

## A determination of the influence of birth control among minority women in thailand: a qualitative study

Piyaporn Sitkulanan<sup>1,\*</sup>, Kunnikar Chaisitsanguan<sup>1</sup>, Prakaipetch Winaiprasert<sup>1</sup>, Amporn Krutwong<sup>1</sup>

<sup>1</sup>Faculty of Nursing, Thammasat University: Pathum Thani, Thailand.

**Corresponding Author:** Piyaporn Sitkulanan **Email:** sitkulanan@hotmail.com

**Received:** 1 September 2022 **Revised:** 1 February 2023 **Accepted:** 2 February 2023 **Available online:** May 2023

**DOI:** 10.55131/jphd/2023/210204

### ABSTRACT

Contraception information and services are the basis of the health and human rights of everyone. Young girls who become pregnant are at greater risk for problems arising from early child deliveries. Contraception in older women likewise results in increased risk. It was found from the particulars of contraception use that the male partner has a great deal of influence, and that the same is true of the perspectives and experiences of the people surrounding his partner, the expectations of her family and her desire for more children. In Thailand, there are ethnic groups of numerous tribes, among whom are the Karen, who make up the largest of any such group. The Karens have a low rate of contraception use and low incomes with reduced resources. Thus, family planning is an important key in reducing their population growth and the impact on their economy, environment and development. The purpose of this study was to explore the determining influence of contraception among minority women in Thailand in the form of descriptive qualitative research. Data were analyzed using Colaizzi's method. The research showed that the use of contraceptive services by Karen women was restricted by the culture, beliefs and social conditions characteristic of their ethnic origin. The husband and extended family influenced their contraceptive decisions. The prevailing belief was that contraception is the duty of women. Some women used herbs for contraception. They had difficulty communicating when receiving contraceptive services. Karen people have little income; so they cannot afford expenses related to contraceptive services requiring them to pay for travel costs. Furthermore, the road conditions make the trip awfully difficult, and their houses are situated far from the hospitals. In conclusion, determining the influence of birth control among minority women in Thailand must be based on their beliefs, society and ability to access health services.

### Key words:

minority women; birth control; contraception; ethnic group; hill tribe

### Citation:

Piyaporn Sitkulanan, Kunnikar Chaisitsanguan, Prakaipetch Winaiprasert, Amporn Krutwong. A determination of the influence of birth control among minority women in thailand: a qualitative study. J Public Hlth Dev. 2023;21(1):40-55 (<https://doi.org/10.55131/jphd/2023/210204>)

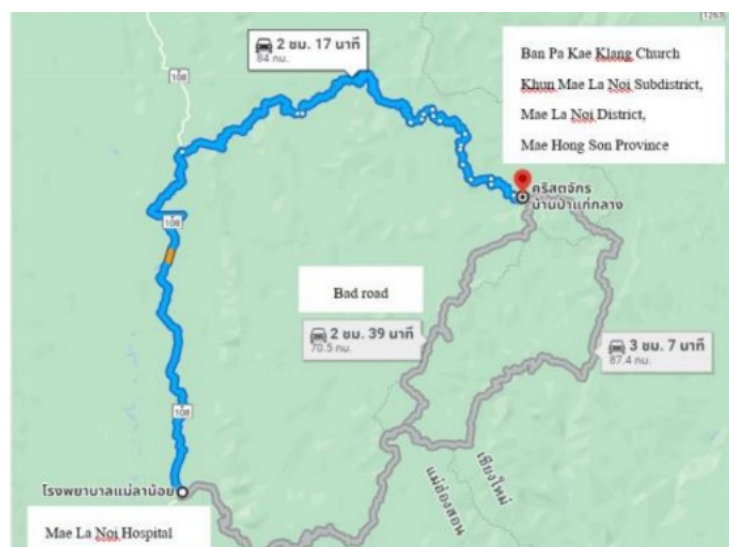
## INTRODUCTION

Contraceptive information and services are fundamental to the health and human rights of all individuals.<sup>1</sup> Delaying pregnancies in young girls who are at increased risk of health problems from early childbearing, as well as preventing pregnancies among older women who also face increased risks, are important health benefits of family planning.<sup>1</sup>

According to 2017 estimates, 214 million women of reproductive age in developing regions have an unmet need for contraception. Reasons for this situation include: limited access to contraception, a limited choice of methods, fear or experience of side-effects, cultural or religious opposition, poor quality of available services and sex-based barriers.<sup>1</sup> The Sustainable Development Goals set for 2030 will need to ensure that sexual and reproductive health services are widely available and used. These goals need to include supporting contraceptive services through effective government policies and the provision of high-quality services for individuals.<sup>1</sup>

Determinants affecting contraception found that the male partners have a strong influence,<sup>2, 3, 4</sup> as do peers' views and experiences,<sup>4</sup> families' expectations,<sup>4</sup> and the urge to have more children.<sup>2</sup> The lack of education<sup>4, 5, 6</sup> and poverty<sup>4, 5, 6</sup> are linked with low contraception use,<sup>4</sup> and social and cultural norms influence contraception<sup>4</sup> and expectations of family size and timing.<sup>4</sup> Contraception use also depends upon geographical region,<sup>6</sup> television sources,<sup>6</sup> information given at birth,<sup>6</sup> age,<sup>6</sup> religion,<sup>6</sup> availability,<sup>4</sup> the accessibility,<sup>4</sup> confidentiality<sup>4</sup> and costs of health services,<sup>4</sup> attitudes,<sup>4</sup> behavior and the skills of health practitioners.<sup>4</sup>

Thailand has many hill-tribe ethnic groups; among which the Karen people make up the largest group. The Karen people live in the mountainous areas of Northern Thailand and along the western border of the country.<sup>7</sup> The population of the Khun Mae La Noi Subdistrict consists entirely of the Karens, totaling 2,950 people, of whom 1,453 are women.<sup>8</sup> A distance of 84 kilometers (Figure 1) separates the Khun Mae La Noi Subdistrict from the Mae La Noi Hospital.<sup>9</sup>



**Figure 1** Map showing the distance from Khun Mae La Noi Subdistrict

to the Mae La Noi Hospital.

The Karen people retain an ethnic identity of their own, together with their own spoken language, dress code and certain traditions that uniquely identify them. Their houses are closely situated to those of their relatives, with a large, extended-family structure. Parents have much influence on their children. In the past, couples were chosen by senior relatives. Today, the frequency of arranged marriages, which were a former characteristic of the Karen culture, has been reduced.<sup>10</sup> Traditionally, Karen people were wary of ghosts and strictly followed a practice of worship and sacrifice for them. More of their people now practice Buddhism or Christianity,<sup>7</sup> while still using inherited traditional folk medicines based on forest herbs. Some of the Karens are uneducated or only completed their elementary education and are satisfied with their very simple way of life.

The beliefs of the Karen concerning childbirth are that each family should have at least three children. These three children may be compared to "the three hearth fire stones." If a mother has three children, then they will be able to support their mother in the same way that they boil their rice. The rice pot is comparable to the mother, while the three children are comparable to the three hearth fire stones caring for the rice pot.<sup>11</sup> The Karen family structure thus consists of a large extended family with members of many different ages living together. Karen women marry at a very young age. Consequently, some Karen families will have as many as ten children to help tend their fields.<sup>10</sup> Undergoing many pregnancies can therefore lead to a number of subsequent health problems, such as hemorrhaging caused by placenta accreta, placenta previa or a poor contraction of the uterus. Furthermore, the Karens believe that abortion is an immoral procedure. Accordingly, the Karens will not resort to

abortion, but will become pregnant willingly, believing that God will provide them to raise their children into adulthood. From a study conducted by Yutthawonsuk,<sup>10</sup> it was found that Karen women 40-50 years of age will practice contraception after having three to four children. The majority of the Karens still entertain the hope of having at least one male child in order to propagate their family lineage and to hand down their tradition of needing a son to look after the household. This finding harmonizes with a study conducted by Senawong,<sup>11</sup> who took up a case study of Karen women in which he found that they wanted to have three children in accordance with their original beliefs. Rueangrit<sup>12</sup> conducted a study of the Karens in the Province of Chiang Mai, whose lifestyles were quite similar to the Karens living in the Province of Mae Hong Son, and found that 76.66% of the Karens have annual family incomes of less than 10,000 baht with increases in the problem of population, resulting in reductions in their arable land, forests and the number of wildlife. In addition, there were fewer fish in the streams. It can be seen from the foregoing data that the Karens have a low contraceptive rate, low incomes and a reduction in resources, for which family planning will be an important key in slowing the growth of their population and reducing the negative impact on the economy, environment and development of the country.<sup>13</sup> For that reason, the researcher is interested in learning what the relevant determinants may be pertaining to the subject of contraception among Karen women. The information obtained could then be used as guidelines in offering contraceptive services to these women.

## METHODS

### *Methodology*

This study took the form of descriptive qualitative research. Data were analyzed using Colaizzi's method. The data analysis of Colaizzi<sup>14</sup> took the form of a Duquesne school education based on structural concepts according to the reality of Husserlian phenomenology.<sup>15</sup> Key participants were Karen women aged 18–49 years who were married and had at least one living child, had lived in Khun Mae La Noi Subdistrict, Mae La Noi District, Mae Hong Son Province for more than five years and had never worked downtown or on the flatlands. The investigators conferred with a public-health academician at a subdistrict health promotion hospital to clarify the objectives of the study, to specify the data collection method and to determine the qualifications of the key participants. This study included no focus group discussions because of the language barrier. Observations and interviews were conducted until the information was saturated with useful insights that had been drawn from 35 key participants.

### *Research Tools*

Research tools consisted of semi-structured interviews that contained questions about beliefs, society, communication, transportation, economy and folk wisdom, which were interviewed by an interpreter. To ensure data trustworthiness in our investigation, we prepared ourselves in the following manner:

1. We practiced the Karen language.
2. We learned and tried to understand more about the context of space, culture and contraceptive practices of Karen women in order to enhance our observations and understand the interview issues they would raise.

### *Data Collection*

1. Upon meeting the key participants, we began our investigation by introducing ourselves and clarifying the objectives of our study and data collection method by reading and describing a subject information sheet and an informed consent form. In this way, participants were allowed time to consult with their families on whether to participate the next day and to take the subject information sheet and informed consent form home to read at their own leisure.

2. On Day 2, the key participants signed their agreements to participate in this study. The principal investigators and the research assistants formed a relationship and a sense of familiarity with the sample group.

3. Once the key participants became more familiar with our research, the in-depth interviews began and continued for 45–60 minutes at a time in line with the prepared questions and also some additional questions. For example, “Tell me about how you traveled to get contraceptive services.” “How many baht per month do you pay for your birth control?” “Who in your society decides the number of children in a family? How do you decide?” “Tell me about your beliefs about birth control methods.” “How do you use folk wisdom for birth control?” and “How does your communication affect birth control?”. During the interview, when engaging in an interesting issue, the investigators asked probing questions and ensured that the data provided by key participants were accurate. This procedure also allowed key participants to elaborate on some points that were unclear. The nature of the interview was conversational and was based on attentive listening with no judgment. Interviewers encouraged the key participants to share their experiences and provided examples to help them understand the actual context of each question. The

assistants recorded and took field notes throughout the interview and made arrangements for an additional interview whenever some of the points were still unclear. The next interview would take approximately 30 minutes. The interview continued until the investigators were fully satisfied. An examination of the information obtained indicated that the information was a duplicate, and that no new information was added.

### **Verification of Research Trustworthiness**

The researcher established a procedural methodology for building data trustworthiness per the concepts of Lincoln and Guba<sup>16</sup> as follows:

1. Credibility: The researcher has defined building reliability as beginning with data collection by:

1.1 Reliability of the researcher: The head researcher is a nursing professor in the position of associate professor with twenty years of experience in the fields of gynecology and women's health. In meeting the informants for the first time, the researcher introduced herself through an interpreter in order to ensure that the informants felt that the researcher was reliable. Such reliability would affect the correctness and truthfulness of this information.

1.2 The interview process: This process was conducted in a relaxed atmosphere allowing for in-depth interviews that were not rushed, so that the informants could reveal their perspectives completely. Prior to carrying out their interviews, the researcher spent a certain amount of time making her observations in the area until she finally became familiar with her informants so that, during the course of the interviews, the informant would be freely able to relate her own experiences and feelings with no tendency to conceal anything. The researcher applied techniques that helped her to carry out her interviews and receive information that was

both complete and factual, such as the repetitive-question technique, the inclusion of examples and the use of feedback.

1.3 Daily verification of information: The researcher verified the accuracy of the information taken from the interviews and observations, and checked whether it had been recorded systematically in brief summary form. She then brought her compiled information back to her informants and asked them to confirm the validity of her information summary as factually correct.

1.4 Review by co-researchers: Three researchers who were nursing instructors with experience in quality research participated. These three researchers separately read the information to get a grasp of the issues and research findings, which they then compiled categorically until they were able to come to a common conclusion.

1.5 Questions exchanged between researcher and experts: The researcher consulted three experts on her findings. The three experts were nursing professors with expertise in quality research and gynecological science. Their purpose was to test for correctness.

2. Dependability, employment of "overlapping methods," and an in-depth methodological description to allow the study to be repeated.

3. Confirmability The researcher performed a triangular test by:

3.1 The triangulation method: The researcher compiled her information by being present in the area where she made her observations and by pairing her observations along with her interviews.

3.2 Investigator triangulation: An appointment was set for an additional interview into certain issues that still lacked clarity. The same questions were repeated, but by a different interviewer, in order to determine whether the information from the second interview would differ at all from

the information derived from the original interview.

3.3 Data-source triangulation: The researcher used the same questions in her interview with other informants to determine whether or not there would be any changes in the information as a result of having interviewed these other individuals.

4. Transferability: Provision of background data of the Karen people to establish the context of study and a detailed description of phenomenon in question to allow comparisons to be made.

### Data Analysis

This study took the form of descriptive qualitative research. Data were

analyzed using Colaizzi's method. Firstly, a full transcription was classified according to the determinants pertaining to contraception as practiced by Karen women. Secondly, the lists of categories were grouped under higher-order headings. Finally, the researchers selectively coded a list of verbatim quotations based on the participants' reflections on the determinants that were related to the use of contraception by Karen women.

## RESULTS

### *Personal Information*

Personal data were analyzed using frequency enumeration, evaluated as percentages, as in Table 1.

**Table 1** Numbers and percentages of the general data.

| General information                    | Headcount (n=35) |            |
|----------------------------------------|------------------|------------|
|                                        | Number           | Percentage |
| <b>Age</b> ( $\bar{x}$ =41, S.D.=4.10) |                  |            |
| 18 – 19 years                          | 6                | 17.14      |
| 20 – 34 years                          | 10               | 28.57      |
| 35 years and up                        | 19               | 54.29      |
| <b>Women's Occupation</b>              |                  |            |
| Agriculture                            | 33               | 94.29      |
| Work as employees                      | 2                | 5.71       |
| <b>Husbands' Occupation</b>            |                  |            |
| Agriculture                            | 33               | 94.29      |
| Work as employees                      | 2                | 5.71       |
| <b>Marital Period</b>                  |                  |            |
| Under 3 years                          | 4                | 11.43      |
| 3-5 years                              | 7                | 20.00      |
| More than 5 years                      | 24               | 68.57      |
| <b>Number of children</b>              |                  |            |
| 1                                      | 3                | 8.57       |
| 2                                      | 6                | 17.14      |
| 3                                      | 9                | 25.71      |
| 4                                      | 9                | 25.71      |
| 5                                      | 8                | 22.86      |
| <b>Contraceptive method</b>            |                  |            |
| Oral contraceptive pills               | 19               | 54.29      |
| Implants                               | 3                | 8.57       |
| Injectables                            | 12               | 34.29      |
| Intra uterine devices                  | 1                | 2.86       |

According to Table 1, most data informants were 35 years old and up, comprising 54.29% of the total. The average age was 41 years. The occupation of most women, 94.29% of the total, was agriculture, and the occupation of most of their men was agriculture. Most, 68.57% of the total, had been married for over five years. Everyone had a national ID card; 25.71% had either three or four children; and 54.29% used oral contraceptives.

### ***General Characteristics of the Participants***

Karen people called themselves "Pga K'nyau". The houses of the Karen were situated on the plain in the middle of the shoulder, near the water and agricultural areas. Most of them were single-story wooden houses, raised above ground level for the purpose of keeping firewood and raising pigs and chickens. Contraception was called "Mathupo". Although the more conventional dresses were being worn by the more forward-looking women, most Karen ladies still preserved the use of their traditionally styled dresses. Unmarried women wore ankle-length V-neck white plain sacks with hanging tufts while married women wore V-neck black tops adorned with job's tears or embroidered with colored yarns and red phasin covered in horizontal strips. Men preferred to wear black cylindrical pants and V-neck red tops with hems attached to hanging tufts. Women selected and proposed to their spouses. Following the weddings, the men must stay at the houses of the women for one harvest season. Important traditions of the Karens were New Year's and wedding traditions. The original New Year's tradition included sacrificing the raised chickens and pigs as an offering to respect the spirits. At present, all Karen people embrace Christianity and have thus changed their worship practices to prayers at church. According to the marriage

traditions of the past, any couple who had indulged in sexual intercourse prior to the wedding would be penalized by being made to walk through the village with no participation in a wedding ceremony. Today, however, such couples can organize the ceremony outside the churches, and there is no penalty.

### ***Determinants of Contraception Use***

Factors determining the use of contraceptives among Karen women included their beliefs, society and ability to access health services.

**Beliefs:** "The prevailing belief was that a woman must have at least three children."

Karen women still believed in the three furnace stones, which resembled a mother who had at least three children to feed her.

"There must be at least three children. In the past, a mother was like a furnace with three stones. It took three children to feed her. It was like cooking rice, where the pot was the mother, and her three children were like three stones holding the pot still. At present, pot stands (Figure 2) are used in place of stones. The pot stands are like three legs, so that three children are just the right number. I'm going to wait until another one is born before taking birth control." (ID1)

"We need to have at least three children, just like those stones supporting the rice pot. Having many children means they can help one another tend the fields and do the farming, so we'll have rice to eat and rice to sell." (ID 29)

"Having so many children is a good thing. Their parents can then depend on them. Children can depend on their siblings. Do we now see those legs supporting the rice pot? It still has three legs; so we can do anything and succeed with three or more children." (ID8)



**Figure 2** A rice-cooking stand of a Karen family.

**Society:** "Authority in the family to make decisions regarding the use of contraception"

A household consisted of five to eight members, including two parents and three to five children. Some families also had their grandparents living with them. Three to five children were needed to help with the farms, paddy lands and household chores. Using contraceptives was the duty of women, but the husband and his extended family had a powerful influence on contraceptive decisions.

"As for birth control, I must first talk to my husband. His parents want three grandkids." (ID21)

"My use of birth control must be the decision of my husband. If he still wants more children, he must get his way." (ID7)

"If my husband says he can raise a child, then I cannot continue to use birth control. He will be displeased if I do." (ID16)

**Ability to access health services:**  
"There was a problem with

communication, transportation and the economy."

The health rights of Karens who had Thai National ID cards were guaranteed. Nonetheless, Karen women still had problems in accessing health services in the area of birth control because of the difficulties they face regarding communication, transportation and the economy. Also, since they often could not access health care, they used alternative methods of birth control, such as herbs.

**Communication:** "If a woman was unable to communicate, then she would be reluctant to get contraception at the hospital."

Most women were unable to write or communicate in Thai or were only partially literate in the language. This limitation caused communication problems when visiting community hospitals for the purpose of receiving contraceptive services.

"My husband and I never studied Thai. I can't read, write, speak or understand Thai. So, it's very troublesome

going to Mae La Noi Hospital, and I don't like going there." (ID22)

"When I make a lot of trips to the hospital, I run into problems. I do not know how to communicate with the doctors, because I do not know the Thai language, So, I don't want to go somewhere and be sterilized." (ID18)

"I don't want to the hospital for birth control, because going to the hospital means I need someone who speaks Thai to go with me. When someone like me can speak just a few words, the doctors don't understand." (ID20)

**Transportation:** "Traveling somewhere to get contraception was quite troublesome."

Transportation in Khun Mae La Noi Subdistrict required traveling up a steep hill. Women, elderly people and children went on foot. Young people rode motorcycles. People in the village could rely on others in their journeys by hitchhiking. There were no costs of traveling within the village. Traveling to a community hospital (Mae La Noi Hospital) was not easy, because the village was 85 kilometers away from the Hospital, and there were no buses. If anyone wanted to

run errands, they would have to hire a pickup truck for their trip. The Karen people of Khun Mae La Subdistrict preferred to go to the hospitals or travel through the Mae Chaem District, Chiang Mai Province, because the distance was shorter, although the street leading into Mae Chaem District was narrow and unpaved (Figure 3).

"Going to the subdistrict health promotion hospital for birth control is easy. It isn't far from home, and the street's accessible, although hardly convenient, since it's unpaved. If it's during the rainy season, there's a deep channel of rainwater flowing through it. It's a little cloudy at times, and a little muddy. If there is a biker coming close by, I usually ask to tag along with that person. If no one is around, I'll go on foot." (ID8)

"People here take their business dealings to Mae Chaem District in Chiang Mai, because the distance is shorter. I like going to Mae Chaem Hospital, even though I'm not eligible for treatment there." (ID19)

"After traveling for more than half a day, I arrive at the Mae La Noi Hospital. It's so tiring. The roads are bad. So, I really don't want to go." (ID11)



**Figure 3** A street in the Khun Mae La Noi Subdistrict.

**Economy:** “Women had no money for the carfare to the hospital for contraception.”

The occupation of most Karen women is agriculture, and they are free from any liabilities. Each Karen family has a per-annum income of USD 1,500-3,000. The Karen people have a growing number of demographic problems. Hence, they must contend with reductions in the workplace and rely only on natural foods. Contraception was free of charge, because people of very modest means had an entitlement to free treatment. However, they were still burdened with the cost of getting to the community hospital, which was far from where they lived and required a bus for transportation.

"People here are poor, but they don't have any debts. In a year, I earn money from rice sales and the corn I plant, totaling USD 1,500. Working as an employee at Mae Chaem District, I make USD 6 a day, but for the most part, I don't work. Someone with low revenue like me needs to live on savings. I receive contraceptive pills at the subdistrict health promotion hospital free of charge, since I qualify by my low-income status. But, if I'm going to get sterilization, I will need to go to the Mae La Noi Hospital, I'll have to rent a car." (ID15)

"I receive birth control pills at the subdistrict health promotion hospital free of charge. But, if I'm going to get sterilization, I will need to go to the Mae La Noi Hospital, I don't have the money to rent a car. There are more people now having trouble making a living, with not much to find in the forest. I get to eat wild game once in a while. The fish in the creeks are becoming scarce; only small ones remain." (ID20)

"Anyone who wants to be sterilized has to go to the Mae La Noi Hospital. Nobody really wants to go, because without a pickup truck, they have to hire a car for

about 28-56 USD. There are no buses here." (ID12)

**Folk Wisdom:** "Also, since they often cannot access health care, they use alternative methods of birth control, such as herbs."

Since they were usually not able to access health care, some Karen women used herbs to control birth, such as Por Ngor Mee and Lor Geu.

"My home's far from the supply center of birth control pills. It's inconvenient to walk several kilometers; so I use a herb called Por Ngor Mee. It's about one cubit high with white flowers and red flowers similar to a cockscomb and grows near the water source. I boil it in three glasses of water and let the water boil down and until it reduces to just one glass. I drink it during menstrual periods once a month." (ID27)

"Going to the hospital is a lot of trouble just getting there. I use an herb called Lor Geu. It has large green leaves and a one-meter-tall stem. I take 2-3 roots, bring them to a boil and drink it during menstrual periods. Now it's hard to find." (ID1)

"Using herbs from the forest is the thing to do! I just boil them and eat them as a contraceptive. They've been handed down from antiquity, and they don't cost any money." (ID17)

## DISCUSSION

From the generally available data, it was discovered that the average age of the informants was 41 years. The majority made their living as farmers. All of them had national ID cards and had three or four children. Also, 54.29% of them were using oral contraceptive pills.

Pregnancies in older women are often associated with an increase in the number of complications such as miscarriage, high blood pressure, diabetes

and chromosomal problems with the baby.<sup>17</sup> The Center for Disease Control and Prevention recommends that contraception is still needed for women older than 44 years who have not reached menopause and wish to avoid pregnancy, and that is based on age alone, all contraceptive methods are considered safe or generally safe for use by women of older reproductive age.<sup>18</sup>

The majority of informants were using oral contraceptive pills. Currently, there are three types of oral contraceptive pills: combined estrogen-progesterone, progesterone-only and continuous or extended-use pills. The birth control pill is the most commonly prescribed form of contraception in the US. Approximately 25% of women aged 15 to 44 who currently use contraception reported using the pill as their method of choice. The most commonly prescribed pill is the combined hormonal pill with estrogen and progesterone. Progesterone is the hormone that prevents pregnancy, and the estrogen component controls menstrual bleeding. Birth control pills are primarily used to prevent pregnancy. The effectiveness of this form of birth control is referred to as typical and perfect use.<sup>19</sup>

The study found that the main occupation of the Karens is farming. Karen women did not control their number of births after marriage, but wanted to have three to five children to help with farming. Furthermore, most of the women wanted male children for the aforementioned practical reasons indicated above. According to the International Labor Organization (ILO), poverty is the main cause of child labor in agriculture.<sup>20</sup> Similarly, the European Commission reported that poverty and inequalities are the main drivers of child labor in agriculture.<sup>21</sup>

The Karen people have no tradition of contraception, as based on the above-mentioned belief of placing stones around rice pots to keep the pots stable. The cultural setting in which people live

influences how they view contraceptives.<sup>22</sup> In a study conducted by Rueangrit,<sup>12</sup> it was found that the contraception beliefs of the Karens had a statistically significant relationship to their receptiveness toward contraceptive services. The beliefs of Karen women on the subject of family planning have been forged from within their culture and are an integral part of their upbringing. Cultural factors, therefore, influence family-planning decisions. Service providers will be able to understand the cultural differences by studying and supporting the decisions that the women make that are related to their beliefs and their sense of awareness.<sup>22</sup>

Husbands influence the decisions of the Karen women on the matter of contraception. The husbands played an important role in determining whether additional children are needed, while their wives are responsible for complying with and selecting the right methods of contraception for themselves. The role and the influence of the husband, therefore, have to be taken into account in the development of family-planning services and programs.<sup>23</sup> In addition, many Karen families consist of extended families, who exert their influence over the use of contraception. This involvement of the extended family is consistent with a study conducted by Hajason et al.,<sup>24</sup> who found that the extended families had an influence on the use of contraceptives. Thus, promoting the use of contraception by Karen women should also include a public-relations effort on contraception involving the husbands and extended-family members.

The majority of Karen women practice contraception by using oral contraceptive pills, while some rely on either implants or injectable and-or intrauterine devices. Although there are some simple contraceptive methods that are effective for men, like the prophylactic condom, such methods are not popular among the Karens for contraceptive

purposes, since the prevailing attitude of the Karens is that contraception is the duty of the women. (Such thinking is dominant even in a country like the United States!) The responsibility for contraception in opposite-sex relationships likewise falls with the woman.<sup>25</sup> The Karens, therefore, need to become more informed on this subject and realize that contraception is the joint responsibility of both men and women. Their men can help take responsibility in this matter,<sup>26</sup> as they usually experience fewer contraception side effects than women. Use of prophylactic condoms, for instance, will cause virtually no chemical side effects at all. Contrary to the practice of contraception in women with its numerous hormonal side effects, sterilization of men can be done easily and in a short length of time, while the sterilization of women is more difficult. A sense of pride needs to be promoted among the Karen men in helping their wives in the area of contraception.

The majority of Karen women were able neither to write nor to communicate in Thai or, in some cases, were only minimally literate in the language. This limitation was the cause of communication problems whenever the women visited their community hospitals for contraceptive services. This situation was similar to the studies conducted by Rueangrit,<sup>12</sup> Gunmongkol<sup>27</sup> and Somsawat,<sup>11</sup> who found that the majority of Karen people were uneducated or completed only their elementary education. In order to correct this problem, interpreters in the Karen language should be provided as a means of promoting a more extensive use of contraceptive services among the Karen women.

The transportation at Khun Mae La Noi Subdistrict is very arduous because of the unpaved streets, side gorges and non-availability of buses. The village is 85 kilometers away from the subdistrict

downtown. It takes two to three hours on foot along a twisting, winding route. Silumbwe et al.<sup>28</sup> found that long-distance trips to infirmaries were an obstacle to receiving contraceptive care. In addition, the cost of USD 30-60 for a charter truck for a trip to a community hospital was another challenge, according to a study conducted by Hunter et al.,<sup>29</sup> who found that travel costs hindered access to contraception. This finding was similar to a study conducted by Tanabe et al.,<sup>30</sup> who found that the ability to pay was a variable that affected access to contraception. These determinants explain why contraceptive services (Tubal Sterilization) at Mae La Noi District Hospital are not popular among Karen women. Communication, transportation and the economy may be considered essential to the "ability of the Karens to access health services." Also, since they often cannot access health care (although everyone has a National ID card and therefore has the right to receive treatment according to his or her National Health Security rights), they use alternative methods of birth control, such as herbs. Regarding the use of herbs for contraceptive purposes, there are limitations resulting from the continual reduction of forests, resulting in a scarcity of herbs. Also, the amount of herbs that should be used and the side effects of using them are still under study. During the course of numerous researches, it was found that the use of herbs for contraception is still unreliable and can incur side effects.<sup>31</sup> Karen women want to see some improvements, first, in the streets leading to the Mae Chaem District Hospital, Chiang Mai, since it only is about 40 kilometers to the Khun Mae La Noi Subdistrict. The travel time is one hour. The government should revise the hospital treatment rights in accordance with the short distance to the Mae Chaem Hospital in Chiang Mai, rather than the service area

of Mae Hong Son, as well as improve the route to the Mae Chaem Hospital. The dirt-gravel pitted street should be reworked into an asphalt or concrete-paved roadway, so that the Karens can have the same access to health services as others do.

## CONCLUSION

The use of contraceptive services by Karen women is restricted by the culture, beliefs and social conditions that are specific to their ethnic origin. Husbands and their extended families are influential in contraceptive decision making. The prevailing attitude has been that contraception is the duty of their women and that the men bear no responsibility in this matter. Some women use herbs for contraception, since they usually do not have good access to health care and often have difficulty communicating when receiving contraceptive services. Karen people have little income, so they cannot afford contraceptive services that require them to pay for the travel costs. In addition, the condition of the travel route makes the trip awfully difficult, since their houses are situated far from the hospitals.

## RECOMMENDATIONS

1. The provision of contraception for the Karens should take into account their culture, beliefs and social conditions. Since husbands and their extended families have expanded their influence in the area of contraceptive decision making for women, the promotion of contraception requires that their husbands and extended families become informed on this subject.

2. The health-promoting hospital policies regarding contraception services for minority groups should be designed so that these services are offered actively rather than passively. Also, in order to reduce the limitations in communication, the hospitals should include the use of language interpreters and thereby make the

administration of their contraceptive services more efficient.

3. The government is making improvements in the travel routes and increasing benefits to the Karens. The government is thus helping them in getting access to hospital care so that they can now access their contraceptive services at the hospital itself in the nearby District of Mae Chaem and not have to travel to the hospital in the District of Mae La Noi, which is much farther away.

## LIMITATION TO THIS STUDY

The majority of informants were older adults and, accordingly, had problems in communicating. Had they, instead, been Karens under the age of 20 years old and functionally literate, they would have been able to express themselves with less difficulty and would have been able to participate in focus-group discussions, as well.

## ACKNOWLEDGMENTS

Our thanks go to Professor Dr. Pranom Othaganont, Professor Dr. Jintana Watcharasin, Associate Professor Dr. Wannee Deoisres, Assistant Professor Dr. Buntarika Chatreewatanakul and Dr. Kanjanee Phanpairot for their valuable advice, which helped to make this research a success.

## RESEARCH ETHICS

The research project was submitted as a proposal to the Human Research Ethics Committee under COA no. 020/2564.

## FUNDING

This study was supported by Thammasat University Research Fund, Contract No. TUFT 39/2564.

## REFERENCES

1. World Health Organization (WHO). Contraception [Internet]. 2022 [cited 2022 Dec 22]. Available from: [https://www.who.int/health-topics/contraception#tab=tab\\_1](https://www.who.int/health-topics/contraception#tab=tab_1)
2. Kaniki FR. Factors influencing the use of modern contraceptive methods among rural women of child bearing age in the Democratic Republic of the Congo. *J Family Med Prim Care*. 2019;28(8):2582-86. doi: 10.4103/jfmpc.jfmpc\_345\_19
3. Afriyie P, Tarkang EE. Factors influencing use of modern contraception among married women in Ho West district, Ghana: descriptive cross-sectional study. *Pan African Medical Journal*. 2019;33:15. doi: 10.11604/pamj.2019.33.15.17500
4. D'Souza P, Bailey JV, Stephenson J, Oliver S. Factors influencing contraception choice and use globally: a synthesis of systematic reviews. *Eur J Contracept Reprod Health Care*. 2022;27(5):364-72. doi: 10.1080/13625187.2022.2096215
5. Noormal AS, Winkler V, Eshraqi AM, Deckert A, Sadaat I, Dambach P. Factors influencing the uptake of short-term contraceptives among women in Afghanistan. *Sci Rep*. 2022;12(1):6632. doi:10.1038/s41598-022-10535-y
6. Ekholuenetale M, Olorunju S, Fowobaje KR, Onikan A, Tudeme G, Barrow A. When Do Nigerian Women of Reproductive Age Initiate and What Factors Influence Their Contraceptive Use? A Contextual Analysis. *Open Access J Contracept*. 2021;12:133-47. doi: 10.2147/OAJC.S316009
7. Princess Maha Chakri Sirindhorn Anthropology Centre. Ethnic Groups Research Database [Internet]. 2013 [cited 2020 Apr 2]. Available from: [https://www.sac.or.th/databases/ethnicr edb/research\\_detail.php?id=156](https://www.sac.or.th/databases/ethnicr edb/research_detail.php?id=156)
8. Khun Mae La Subdistrict Administrative Organization. Khun Mae La Noi. Subdistrict basic information [Internet]. 2021 [cited 2020 Apr 2]. Available from: [www.khunmaelanoi.go.th/main.php?id=25](http://www.khunmaelanoi.go.th/main.php?id=25)
9. Google Maps. Khun Mae La Noi [Internet]. 2020 [cited 2020 Apr 2]. Available from: <https://www.google.com/maps>
10. Yutthawonsuk D. Culture changes: A case study of Karen people at Ban Thi Phu Ye, Chalae subdistrict, Thong Pha Phum district, Kan Chanaburi province. *Kasem Bundit Journal* [Internet]. 2014;15(2):1-16. Available from: <https://so04.tci-thaijo.org/index.php/jkbu/article/view/25232>
11. Somsawat W. Experience and access to justice for ethnic women. Women's Studies Center, Chiang Mai University [Internet]. 2022 [cited 2020 May 2]. Available from: [https://wsc.soc.cmu.ac.th/womancenter/aview\\_detail.php?id=21&lang=th](https://wsc.soc.cmu.ac.th/womancenter/aview_detail.php?id=21&lang=th)
12. Rueangrit C. Factors related to receiving contraceptive services of married Karen women, Omkoi District, Chiang Mai Province [Internet]. 2014 [cited 2020 May 2]. Available from: <http://cmuir.cmu.ac.th/handle/6653943832/14056>
13. World Health Organization (WHO). Family planning/Contraception [Internet]. 2020 [cited 2020 Jul 12]. Available from: <https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception>
14. Colaizzi P. Psychological research as the phenomenologist views it. In: Valle R, King M, editors. *Existential Phenomenological Alternatives for Psychology*. London: Oxford University Press; 1978. p. 48-71.

15. Husserl E. Phenomenology and the crisis of philosophy. Lauer Q, translator. New York: Harper & Row; 1965.
16. Lincoln YS, Guba EG. Naturalistic inquiry. Newbury Park, CA: Sage Publications; 1985.
17. Gregor AM. Contraception for the older woman. Women's Health Concern [Internet]. 2022 [cited 2023 Jan 26]. Available from: <https://www.womens-health-concern.org/wp-content/uploads/2022/12/04-WHC-FACTSHEET-ContraceptionForTheOlderWoman-NOV22-B.pdf>
18. Tepper NK, Godfrey EM, Folger SG, Whiteman MK, Marchbanks PA, Curtis KM. Hormonal Contraceptive Use Among Women of Older Reproductive Age: Considering Risks and Benefits. J Womens Health (Larchmt). 2018; 27(4):413-7. doi: 10.1089/jwh.2018.6985
19. Cooper DB, Patel P, Mahdy H. Oral Contraceptive Pills. StatPearls. Treasure Island (FL): StatPearls Publishing Copyright © 2022, StatPearls Publishing LLC.; 2022.
20. International Labour Organization. Child labour in agriculture [Internet]. 2022 [cited 2022 May 27]. Available from: <https://www.ilo.org/ipecc/areas/Agriculture/lang--en/index.htm>
21. European commission. To eradicate child labour we must focus our attention on agriculture [Internet]. 2022 [cited 2022 May 27]. Available from: [https://ec.europa.eu/international-partnerships/stories/eradicate-child-labour-we-must-focus-our-attention-agriculture\\_en](https://ec.europa.eu/international-partnerships/stories/eradicate-child-labour-we-must-focus-our-attention-agriculture_en)
22. Medscape Nurses. Engaging in culturally competent family planning counseling [Internet]. 2009 [cited 2022 May 27]. Available from: <https://www.medscape.com/viewarticle/717039>
23. Mboane R, Bhatta MP. Influence of a husband's healthcare decision making role on a woman's intention to use contraceptives among Mozambican women. Reprod Health. 2015;12:36. doi: 10.1186/s12978-015-0010-2
24. Hajason JZ, Piña K, Raveloharimisy JL. The influence of family dynamics on contraceptive use in Madagascar and the ensuing impact on family well-being. MEASURE Evaluation [Internet]. 2013 [cited 2022 Mar 7]. Available from: <https://www.measureevaluation.org/publications/wp-13-141.html>
25. Kimport K. More than a physical burden: Women's mental and emotional work in preventing pregnancy. J Sex Res. 2018;55(9):1096-105. doi: 10.1080/00224499.2017.1311834.
26. Donegan M. It's time for men to step up and share responsibility for birth control. The Guardian [Internet]. 2019 [cited 2022 Dec 25]. Available from: <https://www.theguardian.com/commentisfree/2019/jun/05/male-birth-control-step-up-responsibility>
27. Gunmongkol S. The construction of campaign to motivate Karen women to use contraceptive in Omkoi district, Chiang Mai [Internet]. 2013 [cited 2020 Mar 7]. Available from: <http://cmruir.cmru.ac.th/handle/123456789/59>
28. Silumbwe A, Nkole T, Munakampe MN, Milford C, Cordero JP, Kriel Y, et al. Community and health systems barriers and enablers to family planning and contraceptive services provision and use in Kabwe District, Zambia. BMC Health Serv Res. 2018;18(1):390. doi: 10.1186/s12913-018-3136-4
29. Hunter LA, Prata N, Eskenazi B, Njau PF, McCoy SI. Transportation cost as a barrier to contraceptive use among women initiating treatment for HIV in Tanzania. AIDS Care. 2021;33(2):206-13. doi: 10.1080/09540121.2020.1758613
30. Tanabe M, Myers A, Bhandari P, Cornier N, Doraiswamy S, Krause S. Family planning in refugee settings: findings and actions from a multi-

country study. Conflict and Health [Internet]. 2017 [cited 2021 Feb 22]. Available from: <https://conflictandhealth.biomedcentral.com/articles/10.1186/s13031-017-0112-2>

31. Anand AK, Prasad V, Alam M. Herbal or modern methods of contraception! choice is yours. International Journal of Reproduction, Contraception, Obstetrics and Gynecology. 2015;4(4). doi: <https://doi.org/10.18203/2320-1770.ijrcog20150405>