

CERVICAL CANCER SCREENING UPTAKE AND ASSOCIATED FACTORS AMONG MYANMAR MIGRANT WOMEN IN CHIANG RAI PROVINCE, THAILAND

NOVELINN NAW KYAWT THU

MASTER OF PUBLIC HEALTH

IN

BORDER HEALTH MANAGEMENT

SCHOOL OF HEALTH SCIENCE

MAE FAH LUANG UNIVERSITY

2025

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THIS THESIS IS A PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF PUBLIC HEALTH
IN
BORDER HEALTH MANAGEMENT

SCHOOL OF HEALTH SCIENCE
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2025
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THESIS APPROVAL

MAE FAH LUANG UNIVERSITY

FOR

MASTER OF PUBLIC HEALTH

IN

BORDER HEALTH MANAGEMENT

Thesis Title: Cervical Cancer Screening Uptake and Associated Factors among Myanmar Migrant Women in Chiang Rai Province, Thailand

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ACKNOWLEDGEMENTS

First and foremost, I would like to praise the Lord for His abundant blessings, guidance, and unwavering goodness throughout my life. His grace and mercy have sustained me at every step of this process.

I would like to extend my sincere appreciation to my advisor, Asst. Prof. Dr. Pilasinee Wongnuch, and co-advisor, Asst. Prof. Dr. Peeradone Srichan for their dedicated supervision, continuous support, and invaluable feedback throughout the completion of this study. Their guidance and encouragement have been instrumental in shaping this research and my academic development. My sincere thanks are extended to exam committee; Asst. Prof. Dr. Udomsak Narkkul, Asst. Prof. Dr. Soontaree Suratana and Asst. Prof. Dr. Phitsanurak Kanthawee for their valuable comments and insightful recommendations, which greatly contributed to improving the quality of this thesis.

I would like to express my heartfelt appreciation to all participants who generously devoted their time and cooperation during the data collection process. Their willingness to participate made this study possible.

I am truly grateful to my seniors for kindly sharing their experiences and providing guidance throughout my research journey. I would also like to thank my friends for their constant encouragement, motivation, and support while walking this journey together.

I would like to sincerely thank the KAAD/ Bettina Kattermann Scholarship Committee for providing me with the opportunity and financial support to pursue my master's degree. I would also like to extend my sincere gratitude to Mae Fah Luang University for providing research grant support.

Finally, I would like to express my deepest gratitude to my family especially my mother for her unconditional love and unwavering belief in me which have been my greatest source of strength throughout this journey.

Novelinn Naw Kyawt Thu

Thesis title	Cervical Cancer Screening Uptake and Associated Factors among Myanmar Migrant Women in Chiang Rai Province, Thailand
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ABSTRACT

Background: Cervical cancer remains a major public health concern and is largely preventable through regular screening. However, vulnerable populations such as Myanmar migrant women living in Thailand, has limited access to healthcare including cervical cancer screening due to multiple challenges.

Objective: To estimate the percentage of cervical cancer screening uptake and to identify associated factors among Myanmar migrant women in Chiang Rai Province, Thailand.

Materials and Methods: A community-based cross-sectional study was conducted by using self-administered structured questionnaire to gather information on 260 Myanmar migrant women aged between 30-60 years from 6 randomly selected communities in Chiang Rai Province, Thailand. For descriptive statistics, frequencies and percentages were used. For inferential statistic, chi-square test, univariate and multivariable logistic regression were applied to identify significant associations between variables at a significance level of $\alpha = 0.05$.

Results: Of 260 participants, most of the participants were at the average age of 36 (IQR: 31,43), achieved primary school education in Myanmar (46.9%), 8.1% undocumented with 40% without health insurance. Regarding cervical cancer screening uptake, 16.9% of participants had received cervical cancer screening in the past three years. After controlling other variables, five variables were significantly associated with cervical cancer screening uptake among Myanmar migrant women in Chiang Rai Province: health insurance, length of stay in Thailand, contraceptive use, received

information from nurse or health assistant, and attitude. Participants covered under health insurance had 4.17 times higher odds of screening uptake compared to those paid out-of-pocket (95%CI = 1.61-10.85). Those who had stayed in Thailand for more than 5 years had 2.63 times higher odds of screening uptake than those who lived ≤ 5 years (95%CI = 1.05-6.58). The odds of screening uptake were 2.47 times higher in participants who used contraception than those who did not use (95%CI = 1.02-5.97). Participants who received information from nurse or health assistant had 4.47 times higher odds of screening uptake than those who did not received from them (95%CI = 1.60-12.44). Lastly, participants with positive attitude had 3.93 times higher odds of screening uptake than those with negative attitude (95%CI = 1.73-8.92).

Recommendation: Given the positive attitudes but limited knowledge observed, targeted health education in migrant communities and workplaces is recommended to improve awareness of cervical cancer screening. Additionally, providing on-site or outreach screening services in migrant areas may enhance accessibility and support better screening practices.

Keywords: Cervical Cancer, Screening, Migrant, Women, Chiang Rai

TABLE OF CONTENTS

CHAPTER	Page
1 INTRODUCTION	**1**
1.1 Rationale and Background	1
1.2 Research Questions	6
1.3 Research Objective	6
1.4 Study Scope	7
1.5 Operational Definitions	7
1.6 Conceptual Framework	10
2 LITERATURE REVIEW	**11**
2.1 Myanmar Migrant Women in Thailand	12
2.2 Cervical Cancer and its Causes	18
2.3 Cervical Cancer Screening	23
2.4 Knowledge-Attitude-Practice (KAP) Model	29
2.5. Factors Associated with Cervical Cancer Screening Uptake	30
2.6. Related Research	39
3 MATERIALS AND METHODS	**42**
3.1 Study Design	42
3.2 Study Setting	42
3.3 Study Population	43
3.4 Inclusion and Exclusion Criteria	43
3.5 Sample Size Calculation	44
3.6 Sampling Technique	44
3.7 Research tools and its Development	47
3.8 Validity and Reliability of Instruments	50
3.9 Data Collection Procedure	51
3.10 Data Analysis	52
3.11 Ethical Consideration	53
4 RESULTS	**54**
4.1 Descriptive Analysis	54

TABLE OF CONTENTS

CHAPTER	Page
4.2 Comparison of Factors in Relation to Cervical Cancer Screening Uptake	68
4.3 Identification of Factors Associated with Cervical Cancer Screening Uptake through Inferential Statistical Analysis	76
5 DISCUSSION	**85**
5.1 Discussion on Findings	85
5.2 Conclusions	94
5.3 Strengths and Limitations	94
5.4 Recommendations	95
REFERENCES	**98**
APPENDICES	**110**
APPENDIX A ETHICAL APPROVAL CERTIFICATE (THAI VERSION)	110
APPENDIX B. ETHICAL APPROVAL CERTIFICATE (ENGLISH VERSION)	112
APPENDIX C INFORMED CONSENT FORM (ENGLISH VERSION)	114
APPENDIX D INFORMED CONSENT FORM (MYANMAR VERSION)	122
APPENDIX E QUESTIONNAIRE (ENGLISH VERSION)	137
APPENDIX F QUESTIONNAIRE (MYANMAR VERSION)	157
CURRICULUM VITAE	**178**

LIST OF TABLES

Table	Page
3.1 List of Myanmar migrant communities in Chiang Rai Province, Thailand	45
3.2 Proportionate Sampling of Six Myanmar migrant communities in Chiang Rai Province, Thailand	47
4.1 Socio-demographic factors	55
4.2 Health-related factors	58
4.3 Perceived access to healthcare	60
4.4 Perceived social support	62
4.5 Cervical Cancer screening uptake	63
4.6 Reasons for not taking cervical cancer screening	64
4.7 Reasons for taking cervical cancer screening	66
4.8 Comparison of socio-demographic factors in relation to cervical cancer screening	68
4.9 Comparison of health-related factors in relation to cervical cancer screening uptake	71
4.10 Comparison of perceived access to healthcare in relation to cervical cancer screening uptake	74
4.11 Comparison of perceived social support in relation to cervical cancer screening uptake	75
4.12 Univariable analysis to identify factors associated with cervical cancer screening uptake	77
4.13 Multivariable analysis to identify factors associated with cervical cancer screening uptake	84

LIST OF FIGURES

Figure	Page
1.1 Conceptual Framework	10
2.1 Coverage of health insurance schemes for migrants	17
2.2 The timeline and natural history of cervical pre-cancer and cancer development	20
2.3 USPSTF recommendation for routine cervical cancer screening	25
3.1 Map of Chiang Rai Province	43

ABBREVIATIONS AND SYMBOLS

WHO	World Health Organization
USPSTF	US Preventive Services Task Force
HPV	Human Papilloma Virus
SDG	Sustainable Development Goals
UN	United Nations
UNDP	United Nations Development Programme
PAHCQ	Perceived Access to Health Care Questionnaire
MSPSS	Multidimensional scale of Perceived Social Support
SEZ	Special Economic Zone
IOM	International Organization for Migration
NHSO	National Health Security Office
VIA	Visual Inspection with Acetic Acid
LMICs	Low- and Middle-income countries
LBC	Liquid Based Cytology
LEEP	Loop Electrosurgical Excision Procedure
HIC	Health Insurance Card
SSS	Social Security Scheme
MHIS	Migrant Health Insurance Scheme
M-fund	Migrant Fund
NGO	Non-governmental organization
INGO	International non-governmental organization

CHAPTER 1

INTRODUCTION

1.1 Rationale and Background

Cervical cancer is a malignant tumor which can develop anywhere in the cervix, the junction between the lower part of the uterus and the vagina. It typically begins with precancerous changes mainly caused by the perisistent infection with the high-risk strains of human-papilloma virus (HPV), 16 and 18, which is commonly transmitted by sexual contact. If undected or untreated, these abnormal cervical cells may progress into invasive cervical cancer over a period of 15-20 years (World Health Organization, 2024). The majority of cervical cancer cases typically occur between the ages of 35 and 45, making it the foruth most common cancer amon women worldwide (American Cancer Society, 2023). It is one of the cancer that leads to hundreds of thousands of premature deaths among women (World Health Organization, 2013).

Cervical cancer is a significant public health concern with an estimated 660000 new cases and 350000 deaths globally in 2022. The 2024 report of American cancer society indicates that, in 2022, nearly 1,800 women had cervical cancer diagnosis and almost 1,000 women lost their lives from the disease everyday worldwide (Bray et al., 2024). Globally, the age-standardized incidence rate (ASIR) is 13.3 per 100,000 population while age-standardized mortality rate (ASMR) is 7.25 per 100,000 population. Every two minutes, at least one woman worldwide dies from cervical cancer. The burden of cervical cancer is unequally distributed between developed and undeveloped countries. 94% of the deaths are occurred in low- and middle- income countries, particularly in less developed countries. These regional disparities are largely driven by inequilities in access to vaccination, screening and treatment services (World Health Organization, 2024). The mortality rate of cervical cancer has been dropped significantly in high income countries with the effective screening programs to detect precancerous lesions by using cytology (Pap test) (American Cancer Society, 2020). However, it is challenging to achieve high coverage of cervical cancer screening in

most low- and middle income countrities due to competing healthcare priorities, limited financial resources, weak health system capacity, and a shortage of trained healthcare providers (World Health Organization, 2013).

In Southeast Asia, cervical cancer remains a major cause of death among women. It contributed significant portion of the global burden, with 200,000 new cases which is 32% of the global burden and 100,000 deaths which is 34% of global fatalities in 2020 (World Health Organization, 2023a). The age-standardized incidence rate and age-standardized mortality rate are 17.8 and 9.98, respectively. Compared to other regions of the world, Southeast Asia ranked seventh in cervial cancer incidence and mortality (International Agency for Research on Cancer, 2024). Only from ASEAN countries, there are around 69000 cervical cancer cases and 38000 deaths. In 2040, new cases and deaths are predicted to rise by more than 44% and 63%, respectively. However, population-based cervical cancer screening programs have only been started in few countries of ASEAN. In some countries, the participation remains below 50% and it is even lower than 10% in Myanmar and Indonesia (Zhao et al., 2022).

Cervical cancer is a major cause of cancer-related mortality among women in Myanmar, where its prevelance is noticeably high (Thinn et al., 2023). It is the most common cancer among women in Myanmar and among women aged 15 to 44. According to the recent data, it is estimated that there are 7129 women diagnosed and 4497 women died from the disease every year. The ASIR is 22.6 and ASMR is 14.4 in 2020 which is higher than global rate (IARC HPV information center, 2023a) . Despite an increase rate of disease's morbidity and mortality, the screening rate of cervical cancer over the previous 3 years is only about 2% in 2019. (IARC HPV information center, 2023b).

In Thailand, cervical cancer is also the second most common cancer among women, after breast cancer. According to current estimate, 9158 women are diagnosed with cervical cancer and 4705 die from the disease each year. (IARC HPV information center, 2023c). In 2020, the age-standardized incidence rate is 16.4 and age-standardized mortality rate is 7.45. However, Thialand has made significant progress in cervical cancer prevention through HPV vaccination and national screening program. According to the data of past 10 years, the estimated incidence rate of cervical cancer is decreasing due to national screening program. Thai women aged between 30 to 60

have a high screening rate with 67% within the last 5 years and 77% at least once in their lifetime (Wongpratate & Bumrungthai, 2024). The incidence of cervical cancer in upper Northern Thailand especially Chiang Rai and Chiang Mai is 1-3 times higher than average in Northern Thailand. This may be due to their geographical border with Myanmar and the documented challenges to access healthcare including preventive services among migrants (Sripan et al., 2022).

A large number of Myanmar nationals have been migrating to Thailand, due to economic hardships, the search for employment, trade opportunities, and better living conditions. As of July 2024, An estimated 4.1 million of Myanmar migrants were residing in Thailand with 1.8 million in irregular status (International Organization for Migration, 2024a). According to Thailand's Department of Employment, 70% of all registered migrant workers in Thailand are from Myanmar as of March 2024 with actual number likely much higher due to irregular mobility. Women make up approximately 43% of the total Myanmar migrant workers. Although migration from Myanmar to Thailand has remained steady since 2018, irregular entries surged following the military takeover in Myanmar in 2021. As one of the special economic zones (SEZ), Chiang Rai Province plays an important role in border trade and cross-border movement, particularly with Myanmar and Lao PDR. It hosts 5,0900 of Myanmar migrants according to the data in 2024. IOM estimates that the number of migrants in Chiang Rai is nearly 3 times higher than official records (International Organization for Migration, 2024c).

Thailand has made significant efforts to improve healthcare access for migrants through public health policies providing essential health services, migrant-inclusive disease control programs with robust community health system. Migrants are supported by inclusive policies such as Migrant Health Insurance Scheme (MHIS), Social Security Scheme (SSS) and M-fund, a private fund which supports both documented and undocumented migrants (International Labour Organization, 2021). However, Myanmar migrant women in Thailand have various barriers and difficulties in accessing healthcare services including preventive services. The most common barriers are language, high cost of services, distance of healthcare sectors, fear of being arrested and discrimination, lack of documentation and lack of insurance. It is found that 60% of the long-term Myanmar nationals in Thailand had no documentation and 32% of the

households stated that no members have any type of insurance (International Organization for Migration, 2024c). Moreover, most of the migrants don't know what services are covered and what percent is covered highlighting the difficulty using health insurance (International Organization for Migration, 2023). Free community clinics run by NGOs and INGOs, such as Mae Tao Clinic, World Vision, and the International Organization for Migration (IOM) fill healthcare gaps which are common among migrants, but these services are often insufficient due to high demand and the suspension of funding by U.S. Government (Hardman, n.d.; Min, 2025).

In summary, the barriers to accessibility of health services including preventive care, heightens the vulnerability of migrant women to health issues, including cervical cancer. In a study conducted about cervical cancer screening among local and migrant workers in Thailand shows higher incidence of abnormal screening results among migrant workers compared to local Thai women. Specifically, 3.45% of migrant workers (primarily from Myanmar and Cambodia) had abnormal results while no cases were detected among Local Thai Women (Joob & Wiwanitkit, 2020).

Cervical cancer significanly impacts not only individals but also their families. A study found that cervical cancer patients suffer from a lower quality of life with physical, mental and social impacts. Physical symptoms include vaginal bleeding, discharge, fatigue, pelvic pain and pain during intercourse (Swangvaree et al., 2010).They may also suffer from the side effect of treatments such as sexual dysfunction, premature menopause, and loss of fertility (Membrilla-Beltran et al., 2023). Emotionally, cervical cancer patients may face fear of death and disease progresion, leading to feelings of hopelessness and negativity (Akyüz et al., 2008; Ashing-Giwa et al., 2006). More than half of the patient reported that the disease negatively affected their social lives, limiting their networks and causing isolation (Zeng et al., 2011). There is also financial burden catastrophically for the individuals and their families , with treatment costs, loss of employment, and additional caregiving responsibilities which create significant stress (Endale et al., 2022). These economic burdens disproportionately affect women from lower socio-economic backgrounds, exacerbating poverty and financial instability (World Health Organization, 2018).

However, cervical cancer is highly preventable by regular screening, vaccination, and effective management (National Institutes of Health, 2024). Early

detection through regular screening allows for less invasive and effective treatment by improving survival rates and reducing treatment costs. Organized screening plays a major role for the higher coverage of screening. Cervical cancer screening reduces the mortality due to cervical cancer by 80% or more (World Health Organization, n.d.). Under the Universal Health Coverage Scheme, Ministry of Public Health (MoPH), Thailand has been conducting National cervial cancer screening program for women since 2005. The program uses Pap smear for women aged 30-60 and Visual Inspecion with Acetic Acid (VIA) for women aged 35-45 (Ploysawang et al., 2021). However, prior researches around the world, including United States (Endeshaw et al., 2018), China (Holt et al., 2021), Malaysia (Ba-Alawi et al., 2025), and Korea (Eo & Kim, 2019) have shown that migrants, regardless of their country of origin, have lower adherence to cervical cancer screening services than local citizens which is primarily due to language barriers, migration-related issues, challenges in accessing healthcare and insufficient knowledge.

Migrant women face multiple layer of vulnerability both as migrant and as women. As women, they may face additional barriers such as limited autonomy in health decision-making, cultural stigma surrounding reproductive health, and gender-based discrimination (Htun et al., 2021). These challenges are often compounded by socioeconomic hardship, language barriers, and lack of legal documentation, which further restrict access to essential health services as migrants (Min, 2025). Even though there are multiple layers of these disadvantage, migrant women remain underrepresented in both research and public health interventions.

Despite the critical role of cervical cancer screening in reducing mobidity and mortality of cervical cancer, and the high vulnerability of migrant women in Thailand, research on cervical cancer screening coverage among Myanmar migrant women in Thailand remains limited. A study conducted in Mae Sot among Thai and Myanmar populations found that only 13.27% had ever undergone cervical cancer screening (Myint et al., 2024). Other study has primarily focused on marginalized groups such as the Lahu hill tribes in Chiang Rai Province, Thailand, leaving a gap in understanding screening uptake among Myanmar migrant women (Intahphuak et al., 2021). Previous research on migrant health in Chiang Rai Province, Thailand focused on general

healthcare access with less attention to specific preventive service, cervical cancer screening (Min et al., 2025).

This study aims to address this gap by accessing the rates of cervical cancer screening and identifying the associated factors among Myanmar migrant women in Chiang Rai Province, Thailand. This study will examine the impact of socio-demographic characteristics, knowledge, attitude, health-related factors, psychosocial factors, and healthcare accessibility, and the findings will also provide insights into strategies for improving access to preventive healthcare services for this population. Without such data, it is difficult to design effective outreach, education, and screening programs that are appropriately tailored to the unique needs and barriers faced by migrant women in Chiang Rai Province, Thailand.

The results will contribute to public health efforts to reduce disparities in cervical cancer screening among migrant populations by providing valuable evidence for public health providers, policymakers, and non-governmental organizations to develop accessible and targeted screening programs for vulnerable and underserved migrant women which aligns with the WHO's global strategy to eliminate cervical cancer and supporting several SDGs development goals, including SDG 3 (good health and well-being), SDG 5 (gender equality) and SDG 10 (reducing inequality).

1.2 Research Questions

1.2.1 What is the magnitude of cervical cancer screening uptake among Myanmar migrant women in Chiang Rai Province, Thailand?

1.2.2 What are the factors associated with the cervical cancer screening uptake among Myanmar migrant women in Chiang Rai Province, Thailand?

1.3 Research Objective

1.3.1 To estimate the percentage of cervical cancer screening uptake among Myanmar migrant women (30-60 years) in Chiang Rai Province, Thailand.

1.3.2 To determine the factors associated with cervical cancer screening uptake among Myanmar migrant women (30-60 years) in Chiang Rai Province, Thailand.

1.4 Study Scope

A cross-sectional study was conducted from September to November, 2025 among Myanmar migrant women of aged 30 -60 years residing in Chiang Rai Province, Thailand. The study examined the key factors assoicated with cervical cancer screening uptake including socio-demographic factors, knowledge, attitude, health-related factors, healthcare accessibility, and psychosocial factors by using validated tools and self-structured questionnaire by doing extensive literature review.

1.5 Operational Definitions

Cervical cancer screening uptake refers to having received any kind of cervical cancer screening such as pap smear, visual inspection of acetic acid (VIA) or HPV DNA test including self-tested kit at least once in the past three years, as self-reported by participant.

Myanmar migrant women refers to Myanmar women aged 30-60 years who have resided in Chiang Rai Province at least 6 months.

Age refers to participant's age in completed years. The researchers will get the birth date of participant's from their ID card or passport and substract it from interview date to calculate the current age of the participant.

Marital status refers to the marital status of the participant at the time of interview. It will be categorized as single, married, separated, divorced, widowed.

Ethnicity refers to the participant's self identification of her ethnic group which will be categorized as Burmese, Shan, Karen, Mon and other.

Religion refers to the participant's religious affiliation which will be categorized as Christian, Buddhist, Islam, and other.

Education refers to the participant's highest level of education at the time of interview. It is divided into 5 groups: illetrate, primary school , secondary school, high school, undergraduate and graduate.

Occupation refers to the participant's current job she is doing for her living. It will be categorized as unemployment, agriculture worker, construction worker, service worker, factory worker, and other.

Household income refers to the total average amount of money per month received by family of the participants. It will be measured in Thai baht (THB) and treated as continuous variable.

Number of children refers to total number of children they have ever had.

Age at first time of marriage refers to the participant's age at the time of getting married.

Legal status refers to the participant's migrant status. It will be categorized as documented or undocumented migrant.

Health Insurance refers to having coverage for medical expenses under certain type of insurance. It will be categorized as out-of pocket, social security scheme, migrant health insurace scheme or private insurance scheme.

Language proficiency refers to the participant's ability to understand and communicate in Thai language. It will be categorized as none, basic and fluent.

Length of stay in Thailand refers to the duration of participant's stay in Thailand since they first arrived.

Contraceptive use refers to participant's current contraceptive utilization such as pills, injections, implants, surgical sterilization or not using any contraceptive methods.

Family history of cervical cancer refers to having a history of cervical cancer in the blood relative such as mother, sisters and daughters.

History of HPV vaccination refers to the participant history of getting HPV vaccination in their lifetime.

Perceived access to health care refers to accessibility, availability, acceptability, affordability, accommodation, and awareness toward health care resources. The grading will be categorized as low, moderate and high perceived access to healthcare.

Source of information refers to the source of information from which the participant gets health information. For example, family, husband, friends, neighbors, health professional or media such as posters, pamphlets, television and internet.

Knowledge about cervical cancer and cervical cancer screening refers to the participant's understanding about the causes, risk factors, symptoms, prevention of cervical cancer and advantages of screening for early detection and treatment. Knowledge will be defined as good, moderate and poor.

Attitude towards cervical cancer and cervical cancer screening refers to the participant's beliefs or feelings related to cervical cancer and its risks and benefits of cervical cancer screening. Attitude will be defined as positive and negative attitudes.

Perceived social support refers to the support like suggestion, encouragement, and assistance from family, friends and significant person. It will be considered low, moderate and high support.



1.6 Conceptual Framework

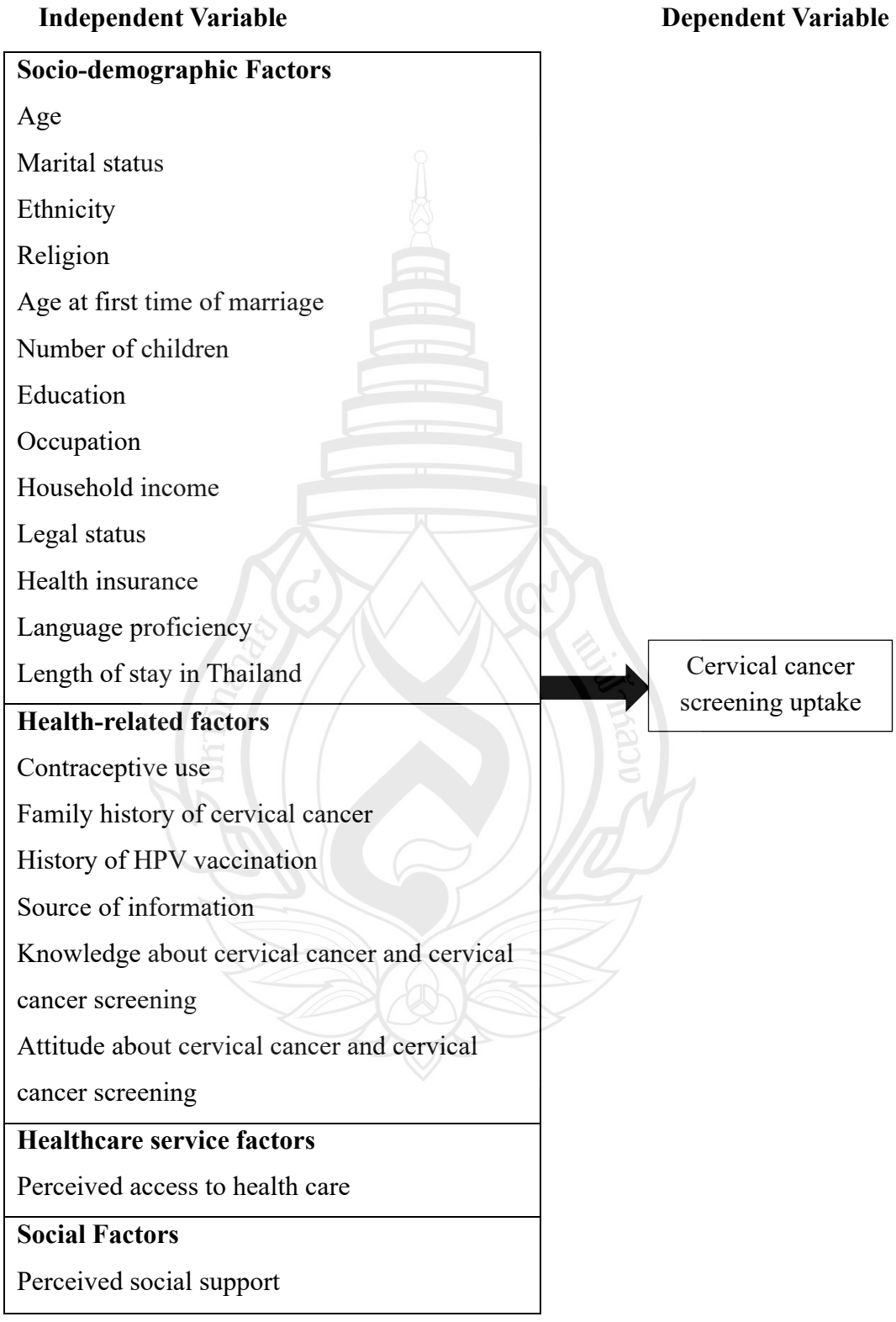


Figure 1.1 Conceptual framework

CHAPTER 2

LITERATURE REVIEW

This chapter review and present several relevant information regarding cervical cancer screening and Myanmar migrant women in Thailand. The literature will start the overview of cervical cancer. Following this, the common cervical cancer screening method, global trends in cervical cancer screening uptake, cervical cancer screening among Migrant populations, and cervical cancer screening in Thailand. After that, the focus will turn to Myanmar migrant women in Thailand, their demographic and socio-economic profile, and healthcare access and challenges for Myanmar migrant women in Thailand. Including, factors Associated with Cervical Cancer Screening Uptake and related research.

2.1 Myanmar Migrant Women in Thailand

2.1.1 Demographic and socio-economic profile of Myanmar migrant women in Thailand

2.1.2 Healthcare access and challenges for migrants in Thailand

2.2 Cervical Cancer and its Causes

2.2.1 Symptoms of cervical cancer

2.2.2 Stages of cervical cancer

2.2.3 Prevention of cervical cancer

2.3 Cervical Cancer Screening

2.3.1 Common screening methods (pap smear, HPV testing, VIA)

2.3.2 Global trends in cervical cancer screening uptake

2.3.3 Cervical Cancer Screening Among Migrant Populations

2.3.4 Cervical Cancer Screening in Thailand

2.4 Knowledge-Attitude-Practice model

2.5 Factors Associated with Cervical Cancer Screening Uptake

2.5.1 Demographic and Socioeconomic Factors

2.5.2 Health Related Factors

2.5.3 Healthcare Service Factors

2.5.4 Social Factors
2.6 Related Research

2.1 Myanmar Migrant Women in Thailand

Migration is the movement of people from one place to another, to settle in a new location. Migration can be voluntary or involuntary and can occur for a variety of different reasons including economic, environmental, and social issues (European parliament, 2024). Globally, there are approximately 258 million international migrants with half of them made up of women (Sinsomboonthong et al., 2021). Migration has lifted millions of people out of poverty and contributed to economic growth of both country of origin and country of destination. However, migration is not always safe. Migrants, especially women, face risks of violence at different stages of their journey of migration (UN Myanmar, 2020).

Women have been participating in migration throughout the world just as long as male. However, the role of women in the global economy, the proportion of women as the migrant workforce, their reasons to migrate have changed in recent decades. This shift is broadly described as the "feminization of migration" (International Organization for Migration, 2018). These trends are particularly evident in Southeast Asia, where migration was male dominated until 1980s. Today, 48% of the 9.87 million migrants in the region are women, and their influence is growing daily. In the past, women often migrated for marriage, to reunite with family or to accompany a spouse migrating for work. This trend is the same in Thailand where a large number of migrant women from Myanmar, Laos and Cambodia move with their husbands to work in sectors such as agriculture, construction, and manufacturing. However, nowadays, millions of women have been migrated independently to work. Migration provides them with the opportunity for social, economic and professional development, enables them to improve the well-being of families back home; and to acquire autonomy and empowerment (International Organization for Migration, 2018). It helps women to become financially independent and confident and offer opportunities outside traditional gender roles (UN Myanmar, 2020).

Many migrant women from Myanmar leave their country due to ongoing military conflicts, poverty and a lack of job opportunities. Some frequently use licensed private recruitment agencies or are directly employed by Thai companies while undocumented migrants rely on friends, families or ever undertake the journey on their own (UNDP, 2023). Most migrant women work in low-paid jobs which is known as '3D work'- dirty, dangerous and demeaning. Although their high demand among employers in many job sectors, they may face exploitative and discriminatory work conditions. This means their economic contributions do not always lead to greater social and economic equality. Despite inequalities and obstacles, many women still choose to migrate to Thailand with the hope of better wages and opportunities to gain skills and experience and improving their own quality of life as well as of their families (Sinsomboonthong et al., 2021). They are an important source of remittances for their home countries. Compared to male migrants, migrant women send a greater portion of their income home more often and for longer periods of time even though they earn less. These remittances often support entire households and significantly contribute to the reduction of poverty (International Organization for Migration, 2018).

In conclusion, despite the challenges and barriers, migrant women significantly contribute to the economic growth of both countries of origin and destination.

2.1.1 Demographic and Socio-economic Profile of Myanmar Migrant Women in Thailand

Based on the Department of Employment data, there are 2.3 million registered Myanmar migrant workers in Thailand which is the 70% of total registered migrants in Thailand. Of these, 43% are female migrants (International Organization for Migration, 2024c). An estimated 1.8 million migrants are working with irregular status. According to the report of UNDP in November 2023, the number and percentage of undocumented migrants are higher in women than in men (UNDP, 2023). Irregular migration is a key factor that puts women at risk, exposing them to several forms of violence such as exploitation, abuse, harassment, trafficking and forced labour with little recourse to seek for help (UN Myanmar, 2020).

Central Thailand, especially Bangkok and Samut Sakhon Provinces, is a main target destination for Myanmar migrants because of its economic opportunities, established peer communities, and proximity to Myanmar (International Labour

Organization, 2023). Average age of migrants is 35 and highest age group is 20-29 years (UNDP, 2023). Undocumented migrants are slightly younger on average. The education among the migrant population is relatively low with majority of the migrants have never attended school or have completed less than 5 years of basic education. A considerable number completed only up to primary school.

Migrant women currently fill significant gaps in Thailand's labour market. They mainly work in factories including seafood processing and garment manufacturing, in the construction sector, and in the formal sector, which includes agriculture and the service sector such as domestic work and the entertainment industry (MAP foundation, 2017). The participation of migrant women in certain sectors is remarkably high. More than 200,000 women are working in the construction industry which is nearly 40 percent of all migrant construction workers. Large numbers of "low status" job positions, such as domestic work, caregiving, hospitality and nursing, are filled by migrant women. These jobs are crucial as Thailand's population ages, increasing demand for workers in these sectors since they are often avoided by locals. Despite their significant contributions, migrant women remain undervalued by society (International Organization for Migration, 2018). Migrant women face discrimination daily and vulnerable to exploitation in terms of wages, working hours, freedom of movement, gender-based violence because of their social and migration status (UN Myanmar, 2020).

The average wage of female migrant workers is lower than male migrant workers even if they perform the same tasks. Women typically make 350 THB per day while men get 400 THB. In areas like Tak, wages can be as low as 200 THB per day (International Organization for Migration, 2024c). Some domestic migrant workers put in long working hours without receiving overtime compensation (United Nations Network on Migration, 2024). Moreover, domestic workers and sex workers in the entertainment industry are not recognized by labour laws and not valued by society. Violence among migrant women is underreported because of their immigration status, as undocumented workers often fear of deportation and losing of job leading continued cycles of exploitation (UN Women, 2021).

In conclusion, Myanmar migrant women in Thailand face significant challenges, not only as migrants but also as women. These struggles not only affect

their working conditions but also create barriers to accessing essential services including health care.

2.1.2 Healthcare Access and Challenges for Migrants in Thailand

Thailand's dual healthcare system, based on an entrepreneurial model, consists of both public and private sectors. However, many migrants still have challenges accessing these services.

Thailand's public health sector is composed of government hospitals and clinics which provide healthcare services at the reasonable prices, but irregular migrants face significant obstacles due to their legal status. Fear of being arrested and deported often discourage them from seeking care at the public sector, while language and cultural differences also deters their access to essential services. Even though private health sector provides high-quality services, the cost remains as a challenge. For migrant workers earning an average of 320–350-baht, private healthcare is largely unaffordable. Healthcare access is even more limited in rural and border areas where many migrants live. In response, free clinics operated by NGOs and INGOs, such as World Vision, International Organization for Migration (IOM), and Mae Tao Clinic help bridging the healthcare gaps. However, increasing demand often exceeds their capacity, making these services insufficient to meet all needs (Min, 2025).

Thailand is recognized as a leader in promoting migrant health because its public health system provides access to essential services, incorporates migrant-inclusive disease control programs, adopts decentralized service delivery policies and maintains a strong community health system.

Although Universal Coverage Scheme (UCS) does not cover migrant workers, regular migrants can access to healthcare through 2 channels: through SSS scheme (which is part of SSF) if they are formal sector migrant worker, and through Migrant Health Insurance Scheme (MHIS) if they work in the informal sector (International Labour Organization, 2021).

The SSS scheme covers employees from the private sector and documented migrants employed in the formal sector. Currently, dependents are not covered under the scheme, except for maternity protection for spouses. Registration is compulsory for private sector employees and regular migrant workers employed in the formal sector in Thailand (International Labour Organization, 2021).

The MHIS scheme for migrant workers is a contributory scheme and paid out-of-pocket by the worker, except for migrant workers in the fishery sector, where the employer must cover the expenses. Differential prices apply depending on pre-defined categories of the population. The standard price of the insurance is a fixed amount, THB3,200 for one year for adults and THB365 for children 7 years and below. The cost is THB1,050 for migrant workers who are expected to register with MHIS during the three-month waiting period to be covered by the SSS scheme (International Labour Organization, 2021; International Organization for Migration, 2021).

The MHIS is a voluntary health insurance scheme that covers documented migrant workers in the informal sector and their dependents (up to 18 years of age), as well as those working in the formal sector for the first three months of their employment before they become covered under the SSS scheme. Prior to May 2020, irregular migrant workers could enroll in the scheme, but now only regular migrant workers are eligible (International Labour Organization, 2021; International Organization for Migration, 2021).

There is also a private fund called Migrant-Fund (M-Fund) which is launched since 2017. This micro-insurance scheme is initially started in Tak province and is currently expanded to most border provinces where significant migrant populations exist. It provides access to both inpatient and outpatient services through a network of more than 200 partner facilities. The costs of M-Fund are comparable to MHIS but can be paid monthly. Government partner hospitals are intended to split the cost if migrants use services beyond what is covered by the M- Fund (Barber & Sciortino, 2024).

The following figure shows the services covered by SSS, MHIS and M-Fund insurance programs.

	Social Security Scheme (SSS)	Migrant Health Insurance Scheme (MHIS)	M-Fund
Coverage	Outpatient, inpatient, accident and emergency, high-cost care Specialist care	Outpatient, inpatient, accident and emergency, high-cost care except for renal replacement therapy and treatment for psychosis, and drug rehabilitation • Inpatient care for more than 180 days of the same condition/disease (unless there are additional complications and/or medical conditions)	Outpatient care up to THB 5,000 Inpatient care up to THB 45,000 (same for treatment and pregnancy) For chronic patients: Outpatient care up to THB 7,000 outpatient care Outpatient care up to THB 43,000 inpatient care

Source Thailand Migration Report (2024)

Figure 2.1 Coverage of health insurance schemes for migrants

However, disparities still remain among migrants in Thailand. They face barriers such as legal barriers, financial constraints, geographical and gender-based barriers, and language difficulties that interfere access to healthcare (Min, 2025). For instance, many undocumented or irregular migrants are excluded from the healthcare system since their migration status influences their eligibility for labour rights and social security benefits (Barber & Sciortino, 2024). The most common barriers are language, cost, distance, fear of being arrested and discrimination. For migrants who arrived in 2022 onwards, cost and fear of being arrested are the most common barriers which discourages them from seeking healthcare. (International Organization for Migration, 2024c).

Migrant women experience additional vulnerabilities due to their gender norms and societal roles while the high prevalence of irregular status further limits their degree of access to services. Although some companies provide basic medical care and contraceptive services on-site, some employers may neglect to enroll qualified migrant workers in the formal sector in the SSF and Workers' Compensation Fund, leaving them without coverage for essential services even when they are eligible for health insurance. It is also found that most common problem among Myanmar migrant women of reproductive age in accessing healthcare are inability to purchase or renew health insurance card (HIC), HIC or social security wage deduction avoidance, communication problems, hospital inexperience, the transit fare, and admission refusal

(Sitkulanan et al., 2024). According to Thailand Migration report 2024, only 51% of migrants were enrolled in a migrant health insurance scheme, indicating that almost half of eligible workers remain without health insurance (Barber & Sciortino, 2024). Most of the migrants don't know what services are covered and what percent is covered highlighting the difficulty using health insurance (International Organization for Migration, 2023). Female migrant workers, particularly those in domestic work encounter additional barriers to healthcare access such as the clinic hours that overlap with work schedules, unwelcoming attitudes from healthcare providers, and long distances to health facilities that exacerbates gender-based health inequities (Min, 2025).

The barriers faced by migrant extend to preventive healthcare services, which are essential for reducing the burden of chronic and preventable diseases. This lack of access to preventive care has serious implications in conditions like cervical cancer which may diagnosed at advanced stages, leading to worse health outcomes and higher treatment costs without regular screenings. A higher risk of cervical cancer was found above the average in Northern Thailand such as Chiang Rai and Chiang Mai which are border with Myanmar. This may be due to high transitional populations and their challenges in associated health care access to HPV prevention strategies, including screening and vaccination under the UHC which are only cover Thai citizens and not migrants (Sripan et al., 2022). Therefore, migrants are more likely to suffer from worsened diseases due to delayed diagnosis and treatment, further straining the healthcare system. Addressing these barriers is critical for improving the health equity and reducing the burden of preventable diseases among migrant populations.

2.2 Cervical Cancer and its Causes

"Cancer is a term used for the malignant, autonomous and uncontrolled growth of cells and tissues. Such growth forms tumor, which may invade the tissues around the cancer and cause new growths which is similar to the original cancer in distant parts of the body, called metastases. As cancer grows, it destroys normal tissues and competes for nutrients and oxygen".

Cervical cancer is a cancer that is found anywhere in the cervix. The cervix is the opening between the vagina and the uterus (womb). The womb is the place where the baby grows when pregnant. The cervix has two main parts: which is called ectocervix and endocervix. Ectocervix is the outer part of the cervix and is covered by squamous cells. Endocervix is the inner part of the cervix which is covered by glandular cells. These two types of cells meet at a place called transformation zone. Most of the cervical cancers begin in this area (National Cancer Institute, 2023).

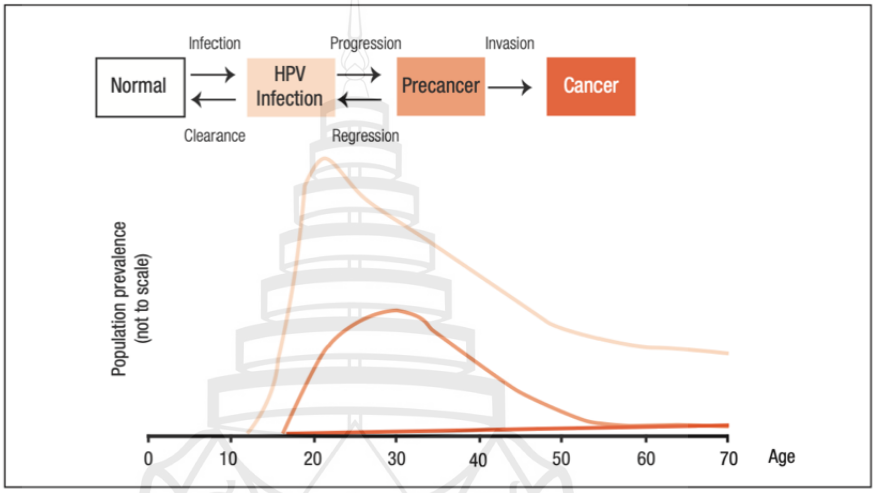
There are two types of cervical cancer which are called squamous cell carcinoma and adenocarcinoma. Up to 90% of cervical cancer are squamous cell carcinoma (National Cancer Institute, 2023b).

The transformation zone on the ectocervix becomes enlarged during puberty and pregnancy and makes it more susceptible to infection. Exposure to HPV at these times may increase the likelihood of infection and that explains the association between squamous cell cervical cancer and early sexual activity, young age at first birth, and a history of multiple pregnancies. Behaviors that can also increase the risk of HPV infection (and thus cervical cancer) include having multiple sexual partners and having partner who has multiple partners (World Health Organization, 2014).

The natural history of cervical cancer is from HPV infection to precancer to invasive cervical cancer. Almost all cervical cancers are caused by persistent infection with certain type of high-risk human papilloma virus (HPV). HPV infection can be transmitted from one to another by skin-to-skin contact of genital area, and any kind of sex. As a result, nearly everyone who engages in sexual activity will acquire HPV infection at some point in their lifetime usually without any symptoms. However, not all HPV types are oncogenic. Only high-risk strains of HPV 16 and 18 can progress to cervical cancer. Other strains can cause genital or skin warts (American Cancer Society, 2020a; World Health Organization, 2024).

Not all women infected with high-risk HPV do not develop cancer. HPV infection subsides by itself most of the time in less than 2 years but persist in some conditions. If the persistent infection of the HPV is left untreated, the cells of the cervix changes into abnormal cells called precancerous lesions which will later lead to cervical cancer. The progress of precancer into invasive cervical cancer is usually slow which takes 15-20 years. However, the progression can be faster and take 5-10 years in women

with weakened immune systems such as those living with HIV (World Health Organization, 2024). The 10- to 20-year interval between pre-cancer and cancer provides a critical window to screen, detect and treat pre-cancer to avoid its progression to cancer (World Health Organization, 2014).



Source Reproduced from Schiffman et al. (2011), as presented in WHO (2014)

Figure 2.2 The timeline and natural history of cervical pre-cancer and cancer development

This figure shows the timeline and the natural history of cervical pre-cancer and cancer development which is in both directions. It means the changes of the disease can be backward because some HPV infection can change into normal and pre-cancer may not develop into cancer if proper treatment is given.

Any woman with cervix has chance to get cervical cancer in her lifetime. here are some risk factors which increase the chance of developing cervical cancer. These conditions include – infection with high-risk HPV, weakened immune system, giving birth to many children, early age at first pregnancy, the use of hormonal contraceptives, having family history of cervical cancer and smoking (National Cancer Institute, 2024; World Health Organization, 2014).

Survival rate of cervical cancer is described in 5-year relative survival rate. 5-year relative survival describes the percent of people with the same type and stage of

cervical cancer are alive 5 years after diagnosis of cervical cancer, compared with people in the overall population. The 5-year relative survival rates for cervical cancer are: (1) The 5-year relative survival rate is 91% when cervical cancer is diagnosed at an early stage, (2) The 5-year relative survival rate is 60% when cervical cancer is diagnosed after it has spread to nearby structures, (3) The 5-year survival rate is 19% when cervical cancer is diagnosed after it has spread to a distant part of the body, and (4) The 5-year relative survival rate for all people with cervical cancer is 67% (National Cancer Institute, 2023a). So, it means the later the diagnosis, the lesser the survival rate.

Cervical cancer is most commonly diagnosed during midlife, and it rarely observed in women younger than 20 years old. The common age of cervical cancer is between the ages of 35 and 44. Many older people didn't realize they still have chance of getting cervical cancer at their age. More than 20% of cervical cancer develops in women over 65 years. However, these cancers rarely occur in women who have been getting regular screening for cervical cancer before they were 65 (American Cancer Society, 2023).

2.2.1 Symptoms of Cervical Cancer

In the early stage of cervical cancer, there is usually no symptoms which makes it difficult to detect. Symptoms usually begin after the cancer has spread. Symptoms of cervical cancer include postcoital bleeding, bleeding after menopause, intermenstrual bleeding or longer than normal periods, watery, foul-smelling, or blood-stained vaginal discharge, pelvic pain or pain during sexual intercourse.

Symptoms of later stage of cancer includes difficult or painful bowel movements or bleeding during bowel movement, difficult or painful urination or blood in the urine, dull back pain, swelling of the legs, abdominal pain and fatigue.

But these symptoms may also occur in some other health conditions. Therefore, the best way to know cervical cancer is getting cervical cancer screening (National Cancer Institute, 2022b).

2.2.2 Stages of Cervical Cancer

The stage of cancer is determined by the extent to which it has spread, either to nearby tissues or to distant parts of the body.

The cancer stage describes the extent of cancer in the body, especially whether the cancer has spread from where it first formed to other parts of the body. It is important to know the stage of cervical cancer to plan the best and most appropriate treatment.

Stage I: Cervical cancer can only be found in the cervix area.

Stage II: Cervical cancer has extended to the upper two-thirds of the vagina or to the surrounding tissues of the uterus (womb).

Stage III: Cervical cancer has spread to the lower third of the vagina and/or to the pelvic wall, and/or has caused kidney complications, and/or has spread to lymph nodes.

Stage IV: Cervical cancer has spread beyond the pelvis, to the nearby bladder or rectum, or to distant parts of the body such as liver, lungs, or bones (National Cancer Institute, 2022).

2.2.3 Prevention of Cervical Cancer

To reduce the morbidity and mortality of cervical cancer, comprehensive prevention and control of cervical cancer by primary prevention, secondary prevention and tertiary prevention consist of community education, social mobilization, vaccination, screening and treatment to palliative care (World Health Organization, 2013). Prophylactic vaccination against HPV and screening and treatment of pre-cancer lesions are effective strategies to prevent cervical cancer and are very cost-effective (World Health Organization, 2024).

Primary prevention consists of HPV vaccination and health education. There are 6 HPV vaccines available worldwide as of 2023. All have been proven to be safe and effective in preventing HPV infection and cervical cancer by protecting against the high-risk HPV types 16 and 18, which cause majority of cervical cancers.

As a priority, HPV vaccines should be given to all girls aged 9–14 years, before the onset of sexual activity. The vaccine may be administered in 1 or 2 doses. People with weakened immune systems should ideally receive 2 or 3 doses. To further reduce the HPV transmission within the community and to prevent HPV-related cancers in men, some countries include boys in vaccination program. Health education about other important ways to prevent HPV infection include not smoking, using condoms to prevent HPV infection and voluntary male circumcision. Even though HPV vaccination plays an important role to prevent cervical cancer, it doesn’t cure the already infected people. So, it still needs to be screened regularly (World Health Organization, 2013).

Secondary prevention consists of cervical cancer screening and treatment of precancerous lesions. Cervical cancer screening is the systematic use of a test to detect abnormalities of cervix in an asymptomatic population. The targeted women may feel perfectly healthy and may not perceive a need to visit health facilities. WHO recommended women above 30 years of aged to be screened regularly. Precancerous lesions are treated by loop electrosurgical excision procedure (LEEP) and performed cryotherapy in low resource settings as recommended by WHO guideline. Cold knife confiscation can also be used in high resource settings (World Health Organization, 2013).

Tertiary prevention is the treatment of cervical cancer and palliative care to reduce the mortality. Treatment of cervical cancer includes surgery, radiotherapy and Chemotherapy. The treatment option depends on many factors including the cancer stage, tumor size, cancer type, grade, depth of invasion and the spread of cancer.

2.3 Cervical Cancer Screening

The main aim of the cervical cancer screening is to identify the precancerous changes in the cells of the cervix. If abnormal precancerous cell changes are detected, it can be prevented from developing cervical cancer by effective treatment. The cervical cancer screening can be conducted by two main categories, organized population-based screening and opportunistic screening. The former one systematically invites eligible women for regular screening and as for the latter one, screening occurs during the routine healthcare visits.

2.3.1 Common Screening Methods (Pap smear, HPV Testing, VIA)

There are three different types of tests for cervical cancer screening: Conventional Pap smear test and liquid based cytology (LBC), Visual inspection with Acetic Acid (VIA), and HPV testing for high-risk HPV types (eg. Types 16 and 18).

Pap smear cytology has been successfully used in high-resource countries. However, However, its applicability in resource-limited settings is constrained by several factors, including the need of laboratory infrastructure and highly skilled personnel which are not readily available in many countries. Pap Smear does not

provide the result immediately and smear-positive women need to be recalled when results are available from the laboratory. Women feel inconvenient for these additional visits and increase drop-out rates. Therefore, Pap smear cytology can only be used in countries where quality-assured laboratory facilities are available (Yin Wint, 2019).

HPV DNA test is more sensitive than other screening tests to detect high risk HPV and it has been widely evaluated worldwide. The benefit of its high sensitivity allows the screening interval to be extended to 10 years for screen-negative women. However, a key limitation of the test is its relatively high cost (Yin Wint, 2019).

Visual inspection with acetic acid (VIA) is a moderately sensitive screening method that can be implemented in most healthcare settings, including resource-limited countries. This test has many advantages such as low-cost, providing immediate results and performed by trained nurses or health workers. However, the limitations of VIA are its subjective nature and low positive predictive value which can result in a higher number of unnecessary referrals. The accuracy of VIA tends to decline in older postmenopausal women since it works best for screening women aged under 50. The most appropriate target age group for a VIA-based screening is 30 to 49 years. Some country may decide to screen women below 50 years by VIA, and older women by cytology, depending on available resources.

There are three main methods to screen for cervical cancer:

The human papillomavirus (HPV) test detects the presence of infection with high-risk HPV strains that lead to cervical cancer.

The Pap test, also known as Pap smear or cervical cytology, collects cervical cells to identify abnormalities caused by HPV that may develop into cervical cancer if left untreated. It can detect both precancerous cells and cervical cancer cells, as well as non-cancerous conditions such as infection or inflammation sometimes.

The HPV/Pap co-test checks for both high-risk HPV and abnormal changes in cervical cells by using an HPV test and Pap test together (National Cancer Institute, 2025).

HPV testing by self-collection of samples is as reliable as samples collected by healthcare providers, and it may be a preferred choice for women (World Health Organization, 2024). The timeline and choice of cervical cancer screening should be tailored based on the patient's age, health history and previous screening results.

Population*	Recommendation	USPSTF Recommendation Grade†
Aged less than 21 years	No screening	D
Aged 21–29 years	Cytology alone every 3 years‡	A
Aged 30–65 years	Any one of the following: • Cytology alone every 3 years • FDA-approved primary hrHPV testing alone every 5 years • Cotesting (hrHPV testing and cytology) every 5 years	A
Aged greater than 65 years	No screening after adequate negative prior screening results§	D
Hysterectomy with removal of the cervix	No screening in individuals who do not have a history of high-grade cervical precancerous lesions or cervical cancer	D

Source The American College of Obstetricians and Gynecologists (2021)

Figure 2.3 USPSTF recommendation for routine cervical cancer screening

US preventive Services Task Force (USPSTF) recommends routine for cervical cancer screening: (1) Cytology screening alone every 3 years for aged 21-29 years, (2) Cytology alone every 3 years, FDA- approved primary high risk HPV testing along every 5 years, or co-testing HPV testing with cytology every 5 years for aged 30-65 years, (3) no screening is needed for aged less than 21 years, (4) no screening is needed after adequate negative previous screening results for aged greater than 65 years, (5) no screening for women who have had their cervix removed and have no history of high-grade cervical precancerous lesions or cervical cancer (The American College of Obstetricians and Gynecologists, 2021).

Regardless of their sexual history or HPV vaccination status, these recommendations apply to all individuals with a cervix who do not have any signs or symptoms of cervical cancer except for those who are at high risk of the disease, such as those who have previously received a diagnosis of a high-grade precancerous cervical lesion, having exposure to diethylstilbestrol in utero or those who have a compromised immune system (e.g. individuals with HIV infection) (The American

College of Obstetricians and Gynecologists, 2021). These individual needs specific timeline for screening based on their specific needs.

In 2020, World Health Organization implemented the global strategy to eliminate cervical cancer as a public health problem. The goal is that all countries must reach and maintain an incidence rate of below 4 per 100 000 women: 90% of girls get full HPV vaccination by the age of 15, 70% of women get screening with a high-performance test by the age of 35 and again by the age of 45, 90% of women diagnosed with cervical disease receive treatment, specifically 90% of women with precancer receive appropriate care, and 90% of women with invasive cancer receive effective management. Each country should meet the 90-70-90 targets by 2030 to get on the path to eliminate cervical cancer within the next century (World Health Organization, 2023a).

2.3.2 Global Trends in Cervical Cancer Screening Uptake

Countries have invested to improve access to screening all over the world (World Health Organization, 2023b). Despite effective screening methods and WHO recommendations to prioritize cervical cancer screening in women aged 30-49 years, two-thirds of women in this age group have never been screened for cervical cancer. Screening coverage differs across global regions. Globally, an estimated 370 million (36%) of women aged 30-49 years have been screened for cervical cancer at least once in their lifetime; 15% in the past year, 28% in the past 3 years and 32% in the past 5 years. Screening rate is estimated to be at least 3 times higher in high-income countries than low- and middle-income countries. In 2019, about 84% of women in high income countries and 48% of women in upper middle-income countries between the age of 3o to 49 years had ever been screened, compared to 9% of women in lower-middle income countries and 11% in low-income countries. The coverage of screening ever in lifetime of SDG regions are Europe and North America (88%), Latin America and the Caribbean (73%) and Australia and New Zealand (95%) which is the highest coverage estimates.

The high coverage of cervical cancer screening in most low- and middle-income countries is difficult to achieve due to competing healthcare priorities, insufficient financial resources, weak health systems, and limited trained providers (World Health Organization, 2013). Across all the low-and middle- income countries, there were high rates of screening among older women, women in the richest wealth quintile and

women residing in urban area. The lower rates of cervical cancer screening are among women with no formal education and women who have never been living with a man.

In conclusion, the majority of adult women worldwide have never had the chance to be screened for cervical cancer and only about one-third of women aged 30–49 years have ever been screened. This highlights the significant gap in reaching the WHO target of screening 70% of women twice between the ages of 35–45 years using a high-performance test, especially in LMICs. To eliminate cervical cancer as a major public health concern, it is essential to improve access to cervical cancer prevention and treatment services worldwide, particularly in low-income and lower-middle-income countries, where coverage remains below 10% and are at the highest disease burden.

2.3.3 Cervical Cancer Screening Among Migrant Populations

Migrants are underprivileged groups who usually receive limited health care access. Limited access to health screening among migrant is a global issue (Guerrero et al., 2016; Rosano et al., 2017). Migrant women have a significantly lower adherence to cervical screening compared to native women irrespective of their country of origin. Women who don't have health insurance and women who have recently immigrated are less likely to have cervical cancer screening (American Cancer Society, 2020).

In many studies, the fact that lower screening rate among migrant women than local women has been shown. In a systematic review and meta-analysis, migrant women have a 46% lower likelihood of participating in cervical cancer screening than native women. The study analyzed data from an average of 126,159 migrant women and 678,037 native women. The screening participation rates are 19.1% and 62.3% respectively (Rosato et al., 2023).

The significance in lower adherence to cervical cancer screening among migrant women are irrespective of their country of origin. A study conducted in U.S also stated that foreign-born women were more than twice as likely to have never received a Pap test as US-born women, with 18.6% and 6.8% respectively (Endeshaw et al., 2018). In a study conducted in China reported that only 27.6% of migrant women received cervical cancer screening compared to 33.2% of local women (Holt et al., 2021). Previous study among Asian immigrant women who are from Vietnam, China and Philippines also states that 76.5% of them had never had a Pap smear test (Eo & Kim,

2019). Another study conducted among migrants in Myanmar also stated the lower screening rate among migrants which is 19.1% (Nandar et al., 2015). A study conducted among Yemeni women in Malaysia also shows that only 9.7% of migrants take screening (Ba-Alawi et al., 2025).

The disparities in screening participation are due to several factors influencing the adherence. The most common barriers experienced by migrants include economic, cultural, language, healthcare system-related, knowledge-related and individual-level barriers (Rosato et al., 2023).

2.3.4 Cervical Cancer Screening in Thailand

In Thailand, cervical cancer is the second most frequent cancer after breast cancer. In 2021, cervical cancer incidence was 13.8%. It is a major public health problem in Thailand affecting quality of life and losing human and economic resources (Ploysawang et al., 2021).

Cervical cancer screening is the best way to reduce the incidence of cervical cancer. In Thailand, the national cervical cancer screening program was established in 2005 by the Ministry of Public Health under Universal Health Coverage Scheme. Screening methods include Papanicolaou smear (Pap smear) for women aged 30-65 years and Visual Inspection with Acetic Acid (VIA) for women aged 35-45 years with a 5-year screening interval. In 2020, HPV testing has been introduced as primary testing method. Another option of self-swab kit for HPV testing is also currently using which may be beneficial for women who are scared or embarrassed to get screened (Gottschlich et al., 2019).

Nowadays, cervical cancer screening accessibility is expanding in remote areas (NHSO, 2022). With the support of National Health Security Office (NHSO), Mae Ho Tambon Health Promoting Hospital in Mae Sariang District has provided free cervical cancer screening to women living in rural areas, where the majority are Karen ethnic groups. This program encourages women in remote areas to receive the test due to its accessibility and no need to worry about the travel cost.

After the implementation of National cervical cancer screening program, estimated incidence rate of cervical cancer in the past 10 years is decreasing in the past 10 years whereas the mortality rate is increasing. In Thailand, cervical cancer screening coverage among Thai women aged 30-60 years was reported to be 67% in the past 5

years and 77% over their lifetime (Wongpratate & Bumrungthai, 2024). But the data on cervical cancer screening coverage among Myanmar migrant women is limited.

In a study conducted about cervical cancer screening among local and migrant workers in Thailand shows higher incidence of abnormal screening results among migrant workers compared to local Thai women. Specifically, 3.45% of migrant workers (primarily from Myanmar and Cambodia) had abnormal results, and no cases were detected among Local Thai Women (Joob & Wiwanitkit, 2020). Due to low screening rates and various barriers to accessing healthcare services, Myanmar migrant may have increased risk of cervical cancer.

2.4 Knowledge-Attitude-Practice (KAP) model

The Knowledge-Attitude-Practice (KAP) model (Schwartz, 1976) is widely used in public health research to understand health behaviors and design effective interventions. It is based on cognitive-affective-behavior theory in the area social psychology. According to Schwartz, there are interrelation between knowledge, attitude and practices in a dynamic and reciprocal way (Yang et al., 2022). KAP surveys are essential to assess the existing level of knowledge within a population about specific health issues. This information is crucial for creating targeted health education messages that are relevant to the target audience (Zarei et al., 2024).

Knowledge alone does not always translate into behavior change; attitudes play a crucial role in determining whether individuals engage in preventive health practices. This information is essential for designing targeted interventions that promote healthier behaviors within the population (Glanz et al., 2008). Moreover, misconceptions and cultural bias that influence health behaviors are revealed by KAP surveys. By identifying these barriers, researchers can create effective strategies to address them and ultimately promote positive behavior change (Gumucio et al., 2011).

KAP surveys are widely applied across various public health topics, including nutrition, environmental health, and chronic disease management. These diverse applications highlight the effectiveness of the KAP model in informing the

development of targeted and effective strategies to promote behavior change and overall improvement in public health (Zarei et al., 2024).

In this study, knowledge refers to the individual's awareness and understanding of cervical cancer, such as its causes, risk factors, symptoms and benefits of prevention methods. Attitude refers to the individual's feelings, beliefs and perceptions toward cervical cancer and its prevention which can be influenced by cultural norms, personal experiences and trust in healthcare system. Practice refers to the combination of knowledge and habit. This is the actual screening behaviors taken by individuals. Moreover, diverse socio-demographic, health service and health-related variables may affect an individual's knowledge and attitude and thus indirectly influence cervical cancer screening behavior.

This KAP model provides a comprehensive framework for understanding the factors associated with cervical cancer screening. By examining knowledge, attitude and practices together with other factors such as socio-demographic, health service and health-related factors, gaps and barriers can be identified which hinder screening uptake and targeted interventions can be designed to improve screening participation.

2.5 Factors Associated with Cervical Cancer Screening Uptake

Factors associated with cervical cancer screening uptake include socio-demographic factors, health-related factors, healthcare service factors and social factors.

2.5.1 Demographic and Socioeconomic Factors

2.5.1.1 Age

Age plays a crucial role in decision-making of getting healthcare services including preventive services. A study conducted in Mae Sot determines age as a significant factor associated with cervical cancer screening uptake. This cross-sectional study included both Thai and Myanmar nationality living in Mae Sot, Tak Province in Thailand. In this study, aged over 40 years old women were more than 2 times likely to have cervical cancer screening than those younger than 40 (Myint et al., 2024). A cross-sectional study conducted among Myanmar women in North Yangon also shares the

same result as aged 40-49 are 1.9 times more likely to take cervical cancer screening than aged 30-39 years (aOR= 1.90, 95% CI= 1.19-3.03) (Nandar et al., 2015). This aligns with a cross-sectional study conducted about non-attendance of cervical cancer screening among migrant women in Portugal. It stated that age less than 34 years have a higher chance to not attending cervical cancer screening (Marques et al., 2022). Another study conducted among Asian immigrant women also have the same result that with one-year increase in participant's age, pap smear practice increased 1.15 times (OR=1.15, 95% CI: 1.07, 1.23) (Eo & Kim, 2019).

In contrast, a qualitative study conducted in Portugal stated that older migrant women usually are not so open to participate in CCS. The older they get; the more they are not willing to talk about their sexual and reproductive health and avoid gynecological exams such as CCS (Marques et al., 2021). A systematic study among migrants in Europe also stated the association between older age (above 40 years) and low participation in CCS. This is also supported by a study conducted among Myanmar women in urban areas, Mandalay which highlighted higher screening uptake among older age group of 36-45 years and above 45 years than younger age (Han et al., 2016). The inconsistency in the association between age and cervical cancer screening uptake may be explained by variations in reproductive health knowledge, perceived susceptibility to disease, frequent contact with reproductive health services, and the implementation of organized screening programs targeting specific age groups.

2.5.1.2 Marital status

Marital status plays an important part in the decision of cervical cancer screening uptake. Previous research done among migrant women in Yangon (Myint et al., 2024) stated the association between marital status and cervical cancer screening with p-value 0.049. Married women are 1.94 times more likely to undergo cervical cancer screening than single, divorced, widow, separated women (OR=1.94, 95%CI= 1.00-3.76). It is supported by a study in Portugal. The quantitative study conducted among migrants in Portugal (Marques et al., 2022) stated that single, divorced, widowed women are 2.74 times more likely to not attend screening compared to married women.

The higher utilization of cervical cancer screening among married women than other may be due to the support by the husband. They may get mental support and

financial support from their husband. Also, husband is the decision-maker and bread winner in some cultural backgrounds. Some women won't get cervical cancer screening if their husband doesn't allow them to do.

2.5.1.3 Ethnicity

Ethnicity is also significantly associated with cervical cancer screening in a study conducted among Nepali women in 2024 with p-value 0.02 (Cruanes et al., 2024). The study found that participants of Dalit ethnicity had the lowest screening rate (4.2%) and participants of Newar ethnicity had the highest screening rate (48.3%).

2.5.1.4 Religion

Religion also plays as an important factor influencing the decision on cervical cancer screening. A study conducted in Portugal stated religion as factors associated with low participation of CCS. This is a qualitative study exploring the perspective of healthcare workers and community workers on the factors influencing the CCS participation of migrant women living in Portugal. According to the experience of healthcare workers, Muslim women seem to have greater difficulty in taking up CCS, as they tend to be more reserved and less autonomous (Marques et al., 2021). A study conducted in Mae Sot also stated religion as a significant factor associated with CCSU. Christian and other religion had 2.19 times the odds of doing cervical cancer screening uptake more than Buddhist women (Myint et al., 2024).

Sometimes, religious and cultural background influences on gender roles. In some situation, the decision on the health status of women is managed by their husband including cervical cancer screening which is mostly seen in Muslim communities.

2.5.1.5 Age at the time of marriage

In a study conducted among Thai and Myanmar women in Mae Sot, the association between age of marriage and cervical cancer screening is found to be associated after controlling other confounders. Women who married at under 25 years old were less likely to be undertaken CCSU. Women who married at 26- 43 had 2.93 times the odds of doing cervical cancer screening uptake more than women who married at younger than 26 (Myint et al., 2024). This is supported by a cross-sectional study conducted among Myanmar women in urban areas, Mandalay which showed women married at 20 to 25 or more than 25 years are 16.4 and 9.5 times more likely to

take screening, with p-value 0.011 and 0.033 respectively (Han et al., 2016). This may be due to the maturity, decision-making capacity, and financial independency among the women married at older age which makes them more likely to engage in reproductive health services.

2.5.1.6 Parity/ Number of children

There is association between number of children and cervical cancer screening uptake. A study conducted among Russia, Somali and Kurdish immigrants in Finland shows that women who has ever given birth are associated with cervical cancer screening among Kurds with p-value 0.014 (Idehen et al., 2017).

In contrast, in a study conducted among migrant in Portugal, parity has been found to be negatively associated with cervical cancer screening uptake, with women without children being more likely to use screening than women with children. This may be because women with children tend to prioritize their children's life or other life priorities which interfere them from seeking preventive services (Marques et al., 2022).

2.5.1.7 Education

Education has positive effect on cervical cancer screening uptake. Higher education is one of the top three facilitators for cervical cancer screening in Southeast Asia (Chua et al., 2021). A population- based study in Finland among immigrants from Russian, Somali and Kurdish origin shows the association between high education and cervical cancer screening uptake among Kurds with p-value 0.014 (Idehen et al., 2017).

This is supported by a cross-sectional study conducted among migrant and local women in China to access the inequalities in cervical cancer screening uptake. In this study, 27.6% of the migrant workers reported having undergo cervical cancer screening. Migrants who have high school or higher education are 2.15 times more likely to have been screened compared to those with less than high school education (aOR=2.15, 95% CI= 4.41-3.27) (Holt et al., 2021).

The odds of not having a pap smear are 1.8 times in refugee women who have never attended school than in refugee women who have attended at least Grade 1 to grade 12 (OR= 0.543, CI = 0.192-1.540). Research conducted in Mandalay (Nyi, 2020) also proves the association between education and acceptance of pap smear screening with p-value 0.006. The participants who have high school level or bachelor's degree and above are more likely to get the screening than illiterates, primary and

middle school level which is the same concept in a study conducted in Taungoo where women with high school and above education are approximately 2 times more likely to take cervical cancer screening than lower education (Yin Wint, 2019)..

This may be because the higher the education, the higher the understanding of health system and knowledge of cervical cancer which leads them to use preventive healthcare services.

2.5.1.8 Occupation

Having occupation is a significant factor associated with cervical cancer screening. One study conducted among Russian, Somalia and Kurdish origin migrants in Finland stated that being employed increased the likelihood of cervical cancer screening with p-value 0.007 (Idehen et al., 2017). A study conducted in Mandalay shared the same associated with p-value 0.019. In this study, blue collar workers are less likely to accept screening than dependents and white-collar workers (Nyi, 2020).

2.5.1.9 Household income

In the study conducted in Mandalay also showed the significant association of family income with acceptance of Pap smear screening with p-value 0.007. Women with high family income are more likely to accept screening than women with low family income (Nyi, 2020). This is relatable because they can spend more money on buying health insurance and using health service like cervical cancer screening which are expensive normally if they have lower income.

2.5.1.10 Legal status

Legal status is very important in accessing healthcare services among migrants. In most of the healthcare system, only legally eligible person can purchase health insurance. People without legal status may be afraid of deportation which stops them from seeking health services. A qualitative study conducted in Portugal stated that undocumented migrant women face more barriers in accessing healthcare services including preventive services (Marques et al., 2021). Without legal status, they will not be able to purchase health insurance which covers preventive services including cervical cancer screening since they are not covered by national screening program.

2.5.1.11 Health insurance

Health insurance is a significant factor associated with pap smear screening uptake in a study conducted in China which is found that the odds of previous cervical

cancer screening are 1.67 times higher in insured migrants than uninsured migrants (aOR= 1.67, 95% CI = 1.14- 2.45). Having no insurance is also a barrier to CCS for migrants living in Europe (Marques et al., 2020).

2.5.1.12 Language proficiency

The proficiency in language is an important factor for migrants to get access in healthcare services in a foreign country. If they don't have language proficiency, they will have difficulty in communicating with healthcare providers and in understanding the health information. Some women use interpreter during the appointments. The most common interpreter is their husband or their relatives. It sometimes acts as barriers to accessing screening services because concerns about privacy may discourage women to discuss their intimate issues in the presence of other people (Marques et al., 2020). It is supported by the study in Finland among Russian, women who have literacy in Finnish or Swedish are significantly associated with cervical cancer screening with p-value 0.003 (Idehen et al., 2017).

2.5.1.13 Length of stay in Thailand

Length of stay is also an important factor associated with cervical cancer screening. A systematic study conducted among migrant women in Europe stated the association between shorter length of stay and lower screening participation. This may be due to migration-related stress, lack of knowledge about the healthcare system in host country, and difficulty in communicating due to language barriers. The longer they stay, they will get the knowledge of healthcare services and proficient in language (Marques et al., 2020). In contrary, a study conducted in Portugal stated that migrant women who moved recently have a higher participation in cervical cancer screening (Marques et al., 2022).

2.5.2 Health Related Factors

2.5.2.1 Contraceptive use

Fertility control is also a crucial factor in cervical cancer screening uptake. A study conducted among Lahu hill tribe states that fertility control has significant association with pap test screening with p-value <0.001. In that study, 92.77% of the participants use contraceptive injection as fertility control, followed by oral contraceptive pill (4.92%) and surgical sterilization (1.85%). There is only 3 persons not taking any contraception. This may be due to people taking contraception are more

in contact with health care provider when taking contraception. By this way, they may get information about cervical cancer screening (Intahphuak et al., 2021).

2.5.2.2 History of Cervical Cancer in the family

Having family history of cervical cancer is a facilitating factor for cervical cancer screening. A study conducted among migrants in Yangon, Myanmar (Nandar et al., 2015) described the association between family history of cervical cancer and screening uptake with p-value 0.029. Women with family history of cervical cancer are 2.89 times more likely to take cervical cancer screening than women who don't have (aOR= 2.89, 95% CI= 1.29- 6.48).

A study conducted in Mandalay showed the significant association between family history of cervical cancer and acceptance of pap smear screening with p-value 0.004 (Nyi, 2020). Similar study in Taungoo, Myanmar shared the same results. A study conducted in Taungoo Myanmar (Yin Wint, 2019) found that the likelihood of cervical cancer screening is 4 times higher among women with family history of cervical cancer compared to women without family history.

This shows that having family history of cervical cancer may increases the knowledge and awareness of the disease which let them to take preventive behaviors like screening by the experiences they have gotten in the family.

2.5.2.3 History of HPV vaccination

A study in Portugal revealed that women who have received HPV vaccination are more likely to use cervical cancer screening practices (Marques et al., 2022). This may be because vaccinated women are more aware of cervical cancer and cervical cancer screening which makes them to get preventive services.

2.5.2.4 Source of information

Source of information is an important factor influencing the decision of cervical screening practices. A study conducted in Taungoo, Myanmar (Yin Wint, 2019) stated that women receiving information from health personnel are about 4 times more likely to get screening when other variables are controlled.

A study conducted in Mandalay also proved the association between source of information and pap cancer screening. It is found that information received from doctors, husband and friends were significantly associated with uptake of pap smear screening with p-value 0.003, 0.008 and <0.001 respectively. Source of information

received from posters and internet have also significant association with pap smear screening with p-value 0.028 and 0.001 respectively (Nyi, 2020).

This may be due to the trust and belief in the health professional since they are the trusted source of information. So, health professionals largely contribute to health education, giving health information and encouraging them to get screened. Active participation and encouragement of male partner in healthcare services may also have positive impact on screening uptake.

2.5.2.5 Knowledge of cervical cancer and cervical cancer screening

Knowledge enhances women for better decision-making. Participants with a higher level of knowledge of cervical cancer were 4.70 times more likely to do CCSU than those with a lower level of knowledge of cervical cancer. Similarly, participants with a good level of knowledge of cervical cancer screening were likely to be screened for cervical cancer than those with poor knowledge (Myint et al., 2024).

A qualitative study conducted in Portugal also stated that most migrant women do not know what cervical cancer is, what cervical cancer screening is for and what are the benefits of screening. This lack of knowledge may lead to the low utilization of cervical cancer screening hinders them from seeking preventive services (Marques et al., 2021). A study conducted in North Yangon, Myanmar shared the same results. The odds of receiving cervical cancer screening are 2.21 times higher in migrants with high knowledge level compared to those with poor knowledge level with p-value 0.001 (aOR= 2.21, 95% CI= 1.40-3.47) (Nandar et al., 2015).

In a study conducted in Mandalay, knowledge about cervical cancer and screening is significantly associated with acceptance of Pap smear screening with p-value <0.001 (Nyi, 2020).A study conducted in Taungoo Myanmar (Yin Wint, 2019), also stated that women with higher knowledge level are nearly 6 times more likely to perform screening practice than those with poor knowledge level with p-value <0.001.A systematic study in Southeast Asia also stated the poor knowledge of screening as one of the most common barriers to get screening (Chua et al., 2021).

This might be acceptable since women who have higher knowledge about the risk factors, symptoms and prevention of disease will be more eager to get preventive services.

2.5.2.6 Attitude towards cervical cancer and cervical cancer screening

Attitude is the individual's belief, perception or feelings related to cervical cancer and cervical cancer screening. It can be both positive and negative. A systematic review for accessing barriers and facilitators to cervical cancer screening among women in Southeast Asia states the most common barriers to cervical cancer screening are embarrassment, time constraints and poor knowledge of screening. Some women embarrassment to expose their body while performing screening which interfere them to get screening (Chua et al., 2021) which is the same as the systematic study accessing the factors associated with cervical cancer screening among migrants in Europe (Marques et al., 2020).

A cross-sectional study among migrant women in Portugal describes the role of attitudinal barriers on cervical cancer screening non-attendance. The study found that low perceived need of screening in the absence of symptoms and lack of motivation were associated with not getting cervical cancer screening. Fear of the test result (25.3%), anxiety about being tested by male doctor (23.8%), perceiving painfulness (23.1%), embarrassment (18.5%), difficulties scheduling the test (14.3%) and having a bad experience (12.4%) are the most reported barriers (Marques et al., 2023). A study conducted among Myanmar women in Mandalay, also showed that people with good perception are 14.5 times more likely to take screening with p-value <0.001 (Han et al., 2016).

2.5.3 Healthcare Service Factors

2.5.3.1 Access to healthcare perception

Accessibility to healthcare services include availability, accessibility, affordability, accommodation, and awareness which has influence on the cervical cancer screening uptake. Astudy conducted in Northern Yangon (Nandar et al., 2015) states that affordability for extra pay to get screening were 4.60 times more likely to have cervical cancer screening with p-value <0.001 (aOR=4.60, 95% CI= 2.72-7.77). Waiting time at the clinics is also associated with cervical cancer screening with p-value 0.014 (OR 1.85, 95% CI = 1.13- 3.03). It is also stated in a systematic review of factors associated with cervical cancer among migrant women in Europe that long waiting times for both the examinations and the results leads women to postpone cervical cancer screening (Marques et al., 2020). It means the longer the waiting time, the lesser the screening uptake.

2.5.4 Social Factors

2.5.4.1 Perceived Social support

Getting social support either from the partner of husband, families or friends have positive impact on cervical cancer screening. Women who don't have social support are probably postpone or avoid screening (Marques et al., 2020).

A study conducted in Mandalay stated that level of social support was significantly associated with acceptance of Pap smear screening with p-value 0.007 (Nyi, 2020). Advice and encouragement from healthcare workers are the most common facilitator for getting cervical cancer screening (Chua et al., 2021).

This is supported by the cross-sectional study conducted in North Yangon (Nandar et al., 2015). In that study, it is found that women who are encouraged to get screened by the nurses are 2.64 times more likely to get cervical cancer screening with p-value <0.001 (aOR= 2.64, 95%CI= 1.53-4.56). In a study conducted among 426 Nepali women residing in Dhulikhel and Banepa municipality, there is significant association between perceived social support and cervical cancer screening. Women who had higher perceived social support from their significant other and family were more likely to have been screened with p-value 0.007 and 0.04 respectively (Cruanes et al., 2024).

2.6 Related Research

The cross-sectional study conducted in Maesot, Thailand among 422 women of aged 30-60 years, composed of 100 Thai nationals and 322 Myanmar nationals found that there is only 13.27% of cervical cancer screening uptake. It is lower than the national coverage of Thailand. Age ≥ 40 years (AOR=2.15, 95%CI: 1.05-4.40), Christian and others religion (AOR=2.19,95% CI:1.08-4.44), married between 26 to 43 years (AOR= 2.93, 95%CI: 1.45-5.93), having good knowledge of cervical cancer (AOR= 4.70, 95%CI: 2.22-9.72), and having good knowledge of cervical cancer screening program (AOR= 6.58, 95%CI: 2.82-17.77) are the significant predictors of cervical cancer screening (Myint et al., 2024).

The cross-sectional study was conducted among adult migrant women living in Portugal based on a web-based survey between February and July of 2021. In that study, a total of 1100 migrant women are participated, and cervical cancer screening non-attendance rate was 24.5%. Younger age, being born in Africa or Asia, being single/divorced/widowed, never having had GP appointment in Portugal and not scheduling regular gynecology consultations are the factors associated with non-attendance. The factors associated with attendance are being born in South and Central America, shorter length of stay, HPV vaccination history and not having children (Marques et al., 2022).

Previous study conducted in 7 different provinces across China in 2015 to access the inequalities in screening uptake between Chinese migrant women and local women found that the screening uptake is lower in migrants compared to local women, with 27.6% and 33.2% respectively. Higher education, having insurance status and awareness of HPV are significantly associated with increased likelihood of previous cervical cancer screening (aOR = 2.15 95%CI: 1.41-3.27 and aOR = 1.67 95% CI: 1.14-2.45, aOR = 2.02 95%CI: 1.41-2.91 respectively) (Holt et al., 2021).

The cross-sectional study conducted in the Northern district of Yangon Myanmar in 2015 included 666 migrant women aged 30-49 years. The cervical cancer screening rate in the previous 3 years was 19.1%. The associated factors are marital status, family history of cervical cancer, knowledge, affordability to pay for extra cost of screening, the quick response of provider, waiting time, source of information, encouragement, and perception. Perceived barriers (aOR=2.42, 95% CI= 1.45-4.04) and knowledge (aOR=2.21, 95% CI= 1.40-3.47) continued to be significant predictors of cervical cancer screening uptake after adjusting for age, family history of cervical cancer and other factors (Nandar et al., 2015).

The quantitative cross-sectional study conducted among Lahu Hill Tribe women at a district in Chiang, Rai, Thailand in 2018 found that 96.15% had taken Pap test and 74.31% obtained the screening more than once. The significantly associated factors are the contraceptive use and frequency of Pap test obtaining with p-value <0.001. The increased rate of pap screening among Lahu hill tribe may be due to the Pap test outreach service for all Lahu hill tribe women every year by health care personnel

which is the strategic plan of Ministry of Public Health, Thailand (Intahphuak et al., 2021).

CHAPTER 3

MATERIALS AND METHODS

This chapter included study design, study setting, sampling technique, study population, sample size, research tools and its development, testing validity and reliability of instruments, data collection, data analysis and ethical consideration.

3.1 Study Design

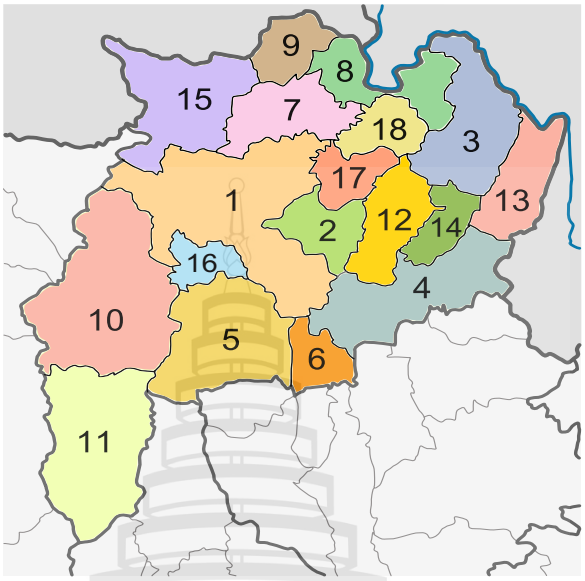
Community-based cross-sectional study was conducted to estimate the percentage and factors associated with cervical cancer screening among Myanmar migrant women in Chiang Rai Province, Thailand.

3.2 Study Setting

This study was conducted in six communities across Chiang Rai Province: Rai Boom rod (Singha Park), Doi Ngam, Api Square, Ta Lard Mae Kron, Tha Sud, and Pa Muead.

Chiang Rai Province is the northernmost province in Thailand. It is one of the special economic zones (SEZ) and significantly important for border trade and cross-border movement with neighboring countries, Myanmar and Lao PDR. It hosts 50,900 of Myanmar migrants according to IOM (International Organization for Migration, 2024b). It has become the most popular destination of migrants from Myanmar from 2020 onwards (International Organization for Migration, 2024c). Chiang Rai Province is bordered by the Shan state of Myanmar to the north, Bokeo province of Laos to the east, Phayao to the south, Lampang to the southwest, and Chiang Mai to the west. The province is subdivided into 18 districts. In Chiang Rai Province, the Tachileik-Myanmar checkpoint in Mae Sai is the important route for the transportation and movement of goods, services and labours into Thailand from Myanmar. In Chiang Rai Province, there are 21 Myanmar migrant communities which are mainly located in

Chiang Rai District and Mae Sai District due to the large composition of migrant workers in those areas.



Source Amphoe Chiang Rai (2023)

Figure 3.1 Map of Chiang Rai Province

3.3 Study population

The study population included Myanmar migrant women aged 30-60 years residing in Chiang Rai, Thailand. According to Thailand National cervical cancer screening program, 30-60 is the recommended age for cervical cancer screening (Ploysawang et al., 2021).

3.4 Inclusion and Exclusion Criteria

3.4.1 Inclusion criteria include:

1. Those of aged 30- 60 years, regardless of their legal status, who had resided in Chiang Rai Province for at least 6 months.
2. Those who were willing to participate in this study.

3.4.2 Exclusion criteria include:

1. Those who had undergone total hysterectomy.

2. Those who were unable to communicate with interviewer due to conditions such as mental illness and other disabilities.

3.5 Sample size Calculation

Sample size was calculated by using the standard formula for a cross-sectional study (Charan & Biswas, 2013).

$$n = \frac{Z^2_{\alpha/2} \text{ x P}(1-P)}{d2}$$

Where:

n = required sample size

$Z^2_{\alpha/2}$ = Value from the standard normal distribution corresponded to the desired confidence level (Z = 1.96 for 95% CI)

p = estimated proportion of cervical cancer screening uptake from previous study = 0.191(Nandar et al., 2015)

d = desired margin of error= 0.05

$$n = \frac{Z^2_{\alpha/2} \text{ x P}(1-P)}{d2}$$

$$n = \frac{(1.96)2*0.191*(1-0.191)}{(0.05)2} = 237.44$$

The sample size was 237, and 10% was added to prevent any errors that would happen in the study process. So, the total required sample size was 260.

3.6 Sampling Technique

For the sampling technique, multi-stage sampling was used to select the participants.

Firstly, study area selections; the two districts, Mueang and Mae Sai were purposively selected for their high population density and for representing rural and urbanize areas.

Secondly, community selections; twenty-one (21) Myanmar migrant communities in Chiang Rai Province were listed from previous studies and field visit. Each community had different characteristics with varying in population size, distance to health center, and types of occupations. The selected communities were classified into large and small categories; those with population of above 100 was defined as a large community (8 large communities), while those with a population of 100 or less was defined as a small community (13 small communities) (Table 3.1). To ensure representation from both community types, 2 large communities and 4 small communities (six in total) were randomly selected from the list of the Myanmar communities (Table 3.2).

Table 3.1 List of Myanmar migrant communities in Chiang Rai Province, Thailand

No	Name of Communities	Estimated population
Mueang district		
1	Rai Boom rod (Singha Park)	200
2	MFU hospital camp	200
3	Koh Loy	100
4	Api Square	100
5	Thai Samut	100
6	Doi Sa Ken	100
7	Huai Pla Kang	150
8	Bab Phlu Thong	100
9	Ban Du	200
10	Ta Lard Mae Kron	50
11	Ta Lard Phob Choke	50

Table 3.1 (continued)

No	Name of Communities	Estimated population
12	Ta Lard Pa Ko	50
13	Tha Sud	50
14	Den Ha	30
15	San Khong	30
Mae Sai district		
16	Koh Sai	250
17	Doi Ngam	300
18	Mai Lung Khon	250
19	Pa Muead	100
20	Ban Chong	100
21	Mae Sai Mittraphap	250
	Total	2,760

Thirdly, participant selections; a total of 260 participants were allocated proportionately based on the estimated size of population of each selected community to prevent selection bias and ensure the representation from each community. A list of households in each selected community was obtained through coordination with community leaders and updated during field data collection. The required number of households was selected by using a simple random sampling. Within each selected household, eligibility screening was conducted to identify migrant women aged 30-60 years. If multiple eligible women were found in the same household, one was randomly chosen for inclusion in the study. (Table 3.2).

Table 3.2 Propotionate Sampling of Six Myanmar migrant communities in Chiang Rai Province, Thailand

Name of Communities	Estimated population	Sample size
Mueang district		
Rai Boom rod (Singha Park)	200	65
Api Square	100	35
Ta Lard Mae Kron	50	17
Tha Sud	50	17
Mae Sai district		
Doi Ngam	300	91
Pa Muead	100	35
Total	800	260

3.7 Research Tools and its Development

The questionnaire was developed according to objective of the study, conceptual framework, literature review and validated tools and the questionnaire was translated by forward and backward method. The questionnaire included 7 parts as following:

Part 1 Socio-demographic and health-related factors

In this part, 21 questions related to socio-demographic characteristics and health-related history of participants which are age, marital status, ethnicity, religion, age at the time of marriage, number of children, education, occupation, household income, legal status, health insurance, language proficiency, length of stay in Thailand, family history of cervical cancer, history of HPV vaccination and history of contraception were included.

Part 2 Source of Information

Questions related to source of information included both persons and media. Participants were allowed to choose multiple responses.

Part 3 Knowledge of cervical cancer and cervical cancer screening and Source of information

A self-structured questionnaire was used to assess the knowledge of cervical cancer and cervical cancer screening. There were 7 questions related to knowledge including causes, symptoms, risk factors, prevention of cervical cancer and benefits of cervical cancer screening. The questionnaire comprised multiple-choice questions with the responses categorized into yes, no and not sure. For the answer 'yes', the score was 1 and for the answer 'no' and 'not sure', the score was 0. The total score was ranged from 0-7 and grading was calculated according to original Bloom's criteria (Bloom et al., 1964). More than or equal 80% of total score was defined as good knowledge, 60-79% of total score as moderate knowledge and less than 60% of total score as poor knowledge. The Index of Item-Objective Congruence (IOC) was 1.00. The Cronbach's Alpha coefficient was 0.846.

Part 4 Attitude towards cervical cancer and cervical cancer screening

Attitude towards cervical cancer and cervical cancer screening was assessed by using a self-structured questionnaire based on literature review and previous research. There were 7 questions, and the questions assessed the participant's belief, perception or feeling about the cervical cancer and its screening.

Likert's scale was used for scoring (Likert, 1932). The answers were categorized as strongly disagree (1 score), disagree (2 score), neutral (3 score), agree (4 score) and strongly agree (5 score). The total score was ranged from 7 to 35 and grading was done into 2 categories as positive and negative attitude according to median score of 27. Scores more than or equal 27 were defined as positive attitude while scores lower than 27 were defined as negative attitude. The Index of Item-Objective Congruence (IOC) was 0.89. The Cronbach's Alpha coefficient was 0.698.

Part 5 Perceived access to health care

Perceived access to health care was measured by Perceived Access to Health Care Questionnaire (PAHCQ) which was developed by Hoseini-Esfidarjani et al in 2021. The Cronbach's alpha values of the questionnaire was 0.86 indicating excellent internal consistency. The PAHCQ is a validated tool consisting of 30 items covering six

dimensions: accessibility, availability, acceptability, affordability, accommodation, and awareness. Specific subscale scores were obtained from each dimension, contributing to total score that reflected the perceived access to healthcare. Each item was rated on a 5-point Likert scale ranged from strongly disagree and strongly agree.

Accessibility was measured by 4 items and total scores ranged from 4 to 20. Availability was assessed by 3 items, with total scores ranging between 3 and 15. Acceptability was evaluated by 9 items, with total scores ranging from 9 to 45. Affordability was measured by 3 items and total scores ranged between 3 and 15. Accommodation was assessed by 6 items, with total score ranging from 6 to 30 and awareness by 5 items, with total score ranging from 5 to 25.

Total score was calculated by summing the scores from all six dimensions, ranging from 30 to 150, with higher scores indicating higher perceived access to health care. For the grading, the scores were divided into three categories by using the Best average score division criteria (1997) (Best & Kahn, 1997). The calculation was as follows:

$$\text{Score range} = \frac{Highest\ score - lowest\ score}{number\ of\ groups} = \frac{150-30}{3} = 40$$

According to the above calculation, the scores were categorized as low perceived access (30-70), moderate perceived access (71-110) and high perceived access (111 – 150). The Index of Item-Objective Congruence (IOC) was 0.99. The Cronbach's Alpha coefficient was 0.909.

Part 6 Perceived social support

Perceived social support was measured by using the validated tools, Multidimensional Scale of Perceived Social Support (MSPSS) which was developed by Zimet et al., 1988. The scale indicated good internal consistency with Cronbach's alpha coefficient value of the total scale 0.88. The MSPSS is a validated tool including 12-item scale designed to measure perceived social support from three sources: family, friends, and a significant other. The responses ranged from very strongly disagree to very strongly agree with 7 possible answers and scored very strongly disagree (1 score), strongly disagree (2 score), mildly disagree (3 score), neutral (4 score), mildly agree (5 score), strongly agree (6 score) and very strongly agree (7 score).

The response scale ranged from 12 to 84. The mean subscales were calculated by:

Significant Other Subscale: Sum across items 1, 2, 5, & 10, then divide by 4.

Family Subscale: Sum across items 3, 4, 8, & 11, then divide by 4.

Friends Subscale: Sum across items 6, 7, 9, & 12, then divide by 4.

The overall social support was calculated by summing all 12 items and divided by 12 to obtain mean score. A mean score ranging from 1 to 2.9 was considered low support, 3 to 5 as moderate support and 5.1 to 7 as high support. The Index of Item-Objective Congruence (IOC) was 1.00. The Cronbach's Alpha coefficient was 0.936.

Part 7 Cervical cancer screening uptake

The questionnaire related to cervical cancer screening uptake whether they received any kind of cervical cancer screening at least once during past 3 years, types of screening they received, reasons why they uptake or don't uptake cervical cancer screening by multiple choice questions and their intention to take screening in the future were included.

3.8 Validity and Reliability of Instruments

3.8.1 Translation Process

The questionnaire was first prepared in English and then translated into Burmese by bilingual professional translator for the clarity, cultural appropriateness and understanding for the targeted study participants. Then, translated questionnaire was translated back into English language by second expert who did not know about the original questionnaire.

3.8.2 Validity

The validity of the questionnaire was checked by using Item Objective Congruence (IOC). The questionnaire was reviewed by three experts including researcher, public health specialist, and field specialist. The questionnaire was refined according to the comments and suggestions of three experts. The experts gave score for each question and scores were calculated. If the score was below 0.5, the question was excluded. If the score was between 0.5 – 0.7 the question was revised and refined by

the suggestions of the experts. If the score was above 0.7, the question was included in the set of questionnaires.

$$IOC = \frac{\sum R}{N}$$

Where,

R= Score from each expert per item

N= Number of experts

3.8.3 Reliability

The questionnaire was tested for clarity, understanding and acceptability by doing pilot testing with 30 respondents who have similar characteristics. The reliability of the questionnaire was tested by using Cronbach's Alpha coefficient.

3.9 Data Collection Procedure

After obtaining the approval from the Ethics Committee on Human Research at Mae Fah Luang University, data collection was conducted from September to November 2025.

The entire process of data collection was done by the researcher. Before collecting the data, the local community leaders were contacted, explained the objective and purpose of the study, and with their support, the information of households in each selected community was obtained to develop the sampling frame.

Eligible participants were identified within selected households during data collection. Participants who met the inclusion criteria and were willing to participate were included in the study. Each participant was clearly explained about the process, objective and benefits of this study before participation and written informed consent was obtained in the participant's language. Participants were assured that their participation was entirely voluntary and were informed their right to withdraw their consent anytime during the interview without any negative consequences.

Data were collected through a structured questionnaire. For those who are able to read and write in Burmese language and can understand the questionnaire, a self-administered approach was used in a private setting to ensure their privacy and confidentiality. For those who were unable to read and write, face-to-face interviews

were conducted by the researcher using the same questionnaire. The questionnaire was designed to take around 20-30 minutes and the participants could ask the researcher at any time if they have anything unclear about the questions during the data collection process. The completed answers were checked for missing responses and errors by the researcher before leaving the interview site.

After the data collection process, participants obtained a brochure which included the information about cervical cancer and its causes, risk factors, symptoms, importance of prevention and the contact information of healthcare center where they can get screened.

The collected data was anonymized and securely stored maintaining confidentiality and ethical standards throughout the process.

3.10 Data Analysis

Data were coded, entered and rechecked by using statistical software. Data analysis was done in two parts: Descriptive statistics and Inferential statistics. Data cleaning was done for errors, missing data and outliers to maintain the data accuracy.

Descriptive statistics was used to describe the general characteristics of the participants. Categorical variables were presented by frequency and percentage. Continuous variables were presented by mean, median, maximum, minimum and standard deviation. The percentage of cervical cancer screening uptake was estimated.

For inferential statistics, Chi-square test and Fisher's exact test were used for the initial screening of associations between independent and dependent variables. Univariate logistic regression was used to determine crude odds ratios (OR) for individual associations. Variables with a p-value <0.20 in the univariate analysis were included in the multivariate analysis. Multivariate logistic regression was then conducted to determine the adjusted odds ratios (aOR) to access the association between each predictor and cervical cancer screening uptake by controlling potential confounders.

3.11 Ethical Consideration

The research proposal was reviewed and approved by the Ethics Committee on Human Research at Mae Fah Luang University (COA: 165/2025). The participants were explained about the objective of the study before the data collection and written informed consent was obtained. The participants were made sure to understand that they had right not to answer, and they could withdraw their consent during their interview if they wanted to. The responses were kept anonymous and made sure to maintain the confidentiality of the respondents. All answers of the respondents were only able to be accessed by the researcher. After data entry and analysis of the data were completed, all the answer sheets were destroyed. In any report that we might published, we didn't include information that could make it possible to identify the participants.

CHAPTER 4

RESULTS

This chapter presents the findings of prevalence and associated factors of cervical cancer screening uptake among Myanmar migrant women. The analysis and interpretation provide a comprehensive understanding of the participants socio-demographic, health-related, healthcare service and social characteristics, followed by their relationship with cervical cancer screening uptake outcomes.

The results are presented as the following topics:

1. Descriptive analysis of socio-demographic, health related, healthcare service, and social characteristics of the study population.

2. Comparison of participants' characteristics in relation to Cervical cancer screening uptake among Myanmar migrant women

3. Identification of factors associated with Cervical cancer screening uptake through inferential statistical analysis.

4.1 Descriptive Analysis

4.1.1 Socio-demographic Factors

A total of 260 Myanmar migrant women from Chiang Rai Province were interviewed. The median of age was 36 with IQR (31.25,43) and more than half of the participants were age between 30-39. Most of the participants (83.8%) were married. Among the women who have ever married (n=248), the median of age at first marriage was 21 with IQR (19,25), while 66.1% were married at the age between 14 to 23. Majority of the participants (89.2%) had children.

Most of the participants were Burmese (90.0%) and Buddhists (92.3%). Regarding education, 46.9% had achieved primary school education in Myanmar. The average length of stay was 9.12 ± 6.91 years, with durations ranging from 0.5 to 40 years and more than half of the participants (62.7%) had been in Thailand for more than 5 years. 91.1% of participants were documented while 60.0% of the participants had

health insurance, 51.3% of which insured under Migrant Health Insurance Scheme. 42.2% of participants were service workers and 51.5% earned less than or equal 13000 Thai Baht monthly as household income. The mean monthly income was 14,019.23 ± 6,008.01 THB, with scores ranging from 3,000 to 40,000 THB which showed variation in household income among the participants. Regarding Thai language proficiency, 90.8% of the participants had no reading skills and 93.4% had no writing skills. However, 48.5% of the participants had basic speaking skills and 64.2% had basic listening skills. (Table 4.1).

Table 4.1 Socio-demographic factors (n=260)

Characteristics	**n**	**%**
Age		
30-39	162	62.3
40-49	71	27.3
50-59	27	10.4
Median= 36 (31.25,43)		
Marital Status		
Single	12	4.6
Married	218	83.8
Separated	13	5.0
Divorced	9	3.5
Widowed	8	3.1
Age at first marriage (n=248)		
14-23	164	66.1
24-32	66	26.6
33-42	18	7.3
Median= 21 (19,25), Min = 14, Max = 42		
Number of children		
No children	28	10.8
1-3	208	80.0
>3	24	9.2
Median = 2 (1,2), Min = 0, Max = 7		

Table 4.1 (continued)

Characteristics	n	%
Ethnicity		
Burmese	234	90.0
Karen	10	3.8
Shan	7	2.7
Ahkar	3	1.2
Rakhine	2	0.8
Other	4	1.5
Religion		
Buddhism	240	92.3
Christianity	15	5.8
Muslim	5	1.9
Education		
Illiterate	13	5.0
Primary school	122	46.9
Secondary school	63	24.2
High school	56	21.6
Undergraduate and Graduate	6	2.3
Occupation		
Unemployment	67	25.8
Service worker	111	42.7
Construction worker	43	16.5
Factory worker	24	9.2
Agriculture worker	15	5.8
Monthly household income		
≤13000	134	51.5
>13000	126	48.5
Mean = 14019.23 ± 6008.01, Median = 13000, Min = 3000, Max = 40000		
Length of stay in Thailand		
≤ 5 years	97	37.3

Table 4.1 (continued)

Characteristics	n	%
>5 years	163	62.7
Mean = 9.12 ± 6.91, Median = 9, Min = 0.50, Max = 40.00		
Legal Status		
Documented	239	91.9
Undocumented	21	8.1
Thai reading		
None	236	90.8
Basic	22	8.4
Fluent	2	0.8
Thai speaking		
None	104	40.0
Basic	126	48.5
Fluent	30	11.5
Thai writing		
None	243	93.4
Basic	15	5.8
Fluent	2	0.8
Thai listening		
None	62	23.9
Basic	167	64.2
Fluent	31	11.9
Health insurance		
Yes	156	60.0
No	104	40.0
Type of health insurance (n=156)		
Migrant Health Insurance Scheme	80	51.3
Social Security Scheme	70	44.9
M-Fund	6	3.8

4.1.2 Health-related Factors

Only 2 participants (0.8%) had family history of cervical cancer and 5.4 % of participants had completed vaccination for cervical cancer. 31.5% of the participants were not using any contraceptive methods and oral contraceptive pills was the most used contraceptive methods among participants (24.2%). The main information sources for cervical cancer and cervical cancer screening were doctor and friend with 21.5% and 20.4% respectively. The main cervical cancer and cervical cancer screening information channels was social media (67.7%).

Nearly half of the participants (43.8%) had poor knowledge, while 38.1% demonstrated moderate knowledge and 18.1% had good knowledge. The mean knowledge score was 3.60 ± 1.97, with scores ranging from 0 to 7, indicating an overall poor to moderate level of knowledge among the participants. Regarding attitude towards cervical cancer and cervical cancer screening, most of the participants (53.1%) had positive attitude while 46.9% showed negative attitude. The mean score of attitudes was 26.45 ± 4.97 and the values ranging from 14 to 35, indicating a relatively even distribution. (Table 4.2).

Table 4.2 Health-related factors (n=260)

Characteristics	**n**	**%**
Family history of Cervical Cancer		
Yes	2	0.8
No	254	97.7
Don’t know	4	1.5
History of cervical cancer vaccination		
Yes	14	5.4
No	246	94.6
Contraception		
Not using any contraceptive methods	82	31.5
Oral pills	63	24.2
Injections	43	16.5
Sterilization	39	15.0
Implant	14	5.4

Table 4.2 (continued)

Characteristics	n	%
Calendar Method	9	3.5
Condom	8	3.1
IUD	2	0.8
Information sources		
Doctor	56	21.5
Friend	53	20.4
Neighbor	37	14.2
Acquaintance	36	13.8
Nurse/Health assistant	34	13.1
Family	21	8.1
Patient peers	13	5.0
Healthcare volunteer	4	1.5
Husband	3	1.2
Translator	3	1.2
Information channels		
Social media	176	67.7
No source of information	22	8.5
Television	17	6.5
Pamphlet	17	6.5
Poster	13	5.0
Knowledge		
Poor (≤3 scores)	114	43.8
Moderate (4-5 scores)	99	38.1
Good (≥6 scores)	47	18.1
Mean = 3.60 ± 1.97, Min = 0.00, Max = 7.00		
Attitude		
Positive attitude (≥27 scores)	138	53.1
Negative attitude (<27 scores)	122	46.9
Mean = 26.45 ± 4.97, Min = 14.00, Max = 35.00		

4.1.3 Healthcare Service Factors

Overall perceived access to healthcare was predominantly high among participants, with 72.3% reported as high perception. For the accessibility domain, 63.5% reported high perceived accessibility and 84.6% also reported high perceived availability. High perceived acceptability was reported by 74.6% of participants. For affordability, 63.8% fell into high category and perceived accommodation was also high in 59.6% of the participants. Lastly, Perceived awareness showed that 60.0% of participants had high awareness (Table 4.3).

69.2% of participants knew the nearest health facility to do cervical cancer screening, among them 94.4% of the participants lived in less than 30 mins distance from nearest health facility to get screening and 91.7% felt convenient to go to health facility. Government hospital was the most common health facility (62.6%). 30.8% of participants did not know where to go to get cervical cancer screening (Table 4.3).

Table 4.3 Perceived access to healthcare (n=260)

Characteristics	**n**	**%**
Perceived access to healthcare		
Low perceived access (30-70 scores)	2	0.8
Moderate perceived access (71-110 scores)	70	26.9
High perceived access (111-150 scores)	188	72.3
Mean = 116.88 ± 15.48, Min = 68.00, Max = 147.00		
Perceived Accessibility		
Low (4-9 scores)	25	9.6
Moderate (10-15 scores)	70	26.9
High (16-20 scores)	165	63.5
Mean = 15.90 ± 4.11, Min = 5.00, Max = 20.00		
Perceived Availability		
Low (3-6 scores)	4	1.5
Moderate (7-10 scores)	36	13.9
High (11- 15 scores)	220	84.6
Mean = 13.08 ± 2.30, Min = 6.00, Max = 15.00		

Table 4.3 (continued)

Characteristics	n	%
Perceived Acceptability		
Low (9-20 scores)	3	1.2
Moderate (21-32 scores)	63	24.2
High (33-45 scores)	194	74.6
Mean = 35.09 ± 5.29, Min = 17.00, Max = 45.00		
Perceived Affordability		
Low (3-6 scores)	15	5.8
Moderate (7-10 scores)	79	30.4
High (11-15 scores)	166	63.8
Mean = 11.28 ± 2.65, Min = 3.00, Max = 15.00		
Perceived Accommodation		
Low (6-13 scores)	1	0.4
Moderate (14-21 scores)	104	40.0
High (22-30 scores)	155	59.6
Mean = 22.52 ± 3.92, Min = 13.00, Max = 30.00		
Perceived Awareness		
Low (5-11 scores)	6	2.3
Moderate (12-18 scores)	98	37.7
High (19-25 scores)	156	60.0
Mean = 19.00 ± 3.19, Min = 7.00, Max = 25.00		
Closest health facility to do screening		
Government hospital	163	62.6
Don’t know	80	30.8
Clinic	13	5.0
Charity hospital	3	1.2
Private hospital	1	0.4

Table 4.3 (continued)

Characteristics	n	%
Distance between home and health facility (n=180)		
< or equal 30 mins	170	94.4
>30 mins	10	5.6
Mean = 19.34, SD = ± 15.00, Min = 3.00, Max = 60.00		
Convenient to go to health facility (n= 180)		
Yes	165	91.7
No	15	8.3

4.1.4 Social Factors

Overall perceived social support was predominantly high, with more than half of the participants (57.7%) classified in the high social support category, while only 7.7% reported low social support. The mean perceived social support score was 62.45.

For the family subscale, 77.3% of respondents reported high support which was the highest proportion among the three subscales showing that family support was the most strongly endorsed domain. In the friend subscale, nearly half of the participants (44.2%) fell into the high-support category. Within the significant other subscale, the highest proportion (61.2%) reported high support (Table 4.4).

Table 4.4 Perceived social support (n=260)

Characteristics	n	%
Perceived Social Support		
Low support (1-2.9)	20	7.7
Moderate support (3-5)	90	34.6
High support (5.1-7)	150	57.7
Mean = 62.35 ± 16.88, Min = 12.00, Max = 84.00		
Family		
Low (1-2.9)	22	8.5
Moderate (3-5)	37	14.2
High (5.1-7)	201	77.3
Mean = 23.76 ± 6.75, Min = 4.00, Max = 28.00		

Table 4.4 (continued)

Characteristics	n	%
Friend		
Low (1-2.9)	74	28.5
Moderate (3-5)	71	27.3
High (5.1-7)	115	44.2
Mean = 17.53 ± 8.78, Min = 4.00, Max = 28.00		
Significant other		
Low (1-2.9)	30	11.5
Moderate (3-5)	71	27.3
High (5.1-7)	159	61.2
Mean = 21.05 ± 6.81, Min = 4.00, Max = 28.00		

4.1.5 Cervical Cancer Screening Uptake

Among 260 participants, the percentage of cervical cancer screening uptake within the past 3 years among Myanmar migrant women is 16.9%. 25.0% had ever screened for cervical cancer in their life and nearly half of the participants (48.8%) had willingness to do cervical cancer screening in the future. (Table 4.5).

Table 4.5 Cervical cancer screening uptake (n=260)

	n	%
Screened past 3 years		
Yes	44	16.9
No	216	83.1
Ever screened		
Yes	65	25.0
No	193	74.2
Not remember	2	0.8
Intention in the future		
Yes	127	48.8
No	54	20.8
Not sure	79	30.4

4.1.6 Reasons for not taking and taking cervical cancer screening

Among the women who had not received cervical cancer screening within past 3 years, the most reported reason was the absence of symptoms which accounted for 51.4% of the participants. This was followed by limited knowledge about the disease and perceiving themselves as not at risk with 43.5% and 29.2% respectively. Other frequently mentioned reasons included not receiving a suggestion to screen (21.3%), having no time (20.4%) and not affordable (14.8%). The remaining reasons were reported by only a small proportion of participants. (Table 4.6).

Table 4.6 Reasons for not taking cervical cancer screening (n= 216)

Reasons (multiple response)	**n**	**%**
I have no symptoms		
Yes	111	51.4
No	105	48.6
Don’t know much about the disease		
Yes	94	43.5
No	122	56.5
I don’t think I am at risk of cervical cancer		
Yes	63	29.2
No	153	70.8
No one suggested to screen		
Yes	46	21.3
No	170	78.7
No time		
Yes	44	20.4
No	172	79.6
Not affordable		
Yes	32	14.8
No	184	85.2
Language barriers (high fees of translator)		
Yes	18	8.3
No	198	91.7

Table 4.6 (continued)

Reasons (multiple response)	**n**	**%**
Worried about test result		
Yes	10	4.6
No	206	95.4
Embarrassed		
Yes	9	4.2
No	207	95.8
Painful		
Yes	9	4.2
No	207	95.8
Other things to worried about		
Yes	6	2.8
No	210	97.2
Noone in my surrounding is doing screening		
Yes	6	2.8
No	210	97.2
It is not a common disease		
Yes	5	2.3
No	211	97.7
Transportation barriers		
Yes	4	1.9
No	212	98.1
Don’t know where to go		
Yes	4	1.9
No	212	98.1
I just don’t want to receive screening		
Yes	4	1.9
No	212	98.1

Table 4.6 (continued)

Reasons (multiple response)	**n**	**%**
Not my home country		
Yes	2	0.9
No	214	99.1
No screening program		
Yes	2	0.9
No	214	99.1

Among the participants who undergone screening within the past 3 years, the most frequently reported reason was routine screening after childbirth (43.2%). This was followed by personal concern for health (27.3%), receipt of advice from healthcare providers (22.7%), presence of symptoms (22.7%), screening program (18.2%), and having knowledge about the disease (13.6%). The remaining reasons were mentioned by only few participants. (Table 4.7).

Table 4.7 Reasons for taking cervical cancer screening (n=44)

Reasons (multiple response)	**n**	**%**
Routine after childbirth		
Yes	19	43.2
No	25	56.8
I am interested in my own health		
Yes	12	27.3
No	32	72.7
Advice from Healthcare professional		
Yes	10	22.7
No	34	77.3
I have symptoms		
Yes	10	22.7
No	34	77.3

Table 4.7 (continued)

Reasons (multiple response)	**n**	**%**
Screening Program		
Yes	8	18.2
No	36	81.8
I have knowledge		
Yes	6	13.6
No	38	86.4
I want to prevent cervical cancer		
Yes	6	13.6
No	38	86.4
Someone suggested me to do screening		
Yes	4	9.1
No	40	90.9
It is affordable		
Yes	2	4.5
No	42	95.5

4.2 Comparison of Factors in Relation to Cervical Cancer Screening Uptake

4.2.1 Comparison of socio-demographic factors in relation to cervical cancer screening uptake

In the comparison of socio-demographic factors in relation to cervical cancer screening uptake among Myanmar migrant women, 4 variables were found to have statistically significant difference: age at first marriage, legal status, health insurance, and length of stay in Thailand (Table 4.8).

Table 4.8 Comparison of socio-demographic factors in relation to cervical cancer screening

Factors	Screening Uptake		χ^2	p-value
	Yes	No		
	44 (16.9%)	216 (83.1%)		
Age				
<40 years	29 (17.9)	133 (82.1)	0.292[a]	0.589
≥40 years	15 (15.3)	83 (84.7)		
Marital status				
living with partner (married)	39 (17.9)	179 (82.1)	0.897[a]	0.344
not living with partner (Single, divorced, separated, widowed)	5 (11.9)	37 (88.1)		
Age at first marriage (n=248)				
≤25 years	40 (20.7)	153 (79.3)	5.308[b]	0.021*
>25 years	4 (7.3)	51 (92.7)		
Number of children				
No children	3 (10.7)	25 (89.3)	2.521[b]	0.361
1-3	39 (18.7)	169 (81.3)		
>3	2 (8.3)	22 (91.7)		

Table 4.8 (continued)

Factors	Screening Uptake		χ^2	p-value
	Yes	No		
	44 (16.9%)	216 (83.1%)		
Ethnicity				
Burmese	40 (17.1)	194 (82.9)	0.049[b]	1.000
Non-Burmese	4 (15.4)	22 (84.6)		
Religion				
Buddhism	44 (18.3)	196 (81.7)	4.414[b]	0.101
Christianity	0 (0.0)	15 (100.0)		
Muslim	0 (0.0)	5 (100.0)		
Education				
Lower education	36 (18.2)	162 (81.8)	0.936[a]	0.333
Higher education	8 (12.9)	54 (87.1)		
Occupation				
Occupation	31 (16.1)	162 (83.9)	0.395[a]	0.530
No occupation	13 (19.4)	54 (80.6)		
Household income				
≤13000	20 (14.9)	114 (85.1)	0.785[a]	0.376
>13000	24 (19.0)	102 (81.0)		
Legal status				
Documented	44 (18.4)	195 (81.6)	4.654[b]	0.030*
Undocumented	0 (0.0)	21 (100.0)		
Health insurance				
Out-of-pocket	8 (7.7)	96 (92.3)	10.505[a]	0.001*
Insurance	36 (23.1)	120 (76.9)		
Thai writing				
None	41 (16.9)	202 (83.1)	0.007[b]	1.000
Basic-Fluent	3 (17.6)	14 (82.4)		

Table 4.8 (continued)

Factors	Screening Uptake		χ^2	p-value
	Yes	**No**		
	44 (16.9%)	**216 (83.1%)**		
Thai speaking				
None	13 (12.5)	91 (87.5)	2.412[a]	0.120
Basic-Fluent	31 (19.9)	125 (80.1)		
Thai reading				
None	39 (16.5)	197 (83.5)	0.288[b]	0.572
Basic-Fluent	5 (20.8)	19 (79.2)		
Thai listening				
None	6 (9.7)	56 (90.3)	3.040[a]	0.081
Basic-Fluent	38 (19.2)	160 (80.8)		
Length of stay in Thailand				
≤5 years	9 (9.3)	88 (90.7)	6.432[a]	0.011*
>5 years	35 (21.5)	128 (78.5)		

Note*Statistically significance level at p-value <0.05

[a]Chi-square test

[b]Fisher's exact test

4.2.2 Comparison of health-related factors in relation to cervical cancer screening uptake

In the comparison of health-related factors in relation to cervical cancer screening uptake, 4 variables were found to have statistically significant difference: contraceptive use, received information from nurse or health assistant, having no source of information, and attitude towards cervical cancer screening. (Table 4.9)

Table 4.9 Comparison of health-related factors in relation to cervical cancer screening uptake

Factors	Screening Uptake		χ^2	p-value
	Yes	**No**		
	44 (16.9%)	**216 (83.1%)**		
Contraceptive use				
Yes	36 (20.2)	142 (79.8)	4.376[a]	0.036*
No	8 (9.8)	74 (90.2)		
Family history of cervical cancer				
Yes	0 (0.0)	2 (100.0)	0.411[b]	1.000
No	44 (17.1)	214 (82.9)		
History of HPV vaccination				
Yes	3 (21.4)	11 (78.6)	0.214[b]	0.712
No	41 (16.7)	205 (83.3)		
Source of information				
Husband				
Yes	1 (33.3)	2 (66.7)	0.581[b]	0.428
No	43 (16.7)	214 (83.3)		
Family				
Yes	2 (9.5)	19 (90.5)	0.890[b]	0.544
No	42 (17.6)	197 (82.4)		
Friend				
Yes	9 (17.0)	44 (83.0)	0.000[a]	0.990
No	35 (16.9)	172 (83.1)		
Neighbor				
Yes	4 (10.8)	33 (89.2)	1.146[b]	0.284
No	40 (17.9)	183 (82.1)		

Table 4.9 (continued)

Factors	Screening Uptake		χ^2	p-value
	Yes	No		
	44 (16.9%)	216 (83.1%)		
Acquaintance				
Yes	7 (19.4)	29 (80.6)	0.189[a]	0.664
No	37 (16.5)	187 (83.5)		
Doctor				
Yes	12 (21.4)	44 (78.6)	1.031[a]	0.310
No	32 (15.7)	172 (84.3)		
Nurse/Health assistant				
Yes	10 (29.4)	24 (70.6)	4.339[a]	0.037*
No	34 (15.0)	192 (85.0)		
Healthcare volunteer				
Yes	1 (25.0)	3 (75.0)	0.189[b]	0.526
No	43 (16.8)	213 (83.2)		
Translator				
Yes	1 (33.3)	2 (66.7)	0.581[b]	0.428
No	43 (16.7)	214 (83.3)		
Patient peers				
Yes	2 (15.4)	11 (84.6)	0.023[b]	1.000
No	42 (17.0)	205 (83.0)		
Social media				
Yes	31 (17.6)	145 (82.4)	0.185[a]	0.667
No	13 (15.5)	71 (84.5)		
TV				
Yes	1 (5.9)	16 (94.1)	1.577[b]	0.321
No	43 (17.7)	200 (82.3)		
Poster				
Yes	0 (0.0)	13 (100.0)	2.788[b]	0.134
No	44 (17.8)	203 (82.2)		

Table 4.9 (continued)

Factors	Screening Uptake		χ^2	p-value
	Yes	**No**		
	44 (16.9%)	**216 (83.1%)**		
Pamphlet				
Yes	2 (11.8)	15 (88.2)	0.344[b]	0.745
No	42 (17.3)	201 (82.7)		
No source of information				
Yes	0 (0.0)	22 (100.0)	4.896[b]	0.032*
No	44 (18.5)	194 (81.5)		
Knowledge				
Poor knowledge	14 (12.3)	100 (87.7)	4.688[a]	0.096
Moderate knowledge	23 (23.2)	76 (76.8)		
Good knowledge	7 (14.9)	40 (85.1)		
Attitude				
Positive attitude	35 (25.4)	103 (74.6)	14.898[a]	<0.001*
Negative attitude	9 (7.4)	113 (92.6)		

Note*Statistically significance level at p-value <0.05

[a]Chi-square test

[b]Fisther's exact test

4.2.3 Comparison of healthcare service factors in relation to cervical cancer screening uptake

In the comparison of healthcare service factors, perceived availability and perceived affordability were found to have statistically significant difference (Table 4.10).

Table 4.10 Comparison of perceived access to healthcare in relation to cervical cancer screening uptake

Factors	Screening uptake		χ^2	p-value
	Yes	No		
	44(16.9%)	216 (83.1%)		
Perceived access to healthcare				
Low- moderate	7 (9.7)	65 (90.3)	3.672[a]	0.055
High	37 (19.7)	151 (80.3)		
Perceived Accessibility				
Low-moderate	14 (14.7)	81 (85.3)	0.509[a]	0.476
High	30 (18.2)	135 (81.8)		
Perceived Availability				
Low-moderate	1 (2.5)	39 (97.5)	6.995[b]	0.008*
High	43 (19.5)	177 (80.5)		
Perceived Acceptability				
Low-moderate	7 (10.6)	59 (89.4)	2.511[a]	0.113
High	37 (19.1)	157 (80.9)		
Perceived Affordability				
Low-moderate	10 (10.6)	84 (89.4)	4.136[a]	0.042*
High	34 (20.5)	132 (79.5)		
Perceived Accommodation				
Low-moderate	15 (14.3)	90 (85.7)	0.871[a]	0.351
High	29 (18.7)	126 (81.3)		
Perceived Awareness				
Low-moderate	12 (11.5)	92 (88.5)	3.575[a]	0.059
High	32 (20.5)	124 (79.5)		

Note*Statistically significance level at p-value <0.05

[a]Chi-square test

[b]Fisher's exact test

4.2.4 Comparison of social factors in relation to cervical cancer screening uptake

In the comparison of social factors related to cervical cancer screening uptake, all variables show no statistically significant association with screening uptake.

Table 4.11 Comparison of perceived social support in relation to cervical cancer screening uptake

Factors	Screening uptake		χ^2	p-value
	Yes	No		
	44 (16.9%)	216 (83.1%)		
Perceived social support				
Low-moderate	15 (13.6)	95 (86.4)	1.465[a]	0.226
High	29 (19.3)	121 (80.7)		
Family				
Low-moderate	6 (10.2)	53 (89.8)	2.476[a]	0.116
High	38 (18.9)	163 (81.1)		
Friend				
Low-moderate	22 (15.2)	123 (84.8)	0.715[a]	0.398
High	22 (19.1)	93 (80.9)		
Significant Other				
Low-moderate	15 (14.9)	86 (85.1)	0.504[a]	0.478
High	29 (18.2)	130 (81.8)		

Note*Statistically significance level at p-value <0.05

[a]Chi-square test

[b]Fisher's exact test

4.3 Identification of Factors Associated with Cervical Cancer Screening Uptake through Inferential Statistical Analysis

4.3.1 Univariable analysis to identify factors associated with cervical cancer screening uptake

In univariable logistic regression analysis, 9 variables were found to be significantly associated with cervical cancer screening uptake: age at first marriage, health insurance, length of stay in Thailand, contraceptive use, received information from nurse or health assistant, knowledge, attitude, perceived availability and perceived affordability.

Women who married after 25 years had 0.30 times lower odds of screening uptake compared to those who marred at or before 25 years (95%CI = 0.10-0.88). The odds of screening uptake were 3.60 times higher for those who had health insurance compared to those who paid out-of-pocket (95%CI = 1.60-8.11). Participants who had lived in Thailand for more than 5 years had 2.67 times greater odds of screening uptake than those who had lived ≤5 years (95%CI = 1.22-5.84). The odds of screening uptake were 2.35 times higher for those who used contraception than those who did not use contraception (95% CI = 1.04-5.30). Moreover, participants who received information of cervical cancer and screening from nurse or health assistant had 2.35 times higher odds of screening uptake compared to those who did not received information from them (95% CI = 1.03-5.36). Those with moderate knowledge of cervical cancer and screening had 2.16 times higher odds of screening uptake than those who had poor knowledge (95%CI = 1.04-4.48). The odds of screening uptake were 4.27 times higher for those with positive attitude towards cervical cancer and screening compared to those with negative attitude (95%CI = 1.96-9.30). Participants who reported high perceived availability had 9.48 times higher odds of screening uptake compared to those reporting low–moderate availability (95% CI =1.27–70.90). Similarly, participants with high perceived affordability had 2.16 times higher odds of screening uptake compared with those with low–moderate affordability (95% CI =1.02–4.61) (Table 4.12).

Table 4.12 Univariable analysis to identify factors associated with cervical cancer screening uptake

Factors	Screening Uptake		Crude OR	95%CI	p-value
	Yes 44 (16.9%)	No 216 (83.1%)			
Age					
<40 years	29 (17.9)	133 (82.1)	1.00		
≥40 years	15 (15.3)	83 (84.7)	0.829	0.42-1.64	0.589
Marital status					
living with partner	39 (17.9)	179 (82.1)	1.612	0.60-4.37	0.347
not living with partner	5 (11.9)	37 (88.1)	1.00		
Age at first marriage (n= 248)					
≤25 years	40 (20.7)	153 (79.3)	1.00		
>25 years	4 (7.3)	51 (92.7)	0.300	0.10-0.88	0.028*
Number of children					
No children	3 (10.7)	25 (89.3)	1.00		
1-3	39 (18.7)	169 (81.3)	1.923	0.55-6.69	0.304
>3	2 (8.3)	22 (91.7)	0.758	0.12-4.96	0.772
Ethnicity					
Burmese	40 (17.1)	194 (82.9)	1.134	0.37-3.47	0.826
Non-Burmese	4 (15.4)	22 (84.6)	1.00		
Education					
Lower education	36 (18.2)	162 (81.8)	1.00		
Higher education	8 (12.9)	54 (87.1)	0.667	0.29 –1.52	0.336

Table 4.12 (continued)

Factors	Screening Uptake		Crude OR	95%CI	p-value
	Yes 44 (16.9%)	No 216 (83.1%)			
Occupation					
No occupation	31 (16.1)	162 (83.9)	1.00		
Occupation	13 (19.4)	54 (80.6)	0.795	0.39-1.63	0.530
Monthly household income					
≤13000	20 (14.9)	114 (85.1)	1.00		
>13000	24 (19.0)	102 (81.0)	1.341	0.70-2.57	0.377
Health insurance					
Out-of-pocket	8 (7.7)	96 (92.3)	1.00		
Insurance	36 (23.1)	120 (76.9)	3.600	1.60-8.11	0.002*
Thai writing					
None	41 (16.9)	202 (83.1)	1.00		
Basic-Fluent	3 (17.6)	14 (82.4)	1.056	0.29-3.84	0.934
Thai speaking					
None	13 (12.5)	91 (87.5)	1.00		
Basic-Fluent	31 (19.9)	125 (80.1)	1.736	0.86-3.50	0.123
Thai reading					
None	39 (16.5)	197 (83.5)	1.00		
Basic-Fluent	5 (20.8)	19 (79.2)	1.329	0.47-3.77	0.593
Thai listening					
None	6 (9.7)	56 (90.3)	1.00		
Basic-Fluent	38 (19.2)	160 (80.8)	2.217	0.89-5.53	0.088
Length of stay in Thailand					
≤5 years	9 (9.3)	88 (90.7)	1.00		
>5 years	35 (21.5)	128 (78.5)	2.674	1.22-5.84	0.014*

Table 4.12 (continued)

Factors	Screening Uptake		Crude OR	95%CI	p-value
	Yes 44 (16.9%)	No 216 (83.1%)			
Contraceptive use					
Yes	36 (20.2)	142 (79.8)	2.345	1.04-5.30	0.041*
No	8 (9.8)	74 (90.2)	1.00		
History of HPV vaccination					
Yes	3 (21.4)	11 (78.6)	1.364	0.36-5.10	0.645
No	41 (16.7)	205 (83.3)	1.00		
Source of information					
Husband					
No	43 (16.7)	214 (83.3)	1.00		
Yes	1 (33.3)	2 (66.7)	2.488	0.22-28.06	0.461
Family					
No	42 (17.6)	197 (82.4)	1.00		
Yes	2 (9.5)	19 (90.5)	0.494	0.11-2.20	0.355
Friend					
No	35 (16.9)	172 (83.1)	1.00		
Yes	9 (17.0)	44 (83.0)	1.005	0.45-2.25	0.990
Neighbor					
No	40 (17.9)	183 (82.1)	1.00		
Yes	4 (10.8)	33 (89.2)	0.555	0.19-1.65	0.290
Acquaintance					
No	37 (16.5)	187 (83.5)	1.00		
Yes	7 (19.4)	29 (80.6)	1.220	0.50-2.99	0.664
Doctor					
No	32 (15.7)	172 (84.3)	1.00		
Yes	12 (21.4)	44 (78.6)	1.466	0.70-3.08	0.312

Table 4.12 (continued)

Factors	Screening Uptake		Crude OR	95%CI	p-value
	Yes 44 (16.9%)	No 216 (83.1%)			
Nurse/Health assistant					
No	34 (15.0)	192 (85.0)	1.00		
Yes	10 (29.4)	24 (70.6)	2.353	1.03-5.36	0.042*
Healthcare volunteer					
No	43 (16.8)	213 (83.2)	1.00		
Yes	1 (25.0)	3 (75.0)	1.651	0.17-16.25	0.667
Translator					
No	43 (16.7)	214 (83.3)	1.00		
Yes	1 (33.3)	2 (66.7)	2.488	0.22-28.06	0.461
Patient peers					
No	42 (17.0)	205 (83.0)	1.00		
Yes	2 (15.4)	11 (84.6)	0.887	0.19-4.15	0.879
Social media					
No	13 (15.5)	71 (84.5)	1.00		
Yes	31 (17.6)	145 (82.4)	1.168	0.58-2.37	0.668
TV					
No	43 (17.7)	200 (82.3)	1.00		
Yes	1 (5.9)	16 (94.1)	0.291	0.04-2.25	0.237
Pamphlet					
No	42 (17.3)	201 (82.7)	1.00		
Yes	2 (11.8)	15 (88.2)	0.638	1.14-2.90	0.560
Knowledge					
Poor knowledge	14 (12.3)	105 (87.7)	1.00		
Moderate knowledge	23 (23.2)	76 (76.8)	2.162	1.04-4.48	0.038*

Table 4.12 (continued)

Factors	Screening Uptake		Crude OR	95%CI	p-value
	Yes 44 (16.9%)	No 216 (83.1%)			
Good knowledge	7 (14.9)	40 (85.1)	1.250	0.47-3.33	0.655
Attitude					
Positive	35 (25.4)	103 (74.6)	4.266	1.96-9.30	<0.001*
Negative	9 (7.4)	113 (92.6)	1.00		
Perceived access to healthcare					
Low-moderate	7 (9.7)	65 (90.3)	1.00		
High	37 (19.7)	151 (80.3)	2.275	0.96- 5.37	0.061
Perceived Accessibility					
Low-moderate	14 (14.7)	81 (85.3)	1.00		
High	30 (18.2)	135 (81.8)	1.286	0.64-2.57	0.476
Perceived Availability					
Low-moderate	1 (2.5)	39 (97.5)	1.00		
High	43 (19.5)	177 (80.5)	9.475	1.27-70.90	0.029*
Perceived Acceptability					
Low-moderate	7 (10.6)	59 (89.4)	1.00		
High	37 (19.1)	157 (80.9)	1.986	0.84-4.70	0.118
Perceived Affordability					
Low-moderate	10 (10.6)	84 (89.4)	1.00		
High	34 (20.5)	132 (79.5)	2.164	1.02-4.61	0.045*

Table 4.12 (continued)

Factors	Screening Uptake		Crude OR	95%CI	p-value
	Yes 44 (16.9%)	No 216 (83.1%)			
Perceived Accommodation					
Low-moderate	15 (14.3)	90 (85.7)	1.00		
High	29 (18.7)	126 (81.3)	1.381	0.70-2.72	0.352
Perceived Awareness					
Low-moderate	12 (11.5)	92 (88.5)	1.00		
High	32 (20.5)	124 (79.5)	1.978	0.97-4.05	0.062
Perceived social support					
Low- moderate	15 (13.6)	95 (86.4)	1.00		
High	29 (19.3)	121 (80.7)	1.518	0.77- 2.99	0.228
Social support from family					
Low- moderate	6 (10.2)	53 (89.8)	1.00		
High	38 (18.9)	163 (81.1)	2.059	0.83-5.14	0.122
Social support from friend					
Low- moderate	22 (15.2)	123 (84.8)	1.00		
High	22 (19.1)	93 (80.9)	1.323	0.69-2.53	0.399
Social support from significant other					
Low- moderate	15 (14.9)	86 (85.1)	1.00		
High	29 (18.2)	130 (81.8)	1.279	0.65-2.53	0.478

Note*Statistically significance level at p-value <0.05

4.3.2 Multivariable analysis to identify factors associated with cervical cancer screening uptake

In multivariable logistic regression analysis, five variables were found to be significantly associated with cervical cancer screening uptake: health insurance, length of stay in Thailand, contraceptive use, received information from nurse or health assistant, and attitude.

Participants covered under health insurance had 4.17 times higher odds of screening uptake compared to those paid out-of-pocket (95%CI = 1.61-10.85). Those who had stayed in Thailand for more than 5 years had 2.63 times higher odds of screening uptake than those who lived ≤ 5 years (95%CI = 1.05-6.58). The odds of screening uptake were 2.47 times higher in participants who used contraception than those who did not use (95%CI = 1.02-5.97). Participants who received information from nurse or health assistant had 4.47 times higher odds of screening uptake than those who did not received from them (95%CI = 1.60-12.44). Lastly, participants with positive attitude had 3.93 times higher odds of screening uptake than those with negative attitude (95%CI = 1.73-8.92) (Table 4.13).

Table 4.13 Multivariable analysis to identify factors associated with cervical cancer screening uptake

Factors	Screening Uptake		OR_{adj}	95%CI	p-value
	Yes	**No**			
	44 (16.9%)	**216 (83.1%)**			
Health insurance					
Out-of-pocket	8 (7.7)	96 (92.3)	1.00		
Insurance	36 (23.1)	120 (76.9)	4.173	1.61-10.85	0.003*
Length of stay in Thailand					
≤5 years	9 (9.3)	88 (90.7)	1.00		
>5 years	35 (21.5)	128 (78.5)	2.627	1.05-6.58	0.039*
Contraceptive use					
Yes	36 (20.2)	142 (79.8)	2.467	1.02-5.97	0.045*
No	8 (9.8)	74 (90.2)	1.00		
Nurse/Health assistant					
No	34 (15.0)	192 (85.0)	1.00		
Yes	10 (29.4)	24 (70.6)	4.465	1.60-12.44	0.004*
Attitude					
Positive	35 (25.4)	103 (74.6)	3.930	1.73-8.92	0.001*
Negative	9 (7.4)	113 (92.6)	1.00		

Note* Statistically significance level at p-value <0.05

CHAPTER 5

DISCUSSION

The objective of the study was to identify the percentage of cervical cancer screening uptake and its associated factors among Myanmar migrant women in Chiang Rai Province, Thailand. This chapter presents the discussion, conclusions and recommendations of the study.

5.1 Discussion on Findings

5.1.1 Socio-demographic Factors of Myanmar Migrant Women

In this study, more than half of the participants were aged 30-39 years old, reflecting working-age population with substantial family responsibilities. Even though the study excluded women under 30 or above 60 years, the predominance of women aged 30-39 years is consistent with the report of Myanmar migrants in Thailand (International Organization for Migration, 2025). Most of the participants were married, already established families in Thailand, most being married at the early age around 20, indicating early introduction to the reproductive life. This finding aligns with the study in Mae Sot, Tak Province (Myint et al., 2024). The majority of the participants had children, showing their caregiving roles in addition to economic responsibilities and also the higher chance of screening after childbirth. Burmese women constituted largest proportion in this study while Buddhism being the most common religion, which is the predominant religion in Myanmar. Regarding education, only a small proportion had completed higher education which explained the major influx of Myanmar migrants to work low-skilled or blue-collar jobs in Thailand. The most common occupations were in service sector, followed by unemployment, which may be due to their childcare responsibilities as many participants had young children needing close care by mother. The median monthly household income was 13,000 baht which may vary according to type of occupation, workplace and the number of income-earning family members. Participants had resided in Thailand for a median of 9 years, which is long enough for

social and cultural adaptation in the host country, but language difficulties still persisted, particularly in reading and writing Thai despite basic speaking and listening ability among migrant women. Therefore, most migrant women require assistance in accessing healthcare in Thai language. This finding aligns with the studies among Myanmar migrant workers in Chiang Rai and Khon Kaen (Min et al., 2025; Win et al., 2023). Although almost all participants were documented, nearly half didn't have health insurance, often due to legal status or financial problem to enroll or renew. This finding aligns with the Thailand Migration report (Barber & Sciortino, 2024). In this study, the lack of health insurance among participants may be attributed to temporary unemployment due to caregiving responsibility, or period of job transition. Among insured participants, Migrant Health Insurance Scheme (MHIS) and Social Security Scheme (SSS) were most reported because in Thailand, documented migrants were needed to purchase health insurance particularly under MHIS for the worker in informal sector and SSS if they work in the formal sector (International Labour Organization, 2021).

Regarding health-related factors, only a few persons had family history of cervical cancer and prior receipt of cervical cancer vaccination, showed low participation in primary prevention. Even though most people had ever heard about cervical cancer, only few had seen cases in their social environment, which may reduce perceived risk and urgency to engage in preventive practices. Majority of the participants use contraception, and the most used contraceptive method were oral contraceptive pills followed by injection which may likely be due to its easy availability and compliance. In terms of source of information about cervical cancer and screening, social media, doctors and friends were the most common sources which showed the important role of social media in disseminating health information while the health personnel being trusted provider of credible guidance. This finding aligns with previous studies highlighting the importance of source of information as a trusted motivation in receiving healthcare services (Nyi, 2020; Yin Wint, 2019). Even though more than half of migrant women in this study expressed positive attitudes towards cervical cancer and screening, limited knowledge remained one kind of barrier for them to be in good preventive practices. Poor knowledge about cervical cancer has been widely reported among Myanmar women, including studies conducted in Taungoo and Mandalay(Nyi,

2020; Yin Wint, 2019). In addition, migrant populations have been shown to have limited knowledge of cervical cancer and screening which may be attributed to their low literacy level, unfamiliar with the healthcare system of host country and socio-cultural factors (Marques et al., 2021). However, a study in Mae Sot reported a relatively higher level of knowledge among Myanmar migrant women (Myint et al., 2024). This may be explained by the high concentration of migrants in that area, and the presence of targeted interventions for migrants implemented by non-governmental organizations, and the supportive role of Mae Tao Clinic which provides culturally, and linguistically appropriate services delivered by Myanmar healthcare providers.

Regarding perceived access to healthcare, most of the participants reported high perceived access including accessibility, availability, acceptability, affordability, accommodation and awareness. They also reported the closest health facility offering cervical cancer screening could be reached withing 30 minutes and was convenient to go. Despite these favorable access conditions, the screening rate remained low. This finding suggests that geographical accessibility and perceived access to healthcare alone are insufficient to promote preventive health behaviors. This may be due to their stigma, their cultural beliefs and limited perceived need for screening in the absence of symptoms. In low-resource settings, healthcare utilization is often oriented toward curative rather than preventive care, with individuals seeking services only when they perceived illness. This is supported by the study among Myanmar migrant workers in Ranong Province, Thailand (Aung et al., 2018). Therefore, even when services are physically accessible, women may not prioritize preventive care unless they aware the value of prevention without sociocultural barriers.

For perceived social support, most participants reported moderate or high levels of perceived social support from family, friends or significant other, with family being the biggest supporter which is common among Asian countries. Family is the closest one who provide emotional, financial or physical assistance when you are in needs. Moreover, encouragement and support from health professionals also foster them to receive cervical cancer screening since they are the trusted sources, and their motivation increases confidence in accessing services. Therefore, social support is very important among migrant communities to have resilience in coping with challenges such as unemployment, financial struggles, sociocultural adaptation and in making-decision

including healthcare. This finding is supported by previous studies, which highlight the importance of social support in receiving cervical cancer screening (Chua et al., 2021; Cruanes et al., 2024; Nyi, 2020; Marques et al., 2020; Nandar et al., 2015). However, social support alone can't ensure access to preventive services when family members have limited knowledge or experiencing similar structural constraints. Therefore, these findings suggest health promotion to include supportive environments and encouragement from health professionals to ensure health information translating into preventive practices since social support being the valuable factor among migrants.

5.1.2 Prevalence of cervical cancer screening uptake among Myanmar migrant women

In this study, only 16.9% of Myanmar migrant women aged 30-60 years reported having received any kind of cervical cancer screening within the past 3 years, indicating low uptake of screening among Myanmar migrant women in Chiang Rai Province, Thailand. Even though a higher proportion of women reported having ever been screened at least once in their lifetime, the low uptake of recent screening highlights their gaps in continuing regular preventive care. The finding is similar with the study done among Myanmar women in Yangon, Mandalay and Taungoo, as well as the study done in Mae Sot, showing the limited participation in cervical cancer screening still being the persist challenge in this population (Han et al., 2016; Nyi, 2020; Myint et al., 2024; Nandar et al., 2015; Yin Wint, 2019). The screening rate among Myanmar migrant women is lower than the screening rate of native Thailand women which is 49% (IARC HPV information center, 2023c). It is also lower than the screening rate among women in Chiang Rai Province border area which is 43.0% due to the targeted outreach screening service every year for them which shows that migrants are often left behind (Theppawong et al., 2025). Therefore, public health intervention is recommended to include migrant women in national cervical cancer screening program and introduce culturally appropriate health education and outreach screening services to reduce stigma and cultural beliefs among them.

Among the women who had been screened in the past 3 years, the most common reason behind their screening behavior was routine screening after childbirth, highlighting the important role of integrating cervical cancer screening into reproductive health services since it provides opportunity to reach women by increasing

accessibility and availability of screening services within routine maternal healthcare. In addition, factors such as personal interest in health, prior knowledge about screening and advice from healthcare professional further promote screening behavior. Healthcare provider recommendation is one of the key factors to increase awareness, trust, and perceived necessity of screening, especially among women who may not actively seek preventive services on their own.

In contrast, there were several barriers which hindered them from screening uptake with the absence of symptoms being the most commonly reported. This reflects their health-seeking behavior which oriented towards curative rather than preventive, indicating limited awareness of the importance of early detection. Other barriers including, limited knowledge about the disease and screening, low perceived susceptibility, lack of suggestion, time constraints and financial limitations further restrict screening uptake. These factors highlight the impact of competing priorities and indirect costs such as translator fees and transportation fees which are common among migrant populations. Moreover, socio-cultural factors such as embarrassment, concerns about pain and fear of diagnosis may also discourage women from undergoing screening. These barriers are consistent with the study conducted in Taungoo, Myanmar (Yin Wint, 2019).

Overall, cervical cancer screening behavior is influenced by a complex interplay of individual factors, interpersonal influences, and structural barriers, highlighting the need to comprehensive and multi-level interventions to improve screening uptake among migrant women.

Despite these obstacles, nearly half of the participants expressed an intention to undergo cervical cancer screening in the future and it is found to be significantly associated with age, monthly household income, contraceptive use, knowledge, attitude, screened within the past 3 years and source of information such as receiving information from friends and social media.

The association of age with intention to undergo cervical cancer screening is consistent with previous studies conducted by Pyae et al. (2012) and Zeno et al. (2022) which identified age as an important factor related to screening intention, but the direction and strength of this association may vary across studies and settings according to their reproductive history, prior engagement with health services, and perceived

susceptibility to disease. The role of knowledge and attitude in screening intention is also consistent with a study in Ethiopia, which emphasized that intention is shaped by cognitive and attitudinal factors (Lahole et al., 2024). The important role of health insurance in shaping screening intention is supported by previous study conducted by (Zeno et al., 2022) which reported lack of health insurance as commonly cited barriers to cervical cancer screening. Association between intention and receiving information from friends or social media highlights the important role of social networks and peer communication in shaping awareness and motivation for cervical cancer screening by normalizing screening behavior, reducing stigma or misconceptions, especially in settings where access to formal health education is limited.

This finding indicates that low screening rate is likely to be driven by structural and informational barriers rather than lack of interest in prevention. Therefore, addressing these barriers through targeted education, encouragement from healthcare providers, and affordable services may turn positive intentions into actual practices.

5.1.3 Factors associated with cervical cancer screening uptake

Firstly, 42 variables were tested for association with cervical cancer screening uptake among Myanmar migrant women by using univariable analysis in binary logistic regression which is conducted at a 95% confidence interval, with crude odds ratios and statistical significance set at a p-value <0.05. From the univariable analysis, 9 variables were found to be significantly associated with cervical cancer screening uptake: age at first marriage, health insurance, length of stay in Thailand, contraceptive use, received information from nurse or health assistant, knowledge, attitude, perceived availability and perceived affordability.

Secondly, the variables with p-value <0.20 in univariable analysis were adjusted in multivariable logistic regression with assumptions checked using Hosmer and Lemeshow test by using backward method to obtain the final model. From multivariable analysis, five variables remained significantly associated with cervical cancer screening uptake: health insurance, length of stay in Thailand, contraceptive use, received information from nurse or health assistant, and attitude at a 95% confidence interval, with statistical significance at a p-value < 0.05.

Health insurance plays an important role in accessing healthcare services and it was a significant factor associated with cervical cancer screening uptake in this study.

The finding indicated that individuals with health insurance were more likely to uptake cervical cancer screening compared to those without coverage. This aligns with the previous studies conducted among migrants in China, where insured migrants and refugees had higher odds of doing cervical cancer screening and a European review also identified lack of insurance as a major barrier to screening among migrant populations which showed the consistent significant role of health insurance through different context (Holt et al., 2021; Marques et al., 2020). This association between insurance coverage and screening uptake may be explained by reduced financial barriers. Insured individuals are less constrained by direct medical costs and may be more willing to seek preventive services. In contrast, individuals without health insurance may be affected not only by the health service costs but also by the indirect costs such as transportation, translator fees and loss of income due to time away from work. In addition, having health insurance is mostly correlated with legal or documentation status. Migrants with documentation status are more likely to be enrolled in health insurances such as social security scheme, migrant health insurance scheme or M-Fund for some minor people. Therefore, health insurance may function as both financial enabler and indicator of broader social inclusion in the healthcare system.

The duration of stay in Thailand is also one of the factors associated with cervical cancer screening uptake in this study. Participants who had stayed in Thailand for a longer duration were more likely to undergone cervical cancer screening compared to those with shorter stay. This finding is consistent with the previous finding from a systematic review among migrant women in Europe (Marques et al., 2020). This association is due to the migration-related stress, lack of awareness about the healthcare system of the host country and language barriers among the migrant women who had moved recently. Therefore, migrants may gradually overcome these barriers through social integration, information sharing, repeated contact with health facilities and may settle down financially. However, this finding is opposed by a study conducted in Portugal where cervical cancer screening is high among recently arrived migrant women (Marques et al., 2022). This difference may reflect contextual factors such as the healthcare system, targeted screening programs for new migrants, or differences in

migrant characteristics, highlighting the association between length of stay and screening uptake may vary across settings.

Contraceptive use is one of the key factors of reproductive health access among women. It is the strategic entry point to enhance women's engagement with comprehensive reproductive health services. In this study, contraceptive use was found to be associated with cervical cancer screening uptake showing that women who use contraception may have greater contact with health professionals, healthcare system and more interesting about their reproductive health and higher health-seeking behavior. This finding aligns with the previous study among ethnic minority group indicating women who use contraception are more likely to engage in cervical cancer screening (Intahphuak et al., 2021). This association may be because women using contraception may get broader reproductive health information including cervical cancer screening while receiving family planning services from healthcare providers. Moreover, through family planning services, healthcare providers also get opportunities to provide education about reproductive health risks and importance of prevention services.

Source of information also plays an important role in translating health information into practices. This study found that receiving information from nurses or health assistants as a significant factor associated with cervical cancer screening uptake. This finding may be due to the central role of nurses or health assistants in providing detail personalized health information and clear explanations during each healthcare visits. Their repeated contact with patients may also build trust and make their encouragement and advice more powerful in promoting preventive behaviors. This finding is consistent with the previous studies where women receiving health information and encouragement from health personnel were more likely to undergo cervical cancer screening (Chua et al., 2021; Nandar et al., 2015; Yin Wint, 2019). Similarly, a study conducted in Mandalay showed significant association between cervical cancer screening and information received from doctors, as well as interpersonal sources such as husbands and friends (Nyi, 2020). Active participation of male partners and peers may facilitate screening uptake by providing both financial and emotional support in making health-related decision. Unlike this study, two Mandalay studies also identified mass media such as posters, magazines, newspapers, television,

radio and internets as significant source of information (Han & Yamarat, 2017; Nyi, 2020). The difference influence of information sources across studies may reflects their individual experiences with healthcare delivery systems, local sociocultural contexts and literacy levels. This suggests the importance of incorporating family- and community-based approaches together with provider-based education to improve cervical cancer prevention strategies.

Attitude is an important factor shaping the translation of intention into cervical cancer screening practices. In this study, women who had positive attitude towards cervical cancer and screening were more likely to uptake screening than those who had negative attitude. This may be explained by the influence of individual beliefs and perceptions on health-related decision-making, since favorable attitudes can enhance perceived benefits and increase motivation to engage in preventive behavior. This finding is supported by previous evidence from different settings, such as Southeast Asia highlighting negative attitudes, such as embarrassment and discomfort, as important barriers to screening uptake. Similarly, evidence among migrant populations in Europe has shown that attitudinal barriers, including low perceived need for screening and lack of motivation, contribute to non-attendance. Although these findings are derived from different study populations and contexts, they consistently demonstrate the significant role of attitude in influencing screening behavior. However, attitude alone may not be sufficient to translate into actual screening practice. The conversion of positive attitude into preventive behavior is likely influenced by other important factors, such as knowledge, accessibility of services and support from healthcare providers (Marques et al., 2021, 2023; Rosato et al., 2023). Therefore, while improving attitude is essential, it should be addressed alongside strategies that enhance awareness and reduce structural barriers to effectively increase cervical cancer screening uptake and recruit migrant women to participate in targeted screening programs.

5.2 Conclusions

This study assessed the notably low prevalence of cervical cancer screening among Myanmar migrant women in Chiang Rai Province, Thailand and identified factors associated with cervical cancer screening uptake such as health insurance status, length of stay in Thailand, contraceptive use, received information from nurse or health assistant and attitude, by using Knowledge-Attitude-Practice model.

The findings from this study provide important evidence including the facilitators and barriers influencing cervical cancer screening among Myanmar migrant women which can inform stakeholders and policymakers to develop targeted intervention to enhance screening uptake and promote the health equity among this vulnerable populations by reducing disparities and promoting preventive healthcare. Enhancing accessibility and utilization of preventive services among this marginalized group not only benefits their health outcomes but may also reduce the long-term healthcare burden of the host country by reducing the morbidity rate of cervical cancer through timely preventive practices.

5.3 Strengths and Limitations

This study fills a gap in the existing literature on cervical cancer screening practices among Myanmar migrant women in Chiang Rai Province, Thailand, which often has been neglected and less reviewed in public health research. This study showed the cervical cancer screening rate among Myanmar migrant women and defined key factors associated with cervical cancer screening uptake. In addition, it offers insight into the reasons underlying both uptake and non-uptake of cervical cancer screening, contributing context-specific evidence that is relevant for designing culturally appropriate and accessible health interventions and policies to promote health equity and improve preventive healthcare practices among migrant women.

However, there are some limitations in this study. Firstly, since cross-sectional study was conducted to measure all variables at the same time, causal relationship between the dependent and independent variables cannot be established. Longitudinal

studies are needed to establish temporal relationships and examine the translation from hesitation, intention to actual screening behavior. Secondly, all variables were assessed by self-reported responses, which may have recall bias or social desirability bias, with possible underreporting of cervical cancer screening practices. Objective measures of screening uptake, such as medical records or registry data, would strengthen the evidence base. Thirdly, the findings may not be generalizable to all Myanmar migrant women in other regions of Thailand or other countries, as healthcare access, sociocultural contexts, and legal conditions may vary across various settings. Therefore, the results should be interpreted within the specific context of the study population. More research is needed from the other regions to understand how cultural and healthcare system contexts shape screening behavior.

5.4 Recommendations

This study showed the lower screening rate of cervical cancer among Myanmar migrant women living in Chiang Rai Province, Thailand by identifying the factors associated with cervical cancer screening uptake, including health insurance, length of stay in Thailand, contraceptive use, received information from nurse or assistant, and attitude. By understanding the associated factors, following recommendations are proposed to design effective intervention to reduce morbidity and mortality rate due to cervical cancer among Myanmar migrant women by increasing the preventive practices including cervical cancer screening.

5.4.1 Recommendation to policymakers

National cervical cancer screening program in Thailand should include migrant women to ensure equitable access to preventive services regardless of legal or insurance status. Moreover, health insurance should be accessible and affordable for all migrants to reduce financial barriers to healthcare access including preventive services. For example, health insurance should be extended to cover not only the individual but also the family members for the comprehensive healthcare access.

5.4.2 Recommendation to Healthcare Providers

Outreach screening program should be organized and implemented in migrant communities including migrant center, their workplaces and dormitories to improve accessibility including the ones who arrived recently. In addition, health education intervention programs should be implemented to enhance awareness and promote routine cervical cancer screening practices. Healthcare personnel especially nurses who have frequent contact with migrant women during healthcare visit should provide culturally appropriate health education and encouragement for regular screening practice. Furthermore, cervical cancer screening should be integrated with reproductive health services such as family planning and contraceptive care, to maximize opportunities for preventive care.

5.4.3 Recommendation to Public Health Practitioners

Even though most of the migrant women had good attitudes towards cervical cancer and cervical cancer screening, limited knowledge hindered them from seeking actual preventive practices. Health education and promotion programs should be organized in the area such as migrant center, workplaces and dormitories where most of the migrant existed by using culturally sensitive materials to address social stigma and barriers to screening for the efficacy of the education program. Health education initiatives should actively involve partners and family members to enhance social support during decision-making.

5.4.4 Recommendation for further study

Based on the findings and limitations of this review, several priorities for future research emerge:

Longitudinal studies are recommended to follow women over time to examine the temporal relationships between determinants and screening uptake, and to assess the translation from hesitation, intention to actual screening behavior. These studies should identify factors that facilitate or impede the intention-behavior gap.

Qualitative studies are recommended to deeply understand the women’s perceptions, lived experiences, decision-making processes, willingness including the barriers that hinder them from cervical cancer screening that cannot be fully captured in the quantitative study. Such evidence would complete the current quantitative findings and support the development of culturally appropriate public health interventions.

Implementation science studies are recommended to understand how evidence-based screening interventions can be effectively scaled up and sustained in real-world healthcare settings. Research should examine barriers and facilitators to implementation, adaptation processes, and strategies for ensuring fidelity and reach.

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APPENDIX A

ETHICAL APPROVAL CERTIFICATE (THAI VERSION)

The Mae Fah Luang University Ethics Committee on Human Research
333 Moo 1, Thasud, Muang, ChiangRai 57100
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หนังสือรับรองด้านจริยธรรมการวิจัย

COA: 165/2025 **รหัสโครงการวิจัย: EC 25144-18**

ชื่อโครงการวิจัย: การตรวจคัดกรองมะเร็งปากมดลูกและปัจจัยที่เกี่ยวข้องในสตรีอพยพชาวพม่าในจังหวัดเชียงราย ประเทศไทย

ชื่อผู้วิจัยหลัก: Novelinn Naw Kyawt Thu

สำนักวิชา: วิทยาศาสตร์สุขภาพ

ผู้สนับสนุนการวิจัย: มหาวิทยาลัยแม่ฟ้าหลวง

การรับรอง :

(1) โครงการวิจัย ฉบับที่ 1 วันที่ 4 มิถุนายน 2568
(2) เอกสารข้อมูลและขอความยินยอมเข้าร่วมการวิจัย ฉบับที่ 2 วันที่ 18 สิงหาคม 2568
(3) แบบสอบถาม และคู่มือการสัมภาษณ์ ฉบับที่ 1 วันที่ 4 มิถุนายน 2568
(4) แบบโฆษณาประชาสัมพันธ์ ฉบับที่ 1 วันที่ 4 มิถุนายน 2568
(5) ผู้วิจัย และผู้วิจัยร่วม
- Asst. Prof. Dr. Pilasinee Wongnuch
- Asst. Prof. Dr. Peeradone Srichan

ขอรับรองว่าโครงการดังกล่าวข้างต้นได้ผ่านการพิจารณารับรองจากคณะกรรมการจริยธรรมการวิจัยในมนุษย์ มหาวิทยาลัยแม่ฟ้าหลวง ว่าสอดคล้องกับแนวทางจริยธรรมสากล ได้แก่ ปฏิญญาเฮลซิงกิ (Declaration of Helsinki) รายงานเบลมองต์ (Belmont Report) แนวทางจริยธรรมสากลสำหรับการวิจัยในมนุษย์ของสภาองค์การสากลด้านวิทยาศาสตร์การแพทย์ (CIOMS) และแนวทางการปฏิบัติการวิจัยที่ดี (ICH-GCP)

วันที่รับรองด้านจริยธรรมของโครงการวิจัย: 27 สิงหาคม 2568
วันสิ้นสุดการรับรอง: 26 สิงหาคม 2569
ความถี่ของการส่งรายงานความก้าวหน้าของการวิจัย: 1 ปี

ลงนาม .....

(อาจารย์ นพ.จุลพงศ์ อจลพงศ์)
ประธานคณะกรรมการจริยธรรมการวิจัยในมนุษย์ มหาวิทยาลัยแม่ฟ้าหลวง

The Mae Fah Luang University Ethics Committee on Human Research
333 Moo 1, Thasud, Muang, ChiangRai 57100
Tel: (053) 917-170 to 71 Fax: (053) 917-170 E-mail: rec.human@mfu.ac.th

ผู้วิจัยที่โครงการวิจัยผ่านการรับรองจากคณะกรรมการจริยธรรมการวิจัยในมนุษย์ มหาวิทยาลัยแม่ฟ้าหลวง ต้องปฏิบัติดังต่อไปนี้

(1) ดำเนินการวิจัยตามที่ระบุในโครงการวิจัยอย่างเคร่งครัด

(2) ใช้เอกสารข้อมูลและขอความยินยอมเข้าร่วมการวิจัย / แบบสอบถาม / แบบบันทึกข้อมูล / เอกสารประชาสัมพันธ์ ที่มีตราประทับของคณะกรรมการจริยธรรมการวิจัยในมนุษย์ มหาวิทยาลัยแม่ฟ้าหลวง เท่านั้น

(3) ผู้วิจัยต้องส่งรายงานความก้าวหน้าของการวิจัย (AP 05/2024) ตามระยะเวลาที่คณะกรรมการฯ กำหนด และ ภายใน 30 วัน ก่อนหมดอายุการรับรอง ในกรณีที่การวิจัยยังไม่เสร็จสิ้น ผู้วิจัยต้องส่งจดหมายขอต่ออายุการรับรอง

(4) เมื่อมีการแก้ไขเพิ่มเติมโครงการวิจัย ผู้วิจัยต้องส่งรายงานส่วนแก้ไขเพิ่มเติมโครงการวิจัย (AP 06/2024) และโครงการวิจัยที่มีการแก้ไขเพิ่มเติม เพื่อแจ้งให้คณะกรรมการฯ พิจารณารับรองก่อนดำเนินการตามที่ได้แก้ไขเพิ่มเติม (ยกเว้นในกรณีที่การแก้ไขเพิ่มเติมนั้นกระทำเพื่อความปลอดภัยของอาสาสมัคร)

(5) เมื่อมีเหตุการณ์ไม่พึงประสงค์ชนิดร้ายแรง "ในสถาบัน" ผู้วิจัยต้องส่งรายงานเหตุการณ์ไม่พึงประสงค์ชนิดร้ายแรง (AP 07/2024) ตามข้อกำหนดของ ICH-GCP

(6) เมื่อมีการเบี่ยงเบนหรือไม่ปฏิบัติตามโครงการวิจัยที่ได้รับการรับรอง ผู้วิจัยต้องส่งรายงานการการเบี่ยงเบนหรือไม่ปฏิบัติตามข้อกำหนด (AP 08/2024)

(7) เมื่อการวิจัยเสร็จสิ้น หรือ มีการยุติโครงการวิจัยก่อนกำหนดเวลาที่กำหนด ผู้วิจัยต้องส่งรายงานปิดโครงการวิจัย (AP 09/2024)

หมายเหตุ สามารถ Download แบบรายงานต่าง ๆ ได้ที่ https://ethic.mfu.ac.th

ข้าพเจ้าในฐานะ ผู้วิจัย ยินยอมที่จะปฏิบัติตามข้อกำหนดดังกล่าว

.....

(Novelinn Naw Kyawt Thu)

วันที่ 3 ก.ย. 2568

APPENDIX B

ETHICAL APPROVAL CERTIFICATE (ENGLISH VERSION)

The Mae Fah Luang University Ethics Committee on Human Research
333 Moo 1, Thasud, Muang, ChiangRai 57100
Tel: (053) 917-170 to 71 Fax: (053) 917-170 E-mail: rec.human@mfu.ac.th

CERTIFICAE OF APPROVAL

COA: 165/2025 Protocol No: EC 25144-18

Title Cervical cancer screening uptake and associated factors among Myanmar migrant women in Chiang Rai province, Thailand

Principal investigator: Novelinn Naw Kyawt Thu

School: Health Science

Funding support: Mae Fah Luang University

Approval:

1) Research protocol — Version 1 Date June 4, 2025
2) Information sheet and informed consent documents — Version 2 Date August 18, 2025
3) Assessment form and interview guide — Version 1 Date June 4, 2025
4) Advertising information sheet — Version 1 Date June 4, 2025
5) Principal investigator and Co-investigators
   - Asst. Prof. Dr. Pilasinee Wongnuch
   - Asst. Prof. Dr. Peeradone Srichan

The aforementioned documents have been reviewed and approved by the Mae Fah Luang University Ethics Committee on Human Research in compliance with international guidelines such as Declaration of Helsinki, the Belmont Report, CIOMS Guidelines and the International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use - Good Clinical Practice (ICH - GCP)

Date of Approval: August 27, 2025
Date of Expiration: August 26, 2026
Frequency of Continuing Review: 1 year

.....
(Jullapong Achalapong, M.D.)
Chairperson of the Mae Fah Luang Ethics Committee on Human Research

The Mae Fah Luang University Ethics Committee on Human Research
333 Moo 1, Thasud, Muang, ChiangRai 57100
Tel: (053) 917-170 to 71 Fax: (053) 917-170 E-mail: rec.human@mfu.ac.th

For research protocol approved by the Mae Fah Luang University Ethics Committee on Human Research (MFU EC), the investigators must comply with the followings:

1. Strictly conduct the research as required by the protocol.
2. Use only the information sheet, consent form, questionnaire, case record form and advertisement bearing the MFU EC stamp of approval.
3. Submit a progress report (AP 05/2024) for continuing review and for renewing the approval within 30 days before expiration date.
4. When there are changes of the protocol, the investigator must submit an amendment report (AP 06/2024) with amended protocol for MFU EC approval before implementing any changes in the research (unless those changes are required urgently for the safety of the research subjects).
5. When there is any unanticipated problem or serious adverse event, the investigator must submit a safety report (AP 07/2024) as set forth in the ICH-GCP.
6. When there is any deviation or non-compliance with the approved protocol, the investigator must submit a protocol deviation/non-compliance report (AP 08/2024).
7. When the research is complete or terminated, the investigator must submit a closing report (AP 09/2024).

Please go to https://ethic.mfu.ac.th to download MFU EC forms for reporting.

I, as an investigator, agree to comply with the above obligation.

.....

(Novelinn Naw Kyawt Thu)

Date 3. 9. 2024

APPENDIX C

INFORMATION SHEET AND INFORMED CONSENT FORM (ENGLISH VERSION)

Version 2 Date 18/8/2025 AP 03_1/2024

Information Sheet and Informed Consent

Research Project Title: CERVICAL CANCER SCREENING UPTAKE AND ASSOCIATED FACTORS AMONG MYANMAR MIGRANT WOMEN IN CHIANG RAI PROVINCE, THAILAND
Principal investigator: Miss Novelinn Naw Kyawt Thu
Affiliation: School of Health Science, Mae Fah Luang University
Advisor: Asst. Prof. Dr. Pilasinee Wongnuch
Source of Research Funding/Sponsor: Mae Fah Luang University

1. Introduction and Project Summary

My name is Novelinn Naw Kyawt Thu. I am a master's student studying Master of Public Health specialized in border health management program at Mae Fah Luang University, Thailand. I am conducting research on cervical cancer screening uptake and associated factors among Myanmar migrant women in Chaing Rai Province, Thailand. This study aims to estimate the percentage of cervical cancer screening uptake and its associated factors among Myanmar migrant women. I invite you to participate in this study and would like to provide you with more information.

Your participation in this study is entirely voluntary. If you don't want to participate in this study, it will not affect your access to any rights. Even during the participation, you can withdraw at any time if you want to without any negative consequences. Please feel free to ask any questions or seek clarification regarding this study. I am here to assist you at any time.

The tentative duration of the study for each participant is approximately 20-30 minutes. During the data collection, participants will independently complete the structured questionnaire. For the participants who are not able to read and write, face-to-face interview will be carried out by the principal investigator. All the survey will be carried out by principal investigator.

The questionnaire will cover topics such as your background, healthcare access, knowledge and attitude towards cervical cancer and screening, social support and screening practices. Data collection will be done in Myanmar language in a private and confidential setting to ensure comfort and privacy. All the information from this research will remain confidential and will only be used for academic and public health purposes.

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2 7 AUG 2025
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There are no medical or physical risks associated with participation, but you may feel uncomfortable for some personal questions related to legal status and their married life. Data collection will be conducted in a private and safe location so that you can feel safe and comfortable to answer. Since participation is entirely voluntary, if you feel uncomfortable at any point during the process, you are free to stop answering at the time, skip the questions, or withdraw from the study entirely without any negative consequences.

If you don't want to participate in this study, your decision is respected, and it won't affect your access to healthcare and any other rights. Your participation in this study is entirely voluntary and you have right to refuse to participate or to stop participation at any time without needing to give a reason and without any consequences. If you have any questions about the research at any time, you are welcome to contact the researcher. We will make sure your rights, safety, and dignity are protected throughout this study.

2. A statement indicating that this is a research project and that the participation in this research is voluntary

You are invited to participate in this research. Please take time to read this document as it provides information about your involvement in the research. The decision to participate is entirely voluntary. If you choose not to participate, your healthcare and rights you are entitled to will not be changed.

Your participation in this research is based on your voluntary decision.

- You have the freedom to decide whether to participate in this research or not.
- You can consult with your family or your physician before making decision. You may also ask any questions; the researcher will provide explanations and answers until you have a clear understanding.
- After deciding to participate in this research, you still have the right to withdraw at any time.

3. Rationale and Significance of the Research

Cervical cancer is the cancer in any part of the cervix. It is mainly caused by the long-term infection with Human Papilloma Virus (HPV) which is sexually transmitted virus. Cervical cancer is one the most common cancer among women and it has negative impacts on both patients and their families by severe symptoms, emotional breakdown, and financial burden etc.

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ETHICS COMMITTEE ON HUMAN RESEARCH
27 AUG 2025
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Cervical cancer is a preventable disease, but it remains one of the leading causes of cancer-related death among women, particularly in underserved populations such as migrants. Regular screening is essential for early detection and prevention. However, many migrant women in Thailand face multiple challenges in accessing healthcare, increasing their vulnerability to preventable diseases like cervical cancer.

This study aims to explore the factors associated with cervical cancer screening, including their knowledge and attitude among Myanmar migrant women in Chiang Rai Province. The findings from the study will provide public health information and evidence-based insights to improve the preventive behaviors of cervical cancer among migrant women. Ultimately, the study will help inform policymakers, healthcare providers and stakeholders in developing targeted and culturally appropriate interventions that promote equity and inclusivity in cervical cancer screening services for migrant women.

4. Qualifications and Number of Participants

Myanmar migrant women of aged 30-60 years, regardless of their legal status who have resided in Chiang Rai Province for at least 6 months, who are willing to participate in this study will be selected. A total of 260 participants will be included.

5. Research Objectives

The objectives of this research are to estimate the percentage of cervical cancer screening uptake and to identify its associated factors among Myanmar migrant women in Chiang Rai Province, Thailand.

6. Research Design

Survey research using questionnaires and face-to-face interviews is conducted to estimate the percentage of cervical cancer screening uptake among Myanmar migrant women in Chiang Rai Province, Thailand together with identifying its associated factors.

7. Research Procedure and Duration of Participation

I invite all Myanmar migrant women aged 30-60 years who have resided in Chiang Rai Province, Thailand to participate in this study. The researcher will explain the study purpose, procedures, and your rights as a participant. If you agree to take part, you will be asked to complete a self-administered structured questionnaire. If you have difficulty in reading and writing, face-to-face interview will be conducted by the researcher. In the questionnaire, you will be asked questions related to your background, socio-economic status, healthcare

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27 AUG 2025
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access, knowledge and attitude towards cervical cancer and screening, and cervical cancer screening experience. The interview will take approximately 20 to 30 minutes to complete and will be conducted in a private setting to ensure your comfort and confidentiality. Your participation will be completed in a single visit, with no follow-up interviews. If necessary, the researcher may contact you once within one week to clarify any responses you provided. Your participation is entirely voluntary. You may choose not to answer any question or withdraw from the study at any time without any negative consequences. Please be assured that all the information you share will be kept strictly confidential and will not be revealed to anyone.

8. Potential Risks and Discomfort from Participating in the Research

Even though no physical harm is anticipated, you may experience emotional discomfort for personal questions like your legal status and married life. These questions are necessary to achieve the study objectives but may cause embarrassment or unease for you. To minimize the risk, data collection will be conducted in a private and safe location, ensuring a comfortable environment where you may feel secure, and your confidentiality is respected. Participation is entirely voluntary, and you can withdraw from the study at any time without any negative consequences. If you experience emotional discomfort, the researcher will offer appropriate support and, if needed, will refer to appropriate health services and counselors. Even though all possible problems are considered, some unexpected issues may still arise. All research ethics will be strictly followed to keep participants safe and respected during the study.

9. Potential Benefits of Participating in the Research

By participating in this study, you will not receive direct benefits. However, your participation may help raise awareness about cervical cancer and the importance of getting regular screenings to help prevent it. It may also encourage you to think about your own health and seek preventive care when needed.

After the interview, you will receive a brochure that provides clear information about cervical cancer, how to prevent it, the importance of screening, and contact details of nearby healthcare centers where you can get screened.

The information collected from this study will help public health authorities, NGOs, and policymakers to better understand the challenges faced by migrant women. This can help

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27 AUG 2025
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improve more inclusive and culturally appropriate health programs and healthcare services by ulitmately reducing health inequalities among migrant communities.

10. Alternatives if Choosing NOT to Participate

If you choose not to participate in this study, it will not impact on the healthcare services you are entitled to. You can still access to cervical cancer screening and other healthcare services through existing public health facilities and community-based health programs. Participation in this study is entirely voluntary, and choosing not to participate will not affect the quality of care or services you receive.

11. Guidelines for Managing Situations that May Arise during the Research

Situations	Guidelines
■ If you decide to withdraw during the research	If you want to discontinue your participation, you can inform the researcher at any stage and with any reason. Your decision will not affect your healthcare access and any other rights.
■ If there is new information regarding the research or your safety	Should any new information arise, that may affect your willingness to continue, the researcher will inform you as soon as possible. You will then have opportunity to decide whether to continue or withdraw from the study.
■ The criteria for ending participation may include completion of all procedures in the research protocol, the study reaches its target sample size or time limit.	If any of these criteria occurred, the researcher will inform the participants promptly and respectfully. The data will be handled confidentially and in accordance with ethical standards.

12. Potential Benefits after the Completion of the Research

After the completion of the research, there may not be direct potential benefits for the participants. The researcher will notify you of the results once the research has been completed.

13. Confidentiality of Data and Limitations

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All information provided by the participants will be treated with confidentiality through the entire research process from the recruitment to the publication. Participants will be fully informed about the study's objectives, their rights and the voluntary nature of participation before giving written informed consent. To ensure confidentiality, all participants will be assigned a unique identification code. Personal identifiers such as name, addresses and identification number will not be collected to prevent direct linkage to the responses. Data collection will made ensure to conduct in private and with respect to participants' comfort and privacy.

All physical data such as written consent form and collected data will be separately and securely stored in a locked cabinet to prevent any accidental disclosure. Digital data will be stored on encrypted, password-protected computers. All the data will only be accessible by the principal investigator. During analysis and dissemination, only de-identified, aggregated data will be used. For any reports, presentations or publications we must made, no personal information will de described. After all the data interpretation and publications, all the data will be destroyed appropriately with the ethical standard.

However, certain individuals or groups such as the ethics committee, research coordinators, research supervisors, and authorized personnel from government institutions or organizations responsible for auditing may be allowed access to identifiable data to verify the accuracy of the information and the integrity of the research procedures. These individuals are also bound to confidentiality and will use the information solely for oversight purposes. The researcher is fully committed to protecting the privacy, dignity, and rights of all participants throughout every stage of the study.

14. Reimbursement for Participation

After the data collection, participants will receive brochure that contains information of cervical cancer such as it causes, symptoms, risk factors and prevention especially benefit of cervical cancer screening. It will also include the information of healthcare services that they can take for cervical cancer screening and other kind of health issues, all aimed to improve their awareness to cervical cancer and their preventive behaviors.

15. Expenses that the participants must bear

Participants must not bear any expenses to participate in this study.

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
2 7 AUG 2025
APPROVED

16. Care and Compensation Guidelines if the participants experience harm or adverse effects from participating in the research

If any harm or adverse effects occurs during participation in the study, the researcher will provide appropriate support and care. Participants may experience emotional discomfort due to sensitive questions related to personal matters such as their legal status or marital life. If they feel distress, participants will be referred to qualified medical professionals or counselors for appropriate care and support. They will also be clearly informed that their participation is entirely voluntary, and participants can withdraw from the study at any time without any negative consequences. All possible risks will be minimized through careful planning and ethical procedures, and participants will have access to safety and support services throughout the research process. If any adverse events or harm do occur, the researcher will take full responsibility for all related medical expenses, including treatment and rehabilitation.

17. Contact Person in Case of Questions or Concerns

If you have any questions or concerns regarding the research or safety during participation, you can ask the researcher directly

Principal investigator
Name: Novelinn Naw Kyawt Thu
Mobile: 0637507368
Email: 6751804011@lamduan.mfu.ac.th

Advisor
Name: Asst. Prof. Dr. Pilasinee Wongnuch
Mobile: 053916921
Email: pilasinee.won@mfu.ac.th

If you have questions regarding your rights, you can contact the Mae Fah Luang University Ethics Committee on Human Research at the Academic Service building (AS), 4th floor, tel. (053) 917-170 to 1 or (053) 916-551, fax. (053) 917-170, or e-mail: rec.human@mfu.ac.th to ensure that your rights, your safety, and your well-being are protected under the international standards of human-research ethics.

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
27 AUG 2025
APPROVED

Informed Consent Form

I, _____, have decided to participate in the research project titiled "CERVICAL CANCER SCREENING UPTAKE AND ASSOCIATED FACTORS AMONG MYANMAR MIGRANT WOMEN IN CHIANG RAI, PROVINCE". I have received information and explanations about this research, and I have had the opportunity to ask questions and receive satisfactory answers. I have had sufficient time to read and understand the information provided in the documents thoroughly and have decided to participate in this research.

I understand that I have the freedom to choose not to participate in this research, and I can withdraw from this research at any time without any impact on my care or rights that I am entitled to.

By signing this document, I do not waive any rights that I am entitled to under the law, and after signing, I will receive a copy of the information sheet and the informed consent.

Participant's Signature _____ Date _____
(_____)

..... (For illiterate participants who can understand though listening) .....

I cannot read, but the researcher has read this information sheet and informed consent form to me, and I understand it well. Therefore, I voluntarily sign or place my fingerprint.

Participant's signature/fingerprint _____ Date _____
(_____)

Signature of the person requesting consent _____ Date _____
(_____)

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
27 AUG 2025
APPROVED

APPENDIX D

INFORAMATION SHEET AND INFORMED CONSENT FORM (MYANMAR VERSION)

Version 2 Date 18/8/2025 AP 03_1/2024

သုတေသနအချက်အလက်နှင့် သဘောတူညီမှု

သုတေသနခေါင်းစဉ်: ထိုင်းနိုင်ငံ၊ ချင်းလိုင်းပြည်နယ်ရှိ မြန်မာရွှေ့ပြောင်း အမျိုးသမီးများအကြား သားအိမ်ခေါင်းကင်ဆာ စစ်ဆေးမှုခံယူခြင်းနှင့် ဆက်စပ်သော အကြောင်းအရာများ
အဓိက စုံစမ်းစစ်ဆေးသူ: မနီဗယ်လင်းနော်ကျော့သူ
တက္ကသိုလ်ဌာနအဖွဲ့အစည်း: မယ်ဖာလုံတက္ကသိုလ်
သုတေသနအကြံပေးပုဂ္ဂိုလ်: လက်ထောက်ပါမောက္ခ ဒေါက်တာ Pilasinee Wongnuch
သုတေသနပံ့ပိုးကူညီမှုအရင်းအမြစ်: မယ်ဖာလုံတက္ကသိုလ်

၁။ နိဒါန်းနှင့် သုတေသနအကျဉ်းချုပ်

ကျွန်ုပ်၏နာမည်မှာ နီဗယ်လင်းနော်ကျော့သူဖြစ်ပါသည်။ ထိုင်းနိုင်ငံ၊ မယ်ဖာလုံတက္ကသိုလ်တွင် ပြည်သူ့ကျန်းမာရေးဘာသာရပ်ကို သင်ကြားနေသော မဟာတန်းကျောင်းသူတစ်ဦးဖြစ်ပါသည်။ ကျွန်ုပ်သည် ထိုင်းနိုင်ငံ၊ ချင်းလိုင်းပြည်နယ်ရှိ မြန်မာရွှေ့ပြောင်း အမျိုးသမီးများအကြား သားအိမ်ခေါင်းကင်ဆာ စစ်ဆေးမှုခံယူခြင်းနှင့် ဆက်စပ်နေသော အချက်များနှင့် ပတ်သက်၍ သုတေသန ပြုလုပ်နေပါသည်။ ဤသုတေသနသည် မြန်မာရွှေ့ပြောင်း အမျိုးသမီးများအကြား သားအိမ်ခေါင်းကင်ဆာ စစ်ဆေးမှု ရာခိုင်နှုန်းနှင့် ၄င်းနှင့် ဆက်စပ်သော အချက်များကို ပိုမိုသိရှိနားလည်ရန် ရည်ရွယ်ပါသည်။ ဤလေ့လာမှုတွင် ပါဝင်ရန် သင့်အား ဖိတ်ခေါ်ပြီး နောက်ထပ် အချက်အလက်များကို ပေးလိုပါသည်။

ဤလေ့လာမှုတွင် သင်၏ပါဝင်မှုသည် လုံးဝဆန္ဒအလျောက်ဖြစ်သည်။ ဤလေ့လာမှုတွင် သင်မပါဝင်လိုပါက၊ ၎င်းသည် သင်၏အခွင့်အရေးများရရှိခွင့်ကို ထိခိုက်စေမည်မဟုတ်ပါ။ ပါဝင်ဆောင်ရွက်နေစဉ်အတွင်း ပါဝင်မှုကို ရုတ်သိမ်းလိုပါက အပျက်သဘောဆောင်သော အကျိုးဆက်များမရှိပဲ အချိန်မရွေး ရုတ်သိမ်း နိုင်ပါသည်။ ဤလေ့လာမှုနှင့် ပတ်သက်၍ မေးခွန်းများ (သို့) မရှင်းလင်းသည်များ ရှိပါက ကျွန်ုပ်အား

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
27 AUG 2025
APPROVED

မေးမြန်းနိုင်ပါသည်။ မည်သည့်အချိန်တွင်မဆို ကျွန်ုပ်သည် သင့်အား ကူညီရန် အဆင်သင့်ရှိနေပါသည်။

ဤလေ့လာမှုတွင် ပါဝင်သူတစ်ယောက်စီတိုင်းအတွက် ကြာချိန်မှာ ခန့်မှန်းခြေ ၂၀-၃၀မိနစ်ဖြစ်သည်။ ဒေတာစုဆောင်းစဉ်အတွင်း ပါဝင်သူများသည် ဖွဲ့စည်းထားသော မေးခွန်းလွှာကို လွတ်လပ်စွာ ဖြည့်သွင်းရမည်ဖြစ်သည်။ စာရေးဖတ်ရာတွင် အခက်အခဲရှိသူများအတွက် အဓိက စုံစမ်းစစ်ဆေးသူမှ မျက်နှင်ချင်းဆိုင် အင်တာဗျူးလုပ်မည်ဖြစ်သည်။ စစ်တမ်းအားလုံးကို အဓိက စုံစမ်းစစ်ဆေးသူမှ ဆောင်ရွက်သွားမည်ဖြစ်သည်။

မေးခွန်းလွှာတွင် သင်၏နောက်ခံ၊ ကျန်းမာရေးစောင့်ရှောက်မှု ရရှိမှု၊ သားအိမ်ခေါင်းကင်ဆာနှင့် စစ်ဆေးခြင်းဆိုင်ရာ အသိပညာနှင့် သဘောထား၊ လူမှုရေးဆိုင်ရာ ပံ့ပိုးကူညီမှုနှင့် စစ်ဆေးမှု အလေ့အကျင့်များကဲ့သို့သော အကြောင်းအရာများ ပါဝင်သည်။ သက်သောင့်သက်သာနှင့် ကိုယ်ရေးကိုယ်တာ လုံခြုံမှုရှိစေရန် ဒေတာစုဆောင်းချင်းကို သီးသန့်နှင့် လျှို့ဝှက်သော နေရာတွင် မြန်မာဘာသာစကားဖြင့် လုပ်ဆောင်မည်ဖြစ်သည်။ ဤသုတေသနမှ အချက်အလက်အားလုံးကို လျှို့ဝှက်ထားမည်ဖြစ်ပြီး ပညာရေးနှင့် ပြည်သူ့ကျန်းမာရေးအတွက်သာ အသုံးပြုမည်ဖြစ်သည်။

ပါဝင်ခြင်းနှင့်ဆက်စပ်သော ဆေးဘက်ဆိုင်ရာ (သို့မဟုတ်) ရုပ်ပိုင်းဆိုင်ရာ အန္တရာယ်များမရှိသော်လည်း တရားဝင်အခြေအနေနှင့် ၎င်းတို့၏ အိမ်ထောင်ရေးဘဝနှင့် သက်ဆိုင်သည့် ကိုယ်ရေးကိုယ်တာမေးခွန်းအချို့အတွက် အဆင်မပြေဖြစ်နိုင်သည်။ ဒေတာစုဆောင်းခြင်းကို လုံခြုံပြီး သက်တောင့်သက်သာရှိစေမည့် သီးသန့်နေရာတစ်ခုတွင် ကောက်ယူမည်ဖြစ်သည်။ ပါဝင်ခြင်းမှာ လုံးဝဆန္ဒအလျောက် ဖြစ်သောကြောင့်၊ လုပ်ငန်းစဉ်အတွင်း မည်သည့် အချက်တွင်မဆို အဆင်မပြေမှုခံစားရပါက ထိုအချိန်တွင် ဖြေဆိုခြင်းကိုရပ်ခြင်း၊ မေးခွန်းများကိုကျော်သွားခြင်း သို့မဟုတ် လေ့လာမှုမှ လုံးဝနုတ်ထွက်နိုင်သည်။

ဤလေ့လာမှုတွင် မပါဝင်လိုပါက၊ သင်၏ဆုံးဖြတ်ချက်ကို လေးစားပြီး သင်၏ကျန်းမာရေးစောင့်ရှောက်မှုနှင့် အခြားအခွင့်အရေးများကို ထိခိုက်စေမည်မဟုတ်ပါ။ ဤလေ့လာမှုတွင် သင်၏ပါဝင်မှုသည် လုံးဝဆန္ဒအလျောက်ဖြစ်ပြီး သင်သည်

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
2 7 AUG 2025
APPROVED

အကြောင်းပြချက်ပေးစရာမလိုဘဲ အကျိုးဆက်များမရှိဘဲ ပါဝင်မှုကို ငြင်းဆိုရန် သို့မဟုတ် ရပ်တန့်ရန် အခွင့်အရေးရှိသည်။ သင့်တွင် သုတေသနနှင့်ပတ်သက်သည့် မေးခွန်းများရှိပါက အချိန်မရွေး၊ သုတေသီထံ ဆက်သွယ်ရန် ကြိုဆိုပါသည်။ ဤလေ့လာမှုတစ်လျှောက်တွင် သင်၏အခွင့်အရေး၊ ဘေးကင်းရေးနှင့် ဂုဏ်သိက္ခာကို ကာကွယ်ထားကြောင်း သေချာစေပါမည်။

၂။ ဤသည်မှာ သုတေသနပရောဂျက်တစ်ခုဖြစ်ပြီး ဤသုတေသနတွင် ပါဝင်မှုသည် ဆန္ဒအလျောက်ဖြစ်ကြောင်း သွန်ပြသောထုတ်ပြန်ချက်

ဤသုတေသနတွင် ပါဝင်ရန် သင့်အား ဖိတ်ကြားအပ်ပါသည်။ သုတေသနတွင် သင်၏ပါဝင်မှုနှင့် ပတ်သက်သော အချက်အလက်များပါဝင်သည့် ဤစာတမ်းကို အချိန်ယူဖတ်ပါ။ ပါဝင်ရန် ဆုံးဖြတ်ခြင်းသည် လုံးဝဆန္ဒအလျောက် ဖြစ်သည်။ မပါဝင်ရန် ရွေးချယ်ပါက သင်၏ကျန်းမာရေးစောင့်ရှောက်မှုနှင့် သင်ရနိုင်သော အခွင့်အရေးများကို ပြောင်းလဲမည်မဟုတ်ပါ။ ဤသုတေသနတွင် သင်၏ပါဝင်မှုသည် သင်၏ဆန္ဒအလျောက် ဆုံးဖြတ်ချက်အပေါ် အခြေခံပါသည်။ ဤသုတေသနတွင် ပါဝင်ခြင်း ရှိ၊ မရှိ ဆုံးဖြတ်ရန် သင့်တွင် လွတ်လပ်စွာ ဆုံးဖြတ်ပိုင်ခွင့်ရှိသည်။ ဆုံးဖြတ်ချက်မချမီ သင့်မိသားစု သို့မဟုတ် သင့်ဆရာဝန်နှင့် တိုင်ပင်ဆွေးနွေးနိုင်ပါသည်။ သင်သည် မည်သည့်မေးခွန်းများကိုမဆို မေးနိုင်သည်၊ သုတေသီသည် သင့်အား ရှင်းလင်းစွာ နားလည်သည်အထိ ရှင်းလင်းချက်များနှင့် အဖြေများကို ပေးပါလိမ့်မည်။ ဤသုတေသနတွင် ပါဝင်ရန် ဆုံးဖြတ်ပြီးနောက်၊ သင်သည် အချိန်မရွေး ရပ်သိမ်းပိုင်ခွင့်ရှိသည်။

၃။ သုတေသန၏ ကျိုးကြောင်းဆီလျော်မှုနှင့် အရေးပါမှု

သားအိမ်ခေါင်းကင်ဆာသည် သားအိမ်ခေါင်း၏ မည်သည့်အစိတ်အပိုင်းတွင်မဆို ဖြစ်သော ကင်ဆာဖြစ်သည်။ အဓိကအကြောင်းအရင်းမှာ လိင်မှတစ်ဆင့် ကူးစက်တတ်သော Human Papilloma Virus (HPV) ပိုး ကြာရှည်စွာ ကူးစက်ခြင်းမှ ဖြစ်ပွားခြင်းကြောင့်ဖြစ်သည်။ သားအိမ်ခေါင်းကင်ဆာသည် အမျိုးသမီးများတွင် အဖြစ်များဆုံး ကင်ဆာတစ်မျိုးဖြစ်ပြီး ၎င်းသည် ပြင်းထန်သော လက္ခဏာများ၊ စိတ်ပိုင်းဆိုင်ရာ ချို့ယွင်းမှုနှင့် ငွေကြေးဆိုင်ရာ ဝန်ထုပ်ဝန်ပိုးတို့ကြောင့် လူနာများနှင့် ၎င်းတို့၏ မိသားစုအပေါ် အနုတ်လက္ခဏာဆောင်သော သက်ရောက်မှုများ ရှိပါသည်။

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
2 7 AUG 2025
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သားအိမ်ခေါင်းကင်ဆာသည် ကြိုတင်ကာကွယ်နိုင်သောရောဂါတစ်ခုဖြစ်သော်လည်း၊ အထူးအဖြင့် ရွှေ့ပြောင်းအမျိုးသမီးများကဲ့သို့ ကျန်းမာရေးဝန်ဆောင်မှုရရှိရန်ခက်ခဲသော အမျိုးသမီးများတွင် သေဆုံးမှုမြင့်မားသော ကင်ဆာရောဂါတစ်ခုအဖြစ် ဆက်လက်ရှိနေဆဲ ဖြစ်သည်။ သားအိမ်ခေါင်းကင်ဆာကို စောစီးစွာ သိရှိနိုင်ရန်နှင့် ကြိုတင်ကာကွယ်ရန်အတွက် ပုံမှန်စစ်ဆေးမှုသည် မရှိမဖြစ် အရေးကြီးသည်။ သို့သော်လည်း ထိုင်းနိုင်ငံရှိ ရွှေ့ပြောင်းအမျိုးသမီးအများစုမှာ ကျန်းမာရေးဝန်ဆောင်မှုကို ရယူရန်ခက်ခဲမှုများ ကြုံတွေ့နေရခြင်းကြောင့် ကာကွယ်နိုင်သော သားအိမ်ခေါင်းကင်ဆာကဲ့သို့သော ရောဂါများဖြစ်ရန် ပိုမိုလွယ်ကူသည်။

ဤသုတေသနသည် ချင်းလိုင်းပြည်နယ်ရှိ မြန်မာရွှေ့ပြောင်းအမျိုးသမီးများအကြား ၎င်းတို့၏ အသိပညာနှင့် သဘောထားအပါအဝင် သားအိမ်ခေါင်းကင်ဆာစစ်ဆေးခြင်းနှင့် ဆက်စပ်သည့်အချက်များကို စူးစမ်းလေ့လာရန် ရည်ရွယ်ပါသည်။ ဤလေ့လာမှုမှ တွေ့ရှိချက်များသည် ရွှေ့ပြောင်းအမျိုးသမီးများအကြား သားအိမ်ခေါင်းကင်ဆာ ကြိုတင်ကာကွယ်မှုဆိုင်ရာ အပြုအမူများ တိုးတက်ကောင်းမွန်လာစေရန် ပြည်သူ့ကျန်းမာရေးဆိုင်ရာ အချက်အလက်များနှင့် အထောက်အထားအခြေပြု ထိုးထွင်းသိမြင်မှုများကို ပံ့ပိုးပေးမည်ဖြစ်သည်။ နောက်ဆုံးတွင် ဤလေ့လာမှုသည် ရွှေ့ပြောင်းအမျိုးသမီးများအတွက် သားအိမ်ခေါင်းကင်ဆာ စစ်ဆေးမှုများတွင် တန်းတူအခွင့်အရေးနှင့် ပါဝင်ခွင့်ကို မြှင့်တင်ပေးရန် ဦးတည်သော၊ ယဉ်ကျေးမှုနှင့် ကိုက်ညီသော နည်းလမ်းအသစ်များ ဖြစ်ပေါ်လာစေရန် မူဝါဒဆောင်ရွက်သူများ၊ ကျန်းမာရေးဝန်ထမ်းများနှင့် သက်ဆိုင်ရာတာဝန်ရှိသူများအား အသိပေးနိုင်မည့် အရေးပါသော အချက်အလက်များ ဖြစ်သည်။

၄။ သုတေသနတွင်ပါဝင်ရန်အရည်အချင်းများနှင့် ပါဝင်သူအရေအတွက်

နေထိုင်မှုအထောက်အထားအပေါ်ခွဲခြားခြင်းမရှိပဲ ချင်းလိုင်းပြည်နယ်တွင် အနည်းဆုံး (၆)လကြာ နေထိုင်သော အသက် ၃၀မှ ၆၀အတွင်းရှိ မြန်မာရွှေ့ပြောင်းအမျိုးသမီးများ၊ သုတေသနတွင် ပါဝင်လိုစိတ်ရှိသူများကို ရွေးချယ်ပါမည်။ စုစုပေါင်းပါဝင်သူ ၂၆၀ ဦး ပါဝင်မည်ဖြစ်သည်။

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
27 AUG 2025
APPROVED

၅။ သုတေသန ရည်ရွယ်ချက်များ

ဤသုတေသန၏ရည်ရွယ်ချက်မှာ ထိုင်းနိုင်ငံ၊ ချင်းလိုင်းပြည်နယ်တွင်နေထိုင်သော မြန်မာရွှေ့ပြောင်းအမျိုးသမီးများ၏ သားအိမ်ခေါင်းကင်ဆာ စစ်ဆေးခြင်းခံယူမှု ရာခိုင်နှုန်းကိုခန့်မှန်းရန်နှင့် ၄င်းနှင့် ဆက်စပ်နေသော အကြောင်းအရင်းများကို ရှာဖွေရန် ဖြစ်သည်။

၆။ သုတေသနဒီဇိုင်း

စစ်တမ်းမေးခွန်းလွှာများနှင့် မျက်နှာချင်းဆိုင် တွေ့ဆုံမေးမြန်းမှုများကို အသုံးပြု၍ ထိုင်းနိုင်ငံ ချင်းလိုင်းပြည်နယ်ရှိ ရွှေ့ပြောင်းမြန်မာအမျိုးသမီးများအကြား သားအိမ်ခေါင်း ကင်ဆာစစ်ဆေးခြင်း ရာခိုင်နှုန်းကို ခန့်မှန်းရန် သုတေသနပြုကာ ၎င်းနှင့်ဆက်စပ်သည့် အချက်များကို ဖော်ထုတ်ခြင်း ဖြစ်သည်။

၇။ သုတေသနလုပ်ထုံးလုပ်နည်းနှင့် ပါဝင်မှုကြာချိန်

ထိုင်းနိုင်ငံ၊ ချင်းလိုင်းပြည်နယ်တွင်နေထိုင်သော အသက်၃၀မှ၆၀နှစ်အတွင်းရှိ မြန်မာရွှေ့ပြောင်းအမျိုးသမီးများအားလုံးကို ဤသုတေသနတွင်ပါဝင်ရန် ဖိတ်ခေါ်ပါသည်။ သုတေသီသည် သင့်အား သုတေသန၏ ရည်ရွယ်ချက်၊ လုပ်ထုံးလုပ်နည်းများနှင့် ပါဝင်သူတစ်ဦးအနေဖြင့် သင်၏ အခွင့်အရေးများကို ရှင်းပြပါမည်။ ဤသုတေသနတွင် ပါဝင်ရန် သဘောတူပါက၊ သင်ကိုယ်တိုင် မေးခွန်းစစ်တမ်းတစ်စောင်ကို ဖြည့်ရမည်ဖြစ်သည်။ စာရေးဖတ်ရာတွင် အခက်အခဲရှိပါက သုတေသီမှ မျက်နှာချင်းဆိုင် မေးမြန်းပေးမည် ဖြစ်ပါသည်။ မေးခွန်းလွှာတွင် သင်၏ကိုယ်ရေးအချက်အလက်များ၊ လူမှုစီးပွားရေး အခြေအနေ၊ ကျန်းမာရေးစောင့်ရှောက်မှု ရရှိမှု၊ သားအိမ်ခေါင်းကင်ဆာနှင့် စစ်ဆေးခြင်း ဆိုင်ရာ အသိပညာနှင့် သဘောထား၊ သားအိမ်ခေါင်းကင်ဆာ စစ်ဆေးခြင်း အတွေ့အကြုံ စသည့် အကြောင်းအရာများ ပါဝင်မည်ဖြစ်သည်။ စစ်တမ်းကောက်ယူမှုသည် ခန့်မှန်းချေ အားဖြင့် မိနစ် ၂၀မှ ၃၀ အထိ ကြာမြင့်မည်ဖြစ်ပြီး သင့်အား သက်သောင့်သက်သာ ဖြစ်စေရန်နှင့် အချက်အလက်လုံခြုံမှုအတွက် သီးသန့်နေရာတွင် ပြုလုပ်သွားမည်ဖြစ်သည်။ သင်၏ပါဝင်ခြင်းသည် တစ်ကြိမ်ဖြင့်သာ ပြီးဆုံးမည်ဖြစ်ပြီး နောက်တစ်ကြိမ် ထပ်မံ ကောက်မည်မဟုတ်ပါ။ လိုအပ်ပါက သုတေသီမှ သင်၏တုံ့ပြန်ချက်များကို ရှင်းလင်းရန် တစ်ပတ်အတွင်း တစ်ကြိမ် ဆက်သွယ်နိုင်ပါသည်။ သင်၏ပါဝင်မှုသည် ဆန္ဒအလျောက်

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
27 AUG 2025
APPROVED

ဖြစ်သည်။ သင်သည် မည်သည့်မေးခွန်းကိုမဆို မဖြေရန် သို့မဟုတ် အချိန်မရွေး လေ့လာမှုမှ နုတ်ထွက်ရန် မည်သည့်အနုတ်လက္ခဏာဆောင်သော အကျိုးဆက်မျှမရှိဘဲ ရွေးချယ်နိုင်သည်။ သင်မျှဝေထားသော အချက်အလက်များ အားလုံးကို တင်းကျပ်စွာ လျှို့ဝှက်ထားမည်ဖြစ်ပြီး မည်သူကိုမျှ ထုတ်ဖော်မည် မဟုတ်ကြောင်း အာမခံပါသည်။

၈။ သုတေသနတွင် ပါဝင်ခြင်းမှ ဖြစ်ပေါ်လာနိုင်သော အန္တရာယ်များနှင့် အဆင်မပြေမှုများ

ဤသုတေသနတွင် ပါဝင်ခြင်းကြောင့် ရုပ်ပိုင်းဆိုင်ရာ ထိခိုက်မှုမရှိများ မရှိနိုင်သော်လည်း သင်၏ နေထိုင်မှုအထောက်အထား သို့မဟုတ် အိမ်ထောင်ရေးဘဝကဲ့သို့ ကိုယ်ရေးကိုယ်တာ မေးခွန်းများအတွက် စိတ်ပိုင်းဆိုင်ရာ အဆင်မပြေမှုများ ကြုံတွေ့ရနိုင်သည်။ ဤမေးခွန်းများသည် လေ့လာမှုရည်ရွယ်ချက်များ အောင်မြင်ရန် လိုအပ်သော်လည်း သင့်အတွက် အရှက်ရစေခြင်း သို့မဟုတ် စိတ်မသက်သာမှု ဖြစ်စေနိုင်သည်။ ထိုကဲ့သို့သော အရာများကို လျှော့ချရန် ဒေတာစုဆောင်းခြင်းကို သင်လုံခြုံသည်ဟု ခံစားရသည့် သက်သောင့်သက်သာရှိသော ပတ်ဝန်းကျင်နှင့် သီးသန့်ရှိ၍ လုံခြုံသောနေရာတွင် ပြုလုပ်မည်ဖြစ်ပြီး သင်၏လျှို့ဝှက်ချက်ကို လေးစားမည်ဖြစ်သည်။ သင်ပေးသော အချက်အလက်များအားလုံးကို လျှို့ဝှက်ထားပြီး မည်သူမျှ ထံမဖော်ထုတ်မည်ဖြစ်ကြောင်း အာမခံပါသည်။ ဤသုတေသနတွင် ပါဝင်ခြင်းမှာ အပြည့်အဝ ဆန္ဒအရဖြစ်ပြီး သင်သည် အပျက်သဘောဆောင်သော အကျိုးဆက်များမရှိပဲ အချိန်မရွေး လေ့လာမှုမှ နုတ်ထွက်နိုင်သည်။ စိတ်ပိုင်းဆိုင်ရာ မသက်မသာ ခံစားရပါက သုတေသီသည် သင့်လျော်သော ပံ့ပိုးကူညီမှုများ ပြုလုပ်ပေးမည်ဖြစ်ပြီး လိုအပ်ပါက သင့်လျော်သော ကျန်းမာရေး ဝန်ဆောင်မှုများနှင့် အကြံဉာဏ်ပေးသူများကို လွှဲပြောင်းပေးပါမည်။ ပြဿနာအားလုံးကို ထည့်သွင်းစဉ်းစားသော်လည်း အချို့သော မမျှော်လင့်ထားသော ပြဿနာများ ဖြစ်ပေါ်လာပါက သုတေသနတွင်ပါဝင်သူများအား ဘေးကင်းမှုရှိ၍ လေးစားသောနည်းလမ်းဖြင့် ဆောင်ရွက်နိုင်ရေးအတွက် သုတေသနကျင့်ဝတ်များအားလုံးကို တင်းကြပ်စွာ လိုက်နာမည်ဖြစ်ပါသည်။

၉။ သုတေသနတွင် ပါဝင်ခြင်းကြောင့် ဖြစ်နိုင်သော အကျိုးကျေးဇူးများ

ဤသုတေသနတွင် ပါဝင်ခြင်းဖြင့် သင်သည် မည်သည့်တိုက်ရိုက် အကျိုးခံစားခွင့်မျှ ရရှိမည် မဟုတ်ပါ။ သို့သော် သင်၏ပါဝင်မှုသည် သားအိမ်ခေါင်းကင်ဆာနှင့် သက်ဆိုင်သော

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
27 AUG 2025
APPROVED

အသိပညာများ မြှင့်တင်ခြင်းနှင့် သားအိမ်ခေါင်းကင်ဆာကို ကာကွယ်ရန် ပုံမှန်စစ်ဆေးခြင်း၏ အရေးပါမှုကို နားလည်စေရန် အထောက်အကူဖြစ်နိုင်ပါသည်။ ထို့အပြင် သင်၏ကျန်းမာရေးကို ကိုယ်တိုင်စမ်းစစ်မှီ၍ လိုအပ်သည့်အခါ ကြိုတင်ကာကွယ်မှုရယူရန် တွန်းအားပေးနိုင်ပါသည်။

စစ်တမ်းကောက်ယူပြီးနောက်တွင် သားအိမ်ခေါင်းကင်ဆာနှင့် ပတ်သက်သော ရှင်းလင်းသောအချက်အလက်များ၊ ကာကွယ်နည်းများ၊ သားအိမ်ခေါင်းကင်ဆာ စစ်ဆေးခြင်း၏ အရေးကြီးပုံနှင့် သင်၏နီးစပ်ရာတွင်ရှိသော သားအိမ်ခေါင်းကင်ဆာ စစ်ဆေးနိုင်သည့် ကျန်းမာရေးဌာနများ၏ ဆက်သွယ်ရန်ဖုန်းနံပါတ်များပါဝင်သော လက်ကမ်းစာစောင်ကို ရရှိမည်ဖြစ်သည်။

ဤသုတေသနမှ စုဆောင်းရရှိထားသော အချက်အလက်များသည် ပြည်သူ့ကျန်းမာရေး တာဝန်ရှိသူများ၊ NGO များနှင့် မူဝါဒချမှတ်သူများအတွက် မြန်မာ့ရွှေ့ပြောင်းအမျိုးသမီးများ ကြုံတွေ့နေရသော စိန်ခေါ်မှုများကို ပိုမိုသဘောပေါက် နားလည်စေရန် အထောက်အကူ ဖြစ်စေနိုင်ပါသည်။ ၎င်းသည် ရွှေ့ပြောင်းလာသူများအတွက် မျှတပြီး ယဉ်ကျေးမှုနှင့် ကိုက်ညီသော ကျန်းမာရေးအစီအစဉ်များနှင့် ဝန်ဆောင်မှုများကို တိုးတက်စေပြီး၊ ရွှေ့ပြောင်းလာသူများအကြား ကျန်းမာရေးမညီမျှမှုများကို လျော့ချရန် အထောက်အကူပြုနိုင်ပါသည်။

၁၀။ သုတေသနတွင် မပါဝင်ပါက အခြားရွေးချယ်စရာများ

သင်သည် ဤလေ့လာမှုတွင် မပါဝင်ရန် ရွေးချယ်ပါက သင်လက်ရှိ ခံစားခွင့်ရှိသော ကျန်းမာရေးဝန်ဆောင်မှုများအပေါ် သက်ရောက်မှု မရှိပါ။ သင်သည် လက်ရှိ ပြည်သူ့ကျန်းမာရေးဌာနများနှင့် ရပ်ရွာအခြေပြု ကျန်းမာရေးအစီအစဉ်များမှတစ်ဆင့် သားအိမ်ခေါင်းကင်ဆာ စစ်ဆေးခြင်းနှင့် အခြား ကျန်းမာရေး စောင့်ရှောက်မှုများကို ဆက်လက်ရရှိနိုင်ပါသေးသည်။ ဤလေ့လာမှုတွင် ပါဝင်ခြင်းမှာ လုံးဝဆန္ဒအလျောက်ဖြစ်ပြီး မပါဝင်ရန် ရွေးချယ်ခြင်းသည် သင်ရရှိသော စောင့်ရှောက်မှု သို့မဟုတ် ဝန်ဆောင်မှုများ၏ အရည်အသွေးကို ထိခိုက်မည်မဟုတ်ပါ။

၁၁။ သုတေသနအတွင်း ဖြစ်ပေါ်နိုင်သော အခြေအနေများနှင့် စီမံခန့်ခွဲရန် လမ်းညွှန်ချက်များ

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
2 7 AUG 2025
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ဖြစ်ပေါ်နိုင်သောအခြေအနေ	စီမံခန့်ခွဲရန် လမ်းညွှန်ချက်များ
▪ သုတေသနအတွင်း နုတ်ထွက်လိုပါက	သုတေသနမှပါဝင်ခြင်းကို ရပ်တန့်လိုပါက မည်သည့်အဆင့်၌မဆို၊ မည်သည့်အကြောင်းဖြင့်မဆို သုတေသီထံ အသိပေးနိုင်ပါသည်။ သင်၏ဆုံးဖြတ်ချက်သည် ကျန်းမာရေးဝန်ဆောင်မှု ရယူခွင့်များနှင့် အခြားအခွင့်အရေးများကို မသက်ရောက်ပါ။
▪ သုတေသနနှင့်သက်ဆိုင်သည့် သတင်းအချက်အလက်သစ် သို့မဟုတ် သင့်ဘေးကင်းရေးဆိုင်ရာ အချက်အလက်အသစ်များရှိပါက	သင်၏ ပါဝင်မှုဆိုင်ရာ ဆုံးဖြတ်ချက် သို့မဟုတ် လုံခြုံရေးအပေါ်သက်ရောက်စေနိုင်သော သတင်းအချက်အလက်အသစ်တစ်စုံတစ်ခု ရရှိလာပါက သုတေသီမှ သင့်အား ချက်ချင်းအသိပေးပါမည်။ ထို့နောက် သင်သည် ဆက်လက်ပါဝင်ခြင်း သို့မဟုတ် မပါဝင်တော့ရန် ဆုံးဖြတ်နိုင်ပါသည်။
▪ ပါဝင်မှုကို ရပ်ဆွဲရနိုင်သည့် အခြေအနေများတွင် သုတေသနလုပ်ငန်းစဉ်များ ပြီးစီးခြင်း၊ သုတေသနအတွက်လိုအပ်သော နမူနာအရေအတွက် ပြည့်ခြင်း သို့မဟုတ် သတ်မှတ်ထားသောအချိန်သက်တမ်း ပြီးဆုံးခြင်း ပါဝင်သည်။	ဤအခြေအနေများမှ တစ်ခုခုဖြစ်ပေါ်ပါက သုတေသီသည်ပါဝင်သူများကို သင့်လျော်စွာ, လေးစားစွာဖြင့်အသိပေးပါမည်။ ထိုအချိန်အထိ စုဆောင်းရရှိထားသောဒေတာအားလုံးကို လုံခြုံစွာဖြင့်ကျင့်ဝတ်ဆိုင်ရာ လမ်းညွှန်ချက်များနှင့်အညီ ကိုင်တွယ်ပါမည်။

၁၂။ သုတေသနပြီးဆုံးပြီးနောက် ရရှိနိုင်သော အကျိုးအမြတ်များ

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
27 AUG 2025
APPROVED

သုတေသနပြီးဆုံးပြီးနောက်တွင် ပါဝင်သူသည် သုတေသနတွင် ပါဝင်ခြင်းအတွက် မည်သည့်တိုက်ရိုက်အကျိုးခံစားခွင့် (သို့မဟုတ်) ကုသမှုများရရှိမည် မဟုတ်ပါ။ သုတေသီသည် သုတေသနပြုပြီးသည်နှင့် ရလဒ်များကို သင့်အား အကြောင်းကြားပါမည်။

၁၃။ ဒေတာ၏ လျှို့ဝှက်မှုနှင့် အကန့်အသတ်များ

ပါဝင်သူများမှ မျှဝေပေးသော အချက်အလက်များကို ပါဝင်သူရွေးချယ်ခြင်းမှ စာတမ်းထုတ်ဝေသည်အထိ သုတေသနလုပ်ငန်းစဉ်တခုလုံးတွင် လျှို့ဝှက်ထားမည်ဖြစ်သည်။ ပါဝင်သူများကို သဘောတူလက်မှတ်မရေးထိုးမှီ သုတေသန၏ရည်ရွယ်ချက်များ၊ မိမိ၏ အခွင့်အရေးများနှင့် စိတ်ဆန္ဒအလျောက်ပါဝင်ခြင်းအကြောင်း အပြည့်အစုံ အသိပေးမည်ဖြစ်သည်။

လျှို့ဝှက်ချက်များကို သေချာစေရန်အတွက် ပါဝင်သူတိုင်းကို မတူညီသော ကိုယ်ပိုင်အမှတ်တခုစီ ချမှတ်ပေးမည်ဖြစ်ပြီး တုံ့ပြန်မှုများနှင့် တိုက်ရိုက်ချိတ်ဆက်မှုကို တားဆီးရန် အမည်၊ လိပ်စာ၊ မှတ်ပုံတင်နံပါတ်ကဲ့သို့သော ကိုယ်ရေးအချက်အလက်များကို စုဆောင်းမည်မဟုတ်ပါ။ ဒေတာစုဆောင်းချင်းကို ပါဝင်သူများ၏ လွတ်လပ်ခွင့်နှင့် သက်သောင့်သာသာရှိမှုကို အလေးထား၍ သီးသန့်နေရာတွင် ဆောင်ရွက်မည်ဖြစ်ပါသည်။

သဘောတူညီချက်ဖောင်နှင့် စုဆောင်းထားသော ဒေတာများကဲ့သို့သော စာရွက်စာတမ်းများကို မတော်တဆထုတ်ဖော်မှုမှ ကာကွယ်ရန် သော့ခတ်ထားသောဗီရိုထဲတွင် သီးခြားစီ ထိန်းသိမ်းထားမည်ဖြစ်သည်။ ဒစ်ဂျစ်တယ်ဒေတာများကိုလည်း စကားဝှက်ဖြင့် ကာကွယ်ထားပြီး၊ လုံခြုံရေးအဆင့်မြင့်ထားသော ကွန်ပြူတာများတွင် သိမ်းဆည်းမည်ဖြစ်ပြီး၊ ဤဒေတာများကို သုတေသနထာဝန်ခံသူတစ်ဦးတည်းသာ ဝင်ရောက်ကြည့်ရှုခွင့်ရှိမည်ဖြစ်သည်။ ဒေတာခွဲခြမ်းစိတ်ဖြာခြင်းနှင့် ဖြန့်ဝေခြင်းအဆင့်တွင် တစ်ဦးချင်းအချက်အလက်ဖယ်ရှားထားသော စုစုပေါင်းအချက်အလက်များသာ အသုံးပြုမည်ဖြစ်သည်။ ကျွန်ုပ်တို့ပြုလုပ်မည့် စာတမ်း၊ တင်ပြချက် သို့မဟုတ် ထုတ်ဝေမှုများတွင် မည်သည့်ကိုယ်ရေးအချက်အလက်ကိုမျှ ထည့်သွင်းဖော်ပြမည် မဟုတ်ပါ။ အချက်အလက်ဖော်ခြင်းနှင့် ထုတ်ဝေမှုများပြီးဆုံးပါက၊ အချက်အလက် အားလုံးကို သက်ဆိုင်ရာ သုတေသနကျင့်ဝတ်စည်းကမ်းများနှင့်အညီ ဖျက်သိမ်းမည် ဖြစ်ပါသည်။

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
2 7 AUG 2025
APPROVED

သို့သော် သက်ဆိုင်ရာကျင့်ဝတ်ကော်မတီ၊ သုတေသနညှိနှိုင်းသူများ၊ သုတေသနကြီးကြပ်သူများ၊ သို့မဟုတ် စစ်ဆေးရေးတာဝန်ရှိ အစိုးရအဖွဲ့အစည်းများက သို့သော တရားဝင်အဖွဲ့များသည် သုတေသနလုပ်ငန်းစဉ်များ၏ တိကျမှန်ကန်မှုနှင့် သမာဓိရှိမှုကို စစ်ဆေးရန်အတွက်သာ မူရင်းအချက်အလက်များကို ဝင်ရောက်ကြည့်ရှုခွင့် ရှိနိုင်ပါသည်။ ဤပုဂ္ဂိုလ်များသည်လည်း လျှို့ဝှက်ချက်ထိန်းသိမ်းခြင်းမူကို လိုက်နာရမည် ဖြစ်ပြီး အချက်အလက်များကို ကြီးကြပ်ရေးရည်ရွယ်ချက်အတွက်သာ အသုံးပြုရမည် ဖြစ်သည်။ သုတေသီသည် ပါဝင်သူအားလုံး၏ ကိုယ်ရေးကိုယ်တာ၊ ဂုဏ်သိက္ခာနှင့် အခွင့်အရေးများကို လေ့လာမှု၏အဆင့်တိုင်းတွင် ကာကွယ်ရန် အပြည့်အဝ ကတိပြုပါသည်။

၁၄။ သုတေသနတွင် ပါဝင်မှုအတွက် ပြန်လည်ပေးဆပ်ခြင်း

ဒေတာစုဆောင်းမှုပြီးဆုံးသောနောက်ပိုင်းတွင် ပါဝင်သူများအား သားအိမ်ခေါင်းကင်ဆာ နှင့် ဆိုင်သော အချက်အလက်များဖြစ်သည့် သားအိမ်ခေါင်း ကင်ဆာ၏ အကြောင်းအရင်းများ၊ ရောဂါလက္ခဏာများ၊ အန္တရာယ်အချက်များနှင့် ကြိုတင်ကာကွယ်နိုင်မှုအခြေအနေများ ပါဝင်သည့် ပညာပေးလက်ကမ်းစာစောင်များ ပေးအပ်မည်ဖြစ်သည်။ ထို့အပြင် သားအိမ်ခေါင်းကင်ဆာ စစ်ဆေးမှုနှင့် အခြားကျန်းမာရေး ပြဿနာများအတွက် ကျန်းမာရေးဝန်ဆောင်မှုများနှင့် ဆက်သွယ်နိုင်မည့် သတင်း အချက်အလက်များလည်း ပါဝင်မည်ဖြစ်ပြီး ပါဝင်သူများ၏ သားအိမ်ခေါင်းဆာအကြောင်း ပိုမိုသတိထားမိစေရန်နှင့် ကြိုတင်ကာကွယ်ရေးအပြုအမူများ တိုးတက်လာစေရန် ရည်ရွယ်ထားခြင်း ဖြစ်သည်။

၁၅။ ပါဝင်သူများ ပေးဆောင်ရမည့် ကုန်ကျစရိတ်များ

ဤလေ့လာမှုတွင် ပါဝင်ရန်အတွက် ပါဝင်သူများသည် မည်သည့် ကုန်ကျစရိတ်မျှ ပေးဆောင်ရန်မလိုအပ်ပါ။

၁၆။ သုတေသနတွင် ပါဝင်ခြင်းကြောင့် ထိခိုက်မှု (သို့) ဆိုးကျိုးများ ကြုံတွေ့ပါက ထောက်ပံ့မှုနှင့် ဖြည့်ဆည်းမှုဆိုင်ရာ လမ်းညွှန်ချက်များ

သုတေသနတွင် ပါဝင်စဉ်အတွင်း မတော်တဆ တစ်စုံတစ်ရာ ဖြစ်ပွားပါက သုတေသီသည် သင့်လျော်သော ပံ့ပိုးကူညီမှုနှင့် စောင့်ရှောက်မှုကို ပေးမည်ဖြစ်ပါသည်။

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
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ပါဝင်သူများသည် နေထိုင်မှုအထောက်အထား သို့မဟုတ် အိမ်ထောင်ရေးဘဝကဲ့သို့သော ကိုယ်ရေးကိုယ်တာ ကိစ္စများနှင့် ပတ်သက်သည့်မေးခွန်းများကြောင့် စိတ်ပိုင်းဆိုင်ရာ အဆင်မပြေမှုများ ကြုံတွေ့ရနိုင်သည်။ စိတ်အဆင်မပြေမှုများခံစားရပါက ပါဝင်သူအား သင့်လျော်သော စောင့်ရှောက်မှုနှင့်ပံ့ပိုးမှုများအတွက် အရည်အချင်းပြည့်မီသော ဆေးဘက်ဆိုင်ရာ ကျွမ်းကျင်ပညာရှင်များ သို့မဟုတ် စိတ်ပိုင်းဆိုင်ရာ အကြံဉာဏ်ပေးသူများထံ လွှဲပြောင်းပေးမည်ဖြစ်သည်။ ထို့အပြင် သုတေသနတွင် ပါဝင်ခြင်းသည် လုံးဝဆန္ဒအလျောက်ဖြစ်ကြောင်း ရှင်းရှင်းလင်းလင်း အသိပေးမည်ဖြစ်ပြီး ပါဝင်သူသည် မည်သည့်အကျိုးဆက်မျှမရှိဘဲ အချိန်မရွေး လေ့လာမှုမှ နုတ်ထွက်နိုင်ပါသည်။ ဂရုတစိုက်စီစဉ်ခြင်းနှင့် စည်းကမ်းကျင့်ဝတ်များအရ ဖြစ်နိုင်ချေရှိသော အန္တရာယ်များကို အနည်းဆုံးဖြစ်အောင် လျှော့ချမည်ဖြစ်ပြီး သုတေသနလုပ်ငန်းစဉ်တစ်လျှောက်လုံးတွင် လုံခြုံမှုနှင့် ပံ့ပိုးကူညီမှု ဝန်ဆောင်မှုများကို ရရှိနိုင်မည်ဖြစ်သည်။ မတော်တဆဖြစ်စဉ် သို့မဟုတ် ထိခိုက်မှုတစ်စုံတစ်ရာဖြစ်ပေါ်လာပါက သုတေသီသည် ဆေးကုသမှုနှင့် ပြန်လည်ထူထောင်ရေး အပါအဝင် သက်ဆိုင်ရာ ကုန်ကျစရိတ်အားလုံးအတွက် တာဝန်ယူမည်ဖြစ်သည်။

၁၇။ မေးခွန်း (သို့) စိုးရိမ်စရာရှိပါက ဆက်သွယ်ရန် ပုဂ္ဂိုလ်

သုတေသနနှင့်ပတ်သက်သော မေးခွန်းများ သို့မဟုတ် သုတေသနတွင် ပါဝင်စဉ်အတွင်း လုံခြုံမှုနှင့်သက်ဆိုင်သော စိုးရိမ်မှုများရှိပါက သုတေသနသီအား တိုက်ရိုက်မေးမြန်းနိုင်ပါသည်။

အဓိက စုံစမ်းစစ်ဆေးသူ
အမည်: နီဗယ်လင်းနော်ကျော့သူ
မိုဘိုင်းဖုန်း: 0637507368
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အမည်: Asst.Prof Dr. Pilasinee Wongnuch

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မိုဘိုင်းဖုန်း: 053916921
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သင်၏အခွင့်အရေးများနှင့်သက်ဆိုင်သောမေးခွန်းများရှိပါက၊သင်၏အခွင့်အရေးများ၊လုံခြုံမှုနှင့်ကျန်းမာရေးကိုနိုင်ငံတကာစံနှုန်းများအောက်တွင်လူသားသုတေသနကျင့်ဝတ်များနှင့်အညီ ကာကွယ်ပေးနိုင်ရန်အတွက် Mae Fah Luang တက္ကသိုလ်လူကျင့်ဝတ်ဆိုင်ရာ သုတေသနကော်မတီ (AS) သို့ ဆက်သွယ်နိုင်ပါသည်။

ဆက်သွယ်ရန်လိပ်စာ – Mae Fah Luang တက္ကသိုလ် လူကျင့်ဝတ်ဆိုင်ရာ သုတေသနကော်မတီ (AS)၊ ၄လွှာ
ဖုန်း – (၀၅၃) ၉၁၇-၁၇၀ သို့ ၁ သို့မဟုတ် (၀၅၃) ၉၁၆-၅၅၁
ဖက်စ် – (၀၅၃) ၉၁၇-၁၇၀
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သဘောတူညီချက်ပုံစံ

ကျွန်ုပ် _____ "ထိုင်းနိုင်ငံ၊ ချင်းလိုင်းပြည်နယ်ရှိ မြန်မာရွှေ့ပြောင်း အမျိုးသမီးများအကြား သားအိမ်ခေါင်းကင်ဆာ စစ်ဆေးမှုခံယူခြင်းနှင့် ဆက်စပ်သော အကြောင်းအရာများ" ခေါင်းစဉ်ဖြင့် သုတေသနပရောဂျက်တွင် ပါဝင်ရန် ဆုံးဖြတ်လိုက်ပါသည်။ ကျွန်ုပ်သည် ဤသုတေသနနှင့်ပတ်သက်သော သတင်းအချက်အလက်နှင့် ရှင်းလင်းချက်များကို လက်ခံရရှိထားပြီး၊ မေးခွန်းများမေးမြန်းပြီး ကျေနပ်လောက်သောအဖြေများကို ကျွန်ုပ်ရရှိခဲ့ပါသည်။ ကျွန်ုပ်သည် စာရွက်စာတမ်းများတွင် ပေးထားသည့် အချက်အလက်များကို စေ့စေ့စပ်စပ် ဖတ်ရှုနားလည်ရန် အချိန်အလုံအလောက်ရှိခဲ့ပြီး ဤသုတေသနတွင် ပါဝင်ရန် ဆုံးဖြတ်ခဲ့သည်။

ဤသုတေသနတွင်မပါဝင်ရန် လွတ်လပ်စွာ ရွေးချယ်ပိုင်ခွင့်ရှိသည်နှင့် ကျွန်ုပ်၏စောင့်ရှောက်မှု သို့မဟုတ် ရပိုင်ခွင့်များပေါ်တွင် ထိခိုက်မှုတစ်စုံတစ်ရာမရှိဘဲ ဤသုတေသနမှ အချိန်မရွေး နှုတ်ထွက်နိုင်သည်ကို ကျွန်ုပ်နားလည်ပါသည်။

ဤစာတမ်းကို လက်မှတ်ရေးထိုးခြင်းဖြင့်၊ ကျွန်ုပ်သည် ဥပဒေအရ ရသင့်ရထိုက်သော အခွင့်အရေးများကို လက်လွှတ်မခံဘဲ လက်မှတ်ရေးထိုးပြီးနောက် အချက်အလက်စာရွက်မိတ္တူနှင့် အသိပေးသဘောတူညီချက်ကို ကျွန်ုပ်ရရှိပါမည်။

ပါဝင်သူ၏ လက်မှတ် _____ ရက်စွဲ _____

(_____)

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ETHICS COMMITTEE ON HUMAN RESEARCH
2 7 AUG 2025
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.....(မဖတ်နိုင်သော်လည်းနားထောင်ခြင်းဖြင့်နားလည်နိုင်သော စာမတတ်သူများအတွက်) .....

ကျွန်တော် မဖတ်နိုင်သော်လည်း သုတေသီမှ ဤအချက်အလက်စာရွက်ကို ဖတ်ပြီး ကျွန်တော့်ဆီအသံပေးသည့် သဘောတူညီချက်ပုံစံကို ကောင်းကောင်း နားလည်ပါတယ်။ ထို့ကြောင့် ကျွန်ုပ်ဆန္ဒအလျောက် လက်မှတ်ထိုးပါသည် သို့မဟုတ် ကျွန်ုပ်၏လက်ဗွေကို နေရာချပါသည်။

ပါဝင်သူ၏ လက်မှတ်/လက်ဗွေ _____ ရက်စွဲ _____

(_____)

သဘောတူညီချက် တောင်းခံသူ၏ လက်မှတ် _____ ရက်စွဲ _____

(_____)

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27 AUG 2025
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သုတေသနတွင် ပါဝင်ပတ်သက်သူမဟုတ်သော သက်သေတစ်ဦး၏ သက်သေခံချက်
(ပါဝင်သူသည် မဖတ်နိုင်သော်လည်း နားထောင်ခြင်းဖြင့် နားလည်နိုင်လျှင်)

သဘောတူညီချက်တောင်းဆိုမှုလုပ်ငန်းစဉ်အတွင်းကျွန်ုပ်ရှိနေခဲ့ပြီး သဘောတူညီချက်တောင်းခံသူသည် အချက်အလက်စာရွက်ကိုဖတ်/ရှင်းပြခဲ့သည်ကို အတည်ပြုကြောင်း အတည်ပြုပါသည်။ အထက်ဖော်ပြပါ ပုဂ္ဂိုလ်သည် မေးခွန်းများမေးခွင့်ရခဲ့ပြီး ဤစာတမ်းပါ အချက်အလက်များကို နားလည်ပြီးနောက် စိတ်ဆန္ဒအလျောက် ပါဝင်ရန် ဆုံးဖြတ်ခဲ့သည်။

သက်သေခံလက်မှတ် _____ ရက်စွဲ _____
(_____)

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27 AUG 2025
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APPENDIX E

QUESTIONNAIRE (ENGLISH VERSION)

Version 1 Date 4/6/2025

QUESTIONNAIRE (ENGLISH VERSION)

District .....

Sub-district .....

Research code .....

Interviewer.....

Date.....

This questionnaire consists of 7 parts as follows:

Part 1 Socio-demographic and Health-related factors Questionnaire

Part 2 Source of information Questionnaire

Part 3 Knowledge about cervical cancer and cervical cancer screening Questionnaire

Part 4 Attitude towards cervical cancer and cervical cancer screening Questionnaire

Part 5 Perceived social support Questionnaire

Part 6 Perceived Access to Healthcare Questionnaire

Part 7 Cervical cancer screening uptake Questionnaire

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ETHICS COMMITTEE ON HUMAN RESEARCH
2 7 AUG 2025
APPROVED

Version 1 Date 4/6/2025

Part 1 Socio-demographic and Health-related factors Questionnaire

1. Age.....years (completed years)

2.What is your marital status?

☐ 1. Single ☐ 2.Married ☐ 3.Separated

☐ 4. Divorced ☐ 5. Widowed

3. Age at the time of first marriage?

.....years

4.Do you have children?

☐ 1. Yes ☐ 2. No (skip to Q 6)

5. How many children do you have?

.....

6.What is your religion?

☐ 1. Buddhism ☐ 2. Christianity ☐ 3.Muslim

☐ 4. Other (please specify) .....

7.What is your ethnicity?

☐ 1. Burmese ☐ 2. Shan ☐ 3. Karen

☐ 4. Mon ☐ 5. Other (please specify)

8.What is your highest level of education?

☐ 1. Illiterate ☐ 2. Primary school ☐ 3. Secondary school

☐ 4. High school ☐ 5. Undergraduate ☐ 6. Graduate

9. How long have you been in Thailand?

..... Months/ years

10. What is your migration status?

☐ 1. Documented ☐ 2.Undocumented (skip to Q 12)

11. What type of document do you possess?

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ETHICS COMMITTEE ON HUMAN RESEARCH
27 AUG 2025
APPROVED

Version 1 Date 4/6/2025

☐ 1. Pink Card ☐ 2. Certificate of Identify

☐ 3. Work Permit ☐ 4. Other (please specify) .....

12. What is your Thai language proficiency?

Reading

☐ 1. None ☐ 2.Basic ☐ 3.Fluent

Speaking

☐ 1. None ☐ 2.Basic ☐ 3.Fluent

Writing

☐ 1. None ☐ 2.Basic ☐ 3.Fluent

Listening

☐ 1. None ☐ 2.Basic ☐ 3.Fluent

13.What is your occupation?

☐ 1. Unemployment ☐ 2. Agriculture worker

☐ 3. Construction worker ☐ 4. Service worker

☐ 5. Factory worker ☐ 6. Interpreter/translator

☐ 7. Other (please specify) .....

14. How much family income do you have monthly?

..... Baht

15.Do you have health insurance?

☐ 1. Out-of-pocket ☐ 2. Social Security scheme

☐ 3. Migrant health insurance scheme ☐ 4.M-fund

☐ 5. Private insurance scheme ☐ 6. Other (please specify) .....

16.What kind of contraception do you use? (can answer more than one)

☐ 1. Oral pills ☐ 2. Injections ☐ 3. Implant

☐ 4. Sterilization ☐ 5. Condom ☐ 6. Calendar method

☐ 7. Not using any contraceptive methods

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ETHICS COMMITTEE ON HUMAN RESEARCH
27 AUG 2025
APPROVED

Version 1 Date 4/6/2025

17. Is there any person in your family having cervical cancer?

☐ 1. Yes ☐ 2. No. ☐ 3. Not sure

18.Have you ever received HPV vaccination?

☐ 1. Yes ☐ 2. No

19.What is the nearest health center that provides cervical cancer screening?

☐ 1. Government hospital ☐ 2. Private hospital

☐ 3. Community clinic ☐ 4. Others (specify)..... ☐ 5. Don't know

20. Approximately how long does it take to go to the nearest health facility that provides cervical cancer screening services from your home?

.....min/hour

21. Is it convenient for you to go to the health center that provides screening?

☐ 1. Yes ☐ 2. No

Part 2 Source of Information Questionnaire

1. Where did you get the information of cervical cancer and screening? (can choose more than one)

☐ 1. Husband
☐ 2. Family
☐ 3. Friends
☐ 4. Neighbor
☐ 5. Doctor
☐ 6. Nurse
☐ 7. Healthcare volunteer
☐ 8. NGO, INGOs
☐ 9. Others (please specify) .....

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ETHICS COMMITTEE ON HUMAN RESEARCH
27 AUG 2025
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2. Where did you get the information of cervical cancer and screening? (can choose more than one)

☐ 1. Social media (TikTok, Facebook, etc.)
☐ 2. TV
☐ 3. Posters
☐ 4. Pamphlets
☐ 5. Newspaper
☐ 6. Others (please specify) .....

Part 3 Knowledge about cervical cancer and cervical cancer screening Questionnaire

Instruction: These are the questions to assess your knowledge related to cervical cancer and cervical cancer screening. Please read carefully and fill (✓) in the appropriate box.

No	Items	Yes	No	Not sure
1	Cervical cancer is caused by a virus which is transmitted by all kind of sexual contact.			
2	Women with HIV infection have higher risk of cervical cancer.			
3	Cervical cancer can occur without symptoms in the early stages.			
4	Foul-smelling vaginal discharge could be symptom of cervical cancer.			

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ETHICS COMMITTEE ON HUMAN RESEARCH
2 7 AUG 2025
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5	Abnormal vaginal bleeding between periods, after sex and after menopause could be symptom of cervical cancer.			
6	Regular screening can detect cervical cancer early.			
7	Women who received HPV vaccine should still get cervical cancer screening.			

Part 4 Attitude towards cervical cancer and cervical cancer screening Questionnaire

Instruction: These are the questions to assess your attitude towards cervical cancer and cervical cancer screening. Please read carefully and fill (✓) in the appropriate box.

		Absolutely Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Absolutely Agree (5)
1	Any sexually active woman, including me, is at risk of getting cervical cancer.					
2	Cervical cancer can be cured if detected early by screening.					

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
2 7 AUG 2025
APPROVED

Version 1 Date 4/6/2025

3	I feel shy to undergo cervical cancer screening.					
4	I would feel uncomfortable during cervical cancer screening.					
5	Even if I don't have symptoms, I should still get screened.					
6	I would go for screening if it were free.					
7	A doctor or a health worker's advice would encourage me to get screened.					

Part 5 Perceived social support Questionnaire

Instruction: We are interested how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement and

Circle the "1" if you Very Strongly Disagree

Circle the "2" if you Strongly Disagree

Circle the "3" if you are Mildly Disagree

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
27 AUG 2025
APPROVED

Version 1 Date 4/6/2025

Circle the "4" if you are Neutral

Circle the "5" if you Mildly Agree

Circle the "6" if you Strongly Agree

Circle the "6" if you Very Strongly Agree

		Very strongly disagree (1)	Strongly disagree (2)	Mildly disagree (3)	Neutral (4)	Mildly agree (5)	Strongly agree (6)	Very strongly agree (7)
1	There is a special person who is around when I am in need.	1	2	3	4	5	6	7
2	There is a special person with whom I can share joys and sorrows.	1	2	3	4	5	6	7
3	My family really tries to help me.	1	2	3	4	5	6	7

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
27 AUG 2025
APPROVED

Version 1 Date 4/6/2025

4	I get the emotional help & support I need from my family.	1	2	3	4	5	6	7
5	I have a special person who is a real source of comfort to me.	1	2	3	4	5	6	7
6	My friends really try to help me.	1	2	3	4	5	6	7
7	I can count on my friends when things go wrong.	1	2	3	4	5	6	7
8	I can talk about my problems with my family.	1	2	3	4	5	6	7

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
2 7 AUG 2025
APPROVED

Version 1 Date 4/6/2025

9	I have friends with whom I can share my joys and sorrows.	1	2	3	4	5	6	7
10	There is a special person in my life who cares about my feelings.	1	2	3	4	5	6	7
11	My family is willing to help me make decisions.	1	2	3	4	5	6	7
12	I can talk about my problems with my friends.	1	2	3	4	5	6	7

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
2 7 AUG 2025
APPROVED

Version 1 Date 4/6/2025

Part 6 Perceived Access to Healthcare Questionnaire

Instruction: These are the questions related to your feeling about accessing to healthcare.

Please read each statement carefully and fill (✓) in the appropriate box.

Subscale		Items	Absolutely disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Absolutely agree (5)
Accessibility	1	The services I need are provided at the health center.					
	2	The distance from the health centers to my house is appropriate.					
	3	The time required to reach the health center is appropriate.					
	4	Getting to and from the health center is easy for me.					

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
2 7 AUG 2025
APPROVED

Version 1 Date 4/6/2025

Availability	5	The health services (immunization, medical visit, family planning, mother and childcare, injections, etc.) I need are provided at the public health center.					
	6	The facilities of the health center meet the health needs of the clients.					
	7	Health staff is tailored to the number of clients and their needs.					
Acceptability	8	The quality of services provided in the					

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
27 AUG 2025
APPROVED

Version 1 Date 4/6/2025

		health center is acceptable.					
	9	The health center staff meets the needs of the clients in various ways, such as being introduced to the community resources.					
	10	Health workers listen carefully to what I have to say.					
	11	The health workers give me enough time.					
	12	I trust the statements of the treatment team (doctor, nurse, midwife, etc.) about my					

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
27 AUG 2025
APPROVED

Version 1 Date 4/6/2025

		health and illness.					
	13	My request for same sex health care professionals is taken into account.					
	14	I accept screening services such as cervical and colon cancer at this center.					
	15	The treatment team at the health center is respectful.					
	16	Health workers (doctors, nurses, midwives, etc.) are familiar with the culture of clients and					

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
2 7 AUG 2025
APPROVED

Version 1 Date 4/6/2025

		communicate with them appropriately.					
Affordability	17	To solve my health problem, I first see a general practitioner.					
	18	With the guidance of a general practitioner, I use specialized and sub-specialized services.					
	19	My healthcare costs are reasonable, and I can afford them.					
Accommodation	20	It is easy to make an appointment at a health center.					

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
2 7 AUG 2025
APPROVED

	21	The expected time to receive the services I need is appropriate.					
	22	I can discuss health issues and changes in my condition over the phone (in person) with the treatment team (doctor, nurse, midwife, etc.).					
	23	The working hours of the public health center are suitable for receiving services from these centers.					
	24	The physical space of the health center is					

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
2 7 AUG 2025
APPROVED

Version 1 Date 4/6/2025

		suitable for receiving services.					
	25	Access to some facilities such as wheelchairs, walkers, etc. is provided in the health center.					
Awareness	26	The education that are given to me are such that I understand them.					
	27	The information I need is expressed in simple language without the use of specialized words.					
	28	Communication of health					

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
2 7 AUG 2025
APPROVED

		workers (doctor, nurse, midwife etc.) with clients is appropriate.					
	29	Health workers try to make sure I fully understand the health information provided.					
	30	My living conditions are taken into accounts, such as marital status, ability to pay, and cultural differences.					

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
2 7 AUG 2025
APPROVED

Version 1 Date 4/6/2025

Part 7 Cervical cancer screening uptake Questionnaire

1. Have you ever had cervical cancer screening test (eg. Pap smear, VIA test or HPV test)?

☐ 1. Yes ☐ 2. No (skip to Q4) ☐ 3. Not sure (skip to Q4)

2. If yes, how many times have you been screened in your life?

☐ 1. .....times ☐ 2. Don't remember

3. When was your most recent screening?

☐ .....Month/ year ☐ 2. Don't remember

4. Have you ever taken cervical cancer screening in the past 3 years?

☐ 1. Yes ☐ 2. No (skip to Q9)

5. What type of screening did you use, if remember?

☐ 1. Pap smear ☐ 2. VIA test

☐ 3. HPV DNA test ☐ 4. Co-test

☐ 5. HPV self-test ☐ 6. Don't remember

6.If yes, where did you receive cervical cancer screening?

☐ 1. Myanmar ☐ 2. Thailand ☐ 3. Both

7. What healthcare facility did you visit to get screening?

☐ 1. Public hospital ☐ 2. Private hospital

☐ 3. Community clinic ☐ 4. Other (please specify) .....

8. If yes, why do you take cervical cancer screening? (can choose more than one)

☐ 1. Interest in own health

☐ 2. I have knowledge of cervical cancer and its prevention

☐ 3. Recommended by healthcare professional

☐ 4. My family or friend encourages me

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
27 AUG 2025
APPROVED

Version 1 Date 4/6/2025

☐ 5. I am afraid of cervical cancer and want to prevent

☐ 6. I have symptoms

☐ 7. Screening is affordable

☐ 8. Other (please specify) .....

9. If no, why don't you take cervical cancer screening? (can choose more than one)

☐ 1. I don't know much information about cervical cancer and screening

☐ 2. I do not have any symptoms

☐ 3. I don't think I am at risk of getting cervical cancer

☐ 4. No one suggested me to do screening

☐ 5. No time to do the test

☐ 6. Not affordable

☐ 7. Husband doesn't allow

☐ 8. Being worried about test result

☐ 9. Embarrassing

☐ 10. Painful

☐ 11. Other (please specify) .....

10. Do you have intention to take cervical cancer screening in the future?

☐ 1. Yes ☐ 2. No ☐ 3. Not sure

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
27 AUG 2025
APPROVED

APPENDIX F

QUESTIONNAIRE (MYANMAR VERSION)

Version 1 Date 4/6/2025

မေးခွန်းလွှာ

ခရိုင် .....

ခရိုင်ခွဲ .....

သုတေသနကုဒ်.....

အင်တာဗျူးသူ.....

ရက်စွဲ.....

ဤမေးခွန်းလွှာတွင် အောက်ပါအပိုင်း (၇)ပိုင်း ပါဝင်ပါသည်။

အပိုင်း ၁။ ယေဘူယျ လက္ခဏာရပ် နှင့် ကျန်းမာရေးဆိုင်ရာ မေးခွန်းများ

အပိုင်း ၂ ။ သတင်းအရင်းအမြစ်ဆိုင်ရာ မေးခွန်းများ

အပိုင်း ၃။ သားအိမ်ခေါင်းကင်ဆာနှင့် သားအိမ်ခေါင်းကင်ဆာ စစ်ဆေးခြင်းဆိုင်ရာ အသိပညာဆိုင်ရာ မေးခွန်းများ

အပိုင်း ၄။ သားအိမ်ခေါင်းကင်ဆာနှင့် သားအိမ်ခေါင်းကင်ဆာ စစ်ဆေးခြင်းဆိုင်ရာ သဘောထား မေးခွန်းများ

အပိုင်း ၅။ လူမှုကူညီထောက်ပံ့မှု အကဲဖြတ်ခြင်း မေးခွန်းများ

အပိုင်း ၆။ ကျန်းမာရေးစောင့်ရှောက်မှု ရယူခြင်းဆိုင်ရာ မေးခွန်းများ

အပိုင်း ၇။ သားအိမ်ခေါင်းကင်ဆာ စစ်ဆေးမှုခံယူခြင်းဆိုင်ရာ မေးခွန်းများ

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
2 7 AUG 2025
APPROVED

Version 1 Date 4/6/2025

အပိုင်း ၁ ။ ယေဘူယျ လက္ခဏာရပ် နှင့် ကျန်းမာရေးဆိုင်ရာ မေးခွန်းများ

၁။ အသက် .....နှစ် (ပြည့်ပြီးအသက်)

၂။ အိမ်ထောင်ရေးအခြေအနေ

☐ ၁။ လူလွတ် ☐ ၂။အိမ်ထောင်သည် ☐ ၃။ သီးခြားစီ

☐ ၄။ ကွာရှင်းပြတ်စဲခြင်း ☐ ၅။ မုဆိုးမ

၃။ အသက်မည်မျှတွင် အိမ်ထောင်ကျခဲ့သနည်း?

.....နှစ်

၄။ ကလေးရှိပါသလား။

☐ ၁။ ရှိသည် ☐ ၂။ မရှိပါ (မေးခွန်း ၆ သို့)

၅။ ကလေးမည်မျှရှိသနည်း။

..... ယောက်

၆။ ကိုးကွယ်သည့်ဘာသာ

☐ ၁။ ဗုဒ္ဓဘာသာ ☐ ၂။ ခရစ်ယာန် ☐ ၃။ အစ္စလာမ်ဘာသာ

☐ ၄။ အခြား .....

၇။ လူမျိုးစု

☐ ၁။ ဗမာ ☐ ၂။ ရှမ်း ☐ ၃။ ကရင် ☐ ၄။ မွန်

☐ ၅။ အခြား .....

၈။ အမြင့်ဆုံးပညာရေးအဆင့်

☐ ၁။ စာမတတ်သူ ☐ ၂။ မူလတန်းအောင် ☐ ၃။ အလယ်တန်းအောင်

☐ ၄။ အထက်တန်းအောင် ☐ ၅။ ဘွဲ့ကြို ☐ ၆။ ဘွဲ့ရ

၉။ ထိုင်းနိုင်ငံတွင် နေထိုင်မှုကြာချိန် မည်မျှရှိသနည်း။

..... လ/နှစ်

၁၀။ သင်၏ တရားဝင် နေထိုင်မှုအခြေအနေ။

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
27 AUG 2025
APPROVED

Version 1 Date 4/6/2025

☐၁။ အထောက်အထားရှိသည်။ ☐၂။ အထောက်အထားမရှိပါ။ (မေးခွန်း ၁၂ သို့)

၁၁။ မည်သည့်အထောက်အထားဖြင့် နေထိုင်သနည်း။

☐၁။ ပန်းရောင်ကဒ် ☐၂။ အထောက်အထားလက်မှတ်

☐၃။ ဝေါ်ပါမစ် ☐ ၄။ အခြား (ဖော်ပြရန်).....

၁၂။ ထိုင်းဘာသာစကား တက်ကျွမ်းမှု မည်မျှရှိသနည်း။

စာဖတ်ခြင်း

☐၁။ မတတ်ပါ ☐၂။ အခြေခံ ☐၃။ ကျွမ်းကျင်အဆင့်

စကားပြောခြင်း

☐၁။ မတတ်ပါ ☐၂။ အခြေခံ ☐၃။ ကျွမ်းကျင်အဆင့်

အရေးအသား

☐၁။ မတတ်ပါ ☐၂။ အခြေခံ ☐၃။ ကျွမ်းကျင်အဆင့်

နားထောင်ခြင်း

☐၁။ မတတ်ပါ ☐၂။ အခြေခံ ☐၃။ ကျွမ်းကျင်အဆင့်

၁၃။ သင်သည် မည်သည့်အလုပ်အကိုင်ကို လုပ်ကိုင်သနည်း။

☐၁။ အလုပ်လက်မဲ့ ☐၂။ စိုက်ပျိုးရေးလုပ်ငန်း

☐၃။ဆောက်လုပ်ရေးလုပ်ငန်း ☐၄။ ဝန်ဆောင်မှုလုပ်ငန်း

☐၅။ စက်ရုံလုပ်ငန်း ☐၆။ ဘာသာပြန် ☐၇။ အခြား (ဖော်ပြရန်).....

၁၄။ တစ်လလျှင် မိသားစုဝင်ငွေပျမ်းမျှ မည်မျှရှိသနည်း။

..... ဘတ်

၁၅။ သင့်တွင် ကျန်းမာရေးအာမခံရှိပါသလား။

☐၁။ ပိုက်ဆံဖြင့်ရှင်းသည် ☐၂။ လူမှုဖူလုံရေးအစီအစဉ်

☐၃။ ရွှေ့ပြောင်းကျန်းမာရေးအာမခံအစီအစဉ် ☐၄။ M-fund

☐၅။ ပုဂ္ဂလိကကျန်းမာရေးအာမခံ ☐၆။အခြား (ဖော်ပြရန်).....

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ETHICS COMMITTEE ON HUMAN RESEARCH
2 7 AUG 2025
APPROVED

၁၆။ မည်သည့် သားဆက်ခြားနည်းကို အသုံးပြုသနည်း။ (တစ်ခုထက်ပို၍ ရွေးချယ်နိုင်ပါသည်။)

☐ ၁။ သောက်ဆေး ☐ ၂။ ထိုးဆေး ☐ ၃။ လက်မောင်းထည့်ခြင်း

☐ ၄။ သားကြောဖြတ်ခြင်း ☐ ၅။ ကွန်ဒုံးသုံးခြင်း ☐ ၆။ ရက်တွက်ခြင်း

☐ ၇။ မည်သည့်သားဆက်ခြင်းနည်းမျှမသုံးပါ

၁၇။ သွေးသားရင်းချာတွင် သားအိမ်ခေါင်းကင်ဆာဖြစ်ပွားဖူးခြင်း ရှိပါသလား။

☐ ၁။ ရှိပါသည် ☐ ၂။ မရှိပါ ☐ ၃။ သေချာမသိပါ

၁၈။ သားအိမ်ခေါင်းကင်ဆာ ကာကွယ်ဆေး ထိုးဖူးပါသလား။

☐ ၁။ ထိုးဖူးပါသည် ☐ ၂။ မထိုးဖူးပါ

၁၉။ သားအိမ်ခေါင်းကင်ဆာစစ်ဆေးခြင်းပြုလုပ်နိုင်သည့် အနီးစပ်ဆုံးကျန်းမာရေးဌာနမှာ မည်သည်နည်း။

☐ ၁။ အစိုးရဆေးရုံ ☐ ၂။ ပုဂ္ဂလိကဆေးရုံ ☐ ၃။ ရပ်ရွာဆေးပေးခန်း

☐ ၄။ အခြား (ဖော်ပြရန်) ..... ☐ ၆။ မသိပါ

၂၀။ သင်၏အိမ်မှ သားအိမ်ခေါင်းကင်ဆာစစ်ဆေးနိုင်သည့် အနီးစပ်ဆုံး ကျန်းမာရေးဌာနနှင့် ပျမ်းမျှအားဖြင့် မည်မျှကြာကြာသွားရသနည်း။

.....မိနစ်/နာရီ

၂၁။ သားအိမ်ခေါင်းကင်ဆာစစ်ဆေးရန် ကျန်းမာရေးဌာနသို့သွားရန် သင့်အတွက် အဆင်ပြေမှုရှိပါသလား။

☐ ၁။ ရှိပါသည် ☐ ၂။ မရှိပါ

အပိုင်း ၂။ သတင်းအရင်းအမြစ်ဆိုင်ရာ မေးခွန်းများ

၁။ သားအိမ်ခေါင်းကင်ဆာနှင့် စစ်ဆေးခြင်းဆိုင်ရာ အချက်အလက်များကို မည်သူ့ထံမှ ရရှိသနည်း။ (တစ်ခုထက်ပို၍ ရွေးချယ်နိုင်ပါသည်။)

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27 AUG 2025
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☐ ၁။ ခင်ပွန်း
☐ ၂။ မိသားစု
☐ ၃။ သူငယ်ချင်း
☐ ၄။ အိမ်နီးနားချင်း
☐ ၅။ ဆရာဝန်
☐ ၆။ သူနာပြု
☐ ၇။ ကျန်းမာရေးစောင့်ရှောက်မှု စေတနာ့ဝန်ထမ်း
☐ ၈။ NGO, INGO များ
☐ ၉။ အခြား (ဖော်ပြရန်).....

၂။ သားအိမ်ခေါင်းကင်ဆာနှင့် စစ်ဆေးခြင်းဆိုင်ရာ အချက်အလက်များကို မည်သည့်မှ ရရှိသနည်း။ (တစ်ခုထပ်ပို၍ ရွေးချယ်နိုင်သည်။)

☐ ၁။ ဆိုရှယ်မီဒီယာ (တစ်တော့၊ ဖေ့ဘုတ် စသည်)
☐ ၂။ TV
☐ ၃။ ပို့စတာ
☐ ၄။ လက်ကမ်းစာစောင်
☐ ၅။ သတင်းစာ
☐ ၆။ မဂ္ဂဇင်း
☐ ၇။ အခြား (ဖော်ပြရန်) .....

အပိုင်း ၃။ သားအိမ်ခေါင်းကင်ဆာနှင့် သားအိမ်ခေါင်းကင်ဆာ စစ်ဆေးခြင်းဆိုင်ရာ အသိပညာဆိုင်ရာ မေးခွန်းများ

အောက်ပါမေးခွန်းများသည် သားအိမ်ခေါင်းကင်ဆာနှင့် သင်အိမ်ခေါင်းကင်ဆာ စစ်ဆေးခြင်းနှင့် ပတ်သက်၍ သင်၏ အသိပညာကို စမ်းစစ်သော မေးခွန်းဖြစ်သည်။

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
2 7 AUG 2025
APPROVED

Version 1 Date 4/6/2025

တစ်ခုချင်းစီကို သေချာစွာဖတ်၍ သင့်ထင်မြင်ချက်ကို (✓) ခြစ်ပြီး ရွေးချယ်ပါ။

		ဟုတ်ပါသည်	မဟုတ်ပါ	မသေချာပါ
၁။	သားအိမ်ခေါင်းကင်ဆာသည် လိင်ဆက်ဆံမှု အမျိုးမျိုးမှ ကူးစက်သည့် ရောဂါပိုးကြောင့်ဖြစ်သည်။			
၂။	HIV ပိုးရှိသော အမျိုးသမီးများသည် သားအိမ်ခေါင်းကင်ဆာ ဖြစ်နိုင်ခြေ ပိုများသည်။			
၃။	သားအိမ်ခေါင်းကင်ဆာသည် အစောပိုင်း အဆင့်တွင် ရောဂါလက္ခဏာ မပြတတ်ပါ။			
၄။	အနံ့ဆိုးထွက်ခြင်းသည် သားအိမ်ခေါင်း ကင်ဆာ၏ ရောဂါလက္ခဏာဖြစ်သည်။			
၅။	ရာသီလာချိန်၊ လိင်ဆက်ဆံပြီးနောက်နှင့် သွေးဆုံးပြီးနောက် ပုံမှန်မဟုတ်သော မိန်းမ ကိုယ်မှ သွေးဆင်းခြင်းသည် သားအိမ်ခေါင်း ကင်ဆာ၏ ရောဂါလက္ခဏာဖြစ်သည်။			
၆။	သားအိမ်ခေါင်းအခွဲရည် ပုံမှန်စစ်ဆေးခြင်းဖြင့် သားအိမ်ခေါင်းကင်ဆာကို စောစီးစွာ သိရှိနိုင်သည်။			
၇။	သားအိမ်ခေါင်းကင်ဆာ ကာကွယ်ဆေးထိုးထားသည့် အမျိုးသမီးများသည်လည်း			

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
2 7 AUG 2025
APPROVED

	သားအိမ်ခေါင်းအခွဲရည် စစ်ဆေးမှုကို ဆက်လက်ခံယူသင့်ပါသည်။			

အပိုင်း ၄။ သားအိမ်ခေါင်းကင်ဆာနှင့် သားအိမ်ခေါင်းကင်ဆာ စစ်ဆေးခြင်းဆိုင်ရာ သဘောထား မေးခွန်းများ

အောက်ပါမေးခွန်းများသည် သားအိမ်ခေါင်းကင်ဆာနှင့် သားအိမ်ခေါင်းကဆာ စစ်ဆေးခြင်းဆိုင်ရာ သင်၏သဘောထားကို စစ်မေးသော မေးခွန်းများဖြစ်သည်။ တစ်ခုချင်းစီကို သေချာစွာဖတ်၍ သင်၏ထင်မြင်ချက်ကို (✓) ခြစ်ပြီး ရွေးချယ်ပါ။

		လုံးဝ မထောက်ခံပါ (၁)	မထောက်ခံပါ (၂)	အသင့် အတင့် (၃)	ထောက်ခံပါသည် (၄)	လုံးဝ ထောက်ခံပါသည် (၅)
၁။	ကျွန်ုပ်အပါအဝင် လိင်ပိုင်းဆိုင်ရာ တက်ကြွသည့် အမျိုးသမီးတိုင်းသည် သားအိမ်ခေါင်းကင်ဆာ ဖြစ်နိုင်ခြေ ရှိသည်။					

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
27 AUG 2025
APPROVED

Version 1 Date 4/6/2025

၂။	သားအိမ်ခေါင်းကင်ဆာကို စောစီးစွာစစ်ဆေးတွေ့ရှိပါက ပျောက်ကင်းနိုင်ပါသည်။					
၃။	သားအိမ်ခေါင်းကင်ဆာစစ်ဆေးရန် ရှက်မိသည်။					
၄။	သားအိမ်ခေါင်းကင်ဆာစစ်ဆေးနေစဉ်အတွင်း သက်သောင့်သက်သာရှိမည်မဟုတ်ပါ။					
၅။	ရောဂါလက္ခဏာများမရှိလျှင်တောင် သားအိမ်ခေါင်းကင်ဆာစစ်ဆေးသင့်ပါသည်။					
၆။	သားအိမ်ခေါင်းကင်ဆာစစ်ဆေးခြင်းသည် အခမဲ့ဖြစ်ပါက, စစ်ဆေးပါမည်။					

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
27 AUG 2025
APPROVED

၇။	ဆရာဝန် (သို့) ကျန်းမာရေးဝန်ထမ်းတစ်ဦးမှ အကြံပေးပါက စစ်ဆေးမှုလုပ်ရန် စိတ်အားထက်သန်ပါမည်။					

အပိုင်း ၅။ လူမှုရေးထောက်ပံ့မှုအပေါ် ရှုထောင့်ပေါင်းစုံမှ လက်ခံထားသောအမြင်ဆန်းစစ်မေးခွန်းလွှာ

အောက်ပါတို့မှ သင်ခံစားမိသည်ကို ရွေးချယ်ပါ။

၁။ အလွန်အလွန်သဘောမတူပါ။

၂။ လုံးဝသဘောမတူပါ။

၃။ အတန်အသင့် သဘောမတူပါ။

၄။ မည်သည့်ဘက်မှ မပါပါက။

၅။အတန်အသင့် သဘောတူသည်။

၆။ လုံးဝသဘောတူသည်။

၇။ အလွန်အလွန်သဘောတူသည်။

		(၁)	(၂)	(၃)	(၄)	(၅)	(၆)	(၇)
၁။	ကျွန်ုပ်လိုသည့်အခါတွင် ကူညီမည့်သူအနီးတွင် ရှိသည်။							

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
27 AUG 2025
APPROVED

၂။	ကျွန်ုပ်၏ပျော်ရွှင်ခြင်းနှင့် ဝမ်းနည်းခြင်းများကို မျှဝေခံစားနိုင်သော ရင်းနှီးသောတစ်ဦးရှိသည်။							
၃။	ကျွန်ုပ်၏ မိသားစုသည် ကျွန်ုပ်ကို ကူညီဖို့ တကယ်ကြိုးစားသည်။							
၄။	ကျွန်ုပ်သည် မိသားစုထံမှ လိုအပ်သော စိတ်ပိုင်းဆိုင်ရာ အကူအညီနှင့် ထောက်ပံ့မှုတို့ကိုရသည်။							
၅။	ကျွန်ုပ်တွင် အမှန်တကယ် နှစ်သိမ့်ပေးနိုင်သော ကူညီမည့်သူတစ်ဦးရှိသည်။							
၆။	ကျွန်ုပ်သူငယ်ချင်းများသည် ကျွန်ုပ်ကို ကူညီဖို့ တကယ်ကြိုးစားသည်။							
၇။	အဆင်မပြေသည့်အချိန်တွင် သူငယ်ချင်းများက အားထားရသည်။							
၈။	ကျွန်ုပ်သည် မိသားစုများအား ကျွန်ုပ်ပြဿနာများဖြောဆိုနိုင်သည်။							
၉။	ကျွန်ုပ်၏ ပျော်ရွှင်ခြင်းနှင့် ဝမ်းနည်းခြင်းများကို မျှဝေခံစားနိုင်သော သူငယ်ချင်းများရှိသည်။							
၁၀။	ကျွန်ုပ်၏ ခံစားချက်များကို ဂရုစိုက်ပေးသော ရင်းနှီးသူတစ်ဦး ကျွန်ုပ်ဘဝတွင် ရှိသည်။							

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
2 7 AUG 2025
APPROVED

၁၁။	ကျွန်ုပ်၏ မိသားစုသည် ကျွန်ုပ်ဆုံးဖြတ်ချက်များချမှတ်နိုင်အောင် ကူညီပေးဖို့ ဆန္ဒရှိကြသည်။							
၁၂။	မိတ်ဆွေ/ သူငယ်ချင်းများကို ကျွန်ုပ်၏ ပြဿနာအကြောင်းများကို ပြောဆိုနိုင်သည်။							

အပိုင်း ၆ ။ ကျန်းမာရေးစောင့်ရှောက်မှု ရယူခြင်းဆိုင်ရာ မေးခွန်းများ

အောက်ပါမေးခွန်းများသည် သင်၏ကျန်းမာရေးစောင့်ရှောက်မှု ရယူခြင်းနှင့် ပတ်သက်သည့် မေးခွန်းများဖြစ်သည်။ တခုချင်းစီကို သေချာဖတ်၍ သင်၏ထင်မြင်ချက်ကို ကို (✓) ခြစ်ပြီး ရွေးချယ်ပါ။

			လုံးဝ မဟုတ်ပါ (၁)	မဟုတ်ပါ (၂)	အသင့် အတင့် (၃)	ဟုတ်ပါသည် (၄)	လုံးဝဟုတ်ပါသည် (၅)
အသုံးပြုနိုင်မှု	၁	ကျွန်ုပ်လိုအပ်သော ကျန်းမာရေး ဝန်ဆောင်မှုများအား ကျန်းမာရေးဌာနတွင် ရရှိနိုင်ပါသည်။					

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
27 AUG 2025
APPROVED

	၂	ကျန်းမာရေးဌာနနှင့် ကျွန်ုပ်အိမ်အကြား အကွာအဝေးသည် သင့်တော်သည်။					
	၃	ကျန်းမာရေးဌာနသို့ သွားရန် ကြာမြင့်ချိန်မှာ သင့်တော်သည်။					
	၄	ကျန်းမာရေးဌာနသို့ သွားလာရန် လွယ်ကူပါသည်။					
ရရှိနိုင်မှု	၅	ကျွန်ုပ်လိုအပ်သော ကျန်းမာရေးစောင့်ရှောက်မှုများ (ကာကွယ်ဆေးထိုးခြင်း၊ ဆေးကုသခြင်း၊ သားဆက်ခြားခြင်း၊ မီခင်နှင့် ကလေးစောင့်ရှောက်ခြင်း၊ ဆေးထိုးခြင်း) ကို ပြည်သူ့ကျန်းမာရေးဌာနများတွင် ဆောင်ရွက်ပေးပါသည်။					

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
2 7 AUG 2025
APPROVED

	၆	ကျန်းမာရေးဌာနအတွင်းရှိ အဆောက်အဦများသည် လူထု၏ ကျန်းမာရေးလိုအပ်ချက်များနှင့် ကိုက်ညီပါသည်။					
	၇	ကျန်းမာရေးဝန်ထမ်းများသည် သုံးစွဲသူဦးရေနှင့် လိုအပ်ချက်အရ ကိုက်ညီမှုရှိသည်။					
လက်ခံနိုင်မှု	၈	ကျန်းမာရေးဌာနတွင် ပေးသော ဝန်ဆောင်မှုများသည် အရည်အသွေးပြည့်မှီသည်။					
	၉	ကျန်းမာရေးဌာနရှိ ဝန်ထမ်းများသည် လူနာများကို လူမှုအသိုင်းအဝိုင်းအရင်းအမြစ်များကို မိတ်ဆက်ပေးခြင်းကဲ့သို့သော နည်းလမ်းမျိုးစုံဖြင့်					

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
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		လိုအပ်ချက်များကို ဖြည့်ဆည်းပေးပါသည်။					
	၁၀	ကျန်းမာရေးဝန်ထမ်းများသည် ကျွန်ုပ်ပြောစကားများကို အာရုံစိုက်၍ နားထောင်ပေးသည်။					
	၁၁	ကျန်းမာရေးဝန်ထမ်းများသည် ကျွန်ုပ်ကို အချိန်အလုံအလောက် ပေးသည်။					
	၁၂	ကျွန်ုပ်၏ကျန်းမာရေး၊ ရောဂါနှင့်ပတ်သက်၍ ကျန်းမာရေးဝန်ထမ်း (ဆရာဝန်၊ သားဖွားမီးယပ်၊ သူနာပြု) များ၏ ထုတ်ပြန်ချက်များကို ယုံကြည်ပါသည်။					
	၁၃	ကျွန်ုပ်၏ အမျိုးသမီးကျန်းမာရေးဝ					

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
27 AUG 2025
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		နှစ်ထမ်း တောင်းဆိုမှုကို အလေးထားသည်။					
	၁၄	ကျွန်ုပ်သည် ကျန်းမာရေးဌာနတွင် သားအိမ်ခေါင်းကင်ဆာနှင့် အူမကြီးကင်ဆာကဲ့သို့ စစ်ဆေးခြင်းများကို ဆောင်ရွက်နိုင်သည်။					
	၁၅	ကျန်းမာရေးအဖွဲ့သည် ကျွန်ုပ်ကို လေးစားမှုရှိသည်။					
	၁၆	ကျန်းမာရေးဝန်ထမ်းများ (ဆရာဝန်၊ သူနာပြု၊ သားဖွားဆရာမများ)သည် လူနာ၏ ဓလေ့ထုံးတမ်းများနှင့် အကျွမ်းတဝင်ရှိပြီး လိုက်လျောညီထွေစွာ ဆက်သွယ် ဆောင်ရွက်ပေးသည်။					
တတ်နိုင်မှု	၁၇	ကျွန်ုပ်၏ ကျန်းမာရေးပြဿနာများ အတွက် ပထမဦးဆုံး					

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
27 AUG 2025
APPROVED

		အထွေထွေဆရာဝန်နှင့် သွားရောက်တိုင်ပင်ပါသည်။					
	၁၈	အထွေထွေဆရာဝန်၏ ညွှန်ကြားမှုအတိုင်း အထူးကု ဝန်ဆောင်မှုများကို အသုံးပြုသည်။					
	၁၉	ကျွန်ုပ်၏ ကျန်းမာရေးကုသမှုအတွက် စရိတ်များမှာ သင့်တင့်ပြီး တတ်နိုင်ပါသည်။					
ဝန်ဆောင်မှုဖြည့်ဆည်းပေးနိုင်မှု	၂၀	ကျန်းမာရေးဌာနတွင် ရက်ချိန်းယူရန် လွယ်ကူသည်။					
	၂၁	လိုအပ်သော ကျန်းမာရေးဝန်ဆောင်မှု ရရှိရန် ကြာမြင့်ချိန်မှာ သင့်တင့်ပါသည်။					
	၂၂	ကျန်းမာရေးပြဿနာများနှင့် ပတ်သက်၍					

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
27 AUG 2025
APPROVED

		ကျန်းမာရေးဝန်ထမ်းများ (ဆရာဝန်၊သူနာပြု၊သား ဖွားဆရာမများ) နှင့် ဖုန်းဖြင့် (လူကိုယ်တိုင်) ဆွေးနွေးနိုင်ပါသည်။					
	၂ ၃	ပြည်သူ့ကျန်းမာရေးဌာန များ၏ အလုပ်ချိန်သည် ကျန်းမာရေးဝန်ဆောင်မှု များရယူရန် သင့်လျော်ပါသည်။					
	၂ ၄	ကျန်းမာရေးဌာနများသ ည် ဝန်ဆောင်မှုရယူရန် နေရာကျယ်ဝန်းမှုရှိသည် ။					
	၂ ၅	ကျန်းမာရေးဌာနတွင် ဘီးတပ်ကုလားထိုင် ကဲ့သို့သော အထောက်အကူပစ္စည်း များကို အသုံးပြုခွင့် ပေးထားသည်။					
အသိပညာရှိမှု	၂ ၆	ကျွန်ုပ်အားပေးသော ကျန်းမာရေးအသိပညာ					

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
2 7 AUG 2025
APPROVED

		များကို နားလည်နိုင်ပါသည်။					
	၂ ၇	ကျွန်ုပ်လိုအပ်သော သတင်းအချက်အလက် များကို အထူးပြုစကားလုံးများ မပါဝဲ ရိုးရှင်းသောဘာသာစ ကားဖြင့် ဖော်ပြပေးသည်။					
	၂ ၈	ကျန်းမာရေးဝန်ထမ်းများ (ဆရာဝန်၊ သူနာပြု၊ သားဖွားစသည်) တို့၏ ဆက်သွယ်မှုနည်းလမ်း များမှာ လူနာများအတွက် သင့်တော်မှုရှိသည်။					
	၂ ၉	ကျန်းမာရေး ဝန်ထမ်းများသည် ကျန်းမာရေး သတင်းအချက်အလက် များကို ကျွန်ုပ်သေချာနားလည် အောင် ရှင်းပြပေးသည်။					

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
27 AUG 2025
APPROVED

	၃ ၀	ကျွန်ုပ်၏ လူမှုဘဝအခြေအနေများ (အိမ်ထောင်ရှိ/မရှိ၊ ငွေပေးဆောင်နိုင်ခြင်းရှိ/ မရှိ၊ ဓလေ့ထုံးတမ်းကွာခြားမှု) များကို ထည့်သွင်းစဉ်းစားပေးသ ည်။					

အပိုင်း ၇။ သားအိမ်ခေါင်းကင်ဆာ စစ်ဆေးမှုခံယူခြင်းဆိုင်ရာ မေးခွန်းများ

၁။ သင်သည် သားအိမ်ခေါင်းကင်ဆာ စစ်ဆေးခြင်းကို ပြုလုပ်ဖူးပါသလား။

☐ ၁။ လုပ်ဖူးပါသည် ☐ ၂။ မလုပ်ဖူးပါ (မေးခွန်း ၄ သို့)

☐ ၃။ မမှတ်မိပါ (မေးခွန်း၄သို့)

၂။ လုပ်ဖူးပါက, အကြိမ်မည်မျှ လုပ်ဖူးသနည်း။

☐ ၁။.....ကြိမ်

☐ ၂။ မမှတ်မိပါ

၃။ နောက်ဆုံးအကြိမ်ကို မည်သည့်အချိန်က လုပ်ခဲ့သနည်း။

☐ ၁။ .....လ/နှစ်

☐ ၂။ မမှတ်မိပါ

၄။ လွန်ခဲ့သည့် (၃) နှစ်အတွင်း သားအိမ်ခေါင်းကင်ဆာ စစ်ဆေးခြင်းကို ခံယူဖူးပါသလား။

☐ ၁။ ခံယူဖူးပါသည်

☐ ၂။ မခံယူဖူးပါ (မေးခွန် ၆ သို့)

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
27 AUG 2025
APPROVED

၅။ မည်သည့်သားအိမ်ခေါင်း စစ်ဆေးခြင်းအမျိုးအစားကို အသုံးပြုခဲ့ပါသနည်း?

☐ ၁။ Pap smear

☐ ၂။ VIA test

☐ ၃။ HPV DNA test

☐ ၄။ Co-test

☐ ၅။ HPV ကိုယ်တိုင်စစ်ဆေးခြင်း

☐ ၆။ မမှတ်မိပါ။

၆။ အကယ်၍ လုပ်ခဲ့ပါက, မည်သည့် နေရာတွင် လုပ်ခဲ့သနည်း?

☐ ၁။ မြန်မာ ☐ ၂။ ထိုင်း ☐ ၃။ နှစ်နေရာစလုံး

၇။ သားအိမ်ခေါင်းကင်ဆာ စစ်ဆေးမှုခံယူရန် မည်သည့်ကျန်းမာရေးဌာနသို့ သွားရောက်ခဲ့သနည်း။

☐ ၁။ ပြည်သူ့ဆေးရုံ ☐ ၂။ ပုဂ္ဂလိကဆေးရုံ

☐ ၃။ ရပ်ရွာဆေးပေးခန်း ☐ ၄။ အခြား (ဖော်ပြရန်).....

၈။ သားအိမ်ခေါင်းကင်ဆာ စစ်ဆေးခဲ့ပါက, အဘယ်ကြောင့် စစ်ဆေးခဲ့သနည်း? (တစ်ခုထပ်ပို၍ ရွေးချယ်နိုင်ပါသည်)

☐ ၁။ ကျွန်ုပ်သည် ကျွန်ုပ်၏ကျန်းမာရေးကို စိတ်ဝင်စားပါသည်။

☐ ၂။ ကျွန်ုပ်သည် သားအိမ်ခေါင်းကင်ဆာနှင့် ကာကွယ်ရေးဆိုင်ရာ ဗဟုသုတ ရှိသည်။

☐ ၃။ ကျန်းမာရေးဝန်ထမ်းများမှ အကြံပြုသောကြောင့် ဖြစ်သည်။

☐ ၄။ ကျွန်ုပ်သည် သားအိမ်ခေါင်းကင်ဆာ ဖြစ်မည်ကို ကြောက်သောကြောင့် ကြိုတင်ကာကွယ်ခြင်းဖြစ်သည်။

☐ ၅။ ကျွန်ုပ်၏ မိသားစု (သို့) မိတ်ဆွေများမှ တိုက်တွန်းသောကြောင့် ဖြစ်သည်။

☐ ၆။ ရောဂါလက္ခဏာ ခံစားရသောကြောင့်ဖြစ်သည်။

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
27 AUG 2025
APPROVED

Version 1 Date 4/6/2025

☐ ၇။ သားအိမ်ခေါင်းကင်ဆာ စစ်ဆေးခြင်းသည် ဈေးနှုန်းသင့်တင့်ပါသည်။

☐ ၈။ အခြား (ဖော်ပြရန်).....

၉။ သားအိမ်ခေါင်ကင်ဆာ စစ်ဆေးမှု မပြုခဲ့ဖူးပါက, အဘယ်ကြောင့်နည်း။ (တစ်ခုထပ်ပို၍ ရွေးချယ်နိုင်သည်။)

☐ ၁။ ကျွန်ုပ်သည် သားအိမ်ခေါင်းကင်ဆာနှင့် စစ်ဆေးမှုအကြောင်း များများမသိပါ။

☐ ၂။ ကျွန်ုပ်တွင် ရောဂါလက္ခဏာမရှိပါ။

☐ ၃။ ကျွန်ုပ်သည် သားအိမ်ခေါင်းကင်ဆာ ဖြစ်နိုင်ချေရှိသည်ဟု မထင်ပါ။

☐ ၄။ မည်သူမျှ သားအိမ်ခေါင်းကင်ဆာ စစ်ဆေးရန် အကြံမပြုပါ။

☐ ၅။ သားအိမ်ခေါင်းကင်ဆာစစ်ဆေးရန် အချိန်မရှိပါ။

☐ ၆။ သားအိမ်ခေါင်းကင်ဆာ စစ်ဆေးရန် မတတ်နိုင်ပါ။

☐ ၇။ ခင်ပွန်းမှ သားအိမ်ခေါင်းကင်ဆာ စစ်ဆေးရန် ခွင့်မပြုပါ။

☐ ၈။ စစ်ဆေးမှုရလဒ်ကို စိုးရိမ်ပါသည်။

☐ ၉။ သားအိမ်ခေါင်းကင်ဆာ စစ်ဆေးမှုခံယူရန် ရှက်ရွံ့မိသည်။

☐ ၁၀။ သားအိမ်ခေါင်းကင်ဆာ စစ်ဆေးလျှင် နာကျင်တတ်ပါသည်။

☐ ၁၁။ အခြား (ဖော်ပြရန်).....

၁၀။ အနာဂတ်တွင် သားအိမ်ခေါင်းကင်ဆာ စစ်ဆေးခြင်း ခံယူရန် စိတ်ကူးရှိပါသလား။

☐ ၁။ ရှိသည် ☐ ၂။ မရှိပါ ☐ ၃။ မသေချာသေးပါ

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
27 AUG 2025
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