การคุมกำเนิดและการใช้บริการอนามัยเจริญพันธุ์ของเยาวชนเมียนม่าร์ทั้งก่อนและหลังสมรส ในเขตบางบอน กรุงเทพมหานคร

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ปีการศึกษา 2552

PRACTICE OF CONTRACEPTION IN PREMARITAL AND MARITAL SEXUAL RELATIONSHIP AMONG MYANMAR YOUTH MIGRANTS IN BANG BON DISTRICT, BANGKOK AND THEIR REPRODUCTIVE HEALTH SERVICES ACCESSIBILITY

Miss Win Mar Han

A Thesis Submitted in Partial Fulfillment of the Requirements

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Thesis Title	PRACTICE OF CONTRACEPTION IN PREMARITAL AND MARITAL SEXUAL RELATIONSHIP AMONG MYANMAR YOUTH MIGRANTS IN BANG BON DISTRICT, BANGKOK AND THEIR REPRODUCTIVE HEALTH SERVICES ACCESSIBILITY
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วิน มา ฮาน: การคุมกำเนิดและการใช้บริการอนามัยเจริญพันธุ์ของเยาวชนเมียนม่าร์ ทั้งก่อนและหลังสมรสในเขตบางบอน กรุงเทพมหานคร (Practice of Contraception in Premarital and Marital Sexual Relationship among Myanmar Youth Migrants in Bang Bon District, Bangkok and their Reproductive Health Services Accessibility)
อ. ที่ปรึกษาวิทยานิพนธ์หลัก : อ. ดร.เขมิกา ยามะรัต 93 หน้า.

การย้ายถิ่นในปัจจุบันนับว่าเป็นมิติที่สำคัญในระดับโลก ที่มิใช่สำคัญแต่ในทางเศรษฐกิจเท่านั้น แต่เป็นมิติที่เกี่ยวข้องกับสุขภาพด้วย ประเทศไทยเป็นประเทศปลายทางของผู้ย้ายถิ่นที่สำคัญแห่งหนึ่งในภูมิภาคเอเชียตะวันออกเฉียงใต้ ผู้ย้ายถิ่นในประเทศไทยกว่าร้อยละ 80 เป็นชาวเมียนม่าร์ ซึ่งจำนวนไม่น้อยเป็นเยาวชนในวัย 15-24 ปี เยาวชนเหล่านี้ไม่ว่าจะอยู่ที่ใดมักจะประสบปัญหาสุขภาพ และการเข้าถึงบริการสาธารณสุขมากกว่าเยาวชนในประเทศนั้น ๆ วัตถุประสงค์ของการศึกษานี้เป็นการศึกษาพฤติกรรมทางเพศ การคุมกำเนิดและการเข้าถึงบริการด้านอนามัยเจริญพันธุ์ของเยาวชนผู้ย้ายถิ่นชาวเมียนม่าร์ ซึ่งอาศัยอยู่ในเขตบางบอน อำเภอบางขุนเทียน กรุงเทพมหานคร การศึกษานี้เป็นการศึกษาแบบพรรณนา โดยการสัมภาษณ์ ณ เวลาหนึ่ง จำนวน 413 คน สถิติที่ใช้ในการวิเคราะห์ความสัมพันธ์ระหว่างตัวแปรตามกับการคุมกำเนิดคือ Chi square, Fisher's Exact test และ Logistic Regression

ผลการศึกษาพบว่าเยาวชนย้ายถิ่นชาวเมียนม่าร์ร้อยละ 24.7 มีประสบการณ์เพศสัมพันธ์ก่อนสมรส และเยาวชนร้อยละ 60 ทั้งที่สมรสและก่อนสมรสใช้การคุมกำเนิด อย่างไรก็ตามเยาวชนเหล่านี้มีความรู้เกี่ยวกับโรคติดต่อทางเพศสัมพันธ์และการคุมกำเนิดค่อนข้างต่ำ แต่มีเจตคติและการรับรู้ต่อการคุมกำเนิดในระดับพอใช้และดี ผลการวิเคราะห์ Multivariate พบว่าสถานภาพสมรส ช่วงเวลาที่อยู่ในกรุงเทพ บุคคลที่อยู่อาศัยด้วย การพูดคุยเกี่ยวกับการคุมกำเนิดกับคู่ครอง ระดับความรู้เรื่องเพศ เจตคติต่อเรื่องเพศ และแหล่งข้อมูลเกี่ยวกับสุขภาพ มีความสัมพันธ์อย่างมีนัยสำคัญทางสถิติกับวิธีคุมกำเนิดที่ใช้อยู่ในปัจจุบัน

ผลการศึกษาแสดงว่าเยาวชนผู้อพยพชาวเมียนม่าร์มีการใช้การคุมกำเนิดอย่างกว้างขวาง แต่การมีความรู้น้อย แสดงถึงความจำเป็นของความต้องการข่าวสารข้อมูลด้านสาธารณสุข การศึกษานี้แสดงว่าการกระจายข้อมูล ความรู้ การสื่อสารและการให้การปรึกษาเป็นความต้องการเร่งด่วนสำหรับเยาวชนเหล่านี้ ผลการศึกษานี้มีความแตกต่างจากการศึกษาก่อนหน้านี้ ซึ่งน่าจะเป็นประโยชน์ต่อผู้กำหนดนโยบายแรงงานต่างด้าว เพื่อเข้าใจเรื่องของเพศและสุขภาพทางเพศของเยาวชนผู้อพยพต่างด้าว

สาขาวิชา สาธารณสุขศาสตร์ ลายมือชื่อนิสิต .....

ปีการศึกษา 2552 ลายมือชื่อ อ.ที่ปรึกษาวิทยานิพนธ์หลัก .....

ลายมือชื่อ อ.ที่ปรึกษาวิทยานิพนธ์ร่วม .....

5279117553 : MAJOR PUBLIC HEALTH
KEYWORDS : CONTRACEPTION/ PREMARITAL AND MARITAL SEX/ MYANMAR MIGRANT YOUTHS/ BAN BON DISTRICT/ REPRODUCTIVE HEALTH SERVICES ACCESSIBILITY

WIN MAR HAN: PRACTICE OF CONTRACEPTION IN PREMARITAL AND MARITAL SEXUAL RELATIONSHIP AMONG MYANMAR YOUTH MIGRANTS IN BANG BON DISTRICT, BANGKOK AND THEIR REPRODUCTIVE HEALTH SERVICES ACCESSIBILITY
THESIS ADVISOR: KHEMIKA YAMARAT, Ph.D.,
THESIS CO-ADVISOR: ALESSIO PANZA, M.D., M.Com.H., D.T.M&H., 93 pp.

Migration becomes a global issue nowadays not only in economic but also in health aspects. Thailand is one of the major migrant receiving countries in South East Asia. More than 80% of migrant workers in Thailand are Myanmar and concentrated in the age group of 15-24 years. No matter where they settle, it is always true that the migrant youths suffer the health problems and inaccessibility more than the native youths. The objective of this study is to assess the sexual practice and contraceptive usage among Myanmar migrant youths in Bang Bon District in Bangkok and their reproductive health services accessibility. The study was cross-sectional descriptive study carried out by face to face interviewing to 413 migrant youths (15-24 years). The results were analyzed by chi square test, Fisher's Exact test and Logistic Regression to see the independent variables as associated factors to the current contraception practice.

The results revealed that 24.7% of migrant youths had premarital sexual relationship and 60.0% of both married and unmarried youths used contraception in their premarital and marital sexual relationship. However, their knowledge towards STIs and contraception was quite low but their attitude and belief were satisfactorily fair and good. After multivariate analysis, marital status (<0.001), duration of stay in Bangkok (0.001), persons staying together (<0.001), discussion about contraception with their partners (0.001), their level of knowledge (0.027) and attitude (0.005) and health information availability (0.005) were found statistically associated with their current usage of contraception.

Overall findings indicated that though the migrant youths practice contraception widely, their level of knowledge was still low indicating their needs of health information. This study indicates that effective communication, information dissemination, sexual health counseling become crucial needs to the migrant youths who are vulnerable to sexual and reproductive health risks. Exploring the differences of the findings of this study and the previous studies, qualitative study would be helpful for the health policy makers of migrants to have better understanding of the youths' nature regarding sexual and reproductive health.

Field of Study: Public Health ..... Student's Signature: .....
Academic Year: 2009 ..... Advisor's Signature: .....
Co-Advisor's Signature: .....

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndromes
ASEAN	The Association of Southeast Asian Nations
CCSDPT	Committee for Coordination of Services to Displaced Persons in Thailand
CPR	Contraceptive Prevalence Rate
CSW	Commercial Sex Worker
HIV	Human Immunodeficiency Virus
IOM	International Organization for Migration
IUD	Intra Uterine Contraceptive Device
MMR	Maternal Mortality Rate
NGO	Non Government Organization
NMWD	Network for Migrant Worker Development
PHAMIT	Prevention of HIV-AIDS Among Migrant Workers in Thailand
RH	Reproductive Health
SEARO	South East Asia Regional Office
STI	Sexually Transmitted Infection
UN	United Nations
UNFPA	United Nations Population Fund
WHO	World Health Organization

CHAPTER I
INTRODUCTION

1.1 Background and Rationale

Migration becomes a global issue nowadays not only in economic but also in health aspects. Worldwide, there are 175 million migrants in 2000 and between 185 and 192 millions in 2005 (IOM, 2005). In 2010, migrant population is expected to be 214 million and 3.1% of total world population which is increased from 2.9% in 1990 (UN, 2008) and 3% in 2008, i.e., one of every 35 persons in the world is a migrant (IOM, 2009).

In 2010, Asia is expected to host 10.9 million migrants or 6.6 per cent of the global number of migrants (UN, 2008). Of these, Thailand is a major receiving country for migrants in Southeast Asia. In 2004, an open registration allowed 1,284,920 migrants and their dependents to register with general identities, of which, 849,552 registered with a work permit. Government and non-government organizations estimate that the total migrant population in Thailand will exceed 2 millions. Nearly 80% of migrating workers in Thailand were from Myanmar (Amnesty International, 2006).

Myanmar, previous known as Burma is one of the ASEAN countries and is a neighbor of China, Laos, Thailand, Bangladesh, and India. The estimated total population in Myanmar is 58 million in year 2005 and there are more than 135 distinct ethnic groups. Youth population is 9,934,000 which consist of 19.5% of total population (World Population Prospects, 2008 Revision). They form a significant part of the labor force, one that is becoming increasingly important as the effects of globalization take hold in each country (PRB, 2006). Employment opportunities for out-of-school youth are very limited and an estimated 90% are unemployed. Many uneducated young people from rural areas and different ethnicities have to migrate to the capital city, Yangon (Rangoon), other larger towns or even neighboring countries such as Thailand and China for work due to economic constraints (ILO, 1998). According to a study in 2007, 85.23% of migrant workers in Thailand were concentrated in the age group of 15-32 years (Sakai, Sillabutra, & Keiwkarnka, 2007). Most of the young people enter from rural to urban migration stream as they are

attracted to cities where they feel that work in industries and services can provide them with a relatively lucrative income (IOM, 2009). Away from their communities of origin, they have the chance to gain new experiences and form new relationships at a time when they are particularly vulnerable to such threats as premarital sexual relationship, unwanted pregnancies, sexually transmitted infections including HIV-AIDS and pregnancy related complications (Soonthorndhada, et al., 1996; WHO, 2003).

Illegality and insecurity also drive such age group into vulnerable trap of contracting such threats. The underlying youth nature, cultural influences and belief weigh their burden more. Moreover, being migrants, superimposed by their illegal status, they have limited access to health care services compared to the others (Anderson, et al., 2009; IOM, 2009; PICUM, 2007). The next major problem among them is that sexuality is often surrounded by strict social, moral and religious beliefs though these age groups are sexually active groups. Besides, according to Eastern Culture, it is perceived as unacceptable and shameful to consult reproductive health services and to become pregnant before marriage. Hence, many unwanted pregnancies among unmarried young women end up with termination of pregnancies secretly and illegally. Moreover, young people are not a primary target group for health services because it is generally believed that they are young and healthy. Most reproductive health services are aimed to married women and pregnant women but not for unmarried young people. There is also no specific health services especially reproductive matter for young men. Migrant groups are also often excluded from health care due to restrictive administrative policies (UNFPA, 2006a).

Reproductive health problems among migrant youths need much more attention nowadays. Adolescent fertility rate in Thailand and Myanmar were 45 and 19 per 1,000 females of aged between 15 and 19 respectively (UNFPA, 2006a). Among reproductive problems nowadays, unplanned and young pregnancy threatens the world and many countries have the burden of adverse effects of it. It affects not only the women but also their families and societies. Women of all ages may have unplanned or unwanted pregnancies, but some groups such as teens, are at highest risk (CDC, 2007). Girls aged 15-19 are twice as likely to die from childbirth as women in

their twenties, those under age 15 are five times as likely to die (WHO, et al., 2000). Though many organizations and agencies are focusing sexually active group of age 18 and above which is commonly acceptable as sexually active and able to give informed consent, evidence is accumulating on circumstances surrounding the sexual initiation of adolescents aged 15-19 (Brown, jejeebhoy, Shah, & Yount, 2001; Cleland, et al., 2000). Evidence from Demographic and Health Survey (DHS) and other sources reveal that one quarter or more of young adolescent boys in many countries have engaged in vaginal intercourse before the age of 15. The same holds true for girls in part of Sub-Saharan Africa and in India and Bangladesh, mostly due to child marriages (Eggleston, et al., 1999; Singh, et al., 2000).

WHO described children and young adolescents, migrants and refugees, persons with alternative sexual identities and sex workers as understudied, underserved and invisible vulnerable populations not only due to the nature and causes of sexual misinformation and distress but also due to the sources to which those people turn for information, advice and treatment (d'Arcangues, Francisco, & Dixon-Mueller, 2007). Many migrated young mothers face unplanned pregnancies as they have low level of health knowledge, perceived threats and poor health access (WHO, 2007). Unplanned pregnancies in unmarried group end up with termination whereas those in married group are associated with delayed prenatal care, family burden, socio-economic problem and poor health. Therefore, when we consider health and benefit for the migrant workers, these young age group should not be neglected and reproductive health plays an important role in such case (PHAMIT, 2009).

During the next few decades, young people will most likely continue the current trend of moving from rural areas to cities in search of education and training opportunities, gainful employment, and adequate health care (PRB, 2006). Among these, migrants settling in big city and more urbanized place suffer the bigger strike than those in rural regions. Because of the modernized technologies and varieties of opportunities, their youth nature cannot cope with the abrupt changes in positive ways. With inaccessible supportive environment, they are vulnerable to many adverse effects and risks (WHO, 2007).

While majority of Myanmar migrants are concentrated in the areas along Thailand-Myanmar border, minority of such population come to the main city, Bangkok, hoping for better life making. Out of 50 districts in Bangkok, Bang Bon District is the one where most of the migrants congregate as it is one of the industrialized zones having various-sized factories. It is located southwest of Bangkok. Previously it was one of the sub-districts of Bang Khun Thian District but now it is established as a separate district due to increasing population. Being industrialized areas, labor demand is quite high and the factory owners nowadays prefer the outside labors due to currently higher cost for local labor. Among total estimated population of 82,585 (National Statistic Office, 2000), more than 7,000 are Myanmar migrant workers working in dry shrimp factories, canned fish factories, plastic factories etc. Majority of the migrants in Bang Bon District are single young aged group. Majorities are Da We and Mon in ethnicity and they came to work in Bangkok to seek greener pastures in a new land. However, in reality, they also suffer health related risks mentioned above. Even the registered workers face certain number of barriers, for example, unable to balance between fixed clinic hours and their working hours.

As Bang Bon District is not situated at Thai-Myanmar border, it is not a common place to study Myanmar migrant workers. No doubt, being youths and migrants, the Migrant youths in that area are suffering reproductive health risk and other inaccessibility not less than those along the border. So, this study aims to explore migrant youths' knowledge on premarital sex and contraception, contraceptive usage and their attitude and their reproductive health access.

1.2 Research questions

1. What are the socio-demographic factors of Myanmar youth migrants in Bang Bon District, Bangkok?
2. What are the personal factors (knowledge, attitude, and belief) of Myanmar youth migrants in Bang Bon District, Bangkok regarding premarital sex and contraception?
3. What is the prevalence of current contraceptive usage among them?
4. Are the required reproductive health information and services available and accessible to them?
5. Are there any associations between socio-demographic, personal, peer and partner factors, health services access and their usage of contraception in premarital and marital sexual relationships?

1.3 Hypothesis

1. Youth migrants in Bang Bon District have low level of contraceptive knowledge and wrong belief on premarital sexual relationship.
2. Youth migrants in Bang Bon District face difficulties in health services access especially reproductive health services and information.
3. There are associations between socio-demographic, personal, peer and partner factors, health services access and their usage of contraception in premarital and marital sex among youth Myanmar migrants in Bang Bon District, Bangkok.

1.4 Objective(s)

1.4.1 General Objective

1. To assess the contraceptive usage during the premarital and marital sexual practice among Myanmar youth migrants in Bang Bon District in Bangkok and their accessibility to reproductive health services

1.4.2 Specific Objectives

1. To determine the socio-demographic factors of Myanmar youth migrants in Bang Bon District, Bangkok
2. To determine the personal factors (knowledge, attitude, and belief) of Myanmar youth migrants in Bang Bon District, Bangkok regarding premarital sex and contraception
3. To determine the prevalence of contraceptive usage among them
4. To determine their health service access especially reproductive health services
5. To determine their socio-demographic factors, personal factors, peer and partner factors, health services access as associated factors to their individual practices of contraception during premarital and marital sexual relationships

1.5 Conceptual Framework

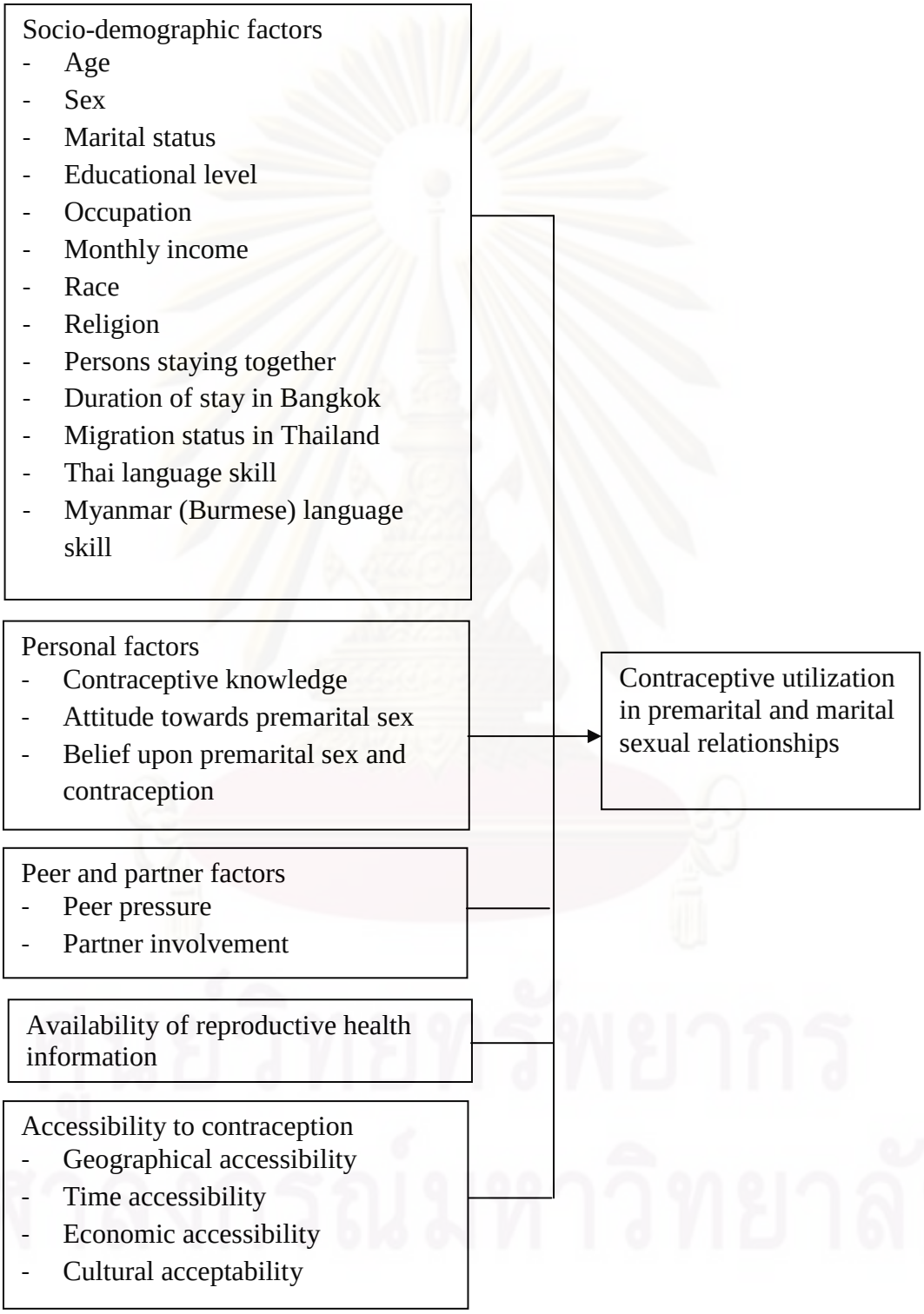

Figure 1.1 Conceptual Framework

1.6 Operational Definitions

1.6.1 General

Youths: There are many definitions for youths and wide variations in defining young people but for this paper, youths mean those of age group between 15 to 24 years according to their vulnerability to risk and United Nations' youth definition and both married and unmarried males and females are taken into account.

Myanmar migrants: Migration can be subdivided into 2 categories – refugees and non-refugees. In this paper, migrants mean non-refugees who migrate in order to make their living better or those who accompany their husbands or wives or families. There are many nationalities among migrants in Thailand and Myanmar is the majority amongst them. So the study population will be any tribes of Myanmar nationality among the non-refugee migrants.

Premarital sex: Premarital sex is sexual intercourse engaged in by persons who are unmarried. It is generally used in reference to children and adolescents who are presumed not yet of marriageable age, or between adults who will presumably marry eventually, but who are engaging in sexual intercourse prior to their legal marriage.

Sexual Intercourse: Though there are many types of sexual intercourses such as vaginal intercourse, anal intercourse, oral sex, etc., in this paper, sexual intercourse refers to the vaginal intercourse - the act in which the male reproductive organ enters the female reproductive tract.

Contraception: In this paper contraception means any types of contraception whether it can prevent STIs or not.

Reproductive health services: Reproductive health services mean any kind of health services related to reproductive health including health education regarding reproductive health.

1.6.2 Independent variables

Age: refers to how old the respondent is at the time of interview.

Sex: refers the respondent's sex characteristics of either male or female.

Marital status: refers to the current marital status of the respondent which is classified into living together and legally married, living together but not legally married, single (never married and not living together), widow and divorced/separated.

Education level: refers to the highest education that the respondent attained and is classified into no education (just read and write or basic monastery school), primary (equivalent to Grade 1 to Grade 5), middle (equivalent to Grade 6 to Grade 8), high school (equivalent to Grade 9 to Grade 11) and university level education.

Occupation: means the income generation job that the respondent relies for his/her survival.

Income/ family income: means the respondent and his/her family members' income in Bahts per month.

Race: means the original ethnic group that the respondent belonged to and mainly classified into Mon, Dawe, Rakhine, Bamar and others.

Religion: refers to that of the respondent and is classified into Christian, Buddhist, Hindu, Islam and others.

Persons staying together: refers if there is any roommate/ friend or partner or spouse or family member staying together with the respondents.

Duration of stay in Bangkok: implies the duration of the respondents' stay in Bangkok in terms of years and months.

Migration status in Thailand: means whether the respondent has the legal permission to live and work in Thailand and classified into registered and unregistered.

Thai language skills: the respondent's ability to understand and speak Thai language and divided into can read and speak fluently, can't read but can speak fluently, cannot speak fluently but can understand and do not know at all.

Myanmar (Burmese) language skills: the respondent's ability to understand and speak Myanmar (Burmese) language and divided into can read, write and speak fluently, can't read but can speak fluently, cannot speak fluently but can understand and do not know at all.

Knowledge of contraception: means the knowledge of different types of contraception methods, their effects and side effects. There are 16 questions and it is differentiated according to scoring of their response to the questionnaires by Benjamin Bloom's criteria, <60% of total score (Scores<24) - poor knowledge, 60-80% (Scores 24-31) - moderate or fair knowledge, >80% (Scores>31) - good knowledge. The respondents will get 1 mark for each correct answer and 0 for incorrect and uncertain answer.

Attitude towards premarital sex: The attitude of the respondents is measured by asking eight questions whether they agree or disagree with the statement used in Likert's scale ranging from strongly agree to strongly disagree and the level is assessed by good when the total score is >80% (Scores>25), moderate or fair when the total score is 60-80% (Scores 19-25) and poor when the total score is <60% (Scores<19). The cut off points were set according to Benjamin Bloom's criteria. The respondents will get 4 marks for strongly agree, 3 for agree, 2 for disagree, 1 for strongly disagree and 0 for uncertain in positive attitude question and will get reverse scores for negative attitude question.

Belief upon premarital sexual relationship and contraceptive usage: means the respondents' belief upon their susceptibility of the consequences of unprotected and unplanned sexual relationship, that upon transmission and ways of prevention of sexually transmitted infections including HIV-AIDS and that upon cultural and social barriers to their health care services accessibility. It has seven belief-related questions, asking about their correct or incorrect belief and classifies into high (>75%, i.e., Scores>5.25), middle (25-75%, i.e., Scores 1.75-5.25) and low (<25%. i.e., Scores<1.75) levels of correct belief.

Partner involvement in contraceptive usage: whether their sexual partners are discussable and helpful in practicing any type of contraception.

Peer pressure in premarital sex and contraceptive usage: If the respondent experience peer pressure to start practicing premarital sex or not, if they receive information about safer sex and proper contraceptive usage from their peers

Availability of reproductive health services: The questionnaires will ask the availability of 1) reproductive health services in terms of informative materials like media, journals or information-education-communication materials such as pamphlets, posters or booklets etc in the language familiar to them, 2) contraceptives, 3) health organization or personnel to consult with reproductive health matters and 4) any health service centers such as public or private hospitals, clinics, including health centers.

Accessibility to reproductive health services and information: the questions will address the distance and time clients have to travel, means of transports, affordability according to their income, and preference for the service provider's gender

1.6.3 Dependent variable

Contraceptive usage in premarital and marital sex: Contraceptive usage means using any methods of contraception and categorized into current user, ever user and never user

CHAPTER II
LITERATURE REVIEW

2.1 Youths and Migration

Youths are those persons falling between the ages of 15 and 24 years inclusive (UN Definition, 1985). The world contains 1 billion young people between the ages of 15 and 24 years and it is nearly 18% of the world's population (World Population Prospects, 2004 Revision). It also takes up large proportion in migrant population (ILO, 2009; Gultiano & Xenos, 2004). Youth is the transition from adolescent to adulthood and the transition of adulthood is a complex process in which young people who have been dependent on parents throughout childhood start taking definitive steps to achieve measures of financial, residential and emotional independence, and to take on more adult roles as citizen, spouse, parent and worker. The transition can be a period of growth and accomplishment, however, some encounter setbacks early on by becoming parents too soon, dropping out of school, failing to find work, or getting in trouble with the legal system. In the transition stage, they have to face many changes both negative and positive and for those who cannot cope with accordingly, negative outcomes weigh more. Of these sexual behavior and knowledge plays an essential part (Altschuler, Stangler, Berkley, & Burton, 2009).

2.2 Sexual and reproductive health

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant (IPPF, 1994).

Sexual health is defined as a state of physical, emotional, mental and social well-being related to sexuality and is holistic and multifaceted concept grounded in the individual's capacity to exercise his or her basic human rights.

Sexual and reproductive health affects, and is affected by people's personal experiences and relationships and by the broader context of their lives, including their economic circumstances, education, employment opportunities, living conditions, family structures and political, social, religious and legal environments. Within-country contrasts across wealth quintiles in these and other indicators of sexual and reproductive health including knowledge and access to care, are equally dramatic (Margaret, et al., 2005). WHO and World Bank's paper on research issues in sexual and reproductive health stated that there are four main sources that attributed to poor sexual and reproductive health;

a.) Physiological, behavioral and peer and partner risk factors and limitations on information and resources that predispose some individuals and groups to poorer health in general and to more sexual and reproductive health problems in particular

b.) Social, economic, cultural and personal factors such as young age, stigma associated with sexual matters, restrictions on physical mobility of women and girls, minority group status, disabled populations, inability to pay or experiences or fears of poor treatment affection people's utilization of formal-sector health services in general, and of sexual and reproductive health services in particular

c.) Development resources and political priorities affecting the quality, quantity and geographical distribution of basic preventive and curative health care in general, and of sexual and reproductive health information and services (public and private) in primary-level care and referral systems in particular

d.) Biomedical and technical tools which affect the ability of sexual and reproductive health programs to deliver effectively services for specific subgroups of the population, such as contraceptives, vaccines which use

(or not) the cold chain, multidose medicines, HIV tests which use saliva and do not require blood testing.

In other words, either a person's health risk or access depends not only on his or her personal factor but also on the nature and urgency of the problem and his or her capacity to act, his or her perceptions of the familiarity, acceptability, convenience, cost, confidentiality and efficacy of the provider, product or service (WB & WHO, 2007).

2.3 Socio-demographic factors

2.3.1 Age, Gender and underlying youth nature

Youths are in the transition from their adolescents to adulthoods and are within a period when physical, mental, social and intellectual changes occur yet emotional maturity has not yet fully developed. At this stage, they are very prone to migrate, explore new things and new behaviors including sexual relationship. Besides the difficulties they face in adapting to the new environment, they are at higher risks for certain diseases and adverse effects such as sexual abuse, drug addiction, sexually transmitted infections, unplanned pregnancies and induced abortion which can even threaten their lives. CDC stated that in United States in 2007, 48% of high school students had ever had sexual intercourse, and 15% of high school students had had four or more sex partners during their life (CDC, 2007).

A study in one of the Malaysia high schools found out that the mean age at first sexual intercourse was 15 years. Premarital sexual intercourse was significantly associated with age and gender (Lee, et al., 2006).

One of the studies in West Africa done by Dann said that the median age for women at first sexual intercourse was 15.9 years. Sexual exposure increased with age and 67% of the studied women at age 20-24 years had sexual exposure (Dann, 2009).

A study done in one of the vocational schools in Northern part of Thailand, Chiang Rai, said that 48% of the male and 43% of the female students reported ever having had sexual intercourse. Range of the age among studied population was between 15-21 years (Manopaiboon, et al., 2003).

2.3.2 Marital status, widening gap of age between puberty and marriage

Nowadays, a trend changes towards a rise in the age at marriage which increases the period of youth before marriage. The widening gap between age at menarche (puberty) and age at marriage increases the possibility that young people will engage in premarital sexual activity. Most sexual intercourse among young people is unprotected and can lead to unwanted pregnancy and abortion. In Myanmar the average age at first marriage is relatively late, 27.5 for men, 26.4 for women (World Marriage Pattern UN, 2000). Only 2.2% of men and 6.6% of women get married before the age of 20 (WHO, 2003). The second concern is the declining age at menarche which leads to an earlier onset in sexual maturity and the ability to reproduce. In Behavioral Surveillance Survey (BSS) in 2003 in Myanmar showed that 16% of the youth population was sexually active. The median age at first sex reported by the youth was 22 years and 19 years for men and women, respectively, in Myanmar youths. (Thwe, et al., 2003).

2.3.3 Unsafe sex and induced abortion among young migrants

Premarital sex is increasingly reported among young men. According to BSS in Myanmar, 2003 a few respondents reported having had sex with sex workers or having had casual sex in the past year (Thwe, et al., 2003). About 3% youth reported having sex with commercial sex workers in the past year; majority of these respondents had two or less non-regular partners (Htoon, Myint, & Thwe, 2000). A WHO study of risk behaviors and attitudes among ninth standard students in Myanmar showed that 2.9% of them had engaged in unprotected sex (WHO, 2007).

There was a high level of premarital sexual experience among young migrant workers in Thailand and of which 80% reported that they used contraception, 9% had premarital pregnancy and 5% had terminated their pregnancies through induced abortion (Gray & Punpuing, 1999).

Induced abortion rate in Thailand is 28.5% though the modern contraceptive prevalence rate is quite high, 72% in 1993. The estimated induced abortion ratio was 19.5 per 1,000 live births. Rate of abortion in migrants is increased from 39.29 per thousand live births in 2004 to 82.82 per thousand live births in 2006 (CCSDPT,

2006). Abortion related maternal deaths rise up approximately 80 and 30 per 100,000 live births in Myanmar and in Thailand respectively (UNFPA, 2006a). Almost half the induced abortions were in young women under 25 years of age, many of whom had little or no access to contraception (Warakamin, Boonthai, & Tangcharoensathien, 2004). Thailand ministry of health has recorded that the rate of abortion in Myanmar migrant women is 2.4 times higher than that of local Thai population (Belton & Maung, 2007). It highlights the more needs of reproductive health promotion among Myanmar migrant workers especially for young women.

Between 1% and 15% of abortions in South East Asia Regions are among youths (De Silva, 1996; Bankole, Singh, & Haas, 1999; Hieu, Hanenberg, Vach, Vinh & Sokal, 1995 & 1999)

According to the 2002 Youth Fertility and Sexuality Study by the University of the Philippines Population Institute (UPPI) and the Demographic Research and Development Foundation, 26 percent of Filipino youth nationwide, from ages 15 to 25 years old, admitted to having a pre-marital sex experience (UPPI, 2002).

Among Myanmar migrants in southern coastal and northern area of Thailand, 25% reported visiting sex workers, 57% reported a regular partner and 6% reported non-regular partner among sexually active young men. Factors related to visiting sex workers included marital status (more visits if not married), longer residence in Thailand (the longer stay migrants had more exposure) and (lower level of) perceived risks (Ford & Chamrathrithirong, 2007; Caoette, 2000).

Among vocational school students (15-21 years old) in Chiang Rai who had had premarital sexual intercourse, 27% of the women and 17% of the men said they or their partner had ever been pregnant. Among the last reported pregnancies that resulted in delivery or abortion, 95% were aborted. 3% of total respondents reported that they had ever accepted money, gifts, or favors in exchange for sex and 6% of male and 21% of female had ever been forced to have premarital sexual intercourse (Manopaiboon, et al., 2003).

2.3.4 Education Background, Occupation and Income

Specific factors such as education, place of residence, and wealth group are often associated with higher levels of sexual activity and modern contraceptive usage in Western African youths (Dann, 2009).

2.3.5 Race, religion and culture

There are strong cultural values rooted against sex before marriage (WHO, 2007). Many studies showed no significant association between race, religion and perception on the premarital sex and contraceptive use (Lee, et al., 2006).

2.3.6 Persons staying together

Family or partner companionship is also important in youth's sexual behavior. Most of the youths staying with their parents or guardian are found to be less premarital sexual exposure because it is one of their cultures that young people have to listen to the elderly and the premarital sexual relationship is strictly prohibited according to culture. There was significant difference in sexual experience among those not staying with their parents or family (12.2% had had premarital sexual exposure) as compared to those staying with their parents or family (only 5.1%) (Lee, et al., 2006).

2.3.7 Migration status

Though the reproductive health services are available widely for married women whether young or old, the migrants still have the resistance because of their illegal status. Unregistered migrants could not use the government's Universal Health Scheme or 30 Baht Scheme which meant only to registered migrants in certain designated areas. Besides, there are many cross-border migrants who are underage and they are illegible neither to be hired to work nor to go to school. Such illegible workers were not covered by social insurance and they could not access the health services provided for the migrant workers (WHO Multicenter Study, 2007).

2.3.8 Language barrier

Moreover, language barrier is one of the important factors in migrants' accessibility of health services. Even though the health information and services are provided, those who are not familiar with Thai language are difficult to be acknowledged if they were in Thai language and so does for Myanmar (Burmese) language. This factor might become worse in illegal migrants who have poor standard of living and quality of life compared to registered workers (WHO Multicenter study, 2007).

2.4 Knowledge and belief

Among sexually active youth, contraceptive use reduces the number of unplanned pregnancies. In Senegal and Burkina Faso, more than 85 percent of young women surveyed knew at least one form of modern contraception, but far fewer (67% and 66% respectively) knew three or more modern methods. Knowledge in Senegal was lower, with only 76 percent of young women knowing one method and only 56 percent having knowledge of three or more (Dann, 2009).

According to FRHS 2001, adolescent girls aged 15-19 years were found to know fewer methods of contraception and a higher proportion of them had no knowledge on contraception 5% compared to other age groups 3.5% and they are less likely to use contraception than women in the mid-childbearing age (20-44 years) (FRHS, 2001).

Moreover, wrong beliefs of the communities as well as themselves make them become more risky population, for example, they are not at risk of getting sick or any other kind of disease as they are at quite young age and they do not need the reproductive health services and information unless they are getting married. Since they have incorrect knowledge and beliefs about contraception, for instance, using of emergency pills, they are very prone to unplanned pregnancies and unsafe abortions. Multicenter study 2007 done by WHO found out that youths beliefs of risk and lack of information and services limit their ability to protect themselves against sexual and reproductive health risks, including prevention against HIV/AIDS, STIs and unplanned pregnancies (WHO Multicenter Study, 2007).

A study by Ford and Kittisuksathit suggested that the very low level of condom use within loving relationships (non-commercial pre-marital intercourse) is for special health concern. The obstacles included lack of perceived risk, desire for a sense of trust and intimacy, and low level's of communication between partners concerning contraceptive use. The burden of prevention from pregnancy falls on women and women have no power to negotiate with men regarding the usage of condoms (WHO Multicenter Study, 2007). Moreover, many believe that contraception is only for married couples and even the married couples think that condoms are for those who have relationship with sex workers and not for husbands and wives relationships. Also many young people did not aware of its dual effect which is birth control as well as prevention from sexually transmitted infections. Some know how to prevent from unplanned pregnancies and adverse effect yet there still exist the barriers to practice (Ford & Kittisuksathit, 1996).

2.5 Attitude towards premarital sex and contraception

The attitude towards premarital sex is rather conservative particularly in Asia: in a study conducted in Myanmar adolescents by the Department of Health Planning, only 5% of men interviewed reported that it was acceptable for women to engage in premarital sex whereas 28% felt the same for men (UNICEF, 2000). Most students in Myanmar expressed a positive attitude towards sexual abstinence during adolescence and on engaging in sexual relationship only after marriage. A majority expressed a negative opinion regarding premarital sex (71.9% of males and 76.3% of females) (WHO, 2007).

A study conducted in migrant workers from Shanghai found out that 60% of the women disapproved of premarital sex; about 80% of them disapproved of premarital pregnancy and approximately 90% believed contraceptive use for premarital sex is required (Qian, et al., 2007).

2.6 Partner and peer involvement

The sexual revolution has ushered in a period where the average youth faces tremendous pressures to have sexual experiences of all kinds. Sexual misinformation

is, therefore, equally shared in the group. Effect of peer and friend is also important in youth nature. Effort to train peer educators and young leaders in sexual and reproductive health have contributed to increased use of contraceptives among youths in program areas (Elizabeth, 2000).

2.7 Access to reproductive health care services

Reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted infections (IPPF, 1994).

Access can be considered as having a sufficient amount of health services available and this availability of services can be measured in terms of costs that an individual incurs in obtaining care, such as travel costs or health benefits that they forgo by not obtaining care (Mooney, 1983).

UN Committee on Economic, Social and Cultural Rights stated that every human being has the right to health and the government has the responsibility to ensure public health program for all which consists of

a) available in sufficient quantity with respect to type and level of service
b) accessible to everyone without discrimination, including physical accessibility (within reasonable distance or reach) and economic accessibility (affordability)
c) acceptable (respectful of cultural differences, sensitive to gender and age or generational requirements, confidential, ethical) and appropriate with respect to their scientific and medical quality, including staff training and supervision, availability of essential supplies, hygienic standards, etc.

2.7.1 Availability of reproductive health services

Availability of health services is defined as functioning public health and health care facilities, goods and services, as well as programs in sufficient quantity. According to ‘The Inverse Care Law’ stated by Julian Tudor Hart (The

lancet, 1971), the availability of good medical care tends to vary inversely with the need for it in the population served. Besides, because of the public health policy which is for “public health” and not for a specific group, young migrants are not classified in health service medical records. The hospital and health center records aggregate the number of patients as 15-59 years old and above 60 years old as old aged people but not youths specifically. Obviously, reproductive health services are provided largely towards pregnant women or married women (United Nations, 2004). Despite these services among married women, there still exist induced abortion cases among them. This is the obvious indicator of the unmet need for contraception (Bankole, 1999; Ganatra, 2000; Jejeebhoy, 2000). Unmet need is defined as the proportion of women who want to space or limit births who are not using contraception. Moreover, when considering reproductive health services, all the services and organizations aim to married women group leading men as well as unmarried women to become a neglected group (WHO Multicenter study, 2007).

Hence, this indicates that both married and unmarried youths are at risk and in need of reproductive health information and services depending upon their underlying youth nature, health services availability, background knowledge and believes.

2.7.2 Accessibility of reproductive health services

a) Geographic accessibility

Geographical accessibility is generally defined as the percentage of the population living within one hour of a service delivery point providing contraception, safe motherhood and sexually transmitted infection services. With an increasing trend towards privatization and a market oriented economy, the poor are at a greater disadvantage. Inequities have increased and the facilities are not sufficient to protect the health of the poor (Country Health Profile Myanmar, 2007). It is not only because of the rapid gaping between the poor and the rich but because of their geographical distribution, for instance, in hilly regions, visiting health care center takes two or three days to walk across steep mountains. Indigenous people in rural areas were less likely to live within 25 kilometres of services and facilities and more than half had to travel more than 50 kilometres to a hospital, which correlates directly with poor health

outcomes. Likewise, some migrants live outreach areas and this becomes one of the barriers for adequate health access (Boustany, 2000).

b) Time accessibility

Most of the unmarried young migrants do not have chance to seek reproductive health services for reasons that include inconvenient schedules and locations, lack of privacy and confidentiality, fear of social stigma, the judgmental attitude of service providers and unaffordable fees (UN, 2004).

One study done in Thailand stated that youths are more likely to use reproductive health services for sexually transmitted infections, reproductive tract diseases and pregnancy tests at private clinics and private hospitals more than at government health centers. Because of lack of privacy, inconvenience, long waiting time, the lack of attention provided by health service providers, afraid of being stigmatized and discriminated, their illegal status and unmarried status, youth migrants prefer private health services rather than public services (Boonmongkon, 2000).

c) Economical accessibility

Migrants are one of the vulnerable groups which have poor health access due to barrier of affordability. Though the Thai government prescribed social insurance scheme (30 Bahts scheme) for migrant workers, it was meant to the registered workers, hence, the illegal and unregistered migrants are still in the vulnerable traps. Many studies found out that the population covered by the insurance can use the health services up to a certain level yet they have to face other barriers such as geographical inaccessibility, poor risk perceptions, privacy and confidential issues etc. Therefore, those uncovered by insurance are more at risk. The relationship between payment for the service and contraceptive use found to be significant. Among the current users, 75.76% were those who can access free services. This indicated that those who could not get free services still have resistance to use the services (Thwin, et al., 2008).

d) Cultural acceptability

WHO stated that all health facilities, goods and services must be respectful of medical ethics and culturally appropriate, as well as sensitive to gender and life-cycle requirements.

Social norms make it inappropriate for unmarried youths to be knowledgeable about reproductive services, information and contraceptive methods. There is also resistance to sex education among many Asians as it is still believed that it may lead to increased sexual activity among younger people. This makes the unmarried youths who have relationship with their partners difficult to find appropriate health services and prevention. Feelings of personal embarrassment, shame and the desire for concealment are likely to favor inaction over action; similarly, youths may favor private solutions over more public ones and non-formal-sector solutions over formal ones (WHO Multicenter study, 2007).

Among young female factory workers near Bangkok, concerns about unwanted pregnancy and STIs play a role in whether or not they will enter into a sexual relationship with a boyfriend. For those deciding to do so and to use contraception, they were more concerned about appropriate places where they could go for services rather than the methods that they should use. They would think about confidentiality and privacy first when they were in need of contraception (Soonthorndhada, 1996).

Unmarried young females felt uneasy because they felt that they were being condemned for their misbehavior either at public health services or factory clinics in which some counseling rooms were not sound proof or the care givers recognized them (WHO Multicenter study, 2007; Qian, et al., 2007).

2.8 Contraception

Universal access to contraceptive services to reduced unintended pregnancies is one of the UNFPA's three-pronged strategies to reduced maternal mortality.

Contraception is a substance or method when a person takes or practices to prevent from becoming pregnant as a result of sexual activity. There are many different types of contraception. Some are controlled by a woman (e.g. hormone

contraceptive pills or injections), and some by a man (e.g. condoms). Both partners are responsible for making decisions about sexual intimacy and contraception.

Reliable types of contraception are:

- Contraceptive injection
- Oral pills
- Emergency contraceptive pills
- Implants
- Condoms
- Diaphragm
- Vaginal ring
- IUD
- Sterilization

2.9 Contraceptive Prevalence Rate (CPR) and Unmet Needs

Strenuous effort on contraceptive programs over decades result dramatically improved contraceptive uptake in middle and low income countries. Nevertheless, in many countries including some with quite high rates of contraceptive prevalence, 40% or more of women who recently gave birth reported that the pregnancy was wanted later or not at all (DHS, 2009). Proportions of married women with an unmet need for contraception also range up to 30-40% or more in a number of countries (Bongaarts, 1997; Westoff , 2001).

The contraceptive prevalence among married migrant women in Thailand improves, yet, that of unmarried young migrants is not well-documented. According to the 2001 Fertility and Reproductive Health Survey (FRHS), approximately 37% of currently married women are using a method of contraception**,** including traditional methods but method failure appears to be a common problem in Myanmar as also 37% of women seeking treatment for complications of abortion report contraceptive use at the time of pregnancy occurred. The contraceptive prevalence rate for modern methods in Myanmar is 32.8%. However, the unmet need has been estimated at 17% in 2001, but would be higher if the needs of unmarried women were included (FRHS, 2001).

Maternal mortality rate (MMR) in Myanmar is 360 cases per 100 000 live births and perinatal condition is the 3rd leading cause of death of the country as per World Health Statistics 2006. Complications from unsafe abortion cause 13% of maternal deaths worldwide, and this can be reduced by preventing unwanted pregnancy through access to contraception (UNFPA, 2006b). It becomes a big challenge to public health as the government targeted 56 per 100 000 live births based on earlier 2001 data. Therefore, according to National and International data regarding MMR and CPR, it has become a great issue to the public health field that supporting environments such as reliable information and reasonable health care services are of need to Myanmar reproductive age women especially in youth migrant populations.

According to the long-term youth development plan (2002-2011) of the National Youth Bureau which stated that they would have equal access to the utilization of various services responding to their needs, adequate reproductive health services and information is a crucial part not only for them particularly but also for the well-being of the communities.

As migrants' quality of life and youths' reproductive health are important according to reaching the unreached policy and such populations exist in many countries and also account the majority of the world population, many operational researches, that can highlight their ill health and barriers or resistances they are facing, should be carried out thereby reaching the millennium development goal 2015.

CHAPTER III
RESEARCH METHODOLOGY

3.1 Research Design

Research design was quantitative cross sectional descriptive study design.

3.2 Study Area

The study was done in Bang Bon District in Bangkok, Thailand, located southwest of Bangkok.

3.3 Study Population

Study population was Myanmar migrant youths of age 15-24 years (United Nations definition of youths) among estimated number of 6,500 Myanmar migrant workers in Bang Bon District.

3.4 Sampling Technique

There was only one sub-district in Bang Bon which was also known as Bang Bon sub-district. Myanmar migrant youths of age 15-24 years, staying in Bang Bon, known NGO based health service providers, was selected by means of convenient sampling, irrespective of their migrant registration and marital status.

Inclusion criteria

- Myanmar migrant youths of age between 15-24 years
- Myanmar migrant youths who could speak Burmese (because some Myanmar migrants grown up along the border spoke their tribe language mainly and more familiar with their tribal language and Thai language)
- Myanmar migrant youths who were willing to participate in the research and give verbal consent

Exclusion criteria

- Myanmar migrant youths who could not completely answer the questionnaires

3.5 Sample & Sample size

According to Cochran's formula

$$n = \frac{Z^2 pq}{d^2} = \frac{(1.96)^2 (0.5) (0.5)}{(0.05)} = 384$$

n = sample size

Z = standard value for 95% confidence interval = 1.96

d = error allowance = 0.05

p = the proportion of targeted population who expected to use contraception = 50% = 0.5 (estimated prevalence of 50% was used in order to have the maximum sample sizes as there were no specific and similar studies on youth migrants)

q = 1-p = 1-0.5 = 0.5

10% of the calculated for missing data = 38

Therefore, sample size was 384+38 = 422 migrant youths.

The number of respondents who refused to participate was 39. Refusal rate of this study was 0.9%. As the sampling technique was convenient sampling, the sample size was continued interviewing until it met the calculated sample size. The total sample analyzed was 413 migrant youths after excluding the missing data.

3.6 Measurement Tools

Interviewer-administered questionnaires were used and the questionnaires were adapted from previous studies of contraception usage among married people and were in Burmese language. There were 4 main components 1) Socio-demographic factors 2) Personal factors 3) Peer and partner factors and 4) Reproductive health services access. These 4 main components were further divided into age, sex, marital status, education level, occupation, monthly income, race, religion, family/partner/friends companionship, duration of stay in Bangkok, migration status in Thailand, Thai and Myanmar (Burmese) language skills; contraceptive knowledge, attitude and belief towards premarital sex and contraception; premarital sexual practice, contraceptive usage; peer pressure in premarital sex

and contraceptive usage, partner involvement in premarital sex and contraceptive usage; and access to reproductive health information and services by means of availability, geographical, time and economical accessibility and cultural acceptability.

3.7 Data Validity and Reliability

The questionnaire was adapted from existing questionnaires which had been already validated by experts in previous studies (San, 2006, Soe, 2007 and Thwin, 2008). Field studies at least 3 times were made for rapid assessment in order to get appropriate design of the questionnaires. Pretest was done with 30 respondents in one of the factories in Bang Khun Thian and analyzed using Cronbach alpha in order to standardize the questionnaires prior to data collection. Cronbach alpha coefficients were 0.906, 0.723, 0.905 and 0.902 for knowledge, attitude, belief and health services accessibility respectively.

3.8 Data Collection

Data was collected by means of face-to-face interviews by the researcher and four research assistants. In order to limit interviewer bias a comprehensive training and field practice on interviewing were provided. Questionnaires were in Burmese language. With the help of the existing non-government organization Network for Migrant Worker Development NMWD at Bang Bon District, the research assistants were recruited and trained regarding research objectives, procedures and the do’s and the don’ts of effective interviewing. The interviews were done by using the same questionnaire. The interviewers were also trained to use alternative or indirect questions or friendly conversation in sexual behavior related questions which were thought to be difficult for the respondents to answer or hard to obtain the reliable information, for instance, the interviewers were trained to ask if the respondent ever accompanied his/her friend visiting club, karaoke, massage or sex worker because it was very popular and usual among young people nowadays and if so, if he/she had tried any of such behavior once and if they still answered yes, the questions were continuing asking if they had had sexual relationship at that time in case of ‘No’ answer to the direct question like if he/she had premarital relationship before. After each interview, the interviewer checked the answer and

clarified with the respondent. All the questionnaires were checked and clarified by the researcher at the end of every day. The interviewers were requested to note down the age and sex of the person who refuses to participate in the study in order to address self-selection biases during the analysis of results. Double counting of the respondents was not likely because health personnel were familiar with the youth community recognizing both partners. Besides, the boyfriends/girlfriends of the respondents were not from the same district mostly, as reported by personal communication with the health officer from the health center located in Bang Bon. Among the married youths, only one respondent either husband or wife was interviewed randomly.

3.9 Data Analysis

SPSS software version 16 for windows was used.

Descriptive statistics: frequency, percentage, mean and standard deviation were used to describe dependent and independent variables.

Inferential statistics: the relationships between the independent variables and dependent variables were determined by using Pearson's Chi-square test, Fisher's Exact test and Logistic Regression. All variables were analyzed with statistical significant level of 0.05.

3.10 Ethical Consideration

Ethical approval was obtained from the Ethical Committee of Chulalongkorn University and the purpose and procedure of the research were clearly explained not only to the research assistants but also to the respondents prior to the interviews. Informed consents were obtained verbally from those who voluntarily commit to participate. Those who were between 15 and 18 years old were assumed to be capable of giving informed consent by their own as they were apart from their guardianship and stood up for themselves for their livings (Civil and Commercial Code of Thailand, 1996). Privacy and confidentiality were strictly maintained; the questionnaires were coded anonymously, the respondents had the right to withdraw at any time throughout the process and none were traced. All the interviews were done according to the convenient time and place of the participants to maintain his/her privacy and comfortableness. The research

assistants were 2 males and 2 females in gender so that the participants were not be annoyed by different gender interviewers. The interviewers were as similar age group as the respondents so that friendlier, comfortable and trusted environment had been provided. Some respondents who needed to be referred to relevant services, research assistants did refer them, for example, those who suffered from forced sex were referred to the nearest counseling center for social supports and health information.

3.11 Limitation

As the research was conducted only in one of the districts in Thailand, the sample cannot be representative of all Myanmar youth migrants around Thailand. The study had age limitation as well, with ages below and above youth not covered and their risks not taken into account. There might also be limitations on the information gathered by the questionnaire, for example, if we asked the monthly income of the respondent, it was difficult to have the correct answer. There were many methods to estimate the actual socio-economic status of the studied population like personal possession and wealth assessment, calculation of income using monthly expense but this study did not undertake these processes due to time limitation and the main focus of the study was on their contraceptive practice and sexual behavior. The female respondents' pregnancy status was not accounted in the questionnaire so this study could not know whether the respondents were pregnant or postpartum mothers at the time of study thereby missing information to conclude the method failure, incorrect and inappropriate health information among the current users, and the number of women who temporarily stopped contraception due to ongoing pregnancy. The convenient sampling technique was used due to time and budget constraint and other limitations to make the systematic sampling, for instance, difficult to get the full census of youths in that area not only because of their migrant nature but also because of the factory owners' reluctance to give the workers' list in his/her factories. This weighed the limitation of the study more and could not provide the probability among Myanmar migrant youths in Bang Bon. Moreover, as the study was cross-sectional study, the variables and their relationship could not be studied in-depth.

Sexual behavior and premarital sexual relationship itself was one of the sensitive issues to get the truthful data especially in unmarried youths and female respondents. Therefore, this study used different research assistants not only for both male and female respondents but also to reduce the bias.

3.12 Expected Benefit & Application

This study will provide the level of contraceptive knowledge, the attitude, the belief and practice of premarital sex and contraception and reproductive health care access of Myanmar migrant youths in Bang Bon District of Bangkok and also the association between these factors and other hindering and favoring factors for their practice. This will highlight the importance of contraceptive and reproductive health knowledge and services which in turn associated to increased rate of unplanned pregnancies, abortion and other sexually transmitted infections. This will also provide the different needs and available services between the migrant youths working in urban area and rural area thereby able to trace the unmet needs of reproductive health services among those staying in cities and more urbanized areas. Based on the findings of the study, public health policy about reproductive health services to the migrants can be developed and strengthened not only along the border areas but also in the urbanized area.

CHAPTER IV

RESULTS

The study was conducted between 15th February and 26th February 2010 among Myanmar migrant youths in Bang Bon District, Bangkok. Total 413 youth migrants were face-to-face interviewed about their contraceptive usage in premarital and marital sexual practice and their reproductive health services accessibility.

This chapter contained the descriptive portion of the variables and the results showing the association between the variables. The descriptive portion was composed of 1) socio-demographic factors, 2) personal factors such as their knowledge, attitude, beliefs upon premarital sexual relationship and contraceptive usage, 3) their history and/or practice on premarital sexual relationship and contraceptive usage, 4) peer and partner factors in premarital sex and contraceptive usage and 5) lastly their reproductive health services accessibility.

4.1 Socio-demographic factors of the respondents

Table 4.1 described the socio-demographic factors (age, sex, marital status, occupation and monthly income). The majority (81.4%) of the respondents was 20 to 24 years old, ranged from 15 to 24 years and the median of 22 years. Gender distribution was nearly equivalent between male 46.7% and female 53.3%. Most of the respondents were single (45.5%), followed by living together and legally married (28.1%) and living together but not legally married (18.9%). The respondents were mainly factory workers (85%), the remaining 15% accounted for all other occupations. Majority (62.2%) of the respondents earned 4000-6000 Bahts monthly, with median income of 6000 Bahts.

Table 4.1 Frequency and Percentage of Respondents' Socio-demographic factors: Age, Sex, Marital status, Occupation and Income (n=413)

Socio-demographic factors			n	%
Age				
15-19 years			77	18.6
20-24 years			336	81.4
Mean ± SD = 21.52 ± 2.34	Median = 22	Range = 15-24		
Sex				
Male			193	46.7
Female			220	53.3
Marital status				
Single			188	45.5
Living together and legally married			116	28.1
Living together but not legally married			78	18.9
Divorced or separated			28	6.8
Widow			3	0.7
Occupation				
Factory worker			351	85.0
Domestic Helper			23	5.6
Seller			18	4.4
Construction worker			9	2.2
Random Laborer			9	2.2
Agriculture/Livestock worker			3	0.7
Monthly income				
< 4000 Bahts			30	7.3
4000-6000 Bahts			257	62.2
>6000 Bahts			126	30.5
Mean ± SD = 5838.74 ± 920.00	Median = 6000	Range = 2500-8000		

Many ethnic groups were represented among Myanmar migrants with Dawe being the majority (40.7%), followed by Bamar (29.3%) and others (30%). The great majority (88.1%) was Buddhist.

Myanmar migrant youths in this study lived with friends (43.1%), the rest stayed with spouse (31.2%), family (17.7%) and their boyfriends/girlfriends (8%). Details were shown in Table 4.2.

Table 4.2 Frequency and Percentage of Respondents' Socio-demographic factors: Race, Religion and Persons staying together (n=413)

Socio-demographic factors	n	%
Race		
Dawe	168	40.7
Bamar	121	29.3
Mon	54	13.1
Other (Karen, Shan)	39	9.4
Rakhine	31	7.5
Religion		
Buddhist	364	88.1
Christian	29	7.0
Islam	14	3.4
Hindu	6	1.5
Persons staying together in Bangkok		
Friends	178	43.1
Spouse	129	31.2
Family	73	17.7
Boyfriend/girlfriend	33	8.0

A little more than half (51.6%) of the respondents had been in Bangkok for one to three years with median of three years.

Almost all of the respondents, i.e., 93% were registered workers in Bangkok.

Majority of the respondents had attended middle school and high school (76.3%). A few had attended primary school and university (22.3%). Details were shown in Table 4.3.

Table 4.3 Frequency and Percentage of Respondents' Socio-demographic factors: Duration of stay, Migration status and Educational status (n=413)

Socio-demographic factors	n	%
Duration of stay in Bangkok		
< 1 yr	59	14.3
1-3 yrs	213	51.6
4-5 yrs	92	22.3
6-7 yrs	32	7.7
> 7 yrs	17	4.1
Mean ± SD = 3.32 ± 1.91 Median = 3 Range = 0.5-10		
Migration status		
Registered	384	93.0
Unregistered	29	7.0
Educational status		
No education (can read and write only)	6	1.5
Attend Primary School	71	17.2
Attend Middle School	187	45.3
Attend High School	128	31.0
Attend University	21	5.1

Regarding language skills, more than half (56.7%) of them could speak Thai well but could not read but most of them (88.4%) could speak, read and write Myanmar (Burmese) language well which was one of the inclusion criteria of this study. Details were shown in Table 4.4.

Table 4.4 Frequency and Percentage of Respondents' Socio-demographic factors: Thai and Myanmar (Burmese) Language skills (n=413)

Socio-demographic factors	n	%
Thai language skill		
Can read and speak well	18	4.4
Can speak well but can't read	113	56.7
Can understand a few	234	27.4
Cannot understand at all	48	11.6
Myanmar (Burmese) language skill		
Can read, speak and write well	365	88.4
Can speak well but can't read	24	5.8
Can understand a few	24	5.8

4.2 Personal factors of the respondents

4.2.1 Knowledge of contraception and premarital sex

There were only a few participants (5.1%) who had never heard of contraception. Those respondents got zero score because the second portion of knowledge question was skipped if they had never heard of contraception before. Almost all (94.9%) of them had heard of at least one type of contraception. Table 4.5 showed the respondents' knowledge upon each contraceptive method. Most of the respondents knew contraceptive methods like male condoms (95.1%), oral contraceptive pills (94.6%), injection (83.1%) and male sterilization (82.9%).

Table 4.5 Frequency and percentage of respondents' knowledge

	n	%
Heard of contraception (n=413)		
Yes	392	94.9
No	21	5.1
Methods of contraception (n=392)		
Male condom	373	95.1
Oral contraceptive pill	371	94.6
Injection	326	83.1
Male sterilization	325	82.9
Female sterilization	267	68.1
Emergency contraceptive pill	218	55.6
Withdraw before ejaculation	210	53.6
Periodic abstinence	171	43.6
Intrauterine device	157	40.0
Female condom	128	32.7
Implant	111	28.3

Few migrants (13.1%) had good level of knowledge and the rest had moderate level (39.0%) and poor level (47.9%) of knowledge.

Table 4.6 Level of knowledge (n=413)

	N	%
Poor knowledge (<24)	198	47.9
Moderate or fair knowledge (24-31)	161	39.0
Good knowledge (>31)	54	13.1
Mean ± SD= 21.81 ± 8.83 Median = 23 Range = 0-39		

Table 4.7 described the frequency and the percentage of the respondents who answered correctly to each knowledge question.

Amongst, the best known concepts were pills and injections should be taken regularly (daily and three monthly), they are not permanent methods like sterilization, linkage of unprotected sex and STIs including HIV-AIDS and unplanned pregnancy and abortion. The respondents' percentage ranged from 80.1% to 94.1%.

The least known concepts were side effects of oral pills, good point of injection that it cannot interfere with lactation, male sterilization cannot reduce sexual desire and cause weakness, condom can break if it is used improperly and its dual protection, the importance of the 2nd dose of emergency pills and the safe period, where the last one is not reliable and effective method due to large personal variation. The percentages ranged from 41.6% to 59.9%.

Table 4.7 The respondents who can answer correctly to the knowledge questions (n=392)

	n	%
1. Induced abortion can sometimes threaten a woman's life.	369	94.1
2. Women who take oral contraceptive (pill) should take a pill everyday to avoid becoming pregnant.	367	93.6
3. If the women do not want the children anymore, sterilization should be used.	361	92.1
4. Improper use of contraception can cause unplanned pregnancy.	356	90.8
5. Women can have children again by stopping to take pill or injection.	336	85.7
6. When you are suffering from STI, you have more chance to be infected by HIV.	324	82.7
7. You have more chance to suffer from STI if you have unprotected sex with many partners.	318	81.1
8. Depo injection should be taken once in 3 months to prevent pregnancy.	317	80.9
9. Using oral contraceptive pill can protect against sexually transmitted infections (STIs) including HIV/AIDS.*	280	71.4
10. Condom can break during using.	235	59.9
11. Oral pill can cause dizziness and nausea.	211	53.8
12. 2nd dose of emergency contraception should be taken 12 hours after the 1st dose.	208	53.1
13. Male sterilization can reduce sexual desire and it can cause weakness to men.*	200	51.0
14. Injection can cause cessation of breast milk.*	199	50.8
15. All contraceptive methods can prevent both STIs and pregnancy if used properly.*	198	50.5
16. Women cannot get pregnancy when they have intercourse 7 days before and 7 days after their menstrual period.	163	41.6

*Negative Statement

4.2.2 Attitude towards premarital sex and contraception

Attitude of the respondents towards premarital sexual relationship and contraception were described in Table 4.8 and Table 4.9. They were measured using five Likert's scales ranging from strongly agree to strongly disagree.

Only a few (8.5%) of the respondents had good attitude towards premarital sexual relationship and contraceptive usage while the rest had moderate (48.9%) and poor (42.6%) levels of attitude.

Though most (43.1%) of the respondents disagreed to practice premarital sexual relationship, some (32.7%) agreed to have premarital sex in men but not in women.

Majority (38.7%) of the respondents agreed that contraceptive utilization should be taught in the schools but they still thought that buying contraception is a shameful manner for unmarried youths (36.1%).

Many (45.0%) thought that discussion on using contraceptive is not a shameful manner among couples and almost half (49.2%) agreed that husband and wife should jointly decide the number of children.

Majority (40.7%) of them agreed that women need negotiation skills to convince her partner to use condom. Almost 45% of them felt uncertain if condom use could interfere with sexual activity.

Though three respondents did not provide their opinion, receiving zero score, they were not excluded as their answers were complete in other portions. But the reasons and any other bias upon this mutual opinion were not followed up due to their confidentiality and ethics.

Table 4.8 Level of attitude (n=413)

	N	Percentage
Poor attitude (<19)	176	42.6%
Moderate or fair attitude (19-25)	202	48.9%
Good attitude (>25)	35	8.5%
Mean ± SD = 19.64 ± 5.4 Median = 20 Range = 0-30		

Table 4.9 Percentage of respondents' attitude towards premarital sex and contraception usage (n=413)

		Percentage (Male/Female)				
		Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
1.	Premarital sexual relation is acceptable for those who promise to marry but can't marry yet.	**10.2** (8.0/ 2.2)	**22.0** (16.5/ 5.6)	**14.5** (8.0/ 6.5)	**43.1*** (13.6/ 29.5)	**10.2** (0.7/9.4)
2.	It is acceptable to have premarital sex for men but not for women.	**13.8** (5.8/ 8.0)	**32.7*** (21.5/ 11.1)	**22.3** (10.2/ 12.1)	**27.1** (8.7/ 18.4)	**4.1** (0.5/3.6)
3.	Contraceptive utilization should be taught in the school.	**36.6** (15.7/ 20.8)	**38.7*** (20.8/ 17.9)	**7.3** (2.2/ 5.1)	**16.0** (8.0/ 8.0)	**1.5** (.0/1.5)
4.	Discussion on using contraceptive is not a shameful manner among couples.	**44.1** (22.3/ 21.8)	**45.0*** (18.6/ 26.4)	**8.7** (5.8/ 2.9)	**1.5** (.0/ 1.5)	**0.7** (.0/0.7)
5.	Buying contraception is a shameful manner for unmarried boy or girl.	**16.7** (7.3/9.4)	**36.1*** (15.3/ 20.8)	**14.5** (9.4/ 5.1)	**26.2** (11.9/ 14.3)	**6.5** (2.9/3.6)
6.	Using condom can interfere with sexual activity.	**5.8** (3.6/ 2.2)	**22.3** (10.9/ 11.4)	**44.6*** (19.1/ 25.4)	**20.8** (9.4/ 11.4)	**6.5** (3.6/2.9)
7.	Husband and wife should jointly decide number of children.	**45.8** (20.1/ 25.7)	**49.2*** (25.2/ 24.0)	**2.9** (1.5/ 1.5)	**2.2** (.0/2.2)	**.0** (.0/.0)
8.	You need negotiation skill to convince your partner to use condom.	**36.8** (15.7/ 21.1)	**40.7*** (23.0/ 17.7)	**14.5** (5.8/ 8.7)	**7.3** (1.5/5.8)	**0.7** (0.7/.0)

***** The most frequent answer

4.2.3 Beliefs towards premarital sex and contraception

More than half (52.1%) of respondents were having high level of correct believes (five correct believes out of seven), 32.9% had middle level (two to five correct believes) and 15.0% had low level (one correct belief). It was shown in Table 4.10.

Table 4.10 The level of correct believes (n=413)

	N	Percentage
Low (<1.75)	62	15.0
Middle (1.75-5.25)	136	32.9
High (>5.25)	215	52.1
Mean ± SD = 4.86 ± 2.02 Median = 6.00 Range = 0-7		

The most frequent incorrect believes were the youths believed that they were not at risk of STI if their sex partners were their lovers or regular partners (30.8%), if the partner uses other contraception (28.3%), and by washing with soap properly after sex (26.3%). More than half (63.4%) of the respondents answered that people or their friends might look down or stigmatize them if they are found with condom.

Table 4.11 showed the detailed distribution of correct and incorrect believes for seven items.

Table 4.11 The frequency and percentage of the respondents' believes towards premarital sexual relationship and contraceptive usage (n=413)

	Correct		Incorrect	
	N	**%**	**N**	**%**
1. All STIs including HIV can be treated and cured.	340	82.3	73	17.7
2. Eating some kind of foods or fruits before sexual intercourse can prevent from becoming pregnant.	319	77.2	94	22.8
3. A woman does not become pregnant when she has unprotected sex with a man for the first time.	312	75.5	101	24.5
4. You cannot get STIs if you wash properly with soap after having sexual relationship.	304	73.6	109	26.4
5. You do not need to use condom to prevent STIs if your partner is using contraception.	296	71.7	117	28.3
6. You have no risk of STIs if you have unprotected sex with your lover or regular partner.	286	69.2	127	30.8
7. If you go for a shop for contraception and if your friends find you with condom, you will be looked down or stigmatized.	151	36.6	262	63.4

4.3 History and Practice of premarital sex and contraception

Table 4.12 showed the frequency distribution of the respondents who practiced premarital sex and contraceptive usage in such relationship.

Among 413 respondents, 75.3% had never practiced premarital sex before. Only 24.7% had such relationship, of which males accounted 70.6%. Median age for first sexual intercourse was 19 years (min - 16 yrs and max - 22 yrs).

Among 102 youths who experienced premarital sex, 91.2% had their wills to have sex at that time. Majority of their sex partners were their lovers (79.4%). Only 20.6% had their first intercourse with sex workers. Most (71.6%) of them used contraception at the time of first sex and the most common used contraception was condom which accounted 71.2%.

Table 4.12 Frequency and percentage of premarital sexual relationship and contraceptive usage

	n (Male/Female)	% (Male/Female)
Practice premarital sex (n=413)		
Yes	102 (72/30)	24.7 (70.6/29.4)
No	311 (121/190)	75.3 (38.9/61.1)
Age at first sexual intercourse (n=102)		
16 yrs	6 (6/0)	5.9 (100.0/.0)
17 yrs	9 (9/0)	8.8 (100.0/.0)
18 yrs	10 (7/3)	9.8 (70.0/30.0)
19 yrs	35 (20/15)	34.3 (57.1/42.9)
20 yrs	30 (24/6)	29.4 (80.0/20.0)
21 yrs	6 (3/3)	5.9 (50.0/50.0)
22 yrs	6 (3/3)	5.9 (50.0/50.0)
Mean ± SD = 19.14 ± 1.428 Median = 19 Range = 16-22		
Willing to have sex (n=102)		
Yes	93 (72/21)	91.2 (77.4/22.6)
No	9 (0/9)	8.8 (.0/100.0)
First sexual partner (n=102)		
Lover	81 (51/30)	79.4 (63.0/37.0)
Sex workers	21 (21/0)	20.6 (100.0/.0)
Contraceptive usage at first intercourse (n=102)		
Yes	73 (55/18)	71.6 (75.3/24.7)
No	29 (17/12)	28.4 (58.6/41.4)
Type of contraception used (n=73)		
Male condoms	52 (43/9)	71.2 (82.7/17.3)
Oral pills	9 (3/6)	12.3 (33.3/66.7)
Emergency pills	9 (6/3)	12.3 (66.7/33.3)
Injection	3 (3/0)	4.1 (100.0/.0)

Table 4.13 described the frequency distribution of contraceptive usage in both premarital and marital sexual relationships. 60% of the respondents were currently using contraception when 40% were not.

The most commonly used contraceptive methods were oral pills (42.4%), condoms (35.3%) and injections (20.1%). Among 90 respondents who were not using contraception currently, 65.6% had ever used one type of contraception whereas 34.4% had never used before. Types of contraception ever used were oral pills (49.2%), injections (25.4%), condoms (20.3%) and emergency contraceptive pills (20.3%). On asking the common reasons for not currently using, it was found that the respondents being afraid of the side effects (61.7%) and want more child (25.0%) among ever-users and lack of knowledge (54.8%) and afraid of side effects (19.4%) in the never-users.

Table 4.13 Frequency and percentage of current contraceptive usage

	n (Male/Female)	% (Male/Female)
Current usage of contraception (n=225)		
Yes	135 (68/67)	60.0 (50.4/49.6)
No	90 (45/45)	40.0 (50/50)
Type of current used contraception (n=135)		
Oral pills	59	42.4
Male Condom	49	35.3
Injection	28	20.1
Others (emergency pills)	3	2.2
Not current users (n=90)		
Ever usage	59 (31/28)	65.6 (52.5/47.5)
Never used before	31 (15/16)	34.4 (48.4/51.6)
Type of contraception ever used (n=59)		
Oral pills	29	49.2
Injection	15	25.4
Male condom	12	20.3
Emergency pills	3	5.1

Table 4.13 (Continued) Frequency and percentage of current contraceptive usage

	n	%
Reasons for discontinue (n=59)		
Afraid of side effects	37	61.7
Want more children	15	25.0
Culture and religion	4	6.7
Spouse lives away	3	5.0
Service unavailable	1	1.6
Reason for never used contraception (n=31)		
Lack of knowledge	17	54.8
Afraid of side effects	6	19.4
Service unavailable	5	16.1
Want children	3	9.7

4.4 Peer and partner factors

Table 4.14 described the peer and/or partner pressure in having sex and partner involvement in contraceptive utilization. About one fifth (23.5%) of those who practiced premarital sex experienced being pressured to have sex either by friends or partner. All of them (100%) used contraception in which 87.5% used condoms and 12.5% used emergency contraceptive pills.

Only 2.9% of the premarital-sex-experienced respondents revealed pressured sex by partner psychologically and they all used condoms (100%) at those events.

None of them accepted gifts/money/favor to practice premarital sex.

Among 225 current users of contraception (either in premarital or marital sexual relationships), 64.4% discussed with partner/spouse to use contraception where 35.6% did not.

Table 4.14 Frequency and percentage of peer pressure in having sex and partner involvement in contraceptive utilization

	n (M/F)	% (M/F)
Sexual relationship by peer pressure (n=102)		
Yes	24 (18/6)	23.5 (75.0/25.0)
No	78 (54/24)	76.5 (69.2/30.8)
Age at first sex by peer pressure (n=24)		
19	9 (6/3)	37.5(66.7/33.3)
20	12 (9/3)	50.0 (75.0/25.0)
21	3 (3/0)	12.5 (100.0/.0)
Mean = 19.75 SD = 0.68 Median = 20		
Contraceptive usage at pressured sex (n=24)		
Yes	24 (18/6)	100.0 (75.0/25.0)
No	0	.0 (.0/.0)
Type of contraception used (n=24)		
Male condom	21 (18/3)	87.5 (85.7/14.3)
Emergency pills	3 (0/3)	12.5 (.0/100.0)
Sexual relationship pressured by partner (n=102)		
Yes	3 (0/3)	2.9 (.0/100.0)
No	99 (72/27)	97.1 (72.7/27.3)
Age at first sex by partner pressure		
20	3 (0/3)	100.0 (.0/100.0)
Contraceptive usage at pressured sex by partner (n=3)		
Yes	3 (0/3)	100.0 (.0/100.0)
No	0	.0 (.0/.0)
Type of contraception used (n= 3)		
Male condom	3 (0/3)	100.0 (.0/100.0)
Sexual relationship by favor/gift/money (n=102)		
Yes	0	.0 (.0/.0)
No	102 (72/30)	100.0 (70.6/29.4)
Discuss with partner/spouse to use contraception (n=225)		
Yes	145 (69/76)	64.4 (47.6/52.4)
No	80 (44/36)	35.6 (55.0/45.0)

4.5 Availability and Accessibility of Reproductive Health Services

More than half of the respondents, i.e. 57.6% received supportive health education materials and health education such as pamphlets, posters, booklets, video show, trainings, etc. Among the youths who received the aids, 41.4% received between one and three different kinds of health information materials, mainly pamphlets, posters and booklets. Majority of the materials they received (44.5%) were in Myanmar (Burmese) language and from their friends (42%).

Three fifth (64.4%) of the respondents thought that they could access the contraception easily when they were in need. The most common places where most Myanmar youth migrants went for their contraception were drug stores (67.3%) by walking (71.1%) and it took for less than half an hour mostly (57.1%).

Nearly one third (29.3%) of the youths who thought to be able to access the contraception could receive them free of charge (mostly condoms) and 70.7% had to pay with subsidized rates. The prices of the contraception they used ranged from 9 Bahts to 300 Bahts depending upon the types and services. Among the youths who had to buy the contraception, 66.0% needed to pay less than 50 Bahts.

Detailed distribution was described in Table 4.15 and Table 4.16.

Table 4.15 Frequency and Percentage of the Availability of reproductive health education and materials

	n	Percentage
Availability of supportive health education/ materials (n=413)		
Yes	238	57.6
No	175	42.4
Number of health education/materials (n=238)		
Receive > 3 IEC materials	67	16.2
Receive 1-3 IEC materials	171	41.4
Receive none	175	42.4
Type of health education/materials (n=674)		
Pamphlets	164	24.3
Poster	148	22.0
Booklets	115	17.1
Health Education	95	14.1
Training	84	12.5
Video	68	10.0
Type of language used in health education/materials (n=238)		
Burmese	106	44.5
Thai	63	26.5
Both	69	29.0
Persons providing health education/materials (n=238)		
Friends	100	42.0
Health personnel (NGO/GO/Private clinic)	55	23.1
Relatives/Family members	45	18.9
Boss/Owner of the factory	38	16.0

Table 4.16 Frequency and Percentage of Accessibility of Contraception

	N	Percentage
Contraception accessibility (n=413)		
Yes	266	64.4
No	147	35.6
Place to get contraception (n=266)		
Drug stores	179	67.3
Health personnel from NGO	51	19.2
Private clinic	18	6.8
Friends	15	5.6
Public clinic	3	1.1
Transportation (n=266)		
Walking	189	71.1
Public vehicle	77	28.9
Time spent to get the contraception (n=266)		
Less than 30 minutes	152	57.1
30-60 minutes	101	38.0
More than 1 hour	13	4.9
Affordability (n=266)		
Free	78	29.3
Have to pay	188	70.7
Cost of contraception per unit (n=188)		
Less than 50 Bahts	124	66.0
50-100 Bahts	33	17.6
More than 100 Bahts	21	11.1
Don't know	10	5.3
Mean = 60.64 SD = 71.319 Median = 30 Range = 9 - 300		

Only 34.1% of the respondents had gender preference of the service providers or shop owner/seller of the drug stores, in which, 22% were males and 78% were females and majority 65.2% were single. Other 65.9% answered that they did not

have any gender preferences. Same gender preference of services provider was shown in Table 4.17 by gender and by marital status.

Table 4.17 Same Gender Preference of Services Provider/Drug Seller

	Preference of same gender provider	
	Yes (N/%)	**No (N/%)**
Sex		
Male	31 (22.0)	162 (59.6)
Female	110 (78.0)	110 (40.4)
Marital status		
Single	92 (65.2)	96 (35.3)
Living together, legally married	23 (16.3)	93 (34.2)
Living together, not legally married	16 (11.3)	62 (22.8)
Divorced/separated	10 (7.1)	18 (6.6)
Widow	0 (.0)	3 (1.1)
Total	141 (34.1)	272 (65.9)

4.6 Statistical analysis of Relationship between independent and dependent variables

The relationship between independent and dependent variables were determined by bivariate analysis. Chi square test and Fisher's Exact test were used to determine the association between the variables and the level of significance was set at P-value 0.05.

4.6.1 Relationship between socio-demographic factors and current contraceptive usage

Table 4.18 showed the relationship between socio-demographic factors and contraceptive usage in premarital and marital sexual relationships.

Current contraceptive usage during premarital and marital sexual relationships was found to be highly significant between marital status of the respondents (P-vale

<0.001). It was found the highest among living together but not legally married couples (73.1%).

It was also found highly significance between its usage and with whom the respondents staying together (P-value < 0.001). The rate of current contraceptive usage was the highest in those staying with spouse (69.0%) and with boyfriend and girlfriend (63.6%).

Statistical significance was also found between the duration of the respondents' stay in Bangkok and their contraceptive usage with P-value 0.006. Those who stayed for less than three years used higher (69.2%) than others.

Contraceptive usage was found significantly difference between the respondents' educational status with P-vale 0.034. Nearly three fourth (73.1%) of the respondents who had attended high school used contraception.

There were no significant difference between current contraceptive usage and other socio-demographic factors such as age, sex, occupation, monthly income, Race, religion, migrant status, Thai language skills and Myanmar (Burmese) language skills with P-values of 0.514, 1.000, 0.252, 0.431, 0.161, 0.829, 1.000, 0.725 and 1.000 respectively.

Table 4.18 Relationship between socio-demographic factors and current contraceptive usage (Chi square test) (n=225)

Socio-demographic factors	Current contraceptive use		x^2	P-value
	Yes	No		
	n (%)	n (%)		
Age				
15-19 years	9 (50.0)	9 (50.0)	0.425	0.514
20-24 years	126 (60.9)	81 (39.1)		
Sex				
Male	68 (60.2)	45 (39.8)	0.000	1.000
Female	67 (59.8)	45 (40.2)		

*** Statistically significant**

Table 4.18 (Continued) Relationship between socio-demographic factors and current contraceptive usage (Chi square test) (n=225)

Socio-demographic factors	Current contraceptive usage		x^2	P-value
	Yes n (%)	No n (%)		
Marital status				
Living together but not legally married	57 (73.1)	21 (26.9)	49.159	< 0.001*
Living together and legally married	77 (66.4)	39 (33.6)		
Widow, divorced and separated	1 (3.2)	30 (96.8)		
Occupation				
Factory worker	109 (62.3)	66 (37.7)	1.312	0.252
Others (construction/ agri & livestock worker/ domestic helper/ random laborer/ seller)	26 (52.0)	24 (48.0)		
Monthly income				
< 4000 Bahts	15 (71.4)	6 (28.6)	1.685	0.431
4000-6000 Bahts	74 (60.7)	48 (39.3)		
> 6000 Bahts	46 (56.1)	36 (43.9)		
Race				
Mon	20 (74.1)	7 (25.9)	5.146	0.161
Bumar	51 (63.0)	30 (37.0)		
Dawe	45 (51.7)	42 (48.3)		
Other (Rakhine, Karen, Shan)	19 (63.3)	11 (36.7)		

*** Statistically significant**

Table 4.18 (Continued) Relationship between socio-demographic factors and current contraceptive usage (Chi square test) (n=225)

Socio-demographic factors	Current contraceptive usage		x^2	P-value
	Yes n (%)	No n (%)		
Religion				
Buddhists	119 (59.5)	81 (40.5)	0.047	0.829
Others (Christians, Hindu, Islam)	16 (64.0)	9 (36.0)		
Persons staying together in Bangkok				
Spouse	87 (69.0)	39 (31.0)	28.816	< 0.001*
Boyfriend/girlfriend	21 (63.6)	12 (36.4)		
Friends	27 (50.0)	27 (50.0)		
Family	0 (.0)	12 (100.0)		
Duration of stay in Bangkok				
< 3 yrs	81 (69.2)	36 (30.8)	10.143	0.006*
3-7 yrs	37 (54.4)	31 (45.6)		
> 7 yrs	17 (42.5)	23 (57.5)		
Migration status				
Registered	126 (60.0)	84 (40.0)	0.000	1.000
Unregistered	9 (60.0)	6 (40.0)		
Education				
Attend primary school or can read and write	19 (51.4)	18 (48.6)	8.641	0.034*
Attend middle school	53 (54.1)	45 (45.9)		
Attend high school	57 (73.1)	21 (26.9)		
Attend university	6 (50.0)	6 (50.0)		

*** Statistically significant**

Table 4.18 (Continued) Relationship between socio-demographic factors and current contraceptive usage (Chi square test) (n=225)

Socio-demographic factors	Current contraceptive usage		x^2	P-value
	Yes n (%)	No n (%)		
Thai language skill				
Can read and speak well	12 (66.7)	6 (33.3)	0.123	0.725
Can speak + Can understand a few but can't read + Cannot understand at all	123 (59.4)	84 (40.6)		
Burmese language skill				
Can read, write and speak well	121 (59.9)	81 (40.1)	0.000	1.000
Can speak well but can't read + Can understand a few + Cannot understand at all	14 (60.9)	9 (39.1)		

4.6.2 Relationship between the respondents' knowledge, attitude, belief and current contraceptive usage

There was significant difference between the respondents' knowledge and current contraceptive usage (P-value = 0.006). The higher the level of knowledge, the more was the usage of contraception with 48.3%, 63.6% and 76.9% respectively. Contraceptive usage was the lowest in the respondents with poor attitude towards premarital sex and its usage (47.1%). It was found highly significant with P-value 0.001. Regarding the level of correct belief and contraceptive usage, there was also found significant difference (P-value = 0.018). Respondents with high level of correct belief (66.0%) practiced contraception more than the other two groups.

Table 4.19 Relationship between the respondents' knowledge, attitude, belief and current contraceptive usage (n=225)

	Current contraceptive usage		x2	P-value
	Yes N (%)	No N (%)		
Level of Knowledge				
Poor	42 (48.3)	45 (51.7)	10.182	0.006*
Moderate or fair	63 (63.6)	36 (36.4)		
Good	30 (76.9)	9 (23.1)		
Level of Attitude				
Poor	48 (47.1)	54 (52.9)	13.840	0.001*
Moderate or fair	78 (72.2)	30 (27.8)		
Good	9 (60.0)	6 (40.0)		
Level of Correct Belief				
Low	7 (35.0)	13 (65.0)	8.046	0.018*
Middle	35 (54.7)	29 (45.3)		
High	93 (66.0)	48 (34.0)		

*** Statistically significant**

4.6.3 Relationship between peer and partner factors and current contraceptive usage

Table 4.20 described the relationship between current contraceptive usage and peer or partner pressure and partner involvement in contraceptive usage.

It was found highly significant between the peer pressure and current contraceptive usage (P-value <0.001). All of the respondents (100%) being pressured by their peers or partners used contraception whereas 59.0% of those being not pressured used contraception.

There was also highly significant (P-value < 0.001) between partner involvement in decision making of contraceptive usage and current contraceptive usage. More than three quarters (77.2%) of the respondents who discussed with their partner about the contraception utilized it currently.

Table 4.20 Relationship between peer and partner factors and contraceptive usage

	Current contraceptive usage		x^2	P-value
	Yes	No		
	N (%)	N (%)		
Sex by peer pressure (n=102)				
Yes	24 (100.0)	0 (.0)	12.505	<0.001*
No	46 (59.0)	32 (41.0)		
Fisher's Exact test				
Discussion with partner (n=225)				
Yes	112 (77.2)	33 (22.8)	48.512	< 0.001*
No	23 (28.8)	57 (71.2)		

*** Statistically significant**

4.6.4 Relationship between reproductive health services accessibility and current contraceptive usage

Table 4.21 and Table 4.22 described the relationship between reproductive health services availability, accessibility, affordability and current contraceptive usage.

There was significant difference between health education materials availability and current contraceptive usage (P-value = 0.004). Youths who received health supports and information used contraception more (67.1%).

Contraceptive usage was the highest among youths who could access the services easily (71.8%). It was found highly significant with P-value < 0.001.

It was also found significant difference between places to get contraception and their practice (P-value < 0.001). Current contraceptive usage was higher in those who accessed the contraception from friends (100%) and drug stores (77.0%).

It was also found significant difference between the time taken to get contraception and the practice (P-value = 0.030). Youths who had to take long (more than an hour) were found the least use of contraception (33.3%).

There were no significant differences between Myanmar migrant youths current contraceptive usage and the number of health education materials they receive, the type of languages used in those materials, persons provided such health information, the transportation they took, their affordability, the cost they had to pay and the gender of the service provider or drug seller with P-values 0.239, 0.600, 0.933, 0.253, 0.357, 0.849 and 0.339.

Table 4.21 Relationship between health education and health education materials availability and current contraceptive usage

	Current contraceptive use			
	Yes n (%)	No n (%)	x^2	P-value
Availability of supportive health education/materials (n=225)				
Yes	100 (67.1)	49 (32.9)	8.445	0.004*
No	35 (46.1)	41 (53.9)		
Number of health education/materials (n=149)				
Receive > 3 IEC materials	24 (58.5)	17 (41.5)	1.388	0.239
Receive 1-3 IEC materials	76 (70.4)	32 (29.6)		
Type of language used (n=149)				
Thai	25 (71.4)	10 (28.6)	1.022	0.600
Burmese	48 (68.6)	22 (31.4)		
Both	27 (61.4)	17 (38.6)		
Persons providing health education/materials (n=149)				
Relatives/Family members	13 (72.2)	5 (27.8)	0.436	0.933
Health personnel (NGO/GO/Private clinic)	22 (68.8)	10 (31.2)		
Boss/Owner of the factory	21 (67.7)	10 (32.3)		
Friends	44 (64.7)	24 (35.3)		

*** Statistically significant**

Table 4.22 Relationship between contraceptive accessibility and current contraceptive usage

	Current contraceptive use		x2	P-value
	Yes n (%)	No n (%)		
Contraception accessibility(n=225)				
Yes	135 (71.8)	53 (28.2)	63.465	< 0.001*
No	0 (.0)	37 (100.0)		
Fisher's Exact test				
Place to get contraception (n=188)				
Friends	13 (100.0)	0 (.0)	17.897	< 0.001*
Drug stores	94 (77.0)	28 (23.0)		
Health personnel from NGO	19 (59.4)	13 (40.6)		
Public/Private clinic	9 (42.9)	12 (57.1)		
Transportation (n=188)				
Walking	95 (74.8)	32 (25.2)	1.308	0.253
Public vehicle	40 (65.6)	21 (34.4)		
Time spent to get the contraception				
Less than 30 minutes	75 (72.8)	28 (27.2)	7.015	0.030
30-60 minutes	57 (75.0)	19 (25.0)		
More than 1 hour	3 (33.3)	6 (66.7)		
Affordability (n=188)				
Free	35 (66.0)	18 (34.0)	0.850	0.357
Have to pay	100 (74.1)	35 (25.9)		
Cost of contraception (n=188)				
< 50 Bahts	75 (75.0)	25 (25.0)	0.036	0.849
≥ 50 Bahts	25 (71.4)	10 (28.6)		
Preference of same gender (n=413)				
Yes	26 (53.1)	23 (46.9)	0.914	0.339
No	109 (61.9)	67 (38.1)		

*** Statistically significant**

4.7 Multivariate Analysis

Logistic regression analysis was performed to reexamine the variables which were significant at bivariate level in order to see the clear picture of the association between variables. In bivariate analysis, 13 variables were found significantly associated but in multivariate analysis, only 7 variables were found significantly associated where educational status, peer pressure, level of correct belief, accessibility of the services, place and time taken to get contraception were turned out to be insignificant. Details were described in Table 4.23.

Marital status was found highly significant (P-value <0.001) even after controlling other variables in multivariate analysis and it has negative effect on current contraceptive usage. Living together but not legally married youths used contraception more than married and widow or divorced or separated youths with odd ration 0.100.

Duration of stay in Bangkok was also found highly significant after doing multivariate analysis (P-value = 0.001). It also had negative effect on contraceptive usage. The longer the stay in Bangkok, the lesser the current practice of contraception with odd ratio 0.381.

Persons staying together also had negative effect upon contraceptive usage (P-value <0.001). Persons stayed with their spouse or boyfriend/girlfriend used contraception more than the others with odd ratio of 0.402.

Discussion with partner or spouse to practice contraception was also found significant (P-value = 0.001) after multivariate analysis. Youths who discussed with their spouse or partner would like to use contraception currently than those who did not with odd ratio 0.008.

Level of knowledge had positive effect on current contraceptive usage after multivariate analysis and also significant (P-value = 0.027). The higher the level of knowledge, the more practice the contraception in their premarital and marital sexual relationships currently with odd ratio 2.274.

The level of attitude had also positive association with the current contraceptive usage with P-value 0.005 and odd ratio 3.074.

Availability of the reproductive health information was also found significantly associated with current contraceptive usage (P-value = 0.005). Youths those received the health information were using contraception more compared to those who did not with odd ratio 6.755.

Table 4.23 Logistic Regression Analysis of variables that maintain significant statistical association

Variables	B	OR	95% CI		P-value
			Lower Bound	Upper Bound	
Marital status	-2.300	0.100	0.040	0.251	<0.001
Duration of stay in BK	-0.966	0.381	0.214	0.678	0.001
Persons staying together in BK	-0.912	0.402	0.247	0.654	<0.001
Discussion with partner	-4.788	0.008	0.000	0.149	0.001
Level of knowledge	0.821	2.274	1.100	4.699	0.027
Level of attitude	1.123	3.074	1.397	6.764	0.005
Health supports availability	1.910	6.755	1.771	25.771	0.005

CHAPTER V
DISCUSSION

5.1 Discussion

This study aimed to assess the contraceptive prevalence rate among Myanmar youth migrants both married and unmarried, males and females residing in one urbanized district of Bangkok. Further details such as their socio-demographic factors, their background knowledge, attitude, belief towards premarital and marital sexual relationships were also browsed together with their reproductive health services and information accessibility hoping the benefits of getting the baseline data for both government and non-government organizations to strengthen the reproductive health related public health policy for migrant populations.

Prevalence of premarital sexual practice among Myanmar migrant youths in Bang Bon District was 24.7% comprising of 37.3% of male respondents and 13.6% of female respondents. The results showed much lower premarital sex than a study done in Chiang Rai Thai vocational students (15-21 years) where 48% of male and 43% of female youths had premarital sexual experiences (Manopaiboon, et al., 2003) and in School-based National Data of United States where 47.8% of youths (15-24 years) had ever had sexual intercourse (CDC, 2007). The study design could be one of the reasons for different findings as this study was face-to-face interview which was one of the hindering factors to get precise information regarding sexual practice whereas Chiang Rai's study was computer-assisted self-interview and CDCs's study used self-administered questionnaire. Different populations, different environments and different cultures could be other reasons for the different findings.

The median age at first sex was 19 years in both genders. Similar study was made in Myanmar youths (15-24 years) and found out that the median ages at first sex were 22 years for men and 19 years for women (Thwe, et al., 2003).

Contraceptive usage among youths in their first sex was 71.6% with 76.4% in males and 60% in females. This is encouraging finding as it is a protecting factor for youths from unwanted pregnancies, however it should be much higher in order to offer more protection. It is also comparable finding with a study done among teens

(14-19 years) in US in which 82% of males and 74% of females used contraception in their first sex (Abma, et al., 2004).

Condom was the most common form of contraception in the first premarital sex (71.2%). This is an encouraging finding because condoms offer dual protection. Similar findings were documented in unmarried youth factory workers (females) in Shanghai and youths in Myanmar where condom used was the commonest in youths' premarital sex, 44% in Shanghai (Qian, 2007) and 60% in Myanmar (Htoon, et al., 2000).

Contraceptive prevalence rate among sexually active Myanmar migrant youths in Bang Bon District was 60%, in which married youths accounted for 57.8% and unmarried youths accounted for 42.2%. This was comparable with the study done among Myanmar married women by UNFPA in which the rate was found to be 37% (UNFPA, 2006), where unmarried youths contraceptive practices were 51% in Thai vocational school students in Chiang Rai (Manopaiboon, et al., 2003) and less than 30% in Senegal (Katz & NARE, 2002).

Moreover, it was consistent with the studies done among Myanmar migrants in Thailand, 73.3% in Phang Nga Province (Soe, 2007) and 72.97% in Tak Province (Thwin, 2008) though it was slightly lower. This could be due to lower profile of the health needs of the migrants residing in city than those along the border as well as the differences of age group between the studies.

The most commonly used contraception were oral pills (42.4%), condoms (35.3%), injection (20.1%) and emergency pills (2.2%). This was generally similar to other Myanmar migrants in Thailand. Majority of Myanmar migrants, mostly reproductive age group (15-49 years) used injections, oral pills and sterilization as their contraception. Supportive findings were found in Myanmar migrants from Phang Nga (Soe, 2007) and Tak Provinces (Thwin, 2008). Regarding youths, a study in Myanmar adolescents (15-19 years) found out that injections (14.9%) and oral pills (8.6%) were the most common used contraceptives among young people (UNESCO, 2001) and a study in Chiang Rai Vocational school stated that Thai youths used oral pills mostly (69.5%) in their sexual relationship (Manopaiboon, et al, 2003). Moreover, Gray and Punpuing stated that oral pills, sterilization, and hormonal

injection accounted for 85% of contraception used in Thailand (Gray & Punpuing, 1999).

Condom used was higher in this study compared to the others because of the condom promotion program nowadays and nearby health center distributed free condoms to the migrant workers. On the other hand, though oral pills and injections were popular among married couples, unmarried couples prefer condoms as it was widely and anonymously available due to free distribution from health center via their peers and did not make them busy and obviously like the other methods, for example, oral pills are needed to take regularly, they need to go to health center for injection 3 monthly in which the health personnel recognized that they had sexual relationship with someone. In addition, it was encouraging practice as condom provides dual protection.

On tracing the history of contraception discontinuation and never using, it was found that due to the side effects (61.7%) and want more children (25.0%) were the main reasons among ever users. Gray and Punpuing stated that the major reason for contraceptive discontinuation throughout the world was due to the occurrence of side effects (Gray & Punpuing, 1999), yet lack of knowledge 54.8%, afraid of side effects 19.4% which was the consequences of the lack of knowledge and service unavailable 16.1% were the main reasons for never users. This indicates that unmarried youths need more information regarding sexual and reproductive health.

Peer pressure and partner involvement were also important in contraceptive usage and premarital sexual practice. As youths have very investigative and exploring mind and nature, peer power plays one of the important roles in modifying the behaviors of youths including sexual behavior (Gray & Punpuing, 1999). In this study, a few of the respondents (23.5%) committed that their first sex experiences were due to peer and partner pressure.

Likewise, partner involvement was also important in contraceptive use decision making especially for women. According to the Asian culture, women are perceived as passive decision makers especially in sexual practice. Those passive behaviors limit the power of young women to negotiate avoidance of pregnancy or disease when sex is likely (Gray & Punpuing, 1999). In this study, 100% of those who

answered that they did not will to have the first sex were female respondents. Regarding interspousal communication, 64.4% of current contraceptive users discussed with the contraceptive usage with their partners or spouses. Similar finding was recorded in the migrant women of Phang Nga Province where 59.1% of the current contraceptive users decided the contraceptive utilization after discussing with their partners (Soe, 2007).

There was no significant relationship between contraceptive use and age groups 15-19 and 20-24 years. CPR among 20-24 years (60.9%) was slightly higher than that among 15-19 years (50%). However, most of the contraceptive studies among Myanmar migrant workers found statistically significant difference between age groups and contraceptive usage. The reasons for the different findings of the previous studies and this study could be due to the differences of study populations and marital status, reproductive age group (15-49 years) versus youths (15-24 years) and married migrants versus both married and unmarried migrants. In this study, the population did not have much age difference, both being sexually active groups. It is reasonable to say that the younger unmarried people are more sexually active and less intention to take responsibility, thus more likely to use contraception but for the young adult married people, they will more likely to have children after settling down and for the older people, they may have less sexual activity. So there could be significant difference in the studies including wider range of age group while there could not be so much difference in the study focusing only on younger age group.

Regarding gender of the respondents, it was also found no significant difference between male and female respondents. The most common reason of the studied population came to Thailand as migrants was to work and earn money for their family stayed in their motherland or for their own survival. Therefore, no doubt, both males and females youths would like to prevent them or their partners from becoming pregnant not only because of the direct socio-economic reasons but also because of the fear of being absence from their works or being fired which indirectly influenced their economy. No matter do they have enough knowledge about STIs and other consequences or be their gender, they would like to use contraception for birth control.

Marital status of the respondents also affects the use of contraception. In bivariate analysis, it was found highly significant with P-value less than 0.001. It was still highly significant after multivariate analysis with P-value less than 0.001. It was reasonable to say that unmarried youths would likely to use contraception than married, divorced, separated or widowed ones. It was consistent with the study done in Burkina Faso where the contraceptive usage was more in unmarried youths (Dann, 2009) but contrary with the study done in Mexico where married used more (Barber, 2007).

Regarding educational status, more educated respondents were found to use contraception more than those who had lower educational level and it was significantly difference between educational status and current contraceptive use with P-value 0.034. Generally, the educated women are expected to use more contraception as they desire for fewer children and have more health knowledge. However, in multivariate analysis, educational status had no effect on current contraceptive usage. The finding was similar to the findings among reproductive aged (15-49 years) Myanmar migrants in Phang Nga Province (Soe, 2007) and Tak Province (Thwin, 2008).

Regarding monthly income of the respondents, 71.4% of the respondents with income less than 4000 Bahts, 60.7% of those with income between 4000-6000 Bahts and 56.1% of those with income more than 6000 Bahts used contraception currently. There was no significant association between monthly income and current contraceptive use and the finding was consistent with other studies among Myanmar migrants in Thailand by Thwin (Thwin, 2008) and Soe (Soe, 2007) and in Ethiopia by Beekle and Mccabe (Beekle & Mccabe, 2006). This could be due to the prices of contraception which had already been subsidized were reasonable and affordable for majority of the youth community and free distribution of condoms in some areas.

Race and religion were also found no significant effect upon the current contraceptive usage. Regarding race, 74.1% of Mon respondents used contraception. In the same manner, 63% of Bumar, 51.7% of Dawe and 63.3% of others like Rakhine, Karen, and Shan ethnic groups used contraception. More than half (59.5%) of Buddhist respondents used contraception currently while similar percentage

(64.0%) of other religions such as Christians, Hindu, and Islam used contraception, too. Similar finding was documented in Malaysian youths and in reproductive aged Myanmar migrants in Tak Province (Lee, et. al., 2006; Thwin, 2008).

Regarding persons staying together, 69% of the respondents staying with spouse, 63.6% of those staying with boyfriends or girlfriends where 50% of those staying with friends and none staying with family used contraception with P-value less than 0.001 in both bivariate and multivariate analyses. Generally, youths with spouse and partner are more likely to prevent themselves from being pregnant as they came to stay in Bangkok for their breadwinning (P-value <0.001). Moreover, as they are staying together, both take the responsibility for their future and would likely to prevent from unplanned pregnancies until they could settle down. A study done in Malaysia stated that youths staying with family and parents had less sexual activity and took less responsibility leading to less contraceptive usage compared with those living with spouse or partner whom had more chance to experience sexual activity freely (Lee, et.al., 2006).

Duration of stay in Bangkok was also found statistically significant with P-value 0.006 among current contraceptive users. The usage was found declining with the increasing duration of stay. Youths who stayed for less than three years practiced more contraception (69.2%) than those stayed for three to seven years (54.4%) and more than seven years (42.5%). Those who recently came would more likely to use contraception as they needed to cope with new environment and would like to settle down first in the previous years. As time passed and they had enough income to look after their own family, they may stop their current contraceptive usage with the expectation of having children (Soe, 2007). It was found statistically associated with current contraceptive practice even after multivariate analysis with P-value < 0.001.

Their registration status had no effect upon current contraceptive usage. In previous studies, the registration status had positively associated with the health practice (Belton & Maung, 2007; IOM, 2009). But, more than 90% of the migrants in Bang Bon District were registered which did not reflect the real picture of the migration status of the migrant population in Bangkok, 66% registered in 2001 (Martin, 2004). This inconsistency could be due to migrants in cities were covered by

the labour policy established in 2004 more than those in other regions (IOM, 2005) or youths might feel afraid and unsecured to disclose their status of migration (Smith, 2006). Whatever they were registered or unregistered, they may use contraception as almost all of the study population came to work in Bangkok to earn money and would like to avoid unplanned pregnancies until they were ready to take care of their own families.

Both Thai and Burmese language skills had no effect upon current contraceptive usage. This could be due to not much necessary of communication and language skills for purchasing and getting contraception. Some youths purchased the contraception mainly from drug stores and/or freely received from health personnel from non-government organizations where the former needed minimal or basic communication skill and for the latter, some health personnel from NGOs could speak Myanmar (Burmese) language. So it was obvious that the contraceptive use was not much different between diversity of language skills.

Regarding their knowledge, attitude and belief towards premarital sex and contraception, they were found significantly associated with current contraceptive usage in bivariate analysis (P-values = 0.006, 0.001 and 0.018). Respondents with high knowledge level, good attitude and high level of correct beliefs would like to practice contraception than those with poor knowledge, attitude and lower level of correct beliefs. This result was similar to the previous studies done in Myanmar adolescents (15-19 years) (FRHS, 2001) and Myanmar migrants (15-49 years) in Phang Nga (Soe, 2007). However, after multivariate analysis, belief had no effect upon the current usage. A study done in Bhutan found out that no association between the belief and the practice (Lhamu, 2004). However, non-user proportion was the highest among poor level of correct beliefs. Therefore, it is still important to provide the migrant youths with adequate information about safe sex behavior and contraception in order correct their wrong beliefs.

The respondents were found little knowledge in commonly used methods such as oral pills, injections, condoms and emergency pills. It was comparable with the migrants in Phang Nga province where the least known concepts were about injection and oral pills but higher knowledge of condoms (Soe, 2007). Therefore, more health

education on contraceptive methods including condoms should be provided to the migrant youths in Bang Bon District as it provides dual protection and they used it widely. Among never users, lack of knowledge (54.8%) was one of the most commonly responses showing that some unmarried youths are still needed to receive the health information.

Some respondents (32.7%) accepted to have premarital sex in men but not in women though they disagreed to practice sex before marriage. It is so usual in Asian countries that gender inequality plays a role especially in sexual practice and decision making (Gray & Punpuing, 1999) Therefore, promoting of gender equality is found as important as the reproductive health education.

Among the poor level of correct beliefs, youths in Bang Bon District were found to have incorrect believes regarding the prevention of STIs. Though they are using condoms widely in their premarital sexual relationship, there still exists the resistance of unmarried youths purchasing and having condoms. This sensitive issue was common in unmarried population of Asian countries (UNESCO, 2001; Soe, 2007).

Interspousal communication is also very important in contraceptive practice. Male involvement and both partners' decision to prevent themselves from contracting STIs as well as unwanted pregnancy are the main mediating variables for the practice (Gray & Punpuing, 1999). Similarly, in this study discussion with partner and current contraceptive usage was found significantly associated in both bivariate (P-value <0.001) and multivariate (P-value = 0.001) analyses.

Availability and accessibility of health services is one of the important factors in migrant health. Majority of the migrants suffer from geographical, time, economic and cultural inaccessibility. Likewise, health information availability was found statistically significant for current contraception usage. Youths who received health supports and information would likely to use contraception in their premarital and marital sexual intercourses (67.1%) than those who did not receive (46.1%). P-values were found to be 0.004 in bivariate analysis and 0.005 in multivariate analysis. However, contraceptive usage was no difference between the numbers of the health supports materials that youths received, the types of languages used and providers

who provided those materials. It was due to the fact that about three quarters (76.5%) of the respondents who received health information materials had these materials in Myanmar (Burmese) language and they did not have much language problem and did not need Thai language skills to understand them.

Majority of the current users accessed the contraception from their friends and drug stores and they could get there by walking and some took less than half an hour. Youths who received from friends (100.0%) or bought from drug store (77.0%) and took less than an hour (75%) would likely to use contraception more than those who received from private or public clinics (62.1%) and took more than an hour (33.3%). Youths feel more comfortable and convenient to use the contraception from their peers and drug stores which could give them more privacy. But after multivariate analysis, they had no effect on current contraceptive usage.

In terms of affordability, the result showed there was no significant difference between different costs of contraception. The contraceptive usage was unnoticeably fewer (66%) in those who received free than those had to pay (74.1%). This indirectly indicates to review the youths' knowledge and information upon freely available services. Moreover, the usage was not much difference between those who had to pay less than 50 Bahts and more than 50 Bahts, 75% and 71.4% respectively. This could be due to the fact that the most common forms of contraception youths used eg. Condoms, pills etc. were freely or heavily subsidized and therefore cheaply available in Thailand. The prices of contraception in Bang Bon District ranged from free of charge to 300 Bahts. This was contrary from the study among Myanmar migrants in Phang Nga province which had wider range of free to 8000 Bahts and significant association between the affordability and the practice (Soe, 2007).

Regarding the preferences of gender of the service provider or seller, majority (61.9%) of those who did not have any same gender preference used contraception where 53.1% of those who cared about gender of service provider used contraception. When females are served by male providers who are equally uneasy about giving women detailed information on the method (Gray & Punpuing, 1999). However, it was found no significant difference between current usage and the gender preference.

5.2 Conclusion

Although many Myanmar migrants were congregated in Bang Bon District, there was no previous documented study about them. Therefore, based upon the findings of this study, public health policy about reproductive health services to the migrants can be strengthened.

Out of 413 youth migrants, a quarter (24.7%) had premarital sexual relationship. As an encouraging factor, majority (71.2%) of them used condoms during their first sex. The main reason for this best practice was due to freely and/or widely availability of subsidized condoms from the existing health center. This good practice should be promoted and carried on as the current contraceptive prevalence rate dropped down to 57% among unmarried youths. Overall current contraceptive prevalence rate was 60.0%.

Majority of the youth respondents had good attitude towards premarital sex and contraceptive usage yet, were still having poor and moderate level of knowledge upon them. Moreover, some had incorrect believes regarding the prevention from unwanted pregnancy and from STIs.

Regarding health information availability, most of the youths in Bang Bon received the information in the language they could understand which is one of the advantages for them to have correct information about the sexual and reproductive health. But youths were found more convenient to have the information and contraception from their peers and drug stores. Though condom practice was higher among them, there was resistance and discrimination for the unmarried youths' contraceptive usage.

The relationship between the independent variables and the current usage of contraception was analyzed by Chi square test and Fisher Exact test, marital status, duration of stay in Bangkok, persons staying together, discussion of contraceptive usage with partner, level of knowledge and attitude and health support availability were found statistically associated with current contraceptive usage after controlling other variables in multivariate analysis

Reviewing the previous studies and the finding of this study persistently indicated that there is the information gap regarding reproductive health information

to the migrants. Poor level of knowledge and high prevalence rate are the best indicators of such gap which can lead to misusage and unwanted effects. Though the migrant youths received health information up to a certain level, some are found not useful and effective for them, for instance, the information are in the languages that they cannot understand and/or in a very formal way that youths are not interested in. Some respondents reported that they would like to receive more sexual health information and other kinds of contraception with cheaper price like condom free distribution.

5.3 Recommendation

- CPR found in this study (60%) is satisfactory; however, the remaining 40% should also be encouraged by providing proper information.
- Condom is found to be the most frequent used contraceptive in the youths' premarital relationship. This is an encouraging factor as compared to the youths in Myanmar where condoms' use accounts only 0.3% of all the contraceptives used in 2001 (UNESCO, 2004).
- Health education on the do's and don'ts including the advantages of the contraception especially the particular methods they are practicing such as oral pills, male condoms, injection and emergency pills, etc. is crucial for the migrant youths in Bang Bon. Eg. dual protection of condoms, importance of the 2nd dose of the emergency pills
- Health education contents should be extended up to the prevention of STIs and unplanned pregnancy and gender equality and equity because a few youths do not recognize how to prevent them from STIs and the finding shows gender inequality as in other Asian culture (Gray & Punpuing, 1999), for example, premarital sex is acceptable for men but not for women.
- Health education to the youths alone is not enough. As the findings show sensitivity of youths' reproductive services seeking behavior, health information should also be disseminated to the elder migrants.

- Sexual and reproductive health information should be started teaching in migrant schools because it is already accepted by the majority (38.7%) of the respondents.
- The contents and ways of health education are also important. More reproductive health information with familiar language, simple usage and description would be helpful to promote youth migrants' knowledge level. As the effectiveness of information dissemination mainly depends upon the preference and acceptance of the recipients (WB, 2009), the effectiveness of the health education materials and methods should be revised.
- Moreover, replacement of health talks and education in the formal ways by alternative participatory discussion and learning methods will be useful so that the services provided will meet the real needs of the youth migrants.
- The contraceptive usage was a little bit fewer (66%) in those who received freely than those had to pay (74.1%). This indirectly indicates to review the youths' knowledge and information upon freely available services and the existing health center nearby. If they do not have enough information, more advertisement or information dissemination will be needed.
- The findings show that majority of unmarried females preferred the same gender service providers though it was not significant. As there are no special health services for youths and such population longs for non-discriminated and warm environment to disclose and consult their feelings and difficulties (UNFPA, 2006a), sexual health counseling program to youths might be helpful for the needy youth community.
- Moreover, among those who had first sex against their will, even with their boyfriends, female respondents represented the whole proportion (100.0%). Women role and gender violence among migrant youths in Bang Bon should be considered and studied more.
- Exploring the differences of the findings of this study and the previous studies, qualitative research would be helpful to the health policy makers of migrants and it will provide better understanding of the youths' nature regarding sexual and reproductive health.

REFERENCES

Abma, J.C., Martinez, G.M., Mosher, W.D., Dawson, B.S. (2004). Teenagers in the United States: sexual activity, contraceptive use, and childbearing, 2002. **Journal of Centers for Disease Control and Prevention** 23(24): 87.

Altschuler, D., Stangler, G., Berkley, K., & Burton, L. (2009). **Supporting Youth in Transition to Adulthood: Lessons Learned from Child Welfare and Juvenile Justice.** Chicago: John, D. and Catherine, T. MacArthur Foundation.

Amnesty International. (2006). **Thailand: The Plight of Burmese Migrant Workers.** Field Report No. 2004-2005. Thailand: Amnesty International.

Anderson E. Stanciole, H. Manfred. (2009). **Access to Health Care for Migrants, Ethnic Minorities, and Asylum Seekers in Europe.** Vienna: European Center for Social Welfare Policy and Research.

Bankole, A., Singh, S., & Haas, T. (1999). Characteristics of Women who Obtain Induced Abortion: A Worldwide Review. **Guttmacher Institute** 25(2): 68-77.

Barber, S.L. (2007). Family planning advice and postpartum contraceptive use among low-income in Mexico. **International Family Planning Perspectives** 33(1): 6-12.

Beekle, A.T. & Mccabe, C. (2006). Awareness and determinants of family planning practice in Jimma, Ethiopia. **International Nursing Review** 53(4): 269-276.

Belton, S. & Maung, C. (2007). Fertility and Abortion: Burmese Women's Health on the Thai-Burma Border. **Health Care Women International** 28(4): 419-33.

Bhushan, A. (September, 2008). Poverty and Health: A Framework for Analysis and Action. **13th Training Course of New Health Leaders, World Health Organization Regional Office for the Western Pacific**. Geneva: World Health Organization.

Bongaarts, J. (1997). Trends in Unwanted Childbearing in the Developing World. **Studies in Family Planning New York** 28(4): 267-277.

Boonmongkon, P. (2000). Towards a Model Gender-sensitive Reproductive Health Care Programme for Rural Women: ARROWS for change. **ARROW's Publications** 6(1): 4.

Boustany, J. (2000). **Rural Health Access Problems Facing the Aboriginal Community** [Online]. Available from: http://www.medicineau.net.au/clinical/abhealth/abhealt3504.html [October 11, 2009].

Brown, A., Jejeebhoy, S. J., Shah, I., & Yount, K. M. (2001). **Sexual Relations among Young People in Developing Countries**. Geneva: World Health Organization.

Caouette, T., Archavanitkul, K., & Pyne, H. H. (2000). **Sexuality, Reproductive Health and Violence: Experiences of Migrants from Burma in Thailand, Bangkok, Thailand**. Doctoral dissertation, Institute for Population and Social Research, Mahidol University, Bangkok.

Center for Disease Control and Prevention [CDC]. (2008). **Morbidity and Mortality Weekly Report 2008.** Washington, DC: Centers for Disease Control and Prevention.

Centers for Disease Control and Prevention [CDC]. (2007). **Youth Risk Behavior Surveillance - United States, 2007.** Washington, DC: Centers for Disease Control and Prevention.

Cleland J., Ingham R. and Stone N. (2000). **Asking Young People about Sexual and Reproductive Behaviors: Illustrative Core Instruments**. Geneva: World Health Organization.

Dann, G. (2009). **Sexual Behavior and Contraceptive Use among Youths in West Africa** [Online]. Available from: http://www.prb.org/Articles/2009/westafricayouth.aspx [January 5, 2009].

d'Arcangues, C., Francisco, A. d., & Dixon-Mueller, R. (2007). **Research Issues in Sexual and Reproductive Health in Low- and Middle-Income Countries**. Geneva: Global Forum for Health Research and World Health Organization.

Demographic and Health Surveys [DHS]. (2009). **Need for Family Planning Services**. Maryland: Demographic and Health Surveys.

Eggleston, E., Jackson, J., & Hardee, K. (1999). Sexual Attitudes and Behavior among Young Adolescents in Jamaica. **International Family Planning Perspectives, Guttmacher Institute** 25(2): 78-84.

Elizabeth T. Robinson. (2000). **Programs for Adolescents: Neighborhood Peer Educators in Mali.** Western Africa: Family Health International.

Fertility and Reproductive Health Survey [FRHS]. (2001). **Ministry of Immigration and Population Myanmar Fertility and Reproductive Health Survey (2001 Preliminary Report).** Yangon: Department of Population and UNFPA.

Ford, K., & Chamrathrithirong, A. (2007). Sexual Partners and Condom Use of Migrant Workers in Thailand. **AIDS and Behavior, Springer Netherlands** 11(6): 905-914.

Ford, N., & Kittisuksathit, S. (1996). **Youth Sexuality: The Sexual Awareness, Lifestyles and Related Health Service Needs of Young, Single, Factory Workers in Thailand.** Institute for Population and Social Research, Mahidol University

Ganatra, B. (2000). Abortion Research in India: What We Know and what We Need to Know. In Ramasubban, R., & Jejeebhoy, J. S (Eds.), **Women's Reproductive Health in India**. Jaipur and New Delhi, India: Rawat Publications.

Gray, A., & Punpuing, S. (1999). **Gender, Sexuality and Reproductive Health in Thailand.** Thailand: Institute for Population and Social Research, Mahidol University

Gultiano, S., & Xenos, P. (2004). **Age-structure and Urban Migration of Youth in the Philippines.** Philippines: University of San Carlos.

Hieu, D. T., Hanenberg, R., Vach, T. H., Vinh, D. Q., & Sokal, D. (1995 & 1999). Maternal Mortality in Vietnam in 1994-95. **Studies in Family Planning** 30(4): 329-338.

Htoon, P. T., Myint, Y. Y., & Thwe, M. (2000). Risk Behaviors, Attitudes and Subjective Norms among Ninth Standard Students in Hlaing Township. **Regional Health Forum** 3(1): 1-10.

International Labor Organization [ILO]. (1998). Forced Labor in Myanmar (Burma). **Commission of Inquiry Appointed under Article 26 of the Constitution of ILO**. Geneva: International Labor Organization.

International Labor Organization [ILO]. (2009). **Migrant and Refugee Youth Statistical Profile 1996 to 2007**. New Zealand: Asian Decent Work Decade Knowledge Network, International Labor Organization.

International Organization of Migration [IOM]. (2005). **World Migration Report 2005.** Thailand: International Organization of Migration.

International Organization of Migration [IOM]. (2009). **Healthy Migrants: Healthy Thailand - Improving Health Conditions of Migrants in Priority Provinces of Thailand.** Thailand: International Organization of Migration.

International Planned Parenthood Federation [IPPF]. (1994). **Resources Glossary** [Online]. Available from: http://www.ippf.org/en/Resources/Glossary.htm?g=R [October 19, 2009]

Jejeebhoy, S. J. (2000). **Women's Reproductive Health in India**. Jaipur and New Delhi: Rewat Publications.

Jekielek, S. & Brwon, B. (2005). **The Transition to Adulthood: Characteristics of Youths Ages 18 to 24 in America.** Washington DC: The Annie E. Casey Foundation, Population Reference Bureau, and Child Trends.

Katz, K. & NARÉ, C. (2002). Reproductive Health Knowledge and Use of Services among Youths in Dakar, Senegal. **Journal of Biosocial Science** 34(2): 215-231.

Lee, L.K, Chen, P.C.Y., Lee, K. K. & Kaur, J. (2006). **Premarital sexual intercourse among adolescents in Malaysia: a cross-section Malaysian school survey**. Singapore: Singapore Medical Association, Singapore.

Lhamu, C. (2004). **Factors Effecting Utilization of Contraceptives among Married Women of Reproductive Age (15-49 years) in Punakha District, Bhutan.** Master's thesis, College of Public Health Sciences, Chulalongkorn University.

Manopaiboon, C., Kilmarx, P. H., Griensve, F. V., Chaikummao, S., Jeeyapant, S., Limpakarnjanarat, K., et al. (2003). High rates of pregnancy among vocational school students: results of audio computer-assisted self-interview survey in Chiang Rai, Thailand. **Journal of Adolescence** 26: 517-530.

Margaret, E., Greene & Merrick, T. (2005). Poverty **Reduction: Does Reproductive Health Matter?** Washington, DC: The World Bank.

Martin, P. (2004). **Thailand: Improving the Management of Foreign Workers.** Thailand : International Labour Organization.

PICUM. (2007). **Access to Health Care for Undocumented Migrants in Europe.** Belgium: Platform for International Cooperation for Undocumented Migrants.

Population Reference Bureau [PRB]. (2006). **The world youth 2006 data sheet.** Washington DC: Population Reference Bureau.

Prevention of HIV-AIDS Among Migrant Workers in Thailand [PHAMIT]. (2009). **Migration in Thailand and Migrants' Vulnerability** [Online]. Available from: http://www.phamit.org/migrants_vuln1.html [September 6, 2009]

Qian, X., Smith, H., Huang, W., Zhang, J., Huang, Y., & Garner, P. (2007). **Promoting contraceptive use among unmarried female migrants in one factory in Shanghai: a pilot workplace intervention**. Shanghai: Fudan University School of Public Health.

Sakai, M., Sillabutra, J., & Keiwkarnka, B. (2007). Preventive Behavior against Dengue Hemorrhagic Fever among Migrants. **Journal of Public Health and Development, Mahidol University** 5(3): 8.

San, K. L. (2007). **Preventive Sexual Practice among Sexual Workers in Yangon, Myanmar.** Master's Thesis, Institute for Population and Social Research, Mahidol University.

Sandhikshetrin, K. (1996) .**Civil and Commercial Code, Books I-VI and glossary. (1996).** Nitibannakaan, Bangkok: The Council of State of Thailand.

Schoemaker, J. (2005). Contraceptive use among the poor in Indonesia 2005. **International Family Planning Perspectives** 31(3): 106-114.

Silva, W. I. D. (1996). The Silent Cry: Socio-cultural and Political Factors Influencing Induced Abortion in Sri Lanka. India: International Union for the Scientific Study of Population.

Singh, S. et al. (2000). Gender differences in the timing of First Intercourse: Data from 14 countries. **International Family Planning Perspectives** 26(1): 43.

Smith, R. (March, 2006). **Protection the Labor Rights of All Migrant Workers in the Americas.** Washington DC: American University Washington College of Law.

Soe, H. H. K. (2007). **Contraceptive Usage among Myanmar Migrant Women of Reproductive Age in Phang Nga Province, Thailand**. Master's Thesis, Colledge of Public Health, Chulalongkorn University.

Soonthorndhada, A. (1996). **Sexual Attitudes and Behaviors and contraceptive use of Late Female Adolescents in Bangkok: A Comparative Study of Students and Factory Workers.** Doctoral dissertation, Institute for Population and Social Research, Mahidol University.

Thwe, D. M., D. A. M. Soe, et al. (2003). **Behavior Surveillence Survey, General Population and Youth.** Union of Myanmar: National AIDS Control Programs, Ministry of Health, Department of Health.

Thwin, T. (2008). **Factors related to the contraceptive use among married migrant women of reporductive age in Mae Sot, Tak Province, Thailand**. Master's Thesis, Institute for Population and Social Research, Mahidol University.

United Nation [UN]. (2009). **Trends in International Migrant Stock: The 2008 Revision.** United Nations: Department of Economic and Social Affairs, Population Division.

United Nation Children's Fund [UNICEF]. (2000). **Men's Knowledge, Attitude and experiences of Sexually transmitted infections.** Union of Myanmar: United Nation Children's Fund.

United Nation Population Fund [UNFPA]. (2006a). **Adolescent Fact Sheets, Myanmar.** Union of Myanmar: United Nation Population Fund.

United Nation Population Fund [UNFPA]. (2006b). **Maternal and Neonatal Health in East and South-East Asia**. Thailand: United Nation Population Fund.

United Nations Educational, Scientific and Cultural Organization [UNESCO]. (2004). **Myanmar Country Profile: Demographic Social and Economic Characteristics of Adolescents.** Thailand: United Nations Educational, Scientific and Cultural Organization.

UPPI. (2002). **Youth Fertility and Sexuality Study.** Philippine: University of the Philippines Population Institute.

Warakamin, S., Boonthai, N., & Tangcharoensathien, V. (2004). Induced abortion in Thailand: current situation in public hospitals and legal perspectives. **Reproductive Health Matters** 12(24 Suppl): 147-156.

Westoff, C. F. (2001). **Unmet Need at the End of the Century**. ORC Macro, Calverton, Maryland USA: MEASURE DHS+.

WHO, UNICEF, & UNFPA et al. (2000). **Maternal Mortality in 2000: Estimates Developed by WHO, UNICEF and UNFPA, World Health Organization**. Geneva: World Health Organization.

World Bank [WB]. (2009). **Information, Education and Communication (IEC) Materials and Events.** Washington DC: The World Bank.

World Bank and World Health Organization. (2007). **Research Issues in Sexual and Reproductive Health for Low- and Middle-income Countries**. Geneva: Global Forum for Health Research and World Health Organization.

World Health Organization [WHO] Multicenter Study. (2007). **Adolescent Migrants in the Greater Mekong Subregion: Are they equipped to protect themselves against sexual and reproductive health risks?** Geneva: WHO.

World Health Organization [WHO]. (2003). **Towards Adulthood: Exploring the Sexual and Reproductive Health of Adolescents in South Asia**. Geneva: Department of Reproductive Health and Research, WHO.

World Health Organization [WHO]. (2007). **Country Health Profile Myanmar**. Union of Myanmar: World Health Organization and Ministry of Health.

World Health Organization, Adolescent Health and Development [WHO, AHD]. (2007). **Adolescent Health FactSheet – Myanmar.** Union of Myanmar: Adolescent Health and Development, WHO.

World Population Prospects: The 2004 Revision and World Urbanization Prospects: The 2004 Revision. (2004). United Nation: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat.

World Population Prospects: The 2008 Revision. (2008). United Nation: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat.

APPENDICES

APPENDIX A

Participant Information Sheet

Title of research project Practice of Contraception in Premarital and Marital Sexual Relationship among Myanmar Youth Migrants in Bang Bon District, Bangkok and their Reproductive Health Services Accessibility

Principle researcher's name Win Mar Han

Position Master of Public Health Student

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1. You are being invited to take part in a research project. Before you decide to participate it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and do not hesitate to ask if anything is unclear or if you would like more information.
2. This research project involves interviewing participants about different factors that include basic information, contraceptive knowledge, attitude and belief towards premarital sex, sexual practice, contraceptive usage and their accessibility of reproductive health services in order to see association between them.
3. Objective (s) of the project: To assess the contraceptive usage during the premarital and marital sexual practice among Myanmar youth migrants in Bang Bon District in Bangkok and their accessibility to reproductive health services.
4. Participants selected for the study will be Myanmar youth migrants between the ages of 15 and 24 years, are able to speak Burmese language fluently, are willing to participate in the study and give informed consent. Youths who cannot participate in this study will be those who cannot communicate in Burmese language and who refuse to give informed consent to participate. This study will need at least 422 youths. You have been invited to be a part of this study because you have been randomly selected and have the necessary criteria that the study requires.
5. The researcher or research assistants will explain you the purpose of the study, its objectives, contents and benefits and will interview you the questions from the study and it will take about one hour. This interview will be at your convenient time and place.
6. All information about the questions will be given to you before the interview, therefore, you can decide if you would like to participate.

6.1 The researcher or the assistants will explain you with all the necessary information verbally

6.2 If your age lies between 15-18 years, you will also be asked to give the verbal consent yourself like those above 18 years as you are assumed to be adult because you came abroad working independently.

6.3 Furthermore, all the information is confidential and anonymous and will not be shared. It will not be used against you in any way and will only be used for the purposes of this study and no identifying information will be collected. By giving the verbal consent, it means that you are willing to participate in the study. You are free to withdraw from the study at any time or refuse to answer certain questions if you feel inconvenient.

7. If it is shown that you do not meet the inclusion criteria after the screening process, then unfortunately, your responses cannot be included in this study as it may alter the results of the study. If you need an advice, please do not hesitate to contact that researcher who will answer any questions or concerns you have.
8. You might feel uncomfortable and inconvenient in answering a few questions regarding your sexual behaviors and practice but it is possible for you not to answer if you feel inconvenient. But for your sake of convenience, we will provide female interviewer for female respondent and male interviewer for male respondent. If you can answer, we'll be very appreciated for your kind support. This study will picture the real needs and practice of reproductive health matters among youth migrants and it will give both government and non-government organizations ideas how to improve and strengthen the reproductive health services.
9. Participation in this study is voluntary and you have the right to deny and/or withdraw from the study at any time they want and without giving any reason. This will not have bad impact on you and you will still receive the same services as normal.
10. Any information that is directly related to you will be kept confidential and will not be told to anyone. The information in the results will be reported as a total picture and no one participant will be used as an example nor will any identifying information about you be used.
11. Participation in this study is completely voluntary. There is no compensation for completing the questions but the researcher will give a small present (a soap) and reproductive health information pamphlets to you as a token of appreciation of your cooperation. If you want social support and further health information, the interviewer will help you finding the necessary health center for social and medical counseling.
12. If the researcher does not follow or treat the participant according to all these items, participants can report the incidence to the Ethical Review Committee for Research Involving Human Research Subjects, Health Sciences Group, Chulalongkorn University (ECCU). Institute Building 2, 4th Floor, Soi Chulalongkorn 62, Phyathai Rd., Bangkok 10330, Thailand, Tel: 0-2218-8147 Fax: 0-2218-8147 E-mail: eccu@chula.ac.th

APPENDIX B

Informed Consent Form

Code number of participant ……

I have been informed about rational and objective(s) of the project and understand the study is to assess the premarital sexual practice, contraceptive usage in premarital and marital sexual practices and the accessibility to reproductive health services. This study information will be useful to highlight the health needs among youths so that reproductive health services to the migrant youths can be developed or strengthened.

I **clearly understand with satisfaction and** willingly **agree** to participate in this research and response to the questionnaires asked focusing on knowledge, attitude, belief and practice of premarital sexual relationship and contraception and reproductive health access, which will take about one hour to complete. I am acknowledged that I might feel a bit uncomfortable in answering the questionnaires regarding my sexual practice.

I have **the right to withdraw** from this research project at any time as wished, with no need to give any reason. Either my withdrawal or my refusal to answer certain questions **will not have any negative impact upon me.**

Researcher has guaranteed that procedure(s) which will be acted upon me would be exactly the same as indicated in the information. Any personal information will be **kept confidential.** Any personal information which could be able to identify myself or part of my family will not appear in the report.

APPENDIX C

Questionnaire on "Practice of Contraception in Premarital and Marital Sexual Relationship among Myanmar Youth Migrants in Bang Bon District, Bangkok and their Reproductive Health Services Accessibility"

Code No. of interviewer ( ) Code No. of participant ( )

Date ----------

Instruction: Please tick in the ☐. Please also write down in the blank space where provided.

Part I Socio-demographic characteristics

1. Age ---------- years
2. Sex ☐Male ☐Female
3. Marital status
   - ☐ 1) Living together and legally married
   - ☐ 2) Living together but not legally married
   - ☐ 3) Single (Never married and not living together)
   - ☐ 4) Widow
   - ☐ 5) Divorced/Separated
   - ☐ 6) Others (specify)
4. Education level
   - ☐ 1) Didn't join to school (No education)
   - ☐ 2) Attend Basic Monastery School or Primary School (read and write)
   - ☐ 3) Attend Middle School
   - ☐ 4) Attend High School
   - ☐ 5) Attend University
5. Occupation
   - ☐ 1) Factory worker ☐ 2) Construction worker
   - ☐ 3) Agriculture/Livestock worker ☐ 4) Domestic helper
   - ☐ 5) General/Random laborer ☐ 6) Other (specify) ----------
6. Income ---------- Bahts/month
7. Race
   - ☐ 1) Mon ☐2) Dawe ☐3) Rakhine
   - ☐ 4) Bumar ☐5) Other (specify) ----------
8. Religious
   - ☐ 1) Buddhist ☐2) Christian ☐3) Hindu
   - ☐ 4) Islam ☐5) Other (specify) ----------
9. Is there anyone who stays together with you in Bangkok? If yes, please specify.
   - ☐ 1) Friends ☐2) Partner ☐3) Spouse
   - ☐ 4) Family ☐5) Other (specify) ----------
10. Duration of stay in Bangkok ----------years----------months

11. Migrant status
    ☐ 1) Registered ☐ 2) Unregistered
12. Thai language skill
    ☐ 1) Can read and speak fluently ☐ 2) Cannot read but can speak fluently
    ☐ 3) Cannot speak fluently but can understand ☐ 4) Do not know at all
13. Myanmar language skill
    ☐ 1) Can read, write and speak fluently ☐ 2) Cannot read but can speak fluently
    ☐ 3) Cannot speak fluently but can understand ☐ 4) Do not know at all

Part II Personal Factors

A. Knowledge of Contraception

14. Have you ever heard of any contraceptive methods?
    ☐ 1) Yes, go to Q 15 ☐ 2) No, go to Q 17
15. Which kind of contraceptive methods have you ever heard? It can be answer more than one. Please read out the remaining if the respondent cannot recall spontaneously.

Methods	Self-reported		Prompted	
	Yes	No	Yes	No
1) Injectables				
2) Oral pills				
3) Emergency pills				
4) Norplant implants				
5) IUD				
6) Male Condom				
7) Female Condom				
8) Female sterilization				
9) Male sterilization				
10) Withdrawal before ejaculation				
11) Periodic abstinence				

16. Knowledge upon contraception and premarital sex (T = True, F = False, NS = Not sure)

		T	F	NS
1)	Women who take oral contraceptive (pill) should take a pill everyday to avoid becoming pregnant.			
2)	Oral pill can cause dizziness and nausea.			
3)	Using oral contraceptive pill can protect against sexually transmitted infections (STIs) including HIV/AIDS.			
4)	Depo injection should be taken once in 3 months to prevent pregnancy.			
5)	Injection can cause cessation of breast milk.			
6)	Women can have children again by stopping to take pill or injection.			
7)	If the women do not want the children anymore, sterilization should be used.			
8)	Condom can break during using.			
9)	Male sterilization can reduce sexual desire and it can cause weakness to men.			
10	Women cannot get pregnancy when they have intercourse 7 days before and 7 days after their menstrual period.			
11	2^{nd} dose of emergency contraception should be taken 12 hours after the 1^{st} dose.			
12	You have more chance to suffer from STI if you have unprotected sex with many partners.			
13	Improper use of contraception can cause unplanned pregnancy.			
14	Induced abortion can sometimes threaten a woman's life.			
15	When you are suffering from STI, you have more chance to be infected by HIV.			
16	All contraceptive methods can prevent both STIs and pregnancy if used properly			

B. Attitude

17. Attitude towards premarital sex and contraception

SA = Strongly Agree, A = Agree, UC = Uncertain, D = Disagree, SD = Strongly Disagree

		SA	A	UC	D	SD
1)	Premarital sexual relation is acceptable for those who promise to marry but can't marry yet.					
2)	It is acceptable to have premarital sex for men but not for women.					
3)	Contraceptive utilization should be taught in the school.					
4)	Discussion on using contraceptive is not a shameful manner among couples.					
5)	Buying contraception is a shameful manner for unmarried boy or girl.					
6)	Using condom can interfere with sexual activity.					
7)	Husband and wife should jointly decide number of children.					
8)	You need negotiation skill to convince your partner to use condom.					

C. Beliefs

18. **Beliefs towards premarital sex and contraception** (T = True, F = False, NS = Not sure)

		T	F	NS
1)	A woman does not become pregnant when she has unprotected sex with a man for the first time.			
2)	You have no risk of STI if you have unprotected sex with your lover or regular partner.			
3)	You cannot get STIs if you wash properly with soap after			

	having sexual relationship.			
4)	All STIs including HIV can be treated and cured.			
5)	Eating some kind of foods or fruits before sexual intercourse can prevent from becoming pregnant.			
6)	You do not need to use condom to prevent STI if your partner is using contraception.			
7)	If you go for a shop for contraception and if your friends find you with condom, you will be looked down or stigmatized.			

Part III History of premarital sex and partner/peer involvement

(In this section, sexual intercourse means penetration of male reproductive organ into the vagina)

19. Did you ever have premarital sexual intercourse (penile-vaginal intercourse)?
    ☐ 1) Yes ☐ 2) No, skip to Q 37
20. How old were you when you had your first intercourse? ---------- years
21. Are you willing to have the first sex?
    ☐ 1) Yes ☐ 2) No
22. With whom was this with?
    ☐ 1) boyfriend/girlfriend ☐ 2) sex workers
    ☐ 3) Casual encounter ☐ 4) others (specify) ----------
23. Did you use any type of contraception for those occasions?
    ☐ 1) Yes ☐ 2) No, skip to Q 25
24. Which of the following contraception did you practice?
    ☐ 1) Injections ☐ 2) Oral pills ☐ 3) Norplant implants
    ☐ 4) IUD ☐ 5) Male/Female Condoms ☐ 6) Emergency pills
    ☐ 7) Other (specify) ----------
25. Have you experienced premarital sexual intercourse (penile-vaginal intercourse) under pressure by your peers?
    ☐ 1) Yes ☐ 2) No, skip to Q 29
26. How old were you when you had experienced that? ---------- years
27. Did you use any type of contraception for those occasions?
    ☐ 1) Yes ☐ 2) No, skip to Q 29
28. Which of the following contraception did you practice?
    ☐ 1) Injections ☐ 2) Oral pills ☐ 3) Norplant implants
    ☐ 4) IUD ☐ 5) Male/Female Condoms ☐ 6) Emergency pills
    ☐ 7) Other (specify) ----------

29. Have you experienced being pressured (physically or mentally) by your partner to practice sexual intercourse (penile-vaginal intercourse)?
☐ 1) Yes ☐ 2) No, skip to Q 33
30. How old were you when you had experienced that? ---------- years
31. Did you use any type of contraception for those occasions?
☐ 1) Yes ☐ 2) No, skip to Q 33
32. Which of the following contraception did you practice?
☐ 1) Injections ☐ 2) Oral pills ☐ 3) Norplant implants
☐ 4) IUD ☐ 5) Male/Female Condoms ☐ 6) Emergency pills
☐ 7) Other (specify) ----------
33. Did you ever accept money/gifts/favors for sexual intercourse (penile-vaginal intercourse) by someone?
☐ 1) Yes ☐ 2) No, skip to Q 37
34. How old were you when you had experienced that? ---------- years
35. Did you use any type of contraception for those occasions?
☐ 1) Yes ☐ 2) No, skip to Q 37
36. Which of the following contraception did you practice?
☐ 1) Injections ☐ 2) Oral pills ☐ 3) Norplant implants
☐ 4) IUD ☐ 5) Male/Female Condoms ☐ 6) Emergency pills
☐ 7) Other (specify) ----------

Practice of contraception (If the respondent is single and has never practiced the premarital sex before, go to Q44.)

For those who are using contraception at the recent time (either the respondent or his/her partner)

37. Have you discussed about any type of contraception with your lover/ spouse/ client?
☐ 1) Yes ☐ 2) No
38. Are you or your partner using contraception now?
☐ 1) Yes ☐ 2) No, skip No. 39
39. What type of contraception are you/your partner using?
☐ 1) Injections ☐ 2) Oral pills ☐ 3) Norplant implants
☐ 4) IUD ☐ 5) Male/Female Condoms ☐ 6) Male/Female Sterilization
☐ 7) Other (specify) ----------

For those who have used contraception before (either the respondent or his/her partner)

40. If you or your partner are not current user of contraception, have you or your partner ever used contraception before?
☐ 1) Yes ☐ 2) No, skip No. 41 and 42

41. What type of contraception have you/your partner used before?
    - ☐ 1) Injections ☐ 2) Oral pills ☐ 3) Norplant implants
    - ☐ 4) IUD ☐ 5) Male/Female Condoms ☐ 6) Male/Female Sterilization
    - ☐ 7) Other (specify) ----------

42. Why does you or your partner discontinue the usage?
    - ☐ 1) Want more children ☐ 2) Expensive
    - ☐ 3) Health reason ☐ 4) Side effect
    - ☐ 5) Service unavailable ☐ 6) Culture and Religion
    - ☐ 7) Other (specify) ----------

For those who have never used contraception before (either the respondent or his/her partner)

43. If you or your partner has not used contraception before, why made you or your partner not to use contraception?
    - ☐ 1) Want more children ☐ 2) Expensive
    - ☐ 3) Health reason ☐ 4) Side effect
    - ☐ 5) Service unavailable ☐ 6) Culture and Religion
    - ☐ 7) Other (specify) ----------

Part IV Access to Reproductive health services

44. Since you have been in Bang Bon, have you ever received any health education materials or health education on contraception?
    - ☐ 1) Yes ☐ 2) No, skip to Q 48

45. What types of health education materials or health education have you received?
    - ☐ 1) Pamphlets/Brochure/Leaflet ☐ 2) Group training/Workshop
    - ☐ 3) Cartoon booklet ☐ 4) Health talk
    - ☐ 5) Wall sheet/Poster ☐ 6) Video
    - ☐ 7) Other (specify) ----------

46. Which language is mostly used in these events?
    - ☐ 1) Thailand ☐ 2) Burmese
    - ☐ 3) Both ☐ 4) Other (specify) ----------

47. Where or from whom did you receive?
    - ☐ 1) Friends ☐ 2) Health Personnel (NGO/Private/Public)
    - ☐ 3) Relatives/family ☐ 4) Boss/owner of the Factory
    - ☐ 5) Other (specify) ----------

48. Can you have any type of contraception easily if you are in need?
    - ☐ 1) Yes ☐ 2) No, skip to Q 50

49. If yes, from where?
    - ☐ 1) Friends ☐ 2) Public clinic
    - ☐

3) Drug Store ☐ 4) Private clinic
☐ 5) Health personnel from NGO ☐ 6) Other (specify) ----------

50. How can you go to family planning service or to get contraception?
☐ 1) Walking ☐ 2) Private vehicle
☐ 3) Public vehicle ☐ 4) Other (specify) ----------

51. How long will it take for you to reach to the nearest contraception available place?
---------- hour----------minute

52. How much does it cost for contraception you used?
☐ Free
☐ Paid
52.1 Contraceptive type ----------
52.2 Cost ---------- Bahts

53. Do you have any preference of same gender service provider? (note: female preference of female service provider and male preference of male service provider)
☐ 1) Yes ☐ 2) No

53. Additional comments from the respondent.

Thank you very much for the time given and your participation in this study.

VITAE

Name - Miss Win Mar Han

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Nationality - Myanmar

Religion - Christian (Baptist)

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Education Background - M.B., B.S (2006),
Institute of Medicine I, Yangon, Myanmar

Work Experience

1. House Officer (Internship) – 1.5.2006 to 30.4.2007

Hospitals
- Yangon General Hospital (Surgical & Medical Units)
- Yangon Children Hospital
- Central Women Hospital

2. Primary Health Care & HIV-AIDS Technician – 1.6.07 to 31.12.07

Organization - World Concern Myanmar (Kachin, Northern Shan and Mon States)

3. Primary Health Care Technical Officer – 1.6.08 to 30.6.08

Organization - World Concern Myanmar (Kachin, Northern Shan and Mon States)

4. Primary Health Care Assistant Technical Associate – 1.7.08 to 30.9.08

Organization - World Concern Myanmar (Kachin, Northern Shan and Mon States)

5. Primary Health Care Technical Associate – 1.10.08 to 7.5.09

Organization - World Concern Myanmar (Kachin, Northern Shan and Mon States)

6. Volunteer History: Volunteer as a Medical Doctor

Organization - Hands in Mission, Australia and Myanmar Baptist Convention

Project areas - Yangon, Myanmar
Mae Sai, Mae Sot, Kachanaburi, Sankhlaburi, Thailand