CHAPTER I

INTRODUCTION

This chapter is divided into six sections presenting rationale and background of the study, research questions, research objectives, research hypotheses, operational definitions and conceptual framework.

1.1 Background and Rationale

This first section describes migration of Myanmar people into Thailand, global and regional situations of HIV epidemic, the HIV/AIDS situations among Myanmar migrant workers in Ranong, Thailand, the HIV-related health education, and health care services run by government sectors and NGOs.

It is important that the HIV problem is examined within a broad global context in which issues such as migration form an integral part. Socio-economic and political circumstances in both Myanmar and Thailand have contributed to a massive, illegal migration from Myanmar into Thailand. Among these Myanmar migrant workers, there is a chronic problem of HIV. Limited access to health care services and labor right issues are the common factors which has inevitably exacerbated the existing HIV epidemic in both countries as well as strained these countries' health care systems (PHAMIT-WVFT, 2004; Caouette et al., 2000). In order to address this growing public health issue, a number of non-governmental organizations such as World Vision Foundation of Thailand (WVFT), Prevention of HIV/AIDS Among

Myanmar Migrant Workers in Thailand (PHAMIT), International Organization for Migration (IOM), have established HIV/AIDS control programs for Myanmar migrants along the border areas and also in Thailand.

Ranong, the province situated in the border area, is well-known in HIV epidemic because of the increasing number of Myanmar migrant workers, limited access to health information and health care services, diversity of ethnic groups, variety of work including sex services (PHAMIT-WVFT, 2004). Even though there has been HIV/AIDS control program including health education and behavior change communication activities for Myanmar migrant workers in Ranong since last ten years back, there is no study exploring how Myanmar migrant workers access and perceive the existing HIV-related health education context and materials, and what they prefer for effective and appropriate HIV-related health education in terms of behavior change rather than knowledge gain. Not in the form of evaluation, but this study was intended to assess the accessibility to, perceptions on, and the preferences for, HIV-related health education among the Myanmar migrant workers in Ranong to some extent (PHAMIT-WVFT, 2004; Chantavanich et al., 2000b).

1.1.1 Migration from Myanmar into Thailand

A number of push and pull factors in Myanmar and Thailand has contributed to the massive influx of Myanmar people into Thailand since the early 1990's. Even though there are six official cross-border points along the 1,800 kilometer-long Thai-Myanmar border, many of these migrants have used mainly Mae Sai-Tachileik, Mae Sot-Myawaddy, Sangkhlaburi-Phayathongsu, and Ranong-Kawthaung (Chantavanich et al., 2000a; Caouette, 2001; Sterne & Crissman, 1998).

The following factors pushed tens of thousands of Myanmar people to neighboring countries with a great majority migrating to Thailand:

- political repression by the socialist government and by its successor military regime;
- military conflicts between the military regime and ethnic opposition groups;
- forced relocation of villages and small towns particularly of ethnic groups by the military regime;
- isolation of the country from the outside world and economic mismanagement by the socialist government; and
- military regime's policy to allow operation of foreign businesses and to accelerate the cross-border trade with neighboring countries (Caouette et al., 2000).

Moreover, other pull factors have made Thailand attractive to Myanmar migrants. The Human Development Index (HDI) of Thailand, a measure of overall social and economic development used by the United Nations Development Program (UNDP), rose from 0.614 in 1975 to 0.781 in 2006. Thailand ranked 78 compared to Myanmar ranking of 123 (HDI 0.583, and GDP per capita ranked 164 of 177 as of 2006) among 177 countries in 2006 (UNDP Human Development Report 2003 and 2006). This socio-economic development prompted many Thai people to avoid dirty, difficult and dangerous occupations. The resultant labor shortage in these sectors attracted a large number of people from Cambodia, Laos, and Myanmar, countries that are economically poorer especially after the early 1990's (Chantavanich et al., 2000b). Second attraction was the relative increase of value of the Thai Baht in relation to the Myanmar Kyat over the last two decades. The exchange rate was 37.5

Kyats to one Baht in unofficial street markets as of December 2007 (New Era and Irrawaddy Online Journals, 2007).

Thai government policy and regulations concerning the employment of illegal migrants have both positive and negative consequences on illegal migration into the country. The Thai government initiated the first regulation in 1992 to give work permit to Myanmar migrants who stayed in the ten border provinces along the Thai-Myanmar border (Chintayananda et al., 1997). Between 1996 and 2003, seven amendments were made to this labor regulation to grant temporary work permits for illegal (unregistered) migrants from Cambodia, Laos and Myanmar (Archavanitkul & Saisunhton, 2005). In 2004, substantial changes were introduced to allow all migrants including children and women to apply for registration. According to the Thai Ministry of Labor, as of February 2005, a total of 1,284,920 migrants applied for a household registration, the first step for issuance of work permit (Archavanitkul & Saisunhton, 2005). 838,943 were registered as laborers, and 60,123 were registered for sea and freshwater fishing, and these accounted 7.2% of the total registration (Ministry of Labor, Thailand, 2005).

1.1.2 HIV/AIDS as a Global and Regional Problem

As world population is growing up to more than 6.5 billion (United Nations, 2006) with the growth rate of 1.17% per year, i.e., population increase is 211,090 every day (United Nations, 2006; CIA's World Factbook, 2007), people have to struggle for survival, facing many problems, and at the same time, over 150,000 people die every day due to both health and non health-related causes (Hebrew for Christian [HFC], 2007; United States Census Bureau, 2007; World Health

Organization [WHO], 2007). Among the health problems, HIV/AIDS still stands as one of the major leading causes of death (U.S Census Bureau, 2007; WHO, 2007). In addition, more than 40 million people are living with HIV worldwide and about 3 million die of AIDS yearly, in other words, about 8,000 people die from AIDS every day, and most of them are in the reproductive as well as productive age of 15-49 years (WHO, 2007; Joint United Nation Program for HIV/AIDS [UNAIDS], 2006b).

Regionally, South-East Asia is the second highest in HIV epidemic with about 7 million people are living with HIV and nearly 600,000 people dying of AIDS every year, meaning that about 1,600 people die of AIDS everyday, and mostly affecting 15 - 49 years age group (UNAIDS, 2006b; WHO, 2007).

1.1.3 The Overall HIV/AIDS Situation in Myanmar

Myanmar is one of the countries hardest hit by the HIV epidemic in Asia. In 2004, an estimation workshop, organized by the National AIDS Program (Myanmar) in collaboration with WHO and UNAIDS, estimated that 339, 000 adults (15 - 49 years) were living with HIV out of a total population of 53.22 million, which means approximately 1.3% of the adult population in Myanmar are infected with HIV (UNAIDS, 2004). Even though HIV infection levels have declined among pregnant women (1.3% in 2005, down from 2.2% in 2000) (National AIDS Program [NAP], Myanmar, 2006) and among men seeking treatment for other sexually transmitted infections (from 8% in 2001 to 4% in 2005) (NAP, Myanmar, 2005), UNIADS estimated that 360,000 were living with HIV in Myanmar by the end of 2005 (UNAIDS, 2006a; NAP, Myanmar, 2006). As in other Asian countries, HIV is highest in groups with high-risk behavior; including sex workers (SW), injecting drug users

(IDU) and men who have sex with men (MSM). Among IDUs, the median HIV prevalence in six sentinel sites in 2005 was 43.2% (range: 18% - 62%). Among sex workers (SW) in Yangon and Mandalay, the HIV prevalence was 29.6% and 34.3%, respectively in 2005, i.e., 32% of sex workers countrywide were living with HIV in 2005. Among sexually transmitted infection (STI) clinic attendees who serve as a proxy for clients of sex workers, the median HIV prevalence was 4.1%. In 2005, HIV prevalence among pregnant women attending antenatal care (ANC) and military recruits ranged from 0% to 7% (mean=1.3% and median= 0.75). Analysis of trends in surveillance data indicates that the epidemic peaked in 2000, and then began to decline thereafter (NAP, Myanmar, 2006).

Starting with nine sentinel sites in 1991, the HIV Sentinel Sero-Surveillance (HSS) system in Myanmar has progressively expanded to 30 sentinel sites in 2005. The groups with high and lower-risk behavior included in the HSS are:

- IDU in five sites; a sample of 100 IDU is included at each site.
- Male STI attendees in 30 sites; a sample of 100 male STI attendees is included at each site.
- Female STI attendees in two sites; a sample of 100 female STI attendees is included at each site.
- Pregnant women attending antenatal care (ANC) clinics in 30 sites; a sample of 100 ANC attendees included in each site.
- Military recruits in two sites, a sample size of 600 recruits at each site.
- Tuberculosis (TB) patients in five sites.

Commercial drivers (taxi and truck drivers) are tested every two years for license renewal, but this group has not been included as part of the population in

the surveillance system. Some groups with high-risk behaviors and vulnerability, including men who have sex with men (MSM), mobile population and prisoners, are not part of the surveillance system (NAP, Myanmar, 2006).

1.1.4 The Overall HIV/AIDS Situation in Thailand

Likewise, in Thailand, one of the South-East Asian countries, with the population of about 64 million (MoPH-NSO, Thailand, 2007; United Nations, 2006; UNFPA, 2005a) hosted almost 3 million refugees including more than 2 million of both registered and unregistered migrant workers of which the majority are from neighboring Myanmar and the rest from Lao, Cambodia, Vietnam, China, Bangladesh and India (UNHCR – CCSDPT, 2007; Naing, 2006; PHAMIT-WFVT, 2004).

From the start of HIV epidemic till 2001, Ministry of Public Health stated that 984,000 people (951,000 adults and 33,000 children) have been infected with HIV, and 289,000 of those people died of AIDS in 2001(MoPH, Thailand, 2001), and in 2002, 700,000 people were infected with HIV. Then in 2003, it was estimated to have a total of 570,000 (310,000 – 1,000,000) people living with HIV and 58,000 (34,000 – 97,000) AIDS deaths, and heterosexual transmission accounted 88% of all total AIDS cases reported.

According to the recent data estimated by UNFPA, UNAIDS and MoPH of Thailand, there are about 600,000 people living with HIV, and more than 30,000 people die of AIDS annually, still remaining as a major health problem of the country, and one of the major causes of death for the reproductive age group of 15-49 years (UNAIDS, 2006b).

1.1.5 The HIV/AIDS Situation among Myanmar Migrant Workers in Ranong

Ranong is also well-known for HIV/AIDS, HIV-related diseases and human trafficking, in addition to migrant workers (WVFT, 2006; Ranong Provisional Health Office, 2005b; PHAMIT, 2005). Among the five districts of Ranong Province, Muang District holds about 80,000 migrant workers (80 % of all the migrants in the whole province), of which 48,974 (61%) are registered as of June 2005, and up to 99% are Myanmar people with low socio-economic background. The number of registered workers decreased to about 15,000 and unregistered workers with three-month temporary stay increased up to 65,000, resulting in the same total number of migrant population with significant decrease in the percentage of registered workers to 25% (Muang District Health Office, Ranong, 2007).

Many of the migrants are working as fishermen, fishery-related workers, factories/ construction workers, agriculture/ rubber plantation/ livestock workers, sex workers and general labors, but some as domestic helpers (housemaids) (Ranong Provisional Health Office, 2005a; World Vision Online Article, 2007). Referring the data from Ranong Provincial Health Office and World Vision (Ranong Office), Ranong, with the total population of about 177,224 (Ranong Provisional Health Office, 2005a; MoPH-NSO, Thailand, 2007), has about 100,000 migrant workers, of which 61,895 are registered and the rest are working illegally (unregistered). In 2006, the number of registered workers declined to 21,286, it was reduced significantly to 17,809 in 2007 because of the change in registration policy for migrant workers.

Although Thailand has Sentinel Sero-surveillance in all of its 76 provinces (Thailand Public Health, 2006-2007), unregistered (illegal) migrants are not

included in this system. Some Thai Provincial Public Health Offices have occasionally conducted this Surveillance among unregistered (illegal) migrants, depending on their policy and the availability of funding, resulting in inconsistent and scattered availability of HIV prevalence data (Naing, 2006).

Among the migrant workers, fishermen and their wives, direct SWs, indirect SWs (service girls) and MSM are in high-risk groups. According to the Disease Control Centre, Ministry of Public Health of Thailand, HIV prevalence among the fishermen, direct sex workers and indirect sex workers in Ranong were 3.3%, 28.8% and 7.3% respectively in the year 2003-04 (PHAMIT, 2005). However, according to the Ranong World Vision clinic data, HIV prevalence among fishermen, MSM, housewives, direct SWs, and indirect SWs (service girls) were 45.5%, 41.7%, 30.8%, 13.2% and 0.0% respectively. More than half of the married women visiting to the clinic are the wives of fishermen (WVFT, 2007). Even though HIV infection rate among migrant population in Ranong has reduced year by year, the figures from June 2005 sentinel HIV Sero-surveillance still showed 21.3%, 4.5%, 1.9%, 1.0% and 0.5% in sex workers (SWs), fishermen, pregnant women, female workers and male workers respectively. So, it was stated that the overall number of HIV infections among migrants was declining and could be related to the declining number of migrants (Migrant Health Project, 2006).

Moreover, there are many legal and labor right issues in government sectors, private sectors, NGOs, resulting in difficulties for migrants to get access to health information and health care services (Ranong Provisional Health Office, 2005a; PHAMIT-WFVT, 2004). Although government sectors and NGOs consistently implement and focus on health education through different contexts and

materials, there are still major problems in understanding health education leading to behavior change among migrants. Lack or limited knowledge about HIV/AIDS, sexually transmitted infections (STI), reproductive health (RH), malaria and tuberculosis (TB), lack of self-efficacy in consistent condom use, negative attitudes on condom use, decoration of male sex organs by making enlargement methods using inserting steel balls or marbles, and injecting oil or hairspray under the fore skin, wrong belief in sexual practices, peer pressure on alcohol and drug use, and difficulty in accessing existing health information are still very common among Myanmar migrant workers (WVFT, 2006; PHAMIT-WVFT, 2004).

1.1.6 HIV-related Health Education in Ranong

Under the guidance and, with some financial support of Ranong Provincial Public Health Office, HIV-related health education activities are mainly implemented by NGOs, like WVFT, PHAMIT and IOM in Muang District of Ranong, but according to their reports, they could reach up to 30% of Myanmar migrant population (about 24,000) by means of the development and distribution of IEC materials, distribution of behavior change-related health products like condoms, penis model (phallus), lubricant gel, etc., distribution of health promo-materials like T-shirt, hat, bag, etc., conducting awareness-raising trainings about HIV/AIDS and STI, conducting HIV-based life skills trainings using bridge model, conducting basic HIV counseling trainings, voluntary HIV counseling and testing (VCCT) and health service delivery at NGO project clinics, community empowerment and participation by using role model, establishment of enabling social environments like self-help groups (SHGs) among PLHIV, SW, Karaoke service girls (SG) and MSM, income

generation (IG) groups, establishment of community-based organizations (CBO), organizing and facilitating advocacy meetings with local health and administrative authorities for some policy enhancement for better health education interventions, conducting formal and informal meetings with business owners and employers, etc. (WFVT, 2007; PHAMIT-WVFT, 2004).

Though with such interventions, limitations in HIV-related knowledge, attitude, and practice among Myanmar migrants are noticed. So, it becomes very important to know the accessibility to and perceptions on the existing health education, and their preferred choices of health education to make the HIV-related health education effective among target groups with different backgrounds and different status, and as a step forward to the effective implementation of HIV/AIDS prevention and control program in future.

1.2 Research Questions

(1) What are the socio-demographic characteristics and registration status of Myanmar migrant workers in Ranong, Southern Thailand?

(2) What are the types and sources of HIV-related health education among Myanmar migrant workers, where they receive, how they access to, and how they perceive on, existing HIV-related health education?

(3) Is there any relationship between the socio-demographic characteristics and registration status of these workers, and their extent of access to and perceptions on existing HV-related health education?

(4) Is there any relationship between the socio-demographic characteristics and registration status of these workers, and their preferences for HIV-related health education?

1.3 Research Objectives

1.3.1 General Objectives

To access the prevalence and determinants of access to, perceptions on, and preferences for, HIV-related health education among the Myanmar migrant workers in Ranong, Southern Thailand

1.3.2 Specific Objectives

(1) To describe socio-demographic characteristics and registration status of Myanmar migrant workers in Ranong, Southern Thailand

(2) To describe the types and sources of HIV-related health education among Myanmar migrant workers, their accessibility to, and their perceptions on existing HIV-related health education

(3) To describe relationship between the socio-demographic characteristics and registration status of these workers, and their extent of access to and perceptions on existing HIV-related health education

(4) To describe relationship between the socio-demographic characteristics and registration status of these workers, and their preferences for HIV-related health education

1.4 Research Hypotheses

(1) There are positive associations between longer length of stay in Ranong, high-risk target groups of fishermen, fishery-related workers, SW, SG, MSM, and more frequent access to existing HIV-related health education.

(2) Among all subjects, there is greater preferences for participatory HIV-related health education (e.g. group trainings/discussions, puzzles/games/contests, health exhibitions/ health talks, HIV counseling, peer education/role modeling, and establishment of enabling environments).

(3) There are positive association between the lower level of education, high-risk target groups of fishermen, fishery-related workers, SW, SG, MSM, and greater preferences for participatory HIV-related health education (e.g. group trainings/discussions, puzzles/games/contests, health exhibitions/health talks, HIV counseling, peer education/role modeling, and establishment of enabling environments).

1.5 Operational Definitions

Accessibility to Existing HIV-related Health Education

It is a situation whether a Myanmar migrant worker receives any type of HIV-related health education using any language, developed by any health organization, anywhere during his/her stay in Ranong, and how many times has he/she received. It is unrelated with their understanding and/or their change after receiving such health education.

Behavior Change Communication (BCC)

Behavior change communication (BCC) is part of an integrated, multi-level, interactive process with communities aimed at developing tailored messages and approaches using a variety of communication channels. BCC aims to foster positive behavior; promote and sustain individual, community, and societal behavior change; and maintain appropriate behavior (FHI, 1992). Behavior change communication (BCC) is an interactive process for developing messages and approaches using a mix of communication channels in order to encourage and sustain positive and appropriate behaviors. (ILO, 2005)

Behavior Change Intervention (BCI)

Any types of activities or intervention Program regarding HIV/AIDS control, in order to promote positive behavior change or to reduce risky sexual behaviors. (FHI, 1992)

Communication

It is a process that allows persons or groups of persons to exchange information by several methods. (Wikipedia, 2007a)

Convenience Sampling

Convenience sampling is the method of choosing items/subjects arbitrarily and in an unstructured manner from the frame. Though almost impossible to treat rigorously, it is the method most commonly employed in many practical situations. Sometimes it is also called *grab* or *opportunity* sampling (Wikipedia, 2007b). In this

study, convenience sampling is a sort of random sampling depending on the availability of Myanmar migrant workers in their residences or workplaces, and their free time and willingness to be interviewed.

Direct Sex Worker

Direct sex workers are brothel-based and acknowledged that they are sex workers. (Naing, 2006)

Enabling

In health education and promotion, enabling means taking action in partnership with individuals or groups to empower them, through the mobilization of human and material resources, to promote and protect their health. (WHO, 1998)

Enabling Environments (Supportive Environments for Health)

Enabling environments (supportive environments for health) offer people protection from threats to health, and enable people to expand their capabilities and develop self reliance in health. They encompass where people live, their local community, their home, where they work and play, including people's access to resources for health, and opportunities for empowerment (WHO, 1998). In other words, it is a supportive social environment with social justices, equity, dignity, and is free from stigma and discrimination, especially for vulnerable people and marginalized target groups like sex workers, IDU, MSM, PLHIV, etc.

Health Communication

Health communication is a key strategy to inform the public about health concerns and to maintain important health issues on the public agenda. The use of the mass and multi-media and other technological innovations to disseminate useful health information to the public, increases awareness of specific aspects of individual and collective health as well as importance of health in development. (WHO, 1998)

Health Education

It is an education that increases the awareness and favorably influences the attitudes and knowledge relating to the improvement of health on a personal or community basis. It comprises consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, including improving knowledge, and developing life skills which are conducive to individual and community health. (WHO, 1998)

Health Products (Behavior Change-related Materials)

Health-related materials like penis model (phallus), condom, lubricant gel, used or distributed in health education, training, HIV counseling, etc. in order to promote behavior change in HIV/AIDS control Programs.

Health Promotion

It is the process of enabling people to increase control over and to improve their health. Health Promotion not only embraces actions directed at strengthening the skills of individuals, but also action directed towards changing social, environmental

and economic conditions so as to alleviate their impact on public and individual health. (WHO, 1998)

High-risk Group (Population with Higher Risk of Exposure to HIV)

Sometimes, it is referred to as 'at-risk groups' or 'most-at-risk populations,' 'vulnerable populations' or 'populations at increased risk'. Members of high risk groups are at increased risk of passing HIV on to others, or of contracting HIV from others. They are often important in establishing, accelerating or sustaining the HIV epidemic. Therefore, it is important to understand the impact that HIV has had within these groups. In Asia, populations at increased risk include sex workers and their clients, injection drug users (IDUs), men who have sex with men (MSM), mobile populations and migrants, out-of-school youth, prisoners and uniformed personnel. (WHO, 2007)

Indirect Sex Worker

Indirect sex workers, also known as service girls (SG), worked in restaurants, bars, karaoke lounges, and do not acknowledge themselves that they were sex workers. (Naing, 2006)

Life Skills

Life skills refers to a large group of psycho-social and interpersonal skills which can help people make informed decisions, communicate effectively, and develop coping and self-management skills that may help them lead a healthy and productive life. Life skills may be directed toward personal actions and actions toward others, as

well as actions to change the surrounding environment to make it conducive to health (UNICEF, 2007). Life skills are abilities for adaptive and positive behavior that enable individuals to deal effectively with the demands and challenges of everyday life. (WHO, 1998)

Life Skills-based Health Education

Life skills-based health education is a combination of learning experiences that aim to develop not only knowledge and attitudes, but also skills (i.e., life skills) which are needed to make decisions and take positive actions to change behaviors and environments to promote health and safety and to prevent disease. (UNICEF, 2007)

Lower Level of Education

In this study, it means education level of basic monastery school attended and primary school attended.

Middle and Higher Level of Education

In this study, it means education level of middle school attended and higher.

Migrant Worker

The term "migrant worker" refers to a person who is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national. (Wikipedia, 2007c)

Participatory Health Education

Generally, there are four different models of health education: (1) information-giving education to bring about particular changes in people's behavior through information giving, (2) self-empowerment education to enhance people's abilities to act rationally and to help people establish personal control over their lives, (3) community-oriented education to bring about changes within organizations and communities so that healthier choices can be made, (4) socially transformatory education to change the structure of society so that inequalities in health no longer exist. Models (2), (3), and (4) can be considered as Participatory Health Education (Homan et al., 1987).

In this study, group trainings/discussions, puzzles/games/ contests, health exhibitions/ health talks, HIV counseling, peer education/role modeling, and establishment of enabling environments are considered as participatory types of health education.

Peer Education

Peer education is the process whereby well-trained and motivated people undertake informal or organized educational activities with their peers (those similar to themselves in age, background, or interests) (UNFPA, 2005b).

People Living with HIV/AIDS Self-help Group (PLHIV SHG)

It is a non-profit social network group formed by people living with HIV/AIDS, in order to share their experiences, knowledge, feelings, problems, etc.

Perceptions on Existing HIV-related Health Education

It is what a Myanmar migrant worker thinks of, or how he/she perceives on, the existing HIV-related health education in Ranong, regarding his/her accessibility to, effectiveness of and satisfaction on such health education, and necessity of Myanmar migrants.

Preferences for HIV-related Health Education

The choices of the Myanmar migrant workers for HIV-related health education in future because they like such health education as they think that these are the most appropriate and effective for them, in terms of HIV/AIDS control.

Promo-materials with Short Health Message

Promotional materials like T-shirt, hat, bag, etc. on which some important short health messages are printed in order to remind the consumers to practice healthy behavior.

Registered Migrant Workers

Regarding the Thai government's renewal of work permit policy announced on December 7, 2006, every migrant worker must register yearly. The one-year extension of stay in Thailand is issued by Ministry of Interior, worker cards are issued by Ministry of Labor, and medical check-up and health insurance are issued by Ministry of Public Health. Without this official procedure and without one-year work permit, migrant workers are represented as unregistered (illegal) (Ministry of Labor, Thailand, 2007).

Unsafe Sex (Risky Sexual Behavior)

Unsafe sex is the practice of sexual intercourse without regard for prevention of STDs. (Wikipedia, 2007)

Safer Sex

No sexual act is 100% safe. Safer sex involves taking precautions that decrease the potential of transmitting or acquiring sexually transmitted infections (STIs), including HIV, while having sex. Using condoms correctly and consistently during sex is considered safer sex. (UNAIDS, 2007)

Socio-demographic Characteristics

Socio-demographic Characteristics of Myanmar migrant workers include age, sex, education, ethnicity, language skills, types of occupation, monthly individual income, and length of stay in Ranong and Thailand.

Social Networks

Social relations and links between individuals which may provide access to or mobilization of "social support" for health. (WHO, 1998)

1.6 Conceptual Framework

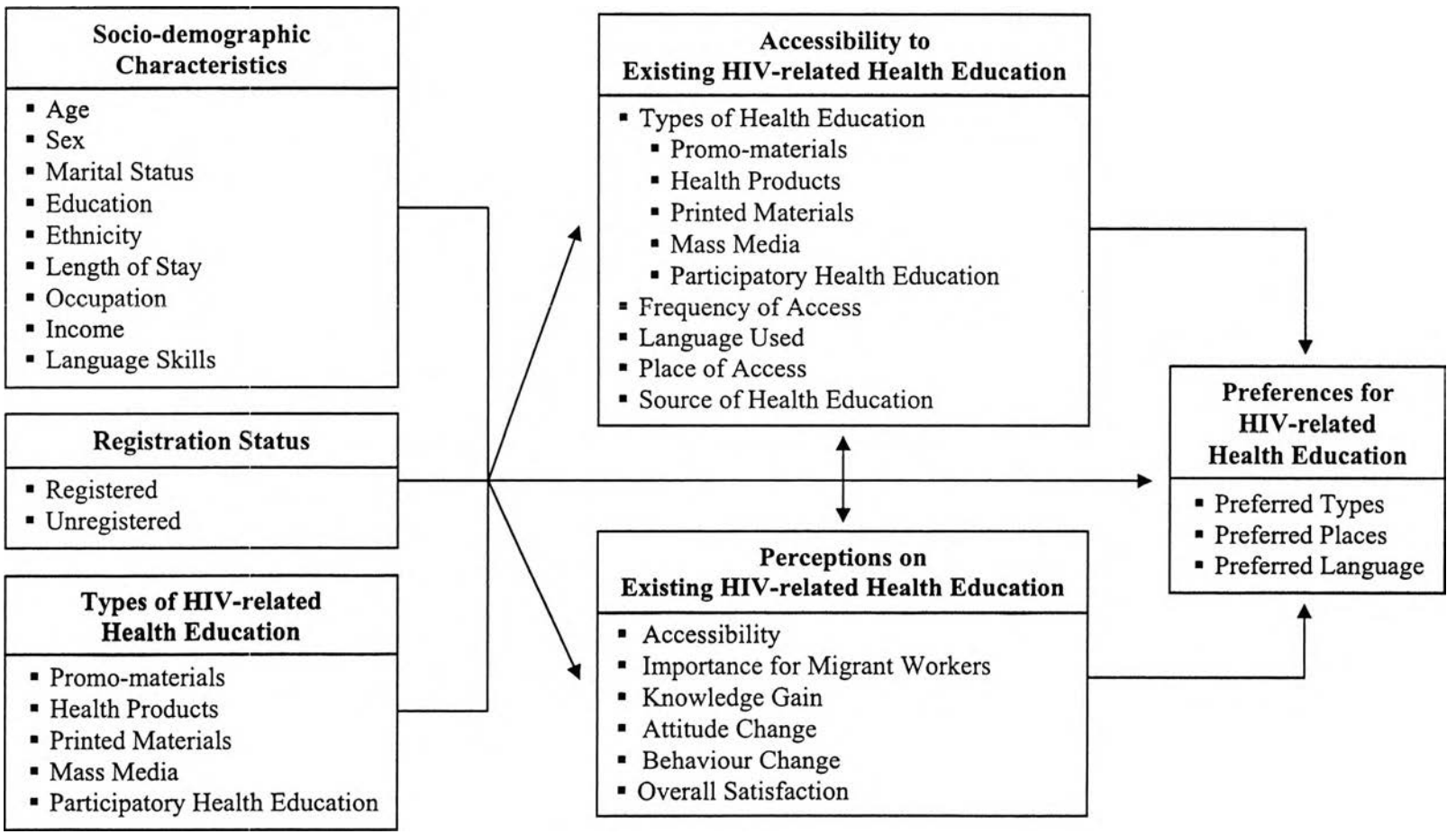

Figure 1: Conceptual Framework