Male Involvement in Family Planning In Myanmar

Myo Min

Myanmar

51st International Course in Health Development/Master of Public Health (ICHD/MPH)

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Vrije Universiteit Amsterdam

Amsterdam, The Netherlands

Male Involvement in Family in Myanmar

A thesis submitted in partial fulfilment of the requirement for the degree of Master of Public Health

By

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Myanmar

Declaration:

Where other people's work has been used (either from a printed source, internet or any other source) this has been carefully acknowledged and referenced in accordance with departmental requirements.

The thesis **"Male Involvement in Family in Myanmar"** is my own work.

Signature: .....

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GLOSSARY OF TERMS AND DEFINITIONS

Access/Accessibility **"**may be defined operationally in terms of presence or absence of any family planning services, of specific contraceptive methods or (preferably) a package of services and methods that is likely to satisfy the needs and preferences of a large majority of target population" (Bertrand et al. 1995).

Administrative accessibility "represents the extent to which unnecessary rules and regulations that inhibit contraceptive choice and use are eliminated" (Bertrand et al. 1995).

Affordability or economical accessibility is "the extent to which the cost of reaching service delivery or supply points and obtaining contraceptives services and supplies are within the economic means of a large a majority of the target population" (Bertrand et al. 1995).

Availability **"**means having the right type of care available to those who need it, such as hours of operation and waiting times that meet demands of those who would use a car, as well as having the appropriate type of service providers and materials" (Peters et al. 2008).

Choice of methods "refers to both the number of contraceptive methods offered on a reliable basis and their intrinsic variability" (Bruce 1990).

Family planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility (*World Health Organization, Department of Reproductive Health and Research, 2015).*

Geographical or physical accessibility "is the extent to which family planning service delivery and supply points are located so that a large proportion of target population can reach them with an acceptable level of support" (Bertrand et al. 1995).

Information given to the clients "refers to the information imparted during service contact that enables clients to choose and employ contraception with satisfaction and technical competence" (Bruce 1990).

Interpersonal relations "are the personal dimensions of service. Bruce also notes that interpersonal relations have a significant impact of client's satisfaction and the possibility of them returning for repeat services" (Bruce 1990).

Male involvement in Family Planning and reproductive "regards men's knowledge of reproductive health and family planning, attitudes about the use of contraception, communication with partners about family planning, choices about appropriate contraceptive methods, gives emotional and behavioral support to their partner' contraceptive use" (Clark et al. 2008).

But, there was no consensus about which term best describes the men's perspectives. The terms used are men's participation, men's responsibility, male motivation, male involvement, men as partners and men and reproductive health.

The Evolution of Male Involvement (Greene et al. 2006)

APPROACH	PURPOSE & ASSUMPTIONS	PROGRAMMATIC IMPLICATIONS
TRADITIONAL FAMILY PLANNING FOR WOMEN	Increase contraceptive prevalence; reduce fertility	Contraceptive delivery to women, in the context of maternal and child health Men absent
----------1994 Cairo International Conference on Population and Development ----------		
MEN AS CLIENTS	Address men's reproductive health Needs	Extend same range of reproductive health services to men as to women Employ male health workers
MEN AS PARTNERS	Men have central role to play in supporting women's health	Recruit men to support women's health, e.g., teach husbands about danger signs in labour, how to develop transportation plans, the benefits of family planning for women's health
MEN AS AGENTS OF POSITIVE CHANGE	Promote gender equity as a means of improving men's and women's health and as an end in itself	Paradigm shift in how programmes are structured and services are delivered, whatever they are
	Addressing inequity requires full participation and cooperation of men	Broader range of activities, working with men as sexual partners, fathers, and community members

ABBREVIATIONS AND ACRONYMS

AH	Adolescent Health
AIDS	Acquired Immune Deficiency Syndrome
ARH	Adolescent Reproductive Health
BCC	Behaviour Change Communication
BHS	Basic Health Staff
BS	Birth Spacing
CPR	Contraceptive prevalence rate
DOH	Department of Health
EC	Emergency contraceptive
FP	Family Planning
GP	General Practitioner
HF	Health Facility
HIV	Human Immuno-deficiency Virus
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
INGO	International Non-government Organization
IUCD	Intrautrine Contraceptive Device
JOICEF	Japanese Organization for International Cooperation in Family Planning
LHV	Lady Health Visitor
LSE	Life Skill Education
MCH	Maternal and Child health Center

MDG	Millennium Development Goal
MOH	Ministry of Health
MOIP	Ministry of Immigration and Population
MMA	Myanmar Medical Association
MMCWA	Myanmar Maternal and Child Welfare Association
NGO	Non-Government organization
NHP	National Health Plan
OC pill	Oral Contraceptive Pill
RH	Reproductive Health
RHC	Rural Health Center
SRHC	Sub-Rural Health Center
SRH	Sexual and Reproductive Health
RTI	Reproductive Tract Infection
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
UN	United Nations
UNFPA	United Nations Population Fund
WHO	World Health Organization

ABSTRACT

Background: Family Planning is one of the most basic and essential health practices. Males are the primary decision-makers regarding many reproductive health decisions such as the use of family planning. Traditionally, family planning has been viewed as the women's responsibility. However, there has been a growing evidence of the need to involve men in family planning programmes.

Objective: To explore the factors influencing male involvement in Family Planning in Myanmar in order to give recommendation for policy and programmes to improve reproductive health in Myanmar.

Methodology: Literature review using the adapted Arundati Char (2011) framework for Male Involvement in Family Planning and Reproductive Health use as guide to analyze the influencing factors.

Findings: Males have high awareness on some family planning methods but it is not comprehensive enough. They well understand the benefits of family planning and have a positive attitude towards family planning, but it needs to change into practice. There is a lack of information on family planning methods. Mass media campaigns are effective for meaningful involvement of men in family planning by raising awareness on family planning through health workers. Mass Media campaign would need more than the health workers. Spousal communication is also an important factor for the use of family planning in this study. Supporting polices for male involvement in family planning are in place, however there is weakness at the implementation level.

Conclusion and Recommendations: There is a need to increase male involvement in family planning in Myanmar. There is a need to strengthen and scale up male involvement programmes and there is need to do more studies.

Key words: family planning, male involvement, contraception, spousal communication, Myanmar

Word count: 12,916

INTRODUCTION

Male involvement in Family Planning in Myanmar was stated since the very first manual of Birth Spacing programme. The growing awareness of the burden of maternal ill-health also calls for better quality maternal health care in which the role of men in reproductive health especially Family Planning cannot be forgotten. Family planning services provide people with knowledge and means to plan when to having children, how many to have, how far apart to have them and when to stop. Therefore, Family planning is the responsibility of both men and women and everyone needs to know about the health benefits of family planning.

I am an assistant director, working in the basic health division of the Department of Public health. I have been working in the public health field since 2004, almost a decade, with various positions and different responsibilities.

Before this I was working as a medical officer at Station Hospital in a rural area and as team leader of a Township School Health Team in Shan State. At that time I had dual responsibility to take charge of the Maternal and Child Health Clinic of the township. During my work, very few male partners were involved in their wife's reproductive health matters as well as family planning and some husbands said that it was not their concern.

Since 2007 I have worked at the central level and in 2010 moved to the Basic health section of the public health division. One of my responsibilities was supervision and monitoring of the rural health centres and sub rural health centres. At that time I also found that utilization of the family planning method was common among females and males were not involved in the family planning process. In 2013, I got a chance to attend third International conference in the Family Planning in Ethiopia. I noticed that male involvement was a huge component of increasing

contraceptive use. After that I wanted to know how males are involved and what are the influencing factors in Family Planning in Myanmar.

Various literature states that providing men with information and involving men in couples counselling can help to support contraceptive use and decision making. I hope this thesis will be influential in development or appropriate interventions and health policies for more meaningful male involvement in FP.

This thesis has seven chapters. The first chapter presents background information of Myanmar including health sector information related to reproductive health. The problem statement, objectives, and methodology including the conceptual framework are describe in chapter two. Chapters three and four describe the study findings. Chapter five covers the discussion session and chapter six describes the conclusion. Finally, chapter seven provides recommendation based on the identified factors.

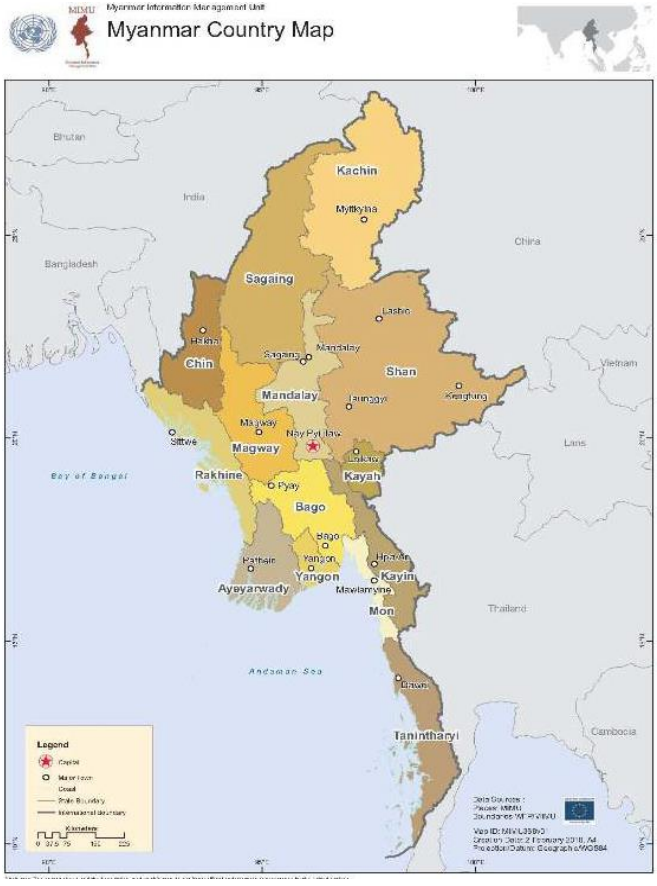
CHAPTER 1 BACKGROUND INFORMATION

This chapter describes the background information of Myanmar such as its geographic features, demography, Myanmar health care system information and information related to reproductive health. Family planning in Myanmar will be specifically described in the subsequent chapters.

1.1 Geographic features

The Republic of the Union of Myanmar is the second largest country in South East Asia. It has an area of approximately 676,578 square kilometers. It shares borders to the west and north-west with the People's Republic of Bangladesh and the Republic of India, to the north and north-east with the People's Republic of China and to the east and south-east with the Laos People's Democratic Republic and the Kingdom of Thailand. The coastline is bounded by the Bay of Bengal on the west and Andaman Sea on the south (Figure 1) (MIMU 2015).

Figure (1) Country Boundary and administrative division of the Republic of the Union of Myanmar 2013



Source: Myanmar Information Management Unit

Myanmar is divided administratively into Nay Pyi Taw Council Territory, seven states (Kachin, Kayah, Kayin, Chin, Mon, Rakhine, and Shan) and seven regions (Ayeyarwady, Bago, Magway, Mandalay, Sagaing, Tanintharyi and Yangon). The states and regions are again divided into 74 Districts and 330 Townships (MOH 2014).

According to the 2014 Population and Housing Census report, the population of Myanmar is 51.4 million people. The population of Myanmar grew from 35.3 million persons in 1983 to 51.4 million persons in 2014. The population density in Myanmar is 76 persons per square kilo-meters and about 30% of the populations resides in urban areas (MOIP 2015).

1.2 Demography

Myanmar is composed of 135 different ethnic groups and is one of the world's most diverse countries, with a rich history and a wealth of cultural and religious traditions. There are eight major ethnic groups: Bamar constituting 60% of the population, Shan (8.5%), Kayin (6.2%), Rakhine (4.5%), Mon (2.4%), Chin (2.2%), Kachin (1.4%) and Kayah (0.4%) respectively. Among these, they speak over 100 languages and dialects but the official language is Myanmar language. Approximately 90% of the population are Buddhist, while Christians and Muslims constitutes about 5% and 4% respectively and other religions constitute about 1% (MOH,2014).

1.3 Myanmar Health Care System

The health care system of Myanmar is being decentralized. The Ministry of Health (MOH) retains the major and leading role as well as providing comprehensive health care (WHO 2014). The MOH takes responsibility for providing comprehensive care covering activities for promoting health, preventing diseases, providing effective treatment, and rehabilitation to raise the health status of the population. These service provisions are extended down to rural settings through a network of health care facilities at different administrative levels (MOH 2014). Currently the Ministry of Health consist of six departments, namely the Department of Public Health, Department of Medical Care Services, Department of Health Professional Resource Development and Management, Department of Food and Drug Administration, Department of Medical Research and Department of Traditional Medicine. The health system is organized hierarchically (Annex 1).

The Department of Public Health was born on 1st of April 2015 and is responsible for the provision of Public Health services to the entire population (Annex 2). The maternal and reproductive health division is under the control of the Director General of Department of Public Health (MOH 2014).

The government is the major source of the finance for health care services in Myanmar with only minor sources from external aid and community contributions. The total government health expenditure was sharply increased between 2001 and 2014 but it is still the country with the lowest figures among the South East Asia and Western Pacific Region (WHO 2014).

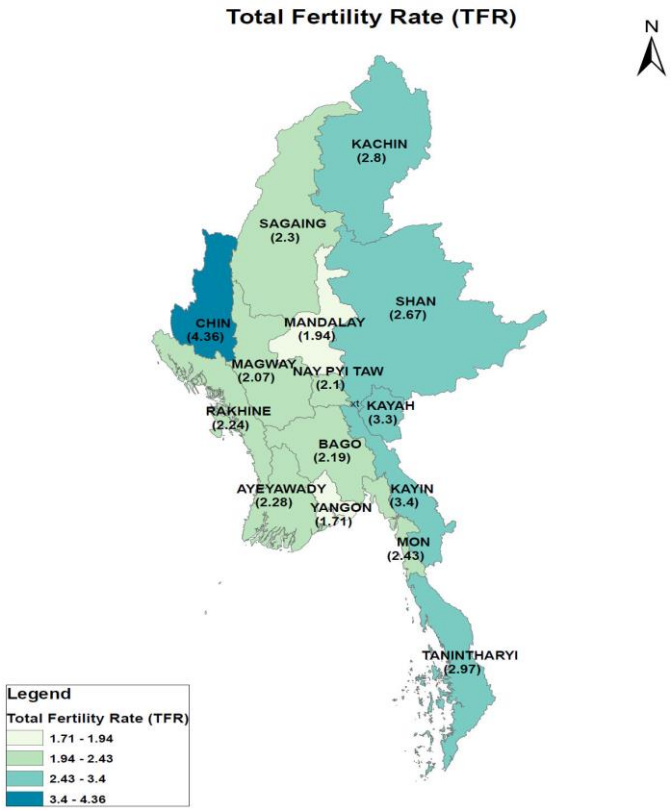
1.4 Overview of the Reproductive Health Program in Myanmar

The National Health Plan (NHP) (2011-2016) was implemented within the framework of the fourth short term National Development Plan and is composed of 11 programmes and 67 projects. The reproductive health program is under Improving Health of Mothers, Neonates, Children, Adolescent and Elderly as a Life Cycle Approach in NHP (2011-2016) (MOH undated). The Myanmar reproductive health program was implemented under the guidance of the Strategic Plan on Reproductive Health (RH) (2014-2018). This strategic plan was based on some initiatives such as the National Population Policy (1992), the National Health Policy (1993), which was followed by formulation of the Myanmar Reproductive Health Policy (2002), and two earlier Strategic Plans on RH (2004-2008 & 2009-2013) (DOH 2014). These reproductive policy and strategic plans of the Ministry of Health (MOH) are a national response to the Programme of Action of the International Conference on Population and Development (ICPD PoA) and the United Nations Millennium Development Goals (MDGs). The last strategic plan was a response to the UN Secretary General's Global Strategy for Women and Children's Health (2010). Myanmar has also pledge to the global partnership initiative- the family planning 2020 (FP2020) committed in 2013 November in Ethiopia (DOH 2015).

According to a census report, the total fertility rate (TFR) of Myanmar is 2.29 children per women and the marital fertility rate is 4.03. The low average number of children per women in the reproductive age may be due to increased age at first marriage and relatively high proportion of young unmarried women in Myanmar (MOPI 2015). The

fertility rate varies by states and regions significantly; the highest (4.4) is in Chin and the lowest (1.4) is in Yangon (Figure 2).

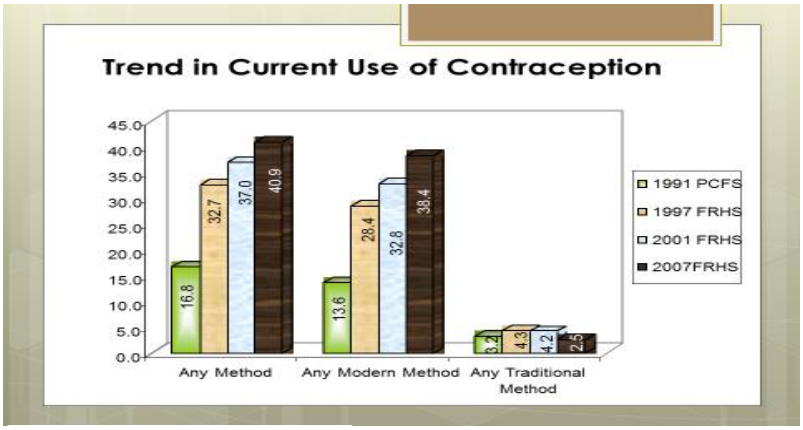
Figure (2) Levels of fertility rate by States / Regions



Source: Census Report Volume 2, 2015

According to the Fertility and Reproductive Health Survey (FRHS) 2007, the Contraceptive Prevalence Rate (CPR) for all methods is 40.9% (38.4% for any modern method and 2.5% for any traditional method) among ever married women. Figure (3) shows the CPR from 1991 to 2007 (MOIP 2009).

Figure (3) Trend in current use of contraception



Source: FRHS 2007

CHAPTER 2 PROBLEM STATEMENT, JUSTIFICATION AND OBJECTIVES

This chapter presents the outline of the study. It provides the problem statement of male involvement in Family Planning (FP), justification, objectives of the study and the study method with the conceptual framework.

2.1 Problem Statement

Reproductive health programmes and services in Myanmar are mainly targeted to women's reproductive health and offer their services to women mainly through Basic Health staffs. Traditionally, Myanmar men remained uninformed about their wives' pregnancy-related experiences and needs. But they are the breadwinner and decision maker relating to pregnancy care and expenditure (UNFPA 2010). Dwei states that the role of men in RH and FP is ignored by the FP programs and most of the contraceptive methods are designed for women only (Kamal et al. 2013). Now it is well recognized that men are the key agents for the sexual and reproductive health practices (Bruijn 2004).

The International Conference on Population and Development (ICPD) in 1994 was one of the cornerstone to raise about male involvement in reproductive health and family planning. The ICPD Programme of Action, urged that: "… special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behavior including family planning; prenatal, maternal, and child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted and high-risk pregnancies; shared control and contribution to family income, children's education, health and nutrition; and recognition and promotion of the equal value of children of both sexes" (UNFPA 2014).

In Myanmar, men have very limited knowledge of sexual and reproductive health such as safe motherhood, complications of pregnancy, birth spacing, and STIs. Many of men did not have sufficient knowledge of contraception leading to misconceptions such as that birth spacing methods can cause ill health. There was low prevalence of condom and IUD use within the community (DOH 2005). Awareness of use of condoms among married men was high but there is low use of condoms. Studies pointed out that married men would have liked to have reproductive health education which was directed to them (Mu 2004, DOH 2005).

A common perception among Myanmar people is that birth spacing (BS) is the responsibility of women only and this attitude may lead to inadequate support from men. Men have positive attitude towards birth spacing and they should provide financial support for use of contraception (DOH, 2005). Moreover, regarding fertility regulation, husbands played the leading role in deciding to use the family planning method and in taking responsibility for obtaining information about FP method (Win et al. 2000).

2.2 Justification

Reproductive health including FP generally has been similar with women's health. Male's contributions to reproductive health of women has received little attention (Collumbine & Hawkes 2000, Singh et al. 1998) Women needed the support of their husbands to attend reproductive health services (Wegner et al. 1998). Studies in India find that men should be knowledgeable about health services for women because men were source of information and financial support for women. Therefore, male involvement in women's RH may encourage more women to use existing reproductive care facilities and may improve overall level of reproductive health (Saha et al. 2007).

The role of men in reproductive health was already included in Myanmar Reproductive Health Policy (2002) Implementation guidelines (MOH, 2002). But the current five year strategic plan on reproductive health (2013-2018) does not mention male involvement in reproductive health strategies and activities for their effective and efficient implementation (DOH, 2014). However, in the Health in Myanmar Report 2014, promoting male involvement in reproductive health is one of the areas that need to be strengthen to achieve MDG (MOH 2014).

In Myanmar also husbands are income earners therefore have a role as decision makers for family expenditures including health, reproductive health, and health-related costs. Therefore, male involvement in women's family planning and reproductive health is important. However, the existing knowledge on male involvement and participation is limited and inadequate to influence further policy and strategy formulation and programme activities to address reproductive health including Family planning. The present literature review will fill the gaps in knowledge on male involvement in FP. It will also determine the outcome of male involvement on women's use of FP services in the context of Myanmar.

2.3 Objectives

General Objectives

To explore the factors influencing male involvement in FP in Myanmar in order to give recommendation for policy and programmes to improve reproductive health in Myanmar.

Specific Objectives

1. To identify/analyze the knowledge, attitude and practice of men which regards to FP.
2. To describe the factors that influence male involvement in contraceptive use.
3. To explore the best practices of male involvement in FP in Myanmar and other countries to strengthen the overall response.
4. To give useful recommendation for the policy and programmes to improve the FP services in Myanmar.

2.4 Methodology

The methodology of this thesis was a literature review of the articles on male involvement in RH and FP in Myanmar and comparable Asian countries.

2.4.1 Literature search

The literature search was done using different search engines like PubMed and Google Scholar with the help of key words. Other organizational websites like the WHO website, UNFPA website, and the Department of Medical Research (Lower Myanmar) website were also used to find the relevant references. Email contact with colleagues from the Ministry of Health, Myanmar was also made.

The literature review includes peer review and gray literature on male involvement in reproductive health and family planning, knowledge, attitude, perceptions and practices of contraceptive use and associated factors. The review also consists of existing National Health Plan (2011-2016), National Population Policy, Reproductive Health policy, Reproductive Health strategy (2013-2018) and Health in Myanmar published by Ministry of Health.

Key words used for search include family planning, reproductive health, contraceptive use, knowledge, attitude, perceptions and practice on contraceptive use, male involvement, male participation, conceptual framework and Myanmar.

Table (1) Search Strategy

Type	Source	Key Words		
		Objective 1	**Objective 2**	**Objective 3**
Electronic journal's /articles/ publications	PubMed, Google scholar, KIT library	Knowledge, attitude, practice, Behavior, FP, BS, motivation, contraceptive method, Male involvement, mass media, Myanmar, Asia	FP, BS, RH, Contraception, male involvement, perception, Spousal communication, interpersonal communication, availability, accessibility, affordability	Best practice, RHCS, male involvement, behavior , contraceptive use, Asia
Published and unpublished reports related to Myanmar information	Google	Knowledge, attitude, practice, FP, BS, Male involvement, Myanmar, Asia	FP, BS, RH, Contraception, male involvement, education, occupation, income, culture, perception service factor	Best practice, FP, contraceptive use, Asia
Website information	MOH,DMR(Lower Myanmar), WHO, UNFPA, Burnet institute, JOICEF	Male participation, Contraceptive prevalence, RH, Health system	FP, behavior, male involvement, spousal communication,	Best practice, RHCS, male involvement, contraceptive use
MOH information and RHCS documents	Key Informants from MOH,DMR(Upper Myanmar),JOICEF	RH, FP, National Health Plan, Male involvement, survey	RH, FP, Survey, data, behavior, perception	Male involvement, FP, behavior

2.4.2 Inclusion and exclusion criteria

Literature from Myanmar in English from 1990 to date is included due to limited literature on male involvement in family planning and reproductive health. This inclusion was also applied to comparable Asian countries. Literature in other languages is excluded.

2.4.3 Conceptual Framework

Two conceptual frameworks; Male involvement in Reproductive Health: Women's Perspective (Sharma 2003) and theoretical framework for male involvement in Family Planning and Reproductive Health (a progression of the de-Bruijn model) (Char 2011) were reviewed. Sharma's study presents women's perception of male involvement in reproductive health. The framework consists of two important factors of perception of reproductive health services by the couple and their attitude towards the utilization of these services (Sharma 2003). This frame is not fit for my study objectives as it is not comprehensive enough to cover the whole spectrum. However, after analysis the Arundati Char (2011) framework was chosen. This model (shown in Figure -4) was selected because it falls in line with the objectives of the study and it offers a broader scope for exploration of the study area. The framework Male Involvement in Family Planning and Reproductive Health in Rural Central India (Char, 2011) was based on the process-context approach developed by de Willekens (1999) and de Bruijn (1999).

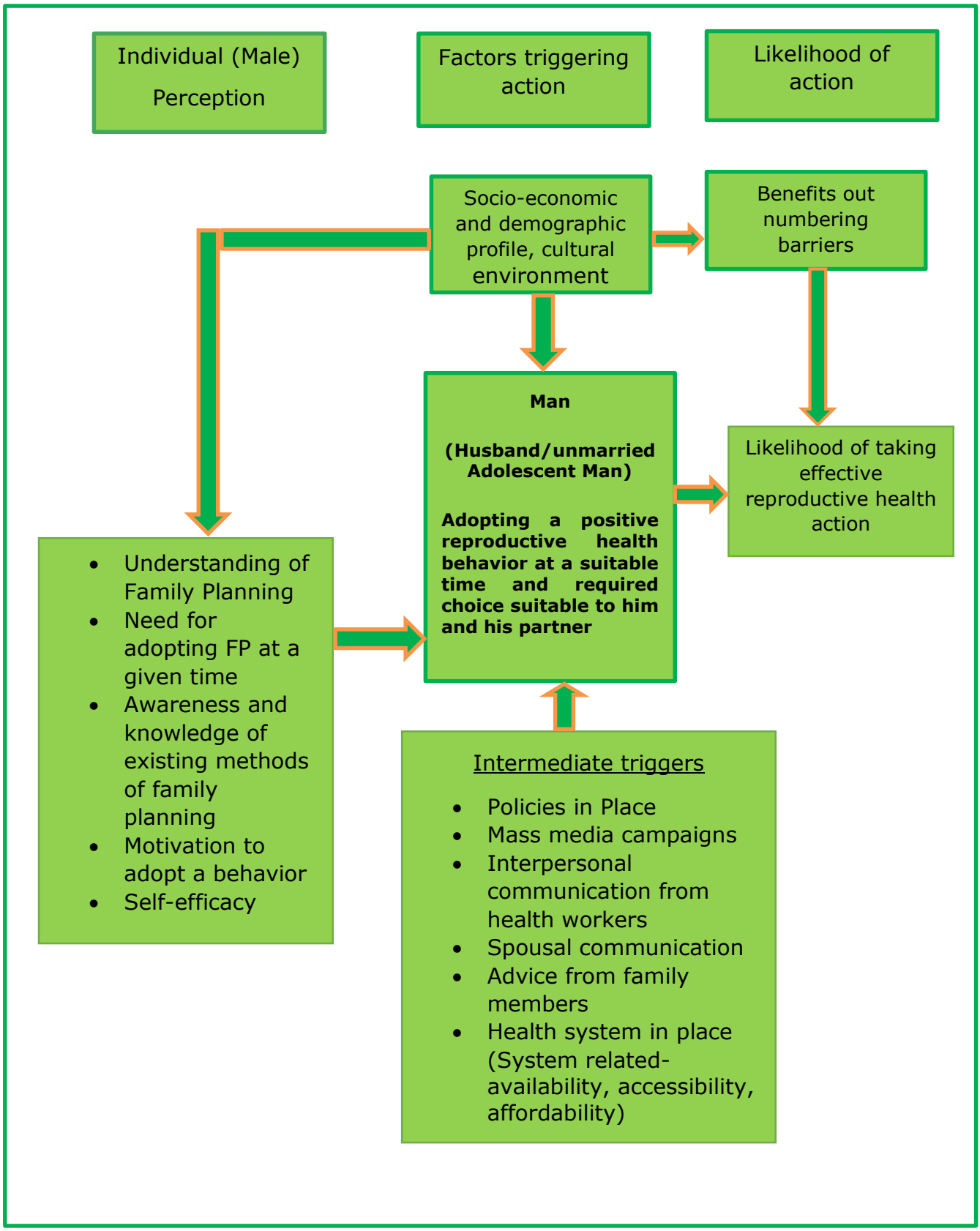
The three theoretical components of the framework namely Choice, Process, and Context are integrated and it aims to understand the mechanisms involved in people's behavior in a specific environment. The concept of choice does not compress people's behavior into the confines of objectively rationality but it provides a tool to identify the decisions frame for people's actions like motivation, representations, and self-efficacy that are produced in the situation and time bound process (Bruijn 1999). The concept of choice is seen as the main mechanism to understand for the individual behavior and provides the framework to identify the effective ways to influence adverse outcomes of behavior at individual and societal levels (Bruijn 2004).

Another dimension of the process context approach is time, which represent the concept of life course. It means that people are in the process of continuous development over the course of their lives and this takes them through different life stages with different needs, expectations, constraints, and opportunities. The stages of development

are influenced by the societal institutions and cumulative experiences resulting in better understanding of behavior (Bruijn 2004).

The framework was transformed for an Asian country by Arundhati Char and provides a holistic and coherent perspective for the study of reproductive health and fertility, providing individual behavior, societal context and life course development.

Figure (4) Framework for Male Involvement in Family Planning and Reproductive Health (Char 2011)



CHAPTER 3 STUDY FINDINGS

This chapter presents the finding on male involvement in FP and influencing factors as guided by the Arundhati Char's framework. These factors include factors triggering action, individual male perception, and likelihood of action. The first section focuses on the socio-economic and demographic profile and cultural environment. The second section focuses on intermediate triggers such as polices in place, mass media campaigns, interpersonal communication from health workers, and advice from family members, spousal communication and health systems in place. The third session focuses on individual perception for knowledge, attitude and practice of men on FP in Myanmar and the last section on likelihood of action. These factors will be explored in the current situation of male involvement and the influencing factors on FP in Myanmar.

3.1 Socio-economic and demographic profile, cultural environment

Socio-demographic factors such as age of husband and wife, education, occupation, family income and marital status play an important role in determining the use of contraceptive (Hossain, 1999).

3.1.1 Age

Age of the husband and wives

There is only one study undertaken in two townships in Upper Myanmar involving 500 couples that talks about age of the husband and male involvement in FP and that study shows there is no association between age of the husband and male involvement in women's reproductive matters (Tint et al. 2013). Another study also showed that the knowledge of men on FP is not influenced by their age (Kyaw 2009).

The same study in Myanmar also showed there was no association between the age of the women and male involvement in women's reproductive matters (Tint et al. 2013). A study in Bangladesh found that male involvement in FP and RH increases with the age of the women. There is also association with age of the women and male involvement in family planning and reproductive health (Kamal et al. 2013, Shahjahan et al. 2013).

A study in Bangladesh showed that male involvement in FP increases with age of the husband. So, the age of the husband and age of women was associated with male involvement in family planning and reproductive health (Kamal et al. 2013, Shahjahan et al. 2013).

In Bangladesh, male involvement in FP increases with age of the husband and wife, so there is a link. The study in Myanmar was only conducted in two township in upper Myanmar with 500 married couples and this would need to further research to show whether it is applicable in the whole country.

3.1.2 Education

A study done in Myanmar found that if males are more educated, they have higher knowledge on birth spacing. Regarding the acceptance of contraception, the study found that the higher the education of the male, the more the acceptance of condom use for contraception and IUCD (DOH 2005).

There is only one study that talks about association between education and male involvement in FP and that study did not find any association between level education of education and male involvement in FP in Myanmar (Tint et al. 2013). Studies in Myanmar show that 27-40.8% of males had gone to primary school, 21.6-43.8% of men to middle school and a small percentage reach high school level and very small percentage of men have university level education (DOH 2005, DOH 2007, Kyaw 2010, Tint et al. 2013). But in Myanmar primary school level has a curriculum for Life skill education (LSE) and sexual and reproductive component is not included. In middle and high school level, LSE is as a co-curriculum and that not much sexual and reproductive health education is given there.

In Bangladesh studies found that when the husbands were more educated, their involvement in FP increased. Husband's education is positively associated with the male involvement in FP and RH (Kamal et al. 2013, Shahjahan et al. 2013).

The education system in Myanmar places very little focus on the issue of sexual and reproductive health (SRH) for male adolescents and gender issues. Efforts are under way by international organizations regarding the inclusion of the sexual and reproductive health education in the school curriculum but this will take time (Personal Observation).

The studies in Myanmar show contradictory findings on education and the role of education in male involvement in FP is not conclusive.

3.1.3 Occupation

A study done in upper Myanmar showed that there was no association between occupation and male involvement in FP (Tint et al. 2013). Regarding occupation, the majority of them fell in the groups of farmers, vendors, fishermen, carpenters, or manual laborers. A very small percentage men working in the government sector (DOH 2005, Tint et al. 2013).

A study in Bangladesh showed that male involvement in FP is higher among skilled and professional workers than unskilled workers. The study indicated that the working status of husbands significantly influenced on the male involvement in FP (Kamal et al. 2013, Shahjahan et al. 2013). Studies in Myanmar do not find an association between the occupation of the men and male involvement in FP and RH. The current studies are done in only one or two townships, so it is further research to explore the association is needed.

3.1.4 Income

The study done in upper Myanmar showed that there was no association between income and male involvement in women's reproductive matter (Tint et al. 2013). The average income of husbands was found to be higher than that of wives.

A Bangladesh study showed that male involvement is proportionally higher among high incomes couples. The study showed that there was a strong association between couples income and male involvement in FP (Kamal et al. 2013, Shahjahan et al. 2013). Again, the limited scope of the study in Myanmar warrants further research.

3.1.5 Marital status

A baseline study on involvement among sexually active married and unmarried males in Myanmar shows that the knowledge of ever married men of modern and traditional methods of contraception is higher than singles except for condoms (DOH 2005). It showed that married males are more interested in the FP methods of their partner than are singles. The study was done in urban and rural areas of only two townships, so further research is needed for application to the whole country.

A study in one township of Mandalay region found that premarital sex among lovers is not unusual and was reported by half of the male adolescents. Three quarters of adolescents in that study showed that

they should know how a girl can get pregnant, contraceptive methods, and that they want to use condom when they have sex (Maung 2005). It shows that they take responsibility for preventing pregnancy. But there was no study on use of emergency contraception (EC) and it is necessary to explore the actual practice of condom use and EC among unmarried couples. The studies show contradictory and inconclusive findings on unmarried people and family planning.

3.1.6 Cultural Factors

Culture and religion are important factors in influencing reproductive health. Sexual and reproductive issues are very sensitive in Myanmar culture. Most parents and children rarely discuss RH issues as they perceived as inappropriate subjects (Zaw et al. 2009). Studies show that the majority of parents and guardians lack knowledge about sex and RH for adolescents and they had no desire to know about it (Win et al. 1998, Nu Oo et al. 2011).The reason that they do not want to know was related to some cultural factors such as it being unnecessary for adolescents, that RH matters are disgraceful things and are against tradition (Win et al. 1998). Nu Oo et al pointed out that the majority of adolescents had low knowledge of pubertal changes and STDs and moderate knowledge of contraception such as being able to identify the oral contraceptive (OC) pill, injection, and condoms as methods of contraception. The majority of adolescents have positive attitudes towards communications with parents on RH matters (Win et al. 1998, Nu Oo et al. 2011). As a result of this limited knowledge about contraception male adolescents are less equipped to support meaningful choices and decision which in turn hampers meaningful male involvement.

A conservative attitude towards premarital sex was associated with parent-adolescent communication (Nu Oo et al. 2011). Premarital sex is culturally sensitive and discouraged. But studies showed that premarital sex among males is more common than among females and is increasingly common among couples who are planning to marry (MOH, UNFPA 1999, Maung 2005, Tint et al. 2008). A participatory sex census conducted with male participants in Pyin Oo lwin town indicated that there was premarital sex among the male youths, non-use of condom when having sex and, suffering from symptoms suggestive of STI (Tint et al. 2008). It indicated that unmarried male adolescents are not involved in the RH matters of their partners.

3.2 Intermediate Triggers

3.2.1 Policies in place

As a signatory country of Bali Declaration on Population and Development 1992 and the Cairo ICPD Programme of action 1994, the concept of reproductive health care activities was introduced in the 1993-1996 National Health Plan (NHP). With the support of the WHO, the programme was started as a Family Health Care project and expanded to the Reproductive Health Care Project in 1996 (DOH 2002).

Myanmar formulated a draft National Population Policy in 1992 under the guidance of the National Health Committee, shifting from a pro-natalist policy to a health-oriented approach (Annex 3). This included the promotion of birth spacing to improve the health status of women and children. Eligible couples can decide on their number of children freely as their right. The population policy drafted already consists of educate of male population about their responsibility for the reproductive behavior. Two other policies were directly about the birth spacing (UNFPA 2010).

Currently, Myanmar is implementing the NHP 2011-2016 which was prepared under the guidance of the National Health Committee. This policy was formulated within the framework of the short term National Development plan and the long term Myanmar Health Vision 2030 with the aim of achieving Health for all Goal (MOH 2014). "Uplifting Health, fitness and education standard of the entire nation" which was one of the social objectives of the State and the National Health Policy (1993) formed the policy basis for the development of this NHP. The NHP (2011-2016) was developed around eleven programs areas for health development. Reproductive health and adolescent health projects were under the programme area of Improving Health of Mothers, Neonates, Children, Adolescents and the Elderly as a Life Cycle Approach (MOH undated). This NHP does not mention male involvement in FP separately.

Under the guidance of the NHP, there is a RH Policy. For the implementation of the reproductive health programmes, specific policy directions were provided in the Myanmar RH policy document (Annex 4). The goal of the RH policy was "to attain a better quality of life by improving RH status of women and men including adolescents through effective and appropriate RH programmes undertaken in a life-cycle approach". Birth spacing or contraceptive use and men's role in RH are already includes in the implementation guidelines of RH policy (DOH 2002).

In the RH policy, the policy implementation guidelines for men's role in reproductive health includes two portions such as "awareness of critical RH needs and the importance of enhancement of men's RH status in improving the reproductive health of the family will be raised and men's role in promotion of successful birth spacing service, prevention of transmission of RTI/ STI and in supporting RH service for the family and the community will be strengthened". (DOH 2002). At the implementation level, workshops on men's role in RH and IEC materials for men's role in family and RH were developed and utilized in the UNFPA supported townships during quality RH training (MOH 2014). There was no separate training, workshop and IEC materials for male involvement in FP in the rest of the Myanmar.

The strategic plan for RH (2014-2018) was formulated based on a review of the above described policies, plans, and the second strategic plan (2009-2013) and is currently implemented. The current RH strategic plan consists of five key strategies and activities for implementation. Engaging men in RH programmes is one of the sub-strategies under the incorporating gender perspectives. The key activities are making advocacy on the value of engaging men in RH and RH care to opinion leaders, production, dissemination of messages and distribution of IEC materials on men's shared responsibility parenthood, sexual and reproductive behavior and RH care, to conduct training for health care providers and community to engage men as a supportive partners to address gender inequality and improve health outcome (DOH 2013). Policy and strategies for male involvement in reproductive health are in place in Myanmar but there is a large gap in implementation with the exception of a quality RH programme.

3.2.2 Mass Media Campaign

A study done in 2005 showed that RH IEC materials were distributed to 100 RH projects townships with the help of Central Health Education Bureau, JOICEF, and UNFPA. But, there was no specific program for men or male participation issues in the study area. Regarding the mass media, they mentioned printed media followed by TV and Videos. Urban males and educated males had more access to printed materials but rural males received more from the radio. Very few of the males received information from folk media (DOH 2005). Other studies also find that TV and radios are the main media sources for contraceptive information (Win et al., 2000, Tint et al. 2013).

A study done in 2007 used behavioral change communication (BCC) intervention by giving RH information through male frontline health promoters (FHPs). FHPs use pamphlets, posters, RH flipcharts, a video called Twin Angles, Twin angles picture theater and wall sheet calendars for dissemination RH information in combination with individual talks, small group discussion with families, relatives and friends at homes, teashops, trishaw stands, billiard shops, work places and on the social occasions. Peer education and health talks were also conducted in the community. The study finds that men's knowledge on essential services at antenatal clinics, men's knowledge on indication for institutional delivery, increased in awareness on birth spacing counselling and condom use rates are increased (DOH 2007). This intervention will be described specifically in the best practices session.

An assessment of the role of men in family in the Philippines finds that posters and flyers are the most common mass media materials followed by TV and Radio ads, comic books, books/monographs, and training modules. Men's health, men's responsibility for their own actions, and men of all ages actively supporting their partners are the main themes of these IEC materials. The assessment finds that the use of these IEC materials is helpful to hasten the acceptance and use of FP methods by men. The assessment also finds that gender equitable IEC strategies are effective in the positive male involvement in FP (Clark et al. 2007). Exposure to FP information on TV led to a positive impact on male involvement in FP in the Philippines and Pakistan (Clark et al. 2007, Farooqui 1994).

So, the use of mass media campaign is effective for to a certain extent in male involvement in RH Myanmar because this intervention is only conducted in urban and rural area of two township and there is a need to scale up of the male involvement programme in RH in Myanmar (DOH 2007).

3.2.3 Interpersonal communication from health workers

Regarding the source of information by person, the studies show that over half of the study males received RH information from friends and peers followed by parents and elders. One fourth of the study population received information from general practitioners (GPs), health centres, basic health staff (BHS), and medical doctors, and a small percentage of men received health information from NGO volunteers (DOH 2005, Win et al. 1993). The study by DOH mentioned a certain

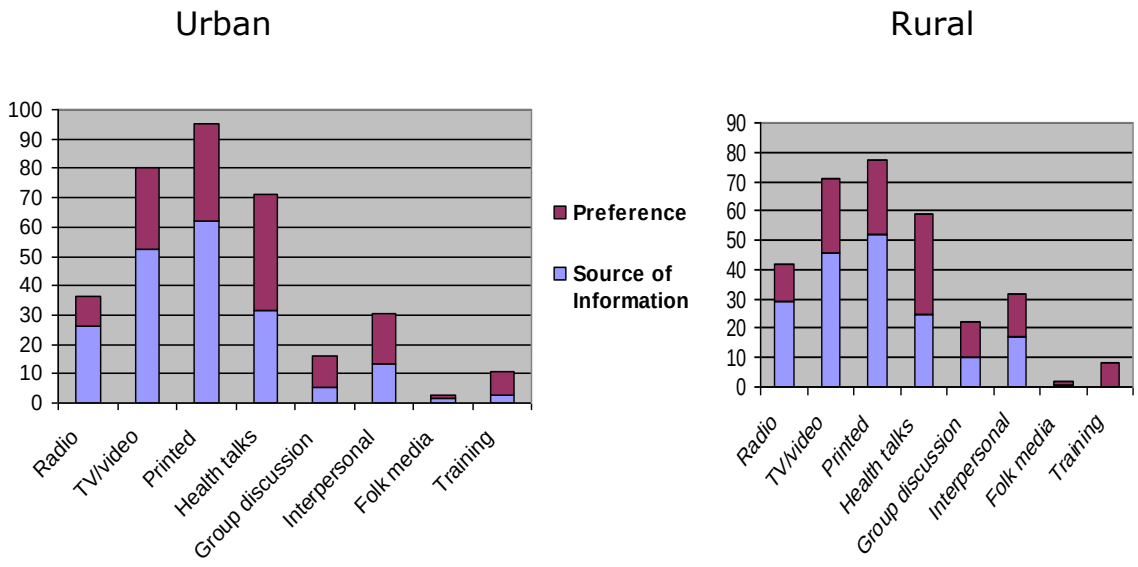
amount of males receive interpersonal one-by-one communication as a source of information, and a small portion receive information from group discussions, and a very few from training (DOH 2005).

For the preference of method of RH information, both urban and rural men mentioned health talks followed by the printed materials and pointed out that their preference is more on the personal communication than the mass media approach. Some of the urban married men liked group discussions as well as one-to-one interpersonal communication. Very few males from both urban and rural area mentioned that they were willing to get training (DOH 2005).

A study in India found that electronic mass media is the main source of reproductive health information. However, married men prefer face to face communication for complete and correct information and they indicated that there is a need for interpersonal communication on sexual and reproductive health matters (Char et al. 2010). This finding is similar with the Myanmar finding mentioned above.

So, in Myanmar there is a gap for interpersonal communication from health workers for the male involvement in FP as pointed out by the previous studies and a need to explore meaningful involvement of males in FP. The following figure show the percent distribution of the respondents on preference and source of RH information in the studied done by DOH, 2005.

Figure (5) Percent distribution of respondents on Preference and Source of information



Source: Base line survey of male involvement in RH 2005

To improve accessibility to information on sexual health and RH to both men, women and adolescents, development of IEC materials and conduct of BCC campaigns were carried out by DOH, NGOs and INGOs. These IEC materials were translated into Chin and Shan languages. IEC/BCC activities were done in 132 townships in Chin, Kachin, Kayin, Mon, Rakhine and Shan States supported by UNFPA (MOH, UNFPA 2015).

3.2.4 Spousal communication

Spousal communication is one of the factors influencing contraceptive use. A study conducted in a rural area of Myanmar in 2008 among married young women revealed that a small percentage of wives and husbands obtained contraceptive knowledge from their spouse. It also showed that more than 90% of the wives and husbands who use contraceptives have spousal communication and nearly 80% of wives and husbands who do not use contraception have spousal communication (Mon 2009). A study on male involvement in MNH done in a satellite township of Yangon showed that 61% of men shared decisions with their spouse regarding health care providers and 69% shared decisions regarding contraceptives (Ampt et al. 2015). Some couples jointly decided to use contraception and for the choice of method urban husbands are more likely to be major decision makers. They revealed that more active male involvement is needed in fertility and FP (Aung Thu et al, 1999).

A study in Nepal found that the majority of contraceptive users discuss FP with their husbands than non-users. The study also found that women who discussed FP with their husbands are more likely to perceive their husband's approval of the contraceptive methods. (Yue et al. 2010).

Spousal communication such as joint decision making on contraceptives use, decisions on health care providers, and on the desired number of children reflects the interest of the husband's involvement in FP.

3.2.5 Advice from the family members

A study done in upper Myanmar on male involvement in RH showed that decision making for health care seeking made by other family member such as father/father-in-law or mother/mother-in-law was very rare (Tint et al. 2013). There was no literature regarding influencing of family members on couples decision on family planning use in Myanmar.

A study done in rural India found that mothers-in-law have an important influence on family decisions regarding daily activities within the household. Mothers-in-law were also likely to influence the number of sons their daughter-in-law had and the timing of their daughter-in-law being sterilized. But there was no influence on the use of reversible modern contraceptive methods, which was mainly made by the couples (Char et al 2010). So, advice from the family members is not an important issue in the male involvement in FP in Myanmar.

3.2.6. Health System in Place (system related- availability, accessibility, affordability)

Family Planning Program in Myanmar

Family Planning programmes in Myanmar started as birth spacing programs in the public sector in 1991 funded by Family Planning International Assistance (FPIA). This program influenced not only the spacing of the children but also limiting the number of children. With the aid of UNFPA, a birth spacing programme was implemented in 1992 in 20 townships and expanded to other townships yearly (Htay & GARDNER 2002). By 2014 it covered 163 of the country's 330 townships (DOH 2014). In the non-programme townships, female sterilization is only provided by the government hospital. Before 2011, the rest of the townships received contraceptives from the private sector facilities such as GPs, drugs stores, the private services of Government staff, and NGOs (UNFPA 2010). Since the 2011-2012 fiscal year the MOH provided the contraceptives to the non-project townships.

For the private sector, there are numerous GPs and drug shops where men, women and adolescents can receive contraceptive services and supplies in the urban area and the rural area. Only condoms, oral pills and injectable contraceptives are sold at the village shops (Htay & GARDNER 2002).

Service factors

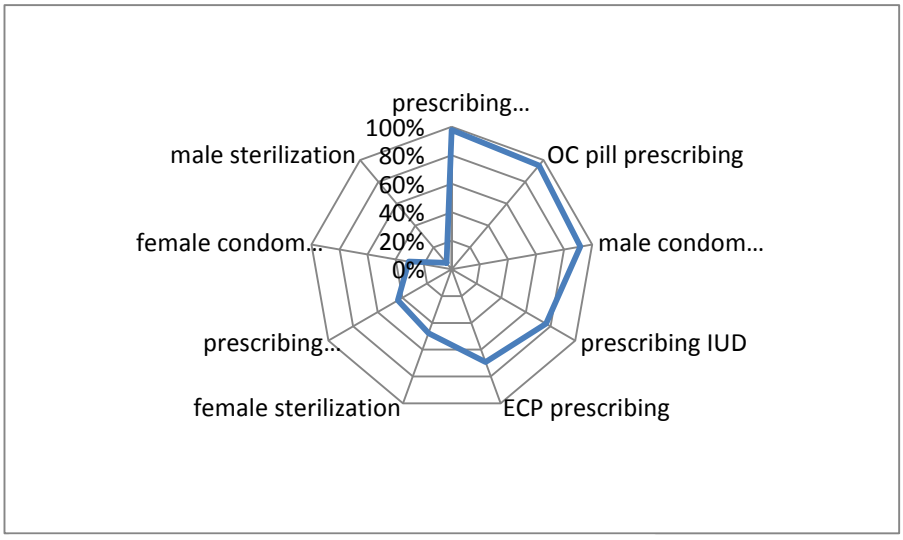
Availability, accessibility, and affordability of FP services are important factors in contraceptive use. In many countries family planning services and clinics are mostly centered on women and men may find it difficult to enter them (Hossain 1999). In Myanmar, MCH clinics, urban health centres, Rural Health Centres (RHCs) and sub-RHCs are provide FP

services. All the Laday Health Visitors (LHVs), Midwives (MWs) and auxiliary Midwives (AMWs) are female and they provide family services to all the community without discrimination but men are embarrassed to consult or discuss with female providers. Health assistants who are head of the RHC are mostly male, but they do not consider birth spacing as their responsibility. Most of the community health workers are male and they are useful for providing condoms to the male community. Thus, males are not largely unreached by birth spacing information and service. So, current health systems should provide male orientated services to all the community and more male can be involved in FP.

Availability

A country-wide survey done by Department of Medical research in 2013 found that three types of RH services can available in the health facility (HF) such as birth spacing services, antenatal and delivery services, and HIV-related services (VCT,PMCT,ART, etc.). Types of birth spacing methods offered by HF are shown in figure (9). Injectable contraceptives, OC pills and male condoms are the most common available contraceptives (DOH 2014).

Figure (6) Type of BS methods offered by HFs



Source: 2013 Health Facility assessment survey

For the private sector, GPs have become the major service provider for the reproductive age population. GP's clinics are the major sources for contraceptives when compared to other private sources such as private hospitals, drug stores and road side stalls.

A study done in Sangyoung Township reveled that all GPs practicing in the township were involved to some extent in delivering FP services. The study found that most of the GPs gave suggestions in the selection of the family planning methods and explained the advantages, disadvantages and side effects of each methods. Some of the GPs gave couples counselling for their choice of FP. In this study all the contraceptive users were married women except one engaged woman. Among those, only three women were sent by their husband and the majority were self-referrals and a few were referred by other health personnel (Win et al. 1993). This shows that males are not actively involved in counselling for FP and this study is only done in one urban township and there is a need to explore further to study meaningful male involvement of FP in the private sector.

The MOH collaborates with three UN organizations, four local Non-Governmental Organizations (NGOs), and thirteen International NGOs to implement the reproductive health services including FP throughout the country. Among the UN organizations, UNFPA and WHO are directly involved in implementing birth spacing, adolescent reproductive health and men's role in reproductive health (WHO 2013).

According to the reproductive health stakeholder analysis 2013, ten INGOs are involved in BS and four INGOs are involved in ARH implementation in their respective townships. Six INGOs, namely Association of Francois-Xavier Bagnoud (AFXB), Burnet Institute, Care Myanmar, JOICEF, Save the Children, and World Vision are involved in implementing men's role in RH (WHO 2013). So, male involvement programmes are implemented in very few townships and there is a need to expand and scale up the programme in other townships.

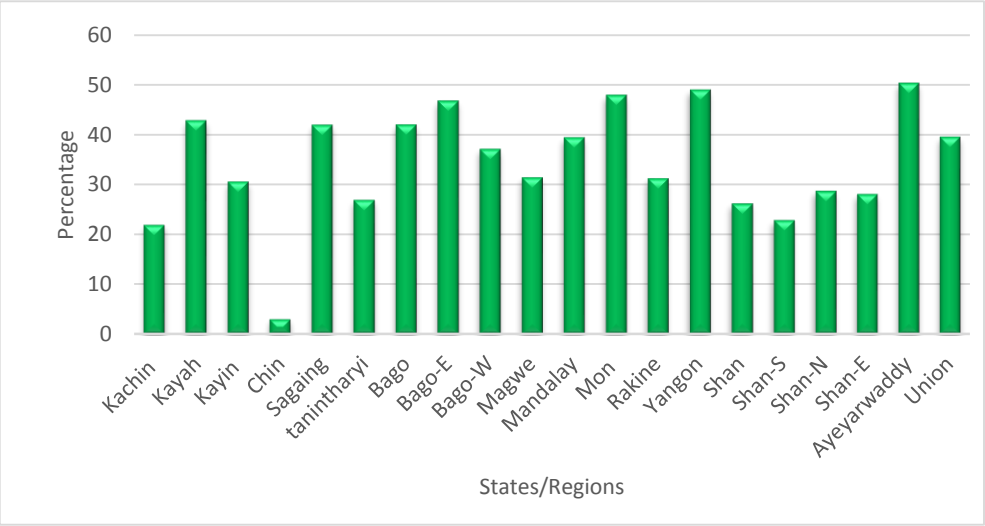
Accessibility

Access to family planning services means geographical or physical accessibility which is the most traditional of access concepts. As described above reproductive health services including contraceptive services are provided through both public and private services providers all over the country. A study done in two townships showed that urban areas have relatively good systems of roads, transportation, and populations are more mobile. So the contraceptives services can be accessed more easily than in rural areas. Rural areas have less access due to limited transportation or difficult terrain and many of the villages are situated a considerable distance from the nearest facility. Due to the above reasons,

the physical access to the contraceptive services differs throughout the country (Htay & GARDNER 2002).

According to the Integrated Household Living Survey 2009-2010, the CPR of Myanmar is 39.5% (IHLCA 2010). There is variation across states / regions; the lowest level is found in Chin state at 3%.

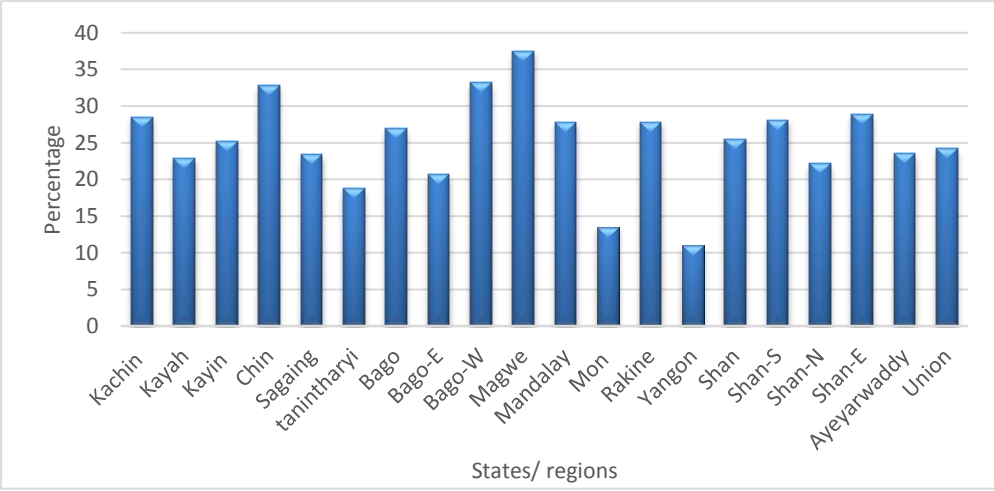
Figure (7) Contraceptive Prevalence Rate by State / Region, 2010



Source: IHLCA Survey 2009-2010

Unmet need for family planning of married women was reported around 24.2% (IHLCA 2010). There are also variations among states / regions; the highest level is found in Magwe Region (37.5%) and Chin State (32.8%) (Figure 7).

Figure (8) Unmet Need for Family Planning by State/Region, 2010

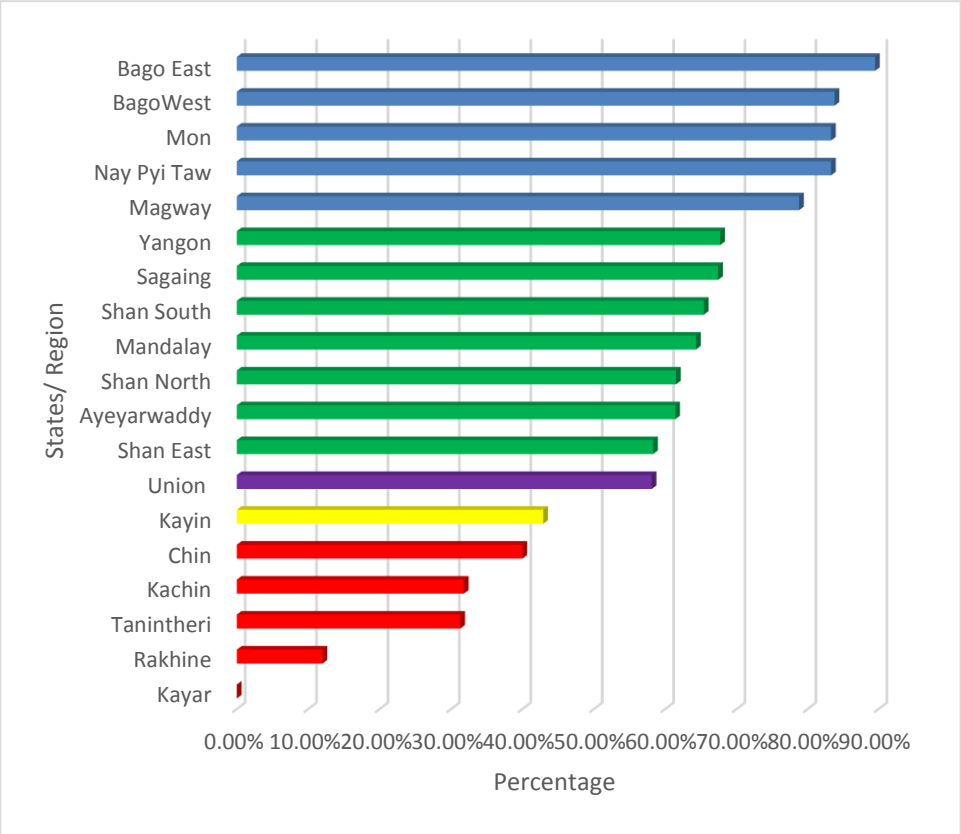


Source: IHLCA Survey 2009-2010

These variations can be explained by the difference in geographical or physical accessibility of states / regions. Due to the difference in the geographical access male involvement in family can be different in states and regions. Husband's disapproval of the use of the contraceptive is the second most common reason for not using contraceptive (DOH 2005). So, if more males are involved in the family planning, unmet need for FP will be reduced.

A nationwide survey done in 2013 revealed that 58% of HF could provide at least five methods of modern contraceptives such as oral contraceptives, injections, intrauterine contraceptive devices (IUCDs), implants and condoms. Urban rural differences for offering five modern contraceptives was significantly seen in this survey 73% and 38% respectively (DOH 2014). So, males cannot access equally in the FP as their method use as well as supporting their partner use of family planning.

Figure (9) Percentage distribution of service delivery points offering at least five modern contraceptive methods by Administrative Unit (Region)



Source: 2013 health facility assessment survey

A study among the youth of the peri-urban area of Mandalay city showed there was one RH service centre within 30-minutes' walk and within one mile from their home. The main mode of transportation is by foot. The study revealed that most of the study youths had a high level of geographical accessibility (Thin Zaw et al. 2012). This showed that male youths who are living in the urban area have more access to FP and more are involved in the FP than their rural counterparts.

A second component of accessibility is administrative accessibility. Actually in Myanmar, there are very few rules and regulations concerned with the birth spacing services provision. The restricted regulation was related to the permanent methods of contraception. For female sterilization, a number of criteria was required (Annex 5). If she fulfills these criteria she can submit an application to the state / regional level sterilization board. When she receives the permission from the board, she can have the surgery. For the male method, vasectomy is illegal. Vasectomy is only legally done to the men whose wives have received permission to be sterilize but who are physically unfit for the surgical procedure. In such cases, the man can apply to the sterilization board for approval for a vasectomy (Htay & GARDNER 2002). If any person intentionally does sterilization to a women or man which is not certified by the Board of sterilization, he/she shall be punished with imprisonment for three years or shall also be liable to fine (The Myanmar Penal Code. undated). But literature about neighboring countries like India, Philippine and Bangladesh vasectomy is used as one method for male (Jayalakahme et al. 2002, Kamal et al. 2013, Calrk Jr. 2007). For the method use by males, condoms and natural methods are the accessible methods for male in Myanmar. As mentioned earlier, husbands are the head of the household and, take the supportive role for female sterilization especially on financial support such as procedure costs, transportation, foods, lodging for those who accompanying them, and costs related to the 5-7 day stay in hospital (WHO 1997, MOH UNFPA 1999).

Affordability

In some research papers, affordability is expressed as economic accessibility. Studies done in 1990 showed that cost is a considerable barrier for many women to access and continue use of contraceptives (WHO 1997, MOH, UNFPA, 1999). A study in two townships of Myanmar showed that 4% of the current contraceptive users gave the reason of cost for why they chose a specific service provider. It also revealed that 21.8% of the 427 current contraceptive users thought that the cost for

their choice method is a little or too expensive. But 3.4% of the 233 past users reported discontinuation of the contraceptives due to cost. This also showed that contraception is more is more expensive in rural than urban areas (Htay & GARDNER 2002).

A community based study done in suburban youth communities showed that only 5% of youth get services free of charge, 20% had to pay less than $1.29, and 75% had to pay more than $1.29. The study said that there was low level of financial accessibility among the youths in the suburban area. The study pointed out that the unmet need for FP services was 32% and the common reason for not utilizing FP services was inability to pay for the services and confidentiality of the unmarried youths followed by less common reasons such as inconvenience of transportation and negative attitude of providers (Thin Zaw et al. 2012). Regarding the cost of the FP, only a quarter of the males could state the cost of a few contraceptive methods. It shows inadequate interest and involvement of male in birth spacing (DOH 2005).

3.3. Individual perceptions

3.3.1 Understanding of Family Planning

A study in rural area of Taikkyi Township among 100 husbands showed that 89% had heard of contraception and 85% knew one or more methods. As regards attitudinal responses, 80% thought that contraception was mainly the wife's responsibility, 72% thought that was the husband's responsibility, 23% thought that it should begin with the start of marriage, 71% preferred male methods, and 51% agreed that contraception should not be practiced. As for the effect of health, 70% thought that it was good for maternal health and 74% thought that it was good for child health. As an opposition, 22% thought that it is against religion, 18% thought that it is against culture, and 17% thought that it is against nature (Tin et al. 1996).

A study done on male involvement in RH in upper Myanmar showed that all the male respondents had heard of contraception. They also understand that contraception is for the prevention of pregnancy (Tint et al. 2013). A study done in Bago and Yangon region found that two thirds of husband had positive attitudes towards their wife / partner's use of contraception. Injections and pills are the most favored methods and IUCD is the least favored. If their wife / partner is not fit to use any methods, men agree to use condoms (DOH 2005). Studies done in Myanmar find that the majority of men have mixed attitudes towards FP;

this attitude should encourage and change practice for meaningful male involvement in FP.

3.3.2 Need for adoption FP at a given time

A behavioral study done by DOH in 2005 found that both husbands and wives perceived the disadvantages of having children too closely. They wanted to space two or three years and some couple preferred to space four or five years. They know reason for adopting of FP at a given time such as health of mother and children, proper breastfeeding, burden on family incomes, and household chores. The study found that half of the couples in the study discussed FP with their spouse before their first pregnancy. They discussed the age of the wife, their financial situation, duration for delaying the first pregnancy, and choice of FP methods and they have the notion of obtaining counselling together with health staff but they rarely practiced fulfilled it (DOH 2005). Husbands promote the use of birth spacing by their wife when they faced difficulties during deliveries or if the wife's health is poor (WHO 1997).

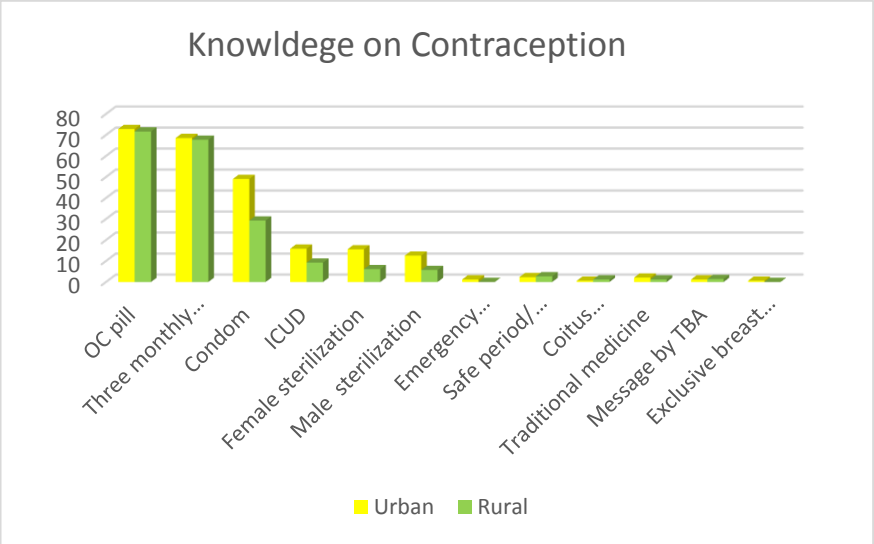
The study showed that if they want to space they want to use the appropriate method of FP. The husbands support their spouse to use an appropriate method and if it is not suitable for their spouse, they choose a male method. But for the couples counselling, they do not practice well. The couples need to be advocated to do couples counselling for FP (DOH 2005).

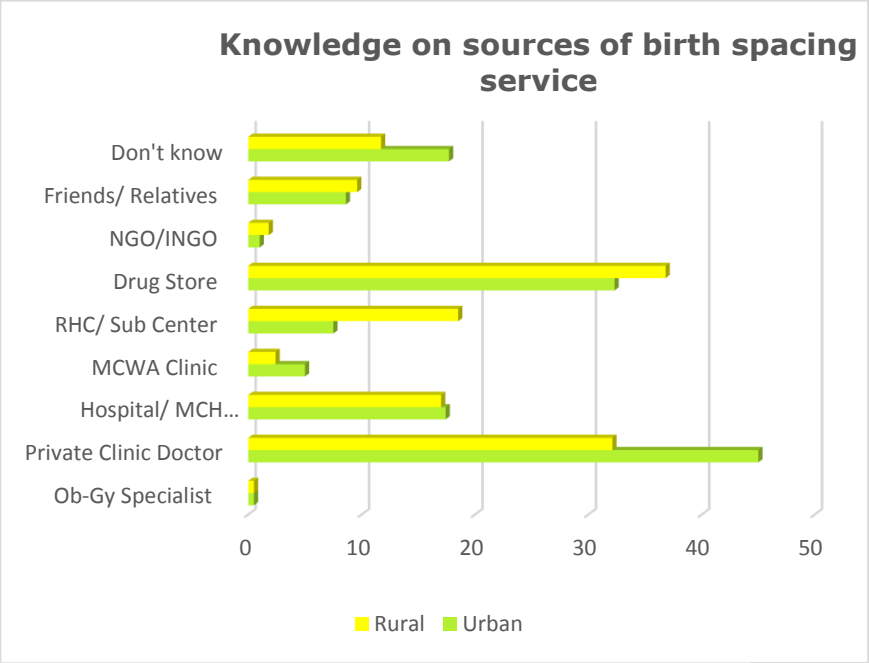
3.3.3 Awareness and knowledge of existing methods of family planning

Adequate knowledge and awareness on methods of contraception is a pre-requisite for the use of contraceptives (Adewuyi & Ogunjuyig 2003, Jayalakshmi 2002). Studies done in Myanmar show that most husbands know about OC pills, three monthly injectable and IUCD, condoms, female and male sterilization, and EC as methods of contraception. Studies also find that most husbands know of other traditional methods such as the safe period / calendar method, coitus interrupts / withdrawals, traditional medicine, exclusive breast feeding, and massage by traditional birth attendant. Among contraception, the best know methods are OC pills, three monthly injectables and condoms. Regarding the knowledge on condoms and IUCD use urban populations showed higher awareness than their rural counterparts. The lower frequency was found in female sterilization and male sterilization and the lowest frequency was found in

exclusive breast feeding and EC in both urban and rural areas (Mya & Khaing 1992, Kyaw 2009, DOH 2005, Tint et al. 2013).

Figure (10) Knowledge on methods of contraception and source of birth spacing services by sexually active married and unmarried men



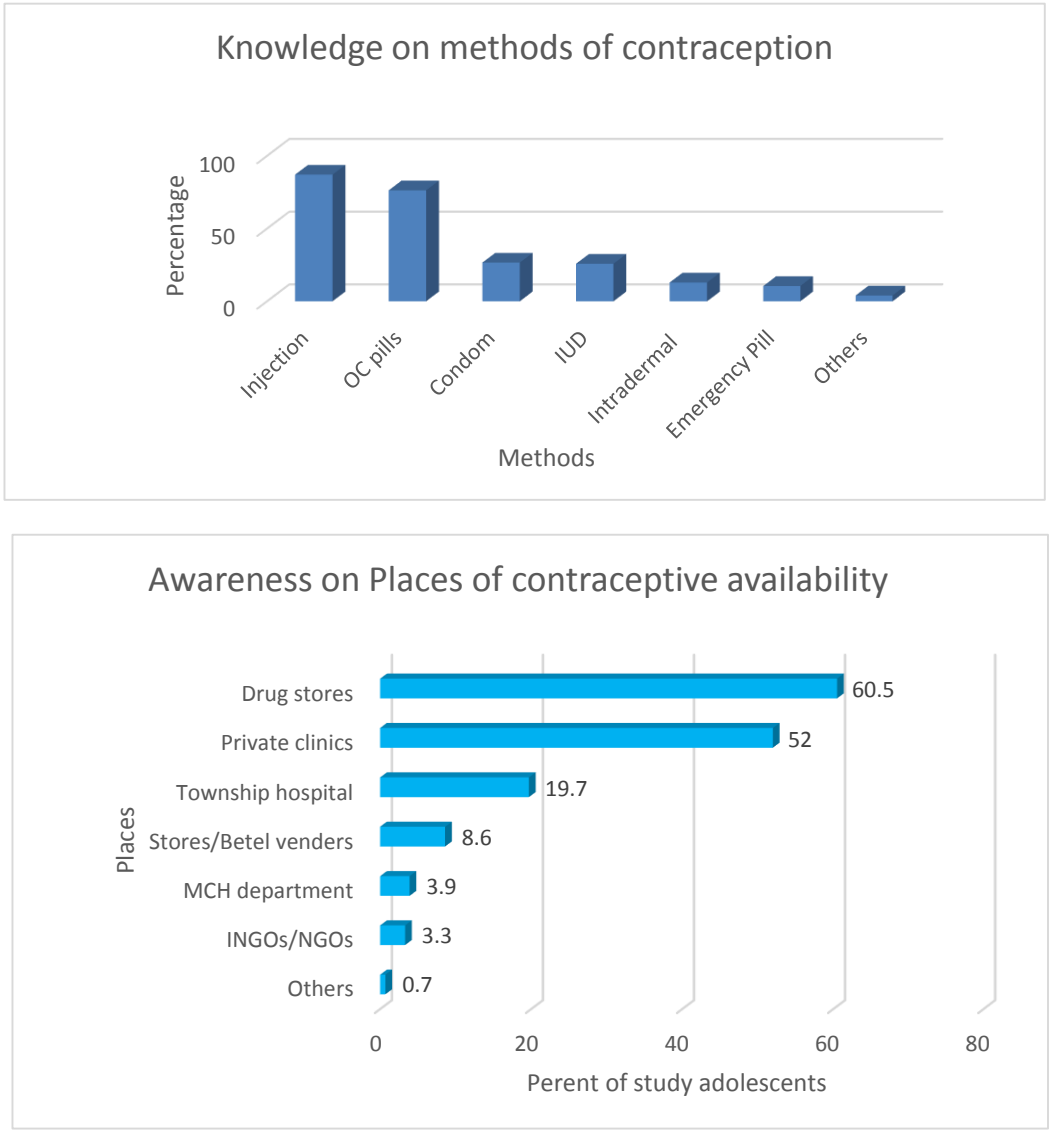


Source: Base Line survey in Male Involvement in RH 2005

Among adolescents, the knowledge of contraception is important for their reproductive life. Studies in Myanmar among male adolescents find that most of are aware of contraception. The most two common methods known by adolescents are injection contraception and oral contraceptives

and a few adolescents know about EC and condoms. A few adolescents do not identify any method of contraception (Lwin 2012). But most of the adolescents knew that they must use condoms to prevent disease when they have sexual indulgence (Maung 2005).

Figure (11) Knowledge on methods of contraception and awareness of places of contraceptives availability by adolescents



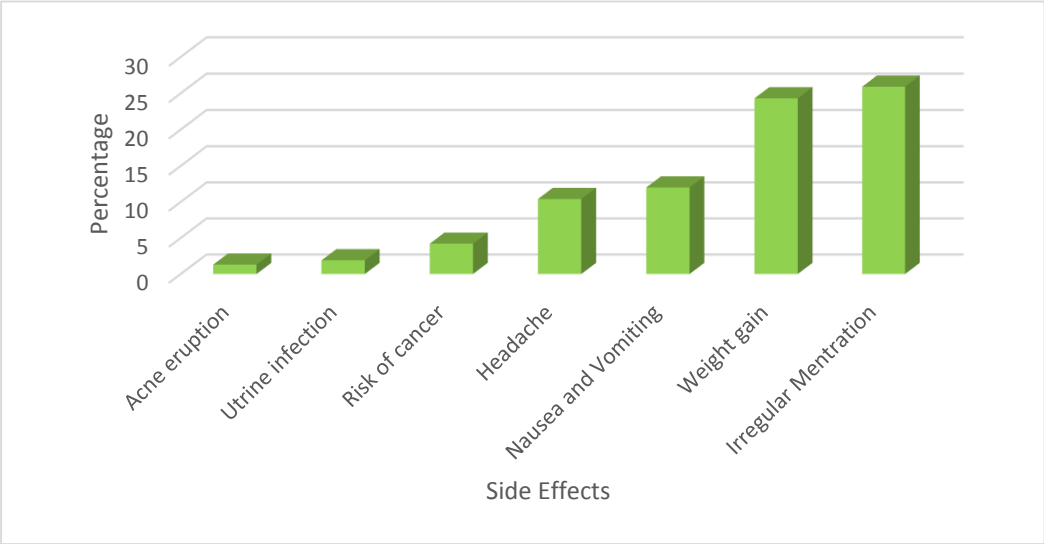
Source: Tin Thitsa Lwin, 2013

Studies find that over half of the men know about side effects of contraception. Irregular menstruation, weight gain, nausea and vomiting were the most common side-effects. The other side-effects included skin pigmentation in face, headaches, acne eruption, uterine infection and risk of cancer Figure (12) (Tint et al. 2013). Other side effects such as

palpitation / tiredness, painful breasts, depression, hypertension, no menstruation, and infertility were also seen in other studies (DOH 2005).

Correct knowledge of contraceptives among men and adolescents is a prerequisite for the effective use. Studies in Myanmar show that they have high awareness on some of FP methods but it is not comprehensive enough.

Figure (12) Percent distribution of respondents by knowledge on side effects/ problems related to various contraceptive methods



Source: Male Involvement in RH in Upper Myanmar, 2013

3.3.4 Motivation to adopt a behavior

Qualitative studies in Myanmar find that most of the couples are aware of birth spacing methods and the husband approval rate is high as is the understanding of the FP. However, only one third of the couples are currently using any male or female method of contraception. The commonly use methods are injection, OC pills, condom, IUCD, and female sterilization (DOH 2005, DOH 2007).

With regard to the male methods, most males have favorable attitude towards condom use if their wives are not fit for a female method. Actually, the studies show that condoms have a stigma attached by the community and there is low prevalence of condom use as a birth spacing method in the community of Myanmar due to some perceptions such as reduced sexual pleasure and its association with promiscuity (WHO 1997, DOH 2005, DOH 2007).

One in depth interview said that *"This issue concerns with both husband and wife. I took pills or injections. I discussed with my husband. My husband agreed because he knew that he would have to work harder if our family size grew bigger"*. (A 20 year old woman from an urban area)(DOH 2007). This shows that if husband have some motivation they are more involved in the use of FP and their self.

3.3.5 Self-efficacy

Self-efficacy can vary between men and women, for instance in the case of condom use, the behavior is not under the women's direct control (Glanz et al. 2008).

A study done in rural area of Ayewarrday region found out the factors influencing decision on contraceptive use among married youth and their husband by using the health belief model. The study find self-efficacy is not a strong predictor of contraceptive use among young couples (Mon, 2009).

A study in Vietnam on male involvement in FP in rural Vietnam by using the Transtheoretical model (TTM) found that self-efficacy is not sensitive to differences in the stage of husband's readiness to encourage his wife in using general contraception. But the study found higher scores for self-efficacy in convincing their wives to use an IUCD in the action / maintenance stage than the pre-contemplation stage (Ha et al. 2003). A study done in Tiwan among college students found higher self-efficacy related to condom use during sex in the action or maintenance stage of the TTM and higher scores meant that they were more confident to use condom (Tung et al. 2010).

The available study in Myanmar on self-efficacy finds that it is not a predictor of contraceptive use among young couples. But studies in Vietnam and Tiwan show that self-efficacy has some influence on the male involvement of FP. There are no studies in Myanmar on self-efficacy of male use and intervention studies using behavior theories should be encouraged.

3.4 Likelihood of action

3.4.1 Benefits out-numbering barriers

As mentioned previously Bangladesh studies find that older husbands, wives over 35, men with wives having secondary or higher education, men who wives are skilled workers, couples who have spousal communication, and couples who have high knowledge of contraception are more likely to participate in FP and RH (Kamal et al. 2013).

Myanmar has limited studies to find out the effect of benefits out numbering barriers in FP and RH. Studies in Myanmar find that most husbands and males can explain the benefits the FP. They said they can give good care and child rearing; they could save more money, they could afford to give a good education to their children, and the health of the mother could be improved. They indicate that they are more likely to use FP if they know the benefits of the FP. Studies find that husbands who completed primary education, who have a high income, who have good knowledge on birth spacing, and who have good attitude on reproductive health care were more likely to be involved in the women's reproductive health matters (Tint et al. 2013). It is also find that if they have some motivation factor such as economic reasons, husband are more likely to support to their partner's use of FP (DOH 2005).

CHAPTER 4 BEST PRACTICES IN FAMILY PLANNING

4.1 Myanmar – Front Line Health Promoter

In 2005, Myanmar was selected as a pilot country along with Indonesia and Mongolia for a four year Asia Regional project "Increasing Male involvement for RH through Effective Behavior Change Communication Strategies (2004-2007)" for the development of a country level strategy and national level capacity building undertaking BCC intervention for male involvement with the support of UNFPA. The projected was executed and implemented by JOICEF in collaboration with DOH and MMA. Before the implementation started the baseline study on Knowledge, Attitude and Practice of Men on Reproductive Health and behavior study was done in 2005. In the study, knowledge, attitude, and practice of men on safe motherhood, maternal health, birth spacing, STI's and HIV/AIDS, gender issues and source and preference of RH related information were identified. Based on the findings of the baseline results, the Myanmar BCC Strategy for male involvement was developed. The project was implemented in Bago Township and South Dagon Township.

The Myanmar strategy consists of three components such as advocacy, social mobilization and communication for Behavior development/Change. To increase involvement of men in RH programmes in support of achieving MDG and ICPD goals was the major aim of this project. The strategies are the recruitment and training of male frontline health promoters (FHPs) for local level BCC activities including peer education and formation of support groups and development of effective and appropriate BCC tools for the frontline health promoters. They produced relevant IEC materials such pamphlets, RH flip charts, reproduced existing one, and developed videos and pictorial illustrations (DOH 2005). To implement this strategy, the Training of trainers is given to GPs and BHS to conduct multiplier training for FHPs. After recruiting and training, FHPs are equipped with knowledge and skills for organizing BCC activities. Youths from project townships were trained on RH including safe motherhood, FP, HIV/AIDS, and male involvement. FHPs and youth volunteers took peer communication and discussion with their neighbors, workplace and the places where men gather like tea shops, trishaw and carry stands by using IEC materials. The activities of FHPs are supervised and monitored by GPs and BHSs (DOH 2007).

After two years of implementation of BCC strategies, the end line survey data collection was done to access the effectiveness of the intervention. The results show that there were increased RH indicators compared with the baseline survey. Some of the FP indicators meet their set target such as percentage of men who can mention four modern contraceptives and percentage of men who agree that men should be involved in the birth spacing counselling (Table 1). The study found that the BCC intervention is effective to some extent and recommended considering scaling up of this program in other townships of Myanmar.

Table (2) Table showing men's knowledge on family planning before and after intervention according to urban and rural areas

	Before Intervention			After Intervention	
	Urban	Rural	**Target**	Urban	Rural
% of men who can mention four modern contraceptive methods	14.2	19.1	**40**	48.9	48.6
% of men who agree that men should be involved in birth spacing counseling	88.6	80.3	**95**	97	94.7
% of men who are using condoms for contraception	3.0	1.4	**10**	9.8	6.5
% of men who used condoms for extra-marital sex	56.9	41.9	**80**	56.9	72.9
% of men whose wives are using IUCD	1.2	1.4	**10**	5.1	3.2

Source: End line data collection & Behavioral study report on Male involvement in RH in Myanmar, 2007

4.2 Vietnam-The Health Bridge Program

Vietnam is one of the programme countries for the promoting male responsibility towards greater gender equality implemented and partially funded by the Health Bridge Foundation of Canada (Health Bridge). Health Bridge found to increase positive male involvement in FP and address violence against women and inequitable gender roles in the family (USAID FAM 2013). The guiding principal of Health Bridge approach was engaging men and valuing women by promoting greater access to use and male centred methods of contraception especially condoms and vasectomy and by valuing women themselves and also by families, communities and service providers.

In Vietnam, the Health Bridge programme was started in 2004 and implemented at both national and provincial levels in collaboration with local organizations including government, academic, and civil society organizations. The projected is implemented in 29 wards / communes of Vietnam and started with qualitative and quantitative baseline research on gender roles, and understanding of perceptions of gender equality and RH in Vietnam. The intervention also included mass media campaigns for public awareness-raising on FP / SRH, capacity building and networking. Mass media campaigns are designed to encourage male involvement and couple-based decisions for SRH by using IEC materials such as pamphlets, billboards, TV-spots, radio broadcast and dramas. Capacity building is conducted in various levels including mass organization, health institutions, and also to journalists. The Health Bridge project developed a curriculum on gender roles and RH which focused on promoting men's roles and decision making roles in SRH. Networking involves sharing and exchange of information with other NGOs and INGOs on how to approach gender issues from the male perspective.

The end line evaluation was done in 2008 including data collection, interviews focus group discussion and observations. The success was seen in the post project evaluation such as changing in attitude and behavioral of men due to the training and information by the project. The evaluated results shows that the men in the participating communities use contraceptive regularly, seeking information about modern contraception, purchasing condoms and participating more in their wife / girlfriend's RH matters. The other indicators are also significantly changed such as decreased abortion rate, doubly increased condom used rate, increase in gynecological visits by female patients and decreases in domestic violence. Due to this success, the Health Bridge programme is considering

scaling up in other communities and there is interest from other NGOs to incorporate this program's approach into their own program (USAID 2013, MacDonald et al. 2013).

4.3 Niger – The School for Husbands

According to a UNFPA survey in 2007, men's dominance and attitudes were major obstacles to women taking advantage of RH care in Niger and to change this condition, the government launched the school for Husbands program by transforming men into allies for women's RH and FP. The uptake of FP was very low with a CPR of 5% and a high maternal death rate. The School for Husbands initiative was based on a project and it is a place of discussion, decision making and action. For their own development, husbands emerged as responsible actors with a spirit of volunteerism and community. The aim of this program is to prepare men to serve as role models for their communities and to bring about change.

To fulfill the above aim, the school has the principle that all members were leaders and there was no hierarchy within the group spirit. The essential principles were active listening and mutual respect based on a participatory approach. To ensure this equality within the group, a different member was identified to gather information such as RH indicators from local health centre and facilitate the discussion during the meeting.

The target group of the school was married men, 25 years and above who as unpaid volunteers, participate in sensitization on importance of RH services. There were 8 to 12 members in most of schools and no more than five schools per health centre. To find out the solutions and to analyze challenges regarding RH in the community, a school meet twice per month. By the end of 2011, there were 177 participating schools in Niger. The results obtained in three years were impressive. The leader of the district observed that visits to the health centre and the utilization of contractive have increased. The indicator from one health centre showed that the utilization of FP services had tripled, the number of child birth attended by the skilled birth attendance had doubled and the rate of antenatal visit increased from 28.62% in 2006 to 87.30% in 2010. After implementing the school of husband programs, one of observed success was behavioral change among men, from conservative attitudes to involvement and commitment of men in favor of reproductive health with better dialogue, listening and

understanding of health issues. A decisive positive behavioral change has been seen due to the involvement of men in promotion of RH, based on the accurate information on RH, contraceptives and post-natal care. Due to individual male involvement, husbands gain a better understanding of RH and help to put an end to some taboos and misconceptions. The School for Husbands initiative gives inspiration to other countries which is the greatest success of this program. (UNFPA 2012).

CHAPTER 5 DISCUSSION

This chapter discusses and concludes the potential influencing factors to male involvement in Family Planning in Myanmar based on the findings and adapted conceptual framework.

Male involvement in Family Planning is described under many heading such as male involvement, men's participation, men's responsibility, male motivation, men as partners, men as decision makers and men and RH in the Myanmar literature as well as the global literature. The general objective of this literature review is to explore the factors influencing male involvement in Family Planning in Myanmar.

Many interrelated socio-demographic and cultural factors for instance, age of husband and wife, education of husband and wife, education, occupation, family income, marital status and cultural factors are identified as important determinants of male involvement in FP in much of the literature. This literature review finds that the age of the husband and wife, occupation, couple's income, and marital status are not associated with male involvement in Myanmar (Tint et al. 2013). This study was done in rural area of only two townships of upper Myanmar. Bangladesh studies find that age of husband and wife are strongly associated with the male involvement in FP. Male skilled workers and professionals workers have a higher male involvement in the FP and RH than the unskilled workers and male involvement in RH and FP is higher in wives who are skilled workers compared to the housewives (Kamal et al. 2013). Couple's income is also one of the important factors for the utilization of the family planning. But male involvement in FP and RH is proportionately higher among higher income couples (Kamal et al. 2013). The Myanmar studies were done in rural area of two township and the findings are totally different from the international literature, so it is necessary to do further research to find out the association between the socio demographic factors and male involvement in FP in a large scale for the application of the whole country.

Regarding the education of the husband and women, this study does not revealed any association with male involvement in FP. This is due to the sexual and reproductive health (SRH) education system in Myanmar. In spite of teaching the LSE programme in different levels of school, sexual and reproductive health education is not effective in Myanmar. Cultural factors are also a barrier to the use FP and male involvement in FP in Myanmar. SRH education including family planning are not insufficient since schooling age due to the cultural barriers. Most

of the parents and teachers think that SRH issue is too sensitive for the students and should not be talked about in front of adolescents. Bangladesh studies pointed out that the education of husband and women has strong effect on male involvement in FP and the more educated couples are taking share responsibility on their reproductive health and family planning (Kamal et al. 2013). So, comprehensive sexual and reproductive health education should be given in the school through LSE and more collaboration with the Ministry of Education is needed. If young male adolescents are fully equipped with adequate and compressive knowledge they will be take responsibility for their SRH as well as for their partners and more involved in RH matters. Community awareness programmes on male involvement in FP and RH should be done to overcome the culture barriers.

The study finds that polices and strategies for male involvement in FP are manifested by a lack of opposition. The population policy, reproductive health policy, and five year strategic plan for RH are in place. As a signatory country of ICPD since 1994, Myanmar still lacks male involvement in RH and FP. Currently in Myanmar a limited number of strategies and polices make reference to men but at the implementation level they do not translate words into practice with the exception of the FHPs programme in very few township. However, concerning with the gender issue, most of the policies and programs are targeted to promote the role, rights and situation of women. This approach can lead to neglect of the male involvement in FP. Cambodian studies found that the way to ensure that policy implementation contributes to effective male involvement in RH matters is to develop clear guidelines for male involvement. For instance, a five year national reproductive health strategy that emphasizes all these areas offers strong opportunities for integrating the male involvement components (Walston 2005). Other policies that support the male involvement of RH also include the specific guidelines for the male involvement. So, health policies should specifically refer to male involvement and give suggestions for how to involve men in program implementation. The issue of gender equality and role of men in supporting their wife / partner's access to FP services should be included in gender related policies.

Mass media play an important role in the male involvement in FP. This study finds that using mass media which include male involvement themes is effective for the male involvement in FP. This study was done in only two townships and the study also found that men's knowledge of RH, antenatal care, postnatal care, danger signs of pregnancy, indication for

institutional delivery, complication of abortion, skilled birth attendants, birth spacing, and consequences of HIV/STI had increased in the male population of the two townships. However, systematic expansion of interventions needs to be supported within the RH strategic plan and programmes to promote participation of men in actions for reproductive health (DOH 2007). Similarly, the Health Bridge programme of Vietnam is also uses mass media which is designed to encourage more male involvement and couple's decision making. It can be applied to the Myanmar setting for male involvement in FP (MacDonald et al, 2013).

Interpersonal communication from the health workers is an influencing factor for the male involvement in FP. This study find that married men prefer interpersonal communication from health workers to get more complete and comprehensive SRH education (DOH 2005). A similar finding was found in an Indian study (Char, 2010). But these finding are from the male preference of the source of information. There was no specific study of provider side perception on male involvement in FP. So, further research is needed to explore how interpersonal communication from the health workers influences the male involvement in FP.

Spousal communication can increase the use of FP by sharing knowledge of contraceptive between couples. This study finds that the majority of the contraceptive using couples have spousal communication (Mon 2008). A similar study find in Nepal found that the women who discussed with their husbands perceived their approval (Yue et al. 2010). Lack of communication between couples about family planning can lead to misconceptions about the spouse' view and also inhibit mutual decision making. Spousal communication is an entry point for community based intervention programs. BCC intervention such as mass media campaigns to promote male involvement in FP can influence psychological factors associated with spousal communication which lead to FP use.

As a culture, husbands are the decision makers of the household. This study find that joint decision making is made for most of the health seeking matters and there is no influence of the relatives (Tint et al. 2013). In Indian studies, mothers-in-law have some influence on the number of sons and timing of sterilize by their daughters-in-law but no influence on reversible contraceptive method use (Char et al. 2010). In Myanmar, husbands as income earners have a role as decision makers for family expenditures including health, reproductive health and health-related costs. BCC intervention program such as school for husband can

be applied in Myanmar. The School for Husband programme is based on a participatory approaches and it can be easily adapted to the values and need of the community. The element of the success was the coherence of the School for Husband with socio-cultural and religious values which ensure appropriation of this strategy.

In Myanmar with the support of UNFPA quality RH training are provided in 163 townships of the country (DOH 2015). Male involvement in RH is one component of the quality RH and BHS can provide male orientated services more than in those than other townships (DOH 2014). Male involvement programme supported by other INGOs are implemented in very few townships. For the service delivery for men, we should consider that family planning service needs can vary at different stage of life. For instance, adolescent need information and services including sexual education and advice on proper use of condoms and other contraceptive methods (Clark Jr. et al. 2007). So, adolescent friendly health services should be expanded in Myanmar. Men in the reproductive age group need information on their role in participation in their wife's use of FP and promoting the value of condom, using long term methods to limit the family size, and consideration of permanent methods when have completed their desired family size (Clark Jr. et al. 2007). For more male engagement in FP, BCC interventions like the health bridge programme in Vietnam should be made because this include mass media campaign for public awareness-raising on FP/SRH, capacity building and networking (MacDonald et al 2013). In Vietnam this programme was first gender equality program that focus on engaging men in SRH. Post evaluation showed that men used contraception regularly and involved more in their partner's RH matters. Vietnamese men stated that their changed attitude and behavior was due to the training provided by the health bridge programme.

For physical accessibility, this study finds that urban married men and adolescents are more accessible than their rural counterparts and accessibility varies around the countries (DOH 2014). Due to this geographical accessibility, CPR and unmet need of FP vary (IHLCA 2010). For the method use by male condom and natural methods are accessible for male but vasectomy is illegal in Myanmar. Availability of contraceptive is important for the male involvement in FP. This study finds that birth spacing services can be available in different types of HF and condom is one of the most common available method throughout the country (DOH 2014). GPs are another main source for FP. Male method of contraception and IEC materials are available at NGOs and INGOs clinics

and they are provided in a very few townships. Only a few males know the cost of the family planning methods and this indicated they are less involved in FP (DOH 2005). Further research on accessibility, availability and affordability of the family planning services related to male involvement should be done.

Men's knowledge, attitude and practice towards family planning also influence the behavior of their wives as well as their involvement in FP. This study finds that men have high levels of knowledge but it is not comprehensive and while they have a positive attitude towards male involvement in FP, it should be changed into practice (DOH 2005). The study also finds that they have motivation to space or limit the children or other economic reasons, men are involved in their partner's use of contraception or their use. The focus on male involvement only as a means to improve women's reproductive health and may cause an oversight of men's own RH needs which are not always met. Men's health status and behavior affect women's health. Involving them increases their awareness, acceptance, and support to their partners' need, choices and rights. Talking of females alone or males alone is not an adequate approach to RH issues, and therefore women and men must work together for themselves, for their families, and for society.

Regarding self-efficacy, this study finds that self-efficacy was not a strong predictor of the contraceptive use (Mon 2008). The literature said that self-efficacy was a significant predictor of sexual behavior that increased condom use, decreased number of sex partners and sexual encounters. Family planning use is an example of healthy behavior that require change (Ha et al. 2003). Motivation to adopt and self-efficacy are complex phenomenon of behavioral change theories such as health belief models and transtheoritical model. There are limited studies in Myanmar as well as in Asia to study the behavioral change for male involvement in FP. So, both qualitative and quantitative studies are still required to study the motivation to adapt a behavior and self-efficacy by using various behavioral theories.

Limitation of the study

The study has some limitation. Firstly, due to the shortage of time, there is limited to a literature review and used available data for analysis. Secondly, there is no much literature in Myanmar specially related to male involvement in family planning and reproductive health in Myanmar. So, study done in other Asia countries with similar study characteristics related to family planning and reproductive are considered. Thirdly, the

limitation is the studies only describe the age of husbands instead of age of married or unmarried men.

CHAPTER 6 CONCLUSION

In this study, some cultural factors and condition especially on sexual and reproductive health education were found that prevent men from being involved in FP. Therefore, male involvement is still needed to be improved in proper ways. All the policies supporting male involvement in the FP are in place but there is a weakness in the implementation of the male involvement in the programme. Health systems are in place also and they also need to extend male orientated health services in Myanmar. Men's knowledge on FP is high but not comprehensive and as knowledge is the very first step towards a behavior change, key messages appropriate for men should be developed. Attitudes towards FP are positive and need to change into practice. For this change BCC intervention is an important component for more male involvement in FP. This study revealed there is a lack of information on male involvement in FP and there is the need to do various research in Myanmar.

CHAPTER 7 RECOMMENDATIONS

The following recommendations are given based on the influencing factors identified in this study to increase male involvement in Family planning and other successful Asia and one African countries experienced to address similar challenges.

Policy Level

- An important first step is to promote male involvement as one main component in the Reproductive Health Policy and Reproductive strategic Plan of Myanmar. Though existing Myanmar policy regarding reproductive health recognize male involvement, they often include a token mention, unsupported by the concrete guidelines.

Importance of having male involvement in FP2020 agenda:

- A set of guiding principles needs to be developed to assist those involved in the male involvement programme of reproductive health. The developed guide line should be short, clear, constructive and easy to adapt existing activities and approaches.
- For more involvement, to advocate for legalization of vasectomy as a male method of FP. Most of the neighboring countries practice vasectomy as a male method but in Myanmar it can be a complex process and it needs a series of advocacy and meetings.
- To strengthen collaboration and coordination with the Ministry of Education to promote sexual and reproductive health education in the Life Skills Education curriculum.
- To expand male involvement in reproductive health programme townships with the aid of local and international NGOs.
- Mass Media Campaign for male involvement in FP should be reviewed and scaled up. Mass media such as TV, radio, poster, pamphlets, wall sheets and calendar including male involvement themes should be reviewed and should be used more frequently and effectively.

Facility level

- The existing health center regarding RH services should be more male friendly. While MCH, RHC and sub RHC centers are successfully providing reproductive health services support to

women, they are perceived as generally inaccessible to men due to embarrassment.

- Basic Health staff need further training in couples counselling and male client counselling and also gender issue should be included in the training.
- Effective outreach services need to be organized to facilitate both men's and women's access to RH services and to facilitate rural community access to RH services.
- The private health sector, especially GPs should participate directly in male involvement efforts.

Community level

- Strengthen community awareness raising campaigns for male involvement in FP. All men should be educated in all aspects of reproductive health as a clients and partners.
- For the male method use, special education programs could be made motivation to the community on dual roles of using condom to prevent unplanned pregnancy and to prevent transmission of STIs/HIV.
- Social mobilization activities to support mass media campaign for male involvement in the family planning should be encourage.

Research

- Behavioral studies regarding male participation in FP in Myanmar need to be explored.

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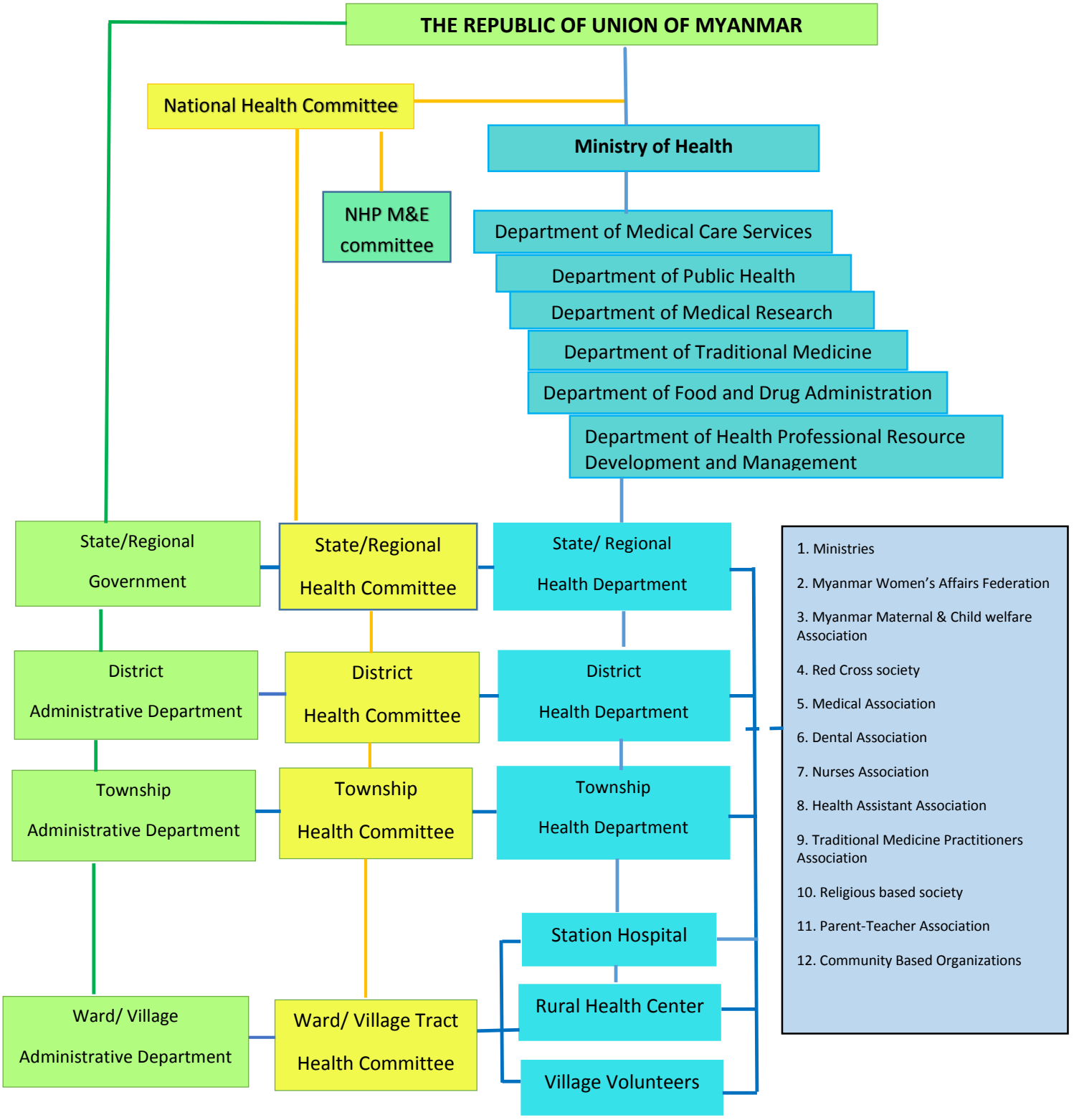
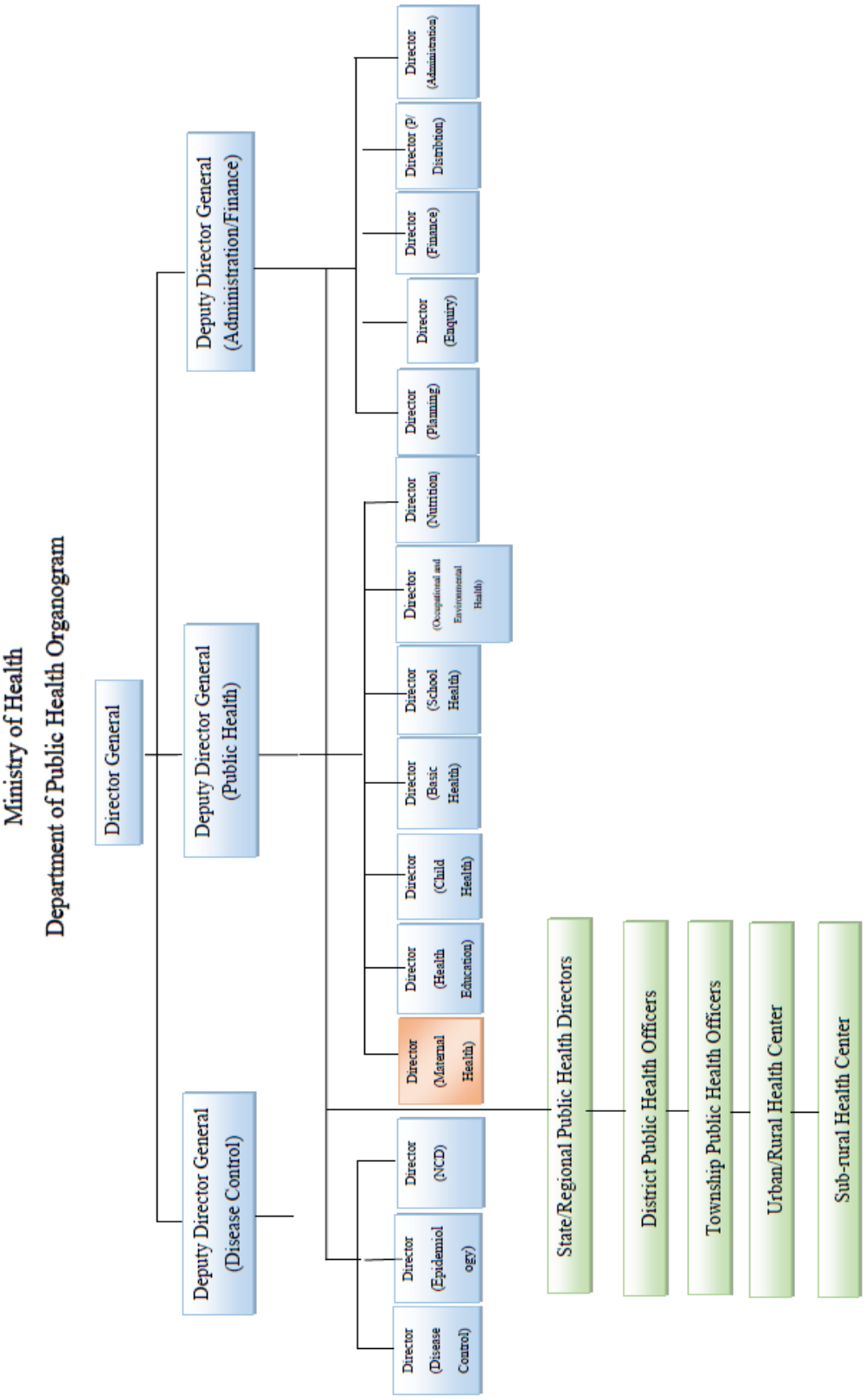
ANNEXES

Annex-1 Organization of Health Service Delivery



Annex - 2 Organization setup of Department of Public Health



Annex-3 Draft National Population Policy (1992) (UNFPA 2010)

1. Improve the health status of Women and Children by ensuring the availability and accessibility of birth-spacing services to all married couples voluntarily seeking such services
2. Provide the community with information, education and communication measures on birth-spacing in advance as it is important.
3. Encourage Myanmar women to fully participate as equal partners in national development by giving them equal status with men.
4. . Promote the awareness of citizens of the nation on the responsibility of the reproductive behavior and also educate the male population of their responsibility.
5. Utilization of young people in national development efforts as youth population of under 18 constitutes about 50% of the total population.
6. The government is committed to a strategy of providing essential health care using the primary health care approach. Therefore, to attain the prevention of diseases and promotion of healthy life-style, the basic facts included in the primary health must be emphasized.
7. Raise the social status of the rural community by taking into account the internal and international migration issues. Integration of comprehensive urbanization policy into the overall development planning process while ensuring effective economic interdependence between towns and villages.
8. . Raise the awareness of the importance of population information and vital statistics for socioeconomic planning.
9. Review and amendment of existing legislation to support the achievement of the objectives of the population policy.

Annex – 4 Myanmar Reproductive Health Policy (DOH 2002)

1. Political commitment should be sustained to improve reproductive health status in accordance with the National Health Policy and to promote rules, regulations and laws on reproductive health.
2. Reproductive health care services and activities should conformed with **National Population Policy**.
3. **Full respect to laws and religion, ethical and cultural values** must be ensured in the implementation of reproductive health services.
4. The concept of **integrated** reproductive health care must be introduced into existing health services and programmes. **Quality reproductive health care** must be provided in integrated packages at all levels of the public and private sector in providing reproductive health.
5. Effective **partnerships** must be strengthen among and between governmental departments, non-governmental organizations and the private sector in providing reproductive health.
6. Reproductive health services must be **accessible, acceptable and affordable** to all women and men, especially underserved groups including adolescents and elderly people.
7. Effective **referral systems** must be developed among and between different levels of services.
8. The development of appropriate information, education and communication (IEC) material must be strengthened and disseminated down to the grassroots level to enhance the **community awareness and participation.**
9. Appropriate and effective traditional medicines and socio-cultural practices beneficial for reproductive health must be identified and promoted.
10. Adequate resources must be ensured for **sustainability** of reproductive health programmes.

Annex - 5 Criteria for Authorized Female Sterilization

1. Pregnant woman with 2 Lower Segment Caesarean Section Scars.
2. Previous Classical Scar.
3. Grand multi-parity irrespective of age.
4. Multipara with 35 completed years of age with 3 alive children.
5. Multipara with 38 completed years of age with 3 alive children.
6. Forty completed years old with one alive child.
7. Previous child with genetic and chromosomal disorders that have a high risk of recurrence.
8. Any medical disorder endorsed by respective specialty (at east consultant level) that contraindicate future pregnancy.
9. Gynecological disease that can harm maternal health.
10. Obstetric emergencies that can endanger the future pregnancy.