Full Length Research Paper

The model development of participatory education on adolescent reproductive life (PEARL) programme to prevent unintended pregnancy among Myanmar migrant adolescent and youth in Samut Sakhon province, Thailand: (situational analysis)

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Accepted 21 March, 2011

Pregnancy among young adolescents is a significant problem in the world. Migrant workers from Myanmar come from a variety of geographical locations and ethnic groups. According to Samut Sakhon provincial health office data, there are 1,507 antenatal care cases, 1,517 delivery cases and 113 abortion cases among 7,000 Myanmar migrant women in 2009. Abortion rate is three times more than 2008 in same population. The objective of the situational study was to get the information from the adolescent (15-19 years) and youth (20-24 years) Myanmar migrants in relation to their knowledge, behavior, practice and supportive services to reduce unintended pregnancy for “PEARL” model intervention. Qualitative research method was applied among a total of 30 Myanmar migrants for in-depth interviews. Myanmar migrants were selected by random sampling in the age group 15 – 24 years old. In addition, 5 in-depth interviews were conducted with key informants from provincial health office and NGOs. The researcher carried out the NIVO version 9, qualitative analysis software. In the finding, youth age (20-24) was mostly found married and separated cases. Male respondents had more active in sexual behavior than female respondents. Family and social support was one factor to relate two ways. Family especially living together with relatives or parents reduced high risk of sexual behavior and social environment supports could get health information especially family planning pills. But social support would be risk to have an information and experience to get high risk of sexual behavior. Education was an important fact in sexual behavior, knowledge and attitude. It had also highly related with leisure activities and personal goal. And then rarely respondents used condom when they have sexual intercourse. Findings were applied and validated at research proposal. Developing appropriate IEC (Information, Education, and Communication) materials for different target groups of migrants, e.g., adolescent and young people especially young people with appropriate education level should be done. The sustainability of the services and education section should be ensured.

Key words: Adolescent, Youth, Myanmar Migrants, Participatory Education, Unintended Pregnancy, Peer Volunteer

INTRODUCTION

Adolescent, the period between childhood and adulthood is a time of profound biological, social, and psychological changes accompanied by increased interest in sex. This interest places young people at risk of unintended pregnancy, with consequences that present difficulties for the individual, family, and community (DiCenso, 1999). There are negative associations between early childbear-
An estimated 1.2 million migrants have settled in Thailand as a result of internal conflict within neighboring countries and economic opportunities and available services in Thailand. Most of the migrants are from Myanmar. Most of Myanmar migrant workers are living in ten provinces of Thailand such as Bangkok, Samut Sakhon, Chaing Mai, Chaing Rai, Ranong, Mae Sot, Phang Nga etc. Many of Myanmar migrants youth, adolescent are working and living in factories (some legally, some most not). They don’t have ready access to contraception, and they are easy prey for both transactional and coercive sex. Education efforts are stymied by low literacy rates (Goldstein, 2009).

Pregnancy among young adolescents is a significant problem in the world. In low- and middle-income countries, almost 10% of girls become mothers by age 16 years, with the highest rates in sub-Saharan Africa and south-central and south-eastern Asia. In Samut Sakhon province, Thailand, registered migrants 55,749 persons and estimated Non-registered Migrants about 20,000-70,000 are living, of which 97% are Myanmar (WHO Border Health Program, 2006).

In Myanmar, the average age at first marriage is relatively late. Only 2.2% of men and 6.6% of women get married before the age of 20. While there are strong cultural values against premarital sex, there is high demand for reproductive health information and services from married and unmarried adolescents. Forty three percents of married women aged 15 have started childbearing by 19 years this number reaches 73.9% (The Department of Family and Community Health, WHO, 2004).

In the study; the baseline survey in 2004 by Institute of Population and Social Research, Mahidol University found that among the Myanmar migrant in coastal provinces of Thailand (including Samut Sakhon), the age between 15-19 years of male was 14.9% (n=2019) and female was 12.9% (n=395). Also they found that the age at first sexual intercourse under 15 years were 2.5% (n=1384) in male and 1.3% (310) in female. More interesting is that the age at first sexual intercourse between the ages 15-19 years were 40.2% (n=1384) in male and 44.5% (n=310) in female (PHAMIT, 2005).

Samut Sakhon is located 30 kms from Bangkok, Thailand. In 2009, there are 1,507 antenatal care cases, 1,517 delivery cases, and 113 abortion cases according to provincial health office data. Abortion rate is three times more than 2008 in same population (Samut Sakhon Provincial Health Office Report, 2006-2009).

The purpose of this paper is to get the information for the situation of Myanmar migrants in relation to their knowledge, sexual behavior, practice and supportive services to reduce unintended pregnancy for PEARL MODEL (Participatory Education on Adolescent Reproductive Life) intervention. The intervention was implemented in Samut Sakhon province, Thailand among the Myanmar migrants from August 2010 as one year program to determine effectiveness of peer-volunteers for preventing unintended pregnancy among Myanmar migrant adolescent and youth.

MATERIAL AND METHODS

The study was performed in May, 2010 at Muang District, Samut Sakhon Province, Thailand. Participants were chosen according to the inclusion criteria of (15-19 years) adolescent age and (20-24 years) youth age Myanmar migrants, both male and female who can communicate with Myanmar language. The identification and recruitment of respondents were carried out in conjunction with the provincial migrant’s health office, Samut Sakhon and announcement for participation was done. Then Myanmar migrant participants were selected by random sampling.

Qualitative method was used including: key informant interviews, in-depth case studies – in which an individual may be interviewed several times. The interview question types were open ended questions and it takes 45 minutes per each interview. All the interviews were held in each migrant’s resident and key informant’s offices.

In key informant’s interview, provincial migrant health system development officers, NGOs and hospital nurse who have responsibility in reproductive health unit were included in the study. Two set of interview guidelines were prepared beforehand for both migrant participants and key informants for the in-depth interview by literature reviewing and consulting with research advisors. Where appropriate, and with informed consent, the interviews were recorded and visual approaches were also used.

Fieldwork guideline questions for migrants were (1) Migrant individual factors and migrants history (age, gender, education, occupation, marital status, why and when left from Myanmar, migration experiences), (2) Personal Goal and Leisure activities, (3) family and social support (do you have family here?, who are your close friends?, how did you spend free time? etc.) (4) Individual experience on sexuality (married/single, have an experience of sexual intercourse?, first experience, with whom?, What is your early initiation of sexual activity, unsafe sex, preventive measures? etc.) (5) Knowledge, attitude and practice concerning about early child bearing, unintended pregnancy and abortion, (6) Access to healthcare services. Fieldwork Guidance questions for In-depth interview with staffs from relevant organizations working with migrants were (1) history of program/project related to migration, migrant health in general, and migrant reproductive health in Thailand (2) history of implementing to reduce adolescent pregnancy activities for migrants in your province (3) services for undocumented migrants (4) adolescent pregnancy risk and vulnerabilities of migrants (Do you think that migrants are at risk for adolescent pregnancy? Why do you think so?) (5) Relevant policy, guideline, coordination, etc.

For data analysis, NIVO version 9, qualitative analyzing management soft ware was used. A set of coding emerging from the interviews and responding to the questions raised above were identified; content analysis will then be carried, searching for these themes in the data.

The Ethical Review Committee for research involving human research subjects, Health Science group, Chulalongkorn University, Thailand, had approved the study and the title number is 038.1/53.
RESULTS

There were 30 respondents for in-depth interview in community side and 5 respondents in health care provider side. From 30 respondents, 10 respondents were adolescent aged (15-19 years old) and 20 respondents were youth. In gender issue, 12 respondents were male and 18 respondents were female. When looking in marital status, 10 respondents were single, 9 respondents were single having girlfriend or boyfriend, 6 respondents were married and 5 respondents were separated. (Table 1)

<table>
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<tr>
<th>Characteristics</th>
<th>Age 15-19</th>
<th>Age 20-24</th>
<th>Total</th>
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<tr>
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</tr>
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<td>Male</td>
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<tr>
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</tr>
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<tr>
<td>Total</td>
<td>10</td>
<td>20</td>
<td>30</td>
</tr>
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</table>

In this situational analysis, adolescent age group (15-19 years) was found more single respondents. Married, separated and single having boy or girl friends were mostly in youth age group (20 – 24 years). Most of adolescent, single, respondents had no experience for sexual intercourse according to their answer.

Impact of migration and reproductive health

One of the health care providers told that, “Most of migrants are 18 – 35 years old, working aged group and also reproductive aged group. So we have to do reproductive health. In 2010, we are doing research for gender and family planning”[Document Provider 2, Paragraph 7, 195 Characters].

Migration experience

All the respondents from this study illegally entered Thailand at the beginning. Most of respondents were directly come to Samut Sakhon province from border area by bus. Mostly they work 3 districts in Samut Sakhon Province. All are working in Fishery industries. “First I came to border by car. Unfortunately, polices were waiting to check. So we hide and walked about 2 hours. After that I took small car to cross the border and needed to hide. When I arrived to Thai side, I took bus to Samut Sakorn. Dangerous experience” [FD 16, Passage, 478 Characters, 20 years old, female, separated].

Age

In this situational analysis, adolescent age group (15-19 years) was found more single respondents. Married, separated and single having boy or girl friends were mostly in youth age group (20 – 24 years). Most of adolescent, single, respondents had no experience for sexual intercourse according to their answer.

“I already separated with my husband. We married last 6 months and separated 3 months after married”

Document FD 16, Paragraph 1-3, 478 Characters (20 years old, female, separated)

Gender and marital status

Single female respondent had low sexual risk behavior. “I got some friends in industry and I also got boyfriend. We met in work. We don’t have love making. It is not good for having sexual intercourse without married” [Document FD 21, Paragraph 5-8, 610 Characters] (18 years old, female, single).

All of adolescent age group in the study (15-19 years old) were found single or single having boy/girl friend. “I had
some friends and boyfriend. I got boyfriend last 2 months. How can I say why? May be we met all time in industry. That’s why it was easy to love him. We had no sexual intercourse because I afraid. I afraid to have pregnancy and I had no experience. ” Document FD 5, Paragraph 1, 484 characters (16 years old, female, single having boyfriend)

Married respondents had sexual risk behavior in both genders because of without using condom. “I had no experience sexual intercourse before married. We did not use condom. He drinks alcohol sometimes. He did not drink and take drug when we have sex. I trust him. He will not go to female sex workers and I think he will not have others diseases. So I did not tell about sexual intercourse without condom.” Document FD 2, Paragraph 1, 671 Characters (21 years old, female, married)

From the study, married and separated conditions were found in most of youth age group. (20-24 years old). When they shared their experience and thinking about why they easily accepted to marry and having sex “Now we already separated. When I arrived to here, I felt new experience and excitation. So it may be encouraged to have boyfriend and married.” [Document FD 16, Paragraph 1, 706 characters] (20 years old, female, separated)

Education

It was a one factors in this study. Unsafe sex behavior was found more in illiterate. “I did not study in my village due to my family economic condition. Last one year, I married with my husband. We did not use condom when we have sex.”

Document FD1, Paragraph 1,791 Characters (21 years old, female, separated) “I studied Eco – major in 10th standard. Now I study in English class in here every Sunday. I will try to know English language. I know about HIV/AIDS. I got this information at school from Myanmar. It can transmit from sex, blood and drug users. It can prevent using condom, blood checking.” Document FD 15, Paragraph 1,340 Characters (22 years old, female, single)

Family and Social support

Majority of study population’s parents were resided in Myanmar and they live in Samut Sakhon with siblings, cousins, relatives and friends. Social and family support can reduce sexual behavior. Sometimes peer support can attract to be in high risk behavior. “I had a lot of friends. I also had girl friend. She also works in industry. Sometimes I drink alcohol with my friends. We need happiness to forget difficulties.” [Document FD 9, Paragraph 4,193 Characters] (24 years old, male, single)

Leisure activities and personal goal

In the study population area, most of them were worked in fishery industries and fishery boat. They have holiday time in every Sunday. Leisure activity was influence in young people’s behavior changing. Their spending time activities were related with their personal goals for their life. Some had no personal goal, female prefer to see romantic VCD and male drink alcohol with their friends especially on Sunday, holiday, to forget difficulties and for happiness. Some of respondents have alcohol drinking and there were no respondents in using narcotic drugs and cigarette smoking. But they had no taking alcohol and taking drugs during sexual intercourse. Some of respondents studied in English Sunday class. They had idealistic strategies how to deal and how to manage their future life plan.

Experience of sexual relationship

Most of female (single, single having boyfriend) respondents were rarely having sexual relationship according to their answers. Some of male respondents had sexual relationships with their girl friends sometimes. Using condom when sexual relationship was answered as a barely behavior. There was risk practices behavior. “I have my boyfriend. We have no sexual intercourse because I afraid. I afraid to have pregnancy and I have no experience. I don’t know about family planning methods and HIV/AIDS.” Document FD5, Paragraph 5-7, 484 Characters

(16 years, single, female) “Honestly, I live with my girl friend sometimes. But I try to control because we did not marry. I need to save money to marry. When I live with my girl friend, I do not use condom because I never go female sex workers and I also trust her” Document FD9, Paragraph 5-9, 977 Characters

(24 years, single, male) Male respondents had an experience with female sexual workers. Most of them were influenced by friends. “Before married I had free times and spent with my friends. Sometimes we drank together alcohol together. But I never use drug. I had an experience to go female sexual worker before married. My friends called me to go for relax. I used condom.” Document FD 6, Paragraph 3, 160 Characters (20 years old, male, married)

Knowledge about family planning

Married and separated women knew about oral contraceptive pills. Most of them got this information from their environment and friends and they bought from medicine shop. Some of them had no correct information. There were few cases in knowing about emergency pills and some of them did not respond. But most of them did
Knowledge about HIV/AIDS

Concerning about knowledge on transmission and prevention of HIV/AIDS, 12 out of 20 (60%) of youth (20-24 years) respondents had the knowledge and followed by 4 out of 10 (40%) of adolescent (15-19 years) had the knowledge.

One third of respondents well know about HIV/AIDS and also they studied over secondary education level in Myanmar.

“For HIV/AIDS, I knew from school in Myanmar. I studied 10th standard. It can transmit from blood, sex, mother to child and can prevent condom using, blood checking and avoid sharing needle.” Document FD 11, Paragraph 5, 153 Characters (20 years old, male, single)

Some respondents did not know about HIV/AIDS. According to their answer, they did not see about HIV/AIDS people in their environment and so they lack of concentration about this information. They don’t care about how important this HIV/AIDS. “NGOs, Provincial health office did health education and promotion. But I never go because of my work. I did not know about it.” Document FD 12, Paragraph 4, 64 Characters (21 years old, male, single)

Access to health care service

Documented migrants can get 30 Baht health service and undocumented migrants have to pay all service fees. They can go hospitals and clinics. They can buy medicine in shop. Most of them rarely to go hospital in minor illness even they have registered. They buy medicine from outside and they go to clinics. For family planning, they buy family planning pills from clinics. From government health care facility, documented migrants get medical checkup for registration and hospital service with 30 Baht /one visit. Undocumented migrants need to pay the cost that they took the treatment. Both documented and undocumented migrants can get disease prevention and education services in community. “We have clear policy for migrants especially for medical checkup in registration and disease prevention. We emphasize on equity and the way to entry of health approach. For undocumented migrants, they live illegally and they can be caught by police according to Thai government responsibility.” (Document Provider2, Paragraph 1, 695 Characters) NGOs gave the services for health, human right and law. “For health services, our provincial health office gives service for medical checkup for register, health promotion especially TB, HIV and other endemic diseases. Hospital gives mobile clinics. Rat-Thai NGO works for HIV and migrant workers law. LBM (Migration Labor Unit) works for migrant workers’ law and right. IOM (International Organization for Migration) finished its project last 8 months. IOM worked especially for hospital linkage for migrant workers. Other clinics and primary health center also have. Later, Thai education system becomes universal education and migrant children also got a chance to study. Other free classes also have according to their communities.” [Document Provider 3;
According to the provider side experience, abortion is illegal in Thailand. Most of aborted Myanmar migrant’s women were 20-30 years old. They tried to be aborted with injection and tablets nowadays. But it could be incomplete abortion. Some abortion cases were done in one community in Bangkok. Providers concern about reproductive health especially family planning issue. “They came to our clinic with unwanted pregnancy. Most of their problems were pregnancy with their boyfriends and their husband passed away. Mostly 20-30 years old were faced. Anyway, they try to abort and aborted. Abortion is ill-legal in Thailand. Last 3 or 4 years, their method to do abortion is entering stick inside the vagina. It is really dangerous. Later, they drink Kay the Pan (Myanmar traditional medicine) and Thai traditional medicine. Now they drink abortion pills and use vaginal tablets. For these medicines, they buy from medicine shops. These drugs selling are illegal selling. Medicine shops sell to people who used to buy these drugs. These drugs can be incomplete abortion. At that moment, they came to OPD (Out Patient Department) and I examined and referred to hospital. Most of Myanmar migrant’s workers were young. And they did not get family planning information, knowledge inside Myanmar before coming to work in Thailand. Educated migrant’s workers are rare. And then they are away from parents and guardians. They have a risk to have sex with their girlfriends or boyfriends without family planning /prevention. When they have pregnancy, they will try to abortion and become unwanted pregnancy problem.”

“Last year, there were 1,108 delivery cases in hospital and 86 abortion cases due to incomplete abortion in hospital among Myanmar migrants”[Document Provider 4, Paragraph 3, 375 Characters]. Provincial health office and NGOs mostly favor for disease prevention especially HIV/AIDS in 2009. For reproductive health issue, they have to give special project and health education within limited budgets situation.

“We have HIV prevention and care, STI and HIV drug adherence counseling and home visit activities for reproductive health. PHAMIT fund gives 5 years round. Last 5 years round, their priorities contained reproductive health and so our organization had Family planning projects. For this 5 years round fund, reproductive health did not contain as a priority and they emphasize HIV/STI. That’s why; we did not run family planning projects in community and health education in community. But we give free services for family planning pills, condom in OPD if they come to OPD.”

DISCUSSION

When analyzing the results of the study, there were clear differentiated behaviors for each in the aspect of gender point of view. It was the same results of other studies in South Eastern Mexico and Quantitative research in Samut Sakorn (Aye, 2003; Pablos, 2006).

Age is a one related factor on sexual experience and HIV/AIDS knowledge. Young aged people are sexually active and starting sexual activity depends on the regions (Lesson Learned Motivation for Safer Sex among Rural Youth Care, 1998). Previous research finding in Samut Sakorn showed 12.2 percent of youth who were ranged in 20 to 24 years age had high sexual risk behavior than younger age group 11 to 19 years (Aye, 2003). It is the same as in our study; most of adolescent age single respondents have no experience for sexual intercourse.

Assumption the behavior depending on age was influenced by the cultural influence and living time in Thailand. Adolescent age (15-19 years) was found as low risk behavior and youth (20-24 years) was more risk than adolescent. Adolescent one who just arrived to Thailand has influenced by cultural and his/her guardian’s shadow. This was the difference between this situational condition and other studies, RIPPLE England and Mexico research (Judith Stephenson, 2008; Pablos, 2006 ).

Education level highly influences in the perception and knowledge of reproductive health. Education is an important role in sexual behavior, knowledge and attitude. Young people who studied in formal education system might have more to gain more knowledge about HIV/AIDS (Ghoh, 1994). Unsafe sex behavior was more in illiterate (Chowdhury, 2001). In our study, most of the respondents were lack of correct knowledge about family planning and HIV/AIDS. And then rarely using of condom when they had sexual relationship. The respondents who had the experience of abortion were youth age.

Family and social support are related with the information and behavior. Even most of respondents had the attitude and perception of abortion with negative point of view, real situations have to face and solve the problem in case of their livelihood conditions. So improving knowledge by giving correct information is the effective prevention way of assumption in this condition. According to their answers, there were rarely sexual relationships in single respondents. Most of married / separated respondents and some of single respondents had the experience of sexual relationship but they are mostly not using of condoms. The assumption shaded the high risk behavior of them. Between documented and undокументed has difference in behaviours.
 According to registration status, the delivery cost in documented migrants is 700 Baht and undocumented migrants needs to pay all cost that they takes health care services. Abortion is illegal issue in Thailand. In provider side saturation, there are migrant’s health office, hospitals and NGOs. Their projects are HIV prevention, TB in 2009.

All of all, this study has stated after the situational analysis; the strong points were Samut Sakhon Province has strong health care facility to migrant workers both government side and NGOs side, strong cooperation with government health care, local NGOs and international NGOs for migration health, possession of strong experience in health care both quality and quantity, having strong evidence data in Provincial migrant health office for documented migrants and free education classes in community for migrant young people. Moreover, there were some opportunities such as easily communicate with Ministry of Public Health, Bangkok, United nation organization such as UNICEF, UNFPA and UNHCR etc, other International and National NGOs in Bangkok those are helping for migrants. On the other hand, there had also weak points including increasing number of under 20 years pregnancy rate, increasing number of abortion, diversification of health care is difficult to implement to complete health care facilities for migrant workers, limited budget to implement reproductive health care, limited situation to access all migrants’ population both documented and undocumented, limited time arrangement for health education section with working hours, education level to catch all correct health information when giving health education, scattering population in community, different ethnicity, i.e. Mon, Karen, Burmese and Yakhine to build correct communication and building trust and arrangement of documented and undocumented migrant (for example – the researcher have to see safely environment for undocumented migrants if there have health campaign or education section).

When considering that those findings give the assumption to point the correct information for knowledge and promote the specific motivation in young age group is urgently needed not only to reduce unintended pregnancies but also to improve reproductive health knowledge.

This allows an invitation to continue the research intervention in the line to correctly wide knowledge about the migrant’s life conditions and the power of place they have in the familiar community, the young migrants group.

This study faced particular challenge due to measurement bias. Tendency of respondents gave the answer for socially desirable issue especially in sexual behavior. Thus, the amount of information related with sexual behavior obtained from the guidelines questions of the research was limited.

**RECOMMENDATION**

As the nature of migrants’ situation, the health education programme should be cooperated with government health care, local provincial health office, international NGOs, migrant free schools and factories. Moreover, need to do appropriate time management in health education section especially in weekend or holidays. For sustainability, relatively educated adolescent and youth migrants should be empowered as peer volunteers among the peer groups.

The Model developments of participatory education on adolescent reproductive life (PEARL) programme is need to implement to prevent unintended pregnancy among Myanmar Migrant Youth in Samut Sakhon Province through empowering peer volunteers. Furthermore, reproductive health education radio section in Myanmar migrant community in Samut Sakhon Province and distribution of VCD or video reproductive health education movie series with different ethnicity language subtitle (Mon, Karen, Myanmar etc) are needed.

**CONCLUSION**

“PEARL” programme will pursue the strategy by diversifying with peer volunteers and facilitators in adolescent and youth aged group in Myanmar migrant, joint venture with provincial health office and seafood processing factories.

**ACKNOWLEDGEMENT**

First of all, we would like to thank the Ninety years Chulalongkorn research scholarship foundation for giving the research grant. Then, we would like to thank the respondents and key informants. Furthermore, we would like to express our appreciation for College of Public Health Science, Chulalongkorn University, Samut Sakhon Provincial Health Office, Rat Thai NGO and Samut Sakhon hospital for their collaborative efforts in this situation analysis. Moreover, we extend our thanks to Dr. Nilar Han and Dr. Nawakamon Suriyan for helping in data collection and NIVO data analysis.

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