



CHAPTER V

DISCUSSION AND CONCLUSION

This chapter presents a discussion of findings, conclusions, and recommendations. Conclusions and recommendations are presented in a single section.

5.1 Discussion

This study was focused on a group of Myanmar migrant workers in Muang District of Ranong Province in Southern Thailand. The objectives of the study were (1) to describe socio-demographic characteristics and registration status of Myanmar migrant workers, (2) to describe the sources of HIV-related health education among Myanmar migrant workers, their access to, and their perceptions on existing HIV-related health education, (3) to describe relationship between the socio-demographic characteristics, registration status of these workers, and their extent of access to and perceptions on existing HIV-related health education, and (4) describe relationship between the socio-demographic characteristics, registration status of these workers, and their preference for HIV-related health education. In this section, findings of the study will be discussed in the context of research questions and objectives.

Regarding the descriptive information, the majority were youth and young adults with the age of 15 to 35 years old among study groups with the ages of 15 to 49 years. The ratios of male to female and also married to single were about 1.1, which was nearly the same with previous figures, about 1.0 estimated by Muang District

Health Office, WVFT and IOM in 2007. The education of the majority was in low and middle level. And, most of them were *Burmese* and *Dawei* came from lower Myanmar. Their length of stay in Ranong varied from several months to several years, but more than half had from six months to six years of stay. Among seven types of occupation in the study, the numbers of fishery-related workers, general workers and fishermen occupied higher. Most of the workers earned from 1,000 to 5,000 Baht per month, and the percentage of registered workers showed 37.8% of total respondents, which was a slightly higher than the figure (~ 25%) estimated by Muang District Health Office in 2007.

Regarding the accessibility to existing HIV-related health education, of total 357 respondents, 68.6% had received HIV-related health education representing the proportion of accessibility to HIV-related health education 0.69, which was more than two times higher than the figure (~ 0.3) estimated in 2005 and 2006 (WVFT, 2006; PHAMIT, 2005).

This study showed that registered workers clearly had both greater access to HIV-related education and longer length of stay in Ranong than did unregistered workers. So, the fact that registered workers had greater access to such health education could be due to their longer length of stay in Ranong, and might not be due to their registration status. When three different age groups were compared, the total times of access to HIV-related health education among youth with the ages of 15 to 25 years were found significantly lower than the other two groups of young adults and adults. However, the ratio of male to female who had received such health education was about 1.0, reflecting both had equal chance to receive such health education.

This study also revealed that the total times of access to HIV-related health education among the seven different groups of occupation were significantly different. Among three high-risk groups, two groups of fishermen, and sex workers (SW) and men who have sex with men (MSM) had significantly greater chance to receive such health education than other non-high-risk groups, but, the remaining high-risk group of fishery-related workers had relatively low access. When the association between accessibility to HIV-related health education and education on other health issues was analyzed, the workers who had received HIV-related health education had also received education on other health issues such as sexually transmitted infections, tuberculosis, malaria, diarrhea, reproductive health and dengue, but it cannot be assured whether health education in Ranong was a package (integrated) education or not.

In addition, Burmese language was used in all types of HIV-related health education, and among which, reading materials like cartoon/comic booklets and pamphlets/ brochures/leaflets were found to be more accessible than other types. The majority of the respondents had received such educational reading materials from their friends/family members/relatives and while distributing in the community. Moreover, most of them recognized that those education materials or activities were developed or organized by a non-governmental health organization called “*World Vision*”. So, it can be assumed that HIV-related reading materials and health education activities for Myanmar migrant communities in Ranong were mostly produced or organized by *World Vision*.

Regarding the perceptions on existing HIV-related health education in Ranong, most of the respondents disagreed with the fact that Myanmar migrant workers in Ranong could easily access or had adequate accessibility to existing HIV-related health education in Ranong, and also had not got satisfied yet, even though 68.6% of them have already received such health educations. It was consistent with some parts of information described in the official reports (Ranong Provincial Health Office, 2005a; PHAMIT-WVFT, 2004). However, most of the respondents believed that HIV/AIDS is one of their important matters, and those health educations could give them proper knowledge about HIV/AIDS, and about half of them agreed that those could change their attitudes towards and their practices for HIV prevention.

This study also explored the preferences for HIV-related health education in future. For non-participatory types of health education, most of migrant workers preferred health products like condoms and lubricant gel, cartoon/comic booklets, real-life photo story booklets, pamphlet/leaflets/brochures, audio-visual drama like TV episodes and VCDs, and TV spots. It highlighted the findings from a national qualitative study in South Africa, which showed that HIV/AIDS communication project consists of TV, radio drama and printed materials gave numerous instance of community change (Goldstein et al., 2005). Moreover, all migrant workers liked all types of participatory health education, which reinforced the comment stated in a study done in Zimbabwe; community-based participatory peer education was often positively associated with successful avoidance of HIV and STI, which, in turn, is positively associated with psychosocial determinants of safer behavior (Gregson et al., 2004).

When preferences for HIV-related health education according to education levels were compared, it was found that low-educated workers preferred non-participatory health education, especially educational VCDs, rather than participatory types. It also reflected the findings of a study done in low socio-economic community in North India, which stated that TV drama and TV spots gave potential behavioral outcomes like condom use, interpersonal communication and gender attitudes (Sood, & Nambiar, 2006). However, for participatory health education, the preferences between low- and better-educated groups were not significantly different.

When compared among occupation groups, high-risk groups of fishermen, fishery-related workers, sex workers and men who have sex with men preferred participatory health education, especially peer education/role modeling and establishment of enabling environments. It was consistent with the findings of a study done in China, and an evaluation study done in Russia and Bulgaria. Participatory involvement was the major driving force for HIV-related safer sex behavior change and could be recommended to promote safer sex practice among gay men and MSM in their broad contexts (Gao & Wang, 2007). HIV prevention, by intervening social networks, is potentially important, and results revealed that social networking produced increases in the level and comfort with which network members talked about AIDS prevention topics in their daily conversations, increased network-level AIDS risk reduction knowledge and improved risk reduction norm perceptions, attitudes, behavioral intentions, and self-efficacy, and increased condom use levels among network members. (Amirkhanian et al., 2003). However, for non-participatory health education, the preferences between the two occupation groups of high-risk and others combined were not significantly different.

Regarding the preferred places to receive such health educations, there was no significant difference among the age groups, but there were some differences among occupation groups. However, when two main groups of high-risk and others combined were compared, high-risk groups of fishermen, fishery-related workers, sex workers and men who have sex with men were more likely preferred to receive HIV-related health education at their workplaces such as harbors, dockyards, fisheries, karaoke bars, brothels, etc., but they did not prefer to receive such kind of education on the way/on the road. In the other hands, all other groups combined preferred to receive health education on the way/on the road, and through their friends/family members and relatives. These findings of preferred places to receive HIV-related health education were relevant with their working nature. In addition, it was found that all migrant workers did not like to receive such health education at border gate, and only seven respondents (2% of all) preferred Thai government health centers.

According to the qualitative findings from the open-ended question, 304 workers (85.2%) expressed their feelings, opinions and gave suggestions regarding HIV-related health education in Ranong. More than half of the respondents complained of ineffective and inadequate health educations, and also requested to do more frequently and to distribute health educational materials more, even though 68.6% of them had received HIV-related health education in Ranong. It was consistent with the findings from the perceptions section of questionnaire, which stated that most of the workers disagreed with the fact that Myanmar migrant workers in Ranong could easily access or had adequate accessibility to existing HIV-related health education in Ranong, and had not got satisfied yet. So, it can be assured that HIV/AIDS stands as one of their important matters, and HIV-related health education

is still demanding. However, most of the migrants especially agriculture, rubber plantation and livestock workers living in the outskirts of Ranong expressed that health care services for acute illness and locally common diseases were their priorities rather than HIV/AIDS.

Some respondents requested provision of a collection of health educational materials preferably in a box or rack or wall-attached bookshelf to be easily accessed by all workers there, but some suggested giving priority to high-risk groups including youth. Moreover, some desired revision of Thai government policy on Myanmar migrants, and requested to cooperate and to coordinate among local health authorities, health organizations, employers and workers. Among all respondents, only 15 (4.2%) admitted that they had changed behavior after learning stories and bad experiences regarding HIV/AIDS from their family or neighbors.

Comparison on quantitative and qualitative results showed that there were some consistencies in how HIV/AIDS was important for migrant workers, complaint of ineffective or inadequate HIV-related health educations, and request for more HIV prevention interventions especially distribution of condoms, lubricant gels, cartoon/comic booklets, VCDs, group trainings/discussions, and health talks.

This study has strengths and limitations. The study was focused only on a group of Myanmar migrant workers in Muang District of Ranong Province in Southern Thailand, and thus, it cannot represent the whole Myanmar migrant population in Thailand. Moreover, the results from qualitative analysis of a single open-ended question are subjective, and cannot be generalized the entire Myanmar migrant community in Ranong and also in Thailand, but it can contribute as supplementary qualitative information to this study.

The study topic and objectives were relevant to current health issues commonly faced by Myanmar migrants in Ranong and elsewhere. Also, to the best of the researcher's knowledge, this kind of study has not been done previously in the Myanmar migrant population in Thailand. However, due to limitations in the cross-sectional study design, the generalizability of the observed variation in accessibility to, perceptions on and preferences for HIV-related health education in Ranong, and the trend of health education time by time, are not certain. Study population between the age of 15 to 49 years was relevant to the study topic as most of the migrants were at those productive ages, and it was also consistent with the most HIV-infected age groups described by UNAIDS and WHO. In addition, according to the working nature and geographically scattered distribution of the migrants, convenience random sampling became the most appropriate for such kind of study even though it had some sampling bias.

Interview, instead of self-administered questionnaire, was an appropriate instrument for this kind of study especially to explore perceptions to and preferences for HIV-related health education, and to record the expressions of migrant workers regarding HIV/AIDS. Moreover, not only about HIV-related health education, and also other health issues, their culture, their real life and the stories how they struggled for their survival were also learned as a chance from face-to-face interview. However, the drawback was taking more time than expected in rapport building and interviewing as some respondents, especially female workers, were reluctant to answer in front of a strange interviewer. Apart from that issue, data collection proceeded smoothly, and most of the migrants were willing to answer if they were free and also had no suspicions regarding signed consent.

5.2 Conclusion and Recommendations

This study showed that there was statistically significant association between longer length of stay in Ranong, high-risk groups of fishermen, sex workers and men who have sex with men, and more frequent access to existing HIV-related health education. However, youth with the ages of 15 to 25 years had significantly less access to HIV-related health education than did the older age groups. Therefore, this study suggested that more effort is needed to maintain the chance of greater access to such health educations among high-risk workers, and to make sure that HIV-related health education can be easily and frequently accessed by the remaining high-risk group of fishery-related workers, and youth.

This study also highlighted that registered workers had longer length of stay in Ranong and more frequent access to HIV-related health educations as well. Even so, results suggested that unregistered workers should be enabled to have more frequent access to such health education. Further research is needed to ascertain the relative importance of length of stay and registration status as determinants of access to education.

Findings from this study also indicated that there were significantly greater preferences for participatory HIV-related health education among all migrant workers. Moreover, there was also a statistically significant association between the high-risk group of fishermen, fishery-related workers, sex workers and men who have sex with men, and greater preferences for participatory health education as well. Thus, the study also suggested that HIV-related participatory health educations together with non-participatory ones should be practiced and sustained among Myanmar migrant communities enable to make sure to get the positive behavioral outcomes regarding

HIV prevention and control. Moreover, even though all migrant workers preferred participatory types of health education, this study revealed that there were also greater preferences for non-participatory ones like health products like condoms and lubricant gel, cartoon/ comic booklets, real-life photo story booklets, pamphlet/ leaflets/ brochures, audio-visual drama like TV episodes and VCDs, and TV spots. Therefore, the study reminded to undertake not only participatory health education but also non-participatory ones.

Additionally, qualitative information from this study also gave some ideas to be considered to provide a collection, preferably a rack or wall-attached bookshelf or a box, of health education materials not only about HIV/AIDS and also about other common diseases, to implement not only HIV-related health education and also care and support for acute illness and other common diseases especially for workers in outskirts, to find out a better way for more lively, friendly, practical and interactive trainings, preferably in informal settings, and to scale up a better cooperation and coordination among local health authorities, health organizations, employers and workers to ensure better health interventions in future.

In this study, data analysis considered only one independent variable at a time. This type of analysis cannot completely determine the relative importance of variables, and it cannot thoroughly address possible confounding among independent variables. This would require multivariable analysis, which considered multiple independent variables simultaneously. Such analysis is beyond the scope of this study.

Even though this was a cross-sectional study, the prevalence and determinants of accessibility to, perceptions on and preferences for HIV-related health education among Myanmar migrants in Ranong was explored both quantitatively and

qualitatively. Moreover, the results of the study could be useful in reviewing and evaluating the health education/promotion program whether it met its communicative objectives (what we want the target group to know) and behavioral objectives (what we expect the target group to change) or not, and whether it reached at its output level or outcome or up to impact level. Likewise, while planning for HIV-related behavior change communication intervention program, some clues to probe the key factors (what we should focus on) in order to shift from existing/risky behaviors to desired/changed behaviors, the approaches (what we should do), and ways to evaluate (how we will measure) could be also found out.

Moreover, it also could be very helpful in planning and implementation of behavior change communication (BCC) activities like communication and training needs assessment, behavioral assessment, development of information, education and communication (IEC) materials production guidelines, production of effective IEC and training materials, content and context analysis for IEC materials, IEC effectiveness survey and training evaluation, behavior change impact study, as the ultimate goal of health education using IEC materials is positive behavior change.

In addition, if a complete picture of the characteristics of accessibility to, perceptions on and preferences for HIV-related health education, and related push-and-pull factors were developed, it would be easier for better interventions in future. Therefore, it is hoped that the results of this study could to be useful for the review and planning of health education, health promotion, information, education and communication (IEC) materials development, and behavior change communication (BCC) interventions regarding HIV/AIDS prevention and control among Myanmar migrant workers in similar settings in Thailand and elsewhere.