CHAPTER V

DISCUSSION

The main purpose of this study was to determine the prevalence of contraceptive usage and to identify the factors relating to the contraceptive use among Myanmar migrant women of reproductive age who were residing in Takuapa District and Kuraburi District in Phang Nga Province, Thailand.

This study was done with the expectation of that the outcome can be used by heath authorities for further family planning program to fulfill the needs among Myanmar migrant workers.

The contraceptive prevalence rate among Myanmar migrant women age between 15 to 49 years residing in Takuapa District and Kuraburi District in Phang Nga Province was 73.3%. It was noted that the practice of contraception was increased among Myanmar migrant in Thailand as compared to Myanmar in which contraceptive prevalence rate 37% in 2001 (UN, 2005). Although the contraceptive prevalence rate was more than double compared to the finding from the study done by CCSDPT at refugee camp in Myanmar-Thai border (32.4%) (CCSDPT, 2006), it was still lower than Thailand in which it was 81.1% (National Statistic Office, Thailand). This is consistent with the study done among immigrant women in Thailand as the contraceptive prevalence for over all methods was lower for immigrant women than for natives (Peailueang, 2002).

In terms of contraceptive methods used, the most common contraceptive method was injection (46.4%) followed by oral pill (39%), female sterilization (8.4%), traditional methods (2.1%), male condoms (1.7%), Norplant implants (0.8%) and male sterilization (0.8%). This finding was compatible with the survey done in Myanmar (WHO, 2007) and the study done in refugee camps in Thailand in which the most common method was injection followed by oral pill and female sterilization (CCSDPT, 2006).

In this study, injection was the most common method followed by oral pill than any other method among Myanmar migrant women. This may be due to convenience to use and easily available. Because of the legal status among migrant women, most of them were afraid of police to arrest. For that reason, injection was more popular than oral pill as the woman needs to get injection once in three months. Moreover, oral pill causes lots of problem such as nausea, dizziness and forgets to take pill regularly which can lead to discontinuation and pregnancy. The low use of condom may be due to their negative attitude on the condom use as their husbands did not like condom because of interference during sexual intercourse even more than half of them had knowledge about condom. Further study in exploring this may help understanding the belief and useful for family planning program.

In the process of practicing contraception, when the women are satisfied with one of method, she may continue using the same method. The reasons for discontinuing use and not use among the ever users and never users were want more children and health reason.

One fifth of the women in this study experienced of at least one time abortion including spontaneous as well as induced abortion. Migrant workers are among the

most marginalized people in Thailand who face the greatest health risks. Migrant women in Thailand have particular problems concerning unwanted pregnancies and often attempt to terminate their pregnancy. Women are pressured by employers, husbands and fear of unemployment to end their pregnancies. Some women report domestic violence as influencing their decision to abort (Belton & Maung, 2007).

Regarding the age, all the women were in reproductive age group between 15 to 49 years old. The average age was 29.75 and the majority of the respondents were distributed in the age group from 20 to 39 years (76%) which were the working age group as they migrate from their country of origin to work in Thailand; this finding is consistent with the study done in Thailand (Caouette et al., 2000). Only a few percentage lied in the age group from 15 -19 years (8.9%) and 40-49 years (15%).

In bivariate analysis, there is a significance difference between age and contraception use with p-value <0.001. The percentage of contraceptive use was lowest among 15-19 years and it was highest among 20-29 years. The percentage of use slightly fell among 30-39 years and 55.1% in 40-49 years as the women became older.

In multivariate analysis, age is also significant after controlling other independent variables. In this study, age has negative effect on current use of contraception as the use of contraception decreased with increasing age. It is reasonable to say that the younger generation women were more likely to use contraception when compared to older women as the women become older, they may have less sexual activities and they perceived lower risk of pregnancy due to lower fecundity or less frequent sexual activity. This finding was compatible with the study

done in Indonesia (Helweldery, 2004) in which the use of contraception declines significantly with increasing age.

Majority of the women in this study were married (91.1%) because Burmese women working outside their country are extremely vulnerable to sexual abuse by their employers, human traffickers, local officials, or others. As a result of this situation, a number of young migrant women report feeling pressure to get married in order to have some protection against unwanted sexual advances from others (The situation of migrant workers, Facts on Human Right Violation in Burma, 2002-2003).

Marital status also affects the use of contraception and the percentage of use among married women was 80.1% while only one separated women used contraception currently. In bivariate analysis, there is significance difference between marital status and contraception use in this study (p-value=<0.001). This significant bivariate result may be due to large proportion of married women in this study. However, after controlling other independent variable in multivariate analysis, the effect of marital status is not significant. This finding is different from the study done in Mexico showing the odds of use were positively associated with being married (Barber, 2007).

Among the married women, 38.7% had duration of marriage $\leq$ 5 years, 23.6% had 6-10 years and 37.7% had > 10 years. In bivariate analysis, it is found that there is significantly difference between duration of marriage and contraceptive use with p-value=0.005. The contraceptive use was more pronounced for shorter marital duration group, 85.6% in $\leq$ 5 years and 81.9% in 6-10 years compared to longer marital duration, 68.7% in >10 years. But in multivariate analysis, marital duration is not significant after controlling other independent variables. It was possibly because from

the reason for not using contraception; there were still large proportion of women who had shorter duration of marriage stated they still need additional children. This is controversy with the study conducted in Myanmar (Wai, 1995) and in Nepal (Dhananjay Narsingh, 1997) in which the use of contraception was decreased as the duration of marriage increased.

Among the women, 99.1% were Buddhist and 0.9% were Muslim and Christian. There was no significance difference between religion and use of contraception and it is controversy with the finding from the study in Thailand (Martin-Cupid, 1990). This is because there were not many respondents with other religions.

As the migrants from Myanmar tend to be less educated and less literate than their population of origin (Labor Migration in the Greater Mekong Sub-region, 2006), more than half of the respondents in this study had primary education and 27.6% had secondary education. Only a few percentage had high school level and higher education. Generally, education is recognized as the vehicle by which people learn about the family planning, which may lead to demand for fewer children. The educated women are expected to use more contraception as they desire fewer children compared with illiterate women.

In bivariate analysis, the result of this study reported that there is significance difference between educational status of the respondents and contraception use (p-value=0.04). The percentage of use was 69.7% in group of women never go to school and primary education. The use of contraception increased with increasing education level and it was highest in secondary education group (83.3%). This is because the low educated women were lack of awareness and acceptability of family planning.

Unlikely, the use of contraception was the lowest among high school level and higher education group; this is because the more they educated, the more they aware of the side effects of contraceptive methods.

However, after controlling other independent variables, education has no effect on use of contraception. This finding was not consitent with the findings form the study done in Bangladesh (Parveen, 2000), in Tehran (Tehrani et al., 2001) and in Indonesia (Helweldery, 2004) in which the education significantly affects on contraception.

Almost half of the women (45.4%) in this study were housewives and the other half (54.6%) were working as rubber plantation worker, construction worker, fishery workers, etc. Occupation often influences the decision making for practicing contraception among women. In bivariate analysis, the result in this study revealed that there is significance difference between occupation and contraception use (p-value=0.006) but housewives were more likely to use contraception (80.4%) than working women (67.4%). The significant bivariate result may be because the Myanmar migrant women came for the purpose of earning money, and for those who had not worked, they might not have enough money for having and raising children compared to the working women who can supplement the family income.

In multivariate analysis, occupation is not significant after controlling other independent variables. This is controversy with the study conducted in Bhutan (Lhamu, 2004) and in Ethiopia (Beekle & Mccabe, 2006) reported that the women working outside their home were more likely to use contraception than housewives.

Average family income was 5270.86 Baht and almost two-third of them got monthly income between 2001 Baht to 6000 Baht as they were labor working in

various sectors. The result from this study showed that there was no significance difference of contraceptive use between the group of women who had total family income ≤ 5000 Baht and > 5000 Baht. The percentage of current use was 73.6% in the women who had ≤ 5000 Baht while 72.9% of women with family income > 5000 Baht. This finding is consistent with the result from the study done in Indonesia (Schoemaker, 2005) and in Ethiopia (Beekle & Mccabe, 2006) as the percentage of use did not show much difference between diverse monthly income levels. This is possibly because the price of the contraception was cheap and sometimes free of charge, so everybody can access regardless of income.

As in the study done in Thailand by WHO and MOPH (MOPH, WHO Thailand and Department of Disease Control, 2005) and survey done in Phang Nga Province by IOM (IOM, 2005), the unregistered migrant women (67.2%) were twice the figure of registered migrant women (32.8%) in this study. This result of this study revealed that there was no significance difference of contraceptive use between registered and unregistered migrant women. Whether the migrant women are registered or unregistered, they came for the purpose of earning money; all of them want to control fertility.

Among the women, half of them had 1 to 2 children while 21% had no children and 27.5% had ≥ 3 children. The number of living children is important factor which can influence the decision making to use contraception. In bivariate analysis, this study found that there was significance difference between number of living children and contraceptive use (p-value=0.001). The percentage of use was 64.1% in women who had no children, 85.9% in women who had 1-2 children (85.9%) and 75% in women having≥ 3 children.

In multivariate analysis, the number of living children has also significant positive effect on contraceptive use as the use of contraception increased with increasing number of living children. It was possibly because the women who reached the desired family size use contraception to stop childbearing. The use declined in women who had ≥ 3 children because they were older, less fertile or more likely to have secondary fertility. The finding from this study is supported by the results from the study done in Myanmar (Panitchpakdi et al., 1993), in Lao PDR (Khouangvichit, 2002) and in Vietnam (Nguyen, 2003) in which the use of contraception is increased as the number of living children increased.

More than half of the migrant women in this study can communicate basically and 34.7% can not communicate at all. Only few percentages were fluent in Thai language. This is similar in the study conducted among migrant people in Thailand in which approximately one-fourth claiming literacy in Thailand (Labor Migration in the Greater Mekong Sub-region, 2006). The use of contraception was 69.9% in women who can not communicate at all, 74.6% in women who can communicate basically and 79.2% in women who were fluent in Thai language. It was observed that the contraceptive use did not show much difference between diverse groups of language skill. This study revealed that there was no significance difference between Thai language skill and contraceptive used and possibly because they can access private clinic or drug store for getting contraception regardless of fluent in Thai language.

Inter-spousal communication about family planning is the main mediating variable that can enhance the decision making of women using contraception. Among the married women, 91.8% discussed with their husbands or partners while only 8.2% did not discuss about family planning. This study revealed that there was no

significance difference between discussion with husband/partner about family planning and contraceptive use. It is controversy with the study done in Nepal (Tamang, 2001) and in Lao PDR (Khouangvichit, 2002) in which there was significance difference between discussion with husband/partner about family planning and contraceptive use. This is because the decision making for contraceptive use was made by both partner (59.1%) and by the respondent herself (28.7%) in this study. The result of this study is supported by the survey done in Myanmar in which the decision making processes for contraceptive use are usually made by both partners or sometimes the wife makes the decision; as the gender equality is relatively high and little discrimination against women in Myanmar (WHO, 1997).

Regarding the knowledge about contraceptive methods and use, majority of the women heard of oral pill, injection, female sterilization, male condom and 85% of them heard of male sterilization although it is illegal in Myanmar. They also heard of other methods such as Norplant implants, traditional methods, IUD to some extent and female condom was the least known method.

Majority of the women knew the benefit of contraception. But they had knowledge about contraceptive methods to some extent. More than half of them had knowledge about condom in preventing pregnancy and preventing sexually transmitted diseases, however, it was used in small percentage. Although injection and oral pill were the most frequently used by the women, only few of them had knowledge about these methods (3.7% and 12% respectively). This suggested that they had limited information on these two methods and IEC materials about contraceptive methods should be produced and introduced.

The knowledge of the respondents were assessed that the main proportion of women at 50.9%was classified into moderate knowledge whereas 41.7% had low knowledge and a few of them had high knowledge (7.4%). In bivariate analysis, it is revealed that there is significance difference between the knowledge towards contraception and use of contraception (p-value=0.005). Regarding the knowledge level of the respondents using contraception, it indicated noticeably that women with moderate and high knowledge participated in more practicing contraception (80.7% and 75% respectively) than those who had low knowledge (63.9%).

Moreover, in multivariate analysis, knowledge towards contraception has significant positive effect on contraceptive use after controlling other independent variables. It was obviously that those who knew well about the benefit of use and understood the real information of side-effects of contraceptive methods; they felt confidently and used more. This result was similar to the previous study done in Nepal (Dhananjay Narsingh, 1997), in China (Jiuling, 2000) and in Bangladesh (Parveen, 2000) that meant the higher knowledge level of family planning practice, the greater incidence of using contraception.

Considering the investigation of women's attitude, it was found that those who had moderate attitude were the highest (75.5%), the positive attitude (12.3%) and negative attitude (12.3%).

The attitude towards the contraception is the most important determinant of practicing contraception. The study done in Missouri (Sable et al., 1997) revealed that infrequent contraceptive users were more likely to have negative attitudes towards contraception. However, in this study, there was no significance difference between attitude towards contraception and use of contraception. It was observed that the

acceptance of using contraception among the respondents with positive, moderate and negative attitude was different a little (77.5%, 71.5% and 80% respectively). It may be due to majority of the respondents in this study were current users (73.3%) and the women who had negative attitude wanted to control the fertility while they were away from their home country and earning money.

Accessibility is one of the important factors that influence to women obtaining information about contraceptive, practicing contraception and can influence on decision making regarding use of contraception.

In terms of place to get contraception, more than half of the current users rely on private clinic and drug store and the other used government, NGO and other sources. The percentage of use of contraception was not obviously difference between different places.

Similarly, the use of contraception was not too difference between different means of transportation such as by walking, public vehicle, private vehicle although nearly half of the current users went to the source by walking.

Majority of the current users (84.5%) perceived that they were convenience to go but the use of contraception was not obviously different between the group of women who perceived convenience and women who perceived not convenience and do not know to go to the source of contraception.

More than half of the respondents resided near the source and nearly one third of them reside not too far from the source; however, the use of contraception was not difference between them.

Majority of the current users (90%) had satisfaction to the service and only 10% did not satisfy the source they got. The use of contraception was not difference

between the respondents who satisfied and did not satisfy the source they got (89.2% and 82.8% respectively).

In Takuapa District and Kuraburi District, International Organization for Migration provides contraceptive methods especially pill and injection for free of charge. The average cost ranged from 0-8000 Baht per month/dose. As the injection and oral pill was most frequently used among migrant women, almost two-third of current user spent less than 100 Baht per month/dose.

In terms of perception of affordability on cost, there was significance difference between the respondents who could afford and could not afford and use of contraception (p-value=0.033) in bivariate analysis. 90.5% of respondents who could afford the contraception used currently while only 79.6% used contraception. In multivariate analysis, perception on cost for contraception is also significant. It has positive effect on use of contraception as if they could afford, they use more contraception. The finding from this study is controversy with the study done in Indonesia (Schoemaker, 2005) in which there was no significance difference between poor and using contraception.

The previous study done in Lao PDR (Vanhnolrath, 2003) found that the place to get contraception, convenience to go to the service center were significantly associated with contraception use. This is controversy with this study in which there was no significance difference between place to get contraception, mean of transportation, convenience to go to the service, distance from home, satisfaction to the service and current use of contraception. This is because majority of the respondents in this study were current users (73.3%) and this makes the group of not current users not having sufficient number for relationship analysis. It may also be

due to migrant women wanted to stop childbearing while they came to Thailand on the purpose of earning money.