FACTORS RELATED TO THE ACCEPTANCE OF CONTRACEPTIVES AMONG MARRIED WOMEN OF REPRODUCTIVE AGE IN URBAN CITY ARANYAPRATHET DISTRIST, SAKAEO PROVINCE, THAILAND

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ABSTRACT

A cross-sectional study was conducted on the factors related to the acceptance of contraceptives among married women of reproductive age in an urban city in Aranyaprathet district, Sakaeo province, Thailand. The aim was to identify the socio demographic characteristics, knowledge, attitude and accessibility factors related to the acceptance of contraceptive methods. Two hundred and seventy five married women of reproductive age, 15 to 49 years old, from five communities were purposively selected and interviewed using structured questionnaires during January 2004. The results of this study revealed that the prevalence of contraceptive use was similar to the national rate (74.5%). Oral pills were the most popular contraceptive used followed by tubectomy as the second choice. Knowledge of the women about IUD was poor with low acceptance among users. 81.5 % of current users did not want more children. About one-third of respondents felt that many children were a valuable asset, while two-third stated that they were a burden. 61.8% of the respondents had 2-3 children and had no sex preference.

About half of the respondents had a fair knowledge of contraception and an equal proportion of the women had a positive or negative attitude towards family planning. Men shared a low responsibility in family planning, only 2% used condoms and another 2% had had a vasectomy. Most contraceptive information was acquired from health personnel; relatives/friends, and the main sources of contraceptive services were community hospitals and pharmacies. Nearly all of the women were satisfied with family planning, most of them who had a residence more than 1 Km from the service center tended to use contraceptives more than those who lived less than 1 Km away. The family planning in this study area was effective and dynamic.

KEY WORDS : CONTRACEPTIVES, PREVALENCE, URBAN CITY, ACCEPTANCE

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CONTENTS

Page

CONTENTS (Cont.)

Page

LIST OF TABLES

TABLE Page

LITS OF TABLES (Cont.)

LIST OF FIGURES

FIGURE Page

LIST OF ABBREVIATIONS

CPR	:	Contraceptive Prevalence Rate
CDHS	:	Cambodian Demographic and Health Survey
CSMBS	:	Civil Servant Medical Benefit scheme
FP	:	Family Planning
ESCAP	:	Economic and Social Commission for Asia and the Pacific
HC	:	Health Center
IUD	:	Intra Uterine Device
ICDP	:	International Conference on Population and Development
IMR	:	Infant Mortality Rate
Km	:	Kilometer
MPHM	:	Master of Primary Health Care Management
MWRA	:	Married Women of Reproductive Age
MMR	:	Maternal Mortality Rate
NFPP	:	National Family Planning Program
PCU	:	Primary Care Unit
SD	:	Standard Deviation
STDs	:	Sexually Transmitted Diseases
SSS	:	Social Security Scheme
TFR	:	Total Fertility Rate
UNFPA	:	United Nations Fund for Population Activities
UNPD	:	United Nation Population Division
VHV	:	Village Health Volunteer
WHO	:	Word Health Organization

CHAPTER I
INTRODUCTION

1.1 Rational and Justification

1.1.1 Magnitude of the problem

Family Planning is one of the essential elements of primary health care (the Alma-Ata declaration in 1978) and plays a significant role in health and socio-economic development. Currently population growth is one of the most serious problems in the world, especially in developing countries. Most developing countries are aware and realize the implication of rapid population growth on the socio-economic status and welfare of people.

The total population of the world has already crossed to 6 billion and it is increasing in succession with more than 1 million after every three months, it would shoot up to 8.5 billion in year 2025 (1). A report published by UNFPA stated that if current rate of growth is not checked by strong and effective measures, the population of the world would cross the 10 billion by year 2050. For the last 50 years, world population multiplied more rapidly than ever before.

All over the world, family planning programs have brought down the maternal mortality rate and fertility substantially in the last 25-30 years. The global contraceptive use has increased from 10% to 53% as WHO Geneva, 1996 (2). All family planning services in the past were extended primarily to the married couples with the aim of controlling the population growth. Therefore there is an unmet need of reproductive health care among the married couples. This unmet need leads unplanned and unwanted pregnancies, which further contribute to abortions, increased maternal morbidity and mortality. Therefore reproductive health care services including contraceptive use play an important and specific role in inducing unwanted pregnancies and their consequences.

The over population is an important cause of poverty. According to the world health report of 1998 (3), There were 600 million people living in life and health threatening. In order to reduce the population growth rate, as well as the risk of women and children and the poverty level of society, contraceptive methods have been used as an effective measure in family planning all over the world.

There are many methods of contraception, which have been used such as the oral pills, injection, condom, intra uterine device (IUD), sterilization, Norplant, etc…, but the rate of using these methods is very different among different countries. The most important findings from demographic research about fertility and population growth rate in developing countries during the last decade were the very strong relationship between the length of birth interval and under 5 children mortality. More than 60% of married women of reproductive age (15 to 49 years) in developing counties are at high risk. Spacing between 2 deliveries is less than 24 months. Eighteen to twenty % babies are at low birth weight with a predisposition of illness. The mortality and morbidity among women and children are higher in developing countries. Experts estimate that more than 120 million married women in developing countries want to limit or space future pregnancies but are not using contraception. International surveys, women say they do not use family planning because health and side effects, lack of sufficient knowledge about methods, and do not have access to the methods they want. Farr G, Ramest Amatya in the Study of Clinical Performance of the IUD in four developing countries family planning clinics, 1994 (4) offering clear explanations of the use, side effects, safety, and effectiveness of contraceptive methods which will reduce the barriers to use and help individuals make informed choices about family planning.

1.1.2 The consequences of the problem

According to a World Health Organization (WHO) publication “Abortion in the developing world”, out of nearly 50 million performed in the world each year (30 million of them in developing countries (5).

Complications from spontaneous and induced abortion-primarily hemorrhage, infection and injury to the cervix and uterus-remain a major cause of maternal death in many countries and contribute to the poor overall health of women in the developing countries. Up to 15% of maternal mortality globally is due to the complications of abortion.

Unsafe abortion may be a problem leading to high levels of maternal morbidity and mortality. Many women suffer chronic and often irreversible health problems as a result of complications from unsafe abortion. Globally, an estimated of 46 million abortions are performed (worldwide each year), of which 20 million are performed in countries where abortion is restricted or prohibited by law. Illegal abortions are more likely to be performed by untrained people, in unsanitary conditions, or with unsafe surgical procedures or drugs. As a result, illegal abortion accounts for an estimated 78,000 deaths worldwide each year, or about one in seven pregnancy-related deaths. In some African countries, illegal abortion may contribute to up to 50 percent of pregnancy-related deaths. In countries where abortion is legal, less than 1 percent of pregnancy-related deaths are caused by abortion (6). Increase in population is contributing to the growth of slums, shantytowns, squatter settlements and unbalanced flow of rural population to urban areas which in turn is shortage of basic infrastructure and facilities in urban centers. High fertility not only gives rise to high population growth but also contributes to high infant and maternal mortality.

In Cambodia, three decades being in civil war everything destroyed especially in Khmer rouge regime (1975-1979). Almost all of health professionals were killed. Only 50 medical doctors and a small number of health staff survived. The decades of war and civil unrest have left Cambodia with a ravaged infrastructure and severely limited human and financial resources. So far the political crises and lacking of government budget, make the development of the country progressed slowly and the health care service is poor and not very successful. The population grows rapidly total fertility is 4.0. The maternal mortality rate is high 437/100,000 life births. The infant mortality rate is 95/1000 life births; that means one child among ten die before his or her first birthday. The National Birth Spacing program was just set up in 1995.

According to the Cambodian Demographic and Health Survey 2000; the percentage of contraceptive use among married women of reproductive age in Cambodia is around 24%. This prevalence shows that Cambodia is the lowest country in the region in practicing contraceptives. It was slightly different between Cambodia and Yemen country, which has prevalence contraceptive use only 21%. (7)

Thailand has a good Family Planning Services compared to most of the developing countries in the region. The National Family Planning Program (NFPP) became successful to reduce the population growth rate from 3% in 1970 to 2.5% in1976; 1.6% in 1986 and 1.3% in 1991.NFPP in Thailand have increased the contraceptive prevalence rate from 14.8% in 1969 to 70.6 in 1987 (8). According to the current information available, the contraceptive prevalence rate of Thailand is 74% (9).

As the contraceptive prevalence use in Thailand is so high and according to literature (10) revealed that the people in the urban area is more likely to use contraceptive than those who live in the rural area (11). But in Aranyaprathet District there is a reverse of contraceptive prevalence rate in the urban city and the rural 77% and 88% respectively (12). Therefore it is worth to conduct this study in order to know the factors related to the acceptance of contraceptives among married women and their life style in urban city Aranyaprathet District Srakeao Province.

1.2 Research questions

1.2.1 What is the prevalence of contraceptive use among married women of reproductive age in urban city Aran Pratheth District?

1.2.2 What is the different method of contraceptive use among married women of reproductive age or their husband in urban city Aranyaprathet District?

1.2.3 What are the factors related to the acceptance of contraceptives among married women of reproductive age in urban city Aranyaprathet District?

1.3 Research Objective

1.3.1 General objective

To study the factors related to the acceptance of contraceptive among married women of reproductive age in urban city Aranyapratheth district.

1.3.2 Specific objectives

To determine the contraceptive prevalence rate base on the acceptance of contraceptive use among the study subjects.

To describe the socio-demographic characteristics towards contraceptive use among the study subject

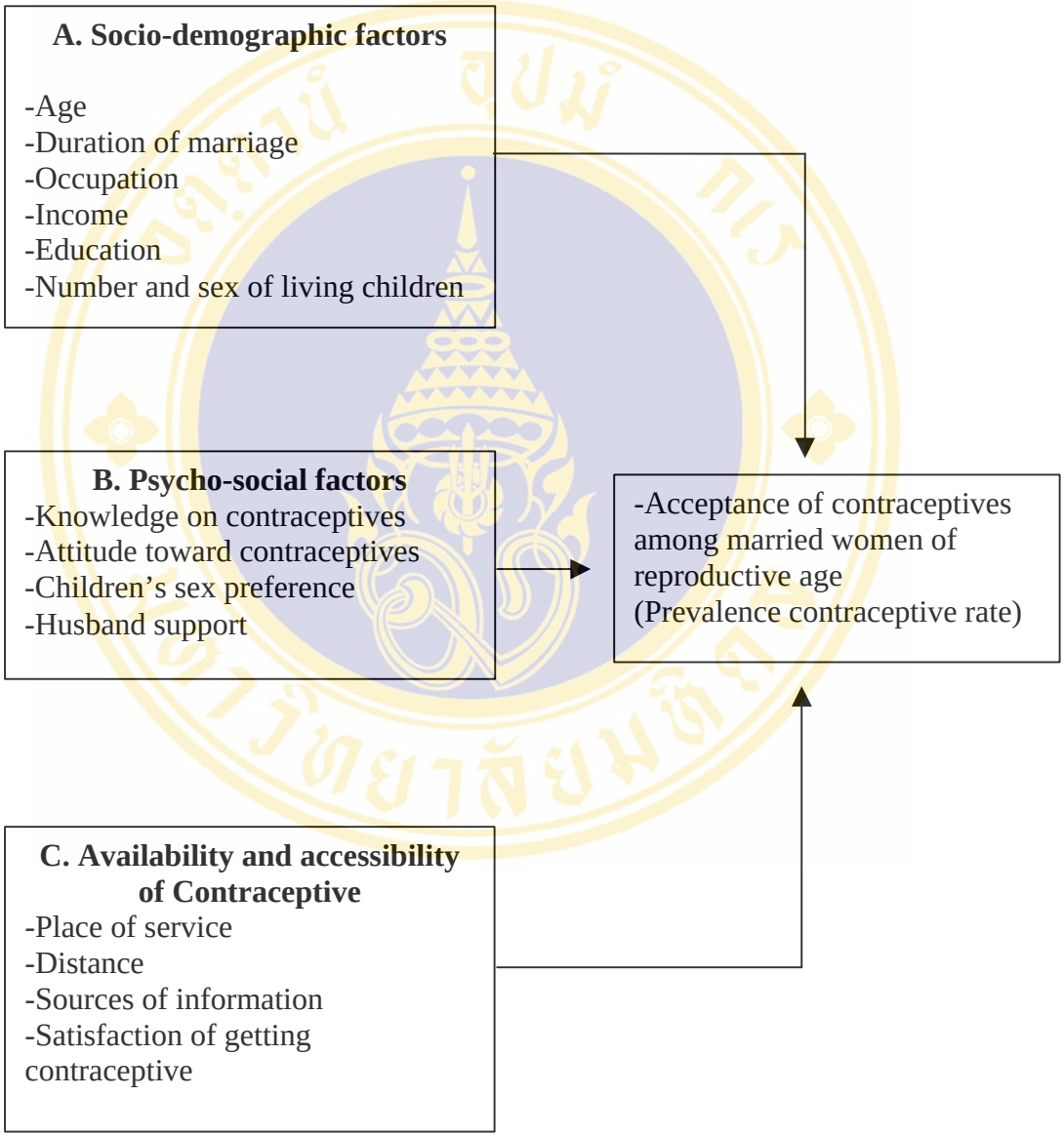
To describe the psycho-social factors including knowledge, attitude toward contraceptive among the study subjects.

To describe the source of information, availability and accessibility to the use of contraceptive among the study subjects.

To assess the contraceptive methods used among the study subjects or their husband.

1.4 Conceptual framework

Independent Variables Dependent Variable



1.5 Operational definition of studied variables

Family Planning: The ability and activity of parents to choose the number and space the birth of their children.

Acceptance of contraceptive: refers to the practice of married women of reproductive age or their husbands including reason for using any method of contraceptive for family planning.

Contraceptive: Contraceptive means the various methods of family planning such as: Oral pill, Condom, Intra Uterine Device (IUD), Injection, Norplant, Tubectomy, Vasectomy and some other methods.

Socio-demographic factors: Socio-demographic factors of married women of reproductive age can be measured by age, duration of marriage, occupation, education, income, number and sex of living children, children's sex reference, husband's support.

Income: Refers to the total family income of all family members per month.

Education: The level of education of MWRA was classified as: 1-No schooling, 2-Primary school, 3-Secondary school, 4-High school, College/University.

Occupation: Refers to the present job of MWRA. It was classified as: 1-Farmer, 2-government employees/officers, 3-Laborer, 4-business, 5-housewife.

Number and sex of living children: Counted only the total number and sex of living children of the married women at present.

Children's sex preference: The desire of the couple to have sons or daughters.

Husband's support: The approval, facilitation and cooperation of husband for the women in practicing family planning or husband himself practicing any method of contraceptive.

Knowledge on contraceptive: Is the understanding of the respondents about contraceptives which include meaning of family planning, various methods, benefits and its side effects.

Attitude toward contraceptive: Refers to the feeling, belief and intention of the respondents regarding the contraceptive methods and usage.

Availability and accessibility: Availability includes place of service that the women can obtain contraceptive. Accessibility refers to the sources of information about family planning, traveling distance, and convenience of the women for getting contraceptive method.

Source of information: Message about the use of contraceptive through media or inter personal conversation.

Current user: Referred to the married women of reproductive age are utilizing a contraceptive method at present in time of interview.

Past user: Referred to the married women of reproductive age who used to utilize any contraceptive method before but discontinued at the time of interview.

Never user: Referred to the married women of reproductive age who never used any contraceptive method at present of interview.

CHAPTRE II
LITERATURE REVIEW

2.1 Population growth is a global problem

The population explosion is a global problem at the present time, the effect of which is worldwide, demanding the attention of all nations; east and west, small and large, developing and developed. In most nations of the developing world, population growth consumes much of their economic growth hinders a nations ability to progress and to satisfy the growing demands of its people for a better life.

According to United Nations Projections, the total fertility rate (TFR) in Asia as a whole is expected to decline from 2.7 births per woman to an estimated 2.1 births per woman between 2000 and 2050. Nevertheless, the region's population is projected to grow by 44% during that period, from3.5 billion to5.0 billion. In central, South and Southeast Asia, the fertility transition began later and is less advanced than in East Asia. (13)

In the next 40 years, the population of Sub Saharan, Africa is projected to almost triple from approximately 600 million to more than 1.6 billion. Over the same period, the population of Asia will rise from 3 billion to over 5 billion. (14)

According to World Health Organization: Women Health Series, Health Messenger 2000 March, every year about 550,000 women die during pregnancy or childbirth and about 14.5 million babies and children under 5 years old die from malnutrition; birth spacing could prevent 20% of these deaths. Multiple and frequent pregnancies can lead to anemia, maternal malnutrition and low birth weight babies. If the women are too young or too old when they get pregnancy, they and their baby's health and life can be danger. (15)

The situation is quite different in the developing world where, in 2000, in developed countries, a woman has only a 1 in 2,125 risk of dying in pregnancy or childbirth over the course of her lifetime .That risk is 33 times higher, at 1 in 65, for women in developing countries. (16)

According to over six years following the U N International Conference on Population and Development (ICPD), unwanted pregnancies led to the deaths of nearly 700,000 women worldwide, accounting for about 21% of maternal mortality. The estimation from a Global Health Council report, at least 338 million unwanted pregnancies occurred during that period. Of these, about 251 million ended in abortions, resulting 441,000 maternal deaths. An additional 88 million unwanted pregnancies were carried to term, with 246,000 women dying from complications of pregnancy, labor and delivery. Rate of death is much lower in industrialized countries than in developing countries, where women are less likely to have ready access to skilled obstetric care and safe abortion services. For about, 675 of every 100,000 abortions and 857 of every 100,000 births resulting from an unwanted pregnancy led to a maternal death in Africa, compared with one per 100,000 abortions and 11 per 100,000 births in North America. (17)

2.2 The need for Birth Control

Contraceptive is the medical technology of family planning or birth control, which save the lives of women and children, improve the health of women and children and benefits of families and communities. In this sense, using contraceptives is a strategy that women themselves can adopt to protect their own health.

At the present time, the worldwide policy makers recognize the important of contraceptive use to women’s health. The birth control or family planning programs are an important measure contributing to the goal of reducing global population growth rate and promoting Health For All in the coming year. (15)

A study by the researcher at the Demographic Health Surveys (18) program finds that children born 3 years or more after a previous birth are healthier at birth and more likely to survive at all stages of infancy and childhood through age five. The study uses data from 18 countries in four regions and assesses outcomes of more than 430,000 pregnancies. Among the findings: compared with children born less than 2 years after a previous birth, children born 3 to 4 years after the previous birth are:

-1.5 times more likely to survive the first week of life;

-2.2 times more likely to survive the first 28 days of life;

-2.3 times more likely to survive the first year of life; and

-2.4 times more likely to survive to age five.

Under the support from WHO, many research have been done and revealed that the personal factors that enter into the individual's decision concerning choice of contraceptive method include age, parity, age of youngest child, reproductive intentions spacing or terminating childbearing, frequency of intercourse, relationship with partner, influence of other in decision-making process, importance of method convenience, and level of comfort with her or his body and reproductive system. (19)

2.3 Socio-demographic factors

A. Age and duration of marriage

The age at which women marry is an important factor in population growth. Marriage often presents the socially sanctioned initiation of sexual activity and childbearing for women. Therefore early marriage is associated with high fertility and late marriage women have low fertility. Late marriage is also associated with many of the beneficial and productive aspects of developed society. It permits women to achieve more on education, to train for useful career, to earn money, to contribute in a more meaningful way to family, community and national life. Later marriage allows women to enter matrimony on a more equal basis with their husbands. Later marriage may also encourage women to make decisions about childbearing and child rising based more on their own abilities and their children's needs than on traditions encouraging high fertility.

A study on the contraceptive acceptors of Bangkok metropolitan polyclinic revealed that the duration of marriage is associated with the continued use of contraception of women with duration of marriage of 10 years or more. (20)

Study investigating the duration of marriage of women realized that the most women who wanted no more children had been married for 10 years and had already the number of children they desired. On the other hand, women with longer duration of married generally desired larger family size than those who married for short time. In a study related to family size in Taiwan during 1961-1976, and knowledge, attitude and practice of family planning in Thailand (8) indicated that marriage duration affects the number of children desired. The results of this survey show different marriage duration for each group of women. For example, the average desired family size of women who had been married for less than five years was 2.6; of women who had five to nine years of marriage was 3.1 while for women who had been married for over ten years the desired family size was 3.3. The data indicates that women who had longer marriage duration had large family than those who had shorter marriage duration.

According to the Population Report, there are at least three important demographic reasons that individual woman who marry early tend to have more children than those who marry late and to hasten population growth. If women marry at young age:

1. They are likely to have sexual intercourse most frequently throughout their most fecund years;

2. They begin childbearing at and earlier age and thus live throughout with along period of exposure to contraception and;

3. They shorten the interval before the next generation is born and began childbearing. (21)

B. Education

Education is an important factor for acceptance of contraceptives. Usually the educated women have more awareness and opportunities to know the importance of contraceptive in respect of birth control. The educated women are more likely to marry late, to the first pregnancy to leave more time between births and have few children in total. In accordance with the many studies there is positive relationship between education and contraceptive use especially studied in El Salvador, England and Philippines have shown this relationship, (Ferguson and MC can 1976, referred from Pagodo Laput, R 1990). (22)

In most countries, the better the education the women had obtained, the more likely they were to use contraceptives, (Aytal Haque 1996). Factors Affecting the Acceptance of Contraceptive Among Married Women (23). Part of the relationship between education and contraceptive use may due to the fact that educated women tended to live in the urban areas where family planning services are more easily available. However, education made no difference in the choice of a modern method over a traditional one. Survey also found that when the husband was well educated, the couple was more likely to practice contraception regardless of the wife's level of education. A study by Virasack 1999 on contraceptive use among rural married women in Xiengngeun district found that 61.2 percent of the married women who had no education were using contraception, 78.0 percent who had primary school were using contraception and 84.1percent of them who had education in secondary and higher were using contraception. There was significant relationship between education of married women and contraceptive use. (24)

The 1992 world fertility survey stated that women's education have significant effect on fertility in all population survey. The survey data of Thailand showed that without exception, there was clear inverse relationship among the rural as well as urban women between the proportion of the currently using contraception and the number of year of schooling completed. Virasak. Contraceptive use among rural married women 1999 (24) revealed that educated women would marry later, showing more responsibility for the welfare of children and discussing problem more freely

and equally with her husband than uneducated women. Therefore, educated women would start bearing children later. It was expected that educated wives would have longer durations of contraception use than those uneducated wives. In the Laos PDR, the situation of education was quite different. The proportion of women with secondary school or higher level of education that use any modern contraceptive methods was about four times higher than women with no formal schooling.

Education attainment is a well-established indicator of social-status of women and an important factor-affecting decline in fertility. Study in several countries have shown that fertility and family planning are influenced by women education. (25)

C. Occupation

Contraceptive Prevalence Survey Report showed that although the highest percentages of married women currently practicing contraception were in the professional and in the sales and business categories, the percentages of women in other occupation groups currently practicing contraception were also in the range of 70 or higher, indicating that influence of this factor on contraceptive is dissipating. The lowest contraceptive prevalence rates were among those who were not working and housewife. There was still positive relationship between women labor force participation and contraception. Leoprapai B 1989 (26)

Determinants of contraceptive use in rural Myanmar, study of Khi Thet Wai. 1995 (27), it was found that women who worked outside their home used contraceptives more and had lower fertility than women who did not work outside their home, and who were engaged in agricultural and non-agricultural occupations were 28 and 24 percent.

Among women of all age groups, those who work outside the home environment have considerably lower fertility than those without such experience. Some evidence suggests that women who have been employed are more likely to use contraception than other women. Study have found that women who have worked

outside the home for cash payment are more likely to use contraceptive than women who have never work outside the home (28)

A study done by Htay, on Factors Affecting Family Planning Behavior of Women of Reproductive Age in Ratchaburi province of Thailand revealed that the majority of women with current users were farmers and laborers in 70.4 percent and 69.6 percent respectively and follows by housewife at 57.1 percent. It was found that there was significant relationship between wife's occupation and family planning behavior. (29)

D. Income

It was found that better educated, higher income status, is being more exposed to family planning communication and having greater access to medical facilities, will be more likely to have contraception and continue such practice, and to practice more effectively than others. (30)

A study in Bangkok concluded that workingwomen had higher continuation rates than those who did not work. This may suggest the labor force participation is directly related to contraceptive continuation. For combined monthly income, women in higher income were more likely to continue than women in other lower income. However continuation rates for Pill and IUD did not appear to be correlated with family income. When they further examine continuation rates by the number of respondents for the Pill and IUD acceptors, data suggested that the burden of extra household member would promote higher continuation, of contraception. Chamratrithirong A. Contraceptive Practice and Fertility Rate in Thailand 1986 (31).

E. Number and sex of living children

Practice of contraception is more common after a certain number of births. The number of contraceptive use increase as parity rises from two to three children. After the third children, the association of old age with less contraceptive use may counterbalance the effect of parity and again, parity and age are closely related. However, after taking into account various combination of the other variables such as women's education, women's knowledge of a source of contraception, the couple's

standard of living, and whether they live in a rural or urban area, the influence of parity on contraceptive use are still obvious. Some young and low parity women have begun to use contraceptive to space birth.

There was a positive relationship between family planning practice and number of living children. Pitaktepsombati, P.and Prachuabmoh, V. (32) found that it is likely that eligible women who have more living children will accept contraception more easily than those who have fewer children.

A study in Thailand found that the percentage of childless women practicing contraception was still low, about 24 percent. However, the percentage of contraceptive use, increase sharply to a much higher level among women with children, reaching the peaks among women with 3 children and declining thereafter. (19)

And also the study conducted by Htay, shown that majority of women had 1-2 children. Among them, 69 percent were current users while 17.3 percent were ever users and 13.7 were never users. Among those who had 3 and more children, majority were current users representing 61.2 percent while ever users and never users were equal at 19.4 percent. There were 50 percent of never users who had no child while 33.3 percent were current users and 16.7 were ever users. As an ideal family size is reached, contraceptive prevalence can be accepted to increase. Nulliparous women or those with one child were much more likely to be non-users than women with 2-4 Children. Htay Win, factors affecting family planning behavior among married women in Thailand, 1993 (29).

According to Djoechraeni R.H, (33) among currently married women age 15-49 who had two living children, nearly 65% wanted no more, 55% of those with no son wanted more, and 85% of women with two sons wanted no more, but 72% of those with a son and a daughter were more likely addition children. In addition, women with a son and a daughter were more likely to practice contraception (72%) than women with two children with the same sex.(66% of those with two sons and

63% of those with two draughts).Amount of 84% of married women with three children said they wanted no more and these two-third of such women used contraception.

Nalavonkit T et al, Continuation of injectable contraceptives in Thailand, Study in family planning in 1982 (34) revealed that continuation rates also increase with parity. The distinction is especially clear between women of parity 0-2 and women with 3 or more children. Continuation rates at 24 months are only 33% for parity 0-2, compared with 47% for women of parity3-4.

F. Children's sex preference

In some countries, parents trend to prefer sons and to treat them better than daughters. As the study 'Effect of Sex Preference on Contraceptive Use, Abortion and Fertility in Matlab, Bangladesh'. Sex preference does not have a strong effect on contraceptive use in Matlab. Its absence, however, would probably increase recourse to abortion, which is used to limit fertility once couples have the number of sons they desire. The effect of sex preference on childbearing is becoming stronger as fertility declines, because couples must achieve their desire number of sons within a smaller overall number of children (35).

The study used data from second Malaysian Family Life Survey, conducted in 1988, to examine parents' preferences for the sex of their children within each of Malaysia's three ethnic groups. While Malay and Indian parents do not show a consistent sex preference, Chinese parents preferred to have all sons, or a combination of sons and daughters, with more son than daughters, or at least an equal number of them. Son preference among the Chinese does not seem to be a constraint to fertility decline among that population. Since 1970, Chinese fertility has dropped rapidly; at the same time, Chinese son preference has become more pronounced. Evidence indicates that further reductions in Chinese fertility, through the reduction in sex preference, would be small. (36)

G. Husband's support

In traditional conservative societies husband is a dominant partner. They are seen to influence not only women's decision to adopt family planning but also the contraceptive method she chooses. Women are compelled to defer to their husbands decision and not surprisingly their attitudes are affected by their husband's views especially in rural settings (22).

Husband's support plays an important role in the practice of contraception. Syed Ihtram shabbir, study acceptance of contraceptive among married women of reproductive age in Thailand 2000(37) and revealed that the women in the group who did not have their husband's agreement had very low contraceptive use rate

A study in Bangkok revealed that acceptors of the pill and IUD who said theirs husband's approval of family planning had longer continuation rates, 64.9% and 64.8% respectively, than acceptors whose husband did not approve, were 54.3% and 59.3%. Those who were not sure of their husband's attitude had continuation somewhere between the two extremes. (38)

The husband's support does not mean that only his agreement with woman to practice contraceptive method, but it should be the cooperation that he himself helps the couple in practicing contraceptive method like condom or vasectomy. Thus the contraceptive prevalence rate of the women would be increased.

2.4 Knowledge and Attitude

Knowledge and attitude are related to the acceptance and practice of contraceptive. A woman must have at least some knowledge about certain contraceptive methods and the source where she can obtain service before she can acquire it for use. Without such knowledge, it is almost impossible for a person to use it. The knowledge of contraceptive methods, therefore, is an important factor that determines whether women will decide to limit childbearing. If women do not know

that effective contraceptive methods exist, or how to obtain them, she may not believe she has a choice about future childbearing. (37)

The study of Doan Duc Luu, contraceptive use patterns in central coast area of Vietnam, 1995 (10) found that Vietnamese women's knowledge of contraceptive methods was relatively high, and that urban women's knowledge was higher when compared to rural women's knowledge. There was still a big gap between knowledge and practice regarding contraceptive use.

Remarkable progress has also been made in extending the knowledge and mean of family planning. In three decades, the number of children born to the average women in the developing world fell from 6.0 to 3.7 overall. The proportion of women using of modern methods of family planning has increased from less than 10% to approximately 50%. And the evidence from contraceptive prevalence in Thailand (1979) showed that 97% of rural women and 98% of urban women know at least one contraceptive method (WHO, 1992). The speed of this changed unprecedented in demographic history, with some 17 nations succeeding in having lower fertility rates in only one generation (United Nation, 1992) (39). Success or failure in contraceptive methods is dependent on how much one knows about contraceptive methods. This means that unless a woman knows about the various methods available in the family planning, it is unlikely that she will practice contraceptive methods. On the other hand, it cannot be assumed that awareness of contraceptive methods will necessarily guarantee that she will accept it use. Knowledge of outlets is correlated with the type of contraceptive use. Women who know about the outlets are less likely to use traditional methods.

Htay W. revealed that majority of women had high knowledge on family planning. 75.9 percent of the women with high level of knowledge were current users while ever users and never users were 16.7 percent and 7.4 percent respectively. For those with middle level of knowledge, 60 percent were current users while ever users and never users were 17.6 percent and 22.4 percent respectively. (29)

According to Family Planning worldwide 2002 data sheet, the researchers had stated that, despite the rise in family planning use evidenced in surveys, mother's attitude towards recent births around the world in late 1990s was more than one-fourth of births worldwide are unplanned. (40)

2.5 Availability and accessibility

Throughout the world, more and more adolescents are sexually active. In some societies this has always been the case. In other societies, this trend marks a change from the past: a change that must be dealt with and accepted as a current reality. It is essential that adolescent sexuality be acknowledged and that adolescent reproductive health information and services be provided to them. It is important that this is done for their own protection and for the well being of society as the whole. (28)

A. Distance of contraceptive service

A study concluded that over 95% of people in the developing world lived in countries that directly supported family planning programs. The average distances that women must travel to their nearest clinic providing contraceptive service varies greatly. In general women had much better access to contraceptive services in urban areas than in rural areas (31).

The majority of pill clients took less than 30 minutes to reach the service facility but a large percentage took about half an hour. However, the IUD cases had a greater proportion of urban clients and showed a vary similar 12 months continuation for less than 30 minutes of travel time (23).

Demographic and Health Survey data to examine the effect of accessibility on use of contraceptives in Vietnam. They find that 84% of Vietnamese women live within one kilometer of at least one source of family planning services, with access considerably higher in urban areas than in rural areas. (11)

Kamuansilpa P et al, revealed that a woman has to travel approximately 20 minutes to get pills and about one hour for a sterilization. Other temporary methods also took about less than half an hour to obtain services. Traveling time for IUD and vasectomy was slightly less than one hour. In general, the accessibility to service-measured preliminary by travel time seems to be fairly favorable in Thailand. (41)

B. Sources of information

In Thailand the private personal communication between husbands and wives, relatives and medical personnel was the major means of communicating information about contraceptive. (42). A study conducted on Community-Base Factor Affecting Contraceptive Use Pattern and Discontinuation Among Thai Women. They found out that in southern Thailand, information seeking behavior first begin with the member of women's kinship group i.e. mother, sisters and cousins who have experience in using contraceptive methods becoming the network of local beliefs, concerning contraceptive use with most effective transmitted. (29)

Personal who had the most contact with the information of program tended to be adopter on the other hand, those who had none, tended not to be adopter. The finding also indicated that direct effect of mass media was much smaller that direct personal contact. However, mass media contact tended to stimulate personal contacts, promoted husband-wife communication and discussion with directly promoted adoption of family planning service. Consequently, husband-wife communication should be stimulated further personal contact with family planning personnel, as a result of mass media messages, and information discussions with friends, neighbors and relatives (43).

Information, education and communication support to family planning service delivery as strengthen and leads to positive attitude towards family planning to promote the practice and acceptance of a small, healthy, happy and prosperous family as a social norm by adequate provision of information on population, development and family planning methods and by mobilization of every member of community to

voluntary participate in the population and family planning program with a view to achieving the general population objective of the country. (44)

Radio reaches almost everybody. Worldwide, there are estimated two thousand million radio receivers and more than thirty-two thousand radio stations in the world. Thus radio has great potential to bring family planning and related health messages to the world people. The most successful of the use of multiple communications media including radio and peer education in Adolescent Sexual Health Intervention in Cameroon Sub-Saharan Africa (45).

CHAPTER III
RESEARCH METHODOLOGY

3.1 Study design.

The research was a cross-sectional study on the acceptance of contraceptive among married women of reproductive age between 15 to 49 years old.

3.2 Study area and study population.

The urban city of Aranyapratheth district was selected as the study site. It is located in Srakaeo province which situated in eastern part of Thailand around 250 Km far from Bangkok. The city consists of 12 communes and 6,500 households.

The target populations of this study were married women of reproductive age between 15-49 years old who were staying with their spouse, not conceiving, and who did not have a child less then one year of age, living in urban city of Aranyapratheth district.

3.3 Sample size estimation.

The sample size was estimated as the following formula:

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

$$n = \frac{(1.96)^2\, 0.77(1-0.77)}{(0.05)^2}$$

n=272.13

n=275

n = sample size

Z = standard normal deviation with 95% confidence interval = 1.96

d = degree of accuracy set at 5%

$\alpha = 0.05$

p = anticipated proportion of using contraceptive = 77%

3.4 Sampling technique

There were 12 communes in the urban city of Aranyaprthet district. Five communities were purposively selected as study sites. The study subjects were proportioned to 55 subjects per commune, with total 275 women. A list of all households was updated by the community headman and the households were numbered serially. The first household was randomly chosen from the list by random start number follow by selection of every third household. The health staff interviewed the married women aged between 15-49 years from each selected households.

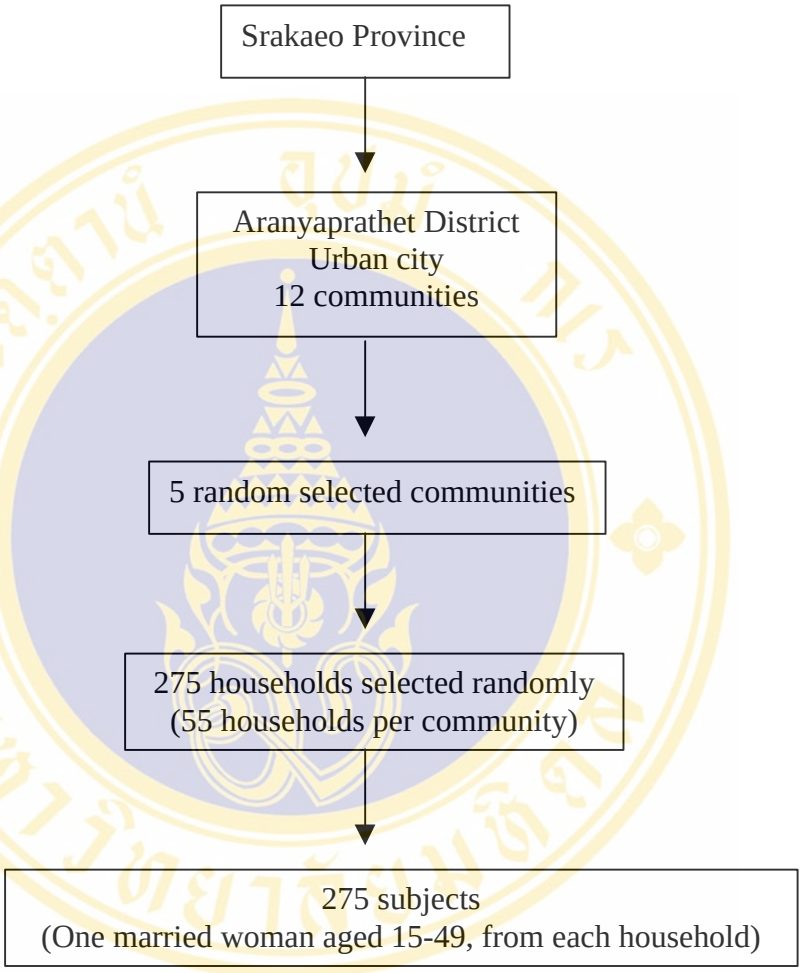


Figure 1: Plan showing the sampling technique

3.5 Research Instrument

The instrument used for data collection was a structured questionnaire which applied by the trained interviewers; the questionnaire divided in 5 parts as:

Part 1 Socio-demographic characteristics

Socio-demographic characteristics of the respondents include age, duration of marriage, income, education, occupation, number and sex of living children, children's sex preference and husband's support.

Part 2 Knowledge on family planning

It consists of questions about the meaning of family planning and contraceptive methods, condition to use, efficacy, advantage or side effects of contraceptive… The knowledge of respondents was measured by 12 questions; each correct answer is given a score of '1' and '0' for incorrect answer. The total score was classified into three groups, according to mean and standard deviation:

1. Good knowledge : > 80% of total score (10-12)
2. Fair knowledge : 60-80% of the total score (8-9)
3. Poor knowledge : < 60% of the total score (0-7)

Part 3 Attitude towards the practice of family planning

To measure the attitude of the respondents by asking 12 questions whether they agree or disagree with the statement use in Likert scale ranging from strongly agree to strongly disagree by the following criteria to give score:

Strongly agree	(SA) = 5
Agree	(A) = 4
Not sure	(NS) = 3
Disagree	(D) = 2
Strongly disagree	(SD) = 1

This was divided into two groups by the mean attitude of 47.8

-Positive attitude if the total score was 48

-Negative attitude if total score was < 48

Part 4 Practice of contraceptive

This part included practice of contraceptive method, reason for acceptance of contraceptive of current users, past users and never users.

Part 5 Availability and accessibility of contraceptive

Measured by asking questions include sources of contraceptive information, place of service, distance from the residence to service center, how to pay for contraceptive and satisfaction to get contraceptive.

3.6 Pre-test

Questionnaire was translated from English to Thai version and approximately 30 women of age between 15-49 years were pre tested to the wording and flow of questions in questionnaire in Aranyapratheth district hospital.

-For the knowledge questions, regarding the reliability test, alpha was 0.3486

-For the attitude question, the reliability test, alpha was 0.6438

After pre-test questionnaire had revised for reliability and validity before the final form was developed.

3.7 Data collection

In five communes of urban city Aranyaprathet district data collection was done through questionnaires comprised of 57 questions for individual interviewee.

There were two interviewers for each commune, one was health personnel another was village health volunteer. All the ten interviewers was trained the

technique interviewing and meaning of the questions before implementing the interview with the respondents.

3.8 Data Analysis

After collecting, the data was entered in the computer and analyzed by using computer software Epi-Info and Minitab program

The results were presented as the frequency and percentage distribution that calculated for all variables.

The association between the independent variables of interest and dependent variable was tested by using Chi-square test.

CHAPTER IV
RESULTS

Two hundred and seventy five married women of reproductive age from five communes of urban city Aranyaprathet District, Sakaeo province were interviewed from 18th to 31st of January 2004.

The result of this study was shown in table as frequency and percentage distribution of the samples, and Chi-square test showed the association between of independent variables and dependent variable. The level of significance for all comparisons was set up at p-value less than 0.05.

The association between the socio-demographic status, knowledge, attitude, accessibility and the practice of family planning of married women of reproductive age was analyzed.

The results were presented in the following tables.

4.1 Socio-demographic characteristics

Table 1 Socio-demographic characteristics

Characteristics		Frequency n = 275	Percentage (%)
Age groups (Years)			
16-29		47	17.1
30-39		108	39.3
40-49		120	43.6
Mean = 37.3	SD = 7.6	Min = 16	Max = 49
Duration of marriage(years)			
1-5		34	12.4
6-10		43	15.6
11-20		114	41.5
>20		84	30.5
Mean = 16	SD = 7.7	Min = 1	Max = 32
Occupation			
Laborer		102	37.1
Housewife		97	35.3
Business		36	13.1
Farmer		27	9.8
Government employees		13	4.7
Family income (monthly)			
Sufficient		98	35.6
Not sufficient		177	64.4
Education levels			
No education		31	11.3
Primary school		150	54.5
Secondary school		37	13.5
High school or higher		57	20.7

Table 1 showed that the majority of women about 83% were in the age group of 30 years and older; the young age group of 15-29 years old covered only 17%. The mean age of respondents was 37.3 years and the youngest and eldest of age were 16 years and 49 years respectively.

According to the duration of marriage, this study revealed that most of the respondents belonged to the duration of marriage more than 11 years; this covered around 72% while the group of 1-5 years and 6-10 years were 12.4% and 15.6% respectively. The mean of marriage duration was 16, the minimum was 1 year and maximum was 32 years.

Regarding the occupation of married women, 35.1% or one-third was unskilled group of housewife. Almost half of respondents about 47% belonged to the semiskilled group; they were farmer and laborer only 18% were government employees and businesswomen. As correspond to the economic status two-third of women had not sufficient income, only 35.6% stated that their income was sufficient.

Most of the respondents got only primary level of education represented 54.5%. About one-third (34.2%) of them got education from secondary school up to high school or higher level. However, there were still 11.3% that had no education.

Table 2 Information on children of the respondents

Characteristics		Frequency n = 275	Percentage (%)
No. of living children			
No child		16	5.8
1 child		64	23.3
2 children		118	42.9
3 children		52	18.9
4 children		19	6.9
5 children		6	2.2
Mean = 2.2	SD = 0.9	Min = 1	Max = 5
No. of living son(s)			
No son		68	24.7
1 son		136	49.5
2 sons		54	19.6
3 sons		14	5.1
4sons		1	.4
5sons		2	.7
Mean = 1.5	SD = 0.7	Min = 1	Max = 5
No. of living daughter(s)			
No daughter		100	36.4
1 daughter		112	40.7
2 daughters		44	16.0
3 daughters		15	5.5
4 daughters		3	1.1
5 daughters		1	.4
Mean = 1.5	SD = 0.8	Min = 1	Max = 5

Table 2 Information on children of the respondents (Cont.)

Characteristics	Frequency n = 275	Percentage %
Age of youngest child(years)	**n = 259**	
<5	101	39.0
5-15	114	44.0
>15	44	17.0
Mean = 9.2 SD = 6.2	Min = 1	Max = 27
Child's sex preference of wife		
Boy	54	19.6
Girl	71	25.8
Both	150	54.5
Child's sex preference of husband		
Boy	83	30.2
Girl	56	20.4
Both	136	49.5

As shown in this table, in terms of number of living children, 94.2% of respondents had children, most of hem (42.9%) had 2 children, followed by 23.3% had 1 child, 18.9% had 3 children and 5.8% had no child, only small number who had 4 or 5 children. The mean of living children was 2.2, minimum was 1 and maximum was 5.

Among 75.3% of women who had sons two-third had one to two sons approximately (69.1%), while 24.7% had no son and small number around 6% had 3-5 sons. The mean of living son was 1.5.

The number of daughter was lower than son (63.4% of women had daughters), it was found that more than one- third of respondents had no daughter, more than half of them had 1-2 daughters and only small number about 7% had 3-5 daughters. The mean of living daughter was 1.5.

Table 2 revealed that among 259 women who had children, those who had the youngest children aged less than 5 years and aged from 5-15 years were similar number 39.0% and 44.0% respectively, about 17.0% of them had youngest children more than 15 years old. The mean age of youngest child was 9.2, minimum was 1 year and maximum was 27 years.

The data corresponded with sex preference of children, wife more preferred girl than boy and vise versa. But most of wives (54.5%) preferred both gender, the desired for boy and girl was 19.6% and 25.8% respectively. As compared to the child's sex preference of the husband, it was similarly that most of the husband (49.5%) preferred both gender and desired for boy and girl was a little different 30.2% and 20.4% respectively.

Table 3 Discussion and decision about family planning

Characteristics	Frequency n = 275	Percentage (%)
Discussion about contraceptive with husband, relative, other		
Yes	**n=185**	67.3
With -Husband	163	88.1
-Relative	15	8.1
-Health personnel	7	3.8
No	90	32.7
Make decision for contraceptive choice (multiple answer)		
Herself	254	92.4
Husband	101	36.7
Health personnel	38	13.8
Relative	16	5.8
Friend/neighbor	10	3.6
Husband agreement for contraceptive use	**(n = 174)**	
Yes	145	83.3
No	20	11.5
Not sure	9	5.2

Concerning to the discussion about contraceptive, most of the women (67.3%) have discussed before using and 32.7% have not discussed. Among 185 women (67.3%) who had discussed before using contraceptive, 88.1% of them have discussed with their husband, 8.1% have discussed with relative and 3.8% have discussed with other people who was health personnel in the hospital.

Table 3 noted that for making the decision for contraceptive choice the majority of women (92.4%) made decision by themselves, 36.7% made by their husband, 13.8% by health personnel, small number made by relative friend or neighbor.

Regarding husband's agreement for contraceptive use, among 174 respondents with whom their husbands have not involved in making the decision for contraceptive choice, majority of them (83.3%) practiced contraceptive by the agreement of their husband, 11.5% did not have agreement and 5.2% were not sure about their husband's support.

Table 4 Opinion towards number of children in the family

Characteristics	Frequency n = 275	Percentage (%)
Want more children in the future		
Yes	62	22.5
No	200	72.7
Not sure	13	4.7
No of desired children	**n = 62**	
1 child	48	77.4
2 children	14	22.6
Appropriate number of children in the family		
1 child	3	1.1
2 children	146	53.1
3 children	117	42.5
4 children	6	2.2
5 children	2	0.7
6 children	1	0.4
Mean = 2.5	Min = 1	Max = 6
Having many children is the asset		
Yes	109	39.6
No	75	27.3
Not sure	91	33.1
Having many children is the burden		
Yes	210	76.4
No	38	13.8
Not sure	27	9.8

In table 4 most of the respondents (72.7%) stated that they did not want any more child follow by 4.7% were not sure whereas approximately 22.5% corresponding 62 women who expressed the desire of additional children. Among 62 women, 77.4% needed one more and 22.6% needed two more children.

Concerning to the thinking about the appropriate number of children in a family 95.6% of the women mentioned that it should be 2 to 3 children while about 4% needed four to six children.

In terms of family asset more than one-third (39.6%) of the respondents said that having many children was the asset to help family every day work but 76.4% of them claimed that having many children was their family burden.

4.2 Distribution of women's knowledge on family planning

Table 5 Frequency and Percentage distribution of MWRA by knowledge on family planning meaning and contraceptive methods

Knowledge items	Correct answer Frequencies n = 275	%
Meaning of family planning (multiple answer)		
Child spacing	79	28.7
Choosing the number of children	82	29.8
Using the contraceptive	114	41.5
Understand all	87	31.6
Contraceptive methods (multiple answer)		
Know all methods	174	63.3
Pills	96	34.9
Injection	86	31.3
Tubectomy	82	29.8
Condom	74	26.9
IUD	52	18.9
Vasectomy	36	13.8
Norplant	17	6.2

Concerning to the three right meanings of family planning in table 5, it showed that there was different understanding of the respondents, 31.6% understood all the three meanings while 28.7% selected the meaning as child spacing, 29.8 % selected the meaning as choosing the number of children and 41.5% selected the meaning as using the contraceptive.

Regarding the knowledge on contraceptive methods, 63.3% of the women knew all the seven modern methods. Moreover, the majority of them knew more about pills,

injection, tubectomy and condom and the knowledge of others methods was slightly declined.

Table 6 Frequency and percentage distribution of MWRA by knowledge statements

Knowledge statements	Correct answers	
	Frequencies n = 275	%
Women have to take pills every day to avoid pregnancy	268	97.5
Oral pill can cause nausea at the beginning	221	80.4
Injection can not cause cessation of breast milk	102	37.1
Vasectomy is an operation for man to prevent pregnancy	206	74.9
Using IUD several years will cause uterine cancer	37	13.5
Withdrawal method is effective for preventing pregnancy	79	28.7
Condom use can prevent pregnancy and sexually transmitted diseases	240	87.3
Women can have children again by stop taking pill or injection	257	93.5
Tubectomy is a method use for women to prevent pregnancy	246	89.5
IUD is a method use for pregnancy prevention in women only	245	89.1
Injection can prevent pregnancy for 3 months	255	92.7
Use oral pill can cause cervical cancer	67	24.4

Regarding to the knowledge with the positive statements, most of the women could provide more correct answers. In terms of knowledge on efficacy of family planning method, the percentage of correct answer was quite high for almost every methods ranging from about 75% to approximately 97.5%, except the score of few negative statements about the complication of the contraceptive method for example IUD, Withdrawal, injection methods that was rather low at about.

Table 7 Frequency and percentage distribution by the score of knowledge on family planning.

Characteristic	Frequency n = 275	Percentage (%)
Knowledge on family planning		
Good (score 10-12)	46	16.7
Fair (score 8-9)	140	50.9
Poor (score 0-7)	89	32.4
Mean = 8. SD = 1.7	Min = 0	Max = 12

Base on the mean (8)and standard deviation (1.7) of the knowledge score, the knowledge of women in this study were categorized into three groups of the knowledge as good, fair and poor which were presented in table 7. Good knowledge group were those who had score from 10-12 while a fair knowledge group was those with score of 8-9 and a poor knowledge group was those with score of 0-7.

It was noted that only 16.7% had good knowledge. The rest had fair and poor (51% and 32% respectively).

4.3 Distribution of women's attitude towards practice of family planning

Table 8 Percentage distribution of MWRA by attitude towards family planning

Attitude statements	SA %	A %	NS %	D %	SD %
Contraceptive use can help a couple in selecting the number of children	49.5	41.1	8.0	1.1	0.4
Family planning is good for mothers' health	47.3	45.8	5.5	0.7	0.7
Oral contraceptive use is safe	24.0	44.0	26.9	4.4	0.7
Family planning should be taught before getting married	43.6	48.4	6.9	0.7	0.4
Women can still work hard after having tubectomy	18.2	31.6	33.1	14.5	2.5
Family planning should be taught at secondary school	43.3	37.1	10.5	7.3	1.8
The couple using contraceptive can have sex freely from pregnancy	32.0	53.8	11.6	1.8	0.7
Contraceptive use should be the couple's agreement	37.5	55.6	5.8	0.7	0.4
Women can still work hard after using IUD	20.0	31.6	39.6	6.9	1.8
IUD method does not disturb sexual intercourse	16.7	31.6	44.4	6.5	0.7
All method of family planning are equal effective	25.1	45.5	23.6	3.3	2.5
Man can still work hard after vasectomy operation	24.0	37.5	32.0	5.1	1.5

Note: SA = Strongly agree
A = Agree
NS = Not sure
D = Disagree
SD = Strongly disagree

As presented in table 8 the majority of the respondent expressed their feeling mainly on “agree” and “strongly agree” with the score up to more than 50% in almost all attitude items, and also they mention about 40% on “not sure” in several items, especially in the statement items of using IUD. However, quite low percentage of score of the respondents who mentioned on disagree and strongly disagree.

Table 9 Frequency and percentage distribution of MWRA by score of attitude towards family planning

Characteristics	Frequency n = 275	Percentage (%)
Attitude towards practice of FP		
Positive attitude (score 48)	140	50.9
Negative attitude (score<48)	135	49.1
Mean = 47.8 SD = 5.1	Min = 30	Max = 60

According to the mean and standard deviation, the attitude towards family planning of respondents in this study was classified into two groups, considered as positive attitude and negative attitude. The positive attitude group were those who had score more than and equal to 48 and for those with score less than 48 were the negative attitude group.

The table 9 revealed that the respondents who had positive and negative attitude score were at almost equal proportion, the positive attitude was 50.9% and negative attitude was 49.1%. The mean attitude was 47.8 ± 5.1. The minimum score was 30 and maximum was 60.

4.4 Frequency and percentage distribution on contraceptive use

Table 10 Frequency and percentage distribution of MWRA by contraceptive use

Characteristics	Frequency n = 275	Percentage (%)
Current user	205	74.5
Past user	58	21.1
Never user	12	4.4
Current users' contraceptive methods	**(n = 205)**	
Pills	95	46.3
Tubectomy	71	34.6
Injection	20	9.8
IUD	7	3.4
Condom	6	2.9
Norplant	6	2.9
Reason for using contraceptive of current user	**(n = 205)**	
Don't want more child	167	81.5
Poor economic	29	14.1
Not healthy	9	4.4
Reason for stopped using contraceptive of past user	**(n = 58)**	
Want more child	21	36.2
Health reason	17	29.3
Husband practiced contraceptive (vasectomy)	6	10.3
Fear of side-effect	4	6.9
menopause	4	6.9
Husband disapproved	3	5.2
Husband away	3	5.2
Reason for not using contraceptive of never user	**(n = 12)**	
Leave it to nature	5	41.7
Want more children	6	50.0
Health reason	1	8.3

Table 10 showed that 74.5% of the studied women were currently using contraceptive, 4.4% had never used any contraceptive methods while 21.1% had used but stop using it at the present.

Among the 205 (74.5%) current users, the most common use around 46.3% were oral pills followed by 34.6% were practicing tubectomy and injection had about 9.8% whereas using condom, IUD and Norplant were only quite low.

The reason for using contraceptive of 205 respondents, “Don’t want more children” was the main reason of the women, it covered about 81.5% of current users while the reason of poor economic was 14.1% and only 4.4% of them used contraceptive due to not healthy.

Regarding reason of 58 women for stopped using contraceptive, 36.2% of them said that they wanted more children, out of this stopped contraceptive due to health reason 29.3%, husband practiced another contraceptive method 10.3% (all of their husband practiced vasectomy), husband disapproved 5.2%, husband away 5.2%, fear of side-effect 6.9% and another reason to stop contraceptive (6.9%) due to menopause.

Concerning with the reason of not using contraceptive among 12 women, half of them said that they wanted children. About 41.7% and 8.4% of women did not use contraceptive for the reason to leave it to nature and health reason respectively.

4.5 Number and percentage distribution about availability and accessibility to contraceptive service

Table 11 Frequency and percentage distribution of MWRA by sources of contraceptive

Characteristics	Frequency n = 263(*)	Percentage (%)
Sources of contraceptive information (multiple answer)		
Health personnel at hospital	193	70.2
Relative/friends	123	44.7
Health personnel at PCU/HC	103	37.5
Village health volunteer	87	31.6
Television	81	29.5
Radio	46	16.7
Newspaper, book and magazine	42	15.3
Drug seller	41	14.9
Leaflets, pamphlets	21	7.6
Know the place of contraceptive service		
Yes	263	100
No	0	0
Main source of contraceptive service		
Community hospital	172	65.4
Pharmacy/Drug store	66	25.1
Private clinic	13	4.9
Provincial hospital	6	2.3
Primary Care Unite (PCU)/Health center	6	2.3
Distance from residence to contraceptive service		
<1 Km	70	26.6
1-2 Km	187	71.1
3-5 Km	6	2.3

Note: (*) Excluded never user 12 cases

Table 11 showed that in terms of sources of contraceptive information, about two-third (70. 2%) of women said that they knew it from health personnel at hospital, 37.5% knew from health personnel at primary care unit (PCU/HC) while around 44.7% knew from relative/friend, 31.6% knew from village health volunteer, and some other knew from television, radio, drug seller, news paper/book or leaflet.

In respect of the place of contraceptive service, 100% of current user and past user were aware of contraceptive providing services in either private or public sector.

With regard to the main source of contraceptive service, more than half of the women (65.4%) received this service from the community hospital, while less than one-third (25.1%) of women received from pharmacy/drugstore, and some small number of them got contraceptive from private clinic, provincial hospital or primary care unit.

In terms of the distance from the residence to the service center, the majority of the women (71.1%) were living about 1 to 2 Km to where they could get the service, while 26.6% were living very close to the service center less than 1 Km and only 2.3% were living a little far about more than 3 Km.

Table 12 Frequency and percentage distribution of MWRA by satisfaction with receiving contraceptive service

Characteristics	Frequency n = 263(*)	Percentage %
Pay for contraceptive service		
Self-paying	104	39.5
30 baht scheme	87	33.1
Civil Servant Medical Benefit Scheme	61	23.2
Social Security Scheme (SSS)	4	1.5
Free of charge	7	2.7
Satisfaction with receiving contraceptive service		
Yes	259	98.5
No	4	1.5
Reason for satisfaction	**n = 259**	
Safe	139	53.7
Effective	15	5.8
Easily available	41	15.8
Easy to use	45	17.4
Cheap	19	7.3
Reason for dissatisfaction	**n = 4**	
Unsafe	2	50.0
Ineffective	2	50.0

(*) Excluded never user 12cases

It was found that for the payment to the contraceptive service, around one-third of the respondents paid by 30 baht scheme, by Civil Servant Medical Benefit Scheme

(CSMBS) and by themselves 33.1%, 23.2% and 39.5% respectively whereas the remaining were paid by Social Security Scheme (SSS) or free of charge.

Regarding satisfaction to the contraceptive service, almost all of the respondents (98.5%) were satisfied only 4 of them representing 1.5% showed their dissatisfaction towards contraceptive service.

In terms of satisfaction, among 259 women, more than half (53.7%) mentioned that contraceptive was safe, 17.4% expressed contraceptive was easy to use, 15.8% expressed that it was easy available, 7.3% expressed that it was cheap and 5.8% said that contraceptive was effective.

Among 4 dissatisfied women, 2 of them (50.0%) claimed that contraceptive was unsafe and other 2 (50.0%), said that the service was not good and was ineffective (be cause one lady after stop using one year of pill she is still not conceiving).

4.6 Result of association between various independent variables of interest and dependent variable.

Table 13 Association between age group, duration of marriage, occupation, family income, education and acceptance of contraceptive

Characteristics	Acceptance of contraceptive				χ^2	p-value
	Current user		Past and never user			
	n=205	%	n=58+12	%		
Age group						
16- 29	35	74.5	12	25,5	2.778	0.249
30-39	86	79,6	22	20.4		
40-49	84	70.0	36	30.0		
Duration of marriage						
1-5	23	67.6	11	32.4	5.530	0.063
6-10	38	88.4	5	11.6		
> 10	144	72.7	54	27.3		
Occupation						
Housewife	70	72.2	27	27.8	6.175	0.186
Laborer	80	78.4	22	21.6		
Farmer	23	85.2	4	14.8		
Government employees	10	76.9	3	23.1		
Business	22	61.1	14	38.9		
Family income						
Not sufficient	141	79.7	36	20.3	6.850	0.009
Sufficient	64	65.3	34	34.7		
Education levels						
No education	26	83.4	5	16.1	1.772	0.621
Primary school	109	72.7	41	27.3		
Secondary school	27	73.0	10	27.0		
High school or higher	43	75.4	14	24.6		

Table 13 shows that with the total number of respondents, according to their age group and its association with acceptance of contraceptives, most of the three age groups were more likely to use contraceptive from 70% to nearly 80%. There was no significant association was seen between age group and acceptance of contraceptive with the p-value of 0.249.

Regarding the duration of marriage, it was similarly between the women who got married more or less than 10 years, they were using contraceptive around 70% to nearly 90%. There was no significant association between duration of marriage and contraceptive use with p-value of 0.063.

Even though all the respondents were in the different group of occupation and different number in each group but regarding to the practice of family planning they were all accepting contraceptive with the same higher level of percentage from more than 60% to more than 80%. However there was no significant association between occupation of the respondents and acceptance of contraceptive with the p-value of 0.186.

According to the contraceptive use among married women by family income, it revealed that the higher percentage 79.7% of using contraceptive was the women who stated that family income were not sufficient with a significant association between family income and acceptance of contraceptive at p-value of 0.009.

Concerning the education levels of the respondents, most of the women had primary school level and the lowest number were no education but in terms of participating to practice contraceptive all of each group of education level had also similar percentage around 70% to 80%. There was no significant association between education levels of married women and acceptance of contraceptive since p-value of 0.621.

Table 14 Association between number of living children, number of living son, number of living daughter, children's sex preference, husband's support and acceptance of contraceptive

Characteristics	Acceptance of contraceptive				χ^2	p-value
	Current user		Past and never user			
	n=205	%	n=58+12	%		
Number of living children n=259 (1)						
1 child	44	68.8	20	31.2		
2-3 children	137	80.6	33	19.4		
> 3children	17	68.0	8	32.0	4.716	0.095
Number of living son n=207 (2)						
1 son	95	69.9	41	30.1		
>1 son	58	81.7	13	18.3	3.390	0.066
Number of living daughter n=175 (3)						
1 daughter	89	79.5	23	20.5		
>1 daughters	50	79.4	13	20.6	0.000	0.988

Table 14 Association between number of living children, number of living son, number of living daughter, children's sex preference, husband support and acceptance of contraceptive (Cont.)

Characteristic	Acceptance of contraceptive				χ^2	p-value
	Current user		Past and never user			
	n=205	%	=58+12	%		
Children's sex preference:						
Child's sex preference of women						
Boy	38	70.4	16	29.6		
Girl	53	74.6	18	25.4		
Both	114	76.0	36	24.0	0.664	0.718
Child's sex preference of husband						
Boy	63	75.9	20	24.1		
Girl	38	67.9	18	32.1		
Both	104	76.5	32	23.5	1.666	0.435
Husband agreement for contraceptive use						
n=174(4)						
Yes	112	77.2	33	22.8		
No	18	62.1	11	37.9	2.945	0.086

(1) Excluded no child 16 cases

(2) Excluded no son 68 cases

(3) Excluded no daughter 100 cases

(4) Excluded women with whom their husband involved to make the contraceptive choice 101 cases

According to the number of the living children, among the three groups of women who had 1 son, 2-3 sons or more than 3 sons they were more likely to be the current user with the same high percentage almost 70% to 80%. There was no significant association between number of living children and contraceptive acceptance with the p-value of 0.095.

It was found that the women who had one son about 70% were the current user this percentage was increased to 80% for those who had more than one son. There was no significant association between number of living sons and contraceptive use with the p-value of 0.066.

Regarding number of living daughters, the table 14 indicated that the women who had only one or more than one daughters were current user with equal percentage with approximately 80%. There was no significant association between number of living daughters and acceptance of contraceptive since the p-value of 0.988.

When examining the children's sex preference and acceptance of contraceptive, in terms of child's sex preference of women, even different number of the three groups preferred different sex of the children but they were in almost the same higher percentage of current user. It means that two-third of each group of them were practicing contraceptive. Compared to the child's sex preference of husband the situation of the women was also the same i.e. similar proportion or two-third of the women were also practicing contraceptive with no significant association between child's sex preference of women or husband and acceptance of contraceptive since the p-value of 0.718 and 0.435 respectively.

With regards to the husband's agreement for contraceptive used, the majority of the women were agreed by their husband and according to the percentage of using contraceptive; it was higher than women who were not agreed 77% and 62% respectively. There was no significant association between husband agreement and acceptance of contraceptive with the p-value of 0.086.

Table 15 Association between knowledge and acceptance of contraceptive

Characteristics	Acceptance of contraceptive				χ^2	p-value
	Current user		Past and never user			
	n=205	%	n=58+12	%		
Knowledge of family planning						
Good	34	73.9	12	26.1		
Fair	109	77.9	31	22.1		
Poor	62	69.7	27	30.3	1.937	0.380

According to knowledge of the respondents on family planning, the result showed that approximately half of women had fair knowledge. But on the contrary all of the three groups of them with even good, fair or poor knowledge, they were likely to practice contraceptive with almost the same percentage around 70%. So there was no significant association between knowledge of married women and acceptance of contraceptive with the p-value of 0.380.

Table 16 Association between attitude and acceptance of contraceptive

Characteristics	Acceptance of contraceptive				χ^2	p-value
	Current user		Past and never user			
	n=205	%	n=58+12	%		
Attitude towards family planning						
Positive attitude	103	73.6	37	26.4		
Negative attitude	102	75.6	33	24.4	0.143	0.706

Concerning with attitude of married women towards family planning, this study revealed that the number of positive and negative attitude of the respondents was almost equal proportion and also their practice of contraceptive was still almost equal percentage (more than 70%). There was no significant association between attitude of married women and acceptance of contraceptive with p-value of 0.706.

Table 17 Association between place of contraceptive service, distance from residence to contraceptive service, satisfaction and acceptance of contraceptive

Characteristics	Acceptance of contraceptive				χ^2	p-value
	Current user		Past user			
	n=205	%	n=58	%		
Distance from residence to contraceptive service						
< 1 Km	47	67.1	23	32.9		
>1 Km	158	81.9	35	18.1	6.477	0.011
Place to get contraceptive services						
	4	66.7	2	33.3		
Provincial hospital	130	75.6	42	24.4		
Community hospital	4	66.7	2	33.3		
PCU/HC	7	53.8	6	46.2		
Private clinic	60	90.9	6	9.1		
Pharmacy/drugstore						
	Using Fisher's exact test		12.29	and p-value =		0.015
Satisfaction with receiving contraceptive						
	202	78.0	57	22.0		
Yes	3	75.0	1	25.0		
No						
	Using Fisher's exact test		0.021	and p-value =		0.633

According to distance from residence to contraceptive service, even two-third of current user who lived farther than 0ne Km from the service center but the percentage of using contraceptive (81%)was higher than one-third of them who were living closely to the contraceptive service less than 1 Km, practicing contraceptive only

67%. There was a significant association between the distance from residence to contraceptive service and the acceptance of contraceptive with the p-value of 0.011.

For the place to get contraceptive services, the largest number of the women went the community hospital about two-third. But according to the percentage of using contraceptive service it was slightly different from one facility to another. Women practiced contraceptive increasingly from more than 50% in the private clinic up to 90% in the pharmacy with significantly associated between place of contraceptive services and acceptance of contraceptive by the p-value of 0.015.

In respect of satisfaction with receiving contraceptive, nearly 100% of current and past user claimed that they were satisfied with contraceptive use; only 4 of them expressed their dissatisfaction. But in term of practicing contraceptive both groups were similar percentage. However, there was no significant association between satisfaction with contraceptive services and acceptance of contraceptive with p-value of 0.633.

Table 18 Association between sources of contraceptive information and acceptance of contraceptive

Characteristics	Acceptance of contraceptive				X^2	P-value
	Current user		Past user			
	n=205	%	n=58	%		
Sources of contraceptive information						
Relative/friend						
Yes	100	81.3	23	18.7		
No	105	75.0	35	25.0	1.512	0.219
Village health volunteer						
Yes	73	83.9	14	16.1		
No	132	75.0	44	25.0	2.688	0.101
Health personnel at PCU/HC						
Yes	77	74.8	26	25.2		
No	128	80.0	32	20.0	1.002	0.317
Health personnel at hospital						
Yes	155	80.3	38	19.7		
No	50	71.4	20	28.6	2.358	0.125
Pharmacy/drug seller						
Yes	32	80.0	8	20.0		
No	173	77.6	50	22.4	0.116	0.734

Regarding to the sources of contraceptive information, the respondents got it from various sources. As shown in table 11, most of them got it from health personnel at hospital, from health personnel at primary care unit or health center and from relative or friend. Concerning percentage of using contraceptive it was so high of women who got contraceptive information from all every sources but there was no significant association between sources of contraceptive information and acceptance of contraceptive with p-value more than 0.05.

CHAPTER V
DISCUSSION

The cross-sectional study was designed to collect data in urban city Aranyaprathet district, Srakaeo province, Thailand. The objectives were to evaluate the contraceptive prevalence rate among 275 married women of reproductive age between 15-49 years who are living with their spouses, not conceiving and do not have a child less than one year of age and were also described the socio-demographic factors, knowledge, attitude, availability, accessibility towards acceptance of contraceptive The study variables were measured in terms of frequencies and percentage distribution, and were cross-tabulated with Chi square test to find out the relationship between the variables of interest and acceptance of contraceptive.

Concerning total knowledge, it was divided in to three groups through scoring: high score as good knowledge, moderate score as fair knowledge and low score as poor knowledge. Attitude was also divided into two groups: high score as positive attitude and low score as negative attitude.

5.1 The contraceptive prevalence rate (CPR) among married women of reproductive age in urban city Aranyaprathet district.

This study explored that the contraceptive prevalence rate was 74.5% of MWRA who were currently using contraceptive, 21.1% of them was past user and 4.4% was never user. It was noted that the most popular of contraceptive method was oral pills and tubectomy, others methods were less accepted by the women. Regarding the most common use of the women was oral pills, this study was similar to the study of Syed Ihtram Shabbir in Puthamonthon district, Nakhon Pathum province, Thailand 2000 (37), it might be due to the pills were most easily available from the pharmacy without consumed the time to wait for getting pill at public sector and it was usable method than other. The female sterilization (tubectomy) was considered as the second

choice of the women in that area, it was higher than the national level, which was 23% stated by Philip Guest in Asia-Pacific Population Journal, June 2003 (9)

Concerning the reason of acceptance of contraceptive of the current user, the majorityof the respondents stated that they do not want to have any more children, while some of them concerned about poor economic and not healthy

However, considering the women who were never users, half of them wanted more children. Other reason was leave it to nature and health reason.

In respect of the discontinuation of contraceptive it was found that among 58 past users, more than one-third of them want more children, others stopped using due to health reason, 6 women discontinued because of their husbands practiced vasectomy and 4 women were being menopause.

5.2 Socio-demographic characteristics

Normally, we can expect to see that young married women who just got married, they still want to have children are less likely to practice family planning than the older ones. However, in this study although the majority was belonged to older age group who want to limit or stop childbearing by using contraceptive may be they were complete the family size but the pattern of family planning practiced were not significantly different from the young age group. That was different from Duong Thi Nhan, found in 2002 that the higher age, the greater use of contraceptive among the Vietnam women (46).

In term of duration of marriage, the women with duration of marriage more or less than 10 years were using contraceptive with almost the same percentage. This result was no significant association between duration of marriage and acceptance of contraceptive. It differed from the study of Virasack Banouvong 1999 stated that the longer the duration of marriage, the higher the use of contraceptive (24).

Concerning occupation of the respondents who were belonged to low or high category of occupation or jobless they were practicing family planning with no different percentage. As compared to the study in Rachaburi province, Thailand (29), Htay Win stated that the majority of current users were farmer, laborer and housewife, and they could find its significant association. However in this study there was no significant association between occupation of the women and acceptance of contraceptive.

But for the women who live with the insufficient income they were more likely to accept contraceptive than those who had sufficient income group with significant association between family income and acceptance of contraceptive. It reversed to the previous study by Doung Thi Nhan 2002, expressed that contraceptive use had significant association with high income status (46).

Regarding education status, majority of the respondents belonged to primary school level. But it was noted that the no education group seemed to practice contraceptive higher than others levels. Compared to the study conducted in Pathumthany province, Thailand by Aytal Haque 1996 (23). He showed that the contraceptive use rate was high among the less educated women. It was observed that in this study the increase of contraceptive use did not depended on the education level of the respondents and the association between education level and acceptance of contraceptive was not found to be significant.

According to the number of living children, the majority of respondents who had 2-3 children were more likely to use contraceptive that was possibly because they reached their desired of family size. Compared to the most recent UN statistics “Two-Child Families are Becoming the Norm” (47) mentioned that fertility in less developed regions has declined to slightly fewer than three children per family. Therefore, in this study there was no significant association between number of living children and acceptance of contraceptive.

In this study sex preference does not have a strong effect on contraceptive use. Approximately half of the women and their husbands needed both gender of their

children but there was no significant association between children's sex preference and acceptance of contraceptive. The result in this study area was different from the Nepal Demographic and Health Survey in 1996 that in Nepal women's contraceptive use exposed to the media, parity, education level and religion are linked to stopping childbearing after the birth of a boy. (48)

In relation with husband's support for contraceptive use, most of respondents had their husband's agreement in contraceptive use. But compared to the women who were not agreed from the husband, contraceptive use was slightly declined. The husband's support does not only mean that his agreement with the women to practice contraceptive method but it should be the cooperation that he himself helps the couple to practice contraceptive method. According to the 'Together For a Happy Family Campaign' ran from March 1998 to March 2000, organizing by the Jordanian National Population Committee showed that 98% of 1,122 men having used a contraceptive method and having discussed family planning with their wife (49). However, in this study there was no significant association between husband's support and acceptance of contraceptive.

5.3 Knowledge of respondents and association between knowledge and acceptance of contraceptive

The knowledge of the respondents was assessed that in terms of having different categories good, fair or poor of knowledge women had not different level of participating in family planning program. That was no significant association between knowledge and acceptance of contraceptive. This study was different from the study of Phetdam Vanhnolrath in Lao PDR 2003 (50) stated that women with the good and fair knowledge participated in more practicing family planning than those who had a poor knowledge.

5.4 Attitude of the respondents and association between attitude and acceptance of contraceptive

Considering the investigation of women's attitude, the score of the two groups positive and negative attitude were at equal proportion (50.9% vs. 49.1%) and also the contraceptive use were equal percentage (73.6% vs. 75.6%). That was no significant association between attitude and acceptance of contraceptive. This study was also different from the study of Phetdam Vanhnolrath (50) stated that women who had positive attitude had participated family planning higher than those who had negative attitude.

5.5 Availability, accessibility and association between family planning services and acceptance of contraceptive

The results explored by this study about the place of service, distance from contraceptive facility, satisfaction and sources of information had been focused to determine the availability and accessibility of contraceptive services.

Regarding the place to get contraceptive, at the time of interview, 100% of current and past users were aware of different contraceptive services. The main source of service center that most of them knew and preferred to get contraceptive method was community hospital and pharmacy. But the higher percentage of using contraceptive was in the pharmacy and than slightly declined in the community hospital with significant association between contraceptive providing services and acceptance of contraceptive.

According to the distance of contraceptive service, the level of percentage of practicing contraceptive were reversible increased from the nearest to the farthest distance with significant association between distance of the residence and acceptance of contraceptive. This result was not relevant to the study of Doung Thi Nhan (46), which was found that the women who had nearer distance were more likely to use contraceptive than those who had farther distance.

Concerning satisfaction with receiving contraceptive, it was shown that nearly 100% of respondents were satisfied to use contraceptive with different aspects. But there was no significant association between satisfaction and acceptance of contraceptive, the same as the study of Syed Ihtram Shabbir (37).

There was not any problem with regard to the payment for contraceptive service, in the study area. Normally, family planning was free of charge or paid by many health care schemes such as 30 baht scheme, Civil Servant Medical Benefit Scheme, Social Security Scheme or self-paying for the private sector.

In terms of contraceptive information the respondents knew it from many sources. Mostly they heard from health personnel and relative or friends but all the groups of women from all sources as shown in table 11 and 18 had similar percentage in practicing contraceptive with no significant association between sources of contraceptive information and acceptance of contraceptive. This finding was the same as the study of Syed Ihtram Shabbir (37).

This study revealed that in spite of low educational, low occupation, low economic status of the women and almost all variables in socio-demographic factors and in psycho-social factors there was not significantly associated with acceptance of contraceptive but the prevalence contraceptive rate was still high. This because of family panning program have been implemented so long time in Thailand (more than 30 years) under the efficient policy making, management, monitoring and evaluation of the Ministry of Public Health and National Family Planning Program. With community participation and involvement of women making the contraceptive service easily available and accessible with effective and dynamic. So far almost all Thai women are being known and understanding about family planning or contraception.

CHAPTER VI
CONCLUSION AND RECOMMENDATION

6.1 Conclusion

Family planning is one of the essential elements of primary health care and plays a significant role in health and socio-economic development. Currently population growth is one of the most serious problems in the world, especially in the developing countries. Hence, the governments of developing countries have been attempting to reduce the population growth rate by developing family planning program. Moreover, family planning not only to space the birth and decrease the population growth, it also can reduce the maternal and infant morbidity and improve the maternal and child health and the quality of family life as well.

The main problem for family planning is the decision of the women who accept contraceptive methods or not.

In Thailand the ministry of public health especially the National Family Planning Program (NFPP) has successful to reduce the population growth by implementing good family planning services compared to most developing countries in the region.

Therefore, this research was attempted to identify socio-demographic factors, psycho-social factors and environmental factors which influenced the acceptance of contraceptive in urban city Aranyaprathet district, Sakaeo province, Thailand.

Base on the result finding in this study the contraceptive prevalence rate was 74.5% similar to the national rate but slightly lower than the district report that was 77% and it was reverse with the rural situation of Aranyaprathet, which was 88%. The most contraceptive methods were oral pills and tubectomy while others methods were less accepted like IUD and Norplant.

The socio-demographic factors related to family planning revealed that the major of contraceptive users belonged to old age group equal or above 30 years old and had got married more than 10 years with low level of education. They were also belonged to the low-income occupation such as laborer, farmer and housewife with no income.

According to the number of living children, the average number perceived by respondents was 2-3 children with no sex preference and most of the women tended to see that having many children was the burden.

Concerning knowledge of the respondents there were not differences of practice contraceptive among different level of knowledge. Furthermore the attitude had no contribution to contraceptive used.

In terms of the environmental factors such as, contraceptive information, payment to the service and satisfaction were not differently contributed to contraceptive used. Only place of contraceptive services and distance of the women's residence were significant association with the acceptance of contraceptive.

6.2 Recommendation

In this study according to the efficiency of health care policy in Thailand the effective and dynamic family planning program have increased the number of acceptance of contraceptive among married women to a great extent. But as the number of the women of reproductive age will be increasing every year there is a need to maintain and expand the good quality of contraceptive service delivery to new clients and to make it more cost effective in order to cover the increasing target population of both men or women.

The study revealed that most of respondents were using oral pill and vasectomy. Moreover, the results also shown that men shared their responsibility in family planning very low, only 6 people (2%) used condom and others 6 men (2%) practiced vasectomy. Therefore health service provider should pay attention to identify the

cause of less using IUD and expand the education to the men to participate in practicing contraceptive methods because family planning are also the part of them and the methods are more effective and less harm to the men.

This study identified the limited socio-demographic, psychological factors, availability and accessibility of acceptance of contraceptive methods. The sample size was small and the information gathered was not conclusive Therefore the following measures suggest for further study.

1. A study with larger sample size could be conducted in order to get more reliable and meaningful results.

2. Another study should be conducted in rural area of Aranyaprathet district that will be helpful to compare the discrepancy of contraceptive prevalence rate and the different situation of acceptance of contraceptive methods.

3. The study should be carried out to measure the knowledge attitude of male participation regarding practicing contraceptive methods.

4. Another research should be conducted to identify the causes of using or not using IUD method. From this study the result shown that only 3.4% of the women were practicing IUD. Moreover, in terms of knowledge and attitude most of respondents were still confused about the danger and complication of using IUD.

REFERENCES

1. Cadwallader WP. Population and development taskforce Bill Cadwallader. [Online]. 2004. Available from: http://www. Worldpopulationgrowth. org/maintext.php29ID=25&lastpageId=0&sid=53628232340e3348ca711 [Accessed 2003 Nov 16].
2. World Health Organization. The world health report 1996: fighting disease forstering development, report of the director-general. Geneva: The Organization; 1996.
3. "----------". The world health report 1998: life in the 21st century a vision for all. Geneva: The Organization 1998.
4. Farr G. Clinical performance of the Tcu 380A and Tcu 220C IUDs in fourdeveloping countries: family planning clinics. North Carolina: Family Health International. 1994.
5. Axel IM, Cynthia I. Abortion-related morbidity and mortality: the global picture. abortion in developing world. Geneva: WHO, 1999.
6. Glenn Mcgee, Jon F Merz. Abortion. n.p.: Microsoft @ Encarta@ Encyclopedia 2003.
7. National Institute of Statistics, Directorate General for Health [Cambodia]and ORC Macro. Cambodian demographic and health survey (CDHS) 2000. Phnom Penh: The Institute; 2001.
8. Koju RB. KAP of family planning among married women of reproductive age inBanpong District, Thailand [M.P.H.M. Thesis in Primary Health Care Management]. Nakhorn Pathom. Faculty of Graduate Studies, Mahidol University; 1995.
9. Guest P. Reproductive health including family planning. Asia Pac Popul J 2003 June; 18(2): 55-79.
10. Doan Duc Luu. Contraceptive use patterns in central coast of Vietnam [M.A. Thesis in Population and Family Planning Research]. Nakhorn Pathom: Faculty of Graduate Studies, Mahidol University; 1996.

11. Nguyen Minh Thang, Dang Nguyen Anh Demographic and health survey. Int Fam Plan Perspect 2002 Dec; 11 (4): 214-19.

12. Boonyarithikarn J. 2003, September 8. Chief of Primary Care Unit of SakaeoProvincial Hospital. Interview.

13. In this issue. [editors]. Int Fam Plann Perspect 2002 Dec; 28(4): 183.

14. Makinwq-adevusoye P. Population and development. [Online]. 2000. Available from: http://server.africapolicy.org/rtable/ade0001.htm [Accessed 2004 Jan].

15. World Health Organization. Women's health profile: Vietnam: Manila: TheOrganization, 1995. Women's Health Series (8).

16. Population Action Bureau. Trends in reproductive health worldwide [Online] Available from: http:/www.populationaction. org/resources/ publications/ worldofdifference/rr 2_introduction.htm [Accessed 2002 Oct 25].

17. Daulaire N et Al., Promises to Keep: the toll of Unintended Pregnancies on Women's Lives in the Developing world, Washington DC: Global Health Council, 2002. International Family Planning Perspective 2002.nuber 4 December.

18. The Johns Hopkins University Bloomberg School of Public Health. Three to five saves lives. Maryland outline: Center of communication programs. [Online]. Available from: http://www.jhuccp.org/pr/113edsum.[Accessed 2002 Dec 15].

19. World Health Organization. Contraceptive method mix: guideline for policy and service delivery. Geneva: The Organization; 1994.

20. Naviraj. Factors affecting the continuation of contraceptive practice in the Bangkok metropolis polyclinics acceptors [M.S. Dissertation in Sociologyand Anthropology]. Bangkok Faculty of Graduate of Studies, Chulalongkorn University.1978

21. Economic and Social Commission for Asia and the Pacific. ESCAP'S populationdata sheet. Manila: The Region Office; 1999.

22. Laput Pagodo R. Selected determinants of family planning behavior among married women in Naga Cebu Philippines [M.P.H.M. Thesis in

PrimaryHealth Care Management]. Nakhorn Pathom: Faculty of the raduate Studies, Mahidol University; 1990.

23. Haque A. Factors affecting the acceptance of contraceptive among marriedwomen of reproductive age in Muslim community in village 12 and 13 sub-district Klong song. district Klong Luang of Pathumthani provinceThailand [M.P.H.M. Thesis in Primary Health Care Management]. Nakhorn Pathom: Faculty of Graduate Studies, Mahidol University; 1996.

24. Banouyong V . Contraceptive use among married women in Xiengngeun District, Luangprabang, Province, Laos PDR [M.P.H.M. Thesis in Primary Health Care Management]. Nakhorn Pathom: Faculty of Graduate Studies, Mahidol, University; 1999.

25. Abuka IM. Determinants of socio-factors on family planning behavior among Thai-Muslim married women age 15-44 years. [M.P.H.M. Thesis inprimary health care management]. Nakhorn Pathom: Faculty of Graduate Studies, Mahidol University; 1991.

26. Leoprapai B, Thong Thai V. A study of family planning incentive programs in Thailand. Nakhorn Pathom: Mahidol University; 1985 IPSR publication No 89

27. Khin Thet Wai. Determinants of contraceptive use in rural Myanmar: the role of motivation and attitude [M.A. Thesis in Population and Family Planning Research]. Faculty of Graduate Studies, Mahidol University.1995.

28. United Nation. Access to family planning/Reproductive health services and contraceptives[Online].Availablefrom:htt://www.unescobkk.org/ips/arhweb/ esources/law/ch_5.pdf [Accessed 2002 Nov 15].

29. Htay Win. Factors affecting family planning behavior among married women ofreproductive age in Rachaburi province of Thailand [M.P.H.M. Thesis inPrimary Health Care Management]. Nakhorn Pathom: Faculty of Graduate Studies, Mahidol University.1993.

30. Sadiga. Nasifis. UNFPA. The state of world population: decision for development women empowerment and reproductive health. New York: United Nation; 1995.

31. Chamratrithiron A, Kamnuansilpa P, Knodel J. Contraceptive practice andertility in Thailand: study of third contraceptive prevalence survey. Study Fam Plan 1986; 17(6). 279.

32. Pitaktep S, Pichitprachuamoh V. Fertility and family planning among rural and urban women in Thailand; Bangkok: Institute of Population Studies, Chulalongkorn University; 1974. Paper No 15.

33. Djoechraeni, Siti R.H. Continuation rate of oral pill use among rural eligiblewomen aged 15-49 years in Ayuthaya province Thailand [M.P.H.M. Thesis in Primary Health Care Management]. Nakhorn Pathom: Faculty of Graduate Studies, Mahidol University; 1990.

34. Nakavonnakit.T, Bunett.T, Balakrisnan.TR. Continuation injectable contraceptive in Thailand. Study Fam Plan 1982; 13 (4): 56-60.

35. Arnold F. Effects of sex preference on contraceptive use, abortion and fertility inMatlab, Bangladesh. Int Fam Plann Perspect 2001 Sept; 27(3): 137-47.

36. Sex preference and fertility in Peninsular Malaysia; Suet-ling Pong. Study Fam Plan 1994; 25(3): 137-48.

37. Syed Ithram Shabbir. Acceptance of contraceptive among married women of reproductive age in Puthamonthon District, Nakhorn Pathom Province, Thailand. [M.P.H.M. Thesis in primary heal Pathom: Faculty of Graduate Studies, Mahidol University; 2000.

38. Aye Sein. The study of side effect of Temporary contraceptives methods among Currently contraceptive users in Rajvithi hospital Bangkok Thailand [M.P.H.M. Thesis in Primary Health Care Management]. Nakhorn Pathom: Faculty of Graduate Studies, Mahidol University; 2000.

39. Youry Se. Knowledge, attitude and practice of family planning among married women of reproductive age in Sangker district, Battambang province, Cambodia [M.P.H.M. Thesis in Primary Helath Care women of reproductive age in Sangker district, Battambang Management]. Nakhon Pathom: Fuculty of Graduate Studies, Mahidol University; 1996.

40. The United Nation Population Division. Popultion reference bureau and familyplanning worldwide 2002. Data Sheet. New York: Population

Reference % from the 1984 prevalence survey: Bangkok; Institute for Population and Social Research, Mahidol University 1984.

42. Charoenloct V, Laoprapai.B. Report on contraceptive continuation rate and of northernThailand.[Online].1996.Abstractfrom:http://www.thai.net/stams/abstract2/strengtheningInfromationEducationandcommunication useeffectiveness in Bangkok Metropolis: 1975. Bangkok: IPSR, Mahidol University; 1976.
43. Jain A. Implication for evaluating the impact of F.P program with reproductive a health orientation. Study Fam Plan 2001 Sept: 220-29.
44. Sripun Tiam-Tong C, Chowsilpa S, Wongbuddha C, Robert GL. Strengthning the information, education and communication components of family planning in selected areas.html [Accessed 2003 Oct 2].
45 Agha S. A quasi-experimental study to assess the impact of four adolescent sexual health interventions in Sub-Saharan Africa. Int Fam Plann Perspect 2002 June; 28(2): 67-70.
46. Nhan Duong Thi. Use of contraceptive methods among married women of reproductive age at Myloc district, Namdinh city, Vietnam. [M.P.H.M. Thesis in Primary Health Care Management] Nakhorn Pathom: Faculty of Graduate Studies, Mahidol University, 2002.
47. Brown B. Update. Int Fam Plnn Perspect 2002 June; 28(2): 56-7.
48. Leone T, Matthews Zoe, Zuanna GD. Impact and Determinants of sex preference in Nepal. Int Fam Plan Perspect 2003 June; 29(2): 69-75.
49. Brown B. Update. Int Fam Plnn Perspect 2003 June; 29(2): 56-7.
50. Vanhnolrath P. Family planning practice among married women of reproductive age in Samneua municipality, Houaphanh province, Lao PDR. [M.P.H.M. Thesis in Primary Health Care Management] Nakhorn Pathom: Faculty of Graduate Studies, Mahidol University, 2003.

APPENDIX

APPENDIX A

QUESTIONNAIRES

FACTORS RELATED TO THE ACCEPTANCE OF CONTRACEPTIVES AMONG MARRIED WOMEN OF REPRODUCTIVE AGE IN URBAN CITY ARANYAPRATHET DISTRICT, SRAKAEO PROVINCE, THAILAND

Date of interview_____/_____/_____

Name of commune:……..

House's number:……..

Name of interviewer:……

Starting time:……to……,total duration:…….

Please inform married women that this questionnaire is for research purposes only and all her answers are confidential.

Part I Socio-demographic characteristics

Please fill in the blank or check (✓) that you think is appropriate

1. How old are you?.....years
2. How long have you been married?.....years
3. What is your main occupation?

   [ ] 1. Housewife

   [ ] 2. Laborer

   [ ] 3. Farmer

   [ ] 4. Government employees/officers

   [ ] 5. Business

   [ ] 6. Others (Specify……)
4. Is your monthly family income sufficient?

   [ ] 1. Yes

   [ ] 2. No
5. What is your educational level?

   [ ] 1. No education

[ ] 2. Primary school

[ ] 3. Secondary school

[ ] 4. High school or higher

[ ] 5. Others (specify…….)

6. How many living children do you have now?.....child(ren)

7. How many sons and daughters you have?

[ ] 1. Sons…….

[ ] 2. Daughters……

8. What is the age of your youngest child…….years

9. When you get pregnant what would your preference for the sex of your child?

[ ] 1. Boy

[ ] 2. Girl

[ ] 3. Both; boy or girl

10. When you get pregnant what would your husband's preference for the sex of your child?

[ ] 1. Boy

[ ] 2. Girl

[ ] 3. Both; boy or girl

11. Do you discuss with your husband, your relative or other people about contraceptive?

[ ] 1. Yes:

[ ]. Husband

[ ]. Relative

[ ]. Other (specify……..)

[ ] 2. No

12. Who make the decision for contraceptive choice? (can answer more than one)

[ ] 1. Yourself

[ ] 2. Your husband (skip question 13)

[ ] 3. Health personnel

[ ] 4. Relative

[ ] 5. Friend/neighbor

[ ] 6. Other (specify……)

13. Does your husband agree with you for using the contraceptive to prevent pregnancy?

[ ] 1. Yes

[ ] 2. No

[ ] 3. Not sure

14. Do you want to have any more children in the future?

[ ] 1. Yes (ask next question)

[ ] 2. No (skip to Q16)

[ ] 3. Not sure (skip to Q16)

15. If yes, how many children do you want to have more?.....child(ren)

16. How many children do you think a family should have?.....child (ren)

17. Do you think that having many children is your asset to help your every day work?

[ ] 1. Yes

[ ] 2. No

[ ] 3. Not sure

18. Do you think that having many children is your burden?

[ ] 1. Yes

[ ] 2. No

[ ] 3. Not sure

Part II knowledge of MWRA on family planning

Please check (✓) in the blank that you think is appropriate

19. What is family planning? (Can answer more than one)

[ ] 1. Child spacing

[ ] 2. Choosing the number of children

[ ] 3. Using the contraceptive

[ ] 4. Others (specify……..)

20. What family planning methods do you know? (Can answer more than one)

[ ] 1. Condom

[ ] 2. IUD

[ ] 3. Pills

[ ] 4. Injection

[ ] 5. Tubectomy

[ ] 6. Vasectomy

[ ] 7. Norplant

[ ] 8. Others (specify:……...)

For the following statements please specify whether you think it is true or false statements, if you are not sure or do not know please check column don't know.

No	Statement	True	False	Don't know
21	Women have to take oral pills every day to avoid pregnancy			
22	Oral pill can cause nausea at the beginning			
23	Injection can not cause cessation of breast milk			
24	Vasectomy is an operation for man to prevent pregnancy			
25	Using IUD several years will cause uterine cancer			
26	Withdrawal method is effective for preventing pregnancy			
27	Condom use can prevent pregnancy and sexually transmitted diseases			
28	Women can have children again by stop taking pill or injection			
29	Tubectomy is a method use for women to prevent pregnancy			
30	IUD is a method use for pregnancy prevention in women only			
31	Injection can prevent pregnancy for 3 months			
32	Use oral pill can cause cervical cancer			

Part III Attitude of MWRA towards the practice of family planning

Please check (✓) in the blank that you think is appropriate

SA = Strongly agree
A = Agree
NS = Not sure
D = Disagree
SD = Strongly disagree

No	Statement	SA	A	NS	D	SD
33	Contraceptive use can help a couple in selecting the number of children					
34	Family planning is good for mothers' health					
35	Oral contraceptive use is safe					
36	Family planning should be taught before getting married					
37	Women can still work hard after having tubectomy					
38	Family planning should be taught at secondary school					
39	The couple using contraceptive can have sex freely from pregnancy					
40	Contraceptive use should be the couple's agreement					
41	Women can still work hard after using IUD					
42	IUD method does not disturbs sexual intercourse					
43	All method of FP are equal effective					
44	Man can still work hard after vasectomy operation					

Part IV Practice about contraception

Please check (✓) in the blank that you think is appropriate

45. Have you ever used any contraceptive method?

[ ] 1. Current user (ask next question)

[ ] 2. Past user (skip to question 48)

[ ] 3. Never user (skip to question 49)

46. If current user (from question 45), which contraceptive method are you using now?

[ ] 1. Condom

[ ] 2. IUD

[ ] 3. Pills

[ ] 4. Injection

[ ] 5. Tubectomy

[ ] 6. Norplant

[ ] 7. Withdrawal

[ ] 8. Safe period

[ ] 9. Other (Specify:……)

47. If current user (from question 45), why did you use it?

[ ] 1. Don't want more children

[ ] 2. Not healthy

[ ] 3. Poor economic

[ ] 4. Other (please specify:……...)

48. If past user from question 45. Why did you stop using contraceptive?

[ ] 1. Husband practiced contraceptive (specify:……...)

[ ] 2. Husband disapproved

[ ] 3. Husband away

[ ] 4. Health reason

[ ] 5. Fear of side-effect

[ ] 6. Pregnant

[ ] 7. Want more child

[ ] 8. Other (specify:……..)

49. If never user from question 45, why don't you use contraceptive method?

[ ] 1. Husband practiced contraceptive (specify:……..…….)

[ ] 2. Husband disapproved

[ ] 3. Leave it to nature

[ ] 4. Fear of side-effect

[ ] 5. Want more children

[ ] 6. Don't know where to service

[ ] 7. Health reason

[ ] 8. Not convenient

[ ] 9. Others (please specify…….)

Part V Availability and accessibility to services

(Ask only the current user and the past user in question 45)
Please check (✓) in the blank that you think is appropriate

50. From whom or which sources do you get information about contraceptives (Can answer more than one)

[ ] 1. Relatives/friends

[ ] 2. Village health volunteers

[ ] 3. Health personnel at PCU/HC

[ ] 4. Health personnel at hospital

[ ] 5. Drug seller

[ ] 6. Radio

[ ] 7. Television

[ ] 8. Leaflets, pamphlets

[ ] 9. News paper, book, and magazine

[ ] 10. Others (specify:……..)

51. Do you know where to get contraceptive service?

[ ] 1. Yes

[ ] 2. No (skip to question 54)

52. If yes (from the question 51), where do you get the contraceptive method?

[ ] 1. Provincial hospital

[ ] 3. Primary Care Unit (PCU)/Health center (HC)

[ ] 4. Private clinic

[ ] 5. Pharmacy/Drug store

[ ] 6. Others (please specify:…….)

53. How far is your residence from the place to receive contraceptive service?

[ ] 1. < 1 Km

[ ] 2. 1-2 Km

[ ] 3. 3-5Km

[ ] 4. > 5 Km

[ ] 5. Others (specify:……..)

54. How do you pay for contraceptive service?

[ ] 1. 30 baht scheme

[ ] 2. Civil Servant Medical Benefit Scheme (CSMBS)

[ ] 3. Social security scheme (SSS)

[ ] 4. Self-paying

[ ] 5. Other (specify:……)

55. Are you satisfied with your receiving contraceptive services?

[ ] 1. Yes (ask next question)

[ ] 2. No (ask question 57)

56. If ‘yes’ from question 55, why do you satisfy?

[ ] 1. Safe

[ ] 2. Effective

[ ] 3. Easily available

[ ] 4. Easy to use

[ ] 5. Cheap

[ ] 6. Others (specify):…….)

57. If ‘no’ from question 55, why don’t you satisfy?

[ ] 1. Unsafe

[ ] 2. Ineffective

[ ] 3. Not available

APPENDIX B

Table 19 Number and percentage distribution of respondents by knowledge on F.P.

No	Statement	True		False/Don't know	
		n	%	n	%
21	Women have to take oral pills every day to avoid pregnancy	268	97.5	7	2.5
22	Oral pill can cause nausea at the beginning	221	80.4	54	19.6
23	Injection can not cause cessation of breast milk	102	37.1	173	62.9
24	Vasectomy is an operation for man to prevent pregnancy	206	74.9	69	25.1
25	Using IUD several years will cause uterine cancer	37	13.5	238	86.5
26	Withdrawal method is effective for preventing pregnancy	79	28.7	196	71.3
27	Condom use can prevent pregnancy and sexually transmitted diseases	240	87.3	35	12.7
28	Women can have children again by stop taking pill or injection	257	93.5	18	6.5
29	Tubectomy is a method use for women to prevent pregnancy	246	89.5	29	10.5
30	IUD is a method use for pregnancy prevention in women only	245	89.1	30	10.9
31	Injection can prevent pregnancy for 3 months	255	92.7	20	7.3
32	Use oral pill can cause cervical cancer	67	24.4	208	75.6

Table 20 Number and percentage distribution of respondents by attitude towards F.P.

No	Statement	SA n (%)	A n (%)	NS n (%)	D n (%)	SD n (%)
33	Contraceptive use can help a couple in selecting the number of children	136 (49.5)	113 (41.1)	22 (8.0)	3 (1.1)	1 (0.4)
34	Family planning is good for mothers' health	130 (47.3)	126 (45.8)	15 (5.5)	2 (0.7)	2 (0.7)
35	Oral contraceptive use is safe	66 (24.0)	121 (44.0)	74 (26.9)	12 (4.4)	2 (0.7)
36	Family planning should be taught before getting married	120 (43.6)	133 (48.4)	19 (6.9)	2 (0.7)	1 (0.4)
37	Women can still work hard after having tubectomy	50 (18.2)	87 (31.6)	91 (33.1)	40 (14.5)	7 (2.5)
38	Family planning should be taught at secondary school	119 (43.3)	102 (37.1)	29 (10.5)	20 (7.3)	5 (1.8)
39	The couple using contraceptive can have sex freely from pregnancy	88 (32.0)	148 (53.8)	32 (11.6)	5 (1.8)	2 (0.7)
40	Contraceptive use should be the couple's agreement	103 (37.5)	153 (55.6)	16 (5.8)	2 (0.7)	1 (0.4)
41	Women can still work hard after using IUD	55 (20.0)	87 (31.6)	109 (39.6)	19 (6.9)	5 (1.8)
42	IUD method does not disturbs sexual intercourse	46 (16.7)	87 (31.6)	122 (44.4)	18 (6.5)	2 (0.7)
43	All method of FP are equal effective	69 (25.1)	125 (45.5)	65 (23.6)	9 (3.3)	7 (2.5)
44	Man can still work hard after vasectomy operation	66 24.0	103 (37.5)	88 (32.0)	14 (5.1)	4 (1.5)

SA = Strongly agree = 5

A = Agree = 4

NS = Not sure = 3

D = disagree = 2

SD = Strongly disagree = 1

BIOGRAPHY

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