

Factors affecting contraceptive utilization in Myanmar youth migrants in Samutsakhon province, Thailand

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Received June 2018
Accepted July 2018

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Abstract

Purpose - Youths are becoming sexually active nowadays and the rate of pre-marital sex has been increasing all around the world. Youth migrants have to face several barriers in accessing reproductive health care services when compared with older migrants. This study aimed to identify the factors affecting the contraceptive utilization among Myanmar youth migrants in Samutsakhon province, Thailand.

Design/methodology/approach - A cross-sectional study was conducted among 372 Myanmar youth migrants residing in Samutsakhon province, Thailand by using convenient sampling method. Data was collected by using self-administered questionnaires.

Findings - Contraceptive utilization rate among Myanmar youth migrants was 59.7 %. The study found that significant factors associated with current use of contraception were education (p -value = 0.000), marital status (p -value = 0.033), ever heard of contraception (p -value = 0.008), level of knowledge (p -value = 0.001), discussion with partners (p -value = 0.006), and peer pressure to use contraception (p -value = 0.001). Moreover, availability of contraceptive information (p -value = 0.037), availability of health education materials (p -value = 0.004), easy availability of contraception in need (p -value = 0.000), convenient opening hours (p -value = 0.000) and long waiting time (p -value = 0.001) had significant associations with current use of contraception in multivariate-analysis.

Originality/value - Low level of contraceptive utilization rate means there is urgent need of health education among Myanmar youth migrants. Providing youth friendly health care services can help fulfill the needs of youth migrants who are vulnerable to sexual and reproductive health risks.

Keywords Contraception use, Youths, Myanmar youths, Myanmar migrants, Thailand

Paper type Research paper

Introduction

Globally, young population are becoming sexually active before marriage nowadays. In many countries, sexual activity begins in early adolescence according to United Nation (UN) [1] and in some South East Asia countries, the prevalence of pre-marital sex in these countries varies differently, ranging from less than 1% to over 50%. According to United Nation Family Planning Association (UNFPA) 2012, three quarters of youth in South East Asia (SEA) regions have had sex before marriage [2]. Studies in Asia and Pacific regions shows that pre-marital sex usually occurs in areas with low level of knowledge of using contraception. There are many negative consequences of pre-marital sex such as unwanted pregnancies, abortions and HIV/STI transmission. Moreover, there are also many barriers that limit the access of youths to reproductive health care services such as restriction of policy and legislation, socio-cultural norms, and unfriendly youth health care services [2].

In 2015, there are 12.8 million of girls who have unmet need for family planning and more than half of girls who are sexually active are not using modern contraception. Globally, highest level of unmet need is found in 15-24 years' age group (43%) when compared with the unmet need of 25-29 age group (17%) and 30-34 age group (15%). The unmet need of unmarried sexually active girls is higher (41%) than that of their married or in union girls (23%) [3]. In Myanmar, the unmet need for contraception among young women is also the highest (32.4%) for 15-24 age group [4]. In frequent sex, fear of side effects, inconvenience use and perception

of low risk of pregnancies are causes of unmet need of contraception among young women.

According to Guttmacher Institute, 84% of unintended pregnancies occur among women who have unmet need for contraception in developing countries [5]. According to 2007 family and youth survey in Myanmar, highest rate of abortion was found in 15-19 years age group and 11.39% of pregnancies in this age group ends in abortion [6]. According to Nation Wide cause specific mortality survey in Myanmar, abortion is the third leading cause of maternal mortality (9.68%) [7]. WHO said that reproductive health problems of Myanmar migrants are higher when compared with Thai population and abortion is another serious consequences of high unplanned pregnancies and low use of contraception among migrants [8].

According to IOM 2015, there were 2.3 million of Myanmar migrants staying in Thailand and estimated one million of Myanmar migrants were documented legally while another 1 million were not documented [9]. There are many challenges for migrants in accessing health care services especially for unregistered migrants. In addition to unregistered migrants, registered migrants also find difficulties in accessing health care services [10]. Moreover, youth migrants face barriers in accessing health care due to tradition and culture, lack of youth friendly health care services [11]. For these reasons, youth migrants become the most vulnerable population who suffered from the highest risks of negative health outcomes in the migrant community. There were studies on contraceptive utilization among Myanmar youth migrants in Thailand. However, those studies mainly focused on the use of contraception among married reproductive aged women (15-49) but not for unmarried youth migrants [12]. Therefore, this study aims to fill in the gap by identifying factors affecting contraceptive utilization among Myanmar youth migrants in Samutsakhon province, Thailand.

Methods

This study is a cross-sectional descriptive study among Myanmar youth migrants between 15-24 years of age residing in Samutsakhon province, Thailand. Total sample size population is 404 rate which was calculated by Cochran's Formula after adding 10% withdrawal rate. Myanmar youth migrants who can speak, read and write Myanmar language well and who are residing more than 3 months in Samutsakhon were included in this study and youth migrants who were not willing to participate, and female migrants who were pregnant and in six weeks post-partum period were excluded from this study.

For sampling method, Samutsakhon province and Mahachai sub-district were selected purposively and then, convenient sampling method was used because the researcher collected the samples from five different sampling sites to achieve the targeted sample size of 404. The first site was from Myanmar migrant youths who were coming to receive services from library (minimum 120). The second site was from migrant youths depending on three different sites of work in Samutsakhon province: fishery related (29.3%) (116), fishery (15.2%) (60) and other manufacturing (15.5%) (64) [13]. Researcher got a total of 360 sample population and then collected the rest of the samples from households in Samutsakhon province until targeted sample size (404) was reached. Out of 404 participants, 32 participants did not give consents to participate in this research. So, total sample population was 372 respondents. The data was collected by self-administered questionnaires and was divided into 6 parts. Part 1: Predisposing factors, Part 2: Enabling factors, Part3: Need factors: Sexual activity status, Part 4: Health system factors, Part 5: Responsiveness factors and Part 6: Current contraceptive utilization in Myanmar youth migrants. The data was collected by self-administered questionnaire and

Cronbach's alpha was used to test the reliability of the internal consistency of the questionnaires. Moreover, pilot test with 10% of similar sample population in Bang Khun Thain district was conducted to detect the duration and sensitivity of the questionnaires. Data analysis was done by SPSS software version 22 (licensed by University). For bivariate analysis, Pearson's Chi square and Fisher's exact test were used and then, binary logistic regression was used to analyze the associations between independent variables and dependent variable at the same time.

Ethical approval (COA No.112/2018) was obtained from the Ethical Committee for Research Involving Human Subjects Health Science Group of the Chulalongkorn University. Researcher received consents from participants under 18 years of age by themselves because parental wavier was used, which was allowed by Ethical Committee for Research.

Results

Table 1, the mean age of respondents was 21 years and majority 76.3% were included in the 20-24 years' age group. Nearly 61 % of the respondents were female while 39.2 % were male. Over half of respondents were in secondary school level and majority of them 45.7% of the respondents were factory workers. Most (93.3%) of respondents living in Samutsakhon were registered. For marital status, nearly half of respondents were legally married. Out of 372 respondents, majority (82.5%) had ever heard of contraception while only 17.5% had not ever heard of contraception. Regarding knowledge level, majority (78.8 %) had poor level of knowledge while only a few 0.5 % had good level of knowledge.

Table 1. Descriptive information on age, sex, education, occupation, marital status and registration status, ever heard of contraception and level of knowledge of respondents

Socio-demographic characteristics	n	%
Age group of respondents (years)		
15-16	6	1.6
17-19	82	22.0
20-24	284	76.3
Sex		
Male	146	39.2
Female	226	60.8
Education level		
Can read and write simple language	31	8.3
Primary school level	67	18
Secondary school level	199	53.5
High school level	75	20.2
Occupation		
Factory worker	170	45.7
Construction worker	59	15.9
Agricultural worker	52	14.0
Domestic helper	55	14.8
General/Random laborer	30	8.1
Others	6	1.6
Registration Status		
Unregistered	25	6.7
Registered	347	93.3
Marital Status		
Single	114	30.4
Legally married	181	48.9
Living together, not legally married	71	19.1

(continued)

Table 1. (continued)

Socio-demographic characteristics	n	%
Widow	2	0.5
Divorced/Separated	4	1.1
Ever heard of contraceptive method		
Yes	307	82.5
No	65	17.5
Level of knowledge		
Poor level of knowledge(<10 scores)	293	78.8
Fair level of knowledge(10- 13 scores)	77	20.7
High level of knowledge (>13 scores)	2	0.5

Table 2. Pre-marital sexual activity rates and current use of contraception among Myanmar youth migrants (n=258)

Pre-marital sexual rate and current use of contraception	n	%
Pre-marital sexual activity rate		
Male	49	69
Female	22	31
Current use of contraception		
Yes	154	59.7
No	104	40.3
Total modern methods used	128	83
Total traditional methods used	33	21.5
Types of contraception currently used		
OC pills	63	40.9
Injections	39	25
Emergency contraceptive pills	2	1.3
IUD	2	1.3
Male condom	29	18.8
Withdrawal	26	16.9
Safe period	7	4.5

Table 2, pre-marital sexual activity rate of Myanmar youth migrants, mostly was male 69% and nearly 60% of the respondents were currently using contraception. Oral contraception and injection were the most popular methods while EC pills and IUD were the least popular methods.

Table 3, the results show that respondents who had high school education were using contraception currently 8 times higher than those who could only read and write simple language and this was significant at p value <0.001 level. Moreover, respondents who had ever heard of contraception and who had fair level of knowledge were 5 times and 3 times more likely to use than those who had never heard of contraception and those with poor level of knowledge. Moreover, youth migrants who discussed with their partners were 2 times more likely to use current contraception and youths who used contraception due to peer pressure were also 7 times more likely to use current contraception than those who did not use contraception due to peer pressure.

Table 4, the result shows that respondents who received health education session and health education materials were 2 times more likely to use current contraception than those who did not. Similarly, respondents who had an easy availability of contraception in need were 3 times more likely to use current contraception and this was significant at p -value <0.001 level. Furthermore, working or opening hours of NGOs, public or private hospitals and clinics had negative significant association with current use of contraception and respondents who said opening hours of NGOs,

Table 3. Binary logistic regression analysis of socio-demographic factors, enabling factors and need factors and current use of contraception among sexually active 258 respondents

Variables	B	S.E	Sig	Current use of contraception	
				Crude OR	95% CI
Education level (Ref: Can read and write simple Myanmar language)			0.000**		
Primary school level	0.008	0.521	0.988	1.008	0.363-2.796
Secondary school level	0.353	0.463	0.446	1.424	0.574-3.530
High school level	2.073	0.572	0.000	7.950	2.591-24.393
Marital Status (Ref: Legally married)			0.033 *		
Living together not legally married	0.843	0.286	0.003	0.431	0.246-0.754
Ever heard of any contraceptive method (Ref: No)					
Yes	1.545	0.585	0.008*	4.687	1.491-14.74
Level of knowledge (Ref; Poor level of knowledge(< 10 scores))			0.001*		
Fair level (10-13 score)	1.228	0.319	0.000	03.413	1.827-6.374
Good level (>13 scores)	-0.077	1.422	0.957	0.926	0.057-15.025
Discussion about contraception with partner (Ref: No)					
Yes	0.708	0.26	0.006	2.03	1.22-3.38
Use of contraception due to peer pressure (Ref: No)					
Yes	1.912	0.555	0.001	6.769	2.279-20.104

Note: **p*-value<0.05, ** *p*-value<0.01

Table 4. Binary logistic regression analysis of health system factors, responsiveness factors and current use of contraception among sexually active 258 respondents

Variables	B	S.E	Sig	Current use of contraception	
				Crude OR	95% CI
Received health education session about contraception (Ref: No)					
Yes	0.534	0.256	0.037*	1.705	1.033-2.817
Received health education materials about contraception (Ref: No)					
Yes	0.742	0.259	0.004*	2.1	1.265-3.487
Easy availability of contraception when needed (Ref: No)					
Yes	1.042	0.296	0.000**	2.834	1.586-5.065
Convenient Working hours (Ref : Yes)					
No	-2.097	.425	0.000**	0.123	0.053-0.283
Waiting a long time (Ref: Yes)					
No	1.881	.547	0.001*	6.557	2.244-19.166

Note: **p*-value<0.05, ***p*-value<0.01

hospitals or clinics were inconvenient were 0.123 times less likely to use current contraception than those who were convenient to opening/working hours. In addition, respondents who did not wait a long time were nearly 7 times more likely to use contraception currently than those who had to wait for a long time and this was significant at *p*-value 0.001 level.

Discussion

The contraceptive utilization rate among Myanmar youth migrants in this study

was 59.7% in which married youths accounted for 66.9% and unmarried youths for 46.5%. The rate of contraceptive utilization rate in this study was slightly lower when comparable to the rates of contraceptive utilization among reproductive aged Myanmar migrant women in Phang-nga province (80.1%) [14] and in Kachanaburi province (78.2%) [15]. However, when it was comparable to the rate of contraceptive utilization among youths in Bang Bon district, and the former was quite nearly similar to the latter which was 60% [16]. In addition, there were higher proportions of respondents who used current modern contraception (83%) than those who used traditional methods (21.5%). However, the rate of traditional method use was considered higher in this study. This might be because Myanmar youths were culturally influenced to use traditional methods according to their parents or older generations' sayings and as majority think traditional methods have less side effects than modern contraception. Most commonly used contraceptive method among youth migrants were OC pills, injections followed by male condom and withdrawal method. For unmarried youths, male condom was the most popular method followed by withdrawal and for married youths, highest percentage of use was found in OC pills followed by injections and withdrawal.

Respondents with higher level of education used current contraception than those with lower level of education and similar findings were found among Myanmar migrants in Phang-Nga province [14] and among female adolescents in Ghana [17]. Moreover, marital status had significant association with current use of contraception and youths who were living together but were not legally married were less likely to use contraception than legally married youths. This finding was consistent with the study done in Chinese migrants [18] and in report done by Guttmacher Institute which showed that married women (77%) used contraception more than unmarried sexually active women (42%) [19]. In this study, majority of respondents had ever heard of contraception (82.5%) and knowledge about contraception had significant associations with the current use of contraception in both bivariate and multi-variate analysis and these findings were consistent with among rural adolescents in east Gojjam zone, Ethiopia [20] and among Myanmar reproductive aged women in Mandalay Division [21].

Rate of pre-marital sexual practice among Myanmar youth migrants in this study was 19.1% in which male involvement was 69% and female involvement 31%. The rate in this study was lower than the rate of pre-marital sex among Myanmar out of school youths (22.5%) [22] and that of young people in Turkey and Kenya with 50.3% [23] and 73% [24] respectively. Therefore, it can be clearly seen that pre-marital sexual activity rates can be different in different population, environment and different cultures. Ever receiving health education session and materials had significant positive associations with current use of contraception in this study. In addition, significant association was found between easy availability of contraceptive methods and current use and consistent findings were found among women in Tanzania [25] and among Myanmar youth migrants in Bang Bon district [26]. Besides, Concerning with opening or working hours of NGOs or clinics or hospitals, it still maintained its significance in multi-variate analysis in this study and similar findings were found in the study among adolescents in Kenya in which majority of adolescents (91.5%) who thought opening hours were not convenient did not use contraception [27]. Among responsiveness factors, waiting time had significant association with current use of contraception and similar finding was seen in the report among young people in Kenya and Zimbabwe and in the survey among Cambodia, Laos, Thailand and Vietnam migrants [28].

Conclusion

Although there were studies about contraceptive utilization for married reproductive aged migrant women in Thailand, only few studies specifically intended for the use of contraception among youth migrants in Thailand. Therefore, this study can be a base-line information concerning with the use of contraception among Myanmar youth migrants in Samutsakhon province. This also can be useful to public health policy makers in strengthening the policy about reproductive health care services to Myanmar youth migrants.

This study showed the contraceptive utilization rate among Myanmar youth migrants was 59.7% which seemed lower when compared with other migrant studies. Moreover, contraceptive utilization rate for unmarried sexually active youths was lower than that of married youths. This study also pointed out that 83% of Myanmar youth migrants used modern contraception while 21.5% of youths used traditional methods that were ineffective. These can be big concerns for sexually active unmarried youths because lower contraceptive use and ineffective traditional methods use can lead to higher risks of transmission of HIV and other STI diseases and unwanted pregnancies and unsafe abortions. Therefore, unmarried youths should be given first priorities in giving reproductive health education, information and reproductive health care services than married group.

Majority of the respondents had poor level of knowledge and there was also higher traditional method use of contraception in this study which considered to be ineffective. Therefore, health education should be given including detailed information of each type of contraceptive method such as their advantages, consequences and side effects in order to change the attitudes about side effects of modern contraceptive use. In this study, married youths got health education sessions and materials more than unmarried youths. Moreover, availability of contraception in need had significant association with current use of contraception and unmarried youth migrants did not receive as much as contraception in need than married youth migrants. These might be the reasons why contraceptive utilization rate of unmarried youths was lower than that of married youths. Another reason might be they had difficulty in accessing to contraception due to being afraid of socially stigmatized or discriminated by family, community and health care workers.

In addition, majority of youths in this study had to face inconvenient opening hours of NGOs or clinics or hospitals and long waiting time problem. Establishing evening opening or working NGOs or clinics and increasing staffs in NGOs, public or private hospitals might be solutions for respondents who were inconvenient to opening hours of clinics or hospitals and for reducing waiting time. Youth friendly health care services should also be provided to youth clients. For suggestions of future research, qualitative research would be helpful to health policy makers in exploring the detail information about youth natures regarding sexual and reproductive health. Since this study is a cross-sectional study and assessed the independent factors and dependent factor at the same time, the research could not determine cause and effect relationship. Besides, this study could not represent to all Myanmar youth migrants in Samutsakhon province as the researcher used convenient sampling method to collect the samples.

Acknowledgements

Author is very grateful to Myanmar youth migrants who were participated in my research and research assistants from See Lone Inn Arr Library in Mahachai sub-district of Samutsakhon province.

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