CHAPTER II

LITERATURE REVIEW

2.1 RISK BEHAVIORS OF MYANMAR MIGRANTS

Several studies suggested that having multiple sex partners is a relatively common practice for the male migrants from Myanmar working in Thailand (Archavanitkul et, al., 2000, CARE, 2000, Oppenheimer et.al., 1998). Studies conducted in Ranong, Mae Sai, and Chaing Mai showed that drinking alcohol/beer, visiting Karaoke and massage rooms, and meeting commercial sex workers and causal partners were common means of recreation among males migrants. In Ranong and Chaing Mai, commercial sex patronage occurred as a group activity with men and their peers going together to visit sex workers, usually after a night of drinking (Archavanitkul et. al., 2000). Their attitudes and behavior may change when away from home, influenced by a range of factors including the types of migration, the duration of time away, the types of location at the destination, living situations, occupation, age and gender (Chantavanich, S. et. al., 2000).

In Samut Sakorn, many brothels are present near some factories and there are some commercial sex workers (CSW) from Myanmar. But most of the sex workers are said to be Thai. Not only brothels, there are also some sex workers who walk around the area of Prawn Markets in Mahachai waiting for the clients (CARE, 1999). The cost for the service of the CSW is Baht 150-300. This is affordable to the men in that area. Some men visit the brothel once or twice a month and if they are regular customers of

the brothel, they do not need to use the condom. X-rated videos are popular and there are about 3-4 video shops (for renting or viewing) showing Western and Myanmar movies and X-rated movies. The residents reported that some men would visit a commercial sex establishment after watching the video. In Samut Sakorn, there are some places selling amphetamines, the Myanmar migrant call as "horses". Lots of Myanmar migrants inject horses. They use the same needles as their friends. This may be one major way of transmitting the disease. To review their HIV status, when 3,000 Myanmar migrants were deported from Mae Sot, Thailand to Myawaddy, they underwent mandatory HIV testing. Out of 3,000 deported migrants, 20 of them were found HIV positive showing a morbidity rate = 666.7 per 100,000 population (Human Rights of Migrants, 2002).

2.2 MIGRATION AND AIDS

Migrant workers from economically less developed countries usually migrate to more developing or developed countries due to uneven nature of development in Asia. In other words, migration takes place from labor rich areas to labor deficit areas (UNDP, 2000, Seshu, M. S., 1999). In both developing and developed countries, migration has been a major way, through which infectious diseases have spread. Communicable diseases usually spread farther and faster as roads and transportation improve. The pattern of spread follows major highways and passes through international airports and seaports. From South East Asia, migrants mainly from Myanmar, Vietnam, Cambodia and Laos move to Thailand, Malaysia, Singapore, Hong Kong and the Middle East countries (Skeledon, R., 1992). Many of the migrants travel without their sexual

partners, but being of an age of high sexual drive, they have to seek their satisfactions and needs for companionship and sexual contact (Wolfers, I., 1999). In response to their sexual desire, many develop new sexual relationships in the host countries. These relationships are formed apart from their traditional social networks and cultural values and may involve increased level of exposure to HIV (Fernandez, I., 1998).

Migration within countries, across borders, and urbanization (e.g., from rural areas to urban centers or industrial sites) cause more people into close contact and creates a greater mixing of people at places of destination, which provides a ready environment for viral transmissions by increased participation in commercial sex and the use of injectable drugs. Professional groups characterized by mobility, for instance, truck drivers, traders and military personnel, have also been associated with a higher risk of HIV infection. Population mobility facilitates the spread of STDs, including HIV. When they are away from their wives and families, they may go to commercial sex workers as well as causal partners for their pleasure. In these times, most of them do not carry condoms and they can get HIV from infected partners. So, they can transmit the virus to other sex workers and other female partners. When they come back home, the infection can be transmitted to his wife and also to their newborn baby. Migrants, those settle in areas with high prevalence of HIV infection, are exposed to the risk behavior of new friends, such as intravenous drug using, and sexual promiscuity. The disruption of social ties and family life that occurs during moves, especially in situation of poverty and crisis, also increase risk of disease, as migrants find new sex partners. Sometimes women have no choice but to sell sex for protection, money, food, and other goods (Population Reports, 1996).

In 1990, a study in KwaZulu/Natal province, which is a major source of migrant workers to the mines of South Africa, found that migrant men had twice the HIV rates than that of non-migrants, while migrant women who attended prenatal clinics in the province had twice the national level of HIV infection (Population Reports, 1996). Not only migrant workers, but also many sex workers move from place to place, whether voluntarily or involuntarily. For example, women from Cambodia, Laos, Myanmar, and Viet Nam work in brothels in Thailand. Sex workers from Thailand and the Philippines work in Singapore and Japan. Nepalase women work in India, where 35% or more of sex workers are infected with HIV (Population Reports, 1996).

A study of HIV/STD prevalence and risk factors among migrant and non-migrant males of Kailali districts in Far-western Nepal shows that rate of having sex with sex workers is much higher among international migrants (19.8%) than among non-migrants (4.3%). The use of condom among international migrants was 37.1% whereas among non-mgrants was 63.9% (Marga, R. Pul, K., 2002).

A study in Uganda showed that the rate of HIV infection was different between moved and unmoved people. There was 5.5% infection rate among people who never moved compared with 12.4% among those who moved to a different village. Similar findings emerged in a study in Senegal (The Associated Press, 1995).

2.3 RELATIONSHIP BETWEEN SOCIO-DEMOGRAPHIC CHARACTERISTICS AND KNOWLEDGE ON HIV TRANSMISSION

Differences in socio-demographic characteristics of a person cause differences in knowledge on HIV transmission of that person directly or indirectly. Myanmar Medical Association (BMA) and National Health and Education Committee (NHEC) collected data on AIDS knowledge, attitude and practices among 725 migrant factory workers (female=492, male=233) from Myanmar in Tak Province, Thailand during July 2000. Responses were grouped into prevention, transmission and risk categories and percentages answered correctly were recorded. Men consistently scored higher than women, with significant gender differences in knowledge on prevention (44.6% versus 31.4%, $p<0.0001$, CI - 8.0-18.4) and transmission questions (46.4% versus 38.9%, $p=0.006$, CI – 3.2-11.8). The survey revealed a difference in knowledge between male and female migrant factory workers, males having more knowledge than females (Mullany, Maung, et. al., 2000).

2.4 ATTITUDES TOWARDS SEXUAL BEHAVIOR AND CONDOM USE

In Philippine, the attitudes of the wives of seafarers towards their husband's and their own vulnerability to HIV/AIDS were assessed. The respondents accepted that it was normal for men to have sex with other women because it was in the nature of men. They said that their husbands had sexual needs that must be satisfied and since they could not be present to satisfy their needs, it was natural for men to look elsewhere for

satisfaction. They also accepted that sex with other women was part of the seafarer's life. One dangerous attitude was that some wives were willing to take the risk of contracting STDs or HIV/AIDS. They said that they missed their husbands so much that they were eager to have sex with them notwithstanding the risks. They think of the risk later so that STDs or HIV may be the price to pay for their happiness. Some women expressed that condom use was not natural and so they felt embarrassed about using them. Some thought the condoms were inconvenient because they disrupted the lovemaking. If wives suggested condom use to their husbands, that would be an indication of mistrust in their husbands that could disrupt their mutual trust. A primary factor that affected the attitudes of the seafarer's wives was their economical dependence upon their husbands. These women did not work outside the home. They accepted the fact that it was all right for their husbands to spend their own money anyway. In this case, the attitude changes with the presence or absence of the occupation (CARAM-Asia 1998).

2.5 RELATIONSHIP AMONG KNOWLEDGE, ATTITUDES AND PRACTICE ON HIV PREVENTION

A study was done in Georgia, the United States of America to describe the knowledge of HIV/AIDS, attitudes about condom use, and the sexual behavior of African-American adolescents who reside in a children's emergency homeless shelter. In this study, they used self-reported questionnaire as an instrument. Although these adolescents were knowledgeable about the prevention of HIV/AIDS, they often did not practice behavior that would decrease their risk of transmission. The adolescents in this

study understood many of the basic facts about HIV transmission, characteristics of high risk behavior, and ways to prevent the spread of HIV/AIDS, however, condoms were not consistently used. It showed that although much knowledge of HIV/AIDS had been achieved, knowledge alone is not enough to facilitate positive behavior change in regards to sexual behavior. Next to knowledge, beliefs and values are important to increase their motivation to change their behavior. This study reveals that sexual behavior and attitudes toward condoms were not consistent with their knowledge and if we want to change their behavior, we need to find out their beliefs or attitudes and other possible factors first, other than assessing knowledge alone. It also shows that knowledge, attitudes and sexual behavior of African-American adolescents should be examined to develop and implement appropriate programs to address the specific needs of this population (Liverpool, McGhee, Lollis, Beckford and Levine, 2002).

The relationship between knowledge and attitude on HIV/AIDS prevention was assessed among people from Bangladesh seeking oversea work during their medical check up before going abroad. The result revealed that their attitudes towards HIV/AIDS were not significantly related to high or low scores of AIDS knowledge among these people, showing that the attitude of a person may not change if they acquire sound knowledge (Rahman, Shimu, Fukui, Shimbo and Yamamoto, 1998).

2.6 RELATIONSHIPS BETWEEN SOCIAL NETWORK AND KNOWLEDGE, ATTITUDES, AND PRACTICES ON HIV PREVENTION

As people live far away from their near and dear ones, they develop their own social and cultural networks which act as strong emotional supports as well as determine peer group behavior and activities. To fulfill their physical and emotional needs, they create their own social networks and relationships. Social networking includes living arrangements of the migrants, friendship patterns, their interaction with their neighbors, and their feeling about working and social environment.

A study was done on the source of information, knowledge and risk behavior for HIV/AIDS transmission among migrant workers in Surat, India. A large majority of migrants (86%) had heard about HIV/AIDS and its mode of transmission. Friends and relatives are the most important source of knowledge (67%), followed by television (65%) and newspaper/magazine (61%). Friends and relatives were the most important source for illiterate or less educated migrants and for those who are living with friends. This study showed that for less educated migrants, social network is the major source of information on HIV/AIDS. Although the prevalence of drug use was very low among all migrants, those living alone were using drugs slightly more than other migrants. Similarly, those living alone and living with friends also visited red light area more, compared to those who live with their families or with relatives. Four percent of the migrants living alone are visiting CSWs compared to two percent who live with family, friends or relatives. More than 10 percent of all migrants had sexual relationship with other girls or women and the percentage is highest among those who

are living alone (19 percent), followed by those who live with friends (15 percent). The migrants also kept personal social relations with sex workers or regular partners to whom they regularly provide gifts or necessary incentives as additional benefits.

There was significant role of social network on drug abuse in both directions depending on the relative dominance of the members in the group. In the case of a substantial proportion of members using drugs, other members of the network have to support the well being of the addicts and eventually they become addicted to the drug. The effect of social network on drug abuse was primarily due to two reasons: peer pressure and poor knowledge about sex coupled with misconception that drug or alcohol consumption heightens sexual pleasure and makes it long lasting. Needle sharing is the important risk factor for the transmission of the disease (Gupta, K., Singh, S. K., 2000).