

## **CHAPTER II**

### **LITERATURE REVIEW**

#### **2.1 Mother to child HIV transmission and Myanmar**

Today, in 40 different townships throughout Myanmar, prevention of HIV mother to child transmission programs provide confidential counseling and testing services as well as Antiretroviral Prophylaxis. Very few national and international NGOs are involved in PMTCT. Eighty percent of HIV positive women delivered babies at home. Most of the women living in the border areas went to Thailand for delivery and to receive free infant formula (*UNICEF, 2003*).

#### **2.2 Migration and HIV/AIDS**

Nowadays, more and more people are migrating. Most people move for economic reasons, but some migrate to escape political or religious persecution or simply to fulfill a personal dream. Some experts divide the many reasons people leave their homes for widespread unemployment, lack of farmland, famine, or war at home. Factors that attract migrants include a booming economy, favorable immigration laws, or free agricultural land in the area to which the migrant is moving.

In 2002, there were 175 million international migrants, that is 2.9 percent of the world's population; 48 percent of migrants are women. Migrant populations are at higher risk of contracting HIV because of their status. (*Migration and HIV/AIDS: UNESCO*). Migrants' vulnerability to HIV/AIDS is increased by a complex set of

factors. Even when migrants have a clear understanding of HIV prevention, condom use is still inconsistent, especially amongst spouses and unmarried partners, which may sometimes include indirect sex workers. Structural barriers, such as language differences, the location of services, documentation, and concerns of arrest or harassment can all hamper migrants' ability to access proper reproductive and general health services, including condoms.

### **2.3 Myanmar migrant in Thailand**

In July 2004, 1,276,837 migrants, including labourers and their family members, attempted to register under the state registry of Thailand - known as the Tor-Ror 38/1. Of that number, 1,161,013 officially completed their registration. Estimates by the Government and NGOs, point to the actual number of migrants present, including those registered, as possibly exceeding two million (not including the 117,000 official refugees). Of those migrants working in Thailand, 849,552 registered for a work permit in 2004, and only 810,730 fully completed the issuing process for work permits. Over 900,000 of the migrants registered under Thailand's state registry - including dependents and family members - come from Myanmar, and there are many more present who are undocumented. (*Ministry of Labour, 2005*).

A study by the UN Development Program found that in Samut Sakhon, a province with a large concentration of migrants, there was a 4.3 percent HIV prevalence rate among pregnant migrant workers, compared to 2 percent amongst pregnant Thai women. Although ARV for prevention of mother to child transmission (PMTCT) is supposedly available to all pregnant mothers, including migrants, actual numbers of migrant women in this program are low. (*Press, B., 2004*). There are

many barriers for migrants to access health care, such as registration or immigration status, fear of arrest, location, transportation, language, and attitude of health providers. (*Rak Thai Foundation*)

#### **2.4 HIV positive pregnant women and PMTCT experience**

Many studies in Africa have found that women often refuse treatment or fail to show up for follow up visits because of program staff's reactions, as well as the program systems. (*Painter. et.al., 2004*). Also, the social supports of HIV positive women, especially that provided by the partner, strongly influence women's decision to participate in the Prevention of Mother to Child Transmission program. The study in sub-Saharan Africa found that, "it could be that a partner who lives with the HIV-positive woman fears the prejudice from the society more, and so will not encourage her to enroll." "Among single women, that the child's father had no influence on their decision to participate in the program". (*Eide et al. 2004*). Different studies found that factors associated with the functioning of a programme, created barriers to the participation of pregnant women who knew that they were HIV positive, in follow up visits that were necessary before starting zidovudine prophylaxis. For many of the women in the studies, these barriers consisted of negative experiences that they had had, or expected to have, during their interactions with staff working at the program. Although programs cannot deal with unexpected events that affect women's lives, these examples show the importance of a staff demeanour that is supportive of women's feelings. Additionally, program policies that are responsive to circumstances that may impede their participation - for example, the costs of transport to the program could be covered.

## 2.5 Theory related to the study

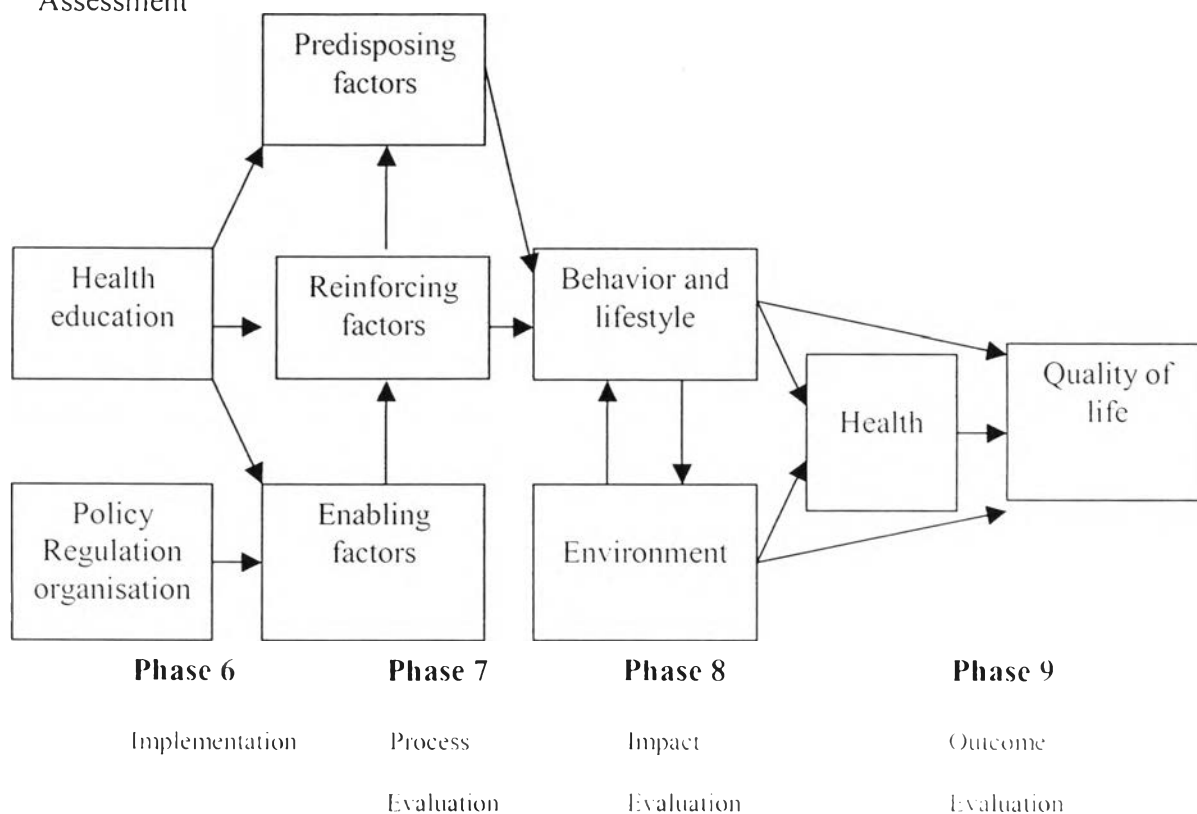
The PRECEDE-PROCEED behavioral model, as described by *Green and Kreuter (1991)*, emphasizes two fundamental propositions: (1) health and health risks have multiple determinants and (2) to be effective, efforts to effect behavioral, environmental, and social change must take these multiple determinants into account. A combination of processes and techniques are required to develop a plan and to determine strategies for health behavior change.

The PRECEDE-PROCEED model was developed as a planning framework from which health education and health promotion programs could be designed (*Green, et al., 1980; Green & Kreuter, 1991*). PRECEDE stands for “Predisposing, Reinforcing, and Enabling Factors in Educational Diagnosis and Evaluation.” Predisposing factors include knowledge, attitudes, beliefs, personal preferences, existing skills, and self-efficacy toward the desired behavior change. Reinforcing factors include factors that reward or reinforce the desired behavior change. Enabling factors are psychological/emotional or physical factors that facilitate motivation to change behavior. This process is composed of five steps of analysis, starting from the current situation of health problems. The problems are then examined backward to identify the causes of the problems and the obtained data is utilised in the planning of further management for behavioral changes. PROCEED stands for “policy, regulation, and organisational constructs in educational and environmental development” was added to the model. The PROCEED component of the model acknowledges the importance of environmental factors in determining behaviors. In summary, the model begins with the outcome of interest and the model is used to design and promote a program to achieve the desired outcome.

**Diagram of PRECEDE-PROCEED Model**

**PRECEDE**

Phase 5	Phase 4	Phase 3	Phase 2	Phase 1
Administrative and policy Assessment	Educational and Ecological	Behavioral and Environmental	Epidemiological Assessment	Social



**PROCEED**

**Figure 1.2: Diagram of PRECEDE-PROCEED Model** (Green & Kreuter, 1999)

**Step 1 Social assessment** is a process of considering and analyzing quality of life. It involves the assessment of problems in various population groups, judging which problems have impacts on an individual, groups of people and their health. The

assessed problems indicate levels of quality of life of the population, for example, unemployment, crime, overpopulation.

**Step 2 Epidemiological assessment** is an analysis of health problems that affect the population being studied. The epidemiological diagnosis helps in specifying health problems, understanding the distribution of the problems and the risk factors related to the problems. The data are then utilised in determining the priority of the problems so that the more important ones can be selected for further management.

**Step 3 Behavioral and environmental assessment** is the process of examining the environmental and behavioral components that are related to health conditions and health problems.

**Step 4 Educational and ecological assessment** is an examination of factors that cause or affect health behavior. The factors are categorised into predisposing, enabling, and reinforcing factors.

**Step 5 Administrative and policy assessment** is associated with the assessment of capacity and resources of an organisation, as well as its policy, which leads to the management plan, and the actions, which should be consistent with the factors influencing health behavior found from step 4.

**Step 6 Implementation** is the utilisation of the plan.

**Step 7-8-9 Evaluation** involves three aspects as follows:

Process evaluation is the evaluation of problems arising during the implementation as well as the evaluation of the progression of the program, in order to assess and ensure that the program is progressed as planned.

Impact evaluation is the evaluation of unexpected impacts, both in positive and negative ways. Outcome evaluation is the evaluation of the outcomes directly

resulted from the program. This evaluation includes three issues: effectiveness, adequacy and efficiency.

My study focuses mainly on steps 3 and 4 of the PRECEDE-PROCEED framework and an examination of factors associated to preventive behaviors against dengue infection. These factors are categorised into predisposing, enabling, and reinforcing factors, as discussed above.