UTILIZATION OF CONTRACEPTIVE METHODS AMONG MYANMAR MIGRANT MARRIED WOMEN IN CHIANG MAI, THAILAND

THET KO AUNG

A THEMATIC PAPER SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF PUBLIC HEALTH FACULTY OF GRADUATE STUDIES MAHIDOL UNIVERSITY 2014

Thematic Paper
entitled

UTILIZATION OF CONTRACEPTIVE METHODS AMONG MYANMAR MIGRANT MARRIED WOMEN IN CHIANG MAI, THAILAND

……
Mr. Thet Ko Aung
Candidate

……
Assist. Prof. Pimsurang Taechaboonsermsak, Ph.D.
Major advisor

……
Assist. Prof. Supachai Pitikultang, M.D., Dip. Thai Board of Paediatrics
Co-advisor

……
Assist. Prof. Sukhontha Siri, Ph.D.
Co-advisor

……
Prof. Banchong Mahaisavariya, M.D., Dip. Thai Board of Orthopedics
Dean
Faculty of Graduate Studies
Mahidol University

……
Assoc. Prof. Oranut Pacheun, Dr.P.H.
Program Director
Master of Public Health
Faculty of Public Health
Mahidol University

Thematic Paper
entitled

UTILIZATION OF CONTRACEPTIVE METHODS AMONG MYANMAR MIGRANT MARRIED WOMEN IN CHIANG MAI, THAILAND

was submitted to the Faculty of Graduate Studies, Mahidol University
for the degree of Master of Public Health
on
March 24, 2014

……
Mr. Thet Ko Aung
Candidate

……
Lect. Malee Geounuppakul,
Ph.D.
Chair

……
Assist. Prof. Pimsurang
Taechaboonsermsak,
Ph.D.
Member

……
Assist. Prof. Sukhontha Siri,
Ph.D.
Member

……
Assist. Prof. Supachai Pitikultang,
M.D., Dip. Thai Board of Paediatrics
Member

……
Prof. Banchong Mahaisavariya,
M.D., Dip. Thai Board of Orthopedics
Dean
Faculty of Graduate Studies
Mahidol University

……
Assoc. Prof. Phitaya Charupoonphol,
M.D., Dip. Thai Board of Epidemiology
Dean
Faculty of Public Health
Mahidol University

ACKNOWLEDGEMENTS

To lunch into writing my research project was a tremendous challenge. Therefore, I would like to express my heartfelt gratitude to my advisor, Assis. Prof. Pimsurang Taechaboonsermsak, for her guidance, encyclopaedic advice, kind support and encouragement throughout the roadmap of my thematic paper. Then, my sincere thank shifts to my co-advisor, Assist. Prof. Supachai Pitikultang, for his systematic hands-on guidance, constructive comments and motivation. In addition, I would like to appreciate my discussant, Assist. Prof. Sukhontha Siri, for her critical review and extensive guidance with statistical analysis of my thematic paper. Without the sound advice of these three teachers, this thematic paper would never have happened.

Besides, my special thanks refer to Lect. Malee Geounuppakul, for her acceptance to be the chair of Thematic Paper Defence Examination Committee. Furthermore, I would like to thank Program Director of Master of Public Health Program, all teachers, colleagues and staffs of Faculty of Public Health, Mahidol University for their kind support, encouragement and warm relation since my very first day to Mahidol University. Moreover, my grateful appreciation extends to Sayardaw U Vaseettha, U Arli, Ko Myo Zaw Latt and Ma Tin Zar Cho in Chiang Mai who helped and guided me to approach to the Myanmar migrant community in Chiang Mai. What is more, I would like to reveal my special thanks to the Myanmar migrant community in Chiang Mai who provided their spare time to collaborate with my research project.

Into the bargain, I am deeply appreciate and eternally grateful to my beloved parents and my aunt for their tender loving care and support not only throughout my study, but also throughout my life. Finally, most heartfelt, my deepest appreciation and gratitude goes to my beloved wife who provided me with enormous emotional support, patience, encouragement, understanding and inspiration in writing of this project. As a token of thanks, I dedicate this research to my parents, my wife and Myanmar migrant community in Thailand.

Thet Ko Aung

UTILIZATION OF CONTRACEPTIVE METHODS AMONG MYANMAR MIGRANT MARRIED WOMEN IN CHIANG MAI, THAILAND

THET KO AUNG 5637187 PHMP/M

M.P.H.

THEMATIC PAPER ADVISORY COMMITTEE: PIMSURANG TAECHABOONSERMSAK, Ph.D., SUPACHAI PITIKULTANG, M.D., Dip THAI BOARD OF PEDIATRICS, SUKHONTHA SIRI, Ph.D.

ABSTRACT

The aim of this cross-sectional study was to determine the proportion of utilization of contraceptive methods and the factors related to the utilization of contraceptive methods among Myanmar migrant married women in Chiang Mai, Thailand. A total of 179 respondents were interviewed by structured questionnaire. The proportion of utilization of contraceptive methods was found to be 61.5% of the respondents. Oral pills and injection were the most commonly used contraceptive methods.

The findings also showed that there was a significant association between utilization of contraceptive methods and age of the respondents (p-value =0.005), knowledge about utilization of contraceptive methods (p-value <0.001), attitude towards utilization of contraceptive methods (p-value <0.001), accessibility to contraceptive services (p-value <0.001), availability of health education materials (p-value =0.015), accessibility to health insurance scheme (p-value =0.024), social support from husband (p-value <0.001) and social support from friends (p-value <0.001).

The findings indicated that there is a need to launch health education and awareness raising programs to establish the client oriented contraceptive services for this community.

KEY WORDS: UTILIZATION OF CONTRACEPTIVE METHODS/ MYANMAR MIGRANT MARRIED WOMEN/ CHIANG MAI/ FAMILY PLANNING

118 pages

CONTENTS

	Page
ACKNOWLEDGEMENTS	**iii**
ABSTRACT	**iv**
LIST OF TABLES	**viii**
LIST OF FIGURES	**x**
LIST OF ABBREVIATIONS	**xi**
CHAPTER I INTRODUCTION	**1**
1.1 Rationale and Justification	1
1.2 Research Questions	3
1.3 Objectives	4
1.4 Hypotheses	5
1.5 Variables of the study	5
1.6 Operational Definitions	6
1.7 Conceptual Framework	8
CHAPTER II LITERATURE REVIEW	**9**
2.1 Contraceptive methods and contraceptive use	9
2.2 Utilization of contraceptive methods in Thailand	14
2.3 Migration and migrant situation in Thailand	16
2.4 The Precede-Proceed Model	19
2.5 Related studies	22
CHAPTER III MATERIALS AND METHODS	**33**
3.1 Study Design	33
3.2 Study Site	33
3.3 Population and Sample	34
3.4 Sample size estimation	34
3.5 Data collection	35

CONTENTS (cont.)

	Page
3.6 Research instrument	36
3.7 Content validity and reliability	39
3.8 Statistical analysis	39
3.9 Ethical Consideration	40
CHAPTER IV RESULTS	**41**
4.1 General characteristics	41
4.2 Utilization of contraceptive methods	44
4.3 Predisposing factors	47
4.4 Enabling factors	50
4.5 Reinforcing factors	53
4.6 Association between various independent variables of interest and utilization of contraceptive methods	58
4.7 Factors influencing utilization of contraceptive methods	66
CHAPTER V DISCUSSION	**68**
5.1 Utilization of contraceptive methods	68
5.2 General characteristics	71
5.3 Predisposing factors	74
5.4 Enabling factors	75
5.5 Reinforcing factors	77
5.6 Limitations of the study	78
CHAPTER VI CONCLUSION & RECOMMENDATONS	**80**
6.1 Conclusion	80
6.2 Recommendations	81
REFERENCES	**84**
APPENDICES	**90**
Appendix A Questionnaires	91
Appendix B Questionnaires (Myanmar Version)	99

CONTENTS (cont.)

	Page
Appendix C Ethical Approval	107
Appendix D Information Sheets	108
Appendix E Informed Consent Form	114
BIOGRAPHY	**118**

LIST OF TABLES

Table		Page
2.1	Efficacy of methods of contraception	13
4.1	Frequencies and percentage distribution of general characteristics of the respondents	43
4.2	Frequencies and percentage distribution of the respondents by contraceptive use	45
4.3	Frequencies and percentage distribution of respondents by correct score of knowledge item	47
4.4	Frequency and percentage distribution of level of knowledge about utilization of contraceptive methods	48
4.5	Frequency and percentage distribution of attitude towards utilization of contraceptive methods	49
4.6	Frequency and percentage distribution of level of attitude towards utilization of contraceptive methods	50
4.7	Frequencies and percentage distribution of respondents by the place of contraceptive service	50
4.8	Frequencies and percentage distribution of respondents by the availability of contraceptive methods in the place of contraceptive service	51
4.9	Frequencies and percentage distribution of respondents by the accessibility to the place of contraceptive service	51
4.10	Frequencies and percentage distribution of respondents by the payment for contraceptive service	52
4.11	Frequencies and percentage distribution of respondents by the availability of health education materials about utilization of contraceptive methods	52

LIST OF TABLES (cont.)

Table		Page
4.12	Frequencies and percentage distribution of respondents by the accessibility to health insurance scheme	53
4.13	Percentage distribution of social support from husband	54
4.14	Frequency and percentage distribution of level of social support from husband	55
4.15	Percentage distribution of social support from friends	55
4.16	Frequency and percentage distribution of level of social support from friends	56
4.17	Percentage distribution of social support from friends	57
4.18	Frequency and percentage distribution of level of social support from friends	58
4.19	Association between the general characteristics factors and utilization of contraceptive methods	60
4.20	Association between knowledge of respondents and utilization of contraceptive methods	61
4.21	Association between attitude of respondents and utilization of contraceptive methods	62
4.22	Association between number of contraceptive services available and utilization of contraceptive methods	63
4.23	Association between the accessibility of contraceptive services and utilization of contraceptive methods	63
4.24	Association between the availability of health education materials and utilization of contraceptive methods	64
4.25	Association between the accessibility of health insurance scheme and utilization of contraceptive methods	64
4.26	Association between social support from husband, friends and health care workers and utilization of contraceptive methods	65

LIST OF TABLES (cont.)

Table		Page
4.27	Variables on utilization of contraceptive methods in binary logistic regression with enter method	67

LIST OF FIGURES

Figure		Page
1.1	Conceptual framework	8
2.1	The PRCEDE-PROCEED Planning Model	20

LIST OF ABBREVIATIONS

CPR	Contraceptive prevalence rate
HIV	Human Immunodeficiency Virus
ID	Identification
IOM	International Organization for Migration
IUD	Intrauterine devices
MDG	Millennium Development Goals
NGO	Non Government Organizations
STIs	Sexually Transmitted Infections
UN	United Nation
WHO	World Health Organization

CHAPTER I
INTRODUCTION

1.1 Rationale and justification

Globally there were 215.8 million international migrants and they comprised 3.2 percent of global population. Women accounted for 48.4 percent of international migrants. In East Asia and Pacific Region, there were 5.4 million migrants, which was 0.3 percent of global population in which 47.4 percent were female migrants (1). In recent decades, the migrant population is dramatically increasing in Thailand due to economic development. According to a situation analysis report on health system strengthening for migrants in Thailand 2012, there were totally 2,581,360 migrant workers and dependents from Myanmar, Cambodia and Laos, of which the majority around 80 percent were from Myanmar (2). Myanmar is one of the South-East Asia countries and it shares the border with China, Laos PDR, Thailand, India and Bangladesh. The high cross-border migration flows from Myanmar into Thailand can be explained by many factors such as economic and poverty, political and social conflict.

Although migration contributed the development of countries, it had raised a number of social and health issues, including access to health care and health problems. Although the Government of Thailand had introduced policies to encourage migrant workers to become registered, most of them were not registered rendering them vulnerable to abuse and exploitation. International Organization for Migration estimated that there were more than one million migrant workers who were not registered (3). Regarding with health seeking behavior of migrants, fifty to seventy percent of those revealed no entitlement to any health welfare or insurance scheme leading to the development of health problems (2). Apart from communicable diseases such as TB, HIV and STIs, reproductive health was one of the major concerns of migrant women.

In reality, reproductive health was an important component of Millennium Development Goals. The targets of MDG Goal 5 were to reduce the maternal mortality ratio by three quarters between 1990 and 2015 and to achieve universal access to reproductive health by 2015 (4). As in detail, family planning was a fundamental component of reproductive health as it allowed for determining the spacing of pregnancies. Ensuring basic access to family planning could reduce maternal deaths by a third and child deaths by as much as twenty percent and also could have a significant impact on society and country development in achieving towards health-related MDGs (5). One effective measure in family planning all over the world was using contraceptive methods by women and men (6). It had been used to control population growth rates as well as to reduce the health risks for women and children and the poverty level of the society. Besides, contraceptive use supported maternal and reproductive health by averting unintended and closely spaced pregnancies and reducing unsafe abortions.

Globally, use of modern contraception had risen slightly, from 54% in 1990 to 57% in 2012 and in Asia it had remained at 62% (7). Although over half of married women in most developing regions were using some form of family planning, African countries showed wide disparities in maternal and reproductive health, emphasizing the need to expand effective interventions. Thailand was internationally recognized for its success in family planning. According to the 2013 United Nations Economic and Social Commission for Asia and the Pacific population data sheet (8), the Total Fertility Rate was reduced dramatically from 6.3 birth per woman in 1966 to 1.4 birth per woman in 2013. Similarly, Contraceptive Prevalence Rate among married women aged 15-49 years was increased tremendously from 53.4% in 1978 to 79.8% in 2013 (8).

Although CPR among Thai population was increased tremendously, CPR of migrant women was lower than Thai population. One report from Institute for Population and Social Research, Mahidol University (9) stated that the CPR of migrant women was found to be as high as 68% for modern methods in 2010. Interestingly, the modern CPR was lowest among Cambodia migrants (54%) while it was highest among Myanmar migrants (72%), but it was still lower than that of Thai population (9). However, the TFR among migrant workers was more than two times higher than the

Thai population at 3.6 per woman (2). Moreover, Thailand Ministry of Health had recorded the rate of abortion in Myanmar migrant women was 2.4 times higher that of local Thai population (10). Besides, despite increasing utilization of contraceptive methods, the rate of abortion in border area was increased to 39.29 per thousand live births in 2006 (11). These figures revealed that many migrant workers did not access to reproductive health services contributing to unplanned pregnancies, resulting in unsafe abortions and other reproductive health problems.

For the above reasons, further information of why Myanmar migrant married women used or did not use the contraceptive methods would be needed to investigate. Therefore, the researcher would like to conduct the research to identify the proportion and determinants of utilization of contraceptive methods among Myanmar migrant married women including the accessibility to health insurance services for migrant workers in order to design the effective strategies that would promote the acceptance and use of contraceptive methods. This research was a cross-sectional study based on Precede-Proceed planning model.

Chiang Mai was chosen as my study area because little was known about the proportion and determinants of utilization of contraceptive methods among Myanmar migrant married women in Chiang Mai. It was one of the major destination sites for migrants from Myanmar. Being a second capital of Thailand and a modern city of the Northern part of Thailand was attractive for Myanmar migrants. Most of them were working in domestic areas, construction sites and markets. Not only those with work permit were working but also those without work permit had to work with less salary. According to 2012 annual report of department of employment (12), there were 83,487 migrant workers in Chiang Mai Province in which 71,008 were registered migrant workers and 12,479 were un-registered migrant workers. Among registered migrants, 36,333 were male and 34,675 were female. For un-registered migrant workers, 7,006 were male and 5,473 were female.

1.2 Research questions

- What was the proportion of utilization of contraceptive methods among Myanmar migrant married women in Chiang Mai, Thailand?

- What was the pattern of utilization of contraceptive methods among Myanmar migrant married women in Chiang Mai, Thailand?
- What were the factors related to the utilization of contraceptive methods among Myanmar migrant married women in Chiang Mai, Thailand?

1.3 Objectives

1.3.1 General objective

- To determine the proportion of utilization of contraceptive methods and its related factors among Myanmar migrant married women in Chiang Mai, Thailand

1.3.2 Specific objectives

- To determine the proportion of utilization of contraceptive methods among Myanmar migrant married women in Chiang Mai, Thailand
- To describe the pattern of utilization of contraceptive methods among Myanmar migrant married women in Chiang Mai, Thailand
- To identify the general characteristics of Myanmar migrant married women in Chiang Mai, Thailand
- To evaluate the predisposing factors; knowledge about and attitude towards the utilization of contraceptive methods among Myanmar migrant married women in Chiang Mai, Thailand
- To assess the enabling factors; availability and accessibility of contraceptive services, availability of health education materials and accessibility of health insurance scheme for utilization of contraceptive methods among Myanmar migrant married women in Chiang Mai, Thailand
- To describe the reinforcing factors; social support for utilization of contraceptive methods among Myanmar migrant married women in Chiang Mai, Thailand
- To analyze the association between general characteristics, predisposing factors, enabling factors, reinforcing factors and the utilization of

contraceptive methods among Myanmar migrant married women in Chiang Mai, Thailand

1.4 Hypotheses

- There was an association between the general characteristics of Myanmar migrant married women and the utilization of contraceptive methods.
- There was an association between the predisposing factors (knowledge about and attitude towards the utilization of contraceptive methods) and the utilization of contraceptive methods among Myanmar migrant married women in Chiang Mai, Thailand.
- There was an association between the enabling factors (availability and accessibility of contraceptive services, availability of health education materials and accessibility of health insurance scheme) and the utilization of contraceptive methods among Myanmar migrant married women at Chiang Mai, Thailand.
- There was an association between the reinforcing factors (social support) and the utilization of contraceptive methods among Myanmar migrant married women at Chiang Mai, Thailand.

1.5 Variables of the study

1.5.1 Dependent variables

- Utilization of contraceptive methods

1.5.2 Independent variable

- General characteristics
  - Age
  - Registration status
  - Ethnicity
  - Duration of stay in Thailand

- Education
- Current occupation
- Monthly family income
- Duration of marriage
- Current number of children
- Desired number of children

- Predisposing factors
  - Knowledge about the utilization of contraceptive methods
  - Attitude towards the utilization of contraceptive methods
- Enabling factors
  - Availability and accessibility of contraceptive services
  - Availability of health education materials
  - Accessibility of health insurance scheme
- Reinforcing factors
  - Social support from husband
  - Social support from friends
  - Social support from health care workers

1.6 Operational definitions

- **Utilization of contraceptive methods:** Referred to those women who used one or more methods of contraception or used by her husband or partner for the purpose of birth spacing at the time of interview.
- **Myanmar migrant married women:** Referred to any women who came from Myanmar to Thailand either to work or as dependent and were staying in Chiang Mai together with her husband or her partner at the time of study. Legal marriage was not necessary to enroll in this study.
- **Age:** Referred to the respondent's completed age in years at the time of interview.
- **Registration status:** Referred to the status of respondent whether they were legally registered as migrant worker or not.

- **Ethnicity:** Referred to Myanmar ethnic group belonged to the respondent, which was common in migrant workers in Thailand. They were Myanmar, Karen, Mon, Rakhine, Shan and Dawei (Tavoy).
- **Monthly family income:** Referred to the total income of all family members per month.
- **Current number of children:** Referred to number of children who were alive the respondent had.
- **Desire number of children:** Referred to the number of children the respondent would like to have if she had the opportunity to choose.
- **Knowledge about utilization of contraceptive methods:** Referred to the respondent's knowledge about contraceptive used in respect of family planning.
- **Attitude towards utilization of contraceptive methods:** Referred to the respondent's attitude about contraceptive used in respect of family planning.
- **Availability of contraceptive services:** Referred to the number of places of service where women could obtain contraceptive methods.
- **Accessibility of contraceptive services:** Referred to the presence or absence of difficulties or barriers to utilize the service where women could obtain contraceptive methods.
- **Availability of health education materials:** Referred to the availability of pamphlets or posters or information given by health care workers that might help the migrant women to understand about contraceptive methods.
- **Accessibility of health insurance scheme:** Referred to the possession of 30 Baht Universal Coverage Scheme, Social Security Scheme or none.
- **Social support from husband:** Referred to emotional support, instrumental support, information support and appraisal support from husband (13).
- **Social support from friends:** Referred to emotional support, instrumental support, information support and appraisal support from friends (13).
- **Social support from health care workers:** Referred to emotional support, instrumental support, information support and appraisal support from health care workers (13).

1.7 Conceptual framework

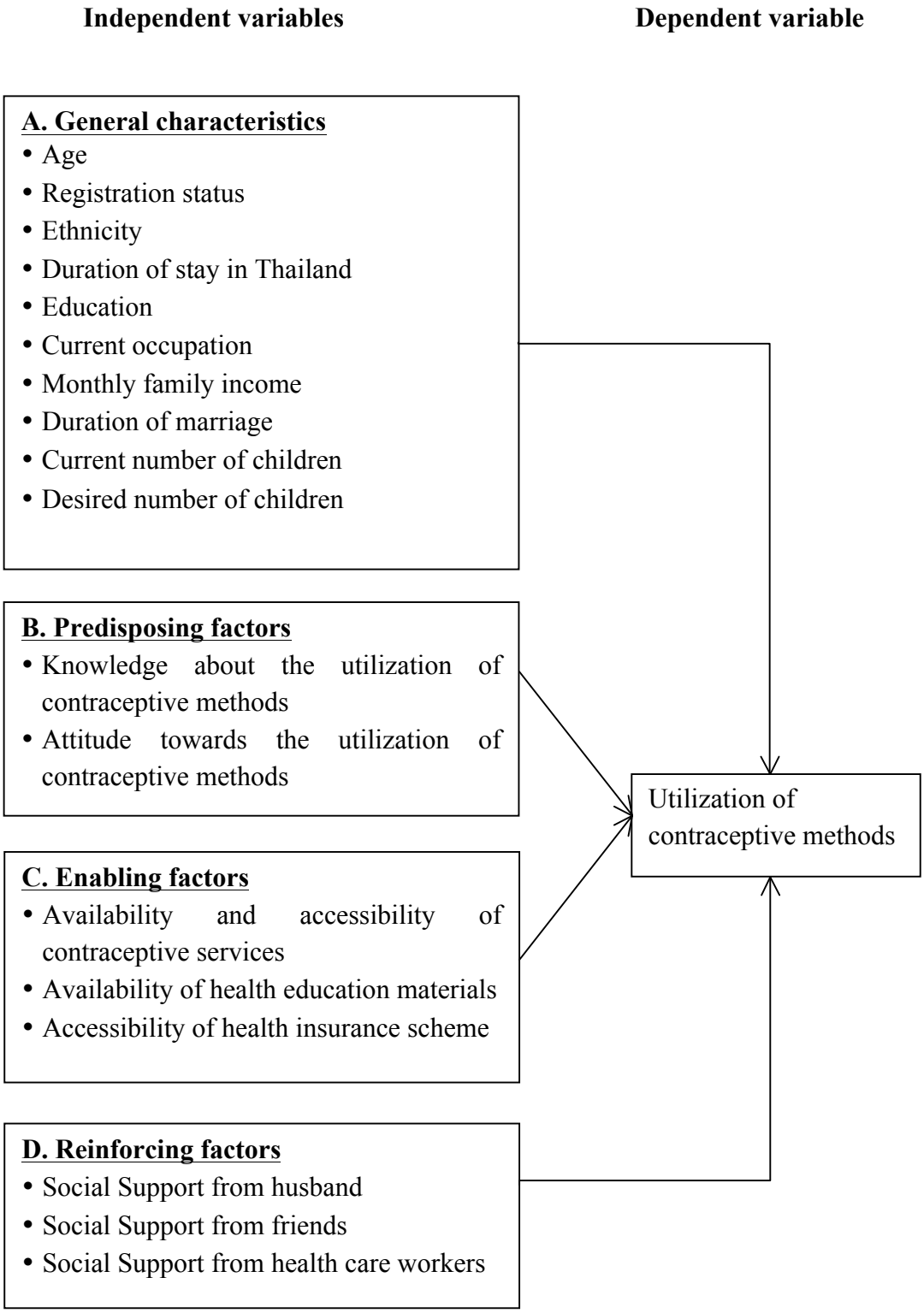

Figure 1.1: Conceptual Framework

CHAPTER II
LITERATURE REVIEW

The reviewed concepts are used to apply to study the proportion and determinants of utilization of contraceptive methods among Myanmar migrant married women in Chiang Mai, Thailand. According to objectives, operational definitions and conceptual framework, this literature review is composed of 5 parts as follow:

2.1 Contraceptive methods and contraceptive use

2.2 Utilization of contraceptive methods in Thailand

2.3 Migration and migrant situation in Thailand

2.4 The PRECEDE-PROCEED model

2.5 Related studies

2.1 Contraceptive methods and contraceptive use

WHO defined family planning as “it 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 use of contraceptive methods and the treatment of involuntary infertility. A woman’s ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy” (6).

The ideal contraceptive would be 100% effective, with no health risks or side effects, independent of intercourse, easily and completely reversible, easily administered and used independently of the medical profession. However, such a method did not yet and might never exist. In practice, there was, therefore, a trade-off between efficacy and safety. Unfortunately, methods, which were very safe, such as barriers or natural method, were not very effective. Meanwhile, the very effective methods, the hormonal contraceptives and intrauterine devices (IUDs), raise more concerns about health risks and side effects.

According to Gyanecology by Ten Teachers (14), the contraceptive methods were classified as follow:

- **Hormonal contraception**
    - Combined oral contraceptive pills
    - Progestogen-only preparations (pills, injectables and subdermal implants)
- **Intrauterine contraception**
    - Copper intrauterine device (IUD)
    - Hormone-releasing intrauterine system
- **Barrier methods**
    - Condoms
    - Female barriers
- **Natural family planning**
- **Emergency contraception**
- **Sterilization**
    - Female sterilization
    - Vasectomy

Combined oral contraceptive pills

It contains a combination of two hormones: a synthetic oestrogen and a progestogen (a synthetic derivative of progesterone). Most modern preparations contains the oestrogen ethinyl oestradiol in a daily dose of between 20 and 35 ug.

Mode of action: Combined oral contraception acts both centrally and peripherally. Inhibition of ovulation is by far the most important effect. Both oestrogen and progestogen suppress the release of pituitary follicle stimulating hormone and luteinizing hormone, which prevents follicular development within the ovary and therefore ovulation. Peripheral effects include making the endometrium atrophic and hostile to an implanting embryo and altering cervical mucus to prevent sperm ascending into the uterine cavity.

Side effects: Side effects include depression, headaches, loss of libido, nausea and vomiting, weight gain, bloatedness, gall-stones, cholestatic jaundice,

cystitis, irregular bleeding, vaginal discharge, growth of fibroids, breast pain, increased risk of breast cancer, chloasma (facial pigmentation) and leg cramps (14).

Progestogen-only contraception

The current methods of progestogen-only contraception are progestogen-only pill, or 'mini-pill', subdermal implant, injectables and hormone-releasing intrauterine system.

Mode of action: All progestogen-only methods work by a local effect on cervical mucus (making it hostile to ascending sperm) and on the endometrium (making it thin and atrophic), thereby preventing implantation and sperm transport. Higher dose progestogen-only methods will also act centrally and inhibit ovulation.

The common side effects of progestogen-only methods include erratic or absent menstrual bleeding, functional ovarian cysts, breast tenderness and acne (14).

Intrauterine contraception

Modern IUDs are highly effective methods of contraception. An IUD is ideal for women who want a long-term method of contraception independent of intercourse and where regular compliance is not required. IUDs protect against both intrauterine and ectopic pregnancy, but if pregnancy occurs, there is a higher chance than normal that it will be ectopic.

Types: The original IUDs were large plastic inert devices, which often caused significantly heavier and more painful menstrual periods. These are no longer available, although some women may still have them in situ. Once fitted, they could be left until the menopause. Most women nowadays will use the smaller copper bearing IUDs, which are available in various shapes and sizes. They cause much less menstrual disruption than the older plastic devices. Most copper-bearing IUDs are licensed for between 3 and 5 years of use, but many will last longer, possibly up to 10 years. The more copper wire a device has, the more effective it is, and some IUDs have silver-cored copper for added efficacy. An IUD without a frame which consists of six copper beads on a prolene thread has been developed and is anchored into the uterine fundus with a knot.

Hormone-releasing devices have also been developed. The levonorgestrel-releasing intrauterine system has the advantages (and disadvantages) of both hormonal and intrauterine contraception. It is associated with a dramatic reduction in menstrual blood loss and is licensed for contraception and the treatment of menorrhagia (14).

Condoms

Male condoms are usually made of latex rubber. They are cheap and are widely available for purchase or free from many clinics (14).

Female barriers

The diaphragm, or Dutch cap, is the female barrier used most commonly in the UK. Other female barriers include cervical caps, vault caps and vimules. They should all be used in conjunction with a spermicidal cream or gel. Female barriers offer protection against ascending pelvic infection but can increase the risk of urinary tract infection and vaginal irritation. Female condoms made of plastic are also available (14).

Natural family planning

This is an extremely important method of contraception worldwide and may be the only one acceptable to some couples for cultural and religious reasons. It involves abstaining from intercourse during the fertile period of the month.

The lactational amenorrhoea method is used by fully breastfeeding mothers. During the first 6 months of infant life, fully breastfeeding gives more than 98 per cent contraceptive protection (14).

Emergency contraception

The terms ‘morning-after pill’ and ‘postcoital contraception’ have now been replaced simply by the term ‘emergency contraception’ (EC). There are two types of emergency contraception in general use (Hormonal emergency contraception and IUD for emergency contraception) (14).

Sterilization

Female sterilization and male vasectomy are permanent methods of contraception and are highly effective. They are generally chosen by relatively older couples who are sure that they have completed their families (14).

Female sterilization

This involves the mechanical blockage of both fallopian tubes to prevent sperm reaching and fertilizing the oocyte (14).

Vasectomy

Vasectomy involves the division of the vas deferens on each side to prevent the release of sperm during ejaculation (14).

Efficacy of methods of contraception

According to Gyanecology by Ten Teachers (14), the efficacy of contraceptive methods are classified as follow:

Table 2.1: Efficacy of methods of contraception

Contraceptive method	Failure rate per 100 women-years
Combined oral contraceptive pill	0.1-1
Progestogen -only pill	0.3-4
Depo-Provera	0.1-2
Implant	0
Copper-bearing IUD	1-2
Levonorgestrel-releasing IUD	0.5
Male condom	2-5
Female diaphragm	1-15
Persona	6
Natural family planning	2-3
Vasectomy	0.02
Female sterilization	0.13

Source: Gynaecology by Ten Teachers (14)

Contraceptive use was a key to slowing unsustainable population growth and the resulting negative impacts on the economy, environment, and national and regional development efforts. There were many advantages of family planning in term of contraceptive use not only for individual and family but also for the community and country. A woman's ability to choose if and when to become pregnant had a direct impact on her health and well-being. First of all, family planning could reduce the risk of health problems and death from early childbearing by delaying pregnancies in young women and could prevent pregnancies among older women who also faced increased risk. Moreover, family planning could reduce the number of unintended pregnancies and the need for unsafe abortion. From the view of HIV, contraceptive use could reduce the risk of unintended pregnancies among women living with HIV, resulting in fewer infected babies and orphans. In addition, male and female condoms provided dual protection against unintended pregnancies and against STIs including HIV (6).

As stated by UN MDG report (4), the total demand for family planning among married women was projected to grow to more than 900 million by the year 2015, mostly due to population growth. This was one indication of the unfinished agenda in reproductive health and the scale of efforts needed to keep pace with the demand for contraceptives, especially more effective modern methods. According to WHO (6), "contraceptive use had increased in many parts of the world, especially in Asia and Latin America, but continues to be low in sub-Saharan Africa. Globally, use of modern contraception had risen slightly, from 54% in 1990 to 57% in 2012. Regionally, the proportion of women aged 15–49 reporting use of a modern contraceptive method had risen minimally or plateaued between 2008 and 2012. In Africa it went from 23% to 24%, in Asia it had remained at 62%, and in Latin America and the Caribbean it rose slightly from 64% to 67%. There was with significant variation among countries in these regions."

2.2 Utilization of contraceptive methods in Thailand

According to the report of population and development indicators for Asia and the Pacific 2013 (8), the CPR of Thailand among married women aged 15-49 years

was 79.8% in 2013. Regarding with the 2009 reproductive health survey of Ministry of Public Health, Thailand (15), the CPR for the North-east Region appeared to be the highest at 81.6%, whereas the Southern Region stood at the lowest at 72.1%. Regarding with methods of contraception, pills were the most prevalent methods with 35% which was followed by female sterilization (23.7%) and injection (14%). However, according to UNFPA report (16), the CPR of Myanmar was 37% which was much lower than that of Thailand.

Regarding with the contraceptive use among migrant women, Huang et al (17) found that 86% of rural-to-urban migrant women in Shanghai who conceived during the observed postpartum period did not use any kinds of contraceptive methods. The reasons for not using contraceptive methods were that they were planning to have more children, lack of knowledge regarding contraceptive methods and services that were available to them in the city and they did not want to use contraception. Regarding with the choice of contraceptive methods, IUDs and female sterilization were the methods used by approximately half of the migrant postnatal women. The male condom was another popular methods of contraception which was followed by COC pills, implants and spermicides. One study from Canada (18) showed that immigrants were less likely to have been using hormonal contraception and more likely to have been using the “counting safe days” method when they conceived.

For Myanmar migrant women in Thailand, Soe et al (19) described that the proportion of current contraceptive use among Myanmar migrant women in Phang-Nga Province, Thailand was 73.3%. Regarding with the choice of contraceptive methods, depo injection was the most popular methods as 46.4% of migrant women chose injection, which was followed by oral pills whereas 39.7% used oral pills. Another 8.4% of respondents used female sterilization. Regarding with the reason for choosing the current methods, a quarter of the respondents used due to easily available, about 20% of the respondents answered due to side effects of other methods and convenience to use the current method. Regarding with the reason for stopping contraceptive methods, the most frequently answers were desire for more children (37.5%), because of their health (20%) and fear of side effects (7.5%).

In addition, one study done on temporary contraceptive use among married Myanmar migrant women in Phuket Province, Thailand (20) revealed that 56.9% of

them currently used temporary contraceptive methods and among them, 50.9% were regularly used. Injection was the most popular method as 37.2% of women chose this method, which was followed by oral pills and the figure was 17.4%. A few women (2.3%) used condom and no one used IUD (0%). The main reason for current use were to space birth (37.2%) and for non-use, it was "want children" (22.5%). Moreover, one study done in Ranong Province in 2008 (21) showed that the proportion of effective birth spacing practice among Myanmar migrant women was 79.2%. Among them, nearly one third of them used oral pills and another third used injection. It was followed by the implant and the least used method was IUD.

Furthermore, another study done in Samut Prakan Province (22) described that 52.9% of the respondents were current users. About three-quarter of the respondents chose injection, 22.8% used oral pills and none of them used IUD. The most common reasons for choosing the current methods were convenience (35.8%) and cheap (29.6%). The most common reason for non-users was that they want more children and the figure was 37.1%. What is more, a study done in Mae Sot Province (23) reported that 80% of the respondents were using contraceptive methods. In this study, oral pill was the most popular methods as 53.4% of respondents used oral pill which was followed by injection and the figure was 37.5%. The most common reasons for not using contraceptive methods were "want more children" (47.7%) and "fear of side effects" (27.3%).

2.3 Migration and migrant situation in Thailand

In recent decades, the migrant population was dramatically increasing in Thailand due to economic development, which in turn, contributed to the country's rapid and sustained development. For the past several years, Thailand had attracted increasing numbers of migrant workers from neighboring countries such as Myanmar, Cambodia and Laos. Because of strong economic development and increased educational attainment of Thai workers, it had allowed many of them to climb up the skills ladder into better jobs. This created the shortage on unskilled workers in Thailand resulting in the migration of low-skilled workers from neighboring countries.

According to a situation analysis report on health system strengthening for migrants in Thailand 2012, there were totally 2,581,360 migrant workers and dependents from Myanmar, Cambodia and Laos, of which the majority around 80 percent were from Myanmar (2). Due to political instability, limited job opportunities and high rate of poverty in Myanmar, many working-aged group of Myanmar people moved to Thailand to earn money to support their families or to build their future (24).

Many of them migrated into Thailand illegally and, consequently, not officially recognized both in terms of residential and working status. IOM estimated that there were more than one million migrant workers who were not registered (3). Although the Government of Thailand had introduced policies to encourage migrant workers to become registered, most of them were not registered rendering them vulnerable to abuse and exploitation.

In fact, international migration had raised a number of social issues, including access to health care and gender aspects of migration. It was very difficult to improve the access to health care and services by migrant workers. Generally, Myanmar migrants who registered for work in Thailand had to undergo a health examination, but were not tested for HIV. If considered fit for work, they were included in Thailand's national insurance scheme. They received a subsidy for health services, were assigned a health provider and the same health provisions as Thai nationals through the 30-Baht scheme. Those not holding work permits were not included in this scheme (25). The main reasons for not accessing to health care services were fear of arrest, lack of health insurance card, fee charged, language barrier and far distance to health services. According to a situational analysis of health system strengthening for migrants in Thailand, fifty to seventy percent of migrants did not access to any kinds of health insurance scheme (2). Most of them utilized self-medication by buying medicine from pharmacy.

From gender aspects of migration, approximately 45 per cent of the low-skilled migrant workers in Thailand were women (26). Myanmar women mostly migrated from small rural villages or towns of Myanmar; those were various socio-demographic backgrounds also from different ethnic groups. Most migrant families came with few assets and women also needed to work in order to keep the family afloat financially. Regardless of their background, experience or education, most of the

migrant women were more likely to be engaged in poorly waged domestic works, factories, entertainment areas, etc. than their male counterparts. Male migrant workers were more likely than female migrants to be employed in agriculture and construction.

Due to a lack of traditional social controls and being independent at a young age, adolescent migrants might have sex at an early age, making them susceptible to unplanned pregnancy, STIs and accompanying health problems (24). Compounding this, migrant women had limited access to appropriate information and reproductive health services, further compromising their reproductive health. Previous study of maternal death reviews from Mae Tao Clinic revealed unsafe abortion was the main cause and two out of five deaths were related to complications from induced abortion in 2005 records (27). One maternal and child health survey in five districts of southern part of Thailand also showed that 22% (n=94) of respondent from Myanmar migrant women had history of one child death with their first year of life and some had lost multiple children (15).

All of above serious implications of migrants' family were related to various limitations to access health services and lead to increase their reproductive health vulnerability and worse in family planning conditions. "Following conditions were the most prominent barriers to access health services and those were mentioned by the NGO's project (24), Thailand in taking care of migrant health.

1. Service provider side with certain level of negative attitudes towards migrants made reluctant to seek treatment from public service. Moreover, assigned health service providers' place (to obtain flat fee of 30 Baht) might be inconvenient to reach or far away, adding the expense and arrangement of transportation and needed to take day off from job.

2. Migrant by themselves had own problems in language barriers that frustrate proper treatment and counseling. Apart from this, fear of arrest or harassment deterred some migrants, especially those who were undocumented or still unfamiliar environment.

3. Many employers kept migrants' ID cards as a form of insurance, restricting migrants' mobility and making them reliant on their employers to receive the benefits of the health insurance they had paid for.

4. Administratively, time of service provision by health providers might conflict with working hours of migrants and also health insurance regulations, such as the requirement of going to assigned health providers, might not be explained to migrants or might be confusing."

Facing these barriers, migrants often resorted to traditional remedies, which might result in delayed treatment or they might seek out traditional healers, some of who might have unsafe practices. Migrants also went to private clinics, which were convenient but expensive, or to NGO clinics, which, although were inexpensive and convenient, were few and far between.

2.4 The Precede-Proceed Model

The underlying model of my study was PRECEDE-PROCEED model. This model provided a comprehensive structure for assessing health and quality-of-life needs and for designing, implementing, and evaluating health promotion and other public health programs to meet those needs. The main purpose of the PRECEDE-PROCEED planning model was to provide a framework for applying theories and concepts in a systematic way for planning and evaluating health behavior change program. This model rather did not predict or explain the relationship among factors thought to be associated with an outcome of interest. Because the model viewed health behavior as influenced by both individual and environmental forces, it had two distinct parts: an "educational diagnosis" (PRECEDE) and an "ecological diagnosis" (PROCEED).

The PRECEDE framework was developed in the 1970s by Green and colleagues. The acronym stood for Predisposing, Reinforcing, and Enabling Constructs in Educational/Environmental Diagnosis and Evaluation. This component of the model posited that, just as medical diagnosis precedes a treatment plan, so should educational diagnosis precede an intervention plan (13). In other words, it outlined a diagnostic planning process to assist in the development of targeted and focused public health programs. It also generated specific objectives and criteria for evaluation.

The PROCEED stood for Policy, Regulatory, Organizational Constructs in Educational and Environmental Development. This element was added in 1991 to take

into account the importance of environmental factors as determinants of health and health behaviors. It guided the implementation and evaluation of the programs designed using PRECEDE.

Together, these two components of the model helped practitioners plan programs that exemplified an ecological perspective. The 2005-revised version of the PRECEDE-PROCEED consisted of four planning phases, one implementation phase and three evaluation phases.

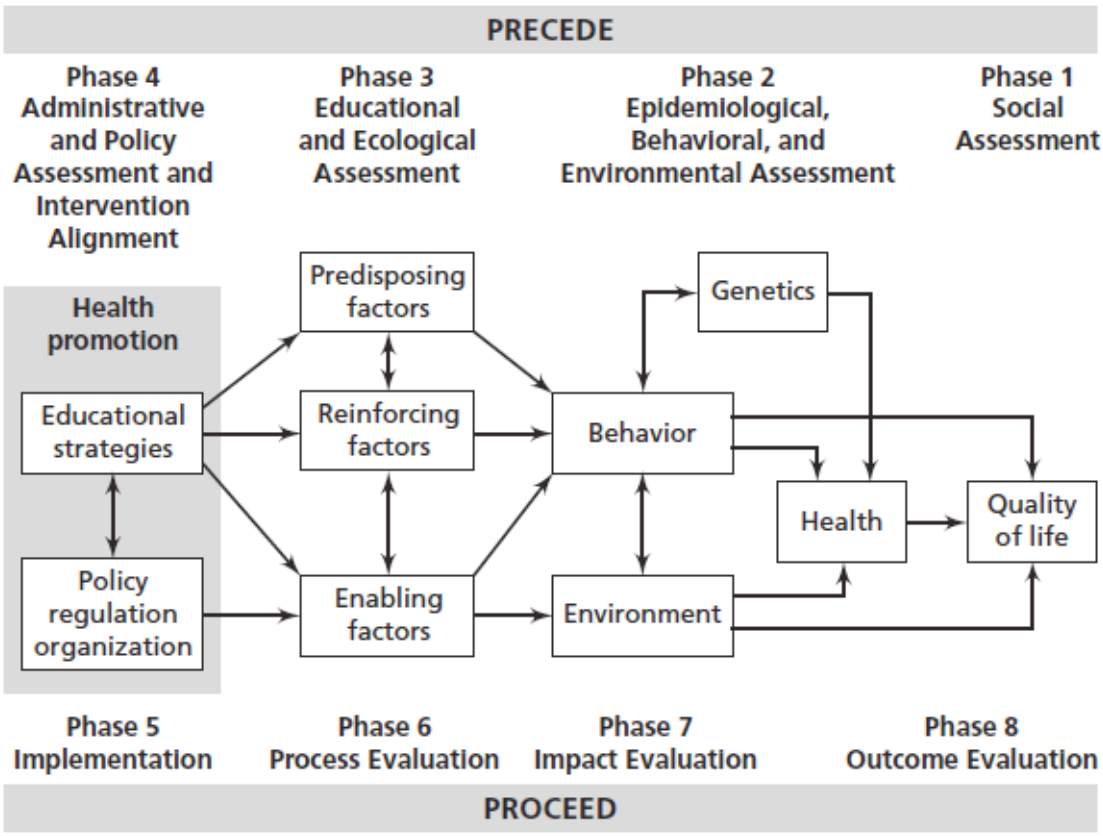

Figure 2.1: The PRCEDE-PROCEED Planning Model

Source: Health behavior and health education: Theory, research and practice (13)

There were four phases in PRECEDE part of the framework.

Phase 1: Social Assessment

The social assessment articulated the community's needs and desires and considers the community members' problem-solving capacity, their strengths and

resources and their readiness to change. It involved determining quality of life or social problems of a given population.

Phase 2: Epidemiological, Behavioral and Environmental Assessments

Epidemiological assessment identified the health problems, issues, or aspirations on which the program would focus, uncovered the behavioral and environmental factors most likely to influence the identified priority health issues, and translated those priorities into measurable objectives for the program being developed (13). It included the prioritization of the community's health needs and establishment of program goals and objectives.

Behavioral determinants included individual behaviors or lifestyles, the behavior of others who could directly affect the behavior of the individual at risk and the action of decision makers whose decisions affected the social or physical environment that influenced the individuals at risk. Environmental determinants were factors outside the person that could be modified to support behavior, health or quality of life.

Phase 3: Educational and Ecological Assessment

This phase identified predisposing, reinforcing and enabling factors, which should be in place to initiate and sustain the change process. They could influence the likelihood that behavioral and environmental change would occur. Predisposing factors were antecedents to behavior that provided the rationale or motivation for the behavior (13). These factors consisted of a person or population's knowledge, attitudes, beliefs, values and perceptions.

Reinforcing factors were those factors following a behavior that provided continuing reward or incentive for the persistence or repetition of the behavior (13). These included social support, peer influence, significant others and vicarious reinforcement. Enabling factors were those skills, resources, or barriers that could help or hinder the desired behavioral changes as well as environmental changes. One could view them as vehicles or barriers, created mainly by societal forces or systems (28).

Phase 4: Administrative and Policy Assessment and Intervention Alignment

This phase focused on the administrative and organizational concerns, which must be addressed prior to program implementation. In this phase, available resources, organizational barriers and facilitators, and policies were identified for program implementation and sustainability.

The phase 5-8 of the PROCEED framework were implementation and evaluation.

2.5 Related studies

2.5.1 General Characteristics

Age was the important factor, which could influence the contraceptive use. Generally, young married women tended to be used contraceptive methods while older members were more conservative and might not support or approve of their use. One study among Myanmar migrant women from Phuket Province (20) showed that contraceptive use was the highest at the lowest age group (15-19 years) and it decreased steadily with the increase in age group. This results was controversy with the study done among Myanmar migrant women in Mae Sot District (23) in which family planning practice was decreased in married women of 40-49 years old although it was high in the age group of 18-29 years and 30-39 years. The study done in Philippine (29) also revealed that increasing age increased the likelihood of contraceptive use though the probability decreased at age more than 45 years of age. Besides, one study done in United States (30) revealed that women who were aged between 35-44 years were nonusers with odd ratio of 3.25. But one study done in Indonesia (31) showed that women at 20-44 years were more likely to use modern contraceptive methods than women at 15-19 years and 45-49 years. Similar results was found in one study done in Kenya (32) that contraceptive use was found to be highest among women aged between 20-39 years old compared to those below 20 years and above 39 years. However, the study done among the women of childbearing age in Ethiopia (33) revealed that age was not found to have a significant association with the contraceptive

use. Therefore, it was evident that age was an interesting factor to be considered for utilization of contraceptive methods.

Regarding with **registration status**, one study from Phuket Province (20) revealed that there was no significant association between registered migrant women and unregistered migrant women with the contraceptive use. There was very few studies to describe the association between registration status and utilization of contraceptive methods, it is worth to identify the association between these two variables. Concerning the association between **ethnicity** and utilization of contraceptive methods, Lee et al (34) revealed that there was no significant association between race and religion and contraceptive use.

Duration of stay in host country also determined the utilization of contraceptive methods. Migrants who just newly migrate to another country had to try to adapt themselves to the new environment and society of destination country as much as they could. One study from Canada (18) showed that immigrant women who had been in Canada for less than 5 years were less likely to use contraceptive methods than those who had immigrated 5 or more years ago. However, one study done among Myanmar migrant women in Bangkok (35) showed the negative association between duration of stay in Bangkok and utilization of contraceptive methods. Migrant women who stayed in Bangkok for less than 3 years used contraceptive methods than those who stayed in Bangkok for more than 3 years. But some studies revealed that there was no association between duration of stay and utilization of contraceptive methods. A study done among Myanmar migrant women in Mae Sot Province (23) showed that there was no significant association between duration of stay in Thailand and family planning practice with the cut-off point of 3 years. Another study done in Mae Sot (27) showed that there was no association between duration of stay in Thailand and contraceptive use. About two-third of Myanmar migrant women with duration of stay in Thailand of less than 1 year, 1-5 years, 6-10 years and more than 10 years practiced contraception. Similarly, a study done among Myanmar migrant women in Samut Prakan Province (22) showed that there was no significant association between duration of stay in Thailand of less than 5 years and more than 6 years and utilization of contraceptive methods. Therefore, it was interesting to find out the association between duration of stay and utilization of contraceptive methods and the relationship

between these two variables might be different depending on the condition of study site.

Education level of the women influenced women's health care including family planning practice. Female education had been seen as a key factor for accepting contraceptive methods and positive effect in shared decision making for their family planning. The better-educated women were more likely to know about contraceptive methods, to discuss freely about family planning with their partners or spouses. One study done by Yati Oo in Mae Sot Province (23) found that educational level was significantly associated with contraceptive use. Women with secondary and above education were more likely to use contraceptive methods than those who had no education and primary education. Similar result was seen in a study done by Soe et al (19) showed that the women who completed secondary education were significantly more likely to practice contraception compared to those with lower education level. Likewise, one study from Ethiopia by Charlie et al (36) revealed that educated women were more likely to know of the contraceptive methods and to use contraceptive methods as compared with uneducated women. In addition, one study from Ranong Province (21) showed that uneducated women were practicing birth spacing less appropriately than literate women although there was no significant relationship with p-value 0.1. Similarly, the study in Philippine (29) revealed that an increase in the education raised the likelihood to use contraception than did those without education. Conversely, one study from Bangladesh (37) showed that 92.7% respondents who were practicing family planning had no education but it was higher from those who have primary education (80.8%) and other higher education (68.0%). This study also showed that there was a significantly association between education of women and family planning practices ($p = 0.003$). In addition, one study done among couples in Southwest Bugerua (38) reported that the educational status did not significantly influence their utilization of contraceptive methods. To conclude, education was positively related to the utilization of contraceptive methods in previous studies, however, there was no relationship in some studies. Therefore, education was an important factor that determine the utilization of contraceptive methods.

Current occupation often influenced the decision making for practicing contraceptive methods among women. The employment factor increased the status of

women and gave them a higher sense of independence. One study from Ethiopia (33) showed that occupation had a significant association with the number of contraceptive methods known by women, which promoted the utilization of contraceptive methods. In the related study in Philippine (29) revealed that there was significant association between occupation and contraceptives use although the women engaged in non-agricultural sector are more likely to use contraceptive methods than women who were not working and working in the agricultural workers. Another study done among African adolescents (39) showed that utilization of contraceptive methods was higher in employed than unemployed and students with significant p-value of less than 0.01. But, some studies showed no association between occupation and utilization of contraceptive methods. A study done by MD. Yunus (40) described that the association between occupation of respondents and utilization of contraceptive methods was not statistically significant, showing 66.7% of business women were current users, while 73.9% of laborer were past users and never users. Another study from Bangladesh (41) described that there was no association between occupation and utilization of contraceptive methods. Regarding with the previous studies, occupation of the respondents was an important factor for utilization of contraceptive methods.

The decision making to use contraceptive methods depended upon **family income**. The study conducted in Indonesia (42) showed that moderately poor women and better-off women had higher odds of using contraceptives than did extremely poor women. Similarly, one study from Ethiopia (33) showed that a higher family income was observed to promote spousal discussion of family planning, which in turn increased usage of contraceptive methods. However, one study done among Myanmar migrant women in Maesot (27) showed that the relationship between family income and utilization of contraceptive methods was not significant, showing that the respondents who had income 4,000 Baht or more were practicing contraceptive methods as compared with the other group. Another study done in Bangladesh (40) found that there was no significant relationship between family income and utilization of contraceptive methods. Therefore, it was interesting to find out the association between family income and contraceptive use.

Duration of marriage was reflected to variation in exposure time to get pregnancy and often lading to a higher number of children and contraceptive use. One

study done among Myanmar migrant women in Phang-Nga Province, Thailand (19) showed that the Myanmar migrant women with longer duration of marriage were less likely to practice contraception currently. However, the study done by Thwin T (27) revealed that there was no significant association between duration of marriage and contraceptive use, showing that about two-third of married women in a duration of marriage of less than 1 year group and more than 10 year group were current contraceptive user. As a result, duration of marriage was an interesting factor to elaborate the association with utilization of contraceptive methods.

Regarding with **current number of children**, one study done among Myanmar migrant women in Phang-Nga Province, Thailand (19) showed that the women who had 1-2 or more than 3 children were significantly more likely to use contraception compared to the women without children. Moreover, another study from Ranong Province (21) found that highest percentage of birth spacing practice was seen in women having two to three children at the time of interview. What is more, in one study among Hispanic immigrants (43), number of children was associated with contraceptive use which described that the higher the number of children, the higher the use of contraceptive methods with adjusted odd ratio of 1.77. Besides, one study done among Myanmar migrant women in Mae Sot Province by Yati Oo (23) showed the significant association between the number of living children and utilization of contraceptive methods depicting 70% of migrant married women with less than 2 children practiced contraceptive methods whereas it was increased to about 90% in those with two or more children. In addition, the studies done in Dawei Township (44) and Hlaing Township (45) in Myanmar stated that there was a strong association between number of living children and utilization of contraceptive methods. On the other hand, a study done in Mogkok Township (46), Myanmar presented that there was no association between the number of living children and utilization of contraceptive methods expressing that there was no difference in contraceptive methods use between the women with less than 3 children and 3 or more children. All in all, the number of living children could influence the decision making to use contraception and the contraceptive usage was increased with increased in number of living children.

Desired numbers of children had an impact on contraceptive use. The proportion of contraceptive use decreased with as the desired number of children

increased. The study from Phuket Province among Myanmar migrant women (20) revealed that the women who wanted to have 3 or more children were less likely to use contraception. Another study in Hlaing Township, Myanmar (45) reported the relationship between these two variables, appointing out that the married women who wanted 2 or fewer children used contraceptive methods as compared with those who wanted more than 2 children. In addition, one study done by Withers et al in Bali (47), Indonesia described that having desire for more children was related to a lower likelihood of using contraceptive methods with confident in their ability to have successful birth outcomes. Likewise, a comparative study in two states of India (48) showed that the desire number of children had an impact on utilization of contraceptive methods. Desire for only one male and female child was higher among younger women (56-96%) in Tamil Naddu State with 51.4% of contraceptive use, as compared to 18-51% of women in Uttar Pradesh State with 22.7% of contraceptive use respectively. In Uttar Pradesh State, 31% of women practiced family planning methods after fulfilling their desire number of children while 72% in Tamil Naddu State. On the other hand, a study done among Myanmar migrant women in Mae Sot (27) found out that there was no association between desire number of children and utilization of contraceptive as about three-quarter of women with desire number of children and without desire number of children were current contraceptive users. Another study from Samut Prakan Province (22) also described that there was no association between these two variables. By reviewing the previous studies, the desire number of children was an interesting factor to find out the association with utilization of contraceptive methods.

2.5.2 Predisposing factors: knowledge about and attitude towards the utilization of contraceptive methods

A women should have at least some knowledge about certain contraceptive methods and the source where she could get service before she practiced family planning. Regarding the knowledge level of utilization of contraceptive methods, it indicated noticeably that women with a good or fair knowledge would practice contraceptive methods more than those who have poor knowledge. This was because

they knew well about the benefit and side effects of contraceptive methods and then, they felt confident and used more.

A study done in Uganda (49) reported that the women who had knowledge on family planning were 4 times more likely to use contraceptive methods than those without knowledge. Moreover, another study done in Malaysia (50) described that the acceptance of contraceptive methods was low in women with poor knowledge and around 40% of the respondents had adequate knowledge about contraceptive methods. In addition, a study done in Tamu Township, Myanmar (51) revealed that there was a significant association between knowledge and family planning practice. Besides, a study done in Sudan (52) stated that the Sudanese women who had good knowledge were significantly related with utilization of contraceptive methods as compared with those who had poor knowledge about family planning. What is more, a study from Ranong Province (21) revealed that 88.4% of Myanmar migrant women with good knowledge about appropriate birth spacing practice were practicing contraceptive methods, whereas 75.3% of those with low level of knowledge were practicing family planning. Moreover, there was a significant association between knowledge of birth spacing practice and appropriate birth spacing practice.

On the other hand, one study done among Myanmar migrant women in Phang-Nga Province (19) showed that only 7.4% of Myanmar migrant women had high-level knowledge regarding contraceptive methods, but there is no significant association between level of knowledge and contraceptive practice. Another study in Dawei Township, Myanmar (44) found out that there was no significant association between knowledge and utilization of contraceptive methods.

The attitude towards the utilization of contraceptive methods was also an another important determinant of utilization of contraceptive methods. The one who had good attitude towards contraception was more likely to use contraception than those who had poor attitude. A study done among Myanmar migrant women in Ranong Province (21) revealed that there was a significant association between women's attitude and appropriate birth spacing practice. Nearly 90% of women with positive attitude were practicing family planning whereas only 61.4% of women with negative attitude practiced contraceptive methods. Another study done in Hlaing Township, Myanmar (45) stated that the women with positive attitude used contraceptive methods

more than those with negative attitude. Moreover, one qualitative study done by Chipeta et al (53) described that many couples were not practicing contraceptive methods due to the fact that they did not like the adverse effects of contraceptive methods and the male also got misconception such as impotency, genital ulcers, weight gain or loss and subsequent infertility which was related with contraceptive use. Besides, Wang et al (54) revealed that the Chinese students who did not use contraceptive methods in their first sex were feeling shy to buy contraceptive methods and about 40% of non-users thought that infrequent sexual intercourse could not get a pregnant.

In contrast, one study in Phang-Nga Province (19) showed that only 11.4% of Myanmar migrant women had positive attitude contraceptive methods, but there is no significant association between level of attitude and contraceptive practice. Another study done among Myanmar migrant women in Maesot Province (27) reported that there was no association between attitude and contraceptive use, showing that there was no big difference of contraceptive use between the respondents with good attitude and moderate attitude. The similar result was found in a study done in Congo (55) which described that perception and attitude were not the significant predictors for current contraceptive use.

According to the previous studies, the knowledge and attitude were the influencing factors on the utilization of contraceptive methods. Therefore, it was important to find out the association in this study.

2.5.3 Enabling factors: availability and accessibility of contraceptive service, availability of health education material and accessibility of health insurance scheme

Availability and accessibility of contraceptive services were the important factors that could influence the women in obtaining information about contraceptive methods, practicing the contraceptive methods and could also influence on decision-making regarding use of contraceptive methods.

Concerning with availability of contraceptive services, a study done among beer promoters in Cambodia, Laos, Thailand and Vietnam (56) revealed that lack of knowledge of beer promoters about reproductive health needs and the services

available to them were sometimes a barrier in accessing health care services. Another study from Lao PDR (57) found out that there was a significant association between source of family planning services and the utilization of contraceptive methods. However, the studies done among Myanmar migrant women in Samut Prakan Province (22) and Phuket Province (20) showed that there was no association between number of contraceptive services and the utilization of contraceptive methods.

Regarding with accessibility of contraceptive services, one study done among Myanmar migrant youth women in Bangkok (35) revealed that there was a significant association between accessibility to contraceptive services and contraceptive use which showed about 72% of migrant youth who could access the service easily were current users. Besides, another study done among Myanmar Migrant women in Ranong Province (21) showed that there was a significant association between accessibility of health care services and contraceptive use. In this study, the accessibility was determined by convenient to opening hour of health care services. Moreover, a study among university students in Lesotho (58) described that about 65% of the respondents could easily access family planning services and one-third ere very satisfied with the services. Similar result was found out in a study done in Lao PDR (57) which revealed that convenience to go to service center were significantly associated with the utilization of contraceptive methods. On the other hand, Soe et al (19) described that about 60% of the migrant women relied on private clinics and drug stores. About 17% had access through NGO clinics and only 10.9% received contraceptive methods from government clinics. Among them, about 85% stated that it was convenient to access the health care services and 90% were satisfied with the health care services that they received. However, there was no significant association between availability and accessibility of contraceptive services and the utilization of contraceptive methods. In addition, another study from Bangladesh (41) indicated that the acceptance of family planning was not significantly associated with availability and accessibility of contraceptive services.

The availability of health education material and accessibility to health insurance scheme were also the major determinants of the utilization of contraceptive methods. In connection with availability of health education materials, a study done among Myanmar migrant youth women in Bangkok (35) stated that there was a

significant association between the availability of health education materials and contraceptive use. Another study from Phuket Province (20) described that there was an association between information provided by health care workers and the utilization of contraceptive methods. The respondents who received health education from health care workers were more likely to use contraceptive methods. As concerned with the accessibility to health insurance scheme, the study done among beer promoter (56) revealed that about 97% of the beer promoter from Thailand had health insurance, but about one-third had accessed to health insurance. The majority from other countries had no health insurance either because their employer did not provide it or because they were part-time employees and the health insurance was not available to them.

By reviewing the previous study, the enabling factors had a significant impact on the utilization of contraceptive methods and it was one of the determinants of the utilization of contraceptive methods.

2.5.4 Reinforcing factor: social Support

Social support from husband, friends and health care workers played an important role for the utilization of contraceptive methods.

Regarding with social support from husband, one study among Myanmar migrant married women in Maesot (27) showed that the association between husband agreement on family planning and the utilization of contraceptive methods found to be statistically significant, showing around 80% of the respondent who had husband's agreement were current contraceptive users. Another study in Cambodia (59) reported that social support from peers, elders and husband were significantly associated with the utilization of contraceptive methods as they could influence the choice of contraceptive methods by women.

Regarding with social support from friends, one qualitative study among migrant beer promoters (56) revealed that friends could act as a support to the beer promoter, recommending health care services and encouraging access to service. Moreover, one study from Myanmar (45) revealed that there was a significant association between partner and friends support and the utilization of contraceptive methods, which described that the women who received good or fair support from partner and friends were about 4 times more likely to use contraceptive methods than

those with low support. The similar result was found out in a study done among Myanmar migrant youth women in Bangkok (35) which reported that all the youth women had peer pressure to use contraceptive methods and there was a significant association between peer pressure and the utilization of contraceptive methods.

Regarding with social support from health care workers, the previous study found that women received information support from health care workers which facilitated the utilization of contraceptive methods. One study from Mexico (60) revealed that women who got family planning information during antenatal care service from health care workers were significantly increased in the utilization of contraceptive methods than those who did not get the information. Another study from Hlaing Township, Myanmar (45) depicted that there was a significant association between social support from health care providers and the utilization of contraceptive methods, describing the married women who received good and fair social support from health care providers were 15 times more likely to use contraceptive methods than those with poor support from health care workers.

According to the previous study, the social support from husband, friends and health care workers were associated with the utilization of contraceptive methods and it was interesting to find out in this study.

CHAPTER III
MATERIALS AND METHODS

3.1 Study design

This study was a cross-sectional design, which was aimed to study the utilization of contraceptive methods among Myanmar migrant married women in Chiang Mai, Thailand based on Precede-Proceed Model.

3.2 Study site

The study was conducted at Chiang Mai City which is located in the northern part of Thailand. To the North, it borders Myanmar's Shan State while to the South, it connects with Sam Ngao district of Tak Province. Chiang Rai, Lamphun and Lampang lie to the East, and the West touches Pai, Khun Yuam and Mae Sareang districts of Mae Hong Sorn province. Chiang Mai City covers the 14 sub-districts of Mueang District, Chiang Mai province. It is also a second capital city of Thailand. Moreover, it is one of the most populated areas of Myanmar migrant workers in Thailand.

The Chiang Mai province covered a population of 1,664,399 (817,524 males and 846,875 females) (61). According to 2012 annual report of department of employment office worker (12), there were 83,487 migrant workers in Chiang Mai province in which 71,008 were registered migrant workers and 12,479 were un-registered migrant workers. Among registered migrants, 36,333 were male and 34,675 were female. For un-registered migrant workers, 7,006 were male and 5,473 were female. Regarding with the statistics from National Statistical Office (62), there were 7,903 (4,581 males and 3,322 females) Myanmar migrant workers in the Northern region of Thailand.

3.3 Population and sample

The respondents were recruited according to the following inclusion and exclusion criteria.

3.3.1 Inclusion criteria

- Women who were in age between 18-49 years and living with their husband or partner
- Women who were residing in the study area (both registered and unregistered migrant women)
- Women who were willing to participate and sign on the informed consent form

3.3.2 Exclusion criteria

- Women who were already pregnant, and had history of hysterectomy
- Women who were seriously ill or mentally retarded at the time of interview
- Women who were not willing to participate in the study

3.3.3 Discontinuation criteria

- Individuals who felt uncomfortable and refused to continue answering the questions could withdraw and would be discontinued from the study.

3.4 Sample size estimation

The required sample size was estimated by the following formula (63).

$$n = \frac{Z^2_{1-\alpha/2}\, P\,(1-P)}{d^2}$$

$$n = \frac{(1.96)^2\,(0.704)\,(0.296)}{(0.07)^2}$$

$$n = 163.3 \sim 163 \text{ (at least)}$$

As the minimum sample size was 163, in order to cover the drop out person, 10% of sample was added up and then total required sample size was 179.

n = estimated sample size

$Z^2_{1-\alpha/2}$ = a standard value given a significant level under a standard normal distribution usually set as at 1.96 which corresponds to 95% confidence interval level.

P = prevalence of contraceptive use among Myanmar migrant married women in Tak Province (9) = 70.4%

α = level of statistical significance which was set at 0.05

d = error of allowance which was set at 0.7

3.5 Data collection

The data from this study was collected among Myanmar migrant married women in Chiang Mai, Thailand. Chiang Mai was selected because of the most populated Myanmar migrant workers. The data was collected after getting approval from ethical committee of Mahidol University. Before conducting the data collection, the researcher trained one Myanmar migrant worker in Chiang Mai. There was one Myanmar monastery namely "Wat Sai Moon" in Chiang Mai and most of the Myanmar migrant workers came and paid homage to the monk especially in the weekends and sabbath day. At first, the researcher planned to collect data only at "Wat Sai Moon", but due to insufficient number of migrants who visited "Wat Sai Moon" during data collection period, the researcher had to expand the data collection sites to construction sites and markets. The researcher and one trained data assistant conducted the data collection by face-to-face interview at construction sites, night bazaar, restaurants and migrant workers' homes on week days and at "Wat Sai Moon" and weekend market on Saturday and Sunday. The researcher and 1 trained assistant explained clearly each and every respondent about the contents of questionnaire and informed consent form. The researcher and trained data assistant applied Myanmar language as a medium language for data collection. Data was collected from 15th January 2014 to 5th February 2014.

3.6 Research instrument

Structured questionnaire was developed as a research instrument based on objectives, conceptual framework and operational definitions. Most of the questions in the questionnaire were contained closed questions, but some were open-ended. It was first developed in English language and then translated into Myanmar language and it was composed of five sections.

Section A: Questions on general characteristics

Section B: Questions on utilization of contraceptive methods

Section C: Questions on predisposing factors

Section D: Questions on enabling factors

Section E: Questions on reinforcing factors

3.6.1 Section A: Questions on general characteristics

There were 10 questions regarding age, registration status, ethnicity, duration of stay in Thailand, educational status, current occupation, monthly family income, duration of marriage, current number of children and desired number of children.

3.6.2 Section B: Questions on utilization of contraceptive methods

This part included the 11 questions about utilization of contraceptive methods to assess whether they used contraceptive methods at the time of interview and what are the reasons of "current use", "ever use" and "non use". The "current use" was categorized as the respondents who answered 'Yes' in the question 11 "Are you and your partner currently using contraceptive methods". Then, the "ever use" was defined as the respondents who answered 'No' in the question 11 and 'Yes' in the question 16 "If you and your partner are not currently using contraceptive methods, did you and your partner use contraceptive methods in the past". For those who answered 'No' for that questions 16 were categorized as "never use".

3.6.3 Section C: Questions on predisposing factors

This section was composed of 15 questions to assess the knowledge on utilization of contraceptive methods and 15 questions to assess the attitude towards the

utilization of contraceptive methods. For questions assessing the knowledge, each correct answer was given a score of "1" and "0" for incorrect answer. The total score was classified into three groups, according to Benjamin Bloom criteria (Good knowledge: >80% of total score, Fair knowledge: 60-80% of total score, Poor knowledge: <60% of total score).

To measure the attitude of the respondent, the researcher asked 15 statements where they agree, uncertain or disagree with the statements. The respondent's score on the answer to each statement was scored from lowest "1" to highest "3", depending on whether the statements were positive or negative aspect.

For the positive attitude questions, the score was given as follows:

Agree = 3 scores

Uncertain = 2 scores

Disagree = 1 score

For the negative attitude question, the score was given as follows:

Disagree = 3 scores

Uncertain = 2 scores

Agree = 1 score

Thus, total score was be "45" for these "15" questions. The highest score was 45 and the lowest score was 15. Finally the levels of attitude were classified into three levels based on total score with mean and standard deviation (SD): ≥Mean+S.D = Good Level, Mean+S.D = Moderate Level and <Mean-S.D = Poor Level.

3.6.4 Section D: Questions on enabling factors

There were three components in this section: availability and accessibility of contraceptive services, availability of health education materials and accessibility of health insurance scheme. There were altogether 15 questions in this section.

3.6.5 Section E: Questions on reinforcing factor

In this study, the reinforcing factor was social support to the utilization of contraceptive methods. According to seminal work by House (13), the statements were constructed to assess emotional support, instrumental support, information support and appraisal support from husband, friends and health care workers. There were 11

statements in this section whether they strongly agree, agree or disagree with the statements for 3 sources of social support (husband, friends and health care workers). Regarding with the social support from husband, the respondent's answer to each statement was scored from lowest "1" to highest "3", depending on whether the statements were positive or negative aspect.

For the positive attitude questions, the score was given as follows:

Strongly agree = 3 scores

Agree = 2 scores

Disagree = 1 score

For the negative attitude question, the score was given as follows:

disagree = 3 scores

Agree = 2 scores

Strongly agree = 1 score

Finally the levels of social support were classified into three levels by using Best's criteria as follows:

$$\text{Range} = \frac{\text{Maximum score} - \text{Minimum score}}{\text{Number of measuring level}}$$

$$\text{Range} = \frac{33\text{-}11}{3} = 7.3 \sim 7$$

The result was taken as:

- Good support: for participants who got total score 26-33
- Moderate support: for participants who got total score 18-25
- Poor support: for participants who got total score less than 18

The similar scoring system was applied to assess the level of social support from friends and health care workers.

3.7 Content validity and reliability

3.7.1 Content validity

The structured questionnaire as an instrument for data collection in this study was developed in consistent with the objectives, conceptual framework and operational definitions. The researcher consulted with the advisor and co-advisors throughout the process of constructing questions and preparing all contents of report. Advisor and co-advisors gave their expert opinion to avoid any discrepancies between the contents of the questions and the meaning. All the content of the questionnaires were translated 1into Myanmar.

3.7.2 Reliability

The internal reliability of the questionnaires was pre-tested on a group of 30 respondents with the same status in Bangkok. The following results were the analysis of the pre-test questionnaire: knowledge on utilization of contraceptive methods was 0.72, attitude towards utilization of contraceptive methods was 0.68, social support from husband was 0.81, social support from friends was 0.83 and social support from health care workers was 0.68 by Cronbach's alpha coefficient test. After adjusting some questions, the Cronbach's alpha coefficient of the questions of the above portions were more than 0.75.

3.8 Statistical analysis

3.8.1 Data entry

After data collection, the error and missing values were checked for all questionnaires and all the data were entered by researcher using EpiData version 3.1. The data analysis was done by using SPSS version 18.

3.8.2 Descriptive analysis

Descriptive statistics including frequency and percentage distribution, mean, standard deviation, median, minimum and maximum number were used to describe the characteristics of the variables.

3.8.3 Inferential analysis

To describe the association between dependent variable and independent variables, chi-square test and binomial logistic regression test were used to find out the factors influencing the utilization of contraceptive methods. The significance was set at p value less than 0.05 and by using 95% confidence level.

3.9 Ethical Consideration

This study was conducted only after the approval of Ethical Review Committee for Human Research, Mahidol University with the approval number 178/2556 (see in Appendix C). The participation of respondents was strictly voluntary and confidential. Before staring data collection, each and every respondent were clearly informed about the objectives, methods, anticipated benefits and the discomfort it might be faced during data collection period as the respect to human subjects. No respondent was pressured to participate and everyone was participated voluntarily and they were allowed to quit or drop out during data collection. There was no incentives in cash to all respondents. The name of the respondent was not recorded in questionnaire and only the identification number was recorded. Due to the confidentiality of respondents, all of the respondents' answers were kept confidentially. The respondents were treated with respect and thankfulness for their participation to this study. All questionnaires were kept in cabinet under lock and key. After all the data had entered into computer and analysis was completed, all the used questionnaires were destroyed.

CHAPTER IV
RESULTS

This cross-sectional study was undertaken to study the utilization of contraceptive methods among Myanmar migrant married women in Chiang Mai, Thailand. The results were presented according to the objectives of the study. Final questionnaires from one hundred and seventy nine Myanmar migrant married women from Chiang Mai were analyzed for results. The results of the descriptive analysis, bivariate analysis by using chi-square test and binary logistic regression analysis were divided into six sections. Those were including with

4.1 General characteristics

4.2 Utilization of contraceptive methods

4.3 Predisposing factors

4.4 Enabling factors

4.5 Reinforcing factors

4.6 Association between independent variables and utilization of contraceptive methods

4.7 Factors influencing utilization of contraceptive methods.

4.1 General characteristics

General characteristics factors were identified by age, registration status, ethnicity, duration of stay in Thailand, education status, current occupation, monthly family income, duration of marriage, current number of children and desired number of children.

As described in Table 4.1, a total of 179 people participated in the study and more than half of the respondents (51.4%) were between 25 and 34 years with the mean age of 30.5±6.3 years. Most of the respondents (88.3%) were working as a registered migrant workers in Thailand. Nearly half of the respondents (42.5%)

belonged to Myanmar ethnic groups. Second common group were Karen and Shan with the same proportion of 20.7%. The others group comprised of Rakhing, Mon, Kachin and Lesu ethnicity which was only 16.2%.

Regarding with duration of stay in Thailand, the study showed that most of the respondents belonged to the group with a duration of stay between 61 to 120 months and it covered more than one third of total respondents (40.8%) with median duration of stay of 84 months in Thailand. The vast majority of the respondents had attended formal education, nearly thirty percent of them finished primary school. About 11 percent of the respondents were illiterate.

Approximately 40 percent of the respondents were vendor, followed by construction workers (24%) and housemaid (21%). About 13 percent of them were dependents at the time of interview. Regarding with monthly family income, nearly 60 percent reported to have monthly family income of less than 10,000 Baht. The median monthly family income was 10,000 Baht, the minimum was 4,500 Baht and the maximum was 30,000 Baht.

This study revealed that about one third of the respondents (34.6%) belonged to a group with a duration of marriage of 13-60 months while another group of 61-120 months and more than 120 months duration were 30.2% and 27.4% respectively. The “less than or equal 12 months” group was only 7.8%. The median duration of marriage was 84 months, the minimum was 12 months and the maximum was 300 months.

The majority of the respondents (35.2%) had only one child. The percentage of women, who had two children was 22.3%, followed by 12.8% and 7.3% had three and more than or equal 4 children respectively. About 20% of the respondents had no children. In response to the desired number of children, more than two third of the respondents expressed their view in favor of two and three children. However, about 20 percent of the respondents belonged to the group of desired number of children more than or equal 4 children.

Table 4.1: Frequencies and percentage distribution of general characteristics of the respondents (n = 179)

Characteristics	Frequencies	Percentage (%)
Age group (years)		
18-24 years	34	19.0
25-34 years	92	51.4
35-45 years	53	29.6
Mean = 30.5±6.3	Min = 18	Max = 45
Registration status		
Registered	158	88.3
Unregistered	21	11.7
Ethnicity		
Myanmar	76	42.5
Karen	37	20.7
Shan	37	20.7
Others	29	16.1
Duration of stay in Thailand (months)		
Less than 12	14	7.8
12-60	53	29.6
61-120	73	40.8
more than 120	39	21.8
Median = 84	Min = 1	Max = 300
Educational level		
No education	20	11.1
Primary school	52	29.1
Secondary school	55	30.7
High school and graduate	52	29.1
Current occupation		
Construction worker	43	24.0
Seller (vendor)	67	37.4
Housemaid	37	20.7
Others	9	5.1
Dependent	23	12.8

Table 4.1: Frequencies and percentage distribution of general characteristics of the respondents (n = 179) (Cont.)

Characteristics	Frequencies	Percentage (%)
Monthly family income (Baht)		
Less than or equal 10,000	103	57.5
More than 10,000	76	42.5
Median = 10,000	Min = 4,500	Max = 30,000
Duration of marriage (months)		
≤ 12	14	7.8
13-60	62	34.6
61-120	54	30.2
> 120	49	27.4
Median = 84	Min =12	Max = 300
Current number of children		
No children	40	22.3
1 child	63	35.3
2 children	40	22.3
3 children	23	12.8
≥ 4 children	13	7.3
Median = 1	Min = 0	Max = 7
Desired number of children		
1 child	8	4.5
2 children	69	38.5
3 children	65	36.3
≥ 4 children	37	20.7
Median = 3	Min = 1	Max = 7

4.2 Utilization of contraceptive methods

From Table 4.2, it can be seen that 85.5% of the respondents ever used contraceptive methods and only 14.5% never used any contraceptive method. Among ever contraceptive use group, 61.5% of the respondents were currently using contraceptive methods, while 38.5% were past users. Among the current contraceptive users, oral pills (65.5%) was the most widely used methods which was followed by injection (25.5%). Those who used emergency contraceptive pills, IUDs and implant

methods, were merely 1.8%, 0.9% and 0.9% respectively. Nearly 90 percent of current temporary method users were regular users. Majority of the current users (47.3%) stated, “convenient” as the reason for using contraceptive methods. “Easily accessible” (18.2%) was the second reason for using contraceptive methods. Nearly 30 percent of the current users had used the contraceptive methods for more than 36 months with the median duration of 24 (2-132) months.

About one third of the past users (32.6%) stopped the contraceptive methods for more than 36 months with a median duration of 36 (1-120) months. Regarding with the reason for stop using the contraceptive methods among the past users, 69.8% revealed that they want more child and 27.9% mentioned due to side effects. Among never users, the most common reason for not using contraceptive methods was they want to get more children (53.8%).

Table 4.2: Frequencies and percentage distribution of the respondents by contraceptive use (n=179)

Characteristics	Frequencies	Percentage (%)
Ever contraceptive use		
Yes	153	85.5
No	26	14.5
Current contraceptive use		
Yes	110	61.5
No	69	38.5
Current user's contraceptive methods (Multiple response allowed) (n=110)		
Temporary methods		
Oral pills	72	65.5
Injection	28	25.5
Male condom	12	10.9
EC pills	2	1.8
IUD	1	0.9
Implant	1	0.9
Permanent methods		
Tubal ligation	7	6.4

Table 4.2 Frequencies and percentage distribution of the respondents by contraceptive use (n=179) (Cont.)

Characteristics	Frequencies	Percentage (%)
Current temporary methods users (n=103)		
Regular use	92	89.3
Irregular use	11	10.7
Reasons for using contraceptive methods (n=110)		
Convenient	52	47.3
Easily accessible	20	18.2
Others	15	13.6
safe	14	12.7
Less side effects	4	3.6
Effective	3	2.7
Husband proposed	2	1.9
Duration of contraceptive use (n=110)		
Less than 6 months	11	10.0
6-12 months	21	19.1
12-24 months	29	26.4
24-36 months	17	15.4
More than 36 months	32	29.1
Median = 24	Min = 2	Max = 132
Duration of stopping contraceptive methods (n=43)		
Less than 6 months	10	23.2
6-12 months	8	18.6
12-24 months	3	7.0
24-36 months	8	18.6
More than 36 months	14	32.6
Median = 36	Min = 1	Max = 120
Reasons for stopping contraceptive methods for previous use (n=43)		
Want more children	30	69.8
Side effect	12	27.9
Cannot afford	1	2.3
Reasons for not using contraceptive methods for never use (n=26)		
Want more children	14	53.8
Fear of side effects	9	34.7
Lack of information	2	7.7
Cannot afford	1	3.8

4.3 Predisposing factors

4.3.1 Knowledge about the utilization of contraceptive methods

According to Table 4.3, there were 15 questions with regard to the knowledge of the respondents about the utilization of contraceptive methods. It revealed that 91.6% of the respondents knew that Depo injection should be taken once in 3 months and 90.5% knew that oral pills, injection and IUD are available at health center or clinic. The percentage of correct answer was poor in the statement of family planning service are available free-of-charge by using health insurance scheme (43%).

Table 4.3: Frequencies and percentage distribution of respondents by correct score of knowledge item (n = 179)

	Characteristics	Correct answer	
		Frequency	Percentage (%)
1	Depo injection should be taken once in 3 months.	164	91.6
2	Oral pills, injection and IUD are available at health center or clinic.	162	90.5
3	Oral pills need to take everyday.	147	82.1
4	Tubal ligation can be done at the hospital.	144	80.4
5	If the women do not want the children anymore, sterilization should be used.	144	80.4
6	Using condom properly can prevent the women becoming pregnant.	139	77.7
7	Women can have a loop or coil (IUD) placed inside them to prevent pregnancy by doctor or nurse.	138	77.1
8	Using contraceptive methods can reduce unplanned pregnancy.	132	73.7
9	Condom and EC pills can buy at drug store or convenience shop.	123	68.7
10	Condom can break during sexual intercourse.	121	67.6
11	*IUD method can protect against sexually transmitted infections including HIV.	116	64.8
12	The man or couple must use condoms or another contraceptive method for 3 months after the vasectomy.	102	57.0

*negative question

Table 4.3: Frequencies and percentage distribution of respondents by correct score of knowledge item (n = 179) (Cont.)

	Characteristics	Correct answer	
		Frequency	Percentage (%)
13	*Depo injection gives more chance to have cervical cancer.	97	54.2
14	Oral pill can induce irregular bleeding in the first few months, but it is not harmful.	89	49.7
15	Family planning service can be available free-of-charge by using health insurance scheme.	77	43.0

*negative question

As shown in Table 4.4, majority of the respondents (60.9%) had fair knowledge, while the percentage of good and poor knowledge were 21.8% and 17.3% respectively.

Table 4.4: Frequency and percentage distribution of level of knowledge about utilization of contraceptive methods (n = 179)

Statements		Frequency	Percentage (%)
Knowledge on utilization of contraceptive methods			
Good (Score 13-15)		39	21.8
Fair (Score 9-12)		109	60.9
Poor (Score 0-8)		31	17.3
Mean = 10.6±2.5	Min = 2	Max = 15	

4.3.2 Attitude towards the utilization of contraceptive methods

As in Table 4.5, for positive statements, most of the respondents (81.6%) agreed that husband agree to use contraceptive methods and 74.9% agreed that contraceptive use can help a couple in selection the number of children. However, only 34.1% of the respondents agreed that emergency contraceptive pills can take after having unprotected sex. Regarding with the negative statements, 76% of the respondent did not agree that discussion on contraception is shameful among the couple, but only 39.7% percent did not agree that IUD can cause uncomfortable during intercourse.

Table 4.5: Percentage distribution of attitude towards the utilization of contraceptive methods (n = 179)

	Attitude statements	Agree (%)	Uncertain (%)	Disagree (%)	Mean
1	Husband agree to use contraceptive methods.	81.6	12.8	5.6	2.76
2	*Discussion on contraception is shameful among the couple.	6.7	17.3	76.0	2.69
3	Contraceptive use can help a couple in selecting the number of children.	74.9	16.2	8.9	2.66
4	Most contraceptive methods have more benefit than their side-effect.	71.5	21.2	7.3	2.64
5	Practicing contraception is the responsibility of a family who do not want more children.	74.3	12.8	12.8	2.61
6	*Oral pill is not effective in preventing women from getting pregnant.	10.1	21.8	68.2	2.58
7	Birth spacing is good for mother's health.	67.0	23.5	9.5	2.58
8	*There will be a serious family problem by using contraceptive methods.	7.3	29.1	63.7	2.56
9	*The condoms are not used in casual relationships.	22.9	15.6	61.5	2.39
10	*Tubal ligation is a nervous method.	26.8	10.6	62.6	2.36
11	*Injection is not preferred due to menstrual irregularities.	24.0	16.8	59.2	2.35
12	*Oral pill is not preferred due to increase body weight.	24.6	21.2	54.2	2.30
13	*Sterilization can reduce sexual desire.	13.4	46.4	40.2	2.27
14	*IUD can cause uncomfortable during intercourse.	19.0	41.3	39.7	2.21
15	Emergency contraceptive pills can take after having unprotected sex.	34.1	49.2	16.8	2.17

*negative statement

As mentioned in Table 4.6, the majority of the respondents (73.2%) had moderate level of attitude. Only 11.2% of the respondents had good level of attitude and the remaining 15.6% had poor level of attitude.

Table 4.6: Frequency and percentage distribution of level of attitude towards the utilization of contraceptive methods (n = 179)

Statement		Frequency	Percentage (%)
Attitude towards utilization of contraceptive methods			
Good (Score 42-45)		20	11.2
Moderate (Score 32-41)		131	73.2
Poor (Score 15-31)		28	15.6
Mean = 37.1±4.9	Min = 22	Max = 45	

4.4 Enabling factors

Enabling factors include availability and accessibility of contraceptive services, availability of health education materials and accessibility of health insurance scheme.

Table 4.7 shows the place of contraceptive service. Forty eight percent of the respondents knew the pharmacy as a source of contraceptive service and 27.9% knew that the contraceptive service were available at government hospitals. However, 11.2% of the respondents did not know the place of contraceptive service. Regarding with the number of sources of contraceptive services, most of the respondents (82.1%) knew less than 2 sources of contraceptive services.

Table 4.7: Frequency and percentage distribution of the respondents by the place of contraceptive service (n=179)

Characteristics	Frequency	Percentage (%)
Sources of contraceptive service (Multiple response allowed)		
Pharmacy	86	48.0
Government hospital	50	27.9
Government health center	22	12.3
Private clinic	20	11.2
NGO clinic	10	5.6
Do not know	20	11.2
Number of Sources of contraceptive services available		
Less than 2 sources	147	82.1
More than or equal 2 sources	32	17.9

The available contraceptive methods in the place of contraceptive service are shown in Table 4.8. Majority of the respondents (79.2%) knew that oral pills was available in the contraceptive service which was followed by injection (60.4%)

Table 4.8: Frequency and percentage distribution of the respondents by the available contraceptive methods in the place of contraceptive service (n=159)

Characteristics	Frequency	Percentage (%)
Availability of contraceptive methods (Multiple response allowed)		
Oral pills	126	79.2
Injection	96	60.4
Male condom	25	15.7
Tubal ligation	25	15.7
IUD	20	12.6
EC pills	9	5.7
Vasectomy	6	3.8
Female condom	1	0.6

In term of the common mode of transportation to the place of contraceptive service, nearly half of the respondents used motorcycle and 28.5% went to the service by walking. Among them, high proportion of them (82.1%) felt that there was no difficulty to access the contraceptive service. These results are shown in Table 4.9.

Table 4.9: Frequency and percentage distribution of the respondents by the accessibility to the place of contraceptive service (n=179)

Characteristics	Frequency	Percentage (%)
Common mode of transportation		
By motorcycle	83	46.4
By walking	51	28.5
By public transportation eg. Bus	15	8.4
By taxi	6	3.4
Do not know	24	13.4
Difficulties to go to service centers		
Do not difficult to access	147	82.1
Difficult to access and not sure	32	17.9

Regarding with the payment for the contraceptive service, majority of the respondents (72.1%) had to pay for the contraceptive services. Some respondents (12.8%) mentioned that contraceptive service was available for free-of-charge. (Table 4.10)

Table 4.10: Frequency and percentage distribution of the respondents by the payment for contraceptive service (n=179)

Characteristics	Frequency	Percentage (%)
Payment for service		
Yes	129	72.1
Free of charge	23	12.8
Do not know	27	15.1

Concerning the availability of health education materials about utilization of contraceptive methods (Table 4.11), about 40% of the respondents received information about contraception from health care workers and about 21% received printed media about the utilization of contraceptive methods. Among them, 10.6% received regularly and nearly 30% did not receive regularly.

Table 4.11: Frequency and percentage distribution of the respondents by the availability of health education materials about utilization of contraceptive methods (n=179)

Characteristics	Frequency	Percentage (%)
Health education materials (Multiple response allowed)		
Information by health care personnel	72	40.2
Nothing	69	38.5
Printed media about contraceptive methods	38	21.2
I do not know	38	21.2
Frequency		
Regularly	19	10.6
Sometimes	53	29.6
Never	69	38.5
Do not know	38	21.2

Table 4.12 depicts the accessibility to health insurance scheme by the respondents. Over three quarter of the respondents possessed health insurance scheme. Among them, the vast majority of them (98.6%) revealed that they had 30 Baht Universal Coverage Scheme and 84.8% of them satisfied with this scheme. Regarding with the reason for not having health insurance scheme, 43.9% responded that they had no legal documents to apply health insurance scheme and 39% answered that they cannot afford to buy health insurance scheme.

Table 4.12: Frequency and percentage distribution of the respondents by the accessibility to health insurance scheme (n=179)

Characteristics	Frequency	Percentage (%)
Have health insurance scheme		
Yes	138	77.1
No	41	22.9
Type of health insurance scheme (n=138)		
30 Baht Universal Coverage Scheme	136	98.6
Social Security Scheme	2	1.4
Satisfaction of provided health insurance scheme (n=138)		
Yes	117	84.8
No	21	15.2
Reason for not having health insurance scheme (n=41)		
Lack of legal documents	18	43.9
Cannot afford	16	39.0
Failed medical test	1	2.4
Others	6	14.6

4.5 Reinforcing factors

Reinforcing factors in this study include social support from husband, friends and health care workers.

4.5.1 Social support from husband

As shown in Table 4.13, nearly all of the respondents (98.9%) disagreed with the statement “discussion with husband about contraception is a nervous issue”. In contrast, 67% of them were strongly agreed that husband is supporting the cost for

receiving contraceptive methods and 54.2% strongly agreed that husband accompanied to go to the contraceptive services. However, 88.3% of the respondents disagreed with the statements "Husband helps to receive pamphlets or document of birth spacing practice information".

Table 4.13: Percentage distribution of social support from husband (n = 179)

	Statements	Strongly agree (%)	Agree (%)	Disagree (%)	Mean
1	*Discussing about contraception with husband is a nervous issue.	0.6	0.6	98.9	2.98
2	Husband is supporting the cost for receiving contraceptive methods.	67.0	12.8	20.1	2.47
3	Husband accompanies to go to contraceptive services.	54.2	24.0	21.8	2.32
4	Husband can be discussed about the problems of using contraceptive methods.	27.4	46.9	25.7	2.02
5	Husband takes care of children while going to contraceptive service.	19.6	35.2	45.3	1.74
6	Husband encourages to use contraceptive methods.	19.6	29.1	51.4	1.68
7	Husband thinks his wife as the one who can give information of family planning to others.	18.4	17.9	63.7	1.55
8	Suggestion or advice to receive contraceptive methods can be received from husband.	16.2	20.1	63.7	1.53
9	Husband recognizes his wife as a good practice of contraceptive methods.	14.0	23.5	62.6	1.51
10	Information about contraceptive methods and family planning services can be obtained from husband.	10.1	26.3	63.7	1.46
11	Husband helps to receive pamphlets or document of birth spacing practice information.	0.6	11.2	88.3	1.12

*negative statement

According to Table 4.14, only 12.8% of the respondents had good level of support from husband. The majority of the respondents (63.1%) had moderate level of support from husband and the remaining 24% had poor level of support from husband.

Table 4.14: Frequency and percentage distribution of level of social support from husband (n = 179)

Characteristics	Frequency	Percentage (%)
Social support from husband		
Good support (score 26-33)	23	12.8
Moderate support (score 18-25)	113	63.1
Poor support (score less than 18)	43	24
Mean = 20.4±4.5 Min = 12	Max = 31	

4.5.2 Social support from friends

From Table 4.15, the majority of the respondent (95.5%) disagreed with the statement "discussion with friends about contraception is a nervous issue". In contrast, 44.1% of the respondents strongly agreed that information about family planning could be obtained from friends and 46.4% of them were strongly agreed that they got suggestion or advice about contraceptive methods from friends. However, 85.5% of the respondents disagreed with the statement "friends is supporting the cost for receiving contraceptive methods".

Table 4.15: Percentage distribution of social support from friends (n = 179)

	Statements	Strongly agree (%)	Agree (%)	Disagree (%)	Mean
1	*Discussing about contraception with friends is a nervous issue.	1.1	3.4	95.5	2.94
2	Information about contraceptive methods and family planning services can be obtained from friends.	44.1	36.9	19.0	2.25
3	Suggestion or advice to receive contraceptive methods can be received from friends.	46.4	27.9	25.7	2.21
4	Friends take care of children while going to contraceptive service.	45.3	26.8	27.9	2.17
5	Friends can be discussed about the problems of using contraceptive methods.	31.8	41.3	26.8	2.05
6	Friends accompany to go to contraceptive services.	24.0	30.2	45.8	1.78

*negative statement

Table 4.15: Percentage distribution of social support from friends (n = 179) (Cont.)

	Statements	Strongly agree (%)	Agree (%)	Disagree (%)	Mean
7	Friends think the one who can give information of family planning to others.	16.8	26.3	57.0	1.60
8	Friends encourage to use contraceptive methods.	11.2	32.4	56.4	1.55
9	Friends recognize as a good practice of contraceptive methods.	11.7	29.6	58.7	1.53
10	Friends help to receive pamphlets or document of birth spacing practice information.	3.4	15.1	81.6	1.22
11	Friends are supporting the cost for receiving contraceptive methods.	0.6	14.0	85.5	1.15

*negative statement

According to Table 4.16, only 14.5% of the respondents had good level of support from friends. The majority of the respondents (58.1%) had moderate level of support from friends and the remaining 27.4% had poor level of support from friends.

Table 4.16: Frequency and percentage distribution of level of social support from friends (n = 179)

Characteristics	Frequency	Percentage (%)
Social support from friends		
Good support (score 26-33)	26	14.5
Moderate support (score 18-25)	104	58.1
Poor support (score less than 18)	49	27.4
Mean = 20.5±4.8 Min = 11	Max = 31	

4.5.3 Social support from health care workers

From Table 4.17, all of the respondent disagreed with the statements "health care workers accompany to go to contraceptive services" and "health care workers take care of children while going to contraceptive service". Only about half of them were strongly agreed that they could discuss with health care workers about the problems of using contraceptive methods. However, more than 90% of the

respondents disagreed with the statement “discussion about contraception with health care workers is a nervous issue”.

Table 4.17: Percentage distribution of social support from health care workers (n = 179)

	Statements	Strongly agree (%)	Agree (%)	Disagree (%)	Mean
1	*Discussing about contraception with health care workers is a nervous issue.	2.8	5.0	92.2	2.89
2	Health care workers can be discussed about the problems of using contraceptive methods.	51.4	26.8	21.8	2.30
3	Information about contraceptive methods and family planning services can be obtained from health care workers.	21.8	32.4	45.8	1.76
4	Suggestion or advice to receive contraceptive methods can be received from health care workers.	17.3	22.9	59.8	1.58
5	Health care workers help to receive pamphlets or document of birth spacing practice information.	15.1	7.3	77.7	1.37
6	Health care workers encourage to use contraceptive methods.	2.8	14.0	83.2	1.20
7	Health care workers think the one who can give information of family planning to others.	6.7	5.0	88.3	1.18
8	Health care workers recognize as a good practice of contraceptive methods.	2.2	8.9	88.8	1.13
9	Health care workers are supporting the cost for receiving contraceptive methods.	0.0	1.7	98.3	1.02
10	Health care workers accompany to go to contraceptive services.	0.0	0.0	100.0	1.00
11	Health care workers take care of children while going to contraceptive service.	0.0	0.0	100.0	1.00

*negative statement

According to Table 4.18, only 0.6% of the respondents had good level of support from health care workers. The majority of the respondents (68.2%) had poor level of support from health care workers and the remaining 31.3% had moderate level of support from health care workers.

Table 4.18: Frequency and percentage distribution of level of social support from health care workers (n = 179)

Characteristics	Frequency	Percentage (%)
Social support from health care workers		
Good support (score 26-33)	1	0.6
Moderate support (score 18-25)	56	31.3
Poor support (score less than 18)	122	68.2
Mean = 16.4±3.1 Min = 11	Max = 26	

4.6 Association between various independent variables of interest and utilization of contraceptive methods

4.6.1 General characteristics and utilization of contraceptive methods

Table 4.19 showed the association between general characteristics factors and utilization of contraceptive methods. Regrouping of certain variables was performed for chi-square test analysis which was depended on the median number and common similarities of certain variables.

It revealed that age was significantly associated with the utilization of contraceptive methods at p-value 0.005, showing the highest percentage of current contraceptive use (70.6%) was among 18-24 years age group. The proportion of current contraceptive use decreased steadily with the increase in age group. In 35-45 years age group, the current use was only 43.4%.

Regarding with registration status, the respondents who had registered were using contraceptive methods more than unregistered group, however, there was no significant association between registration status and utilization of contraceptive methods at p-value 0.232.

Concerning with ethnicity, there were Myanmar ethnic group and Non-Myanmar ethnic group which was composed of Shan, Karen and other ethnic. There was no statistically association between ethnicity and utilization of contraceptive methods at p-value 0.476. There was no significant difference between Myanmar

ethnic group and Non-Myanmar ethnic group regarding with the utilization of contraceptive methods.

Duration of stay in Thailand was regrouped into less than 84 months group and more than or equal 84 months group depending on the median number. The respondents who stayed in Thailand for less than 84 months had higher proportion of contraceptive use (65.1%) as compared with those for more than or equal 84 months (58.1%), but the relationship between duration of stay in Thailand and the utilization of contraceptive methods was not found to be significant (p-value 0.333).

With regard to education, there was no significant association between education and contraceptive use (p-value 0.939) as almost same proportion of the respondents in no education and primary education group and secondary education or higher group were practicing contraceptive methods. Similarly, there was no difference in the proportion of contraceptive use among the respondents with job and housewives (dependents) at p-value 0.951.

Regarding contraceptive use by monthly family income, it was found that the respondent who had monthly family income more than 10,000 Baht were utilizing contraceptive methods than those less than or equal 10,000 Baht. However, there was no significant association between monthly family income and utilization of contraceptive methods at p-value 0.215.

For duration of marriage, the respondents who had duration of marriage of less than 7 years were practicing contraceptive methods (68.7%) as compared with more than or equal 7 years group (55.2%), however, there was no significant association between duration of marriage and contraceptive use (p-value 0.065).

Regarding with current number of children, although the proportion of contraceptive use was higher in the respondents with less than or equal one child than those with more than one child, there was no significant relationship between current number of children and contraceptive use at p-value 0.144.

As concerned with desired number of children, the higher proportion of contraceptive use was found in the respondents with the desired number of children of less than or equal 3 children where the figure was 64.1%, as compared with those who desired for more than 3 children (51.4%). Nevertheless, the relationship between

desired number of children and utilization of contraceptive methods was not found significance (p-value=0.156).

Table 4.19: Association between the general characteristics factors and utilization of contraceptive methods (n=179)

Characteristics	Current use (n=110)		Past and never use (n=69)		Chi-sq	p-value
	Number	Percent (%)	Number	Percent (%)		
Age group (years)						
18-24 years	24	70.6	10	29.4	10.41	0.005*
25-34 years	63	68.5	29	31.5	df=2	
35-45 years	23	43.4	30	56.6		
Registration status						
Registered	100	63.3	58	36.7	1.922	0.232
Unregistered	10	47.6	11	52.4	df=1	
Ethnicity						
Myanmar	49	64.5	27	35.5	0.509	0.476
Non-Myanmar	61	59.2	42	40.8	df=1	
Duration of stay in Thailand (months)						
< 84 months	56	65.1	30	34.9	0.938	0.333
≥ 84 months	54	58.1	39	41.9	df=1	
Educational level						
No education and primary education	44	61.1	28	38.9	0.006	0.939
Secondary education and higher	66	61.7	41	38.3	df=1	
Current occupation						
With Job	96	61.5	60	38.5	0.004	0.951
Housewife	14	60.9	9	39.1	df=1	
Monthly family income (Baht)						
≤ 10,000	59	57.3	44	42.7	1.782	0.215
> 10,000	51	67.1	25	32.9	df=1	

* significant at p-value <0.05

Table 4.19: Association between the general characteristics factors and utilization of contraceptive methods (n=179) (Cont.)

Characteristics	Current use (n=110)		Past and never use (n=69)		Chi-sq	p-value
	Number	Percent (%)	Number	Percent (%)		
Duration of marriage (years)						
< 7 years	57	68.7	26	31.3	3.408	0.065
≥ 7 years	53	55.2	43	44.8	df=1	
Current number of children						
≤ 1 child	68	66.0	35	34.0	2.136	0.144
> 1 child	42	55.3	34	44.7	df=1	
Desired number of children						
≤ 3 children	91	64.1	51	35.9	2.009	0.156
> 3 children	19	51.4	18	48.6	df=1	

* significant at p-value <0.05

4.6.2 Predisposing factors and utilization of contraceptive methods

Table 4.20 described the association between knowledge level of the respondents and the utilization of contraceptive methods. It was revealed that there was a significant association between knowledge level and contraceptive use with p-value <0.001. Among those who had good knowledge, 82.1% were current contraceptive users. The proportion of current contraceptive use was decreased to 63.3% in those who had fair knowledge. In poor knowledge group, 71% were past and never users and only 29% were current users.

Table 4.20: Association between knowledge of respondents and utilization of contraceptive methods

Characteristics	Current use (n=110)		Past and never use (n=69)		Chi-sq	p-value
	Number	Percent (%)	Number	Percent (%)		
Knowledge level						
Good	32	82.1	7	17.9	20.898	<0.001*
Fair	69	63.3	40	36.7	df=2	
Poor	9	29.0	22	71.0		

*significant at p-value <0.05

Concerning the attitude of the respondents towards utilization of contraceptive methods (Table 4.21), 70% of the respondents with good level of attitude and 68.7% with moderate level of attitude were current contraceptive users. Among the respondents with poor level of attitude, 78.6% were past and never users and only 21.4% were current users. There was a significant association between level of attitude and utilization of contraceptive methods at p-value <0.001.

Table 4.21: Association between attitude of respondents and utilization of contraceptive methods

Characteristics	Current use (n=110)		Past and never use (n=69)		Chi-sq	p-value
	Number	Percent (%)	Number	Percent (%)		
Attitude level						
Good	14	70	6	30	22.458	<0.001*
Moderate	90	68.7	41	31.3	df=2	
Poor	6	21.4	22	78.6		

*significant at p-value <0.05

4.6.3 Enabling factors and utilization of contraceptive methods

Enabling factors included the availability and accessibility of contraceptive services, availability of health education materials and accessibility of health insurance scheme.

Regarding with availability of contraceptive services, the sources of contraceptive services were classified into 2 groups: less than 2 sources and more than or equal 2 sources. There was no significant association between number of sources of contraceptive services available and utilization of contraceptive methods (p-value 0.082).

Table 4.22: Association between number of contraceptive services available and utilization of contraceptive methods

Characteristics	Current use (n=110)		Past and never use (n=69)		Chi-sq	p-value
	Number	Percent (%)	Number	Percent (%)		
Number of sources of contraceptive services available						
< 2 sources	86	58.5	61	41.5	3.019	0.082
≥ 2 sources	24	75.0	8	25.0	df=1	

*significant at p-value <0.05

Table 4.23 depicted the relationship between accessibility of contraceptive services and utilization of contraceptive methods. There was a significant association between accessibility of contraceptive services and contraceptive use at p-value 0.000. A high proportion of current contraceptive use was observed in the respondents who did not difficult to access to contraceptive services group. Among those who had difficulties to access to contraceptive services and were not sure, 78.1% were past and never users and about 22% were current users.

Table 4.23: Association between the accessibility of contraceptive services and utilization of contraceptive methods

Characteristics	Current use (n=110)		Past and never use (n=69)		Chi-sq	p-value
	Number	Percent (%)	Number	Percent (%)		
Accessibility of source of contraceptive services						
Do not difficult	103	70.1	44	29.9	25.766	<0.001*
Difficult and not sure	7	21.9	25	78.1	df=1	

*significant at p-value <0.05

Regarding the availability of health education materials, it was classified into 2 groups: “available group” and “not available and not known group”. According to Table 4.24, there was an association between availability of health education materials and utilization of contraceptive methods at p-value 0.015. The respondents

who received health education materials were more likely to use contraceptive methods.

Table 4.24: Association between the availability of health education materials and utilization of contraceptive methods

Characteristics	Current use (n=110)		Past and never use (n=69)		Chi-sq	p-value
	Number	Percent (%)	Number	Percent (%)		
Availability of health education materials						
Available	52	72.2	20	27.8	5.898	0.015*
Not available and not known	58	54.2	49	45.8	df=1	

*significant at p-value <0.05

According to Table 4.25, there was an association between accessibility of health insurance scheme and utilization of contraceptive methods at p-value 0.024. The respondents with health insurance scheme were more likely to utilize contraceptive methods as compared with other group.

Table 4.25: Association between the accessibility of health insurance scheme and utilization of contraceptive methods

Characteristics	Current use (n=110)		Past and never use (n=69)		Chi-sq	p-value
	Number	Percent (%)	Number	Percent (%)		
Accessibility to health insurance scheme						
Yes	91	65.9	47	34.1	5.126	0.024*
No	19	46.3	22	53.7	df=1	

*significant at p-value <0.05

4.6.4 Reinforcing factors and utilization of contraceptive methods

Table 4.26 described the association between social support from husband, friends and health care workers and utilization of contraceptive methods. It was discovered that there were a significant association between social support from husband and friends and utilization of contraceptive methods at p-value <0.001 each. The respondents who received good and moderate level of social support were supposed to use contraceptive methods more as compared with those who receive poor level of social support from husband and friends. However, for social support from health care workers, Fisher-Exact Test was applied as there were 2 cells with expected count less than 5 and there was no association between social support from health care workers and utilization of contraceptive methods (p-value 0.08).

Table 4.26 Association between social support from husband, friends and health care workers and utilization of contraceptive methods

Characteristics	Current use (n=110)		Past and never use (n=69)		Chi-sq	p-value
	Number	Percent (%)	Number	Percent (%)		
Social support from husband						
Good	20	87.0	3	13.0	41.114	<0.001*
Moderate	81	71.7	32	28.3	df=2	
Poor	9	20.9	34	79.1		
Social support from friends						
Good	23	88.5	3	11.5	33.724	<0.001*
Moderate	73	70.2	31	29.8	df=2	
Poor	14	28.6	35	71.4		
Social support from health care workers**						
Good	1	100.00	0	0.00	4.145	0.08
Moderate	40	71.40	16	28.60		
Poor	69	56.60	53	43.40		

*significant at p-value <0.05
**Fisher-Exact Test

4.7 Factors influencing utilization of contraceptive methods

Binary logistic regression with enter method was performed to provide a more simplistic description of the association of the variables, to draw more rich information and the dependent variable was dichotomous outcome. Table 4.27 presented the association of independent and dependent variables with log odd ratios and 95% confidence interval. Regarding with age, the respondents who are in 18-24 years old were 3 times more likely to use contraceptive methods than those in 35-45 years old at p-value 0.015.

For knowledge about utilization of contraceptive methods, there was a significant relationship between knowledge level and contraceptive use as the respondents with good knowledge were 11 times more likely to use contraceptive methods than those with poor knowledge at p-value <0.001. As concern with attitude towards utilization of contraceptive methods, the respondents with good attitude and moderate attitude were 8.6 times and 8.1 times more likely to use contraceptive methods than those with poor attitude at p-value 0.001 and <0.001 respectively.

Regarding with accessibility of source of contraceptive methods, the married women with no difficulties were 8.4 times more likely to use contraceptive methods than those with difficulties to access at p-value <0.001. Moreover, the respondents who received health education about family planning either from health care worker or by communication materials were 2.2 times more likely to use contraceptive methods as compared with those who did not receive health education materials at p-value 0.016. Besides, migrant married women who had health insurance scheme were 2.3 times more likely to use contraceptive methods than those who did not have health insurance scheme at p-value 0.025.

Concerning social support from husband, there was a significant association with utilization of contraceptive methods in which the respondents with good level of support from husband were 25 times more likely to use contraceptive methods as compared with those with poor level of support from husband at p-value <0.001. Similar association was found between social support from friends and contraceptive use. The respondents with good level of support from friends were 19 times more likely to use contraceptive methods than those with poor support from friends at p-value <0.001.

Table 4.27: Variables on utilization of contraceptive methods in binary logistic regression with enter method

Variables	Odds Ratio	95% CI for OR		p-value
		Lower	Upper	
Age group (years)				
18-24 years	3.130	1.252	7.825	0.015*
25-34 years	2.834	1.409	5.700	0.003*
35-45 years	1			
Knowledge level				
Good	11.175	3.620	34.491	<0.001*
Fair	4.217	1.770	10.043	0.001*
Poor	1			
Attitude level				
Good	8.556	2.297	31.871	0.001*
Moderate	8.049	3.035	21.345	<0.001*
Poor	1			
Accessibility of source of contraceptive services				
Do not difficult	8.360	3.367	20.758	<0.001*
Difficult and not sure	1			
Availability of health education materials				
Available	2.197	1.157	4.169	0.016*
Not available and not known	1			
Accessibility to health insurance scheme				
Yes	2.242	1.105	4.549	0.025*
No	1			
Social support from husband				
Good	25.185	6.096	104.046	<0.001*
Moderate	9.562	4.124	22.172	<0.001*
Poor	1			
Social support from friends				
Good	19.167	4.952	74.185	<0.001*
Moderate	5.887	2.784	12.448	<0.001*
Poor	1			

*significant at p-value <0.05

CHAPTER V
DISCUSSION

The main purpose of this study is to determine the proportion of utilization of contraceptive methods and to identify the factors related to the utilization of contraceptive methods among Myanmar migrant married women who were residing in Chiang Mai, Thailand. The hypothesis of this study was assumed that there were an association between the general characteristics, predisposing factors, enabling factors, reinforcing factors and utilization of contraceptive methods among Myanmar migrant married women. There were five discussion parts in this chapter.

5.1 Utilization of contraceptive methods

5.2 General characteristics

5.3 Predisposing factors

5.4 Enabling factors

5.5 Reinforcing factors

5.6 Limitation of study

5.1 Utilization of contraceptive methods

In this study, the proportion of utilization of contraceptive methods among Myanmar migrant married women in Chiang Mai was 61.5%. This result was lowered than the CPR of Thailand among married women aged 15-49 years which was 79.8% (8). However, according to the UNFPA report (16), this result was much higher than the CPR of Myanmar, which was 37%.

Moreover, this finding was contradicted with a study done by Huang et al (17), which reported 86% of rural-to-urban migrant women in Shanghai who conceived during the observed postpartum period did not use any kinds of contraceptive methods. In addition, one study from Canada (18) revealed that

immigrants were less likely to use hormonal contraception, but in this study, 61.5% of Myanmar migrant women were current contraceptive users.

In comparison with the findings from Myanmar migrant women in other provinces in Thailand, the proportion of contraceptive use in this study was lower than one study from Mae Sot Province (23) which was 80%, from Ranong Province (21) where the figure was 79.2% and from Phang-Nga Province (19) which showed 73.3% of Myanmar migrant women current contraceptive users. In contrast, the finding of this study was higher than the study from Phuket Province (20) where the CPR was 56.9% and Samut Prakan Province (22) where the figure was 52.9%.

Although the result of this study was lower than the CPR of Thailand, it was higher than CPR of migrant women's host country, Myanmar. This might be due to the fact that after migrating to another country, they had to struggle and earn money not only for their family in Thailand but also for the dependents in Myanmar, even by working over-time section. This fact might motivate them to use family planning practice.

Regarding with the choice of contraceptive methods, oral pills was the most popular method whereas 65.5% of migrant women chose oral pills. The second popular method in this study was injection (25.5%) which was followed by Male condom (10.9%). The very few migrant women used the permanent method (tubal ligation), EC pills and IUD. This finding was coincided with the 2009 reproductive health survey of Ministry of Public Health, Thailand (15), which reported that oral pills was the most prevalent methods in Thailand. Besides, this result was similar with a study from Mae Sot Province (23) showing oral pill was the most popular method which was followed by injection, though the percentage of use varied. It could be explained that oral pills were easily available in pharmacies and convenient shops and easy to use. However, in other studies among Myanmar migrant women in Thailand (19) (20) (22), injection was the most common methods which was followed by oral pills.

One interesting point was that there was the only one respondent who used IUD. This result was similar with the study from Phuket Province (20), which showed none of the respondent used IUD. However, one study from Shanghai (17) opposed the result of this study that IUD was the most common contraceptive methods among

rural-to-urban migrant women. This might be due to the fact that they had limited knowledge about the long-term contraceptive methods such as IUD and implant and they might think that these newer methods could be expensive and threaten to their health. Moreover, they might not know where they can get this methods in another country. For oral pills, it was cheap and they could easily access oral pills with their motorcycle.

In this study, about 90% of the respondents who used temporary contraceptive methods were using regularly. The result of this study was much higher than the result of the study done in Phuket Province (20), showing about 51% of temporary contraceptive methods users were regular users. This finding could be concluded that the migrant women in the studied area were practicing the contraceptive methods systematically than Myanmar migrant women in other province.

The median duration of utilization of contraception methods in this study was 24 months. The main reason for using contraceptive methods in this study was that they were convenient to use the current contraceptive method. The similar result was found in a study done in Samut Prakan Province (22) although there was some difference in percentage. This finding could facilitate the utilization of contraceptive methods among Myanmar migrant women. As they were working over-time, convenience to use contraceptive methods was a vital factor that determine utilization of contraceptive methods among migrant women.

Among ever use group, the median duration of stopping contraceptive methods was 36 months. The main reason for discontinuing contraceptive methods was that they wanted more children (69.8%) which was followed by due to side effect of previous contraceptive methods (27.9%). Only one respondent in this study answered that she discontinued because she could not effort to use. The result of this study was reasonable that the women would stop taking contraceptive methods if they desired for more children and this was not due to unavailability of contraceptive services in the studied area. The result of this study was similar with a study done among Myanmar migrant women in Samut Prakan (22) and Phang-Nga (19), showing that desire for more children was the frequent answer for discontinuing contraceptive methods.

Regarding with non-use group in this study, the common reason for not using contraceptive methods was “want more children” (53.8%), which was followed by “fear of side effects” and it was 34.6%. This results were also reasonable because the women would not practice family planning if they would desire more children. As some of the women in this study were living in a same compound and workplace, they could get an information about side effects of contraceptive methods. If they were concerned with this side effects, they were not likely to use contraceptive methods for family planning purpose. This results were homogenous with the study done among Myanmar migrant women in Mae Sot Province (23), which described “want more children” and “fear of side effects” were the most common reasons for not using contraceptive methods but there were some variation in percentage.

5.2 General characteristics

In this study, age was the only factor that was associated with utilization of contraceptive methods after performing bivariate analysis by chi-square test and binominal logistics regression.

The finding of this study described that age was statistically related to the utilization of contraceptive methods with p-value less than 0.05. The likelihood of utilization of contraceptive methods was highest among women of 15-24 years age group (OR 3.13) which was followed by women of 25-34 years age group (OR 2.83) as compared with women of 35-45 years age group. Apparently, age had negative effect on utilization of contraceptive methods as the use of contraceptive methods was decreased with increasing age. It could be explained that younger women were more likely to use contraceptive methods as compared with older women due to their awareness on unplanned pregnancy and less sexual activities of older women. Younger women might have a good social network in which they could discuss about family planning practice with their friends. In addition, the younger age group could discuss about family planning with their husband. Another important point was that they were migrating to another country and their first priority was to earn money to be able to stay in another country independently. When the women become older, they might have less sexual activities and thought that they had less chance to get

pregnancy. This finding was compatible with the study done among Myanmar migrant women in Phuket Province (20) in which the utilization of contraceptive methods was the highest at the lowest age group (15-19 years) and it decreased steadily with the increase in age.

The majority of migrant women in this study were registered migrant women, but there was no association between registration status and contraceptive use. One study from Phuket Province (20) supported this finding, showing no association between registration status and contraceptive use. According to this result, the migrant married women made use of contraceptive methods regardless of registration status. Similarly, there was no significant difference between ethnic group of Myanmar and utilization of contraceptive methods.

In this study, there was no association between duration of stay in Thailand and utilization of contraceptive methods. This finding was resembled with one study from Samut Prakan Province, Thailand (22) which showed there was no significant association between duration of stay in Thailand of less than 5 years and more than 6 years and utilization of contraceptive methods. This could be explained that, as most of the Myanmar migrant married women in Chiang Mai were working in groups in constructing sites and in market, so they can discuss about family planning practice with their husband and friend, and they could use contraceptive methods regardless of the period they were stayed in Thailand.

In fact, education had a great impact on utilization of contraceptive methods according to the previous studies. However, there was no relationship between education and utilization of contraceptive methods in this study. About 60% of married women with no education and primary education and married women with secondary and higher education were current users in this study. Similar results of previous studies from Bangladesh (37) and Southwest Bugerua (38) revealed that the education status did not significantly influence the utilization of contraceptive methods. It could be explained that most of the Myanmar migrant women in Chiang Mai were staying together in one compound or in workplace, so they could share the information about family planning with each other. Therefore, there was no difference in proportion of contraceptive use between these two groups of migrant women.

It was noted that there was no association between current occupation and utilization of contraceptive methods in this study. Although migrant women without job was very few in this study, about 60% of them were using contraceptive methods which was almost the same proportion with employed women. The studies done in Bangladesh (41) described that there was no association between occupation and utilization of contraceptive methods. Similarly, although migrant women with monthly family income of above 10,000 Baht were practicing contraceptive methods than those with family income of less than 10,000 Baht, there was no significant association between monthly family income and utilization of contraceptive methods in this study. This result was supported by one study done among Myanmar migrant women in Maesot (27) and another study done in Bangladesh (40). This could be concluded that Myanmar migrant women in the studied area were practicing contraceptive methods regardless of current occupation status and monthly family income and this might be due to easy accessibility to contraceptive services and affordable price.

Furthermore, the relationship between duration of marriage and utilization of contraceptive methods was not significant in this study. Although women who had been married for less than 7 years were practicing contraceptive methods more as compared with those for more than or equal 7 years, the result was not significant. Previous study done among Myanmar migrant women in Maesot (27) also revealed that there was no significant association between duration of marriage and contraceptive use. This might be due to increased awareness on family planning by migrant women and family's main priority might be to earn money and to contribute in a more meaningful way to their family.

Utilization of contraceptive methods did not rely on the current number of children and there was no significant difference between these two variables in this study. This result was revealing that migrant women with less than or equal 1 child were practicing contraceptive methods and it might be due to the fact that they had a fair knowledge on family planning and there might be a great peer influence on utilization of contraceptive methods. According to the previous study, one study done in Mogkok Township, Myanmar (46) described that there was no association between the number of living children and utilization of contraceptive methods.

Regarding with desired number of children, this study revealed that there was no significant association between desired number of children and utilization of contraceptive methods. The Myanmar migrant women in the studied area were practicing contraceptive methods regardless of the desired number of children they desired to have. This result was not relevant with the assumption that women who wanted large family size were less likely to practice family planning than those who did not want. The studies done among Myanmar migrant women in Mae Sot Province (27) and Samut Prakan Province (22) showed that the association between desired number of children and utilization of contraceptive methods was not significant.

To conclude, age was the only factor among general characteristics that was related with the utilization of contraceptive methods in this study.

5.3 Predisposing factors

There are two main portions to assess the predisposing factors for utilization of contraceptive methods; knowledge about and attitude towards utilization of contraceptive methods. According to this study, most of the respondents were in moderate knowledge and moderate attitude level. And the finding revealed that there was a significant association between knowledge about and attitude towards contraceptive use and utilization of contraceptive methods. This could be explained that lack of knowledge due to limited education and information could lead to improper or no utilization of contraceptive methods which could result in unsafe abortion and other complications and finally lead to maternal death.

Because of lack of knowledge, the attitude towards utilization of contraceptive methods also changed. About half of the Myanmar migrant women in this study did not know that they can get the family planning services for free-of-charge by using health insurance scheme although many of them possessed health insurance scheme. Most of them had a poor attitude on modern contraceptive methods such as EC pills and IUD. Some women still had a negative attitude on family planning as they did not agree that family planning is good for mother's health. It is obvious, though not related directly to education, women who have general knowledge

have better understanding of the value of family planning by using contraceptive methods and have good attitude towards the utilization of contraceptive methods.

The result of this study was resemble with the study done among Myanmar migrant women in Ranong Province (21) which revealed that knowledge on and attitude towards family planning were related with the utilization of contraceptive methods.

5.4 Enabling factors

In this study, the availability of services was assessed by the number of sources of family planning services known by the respondents and the accessibility of services was determined by the presence or absence of difficulties to access the services. Regarding with the availability to contraceptive service, almost half of the respondent knew that pharmacy was the source of contraceptive service. This could be explained that they were more likely to take oral pills by buying from the nearest pharmacy shop. Only 20 people out of total respondents in this study answered that they did not know the source of service. This figure might reveal that 6 contraceptive non-users knew the source of contraceptive service, but they did not practice contraceptives. Although they had general knowledge about contraceptive methods, their poor attitude might render them not to use contraceptive methods. As concerned with availability of contraceptive method in the service, the majority of the women in this study knew oral pills and injection. This number was consistent with the most common methods used by the respondents in this study. But, there was no association between the availability of contraceptive service and utilization of contraceptive methods as there was no significant difference between the number of sources of contraceptive services and contraceptive use by respondent. Similar results were found in the studies done among Myanmar migrant women in Samut Prakan Province (22) and Phuket Province (20) showed that there was no association between number of contraceptive services and the utilization of contraceptive methods.

Regarding with the accessibility of contraceptive service, nearly half of the respondent answered that motorcycle was the common mode of transportation. In actual situation, most of the Myanmar migrant workers in Chiang Mai owned a

motorcycle and they can easily access to contraceptive service by their motorcycle. Another around 30% of the respondent accessed by walking. As oral pills were easily available in pharmacies, they could walk to nearby pharmacies and could buy oral pills. Moreover, they could easily approach to nearby private clinic to receive depo injection either by motorcycle or on foot. As a consequence, the greater proportion of the migrant women in this study responded that they had no difficulties to access to contraceptive services. In this study, there was a significant association between accessibility of contraceptive service and utilization of contraceptive methods as the respondent who did not difficult to access to contraceptive service were 8.4 times more likely to use contraceptive methods. The result of this study was homogenous with the study done among Myanmar migrant youth women in Bangkok (35) which revealed that there was a significant association between accessibility to contraceptive services and contraceptive use and another study done in Lao PDR (57) which revealed that convenience to go to service center were significantly associated with the utilization of contraceptive methods.

Another important discussion part was the availability of health education materials regarding with family planning either by health information given by health care workers and printed media about contraceptive methods, for instance, pamphlets. About 60% of the respondents in this study did not receive health education materials. This could be explained that most of the migrant women got access to pharmacies and private clinics instead of approaching government health centers. For vendor, they started to work from morning to mid-night and they had limited time to go to government health center. If they did not receive health educational materials, there will be lack of knowledge about family planning which could affect the utilization of contraceptive methods. In this study, there was a strong association between availability of contraceptive methods and contraceptive use. A study done among Myanmar migrant youth women in Bangkok (35) also reported that there was a significant association between the availability of health education materials and contraceptive use.

Concerning the accessibility of health insurance scheme, about 80% of the respondents had one kind of health insurance scheme. If the migrants possessed health insurance scheme, they could get access to health care service provided by Thailand

government and they could receive family planning service by spending only 30 Baht. However, some migrants who did not have a legal documents (work permit) or who could not afford for the fee for medical test or who failed the medical test, did not possess health insurance scheme. There was a significant association between accessibility of health insurance scheme and contraceptive use in this study. However, the actual figure was that migrant women did not use health insurance card for family planning purpose. The main reason for this fact was that, as described earlier, they had limited time to get access to government health centers by using health insurance card and the cost for oral pills and injections were cheap. One study done among beer promoters (56) revealed that about 97% of the beer promoter from Thailand had health insurance, but about one-third had accessed to health insurance. The majority from other countries had no health insurance either because their employer did not provide it or because they were part-time employees and the health insurance was not available to them.

5.5 Reinforcing factors

Regarding with social support from husband, most of the Myanmar migrant women received instrumental support and emotional support from their husband. The result of this study might be consistent with the fact that Myanmar people usually pool the income among their family and this pool income money can be regarded as a husband support for using contraceptive methods. Moreover, as long as there was a relationship between a couple, the women could discuss with husband about the problem of using contraceptive methods. Even if the women could not buy the contraceptive methods, the husband could buy it on behalf of the women. But, overall, many of them received moderate level of support from their husband and the level of support was related with utilization of contraceptive methods. Similarly, one study in Cambodia (59) reported that social support from husband was significantly associated with the utilization of contraceptive methods.

Myanmar migrant married women in the studied area received emotional support and information support from friends. This could be explained that migrants especially construction workers and vendors were working in the same workplace

such as construction sites and night bazaar. Therefore, migrants had a long time contact with friends and might receive information about family planning from friends. Moreover, peer influence might be an another important factor for social support from friends. If the friends were using contraceptive methods, then migrants could discuss with friends and this fact would facilitate the utilization of contraceptive methods. In this study, there was a significant association between social support from friends and utilization of contraceptive methods. The similar result was found out in one study from Myanmar (45) revealed that there was a significant association between partner and friends support and the utilization of contraceptive methods, which described that the women who received good or fair support from partner and friends were about 4 times more likely to use contraceptive methods than those with low support.

Regarding with social support from health care workers, most of the respondents were in poor social support from health care workers and the association between social support from health care workers and utilization of contraceptive methods was not significant. However, by reviewing the result of this study, most of the migrant women received information support from health care workers. Migrant women in this studies answered that they can consult the health care workers for the problems of using contraceptive methods. Moreover, they received information about contraceptive methods and family planning services from health care workers. Therefore, health care workers still play an important role for utilization of contraceptive methods although there was no relationship between social support from health care workers and utilization of contraceptive methods. Regarding with the previous study, one study from Mexico (60) revealed that women who got family planning information during antenatal care service from health care workers were significantly increased in the utilization of contraceptive methods than those who did not get the information.

5.6 Limitations of the study

As the data collection for this study was performed among Myanmar migrant married women in Chiang Mai, which was a mobile population, the result of the study

cannot be generalized to all Myanmar migrant married women in Thailand. Another important point was that the sample size of this study was rather small due to limitation of time period for data collection among migrant population and difficulties in recruiting illegal migrant women. Regarding with social support from health care workers, there were some questions with unusual results although the result of reliability test among the respondents with same status in Bangkok revealed the promising result.

CHAPTER VI
CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

This cross-sectional study was conducted at Chiang Mai, Thailand. The main objective of this study was to find out the proportion of the utilization of contraceptive methods and factors related to utilization of contraceptive methods such as general characteristics factors, predisposing factors, enabling factors and reinforcing factors among Myanmar migrant married women in Chiang Mai, Thailand. Data were collected by interviewing with structured questionnaires in January 2013. The researcher and one trained data assistant conducted an interview at construction sites, night bazaar, restaurants and migrant workers' homes on week days and at "Wat Sai Moon" and weekend market on Saturday and Sunday. At first, the researcher planned to collect data only at "Wat Sai Moon", but due to insufficient number of migrants who visited "Wat Sai Moon", so the researcher had to extend the data collection sites to construction sites and markets.

The researcher and one data assistant interviewed 179 Myanmar migrant married women in Chiang Mai. The proportion of utilization of contraceptive methods among Myanmar migrant married women in Chiang Mai was 61.5% and the most common contraceptive methods were oral pills and injection. After calculating with Chi-square test and binomial logistics regression test, there were a significant association between the age of the respondent, predisposing factors such as knowledge about and attitude towards contraceptive methods, enabling factors like the accessibility of contraceptive services, the availability of health education materials, the accessibility of health insurance scheme and reinforcing factors which were the social support from husband and friends and the utilization of contraceptive methods.

6.2 Recommendations

Based on the findings of this study, the following recommendations are proposed. Those are relatively specific recommendations related to the area of Chiang Mai, but some may be applicable in other areas where a similar situation of migrants' women conditions exist.

6.2.1 Benefits of the study

The contribution of the study by the respondent would be beneficial to the finding of the influencing factors on utilization of contraceptive methods among Myanmar migrant married women. Government sector and non-governmental organizations would know the real situation of utilization of contraceptive methods among Myanmar migrant women and it would be helpful for future health promotion intervention regarding with family planning among Myanmar migrant women.

6.2.2 Recommendation from the results of the study

According to the results of this study, health promotion about family planning is a vital issue to widen the scope of knowledge and awareness about utilization of contraceptive methods. The health promotion program should focus on production and delivery of health education material in target group's friendly language. Moreover, health promotion program must be target group friendly program and should include the involvement of husband and current contraceptive users to get peer influence. Besides, it is important to disseminate the information about health insurance system and to promote the utilization of contraceptive methods by using health insurance system.

6.2.3 Recommendation for implementation of programs

- This is very important to give health education about family planning to both current users and non users to get awareness on utilization of contraceptive methods. Knowledge about health insurance system must be integrated in the health education package.

- Health education materials, for instance, posters and pamphlets, with sample manual in Myanmar Language should be produced to persuade such kind of target groups for using contraceptive methods.
- Health talk section should organize during their leisure time or free time in their workplace to deliver messages about contraceptive methods, to deliver health education materials and to share their personnel experience. This is also a good entry point to give information about contraceptive services to migrant's women.
- Easily accessible contraceptive services with reasonable price for migrant women should be organized to save their out-of-pocket expenditure. It is important to establish the services to be user friendly places, for instance, compatible with cultural norm, working hours and privacy.
- The counseling service about contraception should be integrated to reduce the information gap between client and provider which will facilitate choosing an acceptable method to suit each woman's situation.
- Service providers should need to provide proper reproductive health education and counseling through husband reproductive health program. It should be in culturally appropriate ways and performed by male migrant workers and it also need to motivate active participations and open discussion of male migrants.
- Peer education program can organize migrants' family members or neighbours of potential family planning users and are appropriate to promote reproductive health of diverge needs of migrants' community and can facilitate out-reach services.

6.2.4 Recommendation for further studies

- This study identified the certain information related to the utilization of contraceptive methods among Myanmar migrant married women in Chiang Mai, Thailand. The sample size was, however, small and the information collected was not conclusive. Therefore, a similar large-scale study and mixed type of qualitative and quantitative approach should conduct to get more reliable and meaningful results.
- In order to get in-depth understanding to their perception on contraceptive use, qualitative research designs are most appropriate for the focus in further researches to get more information on unmet reproductive health needs to

service providers. Then, it can facilitate relevant supports for adequate quality service to diverse needs of migrant groups.

- Further research to find out the utilization of health insurance scheme among Myanmar migrant workers should be carried out to depict the unmet needs for health insurance scheme and the influencing factors about the utilization of health insurance scheme among Myanmar migrant workers.

REFERENCES

1. The World Bank. Migration and remittances fact book second edition 2011.
2. Mahidol University, World Health Organization, European Union. A situation analysis on Health System Strengthening for Migrants in Thailand 2012.
3. International Organization for Migration. Thailand at a crossroads: Challenges and opportunities in leveraging migration for development 2012.
4. United Nations. Millennium Development Goals Report 2013.
5. Ki-moon B (UN Secretary-General). Family planning is a fundamental component of reproductive health. Media release in UN Informative services, Vienna 2008. [cited 2014 March 31]; Available from: www.unis.unvienna.org/unis/pressrels/2008/unissgsm056.html
6. World Health Organization. Family planning fact sheets, May 2013.
7. World Health Organization. Family Planning: a global handbook for provider 2011.
8. United Nations Economic and Social Commission for Asia and the Pacific. Population and development indicators for Asia and the Pacific 2013.
9. Institute for Population and Social Research, Mahidol Migration Centre, Mahidol University. Newsletter, Volume 3, July 1, 2012.
10. Belton S. Borders of fertility: Unplanned pregnancy and unsafe abortion in Burmese women migration to Thailand. Health Care Women International 2007;28(4):419-33.
11. Committee for Coordination of Services to Displaced Person in Thailand (CCSDPT). 2006 Annual health information short report, Thailand-Burma border refugee camps.
12. Department of Planning and Information for foreign workers. Annual report of department of employment 2012.
13. Karen Glanz, Barbara K. Rimer, Viswanath K. Health behavior and health education: theory, research, and practice. Fourth ed. San Francisco: John-Bass; 2008.

14. Campbell S, Monga A. Gynaecology by Ten Teachers, eighteenth edition: Edward Arnold; 2006.
15. Ellis M. Myanmar migrant maternal and child health survey, Foundation for Education and development, Thailand 2010.
16. United Nation Population Fund (UNFPA). The State of The World's Midwifery 2011.
17. Huang YM, Merkatz R, Kang JZ, Roberts K, Hu XY, Donato FD, Ware RS, Cheng LN. Postpartum unintended pregnancy and contraception practice among rural-to-urban migrant women in Shanghai. Elsevier 2012;86:731-38.
18. Wiebe E. Contraceptive practices and attitudes among immigrant and nonimmigrant women in Canada. Canadian Family Physician 2013;59:451-55.
19. Soe HHK, Than NN, Kaul A, Kumar S, Somrongthong R. Determinants of contraceptive usage among Myanmar migrant women in Phang-Nga Province, Thailand. Journal of Medicine & Medical Sciences. 2012;3(11):721-28.
20. Phyu S. Temporary contraceptive use among married Myanmar migrant women in reproductive age in Phuket Province, Thailand. Thematic paper for Master of Public Health Degree, Mahidol University 2007.
21. Soe EM. Birth spacing practice among married Myanmar migrant women in Ranong Province, Thailand. Thematic paper for Master of Public Health Degree, Mahidol University 2008.
22. Oo MM. Modern temporary contraceptive use among married Myanmar migrant young couples in Samut Prakan Province, Thailand. Faculty of Public Health, Mahidol University, 2009.
23. Oo Y. Factors associated with family planning practice among married Myanmar migrant women in Mae Sot District, Tak Province, Thailand. Faculty of Public Health, Mahidol University, 2013.
24. United Nations Development Program (UNDP). Prevention of HIV and AIDS among migrant workers in Thailand 2010.

25. UNDP, ASEAN. HIV/AIDS & Mobility in South-East Asia: Rapid assessment 2008.
26. International Organization for Migration (IOM). Thailand migration report 2011. [cited 2014 March 31]; Available from: www.un.or.th/documents/tmr-2011.pdf
27. Thwin T. Factors related to the contraceptive use among married migrant women of reproductive age in Maesot, Tak Province, Thailand. MPHM Thesis, Faculty of Graduate Studies, Mahidol University, Thailand 2008.
28. Green LW, Kreuter MW. Health Promotion and Planning: An Ecological Approach. Third ed: Mayfield Publishing Company; 1999.
29. Jamie JG. Factors influencing Filipino couples' desired family size and contraceptive use in the Philippines. Master's thesis, Institute of Population and Reproductive Health Research, Mahidol University 2006.
30. Frost JJ, Singh S, Finer LB. Factors associated with contraceptive use and nonuse, United States, 2004. Perspectives on Sexual and Reproductive Health 2007;39(2):90-9.
31. Helweldery S. Factors influencing contraceptive use among currently married women in Sulawesi, Indonesia. Faculty of Graduate Studies, Mahidol University, 2004.
32. Okect TC. Contraceptive use among women of reproductive age in Kenya's City Slums. International Journal of Business and Social Science 2011;2(1):22-43.
33. Beekle AT, McCabe C. Awareness and determinants of family planning practice in Jimma, Ethiopia. International Nursing Review 2006;53(4):269-76.
34. Lee LK, Chen PCY, Lee KK, Kaur J. Premarital sexual intercourse among adolescents in Malaysia: a cross-sectional Malaysian school survey. Singapore Med J 2006;47(6):476-81.
35. Han WM. Practice of contraception in premarital and marital sexual relationship among Myanmar youth migrants in Bang Bon District, Bangkok and their reproductive health services availability. College of Public Health Scirences, Chulalongkorn University, 2009.

36. Gordon C, Sabates R, Bond R, Wubshet T. Women's education and modern contraceptive use in Ethiopia. International Journal of Education 2011; 3(1).

37. Karim M. Factors influencing family planning practice among rural couples in KhoksaUpazila of Bangladesh. Faculty of Public Health, Mahidol University, 2009.

38. Olaitan OL. Factors influencing the choice of family planning among couples in Southwest Nigeria. International Journal of Medicine and Medical Sciences 2011;3(7):227-32.

39. MacPhail C, Pettifor AE, Pascoe S, Rees HV. Contraception use and pregnancy among 15-24 year old South African women: a nationally representative cross-sectional survey. BioMed Central Medicine 2007;5(31).

40. Yunus MD. Factors related to the acceptance of family planning methods among the married women of reproductive age in MethapukurUpazila, Rangpur District, Bangladesh. Faculty of Graduate Studies, Mahidol University 2006.

41. Khan TU. Factors associated with the acceptance of family planning among married women at reproductive age in UllaparaUpazila, Bangladesh. Faculty of Public Health, Mahidol University 2010.

42. Schoemaker J. Contraceptive use among the poor in Indonesia. International Family Planning Perspectives 2005:31(3):106-114.

43. Garces-Palacioa IC, Altaracb M, Scarincia IC. Contraceptive knowledge and use among low-income Hispanic immigrant women and non-Hispanic women. Contraception 2008;77(4):270-5.

44. Aung LM. Family planning attitude, knowledge and experiences in reproductive age married women in Dawei Township, Myanmar. Faculty of Public Health, Mahidol University 2010.

45. Lwin MM. Factors associated family planning practice among reproductive age married women in Hlaing Township, Myanmar. Faculty of Public Health, Mahidol University 2012.

46. Aung NN. Family planning practice among Kachin women in Mongkok Township, Myanmar. Faculty of Public Health, Mahidol University 2012.

47. Withers M, Kano M, Pinatih GN. Desire for more children, contraceptive use and unmet need for family planning in a remote area of Bali, Indonesia. Journal of Biosocial Science 2010;42(4):549-62.
48. Dhillon BS, Chandhiok N. Contraceptive Use and Desire for More Children in Rural Districts of two States in India: A community based cross sectional study. Indian Council of Medical Research 2012.
49. Joseph EJ. Utilization of family planning services among sexually active people living with HIV/AIDS in TasoTororo. School of Graduate Studies, Makerere University 2010.
50. Bachok N, Razak AA, Ismail NM, Hamzah TNT. Acceptance and Knowledge of Family Planning Among Muslim Women in Rural Villages of Kelantan. Journal of the Indian Medical Association 2007;39:109-16.
51. Tun NMNT. Factors related to contraceptive use among married women in reproductive age, Myoma Village Tract, Tamu Township, Myanmar. Faculty of Public Health, Mahidol University 2009.
52. Ibnouf AH, Borne HW, Maarse JAM. Utilization of family planning services by married Sudanese women of reproductive age. Eastern Mediterranean Health Journal 2007;13(6):1372-81.
53. Chipeta EK, Chimwaza W, Kalilani-Phiri L. Contraceptive Knowledge, Beliefs and Attitudes in Rural Malawi: Misinformation, Misbeliefs and Misperception. Malawi Medical Journal 2010;22(2):38-41.
54. Wang XJ, Lou CH, Gao ES. Relationship between contraceptive use behavior and related knowledge and cognition among vocational high school students. Chinese Journal of Preventive Medicine 2006;40(3):184-8.
55. Kayembe PK, Fatuma AB, Mapatano MA, Mambu T. Prevalence and determinants of the use of modern contraceptive methods in Kinshasa Democratic Republic of Congo. Contraception 2006;74(5):400-6.
56. Webber G, Spitzer D, Somrongthong R, Dat TC, Kounnavongsa S. 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 2012;8(21).

57. Vanhnolrath P. Family planning practice among married women of reproductive age in SamneuaMinicipality, Houaphanh Province, Lao PDR. Faculty of Graduate Studies, Mahidol University 2003.

58. Akintade OL, Pengpid S, Peltzer K. Awareness and use of and barriers to family planning services among female university students in Lesotho. South African Journal of Obstetrics and Gynaecology 2011;17(3):72-8.

59. Samandari G, Speizer IS, O'Connel K. The Role of Social Support and Parity On Contraceptive Use in Cambodia. International Perspectives on Sexual and Reproductive Health 2010;36(3):122-31.

60. Barber SL. Family Planning Advice and Postpartum Contraceptive Use Among Low-Income Women in Mexico. International Family Planning Perspectives 2007;33(1):6-12.

61. Chiang Mai Provincial Statistical Office. Statistics of population from registration record in Chiang Mai provincial: 1977-2008. [cited 2014 March 31]; Available from: www.chiangmai.nso.go.th/chmai/index_oldversion.htm#

62. National Statistical Office. Migration statistical table year 2012.

63. Daniel WW, Cross CL. Biostatistics: a foundation for analysis in health sciences, tenth edition: John Wiley & Sons; 2013.

APPENDICES

APPENDIX A
QUESTIONNAIRE

Utilization of contraceptive methods among Myanmar migrant married women in Chiang Mai, Thailand

All of your answer will be kept confidential and data will be used for research purpose only. Your participation is much appreciated.

ID: __ __ __

Date of interview: ___ /___ /_____ (dd/mm/yyyy)

Name of interviewer: _____

Instruction: Please tick (‼) in the answer box where appropriate.

Section A: Questions on general characteristics		
1	How old are you?	_____ years
2	Registration status	1. ( ) Registered 2. ( ) Unregistered
3	Ethnicity	1. ( ) Burmese 2. ( ) Karen 3. ( ) Mon 4. ( ) Rakhine 5. ( ) Shan 6. ( ) Dawei 7. ( ) Other, please specify _____
4	Duration of stay in Thailand	_____ years _____ months
5	Education	1. ( ) Did not attend school 2. ( ) Read and write 3. ( ) Primary school 4. ( ) Middle school 5. ( ) High school and collage 6. ( ) Graduated
6	Current occupation	1. ( ) Construction worker 2. ( ) Seller 3. ( ) Household job 4. ( ) Dependent 5. ( ) Other, please specify _____
7	Monthly family income	_____ Baht/month
8	Duration of marriage	_____ years
9	Current number of children	_____ person
10	Desired number of children	_____ person

Section B: Questions on utilization of contraceptive methods		
11	Are you and your partner currently using contraceptive methods? *(If the answer is 1, please ask 12 to 15)* *(If the answer is 2, please go to 16)*	1. ( ) Use 2. ( ) Do not use
12	Which method(s) are you and your partner currently using? *(You can answer more than one)* <u>Temporary methods</u> 1. ( ) Oral pills 2. ( ) IUD 3. ( ) Injection 4. ( ) Male condom 5. ( ) Female condom 6. ( ) Emergency contraceptive pills <u>Permanent methods</u> 7. ( ) Tubal ligation 8. ( ) Vasectomy 9. ( ) Other, please specify _____	
13	If you and your partner are currently using temporary contraceptive methods, do you or your partner use regularly?	1. ( ) Yes 2. ( ) No
14	How long have you and your partner been using these methods?	_____ months/years
15	Why do you choose this method? 1. ( ) Convenient 2. ( ) Effective 3. ( ) Easily accessible 4. ( ) Less side effect 5. ( ) Safe 6. ( ) Husband proposed 7. ( ) Other, please specify _____	
16	If you and your partner are not currently using contraceptive methods, did you and your partner use contraceptive methods in the past? *(If the answer is 1, please ask 17 to 19)* *(If the answer is 2, please go to 20)*	1. ( ) Previously Used 2. ( ) Never used
17	Which methods did you and your partner use in the past? *(You can answer more than one)* <u>Temporary methods</u> 1. ( ) Oral pills 2. ( ) IUD 3. ( ) Injection 4. ( ) Male condom 5. ( ) Female condom 6. ( ) Emergency contraceptive pills <u>Permanent methods</u> 7. ( ) Tubal ligation 8. ( ) Vasectomy 9. ( ) Other, please specify _____	

18	If you and your partner used temporary contraceptive methods in the past, did you or your partner use regularly?	1. ( ) Yes 2. ( ) No
19	How long have you and your partner been stopped contraceptive methods?	_____ months/years
20	Why did you and your partner stop contraceptive methods? 1. ( ) Want more children 2. ( ) Cannot effort 3. ( ) Side effects 4. ( ) Service unavailable 5. ( ) Other, please specify _____	
21	If you and your partner never use contraception, what is the most important reason(s) of not using contraceptive methods? 1. ( ) Lack of information 2. ( ) Want more children 3. ( ) Cannot effort 4. ( ) Husband objection 5. ( ) Fear of side effects 6. ( ) Service unavailable 7. ( ) Other, please specify _____	

Section C: Questions on Predisposing factors			
C1. Knowledge of utilization of contraceptive methods			
	Statement	**True**	**False**
22	Using contraceptive methods can reduce unplanned pregnancy.	( )	( )
23	You can receive oral pills, injection and IUD at health centre or clinic.	( )	( )
24	You can buy condom and EC pills at drug store or conveinence shop.	( )	( )
25	You can get tubal ligation at the hospital.	( )	( )
26	If you choose oral pill, you should take it everyday.	( )	( )
27	If you have a health insurance scheme, you can get family planning service for free-of-charge.	( )	( )
28	Oral pill can induce irregular bleeding in the first few months, but it is not harmful.	( )	( )
29	Depo injection should be taken once in 3 months.	( )	( )
30	Depo injection gives more chance to have cervical cancer.	( )	( )
31	IUD method can protect against sexually transmitted infections including HIV.	( )	( )
32	Women can have a loop or coil (IUD) placed inside them to prevent pregnancy by doctor or nurse.	( )	( )
33	If the women do not want the children anymore, sterilization should be used.	( )	( )
34	The man or couple must use condoms or another contraceptive method for 3 months after the vasectomy.	( )	( )
35	Condom can break during sexual intercourse.	( )	( )
36	Using condom properly can prevent the women becoming pregnant.	( )	( )

C2. Attitude towards utilization of contraceptive methods (AG: Agree, UC: Uncertain, DG: Disagree)				
	Statement	**AG**	**UC**	**DG**
37	Practicing contraception is the responsibility of a family who do not want more children.	( )	( )	( )
38	There will be a serious family problem if I use contraceptive methods.	( )	( )	( )
39	My husband agree to use contraceptive methods.	( )	( )	( )
40	I do not like to take oral pill as it can increase body weight.	( )	( )	( )
41	I think the oral pill is not effective in preventing women from getting pregnant.	( )	( )	( )
42	If I happened unprotected sex, then I can take EC pills to prevent getting pregnant.	( )	( )	( )
43	I do not want to take injection because it can cause menstrual irregularities.	( )	( )	( )
44	I do not prefer IUD as it can cause uncomfortable during intercouse.	( )	( )	( )
45	I am nervous to perform tubal ligation.	( )	( )	( )
46	I can loose sexual desire if I choose sterilization.	( )	( )	( )
47	The condoms are not used in casual relationships.	( )	( )	( )
48	Contraceptive use can help a couple in selecting the number of children.	( )	( )	( )
49	Birth spacing is good for mother’s health.	( )	( )	( )
50	Discussion on contraception is shameful among the couple.	( )	( )	( )
51	Most contraceptive methods have more benefit than their side-effect.	( )	( )	( )

Section D: Questions on Enabling factors	
52	Do you know where can you receive contraceptive methods? *(You can answer more than 1)* 1. ( ) Government clinic 2. ( ) Government hospital 3. ( ) Private clinic 4. ( ) NGO clinic 5. ( ) Pharmacy 6. ( ) I do not know 7. ( ) Other, please specify _____
53	What types of contraceptive methods can you get in the facility that you know? *(You can answer more than 1)* <u>Temporary methods</u> 1. ( ) Oral pills 2. ( ) IUD 3. ( ) Injection 4. ( ) Male condom 5. ( ) Female condom 6. ( ) Emergency contraceptive pills <u>Permanent methods</u> 7. ( ) Tubal ligation 8. ( ) Vasectomy 9. ( ) Other, please specify _____
54	How can you reach to the facility that you know? 1. ( ) By walking 2. ( ) By public transportation eg. Bus 3. ( ) Taxi 4. ( ) I do not know 5. Other, please specify _____
55	Do you have any difficulties to go to the facility that you know? 1. ( ) Yes, some/little 2. ( ) Yes, very difficult 3. ( ) No 4. ( ) I do not know
56	In overall, how much does it cost for contraceptive methods in the facility that you know? 1. ( ) _____ Baht 2. ( ) Free of charge 3. ( ) I do not know
57	Do you think getting contraceptive method is expensive for you? 1. ( ) Yes, it is very expensive 2. ( ) Yes, but I can hold it 3. ( ) No, it is reasonable 4. ( ) I do not know
58	Are you satisfied with the facility that you know? 1. ( ) Yes *(Please skip question D9)* 2. ( ) No *(Please skip question D8)*
59	If yes, why do you satisfy? _____ _____
60	If no, why do you not satisfy? _____

	_____
61	What kind of health education materials do you receive in the facility that you know? *(You can answer more than 1)* 1. ( ) Nothing 2. ( ) I do not know 3. ( ) Information about contraception methods and how to use them by health care personnel 4. ( ) Printed media about contraceptive methods 5. ( ) Other, please specify _____
62	How often do you receive information about contraception by health care personnel in the facility that you know? 1. ( ) Regularly 2. ( ) Sometimes 3. ( ) Never 4. ( ) I do not know
63	Do you have a health insurance scheme for your health care? 1. ( ) Yes *(Please ask question 64 and 65)* 2. ( ) No (Please ask question 66)
64	If yes, which type of health insurance scheme do you possess? 1. ( ) 30 baht Universal Coverage Scheme 2. ( ) Social Security Scheme 3. ( ) Other, please specify _____
65	Are you satisfied with the provided health insurance scheme? 1. ( ) Yes 2. ( ) No
66	If you do not have health insurance scheme, why? 1. ( ) I cannot afford to pay 2. ( ) My employer does not want to pay 3. ( ) I do not have legal documents (work permit) 4. ( ) I failed medical test 5. ( ) Other, please specify _____

Section E: Questions on Reinforcing factor (Social Support)										
*In this section, there are 3 level of agreement for each statement which is classified as **SA: Strongly Agree**, **AG: Agree** and **DG: Disagree** for 3 sources of support which is classified as **Husband, Friends** and **Health Care Workers (HCW)**. Please ask the level of agreement for 3 sources of support.*										
No	**Statements**	**Husband**			**Friends**			**HCW**		
		SA	AG	DG	SA	AG	DG	SA	AG	DG
67	You get information about contraceptive methods and family planning services from someone.	( )	( )	( )	( )	( )	( )	( )	( )	( )
68	You get suggestion or advice from someone to receiving contraceptive methods for family planning.	( )	( )	( )	( )	( )	( )	( )	( )	( )
69	You have someone who is supporting the cost for receiving contraceptive methods.	( )	( )	( )	( )	( )	( )	( )	( )	( )
70	Someone help me to receive pamphlets or document of birth spacing practice information.	( )	( )	( )	( )	( )	( )	( )	( )	( )
71	You can discuss someone when you have problem in using contraceptive methods.	( )	( )	( )	( )	( )	( )	( )	( )	( )
72	There is someone who encourages me to use contraception.	( )	( )	( )	( )	( )	( )	( )	( )	( )
73	There is someone who accompanies me to go to contraceptive services.	( )	( )	( )	( )	( )	( )	( )	( )	( )
74	There is someone who take care of my family when I go to contraceptive service.	( )	( )	( )	( )	( )	( )	( )	( )	( )
75	You feel nervous about discussing contraception with someone.	( )	( )	( )	( )	( )	( )	( )	( )	( )
76	Someone think that you are recognized as a good practice of contraceptive methods.	( )	( )	( )	( )	( )	( )	( )	( )	( )
77	Someone think that you are the one who can give information of family planning to others.	( )	( )	( )	( )	( )	( )	( )	( )	( )

I could like to thank very much with your cooperation.

APPENDIX B

QUESTIONNAIRE (MYANMAR VERSION)

ထိုင်းနိုင်ငံ၊ ချင်းမိုင်မြို့ ရှိ အိမ်ထောင်ရှိသော ရွှေ့ပြောင်းမြန်မာအမျိုးသမီးများတွင် သားဆက်ခြားနည်းလမ်းများ အသုံးပြုခြင်းအကြောင်း လေ့လာခြင်း

ဤမေးခွန်းလွှာသည် ကျမ်းပြုစုရန်အတွက်သာဖြစ်ပြီး ဖြေဆိုသည့် အဖြေများအားလုံးသည် လျို့ဝှက်ထားပေးမည်ဖြစ်ကြောင်း ဖြေဆိုမည့်သူအား အသိပေးအပ်ပါသည်။ ဤသုတေသနတွင် ပါဝင်ခြင်းအတွက် ကျေးဇူးအထူးတင်ရှိပါသည်။

နံပါတ်စဉ်: __ __ __
နေ့စွဲ: ___ /___ /_____ (ရက်/လ/နှစ်)
မေးသူအမည်: _____

ညွှန်ကြားချက်: ကျေးဇူးပြု၍ အဖြေကို (✓) ထဲတွင် အမှန်ခြစ်ပေးရန်နှင့် လိုအပ်သော ကွက်လပ်များတွင် ဖြည့်စွက်ရေးသားပေးရန်။

အပိုင်း (က) ။ ကိုယ်ရေးအချက်အလက်များနှင့် ပတ်သက်သော မေးခွန်းများ		
၁	အသက်	_____ နှစ်
၂	သင် ထိုင်းနိုင်ငံတွင် ရွှေ့ပြောင်း အလုပ်သမားအဖြစ် မှတ်ပုံ တင်ပြီးပြီ လား။	၁။ ( ) မှတ်ပုံတင်ထားပါသည် ၂။ ( ) မှတ်ပုံမတင်ရသေးပါ
၃	လူမျိုး	၁။ ( ) မြန်မာ ၂။ ( ) ကရင် ၃။ ( ) မွန် ၄။ ( ) ရခိုင် ၅။ ( ) ရှမ်း ၆။ ( ) ထားဝယ် ၇။ ( ) အခြား, ဖေါ်ပြပေးပါ _____
၄	သင် ထိုင်းနိုင်ငံတွင် နေထိုင်တာ ဘယ်လောက်ကြာပြီလဲ	_____ နှစ် _____ လ
၅	ပညာအရည်အချင်း	၁။ ( ) ကျောင်းမတက်ခဲ့ပါ ၂။ ( ) ရေးတတ်/ဖတ်တတ် ၃။ ( ) မူလတန်း ၄။ ( ) အလယ်တန်း ၅။ ( ) အထက်တန်းနှင့် ကောလိပ် ၆။ ( ) ဘွဲ့ရ
၆	လက်ရှိအလုပ်အကိုင်	၁။ ( ) ဆောက်လုပ်ရေး ၂။ ( ) စျေးရောင်း ၃။ ( ) အိမ်ဖေါ် ၄။ ( ) မှီခို ၅။ ( ) အခြား၊ ဖေါ်ပြပေးပါ _____
၇	မိသားစုတစ်လပျမ်းမျှဝင်ငွေ	_____ ဘတ်ငွေ/တစ်လ
၈	သင် အိမ်ထောင်ကျတာ ဘယ် လောက် ကြာပြီလဲ။	_____ နှစ်
၉	လက်ရှိကလေးအရေအတွက်	_____ ယောက်
၁၀	သင့်မှာ ရွေးချယ်ခွင့်ရှိလျှင် သားသမီး	_____ ယောက်

	ဘယ်နှစ်ယောက် လိုချင်ပါသလဲ	

အပိုင်း (ခ) ။ သားဆက်ခြားနည်းလမ်းများ အသုံးပြုခြင်းနှင့် ပတ်သက်သော မေးခွန်းများ		
၁၁	သင်နှင့် သင့်အိမ်ထောင်ဖက်သည် ယခုအချိန်တွင် သားဆက်ခြား နည်းလမ်းများ အသုံးပြုနေပါသလား။ ၁။ ( ) အသုံးပြုနေပါသည်။ (မေးခွန်း ခ၂ မှ ခ၅ အား မေးပါရန်။) ၂။ ( ) အသုံးမပြုပါ။ (မေးခွန်း ခ၆ သို့ ကျော်မေးရန်)	
၁၂	ယခုအချိန်တွင် သင်နှင့် သင့်အိမ်ထောင်ဖက်သည် မည်သည့် သားဆက်ခြားနည်းလမ်းများအား အသုံးပြုနေပါသနည်း။ (တစ်ခုထက်ပို၍ ဖြေဆိုနိုင်ပါသည်။) ယာယီသားဆက်ခြားနည်းလမ်းများ ၁။ ( ) သောက်ဆေး ၂။ ( ) သားအိမ်ထဲ ထည့်သည့် ပစ္စည်း ၃။ ( ) ထိုးဆေး ၄။ ( ) ယောကျ်ားကွန်ဒုံး ၅။ ( ) မိန်းမကွန်ဒုံး ၆။ ( ) အရေးပေါ် သောက်ဆေး အမြဲသားဆက်ခြားနည်းလမ်းများ ၇။ ( ) မိန်းမ အသားကြောဖြတ်ခြင်း ၈။ ( ) ယောကျ်ား အသားကြောဖြတ်ခြင်း ၉။ ( ) အခြား, ဖေါ်ပြပေးပါ_____	
၁၃	အကယ်၍ ယာယီသားဆက်ခြားနည်းလမ်းများ အသုံးပြုနေလျှင် ပုံမှန်အသုံးပြုပါရဲ့လား။	၁။ ( ) ပုံမှန်အသုံးပြုပါသည်။ ၂။ ( ) ပုံမှန်အသုံးမပြုပါ။
၁၄	၄င်းနည်းလမ်း(များ)ကို အသုံးပြုနေသည်မှာ ဘယ်လောက်ကြာပြီလဲ။	_____ လ (သို့) နှစ်
၁၅	အဘယ်ကြောင့် ၄င်းနည်းလမ်း(များ)ကို အသုံးပြုနေပါသနည်း။ ၁။ ( ) အသုံးပြုရတာ အဆင်ပြေသောကြောင့် ၂။ ( ) အစွမ်းထက်သောကြောင့် ၃။ ( ) အလွယ်တကူ ရရှိနိုင်သောကြောင့် ၄။ ( ) ဘေးထွက်ဆိုးကျိုးနဲသောကြောင့် ၅။ ( ) ဘေးအန္တရယ်ကင်းသည်ဟု ယူဆသောကြောင့် ၆။ ( ) အိမ်ထောင်ဖက်က အကြံပေးသောကြောင့် ၇။ ( ) အခြား, ဖေါ်ပြပေးပါ _____	
၁၆	အကယ်၍ သင်နှင့် သင့်အိမ်ထောင်ဖက်သည် ယခုလတ်တလော သားဆက်ခြားနည်းလမ်းများ အသုံးမပြုပါက အရင်က သားဆက်ခြား နည်းလမ်း(များ)အား အသုံးပြုခဲ့ပါသလား။ ၁။ ( ) အရင်က အသုံးပြုခဲ့ပါသည်။ (မေး ခွန်း ၁၇ မှ ၁၉ အား မေးပါရန်။) ၂။ ( ) အရင်က အသုံးမပြုခဲ့ဖူးပါ။ (မေး ခွန်း ၂၀ သို့ ကျော်မေးပါရန်)	
၁၇	အရင်က မည်သည့် သားဆက်ခြားနည်းလမ်းများ အသုံးပြုခဲ့ပါသနည်း။ (တစ်ခုထက်ပို၍ ဖြေဆိုနိုင်ပါသည်။)	

	<u>ယာယီသားဆက်ခြားနည်းလမ်းများ</u> ၁။ ( ) သောက်ဆေး ၂။ ( ) သားအိမ်ထဲ ထည့်သည့် ပစ္စည်း ၃။ ( ) ထိုးဆေး ၄။ ( ) ယောကျ်ားကွန်ဒုံး ၅။ ( ) မိန်းမကွန်ဒုံး ၆။ ( ) အရေးပေါ် သောက်ဆေး <u>အမြဲသားဆက်ခြားနည်းလမ်းများ</u> ၇။ ( ) မိန်းမ အသားကြောဖြတ်ခြင်း ၈။ ( ) ယောကျ်ား အသားကြောဖြတ်ခြင်း ၉။ ( ) အခြား, ဖေါ်ပြပေးပါ _____	
၁၈	အကယ်၍ အရင်က ယာယီ သားဆက်ခြားနည်းလမ်းများ အသုံးပြုခဲ့ ပါက ပုံမှန်အသုံးပြုခဲ့ပါရဲ့လား။	၁။ ( ) ပုံမှန်အသုံးပြုပါသည်။ ၂။ ( ) ပုံမှန်အသုံးမပြုပါ။
၁၉	သားဆက်ခြားနည်းလမ်းများ အသုံးမပြုတော့သည်မှာ ဘယ်လောက် ကြာပြီလဲ။	_____ လ/နှစ်
၂၀	သင်နှင့်သင့်အိမ်ထောက်ဖက်သည် ဘာကြောင့် သားဆက်ခြားနည်းလမ်းများ အသုံးပြုသည်ကို ရပ်လိုက်ရတာလဲ။ ၁။ ( ) ကလေးနောက်ထပ်လိုချင်၍ ၂။ ( ) ပိုက်ဆံ မတတ်နိုင်၍ ၃။ ( ) ဘေးထွက်ဆိုးကျိုးများကို ခံစားရ၍ ၄။ ( ) သားဆက်ခြားဖန်ဆောင်မှုလုပ်ငန်းများ မရရှိနိုင်တော့၍ ၅။ ( ) အခြား၊ ဖေါ်ပြရန် _____	
၂၁	မည်သည့်အကြောင်းအရင်းများကြောင့် သင်နှင့်သင့်အိမ်ထောင်ဖက်သည် သားဆက်ခြားနည်းလမ်းများကို အသုံးမပြုရသနည်း။ ၁။ ( ) သားဆက်ခြားနည်းလမ်းများအကြောင်းမသိ၍ ၂။ ( ) ကလေးလိုချင်၍ ၃။ ( ) ပိုက်ဆံမတတ်နိုင်၍ ၄။ ( ) အိမ်ထောင်ဘက်က သဘောမတူ၍ ၅။ ( ) ဘေးထွက်ဆိုးကျိုးများခံစားရမည်ကိုကြောက်၍ ၆။ ( ) သားဆက်ခြားဖန်ဆောင်မှုလုပ်ငန်းများမရှိ၍ ၇။ ( ) အခြား၊ ဖေါ်ပြရန် _____	

အပိုင်း (၈)။ အလားအလာ ဖန်တီးပေးသော အချက်များနှင့် ပတ်သက်သော မေးခွန်းများ			
၈(၁)။ သားဆက်ခြားနည်းလမ်းများ အသုံးပြုခြင်းနှင့် ပတ်သက်သော ဗဟုသုတ			
	မေးခွန်းများ	**မှန်**	**မှား**
၂၂	သားဆက်ခြားနည်းလမ်းများ အသုံးပြုခြင်းသည် အစီအစဉ်မရှိပဲ ကိုယ်ဝန်ဆောင်ခြင်းကို လျော့ချနိုင်ပါသည်။	( )	( )
၂၃	သင်သည် ကိုယ်ဝန်တား သောက်ဆေး၊ ထိုးဆေးနှင့် သားအိမ်အတွင်း ပစ္စည်းထည့်ခြင်းတို့ကို ကျန်းမာရေးဌာန (သို့) ဆေးခန်းများတွင် ရယူနိုင်ပါသည်။	( )	( )
၂၄	သင်သည် ကွန်ဒုံး (သို့) အရေးပေါ်ကိုယ်ဝန်တားဆေးတို့ကို ဆေးဆိုင် (သို့) စတိုးဆိုင်များတွင် ဝယ်ယူနိုင်ပါသည်။	( )	( )
၂၅	သင်သည် အမျိုးသမီးအသားကြောဖြတ်ခြင်းကို ဆေးရုံများတွင် ပြုလုပ်နိုင်သည်။	( )	( )
၂၆	သင်သည် ကိုယ်ဝန်တားသောက်ဆေးကို ရွေးချယ်ခဲ့လျှင် ၄င်းသောက်ဆေးကို နေ့စဉ် သောက်သုံးရမည်။	( )	( )
၂၇	အကယ်၍ သင့်တွင် ကျန်းမာရေး စောင့်ရှောက်မှု အာမခံ ရှိပါက သင်သည် သားဆက်ခြားခြင်း ဝန်ဆောင်မှု လုပ်ငန်းများကို အခမဲ့ရရှိနိုင်ပါသည်။	( )	( )
၂၈	ကိုယ်ဝန်တားသောက်ဆေးများသည် စသောက်ပြီး လအနည်းငယ်အတွင်း ဓမ္မတာရာသီသွေးမပေါ်ခြင်း၊ မမှန်ခြင်း ဖြစ်စေနိုင်သော်လည်း ကျန်းမာရေးအတွက် စိုးရိမ်စရာ မရှိပါ။	( )	( )
၂၉	သုံးလတစ်ခါ ဒက်ပိုထိုးဆေးထိုးပြီး ကိုယ်ဝန်မရအောင် တားဆီးနိုင်သည်။	( )	( )
၃၀	ဒက်ပိုထိုးဆေးသည် သားအိမ်ခေါင်းကင်ဆာရောဂါကို ဖြစ်စေနိုင်ပါသည်။	( )	( )
၃၁	သားအိမ်အတွင်း ပစ္စည်းထည့်ခြင်းသည် လိင်ဆက်ဆံရာမှတဆင့် ကူးစက်တတ်သော ရောဂါများ (ဥပမာ။ အိပ်ချ်အိုင်ဗွီ) ကူးစက်ခံရမှုကို ကာကွယ်ပေးနိုင်ပါသည်။	( )	( )
၃၂	သားအိမ်အတွင်း ပစ္စည်းထည့်ပြီး ကိုယ်ဝန်မရအောင် တားဆီးနိုင်သည်။	( )	( )
၃၃	အကယ်၍ သင်သည် နောက်ထပ်ကလေးမလိုချင်တော့ပါက အသားကြောဖြတ်သည့်နည်းလမ်းကို အသုံးပြုသင့်သည်။	( )	( )

၃၄	အမျိုးသား အသားကြောဖြတ်ပြီး နောက်၃လအတွင်း ကိုယ်ဝန်မရအောင် ကွန်ဒုံး (သို့) အခြား သားဆက်ခြားနည်းလမ်း တစ်ခုခုကို အသုံးပြုသင့်သည်။	( )	( )
၃၅	လိင်ဆက်ဆံနေစဉ်အတွင်း ကွန်ဒုံး ပေါက်ပြဲတတ်သည်။	( )	( )
၃၆	ကွန်ဒုံးကို စနစ်တကျ အသုံးပြုခြင်းဖြင့် ကိုယ်ဝန်မရအောင် ကာကွယ်နိုင်ပါသည်။	( )	( )

ဂ(၂)။ သားဆက်ခြားနည်းလမ်းများ အသုံးပြုခြင်းနှင့် ပတ်သက်၍ မိမိ၏ သဘောထားအမြင်				
	မေးခွန်းများ	**သဘောတူ**	**မသေချာ**	**သဘောမတူ**
၃၇	ကလေးနောက်ထပ် မလိုအပ်သော မိသားစုများသည် သားဆက်ခြားနည်းလမ်း များ အသုံးပြုသင့်သည်။	( )	( )	( )
၃၈	အကယ်၍ ကျွန်မ သားဆက်ခြားနည်းလမ်းများ အသုံးပြုမိပါက ဆိုးရွားသော မိသားစု ပြဿနာများ ဖြစ်စေနိုင်ပါသည်။	( )	( )	( )
၃၉	ကျွန်မ၏ အိမ်ထောင်ဘက်သည် သားဆက်ခြားနည်းလမ်းများ အသုံးပြုရန် သဘောတူပါသည်။	( )	( )	( )
၄၀	ကိုယ်ဝန်တားဆေးဆက်များသည် ဝစေနိုင်သောကြောင့် မသောက်သုံးလိုပါ။	( )	( )	( )
၄၁	ကိုယ်ဝန်တားဆေးဆက်များသည် ကိုယ်ဝန်မရအောင် တားဆီးရာတွင် အစွမ်းမထက်ဟု ကျွန်မထင်ပါသည်။	( )	( )	( )
၄၂	အကယ်၍ သားဆက်ခြားနည်းလမ်းများ အသုံးမပြုပဲ အိမ်ထောင်ဘက်နှင့် အတူ နေမိခဲ့လျှင် ကလေးမရအောင် အရေးပေါ် ကိုယ်ဝန်တား ဆေးဆက်များ အသုံးပြုနိုင်သည်။	( )	( )	( )
၄၃	ထိုးဆေးများသည် ဓမ္မတာရာသီသွေး မပေါ်ခြင်း၊ မမှန်ခြင်းတို့ ဖြစ်စေနိုင် သောကြောင့် ကျွန်မမကြိုက်ပါ။a	( )	( )	( )
၄၄	သားအိမ်အတွင်း ပစ္စည်းထည့်၍ သန္ဓေတားခြင်းနည်းလမ်းသည် အိမ်ထောင်ဘက် နှင့် အတူနေရာတွင် အနှောင့်အယှက် ဖြစ်စေသောကြောင့် ကျွန်မမကြိုက်ပါ။	( )	( )	( )
၄၅	ကျွန်မအသားကြောဖြတ်ရန် ကြောက်ပါသည်။	( )	( )	( )
၄၆	အကယ်၍ ကျွန်မအသားကြောဖြတ်လိုက်ပါက အိမ်ထောင်ဘက်နှင့် အတူနေရာတွင် အဆင်မပြေ ဖြစ်စေနိုင်ပါသည်။	( )	( )	( )
၄၇	မိမိ၏ အိမ်ထောင်ဘက်နှင့် အတူနေရာတွင် ကွန်ဒုံးသုံးရန် မလိုအပ်ပါ။	( )	( )	( )
၄၈	သားဆက်ခြားနည်းလမ်းများ အသုံးပြုခြင်းအားဖြင့် ကျွန်မတို့ မိသားစုသည်	( )	( )	( )

	လိုချင်သော ကလေးအရေအတွက်အတိုင်း ရရှိအောင် ပြုလုပ်နိုင်ပြီ ဖြစ်သည်။			
၄၉	သားဆက်ခြားခြင်းသည် မိခင်၏ ကျန်းမာရေးကို ကောင်းမွန်စေပါသည်။	( )	( )	( )
၅၀	လင်မယားနှစ်ယောက် သားဆက်ခြားနည်းလမ်းများ အသုံးပြုရန်အတွက် ဆွေးနွေးတိုင်ပင်ခြင်းသည် ရှက်စရာ ဖြစ်သည်။	( )	( )	( )
၅၁	သားဆက်ခြားနည်းလမ်းများ အသုံးပြုခြင်းသည် ဆိုးကျိုးထက် ကောင်းကျိုးက ပို၍ များပါသည်။	( )	( )	( )

အပိုင်း (ဃ)။ အထောက်အကူပြုသော အချက်များနှင့် ပတ်သက်သော မေးခွန်းများ	
၅၂	သားဆက်ခြားနည်းလမ်းများအား ရရှိနိုင်သော နေရာများကို သင်သိပါသလား။ ၁။ ( ) အစိုးရကျန်းမာရေးဌာန ၂။ ( ) အစိုးရဆေးရုံ ၃။ ( ) ပုဂ္ဂလိကဆေးရုံ ၄။ ( ) အန်ဂျီအိုဆေးခန်း ၅။ ( ) ဆေးဆိုင် ၆။ ( ) မသိပါ ၇။ ( ) အခြား၊ ဖေါ်ပြပေးပါ။ _____
၅၃	သင်သိသော နေရာများတွင် မည်သည့် သားဆက်ခြားနည်းလမ်းများ ရရှိနိုင်ပါသနည်း။ <u>ယာယီသားဆက်ခြားနည်းလမ်းများ</u> ၁။ ( ) သောက်ဆေး ၂။ ( ) သားအိမ်ထဲ ထည့်သည့် ပစ္စည်း ၃။ ( ) ထိုးဆေး ၄။ ( ) ယောကျ်ားကွန်ဒုံး ၅။ ( ) မိန်းမကွန်ဒုံး ၆။ ( ) အရေးပေါ် သောက်ဆေး <u>အမြဲသားဆက်ခြားနည်းလမ်းများ</u> ၇။ ( ) မိန်းမ အသားကြောဖြတ်ခြင်း ၈။ ( ) ယောကျ်ား အသားကြောဖြတ်ခြင်း ၉။ ( ) အခြား, ဖေါ်ပြပေးပါ _____
၅၄	သားဆက်ခြားနည်းလမ်းများ ရယူရန်အတွက် သင်သိသောနေရာသို့ ဘယ်လိုသွားရသနည်း။ ၁။ ( ) လမ်းလျှောက်၍ ၂။ ( ) အများသုံး ဘတ်စ်ကား ၃။ ( ) တက်စီ ၄။ ( ) မသိပါ ၅။ အခြား၊ ဖေါ်ပြပေးပါ။ _____
၅၅	သားဆက်ခြားနည်းလမ်းများ ရယူရန်အတွက် သင်သိသောနေရာကို သွားရာတွင် အခက်အခဲရှိပါသလား။ ၁။ ( ) အနည်းငယ်ရှိပါသည် ၂။ ( ) အလွန်ခက်ခဲပါသည် ၃။ ( ) အခက်အခဲမရှိပါ ၄။ ( ) မသိပါ
၅၆	သားဆက်ခြားနည်းလမ်းများ ရယူရန်အတွက် ဘယ်လောက်ကုန်ပါသလဲ။ ၁။ ( ) _____ ဘတ် ၂။ ( ) ငွေကြေးမကုန်ကြပါ ၃။ ( ) မသိပါ
၅၇	သားဆက်ခြားနည်းလမ်းများ ရယူရန်အတွက် ကုန်ကျငွေသည် ဈေးကြီးသည်ဟု သင်ထင်ပါသလား။

	၁။ ( ) အလွန်ဈေးကြီးပါသည် ၂။ ( ) ဈေးကြီးသော်လည်းပဲ တတ်နိုင်ပါသည် ၃။ ( ) ဈေးမကြီးပါ ၄။ ( ) မသိပါ
၅၈	သားဆက်ခြားနည်းလမ်းများ ရယူရန်အတွက် သင်သိသောနေရာနှင့် ပတ်သက်၍ စိတ်ကျေနပ်မှု ခံစားရပါသလား။ ၁။ ( ) ခံစားရပါသည် (မေးခွန်း ၅၉ အား ကျော်မေးပါရန်) ၂။ ( ) မခံစားရပါ (မေးခွန်း ၅၈ အား ကျော်မေးပါရန်)
၅၉	အဘယ်ကြောင့် သင်စိတ်ကျေနပ်မှု ခံစားရပါသလဲ။ ကျေးဇူးပြုပြီး ဖြေဆိုပေးပါ ခင်ဗျာ။ _____ _____
၆၀	အဘယ်ကြောင့် သင်စိတ်ကျေနပ်မှု မခံစားရပါသလဲ။ ကျေးဇူးပြုပြီး ဖြေဆိုပေးပါ ခင်ဗျာ။ _____ _____
၆၁	သားဆက်ခြားနည်းလမ်းများကို ရယူရန်အတွက် သင်သိသောနေရာတွင် မည်သည့် ကျန်းမာရေးပညာပေး ပစ္စည်းများ ရရှိနိုင်ပါသလဲ။ (တစ်ခုထက်ပို၍ ဖြေဆိုနိုင်ပါသည်) ၁။ ( ) ဘာမှမရရှိပါ ၂။ ( ) မသိပါ ၃။ ( ) ကျန်းမာရေးဝန်ထမ်းများမှ သားဆက်ခြားနည်းလမ်းများနှင့် အသုံးပြုပုံအကြောင်း ပြောကြားချက်များ ၄။ ( ) သားဆက်ခြား နည်းလမ်းများနှင့် ပတ်သက်၍ မြန်မာ ဘာသာဖြင့် ပုံနှိပ် ရိုက်ဝေ ထားသော လက်ကမ်းစာ ဆောင်များ၊ ပိုစတာများ ၅။ ( ) အခြား၊ ဖေါ်ပြပေးပါ _____
၆၂	သားဆက်ခြားနည်းလမ်းများကို ရယူရန်အတွက် သင်သိသောနေရာတွင် ကျန်းမာရေးဝန်ထမ်းများမှ သားဆက်ခြားနည်းလမ်းများအကြောင်းကို ပုံမှန်ပြောပြဆွေးနွေးပါသလား။ ၁။ ( ) ပုံမှန် ၂။ ( ) တစ်ခါတစ်ရံ ၃။ ( ) မပြောပြပါ ၄။ ( ) မသိပါ
၆၃	သင့်တွင် ကျန်းမာရေးအာမခံ ရှိပါသလား။ ၁။ ( ) ရှိပါသည် ၂။ ( ) မရှိပါ
၆၄	မည်သည့် ကျန်းမာရေး အာမခံစနစ်ကို သင်ပိုင်ဆိုင်ထားပါသလဲ။ ၁။ ( ) ဘတ် ၃၀ ကျန်းမာရေး စောင့်ရှောက်မှု စနစ် ၂။ ( ) လူမှုဖူလုံရေး ကျန်းမာရေး စောင့်ရှောက်မှု စနစ် ၃။ ( ) အခြား၊ ဖေါ်ပြပေးပါ _____
၆၅	သင်သည် သင်ပိုင်ဆိုင်သော ကျန်းမာရေး အာမခံစနစ်ကို စိတ်ကျေနပ်ပါရဲ့လား။ ၁။ ( ) စိတ်ကျေနပ်ပါသည် ၂။ ( ) စိတ်မကျေနပ်ပါ
၆၆	အဘယ်ကြောင့် သင့်တွင် ကျန်းမာရေး အာမခံ မရှိပါသလဲ။ ၁။ ( ) ကျန်းမာရေး အာမခံ ဂယ်ရန် မတတ်နိုင်၍ ၂။ ( ) အလုပ်ရှင်က မပေးလို၍ ၃။ ( ) တရားဝင် စာရွက်စာတမ်း (အလုပ်ပါမစ်) မရှိ၍

	၄။ ( ) ကျန်းမာရေး စစ်ဆေးမှု ကျရှုံး၍ ၅။ ( ) အခြား၊ ဖေါ်ပြပေးပါ _____

အပိုင်း (c) ။ လူမှုရေးဆိုင်ရာ အကူအညီများနှင့် ပတ်သက်သော မေးခွန်းများ										
ဤအပိုင်း (c) မေးခွန်းများတွင် အိမ်ထောင်ဘက်၊ သူငယ်ချင်းများနှင့် ကျန်းမာရေး ဝန်ထမ်းများမှ လူမှုရေး အကူအညီများနှင့် ပတ်သက်သော မေးခွန်းများကို ဖြေကြားသူ၏ သဘောတူညီမှု အတိုင်းအတာအား မေးရန် ဖြစ်ပါသည်။ ဖြေကြားသူ၏ သဘောတူညီမှုကို "အလွန်သဘောတူပါသည်" (သို့) "သဘောတူပါသည်" (သို့) "သဘောမတူပါ" ဟူ၍ အဆင့် (၃) ဆင့် ခွဲခြားထားပါသည်။										
နံပါတ်	မေးခွန်းများ	အိမ်ထောင်ဘက်			သူငယ်ချင်းများ			ကျန်းမာရေး ဝန်ထမ်းများ		
		အလွန်တူ	တူ	မတူ	အလွန်တူ	တူ	မတူ	အလွန်တူ	တူ	မတူ
၆၇	ကျွန်မသည် သားဆက်ခြားနည်းလမ်း များနှင့် ၎င်းတို့ကို ရရှိနိုင်သော နေရာ များကို တစ်ဦးတစ်ယောက်ဆီမှ သိရှိ ရပါသည်။	( )	( )	( )	( )	( )	( )	( )	( )	( )
၆၈	ကျွန်မကို သားဆက်ခြားနည်းလမ်းများ အသုံးပြုရန် တစ်ဦးတစ်ယောက်က အကြံပေးသည်။	( )	( )	( )	( )	( )	( )	( )	( )	( )
၆၉	သားဆက်ခြား နည်းလမ်းများကို အသုံးပြုရန် တစ်ဦး တစ်ယောက်က ငွေကြေးထောက်ပံ့မှု ပေးသည်။	( )	( )	( )	( )	( )	( )	( )	( )	( )
၇၀	ကျွန်မသည် သားဆက်ခြား နည်းလမ်းများနှင့် ပတ်သက်သော လက်ကမ်းစာဆောင်များကို တစ်ဦး တစ်ယောက်ဆီမှ လက်ခံရရှိပါသည်။	( )	( )	( )	( )	( )	( )	( )	( )	( )
၇၁	ကျွန်မသည် သားဆက်ခြား နည်းလမ်းများ အသုံးပြုခြင်းကြောင့် ဖြစ်လာသည့် ပြဿနာများကို တစ်ဦး တစ်ယောက်နှင့် ဆွေးနွေးတိုင်ပင်နိုင်သည်။	( )	( )	( )	( )	( )	( )	( )	( )	( )

၇၂	တစ်ဦးတစ်ယောက်သည် ကျွန်မကို သားဆက်ခြား နည်းလမ်းများ အသုံးပြုရန်အတွက် အားပေးပါသည်။	( )	( )	( )	( )	( )	( )	( )	( )	( )
၇၃	ကျွန်မ သားဆက်ခြား နည်းလမ်းများ ရရှိနိုင်သည့် နေ ရာကို သွားရာတွင် အဖော်လိုက်ပေးမည့်သူ ရှိသည်။	( )	( )	( )	( )	( )	( )	( )	( )	( )
၇၄	ကျွန်မ သားဆက်ခြား နည်းလမ်းများ ရရှိနိုင်သည့် နေ ရာကို သွားသောအခါ အိမ်တွင် ကျန်ခဲ့သော ကလေးများကို စောင့်ရှောက်ပေးမည့်သူ ရှိပါသည်။	( )	( )	( )	( )	( )	( )	( )	( )	( )
၇၅	ကျွန်မသည် သားဆက်ခြား နည်းလမ်းများ ပတ်သက်၍ တစ်ဦးတစ်ယောက်နှင့် ဆွေးနွေးတိုင်ပင် ရန် ကြောက်သည်။	( )	( )	( )	( )	( )	( )	( )	( )	( )
၇၆	တစ်ဦးတစ်ယောက်က ကျွန်မသည် သားဆက်ခြား နည်းလမ်းများအား မှန်မှန်ကန်ကန် အသုံးပြုနိုင်သည် ဟု ယူဆကြသည်။	( )	( )	( )	( )	( )	( )	( )	( )	( )
၇၇	တစ်ဦးတစ်ယောက်က ကျွန်မသည် အခြားသူများ အား သားဆက်ခြား နည်းလမ်းများနှင့် ပတ်သက်၍ ကောင်းမွန်စွာ အကြံပေးနိုင်သူဟု ယူဆကြသည်။	( )	( )	( )	( )	( )	( )	( )	( )	( )

ပါဂင်ဖြေဆိုပေးမှုအတွက် ကျေးဇူးအထူးတင်ရှိပါသည်။

APPENDIX C

ETHICAL APPROVAL

Certificate of Approval
Ethical Review Committee for Human Research
Faculty of Public Health, Mahidol University

COA. No. MUPH 2014-016

Protocol Title :	UTILIZATION OF CONTRACEPTIVE METHODS AMONG MYANMAR MIGRANT MARRIED WOMEN IN CHIANG MAI, THAILAND
Protocol No. :	178/2556
Principal Investigator :	Dr. Thet Ko Aung
Affiliation :	Master of Public Health (International Program) Faculty of Public Health, Mahidol University
Approval Includes :	1. Project proposal 2. Information sheet 3. Informed consent form 4. Data collection form/Program or Activity plan
Date of Approval :	14 January 2014
Date of Expiration :	13 January 2015

The aforementioned project have been reviewed and approved according to the Declaration of Helsinki by Ethical Review Committee for Human Research, Faculty of Public Health, Mahidol University.

S Nanthamongkolchai

(Assoc. Prof. Dr. Sutham Nanthamongkolchai)
Chairman of Ethical Review Committee for Human Research

(Assoc. Prof. Dr. Phitaya Charupoonphol)
Dean of Faculty of Public Health

420/1 Rajvithi Road, Bangkok, Thailand 10400
Tel. (662) 3548543-9 ext. 1127, 7404 Fax. (662) 6409854

APPENDIX D

INFORMATION SHEET

EC-3 Form

1.Title of project: Utilization of contraceptive methods among Myanmar migrant married women in Chiang Mai, Thailand

2.Study site: Chiang Mai, Chiang Mai Province, Thailand

3.This project is conducted by Dr. Thet Ko Aung **under supervision of Major Advisor** Assist. Prof. Dr. Pimsurang Taechaboonsermsak.

Dr. Thet Ko Aung, Contact address: VM Mansion, Room 610, 102 Soi Rachavitee 2, Samsainnai District, Phayathai, Bangkok 10400, Thailand. Tel: 09-0889-6664 Fax: 02-246-8352 E-mail: dr.thetko@gmail.com

Assist. Prof. Dr. Pimsurang Taechaboonsermsak, Contact address: Department of Family Health, Faculty of Public Health, Mahidol University, 420/1 Rajvithi Road, Rajthavee, Bangkok 10400, Thailand. Tel: 082-656-4699 E-mail: pimsurang.tae@mahidol.ac.th

4.Brief Background, Rationale: (use simple word, understandable by volunteer participant)

Reproductive health is an important component of Millennium Development Goals. Family planning is a fundamental component of reproductive health as it allows for determining the spacing of pregnancies. Ensuring basic access to family planning could reduce maternal deaths by a third and child deaths by as much as twenty percent and also can have a significant impact on society and country development in achieving towards health-related MDGs. Moreover, reproductive health is one of the major concerns of migrant women. One study from Mahidol University revealed that the modern contraceptive prevalence rate is lowest among Cambodia migrants (54%) while it is highest among Myanmar migrants (72%), but it is still lower than that of Thai population (79.8%). Besides, the total fertility rate among migrant workers was more than two times higher than the Thai population at 3.6 per woman. Moreover, Thailand Ministry of Health has recorded the rate of abortion in Myanmar migrant women is 2.4 times higher that of local Thai population. For the above reasons, further information of why Myanmar migrant married women use or do not use the contraceptive methods will be needed to investigate. Therefore, the researcher would like to conduct the research to identify the prevalence and determinants of utilization of contraceptive methods among Myanmar migrant married women. Chiang Mai is chosen as my study area because little is known about the prevalence and determinants of utilization of contraceptive methods among Myanmar migrant married women in Chiang Mai.

5.Objectives:

- To determine proportion of utilization of contraceptive methods and its related factors among Myanmar migrant married women in Chiang Mai, Thailand

6.You are invited to be a volunteer/subject to participate in the project:

You are invited to be a volunteer to participate in this project because you are currently living as a married migrant worker in Chiang Mai. Because the goal of this project is to survey on the prevalence and determinants of utilization of contraceptive methods among Myanmar Migrant married women in Chiang Mai, Thailand.

7. Research activities which involving you when you volunteer to participate in
this research project will be as following: (focus on the parts that involve volunteers/subjects)

If you voluntarily agree to be a respondent, the researcher would like you to sign a written informed consent form. Then the researcher will ask you with a set of questionnaire, which will include questions about your general characteristics, utilization of contraceptive methods, knowledge about and attitude towards utilization of contraceptive methods, availability and accessibility to contraceptive services, accessibility to health education materials, accessibility to health insurance scheme and social support.

8.Period of time that you will be involved in this research activities (Treatment/data collection):

The whole process will take around 20-30 minutes.

9.Expected benefits of the project to you and to others:

This study will not directly benefit you, but the result of this study will be useful for Thai government sector and non-governmental organization to improve the future health promotion intervention regarding with family planning among Myanmar migrant women in your area and other provinces of Thailand.

10.Risks or any undesirable that may occur to you caused by this research and measure or prevention and risk reclusion method which will be provided during participation in the project.

There will be no foreseeable physical risks for you to participate in the study. However, the respondents might experience uncomfortable feelings from recalling memories and answering to the questionnaire. Some questions may be unexpected. Interviewers will use cautious and soft manners while collecting data and will stop immediately when there is a sign of uncomfortable reactions from you. You can stop any time or skip any question if you feel uncomfortable in answering the questionnaire. Your confidentiality and voluntary participation are the top priority to us.

11.How can you securely store the data and keep them confidential? (such as how
to take care data, where are data storage who will access, and how to destroy data and when)

The answer will be anonymous. All of respondents' answers will be kept confidential. All questions will be kept in a locked cabinet. No one other than the researcher has access to the data. After the collected data are entered into the database, then all of the answer sheets will be destroyed. In any sort of report we might publish, we will not include any information that will make it possible to identify the respondents.

12.The right of the subject (he/she) to withdraw from the project.

You have the right to choose not to answer question that makes you feel uncomfortable or to withdraw from the study at any point.

13.Contact address of authorized persons in case of emergency.

Dr. Thet Ko Aung
Student ID: 5637187 PHMP/M
Master of Public Health International Program
Faculty of Public Health, Mahidol University
420/1 Rajvithi Road, Rajthevi, Bangkok 10400 Thailand.

Contact address in Myanmar:
No 476, corner of 81st and 34th street, Chan Aye Thar San Township,
Mandalay, Mandalay Region, The Republic of the Union of Myanmar

Contact address in Bangkok:
VM Mansion, Room 610, 102 Soi Rachavitee 2,
Samsainnai District, Phayathai, Bangkok 10400, Thailand
Tel: 0908896664

This research project be approved by the Ethical Review Committee for Human Research, Faculty of Public Health, Mahidol University. Office address at Building 1, 4th Floor, 420/1 Rajvithi Road, Rajthevi, Bangkok 10400, Telephone: 0-2354-8543-9 Ext. 1127, 7404 Fax: 0-2640-9854

EC-3 Form

သုတေသနနှင့် ပတ်သက်သော အချက်အလက်များ

၁။ သုတေသန ခေါင်းစဉ်။ ။ ထိုင်းနိုင်ငံ ၊ ချင်းမိုင်မြို့တွင် နေထိုင်သော အိမ်ထောင်ရှိသည့် မြန်မာရွှေ့ပြောင်း အမျိုးသမီးများ၏ သားဆက်ခြားနည်းလမ်းများအား အသုံးပြုခြင်းအကြောင်း လေ့လာခြင်း။

၂။ သုတေသန နေရာ။ ။ ချင်းမိုင်မြို့၊ ချင်းမိုင်ပြည်နယ်၊ ထိုင်းနိုင်ငံ။

၃။ တာဝန်ခံ သုတေသနပြုလုပ်သူမှာ **ဒေါက်တာသက်ကိုအောင်၊** အခန်းအမှတ်(၆၁၀)၊ ၁၀၂ ဆွိုင်ရချာဝတ်ထီ ၂၊ ဗွီအမ် မန်းရှင်း၊ ဆမ်စိန်နိုင်ခရိုင်၊ ဖရာထိုင်း၊ ဘန်ကောက်၊ စာတိုက်အမှတ် ၁၀၄၀၀၊ ထိုင်းနိုင်ငံ ဖြစ်ပြီး နည်းပြဆရာ **လက်ထောက် ပေါမောက္ခ ဒေါက်တာပင်ဆူရမ်၊** မဟီဒေါ် တက္ကသိုလ်၊ တိုက်နံပါတ် ရ၊ ၉ လွှာ၊ အမှတ် ၄၂၁/၁ ရာဗီသီလမ်း ၊ ရာသီဗီ၊ ဘန်ကောက် ၁၀၄၀၀၊ ထိုင်းနိုင်ငံ၏ ကြီးကြပ်မှုအောက်တွင် လုပ်ဆောင်မည် ဖြစ်ပါသည်။

၄။ သုတေသန ပြုလုပ်ခြင်းအကြောင်းအရင်းနှဲ့ နောက်ခံရာဇဝင်

မျိုးဆက်ပွါး ကျန်းမာရေးသည် ထောင်စုနှစ် ဖွံ့ဖြိုးတိုးတက်ရေး ရည်မှန်းချက်များ၏ အရေးပါသော ရည်မှန်းချက်တစ်ရပ် ဖြစ်ပါသည်။ သားဆက်ခြားခြင်းသည် မျိုးဆက်ပွါး ကျန်းမာရေး၏ အခြေခံကျသော အစိတ်အပိုင်းတစ်ရပ် ဖြစ်ပါသည်။ သားဆက်ခြားခြင်းကို အခြေခံအသုံးပြုနိုင်အောင် သေချာစေခြင်းသည် မိခင်သေနှုန်းကို သုံးပုံတစ်ပုံ၊ ကလေးသေနှုန်းကို ၂၀ ရာခိုင်နှုန်းလျော့ချနိုင်သည့်အပြင် လူအဖွဲ့အစည်းနှင့် နိုင်ငံများ၏ ကျန်းမာရေးဆိုင်ရာ ထောင်စုနှစ်ဖွံ့ဖြိုးတိုးတက်ရေး ရည်မှန်းချက်များကို ပြည့်မှီအောင် ဆောင်ရွက်နိုင်ခြင်းအပေါ် တွင်လည်း အကျိုးသက်ရောက်မှု ရှိသည်။

ထို့အပြင် မျိုးဆက်ပွါး ကျန်းမာရေးသည် ရွှေ့ပြောင်းအလုပ်သမားများအတွက်လည်း အရေးပါသော အကြောင်းအရာတစ်ခု ဖြစ်ပါသည်။ မဟီဒေါ်တက္ကသိုလ်မှ ပြုလုပ်ထားသော စာတမ်းတစ်ခုတွင် ခေတ်ပေါ် သားဆက်ခြားနည်းလမ်း အသုံးပြုနှုန်းသည် ကမ်ဘောဒီးယား ရွှေ့ပြောင်း အလုပ်သမားများတွင် အနိမ့်ဆုံး (၅၄%) ဖြစ်ပြီး မြန်မာရွှေ့ပြောင်း အလုပ်သမားများတွင် အမြင့်ဆုံး (၇၂%) ဖြစ်သည်ဟု ဖေါ်ပြ ထားသော်လည်း ထိုင်းလူမျိုးများ (၇၉.၈%) နှင့် နှိုင်းယှဉ်လျှင် ခေတ်ပေါ် သားဆက်ခြားနည်းလမ်း အသုံးပြုနှုန်းမှာ နည်းနေဆဲပင် ဖြစ်သည်။ ထို့အပြင် ရွှေ့ပြောင်း အလုပ်သမားများ၏ စုစုပေါင်း ကလေးမွေးနှုန်းသည် ထိုင်းလူမျိုးများ၏ စုစုပေါင်း ကလေးမွေးနှုန်းထက် ၂ဆတိတိ များနေသည်ကို တွေ့ရှိရပါသည်။ ကျန်းမာရေး ဂန်ကြီးဌာန၊ ထိုင်းနိုင်ငံ၏ မှတ်တမ်းများအရ မြန်မာရွှေ့ပြောင်း အလုပ်သမားများ၏ ကိုယ်ဂန်ဖျက်ချမှုနှုန်းသည် ထိုင်းလူမျိုးများ၏ ကိုယ်ဂန်ဖျက်ချမှုနှုန်းထက် ၂.၄ဆ များသည်ဟု သိရပါသည်။

ထို့ကြောင့် မြန်မာ ရွှေ့ပြောင်းအလုပ်သမားများတွင် သားဆက်ခြားနည်းလမ်းများ အသုံးပြု/မပြုကို သုတေသန ပြုလုပ်ရန် လိုအပ်လာသည်။ သို့ဖြစ်ပါ၍ အိမ်ထောင်ရှိသော မြန်မာ ရွှေ့ပြောင်းအလုပ်သမား အမျိုးသမီးများအကြားတွင် သားဆက်ခြားနည်းလမ်းများ အသုံးပြုနှုန်းနှင့် သားဆက်ခြား နည်းလမ်းများ အသုံးပြုခြင်းကို လွှမ်းမိုးသော အချက်များကို သိရှိလိုပါသဖြင့် ဤသုတေသနကို ပြုလုပ်ခြင်း ဖြစ်ပါသည်။

၅။ သုတေသန ရည်ရွယ်ချက်

- ထိုင်းနိုင်ငံ၊ ချင်းမိုင်မြို့တွင် နေထိုင်သော အိမ်ထောင်ရှိသည့် မြန်မာရွှေ့ပြောင်း အမျိုးသမီးများ၏ သားဆက်ခြားနည်းလမ်းများ အသုံးပြုနှုန်းကို သိရှိရန်နှင့် သားဆက်ခြားနည်းလမ်းများ အသုံးပြုခြင်းကို လွှမ်းမိုးသော အချက်အလက်များကို လေ့လာရန်။

၆။ သင်သည် ယခုလက်ရှိ ချင်းမိုင်မြို့တွင် နေထိုင်လျက်ရှိသော အိမ်ထောင်ရှိသည့် မြန်မာရွှေ့ပြောင်း အမျိုးသမီးဖြစ်သောကြောင့် သုတေသနနှင့် ပတ်သက်သည့် မေးခွန်းများကို ဖြေကြားပေးပါရန် လေးစားစွာ ဖိတ်ခေါ်ခံရခြင်း ဖြစ်ပါသည်။

၇။ သုတေသနလုပ်ငန်းတွက် မိမိဆန္ဒအလျောက်ပါဝင်မှု ခဲ့မယ် အောက်ဖေါ်ပြအချက်များကို ကူညီပေးပါခင်ဗျာ။

အကယ်၍ ဖြေဆိုမည့်သူများ သတောတူညီတယ်ဆိုလျှင် ဤသဘောတူညီမှု အသိပေးစာလေးမှာ လက်မှတ်လေး ထိုးပေးပါရန် မေတ္တာရပ်ခံအပ်ပါသည် ခင်ဗျာ။ သုတေသနပြုလုပ်မည့်သူသည် ဒီကဖြေဆိုသူကို မေးခွန်းအချို့မေးမှာဖြစ်ပါတယ်။ အဲဒီမေးခွန်းထဲမှာ ဖြေဆိုသူရဲ့ ကိုယ်ရေး အချက်အလက်နှင့် ပတ်သက်သော မေးခွန်းအချို့၊ သားဆက်ခြား နည်းလမ်းများ အသုံးပြုခြင်းနှင့် ပတ်သက်သော မေးခွန်းအချို့၊ သားဆက်ခြား နည်းလမ်းများ အသုံးပြုခြင်းဆိုင်ရာ ဗဟုသုတနှင့် ခံယူချက်များဆိုင်ရာ မေးခွန်းအချို့၊ သားဆက်ခြား ဂန်ဆောင်မှု လုပ်ငန်းများ ရရှိနိုင်မှုနှင့် အသုံးပြုမှု၊ ကျန်းမာရေး ပညာပေး နည်းလမ်းများ ရရှိနိုင်မှုနှင့် ကျန်းမာရေး အာမခံ ဂန်ဆောင်မှုများကို အသုံးပြုမှုဆိုင်ရာ မေးခွန်းအနည်းငယ်နှင့် လူမှုရေး အကူအညီများနှင့် ပတ်သက်သော မေးခွန်းအချို့ ဆိုတဲ့ အချက်များ ပါဝင်မည်ဖြစ်ပါတယ်။

၈။ သုတေသနမေးခွန်းမေးရာအတွင်ကြာမြင့်မည်အချိန်

မေးခွန်းမေးရာတွင် မိနစ် ၂၀ ကနေ ၃၀ လောက်ကြာမြင့်မည်ဖြစ်ပါတယ်။

၉။ ဒီသုတေသနကိုပါဝင်ရတဲ့အတွက် အကျိုးအမြတ်

ကျွန်တော်တို့ သုတေသနကတော့ သင့်ကို တိုက်ရိုက်ကြီး အကျိုးပြုစေမှာတော့ မဟုတ်ပါဘူး။ ဒါပေမယ့် ရလာတဲ့ သုတေသန အဖြေများဟာ ထိုင်းနိုင်ငံရှိ မြန်မာ ရွှေ့ပြောင်း အလုပ်သမားများ အတွက် အကျိုးရှိစေမယ့်အပြင် နောက်အနာဂါတ်မှာ ထိုင်းအစိုးရသော်လည်းကောင်း၊ အစိုးရမဟုတ်သော အဖွဲ့အစည်း များကသော် လည်းကောင်း **ဤ**ဒေသနဲ့ တစ်ခြားဒေသများတွင် သားဆက်ခြားခြင်းဆိုင်ရာ ကျန်းမာရေး မြှင့်တင်ရေး လုပ်ငန်းများ ဆောက်ရွက်တဲ့အခါ များစွာအထောက်အကူပြုမှာဖြစ်ပါတယ်။

၁၀။ သုတေသနတွင်ပါဝင်သော အခါရရှိလာမည့် ဆိုးကျိုးများ ၊ မမျှောင့်ထားသော အကြောင်းအရာများနဲ့ ပတ်သက်ပြီး တတ်နိုင်သမျှအနည်းဆုံးဖြစ်စေရန်အတွက် ပြင်ဆင်ဆောင်ရွက်ပေးမည်ဖြစ်ပါတယ်။

လူနာသည် သုတေသနနှင့် ပတ်သက်**၍** တစ်စုံတစ်ရာ ထိခိုက်ခြင်း မရှိနိုင်ပါ။ သို့သော် မေးခွန်းများ ဖြေဆိုချိန်တွင် ကိုယ်ရေးရာဇဝင်နှင့် ပတ်သက်သော၊ ခဏတာ စဉ်းစားရသော အကြောင်း အရာများ ပါဝင်နိုင်ပါသည်။ တစ်ချို့သော မေးခွန်းများသည် မထင်မှတ်သော မေးခွန်းများ ဖြစ်နေတတ်ပါတယ်။ မေးခွန်းမေးမြန်းသူသည် တတ်နိုင်သမျှ စိတ်ရှည်သည်းခံပြီး စကားကို ညှင်ညှင်သာသာ ပြောဆို**၍** လိုအပ်သော အချက်အလက်များ စုစည်းမည် ဖြစ်ပါသည်။ အကယ်**၍** ဆက်လက်ပါဝင်ဖြေဆိုရန် ဆန္ဒမရှိသောအခါ မည်သည့် အချိန်တွင်မဆို ရပ်တန့်နိုင်ပါသည်။ ကျွန်တော်တို့က ဖြေဆိုသူ လိုလိုလားလား ပူးပေါင်းပါဝင် ဆောင်ရွက်ခြင်းကို အလေးထားပါသည်။

၁၁။ ဖြေဆိုသူ အချက်အလက်များကို လုံလုံခြုံခြုံ တစ်ပါးသူသို့မပေါက် ကြားအောင် မည်သည့်ကာကွယ်တားဆီးမည်နည်း။

ဖြေဆိုသူ၏ နာမည်ကို အဖြေလွှာတွင် မှတ်သားထားခြင်း မရှိပါ။ ဖြေဆိုသူ အချက်အလက်များကို သေချာစွာ သိမ်းဆည်းထားမည် ဖြစ်ပါတယ်။ မေးခွန်းအားလုံးကိုသေချာစွာ ချိတ်ပိတ်ထားမည် ဖြစ်ပါတယ်။ တာဝန်ခံ သုတေသနပညာရှင်မှအပ ကျန်သည့် မည်သူကိုမျှ ယခုအချက်အလက်များကို ဖတ်ရှုခွင့်၊ ကြည့်ရှုခွင့် မရှိပါ။ အဖြေများကို ကွန်ပျူတာထဲသို့ ပြောင်းရွေ့မှတ်သားပြီးသောအခါ အဖြေလွှာနှင့်မေးခွန်းများ အားလုံးကို ဖျက်ဆီးပစ်မည် ဖြစ်ပါတယ်။ အကယ်၍ စာအုပ်များနှင့် ဂျာနယ်တွင် ရေးသားသောအခါ ဘယ်သောအခါမျှ ဖြေဆိုသူကို မည်သူမည်ဝါ မှတ်မိစေနိုင်သော အကြောင်းအရာများကို ထည့်သွင်းဖော်ပြမည် မဟုတ်ပါ။

၁၂။ သုတေသနမှ နှုတ်ထွက်မှုလိုမှုနှင့်ပတ်သက်၍ ဖြေဆိုသူ၏လုပ်ပိုင်ခွင့်

အကယ်၍ ဖြေဆိုသူသည် မေးခွန်းကို ဆက်လက်မဖြေဆိုရန် ဆုံးဖြတ်ခြင်း ၊ ဖြေဆိုရခက်၍ စိတ်ကသိ ကအောင့်ဖြစ်ခြင်းနှင့် ဆက်လက် ပူးပေါင်းဆောင်ရွက်လိုစိတ် မရှိသောအခါ မည်သည့် အချိန်တွင်မဆို သုတေသန မေးမြန်းခြင်းမှ နှုတ်ထွက်နိုင်ပါတယ်။

၁၃. အရေးအကြောင်းရှိသောအခါ တာဝန်ခံပုဂ္ဂိုလ်၏ ဆက်သွယ်ရန် လိပ်စာ

ဒေါက်တာ သက်ကိုအောင်

ကျောင်းသားအမှတ်စဉ် - ၅၆၃၇၁၈၇ ပီအိပ်ချ်အမ်ပီ/အမ်

လူထုကျန်းမာရေး မဟာသိပ္ပံဘွဲ့

လူထုကျန်းမာရေးဌာန၊ မဟီဒေါတက္ကသိုလ်

ဘန်ကောက်မြို့ ၊ ထိုင်းနိုင်ငံ။

မြန်မာပြည်လိပ်စာ။
အမှတ် (၄၇၆)၊ ၈၁လမ်း၊ ၃၄လမ်းဒေါင့်၊ ချမ်းအေးသာစံမြို့နယ်၊
မန္တလေးမြို့ ၊ မန္တလေးတိုင်း ဒေသကြီး ၊ ပြည်ထောင်စု သမ္မတ မြန်မာနိုင်ငံ။

ဘန်ကောက်လိပ်စာ:
အခန်းအမှတ် (၆၁၀) ၊ ၁၀၂ ဆွိုင် ရချာဝတ်ထီ ၂၊ ဗွီအမ် မန်းရှင်း
ဆမ်စိန်နိုင်ခရိုင် ၊ ဖရာထိုင်း ၊ ဘန်ကောက်
စာတိုက်အမှတ် ၁၀၄၀၀ ၊ ထိုင်းနိုင်ငံ
ဖုန်း ၀၉ ၀၈၈၉ ၆၆၆၄

ဤသုတေသနကို လူသားများနှင့် ပတ်သက်သော သုတေသန ကျင့်ဝတ်ကော်မတီ၊ ပြည်သူလူထု ကျန်းမာရေးဌာန၊ မဟီဒေါတက္ကသိုလ် မှ အတည်ပြုပြီး ဖြစ်ပါတယ်။ လိမ်စာမှာ တိုက်နံပါတ် ၁၊ လေးလွှာ၊ အမှတ် ၄၂၁/၁ ရာဗီသီလမ်း ၊ ရာသီဗီ၊ ဘန်ကောက် ၁၀၄၀၀။ ဖုန်း ၀-၂၃၅၄-၈၅၄၃-၉ လိုင်းခွဲ ၁၁၂၀၊၄၄၀၄ ကြေးနန်း ၀-၂၆၄၀-၉၈၅၄.

APPENDIX E

INFORMED CONSENT FORM

EC-4 Form

Project Title: Utilization of contraceptive methods among Myanmar migrant married women in Chiang Mai, Thailand

Responsible person(s) and institute:

Dr. Thet Ko Aung

Student ID: 5637187 PHMP/M

MPH International Program

Faculty of Public Health, Mahidol University

Bangkok 10400, THAILAND

Date ……...……..

(day/month/year)

I (Mr./Mrs./Ms.)…….…….…..……...……

Home address……..…… Street…….…… Village number……..

Sub district……. District…...…….. Province……..…….. Postal code…..….

I have read and understood all statements in the **information sheet**. I have also been explained the objectives and methods of the study, as well as possible risks and benefits that may happen to myself upon the participation in the study. I understand that the information will be kept confidential and my name will not be declared in any case. I shall be given a copy of the signed **informed consent form**.

I have the right to withdraw from the project at any time without any adverse effects upon myself.

Signature…..……..… (Respondent/informant)

(…….……..)

Signature…… (Researcher)

(Dr. Thet Ko Aung)

I cannot read but before having finger print on this **informed consent form**, the investigator/interviewer has read and explained to me in detail about the study, the information sheet and the **informed consent form** until I completely understood.

Signature……..… (Respondent/informant)

(…….)

Signature……..… (Researcher)

(Dr. Thet Ko Aung)

EC-4 Form

အသိပေး သဘောတူညီမှု အကြောင်းကြားစာ

စာတမ်းခေါင်းစဉ်။ ။ ထိုင်းနိုင်ငံ၊ ချင်းမိုင်မြို့တွင် နေထိုင်သော အိမ်ထောင်ရှိသည့် မြန်မာရွှေ့ပြောင်း အမျိုးသမီးများ၏ သားဆက်ခြားနည်းလမ်းများအား အသုံးပြုခြင်းအကြောင်း လေ့လာခြင်း။

တာဝန်ရှိသောသူ။ ။ ဒေါက်တာ သက်ကိုအောင်

ကျောင်းသားအမှတ်စဉ် - ၅၆၃၇၁၈၇ ပီအိပ်ချ်အမ်ပီ/အမ်

လူထုကျန်းမာရေး မဟာသိပ္ပံဘွဲ့

လူထုကျန်းမာရေးဌာန၊ မဟီဒေါတက္ကသိုလ်၊ ဘန်ကောက်မြို့ ၊ ထိုင်းနိုင်ငံ။

နေ့စွဲ .....(ရက် ၊ လ ၊ နှစ်)

အိမ်အမှတ်.....၊ လမ်း.....၊ ရပ်ကွက်..... ၊ မြို့နယ်..... တွင်နေထိုင်သော ကျွန်တော်/ကျွန်မ..... သည် ဤသဘောတူညီမှုပုံစံ တွင်ပါဝင်သော အချက်အလက်များကို ဖတ်ရှုပြီး နားလည် သဘောပေါက်ပါသည်။ ကျွန်တော်/ကျွန်မအား သုတေသနပြုလုပ်ရခြင်း၏ ရည်ရွယ်ချက်များ၊ လုပ်ကိုင်ပုံ နည်းလမ်းများနှင့် သုတေသနတွင် ပါဝင်ကူညီခြင်း၏ ကောင်းကျိုးဆိုးကျိုးများကို သေချာစွာ ရှင်းပြခဲ့ပါသည်။ ထို့အပြင် ဖြေဆိုသူများ၏ ကိုယ်ရေးအချက်အလက်များနှင့် ပတ်သက်၍ အခြားသူများထံ မပေါက်ကြားစေရန် လျှို့ဝှက်ထိန်းသိမ်းထားရှိမည်ကို သိရှိပြီးဖြစ်ပါသည်။ သိရှိသဘောတူကြောင်း မိတ္တူတစ်စောင်ကိုလည်း ရရှိပြီး ဖြစ်ပါသည်။ အထက်ပါ အကြောင်းအရာများကို ကျွန်တော်/ကျွန်မ သဘောတူညီကြောင်း လက်မှတ် ရေးထိုးပါသည်။

ကျွန်တော်/ကျွန်မသည် မည်သည့်ဆိုးကျိုးများမှ မရှိစေပဲ မေးမြန်းပြောဆိုခြင်းမှ အချိန်မရွေး နုတ်ထွက်ခွင့် ရှိသည်ကိုလည်း သိရှိပြီး ဖြစ်ပါသည်။

လက်မှတ်..... (ဖြေဆိုသူ)

(.....)

လက်မှတ်..... (သုတေသနပြုသူ)

(ဒေါက်တာ သက်ကိုအောင်)

ကျွန်တော်/ကျွန်မသည် စာမဖတ်တတ်သော်လည်း မေးခွန်းမေးမြန်းသူသည် သုတေသနတွင်ပါဝင်သော အချက်အလက်များကို နားလည်သည်အထိ သေချာစွာ ရှင်းလင်းဖတ်ကြား၍ လက်ဗွေနှိပ်စေပါသည်။

လက်မှတ်..... (ဖြေဆိုသူ)

(.....)

လက်မှတ်..... (သုတေသနပြုသူ)

(ဒေါက်တာ သက်ကိုအောင်)

BIOGRAPHY

NAME	Thet Ko Aung
NATIONALITY	Myanmar
DATE OF BIRTH	16th June 1985
PLACE OF BIRTH	Mandalay, Myanmar
INSTITUTION ATTENTED	University of Medicine, Mandalay, Myanmar Bachelor of Medicine and Bachelor of Surgery, M.B.,B.S. (2001-2006)
WORKING EXPERIENCES	Program Manager, Integrated HIV Care (IHC) Program, The Union Office in Myanmar, March 2012 to January 2013. HIV Clinical and Program Coordinator, Integrated HIV Care (IHC) Program, The Union Office in Myanmar, November 2008 to February 2012. Part time facilitator, Electronic Short Course on Anti-Retroviral Therapy (eSCART) in Resource limited settings, Institute of Tropical Medicine, Antwerp, Belgium.
HOME ADDRESS	No.476, Corner of 81st and 34th streets, Chanayetharzan Township, Mandalay, Myanmar Tel. +95-9-2014926 E-mail: dr.thetko@gmail.com