CHAPTER I

INTRODUCTION

1.1 Background and Significance of the Problem

Acquired immunodeficiency syndrome (AIDS) is caused by Human Immunodeficiency Virus (HIV). The HIV is most commonly transmitted by infected persons to their partners during sexual contact (including homosexual contact); by transfusion of infected blood to the recipient; by infected mothers to their children during pregnancy; and by multiple syringe needle use involving infected person(s). (CDC, 2002). Proper knowledge and awareness of the causes of HIV, therefore, is widely believed to be the most effective deterrent to the spread of the infection.

AIDS was first recognized in the United States in 1981. Later evidence showed that AIDS cases had occurred in many other countries before 1981 and the epidemic began at roughly the same time in several parts of the world, including the United States and Africa. (WHO, 1997).

The Global estimates indicate that by the end of 2001, 40 million people were living with HIV/AIDS. During 2001 alone, about 5 million people were newly infected with HIV, and 3 million had died because of AIDS. About 14 million children, aged less than 15 years, were orphaned having lost one or both of the parents to AIDS (UNAIDS, 2002). AIDS now kills more people worldwide than any other infection. (Vitchek, 2002).

The geographical spread, by the end of 2001, indicates that Sub-Saharan Africa had the largest number of 28.5 million people living with HIV/AIDS, followed by South and South East Asia 5.6 million, Latin America 1.5 million and East Asia and Pacific, and Eastern Europe and Central Asia, 1 million each. Within South and South East Asia India had the largest number of 3.97 million people living with HIV/AIDS, followed by Thailand 670,000, Myanmar 180,000-400,000, Cambodia 170,000 and Vietnam 130,000 (UNAIDS, 2002).

In South East Asia, Myanmar with a population of 48.4 million has the second highest number of people living with HIV/AIDS. The sentinel survey of 2001 shows the HIV prevalence being the highest of 54.6% in injecting drug users in 'major urban areas' (MUA) and 52.5% in localities 'outside major urban areas' (OMUA). The prevalence among commercial sex workers was 33.5% in MUA. The prevalence in cases of sexually transmitted infections was 20.5% in MUA and 4% in OMUA. A rising trend in HIV prevalence in the country has been observed over years (UNAIDS, UNICEF, & WHO, 2002).

Vitchek (2002), points out the main reasons for the rising HIV prevalence in Myanmar as increased population mobility, poverty and frustration that breeds risky behavior in sexual contacts and drug taking. Myanmar has common border with China in the north and northeast, with Laos in the east, with Thailand in the southeast, and with India and Bangladesh in the west. Because of difficult geographical terrain it is hard to control these borders, and hence the cross-border movement of people, which facilitates the spread of HIV. It is to be noted that the Thai-Myanmar border was selected as the first one in mainland Southeast Asia where an assessment of

HIV/AIDS was carried out, because "it is the most volatile and dynamic of all the borders in the region" (Oppenheimer et al, 1998).

In Myanmar, most of the ethnic minority population, comprising Kayah, Kayin, Mon, Shan, Chin, Kachin and Rachine, live in areas bordering Thailand. Many of these ethnic minority groups have been engaged in armed conflict with the government for many years. These conflicts are one of the major sources of population displacement in and outside the country, the other causes being government repression including forced labor and rising poverty and unemployment. The economic hardship and political isolation of the country has led to a health crisis, among others, thereby increasing the spread of HIV. (Myanmar HIV information, 2002).

The persistence of the above situation over many years has forced millions of Myanmar people to move from place to place for livelihood and security. Between 1.5-2.0 million are thought to be in Thailand. The Ministry of Labor of Thailand started a registration scheme for migrant workers in 2001, resulting in the registration of 568,249 migrant workers; of these, 451,335 (80%) were from Myanmar. For many reasons the majority of migrant workers did not avail the registration scheme.

There is a lack of information and data on the prevalence of HIV among migrants in Thailand. The results of HIV test conducted on a small sample of Myanmar migrant workers in Tak province in 2002 provide some indication. The prevalence of HIV infection among the migrants employed in industrial and agricultural sector was found to be 1.33% and 1.00%, respectively. These are among

the main sectors employing migrants. HIV infections were also present in 8.72% of the STD positive cases and 2.3% of the TB positive cases.

Provincial Health authorities in Thailand have often cited poor knowledge as a major cause of the high prevalence of HIV among migrants. Chamnan (1995), a provincial health chief, observed that lack of knowledge among the hill tribes and Myanmar migrants was leading to the spread of HIV/AIDS. Also noted that many Karen and Shan illegal migrants carried the virus across the border into Mae Hong Son, the region of his posting in Thailand. The major reason is there were no HIV awareness programs in the border areas. Another source noted that thousands of young people have died without ever hearing of the disease that killed them (Regional AIDS News, 2002). A study conducted on HIV vulnerability at Thai-Myanmar border shows about half the migrants lacking adequate knowledge of HIV/AIDS (Chantavanich et al, 2000).

No systematic study has been conducted so far to investigate the Myanmar migrant workers' knowledge, attitudes and risk behaviors regarding HIV/AIDS in Bangkok, where 76,586 migrants from Myanmar were registered by Ministry of Labor in 2001. The actual number is estimated to be around 200,000. The findings of the study will provide information and analyses necessary for designing appropriate interventions to enhance the knowledge of HIV/AIDS among the migrant workers, thus reducing the potential for their risk behaviors.

1.2 Purpose of the Study

The purpose of this study is to assess knowledge, attitude and high-risk behavior in relation to HIV/AIDS and to examine the effects of demographic factors on these variables.

1.3 Objectives of the Study

Focusing on Myanmar migrants in Bangkok, the objectives of the study are:

1. To assess the level of knowledge regarding HIV/AIDS
2. To determine various attitudes regarding HIV/AIDS
3. To determine the kind and extent of various risk behaviors regarding HIV/AIDS.
4. To identify the factors influencing risk behaviors regarding HIV/AIDS.

1.4 Research Questions

1. How knowledgeable the migrant workers are regarding HIV/AIDS?
2. What are the different attitudes regarding HIV/AIDS?
3. What are the different high-risk behaviors regarding HIV/AIDS?

1.5 Research Variables

The FOUR research variables are as follows:

1. Socio demographic characteristics
2. Knowledge regarding HIV/AIDS

3. Attitude regarding HIV/AIDS

4.Risk behaviors regarding HIV/AIDS

1.6 Operational Definitions

	Variable	Operational definition
Dependent Variable	Risk behavior	Practices and activities, which put the individual at the risk of contracting the HIV infection.
Independent Variables	Knowledge	An understanding of the current information about HIV/AIDS including its transmission and prevention
	Attitude	The concepts, beliefs, feelings and intent to act regarding risk behavior leading to HIV/AIDS.
	Socio demographic factors of Myanmar migrant workers	Which include, age, gender, marital status, education, occupation, monthly income, ability of Thai language, ethnicity, access to information of HIV/AIDS and access to health services.