



CHAPTER II

LITERATURE REVIEW

2.1 Sexual Risk Behavior of Myanmar Migrants in Thailand

Several studies stated that having regular sex with sex workers, having multiple sexual partners, wrong belief about sexual pleasure and decoration of male organs are relatively common risky practices for male Myanmar migrant workers in Thailand (Naing, 2006; Ni, 2002; Caouette et al., 2000). Study conducted in Phuket also showed that drinking alcohol/beer, visiting Karaoke bar, and having sex with sex workers/service girls of karaoke bar are the routine recreation of the Myanmar migrant fishermen (Naing, 2006). In Ranong and Chiang Mai, sex patronage occurred as a group activity, especially after drinking (Caouette et al., 2000). Moreover, sex business exists in a variety of forms ranging from restaurants, to karaoke to street-based freelance sex workers. Two studies conducted by World Vision Foundation Thailand in 2000 and 2002, and the seafarer study initiated by UNICEF in 1999 also highlighted that the majority of the fishermen were Myanmar and had several sexual networks with Thai Sex Workers, Thai Service Girls, Myanmar Sex Workers, Myanmar Service Girls, girl friends, wives, and Men Who Have Sex With Men (MSM), and these studies and another study (Naing, 2006) also revealed that decoration of male organs like inserting marble or glass balls, using drugs like injecting oil or some lotion for abnormal enlargement of male organs, peer pressure

on alcohol drinking and patronizing sex workers were very common among Myanmar migrant workers, especially fishermen.

Among the Myanmar migrants, fishermen and fishery-related workers are vulnerable to HIV/AIDS infection. They tend to engage more often in risky sexual behaviors when they are onshore, as they are in vulnerable conditions of being away from family with no social and cultural limitations, easy availability of alcohol and sex and persistent peer pressure. Using the services of a sex worker is a bonus for their hard work (Kominbut, 1995). About 60% of the surveyed fishermen had admitted to having multiple partners and visited commercial sex workers while away from home (Wongkhomthong & Ohsawa, 1998).

2.2 Attitudes towards Sexual Risk Behavior and Condom Use

Condom use is the only reliable method of HIV/STD prevention for those who choose to be sexually active. The rates of condom use among young people in United States are still consistently low (Jemmott et al., 1998), and condom use is particularly rare among individuals who consider themselves to be in stable relationships (Misovich et al., 1997). Effective interventions like Information-Motivation-Behavioral Skills (IMB) model to increase condom use among sexually active young people are needed ($p < 0.001$) (Fisher & Fisher, 1992, 1996, 2000). Among Latinos and other groups, those who are more embarrassed to buy condoms carry and use them less often than those who are less embarrassed (Van Oss Marin et al., 1993). Moreover, sexual comfort has been strongly associated with self-efficacy to use condoms in Latino men with multiple heterosexual partners.

Hispanic men have been found to consistently use condoms with their primary partners only 8.8% of the time (Harrison et al., 1991). However, condom use with secondary partners ranges from less than 20% to greater than 60% (Donnell et al., 1994). Another study by Donnell et al. (1994) reported that Hispanic men used condoms 19.2% of the time with non-primary partners. Similarly, in a random sample of 4,658 heterosexual Hispanics, the reported rate of condom use in the past year for men with secondary partners was 29%. In their random sample of 361 Hispanic men in the Northeast and Southwest who had secondary sex partners, 60.1% said that they always used condoms in the past six months with their secondary partner (Van Oss Marin et al., 1993). Condom use during each sexual intercourse currently proves to be the only efficient way to prevent the spread of STD and HIV (Carey et al., 1992). In a European study, among the respondents who have more than one partner in the year preceding the study, only 52% of the men and 41% of the women declared having used a condom at least once (Guiguet et al., 1994). Indeed, 78% of respondents in an American study declared that they did not always use a condom during sexual intercourse (Choi & Catania, 1996). Another study carried out among American adults revealed that 61% of the respondents had unsafe sex with their last partner (Kusseling et al., 1996).

Several psychosocial models assume that people are more likely to use condoms when they believe that condom use will result in desirable outcomes. For example, most people think that condom use prevents HIV/AIDS and sexually transmitted diseases (STDs). Some people believe strongly in these positive outcomes and perceive other negative outcomes (e.g., condom use decreases sexual pleasure) to be unlikely; their attitudes toward using condoms are likely to be positive (Fisher, Fisher,

& Rye, 1995); and their use of condoms is likely to be frequent (Fishbein et al., 1995). Moreau-Gruet et al. (1996) found that males held more favorable attitudes toward condoms and their regular use. Positive attitudes about condom use may lead to purchasing condoms, having them available, and discussing condom use with a partner, which in turn facilitates condom use itself (Ajzen, 1991; Ajzen & Madden, 1986). Regarding attitudes about condom use, researchers have found that, in general, a negative attitude serves as a barrier to condom usage while a positive attitude facilitates safer sex practice (Lollis et al., 1996).

Thu (2003) conducted a study to determine socio-demographic, social network characteristics and knowledge and attitude towards HIV/AIDS transmission among Myanmar migrant factory workers in Mahachai district, Samut Sakorn province, Thailand. The result showed that only attitude of the respondents was associated with using condom during non-marital sex. The respondents with poor attitude were less likely to use condom with non-marital sex ($p < .033$).

One study conducted in Ranong, Thailand revealed that just over half of the fishermen, in the study, have more than 70% positive attitude towards HIV/AIDS, More than 40% disagree that everybody has an equal chance to get HIV/AIDS and 67.7% believe that one should not have sex if the partner refuses condom use. However, 44% of respondents agree that use of condom makes sex less enjoyable and more than 50% agree that there is no need to use condom with a steady partner (Paw, 2006). Likewise, one study conducted among Myanmar migrant workers in Samut Sakorn, Thailand also showed that about 41% of males and 52% of female workers have more than 70% positive attitude towards HIV/AIDS prevention, and 28% of

males and 29% of female workers believe that having sex only once without using condom will not get HIV (Thu, 2003).

2.3 Health Communication and Effect of Media on HIV/AIDS control

Health communication is one of the important interventions for HIV/AIDS program. One national study conducted in Norway in 1998 stated that the most important sources of information related to HIV/AIDS are television, radio and newspaper, and, totally, 2% reported having changed sexual behavior because of fear of HIV/AIDS. The youngest age group reported change (4%) and intended change (6%) more often than did the other age groups (Kraft & Rise, 1988). One national qualitative evaluation study conducted in South Africa showed that HIV/AIDS communication project consists of television, radio drama and print materials gave numerous instance of community change (Goldstein et al., 2005). Some print media like booklet or cartoon are also effective for HIV information. One qualitative study done by family-based intervention in South Africa concluded that the potential role of micro-media like cartoon narrative was a useful medium for informing the development and diffusion of health-enhancing social representations that shape the potential for health-related behavior change (Petersen et al., 2006).

Moreover, numerous studies show that exposure to entertainment-education-based mass media campaigns is associated with reduction in risk behaviors. One study done in North India stated that TV drama and TV spots gave positive behavioral outcomes like condom use, interpersonal communication and gender attitudes (Sood & Nambiar, 2006). Another study done by UNAIDS and VISION Project of Nigeria also revealed that exposure to mass media programs about reproductive health and

HIV prevention topics can help increase HIV/AIDS awareness, reduce barrier to condom use, resulting in improvements in HIV/AIDS prevention behavior (Keating et al., 2006). Mass media is one of the contributing factors for HIV/AIDS control program. One review study stated that mass media campaigns designed to raise awareness of HIV and AIDS have shown immediate and significant effects in the promotion of voluntary counseling and testing for HIV (VCCT) (Vidanapathirana et al., 2005). Another study for the impact of mass media campaign, conducted among 2,213 sexually experienced male and female Kenyans, also showed that Exposure to branded messages was also associated with a higher level of personal self-efficacy, a greater belief in the efficacy of condoms, a lower level of perceived difficulty in obtaining condoms and reduced embarrassment in purchasing condoms. Moreover, there was a dose-response relationship: a higher intensity of exposure to advertising was associated with more positive outcomes. Exposure to generic advertising messages was less frequently associated with positive health beliefs and these relationships were also weaker. Branded mass media campaigns that promote condom use as an attractive lifestyle choice are likely to contribute to the development of perceptions that are conducive to the adoption of condom use (Agha, 2003).

2.4 Participatory Health Education and HIV Prevention

Even though there are many approaches for health education in HIV/AIDS control, the ultimate goal is the positive behavior change because HIV infection is mainly due to risky sexual behavior (UNAIDS, 1999). So, knowledge is not enough for HIV prevention.

One study done in China, a country with estimated more than one million HIV-infected people, examined effectiveness of peer-led health message diffusion in promoting condom use through a participatory communication approach among these men in the Program, showed that the peer-based participatory communication strategy was effective for encouraging condom use with casual sexual partners in the intervention group. There was no significant change in the comparison group. It indicates that participatory involvement is the major driving force for HIV-related safer sex behavior change and can be recommended to promote safer sex practice among gay men and MSM in their broad contexts (Gao & Wang, 2007). Likewise, one study done in Zimbabwe, Southern Africa showed that community-based participatory peer education was often positively associated with successful avoidance of HIV and STI, which, in turn, is positively associated with psychosocial determinants of safer behavior (Gregson et al., 2004).

Participatory health education can enhance HIV prevention not only in normal community but also in hidden community like injecting drug users. One randomized controlled trial involving HIV and HCV antibody-negative IDU, aged 15-30 years, recruited in five United States cities revealed a 29% greater decline in overall injection risk 6 months post-intervention relative to the control [proportional odds ratio 0.71; 95% confidence limit (CL) 0.52, 0.97], and a 76% decrease compared with baseline. Decreases were also observed for sexual risk behaviors, but they did not differ by trial arm. Overall HCV infection incidence (18.4/100 person-years) did not differ significantly across trial arms (relative risk 1.15; 95% CL 0.72, 1.82). No HIV Sero-conversions were observed, stating that interventions providing information, enhancing risk-reduction skills, and motivating behavior change through participatory

peer education training can reduce injection risk behaviors, although risk elimination might be necessary to prevent HIV and hepatitis C virus transmission (Garfein et al., 2007).

One study on the impact of peer group education on HIV prevention among women was done in Botswana. There was a peer group HIV prevention intervention based on social-cognitive learning theory, gender inequality, and the primary health care model for community-based health promotion was developed for more than 300 urban employed women in Botswana. The study resulted that women in the intervention group had significantly higher post-intervention levels of knowledge of HIV transmission, sexually transmitted diseases (STDs), and HIV prevention behaviors; positive condom attitudes and confidence in condom use; personal safer sex behaviors; and positive attitudes toward persons living with HIV/AIDS and community HIV/AIDS-related activities. Besides, the peer group leaders have sustained the program for more than 5 years after the end of research funding. Peer groups are a low-cost and sustainable intervention that can change HIV prevention knowledge, attitudes, and behaviors for ordinary urban employed women in sub-Saharan Africa. And, the study clearly stated that the strategy for change used peer education and support groups led by trained community women to achieve lasting behavioral changes that promote health. (Norr et al., 1992, 2004).

2.5 Enabling Environments, Social Networks and HIV Prevention

Behavior change communication often focuses on individual-level variables such as knowledge, perceived risk, self-efficacy, and behavior. A growing body of evidence suggests, however, that structural interventions to change the policy

environment and environmental interventions designed to modify the physical and social environment further bolster impact. Therefore creating an enabling environment like PLHIV groups, CBOs, MSM groups enhance increased sharing of health information, increased psycho-social support, and decreased stigma and discrimination about HIV/AIDS, resulting positive behavior change (PHAMIT-WVFT, 2004).

An evaluation study done in Russia and Bulgaria stated that HIV prevention, by intervening social networks, is potentially important, and results revealed that social networking produced increases in the level and comfort with which network members talked about AIDS prevention topics in their daily conversations, increased network-level AIDS risk reduction knowledge and improved risk reduction norm perceptions, attitudes, behavioral intentions, and self-efficacy, and increased condom use levels among network members. Although not a controlled, randomized trial, these program evaluation findings strongly support the feasibility of social network-level HIV prevention approaches. (Amirkhanian et al., 2003).

In United States, a study done by CDC in 2003-2004 showed that community-based organizations using social network strategy identified the persons at risk for HIV infection and directed them to HIV counseling, testing, and referral (MMWR Weekly, June 24, 2005). Likely, a study conducted in Netherlands in 1998 concluded that social network of IDU played an important role in transmission dynamic and success of HIV prevention (Kretzschmar & Wiessing,1998). Moreover, in 2006, a randomized control trial study was done to determine the effects of a behavioral intervention for prevention of HIV and sexually transmitted diseases that identified, trained, and engaged leaders of Roma (Gypsy) men's social networks to counsel their

own network members. It was designed to measure the occurrence of unprotected intercourse during the three months before each assessment, and its result reported prevalence of unprotected intercourse in the intervention group fell more than in control group (from 81% and 80%, respectively, at baseline to 65% and 75% at three months and 71% and 86% at 12 months). Changes were more pronounced among men with casual partners. Effects remained strong at long term follow-up, consistent with changes in risk reduction norms in the social network. Other measures of risk reduction corroborated the intervention's effects, so concluded that Endorsement and advice on HIV prevention from the leader of a social network produces well maintained change in the reported sexual practices in members of that network (Kelly et al., 2006). Besides, AIDS Action Journal also stated that participatory research and community discussion can, however, help people to acknowledge relevant issues and look for solutions. The process may span several years and require the involvement of key decision makers. Health or education team staffs often begin by raising the issue with community leaders, allowing people to explore the problems and decide upon appropriate strategies. People then often decide to select a few individuals to be trained as community counselors who act as advisors and link the community with the health service (AIDS Action, 1995). The Social Network and Social Support Model posit that there are mutually beneficial relationships between social network and social support and (a) physical, mental and social health; and (b) modification of behavioral risk factors and acquisition of preventive health practices. The model describes the characteristics of social networks as follows:

- (1) “The extent to which resources and support are both given and received in a relationship”
- (2) “The extent to which a relationship is characterized by emotional closeness”
- (3) “The extent to which a relationship serves a variety of functions”
- (4) “The extent to which network members know and interact with each other”

Four types of social support are also identified: “emotional support (empathy, love, trust, and caring)”; “instrumental support (tangible aid and service)”; “informational support (advice, suggestions, and information)”; and “appraisal support (constructive feedback or information useful for self-evaluation)” (Heaney & Israel, 1997).

In a community-based intervention to promote ante-natal care among Mexican migrants in three poor rural farming communities in Arizona, identification and training of Mexican speaking women from these communities enhanced existing networks, facilitated provision of health education, social support and referrals for delivery, and increased involvement of community members in the program and in service utilization (Meister et al., 1992). In another community-based study to promote breast cancer screening for African American women in a rural community in North Carolina, Lay Health Advisors (from the community) provided information and referrals, emotional caring, and tangible assistance, raised funds for poor women who needed financial assistance for a mammogram, created a bridge between the lay community and the medical care system, produced educational 40 materials, and established a non-profit community-based organizations to sustain project interventions (Eng, 1993). Although the Social Network and Social Support model

has evolved as an ecological approach for health promotion, the utilization of the model in prevention of HIV in developing country settings has not been reported.

2.6 Socio-economic Status and HIV Prevention

There are some linkages between socio-economic status especially education level and living standards, and positive behavior change for HIV prevention, even though it is still controversial. One cohort study was conducted between 2001 and 2004 in rural South Africa, using structured questionnaires and in-depth interviews 3881 individual aged 14-35 years, and Data on sexual behavior were available from 1967 individuals at both time points. A total of 1286 HIV-negative individuals at baseline contributed to the analysis of incidence. HIV incidence was 2.2/100 person-years among men and 4.9/100 person-years in women, among whom it was highest in the least educated group. Median age at first sex was lower among later birth cohorts. A higher number of previously sexually active individuals reported having multiple partners in the past year in 2004 than 2001. Condom use with non-spousal partners increased from 2001 to 2004. Migrant men more often reported multiple partners. Migrant and more educated individuals of both sexes and women from wealthier households reported higher levels of condom use. So that study concluded that high incidence and some risky sexual behavior like early sexual debut, multiple sexual partners are common in low educated women (Hargreaves et al., 2007). A paper presented at the 7th International Conference on AIDS in Florence which reflected the theme of the relationship between knowledge and behavior change, and it stated that Education and skill building intervention were related to increased skills in prevention of risky sexual and drug behavior among California high school students (Ross,

1991). Social Determinants of Health described that policy implications for improving sexual health globally must include interventions to include socio-economic and cultural environments and not only biochemical interventions and programs for individual behavior change (Marmot & Wilkison, 2003).

However, South African Demographic and Health Survey conducted in 1998 showed that Women in poorer households were slightly less knowledgeable about HIV/AIDS, while the Socio-economic inequalities in risky sexual behavior were negligible (Booyesen Fle et al, 2002). Likewise, two studies done among Myanmar migrants workers in Thai-Myanmar border areas also stated that education level and income had no association with their risky sexual behaviors ($p \geq 0.5$) (Paw, 2006; Thu, 2003).