CHAPTER I

INTRODUCTION

1.1 Background

Total population of the world is increased from 2.5 billion in 1950 to 5.3 billion in 1990 (United Nations [UN], 1999). United Nation projected that world population is projected to grow from 6.1 billion in 2000 to 8.9 billion in 2050 (UN, 2003). UNFPA estimated that the world population is likely to reach 20.7 billion a century later. World population has been growing at 176 people per minute; 10,564 people per hour; 253,542 people per day; and 92,543,000 people per year. About three fourths of the world's population lives in the developing countries (Park, 2005). The rapid population growth of many developing countries makes it more difficult for these countries to achieve improvements in the standard of living as well as to protect their environments (UN, 1999).

As the population in the developing countries increase day after day, most of the people residing in these countries face economic and social unfairness which leads to poverty. Generally, people move for so many reasons but economic differential are still the main determinants of migration from developing to developed countries as well as from less developing countries to more developing countries. For that reason, migration is often seen as a flight from poverty when there are no opportunities available locally, and people migrate in order to survive. Moreover, there are many

"push" and "pull" factors which leads migration all over the world. The dominant push factors are rapid population growth, inadequate economic opportunities and high unemployment which are more prominent in developing countries. Pull factors include expanding markets, labor shortage and ageing population which occur more in industrialized countries (International Organization for Migration [IOM], 2005).

Migration is a multifaceted and complex global issue which happens in every country all over the world. In 1965, the number of persons residing outside their country of birth had been 75 million and it represented 2.2 percent of the world population. In 2000, United Nation estimated that there were 175 million migrants globally and this represents 2.9 percent of the global population. And United Nation also estimated that there would be 257 million migrants in the world in 2050 (Huget & Punpuing, 2005). Among this population, it is often thought to be dominated by male population. But since the last decade, the female migration has become increasing. Almost half of this migrant population is women who comprise 49% in 2000, especially in Asia and Africa (IOM, 2005).

Myanmar is one of the South-East Asia countries and it is located on the Western edge of Indo-China peninsular. It shares the border with China, Laos PDR, Thailand, India and Bangladesh. Every year thousands of Myanmar people flee across the border to neighboring countries especially into Thailand. The high cross-border migration flows from Myanmar into Thailand can be explained by many factors such as social, political and economic push and pull factors. For the past several years, Thailand has attracted increasing numbers of migrant workers from neighboring countries. Because of strong economic growth since 1990s and increased educational attainment of Thai workers; it had allowed many to climb up the skills ladder into

better jobs. This created the shortage on unskilled workers and this become the "pull" factor for people in neighboring countries especially, Myanmar. The "push" factors that cause Myanmar people to migrate is economic and poverty, political and social conflict. Moreover, because of the government resettlement program, there are a large number of internally displaced persons especially ethnic minorities which contribute large proportion of the migrant population in Thailand (Labor Migration in the Greater Mekong Sub-region, 2006). According to the United States Committee for refugees, between 600,000 and one million Burmese were internally displaced at the end of 2003 (Women Commission for refugee women and children). The study carried out by world Vision Foundation of Thailand and the Asian Research Center for Migration revealed the causes of migration which are (a) low earnings in Myanmar, (b) unemployment in Myanmar, (c) family poverty, (d) traumatic experiences such as forced labor, and (e) a lack of qualification for employment (Huget & Punpuing, 2005).

Since 2000, the migrant population is dramatically increasing in Thailand. Registered migrant population is 1,280,053, registered camp population is 120,853 and estimated non-registered migrant population is more than 1 million. In this migrant population, women take large proportion which comprises 48.32 per cent (Ministry of Public Health [MoPH], WHO Thailand and Department of Disease Control, 2005). Generally, migrant population as a whole is vulnerable group of engaging risky behaviours. Most of them live under stressful conditions such as poor housing, poor working conditions, and absence of welfare benefits. Moreover, many migrant people cannot have access to the primary health care, antenatal care nor family planning services (Stern, 1998).

1.2 Rationale of the study

In Thai-Myanmar border area, annual growth rate is 10.1% and crude birth rate is 31.5 per thousand live births which are higher than those rates not only in Thailand but also in Myanmar. The contraceptive prevalence rate in Thai-Myanmar border area is increased from 18.77 per cent in 2003 to nearly double as 32.4per cent in 2006 (Committee for Coordination of Services to Displaced Person in Thailand [CCSDPT], 2006). Though the contraceptive prevalence rate of Myanmar migrant people is increased but it is still lower than Thailand which has contraceptive prevalence rate of 81.1%% (Ministry of Information and Communication Technology [MICT], National Statistics Office, 2006). Despite increasing utilization of birth contraception, the rate of abortion in border area is increased from 39.29 per thousand live births in 2004 to 82.83 per thousand live births in 2006 (CCSDPT, 2006) as consequences of increasing migration and low utilization of contraception. This reveals that there is not only the limited knowledge about family planning and contraceptive usage but also unmet need of contraception in Myanmar migrant women. Unable to access family planning and safe sex services, many female workers suffer unplanned pregnancies and unsafe abortion (The Human Rights Sub-Committee on Ethnic Minorities, Stateless, Migrant Workers and Displaced Persons, The Lawyers Council of Thailand). Thailand Ministry of Health has recorded the rate of abortion in Myanmar migrant women is 2.4 times higher than that of local Thai population (Belton & Maung, 2007).

Phang Nga Province is located in southern part of Thailand and it takes about 3 hours to get there by boat from Southern Myanmar. Burmese migration population is increasing in Phang Nga province since few years ago. In 2005, the estimated

registered Burmese migrant population in this province is 22,284 (IOM, 2005) and the non-registered migrant population is estimated as twice of this figure. Among this population, female migrant workers comprise 33 percent in which reproductive age group takes part 77.6 percent. Moreover, 67.9 percent of Myanmar migrant workers in Phang Nga is married (IOM, 2007). Although Phang Nga Province had quite a lot of Myanmar migrant people, there was no baseline data on contraceptive used by Myanmar migrant.

Migration is another life course event that can have profound implications for sexual and reproductive health (World Health Organization [WHO], 2007). By and large, migrant people are highly mobile and they move from the economically less developed countries to more developed countries due to severe economic hardship and conflict (IOM, 2005). Because of their tenuous legal status, barriers that limit access to health services are legal mechanisms, migration in all seasons to earn money for their survival, poor living conditions, language barrier, unaffordable to health services, far distance to health care provider and police arrest of migrants. For that reasons, they are not being able to receive full or proper knowledge for related health conditions especially family planning (World Vision Foundation Thailand [WVFT], 2007). Insufficient knowledge of family planning and usage of contraception is becoming a significant burden not only on the women in terms of morbidity and mortality associated with short birth interval and unwanted pregnancy but also on the host country, Thailand (Belton & Maung, 2007).

1.3 Research Questions

- What is the prevalence of contraceptive usage among Myanmar migrant women of reproductive age in Takuapa District and Kuraburi District, Phang Nga Province?
- What are the factors related to the contraceptive usage among Myanmar migrant women of reproductive age in Takuapa District and Kuraburi District, Phang Nga Province?

1.4 Research Objectives

1.4.1 General objective

- To determine the prevalence of contraceptive usage and factors relating to the contraceptive usage among the Myanmar migrant women of reproductive age in Takuapa District and Kuraburi District, Phang Nga Province.

1.4.2 Specific Objectives

- To determine the prevalence of contraceptive usage among Myanmar migrant women of reproductive age in Takuapa District and Kuraburi District, Phang Nga Province.
- To describe the knowledge about contraception among Myanmar migrant women of child bearing age in Takuapa District and Kuraburi District, Phang Nga Province.

- To describe the attitude towards contraception methods and use among Myanmar migrant women of child bearing age in Takuapa District and Kuraburi District, Phang Nga Province.
- To describe the accessibility of family planning service among Myanmar migrant women of reproductive age in Takuapa District and Kuraburi District, Phang Nga Province.
- To determine the relationship between socio-demographic characteristics, knowledge about contraception, attitude towards contraception, accessibility of health care services and utilization of contraception.

1.5 Hypothesis of the Study

- There is association between socio-demographic factors and utilization of contraception.
- Respondents with high level of knowledge about contraception are more likely to use contraception.
- Respondents with negative attitude towards contraception are less likely to use contraception.
- Respondents who can access the family planning services are more likely to use contraception.

1.6 Variables Employed in the Study

Independent Variables

- Age
- Religion
- Education
- Occupation
- Marital status
- Total family income
- Number of living children
- Marital duration
- Migrant status in Thailand
- Thai Language skill
- Interspousal communication
- Knowledge about contraception methods and use
- Attitude towards contraception methods and use
- Accessibility to family planning service (time, cost, distance, transportation, satisfaction to service, source of service)

Dependent Variable

- Usage of contraception

1.7 Operational Definitions

"Age" refers to the age of the respondent at the time of interview.

"Religion" refers to the religion of respondent at the time of interview. Religion is classified into 4 groups which are Buddhist, Muslim, Christian and others.

"Education" refers to the highest level of education that the respondent had attained at the time of interview. Education is classified into 5 groups which are never go to school, primary school level (1-4 years of school), secondary education level (5-8 years of school), high school level (9-10 years of school) and higher education (university).

"Occupation" refers to the type of job that the respondent has to earn at the time of interview. Occupation is classified into 6 groups which are housewife, rubber plantation worker, fishery worker, general worker, and construction worker and others.

"Marital status" refers to the legal (conjugal) status of each individual in relation to the marriage laws or customs of the country. This is categorized into single, married, divorced, separated, widowed and co-habit marriage (UN).

"Total family income" refers to the total amount of monthly income earning of the whole household. Economic status of the respondents was classified as ≤2000 Baht, 2001-4000 Baht, 4001-6000 Baht, 6001-8000 Baht and ≥8001 Baht.

"Number of living children" refers to the total number of living children in the family.

"Marital duration" refers to the period of time that the respondent has been married.

"**Interspousal communication**" is measured by asking the wife if she has talked with her husband or partner about family planning. This is categorized into discussed or never discussed.

"Language skill" is categorized into 4 categories which are can not communicate at all, can communicate basically, can speak fluently but can not read and write, and fluently in Thai language.

"Migrant status in Thailand" refers to the having permission for employment and staying in Thailand. This is classified into 2 categories such as registered and unregistered migrant (IOM, Thailand).

According to Merriam Webster Dictionary, **"Knowledge"** is defined as

- Cognizance.

- The fact or condition of knowing something with familiarity gained through experience or association, acquaintance with or understanding of a science, art, or technique.

- The fact or condition of being aware of something, the range of one's information or understanding (Marriem-Webster).

In this study, knowledge refers to the respondents' ability to answer the types of contraceptive methods and knowledge about contraception. Knowledge will be categorized into high, moderate and low. The knowledge part consists of 18 questions and the score will be 1 for correct answer and 0 for incorrect answer. The highest score is 20 and the lowest is 0.

"Attitude towards contraception" in this study, attitude towards contraception refers to the respondent's opinion of agreement or disagreement to the statement concerning contraception. Attitude will be measured in 3 categories according to the Likert scale (McDowel Ian & Newell C).The attitude part consists 9 questions and the questions consist of both negative and positive aspects. For positive questions, the score will be given 5 for strongly agree, 4 for agree, 3 for uncertain, 2 for disagree and

1 for strongly disagree. For negative questions, the score will be given 5 for strongly disagree, 4 for disagree, 3 for uncertain, 2 for agree and 1 for strongly agree.

WHO (2000) defines **"Accessibility to the family planning service"** into 3 aspects such as financial accessibility, geographical accessibility and cultural accessibility. In this study, accessibility to family planning service refers to the ability of using the family planning services in terms of distance from the service, transportation to get to the service, cost and affordability, sources of service and satisfaction to service are considered.

"Usage of contraception" refers to the continuous use of contraception within last three months until the time of interview and use at least one method, traditional method or modern method such as pills, injections, IUD, condom, female sterilization, male sterilization, Norplant implants, diaphragm, withdrawal, fertility awareness and abstinence either used by the women or her husband.

- "Contraception" refers to the use of the artificial or natural means to prevent conception or pregnancy.
- "Traditional methods" refers to the natural methods including abstinence, withdrawal, rhythm and fertility awareness method.
- "Modern methods" refers to the artificial methods which include condoms, diaphragm, oral contraceptive pills, injectable contraceptives, intrauterine devices (IUD), Norplant implants, male sterilization and female sterilization (Health Encyclopedia).

"Not used" in this study refers to the respondent who doesn't use the any method of contraception within last 3 months .

"Contraceptive prevalence rate" means the percentage of women of reproductive age who are using (or whose partner is using) any form of contraception at the time of interview (UNFPA).

"Women of reproductive age" or **"Women of child bearing age"** refers to all women aged 15 to 49 years (WHO).

1.8 Conceptual Framework

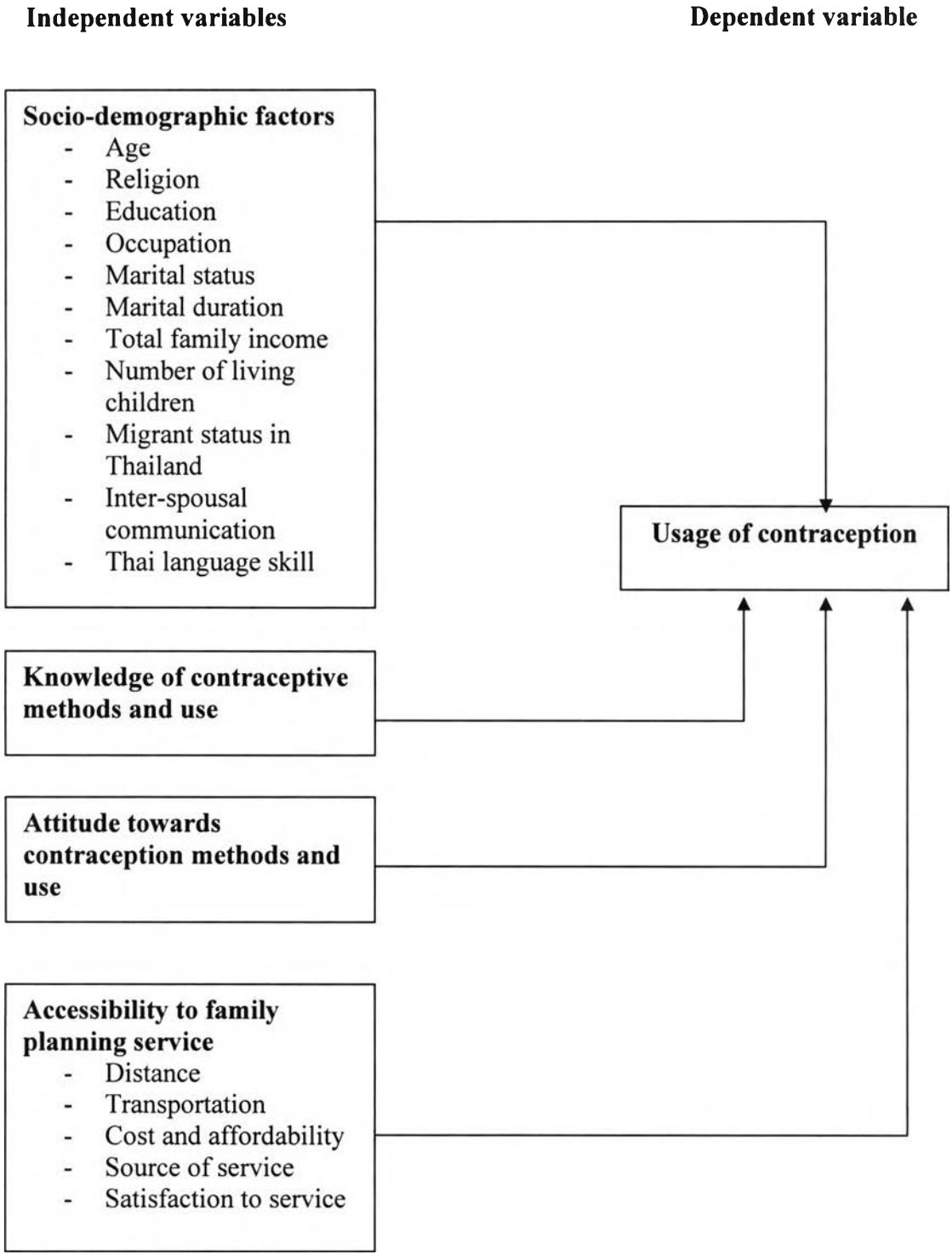

Figure 1: Conceptual Framework