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Research Note

# Readiness of primary school teachers and auxiliary midwives to provide sexual reproductive health education to young people in Myanmar

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In recent years, Myanmar has experienced drastic changes on the both economic and political fronts. As a result of these changes, the country has been experiencing an influx of people, new information, and technologies. This has made both unsafe abortion practices and sexually transmitted infections including HIV/AIDS among young people serious social issues. Since the population of young people is large in Myanmar, issues affecting them may have a substantial impact on society. Therefore, educational programs for Sexual and Reproductive Health (SRH) to young people are critically needed. This study is a preliminary study to explore the readiness of educators who will be in charge of providing SRH education to young people in the community. Also, it will determine appropriate factors to consider in the development of effective SRH educational programs.

The study used descriptive qualitative research design. Research methods used are as follow: semi-structured individual interviews with three teachers at the primary school and with two Auxiliary Midwives (AMWs), observation of classes, reviews of materials on SRH education.

Data obtained were categorized into four groups: (1) educators' commitment to SRH education, (2) educators' ideas for effective teaching methods and contents for SRH education, (3) recognition of social changes in the evaluation of SRH, and (4) resources for gathering information about SRH.

It was then found that both types of educators have their own knowledge to educate people. The educators' awareness of the issues and motivation for learning about SRH will make it possible to teach young people about SRH. It was considered that they were partially ready for SRH education, and they need a training which is composed with contents of focused and detailed SRH information and teaching methods by professionals in a culturally appropriate way. Additionally, organizational efforts and institutional networking are vital to the development of effective teaching style, materials and contents. Also, AMWs should be trained to utilize and update their ability to teach SRH education to young people.

**Key words: Myanmar, educators, primary school teachers, AMWs, sexual and reproductive health education, young people, readiness**

## I. Introduction

Myanmar was under military rule until 2011 and had closed its doors to other countries. In 2011, however, the government shifted from a military-controlled regime into a democracy, which allowed their doors to be opened to the outside world[1),2)]. This has led to drastic changes on both economic and political fronts. These changes have influenced people's lives and behaviors.

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Since the new government was established in 2011, many organizations around the world have visited this country to seek its rich natural and human resources for their businesses[2]. These businesses, specifically the telecommunication services, that operated under market economics in Myanmar's history enabled the people unprecedented access to the Internet and mobile phones unlike ever before[3]. According to Internet World Stats, Internet users increased from only 1,000 people in 2000 to 668,955 people in 2013[4]. As a result, the country has been experiencing an influx of people, new information, and technologies[1]. One type of notable information becoming available from other countries is data on sexual and reproductive health (SRH). For example, pre-censorship was abolished in 2012, and the first magazine for sex education was published in Myanmar that same year[5]. In addition, since limitations on TV programs and Internet access were deregulated, information about SRH has become easily accessible[6]. This accessibility was expected to increase the opportunity to learn about SRH in a more open manner.

Unfortunately, there has been a negative reaction to open access to SRH information. The sale of magazines for sex education was prohibited in 2012 based on the rationale that the contents were inappropriate[5]. This suspension indicates that many people still have conservative beliefs regarding SRH information. Although it is understandable that SRH is a sensitive topic to discuss in public, there are serious SRH issues that need to be addressed. For example, unsafe abortion practices and sexually transmitted infections (STIs), including HIV/AIDS, are serious social issues[7~13].

In terms of unsafe abortion practices, religious beliefs and law do not allow abortion unless women have life-threatening health conditions in Myanmar[11),12]. If a woman has an unintended pregnancy, she may choose to undergo an illegal abortion[9),11]. In many cases, this illegal practice is performed by non-professionals or even at home. As a result of these risky practices, women may die or experience serious lifelong complications[8,12]. The report from The Nationwide Cause-Specific Maternal Mortality Survey (2004-2005) indicated that 10% of maternal mortality was caused from abortion-related complications[14]. Even though it is not current data, the law regarding the guidelines of abortion have not been revised to date and still 24% of the population remains in need of family planning in 2011[10]; thus, women still live under the reality that they may endure the burden of an unsafe abortion resulting from an unintended pregnancy or other SRH issues. STIs are also a serious SRH concern in Myanmar. There are still a number of deaths due to HIV infection, even though the prevalence of HIV is declining[10]. Moreover, it is revealed that 72.8% of HIV cases are sexually transmitted[15]. Put simply, practicing safe sex would prevent many infections, and several studies have indicated that sexual activity at an early age, 16 years old or younger, results in risky behaviors such as having sex without protection[7, 15]. Such risky sex not only leads to STIs or HIV but also to unintended pregnancies. If young people know about the consequences of risky behaviors before they become sexually active, it may help reduce these problems in the future.

SRH problems place a significant burden on a person’s life. Thus it is critical to implement SRH education programs to improve quality of life for young people. In addition, in Myanmar, young people (10-24 years old) account for 30% of the population; these people are generally within their reproductive years[16]. Thus, if they are not healthy enough to maintain their lives, they will not be able to contribute to the development of the country. In other words, issues affecting these young people may have a substantial impact on society.

As mentioned, society in Myanmar still generally holds conservative beliefs regarding SRH education due to political and cultural factors[17]. Therefore, educational programs should be designed to help overcome these obstacles. According to Mary Ann Pentz, who presented the original concept of “community readiness” when she headed the

Midwest Prevention Project, a preventive program will fail if a community is not ready to accept it[18]. It is thus important to determine the readiness of a society or community to accept a program before developing the program itself.

This study is a preliminary study to explore the readiness of educators who will be in charge of providing SRH education to young people in the community. Its purpose is to illuminate and evaluate the level of readiness of the educator's preparedness to carry out a planned sequence of actions on the issue. The results from this study will be utilized to develop further study program for ensuring the community readiness. Also, it will determine appropriate factors to consider in the development of effective SRH educational programs.

Primary school teachers and community midwives (Auxiliary Midwives: AMWs) were considered the main educators of SRH in this study. The SRH education should be easily accessible to young people. Many young people have opportunities to meet with a primary school teacher and AMWs more than health professional, especially as adolescents, since the rate of enrollment in primary education is high in Myanmar and AMWs are working at community level. It is assumed that it would be easier to take SRH education class at a school where young people are going everyday than going to a hospital where healthy young people do not visit regularly.

## II. Materials and Methods

### 1. Study design and study site

This was a descriptive qualitative research study conducted in Yangon and a suburb of Yangon in Myanmar.

### 2. Subjects/Participants

Three primary school teachers and two AMWs in a single community were recruited for interviews (Table 1). Classes in the primary school and a maternal waiting home (MWH) were observed to learn about teaching styles. Current materials, books, and items related to SRH were also reviewed. The school teachers had no experience of teaching SRH, and AMWs already had some experiences of SRH education in their career.

1) Reasons for recruitment of primary school teachers

Primary school teachers were recruited because it was thought that they would be able to reach many of the children in need. The participating teachers were working in one monastery, which is run by monks and managed by the Ministry of Religious Affairs. There were 1,429 monasteries in Myanmar, which included primary and secondary educational institutions (from 5 years old to 15 years old). The proportion of monasteries accounted 1% of all the schools in 2011[19]. Masuda reported that the rate of enrollment in the monastery is increasing, even though the rate of public primary school students have remained at the same level since 2001[20]. The children in monastery usually came from families in a low socio-economic status (SES) because tuition is free[20]. Some articles revealed that young people who are in a low SES were more likely to be at a high risk for unsafe sexual behavior[15].

2) Reasons for recruitment of AMWs

AMWs have professional knowledge about SRH due to the training provided by the central government with support from UNICEF[21]. In addition, they work closely with their community so they likely have good relationships with the community members.

### 3. Data collection

Individual semi-structured interviews were conducted with the five participants in a single room at the monastery. The interview guide shown in Table 2 was used for both teachers and AMWs, and an interpreter who was able to speak both Japanese and Burmese interpreted the interview sessions. Teaching observation sessions took place in two classes at the monastery (Science and English) and in the antenatal care (ANC) class at the MWH. Due to the fact that there were not any classes regarding SRH in the monastery, it was not possible to observe the issue relevant to this study as a class. Instead of

this, Science and English classes were observed in order to understand the educational teaching style in Myanmar. In addition, materials including teaching tools, items related to SRH, and books about SRH were collected at the monastery, MWH, markets, and bookstores and were reviewed. If items could not be purchased, they were copied using a scanner or camera. The interpreter helped to translate the materials.

### 4. Data analysis

Interviews were recorded, translated and transcribed. The transcribed text was separated into paragraphs and those paragraphs were organized into sentences with a single meaning. These abstract sentences were separated along factors of readiness, then coded. An analogous cade was aggregated into sub-categories and they were compiled into the main categories. There were twenty-four codes, twelve sub-categories and four main categories (Table 3).

### 5. Term definition

1) Sexual and Reproductive Health

All couples and individuals have the right to decide freely and responsibly the number, spacing, and timing of their children. SRH also includes prevention, care, and treatment for STIs and HIV/AIDS[22].

2) Young People

Young people were defined as those aged 10 to 24 years. This range combines adolescents (10-19) and youth (15-24) as defined by the United Nations[23].

### 6. Ethical consideration

This study was implemented after receiving approval from the ethics committee at the Japanese Red Cross Kyushu International College of Nursing (Approval No.13-8). Written informed consent was received from participants and the heads of the monastery and MWH. At the beginning of the interviews, study objectives, procedures, protection of privacy, and right to quit the interviews were explained.

Table 1. Characteristics of participants

| | Sex | Age | Occupation | Occupational Work Experience | Marital Status | Experience for SRH education |
|---|---|---|---|---|---|---|
| A | F | 52 | AMW | 26 yrs | Married | Yes |
| B | F | 46 | AMW | 26 yrs | Married | Yes |
| C | F | 28 | School Teacher | 2 yrs | Single | No |
| D | F | 34 | School Teacher | 4 yrs | Single | No |
| E | F | 23 | School Teacher | 1 yr | Single | No |

Table 2. Interview guide

1.Knowledge about the issues
What is your understanding of the issues surrounding unsafe abortions and STIs?
2. Opinion on SRH education
What do you think about SRH education?
3. Resources for SRH education
What resources do you have for SRH education and how do you use them?
4. Feelings about discussing SRH in a class
How do/will you feel when you talk about SRH in your class?

## III. Results

Data obtained were categorized into four groups along factors of readiness: (1) educators' commitment to SRH education, (2) educators' ideas for effective teaching methods and contents for SRH education, (3) recognition of social changes in the evaluation of SRH, and (4) resources for gathering information about SRH (Table 3).

### 1. Educators' commitment to SRH education

This category consisted of the following sub-categories: active willingness to educate people, high motivation for learning new subjects, and responsibility for protecting lives and health of people.

1) Active willingness to educate people

Even though schoolteachers do not teach children about health as a subject in their curriculum, they talk about sanitation practices and infection control whenever they have time. AMWs make efforts to convey SRH information to people. For instance, they attract the attention of community members by giving people incentives to participate in educational classes.

2) High motivation for learning new subjects

The educators were eager to update their knowledge. Teacher D mentioned, *"I watch TV programs about health, though I usually do not watch other TV shows. If I do not have time to watch them, I ask my sister to check them out instead of me. I want to teach children updated information."*

3) Responsibility for protecting lives and health of people

AMWs sometimes provide contraceptives and medicines that they pay for themselves to women who cannot afford them. An AMW said, *"I do not put value on money for the medicine, but I do put value on people's lives. If mothers die, their children will suffer."* In addition, teacher D said, *"Children could make a mistake if they do not know anything about skills to live healthy. So, it is a teacher's responsibility to teach them about it."*

**2. Educators' ideas for effective teaching methods and contents for SRH education**

This category consisted of the following sub-categories: interactive communication with participants, early education, and education by professionals.

1) Interactive communication with participants

Both teachers and AMWs indicated that it would be more effective to exchange opinions between educators and participants in a health education class than to provide teacher-centered classes. At the monastery, it was observed that memorization based on the teacher-centered approach (TCA) was the main method of education in classes. In sessions at MWH, AMWs and some instructors use teaching materials developed by some non-governmental organizations. One of the materials was to share knowledge with mothers and their husbands about pregnancy by asking questions. Participants were then able to join the class actively. Teacher C stated, *"It is better to have a discussion type of class with women and friends when we have problems with SRH."*

2) Early education

Both educators described that SRH education for young people was needed. They indicated that age 10, when children become secondary school students, is an appropriate age to start SRH education. Teacher D explained, *"When girls become 11 or 12 years old, they turn into adults physically and mentally. Thus in order for them to manage their lives, it is proper to educate them about SRH around that age."*

3) Education by professionals

AMWs were trained to help improve women and children's health, so they were already in charge of providing SRH education, but not specifically for young people. Teachers C, D, and E mentioned, *"SRH education should be provided by professionals who are knowledgeable about it."*

**3. Recognition of the social changes in the evaluation of SRH**

This category consisted of the following sub-categories: influence of globalization and mass media, improved health awareness, and taboos around SRH.

1) Influence of globalization and mass media

AMWs indicated that *"Many young people have been exposed to SRH information through videos and dramas from foreign countries."* Teachers C and D said, *"Myanmar is becoming international"* and realized that chances of receiving SRH information from other countries were increasing. Additionally, teacher C mentioned, *"Some young people these days do not hesitate to speak out about SRH topics compared with young people in the past."*

2) Improved health awareness

AMWs said, *"Even though talking about SRH is shameful in public for young people, we understand that it is necessary for them to prepare for their*

*healthy life in the future."* Teacher C stated, *"Although parents have not been comfortable with talking about SRH to their children in the past, in these days the parents understand the importance of SRH education for a healthy life."*

3) Taboos around SRH

The educators implied that SRH was still a taboo subject in some situations. For example, teacher D said, *"A single woman should not read a book about sex, but I have read it because I wanted to know,"* and *"Women should not talk and read about sex in front of men."* Teacher E stated that it would be shameful to talk about sex in public. AMWs would like to involve men in the ANC class, but one such class with 40 women contained only 2 or 3 men.

**4. Resources for gathering information about SRH**

This category consisted of the following sub-categories: information from professionals and older people, information from social media, and information from specialized books.

1) Information from professionals and older people

The educators have access to SRH information. AMWs were trained by professionals when they were recruited. In terms of HIV information, the teachers have attended seminars and training courses held by some organizations. Teacher C mentioned, *"I ask questions about SRH when I go to see a doctor."* Teacher E said, *"I usually ask an older family member about SRH concerns, because it is very rare for me to go to see a doctor."*

2) Information from social media

There are many types of media in the community such as posters, magazines, and billboards. In addition, social media sites like Facebook can be a new source of SRH information. Teacher D said, *"One broadcast station became international, so now I am able to gain more information than before."*

3) Information from specialized books

Teachers C, D, and E all mentioned that they have learned about health from a specialized book in a library or a bookstore. In the bookstore, there were some books available about health, including books on pregnancy and birth. In addition, teachers have used textbooks from School-based Healthy Living and HIV/AIDS Prevention Education (SHAPE) distributed in 1998 by UNICEF[24]. The textbooks were used in class until a few years ago, but they are no longer used.

Table 3. Overview of categories for readiness of educators to provide SRH education to young people

| Main Category | Sub-Category | Code |
|---|---|---|
| Educators' commitment to SRH education | Active willingness to educate people | Sharing my knowledge with people who do not have the knowledge |
| | | Teaching important skills to students about living a healthy life whenever there is time |
| | High motivation for learning new subjects | Searching actively for information |
| | | Eager to learn about SRH |
| | Responsibility for protecting lives and health of people | Valuing people's lives more than money |
| | | Teachers' responsibility to guide students in the right direction |

| | | |
|---|---|---|
| Educators' ideas for effective teaching methods and contents for SRH education | Interactive communication with participants | More effective to have a counseling sessions to teach SRH than one-way educational classes |
| | | Using games and quizzes to confirm participants' knowledge |
| | Early education | Important to educate young people before they get in trouble |
| | | Adequate to start SRH education around 10 years old |
| | Education by professionals | More reliable if instructors are from public sectors |
| | | Professionals who are related to healthcare are the right people to teach about SRH |
| Recognition of social changes in the evaluation of SRH | Influence of globalization and mass media | Young people learn about sexual matters from foreign TV shows |
| | | Young people today express their own opinions, unlike people in the past |
| | Improved health awareness | Talking about SRH is shameful, but necessary for young people to live a healthy life |
| | | Adults understand young people's needs to receive SRH education for their health |
| | Taboos around SRH | A single woman should not read a book about sex |
| | | It is shameful to talk about sex |
| Resources for gathering information about SRH | Information from professionals and older people | Attending training courses |
| | | Asking my older family member about health |
| | Information from media/social media | International TV programs provide comprehensive information about SRH |
| | | Posters and magazines are available |
| | Information from specialized books | Studying about SRH using textbooks |
| | | Textbooks from SHAPE |

## IV. Discussion

### 1 .Professional knowledge of school teachers and AMWs

The teachers showed a passion to teach children and explained effective ways of teaching. They also indicated that they understand children's physical and mental growth and development levels at each age. More importantly, they were close to children's daily lives. Even though the teachers did not have experience of teaching SRH, it would be advantageous that they have knowledge of characteristics in young people to deliver important information related to health in appropriate manner.

As for AMWs, they were recruited from their community and trained through programs implemented by the central government and UNICEF in order to improve maternal and newborn health[21]. Therefore, they were knowledgeable of SRH information and had experience of teaching about it mainly for mothers. Because they were from their community, they understood the communities' beliefs and cultural values. According to statistics from the United Nations Population Fund, 9,226 midwives (including nurse-midwives) and 22,757 AMWs lived in Myanmar in 2011[25]. Qualified midwives are increasing, but there are still more AMWs than midwives. These AMWs fill important roles to meet the health needs of their community. Therefore, AMWs will be able to take a leadership role for SRH education.

As mentioned, both types of educators had their own professional knowledge. Although teachers were not confident about teaching SRH in the future, they indicated that they would use their knowledge if they have proper training regarding SRH education. While AMWs already had knowledge about SRH and experiences of teaching, they did not have much access to young people. So, it would be meaningful to find a way to combine their knowledge to design effective SRH education for young people.

### 2. Feelings about teaching SRH and motivation to learn about the issue

Both types of educators were aware of HIV/AIDS issues. This is because there were still a number of deaths due to HIV infection[10]. In light of the burden of disease, many organizations are making efforts to eliminate this burden, and educators were taking advantage of opportunities to learn about HIV/AIDS through media and textbooks from SHAPE[24, 26].

Unsafe abortions cause up to 60% of maternal deaths, and the repeat abortion rate in Myanmar ranges from 31% to 67%[9]. Some of this information was known by AMWs, but school teachers were unaware of these figures. This may be because all teachers who participated in this study were single. Since premarital sex is still uncommon in Myanmar, it would be taboo to obtain this type of information while they are single. Also, some teachers stated that it was shameful to discuss SRH in public. However, at the same time, teachers mentioned the necessity of SRH education at an early age and their willingness to learn about it to help educate children.

Put simply, though school teachers were feeling shameful to discuss SRH in public, because AMWs and teachers are either aware of the issues or motivated to learn about them, it appears that if there were focused and detailed training programs provided by professionals in culturally appropriate ways, they could be in charge of SRH education.

### 3. Concerns for teaching methods and contents of SRH

Both types of educators pointed out that effective teaching methods and attractive contents are needed to educate young people. AMWs were already using the methods in education classes, but teachers were using TCA most of the time in their classes. Teachers are not ready for use the methodology that was said it is effective. In light of advancements in students' independence, the Japan International Cooperation Agency started a project titled "Project for Strengthening the Child Centered Approach (CCA) Education in the Union of

Myanmar" in 2004[27]. However, the ideas have not been expanded to teachers in the monastery, so children and teachers are still accustomed to learning and teaching that style. Thus, to begin with, teachers must understand CCA and make efforts to develop their teaching methods using CCA with the support of educational entities. They then will be able to use these new skills effectively for interactive educational classes. Even AMWs need to make efforts to update teaching materials and content according to social changes.

## V. Conclusion

The readiness of educators to provide SRH education was explored. It was found that both types of educators have their own knowledge that they can use to educate people. However, having knowledge either SRH or characteristics of young people is not enough to teach SRH effectively. Hence, it would be ideal to put their knowledge together to implement effective SRH education to young people. Even though school teachers were still feeling uncomfortable to discuss SRH in public, their awareness of the issues and motivation for learning about SRH will make it possible to teach young people about SRH. Therefore, it was considered that both educators were partially ready for SRH education and they need a training to teach about SRH in effective way, which should be implemented before starting SRH education program to young people. The training for school teachers should be composed with contents of focused and detailed SRH information by professionals in a culturally appropriate way. Besides that, teachers were not fully ready for using an effective methodology to teach SRH to young people. Therefore, in addition to personal efforts, organizational efforts and institutional networking such as involvement of educational entities are vital to the development of effective teaching style, materials and contents. Also, AMWs should be trained to utilize and update their ability to teach SRH education to young people.

Information on each of these factors is still vague, so it is essential to conduct further research to ensure not only educators' readiness but also the readiness of communities as a whole. Moreover, it is challenging but imperative to understand cultural beliefs and establish reliable relationships with local people.

## VI. Limitations and future issues

1. The number of teachers and AMWs interviewed was small, and they were recruited from a single community. Thus, results may not be generalizable. In the future, studies should involve expanded recruitment with more detailed sampling criteria.
2. The classes observed were limited, so the teaching methods and contents were not fully collected and analyzed.
3. Because SRH is a culturally sensitive topic, the researcher needed to be culturally competent. However, the researcher was a foreigner, and there was a time constraint for establishing reliable relationships. It is necessary for a researcher to be close to a community and share local beliefs and cultural values for a long period as well as find a local researcher to work with.
4. It was possible that there were some biased interpretations because of the language barrier. In addition to learning the local language, it is important to know more about the country and culture behind a language.

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研究ノート

# ミャンマーの若者へのセクシュアル／リプロダクティブヘルス教育に対する小学校教員と地域助産師（AMWs）のレディネスに関する研究

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2010 年の新政権発足以降、世界中の企業が豊富な労働力や資源を求めてミャンマーを訪れており、急速に経済発展が進んでいる。その経済発展に伴い、人やモノの往来が増え、ミャンマーには今、様々な国の情報や文化が流入している。ミャンマーでは、若者の HIV を含む性感染症が深刻な社会問題となっていた。ミャンマーはアジアの中でも若者が多い国の一つであり、それらの問題が社会に与える影響は大きい。その若者がより健康に社会活動が行えるようにするために彼らを対象とした SRH 教育の拡充は早急に必要とされる。

今回の調査では、SRH 教育において重要な役割を持っていると考えられる教育者を小学校教員と AMW とし、彼らがどれくらいミャンマーでの SRH 教育に対してレディネスが整っているかを調べ、今後どのような対策が必要であるか考察するための資料を収集した。教育者たちへ半構成面接、参与観察および教材収集を行い、質的記述的に分析した。その結果、教育者たちは【教育者としての使命感】のもと、【効果的な教育方法や内容】、【SRH を取り巻く社会の変化】や【利用可能な情報源】を認識した状態であることが分かった。しかし、実践するにあたっての課題もある。教育者たちは部分的にレディネスが整っている状態であると言えるが、効果的な SRH 教育のためには、それぞれの教育者が持っている専門性を統合させ、文化的背景を考慮した上での焦点化された教育者のトレーニングプログラムの導入が必要であると考える。さらに AMW の技術や知識の更新や教育機関などの組織的な努力やネットワーク作りも必要だと考えられる。

**キーワード：ミャンマー、教育者、小学校教員、AMWs、セクシュアル・リプロダクティブヘルス教育、若者、レディネス**

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