

CHAPTER I

INTRODUCTION

1.1 BACKGROUND AND RATIONALE

Acquired Immunodeficiency Syndrome (AIDS) is a pandemic disease that is more terrible than any terrorist attack or activity in the world since the infection rate in 2002 is 13,700 per day worldwide (UNAIDS/WHO, 2002). It can even lead to the extinction of the human species. The global AIDS epidemic is entering its third decade. There is no country that is free of AIDS patients even though the prevalent rates vary from one place to another. The epidemic has driven many people to destitution, and is undermining poor countries' chances of development.

Thailand and AIDS Problem

Thailand has the largest number of people with HIV in East Asia. The first case was recorded in 1984. Nationally, HIV prevalence among injecting drug users rose quickly in 1988 to approximately 35 percent. HIV among brothel-based sex workers rose from 3.5 percent in 1989 to 33 percent by late 1994. Infection levels in males at STD clinics grew from 0 percent to 8.6 percent over the same time period. HIV prevalence in women attending antenatal clinics has continued to rise steadily from 0 percent in 1989 to 2.3 percent in 1995. The data on baseline scenario of HIV/AIDS from Ministry of Public Health expressed that 984,000 people (951,000 adults and 33,000 children) have been affected with HIV in Thailand from the start of the epidemic till 2001. 289,000 of

these people have subsequently died of AIDS in 2001 (The Thai working group on HIV/AIDS projection, 2001). In 2002, about 700,000 people carried the virus. It is not difficult to see why Thailand has been so badly affected (UNAIDS/WHO, 2002).

According to WHO (Asia Pacific Report, 1997), about 80,000 to 100,000 female sex workers were working in Thailand. Head (2001) reported more than a million people working in the sex industry. Of course the latter refers to male, female, direct and indirect sex workers as well as support staffs. It is probably safe to state that Thailand has a few hundred thousand sex-workers. Typical places for part-time sex work include bars, fitness centers, clubs, massage parlors, and restaurants. Sex sector's annual earnings account for up to 1 to 14% of Gross Domestic Products in Thailand (Science and Medicine, 2001). Nowadays, Thai sex workers have been gradually replaced by cross border migrants (Chantavanich, S., Beesey, A., Paul, S., 2000). In Thailand, meanwhile, recent modeling suggests that the main modes of transmission have been changing. Whereas most HIV transmission in the 1990s occurred through commercial sex, half the new HIV infections now appear to be occurring among the wives and sexual partners of men who were infected several years ago. There are also many indications that unsafe sexual behavior is on the increase among young Thais (UNAIDS/WHO, 2002).

Table 1: HIV SENTINEL SURVEILLANCE FINDINGS IN MYANMAR AND THAILAND DURING 2000

Sentinel Population	Myanmar	Thailand
Intravenous drug Users (IDU)	62.7%	47.2%
Direct Female Sex Worker	38.0%	18.5%
Male STI Patients	7.1%	5.9%
Military Recruits	1.4%	1.4%
Antenatal Care (ANC)	2.15%	1.46%

(WHO, 2001)

Table 2: MODES OF TRANSMISSION OF HIV/AIDS IN MYANMAR AND THAILAND

Modes of Transmission	Myanmar	Thailand
Heterosexual	57%	86.82%
Homo/Bisexual	1.2%	1.12%
Intravenous Drug User	22.1%	5.03%
Blood	4.4%	0.03%
Perinatal	1.8%	4.80%
Other/Known	0%	0.02%
Other/Unknown	13.5%	0.69%

(WHO, 2002)

Myanmar and AIDS Problem

The epidemic in Myanmar is one of the most serious in the South East Asian region. The epidemic began with the infection of large numbers of injecting drug users in the late 1980s, with a prevalence of 60 to 70 percent since 1992. HIV prevalence in sex workers has steadily risen from 4.3 percent in March 1992 to 18 percent in March 1995. There is substantial geographic variability, with infection rates in pregnant women varying according to region between 0 and 12 percent in 1993. High levels of other STDs, low levels of condom use, the clandestine nature of commercial sex, and limited blood screening due to cost constraints are contributing factors to HIV spread (UNAIDS/WHO, 2002). The United Nations Program on HIV/AIDS Program put the estimate at 530,000 of a total of 48 million people being infected. The figure could be higher because of the low rate of reporting cases and Myanmar's limited capacity to test for the virus. Doctors from Medecins Sans Frontieres believe it is as high as 1 million people infected. Dr. Chris Beyrer from John Hopkins University estimated that 3.46 per cent of the adult population in Myanmar was infected (Herald, K. and Chelala, C., 2002). Myanmar is the largest source of illicit heroin in the world, e.g. in the USA, Myanmar opium makes up about 60% of the heroin market. The reason for the high rates of HIV infection among injecting drug users in Myanmar is needle sharing, a necessary measure among addicts because of the extremely short supply of syringes in the country. Furthermore, the "paraphernalia" laws in Myanmar make carrying needles without medical license a crime (Beyrer, C. and Chelala, C., 1999).

There is intensive drug abuse in Myanmar particularly high on the eastern border region of Thailand and the northern border with China. The overall rate in Myanmar at which people get infected is 5.3 per cent (Herald, K. and Chelala, C, 2002). Nowadays, the infection rate among sex workers in Myanmar is 47 per cent, which is 3 times that the rate found in Thailand (Cesar Chelala, 2002).

HIV/AIDS and Myanmar Migrant Workers in Mahachai, Samut Sakorn, Thailand

The study site is Mahachai, Samut Sakorn province, which is about 45 kilometers away from Bangkok. It is one of the largest Myanmar migrant communities in Thailand. There are many buses from Bangkok to Mahachai. It takes about 1 hour to go there. There are about 200,000 Myanmar migrant workers in Mahachai, Samut Sakorn, Thailand. A diverse spectrum of ethnic minority groups comprises the migrant population from Myanmar in Mahachai, including Baman, Shan, Mon, Karen, Pa-O and Rakhine (Federation of Trade Unions-Burma, 2002). Most of them are Buddhist and some are Christian. Some are illiterate but most have finished middle school education. But the ability to speak Thai Language depends on the duration of stay in Thailand. Most factory workers have migrated to Thailand since last more than 5 years and so they can communicate in Thai language, but very few can read and write Thai language.

Ignorance of the disease and ways to prevent it are widespread (Herald, K. and Chelala, C., 2002). They do not have any travel documents or visa and illegally crossed the

borders. During the last few years, the Thai Government pity on them and issued them permission to live and work only in that area. Because of the migrant status and not having actual visa, there is no health education program or health care service from the government side. CARE International (Thailand) is the only non-government organization (NGO) that has a clinic in an office next to the Mahachai Shrimp Center. The clinic is the only resource for the very poor or unemployed Myanmar when they are ill (BI weekly, 2001). They work in seafood factories, building and construction industry, the aluminium, glass and plastic product manufacturing industries and machinery and garage factory. Ages of workers range from as young as 10 years to as old as 60 years of age. The factory workers live in workers' quarter or informal arrangements with no or little security or protection. Those employed at the larger factories in Mahachai typically rent rooms together as many as twenty persons might stay in one room, dividing the living space with cloths (Thai Action Committee for Democracy in Burma, 1998).

The exact number of HIV cases in Mahachai is not available since there is no health service nor education program except CARE International, Thailand, the only Non-Governmental Organization working at Mahachai. According to the data of medical examination for work permits in 1999, 48% of migrant workers were found to be HIV positive (Ahmed, S., 2001). Since the real sample size could not be obtained, the representativeness of this proportion is questionable. The number of HIV infected cases among Myanmar migrants in Samut Sakorn province from 1998 to 2000 was 1,929 (CARE, 2001).

There are many reasons why they are in high risk of HIV infection.

- (1) Most are between 17 and 25, an age of high sexual derive (Bangkok Post, 2003).
- (2) Some people who are single have to live apart from their parents or guardians, and so they are out of control (Chantavanich, Beesey and Paul, 2000).
- (3) Some married persons have to live apart from their wives and family and so they feel lonely and homesick in their new surroundings, and sexual relationships may help fill their craving for companionship (Chantavanich, Beesey and Paul, 2000).
- (4) Some are under the guidance of peer pressure (U.S. Census Bureau, 1999).
- (5) Low education (Herald, K. and Chelala, C., 2002).
- (6) Ignorance of disease and its preventive methods (Herald, K. and Chelala, C., 2002).
- (7) Limited preparation for entering into a very different world (Chantavanich, Beesey and Paul, 2000).
- (8) Government health personnel are not responsible for providing health education for migrant workers and are not capable to do so because of language differences (CARE, April 2001).
- (9) No counseling before or after HIV testing (CARE, April 2001).
- (10) For female factory workers, they are often bullied by employers and policemen causing them moral instability (BI Weekly, 2001).
- (11) A large number of locally operated brothels in Mahachai (Thai Action Committee for Democracy in Burma, 1998).

- (12) There are sex workers walking around the Prawn market in Mahachai (CARE, 1999).
- (13) Being factory workers, they usually drink alcohol and during under the action of alcohol, their social and sexual behavior can change and this may threat for HIV transmission (Chantavanich, S. et. al, 1999).

1.2 RESEARCH QUESTIONS

1. What are the socio-demographic characteristics, source of information on HIV/AIDS and social network and social support systems of Myanmar migrant factory workers in Mahachai?
2. What is the level of basic knowledge, attitudes and practices on prevention of HIV/AIDS among these workers?
3. Is there any relationship between the socio-demographic characteristics and knowledge, attitude and practices of these workers?
4. Is there any relationship between social support, social network system and knowledge, attitude and practices of these workers?
5. Is there any relationship between source of information and knowledge, attitude and practices of these workers?
6. Is there any relationship among knowledge, attitude and practice of these workers?

1.3 OBJECTIVES

(i) GENERAL OBJECTIVE

To assess the level of knowledge, attitude and practice concerning prevention of HIV/AIDS transmission in Myanmar migrant factory workers in Mahachai, Samut Sakorn, Thailand.

(ii) SPECIFIC OBJECTIVES

- (a) To describe socio-demographic characteristics, source of information on HIV/AIDS and social network and social support systems of the migrant factory workers.
- (b) To describe the basic knowledge, attitudes and practices of the Myanmar migrant factory workers on HIV/AIDS and its preventive method.
- (c) To describe relationship between the socio-demographic characteristics and knowledge, attitude and practices of these workers.
- (d) To describe relationship between social support, social network system and knowledge, attitude and practices of these workers.
- (e) To describe the relationship between source of information and knowledge, attitude and practices of these worker.
- (f) To describe relationship among knowledge, attitudes and practices of these workers.

1.4 RESEARCH HYPOTHESES

1. There are positive correlations between the younger age, higher education, better income and longer duration in Thailand and better knowledge, more positive attitude and safer practices of the Myanmar migrant workers.
2. There are positive correlations between more frequent contact with confidants and better knowledge, more positive attitude and safer practices of these workers.
3. There are positive correlations between source of information from NGOs and better knowledge, more positive attitude and safer practices of these workers.
4. There are positive correlations among knowledge, attitudes and practices of these workers.

1.5 VARIABLES OF THE STUDY

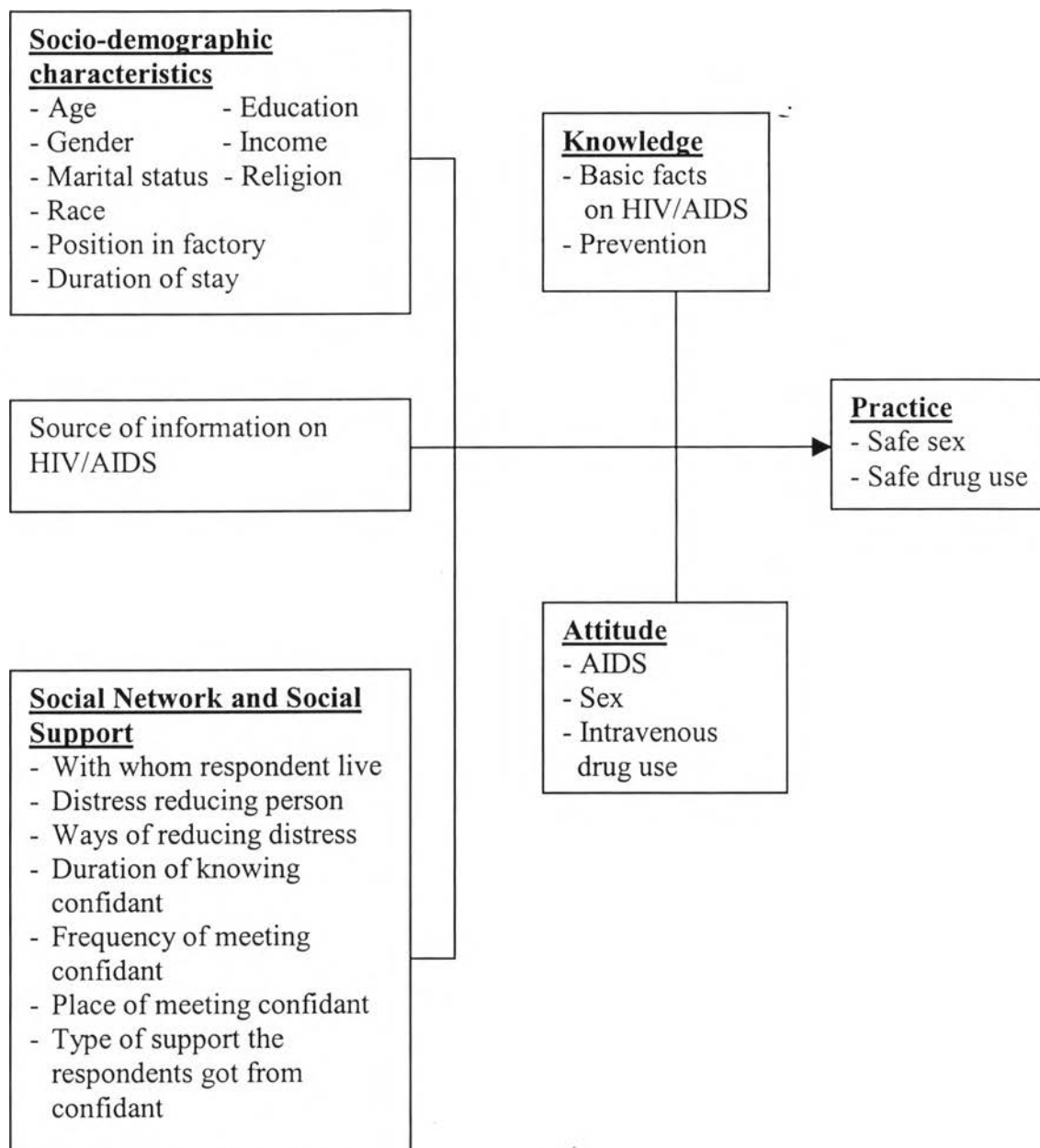
In this study, the variables are-

1. Independent variables
 - a. Socio-demographic characteristics
 - b. Social network and social support
 - c. Source of information about HIV/AIDS
2. Dependent variable
 - a. Knowledge about AIDS and its prevention
 - b. Attitudes towards AIDS prevention
 - c. Practice on safe sexual behavior and safe drug use

1.6 OPERATIONAL DEFINITIONS

- (1) **Socio-demographic characteristics** of migrant workers include age, gender, marital status, education, race, religion, occupation, income, duration of stay in Thailand.
- (2) **Social network and social support** include with whom the respondents live, who reduce their distress, duration of knowing confidant, the ways of reducing distress by confidant, place of meeting confidant, frequency of meeting confidant, and types of support the respondents got from confidant.
- (3) **Sources of information about HIV/AIDS** include those who or which can convey the information on HIV/AIDS (e.g. family members, friends, television, radio, magazine, newspaper, NGO's activities, etc.)
- (4) **Knowledge on HIV/AIDS** means the basic facts about HIV/AIDS and its preventive methods known by a person.
- (5) **Attitude towards HIV/AIDS**, in this study, means beliefs, needs and values on AIDS itself, safe sex and intravenous drug use.
- (6) **Practice**, in this study, includes practices regarding to safe sex and safe intravenous drug use.
- (7) **Confidant** means someone to whom the respondent confided in or told something in confidence
- (8) **Distress**, in this study, includes problems at work itself (or) work condition, financial problem and loneliness. It does not include sexual distress.

1.7 RESEARCH CONCEPTUAL FRAMEWORK (Figure 1.1)



This conceptual framework is based on the Social Support Theory (Koepl, 2003), stating that the extent and nature of one's social relationships affects one's health and health decision. Rationale for using this theory is that the migrant community has no typical social support like those in their native community (e.g. support from family members or relatives and society as a whole). They have to rely on an atypical informal social network (e.g. informal society like co-workers, new friends, religious group, and cultural society).