

Factors Influencing Family Planning Practice among Reproductive Age Married Women in Hlaing Township, Myanmar

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Objective: To study the factors that influence the family planning practice among married, reproductive age women in Hlaing Township, Myanmar.

Material and Method: Cross-sectional survey research was conducted among 284 married, reproductive age women using stratified random sampling. The data were collected through questionnaire interviews during February and March 2012 and analyzed by frequency, percentage, Chi-square test, and multiple logistic regression.

Results: The proportion of families practicing family planning was 74.7%, contraceptive injection being the most commonly used method. The factors influencing family planning practice were attitude towards family planning, 24-hour availability of family planning services, health worker support, and partner and friends support. The women with a positive attitude toward family planning practiced family planning 3.7 times more than women who had a negative attitude. If family planning services were available for 24 hours, then women would practice 3.4 times more than if they were not available for 24 hours. When women got fair to good support from health workers, they practiced 15.0 times more on family planning and 4.3 times more who got fair to good support from partners and friends than women who got low support.

Conclusion: The factors influencing family planning practice of married, reproductive age women were attitude toward family planning, 24-hour availability of family planning services, health worker support, and partner and friends support. The findings suggest that empowerment of health workers, training of volunteers, pharmacists and contraceptive drug providers, encouraging inter-spousal communication, and peer support, as well as an integrated approach to primary health care in order to target different populations to change women's attitudes on family planning, could increase family planning practice among Myanmar women.

Keywords: Family planning practice, Reproductive age, Attitude toward family planning, Married women, Myanmar

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Rapid population growth is one of the major burdens of the world, especially in developing and underdeveloped countries. Therefore, an effective and acceptable family planning program plays a significant role in health, social and economic growth of a country. Population growth rates are depend on an effective family planning program and how people adopt family planning practices. All the married, reproductive age women have to receive enough information about modern contraceptive methods to practice effective family planning. However, millions of women in developing countries, who would like to postpone or

avoid pregnancy, do not use contraceptive methods for various reasons. 200 million women want to use safe and effective family planning methods, but lack access to information and services or lack support from their husbands and communities which leads to improper use of family planning practice⁽¹⁾.

Inappropriate contraceptive choices lead to high rates of unwanted pregnancies and abortion. Every day, approximately 1,000 women die from preventable causes related to pregnancy and childbirth and 99.0% of all maternal deaths occur in developing countries⁽²⁾. In Southeast Asia region, a woman has one in 35 chance of death in her life time due to the consequences of unsafe abortion, pregnancy or delivery⁽³⁾. It is related to various factors such as education, culture, economic, and social, psychosocial factors, all of which influence family planning practices. It also depends on

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accessibility and availability of various methods of family planning.

In Myanmar, the total fertility rate (TFR) for 15-49-year old women is estimated to be in 2007, 2 births per woman. The total marital fertility rate (TMFR) is 4.7 per married woman. This difference is due to high proportion of unmarried women (46.0%)⁽⁴⁾. Maternal mortality ratio (MMR) in Myanmar is 360 per 100,000 live births in 2005⁽⁵⁾. Unsafe abortion accounted for 50.0% of the total maternal deaths and 20.0% of all hospital admissions came about because of complications arising from unsafe abortions. The causes of unwanted pregnancies and abortions are contraceptive method failures from inconsistent use and non-use of family planning practice⁽⁵⁾. 20.0% of women did not want to get pregnant but were not using contraception and were at risk of pregnancy. 14.0% wanted to limit their births and 6% wanted to delay their next pregnancy⁽⁴⁾. This shows that there are lacks of acceptable temporary and long-term contraceptive methods in the country.

Among married women of reproductive age, 96.0% of women know different kinds of contraceptive methods. Although it is very high percentage of knowledge on contraception, the actual utilization of contraception is only 41.0%⁽⁴⁾. The preference of contraceptives among married women of reproductive age is injectable (19.7%) and pill 10.8%. Intrauterine device (IUD) usage is very low choice among methods (1.8%) of contraception among Myanmar women⁽⁶⁾.

Family planning services are provided by the public sector, private sector, and national and international NGOs in Myanmar. Although a range of contraceptive methods are available in Myanmar⁽⁷⁾, the contraceptive prevalence rate is only 41.0%; 8.4% are using modern methods and 2.6% using traditional methods⁽⁴⁾. It is quite low compared with other Southeast Asia countries; the Southeast Asian region averages 62.2% (2007), Thailand 81.1% (2006), Vietnam 79.0% (2007), and Indonesia 61.4% (2007) for any contraceptive methods⁽⁶⁾.

Contraceptive prevalence rate is difference from one area to another in Myanmar because of demographic, economic, social, culture and accessibility factors. Free family planning services (temporary method) in the public sector currently provides services in 132 townships out of total 325 townships of Myanmar mainly supported by UNFPA reproductive health projects⁽⁸⁾. The study area (Hlaing Township) is not included in Project Townships for family planning services by the public sector. Hlaing Township is one

of the townships of the Yangon Division located in the western part of Yangon. It is urban area with a total population of 241,937 which women of child-bearing age (15-49 years) are 55,645⁽⁸⁾. A majority of the population is of the grass root community. MMR is 530/100,000 live birth⁽⁹⁾ which is very much higher than national figure 360/100,000 live birth⁽⁵⁾. MMR is increased by many factors but main cause is complications arising from unsafe abortions⁽⁵⁾. The exact data for contraceptive prevalence rate were not available in study area because there is no government reproductive health project. Sometimes these populations are neglected and their needs go unnoticed.

Most of the previous studies about family planning practice focus mainly in rural areas of Myanmar. This study tries to find out what the influencing factors like knowledge, attitude, reinforcing and enabling factors for family planning practice among urban populations. Phase 3 of PRECEDE-PROCEED framework⁽¹⁰⁾ is used to identify factors that require initiating and sustaining the process of behavior and environmental change and to design and evaluate the intervention needs which influence both behavior and living conditions. In the present study the model is used to identify selected independent factors like socio-demographic factors, knowledge, attitude, accessibility of services and support from health workers, partner and friends and information received from media and its association with family planning practice. It will help for future universal access to and equity for family planning services as well as to understand the needs and gaps of family planning in grass root community of the urban area.

Material and Method

The present study was a cross-sectional survey conducted in Hlaing Township, Yangon Division, Myanmar. The subjects consisted of 284 married women of reproductive age (18-49 years) and were selected using stratified random sampling obtained from 16 wards in Hlaing Township of Yangon, Myanmar. Four out of sixteen wards were selected randomly. The samples were proportionally allocated to each ward according to selected wards household numbers. The data were collected by the researcher and four trained interviewers by means of face to face interviewed in four wards of Hlaing Township during February to March of 2012. The instrument used was a structured questionnaire designed by the researchers based on extensive literature review and supported by studying

conceptual framework. The questionnaires consisted of five parts, which were: socio-demographic characteristics of respondent, predisposition, enabling, reinforcing factors of family planning practice, and contraceptive usage. Part 1: Socio-demographic factors of respondents were age, education, religion, occupation, family income, number of living children and number of desire children. A continuous scale was used for age, family income, nominal scale for religion, occupation and ordinal scale for number of children and number of desire children. Part 2: Predisposition factors composed of knowledge and attitude on family planning. Knowledge of family planning was divided into two categories: Yes and No. Score 1 for correct answer and 0 for incorrect; the range of scores was 0 to 13 for 13 questionnaires. The knowledge score was computed as good ($\geq 80\%$ of total score), fair (60-79% of total score), and needs improvement ($< 60\%$ of total score). Attitude on family planning was divided into three categories: agree, uncertain and disagree. The attitude score was computed and classified into two groups as positive attitude ($> \text{mean}$) and negative attitude ($\leq \text{mean}$). Part 3: Enabling factors were measured by questionnaire for availability, travel distance, waiting time and cost for the service of family planning. Descriptive statistics were used for these questions. Part 4: Reinforcing factors was divided into three categories: support from health workers, support from partners and friends and information received from media. Support from health workers consisted of six questions and support from partners and friends consisted of 10 questions; score 1 for yes and 0 for no answer. The range of scores was computed as good ($\geq 80\%$ of total score), fair (60-79% of total score), and low ($< 60\%$ of total score).

Information received from the media was multiple response answers and described by frequency and percentage. Part 5: Use of contraception by respondent was accessed by 4 questions. It consisted of a choice of contraception, duration of practice by user and reasons of not using for non-users. These questions were aimed at descriptive purposes to categorize user and non-user and find out the reasons for non-use of contraception.

The questionnaires were developed after consultation with 3 experts for content validity, clarification and appropriate wording and were pretest for reliability to 30 respondents who had similar general characteristics as the target population. The reliability of the questionnaire was tested by Kuder Richardson method and Cronbach's coefficient of

alpha. Knowledge on family planning was 0.702 by Kuder Richardson method and for attitude towards family planning was 0.703 by Cronbach's coefficient of alpha after adjusting and removing some questions.

Data were analyzed by frequency, percentage, mean, and standard deviation and were employed for developing the overview narrative. Data analyzed utilizing multiple logistic regression were employed to determine factors influencing family planning practice of the married, reproductive age women. A p-value of less than 0.05 was considered statistically significant.

Ethical consideration

The research was approved by the Ethical Committee for Human Research, Faculty of Public Health, Mahidol University, Bangkok, Thailand with the approval number MUPH 2012-017.

Results

Statistical information regarding the married, reproductive age women

The youngest respondent age was 20 and eldest was 49 with average age of 35.4 years. Nearly half of respondents (49.1%) were 30-39 years age group. Majority of the respondents attended at least primary school (98.1%), more than half of respondents reached to high school and above (High school 31.2% and College or University 20.4%). Vast majority of respondents were Buddhist 92.9%. Regarding occupation, 42.8% of women were homemakers. Nearly half (49.8%) of respondents earned 100,000 Kyats (~125 US\$) or less. About half 50.9% were sufficiency for their income. More than two-thirds of respondents had children: 2 or less (1 child-32.3%, 2 children-29.8% and no child-10.0%). More than half of respondents (64.7%) wanted 2 or less children (Table 1).

Pattern of family planning practice

Regarding family planning practice, about 74.7% of the respondents practice family planning and among them they used mainly injection methods 71.1% and oral contraceptive pill 58.7%. There were low usages of intra-uterine devices (IUD) 4.0% and subcutaneous implant 0.5% (Table 2). About one-quarter of respondents never practice a family planning method, the main reason for about two-thirds, 63.2%, of those who did not use any, was fear of side effects.

Factors influence on family planning practice

The results showed the factors influencing family planning practice were attitude toward family

Table 1. Number and percentage of socio-demographic characteristic of respondents (n = 269)

Socio-demographic characteristic	Number	Percentage
Age (year)		
18-29	53	19.7
30-39	132	49.1
40-49	84	31.2
Mean \pm SD = 35.4 \pm 6.8; Min = 20; Max = 49		
Education level		
No education	5	1.9
Primary	60	22.3
Secondary	65	24.2
High school	84	31.2
College/university or higher	55	20.4
Religion		
Buddhist	250	92.9
Christian	13	4.9
Muslim	3	1.1
Hindu	3	1.1
Occupation		
House wife	115	42.8
Vendor	58	21.6
Government Staff	45	16.7
Company/factor worker	32	11.9
Daily worker	10	3.7
Business owner	9	3.3
Total family income		
\leq 100,000 Kyats	134	49.8
>100,000-200,000 Kyats	105	39.0
>200,000 Kyats	30	11.2
Mean \pm SD = 141,732.3 \pm 83,928.7; Min = 20,000; Max = 850,000		
Sufficient income		
Can save	19	7.1
Just enough	137	50.9
Need to borrow sometime	68	25.3
Need to borrow every month	45	16.7
Number of living children		
0	27	10.0
1	87	32.3
2	80	29.8
3	51	19.0
\geq 4	24	8.9
Number of desire children (n = 261)		
1	39	14.9
2	130	49.8
3	67	25.7
\geq 4	25	9.6

planning, 24 hr, availability of contraceptive services; health worker support, and partner and friend support. The women with positive attitude of family planning practiced family planning 3.7 times more than women who have a negative attitude ($p = 0.017$). If family planning services were available for 24 hours, women

practiced 3.4 times more than if there were not available for 24 hours ($p = 0.027$). When women got fair to good support from health workers they practiced family planning 15.0 times more ($p < 0.001$) and 4.3 times more who got fair to good support from partners and friends ($p = 0.006$) than women who got only low support.

Table 2. Number and percentage of family planning practice among respondents

Contraceptive usage	Number	Percentage
Practice on family planning (n = 269)		
Yes	201	74.7
No	68	25.3
Method of choice* (n = 201)		
Contraceptive injection	143	71.1
Oral contraceptive pill	118	58.7
Condom	20	10.0
IUD	8	4.0
Contraceptive subcutaneous implant	1	0.5

* Multiple responses

Age, education, number of living children, desire number of children, knowledge on family planning, distance to services, comfortable with services, waiting time, and media support were factors that had no influence upon practicing family planning. (Table 3).

Discussion

Study results showed 74.7% of respondents practiced family planning. It was high in comparison with the results from Myanmar fertility and reproductive health survey reports (FRHS), 2009⁽⁴⁾, which found 63.0% of women used some method of family planning during their reproductive life. This difference might be due to the difference in sample population and area of study. This study represented only women from an urban population living in Hlaing Township and the FRHS represented the whole country, including urban and rural population. This study result showed 3-month contraceptive injections (71.1%) and oral contraceptive pills (58.7%) were the methods most often used among study population. Condom (10.0%) and intra-uterine devices (4.0%) were rarely used. FRHS, 2009⁽⁴⁾ also showed 3-month contraceptive injections were the most commonly used methods 41.0%, followed by OC pill 34.6% and IUD 4.0%. The popular use of 3-month contraceptive injections and OC pill could be explained in that they are easily available at the pharmacy and general practitioners at reasonable prices. According to attitude, women with a positive attitude practiced 3.7 times more, family planning, than women who had a negative attitude. Wrong perception and poor attitude regarding the risk of pregnancy resulted in a low practice of family planning. Findings were similar in a study in United State by Frost et al⁽¹¹⁾ of adult women; those who had a negative attitude towards

pregnancy were more likely to be non-users. A study in China among students by Wang et al⁽¹²⁾ showed that 41% of contraception non-user considered that infrequent intercourse can prevent pregnancy.

Accessibility to a family planning service is one of the most important factors that is unmet for family planning practice in developing countries⁽¹³⁾. In the present study, women practiced 3.4 times more on family planning if services are available for 24 hours. The result showed main sources of contraceptive for respondents were a general practitioner and pharmacy (>50%), and rarely went to the public sector (<4%). This might be due to public sector's not providing fee-free family planning. Another possible explanation was that there are many general practitioners and pharmacies in the township, which were closer to respondents' residences than the public sector facilities.

The respondents who received good and fair support from health workers practiced above 90% a family planning program and women who received low support practiced only 50.8%. When women got good and fair support from health workers they practiced family planning 15.0 times more than those who received only low support. More than two-thirds of the respondents got encouragement for family planning practice, explanation of advantages and disadvantages about contraception and places where contraceptive programs were available from health workers. However, less than one-third of respondents had received counseling and enough time to discuss about family planning practices. That might be due to health workers' heavy word load or respondents buy contraceptives themselves from the pharmacy. As with the above findings, health worker support had a strong association and thus it is better to improve some weak points on health workers side, which might lead to better

Table 3. Factors influencing the family planning practice (n = 269)

Factors	B	SE	p-value*	OR _{adj}	95% CI	
Age (year)						
18-29	-0.035	0.713	0.961	0.966	0.239	3.908
30-39	-0.026	0.613	0.967	0.975	0.293	3.243
40-49				1		
Education						
High school or above	0.763	0.606	0.208	2.144	0.654	7.034
No education, primary or secondary school				1		
Number of living children						
≤2	-0.596	0.774	0.441	0.551	0.121	2.512
>2				1		
Desire number of children						
≤2	-0.608	0.738	0.410	0.545	0.128	2.313
>2				1		
Knowledge on family planning						
Good or fair knowledge	0.451	0.536	0.400	1.571	0.549	4.490
Need to improve				1		
Attitude toward family planning						
Positive attitude	1.314	0.553	0.017	3.720	1.260	10.987
Negative attitude				1		
Services availability for 24 hours						
Yes	1.225	0.553	0.027	3.405	1.152	10.060
No				1		
Distance to services						
<0.5 mile	0.790	0.554	0.154	2.202	0.743	6.528
≥0.5 mile				1		
Comfortable with services						
Yes	0.222	0.520	0.669	1.249	0.451	3.459
No/no answer				1		
Waiting time						
<30 minutes	0.573	0.524	0.274	1.773	0.635	4.950
≥30 minutes				1		
Health worker support						
Good or fair support	2.710	0.679	<0.001	15.031	3.972	56.876
Low support				1		
Partner and friends support						
Good or fair support	1.449	0.523	0.006	4.260	1.529	11.873
Low support				1		
Media support						
Yes	0.086	0.713	0.904	1.090	0.269	4.414
No				1		

* test by multiple logistic regression; Percentage of overall predicted value = 87.4%

1 = reference group; OR_{adj} = adjusted OR

outcomes. The finding was similar with findings in Pakistan by Pasha et al⁽¹⁴⁾ which showed 90% of users had heard of family planning from a health care provider in compared with only 73% in non-users. Further evidence by Barber SL⁽¹⁵⁾ in Mexico; women who received family planning information during antenatal care were significantly more inclined to practice family planning than those who did not receive information.

In Bangladesh, field family planning workers visited areas had 23.3% usage, while only 9.8% used contraceptive in non-visited area⁽¹⁶⁾.

Support from partner and friends: friends were the top source of information that respondents received for family planning but rarely heard from their husbands. Less than one-quarter of the respondents were received good support from partners and friends, and 42%

received fair support but about one-third (34.2%) received only low support. This might be due to partners and friends not knowing how to support the concept of family planning. When there was good support, 98.4% practiced family planning, which decreased to 82.3%, who only received fair support and less than half of women practiced family planning practice if they got low support. 4.3 times more practiced family planning when women received good or fair support from partners or friends than women who got only low support. Study findings were consistent with other studies, one which was done in the Congo by Kayembe et al⁽¹⁷⁾ who found that those who had discussed family planning with someone during past 12 months were 3 times more likely to be current users. In a study in Indonesia by Schemaker J⁽¹⁸⁾ he found that socioeconomic status was also related whether they had discussed family planning with a partner. Better off women were more likely than moderately and extremely poor women to have a discussion with their husbands (52%, 46% and 42% respectively). Thus, joint decision-making showed association with higher use of family planning practices.

Knowledge on family planning practice also had an association with family planning practice. 86.3% of women with good or fair knowledge and only 57.4% of women with poor knowledge practiced family planning. These level of knowledge was associated with family planning practice ($p < 0.001$). This study proved that women who had more knowledge about family planning increased acceptance of family planning practices even though having knowledge does not mean practicing it, but it was the initial step in the process of practicing family planning.

For the support from media, the main sources of media that respondents heard about family planning practice in the present study were television and pamphlets. They rarely heard from radio and 10% of respondents never heard from media. It was possible that study population was living in an urban area and they could easily access television as their daily entertainment. Nevertheless, some respondents were busy with their daily living so they could not develop interest or notice unrelated things. The resulting findings showed women heard information from some kinds of media, they practice family planning up to 78.1%; but only 44.4% practice if they had never heard. Statistically, it was associated with the p-value of less than 0.001. This factor might be linked to knowledge and attitude where women got knowledge through information and subsequently changed to a positive

attitude on family planning practice.

From the results of the study, they suggest that empowerment of health workers, training of volunteers, general practitioners, pharmacists and contraceptive drug providers, encouraging inter-spousal communication, and peer support, as well as an integrated approach to primary health care in order to target different populations to change women's attitudes on family planning, could increase family planning practice among Myanmar women.

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Potential conflict of interest

None.

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ปัจจัยที่มีอิทธิพลต่อการวางแผนครอบครัวของสตรีวัยเจริญพันธุ์ที่สมรสแล้วในเขตเมืองเหลียง สหภาพเมียนมาร์

เมี้ยว มิน วิน, โชคชัย หมั่นแสวงทรัพย์, สุธรรม นันทมงคลชัย

วัตถุประสงค์: เพื่อศึกษาปัจจัยที่มีอิทธิพลต่อการวางแผนครอบครัวของหญิงวัยเจริญพันธุ์ที่สมรสแล้วในเขต เมืองเหลียง สหภาพเมียนมาร์

วัตถุประสงค์และวิธีการ: เป็นการศึกษาเชิงสำรวจภาคตัดขวาง ในหญิงวัยเจริญพันธุ์ที่สมรสแล้วจำนวน 284 ราย ซึ่งได้จากการสุ่มตัวอย่างแบบแบ่งชั้น เก็บข้อมูลโดยการสัมภาษณ์หญิงวัยเจริญพันธุ์ระหว่างเดือนกุมภาพันธ์ถึงเดือนมีนาคม พ.ศ. 2555 วิเคราะห์ข้อมูลโดยใช้ความถี่ ร้อยละ ไขว้ตาราง และการวิเคราะห์ถดถอยแบบโลจิสติก

ผลการศึกษา: หญิงวัยเจริญพันธุ์มีการวางแผนครอบครัวร้อยละ 74.7 ไม่วางแผนครอบครัว ร้อยละ 25.3 โดยเลือกใช้อนุทินคุมกำเนิดมากที่สุด ปัจจัยที่มีอิทธิพลต่อการวางแผนครอบครัวได้แก่ เจตคติต่อการวางแผนครอบครัว การให้บริการวางแผนครอบครัว 24 ชั่วโมง การสนับสนุนจากเจ้าหน้าที่ด้านสุขภาพ และการสนับสนุนจากคู่อุปการและเพื่อน หญิงวัยเจริญพันธุ์ที่มีเจตคติในเชิงบวกต่อการวางแผนครอบครัวมีการคุมกำเนิดเป็น 3.7 เท่า ของหญิงที่มีเจตคติในเชิงลบต่อการวางแผนครอบครัว หากมีการให้บริการการวางแผนครอบครัว 24 ชั่วโมง จะมีหญิงใช้บริการวางแผนครอบครัวเป็น 3.4 เท่า เมื่อเทียบกับการไม่มีบริการตลอด 24 ชั่วโมง เมื่อหญิงได้รับข้อมูลสนับสนุนในระดับปานกลางถึงระดับดีจากบุคลากรด้านสุขภาพจะมีการวางแผนครอบครัวมากเป็น 15 เท่า และเป็น 4.3 เท่า เมื่อได้รับข้อมูลสนับสนุนในระดับเดียวกันจากคู่อุปการหรือเพื่อน เมื่อเทียบกับการได้รับข้อมูลสนับสนุนระดับน้อย

สรุป: ปัจจัยที่มีอิทธิพลต่อการวางแผนครอบครัวของสตรีวัยเจริญพันธุ์ที่สมรสแล้วได้แก่ เจตคติต่อการวางแผนครอบครัว การให้บริการคุมกำเนิด 24 ชั่วโมง การสนับสนุนจากเจ้าหน้าที่ด้านสุขภาพ และการสนับสนุนจากคู่อุปการและเพื่อน ดังนั้นจึงควรมีการเสริมศักยภาพเจ้าหน้าที่ด้านสาธารณสุข อาสาสมัคร เกสซักร และผู้จำหน่ายยาเกี่ยวกับการคุมกำเนิด ส่งเสริมการสื่อสารระหว่างคู่อุปการ กลุ่มเพื่อน รวมถึงการบูรณาการงานบริการปฐมภูมิ เพื่อเปลี่ยนแปลงเจตคติต่อการวางแผนครอบครัว ซึ่งสิ่งเหล่านี้สามารถเพิ่มอัตราการวางแผนครอบครัวในสตรีชาวเมียนมาร์ได้
