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Factors associated with Access to Sexual and Reproductive Health Services during COVID-19 Pandemic among Female Immigrant Workers in Thailand

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Abstract

The COVID-19 pandemic has significantly impacted Samut Sakhon in Thailand, home to the second-highest number of migrant workers from Myanmar. This has led to decreased contraceptive access, unsafe abortions, postponed procedures, decreased sexual health education, gender-based violence, mental health issues, and increased unintended pregnancies. This cross-sectional study aimed to explore factors associated with access to sexual and reproductive health (SRH) services among female migrant workers (FMWs) from Myanmar in Samut Sakhon, Thailand, who were recruited by purposive sampling. The data were collected through a questionnaire from May to July 2021. Descriptive statistics, ANOVA, and ANCOVA were used to analyze the data. More than half of Myanmar FMWs in our study did not receive SRH services from public hospitals (60.78%), or private clinics or hospitals (63.38%). Furthermore, most of them cannot read and write Thai (84.77%). The factors associated with access to SRH services were marital status ($P<0.05$), education ($P<0.05$), monthly income ($P<0.001$), and daily expenses ($P<0.05$). The important finding indicated that the top three reasons that participants chose not to use SRH services were: services were available only during working hours (54.32%), unfriendly healthcare workers (40.00%), long distance to the health center, and difficulty traveling to the health center (35.45%). Access to SRH services is limited among Myanmar FMWs due to their education level, monthly income, and daily expenses. Our recommendations to overcome these barriers should include having friendly healthcare workers, free services, and services available after working hours. Additionally, SRH clinics should be in or near migration sites to allow for easy transportation.

Keywords: Sexual and reproductive health, female migrant workers, access to health care, migrant health

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Introduction

Thailand is a major destination for migrant workers from neighboring countries. with 3.7 million being documented and undocumented Nearly half of these workers are female (Harkins B., 2019) and their access to healthcare services is often more limited than that of male workers. Factors such as political and cultural reasons, language barriers, socioeconomic level, gender inequality, and concern about illegally living contribute to these issues, potentially increasing health problems among female migrants, particularly reproductive health (Kumar AX, Tresise CB, Compas C & Murphy AM., 2018, UNFPA, 2011).

Female Migrant Workers (FMWs) are one of the high-risk groups for sexual and reproductive health (SRH) issues including diseases, cancers, HIV, and unintended pregnancies (Songchai T., 2020 and Webber G, Spitzer D, Somrongthong R, Dat TC & Kounnavongsa S., 2012). Limited access to SRH information and services can lead to unsafe abortions, unintended pregnancies, and poor pregnancy outcomes, compared to female citizens of the host countries. (Tousaw E, La RK, Arnott G, Chinthakanan O & Foster AM., 2017).

Modern family planning and contraceptive methods can prevent sexual and reproductive health problems, promote gender equality, and provide better fertility control. However, female migrant workers in Thailand may not know about other modern contraceptive methods leading to high fertility rates and limited access to the SRHR information and services. Despite Thailand's Universal Health Coverage Scheme (UHC), these workers still face challenges (Kumar AX, Tresise CB, Compas C & Murphy AM., 2018, Tangcharoensathien V, Thwin AA & Patcharanarumol W., 2017., Country Office for Thailand WHO., 2013 and Sricharoen T., 2020).

The COVID-19 pandemic has had a significant impact on Samut Sakhon, which is home to the second-highest number of migrant workers from Myanmar. These effects include decreased access to contraceptives, unsafe abortions, procedures being postponed or canceled, decreased sexual health education, an increase in gender-based violence, problems with mental health, and difficulties for vulnerable populations, which increases the risk of unintended pregnancies and unsafe abortions (Suphanchaimat, Rapeepong, et al., 2021and Khamthanet R & Suthutvoravut S., 2020).

Limited information exists on factors affecting access to sexual and reproductive health (SRHR) information and services among female migrant workers in Samut Sakhon during the COVID-19 pandemic. Healthcare providers need this information to design programs and interventions for these workers. This cross-sectional study aimed to determine factors associated with SRH and to describe the reason for accessing SRH services among female migrant workers (FMWs) from Myanmar in Samut Sakhon. The results from this study will be used to draw recommendations on appropriate strategies to promote sustainable access to SHR services among female migrant workers. These efforts can lead to better access to sexual health and reproductive services among female migrant workers in Thailand and neighboring countries.

Research Methodology

Study Population and Sample

A cross-sectional study was conducted in May- July 2021. The number of female migrant workers in Samut Sakhon was 113,232 (Foreign Workers Administration Office, 2020). The sample size was determined using the Krejci and

Morgan formula (Bukhari SA,2021). The following assumptions: confidence level was 95%, sample proportion (p) was 0.5, the margin of error (e) was 0.05, the study population was 113,232, and Z score (Z) was 1.96. The minimum sample size was calculated to be 384. Allowing for 15% attrition, the total sample size was 440. The purposive sampling was used. Inclusion criteria were female migrant workers from Myanmar in Samut Sakhon, aged 18-45 years, able to read and write Myanmar, and willing to participate in this research project. Female migrant workers who never experienced sexual intercourse were excluded from this study.

Data Collection

The researcher trained the research assistant who was based in the Samut Sakhon area during the COVID-19 pandemic when travel across provinces was restricted. Researchers provided information on the project and data collection methods to research assistants virtually. The research assistant contacted migrant community leaders who spoke Myanmar. The community leaders were asked to help publicize and give information about the research project in their communities. Female migrant workers who were interested in participating in this research were provided with information on study objectives, and how data would be collected, analyzed, and disseminated. Information on confidentiality and participants' rights to leave the study at any time was provided. We checked to ensure that female migrant workers fully understood the informed consent form. The consent form was signed by participants before participating in this research project.

There were three main questionnaires used in this study:

Part 1: The questionnaire about participant characteristics collected information on the participants' age, marital status, ability to read, write, speak, listen to, and understand the Thai language, education, income, daily expenses, monthly expenses, and previous experience with sexual intercourse.

Part 2: The questionnaire on access to SRH information and services consisted of 9 items. For each item, a 4-point response scale was used: 1= never, 2= rarely, 3 = frequently, and 4= very frequently. This questionnaire was based on an assessment tool to prevent unplanned pregnancy among adolescents. The original assessment total was developed by the Health Education Division, Department of Health Service Support, Ministry of Public Health, Thailand (Health Education Division., 2014).

Part 3: The questionnaire about reasons that participants chose to access SRH information and services questionnaire was developed and identified by using results from prior studies (Thongmixay, Souksamone, et al., 2019, Meherall, Salima, et al.,2020). In this questionnaire, we provided 11 possible reasons that participants chose to SRH services, and 11 possible reasons participants chose not to use SRH services. After participants completed the questionnaire, we also asked them open-ended questions.

The questionnaires were applied in this study. The questionnaires were reviewed by 3 experts on SRHR for content validity. The content validity index (CVI) was 0.66-1.00. The questionnaires were translated from Thai to Myanmar by a cultural and language expert who is a native Myanmar speaker. Back translation and dual-panel translation methods were performed to ensure linguistic and cultural equivalence. The Coefficient alpha of Cronbach's confidence was 0.91.

Data Analysis

We performed appropriate statistical analysis based on the characteristics of the data. For categorical data including sociodemographic data, we calculated frequency and percentages. To analyze continuous data, we computed the mean and standard deviation. We conducted the analysis of variance (ANOVA), followed by the Bonferroni test, to compare the mean scores for access to SRH information and services among different groups of participants. We conducted analysis of

covariance analyzed covariance (ANCOVA) to analyze factors that influence access to SRH information and services.

Ethical consideration

The protocol of this study was reviewed and approved by the Samut Sakhon Provincial Health Office Ethical Review Board on 11 June 2020. The ethical approval number is SK0032.

Results

Sample characteristics

The characteristics of our study participants are shown in Table 1. The average age was 31.51 years (SD=8.14, IQR 18-57). Most participants (84.77%) could not read Thai. More than half of the participants could speak Thai (65%). Almost all participants had experienced sexual intercourse (90.91%). About half of the participants had a monthly income of around 5,000 – 10,000 Baht (43.41%) and had personal daily expenses of 61-100 Baht per day (41.59%).

Table 1. Demographic characteristics of Myanmar female migrant workers in Samut Sakorn province.

Characteristics	N	%
Age (years)		
≤ 20	47	10.68
21-30	168	38.18
31-40	163	37.05
>40	62	14.09
Can read and write Thai		
Yes	67	15.23
No	373	84.77
Can speak Thai		
Yes	286	65.00
No	154	35.00
Monthly income (Thai baht)		
≤ 2,000	70	15.91
2,001-5,000	70	15.91
5,001–10,000	191	43.41
10,001–20,000	106	24.09
Daily Expenses per day (Thai Baht)		
≤30	54	12.27
30-60	81	18.41
61-100	183	41.59
101-200	76	17.27
201-300	38	8.64
>301	5	1.14
Experienced sexual intercourse		
Yes	400	90.91
No	40	9.09

Access to sexual and reproductive health services

Some female migrant workers had never used SRH services from government hospitals (13.86 %). Some participants had never used SRHR services and information from clinics and

private hospitals (12.73 %). However, half of them reported having access to safe abortion care from a legally safe abortion care clinic when needed (53.18%) (Table 2).

Table 2. Number and percentage of access to sexual and reproductive health services among Myanmar female migrant workers.

Content	How often accessed SRH information and services N (%)			
	Very Frequently	Frequently	Rarely	Never
1. Access SRH information	225(51.14)	71(16.14)	40(9.09)	104 (23.64)
2. Access SRH information and felt comfortable asking others about SRHR	217 (49.32)	74 (16.82)	79 (17.95)	70 (15.91)
3. Understand SRH information from sources such as reading newspapers or the Internet	186 (42.27)	120 (27.27)	68 (15.45)	66 (15.00)
4. Recheck SRH information and ensure receive the right information	233 (52.95)	70 (15.91)	58 (13.18)	79 (17.95)
5. Recheck family planning products before buying (expiration date)	214 (48.64)	86 (19.55)	65 (14.77)	75 (17.05)
6. Use government SRH health services	253 (57.5)	74 (16.82)	52 (11.82)	61 (13.86)
7. Use SRH health services from clinics and private hospitals	272 (61.82)	64 (14.55)	48 (10.91)	56 (12.73)
8. Use SRH services from health service providers that speak migrants' native languages	243 (55.23)	71 (16.14)	68 (15.45)	58 (13.18)
9. Have access to safe abortion care from a legal, safe abortion care clinic when need their services	234 (53.18)	61 (13.86)	60 (13.64)	85 (19.32)

Comparing access to sexual and reproductive health services among female migrant workers by participant characteristics

The data in Table 3 indicated significant differences in the mean scores for how often FMWs accessed SRH services among different groups of FMWs defined by marital status (P <0.01), education level (P<0.05), monthly income (P<0.001), and daily expenses (P<0.01).

Table 3. Comparing access to sexual and reproductive health services among female migrant workers by characteristics of participants.

Characteristic	Frequency	The score for accessing SRH service	
		Mean ± SD	P-value
Marital status			0.0069*
Single	90	16.48 ± 8.05	
Married	330	17.44 ± 7.94	
Widowed	13	20.70 ± 7.51	
Divorced	7	16.48 ± 8.05	
Education			0.0121*
Less than primary	60	18.62 ± 7.6	
Primary	183	16.3 ± 7.58	
Junior high school	142	18.93 ± 8.42	
High school	55	16.42 ± 7.99	
Monthly income (Thai baht)			<0.0001*
≤ 2,000	70	21.40 ± 9.11	
2,001-5,000	70	19.33 ± 7.29	
5,001–10,000	191	17.32 ± 7.88	
>10,001	106	13.83 ± 6.09	
Daily expenses (Thai baht)			0.0079*
≤30	54	17.84 ± 8.01	
30-60	81	17.04 ± 6.82	
61-100	183	17.42 ± 8.66	
101-200	76	15.43 ± 7.39	
201-300	38	21.50 ± 6.94	
>301	5	22.60 ± 3.79	

Reasons that female migrant workers (FMWs) choose to use or not use sexual and reproductive health (SRH) services.

To better understand the need for SRH information and services among female migrant workers from Myanmar, we asked FMWs about reasons they chose to use or not use the SRH services. The FMWs provided many different reasons for their decisions. The top three reasons that they chose to use SRH services were: 1) services were free of charge, 2) friendly nurses and doctors, and 3) private and secrets were respected while using the services (Table 4). The top three reasons that FMWs chose not to use SRH services were: 1) health clinics were only open during hours that FMWs were busy working (56.13%), 2) unfriendly health providers (40.89%), 3) clinics are far away (40.33%) (Table 5).

Table 4. Reasons to use or not sexual and reproductive health (SRH) services of Myanmar female migrant workers.

Reasons that they used SRH services and safe abortion care	N	%
• Friendly, nice doctors and nurses	251	57.05
• Free-of-charge services	262	59.55
• Privacy and confidentiality were respected.	161	36.59
• Clinics near migrant sites	145	32.95
• Could call to consult	112	25.45
• Open outside of normal office hours	59	13.41

Table 5. Reason to choose not to receive sexual and reproductive health (SRH) services and safe abortion care of Myanmar female migrant workers.

Reasons to not use SRH services and safe abortion care	N	%
Open only during office hours of migrant work	239	54.32
Unfriendly health providers	176	40.00
Clinic is far	156	35.45
Only allowed to come to the clinic alone	136	30.91
No information about the clinic is available	148	33.64
Do not know the clinic's location	137	31.14
The clinic is too close; fear that someone may recognize the participant	81	18.41
The employer does not permit workers to visit the clinic	83	18.86

Discussion

Factors associated with access to sexual and reproductive health (SRH) information and services.

The results showed that factors associated with access to SRH information and services among female migrant workers included marital status, education, monthly income, and daily expenses. However, some FMWs from Myanmar in this study had never used SRH services in either government or private health clinics. Some female migrant workers (FMWs) were required to use pregnancy prevention methods and family planning services provided by their employers while working in Thailand (Tangcharoensathien V, Thwin AA & Patcharanarumol W., 2017). If the migrant workers legally worked and earned money in Thailand, contraceptives and other SRH services would be provided by their companies (Tangcharoensathien V, et al., 2019). Those FMWs who were pregnant could access antenatal care and legally safe abortion care under the universal health coverage scheme provided by the Thai government (Suphanchaimat, Rapeepong, et al., 2021).

Previous studies reported that FMWs with higher education were more likely to access SRH services than those with lower education (Health Education Division., 2014 Thongmixay, Souksamone, et al. (2019). Moreover, this study showed that more than half of FMWs can speak Thai. However, only a small percentage of them reported that they could read and write Thai. A previous study indicated that Thai literacy was a factor associated with the ability of FMWs to access SRH care (Khamthanet R & Suthutvoravut S., 2020). Many interventions to improve SRH services for FMWs have addressed the lack of Thai literacy among FMWs in the past. Yet, FMWs still had limited access to SRH services (Webber G, et al., 2012, Tousaw E. et, 2017, Sricharoen T., 2020 Suphanchaimat, Rapeepong, et al., 2021). Therefore, the interventions should be comprehensive and universal. They must address the diversity of situations and barriers to access to SRH services faced by migrants (Health Education Division., 2014 Thongmixay, Souksamone, et al., 2019).

We found that those FSWs who had low incomes were more likely to access SRH services. We hypothesize that FSWs with low income may have more flexible working schedules due to the unstable nature of their jobs or intermittent unemployment. Therefore, these FSWs may have had more time to go to health clinics that open during office hours. Our study results are consistent

with a previous study conducted among migrant workers in Thailand. That study indicated that legal status, income, and knowledge about health services were key factors affecting migrant workers' access to health services encompassing sexual and reproductive health. (Tousaw E, et., 2017, Chatchawalchanchanakit P & Apornpisal P., 2017 and Thein, Shwe Sabai & Thepthien, Bang-on., 2020).

FMWs with higher daily expenses were more likely to have better access to SRH services. We theorize that migrant workers may be able to purchase contraceptives and condoms in drug stores and convenience stores that are easier to access, though have higher prices. Our study aligns with a previous study conducted among migrant workers that suggested that increasing the visibility of sexual and reproductive healthcare services was a successful intervention to increase access to SRH services (Chatchawalchanchanakit P & Apornpisal P., 2017).

Previous studies have shown that migrant workers are at high risk of sexual and reproductive health problems due to their socioeconomic status, culture, beliefs, and lack of fluency in the host country's language (Niramit R. & Phompukping B., 2019). Our study concurred with these findings. We found that marital status, education, monthly income, and daily expenses were all associated with access to SRH services from both government and private health services among FMWs.

Reasons that FMWs chose to use or not use SRH services.

FMWs shared that they did not use SRH services because health clinic hours were only open during their working hours, health care providers were unfriendly, and the clinic was far from migrant sites, which led to difficulty in traveling to clinics. Thus, we recommend that these first three issues should be addressed by providing SRH services that include: 1) friendly healthcare service providers, 2) services that are free of charge, and 3) privacy and patient confidentiality.

Although SRH services were free of charge for migrants, the clinics were far from the FMWs' workplace. Only FMWs without regular work could access the service during office hours, which meant the lower-income group of FMWs had the most access to SRH services. On the other hand, FMWs who did not have time to visit clinics during office hours would have to pay higher costs to receive SRH services from pharmacies or private clinics.

Conclusion

Important factors related to access to SRH information and services among female migrant workers from Myanmar include personal characteristics including marital status, education, monthly income, and daily expenses. The strategies to improve FMWs' access to SRH services should be universal, comprehensive, and address many associated factors at the same time. The policymakers at the local or national level should consider expanding the migrant-friendly and free SRH services, which are close to migration sites, and that provide SRH service times that are outside of regular office hours. The results can be used to set up a program or model to improve SRH among female migrant workers.

Further study should include more factors and use multivariate analysis to determine associated factors. Moreover, qualitative techniques should be conducted.

Implication and suggestion

This data may be generalizable to migrant workers living in other host countries who are facing challenges in accessing SRHR information and services during the COVID-19 Pandemic. We hope that our findings will inform future policies

or strategies to improve the accessibility of the SRHR services provided to migrant workers, especially when other new emerging diseases occur. The migrant-friendly and free-of-charge SRH services, which are close to migration sites, and that provide SRH service times that are outside of regular office hours are the reasons to encourage female migrant workers to access SRHR information and service. The results can be used to set up a program or model to improve SRH among female migrant workers. Further study should include more factors and use multivariate analysis to determine associated factors. Moreover, the qualitative technique should be conducted.

Suggestions for further study

There are some limitations in our study. Our examination of factors associated with SRHR information and services was conducted with only FMWs from Myanmar and did not include migrants from other nationalities such as Lao PDR, Vietnam, and Cambodia.

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References

Bukhari SA(2021). Sample Size Determination Using Krejcie and Morgan Table. DOI: 10.13140/RG.2.2.11445.19687

Chatchawalchanchanakit P & Apornpisal P. (2017). The feature of factor affecting access to health service of Myanmar Transnational worker: A case study of Thai seafood processing industry in Samut Sakhon Province. *Journal of MCU Social Science Review*, 6.2 (4): 645-658.

Country Office for Thailand WHO. (2013). Migration and health service system in Thailand: situation, responses, and challenges in a context of AEC in 2015: World Health Organization and European Union.

Foreign Workers Administration Office. (2020). Statistics on foreigners who are allowed to work throughout the kingdom. Bangkok: Information Department a0bf3232bdb42f5fe6dbe66cfa75b02c.pdf (doe.go.th)

Harkins B. (2019).Thailand Migration Report 2019. Bangkok: United Nations Thematic Working Group on Migration in Thailand.

Health Education Division. (2014). Health Literacy Scale for Unwanted Pregnancy Prevention of Thai Female Adolescents. Nonthaburi: Ministry of Public Health.

Khamthanet R & Suthutvoravut S. (2020). Comparison of Knowledge, Attitude, and Behavior of Reproductive Health Between Thai and Immigrant Women Workers in Factories in Samut Sakhon, Thailand. *Rama Med J*, 43(1):24-34.

Kumar AX, Tresise CB, Compas C & Murphy AM. (2018). Overview of Internal Migration in Thailand. In: Vize S, editor. Internal migration in Southeast Asia: Towards Better Inclusion of Internal Migrants: IOM, UN-ACT, UN-Habitat, and UNDP.

Labour Department Samut Sakhon Province. (2020). Labor Situation Report in Samut Sakhon Province Quarter 2 of the Year 2020.

McMichael C & Healy J. (2017). Health equity and migrants in the Greater Mekong Subregion. Glob Health Action, 10(1):1271594.

Meherall, Salima, et al. (2020). Barriers to and facilitators of South Asian immigrant adolescents' access to sexual and reproductive health services in Canada: A qualitative study. *The Canadian Journal of Human Sexuality*. Retrieved February 25, 2023 from https://www.researcher-app.com/paper/8282127.

Niramit R. & Phompukping B.(2019).Factors Affecting Access to Health Services of Female Laos's Sex and Service Workers at The Border Ubon Ratchathani Province. 21(2): 78-95.

Satawedin P. (2014). Health communication issues among migrant workers in Thailand: A systematic review for health communication practices. BU Academic Review, 16(1):87-100.

Songchai T. (2020). Body of Knowledge about Translational Migrant and Health: The Result of Research Synthesis of Translational Migrant Labour in Thailand. *Thai Journal of Health Education*, 43(2):1-17.

Sricharoen T. (2020). Migration in the Mekong Subregion: Route from Myanmar Cambodia and Lao to Thailand and Social Welfare Arrangement. London Journal of Research in Humanities and Social Sciences, 20(8):31-50.

Suphanchaimat, Rapeepong, et al. (2021). Predicted Impact of Vaccination and Active Case-Finding Measures to Control Epidemic of Coronavirus Disease 2019 in a Migrant-Populated Area in Thailand. Risk Management and Healthcare Policy, 14: 3197.

Tangcharoensathien V, Patcharanarumol W, Kulthanmanusorn A, Saengruang N & Kosiyaporn H. (2019). The Political Economy of UHC Reform in Thailand: Lessons for Low- and Middle-Income Countries. Health systems and reform, 5(3):195-208.

Tangcharoensathien V, Thwin AA & Patcharanarumol W. (2017). Implementing health insurance for migrants, in Thailand. World Health Organization, 95(2):146-51.

Thein, Shwe Sabai & Thepthien, Bang-on. (2020). Unmet need for family planning among Myanmar migrant women in Bangkok, *Thailand. British Journal of Midwifery*, 28.3: 182-193.

Thongmixay, Souksamone, et al. (2019). Perceived barriers in accessing sexual and reproductive health services for youth in Lao People's Democratic Republic. PLoS One, 14.10: e0218296.

Tousaw E, La RK, Arnott G, Chinthakanan O & Foster AM. (2017). "Without this program, women can lose their lives": migrant women's experiences with the Safe Abortion Referral Programme in Chiang Mai, Thailand. Reproductive health matters, 25(51):58-68.

UNFPA Asia and the Pacific Regional Office. (2011). Socio-Cultural Influences on the Reproductive Health of Migrant Women: A Review of Literature in Cambodia, Lao PDR, Thailand, and Viet Nam. Bangkok: UN service building.

Webber G, Spitzer D, Somrongthong R, Dat TC & Kounnavongsa S. (2012).Facilitators and barriers to accessing reproductive health care for migrant beer promoters in Cambodia, Laos, Thailand, and Vietnam: A mixed-methods study. *Globalization and Health*, 8(1):21.