CHAPTER II

LITERATURE REVIEW

2.1 Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS)

Human Immunodeficiency Virus (HIV) infects cells of immune system destroying or impairing their function in the process. Progressive HIV infection results in the progressive depletion of immune system, leading to immune deficiency. The immune system is said to be deficient when it can no longer play its role: fighting off infections, and keeping cancers from developing. People with cellular immune deficiency are much more vulnerable to infections than people without immune deficiency. Some of these diseases, namely those that are strongly associated with severe immunodeficiency, are called "opportunistic" disease, because they use the opportunity of a weaken immune system to develop.

In the studies of AIDS it was soon apparent that the syndrome was frequent in groups with certain behavioral characteristics, such as homosexuals or injecting drug users, and certain geographical groups. The missing link that explained why some people in these groups developed AIDS, and others with the same behavioral or ethnic backgrounds did not, was found in 1983-84, when HIV was discovered. In cohort studies of such groups, the presence of HIV infection predicted overwhelmingly who would develop AIDS.

HIV infection typically follows the following course: a) primary acute infection with a characteristic clinical picture; b) prolonged period without obvious, visible symptoms- although laboratory studies can demonstrate continuous disease progression and c) a severe immunodeficiency resulting in the development of secondary; opportunistic infections and tumor that, in turn, represent the major causes of death in AIDS patients. (UNAIDS, UNICEF, UNDP, UNFPA, UNDCP, ILO, UNFSCO, WHO & World Bank, 2002)

2.1.1 Prevention of HIV/AIDS

HIV is blood borne virus isolated in blood, semen, breast milk and cerebrospinal fluids of infected persons. It is principally a sexually transmitted virus. However, transmission can occur via a variety of methods involving contact with blood, blood products and other body fluids. HIV transmission is noted to occur through three mechanisms: heterosexual and homosexual activity; direct contact with infected blood from intravenous drug use, and prenatal transmission from infected mothers to their infants, which may occur either during pregnancy or at birth, or during lactation (WHO, 1997).

A comprehensive approach to cause, prevention, and cure is needed to control the spread of HIV infection. Preventing the transmission of HIV requires changes in behaviors that increase the risk of HIV infection. Risk behaviors include early age of sexual debut, multiple sexual partners, the presence and or history of sexually transmitted infections, inconsistent or no condom use, substance use concurrent with sexual encounter, and difficulty in following safer sex practices (Yu, 2000).

Sexual behavior is usually the most important factor to change to prevent HIV transmission. In many areas intravenous drug practices are also important. Behavior change is not a simple event that occurs at ones sole discretion. We need to think of behavior change as a process that takes time, and often involves repeated attempts (Yu, 2000).

Integration of HIV/AIDS and STD prevention strategies into primary health care is a priority because it is necessary for ensuring sustainability. Two examples of an integrated approach are the implementation of HIV/AIDS care and STD prevention and control. For example, a continuum of HIV/AIDS care is being promoted as part of primary health care, with linkages to be established between institutional, community and home levels. In the area of STD prevention and control, a syndromic approach to STD diagnosis is most suitable in the developing world as it does not require laboratory tests, and treatment can be given at the first contact with health services. WHO strongly advocates that all primary health care workers be trained in the syndromic approach to STD management (WHO, 1997).

While there is currently no reliable vaccine that could prevent HIV infections, anti-retroviral therapy is now being made increasingly available to the patients. The therapy, however, remains very costly though research is underway to find cheaper therapies that are affordable to the poor. Providing knowledge to and improving awareness of especially the vulnerable groups about the ways of HIV transmission, and attitudinal and behavior change towards high risk situations, remain the best strategies to control the spread of HIV/AIDS.

2.1.2 Migrants and HIV/AIDS

Migration across borders can takes place for both voluntary (migration for work, joining of family, etc.) and forced reasons (escape from violent conflict, environmental disasters, etc.). Migration takes place both legally and illegally. All these factors influence the treatment of migrants in the host country, including their access to information and basic services such as health (UNAIDS & UNESCO, 2001).

The above study also notes that factors related to the greater risk of HIV infection among migrant population include demographic and behavioral differences within the migrant community, difficulties in interactions with and integrating into the host society, less access to medical services, and language and communication problems with health care personnel.

Illegal migration is often characterized by unstable and insecure, and often exploitative, conditions for migrants in the host country, where they are also faced with the challenge of understanding the new environment. A study on Myanmar migrants in Thailand notes that the migrants are vulnerable for a range of reasons: away from their family for long periods, living as illegal aliens, limited access to health care, limited knowledge on HIV/AIDS and low literacy in destination or place of origin (Beesey, 2000).

The above study also surveyed the migrant seafarers in North-eastern Thailand and found that while most men were aware of the AIDS and the means by which HIV is transmitted, the condom use still appeared to be quite low among those having commercial sex.

According to a study, migrant population have a greater risk for poor health in general and HIV infection in particular. This is due to the imoact of sociocultural pattern of the migrant situation on health, their economic transistion , reduced avariablility and accessibility of health services, and the difficulty of the host country health care systems to cope with the traditions and the pratices of the migrants. An examination of epidemiological and behavioral data suggests that part of the greater apparent risk for HIV infection among migrant populations may stem from the living conditions variables and could be reduced by controlling or correcting these variables (e.g. improving access to information and health care, among others) (UNAIDS & UNESCO, 2001).

2.1.3 Knowledge Regarding HIV/AIDS

Knowledge is described in Merriam-Webster's dictionary (1995) as understanding gained by experience or range of information. It is the body of the truth, information and principles gained by mankind. As AIDS was first recognized in 1981, knowledge about AIDS had increased more and more through many kinds of research.

In countries affected by HIV/AIDS on a large scale, lack of knowledge and misconceptions about the causes of, and other factors associated with, the viruses are found to be common. Many studies have found that the knowledge among adolescents of what causes HIV is inadequate (Yu, 2000). Misconceptions and a lack of knowledge prevail especially among communities having lower educational attainment and restricted access to public information sources and health services.

Myanmar migrant workers in Thailand tend to have all these characteristics, which are compounded by limitations in Thai language and their illegal migration status in the country. (Chantavanich, et al, 2000).

Knowledge of HIV/AIDS among Myanmar migrant workers in Sangkhlaburi, a province bordering Myanmar, was found to be very low (mean score of 0.4 on a scale of 1.0). The knowledge varied from one religious group to another, with Buddhists having less knowledge than the Christians. Among various occupational groups, construction workers had significantly low knowledge of HIV/AIDS (Chantavanich et al, 2000).

2.1.4 Attitude Regarding HIV/AIDS

Attitude can be defined as readiness to respond to a psychological object with some degree of favor or disfavor. The evaluative reaction of favor or disfavor can range from extremely negative to extremely positive, through the natural point, on a dimension such as "good-bad", "pleasant-unpleasant", or "in favor-opposed". Attitudes are based on learned knowledge and predispose the person to action (http://www.unix.oit.umass.edu, 2002).

Attitudes regarding sexuality, for instance, are related to the presence or absence of risky behavior that could lead to contracting HIV. The attitudes can also be based on misconceptions or myths that are more likely to be prevalent in societies where any public discussion on sexual behavior is considered culturally or religiously offensive. (UNAIDS & UNESCO, 2001). Insufficient or lack of knowledge about HIV/AIDS could also lead to similar attitudes (Yu, 2000).

A study of Myanmar migrants in border provinces of Thailand found that males were more favorable to the notion of single men having commercial sex than women. Most migrants also believed that people suffering from HIV/AIDS should not be allowed to stay with their family, and more than half of them even declined to visit a friend having HIV (Chantavanich, et al, 2000).

2.1.5 Risk Behaviors Regarding HIV/AIDS

Behavior respects manner of acting in particular cases and given situations. The manner of behaving could be seen as "good" or "bad", among others (http://www.unix.oit.umass.edu, 2002).

From HIV/AIDS perspective, the high-risk behaviors are those that might lead to the transfer of HIV through sexual intercourse or blood transfer from an infected to a non-infected individual. In practice these behaviors consist of having multiple sex partners, having commercial sex, not using condoms, and multiple needle use among intravenous drug users (Yu, 2000).

A study conducted by World Vision in 1994 found fishermen (mainly migrants) engaged in high risk behaviors with regard to HIV/AIDS. More than half of the sample had multiple sexual partners and low condom use. Also a new fad described by the same study in Ranong was that some fishermen inject 15cc of olive oil (hair oil) around their penis in order to increase its size. World Vision field staff reported that perhaps as many as 2-3 fishermen on every boat have done this but the numbers are unkown. No one can as yet be sure about the longer term consequances of such injections, though impotence as well as local abscesses have been reported.

However those who injected their penises in this manner put themselves at risk for at least the following reason: sharing of needles while injecting oil; and condoms not fitting properly (Oppenheimer et al, 1998).

In the study on Myanmar migrants quoted 23% admitted having sex outside their wedlock, but 81% of them never used condoms. Poor knowledge and lower acceptance of condoms, as well as their restricted availability, were cited among the main reason for low condom use. The study also found that sex workers and fishermen were most likely to have unsafe sex and use drugs than other groups (Chantavanich, et al, 2000).

Youths with few economic resources and those with less stable living environments are more likely than other youths to engage in sexual behaviors that put them at risk of contracting HIV.

2.2 Conceptual Framework of the Study

The Myanmar migrants in Thailand mostly have an illegal migration status that makes them insecure, they are confined to low-paying jobs in hard working conditions, they live away from families which make them lonely, and they don't have much social relationship with Thai community. Mostly, they make friends with their fellow migrants who are in a similar situation. Loneliness, absence of traditional social control mechanisms, and pressure from group of friends leads them to high-risk behaviors of substance abuse and commercial sex. Their lack of access to health care and limited language skills prohibits them from gaining any knowledge of HIV/AIDS that could have otherwise served to check their attitude towards high-risk behaviors.

Study conceptual framework