ORIGINAL ARTICLE

Information behaviour and factors influencing family planning knowledge of Myanmar ethnic migrants: a qualitative study

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ABSTRACT

The accessibility to quality family planning (FP) information and counselling for Myanmar ethnic migrants in Thailand is questionable. Inadequate knowledge and lack of informed choice to practice FP methods increase the risk of unmet needs and method failures in FP, which could result in unplanned pregnancies and induced abortions. This research aimed to understand the FP information behaviour of a Pa-O migrant group, as well as structural and agency influencing factors on FP knowledge acquisition in Chiang Mai. A qualitative research based on the Information Behaviour model and Structuration theory was conducted using participant observation, in-depth interviews, focus group discussions, and key informant interviews. A non-probability sampling method was employed, and 31 respondents participated in the study. The study found that actively seeking FP information from formal sources to make an informed decision was not common among Pa-O migrants. Instead, there was more reliance on informal information sources for choosing FP methods. Cultural norms related to sex, marriage, and age hinder migrant health information-seeking behaviour from formal and informal information sources. Pa-O migrants were alienated from structural resources, limiting the opportunities to promote FP knowledge. The personal and situational factors that significantly influenced the agency of migrants were lack of awareness of the right to information, language barriers, and perceived communication barriers with health staff. Limited resources of migrant-friendly health education programmes adversely affect migrant FP information behaviour. Reproductive health education programmes, including quality FP counselling services, should be accessible for marginalised migrants to ensure that their choices of FP are well-informed.

Key words:
family planning; information behaviour; Myanmar migrants; Pa-O ethnic; structure and agency

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INTRODUCTION

Labour migration from Myanmar to Thailand began in the middle to the late 1980s because of the unstable political and economic situations.[1] According to the latest Myanmar Census data in 2014, over two million Myanmar citizens have migrated overseas with the largest number (70.2%) in Thailand, mostly working in low-skilled jobs.[2] 'Myanmar migrant' is an umbrella term representing every immigrant who migrates from Myanmar regardless of ethnicity. Pa-O is the second largest ethnic group in Shan State, Myanmar, bordering Thailand.

The Myanmar migrant demographic data in Thailand indicates a high demand for reproductive health services, with approximately 2.3 million Myanmar migrants residing in Thailand.[3]A survey among Myanmar migrants stated that more than half of the migrants are married, with 90% staying with their married partners in Thailand. Most are of reproductive age, with the highest number in the age group of 25–34 years and the second highest in the age group of 15–24 years.[3] Family Planning (FP) is one of the main components of reproductive health.

> 'Family Planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through the use of contraceptive methods and the treatment of involuntary infertility'.[4]

In Myanmar, most Pa-O people live in rural areas for agriculture-based livelihoods. The public health sector in Myanmar cannot fulfil the basic Essential Package of Health Services (EPHS) for the entire population, [5] which causes FP service gaps for people living in rural areas, including Pa-O community. Due to resource limitations in promoting FP knowledge in the country of origin, FP knowledge inadequacy persists when they migrate. Meanwhile, the demand for FP methods has increased because of the transition from pro-natal practices to a preference for downsizing the number of children owing to the unstable nature of migrant living and financial insecurity. Interactive discussions with healthcare providers regarding the informed choice of FP methods are hindered for Pa-O migrants by language barriers in the land to which they migrated. An informed choice of contraceptive is critical for successful FP. Informed decision-making means that users are provided with information on different FP methods with pros and cons, health advantages, risks, and side effects, enabling them to compare various methods.[6] Without a thorough understanding of FP methods, users cannot make an informed choice among methods, which could result in contraceptive discontinuation,[7] followed by the risk of an unintended pregnancy and unsafe abortion.[8] As such, the Pa-O migrant population in Thailand is vulnerable as they come from an environment with limited resources for FP knowledge and services, and face challenges in the host country to access quality FP counselling for informed choice. When FP information and services are not accessible due to limited resources, language, and cultural barriers, it could lead to increased numbers of unintended pregnancies and a sense of powerlessness over FP among the migrant population.[9]

WHO defines women with unmet needs for FP as '… those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child. The concept of unmet

need points to the gap between women's reproductive intentions and their contraceptive behaviour.[10] The unmet needs for FP of Myanmar migrant women living together with their partners in Bangkok is moderately high (15.8%), with one in every six women having unmet needs for FP.[11] Low FP knowledge contributes three-fold to an increased potential of unmet needs compared to adequate knowledge in women.[11] Approximately 48% of pregnancies in low- and middle-income countries are unintended, and 61% of the unintended pregnancies terminated in abortion in 2015–2019 globally.[12]

Further analysis of the contraceptive utilisation rate of Myanmar migrants reveals that the increased contraceptive utilization rate does not positively correlate with the knowledge adequacy of FP methods. Thawu found that despite an 85.7% contraceptive prevalence among Myanmar migrant women in Samutsakhon Province, only 5.4% of participants knew all choices of contraception.[13] Soe et al. reported 80.1% contraceptive prevalence in their study group of Myanmar migrant women in Phang-Nga Province, whereas only 7.4% had a high level of knowledge about contraception;[14] the authors concluded that there is a gap between knowledge and utilisation. Although migrant women are using contraception, many do not have correct and adequate knowledge for effective utilisation to achieve the desired outcome.[14]

Several quantitative studies have focused on contraceptive prevalence rates; the influencing factors of contraceptive utilisation; unmet needs of FP; and knowledge, attitude, and practice of FP among Myanmar migrant women.[11,13,14,15] However, few qualitative studies have explored the information behaviour of Myanmar migrant population related to FP.

There are three main Myanmar ethnic migrant groups in Chiang Mai; the Burmese, Shan, and Pa-O. Among them, Burmese and Shan have larger populations than Pa-O with a prominent presence and are well known for their ethnically related public places, such as Wat Sai Mun, the Chin Haw market, and Wat Pa Pao. By contrast, the presence of Pa-O migrants in Chiang Mai is barely noticeable, with a smaller population. In terms of language, Burmese is a mainstream language among Myanmar migrants. The Shan language has mutual intelligibility with Thai; hence, Shan migrants can understand and speak Thai faster than other Myanmar ethnic groups. Burmese and Shan have more advantages in seeking information owing to the broader applicability of their dialects, whereas Pa-O's unique language and smaller community networks restrict their help seeking behaviour.

The same ethnicity, language, and culture, with strong social cohesion and interdependence, create a small world for Pa-O migrants. Chatman's theory of *life in the round* refers to a small world where community members have similar viewpoints and comprehend each other because they belong to a particular culture and language.[16] Ethnic minorities with small populations in a small world tend to seek information within their group and will not go beyond their small world for information.[16] Chatman claims that the social groups' preference to confine themselves within their groups creates gaps in obtaining helpful information from other groups.[17] The information-seeking behaviours of Pa-O migrants could be affected by the small world effect. For this reason, this study was focused on Pa-O ethnic migrants due to their higher vulnerability to information gaps from external resources and being a minority among minorities.

This study aimed to understand the information behaviour of Pa-O ethnic migrants related to FP methods and influencing factors on their FP knowledge acquisition. Focusing on a specific ethnic

migrant group provides a better understanding of how the cultural norms, traditional practices, and social networks of a given group relate to their information behaviours and the factors influencing their FP knowledge acquisition.

Theory guiding the research

The theoretical foundations of the study are premised on the structuration theory by Giddens and the information behaviour models by Wilson. Structuration theory explains the creation and reproduction of social systems through agency and structure. Structures can be abstracted as the rules and resources upon which the actors' practices rely.[18] Giddens recognise agency with reflexive monitoring ability for reasonable daily activities and rationalisation skills to understand current activities within social structures.[19] The study considered both s

structure and agency to understand the influencing factors on information behaviour of the study group. Wilson defines information behaviour and information-seeking behaviour as '… the totality of human behaviour in relation to sources and channels of information, including both active and passive information seeking, and information use',[20, p49] whereby the information seekers demand information from formal and informal sources to fill their information needs.[21] People seek information to have more knowledge and to be able to make better and more informed decisions related to the situation in which they have to make a decision.[22] The personal and situational factors influence individual information behaviour based on types, levels and sources of information, and seeking methods.[23] (Refer Conceptual Framework, Figure 1).

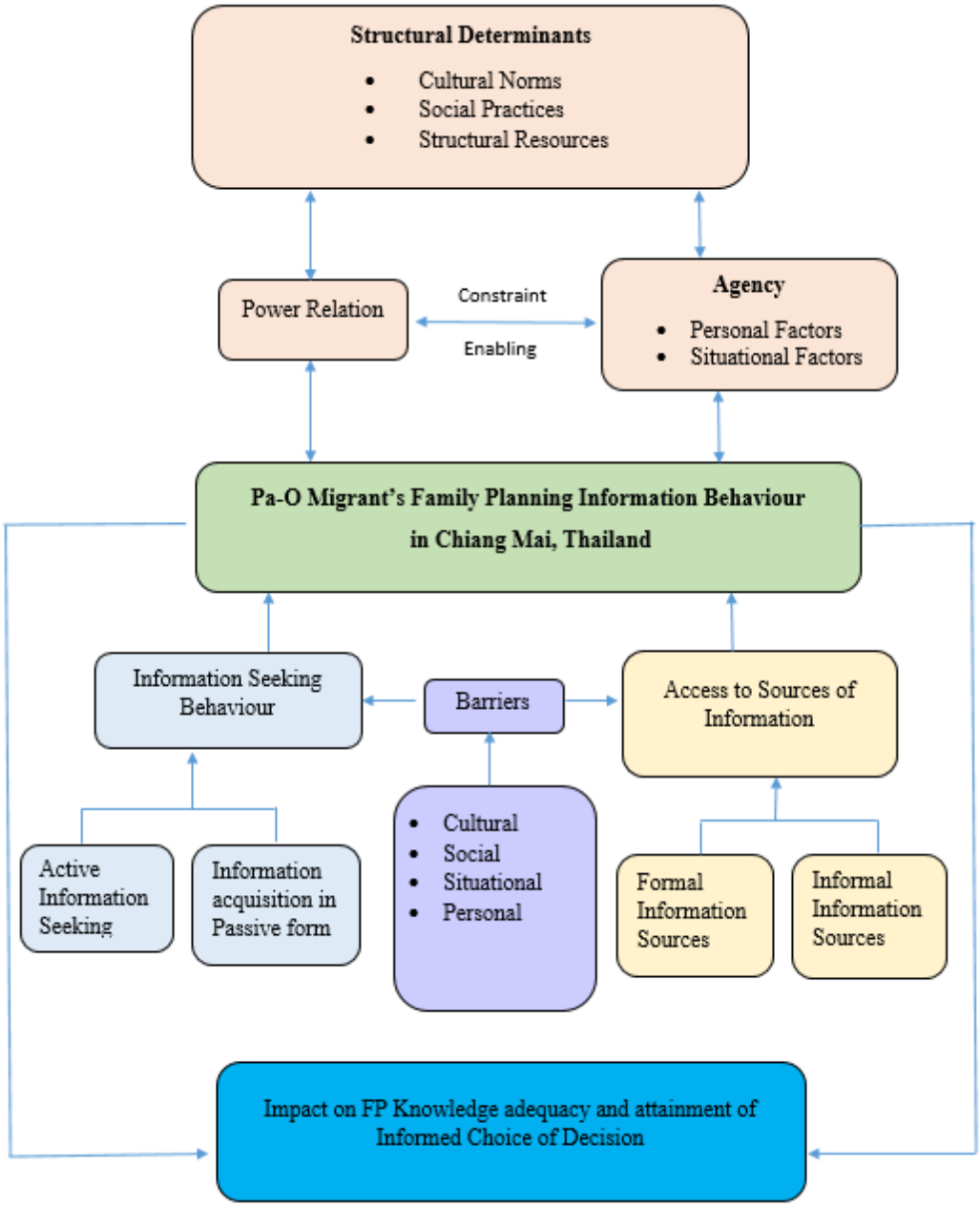


Figure 1. The conceptual framework for the qualitative study of information behaviour and factors influencing family planning knowledge of Myanmar ethnic migrants

METHOD

A qualitative study utilising non-probability sampling was conducted with 16 in-depth interviews (IDIs), 3 focus group discussions (FGDs), and 7 key informant interviews in Chiang Mai (Refer Table 1 Participant Demographic Profile). Inclusion criteria for IDIs and FGDs were Pa-O ethnic migrants who had lived in Thailand for at least 2 years and were aged 18–49 years. Snowball sampling was applied to identify the research participants following a two-month participant observation at Wat Nong Kham temple in Chiang Mai. Historically, this temple has provided teaching and spiritual comfort for Pa-O ethnic groups, with the Abbott and many of the monks being Pa-O. Over two months, the first author, who shares the

same ethnicity and language, engendered rapport and trust with the Pa-O migrant population by actively participating in various temple activities, including Sunday meal donation events and attending a funeral ceremony. In preparation for the interviews and focus group discussions, the first author developed an interview guide (Table 2) that facilitated a semi-structured interview style that encouraged participants to share sensitive information as they felt comfortable. Prior to the start of interviews, all participants and key informants were given an Information and Consent Letter in either English or Burmese language, and the researcher explained in detail the objectives of the research and the voluntary nature of participation. The interview guide was reviewed and updated after the pilot study. In this way, the primary data was collected whereby different individuals' FP experiences based on the age, gender, marital status and fertility intention were explored.

Table 1. The Participant Demographic Profile

Participant by ID	Type of Interviews	Sex	Age	Education	Occupation	Years of migrated in Thailand	Marital Status	Date of Interview
I-1	Individual In-Depth Interview	Female	25	Primary School	Unemployed	9	Married in Union	01-Aug-21
I-2		Female	23	Secondary School	House Keeping	6	Married in Union	29-Sep-21
I-3		Female	27	Secondary School	Vendor	6	Married in Union	02-Oct-21
I-4		Female	44	Secondary School	Unemployed	9	Married in Union	02-Oct-21
I-5		Female	46	No School Education	Unemployed	20	Married in Union	17-Oct-21
I-6		Female	36	No School Education	Unemployed	10	Married in Union	17-Oct-21
I-7		Female	33	No School Education	Unemployed	6	Married in Union	07-Nov-21
I-8		Female	27	Primary School	Unemployed	7	Married in Union	02-Dec-21
I-9		Female	29	Primary School	House Keeping	5	Single	02-Dec-21
I-10		Female	24	High School	Sale staff	8	Single	02-Oct-21
I-11		Male	28	Secondary School	Random	8	Single	05-Dec-21
I-12		Male	48	Monastic education	Painter	20	Married in Union	05-Dec-21
I-13		Male	43	Primary School	Work at restaurant	20	Single	05-Dec-21
I-14		Male	42	Primary School	Construction worker	20	Married in Union	06-Dec-21
I-15		Male	39	Secondary School	Construction worker	22	Married in Union	06-Dec-21
I-16		Male	35	High School	Construction worker	3	Single	12-Dec-21
F1-1	Focus Group Discussion (1)	Female	41	Primary School	Housekeeping	20	Married in Union	25-Jul-21
F1-2		Female	44	No School education	Housekeeping	20	Single Mom	25-Jul-21

Participant by ID	Type of Interviews	Sex	Age	Education	Occupation	Years of migrated in Thailand	Marital Status	Date of Interview
F2-1	Focus Group Discussion	Female	41	High School	Unemployed	16	Married in Union	08-Aug-21
F2-2	(2)	Female	32	Primary School	Housekeeping	10	Married in Union	08-Aug-21
F2-3		Female	37	No School Education	Vendor	21	Married in Union	08-Aug-21
F3-1	Focus Group Discussion	Female	41	Primary School	Housekeeping	20	Married in Union	31-Oct-21
F3-2	(3)	Female	44	No School education	Housekeeping	20	Single Mom	31-Oct-21
F3-3		Male	37	Primary School	Painter	10	Married in Union	31-Oct-21
KI-1	Key Informant Interview	Female			B.Sc (Nursing) Student, Chaing Mai University			21-Aug-21
KI-2		Female			A former staff at Shan Youth Organization, Chiang Mai			23-Aug-21
KI-3		Male			Staff, Non-Governmental Organization, Chiang Mai			19-Sep-21
KI-4		Male			Medical Officer, Chiang Mai			03-Nov-21
KI-5		Female			Nurse, Chiang Mai			03-Nov-21
KI-6		Female			Nurse, Chiang Mai			03-Nov-21
KI-7		Female			An obstetrician and gynecologist, Chiang Mai			03-Feb-22

Table 2. Interview Guide

Pa-O migrants (Individual)	Pa-O migrants (Group)	NGO Staff/ Medical Staff
Socio-Demographic info - Types of Migrant Status - Occupation - Age of Married - Family structure - Utilization of health service - History of contraceptive practice	Social norm - Cultural norm on marital relationship - Social practices - Premarital relationship - Pro-natal attitude and practice - Social networks and communication - Gender norms	Health service accessibility - Types of health service provided by NGO/ Hospital - Migrant accessibility to health/FP service - Accessibility of informed decision of FP methods.
Family Planning - Migration and access to health - Availability and Accessibility of FP service and knowledge - Cultural practice, social norms, and marital relationship impact on FP	Family Planning - Preference of source of FP service - Access to the FP knowledge - Male involvement - Barrier to Comprehensive FP service	Family Planning - FP Counselling - Informed Choice of Decision - Common Contraceptive methods - Challenges in providing health service to migrant

Pa-O migrants (Individual)	Pa-O migrants (Group)	NGO Staff/ Medical Staff
Information Behaviour - Experience of seeking FP information - Source of information - Decision choice of method - Knowledge, attitude, and practice of FP methods - Fertility intention - Meet or unmet need of FP	Information Behaviour - Experience of seeking FP information - Source of information - Decision choice of method - Knowledge, attitude, and practice of FP methods - Fertility intention	Information Behaviour - Health education Channel - Premarital FP counselling - Post-partum FP counselling - Barriers

Following the data collection, an inductive thematic analysis began with transcribing the interviews which were then reviewed and coded. Following this process, the data were transferred to Microsoft Excel to categorise the coding into meaningful themes based on their relationship to each other. The potential themes and thematic maps were developed and reviewed again for coherency, consistency and distinctiveness. Detailed analysis for each theme began after developing the reasonable thematic map, and the process was guided by the theoretical framework. The research method was compatible with exploratory qualitative research, with data triangulation from four data collection methods: participant observation, individual in-depth interviews, focus group discussions, and key informant interviews. This research was approved by the Graduate School, Chiang Mai University, on 25 June 2021. All participants involved in this study provided informed consent. The personal information and data shared by the participants was handled with confidentiality by using pseudonyms.

RESULTS

The following themes emerged from the data: (1) the information behaviour of Pa-O migrants concerning information sources, (2) structural influence on the information behaviour of Pa-O migrants, and (3) factors influencing the agency of Pa-O migrants in information behaviour.

(1) The information behaviour of Pa-O migrants concerning information sources

Under this theme, two sub-themes became apparent from the findings: active information seeking and passive receiving of FP knowledge, both from formal and non-formal sources.

Active information seeking from formal and non-formal information sources

The first author discovered that the majority of Pa-O ethnic migrants did not actively seek FP information and counselling services from health personnel for informed decision-making, regardless of their current knowledge level. Among the participants of individual IDIs (10 women and 6 men), only one participant reported the experience of purposively seeking FP information from health professionals. The others described practising contraception without consulting health staff.

"I didn't consult with a doctor, I bought the pills and took it by myself after getting married. I went to the shop and said I want to have pills." (I-3)

"We took pills (contraceptive) by ourselves after purchasing at the pharmacy." (I-14)

"No, I just went and bought them at the pharmacy. There was no consultation with doctors." (I-15).

These interview excerpts show that Pa-O migrant women developed their knowledge of contraceptives mainly from non-formal information sources, such as their social networks and kinship relationships consisting of friends, neighbours, parents, relatives, and siblings. The following responses are related to how they develop knowledge of contraception.

"I just ask people who stay around me." (I-8)

"Most knowledge transfer occurs among family, relatives, friends. We seek advice from each other when something happens to my wife, like "What should I do". By combining my limited knowledge with that of my friends, we are able to conclude what is right or wrong." (I-14)

"Some people say like "Oh you get married, then take (contraceptive) pills", there are shops that sell all types of (contraceptive) pills." (F3-1)

"There is no discussion about this among relatives. Because of family relationships, some do not talk about this. Mostly, these conservations happen among friends." (I-13)

Pa-O migrants felt more comfortable seeking information from non-formal sources, which were convenient and costless. However, missing the step to acquire information from formal sources resulted in knowledge inadequacy of the FP method they were using, contributing to method failure and unplanned pregnancy.

"I was shocked to know I was pregnant. I was shocked. ... I did not want to have a baby yet. I did not plan to have a baby at that time. I did not have enough money. I planned to take oral pills at the end of the month, I didn't think anything would happen, just skipping 4 to 5 days. I thought it would be okay, and I did not take the pills for just 4 or 5 days, and I got pregnant." (I-3)

Passive receiving FP knowledge from formal and non-formal information sources

Health information was received not only through active exploration for a particular purpose but also via passive acquisition without intending to seek or use the information. Although active information behaviour from formal sources was less likely to occur among Pa-O migrants, passive information behaviour from formal sources occurred at postpartum follow-ups. Those who gave birth at hospitals received FP counselling and information regarding available services from health staff during follow-up visits. This could be a window of opportunity for informed choice because it enabled the Pa-O migrants to access comprehensive FP counselling, including information and services on long-term reversible and permanent contraceptive methods in Thailand.

Although postpartum contraceptive counselling promoted informed choice with increased service accessibility, it was not beneficial for some individuals who strongly relied on information from informal sources for decision-making. The knowledge from informal sources had a greater influence than the formal sources among Pa-O migrants, regardless of the information quality.

"The doctors advised me that if I do not want to have a baby yet, I could choose between injectables and taking oral pills". I was about to take oral pills. However, they (sisters and friends) told me that I could only get pregnant after menstrual cycle appears after giving birth, so I didn't take oral pills. The doctor encouraged me to take injectable, but I didn't do it." (I-8)

Although this participant attended FP counselling at her postpartum appointment, her decision to take oral contraceptive pills was not implemented because she followed the information received from informal sources. Due to this action, she was shocked when she was

pregnant five months later. Besides inadequate knowledge of FP methods and fertility, sole reliance on informal sources for contraceptive decision-making posed the risk of having unplanned pregnancies.

(2) Structural influence on the information behaviour of Pa-O migrants

Sex-related cultural norms and accessibility to reproductive health education were the crucial structural factors influencing the information behaviour of Pa-O migrants. Culturally, seeking contraceptive information and knowledge was generally considered shameful.

"As women, everyone are shy to discuss it (Contraception). It's still embarrassing to discuss it among women. It is not convenient to go and ask elder people, either man or woman. They may give advice, but we feel discomfort, worry and shyness about what they will criticize when someone come and seek such information."(I-1)

Myanmar migrants came from a society that disapproves premarital sex, with social punishment in several remote areas. An unmarried participant perceived disapproval when seeking knowledge regarding FP from health care providers. The social perception that contraceptives were only for married people, influenced FP information behaviour.

"It is kind of weird to ask it (contraception) without getting pregnant. Like, if we want to ask, we can ask about it after giving birth. It is not convenient just to go and ask." (I-5)

"After getting married, I am not virgin anymore, because of this, I can consult more openly. But before getting married, I am too shy to ask about it." (F2-3)

Similarly, a male participant expressed shame to seek contraceptive information without a spouse.

"I think it would be better to go and ask with your spouse, as married couple should go together to see doctors or nurses. I would not be comfortable to go alone. It is a bit of shameful". (I-11)

Another cultural norm that impacted the FP information behaviour of Pa-O migrants was age-related. In Myanmar, middle-aged adults (>40 years old) are expected to avoid sexual relationships and engage in religious activities. A participant who became pregnant at 41 years, shared her concern when she visited a hospital for antenatal care.

"I went to that hospital, I was worried, like, I had pregnancy at older age, whether the health staff would take care of me or not." (I-4)

"Interviewer: Why do you think doctors and nurses won't take care of you?"

"Because I was scared of being scolded, "You are too old to get pregnant and why do you have a baby?". I used to hear such blame directed towards old-aged pregnancies in Myanmar." (I-4)

Another interviewee shared a similar concern:

"I think the doctors will scold me as I am too old to have a child. I am about 40 (years old). I am getting old now. I am afraid of being blamed for not consulting doctor beforehand." (F2-1)

Besides cultural-related structural factors, another contributing factor was the accessibility to reproductive health education programmes. There were limited formal resources to promote sexual and reproductive knowledge, including FP methods, for migrants in Chiang Mai. Although reproductive health education is integrated into the formal Thai education system, Pa-O migrants are unintentionally alienated from these structural resources as

majority of younger population did not attend formal schools.

A non-governmental organisation (NGO) staff, who was working on migrant health projects shared,

"The health literacy of migrants is not the same as Thai Citizens, it is different, because there are a variety of information *sources and tools for Thai people. They (migrants) can get information only when an NGO goes to their workplace, such as a construction site… this one way only. Another reason is that their primary intention to come here (Thailand) is to earn money, that's why they do not spare time for it." (KI-3)*

When migrants were asked about the accessibility of health education sessions in Chiang Mai, the response was,

"There is less chance than Myanmar since we are constantly working here. Our routine is just going from work to the rented room and rented room back to work." (I-15)

A key informant responded to the question 'Where can migrants access FP knowledge from formal information sources?' as the following:

"Ah…normally, I would say it's difficult. But, there are some NGOs in Thailand. NGOs working for health are sharing health knowledge. I think they (migrants) can get it only from NGOs. For Thai citizens, that topic is not strange to them. For migrants, they will not know that." (KI-1)

(3) Factors influencing the agency of Pa-O migrants in information behaviour

Two significant sub-themes linked with personal and situational factors emerged under this theme: the lack of awareness of the right to information and barriers to seeking information.

Lack of awareness of the right to information

Pa-O migrants had no tradition of actively consulting with professionals for an informed choice regarding contraception. Most Pa-O migrants failed to practice their right to information due to a lack of supportive factors. First, they were unaware of the location of FP services and ways to access FP knowledge and quality FP counselling. Second, they had no confidence in approaching health personnel for comprehensive FP counselling services, as it was unfamiliar among this ethnic migrant group. Additionally, they also had low awareness of the benefits of informed choice.

"There is a reproductive clinic for premarital FP counselling. Burmese migrants rarely come for service, just a few, very few. Most of them do not know the service's existence." (KI-5)

"There are some people (migrants) who come and ask about FP methods, but those are just a few numbers. They do not dare to ask." (KI-6)

"Normally, Myanmar people who work in Chiang Mai, they usually attend the antenatal clinic, however, only a few couples use pre-marital counselling." (KI-7)

Personal and situational barriers which influence Pa-O migrant's information behaviour

Personal and situational barriers hindered Pa-O migrants practising agency for their information behaviour, especially in seeking FP information. The language barrier was expressed,

"Since I could not communicate in Thai very well, I was anxious to talk to doctors. Hospital is crowded with Thais...almost all. They communicate in Thai only, Burmese language is not used." (I-7)

"It was difficult since I did not know anything. With limited knowledge on the meaning of words, I could not communicate well." (I-1)

Furthermore, previous negative communication experiences with healthcare providers hindered the migrants from

seeking health information in the public health sector,

"I was afraid of being scolded by the doctor. The doctor did not scold me. There were health staff who scold the patient at another hospital". (I-4)

Some migrants also expressed situational barriers in seeking information from healthcare providers, such as the experience of long waiting time in public health settings. They presumed that service providers might have little time for interactive discussions to develop their knowledge of FP methods.

"Even in the hospital, they (health staff) answer just what we ask. They did not go beyond what we asked. I have to queue. There are many people waiting in front of you. Health care providers are busy, and the clients are waiting in long queues and they don't have much time for each patient, they respond only to what we ask and no time for consultation." (F1-1)

Based on their self-reflection and rationalisation of the barriers in seeking health-information at public health settings, most Pa-O migrants perceive that seeking health-information from formal information source is challenging.

DISCUSSION

This study indicates that active information seeking from professionals to make an informed decision on FP methods is not common among migrants. Instead, migrants develop contraceptive knowledge based on the information acquired from non-formal sources (social networks and kinship relationships). Although active FP information-seeking can be acknowledged as a positive behaviour to facilitate health-related decisions and practice, the information source matters. Informed decision regarding choice of contraception by medical personnel should not be replaced by information from non-formal sources. Sole reliance on information from informal sources places the migrants at high risk of having unplanned pregnancies from method failure and unmet needs for FP. This result concurs with that of a previous study, which showed that inadequate knowledge and limited access to FP contributed to unmet needs for FP.[11]

The study also found that information behaviour for FP mainly occurs within informal settings. Several authors agreed that social networks, including friend and kinship relationships, play a significant role in searching for health-related information.[9,24-26] This kind of information-seeking is more prominent among migrants due to language and cultural barriers in communicating with health staff,[9,24] as it is more convenient to communicate with a sense of belonging.[26] Although the information from informal sources is sometimes mixed with subjective opinions derived from individualised experiences and knowledge, they have more influence on Pa-O migrants regarding the choice of FP methods. According to Low et al., social network serves as a primary information source and exerts a remarkable influence on individual behaviour.[27]

Culturally, sex has been articulated as shameful in the Pa-O migrant society, and there is almost no space left to discuss it from a health perspective. The absence of traditional practices for discussing FP from the aspect of reproductive health limits reproductive health information-seeking behaviour, including contraception. Culture does not favour women to freely practicing contraception due to shame,[9] religious beliefs, and lack of partner support, as well as social norms and pressure.[24] Sexual abstinence before marriage is a moral standard deeply rooted in the social perception under tradition, culture, and

religious values. Therefore, it is assumed that FP knowledge only concerns married persons, and it is considered inappropriate to discuss this among unmarried people, regardless of their sexual activity status. Social disapproval of premarital sex prohibits FP knowledge-seeking by unmarried persons. Our findings support the claim that unmarried people are more vulnerable to pregnancy-related morbidity and mortality due to the limited availability and access to FP services.[28]

Socially constructed age-related cultural norm brings adverse social interaction toward pregnant women in their middle adulthood. The social expectation to refrain from sex and devoting oneself to religious activities during middle adulthood has impeding effects on information-seeking behaviour. The social practice of placing the blame for having pregnancies in middle adulthood causes older pregnant women to fear being blamed, resulting in lack of confidence to seek FP information and services. Several authors agree that specific cultural norms influence the pattern of seeking FP information and utilisation by individuals, [9,24,29,30] the study results were similar. Cultural norms related to sex, marriage, and age hindered the FP information behaviour of Pa-O migrants. Hence, culture as a structural barrier should be considered when designing migrant-targeted health education programmes.

As another structural barrier, the reproductive health education programme under the education system alienates migrants since most migrants, especially first-generation migrants, have no association with the host-country education system. NGOs are alternative sources for migrants to seek FP services and information. However, their reproductive health projects are mostly at the border areas of Thailand and Myanmar, and only a few are in the metropolitan area of Chiang Mai.

It was found that Pa-O migrants had less experience of receiving information education. Myanmar migrants need FP information education, especially to know each method's side effects and correct misperceptions.[11] Public health education services, including health consultation, SMS, face-to-face consultation, and promotional materials, significantly benefit the FP of the rural migrant populations.[31]

The situational and personal barriers that weaken the agency of migrants to practice the right to information were language barriers, perceived perception of unfeasible situations for interactive discussions with healthcare providers, and fear of being disrespectfully treated by health staff. Past experiences of negative communication with health staff increased hesitance to acquire health information, which is a nuance factor obstructing active information-seeking in health settings. Healthcare settings should be a space that facilitate sexual and reproductive rights, including the right to access FP information and services. However, Pa-O migrants perceived that seeking FP information from health personnel is difficult. They rely on friends, parents, and kinship networks as convenient sources of FP information. They do not expect to undergo FP consultations with healthcare providers. Instead, they seek easily available short-term contraception from nearby GP clinics and pharmacies. This contributed to knowledge inadequacy despite a high contraceptive prevalence rate.

Accessing contraceptive services at GP clinics and pharmacies does not represent comprehensive FP counselling and informed choice. The information they receive from pharmacy and GP clinics is specific to their predetermined methods. Furthermore, their choices are limited to oral contraceptive pills and injectables due to the lack of opportunity to familiarise themselves with other contraceptive methods. A study argued that having good contraceptive knowledge is different from accessing comprehensive FP information and the capacity to make informed

choices.[32] Those depending on the short-term methods are more likely to stop using them at some point compared to those who use long-term methods.[32] This could lead to unmet FP needs.

This study has several limitations. This study focused on ways of seeking information from information sources to understand how migrants construct their FP knowledge; hence, less emphasise was given to information utilisation. Furthermore, it focused on the contraceptive aspect of FP and excluded the treatment for involuntary infertility. Despite the mentioned limitations, this study explored the FP information behaviour with respect to information sources, along with influence of structure and agency.

RECOMMENDATIONS

Prolonged insufficient public health services with limited resources for FP information in the country of origin, cultural barriers, and lack of migrant-friendly FP resources in the migrated country were contributing to the FP information behaviour of migrants. Despite Myanmar migrants having several deterrents to accessing FP information and counselling for informed choice, the problem was understated. Public and private health facilities providing FP services and NGOs should support and address the structural and agency barriers to ensure access to comprehensive FP counselling for the migrant population. This study informs the behaviour and challenges which should be considered for the effective and inclusive migrant-friendly FP programmes. Customised migrant-targeted health education programmes are required to promote FP knowledge among this marginalised migrant population.

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REFERENCES

1. Ma A. Labor migration from Myanmar: Remittances, reforms, and challenges. Migration Policy Institute.; 2017 p.18.
2. Department of Population. The 2014 Myanmar Population and Housing Census-The Union Report: Census Report. Volume 2. Nay Pyi Taw: Ministry of Immigration and Population; 2015.
3. Vungsiriphisal P, Jayagupta R, Jitpong W, Senapan P, Ito M, Heli L. Assessing Potential Changes in the Migration Patterns of Myanmar Migrants and Their Impacts on Thailand. Bangkok: International Organization for Migrati on; 2013.
4. World Health Organization. Contraception. World Health Organization [Internet]. 2022 [cited 2022 Oct 10]. Available from: https://www.who.int/health-topics/contraception#tab=tab_1.
5. Ministry of Health and Sports. Myanmar National Health Plan (2017–2021). Nay Pyi Taw: Ministry of Health and Sports; 2016.
6. World Health Organization. Ensuring human rights in the provision of contraceptive information and services: guidance and recommendations. World Health Organization; 2014.
7. Samuel B, Tsegaye B, Dulla D, Aynalem A, Israel E, Gebrie M.

Informed choice and its associated factors among women received immediate postpartum long-acting reversible contraceptives at public hospitals in Sidama Regional State, Ethiopia, 2022. Contracept Reprod Med. 2023;8(1):32. doi: 10.1186/s40834-023-00229-9
8. Population Council. Contraceptive Discontinuation: Reasons, Challenges, and Solutions. FP2030 RESOURCES [Internet]. 2015 [Cited 2023 Oct 2]. Available from: https://fp2030.org/resources/contraceptive-discontinuation-reasons-challenges-and-solutions.
9. Khin YP, Nawa N, Fujiwara T, Surkan PJ. Access to contraceptive services among Myanmar women living in Japan: A qualitative study. Contraception. 2021;104(5):538-46. doi: 10.1016/j.contraception. 2021.05. 008.
10. World Health Organization. Unmet need for FP (%). World Health Organization [Internet]. 2022 [cited 2022 Oct 10]. Available from: https://www.who.int/data/gho/indicator-metadata-registry/imr-details/3414.
11. Thein SS, Thepthien BO. Unmet need for family planning among Myanmar migrant women in Bangkok, Thailand. Br J Midwifery. 2020;28(3):182–93.
12. Bearak J, Popinchalk A, Ganatra B, Moller AB, Tunçalp Ö, Beavin C, et al. Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990-2019. Lancet Glob Health. 2020;8(9):e1152-e61. doi:10.1016/ S2214-109X(20) 30315-6
13. Thawu M. Unmet reproductive health needs and use of different FP methods among Myanmar migrant women, Samutsakhon Province, Thailand [master thesis]. Bochum: Ruhr-University; 2013.
14. Soe HH, Than NN, Kaul A, Kumar S, Somrongthong R. Determinants of contraceptive usage among Myanmar migrant women in Phang-Nga Province, Thailand. Int Res J Med Sci. 2012;3(11):721–28.
15. Khamthanet R, Suthutvoravut S. Comparison of knowledge, attitude, and behavior of heproductive Health between Thai and immigrant women workers in factories in Samut Sakhon, Thailand. Rama Med J. 2020;43(1):24–34.
16. Zhu M, Liao X. Chatman's theory of life in the round applied to the information seeking of small populations of ethnic minorities in China. Information Research [Internet]. 2020 [cited 2023 Sep 30]. Available from: https://research.ebsco.com/linkprocessor/plink?id=0c70a220-7b1a-3a63-b716-418be4c52fbd
17. Akbar MM. Toward a Theoretical Model for Scientific Information Seeking. Library Philosophy and Practice; 2022. p.1-6.
18. McPhee RD, Poole MS, Iverson J. Structuration theory. The SAGE handbook of organizational communication: Advances in theory, research, and methods. 2020;3:75-100.
19. Canary HE, Tarin CA. Structuration theory. The international encyclopedia of organizational communication; 2017. p.1-5.
20. Wilson TD. Human information behavior. Inf Sci. 2000;3(2):49–55.
21. Kundu DK. Models of information seeking behaviour: a comparative study. Int J Lib Inf Stud. 2017; 7(4):393–405.
22. Kolarić A, Stričević I. Information seeking behavior for decision making in everyday life: a pilot study on adolescents. Libellarium: Journal for the Research of Writing, Books & Cultural Heritage Institutions. 2016;9(2).

23. Lambert SD, Loiselle CG. Health information seeking behavior. Qual Health Res. 2007;17(8):1006–19.
24. Gele AA, Musse FK, Shrestha M, Qureshi S. Barriers and facilitators to contraceptive use among Somali immigrant women in Oslo: A qualitative study. PLOS ONE. 2020; 15(3):e0229916. doi: 10.1371/journal. pone.0229916
25. Bernadas JM, Jiang LC. "Of and beyond medical consequences": Exploring health information scanning and seeking behaviors of Filipino domestic service workers in Hong Kong. Health Care Women Int. 2016;37(8):855-71. doi: 10.1080/ 07399332.2015.1107071
26. Kim W, Kreps GL, Shin CN. The role of social support and social networks in health information-seeking behavior among Korean Americans: a qualitative study. Int J Equity Health. 2015;14:40. doi: 10.1186/s12939-015-0169-8
27. Low LL, Tong SF, Low WY. Social Influences of Help-Seeking Behaviour Among Patients With Type 2 Diabetes Mellitus in Malaysia. Asia Pac J Public Health. 2016;28(1 Suppl):17s-25s. doi: 10.1177/1010539515596807
28. Win T. Factors influencing family planning in Myanmar and health outcomes [master thesis]. Amsterdam: Vrije Universiteit Amsterdam; 2015.
29. Kiden P. Evaluation of factors that contribute to low utilization of methods for family planning among adolescents at Adjumani Hospital, Adjumani District. IDOSR J Sci Res. 2023;8(2):89–104.
30. Hakizimana S, Odjidja EN. Beyond knowledge acquisition: factors influencing family planning utilization among women in conservative communities in Rural Burundi. Reprod Health. 2021; 18(1):94. doi: 10.1186/s12978-021-01150-7
31. Huang Y, Miao L, Lyu B. Urban public health education services, health status, and increased fertility intentions of the rural migrant population. Reprod Health. 2023; 20(1):108. doi: 10.1186/s12978-023-01648-2
32. Tin KN, Maung TM, Win T. Factors that affect the discontinuation of family planning methods in Myanmar: analysis of the 2015-16 Myanmar Demographic and Health Survey. Contracept Reprod Med. 2020;5(1):20. doi: 10.1186/s40834-020-00126-5.