkbox"/> b. Long time to wait |
| <input type="checkbox"/> c. Low cost or free | <input type="checkbox"/> c. High cost |

d. Privacy and Confidentiality

d. No privacy, No confidentiality

e. Near from home

e. Far from home

f. Others (specificity)

f. Others (specificity)

.....

.....



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Knowledge questions on contraception

22. Which kind of contraceptive methods have you ever heard? It can be answer more than one. (Please check in the following boxes by interviewer according to the answers from the respondents) Please read out the remaining if the respondent cannot recall spontaneously.

No	Methods	Yes	No	Not sure
1	Combined oral contraceptives (COCs)			
2	Progestogen-only pills (POPs)			
3	Emergency Contraceptive Pills			
4	Progestogen only injectable			
5	Monthly injectable or combined injectable contraceptives (CIC)			
6	Male Condom			
7	Female Condom			
8	Jadelle			
9	Implanon			
10	Intrauterine device (IUD): copper containing			
11	Intrauterine device (IUD) levonorgestrel			
12	Female Sterilization			
13	Male Sterilization			
14	Calendar method or rhythm method			
15	Withdrawal (coitus interruptus)			
16	Lactational amenorrhea method (LAM)			

23. Knowledge upon contraception (T = True, F = False, Don't Know=DK)

No	Methods	True	False	Don't know
1	Women who take oral contraceptive (pill) should take a pill every day to avoid becoming pregnant.			
2	Oral pill can cause dizziness and nausea.			
3	Using oral contraceptive pill can protect against sexually transmitted infections (STIs) including HIV/AIDS.			
4	Depo injection should be taken once in 3 months to prevent pregnancy.			
5	Injection can cause cessation of breast milk.			
6	Women can have children again by stopping to take pill or injection.			
7	If the women do not want the children anymore, female sterilization should be used.			
8	Condom can make men impotent or weak.			
9	Male sterilization can reduce sexual desire and it can cause weakness to men.			
10	Woman cannot get pregnant if she has sex during monthly bleeding.			

No	Methods	True	False	Don't know
11	Emergency contraception have to take within 72 hours after unprotected sex.			
12	You have more chance to suffer from STI if you have unprotected sex with many partners.			
13	IUD can change in bleeding patterns (especially in the first 3 to 6 months)			
14	IUD can protect against cancer of the lining of the uterus (endometrial cancer) and cervical cancer			
15	Implant cannot get infrequent bleeding, prolonged bleeding, no monthly bleeding, or irregular bleeding.			
16	Implant can sometimes be expelled out.			
17	Improper use of contraception can cause unplanned pregnancy.			
18	Induced abortion can sometimes threaten a woman's life.			
19	When you are suffering from STI, you have more chance to be infected by HIV.			
20	All contraceptive methods can prevent both STIs and pregnancy if used properly			

Attitude toward contraception

24. How do you think about following?

(Strongly Agree/Agree/Not sure/Disagree/Strongly Disagree)

No	Statements	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
1	I believe that family planning can improve mother's life.					
2*	Using oral contraceptive is bad because it can get overweight.					
3	Husband and wife should decide number of children.					
4*	Using condom can interfere with sexual activity.					
5	Contraceptive utilization should be taught in the school.					
6	I believe that both men and women should have some knowledge about using contraception.					
7*	I believe that women should stop using Depo injection if she has no menstrual bleeding for a month.					

8*	Discussion on using contraception is ashamed among couples.					
9*	IUD methods disturbs sexual intercourse.					
10*	Female sterilization can affect the woman's good health.					

Field work note:

.....

 **“Thank you for your participation”**



APPENDIX C. A QUESTIONNAIRE (MYANMAR)

သုတေသနမေးခွန်းလွှာ

“ကရင်ပြည်နယ် ဘားအံမြို့နယ်၏ ကျေးလက်ဒေသနေရာများတွင် နေထိုင်လျက်ရှိသော မျိုးဆက်ပွားနိုင်သော အသက်အရွယ်တွင်းရှိ အိမ်ထောင်သည် အမျိုးသမီးများ (၁၈ နှစ်-၄၉ နှစ်) အကြား မိသားစုစီမံကိန်းနှင့် သားဆက်ခြားနည်းလမ်းများ အသုံးပြုခြင်းနှင့် ပတ်သက်၍ ကျန်းမာရေးစောင့်ရှောက်မှုရယူခြင်း ဆိုင်ရာ အမူအကျင့်များကို လေ့လာသော သုတေသန”

သက်ဆိုင်ရာ အဖြေအား အမှန်ဖြစ်ပေးပါ။ ကွက်လပ်ဖြစ်ပါက ယင်းကွက်လပ်နေရာတွင် ဖြည့်ပေးပါ။

သုတေသန နံပါတ်

ရက်စွဲ (ရက်/လ/နှစ်)/..... /.....

ကျေးရွာအမည်

၁။ အသက် (ပြည့်ပြီးအသက်) နှစ်

၂။ သင်မည်သည့် တိုင်းရင်းသားဖြစ်သလဲ။

က။ ကရင်

ခ။ ပအိုဝ်း(ဂ်)

ဂ။ ဗမာ

ဃ။ အခြား(ဖော်ပြရန်)

၃။ သင်မည်သည့်ဘာသာ ကိုးကွယ်ပါသလဲ။ (အဖြေမှန်တစ်ခုတည်းကိုသာ အမှန်ဖြစ်ပေးပါ။)

က။ ဗုဒ္ဓ

ခ။ ခရစ်ယာန်

ဂ။ အစ္စလာမ်

ဃ။ အခြား(ဖော်ပြရန်)

တက်ခွဲဖူးသည့် အမြင့်ဆုံးပညာရေး (သို့မဟုတ်) အတန်းပညာ

၄။ (အဖြေမှန်တစ်ခုတည်းကိုသာ အမှန်ဖြစ်ပေးပါ။)

က။ ကျောင်းမနေဖူးပါ။

ခ။ ဘုန်းတော်ကြီးသင် အခြေခံပညာ (ရေးတတ်ဖတ်တတ်)

ဂ။ မူလတန်းပညာ

ဃ။ အလယ်တန်းပညာ

င။ အထက်တန်းပညာ

စ။ ဘွဲ့ရ ပညာ နှင့် ဘွဲ့လွန်ပညာ

၅။ သင်၏အဓိက လုပ်ငန်း အလုပ်အကိုင် (အဖြေမှန်တစ်ခုတည်းကိုသာ အမှန်ဖြစ်ပေးပါ။)

က။ ပန်ထမ်း (အစိုးရ)

ခ။ အိမ်ရှင်မ (မိမိ)

- ဂ။ လယ်ယာ၊ တံငါသည်
- င။ ကိုယ်ပိုင်စီးပွားရေးလုပ်ငန်း
- ဆ။ ကျောင်းသူ
- ဃ။ အလုပ် လက်မဲ့
- စ။ လက်လုပ်လက်စား (ကျုပ်နန်း)
- ဈ။ အခြား (ဖော်ပြရန်)

၆။ သင့်မှာ ယခုလက်ရှိ ကလေးအရေအတွက်မည်မျှ ရှိပါသလဲ။

.....ယောက်

၇။ သင်၏ စုစုပေါင်းမိသားစု ဦးရေ ယောက်

၈။ မိသားစုတွင် အလုပ်လုပ်သော မိသားစုဝင် အရေအတွက် ယောက်

၉။ သင့်မိသားစု၏ တစ်လဝင်ငွေ ကို ပြောပြပါ။ကျပ်

၁၀။ သင်(သို့မဟုတ်)သင်၏ ခင်ပွန်း၊ အဖော်မှ သားဆက်ခြားခြင်း နည်းလမ်းများ အသုံးပြုခြင်း ရှိပါသလား။

- | | | |
|--|--|---|
| <input type="checkbox"/> က။ ရှိပါသည်။ (ယခုလက်ရှိ အသုံးပြုနေပါသည်။) | <input type="checkbox"/> ခ။ အရင်က အသုံးပြုဖူးခဲ့သည်။ (ယခု မသုံးတော့ပါ။) | <input type="checkbox"/> ဂ။ တစ်ခါမျှအသုံးမပြုဖူးပါ။ |
| <input type="checkbox"/> မည်သည့် သားဆက်ခြား နည်းလမ်းကို အသုံးပြုပါသလဲ။
.....
..... | <input type="checkbox"/> သားဆက်ခြား နည်းလမ်း အသုံးပြုခြင်းအား ရပ်တန့် လိုက်သည်မှာ မည်မျှကြာပြီလဲ။
.....(ရက်၊လ၊နှစ်) | |

မည်သည့်အချက်က သင့်ကို သားဆက်ခြားနည်းလမ်း သုံးစွဲခြင်း၏ အဓိက အကြောင်းရင်း ဖြစ်စေပါသလဲ။

က။ ကိုယ်ဝန်တားပေးခြင်း။

ခ။ လက်ရှိကလေးများ၏ ဘဝပိုမိုကောင်းမွန်စေခြင်း။

မည်သည့်အချက်က သင့်ကို သားဆက်ခြားနည်းလမ်း သုံးစွဲခြင်းကို ရပ်လိုက်ခြင်း၏ အဓိကအကြောင်းရင်း ဖြစ်စေပါသလဲ။	မည်သည့်အချက်က သင့်ကို သားဆက်ခြား နည်းလမ်း မသုံးစွဲခြင်း၏ အဓိကအကြောင်းရင်း ဖြစ်စေပါသလဲ။
.....

<input type="checkbox"/> ဂ။ ရာသီမှန်မှန်လာစေခြင်း။
<input type="checkbox"/> ဃ။ မိမိကျန်းမာရေးကို ထိန်းသိမ်းရန်။
<input type="checkbox"/> င။ မိသားစုဘဝအခြေအနေ တိုးတက်ကောင်းမွန်လာစေခြင်း။
<input type="checkbox"/> စ။ အခြား(ဖော်ပြရန်)

မေးခွန်းနံပါတ် (၁၁) သို့သွားပါ။

မေးခွန်းနံပါတ် (၁၀.၁) သို့သွားပါ။

၁၀. သားဆက်ခြားနည်းလမ်း အသုံးမပြုရခြင်းအကြောင်းအား အသေးစိတ်ထပ်မံပြောပြပေးပါ။

၁။

မိမိ အသုံးပြုလိုသော သားဆက်ခြားနည်းလမ်းအားအသုံးပြုနိုင်ခြင်း နှင့် ပတ်သက်၍

.....

သားဆက်ခြားနည်းလမ်းအား ရယူခြင်းနှင့် ပတ်သက်၍

.....

မိသားစု အခြေအနေနှင့် ပတ်သက်၍

.....

ပတ်ဝန်းကျင် လူမှုစလေ့ထုံးတမ်းများနှင့် ပတ်သက်၍

.....

သားဆက်ခြားနည်းလမ်းများ အကြောင်းဗဟုသုတ နှင့် ပတ်သက်၍

.....

၁၁။ သင့်၏ မိသားစု စီမံကိန်းအား မည်သူဆုံးဖြတ်သနည်း။ (အဖြေမှန်တစ်ခုတည်းကိုသာ အမှန်ဖြစ်ပေးပါ။)

က။ မိမိကိုယ်တိုင် ခ။ သူငယ်ချင်း၊ အိမ်နီးနားချင်း၊ မိတ်ဆွေ

ဂ။ ခင်ပွန်း ဃ။ ကျန်းမာရေးဆရာမ

င။ ယောက္ခမ စ။ အခြား (ဖော်ပြရန်)

၁၂။ သားဆက်ခြားနည်းလမ်းဝန်ဆောင်မှုများကို သင် မည်သည့်နေရာ တွင် ရယူနိုင်ပါသလဲ။
(အဖြေမှန်တစ်ခုတည်းကိုသာ အမှန်ဖြစ်ပေးပါ။)

က။ ဆေးရုံ ခ။ ကျေးလက်ကျန်းမာရေးဌာန

ဂ။ ဆေးဆိုင် ဃ။ ပုဂ္ဂလိကဆေးခန်း၊ဆေးရုံ

င။ NGO/INGO ဆေးခန်း စ။ အခြား (ဖော်ပြရန်)

၁၃။ သားဆက်ခြားနည်းလမ်းအတွက် ဝန်ဆောင်မှုပေးသည့်နေရာသို့ သင်မည်သို့သွားနိုင်ပါသလဲ။ (အဖြေမှန်တစ်ခုတည်းကိုသာ အမှန်ဖြစ်ပေးပါ။)

က။ လမ်းလျှောက်သွားသည်။ ခ။ လိုင်းကား

ဂ။ ကိုယ်ပိုင်ယာဉ်ဖြင့်သွားသည်။ ဃ။ တစ်စုံတစ်ယောက်ကို ဝယ်ခိုင်းသည်။
.....

င။ မသွားတတ်ပါ။ စ။ အခြား (ဖော်ပြရန်)

၁၄။ ဝန်ဆောင်မှုပေးသည့်နေရာသို့ ရောက်ရန်အချိန်မည်မျှသွားရပါသနည်း။

က။ နာရီပတ် မှ တစ်နာရီ ခ။ တစ်နာရီ

ဂ။ နှစ်နာရီ ဃ။ နှစ်နာရီ နှင့် အထက်

င။ မသွားတတ်ပါ။ စ။ အခြား (ဖော်ပြရန်)

၁၅။ ဝန်ဆောင်မှုပေးသည့်နေရာ တွင် မည်သည့်သားဆက်ခြားနည်းလမ်းများကို ရရှိနိုင်သနည်း။ (သင်သိသလောက်ပြောပြပါ။)

က။ ထိုးဆေး ခ။ နေ့စဉ်သုံးသားဆက်ခြား စားဆေး

ဂ။

အရေးပေါ်သားဆက်ခြားသောက် ဃ။ ကွန်ဒုံး

ဆေး

င။ သားအိမ်တွင်းထည့်သွင်း
သားဆက်ခြားပစ္စည်း စ။ လက်မောင်း အရေပြားအောက် သွင်း
သားဆက်ခြားပစ္စည်း

ဆ။ Female Sterilization ဇ။ အခြား (ဖော်ပြရန်)

၁၆။ သားဆက်ခြားခြင်းဝန်ဆောင်မှုအတွက် အခကြေးငွေမည်မျှပေးရပါသနည်း။

Cost..... (per month/per dose)

၁၇။ ကုန်ကျစရိတ်များကို သင်ဘယ်လိုမြင်ပါသလဲ။

က။ တတ်နိုင်ပါသည်။ ခ။ မတတ်နိုင်ပါ။ဈေးအလွန်ကြီးပါသည်။

၁၈။ ကျန်းမာရေးဝန်ဆောင်မှုအား အများအားဖြင့် မည်သူထံမှ ရရှိလေ့ရှိပါသနည်း။

က။ အမျိုးသား ကျန်းမာရေးဆရာ ခ။ အမျိုးသမီး ကျန်းမာရေးဆရာမ ထံ မှ
ထံ မှ ရရှိပါသည်။ ရရှိပါသည်။

ဂ။ အမျိုးသား ကျန်းမာရေးဆရာ (သို့မဟုတ်) အမျိုးသမီး ကျန်းမာရေးဆရာမ ထံ မှ
ရရှိပါသည်။

၁၉။ သားဆက်ခြားခြင်းဝန်ဆောင်မှု အား အမျိုးသမီး ကျန်းမာရေးဆရာမ မှပေးသည်ကို ပို၍
သဘောကျပါသလား။

က။ ကျပါသည်။ ခ။ မကျပါ။

၂၀။ သားဆက်ခြားခြင်းနှင့် ပတ်သက်သော ကျန်းမာရေးပညာပေးဟောပြောပွဲများ
(သို့မဟုတ်) ကျန်းမာရေးအချက်အလက်များ ကို လက်ခံရရှိဖူးပါသလား။

က။ ရရှိဖူးပါသည်။ ခ။ မရရှိဖူးပါ။
လက်ခံရရှိဖူးသော သားဆက်ခြားခြင်းနှင့် မည်ကဲ့သို့သော
ပတ်သက်သော ကျန်းမာရေး ပညာပေးဟောပြောပွဲများ (သို့မဟုတ်) သားဆက်ခြားခြင်းနှင့်
ကျန်းမာရေး အချက်အလက်များမှာ ပတ်သက်သော ကျန်းမာရေး
မည်ကဲ့သို့သော အရာများဖြစ်ပါသလဲ။ ပညာပေးဟောပြောပွဲများ
(သို့မဟုတ်) ကျန်းမာရေး

အချက်အလက်များ ကို ရရှိလိုပါသလဲ။

- က။ လက်ကမ်းစာစောင်
- ခ။ ကာတွန်းရုပ်ပြ
- ဂ။ ပိုစတာ (သို့မဟုတ်) နံရံကပ်စာစောင်

က။ သားဆက်ခြားနည်းလမ်းများ အားလုံး၏အကြောင်းနှင့် ပတ်သက်သော သတင်းအချက်အလက်များကို သိရှိလိုပါသည်။

- ဃ။ အုပ်စုလိုက် သင်တန်းပေးဆွေးနွေးခြင်း။

ခ။ သားဆက်ခြားဝန်ဆောင်မှုများ ရရှိနိုင်သော နေရာများ အကြောင်းသိရှိလိုပါသည်။

- င။ ကျန်းမာရေးဟောပြောပွဲ

ဂ။ သားဆက်ခြားနည်းလမ်းများ၏ ဘေးထွက်ဆိုးကျိုးများကို သိရှိလိုပါသည်။

- စ။ ဗီဒီယို

- ဆ။ အခြား (ဖော်ပြရန်)

ဃ။ အခြား (ဖော်ပြရန်)

.....
သင်ရရှိသော သားဆက်ခြားခြင်းနှင့် ပတ်သတ်သည့် ဝန်ဆောင်မှုများကို

၂၁။ ကျေနပ်မှုရှိပါသလား။

- က။ ရှိပါသည်။ ခ။ မရှိပါ။

ဘာကြောင့်ကျေနပ်ပါသလဲ။ ဘာကြောင့်ကျေနပ်မှု မရရှိပါသလဲ။

- က။ ဝန်ထမ်းများ၏ရင်းနှီးဖော်ရွေမှု။ က။ ဝန်ထမ်းများ၏ရင်းနှီးဖော်ရွေမှု မရှိခြင်း။

- ခ။ စောင့်ဆိုင်းနေရန်မလိုခြင်း။ ခ။ ကြာမြင့်စွာ စောင့်ဆိုင်းနေရခြင်း။

- ဂ။ ကုန်ကျစရိတ်သက်သာခြင်း။ ဂ။ ကုန်ကျစရိတ်များခြင်း။

- ဃ။ လျှို့ဝှက်ထိန်းသိမ်းခြင်း နှင့်သီးသန့်ရှိခြင်း။ ဃ။ လျှို့ဝှက်ထိန်းသိမ်းခြင်းမရှိ၊ သီးသန့်မရှိခြင်း။

- င။ မိမိအိမ်နှင့်နီးခြင်း။ င။ အိမ်နှင့်ဝေးလံခြင်း။

- စ။ အခြား (ဖော်ပြရန်) စ။ အခြား (ဖော်ပြရန်)

သားဆက်ခြားနည်းလမ်းများနှင့် ပတ်သက်သည်။ ဗဟုသုတ

၂၂။ သင်သိသော သားဆက်ခြားနည်းလမ်းများကို ဖော်ပြပါ။ (အဖြေသည် တစ်ခုထက်ပိုနိုင်သည်။ အမှန်ဖြစ်ပေးပါ။) ဖြေဆိုသူမှ မဖြေနိုင်လျှင် မေးမြန်းသူမှ အောက်ပါသားဆက်ခြားနည်းလမ်းများကို ဖော်ပြလိုက်ပါ။

စဉ်။	သားဆက်ခြားနည်းလမ်းများ	ကြားဖူးပါသည်။	မကြားဖူးပါ။	မသေချာပါ။
၁။	နေ့စဉ်သုံးသားဆက်ခြား စားဆေး (ဟော်မုန်း ၂ မျိုးပါ)			
၂။	နေ့စဉ်သုံးသားဆက်ခြား စားဆေး (ဟော်မုန်း ၁ မျိုးပါ)			
၃။	အရေးပေါ်သားဆက်ခြားသောက်ဆေး			
၄။	သုံးလခံသားဆက်ခြားထိုးဆေး			
၅။	တစ်လခံသားဆက်ခြားထိုးဆေး			
၆။	အမျိုးသားသုံး ကွန်ဒုံး			
၇။	အမျိုးသမီးသုံး ကွန်ဒုံး			
၈။	(၅) နှစ်ခံ လက်မောင်း အရေပြားအောက် သွင်း သားဆက်ခြားပစ္စည်း Jadelle			
၉။	(၃) နှစ်ခံ လက်မောင်း အရေပြားအောက် သွင်း သားဆက်ခြားပစ္စည်း Implanon			
၁၀။	သားအိမ်တွင်းထည့် သားဆက်ခြားပစ္စည်း (ဟော်မုန်းမပါ) Copper-Bearing IUD			
၁၁။	သားအိမ်တွင်းထည့် သားဆက်ခြားပစ္စည်း (ဟော်မုန်းပါ) Levonorgestrel IUD			
၁၂။	အမျိုးသမီး သားကြောဖြတ်ခြင်း			
၁၃။	အမျိုးသား သားကြောဖြတ်ခြင်း			
၁၄။	ရက်ရှောင်ခြင်း			

၁၅။	အမျိုးသား၏သုတ်ပိုးကို အမျိုးသမီးကိုယ်တွင်း သို့ မဝင်စေဘဲ အပြင်သို့စွန့်ထုတ်ခြင်း			
၁၆။	နို့တိုက်ခြင်း			

၂၃။ သားဆက်ခြားနည်းလမ်းများနှင့် ပတ်သက်သည့် ဗဟုသုတ
(ဖြေဆိုသူ ၏ အဖြေအား သေသေချာချာ အမှန်ဖြစ်ပေးပါ။ မသေချာပါက မသေချာအကွက်တွင်
ဖြည့်ပါ။)

စဉ်။	နည်းလမ်းများ	မှန်ပါသည်။	မှားပါသည်။	မသေချာပါ။
၁။	နေ့စဉ်သုံးသားဆက်ခြား စားဆေး များကို ကိုယ်ဝန်မရရှိနိုင်အောင် နေ့စဉ် ပုံမှန် သောက်သုံးရမည်။			
၂။	နေ့စဉ်သုံးသားဆက်ခြား စားဆေးများသည် မူးဝေအော့အန်ခြင်းကို ဖြစ်စေနိုင်ပါသည်။			
၃။	နေ့စဉ်သုံးသားဆက်ခြား စားဆေးများသည် HIV/AIDS အပါအဝင် လိင်မှတစ်ဆင့် ကူးစက်တတ်သောရောဂါများကို ကာကွယ်ပေးနိုင်ပါသည်။			
၄။	ကိုယ်ဝန်မရရှိနိုင်အောင် သားဆက်ခြား ထိုးဆေးများကို သုံးလတစ်ခါထိုးပေးသင့်သည်။			
၅။	သားဆက်ခြား ထိုးဆေးများသည် မိခင်နို့ရည်ထွက်ခြင်းကို ရပ်တန့်စေနိုင်သည်။			
၆။	သားဆက်ခြားစားဆေးထိုးဆေးများကို ရပ်တန့်လိုက်ပါက ကိုယ်ဝန်ပြန်ရမည်ဖြစ်သည်။			
၇။	ကလေးလုံးဝမလိုချင်တော့သော မိခင်များသည် သားကြောဖြတ်သင့်သည်။			
၈။	ကွန်ဒုံးသည် အမျိုးသားများကို မြို့စေပြီး အားနည်းစေသည်။			
၉။	အမျိုးသား သားကြောဖြတ်ခြင်းသည် လိင်ဆက်ဆံလိုစိတ်ကို လျော့နည်းစေပြီး အားနည်းခြင်းကို ဖြစ်စေနိုင်သည်။			

၁၀။	ရာသီလာနေစဉ် လိင်ဆက်ဆံခြင်းသည် ကိုယ်ဝန်မရစေနိုင်ပါ။			
၁၁။	အရေးပေါ်သားဆက်ခြားသောက်ဆေးကို အကာအကွယ်မပါဘဲ လိင်ဆက်ဆံမှုအပြီး ဂျပနာရီ အတွင်း သောက်ရမည်။			
၁၂။	လိင်ဆက်ဆံဖော်များစွာနှင့် အကာအကွယ်မပါဘဲ လိင်ဆက်ဆံခြင်းသည် လိင်မှတစ်ဆင့် ကူးစက်တတ်သောရောဂါများ ကူးစက်နိုင်ခြေအား ပိုမိုမြင့်မားစေနိုင်ပါသည်။			
၁၃။	သားအိမ်တွင်းထည့် သားဆက်ခြားပစ္စည်း သည် ရာသီသွေးကစားခြင်းကို ဖြစ်ပေါ်စေနိုင်သည်။ (အထူးသဖြင့်) ထည့်ပြီးကာစ ပထမ ၃-၆ လ အတွင်း)			
၁၄။	သားအိမ်တွင်းထည့် သားဆက်ခြားပစ္စည်း သည် သားအိမ်တွင်းအမြှေးပါးကင်ဆာ နှင့် သားအိမ်ခေါင်းကင်ဆာ ဖြစ်ပွားမှုကို ကာကွယ်နိုင်သည်။			
၁၅။	လက်မောင်း အရေပြားအောက် သွင်း သားဆက်ခြားပစ္စည်းသည် ရာသီသွေးကစားခြင်း ကို မဖြစ်စေပါ။			
၁၆။	လက်မောင်း အရေပြားအောက် သွင်း သားဆက်ခြားပစ္စည်းသည် တစ်ခါတစ်ရံတွင် ပြန်ထွက်လာနိုင်သည်။			
၁၇။	သားဆက်ခြားနည်းလမ်းများကို စနစ်တကျ မသုံးစွဲပါက မလိုချင်သောကိုယ်ဝန်ကို ရစေနိုင်သည်။			
၁၈။	ကလေးဖျက်ချခြင်းသည် အသက်ကို အန္တရာယ်ဖြစ်စေနိုင်သည်။			
၁၉။	လိင်မှတစ်ဆင့် ကူးစက်တတ်သောရောဂါများ ခံစားနေရပါက HIVပိုး ကူးစက် နိုင်ချေများသည်။			
၂၀။	သားဆက်ခြားနည်းလမ်းများအားလုံးသည် ကိုယ်ဝန် နှင့် လိင်မှတစ်ဆင့်			

ကူးစက်တတ်သောရောဂါများ ကို ကာကွယ်ပေးနိုင်သည်။			
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သားဆက်ခြားနည်းလမ်းသုံးစွဲမှုနှင့် ပတ်သက်သော သဘောထားခံယူချက်များ
 ၂၄။ အောက်ဖော်ပြပါ မေးခွန်းများနှင့် ပတ်သက်ပြီး သင်၏ သဘောထားထင်မြင်ချက်ကို ပြောပြပေးပါ။

စဉ်။	သတင်းအချက်အလက်	အလွန် သဘော တူသည်။	သဘောတူ သည်။	သေချာ ၊ မသိပါ။	သဘော မတူပါ။	ပြင်းထန်စွာ သဘောမ တူပါ။
၁။	မိသားစုစီမံကိန်းသည် မိခင်များ၏ဘဝ ကို ပိုမို တိုးတက် လာစေနိုင်သည် ဟု ယုံကြည်သည်။					
၂။	နေ့စဉ်သုံးသားဆက်ခြား စားဆေးများသည် ကိုယ်အလေးချိန် ကို တက်စေနိုင်သည်။					
၃။	ကလေးမည်မျှ ယူမည်ကို ခင်ပွန်းနှင့် ဇနီးသည် နှစ်ယောက်စလုံးမှ ဆွေးနွေး ဆုံးဖြတ်သင့်သည်။					
၄။	ကွန်ဒုံးအသုံးပြုခြင်းဖြင့် လိင်ဆက်ဆံ ခြင်းကို အနှောင့်အယှက် ဖြစ်စေနိုင်သည်။					
၅။	သားဆက်ခြားနည်းလမ်းများ အကြောင်းကို ကျောင်းသင်ခန်းစာ များ တွင် ထည့်သင် သင့်သည်။					
၆။	သားဆက်ခြားနည်းလမ်းများ အသုံးပြုခြင်းနှင့် ပတ်သက်သော ဗဟုသုတများကို ခင်ပွန်း နှင့် ဇနီးသည် နှစ်ဦးစလုံး					

စဉ်။	သတင်းအချက်အလက်	အလွန် သဘော တူသည်။	သဘောတူ သည်။	သေချာ ၁ မသိပါ။	သဘော မတူပါ။	ပြင်းထန်စွာ သဘောမ တူပါ။
	သိသင့်သည်ဟု ယုံကြည်ပါသည်။					
၇။	သားဆက်ခြား ထိုးဆေးအသုံးပြုနေသော အမျိုးသမီးသည် ရာသီတစ်လမလာခြင်းဖြစ်ပေါ်ပါက ထိုးဆေးအသုံးပြုခြင်းကို ရပ်စဲရမည် ဟု ယုံကြည်သည်။					
၈။	ခင်ပွန်း နှင့် ဇနီးသည် အကြားတွင် သားဆက်ခြားနည်းလမ်းအကြောင်း ဆွေးနွေးတိုင်ပင်ခြင်းသည် ရှက်စရာကောင်းသည်။					
၉။	သားအိမ်တွင်းထည့် သားဆက်ခြားပစ္စည်း အသုံးပြုခြင်းဖြင့် လိင်ဆက်ဆံ ခြင်းကို အနှောင့်အယှက် ဖြစ်စေနိုင်သည်။					
၁၀။	အမျိုးသမီးသားကြောဖြတ်ခြင်းသည် အမျိုးသမီး၏ ကျန်းမာရေးကို ထိခိုက်စေသည်။					

Field work note:

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“Thank you for your participation”

APPENDIX D. TIME FRAME

Research Activities	Time Frame								
	Sept, 2018	Oct, 2018	Nov, 2018	Dec, 2018	Jan, 2018	Feb, 2019	Mar, 2019	Apri, 2019	May, 2019
Literature review									
Thesis Proposal Writing and Preparation									
Tool development for data collecting									
Thesis Proposal Defense									
Ethical Approval									
Data collection in the field									
Analyzing the collected data									
Thesis paper writing									
Defense Exam for Thesis paper									
Submitting Final Thesis									
Total	9 months								

APPENDIX E. Budget

NO.	Description	Estimated Expenses (THB)
1	Data Collection (A4, Copy, Stationary, etc.)	5,000
2.	Travel Related Cost (Field study)	15,000
3.	Advocacy with authorities(treating lunch)/Giving Present to respondents for appreciation of their participation	5,000
4.	Training for research assistants and Pretests	10,000
5.	Daily Peridium for five research assistants	10,000
6.	Preparation and Printing of Thesis Paper	2,000
7.	Publication Fees	3,000
	Total	50,000

VITA

NAME Ms. Sabai Tun

DATE OF BIRTH 16 June 1992

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