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Family Planning Practice and Reproductive Health Needs among Rural Married Women in Laukkai Township, Kokang Self-Administered Zone, Northern Shan State, Myanmar

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Information on Reproductive Health (RH) in Kokang Self-Administered Zone is scarce. This community-based, cross-sectional descriptive study aimed to explore family planning practice and RH needs among rural married women in Laukkai Township during 2012. Three-hundred women were interviewed face-to-face for exploring family planning practice. A total of 10 Focus Group Discussions were conducted with the women who actively participated in the face-to-face interviews to understand the RH needs. Over 95% of the women knew at least one method of family planning and 47% were current users. About 16% already had at least 4 children at initial practice. Methods used are daily-pill (37.7%), three-month injection (29.1%), intrauterine device (19.1%), condom (10.6%) and others (3.5%). Incorrect use of contraception is common and 46% of non-users intended to use in future. More than half took at least one ante-natal visit during pregnancy. Most women practised home delivery without a skilled help but they went to hospital if there was complication. Post-natal care was very rare. Unwanted pregnancies usually ended in medical induced abortion. About half of women have heard of HIV/AIDS and its transmission but few had knowledge on signs and symptoms. Menstrual irregularity, foul smelling white discharge and dysuria were common but few sought proper treatment. All said they never heard of maternal death within previous twelve months. They practised monogamy system and both husband and wife participated in decision making for health seeking. It is required to improve knowledge on appropriate use of family planning, taking proper pre-natal, intra-natal and post-natal care, HIV/AIDS and gynaecological problems.

Key words: Family planning, Reproductive health needs, Rural, Myanmar

INTRODUCTION

Over half a million of women died due to pregnancy-related conditions in 2005 and 99% of these deaths occurred in developing countries.[1] In Myanmar, maternal mortality ratio was estimated to be 316 per 100,000 live-births in 2004-2005.[2] Guaranteeing access to birth spacing alone reduces a quarter of maternal death. Antenatal care is one of the strategies for reducing maternal mortality.[3] All women in high-income countries have at least four ANC visits. In low- and middle-income countries, just above two-thirds of women get at least one ANC visit.[4, 5] In Myanmar, frequency of ANC visits varies with the availability of health facilities.[5]

Ensuring all births attended by a skilled health worker is a key strategy in order to reduce maternal mortality. There is an association between having a partnership skilled health worker at delivery and reduction of maternal mortality.[6] World-wide, 45 million births are occurring at home without skilled health personnel each year. Skilled attendants assist in more than 99% of births in developed countries but

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62% in developing countries.[7] In Myanmar, home deliveries are 80-90% of which over a third are delivered by Traditional Birth Attendants (TBAs) and by other untrained personnel like relatives, neighbors or by themselves in rural area.[8, 9] Post-natal care occurs daily in the first week and a follow-up visit is conducted only if the woman is experiencing problems.[8] In Myanmar, many women seek abortion for unwanted pregnancy and approximately 50% of maternal mortality is due to abortion in 1990s.[8] The information of RH is crucial for the planners to allocate adequate human resources for the area. Very little information is available concerning family planning practice and reproductive health conditions of married women in Kokang Self-Administered Zone, Northern Shan State of Myanmar.

MATERIALS AND METHODS

Study design

This was a community-based, cross-sectional descriptive study using both quantitative and qualitative methods.

Study area

Villages under the cover of Par-Sin-Kyaw Rural Health Centre (RHC), Laukkai Township, Kokang Self-Administered Zone, Northern Shan State, Myanmar, in 2012.

Study population and sample size

Among estimated total 26813 reproductive-age women, a total of 300 married women aged 15-45 years were selected for the interview with the assumption that prevalence of contraception was 38%, committing 5.5% difference between the estimated prevalence and wanted to be in 95% confidence interval.

Face-to-face interview

Semi-structured questionnaires exploring background information, knowledge on methods and practice of family planning were included for quantitative study. Principal Investigator was a Kokang language speaker. Interpreter was required among interviews by non-Kokang speaking interviewers.

Focus group discussion

Focus group discussion (FGD) method was used for qualitative data collection.Ante-natal, intra-natal and post-natal practice, abortion, presence of maternal deaths within previous twelve months, detailed information on family planning practice, reproductive tract infection including STI and HIV/AIDS, and gender issue on making decision on health affair and sexuality were explored during FGD according to the guideline.

Married women actively participated in face-to-face interviews with informed consent were included in 10 FGDs, each session included 6-12 married women.

Data analysis

Quantitative data

Data were analysed by using R 2.12.1, free available software with Epicalc 2.10.1.1 commands. Chi square test was used for testing the association of categorical data. Critical level of significant was set at $p=<0.05$.

Qualitative data

Video tape-recorded data were fully transcribed in Myanmar language by the principal investigator and organized by using Atlas-ti 5.2 Demo version. All transcripts were read several times by the investigators separately to distil the main ideas, which were further discussed among the investigators till a consensus was achieved. Thematic analysis was performed and quotations were taken with the agreements by the majority of the investigators.

Ethical consideration

Ethical approval was obtained from the Ethics Review Committee of Department of Medical Research before any data collection.

RESULTS

Background characteristics of participants

Among the participants, 83.8% were Kokang, 10.7% were Palaung and the rest (5.7%) belonged to Myaung, Kachin and

Wa Ethnics. Teenage mothers constituted for about 3.7%. Nearly 25% were 25-29 years old. More than 80% of them had never attended school. Eighty-eight percent worshiped ancestor. More than 79% were farmers. Mean age (±SD) of marriage was 20 years (±2.5). Mean number of children was 3.5 and it ranged from 0 to 10. About 16% of the women already had four and above children at the time of contraceptive utilization. Household members ranged from 2 to 21. About 25% had history of abortion and 34.2% of them were induced medically. History of stillbirth was 3%.

Knowledge on methods and practice of family planning

Knowledge on at least one modern method of family planning method was 95.3% and about 31% knew at least one traditional method. Among the modern methods, most widely known were daily-pill (86%), IUD (81%), three-month injection (79.7%), condom (79%), monthly-pill (72%), monthly- injection (66.7%), female sterilization (57.7%), male sterilization (30.7%) and emergency contraception (14.3%). Sources of information were mainly from their neighbors including friends (90.8%), followed by health care providers (7.7%), drug sellers (1.5%) and from media such as TV and reading magazines (1.1%).

More than 68% of the women had used one method of family planning at some time during their reproductive life. Only 1.3% of them had ever used a traditional method. Prevalence of current family planning practice was 47%: about 46% practiced modern methods and more than 1% traditional method. Daily-pill was the most commonly used method (37.6%) followed by three-month injection (29.1%), IUD insertion (19.1%), condom (10.6%), monthly-pill (1.4%) and female sterilization (0.7%).

According to the qualitative findings, using contraception after delivery was mostly started only at the last day of first menstrual commencement. The interval ranged from one month to one and a half year. On exploring how they took the oral contraception, they said iron tablets from the strip were not taken; instead they continue taking another strip for a couple of months. After that, they stopped taking it for some days to have menstruation commence again giving the reason of good health. Switching methods such as stop taking three-month injection and change to daily-pill or monthly-pill was common. The main reason was having irregular bleeding. Among those never users, desire of more children was the main reason for non-use.

Antenatal care

According to the FGD discussion, more than half of the women had at least one visit to the health care providers during their pregnancy. Underlying reasons of prompting the women to visit health care providers were having abdominal pain, fever, or cough and cold and they received ante-natal care during such visits. Some visited private clinics for the availability of ultra-sonography. Number of visits ranged from one to eight times. Only few women having no ailment during pregnancy took the ante-natal care. Blood pressure (BP) and abdominal examination, injection on the right upper arm (Tetanus Toxoid) and some rusty-colour tablets were provided from public health facilities.

But none of them had such services from private clinics. Among those who did not visit a health care provider were mostly from remote villages. Other reasons given for not visiting a health care provider were financial difficulty, being in good health, perceiving pregnancy as a natural phenomenon, having language barrier with health care providers or feeling of shyness.

Routine delivery care

Most of women practiced home deliveries for easy and uncomplicated labours. Attendants were mostly family members, neighbours and friends. Some delivered with a TBA, or herself and very few with

a midwife. They chose unskilled home delivery as it cost nothing, being convenient due to the help of their family members, no need to transport the expectant mothers to the hospital, and having previous experience of easy labour. All of them described that they went to the hospital in case of prolonged labour, mal-position, bleeding during pregnancy or no coming out of placenta after delivery.

Most of them perceived that delivery in the public hospital was the safest for both mother and the baby and they wanted to do so if there was no financial limitation. Some expressed that they wanted to have a facility with available emergency obstetric care being provided in their villages.

Problems of abortion

Information on abortion was explored during the FGD and it was found that induced abortion for the unwanted pregnancies was common in this area. Unwanted pregnancies with early gestation, up to two and a half months, were induced by taking medication bought from drug shops. They said that medicine which can be used to induce abortion were widely available in the market. In case of pregnancy with older gestation, they had it induced at private clinics. Such occurrence was rare among Palaung and Myaung ethnic groups.

Almost all of them have heard of the complications of abortion and they mostly described heavy bleeding and severe weakness. Complications were common among those who did not follow the instruction and induced the pregnancy at an older gestation. They described that they had such experiences of bad complication was due to the irregular use of contraception. The reason for irregular use was stated as fear of having irregular bleeding.

Maternal death during previous twelve months

During the FGDs, any maternal death from the villages of their own and nearby villages was explored. According to the discussions, there was no maternal death during the past one year.

Reproductive tract infection including STI, HIV/AIDS

Some women had experienced of foul smelling white discharge with or without itchiness, pain on micturation or menstrual irregularity according to the FGD findings. They described that white discharge occurred frequently and it was troublesome. Most took treatment from drugshops prescribed by the shop keepers or according to the advertisement on Kokang Television (TV), or self-medication. Some took herbal medicine and few took treatment from private clinics.

Most women said there were a lot of "*Mai Du*" cases, meaning venereal diseases. Some of them described its symptoms as groups of vesicles or cauliflower-like warts or ulcers in and around the genital organ. They said "*Mai Du*" is common especially among men who have multiple sexual partners, and they usually take treatment at public hospital and private clinics".

More than half of the women have heard of HIV/AIDS. Sexual contact was the mostly described mode of transmission; few said it was possible to infect the child from mother or through contact of a patient's wound secretion with the skin lesion of a normal one. Most of the participants do not know its signs and symptoms. Some said it was not possible to know who is having the infection by looking external appearance.

However, they had no idea on the treatment of HIV/AID. Source of information was mostly from peer group, health talk by INGO such as Asia Medical Doctor Association (AMDA) which is available sometimes at their villages, or from Kokang TV news or reading books.

Decision maker on health affair and sexuality

Most of households were headed by both man and women. Men usually took the role of making money and women

controlling it. In case of ill health, both of them made decision for seeking treatment. Most of people in this area practiced monogamy system.

DISCUSSION

Family planning practice

In this study knowledge on at least one method of family planning was 95.3%, and contraceptive prevalence rate was 47%, current IUD and condom users were 19.1% and 10.6%, respectively. In FRHS 2007, knowledge on at least one method was 96.8%, contraceptive prevalence rate was 41%, IUD and condom users were 1.8% and 0.7%. Reason for not using a method was mainly due to the desire of more children.[5] Fearing of the side effects of modern contraceptive methods was the main cause of switching among methods and these findings are similar to the findings of other study.[8] Malpractices of contraception were common such as discarding iron tablets and late use of contraception after deliveries. These behaviors need to be changed through appropriate health education channel which really cured in that area.

Antenatal care

Most of women in this study visited a health care provider during their pregnancy only when they suffered from an illness and this is similar to the studies done in Kunlong and Hopan.[10, 11] Although BP checking, abdominal examination, provision of iron tablets and injection of anti-tetanus toxoid are provided by the public staff during such visits, there was no one described about checking for urine or blood testing for VDRL. Most women visited a private clinic during their pregnancy due to the availability of ultrasound. Providing ultrasound machine at the public hospital might be one of the incentives for the pregnant to have antenatal care there. Reasons for no antenatal visits were remote or inaccessible health facility, low socio-economic status, and communication barrier; perceive benefit and feeling of shyness and these were similar to the findings of studies done in India, Bangladesh and Myanmar.[12-15]

Routine delivery and post-natal care

Unskilled home deliveries were common with the reasons of convenience in terms of family support, previous experience of easy labour and less cost. These findings were similar to the findings found among Bama, Wa and Kokang ethnics from other parts of Myanmar and Nepal.[10-13] Most of them regarded delivery in the public hospital was ideal for both the mother and the baby and they wanted to deliver there if there was no financial limitation. Some women also expressed that they wanted to have a facility with available emergency obstetric care being provided in their villages. Provision of knowledge on safe delivery and accessible service could increase the number of facility-based deliveries in this area. Lack of post-natal care was found and this needed to be further explored in depth among both providers and confined mothers to understand the underlying reasons.

Abortion and complication

Unwanted pregnancies were induced by using medicines available from the markets. There was not a single women described that doing massage, insertion of foreign bodies such as bicycle spokes, twigs to induce abortion as found in other parts of our country.[8] Wide availability of the medicine and abortionists might be the causes of different findings from other studies in methods that used for induced abortion. Appropriate health education is needed for improving proper use of family planning methods to reduce unwanted pregnancies.

Gynaecological problems including STI, HIV/AIDS

Patients who suffered from signs and symptoms of STI usually sought treatment from health care providers either at public or private clinics. Women with signs and

symptoms of reproductive tract infection usually took treatment from drug shops or taking herbal medicine. This may be due to their awareness on the severity of STI. Health care provider's management on STI should be explored if it is in line with national treatment guideline. Majority of them have heard of HIV/AIDS and could describe some mode of transmission, but very few could describe the signs and symptoms and its treatment. Health education on RTI including STI, HIV/AIDS is needed to be provided in this area.

Maternal mortality and decision maker on health affair and sexuality

According to the FGDs, there is no maternal death last year, having joint decision making for use of money including health seeking and the practice of monogamy showed that women's right in the study area is maintained. However, this is the first exploratory study shared only by the selected participants and further study with enough sample size is recommended.

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