FACTORS INFLUENCING CONTRACEPTIVE USE AMONG MYANMAR MIGRANT WOMEN IN BANGKOK, THAILAND: A COMMUNITY-BASED SURVEY

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ABSTRACT

Objectives: Nowadays, more people are moving residence permanently or temporarily, and international migration is one of the dominant issues globally. During migration, the individuals may experience poverty and unavailability of health care services -- especially for women – and that leads to unmet need for reproductive health and inadequate access to contraception which increases risk of unplanned pregnancy and unsafe abortion. This study explored the level of contraceptive use and associated factors among Myanmar migrant women in Bangkok.
Method: A cross-sectional study was conducted during March to April, 2018, 314 women were selected by snowball sampling and interviewed using a structured questionnaire. Descriptive statistics and logistic regression were used for data analysis.
Results: The prevalence of contraceptive use among women who were living with their husband/partner was 77.1%; oral pills and injection were the most common methods. The sample's median age was 30 years (QD = 4.5 years), half of the respondents were ethnic Burmese (51.9%), and were covered by health insurance (47.5%). Only one-fourth of the women (25.5%) could communicate well in Thai. Predictors of contraceptive use include being younger than 25 years (AOR=9.6; 95% CI=3.07–31.59), having more than one child (AOR=8.5; 95% CI=2.72-26.37), having a supportive husband and friends, neighbors (AOR=4.9; 95% CI=2.43-10.26, AOR=4.2; 95% CI=1.96-8.89) having easy access to contraception (AOR=3.2; 95% CI=1.50–6.780) and being able to access contraception at local health outlets (AOR=12.9; 95% CI=4.01-41.93).
Conclusion: The study suggests that provision of community and workplace education, health care services and initiation of help-lines in the Burmese language may increase visibility of reproductive health services and bridge the gap between the foreign migrants and the Thai public health system. Active male involvement in their partner's reproductive health is an important source of support.

Keywords: contraception/ Migrants/ Myanmar women/ Bangkok/ Thailand

1. INTRODUCTION

Migration is considered one of the significant global issues of the early 21st century, as more and more people are on the move today than ever before. For decades, Myanmar migrants have crossed the border to work in Thailand due to dissatisfaction of the socio-economic and political situation at home, and because the Thai economy is more developed and stable than most of its neighbors in the Greater Mekong Sub-region (Acuin et al. 2011, Chantavanich and Vungsiriphisal 2012). At the time of this study, Myanmar migrants account for about three-fourths of low-wage labor migration to Thailand (Department of Population 2015). During temporary migration, women experience poverty, unmet need for reproductive health care and limited access

to family planning services, which contributes to high rates of unintended pregnancy and unsafe abortion (Hegde et al. 2012). The person has to be informed and endowed the facts of sexual/reproductive health (SRH) such as protection from transmission of sexually transmitted diseases, deciding when and how many children to have, antenatal care, safe labor and post-natal care including birth spacing services (Greene et al. 2012). Millions of women in low-income countries at the present don't have the SRH choices to avoid pregnancy or childbearing, and many are powerless to plan their families (UNFPA 2017) due to the information gap, poor education status, lack of contraceptive counselling, lack of access to contraceptive methods by social norms, financial or cultural obstacles, as well as discrimination, coercion and violence in their lives (Lasimbang et al. 2016). Every year in low-income countries, 89 million pregnancies are unplanned, 48 million result in miscarriage, 10 million are aborted, and 1 million result in stillbirth. One of the measures of access to SRH services is a calculation of the number of women want to practice modern contraceptive methods (UNFPA 2017). Contraception plays an important role in reproductive health. Use of contraception can prevent unintended pregnancy, reduce abortion and increase the opportunity to attain higher education and stimulate economic growth (WHO 2017). Even though there are many benefits from using contraceptive methods, 216 million married, reproductive-age women worldwide are not using modern contraceptive methods, despite the desire to delay the pregnancy. WHO stated that the groups such as migrants, urban slum dwellers, refugees and post-partum women are vulnerable for unmet need for contraception (WHO 2017) due to the barriers such as lack of awareness of health services, lack of medical insurance, and difficulty in communication, especially among migrants (Huguet and Martin 2015). Hence, whether women use contraception or not will be determined by a wider set of socio-cultural influences as well as their own characteristics. A socio-ecological model is set up to identify the social factors of health at the level of socio-demographic background, intrapersonal and interpersonal layers. There are very few published works which have explored contraceptive use among Myanmar migrants and its associated factors at various level and, therefore, our study aims to fill that gap. Its objectives were to estimate the percentage of modern contraceptive use among Myanmar migrant women of reproductive age (15-49 years) in Bangkok, and to identify associated factors of use.

2. METHODOLOGY

A. Setting

Bangkok is the capital and also the most crowded city of Thailand. It is also one of most populated areas of international migration: most migrants are from the neighboring countries of Myanmar, Cambodia, Lao PDR (Kantayaporn and Mallik 2015, Social Policy and Poverty research group, Yangon 2016). The estimated number of Myanmar migrants in Bangkok is about 63,498 with an even gender split in 2013-2015 (National Statistical Office 2016). This figure is surely an underestimate due to the large estimated population of unregistered migrants (Tangcharoensathien et al. 2017).

B. Study design

This is a community-based descriptive cross-sectional study conducted among Myanmar migrant women of reproductive age, that is, 15–49 years of age. Due to the fact that a majority of migrant workers are undocumented, it was not possible to obtain all the necessary information about the population of migrants in order to draw respondents from a sampling frame. Therefore, the snowball technique was used to recruit respondents. The field supervisor developed a worksheet and located ''seeds'' (the starting cases). From each seed, interviewers identified ten additional respondents. The total number of seeds was calculated by dividing the target number of cases by ten. The sample size was about 330. The data were gathered by five trained research assistants. The

questionnaire had sections on the sociodemographic characteristics of the respondents, intrapersonal factors and interpersonal factors as independent variables and modern contraceptive methods use was dependent variable (WHO 2017). Data were entered using Epi Info version 4.2 and analyzed using SPSS version 21 for descriptive and logistics regression to identify the factors influencing contraceptive use. Adjusted odds ratios (AORs) with 95% confidence intervals (CIs) were calculated, and p-values <0.05 were considered to indicate statistical significance. It was approved by the Ethical Review Committee of Mahidol University, with approval No: 2018/040.2702. Written consent and confidentiality was ensured throughout the study period and questionnaires were coded with numbers only.

3. RESULTS

In this study, 330 respondents were recruited; however, only 314 respondents gave full responses to the questionnaire, giving a response rate of 95.1%. According to statistics of the respondents' background characteristics shown in Table 1, the median age of respondents was 30 ± 4.5 years, with just over half age 26-35 years. Half of the participants were ethnic Burmese (51.9%) and nearly half the respondents went to secondary school. Almost all participants (95.5%) were working, and the most were the factory worker (87.3%). Monthly income can be divided into three groups: less than 8,600 baht (37.9%), between 8,650 baht and 9,400 baht (36.9%) and more than 9,400 baht (20.7%). One-third of the women wanted more than three children and only 25.5% of respondents can communicate well in the Thai language. Regarding contraceptive information, just 15.3% of migrant women had been discussed contraception by health care workers within the past year. The majority of the respondents reported that a pharmacy was the most common source of contraceptive methods, with 82.8% and 71.3% reporting availability and accessibility of services, respectively. The way to access these facilities was by foot/walking (75%) and cost of contraception was not expensive (88.2%). Over one-third (38.5%) of the participants received information about contraception from many kinds of media in which the internet/social media was the most widespread (61.2%). Approximately 50% of the respondents had any kind of health insurance and, among these, the vast majority of the respondents were satisfied to apply it. The reasons for not having insurance include the high cost (55.2%). About half of the participants had high scores about short-term and long-term methods of contraception. However, the majority of the participants (around 90%) had low scores about permanent, barrier methods and emergency contraception.

Table 1: Socio-demographic, intra- and inter-personal characteristics

Variables	Frequency (n)	Percentage (%)	Variables	Frequency (n)	Percentage (%)
Age groups			**Discussion with HCW within one year**		
18-25 years	91	29.0	Yes	48	15.3
26-35 years	168	53.3	No	266	84.7
36-45 years	55	17.5	**Available places (multiple answers)**		
Ethnicity			Government	204	65.0
Burmese	163	51.9	Private	168	53.5
Karen	55	17.5	Pharmacy shop	260	82.8
Mon	45	14.3	Others	62	19.7
Dawei	36	11.5	**Ever been to facilities (multiple answers)**		
Others	15	4.8	Government	62	19.7
Education			Private	85	27.1
Illiterate	5	1.6	Pharmacy	224	71.3
Primary	99	31.5	Others	9	2.9

Variables	Frequency (n)	Percentage (%)
Secondary	156	49.7
Tertiary	41	13.1
Working status		
Yes	300	95.5
No	14	4.5
Type of occupation (n=300)		
Factory worker	262	87.3
Vendor	10	3.2
Salesperson	10	3.2
Construction worker	7	2.3
Housemaid	4	1.3
Other	7	2.3
Current monthly income (n=300), 1USD – 32 baht		
≤ 8,600 baht	119	37.9
8,650-9,400 baht	116	36.9
> 9,400 baht	65	20.7
No income	14	4.5
Desired no. of children		
No child	1	0.3
1 child	80	25.5
2 children	136	43.3
≥ 3 children	97	30.9
Thai language skill		
Poor	73	23.2
Fair	161	51.3
Good	80	25.5
Never been there	23	7.3
Way to reach the facilities		
Walking	218	74.9
Other ways	73	25.1
Cost of contraception		
Not expensive	277	88.2
Expensive	37	11.8
Message from media		
No	193	61.5
Yes	121	38.5
Type of media (n=121) (multiple answer)		
Internet/ social media	74	61.2
TV	43	35.3
Pamphlets/posters	35	28.9
Others	11	9.1
Any insurance scheme		
No	165	52.5
Yes	149	47.5
Satisfy the scheme? (n=149)		
No	27	18.1
Yes	122	81.9
Why don't you have the scheme? (n=165)		
I can't afford to pay	91	55.2
Employer doesn't want to pay	28	17.0
Waiting approval of documents	28	17.0
Others	18	10.8

The proportion of contraceptive use among Myanmar migrant women who currently live together with their husband or partner was 77.1%. Among the users, OCs was the most common type and fear of side effects with 72.2% were the main the reasons for not using. (see in Table 2)

Table 2: Analysis of modern contraceptive use

Variables/ Categories	n	%
Using currently any modern method		
Yes	**242**	**77.1**
No	72	22.9
Type of contraceptive method used (n=242)		

Variables/ Categories	n	%
Reasons for not using contraception (n=72)		
Fear of side effects	52	72.2
Wants more children	46	63.9
Infrequent sex	10	7.2

IUD	1	0.4
Implant	6	2.5
Tubal ligation	9	3.7
Injection	80	33.1
OCs	146	60.3

Family member opposition	3	4.2
others	7	9.7

Factors associated with contraceptive use were age of the woman and total number of living children, knowledge level and satisfaction to stay in Thailand, social support from husband/friends/neighbors, and availability and accessibility of contraceptive methods, with statistical significance of $p < 0.05$ (see Table 3).

Table 3: Factors Associations with contraceptive use

Variables/ Categories	Contraceptive use (%) Yes	No	χ2 (P value)	Variables/ Categories	Contraceptive use (%) Yes	No	χ2 (P value)
Sociodemographic factors							
Age groups			9.05 (**0.011**)	**Total no. of children**			9.52 (**0.009**)
≤ 25 years	87.9	12.1		No children	80.3	19.7	
26-35 years	73.8	26.2		1 child	66.3	33.7	
> 35 years	69.1	30.9		>1 child	85.1	14.9	
Intrapersonal factors							
Knowledge level			4.40 (**0.036**)	**Satisfaction for staying in Thailand**			7.29 (**0.007**)
Poor	72.8	27.2		No	71.5	28.5	
Good	82.8	17.2		Yes	84.4	15.6	
Interpersonal factors							
Social support (SS) from husband			28.44 (**<0.001**)	**SS from friends/ neighbors**			15.37 (**<0.001**)
Poor	64.8	35.2		Poor	69.4	30.6	
Good	90.1	9.9		Good	88.3	11.7	
Available sources for contraception			4.13 (**0.042**)	**Easily accessible**			10.89 (**<0.001**)
<3 sources	74.7	25.3		Yes	61.3	38.7	
≥ 3 sources	86.9	13.1		No	81.0	19.0	

Variables/ Categories	Contraceptive use (%) Yes	No	χ2 (P value)
Able to access			25.11 **(<0.001)**
Yes	80.4	19.6	
No	34.8	65.2	

Variables/ Categories	Contraceptive use (%) Yes	No	χ2 (P value)

After all, associated variables were adjusted and analyzed by multivariate logistics regression, predictors of contraceptive use among the sample of migrant women from Myanmar include being younger than 25 years, having more than one child, having a supportive husband and friends having easy access to contraception and being able to access contraception at local health outlets (see Table 4).

Table 4: Predictors of modern contraceptive use

Determinants	AOR	95% CI	P value
Socio demographic factors			
Age groups (Ref: > 35 years)			
≤ 25 years	**9.6**	**(3.07 – 31.59)**	**<0.001**
26 -35 years	2.4	(0.93 – 6.01)	0.072
No. of Children (Ref: No child)			
More than one child	**8.5**	**(2.72 – 26.37)**	**<0.001**
Interpersonal factors			
Good husband support (Ref: Poor)	**4.9**	**(2.43 – 10.26)**	**<0.001**
Good friends/neighbors support (Ref: Poor)	**4.2**	**(1.96 – 8.89)**	**<0.001**
Easily accessible (Ref: No)	**3.2**	**(1.50 – 6.78)**	**0.003**
Able to access at local health outlets (Ref: No)	**12.9**	**(4.01 – 41.94)**	**<0.001**

4. DISCUSSION

This study assessed the percentage distribution of contraceptive use and its correlates, including socio-demographic, intrapersonal and interpersonal factors. Our findings show that younger women (≤25 years) were more likely to use contraception compared to the older age groups. This might be due to being more sexually active and vulnerable to pregnancy. Other study, e.g., in Kenya, found that older women (≥ 35 years) were less likely to use modern contraception than their younger counterparts (Ochako et al. 2016). Also, in Australia, a study of Sri Lankan migrants found that the use of less effective contraceptive methods was associated with women age ≥40 years (Ellawela et al. 2017). The number of living children was positively associated with contraceptive use in this study, and nearly 75% of the migrant women wanted 2 or 3 children. In a studies in Ghana and Bangladesh, having more than 1 child was a determinant of contraceptive use (Achana et al. 2015, Islam et al. 2016). The support of the husband, friends or neighbors also promoted contraceptive use. This finding is consistent with a study in rural Poland which found that contraceptive behavior of friends and family is more influential than the woman's own characteristics (Colleran and Mace 2015). Other studies among populations along the Thai-Myanmar border mentioned that migrant women relied heavily on the opinions and experiences of their friends and family when making reproductive health decisions (Gedeon et al. 2015). Therefore, designing family planning (FP) programs with peers and family involvement could increase the practice of contraception, as

suggested by one Myanmar study (Jirapongsuwan et al. 2015). Knowledge was statistically significant in the univariate analysis, even though it was not an associated factor in the multivariate analysis. By contrast, knowledge was an important predictor of use in other studies (Decat et al. 2011, Nyein et al. 2014). Regarding the availability and accessibility of contraceptive services, the more sources the migrant women know, the more chance there is to access contraceptive services. The migrants who had no difficulty to use contraception and could easily access it at local health outlets (government, private, pharmacies) were more likely to be practicing contraception than their counterparts. These findings are consistent with other studies in Ghana and rural Kenya (Nyarko 2015, Jalang'o et al. 2017). The percentage of modern contraceptive use among Myanmar migrants was 77.1% and this result was higher than those in 2 studies such as in Natmauk Township, Magway Region, Myanmar (Myint et al.) and Thailand survey among Myanmar migrant women (IPSR 2012). This might be due to living in an urban area and ease of access to at least one kind of contraceptive method. The most common method used by migrants was OCs, as most women reported that the most convenient source was a pharmacy or drug shop, almost all women know multiple outlets for contraception. The least popular methods were IUD, implants, tubal ligation, and condoms. The main reason for not using contraception was fear of side effects. That finding is consistent with a study of migrants in Thailand which found that nearly all women knew where to access FP supplies, there was low up-take of LARC (Tangcharoensathien et al. 2015, Salisbury et al. 2016) and there were misconceptions surrounding female sterilization (Salisbury et al. 2016) although Universal Health Coverage covers almost all relevant FP methods except emergency contraceptive pills in Thailand. Among the users, pill failure was also significant among those who reported that their most recent birth was unintended due to forgetting to take their pills with 38% (Tangcharoensathien et al. 2015). In this study only a few migrant women discussed FP with a health care worker within one year prior to the survey. Thus, the migrant women were using the contraception without necessarily an informed choice, and that may lead to discontinuation and failure. One study in Mumbai found that the myths and misconceptions about contraception could be dispelled by health providers which would, in turn, reduce unmet need (Begum et al. 2017). It was mentioned in an analysis of 34 countries of the Demographic Health Survey that 19% of the past users who had discontinued method use and subsequently had unmet need accounted for 38% of the total estimated unmet need. Both access to and composition of available methods were associated with a reduction in the relevant discontinuation rate (Jain et al. 2013). Nearly half of the women in this study had health insurance. The main reasons for not having health insurance was cost. This might be an important factor for migrants who cannot access or afford the migrant health insurance of the Thai Ministry of Public Health, which requires registration and the purchase of an annual premium (Tangcharoensathien et al. 2017). Among health insurance members, the health-service utilization rate was low and that might be related to fear of arrest or deportation (Tangcharoensathien et al. 2017). In this study, most of the sample relied on a pharmacy or drug shop for contraception due to convenience, anonymity and lack of need for clinical assistance. One study of health insurance for migrants suggested that Thailand needs to increase recruitment into the insurance scheme and to scale-up migrant-friendly services (Tangcharoensathien et al. 2017).

5. CONCLUSIONS

Based on the study's findings, the women mostly relied on their personal network to obtain information on contraception, and the sources were mainly pharmacy shops and health care facilities. This study could not provide data on consistency of use of contraceptive methods, discontinuation rates and unmet need for contraception. The findings of the study suggest that enhancing open communication on sexuality and promoting knowledge transfer on SRH issues may result in improved SRH awareness and self-determination. Through visits at worksites, the

community, or help-lines in the Burmese language, one should be able to increase the visibility of SRH care services and to bridge the gap between the migrant population and the public health system. In addition, improving health insurance coverage for migrant workers will likely benefit the SRH of this population.

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