CHAPTER I

INTRODUCTION

1.1 Background and significance of the problem

World situation of reproductive health

Reproductive health is fundamental to the social and economic development of communities and nations, and is at the core of human development (World Health Organization [WHO], 2003). Since The International Conference on Population and Development (ICPD) occurred in Cairo, Egypt in 1994, Programme of Action (PoA) was recommended to the international community as a set of important population and development objectives, as well as qualitative and quantitative goals that are mutually supportive and of critical importance to these objectives. The provision of universal access to reproductive health services, including family planning and sexual health was emphasized (United Nations Population Fund [UNFPA], 1994).

Even though the PoA was implemented in many countries, most of women in the world, especially in developing countries, still encounter reproductive health problems. UNFPA indicated for the years 1990, 1995 and 2000 that more than half a million women die every year from complications of pregnancy and childbirth, of which more than 50% occur in Africa and 40% in Asia (WHO, 2006a). In 2005, unsafe abortions were a leading cause of maternal mortality and resulted in permanent injuries.

The lack of access to family planning results in some 76 million unintended pregnancies every year in the developing world alone. Each year, 19 million abortions are carried out under unsanitary or medically unsound conditions. These result in some 68,000 deaths. Research suggests that 1 in 10 pregnancies will end in an unsafe abortion, with Asia, Africa and Latin America accounting for the highest numbers (UNFPA, 2005b).

Reproductive health situation in Thailand

Reproductive and sexual health services including family planning have greatly improved in Thailand over the last decade. In July 1997, Thailand released a National Reproductive Health Policy statement reinforcing that "*All Thai citizens at all ages must have good reproductive health throughout their entire lives.*" Reproductive health indicators were presented the improvement. Contraceptive use increased from 74.2 percent in 1993 to 79.2 percent in 2001 (Ministry of Public Health, 2003). Total Fertility Rate (Birth rate) decreased, 2.0 in 1993 to 1.7 in 2004. Maternal mortality rate and infant mortality rate decreased a considerable amount. However, it was estimated that 200,000 to 300,000 criminal abortions are carried out each year (UNFPA, 2005a). Nowadays, public health services including reproductive health services are available in all sub-districts (9,689) through a total of more than 69,331 community PHC centers (UNFPA, 2005a). Furthermore, the 30 Baht scheme enhanced affordability of the reproductive health services for Thai women.

Minority situation in Thailand

Thailand has been providing refuge to persons fleeing conflict or political repression in nearby countries since 1949. Even though Thailand has long been providing sanctuary to these groups, it has not signed the 1951 Convention Relating to the Status of Refugees or its 1967 Protocol. Thai law does not make provisions for the categories "asylum seekers" or "refugee". These groups were so called by Thai government as displaced persons (Huguet & Punpuing, 2005). Although Thai government does not have this law, in practice, it closely cooperated with UNHCR. Therefore, some displaced persons were categorized by UNHCR as asylum seekers, and some were categorized as refugees, and after the Provincial Admission Board (PAB) in each province will approve their status. They would be admitted to live in refugee camps along Thai-neighboring countries borders. Those refugees living in camps were provided for basic needs such as shelter, food, clothes, and medical services by international non-government organizations.

However, there are some minority groups who do not meet the UNHCR criteria. Those groups have been living within Thai communities or hills in every province of Thailand. Some minorities have been living in Thailand for over 50 years. They are quite well integrated with local Thai people among whom they live. Currently, those minorities and their descendants comprised 514,420 persons (Institute for Population and Social Research [IPSR], 2005).

The top five provinces where those minorities have been settling are Chiang Rai, Chiang Mai, Karnchanaburi, Tak, and Mae Hong Son, respectively. The number

of minorities in these 5 provinces is equal to 73.82 per cent (288,902 out of 391,368 persons) of total minorities in 2001 (Ministry of Interior, 2001).

Census and registration among those minorities are conducted following the Thai cabinet resolutions from time to time. The Non-Thai Citizen Identity Cards (Alien ID card or color identity cards) are issued for minorities (Ministry of Interior, 2001; Saisoonthorn, 2006). Types and colors of the cards depend upon the context of minorities. The date of entering the country, countries of origins, and ethnicity are the major criteria of categorization. Even though some minorities may have ID cards, they do not have right equal to those people who have Thai ID cards because they are not Thai Nationality by law (Asian Research Center for Migration [ARCM], 2004). They have limited travel, work, and access to public services such as health services (Saisoonthorn, 2006).

At present, the minorities with or without all kinds of color identity cards are not include into the 30 Baht scheme (ARCM, 2004). They need to pay for health services themselves. Some hospitals located in the border areas sell health insurance cards for minorities in their catchments areas to provide health insurance for those people who do not have any health insurance. Nevertheless, the price is unaffordable for some minorities who usually get fewer wages than Thai people. Furthermore, this health insurance card does not cover health service expenditures in other health facilities except the issued facilities. When minorities have serious illnesses and require a referral, they can encounter catastrophic medical expenditures. Otherwise, they might choose self-healing in their homes.

Minority women and reproductive health in Thailand

There were very few studies of reproductive health among minority women; most of which are limited to study of hill-tribe people in Northern Thailand. Reports on the reproductive health situation survey among hill-tribes and minorities in Northern Thailand since 1997 - 2005 showed poor rates of the use of reproductive health services. The rate of antenatal care usage was 60 – 75.7 percent, contraceptive rates were 65.6 – 78.3 percent, birth attended by skilled health personnel rates were 56.3 – 79.0 percent, the usage rate of postpartum care was 37.8 – 43.8 percent, the rate of breast examination for breast cancer screening, and the rate of Pap smear for cervical cancer screening were both less than 45 percent (Jaikrajang & Sanglek, 2005; Pasuwan & Sanglek, 2005; Sanglek, 2004). The reasons that the hill-tribes did not use the services stem mainly from their beliefs, language barriers, less awareness of their health needs, and less accessibility (Kiatinan & Kumarnpawa, 1998).

However, research of reproductive health among migrant women from neighboring countries and stateless women indicated that the use of reproductive health services was significant lower than Thai women. Only one third of those women used antenatal care, and had births attended by skilled health personnel. One forth of them used post partum care service (Archavanitkul et al., 2000) (Chamratrithirong et al., 2004). In Mae Tao Clinic, Tak Province research indicated that a quarter of women with post-abortion complications have self-induced abortion (Belton & Maung, 2003).

Minority in Karnchanaburi Province

Karnchanaburi is a Thai-Myanmar border province where a large number of minorities settled. Figures from The Ministry of Interior in 2001 showed that there were 55,543 minorities in the provinces during this year (Ministry of Interior, 2001). Karnchanaburi ranked third out of all Thai provinces with the highest number of minorities. Similar to other minorities in the country, they have limitations on access to public services including reproductive health services. The data given by a chief of social medical services department of Thong Pha Phume hospital in January 2007 indicated that, in the district, some minorities hold health insurance cards issued by the hospital which are subject to a fee charge. The remaining minorities do not have any health insurance. There are two types of the health insurance cards; the first type is a family card with a cost of 1,000 Baht for one family, which includes a husband, a wife and children under 15 years (but no more than 3 children). The second type of card is a health card for a single person, which costs 700 Baht for a year. The card needs to be reissued every year. The limitation of these cards is that they can be used only in Thong Pha Phume district; they are not valid outside the district. Furthermore, they do not cover some services such as dental services, and anti-retroviral drugs. The patients who require referral to other hospitals must pay the medical expenditures themselves.

Regarding the budget constraint of the 30 Bath scheme, most government health facilities have to reduce some expenditures for their survival (UNFPA, 2005a). Prior to 30 Baht scheme, some health facilities were able to provide free-of-charge services for those people who were uninsured (IPSR, 2005). Economic constraints

mean these hospitals can no longer provide these kind of services. This matter would also affect the health of minorities.

1.2 Purpose of the study

To assess the reproductive health situation, the use of reproductive health services and factors influencing the use of reproductive health services among minority reproductive women in Thong Pha Phume Minority Settlement, Thong Pha Phume District, Kanchanaburi Province.

1.3 Objectives of the research

1. To assess reproductive health needs defined by reproductive health status among minority women of reproductive age.
2. To assess the use of reproductive health services among minority women of reproductive age.
3. To determine factors influencing the use of reproductive health services among minority reproductive women.
4. To give recommendation to the policy makers or the authorities who respond on reproductive health services for the target population.

1.4 Research questions

1. What were the reproductive health needs among minority women of reproductive age?

2. How was the use of reproductive health services among minority women of reproductive age?
3. What factors influenced the use of reproductive health services among minority women of reproductive age?

1.5 Conceptual framework of the research

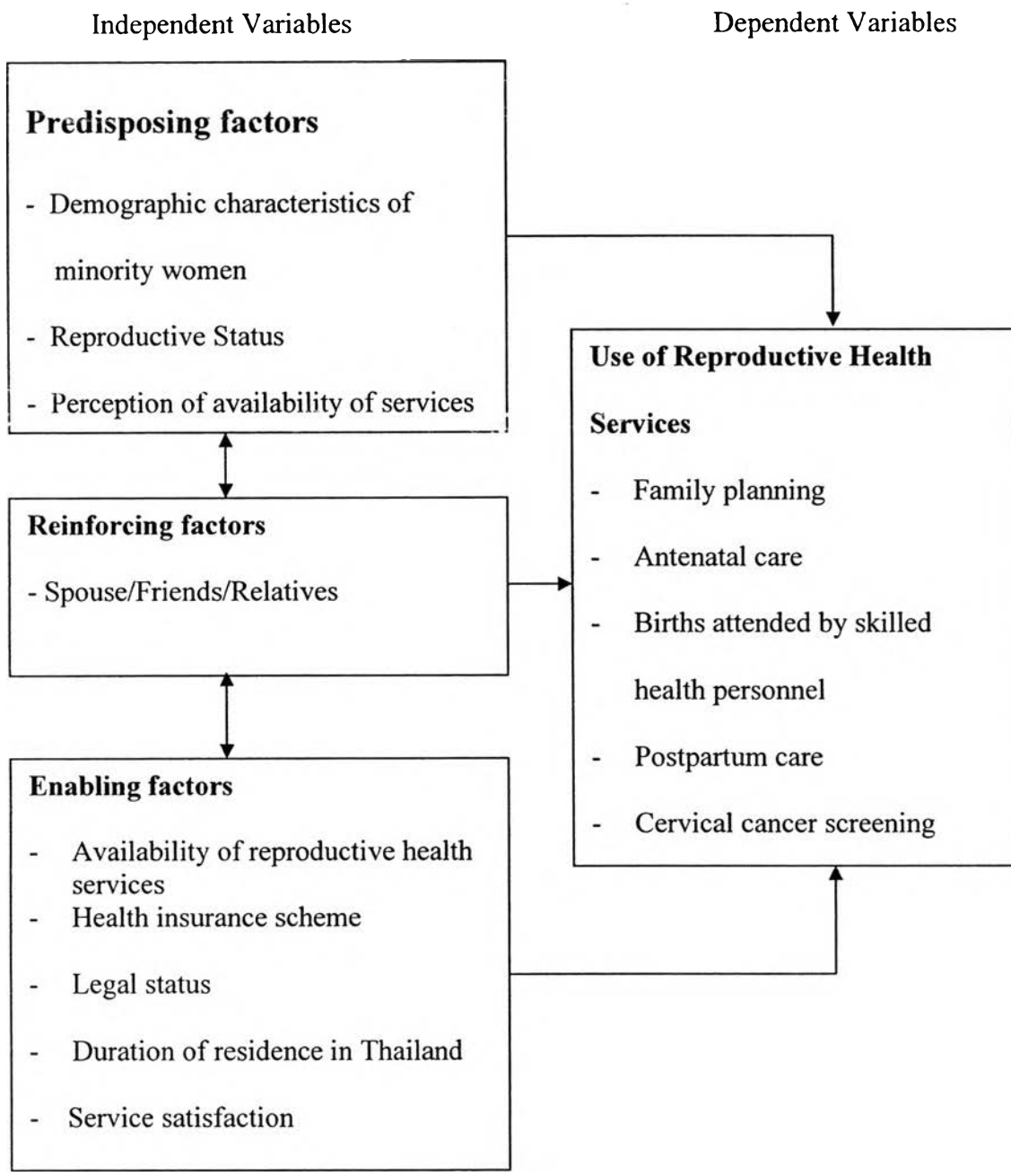

Figure 1: Application of PRECEDE model to conceptual framework

1.6 Research variables

The study will scope in 6 vital reproductive health services that are recommended by UNFPA as fundamental services for reproductive women, and unmet services are the leading death causes in women (UNFPA, 2006a).

1.6.1 Independent variables include

1. Predisposing factors

- Demographic characteristics of minority women that were age, ethnicity, education, religion, employment and income
- Reproductive status (i.e. adolescent, married, pregnant women)
- Perception of the availability of the services

2. Reinforcing factors: the influence of

- Spouse/Friends/Relatives

3. Enabling factors:

- Availability of reproductive health services
    a. Family planning
    b. Antenatal Care
    c. Birth attended by skilled health personnel
    d. Postpartum care
    e. Cervical cancer screening
    f. Breast examination of breast cancer screening
- Health insurance scheme

- Legal status
- Duration of residence in Thailand
- Thai speaking ability
- Service satisfaction

1.6.2 Dependent variable: Use of Reproductive Health Services

1.7 Operational definitions of terms used in the research

These operational definitions specify details about independent variables that are used in the research as the following:

Women of reproductive age refers to all women aged 14 – 49 years in Thong Pha Phume minority settlement

Reproductive status refers to the particular condition of reproductive women at the time of data collection, e.g. adolescent, married, pregnant, post partum.

Family planning refers to modern contraceptive methods for birth control including female and male sterilization, intrauterine devices (IUDs), hormonal methods (oral pills, injections, hormone-releasing implants), and condoms.

Antenatal care refers to those women who were attended by, at least once during their pregnancy, skilled health personnel for reasons relating to pregnancy.

Births attended by skilled health personnel refers to births attended by an accredited health professional, such as a midwife, doctors, or nurse, who has been educated and trained in the skills needed to manage normal (uncomplicated) pregnancies, child birth, and the immediate postnatal period and in the identification, management and referral of complications in women and newborns.

Abortion refers to the termination of a pregnancy before the fetus has attained viability, i.e. become capable of independent extra uterine life.

Abortion-related complication treatment refers to hemorrhage, local and systemic infection, injury to the genital tract and internal organs, and toxic or chemical reactions caused by agents use to induce the abortion.

Annual screenings for breast cancer refers to the women aged 35 years and above who received breast cancer screening by health personnel with the palpation method, or other methods such as mammography.

Annual screenings for cervical cancer refers to the women aged 35 years and above who received the basic cervical cancer screening; Pap smear, or other methods.

Legal status refers to the color identity cards issued by the Ministry of Interior to identify the legal status of the minority women, e.g. highlanders who hold the green with red edge card, Burmese displaced person who hold the pink card, etc.