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Original Research Article

Awareness and perception on sexual and reproductive health and self-reported premarital sex among never married youth in Chaungzone township, Mon State, Myanmar (2018)

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ABSTRACT

Background: Premarital sexual practices among youth and adolescents have been highly recognized and are increasing worldwide. This study aimed to assess the awareness and perception on sexual and reproductive health and self-reported premarital sex among never married youth.
Methods: The study used mixed method approach among 404 youth of equal number of male and female youth from urban and rural community using guided self-administered questionnaire and in-depth interview among 12 youth and key informant interview among 6 health professionals.
Results: The study found that 11.4% (95% CI: 8.3, 14.5) of youth had premarital sex practice. After adjusting the covariates, the odds of practicing premarital sex were higher among 18 years and above (AOR=3.5, 95% CI: 1.2, 9.6), low education (AOR=3.3, 95% CI: 1.1, 10.7), youth having relationship (AOR=8.0, 95% CI: 3.0, 21.2) and youth who accepted premarital sex practice (AOR=10.9, 95% CI: 3.6, 33,1), having friends who had experience in premarital sex (AOR=3.9, 95% CI: 1.3, 11.4), compared to their counterparts. The qualitative findings revealed that most of youth and service providers did not accept premarital sex among youth because of its contradiction to traditional norms. Health care providers and youth suggested that privacy was the most critical thing in accessibility of reproductive health services among youth. All levels of providers pointed out that there were insufficient resources for provision of effective reproductive health services.
Conclusions: Youth-friendly reproductive health services should be implemented to prevent unwanted pregnancy, abortions and sexually transmitted diseases to ensure safer sex practices among youth.

Keywords: Premarital sex, Sexual and reproductive health, Traditional norms, Youth, Youth-friendly service

INTRODUCTION

Youth are a significant group in the world. The number of youths between the ages of 15 and 24 is about 1.1 billion, 18% of the global population. Among them, about 85 percent of youth live in developing countries.[1] Premarital sexual practices among youth and adolescents have been recognized high and increasing worldwide. An expanding prevalence of early sexual activity among youth has been reported around the world for the past decade.[2] Young people's lives will be negatively impacted without sexual and reproductive health (SRH) knowledge. Similarly, if they lack access to opportunities to learn, contribute and explore reproductive health services, the negative

outcomes of adolescent and youth development such as unwanted pregnancy, early marriage, and sexual violence can occur.[3]

Sexual behaviors needed to be assessed among youth were (1) consensual sexual intercourse (lifetime); (2) age at first consensual intercourse (younger than 13; 13 or older); (3) use of protection during consensual intercourse (never/rarely/sometimes; often/always); (4) ever been pregnant (consensus).[4] Similar to other developing countries, Myanmar is also facing with the adverse consequences of early marriage, unprotected sex and increasing premarital sex among youth. One of Myanmar studies pointed out that premarital sex practice was about 10.1% in medical students and 11.9% in community youth.[5] Another Myanmar study conducted in University of Magway found that 45% of the distance education of university students engaged into premarital sex.[6] And about 40% of male respondents and 28% of female respondents had positive attitude of premarital sex in a study done in Myanmar.[7] Moreover, there was 30.2% of self-reported sexual practice among rural youth in Mon state.[8]

Chaungzone township is situated in Mon State where both urban and rural settings exist. Youth reproductive health services have not been launched by other non-state agencies. Chaungzone township has been developed in transportation with other areas in Mon state in recent year, and there will be more opportunities to learn and expose to sexual and reproductive health issues and risk behaviors. Furthermore, most people in Chaungzone Township are migrant workers in neighboring country, Thailand, where there is much opportunities to practice and expose to sexual risky behaviors. This study aimed to assess the awareness and perception on sexual and reproductive health and self-reported premarital sex among never married youth including health care providers' perception in Chaungzone township.

METHODS

It was a mixed methods study and conducted in Chaungzone township, from September, 2018 to December, 2018. Never married youths and reproductive health service providers in selected township were study populations. All never married youths (both sexes) between aged 15 and 24 years and reproductive health service providers who had more than 5 years' service in relatively higher prevalent area of self-reported premarital sex were included in this study. Youths who were migrants, were mentally ill, can't read and write well in Myanmar language and were monks and nuns as well as service providers who were in official leaves at data collection time were excluded in this study.

Total sample size (424) was required for assumed premarital sex practice 21%, absolute precision (d) 5% and type I error set at 5% and; accounted the cluster design by multiplying the sample size with the design effect (1.5) and added 10% non-response rate. For quantitative study, multi-stage sampling method was used to collect data. Chaungzone township was purposively selected. There were three wards in urban and seven Rural Health Centers (RHCs) in rural areas of the township. In first stage, two wards from urban area and four RHCs from rural area were selected by simple random sampling method. Then two villages were randomly chosen from each RHC. Hence two wards from urban area and eight villages from rural area were selected as clusters. Sampling procedures to select required clusters were done by the help of township medical officers and other basic health staffs. And then all basic health staffs (health assistants, lady health visitors and midwives) of selected clusters were invited and explained the purpose of study and sampling procedures. Responsible health staffs were requested to collect the current household lists of eligible youth in their respective clusters. They were provided the formats of youth' lists and trained how to complete them. In this study, all the youth-households with different sexes from the selected clusters served as sampling frames.

In second stage, from the sampling frames for each sex that were developed by basic health staff, 12 youth-households from each ward and 23-24 households from eight villages were selected by using simple random sampling for each sex of never married youth. In third stage, one respondent among 15-24 years of never married youth was selected from each household. If there were more than one person of the age group in a household, the most educated person was selected. A total of 424 respondents were selected with consent in equal sex ratio. With the help of local authorities and health staff, selected youth were invited by using invitation cards at least two days before data collection day. The places for answering semi-structured questionnaires were school, monastery and meeting room with privacy and researchers explained the questionnaires before the start of the session. For qualitative study, in depth interview (IDI) with guidelines was conducted only after quantitative data collection. Firstly, the three highest premarital sex prevalent areas (one ward and two villages) were determined from the answered-quantitative questionnaires. And then 12 youth including both sexes were purposively selected by mean of their education status. IDI was restricted for only 18 years old and above.

To keep confidentiality and privacy, IDI was done in private room at health centers. Interviews were conducted by woman and man trained staffs to female and male respondents respectively. For key informant interview (KII), total 6 service providers with more than five years' service were selected from relatively higher prevalent areas of reported practice. All interviews were recorded using recorder after taking permission from respondents. The pretested, structured and guided self-administered questionnaire was used in quantitative method. Ten research assistants were trained for both quantitative and qualitative data collection.

Twenty inconsistent and incomplete responses were excluded in this study. Hence, a total of 404 youths was included in the quantitative study. Background characteristics were presented using frequency distribution tables. The prevalence of premarital sex in different sex groups was presented using bar chart with respective 95% confident intervals (95% CI). Multiple logistic regression analysis was done to assess the influencing factors of premarital sex among youth. Hosmer Lemeshow goodness of fit test was used to assess the model fitness. The results were presented with adjusted odds ratios with 95% CI for significant predictors. P<0.05 was set as a statistical significance. For qualitative data analysis, all IDI and KII recordings were transcribed in verbatim and the full transcripts were coded and organized from field notes on the basis of guidelines and topics. Thematic analysis was performed by using qualitative data analysis (QDA) application. Qualitative findings were presented by texts, quotations and dialogue.

Statistical analysis

Data entry was done by Epi Data version 3.1. After checking the missing data, inconsistencies, duplication and outlier distribution during data collection and during and after data entry, data analysis was conducted by using Stata software version 15.1.

RESULTS

A total of 404 never married youth were participated in this study. The background characteristics of youth with different sexes are shown in Table 1. As a whole, the majority were aged less than 18 (57.9%), were living in rural setting (89.6%), had above middle school education (85.4%), were not employed (91.6%), did not have relationship i.e. had boyfriend/girlfriend (73.3%), lived with their parents (78.5%), did not take alcohol and narcotic (93.3% and 99.8%), did not accept premarital sex practice (90.1%), had low knowledge but good attitude in sexual and reproductive health (73.3% and 92.6%), did not discuss about reproductive health with friends (74%) and did not have friends who had premarital sex (86.4%) (Table 1).

Regarding to premarital sex practice, 36 male youth and 10 female youth (11.4%) reported that they had previous sexual exposure. The overall prevalence of self-reported premarital sex practice among never married youth in the study area was 11.4% (95% CI 8.3%, 14.5%). Figure 1 shows the prevalence with 95% CI by age groups, gender and residence. The higher prevalence was found in 18 years and above age group (20%, 95% CI=13.9%, 26.1%), male (17.8%, 95% CI=12.5%, 23.1%) and urban setting (23.8%, 95% CI=10.4%, 37.2%) (Figure 1). Mean (SD) age of respondents at first sex was 17.4 (2.8) years with minimum 10 years and maximum 23 years. Among these 46 youth, 24 youth had sexual exposure during last 3 months before the survey and the study asked about their sexual behaviors. The sexual types of premarital sex among 24 exposed youth during last 3 months included not only heterosexual (83.3%) but also homosexual (12.5%) and bisexual (4.2%). About half of them stated that they did not used condoms (58.3%) and any contraceptives (54.2%) (Table 2).

Table 1: Background characteristics of never married youth by gender (n=404).

Variables	N (%)
Age group (years)	
15-17	234 (57.9)
18-24	170 (42.1)
Sex	
Male	202 (50.0)
Female	202 (50.0)
Residence	
Rural	362 (89.6)
Urban	42 (10.4)
Education	
Middle and above	345 (85.4)
Below middle	59 (14.6)
Race	
Mon	258 (63.9)
Burma and others	146 (36.1)
Occupation	
Not employed	370 (91.6)
Employed	34 (8.4)
Relationship (Boyfriend/Girlfriend)	
No	296 (73.3)
Yes	108 (26.7)
Living with parents	
No	87 (21.5)
Yes	317 (78.5)
Alcohol drinking	
No	377 (93.3)
Yes	27 (6.7)
Narcotics uses	
No	403 (99.8)
Yes	1 (0.2)
Perception on premarital sex	
Not accept	364 (90.1)
Accept	40 (9.9)
Knowledge level	
Low	296 (73.3)
High	108 (26.7)
Attitude level	
Good	374 (92.6)
Poor	30 (7.4)
Discussion with friends about SRH	
No	299 (74.0)
Yes	105 (26.0)
Having friends with premarital sex	
No	349 (86.4)
Yes	55 (13.6)

SRH=Sexual and reproductive health.

Table 2: Last 3-month sexual experiences among youth who had premarital sex (n=24).

Self-reported sexual practice	N (%)
Sexual practice last 3 month (n=46)	
No	22 (47.8)
Yes	24 (52.2)
Sex	
Male	22 (91.6)
Female	2 (8.4)
No. of partners	
1	21 (87.5)
> 1	3 (2.5)
Sexual type	
Homosexual	3 (12.5)
Heterosexual	20 (83.3)
Bisexual	1 (4.2)
Sex with whom?	
Boyfriend/girlfriend	22 (91.6)
Other	2 (8.4)
Condom use	
No	14 (58.3)
Yes	10 (41.7)
Contraceptives use	
No	13 (54.2)
Yes	11 (45.8)

The multiple logistic regressions analysis was done to identify influencing factors of premarital sex practice among never married youth and the results were shown in Table 3. Fifteen significant variables from bivariate analysis were analyzed altogether by using enter method in multiple logistic regression analysis. It was found that premarital sex practice was influenced by many factors such as age group, educational levels of the respondents, their relationship status, perceptions on premarital sex, and peer pressure of having friends with premarital sex experiences. The odds of practicing premarital sex among youth over 18 years were 3.5 times (95% CI=1.2, 9.6) more than the younger group. The respondents with educational level of below middle school had 3.3 times increased odds (95% CI=1.1, 10.7) of undergoing premarital sex compared to respondents with higher education group. Youth who had girlfriends or boyfriends were 8.0 times (95% CI=3.0, 21.2) more likely to expose premarital sex than youth who did not have relationships. Respondents who accept premarital sex practice as a usual thing had 10.9 (95% CI=3.6, 33.1) increased odds of having premarital sex compared to respondents who did not accept it. Youth who had friends with premarital sex experience were 3.9 times (95% CI=1.3, 11.4) more likely to undergo premarital sex compared to youth who did not have such friend (Table 3).

Table 3: Multiple logistic regression analysis to identify influencing factors of premarital sex practice among never married youth.

Variables	Crude OR (95% CI)	Adjusted OR (95% CI)
Age (year)		
< 18	1	1
≥ 18	4.6 (2.3, 9.2)***	3.5 (1.2, 9.6)*
Sex		
Female	1	1
Male	4.2 (2.0, 8.7)***	1.9 (0.7, 5.5)
Residence		
Rural	1	1
Urban	2.8 (1.2, 6.2)*	2.9 (0.9, 9.2)
Education level		
Above middle school	1	1
Below middle school	4.4 (2.2, 8.7)***	3.3 (1.1, 10.7)*
Race		
Mon	1	1
Burma and others	2.9 (1.5, 5.3)**	3.1 (1.2, 8.4)*
Occupation		
Unemployment	1	1
Employment	4.6 (2.0, 10.1)***	0.8 (0.2, 3.1)
Relationship		
No	1	1
Yes	16.6 (7.7, 36.0)***	8.0 (3.0, 21.2)***
Alcohol drinking		
No	1	1
Yes	3.8 (1.5, 9.2)**	0.7 (0.2, 2.9)

Continued.

Variables	Crude OR (95% CI)	Adjusted OR (95% CI)
Discussion about SRH		
No	1	1
Yes	3.7 (2.0, 7.0)***	1.6 (0.5, 5.3)
Perception on premarital sex		
Not Accept	1	1
Accept	20.0 (9.4, 42.7)***	10.9 (3.6, 33.1)***
Having friends who experienced premarital sex		
No	1	1
Yes	5.6 (2.8, 11.0)***	3.9 (1.3, 11.4)*
Contraceptive knowledge level		
Low	1	1
High	2.6 (1.3, 5.3)**	1.9 (0.6, 6.5)
Total knowledge level		
Low	1	1
High	1.9 (1.01, 3.6)*	1.6 (0.5, 4.8)
Reproductive health attitude level		
Good	1	1
Poor	2.7 (1.1, 6.4)*	2.2 (0.6, 8.0)
Premarital sex attitude level		
Good	1	1
Poor	2.58 (1.1, 5.6)*	1.2 (0.3, 4.4)

SRH: Sexual and reproductive health, Nagelkerke R^2=0.591, Hosmer and Lemeshow p=0.898, ***p<0.001, **p<0.01, *p<0.05.

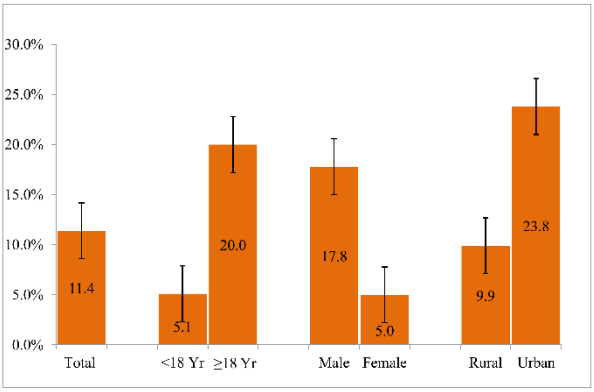

Figure 1: Prevalence of premarital sex practice among youth according to their age group, gender and residence.

The qualitative findings to the awareness and perception of premarital sex revealed that most of youth and service providers did not accept premarital sex among youth because of its contradiction to traditional norms, customs and beliefs. Few youth could accept premarital sex practice as it had been a modernized habituation among youths and a behavior that strengthened the relationship between the partners. Some mentioned that it had been greatly influenced by increasing accessibility of internet in Myanmar. A 20 years old manual worker, with low education living in rural setting said, "Premarital sex is cohabitation (habitual modernization) as accessibility and availability to mobile phone and Facebook becomes increase to learn and practice premarital sex." Concerning to the peers' pressure to practice premarital sex, some youth mentioned that there were many friends who practice premarital sex among their peers and used emergency oral contraceptive pills to prevent unwanted pregnancy. However, few youth contradicted the formers that their peers did not have it. Some of them mentioned that they avoided premarital sex because they heard peers who had premarital sex were blamed, backbite and disparaged from environment. And a manual worker, 18 years old with low education living in rural village said "Some parents accept with premarital sex practice and they let their children to live together in girlfriend's home."

Most youth mentioned that nothing could prohibit premarital sex because it was a natural human behavior and a modernized habituation in global as well as a secret event between partners and a hidden behavior. A 20 years old university student from rural area said, "I think premarital sex cannot be prohibited because it is due to modern lifestyle. Health centers and parents cannot prohibit youth for such behavior."

Some service providers pointed out that most of their clients were married; hence, youths were reluctant to seek for reproductive health care in government health centers because of embarrassment and fear of noticing on utilization of reproductive health services by anybody as they were unmarried. Some youths and service providers suggested that reproductive health issues should be included in school/university curriculum and should be taught by health personnel. Besides, most providers

mentioned that youth specific reproductive health services should be provided ensuring privacy for man and women separately. Most providers suggested that youth's reproductive health information should be disseminated through various media and channels to prevent consequences of premarital sex. A 52 years old lady health visitor suggested, "We would like to broadcast youth's reproductive health programs in TV channels and social media such as Facebook." In addition, all health care providers and youth perceived that privacy was the most critical thing in providing reproductive health services to youth. All levels of providers pointed out that to implement effective and efficient youth-friendly reproductive health services, not only resources including infrastructures, but also need to formulate specific, targeted strategies and activities by maternal and reproductive health program in Myanmar.

DISCUSSION

At least one in every ten youths had premarital sex practice. Male youths had four times of practice than females. There were heterosexual, homosexual and bisexual among both sexes. Only one in ten youths stated that they accepted premarital sex practice. Above a quarter of youths were high in knowledge level in reproductive health, premarital sex, HIV/AIDS and contraceptive issues. But most of youths were good in attitude level in these issues. After adjusting the covariates, the main influencing factors of premarital sex practice were age group, education status, relationship status, perception on premarital sex and having friends who practice premarital sex. In qualitative finding concerned with the awareness and perception of premarital sex, most of youths and service providers did not accept premarital sex due to the traditional norms, customs, belief and threats to women's dignity. But few of both accepted premarital sex because it is a habitual modernization. All health care providers and youths perceived that privacy is the most critical thing to be youth-friendly service and more resources would be needed for the provision of effective reproductive health services to youths.

Premarital sex practice of youth

In a similar study of self-reported sexual practice among rural youth in Mon state, it was found that 30% had had sex among youth.[8] There is much difference in self-reported sexual practice in compared with this study (11.4% and 30%). This is due to the fact that respondents recruited in this study were never married youth, however, the study conducted in Mon state included both married and unmarried youth. The proportions of these two studies are not much significantly different (11.4% and 9.6%) if the study population was restricted to unmarried youth. It indicates that youth-friendly and easily accessible reproductive health service should be implemented to achieve safer sex among them. Moreover, premarital sexual practice in this study coincides with study of the risk behaviors inherent premarital sex among community youth from selected townships in Myanmar.[5]

Mean age of first sex among youth in this study was consistent with Ethiopian study conducted among university students in Ambo, central Ethiopia.[9] It indicates that the experience of first sexual behavior was started during high school age and therefore, strengthening of reproductive health program should be promoted in schools.

Nearly half of youth who had premarital sex practice revealed the use of condom and contraceptive methods in their last sexual intercourse in this study. It shows that condom use was relatively lower in Myanmar youth than adolescents from rural communities in Bahia, Brazil where 78% of them used condom during their last intercourse.[10] The reason for low utilization of condom and contraceptives might be due to inadequate knowledge of contraceptives availability and accessibility and the practice happened unintentionally and accidentally.

It was established that premarital sex practice among male was more than female, and urban youth had more practice than rural youth. These findings were consistent with the finding of a study in Thailand that reported urban slums had higher in premarital sex practice and higher in risky sexual behavior.[11] This finding shows that urban youth had more opportunities to learn and practice premarital sex than rural youth. Nowadays most youth from rural are migrating to urban for various purposes. This fact shows that youth friendly reproductive health services including information corner should be implemented in the places where youth are concentrated.

Concerning with the reproductive health knowledge, higher educated youth were 3 times more knowledgeable than those with lower educated. This finding was consistent with the findings from a study done in Mon state.[8] This finding highlighted that education status has a dominant role to access and understand health and other knowledge.

Although this study could not provide the association between living with family and premarital sex practice, a study carried out in Meikhtila township found that respondents who were living with family had lower sexual risk behavior than living with non-family.[12] This indicates that youth becomes great interest in premarital sex and try to practice it even under the guardianship of family especially their parents.

The premarital sex practice was relatively lower among basic high school students than any other youth in this study. Similarly, it was shown that school attendance reduced the risky sexual behavior in a study in Lao in 2011.[13] This is because the more educated the youth, the more knowledgeable about premarital sex including its consequences. It shows that youth friendly reproductive

activities should be more emphasized on school drop-out/working youth.

Peer pressure

This study presented that having sexually experienced friends was associated with sexual behavior of the youth. It coincides with the findings from a study in Japan in which sexual behavior of youth can be dominated by peer pressure and attitudes toward sexual activity of youth can be affected by their peers' sexual experience and practice.[14] The finding in this study also agreed with that of a study done in medical students which stated peer behaviors influenced on premarital sexuality especially for female.[15] This shows peer's behavior was a significant determinant for premarital sex. It should be considered peers education would be effective in disseminating sexual and reproductive health knowledge among youth.

Youth' perception on premarital sex

Most of youth did not accept premarital sex because of Myanmar's traditional norms, customs and belief. They all strongly agreed that sex should be practiced only after marriage. These findings do not agree with that of a qualitative study done in Iranian adolescents that mentioned some of them had a positive attitude to having sex and believed that the premarital sexual intercourse was necessary and few had a negative attitude towards premarital sexual intercourse.[15] In this study, one youth with low education explored that he can accept premarital sex. It is consistent with the findings in the study of young people's perceptions about premarital sex in Ghana.[16] This is because most of respondents in this study might be influenced by traditional norms, customs and belief and respondents may thought they would be looked down if they responded premarital sex is acceptable even though they had practiced it. It signals that the premarital sex practice among never married youth may be still hidden and difficult to explore it. As for policy makers, it will be needed to strengthen the programs for achieving safer sex among youth.

Provider's perception on youth reproductive health service

Concerning with the provision of youth reproductive health service, most providers realized that there was a need to provide reproductive health services to never married youth. This finding agrees with that of an Ethiopia's study that showed the majority of service providers had positive attitudes on the provision of sexual and reproductive health services to unmarried adolescents.[17] All health care providers perceived that privacy was essential in the provision of youth-friendly reproductive health services to never married youth. This finding agrees with the study done in Nigeria that mentioned that there must be privacy to ensure adolescents' willingness to access health services.[18] In addition, they also pointed out that health education program is very important for providing effective reproductive health services to never married youth. Similarly, a study done in Nigeria presented that more than half of all the providers replied that it was more effective by telling to abstain from premarital sex rather than giving them contraceptives when they requested for it.[19] Above findings indicate that youth-friendly reproductive health services are still far from youth. It shows service providers had difficulties and needs to implement these services effectively and efficiently. Specific and targeted strategies, methodologies, capacities, activities and more resources should be considered for implementing effective and efficient youth-friendly reproductive health services.

There were some limitations in this study; 1) This study recalled last 3 month memory and guided self-administered questionnaire was used so some recall bias might be present; 2) Since nearly one-third of the respondents were basic high school students and the study excluded migrant youths, the prevalence of self-reported premarital sex may be underestimated in this study and; 3) Though sampling frames of youth-households lists for selected clusters were collected and developed by basic health staffs under the guidance of researchers, the accuracy and all-inclusiveness of them cannot be checked in this study.

CONCLUSION

This study concluded that premarital sex was prevalent among never married youth in Chaungzone Township. The prevalence was higher in male than in female. The main influencing factors of premarital sex were older age group, lower education, having relationship status, perception on premarital sex and having friends who practice premarital sex. All of health care providers and youth suggested that the provision of youth-friendly and privacy ensured reproductive health services is the best way to achieve safer sex among youth in Myanmar.

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