Sexual and Reproductive Health Behaviors of Young People in Southern Shan State

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1 Executive summary

Background: Currently available Sexual and Reproductive Health (SRH) information on youth are mostly among married people despite the fact that many health organizations including the Ministry of Health and Sports estimate high levels of unwanted pregnancies, unsafe abortions, and maternal mortalities among young unmarried women. The limited number of available studies suggested that youths do not access public facilities for their FP needs and often rely on poor quality private sector services such as street drug vendors and quacks, particularly in remote areas. While basic characteristics of unmet need and non-use, as well as the negative consequences of the lack of SRH services for young people are anecdotally known, there is little scientific data to inform youth SRH policy and programming. Research on SRH of young people is severely needed to better understand pathways to change and develop effective interventions.

Aim: In Myanmar apart from the fact that many male youth are engaging in sexual activity before marriage, the information about sexual activity among unmarried youth is not available. This study was carried out with the aim of identifying the sexual reproductive behaviors of young people and their contraceptive utilization in order to provide evidence in establishing contraceptive service delivery which will fulfill the young people needs.

Methods: A mixed method research was carried out targeting unmarried men and women between the aged of 18 to 24 both in-school and out-of-school in two townships of Southern Shan State, Myanmar. This study involved structured self-administered tablet based questionnaire survey with 424 young people and 12 focus group discussions with young people. Focus groups were assigned by residential area (rural or urban) and sex of the respondents.

Results: About 50% of the study respondent did not know any kind of contraceptive methods. Half of them (222, 52.4%) had boy/girlfriends and 50 (11.8%) had pre-marital sex. The average age of first sex was 19±1.8 years. Among those who have had sex, 31 (62%) had used contraceptives. They mostly obtained contraceptives from drug shops (23, 74.2%). Focus group discussions revealed that most of them encountered challenges in obtaining contraceptives and social stigma was the key barriers in accessing contraceptives. Financial barrier to obtain contraceptives was rarely found. Family planning services provided at government-health-facilities were hardly aware. Being young and unmarried was also a barrier in receiving contraceptive services. Almost all agreed that contraceptive

information and services should be given to unmarried young people to prevent unwanted pregnancy, abortion and sexually transmitted infections (STIs). Base on both qualitative and quantitative findings facebook was one of the most popular and influential media among them in obtaining reproductive health related information.

Discussion and conclusion: Our study highlighted the urgent need for the youth friendly sexual and reproductive health programs targeting unmarried young people for several reasons. First, premarital sex became common among young people and the age of sexual debut was as young as 16 years. Second, young people were less aware of the contraceptive methods, their sources and information on HIV/STIs. Third, they faced several challenges including social stigma for obtaining or using condoms and other contraceptives. Lastly, contraceptive services are not targeting towards unmarried young people.

Therefore, we suggest 1) provision of contraceptive knowledge and services to young people before puberty and 2) promoting awareness among communities, parents and young people on the benefits of using contraceptive and danger of unprotected sex in order to reduce social stigma of obtaining contraceptive among unmarried youth.

We also recommend using facebook as a platform for sexual and reproductive health (SRH) information delivery and setting up youth friendly health facilities where youth could access SRH information and services openly without affecting their privacy and confidentiality.

2 Introduction

The world's youth population has reached 1.2 billion in 2016 and the vast majority of the global youth population exists in the developing countries in Asia and Africa. Asian countries constitute more than 60 % of the youth population (1). According to the 2014 Myanmar Population and Housing Census, young people, aged 10-24, account for almost 30 % of Myanmar's total population (2). Many young people engage in sexual risk behaviors that can result in unintended health outcomes and social issues such as unwanted pregnancy and unsafe abortion (3).In spite of knowing that the sexual and reproductive health needs of youth differ from those of adults, these needs remain inadequately served in many parts of the world. It is undoubtedly a challenge for many countries to address the needs of youth (4). About 20% of college students reportedly experience pre-marital sex in some developing countries (5). Pre-marital sexual behavior among adolescents and youth remain poorly explored topics in Myanmar (6) but a one Myanmar study revealed that pre-marital sex was found to be common among the youth of poor families and the first sex experience took place between 16 to 20 years (7). Another study conducted in rural areas of Myanmar indicated that among the rural young people who had sex experiences, more than half had sex before marriage, only 15.9% of them always use condom and 27% of them have had more than one partner. Age, marital status, occupation, monthly income and level of knowledge were found to be significantly associated with level of risk behaviors (8).

Earlier age at first sex is likely to increase the likelihood of multiple and concurrent partners, a lower probability of using modern contraceptive methods and an increased chance of getting Sexually Transmitted Infections, unwanted pregnancy which could lead to unsafe abortion and other social consequences (7). The highest reported rates of STIs are found among young people aged 15-19 and 20-24; in developing countries, the proportion is even higher. Adolescents and youths were found to account for 30% of the total number of patients attending the STD clinic in Nigeria (9). Studies in Myanmar show similar situations where youth were vulnerable to reproductive health problems, which included unwanted pregnancies, abortions, and STIs, including HIV/AIDS. The accurate incidence of sexual activity among unmarried youth is not known; however, a few qualitative studies have indicated that many male youths are engaging in sexual activity before marriage (10–12).

There is a dearth of information on Adolescent and Youth Sexual Reproductive Health (AYSRH). Currently available SRH information on youth are mostly among married women despite the fact that many health organizations including the Ministry of Health and Sports estimate high levels of unwanted pregnancies, unsafe abortions, and maternal mortalities among young unmarried women. The limited number of available studies suggested that youths do not access public facilities for their FP needs and often rely on poor quality private

sector services such as street drug vendors and quacks, particularly in remote areas. While basic characteristics of unmet need and non-use, as well as the negative consequences of the lack of SRH services for young people are anecdotally known, there is little scientific data to inform youth SRH policy and programming. Research on SRH of young people is severely needed to better understand pathways to change and develop effective interventions.

3 Objectives

This study aims aimed at identifying the sexual reproductive behaviors of young people and their contraceptive utilization in order to provide evidence in establishing contraceptive service delivery which will fulfill the young people needs.

Specific Objectives

Among young people aged 18-24 years from Taunggyi and Pinlaung Townships, Southern Shan State, Myanmar,

1. To explore sexual behaviors and contraceptive use
2. To assess the source of contraceptives
3. To identify the source of reproductive health information
4. To find out the opinion and suggestion on contraceptive availability, use and contraceptive services

4 Methods

In collaboration, the MOHS and MPPR with the funding from Pathfinder International, a mixed method research was carried out targeting unmarried men and women between the ages of 18 to 24 on FP/SRH behaviors in 2 townships, Taunggyi and Pinlaung, in Southern Shan State. This study involved both quantitative questionnaire interviews and focus group discussions. The quantitative and qualitative findings complemented each other and triangulated to draw conclusions.

Study Design: A cross-sectional study using both quantitative and qualitative methods was carried out.

Study Population: Young unmarried people aged 18-24 years from Taunggyi and Pinlaung Townships involved in this study. We had classified young people into four clusters 1) urban In-school*, 2) urban out-of-school, 3) rural in-school and 4) rural out-of-school

** in-school young people refers to those who currently attending high school or university or university graduates*

*** out of school young people refers to those who have left school*

Study area: This study was carried out in Taunggyi and Pinlaung Townships which are the project areas of MPPR.

Sample size:

Townships	Urban in school	Urban out of school	Rural in school	Rural out of school	Total
Pinlaung	27	14	39	21	101
Taunggyi	101	44	122	56	323
Total	**128**	**58**	**161**	**77**	**424**

Study period: November 2016 to March 2017

Data collection

Quantitative data was collected through structured self-administered tablet based questionnaire. Variables collected were-

- Socio-demographic background
- Sexual behaviors
- Use of contraception
- Source of information about contraceptive methods
- Preferred source of information about contraceptive methods
- Source of contraceptives they used
- Preferred source where they want to get contraceptives

Focus Group Discussion (FGD): A total of 12 focus group discussions (five in Pinlaung Township and seven in Taunggyi Township) were conducted. Each focus group consisted of 5-8 participants of same gender. Two teams of 3 researchers (male and female groups) served as a facilitator and note takers. The conversations were audio-recorded for note taking purposes.

Both quantitative and qualitative data collection were taken place at the places with privacy.

Sampling: Multistage sampling method was applied. Wards and villages from Taunggyi and Pinlaung Townships were selected randomly. Then, a list of unmarried young people aged 18-24 years were obtained through local youth committees, local basic health staff, youth centers, and schools. From then, participants were recruited consecutively until a required sample size in the location is obtained. Recruitment of the participants was assisted by the local youth committees and local basic health staff of selected villages.

Prior to the recruitment and data collection activities, the research team convened Township Health Committee, youth representatives, and other stakeholders to inform the purposes and process of the study to solicit the parental understanding of the study. Members included parents of young people, civil society, health providers, youth advocates, as well as representatives of youth in the townships. This stakeholder group assisted the recruitment of participants, and raising additional study questions that the community would like to explore in order to improve youth related national policies and guidelines. Following the community discussions, the research team incorporated the inputs received from the members into study questions.

Interviewer training and pretesting

Interviewer training and pretesting of the questionnaire were done at Hlaingtharyar Township just before data collection in Shan State. Pretesting was carried out by interviewing 20 young people, 5 out-of- school and 15 in-school young people, for feasibility, acceptability and validity. Feasibility and acceptability of the questionnaire was examined by interviewer-reported acceptability and time and ease of administration, and then adapted accordingly.

Data management

Quantitative data: Data was analyzed by stata 11.0. Descriptive statistic was used to summarize the data. Chi-square test and t-test were used to identify association of background characteristics and risky sexual behaviors and contractive use. P-values less than 0.05 was considered statistically significant.

Qualitative data: The contents of the discussions were transcribed and analyzed. The semi-structured discussions were intended to gather in depth information about youth knowledge, opinions, attitudes, and behaviors related to SRH. The qualitative data was also being used to triangulate data collected through the quantitative questionnaire.

Ethical Consideration

Ethics approval: Ethical approval for this study was obtained from Institutional Ethics Review Committee, Department of Medical Research.

Confidentiality: All participants and people in their community were explained thoroughly about the purpose of the study through pre-study community orientation sessions. Informed consent was obtained from participants. In order to ensure confidentiality of responses, the questionnaires were responded with self-administered tablet based and code numbers were assigned on the questionnaire instead of the participants' name. Only investigators have access to the data and all the information are kept confidentially

Dissemination: The study team planned to carry out central and township level disseminations in Nay Pyi Taw, Taunggyi and Pinlaung Townships in order to inform the results of the study to the decision makers, health care providers and implementing partners so that appropriate reproductive health interventions for young people could be established based on the study evidences.

5 Results

Background characteristics of the respondents, their social and sexual behaviors, contraceptive use and the association between background characteristics and sexual behaviors and use of contraceptives are expressed in this session.

5.1 Background characteristics of young people

A total of 424 young people from Taunggyi and Pinlaung Townships involved in this study. Background characteristics of young people are shown in table (1). Just above three quarters (323, 76.2%) of respondents were from Taunggyi Township. Urban-rural and sex proportion of the respondents were nearly equal in both townships. Mean age of the respondents was 20±2.1 years with a range of 18 to 24 years. There were 415 (97.9%) young people who have ever attended school and the highest level of education most of them completed was university (226, 54.5%). Nearly 70% of them were currently attending school. Majority of them (308, 72.6%) were living with both of their parents. Nearly 60% of them were working unpaid works such as helping family business.

Table 1 Background characteristics of young people (n=424)

Characteristics	Number	Percent
Township		
Taunggyi	323	76.2
Pinlaung	101	23.8
Area		
Rural	238	56.1
Urban	186	43.8
Sex		
Male	206	48.6
Female	218	51.4
Age		
<21 years	254	59.9
21-24 years	170	40.1
Ever attended school		
Yes	415	97.9
No	9	2.1
Highest level of education		
Primary	11	2.7
Middle	30	7.2
High	148	25.7
University	226	54.5

Currently attending school		
Yes	289	68.1
No	135	31.9
Person with whom young people live mostly		
Both parents	308	72.6
One parents	43	10.1
Other relatives	10	2.4
Guardian	18	4.3
Friends	41	9.7
Alone	1	0.2
Monastery	2	0.5
Others	1	0.2
Job		
Paid work	127	30
Unpaid work	240	56.6
No job	72	13.4

Table (2) mentions the mean of hours of work per week among young people, their weekly income and income per hour. They worked 29 hours as an average for paid work and they were paid 2,377 kyats per hour.

Table 2 Mean working hours and income per week of the young people (n=424)

Variables	Mean (SD)	Minimum	Maximum
Working hours per week (paid work)	29.2 (25.6) hours	1 hour	99 hours
Income per week	29,460 (28181) kyats	1,500 kyats	300,000 kyats
Income per hour	2,377 (3887) kyats	45 kyats	35,000 kyats

5.2 Social activities and sexual relationship

5.2.1 Social activities among young people

Social activities (risk behaviors) of young people are mentioned in table (3). Majority of them (288, 67.9%) did not go to any place for entertainment within last 30 days. One third of respondents (142, 33.5%) drink alcohol, 71 (16.8%) smoke and only a few (8, 1.9%) use narcotics.

Table 3 Social activities or risk behaviors among young people (n=424)

Social activities (risk behaviors)	Number	Percent
Went to places for entertainment within last 30 days	288	67.9
None	131	30.9
1 to 5 times	5	1.2
6 to 20 times		
Alcohol drinking		
Yes	142	33.5
No	282	66.5
Smoking		
Yes	71	16.8
No	353	83.2
Narcotic use		
Yes	8	1.9
No	416	98.1

The most common occasions for young male and female to meet each others were social gatherings such as wedding receptions, religious events, stage shows, funerals and traditional events. Some also mentioned that they can meet at school/university, gardens or during picnics and trips to pagoda.

"(Boys and girls usually meet at) fun fairs, wedding receptions, funerals, and during Thingyan Festival."

(FGD with young male from Pinlaung)

"(ယောကျ်ားလေးမိန်းကလေးတွေ့ကြတာက) ပျော်ပွဲရွှင်ပွဲ၊မင်္ဂလာပွဲ၊နာရေး၊သင်္ကြန်ချိန်တွေ"

(FGD with young male from Pinlaung)

"At school and university, at the concerts, in the parks, Ta SaungTaing Festival, on picnic "(boys and girls usually meet)"

(FGD with young female from rural Taunggyi)

"ကျောင်းတက်နေတဲ့အချိန်၊ရှိုးပွဲ၊ပန်းခြံ၊ဘုရားဖူး၊တန်ဆောင်တိုင်၊ပျော်ပွဲစားထွက်တဲ့အချိန်တွေမှာ
"(ယောကျ်ားလေးမိန်းကလေးဆုံဖြစ်ကြတယ်)"

(FGD with young female from rural Taunggyi)

5.2.2 Sexual relationship among young people

Table (4) indicated sexual relationship (behaviors) of young people. Just above of half of them (222, 52.4%) had ever had boyfriend/girlfriend and the youngest age of starting

relationship was 10 years with an average of 17.9±2 years. Among those who had relationship, a large number (170, 76.6%) had physical contacts such as kissing, touching etc. with their boyfriends/girlfriends. Only 12% had experienced of having sex. The mean age of first sex was 19.2±1.9 years while the youngest age was 16 years and the oldest was 24 years. Among young people who did not have sex before, 63.4% planned to wait until they get married and one third of them did not have any plan about having sex.

Table 4 Sexual relationship (behaviors) among young people

Sexual relationship/behaviors	Number	Percent
Having boyfriend/girlfriend (n=424)		
Yes	222	52.4
No	202	47.6
Age of starting relationship (n=222)		
10 to 15 years	21	9.5
16 to 20 years	190	85.6
21 to 24 years	11	4.9
Physical contact with boyfriend/girlfriend (n=222)		
Yes	170	76.6
No	52	23.4
Ever had sex with anyone (n=424)		
Yes	50	11.8
No	374	88.2
Plan for sex (for those who do not have sex before) (n=374)		
Wait until marriage	237	63.4
Wait until engaged	7	1.9
Wait until finding love one	9	2.4
Will do when opportunity comes	7	1.9
No plan	114	30.5

All focus group discussions disclosed that most of the young people in the study areas had dating experiences and age of first date ranged from 14 to 19 years. Young people from Pinlaung usually had date at public places such as gardens, restaurants and pagoda festivals. Some young female revealed that they rarely had date and if they had, they usually met their boyfriends at their home.

"(Have a date) in the park, at a restaurant, at the pagoda, Myanmar traditional concert (zatpwe)"

(FGD with young male from Pinlaung)

"ပန်းခြံ၊စားသောက်ဆိုင်၊ဘုရား၊ဇာတ်ပွဲ၊(တို့မှာချိန်းတွေ့တယ်)"
(FGD with young male from Pinlaung)

"There is not much dating (between a boy and a girl alone), spend time together with a group of friends and visit each other at home, meet in the kitchen."
(FGD with young female from Pinlaung)
"(ယောကျ်ားလေး၊မိန်းကလေးချိန်းတွေ့တာ)သိပ်မရှိဘူး။အုပ်စုလိုက်လာလည်။အိမ်မှာပဲတွေ့တယ်။မီးဖို ဆောင်မှာတွေ့တယ်။"
(FGD with young female from Pinlaung)

Both male and young female from urban and rural Taunggyi commonly dated at the public places such as cinema, gardens, famous places, pagodas, restaurants and monasteries. They also hanged out with their partners at private places like guest houses, hotels, friend's house and in the bushes.
"We have a date in the park, in popular places, at cinema. We also choose an isolated places like behind the bushes on a hill, at guesthouses and KTV. If we have a date (in those isolated places) we cannot satisfy with just touching hands. We also spend time together at a friend's place."
(FGD with young male from rural Taunggyi)
"ပန်းခြံ၊နာမည်ကြီးတဲ့နေရာ၊ရုပ်ရှင်ရုံ (တွေ့မှာလည်းချိန်းတွေ့တယ်)။ လူမမြင်တဲ့နေရာတောင်ပေါ်က ချုံတွေကြားတွေ့၊တည်းခိုခန်းတို့၊ KTV တို့လည်းသွားတယ်။ (အဲ့ဒီလူမမြင်တဲ့နေရာတွေ) သွား ချိန်းတွေ့ ရင်လက်ထိရုံနှင့်မနေနိုင်ဘူး၊သူငယ်ချင်းအိမ်သွားတာလည်းရှိတယ်။"
(FGD with young male from rural Taunggyi)

Apart from one FGD with young female from Pinlaung, all others admitted that young male and female in their area usually have sex with their boyfriends/girlfriends and the age of first sex varied from 16 years to 19 years. They generally went to hotels, guest houses, their friends' houses or bushes for having sex.
"(To make love with boyfriend/ girlfriend) we go to guest-houses, hotels, a friend's house, bushes and up the hill."
(FGD with young male from urban Taunggyi)
"(သမီးရည်းစားအတူနေဖို့တော့) တည်းခိုခန်း၊ဟိုတယ်၊သူငယ်ချင်းအိမ်၊ချုံဘုတ်၊ တောင်ပေါ်တွေ သွားတယ်။"
(FGD with young male from urban Taunggyi)

5.3 Knowledge of contraceptive among young people

In this study, we access the knowledge of young people on contraceptives by asking 1) types of contraceptive they had ever heard and 2) the source from where they can get contraceptives. Types of contraceptive methods known among young people are shown in

table (5). The study population was largely occupied by the young people who did not know the methods. Majority of the respondents could spontaneously name pills (180, 42.5%), condom (162, 38.2%) and injection (131, 30.9%) as contraceptive methods. In addition to these methods, young people also heard largely about female sterilization (224, 52.8%) and Intrauterine Device (IUD) (132, 31.1%) as well.

Table 5.Types of contraceptive methods known among young people (n=424)

Knowledge of contraceptives	Number	Percent
Pills		
Spontaneous	180	42.5
Prompted	29	6.8
Don't know	215	50.7
Injection		
Spontaneous	131	30.9
Prompted	62	14.6
Don't know	231	54.5
Condoms		
Spontaneous	162	38.2
Prompted	48	11.3
Don't know	214	50.5
Emergency contraceptive pills		
Spontaneous	33	7.8
Prompted	30	7.1
Don't know	361	85.1
Withdrawal		
Spontaneous	24	5.7
Prompted	29	6.8
Don't know	371	87.5
Periodic Abstinence/Rhythm		
Spontaneous	30	7.1
Prompted	27	6.4
Don't know	367	86.6
Others		
IUD	132	31.1
Implant	71	16.8
Jelly/form	9	2.1
Female sterilization	224	52.8
Male sterilization	39	9.2

Table (6) shows the proportion of young people who knew the source of contraception among those who had been heard about different contraceptive methods. Less than one third of the young people who had heard about contraceptive methods were aware where contraceptives could be obtained.

Table 6.Knowing source of contraceptives

Knowledge of source of contraceptives	Number	Percent
Know where pills can be obtained (n=209)		
Yes	65	31.1
No	79	37.8
No answer	65	31.1
Know where injection can be obtained (n=193)		
Yes	46	23.8
No	79	40.9
No answer	68	35.3
Know where condoms can be obtained (n=210)		
Yes	61	29.1
No	52	24.8
No answer	97	46.1
Know where emergency pills can be obtained (n=63)		
Yes	14	22.2
No	18	28.6
No answer	31	49.2
Know how to do withdrawal (n=53)		
Yes	9	17
No	14	26.4
No answer	30	56.6
Know how to do Periodic Abstinence/Rhythm (n=57)		
Yes	10	17.5
No	11	19.3
No answer	36	63.2

We found out in FGDs that the drug shops and GP clinics were the best-known sources of contraception among the young people. Some were aware that contraceptives could be obtained from public health facilities but two focus groups from Taunggyi did not know about it. A few also knew that government health staff such as Health Assistants and midwives could provide contraceptives. They mainly obtained information about sources where they can get contraceptives from their friends and a few knew from midwives, PSI clinics, facebook and pamphlets.

The respondents also suggested the methods that are suitable for young people (figure-1). The most suitable method for young people indicated by the most of the respondents was condom (175, 41.3%). However, more than one quarter of them (117, 27.6%) did not know what contraceptive methods would be appropriate for young people.

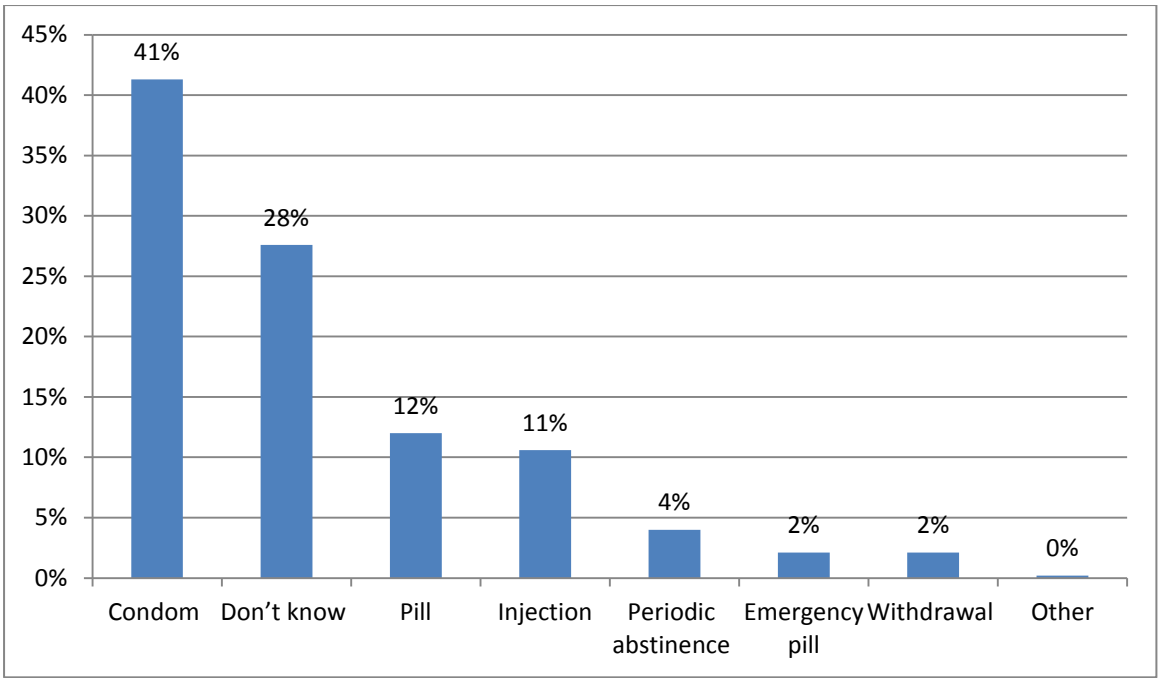

Figure 1 Respondents' opinion on most suitable contraceptive methods for young people (n=424)

5.4 Sexual contact, use of contraceptive and outcome

Table 7 Sexual contact and use of contraceptives among young people

Use and source of contraceptives	Number	Percent
Number of sexual partners (n=50)		
Only one	32	64
2 to 4	10	20
5 to 20	8	16
Use of contraceptive apart from first sex (n=50)		
Always	6	12
Sometimes	25	50
Never	19	38
Type of contraceptive mostly used (n=31)		
Condom	14	45.2
Pills	8	25.8
Injection	2	6.5
Emergency pills	3	9.7
Withdrawal	4	12.9

Source of contraceptives (n=31)		
Shops/vendors	4	12.9
Pharmacies	23	74.2
Government clinics/hospitals/health centers	1	3.2
Private doctors/nurses/clinics	1	3.2
Friends	2	6.5
Easiness to get contraceptives of choice (n=31)		
Very difficult	3	9.7
Difficult	6	19.4
Average	12	38.7
Easy	9	29
Very easy	1	3.2
Reasons for not using contraceptives (n=19)*		
Don't know where to obtain/buy	6	31.6
Not easily available nearby	6	31.6
Too shy to obtain/buy	7	36.8
Too afraid to obtain/buy	6	31.6
Too expensive to buy	3	15.8
Don't want to use	10	52.6
Others	6	31.6

* Multiple responses

Table (7) shows sexual contact and use of contraceptive among young people. In the 50 respondents who have had sex before, 36% had more than one sexual partner and there were a few young people (6, 12%) who had 17 to 20 partners. Apart from their first sex, thirty one (62%) respondents had used contraceptives and a lot of them used condom (14, 45.2%) and pills (8, 25.8%). They mostly obtained contraceptives from the pharmacies (23, 74.2%). Twenty two (71%) out of 31 respondents who had ever used contraceptives revealed that they obtained them without difficulties. It had also been explored the reasons for not using contraceptives and the commonest reasons were unwilling to use (10, 52.6%) and too shy to obtain/buy (7, 36.8%). However, in depth questions during FGDs elicited that many young people in the study areas had challenges in obtaining contraceptives and the key barriers revealed were too shy to buy, being scared to be noticed by their parents and neighbors and afraid of being reproached by others as they were young and unmarried. Apart from some respondents, financial barrier to obtain contraceptives was less likely to find in both qualitative and quantitative assessments.

"If someone is not married, it will be difficult to get (contraceptives). (Other people) can misjudge. People can say bad things about them. Money is not a problem to buy contraceptives."
(FGD with young female from rural Taunggyi)
"အိမ်ထောင်မရှိတဲ့အခါမှာ၊(တားဆေး)သွားယူတဲ့အခါမှာအဆင်မပြေနိုင်ဘူး။(ပတ်ဝန်းကျင်က) အထင်လွဲနိုင်တယ်။ပတ်ဝန်းကျင်ကငြိုငြင်မယ်။ဝယ်ရမယ်ဆိုရင်ငွေရေးကြေးရေးကတော့အခက်အခဲမရှိနိုင်ဘူး။"
(FGD with young female from rural Taunggyi)

"We are shy to go and buy (contraceptives/condoms). Sometimes we do not have enough money. We are worried that other people know about it. We can borrow money from friends to buy contraceptives. I will ask someone to get it for me."
(FGD with young male from urban Taunggyi)
"(တားဆေး/ကွန်ဒုံးသွား၀ယ်ရမှာ)ရှက်တယ်။တစ်ခါတလေလည်းပိုက်ဆံမရှိဘူး(၀ယ်ဖို့)။တခြားလူတွေသိမှာစိုးတယ်၊အသိတစ်ယောက်ဆီကနေပိုက်ဆံချေးဝယ်မယ်။သူများနဲ့ဝယ်ခိုင်းမယ်"
(FGD with young male from urban Taunggyi)

Since they dared not go and obtain contraceptives due to their embarrassment and fear, most of them disclosed that they would ask their friends or partners to buy contraceptives for them.

(If I need to buy condom or contraceptive), I will probably ask a friend or someone who is married."
FGD with young female from Pinlaung)
"(တားဆေး/ကွန်ဒုံး၀ယ်ဖို့လိုလာရင်) သူငယ်ချင်းကိုဝယ်ခိုင်းမယ်။ သူတို့ခင်တဲ့တစ်ယောက်ကိုဝယ်ခိုင်းမယ်။အိမ်ထောင်ရှိတဲ့သူဝယ်ခိုင်းမယ်။"
(FGD with young female from Pinlaung)

In addition, it was difficult for most of them to negotiate with their boyfriends/girlfriends for using contraceptives as majority of female youth were shy and worry about being reproached by their environment.
"It won't be OK. Girls worry a lot. They are also shy and care too much about personal dignity. They are worried about the criticism from the people around them."
(FGD with young male from urban Taunggyi)

"အဆင်မပြေလောက်ဘူးမိန်းကလေးတွေကအပူအပင်များတယ်၊အရှက်နှင့်သိက္ခာကရှိသေးတယ်။ပတ်ဝန်းကျင်ကလည်းကဲ့ရဲ့မှာစိုးတာရှိတယ်။"
(FGD with young male from urban Taunggyi)

Whether they used contraceptive or not most of the young male and female were afraid of getting pregnancy. Fear to take responsibility was the most common reason among male and worrying about social consequences was the important issue among female.
"I am worried that I get pregnant. If so, my family's reputation will also be damaged. Our neighbourhood will stigmatize me if they find out."
(FGD with young female from Pinlaung)

"ကိုယ်ဝန်ရမှာကြောက်တယ်။အမျိုးနာမယ်။နာမည်ပျက်မယ်။မကောင်းတဲ့သူလို့ထင်မှာ။ရပ်ကွက်ကမကြိုက်ဘူး။ဒဏ်ရိုက်တယ်။"
(FGD with young female from Pinlaung)
"I am scared that my girlfriend to be pregnant and also scared that such condition would be noticed by our parents. I am afraid of getting married. We will be in trouble if we marry before we settle for our living. I don't want to be starving."
(FGD with young male from rural Taunggyi)
"ကိုယ်ဝန်ရသွားမှာကြောက်တယ်၊မိဘတွေသိမှာစိုးတယ်။ကိုယ်ဝန်ရသွားရင်ယူလိုက်ရမှာကြောက်တယ်။ နေရေးထိုင်ရေး အဆင်သင့်မဖြစ်သေးဘဲယူလိုက်ရရင် ထမင်းငတ်မှာစိုးလို့။"
(FGD with young male from rural Taunggyi)

However a few said they did not afraid to getting pregnancy they thought that pregnancy could be aborted.
"I am not worried about getting pregnant, because if I got pregnant, I could have it aborted. I have ever heard about it. Someone got married unexpectedly and so they sought help from traditional birth attendants. Mostly, they are not well-educated. Well-educated people know how to prevent pregnancy."
(FGD with young female from rural Taunggyi)

"ကိုယ်ဝန်ရှိလည်းမကြောက်ဘူး၊ဖျက်ချလို့ရတယ်ထင်လို့။အဲ့လိုမျိုးတွေကြားဖူးတယ်။မထင်မှတ်ဘဲကိုယ်ဝန်ရလာတယ်။လက်သည်နဲ့ဖျက်ချတယ်။ဖျက်ချတဲ့လူတွေကတော့ပညာမတတ်တာများတယ်။ပညာတတ်တဲ့လူတွေကတော့ကိုယ်ဝန်မရအောင်ကာကွယ်နိုင်တယ်။"
(FGD with young female from rural Taunggyi)

Stigma of using contraceptive among unmarried young people: Almost all respondents said they could be looked down by their environment if they used contraceptive since they were young and unmarried.
"If our friends know that (using contraceptives), I think they will criticize me. Because we are young and not married."
(FGD with young male from urban Taunggyi)

"(တားဆေးသုံးတာ) အချင်းချင်းသိရင် ကဲ့ရဲ့ကြမယ်ထင်တယ်။ ဘာလို့လဲဆိုတော့ ငယ်ရွယ်တာရယ် အိမ်ထောင်လည်း မရှိတာရယ်ကြောင့်။"

(FGD with young male from urban Taunggyi)

Table (8) indicates the outcome of sexual contact among young people who had sex before. Majority of them (37, 74%) had been worrying about getting pregnancy but some of them (10, 20%) revealed that their sexual contact ended up with pregnancy and their pregnancy outcomes are shown in table (8). About one third of them (19, 38%) always had enough money to get contraceptives of their choice. Marriage was the most frequent response while asking their action if they or their girlfriends would become pregnant today (43, 86%).

Table 8 Pregnancy related concerns among young people (n=50)

Variables	Male n (%)	Female n (%)
Worried about getting pregnant (n=50)		
Yes	24 (72.7)	13 (76.5)
No	3 (9.1)	1 (5.9)
Never thought about it	6 (18.2)	3 (17.6)
Enough money for obtaining contraceptive of choice		
Always	13 (39.4)	6 (35.3)
Sometimes	15 (45.5)	9 (52.9)
Never	5 (15.1)	2 (11.8)
Ever made a girl pregnant/ever been pregnant		
Once	1 (3.0)	3 (17.7)
Twice	4 (12.1)	2 (11.8)
Never	23 (69.7)	11 (64.7)
Not sure/refuse to answer	5 (15.2)	1 (5.9)
Condition of last pregnancy (n=10)		
Currently pregnant	1 (20.0)	2 (40.0)
Abortion	0	1 (20.0)
Miscarriage	1 (20.0)	0
Live-birth	2 (20.0)	1 (20.0)
Not sure/ refuse to answer	1 (20.0)	1 (20.0)
Action if the respondent/girlfriend become pregnant today		
Get married	27 (81.8)	16 (94.1)
Get abortion	0	0
Have child without marrying	1 (3.0)	0
Not sure	5 (15.2)	1 (5.9)

5.5 Association between background characteristics and sexual behaviors

Association between background characteristics and risk behaviors is shown in table (9). The proportion of young people who committed all risk behaviors was significantly higher among male than female. Alcohol drinking was higher among older age group. More out-of-school young people were more likely to go to the places for entertainments and smoke comparing to in-school young people.

Table 9 Association between background characteristics and risk behaviors

Characteristics		Ever went to place of entertainments n=136	Drink alcohol n=142	Smoke n=71	Use narcotic n=8
Area					
	Rural	78 (32.8)	84 (35.3)	44 (18.5)	5 (2.1)
	Urban	58 (31.2)	58 (31.2)	27 (14.5)	3 (1.6)
	p-value	0.73	0.37	0.28	1
Sex					
	Male	94 (45.6)	109 (52.9)	69 (33.5)	8 (3.9)
	Female	42 (19.7)	33 (15.1)	2 (0.9)	0
	p-value	<0.0001*	<0.0001*	<0.0001*	0.003*
Age					
	<21 years	73 (28.7)	72 (28.5)	44 (17.3)	7 (2.8)
	21-24 years	63 (37.1)	70 (41.2)	27 (15.9)	1 (0.6)
	p-value	0.07	0.006*	0.69	0.15
Schooling					
	In-school	80 (27.7)	90 (31.1)	40 (13.8)	7 (2.4)
	Out-of-school	56 (41.5)	52 (38.5)	31 (23)	1 (0.7)
	p-value	0.005*	0.13	0.02*	0.45

Table (10) indicates the association between background characteristics and sexual behaviors. The proportion of young male who had relationship, physical contact with their girlfriends and sex was significantly higher than the proportion of young female who had the same conditions. More young people from older age group had relationship than those from younger age group.

Table 9 Association between background characteristics and sexual behaviors (n=424)

Characteristics		Having relationship n=222	Having physical contact n=170	Having sex n=50	More than one sexual partner n=18
Area					
	Rural	126 (52.9)	98 (77.8)	31 (13)	10 (41.7)
	Urban	96 (51.6)	72 (75)	19 (10.2)	8 (30.8)
	p-value	0.78	0.63	0.37	0.42
Sex					
	Male	132 (64.1)	111 (84.1)	33 (16)	12 (38.7)
	Female	90 (41.3)	59 (65.6)	17 (7.8)	6 (31.6)
	p-value	<0.0001*	0.001*	0.009*	0.61
Age					
	<21 years	113 (44.5)	85 (75.2)	26 (10.2)	8 (30.8)
	21-24 years	109 (64.1)	85 (77.9)	24 (14.1)	10 (41.7)
	p-value	<0.0001*	0.63	0.23	0.42
Schooling					
	In-school	144 (49.8)	116 (80.6)	33 (11.4)	13 (35.1)
	Out-of-school	78 (57.8)	54 (69.2)	17 (12.6)	5 (38.5)
	p-value	0.13	0.06	0.73	0.83

Association between background characteristics and mean age of first relationship and sex are mentioned in table (11). The mean age of first relationship and sex were significantly lower among young people from younger age group.

Table 10 Association between background characteristics and mean age of first relationship and sex

Characteristics		Mean age of first relationship	Mean age of first sex
Area			
	Rural	17.9 ± 2.2	19.4 ±2
	Urban	18.1 ±1.6	18.6 ±1.6
	p-value	0.44	0.51
Sex			
	Male	17.8 ±2	18.8 ±1.7
	Female	18.3 ±2	20.3 ±2
	p-value	0.11	0.13
Schooling			
	In-school	17.9 ±2	18.9 ±1.8
	Out-of-school	18.2 ±2	19.9 ±1.8
	p-value	0.46	0.13

5.6 Association between background characteristics and contraceptive knowledge and use

Table (12) shows association between background characteristics and knowing types of contraceptives among young people. Pills, injection and implant had been heard more among young female. Condom was highly known among urban young people and male. More in-school young people and male knew withdrawal method.

Table 11 Association between background characteristics and knowing types of contraceptives

Characteristics		Pills n=209	Injection n=193	Condom n=209	EC pills n=210	Withdrawal n=53	Period n=57	IUD n=132	Implant n=71	Jelly/form n=9	Female Sterilization n=224	Male sterilization n=39
Area												
	Rural	116 48.7)	103 (43.3)	107 (45)	31 (13)	36 (15.1)	29 (12.2)	67 (28.2)	35 (14.7)	5 (2.1)	126 (52.9)	18 (7.6)
	Urban	93 (50)	90 (48.4)	103 55.4)	32(17.2)	17 (9.1)	28 (15.1)	65 (35)	36 (19.4)	4 (2.2)	98 (52.7)	21 (11.3)
	p-value	0.79	0.29	0.033*	0.23	0.06	0.39	0.13	0.20	0.97	0.96	0.18
Sex												
	Male	60 (29.1)	58 (28.2)	141(68.5)	28(13.6)	37 (18)	23 (11.2)	62 (30.1)	15 (7.3)	5 (2.4)	102 (49.5)	16 (7.8)
	Female	149 68.4)	135 (61.9)	69 (31.7)	35 16.1)	16 (7.3)	34 (15.6)	70 (32.1)	56 (25.7)	4 (1.8)	122 (56)	23 (10.6)
	p-value	<0.0001*	<0.0001*	<0.0001*	0.48	0.001*	0.18	0.66	<0.0001*	0.67	0.18	0.32
Age												
	<21 years	121 47.6)	116 (45.7)	119(46.9)	31(12.2)	31 (12.2)	39 (15.4)	72 (28.4)	29 (11.4)	6 (2.4)	135 (53.2)	21 (8.3)
	21-24 years	88 (51.8)	77 (45.3)	91 (53.5)	32(18.8)	22 (12.9)	18 (10.6)	60 (35.3)	42 (24.7)	3 (1.8)	89 (52.4)	18 (10.6)
	p-value	0.41	0.94	0.18	0.06	0.82	0.16	0.13	<0.0001*	0.68	0.87	0.42
Schooling												
	In-school	139(48.1)	127 (43.9)	151(52.3)	44(15.2)	43 (14.9)	36 (12.5)	91 (31.5)	45 (15.6)	7 (2.4)	153 (52.9)	26 (9)
	Out-of-	70 (51.9)	66 (48.9)	59 (43.7)	19(14.1)	10 (7.4)	21 (15.6)	41 (30.4)	26 (19.3)	2 (2.5)	71 (52.6)	13 (9.6)
school		0.47	0.34	0.1	0.76	0.03*	0.38	0.82	0.34	0.53	0.95	0.83
	p-value											

Table (13) mentions association between background characteristics and use of contraceptives. The statistically significant association was found among area (rural-urban) and using contraceptives. Young people from urban area were more likely to use contraceptives when they had sex.

Table 12 Association between background characteristics and use of contraceptives

Characteristics		Ever use contraceptive n=31	Easy to access contraceptive n=22
Area			
	Rural	15 (48.4)	11 (73.3)
	Urban	16 (84.2)	11 (68.8)
	p-value	0.01*	1
Sex			
	Male	21 (63.6)	14 (66.7)
	Female	10 (58.8)	8 (80)
	p-value	0.7	0.68
Age			
	<21 years	14 (53.9)	8 (57.1)
	21-24 years	17 (70.8)	14 (82.4)
	p-value	0.22	0.23
Schooling			
	In-school	19 (57.6)	12 (63.2)
	Out-of-school	12 (70.6)	10 (83.3)
	p-value	0.37	0.42

5.7 Attitude on sexuality, gender and norms

This study also revealed the attitude of the young people on sexuality, gender and norms and the results are shown in table (14). Majority agreed to the facts that having pre-marital sex among boys and girls is acceptable if they love each other, a boy has to force a girl to have sex if he loves her and they won't be respected if they use contraceptives. They mostly disagreed on the statement that ensuring regular use of contraception is women's responsibility. Just above one third unsure about the statement "I am confident that I can obtain a contraceptive and use it when I want to".

Table 14 Attitude on sexuality, gender and norms among young people (n=424)

Statements	Agree n (%)	Not sure n (%)	Disagree n (%)
I believe there is nothing wrong with unmarried boys and girls having sexual intercourse if they love each other.	**280 (66)**	58 (13.7)	86 (20.3)
I think that sometimes a boy has to force a girl to have sex if he loves her.	**198 (46.7)**	113 (26.6)	113 (26.6)
It is mainly the woman's responsibility to ensure that contraception is used regularly.	147 (34.7)	113 (26.6)	**164 (38.7)**
I feel like I would not be respected if I use contraceptives.	**198 (46.7)**	159 (37.5)	67 (15.8)
I am confident that I can obtain a contraceptive and use it when I want to	149 (35.1)	**175 (42.3)**	100 (23.6)

5.8 Reproductive health information among young people

5.8.1 Information sources of reproductive health among young people

Figure (2) shows the most and second most frequently used and most preferred source of reproductive health information among young people. Majority of them mentioned midwives (72, 17%) internet/ facebook (70, 16.5%), and printed media such as magazine or books (57, 13.4%) as most frequently used source of reproductive health information. Friends (64, 15.1%), printed media (57, 13.4%) and midwives (50, 11.8%) were the second most frequently used source of information. FGDs also revealed that the common source of RH information among young people were facebook, friends, TV, video, printed media such as pamphlets, books and journals and health care providers and all agreed that the most influential media for young people was **"facebook"**. However, half of the FGD respondents thought the RH information provided by the media could not be correct.

"I don't think the information about sexual health from Facebook and the Internet is reliable. There may be correct and also incorrect information. Gaining good knowledge depends on ourselves"

(FGD with young female from rural Taunggyi)

facebookတို့၊internet တို့၊တခြားဂျာနယ်တို့ကရတဲ့လိင်ကိစ္စနဲ့ ပတ်သက်တဲ့အချက်တွေက မှန်ကန်မှု ရှိမယ် မထင်ဘူး၊ လွဲနိုင်တယ်လို့ထင်တယ်။ ကောင်းတာတွေရော မကောင်းတာ တွေရောဖြစ်နိုင်တယ်။ အသိဉာဏ်ကောင်းကောင်း ရဖို့ကကိုယ့်ပေါ်မှာပဲမူတည်တယ်။"

(FGD with young female from rural Taunggyi)

Therefore, a large proportion of them preferred to receive reproductive health information from doctors (114, 26.9%), midwives (88, 20.8%) and internet (43, 10.1%).

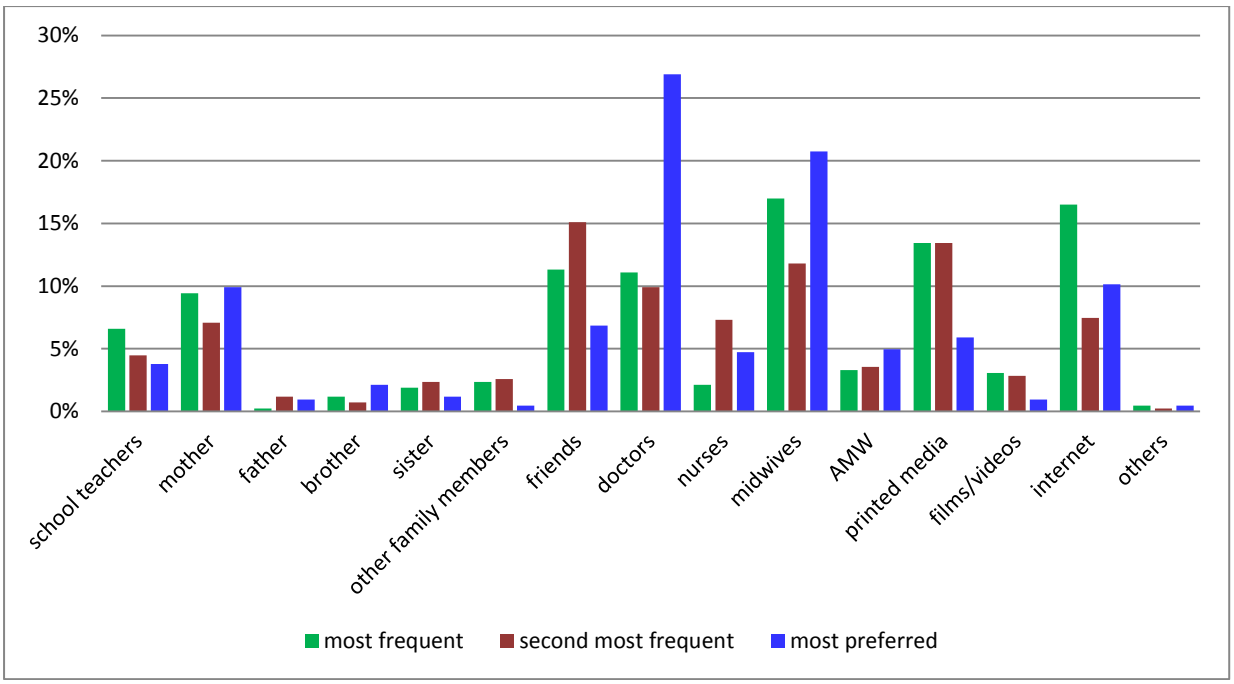

Figure 2 Most and second most frequent sources and most preferred sources of reproductive health information among young people (n=424)

Most suitable media for both literate and illiterate: Health talks using pictorial, broadcasting via TV and radio were indicated by all FGD respondents as the suitable media for both literate and illiterate for provision of RH information to young people.

"Health education can be more effective with pictures and images because it can convey messages even to the illiterate. Education through TV and the radio is also good."
(FGD with young female from Pinlaung)

"စာတတ်တဲ့သူတွေပါအဆင်ပြေအောင်ဆိုရုပ်ပုံတွေနဲ့ပြီးကျန်းမာရေးပညာပေးတာပိုအဆင်ပြေမယ်၊ ကာတွန်းလိုပုံစံတွေ၊ TV တို့၊radio တို့ကလွှင့်တာမျိုးလည်းအဆင်ပြေနိုင်တယ်။"
(FGD with young female from Pinlaung)

5.8.2 Reproductive health information that young people want to know more

All of them admitted that they did not know much about reproductive health. They wanted to be acquainted with use of condom, contraceptive methods, their use and side effects, STIs and its transmission and prevention.

"I think I have some knowledge about the medicines which can prevent pregnancy. But I do not know all about their side effects, which and how to use, what kind of diseases I can

contract (sexually). It means I do not have all the information about sexual health. I want to receive this information from others, especially our teachers. I want to read the books about it and watch on TV too."

(FGD with young male from rural Taunggyi)

"နည်းနည်းပါးပါးသိတယ်လို့ထင်ပါတယ်။ကိုယ်ဝန်တားနိုင်တဲ့ဆေးတွေအကြောင်းကို။ဒါပေမယ့်သုံးပြီး နောက်ဆက်တွဲဘာတွေဖြစ်နိုင်သလဲ။နည်းလမ်းအလိုက်ဘယ်လိုသုံးလို့ရမလဲဆိုတာတွေ(လိင်ဆက်ဆံမှုက နေ)ဘယ်လိုရောဂါမျိုးကူးစက်နိုင်လဲ။လိင်အင်္ဂါကျန်းမာရေးနဲ့ပတ်သက်ပြီးပြည့်စုံမှုမရှိသေးဘူး။ သူများပြောပြတာနားထောင်ချင်တယ်၊ကြည့်ချင်တယ်၊ရင်းနှီးတဲ့ဆရာ/ဆရာမတွေဆီကသိချင်တယ်၊စာအုပ်၊ TV ကနေကြည့်ချင်တယ်။"

(FGD with young male from rural Taunggyi)

5.8.3 How they would like to get reproductive health information

Majority wanted to acquire reproductive health information from internet, facebook, TV and health talk. Only some of them suggested face-to-face health education with health care providers and midwives.

"I like to have health talks which are provided one village after another. I don't think it's a problem to educate men and women together, but for the ones who are shy, they can be provided information one by one. I would like to get information on TV and through Facebook as almost all young people use facebook."

(FGD with young male from rural Taunggyi)

"ဟောပြောပွဲ၊တစ်ရွာဆင်းတစ်ရွာတက်**လိုက်လုပ်ပေးတာမျိုး**။အမျိုးသား၊အမျိုးသမီးပေါင်းပြော**လို့ရတယ်။ ရှက်ကြောက်နေမယ်ဆိုရင်တော့**တစ်အိမ်တစ်ယောက်ခေါ်ပြီးပြောစေချင်**တယ်။**TV, Facebookတို့မှာလည်းပညာပေးစေချင်တယ် (Facebook **ကလူငယ်တိုင်းသုံးတာဆိုတော့**)။"

(FGD with young male from rural Taunggyi)

"I want health staff or midwives to educate us one by one in privacy without other people around us. I like receiving the information through health journals and the Internet. I also welcome health talks."

(FGD with young female from Pinlaung)

"ကျန်းမာရေးဝန်ထမ်း၊သားဖွားဆရာမ**တွေက** လူရှင်းတဲ့အချိန်၊ နှစ်ယောက်ထဲပေးတာပိုကြိုက်**တယ်။** ကျန်းမာရေး**စာစောင်**၊အင်တာနက်**တွေကတစ်ဆင့်လိုချင်တယ်။**ကျန်းမာရေးပညာပေးဟောပြောပွဲ**လုပ်တာ ကြိုက်တယ်။**"

(FGD with young female from Pinlaung)

Some suggested to provide male and female separately and some suggested information can be provided both in the same group.

"I think boys and girls should be educated and provided this information separately, one by one or in groups."

(FGD with young male from rural Taunggyi)

"မိန်းကလေးတွေအနေနဲ့သီးသန့်ခေါ်ပြီးပေးသင့်တယ်။တစ်ဦးချင်းခေါ်ပေး၊တိတ်တိတ်လေးခေါ်ပြောပေးပါ။ အဖွဲ့လိုက်ဟောပြောပွဲလိုပြောပေးစေချင်တယ်။ယောကျ်ားလေးတွေကိုလည်းသီးသန့်သင်တန်းပေးစေချင်တယ်။"

(FGD with young male from rural Taunggyi)

Apart from some male and female respondents from Taunggyi who stated that reproductive information were attained more from the out-of-school environment, most of them perceived that schooling status was one of the factors determining availability of reproductive health information among young people and they had more chance to get information at schools since health talks were provided at schools by health care providers.

"(I don't think we can get more information about reproductive health at school/university). People talk about it more outside school and university. Peers share information about (how to prevent) pregnancy. Some people tell us about it based on their own experience so the information is more likely to be practical."

(FGD with young male from rural Taunggyi)

"(ကျောင်းမှာမျိုးဆက်ပွားကျန်းမာရေးနဲ့ပတ်သက်တဲ့အချက်အလက်တွေပိုရတယ်လို့မထင်ပါဘူး)အပြင်ဇလာကမှာသိချင်တဲ့အကြောင်းပိုပြောဖြစ်ကြတယ်။အပြင်မှာပိုသိတယ်။ကိုယ်ဝန်မရအောင် (ဘယ်လိုတားရမလဲ)သူငယ်ချင်းအချင်းချင်းပြောကြတယ်။သူတို့ရဲ့ကိုယ်တွေ့နဲ့ယှဉ်ပြောပြတော့ပိုယုံတယ်"

(FGD with young male from rural Taunggyi)

I think the chance to get the information about reproductive health depends on the fact that someone go to school/university or not. At school/ university, students receive health education provided by health assistants or teachers.

(FGD with young female from Pinlaung)

(မျိုးဆက်ပွားကျန်းမာရေးနဲ့ပတ်သက်တဲ့အချက်အလက်တွေပိုရမရကကျောင်းနေနဲ့ကျောင်းမနေ) နည်းနည်းတော့ဆိုင်တယ်၊ကျောင်းမှာပြောတာရှိတယ် ကျန်းမာရေးမှူးကလာပြောတယ်။ကျောင်းဆရာမကပြောတာရှိတယ်။

(FGD with young female from Pinlaung)

5.9 Young people opinion and suggestions on contraceptive availability and use

During FGD with young people, they mostly referred sources of reproductive health services for youth as public hospitals, general practitioners' clinics, drug shops and health care providers such as doctors and midwives. Some also indicated INGO's clinics and auxiliary midwives as sources of RH services.

A large number of both young male and female pointed out that contraceptive services should be given to unmarried youth with the main reasons of preventing unwanted pregnancy, abortion and their social consequences. And they also suggested that reproductive health education should be started early since the time when they have not known about sex.

"I think abortion rate can be decreased if (contraceptive service) is provided. These services can allow more open discussions. It can help people to increase understanding about do's and don'ts. If a person attains the age of 16-18, they should be provided this education. I believe that (reproductive health education) should be provided at school when the children are going through development stages and before they have exposure to sex."
(FGD with young female from urban Taunggyi-group-1)
"(သန္ဓေတားခြင်းနဲ့ဆိုင်တဲ့ဝန်ဆောင်မှုတွေ) ပေးလိုက်ရင်ကိုယ်ဝန်ဖျက်ချနှုန်းကျမယ်ထင်တယ်၊ ပွင့်ပွင့်လင်းလင်းပိုဆွေးနွေးနိုင်မယ်။ဆောင်ရန်၊ရှောင်ရန်ပိုသိသွားမယ်၊၁၆-၁၈အရွယ်ဆိုပေးသင့်ပြီ၊ (မျိုးဆက်ပွားကျန်းမာရေးပညာပေးတွေကို)ကျောင်းတွေမှာငယ်ငယ်ရွယ်ရွယ်ကလေးဦးနှောက်ဖွံ့ဖြိုးစ အရွယ်တွေကတည်းစပေးသင့်တယ်ထင်တယ်။လိင်ကိစ္စမသိခင်အရွယ်တည်းကပေးသင့်တယ်ထင်။"
(FGD with young female from urban Taunggyi-group-1)

"Education should be provided to help people become knowledgeable about health, to prevent unwanted pregnancy, and to prevent bad things from happening unnecessarily."
(FGD with young female from rural Taunggyi)
"ကျန်းမာရေးအသိပညာရှိအောင်လို့ပေးသင့်တယ်။မလိုလားအပ်ပဲကိုယ်ဝန်တွေမရအောင်လို့ပေးသင့်တယ်။ မလိုလားအပ်သောအရာတွေမဖြစ်အောင်လို့ကြိုပြီးတော့ကာကွယ်ထားရမယ်။"
(FGD with young female from rural Taunggyi)

"During health talks, the information such as how to prevent pregnancy after having sex, how to prevent sexually transmitted diseases, how to use contraceptive methods and medicines should be discussed. These programs should also reach villages, not just towns and cities. School teachers, children before reaching adolescence, and parents should be targeted, if possible. Children should get this kind of information from their parents, too. It is more beneficial if young people are educated. This information should not be keep from young people."
(FGD with young female from urban Taunggyi-group-2)

"တစ်ယောက်နဲ့တစ်ယောက် လိင်ဆက်ဆံတဲ့အခါမှာဘယ်လို ဘယ်လိုကာကွယ်ပြီးတော့မှ ကလေး မရနိုင်အောင်၊ ကိုယ်ဝန်/ရောဂါ မရအောင်၊ ဆေးတွေကိုဘယ်လိုသုံးရမလဲဆိုတဲ့ ကာကွယ်နည်း တွေဟောပြောစေချင်တယ်။ရွာဘက်တွေထိဟောပြောစေချင်တယ်။တတ်နိုင်ရင် ဆရာ၊ဆရာမတွေအနေနဲ့ လူပျို/အပျို မဖြစ်ခင် ကလေးတွေ၊ ကလေးတွေရဲ့မိဘတွေကိုလည်းပြောစေချင်တယ်။ မိဘများဆီကလည်း တဆင့်ပြန်ရစေချင်တယ်။လူငယ်တွေကိုလိင်ပညာပေးပြောတာပိုအကျိုးရှိမယ်ထင်တာပဲ။ ဖုံးကွယ် ထားဖို့တော့ မသင့်ဘူး"
(FGD with young female from urban Taunggyi-group-2)

On the other hand, a few young people though contraceptive service should not be given to unmarried youth as they perceived provision of contraceptive services to young people would make them spoiled especially female.
"I think contraceptive service should not be provided because it can spoil young women and girls. It may have negative impacts. If they are easily accessible free of charge, they may tend to think that they can do it any time. If this kind of service is always available free of charge, the adolescents can be spoilt."

(FGD with young female from rural Taunggyi)

"မပေးသင့်တာကမိန်းကလေးအများစုပျက်စီးမှာစိုးလို့၊ဆိုးကျိုးတွေဖြစ်လာနိုင်တယ်။ဆေးရှိရင်အမြဲတမ်းလုပ် နိုင်မယ်ထင်သွားမယ်။မိန်းကလေးတွေအတွက်ပျက်စီးလွယ်သွားမယ်။အမြဲတမ်းအခမဲ့ရနေရင်အရွယ်ရော က်တဲ့ကလေးတွေပျက်စီးနိုင်တယ်"
(FGD with young female from rural Taunggyi)

5.9.1 Opinion on services currently provided at public health facilities

Young people were hardly aware of the contraceptive services providing at the public health facilities. Even those who were aware of the services from public facilities seldom used them as they felt ashamed and afraid of being blamed or criticized by the midwives. They saw public health facilities as service provision places for married.

"I don't know that there is a midwife in our ward. I am worried that the midwife can be judgmental. I don't want to ask her to provide me contraceptives. I am shy. I don't want her to look down upon me. If she is act professionally, I may not be shy."
(FGD with young male from urban Taunggyi)

"သားဖွားဆရာမတွေရပ်ကွက်ထဲမှာရှိမှန်းတောင်မသိဘူး။သားဖွားဆရာမကကဲ့ရဲ့မှာကြောက်တယ်၊သားဖွား ဆရာမဆီကမတောင်းချင်ဘူး၊ရှက်တယ်။အထင်သေးမှာလည်းစိုးတယ်၊မျက်နှာပူတယ်။ပညာရှင်ဆန်ဆန်ေ ပးရင်တော့မရှက်ဘူး"
(FGD with young male from urban Taunggyi)

"I have ever found that contraceptives and condoms are provided to the married."
(FGD with young female from Pinlaung)
"ကျန်းမာရေးဆေးခန်းတွေမှာတော:ဆေးတို့ကွန်ဒုံတို့ကိုအိမ်ထောင်သည်တွေကိုပဲပေးတာတွေ့ဖူးတယ်"
(FGD with young female from Pinlaung)

5.9.2 Opinion on the ways to promote contraceptive use among young people

They stated that the most influencing factor for using contraception among young people was being afraid of getting pregnancy and peer pressure. Although peer pressure was indicated by most of the focus group discussions as the most effective way to promote contraceptive use among young people, they also suggested providing contraceptive education through social media such as facebook, printed media and health talks were also necessary.

"I think peer education will be effective for using contraceptives."
(FGD with young female from urban Taunggyi)
"သားဆက်ခြားနည်းတွေသုံးလာဖို့ဆိုရင်သူငယ်ချင်းအချင်းချင်းတိုက်တွန်းတာပိုထိရောက်မယ်ထင်။"
(FGD with young female from urban Taunggyi)
"They need to learn by themselves by attending health talks. Awareness raising and education should also be conducted through Facebook, magazines and leaflets."
(FGD with young female from rural Taunggyi)
"ပညာပေးဟောပြောပွဲတွေကတစ်ဆင့်သူတို့ကိုယ်တိုင်လည်းသိအောင်လုပ်ဖို့လိုတယ်။ Facebook မဂ္ဂဇင်း၊လက်ကမ်းစာစောင်၊ကလည်းအသိပေးတာလုပ်ဖို့လိုတယ်။"
(FGD with young female from ruralTaunggyi)

5.9.3 Suggestions on youth friendly contraceptive services

We found out that they had a desire to get contraceptive services from public health care providers such as midwives. But they wanted to be treated warmly, friendly by the health care providers and some requested services from same sex providers. Privacy was also their crucial concern. They wanted providers to be patient and understand them well.

"Regarding (contraceptive) services, we expect these services to be youth friendly. We want to receive warm treatment and services from well-informed people."
(FGD with young male from Pinlaung)

"(သားဆက်ခြား)ဝန်ဆောင်မှုပေးတာကိုရင်းနှီးကျွမ်းဝင်တဲ့၊ပန်ဆောင်မှုမျိုးကိုလိုချင်တယ်၊အသိပညာရှိတဲ့လူဆီက၊နွေးထွေးမှုရှိတဲ့ဝန်ဆောင်မှုကိုလိုချင်တယ်။"
(FGD with young male from Pinlaung)

"Privacy is also important in providing these services, I think. The service should be provided at health centres and clinics. But youth may be reluctant to go to health centres and clinics to seek care. The place where the service is provided should be the one which has privacy and people do not notice (where we are not seen by many people). But young people should be aware of the place where they can get youth friendly services. Health talks should be organized to educate them about negative consequences if they do not have access to these services. A separate center for this is also a good idea."
(FGD with young female from urban Taunggyi)

"ဘေးပတ်ဝန်းကျင်ကမသိအောင်၊ရင်းရင်းနှီးနှီးလုံခြုံမှုရှိအောင်ပေးသင့်လို့ထင်တယ်။ကျန်းမာရေးဌာနမှာဖွင့်သင့်တယ်လို့ထင်တယ်၊ဒါပေမယ့်လူငယ်တွေမလာရဲလောက်ဘူးလို့လည်းထင်တယ် လူရှင်းတဲ့နေရာဖြစ်စေချင်တယ် (ကိုယ်ကိုလူမမြင်တဲ့နေရာ)။ လူငယ်တွေလည်းသိတဲ့နေရာဖြစ်ရမယ်။ ဟောပြောပွဲလုပ်စေချင်၊ဆိုးကျိုးတွေကိုသိစေချင်လို့၊အပြင်မှာသီးသန့် Center ဖွင့်စေချင်တယ်"
(FGD with young female from urban Taunggyi)

"The service provider should be the one who can discusss (about contraceptive services), who is friendly and patient, who understand very well about young people and their nature. We also want to receive it from female health staff. If auxiliary midwives can keep our information confidential (from other people), it is ok."
(FGD with young female from rural Taunggyi)

"(သားဆက်ခြားပန်ဆောင်မှုတွေကို)ဆွေးနွေးလို့ရတဲ့လူ၊ ဖော်ရွေသူ၊စိတ်ရှည်တဲ့သူ။လူငယ်တွေရဲ့သဘောသဘာဝကိုနားလည်သူ၊နားလည်ပေးနိုင်သူမျိုးကပန်ဆောင်မှုပေးသင့်တယ်။ ကျန်းမာရေးဆရာမကပေးတာကိုလိုချင်တယ်။အရန်သားဖွားဆရာမတွေကကိုယ့်ရဲ့အကြောင်းကို (တခြားလူမသိအောင်) ထိန်းသိမ်းထားနိုင်ရင်အဆင်ပြေတယ်။"
(FGD with young female from rural Taunggyi)

6 Discussion

This study analyzed the sexual behavior, contraceptive use and availability of reproductive health information and contraceptive among in school and out of school unmarried young people age between 18 to 24 years in Taunggyi and Pinlaung townships. About 50% of study respondents did not know any kind of contraceptive methods. Pre-marital sex was found among 11.8% of study respondent and the average of first sex was 19±1.8 years. Among those who have had sex, 62% had used contraceptives. Contraceptive were mostly obtained from drug shops (74%). Being afraid or shy to buy contraceptive and lack of access to sources of contraceptives were the major reasons of not using contraceptives among non-users. Contraceptive users also faced challenges in accessing contraceptives and social stigma was found to be the key barrier. Their use of contraceptive was being stigmatized as they were unmarried. However, financial constraint to obtain contraceptives was rarely found. Young people hardly aware the family planning services provided at government-health-facilities. Almost all respondents agreed that contraceptive information and services should be given to unmarried young people to prevent unwanted pregnancy, abortion and sexually transmitted infections (STIs). Base on both qualitative and quantitative findings facebook was one of the most popular and influential media among them in obtaining reproductive health related information.

This study alarmed the urgent need for the youth friendly sexual and reproductive health programs targeting unmarried young people for many reasons: 1) pre marital sex became common among young people and the age of sexual debut was as young as 16 years, 2) less awareness on contraceptives methods and their sources, 3) challenges including social stigma hindering unmarried young people's access to contraceptives and 4) being non target population of SRH information and services.

6.1 Pre marital sex

Although there was no nationwide data showing the magnitude of premarital sex in Myanmar, small scales studies indicated that 10% to 17% of young people had sexual exposure before marriage (13,14). Being in a context where pre marital sex is a still a taboo, Myanmar unmarried young people are at high risk of unwanted pregnant pregnancy and its social consequences, unsafe abortion and contracting with sexually transmitted infections due to limitations in accessing SRH education. Therefore it is important not only to educate

unmarried young people with SRH information but also to raise awareness among parents, teachers and community about the benefit of early initiation of SRH education and services to young people. Evidences, including this study, suggested to initiate SRH information and services before the age of puberty ensuring inclusiveness of rural and out-of-school youth (15).

6.2 Less awareness on contraceptives methods and their sources

Similar to this study, poor awareness on different contraceptive methods and lack of knowledge about source of contraception were also found in some South East Asia countries like Malaysia, Lao PDR and Viet Nam (16–18). This might be due to limitations for the unmarried youth to access contraceptive information such as social stigma, unopened parent-child communication about SRH related issues. Melaku et al indicated discussing sexual and reproductive health issues with parents and peers significantly increased contraceptive awareness among young people (19). Hence, we recommend initiating strategies to improve open parent-child communication and enhancing appropriate peer education programs.

Currently, our study respondents commonly received SRH information from midwives, internet and printed media. However, their preferred sources of information were doctors, midwives and internet including facebook which is the most influential media among young people regardless of their schooling status. On the other hand, young people were suspicious of the validity of the RH information provided in the electronic media. Again, a previous study in Myanmar identifying credibility of various sources of SRH information among young people indicated health staff as the most credible source and electronic media as the least credible source (20). Therefore, ensuring the validity of the SRH information available in the media which have huge influence on young people is as equally important as delivering information through their preferred channel or the most credible source. Again, development of effective IEC materials using pictures should be considered as young people suggested health talks using pictorials could be effective for both literate and illiterate.

Additionally, better understanding of the information needs of young people is important for designing health information delivery programs. As they did not know much about reproductive health, they wanted to get more information particularly related to contraceptive methods, their use and side effects and STIs, its' transmission and prevention. According to a study done in Myanmar during 2014, young people were not acquainted with

knowledge related to HIV/STIs, correct usage of contraceptive methods and their side effects (20). Since young people are at risk of reproductive health related consequences, the information gap among young people should be filled without delay.

6.3 Challenges hindering unmarried young people's access to contraceptives

Like in neighboring countries, young people in this study encountered several social and cultural challenges in obtaining contraceptives (21,22) and the obstacles were mainly due to stigma of premarital sexual activity. Financial barrier to obtain contraceptives was rarely found. Overall, the sexual behavior and contraceptive use among young people suggest that they are at high risk of contracting HIV, and other STIs, unwanted pregnancy and its social consequences including unsafe abortion. Again this information highlighted the urgent need for the quality sexual and reproductive health programs which cover all sorts of young population.

6.4 Being non target population of SRH information and services

Saw Saw et al mentioned current SRH programs in Myanmar were mostly targeting married couples (11) and unmarried youth also assumed contraceptives services at public health facilities are only for married people. Not only health care providers were reluctant to provide contraceptive information and services (23), but also unmarried youth were hesitant to obtain contraceptive services from public health facilities. In addition, young people were hardly aware of the family planning services provided by the government health facilities.

6.5 Opinion and suggestions on current and future contraceptive services

Although they had low knowledge and utilization on contraception, the study population was well aware that contraceptive services should be given to unmarried youth with the main reasons of preventing unwanted pregnancy, abortion and their social consequences. Despite the hesitation due to fear of being blamed at public health facilities, young people had a desire to obtain contraceptive services from public health facilities if they provide services in youth friendly ways. Similar finding was found in a study done in Myanmar in 2014 covering the typical geographic area of Myanmar, hilly, central plane and delta (11). Therefore it is important to set up health facilities to be youth friendly; treating them warmly, patiently with understanding and ensuring confidentiality, especially for the unmarried young people.

6.6 Limitation of the study

Although this study provides the detail insights of sexual behavior and contraceptive use among young unmarried people in Taunggyi and Pinlaung townships, generalizability of the study finding is low as it covers only one ethnic population. Again, the study encountered validity constraints related to self-reported sexual behavior. Therefore, a further representative study exploring SRH needs of young people in Myanmar should be carried out for better decision making and effective implementation.

6.7 Conclusion

The average age of first sex among respondents was compatible with other Asian studies. Although pre-marital sex becomes increasing among young people, contraceptive services are not targeting towards them. In order to avoid contracting STIs including HIV, unwanted pregnancy, unsafe abortion and their social consequences, sexual and reproductive health information including knowledge about contraception should be provided to youth before puberty using different approaches such as delivering health information through most credible sources as well as most influential source of information among young people, "facebook". Usage of pictorals while giving health talks is also suitable for both literate and illiterate young people. Since contraceptive services targeting unmarried young people are urgently needed, rapid establishment of youth friendly health facilities and service delivery is suggested.

7 Recommendations

- To provide contraceptive knowledge and services to young people before puberty as they are at high risk of contracting HIV and other STIs as well as unwanted pregnancy, unsafe abortion and their social consequences
- To promote awareness raising to communities, parents and young people themselves on the benefits of using contraceptive and danger of unprotected sex among unmarried youth and to enhance parent-child communication and appropriate peer-to-peer communication on SRH issue
- To enhance delivery of SRH information through the influential and credible media among young people including facebook and to develop and use pictorials about SRH while providing health talks to young people
- To establish government health facilities to be youth friendly so that both married and unmarried young people could easily and safely accessible to contraceptive services provided there
- To conduct further representative research exploring SRH needs of young people in Myanmar

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