



CHAPTER IV

RESULTS

This chapter presents the findings of data analysis, and is divided into three main sections: (1) descriptive information, (2) analytical findings: relationships among variables, and (3) qualitative information. The first two sections present findings from quantitative analysis and the last one presents qualitative outcomes from an open-ended question about suggestions, opinions, and feelings of the respondents regarding HIV-related health education.

4.1 Descriptive Information

This section includes frequency distributions of respondents by their socio-demographic characteristics including language skills and registration status, their accessibility to and perceptions on existing HIV-related health education, and their preferences for HIV-related health education in future.

4.1.1 General Characteristics

Table 2 presents general characteristics regarding socio-demographics, language skills and registration status of Myanmar migrant workers in Ranong, Thailand. It showed that youths between 15 to 25 years of age were 45.4%, young adults from 26 to 35 years of age were 36.7%, and adults from 36 to 49 years of age were 17.9% of all respondents. Males and females constituted 52.9% and 47.1% respectively (ratio about 1.1). Among the respondents, 52.1% were married and 7.9%

were single. Their education varied from basic monastery education to university graduate, and it was categorized into three main levels: low (basic monastery and primary school education), middle (middle school education), and high (high school education and higher). 42.6% of respondents were low-educated, 37.5% were in middle, and the remaining 19.9% were in high level. The majority of the respondents were *Dawei* and Burmese which occupied 38.1% and 34.2% respectively. Other ethnic groups included *Beik*, *Mon*, *Rakhine* and other ethnic minorities. Their length of stay in Ranong varied from 6 to 408 months (from 6 months to 34 years), but nearly half of them stayed from six months to three years, representing 43.1% of all. Among the respondents, the largest groups were fishery-related workers and general/random workers, representing 30.5% and 28.3% respectively. The remaining groups of fishermen, domestic helpers, agriculture & livestock workers, construction & factory workers, and sex workers (SW) and men who have sex with men (MSM) occupied 15.4%, 3.9%, 11.2%, 5%, and 5.6% respectively. Regarding individual monthly income, nearly half of them (47.5%) earned between the ranges of 3,001 to 5,000 Baht, 39.5% earn from 1,000 to 3,000 Baht, and the ones who earned more than 5,000 Baht were only 12.9%.

Their Burmese language skills showed that all of respondents could understand others' talk, and 99.4% and 89.9% could speak and read Burmese, respectively. In Thai language skills, 72.8% could understand what other's talk, and 28.6% could speak. However, only three respondents (0.8%) could read Thai language. Of all respondents, only 37.8% were registered workers, and the remaining 62.2% were unregistered.

Table 2: General Characteristics of Respondents

General Characteristics		Number (n = 357)	%
Age:	15 - 25 Yr.	162	45.4
	26 - 35 Yr.	131	36.7
	36 - 49 Yr.	64	17.9
Sex:	Female	168	47.1
	Male	189	52.9
Marital Status:	Married	186	52.1
	Single	171	47.9
Education Level:	Low	152	42.6
	Middle	134	37.5
	High	71	19.9
Ethnicity:	Burmese	122	34.2
	Dawei	136	38.1
	Beik	37	10.4
	Mon	30	8.4
	Rakhine and Others	32	9.0
Length of Stay in Ranong:	6 Mo. - 3 Yr.	154	43.1
	4 - 6 Yr.	80	22.4
	7 - 9 Yr.	43	12.0
	8 - 12 Yr.	43	12.0
	> 12 Yr.	37	10.4
Occupation:	Fishermen†	55	15.4
	Fishery-related Workers†	109	30.5
	Domestic Helpers	14	3.9
	Agriculture & Livestock Workers	40	11.2
	Construction & Factory Workers	18	5.0
	General/Random Workers	101	28.3
	Others (SW & MSM) *†	20	5.6

Table 2: (Continued) General Characteristics of Respondents

General Characteristics		Number (n = 357)	%
Monthly Average	1000 - 3000 Baht	141	39.5
Individual Income:	3001 - 5000 Baht	170	47.6
	> 5000 Baht	46	12.9
Burmese Language Skills:	Listening	357	100.0
	Reading	321	89.9
	Speaking	355	99.4
Thai Language Skills:	Listening	260	72.8
	Reading	3	0.8
	Speaking	102	28.6
Registration Status:	Registered	135	37.8
	Unregistered	222	62.2

* Sex Workers and Men Who Have Sex with Men. † High-risk occupational group.

4.1.2 Accessibility to Various Types of Existing Health Education

Table 3 shows frequency distributions of respondents who had received any of the various types of health education in Ranong. Percentage distribution of previous access to any type of health education about HIV/AIDS, sexually transmitted infection, tuberculosis, malaria, diarrhea, reproductive health, and dengue were 68.6%, 60.5%, 28.3%, 15.7%, 11.2%, 10.4%, and 9.2% respectively.

Table 3: Previous accessibility to Various Types of Health Education

Topics	Have Received	
	Number (n = 357)	%
HIV/AIDS	245	68.6
Sexually Transmitted Infections	216	60.5
Tuberculosis	101	28.3
Malaria	56	15.7
Diarrhea	40	11.2
Reproductive Health	37	10.4
Dengue	33	9.2

4.1.3 Accessibility to HIV-related Health Education

Table 4 shows frequency distribution of the respondents' accessibility to existing HIV-related health education by their socio-economic characteristics and registration status. Among total 357 respondents, 245 (68.6%) had received HIV-related health education, but 112 (31.4%) had not received it at all. The results also showed that accessibility to HIV-related health education among youth from 15 to 25 years of age, young adults from 26 to 35 years of age and adults from 36 to 49 years of age were 60.5%, 74.8% and 76.6% of each respective group. Male and female respondents had nearly equal access HIV-related health education, standing 69.3% and 67.9% respectively of all. In all, 51.9%, 78.8%, 86%, 86% and 75.7% of the respondents who stayed in Ranong from 6 months to 3 years, from 4 to 6 years, from 7 to 9 years, from 10 to 12 years, and more than 12 years respectively could access HIV-related health education. According to their different types of occupation, all sex workers and men who have sex with men had received HIV-related health education, but among the remaining groups, it ranged from 37.5% to 78.2%. Among all, 80.7%

of registered and 61.3% of unregistered workers had accessed HIV-related health education.

Table 4: Accessibility to HIV-related Health Education by Socio-demographic Characteristics and Registration Status

Socio-demographic Characteristics and Registration Status	Have Received		Never Received	
	Number (n = 245)	%	Number (n = 112)	%
Age				
15 - 25 Yr.	98	60.5	64	39.5
26 - 35 Yr.	98	74.8	33	25.2
36 - 49 Yr.	49	76.6	15	23.4
Sex				
Female	114	67.9	54	32.1
Male	131	69.3	58	30.7
Length of Stay in Ranong				
0.5 - 03 Yr.	80	51.9	74	48.1
04 - 06 Yr.	63	78.8	17	21.3
07 - 09 Yr.	37	86.0	6	14.0
10 - 12 Yr.	37	86.0	6	14.0
> 12 Yr.	28	75.7	9	24.3
Occupation				
Fishermen †	42	76.4	13	23.6
Fishery Related Workers †	69	63.3	40	36.7
Domestic Helpers	7	50.0	7	50.0
Agriculture & Livestock Workers	15	37.5	25	62.5
Construction & Factory Workers	13	72.2	5	27.8
General/ Random Workers	79	78.2	22	21.8
Others (SW & MSM) * †	20	100.0	0	0.0
Registration Status				
Registered	109	80.7	26	19.3
Unregistered	136	61.3	86	38.7

* Sex Workers and Men Who Have Sex with Men. † High-risk occupational group.

4.1.4 Accessibility to HIV-related Health Education by Its Characteristics

Among 245 respondents who had received HIV-related health education, 65.8% and 51% of them had received health education materials like cartoon/comic booklets and pamphlet/brochure/leaflet respectively. 24.1% had received group training/discussion, and 19.9% had received health products like condom/lubricant gel. Burmese language was used for all types of health education. More than half the respondents (51.4%) had received those education materials from their friends, family members and relatives. 39.6%, 29.8%, 22% and 7.8% of them had received during in the community, at NGO health centers, at their workplaces, and in transit/on the road respectively. Regarding the source of those health educations, 71.8% of the respondents told that those were developed or organized by an NGO named *World Vision*, but 28.2% did not know.

Table 5: Accessibility to HIV-related Health Education by Its Characteristics

Characteristic	Number (n = 245)	%	
Types	Cartoon/Comic Booklet	235	65.8
	Pamphlet/Brochure/Leaflet	182	51.0
	Group Training/Discussion	86	24.1
	Health Products (Condom/Lubricant)	71	19.9
	Community Health Talk	25	7.0
	Billboard/Wall Sheet/Poster	13	3.6
	Promo-materials	11	3.1
	HIV Counseling	9	2.5
	Audio-visual Mass Media	0	0.0
Language Used	Burmese	245	100.0
Places of Access	Friends/Family/Relatives	126	51.4
	Community	97	39.6
	NGO Health Centers	73	29.8
	Workplaces	54	22.0
	In transit/On the Road	19	7.8
	Thai Government Health Centers	0	0.0
	Border Gate	0	0.0
Sources	NGO	176	71.8
	I don't know	69	28.2
	Thai Government	0	0.0

4.1.5 Total Times and Frequency of Access to HIV-related Health Education

In table 6, among 245 respondents who had received HIV-related health education, 39.2%, 18.2%, and 11.2% of them had one to two times, three to five times, and more than five times of access respectively. Moreover, frequency of access varied individually. During their stay in Ranong, 3.1%, 21%, 21%, 13.7% and 9.8% of them had received any type of HIV-related health education once every month, once in every 2 - 12 months, once in every 13 - 36 months, once in every 37 - 60 months, and once in every more than 60 months respectively.

Table 6: Total Times and Frequency of Access to HIV-related Health Education

Frequency		Number (n = 357)	%
Total Times of Access	1 - 2 times	140	39.2
	3 - 5 times	65	18.2
	> 5 times	40	11.2
	Never Received	112	31.4
One Time of Access in	Every month	11	3.1
	Every 2 – 12 months	75	21.0
	Every 13 – 36 months	75	21.0
	Every 37 – 60 months	49	13.7
	Every > 60 Months	35	9.8
	Never Received	112	31.4

4.1.6 Perceptions on Existing HIV-related Health Education

Of all the migrant workers, 245 had received HIV-related health education and 112 had never experienced that. They were asked how they perceive on existing HIV-related health education in Ranong in the fields of adequate accessibility, importance for them, knowledge gain, attitude change, practice change and overall satisfaction. Those exposed to education answered according to their own experience of change in knowledge, attitude and practice, while the non-exposed ones responded according to their own perceptions and ideas, and their thoughts of receiving such education to be good enough for the change.

Responses are summarized in table 6. 85.4 % of respondents disagreed that Myanmar migrant workers in Ranong could easily access, or they had adequate accessibility to HIV-related health education, but all of them accepted that HIV/AIDS is one of the important matters in their life. In terms of effectiveness, 95.8% of respondents agreed that the existing HIV-related health education could give proper knowledge about HIV/AIDS. 86.6% and 51.8% responded that those health educations could change their attitudes towards, and their practices for HIV prevention respectively. However, for those health education interventions overall, 72.5% of respondents had not yet received satisfaction.

Table 7: Perceptions on Accessibility to Existing HIV-related Health Education

Perceptions on:		Number (n = 357)	%
Adequate Accessibility	Strongly Agree	2	0.6
	Agree	20	5.6
	No Opinion	30	8.4
	Disagree	215	60.2
	Strongly Disagree	90	25.2
Importance for them	Strongly Agree	348	97.5
	Agree	9	2.5
	No Opinion	0	0.0
	Disagree	0	0.0
	Strongly Disagree	0	0.0
Knowledge Gain	Strongly Agree	203	56.9
	Agree	139	38.9
	No Opinion	9	2.5
	Disagree	6	1.7
	Strongly Disagree	0	0
Attitude Change	Strongly Agree	177	49.6
	Agree	132	37.0
	No Opinion	36	10.1
	Disagree	11	3.1
	Strongly Disagree	1	0.3
Practice Change	Strongly Agree	116	32.5
	Agree	69	19.3
	No Opinion	115	32.2
	Disagree	35	9.8
	Strongly Disagree	22	6.2
Overall Satisfaction	Very Satisfied	4	1.1
	Satisfied	37	10.4
	Normal	57	16.0
	Unsatisfied	189	52.9
	Very Unsatisfied	70	19.6

4.1.7 Preferred Language and Places for HIV-related Health Education

Table 8 shows respondents' preferred choices of language to be used, and places to receive HIV-related health education in future. Nearly all of them (97.8%) preferred Burmese (Myanmar) language except eight respondents (2.2%) who preferred *Mon* language as they were *Mon* ethnics. For preferred places of access, more than 85% of them preferred to receive such health educations during community health talks or group trainings/discussions, at NGO health centers, at their workplaces, from their friends/family members/relatives, and in transit/on the road. Very few respondents desired to receive such education at a government health centers or border gate.

Table 8: Preferred Language and Places for HIV-related Health Education

Preferences for:		Number (n = 357)	%
Language	Burmese	349	97.8
	<i>Mon</i> Language	8	2.2
Places	Community	351	98.3
	NGO Health Centers	325	91.0
	Workplaces	318	89.1
	Friends/Family/Relatives	309	86.6
	In transit/On the Road	304	85.2
	Thai Government Health Centers	7	2.0
	Border Gate	1	0.3

4.1.8 Preferred Types of Non-participatory HIV-related Health Education

All respondents were asked about their preferences for 17 types of HIV-related health education, and the results are shown in table 8. 69.5% of respondents liked promo-materials with short health messages as they thought that those could give some HIV knowledge or could remind them to avoid risky behaviors. Likewise, 96.1% of them preferred health products like condoms and lubricant gel as they all of these respondents agreed that only condom could prevent HIV and sexually transmitted infections, and lubricant gel could also do by reducing abrasion and trauma during sex.

Regarding printed materials, almost all the respondents (98.9%) preferred cartoon/ comic booklets, and they agreed that presenting health education materials with pictures and illustrations would be more attractive and effective to Myanmar migrant workers as they were low in education and level of understanding. Likewise, 98.3% of them like real-life photo story booklets, and they believed that they could learn good lessons from such stories. Moreover, they thought that they would deeply consider, and could control themselves not to be like that. 97.2% of the respondents also liked conventional health education materials like pamphlet/brochure/leaflet, and they agreed that such materials were very handy and cheap, and could be reached to all. Finally, 61.3% of respondents liked billboard/poster/wall sheet, and they said that it could be noticed easily because of its big visual size, making people aware of HIV/AIDS.

Among the mass media, almost all the respondents (99.7%) preferred health educational VCDs, and TV/video episodes, and they agreed that almost all the Myanmar migrant workers owned a set of TV & VCD player as an outlet of

recreation. Likewise, 93% of them liked TV/video spots also. For journal/magazine/newspaper, 69.2% wanted to put at least a short message or an advertisement or an article about HIV/AIDS in some locally popular Myanmar periodicals like “*Khit Pyine*” News Journal and “*Arr-Kasar*” Sport Journal. However, only 23% and 28.3% of the respondents desired radio spots and radio drama respectively for HIV-related health education.

Table 9: Preferred Types of Non-participatory HIV-related Health Education

Preferences for:		Number (n = 357)	%
Promo-material with Short Health Message	Strongly Agree	17	4.8
	Agree	231	64.7
		248	69.5
Health Products E.g. Condom, Lubricant Gel	Strongly Agree	311	87.1
	Agree	32	9.0
		343	96.1
Cartoon/Comic Booklet	Strongly Agree	335	93.8
	Agree	18	5.0
		353	98.9
Real-life Photo Story Booklet	Strongly Agree	330	92.4
	Agree	21	5.9
		351	98.3
Pamphlet/Brochure/Leaflet	Strongly Agree	121	33.9
	Agree	226	63.3
		347	97.2
Billboard/Poster/Wall Sheet	Strongly Agree	72	20.2
	Agree	147	41.2
		219	61.3
Audio-visual Drama	Strongly Agree	336	94.1
	Agree	20	5.6
		356	99.7
Audio-visual Spot	Strongly Agree	108	30.3
	Agree	224	62.7
		332	93.0
Journal/Magazine/ Newspaper	Strongly Agree	79	22.1
	Agree	168	47.1
		247	69.2
Radio Drama	Strongly Agree	28	7.8
	Agree	73	20.4
		101	28.3
Radio Spot	Strongly Agree	2	0.6
	Agree	80	22.4
		82	23.0

4.1.9 Preferred Types of Participatory HIV-related Health Education

Table 10 shows the frequency distribution of respondents by their preferences for six types of participatory HIV-related health education, and more than 90% of them liked all such kinds of health education. However, the preferences for two types health educations: group trainings/discussions and puzzles/games/ contests were the highest, both representing 99.7% of the respondents, who said that such kind of health educations could make them more interesting and more knowledgeable. In addition, they agreed that they could discuss, they could ask, and they could share their experiences among themselves. Then, 98.9% of the respondents preferred health exhibitions and community health talks, and the majority of them wanted to reach such kind of health educations three to four times a year, especially during the local festival seasons or in holidays.

For HIV counseling, 98.6% of them liked it because they could have a chance to discuss with the counselor. Moreover, they preferred a doctor or a nurse as a HIV counselor to be enabled to discuss about HIV/AIDS in detail. For enabling environments like PLHIV self-help group, MSM working groups, SW network, etc., 96.1% of the respondents liked it, and they agreed that creating such kind of supportive environments could desensitize the community about HIV/AIDS, could minimize the stigma and discrimination on marginalized people and PLHIV, could build team spirit and mutual understanding among Myanmar workers, and could raise the HIV/AIDS awareness in the community. Finally, 90.8% of the respondents liked peer education and health education by role models, and they said that they could learn lessons and experiences, and could apply the ways for positive change from those peers and role models.

Table 10: Preferred Types of Participatory HIV-related Health Education

Preferences for:		Number (n = 357)	%
Group Training/ Group Discussion	Strongly Agree	346	96.9
	Agree	10	2.8
		356	99.7
Puzzle/Game/Contest	Strongly Agree	346	96.9
	Agree	10	2.8
		356	99.7
Health Exhibition/ Community Health Talk	Strongly Agree	333	93.3
	Agree	20	5.6
		353	98.9
HIV Counseling	Strongly Agree	330	92.4
	Agree	22	6.2
		352	98.6
Enabling Environments e.g. PLHIV Self-help Group	Strongly Agree	278	77.9
	Agree	65	18.2
		343	96.1
Peer Education/ Role Modeling	Strongly Agree	225	63.0
	Agree	99	27.7
		324	90.8

4.2 Analytical Findings: Relationships among Variables

This section summarizes hypothesis testing to examine the associations between: (1) length of stay in Ranong and registration status of the Myanmar migrant workers, and accessibility to existing HIV-related health education, (2) registration status and length of stay in Ranong, (3) age groups and occupation, and the accessibility to existing HIV-related health education, (4) the accessibility to health educations regarding HIV/AIDS and to other health issues, (5) preferences for participatory and for non-participatory types of HIV-related health education among all migrant workers, (6) education level and occupation, and preferred types of HIV-related health education, and (7) age groups and occupation, and preferred places to receive HIV-related health education.

4.2.1 Association between Length of Stay in Ranong and Accessibility to Existing HIV-related Health Education

Findings in tables 11a and 11b show that longer length of stay in Ranong was significantly associated with greater accessibility to existing HIV-related health education ($p \leq 0.005$).

Table 11a: Correlation between Length of Stay in Ranong and Accessibility to Existing HIV-related Health Education

	Spearman's <i>rho</i> Correlations	Total Times of Access
Length of Stay in Ranong (Months)	Correlation Coefficient	0.201(**)
	p Value	< 0.001
	N	357

** Correlation is significant at the 0.01 level (2-tailed).

Table 11b: Categorical Analysis of Length of Stay in Ranong with Total Times of Access to HIV-related Education

Length of Stay in Ranong	N	Total Times of Access		Kruskal-Wallis Test	p Value
		Mean Rank			
6 Mo. - 3 Yr.	154	156.83			
4 - 6 Yr.	80	185.56			
7 - 9 Yr.	43	197.05		15.083	0.005
10 - 12 Yr.	43	212.03			
> 12 Yr.	37	197.73			

4.2.2 Association between Registration Status and Accessibility to Existing HIV-related Health Education

Findings in table 12 shows that registered workers were more likely to have received such health educations than unregistered ones ($p = 0.021$).

Table 12: Association between Registration Status and Total Number of Access to Existing HIV-related Health Education

Registration Status	N	Total Times of Access		P Value
		Mean Rank	Mann-Whitney U Test	
Registered	135	194.82		
Unregistered	222	169.38	12,849.50	0.021

4.2.3 Association between Registration Status and Length of Stay in Ranong

Table 13 shows that registration status of the migrant workers was significantly positively associated with length of stay in Ranong; registered workers had longer length of stay than unregistered ones ($p < 0.001$). According to the findings from tables 10 and 11, workers with longer length of stay in Ranong and

registered workers had greater chance of accessibility to existing HIV-related health education, ($p \leq 0.005$ and 0.021 respectively). At the same time, table 12 shows that registered workers had longer length of stay than unregistered ones ($p < 0.001$).

Table 13: Association between Registration Status and Length of Stay in Ranong

Registration Status	N	Length of Stay in Ranong		p Value
		Mean Rank	Mann-Whitney U Test	
Registered	135	241.14	6,596.500	< 0.001
Unregistered	222	141.21		

4.2.4 Association between Age Groups and Accessibility to Existing HIV-related Health Education

According to the findings in table 14, total times of access were significantly different among the three age groups ($p = 0.010$), and youth between the ages of 15 to 25 years had less times of access to HIV-related health educations than the older age groups.

Table 14: Association between Age Groups and Total Times of Access to Existing HIV-related Health Education

Age Groups	N	Total Times of Access		p Value
		Mean Rank	Kruskal-Wallis Test	
15 - 25 Yr.	162	164.48	9.149	0.010
26 - 35 Yr.	131	190.03		
36 - 49 Yr.	64	193.16		

4.2.5 Association between Occupation and Accessibility to Existing HIV-related Health Education

According to the findings in table 15, total times of access were significantly different among the occupation groups ($p < 0.001$), and sex workers and men who have sex with men, fishermen and general workers had greater chance to receive HIV-related health education than other groups. However, fishery-related workers had relatively fewer times of access among the high-risk groups.

Table 15: Association between Occupation and Total Times of Access to Existing HIV-related Health Education

Occupation	N	Total Times of Access	Kruskal- Wallis Test	p Value
		Mean Rank		
Fishermen †	55	194.77		
Fishery-related Workers †	109	160.72		
Domestic Helpers	14	139.61		
Agriculture & Livestock Workers	40	121.84	54.983	< 0.001
Construction & Factory Workers	18	184.33		
General/Random Workers	101	191.50		
Others (SW & MSM) * †	20	309.23		

* Sex Workers and Men Who Have Sex with Men. † High-risk occupational group.

4.2.6 Association between the Accessibility to Existing HIV-related Health Education and Education on Other Health Issues

As shown in table 16, there were highly significant positive relationships between receiving education regarding HIV and regarding other health conditions ($p < 0.001$). Specifically, 34.6% - 100.0% of respondents, 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.

Table 16: Association between the Accessibility to Existing HIV-related Health Education and Education on Other Health Issues

Accessibility to Existing Health Education regarding:		HIV/AIDS		Pearson Chi-Square	P Value
		No	Yes		
		N (%)	N (%)		
Sexually Transmitted Infections	No	112 (79.4)	29 (20.6)	250.009	< 0.001
	Yes	0 (0)	216 (100)		
Tuberculosis	No	111 (43.4)	145 (56.5)	60.388	< 0.001
	Yes	1 (1)	100 (99)		
Malaria	No	109 (36.2)	192 (63.8)	20.879	< 0.001
	Yes	3 (5.4)	53 (34.6)		
Diarrhea	No	110 (34.7)	207 (65.3)	14.552	< 0.001
	Yes	2 (5.0)	38 (95.0)		
Reproductive Health	No	110 (34.4)	210 (65.6)	12.928	< 0.001
	Yes	2 (5.4)	35 (94.6)		
Dengue	No	111 (34.5)	211 (65.5)	14.655	< 0.001
	Yes	1 (2.9)	34 (97.1)		

4.2.7 Association between All Migrant Workers and Greater Preferences for Participatory HIV-related Health Education

Table 17a and 17b show that there was a significant difference between preferences for participatory and for non-participatory types of HIV-related health education among all subjects. Specifically, subjects clearly and statistically significantly preferred participatory over non-participatory types of HIV-related health education ($p < 0.001$).

Table 17a: Comparison on Adjusted Scores of Preferences for HIV-related Participatory and Non-participatory Health Education

Occupation	Adjusted Scores of Preferences for	
	Participatory Health Education (6 Items)	Non-participatory Health Education (11 Items)
Fishermen †	1.90	1.25
Fishery-related Workers †	1.84	1.14
Domestic Helpers	1.74	1.27
Agriculture & Livestock Workers	1.85	1.23
Construction & Factory Workers	1.92	1.19
General/Random Workers	1.79	1.22
Others (SW & MSM) * †	1.89	1.21

* Sex Workers and Men Who Have Sex with Men. † High-risk occupational group.

Table 17b: Test of Significance among Preferences for Two Types of HIV-related Health Education

Adjusted Scores of Preferences	Signed Ranks	N	Mean Rank	Wilcoxon Signed Ranks Test	p Value
Participatory - Non-participatory	Negative	13 ^(a)	44.85	-16.082	< 0.001
	Positive	344 ^(b)	184.07		
	Ties	0 ^(c)			
	Total	357			

^(a) Participatory < Non-participatory

^(b) Participatory > Non-participatory

^(c) Participatory = Non-participatory

4.2.8 Association between Education Level and Preferred Types of HIV-related Health Education

In table 18a and 18b, preferences for non-participatory types of health education were nearly always higher in middle- and high-educated respondents, than low-educated ones. Also, preference for pamphlet/brochure/leaflet was significantly higher in better-educated workers ($p < 0.001$). Moreover, higher educated workers preferred health products such as condom and lubricant gel ($p = 0.011$), but their preference for real-life photo story book was marginally significant ($p = 0.062$). Likewise, preferences for participatory type of health education were always higher in better-educated workers, than low-educated ones, especially preference for puzzles/games/contests ($p = 0.042$). Also, as shown in in table 18c, middle- and high-educated workers exhibited significantly higher preference than lower-educated ones for non-participatory health education ($p = 0.001$).

Table 18a: Association between Education Levels and Preferences for Non-participatory HIV-related Health Education

Non-participatory Health Education	Mean Rank		Kruskal-Wallis Test	P Value
	Low (n = 152)	Middle & High		
Promo-materials with Short Health Message	175.91	181.29	0.339	0.560
Health Products E.g. Condom, Lubricant Gel	169.57	185.99	6.538	0.011
Pamphlet/Brochure/Leaflet	155.32	196.56	19.698	< 0.001
Cartoon/Comic Booklet	175.92	181.28	1.357	0.244
Real-life Photo Story Book	173.58	183.02	3.475	0.062
Billboard/Poster/Wall Sheet	173.76	182.89	0.790	0.374
Radio Spot	177.70	179.96	0.079	0.779
Radio Drama	175.78	181.39	0.415	0.519
Audio-visual Spot	178.73	179.20	0.003	0.960
Audio-visual Drama	180.06	178.21	0.169	0.681
Journal/Magazine/Newspaper	170.51	185.30	2.094	0.148

Table18b: Association between Education Levels and Preferences for Participatory HIV-related Health Education

Participatory Health Education	Mean Rank		Kruskal-Wallis Test	p Value
	Low (n = 152)	Middle & High (n = 205)		
Health Exhibition/ Community Health Talk	174.51	182.33	2.666	0.103
Puzzle/Game/Contest	175.13	181.87	4.151	0.042
Group Training/ Group Discussion	178.61	179.29	0.043	0.837
Peer Education/ Role Modeling	170.47	185.32	2.483	0.115
HIV Counseling	177.27	180.28	0.354	0.552
Enabling Environments e.g. PLHIV Self-help Group	178.58	179.31	0.008	0.927

Table 18c: Association between Education Levels and Preferred Types of HIV-related Health Education

Types of Health Education	Mean Rank		Mann-Whitney U Test	p Value
	Low (n = 152)	Middle & High (n = 205)		
Non-participatory	158.58	194.14	12,476.00	0.001
Participatory	171.49	184.57	14,439.00	0.204

4.2.9 Association between Occupation and Preferred Types of HIV-related Health Education

Regarding the occupation, the respondents were divided into two main groups: high-risk group (fishermen, fishery-related workers, sex workers and men who have sex with men), and other occupations combined (domestic helpers, agriculture/livestock workers, construction/factory workers, and general/random workers). According to table 19a and 19b, preferences for non-participatory health educations were nearly always lower in the high-risk group than in other group combined. Among these, preferences for audio-visual spot and real-life photo story book were highly significant ($p = 0.001$ and 0.013 respectively). Likewise, for audio-visual drama and journal/magazine/newspaper, the preferences were also marginally significant than in other group combined ($p = 0.059$ and $p = 0.082$ respectively). However, the preference for radio drama was significantly higher in the high-risk group ($p = 0.001$). For participatory health education, high-risk group prefer peer education/role modeling, and establishment of enabling environments, than other group combined ($p = 0.011$ and $p = 0.021$ respectively). Regarding the overall findings in table 19c, the non-high-risk group seemed to prefer non-participatory health educations more strongly than the high-risk group, but generally not significantly so. The high-risk group preferred participatory health education more strongly than did the other group ($p = 0.009$).

Table 19a: Association between Occupation and Preferences for Non-participatory HIV-related Health Education

Non-participatory Health Education	Mean Rank		Kruskal-Wallis Test	p Value
	High-risk Group (n = 184)	Other Group (n = 173)		
Promo-materials with Short Health Message	178.48	179.55	0.014	0.906
Health Products E.g. Condom, Lubricant Gel	178.63	179.39	0.014	0.904
Pamphlet/Brochure/Leaflet	174.95	183.31	0.828	0.363
Cartoon/Comic Booklet	176.33	181.84	1.462	0.227
Real-life Photo Story Book	172.98	185.40	6.146	0.013
Billboard/Poster/Wall Sheet	172.36	186.06	1.817	0.178
Radio Spot	184.30	173.36	1.887	0.170
Radio Drama	192.38	164.77	10.249	0.001
Audio-visual Spot	163.89	195.07	11.230	0.001
Audio-visual Drama	174.93	183.33	3.551	0.059
Journal/Magazine/Newspaper	170.48	188.06	3.022	0.082

Table 19b: Association between Occupation and Preferences for Participatory HIV-related Health Education

Participatory Health Education	Mean Rank		Kruskal-Wallis Test	P Value
	High-risk Group (n = 184)	Other Group (n = 173)		
Health Exhibition/ Community Health Talk	180.32	177.60	0.329	0.566
Puzzle/Game/Contest	177.70	180.38	0.674	0.412
Group Training/ Group Discussion	176.73	181.41	2.049	0.152
Peer Education/ Role Modeling	190.51	166.76	6.493	0.011
HIV Counseling	181.76	176.07	1.292	0.256
Enabling Environments e.g. PLHIV Self-help Group	187.82	169.62	5.310	0.021

Table 19c: Association between the Occupation and Preferred Types of HIV-related Health Education (continued)

Types of Health Education	Mean Rank		Mann-Whitney U Test	p Value
	High-risk Group (n = 184)	Other Group (n = 173)		
Non-participatory	173.32	185.04	14,871.00	0.278
Participatory	191.81	165.38	13,559.00	0.009

4.2.10 Association between Age Groups and Preferred Places to Receive HIV-related Health Education

Findings from table 20 showed that preferred places to receive HIV-related health education did not differ significantly among the three age groups.

Table 20: Association between the Age Groups and Preferred Places to Receive HIV-related Health Education

Preferred Places	Mean Rank			Kruskal-Wallis Test	P Value
	15 - 25 Years	26 - 35 Years	36 - 49 Years		
Border Gate	179.00	179.00	179.00	0.000	1.000
Govt. Health Centers	181.01	175.50	181.08	4.127	0.127
NGO Health Centers	177.37	178.65	183.84	0.747	0.688
Workplaces	181.97	175.34	178.98	1.026	0.599
In transit/On The Road	180.16	178.25	177.61	0.103	0.950
Friends/Family/Relatives	182.06	173.02	183.48	2.013	0.366
Community	176.49	180.64	182.00	3.688	0.158

4.2.11 Association between Occupation and Preferred Places to Receive HIV-related Health Education

Findings from table 21a and 21b show that preferred places to receive HIV-related health education were significantly varied among all migrant workers ($p < 0.001$). The community and government centers were the most and least preferred places, respectively, in which to receive education. Moreover, high-risk group of fishermen, fishery-related workers, sex workers and men who have sex with men had higher preference to receive HIV-related health education at their workplaces, but they really did not like to receive such health educations in transit/on the road ($p < 0.001$).

Table 21a: Comparison of Preferred Places of All Migrant Workers to Receive HIV-related Health Education

Preferred Places	N (n = 357)	Mean Rank	Friedman Test	p Value
Community	351	5.18		
NGO Health Centers	325	4.93		
Workplaces	318	4.86		
Friends/Family/Relatives	309	4.77	1602.528	< 0.001
In transit/On The Road	304	4.72		
Govt. Health Centers	7	1.81		
Border Gate	0	1.74		

Table 21b: Association between Occupation and Preferred Places to Receive HIV-related Health Education

Preferred Places	Mean Rank		Kruskal-Wallis Test	p Value
	High-risk Group (n = 184)	Other Group (n = 173)		
Community	180.06	177.87	0.808	0.369
NGO Health Centers	182.39	175.40	1.672	0.196
Workplaces	183.95	173.74	2.990	0.084
Friends/Family/Relatives	172.93	185.46	3.767	0.052
In transit/On The Road	162.82	196.21	24.623	< 0.001
Govt. Health Centers	180.35	177.56	1.128	0.288
Border Gate	179.00	179.00	0.000	1.000

4.3 Qualitative Information

4.3.1 Introduction

The purpose of this section is to explore and to describe the feelings, opinions, suggestions of the migrant workers regarding HIV-related health education in Ranong, and it was intended enable to contribute for better health education in future. For this reason, they were asked an open-ended question at the end of the structured interview, and their responses were recorded. This section includes frequency distributions of respondents by their responses to the open-ended question, and description of some of their expressions as supplementary qualitative information.

4.3.2 Frequency Distribution of Respondents by Their Responses

Table 22 shows the frequency distribution of respondents according to the similarity of their expressions to an open-ended question. Among total 357 workers, 53 (14.8%) did not answer to the question, but the remaining 304 workers

(85.2%) expressed their feelings and opinions, and gave their suggestions regarding HIV-related health education. The number of respondents, who complained of ineffective existing HIV-related health education, and requested for expansion of health education activities, especially group trainings/discussions, showed the highest representing 196 (54.9%) of all. Likewise, those who requested for distribution of health education materials including educational VCDs showed as the second highest, representing 187 (52.4%) of all. However, the respondents, who said that they had already changed after getting bad experiences in their life, and after knowing true stories from their neighbors regarding HIV/AIDS, were only 15 (4.2%) of all.

Table 22: Responses of the Migrant Workers to an Open-ended Question

No.	Responses to Open-ended Question	N	%
1.	Complained of existing HIV-related health education to be ineffective and inadequate, and requested for expansion of health education activities especially trainings & group discussion.	196	54.9
2.	Requested for distribution of health education materials especially cartoon/comic booklets, real-life photo story booklets and educational VCDs, and also health products like condom and lubricant gel	187	52.4
3.	Requested not only for HIV-related health education and also for care & support for AIDS patients, minor illnesses and other common diseases.	63	17.6
4.	Requested for a collection of health education materials not only for HIV/AIDS and also for other common diseases to be placed at workplaces, residences and in the boat (preferably in racks/boxes).	62	17.4
5.	Requested to prioritize to youth, not only limiting to HIV/AIDS but also life skills, alcohol & drug use.	59	16.5
6.	Complained regarding Thai government's policy on Myanmar migrants, and requested to cooperate among local health authorities, employers and workers.	49	13.7
7.	Requested to give priority to high-risk groups like fishermen, sex workers and men who have sex with men.	42	11.8
8.	Complained of existing HIV-related training style & approach which looked like a one-way lecture, and requested for the trainings to be more lively, friendly, interesting & practical, preferably in informal setting.	42	11.8
9.	Requested to raise awareness on HIV/AIDS among migrant communities through health exhibitions, health talks with games/puzzles/contests, billboards, public announcement, etc.	41	11.5
10.	Complained of having no spare time for HIV-related health education as they are struggling for their survival even though they accepted HIV/AIDS as one of their priorities.	28	7.8
11.	Felt sorry that they never received HIV-related health education or received only one time during their long stay in Ranong.	19	5.3
12.	Already changed after learning stories and bad experiences regarding HIV/AIDS from their family or neighbors.	15	4.2
13.	No opinion/ No expression	53	14.8

4.3.3 Supplementary Qualitative Observations

In this section, supplementary qualitative information was presented to reinforce the summary descriptions in the first 12 items of table 21 above. For each item, selected remarks of subjects are given, using the subjects' actual words as transcribed by this researcher.

Item 1: 54.9% of all complained that existing HIV-related health education in Ranong was not effective and not adequate, and they requested more health education activities especially group trainings and group discussion not only in the communities and also at the workplaces.

“I think health educations done by organizations working in Ranong are still not effective. Even if trainings cannot be done due to shortage of staff, health educational materials, educational VCDs should be distributed enough.”

(31 year old male, livestock worker)

“I really want HIV-related health education to be done frequently. Health education and trainings are needed to be done repeatedly as people are so careless here. I want them to realize that AIDS is a deadly disease. As a hotel-room cleaner, I know how people are so fond of sex, and how infrequently they use condom. I noticed that about half of them don't use condom when I checked during room-cleaning. Almost all the drunkards never use it”

(35 years-old female, hotel-room cleaner)

“I think, since Myanmar migrant population here is increasing day by day, HIV-related health education needs to be done more intensively. We hear deaths due to AIDS off and on. The activities done these days are good but, I think, still not that effective, so it needs to be done in a better way.....”

(22 years old female, street vendor)

“I have been here for more than 2 years, but I have never received such trainings or health educational materials. I have heard that deaths due to AIDS are quite a lot here. I would like to say that health education activities should be done more here.”

(19 years old male, general worker)

Item 2: Some of the respondents (52.4%) requested to distribute of health education materials especially cartoon/comic booklets, real-life photo story booklets and VCDs, and also health products like condom and lubricant gel. As they were busy with their works, they preferred health education materials rather than participating in health talks and group discussions. Moreover, they accepted that condom and lubricant gel as preventive health products.

“Many of the fishing boats have television and video sets, so it will be the best to distribute VCDs as health educational material. As fishermen have nothing much to do in their spare time in the boat, it will also be so effective to have cartoons and comic booklets too...”

(25 years old male, fisherman)

“It will be good to distribute health educational materials in community. For families, VCDs will be more appropriate. If reading materials are distributed, I think, only half of the people will read it. But for VCDs, it is more likely to be watched, it can be watched as a recreation in family also...”

(29 years old female, general worker)

“It will be the best that condoms and lubricants are kept to be easily accessible and can be taken free on road-side, in restaurants, in public restrooms, etc. It will be better that health educational pamphlets are also attached. People feel ashamed to buy condom, but to go to brothels, they just don’t care...”

(17 years old male, general worker)

Item 3: Even though all accepted AIDS as a deadly disease, and agreed that HIV/AIDS is one of their priorities, some workers at fishery ponds, livestock farms and rubber plantations in the outskirts of town thought that minor illness and common diseases are priorities as well. So, they also requested care & support for AIDS patients, minor illnesses and other common diseases, together with health education.

“Health education should not be focused on HIV/AIDS only; all health issue should be included for us. There are many important issues than AIDS here. If we can control ourselves, AIDS is no more a problem for us, but, if diarrhea occurs, for example, all the family members as well as the community have to suffer. That’s all I can suggest...”

(36 years old male, general worker)

"I had read such educational pamphlets and attended trainings, when I was in Myanmar. I know a bit better than others. But here in the outskirts of town, there are more important issues than AIDS; there is a big need of basic health care services here. We felt as if we are under a house arrest as we are allowed to go out only one day a month. Transportation to town is also very difficult. There were losses of life due to that. We have to ask lift from good-carrying cars. As we have to go to town illegally, insecure feeling of being arrested is always in our mind. If arrested, whole month's salary is gone to bribe the police. So, if possible, please come to us on a monthly basis and give the basic health care service as well as the health education"

(29 years old male, livestock worker)

"In fact, for workers living in this outskirts area, AIDS is not as important as other acute illnesses. There were so many incidents of loss of life because of unfavorable situations to go and seek treatment to town. Some bosses are good-hearted, so if someone is sick, they arrange to visit to clinics. But, we do not get much care in clinics as we are Myanmar people. If possible, please provide health care services together with health education on AIDS. For unregistered people, it is really difficult to go to town, so has to ask help to other people to buy drugs from store, and rely on self-treatment..."

(37 years old male, livestock worker)

Item 4: 17.4% of the respondents requested bookshelves/racks/boxes to collect health education materials as a mini-library, not only for HIV/AIDS and also for other common diseases to be placed at workplaces, at their residences, and also in the boats.

“In workplaces, wall-attached bookshelves with health educational materials, VCDs should be made available. Not only limiting to the HIV/AIDS, varieties of materials covering common diseases like diarrhea, malaria, tuberculosis, etc. should better be included. We can read there, we can borrow and read at home, and I think, it is not expensive. It is also easy to share it to other people after we have read. The only thing health organizations have to take responsibility is to refill the shelves as necessary.”

(31 year old male, livestock worker)

“My suggestion is to provide a box of collection of all health education materials including educational VCDs for fishermen. When they go out for fishing, which will take several days sometime up to months, they can bring it, and read the education booklets or they can watch educational VCDs in the boat. It's hard to arrange a health talk for fishermen as they usually have a few holidays. I think, it is not needed to arrange health talks, if we do so...”

(43 years old male, fisherman)

Item 5: Some respondents (16.5%) said that youth are one of the high-risk groups, and they requested to prioritize to youth, not only limiting to HIV/AIDS but also about life skills, alcohol & drug use.

“While away from home, youths should have trainings on HIV/AIDS, and in addition, to help them choose the right options, make the right decisions in their life, they should have life skills training also. Health education related to drug and alcohol should also be given to them. One thing I want to suggest to all youth is to avoid sex, and if unavoidable, use condom.”

(30 years old male, fisherman)

“The purpose of youth coming to Ranong is to earn and to save money for family, but after coming here, they use it for drug and sex. So, to avoid such happenings, to guide youth to reach their goals and make right decisions, training based on life skills should be given, just providing reading materials is not enough anymore. And group trainings or group discussions off and on will also be good for us.”

(16 years old female, general worker)

“As this disease occurs more in youth, they should be prioritized for health education. To have better participation of youth in HIV education, their parents or guardians should be explained first, for example by giving VCDs to their parents or guardians, so that they understand well and. they will encourage educating their children...”

(43 years old female, fishery worker)

Item 6: Some respondents (13.7%) complained regarding Thai government's policy on Myanmar migrants, and requested to cooperate and coordinate among local health authorities, health organizations, employers and workers for effective health education.

“Thai employers are just thinking of getting cheap Labor. They don't do anything for the health of the Myanmar workers. Even registered workers rarely get proper care while visiting to hospitals. There are no health organizations working effectively for us. So, we want to have our own groups, and have regular discussions on health. But what we will need is supports from organizations like World Vision.”

(20 years old female, fishery worker)

“Such health education should be done more. This is not only a health issue; it is also related with policy. Thai government is also responsible. For example, Thai employers should order the senior fishermen to ensure that they take along the health educational materials when they go for fishing, and in coming back also, while settling the Labor charges, insist the fishermen to use of condoms. It should be set up as a rule. Thai employers just need to give order, it is not that difficult and will be very effective.”

(39 years old male, fisherman)

“It will be good that Thai employers, health authorities, NGOs and Laborers should discuss and negotiate to have the regular health talks in workplaces. In community, although it is easy to do, gathering people is difficult. If in workplace, everybody will get the chance to listen at the same time.”

(39 years old male, factory worker)

Item 7: For HIV-related health education, 11.8% of the respondents requested to give priority only to high-risk groups like fishermen, sex workers and men who have sex with men.

“I want to say that fishermen should be targeted for such health education, because, in Ranong, fishermen are becoming the source of HIV transmission. As fishermen hate to go and attend trainings at somewhere else, it will be the best to come and give group discussion or training in their resting places...”

(38 years old male, fisherman)

“As fishermen are very much fond of sex, they should be the target for health education. It will be good that educational materials including VCDs are given when they go for fishing, and condoms are given when they come back from fishing with effective timing. These guys should be repeatedly given the education so that it goes into their heart...”

(31 years old male, general worker)

“I know my surrounding very well; who is doing what, what is happening where, almost everything, as I am wondering around. So, what I want to suggest is to focus on fishermen and karaoke girls as they are sexually very promiscuous and they are transmitting HIV, I think.”

(39 years male, street vendor)

Item 8: 1.8% of the respondents did not get satisfaction on training style & approach which, they thought, looked like a one-way lecture. And, they requested for all health talks, trainings and group discussions to be more lively, friendly, interesting and practical, preferably in informal setting.

“Training should be done in the way that the participants really understand, not just superficially. Quiet place should be chosen, and fear-based talk should be avoided for HIV-related health education. It should be in a friendly, lively and interactive way, not like a lecture. And I think, it will be the best if positive change happens among participants, rather than knowledge gain only.”

(28 years old male, fisherman)

“Frankly, I really don’t like lecture-type training. I want it to be in a very friendly, lively, and participatory way. People living with HIV should also be involved in such activities, so that we can learn from them and we can change.”

(23years old female, general worker)

“My suggestion is that training will be more effective if simple laymen words are used rather than medical terms and some high words, in friendly & lively ways, using real-life true stories and examples that reflect the reality.”

(33 years old male, fisherman)

Item 9: In order to raise awareness on HIV/AIDS among migrant communities, 11.5% of respondents suggested to organize health exhibitions, health talks with games/puzzles/contests, especially during the festival seasons and holidays, and also billboards, posters and public announcement to be done frequently.

“What I would like to suggest is that health education should be done in many places. Going round by car and making public aware through loud speakers and distributing health education materials, health exhibitions and role play in festivals should be done, so that everybody gets the knowledge.”

(33 years old male, petrol shop worker)

“There should be visible reminders like billboards, posters and wall sheets in public places, junctions, restaurants, karaoke bars and even in workplaces, so that everybody can notice easily, and control themselves automatically.”

(31 years old male, fisherman)

Item 10: A few workers (7.8%) complained of having no spare time for HIV-related health education as they are struggling for their survival even though they accepted HIV/AIDS as one of their priorities.

“People here are struggling for survival so they don't have spare time. I think it will not be easy to give trainings or health talks to them. We know that HIV/AIDS is important for us, but the problem is, not having spare time.”

(26 years old male, general worker)

“What I would like to say is that it will be good if the trainings & health talks can be arranged beyond our working hours. It will be impossible for us to join if it is in the working time, no matter how effective or beneficial it is.”

(29 years old, man who have sex with man)

Item 11: However, a few respondents (5.3%) felt sorry that they had never received HIV-related health education or received only one time during their long stay in Ranong.

“I want to say that health talks and group discussions should be done more. Thanks for what have been done for us, but I still don't feel satisfied. I don't know, may be because of my luck or may be my boss did not allow such activities at workplace; I got training only for one time during my 10 years of stay in here. I feel so sorry.”

(27 years old female, fishery worker)

“Due to this interview, I now realize myself that I really don't know about HIV/AIDS, I feel so small. I want to get health educations. I would like to request that more health talks are done in our quarter. Many deaths due to AIDS are here.”

(18 years old female, fishery worker)

“I feel so sorry for getting health talk only one time during 9 years of stay here. There are so many fishermen like me here in this difficult to reach places, so we should be considered.”

(37 years old male, fisherman)

Item 12: Very few respondents (4.2%) confessed that they had already changed after learning stories and bad experiences regarding HIV/AIDS from their friends, family and neighbors.

“Youth in Ranong are very much fond of sex and drug. Whole family of my younger sister had died of AIDS. Whoever experienced such bitter feelings will automatically be changed, without health education, I believe.”

(25 years old male, factory worker)

“I had experience of decorating my penis and made it enlarged by inserting steel balls. First, it was quite OK. Later, an abscess appeared and I felt so painful, so I had an operation at World Vision clinic, I suffered a lot. After that, I came to know that I was HIV positive. There are so many fishermen like me. And, still a lot who want to experiment. I keep on giving education to them as much as I can. I don't want the other fishermen to suffer like me, so I request effective health education for them.”

(34 years old male, fisherman)

“Now, I don't care for money anymore, and I don't accept any client without condom. But, my dream of having my own family will never come true, as I am HIV positive now. I always share my story to my friends, and I don't want them to face such bitterness.”

(21 years old female, sex worker)