

KNOWLEDGE ATTITUDE AND PRACTICE TOWARDS HIV/AIDS
PREVENTION AMONG MYANMAR FEMALE SEX WORKERS
IN MAE SOT DISTRICT, TAK PROVINCE, THAILAND



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บทคัดย่อและแฟ้มข้อมูลฉบับเต็มของวิทยานิพนธ์ตั้งแต่ปีการศึกษา 2554 ที่ให้บริการในคลังปัญญาจุฬาฯ (CUIR)
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ความรู้ เจตคติและการปฏิบัติต่อการป้องกันโรคเชื้อไวรัส/เอดส์ของหญิงบริการชาวเมียนมา
ในอำเภอแม่สอด จังหวัดตาก ประเทศไทย



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การศึกษาได้ดำเนินการโดยใช้วิธีการวิจัยเชิงปริมาณ ในช่วงวันที่ 20-31 ตุลาคม พ.ศ. 2559 ได้รวบรวมข้อมูลจากหญิงบริการชาวเมียนมา จำนวน 120 คน จากธุรกิจบริการทางเพศในพื้นที่ต่างๆ ของเขตอำเภอแม่สอดโดยการตอบแบบสอบถามด้วยวิธีสัมภาษณ์ การศึกษาครั้งนี้มีจุดมุ่งหมายเพื่ออธิบายลักษณะทางประชากรของหญิงบริการชาวเมียนมาเพื่อเข้าถึงระดับความรู้ ทัศนคติ และการปฏิบัติตนในการป้องกันเชไอวี/เอ็ดส์และเพื่อตรวจสอบความสัมพันธ์ระหว่างตัวแปรอิสระเหล่านี้ กับระดับการปฏิบัติตนในการป้องกันโรคเชไอวี/เอ็ดส์ของหญิงบริการชาวเมียนมา

ผลการศึกษารายงานว่า ร้อยละ 52.5 ของผู้ตอบแบบสอบถามมีอายุระหว่าง 18 ถึง 24 ปี ร้อยละ 21.7 เป็นชาวกะเหรี่ยง ร้อยละ 90 เป็นชาวพุทธ ร้อยละ 56.7 เป็นแรงงานข้ามชาติผิดกฎหมาย และร้อยละ 78.3 ทำงานบริการมาเป็นเวลา 3 ปี โดยทั่วไปผู้ตอบแบบสอบถามมีความรู้ ทัศนคติและการปฏิบัติต่อการป้องกันเชไอวี/เอ็ดส์ในระดับปานกลาง เมื่อใช้การทดสอบ Mann-Whitney U การทดสอบ Kruskal-Wallis และสถิติสหสัมพันธ์ของ Spearman สำหรับการวิเคราะห์ความสัมพันธ์ระหว่างตัวแปรอิสระและตัวแปรตามผลการวิจัยพบว่ารายได้ ในเดือนที่ผ่านมา มีความสัมพันธ์ทางลบกับการปฏิบัติตนในการป้องกันเชไอวี/เอ็ดส์ ($r = -0.233$ และ $p = 0.010$) และปัจจัยอื่น ๆ ที่ส่งเสริมหรือมีอิทธิพลต่อผู้ตอบในการป้องกันโรคเชไอวี/เอ็ดส์ ซึ่งรวมถึงประเภทของธุรกิจบริการสถานที่และการสนับสนุนหรือแรงกดดันจากนายจ้างหรือเพื่อนร่วมงาน

ควรมีการศึกษาเบื้องต้นและการสำรวจเกี่ยวกับเชไอวี/เอ็ดส์เพื่อสนับสนุนบุคลากรสาธารณสุขในการวิเคราะห์แนวทางดำเนินงานกิจกรรมการป้องกันโรคเชไอวี/เอ็ดส์ นอกจากนี้การดำเนินโครงการป้องกันโรคเชไอวี/เอ็ดส์จำเป็นต้องพัฒนาเพื่อตอบสนองความต้องการและให้ความสำคัญกับประเด็นที่มีความละเอียดอ่อนด้านเพศภาวะและวัฒนธรรมของกลุ่มเป้าหมาย

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The study was carried out by using quantitative research method. The information of 120 Myanmar female sex workers (MFSW) from various prostitution businesses in different areas in Mae Sot district was collected during 20-31 October 2016 by face-to-face interview using structured questionnaires. This study aimed to describe the characteristics, to assess the level of knowledge, attitude and practices on HIV/AIDS prevention and to examine the association between these independent variables with the HIV/AIDS preventive practice of MFSW.

The data showed 52.5% of MFSW aged between 18 to 24 years old, 21.7% were from Karen State, 90% were Buddhist, 56.7% were illegal migrants, and 78.3% worked 3 years as FSW. In general, MFSW respondents had *moderate* level of overall knowledge, attitude and practice towards HIV/AIDS prevention. In addition, Mann-Whitney U test, Kruskal-Wallis test and Spearman's correlation Statistics were used for analysing the associations and correlations between independent and dependent variables. The findings revealed that earning last month of MFSW significantly associated with negative correlation ($r = - 0.233$ and $p = 0.010$). There were other factors facilitated or influenced the respondents in performing their HIV/AIDS preventive practice including type of prostitution business they belong to, location of the business and also the influence or pressure from their employers or work colleagues.

Initial baseline studies and survey on HIV/AIDS should be carried out for supporting public health workers in identify interventions. Also, HIV/AIDS programme intervention needs to concern more about gender and cultural sensitivity.

Field of Study: Public Health

Student's Signature

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LIST OF ABBREVIATIONS

ACHIEVED	Aligning Care and Comprehensive HIV-Prevention by Promoting Integrated Outreach and Networking with Government Decentralization to Achieve Coverage and Impact
AIDS	Acquired Immuno Deficiency Syndrome
ARRM	The AIDS Risk Reduction Model
ARS	Acute Retroviral Syndrome
ART	Antiretro Viral Therapy
CCU	Consistent Condom Use
CSOs	Civil Society Organisations
FHI	Family Health International
FSW	Female Sex Workers
HBM	The Health Belief Model
HIV	Human immunodeficiency virus
IBBS	Integrated Behavioural Biological Survey
ILO	International Labour Organization
IOM	International Organization for Migration
IRC	International Rescue Committee
KAP	Knowledge, attitudes and practices

MAP	Migration Assistance Programme
MFSW	Myanmar female sex workers
MOPH	Ministry of Public Health
MSM	Men having sex with men
MSW	Male sex workers
MTC	Mae Tao Clinic
MTCT	Mother-to-child-transmission
NAC	The National AIDS Centre of Thailand
NGOs	Non-Governmental Organisations
NV-FSW	Non-Venue-based Female Sex Workers
PLHIV	Persons Living with HIV
PPAT	Planned Parenthood Association of Thailand
PWID	People Who Inject Drugs
SD	Standard Deviation
SDG	Sustainable Development Goal
SEZ	Special Economic Zone
STD/STIs	Sexual Transmitted Disease/Sexual Transmitted Infections
STI	The Sexual Transmitted Infection
TB	Tuberculosis
TCC	Tak Chamber of Commerce

TG	Transgender
TRA	The Theory of Reasoned Action
UNAIDS	United Nations Programme on HIV/AIDS
VCT	Voluntary Counselling and Testing
V-FSW	Venue-based Female Sex Workers
WHO	World Health Organization
WWFT	World Vision Foundation of Thailand



CHAPTER I

INTRODUCTION

1.1 Background

The human immunodeficiency virus (HIV) is a retrovirus that infects cells of the immune system by destroying the white blood cells and damaging the function of human bodies. After such infection operated, the immune systems of human bodies become weaker and they become more vulnerable to HIV infections. Eventually, the final stage of HIV infection has developed which called acquired immunodeficiency syndrome (AIDS). People become HIV infected by having unprotected sexual intercourse, both anal and/or vaginal, contaminated blood transfusion, sharing of contaminated needles, and from mother to child during pregnancy, childbirth and breastfeeding (World Health Organization, 2014a).

Since the HIV/AIDS epidemic has begun in 1980s and spread to every corner of the world, globally around 78 million (71 million-87 million) people have become infected and died with HIV. There numbers are included 35 million (33.2 million-37.2 million) people are living with HIV worldwide and around 39 million people have died of AIDS related illnesses (The Joint United Nations Programme on HIV/AIDS, 2014). In 2013, Asia and the Pacific region had 4.8 million [4.1 million – 5.5 million] people living with HIV. It also estimated that 350, 000 [250 000 – 510 000] new HIV infections in the

region and 250,000 [210, 000 – 290,000] people died of AIDS related causes (The Joint United Nations Programme on HIV/AIDS, 2014). At the end of 2013, about 35 million people were living with HIV. That same year, some 2.1 million people became newly infected. With this respect, international communities have raised serious concern about the HIV/AIDS epidemic and the United Nations also set targets under the Sustainable Development Goal (SDG) Goal 3 for Ensure healthy lives and promote well-being at all ages. The SDG Goal 3 Targets stated that “by 2030, end the epidemics of AIDS, tuberculosis (TB), malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases” (United Nations, 2017). Apart from United Nations, other agencies such as Global Fund, International communities, government agencies, civil society organisations (CSOs) and other stakeholders also provide financial and technical supports in combating HIV/AIDS globally. However, numerous challenges are remaining due to different factors, particularly the decreasing of financial supports due to economy crisis globally. Globalisation, migration, socio-political and economic factors as well as continuation of risk behaviours are crucially factors in facilitating the HIV/AIDS epidemic and infection among people in every small part of the world.

1.1.1 HIV/AIDS Situation in Thailand

On 7 June 2016 Thailand was validated by the World Health Organisation (WHO) to be the first country in eliminating mother-to-child transmission (MTCT) of HIV and syphilis in Asia and Pacific region (The Joint United Nations Programme on HIV/AIDS, 2016) although the HIV/AIDS coverage in Thailand is still insufficient for reducing new infection among Thai and migrant population in Thailand, particularly migrant women.

The National AIDS Centre of Thailand (NAC), Ministry of Public Health (MOPH) of Thailand reported that in 2014, there were 445,504 persons living with HIV (PLHIV), 20,492 people passed away with AIDS related deaths and 7,816 people were new HIV infections. Moreover, among the total number of 445,504 PLHIV, 39% are females and 47% are children living with HIV (National AIDS Committee, 2015) and particularly 30% are female sex workers who never return for their HIV test result (National AIDS Committee, 2015). Also, the 2014 HIV/AIDS prevalence in Thailand was approximately 1.1% among Thai adult population, 12% among male sex workers and 2% among female sex workers, with the estimation of 141,769 sex workers in Thailand (National AIDS Committee, 2015). An estimated 7,816 new cases of HIV infection are reported in Thailand each year, and approximately 445,504 people are living with HIV and AIDS throughout the country (National AIDS Committee, 2015). HIV infection rate has not significantly declined especially among men having sex with men (MSM). The sexual

transmitted infection (STI) is also increasing among young population (National AIDS Committee, 2015).

In addition to Thailand's initiative in ending HIV/AIDS by 2030, the Thai government has committed itself and set the ten respective targets for 2012-2013. The Thai government has continued increasing its focus on HIV prevention among vulnerable populations both Thai and Myanmar migrants, including men who have sex with men (MSM), transgender (TG), male sex workers (MSW), female sex workers (FSW) and their clients. Thailand also has been collaborating greatly with international communities, UN agencies and the Global Fund. Numbers of strategies are being implemented nationwide for increasing access to sexual transmitted disease/sexual transmitted infections (STD/STIs) and HIV/AIDS. The service provision of HIV/AIDS prevention and treatment has improved, and protective behaviours keep practicing more regularly. As a result, Thailand successfully has reached the achievement of 2012-2013 targets. Nevertheless, the HIV/AIDS coverage is still insufficient for reducing new infection among Thai and migrant population in Thailand. HIV infection rate has not yet declined as intended, especially in among MSM, and the STI infection is also increasing among young population (National AIDS Committee, 2015).

1.1.2 HIV/AIDS Situation in Myanmar

The HIV/AIDS epidemic in Myanmar demonstrates that the prevalence in Myanmar declined from 0.94% in 2000, 0.6% in 2010 and estimated 0.47% in 2013 among general population aged 15 years and above (National AIDS Programme of Myanmar, 2014).

The 2011 and 2013 HIV/AIDS surveillance data demonstrated the fall of prevalence in the high risk groups, including People who inject drugs (PWID), MSM as well as FSW and their clients from 9.6% to 8.1% in FSWs, 21.9% to PWID, but the prevalence of MSM increased from 7.8% to 10.4% (National AIDS Programme of Myanmar, 2015).

Also, the 2015 HIV/AIDS surveillance highlighted that the HIV/AIDS prevalence of general population (15 years of age and above) slightly increased at 0.5%. Meanwhile, HIV/AIDS prevalence among sex workers had decreased at 6.3% (World Health Organization, 2014b).

1.1.3 HIV/AIDS Vulnerability and Thai-Myanmar Cross Border Migration

In addition to the rapid spread of HIV/AIDS, it is undeniable about the relationship between the HIV/AIDS epidemic and international migration. Some may consider that migrant workers and mobile populations crucially facilitate the blow out of HIV/AIDS epidemic both in the country of transit and the country of destination, and even in the country of origin when they repatriated. While, many studies demonstrated that migrants and mobile populations are even more vulnerable in HIV infection rather than the local population (International Organization for Migration, 2008, 2013).

For centuries, Thailand has been marked as a hub for almost 3 million migrant workers from the neighbouring countries, including Lao PDR, Cambodia and particularly Myanmar. Since Thailand shares the border with Myanmar for 2,837 Kilometres, Myanmar migrant population has become the largest migrant populations which are about 2,546,410 Myanmar migrant workers or 70% of the total migrant populations in Thailand (Archavanitkul, 2014).

In addition to the HIV/AIDS prevalence among migrant populations from Cambodia, Lao and Myanmar in Thailand, the 2012 Integrated Behavioural Biological Survey (IBBS) revealed that Myanmar migrants reached the highest of prevalence of HIV infection among the three nationalities, including Myanmar, Cambodia and Laos, corresponding prevalence was which was 1.0%, 0.9% and 0.8% (National AIDS Committee, 2014). Also, International Organization for Migration (IOM) stated that there are numerous Myanmar populations have been migrating to Thailand without having proper knowledge of HIV/AIDS (International Organization for Migration, 2008). Furthermore, the 2016 study of Musumari and Chamchan about HIV/AIDS testing experience among 2,000 Myanmar migrants in Thailand revealed that more than half did not know about HIV/AIDS or where to get HIV testing (Musumari & Chamchan, 2016). Even though most of Myanmar migrants mainly are working age and being healthy, they can also be crucially vulnerable to serious sickness, especially HIV/AIDS infection (United Nations Thematic Working Group on Migration in Thailand, 2014). Owing to their mobility, working

condition, lifestyle and the lack of life skill education and knowledge of HIV/AIDS, and lack of access to HIV/AIDS prevention and services, Myanmar migrants, in particular Myanmar female sex workers (MFSW) and their clients are highly vulnerable.

With this respect, it is very important to pay highest attention to Myanmar migrant population living along the Thai-Myanmar border since they may not have enough knowledge about HIV/AIDS prevention and health facilities and HIV/AIDS prevention and treatment interventions are still insufficient. Furthermore, massive influxes of migrants into Thailand also raised significant concerns about the potential increased risk of infectious diseases and increased demands on the health-care delivery system by the Thai government, especially along the border areas of the Thailand-Myanmar. Besides, Thailand is still struggling for expanding the coverage of HIV/AIDS prevention and treatment for the most vulnerable, marginalised and “hard to reach” populations, particularly Myanmar female sex workers (MFSW) and their clients both Thais and migrants who live and commute along the Thai-Myanmar border.

1.2 Rationale of the Study

Generally, Thai and Myanmar female sex workers (MFSW) have faced common vulnerability for HIV/AIDS infection by having multiple sexual relationships and not using condoms with their casual partners (husbands, boyfriends or lovers) consistently. Nevertheless, Thai female sex workers are not at risk in contacting with HIV/AIDS since

they regularly receive out-reach HIV/AIDS prevention and treatment services (i.e. HIV/AIDS education, condom distribution, blood checking, voluntary counselling and testing (VCT) and referral) by government and NGOs service providers. Meanwhile, MFSW in Mae Sot district are seriously at risk of HIV/AIDS infection and transmission since they have migrant status and they are also “hard-to-reach population”. Consequently, they hardly access and/or being accessed to HIV/AIDS prevention and treatment services by any service providers. Several factors facilitating such risky situation are including: language barrier, limitation of movement and mobility and fear of being arrest due to their illegal work and their illegal status in Thailand. Besides, some MFSW also live in Myanmar side but keep crossing Thai-Myanmar border for performing their prostitution works in Thai side occasionally, regularly or daily (Planned Parenthood Association of Thailand, 2015).

From the overall numbers of MFSW in Mae Sot district, some MFSW serve as venue-based female sex workers (V-FSW) in remote areas. While, unknown numbers of MFSW are also serving as non-venue-based female sex workers (NV-FSW) who work under mobile conditions. Due to such mobility, it is totally impossible for health service providers, particularly from the government sector (i.e. Mae Sot Hospital) to access all types of MFSW for providing HIV/AIDS prevention and services. Therefore, most of MFSW have been relying on service provisions from HIV/AIDS outreach activities of NGOs in Tak Province especially in Mae Sot and Poppra districts. However, currently

many NGOs face serious financial constraints in implementing their outreach programming for supporting MFSW since international aid decreased dramatically.

During the past few years, most of health interventions, especially HIV/AIDS, Tuberculosis (TB) and Malaria for both registered and unregistered migrant populations in 36 provinces in Thailand supported by the Global Fund (National AIDS Committee, 2015). This also included Planned Parenthood Association of Thailand's project on the Aligning Care and Comprehensive HIV-Prevention by Promoting Integrated Outreach and Networking with Government Decentralization to Achieve Coverage and Impact (ACHIEVED). This project had implemented during 2011-2014 which was one of the most significant programmes that focusing on MFSW in Mae Sot district, Tak Province. However, after rapid political change in Myanmar in 2013, financial support from the Global Fund and other donors on HIV/AIDS, STI/STD prevention and treatment for Thai-Myanmar border population, particularly Mae Sot district, Tak province already decreased and ended dramatically. Many programme and projects on HIV/AIDS prevention already closed down due to the lack of funding support (Planned Parenthood Association of Thailand, 2015; The Diplomat, 2013). Besides, health service providers both government and CSOs are facing even serious burden in expanding the coverage of STI/STDs and HIV/AIDS prevention and services in Tak province, particularly for both venue-based and non-venue based MFSW and their clients in Mae Sot district. On the contrary, new waves of Myanmar migrant, especially MFSW and their potential

clients keep crossing border and commuting for responding the rapid economic growth with large demand and supply for sex industry which resulting from successful establishment of the special economic zone in Mae Sot district.

As a result, serious concern about HIV/AIDS infection and transmission among Myanmar migrants in Mae Sot district, Tak province has been raised up due to the fact that many programmes on HIV/AIDS prevention already closed down and scaled down their operations. Meanwhile, new waves of migrants and FSWs from Myanmar keep arriving in this newly special economic zone without having knowledge and life skill on HIV/AIDS prevention. With this respect, there is a great need of assessment of knowledge, attitudes and practice towards HIV/AIDS prevention and sexual behaviour among MFSW. This is because there is no recent study on this issue for health service providers and other stakeholders to tailor their HIV/AIDS prevention programmes as well as other interventions effectively (Guadamuz et al., 2010; Htoo, 2008; Htun, 2008; International Organization for Migration, 2010; Press, 2005).

1.3 Benefits of the Study

This study will highly benefit for Myanmar female sex workers in increasing perception about the important of safe sex and HIV/AIDS prevention. Also, this research will be useful for health service providers from both government and CSOs in implementing their HIV/AIDS interventions more effectively. Moreover, this study will be benefited

for the implementation of the Master Plans on Border Health and particularly the Master Plan on Mobility of HIV and the National AIDS Strategy of the MOPH and other interventions on HIV/AIDS prevention and treatment of government and non-governmental organisations (NGOs) in Thailand and Myanmar for covering all groups of border populations, including MFSW in Mae Sot district, Tak province.

1.4 Objectives of the Study

1.4.1 General Objectives

The general objective of the study is to assess level of knowledge, attitude and practice on HIV/AIDS prevention and also to examine the association between HIV/AIDS preventive sexual practice among MFSW in Mae Sot district, Tak Province towards related factors.

1.4.2 Specific Objectives

- 1) To describe the socio-demographic characteristics of MFSW, sex work characteristics, sexual partner characteristics, availability of HIV prevention information and condom usage, influence from peers, employers, clients and regular partners, drug and alcohol use and preventive sexual practices with their sexual partners.
- 2) To describe and to assess the level of knowledge, attitude, practices on HIV/AIDS prevention among MFSW.

- 3) To examine the association between HIV/AIDS preventive sexual practice with their sexual partners towards related factors.

1.5 Research Questions

- 1) What are socio-demographic and sex works characteristics of MFSW in Mae Sot district, Tak Province and their availability and accessibility of HIV/AIDS information and service, their influence/pressure for performing preventive sexual practice?
- 2) What are the level of knowledge, attitude, practices on HIV/AIDS prevention among MFSW in Mae Sot district, Tak Province?
- 3) Are there any association between HIV/AIDS preventive sexual practice among MFSW in Mae Sot district, Tak Province and MFSW characteristics?

1.6 VARIABLES OF THE STUDY

1.6.1 Independent variables

- 1) Socio-demographic characteristics, i.e. age, race/ethnicity, religion, education, Thai language ability, marital status, migration status and length of stay in Thailand and number of year working as FSW
- 2) Sex work characteristics, i.e. type of sex works, no. of client per day, earning per prostitution service and earning (last month)
- 3) Sexual partner characteristics, including clients characteristic and regular partner characteristic
- 4) Availability and accessibility of HIV information and service
- 5) Influence from peers, employers, clients and regular partners
- 6) Knowledge and attitude towards HIV/AIDS prevention

1.6.2 Dependent variables

- 1) Preventive sexual practice toward HIV/AIDS with male clients and casual partners (negotiation of condom uses at sex and using condom at sex)

1.7 Conceptual Framework

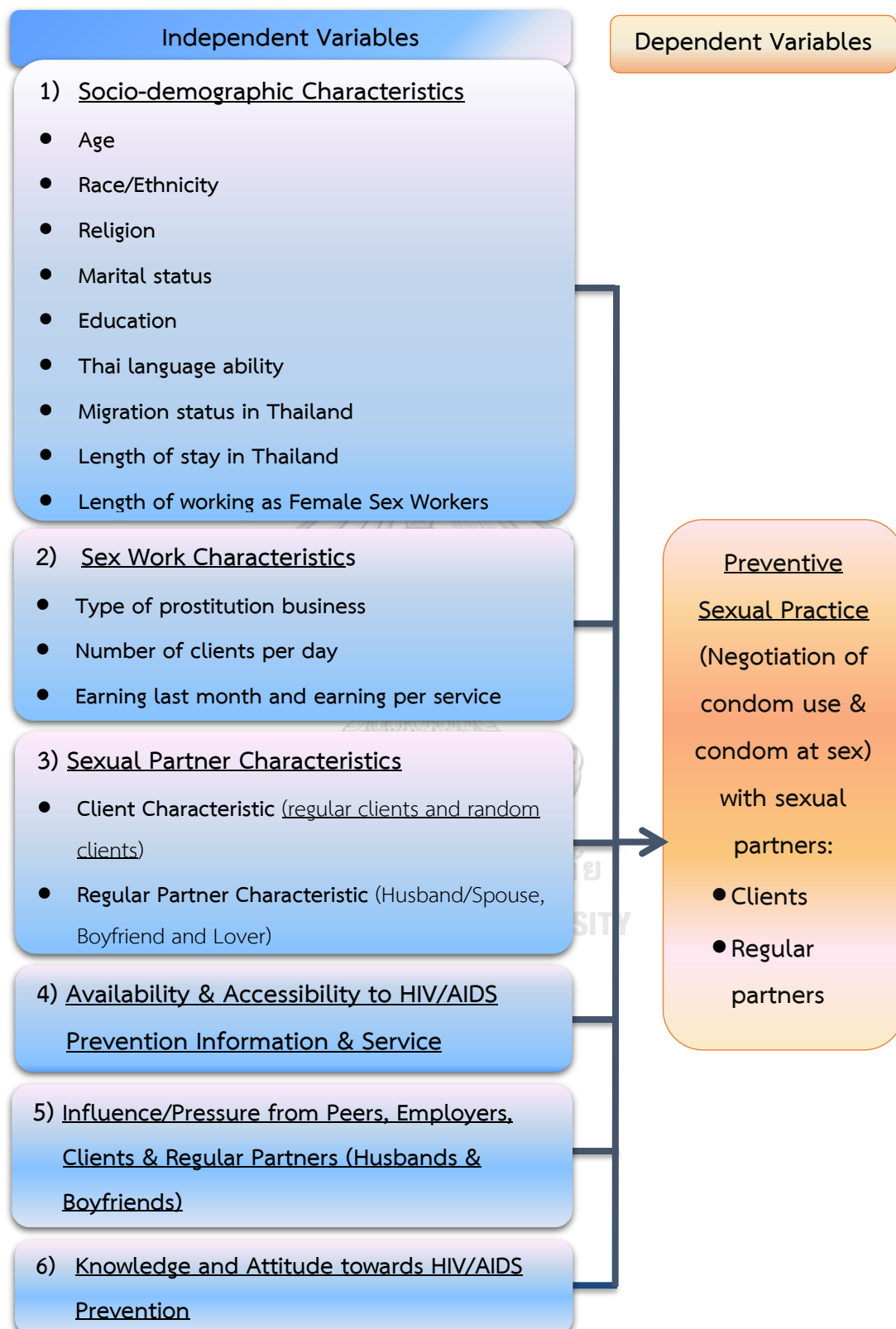


Figure 1: Conceptual Framework

1.8 Operational Definitions

- 1.8.1 **Myanmar female sex workers (MFSW)** refer to Myanmar migrant women who provided sexual services for their livings. In this study, it only focuses on Myanmar female sex workers (MFSW), aged 18 years and above who are venue-based female sex workers (V-FSW) in Mae Sot district, Tak Province.
- 1.8.2 **Sex Workers** refer to a contractual arrangement where the term of engagement of sexual service provisions having been agreed upon for the provisions of sexual services for money or good between the seller and the buyer.
- 1.8.3 **Sexual activities** mean activities associated with sexual intercourse
- 1.8.4 **Sexual services** or Prostitution services are the performance of any sexual acts and sexual activities by using any part of the body or an object for another person for payment, including oral sex, nude massage, sexual intercourse and masturbation by using hand jobs and body slides.
- 1.8.5 **Socio-demographic characteristics** refer to the socio-demographic characteristic of MFSW in Mae Sot district, Tak province which including age, race/ethnicity, religion, marital status, education, Thai language ability, income, migration status and Length of stay in Thailand and years of working as female sex workers.
- 1.8.6 **Sexual partner characteristics** are characteristics of persons who have sexual relationship with MFSW, including regular partner characteristics (husband/spouse, boyfriends/lovers) and client characteristics, including regular

clients (whom visited repeatedly) that paying per prostitution service and long term payment and random clients whom visited occasionally).

- 1.8.7 **Sex work characteristics** refer to type of prostitution business (type of sex works), location of workplace, number of clients of MFSW (per day) and payment of prostitution services.
- 1.8.8 **Location of workplace** refers to geographical locations or the areas where prostitution business situated and MFSW are employed for carrying out their works, i.e. Zone 1: Central area of Mae Sot district, Zone 2: Outskirt area of Mae Sot district, Zone 3: North of Mae Sot district, Zone 4: South of Mae Sot district and Zone 5: West of Mae Sot district.
- 1.8.9 **Type of prostitution business** refers to type of entertainment and hospitality business that also provided prostitution services, including massage shops, prostitution houses, karaoke shops and café.
- 1.8.10 **Venue-Based Sex Workers (V-FSW)** refer to MFSW who provide sexual services for their living in the permanent places where prostitution business operated like brothels, Thai traditional massage parlour, café and karaoke bars in Mae Sot district, Tak province. These also include MFSW who stay in the houses where prostitution business operated and managed by agents and sexual services provide outside the house such as hotels, resorts or any places where the clients requested.

- 1.8.11 **HIV/AIDS Service Provisions** refer to the provision of HIV/AIDS, including HIV/AIDS awareness rising activities, trainings on HIV/AIDS prevention and condom usage, condoms and lubricants distributions, Voluntary Counselling and Testing (VCT) (HIV blood checking) service and referral.
- 1.8.12 **Health Service Providers** refer to health workers, health volunteers from local government organization (Mae Sot Hospital), Mae Tao Clinic and staffs of IOM and non-governmental organisations (NGOs) both local and international NGOs operating their works in Mae Sot district, Tak province. International and local NGOs are included Planned Parenthood Association of Thailand (PPAT), Migration Assistance Programme (MAP) Foundation, World Vision Foundation of Thailand (WVFT), International Rescue Committee (IRC), and Mae Tao Clinic (MTC)
- 1.8.13 **Peers** refer to friends, co-workers or colleagues who work in the same workplace of MFSW.
- 1.8.14 **Employers** refer to persons who employ MFSW who also owned and operated different kinds of prostitution related business such as owners of brothel or prostitution house, owners of massage shop, barbers and karaoke bars, owners of café as well as pub and restaurants.
- 1.8.15 **Sexual partners** are anyone who has sexual relationship with MFSW, including regular partners (husband, spouse, boyfriend and lover) and clients
- 1.8.16 **HIV/AIDS preventive behaviour** is a behaviour of a person who *intends or plans* to prevent HIV infection.

- 1.8.17 **Knowledge of HIV/AIDS** refers to ability of respondents to answer questions about the basic HIV/AIDS facts, i.e. causes, symptoms, signs, diagnosis, infections, transmissions and practice of prevention measures and available treatment.
- 1.8.18 **Attitude of HIV/AIDS** refers to respondents' feeling, belief, value towards HIV/AIDS and awareness of HIV/AIDS prevention, i.e safe sex and condom use.
- 1.8.19 **Practice of HIV/AIDS prevention** means *regular actions in performing HIV/AIDS prevention*, i.e. using condoms every time at sex with sexual partners and avoiding using substance abuse, particular injecting drugs and having sexual relationship with injecting drug users
- 1.8.20 **Risks of Contacting with HIV/AIDS** are the risk factors facilitating MFSW in contacting, infecting and transmitting HIV/AIDS. These are included:
- having multiple sexual partners and boyfriends or lovers;
 - drinking alcohol and taking drugs;
 - does not use condoms every time at sex with their sexual partners (clients, regular partners or others).
- 1.8.21 **Preventive sexual practices** refer to *behaviour of MFSW in negotiating and using condoms every time* when they have sexual intercourses with their regular partners and their clients.

CHAPTER II

LITERATURE REVIEW

2.1 HIV/AIDS Symptoms, Infections and Transmissions

According to World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), it was estimated that in 2014 almost 36.9 million people all over the world were HIV infected. Meanwhile 2 million people became newly HIV infected and 1.2 million also passed away with AIDS related causes. Since the human immunodeficiency virus (HIV) infects cells of the immune system, all functions in human bodies also destroyed and impaired and the immune system became deficient and could not fight against infection and disease. Infection associated with severe immunodeficiency also called “opportunistic infections” due to the fact that such infection takes advantage in attacking weakened immune system of HIV infected persons. Then, the most advanced stages of HIV infection become AIDS or Acquired immunodeficiency syndrome which defined by the occurrence of numerous opportunistic infections or HIV-related cancers (World Health Organization, 2014a).

2.2 Knowledge, Attitude and Practices (KAP) of HIV/AIDS Prevention

From the past until now, overall stakeholders, including international communities, government agencies, NGOs, private sectors and community members have been working and identifying several approaches to increase knowledge, attitudes and practices (KAP) of HIV/AIDS prevention globally. In many developing and low-income countries, numerous interventions and tailored programmes already developed for promoting protective sexual behaviours and encouraging sexual risk reduction, including HIV/AIDS awareness training, promoting of condom use and contraception. Nevertheless, more than 50% of people living in the 15 countries with the highest HIV prevalence cannot answer basic questions on HIV and its transmission. Besides, there is a significant difference between the proportion of individuals who used condom during the last sexual intercourse and the number of sexual partners accessed to HIV/AIDS information worldwide (Nylander, 2012).



In Asia and Pacific, HIV infection rates have fallen during the past decade, there are growing epidemics in some geographical areas and within key populations at higher risk, including sex workers, PWID and MSM in many countries. Existing interventions on the preventive knowledge and awareness of HIV/AIDS are still insufficient due to the light of the fact that these key populations at higher risk have not yet known about their HIV status (The Joint United Nations Programme on HIV/AIDS, 2013a). With this

respect, KAP of HIV/AIDS prevention among vulnerable population and high-risk group like migrant female sex workers and their clients are crucially important.

2.2.1 Knowledge, Attitude and Practices (KAP) of HIV/AIDS Prevention among Myanmar Migrant Workers in Thailand

Several studies reported that Myanmar migrant population migrated to Thailand with very little knowledge of HIV/AIDS and sexual health. Later, their knowledge of HIV/AIDS had been improved at moderate level since they could access more information on HIV/AIDS through mass media and health service providers both from government agencies and NGOs during the period that they were working in Thailand (Htoo, 2008; Htun, 2008; International Organization for Migration, 2010; Nylander, 2012) About 83.9% of respondents in Ranong Province knew that use of condom could prevent HIV/AIDS infection and transmission (Htoo, 2008) while only 42.6% of respondents in Kao San Road, Bangkok had moderate knowledge level of HIV/AIDS prevention (Htun, 2008). According to IOM's studies in 2006, the risk of HIV/AIDS infection could be increased by misconceptions and ignorance about this issue among Myanmar migrants. Furthermore, Htoo's study highlighted unsafe sex behaviour among Myanmar fishermen in Ranong Province since 90% of them had more than one sexual partners and 60-80% of them paid for sex and had sex with sex workers.

Even though Myanmar migrants had moderate level of HIV/AIDS, they are still being at risk of HIV/AIDS infection and transmission due to inconsistent use of condom. More

than 78% of male respondents in Kaosan Road, BKK stated that they had no experience in using condom with their spouses while 72.3% of female respondents also did not use condom with their spouses since they trusted each other. For having sex with boyfriends/girlfriends, 42.8% did not use condom during their sexual intercourse since they trusted each other. Surprisingly, only 14.3% of respondents reported that using condoms could reduce the chance of HIV infection and transmission (Htoo, 2008). In addition to IOM's study in 2008, about 22% of married Myanmar women and 26% of single Myanmar women reported having never heard about condoms, and Myanmar women are more likely to have less knowledge than men (International Organization for Migration, 2008). On the contrary, the finding of Nylander study of Myanmar migrant workers in Samut Sakhorn Province in 2012 demonstrated that overall respondents had better knowledge than men. Less than 50% of male migrants reported they had ever received information on HIV. Also, between male and female Myanmar migrant workers had different knowledge, attitudes and practice of HIV prevention (Nylander, 2012).

2.2.2 Knowledge, Attitude and Practices of HIV/AIDS Prevention among Sex Workers

Several HIV KAP studies among FSWs in Nepal, Ukraine and India, revealed that FSWs highly reported that they had heard about HIV/AIDS and condom (AIDS Alliance, 2013; Hemalatha, Kumar, Venkaiah, Srinivasan, & Brahmam, 2011; Singh, Lall, Gupta, K.Bose, & Singh, 2014). In Nepal, 84.9% of them were educated and about 98.9% of respondents had heard about HIV, and 100.0 % of them had heard about AIDS and they had heard or seen condoms as well as used condom. Also, 89% of them had known that they can protect from HIV by using condom (Singh et al., 2014). On the contrary, the findings on the practice of sexual risk behaviour among FSWs in Nepal, Ukraine and India demonstrated high risk of HIV infection and transmission. In Nepal, the frequency of condom use was unsatisfactory, and alcohol use as well as negligence to use condom during sexual activity was high. Although most of FSWs in Nepal, which was 98.6%, reported that they had insisted their clients to use condoms but many times they did not use condom due to their client's objection. Also, 75% of them reported that partner's objection is the most common reason for not using condom (Singh et al., 2014). In Ukraine, 46% of FSWs stated that they refused to engage in unprotected sex under any situation or even they received more payment, while 73% of clients reported that they offered to pay extra for not using condoms during sexual intercourse (AIDS Alliance, 2013). In India, 91% of FSWs used condom in last sex and

84.7% with occasional and regular clients but consistent condom use (CCU) was slightly lesser with regular clients compared to occasional clients. Also 28.7% of the FSWs could not use condom as intended. Furthermore, all of them raised significant concern about being at risk of HIV and STDs/STI infection and transmission. In Ukraine, 92% of FSWs reported that they were at risk of STI and 88% of HIV infection (AIDS Alliance, 2013). Over 50% of them perceived their high risk to HIV/AIDS infection due to their sexual risk behaviour (Hemalatha et al., 2011).

In addition to these findings, HIV/AIDS prevention programmes needed to focus on increasing of knowledge and awareness of preventive behaviour and practices on STI/STDs and HIV/AIDS prevention, including the consistent condom use. Besides, it needed to change attitude of male clients that using condom was a sign of caring of health since they had crucial role of HIV transmission to their wives or other sexual partners. Moreover, IOM's study in 2010 revealed that numerous MFSW had never heard about HIV/AIDS and STD/STI issues, particularly symptoms and transmission or how to do prevention when they lived in Myanmar (International Organization for Migration, 2010). The National AIDS Centre (NAC) also reported that it needs to pay significant attention to young populations (those under age 25 years) and particularly "mobile" FSW or "non-venue-based FSWs" on STD/STIs and HIV/AIDS prevention and treatment since they have lower level of knowledge of HIV/AIDS (National AIDS Committee, 2014).

2.2.3 General Socio-Demographics Characteristics of Myanmar Migrants in Thailand

Owing to the fact that most of Myanmar migrant workers set their final goal in accumulating enough capital to eventually return to their home country, they demonstrate enormous efforts in having employment opportunity with better quality of lives. For female sex workers (MFSW) in Thailand, they also set the same final goal just like others with the aim to collect significant amount of income for their futures and family members. Besides, many studies demonstrated socio-demographical factors influencing numerous women and girls from Lao PDR, Myanmar, Vietnam and Cambodia in joining prostitution business and being at risk of HIV/AIDS infection (Mekong Migration Network & Asian Migrant Centre, 2007; Sunthornthada, 2011; Tran et al., 2014). Sunthornthada mentioned about significant reasons why Laotian women joining sex industry in Thailand, they are included: 1) economic reason as they wanted to earn good income; 2) low education background, 3) no options or alternatives for their own livelihood; 4) want to learn more about commercial sex work and 5) being trafficked, deceived or forced to join prostitution work (Sunthornthada, 2011). IOM's study on mobility and HIV vulnerability among Myanmar sex workers in Mae Sot district in 2007 also stated that most of MFSW had financial burdens caused by their family's difficulties such as debt bondage, sickness and death of family members, no breadwinner and low payment from their employment in Myanmar; and several of them

had been married and divorced. Therefore, they had to provide financial and other supports for their dependents (parents, children, siblings, husbands and even extended family members living with them in Thailand or residing in Myanmar (International Organization for Migration, 2007).

Length of Stay in Mae Sot district

MFSW usually worked in Mae Sot district for an initial four to eight months or depend on the situation that allowed them to work and to save their capital. Then, such saving or capital would be used for investing in a business or other financial burden in Myanmar. After paying all the debts to brothel owners and karaoke boss, they returned to Myanmar via Myawaddy district. Later, they started up their small business such as teashop or providing financial support to farming of their families inside their hometowns. Many of MFSW in Mae Sot district had repatriated in Myanmar for 1 year or more and they did not have much intention for returning to Thailand. Crucially, most of them wanted to stop working as MFSW so they were actively building their savings for the future (International Organization for Migration, 2007). According to PPAT, MFSW who work as venue-based sex workers (VSW) like Karaoke lounge, café' and massage shops in Mae Sot sub district also express similar idea about their plans in the future (Planned Parenthood Association of Thailand, 2015).

2.3 Socio-Political, Economic and Cultural Factors facilitating HIV/AIDS Epidemic and HIV/AIDS Infection in Mae Sot district

The Joint United Nations Programme on HIV/AIDS (*UNAIDS*)'s Policy Brief on HIV and International Labour Migration (The Joint United Nations Programme on HIV/AIDS, 2008) also reaffirm that there are different socio-political, cultural and economic factors in both origin and destination countries that influencing the risk of HIV infection of international labour migrants. Such significant factors are included loneliness due to separation from spouses, families and unfamiliar social and cultural norms, language difficulties and barriers, poor quality of life and living conditions, and exploitative working conditions, including sexual violence. Consequently, the resulting from isolation and stress persuaded migrant workers to engage with risk behaviours, such as unsafe casual or commercial sex, which potentially increase the risk of exposure to HIV (The Joint United Nations Programme on HIV/AIDS, 2008). Over centuries, Thailand has been struggling in intensifying the coverage of STI/STDs and HIV/AIDS prevention and service for Myanmar migrants who work irregularly and illegally under mobile conditions in the significant border areas of Thailand. Major communicable disease, including Malaria, Tuberculosis, diarrheal diseases, emerging infections and re-emerging disease, STI and particularly HIV/AIDS are highly reported long the border areas of Thailand.

The development and expansion of international transportation routes as well as active dynamic border commuting have also increased the risk of contacts and the spread of disease along the Thai-Myanmar borders. With this respect, the Thai Ministry of Health already addressed communicable disease as border health concerned according to the first and the second Border Health Development Master Plan of Thailand (2007-2011 and 2012-2016). The massive influxes of Myanmar migrants migrating into Thailand raised significant concerns about the potential increased risk of communicable diseases and increased demands on the health-care delivery system, particularly the Thailand-Myanmar border. Mae Sot district is one of the most critical Thai-Myanmar border city where the Thai government has been combating with illegal trading, smuggling and trafficking of human and drugs, labour exploitation and the epidemic of communicable diseases such as TB, Malaria and particularly HIV/AIDS (International Organization for Migration & World Health Organization, 2009).



2.3.1 Push Factors Facilitating Myanmar Women and Girls in joining Sex Trade

For decades, Mae Sot district is notable as the first gate and the most significant border crossing channels where Myanmar migrants continue trading, migrating and even fleeing from socio-political and economic reasons by having Mei River as a natural border between Mae Sot district, Tak province, Thailand and Myawaddy district, Kayin state, Myanmar. Myanmar population have suffered from the result of socio-political isolation and economic stagnation from international communities for over 50 years

as Myanmar is one of the lowest income countries in Asia (CIA Factbook Myanmar, 2015). Although the rapid socio-political and economic change and opening market for international investors demonstrate potential shining future of economic growth and development inside Myanmar, deepening poverty among Myanmar population is still existing. Such economic factor has been pushing numbers of Myanmar women in joining sex trade both in Thailand and Myanmar for supporting all the needs of their families. The figure in 2013 from the Myanmar government and the United Nations estimated that 0.45% or 40,000-80,000 of Myanmar women aged between 15-19 years was engaged with commercial sex work in Myanmar (Htet, 2015).

Beyond economic factor, cultural patterns like “good daughter” who sacrificed herself to be the only one who take the overall financial burden for supporting all family members have been playing similar drama patterns in pushing women and girls in the GMS for joining sex trade. Then, they become at risk of HIV/AIDS infection and transmission (Mekong Migration Network & Asian Migrant Centre, 2007; Sunthornthada, 2011; Tran et al., 2014). For Cambodian culture, Cambodian women and girls who become female sex workers (FSW) can be condemned as “ignorant girls” who deceived into prostitution. On the contrary, those who have to join prostitution work for clearing financial burdens and have better lives of their parents and other family members will be praised as “sacrificing daughter” (Derks, 2008). Also, Myanmar women and girls culture carry the same cultural drama pattern in sacrificing their lives to

become MFSW in order to earn large amount of money for supporting their family members (International Organization for Migration, 2007).

2.3.2 Pull Factor Facilitating Large Demand for Flesh Trade in Mae Sot district

Apart from push factor facilitating large supplies of MFSW in the sex industry, there is a significant pull factor as Mae Sot is also a newly special economic zone (SEZ) where accommodate large number of Thai and foreign investors, businessmen and others who always need sexual entertainment. As a consequence, these new visitors even expend rapid economic growth in this border city with highly demand for Myanmar female sex workers to fill up flesh trade in the sex industry (Planned Parenthood Association of Thailand, 2015). According to the Tak Chamber of Commerce (TCC), during the last three years, about 20 news hotels are being pop up for accommodating business visitors. Besides, Big C and Lotus supermarkets, fancy cinemas and department stores also demonstrate the sign of prospect economic growth in Mae Sot district (Burmese Migrant Workers' Education Committee, 2013).

In addition to Mae Sot-Myawaddy twin city project, this is a part of Thailand's preparation for the ASEAN Single window system. Such development plan aims to facilitate trade, investment, logistics and commuting among the 10 ASEAN member countries. According to the Governor of the Industrial Estate Authority of Thailand, a successful establishment of the special economic zone in Mae Sot will particularly

increase border trade as the area is a part of the Asian's East-West Corridor that connects Myanmar with Laos and Vietnam (Burmese Migrant Workers' Education Committee, 2013; Hong Kong Trade Development Council, 2015; National News Bureau of Thailand, 2013). Such prospect glory of the rapid economic booming and extensive development plan in Mae Sot district, Tak province have been attracting a rising number of Myanmar women who want to earn significant amount of incomes by joining sex industry as MFSW in Thailand and even in the other countries.



Figure 2: Mapping of East-West Economic Corridor for Thailand, Myanmar, Laos and Vietnam

Source: Hong Kong Trade Development Council (Hong Kong Trade Development Council, 2015)

In addition, Thailand's national minimum labour wage increased at 300 Baht a day is the crucial pulling factor attracting large number of Myanmar migrant populations to leave poverty inside Myanmar and to search for sun raise in the Thai territories.

Currently, it has been estimated that about 200,000-300,000 Myanmar migrants are residing and working in over 350 workplaces in Mae Sot district. These are included 60,000-80,000 Myanmar migrants working for different business sectors, including garment factories as well as entertainment and hospitality sectors which inter related with sex industry. Among these numbers 70% could be Myanmar female migrants (Kanchanadiut, Biel, Pollock, & Press, 2014).

Even though, numbers of Myanmar migrants in Mae Sot district are extremely high, not many of them are registered migrant workers since the Thai employers hardly register them under the Migrant Worker Registration Scheme of the Ministry of Labour of Thailand. Therefore, they are extremely vulnerable for labour exploitation, particularly those who work in farms, small factories and sweatshops. Mae Sot district is being richer, but labour exploitation and employment situation of Myanmar migrants in this area have not yet getting better. Due to labour exploitation and lack of decent employment opportunity, numbers of Myanmar female migrants have been persuaded in joining prostitution business whether full time or part-time jobs as direct and/or indirect sex workers for earning significant amount of income to serve their family members (MAP Foundation, 2013). In addition, the rapid growth of business, socio-economic prosperity, investment and employment opportunities in Mas Sot district as a Special Economic Zone (SEZ) also pave the way for the expansion of numerous entertainment businesses, tourisms and particularly industry in the area. Large

numbers of red lights business such as massages parlours, karaoke lounge, pubs and restaurants as well as night life and red-light businesses also pop up for entertaining different male clients. This is a significant pull factor persuading women and girls from Myanmar to join sex industry and prostitution business in filling the clients' demands and the growth of sex industry. Women and girls from Myanmar are considered as "exotic, beautiful and decent price product" for local customers and foreigners. Moreover, many clients also have high demand of young women and girls from Myanmar; particularly the virgins as they are still young and innocents, more attractive and clean than young Thai women. Also, male clients also assume that young women and girls from Myanmar have a very low risk of HIV/AIDS and STI/STDs infection.

With this respect, it cannot deny that socio-political, economic and cultural factors that pushing and pulling cross border migration also facilitated HIV/AIDS epidemic and HIV/AIDS infection both in Thailand and Myanmar since both MFSW and their clients do not decent knowledge and awareness of STI/STDs and HIV/AIDS prevention. Besides, cross border migration and mobility of MFSW and their clients who regularly crossing and commuting along the borders as well as different places both inside Thailand and Myanmar also highly facilitated the HIV/AIDS vulnerability and blow out of HIV/AIDS epidemic and infection.

2.4 Sex Industry and Myanmar female sex workers (MFSW) in Mae Sot district

According to PPAT's mapping survey of female sex workers (FSW) under ACHIEVE project (Mapping Round 4) in Mae Sot district in 2013, about 830 FSW were identified, including 225 Thai FSW and 605 Myanmar FSW (MFSW) working in different prostitution business. However, the actual numbers of MFSW in Mae Sot district usually more than the estimated figures as they work. Most of Myanmar women who join prostitution business voluntarily were mainly forced by poverty and economic reason (Oo, 2013). They generously earn very low payment both in Thailand and inside Myanmar, so they have insufficient income for feeding their family members. Some of them were involuntary as they were lure or trafficked for joining sex trade however they accepted their fates, they keep working and saving money, and waiting for the time to leave this ungrateful profession.

In general, Myanmar female sex workers (MFSW) in Mae Sot district are included: 1) those who already live and work in Mae Sot district as migrant workers, 2) those who live in Myawaddy with families and regularly crossing border to carry out their prostitution works in Mae Sot district, and 3) those who directly imported from different States and Townships inside Myanmar for sending to brothels and other prostitution places in Mae Sot district, and many cases highly involved with human trafficking for sexual exploitation (Planned Parenthood Association of Thailand, 2015).

For “direct sex workers” are MFSW who provide prostitution services in brothels or prostitution houses and also those who openly demonstrate about their commercial sex work in red light and prostitution areas. While “indirect sex workers” are those MFSW who work as workers in the entertainment and service places like karaoke bars, massage parlours, lounges, pub and restaurants, drink shops and barbers. Apart from normal service, they also provide prostitution services if their clients need. Besides, MFSW who provide their prostitution services secretly or indirectly as full time or part time jobs through agents, pimps or work independently are also called “indirect sex workers” or so called “called girls or side-line girls”. Also, among these MFSW are migrant workers who carry out full time working in factories, farms or other work places such as waitress, shop keeper and farm workers, but performing prostitution works as their “part-time” or “side-line” jobs for extra pocket money for fill the needs of their families (Planned Parenthood Association of Thailand, 2015).



This study divides MFSW into three different groups based on the Mapping Survey of sex workers in Mae Sot district under PPAT’s ACHIEVED Project which implemented during 2011-2014 (Mapping Round 3, 2013). This Mapping Survey had developed for identifying intervention strategies and strategic intervention areas for operating HIV/AIDS prevention programme activities. MFSW in this mapping survey are included 1) “venue-based female sex workers” (V-FSW), 2) “non-venue-based female sex

workers” (NV-FSW) as well as 3) “social network sex workers”. Among these three groups, MFSW who are direct sex workers or indirect sex workers are also included.

2.4.1 Venue-Based Female Sex Workers (V-FSW) in Mae Sot district, Tak province

For MFSW who openly provide prostitution services are so called “direct sex workers” and they mainly are “venue-based female sex workers” (V-FSW) who work in permanent prostitution places, including traditional massage parlours, karaoke lounges, brothels, prostitution houses as well as pub and restaurants in red light areas in Mae Sot district. These permanent prostitution places normally operated in different timing due to the following types of their prostitution business:

- Café, pub and restaurants with singers and dancers operate from 20.00 p.m.– 02.00 a.m.
- Karaoke lounges operate from 19.00 p.m. to 01.00 a.m.
- Brothels or prostitution houses operate from 19.00 p.m. – 02.00 a.m.
- Traditional massage parlours operate from 10.00 p.m. – 23.00 p.m.

According to PPAT’s mapping survey of sex industry in 2013 (Mapping Round 4), there were about 333 Myanmar female sex workers (MFSW) working as venue-based sex workers in 24 prostitution places. These prostitution places have been operating openly and invisibly in different sub districts in Mae Sot district, Tak Province.

Table 1: Venue-based female sex workers (V-FSW) in Mae Sot district

No.	Nationality	Age range of Venue-based female sex workers (V-FSW)					Total No.
		< 18 Yrs	18-25 Yrs	26-35 Yrs	35-36 Yrs	>45 Yrs	
1.	Thai FSW	0	64	39	2	0	105
2.	Myanmar FSW	0	275	53	5	0	333
Total Numbers of Venue-based female sex workers (V-FSW)							438

Source: (Planned Parenthood Association of Thailand, 2014)

Nevertheless, the recent survey of PPAT in June 2016 revealed that the number of venue-based MFSW in Mae Sot district had been decreasing due to active prostitution suppression policy of the recent government. Different prostitution places have to stop or to close down their prostitution business or to operate invisibly. Also, numbers of venue-based MFSW have become non-venue-based MFSW or social network FSW. Therefore, there are only about 150 venue-based MFSW who could be found in different visible prostitution places in Mae Sot district (Planned Parenthood Association of Thailand, 2016).

2.4.2 Non Venue-based Female Sex Workers (NV-FSW)

Non Venue-based Female Sex Workers (NV-FSW) are included Myanmar female sex workers (MFSW) who perform their sexual services under mobile situations or non-permanent places where their clients requested. According to PPAT's Mapping Survey

(Mapping 4) carried out in 2014, there were 65 MFSW aged between 18-45 years old generally performing their works as NV-FSW in significant prostitution areas in Mae Sot district. Moreover, they usually gather together between 20.30-23.00 p.m. Also, their clients generally purchase their prostitution services extensively during the weekend and holidays (Planned Parenthood Association of Thailand, 2014).

Table 2: Non-Venue-based female sex workers (NV-FSW) in Mae Sot district

No.	Nationality	Age range of NV-FSW					Total No.
		< 18 Yrs	18-25Yrs	26-36 Yrs	35-36 Yrs	>45 Yrs	
1.	Thai Sex Workers	2	15	12	0	0	29
2.	Myanmar Female Sex Workers	0	65	0	0	0	65
Total Numbers of NV-FSW in Mae Sot district							94

Source: Mapping Round 4 (Planned Parenthood Association of Thailand, 2013)

2.4.3 Social network sex workers

Social network sex workers are Myanmar female sex workers who carry out their prostitution business via different social networks such as prostitution agents, pimps, friends, colleagues, and even relatives. Also, social networks also include social media such as Facebook, websites, LINE and other chat programme where they could coordinate on their prostitution business directly with the clients. However, for MFSW

in Mae Sot district usually carried out their commercial sex works via prostitution agents in order to avoid security problems from being arrested by the Thai police. According to PPAT's mapping survey in 2013, there were about 207 MFSW who join social networks via 20 prostitution agents both Thai and Burmese who served as middlemen coordinating between MFSW and clients on prostitution business (Planned Parenthood Association of Thailand, 2014).

Table 3: Social Network Sex Workers in Mae Sot district

No.	Nationality	Age range of Venue-based female sex workers (VSW)					Total No.
		< 18 Yrs	18-25Yrs	26-37 Yrs	35-36 Yrs	>45 Yrs	
1.	Thai Sex Workers	12	75	4			91
2.	Myanmar Female Sex Workers	6	143	56	2	0	207
Total Numbers of Social Networks Sex Workers in Mae Sot district							298

Source: Mapping Round 4 (Planned Parenthood Association of Thailand, 2013)

2.5 Mobility and HIV/AIDS Vulnerability of HIV/AIDS Infection and Transmitted

2.5.1 Mobility of MFSW in Mae Sot district

For MFSW who are venue-based female sex workers (VSW), generally, they hardly commute around Mae Sot district due to security reason and language difficulty. They

are afraid of being arrested by the Thai police as prostitution business is illegal according to the Thai law. Moreover, several of MFSW do not have work permit for working as indirect sex workers in entertainment business and service industry in Mae Sot district. Therefore, all brothels owners or those who operate prostitution business generally pay monthly “protection fee” to local authorities or local mafias so they can be free from being arrested or they will be initially inform about the upcoming arrest by the Thai police officers (Planned Parenthood Association of Thailand, 2015). Due to illegal status and illegal profession, most of Myanmar female sex workers in Mae Sot district have limitation of their movement and visibility. Then, health service providers both Mae Sot hospital and NGOs also face difficulties in implementing HIV/AIDS prevention and treatment interventions for MFSW, particularly those indirect sex workers who are also NV-FSW and social network sex workers. Consequently, they hardly access to information and services on HIV/AIDS prevention as well as other health services which facilitated more risks of HIV/AIDS infection and transmission among these groups, clients and their regular partners.

2.5.2 HIV/AIDS Vulnerability

Generally, MFSW and their clients are the most vulnerable population for HIV/AIDS infection. Due to their profession, illegal status, mobility, invisibility and language boundary, they have numerous HIV/AIDS vulnerabilities. MFSW, particularly non venue-based female sex workers (NV-FSW) and social network sex workers face

difficulties in accessing basic health care service as well as HIV/AIDS prevention and treatment services. Besides, local health service providers also face difficulties in reaching them out.

In regard to HIV/AIDS vulnerability, MFSW in Mae Sot district have shared the same circumstances however and different types of MFSW might have different level of vulnerability depended on their working environment and situation. In general, sex workers all over the world are often stigmatised, marginalised and criminalised by their societies in different ways. Then, such factors contribute greatly to their vulnerability of HIV/AIDS infection and transmission as well as physically and sexual abuse (United Nations Population Fund & United Nations Development Programme, 2015). MFSW in Mae Sot district also encounter similar security and vulnerability problems. Many of them do not have strong power to negotiate with their clients about condom usage, types of sexual services, payment, movement and even their own security (International Organization for Migration, 2008; Planned Parenthood Association of Thailand, 2015).

2.5.3 Safe Sex Behaviour and Condom Use

In addition to condom usage, there are unpredictable situations pushing them to be HIV/AIDS infected, including inconsistency and incorrectly condom usage, unavailable of condoms, denial of condom usage by clients, breaking of condoms during sexual

intercourse as well as unprotected sexual intercourse with their clients and particularly their casual partners/regular partners or even clients who become their sweethearts (AVERT, 2015; United Nations Development Programme, 2011). According to PPAT, socio-demographic of different type of clients of MFSW such as ethnicity, education background and career demonstrate different and similarity of unsafe sexual behaviours, particularly denial of condom use. For clients who are Thai with ethnic background, especially Thai male-Hmong farmers who lived in rural areas or remote farming areas do not have much knowledge about HIV/AIDS and always refuse to use condoms. While Thai male clients generally know about HIV/AIDS however they always refuse to use condom when they already get drunk or when they have a chance in having sexual intercourse with virgin girls (Planned Parenthood Association of Thailand, 2015). Besides, some studies demonstrated that many truck drivers who usually buy services from female sex workers (FSWs) always think that they have less chance in getting HIV infection (Moon, 2002).

Even though the availability and promotion of condom use in Thailand is slightly high, only of proportion of Myanmar migrants and MFSW understand about the correct condom use and safe sexual practice. According to IOM study in 2008, it stated that “only 21.9 percent of male and 17.5 percent of female migrant populations in the survey believe that condom use can prevent HIV infection”. Also, condom use with regular partners among married Myanmar migrants was rare due to trust relationship

and sometime female migrants cannot negotiate with their partners to use condom (International Organization for Migration, 2010). Most of married Myanmar migrants, including MFSW generally perceived that condom use is only for sexual intercourse with someone who are not their regular partners or husbands like clients and female sex workers (International Organization for Migration, 2008). Furthermore, a baseline survey of PHAMIT project revealed that “nearly 75 percent of respondent’s primary distaste for the use of condoms was the reduction of pleasure during intercourse” (International Organization for Migration, 2008).

According to the 2010 UNAIDS Global Report, it revealed that “only a third of the 86 countries surveyed reported 90 percent of sex workers using a condom with their last client, while more than half reported condom use by 78 percent of sex workers” (The Joint United Nations Programme on HIV/AIDS, 2013b). It was reported in the other countries that sometimes sex workers have no access to condoms and they are simply powerless to negotiate safer sex. “Clients may refuse to pay for sex if they have to use a condom” (AVERT, 2015). Furthermore, young Myanmar woman and girls expressed their tragedy experiences that they had entre into sex trade as their parents, guardians, brokers or traffickers firstly sold their virginity and those clients refused to use condoms during the sexual intercourse (International Organization for Migration, 2007; Planned Parenthood Association of Thailand, 2015).

For venue-based female sex workers (V-FSW) in Mae Sot district, they are generally aware of condom use as safe sexual practice and HIV/AIDS prevention when they provide sexual services with their clients since they are regularly approached by health service providers from Mae Sot Hospital and NGOs. Furthermore, owners of brothels, karaoke bars or drink shops play crucial roles in facilitating HIV/AIDS prevention, including distributing and monitoring condom usage of FMSW with their clients as they have to ensure credibility and reputation of their business. However, some MFSW usually do not use condom with their husband, regular partners or regular customers whom have treated as their sweetheart. In addition to this, MFSW are still extremely vulnerable for HIV/AIDS infection and transmission as they or their regular partners may have more than one partner or sweetheart (Planned Parenthood Association of Thailand, 2015). On the other hand, some MFSW in Mae Sot district, particularly social network sex workers and NV-FSW who work under “out of reach” conditions due to their invisibility and mobile conditions, they hardly access to free condoms distributed as well as other HIV/AIDS prevention and treatment services by Mae Sot Hospital and NGOs (Planned Parenthood Association of Thailand, 2015).

2.5.4 Malpractice of Law Enforcers Facilitated HIV/AIDS Vulnerability of MFSW

Owing to the fact that prostitution or commercial sex work is illegal in many countries, most of police officers usually perform malpractice by using possession of condoms as ground for arresting, harassing and exploiting sex workers such as asking for bribes

or trading of free sexual services with paying bribe (Open Society Foundation, 2014). From global legal perspective, condoms do not accept as evidence at court level however polices perform such practices only for the arrest of sex workers whom hardly pursuit their cases at court level (IRIN Asia, 2010). In Thailand, Thai police officers also apply similar malpractice by using “condom” as significant evidence for arresting and accusing sex workers in violating the 1949 Suppression of Prostitution Act of Thailand (Planned Parenthood Association of Thailand, 2015). In Myanmar, police officers also applied similar mal practice. According to Kay Thi Win, *Programme Manager of the Targeted Outreach Programme initiative in Myanmar* stated that *“To avoid arrest that can involve violence, rape and other trauma, many sex workers try to avoid things that may identify them as sex workers like carrying condoms or visiting health clinics for check-ups.”* (AVERT, 2015). For MFSW in Mae Sot district, in particular NV-FSW and social network sex workers, they are also protecting themselves by not keeping a lot of condoms with them as the police officers can notified them as “sex workers” who are subjected to be arrested (Planned Parenthood Association of Thailand, 2015). At this point, the fear of arrest by Thai police officers is the fundamental barriers in elimination of HIV/AIDS infection and transmission. Avoiding possession of condoms while engaging prostitution works in red light areas and limiting their movements for accessing HIV/AIDS service in venue based health service providers are common practices of MFSW in Mae Sot district, especially those who do not hold work permit in venue based prostitution places, like karaoke

bars, café and massage shops (Planned Parenthood Association of Thailand, 2015). Resulting from the overall HIV/AIDS vulnerabilities faced FMSW, their clients, husbands and regular partners as well as children also face HIV/AIDS infection and later died with HIV/AIDS (Planned Parenthood Association of Thailand, 2015).

2.6 HIV/AIDS Prevention and Treatment Interventions in Thailand

The Thai-Myanmar border, particularly Mae Sot district is one of the most significant concern areas for controlling and monitoring communicable disease, including HIV/AIDS, TB and Malaria by the Thai government and international communities. Over centuries, different organisations, including Mae Sot Hospital (MSH), Mae Tao Clinic (MTC), World Vision Foundation of Thailand (WVFT), Migration Assistance Program (MAP), International Rescue Committee (IRC), International Organization for Migration (IOM) and Planned Parenthood Association of Thailand (PPAT) have been operating public health intervention programming, in particular HIV/AIDS prevention and treatment services for border populations, especially migrants and displaced persons from Myanmar. In general, public health intervention programming that operated globally, including Thailand are based on theories and models of behavioural change for identifying how to change their negative behaviours and what are the reason why people changing their behaviours. Several theories related to HIV/AIDS prevention already cited and utilised by different organisations for implementing HIV/AIDS interventions are as follows.

2.6.1 Theories and Models related to HIV/AIDS Interventions

Family Health International (FHI) and the United Nations Programme on HIV/AIDS (UNAIDS) have identified four significant theories and models, included: 1) the Health Belief Model, 2) the AIDS Risk Reduction Model, 3) the Stages of Change Model, 4) the Theory of Reasoned Action (TRA) (Family Health International, 2002; The Joint United Nations Programme on HIV/AIDS, 1999).

1) The Health Belief Model (HBM)

The Health Belief Model (HBM) is a psychological model attempting to explain and to predict health behaviours of individuals by focusing on his/her belief and attitudes. This model was developed in the 1950s for explaining the lack of public participation in health screening and prevention programme. Later, this model has been adopted for discovering short-long term health behaviours such as HIV/AIDS transmission and sexual risk behaviours (Family Health International, 2002). According to HBM model, someone must hold the following beliefs for enable their behaviour changing:

- **Perceived susceptibility** to a specific health problem, e.g. asking question whether “am I at risk for HIV?”
- **Perceived seriousness** of the condition, e.g. “if I got HIV/AIDS, how difficult of my life would be?”
- **Belief in effectiveness** of the new behaviour, e.g., “condom is an effective method for HIV prevention”.

- **Cues to action**, having seen people living or dying with HIV/AIDS.
- **Perceived benefits of preventive action**, e.g. “if I start using condoms, I prevent HIV infection and transmission”.
- **Barrier to taking action**, such as “I don’t like using condom at all” (The Joint United Nations Programme on HIV/AIDS, 1999).
- **Other variables**, such as diverse demographic, socio-psychological and structural variables that affect someone’s perceptions as well as indirect influence health-related behaviour (Family Health International, 2002).
- **Self –Efficacy**, it is the belief in being able to successfully execute the behaviour required to produce the desire outcomes (Family Health International, 2002).

In addition, the HBM model also has some limitation since it is a psychological model that does not take consideration of other factors like economic and environmental factors influencing social norms and peer influences, particularly for working with adolescents on HIV/AIDS issues (Family Health International, 2002).

2) The AIDS Risk Reduction Model (ARRM)

The ARRM was introduced in 1990. It is a three stage models combining different variables from other behaviour change theories such as the Health Belief Model, “efficacy” theory, emotional influences, and interpersonal processes, as well as the hypothesized factors used for explaining and predicting individuals’ effort in changing

their behaviour in regard to HIV/AIDS sexual transmission. This model contains three stages, including:

- *Stage 1:* Recognition and labelling of one's behaviour as high risk;
- *Stage 2:* Making a commitment to reduce high-risk sexual contacts and to increase low risk activities;
- *Stage 3:* Taking action which contained three phases, including information seeking, obtaining remedies and enacting solutions. Each phase may occur alongside of each phases or phases may be skipped.

The authors of the ARRM also identified other internal and external factors motivating someone to change their behaviour across the stage (Family Health International, 2002). Nevertheless, this model has limitation as it only focuses on the individuals, not their sexual partners. According to an ARRM study of several women in Kampala, Uganda, it revealed that these women felt that they were at risk of HIV due to the behaviour of their sexual partners, not due to their own behaviour. This model may take strong consideration of the sociocultural issues that influence and it would be limited choices and ability of individual to take action in changing their behaviour (Family Health International, 2002).

3) The Stages of Change Model

The Stage of Change Model was developed by psychologists. FHI stated that this model was developed in 1982 (Family Health International, 2002) however UNAIDS

mentioned that it developed in the 1990s. It is a model to tailor therapy to someone's needs at his/her significant stage in the process of behaviour changing. The model contains stages and process on the behaviour changing of individuals or groups for comparing smokers in therapy and self-changers alongside with their continuing behaviour changing. These stages are included:

- Precontemplation: Individual has the problem and do not have any intention of changing his/her behaviour (whether he/she recognizes it or not).
- Contemplation: Individual realise the problem and he/she is seriously considering about changing his/her behaviour.
- Preparation for Action: Individual realise the problem and he/she intends to change his/her behaviour within a month.
- Action: Individual set his/her own rule about their consistent behavioural changing for less than six months such as using condom consistently.
- Maintenance: Individual maintains his/her new behaviour for six months or more (Family Health International, 2002).

Nevertheless, this model has some limitation since it focuses on the individual without assessing the environmental factors affected his/her ability in behavioural changing. Also, the stage of change model presents a descriptive rather than a causative explanation of behaviour, so it may not be the right model in applying with all types of populations (Family Health International, 2002).

4) The Theory of Reasoned Action (TRA)

The TRA was developed in the mid-1960 by Fishbein and Ajzen which aims to explain and to predict several human behaviours. This theory is based on the assumptions that human beings are usually quite rational and make systematic use of the information available to them, and the behaviour lays under their decision makings (Family Health International, 2002; The Joint United Nations Programme on HIV/AIDS, 1999). It provides a structure that link with individual belief, behaviour, attitudes and intentions (Family Health International, 2002). The concept of this theory is similar to the health belief model but adds the construct of personal behavioural intention as a determinant of health behaviour. A person's intention consists of the two basic determinants, including (1) attitude (toward the behaviour), and (2) 'subjective norms', i.e. social influence. In this theory, 'normative' beliefs play a crucial role in focusing on what an individual believes other people, especially influential people, would expect him/her to do. For example, someone who starts to use condoms, his/her attitude might be "having sex with condoms is just as good as having sex without condoms" and subjective norms or the normative belief could be "most of my peers are using condoms, they would expect me to do so as well". Several behaviour changing interventions using this theory to guide activities focus on attitudes about risk-reduction, response to social norms, and intentions for changing risky behaviours (The Joint United Nations Programme on HIV/AIDS, 1999). In order to measure the

accuracy and effectiveness of the TRA, the intention should be defined by using the same components in defining the behaviour (Family Health International, 2002).

Fishbein also provides an example on the implementation of sexual HIV risk reduction strategy (action) by using condoms with sex workers (target group) in brothels (context every time (time)). The intention in performing behaviour is a crucial predictor identifying individual desire behaviour (Family Health International, 2002). While, Kippax and Crawford highlighted some limitation of the TRA due to its individualistic approach in considering the environmental factor and structural issues as well as the linearity of the theory components. Someone may first change their behaviour and then their beliefs/attitudes about it (Family Health International, 2002). Another example from the studies in US about the impact of seatbelt laws, it revealed that since people become accustomed to the new behaviour, they often changed their negative attitudes about the use of seatbelts (The Joint United Nations Programme on HIV/AIDS, 1999). In addition to the four given theories and models, none of them are well-suited with this study. Although the Theory of Reasoned Action (TRA) has some similar objective with this study in aiming to explain and to predict several human behaviours, the major different is the construct of personal behavioural intention” as a determinant of health behaviour. While, this study does not focus on “personal behavioural intention” but more about “actions” or “practices” of MFSW on HIV/AIDS prevention that they already done in the past, (i.e. during the last 3 months).

CHAPATER III

RESEARCH METHODOLOGY

3.1 Research Design

This research is a cross sectional, descriptive and analytical study, regarding knowledge, attitude and practice of HIV/AIDS prevention among Myanmar female sex workers in Mae Sot district, Tak Province, Thailand. Quantitative research method was used for data collection. For describing and analysing the relationship between socio-demographic and behavioural factors with practices toward HIV/AIDS prevention, Mann-Whitney U Test, Kruskal-Wallis Test and Spearman's correlation were considered as appropriated measure for analysing the association between the level of HIV/AIDS prevention and socio-demographic characteristics, sex work characteristics and sexual partner characteristics (regular partners and client characteristics), availability and accessibility to HIV/AIDS information and service, influencing factors/pressure towards HIV/AIDS prevention as the data did not normally distributed.

3.2 Study Area

The study was carried out in the selected sub districts in Mae Sot district, Tak Province, Thailand. This area was considered one of the most critical areas of the government of Thailand and Myanmar since it was the most crucial border city between Thailand and Myanmar where at risk of communicable diseases among Thai-Myanmar border

populations such as TB, malaria and particularly the HIV/AIDS. Besides, Mae Sot district was a strategic area for sex industry with large demand and supply of prostitution business, especially MFSW.



Figure 3: Map of Mae Sot district, Tak Province

(Source: <http://maesotsojourm.blogspot.com>)

3.3 Study Population

Study populations were MFSW, aged 18 years and above who were venue-based MFSW in Mae Sot district, Tak Province, Thailand. The recent survey of PPAT in June 2016 estimated that there were about 150 venue-based MFSW who carried out their works in different visible prostitution places in Mae Sot district (Planned Parenthood Association of Thailand, 2016).

Research Criteria

3.3.1 Inclusion Criteria

- Myanmar female sex workers (MFSW), aged 18 years and above who performed sexual services to their clients directly/indirectly in permanent prostitution places (venue based prostitution places) in Mae Sot district, Tak Province.

3.3.2 Exclusion Criteria

- MFSW who were engaging with clients or personal issues are not available for answering the question
- MFSW who got sick

3.4 Sample Size Calculation

Taro Yamane formula was used for calculating the sample size (Yamane, 1973).

$$n = \frac{N}{1 + N(e)^2}$$

N = the population size

e = Sampling error, the value of 5%

n = the estimated sample size

$$n = \frac{150}{1 + 150(0.05)^2} = 109$$

With this respect, calculation of sample size of MFSW in Mae Sot district demonstrated as following:

N = the population size is 150 venue-based MFSW in Mae Sot district

e = Sampling error, the value of 5% will be selected

n = the estimated sample size is 109

With estimated of 10% of incomplete data ($152 \times 10\%$), 120 respondents were required for the study. Therefore, approximately 120 respondents of venue-based MFSW who were currently working in the permanent places where prostitution business operated (venue-based prostitution places) in Mae Sot district were interviewed in this survey.

3.5 Sampling Techniques

Since the target population of this study was MFSW in Mae Sot district, Tak Province. They were “hard to reach population” as prostitution business was considered illegally and some of them work without obtaining work permits and proper travel documents according to the Thai laws (The Immigration Act of Thailand, 1979 and the Prevention and Suppression of Prostitution Act of Thailand, 1996). Therefore, they had to operate their prostitution works invisibly in the undisclosed areas of Mae Sot district. They mainly worked in brothels, massage parlours/shops, pub and restaurants, café, bars, karaoke bars. Besides, MFSW usually carried out their prostitution work during night time and rest during day time in their own places. Moreover, some MFSW did not have residences in Mae Sot, they kept commuting from Myawaddy-Mae Sot-Myawaddy

for operating their prostitution works daily or regularly. They crossed border to Mae Sot district, Thailand in the morning and they headed back to Myawaddy Township, Myanmar when they earned sufficient income, or someone called them to return. Besides, currently the Thai government was strictly enforced the law against illegal migrants and sex workers. Therefore, numerous MFSW and those who worked in these prostitution business, particularly those venue base sex workers decided to perform their work invisibly or secretly.

A cross-sectional study was carried out among MFSW who worked in permanent prostitution places (venue base prostitution places) in different sub districts (Tambon) in Mae Sot district, Tak Province. Non-probably sampling method with purposive and convenient sampling techniques were used for collecting data. This method commonly used for KAP surveys of sex workers where the target population of this study was difficult to reach and or located (Gumucio et al., 2011).

- In addition to the first stage, purposive sampling technique was used for selecting sub districts (Tambon) in Mae Sot district (Amphor), Tak Province where venue-based prostitution places highly operated.
- For the second stage, venue-based prostitution places in the selected sub districts (Tambon) were selected by convenient sampling technique.

- At the final stage, Myanmar female sex workers (MFSW) in the selected venue-based prostitution places who meet the eligible criteria and available for participation were selected by convenient sampling technique.

3.6 Measurement Tools and Measurement Methods

The structured questionnaire (Appendix A) were used as a measurement tool for assessing knowledge, attitude as well as practice of preventive behaviour toward HIV/AIDS among Myanmar female sex workers in Mae Sot district, Tak Province, Thailand. This structured questionnaire was based on a modification of a set of an existing questionnaire in English and they were translated into Thai and Myanmar languages for structure questionnaire with face to face interview by researcher and research assistants with local language skills. The questionnaire survey tool had developed from the 2011 HIV KAP Survey Model of Médecins du Monde (Doctors of the World), previous research questionnaires (Bubpa, 2004; Charoenchokpanit, 2012; Family Health International, 2000; Hemalatha et al., 2011; Htoo, 2008; Htun, 2008; Mureed, 2008; Nylander, 2012; Singh et al., 2014) and recommendations from thesis advisor and expert committees of this study. This structured questionnaire survey contained 63 questions (No.1-63) which divided into 7 parts, they were as follows:

Part I: Socio Demographic Characteristics

There were 14 questions (No.1-14) in this part asking about general information and characteristic data of commercial sex work, including age, ethnicity, religion, marital status, number of children, years of working as female sex workers, education level, Thai language ability, income, saving, homeland, migration status, length of stay in Thailand and Myanmar.

Part II: Clients Characteristics

This part had 3 questions (No.15-17) asking about characteristics of sexual partners (regular partner (s) and clients of MFSW).

Part III. Availability of HIV/AIDS Information & Services

This part had 7 questions (No.18-24) asking whether they knew about HIV/AIDS, how they accessed to HIV/AIDS information and services as well as condom distribution, and also asked about significant obstacles in accessing health services.

Part IV: Knowledge of HIV/AIDS

In this part contains 15 questions in total (No.25-39) with True/False/Don't know answer. It had divided into three following sub-parts:

- 4.1) General Knowledge of HIV/AIDS: This sub-part had 4 questions (No.25-28), including 1 negative and 3 positive statements which aimed at asking about general HIV/AIDS knowledge of MFSW respondents.

- 4.2) HIV/AIDS Symptoms: This sub-part had 5 questions (No.29-33), including 5 positive statements which aimed at asking about knowledge of HIV/AIDS symptoms among MFSW respondents.
- 4.3) HIV/AIDS Transmissions: This sub-part had 6 questions (No.36-39), including 1 positive and 5 negative statements which aimed at asking to about knowledge of HIV/AIDS transmission among MFSW respondents.

From all 15 given statements included both negative and positive statements. With positive statements, the score for correct answer (True) was 1 and the score for incorrect answer (False) and don't know answer (don't know) are 0. On the contrary, with negative statements, the score for correct answer (False) was 1 and the score for incorrect answer (True) and don't know answer (don't know) were 0.

Table 4: Scoring for negative and positive statements of Knowledge

Positive Statement		Negative Statement	
Choice	Score	Choice	Score
True	1	True	0
False	0	False	1

From all 15 statements in this part, the score varies from 0-15. The MFSW respondents' knowledge was classified into 3 levels according to Bloom's cut-off point (Bloom, 1975) as follows:

Table 5: Table demonstrates the Cut-Off Point of the Bloom's Theory on Knowledge Level

Level	Cut-Off Point	Percentage
● Poor knowledge	0- 8.9 points	● < 60%
● Moderate knowledge	9.0- 11.9 points	● 60-80%
● Good knowledge	12.0- 15.0 points	● > 80%

Part V: Attitude towards HIV/AIDS Prevention

This part contained 10 questions/statements in total, including 5 positive and 5 negative statements with *Strongly Agree/Agree /Not Sure/Disagree/ Strongly Disagree* answers. The MFSW respondents were asked to rate their level of agreements on the statement in the Five-score Likert's scale.

Table 6: Scores of the Likert's scale for negative and positive statements of Attitude

Positive Statement		Negative Statement	
Choice	Score	Choice	Score
Strongly Agree	5	Strongly Agree	1
Agree	4	Agree	2
Not Sure	3	Not Sure	3
Disagree	2	Disagree	4
Strongly Disagree	1	Strongly Disagree	5

The score from all answers in this part summed up to a total score and calculate for mean for classifying the level of attitude, and the total score ranged from 10 to 50. After that, the MFSW respondents' attitudes were classified into 3 levels by using means \pm standard deviation, they were as follows:

- the score less than mean – standard deviation (SD) referred to poor attitude;
- the score within mean – standard deviation (SD) and mean + standard deviation referred to moderate attitude;
- the score more than mean + standard deviation referred to good attitude

Table 7: The classification of level of attitudes

Level of Attitude	Range of Score
Poor attitude	< 31.2
Moderate attitude	31.2 to 42.1
Good attitude	> 42.1

*Mean = 36.68, Standard Deviation = 5.450, Median = 37, Min = 22 and Max = 49

Part VI: Influence or Pressure from Peers, Employers, Clients and Regular Partners and Obstacles towards HIV/AIDS Prevention

This part contained 4 questions (No. 50-53), including 2 negatives and 2 positive questions asking MFSW to answer questions about influence or pressure from peers, employers, clients and regular partners and obstacles towards HIV/AIDS prevention.

For respondents who answered in any form of influencing or pressuring by employers,

work colleagues, regular partners and clients in supporting them or not supporting them to use condom at sex, it could be implied that MFSW already got influenced or pressured in performing HIV/AIDS prevention.

Part VII: Preventive sexual practice with male clients/regular partners (negotiation on condom using and condom used at sex)

This part had 10 questions (No. 54-63) of correct and incorrect behaviour with rating *always/often/sometimes/never* answers. This set of questions aimed to assess MFSW about their sexual practices towards HIV/AIDS prevention.

Table 8: Scores of the Likert's Scale for Correct and Incorrect Practice

Correct Practice (Positive)		Incorrect Practice (Negative)	
Choice	Score	Choice	Score
Always	3	Always	0
Often	2	Often	1
Sometimes	1	Sometimes	2
Never	0	Never	3

The score of this part ranged from 0-30. The MFSW respondents' sexual practice classified into 3 levels by using means \pm standard deviation, they were as followed:

- the score less than mean – standard deviation (SD) referred to poor practice;
- the score within mean – standard deviation (SD) and mean + standard deviation referred to moderate practice;
- the score more than mean + standard deviation referred to good practice

Table 9: The Classification of Level of Practice

Level of Practice	Range of Score
Poor practice	< 14.5
Moderate practice	24.7 to 19.60 + 24.7
Good practice	> 24.7

*Mean = 19.60, Standard Deviation = 5.083, Median = 20.00, Min = 9 and Max = 29

3.7 Validity and Reliability

3.7.1 Validity Test

Construct Validity was used for verifying whether the conceptual framework met the behavioural theory and methodology for conducting the research on knowledge, attitude and practice toward HIV/AIDS among MFSW.

Content Validity was used in this study. The content of the questionnaire was verified by consulting expert committees. Their comments and feedbacks also incorporated in consultation with the thesis advisor and the index of item-objective congruence (IOC) results was 0.67-1.00.

3.7.2 Reliability Test

After completing the validation process, a pre-test of questionnaires carried out for testing the reliability on the pilot study by interviewing of 30 MFSW respondents in the

selected permanent prostitution places in Mae Sot district, Tak Province. With this respect, the selected 30 MFSW respondents for testing the reliability of this study were different group of MFSW respondents for the data collection process. For reliability test of knowledge, Kuder-Richardson 20 (KR20) was used and the score was 0.81. For attitude and behaviours parts, Cronbach's alpha co-efficient was analysed separately and the score for attitude part was 0.761 while preventive practice part was 0.725. The Cronbach's alpha co-efficient was 0.70.

3.8 Data Collection

Data collection process carried out after obtaining ethical approval from the Ethics Review Committee for Research Involving Human Research Subjects, Health Science Group, Chulalongkorn University. Data collection carried out in both day time and night time in residences and/or workplaces of MFSW depending on their available periods. MFSW respondents were required answering face to face interview questionnaires survey.

Research tool: Questionnaire survey and information sheet originally developed in English and translated into Thai by researcher and translated into Burmese by a professional English-Burmese translator who worked in Mae Sot on sexual reproductive health programme. Also, back to back translation of Burmese questionnaire survey was conducted by Burmese research assistant.

Research team: Team members of this study consisted of 5 members, including: 1 researcher, 4 research assistants with native Thai, Karen and Burmese language skills. All of them had strong experience working with MFSW in Mae Sot district on HIV/AIDS prevention projects. Some of them used to work for PPAT's ACHIEVED Project which already finished its funding in 2014.

Research operation: At the beginning, the researcher carried out a training workshop for building good understanding among research team members, about research objectives, rationales, questionnaire tools and the length of time for conducting face to face interview (which took about 30-40 minutes per person). Moreover, operational plan, ethical and sensitive concerns, roles and responsibilities and division of labour also discussed prior rolling out the survey. Data collection rolled out in October 2016 and convenience sampling technique was used. This was because the team members could approach only prostitution places that employers allowed them to conduct face to face interview with their MFSW who were available and willing to participate in this study.

3.9 Data Entry, Statistical Technique and Data Analysis

3.9.1 Data Entry

The licensed SPSS software for window version 16 was used for data analysis.

3.9.2 Statistical Technique

- Descriptive statistics were used for summarizing and describing the socio-demographic characteristics, knowledge, attitude and behaviour data by percentage, frequencies, mean and standard deviation calculation.

3.9.3 Data Analysis

- Kolmogorov-Smirnov Test of normality was used to test data distribution of practice scores. Mann-Whitney U Test, Kruskal-Wallis Test and Spearman's correlation were considered as appropriated measure for analysing the association between the score of HIV/AIDS preventive practice and socio-demographic characteristics, sex work characteristics and sexual partner characteristics (regular partners and client characteristics), availability and accessibility to HIV/AIDS information and service, influencing factors/pressure towards HIV/AIDS prevention as the statistical data did not normally distributed, and the significant level was P value < 0.05 .
- Associations between the score of HIV/AIDS preventive practice and socio-demographic characteristics (age, number of children, number of years working as sex workers and length of stay in Thailand) and sex work characteristic (number of

clients per day, earning per client and earning last month) and the knowledge and attitude score were analysed by Spearman Correlation.

- Association between the score of HIV/AIDS preventive practice and the rest variables of socio-demographic characteristics, sex work characteristics, sexual partner characteristics, availability and accessibility to HIV information & service and influencing factors and pressure from peers, employers, clients and regular partners which were categorised scales were analysed by Mann Whitney U-Test and Kruskal-Wallis Test.

3.10 Ethical consideration

Ethical approval of this study obtained from the Ethics Review Committee for Research Involving Human Research Subjects, Health Sciences Group, Chulalongkorn University on 21 October 2016 (COA No.180/2559). Prior the interview, information about the survey was provided to all MFSW respondents. Also, they were informed about the objectives, methods and benefits of the study and they were free to abstain or withdraw any time. Coding system was used and their names, the names of their workplaces and location also did not mention in this study. Crucially, the respondents' privacy and confidentiality were strictly maintained with respect.

3.11 Limitation of the study

This study had numbers of limitation due to the nature of convenient sampling technique that could not provide accurate representation on the situation of MFSW in Mae Sot district. Since MFSW in this study was lived and worked in illegally and their workplaces situated in inaccessible and/or invisible areas and they also had unusual working hours, the researcher and research team members could access those undisclosed workplaces. Besides, there was a serious limitation during the data collection period. Many entertainment businesses, including venue-based prostitution places had to close temporarily or operated invisibly due to the mourning period following the death of the King Rama Nine of Thailand on 13 October 2016. Therefore, convenient sampling technique was considered the most appropriate sampling technique for this study under the indicated condition. Furthermore, some MFSW felt uncomfortable to provide truthful answers for questions asking about their personal matter like sexual partners and sexual practices on HIV/AIDS prevention. Also, team members had faced difficulties during the period of face to face interview as translation of questionnaire survey did not provided proper back-to back translation. As a result, some questions contained answers demonstrated contradictions or required clarification.

CHAPTER IV

RESULTS

This cross-sectional study aimed to examine knowledge, attitude and preventive practices towards HIV/AIDS prevention among MFSW in Mae Sot district, Tak Province.

This study carried out by using quantitative research method. The information of 120 MFSW from various prostitution businesses in different areas in Mae Sot district was collected by structured questionnaires during 21-31 October 2016. This chapter presented the findings from the data collection and data analysis which divided into two main sections: (1) The descriptive information and (2) The analytical information.

4.1 The Descriptive Information

4.1.1 Socio-Demographic Characteristics

This part described the background characteristics of MFSW respondents. The Table 10 showed the overall socio-demographic characteristics of 120 MFSW respondents, including age, race/ethnicity, religion, marital status, number of children, educational level, Thai language ability, hometown and migration status.

Table 10: Socio-demographic characteristic of Myanmar female sex workers (n = 120)

Socio-demographic characteristics	Number	Percentage (%)
Age		
18-24 years	63	52.5
25-34 years	46	38.3
35-41 years	11	9.2
Ethnicity		
Burmese (Burman)	81	67.5
Karen	26	21.7
Mon	12	10.0
Indian-Muslim	1	0.8
Religion		
Buddhist	108	90.0
Muslim	7	5.8
Christian	5	4.2
Marital Status		
Single	46	38.3
Divorced	36	30.0
Married	33	27.5
Widow	5	4.2
Number of Children		
No child	56	46.7
1 child	35	29.2
2 children	19	15.8
More than 2 children	10	8.3

**Table 10: Socio-demographic characteristic of Myanmar female sex workers
(n = 120) (continued)**

Socio-demographic characteristics	Number	Percentage (%)
Educational Level		
Never went to school but literate	27	22.5
Never went to school & illiterate	20	16.7
Primary Education	48	40.0
Secondary Education and higher education	25	20.8
Thai language communication ability		
No ability	25	20.8
Little communication skill	59	49.2
Good communication skill	36	30.0
Hometown		
Karen State	39	32.5
Mon State	31	25.9
Yangon Division	25	20.8
Bago Division	15	12.5
Ayeyarwady Division	6	5.0
Shan State	3	2.5
Mae La Temporary shelter, Tak Province	1	0.8
Migration status in Thailand		
Unregistered (Undocumented/illegal) migrant worker	68	56.7
Registered (Documented/legal) migrant worker	44	36.7
Tourist passport/ Border pass/ Residential permit	8	6.6
Length of stay in Thailand		
Less than 1 year	2	1.7
1-3 years	50	41.7
4-6 years	37	30.8
7-9 years	8	6.7
10-12 years	7	5.8
13-15 years	6	5.0
More than 15 years	10	8.3

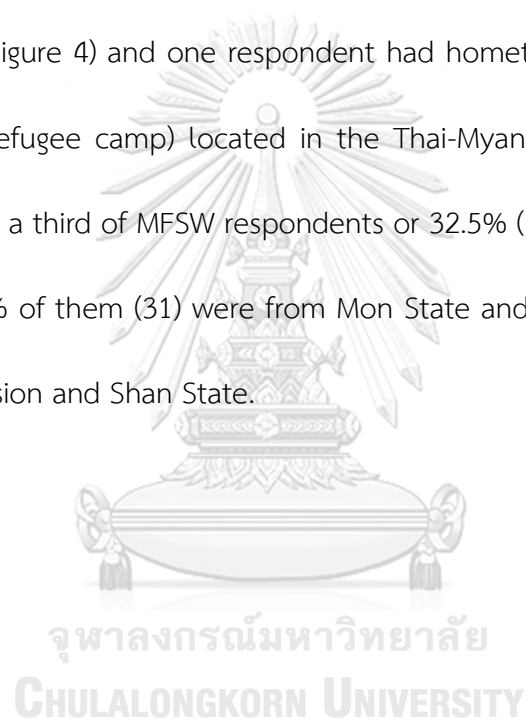
Table 10: Socio-demographic characteristic of Myanmar female sex workers (n = 120) (continued)

Socio-demographic characteristics	Number	Percentage (%)
Year of Working as sex worker		
Less than 1 year	4	3.3
1-3 years	94	78.3
7-9 year	2	1.7
4-6 years	17	14.2
10-12 years	3	2.5

In regard to Table 10, the age of MFSW respondents ranged from 18 to 41 years and the median was 24 years old. Over half of them were aged 18 and 24 years old which were 52.5% (63) of all respondents, followed by 38.3% (46) who were 25-34 years old and the rest of them were 35-41 years old which were 9.2% (11). The ethnicity of MFSW respondents, more than half of them or 67.5% (81) were Burmese and others were Karen, Mon and Indian-Muslim. Also, the majority of them were Buddhist or 90% (108) and the rest were Muslim and Christian. More than one third of them were single women which were 38.3% (46), followed by 30% (36) of them were divorced and 27.5% (33) and 4.1% (5) were married and widow, respectively. The range of the number of children of all MFSW respondents was between 0-6 children. Nearly half of them did not have children which were 46.7% (56), followed by 29.2% of those who had only one child and a few number of them had more than 2 children.

For education level of MFSW respondents, slightly less than half of them had primary educational level which was 40% (48) and 39.2% were never attended school. Meanwhile, almost half of them had little Thai communication skills which were 49.2% (59) while 20.8% (25) of them could not communicate in Thai at all.

For hometown, the 119 MFSW respondents had hometown in 3 States and 3 Divisions inside Myanmar (Figure 4) and one respondent had hometown in Mae La temporary shelter (Mae La refugee camp) located in the Thai-Myanmar border, Tak Province, Thailand. Almost a third of MFSW respondents or 32.5% (39) were from Karen State, followed by 25.9% of them (31) were from Mon State and others were from Yangon Division, Bago Division and Shan State.



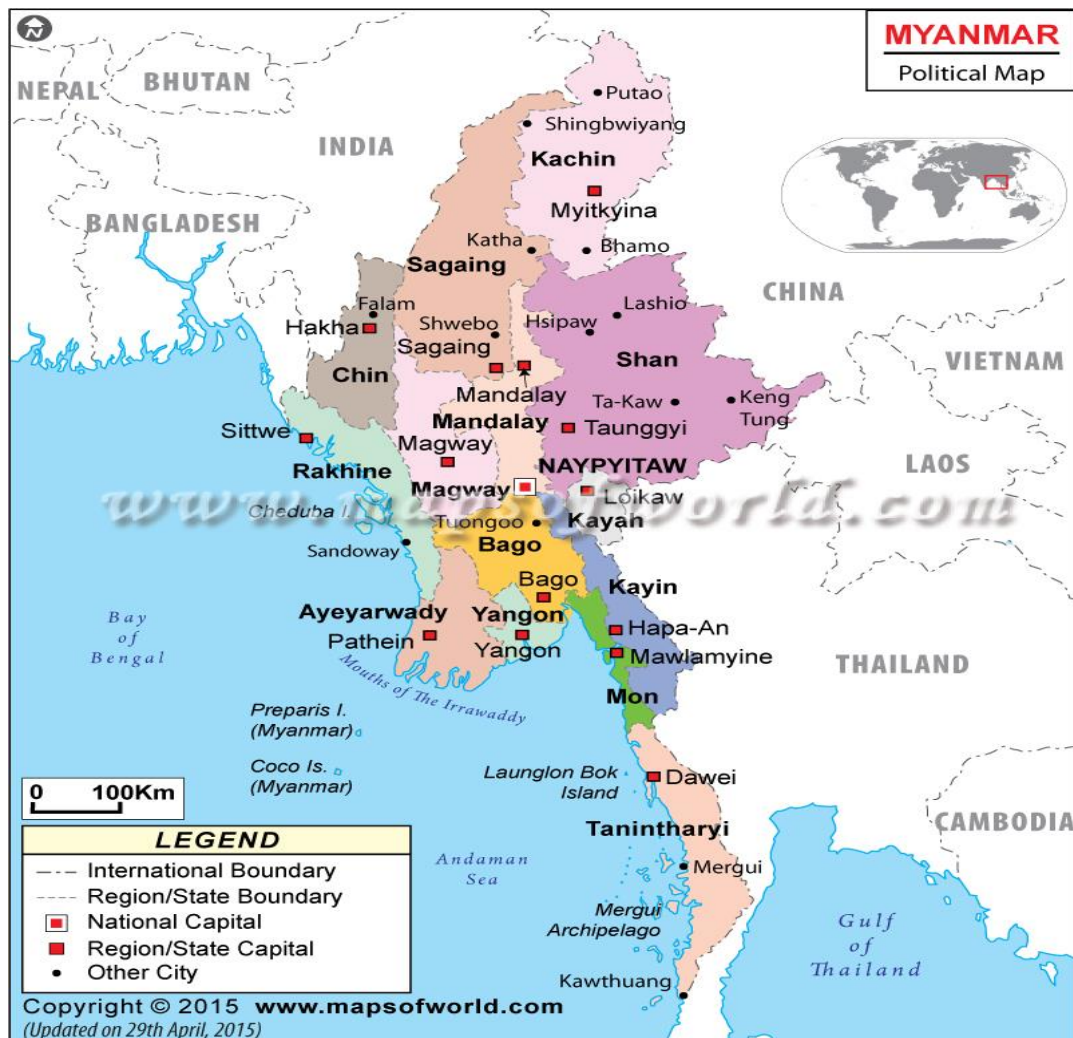


Figure 4: Map of Myanmar (Source: www.mapsofworld.com)

More than half of MFSW respondents or 56.7% (68) were unregistered migrant workers, followed by 36.7% (44) of them who were registered migrant workers and others had entered into Thailand with tourist passport, border pass card and 10 years residential permit.

In addition to the length of stay in Thailand and years of working as sex workers, the 120 MFSW had lived in Thailand for a period ranging from 11 months to 41 years.

Almost half of them (41.7%, 50) lived in Thailand for 1-3 years, followed by 30.8% (37) who had lived in Thailand for 4 to 6 years. Only 2 respondents stated that they lived in Thailand for less than a year (6 and 9 months). Meanwhile, the duration of working as sex worker regardless Thailand or Myanmar ranged between 11 months to 12 years and the majority or 78.3% (94) of them worked as FSW for 1-3 years.

4.1.2 Sex Work Characteristic

Table 11 demonstrated data of sex work characteristic of MFSW. For the type of prostitution business and location, almost one third of MFSW or 31.6 % (38) worked in karaoke shops and cafes in Zone 1 which equally with others who worked in prostitution houses in Zone 2. While, there was only 3 MFSW or 2.5% of them worked in karaoke shops and cafes in Zone 5. Also, their payment per each prostitution service ranged between 100 Baht to 1,500 Baht. Majority of 120 MFSW respondents or 60% (72) earned 300-599 Baht. Nearly 25% of them earned less than 300 Baht (100-200 Baht) and around 15% of them could earn between 600-1,500 Baht per prostitution service. For their income last month from working both full-time and part-time jobs ranged from 1,500 Baht to 10,000 Baht. Slightly more than one fourth or 29.2% (35) of them earned 4,000-5,000 Baht per month which equally with those who earned 6,001-7,000 Baht per month. The minority of them or 10.8% (13) of respondents earned more than 7,000 Baht per month which some of them could earn up to 10,000 Baht per month.

Generally, MFSW provided services between 1 to 10 clients a day. Half of MFSW respondents or 50.8% (61) provided services for 1-2 clients per day, followed by 40% (48) of them provided services for 3-4 clients. Nearly 10% of them provided service for 5-10 clients per day.

Table 11: Sex work characteristics (n=120)

Sex Work Characteristics	Number	Percentage (%)
Type and location of prostitution business in Mae Sot district		
Karaoke shops & cafés in Zone 1	38	31.6
Prostitution houses in Zone 2	38	31.6
Karaoke shops & cafés in Zone 3	23	19.2
Massage shops in Zone 1	12	10.1
Karaoke shops & cafés in Zone 4	6	5.0
Karaoke shops & cafés in Zone 5	3	2.5
Average earning per client		
Less than 300 Baht	29	24.2
Between 300-599 Baht	72	60.0
Between 600-1,500 Baht	19	15.8
Number of clients per day		
1-2 clients	61	50.8
3-4 clients	48	40.0
5-6 clients	6	5.0
7-8 clients	3	2.5
9-10 clients	2	1.7

Table 11: Sex work characteristics (n=120) (continued)

Sex Work Characteristics	Number	Percentage (%)
Average monthly income		
Less than 4,000 Baht	17	14.2
4,000-5,000 Baht	35	29.2
5,001-6,000 Baht	20	16.6
6,001-7,000 Baht	35	29.2
More than 7,000 Baht	13	10.8

4.1.3 Sexual Partner Characteristic

For regular partner characteristics, the majority of them or 65.8% (79) stated that they had regular partners. Among 79 MFSW who had regular partners, 20.3% of them and 57.0% (45) had husband or spouse and boyfriends or lovers, respectively. While 22.8% of MFSW who had regular partners stated that they had both husband and boyfriend at the same time.

In addition to client characteristics, 66.7% (80) of MFSW had regular clients who repeatedly visited them. Among 80 MFSW who had regular clients, 91.3% (73) of them had regular clients paid per each prostitution service or per visit and 8.8% (7) had regular clients with long term payment (steady clients). While 36.3% (29) of them had regular client, who had become their boyfriends or lovers (Table 12).

Table 12: Sexual partner characteristic (regular partner & client characteristics) (n=120)

Sexual Partner Characteristics	Number	Percentage (%)
Regular Partner Characteristic (Multiple Answer)		
Having regular partner (s)	79	65.8
Husband/spouse	16	20.3
Regular boyfriend/lover	45	57.0
Having both husband and boyfriend	18	22.8
Client characteristic (Multiple Answer)		
Having regular clients (repeatedly visited)	80	66.7
Having regular clients paying per each service/visit	73	91.3
Having regular clients with long term payment (steady clients)	7	8.8
Having regular client (s) who had become boyfriend/lover (s)	29	36.3

4.1.4 Availability and Accessibility of HIV/AIDS Information and Services

Table 13 demonstrated results of availability and accessibility of HIV/AIDS information and services, it revealed that most of 120 MFSW respondents or 96.7% (116) had heard about HIV/AIDS, while only 4 of them (3.3%) had never heard of HIV/AIDS at all. Among these 116 respondents, 45.7% of them (53) knew about HIV when they migrated to Mae Sot district, Thailand. However, 22.4% (26) of them knew about HIV/AIDS since they lived in Myanmar. Slightly more than half of MFSW respondents or 54.3% (63)

learned more about HIV/AIDS from both NGO health providers such as staffs and volunteers from Planned Parenthood Association of Thailand (PPAT), World Vision Foundation of Thailand (WVFT) and Mae Tao Clinic (MTC). Almost half or 48.3% (56) of them stated that they received HIV/AIDS information from health providers from government sector, mainly community health volunteers and health professionals from community health centres and Mae Sot Hospital. Others got information from posters/leaflets and brochures, Myanmar TV, radio programme, internet, social media (LINE/Facebook) and others around them.

For access to condoms, Half of MFSW respondents or 51.7% (62) got free condoms from local NGOs, followed by others who got free condoms from government agencies, and those who purchased condoms from drugstore or convenience stores. A few percentage of MFSW (5.0%) got free condoms from their employers.

In addition to experience having HIV blood testing and access to HIV blood testing services, the majority of respondents or 74.2% (89) revealed that they already experienced receiving HIV blood testing. While, 25.8% (31) of them had never done HIV blood testing at all. For accessing to Voluntary Counselling and Testing (VCT) and referral services for HIV blood testing services, about 59.6% (53) of MFSW who receiving HIV blood testing participated in the out-reach HIV/AIDS services of Mae Sot hospital and 25.8% (23) of them received the same services from NGO, mainly by PPAT.

For obstacles in accessing HIV blood testing among MFSW respondents, 40% (48) of them revealed that they were afraid of being arrested by the police officers, followed by 37.5% (45) of them stated that they did not have enough money to pay for medical bills. While, others did not have any means of transportation and faced problem of language barrier and only 15.8% of them did not have problem in accessing services.

Table 13: Availability and accessibility to HIV/AIDS information and services

Characteristic	Number	Percentage (%)
Heard of HIV/AIDS (n = 120)	116	96.7
Had heard of HIV/AIDS when (n = 116)		
● Living in Myanmar	26	22.4
● Migrating to Mae Sot, Thailand	53	45.7
● Working as FSW in Mae Sot, Thailand	18	15.5
● Working in Myanmar and Thailand	19	16.4
Source of Information about HIV/AIDS (Multiple Answers) (n = 116)		
Internet/Social media (Line/Facebook)	40	34.5
Myanmar TV & Radio	40	34.5
Poster/Leaflets/Brochures	47	40.5
Employers	18	15.5
Friends/Peer educators	28	24.1
Clients	19	16.4
Regular partners	22	19.0
Family members & relatives	24	20.7
NGO health providers	63	54.3
Government health providers	56	48.3
Government Health service providers	39	32.5

Table 13: Availability and accessibility to HIV/AIDS information and services (Continued)

Characteristic	Number	Percentage (%)
Source and Access to Condoms: (Multiple Answers) (n = 120)		
Health service providers from NGOs & MTC	62	51.7
Employers/Agents/Mama Sang/Shop or Café owner	6	5.0
Drug stores/Convenience store	24	20.0
Clients	12	10.0
Work colleagues/Friends	13	10.8
Peer educators	18	15.0
Experienced HIV Blood Testing (n = 120)	89	74.2
VCT & Referral Services for HIV Screening (Multiple Answers) (n = 89)		
Out-reach HIV/AIDS services by NGOs Health Providers	23	25.8
Out-reach HIV/AIDS services by GOs Health Providers	9	10.1
Nearby public health centres of the MOPH	13	14.6
Visiting private clinics or hospitals	16	18.0
Mae Sot Hospital (MSH)	53	59.6
Mae Tao Clinic	18	20.2
Obstacles in accessing HIV blood testing (Multiple Answers) (n = 120)		
Lack of financial means	45	37.5
Fear of arrest by police	48	40.0
No means of translation	34	28.3
Language barrier	28	23.3
No obstacles as MSH provided referral arrangement	19	15.8

4.1.5 Level of Knowledge towards HIV/AIDS

The assessment of knowledge of 120 MFSW respondents towards HIV/AIDS prevention contained 15 questions for measuring their knowledge. Three parts of questions about HIV/AIDS knowledge were included 1) general knowledge of HIV/AIDS, 2) HIV/AIDS Symptoms and 3) HIV/AIDS Transmissions. There were 9 positive statements and 6 negative statements in this questionnaire, and the full score was 15 points.

In addition to the level of HIV/AIDS knowledge, the Table 14 demonstrated that half of MFSW respondents had *moderate* level of overall HIV/AIDS knowledge. While 25.8% (31) of them had *good* HIV/AIDS knowledge and 23.4% (28) of them had *poor* knowledge. The Median of knowledge score of 120 MFSW respondents were 10 points with the minimum and maximum score 0 and 14 accordingly.

For general HIV/AIDS knowledge, there was no MFSW respondents had good knowledge, while, majority or 87.5% (105) of them had *poor* knowledge. In addition to HIV/AIDS symptoms, almost half 47.3% or (57) of MFSW respondents had *moderate* level of knowledge. For HIV/AIDS transmission, majority (56.6%) or (68) of them had *good* knowledge, while 26.7 % (32) of them had *poor* knowledge.

Table 14: Number and percentage distribution of the level of HIV/AIDS knowledge (n = 120)

Statement	Level of Knowledge					
	Good		Moderate		Poor	
	More than 80% (12-15 points)		Between 60-80% (9-11 point)		Less than 60% (0-8 points)	
	n	%	n	%	n	%
Overall Knowledge	31	25.8	61	50.8	28	23.4
General HIV/AIDS knowledge	0	0	15	12.5	105	87.5
HIV/AIDS Symptoms	17	14.2	57	47.5	46	38.3
HIV/AIDS Transmissions	68	56.7	20	16.6	32	26.7

Number and Percentage Distribution of HIV/AIDS Knowledge

Table 15 demonstrated number and percentage of correct answers about HIV/AIDS knowledge. For general HIV/AIDS knowledge, the majority of MFSW respondents or 79.2% (95) of them knew that HIV is a virus which attacks the human immune system, the body's defence against disease. However, only 33.3% (44) of them knew that a person with HIV may feel completely well and have no symptoms. Furthermore, 74.2% of them (89) knew that having blood test for HIV is the only way to ensure that they are HIV infected.

In addition to knowledge of HIV symptoms, the majority or 69.2% (83) of them knew that one of HIV/AIDS symptoms were included chronic diarrhoea (more than a week)

and weight loss. However, only few of respondents (41) or 34.2% knew that in some cases HIV/AIDS may take as many as ten years for more severe symptoms to appear.

In relation to HIV/AIDS transmission, majority of respondents or 86.7% (104) knew that HIV/AIDS could be transmitted via the exchange of a variety of body fluids from infected individuals, such as blood, breast milk, semen and vaginal secretions. On the other hand, 40.0% (48) misunderstood that there was absolutely no risk of HIV transmission when having body piercing and tattooing in the place that shared instruments contaminated with blood without sterilising or changing new needles between clients.

Table 15: Number and percentage distribution of correct answers of HIV/AIDS knowledge (n = 120)

Knowledge	Correct Answers	
	n	(%)
General Knowledge of HIV/AIDS		
HIV is a virus attacked the human immune system.	95	79.2
PLHIV may feel well and have no symptoms.	40	33.3
Blood test is the only way to check HIV infection.	89	74.2
PLHIV can survive without treatment.	81	67.5
HIV/AIDS Symptoms		
Prolong fever, headache and sore throat are one of HIV/AIDS symptoms.	63	52.5
Swollen glands, lymph nodes, rash and having white spots or unusual blemishes are one of HIV/AIDS symptoms.	75	62.5

Table 15: Number and percentage distribution of correct answers of HIV/AIDS knowledge (n = 120) (Continued)

Knowledge	Correct Answers	
	n	(%)
Prolong chronic Diarrhoea and weight loss are one of HIV/AIDS symptoms.	83	69.2
Fatigue and lack of energy are one of HIV/AIDS symptoms.	75	62.5
HIV/AIDS may take up to 10 years for symptoms to appear.	41	34.2
HIV/AIDS Transmissions		
HIV/AIDS can be transmitted via the exchange of a variety of body fluids.	104	86.7
Having body piercing and tattooing that shared instruments have no HIV risk.	72	60.0
Visiting the barber that shared instruments have no HIV risk.	76	63.3
Using the same toilet can get HIV/AIDS.	83	69.2
Kissing and drinking same glass can get HIV/AIDS.	84	70.0
Massaging, hugging and touching can get HIV/AIDS.	89	74.2

4.1.6 Level of Attitude towards HIV/AIDS

The level of attitude of 120 MFSW respondents had assessed by 10 questions/statements in total including 5 positive and 5 negative statements. They were asked to rate their level of agreements on the statement in the Five-score Likert's scale (*Strongly Agree/Agree /Not Sure/Disagree/ Strongly Disagree*). The score from all answers in this part sum up to a total score and calculate for mean for classifying the level of attitude, and the total score ranged from 10 to 50. After that, the MFSW

respondents' attitudes also classified into 3 levels by using means \pm standard deviation.

Number and Percentage Distribution of the Level of Overall HIV/AIDS Attitude

Table 16 demonstrated that the majority (71.7%, 86) of 120 MFSW respondents had *moderate* level of overall attitude toward HIV/AIDS prevention. Meanwhile 15.8% (19) of them had *poor* level, followed by 12.5% (15) of them had *good* level of HIV/AIDS attitude.

Table 16: Number and percentage distribution of the level of overall HIV/AIDS attitude

The Level of Overall HIV/AIDS Attitude	Number (n=120)	Percentage (%)
● Good attitude	15	12.5
● Moderate attitude	86	71.7
● Poor attitude	19	15.8
Mean = 36.68 Standard Deviation = 5.450 Median = 37 Min = 22 Max = 49		
Total	120	100.00

Number and Percentage Distribution of HIV/AIDS Attitude

Table 17 demonstrated Mean, Median, Standard Deviation (SD) and 95% CI distribution of the level of attitude towards HIV/AIDS prevention. The result revealed that generally MFSW respondents had *moderate level* towards all questions about HIV/AIDS attitude.

Table 17: Mean, median, standard deviation (SD) and 95% CI of level of HIV/AIDS attitude (n=120)

Attitude toward HIV/AIDS	Mean	Median	SD	95% CI	Result
Having sex with a healthy-looking person would not get HIV/AIDS.	3.55	4	1.229	3.33-3.77	Moderate attitude
Having sexual intercourse with clients, especially regular clients, there is no need to use condom.	3.69	4	1.165	3.48-3.90	Moderate attitude
Having sexual intercourse with regular partners, there is no need to use condom.	3.17	4	1.422	2.91-3.42	Moderate attitude
Condoms are not suitable to use with a regular partner.	3.08	3	1.278	2.84-3.31	Moderate attitude
Using condoms would cause regular partner to feel distrusted.	2.93	3	1.367	2.68-3.17	Moderate attitude
PLHIV should inform health personals for the best services.	4.28	5	1.012	4.09-4.46	Moderate attitude

Table 17: Mean, median, standard deviation (SD) and 95% CI of level of HIV/AIDS attitude (n=120) (Continued)

Attitude toward HIV/AIDS	Mean	Median	SD	95% CI	Result
HIV screening is very important for sex workers.	4.27	5	1.019	4.08-4.45	Moderate attitude
HIV screening is very important for injecting drug users.	4.23	4.5	1.049	4.04-4.41	Moderate attitude
FSW have a chance of STI/STDs infection.	3.87	4	1.084	3.67-4.06	Moderate attitude
FSW have a chance of HIV/AIDS infection.	3.63	4	1.216	3.41-3.85	Moderate attitude
Total	36.68	37	5.450	35.69-37.66	Moderate attitude

Table 18 demonstrated the number and percentage distribution of attitude towards HIV/AIDS prevention. The result revealed that generally MFSW respondents had *moderate level* towards all questions about HIV/AIDS attitude.

In addition to having sex with a healthy-looking person would not get HIV/AIDS, 64.2% of them *disagreed* and *strongly disagreed* (42.5% and 21.7% respectively) with this statement. Nearly 75% of them *disagreed* and *strongly disagreed* (52.5% and 21.7% respectively) that there was no need to use condoms during sexual intercourse with clients, particularly regular clients.

Also, 55.8% of them *disagreed* and *strongly disagreed* (39.2% and 16.6% respectively) that there was no need to use condom during sexual intercourse with regular partners, and 47.5% of them *disagreed* and *strongly disagreed* (34.2% and 13.3% respectively) that condom was not suitable to use with regular partners. Furthermore, 42.5% of them *disagreed* and *strongly disagreed* (29.2% and 13.3% respectively) that using condoms could cause their regular partners to feel distrusted.

For attitude towards HIV screening, half of MFSW or 88.3% (with 50.8% *strongly agreed*) of them *agreed* that it was very important for high risk group like sex workers and 85.8% of them *agreed* (with 50.0% *strongly agreed*) that it was very important for another high-risk group like injecting drug users.

Regarding attitude towards accessing to health care services, 87.5% (with 52.5% *strongly agreed*) of MFSW respondents *agreed* that people living with HIV should inform health personals, including doctors, nurses, dentists, health service providers or health volunteers that they were HIV infected for having the best medical services.

For attitude towards awareness of HIV, STI and STD infection and transmission, 73.4% (with 30.0% *strongly agreed*) of MFSW respondents *agreed* that they might have a chance to get HIV/AIDS infection and due to their profession as female sex workers. Also, 69.2% (with 24.2% *strongly agreed*) of them *agreed* that they might have a chance to get STI/STDs infection due to their profession.

Table 18: Number and percentage distribution of level of attitude towards HIV/AIDS

Attitude toward HIV/AIDS	Level of Attitude					
	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree	Total
	Number	Number	Number	Number	Number	n = 120
	%	%	%	%	%	100
Having sex with a healthy-looking person would not get HIV/AIDS.	12	13	18	51	26	120
	10.0	10.8	15.0	42.5	21.7	100.0
Having sexual intercourse with clients, especially regular clients, there is no need to use condom.	10	12	9	63	26	120
	8.3	10.0	7.5	52.5	21.7	100.0
Having sexual intercourse with regular partners, there is no need to use condom.	25	17	11	47	20	120
	20.8	14.2	9.2	39.2	16.6	100.0

Table 18: number and percentage distribution of level of attitude towards HIV/AIDS (Continued)

Attitude toward HIV/AIDS	Level of Attitude					
	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree	Total
	Number	Number	Number	Number	Number	n = 120
	%	%	%	%	%	100
Condoms are not suitable to use with a regular partner.	13	38	12	41	16	120
	10.8	31.7	10.0	34.2	13.3	100.0
Using condoms would cause regular partner to feel distrusted.	24	28	17	35	16	120
	20.0	23.3	14.2	29.2	13.3	100.0
HIV screening is very important sex workers.	61	45	5	3	6	120
	50.8	37.5	4.2	2.5	5.0	100.0
HIV screening is very important for injecting drug users.	60	43	7	4	6	120
	50.0	35.8	5.8	3.4	5.0	100.0
PLHIV should inform health personals for the best medical services.	63	42	4	7	4	120
	52.5	35.0	3.3	5.9	3.3	100.0

Table 18: number and percentage distribution of level of attitude towards HIV/AIDS (Continued)

Attitude toward HIV/AIDS	Level of Attitude					
	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree	Total
	Number	Number	Number	Number	Number	n = 120
	%	%	%	%	%	100
FSW have a chance be STI/STDs infected.	36	52	19	7	6	120
	30.0	43.4	15.8	5.8	5.0	100.0
FSW have a chance be HIV/AIDS infected.	29	54	10	18	9	120
	24.2	45.0	8.3	15.0	7.5	100.0

4.1.7 Influence or Pressure from Peers, Employers, Clients and Regular Partners and Obstacles towards HIV/AIDS Prevention

This part contained 4 questions, including 2 negatives and 2 positive questions asking MFSW to answer about influence or pressure from peers, employers, clients and regular partners and obstacles towards HIV/AIDS prevention. Numbers and percentages of such significant influences/pressures demonstrate in the Table 19.

In addition to significant influences from employers that supporting MFSW respondents in using condoms during sexual intercourse with clients, 30.0% (36) of them stated that their employers told them about the risks of HIV/AIDS and their employers also took care of their health. But almost half of them or 41.7% (50) said that they did not gain support from their employers on this matter.

For significant influences from work colleagues, peers or peer educators supporting these respondents in using condoms during sexual intercourse with clients, nearly 40% or (46) of MFSW stated that their friends, who were peer educators told them about HIV/AIDS risks, provided condoms and insisted them to use for prevention. While 30.8% (37) of them stated that there was no influence from friends, peer educators supporting them in using condom.

In relation to significant pressures from friends, work colleagues, peers and employers towards you for not using condom during sexual intercourse with clients, almost a quarter of them or 24.2% (29) revealed that if their clients preferred not using condoms, their employers asked them to response the needs of their clients.

While, 15.0% (18) of them stated that they would get more clients and more tips, if they had sexual intercourse with clients without using condoms according to their work colleagues, friends or employers. Also, 13.3% (16) of them followed their work colleagues for not using condom every time with clients as their work colleagues were

still fine. Nearly half of 120 MFSW respondents or 46.7% (56) said that there was no significant pressure from their friends work colleagues, peers and employers towards them for not using condom with clients.

For significant pressure from regular partners (husband/boyfriends/lovers) that pressuring them for not using condom during sexual intercourse, fortunately, most of respondents or 60.8% (73) exposed that there was no significant pressure from regular partners in pressuring them for not using condom. However, 15.0% (18) of them revealed that their regular partners did not want to use condoms during sexual intercourse and it would feel distrust each other. Also, 11.7% (14) of them said that their regular partners did not want to use condoms during sexual intercourse as he wanted to have natural feeling, more fun and pleasure.

Table 19: Number and percentage distribution of influencing factors/pressure from peers, employers, clients and regular partners and obstacles towards HIV/AIDS prevention (n=120)

Influencing Factors/Pressures	Number	Percentage
Influence from employers in supporting you to use condoms at sex with clients		
Employers informed about HIV/AIDS risks.	36	30.0
Employers always provided condoms and insisted to use them.	19	15.8
Employers provided supports in negotiating with clients on condom using.	4	3.3

Table 19: Number and percentage distribution of influencing factors/pressure from peers, employers, clients and regular partners and obstacles towards HIV/AIDS prevention (n=120) (Continued)

Influencing Factors/Pressures	Number	Percentage
Employers set regulation and enforcing practices with clients and FSW in using condoms during sexual intercourse.	11	9.2
There is no support from employer in using condom.	50	41.7
Influence from work colleagues, peers or peer educators in supporting you to use condoms at sex with clients		
Friends, who were peer educators informed about HIV/AIDS risks, provided condoms and insisted to use them.	46	38.3
Friends at workplace informed about HIV/AIDS risks and insisted to use condoms.	20	16.7
Having friends or someone whom did not use condom regularly suffered and died from HIV/AIDS.	12	10.0
Friends taught on how to deal with clients whom refused to use condoms.	5	4.2
There is no influence from friends, peer educators in condom use supporting.	37	30.8

Table 19: Number and percentage distribution of influencing factors/pressure from peers, employers, clients and regular partners and obstacles towards HIV/AIDS prevention (n=120) (Continued)

Influencing Factors/Pressures	Number	Percentage
Pressure from friends, work colleagues, peers and employers towards you for not using condom at sex with clients		
Employers asked to response clients' needs.	29	24.2
Friends, work colleagues or employers said that not using condoms at sex with clients would get more tips.	18	15.0
Followed work colleagues whom not using condom at sex with clients.	16	13.3
My friends and work colleagues said that not using condoms at sex with clients would be more fun and pleasure.	1	0.8
There is no significant pressure from friends work colleagues, peers and employers for not using condom.	56	46.7
Pressure from regular partners pressuring you for not using condom at sex		
I and regular partner did not to use condom as it wasted money.	8	6.7
Regular partners did not want to use condoms at sex for natural feeling.	14	11.7
Regular partners did not use condoms at sex as it would feel distrusted.	18	15.0
Having regular partner whom used to be clients and did not use condom at sex.	7	5.8
There is no significant pressure from regular partners for not using condom.	73	60.8

4.1.8 Level of HIV/AIDS prevention and Sexual Behaviour

This part had 10 questions (No. 54-63) of correct and incorrect behaviour asking 120 MFSW respondents with rating always/often/sometimes/never answers. This set of questions aimed to assess MFSW about their sexual behaviour and practices, including negotiation on condom using and condom used at sex towards HIV/AIDS prevention during the last 3 months. The total score of this part was 30, ranging from 0-30. The MFSW respondents' sex behaviour and preventive practices had classified into 3 levels by using means \pm standard deviation.

The Table 20 demonstrated that during the last 3 months, the majority or 61.6% (74) of 120 MFSW respondents had *moderate* level of HIV/AIDS prevention. While, 20.8% (25) of them had *good* preventive practice and 17.5% (21) had *poor* preventive practice.

Table 20: Number and percentage distribution of level of overall HIV/AIDS prevention during the last 3 months

Level of overall HIV/AIDS prevention	Number	Percentage (%)
● Good Preventive Practice	25	20.8
● Moderate Preventive Practice	74	61.6
● Poor Preventive Practice	21	17.5
Mean = 19.60, Standard Deviation = 5.083 Median = 20.00, Min = 9, Max = 29		
Total	120	100.0

During the last 3 months, all 120 MFSW respondents also reached moderate level of all HIV/AIDS prevention and behaviour statements (Table 21). The results of assessment of their sexual behaviour and practices, including negotiation on condom using and condom used at sex) towards HIV/AIDS prevention during the last 3 months demonstrated in the Table 22. They are as follows:

Alcohol and Drug Use Before/During Sexual Activity

Slightly more than half of MFSW respondents or 52.5% (63) *sometimes* drunk alcohol before or during sexual intercourse, which also included 5.8% (7) of those who *always* did such the same behaviour. While 24.2% of them had *never* drunk alcohol before or during sexual intercourse. For drug use before or during sexual intercourse, 52.5% (63) of respondents stated that they had *never* used drugs before or after having sex, while 6.7% (8) of them *always* did such behaviour.



Condom Use with Regular Partners

The majority or 60.0% (70) of respondents used condoms with their regular partners at sex meanwhile 10.0% (12) of them stated that they *never* used condoms with their regular partners. At the same time, around 44.3% (35) of them *always* insisted their regular partners to use condom at sex, but 11.4% (9) of them had never insisted their regular partners. For experiencing the situations that regular partners denied using

condom at sex, 39.1% (31) of respondents *sometimes* had such experience, but 20.3% (16) had never faced such experience.

Besides, slightly half or 55% (43) of respondents *always* met their success in convincing and insisting their regular partners to use condom during sexual intercourse, but 10.8% (9) had *never* met their success. Moreover, 36.7% (29) of MFSW respondents *always* refused to have sexual intercourse when their regular partners denied using condoms, but 10.0% (8) of them *never* refuse their regular partners. Also, during the last 3 months, 49.2% (39) of respondents *always* used condoms during sexual intercourse with their regular partners, but 10.8% (8) had *never* done so.

Condom Use with Clients

In addition to condom use with clients during the last 3 months, less than half or only 44.2% (53) of all 120 MFSW respondents revealed that they *always* used condoms during sexual intercourse with their clients, and 10.8% (13) of them revealed that they had *never* used condoms with their clients. Around 36.6% (44) of respondents *sometimes* tried to convince their clients to use condoms at sex, but up to 12.5% (15) of them had *never* tried to do it. However, 34.2% of them *always* convinced their clients to use condoms.

Table 21: Mean, median standard deviation (SD) and 95% CI of HIV/AIDS prevention (n=120)

HIV/AIDS Preventive Behaviour & Practice	Mean	Median	SD	95% CI	Result
Consumed alcohol before/during sexual intercourse	1.95	2	0.808	1.80-2.10	Moderate Practice
Consumed drugs before/during sexual intercourse	2.29	3	0.902	2.13-2.45	Moderate Practice
Used condom (s) with my regular partner (s) during sexual intercourse.	2.18	3	1.097	1.98-2.37	Moderate Practice
Insisted my regular partner (s) to use condom during sexual intercourse	1.93	2	1.083	1.74-2.13	Moderate Practice
Experienced the situation that my regular partner (s) denied using condom during sexual intercourse.	1.58	2	1.034	1.39-1.76	Moderate Practice
Met success in convincing and insisting regular partner (s) to use condom during sexual intercourse	2.06	2	1.125	1.85-2.26	Moderate Practice
Convinced and insisted clients to use condom during sexual intercourse	1.73	3	1.069	1.53-1.92	Moderate Practice

Table 21: Mean, median standard deviation (SD) and 95% CI of HIV/AIDS prevention (n=120) (Continued)

HIV/AIDS Preventive Behaviour & Practice	Mean	Median	SD	95% CI	Result
Refused to have sexual intercourse with regular partner (s) when they denied using condom	1.83	2	1.031	1.67-2.04	Moderate Practice
Used condoms during sexual intercourse with clients during the last 3 months.	2.00	2	1.053	1.81-2.19	Moderate Practice
Used condoms during sexual intercourse with regular partner (s) during the last 3 months	2.03	2	1.084	1.84-2.23	Moderate Practice
Total	19.60	20.00	5.083	18.68-20.52	Moderate Practice

Table 22: Number and percentage distribution of preventive sexual practice with male clients/regular partners (n=120)

Preventive sexual practice and Practice	Always	Often	Some times	Never	Total
	No.	No.	No.	No.	Number
	%	%	%	%	%
Consumed alcohol before/during sexual intercourse	7	21	63	29	120
	5.8	17.5	52.5	24.2	100.0

Table 22: Number and percentage distribution of preventive sexual practice with male clients/regular partners (n=120) (Continued)

Preventive sexual practice and Practice	Always	Often	Some times	Never	Total
	No.	No.	No.	No.	Number
	%	%	%	%	%
Consumed drugs before/during sexual intercourse	8	12	37	63	120
	6.7	10.0	30.8	52.5	100.0
Used condom (s) with regular partner (s) during sexual intercourse with regular partner (s)	47	6	18	8	79
	60.0	7.5	22.5	10.0	100.0
Insisted regular partner (s) to use condom at sex	35	12	23	9	79
	44.3	15.2	29.1	11.4	100.0
Experienced the situation that my regular partner (s) denied using condom at sex	16	16	31	16	79
	20.3	20.3	39.1	20.3	100.0
Convinced and insisted clients to use condom at sex	41	20	44	15	120
	34.2	16.7	36.6	12.5	100.0
Met success in convincing and insisting regular partner (s) to use condom during at sex	43	5	26	10	79
	55.0	6.7	27.5	10.8	100.0
Refused to have sexual intercourse with regular partner (s) when they denied using condom	29	18	24	8	79
	36.7	22.5	30.8	10.0	100.0

Table 22: Number and percentage distribution of preventive sexual practice with male clients/regular partners (n=120) (Continued)

Preventive sexual practice and Practice	Always	Often	Some times	Never	Total
	No.	No.	No.	No.	Number
	%	%	%	%	%
Used condoms during sexual intercourse with clients during the last 3 months	53	27	27	13	120
	44.2	22.5	22.5	10.8	100.0
Used condoms during sexual intercourse with regular partner (s) during the last 3 months	39	13	19	8	79
	49.2	15.8	24.2	10.8	100.0

4.2 The Analytical Information

In this study, Mann-Whitney U Test, Kruskal-Wallis Test and Spearman's correlation were considered as appropriated measure for analysing the association between the score of HIV/AIDS prevention and socio-demographic characteristics, sex work characteristics and sexual partner characteristics, availability and accessibility to HIV/AIDS information and service, influencing factors/pressure towards HIV/AIDS prevention, knowledge score and attitude score regarding to HIV/AIDS prevention did not normally distributed.

Associations between the score of HIV/AIDS prevention and socio-demographic characteristics, i.e., age, number of children, years of working as female sex workers

and length of stay in Thailand and sex work characteristic, i.e., number of clients per day and earning per client) were analysed by Spearman Correlation. While the association between the score of HIV/AIDS preventive practice and some variables of socio-demographic characteristics, sex work characteristics, sexual partner characteristics (regular partner and client characteristics), availability and accessibility to HIV information & service and influencing factors and pressure from peers, employers, clients and regular partners, which were categorised scale, were analysed by Mann Whitney U-Test and Kruskal-Wallis Test. Besides, associations between the score of HIV/AIDS prevention and the score of HIV/AIDS knowledge and attitude score were analysed by using Spearman Correlation.

4.2.1 Association between Practice towards HIV/AIDS Prevention and Socio-Demographic Characteristics

Table 23 demonstrated that none of socio-demographic characteristics variables, i.e., age, number of children, years of working as FSW and length of stay in Thailand were significant associated with the level of practice towards HIV/AIDS prevention.

Table 23 Association between practice towards HIV/AIDS prevention and socio-demographic characteristics

Socio-Demographic Characteristics	HIV/AIDS Practice	
	Spearman Correlation	P-value
Age	-0.007	0.941
Number of Children	0.003	0.976
Length of years working as female sex workers	-0.068	0.459
Length of stay in Thailand	0.033	0.718

*Significant level at 0.05

Table 24 demonstrated that the score of HIV/AIDS prevention of MFSW was significantly associated with these variables, including religion ($p = 0.010$), ethnicity ($p = 0.031$) and hometown ($p = 0.001$). It was notable that MFSW respondents who were Buddhist performed less preventive practice than MFSW who were Muslim and Christian.

Table 24 Association between the scores of practices towards HIV/AIDS prevention and socio-demographic characteristics

Socio-Demographic Characteristics	HIV/AIDS prevention	
	Mean Rank	P-value
Religion^a		
Buddhist	57.80	0.010*
Others (Muslim & Christian)	84.83	
Ethnicity^b		0.031*
Burman	61.31	
Karen	48.54	
Others (Mon, Shan, Indian-Muslim)	79.35	

Table 24 Association between the scores of practices towards HIV/AIDS prevention and socio-demographic characteristics (Continued)

Socio-Demographic Characteristics	HIV/AIDS prevention	
	Mean Rank	P-value
Marital Status^b		0.839
Single	61.01	
Married	59.27	
Divorced	59.13	
Widow	73.80	
Educational Level^b		0.118
Cannot read and write	69.88	
Can read and write	64.85	
Primary education	51.30	
Secondary and higher education	65.96	
Thai Language Ability^b		0.256
No Thai communication skill	56.42	
Little Thai communication skill	65.78	
Good Thai communication skill	54.68	
Home town		0.001*
Mon State	57.11	
Karen State	55.51	
Shan State	67.17	
Ayeyarwady	26.75	
Yangon Division	83.82	
Bago Division	49.83	
Mae La, Tak Province, Thailand	119.50	

Table 24 Association between the scores of practices towards HIV/AIDS prevention and socio-demographic characteristics (Continued)

Socio-Demographic Characteristics	HIV/AIDS prevention	
	Mean Rank	P-value
Migration Status^b		0.426
Unregistered migrant workers	61.19	
Registered migrant workers	62.23	
Others (Passport, border pass and residential permit)	45.13	

^aMann Whitney U Test

^bKruskal-Wallis Test

*Significant level at 0.05

4.2.2 Association between Practice towards HIV/AIDS Prevention and Sex Work Characteristics

Table 25 showed that earning last month of MFSW respondents was significantly associated with negative correlation ($r = -0.233$ and $p = 0.010$).

Table 25 Association between the scores of practices towards HIV/AIDS prevention and income and number of clients

Sex Work Characteristics	Spearman Correlation	P-value
Earning per client	0.073	0.430
Number of clients per day	0.064	0.489
Earning last month	-0.233	0.010*

*Significant level at 0.05

Table 26 demonstrated that MFSW respondents who worked in different type of prostitution business performed differently in HIV/AIDS prevention. Furthermore, the MFSWs in Karaoke shops had the highest score of practice towards HIV/AIDS prevention while those MFSW in prostitution houses had lowest practice. Not only the prostitution type but the zone of prostitution located also associated with the performing HIV/AIDS preventive practice of MFSWs, the MFSWs working in the prostitutions located in the area of outskirt and West of Mae Sot district had the highest level of HIV/AIDS preventive practice. While, the MFSWs working in the prostitutions in South of Mae Sot district had the lowest level of HIV/AIDS preventive practice.

Table 26 Association between the scores of practices towards HIV/AIDS prevention and type and zone of prostitution business

Sex Work Characteristics	HIV/AIDS Practice	
	Mean Rank	P-Value
Type of prostitution business^b		0.002*
Massage shop	63.98	
Prostitution house	41.46	
Karaoke shop	71.41	
Zone of prostitution business^b		0.002*
Zone 1: Central Area of Mae Sot district	69.80	
Zone 2: Outskirt & Zone 5: West of Mae Sot district	107.96	
Zone 3: North of Mae Sot district	69.00	
Zone 4: South of Mae Sot district	66.58	

^bKruskal-Wallis Test *Significant level at 0.05

4.2.4 Association between Practice towards HIV/AIDS Prevention and Sexual Partner Characteristics (Regular Partner and Client Characteristics)

Table 27 demonstrated that there was no significant association between the score of practice and sexual partner characteristics (regular partner and client characteristics).

Table 27 Association between the scores of practice and sexual partner characteristics (regular partner and client characteristics) towards HIV/AIDS prevention

Sexual Partner Characteristics (Variables)	HIV/AIDS prevention	
	Mean Rank	P-value
Regular partner Characteristics^b		0.510
Did not have regular partners	66.61	
Having husband/spouse	61.94	
Having boyfriends/lovers	56.63	
Having both husbands and boyfriends	54.93	
Regular partners knew about sex work profession ^a		0.088
Yes	36.60	
No	45.51	
Regular Client Characteristics^b		0.908
Did not have regular clients	58.55	
Having regular client (s) paying per each service	61.41	
Having regular clients with long term payment	62.14	
Having regular clients who had become boyfriends	56.45	

^aMann Whitney U Test;

^bKruskal-Wallis Test;

*Significant level at 0.05

4.2.5 Association between the Practice towards HIV/AIDS Prevention and Availability and Accessibility to HIV/AIDS Information & Service

Table 28 demonstrated that there was only HIV/AIDS blood testing ($p = 0.001$) significantly associated with the score of practice towards HIV/AIDS prevention.

Table 28 Association between the scores of practices towards HIV/AIDS prevention and availability and accessibility to HIV/AIDS information & services

Access to HIV/AIDS Information & Services	HIV/AIDS prevention	
	Mean Rank	P- Value
Access to HIV Information		
<u>Heard about HIV/AIDS</u> ^a		0.496
Yes	60.90	
No	48.88	
<u>Had heard of HIV/AIDS when</u> ^b		0.707
Living in Myanmar	68.56	
Migrating to Mae Sot, Thailand	59.08	
Working as FSW in Mae Sot, Thailand	56.8	
Living in Myanmar and Thailand	59.32	
Access to Service		
<u>HIV Blood Testing</u> ^a		0.001*
Yes	66.72	
No	42.65	

^aMann Whitney U Test;

^bKruskal-Wallis Test;

*Significant level at 0.05

4.2.6 Association between the Practice towards HIV/AIDS Prevention and Pressure & Influenced Factors from Employers, Peers, Clients and Regular Partners

Table 29 demonstrated that influence from employers in supporting on condom use at sex with client ($p = 0.002$) and pressure from work colleagues for not using condom at sex ($p = 0.013$) were significantly associated with the score of HIV/AIDS preventive practice.

Table 29 Association between the scores of practices towards HIV/AIDS prevention and pressure & influenced factors from employers, peers, clients and regular partners

Pressure & Influenced Factors from Employers, Peers, Clients and Regular Partners	HIV/AIDS prevention	
	Mean Rank	P-value
Pressure and Influencing Factors		
Influence from employers supporting to use condoms ^a		0.002*
Yes	68.81	
No	48.87	
Influence from work colleagues supporting to use condoms ^a		0.322
Yes	62.60	
No	55.80	
Pressure from work colleagues for not using condom ^a		0.013*
Yes	53.16	
No	68.88	

Table 29 Association between the scores of practices towards HIV/AIDS prevention and pressure & influenced factors from employers, peers, clients and regular partners (Continued)

Pressure & Influenced Factors from Employers, Peers, Clients and Regular Partners	HIV/AIDS prevention	
	Mean Rank	P-value
Pressure from regular partners for not using condom ^b		0.659
Yes	58.76	
No	61.62	

^aMann Whitney U Test;

^bKruskal-Wallis Test;

*Significant level at 0.05

4.2.7 Association between the Practice, the Knowledge and the Attitude of MFSW Respondents towards HIV/AIDS prevention

Table 30 demonstrated that there was no significant association between the score of practice, the knowledge and the attitude of MFSW respondents towards HIV/AIDS prevention.

Table 30 Demonstrate the association between the scores of HIV/AIDS knowledge, attitude of and HIV/AIDS prevention of MFSW respondents (by Spearman Correlation and P-value, n=120)

Knowledge and Attitude of HIV/AIDS	HIV/AIDS prevention	
	Spearman Correlation	p-value
Summary of total HIV/AIDS knowledge	0.005	0.956
Summary of HIV/AIDS attitude	-0.052	0.569

*Significant level at 0.05 level

CHAPTER V

DISCUSSIONS, CONCLUSION AND RECOMMENDATION

5.1 DISCUSSION

Socio-Demographic Characteristics

The majority (52.5%) of MFSW respondents aged between 18 to 24 years old and around 38.3% of them were single women. Mostly, they were Buddhist (90%) and mainly they were Burman (Burmese) (67.5%). Also, 32.5% of them were from Karen State, followed by those who were from Mon State, Yangon Division, Bago Division, Ayeyarwady Division and Shan State. Almost half of them had little Thai communication skills. For Length of stay in Thailand, almost half of them (41.7%) had lived in Thailand for 1-3 years and majority of them (78.5%) worked as FSWs for 1-3 years.

Socio-demographic characteristics of MFSW respondents in this study had similar findings with the other studies about migrants from Myanmar and male sex workers, particularly the study of Shan sex workers in Chiang Rai (Guadamuz et al., 2010). For educational level, 40% of MFSW respondents in this study had only primary education level while Shan male sex workers in Chiang Rai Province had 36.4% of primary level and 34.1% of informal education (Guadamuz et al., 2010).

According to the age of MFSW, many findings demonstrated the same range of the age of sex workers, 56.6% of Shan male sex workers aged between 18-21 years old and 58.9% of FSWs in Nepal were in 20-25-year age group (Singh et al., 2014) and 52.5% of MFSW respondents aged between 18-24 years old for this study. In addition to work place, majority of MFSW respondents worked in the same type of prostitution business as Shan sex workers such as massage shops, karaoke shops and bars.

Also, 40% of FSW in major cities in Myanmar had middle level of education (Swe & Rashid, 2013). Many findings demonstrated the same range of the age of sex workers, 56.6% of Shan male sex workers aged between 18-21 years old, 58.0% of FSW in Myanmar were in 22-29-year age group, 58.9% of FSWs in Nepal were in 20-25-year age group (Singh et al., 2014) and this study 52.5% of MFSW respondents aged between 18-24 years old. In addition to work place, sex workers, particularly MFSW in Thailand and Myanmar worked in the same type of prostitution business (i.e. massage shops, karaoke shops, bars, brothels or prostitution houses) as sex workers in Chiang Rai Province and in major cities in Myanmar (Yangon, Myitkyina, Taunggyi, Mandalay and Lashio). But FSWs in Nepal and India mainly worked in brothels or prostitution houses.

5.1.2 Availability and Accessibility of HIV/AIDS Information and Services

In this study, most of 120 MFSW respondents or 97% (116) had heard about HIV/AIDS while only 4 of them (3.3%) had never heard of HIV/AIDS at all. Among these respondents, 44.2% of them (53) knew about HIV when they migrated to Mae Sot district, Thailand, and 21.7% (26) of them knew about HIV/AIDS since they lived in Myanmar. However, in the other study stated that 100% of FSW respondents in major cities in Myanmar were aware of HIV (Swe & Rashid, 2013).

For HIV/AIDS information, majority of MFSW respondents or 52.5% (63) learned more about HIV/AIDS from both NGO health providers such as staffs and volunteers from Planned Parenthood Association of Thailand (PPAT), World Vision Foundation of Thailand (WVFT) and Mae Tao Clinic (MTC). Almost half or 46.7% (56) of them stated that they got HIV/AIDS information from health providers from government sector, mainly community health volunteers and health professionals from community health centres and Mae Sot Hospital.

About 33.3% (40) of respondents got information about HIV/AIDS from internet, social media (LINE/Facebook), Myanmar TV and radio programme, and 39.1% (47) from posters/leaflets and brochures. While 15% (18) of MFSW got HIV/AIDS information from their employers, agents, bar/café owners, followed by 15.8% (19) those who got information from their regular partners (husband/boyfriends).

For access to condom, most of 120 MFSW respondents could access to condoms. Half of MFSW respondents or 51.7% (62) got free condoms from local NGOs, followed by others who got free condoms from government agencies, those who purchased condoms from drugstore or convenience stores and those got free condoms from employers, prostitution agents and Mama Sang/shop or café owners. Nevertheless, around 50% of MFSW in this study used to get free condoms, such prevention services did not clearly indicate that they performed sufficient preventive practice by using condoms every time during sexual intercourse and did not do any risk behaviour like drinking, using drugs and having more than one regular partners.

In addition to HIV/AIDS blood testing, the majority or 74.2% of MFSW respondents already experience receiving HIV blood testing services. Likewise, nearly a half of the FSWs in Southwest China had ever tested for HIV, and almost 73% had participated in at least one type of HIV prevention activities including condom provision/VCT, needle exchange, and peer HIV/AIDS education (Qiao et al., 2014). Also, 35% of FSW in major cities Myanmar ever had counselling for HIV and 68% already received HIV testing (Swe & Rashid, 2013). According to the study on HIV testing experience among Myanmar migrant workers in Thailand, HIV testing significantly low among Myanmar migrant workers and one of the crucial barrier in accessing to HIV testing is knowing about the places that providing such service (Musumari & Chamchan, 2016). In this study, the barriers in accessing HIV/AIDS testing and services were differ from this study as more

than 90% of migrant worker respondents were registered migrant workers and they worked legally in Thailand. While more than half of MFSW respondents in this study had irregular status (unregistered migrant workers) they performed prostitution works which considered illegal in Thailand. As a result, 40% of them stated that the significant obstacles in accessing HIV blood testing was the fear of arrest by the police officers. Similarity, the study of Ugandan female migrant sex workers in Guangzhou, China stated that the lack of legal documentation was a major barrier to health services access at hospitals. Because many hospitals ask for identification (though not a valid visa specifically). Many of them were afraid that they would be arrested if they went to the hospital (Davis et al., 2016).

Furthermore, the study on condoms and sexual health education as evidence: impact of criminalization of in-call venues and managers on migrant sex workers access to HIV/STI prevention in a Canadian setting revealed that police officers also used condoms as evidence are particularly harmful for migrant sex workers, for whom police contact increases vulnerabilities related to immigration status concerns. In addition to fears of arrest and deportation and language barriers between migrant sex workers and police further frustrates migrant sex workers, who find themselves vulnerable to miscommunication with police and intimidation. Meanwhile, migrant sex workers' individual access to condoms is also constrained by the broader social stigmatization of sex work, including taboos against the purchase of large number of condoms, which

makes it difficult for sex workers to access adequate quantities on their own (Anderson et al., 2016). With this respect, it can be noted that migrant sex workers whether in Thailand, Canada or other countries, they have faced similar barriers in accessing sexual health services. Fear of arrest by police enforcers due to irregular migration status and prostitution works are significant barriers in accessing condoms and other sexual health services.

In addition to other barriers, 37.5% of MFSW respondent worried that they did not have enough money to pay for medical bills. While, others concerned about the lack of mean of transportation and language barrier. Besides, 15.8% (19) of respondents stated that they did not face any problem as they could access to HIV/AIDS out-reach service from Mae Sot Hospital. Health volunteers and officers regularly visited them and provided transportation and referral services from their workplaces to Mae Sot Hospital.



5.1.3 The Level of Knowledge, Attitude, Practices on HIV/AIDS prevention

Nearly 100% (96%) of MFSW respondents had heard of HIV/AIDS however the figure of the level of knowledge of HIV/AIDS prevention did not demonstrate the same results. Only half of them (50.8%) had moderate level of the overall HIV/AIDS knowledge. The other studies also revealed similar findings, over 60% of low pay female sex workers in Southwest China reported that they knew some or a lot about HIV/AIDS, but around

80% perceived a low HIV susceptibility (Qiao et al., 2014). While, the study of FSW in Nepal found that 100% of FSWs had heard about AIDS but 75.3% had HIV/AIDS knowledge (Singh et al., 2014). Also, 95% of FSWs in India heard of HIV, but about 99% of respondents believed that HIV/AIDS could not be prevented (Hemalatha et al., 2011).

In regard to general HIV/AIDS knowledge, none of MFSW respondents had good knowledge and mostly or 87.5% of them had poor knowledge. Besides, only 33.3% (40) of them could provide correct answer on the statement said that “People Living with HIV (PLHIV) may feel well and have no symptoms”. Also, only 34.1% (41) respondents could provide correct answer stating that “HIV/AIDS may take up to 10 years for symptoms to appear”. It can be noted that majority of MFSW respondents seemed to have improper knowledge about HIV/AIDS symptoms that could facilitated further risks on HIV/AIDS infection and transmission.

For knowledge about HIV/AIDS transmission, 60% of MFSW respondents in this study provided correctly answer. Also, the study of Birenda stated that More than two third (82.2%) of respondents thought that a healthy-looking person can be infected with HIV (Singh et al., 2014). While, 42.5% of MFSW in this study disagreed with the fact that having sex with a healthy-looking person would not get HIV/AIDS.

In addition to attitude towards HIV/AIDS prevention, the level of knowledge of MFSW respondents was modestly but significantly highlighted important concerns about their attitudes towards condom use with regular partners (husband, spouse, boyfriend or lover). Around 30-40% of respondents *agreed* that using condoms would cause their regular partner to feel distrusted and they did not use condoms as they thought that condoms were not suitable to use with regular partners. Moreover, 45% of MFSW respondents in this study *agreed* that they might have a chance to get HIV/AIDS due to their sex work profession. However, some respondents still had improper attitude towards condoms use with their regular partners that could also lead to HIV/AIDS infection and transmission. The study of FSW in India also demonstrated similar finding, more than 35 per cent of them felt that they were 'at-risk' for HIV infection (Hemalatha et al., 2011). Also, the majority (42.5%) of FSW in Nepal did not know the level of chance for contracting HIV infection.



In addition to the level of HIV/AIDS prevention among MFSW respondents, majority of them or 66.7% had moderate level of preventive practice. For risk behaviour of MFSW respondents, some of their risk behaviours highlighted crucial concerns. Slightly more than half of respondents or 52.5% stated that they *sometimes* drunk alcohol before and during sexual intercourse and included 17.5% of those whom *often* did such behaviour. However, it was some concerned issues that facilitating them to fall into vulnerable situation or sexual risk behaviour such as using drug and taking alcohol

before and/or during sexual intercourse and condom negotiating with regular partners. Comparing to the study of FSW in India, the practice of alcohol use prior to sex among both FSWs and their clients has a significant association with consistent condom use during paid and unpaid sex (Verma, Saggurti, Singh, & Swain, 2010). Also, in Nepal. More than two third or 71.2% of the respondents had used alcohol during sexual activity and more than half of them or 59.6% had neglected to use condom (Singh et al., 2014).

For drug use, majority or 52.5% of MFSW respondents stated that they had never used drugs before and/or during sexual intercourse. However, up to 37% of them *sometimes* used drugs, which mainly amphetamines before and/or during sexual intercourse. These also included 10% (12) of respondents who *sometime* did it and 6.7% (8) of those who always did the same behaviour.

Comparing to the study of Chinese female sex workers in Southwest China, 3.3% of them had ever used drug and 5.7% had ever been arrested by the police (Qiao et al., 2014). It can be noted that drinking alcohol and taking drugs, particularly amphetamines before or during sexual intercourse could also affect their capacity in performing HIV/AIDS prevention, especially using condom at sex.

In addition to condom use with regular partners, the majority or 60% (70) of MFSW respondents in this study used condoms with their regular partners at sex. Meanwhile, 10% (12) of them stated that they *never* used condoms with their regular partners. Crucially, nearly 30% of MFSW respondents stated that their regular partners did not know that they worked as female sex workers.

Also, 15.8% of them revealed that they had husband and boyfriend at the same time. There was a significant inconsistency of answer about the use of condom which 60% (70) of them stated that they always used condoms with their regular partners but only 20% (24) of them stated that they had never experienced the situation that their regular partners denied using condom at sex. Such contradiction could highlight the issues during the data collection process, including trust relationship, language difficulties, limited of time and etc. that could lead to the inconsistencies of answers of MFSW respondents. Such behaviour demonstrated serious concerns about STI/STDs and HIV/AIDS transmission and infection among Myanmar migrant communities and also their potential clients as there was no consistency in condom use among MFSW and their regular partners.

For condom use with clients, less than half or only 44.2% (53) of all 120 MFSW respondents revealed that they *always* used condoms during sexual intercourse with their clients, and 10.8% (13) of them revealed that they had *never* used condoms with

their clients. Comparing with the other studies, the study on HIV and sex work in Thailand stated that 92.2% of FSW used condom with their last clients (The United Nations General Assembly Special Session on Drugs, 2014). Besides, the study of sex workers in Cambodia revealed that female sex workers working in brothels, guesthouses and karaoke parlors experience a significant vulnerability towards sexual risks. Some brothel based sex workers are pressured to take as many clients as possible by brothel owners or pimps. Consequently, they are at increased risk of HIV infection. Although other women in brothels and karaoke parlors report being paid per guest, they too are vulnerable as they have little discretion over who they will have sex with and limited power to negotiate with them. Moreover, FSW in Cambodia stated that they faced difficulties in negotiating condom use with male clients as they depend upon pleasing these clients for their economic well-being. In the other cases, violence and drunkenness also discouraged condom use during sexual intercourse with their clients (Nishigaya, 2002). Furthermore, less than 39% of FSW in Southwest China reported consistent use of condoms with clients in past months (Qiao et al., 2014). Comparing to the study of FSW in India, condom use in last sex was 91% and 84.7% with occasional and regular clients, respectively. Consistent condom use (CCU) was slightly lesser with regular clients compared to occasional clients and 28.7% of the FSWs could not use condom though they desired (Hemalatha et al., 2011). It can be noted that the situation of MFSW respondents in Mae Sot district was highly differ from general female sex workers in the national surveys both in Thailand and India as

national female sex workers mainly probably had better migration status, protective environment, situation and power situation in facilitating condom use at sex with clients, especially negotiation for condom use.

For MFSW respondents in this study, they had migrant status, mainly illegal migrants who worked illegally as sex workers under Thai law. Many of them had socio-political and economic difficulties background that pushed them to do everything for earning significant income, including not using condom at sex with clients. Such vulnerable situation and low position in power relation towards negotiating on condom use with client affected their condom use behaviour.

There were other factors facilitated or influenced the respondents in performing their HIV/AIDS prevention. 24.1% of these respondents revealed that their employers informed them to please the clients when they denied using condoms, followed by 15% of them who thought they could get more tips and 13.3% of them followed their healthy-looking work colleagues who did not use condoms at sex with clients at all times. Also, 15% of them declared that their regular partners did not want to use condoms every time at sex as it would feel distrusted among each other and 11.7% of them wanted to please their regular partners by not using condoms at sex as he wanted to have more natural feeling and more pleasure. Comparing to the study of FSW in Myanmar, 54.5% of respondents stated that the most common reason for not

using condoms was because their clients refused and those respondents with regular partners who refused to use condoms at sex were at risk of being HIV-positive (Swe & Rashid, 2013).

The Association between the Level of Practice Characteristics and Socio-Demographic Characteristics, Sex Work Characteristics and Sexual Partner Characteristics, HIV/AIDS Information and Service, Pressure and Influencing Factors towards HIV/AIDS Prevention

For association between HIV/AIDS practice and socio-demographic characteristic, sex work characteristics and sexual partner characteristics, HIV/AIDS information and service, pressure and influencing factors towards HIV/AIDS prevention of MFSW respondents, some variables were significantly associated and correlated both positively and negatively. Generally, the findings did not demonstrate significant association, except earning last month which significantly associated with negative correlation ($r = - 0.233$ and $p = 0.010$). It can be noted that the more MFSW earned from their prostitution works, the less HIV/AIDS preventive practice they performed. On the contrary, the study of HIV prevalence and risk behaviours of FSW in Myanmar revealed that FSW respondents who earned less than 200,000 kyats were almost three times at higher odds of being HIV-positive (Swe & Rashid, 2013). However, IOM's study on MFSW in Thailand in 2007 stated similar finding with this study. It was stated that

“FSW with good income may be more insistent on the use of condoms by their clients whereas sex workers who do not make enough money for their daily needs may be more inclined to give into the demands of the clients who do not wish to use condoms” (Swe & Rashid, 2013).

The association between the level of HIV/AIDS practice was significantly associated with these variables, including religion ($p = 0.010$), ethnicity ($p = 0.031$), type and location of prostitution business ($p = 0.002$), HIV/AIDS blood testing ($p = 0.001$), influence from employers in supporting on condom use at sex with client ($p = 0.002$), pressure from work colleagues for not using condom at sex ($p = 0.013$). This study revealed that MFSW respondents who were Buddhist performed less preventive practice than MFSW who were Muslim and Christian. While those who were from Yangon Division and the one who came from Mae La temporary shelter had the highest preventive practice and respondents from Ayeyarwady Division had the lowest preventive practice. On the contrary, the study of FSW in Myanmar stated that FSW who were non-Buddhist and those from ethnic minorities, particularly those from Shan State had higher chance to be HIV-positive (Swe & Rashid, 2013). The difference of these two findings can be explained that this study there was only few MFSW from Shan State (3) and many of MFSW respondents were Burman with Buddhist religion from Ayeyarwady Division (6) that had the lowest level of HIV/AIDS prevention. However, generally MFSW respondents in this study faced more vulnerable situation

that did not facilitate to have decent HIV/AIDS prevention than FSW in Myanmar since they were migrants in Thailand.

For HIV/AIDS blood testing, MFSW who experienced HIV blood testing had better HIV/AIDS prevention than those respondents who never had HIV blood testing. In addition to pressure and influence factors, MFSW who gained support from employers in using condoms during sexual intercourse with clients had better HIV/AIDS prevention than those respondents who did not gain such support. Meanwhile MFSW respondents who had pressure from work colleagues for not using condoms during sexual intercourse with clients had less HIV/AIDS prevention than those who did not have such pressure. Likewise, the study of migrant female sex workers in Canada revealed that they may not have good knowledge in HIV/AIDS prevention as their brothel owners or managers did not allow health outreach to provide free condoms, to do onsite HIV/STI testing and other medical referrals and HIV/AIDS prevention activities due to occupational stigma. Migrant female sex workers stated that their bosses were afraid of the government inspection because this business was not legal, so both migrant sex workers and owners did not support outsiders to come in and give supplies and do blood testing (Anderson et al., 2016).

The association between the level of practice and the type and location of prostitution business was significantly associated ($p = 0.002$). MFSW respondents who worked in

Karaoke shops had the highest level of practice towards HIV/AIDS prevention while those MFSW in prostitution houses had lowest practice. For the zone of prostitution business, zone 2: Outskirt & zone 5: West of Mae Sot district had the highest level of HIV/AIDS preventive practice. While, zone 4: South of Mae Sot district had the lowest level of HIV/AIDS preventive practice. It could imply that MFSW respondents who worked in zone 2 & 5 which was the central area of Mae Sot district had better skills on HIV/AIDS prevention than MFSW respondents who worked in the other zones that did not have a chance to receive HIV services regularly.

Moreover, this can be explained that those respondents in Karaoke shops & cafes had different factors facilitating them to have better HIV/AIDS prevention, including availability of service, particularly out-reach and referral service for HIV blood testing provided by Mae Sot hospital and PPAT and their employers or owners highly collaborative with health service providers. These included allowing health service providers to do out-reach activities in their workplaces, serving as HIV/AIDS peer education members and participate in HIV/AIDS prevention event regularly and ensuring that their sex workers could access health services. While, those respondents who worked for prostitution house, their employer/agent did not make their workplace accessible for service providers, especially HIV blood testing service, and they did not ensure about HIV/AIDS prevention among MFSW and clients, particularly condom use at sex.

For number of years of working as FSW, findings from this study did not demonstrate significant association with HIV/AIDS prevention. While, study of Kunawararak and the study of Shan male sex workers in Mae Sai district, Chiang Rai Province revealed that longer duration of sex work could made them to become more “professional” sex workers, particularly the skills in negotiating on condom use with both male and female clients (Guadamuz et al., 2010).

5.1.5 The associations between the score of practice and knowledge and attitude scores towards HIV/AIDS prevention

According to such finding, it can be explained that it could not assume that MFSW respondents who had good or high knowledge and attitude of HIV/AIDS would be performed good HIV/AIDS prevention. Cultures, socio-economic factors, social norms, believes and power relationships (i.e. gender, economic) also play significant roles in changing attitudes and practice towards HIV/AIDS prevention among MFSW. Generally, MFSW have modest knowledge, attitudes and practice towards HIV/AIDS prevention.

At personal level, they seem to have better attitude and practice. But when they have to deal with power relationship with regular partners like spouses, husbands, boyfriends or lovers and sometime with male clients, the findings clearly pinpoint “power imbalance and gender inequality issues” in negotiation for having safe sex and using condoms with their male sexual partners both regular partners and male clients. Furthermore, in the other studies focusing on sex workers who were from Myanmar,

particularly those ethnic background concluded that HIV/AIDS interventions with cultural sensitivity were needed in order to carry out effective programme implementation (Guadamuz et al., 2010; Swe & Rashid, 2013).

Also, many of MFSW are Buddhist and Christian, working as sex workers is not accepted in their religion believes as well as their cultures. Therefore, some MFSW did not inform their family members and their regular partners about their profession. While, others also did risk behaviours like drinking alcohol and using drugs before or during having sexual intercourse for booting their self-esteem and confident to do provide sexual services for clients as they felt shy and shameful. Besides, some MFSW preferred to respond their clients' need for not using condoms as they wanted to have higher payment for their sexual services.

5.2 CONCLUSION

Although Thailand reached its success implementing HIV/AIDS prevention and particularly reducing HIV prevalence and mother-to-child-transmission (MTCT) rate, Thailand still has problem of HIV rapid spread among men who have sex with men (MSM) sex workers and drug-users crucial proportion of MFSW respondents. This study revealed that generally, MFSW respondents had *moderate* level of overall knowledge, attitude and practice towards HIV/AIDS prevention. Also, only some type of socio-demographic characteristic of MFSW respondents demonstrated significant association

and correlation with their HIV/AIDS prevention, including religion ($p = 0.010$), ethnicity ($p = 0.031$) and hometown ($p = 0.001$) and earning last month ($r = - 0.233$ and $p = 0.010$) with negative correlation.

For sex work characteristic, type and location of prostitution business ($p = 0.002$) was significantly associated with positive correlation. While sexual partner characteristics (client and regular partner characteristics) did not demonstrate any significant. In addition to availability and accessibility to HIV/AIDS information and service, there was only HIV/AIDS blood testing ($p = 0.001$) that significantly associated with the level of practice towards HIV/AIDS prevention.

In regard to the association between the level of practice and knowledge and attitude of MFSW respondents towards HIV/AIDS prevention, there was no statistically significant association. However, there were numbers of misunderstanding and misconceptions about HIV/AIDS among MFSW respondents and their practices also correlated with barriers or influencing factors. With this respect, it is very important to improve their knowledge, attitude and particularly practices on HIV/AIDS prevention. In conclude, the findings of this study address hidden critical alarms for more opportunity for HIV infection and transmission among MFSW in Mae Sot district and other areas in Thailand which also similar to the findings of other studies. According to Joint United Nations Initiative on Migration, Health and HIV in Asia, Thailand reaches numbers of success in

combating HIV/AIDS, prevalence of HIV/AIDS infection among sex workers, still keep increasing.

5.3 RECOMMENDATION

Since Mae Sot district become a special economic zone and a Western ASEAN Economic Corridor, it is very important to implement critical and comprehensive HIV/AIDS programme interventions urgently for responding such critical situation.

Initial baseline studies and survey on HIV/AIDS, particularly HIV/AIDS prevalence among Burmese migrants, including MFSW in Mae Sot district should be carried out for assessing the situations, problems and upcoming issues and identifying strategic interventions. Such interventions will highly benefit to the work of health providers in Mae Sot district. Furthermore, health workers in Mae Sot district have to carry out proactive actions in reaching MFSW for building trust relationship and facilitating them to have better opportunity in accessing the service (e.g. HIV blood testing and condom distribution). Meanwhile, programme intervention for controlling and monitoring the situation of HIV/AIDS infection and transmission such as HIV screening and referral for treatment need to be carried out urgently.

At the same time, HIV/AIDS prevention interventions like communication for behaviour changing as well as condom distribution and usage need to be carried out among MFSW, potential clients, employers and regular partners. Crucially, HIV/AIDS prevention programme interventions for educating, raising awareness and promoting safe sex and HIV prevention should be carried out specifically for other influential persons around MFSW like regular partners, clients and employers. Also, HIV blood testing service programme should be implemented for providing accessible and friendly services and it could be one of the best way to advocate on HIV/AIDS awareness and prevention. Furthermore, overall HIV/AIDS interventions should pay attention on cultural sensitivity into every intervention and programme activities. Since this study has demonstrated numbers of limitations and difficulties in conducting data collection of MFSW in Mae Sot district that demonstrated some contradiction of answers of MFSW respondents. For further studies, it needed to pay more attention with factors or difficulties, including language barrier due to different ethnic background, interviewing skills, building trust relationship with female sex workers that could affected the results of the study.

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APPENDICES



จุฬาลงกรณ์มหาวิทยาลัย
CHULALONGKORN UNIVERSITY

APPENDIX A

**Questionnaires Survey: Knowledge, Attitude, Practice towards HIV/AIDS
Prevention among Myanmar Female Sex Workers in Mae Sot district, Tak
Province, Thailand**

Interviewed Date: _____ Ref. Code: _____

Interview Team member: _____

Part I: Socio Demographic Characteristics (15 Questions: No.1-15)

1. How old are you? Age _____ Years

2. What is your ethnicity?

1) Burmese 2) Karen 3) Kayah 4) Mon 5) Other, specify _____

3. What is your religion?

1) Buddhist 2) Muslim 3) Christian 4) Other, specify _____

4. What is your marital status?

1) Single 2) Married 3) Divorced 4) Widow

5. Do you have children? 0) No 1) Yes, I have _____ children

6. What is your educational level?

1) Never went to school and illiterate (cannot read or write)

2) Never went to school but literate (can read or write)

3) Primary Education 4) Secondary Education 5) Higher Education, specify

7. Can you communicate in Thai?

- 0) No 1) Yes, with a little conversation skill 2) Yes, very good conversation skill

8. Your Hometown in Myanmar _____ (Township)

9. What is your migration status in Thailand?

- 1) Unregistered migrant workers 2) Registered migrant workers 3) Other _____

10. How long have you been working as a Commercial Sex Worker? ____ Years

11. How long have you been living in Thailand? ____ Year (s)

12. During the past 3 months, how much you earn generally from providing sexual services from each client? _____ (Baht)

13. How many clients you provide sexual services per day (average)? _____ (Clients)

14. How much you earn from providing sexual services to clients last month? (Baht)

- 1) Less than 4,000 Baht, specify _____
- 2) 4,000-5,000 Baht 3) 5,001-6,000 Baht
- 4) 6,001-7,000 Baht 5) More than 7,000, specify _____

Part II: Sexual Partner Characteristics (6 Questions: No.16-21) *Instruction: Please answer and please tick (✓) on the following questions*

15. Regular Partners Characteristics	Yes	No
<ul style="list-style-type: none"> Do you have regular partner? <p>If yes, please answer the following questions, if no, please answer question no.18</p>		
<ul style="list-style-type: none"> Do you have regular partner who is <i>husband or spouse</i>? 		
<ul style="list-style-type: none"> Do you have regular partner who is <i>boyfriend or lover</i>? 		

16. Did your regular partner (s) know about your profession?

0) No 1) Yes

17. Client Characteristics	Yes	No
<ul style="list-style-type: none"> Do you have clients whom regularly visited you? 		
<ul style="list-style-type: none"> Do you have regular clients? 		
<ul style="list-style-type: none"> Do you have clients whom had become your boyfriends or lover? 		

Part III. Availability of to HIV/AIDS Information & Services (7 Questions: No.18-24)

Please answer questions and please tick (✓) on the following questions

18. Have you ever heard about HIV/AIDS?

1) Yes, I do (please answer question no.23) 0) No, if No, skip to no.24)

19. If yes, when you know about it? (Only one answer)

1. I knew about HIV/AIDS since I lived in Myanmar.
2. I knew about HIV/AIDS since I migrated to Mae Sot district.
3. I did not know about HIV/AIDS when I migrated to Thailand but I know only when I work as FSW in Mae Sot.
4. I knew about HIV/AIDS both when I was in Myanmar and in Thailand.

20. In Thailand, from where did you hear or learn more about HIV/AIDS issue, particularly HIV/AIDS prevention during the last 3 months? (Yes/No answers)

Source of information about HIV/AIDS	Yes	No
<i>Instruction: Please tick (✓) in the appropriate blank tables</i>		
❖ Internet or social media (Line/Facebook)		
❖ Myanmar TV/Radio		
❖ Posters/Leaflets/Brochures		
❖ Employers/Agents/ Bar, Shop or Café owners		
❖ Peers/Colleagues & Peer Educators		
❖ Clients		
❖ Regular sex partners (Boyfriend/Husband)		
❖ Family members & relatives		
❖ NGO health providers e.g. staffs & volunteers from PPAT, WW & MTC		
❖ GO health providers from e.g. Community Health Volunteers & Mae Sot Hospital		
❖ Others, please specify _____		

Part IV: Knowledge of HIV/AIDS (15 Questions: No. 25-39)

Questions and Statements		Knowledge of HIV/AIDS		
<i>Instruction:</i> For each statement, please tick (✓) (True/False/Don't know) about your knowledge of HIV/AIDS (Only One Answer)				
4.1 General Knowledge of HIV/AIDS (4 Questions: No. 25-28)		True	False	Don't know
25.	HIV is a virus which attacks the human immune system, the body's defence against disease.	✓ 1	0	0
26.	Person with HIV may feel completely well and have Symptoms.	✓1	0	0
27.	Having blood test for HIV is the only way to ensure that you are HIV infected.	✓ 1	0	0
28. *	People living with HIV/AIDS can survive without treatment	0	✓1	0
4.2 HIV/AIDS Symptoms (5 Questions: No.29-33)		True	False	Don't know
29.	One of HIV/AIDS symptoms are included prolong fever, headache and sore throat.	✓1	0	0
30	One of HIV/AIDS symptoms are included swollen glands, lymph nodes, rash and having white spots or unusual blemishes on the tongue, in the mouth or in the throat.	✓1	0	0
31.	One of HIV/AIDS symptoms are included chronic Diarrhoea (more than a week) and weight loss.	✓1	0	0
32.	One of HIV/AIDS symptoms are included fatigue and lack of energy	✓1	0	0
33.	In some cases, HIV/AIDS may take as many as ten years for more severe symptoms to appear.	✓1	0	0

4.3 HIV/AIDS Transmissions (6 Questions: No.34-39)		True	False	Don't know
34.	HIV/AIDS can be transmitted via the exchange of a variety of body fluids from infected individuals, such as blood, breast milk, semen and vaginal secretions.	√1	0	0
35. *	There is absolutely no risk of HIV transmission when having body piercing and tattooing in the place that shared instruments contaminated with blood without sterilizing or changing new needles between clients.	0	√1	0
36. *	There is absolutely no risk of HIV transmission when visiting the barber that sharing instruments contaminated with blood without sterilizing or changing new blades between clients.	0	√1	0
37. *	People can get HIV/AIDS by using the same toilet	0	√1	0
38.*	People can get HIV/AIDS by kissing and drinking from the same glass.	0	√1	0
39. *	People can get HIV/AIDS by massage, hugging and touching.	0	√1	0

Part V: Attitude toward HIV/AIDS Prevention (10 Questions: No. 40-49)

Questions and Statements		Attitude of HIV/AIDS				
		SA	A	NS	DA	SD
<p>Instruction: For each statement, please tick (✓) whether you: Strongly Agree = SA, Agree = A, Not Sure = NS, Disagree = DA, or Strongly Disagree = SD</p>						
40. *	I think, having sex with a healthy looking person will not get HIV/AIDS.	1	2	3	4	5
41. *	I think, having sexual intercourse with clients, especially regular clients, there is no need to use condom.	1	2	3	4	5
42*	I think, having sexual intercourse with regular partners, especially husband, spouse or boyfriends, there is no need to use condom.	1	2	3	4	5
43.*	I think, a condom is not suitable to use with a regular partner (boyfriend/spouse/lover).	1	2	3	4	5
44.*	I think, using condoms would cause my regular partner (husband, spouse or boyfriends) to feel distrusted.	1	2	3	4	5
45.	I think taking HIV screening is very important for high risk group like sex workers.	5	4	3	2	1
46.	I think taking HIV screening is very important for high risk group like injecting drug users.	5	4	3	2	1
47.	In my view, people living with HIV should inform health personals, including doctors, nurses, dentists, health service providers or health volunteers that they are HIV infected for having the best medical services.	5	4	3	2	1
48.	Due to my profession as female sex workers, I think I may have a chance to get STI/STDs infection.	5	4	3	2	1
49.	Due to my profession as female sex workers, I think I may have a chance to get HIV/AIDS infection.	5	4	3	2	1

Part VI: Influence or Pressure from Peers, Employers, Clients and Regular Partners and Obstacles towards HIV/AIDS Prevention (4 Questions: No. 50-53)

Instruction: Please answer questions and please tick (✓) your answers on the following questions

50. What is the most significant influence from employers that supporting you in using condoms during sexual intercourse with clients? (Only one answer)

- 1. My employers tell me about HIV/AIDS risks and take care of my health.
- 2. My employers always provide me condoms and insist me to use them.
- 3. My employers help me to deal with clients in negotiating with clients on condom using.
- 4. My employers set regulation and work practice in enforcing my clients, myself and my work colleagues in using condoms every time during sexual intercourse.
- 5. There is no support from employer in using condom.

51. What is the most significant influence from work colleagues, peers or peer educators supporting you in using condoms during sexual intercourse with clients? (Only one answer)

- 1. My friends, who are peer educators told me about HIV/AIDS risks, provide condoms and insist me to use them for prevention.
- 2. My friends at workplace tell me about HIV/AIDS risks and insist me to use condoms for prevention.
- 3. My friends or someone I knew have suffered and died from HIV/AIDS so I am aware of HIV/AIDS infection and I always use condom for prevention.
- 4. My friends teach and help me in dealing with clients whom refused to use condoms.
- 5. There is no influence from friends, peers educators supporting me in using condom.

52.* What is the most significant pressure from friends, work colleagues, peers and employers towards you for not using condom during sexual intercourse with clients? (Only one answer)

- 1. My employers ask me to response clients' needs. If they prefer not using condoms, I should response their needs.
- 2. My friends, work colleagues or employers said that I would get more clients and more tips if I have sexual intercourse with clients without using condoms.
- 3. My work colleagues said that it is not necessary to use condom every time during sexual intercourse with clients and they are fine so I follow them.
- 4. My friends and work colleagues said that it is more fun and pleasure in having sexual intercourse without condom with clients.
- 5. There is no significant pressure from friends work colleagues, peers and employers towards me for not using condom.

53.* What is the most significant pressure from regular partners (husband/boyfriends/lovers) that pressuring you for not using condom during sexual intercourse? (Only one answer)

- 1. My regular partner usually does not get free condoms and me neither so if both of us has to buy condom ourselves, it would waste money so we prefer not to use it.
- 2. My regular partners did not want to use condoms during sexual intercourse as he wanted to have natural feeling, more fun and pleasure.
- 3. My regular partner (s) does not want to use condoms during sexual intercourse and we would feel distrust if we used condoms.
- 4. I have clients who have becomes my regular partner (as a husband/lover/boyfriend) so we prefer not to use condom as we trust each other.
- 5. There is no significant pressure from regular partners in pressuring me for not using condom

Part VII. Preventive sexual practice with male clients/regular partners (negotiation on condom using and condom used at sex) (10 Questions: No.54-63):

Instruction: Please answer questions and please tick (✓) on the following questions of situation occurring during the last 3 months.

No	Preventive sexual practice	Always	Often	Some times	Never
54.*	I consume alcohol before/during sexual intercourse	0	1	2	3
55.*	I consume drugs before/during sexual intercourse	0	1	2	3
56.	I used condom (s) with my regular partner (s) during sexual intercourse.	3	2	1	0
57.	I insist my regular partner (s) to use condom during sexual intercourse.	3	2	1	0
58.*	I experienced the situation that my regular partner (s) denied using condom during sexual intercourse.	0	1	2	3
59.	When my client (s) denied using condom during sexual intercourse, I tried to convince and to insist him (them) to use condom.	3	2	1	0
60.	I meet success in convincing and insisting my regular partner (s) to use condom during sexual intercourse.	3	2	1	0
61.	When my regular partner (s) denied using condom, I refused to have sexual intercourse with him (them).	3	2	1	0
62.	During the last 3 months, I have been using condoms during sexual intercourse with my clients.	3	2	1	0
63.	During the last 3 months, I have been using condoms during sexual intercourse with my regular partner (s).	3	2	1	0

APPENDIX B

แบบสอบถาม: “ความรู้ เจตคติและการปฏิบัติต่อการป้องกันโรคเอดส์
ของหญิงบริการชาวเมียนมาในอำเภอแม่สอด จังหวัดตาก ประเทศไทย”

วันที่สัมภาษณ์ (Interviewed Date): _____ รหัสอ้างอิง (Ref. Code): _____

ผู้ทำการสัมภาษณ์ (Interview Team members) _____

ส่วนที่ 1: ลักษณะทางสังคมและประชากร (จำนวน 14 คำถาม ข้อ 1-14) โปรดตอบ

คำถาม โดยทำเครื่องหมาย (✓) หน้าคำตอบสำหรับคำถามดังต่อไปนี้

1. คุณมีอายุกี่ปี _____ ปี ?
2. คุณมีเชื้อชาติอะไร? 1) พม่า 2) กระเหรี่ยง 3) คะยา 4) มอญ
 5) อื่น ๆ, โปรดระบุ _____
3. คุณนับถือศาสนาอะไร? 1) พุทธ 2) อิสลาม 3) คริสเตียน
 4) อื่น ๆ, โปรดระบุ _____
4. คุณมีสถานะทางครอบครัวแบบใด? 1) โสด 2) แต่งงาน 3) หย่าร้าง
 4) เป็นม่าย
5. คุณมีลูกหรือไม่ หากมี จำนวนกี่คน? 0) ไม่มี 1) ใช่, ฉันมีลูก _____ คน
6. คุณสำเร็จการศึกษาในระดับใด?
 1) ไม่ได้เข้าเรียนและไม่รู้หนังสือ อ่านไม่ออกหรือเขียนไม่ได้
 2) ไม่ได้เข้าเรียนแต่รู้หนังสือ อ่านออกหรือเขียนได้
 3) การศึกษาระดับประถม 4) การศึกษาระดับมัธยมต้น
 5) การศึกษาระดับมัธยมปลายหรือสูงกว่า, โปรดระบุ _____
7. คุณสามารถสื่อสารเป็นภาษาไทยได้หรือไม่?
 0) ไม่สามารถ 1) มีทักษะสามารถสนทนาได้เล็กน้อย 2) ใช่, ฉันมีทักษะสนทนาภาษาไทยได้ดี
8. ภูมิลำเนาของคุณในประเทศพม่าอยู่ที่ใด? _____
9. คุณมีสถานะในการย้ายถิ่นฐาน สถานะทางกฎหมายเข้ามาทำงานในประเทศไทยประเภทใด ?
 1) แรงงานต่างชาติที่ไม่จดทะเบียน 2) แรงงานต่างชาติที่จดทะเบียน
 3) อื่นๆ _____
10. คุณทำงานการให้บริการทางเพศมานานเท่าใด? _____ ปี

11. คุณอาศัยอยู่ในประเทศไทยมานานเท่าใด? _____ ปี
12. ในระยะเวลา 3 เดือนที่ผ่านมา คุณได้รับตอบแทนในการขายบริการทางเพศจากลูกค้าต่อคนเป็นจำนวนเท่าไร? _____ บาท
13. ในระยะเวลา 3 เดือนที่ผ่านมา แต่ละวันคุณให้บริการแก่ลูกค้าโดยเฉลี่ยกี่คน? _____ คน
14. ในเดือนที่ผ่านมา คุณมีรายได้จากการขายบริการทางเพศจำนวนเท่าไร?
- 1) น้อยกว่า 4,000 บาท, ระบุ _____ 2) 4,000-5,000 บาท 3) 5,001-6,000 บาท
- 4) 6,001-7,000 บาท 5) มากกว่า 7,000 บาท, ระบุ _____

ส่วนที่ 2: คุณลักษณะของคู่นอน (sexual partners) จำนวน 3 คำถาม ข้อที่ 15-17)

โปรดตอบคำถามโดยทำเครื่องหมาย (✓) หน้าคำตอบสำหรับคำถาม ใช่/ไม่ใช่/

15. คุณลักษณะของคู่นอนประจำ (regular partner)	มี	ไม่มี
• คุณมีคู่นอนประจำหรือไม่? หาก มี กรุณาตอบคำถามดังต่อไปนี้ หาก ไม่มี กรุณาตอบคำถามข้อ 17		
• คุณมีคู่นอนประจำที่มีสถานะเป็นสามีหรือคู่ครองหรือไม่?		
• คุณมีคู่นอนประจำที่มีสถานะเป็นแฟนหรือคนรักหรือไม่?		

16. คู่นอนประจำ (regular partners) ของคุณรับรู้เกี่ยวกับอาชีพขายบริการของคุณหรือไม่?

- 0) รู้ 1) ไม่รู้

17. คุณลักษณะของลูกค้า (client characteristic)	ใช่	ไม่ใช่
• คุณมีลูกค้าประจำ (regular clients หรือ repeated customers) ที่ใช้บริการเป็นประจำหรือไม่?		
• คุณมีลูกค้าประจำที่จ่ายค่าตอบแทนในการให้บริการเป็นรายครั้งหรือไม่?		
• คุณมีลูกค้าที่กลายเป็นแฟนหรือคู่รักกับคุณหรือไม่?		

ส่วนที่ 3 : การได้รับข้อมูลและการให้บริการเกี่ยวกับโรคเอดส์/เอชไอวี/เอดส์ จำนวน 7 คำถาม: ข้อ 18-24

โปรดตอบคำถามโดยทำเครื่องหมาย (✓) หน้าคำตอบสำหรับคำถามดังต่อไปนี้

18. คุณเคยได้ยินเกี่ยวกับโรคเอดส์/เอชไอวี/เอดส์หรือไม่?

- 1) ใช่ เคยได้ยิน/รับรู้ (ตอบคำถามข้อ 19) 0) ไม่ใช่ (ถ้าไม่เคยได้ยินข้ามไปตอบข้อที่21)

19. หากเคย ได้ยินเกี่ยวกับโรคเอดส์/เอชไอวี/เอดส์เมื่อใด?

1. ฉันรู้เกี่ยวกับโรคเอดส์/เอชไอวี/เอดส์ตั้งแต่อยู่ที่พม่า
 2. ฉันรู้เกี่ยวกับโรคเอดส์/เอชไอวี/เอดส์เมื่อฉันย้ายมาอยู่แม่สอด
 3. ฉันไม่รู้เกี่ยวกับโรคเอดส์/เอชไอวี/เอดส์เมื่อฉันมาอยู่ไทย แต่ได้รับรู้เกี่ยวกับโรคนี้เมื่อมาทำงานขายบริการที่แม่สอด
 4. ฉันรู้เกี่ยวกับโรคเอดส์/เอชไอวี/เอดส์ทั้งตอนที่อยู่พม่าและที่ไทย

20. ในประเทศไทย คุณได้รับรู้หรือเรียนรู้เกี่ยวกับโรคเอดส์/เอชไอวี/เอดส์ โดยเฉพาะการป้องกันโรคเอดส์/เอชไอวี/เอดส์จากที่ไหนในระยะเวลา 3 เดือนที่ผ่านมา?

แหล่งข้อมูลเกี่ยวกับโรคเอดส์/เอชไอวี/เอดส์	ใช่	ไม่ใช่
โปรดทำเครื่องหมาย (✓) ในช่องที่เหมาะสม		
อินเทอร์เน็ตหรือสื่อทางสังคม (ไลน์/เฟสบุ๊ก)		
รายการโทรทัศน์/วิทยุของประเทศพม่า		
โปสเตอร์/แผ่นพับ/โบรชัวร์		
นายจ้าง/นายหน้า/เจ้าของบาร์ ร้าน หรือคาเฟ่		
เพื่อน/เพื่อนร่วมงาน & แกนนำให้ความรู้		
ลูกค้า (ผู้ซื้อบริการทางเพศ)		
คู่นอนประจำ (แฟน/สามี)		
สมาชิกในครอบครัว & ญาติพี่น้อง		
บุคคลากรทางสาธารณสุขจากองค์กรพัฒนาเอกชน เช่น จนท. & อาสาสมัคร จาก สวท ศุภนิมิตร .& แม่ตาวคลินิก		
บุคคลากรทางสาธารณสุขจากภาครัฐ เช่น อาสาสมัครชุมชน & จนท จาก รพ.แม่สอด		
อื่น ๆ โปรดระบุ _____		

21. คุณได้รับรณรงค์จากที่ไหน? (ตอบได้มากกว่า 1)

1. ผู้ให้บริการสาธารณสุขจากองค์กรพัฒนาเอกชน (NGOs & แม่ตาวคลินิก เช่น จนท. & อาสาสมัคร (NGO)
 2. ผู้ให้บริการสาธารณสุขจากภาครัฐ เช่น จนทสาธารณสุขและจนท.แพทย์จากกระทรวงสาธารณสุข.
 3. นายจ้าง/นายหน้า/มาฆ่าช่าง/เจ้าของร้านหรือคาเฟ่
 4. ร้านขายยา/ร้านสะดวกซื้อ 5. ลูกค้าผู้ซื้อบริการ
 6. เพื่อนร่วมงาน/เพื่อนฝูง 7. แกนนำให้ความรู้ 8. อื่นๆ โปรดระบุ _____

22. คุณเคยได้รับการตรวจเลือดเพื่อหาเชื้อเอชไอวีหรือไม่?

- 1) ใช่ ฉันเคยตรวจ 0) ไม่ใช่ ฉันไม่เคยตรวจ

23. หากเคยได้รับการตรวจ คุณได้รับการจากที่ไหน การประสานงานการส่งต่อและการให้

คำปรึกษาก่อนการตรวจเลือดโดยสมัครใจ หรือ VCT)? (ตอบได้มากกว่า1)

- 1) บริการหน่วยเคลื่อนที่เอชไอวี/เอดส์โดยจนท.NGO 2) บริการหน่วยเคลื่อนที่เอชไอวี/เอดส์โดยจนทภาครัฐ.
 3) หน่วยสาธารณสุขของกระทรวงสาธารณสุขที่ใกล้เคียง 4) เข้าตรวจที่คลินิกเอกชน/โรงพยาบาลเอกชน
 5) รพแม่สอด. 6) แม่ตาวคลินิก 7) อื่นๆ โปรดระบุ _____

24. อะไรที่เป็นอุปสรรคสำคัญของคุณในการเข้าถึงการบริการตรวจเลือดเพื่อคัดกรองเชื้อเอชไอวี?
(ตอบได้มากกว่า1)

- 1) ไม่มีเงินจ่ายค่ารักษาพยาบาล 2) กลัวการถูกจับกุมโดยเจ้าหน้าที่ตำรวจ
 3) ไม่มีรถโดยสาร 4) ข้อจำกัดทางภาษา 5) เหตุผลอื่นๆ โปรดระบุ _____

ส่วนที่ 4 : ความรู้เกี่ยวกับโรคเอชไอวี/เอดส์ (15 คำถาม: ข้อ 25-39)

โปรดทำเครื่องหมาย)v) หน้าคำตอบ(ถูก/ผิด/ไม่ทราบ)ในแต่ละประโยคคำถามเกี่ยวกับความรู้ของท่านเกี่ยวกับโรคเอชไอวีเอดส์/			
4.1 ความรู้ทั่วไปเกี่ยวกับโรคเอดส์ (4 คำถาม : ข้อ. 25-28)	ถูก	ผิด	ไม่ทราบ
25. เชื้อเอชไอวี เป็นไวรัส ที่โจมตีระบบ ภูมิคุ้มกันของมนุษย์ และ การป้องกันเชื้อโรคของร่างกาย			
26. คนที่มีเชื้อเอชไอวี อาจจะรู้สึกว่าร่ากาย สมบูรณ์ดีและไม่มีอาการ			
27. การตรวจเลือดเพื่อหาเชื้อเอชไอวี เป็นวิธีเดียวที่ยืนยันว่าคุณติดเชื้อเอชไอวี?			

28.*	คนที่ติดเชื้อเอชไอวี/เอดส์สามารถมีชีวิตอยู่รอดได้โดยไม่ต้องรับรักษา			
4.2 อาการของโรคเอดส์)5 คำถาม : ข้อ. 29-33)		ถูก	ผิด	ไม่ทราบ
29.	หนึ่งในอาการของโรคเอชไอวีเอดส์คือ มีไข้เป็นระยะๆ/ เวลานาน ปวดศีรษะ เจ็บคอ			
30.	หนึ่งในอาการของโรคเอชไอวีเอดส์คือ มีไข้เป็นระยะๆ/ เวลานาน ปวดศีรษะ เจ็บคอ ต่อม้ำเหลืองบวม มีผื่น และมี จุดสีขาว หรือ สีว ที่ผิดปกติในลิ้น ปาก หรือ ใน ลำคอ			
31.	หนึ่งในอาการของโรคเอชไอวี เอดส์คือ/ท้องเสีย เรื้อรัง (มากกว่า สัปดาห์) น้ำหนักลด			
32.	หนึ่งในอาการของโรคเอชไอวี เอดส์คือ/เมื่อยล้า และไม่ มีเรี่ยวแรง (ไม่มีแรง)			
33.	ในบางกรณี โรคเอชไอวีเอดส์ใช้เวลานับสิบปีจึงจะ/ ปรากฏอาการรุนแรง			
4.3 การติดต่อของโรคเอชไอวี/เอดส์ (6 คำถาม: ข้อ 34-39)		ถูก	ผิด	ไม่ทราบ
34.	โรคเอชไอวี/เอดส์ สามารถติดต่อทางการได้รับการ แลกเปลี่ยน สารคัดหลั่งจากผู้ติดเชื้อ เช่น เลือด น้ำนม น้ำอสุจิ และสารคัดหลั่งจากช่องคลอด			
35.*	ไม่มีความเสี่ยงในการแพร่เชื้อเอชไอวีอย่างแน่นอน เมื่อ มีการเจาะร่างกาย การสักยันต์ โดยมีการใช้เครื่องมือที่ มีการสัมผัสกับเลือดร่วมกันระหว่างลูกค้า โดยปราศจาก การฆ่าเชื้อ หรือไม่มีการเปลี่ยนเข็มฉีดยาอันใหม่			
36.*	ไม่มีความเสี่ยงในการแพร่เชื้อเอชไอวีอย่างแน่นอน เมื่อ เข้าใช้บริการในร้านตัดผมชายโดยมีการใช้เครื่องมือที่มี การสัมผัสกับเลือดร่วมกันระหว่างลูกค้า โดยปราศจาก การฆ่าเชื้อ หรือไม่มีการเปลี่ยนใบมีดอันใหม่			
37.*	คนเราสามารถติดโรค เอชไอวี เอดส์ โดยการใช้ / ห้องน้ำห้องร่วมกัน			
38.*	คนเราสามารถติดโรค เอชไอวี เอดส์ โดยการจูบและ / ตีมาจากแก้วเดียวกัน			
39.*	คนเราสามารถติดโรค เอชไอวี เอดส์ โดย การนวด / กอดและสัมผัส			

ส่วนที่ 5: เจตคติต่อการป้องกันโรคเอชไอวี/เอดส์ (10 คำถาม: ข้อ 40-49)

ในแต่ละประโยคคำถามโปรดทำเครื่องหมาย ✓ ในคำตอบว่าท่าน : = เห็นด้วยอย่างยิ่ง SA, เห็นด้วย =A, ไม่แน่ใจ =NS, ไม่เห็นด้วย =DA หรือ ไม่เห็นด้วยอย่างยิ่ง =SD		ความรู้ด้านโรคเอชไอวี/ เอดส์				
		SA	A	N S	D A	SD
40.*	ฉันคิดว่าการมีเพศสัมพันธ์กับคนที่ดูมีสุขภาพดีจะไม่มีทางติด โรคเอชไอวี/ เอดส์					
41.*	ฉันคิดว่าการมีเพศสัมพันธ์กับลูกค้า โดยเฉพาะอย่างยิ่งกับ ลูกค้าขาประจำ มันไม่จำเป็นต้องใช้ถุงยางอนามัย					
42.*	ฉันคิดว่าการมีเพศสัมพันธ์กับคู่นอนประจำ โดยเฉพาะอย่างยิ่ง กับสามี คู่สมรส หรือแฟน มันไม่จำเป็นต้องใช้ถุงยางอนามัย					
43.*	ฉันคิดว่าถุงยางอนามัยไม่เหมาะที่จะใช้กับคู่นอนประจำ (แฟน/คู่สมรส/คนรัก)					
44*	ฉันคิดว่าการใช้ถุงยางอนามัยกับคู่นอนประจำ แฟน/คู่ สมรส/คนรัก)จะเป็นสาเหตุให้คู่นอนประจำของฉันรู้สึกไม่ ไว้วางใจ					
45.	ฉันคิดว่าการตรวจเลือดเพื่อเชื้อเอชไอวีเป็นสิ่งที่สำคัญสำหรับ กลุ่มเสี่ยง อย่างเช่นหญิงบริการ					
46.	ฉันคิดว่าการตรวจเลือดเพื่อเชื้อเอชไอวีเป็นสิ่งที่สำคัญสำหรับ กลุ่มเสี่ยง อย่างเช่นผู้เสพยาเสพติดโดยใช้เข็มฉีดยา					
47.	ในมุมมองของฉัน คนที่ติดเชื้อเอชไอวีควรแจ้งให้บุคลากรทาง สาธารณสุข รวมทั้ง แพทย์พยาบาล ทันตแพทย์ ผู้ให้บริการ ทางสุขภาพหรือ อาสาสมัครสาธารณสุขให้ทราบว่าพวกเขา เป็นผู้ติดเชื้อเพื่อที่ว่าพวกเขาจะได้รับบริการทางการแพทย์ที่ ดีที่สุด					
48.	เนื่องด้วยอาชีพของฉันคือหญิงบริการฉันคิดว่าฉันน่าจะมี โอกาสเสี่ยงที่จะติดโรคติดต่อทางเพศสัมพันธ์					
49.	เนื่องด้วยอาชีพของฉันคือหญิงบริการฉันคิดว่าฉันน่าจะมี โอกาสเสี่ยงที่จะติดโรคเอชไอวี เอดส์ /					

ส่วนที่ 6: อิทธิพลหรือแรงกดดันจากเพื่อน นายจ้าง ลูกค้าและคุ่นอนประจำและอุปสรรคในการป้องกันโรคเอชไอวี/เอดส์)4 คำถาม: ข้อ 50-54)

50. การกระทำใดจากนายจ้างที่มีอิทธิพลที่สำคัญที่สุดในการสนับสนุนให้คุณใช้ถุงยางอนามัยขณะมีเพศสัมพันธ์กับลูกค้า? (ตอบเพียงข้อเดียว)

- 1. นายจ้างของฉันบอกเกี่ยวกับอันตรายของโรคเอชไอวี/เอดส์ และให้ฉันดูแลสุขภาพตัวเอง
- 2. นายจ้างของฉันแจกถุงยางและกำชับให้ฉันใช้เป็นประจำ
- 3. นายจ้างของฉันช่วยฉันเจรจาและจัดการกับลูกค้าในการใช้ถุงยาง
- 4. นายจ้างของฉันตั้งกฎระเบียบข้อปฏิบัติในการบังคับให้ลูกค้าของฉัน ตัวฉันและเพื่อนร่วมงานใช้ถุงยางทุกครั้งเมื่อมีเพศสัมพันธ์
- 5. ฉันไม่ได้รับการสนับสนุนใดๆ จากนายจ้างในการใช้ถุงยาง

51. อิทธิพลจากเพื่อนร่วมงาน เพื่อนคนอื่น ๆ และแกนนำ (Peer Educators) ใดที่สำคัญที่สุดในการสนับสนุนคุณเพื่อใช้ถุงยางอนามัยขณะมีเพศสัมพันธ์ กับลูกค้าผู้ให้บริการทางเพศ? (ตอบเพียงข้อเดียว)

- 1. เพื่อนของฉันที่เป็นแกนนำ (Peer Educators) บอกฉันเกี่ยวกับอันตรายของโรคเอชไอวี/เอดส์ ได้ให้ถุงยางอนามัยและรับรู้ว่าให้ฉันใช้ถุงยางอนามัยเพื่อการป้องกัน
- 2. เพื่อนร่วมงานของฉันบอกฉันเกี่ยวกับอันตรายของโรคเอชไอวี/เอดส์ได้ให้ถุงยางอนามัยและรับรู้ว่าให้ฉันใช้ถุงยางอนามัยเพื่อการป้องกัน
- 3. เพื่อนของฉันหรือคนที่ฉันรู้จักป่วยเป็นโรคเอดส์และเสียชีวิตจากการเป็นโรคนี้นี้ ดังนั้นฉันจึงตระหนักถึงการติดเชื้อโรคเอชไอวี/เอดส์และฉันใช้ถุงยางอนามัยเพื่อการป้องกันเป็นประจำ
- 4. เพื่อนร่วมงานของฉันสอนและช่วยฉันในการจัดการเกี่ยวกับลูกค้าผู้ให้บริการที่ไม่ยอมใช้ถุงยางอนามัย
- 5. ฉันไม่ได้รับการสนับสนุนจากเพื่อนหรือแกนนำในการมีอิทธิพลที่สนับสนุนการใช้ถุงยางอนามัยของฉันเลย

52. แรงกดดันจากเพื่อนร่วมงาน เพื่อนฝูงและ นายจ้างใดที่สำคัญที่สุดที่ทำให้คุณไม่ใช่ ถุงยางอนามัยขณะมีเพศสัมพันธ์ กับลูกค้าผู้ให้บริการทางเพศ? (ตอบเพียงข้อเดียว)

- 1. นายจ้างของฉันบอกให้ฉันตอบสนองความต้องการของลูกค้า ถ้าพวกเขาเลือกที่จะไม่ใช่ถุงยางฉันควรจะตามใจลูกค้า
- 2. เพื่อนของฉัน เพื่อนร่วมงานหรือนายจ้างบอกว่าฉันจะได้ลูกค้าและได้ค่าทิปเพิ่มมากขึ้น ถ้าฉันมีเพศสัมพันธ์กับลูกค้าโดยไม่ใช้ถุงยางอนามัย
- 3. เพื่อนร่วมงานของฉันบอกว่า มันไม่จำเป็นของฉันที่จะใช้ถุงยางอนามัยทุกครั้งเมื่อมีเพศสัมพันธ์กับลูกค้า และพวกเขาก็ยังสุขภาพปรกติดี ฉันจึงทำตามพวกเขา
- 4. เพื่อนของฉันเพื่อนร่วมงานของฉันบอกว่าถ้าไม่ใช่ถุงยางอนามัยจะรู้สึกสนุกและเพลิดเพลินระหว่างมีเพศสัมพันธ์กับลูกค้าเพิ่มมากขึ้น
- 5. ฉันไม่มีแรงกดดันที่สำคัญจากเพื่อนฝูง เพื่อนร่วมงานและนายจ้างในการไม่ใช่ถุงยางระหว่างมีเพศสัมพันธ์

53. แรกกดดันจากคู่่นอนประจำ (regular partner) (สามี/แฟน/คนรัก) ใดที่สำคัญที่สุดที่ทำให้คุณไม่ได้ใช้ ถุงยางอนามัยขณะมีเพศสัมพันธ์คู่นอนประจำของคุณ? (ตอบเพียงข้อเดียว)

1. โดยปกติทั้งฉันและคู่นอนประจำของฉันไม่ได้รับถุงยางอนามัยฟรี ถ้าเราต้องซื้อถุงยางอนามัยเองก็สิ้นเปลืองเงิน ดังนั้นเราจึงเลือกที่จะไม่ใช้
2. คู่นอนประจำของฉันไม่ต้องการใช้ถุงยางอนามัยระหว่างมีเพศสัมพันธ์เพราะเขาต้องการมีความรู้สึกที่เป็นธรรมชาติ มีความสุขและเพลิดเพลินมากขึ้น
3. คู่นอนประจำของฉันไม่ต้องการใช้ถุงยางอนามัยระหว่างมีเพศสัมพันธ์เพราะเราจะรู้สึกไม่เชื่อใจกัน ถ้าเราใช้ถุงยางอนามัยเมื่อมีเพศสัมพันธ์
4. ฉันมีลูกค้ำที่ตอนหลังเป็นคู่นอนประจำของฉัน (เป็นสามี/คู่รัก/แฟน) เราจึงเลือกที่จะไม่ใช้ถุงยางอนามัยเพราะเราเลือกที่จะไว้ใจซึ่งกันและกัน
5. ฉันไม่มีแรงกดดันที่สำคัญจากคู่นอนประจำในการไม่ใช้ถุงยางอนามัยระหว่างมีเพศสัมพันธ์

ส่วนที่ 7: พฤติกรรมทางเพศของหญิงบริการกับลูกค้าชาย/คู่นอนประจำ (การเจรจาในการใช้ถุงยาง และการใช้ถุงยางขณะมีเพศสัมพันธ์10 คำถาม: ข้อ 54-63) โปรดตอบคำถามและโปรดทำเครื่องหมาย(✓)

หน้าคำตอบสำหรับคำถามเกี่ยวกับสถานการณ์ที่เกิดขึ้นต่อไปนี้เป็นระยะเวลา 3 เดือนที่ผ่านมา

	พฤติกรรมทางเพศ	ทุก ครั้ง	บ่อยๆ	บาง ครั้ง	ไม่ เคย
54.*	ฉันดื่มเครื่องดื่มแอลกอฮอล์ ก่อน / ระหว่างมีเพศสัมพันธ์				
55.*	ฉันใช้สารเสพติด ก่อน / ระหว่างมีเพศสัมพันธ์ ?				
56.	ฉันใช้ถุงยางอนามัยกับคู่นอนประจำของฉันระหว่างมีเพศสัมพันธ์				
57.	ฉันรบเร้าให้คู่นอนประจำของฉันใช้ถุงยางอนามัยระหว่างมีเพศสัมพันธ์ทุกครั้ง				
58.*	ฉันมีประสบการณ์ในสถานการณ์ที่คู่นอนประจำของฉันปฏิเสธการใช้ถุงยางอนามัยขณะมีเพศสัมพันธ์				
59.	เมื่อลูกค้าของฉันปฏิเสธการใช้ถุงยางอนามัย ฉันได้พยายามโน้มน้าวและรบเร้าเขาเพื่อใช้ถุงยางอนามัยขณะมีเพศสัมพันธ์				

60.	ฉันประสบความสำเร็จในการโน้มน้าว และบ ริ้ว คุณอนประจํา ของฉันในการใช้ถุงยางอนามัย ระหว่างมีเพศสัมพันธ์				
61.	เมื่อ คุณอนประจํา ของฉัน ปฏิเสธ การใช้ ถุงยางอนามัย ฉันจึง ปฏิเสธ ที่จะมี เพศสัมพันธ์กับ เขา				
62.	ในช่วง 3 เดือนที่แล้ว ฉันได้ ใช้ถุงยางอนามัย ขณะมี เพศสัมพันธ์กับ ลูกค้า ของฉัน				
63.	ในช่วง 3 เดือนที่แล้ว ฉันได้ ใช้ถุงยางอนามัย ขณะมี เพศสัมพันธ์กับ คุณอนประจํา ของฉัน				



APPENDIX C

နောက်ဆက်တွဲ (က)

မေ့ရန်လွှာများအသုံးပြု၍ လေ့လာသုံးသပ်ခြင်း

ထိုင်နိုင်း၊ ထာ(စ်) ခရိုင်၊ မဲဆောက်မြို့ရှိ လိင်ဖြင့် အသက်မွေးဝမ်းကြောင်းပြုနေသော

မြန်မာအမျိုးသမီး (လိင်လုပ်သား) များ၏

စုခံအားကျဆင်းမှုရောဂါ (HIV/AIDS) တာတွယ်တားဆီးခြင်းဆိုင်ရာ

တဟုထုတ်၊ သဘောထား နှင့် လက်တွေ့ကျင့်သုံးလုပ်ဆောင်မှုများ

အင်တာဗျူးသည့်ရက်စွဲ (Interviewed Date) _____ လျှို့ဝှက် နံပါတ် Ref. Code: _____

အင်တာဗျူးသည့်အဖွဲ့ဝင် (Interview Team member) _____

နေရာ/အရပ်ဒေသ (Location/Sub District): _____

အလုပ်အမျိုးအစား Type of Business: _____

Part I: Socio Demographic Characteristics

အပိုင်း ၁။ လူနေမှု၊ လူ့အရေအသွယ်နှင့် လိင်တူကာများ (မေ့ရန် ဘုရား နံပါတ် ၁ မှ ၁၅)

1. ၁. အသက်ဘယ်လောက်ရှိပြီလဲ? _____ နှစ်
2. ၂. သင်ဘာလုပ်မျိုးလဲ?
 - 1) မြန်မာ 2) ကရင် 3) ကယား 4) မွန် 5) အခြား၊
 - တိကျစွာဖော်ပြရန် _____.
3. ၃. သင်ဘယ်ဘာသာကိုကိုးကွယ်ပါသလဲ?
 - 1) ဗုဒ္ဓ 2) မူစလင် 3) ခရစ်ယာန် 4) အခြား၊တိကျစွာဖော်ပြရန် _____.
4. ၄. သင့် အိမ်ထောင်ရေး အခြေအနေ ဘယ်လိုရှိပါသလဲ?
 - 1) အိမ်ထောင်မရှိ 2) အိမ်ထောင်ရှိ 3) အိမ်ထောင်ကွဲ 4) မုဆိုးမ (အိမ်ထောင်ဖက်ဝေးဆုံး)
5. ၅. သားသမီး ရှိပါသလား? 0) မရှိ 1) ရှိသည် _____ ယောက်

6. ဇ. သင့်ပညာအရည်အချင်း?

- 1) ကျောင်းတစ်ခါမှမတက်ခဲ့ဘူးပါ။(မရေးတက်မဖတ်တက်ပါ)
- 2) ကျောင်း တစ်ခါမှမတက်ခဲ့ဘူးပါ။သို့သော်စာတက်သည်(ရေးတက်ဖတ်တက်သည်)
- 3) မူလတန်းပညာရေး
- 4) အလယ်တန်းပညာရေး 5) အထက်တန်းပညာရေး, တိကျစွာဖော်ပြပေးရန်_____

7. ဇ. သင်ထိုင်းစကားပြောတတ်ပါသလား?

- 0) မတတ်ပါ 1) နည်းနည်းပါးပါးပြောတတ်သည် 2) ကောင်းမွန်စွာပြောတတ်သည်

8. ဇ. သင့်မွေးရပ်ဇာတိ(မြန်မာနိုင်ငံအတွင်း) _____ (မြို့, နယ်)

9. ဇ. ထိုင်းနိုင်ငံမှာနေသောအထောက်အထား ?

- 1) တရားမဝင်ရွေ့ပြောင်းအလုပ်သမား 2) တရားဝင်ရွေ့ပြောင်းအလုပ်သမား
- 3) အခြား _____

10. ဇ. သင်လိင်လုပ်သားလုပ်တာဘယ်နှနှစ်ရှိပြီလဲ _____ နှစ်

11. ဇ. သင်ထိုင်းနိုင်ငံမှာနေတာဘယ်နှနှစ်ရှိပြီ လဲ _____ နှစ်

12. ဇ. လွန်ခဲ့တဲ့ ၃လ အတွင်းမှာ သင့် ဧည့်သည်တွေကို လိင်ပန်ဆောင်မှုပေးပြီး သူတို့၊ သူတို့ တစ်ယောက်ချင်းဆီက ပျမ်းမျှ ငွေဘယ်လောက်စုမိပါသလဲ ?ဘတ်

13. ဇ. တစ်နေ့ကို ဧည့်သည် ဘယ်နှစ်ယောက်ပန်ဆောင်မှုပေးပါသလဲ? _____ ယောက်

14. ဇ. လွန်ခဲ့တဲ့လတုန်းကပင်ငွေဘယ်လောက်ရပါသလဲ (ဘတ်)

- 1) ဘတ် ၄၀၀၀ ထက်နည်းသည် 2) ဘတ် ၄၀၀၀ မှ ၅၀၀၀ ကြား 3) ဘတ် ၅၀၀၀ မှ ၆၀၀၀ ကြား
- 4) ဘတ် ၆၀၀၀ မှ ၇၀၀၀ ကြား 5) ဘတ် ၇၀၀၀ အထက်, တိကျစွာဖော်ပြရန် _____

Part II: Sexual Partner Characteristics (Questions: No.16-20) *Instruction: Please answer and please tick (✓) on the following questions*

အပိုင်း (၂) : လိင်ဆက်ဆံဖော်ဆောင်ဖော်၏ သွင်ပြင်လက္ခဏာများ (မေးခွန်း ၆မှ နံပါတ် ၁၅မှ ၂၀)

ညွှန်ကြားချက်: အောက်ပါမေးခွန်းများတွင်အဖြေမှန်ဖြစ်ပေးပါ။

15. ၁၅ . ပုံမှန်လိင်ဆက်ဆံဖော်ဆောင်ဖော်၏ သွင်ပြင် လက္ခဏာများ	မှန်	မှား
<ul style="list-style-type: none"> • သင့်မှာပုံမှန်လိင်ဆက်ဆံတဲ့လူရှိပါသလား? ရှိခဲ့လျှင်အောက်ပါမေးခွန်းများကိုဖြေပါ အကယ်၍မရှိခဲ့လျှင်မေးခွန်းနံပါတ် ၁၆ ကိုဆက်ဖြေပေးပါ 		
<ul style="list-style-type: none"> • သင့်မှာပုံမှန်လိင်ဆက်ဆံသူ ခင်ပွန်း (အိမ်ထောင်ဖက်) ရှိပါသလား? 		
<ul style="list-style-type: none"> • သင့်မှာပုံမှန်လိင်ဆက်ဆံသူ ရည်စားချစ်သူရှိပါသလား? 		

16. ၁၆. သင့်ရဲ့ ပုံမှန်လိင်ဆက်ဆံဖော်ကသင့်ရဲ့ အသက်မွေးဝမ်းကြောင်း အကြောင်းသိပါသလား?

- သိသည် မသိပါ

17. ၁၇. သင့်ဆီ ပုံမှန်လာသောဧည့်သည်များရှိပါသလား	မှန်	မှား
<ul style="list-style-type: none"> • သင့်ဆီ ပုံမှန်မှန်လာပြီးတစ်ကြိမ်လိင်ဆက်ဆံပြီးတိုင်းပိုက်ဆံသည့်ဧည့်သည်ရှိပါသလား 		
<ul style="list-style-type: none"> • သင့်ဆီလာတဲ့ ဧည့်သည်နဲ့ ဧည့်သည်အဆင့်ကနေ ရည်စား(သို့)ချစ်သူဖြစ်သွားတာရှိပါလား 		

Part III. Availability of to HIV/AIDS Information & Services (7 Questions: No.22-27)

Instruction: Please answer questions and please tick (✓) on the following questions

အပိုင်း (၃): စုစံအားကျဆင်းမှုရောဂါ (HIV/AIDS) ဆိုင်ရာ သတင်းအချက်အလက်နှင့် ဝန်ဆောင်မှုများအား စုစုံနိုင်မှု

ညွှန်ကြားချက် : အောက်ပါမေးခွန်းများတွင် အဖြေမှန်ဖြစ်ပေးပါ

18. ၁၈. စုစံအားကျဆင်းမှုရောဂါ (HIV/AIDS) အကြောင်းကြားဖူးပါသလား?

- 1) ကြားဖူးပါသည် (မေ့ရှားနံပတ် ၁၉ ကိုဆတ်ဖြေပါ) 2) မကြားဖူးပါ (နံပတ် ၂၀ သို့ကျော်ပါ)

19. ၁၉. ကြားဖူးခဲ့သော် ဘယ်အချိန်က ကြားဖူးတာလဲ? (အဖြေတစ်ခုထဲဖြေပါ)

- 1) မြန်မာပြည်မှာ နေကတည်းက စုစံအားကျဆင်းမှုရောဂါ (HIV/AIDS) အကြောင်းကို သိခဲ့တယ်။
- 2) မဲဆောက်ကို ရွှေ့ပြောင်းလာကတည်းက သိခဲ့တယ်။
- 3) ထိုင်းနိုင်ငံကို စတင်ရွှေ့ပြောင်းချိန်တုန်းက မသိခဲ့ပေမယ့် မဲဆောက်မှာ လိင်လုပ်သား အလုပ် လုပ်တော့ သိခဲ့တယ်။
- 4) ထိုင်း /မြန်မာ နှစ်နိုင်ငံစလုံးမှာ နေကတည်းက သိခဲ့တယ်။

20. ၂၀. ထိုင်းနိုင်ငံမှာနေတဲ့အတောအတွင်း စုစံအားကျဆင်းမှုရောဂါ (HIV/AIDS) အကြောင်း (အထူးသဖြင့် ကာကွယ်တဲ့ နည်းလမ်းတွေအကြောင်း) ကို လွန်ခဲ့တဲ့ ၃လအတွင်းမှာ ဘယ်ကနေ ကြားပြီး သိရှိလေ့လာခဲ့သလဲ။

စုခံအားကျဆင်းမှုများရောဂါ (HIV/AIDS) နှင့် ပတ်သက်သော သတင်းအချက်အလက်များရရှိရာ အရင်းအမြစ်	မှန်/YES	မှား/NO
ညွှန်ကြားချက်: သင့်တော်သော ကွက်လပ် နေရာတွင်အမှန်ခြစ်ပါ		
❖ အင်တာနက်(သို့)လူမှုကွန်ယက် (Line/Facebook)		
❖ ပြန်မာတီဗွီ/ရေဒီယို		
❖ နံရံကပ်စာစောင်များ/လက်ကမ်းစာစောင်များ		
❖ အလုပ်ရှင်များ/ပွဲစားများ/ဘား၊ ဈေးဆိုင်၊ ကော်ဖီဆိုင် ပိုင်ရှင်များ		
❖ သက်တူရွယ်တူများ/ လုပ်ဖော်ကိုင်ဖက်များ/ သက်တူရွယ်တူ ပညာပေးသူများ		
❖ ဧည့်သည်များ		
❖ ပုံမှန်လိင်ဆက်ဆံသူများ (ရည်းစားသို့မဟုတ်ယောက်ကျား)		
❖ မိသားစုဝင်များနှင့်ဆွေမျိုးသားချင်းများ		
❖ အစိုးရမဟုတ်တဲ့ အဖွဲ့အစည်း (NGO) မှ ကျန်းမာရေးထောက်ပံ့သူများ ဥပမာ ဝေါစေးရှင်း နှင့် မယ်တော်ဆေးခန်းမှဝန်ထမ်းများ နှင့် စေတနာ့ဝန်ထမ်းများ		
❖ အစိုးရ အဖွဲ့အစည်းမှ ကျန်းမာရေးထောက်ပံ့သူများ ဥပမာ ကျန်းမာရေးလုပ်သားနှင့် မဲဆောက်ဆေးရုံကြီးမှဝန်ထမ်းများ နှင့် စေတနာ့ဝန်ထမ်းများ		
❖ အခြား,တိကျစွာဖော်ပြရန်.....		

21. ၂၁. ကွန်ပွဲကိုပုံမှန်ဘယ်ကနေ ရပါသလဲ?

1) ကျန်းမာရေးဝန်ဆောင်မှုပေးသော အစိုးရမဟုတ်သောအဖွဲ့အစည်း နှင့် မယ်တော်ဆေးခန်း

ဝန်ထမ်းများမှရရှိသည်

2) ကျန်းမာရေးဝန်ဆောင်မှုပေးသောအစိုးရအဖွဲ့အစည်းမှရရှိသည် **ဥပမာ** ပြည်သူ့ ကျန်းမာရေး ဌာနမှ ကျန်းမာရေးဝန်ထမ်းများ၊ ဆရာဝန်များ

3) အလုပ်ရှင်/ပွဲစား /Mama Sang/ ဈေးဆိုင်ပိုင်ရှင်များ/ ကော်ဖီဆိုင်ပိုင်ရှင်များ

4) ဆေးဆိုင်များ/ကုန်စုံဆိုင်များ 5) ဧည့်သည်များ

6) လုပ်ဖော်ကိုင်ဖက်များ/သူငယ်ချင်းများ 7) သက်တူရွယ်တူ ပညာပေးသူများ

8) အခြား,တိကျစွာဖော်ပြပေးပါ.....

22. ၂၂. HIVသွေးစစ်ဖူးပါသလား?

- ၁.စစ်ဖူးသည်
- ၂.မစစ်ဖူးပါ

23. ၂၃. စစ်ဖူးပါကဘယ်ပန်ဆောင်မှုဌာနမှာစစ်ဖူးတာလဲ? (အဖြေ တစ်ခုထက်မက ဖြေနိုင်သည်)

- 1) အစိုးရမဟုတ်သောအဖွဲ့အစည်းများမှထောက်ပံ့သော ပန်ဆောင်မှုများ
- 2) အစိုးရအဖွဲ့အစည်းများမှထောက်ပံ့သော ပန်ဆောင်မှုများ
- 3) ပြည်သူ့ကျန်းမာရေးဌာန၊ လူထုကျန်းမာရေးစင်တာအနီးမှာ
- 4) ပုကလိကဆေးရုံ ဆေးခန်းများ
- 5) မဲဆောက်ဆေးရုံ
- 6) မယ်တော်ဆေးခန်း
- 7) အခြား တိကျစွာဖော်ပြပေးပါ.....

24. ၂၄. HIVသွေးစစ်ပေးတဲ့ ပန်ဆောင်မှုတွေကို ရဖို့ သင်ကြံ့ရသော သိသိသာသာ ချိတ်၊ အတားအဆီး အခက်အခဲတွေက ဘာတွေ ဖြစ်မလဲ?

- 1) ကုသမှုစရိတ်ပေးဖို့၊ ငွေမလုံလောက်ခြင်း
- 2) ပုလိတ်ဖမ်းဆီးမှုခံရခြင်း
- 3) သွားရလာရခက်ခဲခြင်း
- 4) ဘာသာစကားအခက်အခဲ
- 5) အခြားတိကျစွာဖော်ပြပေးပါ.....

Part IV: Knowledge of HIV/AIDS (8 Questions: No. 29-35)

အပိုင်း ၄ : HIV/AIDS နှင့်ပတ်သတ်သောဓမ္မစာတမ်းများ (ခေတ္ကအရ နံပါတ် 29မှ35)

ခေတ္ကများနှင့် ဖော်ပြချက်များ ညွှန်ကြားချက် - အောက်ပါခေတ္ကများကိုတော့ဖြည့်ပြီး အမှတ်ခြစ်ပါ (အမှန် ၊ အမှား ၊ မသိ) (အဖြေ တစ်စုတည်းသာ ရှေးပါ)		HIV/AIDS နှင့်ပတ်သတ်သော ဓမ္မစာတမ်းများ		
4.1 General Knowledge of HIV/AIDS (4 Questions: No. 25-28) ၄-၁ HIV/AIDS ရဲ့အထွေထွေဓမ္မစာတမ်း(ခေတ္ကနံပါတ် ၂၅ မှ ၂၈)		မှန်	မှား	မသိ
၂၅	HIV ဆိုတာ လူတွေရဲ့ ခုခံအား (ဆိုလိုတာက ရောဂါ တွေကနေ ကာကွယ်ပေးတဲ့ ဓန္ဓာကိုယ်ရဲ့ ခုခံအား) ကို တိုက်ခိုက်တဲ့ ဝိုင်းရပ်စ်ပိုး တစ်မျိုး ဖြစ်တယ်။			
၂၆	HIV ရောဂါသည်တစ်ဦးကသူ့ကိုသူ့ဘာရောဂါလက္ခဏာမရှိဘူး၊ လုံးဝ ကျန်းမာတယ် လို့ခံစားရတယ်			
၂၇	သွေးဖောက်ပြီး HIV ပိုးကို စစ်ဆေးခြင်းဟာ သင့် မှာ HIV ရောဂါပိုး ကူးစက်မှုရှိ မရှိ အသေအချာ ပြောနိုင်ဖို့ တစ်စုတည်းသော နည်းလမ်း ဖြစ်တယ်။			
၂၈	HIV/AIDS ရောဂါရှိတဲ့သူတွေကဆေးကုသမှုမခံယူပဲအသက်ရှင်လို့ရသည်။			
4.2 HIV/AIDS Symptoms (5 Questions: No.29-33) ၄-၂ HIV/AIDS ရဲ့ရောဂါလက္ခဏာများ (ခေတ္ကနံပါတ် ၂၉ မှ ၃၃)				
၂၉	HIV/AIDS ရဲ့ရောဂါလက္ခဏာတွေထဲမှာ အဖျား၊ ကြာရှည်ခြင်း၊ခေါင်းကိုက်ခြင်း နှင့် လည်ချောင်းနာခြင်း တို့ ပါဝင်တယ်။			
၃၀	HIV/AIDS ရဲ့ရောဂါလက္ခဏာတွေထဲမှာ အကျိတ်များ၊ ယောင်ယမ်းခြင်း၊ အယားဖုများ၊ လျှာ၊ ပါးစပ်နှင့် လည်ချောင်းအတွင်း အဖြူ အစက်အကွက်များ ပေါ်ခြင်း နှင့် ပုံမှန်မဟုတ်သော စိုးလိုးရလှ ခံစားရခြင်း တို့ ပါဝင်တယ်။			

31၃	HIV/AIDS ရဲ့ ရောဂါလက္ခဏာတွေထဲမှာ			
၁.	နာတာရှည်ဝမ်းလျှောခြင်းသည် (တစ်ပတ်ထက်ပို၍) နှင့် ကိုယ်အလေးချိန်ကျဆင်းခြင်း တို့ ပါဝင်တယ်။			
32.	HIV/AIDS ရဲ့ ရောဂါလက္ခဏာတွေထဲမှာ မောပန်းခြင်း နှင့် အားအင်			
၃၂	လျော့ကျ ကုန်ခမ်းခြင်းတို့ ပါဝင်တယ်။			
33၃	အချို့ HIV/AIDS ရောဂါသည်တွေမှာ ရောဂါလက္ခဏာ			
၃.	ဆိုးဆိုးရွားရွားတွေပေါ်ဖို့ ရာ ၁၀ နှစ် နီးနီး ကြာတတ်ပါတယ်။			
4.3 HIV/AIDS Transmissions (6 Questions: No.34-39)				
၄-၃ HIV/AIDS တူးဆက်ခြင်း (မေ့စွန်း ၆ခု၊ နံပါတ် ၃၄ မှ ၃၉)				
34၃	HIV/AIDS ဟာ ရောဂါရှိသူရဲ့ ကိုယ်ခန္ဓာက ထွက်တဲ့ အရည်တွေ			
၄.	(ဥပမာ သွေး၊ နို့ရည်၊ သုတ်ပိုး နဲ့ မမျိုးပွါး အင်္ဂါလမ်းကြောင်းက ထွက်တဲ့ အရည်) ကနေ တဆင့်ကူးစက်နိုင်ပါသည်။			
35.	ရောဂါပိုး ကူးစက်ထားသူရဲ့ သွေးနဲ့ ထိတွေ့ထားတဲ့ ကိရိယာတွေကို			
၃၅	ပိုးသတ်ထားခြင်း မပြုဘဲ အတူတူ အသုံးပြုပြီး ဆေးမှင်ကြောင်ထိုးတာ၊ ကိရိယာတွေကို အသစ်မလဲဘဲ ဆေးမှင်ကြောင်ထိုးတာ တွေကြောင့် HIV ကူးစက်နိုင်ခြေ လုံးဝ မရှိပါ။			
36၃	ဆံပင်ညပ်ဆိုင်သွားတဲ့ အခါ ရောဂါပိုး ကူးစက်ထားသူရဲ့ သွေးနဲ့			
6	ထိတွေ့ထားတဲ့ ဘလိတ်ခါးတွေကို ပိုးသတ်ထားခြင်း မပြုဘဲ အတူတူ အသုံးပြုတာ၊ ဘလိတ်ခါးတွေကို အသစ်မလဲဘဲ အသုံးပြုတာ တွေကြောင့် HIV ကူးစက်နိုင်ခြေ လုံးဝ မရှိပါ။			
37၃	အိမ်သာ တစ်ခုတည်း အတူတူ သုံးရာကနေ တဆင့် HIV/AIDS			
၇.	ကူးစက်နိုင်တယ်။			
38.၃	ဖန်ရွက် တရွက်တည်းအတူတူသောက်ခြင်း၊			
၈	နမ်းခြင်း ကနေ တဆင့် HIV/AIDS ကူးစက်နိုင်တယ်။			
39.	နိပ်ခြင်း ၊ ဝေ့ဖက်ခြင်း ၊ ထိတွေ့ခြင်းမှတဆင့် HIV/AIDS			
၃၉	ကူးစက်နိုင်တယ်။			

Part V: Attitude toward HIV/AIDS Prevention (10 Questions: No. 40-49)

အပိုင်း ၅ : HIV/AIDS တာတွယ်တားဆီးချိန်အပေါ် သဘောထား (မေးခွန်း ၁၀ခု နံပါတ် ၄၀ မှ ၄၉)

မေးခွန်းများနှင့် ဖော်ပြချက်များ ညွှန်ကြားချက် - ကျေးဇူးပြုပြီး ဖော်ပြချက် တစ်ခုစီအတွက် သင်သဘောတူသည့်အကွက်တွင် အမှတ်ခြစ်ပါ။		HIV/AIDS ဖော်ပြချက်များ				
		လုံစာ သဘော တူ/SA	သေ သာတူ /A	မသေချာ /NS	သေ သာမ တူ/DA	လုံစာ သေ သာမ တူ/SD
40	ကျွန်ုပ်အထင်ကျန်းမာရေးကောင်းတဲ့ပုံပေါက်တဲ့ ၄၀. လူနဲ့လိင်ဆက်ဆံတဲ့ အခါမှာ HIV//AIDSဦးမကူးစက်နိုင်ပါ။					
41	ကျွန်ုပ်အထင် ဧည့်သည်တွေနဲ့ (အထူးသဖြင့် ၄၁. ပုံမှန်လာနေကျ ဧည့်သည်တွေ) လိင်ဆက်ဆံတဲ့အခါမှာ ကွန်ဒုံး သုံးဖို့ မလိုပါ။					
42	ကျွန်ုပ်အထင် ပုံမှန် ဆက်ဆံနေကျ သူ ၄၂. (အထူးသဖြင့် လင်ယောက်ျား၊ အိမ်ထောင်ဖက် သို့၊ ရည်းစား) နဲ့ လိင်ဆက်ဆံတဲ့အခါမှာ ကွန်ဒုံး သုံးဖို့ မလိုပါ။					
43	ကျွန်ုပ်အထင်ပုံမှန် ဆက်ဆံနေကျသူ (ရည်းစား၊ ၄၃. အိမ်ထောင်ဖက်၊ ချစ်သူ) တွေနဲ့ ဆက်ဆံဖို့ ရာ ကွန်ဒုံး မလိုအပ်ပါ။					
44	ကျွန်ုပ်အထင် ကွန်ဒုံး သုံးတာဟာ ကျွန်ုပ် ရဲ့ ၄၄. ပုံမှန်ဆက်ဆံနေကျသူ (ရည်းစား၊ အိမ်ထောင်ဖက်၊ ချစ်သူ) တွေနဲ့ အတူနေတဲ့ အခါ အတားအဆီး ဖြစ်တယ် လို့ ခံစား ရတယ်။					
45	ကျွန်ုပ်အထင် HIV ကြိုတင် ၄၅. ဝမ်းသပ်စစ်ဆေးခြင်းဟာ ရောဂါ ဖြစ်နိုင်ချေ များတဲ့ လိင်လုပ်သား လို့ သူတွေအတွက် အရမ်း အရေးကြီးပါတယ်။					

<p>46 ၄၆.</p>	<p>ကျွန်ုပ်အထင် HIV ကြိုတင် စမ်းသပ်စစ်ဆေးခြင်းဟာ ဧရာဂါ ဖြစ်နိုင်ချေ များတဲ့ ဆေးထိုးအပ်သုံးတဲ့၊ ဆေးစွဲသူတွေအတွက် အရမ်း အရေးကြီးပါတယ်။</p>					
<p>47 ၄၇.</p>	<p>ကျွန်တော့်အမြင် HIV ကူးစက်ခံနေရသူတွေအနေနဲ့၊ အကောင်ဆုံးစေးကုသမှုများ၊ ဝန်ဆောင်မှုများ ရရှိရန်အတွက် ကျန်းမာရေး ဝန်ထမ်းများ (ဆရာဝန်၊ သူနာပြု၊ သွားဆရာဝန်များနှင့် ကျန်းမာရေး မာရေးထောက်ပံ့ပေးသူများ၊ ကျန်းမာရေးစေတနာ့ဝန်ထမ်းများ)ကို အကြောင်းကြားသင့်တယ်။</p>					
<p>48 ၄၈.</p>	<p>ကျွန်ုပ်ဟာ အမျိုးသမီး လိင်လုပ်သား အနေနဲ့၊ အသက်မွေးဝမ်းကြောင်းပြုနေရတဲ့အတွက် ကျွန်ုပ်မှာ လိင်မှတစ်ဆင့် ကူးစက်တတ်သော ဧရာဂါ (STI/ STDs) တွေ ဖြစ်နိုင်လိမ့်မယ် ထင်တယ်။</p>					
<p>49. ၄၉</p>	<p>ကျွန်ုပ်ဟာ အမျိုးသမီး လိင်လုပ်သား အနေနဲ့၊ အသက်မွေးဝမ်းကြောင်းပြုနေရတဲ့အတွက် ကျွန်ုပ်မှာ HIV/ AIDS ဧရာဂါ ဖြစ်နိုင်လိမ့်မယ် ထင်တယ်။</p>					

Part VI: Influence or Pressure from Peers, Employers, Clients and Regular Partners and Obstacles towards HIV/AIDS Prevention (4 Questions: No. 50-53)

ညွှန်ကြားချက် - အောက်ပါမေးခွန်းများကိုကျေးဇူးပြုပြီး သင်သဘောတူသည့်အကွက်တွင် အမှတ်ခြစ်ပါ

အပိုင်း ၆ HIV / AIDS တာတွယ် တားဆီးရာတွင် သက်တူရွယ်တူများ အလုပ်ရှင်များ ဧည့်သည်များ နှင့် ပုံမှန် ဆက်ဆံသူများ၏ ဖိအားပေးမှုများ လွှမ်းမိုးမှုများနှင့် အခက်အခဲ အတားအဆီးများ

50. ၅၀. ဧည့်သည်နှင့်လိင်ဆက်ဆံချိန်မှာ အလုပ်ရှင်မှ ကွန်ဒုံးအသုံးပြုရန် အတွက်သင့်ကိုအဓိကလွှမ်းမိုးမှုက ဘာလဲ? (အခြေတစ်ခုထဲရွေးပါ)

- 1) အလုပ်ရှင်မှ HIV/AIDS ဖြစ်နိုင်တဲ့ အခြေအနေတွေအကြောင်းကိုပြောပြထားပြီး ကိုယ်ကျန်းမာရေးကို လည်ဂရုစိုက်ဖို့ ပြောပြထားတယ်
- 2) အလုပ်ရှင်မှကွန်ဒုံးအမြဲပေးလေ့ရှိပြီး ကျွန်ုပ်ကို တကယ်သုံးဖို့ တိုက်တွန်းပါတယ်။
- 3) အလုပ်ရှင်မှဧည့်သည်တွေလည်းကွန်ဒုံးသုံးရန်အတွက် ညှိနှိုင်းတောင်းဆိုပေးပါတယ်
- 4) အလုပ်ရှင်မှ ကျွန်ုပ်အပါအဝင်ကျွန်ုပ်၏ ဧည့်သည်နှင့် လုပ်ဖော်ကိုင်ဖက်တွေကိုလည်းလိင်ဆက်ဆံတဲ့အချိန်တိုင်းမှာကွန်ဒုံးသုံးဖို့ စည်းမျဉ်းစည်းကမ်းများထုတ်ထားပါတယ်
- 5) အလုပ်ရှင်မှကွန်ဒုံးသုံးရန်အတွက်ဘာအထောက်အပံ့မှမပေးပါ

51. ၅၁. ဧည့်သည်နှင့်လိင်ဆက်ဆံတဲ့အခါမှာကွန်ဒုံးသုံးရန်အတွက်သင့်ရဲ့လုပ်ဖော်ကိုင်ဖက်၊ သက်တူရွယ်တူမှအပြန်အလှန်ပညာပေးခြင်းဖြင့်သင့်အတွက်အဓိက လွှမ်းမိုးမှုက ဘာလဲ?

- 1) အချင်းချင်းပညာပေးနေသောသူငယ်ချင်းမှ HIV/AIDS ဖြစ်နိုင်သော အခြေအနေများ အကြောင်းကိုပြောပြပေးပြီးကာကွယ်တားဆီးရန်အတွက်လည်း ကွန်ဒုံးများပေးခဲ့သည်။ တကယ်အသုံးပြုရန်လည်း တိုက်တွန်းအားပေးခဲ့ပါသည်။
- 2) အလုပ်မှာရှိတဲ့သူငယ်ချင်းများမှ HIV/AIDS ဖြစ်နိုင်သော အခြေအနေများ အကြောင်းကိုပြောပြပေးပြီး ကွန်ဒုံး အသုံးပြုရန် တိုက်တွန်းအားပေးခဲ့ပါသည်။

□3) ကွန်ပဿူဝယ်ချင်း သို့ ကျွန်ုပ်အသိ တစ်စုံတစ်ယောက်ဟာ HIV/AIDS ဝေဒနာခံစားနေရဦး (သို့) အသက်ဝေဆုံးခဲ့တဲ့ အတွက် ကျွန်ုပ်ဟာ HIV/AIDS ရောဂါအတွက် သတိ အမြဲ ရှိပြီး ရောဂါကင်းဝေးရန် အတွက်အမြဲတမ်းကွန်ဒုံးသုံးပါသည်။

□4) ကွန်ဒုံးမသုံးချင်တဲ့ဧည့်သည်တွေကို ပြောပြလည်လည် ဘာလို ညှိရမယ်ဆိုတာကို ကွန်ပဿူဝယ်ချင်းက သင်ပေးတယ် ကူညီပေးတယ်။

□5) ကွန်ဒုံးအသုံးပြုရန်အတွက်သူဝယ်ချင်းများနှင့် အချင်းချင်းလိုက်လံပညာပေးသောသူများမှမည်သည့် လွှမ်းမိုးမှုမျှ မရှိပါ။

52. ၅၂. ဧည့်သည်နှင့်လိင်ဆက်ဆံတဲ့အခါသောအခါတွင်ကွန်ဒုံးမသုံးရန်အတွက် သင့်ရဲ့ သူဝယ်ချင်း၊ လုပ်ဖော်ကိုင်ဖက်၊ သက်တူရွယ်တူနှင့်အလုပ်ရှင်တို့က အဓိကဖိအားပေးတာ ဘာလဲ?

□1) ကျွန်ုပ်အလုပ်ရှင်က ဧည့်သည်၏ဆန္ဒကိုဖြည့်ဆည်းခိုင်းပြီး ကွန်ဒုံးမသုံးချင်ပါကသူတို့ရဲ့ဆန္ဒအတိုင်း လုပ်ဆောင်ပေးရသည်

□2) သူဝယ်ချင်း ၊ လုပ်ဖော်ကိုင်ဖက်နဲ့အလုပ်ရှင်ကပြောတယ် ဧည့်သည်နှင့်လိင်ဆက်ဆံတဲ့အခါမှာကွန်ဒုံးမသုံးရင်ဧည့်သည်ပိုရဦး မှန်ဖိုးလည်းရတယ်လို့ပြောတယ်

□3) သူဝယ်ချင်း ၊ လုပ်ဖော်ကိုင်ဖက်နဲ့အလုပ်ရှင်ကပြောတယ် ဧည့်သည်နှင့်လိင်ဆက်ဆံတဲ့အခါ အမြဲတမ်း ကွန်ဒုံးသုံးဖို့ မလိုပါဘူး ဧည့်သည်တွေလည်း ပိုအဆင်ပြေတယ်လို့ ပြောတယ်။ ဒါကြောင့် သူတို့ ပြော တဲ့ အတိုင်း လုပ်ပေးခဲ့ရတယ်။

□4) ကွန်ဒုံးမသုံးပဲလိင်ဆက်ဆံတဲ့အခါမှာစိတ်ပျော်ရွှင်မှုပိုရရှိတယ်လို့သူဝယ်ချင်းနဲ့ လုပ်ဖော်ကိုင်ဖက်တွေက ပြောတယ်။

□5) ကွန်ဒုံးမသုံးဖို့အတွက်သူဝယ်ချင်းလုပ်ဖော်ကိုင်ဖက်၊ သက်တူရွယ်တူ အလုပ်ရှင်တွေထံမှ တဆင့် ထူးထူးခြားခြား ဘာဖိအားမှမရရှိခဲ့ပါ

53. ရှာ့ သင့်ရဲ့ ပုံမှန်လိင်ဆက်ဆံဖော်ဆက်ဆံဖက်(ယောကျ်ား၊ ရည်းစားချစ်သူ)

တွေ့ဆီကသင်လိင်ဆက်ဆံတဲ့အခါကွန်ဒုံးမသုံးဖို့ အတွက် အဓိကဖိအားပေးတာ ဘာတွေလဲ?

1) ကွန်ဒုံးရဲ့ ပုံမှန်လိင်ဆက်ဆံဖော်ဆက်ဆံဖက်ကော ကွန်ဒုံးကော ကွန်ဒုံးကိုအပြုတမ်းအလကားမရပါ။
ဒါကြောင့် ကိုယ့်ဘာသာ ပယ်ရတာ ဖြစ်လို့ ပိုက်ဆံ အလဟဿ ဖြစ်မှာ စိုးတဲ့အတွက် ကွန်ဒုံး မသုံးဖြစ်တာ
များတယ်။

2) ကွန်ဒုံး ရဲ့ ပုံမှန်လိင်ဆက်ဆံဖော်ဆက်ဆံဖက် သာသာပအရသာ လိုချင်တာရယ်၊ စိတ်ပျော်ရွှင်ပြီး
စိတ်သက်တောင့်သက်သာ ဖြစ်ချင်တာရယ်ကြောင့် ကွန်ဒုံး မသုံးစေချင်ဘူး။

3) ကွန်ဒုံး ရဲ့ ပုံမှန်လိင်ဆက်ဆံဖော်ဆက်ဆံဖက် ကွန်ဒုံး သုံးခဲ့လျှင် မိမိတို့အတွက်အနှောင့်အယှက်
ဖြစ်စေတယ်လို့ခံစားရတဲ့ အတွက်ကြောင့် မသုံးစေချင်ပါ။

4) ကွန်ဒုံးဖောက်သည် မှ ပုံမှန်လိင်ဆက်ဆံဖော်ဆက်ဆံဖက် (ချစ်သူသမီးရည်းစား၊ ယောကျ်ား)
ဖြစ်သွားသောကြောင့် ကျွန်ုပ်တို့တစ်ယောက်ကိုတစ်ယောက်ယုံကြည်ပြီးကွန်ဒုံးမသုံးတော့ပါ

5) ကွန်ဒုံးရဲ့ပုံမှန်လိင်ဆက်ဆံဖော်ဆက်ဆံဖက်မှကွန်ဒုံးမသုံးဖို့ အတွက် ထူးထူးခြားခြား ဘာဖိအားမှရရှိခဲ့ပါ။



Part VII. Preventive sexual behaviour with male clients/regular partners (negotiation on condom using and condom used at sex) (10 Questions: No.54-63):

Instruction: Please answer questions and please tick (✓) on the following questions of situation occurring during the last 3 months.

မိမိတို့ယ်တို့ပြောင်းလဲနိုင်သောအရာများ

အပိုင်အုတ် ယောက်ျားလေးအညွှန်သည်နှင့်ပုံမှန်ဆက်ဆံနေသောသူများနှင့်ဆိုင်သော ကြိုတင်ကာတွယ်ထားဆီနိုင်မည့် လိင် အမှုအကျင့် အလေ့အထများ (တွန်းခံ အသုံးပြုခြင်းနှင့် လိင်ဆက်ဆံမှု တွန်းခံ အသုံးပြုခြင်း နဲ့ ဝတ်သက်ပြီး ညှိနှိုင်းမှုပြုလုပ်ခြင်း) (ခေတ္တနှင့် သေ စွာ နံပါတ် ၅၄ မှ ၆၃)

ညွှန်ကြားချက် - လွန်ခဲ့သည့်၃လတွင်သင်၏အတွေ့အကြုံအရအောက်ပါမေးခွန်းများကိုကျေးဇူးပြု၍ သင်သဘောတူသည့်အတွက်တွင် အမှတ်ခြစ်ပါ။

နံပါတ်	ကြိုတင်ကာတွယ်ထားဆီနိုင်မည့် လိင် အမှုအကျင့် အလေ့အထများ	Always အမြဲ	Often ဖြောင့်က	Sometimes တစ်ခါတစ်လေ	Never ဘယ်တော့မှ
54. ၅၄	ကျွန်ုပ်ဟာ လိင်မဆက်ဆံခင် နှင့် လိင်ဆက်ဆံနေတဲ့အခါ အရက်သောက် တယ်။				
55. ၅၅	ကျွန်ုပ်ဟာ လိင်မဆက်ဆံခင် နှင့် လိင်ဆက်ဆံနေတဲ့အခါ မူးယစ်ဆေး သုံးတယ်။				
56. ၅၆	ပုံမှန်လိင်ဆက်ဆံနေကျလူနဲ့ဆက်ဆံတဲ့အခါမှာ ကွန်းခံ အပြီသုံးဖြစ်ပါတယ်				
57. ၅၇	ပုံမှန်လိင်ဆက်ဆံနေကျလူနဲ့ဆက်ဆံတဲ့အခါမှာ ကွန်းခံသုံးဖို့ အတွက် မနည်း သိမ်းသွင်း စည်းရုံးခဲ့တယ်				

58. ၅၈.	ကျွန်ုပ်ရဲ့ လိင်ဆက်ဆံဖော်နှင့် ဆက်ဆံတဲ့အချိန် သူတို့က ကွန်ဒုံးသုံးဖို့ ငြင်းဆိုတာကို ကြုံခဲ့ရဖူးတယ်။				
59. ၅၉.	ကျွန်ုပ်ရဲ့ ဧည့်သည်တွေနဲ့ လိင်ဆက်ဆံတဲ့အခါ သူတို့က ကွန်ဒုံးသုံးဖို့ ငြင်းဆိုတာကို ကြုံခဲ့ရဖူးတယ်။ ဒါကြောင့် ကျွန်ုပ်က သူတို့ သုံးအောင် စည်းရုံး သိမ်းသွင်းခဲ့ရတယ်။				
60. ၆၀.	ကျွန်ုပ်ရဲ့ ပုံမှန် လိင်ဆက်ဆံဖော်ကို ကွန်ဒုံး သုံးဖို့ စည်းရုံးတာ အောင်မြင်တယ်။				
61. ၆၁.	ကျွန်ုပ်ရဲ့ လိင်ဆက်ဆံဖော်နှင့် ဆက်ဆံတဲ့အချိန် ကွန်ဒုံးသုံးဖို့ငြင်းဆိုတဲ့အတွက် သူ (သူတို့) နဲ့ဆက်ဆံဖို့ ပြန်ငြင်းခဲ့တယ်				
62. ၆၂.	လွန်ခဲ့တဲ့သုံးလလောက်က ကျွန်ုပ်ရဲ့ ဧည့်သည်နဲ့ လိင်ဆက်ဆံတော့ ကွန်ဒုံး သုံးခဲ့ပါတယ်။				
63. ၆၃.	လွန်ခဲ့တဲ့သုံးလလောက်က ကျွန်ုပ်ရဲ့ ပုံမှန် လိင်ဆက်ဆံဖော်နဲ့ လိင်ဆက်ဆံတော့ ကွန်ဒုံး သုံးခဲ့ပါတယ်။				



บันทึกข้อความ

วิทยาลัยวิทยาศาสตร์สาธารณสุข
จุฬาลงกรณ์มหาวิทยาลัย
เลขรับที่: 1198
วันที่: 28 ตุลาคม 2559 เวลา 15:20

ส่วนงาน คณะกรรมการพิจารณาจริยธรรมการวิจัยในคน กลุ่มสหสถาบัน ชุดที่ 1 โทร.D-2218-3202

ที่ จว 143/2559 วันที่ 26 ตุลาคม 2559

เรื่อง แจ้งผลผ่านการพิจารณาจริยธรรมการวิจัย

เรียน คณะบดีวิทยาลัยวิทยาศาสตร์สาธารณสุข

สิ่งที่ส่งมาด้วย เอกสารแจ้งผ่านการรับรองผลการพิจารณา

ตามที่นิสิต/บุคลากรในสังกัดของท่านได้เสนอโครงการวิจัยเพื่อขอรับการพิจารณาจริยธรรมการวิจัย จากคณะกรรมการพิจารณาจริยธรรมการวิจัยในคน กลุ่มสหสถาบัน ชุดที่ 1 จุฬาลงกรณ์มหาวิทยาลัย นั้น ในการนี้ กรรมการผู้แทนหลักได้เห็นสมควรให้ผ่านการพิจารณาจริยธรรมการวิจัยได้ ดังนี้

โครงการวิจัยที่ 156.1/59 เรื่อง ความรู้ เจตคติ และการปฏิบัติต่อการป้องกันโรคเอดส์ของหญิงขายบริการชาวเมียนมาในอำเภอแม่สอด จังหวัดตาก ประเทศไทย (KNOWLEDGE, ATTITUDE, AND PRACTICE TOWARDS HIV/AIDS PREVENTION AMONG FEMALE SEX WORKERS FROM MYANMAR IN MAE SOT DISTRICT, TAK PROVINCE, THAILAND) ของ นางนภาพรณ เดอร์ คินเตอเรน

จึงเรียนมาเพื่อโปรดทราบ

Dr. Pichan
(ผู้ช่วยศาสตราจารย์ ดร.ปัทมา ชัยชนวงศาโรจน์)
กรรมการและเลขานุการ
คณะกรรมการพิจารณาจริยธรรมการวิจัยในคน
กลุ่มสหสถาบัน ชุดที่ 1 จุฬาลงกรณ์มหาวิทยาลัย

①
เรียน ท่านรองฯ (รศ.ดร.รัตนา)
เพื่อโปรดทราบและพิจารณา
สำเนา-ขอฝ่ายวิชาการ
Bir
วันที่ 29 ต.ค. 2559 เวลา 15:08

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11/10/16
55
31/10/16

11/11/59
11/11/59

AF 01-12



คณะกรรมการพิจารณาจริยธรรมการวิจัยในคน กลุ่มสถาบัน ชุตที่ 1 จุฬาลงกรณ์มหาวิทยาลัย
254 อาคารจามจุรี ชั้น 2 ถนนพญาไท เขตปทุมวัน กรุงเทพฯ 10330
โทรศัพท์โทรสาร: 0-2218-3202 E-mail: eccu@chula.ac.th

COA No. 180/2559

ใบรับรองโครงการวิจัย

โครงการวิจัยที่ 156.1/59 : ความรู้ เจตคติ และการปฏิบัติต่อการป้องกันโรคเชไอเอดส์ของหญิง
ขายบริการทางเพศในย่านกอบเน่สอค จังหวัดลวก ประเทศไทย
ผู้วิจัยหลัก : นางนภาพรรณ เฮอร์ อินเดยวิน
หน่วยงาน : วิทยาลัยวิทยาศาสตร์สาธารณสุข จุฬาลงกรณ์มหาวิทยาลัย

คณะกรรมการพิจารณาจริยธรรมการวิจัยในคน กลุ่มสถาบัน ชุตที่ 1 จุฬาลงกรณ์มหาวิทยาลัย
ได้พิจารณา โดยใช้อำนาจของ The International Conference on Harmonization – Good Clinical Practice
(ICH-GCP) อนุมัติให้ดำเนินการศึกษาวิจัยเรื่องดังกล่าวได้

ลงนาม.....
(รองศาสตราจารย์ นายแพทย์วิลา หัสมาประคิมฐ)
ประธาน

ลงนาม.....
(ผู้ช่วยศาสตราจารย์ ดร.มนตรี ชัยชนะวรสารโรจน์)
กรรมการและเลขานุการ

วันที่รับรอง : 21 ตุลาคม 2559

วันหมดอายุ : 20 ตุลาคม 2560

เอกสารที่คณะกรรมการรับรอง

- 1) โครงการวิจัย
- 2) ข้อมูลสำทกรในกลุ่มประชากรหรือผู้มีส่วนร่วมในการวิจัยละไว้ในขอบเขตของกลุ่มประชากรหรือผู้มีส่วนร่วมในการวิจัย
- 3) ผู้วิจัย
- 4) แบบสอบถาม



เลขที่โครงการวิจัย..... 156.1/59
วันที่รับรอง..... 21 ต.ค. 2559
วันหมดอายุ..... 20 ต.ค. 2560

- เงื่อนไข
1. ขีดเขตรับทราบเรื่องจริยธรรมของโครงการฯ หากดำเนินการเกินขีดขอบเขตไว้ก่อนให้รีบขอขออนุญาตคณะกรรมการพิจารณาจริยธรรมการวิจัย
 2. หากผู้รับรองโครงการวิจัยหมดอายุ องค์กรสนับสนุนวิจัยต้องยุติเมื่อถึงคราวต่ออายุของใบอนุญาตก่อนที่ผู้วิจัยจะดำเนินการวิจัย
ความถี่รวมการวิจัย
 3. ต้องแจ้งนิเทศวิจัยตามระเบียบไว้ในโครงการวิจัยต่อองค์กรวิจัย
 4. วัตถุประสงค์ของโครงการวิจัยกลุ่มประชากรหรือผู้มีส่วนร่วมในการวิจัย ใบยินยอมของกลุ่มประชากรหรือผู้มีส่วนร่วมในการวิจัย และเอกสารวิจัย
สำเนาให้เก็บไว้ที่คณะกรรมการพิจารณาจริยธรรมการวิจัย
 5. หากเกิดเหตุการณ์ไม่พึงประสงค์หรือเหตุร้ายในสถานที่ที่ดำเนินการวิจัยของผู้นิติบุคคลคณะกรรมการฯ ศึกษาของคณะกรรมการภาคใน 3 ใบที่มอบ
 6. กรณีการเปลี่ยนแปลงโครงการวิจัย ให้ส่งคณะกรรมการพิจารณาจริยธรรมก่อนดำเนินการ
 7. โครงการวิจัยไม่เกิน 2 ปี สิ้นสุดบทลงโทษโครงการวิจัย 18 05 12) และบทลงโทษโครงการวิจัยภายใน 10 วัน เมื่อโครงการวิจัยเสร็จสิ้น สำทกร
โครงการวิจัยที่ดำเนินการไว้ที่กรรมการพิจารณาจริยธรรมการวิจัย 3 ภายใน 30 วัน เมื่อโครงการวิจัยเสร็จสิ้น

VITA

Name	Miss Napapan Der Kinderen
Date of birth	October 22, 1975
Place of birth	Bangkok, Thailand
Education	B.A. Law, Thammasat University (1999) M.A. Human Rights, Mahidol University (2004)

Work Experiences

- Gender Equality and Social Inclusion Advisor: USAID Asia & Thailand Counter Trafficking in Persons (CTIP) Projects, Winrock International, Bangkok, Thailand (Aug-Nov 2017)
- National Researcher: The Independent High-Level Evaluation (HLE) of the Decent Work Country Programme (DWCP), the International Labour Organization (ILO) for Thailand and Lao PDR (April-July 2017)
- National Consultant: Gender Analysis Thailand and Malaysia (European Union), Development Alternative Inc. (DAI), London, UK (Nov 2016-Feb 2017)
- Gender/GBV (Gender Based Violence) Program Specialist, United Nations Population Fund (UNFPA), Timor Leste (Apr 2014- May 2015)
- National Program Officer, United Nations Population Fund (UNFPA) Thailand (Feb2012- 2014)
- Gender Advocacy Capacity Building Advisor for Rede Feto, Timor Leste (Women NGOs Network), Progressio, Timor Leste (Apr 2009-2010)
- Child Protection Training Officer, United Nations Mission in Sudan (UNMIS) HQ, Khartoum, Sudan (Aug 2006-Dec 2007)
- Humanitarian Affairs Officer, UNOCHA, Rumbek Office, South Sudan (Dec 2005 - Jun 2006)
- Assistant Regional Project Coordinator, International Organization for Migration (IOM), Regional Office, Bangkok, Thailand (Jun 2002-Dec 2004)
- Refugee Lawyer, International Rescue Committee (IRC), Bangkok, Thailand (Aug 2000-Jul 2001)